**Beyond efficacy: How acceptable do people with symptoms of common mental health disorders find self-help interventions?**

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Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy

June 2015

**Acknowledgments**

First and foremost, I would like to thank the Howard Morton and Les Robinson Trusts for jointly funding this PhD. Great thanks and gratitude also to my supervisors, Dr Thomas Webb, Professor Paschal Sheeran and Professor Graham Turpin. Described to me as the “dream team” during my first week, they have certainly lived up to the hype! Their continuous support, patience, motivation, enthusiasm, and immense knowledge have been invaluable. My former colleagues and mentors, Dr Ann Walker and Dr Manny Madriaga also deserve huge thanks, for their continued support, advice and inspiration.

Christopher Peterson, one of the founders of the field of positive psychology, summed up his research on happiness in three words: “Other people matter” (2010, p. 16). Without the people listed below, I simply would not be the person I am today, and I would not be where I am today. I am forever grateful.

My loving parents, Maggie and John. Who taught me that with hard work and determination, anything is possible. Without your love and support over the years I would never have been able to aim so high and achieve so much. My wonderful sister, Marie. Her role as senior proofreader for my BSc, MSc and now a PhD has been a godsend to me. She now knows far more about psychology than she ever intended to! My dear friends, with special thanks to Kathryn, Kelly, Davina, Jessica, Louise and my sister Marie, too. You are all an inspiration to me and I am proud to call such talented women my friends. I also want to thank the Murdoch/Green family; I couldn’t ask for a better ‘second’ family. Finally and most importantly, my fiancé Ian. You have been my rock throughout this whole process, through the ups and the downs and the adventures of life you have always been there, always believed in me and always been proud of me. I absolutely, unquestionably, could not have done this without you.

**Summary**

Much literature points to the clinical-effectiveness of self-help for common mental health disorders such as depression and anxiety, yet we know relatively little about how self-help is perceived or how it is used, and whether these issues matter when it comes to how effective self-help is. Study 1presents an analogue study that explores how acceptable self-help treatments for depression are and how severe any perceived side effects are deemed to be. Self-help treatment options, as well as psychotherapy and antidepressant medications were ranked in order of preference. Guided self-help was rated as acceptable for treating depression as psychotherapy. Unguided interventions were rated as less acceptable than psychotherapy or guided self-help. Psychotherapy and guided self-help were rated as the two most preferred treatment options.

Study 2 presents a systematic review of rates of engagement with self-help interventions for depression and anxiety in randomised controlled trials, finding, for example, that on average around 66% of the self-help content was adhered to.

Study 3 presents an intervention study designed to test an established self-help program in an unguided setting for the first time. Study 3 also seeks to assess whether attitudes and engagement with self-help impact upon efficacy, and whether interventions can be augmented to improve engagement rates and efficacy. Five conditions were examined; standard self-help (received either immediately or after an eight week waiting period), augmented self-help (again received either immediately or after an eight week waiting period) and no-treatment control. Study 3 found that although the self-help intervention was effective in an unguided context, the control group also experienced a decrease in depression symptomology. Attitudes towards the self-help intervention and engagement rates during the intervention did not impact upon efficacy. Augmenting the intervention did not lead to improved rates of engagement or efficacy. However, both experimental groups had very high levels of engagement (over 80%), perhaps limiting the impact of augmentation.

Findings from these studies can be used to inform future research and practice.

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**Chapter 1: Introduction**

**1.1 Depression**

Depression is an extremely common and prevalent mental health condition, with the World Health Organisation (WHO) reporting 121 million sufferers worldwide (WHO, 2011). NICE (2011a) estimate that up to 10% of the UK population will experience depression during the course of their lives. For the year 2000, the WHO also concluded that the impact of depression on an individual’s level of functioning was 50% more serious than angina, asthma, diabetes and arthritis (Moussavi et al., 2007). Rates of depression have risen over the past century, especially in recent decades, although it is not clear the role detection and improved diagnostic tools play in this increase. SSentif (2012) analysed NHS data regarding depression rates between 2008/09 and 2010/11, finding that depression rates rose across England, with some Primary Care Trusts (PCTs) reporting increases of more than 40% in the number of people seeking treatment in the last three years. Research also suggests that younger cohorts are exhibiting an earlier age-of-onset and experiencing an increased lifetime risk (Hidaka, 2012). Brown (2001) predicts that by 2020 depression will be the primary cause of disease burden in the developed world.

Depression statistics are often reported alongside anxiety disorders under the heading “common mental health disorders” (e.g. NICE, 2011a; McManus, Meltzer, Brugha, Bebbington, & Jenkins, 2009) due to high occurrence of comorbidity (e.g. Lamers et al., 2011). For example it is reported that just over 16% of the adult population in the UK suffer from depression and/or anxiety disorders at any one time (McManus et al., 2009). In addition, the Psychiatric Morbidity Survey found that in 2000, 40% of all disability in the UK was caused by either depression or anxiety (Singleton, Bumpstead, O‘Brien, Lee & Meltzer, 2001). It can be problematic when statistics are not further broken down and reported for depression and anxiety separately. For example, in Singleton et al’s. (2001) study, it is unclear the percentage of disability that is caused by depression alone. As a result, we do not know which mental health disorder accounts for the largest variance in disability. If one wanted to develop policies designed to reduce the level of disability cause by common mental health problems, the research cited above would not indicate whether depression or anxiety should be targeted. For further information on anxiety see chapter 3.

**1.1.1 Symptoms and experiences of depression.** The fifth edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-5; American Psychiatric Association, 2013) characterises depression by a number of symptoms, such as a depressed mood (e.g. feeling sad, empty or tearful), a markedly diminished interest or pleasure in activities that were previously enjoyable, weight loss/gain or an increase/decrease in appetite, observable psychomotor agitation, fatigue or loss of energy, changes to sleep patterns (e.g. insomnia or hypersomnia), feelings of worthlessness or excessive/inappropriate guilt, an inability to concentrate or indecisiveness and recurrent thoughts of death or suicide. For a diagnosis of depression to be made a depressed mood or a loss of interest in activities that were once enjoyable must be present for two weeks and at least five of the above symptoms must be present nearly every day. These symptoms must signify a change from the individual’s usual mood or personality and must impair their ability to function. This method of diagnosing depression represents a categorical approach (e.g. the patient either has depression or they do not), however the need for a continuous or dimensional approach to diagnosing depression is much debated within the literature (e.g. Andrews et al., 2007; Whitney, Steiner, Lysaker, Estes & Hanna, 2010). As a result, the DSM-5 (American Psychiatric Association, 2013) also classify an episode of depression using three levels of severity; mild, moderate and severe. The symptoms of depression listed above are subdivided into either type A (e.g. a depressed mood, a loss of interest in activities that were usually enjoyable, and a reduction in energy or a reduction in activities that were previously undertaken) or Type B (e.g. a decrease in self-esteem and/or confidence, feelings of unnecessary guilt and/or unworthiness, pessimistic thoughts, changes in sleep or appetite and finally thoughts of self-harm). For an episode of depression to be classed as mild, one type A symptom and one or two type B symptoms must be present. A moderate episode of depression would have one type A symptom and two or three type B symptoms. Finally, a severe episode of depression would have all three type A symptoms plus more than three type B symptoms.

Depression is a serious condition, yet it can sometimes be difficult for an outsider to understand how those experiencing depression are feeling. Below are two descriptions of how it feels to be depressed. Stewart (2004, p. 7), writing for Mind, the mental health charity, says that depression “is like hell on earth, it's dark, lonely and very selfish. The feeling of not wanting to live (but not wanting to die)... I can't get going and feel like I can't do anything” While Brampton (2008, p 57 - 58) describes her battle with depression as follows, “I felt constantly low and depressed… I couldn’t throw off the mood I have developed, a low feeling that seems always to envelop me like a cold, grey blanket… the crying grows worse and by now I am scarcely sleeping. I have started to cry in unexpected places, at inconvenient times. One day, I cried at work. I was mortified. I never cry at work. I decided that I must be exhausted, and take a week off. It is the end of June. I spent the days walking around the streets, wearing dark glasses, with tears streaming down my face. I walked for hours every day.” These personal accounts of how it feels to be depressed speak volumes about how debilitating, isolating and terrifying depression can be.

**1.1.2 The wider effects of depression.** Depression not only severely affects the quality of life of the victim, their families and loved ones, but it also has a wider impact on society, indeed in The Depression Report, Layard et al. (2006) described depression as one of Britain’s biggest social problems (alongside anxiety disorders – see section 3.1).

The direct costs of depression in the UK are the costs incurred by the National Health Service (NHS), including the cost of prescribing antidepressant medications and providing psychotherapy. In 2010/11, The Centre For Economic Performance (2012) reported that of the £14 billion spent by the NHS on mental illness (including schizophrenia, dementia, depression, anxiety, addiction etc.) £0.2 billion was spent providing psychotherapy for depression and anxiety disorders (through the Improving Access to Psychological Therapies (IAPT) program - see 1.2). The National Prescribing Centre (2010) also reported that the NHS spent around £227 million in 2009 on antidepressant prescriptions. Research shows that these costs have increased over time. For example, Jönsson and Bebbington (1994) calculated the direct treatment costs of depression at £222 million, while Thomas and Morris (2003) later calculated the same costs at £370 million, showing a substantial increase over time. In addition to the direct cost of depression, research has also shown that patients experiencing other medical conditions, who are also depressed, have medical care expenses that are 50% higher than patients with the same medical conditions minus the depression (Katon, 2003).

The indirect costs of depression are those that occur as a result of the person experiencing the depression being unable to function, including the cost of lost working days, or a temporary or permanent loss of income. Thomas and Morris (2003) found that in 2000 there were nearly 110 million working days lost as a result of depression, with £8 billion of lost earnings. In terms of deaths, 2507 suicides in the year 2000 were related to depression and 108 deaths were due to poisoning caused by antidepressant medications. The loss of future lifetime earnings associated with these premature deaths was calculated at £562 million (Thomas & Morris, 2003). Rates of suicide have risen over the past nine years, with The Samaritans Suicide Statistics Report (2013) showing that suicide rates for males in 2011 were at there highest since 2002. Suicide rates for females have also significantly increased since 2007. Although not all suicides are caused by depression, Moscicki (2001) report that 90% of people who die by suicide have depression or other mental disorders (such as anxiety disorders – see section 3.1).

Thomas and Morris (2003) calculated the overall cost of depression in the year 2000 at over £9 billion. They caution that this is likely to be an underestimation rather than an overestimation and is also likely to have substantially increased year on year over the past ten years, and is likely to continue rising. A review was also conducted by McCrone, Dhanasiri, Patel, Knapp and Lawton-Smithto (2008) to estimate mental health expenditure, including depression, in England for the next 20 years (to 2026). The number of people with depression in England was projected to rise by 17% to 1.45 million by 2026. Based on these figures, the authors estimated the total costs (both direct and indirect) for depression by 2026 to be £3 billion.

**1.1.3 Overview.** To reiterate, depression is a common and prevalent condition that is characterised by severe negative and distressing symptoms. Depression has a substantial negative impact upon those experiencing the disorder, their family and loved ones, our society and the economy. As a result, the effective management of depression (and other common mental health disorders such as anxiety – see chapter 3) in the UK is seen as a priority by the Department of Health (2013) who recently announced £400 million of funding between 2011 and 2015 to give more people access to psychological therapies, and £16 million of funding over four years for a campaign against mental health stigma and discrimination.

**1.2 Treatment as Usual**

In the UK, the NHS currently runs the IAPT program, which was piloted in 2007 and rolled out nationwide from 2008. Prior to the implementation of IAPT in 2008, access to psychological therapies for depression was poor. Patients presenting to their general practitioner (GP) were all too frequently offered antidepressant medication only, due to the lack of lack of trained therapists. When psychological therapy was offered there was often a long waiting list (e.g. over twelve months in some areas) (Layard et al., 2006), a lack of available therapy options (Layard et al., 2006; Turpin, Richards, Hope & Duffy, 2008), and the National Institute for Health and Clinical Excellence (NICE) found that 20% of patients diagnosed with depression were still unwell two years after diagnosis (NICE, 2004).

The principal aim of IAPT was to help PCTs implement NICE guidelines, which stated that adults experiencing depression should be treated with evidence-based psychological therapies in the form of a stepped-care model (NICE, 2009). IAPT sought to improve the standard of care received by patients experiencing depression, as at the time of implementation (2008) only a quarter of the 6 million people in the UK experiencing depression were receiving psychological treatment (Layard et al., 2006). The low uptake of treatment for depression had a debilitating effect on society and the economy (see 1.1.2), and as a result the government sought to improve this situation through the funding of IAPT, which has received a total of £309 million from its implementation in 2008 until 2010/11 (Department of Health, 2012). Layard, Clark, Knapp and Mayraz (2007) conducted a cost-benefit analysis of the IAPT program prior to its implementation, estimating that by 2016, the IAPT program could have reduced the number of people on incapacity benefits by 160,000, which would save £1.4 billion a year.

Since 2008, the IAPT program has delivered significant improvements with regards to access to some of the psychological interventions recommended by NICE. However, there is evidence that the demand for the stepped-care interventions recommended by NICE continue to outstrip capacity in many areas of the UK. In 2011, antidepressant medications were the most frequently prescribed course of treatment for depression and anxiety disorders (see section 3.1 for a discussion of anxiety disorders) in primary care, simply because the availability of psychotherapy was still limited (NICE, 2011b).

The principle aim of IAPT was to support the implementation of a stepped-care approach to depression treatment that was structured and organised. Figure 1 outlines the stepped-care model, where the patient receives the least intrusive intervention first; if the patient does not benefit from the intervention initially offered, or declines the intervention, then they are offered an appropriate intervention from the next step (NICE, 2009).

**Figure 1: The Stepped-Care Model**

Step Who is responsible for care? Depression severity Treatment

Step 1 GP or practice nurse Recognition Assessment

Step 2 Primary care team, primary care graduate Mild depression Watchful waiting, guided self-help, computerised mental health worker (GMHW) CBT, exercise, brief psychological interventions

Step 3 Primary care team, primary care GMHW Moderate or Medication, psychological interventions, social support

& gateway nurse severe depression

Step 4 Mental health specialists including crisis Treatment-resistant, Medication, complex psychological interventions,

teams recurrent, atypical and combined treatments

psychotic depression and

those at significant risk

Step 5 Inpatient care, crisis teams Risk to life, severe Medication, combined treatments, ECT

self-neglect

Although the present thesis focuses predominately on the UK, depression is a worldwide problem. For example in the USA, depression affects more than 16% of the adult population at some point during their lifetime (Kessler, Chiu, Demler, Merikangas and Walters, 2005) and The European Depression Association (2013) report that more than one in ten of the European population suffer from depression at any one time. In addition, the problems faced in the UK that lead to the introduction of the IAPT program (e.g. a lack of trained therapists who are able to meet demand for services) are problems faced worldwide (Scogin, Hanson & Welsh, 2003) and as a result the stepped-care model is used internationally (Kazdin & Blasé, 2011; Rotheram-Borus, Swendeman, & Chorpita, 2012). For example, in Australia the “Better Access” initiative is designed to improve access to psychological therapies for depression and anxiety disorders (Harris, Burgess, Pirkis, Slade & Whiteford, 2011). The wider effects of depression are also felt worldwide. For example in the USA the estimated economic burden of depression is approximately $83 billion per year (Wu et al., 2008) with reported losses of $24 to $36 billion as a result of workplace productivity losses (Birnbaum et al., 2009; Kessler et al., 2006).

Below the treatments offered for depression as part of the UK IAPT stepped-care model are discussed further, including antidepressant medications, psychotherapy and self-help.

**1.2.1 Antidepressant medication.** NICE (2009) do not recommend the use of antidepressant medications for symptoms of mild depression, as the risk-to-benefit ratio is unsatisfactory. For example, Barbui, Cipriani, Patel, Ayuso-Mateos and van Ommeren (2011) conducted a meta-analysis of six randomised controlled trials (RCTs) comparing antidepressant medications versus placebo controls in adults diagnosed with minor depression (minor depression is defined by the authors of this meta-analysis as a patient with symptoms of depression, who does not meet the criteria for severe depression as previously described – see section 1.1.1). No significant differences were found in depression symptoms, between those who were prescribed antidepressant medication and those who were prescribed placebo medication.

For those with symptoms consistent with moderate or severe depression, selective serotonin reuptake inhibitors (SSRIs), which are classed as a second-generation antidepressant medication, now comprise most prescriptions (Gartlehner et al., 2011). SSRIs are recommended by NICE (2009) as they have been found to be as effective as other antidepressants and have a more favourable risk-to-benefit ratio. For example, Gartlehner et al. (2011) conducted a meta-analysis to assess the efficacy of second-generation antidepressant medications. A total of 93 studies were included. Findings showed that the treatment effects were similar between all the second-generation antidepressant medications, with any differences modest and not clinically relevant. In terms of the risk-to-benefit ratio, Schueler et al. (2011) conducted a meta-analysis of 68 studies. The findings suggested that discontinuation due to adverse events was significantly lower for SSRIs in comparison to other second-generation antidepressant medications, such as venlafaxine and duloxetine.

There have been improvements in antidepressant medications, with second-generation antidepressant medications such as SSRIs reported to have fewer side effects than older antidepressant medications (such as tricyclic antidepressants). For example, Anderson (2000) conducted a meta-analysis of 102 RCTs, to compare the tolerability of tricyclic antidepressants against SSRIs in depressed patients, finding that SSRIs were better tolerated, with significantly lower rates of treatment discontinuation due to side effects. However, second-generation antidepressant medications do still have associated side effects. Masand and Gupta (2002) report that the long-term use of SSRIs is associated with side effects such as weight gain, sexual dysfunction, drug interactions, and discontinuation symptoms. As such, patients may still be unwilling to use antidepressant medications and may seek an alternative treatment, such as psychotherapy or self-help interventions.

Another concern is the medicalisation of depression and the symptoms that categorise depression. Chodoff (2002) states that the medicalisation of mental disorders has gone too far and that psychiatrists who are eager to include all the diversities of human emotions and behaviours in their professional domain are running the risk of medicalising the human condition. For example, the symptoms of mild or moderate forms of depression cannot always be accurately distinguished from ordinary human unhappiness or “the blues”; feelings and emotions that do not justify a diagnostic label or drugs to treat them. In the case of diagnosed cases of mild to moderate depression, antidepressant medications may be inappropriate and alternative treatments such as psychotherapy or self-help may be more suitable for those patients who wish to seek help in overcoming their negative emotions and behaviours.

**1.2.2 Psychotherapy.** Psychotherapy is defined by Strupp (1978, p. 3) as “an interpersonal process designed to bring about modifications of feelings, cognitions, attitudes and behavior which have proved troublesome to the person seeking help.” NICE (2009) guidelines class psychotherapy as a high-intensity intervention for depression that ranges from mild to severe, but has not responded to low-intensity interventions such as self-help (see 1.3). NICE (2009) advocates the use of interpersonal therapy (IPT), cognitive behavioural therapy (CBT), behavioural activation, counselling or short-term psychodynamic psychotherapy. The length of treatment is dependent on symptom severity, treatment approach and recovery; however NICE (2009) recommend 16-20 sessions delivered over three to four months for IPT, CBT and behavioural activation, whereas six to ten sessions over three to four months are recommended for counselling and 16-20 sessions over four to six months are recommended for short-term psychodynamic psychotherapy. Typically sessions are more frequent in the initial stages (e.g. two sessions per week for the first couple of weeks) before becoming less frequent as the patient improves over the course of treatment (NICE, 2009).

***1.2.2.1 IPT.*** IPT postulates that the symptoms of depression, such as low mood, are a response to current relationship difficulties. As a result, IPT focuses on the conflict experienced within relationships, life changes that affect relationships, grief and loss experienced due to the end of a significant relationship and the difficulties experienced in starting or keeping a relationship going (Markowitz & Weissman, 2004). IPT has been found to be an effective way to treat the symptoms of depression with Cuijpers et al. (2011b) conducting meta-analysis of 16 studies that compared IPT to no treatment and other psychotherapies. IPT was found to be more effective than no treatment controls, with a large effect size (according to Cohen’s (1992) criteria) of *d*+ = 0.63 reported. There were also no significant differences in treatment outcomes when comparing IPT to other forms of psychotherapy (*d*+ = 0.04).

***CBT.*** CBT is a form of therapy that hypothesises that the symptoms of depression, such as low mood, are a result of maladaptive thoughts, beliefs and attitudes affecting feelings and behaviour. As a result, CBT aims to identify and challenge negative thinking patterns and behaviours that may be causing symptoms of depression to occur. For example by identifying the thinking traps a patient uses, CBT can help the patient move from a negative style of thinking (e.g. “I’m useless”) to a more realistic thinking style (e.g. “I am doing my best”), which leads to a reduction in symptoms of depression. CBT focuses on “the problems and difficulties in the ‘here and now’ instead of addressing the causes of distress or symptoms. CBT looks for ways to improve the patients’ state of mind by exploring how the patient currently thinks about themselves, the world and other people and how that affects their reaction to situations” (NHS, 2010 p. 2). NICE (2009) recommend that guided or computerised CBT be used for symptoms of mild depression (see sections 1.3.1 & 1.3.2). For moderate to severe depression NICE (2009) recommend a course of treatment that includes the use of antidepressant medications (see section 1.2.1) alongside face-to-face CBT. CBT has been found to be an effective way to treat the symptoms of depression with Cuijpers et al. (2011a) conducting a meta-analysis of seven studies that compared CBT to treatment as usual (TAU) or waitlist controls. CBT was found to alleviate depression symptoms in 90% of the studies, with a small effect size (according to Cohen’s (1992) criteria) of *d+* = 0.28 reported. A more recent meta-analysis by Cuijpers et al. (2013) also found that CBT was more effective than control conditions. 75 studies compared CBT with control conditions, with a large effect size noted (*d+* = 0.71) in favor of CBT. Cuijpers et al. (2013)’s meta-analysis also sought to compare the effectiveness of CBT in comparison to antidepressant medications and psychotherapies, as well as exploring the benefits of combining CBT with antidepressant medications. 20 studies compared CBT to antidepressant medications with no differences noted between the two treatment types (*d+* = 0.03). 11 studies compared CBT plus antidepressant medications to antidepressant medications only, finding a medium to large effect size (*d+* = 0.49) in favor of CBT plus antidepressant medications. Finally, 46 studies compared CBT to various types of psychotherapy, effect sizes ranged from *d+ =* -0.02 for behavioural activation to *d+ =* 0.25 for psychodynamic psychotherapy, indicating little difference in treatment outcome between CBT and other forms of psychotherapy. Limitations were however noted, especially in relation to the comparisons made between CBT and psychotherapies, as often the number of studies included in the analysis was small. For example only five studies were included that compared CBT with psychodynamic psychotherapy.

***1.2.2.3 Behavioural activation.*** Lewinsohn, Biglan and Zeiss (1976) developed a type of psychotherapy known as behavioural activation, which was designed for the treatment of depression. Patients learn how to monitor their mood states and daily activities, to see how the two are connected. Patients are then taught how to increase the number of pleasant activities and positive interactions within their environment. In this approach, specific attention is paid to social skills and interactions with other people (Cuijpers, van Straten & Warmerdam, 2007). Research suggests that behavioural activation is an effective treatment for depression. For example, Cuijpers, van Straten and Warmerdam (2007) conducted a meta-analysis of 16 RCTs that compared behavioural activation for depression with no treatment controls. Large effect sizes (*d*+ = 0.87) were found in relation to no treatment controls, indicating that this form of treatment is effective in reducing the symptoms of depression. There were also no significant differences in treatment outcomes when comparing behavioural activation to other forms of psychotherapy (*d*+ = 0.13).

***1.2.2.4 Counselling.*** The term Counselling can be used in two ways. Firstly, to generally describe all types of therapy, or secondly, to refer to a precise type of therapy (NHS, 2013a). Counselling as a form of therapy “allows a client to talk to a trained counsellor about a specific problem with the aim of helping the client to understand their problem more clearly and to come up with their own solutions to deal with these difficulties. The role of the counsellor is to listen and be non judgmental towards the client, providing them with a safe and confidential environment to discuss their difficulties” (NHS, 2010 p. 3). There is a lack of RCTs assessing the efficacy of counselling therapy for depression and those that have been conducted have tended to have comparatively low numbers of participants, meaning they may lack sufficient power to detect significant findings (Cooper, 2011). The British Association of Counselling and Psychotherapy (BACP) has developed a systematic, person-centred experiential treatment for depression, based on evidenced humanistic competences known as Counselling for Depression (CfD). For people with mild to moderate depression, six to ten sessions of CfD are recommended; while up to 20 sessions are recommended for people with more severe cases of depression (Cooper, 2011). The development of this intervention and its use in some IAPT services gives the counselling community one of its best opportunities yet, to develop a body of RCT evidence in support of counselling (Hill, 2010). Training for IAPT counsellors in CfD began in 2010, with 90 counsellors initially trained, who would deliver CfD across a variety of IAPT sites. In January 2014 the University of Sheffield received funding to begin a large scale RCT trial to assess the efficacy of CfD in comparison to CBT. Both treatments will be delivered via the IAPT service in Sheffield, with funding provided by the British Association for Counselling & Psychotherapy. Results are expected from 2016 onwards (Barkham, 2013).

***1.2.2.5 Psychodynamic psychotherapy.*** Psychodynamic psychotherapy refers to techniques that are psychoanalytical in nature. It is a “form of in-depth therapy that focuses on the unconscious and past experiences and their effect they have on current behaviour and thinking. The client is encouraged to talk about childhood relationships and experiences during the sessions. The aim of the therapy is to help a person to understand how experiences in the past can unconsciously affect their behaviour and thinking” (NHS, 2010, p. 2). Driessen et al. (2010) conducted a meta-analysis of five studies to assess the efficacy of short-term psychodynamic psychotherapy for depression versus no treatment controls. Large effect sizes were noted (*d*+ = 0.80) in favour of short-term psychodynamic psychotherapy. There were significant differences in treatment outcomes immediately post-treatment when comparing short-term psychodynamic psychotherapy to other forms of psychotherapy (*d*+ = -0.30) in favour of other forms of psychotherapy, however these differences had disappeared by the three month (*d*+ = -0.05) and 12 month (*d*+ = -0.29) follow-ups.

Over 1.25 million people used the NHS mental health services in 2010, the highest number of individuals since data collection began and 4% higher than in the previous year (NHS, 2011). Although this increase is not solely due to a rise in rates of depression, research does show there are increasing numbers of people seeking treatment for depression. SSentif (2012) report that in the UK, there has been a rise of over 11% in the number of people seeking treatment for depression on the NHS. As such, NICE guidelines are simply not being implemented due to a lack of therapists within the NHS (Layard et al., 2007) and, therefore, there is still a shortage of psychological therapies available for depression, even after the implementation of IAPT (NICE, 2011b).

As a result, alternative forms of treatments are required, such as low intensity self-help interventions that are guided and unguided.

**1.3 Self-Help**

Self-help interventions, also known as low intensity interventions, have been identified as one way in which the UK NHS can overcome the problems facing treatment as usual for depression; namely the oversubscription of services (Lovell & Richards, 2000). By creating more access points and focused shorter interventions that can be undertaken alone without outside supervision or with less intensive guided support, patients may be able to skip the long waiting lists for psychotherapy, but still gain access to treatment. Lovell and Richards (2000) argued that there was growing evidence that psychological therapies could successfully be delivered as a self-help provision and that patients with symptoms of mild to moderate depression should be offered these self-help treatments, before being offered face-to-face psychotherapy.

Marrs (1995) defines self-help as “the use of written materials or computer programs, or the listening/viewing of audio/videotapes for the purpose of gaining understanding or solving problems relevant to a person’s developmental or therapeutic needs” (p. 846). Self-help materials typically provide the user with the means to identify their problem by offering information about the symptoms commonly experienced. Self-help materials also usually offer advice on how to overcome problems; however to be considered self-help, techniques for managing or alleviating symptoms, and examples of how to use these techniques must also be provided. This means that a leaflet containing information about the symptoms of depression would not be considered self-help because it does not contain any information about how to overcome this condition. So for materials to be defined as self-help they must contain advice, techniques and methods for treating the condition independently (Cuijpers, 1997).Self-help has many guises and can take on many forms; Campbell and Smith (2003, p 1) state that “self-help activities can refer to reading books, watching movies, surfing the Internet, and attending groups”.Self-help can also be managed in different ways, for example, the user can solely direct their own treatment, they can follow professionals’ recommendations, or they can integrate self-help materials alongside more formal psychological treatments (Campbell & Smith, 2003). The latter two methods of using self-help refer to guided self-help (see 1.3.1). As discussed previously, self-help is available in many forms, and interventions can be delivered via books or booklets (termed “bibliotherapy”) or electronically (including online resources, computerised packages, or downloads) (Williams & Whitfield, 2001). Self-help interventions may be undertaken independently without help from professionals (termed “pure” or “unguided” self-help) or overseen by a professional (termed “guided” self-help) who meets with the user to discuss progress or contacts them periodically (e.g. through phone or email contact) (Khan, Bower & Rodgers, 2007), see section 1.3.1. Self-help interventions, such as guided self-help and computerised self-help, are viewed as low intensity interventions, and feature in Step 2 of the IAPT stepped-care model, see figure 1. Other methods of delivering self-help, such as bibliotherapy, are not formally incorporated into the IAPT model but they may be offered during guided self-help. They are also used in the UK as part of the books on prescription scheme (Frude, 2005). Different forms of self-help are discussed in more detail below.

**1.3.1 Guided self-help.** The majority of research on self-help interventions for depression has focused on guided self-help, in which a professional therapist or coach supports the patient when working through the treatment (Cuijpers et al., 2011a). Guided self-help is defined as “a structured treatment method with which the patient can help themselves with some support from another person. There is a distinction between simply providing information to people and providing guided self-help. Guided self-help is a more structured approach, which requires the recipient to work with the contents of the self-help material to overcome their problems and achieve their goals” (Turpin, 2010, p 3). Guided self-help is recommended for the treatment of mild to moderate levels of depression (NICE, 2009) and is one of the low-intensity interventions offered as part of the IAPT program. In the UK workers trained to provide low-intensity interventions offer guided self-help, and one-year part-time courses have been commissioned throughout England to train these workers (Lucock, Lawson & Lloyd, 2009). Guided support during a self-help intervention may be provided face-to-face, via emails or websites, or by telephone, and the amount of support offered varies from patient to patient, especially with regards to the amount of sessions prescribed (Turpin, 2010). Additionally, the content of guided self-help also differs from patient to patient, with bibliotherapy and computerised self-help often offered to patients. One of the key elements of providing guided self-help is to identify the appropriate self-help materials for each patient’s needs. Alongside this, Turpin (2010) outlined five other key elements to providing guided self-help for depression: engaging the patient; identifying the key problems and goals to work on; supporting the patient; reviewing progress and the need for further help; and the use of assessment measures to review the patients progress.

Guided self-help has been found to be an effective way to reduce the symptoms of depression with Berger, Hämmerli, Gubser, Andersson & Caspara (2011b) and Gellatly et al. (2007) both finding that guided self-help is more effective than no treatment controls. Large effect sizes of *d*+ = 1.14 and 0.80 were reported respectively. Cuijpers, Donker, van Straten, Li and Andersson (2010) went on to conduct a meta-analysis of 21 studies, which compared guided self-help for depression and anxiety disorders with face-to-face psychotherapy. No significant differences were found in symptom reduction at post-test between those received guided self-help and those who received face-to-face psychotherapy. The overall effect size, was however small according to Cohen’s (1988) criteria (*d+* = 0.02). At the one-year follow-up, there was again no significant difference between the two treatments in terms of symptom reduction, with small effect sizes noted. These findings indicate that guided self-help may be as effective for depression and anxiety as face-to-face psychotherapy, at least in some patients. The authors noted that only participants willing to be randomised to receive either treatment would have been included in these trials, with those participants unwilling to be randomised to receive guided self-help excluded. As a result we do not know how effective guided self-help is, in comparison to face-to-face psychotherapy, for those will are hesitant to use this type of treatment. Further research is also required to replicate these findings in a clinical population as the majority (*K* = 17) of studies included in this meta-analysis recruited participants from the general population, rather than from clinical populations. This meta-analysis also failed to report on the efficacy of the guided interventions by mental health problem, and so we do not know how effective guided self-help is in comparison to face-to-face psychotherapy, for depression only. Only six of the twenty-one studies included in this meta-analysis sampled a depressed population, with the remaining 15 studies examining anxiety disorders. A further meta-analysis of guided self-help interventions versus face-to-face psychotherapy targeting those with clinical diagnoses of depression only, is required to establish whether guided self-help is as effective as face-to-face treatments for depression.

**1.3.2 Computerised self-help.**The way that self-help materials are accessed has evolved over time to meet the developments of new technologies, so instead of only being able to access self-help materials through books, as was done in the past, now interactive websites have been designed that allow materials to be viewed onscreen (either on a computer or smartphone) or downloaded. The nature of self-help and the means by which it can be accessed will continue to develop to keep up with the changes in technology that occur.

In 2012, 33 million adults accessed the Internet every day (Office for National Statistics, 2012) and many people use the Internet as a means of understanding and treating health related issues; indeed the NHS Direct website is one of the major sources of health information online and it attracts more than 1.5 million visits each month (NHS, 2013b). As a result of so many people using the Internet as a source of health information, it is being used to provide self-help treatments for depression. Below are a few of the most popular online self-help resources for depression.

*Living life to the full* (http://www.llttf.com/) is a website based course that aims to provide access to CBT. The website aims to offer high quality, user-friendly training that can be used in the users own life. The course teaches skills such as how to tackle and respond to difficulties that occur in everyday life. The course contains modules on issues such as ‘understanding why we feel as we do”, “practical problem solving skills”, “anxiety control”, “relaxation”, “overcoming reduced activity”, “helpful and unhelpful behaviours”, “noticing and changing unhelpful thoughts”, “healthy living” (e.g. sleep, diet and exercise) and “staying well”. The course delivers sound, text and video clips as well as short downloadable hand-outs and longer detailed practical workbooks. The website also offers moderated discussion forums that allow course users to swap ideas, information and provide support. Nothing on the website is compulsory; the user can choose the aspects they wish to use. After completing the initial registration process and one module, the user if free to choose to complete as many of the remaining modules as they wish to.

*MoodGYM* (http://www.moodgym.anu.edu.au/). MoodGym is made up of a series of interactive online modules. The modules are: feelings, thoughts, de-stressing, and relationships. Once each module is complete the user is invited to apply the knowledge they have gained from that module to their own circumstances via a series of activities such as animated demonstrations, quizzes and “homework” exercises. The users answers are recorded in a workbook, which keeps track of progress and can be viewed after all the modules have been completed.

*The Centre for Clinical Interventions* (http://www.cci.health.wa.gov.au/) website offers free downloadable workbooks that provide self-help guidance for depression. The depression workbook contains nine modules that cover everything from the symptoms and causes of depression, right through to how to maintain the progress made once the user has completed the modules. Specific self-help activities include, behavioural strategies to increase activity levels, how to challenge automatic thoughts that negatively impact upon feelings and finally core beliefs are examined and advice and techniques are given to help the user confront the core beliefs they hold that may be leading to depression (e.g. I’m unlovable).

Computerised self-help interventions, such as the ones discussed above have been found to be effective in comparison to no-treatment. Andersson and Cuijpers’ (2009) meta-analysis compared computerised self-help to no treatment controls in 12 studies. Computerised self-help was more effective than no treatment controls at reducing depression symptomology with a medium effect size (d+ = 0.38) noted. Andersson and Cuijpers (2009) also examined the effect of guided support on the efficacy of computerised self-help interventions, reporting significant differences between guided (d+ = 0.61) and unguided (d+ = 0.25) interventions with guided interventions having larger treatment effects in comparison to controls. The guided support offered in these interventions varied from emails and telephone calls to face-to-face support, however no analysis was conducted to assess which form of guided support is most effective when administering computerised self-help interventions. Vernmark et al. (2010) did however explore the impact on efficacy of different forms of guided support. Vernmark et al. conducted an RCT in which 75 participants were randomly allocated to a guided online self-help condition, an individual email therapy condition or a waitlist control. The subject matter of both treatment conditions was similar but in the email therapy condition the therapist could tailor the treatments depending on the patients needs, whereas in the guided online self-help condition the therapist gave out module information in a specific order. At post-test both guided online self-help and individual email therapy had significantly reduced depression symptomology in comparison to the control group, with large effect sizes reported (d = 0.56 and 0.96 respectively). Six months later both treatment groups had sustained their treatment gains, with no significant differences noted between the two types of guided support. In terms of comparing computerised interventions with face-to-face psychotherapy, less research has been conducted to directly compare the treatment gains of computerised self-help versus face-to-face treatments. Wagner, Horn and Maercker (2013) conducted a RCT to compare guided Internet based CBT (N = 32) to face-to-face CBT (N = 30) for depression. Participants in both groups received the same module content, in the same order, over a period of eight weeks but those in the face-to-face condition attended hourly appointments with a psychologist once a week, while those in the guided Internet condition received the same amount of support via email. After eight weeks of treatment both groups had a significant reduction in depression symptomology, with little difference noted between the two groups (*d* = 0.00). However, at the three month follow-up the Internet condition had continued to improve, whereas the face-to-face condition had a slight increase in depression symptomology compared to post-intervention. The effect size between the conditions at this point was large (*d* = 0.61), in favour of guided Internet support; although it should be noted that only around two thirds of the sample completed the three month follow-up questionnaire. Wagner, Horn and Maercker’s (2013) study was the first of its kind to directly compare guided and face-to-face interventions for depression whilst controlling for intervention content, timeframe and amount of support. Although it found that computerised self-help can effectively reduce depression symptomology in comparison to brief face-to-face treatments, replication with a larger sample of clinical patients who are referred from their GP is needed. The study may be underpowered, especially at the 3-month follow-up. In addition the self-referral nature of the sample, who were all well educated and often had prior experience of psychotherapy (50% of the sample) may limit the generalisability of the findings.

**1.3.3 Bibliotherapy.** The purpose of bibliotherapy is to provide information, generate insight, stimulate discussion and create awareness of problems (Pantalon, Lubetkin & Fisher, 1995). The first self-help book, *Self-Help: With Illustrations of Character and Conduct*, was published in 1859 by Samuel Smiles (Smiles, 1959). Today self-help books are hugely popular, with Meyers (2008) reporting that approximately 2,000 self-help books are published each year.

Self-help books provide the user with the means to identify their problem by discussing the symptoms suffered. These books also offer advice on how to overcome the problems the user is experiencing. Often techniques are described and examples of how to use these techniques are given so that the user can clearly see what they are required to do. Many self-help books have space allocated for the user to work through the techniques on the pages of the book. Self-help can be self-prescribed (so the user buys the book independently), used alongside therapy or guided self-help, or prescribed as part of a books on prescription scheme (Frude, 2005).

The books on prescription scheme was first piloted by Frude (2005) in Cardiff in 2004. Frude identified 35 self-help books for common mild to moderate mental health problems such as depression, anxiety, phobia etc. Many of these books are based on the principles of CBT and are derived from well-established clinical treatments. The books are prescribed to patients by GP’s, much the same way that antidepressant medications are prescribed. The prescription is then taken to a local library that stocks the self-help books. The initial pilot of this scheme performed well, with over 1,600 books prescribed to patients in Cardiff in the first year. A national books on prescription scheme was launched in Wales in 2005. Although bibliotherapy can be used as a guided intervention, it is important to note that the Welsh model offers self-help books as a purely unguided intervention. Patients receive the book but no additional support, they may return to their GP if the symptoms persist and they are seeking alternative treatment, but the GP will not provide support alongside the use of the book. A similar scheme was launched across the UK in 2013 (The Reading Agency, 2013).

Cohen (1993) interviewed participants who had effectively used bibliotherapy to overcome issues such as depression, finding that participants reported that the main benefits experienced when using a self-help book came from: (1) reading self-help books with the purpose of understanding and overcoming a problem; (2) being able to relate to the characters discussed in the book and their problems; and (3) the sense of emersion and escapism experienced when engaging with a self-help book. Cohen (1994) conducted further qualitative interviews with people who had used bibliotherapy. Eight themes emerged providing insight into the experiences of those who use these resources. Participants spoke of recognising themselves in the characters described, leading to a feeling that their problem was not an isolated, unusual experience; rather it was a shared experience that validated their feelings and experiences. Participants also spoke of experiencing feelings of comfort, hope, inspiration and catharsis, as well as gaining knowledge and insight into the problems they faced.

Some of the most popular self-help books for depression are described below. *Overcoming Depression: A self-help guide using cognitive behavioural techniques* (Gilbert, 1997) is written by an expert in the field of depression and is based on cognitive and behavioural principles. Part One of the book helps the user to gain an understanding of depression and its causes. Part Two provides the user with guidance on managing their depression. It focuses on increasing the user’s activity levels, breaking problems down into manageable steps, and looks briefly into issues such as lack of sleep, poor nutrition, exercise and alcohol or drugs misuse. The book also explores the role of thoughts and feelings in depression, and identifies methods for labelling and challenging negative thoughts that may contribute to the symptoms of depression. Part Three of the book looks at particular problems associated with depression, such as guilt, shame, anger, assertiveness, disappointment, perfectionism and the need for approval.

*Overcoming Depression and Low Mood: A Five Areas Approach* (Williams, 2001) contains a number of self-help booklets that can be used in guided and unguided formats by those experiencing symptoms of depression. The course allows access to the CBT approach to treatment. Part One of the book helps the user to understand why they feel as they do. Part Two of the book is all about making changes to the users life that will help them to overcome their depression. Topics covered include: making changes to do with people and events (such as practical problem solving, being assertive and building relationships with family/friends); making changes to behaviours and activity levels (such as using exercise to boost positive feelings and recognising helpful and unhelpful behaviours); making changes to negative and upsetting thinking; making changes to things that affect physical well-being (such as overcoming insomnia); and finally making changes for the future, which is all about planning for a future that is healthy and free of depression.

*Feeling Good: The New Mood Therapy* (Burns, 1980) is a self-help book for depression. Research data is cited within the book that suggests people can learn to control their thoughts and behaviours, which enable them to boost their mood and overcome the symptoms of depression. Techniques are described throughout the book. The author describes faulty thinking styles and thinking traps that cause low mood, and feelings of depression. David Burn’s theory involves helping the user to become aware of the interplay between their faulty thinking styles, how they feel and how they subsequently behave. The book teaches the user to identify their automatic thoughts, and the thinking traps they are experiencing, with the focus then on how to replace these thoughts with rational thoughts. Throughout the chapters, the user is taught techniques for building self-esteem, and for handling criticism, anger and guilt, as well as other symptoms of depression.

Bibliotherapy, with various forms of guided support (ranging from weekly telephone calls to weekly face-to-face support sessions) has been shown to effectively reduce the symptoms of depression with Cuijpers’ (1997) meta-analysis finding that bibliotherapy is more effective than no treatment controls with a large effect size (*d*+ = 0.82) reported. However, only six studies were included in this meta-analysis, with the authors noting the small sample sizes of the studies included. Participants also self-selected to take part in the studies and as such this meta-analysis does not inform us of the efficacy of bibliotherapy that is prescribed (e.g. via the books on prescription scheme).

Bibliotherapy is not always delivered alongside guided support. In the UK, for example, books can be prescribed by GP’s to be used independently of any outside guided support. Naylor et al. (2010) found that patients (n = 19) who were prescribed the self-help book Feeling Good: The New Mood Therapy (Burns, 1980) experienced an equal reduction in depression symptomology as those prescribed TAU (n = 19) indicating that unguided bibliotherapy prescribed by a GP can lead to reductions in symptoms of depression that are equivalent to those reported for TAU. However, replication with a larger sample is needed to confirm the findings reported. There are mixed findings within the literature concerning the effectiveness of both guided and unguided bibliotherapy in comparison to face-to-face psychotherapies. For example, a meta-analysis by Cuijpers (1997) examined four studies that compared both guided and unguided bibliotherapy to face-to-face psychotherapy, they found no significant differences between these two treatment options in terms of efficacy (*d+* = 0.10). Again these studies had small sample sizes and this meta-analysis did not explore whether guided bibliotherapy was more effective than unguided in comparison to psychotherapy. In addition, Floyd, Scogin, Mckendree-Smith, Floyd, and Rokke (2004) conducted an RCT to compare the efficacy of the self-help book Feeling Good: The New Mood Therapy (Burns, 1980) in comparison to 12 to 20 sessions of individual psychotherapy. 31 participants aged over 60 were recruited, with participants randomly assigned to receive unguided bibliotherapy or psychotherapy. Both conditions significantly decreased depression symptomology in comparison to no-treatment controls with large effect sizes reported (*d* = 0.93 & 0.79 respectively). Psychotherapy was significantly more effective than bibliotherapy at post-treatment assessment (*d* = 0.75), however participants using bibliotherapy continued to improve and at the three month follow-up there were no significant differences in efficacy between bibliotherapy and psychotherapy. In summary, bibliotherapy for depression, that is both guided and unguided, is more effective than no treatment and may be comparable to psychotherapy, although larger more robust studies are required to confirm the latter.

**1.3.4 Self-help based on the principles of positive psychology.**The most commonly used and most well researched forms of self-help, such as guided self-help, computerised self-help and bibliotherapy were discussed above. However, there are alternative forms of self-help available. For example, self-help interventions have been developed based on the principles of positive psychology. Positive psychology is the “scientific study of optimal human functioning that aims to discover and promote the factors that allow individuals and communities to thrive” (Seligman & Csikszentmihalyi, 2000). In terms of depression, positive psychology focuses on improving well-being rather than alleviating the symptoms of depression, and there is emerging evidence to suggest that this approach could reduce the symptoms of depression.

Seligman, Rashid and Parks (2006) report two studies that examine the use of positive psychotherapy in the treatment of depression. Study 1 sampled students who were experiencing symptoms of mild to moderate depression. They received six weeks of group positive psychotherapy with a two-hour session per week. Each session contained a presentation of the intervention they were to perform that week, plus a discussion of the previous week’s intervention. The interventions given to the group were all based on the principles of positive psychology. For example, one week the “three blessings” task was introduced, which involved the participant writing down three things to be grateful for. Participants who received group positive psychotherapy experienced a significant reduction in their Beck Depression Inventory-II (BDI-II, Beck, Steer & Brown, 1996) scores, whereas scores for participants in the control group did not significantly change from pre to post intervention. Furthermore, participants in all conditions experienced no changes in their levels of depression symptomology at post intervention follow-ups (three months, six months and one year afterwards), suggesting that participants in the positive psychotherapy condition maintained their improved depression scores, while the controls’ depression scores also remained unchanged. Although this study shows the potential for group based positive psychology interventions to reduce depression symptomology, several limitations are noted. The sample used was a non-clinical student sample that was not actively seeking treatment. Participants did not have a formal clinical diagnosis of depression, rather a BDI-II scores was used which indicates the presence of depression symptomology only. Finally only forty students were sampled, with around half receiving the intervention and half making up the control group. The findings of this study need to be replicated with a larger clinical sample.

In Seligman, Rashid and Parks’ (2006) second study, 46 students who had a formal diagnosis of depression and were seeking treatment for depression from the universities counselling service were randomly allocated to receive either individual positive psychotherapy (PPT), or TAU (Individual counselling at the university’s counselling service). In addition, a group of nonrandomised matched patients receiving TAU plus antidepressant medication (TAUMED) were also examined for comparison. Three measures of depression were administered pre and post intervention; there were no significant difference between the three groups at baseline. However, post intervention the PPT condition had significantly exceeded the TAU condition and the TAUMED condition in improving their depression scores with large effect sizes (*d*+ = 1.12 and 1.22) noted respectively. As above, Seligman, Rashid and Parks’ (2006) second study shows that PPT can lead to significant decreases in levels of depression symptomology. However, limitations must again be noted, such as a small sample size. Study 2 only recruited 46 students, with 28% of these dropping out of treatment, leaving only eleven participants who received the PPT intervention. Future research should aim to replicate the above study, using a larger clinical sample, to assess the robustness of the above findings.

To date, researchers have not replicated Seligman, Rashid and Parks’ (2006) studies (as cited above), however researchers have continued to explore the effectiveness of positive psychology interventions, often with a focus on guided and unguided self-help interventions.

One such study was conducted by Seligman, Steen, Park and Peterson (2005), who recruited 577 adults via the website that accompanies Seligman's (2002) book; Authentic Happiness. Participants were randomised into one of four unguided positive psychology interventions that were delivered via the Internet, or into a placebo control group. There were no differences in depression at baseline, but those who used the “three blessings” task or who identified and used their “signature strengths” (participants fill out the character strengths and virtues questionnaire (Peterson & Seligman, 2004) which identifies 24 character strengths (e.g. creativity, persistence, social intelligence, teamwork, prudence or gratitude, etc.) and six virtues (e.g. wisdom and knowledge, justice, etc.); participants then aim to use their highest scoring strengths in their daily lives) had significantly decreased depression scores for up to six months post intervention in comparison to controls. One drawback to this study is the nature of the sample, who were all interested in positive psychology to begin with. Participants visited a website that accompanies a popular positive psychology book and self-selected to take part in the study from there. Perhaps a placebo effect took place, for example the website and book both say that positive psychology can improve happiness and well-being, so potentially participants would have taken part in the study expecting to feel better. Researchers should assess how effective these interventions are in a sample who have not expressed a previous interest in positive psychology and have not self-selected to take part in a positive psychology research trial. The sample used in Seligman et al. (2005) were also not a clinically depressed sample and further research should assess how effective these interventions are when treating clinically diagnosed depression, rather than depression symptomology identified via the administration of a depression measure such as the BDI-II.

Self-help books based on the positive psychology interventions discussed above have been written, for example *The How of Happiness: A Practical Guide to Getting the Life you Want* (Lyubomirsky, 2007). Positive psychology interventions, such as the ones outlined in Lyubomirsky (2007), have been found to effectively reduce depression symptoms. Sin & Lyubomirsky (2009) conducted a meta-analysis of 51 studies that examined positive psychology interventions for well-being and depression using face-to-face, group and guided and unguided self-help interventions, in comparison to no treatment or TAU. In terms of depression, 25 studies looked at the impact of positive psychology interventions on symptomology, with small to large effect sizes (*d*+ = -0.28 to 0.81) noted, 80% were in favour of positive psychology interventions. In terms of the impact of the mode of delivery, effect sizes were greatest for face-to-face therapy (*d*+ = 0.50) and group therapy (*d*+ = 0.34), with self-help interventions (both guided and unguided) reporting a small–medium effect size (*d*+ = 0.20). More recently, Boiler et al. (2013) conducted a similar meta-analysis of 14 studies, that examined positive psychology interventions for depression. Smaller effect sizes were noted for self-help interventions (both guided and unguided) (*d*+ = 0.15) than Sin & Lyubomirsky (2009), which the authors note may be due to a stricter inclusion criteria (e.g. RCTs only). Although the meta-analyses outlined above point to the potential effectiveness of the interventions and exercises contained in positive psychology self-help books such as Lyubomirsky (2007), researchers have yet to explore how effective a self-help book based on these techniques is. Future research should seek to conduct RCT’s that assess the effectiveness of a positive psychology self-help book against TAU.

In summary, positive-psychology-based interventions seem to offer a new approach for treating depression. Further research using larger clinical samples and comparing positive psychology interventions with psychotherapy is required to further strengthen the evidence base for these interventions, but it seems there may be promising advances to be had in terms of treating both well-being and depression symptoms.

**1.3.5 Advantages of self-help.** Self-help that is both guided and unguided does have a number of advantages. Self-help can be a much cheaper option than face-to-face psychotherapies or antidepressant medications. For example, from the patient’s perspective it would be significantly cheaper to buy a self-help book, and use this as an unguided self-administered intervention, than to see a private therapist. For the NHS it may be more cost effective to prescribe access to a website that provides guided support than to provide face-to-face therapy for depression. This is due to research showing that computerised CBT (CCBT) can still effectively reduce the symptoms of depression even when the guided therapist support that accompanies the intervention is less than 50% of the face-to-face contact offered in psychotherapy (e.g. Wright et al., 2005). As a result guided self-help for depression typically involves less face-to-face contact than psychotherapy. Marks et al. (2003) calculated a cost comparison for CCBT versus face-to-face CBT, finding that the estimated per-patient cost advantage of using CCBT (which contained a reduced amount of therapist contact) was around 41% per patient for 1,350 patients per year. Marks et al. (2003) study was examining CCBT for a number of conditions including depression, but also anxiety, phobia etc. As a result, the exact cost effectiveness of using guided self-help for depression over face-to-face treatment has yet to be calculated.

As well as being potentially being more cost-effective, self-help (both guided and unguided) may also allow faster and more convenient access for patients. For example, there are no waiting lists associated with many forms of unguided self-help, such as the books on prescription scheme (Frude, 2005). In terms of guided self-help, the reduced face-to-face contact may enable therapists to see a higher volume of patients (Hof, Cuijpers, & Stein, 2009), thus reducing waiting times. In addition, the unguided elements of self-help (such as homework, CCBT, bibliotherapy etc.) can often be accessed at times that suit the patient’s schedule, rather than having to fit around the appointments available to see the doctor or therapist. Marks et al. (1998) found that participants using computerised self-help for obsessive compulsive disorder accessed the facilities outside of conventional office hours, suggesting a need for treatments to be available to fit around the patient’s commitments (such as work or childcare). Although further research is needed to verify whether this is the case for depression, Marks et al. (1998) findings do show that one of the advantages to the unguided elements of self-help is the ability to use these treatments at a time that is convenient to the patient.

Finally, in addition to more convenient access, patients may also wish to access a type of treatment that is more discreet. Having to take time off work for a therapist sessions may make it difficult for the patient to keep their depression private. They may not wish for their condition to be public knowledge or they may fear stigma or discrimination and hence self-help may offer them a way of receiving treatment that is more discreet. Unguided self-help could be kept completely private, whilst guided interventions typically involve less face-to-face contact than psychotherapy thus reducing the amount of time needed off work for example. Proudfoot et al. (2010) conducted an analogue survey to assess how acceptable mobile phones would be for the monitoring and self-management of depression, anxiety and stress amongst 525 Australian adults with and without symptomology. Privacy was highlighted as an issue of significant importance, with the majority of participants stating that a secure log-in should be a mandatory feature.

**1.3.6 Disadvantages of self-help.** As with the other treatments for depression discussed earlier, self-help has a number of potential drawbacks. Certain types of self-help may be inaccessible for some. For example, illiterate individuals would not benefit from bibliotherapy. Martinez, Whitfield, Dafters and Williams (2008) examined the reading ages of eight popular self-help books for depression and found that the books’ reading ages ranged from 12.6 to 15.4. This could be problematic given that the National Literacy Trust (Jama & Dugdale, 2012) report that around 16% or 5.2 million adults in England, can be described as “functionally illiterate”, meaning that they have literacy levels at or below that of an 11-year-old and would struggle to read information from unfamiliar sources on unfamiliar topics. Physical impairments may also limit a person’s use of self-help materials. For example, the blind cannot use bibliotherapy or computerised self-help and the deaf cannot use audio-based self-help. There may be ways to overcome these challenges, such as brail self-help books, but access is more complicated. In addition, those living in poverty may not be able to afford self-help books or computers to access computerised self-help (that is not funded by the NHS).

By the nature of depression symptoms, patients may not be able concentrate for long enough to benefit from self-help. Many self-help techniques require the patient to focus for long periods of time and this may prove difficult for some (Scogin, Jamison & Gochneaur, 1989). This may lead to low levels of adherence or to the discontinuation of the self-help intervention (Williams & Whitfield, 2001) and this is likely to cause feelings of despondency and inadequacy, all of which may be a trigger for the depression already suffered to worsen.

A mismatch may also occur between the patient and the self-help intervention prescribed. A number of research studies have found that individual differences such as personality traits may be linked to the successful usage of self-help treatments for depression. For example, Mahalik and Kivlighan (1988) found that those with a realistic personality type experienced the greatest gains from self-help, whilst those with an enterprising personality type were the least successful. More recently, Haeffel (2010) found that those with a tendency to ruminate could actually experience negative mood states when using self-help materials and as such they may not be suitable candidates for self-help interventions.

**1.4 Plan for the Thesis**

As we have seen, self-help treatments for depression are a valid treatment option with many advantages over antidepressant medications and face-to-face psychotherapy. However, there are still areas where self-help could be improved and further enhanced. The present thesis will aim to identify and address these issues in an effort to understand how we can best utilise self-help provisions.

**1.4.1 How acceptable are self-help interventions?** Although much is written about the clinical effectiveness of self-help treatments for depression (and other mental health problems such as anxiety – see chapter 3) (Bower, Richards & Lovell, 2001) relatively little is known about attitudes toward self-help treatments for depression (Waller & Gilbody, 2010). The literature demonstrates the depressed patient’s preference for psychotherapy over medication. For example, when Bedi et al. (2000) conducted a partially randomised preference trial with depressed patients, they found that almost twice as many patients would prefer psychotherapy over antidepressant medication. Yet few studies examine the attitudes and preferences held towards self-help treatments for depression.

One study that did look at attitudes towards self-help as a treatment option for depression was Landreville, Landry, Baillargeon, Guérette and Matteau (2001), who found that bibliotherapy was seen as an acceptable treatment option for patients suffering from mild to moderate levels of depression only. Patients suffering from severe depression found antidepressant medication and psychotherapy more acceptable treatment options. This study was limited in scope as it only sampled elderly patients (aged 65 and over) and therefore further work is needed to examine the acceptability of self-help within a broader age range.

Schneider, Foroushani, Grime, and Thornicoft (2014) also conducted a study that explored the acceptability of a self-help intervention for depression. 637 employees, who were experiencing symptoms of depression, took part in a guided online CCBT intervention for five weeks. Participants were called weekly to ensure they were not at risk of self-harm and to ensure they had no computer-based issues whilst using the CCBT intervention. Participants were asked prior to beginning the intervention to rate how acceptable they would find using a computerised intervention over going to a health care professional (including a GP, counsellor, psychologist or psychiatrist). They were also asked post intervention (six weeks) and at follow-up (12 weeks) to say how acceptable they had found using a computerised intervention over going to a health care professional. Thus, this study measured perceived and actual acceptability. Schneider et al. (2014) found that at baseline the mean ratings of perceived acceptability for CCBT in comparison to seeing health care professionals ranged from a low of 65% (CCBT in comparison to seeing a psychologist) to a high of just over 80% (CCBT in comparison to seeing a GP), meaning that between 65 and 80% of the sample rated self-help to be at least as acceptable as seeing a health care professional. There was no significant change in acceptability ratings at post intervention or follow-up, indicating that participants who used the guided CCBT still found it to be acceptable in comparison to seeing health care professionals on a face-to-face basis. This study was also limited in that it used a self-selecting sample; as a result those who find self-help unacceptable would be unlikely to take part in a CCBT intervention to begin with. There was also a high level of drop-out and thus the acceptability ratings of these participants are not measured post intervention, does this drop-out reflect participants who upon using the intervention found it unacceptable?

Although the studies described above provide some insight into how acceptable people find different treatments for depression, a number of important questions remain unanswered. First, no study to date has compared how acceptable people find different types of self-help (including guided self-help, bibliotherapy, computerised self-help, and self-help interventions based on the principles of positive psychology). Second, research to date has focused on how acceptable people find different treatments, but has not yet explored treatment preferences. Specifically, if people’s first choice of treatment is unavailable (e.g. there is a long waiting list for psychotherapy), then it is currently unclear what type of treatment they might prefer instead. Finally, previous research offers little insight into the factors that influence people’s preferences for treatments for depression. For example, individual difference variables might influence preferences for one treatment over another. If so, this will help to elucidate not only the basis for treatment preferences, but could also suggest how treatments could be tailored to people who are most likely to find them preferable.

Chapter 2presents an analogue questionnaire based study that aimed to assess how acceptable self-help for depression is, how severe any side effects are deemed to be and where self-help ranks in terms of preference, in comparison to psychotherapy and antidepressant medications.

**1.4.2 Engagement with self-help interventions.** Engagement with self-help interventions is another area where self-help could be further understood (Waller & Gilbody, 2010). How does the patient use and interact with the self-help treatments prescribed? Treatments for mental health problems such as depression and anxiety (see chapter 3) are only effective if they are used correctly. Although self-help interventions for common mental health disorders such as depression and anxiety have been consistently shown to be effective, one of the major limitations associated with them is high levels of dropout. Christensen, Griffiths and Farrer (2009) conducted a systemic review of adherence to computerised interventions for depression and anxiety and found that rates of attrition in randomised control trials were as high as 50%, although they did not distinguish whether attrition rates were higher for those with depression versus anxiety. Williams and Whitfield (2001) also report dropout rates approaching 50% in UK-based studies that were targeting depression only. However, this 50% figure is only based on four studies and it would be helpful to understand the nature of the problem more widely. To date no systematic review has addressed issues such as adherence and dropout. The following questions need to be asked for us to greater understand this issue. Do different types of self-help experience different rates of dropout and adherence, and what external factors impact upon and/or predict dropout and adherence?

Chapter 3 presents a quantitative review of studies that examine engagement with self-help interventions for depression and anxiety. In doing so, the study provides the first assessment of rates of engagement with self-help interventions.

**1.4.3 Improving rates of engagement and efficacy.** By understanding the extent of the problem and the reasons behind low levels of engagement, it may be possible to implement changes to the self-help treatments that increase rates of engagement, thus improving the levels of symptomology experienced by the patients using the self-help techniques. To date little research has been done in the area of augmenting self-help interventions for common mental health disorders such as depression and anxiety (see chapter 3), with a view to improving rates of engagement and efficacy. These issues may be intertwined as Landreville and Guérette (1998) say that treatment acceptability is a very important issue from a clinical perspective as it is likely to influence adherence. A client is unlikely to use a treatment, even if it is effective, if they do not like it. On the other hand, the more acceptable a treatment is, the more likely it is that it will be used effectively (Richards & Bower, 2011). Therefore developing tools that enhance engagement are likely to be particularly beneficial as they may have a knock on effect on efficacy, and vice versa. Research supports this view to an extent. For example, Gould and Clum (1993) conducted a meta-analysis looking at the effectiveness of 40 self-help interventions for a wide range of outcomes including depression, weight loss etc. Within their analysis Gould and Clum (1993) also examined the impact of adherence on the efficacy of the intervention. Seven studies with relatively high levels of adherence (between 75% and 100%) were compared with four studies with relatively low levels of adherence (less than 75%). The main finding was that effect sizes were more than three times greater for the high adherence group (*d*+ = 1.47) than the low adherence group (*d*+ = 0.41). Further research is needed as Gould and Clum (1993) did not state the nature of the self-help intervention content included in this analysis, and did not analyse whether the association between adherence to the intervention and treatment outcome held across different interventions with different content. As a result we do not know how many (if any) of the self-help studies included here were utilising content that specifically targets the symptoms of depression or anxiety and so we do not know the impact adherence has on the efficacy of self-help interventions targeting mental health conditions as opposed to other interventions with content that targets weight loss or smoking cessation, for example. This study does point to the possibility that adherence to self-help interventions can lead to increased efficacy, however further research is needed to clarify whether this is the case for all forms of self-help. The possibility remains that intervention content may mediate the link between adherence and efficacy and it may be that this association is found for outcomes such as weight loss but not mental health disorders such as depression or anxiety, due to the varying nature of the intervention.

Implementation intentions (see 4.3) have previously been used to augment self-help interventions, with Varley, Webb and Sheeran (2011) finding that participants who received self-help augmented with implementation intentions had significantly lower anxiety scores at follow up, compared with the standard self-help and control conditions. Engagement, in the form of rates of adherence, has also been improved by the use of implementation intentions. For example Brown, Sheeran and Rueber (2009) found patients were more likely to take medication if they were using implementation intentions. However, as yet in the field of depression no research has explored the link between implementation intentions and rates of efficacy and engagement to self-help materials. If implementation intentions were found to improve both rates of efficacy and engagement to self-help for depression, then they could easily and cheaply be built into existing self-help materials, benefiting both the patient and the self-help provider.

Chapter 4 presents an intervention study designed to test an established self-help program in an unguided setting for the first time, with the aim of assessing whether this intervention could successfully reduce levels of depression and anxiety if used without guided support. This study also sought to assess whether attitudes towards self-help and engagement with self-help impact upon the efficacy of the intervention, and whether self-help interventions can be augmented to improve both engagement rates and efficacy.

**1.5 Conclusions**

Depression is an extremely common, serious and widespread mental health condition. Depression seriously impacts upon the lives of those suffering from this condition and those close to them. In addition, depression has a marked impact upon our society and economy. In the UK, both the government and the NHS are committed to treating depression more effectively and easing the burden it causes.

Depression in the UK is currently dealt with using a stepped-care approach known as IAPT. Patients are given access to antidepressant medication, psychotherapies, self-help or combinations of these depending on the nature and seriousness of the depression. Self-help can be accessed in this formal way or it can be undertaken independently, again depending on the seriousness of the condition and the patient’s preferences. All treatment options for depression have associated advantages and disadvantages and patients will suit some types of treatments over others.

The focus of this PhD is on understanding attitudes towards self-help, engagement with interventions and how we can enhance both engagement and efficacy by augmenting self-help interventions to best maximise treatment outcome. The efficacy of self-help has been widely studied, yet despite this less research has examined the issues currently facing self-help for depression. Issues such as the patient’s attitudes towards self-help as a treatment option, as we know patients would prefer psychotherapies to medication (Bedi et al., 2000) but we do not know where self-help factors into this. Self-help also suffers from high levels of dropout and low levels of adherence. Researchers to date however, have yet to establish an accurate figure for this dropout or examine the reasons it occurs. In addition, little empirical work has focused on trying to improve engagement with self-help interventions, with the view of best maximizing treatment outcome.

By understanding attitudes towards self-help and understanding why some patients don’t adhere to self-help treatment plans we can begin to build a more comprehensive picture of self-help for common mental health disorders such as depression and can further enhance it. If we can understand attitudes and perceptions of self-help we can begin to change them and make self-help a viable treatment option; this in turn may make patients keener to undertake self-help treatments and be more likely to adhere to them. Self-help works but by understanding attitudes and engagement, and how best we can improve both of these constructs, we can ensure it reaches its full potential.

**Chapter 2: How Acceptable are Self-Help   
Treatments for Depression?**

**2.1 Attitudes Towards Self-Help Treatments for Depression**

Chapter 1 briefly outlined evidence to suggest that there may be differences in how treatments for depression are viewed in terms of how acceptable they are, with studies such as Landreville et al. (2001) and Schneider et al. (2014) suggesting that self-help interventions may be an acceptable treatment for depression. For example, Landreville et al. (2001) reported that bibliotherapy was rated as more acceptable than antidepressant medication for treating mild to moderate levels of depression. In addition, Schneider et al. (2014) reported that both prior to and after using a computerised self-help intervention for depression, between 65% and 80% of the participants rated self-help to be at least as acceptable as seeing a health care professional. Other studies have reported on how acceptable a specific intervention was rated by participants. For example, Whitfield, Williams and Shapiro (2001) sampled 42 patients from a GP surgery in the north of England, who were all suffering from low mood, depression and anxiety. Participants were offered a 20 minute interview to explain the use of the bibliotherapy book *Mind Over Mood: Change How You Feel by Changing the Way You Think* (Padesky & Greenberger, 1995) and the setting in which they were to be used (a private self-help room at the GP’s surgery). Participants were advised to use the materials for six weeks spending one hour a week in the self-help room. Participants rated how acceptable the treatment was post intervention, with 85% rating the treatment as “acceptable” or “very acceptable”. Whitfield et al. (2001) did not report whether there were differences in acceptability between those with depression and those with anxiety/low mood and so this study does not specifically tell us how acceptable the above self-help book is rated for those with depression versus those with anxiety or low mood. Another drawback to this study is the low uptake of the self-help treatment offered to patients. Of the 42 participants who were sampled, only 20 actually went on to use the self-help room. Whitfield et al. (2001) did not explore the issue of non-attendance for the 22 patients who chose not to use the room; was this because they found it to be an unacceptable treatment method? Whitfield et al. (2001) also did not explore whether participants who did not attend were experiencing depression or anxiety/low mood and whether this impacted upon their ability to use the self-help room? Often those with symptoms of depression experience low levels of motivation and this may have impacted upon their ability to attend the GP surgery and use the self-help room. Macdonald, Mead, Bower, Richards and Lovell (2007) conducted qualitative interviews with depressed participants who had used a guided self-help intervention. These participants identified low motivation as one of the main barriers to using the intervention. In Whitfield et al (2001) study the intervention used was mainly unguided, perhaps meaning that low motivation was more of a barrier for those participants experiencing symptoms of depression. In addition, the results from this study and others that use the same method cannot tell us how acceptable bibliotherapy is generally, rather, they tell us how acceptable a particular self-help book is (in this case *Mind Over Mood*). Furthermore, how acceptable the treatment is deemed to be, in studies based on treatment experience, may be confounded by the treatment outcome, as people who are still experiencing depression post intervention may not be likely to rate a treatment that did not work for them as acceptable. So, while asking participants how they found a specific intervention that they have received is informative and has good ecological validity, the approach is limited to the extent that it cannot provide information for participants who dropped out of the intervention, it cannot tell us about the acceptability of self-help more generally and it may be confounded by treatment outcome.

The studies described above provide some insight into how treatments for depression are viewed, in terms of how acceptable they are. However, the major disadvantage to the cited literature, is that these studies do not compare multiple forms of self-help. As a result, we do not know how different forms of self-help compare (e.g. bibliotherapy versus computerised self-help). The current study aims to assess attitudes towards multiple forms of self-help in terms of how acceptable it is deemed to be for the treatment of depression.

**2.1.1 Choice of treatments.** The current study sought to investigate attitudes toward and preferences for three forms of self-help that are commonly available in the UK as part of the IAPT program or the “Books on Prescription” scheme; namely guided self-help, computerised self-help and bibliotherapy (see 1.3.1, 1.3.2 & 1.3.3). In addition, the current study sought to assess attitudes toward self-help materials that are based on the principles of positive psychology. Self-help is not always accessed through official access points such as the NHS or via a GP and so the current study aimed to assess a form of self-help that is not available via these access points; namely, self-help based on the principles of positive psychology. As noted in section 1.3.4, researchers studying interventions designed to increase positive emotions, found that these interventions can also decrease symptoms of depression (e.g. Boiler et al., 2013; Sin & Lyubomirsky, 2009) and, as a result, self-help resources based on these interventions have emerged. For example, Lyubomirsky (2007) (see 1.3.4) but also more recently a self-help book titled “Positive Psychology for Overcoming Depression” (Akhtar, 2012) has been published. It is of interest to examine attitudes towards newer treatments not available via the NHS as, if they are acceptable to patients and research trials can demonstrate there efficacy in decreasing symptoms of depression, then they may offer an alternative treatment approach that could be offered alongside traditional treatments, thus increasing the number of treatment options available to patients.

**2.2 Using an Analogue Design**

Like Landreville et al. (2001) the study reported in chapter 2 (hereby known as study 1) opted to use an analogue design using a non-clinical sample, as studying non-clinical samples allows researchers to measure attitudes towards treatments (e.g. concerning acceptability, side effects and preferences) that are not confounded by factors that influence actual help-seeking behaviour (e.g. treatment outcome, privacy, side effects, time constraints, etc.), which might be the case in a clinical help-seeking sample or a sample who have received the treatment they are asked to rate. In the USA, the public health services recommend primarily consulting nonclinical analogue samples when assessing attitudes towards treatments and preferences for treatment (Gold, Siegel, Russell & Weinstein, 1996) as often the general public bears the brunt of the costs associated with treatment distribution and should therefore have a say in how resources are allocated. In addition nonclinical samples are likely to be more objective, as they are less likely to have a hidden agenda or strategic bias when evaluating treatments (Dolan, 1999) and may be less likely to be influenced by actual treatment experience (e.g. if they found a particular self-help book ineffective, this does not mean that all bibliotherapy books would be unacceptable to them). Evidence suggests that the opinions of an analogue sample may be comparable to a clinical sample when it comes to attitudes and preferences towards treatments for psychiatric disorders such as depression. For example, McHugh, Whitton, Peckham, Welge and Otto (2013) conducted a meta-analysis of 34 studies that examined preferences towards medication and therapy for psychiatric disorders (such as depression, anxiety, insomnia and eating disorders etc.) in clinical and analogue samples. They found a preference for therapy over medication in both clinical and analogue samples, however they did not analyse preference separately by psychiatric disorder and so it is unclear whether differences in preference for therapy over medication occur between those with depression and those with other disorders. To date no study has compared preferences for therapy versus medication for those with depression versus other psychiatric disorders in analogue and clinical samples simultaneously. As such there is a gap in the literature regarding the differing attitudes of preferences to treatments between those experiencing different forms of psychiatric disorder. Future research could explore this issue, as it may be inappropriate to offer treatments for certain disorders that those experiencing the disorder find un-preferable.

**2.3 Preferences for Depression Treatments**

As discussed previously an additional way to investigate patients’ opinions and feelings about different forms of treatment is to investigate preferences, wherein participants are asked to indicate which would be their preferred treatment option from a range of approaches and/or to rank order intervention approaches. For example, Kwan, Dimidjian and Rizvi (2010) conducted a RCT comparing medication and psychotherapy for depression. Participants were asked to state whether they preferred medication, psychotherapy or neither treatment (i.e. they had no preference). When participants were not randomised to their preferred treatment (i.e. they stated that they preferred psychotherapy but were randomised to receive medication), there was a greater chance of premature attrition from the treatment. These findings show how important treatment preference is, as preference for a given type of treatment for depression may influence levels of uptake, adherence and attrition (Raue & Schulberg, 2007). Although we know much about preferences for therapy versus antidepressant medication and its impact upon engagement with the given treatment, little research has examined preferences towards self-help treatments and how they fare in relation to therapy or medication (Cooper-Patrick et al., 1997).

**2.4 What Variables Influence Treatment Preferences?**

In addition to understanding treatment preferences, it is important to understand individual differences between people in their preferences for treatment. Information regarding patient treatment preferences and of the individual differences associated with such preferences could help primary care trusts by highlighting both the preferences that need to be supported via practice infrastructure and the patients who may be at risk for not receiving their preferred treatment, potentially leading to problematic rates of engagement (Schulberg, Magruder & DeGruy, 1996).

Studies have found that individual differences such as gender, ethnicity, age, income, body mass index and family composition influence treatment preferences for depression (Dwight-Johnson, Sherbourne, Liao & Wells, 2000; Morey, Thacher & Craighead, 2007). Although, to our knowledge, researchers have yet to assess individual differences in preference for UK samples and have yet to explore other individual difference variables, such as optimism, self-efficacy, locus of control, the big-5 personality dimensions (openness, conscientiousness, extraversion, agreeableness and neuroticism) and beliefs about the malleability of depression in relation to treatment preference. Examining these moderators might be informative to practitioners. For example, patients who view depression as a fixed entity (i.e. who believe that “No matter how hard they try, people can’t really change the emotions that they have”, Tamir, John, Srivastava & Gross, 2007) may be more likely to prefer antidepressant medications over self-help interventions designed to change negative emotions. In addition patients who are introverted (i.e. who see themselves as “reserved and quiet”, Gosling, Rentfrow & Swann, 2003) may be more likely to prefer self-help interventions, where they can work through their problems independently. Although treatments for depression are effective, individual patients vary in how they respond to specific treatments and perhaps by further exploring individual differences we can understand more about why some people respond better to certain types of treatment, while others do not.

**2.5 Study 1 Aims**

Study 1 aimed to (1) examine the perceived acceptability of multiple types of self-help simultaneously, examining: (i) guided self-help; (ii) unguided bibliotherapy; (iii) unguided computerised self-help; and (iv) unguided self-help interventions based on the principles of positive psychology, (2) compare how acceptable people find traditional treatments (face-to-face psychotherapy and antidepressant medication) in comparison to self-help that is both guided and unguided, (3) explore treatment preferences, by specifically asking participants to rank the six treatments in order of preference, and (4) explore whether individual difference variables impact upon treatment preference rankings.

The present research asks participants to imagine that they are depressed (a description and personal account are provided to facilitate this process) and then randomly allocates one of six treatment options to each participant. Participants read about the treatment and then rate how acceptable they find it, as well as how severe they perceive the side effects to be. The advantage of this design is that potential confounds such as past experience and demographic factors are controlled for. Moreover, the design enables us to carefully control the amount and the nature of information that participants receive about each treatment. In addition to making between-participants comparisons (e.g. comparing treatment ratings of participants randomly allocated to guided self-help versus antidepressants), the present research also capitalises on the benefits of a within-participant design. Specifically, after participants have rated the treatment option to which they were assigned, they are asked to read brief descriptions of the other treatment options before ranking the options in order of preference. By so doing, the present research can directly answer questions about treatment preferences (e.g. if treatment X was unavailable, would people prefer treatment Y or Z instead?), as well as investigate the factors that influence preference.

**2.6 Study 1 Preliminary work**

Preliminary work was conducted to develop materials to be used in the main study. Specifically, we wanted to ensure that the personal account of depression would enable the participants to understand how it feels to be depressed. In addition, we wanted to ensure that the treatment descriptions were comparable in terms of readability, understandability, and perceived bias. Finally, we wanted to ensure that the brief treatment descriptions were reflective of there full-length counterparts.

**2.6.1 Participants and Procedure.** The preliminary study recruited 54 postgraduate students studying in the Psychology department at the University of Sheffield. The sample was made up of 42 females (77.80%) and 12 males (22.20%). Participants were emailed a link to an online questionnaire (see appendix 1), which took around 20 minutes to complete. Ethical approval for the preliminary work was granted alongside the main study from the University of Sheffield (see appendices 2 & 3).

Participants read two different accounts of depression (one referring to ‘Helen’, the other referring to ‘David’) in a counterbalanced order (see appendix 1 for the two accounts).

Participants were asked seven questions about each of the accounts of depression (see Table 1) and asked which of the two accounts they felt best captured the essence of how it feels to be depressed. Participants were then asked to read the treatment descriptions before being asked to answer four questions about each of the longer treatment descriptions (see Table 2) and five questions about each of the brief treatment descriptions (see Table 3).

**2.6.2 Results.**

***2.6.2.1 Personal accounts of depression.*** Two personal accounts of depression (Helen’s and David’s) were presented to the participants. The participants answered seven questions about each of the personal accounts, see Table 1 for these seven questions and the associated descriptive statistics. All questions were answered using a seven point Likert scale ranging from one (strongly disagree) to seven (strongly agree).

**Table 1: Descriptive Statistics for the Seven Questions assessing the Personal Accounts of Depression**

Question Mean N SD

1. Helen's account of depression was easy to read? 4.90 52 1.81

2. David’s account of depression was easy to read? 5.57 52 1.91

3. Helen's account of depression brought to life the experience of depression? 5.25 52 1.33

4. David's account of depression brought to life the experience of depression? 5.62 52 1.33

5. Helen's account of depression fitted my understanding of how it might feel to be depressed? 5.22 51 1.38

6. David’s account of depression fitted my understanding of how it might feel to be depressed? 5.78 51 1.14

7. Helen's account of depression made me realise the severity of depression? 4.96 52 1.48

8. David's account of depression made me realise the severity of depression? 5.60 52 1.36

9. Helen's account of depression made it easy for me to imagine that I was depressed? 4.35 51 1.81

10. David's account of depression made it easy for me to imagine that I was depressed? 4.61 51 1.80

11. Helen's account of depression highlighted a number of the symptoms of depression? 5.02 51 1.59

12. David's account of depression highlighted a number of the symptoms of depression? 5.67 51 1.05

13. Helen's account of depression made it easy for me to imagine how suffering from 5.13 52 1.50

depression would affect my day-to-day life?

14. David's account of depression made it easy for me to imagine how suffering from 5.56 52 1.29

depression would affect my day-to-day life?

Table 1 shows that participants rated each of the accounts of depression relatively positively (in the sense that they were easy to read, brought to life the experience of depression and so on). Scores were summed to create an overall score for Helen’s account (α = 0.86) and David’s account (α = 0.85). In order to establish whether there were significant differences between the overall mean scores for the two accounts of depression, a repeated measures analysis of variance (ANOVA) was used. Significant differences were observed between Helen (*M* = 5.01, SD = 1.14) and David’s (*M* = 5.52, SD = 1.04) personal accounts, with participants showing a preference for David’s account, *F*(1,48) = 8.47, *p <* .01. When asked to choose a personal account of depression that best captured the essence of how it feels to be depressed, the majority of participants voted for David’s account (32 participants) rather than Helen’s account (17). Please note that five participants did not vote. We therefore used David’s account of depression in the main study.

***2.6.2.2 Treatment descriptions.*** Four questions were asked of each of the treatment descriptions, concerning readability, understandability, ability to imagine what the treatment entailed and the neutrality/bias of the treatment descriptions. See Table 2 for the descriptive statistics for each of the six treatment descriptions. All questions were answered using a seven point Likert scale ranging from one (strongly disagree) to seven (strongly agree).

**Table 2: Descriptive statistics for the six treatment descriptions**

Question Mean N SD

Psychotherapy

1. How easy was the treatment description to read? 2.02 45 1.16

2. How easy was it to understand what this treatment involved? 2.42 45 1.22

3. How easy was it to imagine what receiving this type of treatment would be like? 2.64 45 1.38

4. The treatment description was neutral and unbiased? 3.89 45 2.13

Antidepressants

1. How easy was the treatment description to read? 2.76 46 1.69

2. How easy was it to understand what this treatment involved? 2.66 44 1.36

3. How easy was it to imagine what receiving this type of treatment would be like? 3.30 46 1.62

4. The treatment description was neutral and unbiased? 3.93 44 1.99

Bibliotherapy

1. How easy was the treatment description to read? 2.57 46 1.36

2. How easy was it to understand what this treatment involved? 2.61 46 1.15

3. How easy was it to imagine what receiving this type of treatment would be like? 2.98 46 1.34

4. The treatment description was neutral and unbiased? 3.83 46 1.90

Positive Psychology

1. How easy was the treatment description to read? 2.30 47 1.43

2. How easy was it to understand what this treatment involved? 2.57 47 1.33

3. How easy was it to imagine what receiving this type of treatment would be like? 2.81 47 1.35

4. The treatment description was neutral and unbiased? 3.79 47 1.84

Internet

1. How easy was the treatment description to read? 2.34 47 1.55

2. How easy was it to understand what this treatment involved? 2.57 47 1.43

3. How easy was it to imagine what receiving this type of treatment would be like? 2.81 47 1.23

4. The treatment description was neutral and unbiased? 3.68 47 1.81

Guided

1. How easy was the treatment description to read? 2.38 45 1.23

2. How easy was it to understand what this treatment involved? 2.30 46 1.03

3. How easy was it to imagine what receiving this type of treatment would be like? 3.02 46 1.37

4. The treatment description was neutral and unbiased? 3.63 46 1.93

Table 2 shows that the participants rated the detailed treatment descriptions as easy to read and understand, and allowing them to imagine what receiving the treatment would be like (i.e., all of the means were below the midpoint of the scale). Participants felt that all of the treatment descriptions were slightly biased (i.e., all means were above the midpoint of the scale). In order to investigate whether there were significant differences between ratings of the different treatments, a series of repeated measures ANOVAs were performed, using Bonferroni adjustment to correct for multiple tests (*p* = 0.01). No significant differences were observed between the five treatment descriptions for any of the four questions (*p >* 0.05 in all cases).

***2.6.2.3 Brief treatment descriptions.*** Five questions were asked of each of the brief treatment descriptions, concerning readability, understandability, ability to imagine what the treatment entailed, neutrality/bias and the extent to which the brief treatment description reflected the longer treatment description. See Table 3 for the descriptive statistics for each of the six brief treatment descriptions.

**Table 3: Descriptive statistics for the six brief treatment descriptions**

**Question Mean N SD**

Psychotherapy

1. How easy was the treatment description to read? 1.66 38 1.30

2. How easy was it to understand what this treatment involved? 2.24 38 1.26

3. How easy was it to imagine what receiving this type of treatment would be like? 2.55 38 1.35

4. The treatment description was neutral and unbiased? 3.74 38 2.06

5. The brief treatment description captured the essence of the longer treatment description? 4.76 38 1.91

Antidepressants

1. How easy was the treatment description to read? 1.74 38 1.25

2. How easy was it to understand what this treatment involved? 2.18 38 1.52

3. How easy was it to imagine what receiving this type of treatment would be like? 2.79 38 1.56

4. The treatment description was neutral and unbiased? 4.05 38 2.05

5. The brief treatment description captured the essence of the longer treatment description? 4.75 36 1.70

Bibliotherapy

1. How easy was the treatment description to read? 2.03 38 1.53

2. How easy was it to understand what this treatment involved? 2.53 38 1.45

3. How easy was it to imagine what receiving this type of treatment would be like? 3.11 38 1.49

4. The treatment description was neutral and unbiased? 4.03 37 2.17

5. The brief treatment description captured the essence of the longer treatment description? 4.76 38 1.76

Positive Psychology

1. How easy was the treatment description to read? 1.68 38 1.38

2. How easy was it to understand what this treatment involved? 2.87 38 1.61

3. How easy was it to imagine what receiving this type of treatment would be like? 3.26 38 1.64

4. The treatment description was neutral and unbiased? 4.00 38 2.09

5. The brief treatment description captured the essence of the longer treatment description? 4.19 36 1.86

Internet

1. How easy was the treatment description to read? 1.61 38 1.20

2. How easy was it to understand what this treatment involved? 2.45 38 1.39

3. How easy was it to imagine what receiving this type of treatment would be like? 3.11 38 1.56

4. The treatment description was neutral and unbiased? 3.92 38 2.25

5. The brief treatment description captured the essence of the longer treatment description? 4.78 37 1.86

Guided

1. How easy was the treatment description to read? 1.71 38 1.35

2. How easy was it to understand what this treatment involved? 2.03 38 1.33

3. How easy was it to imagine what receiving this type of treatment would be like? 2.37 38 1.10

4. The treatment description was neutral and unbiased? 3.61 38 2.52

5. The brief treatment description captured the essence of the longer treatment description? 5.46 37 1.48

Table 3 shows that the participants rated the brief treatment descriptions as easy to read, easy to understand and allowed them to imagine what receiving the treatment would be like (i.e., all means were below the midpoint of the scale). As with the detailed treatment descriptions, participants tended to feel that the brief treatment descriptions were slightly biased (i.e., all means were above the midpoint of the scale). Participants did, however, agree that the brief treatment descriptions captured the essence of the longer treatment descriptions (i.e., all means were above the midpoint of the scale). In order to investigate whether there were significant differences in ratings of the five brief treatment descriptions, a series of repeated measures ANOVAs were performed, with Bonferroni adjustment as before.

Significant differences were observed between the five brief treatment descriptions for question three only (“How easy was it to imagine what receiving this type of treatment would be like”?) *F*(4, 34) = 3.56, *p* < 0.01 (all other *F*s < 2.53, *p* > .06). Post hoc analysis showed that the brief treatment description for Internet self-help (*M* = 3.11, SD = 1.56) enabled participants to more easily imagine what the treatment would be like than the brief treatment description for guided self-help (*M* = 2.37, SD = 1.10).

***2.6.3 Discussion.***

The preliminary study was able to fulfill its three main aims, which were to establish (a) which personal account of depression best captured the essence of how it feels to be depressed, (b) whether the detailed and brief treatment descriptions were comparable and (c) whether the brief treatment descriptions accurately portrayed there longer counterparts. In terms of the personal accounts of depression, participants favored David’s account and so that is the one that was used in the main study. In terms of the full length and brief treatment descriptions only one difference was noted, with participants rating the brief treatment description for Internet self-help as more easily enabling them to imagine what the treatment would be like than the brief treatment description for guided self-help.

**2.7 Study 1**

**2.7.1 Method.**

***2.7.1.1 Sample.*** Staff and students at the University of Sheffield were emailed an invitation (see appendix 4) to take part in a study examining attitudes toward treatments for depression; *N* = 639 participants responded, of whom 78.32% were female. There were no significant differences between males and females in terms of previous experience of depression, current mean depression scores, how acceptable they rated the treatment, how severe they perceived the side effects to be or how they ranked the treatments in terms of preference (*p* > 0.05 in all cases). Participants were aged between 17 and 76 years, (*M* = 29.53, *SD* = 12.57); 68.59% were students and 80.88% were White British. The next highest proportion of participants indicated that they were from an “other White background” (3.96%) or were “Asian Bangladeshi” (3.08%). The sample was assessed for current depression using theCenter for Epidemiologic Studies Depression Scale (CES-D, Radloff, 1977). The CES-D is one of the most frequently used self-report measures of depression symptomology (Santor, Gregus & Welch, 2006) and has robust psychometric properties, with high levels of convergent validity (e.g. r = 0.81) with the Beck Depression Inventory (Beck et al., 1996) and good sensitivity for detecting depression (e.g. 99% sensitivity for severe depression) (Weissman, Sholomskas, Pottenger, Prusoff & Locke, 1977). Unlike other measures of depression, the CES-D is designed to assess levels of depression symptomology amongst the general population (Wood, Taylor & Joseph, 2010) making this measure suitable for the current study, as the population sampled is non-clinical. The CES-D includes twenty items (e.g. “*I was bothered by things that don’t usually bother me*”) and participants are asked to rate how often they have felt this way during the last week. High scores indicate the presence of more symptoms (α = 0.90). See appendix 5. The mean score was 26.60 (*SD* = 13.45), which indicates relatively high levels of depression symptoms across the sample (Radloff, 1991). Just over half (50.28%) of participants reported having previously experienced depression. Table 4 shows the characteristics of the sample by condition (one of six treatment options). There were no significant differences between the six conditions in terms of gender split, mean age, occupation, ethnicity, previous experience of depression or current mean depression scores, (*p* > 0.05 in all cases).

**Table 4: Participant Characteristics by Treatment Option**

Treatment Option % Female Age (SD) % White British % with Depression History CES-D (SD)

Psychotherapy 61.49% 32.87 (14.66) 60.42% 37.50% 25.11 (13.10)

Guided 60.00% 32.79 (14.98) 52.38% 43.81% 25.72 (32.79)

Positive 67.96% 27.61 (11.50) 58.25% 47.57% 25.83 (12.44)

Bibliotherapy 66.98% 28.32 (11.49) 55.66% 44.34% 26.52 (13.61)

Internet 70.18% 27.50 (10.29) 62.28% 39.47% 26.35 (13.71)

Antidepressants 66.09% 28.67 (11.35) 56.52% 40.00% 29.80 (13.19)

***2.7.1.2 Procedure.*** Participants were first asked to read a brief description of depression (“*Depression is a serious mental illness that is characterised by a number of unpleasant symptoms. These symptoms include a low depressed mood which is constantly present every day*…”) followed by a personal account of how it feels to be depressed (“*I felt detached from the world around me. All emotions – love, affection, anger – were gone*…”). The description and personal account totalled 276 words in length, and were both taken from the website of the mental health charity, Mind (Stewart, 2010). See appendices 6 and 7.

Once participants had read the description and personal account of depression they were randomly[[1]](#footnote-1) allocated a detailed description of one of the following to read: psychological therapy, antidepressant medication, guided self-help, unguided bibliotherapy, unguided Internet-based self-help, or unguided self-help based on the principles of positive psychology. Each description contained information regarding what the treatment involved, what the different treatment subtypes were (e.g. examples of the different types of psychotherapy available) and how the treatment could be accessed. The descriptions of psychological therapy and antidepressant medication were taken from a leading UK mental health charity, Rethink (Rethink, 2012a, 2012b). These documents were edited to make them shorter and they were used as a template for the descriptions of the four self-help treatments. See appendix 8 for the detailed treatment descriptions. Once participants had read the detailed treatment description, they rated how acceptable they found it using the Treatment Evaluation Inventory (Landreville & Guérette, 1998). All participants were then asked to read brief descriptions of the six treatments, which were developed by shortening the detailed treatment descriptions. See appendix 9. Having read all of the brief descriptions, participants were asked to rank the six treatments in order of preference. Participants were then asked to fill out a questionnaire designed to measure the factors that may impact upon how acceptable a treatment is deemed to be. The questionnaire measured depression, optimism, self-efficacy, locus of control, big-5 personality dimensions and beliefs about the malleability of depression. Ethical approval for the study was granted alongside the preliminary work from the University of Sheffield (see appendix 2 & 3).

***2.7.1.3 Measures.*** Participants rated how acceptable they found the treatment option they were allocated using the Treatment Evaluation Inventory (Landreville & Guérette, 1998).This inventory was developed to measure how acceptable people find different treatments for depression, and consists of nine questions: (1) “*How acceptable would you find this treatment for treating your depression?*”, (2) “*How consistent is this treatment with your common sense or everyday notions about what a treatment for depression should be?*”, (3) “*To what extent do you think there might be risks in undergoing this kind of treatment?*”, (4) “*How much do you like the procedures used in this treatment?*”, (5) “*How effective do you think this treatment is likely to be?*”, (6) “*How likely is this treatment to make permanent improvements to your depression?*”, (7) “*To what extent do you think undesirable side effects are likely to result from this treatment?*”, (8) “*How much discomfort do you think you would be likely to experience during the course of treatment?*” and (9) “*Overall, what is your general reaction to this form of treatment?*” Participants were asked to respond to each question on a seven point Likert scale with high scores indicating that they found the treatment acceptable and associated with few side effects. The nine items of the Treatment Evaluation Inventory were entered into aprinciple components analysis with oblimin rotation. Consistent with Landreville and Guérette (1998), two components were extracted based on Kaiser’s (1957) criterion (i.e. had eigenvalues greater than 1.00) that accounted for 69.12% of the variance. Both factors proved internally reliable (α = 0.92 and 0.68) and were labelled “acceptability” (items one, two, four, five, six, and nine) and “side effects” (items three, seven, and eight), respectively, see Table 5. Factor scores were computed for each component.

**Table 5: Direct Oblimin Rotation for the Two Factor Solution for the Modified Treatment Evaluation Inventory Items**

Item Component 1: Component 2:

Acceptability Side effects

How effective do you think this treatment is likely to be? 0.88

Overall, what is your general reaction to this form of treatment? 0.91

How acceptable would you find this treatment for treating your depression? 0.86

How likely is this treatment to make permanent improvements to your depression? 0.85

How consistent is this treatment with your common sense or everyday notions about what a

treatment for depression should be? 0.76

How much do you like the procedures used in this treatment? 0.83 -0.40

To what extent do you think there might be risks in undergoing this kind of treatment? 0.83

How much discomfort do you think you would be likely to experience during the course of treatment? 0.77

To what extent do you think undesirable side effects are likely to result from this treatment? 0.73

Note. Loadings < 0.40 are suppressed

Participants also filled out the following questionnaires once they had ranked the treatments in order of preference. TheCES-D (Radloff, 1977) was used to measure current symptoms of depression (see 2.7.1.1 for further details).

The Life Orientation Test (LOT-R; Scheier & Carver, 1985) was used to measure levels of dispositional optimism. The scale comprises of ten items divided into items measuring optimism (e.g. “*In uncertain times I usually expect the best*”), items measuring pessimism (e.g. “*If something can go wrong for me, it will*”) and filler items (e.g. “*It is easy for me to relax*”). Participants are asked to rate their level of agreement (from one (strongly agree) to six (strongly disagree)) with high scores indicating high levels of dispositional optimism (α = 0.79). See appendix 10.

The Generalised Self-Efficacy Scale (Schwarzer & Jerusalem, 1995) was used to assess participants’ general sense of perceived self-efficacy. The scale contains ten items (e.g. “*I can always manage to solve difficult problems if I try hard enough*”), to which participants respond on a four point Likert scale that ranges from one (strongly disagree) to four (strongly agree). High scores reflect high levels of self-efficacy (α = 0.92). See appendix 11.

The **Multidimensional Health Locus of Control (MHLC) scales (**Wallston, Wallston & DeVellis, 1978) were used to assess three types of health-related locus of control. The first, “*internal*” subscale contains six items that measure the extent to which participants believe that they are responsible for their own health (e.g. “*If I get sick, it is my own behaviour which determines how soon I get well again*”). The second subscale, “*powerful others*” again has six items which measure participants’ belief that external people (e.g. doctors, nurses, therapists, etc.) hold the key to their health (e.g. “*If I see an excellent doctor regularly, I am less likely to have health problems*”). Finally, the third subscale, “*chance*” contains six items that measure the extent to which participants believe that health is a matter of luck or chance that is outside of external control (e.g. “*No matter what I do, if I am going to get sick, I will get sick*”). Participants respond to the items on a six point Likert scale, ranging from one (strongly disagree) to six (strongly agree), and high scores indicate that participants believe that either themselves, powerful others, or luck are key to maintaining good health, respectively (α = 0.65, 0.73, and 0.58, for the three subscales respectively). See appendix 12.

The Ten-Item Personality Inventory (TIPI; Gosling, Rentfrow & Swann, 2003) was used to measure the big-five personality dimensions. Participants were asked to indicate, using a seven point Likert scale ranging from one (strongly disagree) to seven (strongly agree), the extent to which they agree with ten statements (e.g. “*I see myself as extraverted, enthusiastic*”). The two items for each personality trait were summed to create measures of extraversion (*r* = 0.60), agreeableness (*r* = 0.26), conscientiousness (*r* = 0.47), emotional stability (r = 0.57) and openness to experience (*r* = 0.25). See appendix 13.

To measure beliefs about the malleability of depression, items from the Implicit Theories of Emotion Scale (Tamir et al., 2007) were modified to refer to beliefs about the fixed versus malleable nature of depression (i.e. an entity versus incremental view of depression, respectively). The original scale contains two items that reflect the idea that emotions are malleable, “*Everyone can learn to control their emotions*” and “*If they want to, people can change the emotions they have*”, which were changed to “*Everyone can learn to control their depression*” and “*If they want to, people can change the feelings of depression that they have*”. Two further items reflected the idea that emotions are fixed, “*No matter how hard they try, people can’t really change the emotions that they have*” and “*The truth is, people have very little control over their emotions*”, which were changed to “*No matter how hard they try, people can’t really change the depression that they suffer from*” and “*The truth is, people have very little control over their depression*”. Items were rated on a six point Likert scale ranging from one (strongly disagree) to six (strongly agree). To create an overall score, the two entity items are reversed, before the four scores are summed (α = 0.81). High scores therefore indicate an incremental (malleable) view of depression and low scores represent an entity (fixed) view of depression. See appendix 14. Participants were also asked their gender, age, ethnic origin, occupation and history of depression.

**2.7.2 Results.**

***2.7.2.1 How acceptable is self-help for depression?*** Table 6 shows the mean acceptability and side effects scores for each of the six treatment options. A one-way between-groups multivariate analysis of variance (MANOVA) was performed to investigate differences in ratings of acceptability and side effects between the six treatment descriptions. There was a statistically significant difference between the treatment conditions on the combined dependent variables, *F* (10, 618) = 15.92, *p* < 0.00 eta2 = 0.11. Perceptions of both acceptability, *F* (5, 618) = 15.00, *p* < 0.00, eta2 = 0.11, and side effects, *F* (5, 618) = 15.32, *p < 0.00*, eta2= 0.11, differed between treatments. Pairwise comparisons with Bonferroni adjustment revealed that psychological therapy and guided self-help were believed to be the most acceptable treatment options for depression. There was no significant difference between how acceptable participants viewed psychological therapy and guided self-help (*p* = .82). Psychological therapy and guided self-help were, in turn, rated as significantly more acceptable treatment options than antidepressant medication, bibliotherapy, and Internet-based self-help (*p* < 0.01 in all cases). There were no differences in how acceptable participants found self-help interventions based on the principles of positive psychology and guided self-help (*p* = .14), but therapy was rated as more acceptable than self-help interventions based on the principles of positive psychology (*p* < 0.00).

In terms of perceived side effects, pairwise comparisons with Bonferroni adjustments revealed that antidepressant medication was rated as significantly (*p* = 0.00) more likely to have side effects than psychological therapy, which in turn was deemed to have significantly more side effects than bibliotherapy, guided self-help, Internet-based self-help interventions, and self-help interventions based on the principles of positive psychology. There were no differences in perceived side effects between any of the other self-help interventions (*p* < 0.05 in all cases).

***2.7.2.2 Do current symptoms of depression or previous experience of the treatments influence how acceptable people find treatments for depression?*** Radloff (1991) proposed that scores of 16 or higher on the CES-D scale indicate the presence of depression symptoms, with higher scores indicating higher levels of symptomology. In the present sample 64.16% of participants scored above this cut off point. Table 6 also shows the mean acceptability and side effects scores for each of the six treatments separated by participants with and without symptoms of depression (using Radloff’s, 1991, cut off) and participants with and without treatment experience.

**Table 6: Mean Levels of Treatment Acceptability and Side Effects by Treatment Condition for the Whole Sample and Broken Down by Symptoms of Depression versus No Symptoms of Depression and Treatment Experience versus No Treatment Experience.**

Therapy Guided Positive Bibliotherapy Internet Antidepressants

N Mean (SD) N Mean (SD) N Mean (SD) N Mean (SD) N Mean (SD) N Mean (SD)

Whole Sample

Acceptability 96 0.59 (0.87)a 99 0.33 (0.95)b 102 -0.02 (0.97)a 104 -0.27 (1.03)a, b 111 -0.26 (0.95)a, b 112 -0.27 (0.92)a, b

Side effects 96 0.10 (0.94)a, c 99 -0.07 (0.92)a 102 -0.20 (0.99)a 104 0.37 (1.01)a 111 -0.16 (0.97)a 112 0.65 (0.87)a, c

Symptoms of depression

Acceptability 60 0.61 (0.87) 60 0.17 (0.91)d  63 -0.19 (0.86) 70 -0.09 (1.03) 71 -0.32 (0.96) 77 -0.21 (0.95)

Side effects 60 0.15 (0.96) 60 -0.05 (0.95) 63 -0.34 (0.96) 70 -0.40 (0.99) 71 -0.16 (1.04) 77 0.61 (0.87)

No symptoms of depression

Acceptability 23 0.77 (0.89) 27 0.76 (0.93)d 23 0.24 (1.18) 25 -0.49 (0.93) 29 -0.24 (0.98) 17 -0.24 (0.87)

Side effects 23 -0.06 (0.97) 27 -0.18 (0.84) 23 0.01 (1.05) 25 -0.46 (1.13) 29 -0.16 (0.89) 17 0.42 (0.89)

Experience of treatment

Acceptability 25 0.66 (0.84) 2 0.26 (1.03) 1 -0.21 (0.94) 13 -0.18 (1.15) 7 -0.41 (1.08) 25 -0.16 (1.04)

Side effects 25 0.18 (1.05) 2 0.03 (0.81) 1 -0.15 (1.09) 13 -0.05 (1.04) 7 -0.02 (1.18) 25 0.54 (0.98)

No experience of treatment

Acceptability 43 0.62 (0.84) 71 0.30 (0.95) 60 0.01 (0.99) 61 -0.26 (0.96) 63 -0.30 (0.86) 48 -0.34 (0.89)

Side effects 43 0.00 (0.92) 71 -0.09 (0.96) 60 -0.31 (1.01) 61 -0.40 (0.88) 63 -0.09 (0.74) 48 0.71 (0.91)

a = Significantly different from Psychotherapy

b = Significantly different from Guided self-help

c = Significantly different from Antidepressant medication

d = Significant differences found between those with and without symptoms of depression

A series of one-way between-groups MANOVAs were performed to investigate differences in acceptability and side effects associated with the six treatments between those with and without symptoms of depression. There was a statistically significant difference between participants with symptoms of depression and those without symptoms of depression on the combined dependent variables for guided self-help only, *F* (2, 84) = 3.82, *p* = .03, eta2 = 0.08. Inspection of the univariate statistics revealed that those with and without symptoms of depression differed in how acceptable they found guided self-help, *F* (1, 85) = 7.72, *p* = .01, eta2 = 0.08, but not in the perceived side effects associated with guided self-help (*p* = .76). Pairwise comparisons revealed that participants with no symptoms of depression found guided self-help significantly more acceptable than participants with symptoms of depression. There were no differences in acceptability and side effects between participants with and without symptoms of depression for the remaining treatment conditions (*Fs* < 2.99, *ns* in all cases).

Table 6 also shows levels of acceptability and side effects associated with each of the six treatments for participants who have previous experience of the treatments versus those who do not. However, a series of one-way between-groups MANOVAs revealed no statistically significant differences between those with and those without treatment experience on the combined dependent variables (*F*s < 2.61, *ns* in all cases). Although caution should be noted when interpreting these findings as some treatments had very few people who had previous experience.

***2.7.2.3 Which treatments for depression do participants prefer?*** Once participants had rated how acceptable they found the detailed treatment description that they read about, they were asked to read shorter descriptions of all six treatments and to rank the treatments in order of preference. Table 7 shows the treatment options in order of preference.

**Table 7: Brief Treatment Descriptions in Order of Preference**

Treatment Mean SD

Psychotherapy 1.77 1.25

Guided self-help 3.25 1.40

Positive psychology 3.26 1.43

Antidepressants 3.76 1.86

Bibliotherapy 4.23 1.27

Internet-based 4.68 1.32

A Friedman test indicated that there were significant differences between the mean rank scores for the six brief treatment descriptions (*X2* = 853.34, *p* < 0.00). A series of Wilcoxon sign-ranks tests were carried out to provide post-hoc comparisons of mean ranks. Psychotherapy was ranked as significantly more preferable than all other treatments for depression; guided self-help (*z* = -14.23, *p* < 0.00), self-help based on the principles of positive psychology (*z* = -14.22, *p* < 0.00), antidepressant medication (*z* = -16.79, *p* < 0.00), bibliotherapy (*z* = -18.55, *p* < 0.00), and Internet-based self-help (*z* = -18.99, *p* < 0.00). Guided self-help was ranked significantly higher, in terms of preference, than antidepressant medication (*z* = -4.53, *p* < 0.00), bibliotherapy (*z* = -10.79, *p* < 0.00), and Internet-based self-help (*z* = -14.77, *p* < 0.00). Self-help based on the principles of positive psychology was ranked significantly more preferable than antidepressant medication (*z* = -4.45, *p* < 0.00), bibliotherapy (*z* = -10.73, *p* < 0.00) and Internet-based self-help (*z* = -13.79, *p* < 0.00). There were no significant differences in mean rank scores between guided self-help and self-help based on the principles of positive psychology (*z* = -0.10, *ns*). Antidepressant medication was ranked significantly higher than bibliotherapy (*z* = -4.38, *p* < 0.00) and Internet-based self-help (*z* = -8.31, *p* < 0.00). Finally, bibliotherapy was ranked significantly higher than Internet-based self-help (*z* = -6.09, *p* < 0.00). In summary, within-participants treatment preferences as measured by the ranking exercise supported the between-participants findings when participants were provided with detailed information and then rated the acceptability of that particular treatment.

***2.7.2.4 What factors influence treatment preferences for depression?***In order to evaluate the impact of various factors on treatment preferences, we computed correlations between the factors of interest and the ranked preference scores. To ensure that high scores represented more preferable treatments, mean rank scores were multiplied by -1 and standardised before being correlated with the factors of interest. Current symptoms of depression were negatively correlated with preferences for psychotherapy (*r* = -0.09, *p* = .03) and positively correlated with preferences for Internet-based self-help (*r* = 0.10, *p* = .02) suggesting that high levels of depression symptomology were associated with a preference for Internet-based interventions and a lack of preference for therapy.

Dispositional optimism was negatively correlated with preferences for Internet-based self-help (*r* = -0.11, *p* = .01) and positively correlated with preferences for self-help based on the principles of positive psychology (*r* = 0.12, *p* = .01) indicating that participants with high levels of dispositional optimism preferred self-help based on the principles of positive psychology over Internet-based self-help.

The internal sub-scale of the health locus of control scale was negatively correlated with preferences for antidepressants (*r* = -0.10, *p* = .01) indicating that participants who view themselves as central to maintaining their own good health tended not to prefer antidepressant medication. The chance sub-scale of the health locus of control scale was negatively correlated with preferences for positive psychology self-help interventions (*r* = -0.09, *p* = .03) suggesting that participants who view their good health as being down to chance or luck tended not to prefer self-help based on the principles of positive psychology.

Of the big-5 personality dimensions, extraversion was negatively correlated with preferences for bibliotherapy (*r* = -0.10, *p* = .02), conscientiousness was correlated with preferences for positive psychology self-help interventions (*r* = 0.11, *p* = .02), and emotional stability was correlated with preferences for self-help based on the principles of positive psychology (*r* = 0.09, *p* = .04). See Table 8, which shows that all the significant correlations reported here classified as small (r < 0.12 in all cases) according to Cohen’s (1988) criteria.

**Table 8: Correlations between Treatment Preference and Individual Difference Variables**

Therapy Guided Positive Bibliotherapy Internet Antidepressants

Depression Symptoms -.09\* .04 -.03 -.01 .10\* -.01

Optimism .05 .01 .12\*\* -.03 -.11\* -.03

Self-efficacy -.02 -.02 .08 .04 -.05 -.02

Locus of control – internal .01 -.01 .07 .08 -.01 -.10\*

Locus of control – chance .04 -.01 -.09\* .08 -.05 .06

Locus of control – powerful others -.03 -.00 -.05 .03 .04 .03

Extraversion .00 .02 .08 -.10\* -.02 .01

Agreeableness .04 .08 .03 -.03 -.08 -.03

Conscientiousness -.02 -.05 .11\* .01 -.06 .01

Emotional stability -.04 .01 .09\* -.03 -.01 -.01

Openness to experience -.02 .03 .02 .02 .01 -.05

Beliefs about depression .03 .02 .05 -.01 -.05 -.03

\* correlation is significant at the 0.05 level \*\* correlation is significant at the 0.01 level

**2.7.3 Discussion.** Self-help interventions have been found to be an effective way to manage the symptoms of depression (e.g. Cuijpers et al., 2010) and may offer a solution to the rising number of people requiring treatment for mental health problems. Unfortunately, however, relatively little research has been conducted on people’s attitudes toward self-help treatments and this is problematic given that one of the main assumptions underlying the use of low-intensity interventions, is that they are acceptable to patients (Bower & Gilbody, 2005). When self-help is seen as an unacceptable treatment option, patients may be unwilling to use it (Landreville & Guérette, 1998) and be unmotivated to adhere to the treatment plan correctly (Martin, Williams, Haskard & DiMatteo, 2005). To address this gap, the present research compared perceptions of four types of self-help with perceptions of psychological therapy and antidepressant medication. Preference for treatment and the impact of individual differences on treatment preferences were also explored.

***2.7.3.1 Psychotherapy.***

Psychotherapy was rated as being more acceptable and more preferable than antidepressant medications, which is in line with the previous literature (e.g. Raue & Schulberg, 2007). Previous literature had yet to explore how acceptable different forms of self-help are in relation to psychotherapy, however some initial studies (e.g. Landreville et al., 2001; Mohr et al., 2010; Schneider et al., 2014) had examined how acceptable one type of self-help was for depression (e.g. bibliotherapy or CCBT) in contrast to psychotherapy or seeing a psychologist. The current study found that when comparing multiple forms of self-help to psychotherapy, psychotherapy was the most preferred and most acceptable treatment option. These results held when controlling for current depression symptoms and treatment experience. Psychotherapy was rated as more acceptable than bibliotherapy, Internet based self-help and interventions based on the principles of positive psychology, which is in contrast to the findings reported by Landreville et al. (2001) and Schneider et al. (2014), however differences between these studies and the current study may account for this. For example, Landreville et al. was looking at the acceptability of bibliotherapy for mild symptoms of depression, whereas the current study did not specify the severity of the depression symptoms.

***2.7.3.2 Guided self-help.*** Although psychotherapy was rated as more acceptable and more preferable than unguided interventions, there were no differences in ratings of acceptability between psychotherapy and guided self-help, which was also the second most preferred treatment option. Guided self-help was also found to be the most acceptable self-help treatment option and was rated as more acceptable and more highly preferable than unguided interventions, indicating that participants favored treatments that contained some form of support. This finding is consistent with the findings of Mohr et al. (2010), who found that greater interest in receiving mental health treatment was associated with greater interest in receiving face-to-face contact. These findings also have clinical relevance as one of the main assumptions of IAPT and the stepped-care model is that the low intensity treatments offered to patients are acceptable (Bower & Gilbody, 2005). The present research finds that, although guided self-help is seen as a highly acceptable treatment option for depression, other unguided self-help interventions that are offered as part of the stepped-care approach are less acceptable. This may be problematic as low levels of treatment acceptability may lead to poor uptake or adherence, and higher levels of drop-out (Kaltenthaler et al., 2008). This would be unfortunate as, although less effective than guided self-help (Gellatly et al., 2007), unguided interventions have been found to be effective in reducing depression (e.g. Cuijpers, 1997).

***2.7.3.3 Side effects.*** The present research is, to our knowledge, the first to compare attitudes toward self-help interventions and antidepressant medication. Previous research has tended to find that antidepressant medication is an unpopular treatment option (Bedi et al., 2000), possibly due to the associated side effects (Khawam, Laurencic & Malone, 2006). The present research supports this idea, as antidepressant medication was perceived to have greater side effects than all other forms of treatment. However, the presence of side effects is unlikely to be the only reason that participants found treatments less acceptable, as there were no differences in perceived side effects between the four types of self-help – all were viewed as having low levels of negative risks associated with them – yet, bibliotherapy and Internet-based self-help were deemed to be less acceptable than guided self-help. The present study measured side effects as the risks and discomfort that might be experienced during treatment. The side effects for self-help treatments may be less risky and uncomfortable than, say, those associated with antidepressant medication, but there are other issues with self-help that the present study did not measure. For example, the commitment and effort required to undertake the treatment successfully and the associated burden. Perhaps guided self-help is perceived to be less of a burden than unguided self-help that requires higher levels of motivation and commitment to adhere to the treatment program.

***2.7.3.4 Treatment preferences.***In terms of preferences for treatment, the present study found that psychological therapy was the most preferred treatment option, followed by guided self-help. There is evidence to suggest that participants allocated to their preferred treatment (here, psychological therapy or antidepressant medication) perform significantly better (e.g. Chilvers et al., 2001, Kocsis et al., 2009; Kwan et al., 2010; Lin, et al., 2005; Mergl et al., 2011; Moradveisi, Huibers, Renner, & Arntz, 2014) and are less likely to drop out of treatment prematurely (Swift, Callahan & Vollmer, 2011) than participants who are randomly allocated to treatment conditions. Other studies, however, have found no impact of patient preference on treatment outcomes (e.g., Leykin et al., 2007; Moradveisi et al., 2014; Raue, Schulberg, Heo, Klimstra, & Bruce, 2009) and these discrepancies have led researchers to explore variables, such as engagement with treatment (e.g. Kwan et al., 2010) which may moderate the link between preference and treatment outcome. Specifically, there is evidence that treatment preference influences factors of engagement such as attrition. For example, Kwan et al. (2010) research shows that the impact of attitudes and preferences on treatment efficacy is mediated by engagement, whereby people who receive their preferred treatment engage with it more successfully, which leads to higher rates of efficacy post intervention. Future research needs to assess whether this is also the case for unguided self-help interventions. If unguided self-help interventions are less acceptable and less preferable to patients, and if this impacts upon engagement with the treatment and the treatment outcome, then this is problematic for service providers. Although less effective than guided self-help (Gellatly et al., 2007), unguided interventions have been found to be effective in reducing depression (e.g. Cuijpers, 1997), however they do often have problematic levels of engagement in the form of premature treatment discontinuation (e.g. Christensen et al., 2009). Researchers need to assess whether this is due to the patient feeling the treatment is unacceptable and/or having a preference for an alternative treatment. If this is the case then it would seem logical to provide extra funding to increase the amount of acceptable treatment options that are available for those with depression, (namely psychotherapy and guided self-help), rather than continuing to use unguided interventions that are unpopular with patients as treatment acceptability potentially leads to greater levels of engagement and thus higher rates of efficacy.

***2.7.3.5 Moderators of treatment preference.***A number of individual difference variables were found to be related to how participants perceived different treatments in terms of preference. For example, introverted participants showed a preference for bibliotherapy, while those who had less symptoms of depression showed a preference for therapy. However, these results should be interpreted with caution as it was noted that the correlations were all small (*r* < 0.12 in all cases), according to Cohen’s (1988) criteria, suggesting that individual difference variables (including depression symptoms, dispositional optimism, self-efficacy, locus of control, personality, and beliefs about the malleability of depression) may not have a substantial impact on treatment preference.

***2.7.3.6 Limitations.*** One limitation of the current study is the potential confound between intervention content and mode of treatment delivery. The descriptions of three of the self-help conditions examined, namely guided self-help, bibliotherapy and computerised self-help, described the mode of treatment delivery (e.g. via a book, computer program or guided support session), whereas the positive psychology self-help condition described the intervention content (e.g. The gratitude task) and this content could have been delivered via any of the modes covered in the other self-help conditions. As a result, it is possible that participants were focusing on mode of delivery when rating their attitudes toward guided self-help, bibliotherapy and computerised self-help, but intervention content when rating positive psychology self-help interventions. As such, further research is needed that carefully matches descriptions of different treatment content with mode of delivery (and vice versa). It should, however, be noted that in practice content and mode of delivery are rarely independent and that the treatment descriptions employed in the present research represent the nature of treatments that are currently available.

The current study sought the opinions of postgraduate psychology students when assessing the treatment descriptions in the preliminary work. These students were made up of academic psychologists and clinical psychologists, although no distinction could be made in their views of the descriptions due to the anonymous nature of the data collected. Perhaps the preliminary study should have only sought the opinions of clinical postgraduate students, given the nature of the study, or recorded whether they were an academic or clinical psychologists, to assess if differences occurred in their opinions of the treatment descriptions.

Another drawback to the present research is the between sample design, where participants read one of six detailed treatment descriptions before rating that treatment in terms of acceptability. In a clinical setting, patients are not typically offered only one treatment, rather multiple treatment options are discussed with the patient. However, the present research simulated this process in the within sample design, where participants rated all six treatments in terms of preference. The preference data matched the acceptability data, in that both psychotherapy and guided self-help were viewed as the most acceptable and most preferred treatment options.

The sample of the present research was also nearly 80% female, which is much higher than the percentage of females found in the broader population and from which the sample was drawn. No differences were found in terms of attitudes or preferences towards the treatment options between males and females.

An analogue design was used, recruiting participants who were not actively seeking help for depression. The advantage of this design is that attitudes towards treatments are not clouded by actual help-seeking behaviour. In retrospect, no differences were found in treatment acceptability and perceived side effects between participants with previous experience of treatment for depression and participants without. Furthermore, there were few differences between those who had current symptoms of depression and those who did not. Both these findings suggest that our analogue sample is likely to closely approximate the beliefs of a more clinical sample. Having said this, further research could aim to replicate the present approach in a help-seeking sample (e.g. those contacting counselling services or referred to primary care).

Finally, it will be important for future research to try to understand the determinants of the different attitudes towards psychotherapy and guided self-help versus unguided self-help for depression. For example, qualitative interviews could be conducted with participants who have received unguided self-help for depression. Macdonald et al. (2007) interviewed participants who had received guided self-help for depression. These interviews uncovered themes that may point to potential reasons why attitudes toward psychotherapy and guided self-help versus unguided self-help may differ. For example, participants reported difficulties engaging with the intervention due to the symptoms of depression, such as low motivation, or poor concentration. These issues may be even more salient for those receiving unguided self-help as they have no-one to help them to overcome these barriers. In addition, treatments that incorporate face-to-face contact may be perceived to provide more helpful and specific guidance/coaching around the implementation of self-help techniques, however further research is required to ascertain whether this is the case. In summary, a lack of social support for engaging with self-help interventions may be one factor underpinning the finding that unguided self-help is less acceptable than guided self-help and psychotherapy; however, future research is warranted to test this idea.

***2.7.3.7 Conclusions.*** Evidence suggests that self-help is an effective treatment for depression, however less is known about how acceptable self-help is or how it fares in terms of preference in comparison to antidepressant medication or psychotherapy. The present research found that psychotherapy was the most acceptable and most preferred treatment option. While guided self-help was the second most preferred treatment option (after psychotherapy) and was perceived to be as equally acceptable as psychological therapy.

Other self-help treatments for depression that were unguided were found to be less acceptable and less preferable. Future research should focus on understanding why treatments with some form of additional support, such as psychotherapy and guided self-help, are deemed to be more acceptable and preferable than unguided interventions, as the latter can offer an effective method of treating depression with some benefits above and beyond psychotherapy and guided self-help (such as increased privacy - see section 1.3.5 for more information). Thus it is in the interest of primary care trusts to further understand why unguided interventions are perceived as less acceptable and assess the impact these attitudes and preferences have on treatment outcome. If the finding that unguided is unacceptable and un-preferable in comparison to guided self-help and psychotherapy is replicated in a clinical help-seeking sample, and these views are found to impact upon treatment engagement and efficacy then it would seem logical to increase the funding for guided self-help and psychotherapies so that patients can have greater access to their most preferred treatments, as this leads to higher rates of engagement and greater efficacy.

**Chapter 3: A Systematic Review of Rates of Engagement with Self-Help for Depression and Anxiety Disorders**

**3.1 Anxiety disorders**

Anxiety disorders (included here as generalised anxiety, social anxiety, panic disorders, phobias or post traumatic stress disorder (PTSD)) are the most frequently occurring class of mental health disorders that occur in the general population (Kessler et al. 2009). Estimates of worldwide prevalence rates for anxiety disorders are reported as high as 28.30% (Baxter, Scott, Whiteford, 2013), with NICE (2011a) estimating that up to 5.7% of the UK population will experience generalised anxiety disorder, 12% will experience social anxiety disorder, 1.4% will experience panic disorders, 12.15% will experience phobias, and 6.8% will experience PTSD during the course of their lives.

**3.1.1 Symptoms of Anxiety Disorders**

Anxiety has previously been defined as “a future-oriented mood state associated with preparation for possible, upcoming negative events” (Barlow, 2000). The DSM-5 (American Psychiatric Association, 2013) characterises five separate anxiety disorders, for example generalised anxiety disorder is characterised by constant worry, which occurs daily and interferes with life (e.g. work, relationships etc.). Other physical symptoms often occur such as muscle tension, loss of energy or fatigue, agitation, edginess or restlessness, an irritable mood and sleep problems such as insomnia. Social anxiety disorder is characterised by an extreme and debilitating fear of being negatively perceived or judged by others. Panic disorder is characterised by frequent panic attacks and a fear of reoccurrence of these attacks, which often occur spontaneously without warning. Phobias are characterised by irrational fear, for example a fear of flying, heights, germs etc. People with phobias seek to avoid their feared stimulus (e.g. planes, airports, airfields etc.) even though they often realise their fear is irrational. Often thinking about the feared stimulus is enough to induce feelings of extreme anxiousness. Finally, PTSD is characterised by flashbacks, nightmares, or intrusive memories following a traumatic event (e.g. terrorism, rape, violence etc.)

**3.1.2 Wider effects of Anxiety Disorders**

As discussed in section 1.1.2 mental health disorders such as depression or anxiety don’t only impact upon the quality of life of those experiencing symptoms, but they have a wider impact on society in terms of direct and indirect costs. As noted in section 1.1.2, Layard et al. (2006) described the prevalence of anxiety and depression disorders as one of Britain’s biggest social problems. The direct cost of anxiety refers to the costs sustained by the NHS in terms of providing treatment. In comparison, the indirect costs associated with anxiety disorders refer to the cost of lost working days, or loss of income. A review of the total costs (both direct and indirect) of a number of mental health disorders was conducted by Fineberg et al. (2013), who estimate that the cost of anxiety disorders in the UK for 2010 was £9.8 billion. A review was also conducted by McCrone et al. (2008) to estimate mental health expenditure, including anxiety disorders, in England for the next 20 years (to 2026). The number of people with anxiety disorders in England is projected to rise to 2.56 million by 2026. Based on these figures, the authors estimated the total costs for anxiety by 2026 to be £14.2 billion. As a result, the Department of Health (2013) views the effective treatment of anxiety disorders in the UK (alongside other common mental health disorders such as depression - see section 1.1) as a priority, with substantial amounts of extra funding announced (see section 1.1) to increase access and availability of stepped care (through the IAPT programme) for those experiencing common mental health disorders such as anxiety or depression disorders.

**3.1.3 Overview.** To recap, anxiety is a widespread and prevailing condition that is characterised by severe negative and distressing symptoms. Anxiety has a substantial negative impact upon those experiencing the disorder and it also adversely affects our society and the economy. As a result, the effective management of anxiety (and other comment mental health disorders such as depression – see section 1.1) in the UK is seen as a priority by the Department of Health (2013).

As noted in chapter 1, anxiety and depression are often discussed together under the heading “common mental health disorders” due to high occurrence of comorbidity (e.g. Lamers et al., 2011). It can be problematic to generalise from one condition to another in this way, as although these disorders often co-occur, they have differing symptoms, which may impact upon treatment efficacy, acceptability of treatment or engagement with treatment. Although chapter 3 is concerned with rates of engagement to both depression and anxiety disorders, the systematic review presented here aims to explore condition (e.g. depression or anxiety disorder) as a moderator of engagement (see section 3.5).

**3.2 Efficacy of Self-Help for Depression and Anxiety Disorders**

Although self-help can be effective (see 1.3) for treating depression, it can also be successfully used to treat anxiety disorders. Hirai and Clum (2006) and Haug, Nordgreen, Öst and Havik (2012) both conducted meta-analyses of RCTs that used self-help for anxiety disorders (*k* = 33 and 56 respectively), finding that self-help was more effective than no treatment, with large effect sizes noted (*d*+ = 0.62 and 0.78 respectively). In comparison to face-to-face psychotherapies, self-help was less effective, however only small effect sizes were noted (*d*+ = -0.42 and -0.20) indicating that self-help may be used to effectively treat anxiety disorders, especially where there is limited access to psychological therapies.

**3.3 Engagement with Self-Help for Depression and Anxiety Disorders**

As briefly discussed in section 1.4.2, how self-help is engaged with may be problematic, for example Christensen et al. (2009) conducted a systematic review of rates of engagement with computerised self-help interventions targeting depression and anxiety disorders. The review noted attrition levels as high as 50%, while rates of adherence ranged from 50 - 70%. So although research suggests that self-help can be effectively used to treat depression and anxiety disorders, engagement with the treatment is an issue that requires further consideration. There is a gap in the literature concerning engagement with self-help for depression and anxiety disorders. Little is known about how people actually engage with self-help treatments, e.g. how much of a bibliotherapy self-help book do people typically read and how many modules do they complete when using computerised self-help packages, etc. Individual studies often report engagement information, however there is often a lack of consensus in how engagement information is reported in the literature, and often the data reported is specific to the self-help content used and is not generalisable. To date a systematic review of engagement to multiple forms of self-help interventions for depression and anxiety disorders has yet to be conducted and as such the present systematic review explores engagement with self-help interventions targeting depression and anxiety disorders.

### 3.4 Defining Engagement

### For the purpose of the present thesis engagement is described as levels of uptake to the intervention, adherence during the intervention period, levels of attrition, and maintenance post intervention. Uptake refers to people’s willingness to use a treatment intervention when they are offered it (Murray et al., 2003). For example, uptake would be the proportion of participants who are offered a bibliotherapy self-help program that subsequently go on to use the program. Adherence is the extent to which an individual experiences the content of an intervention (Christensen et al., 2009) as well as any homework tasks set (Scholes, Turpin & Mason, 2007). For example, a self-help book may contain ten chapters and five homework assignments. However, if only two chapters are read and one homework assignment completed then the participant has not exposed him or herself to the full intervention. Adherence may be measured via self-report questionnaires, which ask the participant to state how much of the invention they have completed, or assessed independently via a computer programme that measures which content is accessed by each of the participants.Attrition is the early discontinuation of treatment during the intervention period (Davis & Addis, 1996), and is important because it means that the participant has not been exposed to the full intervention content. Finally, maintenance refers to the extent to which participants return to the self-help materials and relearn the specific skills used previously to overcome their symptoms (Bilich, Deane, Phipps, Barisic, & Gould, 2008). The rates of engagement outlined above may differ between self-help interventions. However, to date, researchers have not systematically examined rates of engagement for different self-help treatments. Understanding engagement would be valuable, because it could (a) indicate how acceptable self-help treatments are (e.g. Kaltenthaler et al. (2008), noted that researchers often operationalise acceptability in terms of uptake), (b) help to establish average rates of engagement for common self-help techniques and inform treatment allocation (e.g. how many guided self-help sessions are commonly attended, allocating sessions over this amount may be a waste of resources), and (c) inform the design of future self-help interventions (e.g. if adherence to bibliotherapy is found to be 33%, then it would make sense to include the key messages and techniques within the first one-third of the book in order to ensure maximum impact).

### 3.5 What Factors Influence Engagement?

### The present systematic review also examines a number of factors that could influence levels of engagement, as engagement to other medical treatments have previously been shown to be related to intervention factors (van Dulmen et al., 2007) or patient factors (DiMatteo, 2004, 2007). However, within the self-help literature, less is known about how intervention or patient factors influence engagement (Simco, McCusker & Sewitch, 2014).

### Firstly, the method used to deliver the self-help intervention (e.g. books and computer packages) was explored. To date researchers have focused on comparing one mode of self-help delivery in comparison to face-to-face psychotherapies. For example, Mohr et al. (2012) explored rates of attrition (*N* = 325) from a telephone based CBT intervention versus a face-to-face CBT intervention for depression, finding that significantly more participants dropped out of the face-to-face intervention. In addition, van Ballegooijen et al. (2014) conducted a meta-analysis of 24 studies (*N* = 961) to compare adherence to Internet based CBT interventions with face-to-face CBT interventions for depression. On average, participants using both treatment modalities completed around 80% of the intervention, although significantly more participants in the face-to-face interventions completed the full intervention. Researchers have yet to directly compare different self-help treatment modalities in terms of engagement. As a result, the current systematic review makes no specific hypotheses regarding treatment delivery method and rates of engagement.

### Whether the intervention was guided or not, was also explored. Previous research has shown that guided interventions for social anxiety disorders (SAD) have higher rates of adherence during the treatment intervention than unguided interventions. For example, Nordgreen et al. (2012) conducted a meta-analysis of four studies that compared guided and unguided self-help interventions for SAD (*N* = 206). There was a significant difference between the guided and unguided conditions, with 20% more of the participants who used the guided self-help completing seven or more treatment modules, than those participants who used the unguided self-help. Further research is needed to assess whether guided self-help also experiences higher rates of adherence for other mental health disorders (such as depression) but based on the findings reported by Nordgreen et al. (2012) the current study hypotheses that guided self-help will have higher rates of adherence than unguided self-help. In addition, further research is also needed to assess other forms of engagement in relation to guided and unguided interventions. Rates of attrition from unguided interventions are regarded as being consistently high (e.g. Eysenbach, 2005), however little is known about rates of uptake or maintenance to unguided interventions for depression and anxiety. As such the present systematic review also hypotheses that unguided interventions will have higher rates of attrition, although no specific hypotheses are made in relation to uptake or maintenance.

### The target problem (e.g. depression versus anxiety) was also explored as features of each disorder may impact upon engagement and it is problematic to generalise from one condition to another. For example, symptoms of depression can include fatigue, loss of energy or an inability to concentrate (see 1.1.1) and these symptoms may make engagement more problematic. As a result problems with engagement to self-help treatments for depression have been noted in the literature (e.g. Morgan, Jorm & Mackinnon, 2012; van Ballegooijen et al., 2014). Problematic engagement rates have also been noted for anxiety disorders (e.g. Al-Asadi, Klein, Meyer, 2014; Farvolden, Denisoff, Selby, Bagby & Rudy, 2005). However, to date researchers have yet to directly compare rates of engagement for those with either depression or anxiety and as such the present systematic review makes no specific hypotheses regarding target problem and rates of engagement.

### Symptom severity was also explored as research suggests that less severe symptoms of depression and anxiety at baseline are associated with increased rates of adherence to Internet based self-help interventions for depression and anxiety (Christensen et al., 2009). The present systematic review therefore hypotheses that less severe symptoms of depression or anxiety at baseline will be associated with increased rates of adherence. Further research is required to assess the impact of symptom severity on other aspects of engagement and as a result the present meat-analysis makes no specific hypotheses regarding severity of symptoms and rates of uptake, attrition or maintenance.

### The length of the self-help intervention was also explored. Previous research shows that longer treatments are associated with higher levels of premature attrition and lower levels of adherence. For example, Christensen, Griffiths, Groves and Korten (2006) explored adherence to MoodGYM, a CCBT intervention for depression and anxiety (*N* = 58,580). They found that attrition from the intervention increased as program length progressed, indicating that treatment length may be linked to premature attrition, although further work is needed to directly compare interventions of differing lengths. In addition, Christensen et al. (2009) conducted a systematic review of Internet based interventions targeting depression and anxiety disorders. They examined rates of adherence in twenty-three studies (*N* = 3830) and found that treatment length was able to significantly predict rates of adherence. Self-reported reasons for dropout were also examined, with time constraints being cited in ten of the studies examined. Perhaps indicating one reason why shorter interventions have higher rates of retention and compliance. Based on these findings the present systematic review hypotheses that longer treatments will have higher rates of attrition and lower rates of adherence, although no specific hypotheses are made regarding uptake and maintenance.

### Participant characteristics such as age, gender and education were also explored. In terms of age, studies have reported that age is associated with attrition from antidepressant medication (e.g. Arnow et al., 2007; Warden et al., 2009), psychotherapy (e.g. Arnow et al., 2007), self-help (e.g. Wojtowicz, Day, & McGrath, 2013) and post intervention follow-up (e.g. Lamers et al., 2012), with younger participants more likely to drop-out in all cases. As such, the present systematic review hypotheses that age will be associated with attrition, with younger participants being more likely to drop-out of the intervention than older participants. There is a need for research to assess age in relation to other features of engagement, which the present systematic review will do, and as such no specific hypotheses are made regarding age and rates of uptake, adherence or maintenance.

In terms of gender, prevalence rates of depression and anxiety are higher in females than males (Angst et al., 2002; McLean, Asnaani, Litz & Hofmann, 2011), with males also less likely to seek help from mental health services such as psychotherapy and counselling (Addis & Mahalik, 2003). Researchers have examined factors that prevent men from seeking help for mental health problems, such as belief in traditional masculine norms (e.g. “men don’t cry”) and self-stigma; which refers to the tendency to internalise mental health stigma, thus viewing of oneself as ‘weak’ for experiencing symptoms of depression or anxiety (Vogel, Heimerdinger-Edwards, Hammer & Hubbard, 2011). Pederson and Vogel (2007) tested the above factors in relation to attitudes towards seeking help in the form of counselling (N = 575), finding that males with a strong belief in masculine norms tended to hold negative help seeking attitudes and this relationship was mediated by self-stigma. Less is known about gender differences in relation to help seeking for depression and anxiety in relation to self-help treatments. It may be that the findings of Pederson and Vogel (2007) hold, meaning that males are less likely to use self-help. Or it may be that some of the features of self-help, such as increased privacy and ability to undertake treatment independently (in the case of an unguided intervention, such as CCBT or bibliotherapy) make self-help more appealing to males. As a result, the present systematic review makes no specific hypotheses regarding gender differences and engagement with self-help interventions.

### In terms of education, research suggests that those with lower levels of education are more likely to drop out of antidepressant medication and psychotherapy treatments for depression (e.g. Arnow et al., 2007; Warden et al., 2009) and may be less likely to take up the offer to use self-help for anxiety to begin with (e.g. Al-Asadi, Klein & Meyer, 2014). As a result, the present systematic review hypotheses that less years spent in education will be associated with lower levels of attrition and uptake. Again, there is a gap in the literature regarding other features of engagement, and as a result the present systematic review makes no specific hypotheses regarding level of education and adherence and maintenance.

Finally, study quality was assessed using the Jadad scale (Jadad et al., 1996) to assess whether the overall quality of the RCT impacted upon rates of engagement. The Jadad scale has five items (1. Was the study described as randomised? 2. Was the randomisation technique appropriate? 3. Was the study described as double blind? 4. Was the method of double blinding appropriate? 5. Was there a description of withdrawals and dropouts?) with each item scored as either no (awarded zero points) or yes (awarded 1 point). Scores ranged from zero to five, with higher scores indicating higher quality studies. Olivo et al. (2008) conducted a systematic review of twenty-one quality appraisal checklists used in healthcare research, finding that the Jadad scale had the more robust evidence to support its validity and reliability. In addition, other systematic reviews of self-help interventions for depression and anxiety have used the Jadad scale to successfully code for study quality (e.g. Kaltenthaler et al., 2002). Ratings of study quality, per study included in the systematic review, are reported in Table 10.

### The factors discussed above may impact on levels of engagement with the self-help interventions, yet, to date, researchers have not systematically examined these factors in relation to engagement with self-help for depression and anxiety. Further research is needed (Melville, Casey, Kavanagh, 2010) to explore the impact of the above factors on engagement as often only one feature of engagement has been explored or only one type of self-help. It may be the case that these factors need to be considered when allocating self-help provision.

**3.6. Method**

***3.6.1 Aims of the study.*** The primary aim of the present systematic review is to compute the sample-weighted average rates of uptake, adherence, addition and maintenance for self-help interventions targeting depression and anxiety disorders. In addition, we examine the impact of a number of factors on levels of uptake, adherence, addition and maintenance including the type of self-help intervention, target problem, severity of symptoms, length of the intervention period, participant characteristics and study quality.

***3.6.2 Inclusion criteria.*** The present systematic review sought to identify published or unpublished RCTs of self-help interventions. Studies addressing anxiety and depression disorders were included. Diagnosis of these conditions could be based on either a structured clinical interview or an assessment scale with validated cut-off scores (e.g. the Hospital Anxiety and Depression Scale (HADS); Zigmond & Snaith, 1983). Studies needed to include sufficient information to identify rates of at least one of the following: uptake, attrition, adherence or maintenance for the self-help condition. Often studies provided aggregated data across the whole sample and, in these instances rates of uptake, adherence, attrition or maintenance were unquantifiable for the separate self-help conditions of the study. In addition, some studies reported rates of attrition, for example, but failed to report rates of adherence to the intervention examined. In these instances studies were included as long as data for either uptake, adherence, attrition or maintenance could be calculated. Consistent with previous reviews of self-help interventions (e.g. Den Boer, Wiersma, & Van Den Bosch, 2004; Hirai & Clum, 2006), studies that sampled children or adolescents and articles that were not written in English were excluded.

***3.6.3 Search strategy.*** Four strategies were used to locate studies. First, we searched the reference lists of previous reviews of self-help interventions for suitable studies (Anderson et al., 2004; Andrews, Cuijpers, Craske, McEvoy and Titov, 2010; Bower et al., 2001; Cuijpers, 1997; Den Boer et al., 2004; Gellatly et al., 2007; Gould & Clum, 1993; Gregory, Canning, Lee & Wise, 2004; Hirai & Clum, 2006; Hof, et al., 2009; Marrs, 1995; Menchola, Arkowitz & Burke, 2007; Scogin, Bynum, Stephens & Calhoon, 1990; Spek et al., 2007). Second, the Web of Knowledge database (that encompasses Medline, Science Citation Index, Arts and Humanities Citation Index, and the Social Science Citation Index) was used to locate studies that had cited these meta-analyses and that met the inclusion criteria. Third, a Web of Knowledge search was conducted in October 2011 using two search filters; self-help (terms: “self-help”, “self-help interventions”, “self-help techniques”, “self instruction”, “self-management”, “self-treatment”, “self-care”, “self administration” and “self-administered treatment”) and mental health problem (terms: “depression”, “anxiety”, and “PTSD”). Studies had to include respective terms in the title or abstract of the report. Finally, the authors of studies that met the inclusion criteria were contacted to ask for further studies (61% replied) and the reference lists of identified studies were examined for further eligible studies.

Figure 2 shows the flow of papers through the phases of the systematic review. A total of 10,785 possible studies were identified, and 335 full-text articles were assessed for eligibility. Seventy-one studies met the inclusion criteria. Of these, ten studies reported levels of uptake per condition, twenty-three studies reported adherence to the intervention and sixty-five studies reported rates of attrition from the intervention; only one study reported maintenance of self-help strategies post intervention by condition, although a further study also discussed maintenance for the sample as a whole.

**Figure 2: Flow of Studies Through the Systematic Review**

10,450Excluded as did not meet inclusion criteria

**Search strategies**

330 Previous meta-analyses

934 Papers that cite previous meta-analyses

9,521 Web of Knowledge

10,785 **Total records screened**

**264 Excluded:**

114 – Were examining issues other than depression/anxiety/PTSD, e.g. weight loss, smoking cessation etc.

150 – Did not contain sufficient information to calculate rates of uptake, adherence, attrition or maintenance

**335 Full text articles**

**assessed for eligibility**

**71 papers included in quantitative synthesis**

10 tests of uptake

23 tests of adherence

65 tests of attrition

1 test of maintenance

Total = 133 tests from 71 different interventions

Table 9 shows the number of studies included in the present systematic review, by type of self-help and target problem.

**Table 9: Number of Self-Help Interventions Identified by Target Problem**

Type of Self-Help Depression Anxiety D&A Total

Audio Tape *k* 0 2 0 2

*n* 0 133 0 133

Bibliotherapy *k* 16 23 2 41

*n* 2297 1921 307 4525

Computerised *k* 11 16 1 28

*n* 2747 1010 213 3670

DVD/Video *k* 0 3 0 3

*n* 0 84 0 84

Writing *k* 0 2 0 2

*n* 01780178

Overall *k* 35 33 3 71

*n* 5044 3326 520 8890

K = Number of studies

N = Number of participants

D & A = Depression and Anxiety

Table 10 summarises the studies used in the present systematic review, the mental health problem that they targeted, the format of the self-help intervention, the type of control group and percentages for uptake, adherence, attrition and maintenance for each condition.

**Table 10: Summary of Studies Included in the Systematic Review**

Author (Year) Target Intervention *n* Study Quality Uptake Adherence Attrition Maintenance

Anderson et al. (2007) Anxiety CB/TC 10 1 83.33% 26.00% f 10.00% -

Andersson et al. (2005) Depression CB/EC 57 5 - 74.00% b 36.84% -

WL 60 - - 18.33% -

Andersson et al. (2006) Phobia CB/EC 32 3 - 83.33% b 6.25% -

WL 32 - - 0.00% -

Baker et al. (1973) Phobia AT 9 0 - - - 60.50% n

WL 13 - - - -

T 7 - - - 40.00% n

Başoğlu et al. (2009) PTSD B 15 1 60.87% 57.14% d 42.86% -

Berger et al. (2011a) Phobia CB 27 2 - 86.00% n 3.70% -

CB/EC 27 - 90.00% n 11.11% -

CB/EC/PC 27 - 92.00% n 7.41% -

Berger et al. (2009) Phobia CB 31 3 - 85.00% g 9.68% -

WL 21 - - 9.52%

Botella et al., (2010) Phobia CB 62 2 - - 51.61% -

T 36 - - 38.89% -

WL 29 - - 13.79% -

Bowman et al. (1995) Depression T 11 2 - 100.00% l 9.09% -

B 11 - 100.00% l 18.18% -

WL 11 - - 18.18% -

Bright et al. (1999) Depression SG 22 3 - - 36.36% -

GT 21 - - 38.10% -

B /SG/TC 28 - - 21.43% -

B/GT/TC 27 - - 33.33% -

Brown and Lewinsohn Depression B /PC 15 2 - - 6.67% -

(1984) WL 15 - - 13.33% -

B/T 15 - - 6.67% -

B/GT 32 - 88.20% i 3.13% -

Bugg et al. (2009) PTSD W 72 5 68.06% - 59.72% -

IO 76 - - - -

Carlbring et al. (2001) Anxiety CB 21 a 4 - - 20.00% -

WL 21 a - - 5.00% -

Carlbring et al. (2006) Anxiety CB 30 3 - 80.00% a 3.33% -

WL 30 - - - -

Carlbring et al. (2011) Anxiety CB 27 3 - 79.60% b 7.40% -

AP 27 - - 0.00% -

Cavanagh et al. (2011) Depression CB 295 0 84.29% 52.90% k 38.98% -

Christensen et al. (2004) Depression CB 165 3 - - 15.15% -

CB 182 - 51.03% g 25.27% -

CON 178 - - 10.67% -

de Graaf et al. (2009) Depression CB 100 2 - 36.00% k - -

CB/TAU 103 - 11.65% k - -

TAU 100 - 31.00% k - -

Donnan et al. (1990) Anxiety AT/B/TAU 51 1 - - 0.00% -

TAU 50 - - 1.92% -

Dozeman et al. (2011) Depression B 90 3 - - 25.56% -

& Anxiety TAU 95 - - 34.74% -

Ehlers et al. (2003) PTSD B 28 3 - - 10.71% -

T 28 - - 0.00% -

NTC 29 - - 6.90% -

Gallego et al. (2011) Phobia CB 24 2 - - 45.83% -

WL 17 - - 35.29% -

Ghosh and Marks (1987) Phobia B 15 2 - - 13.33% -

T 14 - - 14.29% -

CB 17 - - 11.76% -

Gould and Clum (1995) Anxiety B/AV/AT 15 2 - - 20.00% -

WL 15 - - 13.33% -

Grant et al. (1995) Depression GT/B 16 1 - - 18.75% -

Haeffel (2010) Depression B 22 1 - - 4.55% -

B 26 - - 0.00% -

Heading et al., (2001) Phobia CB 14 2 - - 14.28% -

T 13 - - 0.00% -

WL 13 - - 23.08% -

Hellström and Öst (1995) Phobia B 10 2 - - 0.00% -

B 11 - - 0.00% -

CON 11 - - 0.00% -

CON 10 - - 0.00% -

T 10 - - 0.00% -

Hirai and Clum (2005) PTSD CB 33 1 - - 15.15% -

WL 15 - - 6.67% -

Holdsworth et al. (1996) Depression B/TAU 53a 2 - 100.00% g - -

& Anxiety TAU 53a - - - -

Holländare et al. (2011) Depression CB 42 2 - - 9.52% -

NTC 42 - - 7.14% -

Jorm et al. (2003) Depression B 525 2 - 72.00% h 36.76% -

CON 569 - 78.00% h 41.12% -

Kenardy et al. (2003) Anxiety CB 43 2 - - 13.95% -

WL 40 - - 5.00% -

Klein et al. (2006) Anxiety CB 19 5 - - 5.26% -

B 18 - - 16.67% -

WL 18 - - 27.78% -

Landreville et al. (1997) Depression B 10 1 - 46.66% m 20.00% -

WL 13 - 52.00% m 15.38% -

Levin et al. (2011) Depression CB 100 3 - - - -

TAU 91 - - 0.00% -

Liu et al. (2009) Depression B 27 2 - 78.30% e 22.22% -

WL 25 - - 24.00% -

Lovell et al. (2003) Phobia B 25 1 96.15% - 20.00% -

Lucock et al. (2008) Anxiety B 48 4 - - 2.08% -

WL 48 - - 0.00% -

Lucock et al. (2011) Depression B 63 1 - - 37.74% -

& Anxiety WL 59 - - 30.61% -

Mall et al. (2011) Anxiety AV/EC 12 4 - - 8.33% -

WL 12 - - 0.00% -

Marshall et al. (1976) Anxiety B 11 2 - - 45.45% -

B/MC 11 - - 18.18% -

B/MC/AP 11 - - 18.18% -

T 11 - - 18.18% -

AP 11 - - 18.18% -

NTC 11 - - 18.18% -

McNamee et al. (1989) Anxiety B 13 2 - - 30.77% -

R 10 - - 10.00% -

Mead et al. (2005) Depression B 57 4 - 88.00% j 12.28% -

& Anxiety WL 57 - - - -

Naylor et al. (2010) Depression B 19 2 - 50.90% m - -

TAU 19 - 73.50% m - -

Nordgreen et al. (2010) Anxiety B 27 1 94.44% 98.00% a 25.93% -

Nordin et al. (2010) Anxiety B 20 2 - - 0.00% -

CON 20 - - 5.00% -

Öst et al. (1991) Phobia T 17 2 - - 0.00% -

B 17 - - 0.00% -

Parry and Killick (1998) Anxiety AV 10 2 - - 0.00% -

W 10 - - 0.00% -

WL 10 - - 0.00% -

Proudfoot et al. (2003) Depression C 89 2 - - 13.48% -

& Anxiety TAU 78 - - 15.38% -

Purves et al. (2009) Depression CB 100 0 69.89% - 42.00% -

Reeves (2010) Anxiety B 29 1 - 53.00% c 27.59% -

WL 22 - - 0.00% -

Richards et al. (2003) Depression B 75 5 - - 37.33% -

TAU 64 - - - -

Robinson et al. (2010) Anxiety CB/TS 50 2 100.00% - 10.00% -

CB/TC 51 92.16% - 9.80% -

CON 49 97.96% - 2.04% -

Rosen et al. (1976) Phobia B/PC 11 3 - - 0.00% -

B 11 - - 0.00% -

T 11 - - 36.36% -

NTC 11 - - 0.00% -

CON 11 - - 0.00% -

Ruwaard et al. (2010) Anxiety CB 27 1 - - 11.11% -

WL 31 - - 3.23% -

Salkovskis et al. (2006) Depression B/TAU 50 2 - - 24.00% -

TAU 46 - - 15.22% -

Schelver et al. (1983) Anxiety B 15 3 - - 26.67% -

NTC 15 - - 20.00% -

AP 15 - - 20.00% -

Schmidt et al. (1983) Depression T 12 3 - - 8.33% -

GT 11 - - 0.00% -

GT 11 - - 0.00% -

B 12 - - 8.33% -

WL 10 - - 0.00% -

Scholes et al. (2007) PTSD B 82 4 - - 21.95% -

CON 86 - - 22.09% -

CON 83 - - 9.64% -

Scogin et al. (1989) Depression T 22 2 - 85.00% m - -

B 23 - 85.00% m - -

WL 22 - - - -

Selmi et al. (1990) Depression CB 12 4 - - 0.00% -

T 12 - - 0.00% -

WL 12 - - 0.00% -

Sorby et al. (1991) Anxiety B 30 2 - - 0.00% -

CON 23 - - 17.39% -

Titov et al. (2010) Depression CB/TS 47 2 - 80.00% j 6.38% -

CB/TC 49 - 70.00% j 10.20% -

WL 45 - - 2.22% -

Turpin et al. (2005) PTSD B 146 4 - - 19.86% -

CON 145 - - 27.59% -

van Boeijen et al. (2005) Anxiety B 59 3 98.31% - 1.69% -

T 67 94.03% - 11.94% -

TAU 28 100.00% - 0.00% -

van Straten et al. (2008) Depression CB 107 2 - - 35.51% -

& Anxiety WL 106 - - 0.00% -

Varley et al. (2011) Anxiety B 86 2 - - - -

B/II 90 - - 0.00% -

CON 86 - - - -

Warmerdam et al. (2010) Depression CB 88 1 - 38.60% a - -

CB 88 - 37.50% a - -

WL 87 - - - -

White (1995) Anxiety B 21 1 - - 0.00% -

WL 21 - - 14.28% -

CON 20 - - 10.00% -

Willemse et al. (2004) Depression T/B 107 2 - - 48.19% -

TAU 109 - - 0.00% -

Note. AP = Attention Placebo, AV = Audio-visual, AT = Audio Tape, B = Bibliotherapy, CB = Computerised self-help, CON = Control Group, DG = Discussion Group, EC = Email Contact, G = Guided Self-Help, GT = Group Therapy, IO = Information Only, II = Implementation Intentions, M = Monitoring, MC = Minimal Contact, NTC = No Treatment Control, P = Postcard reminders, PC = Phone Contact, R = Relaxation, SG = Support Group, T = Therapy, TC = Therapist Contact, TAU = Treatment As Usual, TS = Technician Support, W = Writing, WL = Waitlist

a. % of sample who completed the full course, b. % of sessions/modules completed, c. % of sample who said they were using the self-help techniques in their daily lives, d. % who read the manual, e. % of chapters read, f. mean no. of minutes spend on the first two sessions, g. % of exercises completed, h. % who said they had read all or most of the book/leaflet, i. % of course attended, j. % who had read at least half the book, k. % of course completed, l. % who reported reading 25% of the book, m. % of the book read, n. % of lessons completed.

**3.6.4 Data extraction and coding.** All of the study characteristics, including rates of engagement (e.g. rates of uptake etc.) moderators of engagement (e.g. whether the intervention was guided or unguided etc.) and study quality were coded initially by the PhD candidate. Second coding of rates of engagement and moderators of engagement was undertaken by a PhD candidate in the Psychology department at The University of Sheffield who was qualified to Master’s degree level in Psychology. A coding worksheet was used to outline the characteristics of the study that were coded by the second coder (see appendix 15), with the reviewers meeting prior to coding to review this document. Upon completion of the second coding and before disagreements were resolved, SPSS version 20 was used to calculate intercoder reliabilities, which were measured using Cohen’s Kappa coefficients. Rates of intercoder reliability were all greater than 0.70 for each variable indicating an acceptable level of inter-rater reliability (Cohen, 1960). Disagreements between the two coders were then resolved by discussion, creating the final data set.

Overall rates of uptake, adherence and attrition were computed across the reviewed studies by weighting rates of engagement by the number of participants in the study at the start of the intervention. In this way, average rates of uptake, adherence and attrition across the studies were sample-weighted, such that studies with larger sample sizes contributed more to the estimate of average rates than studies with smaller sample sizes.

Nine facets of the studies that could influence rates of engagement were also coded. Mode of self-help delivery was coded into five categories; (a) audio (including tapes, CDs and MP3s), (b) audio-visual (including videos and DVDs), (c) bibliotherapy (including books, booklets, and leaflets that were described as self-help, rather than information only), (d) computerised (including websites and CDs, and (e) writing interventions.

We also coded whether or not the intervention was guided. Interventions were categorised as guided if there was meaningful contact with another person during the intervention period (e.g. contact with a trained professional regarding the self-help intervention, progress made or to provide insights into the participants’ problems). Contact that was purely concerned with technical support or distributing questionnaires was not deemed to be meaningful in a treatment sense and so these interventions were classified as unguided. Guided self-help interventions could include face-to-face contact, as well as indirect contact over the telephone or via email/the Internet.

The target problem was broken down into three categories: (i) depression; (ii) anxiety (including phobias or PTSD) or; (iii) depression and anxiety (as studies often targeted both conditions simultaneously). The severity of symptoms was measured by the percentage of participants allocated to self-help conditions that were above the clinical cut-off scores for the measure of depression or anxiety taken prior to the intervention. The duration of the intervention was measured by the number of days that participants took part in the intervention. The age of the sample (reported as mean age by condition), gender (percentage of females per condition), education status (percentage with a higher education qualification) and quality of study (scores ranged from 0 – 5 with higher scores indicating higher study quality) were also coded.

**3.7 Results.**

**3.7.1 Overall rates of uptake, adherence, attrition and maintenance.**Table 11 shows the overall rates of engagement across the reviewed studies. Rates of uptake for self-help intervention conditions were reported in ten studies. Many studies reported levels of uptake but most failed to separate this information for treatment versus control conditions and so rates of uptake to self-help treatments could not be ascertained in such cases. Uptake for self-help interventions ranged from 60.87% to 100%, with a sample-weighted average of 83.74%; this means that, on average, around six out of every seven people who were recruited started the intervention.

Adherence was reported in twenty-two studies. Adherence rates ranged from 11.65% to 100% and the sample-weighted average level of adherence to self-help materials across the reviewed studies 65.70%. Thus, just under two-thirds of the self-help content, on average, was utilised by the participants.

Attrition was reported in sixty-five studies. Rates of attrition from self-help interventions ranged from 0% to 59.72% and the sample-weighted average level of attrition was 23.90%. This means that approximately three-quarters of participants who started using a self-help intervention completed it.

Rates of maintenance for self-help interventions were only reported by one study. Baker, Cohen and Saunders (1973) examined therapist versus self (audio-tape) directed desensitisation for acrophobia. At follow-up there were significant differences between the therapist-directed group (40%) and the self-directed group (60%) in terms of the percentage who had attempted their behavioural situations since the end of the intervention period.

## Table 11: Rates of Uptake, Adherence, Attrition and Maintenance for Self-Help Conditions, by Type of Self-Help

Self-Help Uptake Adherence Attrition Maintenance

Type % k n % k n % k n % k n

Overall 83.74 10 1021 65.70 25 3652 23.90 63 7103 60.50 1 29

Depression 81.17 3 406 60.17 15 2554 28.74 21 2086 - 0 0

Anxiety 87.70 7 309 60.18 10 372 15.74 39 1516 60.50 1 29

D&A - 0 0 - 0 0 32.61 3 260 - 0 0

Audio tape - 0 0 - 0 0 4.55 2 66 - 0 0

Audio-visual - 0 0 - 0 0 10.81 3 37 - 0 0

Bibliotherapy 87.62 5 254 59.45 13 1959 23.16 40 4489 - 0 0

Computer 88.25 5 1226 56.73 11 1891 27.60 25 2702 - 0 0

Writing 68.06 1 148 - 0 0 52.44 2 178 - 0 0

Guided 88.14 6 458 74.77 17 1525 28.83 35 3103 - 0 0

Unguided 77.32 4 558 67.92 7 2087 19.36 30 4126 - 0 0

**3.7.2 Factors influencing rates of uptake, adherence and attrition.** Chi-square analysis was used to investigate whether there were significant differences in rates of engagement to self-help interventions targeting depression and anxiety for the following moderators; type of self-help, whether the intervention was guided and the nature of the target problem. See Table 11.

***3.7.2.1 Type of self-help.*** Bibliotherapy studies (87.62%, *k* = 5, *n* = 254) and computer based interventions (88.25%, *k* = 5, *n* = 1,226) had a significantly higher rate of uptake than writing self-help interventions (68.06%, *k* = 1, *n* = 148), χ2(2, *n* = 1,628) = 16.25, *p* < 0.01. Uptake data was not available for audio or audio-visual self-help interventions. No significant differences were found between the different types of self-help in rates of adherence, with rates of adherence being comparable between bibliotherapy (59.45%, *k* = 13, *n* = 1,959) and computerised (56.73%, *k* = 11, *n* = 1,891) self-help interventions, χ2(1, *n* = 3,850) = 0.15, *p* = *ns*. No adherence data was available for audiotape, audio-visual or writing self-help interventions. Significant differences were found in attrition rates between the different self-help interventions, with audio tape interventions having the lowest dropout rates (4.55%, *k* = 2, *n* = 66), followed by audio-visual interventions (10.81%, *k* = 3, *n* = 37), bibliotherapy (23.16%, *k* = 40, *n* = 4,489), and computer-based interventions (27.60%, *k* = 25, *n* = 2,702); writing (52.44%, *k* = 2, *n* = 178) self-help interventions had the highest rate of attrition, χ2(4, *n* = 7,472) = 75.98, *p* < 0.01.

***3.7.2.2 Guided versus unguided self-help.*** Guided interventions (88.14%, *k* = 6, *n* = 458) had significantly higher rates of uptake than unguided (77.32%, *k* = 4, *n* = 558) self-help interventions, χ2(1, *n* = 1,016) = 4.10, *p* < 0.05. There were no significant differences between guided interventions (74.77%, *k* = 17, *n* = 1,525) and unguided self-help interventions (67.92%, *k* = 7, *n* = 2,087) in terms of adherence to the intervention, χ2(1, *n* = 3,612) = 1.15, *p* = *ns*. There were also no significant differences, in rates of attrition between guided (28.83%, *k* = 35, *n* = 3,103) and unguided self-help interventions (19.36%, *k* = 30, *n* = 4,126), χ2(1, *n* = 7,229) = 2.45, *p* = *ns*.

***3.7.2.3 Nature of the target problem.***Interventions targeting anxiety had higher rates of uptake (87.70%, *k* = 7, *n* = 309) compared to interventions for depression (81.17%, *k* = 3, *n* = 406) χ2(1, *n* = 747) = 4.76, *p* < 0.05. Although, there were no differences in adherence between those interventions targeting depression (60.17%, *k* = 15, *n* = 2,554) and those interventions targeting anxiety (60.18%, *k* = 10, *n* = 372) χ2(1, *n* = 3,012) = 0.00, *p* > 0.05. Finally, there was a significant difference in rates of attrition; with interventions targeting anxiety (15.74%, *k* = 39, *n* = 1,516) having lower rates of attrition than interventions that target depression (28.74%, *k* = 21, *n* = 2,086) and interventions that target comorbid depression and anxiety (32.61%, *k* = 3, *n* = 260) χ2(2, *n* = 3,861) = 14.68, *p* < 0.01.

A series of weighted least-squares regressions were used to assess the relationship between symptom severity, length of intervention, study quality and the participant’s age, gender, education and rates of engagement.

***3.7.2.4 Symptom severity.*** There were no significant associations between symptom severity and rates of uptake, adherence and attrition (β = -0.00, -0.68 and 0.20 respectively, *ns*).

***3.7.2.5 Length of intervention.*** There were no significant associations between the length of the intervention and rates of uptake (β = 0.14, *ns*) or adherence *(*β = 0.47, *ns*). Length of the intervention was significantly related to rates of attrition (β = 0.35, *p* < 0.05), however.

***3.7.2.6 Study Quality.*** There were no significant associations between study quality and rates of uptake, adherence and attrition (β = -0.03, 0.30 and -0.16 respectively, *ns*).

***3.7.2.7 Participant characteristics*.** There were no significant associations between age, gender or education and rates of uptake, adherence or attrition (-0.03 ≤ β ≤ 0.46, *ns*).

**3.8 Discussion.** Understanding levels of engagement with self-help interventions is important because these interventions are known to be effective in alleviating symptoms of depression and anxiety. The present systematic review estimated the overall rates of uptake, adherence, attrition and maintenance for self-help interventions targeting these common mental health problems. In addition, a series of factors (the type of self-help intervention used; the target problem; whether the intervention was guided or unguided; symptom severity; the length of intervention; study quality and sample characteristics such as age, gender and level of education) were evaluated in relation to rates of engagement.

**3.8.1 Uptake*.*** Uptake of self-help interventions was relatively high across the reviewed studies; of the people who were offered this treatment, nearly 84% accepted. There is a gap in the literature regarding average rates of uptake to psychotherapy. Rates of uptake to face-to-face treatments have been reported for individual studies. However, to date no review of rates of uptake to psychotherapy has been conducted, and so it would be premature to compare the present findings to those reported in specific studies of psychotherapy. In addition, there is also a gap in the literature regarding uptake of antidepressant medications, with research tending to focus on adherence to medication schedules. Again, a review of rates of uptake to antidepressant medications needs to be conducted before meaningful comparisons can be made between rates of uptake of the different treatments available for depression and anxiety (namely psychotherapy, antidepressant medication and self-help).

**3.8.2 Adherence.** The overall rate of adherence to self-help interventions was nearly 66%, meaning that just over a third of the intervention content went unused. By way of context, Horvitz-Lennon, Normand and Frank (2003) noted that only 55% of adults attending psychotherapy for depression in the USA attended at least four sessions, however no reviews have been conducted for comparison. Four meta-analyses of antidepressant medication (Anderson, 1998; Anderson & Tomenson, 1995; Montgomery & Kasper, 1995; Steffens, Krishnan, & Helms, 1997) observed adherence rates that ranged from 21% to 33% for tricyclic antidepressants and SSRI’s. Thus, it appears that self-help treatments have adherence rates that are higher than those reported for antidepressant medications.

**3.8.3 Attrition.** The average rate of attrition was nearly 24%, meaning that around one-quarter of those who start self-help interventions for depression and anxiety disorders drop out of the intervention prematurely. By way of comparison, Wierzbicki and Pekarik’s (1993) meta-analysis of 123 studies of attrition rates for face-to-face therapy psychotherapy, reported that less than 47% of participants completed the agreed treatment program. Therefore, it seems that adherence rates for self-help interventions are much lower than the levels of adherence found for face-to-face therapy. The waste of clinical resources that accrues from clients who do not complete the set treatment program is a substantial issue (see Oldham, Kellett, Miles, & Sheeran, 2012).

**3.8.4 Maintenance.**The present systematic review identified only one study (Baker et al., 1973) that investigated maintenance of self-help techniques (that is, the continued use of self-help techniques and skills beyond the intervention period). There is clearly a gap in the literature concerning the continued use of self-help procedures after the initial treatment phase has ended, and this could potentially be a useful topic to explore in future research. Researchers routinely follow-up participants who have used self-help interventions in RCTs to measure efficacy, so it would seem a relatively simple matter to also measure the continued use of self-help materials at these time points. For example, a questionnaire could be administered alongside efficacy measures, that asks participants questions regarding their continued use of the self-help since the end of the intervention.

**3.8.5 Moderators of engagement with self-help interventions.** The findings from the present systematic review indicate that several of the moderator variables explored are related to increased engagement with self-help for depression and anxiety. For example, interventions targeting anxiety, that are guided, and utilise bibliotherapy or computerised self-help have the highest rates of uptake. While interventions that target anxiety, that are relatively short, and delivered via audio or audio-visual methods, offer the greatest benefit in terms of lower rates of attrition.

Although the present systematic review found that uptake of self-help interventions was relatively high, uptake rates depended on the type of self-help. Bibliotherapy and computerised self-help had the highest levels of uptake whereas writing self-help interventions (e.g. those based on Pennebaker’s (1997) writing paradigm) had the lowest level of uptake. Having said this, self-help interventions based on writing are relatively under used in comparison to bibliotherapy and computerised self-help. Wright and Chung (2001) reported that, although empirical support for writing interventions is well established (e.g. Smyth, 1998), expressive and reflective writing interventions are not widely used in the UK or USA, in either psychological therapy or self-help. In comparison, Meyer (2008) reported that approximately 2,000 self-help books are published each year and Norcross (2000) suggested that 85% of psychotherapists recommend self-help books to their clients. Thus, the lower rates of uptake for writing interventions could be explained by a general lack of awareness of such interventions.

Engagement with the intervention content, in the form of adherence or attrition, was found to be no different when comparing guided and unguided interventions. Previous meta-analyses had reported higher rates of adherence for guided interventions targeting anxiety disorders (e.g. Nordgreen et al., 2012), however only four RCT’s were included. The present study analysed 70 studies, 10 of which reported rates of adherence to interventions targeting anxiety disorders, perhaps accounting for the discrepancy in findings. Previous researchers have also commented on the increased likelihood of attrition from unguided interventions (Eysenbach, 2005), however to date no meta-analyses had previously been conducted to compare rates of attrition between guided and unguided interventions.

Engagement rates, in the form of rates of uptake, were however found to be significantly higher for guided interventions, perhaps due to guided intervention being more acceptable to those they are offered to (in line with the findings from Chapter 2), although more research is required to verify this. Research also suggests that guided interventions are more effective than unguided interventions (e.g. Gellatly et al., 2007), so it would seem valuable to provide guided support alongside self-help interventions as they are more acceptable, have higher rates of uptake and are more effective. Richardson and Richards (2006) have suggested that the common features that occur in interventions with face-to-face contact, such as therapeutic alliance or therapist responsiveness, may be one of the reasons that guided self-help is more effective than unguided self-help. Richardson, Richards, and Barkham (2010) suggest that it may be possible to boost unguided self-help interventions such as bibliotherapy by incorporating into them some of the common features of face-to-face psychotherapy. A model of the common features of therapy has been developed that shows the three stages that occur in the therapist-patient relationship (Cahill et al. 2008). Establishing the relationship is the first stage of the model and this includes common features such as empathy, warmth and genuineness from the therapist and a negotiation between patient and therapist regarding the goals that they wish to achieve during therapy. The second stage, developing the relationship, requires the development of a secure base for the patient, feedback from the therapist, and therapeutic responsiveness. The final stage, maintaining the relationship, requires keeping the therapeutic relationship on track when difficulties occur, and flexibility/responsiveness from the therapist.

Richardson et al. (2010) used this model to establish the extent to which a selection of unguided self-help books for depression incorporated these common features. Three self-help books were qualitatively analysed; *A self-help guide to managing depression* (Barker, 1997), *Overcoming depression: A self-help guide using cognitive behavioral techniques* (Gilbert, 2000) and *Mind over mood: change how you feel by changing the way you think* (Padesky & Greenberger, 1995). The results of this analysis suggest that the authors of these three books have incorporated some of the common features of therapy into the text. For example, multiple examples of empathy, warmth and genuineness can be found throughout all three books (e.g. “*when we are depressed, all the activities we have to perform each day can seem overwhelming*” (Gilbert, 2000, p. 69). However, other common features of therapy, such as goal setting, are not well represented within the texts. For example, neither Barker (1997) nor Padesky and Greenberger (1995) encourage the reader to set out the goals that they would like to achieve through reading the book. Gilbert’s (2000) book contains a little information on goal setting, but not instructions for how to set achievable goals. In addition, Richardson et al. (2010) noted that all three books contained little information regarding maintaining the treatment and dealing with difficulties experienced during the course of reading the book. This study provides insight into why guided self-help is often found to be more effective, more acceptable (as found in Chapter 2), with higher rates of uptake, as the common features missing from these self-help books may be replaced during guided support. However, for unguided self-help there is no opportunity to replace the common features of therapy that are not provided in the intervention itself. Richards et al’s (2010) study is limited in that it only explored three self-help books. Future research could assess the common features of therapy in other forms of self-help to assess if they occur and whether they could be a factor impacting upon levels of treatment efficacy, acceptability or uptake.

Self-help interventions that target anxiety, rather than depression, were found to have higher rates of uptake and lower rates of attrition during the intervention, although no differences were found in rates of adherence with both groups utilising around 60% of the intervention content. Attrition was particularly problematic for those experiencing symptoms of depression or comorbid symptoms of depression and anxiety, at around twice the rate of attrition reported for those experiencing symptoms of anxiety only. Researchers have reported problematic rates of engagement for self-help treatments targeting either depression or anxiety (see 3.3), but the present study is the first systematic review to compare rates of engagement to self-help between conditions and the first to explore the impact of comorbid depression and anxiety on rates of engagement. Previous research has explored the impact of comorbidity on engagement to psychotherapy and antidepressant medications, with mixed results reported. For example Lenze et al. (2003) compared attrition rates from antidepressant medications for those with depression only (*N* = 160) and those with comorbid depression and anxiety (*N* = 84). They found no difference in rates of attrition between the two groups. In comparison, Issakidis and Andrews (2004) analysed attrition to treatment for anxiety disorders in an out patient clinic (*N* = 731), they found that rates of attrition were greatest amongst those patients with comorbid depression. Further research is needed to assess treatment engagement to self-help interventions targeting comorbid depression and anxiety, especially as the present systematic review only sampled three studies where comorbid depression and anxiety symptoms were assessed. In addition, further research is required to establish which aspects of depression symptomology make premature attrition more likely and how best to support those experiencing depression symptoms or comorbid depression and anxiety symptoms to ensure they are able to remain engaged with the intervention.

Shorter interventions were found to have lower levels of attrition, suggesting that shorter interventions are more appealing and easier to complete. In addition, differences in attrition rates were also found between different modes of self-help delivery. For example, studies that utilised audio/audio-visual sources, such as CDs and DVDs were found to have the lowest levels of attrition. This could be due to the length of the intervention and the level of commitment required, as watching a DVD may require less time and commitment than reading a self-help book.

**3.8.6 Limitations*.*** One of the main limitations of the present systematic review is the relative paucity of studies that provided information concerning rates of uptake, adherence, attrition and (particularly) maintenance. This issue is also noted in other reviews of engagement to self-help interventions that target depression and anxiety. For example, Simco, McCuster and Sewitch (2014) noted that of the forty studies assessed in their systematic review of adherence to self-help for depression and anxiety disorders, only 55% report adherence information. In addition, many studies that examined self-help for depression and anxiety had to be excluded from the present systematic review either because they either did not provide sufficient detail concerning the forms of engagement assessed or because information concerning engagement was presented for the whole sample, rather than by treatment condition. Information concerning the maintenance of self-help techniques post-intervention was rare in the literature (only one study reported this information). The lack of studies reporting engagement information also affected the number of studies that could be used to investigate factors that might influence engagement (e.g. depression severity, education, gender etc.). The consequence of this is that this analysis was likely underpowered and may risk type 1 errors. This limitation tempers the conclusions that can be drawn about the rates of engagement reported here, and the role of the moderator variables explored.

A further limitation is the quality of the studies included, as categorised by the Jadad scale (Jadad et al., 1996), as sixty studies included in the review, had quality ratings of three or less. Previous researchers have suggested that studies with a score of three or less be excluded from systematic reviews as they are not of sufficient quality (Simon, 2006). The present systematic review did not adhere to these guidelines. As noted above there is a dearth of literature reporting rates of engagement to self-help interventions and to exclude all studies with a score of three or less on the Jadad scale would have severely limited the number of studies that could have been analysed. As a result, the results of the present review should be interpreted with caution.

Finally the reliance on self-report data to calculate rates of adherence to the self-help treatments is problematic. With the exception of computerised interventions, where adherence could be logged by the computer program or website hosting the intervention, the remaining studies (*k* = 48) relied on participants honesty and ability to report how much of the self-help content they had used (e.g., how much of a self-help book had they read). Participants were all part of RCT’s and were contacted by researchers requesting information regarding how much of the self-help intervention they had used. It is possible that this may have led to inflated rates of adherence, and in studies that did not use independent measures of adherence (e.g. computer programmes that record how much of a intervention has been completed) this could not be verified. However, the results of the present thesis suggest that this did not occur, as no significant differences were found in rates of adherence between those who self-reported how much of the self-help book they had read (e.g. those who received bibliotherapy) and those who did not self-report adherence ratings to a computerised intervention (e.g. where adherence was objectively measured as number of CCBT modules completed etc.).

**3.8.7 Conclusions.** Evidence suggests that self-help is an effective treatment for depression and anxiety disorders, however less is known about how people engage with self-help interventions for these disorders. The present systematic review offers a review of rates of engagement with multiple forms of self-help interventions targeting anxiety and depression disorders. Approximately 85% of those who were interested in taking part took up the offer of the self-help intervention. However, of those participants who took part in the self-help interventions, on average they left nearly 40% of the content unused, potentially limiting efficacy. Similarly, on average, only three-quarters of those who started using a self-help intervention completed it. The present systematic review found that shorter interventions reported lower rates of attrition, while guided interventions had higher rates of uptake. The continued use of self-help techniques beyond the end of the intervention was also measured, however only one study reported this information. Studies should, in future, measure and report maintenance rates at each follow-up as supporting and promoting the long-term use of self-help interventions may impact upon the long-term rates of efficacy reported for self-help. In addition, future studies, should also report rates of engagement (e.g. uptake, adherence and attrition) with self-help interventions by condition rather than for the whole sample so that the present systematic review can be replicated with a larger sample. This would overcome some of the limitations noted in section 3.8.6.

Future research should now focus on understanding why certain interventions (e.g. shorter versus longer interventions or guided versus unguided interventions etc.) have different rates of engagement than others; what aspects of these interventions promote engagement and what aspects make engagement more problematic, and how can we best support those who use these interventions to boost engagement. For example, Chapter 2 reported that unguided interventions were less acceptable than guided interventions for depression, which perhaps goes someway to explaining the finding, reported here, that unguided interventions have lower rates of uptake. Is this because the people offered this treatment found it an unacceptable treatment option? If this is the case then it is in the interest of primary care trusts to further understand why unguided interventions are perceived as less acceptable and assess the impact these attitudes and preferences have on treatment outcome and engagement. If the finding that unguided is unacceptable and un-preferable in comparison to guided self-help and psychotherapy is replicated in a clinical help-seeking sample, and these views are found to impact upon engagement (e.g. uptake) and efficacy then it would seem logical to increase the funding for guided self-help and psychotherapies so that patients can have greater access to their most preferred treatments, as this leads to higher rates of uptake and greater efficacy

**Chapter 4: Augmenting self-help to enhance efficacy and engagement**

**4.1 Unguided self-help**

Although the studies reported in this thesis so far report that guided self-help is more acceptable than unguided interventions (Chapter 2) and has higher rates of engagement (Chapter 3) in the form of uptake, unguided interventions may offer a solution to two of the problems faced when treating common mental health problems such as depression and anxiety. Namely, the demand for effective treatments and the cost associated with providing this treatment. As a result the use of unguided interventions should not be overlooked. Rates of depression (see section 1.1) and anxiety (see section 3.1) are sizeable, and in the case of depression, figures seem to suggest they are rising (see section 1.1). Thus demand for treatment is also rising (SSentif, 2012). Unguided self-help could be rolled out to a large number of patients in a cost-effective manner as it does not require a physical location (e.g. a clinic) and no therapists need to be trained (Furmark et al., 2009). As such it could be used as a first point of contact for those patients presenting with mild symptoms of depression or anxiety. The use of unguided self-help in this manner could also be a cost-saving strategy, as it would free up guided self-help and psychotherapy spaces for those with more severe symptomology. Although few cost-effective analyses have been conducted for mental health disorders, such as depression and anxiety, there is some evidence to suggest that unguided self-help could be more cost-effective than TAU for a range of mental health issues. For example, Purves et al. (2009) analysed the CCBT intervention “*Blues Begone*” in comparison to the IAPT service, using data from Clark et al. (2009). The findings suggested that the unguided “*Blues Begone*” program cost around 25% of the IAPT program per patient. See also Ebert et al. (2014) and van Spijker, Majo, Smit, van Straten and Kerkhof (2012). Research suggests that unguided interventions may be less effective than guided ones (e.g. Andersson & Cuijpers, 2009), however they have a reported effect size of 0.28 in comparison to no-treatment controls (Cuijpers et al., 2011a), meaning that at a population level they could substantially reduce the burden of depression (Ebert et al., 2014). Although further research is needed to fully explore the cost-effectiveness of unguided self-help interventions for depression and anxiety, they should not be overlooked as they can successfully widen access to treatment for those with mild levels of symptomology.

**4.2 CBT**

One of the NICE recommended treatments for depression and anxiety is CBT (see section 1.2.2.2). NICE (2009) recommends individual face-to-face or guided CBT for symptoms of depression and anxiety, with approximately 16-20 sessions provided over three to four months for individual CBT and approximately six to eight sessions provided over nine to 12 weeks for guided CBT. However, it can be problematic for primary care trusts to provide face-to-face or guided CBT due to the large volume of patients requiring treatment (Williams & Garland, 2002). As a result other forms of CBT are offered, such as bibliotherapy, computerised self-help or group-based interventions, as part of the IAPT stepped care programme (Department of Health, 2008) and the books on prescription scheme (The Reading Agency, 2013), as these methods of delivery allow for larger volumes of patients with mental health disorders, such as depression and anxiety, to receive treatment.

CBT is said to be the most researched of all the psychotherapy approaches and as such has the largest evidence base (Anderson, Yeeles & Burns, 2011). CBT that is delivered face-to-face, in groups, or via guided self-help has been found to be effective in comparison to TAU or waitlist controls, with little difference found between CBT and antidepressants or CBT and other forms of Psychotherapy, however CBT plus antidepressant medication was more effective than antidepressants only with a medium effect size noted (Cuijpers et al., 2013) (see section 1.2.2.2). CBT that is delivered via self-help only, without the aid of guided or face-to-face support, has also been found to be more effective than TAU or waitlist controls (Cuijpers et al., 2011a) and as such is offered in the UK as a low intensity intervention (Department of Health, 2008) or as part of the books on prescription scheme (The Reading Agency, 2013).

**4.3 Living Life to the Full**

Living Life to the Full (LLTTF) is a self-help CBT based intervention based on the five areas approach (Williams & Chellingsworth, 2010), it aims to convey the principles and interventions of the traditional CBT model in a way that is more accessible, thus is has a reading age of 12 years, and is jargon-free. This allows it to be delivered by a wide range of practitioners outside of a traditional face-to-face psychotherapy session (including psychiatrists, psychiatric nurses, clinical psychologists, behavioral nurse therapists, general practitioners, health visitors and practice nurses). The model conveys the key principle of CBT, whereby a person’s thoughts impact upon their feelings and their behaviors. For example someone with depression may think they are unlovable and this thought affects how they feel. In this case they may feel alone, sad, worthless etc. This thought may also affect how they behave, so they may limit social contact. Within the five areas approach the interaction between thoughts, feelings and behaviors is seen as a vicious circle whereby thoughts impact upon feelings and behaviors, but feelings and behaviors also impact upon thoughts (often worsening the original negative thought). The five areas approach aims to tackle five areas whereby negative thoughts, feelings or behaviors occur. These areas are 1. life situations, relationships and practical problems, 2. altered thinking, 3. altered emotions (or feelings), 4. altered physical feelings/symptoms, 5. altered behavior or activity levels. So a person may lose their job (area 1), which leads them to think they are useless (area 2), which leads them to feel depressed, low, worthless etc. (area 3), the depression then causes them to feel lethargic and sluggish (area 4) and finally this leads them to reducing the amount of time they are able to leave the house or even get out of bed (area 5). The five areas approach aims to tackle each of these altered thoughts, feelings or behaviors using traditional CBT methods, as by improving one area of this vicious circle, the model hypotheses that improvements will be made in other areas. For example if you tackle the negative thought “I am unlovable” using the ABC method (whereby you tackle the negative thought by looking for evidence to refute it) you dispute the negative thought and also the feelings that go alongside this thought (Williams & Chellingsworth, 2010; Williams & Garland, 2002). The LLTTF program is bibliotherapy based and in relation to depression and anxiety, eight booklets are utilised (Williams, 2008 a, b, c, d, e, f, g, h). These booklets set out the five areas approach, the CBT model and interventions for the user to undertake throughout the course of the booklets.

The LLTTF program has traditionally been delivered via guided self-help that is offered in group-based settings. Here it has been found to effectively reduce symptoms of depression and anxiety, for example Williams et al. (2012) recruited one hundred and forty-two participants with symptoms of depression into an RCT whereby participants either received the LLTTF as a group-based guided intervention or were placed on a waiting list to receive the same intervention at a later date. Participants worked through eight of the living life booklets (Williams, 2008 a, b, c, d, e, f, g, h) with weekly one and a half hour-long group based sessions. Symptoms of depression and anxiety were measured at baseline and again after the eight-week intervention, with rates of depression and anxiety symptoms reducing for those who received the intervention. Prior to the intervention, around 17% of the participants who used the LLTTF classes scored below the clinical cut-off for depression (the PHQ-9 (Kroenke, Spitzer & Williams, 2001) was used to measure depression symptomology, which has a clinical cut off of <10). Post intervention this figure had increased to around 60%. Other researchers have used the LLTTF booklets as part of guided group-based self-help classes; see McClay, 2012 and The Canadian Mental Health Association (2011, 2012 & 2013) and this program is used extensively across Scotland (Lloyd & Abdulrahman, 2011) and British Columbia, Canada (The Canadian Mental Health Association, 2011, 2012, 2013) in this way. In the UK the NHS choices website also hosts a link to the Living Life to the Full website on its depression and anxiety page (NHS, 2014).

The bibliotherapy design of this intervention means that it has the potential to be used as an unguided intervention. To date, the efficacy of the LLTTF program as an unguided intervention has not been tested in an RCT setting and the study presented in Chapter 4 is the first to explore the efficacy of this intervention when used without guided support. Delivering this intervention in an unguided context would enable the intervention to be rolled out to a larger number of the people experiencing symptoms of depression and anxiety, as currently the use of LLTTF as a guided intervention is restricted by the number of therapists trained to deliver it. It may also be able to reach those who would otherwise not find help due to the lack of trained therapists, long waiting lists or the fact that treatment is inaccessible (e.g. because people may live in more rural areas, may not be able to take time off work to attend regular therapist appointments or may not be able to afford associated costs of attending appointments such as transport, childcare and days off work) (Berger et al., 2011a). The eight LLTTF booklets for depression and anxiety (Williams, 2008 a, b, c, d, e, f, g, h), that have been shown to reduce symptoms of depression and anxiety in a group based guided self-help settings, have yet to be evaluated when used independently, in an unguided context. The present study (known from here on as Study 3) therefore aims to assess the efficacy of the LLTTF books (Williams, 2008 a, b, c, d, e, f, g, h) when used independently in an unguided context.

Chapter 4 also aims to explore the interaction between how acceptable self-help is deemed to be by those using it and treatment efficacy.As noted in Chapter 2, how acceptable an intervention is considered to be can be measured in two ways. Firstly by examining levels of engagement with the intervention (see 3.4 for definitions of engagement) and secondly by examining ratings of how acceptable the treatment is deemed to be and how severe any associated side effects are.

Levels of adherence can indicate how acceptable an intervention is, as those participants who view the treatment as unacceptable have lower levels of adherence to the treatment program (Kaltenthaler et al., 2008). Chapter 3 explored what the average rates of engagement to self-help interventions targeting depression and anxiety were, as well as exploring possible moderators of engagement. Chapter 3 also cited research which found that rates of adherence to self-help interventions had been linked to the efficacy reported at follow-up (e.g. de Graaf et al., 2009; Gould & Clum, 1993), finding that those with higher rates of adherence reported better treatment outcomes (see 1.4.2). Chapter 4 therefore aims to further explore engagement with self-help interventions, and aims to specifically explore whether self-help interventions can be augmented to enhance engagement and efficacy.

Chapter 2 examined engagement with self-help by exploring attitudes surrounding how acceptable a self-help intervention is perceived to be, as well as how severe the associated side effects are (see 2.7.1.3for further discussion of these variables). Chapter 4 also aims to explore the interaction between ratings of acceptability and side effects, and the efficacy of the self-help intervention. Do participants who view the self-help intervention as highly acceptable, with fewer side effects, experience higher levels of efficacy post intervention?

**4.4 Implementation Intentions**

Study 3 is also interested in whether unguided interventions for depression can be augmented to improve rates of engagement, as research suggests that treatment outcomes are significantly improved when participants engage with the self-help intervention they are using (see de Graaf et al., 2009; Gould & Clum, 1993). One method by which engagement could be improved is by augmenting self-help interventions with if-then plans or *implementation intentions* (Gollwitzer, 1999; Gollwitzer & Sheeran, 2006) that stipulate when, where and how the participant will use the self-help materials or the techniques learnt. For example, if situation *Y* is encountered, then I will initiate goal directed behaviour *X*. (Gollwitzer & Sheeran, 2006). In terms of self-help for depression and anxiety the participant may use if-then plans to work out when to use the self- help techniques, for example: ‘*If* I catch myself thinking critical thoughts about myself, *then* I will work though the unhelpful thinking styles exercise I learnt last week.” or the participants may want to use if-then plans to help schedule time to work through the self-help materials, for example: “*If* I get my husband to put the kids to bed two nights a week, *then* I can spend that time working through my self-help book”.

The efficacy of self-help materials has been improved by the use of implementation intentions. For example, Varley, Webb and Sheeran (2011) augmented an unguided self-help booklet (*Feeling Less Worried: A Three-Step Plan to Help Manage Your Anxiety)* for anxiety with implementation intentions. The self-help booklet was received as either a stand-alone intervention (*N* = 86) or administered alongside implementation intentions (*N* = 90), which asked the participants to form two implementation intentions specifying when they would use the self-help techniques described in the self-help booklet. The first implementation intentions asked participants to identify a particular anxiety-related symptom and to use this symptom as a prompt to use the self-help techniques described. For example “If I feel (INSERT anxiety symptom), then I will use my breathing techniques to relax”. The second implementation intention asked the participants to identify an appropriate time to fit the self-help techniques into their routine. For example “If I am in the shower, then I will use my relaxation techniques”. At baseline participants HADS anxiety subscale scores (Zigmond & Snaith, 1983) for both the standard (10.95, SD = 3.77) and augmented (11.41, SD = 4.03) conditions indicated that the sample was experiencing mild to moderate levels of anxiety symptoms based on Zigmond and Snaith’s (1983) cut-off’s. Varley et al. (2011) found that participants who received the augmented self-help (6.81, SD = 4.83) had significantly lower scores HADS anxiety subscale scores compared with the standard self-help (10.14, SD = 4.85). Adherence rates have also been improved by the use of if-then plans. For example, Varley et al. (2011) found that participants in the augmented self-help condition used the self-help techniques more frequently (e.g. 3.65 times during the course of the intervention) than those who did not create if-then plans (e.g. 3.02 times). However, as yet in the field of depression no research has explored the link between implementation intentions and adherence to self-help materials. If implementation intentions were found to improve both rates of efficacy and adherence to self-help for depression, then they could easily and cheaply be built into existing self-help materials. If-then plans could be incorporated into self-help workbooks, or messages could be sent to remind participants of their if-then plans. For example Prestwich, Perugini, & Hurling (2009) found that participants who received text messages to remind them of their if-then plans to exercise had the highest rates of exercise compared to controls and those who just used if-then plans without the reminder text messages. Study 3 therefore aims to assess whether implementation intentions positively impact upon the efficacy of the self-help intervention and levels of adherence to the intervention during treatment.

**4.5 Study 3**

Study 3, a RCT with five conditions (standard self-help, augmented self-help, waitlist standard self-help, waitlist augmented self-help and a no treatment control group) aimed to (1) assess efficacy of the LLTTF books (i.e. are these booklets still effective when used as an unguided intervention?), (2) assess how augmenting the self-help intervention with implementation intentions impacts upon efficacy and the level of engagement with the self-help booklets (measured by examining rates of adherence and maintenance post intervention), (3) assess how acceptable the intervention is, and how severe any perceived side effects (e.g. risks and discomfort) are deemed to be, impacts upon efficacy and engagement. Study 3 hypotheses that those who receive the self-help intervention will experience a significant decrease in depression and anxiety scores, over those who receive no treatment. With regards to augmenting the intervention, Study 3 hypotheses that those receiving the augmented self-help will experience a larger decrease in symptomology and a higher rate of adherence to the intervention than those receiving the standard self-help. No specific hypotheses regarding treatment acceptability, side effects or maintenance post intervention are made due to a lack of relevant literature on the subject.

**4.5.1 Method.**

***4.5.1.1 Sample.*** Approximately 31,000 staff and students at the University of Sheffield were emailed an invitation to take part in the study (see appendix 16). The University of Sheffield operates a staff and student volunteer distribution email list, which allows researchers to advertise for research participants at the University. The exact number of staff and students on this distribution list is unknown as both staff and students can choose to opt out and opt back into receiving these emails. There are approximately 25,000 students and 6,000 members of staff on this list.

Participants were asked in the email invitation if they were feeling low, sad or depressed, as the study required a sample of individuals who were experiencing symptoms of depression. The email contained a link to an online questionnaire (see appendix 17), which the participants were required to fill out if they wish to take part in the study.

*N* = 217 participants responded (an approximate response rate of 0.7%) however only 144 participants were eligible to take part (participants were excluded if they were receiving other forms of treatment (*N* = 45), left no contact email address, or left an incorrect email address (*N* = 13), had CES-D scores that were below the clinic cut-off of 16 (*N* = 10) or withdrew (*N* = 5) prior to receiving the booklets).

***4.5.1.2. Participant flow.*** Forty-five participants were randomised[[2]](#footnote-2) to the standard self-help condition, forty-five were randomised to the augmented self-help condition and fifty-four were placed on an eight-week waitlist. Those in the waitlist control group were told that after eight weeks that they would be eligible to receive the self-help content. Twenty-one participants from the waitlist control group took up the offer of using the self-help materials after the eight week waiting period, with twelve randomised[[3]](#footnote-3) to receive the standard self-help (known as the WSSH group) and nine randomised to receive the augmented self-help (known as the WASH group). Figure 3 shows the flow of participants through the trial.

**Figure 3: Flow of Participants Through the Trial**

Approx. 31,000 staff and students invited to take part in the research

217 filled out questionnaire

73 excluded:

12 provided no contact email

10 had CES-D scores below the cut off

5 withdrew pre intervention

1 email address incorrect

45 were receiving other treatment

144 were offered a place on the study and asked to provide their address

144 accepted

Waitlist = 54

Augmented self-help = 45

Standard self-help = 45

54 were offered a place on the study after the 8 week waitlist period was over

21 accepted

Wait list standard self-help = 12

Wait list augmented self-help = 9

No-treatment = 33

***4.5.1.3. Power analysis.*** Power analysis was conducted using the computer program G\*Power (Erdfelder, Fauchner & Buchner, 1996). This analysis revealed that for an analysis of variance between groups, with 95% power and an alpha level of 0.05, a total sample size of 145 participants was required for a large effect size (*d* = 0.8) similar to those reported in the self-help literature for depression (e.g. Cuijpers’, 1997 meta-analysis of unguided bibliotherapy reported an overall effect size of *d+*= 0.82, with four of the six included studies reporting effect sizes > 0.8). Post-hoc power analysis showed that the reduced sample size (N = 144) did not reduced the power of the study when looking for a large effect size.

***4.5.1.4 Measures.*** At baseline (0-weeks), eight, sixteen and twenty-four week follow-up the participants filled out a questionnaire.

TheCenter for Epidemiologic Studies Scale (CES-D, Radloff, 1977) was used to measure depression symptoms. The CES-D is designed to measure symptoms of depression in the general population and is focused on the presence of dysphoria (Stafford et al., 2014). Participants are asked to rate 20 items in terms of how often they have felt this way during the last week with items measuring depressive affect (e.g. “*I was bothered by things that usually don’t bother me”)*, somatic symptoms (e.g. “*I did not feel like eating; my appetite was poor*”), positive affect (e.g. “*I felt hopeful about the future*”) and interpersonal relations (e.g. “*People were unfriendly*”). Mean scores were calculated for each participant, with scores ranging from 0 to 3, with higher scores indicating the presence of more symptomatology. Cronbach alpha scores were calculated for the CES-D items at baseline, a score of 0.84 was found showing good levels of internal consistency.

The HADS (Zigmond & Snaith, 1983) was also administered. This scale was administered to assess levels of anxiety amongst the sample, as well as symptoms of depression that are more focused on anhedonia rather than dysphoria (which is the focus of the CES-D scale) (Stafford et al., 2014). This scale measures levels of anxiety and depression using 14 items, with seven items measuring anxiety (e.g. “*I feel tense or wound up*”) and seven items measuring depression (e.g. “*I still enjoy the things I used to enjoy*”), which the participants rate based on their experience over the past week. Again mean scores were calculated, with scores ranging from 0 - 3, with higher scores indicating the presence of more symptomatology. Cronbach alpha scores were calculated for the HADS items at baseline, a score of 0.55 was found.

The state anxiety subscale of Spielberger, Gorsuch, Lushene, Vagg and Jacob’s (1983) STAI was also administered to detect current feelings of anxiousness such as apprehension, worry and tension etc. 20 items measure levels of state anxiety (e.g. “*I feel calm*”). Mean scores ranged from 1 - 4, with higher scores indicating the presence of more symptomatology. Cronbach alpha scores were calculated for the STAI items at baseline, a score of 0.89 was found showing good levels of internal consistency.

The Treatment Evaluation Inventory (Landreville & Guérette, 1998) was administered at the eight-week follow-up. This inventory was developed to measure how acceptable people find different treatments for depression and how severe they perceive the side effects to be (see 2.7.1.3).The nine items of the Treatment Evaluation Inventory were entered into aprinciple components analysis with oblimin rotation. Consistent with Landreville and Guérette (1998), and the factor analysis reported in section 2.7.1.3, two components were extracted based on Kaiser’s (1957) criterion (i.e. they had eigenvalues greater than 1.00) that accounted for 72.36% of the variance. Both factors proved internally reliable (α = 0.93 and 0.68) and were labeled “*acceptability*” (items 1, 2, 4, 5, 6 and 9) and “*side effects*” (items 3, 7 and 8), respectively, Factor scores were computed for each component.

Adherence was also measured at the eight-week post intervention follow-up. Participants were asked, “How much of each of the eight booklets have you read” with responses ranging from “none of this booklet – 0%” to “all of this booklet – 100%”. Participants gave a separate answer for each of the booklets, an overall adherence score was created from this data by summing the answers given for each booklet and then dividing this score by eight to create an overall adherence percentage. Maintenance was measured at the 16-week follow-up. Participants were asked “Have you kept the booklets” (responses were coded Yes or No) and “If yes, which booklet have you revisited” (participants were required to tick which if the eight booklets they had revisited). Participants were also asked “And have you completed any of the exercises in the booklets since the eight week research period ended” (again responses were coded Yes or No) and “If yes, which of the exercises have you completed from the "Write all over the bathroom mirror" booklet. Please tick all those that apply”. Participants were asked the above question for each booklet, they were required to tick each of the exercises within that booklet that they had completed again since the intervention period had ended.

***4.5.1.5 Materials.***All participants received eight LLTTF booklets (participants in the WSSH/WASH groups received them after an eight week delay). See appendix 18. Each booklet gave advice on where to go for further help and advice. For example, the "*I can't be bothered doing anything*" booklet, stated that "*Sometimes, it can seem too difficult to start getting going again, even with small steps. That's when you need a bit more help than this little book can give. You can get it at www.livinglifetothefull.com where you'll connect with other people who feel like you, and find out how to contact professionals who can make changes to your life*" (Williams 2008b, p. 22). All participants also received a set of eight planning/reviewing sheets (again participants in the WSSH/WASH groups received these sheets after an eight week delay). These sheets could be used alongside the booklets to plan out and review the exercises within the books. One side of the A4 sheet was aimed at planning out the exercise, for example what you aim to do and when, and any problems you may face. The reverse side of the sheet dealt with reviewing the exercise carried out, for example what went well, what didn’t go so well and why. See appendix 19.

Finally all participants received an accompanying letter to explain how to use the books and planning sheets. Participants in the standard self-help condition received a letter which thanked them for their participation in the study and informed them that they should use one booklet per week, and that the booklets should be read in a certain order. Participants in the augmented self-help condition received a slightly different letter. It contained all the same information that the standard self-help group received concerning the order to read the books in, etc. but it also contained instructions for how to create implementation intentions. So participants were given an example of an implementation intention and then asked to create their own with the aim of planning when in the week they would use the self-help booklet. Please see appendices 20 and 21.

***4.5.1.6 Procedure.*** Approximately 31,000 staff and students were emailed an invitation to take part in the study. The email contained a link to an online questionnaire, which measured current levels of depression and anxiety before asking the participants to provide basic demographic information; including gender, age, ethnicity and occupation. Participants were asked to provide their contact email addresses and were told the act of doing so granted their consent to take part. Finally the participants were asked if they were currently receiving any other treatment for their depression. Participants were excluded who failed to provide contact information, were not depressed (as measured by a CES-D score of less than 16) or were receiving other forms of treatment for depression/anxiety. Eligible participants were emailed to ask for the address they wished the self-help booklets to be delivered to, before being allocated to one of three conditions. Participants used the booklets unaided for eight weeks, after which time they filled out the depression and anxiety measures again at post intervention and then again at 16-weeks and 24-weeks post intervention. Levels of adherence to the intervention and maintenance of self-help post intervention were also measured. Participants who were initially allocated to the waitlist condition were offered the self-help booklets after eight weeks. Those who wished to receive the booklets were randomly allocated to either WSSH or WASH. Those who did not wish to receive the booklets remained in a no-treatment control group. Ethical approval for the study was granted by the University of Sheffield (see appendix 22 & 23).

**4.5.2. Results.**

***4.5.2.1 Sample characteristics.*** Table 12 shows the characteristics of the sample for those in the standard self-help (N = 45), augmented self-help (N = 45), WSSH (N = 12), WASH (N = 9) and no-treatment (N = 33).Chi square analysis found no significant differences between the five conditions for gender allocation, occupation (e.g. academic staff, clerical staff or student) or ethnic diversity (*p* > 0.05 in all cases). An analysis of variance (ANOVA) indicated no significant differences between the five conditions for mean age (*p* > 0.05).

Depression and anxiety scores for the whole sample (N = 144) were calculated.The CES-D score at baseline was 34.29 (*SD* = 10.61), which indicates the presence of depression symptoms in the sample, as it is above the cutoff point of 16 set by Radloff (1977). The HADS depression and anxiety scores at baseline were 10.10 (SD = 3.49) and 12.96 (*SD* = 3.15) respectively, which indicate mild (or ‘possible case’) levels of depression symptomology and moderate (or 'probable case') anxiety symptomology (Zigmond & Snaith, 1983). The state STAI score at baseline was 59.27 (*SD* = 12.93), which is above the clinical cut off of 54/55 set by Kvaal, Ulstein, Nordhus and Engedal (2005).

Table 13 shows the mean baseline (0-weeks) depression and anxiety scores for each of the five conditions. An analysis of variance (ANOVA) indicated no significant differences between the five conditions for mean CES-D depression scores and mean HADS anxiety scores (*p* > 0.05 in all cases) at baseline. However, significant differences were noted for mean HADS depression scores (*F* (4) = 0.65, *p* < 0.01). Those in the WASH condition (*M* = 0.76, SD = 0.42) had a lower HADS depression score than participants in the four remaining conditions (*M’s* > 1.29 in all cases). Significant differences were also noted for mean STAI scores (*F* (4) =10.19, p < 0.01). Those in the WSSH (*M* = 2.22, SD = 0.19) and WASH (*M* = 2.19, SD = 0.21) conditions scoring lower than those in the remaining three conditions (*M’s* > 2.94 in all cases).

**Table 12: Sample Characteristics for the Standard Self-Help, Augments Self-Help, WSSH, WASH and No-Treatment Conditions**

Measure Standard Augmented Waitlist Waitlist No Treatment

Self-Help Self-Help Standard Augmented

Self-Help Self-Help

(WSSH) (WASH)

% Female 75.56% 72.73% 83.33% 66.67% 81.25%

Mean Age (SD) 26.95 (10.15) 28.11 (9.49) 24.83 (6.41) 27.44 (11.08) 26.00 (11.16)

% Student 70.45% 68.89% 75.00% 87.50% 75.00%

% Academic Staff 13.64% 17.78% 8.33% 12.50% 18.75%

% Clerical Staff 15.91% 13.33% 16.67% 0.00 6.25%

% White British 57.78% 68.89% 33.33% 77.78% 45.45%

**Table 13: Mean depression and anxiety scores at 0, 8, 16 and 24 - weeks**

Time Measure Standard Augmented Waitlist Waitlist No-treatment

Self-Help Self-Help Standard Augmented

Self-Help (WSSH) Self-Help (WASH)

N Mean SD N Mean SD N Mean SD N Mean SD N Mean SD

0 Weeks CES-D 45 1.80 0.55 45 1.71 0.55 11\* 1.85 0.32 7 1.89 0.29 33 1.67 0.48

8 Weeks 24 1.13 0.68 29 1.17 0.76 4 2.09 0.43 6 1.17 0.75 24 1.17 0.76

16 Weeks 14 1.10 0.69 26 1.14 0.68 6 2.11 0.66 3 0.93 0.97 18 1.10 0.64

24 Weeks 9 0.89 0.78 11 0.82 0.98 9 1.72 0.96 5 1.50 1.39 16 1.12 0.50

0 Weeks HADS-D\*\* 45 1.42 0.50 44 1.48 0.51 12 1.19 0.41 9 0.76 0.42 31 1.29 0.46

8 Weeks 24 1.83 0.38 29 1.86 0.35 5 2.07 0.69 6 2.00 0.00 24 1.96 0.20

16 Weeks 11 1.36 0.50 24 1.36 0.49 6 1.96 0.88 4 1.22 1.22 18 2.04 0.79

24 Weeks 20 3.05 0.70 20 3.07 0.78 8 1.65 0.99 5 1.03 0.89 20 2.54 0.38

0 Weeks HADS-A\*\*\* 45 1.87 0.50 45 1.87 0.46 11 1.70 0.61 9 1.41 0.45 33 1.85 0.36

8 Weeks 24 1.67 0.48 29 1.41 0.50 2 2.08 0.89 6 1.67 0.52 24 1.42 0.50

16 Weeks 11 1.09 0.30 24 1.21 0.41 8 1.91 0.74 2 1.07 1.32 18 1.85 0.74

24 Weeks 11 2.43 0.39 24 2.35 0.37 7 1.67 0.91 3 1.43 0.99 20 2.48 0.30

0 Weeks STAI 45 3.13 0.59 45 3.13 0.59 10 2.22 0.19 9 2.19 0.21 33 2.94 0.61

8 Weeks 28 2.18 0.55 36 2.18 0.55 4 1.98 0.72 6 2.17 0.41 23 2.04 0.20

16 Weeks 11 2.18 0.40 24 2.18 0.40 9 1.95 0.72 5 1.62 0.85 18 2.20 0.25

24 Weeks 17 2.23 0.20 17 2.23 0.20 6 1.82 0.93 6 0.52 0.77 10 2.22 0.22

\* Missing data meant that not all those allocated to each condition had scores for each measure of depression and anxiety

\*\*HADS – D = the depression subscale of the HADS scale

\*\*\* HADS – A = the anxiety subscale of the HADS scale

***4.5.2.2 Attrition analysis.*** Table 14 shows overall attrition from the study, as well as attrition by condition at eight, sixteen, twenty-four weeks post-intervention. Table 15 shows the characteristics of those who withdrew at eight, sixteen and twenty-four weeks post-intervention. Data was pooled across the five conditions for those who withdrew and those who remained in the study. There were no significant differences between those who failed to provide follow-up data at the first follow-up (eight weeks) and those who did, in terms of gender, age, ethnicity, occupation or baseline depression and anxiety scores (*p >* 0.05 in all cases). There were significant differences between those who failed to provide follow-up data and those who did at the 16-week follow-up for baseline STAI only (*t* (140) = -2.17, *p* < 0.05), with those who withdrew (*M* = 3.06, SD = 0.57) scoring significantly higher than those who remained in the study (*M* = 2.84, SD = 0.65) at 0 weeks. At the 24-weeks follow-up there were again significant differences for baseline STAI only (*t* (140) = -2.58, *p* < 0.05), with those with withdrew (*M* = 3.13, SD = 0.60) scoring significantly higher than those who remained in the study (*M* = 2.85, SD = 0.62) at 0 weeks. No other significant differences were reported for those who failed to fill out the 16 and 24-week follow-up questionnaires (*p* > 0.05 in all cases).

**Table 14: Number of participants who completed the post-intervention follow-up questionnaires (% of those originally allocated)**

Time Post Overall Standard Augmented Waitlist Waitlist No-Treatment

Intervention Self-Help Self-Help Standard Augmented

Self-Help Self-Help

(WSSH) (WASH)

8 weeks 99 (68.75%) 28 (62.22%) 36 (80.00%) 5 (40.67%) 6 (66.67%) 24 (72.73%)

16 weeks 72 (50.00%) 14 (31.11%) 26 (57.78%) 9 (75.00%) 5 (55.56%) 18 (54.55%)

24 weeks 79 (54.86%) 20 (44.44%) 24 (53.33%) 9 (75.00%) 6 (66.67%) 20 (60.61%)

**Table 15: Characteristics of participants who dropped out, including the percentage female, mean age (SD), percentage White British, % occupation (student, academic or clerical staff) and baseline depression and anxiety scores**

Time Measure 8-weeks 16-weeks 24-weeks

8 weeks % Female 75.00% 76.56% 71.74%

Age (SD) 26.43 (9.03) 25.74 (8.64) 25.79 (9.58)

% White British 62.50% 60.61% 59.57%

% Student 82.50% 80.00% 78.26%

% Academic 7.50% 10.77% 10.87%

% Clerical 10.00% 9.23% 10.87%

CES-D 1.84 (0.63) 1.74 (0.53) 1.78 (0.55)

HADS-D 1.25 (0.49) 1.38 (0.50) 1.35 (0.50)

HADS-A 1.81 (0.58) 1.88 (0.48) 1.91 (0.46)

STAI 3.02 (0.61) 3.06 (0.57) 3.13 (0.60)

***4.5.2.3 Effects of unguided self-help on levels of depression and anxiety.*** Table 13 shows the mean CES-D, HADS (depression and anxiety) and STAI scores for participants who received standard self-help, augmented self-help, WSSH, WASH or no-treatment. A series of multivariate analysis of variances (MANOVAs) were performed with bonferroni adjustments (*p* = 0.02) for the standard self-help, augmented self-help and no-treatment conditions only (unfortunately the sample size for the WSSH & WASH conditions was too small for this type of analysis). The analysis showed that there were no significant differences between the three groups in terms of the CES-D (*F* (8, 26) = 1.43, *p* > 0.02, eta2 = 0.31), the depression subscale of the HADS (*F* (8, 20) = 2,12, *p* > 0.02, eta2 = 0.45), the anxiety subscale of the HADS (*F* (8, 20) = 0.24, *p* > 0.02, eta2 = 0.51) and the STAI (*F* (8, 18) = 0.56, *p* > 0.02, eta2 = 0.20) at baseline (0-weeks), eight week, 16-week and 24-week follow-up.

Table 16 shows four 3-way between-subjects (standard self-help versus augmented self-help versus no-treatment) by 4-way within-subjects (time: baseline (0 - weeks) versus eight week versus 16-week versus 24-week follow-up) ANOVAs, which were conducted controlling for baseline scores.[[4]](#footnote-4) Scores on the CES-D, HADS – D (Depression subscale), HADS - A (Anxiety subscale) and STAI scales were used as dependent variables (DV) to determine whether there were differences between the three conditions. Again the sample size for the WSSH & WASH conditions was too small for this type of analysis and given that time was being examined it seemed unwise to combine the conditions, as this would mean combining data from different time points (e.g. standard self-help had the first post intervention follow-up at eight weeks, while WSSH had theirs at 16-weeks).

The analysis found that for those in the standard self-help, augmented self-help and no-treatment conditions there was a significant main effect of time for all measures of depression and anxiety, indicating significant changes in depression and anxiety symptomology from baseline to follow up, all with medium to large effect sizes according to Cohen’s (1988) criteria. Table 16 shows that while CES-D and STAI scores decreased from baseline to the final 24-week follow-up, scores on both subscales of the HADS actually increased. The main effect of condition was not significant for CESD, HADS - D or the STAI. However, the HADS - A there was a significant main effect for condition, again with a medium to large effect size, with the no-treatment condition experiencing a significantly larger increase in HADS - A scores than the standard self-help condition. There were no significant interactions between time and condition for any of the depression and anxiety measures.

**Table 16: Four 3x4 mixed ANOVAs investigating the effects of time and condition on levels of depression and anxiety symptoms**

Main effect DV df F p η2

Time CES-D 3 10.57 0.00\* 0.69

HADS - D 3 8.87 0.00\* 0.71

HADS - A 3 21.85 0.00\* 0.86

STAI 3 4.56 0.03\* 0.58

Condition CES-D 2 4.00 0.34 0.33

HADS - D 2 0.89 0.44 0.12

HADS - A 2 10.08 0.00\* 0.61

STAI 2 0.71 0.51 0.11

Interaction CES-D 6 1.19 0.34 0.20 HADS - D 6 2.18 0.09 0.37 HADS - A 6 1.72 0.16 0.32 STAI 6 0.68 0.68 0.17

***4.5.2.4 Acceptability and Side Effects.*** Table 17 shows the mean factor scores for ratings of how acceptable the treatment was deemed to be and the associated side effects for participants who received the standard or augmented self-help interventions (data was pooled across those who received the intervention immediately and those who received the treatment after an eight week wait). A MANOVA was used to examine differences between the standard and augmented self-help conditions, for their mean acceptability and side effect scores. No significant differences were found (*F* (4, 96) = 0.54, *p* > 0.05, eta2 = 0.02).

**Table 17: Acceptability and Side Effect Mean Factor Scores by Condition**

N Min Max Mean SD

Standard self-help Acceptability 13 -1.90 1.17 -0.13 1.13

Side effects 13 -0.97 1.79 0.14 0.98

Augmented self-help Acceptability 20 -1.65 1.44 -0.08 -0.87

Side effects 20 -1.06 2.28 0.18 1.16

***4.5.2.5 Do ratings of treatment acceptability and side effects predict treatment outcomes?*** A series of moderated linear regression analyses were used to determine if ratings of treatment acceptability or side effects moderated the effect of receiving self-help (both standard and augmented) versus no-treatment on depression and anxiety scores post intervention. Baseline depression and anxiety scores, condition (self-help versus no treatment control) and ratings of treatment acceptability and side effects were standardised prior to computing the interaction term to reduce potential multicollinearity (Aiken & West, 1991). We then conducted a three-step hierarchical regression. Depression and anxiety scores (at the eight week, 16-week and 24-week follow-ups) were regressed on baseline depression and anxiety scores at step one, on acceptability, side effects and condition at step two, and the acceptability × condition and side effects × condition interaction terms were added to the equation at step three. Appendix 24 shows the result of these analyses, which indicate that at the eight-week follow-up the six predictors (baseline CES-D, condition (self-help versus no treatment control) treatment acceptability, side effects, the interaction term between condition and acceptability and the interaction term between condition and side effects) explained 13% of the variance in CES-D scores at the eight-week follow-up, however this effect was non-significant. At the 16-week follow-up, the six predictors explained 22% of the variance in CES-D scores. Baseline CES-D scores significantly explained 13% of the variance at step one (Δ*R*2 = .13, *p =* 0.03), however this effect disappeared at steps two and three. At the 24-week follow-up 28% of the variance in CES-D scores was explained, although again this finding was non-significant. For the HADS depression measure the results indicate that at the eight week, 16-week and 24-week follow-ups the six predictors explained 15%, 10% and 30% of the variance in scores respectively. For the HADS anxiety measure the results indicate that at the eight week, 16-week and 24-week follow-ups the six predictors explained 8%, 12% and 19% of the variance in scores respectively. Finally for the STAI measure the results indicate that at the eight week, 16-week and 24-week follow-ups the six predictors explained 21%, 11% and 44% of the variance in scores respectively, however all were non-significant.

***4.5.2.6 Adherence.*** Adherence levels were pooled for those who received the standard self-help and those who received the augmented self-help. Table 18 shows the mean adherence levels for type of self-help (standard versus augmented). An independent samples t-test was used to examine differences between standard self-help and augmented self-help in mean adherence levels. No significant differences were found in terms of levels of adherence (*t* (37) = 0.34, *p* > 0.05) between the two groups.

**Table 18: Mean Adherence (%) to the Self-Help Booklet During the 8 week Intervention Period**

N % Adherence SD

Standard self-help 18 89.33% 16.49

Augmented self-help 23 87.52% 16.91

\* Please note there are differences in the N’s reported in Table 18, which show the % adherence during the eight week intervention, and the df2 figures reported on the next page, this is due to missing data on the depression and anxiety measures.

Table 19 shows the mean depression and anxiety scores at baseline (0-weeks), eight week, 16-week and 24-week follow-up for those with high (75–100%) and (low < 75%) levels of adherence pooled across the two self-help conditions; data was divided in this way to replicate Gould and Clum (1993). Those with high levels of adherence had the greatest increase in HADS depression scores and the lowest fall in CES-D scores. Four 2-way between-subjects (high adherence (75–100%) versus low adherence (less than 75%) by 4-way within-subjects (time: baseline (0-weeks) vesus eight week versus 16-week versus 24-week follow-up) ANOVAs were conducted with depression and anxiety scores on the CES-D, HADS and STAI scales as dependent variables to determine the impact of adherence on the efficacy of the intervention at the eight-week follow-up. The main effect of time was significant for the CES-D scale (*F* (3, 16) = 3.63, *p* = 0.04, *η2* = 0.41), the depression subscale of the HADS (*F* (3, 12) = 6.16, p = 0.01, *η2* = 0.61) and the anxiety subscale of the HADS (*F* (3, 12) = 7.78, *p* = 0.00, *η2* = 0.66). There was no significant main effect of time for the STAI scale (*F* (3, 11) = 2.14, *p* = 0.15, *η2* = 0.37). There was no significant main effect of adherence for the CES-D (*F* (1) = 1.82, *p* = 0.19, *η2*= 0.17), the depression subscale of the HADS (*F* (1) = 2.74, *p* = 0.10, *η2* = 0.28), the anxiety subscale of the HADS (*F* (1) = 1.23, *p* = 0.32, *η2* = 0.15) or the STAI (*F* (1) = 0.20, *p* = 0.82, *η2* = 0.03). There were also no significant interactions between time and adherence for the CES-D (*F* (6, 32) = 1.39, *p* = 0.25, *η2*= 0.21), the depression subscale of the HADS (*F* (6, 24) = 1.57, *p* = 0.20, *η2* = 0.28) the anxiety subscale of the HADS (*F* (6, 24) = 1.54, *p* = 0.21, *η2* = 0.28) and the STAI (*F* (6, 22) = 0.44, *p* = 0.85, *η2* = 0.11).

**Table 19: Depression and Anxiety Scores at 0, 8, 16 and 24 Week Follow-Up for those with High and Low Adherence Levels.**

Adherence to treatment

Measure High (75-100%) Low (< 75%)

N Mean SD N Mean SD

CES-D Baseline 39 1.69 0.52 10 1.90 0.32

CES-D 8 weeks 30 0.85 0.77 7 1.49 0.50

CES-D 16 weeks 32 1.01 0.68 8 1.28 0.67

CES-D 24 weeks 25 0.90 0.77 3 0.67 0.58

HADS – D\* Baseline 38 1.37 0.49 10 1.80 0.42

HADS - D 8 weeks 30 1.70 0.47 7 2.00 0.00

HADS - D 16 weeks 32 1.60 0.75 8 1.80 0.73

HADS - D 24 weeks 21 2.94 0.60 4 2.27 0.31

HADS – A\*\* Baseline 39 1.79 0.47 10 1.80 0.42

HADS - A 8 weeks 30 1.40 0.50 7 1.71 0.49

HADS - A 16 weeks 32 1.43 0.68 8 1.41 0.57

HADS - A 24 weeks 17 2.47 0.27 3 2.09 0.08

STAI Baseline 40 2.95 0.60 11 3.00 1.00

STAI 8 weeks 34 2.18 0.46 7 2.00 0.00

STAI 16 weeks 32 2.25 0.42 8 2.23 0.36

STAI 24 weeks 14 2.24 0.20 2 2.28 0.25

***4.5.2.7 Maintenance post intervention.*** At the 16-week follow-up participants in the standard self-help and augmented self-help conditions were asked about their use of the booklets since the eight-week intervention ended, participants in the WSSH/WASH conditions were asked at the 24-week follow-up. Data was pooled, so as to combine the standard self-help and WSSH conditions, and combine the augmented self-help and WASH conditions. Of the 111 participants who received the booklets, 48 participants (33.33%) kept the booklets post intervention and of those who kept the booklets 30 participants (62.50%) said that they had revisited the booklets since the intervention ended. The most popular booklets to be reused were *10 things you can do to feel happier straight away* (76.67% who reused the booklets revisited this text) and *I can’t be bothered doing anything* (70.00% revisited this text). Participants were also asked if they had used any of the exercises from the self-help booklets since the intervention ended, with 32 participants (28.83%) stating that they had. The most popular exercises to be reused by the participants once the intervention period was over were largely physical exercises, such as going for a walk, taking the stairs, eating breakfast and listening to music.

Chi-square analysis was used to investigate whether there were significant differences between the standard and augmented self-help conditions in terms of who kept the booklets and revisited both the booklets and the exercises. There were no significant differences between standard self-help (40.35%) and augmented self-help (46.30%) in terms of the number of participants who kept the booklets, *X2* (1) = 3.44, *p* = 0.06. There were, however, significant differences between the two groups in terms of how many participants revisited the booklets and the exercises. Participants in standard self-help (29.82%) revisited the booklets significantly more than participants in augmented self-help (24.07%), *X2* (1) = 5.44, *p* = 0.02. Participants in standard self-help (35.09%) also reused significantly more of the exercises than participants in augmented self-help (22.22%), *X2*(1) = 11.55, *p* = 0.00. The present study is unable to explore the impact of maintenance on post intervention efficacy due to a lack of power. [[5]](#footnote-5)

**4.5.3. Discussion.** The primary aims of Study 3 were to test the intervention in an unguided context and assess the impact of augmenting the LLTTF self-help booklets with implementation intentions; i.e. did implementation intentions impact upon the efficacy of the intervention or adherence to the intervention? Furthermore Study 3 also sought to establish whether engagement with the self-help intervention, in the form of adherence, impacted upon the efficacy of the intervention. How acceptable the intervention was deemed to be, and the views regarding the associated side effects were also explored.

***4.5.3.1 Efficacy of intervention in an unguided context*** Findings from the literature regarding the use of self-help (e.g. Cuijpers, 1997; Cuijpers et al., 2009; Den Boer et al., 2004; Haug et al., 2012; Hirai & Clum, 2006; Marrs, 1995; Scogin et al., 1990) suggest that those who receive self-help should see an improvement in anxiety and depression scores, over those who receive no treatment. As a result, the present study hypothesised that those who received the self-help intervention would experience a significant decrease in depression and anxiety scores, over those who received no treatment. This hypothesis was not supported as Study 3 found that both participants who received treatment (here standard self-help or augmented self-help) and participants who received no-treatment experienced a significant change in depression and anxiety scores from baseline to 24-week follow-up. Perhaps a therapeutic gain occurred as a result of taking part in a RCT. Indeed, those in the no-treatment control group were told that after an eight week waiting period they would be eligible to receive the self-help content, however these participants chose not to receive the treatment after the waiting period (only 38% of those offered chose to receive the booklets). This may be because the participants were already feeling less depressed and no longer felt the need to undertake self-help. Alternatively, as the study used a non-clinical sample, perhaps the sample experienced a normal fluctuation in low mood that simply improved over time.

***4.5.3.2 Efficacy and augmented self-help.*** Findings from the wider literature (e.g.Varley et al., 2011) regarding the use of implementation intentions, suggests that those who receive augmented self-help should experience a larger decrease in symptomology than those who receive self-help only. As a result the present study hypothesised that those who received the augmented self-help would experience a larger decrease in symptomology than those who received the standard self-help. This hypothesis was not supported as, contrary to the findings reported by Varley et al. (2001), Study 3 found no differences in symptoms of depression and anxiety between those who used who used the implementations and who who did not; meaning that augmenting the LLTTF self-help booklets was not beneficial in terms of efficacy for this sample.

***4.5.3.3 Treatment acceptability.*** How acceptable the treatment undertaken is deemed to be is a key assumption in the implementation of low-intensity interventions (Bower & Gilbody, 2005). Self-help interventions that are deemed to be unacceptable are likely to lead to high levels of disengagement with the intervention, potentially leading to lower levels of efficacy. However, to date there is a gap in the literature regarding the impact of treatment acceptability on treatment outcome (in the form of efficacy) and as a result no specific hypotheses were made. Both Whitfield et al. (2001) and Kaltenthaler (2009) examined treatment acceptability, but both studies failed to assess whether ratings of acceptability impacted upon the treatment efficacy.

Study 3 measured the acceptability of the LLTTF self-help booklets at the first follow-up. At the second follow-up how acceptable the treatment was and how severe any associated side effects were deemed to be did not significantly predict the variance in depression and anxiety scores, meaning that those who found the treatment more acceptable did not obtain better treatment outcomes. Due to the small sample size and potential for the current study to be underpowered (for further discussion of these limitations see section 4.5.3.6) and the fact Study 3 may be the first to explore the link between how acceptable the treatment is to the patient and how effective it is, caution is needed when interpreting these findings.

***4.5.3.4 Adherence.*** Levels of adherence during the intervention period may indicate levels of treatment acceptability (Kaltenthaler, 2009) and may be linked to treatment efficacy; as those who fully adhere to the treatment program experience all of the intended content and all of the interventions and exercises set. Adherence to the self-help intervention used in Study 3 was extremely high (> 87%), with no difference found in adherence levels between those who used implementation intentions and those who didn’t. Augmenting interventions with implementation intentions has previously been found to improve levels of adherence to a treatment program (Varley et al., 2011) and so the present study hypothesised that this would also be the case for the LLTTF intervention. The findings reported in Study 3 are not in line with this literature and do not support our original hypothesis regarding adherence rates.

Given that both conditions experienced very high levels of adherence, it may be that implementation intentions had no chance to confer additional benefit. Jackson et al. (2006) found that there were no significant differences between those who used implementation intentions and those who didn’t, for adherence to antibiotic medication. Within Jackson’s sample adherence was also high (76%) and the researchers discussed the possibility that those participants who didn’t receive implementation intentions may have formed spontaneous implementation intentions due to an external motivation (e.g. improving symptoms). This seems very plausible for the participants in Study 3, given that they were a highly motivated sample (Gollwitzer & Brandstatter, 1997) and that each condition received instructions that they were allocated one booklet for every week of the intervention.

In terms of understanding how adherence levels impacted upon the efficacy of the intervention, the findings of Study 3 are clear. High versus low levels of adherence to the intervention did not influence levels of depression post intervention. Due to the limitations of the research (see 4.5.3.6) and the fact the Study 3 may be the first to explore the link between adherence and efficacy in self-help for depression, caution is needed when interpreting these findings.

***4.5.3.5 Maintenance.*** For people who seek treatment for depression, success is not simply the reduction of symptoms following an eight-week intervention, but the continued improvement and eventual absence of symptomology over the coming weeks, months and years. Given that even people who are successful at starting a new behavioural pattern (e.g. using self-help techniques) find it difficult to maintain these new behaviours over a sustained period of time (e.g., Jeffery et al., 2000; Ockene et al., 2000), there is a need for greater understanding of the factors that regulate both the initiation and maintenance of behaviour over time. The maintenance of self-help techniques once the initial intervention period is over is an under-researched area and as a result no specific hypotheses were made regarding maintenance. The lack of research in this area is surprising given that researchers often follow-up with participants at multiple points post intervention to measure treatment efficacy; at these follow-up points maintenance could also be measured. In addition, by not measuring levels of maintenance, a moderator of efficacy post intervention may be being overlooked.

In Study 3 participants were asked about their use of the booklets since the eight-week intervention ended. Specifically, they were asked if they had kept the booklets and if they had revisited any of the booklets and/or exercises. Around a third of the sample kept the booklets once the intervention period was over, with no differences between those who received self-help only and those who received augmented self-help. Just over 60% of those who kept the booklets said that they had revisited them since the eight-week intervention period ended. Finally, over 28% of those who kept the booklets had reused one of the exercises since the intervention ended. Those who received the standard self-help were significantly more likely to have both revisited the booklets and reused the exercises than those who received the augmented self-help, meaning that the use of implementation intentions, in this case, lead to less engagement with the self-help materials post intervention. This finding runs contrary to the findings reported in the wider literature. For example, within the sport and exercise literature Hurling, Fairley and Dias (2006) reported that seven months post intervention, participants who received an online intervention that was augmented with implementation intentions had higher levels of motivation to exercise and reported a higher frequency of exercise participation (maintenance) than participants who received the online content only.

***4.5.3.6 Limitations.*** Study 3 was perhaps underpowered, as the power analysis undertaken was based on the hypothesis that a large effect size would be observed. Cuijpers et al. (1997) review reported a large effect size when comparing unguided bibliotherapy to no-treatment and this study was the basis of the rationale for the decision to calculate power using a large effect size. However, other meta-analyses and RCT’s have not reported large effect sizes. For example, both Gregory et al. (2004) and Marrs (1995) meta-analysis reported medium effect sizes of 0.77 and 0.57 respectively when comparing bibliotherapy for depression with no-treatment controls. However, several of the RCT’s included in the above meta-analyses reported small effect sizes. For example, Scogin et al., (1989) and Brown and Lewinsohn (1984) reported effect sizes of 0.35 and 0.45 respectively. As such, more caution should have been taken when calculating the power analysis for study 3 and the subsequent sample size used. Post-hoc power calculations using G\*Power showed that at baseline, when sample size was N = 144 and the alpha level was set to 0.05, the study was sufficiently powered to detect large and medium effect sizes (1.00 & 0.99 respectively). The study was however, underpowered in relation to detecting a small effect size (power = 0.62). At the eight week follow-up, when the sample size was *N* = 77 and the alpha level was set to 0.05, the results of the post-hoc power analysis remained the same, with the study sufficiently powered to detect both large and medium effect sizes (1.00 & 0.99 respectively) but underpowered in relation to detecting a small effect size (power = 0.42).

Study 3 also suffered from having a smaller sample size than was anticipated as, although 144 participants were initially recruited based on the initial power calculations, levels of dropout were considerable and uptake from the waitlist group was low as only 38% of those on the waitlist for booklets chose to receive them. The present study failed to follow-up with those who chose not to receive the booklets, and as a result we do not know why they made this choice. Did these participants feel better after eight weeks on the waiting list, or did they see self-help as an unacceptable treatment option? The small sample size also meant that Study 3 was unable to explore the impact of maintenance on the post intervention efficacy of the booklets and also means that we must be cautious of reading too much into the findings reported here, especially in light of contradictory findings reported in the literature. For example Varley et al. (2011), who recruited over 100 more participants than the present study, found that self-help augmented with if-then plans was more effective at reducing scores on the HADS and STAI compared with the self-help only and control conditions, however only small effect sizes were noted (0.04), which as noted previously the present study was underpowered to detect. Study 3 experienced a disproportionate amount of attrition during the intervention period from students (82% at the eight week follow-up) in comparison to staff members (around 18% at the eight week follow-up). Reasons for attrition were not obtained in the current study and so we do not know why so many more students chose to withdraw from the study. Participants who withdrew (at the 16-week & 24-week follow-up) had higher levels of STAI at baseline and perhaps they found their symptoms acted as a barrier to engaging with the self-help booklet? Alternatively, perhaps these participants found the books an unacceptable treatment option? Or perhaps they felt the books were not working, and they felt their symptoms were not improving? Alternatively, perhaps symptoms improved and these participants felt they no longer needed to use the booklets. Future research should assess reasons for discontinuation as they may provide insight into engagement with the LLTTF booklets. Although attrition from the study was predominately by students, there were no differences in occupation distribution at the three follow-up points and the three conditions were still predominately made up of students meaning the results can still be generalised to a student sample.

In the present study the augmented self-help group received instructions to create an implementation intention that would allow them to schedule a time during the week when they could work on the booklets, e.g. “*If* I get my husband to put the kids to bed two nights a week, *then* I can spend that time working through my self-help book.”. However, implementations can also be used to work out when to use the self-help techniques, for example ‘*If* I catch myself thinking critical thoughts about myself, *then* I will work though the unhelpful thinking styles exercise I learnt last week.”. Study 3 did not ask participants to use this latter technique. Varley et al. (2011) instructed participants to use both types of implementation intentions, perhaps explaining why they found that participants who used augmented self-help experienced significant treatment gains, while the present study did not. Furthermore, the present study asked participants to write their implementation intentions privately, and these were not collected or verified by the researcher to ensure that they were a. carried out, and b. carried out correctly. This is line with Varley et al. (2011) who gave instructions for forming implementation intentions in the augmented self-help booklet, which was not later collected and verified by the research team. However, other studies have asked participants to record their implementations in the baseline questionnaire (e.g. Sheeran, Webb & Gollwitzer, 2005) and as such they were able to ensure that the instructions for forming implementations were followed correctly. Perhaps participants failed to read the self-help instruction letter that accompanied the self-help booklets, and therefore failed to create any implementation intentions to begin with. Future research should implement a mechanism to check implementation intentions have been created; either by asking participants to record these in the baseline questionnaire or directly asking participants in the follow-up questionnaire whether they a. formed implementations, and b. used them.

***4.5.3.7 Conclusions.*** Research suggests that unguided self-help has the potential to meet the rising demand for depression treatments, with previous studies finding that unguided self-help is more effective than no treatment. Study 3 did not find parallel results as the no-treatment control group also improved. Prior research also suggests that higher rates of engagement with self-help, in the form of adherence, lead to higher levels of efficacy. In addition previous studies have also found that self-help interventions can be augmented to improve both rates of adherence and efficacy. The findings from the present study are partially in line with the previous literature. For example, those participants with the higher rates of adherence experienced the greatest decrease in CES-D scores; however, this group also experienced the biggest increase in HADS scores. Augmenting the self-help with implementation intentions did not lead to higher rates of adherence; both groups reported very high levels of adherence, perhaps because those in the standard self-help group spontaneously created their own implementation intentions. Limitations with the present study mean that caution should be taken when interpreting the findings and further work is needed using larger, clinical samples. Unguided self-help offers a solution to the rising demand for treatments for depression and so, further research is needed to ensure we can best utilise unguided support.

**Chapter 5: Conclusions**

**5.1 Thesis Questions**

The present thesis seeks to explore three main topics within the self-help literature: how acceptable are self-help interventions for depression in comparison to psychotherapy and antidepressant medications; how does someone using self-help for depression and anxiety disorders engage with the intervention; and how can we augment self-help for depression and anxiety to ensure that people using self-help have positive treatment outcomes and rates of engagement.Chapter 2 assessed how acceptable self-help interventions for depression are, how severe the associated side effects are perceived to be, and whether or not they are preferred to other forms of treatment (namely psychotherapy and antidepressant medication). Chapter 3 measured average rates of engagement to self-help that was administered for depression and anxiety disorders as part of RCTs, and examined potential moderators of engagement. Chapter 4 also evaluated the effectiveness of a bibliotherapy intervention for depression and anxiety disorders that had previously only been tested alongside guided support. In addition, Chapter 4 assessed the impact of how acceptable the intervention was deemed to be and how severe any side effects were perceived to be on treatment efficacy. Finally, Chapter 4 also augmented the self-help intervention used with implementation intentions to establish whether this would boost engagement rates and the efficacy of the intervention.

**5.2 Key Findings**

Two findings emerged from the present systematic review. Firstly, study 1 found that psychotherapy was the most preferred and most acceptable treatment option out of the six treatment types assessed, which is in line with previous research that has demonstrated a preference for psychotherapy (e.g. Raue & Schulberg, (2007) who found a preference for psychotherapy over antidepressant medications). This finding held when controlling for symptoms of depression and prior treatment experience although further replication is needed due to the limitations noted in section 2.7.3.6. Researchers have found that patients who undergo psychotherapy, who have shown a preference for this type of treatment, engage more effectively with the treatment program (e.g. Kwan et al. 2010), have better treatment outcomes in terms of efficacy (e.g. Chilvers et al., 2001) and are less likely to drop out of treatment prematurely (e.g. Swift et al., 2011). Given the mounting evidence that patients with symptoms of depression seem to show a preference for psychotherapy and this seems to bolster treatment efficacy and engagement, one of the solutions to the increasing number of people experiencing depression in the UK, and worldwide, might be to increase the provision of psychotherapy interventions. In the UK, The Mental Health Policy Group (2015), called on the government to increase funding for the treatment of mental health, as currently only 13% of NHS expenditure is spent of mental health disorders, even though these disorders make up 23% of the total disease burden in the UK. The result of this disparity is that people often receive no treatment for mental health problems. In the case of depression, the Psychiatric Morbidity Survey found that in 2007, only 24% of those with depression and anxiety disorders were receiving treatment (McManus et al., 2009). In comparison, 90% of patients presenting to the NHS for physical ailments such as diabetes etc. begin treatment within 18 weeks (Department of Health, 2009). Where depressed patients are receiving treatment there are often long waiting lists, with Professor Simon Wessely, the president of the Royal College of Psychiatrists, noting that patients are often waiting “more than 18 weeks, possibly up to two years, for their treatment and that is routine in some parts of the country” (Boseley, 2014, p. 1). The IAPT program has received large investments from the government, since 2008, to increase access to psychotherapies such as CBT with £309 million invested from 2008 to 2010/11 (Department of Health, 2012) and approximately 6,000 high and low-intensity CBT workers trained to date (IAPT, 2012). There does however, still seem to be a gap between unmet treatment need and availability of psychotherapies for those presenting with mental health problems such as depression. Data for The Psychiatric Morbidity Survey was collected again in 2014 and once published this report will provide insight into how much of a gap remains since the introduction of the IAPT program and how much extra funding is required to ensure that there is parity between mental health disorders and physical disorders, in terms of waiting times and access to treatments such as psychotherapy.

Secondly, studies 1 and 2 found that guided self-help fared the most successfully (in terms of ratings of acceptability, preference and uptake) out of all the self-help treatment options explored, which is in line with Mohr et al. (2010) who found that guided telephone-based treatments were more acceptable than unguided CCBT interventions. Guided self-help was rated as the most acceptable self-help option and the most preferred, with no differences in perceived side effects noted between the self-help options explored, which were all rated as having less side effects than antidepressant medications and psychotherapies (Chapter 2). In terms of engagement rates when used as part of an RCT, guided interventions performed well, with the highest rates of uptake (Chapter 3). However, caution should be noted regarding the findings discussed above, as several limitations are noted (see section 2.7.3.6 & 3.8.7).

In terms of the non-guided self-help options explored in this thesis, both bibliotherapy and Internet-based interventions were found to be as acceptable as antidepressant medication. In terms of the wider literature, Landreville et al. (2001) found that bibliotherapy was more acceptable than antidepressant medication, which is not replicated in the present thesis. The present thesis also found that antidepressant medications were preferred to bibliotherapy and Internet-based interventions, even though these treatments were deemed to have fewer side effects (Chapter 2). Differences were noted between bibliotherapy and Internet-based interventions in terms of engagement, with bibliotherapy having higher rates of uptake and adherence (Chapter 3). Chapter 4 also reported very high rates of adherence to a bibliotherapy intervention, however adherence rates in this scenario were not linked to treatment outcome, as has been noted in the previous literature (e.g. Gould and Clum, 1993).

**5.3 Clinical And Theoretical Implications**

Chapter 5 will discuss possible implications of the three studies reported in the present thesis, in relation to self-help interventions, by assessing the clinical and theoretical implications.

**5.3.1 Guided and unguided self-help.** Low intensity interventions, including guided self-help, were implemented as part of the IAPT stepped care program, with the aim of increasing the number of people who could access treatments for depression (NICE, 2009). Within the IAPT program the patient is generally offered a low intensity intervention first (however, where the patient was showing symptoms of severe depression, they would usually skip the low intensity interventions and be stepped up to a higher intensity intervention such as face-to-face psychotherapy) with close monitoring to ensure that their symptoms were not worsening. Patients who did not improve or who worsened during the course of treatment would be stepped-up to a higher intensity intervention. Prior to the IAPT program patients were mainly allocated to psychotherapy or antidepressant medications, which led to increasing waiting times for treatment due to the shortage of trained therapists. By implementing a stepped care approach more patients could receive treatment as those with less severe symptoms would not have to wait to see a therapist, instead they could use a lower intensity intervention such as guided self-help or CCBT. One of the principle assumptions underlying the use of self-help in this way is that this form of treatment is acceptable to patients (Bower & Gilbody, 2005). Researchers had previously compared one form of self-help to an alternative treatment such as psychotherapy, in order to assess how acceptable it was in comparison to the alternative (e.g. Landreville et al. 2001; Schneider et al., 2014) or asked participants to rate one type of self-help (such as bibliotherapy) in terms of how acceptable it was as a treatment for depression (e.g. Whitfield et al., 2001). However, few researchers had compared multiple forms of self-help for depression in terms of how acceptable they were and how severe the associated side effects were deemed to be and as a result less was known about how different forms of self-help compared in terms of acceptability and perceived side effects. The present thesis sought to explore this issue and principally found that guided self-help was as acceptable as face-to-face psychotherapy, while unguided interventions were less acceptable. In terms of clinical implications, the finding that guided self-help is comparable to psychotherapy underlines its use in the IAPT program as a low-intensity intervention, as these treatments are effective and acceptable to patients, although further replication is needed to verify this finding.

In terms of understanding the theoretical reasons why guided self-help was rated as acceptable as psychotherapy but unguided self-help was not, there may be a number of factors underlying these findings. One possibility is that the common features of therapy, such as therapeutic alliance or therapist responsiveness, may be a factor underlying the reason that guided self-help was rated as more acceptable than unguided self-help by the participants recruited in study 1. Richardson et al. (2010) analysed self-help books to assess the extent that they incorporated the common features of therapy, finding that often they were lacking (e.g. information on goal setting was often missing). Richardson et al. (2010) suggested that with guided interventions, the patient still benefits from the common features of therapy as they can build a therapeutic relationship during the guided support (which may comprise face-to-face or online support, etc). However, for unguided interventions, if the common features of therapy are not built into the intervention (and Richards et al (2010) found they often weren’t) then there is no opportunity to benefit from the therapeutic alliance or the other common features of therapy.

Although guided self-help is effective (see Berger et al., 2011b; Cuijpers et al., 2010; Gellatly, 2007; Menchola et al., 2007), and potentially more cost-effective than psychotherapy (Layard et al., 2007; Marks et al., 2003; van Spiker et al., 2012), one of its main disadvantages is that it is still costly in terms of the training required to deliver guided self-help. For example, in the UK to date, IAPT (2012) has trained more than 3,600 high-intensity and low-intensity CBT workers in its first three years and expects to train a further 2,400 by 2015. One solution to this problem may be unguided interventions.

Unguided support can be much cheaper to deliver (as it does not require therapists to be trained) and thus in terms of clinical implications the use of unguided self-help could be a cost-saving strategy that could be implemented for those with mild or moderate symptomology. For example Purves et al. (2009) analysed cost per referral for the unguided CCBT intervention “*Blues Begone*” in comparison to the IAPT program, using data from Clark et al. (2009). The findings suggested that the unguided “*Blues Begone*” program was significantly less costly (£83 per referral) than the IAPT program (£358 per referral).

The present thesis highlights one potential theoretical issues facing the widespread use of unguided self-help for depression, which is perceptions of this form of treatment being less acceptable than other types of treatment (such as guided self-help or psychotherapy). Chapter 2 found that guided self-help is more acceptable and more preferable than unguided self-help, while Chapter 3 found that guided interventions had higher levels of uptake than unguided interventions when used in an RCT setting. Qualitative studies may shed some light on why unguided interventions are less popular (in terms of acceptability and uptake). For example, Bendelin et al. (2011) found that people who used a guided CCBT intervention for depression fit into a number of categories. Participants who were classed as readers struggled to successfully use the guided support and could not motivate themselves when facing difficult tasks and some even stated that the treatment was adding to their burden. A second group of participants, doers, reported that valuable lessons were learned from working though the materials and overcoming issues independently without external support; they appreciated the responsibility to treat themselves and found that the intervention bolstered their autonomy and self-sufficiency, enabling them to overcome their depression and feel that they could cope with future relapses. Unguided interventions may suit participants with a doer mind-set, who value the opportunity to help themselves. A further example is the work of Gerhards et al., (2011) who also conducted qualitative research, interviewing participants who had struggled to use an unguided CCBT intervention for depression. Participants noted several issues they faced when taking part in the intervention; such as difficulties applying the theory and homework assignments to their own problems, cherry-picking the parts of the intervention they deemed to be beneficial, computer-based issues (which ranged from a lack of privacy to technical issues) and the need for guided support to either motivate them to complete the intervention, provide social contact or to provide feedback.

**5.3.2 Preferences.** Although much is known about patient preference for psychotherapy versus antidepressant medications for common mental health disorders such as depression, preferences for self-help interventions are less well understood, especially when comparing multiple forms of self-help treatment options. Within the depression literature there is much evidence to suggest that patients strongly prefer psychotherapy to antidepressant medications (e.g. Bedi et al., 2000), and that matching patients to their preferred treatment option can be beneficial in terms of efficacy (e.g. Chilvers et al., 2001) and engagement (e.g. Kwan et al., 2010; Swift et al., 2011). However, to date few researchers have assessed how different forms of self-help fare in comparison to psychotherapy and antidepressant medications (Cooper-Patrick et al., 1997).

In terms of preference, Chapter 2 replicated the findings in the wider literature that show that psychotherapy is preferred over antidepressant medications (e.g. Bedi et al, 2000). It also found that guided self-help was the second most preferable treatment option after psychotherapy, and that unguided interventions (such as bibliotherapy and Internet-based self-help) were less preferable than antidepressant medications. The qualitative studies described above may be able to offer some insight into why guided support was rated as more preferable than unguided interventions (e.g. Bendelin et al., 2011; Gerhards et al., 2011) however, future research is required to fully understand why patients might prefer interventions with some form of support or contact (namely psychotherapy and guided interventions) over purely unguided intervention. In terms of clinical implications research suggests that matching patients to their preferred treatment option can be beneficial (e.g Chilvers et al., 2001, Kwan et al., 2010; Swift et al., 2011), however this research is based on antidepressant medication and psychotherapy only. Future research is needed to assess the benefits of matching patients to their preferred self-help option (see 5.6). If matching patients to their preferred self-help treatment is beneficial (in terms of efficacy, engagement etc.) then this has clinical implications for how we allocate treatment provisions.

**5.3.3 Augmenting self-help.** One of the aims of the present thesis was to assess whether self-help could be augmented to boost rates of engagement and efficacy. Chapter 4 found that augmenting self-help with implementation intentions did not lead to higher levels of engagement as was hypothesised and previously reported in the literature for self-help for anxiety (Varley et al., 2011). Both the standard and augmented experimental condition reported in Study 3 had very high levels of adherence, nearly 90%, which is around 30% higher than was found in the rates of adherence reported in Chapter 3. Varley et al. (2011) did not directly report the percentage of the self-help booklet used during the intervention (which was how we defined adherence in Chapter 4) instead they reported the frequency of self-help techniques used during the intervention period. For the standard self-help condition this was 3.00 times and for the augmented self-help group this was 3.65 times during the course of the eight-week intervention, which is not particularly high for either group. Perhaps this can explain why Varley et al. (2011) found a significant effect of augmenting the self-help materials in terms of engagement with the self-help content, whilst Chapter 3 did not. It is conceivable that implementation intentions only boost rates of engagement with self-help for those with low levels of adherence, who struggle to engage with the self-help. Jackson et al. (2006) found similar findings to Chapter 4, in that they found that there were no differences between those who used implementation intentions and those who didn’t, for adherence to antibiotic medication. Jackson et al. (2006) suggested that as adherence in both groups was high, spontaneous implementation intentions were formed by those in the standard self-help group due to an external motivation (e.g. improving symptoms). Further research is needed (see 5.6).

**5.4 Strengths**

The present thesis has a number of strengths. Chapter 2 explored how acceptable a range of self-help treatments for depression were rated. Previous research had explored how acceptable one type of self-help was in isolation (e.g. Landreville et al., 2001 explored how acceptable bibliotherapy was), but less was known about how the different types of self-help compared in terms of ratings of acceptability. Chapter 2 also explored preference ratings for self-help, as previous research had mainly focused on the preferences for psychotherapy and antidepressant medication only (e.g. Kwan et al., 2010). Chapter 3 presented a systematic review of rates of engagement with a range of self-help interventions. Previous reviews had reported on aspects of engagement with one type of self-help only. For example, Christensen et al. (2009) conducted a systemic review of adherence to CCBT interventions for depression and anxiety. This study did not explore other aspects of engagement (e.g. attrition) and could not tell us about the average rates of adherence to other forms of self-help (e.g. bibliotherapy). Finally, Chapter 4 explored the efficacy of the LLTTF series in an unguided context, which is important as this resource is available to purchase and use as an unguided intervention. It also explored the impact of ratings of treatment acceptability, adherence and maintenance to the self-help intervention in relation to treatment outcome, which was less well understood within the literature.

Rates of depression and anxiety are considerable (see section 1.1 & 3.1) and as a result the need to provide treatments that are effective and cost-effective is important. The present thesis aimed to further explore how to make treatments for depression more effective (by examining treatment acceptability, preference and engagement) and more cost-effective (by examining self-help interventions). Previous research had tended to focus on the efficacy of the intervention only, with less consideration for how people might view self-help and how they might engage with it. But efficacy, attitudes and engagement may be linked, as Landreville and Guérette state “Treatment acceptability is a construct which is relevant to both compliance and treatment effectiveness.... The more a given treatment is judged as being effective, appropriate, ethical [and] comfortable, the more acceptable it is. Treatment acceptability is very important from a clinical perspective because it is likely to influence adherence. If a client does not like a treatment, he or she is unlikely to use it even if it is effective” (1998, p. 415). The present thesis aimed to make strides to begin to explore how efficacy, attitudes and engagement are linked.

**5.5 Limitations**

Three limitations within the present thesis are noted. Firstly, the measure of depression symptomology used in Chapters 2 and 4, the CES-D (Radloff, 1977), has a number of potential drawbacks. A number of researchers have hypothesised that several items may inflate CES-D scores for certain populations (Carleton et al., 2013). For example, participants who are elderly or who suffer from chronic pain may be more likely to agree with item seven *"I felt that everything I did was an effort"* (Ohayon & Schatzberg, 2003; Snarski & Scogin, 2006). Item 15 *"People were unfriendly"* and similar items may inflate CES-D scores for those who experience social anxiety disorders (Shafer 2006; Stansbury, Ried & Velozo, 2006). Furthermore, item 17 *"I had crying spells"* may inflate CES-D scores for female participants, as males are less likely to endorse this item due to cultural norms (Carleton et al., 2013). In addition to the concerns over the validity of certain items of the CES-D, researchers have also expressed concern over its sensitivity and specificity as a tool for accurately diagnosing depression. Researchers have compared the CES-D with GP detection using the DSM-III (American Psychiatric Association, 1980) diagnostic criteria, noting high sensitivity (Beekman, et al., 1997; Kilinkman, James, Coyne, Gallo & Schwenk, 1997; Weissman et al., 1977) and low specificity (Kilinkman et al., 19997) although this latter finding is not consistently reported within the literature (Beekman, et al., 1997); meaning that as a diagnostic tool the CES-D may be likely to overestimate prevalence rates. As a result of the limitations outlined, the CES-D (Radloff, 1977) was revised in 2004 (Eaton, Smith, Ybarra, Muntaner & Tien, 2004). The Center for Epidemiologic Studies Depression Scale - Revised (CESD-R) has however, received little publicity until more recently (e.g. Eaton, Ybarra & Schwab, 2012) with researchers noting its scarcity within the literature since its development (e.g. van Dam & Earleywine, 2011). As a result, the original 1977 version of the CES-D was used throughout the present thesis meaning that the CES-D results reported here my overestimate the prevalence of depression within the samples presented.

Secondly, the study reported in Chapter 2 used an analogue sample rather than a clinical sample, however there were several important reasons for doing so (see 2.2); namely to replicate previous research (Landreville et al., 2001; Mohr et al., 2010) and avoid measuring attitudes towards self-help that were confounded by factors that influence actual help-seeking behaviour (e.g. treatment outcome, cost of treatment, privacy, side effects, time constraints, etc.), which might be the case in a clinical help-seeking sample or a sample who have received the treatment they are asked to rate. Evidence also suggests that the opinions of an analogue sample may be comparable to a clinical sample when it comes to attitudes and preferences towards treatments for psychiatric disorders such as depression (McHugh et al., 2013). It should also be noted that the present thesis found few differences in attitudes towards self-help treatments for depression between those with current symptoms of depression and those without. Even so, it is risky to generalise from an analogue to clinical sample (Roth & Parry, 1997) and as such further research is needed (see 5.6).

Thirdly, the systematic review reported in Chapter 3 only sampled RCTs. No data existed outside of an RCT setting that would allow the analysis of rates of engagement with self-help; as a result conducting a systematic review of RCTs was the only viable method of assessing rates of engagement with self-help at this time.

**5.6 Future Research**

Future research should aim to explore why unguided interventions are rated as less acceptable (Chapter 2) and why participants are less likely to take up the offer of using an unguided intervention when offered (Chapter 3). Qualitative interviews could be conducted to assess how patients engage with unguided self-help intervention to assess the issues and barriers they face. To date, only a handful of studies have explored engagement with unguided self-help using qualitative methods (e.g. Bendelin et al., 2011; Gerhards et al., 2011). Further qualitative studies are required to assess the issues raised by the above authors, for example do the findings of Gerhards et al. (2011) relate to other forms of unguided self-help such as bibliotherapy. In addition, it would be beneficial to assess how people who find unguided self-help useful experience the intervention and what techniques they use to help them adhere to the treatment plan and achieve success. For example, Bendelin et al. (2011) found that participants who were using guided self-help, who were categorised as doers reported that valuable lessons were learned from working though the materials and overcoming issues independently without external support. Unguided interventions may suit participants with this mind-set, who value the opportunity to help themselves, however further research is required to assess this mind-set in people using unguided self-help and develop strategies to boost this mind-set.

There is less known, in the self-help literature, about the side effects experienced by those using self-help interventions. The findings from Chapter 2 suggest that there would be no differences in side effects between different types of self-help, but that those using antidepressant medications and psychotherapy would report higher levels of side effects. In terms of future research, this research needs to be replicated amongst a clinical, help-seeking sample. Qualitative interviews or questionnaires could be used to assess whether our predictions are true. Some research has been done in this area. For example Bendelin et al. (2011) found that some participants reported that the use of a guided CCBT intervention for depression added to their burden, but further work is needed to specifically ask participants what side effects they encounter. This research has potential clinical implications (see 5.3).

Future research should also aim to replicate the findings of Chapter 2 in a help-seeking sample (e.g., those contacting counselling services or referred to primary care) to assess if actual ratings of treatment acceptability, side effects and preference matches hypothetical preference, although the findings of Study 1 suggested that there were few differences in attitudes regarding acceptability and preference between those who were depressed and those who were not. If the hypothetical attitudes reported in Chapter 2 were found to reflect attitudes amongst a clinical sample then this would have clinical implications for how treatments for depression are allocated (see 5.3).

Future research could also assess how treatment preference impacts upon efficacy and engagement when people are given a choice of self-help treatment (for example bibliotherapy versus CCBT versus guided self-help). Do those patients who receive their preferred self-help treatment, experience gains in efficacy and enhanced engagement in the same way that those who receive their preferred treatment, out of psychotherapy or antidepressant medications (Raue & Schulberg, 2007), do? If this were the case then it would have clinical implications for how patients are allocated to low-intensity self-help interventions (see 5.3).

Future research should also aim to assess engagement rates with self-help materials in real world settings, as the study reported in Chapter 3 only included RCTs. Differences may occur between patients and participants in terms of how they engage with self-help inventions and research should seek to explore this as it has implications for how we best support those using self-help. Researchers could assess engagement with self-help for patients using low-intensity interventions as part of the IAPT program. GPs, psychological wellbeing practitioners and therapists could record uptake data, i.e. when a patient is offered a low-intensity self-help treatment option, do they take up the offer of treatment or prefer an alternative course of treatment? Adherence and attrition could be measured via a questionnaire that is distributed to patients upon completion of the treatment to ask patients how much of the treatment content (e.g. CCBT or bibliotherapy, etc.) they used and whether they completed the full intervention or stopped using the treatment prematurely. Maintenance could also be assed via a questionnaire sent to the patients at a designated time point after treatment is completed (e.g. six months or one year, etc.) to assess if the patient is still using the techniques learnt or re-visiting the self-help materials). Such a study would require huge amounts of time and resources and was beyond the scope of a PhD thesis. The systematic review reported in the present thesis does however go some way to building a comprehensive picture of how people engage with self-help treatments for depression, but it would be useful to also assess engagement rates in a real world setting.

Further research is also needed to confirm the hypothesis that augmenting self-help with implementation intentions is only beneficial when adherence is problematic. This could be achieved by designing a 2 x 4 study that separated participants into those who have high adherence rates and those who have issues with adherence. Each group would be further divided into two: those who receive the standard self-help and those who receive the augmented self-help. This design would allow us to directly compare those with high and low levels of adherence, who received either the augmented or standard self-help. This would tell us whether augmenting the self-help was more effective for those with low levels of adherence.

There is a gap in the literature concerning the maintenance of self-help techniques post interventions (Chapters 3 & 4). How do people who use self-help continue to use the techniques learnt after the initial treatment phase has ended? This could potentially be a useful topic to explore in future research as maintenance levels post intervention could account for efficacy at long-term follow-ups. If this is the case, then this has obvious clinical implications (see 5.3). Researchers routinely follow-up with participants who have used self-help interventions in RCTs to measure long-term treatment efficacy, so it would seem a relatively simple matter to also measure the continued use of self-help materials at these time points. For example, a questionnaire could be administered alongside efficacy measures, that asks participants questions regarding their continued use of the self-help since the end of the intervention.

**5.7 Concluding Remarks**

The findings of the present thesis point to methods of implementing treatments for depression that could potentially benefit both the care provider (e.g. the NHS) and the patient. Further research is needed, but if the findings from the present thesis were replicated in clinical samples, they could be used to inform decisions on how treatments were allocated for depression. A patient presenting with symptoms of depression would be screened to establish which of the treatments available to them they would find acceptable and which they would prefer (Chapter 2). Matching patients to the treatments that they view as acceptable and preferable could potentially lead to high levels of engagement with the treatment, lower rates of drop-out and higher rates of treatment efficacy (further research is needed here in relation to self-help interventions). Patients would also be given advice on how to continue to use the techniques taught, with a view to either maintaining their treatment gains or treating the re-emergence of depression symptomology (Chapter 3), preventing relapse and the need to re-enter treatment (again further research is needed). Patients would also be asked during treatment to assess how they engage with the treatment (Chapter 3) so that in the future support could be put in place for problematic treatments or at-risk individuals who need additional support to ensure that they maximise treatment outcomes. In the present thesis, implementation intentions were not found to be effective at improving engagement (Chapter 4), but this was felt to be due to the already high levels of engagement; perhaps for those patients who have low levels of engagement this support could be effective. Other support systems to promote engagement need to be devised, but the first step in doing so is to assess which interventions patients find the most problematic to engage with.

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**Appendices**

**Appendix 1: Preliminary study questionnaire**

**Appendix 2: Study 1 ethics application**

**Appendix 3: Study 1 ethical approval letter**

**Appendix 4: Study 1 email invitation**

**Appendix 5: The CES-D (Radloff, 1977)**

**Appendix 6: Depression Description**

**Appendix 7: Personal Account of Depression**

**Appendix 8: Detailed Treatment Descriptions**

**Appendix 9 Brief Treatment Descriptions**

**Appendix 10 The LOT-R (Scheier & Carver, 1985)**

**Appendix 11 The Generalised Self-Efficacy Scale (Schwarzer & Jerusalem, 1995)**

**Appendix 12 The MHLC (Wallston et al., 1978)**

**Appendix 13 The TIPI (Gosling, Rentfrow, & Swann, 2003)**

**Appendix 14: The Modified Implicit Theories of Emotion Scale (Tamir et al., 2007)**

**Appendix 15: Coding booklet**

**Appendix 16: Email Invitation**

**Appendix 17: Baseline Questionnaire**

**Appendix 18 Booklet descriptions**

**Appendix 19: Planning and reviewing sheets**

**Appendix 20: Standard Self-Help Instructions**

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**Appendix 21: Augmented Self-Help Instructions**

**Appendix 22: Study 3 ethics application**

**Appendix 23: Study 3 ethical approval letter**

**Appendix 24 Hierarchical linear regression tables**

1. In order to randomly allocate participants to one of the six treatment conditions, a method of quasi-randomisation was used. Participants entered their date of birth into the online questionnaire. The questionnaire then filtered participants into one of the six conditions depending on their day of birth. Those participants born between the 1st of the month and the 5th were allocated to the medication condition, those born between the 6th and the 10th of the month were allocated to the bibliotherapy condition, those born between the 11th and 15th of the month were allocated to the guided self-help condition, those born between the 16th and 20th of the month were allocated to the Internet self-help condition, those born between the 21st and 25th of the month were allocated to the positive psychology self-help condition and finally, those born between the 26th and 31st of the month were allocated to the psychotherapy condition [↑](#footnote-ref-1)
2. Participants were randomised using the alternation method, whereby the list of eligible participants (ordered by date of baseline questionnaire completion) were allocated to either the standard self-help group (group 1), the augmented self-help group (group 2) or the waitlist control condition (group 3) alternating between group 1, group 2 and group 3 in that order. So participant 1 was allocated to group 1, participant 2 to group 2, participant 3 to group 3, participant 4 to group 1 and so on. This resulted in 50 participants in group 1, 49 in-group 2 and 49 in the waitlist control group. However, due to the findings from the meta-analysis that often participants drop-out of self-help studies for depression, the decision was taken to allocate more people to the waitlist control group so that if there were large numbers dropping out we would still have an adequate sized control group for comparison. Nine people from the treatment conditions (groups 1 & 2) were randomly allocated to the waitlist control group (group 3). This was done by selecting nine participant numbers at random using Excel’s random number generator formula (e.g. =RANDBETWEEN(1,144)) and allocating these participants to group 3. [↑](#footnote-ref-2)
3. Using Excel’s random number generator formula (e.g. =RANDBETWEEN(1,21)). [↑](#footnote-ref-3)
4. The analysis was repeated without baseline scores. Four 3-way between-subjects (standard self-help versus augmented self-help versus no-treatment) by 3-way within-subjects (time: 8-week versus 16-week versus 24-week follow-up) ANOVAs were conducted. Scores on the CES-D, HADS (anxiety and depression subscales separately) and STAI scales were used as dependent variables, to determine whether there were differences between the three conditions. There was no significant main effect of time for the CES-D scale (*F* (2) = 5.54, *p* > 0.05, *η2* = 0.05). However, the main effect of time for the depression subscale of the HADS (*F* (2) = 19.34, *p* < 0.01, *η2* = 0.73), the anxiety subscale of the HADS (*F* (2) = 27.89, *p* < 0.01, *η2* = 0.82) and the STAI scale (*F* (2) = 0.30, *p* < 0.05, *η2* = 0.60) was significant, indicating changes in depression and anxiety scores from baseline to follow-up, all with medium to large effect sizes according to Cohen’s (1988) criteria. Table 13 shows that while STAI scores decreased from baseline to the final 24-week follow-up, scores on both subscales of the HADS scale actually increased. The main effect of condition was significant for the CES-D (*F* (2) = 5.54, *p* < 0.05, *η2* = 0.41) and the anxiety subscale of the HADS (*F* (2) = 8.83, *p* = < 0.05, *η2* = 0.58), with medium effect sizes reported. Table 13 shows that the standard self-help condition experienced the largest reduction in CES-D scores and the no-treatment condition experienced the largest increase in HADS anxiety scores. However, for the depression subscale of the HADS (*F* (2) = 1.61, *p* > 0.05, *η2* = 0.18) and the STAI (*F* (2) = 0.42, *p* > 0.05, *η2* = 0.07) there was no significant main effect for condition. There were no significant interactions between time and condition for the CES-D (*F* (4) = 0.10, *p* > 0.05, *η2* = 0.01), the anxiety subscale of the HADS (*F* (4) = 1.66, *p* > 0.05, *η2* = 0.22) and the STAI (*F* (4) = 0.97, *p* > 0.05, *η2* = 0.15). There was however a significant interaction between time and condition for the depression subscale of the HADS (*F* (4) = 4.19, *p* < 0.01, *η2* = 0.38) with small to medium effect size noted. Table 13 shows that those in the augmented self-help condition experienced the largest increase in HADS depression scores over the three time points. [↑](#footnote-ref-4)
5. 23 participants who received standard self-help and 29 who received augmented self-help provided maintenance data, however by the next follow-up only one participant who received standard self-help and three participants who received augmented self-help remained who had reported not maintaining their self-help practice (measured by keeping the booklets). [↑](#footnote-ref-5)