Quality of and Patient Satisfaction With Primary Health Care for Anxiety Disorders

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Background: Most patients with anxiety disorders receive their care from primary care practitioners (PCPs). The purpose of this study was to evaluate quality of and patient satisfaction with primary health care for anxiety disorders.

Method: A survey was performed among 1,004 outpatients with anxiety disorders (diagnosed according to *DSM-IV*) referred by their PCPs from 17 primary care clinical settings (3 of which were university-affiliated) in 4 regions of the United States for participation in the Coordinated Anxiety Learning and Management (CALM) study, a therapeutic trial. Participating research institutions were the University of Washington at Seattle, the University of California at San Diego and Los Angeles, and the University of Arkansas for Medical Sciences at Little Rock. Enrollment took place between June 2006 and April 2008. Patients were contacted by telephone after enrollment to provide information about previous care received (during the 6 months prior to referral) and satisfaction with that care. Quality-of-care indicators were self-reported type, dose, and duration of antianxiety medication treatment and self-reported psychotherapy with cognitive-behavioral therapy (CBT) elements.

Results: A total of 576 patients (57.4%) had received an appropriate antianxiety medication in the previous 6 months, but only 289 patients (29.4% of 983 who answered this question) had received the medication at adequate dose for at least 2 months. A total of 465 patients (46.3%) had received some counseling with at least 1 element of CBT, but only 213 patients (21.2%) had received counseling with a strong (3+ elements) CBT focus. Overall, 416 patients (41.4%) had received quality pharmacotherapy or psychotherapy, and 81 patients (8.1%) had received both. Only 432 patients (44.8% of 964 who answered this question) were at least somewhat satisfied with their mental health care. Receipt of quality psychotherapy was the sole positive predictor (adjusted odds ratio = 2.71; 95% CI, 1.94–3.80; $P < .0005$) of satisfaction with mental health care for anxiety. Moreover, there was a dose-response relationship between the number of CBT elements consistently delivered and satisfaction with care (test for trend, $z = 4.06$, $P < .0005$).

Conclusions: Despite recognition of these patients' anxiety disorders and referral by their PCPs to an anxiety treatment study, fewer than half of the patients had in the prior 6 months received quality pharmacologic and/or psychosocial mental health care. Receipt of CBT-oriented, quality psychosocial (but not pharmacologic) care showed a strong dose-response relationship with satisfaction with mental health care.

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Anxiety disorders are common, costly, and debilitating.[1–6] Most patients with anxiety disorders seek and receive their mental health care in the primary health care setting,[7,8] but many disorders go unrecognized or are inadequately treated.[9–15] Whereas there is some evidence of improvements in rates of care for mental disorders in the United States in recent years,[16] including a marked increase in the proportion of affected individuals who seek help for anxiety disorders in the last 10 years,[17] the care received may still be less than optimal, especially when provided by nonspecialists.[18]

The purpose of the present study was to systematically look at satisfaction with care, and its relationship to types and quality of care received, among primary care patients with anxiety disorders. We utilized baseline (ie, referring to the 6 months prior to entry into the study) data from the Coordinated Anxiety Learning and Management (CALM) study (clinicaltrials.gov identifier: NCT00347269), the largest (N = 1,004) randomized controlled trial of collaborative care for anxiety disorders conducted to date.[19] Subjects in the CALM study were referred by their primary care practitioners (PCPs) for collaborative management of their anxiety disorder(s), indicating that there was some level of PCP recognition of the presence and seriousness of these conditions. Evaluation of the CALM data therefore provided us with a unique perspective on primary care anxiety management among patients who had been identified as having a problem with anxiety.

It was hypothesized that few patients at baseline (ie, prior to entering the CALM study) would report having received evidence-based psychotherapies or pharmacotherapies in the 6 months leading up to referral and that patient satisfaction with care received would mirror the quality of care that had been provided. Moreover, we expected to find racial and ethnic disparities in care received, given suggestions from other recent studies (mostly in depression) that Hispanics receive poorer-quality mental health care,[20,21] which may relate to preferences and beliefs about mental health treatments.[22] Other potential determinants of quality care (eg, gender, comorbidity) and satisfaction with care (eg, type of treatment provided) were also examined, with the aim

of identifying patient and/or treatment characteristics that might be suitable targets for future efforts at quality improvement.

METHOD

Sample

Data came from the baseline assessment (ie, retrospective assessment of the 6 months of care prior to beginning the intervention trial) of 1,004 primary care patients with panic disorder, social anxiety disorder, generalized anxiety disorder, or posttraumatic stress disorder enrolled between June 2006 and April 2008 in the CALM study.[19] Participating research institutions were the University of Washington (Seattle), the University of California at San Diego and Los Angeles, and the University of Arkansas for Medical Sciences (Little Rock). A total of 17 clinics (3 of which were University-affiliated) were purposely selected on the basis of a number of considerations, including provider interest, space availability, size and diversity of the patient population, and insurance mix. Primary care providers directly referred potential subjects. At some sites, a simple 5-question anxiety screener was used to facilitate identification of patients with anxiety disorders,[23] but information was not collected on whether or not the screener was used in advance of a referral.

Referred subjects met with a specially trained study clinician (usually a nurse or a social worker) to determine eligibility for CALM. An eligible subject had to be a patient at a participating clinic; be 18–75 years old; meet *DSM-IV* criteria for 1 or more of generalized anxiety disorder, panic disorder, social anxiety disorder, or posttraumatic stress disorder, based on the Mini-International Neuropsychiatric Interview[24]; and score at least 8 (moderate but clinically significant anxiety symptoms on a scale ranging from 0 to 20) on the Overall Anxiety Severity And Impairment Scale (OASIS).[25] Co-occurring major depressive disorder, expected to be common among anxious outpatients, was permitted.[26]

Exclusion criteria were few and were intended to exclude persons who would be unlikely to benefit (or be at increased risk) from the intervention. They included unstable medical conditions, marked cognitive impairment, active suicidal intent or plan, psychosis, or bipolar I disorder. Alcohol and/or marijuana abuse (but not dependence) were permitted, but other drug abuse was exclusionary. Subjects already receiving ongoing cognitive-behavioral therapy (CBT) (N = 7) were excluded. Finally, persons without routine access to a telephone, or who could not speak English or Spanish, were excluded. All subjects gave informed, written consent to participate in this study, which was approved by each institution's institutional review board.

Quality of Care and Satisfaction Indicators

Eligible subjects were contacted by telephone, usually within 1 week (median = 7 days, mean = 9.6 days, SD = 8.4 days) of enrollment, to provide information about previous care received and satisfaction with that care.

Respondents were asked about the care they had received during the previous 6 months (ie, prior to enrolling in the CALM study). These questions were modeled after those from our prior study[12] and were augmented with questions about satisfaction with care. Using patient reports of the name and daily dosage of each prescribed medication they had "taken several times a week for at least a month in the last 6 months," we derived separate indicators of (1) use of any psychotropic medication, (2) use of any antianxiety medication (ie, antidepressant or benzodiazepine—or buspirone for generalized anxiety disorder), (3) use of any antianxiety medication in an appropriate daily dosage for any duration, and (4) use of any antianxiety medication in appropriate daily dosage for at least 2 months. The latter was considered to meet the minimal criterion for "quality pharmacotherapy." Determination of what was an antianxiety medication and what was an appropriate daily dosage was made a priori by consensus of the psychiatrist investigators in the study on the basis of consensus statements and the investigators' collective knowledge of the evidence-based pharmacotherapy literature for anxiety.[27]

Using patient responses to questions about the content of outpatient visits with any provider in the prior 6 months, we derived separate indicators of (1) receipt of any psychotherapy; (2) receipt of psychotherapy with a CBT focus, ie, at least 3 of 6 possible CBT elements ([1] practice dealing with things that made you afraid, [2] teach you methods of relaxation, [3] help you look at your thoughts more realistically, [4] help you see mistakes in your thinking, [5] help you understand how your thoughts and feelings are related, and [6] ask you to do homework or practice between sessions) reported as covered at least "sometimes"; and (3) receipt of psychotherapy with an intensive CBT focus (ie, at least 3 of 6 possible CBT elements reported as covered at least "usually"). Receipt of psychotherapy with a CBT focus (rather than the more rigorous definition involving an *intensive* CBT focus) was considered to meet the minimal criterion for "quality psychotherapy."

Satisfaction with overall health care was assessed by asking respondents, "How dissatisfied or satisfied were you with the health care available to you in the past 6 months?" Satisfaction with mental health care was assessed by asking, "How dissatisfied or satisfied were you with the health care available to you *for personal or emotional problems* in the past 6 months?" Response choices for both questions were "very dissatisfied," "dissatisfied," "neither satisfied nor dissatisfied," "satisfied," or "very satisfied." The latter 2 responses were considered to reflect satisfaction with care for purposes of this report and the analyses described herein.

Statistical Analyses

We evaluated the kinds of care received, the main quality indicators, and the satisfaction indices across a number of sociodemographic and diagnostic factors to determine whether any of these were associated with a differential

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likelihood of receipt of care or satisfaction. These comparisons used multivariate logistic regression procedures wherein presence or absence of particular care types (or satisfaction with care) was the dependent variable, and the model included the following predictors: study site (dummy coded); age; sex; ethnicity; education; income (below the poverty line vs at or above it); chronic physical disease burden (consisting of a count of reported chronic physical illnesses) and, in some models, marital status (dummy coded as married or living together vs not) and presence or absence of major depressive disorder; and/or overall anxiety-associated impairment. These analyses enabled us to determine whether there were substantive differences in care received or satisfaction with care on the basis of presence or absence of particular sociodemographic or diagnostic characteristics.

For the multivariate logistic regression analyses, although a formal Bonferroni correction was not used, a priori we considered predictors significant at the $P \leq .005$ level to be statistically significant, and we interpreted the results in this statistical context. Adjusted odds ratios (AORs) for the predictors, derived from the multivariate logistic regression analyses, are presented, along with 95% confidence intervals (CIs).

RESULTS

Demographic and diagnostic characteristics of the patients are shown in Table 1. The sample was predominantly female, relatively well educated, middle-aged or younger (mean = 43.5 years, SD = 13.4 years [range, 18–75 years]), and ethnically diverse. Many patients had 1 or more chronic physical conditions (median = 2 [range, 0–11]). Generalized anxiety disorder was the most prevalent anxiety disorder, followed by panic disorder, social anxiety disorder, and posttraumatic stress disorder. The modal number of anxiety disorders per patient was 1, but approximately 60% of patients had 2 or more anxiety disorders. Nearly two-thirds of patients had comorbid major depressive disorder.

Table 1. Demographic and Diagnostic Characteristics of the Study Sample (N = 1,004)

Characteristic	N (%)
Sex	
Male	290 (28.9)
Female	714 (71.1)
Age, y	
Over 50	317 (31.6)
50 or younger	687 (68.4)
Education[a]	
Some college or more	782 (78.0)
Less than college	220 (22.0)
Married or living together, yes	539 (53.7)
Race	
White (non-Hispanic)	568 (56.6)
Hispanic	196 (19.5)
African American	116 (11.6)
Other or unspecified	124 (12.4)
Chronic illnesses	
2 or more	422 (42.0)
1 or none	582 (58.0)
Generalized anxiety disorder, yes	756 (75.3)
Panic disorder, yes	475 (47.3)
Social anxiety disorder, yes	405 (40.3)
Posttraumatic stress disorder, yes	181 (18.0)
Number of anxiety disorders	
1	421 (41.9)
2	387 (38.5)
3	162 (16.1)
4	34 (3.4)
Comorbid major depressive disorder, yes	648 (64.5)

[a]Missing data for 2 people.

Provider Visits for Mental Health Problems

A total of 992 patients (98.8%) reported that they had at least 1 visit with their PCP in the previous 6 months during which they discussed personal or emotional problems; the modal number of such visits was 2 (range, 0–30 visits). A total of 181 patients (18.0%) had at least 1 visit with a psychiatrist (range, 0–40 visits), and 351 patients (35.0%) had a least 1 visit with a "psychologist, social worker, psychotherapist, psychiatric nurse, or other counselor or therapist" (range, 0–45 visits). The next section describes the types and quality of care received by the patient, integrated across any and all providers.

Types and Quality of Care Received

A total of 635 patients (63.3%) reported that they had been taking a prescription medication to help with anxiety, depression, or sleep in the previous 6 months: 462 (46.0%) had taken an antidepressant, 252 (25.1%) had taken a benzodiazepine, and 48 (4.8%) had taken another type of prescription antianxiety medication (eg, buspirone).

A total of 576 patients (57.4%) had taken an appropriate antianxiety medication in the previous 6 months, but only 460 patients (46.3% of 994 who answered this question) had taken an appropriate antianxiety medication for at least 2 months, and only 289 patients (29.4% of 983 who answered this question) had taken an appropriate antianxiety medication for at least 2 months at an adequate dose (ie, our indicator of quality pharmacotherapy) (Table 2).

A total of 929 patients (92.6% of 1,003 who answered this question) reported receiving some counseling from their PCP or a therapist (eg, psychiatrist, psychologist, social worker) in the previous 6 months: 465 patients (46.3%) reported that their counseling included at least 1 element consistent with CBT principles at least some of the time; 213 patients (21.2%) reported that 3 or more elements consistent with CBT were included at least some of the time (ie, our indicator of quality psychotherapy); and 45 patients (4.5%) reported that 3 or more CBT elements were included consistently (ie, we considered this to be an indicator of care that exceeded the minimal requirement for quality psychotherapy) (Table 2).

Using either the provision of counseling with 3 or more CBT elements at least some of the time *or* appropriate pharmacotherapy at minimally adequate dose and duration as indicative of quality care, 416 patients (41.4%) had received care in the previous 6 months that met this criterion; 81 patients (8.1%) had received care that met the quality criteria for *both* pharmacotherapy and psychotherapy.

Table 2. Indicators of Quality of Care for Anxiety During the Previous 6 Months

Indicator	Any Anxiety Disorder (N = 1,004), %	Panic Disorder (n = 475), %	Social Anxiety Disorder (n = 405), %	Posttraumatic Stress Disorder (n = 181), %	Generalized Anxiety Disorder (n = 756), %
Any psychotropic	63.3	66.7	65.4	62.4	61.9
Any appropriate antianxiety medication	57.4	60.2	59.3	57.5	56.5
Any appropriate antianxiety medication for 2+ months	46.3	47.4	44.5	48.0	46.3
Any appropriate antianxiety medication at adequate dose for 2+ months[a]	29.4	28.1	30.2	34.4	29.3
Any counseling	92.6	94.1	93.9	92.2	93.5
Counseling with at least 1 CBT element	46.3	50.1	46.2	50.8	47.9
Counseling with 3+ CBT elements[b]	21.2	22.1	21.5	23.8	22.8
Counseling with 3+ CBT elements delivered consistently	4.5	4.6	4.0	7.2	4.4
Counseling with 3+ CBT elements, or appropriate antianxiety medication at adequate dose for 2+ months[c]	41.4	41.8	43.7	50.6	43.8

[a]Indicator of quality pharmacotherapy for anxiety.
[b]Indicator of quality psychotherapy for anxiety.
[c]Indicator of overall quality care for anxiety.
Abbreviation: CBT = cognitive-behavioral therapy.

Table 3. Factors Associated With Satisfaction With Mental Health Care Received[a]

Factor	Adjusted Odds Ratio	95% CI	*P* Value
Female sex	1.34	0.99–1.82	.060
Age	0.99	0.98–1.00	.185
Married or living together	0.83	0.62–1.11	.203
College education	0.50	0.36–0.71	<.001
Hispanic ethnicity	1.04	0.73–1.50	.816
Two or more chronic illnesses	0.92	0.68–1.23	.577
Comorbid depression	1.18	0.86–1.61	.309
Sheehan Disability Scale	0.96	0.94–0.98	<.001
Quality pharmacotherapy	1.00	0.74–1.35	.979
Quality psychotherapy	2.71	1.94–3.80	<.001

[a]Age and Sheehan disability are continuous measures, whereas all the others are dichotomous, so both of these show the odds of satisfaction per unit of measure (ie, per year of age or per unit of disability).

Factors Associated With Types and Quality of Care Received

Patients who saw a psychiatrist at least once in the previous 6 months were more likely to have received an anxiolytic (AOR = 1.92; 95% CI, 1.34–2.75; *P* < .0005). There were no significant differences in likelihood of receiving an anxiolytic medication on the basis of age, sex, education, ethnicity, chronic physical disease burden, poverty, presence of comorbid major depressive disorder, number or type of anxiety disorders, or study site. The only other predictor of receipt of an anxiolytic medication was extent of anxiety-related disability: for each 1-point increase on the Sheehan Disability Scale[28] (higher scores indicate greater disability), the odds of receiving anxiolytic medication increased by 4% (AOR = 1.04; 95% CI, 1.02–1.07; *P* < .0005).

Patients who saw a psychiatrist at least once in the previous 6 months were more likely to have received quality pharmacotherapy for their anxiety (AOR = 2.21; 95% CI, 1.55–3.16; *P* < .0005). Extent of disability as measured by the Sheehan Disability Scale was also associated with increased odds of receiving quality pharmacotherapy for anxiety (AOR = 1.04; 95% CI, 1.02–1.06; *P* = .001), suggesting that physicians were cognizant of the need to treat such patients. Hispanics were about half as likely as non-Hispanics to be recipients of quality pharmacotherapy (AOR = 0.53; 95% CI, 0.34–0.80; *P* = .003).

Patients who saw a psychologist or other nonmedical therapist in the previous 6 months were more likely to have received psychotherapy with at least 1 CBT element (AOR = 2.67; 95% CI, 2.02–3.51; *P* < .0005), as were patients with some college education (AOR = 1.66; 95% CI, 1.19–2.31; *P* = .003).

The only factor significantly associated with a differential likelihood of receiving quality psychotherapy (ie, 3 or more CBT elements delivered at least some of the time) for anxiety was having seen a psychologist or other nonmedical therapist in the previous 6 months (AOR = 4.37; 95% CI, 3.16–6.06; *P* < .0005).

Satisfaction With Care Received

Two-thirds of the patients (66.6%; N = 667) reported being satisfied or very satisfied with their overall health care. Only 432 patients (44.8% of 964 who answered this question) reported being satisfied or very satisfied with their mental health care.

Factors associated with satisfaction with mental health care received. Results of simultaneous multivariate logistic regression analysis of factors associated with satisfaction with mental health care are shown in Table 3. Receipt of quality pharmacotherapy was not significantly associated with satisfaction with mental health care that had been received in the previous 6 months. Neither was age, sex, ethnicity, being married or living together, chronic physical illness burden, or presence of comorbid major depressive disorder. Higher education (some college or more) and greater anxiety severity (as indicated by more anxiety-related disability on the Sheehan Disability Scale) were significantly associated with lower likelihood of being satisfied or very satisfied with mental health care that had been received.

The only positive predictor of satisfaction with mental health care was receipt of quality psychotherapy. Moreover, there was a dose-response relationship between "dose" of CBT and likelihood of satisfaction with mental health care: If at least 1 CBT element was delivered at least some of the

time, the odds of satisfaction were about twice as high as when no CBT elements were delivered (AOR = 1.94; 95% CI, 1.47–2.56; $P < .0005$). If 3 or more CBT elements were delivered at least some of the time (ie, our indicator of quality psychotherapy, shown in Table 3), the odds of satisfaction were higher (AOR = 2.71; 95% CI, 1.94–3.80; $P < .0005$), and, if 3 or more CBT elements were delivered consistently, the odds of satisfaction were higher still (AOR = 5.25; 95% CI, 2.51–10.98; $P < .0005$); test for trend, $z = 4.06$, $P < .0005$). These associations were *not* attenuated by the inclusion in the models of number (or presence or absence) of mental health visits to a PCP, psychiatrist, and/or psychologist (data not shown).

DISCUSSION

Most individuals with anxiety disorders receive their mental health care from primary care providers.[7,17] Many patients seen in primary care receive little or no treatment for their anxiety disorders.[18] When care is received, it has often been noted to be suboptimal in terms of quality.[12,29] Whereas an outpatient trend toward increased use of antidepressants and decreased use of psychotherapy for anxiety disorders was noted in the late 1990s,[30] it is uncertain to what extent there has been an overall trend toward quality improvement.

The present study suggests that there remains a lot of room for improvement in the quality of care delivered to primary care outpatients with anxiety disorders. This study is neither a nationally representative sample, nor a longitudinal study, so direct comparison to other studies or to earlier times is not possible. However, the data show that less than half of outpatients in this relatively large sample (N = 1,004) received guideline-concordant care. This observation is particularly interesting (and worrisome) in that all patients had been recognized by their PCP as having a problem with anxiety by virtue of their referral to this study. In particular, although nearly one-third of patients received quality pharmacotherapy, only approximately one-fifth received quality psychotherapy. These data are consistent with prior studies that have pointed to particularly low rates of psychotherapy utilization and/or quality among primary care outpatients with anxiety disorders.[12,18,30] But they also extend the findings by suggesting that awareness by the PCP of a current anxiety problem (although not necessarily its precise diagnostic type or severity) seems to have had little impact on quality of care (although more disabled patients were more likely to get better pharmacotherapy). The inference is that identification alone (ie, making PCPs aware of their patient's diagnosis and/or need for anxiety treatment) is unlikely to have a positive impact on quality of care for anxiety disorders.

Meta-analysis of knowledge transfer methods for improvement of primary care anxiety treatment shows that conventional educational strategies (eg, conferences or passive dissemination of guidelines) have minimal impact on clinical practice and patient outcomes, whereas collaborative care approaches are much more promising.[31] Our data point to several potential targets for improving such care in the future.

First, we noted the possible existence of particular sociodemographic disparities in the provision of quality care. Hispanic patients were less likely than other ethnic groups to receive quality pharmacotherapy. It is difficult to be certain about the origins of this disparity, which may, at least in part, reflect reduced preference for pharmacotherapy (eg, with antidepressants) among certain minority groups.[22] Although rates of antianxiety medication use were not lower among Hispanic patients, the lower rate of quality antianxiety pharmacotherapy may nonetheless reflect more subtle attitudinal factors consistent with lower preference for pharmacotherapy that could influence patient adherence (eg, reluctance to increase dosage or to stay on the medication for adequate duration). This is an area that clearly requires more study, especially in light of other recent reports of ethnic disparities in mental health care for anxious and depressed outpatients.[20,21]

Second, we noted that persons with less education were significantly less likely to receive psychotherapy. Although this did not carry over to a significantly lower likelihood of receiving quality psychotherapy (perhaps because these rates were so low overall that a difference could not be detected), the fact that less-educated persons were less likely to receive psychotherapy is a disparity that must be addressed in future research.

Third, we found higher rates of quality pharmacotherapy and psychotherapy when patients received some or all of their mental health care in specialty settings (eg, seen by psychiatrists or psychologists, respectively). These observations underscore the notion that it is reasonable to expect that specialists can often (although not always)[18] provide more intensive or higher quality care than can reasonably be provided by PCPs, who must juggle many medical priorities in each time-limited visit. The fact that mental health specialists can bring added value does strongly suggest, however, that their integration into the primary health care equation cannot be overlooked. The challenge is how to most efficiently and cost-effectively incorporate their expertise.

The most striking finding to emerge from this study pertained to satisfaction with care and its relationship to the provision of quality care. Patients who received quality psychotherapy (defined on the basis of the inclusion of elements consistent with evidence-based CBT for anxiety disorders) were the most satisfied with their mental health care. In fact, this was the only positive predictor of satisfaction. Moreover, a dose-response relationship was evident: the more CBT elements provided, and the greater the consistency of their delivery, the greater was the satisfaction with care. This relationship was not explained by the number of visits. On the contrary, it was the specific content of the visits, and not the number of visits, that tracked with satisfaction. Interestingly, the delivery of quality pharmacotherapy was not associated with satisfaction with care.

How are these findings pertaining to satisfaction to be interpreted? It seems readily apparent that patients both

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detect and value psychotherapies that target their principal complaint(s) in a direct fashion. Although it is improbable that many patients in this study were aware of the evidence in favor of CBT as a treatment for anxiety disorders, they nonetheless reported satisfaction with therapies that included CBT components, especially when these components were provided consistently throughout the course of therapy. These data are consistent with the expressed treatment preferences of primary care patients with anxiety disorders for psychotherapies,[32] which may be an additional reason to increase their availability. In contrast, patients did not seem to value quality pharmacotherapy in the same way, possibly—at least in part—because it would have been difficult for them to know whether or not the medication provided was at optimal dose or duration.

This study has a number of limitations that influence its interpretation. As noted earlier in this discussion, although the study included a large, diverse sample of anxious outpatients in 17 clinical settings spread across 4 regions of the United States, the sample was purposely selected and cannot be expected to be representative of US outpatients with anxiety disorders. The fact that patients were referred by their PCPs suggests that this group may have been biased toward being more difficult to treat, and the generalizability of our findings should be considered in that context. Although this fact can be viewed as a limitation, this kind of sample is probably more relevant from a public health point of view since the spontaneous remitters or rapid responders are unlikely to occupy clinician time and service delivery resources.

Our methods for assessing quality of pharmacotherapy and psychotherapy, although built upon our prior work in this area,[12] are still subject to possible response biases and to errors in reporting. In future work, it would be useful to have available objective measures of quality (eg, from direct review of medical records) that do not rely on patient self-reporting. It could also be argued that our definition of quality psychotherapy was either too narrow or too broad. It is clear from our data that the mere act of seeing a therapist did not increase satisfaction with care. Although we based our quality indicators on the reported inclusion of particular CBT elements in therapy, critics might argue that other, more subtle (eg, sense by the patient that the therapist was empathic) or less CBT-specific indicators of quality—taking into consideration the possibility that other forms of psychotherapy may be useful for anxiety disorders[33]—should also have been included. Accordingly, additional research is needed to map out the various means by which quality and satisfaction can be increased.

Regardless of the explanation for the finding that CBT provision was strongly associated with satisfaction, the finding is robust and leads to the obvious recommendation that CBT should be included more often if the aim is to improve satisfaction with outpatient care for anxiety disorders. This recommendation would be even stronger if it is shown that the inclusion of CBT leads not only to greater satisfaction, but also to improved symptomatic and functional outcomes. We are hopeful that future results from the CALM study, which included the option of a brief, computer-assisted form of CBT for primary care outpatients with anxiety disorders,[19,27,34] will further inform this recommendation.

ADDENDUM

After this manuscript was accepted for publication, the main outcomes report for the CALM study was published. The reference is as follows: Roy-Byrne P, Craske MG, Sullivan G, et al. Delivery of evidence-based treatment for multiple anxiety disorders in primary care: a randomized controlled trial. *JAMA*. 2010;303(19):1921–1928.

Drug names: buspirone (BuSpar and others).

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Potential conflicts of interest: **Drs Stein**, **Roy-Byrne**, and **Bystritsky** report consulting fees and/or research grants in the past 3 years from several pharmaceutical companies that make antidepressants and/or anxiolytic medications; details are available upon request. None of these associations are felt by these authors to represent competing interest with reference to the present study. **Drs Craske**, **Campbell-Sills**, **Lang**, **Golinelli**, **Rose**, **Sullivan**, and **Sherbourne** report no competing interests.

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