Appendix 15a: Experience of care study characteristics

In the following table, studies were categorised as quantitative if a theory and/or hypothesis was tested using systematic empirical methods of investigation. Studies were defined as qualitative according to the *Cochrane Handbook for Systematic Reviews of Interventions* (Oxford: Cochrane Collaboration, 2011, http://www.cochrane-handbook.org/):

'Qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them (Denzin 1994[1]). Qualitative research is intended to penetrate to the deeper significance that the subject of the research ascribes to the topic being researched. It involves an interpretive, naturalistic approach to its subject matter and gives priority to what the data contribute to important research questions or existing information.

Within health care an understanding of the value of evidence from qualitative research to systematic reviews must consider the varied and diffuse nature of evidence (Popay 1998b[2], Pearson 2005[3]). Qualitative research encompasses a range of philosophies, research designs and specific techniques including in-depth qualitative interviews; participant and non-participant observation; focus groups; document analyses; and a number of other methods of data collection (Pope 2006[4]). Given this range of data types, there are also diverse methodological and theoretical approaches to study design and data analysis such as phenomenology; ethnography; grounded theory; action research; case studies; and a number of others. Theory and the researchers' perspective also play a key role in qualitative data analysis and in the bases on which generalizations to other contexts may be made.'

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[1] Denzin NK, Lincoln YS. Introduction. Entering the field of qualitative research. In: Denzin NK, Lincoln YS (editors). *Handbook of Qualitative Research*. Thousand Oaks (CA): Sage Publications, 1994.

[2] Popay J, Williams G. Qualitative research and evidence-based healthcare. *Journal of the Royal Society of Medicine* 1998; 91 (Suppl 35): 32-37.

[3] Pearson A, Wiechula R, Court A, Lockwood C. The JBI model of evidence-based healthcare. *JBI Reports* 2005; 3: 207-216.

[4] Pope C, Mays N. Qualitative methods in health research. In: Pope C, Mays N (editors). *Qualitative Research in Health Care* (3rd edition). Malden (MA): Blackwell Publications/BMJ Books, 2006.

Study	Sampling strategy/country	Design/method	Population/diagnosis	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. US	Quantitative study Structured interview about use of mental health services, interest in psychosocial services and perceived barriers to treatment	N=105 Depression n=69 Anxiety n= 25 15% (n=16) of total sample had GAD Diagnosis: PRIME-MD	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 *et al*., 2003 'Content of worry in the community: what do people with generalized anxiety disorder or other disorders worry about?'	Sample drawn randomly from German government registry of residents. 2,064 women administered a structured clinical interview. Germany	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	Worry in GAD is most commonly characterised by concerns about work, family and finances. High level of uncontrollability of worry.	Generalisable 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 benzodiazepines and minor opiates issued by all doctors in Oslo and a neighbouring country. Strategic sampling of 38 GPs selected. Letters requesting for interview, then phone call. Norway	Qualitative study Semi-structured interview Questions: general questions on prescribing and most recent patients prescribed benzodiazepines	N=38 (GPs) 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-pharmacological solution	Selection bias; only focused on prescriptions issued during consultation and not indirect GP-patient contact. Also: 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 *et al*., 2004 'Needs for mental health treatment among general practice attenders'	Includes five practices. Patients attended practice, asked to complete GHQ and provide demographics. A doctor or nurse completed encounter form (rates patient psychiatric disturbance). Patients with psychological problem assigned to GP case group. Subgroups systematically sampled and randomly selected. UK	Quantitative study Cross-sectional survey and longitudinal study. Medical Research Council Needs for Care Assessment schedule	GAD n=77 MDD n=108 DSM-IV Anxiety prevalence 11.7% GAD prevalence 7.7%	Unmet need in those with anxiety was 13.9%, and depression 9.5% Overall unmet need for 59.6%	Practices were smaller than average for the area and there was a time pressure on doctors. No hierarchy of diagnosis applied - mainly mixed anxiety and depression. Overall need for treatment in mixed anxiety and depression 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. US	Quantitative study 583 college students completed GAD-Q (self-report) 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	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 DSM-IV GAD by 20% Reasons to Worry questionnaire includes only six reasons of worry.
Breitholtz and Westling, 1998 'Cognitions in generalized anxiety disorder and panic disorder patients'	Referrals from GPs and advertisement in newspaper Sweden	Qualitative study Semi-structured interview Questioned on thoughts and images during anxiety	N=87 GAD patients who do not have PD n=43 PD patients who do not have GAD n=44 DSM-III-R GAD patients: 32 female, 11 male PD patients: 30 female, 14	Thoughts on social acceptance and rejection Loss of self-control and inability to cope	Different interviewers used for different patient groups (but one interview data scorer). GAD patients were older with longer duration of anxiety than PD patients.

			male		
Bystritsky *et al*., 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 US	Quantitative study Data used from Collaborative Care for Anxiety and Panic study (RCT delivering CBT and pharmacotherapy). Patients screened with self-report questionnaire, telephone interview, randomised 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, PTSD, GAD DSM-IV CIDI	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 *et al*., 2004 'Care pathways for south Asian and white people with depressive and anxiety disorders in the community'	General population. Deprived inner-city catchment area, 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. UK	Qualitative study Semi-structured interview Questions: perceived cause, help seeking, discussion with friends, GP, offered help	N=77 Anxiety or depression GAD n=15 Any anxiety disorder n=57 Any depressive disorder n=49 Other n=11 Total comorbidity n=25 South Asian and white people DSM-III-R	Few consult GPs and fewer receive medication Fear of stigmatisation South Asian women more likely to see GP than white women	Setting in deprived urban area, may not be generalisable. Language difficulties contributed to non-response rate. Subjects refused interview while waiting for interpreter. More south Asian people refused to participate than white people, which may have introduced bias. What is the validity of applying instruments from Western psychiatry in studies of ethnic minorities?
Craske *et al*., 1989 'Qualitative dimensions of worry in DSM-III-R	GAD patients were recruited from the Centre for Stress and Anxiety disorders prior to treatment. Controls were drawn from as sample of	Quantitative study Both groups completed a questionnaire as soon as possible after they noticed	N=45 GAD n = 19 Non anxious controls n = 26	GAD patients worried more about illness, health and injury issues, and had a tendency to worry about more minor issues	No operational definitions of worry used Completion rates: on

generalized anxiety disorder subjects and non anxious controls'	friends of clients attending the above centre and were paid $6. US	themselves worrying (excluded the concerns of panic attacks/phobic fears).	ADIS-R	Almost 40% of GAD worriers, compared to only 12% of controls were reported to have worries without a precipitant/cue Worries monitored by the GAD group were rated as less controllable, less realistic and less successfully alleviated when preventative or corrective measures were engaged in	average GAD group completed 2.3/3 questionnaires and control group 2.4/3
Deacon & Abramowitz, 2005 'Patients' perceptions of pharmacological and cognitive-behavioral treatments for anxiety disorders'	Patients evaluated in anxiety disorders clinic. Self-referrals, referrals from physicians and mental health professionals. US	Quantitative study Semi-structured diagnostic interview. Review of medical records and interviews examining medical and pharmacological history. Treatment Perceptions Questionnaire (TPQ)	N=133 Mixed anxiety 10.7% GAD 41.7% Axis I comorbidity Additional diagnosis of anxiety (13.6%) and mood disorders (11.7%) MINI	CBT rated as treatment of choice. 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 favourably.	Generalisability to patients who seek 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 *et al.*, 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. US	Quantitative study Participants completed daily diaries and questionnaires measuring emotion regulation strategies.	N= 138 GAD n=33 Control n=105 111 female, 27 male PSWQ, GAD-Q, ERSQ	Intense negative emotions No difference in positive emotions compared with controls. Emotion regulation strategies used: situation selection, distraction, masking emotions, hiding emotions, and so on	Graduate and undergraduate population. Results may be different in treatment-seeking population. Looks at most intense emotional daily experiences, not baseline moods.
Diefenbach *et al.*, 2001a 'Worry content reported by older adults with and without generalized anxiety disorder'	Recruited through media and community announcements US	Quantitative study Worry content evaluated from ADIS-R. Worry topic coded and worry statements categorised into five content	N= 88 GAD n=44 Control (free from diagnosis) n=44 Mean age: 67 years	Report wider variety of worry topics than control No difference in worry content Older people worry more about health and less about work-related concerns than younger people with GAD.	Comparison of older versus younger samples was not in the same study. Small sample

		areas.	30 female, 11 male DSM-III Anxiety disorders interview schedule-revised (ADIS-R)		
Diefenbach *et al*., 2001b 'Anxiety, depression and the content of worries'	Patients selected from outpatients who completed questionnaire during pre-treatment assessment at a psychological research clinic US	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	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.	Not reported
Gum *et al*., 2006 'Depression treatment preferences in older primary care patients'	Selected from 18 primary care clinics belonging to eight healthcare organisations in five states US	Quantitative study Multisite RCT comparing usual care and collaborative care, offered counselling and medication <12months. After 12 months of services received, satisfaction and depression outcomes assessed.	N=1,602 Depression: 30% comorbid with anxiety. DSM-IV Age: 60 years+ 67% female	More patients preferred counselling (57%) than medication (43%).	Not reported
Haslam *et al*., 2004 'Patients' experiences of medication for anxiety and depression: effects on working life'	Liaison with established contacts in organisations, health and safety contacts, mail shots, telephone calls, emails newspaper advertisements, professional publications, radio, posters UK	Qualitative study Focus group interviews Nine focus groups with patients taking medication Three focus groups with people attending anxiety management courses, from different occupations Three focus groups with HR staff, personnel, occupational health and health/safety sectors	People with anxiety and depression N=54 Organisational reps N=20 36 female, 18 male Diagnosis or assessment not reported	Initially unaware of symptoms Thought to stem from physical illness Feeling tired, confused, emotional, and so on 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	Not reported, but no diagnosis/assessment

				and explain side effects Lack of compliance	
Hoyer *et al.*, 2002 'Generalized anxiety disorder and clinical worry episodes in young women'	A representative sample of young (18-25 years) women from the community Germany	Quantitative study All participants were interviewed about the frequency, intensity and uncontrollability of diverse worry topics Psychosocial functioning was rated using the Global Assessment of Functioning (GAF)	N=2064 GAD or GAD comorbid with other disorders ADIS-L	Comorbid GAD had one of the lowest psychosocial functioning ratings and had significantly lower scores than those with other anxiety disorders Those with GAD or subthreshold GAD seem to have a specific 'worry syndrome' that is highly distinguishable from everyday worry	Only young women examined, thus results may not be generalisable to men or the older population Also, conducted in Eastern Germany and thus may not be generalisable 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 *et al.*, 2001 'A qualitative study of patients' views on anxiety and depression'	Randomly selected 50% sample from four partner group GP practice population registers. Sent HADS questionnaire. High scorers sent invitation for interview. 29 randomly selected patients completed interview. UK	Qualitative study Semi-structured individual interviews (n=18) and focus group interviews (n=9) Questions focus on onset, feelings, coping, seeking help, and so on	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 HADS	Negative thoughts and 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. Also: Older population Did not report exact number of participants with anxiety and depression or which

					criteria were used in prior diagnosis. 50% had either anxiety or depression from a record taken 12 months previously
Lang, 2005 'Mental health treatment preferences of primary care patients'	Patients completed questionnaires while waiting for appointments at two clinics and mailed back additional material US	Quantitative study Questionnaires on treatment preferences, expectations and barriers to treatment	N=298 BSI-18 45% distressed (BSI score ≥ 68). 35% reached 'caseness' on somatisation scale, 30% on depression scale and 20% on anxiety scale (n=60). 199 male, 196 female.	69.6 % prefer individual treatment. 17% prefer group treatment. 14.2% prefer medication. Practical barriers to treatment: time, transportation, and so on. 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 generalisable to broader primary care patients (two clinics may not be representative of different health systems). Mail-back procedure opens self-selection bias and missing data points compared with personal administration. (Mail-back was used to limit patients' waiting time).
Mojtabai *et al.*, 2002 'Perceived need and help-seeking in adults with mood, anxiety, or substance use disorders'	Sample taken from National Comorbidity Survey US	Quantitative study Questions on levels of impairment, suicidality, physical health, attitudes of mental health, support networks, parental psychopathology	N=648 Anxiety DSM-III	People with comorbid mood and anxiety disorders are three times more likely to perceive need for help than anxious people alone.	Limited to National Comorbidity Survey diagnosis. Recall period of 12 months may be too long.
Porensky *et al.*, 2009 'The burden of late-life generalized anxiety disorder: effects on disability,	Screening and referral from primary care and mental health practice. Community advertisement. US	Quantitative study Measured disability, health related QoL, healthcare utilization, anxiety, depression, medical burden,	N=206 GAD n=164 Healthy control n=42 Mean age 73 years	Older adults with GAD are more disabled (less engagement and activity), have worse HRQoL (role functioning and social function) and greater healthcare utilisation than non-anxious controls.	Older people who consented to a treatment study. May not be generalisable to younger and non-

health-related quality of life, and healthcare utilization'		cognition.	DSM-IV, HAM-A 141 female, 65 male		treatment seeking population.
Prins *et al*., 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 The Netherlands	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 Anxiety n=516 (28% GAD)Depression n=417 40% comorbidity CIDI	Patients with anxiety and depression prefer to receive counselling or information as part of their care than medication or practical support.	Not reported
Rijswijk *et al*., 2009 'Barriers in recognizing, diagnosing and managing depressive and anxiety disorders as experienced by family physicians: a focus group study'	Three focus groups from three regions in Netherlands. Group 1. Continuous medical education group of family physicians discussing topics on monthly basis. Group 2. Family physician trainers from 1/8 residency training programmes. Group 3. Randomised family physician group with practices in a university area. 120 invitations sent, 8 participated. All family physicians paid €125. All completed Depression Attitude Questionnaire (valid measure of attitude to depression)	Qualitative study Focus group of loosely structured interviews	23 family physicians from all types of practices (urban, suburban and rural). Focused on depression and anxiety	Diagnosis and management is time consuming Doubts of DSM-IV criteria Diagnosis is difficult due to overlapping symptoms and presentation of physical symptoms Not enough knowledge of different anxiety disorders and drugs available	Not reported

Roemer *et al*., 1997 'An investigation of worry content among generally anxious individuals'	Clinical samples taken from GAD patients in a previous investigation (Roemer, 1995). Analogue samples taken from undergraduate students US	Quantitative study Worry topics obtained from ADIS-R and GAD-Q and categorised	N=402 GAD n=234 Non-anxious control n=168 GAD: 166 female, 68 male Control: 168 female, 48 male ADIS-R, GAD-Q	GAD patients worry about a greater number of topics. Higher frequency in 'miscellaneous' worries (minor/routine issues/daily hassles) and lower worries for work/school compared with non- anxious controls.	High heterogeneity of worries included in the miscellaneous worries category: not an ideal content categorisation
Ruscio & Borkovec, 2004 'Experience and appraisal of worry among high worriers with and without generalized anxiety disorder'	Students who were enrolled in university psychology courses US	Quantitative study Laboratory setting. Pre-experiment measures: PSWQ and GAD-Q. Post-experiment measures: Post Task Questionnaire on nature, frequency and intensity of worry. Metacognitions Questionnaire assessing beliefs and control of worry. Participants had a focused task on breathing, induced worry and feedback using the above questionnaires	N=60 GAD n=30 Non-GAD worriers n=30 Female 78%, Caucasian 88% DSM-IV GAD	More people with GAD reported negative intrusions after worry induction No difference between the quantity, frequency, intensity of worry and levels of distress caused by worry in GAD and non-GAD worriers There are differences in perception, in that people with GAD perceive their worry as less controllable and more dangerous	Student population may not be generalisable to a treatment seeking population Highly controlled laboratory setting where worry was evoked does not reflect unrestrained worry in a natural setting The worry scores of students were matched to those of a treatment-seeking population so this is not a major limitation.
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 DSM-III	Presentation of somatic symptoms Normalising/minimising symptoms affect identification	Not reported
Wagner *et al*., 2005 'Beliefs about psychotropic medication and psychotherapy among primary care patients with anxiety	8,315 screened in clinic waiting room (given self-report questionnaire) to assess anxiety and depressive symptoms. 1,319 subjects positive for anxiety and random sample of subjects with no disorder	Quantitative study Self-report questionnaire Diagnostic interview. Belief about medication (6 items, anxiety specific). Belief about psychotherapy (8	Anxiety and depression (31% GAD) n=273 No disorder n=69 DSM-IV	Depression diagnosis related to slightly more favourable attitude about medication Ethnic minority patients have less favourable views about medication and psychotherapy. Socioeconomic status or any other demographic	Diagnostic composition of sample inadequate to compare strength of beliefs between those with anxiety only and depression only.

disorders'	(telephone diagnostic interview requested). 801 completed telephone diagnostic interview assessing beliefs in therapy and psychotropic medication. US	items, not anxiety specific). 5 point Likert scale.		variable is not related to treatment belief.	Sample consisted of depression and anxiety comorbidities. Cannot examine beliefs in discrete diagnostic groups (although sample is 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 generalisable.
Wittchen *et al*., 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 and geographical location	Quantitative study Measured impairment (for example, days lost in past month, reduced functioning, and perceived state of health) and QOL	N=4,181 Pure GAD, n= 33 Pure MDD, n= 344 Comorbid GAD and MDD n= 40 Neither GAD nor MDD n= 3,764 Assessed by the Composite International Diagnostic-Screener and a structured diagnostic interview for DSM-IV Axis I disorders	Both pure and comorbid GAD are associated with high impairment (that is, poor perceived health, activity reduction) and low quality of life Those with comorbid GAD seem to have the highest impairments Pure GAD respondents report more impairments than pure MDD respondents.	Few GAD participants

Excluded studies

Anderson, T., Watson, M. & Davidson, R. (2008) The use of cognitive behavioural therapy techniques for anxiety and depression in hospice patients: a feasibility study. *Palliative Medicine*, *22,* 814-821.

Baughan, D. M. (1995) Barriers to diagnosing anxiety disorders in family practice. *American Family Physician*, *52,* 447-450.

Berg, A. L., Sandahl, C. & Clinton, D. (2008) The relationship of treatment preferences and experiences to outcome in generalized anxiety disorder (GAD). *Psychology and Psychotherapy: Theory, Research and Practice*, *81,* 247-259.

Billhult, A. & Maatta, S. (2009) Light pressure massage for patients with severe anxiety. *Complementary Therapies in Clinical Practice*, *15,* 96-101.

Chung, K. F., Cheung, R. C. & Tam, J. W. (1999) Long-term benzodiazepine users: characteristics, views and effectiveness of benzodiazepine reduction information leaflet. *Singapore Medical Journal*, 40, 138-143.

Cooper, L. A., Brown, C., Vu., H. T., *et al.* (2000) Primary care patients' opinions regarding the importance of various aspects of care for depression. *General Hospital Psychiatry*, *22,* 163-173.

Funicane, A. & Mercer, S. W. (2006) An exploratory mixed methods study of the acceptability and effectiveness mindfulness -based cognitive therapy for patients with active depression and anxiety in primary care. *BMC Psychiatry*, *6,* 1-14.

Goodwin, R. & Anderson, R. M. (2002) Use of the behavioral model of health care use to identify correlates of use of treatment for panic attacks in the community. *Social Psychiatry and Psychiatric Epidemiology*, *37,* 212-219.

Halbreich, U., Alarcon, R. D., Calil, H., *et al.* (2007) Culturally-sensitive complaints of depressions and anxieties in women. *Journal of Affective Disorders*, *102,* 159-176.

Jorm, A. F., Medway, J., Christensen, H., *et al.* (2000) Public beliefs about the helpfulness of interventions for depression: effects on actions taken when experiencing anxiety and depression symptoms. *Australian and New Zealand Journal of Psychiatry*, *34,* 619-626.

Kumari, N. (2004) South Asian women in Britain: their mental health needs and views of services. *Journal of Mental Health Promotion*, *3,* 30-38.

Ladouceur, R., Dugas, M. J., Freeston, M. H., *et al.* (2000) Efficacy of a cognitive-behavioral treatment for generalized anxiety disorder: evaluation in a controlled clinical trial. *Journal of Consulting and Clinical Psychology, 68,* 957-964.

Lecrubier, Y., Dolberg, O. T., Anderson, H. F., *et al.* (2008) Qualitative changes in symptomatology as an effect of treatment with escitalopram in generalized anxiety disorder and major depressive disorder. *European Archives of Psychiatry and Clinical Neuroscience, 258,* 171/178.

Lefebre, J., Cyr, M., Lesage, A., *et al.* (2000) Unmet needs in the community: can existing services meet them? *Acta Psychiatrica Scandinavica*, *102,* 65-70.

Lehman, H. E. (1983) The clinician's view of anxiety and depression. *Journal of Clinical Psychiatry*, *44*, 3-7.

Levy, B., Sandahl, C. & Clinton, D. (2008) The relationship of treatment preferences and experiences to outcome in generalized anxiety disorder (GAD). *Psychology & Psychotherapy: Theory, Research & Practice*, *81*, 247-259.

MacGregor, A. D., Hayward, L., Peck, D. F., *et al.* (2009) Empirically grounded clinical interventions clients' and referrers' perceptions of computer-guided CBT (FearFighter). *Behavioural & Cognitive Psychotherapy*, *37*, 1-9.

McCall, L., Clarke, D. M. & Rowley, G. (2002) A questionnaire to measure general practitioners' attitudes to their role in the management of patients with depression and anxiety. *Australian Family Physician*, *31*, 299-303.

Mittal, D., Fortney, J. C., Pyne, J. M., *et al.* (2006) Impact of comorbid anxiety disorders on health-related quality of life among patients with major depressive disorder. *Psychiatric Services*, *57*, 1731-1737.

Olatunji, B. O., Cisler, J. M. & Tolin, D. F. (2007) Quality of life in the anxiety disorders: a meta-analytic review. *Clinical Psychology Review*, 27, 572-581.

Payne, R. H. (1990) Anxiety and the human family unit: a perspective. *Journal of the South Carolina Medical Association*, *86*, 507-510.

Reesal, R. T. (1998) What patient preparation techniques can be applied in a case of generalized anxiety disorder (GAD) to enhance compliance and improve outcome? *Journal of Psychiatry & Neuroscience*, 23, 328.

Rogers, A., Oliver, D., Bower, P. (2004) Peoples' understandings of a primary care-based mental health self-help clinic. *Patient Education and Counselling*, *53*, 41-46.

Roy-Byrne, P.P. & Wagner, A. (2004) Primary care perspectives on generalized anxiety disorder. *Journal of Clinical Psychiatry*, *6 5* (Suppl. 13), S20–S26.

Townsend, M., Hunt, K. & Wyke, S. (2003) Managing multiple morbidity in mid-life: a qualitative study of attitudes to drug use. *British Medical Journal*, 327, 837-840.