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Age and racial differences in the presentation and treatment of Generalized Anxiety Disorder in primary care

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Abstract

Despite the prevalence and impact of Generalized Anxiety Disorder (GAD) in the primary care setting, little is known about its presentation in this setting. The purpose of this study is to examine age and racial differences in the presentation and treatment of GAD in medical patients. Participants were recruited from one family medicine clinic and one internal medicine clinic. The prevalence of GAD was lowest for older adults. Age differences were found in the presentation of GAD, with young adults reporting greater cognitive symptoms of anxiety, negative affect, and depressive symptoms. African-Americans with GAD reported more positive affect and lower rates of treatment. The lower levels of negative affect and depressive symptoms reported among older adults may affect the recognition of GAD by primary care physicians. Further research is needed to better understand the causes of racial differences in treatment.

Keywords

age differences; anxiety; elderly; Generalized Anxiety Disorder; racial differences

Generalized Anxiety Disorder (GAD) is characterized by excessive and uncontrollable worry lasting for at least 6 months and at least 3 of the following symptoms: feeling restless, keyed up, or on edge; fatigue; impaired concentration; irritability; muscle tension; and sleep

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disturbance (APA, 2000). Results of the National Comorbidity Survey-Replication (NCS-R) indicate lifetime prevalence for GAD of 5.7% (Kessler et al., 2005). GAD is associated with both emotional and physical symptoms and impairments in quality of life; these impairments are comparable to those experienced by persons with major depression and physical conditions, and greater than those associated with substance abuse. It is also associated with significant economic burden, through higher use of medical services and missed work days (for a review, see Hoffman, Dukes, & Wittchen, in press).

Understanding GAD within the context of primary care settings is important. The prevalence of GAD is higher in the primary care setting than in community-based epidemiological studies, with rates as high as 14.8% (Olfson et al., 2000), and when anxiety is comorbid with a physical condition, even greater impairments in quality of life and disability result (Katon, Lin & Kroenke, 2007; Sareen et al., 2006). Anxiety is characterized by a number of somatic symptoms which may be easily mistaken for a medical problem. Also, anxious patients in a primary care setting are likely to present with a complex constellation of symptoms, as anxiety is often associated with unexplained medical symptoms (Katon, Sullivan, & Walker, 2001; Kroenke et al., 1994). All of these factors contribute to the lack of recognition and undertreatment of anxiety in the primary care setting (Kessler, Lloyd, Lewis, & Gray, 1999; Lowe et al., 2003; Young, Klap, Sherbourne, & Wells, 2001).

Both age and race are important factors to consider when addressing anxiety. Anxiety confers additional burden on older adults, including incident mobility disability (Mehta et al., 2007), activities of daily living disability (Brenes et al., 2007), and even mortality (Brenes et al., 2005). Furthermore, African Americans are the largest minority group in the US yet little is known about racial differences in anxiety. African Americans are more likely to go to their primary care physician than a mental health specialist (Cooper-Patrick, Crum, Ford, 1994), emphasizing the importance of understanding racial differences in this setting. Thus, identifying age and racial differences in anxiety in the primary care setting may aid in its recognition and treatment.

Results of epidemiological studies indicate that there are age differences in the prevalence of GAD. Data from the NCS-R indicate an increase in lifetime prevalence of GAD from young (4.1%) to middle adulthood (6.8–7.7%), with a decline in prevalence over the age of 60 years (3.6%; Kessler et al., 2005). Despite these differences in prevalence and the significant impact that GAD has on multiple domains of functioning, surprisingly little is known about possible age differences in the presentation of GAD. There is evidence of age differences in the nature of anxiety in nonclinical samples (Lawton, Kleban, & Dean, 1993). Negative affect, which is hypothesized to be related to anxiety (Clark & Watson, 1991), declines with age (Charles, Reynolds, & Gatz, 2001), and some studies suggest age differences in the content and frequency of worry (Brenes, 2006; Diefenbach, Stanley, Beck, 2001; Hunt, Wisocki, & Yanko, 2003; Powers, Wisocki, & Whitbourne, 1992). There may also be age related differences in the physiological symptoms associated with GAD, such as restlessness, fatigue, and tension, with older adults experiencing decreased physiological reactivity and/or tension to anxiety (Christensen et al., 1999; Kogan, Edelstein, & McKee, 2000). Physiological or somatic symptoms of anxiety may be less prominent in older adults (Depp, Woodruff-Borden, Meeks, Gretasdottir, & DeKryger, 2005). However, given the prominence of somatic symptoms in the primary care setting, it is not known if this finding is also true for older adults with GAD presenting in the primary care setting.

Less is known about age differences with respect to treatment for anxiety. Effect sizes for cognitive-behavioral treatment of GAD are lower for older adults (Ayers, Sorrell, Thorp, & Wetherell, 2007), and use of benzodiazepines is disproportionately higher (Klap, Unroe, & Unutzer, 2003). Further, both young and old are less likely to receive appropriate treatment for

anxiety than are middle aged adults (Young, Klap, Sherbourne, & Wells, 2001). However, no one has examined this within the context of GAD.

Even less research has examined racial differences in GAD. Lifetime prevalence of GAD is lower in African-Americans than in whites (5.1% vs. 8.6%; Breslau et al, 2005; 3.0% vs. 4.6%; Grant et al., 2005). A similar pattern was reported for 12-month prevalence (1.9% vs. 2.2%, Grant et al., 2005). Although there is no evidence of racial differences in the frequency and intensity of worry in nonclinical samples (Gillis, Haaga, & Ford, 1995; Scott, Eng, & Heimerg, 2002), there are differences in the content of worries. African-Americans report fewer worries about relationships, lack of confidence, future, and work incompetence than Whites (Scott et al., 2002). Other evidence of racial differences are found in the context of panic attacks and panic disorder, with African-Americans reporting higher levels of phobic avoidance (Chambless & Williams, 1995), numbing and tingling, (Horwath, Johnson, & Horning, 1993; Smith, Friedman, & Nevid, 1999), fears of dying and going crazy (Smith et al., 1999), and sleep paralysis (Bell & Jenkins, 1994). Similarly, racial differences exist with respect to treatment for anxiety disorders, with African-Americans being less likely than whites to receive appropriate treatment (Young et al., 2001). Racial differences in the presentation of anxiety may contribute to underrecognition and lack of treatment.

The present study furthers our understanding of age and racial differences in anxiety symptoms and GAD in the primary care setting by using a large sample of patients with a wide age range and a large proportion of African-Americans. The purpose of this paper is to address the following questions: Are there age or racial differences in the presentation of anxiety and GAD in terms of somatic, cognitive, and affective symptoms among medical patients?; and, Are there age or racial differences in the treatment of GAD among medical patients?

Method

Participants and Procedures

The sample consisted of 1,111 patients from one university-affiliated family medicine clinic and one university-affiliated internal medicine clinic. All participants were approached by a trained research assistant after they checked in for their appointment with their physician. The only exclusion criterion was age less than 18 years. Interested participants then provided informed consent. Participants who had difficulty reading or writing were provided with assistance in completing the questionnaires. No information was collected relating to participants who declined to participate in the study. Data were collected between May 2004 and February 2007.

Measures

Patient Health Questionnaire—The Patient Health Questionnaire (PHQ; Spitzer, Kroenke, & Williams, 1999) is a self-report version of the PRIME-MD (Spitzer et al., 1994), a measure of common mental disorders based on DSM-IV symptoms. In the current study, the 7-item anxiety module and the 9-item depression module were used. For the anxiety module, participants rated the frequency of 7 anxiety symptoms on a 3-point scale that ranged from “not at all” to “more than half the days.” Participants who endorsed feeling anxious or worrying AND endorsed at least 3 of the other 6 symptoms for “more than half the days” were diagnosed with “other anxiety syndrome.” Because these symptoms correspond with the DSM-IV symptoms of GAD, this will be referred to as self-report GAD in this manuscript. For the depression module, participants rated the frequency of 9 symptoms of depression on a 4-point scale that ranges from “not at all” to “nearly everyday.” Participants who endorsed experiencing a depressed mood or anhedonia AND endorsed at least 5 of the 9 symptoms for “more than half the days” were diagnosed with “major depressive syndrome.”

Positive and Negative Affect Schedule—The Positive and Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988) is a 20-item measure of positive and negative affect. Participants rated each adjective on a scale from 0 (very slightly or not at all) to 4 (extremely). Responses to the positive and negative adjectives were summed separately, creating a positive affect and a negative affect score. The PANAS has been used in studies of younger (Chambers, Power, & Durham, 2004) and older (Beck et al., 2003) patients with GAD. The internal consistency for the positive and negative subscales in the current sample were .92 and .91, respectively.

Beck Depression Inventory—The Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) is a 21-item measure of depressive symptoms. Responses were summed and can range from 0 to 63. Higher scores indicated greater depressive symptoms. The BDI has good psychometric properties in samples of both younger and older adults with GAD (Beck, Stanley, & Zebb, 1996; Weeks & Heimberg, 2005). The internal consistency of the BDI in the current sample was .92.

Penn State Worry Questionnaire-Abbreviated—The Penn State Worry Questionnaire-Abbreviated (Hopko et al., 2003) is a measure of the frequency and intensity of worry. Participants rated each item on a 5-point scale and responses were summed, with higher scores indicating greater worry. The PSWQ-A was derived from a factor analysis of the full PSWQ (Meyer, Miller, Metzger, & Borkovec, 1990) and consists of 8 items. It has demonstrated reliability and validity in older adults with GAD. The correlation between the full PSWQ and the PSWQ-A was high ($r = .92$); similarly, the PSWQ-A and PSWQ correlated similarly with other measures of anxiety and depressive symptoms. The PSWQ-A was used in order to reduce participant burden. The internal consistency of the PSWQ-A in the current sample was .94.

Demographics and health-related information—Participants indicated their age and education in years, gender, race, and marital status. They were provided a checklist of medical conditions and indicated which conditions they had. Participants also rated their health on a 100-point scale, with higher scores representing better health.

Mental health treatment—Participants answered “yes” or “no” to the following question from the PHQ: “Are you taking any medicine for anxiety, depression, or stress?” They also indicated if they had discussed any personal problems with a psychiatrist, psychologist, or other mental health professional.

Analyses

The sample was divided into 3 groups on the basis of age: young adults (18–39 years old), middle aged adults (40–59 years old), and older adults (60 years and older). Due to their small number, minorities other than African-Americans were excluded from these analyses (9 Asians, 8 Hispanics, and 7 American Indian/Pacific Islanders). In order to determine if there were significant age and racial differences in demographic characteristics, chi-square tests of association and ANOVAs were conducted. Demographic characteristics that differed significantly by age or race were included as covariates in all analyses. Another series of analyses was conducted to examine possible age and racial differences in the nature and prevalence of anxiety symptoms and self-report GAD. First, chi-square analyses were conducted to examine age or racial differences in the prevalence of anxiety symptoms and self-report GAD. Second, age and racial differences in the nature of anxiety symptoms were analyzed with one-way ANOVAs. Third, to determine if there were age or racial differences in the presentation of symptoms associated with self-report GAD, these analyses were repeated using only participants with GAD. Finally, chi-square analyses were conducted on the self-report GAD sample to determine if there were age or racial differences in treatment. Post hoc

analyses were conducted using Fisher's protected least significant difference tests on all analyses of age.

Results

Demographic and health-related characteristics of the sample are presented in Table 1. Participants ranged in age from 18 to 94 years old. The majority of the sample was well-educated and female; over one third of the sample was African-American. There were significant differences in demographic characteristics by age and race. Younger adults were most likely to have never married ($\chi^2(8) = 299.42$, $p < .001$) and be female ($\chi^2(2) = 27.55$, $p < .001$). A greater proportion of whites were male ($\chi^2(1) = 14.69$, $p < .001$) and married ($\chi^2(4) = 86.95$, $p < .001$). Whites also had an average of one additional year of college compared with African-Americans ($F(1, 1086) = 28.12$, $p < .001$). Thus, marital status and gender were included as covariates in all analyses of age and racial differences while education was also included as a covariate in analyses of racial differences.

Age and racial differences in prevalence of self-report GAD, related symptoms, and treatment-analyses of the entire sample

Overall prevalence of self-report GAD was 12.2%, although as seen in Table 2, self-report GAD was less prevalent among older adults than among younger or middle-aged adults. Similarly, ANOVAs were conducted to determine if there were age differences in anxiety, worry, affect, and depressive symptoms. Older adults reported significantly less anxiety, worry, negative affect, and depression than both younger and middle-aged adults, and older adults reported significantly fewer somatic symptoms of anxiety and significantly greater positive affect than middle-aged adults. Furthermore, younger adults reported significantly fewer somatic symptoms of anxiety but greater worry and negative affect than middle-aged adults. Although there were no significant age differences in taking medications, the percentage of people seeing a mental health provider declined with age. One significant racial difference emerged with respect to symptoms: African-Americans reported significantly greater positive affect than whites. Furthermore, African-Americans were less likely to be taking medications and seeing a mental health provider than whites (see Table 3).

Age and racial differences in the presentation of self-report GAD-GAD subsample analyses

There were age and racial differences in the presentation of self-report GAD (see Tables 4 and 5). Younger adults reported significantly more depressive symptoms than middle-aged or older adults. Younger adults also reported significantly greater cognitive symptoms of anxiety and negative affect than older adults. Again, only one significant racial difference emerged, with African-Americans reporting greater positive affect than whites.

Age and racial differences in the treatment of self-report GAD-GAD subsample analyses

The percentage of patients taking medications (50.0% of young, 56.3% of middle-aged, and 68.2% of old) was highest among older adults while the percentage of patients seeing a mental health care provider (43.9% of young, 40.0% of middle-aged, 27.3% of old) was lowest among older adults; however, these differences were not significant ($p = .38$ and $p = .43$, respectively). Racial differences did emerge with respect to treatment. Whites were more likely to report taking medication for anxiety or depression (66.7% vs. 41.8%; $\chi^2(1) = 8.24$; $p = .004$) and were also more likely to have seen a mental health provider within the last year (50.0% vs. 24.1%; $\chi^2(1) = 9.06$; $p = .003$).

Discussion

This is the first study to examine both age and racial differences in the presentation and treatment of anxiety symptoms and self-report GAD in a broad sample of patients seen in a primary care setting. Given the increased reliance on primary care providers for the identification and treatment of mental health problems, it is important to study patients in this setting. The current study found significant age and racial differences in anxiety symptoms and in the presentation and treatment of GAD in medical patients.

As with depression (Kessler et al., 2005), we found a 50% lower prevalence of self-report GAD in older adults relative to young and middle-aged adults. One possible explanation for the decreased prevalence of anxiety with age is that those with significant anxiety may be deceased or institutionalized. Indeed, Brenes and colleagues found that anxiety symptoms are associated with incident disability and mortality (Brenes et al., 2005; Brenes et al., 2007). Another possible reason for this difference in prevalence is that older adults reported a decrease in negative affect and depressive symptoms compared with younger adults. This is consistent with findings that negative affect decreases with age (Lawton et al., 1993; Gross, Carstensen, Tsai, Skorpen, & Hsu, 1997). It is also consistent with findings of age differences in the presentation of MDD, in which older adults tend to report less dysphoria and less depressed mood (Gallo, Anthony, & Muthen, 1994; Kasl-Godley, Gatz, & Fiske, 1998). A third possible reason is that older adults were more likely to be treated for GAD, therefore lowering the prevalence. However, analyses of the entire sample indicate lower rates of treatment for older adults, suggesting that this explanation is unlikely. Another age difference was that younger adults reported more cognitive symptoms of anxiety than older adults which may reflect age-related declines in cognitive capacity.

Fewer racial differences emerged. In analyses of the entire sample and those limited to patients with self-report GAD, African-Americans reported greater positive affect than whites. This is consistent with the NCS-R findings of a lower prevalence of depressive disorders among African-Americans than whites (Breslau et al., 2005). However, very few studies have examined racial differences in the presentation of GAD. Brown and colleagues reported no significant racial differences in the number or type of symptoms reported among primary care patients with GAD (Brown, Shear, Schulberg, & Madonia, 1999). Similarly, Kraus et al. (under review) reported few racial differences among older adults with GAD. The only significant differences they found were that African-Americans reported more somatic and general symptoms of anxiety than whites.

With respect to treatment, African-Americans were less likely to report taking a medication for anxiety or depression and were less likely to report seeing a mental health provider. No research has examined racial differences in treatment preferences of patients with GAD. In general, African-Americans are less likely to receive treatment for anxiety than whites (Skaer, Sclar, Robison, & Galin, 2000) and when they do receive treatment, it is of lower quality (Wang, Berglund, & Kessler, 2000; Young et al., 2001). Our finding of a decrease in use of medications by African-Americans is consistent with other studies that have reported that African-Americans are more likely to prefer psychotherapy over medications (Cooper et al., 2003; Dwight-Johnson, Sherbourne, Liao, & Wells, 2000; Hazlett-Stevens et al., 2002). Alternatively, it is possible that African-Americans were less likely to be offered medication for anxiety than whites.

There are some limitations of this study. First, the diagnosis of GAD is based on a self-report measure rather than a clinical interview. Second, the sample is well-educated which may limit the generalizability. Relatedly, we do not have information on how many people refused to participate in the study. However, the demographic characteristics of the sample are similar to

the characteristics of the clinic population. Finally, because the number of participants with GAD was relatively small ($N = 135$), particularly among older adults ($N = 22$), the power to detect age differences may be limited.

In summary, significant age and racial differences emerged in the presentation and treatment of self-report GAD in the primary care setting. The most notable difference was that older adults reported less negative affect and depressive symptoms than younger and middle-aged adults with self-report GAD. These differences may contribute to the underrecognition and undertreatment of anxiety in the primary care setting (Kessler, Lloyd, Lewis, & Gray, 1999; Lowe et al., 2003; Young, Klap, Sherbourne, & Wells, 2001). Further, African-Americans were significantly less likely to report taking medications or seeing a mental health provider. This suggests that more efforts are needed to identify and appropriately treat African-Americans with GAD in the primary care setting.

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Table 1

Demographic and health-related characteristics

	Total sample N = 1,111	Young adults N = 293	Middle-aged adults N = 490	Older adults N = 312	Whites N = 720	Blacks N = 383
Age (years)	50.21 (16.09)	30.50 (6.14)	49.07 (5.62)	70.12 (7.57)	52.75 (17.03)	45.40 (12.85)
Education (years)	14.01 (2.98)	13.90 (2.82)	14.05 (2.96)	14.02 (3.15)	14.36 (3.09)	13.36 (2.65)
Gender-female	73.2%	80.3%	75.9%	62.5%	69.5%	80.2%
Race-white	65.3%	56.7%	58.5%	84.0%	---	---
Marital status						
Never married	16.7%	42.3%	9.8%	3.8%	11.0%	27.4%
Married	59.7%	43.0%	64.0%	69.2%	68.6%	42.8%
Divorced	13.0%	9.2%	17.4%	9.1%	10.8%	17.2%
Separated	4.5%	5.1%	6.5%	0.9%	3.0%	7.3%
Widowed	6.1%	0.3%	2.2%	17.0%	6.5%	5.2%
Medical conditions						
Asthma	11.6%	12.5%	12.7%	9.1%	12.3%	10.2%
Cancer	4.7%	0.4%	3.0%	11.1%	6.4%	1.5%
Cholesterol	22.6%	4.2%	21.8%	40.1%	25.4%	17.2%
Chronic obstructive pulmonary disease	2.7%	0.0%	2.1%	6.1%	3.0%	2.0%
Congestive heart failure	3.8%	0.0%	3.0%	8.1%	3.6%	4.1%
Coronary artery disease	3.6%	0.0%	3.2%	7.1%	4.4%	2.0%
Diabetes	14.9%	7.2%	16.9%	18.9%	12.1%	20.1%
Heart attack	4.4%	0.0%	3.0%	10.4%	4.7%	3.8%
Hypertension	33.8%	10.2%	35.8%	51.5%	29.7%	41.7%
Osteoarthritis	35.2%	13.3%	35.8%	52.9%	36.1%	33.5%
Osteoporosis	5.2%	0.8%	2.8%	12.8%	7.0%	1.7%
Rheumatoid arthritis	2.9%	2.3%	3.5%	2.7%	2.6%	1.7%
Stroke	2.8%	0.8%	2.3%	5.1%	2.7%	3.5%
Self-rated health	76.40 (20.40)	77.04 (20.76)	75.09 (21.71)	77.77 (17.77)	77.10 (20.17)	75.07 (20.80)

Table 2
Age differences in prevalence of GAD, anxiety, worry, affect, depression, and treatment

	Young N =293	Middle N =490	Old N =312	Statistic	p	η^2
GAD	14.3%	14.4%	6.9%	$\chi^2 (2) = 6.63$	.036	
BAI	9.18 _a (10.68)	10.18 _a (10.79)	6.61 _b (8.65)	F(2, 1076) = 11.01	<.001	.02
BAI-Cognitive symptoms	3.38 _a (5.15)	3.40 _a (4.47)	1.71 _b (3.02)	F(2, 1076) = 21.96	<.001	.039
BAI-Somatic symptoms	5.33 _a (6.44)	6.78 _b (7.11)	4.92 _a (6.23)	F(2, 1075) = 7.20	.001	.013
PSWQ-A	30.96 _a (7.92)	29.30 _b (8.59)	24.60 _c (8.15)	F(2, 806) = 30.76	<.001	.071
PANAS-positive affect	20.74 _{ab} (9.19)	20.50 _a (9.01)	22.21 _b (8.61)	F(2, 1075) = 3.09	.046	.006
PANAS-negative affect	9.41 _a (8.21)	7.96 _b (7.52)	5.54 _c (6.05)	F(2, 1076) = 24.73	<.001	.044
BDI	10.79 _a (10.75)	10.25 _a (9.56)	6.97 _b (6.39)	F(2, 1076) = 17.99	<.001	.032
Taking medication	23.0%	30.0%	24.8%	$\chi^2 (2) = 5.30$	.07	---
Seeing mental health provider	21.5%	19.5%	11.6%	$\chi^2 (2) = 11.89$	.003	---

Note. The PSWQ-A was omitted from the battery of measures administered to the first 270 people. Means in the same row that do not share subscripts differ at $p < .05$ in post hoc analyses. GAD = Generalized Anxiety Disorder; BAI = Beck Anxiety Inventory; PSWQ-A = Penn State Worry Questionnaire Abbreviated; PANAS = Positive and Negative Affect Scale; BDI = Beck Depression Inventory

Table 3
Racial differences in prevalence of GAD, anxiety, worry, affect, depression, and treatment

	White N = 720	Black N = 383	Statistic	p	η^2
GAD	11.2%	14.2%	$\chi^2(1) = 0.16$	.69	
BAI	8.51 (10.37)	10.37 (10.16)	$F(1, 1061) = 0.13$	.72	.00
BAI-Cognitive symptoms	2.88 (4.36)	3.33 (4.42)	$F(1, 1061) = 0.25$	.62	.00
BAI-Somatic symptoms	5.64 (6.83)	6.32 (6.62)	$F(1, 1060) = 0.05$	.83	.00
PSWQ-A	28.30 (8.65)	28.95 (8.55)	$F(1, 793) = 0.04$	.84	.00
PANAS-positive affect	20.84 (8.95)	21.41 (9.02)	$F(1, 1060) = 5.98$	.02	.006
PANAS-negative affect	7.25 (7.36)	8.40 (7.59)	$F(1, 1061) = 1.50$	.22	.001
BDI	9.02 (9.11)	10.30 (9.38)	$F(1, 1063) = 0.60$	.44	.001
Taking medication	30.9%	18.9%	$\chi^2(1) = 18.44$	<.001	---
Seeing mental health provider	20.1%	13.5%	$\chi^2(1) = 7.35$	.007	---

Note. GAD = Generalized Anxiety Disorder; BAI = Beck Anxiety Inventory; PSWQ-A = Penn State Worry Questionnaire Abbreviated; PANAS = Positive and Negative Affect Scale; BDI = Beck Depression Inventory

Table 4
Age differences in the presentation and severity of symptoms in patients with GAD

	Young N = 42	Middle N = 71	Old N = 22	Statistic	p	η^2
BAI-total	24.10 (12.76)	25.02 (13.44)	22.73 (13.55)	F (2, 128) = 0.44	.64	.007
BAI-cognitive	10.69 _a (5.78)	9.17 _{ab} (5.77)	7.24 _b (5.08)	F (2, 128) = 3.12	.048	.046
BAI-somatic	13.40 (8.48)	15.88 (9.01)	15.48 (9.44)	F (2, 128) = 0.81	.45	.013
PSWQ-A	36.73 (5.62)	35.41 (6.05)	34.25 (6.63)	F (2, 94) = 0.54	.59	.011
PANAS-positive affect	11.68 (8.19)	15.09(8.67)	15.81 (6.37)	F (2, 128) = 2.18	.12	.033
PANAS-negative affect	19.55 _a (9.86)	15.58 _b (8.28)	12.48 _b (7.43)	F (2, 128) = 5.28	.006	.076
BDI	26.69 _a (11.75)	21.07 _b (11.52)	15.17 _b (9.74)	F (2, 127) = 7.62	.001	.107
Comorbid MDD	66.7%	57.7%	50.0%	χ^2 (2) = 0.92	.63	---

Note. Means in the same row that do not share subscripts differ at $p < .05$ in post hoc analyses. GAD = Generalized Anxiety Disorder; BAI = Beck Anxiety Inventory; PSWQ-A = Penn State Worry Questionnaire Abbreviated; PANAS = Positive and Negative Affect Scale; BDI = Beck Depression Inventory

Table 5
Racial differences in the presentation and severity of symptoms in patients with GAD

	White N = 81	Black N = 55	Statistic	p	η^2
BAI-total	24.87 (13.65)	23.73 (12.80)	$F(1, 126) = 0.21$	.62	.002
BAI-cognitive	9.33 (5.84)	9.23 (5.68)	$F(1, 126) = 0.02$	.90	.00
BAI-somatic	15.53 (9.31)	14.54 (8.46)	$F(1, 126) = 0.39$	.54	.003
PSWQ-A	36.00 (6.40)	35.35 (5.63)	$F(1, 92) = 0.42$	.52	.005
PANAS-positive affect	12.70 (8.26)	16.23 (8.09)	$F(1, 126) = 7.28$	.008	.055
PANAS-negative affect	16.31 (9.52)	16.10 (8.23)	$F(1, 126) = 0.05$	.82	.00
BDI	22.53 (12.74)	20.71 (10.58)	$F(1, 125) = 1.14$	.29	.009
Comorbid MDD	58.0%	60.0%	$\chi^2 (1) = 0.07$	.79	---

Note. GAD = Generalized Anxiety Disorder; BAI = Beck Anxiety Inventory; PSWQ-A = Penn State Worry Questionnaire Abbreviated; PANAS = Positive and Negative Affect Scale; BDI = Beck Depression Inventory