Experience of Care: Study characteristics of included studies

Title	Sampling strategy	Design/method	Population/Diagnosis/ Setting	Findings	Limitations
Alvidrez & Azocar 1999 Distressed women's clinic patients: preferences for mental health treatments and perceived obstacles	Recruited while waiting for appointment in women's hospital clinic. Paid $5 for interview.	Quantitative study Structured interviewed for use of mental health services, interest in psychosocial services and perceived barriers to treatment.	N=105 Depression (69) and anxiety(25) 15% (n=16) of total sample had GAD Diagnosis: PRIME-MD U.S.A	Preference of individual/group therapy and mood management classes over medication treatment. High barriers to treatment: high cost, lack of time. More fear of stigma in anxious patients than non anxious.	No follow up data on which services women actually used. Obstacles to treatment could depend on type of treatment need but patients were asked about barriers to services globally.
Becker and colleagues 2003 Content of worry in the community: what do people with generalized anxiety disorder or other disorders worry about? (The Netherlands)	Sample drawn randomly from government registry (Germany) of residents. 2,064 women administered a structured clinical interview.	Quantitative study Results taken from the baseline survey of a epidemiological study (to collect data on prevalence, risk factors etc of mental disorders)	N= 2028 GAD N=37 Anxiety without GAD N=316 Mood, somatoform, substance related or eating disorders N=71 No disorder N=1604 All female samples F-DIPS The Netherlands	Worry in GAD is most commonly characterized by concerns about work, family and finances. High level of uncontrollability of worry.	Generalizable only to females.

Bjorner & Kjolsrod 2002 How GPs understand patients' stories. A qualitative study of benzodiazepine and minor opiate prescribing in Norway.	Based on a prescription registration of BZDs and minor opiates issued by all doctors in Oslo (Norway) and a neighbouring country. Strategic sampling of 38 GPs selected. Letters requesting for interview, then phone call.	Qualitative study Semi-structured interview Questions: general questions on prescribing and most recent patients prescribed BZ.	N=38 GPs. Patients had a range of physical conditions, some comorbid with anxiety. Diagnosis not reported Norway	• Feel the need to fulfil patient demands • Difficult to offer non drug solution	Selection bias; only focussed on prescriptions issued during consultation and not indirect GP-patient contact. No diagnosis or assessment of anxiety reported.
Blair & Ramones 1996 The under treatment of anxiety: overcoming the confusion and stigma	n/a	Non-systematic review	Anxiety	• Unrelieved anxiety leads to poor treatment compliance and negative outcome. • Patients can become irritable and demanding. • Lack of case identification causes poor treatment practice.	n/a
Boardman and colleagues 2004 Needs for mental health treatment among general practice attenders	Includes 5 practices. Patients attended practice, asked to complete GHQ and provide	Quantitative study Cross sectional survey and longitudinal study. Medical research council needs for care assessment schedule	N=77 GAD N=108 MDD DSM-IV Anxiety prevalence 11.7%. GAD prevalence 7.7%.	Unmet need in those with anxiety was 13.9%. Depression 9.5%. Overall unmet need for 59.6%	Practices were smaller than average for the area. Time pressure on doctors. No hierarchy of diagnosis applied, mainly mixed anxiety and depression.

	demographics. doctor/nurse completed encounter form (rates patient psychiatric disturbance). Patients with psychological problem assigned to GP case group. Subgroups systematically sampled and randomly selected.		U.K		Overall need for treatment in mixed anxiety and depression cases not assessed. Looked at individual disorders. Patient's view of treatment is complex and acceptance of treatment, need and met need is likely to change.
Borkovec & Roemer 1995 Perceived function of worry among generalized anxiety disorder subjects: distraction from more emotionally distressing topics?	College students. Strategy not reported.	Quantitative study 583 college students completed GAD-Questionnaire (self-reported) and Reasons to worry questionnaire.	N=250 GAD N=74 Partial GAD (did not meet all parts of the criteria) N=76 Non anxious N=100 GAD-Q U.S.A	Main reasons for worry: Motivation, preparation and avoidance/prevention. Pure GAD patients rated 'distraction from more emotional topics' higher than other groups. A way of avoiding emotionally distressing topics like prior traumatic events or unhappy childhood memories.	Only college student sample GAD-Q can over-estimate the incidence of of DSM-IV GAD by 20% . Reasons to worry questionnaire includes only 6 reasons of worry.
Breitholtz and Westling 1998	Referrals from GPs and advertisement	Qualitative study Semi-structured interview	N=87 N=43 GAD patients	• Thoughts on social acceptance and rejection • Loss of self-control &	Different interviewers used for different patient

Cognitions in generalized anxiety disorder and panic disorder patients	in newspaper.	Questioned on thoughts and images during anxiety	who do not have PD N=44 PD patients who do not have GAD DSM-III-R (GAD patients) 32 female, 11 male) (PD patients) 30 female, 14 male) Sweden	inability to cope	groups (but one interview data scorer). GAD patients were older with longer duration of anxiety than PD patients.
Bystritsky and colleagues 2005 Assessment of beliefs about psychotropic medication and psychotherapy: development of a measure for patients with anxiety disorders	Patients screened and recruited from six university-affiliated primary care clinics.	Quantitative study Data used from CCAP (randomized control trial where CBT and pharmacotherapy was delivered). Patients screened with self-report questionnaire, telephone interview, randomized to treatment groups. Factor analysis with Varimax rotations used to determine factor structure of beliefs scale. Assessed validity and consistency of scale.	N=762 Panic disorder, social phobia, posttraumatic stress disorder, generalized anxiety disorder DSM-IV CIDI U.S.A	A belief in medication is associated with appropriate medication use, however, a belief in psychotherapy or medication does not predict adherence to psychotherapy.	Convenience sample: Patients selected based on willingness to consider medication and psychotherapy therefore would not include patients who have more negative view of treatments. Items assessing belief about psychotherapy was not specific to anxiety.
Commander and colleagues 2004 Care pathways for south asian	General population. Deprived inner-city catchment area,	Qualitative study Semi-structured interview Questions:	N=77 Anxiety OR depression GAD (15) Any Anxiety Disorder	• Few consult GPs and fewer receive medication • Fear of stigmatization • South asian women more	Setting in deprived urban area, may not be generalizable. Language difficulties contributed to non-

and white people with depressive and anxiety disorders in the community	Birmingham. Random sample of residents registered with GP drawn from a database. Contacted by letter then interviewed in homes (semi-structured diagnostic interview). Payment <£10.	Perceived cause, help seeking, discussion with friends, GP, offered help.	(57) Any depressive disorder (49) Other (11) Total comorbidity (25) South asian and white people Disgnosis: DSM-IIIR U.K	likely to see GP than white women	response rate. Subjects refused interview while waiting for interpreter. More south Asian refused to participate than white people may have introduced a bias. What is the validity of applying instruments from western psychiatry in studies of ethnic minority?
Craske and colleagues 1989 Qualitative dimensions of worry in DSM-III-R generalized anxiety disorder subjects and non anxious controls	GAD patients were recruited from the Centre for Stress and Anxiety disorders prior to treatment. Controls were drawn from as sample of friends of clients attending above centre & were paid $6. US	Quantitative study Both groups completed a questionnaire as soon as possible after they noticed themselves worrying (excluded the concerns of panic attacks/phobic fears).	N=45 GAD, N = 19 Non anxious controls N = 26 Assessed by the ADIS-R U.S.A	• GAD patients worried more about illness, health & injury issues, & had a tendency to worry about more minor issues • Almost 40% of GAD worriers, compared to only 12% of controls were reported to occur without a precipitant/cue • Worries monitored by GAD group were rated as less controllable, less realistic, & less successfully alleviated when preventative or corrective measures were engaged in	• No operational definitions of worry used • Completion rates: On average GAD group completed 2.3/3 questionnaires & control group 2.4/3
Deacon & Abramowitz 2005	Patients evaluated in	Quantitative study	N=133 Mixed anxiety	• CBT rated as treatment of choice	Generalizability to patients who seek

Patients' perceptions of pharmacological and cognitive-behavioral treatments for anxiety disorders	anxiety disorders clinic. Self- referrals, referrals from physicians and mental health professionals.	Semi-structured diagnostic interview. Review of medical records and interview examining medical and pharmacological history. Treatment perceptions questionnaire (TPQ)	10.7% GAD 41.7% Axis I comorbidity Additional diagnosis of anxiety (13.6%) and mood disorders (11.7%). MINI U.S.A	• CBT is more acceptable and more likely to be effective in long-term. • Patients taking medication equally favour both treatments. • Unmediated patients rate CBT more favourable.	help in primary care is unknown. Psychometric propertied of TPQ unknown. Did not ask if a combined treatment was preferable. TPQ description of treatments influenced perception ratings.
Decker and colleagues 2008 Emotion regulation among individuals classified with and without generalized anxiety disorder	Participants recruited from classroom visits. Explained study rationale and requirements and obtained consent. Given questionnaires and diaries to complete.	Quantitative study Participants completed daily diaries and questionnaires measuring emotion regulation strategies.	N= 138 GAD N=33 Control N=105 Diagnosis: PSWQ, GADQ, ERSQ 111 Female 27 Male U.S.A	• Intense negative emotions • No difference in positive emotions compared to controls. • Emotion regulation strategies used: situation selection, distraction, masking emotions, hiding emotions etc	Graduate and undergraduate population. Results may be different in treatment-seeking population. Looks at most intense emotional daily experiences, not baseline moods.
Diefenbach and colleagues 2001 A Worry content reported by older adults with and without	Recruited through media and community announcements.	Quantitative study Worry content evaluated from ADIS-R. Worry topic coded and worry statements categorized into 5 content areas.	N= 88 GAD N=44 Control (free from diagnosis) N=44 Mean age: 67yrs DSM-III	• Report wider variety of worry topics than control • No diff in worry content • Older people worry more about health and less about work related concerns than younger people with GAD.	Comparison of older vs younger samples was not in the same study. Small sample

generalized anxiety disorder			Anxiety disorders interview schedule-revised (ADIS-R) 30 Female 11 Male U.S.A		
Diefenbach and colleagues 2001 B Anxiety, depression and the content of worries	Patients selected from outpatients who completed questionnaire during pretreatment assessment at a psychological research clinic.	Quantitative study Worry domains questionnaire (WDQ). Self-report rating each worry domain for frequency.	N=60 GAD N=20 Depression and GAD N=20 Depression without anxiety N=20 DSM-III-R U.S.A	• Worry content differs in depression and anxiety. • Anxious patients worry in the domain of loss of control and physical threat. People with comorbidity present mixed depressive and anxious worries.	
Gum and colleagues 2006 Depression treatment preferences in older primary care patients	Selected from 18 primary care clinics belonging to 8 health care organizations in 5 states.	Quantitative study Multisite, randomized clinical trial comparing usual care and collaborative care, offered counselling and medication <12months. After 12 months services received, satisfaction and depression outcomes assessed.	N=1,602 Age: 60 years+ Depression: 30% comorbid with anxiety U.S.A	More patients preferred counselling (57%) than medication (43%).	
Haslam and colleagues 2004 Patients'	Liaison with established contacts in organizations,	Qualitative study Focus group interviews	N=54 Anxiety and depression N=20	• Initially unaware of symptoms • Thought to be stemmed from	Not reported

experiences of medication for anxiety and depression: effects on working life	health and safety contacts, mail shots, telephone calls, emails newspaper advertisements, professional publications, radio, posters.	9 focus groups (patients on medication) 3 focus groups (people attending anxiety management courses, from different occupations) 3 focus groups (staff of HR, personnel, occupational health and health/safety sectors)	Organizational reps Diagnosis or assessment: not reported 36 Female, 18 Male U.K	physical illness • Feel tired, confused, emotional etc • Impairs work performance • Negative effects of drugs are the same as anxiety symptoms • Inability to work Worry about dependency • Participants require more information and consultation time • Difficult to explain benefits of drugs and explain side effects • Lack of compliance	No diagnosis/assessment
Hoyer and colleagues 2002 Generalized anxiety disorder and clinical worry episodes in young women	A representative sample of young (18-25) women from the German community	Quantitative study All participants were interviewed about the frequency, intensity & uncontrollability of diverse worry topics Psychosocial functioning was rated using the GAF	N=2064 GAD or GAD comorbid with other disorders ADIS-L Germany	• Co-morbid GAD had one of the lowest psychosocial functioning ratings & had significantly lower scores than those with other anxiety disorders • Those with GAD or sub-threshold GAD seem to have a specific 'worry syndrome' that is highly distinguishable from everyday worry	• Only young women examined, thus results may not be generalizable to men or the older population • Also, conducted in Eastern Germany and thus may not be generalizable to the UK population • The interviewers

					who administered diagnosis were either psychology students in their last year of study or physicians (training given over 1 week) • No other direct/objective measures of impairment other than the DSM-rating of psychosocial functioning
Kadam and colleagues 2001 A qualitative study of patients' views on anxiety and depression	Randomly selected 50% sample from four partner group GP practice population register. Sent HAD questionnaire survey. High scorers sent invitation for interview. 29 randomly selected	Qualitative study Semi-structured individual interviews (n=18) and focus group interviews (n=9) Questions focus on onset, feelings, coping, seeking help etc	N=27 High anxiety and depression score OR high depression score irrespective of anxiety. 13/27 had a prior diagnosis of anxiety or depression 18 Female, 9 Male HAD questionnaire U.K	• Negative thoughts & Inability to cope • Used distraction techniques • Feelings of shame and embarrassment • Present physical symptoms • Actively seek therapy • Critical of drugs interventions	Study sample chosen from general practice population in a particular provincial city. ---------- Older population. Did not report exact no. of participants with anxiety and depression or which criteria were used in prior diagnosis. 50% had either anxiety or depression from a

	patients completed interview.				record taken 12 months previously
Lang 2005 Mental health treatment preferences of primary care patients	Patients completed questionnaires while waiting for appointments at 2 clincis and mailed back additional material.	Quantitative study Questionnaires on treatment preferences, expectations and barriers to treatment.	N=298 45% distressed (BSI score ≥ 68). 35% reached 'caseness' on somatization scale, 30% on depression scale and 20% on anxiety scale (n=60). Brief Symptom Inventory (BSI-18) U.S.A	• 69.6 % Prefer individual treatment. 17% prefer group treatment. 14.2% prefer medication treatment. • Practical barriers to treatment: time, transportation etc. • Caucasians receive more mental health treatment than non Caucasians. • 46.5% of people received treatment in the past. Of these, 78% received medication, 74% individual counselling, 31% group counselling, 3% other.	In treatment history, more people received individual counselling than group therapy which could have influenced their preference. Results may not be generalizable to broader primary care patients (2 clinics may not be representative of different health systems). Mail-back procedure opens self-selection bias and missing data points compared to personal administration. (Mail-back was used to limit patients waiting time).
Mojtabai and colleagues 2002 Perceived need and help-seeking in adults with	Sample taken from national comorbidity survey	Quantitative study Questions on levels of impairment, suicidality, physical health, attitudes of mental health, support	N=648 Anxiety DSM-III	People with comorbid mood and anxiety disorders are 3 times more likely to perceive need for help that anxious people alone.	Limited to NCS diagnosis. Recall period of 12months may be too long.

mood, anxiety, or substance use disorders.		networks, parental psychopathology.	U.S.A		
Porensky and colleagues 2009 The burden of late-life generalized anxiety disorder: effects on disability, health-related quality of life, and healthcare utilization	Screening and referral from primary care and mental health practice. Community advertisement.	Quantitative study Measured disability, health related QoL, healthcare utilization, anxiety, depression, medical burden, cognition.	N=206 GAD N=164 Healthy control N=42 Mean age 73 years DSM-IV, HRSA 141 Female Male 65 U.S.A	Older adults with GAD are more disabled (less engagement and activity), have worse health related QoL (role functioning and social function) and greater healthcare utilization than nonanxious control.	Older people who consented to a treatment study. May not be generalizable to younger and non-treatment seeking population.
Prins and colleagues 2009 Primary care patients with anxiety and depression: need for care from the patients' perspective	Data derived from the Netherlands Study of Depression and Anxiety: a longitudinal cohort study. Patients recruited from primary care centres	Quantitative study Patients completed Kessler-10 screening questionnaire for affective/anxiety disorders (n=10,706). Interviewed with CIDI. Completed Perceived Need for Care Questionnaire.	N=662 N=516 Anxiety (28% GAD) N=417 Depression 40% comorbidity CIDI The Netherlands	Patients with anxiety and depression prefer to receive counselling or information as part of their care than medication or practical support.	
Rijswijk and colleagues 2009 Barriers in recognizing, diagnosing and	3 focus groups from 3 regions in Netherlands. Grp 1. Continuous	Qualitative study Focus group of loosely structured interviews.	23 family physicians from all types of practices (urban, suburban and rural). Focussed on	• Diagnosis and management is time consuming • Doubts of DSM-IV criteria • Diagnosis is difficult due to overlapping of symptoms	Not reported

managing depressive and anxiety disorders as experienced by family physicians: a focus group study	Medical Education (CME) group of FPs discussing topics on monthly basis. Grp 2. FP trainers from 1/8 residency training programmes. Grp 3. Randomised FP group with practices in a university area. 120 invitations sent, 8 participated. All FPs paid €125. All completed Depression attitude Questionnaire (valid measure of attitude to depression).		depression and anxiety The Netherlands	and presentation of physical symptoms • Not enough knowledge on diff anxiety disorders and drugs available	
Roemer and colleagues 1997 An investigation of worry content among generally anxious	Clinical samples taken from GAD patients in a previous investigation (Roemer 1995). Analogue	Quantitative study Worry topics obtained from ADIS-R and GAD-Q and categorized	N=402 GAD N=234 Non anxious control N=168 ADIS-R, GAD-Q	GAD patients worry about a greater number of topics. Higher freq in 'miscellaneous' worries (minor/routine issues/daily hassles) and lower worries for work/school compared to non anxious controls.	High heterogeneity of worries included in the miscellaneous worries category: not an ideal content categorization.

individuals	samples taken from undergraduate students		GAD: 166 female 68 male Control: 168 female 48 male U.S.A		
Tylee & Walters 2007 Underrecognition of anxiety and mood disorders in primary care: why does the problem exist and what can be done?	n/a	Non-systematic review	Anxiety and depression Diagnosis: DSM-III	• Presentation of somatic symptoms • Normalizing/minimizing symptoms affect identification	Not reported
Wagner and colleagues 2005 Beliefs about psychotropic medication and psychotherapy among primary care patients with anxiety disorders	8,315 screened in clinic waiting room (given self-report questionnaire) to assess anx and dep symptoms. 1,319 subjects positive for anx and random sample of subjects with no disorder (telephone diagnostic int	Quantitative study Self-report questionnaire Diagnostic interview. Belief about medication (6 items, anxiety specific). Belief about psychotherapy (8 items, not anxiety specific). 5pt likert scale.	DSM-IV N=273 Anxiety and depression (31% GAD) N=69 No disorder U.S.A	Depression diagnosis related to slightly more favourable attitude about medication Ethnic minority patients have less favourable views about medication and psychotherapy. SES or any other demographic variable is not related to treatment belief.	Diagnostic composition of sample inadequate to compare strength of beliefs between those with anxiety only and depression only. Sample consisted of depression and anxiety comorbidities. Cannot examine beliefs in discrete diagnostic groups (although sample is

	requested). 801 completed telephone diagnostic interview assessing beliefs in therapy and psychotropic medication.				characteristic of primary care population). Measure used for treatment belief is new, limited data on its psychometric properties. Items assessing therapy were not anxiety specific. Sample of primary care patients was small and from selected west coast clinics so not generalizable.
Wittchen and colleagues 2000 Disabilities and quality of life in pure and co-morbid generalized anxiety disorder and major depression in a national survey	A large stratified national representative sample of 130 GP sites in Germany. Data were adjusted by age, sex & geographical location.	Quantitative study Measured impairment (e.g. days lost in past month, reduced functioning, & perceived state of health) & QOL	N=4181 Pure GAD, N= 33 Pure MDD, N= 344 Co-morbid GAD & MDD, N= 40 Neither GAD nor MDD N= 3764 Assessed by the Composite International Diagnostic-Screener & a structured diagnostic interview for DSM-IV Axis I disorders.	• Both pure & co-morbid GAD are associated with high impairment (i.e. poor perceived health, activity reduction) & low quality of life • Those with co-morbid GAD seem to have the highest impairments. • Pure GAD respondents report more impairments than pure MDD respondents.	• Few GAD participants

			Germany		