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Disseminating treatment for anxiety disorders step 2: Peer recommendations to seek help

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ABSTRACT

Despite the high prevalence of and significant psychological burden caused by anxiety disorders, as few as 25% of individuals with these disorders seek treatment, and treatment seeking by African-Americans is particularly uncommon. This purpose of the current study was to gather information regarding the public's recommendations regarding help-seeking for several anxiety disorders and to compare Caucasian and African-American participants on these variables. A community sample of 577 US adults completed a telephone survey that included vignettes portraying individuals with generalized anxiety disorder (GAD), social phobia/social anxiety disorder (SP/SAD), panic disorder (PD), and for comparison, depression. The sample was ½ Caucasian and ½ African American. Respondents were significantly less likely to recommend help-seeking for SP/SAD and GAD (78.8% and 84.3%, respectively) than for depression (90.9%). In contrast, recommendations to seek help for panic disorder were common (93.6%) and similar to rates found for depression. The most common recommendations were to seek help from a primary care physician (PCP). African Americans were more likely to recommend help-seeking for GAD than Caucasians. Findings suggested that respondents believed individuals with anxiety disorders should seek treatment. Given that respondents often recommended consulting a PCP, we recommend educating PCPs about anxiety disorders and empirically-supported interventions.

Anxiety disorders affect over 40 million Americans each year (Kessler, Chiu, Demler, & Walters, 2005) and are associated with elevated rates of unemployment, increased rates of suicidal ideation and attempts, and decreased quality of life (Greenberg et al., 1999; Sareen et al., 2005). It is estimated that the national economic burden of anxiety disorders is between $108.6 million and $615.4 million per year per million inhabitants (for a meta-analysis, see (Konnopka, Leichsenring, Leibing, & König, 2009) and that anxiety disorders account for approximately 1/3 of mental health care costs (Rice & Miller, 1998).

Cognitive-behavioral therapy (CBT) and selective serotonin reuptake inhibitors (SSRIs) are both efficacious treatments for anxiety disorders (Hofmann & Smits, 2008; Koen & Stein, 2011; Norton & Price, 2007; Ravindran & Stein, 2010). Across anxiety disorders, approximately 60–85% of individuals achieve substantial symptom reduction after 12–16 sessions of CBT, and these gains are typically maintained at 1-year follow-up (for a meta-analysis, see Hofmann & Smits, 2008). SSRIs have also been shown to frequently reduce anxiety symptoms (Koen & Stein, 2011).

Despite the availability of these effective treatments, up to 75% of individuals suffering from anxiety disorders never seek professional help (Roness, Mykletun, & Dahl, 2005). Further, data suggest that the rates of treatment-seeking are even lower among African Americans than among Caucasians (Alegría et al., 2002; Alvidrez, 1999; Gonzalez, Alegría, Prihoda, Copeland, & Zeber, 2011; Snowden & Yamada, 2005; Thompson et al., 2013). These rates are particularly concerning given that prevalence rates for anxiety disorders are approximately equal, or slightly higher, in African Americans as compared to Caucasians (for a review, see Neal & Turner, 1991).

Low rates of treatment seeking for anxiety disorders may be partially explained by a reticence to seek mental health services. However, rates of treatment seeking for depression are quite a bit higher than for anxiety disorders, so simple reticence to seek help is unlikely to be the sole explanation. Indeed, prior work has shown that up to 60% of individuals with depression disorders seek help (Roness et al., 2005), compared to only about 25% for anxiety

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disorders. Furthermore, a large majority of individuals with depression seek services within one year of symptom onset (Roness et al., 2005), whereas those with anxiety disorders have been found to delay help-seeking for up to 23 years after onset of their symptoms (Wang et al., 2005).

Low mental health literacy (MHL), an individual's knowledge and beliefs regarding mental illness and its treatment (Jorm, 2000; Jorm et al., 1997), may also impede seeking help for anxiety disorders. Specifically, a person's inability to recognize the symptoms of an anxiety disorder as a problem warranting intervention is likely to decrease help seeking. Beliefs that the symptoms will go away on their own or that beneficial treatments are not available will have similar effects. In addition, it is currently unknown whether levels of MHL are similar across the different anxiety disorders, given shared features/overlapping characteristics of anxiety disorders, or whether levels of MHL differ between anxiety disorders as a result of their unique features. Therefore, documenting current levels of MHL for anxiety disorders, and the extent to which MHL varies among them in members of the general public is important.

Prior work has shown that many individuals do not recognize symptoms of depression or schizophrenia when portrayed in a vignette (Gulliver, Griffiths, & Christensen, 2010; Schomerus et al., 2012). Initial data suggest that recognition of anxiety disorders may also be poor. Specifically, a recent study of college students found that even when presented with a list of possible conditions from which to choose, recognition of generalized anxiety disorder (GAD) and panic disorder (PD) were both lower than recognition of depression (Coles & Coleman, 2010). Given the highly educated nature of the sample, it is likely that these estimates provide a 'best-case' scenario and that members of the general community would show poorer recognition of anxiety disorders. More recently, two independent studies examining MHL for anxiety in a large community sample found that again, the lay public recognizes anxiety disorders at a lower rate than depression (Coles, Schubert, Heimberg, & Weiss, 2014; Furnham & Lousley, 2013). Together, these findings suggest that rates of treatment-seeking in the anxiety disorders may be associated with poor MHL, specifically low recognition of symptoms and need for professional help.

The current study builds on previous research by examining help-seeking recommendations for anxiety disorders in a large community sample and comparing recommendations provided by Caucasians and African-Americans. Specifically, this study had three primary aims. The first was to document rates of recommendations for treatment-seeking by the lay public for a variety of anxiety disorders. In aim two, we sought to examine whether rates of recommendations to seek treatment differed significantly among the various anxiety disorders. This would provide insight as to whether public education campaigns can group the anxiety disorders together or if addressing them separately may be more advantageous. The third aim was to examine potential differences between Caucasians' and African Americans' recommendations about treatment-seeking behaviors for anxiety disorders. Finally, exploratory analyses were conducted to assess whether age, sex, level of education, and personal history of mental health treatment predicted the likelihood of recommending any type of help for the three anxiety disorders. These factors were selected as they are basic variables that can impact help-seeking.

1. Method

1.1. Sampling method

The methods for this study were reviewed and approved by the Institutional Review Boards of both Binghamton University and Temple University. We sampled adult community members from across the United States by telephone survey. Telephone numbers of potential participants from throughout the US ($N = 10{,}546$) were obtained by the Institute for Survey Research (ISR) at Temple University from the national 48-State Landline Random Digit Dialing (RDD) sample provided by Genesys Sampling Systems. Demographic profiles of individuals in the RDD database were examined to generate a sample based on specific demographic factors of interest (e.g., race: African American, Caucasian). Of the initial 10,546 phone numbers, 4578 were nonworking numbers.

1.2. Measures

During the telephone calls, interviewers administered the Anxiety Knowledge Survey (AKS), a structured interview designed to assess MHL for anxiety disorders. The AKS presents participants with vignettes portraying anxiety disorders (SP/SAD, GAD, PD) and also a vignette of a patient with depression that is included for comparison. The AKS then presents participants with a series of open-ended response questions regarding the disorders and treatment. Frequencies of help-seeking recommendations for each anxiety disorder vignette (SP/SAD, GAD, PD) were calculated. For comparison, frequencies of help-seeking recommendations were also calculated for the depression vignette. Next, respondents were asked open-ended questions about potential sources of help for each anxiety disorder. Responses were coded into the following categories: (1) primary care physician (PCP), (2) psychologist, (3) psychiatrist, (4) nonspecific mental health providers (e.g., "therapist," "counselor," "mental health specialist," "social worker"), (5) clergy, and (6) other. Additional information regarding the AKS, including scripts of the vignettes, has been previously published (Coles et al., 2014).

1.3. Procedure

Calls were made by the ISR staff within five time blocks (10:00 AM–12:00 PM, 12:00–4:00 PM, 4:00–6:00 PM, 6:00–8:00 PM, 8:00–9:00 PM) between December 2010 and October 2011. Attempts to reach any phone number were discontinued following six unsuccessful calls. When a call was answered, the interview continued only if an individual age 18 or older was available. If the speaker declined participation, interviewers asked for another individual at the residence. Race information was obtained by the interviewers via self-report. Participants were paid $20 for participating in the interview.

1.4. Analytic plan

To test whether frequencies of recommendations to seek treatment differed significantly across the vignettes, Cochran's *Q*-tests were conducted comparing rates of recommending professional help-seeking, medication, or psychotherapy across anxiety disorder vignettes. Where overall significant differences were found, follow-up McNemar tests were performed to determine more specifically which anxiety disorders differed from one another on each index. Bonferroni corrections were applied to all McNemar tests to correct for multiple comparisons. Specifically, a critical alpha level of 0.008 was used (0.05/6) in comparisons among three anxiety disorder vignettes plus depression for all follow-up significance tests. Finally, binary logistic regressions were conducted for each of the anxiety disorders in order to examine moderators of help-seeking recommendations. Specifically, age, race, sex, level of education, and personal history of mental health treatment were entered as predictors.