

Survey of West Australian anxiety support group participants' views on treatment processes and outcomes

ANDREW C. PAGE¹, ROGER JONES², & FAWZIA WILSON¹

¹*School of Psychology, University of Western Australia, Crawley, Western Australia, Australia, and* ²*Anxiety Self-Help Association, Nedlands, Western Australia, Australia*

Abstract

Members of an anxiety disorders self-help group were surveyed to provide a better understanding of the members of these organisations in Australia and thereby assist psychologists providing for their needs. Thirty-four members of the West Australian Anxiety Self-Help Association (ASHA) completed an open-ended survey asking about the type of professionals from which help was sought, the length of time before a diagnosis was made, the type of treatment received and the type of treatment that was preferred. Responses were then classified into categories for analysis. The membership of the Australian group was comparable to U.S. studies. Most members (88%) initially consulted a general practitioner about their anxiety disorder. It took 4.7 visits to health professionals over 3 years before a diagnosis of an anxiety disorder was made. The most commonly provided treatment was medication, with 91% being prescribed medication at some point, and one third were not happy with their current medication. Nearly all of the participants had tried "alternative" therapies, yet only 44% had tried cognitive behaviour therapies. In conclusion, understanding the needs and experiences of members of self-help organisations will permit greater integration with other mental health services.

Key words: *Anxiety disorders, pharmacotherapy, self-help.*

Anxiety disorders are common and disabling conditions. Summarising the Australian National Survey of Mental Health and Well-being, Andrews (2002) notes that due to their high prevalence, the number of disability days and medical consultations generated by anxiety were comparable to those of the affective disorders. Thus, it is important that available services are clearly identified and integrated into a coordinated health strategy. Many groups are involved in the delivery of services to people with anxiety disorders and there are many modes of service delivery. However, one area that has traditionally received less attention than others is the self-help sector (Bland, Newman, & Orn, 1997).

Consumers of services provided by the self-help sector are an important group to study for four reasons. First, many people use the self-help sector. Kessler, Zhao, Kouzis, Frank, Edlund, & Leaf (1999) reported that approximately one quarter of those who had accessed outpatient services for a psychological condition in the past 12 months had sought help in the self-help sector. The rate increased to one third

for people with an anxiety disorder. Second, people who use self-help services are frequent consumers of other services. For instance, two thirds of the people who seek assistance in the self-help sector are most likely to seek services from other sectors (general medicine, specialty mental health services, and other human services). Therefore self-help groups represent a useful avenue to channel people towards optimal treatment options. Third, there is evidence that among some disorders, attendance at support groups is associated with more favourable outcomes (e.g., Moos, Schaefer, Andrassy, & Moos, 2001). Thus, maximising these beneficial outcomes should be an important goal in addressing anxiety disorders within the population. Fourth, there are an increasing number of calls for formal health delivery systems, such as clinical psychology, to collaborate more effectively with the self-help sector, to the mutual benefit of both (Davison, Pennebaker, & Dickerson, 2000; Reissman & Banks, 2001).

To date few data have been collected regarding the composition of self-help and support groups for

sufferers of anxiety disorders. Segee et al. (1999) studied members of the two support groups affiliated with the Anxiety Disorders Association of America. They found that the largest proportions of sufferers reported panic disorder with agoraphobia and social phobia, as well as high lifetime rates of depression. Of the participants, 78% had consulted a psychiatrist, 63% a psychologist, and 56% their family doctor. Thus, although most had consulted appropriate services, the authors concluded that empirically validated treatments (Beck, Sokol, Clark, Berckick, Wright, 1992; Boerner & Moller, 1998; Nathan & Gorman, 1998; Otto et al., 2000; van der Linder, Stein, & van Balkom, 2000) for anxiety disorders were under-utilised relative to those that have not been thoroughly evaluated. For instance, less than one third of sufferers reported a trial of exposure to the feared situations. Given the absence of any Australian data it was decided to examine an Australian sample to determine the composition of an anxiety disorder support group, the types of treatments received, and the pathways to receive those treatments.

Method

Participants

Participants consisted of 34 members of the West Australian Anxiety Self-Help Association (ASHA). The sample consisted of people who reported that they were diagnosed with a primary diagnosis of panic disorder with and without agoraphobia (50%), social phobia (20.6%), generalised anxiety disorder (11.8%), obsessive–compulsive disorder (5.9%) and depression (2.9%).

Procedure

Participants completed an anonymous questionnaire consisting of 23 open-ended questions during one of the group's regular meetings. Questions covered the type of professionals from which help was sought, the length of time before a diagnosis was made, the type of treatment received and the type of treatment that was preferred. The open-ended responses were then classified into categories for analysis.

Results

Participants responded to questions about the number of visits they made to health professionals before being diagnosed with an anxiety disorder. The mean number of visits to health professionals before receiving a diagnosis of an anxiety disorder was 4.7 ($SD = 11.5$). On average it took participants 3 years and 2 months between their first visit to a

health professional and the time they were diagnosed with an anxiety disorder ($SD = 6$ years, 9 months).

Participants identified which type of health professionals they consulted. Of the respondents, 88% first consulted a general practitioner (GP) for help, while 9% first consulted a psychologist and 3%, a psychiatrist. In addition, 18% reported that they remained solely with their original health professional, while 79% reported that they sought additional assistance, and 3% of participants did not provide information on this issue.

Participants provided information on which types of treatment they received. Sixty-five per cent of participants described their initial treatment as medication, 15% as seeing a psychologist, 6% as relaxation, 6% as cognitive behavioural therapy (CBT), 3% as hypnosis, 3% as group therapy and 3% of participants reported some other initial therapy. Perhaps not unexpectedly, 91% of respondents were prescribed medication at some point during their treatment, but 50% stated that at some time they indicated to their health professionals that they would prefer treatment not involving medication. Of those who took medication, it was taken for an average of 3 years, 7 months ($SD = 7$ years, 10 months). Of those who took medication, 30% were not satisfied with their medication. In terms of treatments other than medication, 44% reported having tried CBT, 18% reported having tried relaxation, and 18% reported having tried hypnosis. In addition to these treatments, 88% of participants reported trying alternative therapies. Participants indicated which treatment they believed to be most effective. Of the sample, 41.2% considered medication to be one of the most effective treatments and 64.7% considered a nonpharmacological treatment to be one of the most effective treatments.

Discussion

The results of this study were intended to examine a variety of issues related to anxiety support groups in Australia. In comparison to the U.S. data, the rates of diagnoses of people attending the self-help group with panic disorder with and without agoraphobia (50%), social phobia (20.6%), generalised anxiety disorder (11.8%), and obsessive–compulsive disorder (5.9%) were similar to the proportions reported by Segee et al. (1999; panic disorder with agoraphobia, 46%; social phobia, 35%; generalised anxiety disorder, 6%; obsessive–compulsive disorder, 10%).

In terms of the pathways to care, the majority of people with anxiety disorders in this sample (88%) consulted their GP before consulting any other health professionals. Only a small proportion of people initially sought help from a psychologist (9%)

or a psychiatrist (3%). Thus, it is important that GPs continue to be trained in skills in assessing mental disorders and continue to be equipped in the front-line management of these disorders. There is a potential niche for clinical psychologists to work with GPs to ensure that they are providing effective services.

The length of time it took for participants to be diagnosed with an anxiety disorder was also examined. The average number of visits to health professionals before receiving a diagnosis of an anxiety disorder was 4.7, although this varied greatly. Additionally, the visits were spread over a long period of time. It took participants an average of 3 years and 2 months between their first visit to a health professional and the time they were diagnosed with an anxiety disorder. Again, there was considerable variability in the length of time it took for participants to be diagnosed. Although it is possible that some people were not aware that a diagnosis had been made, it is clear that improvement in the speed of diagnosis would be beneficial. However, it should also be borne in mind that to make a diagnosis of an anxiety disorder requires that certain conditions be ruled out (e.g., physical diseases, the effects of medication, nonprescription drugs, and alcohol). Therefore, it would be unreasonable to expect the minimum number of consultations before a diagnosis is made, to be one. If one assumes that a person might see a GP initially, be referred once to a specialist to rule out physical diseases, and then to a psychiatrist for diagnosis, the minimum number of consultations would be three. Hence, the reported value of just under five is not far above the reasonable minimum.

It is important that research examines not only what the most effective treatment for particular disorders is, but also what treatments are actually being accessed. It was clear from the results of this study that the most commonly provided treatment for anxiety disorders was medication, with 65% of participants in this study describing their initial treatment as medication and 91% prescribed medication at some point during their treatment. This finding is consistent with the Barlow (1994) observation that pharmacological interventions are being more widely administered than nonpharmacological interventions which, he argues, is due to economic reasons. It is interesting to note that 30% of those who took medication were not satisfied with their medication, and 64.7% considered a nonpharmacological treatment to be one of the most effective treatments. Thus, ongoing monitoring of satisfaction with medication is an important clinical activity and it is important to provide empirically validated nonpharmacological treatment strategies (Andrews et al., 2003).

Notwithstanding these points, the present investigation is a first step in understanding the place of support groups in health-care delivery. The present findings raise many research questions. First, it is clear that there are many unanswered issues regarding medication provision and compliance. For instance, it is important to assess the optimal sequence of empirically validated treatments for anxiety disorders, to ensure cost-effective service delivery. Second, nonpharmacological treatments were viewed to be effective, yet much of our psychological literature is based on efficacy studies conducted in controlled settings. The present clinical data are encouraging with respect to the effectiveness of these treatments outside clinical trials, but many issues remain unresolved. Further, the present data highlight a possible place for clinical psychologists to work alongside GPs in the provision of mental health services, thereby complementing the work conducted in these settings. However, much work is needed in this context. For instance, Lyn Littlefield (2003), Executive Director of the Australian Psychological Society (APS), has recently discussed the need for psychologists to take up just such a role and has commented that psychologists "have qualifications and experience in counselling, assessment and diagnosis of mental health disorders, and knowledge and skills in the delivery of cognitive-behavioural interventions" (p. 8). Curiously only one of these (i.e., assessment) appears in the APS course accreditation guidelines for undergraduate programs, although they appropriately appear in the postgraduate clinical psychology training guidelines. Thus, with the present methods of training in Australia, to what extent can we generalise from studies that typically use postgraduate-level clinicians, to possible outcomes with 4-year trained psychologists and how effective are the programs offered by people with different levels of membership? Third, support groups tend to represent a group of people who remain unwell despite treatment. We need to broaden our research agenda from focusing mainly on individuals with a given disorder, to identifying treatments that are particularly appropriate for treatment nonresponders or individuals prone to relapse (see Segal, Williams, & Teasdale, 2002 for a good example in depression).

In summary, sufferers of anxiety disorders who attended this support group were likely to have a long history of anxiety disorders treated with pharmacological and psychological treatments. Thus, these sufferers serve as a potent reminder that despite effective treatments being available for anxiety disorders (Nathan & Gorman, 1998; Page, 2002), a substantial number of individuals remain chronically affected by anxiety. Nearly all of the participants had tried alternative therapies, which is

hardly surprising if they had not received adequate therapeutic benefit from existing empirically validated treatments. Thus, it is important to continue to support these long-term sufferers of anxiety and search for treatments that are effective for those for whom the empirically validated treatments failed.

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