SELF-HELP INTERVENTIONS FOR MENTAL HEALTH PROBLEMS

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CHAPTER ONE: INTRODUCTION

1.1 Policy background

1.11 Importance of mental health problems

The UK Government and Department of Health have identified mental health as an area of special policy concern. This is reflected in its status in *Saving Lives: Our Healthier Nation (1999)* and the *National Service Framework for Mental Health (1999)*. Mental health has its own National Director within the Department of Health.

There are probably two reasons why mental health is given this importance by the government. The first is that mental health services account for a substantial proportion of the NHS budget. There is concern that standards vary widely across different services and that many service users are not receiving the best possible care. Mental health is a complex area for policy as it requires both health and social care to work together. There are also concerns about the relationship between the health service and the criminal justice system.

The second reason for the importance of mental health is the burden it creates from a public health perspective. Depression and anxiety are the major mental health problems from the perspective of the community and primary care. This is reflected in the Global Burden of Disease study commissioned by the World Bank in which depression is predicted to become the second most important cause of disability by the year 2020. In all health care systems, the burden of care for the common mental disorders (CMD) of depression and anxiety is in primary care. Despite this, in the UK, policy has concentrated on the management of severe mental illness in secondary care increasingly leaving primary care to provide the lead on treatment for CMD. For many general practitioners there are few options available for the management of CMD. Perhaps, as a result, there has been a dramatic increase in the number of prescriptions for antidepressants that are issued each year in England. It has risen from about 10m in 1990 to about 25m prescriptions in 1998.

From a public health perspective relatively minor but commoner forms of depression and anxiety probably contribute most to the aggregate burden of psychiatric disorder in the community. For these milder conditions, brief and inexpensive interventions would seem the most appropriate option. Both primary care and secondary care would then concentrate more on the more severely disabled individuals.

The standards set in the National Service Framework cover the whole range of mental health services including health promotion and primary care. Of particular relevance to this paper are standards 1, 2 and 3 that include an emphasis on accessibility, public education and the timely availability of simple treatments suitable for use in the community.
1.12 Availability of psychological treatments

Recent reviews have summarised the evidence that some psychological treatments are effective for a wide range of psychiatric disorders.\textsuperscript{7,8} There is also much public enthusiasm for psychological interventions.\textsuperscript{9} The recent Dept of Health guideline\textsuperscript{8} on psychotherapy has identified a number of psychotherapies that possess an evidence base for effectiveness but it does not address the issue of how these services are to be delivered. There are a number of potential problems for the implementation of a policy aimed to offer psychotherapeutic interventions to the people who would benefit. Take for example, cognitive behaviour therapy (CBT) for depression and anxiety. It is one of the psychotherapies with good evidence to support effectiveness. In September 2002, there were only 712 CBT practitioners accredited by the lead body for CBT in the United Kingdom – the British Association for Behavioural and Cognitive Psychotherapies (www.babcp.com). Though there will be many competent CBT practitioners that are not accredited with the BABCP, the number of accredited CBT practitioners in the best served areas of England and Wales was 70 times that in the least well served areas.\textsuperscript{10} Finally, specialist training in CBT is only available in relatively few centres in the UK so this apparent deficit in trained practitioners will not be addressed in the short term. It is also important to mention that there is now good evidence to support the effectiveness of cognitive behavioural therapy (CBT) for schizophrenia\textsuperscript{11} and CBT for bipolar disorder is also being developed.

One way of addressing this deficit is to provide a range of different intensities of therapy. Although some patients will require more complex and intensive psychotherapy delivered via a specialist practitioner, many may benefit from shorter interventions given by people with less specialist training. Within the service it is therefore sensible to provide a range of interventions ranging from self-help to longer-term individual treatments.\textsuperscript{12,13}

1.13 User Involvement and Expert Patients

Current policy is placing emphasis on increasing the involvement of service users in all aspects of service delivery.\textsuperscript{1} The principle of empowering mental health service users is behind these initiatives. The intention is to move away from a paternalistic system in which patients follow doctors advice, to a partnership in which both professional and service user find a solution to the user’s problems. Self-help has become increasingly relevant in the management of chronic illness due to the increasing awareness of the need of partnership and collaboration between professional and user in order to improve both effectiveness and efficiency. Empowering the service user might be especially important in dealing with feelings of hopelessness and despair associated with depressive symptoms.

Linked with this evolution in attitudes is the realisation that the health service is often not using the expertise and experience of the users themselves. The concept of the expert patient is long overdue.\textsuperscript{14,15} Lorig and colleagues have developed self-help groups led by sufferers that provide a structured course in self-management. The course is both about how to use health services as well as developing skills and coping strategies to remain independent of the health service unless it is really needed. Self-help can also be seen as a
way of increasing knowledge and disease-management skills in users so as to reduce reliance upon professional help.

1.14 The Workforce

One of the constraints of modernising the NHS and improving the service provided is the potential shortage of appropriately trained staff (http://www.doh.gov.uk/mentalhealth/watmainreport.pdf). This is certainly the case in providing psychotherapy both within secondary and primary care. Using the skills of NHS staff more effectively must therefore be an important issue in improving services. Recruiting non-professional staff and giving them focussed brief training for specific tasks might be a way of improving the service even if professionals are in short supply. The new Graduate Mental Health Workers suggested in the National Service Framework are proposed as less highly trained workers who could still provide a useful function in primary care. Finding additional useful and effective roles for these workers would also be of benefit.

1.15 Economics

There will always be constraints on the money available for the health service. Developing new ways of working that will improve efficiency will be important to ensure the fair distribution of resources. Interventions that lead to more effective use of professional time should have economic benefits.

1.2 What is self-help?

1.21 Difficulties in Defining Self-Help interventions

The definition of self-help has been applied loosely to different areas in the past causing confusion and it lies interchangeably in the literature with other terms such as self-management, self-instruction, self-care or “psycho-educational” interventions. Cuijpers provides one definition of self-help. “The patient receives a standardised treatment method with which he can help himself without major help from the therapist. In the self-help approach it is necessary that treatment is described in sufficient detail, so that the patient can work independently. Books, in which only information about depression is given to patients and their families cannot be used”.

This concept of working through materials independently implies that the structure of the materials provides sufficient clarity to allow this. As Cuijpers indicated a distinction has to be made between providing information to people and providing “self-help”. Provision of information is important in its own right but self-help implies a more structured approach which requires the subject to act on advice provided within the self-help material. For example, a leaflet on depression may provide a description of symptoms, various treatments available and some general advice. A self-help intervention should do more than that and teach users relevant skills to overcome and better self-manage their symptoms and related difficulties.
1.22 Definition used in this review

At one end of a continuum is a self-help book that someone might buy in a bookstore without any advice from a professional. Somewhere in the middle of this continuum, are some of the briefer structured therapies which put emphasis on work outside the session. At the other extreme there are psychotherapies that are concerned entirely with what occurs within the session with the professional. A similar continuum exists in providing treatment in a group format from self-help groups through to structured groups led by a health care practitioner.

Our definition of self-help proposes that self-help approaches utilise a clear model and structure of treatment which focus on problems of relevance to the patient. Almost all self-help approaches have used a cognitive, behavioural or problem solving approach. These psychotherapies themselves place a great deal of emphasis upon “homework” and putting into practice what has been learned between the therapeutic sessions. Such therapies are therefore essentially self-help in nature and the therapist role includes that of teacher.

For the purposes of this expert paper we would propose that self-help approaches are characterised by two particular features. First, that they either require no or only “minimal” practitioner input. Cuijpers has suggested that this could be defined as one hour or less of professional face-to-face time and up to six 15 minute telephone calls. For non-professional guidance we will allow “guided self-help” with up to 5 hours of non-professional time allocated. We have included this longer criterion as non-professional time is in less short supply in the NHS and we also wanted to include self-help interventions led by service users. We use the term professional here to include all health care professionals whether or not they have a mental health specialty.

The second criterion we will adopt concerns the requirement that self-help includes instruction on how the user can improve their skills to cope and manage their difficulties. Though this criterion is difficult to define precisely, it intends to exclude books that just provide information and a few words of advice.

This definition is of course arbitrary but has been set in order to focus on self-help that is occurring largely with little professional input. Self-help materials have been used and evaluated as a means of increasing the efficiency of therapist time but we have considered this to be outside the remit of the current paper as we wished to concentrate on the use of self-help materials on their own or with limited guidance. Using self-help materials as part of a longer therapy or to reduce therapist time is a different kind of use to that we are considering here.

1.3 Potential Advantages of the Self-help approach

1.3.1 User Focus & Empowerment

Patients are often attracted by the idea of working on their own to deal with their problems thus avoiding the potential embarrassment of formal psychotherapy and the time and travel...
involved. Research into computer-based treatments of obsessive compulsive disorders and anxiety disorders has found that the most important reasons sufferers give for valuing this treatment over therapist-aided treatment was that it reduced stigma and increased confidentiality. Self-help may enable patients to receive help that they would otherwise reject. It is available at low cost and can be returned to as often as the patient wishes. Self-help enlarges the choice for patients.

The patient is able to take responsibility for self-management and is able to do this in their own time and at their own pace. The approach can empower the patient and enhance their sense of control over their illness. Self-help is collaborative in nature and addresses any imbalance of power between service user and professional. Its use may therefore be conceptualised as a resource in changing the balance of power between mental health service user and mental health professional.

1.32 More efficient use of professional time

Self-help materials are increasingly available within the public domain. Some general practitioners, psychiatrists, psychologists and counsellors use written material to supplement their treatment. Several researchers have examined the use of self-help materials by mental health practitioners in the USA and UK and find that between 60% and 89% of practitioners recommended or used self-help materials. These surveys were of those who practised psychotherapy. There is a hope that using self-help materials will improve outcomes and reduce the time needed with the therapist.

Self-help interventions could also be used by professionals who do not have psychotherapeutic skills, indeed one would suppose that they would be more useful for this group. Ironically, it would appear that use of self-help materials are less likely amongst professionals who are less familiar with the psychotherapeutic approach, though there is no empirical data on this. In principle, self-help could be used for people on waiting lists or in areas where psychotherapeutic expertise is in short supply. It could be thought of as the first step within a stepped care approach.

1.33 Availability and Accessibility

Self-help approaches are also popular with the general public, and most large bookshops possess sizeable self-help sections. Self-help books are frequently amongst the top 100 best-selling books. Large population-based surveys confirm that self-help approaches are rated highly by members of the public with self-help more positively endorsed than treatment with medication or psychotherapy, or by a health care practitioner. Their popularity is seen in the growing number of self-help resources available on the internet. Figure 1.1 summarises the month-by-month increase in “hits” for self-help by a popular search engine.

Self-help materials should increase the availability and speed of intervention. For self-help books there is little waiting time and few geographical restrictions on access. Self-help
material can be used at any time and does not need to interfere with work or family commitments.

Many general practitioners and patients want to have alternatives to pharmacotherapy for depression and anxiety. The availability of psychotherapy is quite limited in many parts of the UK. Self-help has the potential to provide help without any geographical barriers and can be pursued by the patient in his or her own time.

**Figure 1.1:** “Hits” for self-help identified by the search engine Google.com from 15th August 2001 to 14th August 2002

1.4 Aims of the Expert Paper

There are three aims:
1. To systematically review and identify materials on self-help interventions for mental health problems.
2. To describe and classify existing English language self-help interventions for mental health problems. We will classify the self-help interventions along the following dimensions:
   - Professional involvement (time & training requirements)
   - Process (the nature of advice or therapy given and expectations of user)
   - Diagnosis or symptom
   - Medium of delivery (Book/Audiotape/Video/CDRom etc)
   - Any basis in psychological theory and what theory
   - Description: length, language difficulty
   - Availability
3. To review the literature that has evaluated self-help interventions for mental health problems in relation to the following outcomes:
   - clinical symptoms
   - quality of life
   - costs
   - acceptability to users

1.41 Approach towards identification of self-help materials

We were aware that a number of systematic reviews had already been performed in the area of self-help. In accord with the usual attitude towards evidence, we presume that the best evidence for effectiveness is provided by a systematic review of randomised controlled trials. We therefore chose as a first step to identify and the systematic reviews already carried out and to review them in a systematic way. Following that exercise we were able to identify various areas in which there appeared to be gaps in evidence. Either because the reviews had not addressed that particular area, or perhaps because there was an absence of literature in that field. Therefore our second step was to carry out some focussed searches in areas of importance or in which we had identified an absence of evidence. Finally we decided to examine publishers’ lists, voluntary organisation websites and best-sellers so that we had an idea of the self-help materials recommended and bought. Because of limited time we had to restrict our searches to a number of key disorders. We chose to study depression, anxiety and eating disorders as these are the clinical conditions that have received most attention. We also included bipolar disorder and schizophrenia because of their importance to secondary care.

1.42 Structure of Report

Chapter 2 describes the systematic review of systematic reviews. Chapter 3 describes those studies that we identified following our supplementary searches. Chapter 4 lists the recommended materials and provides a summary of their content and any evidence for effectiveness. Chapter 5 provides our discussion of our findings, conclusions and recommendations for future research.
CHAPTER TWO: REVIEW OF SYSTEMATIC REVIEWS

2.1 Introduction

The purpose of this expert paper is to provide a classification of self-help interventions for mental health problems emanating from the evidence base in the literature. The process for identifying the systematic reviews to be included in this paper, assessing the quality of each review and extracting the data on which the classification framework would be based had to be robust and replicable. The Cochrane Collaboration review process\textsuperscript{33} was adapted to ensure that this was the case. As stated above, we restricted our search to the main mental health problems affecting adults of working age: depression, anxiety, eating disorder, bipolar disorder and schizophrenia.

2.2 Criterion for considering systematic reviews for the expert paper:

2.2.1 Study design

The reviews had to conform to the definition of a systematic review i.e. an overview of primary studies which use explicit and reproducible methods to identify the studies and record the content.

2.2.2 Type of participant

The reviews had to include subjects who were \( >16 \text{yrs} \) and \( < 65 \text{yrs} \) with mental health problems - anxiety, depression, bipolar disorder, schizophrenia or eating disorder. The setting was not defined as we were aware that many of the early studies in this area were not undertaken on clinical subjects but had evaluated in controlled trials self-help material which would be of relevance to this expert paper.

2.2.3 Types of intervention

For inclusion in this paper, the systematic review had to provide data from studies which had evaluated a self-help intervention which was administered through written, audiotape, videotape or computer text or a combination and which was designed to be predominantly conducted independently of professional or paraprofessional support. Once papers had been identified as of potential interest, this had to be defined as one hour or less of professional face-to-face time and up to six 15 minute telephone calls. For non-professional guidance or “guided self-help” up to 5 hours of non-professional time could be allocated.

2.2.4 Types of outcome

At least one of the following outcome measures was used: clinical symptoms, quality of life, costs and acceptability to users.
2.25 Search Strategy

The search strategy for the electronic databases included in this review was developed in the first instance to produce systematic reviews which were within predetermined criteria relating to condition and intervention. Medline, PsychINFO, Embase and CINAHL were searched. The first set of terms in the search strategy covered anxiety, depression, schizophrenia, bipolar disorder and eating disorders. The search terms were expanded from strategies previously developed by the Cochrane Groups for Depression, Anxiety and Neurosis and Schizophrenia. The second set covered self-help approaches and included terms relating to bibliotherapy, computer and audiovisual aids to therapy.

These were then combined with terms that would limit the therapeutic approach to minimal or no professional contact (self-help; self-evaluation; user-manual; workbook and diary). All terms were exploded and text words were also included to ensure maximum capture of relevant material. This set was then combined with a set for producing meta-analyses, drawn from the work of HEBW http://hebw.uwcm.ac.uk/

As searching progressed, this strategy was refined so that reviews which were not condition specific were identified.

A search was also undertaken of the Cochrane Library (which includes the Cochrane Database of Systematic Reviews, the Cochrane Controlled Trials Register (CCTR), the Database of Abstracts of Reviews of Effectiveness (DARE), the Health Technology Assessment (HTA) and NHS Economic Evaluation (EED) databases) and the National Research Register (NRR). Electronic updates were received regularly, the last in September 2002.

Reference lists of all identified papers were examined and authors and experts in the field contacted for further or unpublished works.

2.3 Identifying the Reviews for inclusion

Once the results of the search of electronic databases was complete the results were transferred onto Reference Manager version 9. Any references found through additional searches were appended. A list of abstracts was generated and scrutinised by two of the research team independently and coded. Any disagreements were discussed. Once both raters agreed, the papers for each abstract on the final list were obtained and again two researchers independently screened each paper for inclusion. At this point, the inclusion criterion were more focused, to the extent that the paper had to meet the formal definition for a systematic review (narrative literature reviews were not discarded but kept so that the reference lists could be examined) and must include studies which evaluated self-help materials administered according to our criterion for therapist contact (see appendix).

Once a systematic review had been formally included, it was subjected to a quality assessment and data extraction process adapted from a checklist used on meta analyses33.
Again, this was conducted independently by two of the research team and the extraction form is in the appendix.

For each systematic review, data were extracted which were comparable and presented in table format. Studies which were relevant to the aims of this expert paper were also listed, with details of the type of self-help intervention and problem type for information and to establish the level of clinical as opposed to statistical heterogeneity. Where the self-help intervention was published, this was highlighted.

2.4 Results of search strategy and applying exclusions

The search identified 344 potential papers. Of these 6 were excluded because the subjects were not within our defined age limits; 162 were excluded because the focus was not on one of the target mental health problems; 38 were excluded because the intervention was not self administered and 103 were excluded because they were not systematic reviews. Thirty-five reached the stage at which the papers were obtained for further examination. Of these 16 were not systematic reviews; 10 did not meet the criterion for professional input or were not self-help interventions 1 was not studying mental health and 1 was a duplicate publication. Details of the excluded studies are given in Table 3.1. A flow chart for the review is given in Figure 3.1.

We decided to exclude Franzoni from this review. Franzoni carried out a systematic review of “self-help groups” but did not provide any details about any therapeutic content of the self-help groups included in the review. Since a large number of self-help groups do not include a therapeutic element but exist to provide more general support or advice, we decided that this study should be excluded from the review.

Seven systematic reviews fulfilled the criterion for inclusion in the study. After the reviews had been identified we chose to divide them into two groups. The first group of 3 reviews (Table 3.2) (Scogin, Gould, Marrs) included studies of a wide range of medical conditions. However, all also provided analyses that were restricted to mental health outcomes. The second group of 4 reviews (Table 3.3) (Cuijpers, Hay, Bower, Kaltenhaler) only included studies of mental health outcomes.

The reviews were all conducted within an eleven year span, from 1990 to 2001, three from North America, one from Holland, one as a Cochrane review, one on behalf of NICE and one in the UK. Cuijpers has also published a protocol of an ongoing review with the Cochrane Depression Anxiety and Neurosis group that aims to review RCTs of “minimal psychotherapy” for depression. Cuijpers definition of minimal psychotherapy is the same as our definition of self-help.

The papers that were included in the systematic reviews that were relevant our aims are listed in the appendix.
FIGURE 3.1 FLOWCHART FOR PROGRESS THROUGH THE SYSTEMATIC REVIEW.

Inclusion/Exclusion criteria set and search strategy established

data strategy carried out

No. of abstracts identified N=344

Abstracts of identified studies reviewed and categorised for inclusion/exclusion

Exclusions
N=162 not mental health
N=103 not systematic reviews
N=38 not self-help
N=6 outside age limits

Exclusions
N=1 not mental health
N=16 not systematic reviews
N=10 not self-help
N=1 duplicate publication

Paper copies of 35 studies obtained for further review

Data extracted from included studies N=7
TABLE 3.1  STUDIES EXCLUDED FROM REVIEW


Jorm A., Christensen H., Griffiths K., & Rodgers B., Effectiveness of complementary and self-help treatments for depression. 6-20-0002.  \textit{Not Systematic Review}


2.5 Generic Reviews

2.51 Definition of Self-Help

The older reviews tended to be less specific about their definition of self-help. The definition we adopted allowed up to a total of 1 hour of professional time for a self-help intervention. There is also some ambiguity about whether the time required for assessment should be included in the time allocated for self-help. Scogin\(^6\) included a category of minimal contact self-help defined as “weekly phone calls to brief weekly check-in sessions”. Gould\(^7\) defined a similar category as “weekly or monthly contacts to monitor progress, clarify procedures … or to provide general support or encouragement.” Marrs\(^8\) took a different approach and measured the amount of contact and then studied this in the analysis. They found that there was a significant relationship between therapist time and outcome for their anxiety category.
Scogin\textsuperscript{36} and Gould\textsuperscript{37} included all forms of self-help whether as book, audiotape, videotape while Marrs\textsuperscript{38} included only bibliotherapy studies.

2.52 Search strategies

The search strategies adopted by the reviews were not very comprehensive by current standards of reviewing. Scogin\textsuperscript{36} does not mention searching electronic databases while Marrs\textsuperscript{38} did not search medical databases, only PsycLit, Dissertation Abstracts, Educational Resources Information Centre and Infotrac. Gould\textsuperscript{37} searched PsycLit, Psychological Abstracts and Medline. None of the reviews included EMBASE that has a higher proportion of European literature.

2.53 Participants

The reviews did not explicitly describe the source of participants for the constituent studies. Gould\textsuperscript{37} mentioned that 25 of the 40 studies they identified had recruited patients by advertisement. They did not break this down according to the outcome studied.

2.54 Comparison groups

The reviews have adopted varying policies in relation to comparison groups. Scogin\textsuperscript{36} includes conventional psychotherapy as a comparison condition, along with waiting list and “no treatment”. Scogin\textsuperscript{36} instead analyses the no treatment and therapy groups separately in one of the tables. Marrs\textsuperscript{38} includes therapist only and waiting list as the comparison groups for the self-help conditions. This would presumably reduce the effect size. Gould\textsuperscript{37} only includes no treatment, waiting list or placebo treatments in the comparison with self-help.

2.55 Results

The reviews presented results in terms of effect sizes, the mean difference between groups divided by the standard deviation. As the reviews had included studies on self-help irrespective of outcome, it makes it difficult to draw conclusions about the effectiveness of self-help in mental health outcomes. It appears that the authors calculated an effect size for each comparison within a study. This would result in boosting the size of the groups as individuals will be counted twice in the meta-analysis. This problem is explicitly acknowledged by Marrs\textsuperscript{38} but is probably also occurring in the other reviews.

The three reviews classified the type of problem addressed by the self-help intervention after the studies had been identified. Scogin\textsuperscript{36} groups mental health problems into affective disorders (depression and anxiety) and phobias. Marrs\textsuperscript{38} has a similar classification. Gould\textsuperscript{37} distinguishes fear reduction (presumably anxiety and phobias) from depression. None of the reviews categorised their references according to problem type though this can be deduced from the reference list.

The results in Table 3.2 illustrate that all studies found better outcome for self-help compared to the comparisons. Scogin\textsuperscript{36} and Gould\textsuperscript{37} do not report individual significance.
values for the subgroup comparisons we are interested in. Marrs\textsuperscript{38} found a statistically significant benefit for anxiety but this was not statistically significant for depression. However, as mentioned, Marrs\textsuperscript{38} compared self-help to therapist administered as well as no treatment conditions and this would have underestimated the treatment effect. On the other hand, Marrs also included interventions with a more substantial therapist involvement than the other reviews and this might have increased the effect size. Of interest, Marrs\textsuperscript{38} did find a significant relationship between effect size and therapist contact time in the trials that studied anxiety.

An assessment of the quality of the reviews is given in Table 3.4.
<table>
<thead>
<tr>
<th>Paper</th>
<th>Aim</th>
<th>Inclusion / Exclusion criteria</th>
<th>Outcome measures used in meta analysis</th>
<th>MH Conditions (reported as subgroups)</th>
<th>No of relevant studies</th>
<th>Partic</th>
<th>Setting</th>
<th>Recruitment</th>
<th>F/up</th>
<th>Meta analysis methods</th>
<th>Results Intervention vs no treatment control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scogin 1990</td>
<td>Meta-analysis of the efficacy of self-administered treatment programs</td>
<td>Self-administered, i.e. administered primarily by individual, treatments versus control condition</td>
<td>Self report, other rated, observational data, physiological recording. Therapist contact limited. Search strategy: do not mention searching electronic databases</td>
<td>Affective disorders (Depression &amp; anxiety), Phobias</td>
<td>9 effect sizes calculated, 8 effect sizes calculated, 40 (81 effect sizes)</td>
<td>Adults</td>
<td>Varied - clinical and non-clinical. Not identified in review by study.</td>
<td>Varied - some studies recruited via advertisement. Not identified in review by study.</td>
<td>?</td>
<td>Effect size calculation (Glass)</td>
<td>Affective disorders 0.73 (s/a) 1.05 (min contact)</td>
</tr>
<tr>
<td></td>
<td>Manual Videotape Audiotape Combination</td>
<td>Included Minimal contact = ranging from “weekly phone calls to brief weekly check-in sessions”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Phobias 0.92 (s/a) 0.77(Min contact)</td>
<td>No further statistical details</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Average Effect size .96, p&lt;.0001 z = 3.97 SD = 0.50</td>
<td></td>
</tr>
</tbody>
</table>

**Comment:** All studies therapist time limited. Controls varied from no treatment to therapist administered. Examined various subgroups including self administered vs minimal contact, no sig difference in effect size.
<table>
<thead>
<tr>
<th>Paper</th>
<th>Aim</th>
<th>Inclusion / Exclusion criteria</th>
<th>Outcome measures used in meta analysis</th>
<th>MH Conditions (reported as subgroups)</th>
<th>No of relevant studies</th>
<th>Partic Setting</th>
<th>Recruitment</th>
<th>F/up</th>
<th>Meta analysis methods</th>
<th>Results: self-help compared to no treatment, wait list or placebo treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gould 1993</td>
<td>Meta analysis of self-help treatment approaches</td>
<td>Self-help studies which employed media based treatment approach used independently of professional. Minimal contact = “weekly or monthly contacts to monitor progress, to clarify procedures or provide general support or encouragement”</td>
<td>Classified as self-report, behav. observation, Physiological. Search strategy: PsycLit, Medline &amp; Psychological abstracts searched. Studies had to have used a control group (no treatment, wait list or placebo).</td>
<td>Fear reduction</td>
<td>8 Adults</td>
<td>Varied - clinical and non clinical. Not identified in review by study.</td>
<td>Varied – 25 of the 40 studies recruited via advertisement Not identified in review by study.</td>
<td>None One study provides f/up data</td>
<td>Effect size calculated (Glass)</td>
<td>Fear reduction 1.11 Depression 0.74</td>
</tr>
<tr>
<td>Book Manual Audiotape Videotape Combination</td>
<td></td>
<td></td>
<td></td>
<td>Depression</td>
<td>3 Adults and older adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comment:** All studies therapist contact limited. Large ES for fear reduction, uniformity in treatment approaches (systematic desensitization). Depression also large effect size. No significant difference between self-help alone and therapist assisted intervention, therapist assisted intervention poorer results. Type of control impact on ES - as control condition approximated actual treatment conditions effect size decreased. Slightly stronger effect size (0.77) using videotape relative to written materials. Combination of self-help formats, bibliotherapy with videotape or audiotape, effect size doubled, 1.64 and 1.53 respectively.
<table>
<thead>
<tr>
<th>Paper</th>
<th>Aim</th>
<th>Inclusion / Exclusion criteria</th>
<th>Outcome measures used in meta analysis</th>
<th>MH Conditions (reported as subgroups)</th>
<th>No of relevant studies</th>
<th>Particip</th>
<th>Setting</th>
<th>Recruitment</th>
<th>F/up</th>
<th>Meta analysis methods</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marrs 1995</td>
<td>Meta analysis of bibliotherapy studies</td>
<td>Treatment is with bibliotherapy. Adults only. Comparison group must be from same population as study group. Bibliotherapy must be primary treatment. Bibliotherapy must be longer than 10 pages. Study report in English. Recorded therapist contact but did not exclude according to time limit. Included therapist only and waiting list comparisons in meta-analysis.</td>
<td>Physiological. Observed behaviours. Rating by others. Standardized self report measures. Self report behaviours. Search strategy: PsycLit, Dissertation abstracts but no medical databases.</td>
<td>Anxiety</td>
<td>Adults</td>
<td>Adults</td>
<td>Varied - more likely to be non clinical. Not identified in review by study.</td>
<td>Not mentioned in review</td>
<td>Not described by study but 35% of all studies reported f/up data which was compared to posttest data</td>
<td>Effect size calculated d++ (Hedges &amp; Olkin 1985) QT test for homogeneity Exploration of heterogeneity by subgroup analysis Sensitivity analysis conducted</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Depression</td>
<td>15 (studies or samples)</td>
<td>Adults</td>
<td>Varied - more likely to be non clinical. Not identified in review by study.</td>
<td>Not mentioned in review</td>
<td>Not described by study but 35% of all studies reported f/up data which was compared to posttest data</td>
<td>Effect size calculated d++ (Hedges &amp; Olkin 1985) QT test for homogeneity Exploration of heterogeneity by subgroup analysis Sensitivity analysis conducted</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Depression</td>
<td>5 (studies or samples)</td>
<td>Adults</td>
<td>Varied - more likely to be non clinical. Not identified in review by study.</td>
<td>Not mentioned in review</td>
<td>Not described by study but 35% of all studies reported f/up data which was compared to posttest data</td>
<td>Effect size calculated d++ (Hedges &amp; Olkin 1985) QT test for homogeneity Exploration of heterogeneity by subgroup analysis Sensitivity analysis conducted</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Depression</td>
<td>79</td>
<td>Adults</td>
<td>Varied - more likely to be non clinical. Not identified in review by study.</td>
<td>Not mentioned in review</td>
<td>Not described by study but 35% of all studies reported f/up data which was compared to posttest data</td>
<td>Effect size calculated d++ (Hedges &amp; Olkin 1985) QT test for homogeneity Exploration of heterogeneity by subgroup analysis Sensitivity analysis conducted</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total included in review</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Anxiety**
- 0.906 95% CI (0.731-1.080) p<.001
- 0.739 after removing outliers (significant relationship between therapist contact time and Effect Size for anxiety trials, p<0.001)

**Depression**
- 0.567 (0.246-0.887) P=0.1

**Overall effect size**
- 0.565 (0.494-0.636)

**48 samples (all outcomes) where therapist contact <8mins**
- 0.506
Comment: Included studies not confined to those where therapist contact restricted to same parameters as Scogin or Gould. However, all but two of the studies in anxiety group are self-help and limited therapist contact. All studies in depression group are self-help and all but one included in Scogin and Gould reviews. Therapist contact examined as "moderator" variable and there was a significant difference in effect sizes. Effect size for depression lower than in Gould review but inclusion criterion were that subjects should not be recruited via media.
2.6 Reviews of self-help interventions for mental health outcomes

Four systematic reviews examined self-help interventions in relation to mental health outcomes. Cuijpers\(^\text{16}\) investigated bibliotherapy in depression, Hay\(^\text{39}\) investigated all forms of self-help for bulimia nervosa and binge eating disorder. Bower\(^\text{43}\) investigated any self-help intervention that had been studied in primary care for any mental health outcome while the Kaltenhaler\(^\text{41}\) review investigated self-administered computerised cognitive behavioural therapy for depression and anxiety.

2.6.1 Definition of Self-Help

The studies varied in their definition of self-help. Hay\(^\text{39}\) only included self-help if there was no therapist involvement, while Kaltenhaler\(^\text{41}\) recorded the amount of time a therapist was involved with Computerised Cognitive Behaviour Therapy (CCBT). Cuijpers\(^\text{16}\) only studied bibliotherapy and Bower\(^\text{44}\) described self-help as carried out “predominantly independently” of a professional.

2.6.2 Search strategies

Cuijpers\(^\text{16}\) only included MEDLINE, PsycLit and PsycINFO in his search of electronic databases. The other three used a more thorough strategy, in particular all also searched EMBASE and Hay\(^\text{39}\) and Kaltenhaler\(^\text{41}\) carried out the reviews in conjunction with Cochrane review groups.

2.6.3 Participants

There is a varying degree of detail about the participants in the constituent trials. Kaltenhaler\(^\text{41}\) gives considerable detail and most of the participants had been recruited from clinical settings. In contrast, Cuijpers\(^\text{16}\) mentioned that all the studies in his review had recruited subjects by advertisement. Bower\(^\text{45}\) used a primary care setting as an inclusion criterion. However, Bower included a chronic fatigue study of self-help along with the others investigating anxiety and depression.

2.6.4 Comparison groups

All the reviews (except Hay\(^\text{39}\)) were clear about the comparison groups and carried out separate analyses for the “treatment as usual” or waiting list comparison from studies in which alternative therapies had acted as comparator. The Hay\(^\text{39}\) review covered all psychotherapies for bulimia nervosa and binge eating disorder that make the results difficult to interpret. It included a category in the results of “CBT: guided or unguided form compared to self-help CBT”. Since self-help and unguided CBT would appear to be the same it is difficult to draw conclusions from this review. A subsequent narrative review by the same authors (www.nelh.nhs.uk/clinical_evidence.asp) have concluded that “CBT in full or less intensive form was not significantly superior to CBT in pure self-help form”.

26
2.65 Results

Cuijpers\textsuperscript{16} reported a significant effect size for bibliotherapy compared to waiting list controls with an effect size of 0.8 (95% CI 0.5-1.2). However, Cuijpers included 7 comparisons even though there were only 6 studies. He therefore effectively included the same comparison group twice and this would have slightly increased the statistical significance of his results and underestimated the width of the confidence limits. None of the studies were sufficiently large to include more than 50 participants in a single group.

Bower\textsuperscript{46} calculated an overall effect size compared to usual care that included the result from the chronic fatigue study as well as combining anxiety and depression. The result was 0.4 (95% CI 0.1-0.7) and the test for homogeneity (sic) was not significant. Three of the studies had a group size of more than 50.

Kaltenhaler\textsuperscript{41} did not perform a quantitative synthesis of the results. They mention 6 studies that compared CCBT to “treatment as usual”. Four of these studies found a significant benefit of CCBT and the two studies that did not find a significant difference were either carried out in an inpatient setting or studied CCBT in a workplace setting where subjects might not necessarily have been depressed or anxious. Only one of the studies included in this review had more than 50 subjects in a group.

An assessment of the quality of the reviews is given in Table 3.4.

2.7 Discussion

We identified 7 systematic reviews that had examined the effectiveness of self-help interventions. All reported or concluded that there were significant benefits for self-help on clinical outcome when compared to treatment as usual. Despite this finding there are significant limitations in these reviews.

2.7.1 Generic Reviews

Three of the reviews (Scogin\textsuperscript{36}; Marrs\textsuperscript{38}; Gould\textsuperscript{37}) were investigating the effectiveness of self-help interventions across a wide range of medical conditions. It was difficult to be sure about what comparisons were being made in the subgroup analyses they performed for the mental health outcomes. Few details were given about the constituent studies and there was little assessment of the methodological quality of the studies included in the review. No mention was made of the sample size in the constituent studies. In any case the methodology used for these systematic reviews was weak with an inadequate search strategy and some confusion about the most appropriate comparison group. We are particularly interested in the comparison between self-help and “treatment as usual” or waiting list controls. Some of the comparisons made in these generic reviews did not provide separate analyses for groups with quite different expected outcomes.

In conclusion, the three generic reviews offer little evidence with which to judge the effectiveness of self-help treatments in depression and anxiety. The systematic reviews are of poor quality and omit important information.
2.72 Mental health reviews

The four reviews (Cuijpers\textsuperscript{16}; Bower\textsuperscript{47}; Hay\textsuperscript{39}; Kaltenhaler\textsuperscript{41}) with a mental health focus are more recent and address some of the concerns raised above. However, the review by Hay\textsuperscript{39} of bulimia nervosa interventions cannot be used because of a lack of clarity about the comparison group for self-help interventions. One of the included trials, Peterson\textsuperscript{48} did not individually randomise subjects and should have been excluded from the review.

Cuijpers\textsuperscript{16} compared bibliotherapy with waiting list controls. He found quite a large treatment effect but all of the constituent trials were small. None included a randomised group with more than 50 subjects. The statistical power of a randomised controlled trial with 50 subjects is quite low. For a categorical outcome such a trial would be able to detect the difference between 40% and 70% recovery with 80% power at the 5% significance level. This is a very large difference corresponding to a number needed to treat of about 3 and larger than the expected response to antidepressants in depression. Though the power would probably be greater for continuous outcomes, the above power calculation indicates the kind of differences that can be detected using such small trials. Small trials also can lead to an imbalance between the randomised groups, thereby undermining the fair comparison upon which randomised controlled trials are based. Meta-analysis of small trials can address the issue of statistical power but cannot overcome the unreliability of randomisation as a means of preventing confounding in those circumstances. Finally, small trials are more likely to be subject to a publication bias. This possibility could not have been investigated with such a small number of trials. Nevertheless, meta-analysis of a small number of small trials is an unreliable method of evaluating effectiveness.

There is a further important limitation of the studies in Cuijpers\textsuperscript{16} review. All the studies had recruited by means of advertisement in local media. Though many of the studies would have ensured that participants had significant symptoms of depression and anxiety, this method of recruitment severely limits the generalisability of these studies to circumstances in the NHS. Subjects responding to adverts might be much more prepared to accept the need for self-direction implied by self-help or particularly attracted towards self-help approaches. Some of the studies recruited from student populations in which independent study is the norm. It is therefore likely that the subjects recruited in this way would find self-help interventions more acceptable and that their compliance and adherence to the model would be greater than in a less selected population.

Bower\textsuperscript{49} restricted their review to studies that had been based in primary care. They identified a completely different set of studies from those in the Cuijpers\textsuperscript{16} review and the methodology of this trial was in line with current expectations for systematic reviews. However, their overall estimate of effect included a large self-help study for chronic fatigue syndrome that would have narrowed the confidence limits. The effect size they reported of 0.4 (95% CI 0.1-0.7) was smaller than that of Cuijpers\textsuperscript{16}. Unfortunately, it is difficult to make a clinical judgement about the importance of the result when given in these terms. However, it would seem likely that the confidence intervals they report would include a clinically unimportant effect size.
The Bower\textsuperscript{50} review mostly reports papers on self-help for anxiety thought the outcome measures used also assessed depressive symptoms. There appears to be less evidence therefore for the treatment of depression with self-help interventions in primary care.

Kaltenhaler\textsuperscript{41} did not perform a meta-analysis but did report 4 studies that all found a significant benefit of computerised CBT for depression or anxiety compared to a treatment as usual or waiting list group. There is no indication of the size of effect they observed and only one of those trials had more than 50 subjects in a group.

2.73 Economic analysis

There was little or no data about outcomes apart from clinical symptoms in any of the reviews. Both the Kaltenhaler\textsuperscript{41} and Bower\textsuperscript{51} reviews remarked on the absence of any economic analysis apart from one study that had looked at GP consultation rate.

2.74 Acceptability and possible harm

There was nothing about possible side effects or harmful effects. Bower\textsuperscript{52} remarked on the absence of research on the use by participants of the self-help materials in the trials they included though also commented on the large attrition rates in the trials they included. For example, Holdsworth\textsuperscript{53} had a completion rate of less than 60\% at 3 months. Kaltenhaler\textsuperscript{41} recorded all the information from the studies on the use of CCBT. They came to no overall conclusion though mentioned that about a third of participants in the Beating the Blues studies had not completed the 8 sessions. Kaltenhaler and Holdsworth are some of the few trials that have recruited in primary care. There was no overall analysis of drop outs from treatment in any of the reviews.

2.8 Conclusions

The current evidence to support self-help is patchy and weak. The current systematic reviews do not adequately bring together the results from previous studies, classified in a clinically meaningful way. Though on balance there is evidence to support self-help materials, the evidence is not good enough to be that certain there is a benefit. In particular, the studies have been small and even in the meta-analyses that have been reported the confidence intervals are wide enough to include possible effect sizes that are not of clinical value. These reviews indicate that further primary research in a UK context would be of value. This finding together with the difficulty of generalising from much of this research to the UK context suggests that the possibility of a lack of benefit from self-help materials should be acknowledged and incorporated in any advice or recommendation that is made.
**TABLE 3.3 SUMMARY OF SYSTEMATIC REVIEWS – MENTAL HEALTH**

<table>
<thead>
<tr>
<th>Paper</th>
<th>Aim</th>
<th>Inclusion / Exclusion criteria</th>
<th>Outcome measures used in meta analysis</th>
<th>MH Conditions</th>
<th>No of relevant studies</th>
<th>Partic Setting</th>
<th>Recruitment</th>
<th>F/up</th>
<th>Meta analysis methods</th>
<th>Results vs waiting list control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cuijpers 1997</td>
<td>To compare the effectiveness of bibliotherapy with other treatments for unipolar depression</td>
<td>Not explicit All studies were RCTs</td>
<td>All studies used standardized measures</td>
<td>Unipolar depression</td>
<td>7 (6 used in meta analysis, seven comparisons)</td>
<td>N = 272 Adults, two studies specifically used older adults.</td>
<td>Subjects either met diagnostic criterion for depression or were scored using validated measure before entering trial.</td>
<td>Announcement in media</td>
<td>Ranged from 4-11 wks</td>
<td>Effect size calculated using Meta5.3. Random effects model used, includes test for homogeneity. Fail-safe N calculated.</td>
</tr>
</tbody>
</table>

**Comment:** Small number of studies.
<table>
<thead>
<tr>
<th>Paper</th>
<th>Aim</th>
<th>Inclusion / Exclusion criteria</th>
<th>Outcome measures used in meta analysis</th>
<th>MH Conditions</th>
<th>No of relevant studies</th>
<th>Partic</th>
<th>Setting</th>
<th>Recruitment</th>
<th>F/up</th>
<th>Meta analysis methods</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bower</td>
<td>To determine the clinical and cost-effectiveness of self-help treatments in anxiety and depressive disorders in primary care. a) RCTs and controlled before/after studies b) disorder to include significant anxiety &amp; depressive symptoms c) recruitment via GP or primary care setting d) intervention must meet criterion of self-help</td>
<td>Most frequently used measures of anxiety &amp; depression in each study - GHQ, HADS, SCL-90, STAI)</td>
<td>Depression Anxiety Chronic fatigue Anxiety &amp; depression</td>
<td>1 5 1 1</td>
<td>N=636 Predominantly female adults</td>
<td>Primary care GP recruitment</td>
<td>Range from 2-24 weeks</td>
<td>Effect size calculated using Meta5.3. Random effects model used, includes test for homogeneity not significant.</td>
<td>Effect Size for six studies 0.41 (95% CI=0.09-0.72) Test for homogeneity not significant.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paper</td>
<td>Aim</td>
<td>Inclusion / Exclusion criteria</td>
<td>Outcome measures used in meta analysis</td>
<td>MH Conditions</td>
<td>No of relevant studies</td>
<td>Partic</td>
<td>Setting</td>
<td>Recruitment</td>
<td>F/up</td>
<td>Meta analysis methods</td>
<td>Results</td>
</tr>
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</tr>
<tr>
<td>Hay</td>
<td>To evaluate the evidence for the efficacy of CBT and compare it with other psychotherapies in the treatment of adult patients with Bulimia Nervosa</td>
<td>Participants: people with purging and non purging Bulimia Nervosa; binge eating disorder; EDNOS with recurrent binge eating; and related eating disorder syndromes; adults aged&gt;16yrs</td>
<td>Abstinence from binge eating; mean bulimic scores; proportion of non completers or dropouts due to any reason or those due to adverse events</td>
<td>Purging and non purging Bulimia Nervosa Binge eating disorder</td>
<td>1 3 27</td>
<td>Adults</td>
<td>Tertiary care center Non clinical</td>
<td>Referrals Advert in media</td>
<td>18 mths 8-12 wks</td>
<td>Relative risk calculated using REVMAN Sensitivity analysis conducted Fixed effects model used Chi-square test for homogeneity at 5% significance level</td>
<td>Relative Risk 0.90 (95%CI 0.74, 1.10) Test for heterogeneity p=0.4781</td>
</tr>
</tbody>
</table>

Comments: No advantage to treatment
<table>
<thead>
<tr>
<th>Paper</th>
<th>Aim</th>
<th>Inclusion / Exclusion criteria</th>
<th>Outcome measures used in meta analysis</th>
<th>MH Conditions (reported as subgroups)</th>
<th>No of relevant studies</th>
<th>Participants</th>
<th>Setting</th>
<th>Recruitment</th>
<th>F/up</th>
<th>Meta analysis methods</th>
<th>Results Intervention vs no treatment control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaltenhaler</td>
<td>To assess the clinical effectiveness of computer based CBT for treating anxiety, depression and phobias. To compare cost effectiveness with delivering CBT by conventional methods and standard care.</td>
<td>Participants: Adults with depression/anxiety (incl generalized anxiety) Intervention: CCBT delivered alone or part of a package of care Study type: RCTs or observational studies where RCTs unavailable for outcomes.</td>
<td>Meta analysis not conducted. All trials and studies in the review described in detail.</td>
<td>Subgroup analysis not performed.</td>
<td>11 RCTS 5 non RCTS But only 6 compared to treatment as usual.</td>
<td>Adults with depression/anxiety.</td>
<td>Varied - includes primary care, inpatient and outpatient setting. UK, USA, Australia.</td>
<td>Recruitment varied from self referral through to newspaper adverts. GP referral, referral.</td>
<td>Range 3 wks - 12m All studies report numbers lost to follow up.</td>
<td>Meta analysis not undertaken.</td>
<td>This is a qualitative report and meta analyses are not undertaken on any of the data. All studies are described in detail and the conclusion is that there is limited evidence that CCBT may be effective in the treatment of depression/anxiety and phobias. Data too poor to draw any conclusions re cost.</td>
</tr>
</tbody>
</table>

**Comment:** This report provided the basis for NICE guidance on CCBT.
### Table 3.4 Summary of Quality Assessment

<table>
<thead>
<tr>
<th></th>
<th>Aim</th>
<th>Inc/exc</th>
<th>Search</th>
<th>Unpubl.</th>
<th>List incl</th>
<th>List excl</th>
<th>Quality assess</th>
<th>Heterogeneity tested</th>
<th>Heterogeneity investigated</th>
<th>No studies</th>
<th>Limitations of studies</th>
<th>Limitations of review</th>
<th>Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scogin</td>
<td>x</td>
<td>?</td>
<td>x</td>
<td>x</td>
<td>?</td>
<td>x</td>
<td>x</td>
<td>?</td>
<td>?</td>
<td>40 (17?)</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Marrs</td>
<td>x</td>
<td>X</td>
<td>x</td>
<td>x</td>
<td>?</td>
<td>?</td>
<td>x</td>
<td>?</td>
<td>?</td>
<td>79 (20)</td>
<td>x</td>
<td>?</td>
<td>x</td>
</tr>
<tr>
<td>Cuijpers</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>?</td>
<td>x</td>
<td>x</td>
<td>?</td>
<td>?</td>
<td>6 (6)</td>
<td>x</td>
<td>?</td>
<td>x</td>
</tr>
</tbody>
</table>

1. Is there a clear statement of aims that self-help is compared to waiting list or treatment as usual comparison group?  
2. Are there clearly defined incl/excl criteria for self-help?  
3. Is there a clearly defined search strategy that includes both medline and embase?  
4. Has the search strategy included unpublished studies?  
5. Does the review provide a list of included studies?  
6. Does the review provide a list of excluded studies?  
7. Does the review use a validated tool to quality assess the included studies?  
8. Does the review test heterogeneity?  
9. Does the review investigate heterogeneity?  
10. Number of studies in review (relevant studies in parentheses)  
11. Does the review discuss the limitations of the included studies in relation to the conclusions drawn?  
12. Are the limitations of the review itself discussed?  
13. Are ongoing trials listed?  

? = fulfills criterion completely  
? = partially meets criterion  
X = does not fulfill criterion
CHAPTER THREE: OTHER IDENTIFIED STUDIES

3.1 Introduction

The systematic reviews identified certain areas of the literature that were unlikely to have been previously searched. The most recent review for depression and anxiety had only included studies undertaken in primary care \(^\text{54}\), whilst another had only examined bibliotherapy for depression, not anxiety \(^\text{55}\). Of the other more recent reviews Hay \(^\text{56}\) examined only CBT for bulimia nervosa and binge eating disorder and did not review anorexia or other self-help materials based upon alternative approaches and Kaltenthaler \(^\text{57}\) reviewed computerized CBT for anxiety and depression. Because of the heterogeneity of the search strategies undertaken for these systematic reviews, it was extremely difficult to identify obvious gaps and narrow the search.

We therefore chose to carry out several searches addressing particular areas where previous reviews might have omitted published articles. We wanted to include all randomized trials, but also needed to identify observational studies (i.e. non randomised) where no RCTs could be found. For anxiety and depression we restricted the search to those articles published after 1990 on the grounds that the older reviews \(^\text{36-38}\) should have identified all early literature. We recognise that we have already criticised some of the search strategies for some of the older reviews but think that the combined strategies, together with examining the reference lists of papers obtained will still identify the relevant literature in a more efficient manner. The systematic reviews had not identified any self-help material for bipolar disorders and schizophrenia so we searched for articles on self-help for these two conditions from the beginning of the available databases. Finally we also carried out some specific searches for self-help groups and qualitative studies.

In this chapter we therefore describe those randomised controlled trials that investigated self-help materials and that had not been included in the systematic reviews identified in Chapter 2.

3.2 Methods: Inclusion & exclusion criteria

3.21 Study design

Randomised controlled trials and longitudinal studies were included in our search. We chose to review the observational studies where there was insufficient evidence from randomized controlled studies.

3.22 Type of participant

Adults (aged > 16 years) with a diagnosis or symptoms of at least one of the following: anxiety, depression, bipolar disorder, schizophrenia or eating disorder. We did not restrict the setting or method of recruitment of the subjects as we were aware that many of the early studies in this area were not undertaken on clinical subjects. However, we wanted to be inclusive of all available evidence at this stage.
3.23 Types of intervention

A self-help intervention administered through written, audiotape, videotape or computer text or a combination and which was designed to be predominantly conducted independently of professional or paraprofessional support. Once papers had been identified as of potential interest, this had to be defined as one hour or less of professional face-to-face time and up to six 15 minute telephone calls. For non-professional guidance or “guided self-help” up to 5 hours of non-professional time could be allocated. The self-help intervention had to be designed with the aim of improving symptoms and developing skills for coping or managing symptoms.

3.24 Comparison groups

The primary comparison we were interested in was between self-help interventions and a no-treatment or waiting list comparison group. This was because we saw the main application for self-help as an intervention available when there was little other professional psychological help available. Though self-help materials have been used to reduce therapist time spent with patients, we were less concerned with their use in this circumstance.

3.25 Types of outcome measure

At least one of the following outcome measures: clinical symptoms, quality of life, costs and acceptability to users.

3.3 Methods: Search Strategy & data extraction

3.31 Electronic databases

Medline; CINAHL; PsychINFO; Embase and the Cochrane Controlled Trials Register (CCTR) were searched. The search terms for problem type were refined in the light of previous experience and the set for self-help terms improved. Search terms for anxiety and depression and schizophrenia were adapted from the relevant Cochrane Group’s search strategies and the Cochrane search terms for randomized controlled trials applied.

A combined search was undertaken on Medline; CINAHL; Embase and CCTR, limited to years 1990-present for depression anxiety and eating disorders. For bipolar disorder and schizophrenia Medline was searched 1966-present; CINAHL 1982-present; Embase 1980-present. The same search was adapted and repeated on PsychInfo and the results combined.

A new database called PsiTri, was also searched. This database is a joint effort of the Cochrane Collaborative Review Groups within mental health and provides access to their specialist registers. Further information can be found on URL, [http://www.psitri.helsinki.fi/about.htm](http://www.psitri.helsinki.fi/about.htm) The National Research Register was also searched for ongoing trials. All searches were last run in July 2002.

3.32 Other Search Strategies
The reference lists of all papers finally included were hand searched. We are still awaiting responses from authors who have been contacted to establish whether there are any further data or ongoing trials.

3.33 Screening abstracts

Once the initial search results had been screened by LA to exclude trials which were not within the defined conditions or age range, the abstracts were examined by two of the research team independently using the IN/OUT form in the appendix. Once agreement had been reached to include studies for consideration, the papers were obtained and data extracted, again independently by two of the research team using the data extraction form in appendix.

3.34 Data extraction and Quality assessment

Data was extracted on a specially designed form by two people. The assessment of quality was based on four criteria. 1) the adequacy of random allocation concealment, 2) the percentage followed up 3) whether a primary outcome measure had been stated and 4) a priori power calculation made.

3.4 Results of search strategy and applying exclusions

3.41 Depression, anxiety and eating disorders

The combined search for these conditions produced a list of 1,159 papers; of these, 938 were excluded as they were either not one of the specified conditions, were clearly not investigating self-help interventions or the subjects were less than 16 years old. (Figure 3.1)
Inclusion/Exclusion criteria set and search strategy established

search strategy carried out

No. of abstracts identified
N=1,159 (430) {97}

Abstracts of identified studies reviewed and categorised for inclusion/exclusion

Exclusions
N=938 (344) {53} not mental health/outside age
N=44 (2) {2} not studies
N=88 (82) {35} not self-help
N=5 outside age limits
N=48 (2) {3} self-help groups

Paper copies of 41 (0) {4} studies obtained for further review

Exclusions
N=2 not mental health
N=12 not self-help
N=1 same study
N=7 (4) self-help group

Data extracted from included studies N=19
The remaining 221 abstracts were considered for inclusion. At this stage 44 were excluded as they were not randomized controlled trials or observational studies and 88 were excluded as the intervention was not self administered. 41 papers were ordered for closer scrutiny. Of these, 22 were excluded leaving a total of 19 papers to examine in detail. A flowchart for this review of the literature is given in figure 3.1.

3.42 Bipolar disorder and schizophrenia.

The search for schizophrenia produced a total of 430 papers, 344 were screened out. Of the remaining 86 abstracts, 82 were not investigating a self-help intervention, 2 were not studies, either randomized or observational and two were investigating the impact of self-help groups. (Figure 3.1)

The search for bipolar disorder produced a total of 97 papers. Of these, 53 were excluded because they were not relevant to problem type or age range, 35 were excluded on the grounds that the intervention was not self administered, 2 were not studies, either randomized or observational and 3 were investigating the impact of self-help groups. Four papers were identified as suitable for inclusion.

3.5 Results: Generalised Anxiety Disorder

Two observational studies and one RCT were identified. The only RCT included in this section (Table 3.1; Bowman, 1997) suffered from multiple methodological problems (small possibly unrepresentative sample, no concealed randomisation, no a priori defined outcome measure, multiple outcomes, and no power calculation). Nevertheless this self-examination technique assisted by a booklet did significantly better than a delayed treatment control group in all the outcome measures reported. We also identified the three year follow-up to the White paper included in the Bower review.

The observational studies (Table 3.6) involved different therapeutic tools (tapes, books, and videos), all of which were found to be acceptable for users. One of these studies (Finch, 2000) also reported a statistically significant clinical improvement at 6 weeks but since this was an uncontrolled study no conclusions can be reached. Blenkiron (2001) recruited individuals with both depression and anxiety and is therefore included in Table 3.8 with other observational studies on depression.
<table>
<thead>
<tr>
<th>Study: Bowman</th>
<th>Setting</th>
<th>Participants</th>
<th>Recruitment</th>
<th>Groups</th>
<th>Quality</th>
<th>Primary outcome, main findings,</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medium 45 page booklet (SET)</td>
<td>Describe</td>
<td>Subjects recruited via newspaper &amp; TV announcements. 75 expressed interest, 24 failed to meet eligibility criteria, 13 chose not to participate. Participants had to complete min of 7 worksheets for data to be used. All did.</td>
<td>Self-help Intervention Delayed treatment. Received SET after 4 weeks. Total N=38, how randomized unclear.</td>
<td>Concealment NO</td>
<td>Four main clinical outcome measures plus one measuring an understanding of booklet. Statistically significant benefit reported for intervention on all 4 outcome measures.</td>
<td>Four main clinical outcome measures plus one measuring an understanding of booklet. Statistically significant benefit reported for intervention on all 4 outcome measures.</td>
<td></td>
</tr>
<tr>
<td>Duration 4 wks 3m f/up</td>
<td>CBT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Booklet also tested in previous study for use with depression. Subjects who showed improvement of understanding of the SET material but no correlation found between decrease in anxiety &amp; understanding.</td>
<td></td>
</tr>
</tbody>
</table>
3.6 Results: Panic Disorder

We identified 4 studies that were randomised (Table 3.2) and one observational study, an uncontrolled longitudinal study (Table 3.7).

3.6.1 Randomised studies

The 4 randomised studies (Lidren 1994; Gould 1995; Febbraro 1999; Wright 2000) were all carried out by the same research group from the USA and all involved evaluating the self-help book *Coping with Panic* written by the same group. The studies by Febbraro and Wright were two phases of a study on a single group of participants.

The 4 trials are poorly reported and analysed. None of the trials give any information on concealment of randomisation or method of randomisation. None mention a pre-specified outcome variable as a primary outcome. One of the papers gives a power calculation but this was calculated after the study. Confidence intervals might be more appropriate in interpreting the findings of this group of studies but none are given. Febbraro et al (1999) did not mention the numbers of subjects randomised to each group and like the other papers only presented data on those who had completed the study. Lidren (1994) does not mention that any of the participants dropped out of the trial but this might have been a reporting omission.

Most of the outcome measures that are used in these trials have markedly skewed distributions. This means that the main method of analysis used by the authors is unreliable. There were a large number of tests carried out though in Lidren 1994 and Gould 1995 there was a significant benefit of self-help compared to waiting list for all outcome measures included in the papers.

The Febbraro 1999 study did not find any significant results. The authors explanation of this was that the study was performed entirely by post and the contact with a clinician provided in the other studies had been an important element of the improvement. However, the Febbraro study recruited by advertisement and did not screen the participants for panic disorder. Only 47 of the 98 participants had panic disorder so this would have severely reduced the power of the study to find any differences.

3.6.2 Observational studies

Ost and colleagues (1998) carried out an observational study of a self-help manual written by this group and based upon behavioural therapy principles (Table 3.7). They adopted a stepped care design in which participants were given the book and then recontacted 4 weeks later. Participants who had not recovered were then provided with a video and those who had not recovered were offered group treatment and finally individual treatment. This idea fits in more closely with real clinical practice. However, the subjects they recruited were those with spider phobias. They found that 38 of the 103 recruits dropped out before the end of the manual phase of the study. Only 44 participants dropped out of the whole study so it appears that this was the least acceptable element of the process. Spider phobias tend to be common but not very disabling and generalising to more severe cases of anxiety might be difficult.
3.63 Discussion

The studies on panic disorder are severely limited and of poor quality. A single group of investigators has carried out all the randomised controlled studies and have failed to address some of the key methodological aspects of randomised trials. They do not provide good evidence to justify using self-help interventions based on CBT for panic disorder.

There is a further confusion with this literature. Panic disorder as a diagnostic category was developed in the USA and tends not to be used as widely in the UK. Most of the people with panic disorder as diagnosed according to DSM-III-R or related criteria will have severe phobias, often agoraphobia according to UK psychiatrists. Behavioural treatment has long been regarded as the treatment of choice for phobias in the UK. However, some of the participants of these trials will also have had panic disorder not precipitated by phobic anxiety.

We also came across articles concerned with the computerised self-help management of phobic anxiety in the review by Kaltenhaler\(^41\). In particular the studies by Marks and colleagues\(^73\) that have included the self-help book *Living with Fear*\(^74\). However, this trial did not compare the self-help interventions with a waiting list control and the participants in the book condition also received 1.5 hours of therapist time, over our inclusion criteria for the review. The conclusions made by the authors of this paper that self-help interventions (book or computer) were as effective as therapist administered behavioural treatment did not give sufficient emphasis to the possibility of a type 2 error. It was a small trial with fewer than 30 subjects in each randomised group.
<table>
<thead>
<tr>
<th>Study: Wright 2000</th>
<th>Setting Participants Recruitment</th>
<th>Groups</th>
<th>Quality Concealment</th>
<th>Primary outcome, main findings, Comment</th>
<th>Duration</th>
<th>Theory</th>
<th>Guided or unguided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Help Intervention</td>
<td>Structured Relapse Prevention Programme inc <em>Coping With Panic</em> 6 mths</td>
<td>Describes Subjects had all completed phase two of the project (Febbraro 1999) Original sample recruited by adverts in campus, local media, support groups. Subjects adults, no formal diagnosis of panic disorder</td>
<td>Self-help N=?, 17 completers Wait list N = ?, 19 completers 45 randomised</td>
<td>NO NO Follow-up 80% (36/45) Power calc NO Primary Outcome NO</td>
<td>Ten outcome measures. Found a significant benefit of the relapse prevention program on depression and avoidance but not significant for the other 8 outcomes measures. For 9 outcomes measures the mean was less than 2 SDs. Data only on completers.</td>
<td>6 mths</td>
<td>CBT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Study: Wright 2000</th>
<th>Setting Participants Recruitment</th>
<th>Groups</th>
<th>Quality Concealment</th>
<th>Primary outcome, main findings, Comment</th>
<th>Duration</th>
<th>Theory</th>
<th>Guided or unguided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Help Intervention</td>
<td>Structured Relapse Prevention Programme inc <em>Coping With Panic</em> 6 mths</td>
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<td>Self-help N=?, 17 completers Wait list N = ?, 19 completers 45 randomised</td>
<td>NO NO Follow-up 80% (36/45) Power calc NO Primary Outcome NO</td>
<td>Ten outcome measures. Found a significant benefit of the relapse prevention program on depression and avoidance but not significant for the other 8 outcomes measures. For 9 outcomes measures the mean was less than 2 SDs. Data only on completers.</td>
<td>6 mths</td>
<td>CBT</td>
<td>Researchers telephoned subjects to check progress &amp; advise how to cope with panic attacks. Total 3 hrs but included time for research assessments.</td>
</tr>
</tbody>
</table>

Paper reports phase three of a study (Phase 2: Febbraro 1999) 25 of the 36 completers met criteria for DSM-IV panic disorder.
<table>
<thead>
<tr>
<th>Study: Gould 1995</th>
<th>Setting</th>
<th>Participants</th>
<th>Recruitment</th>
<th>Groups</th>
<th>Quality</th>
<th>Primary outcome, main findings,</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Help Intervention</strong></td>
<td>“Coping with Panic” + videotape + audiotape</td>
<td>Flyers to university staff &amp; students, local media.</td>
<td>Respondents = 128 then screened to assess DSM-III-R panic disorder criteria (N=33)</td>
<td>Self-Help N=15, 12 completers</td>
<td>Concealment NO</td>
<td>5 outcome measures and 4 outcomes had mean less than 2SDs</td>
<td>Seeks to replicate earlier study (Gould 1993a)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Wait List N=15, 13 completers</td>
<td>Follow-up 84% (25/30)</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Primary Outcome NO</td>
<td>Further 3 improved in Int group at follow up 8 wks after treatment.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>All 5 outcome measures significantly better for self-help.</td>
<td></td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>6 wks treatment then 8 wks follow-up</td>
<td></td>
<td></td>
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<tr>
<td><strong>Theory</strong></td>
<td>CBT</td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Guided or unguided</strong></td>
<td>3 hours but this included initial and follow up assessments for research purposes</td>
<td>21/30 with agoraphobia</td>
<td>11/30 subjects taking medication throughout study</td>
<td>Self-Help N=15, 12 completers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study: Lidren 1994</td>
<td>Setting</td>
<td>Participants</td>
<td>Recruitment</td>
<td>Groups</td>
<td>Quality</td>
<td>Primary outcome, main findings,</td>
<td>Comment</td>
</tr>
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<td>---------</td>
</tr>
<tr>
<td>Self-Help Intervention</td>
<td>Coping with Panic</td>
<td>Flyers to university employees, students, newspaper ads, physician referrals. Respondents=150</td>
<td>Telephone screening for PD criteria = 100</td>
<td>Self-help N=12 Wait list N=12 Group Therapy N=12</td>
<td>Concealment YES/NO Follow-up 100%? Power Calc NO Primary Outcome NO</td>
<td>2 of 6 outcome measures had means greater than 2SDs. All 6 outcomes were significantly improved in the self-help group compared to the waiting list group</td>
<td>Small trial and there is no mention if all 36 subjects completed the trial. Both the self-help and group treatments appeared to do better than wait list.</td>
</tr>
<tr>
<td>Duration</td>
<td>8 wks treatment, 3 and 6 mths follow-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theory</td>
<td>CBT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guided or unguided</td>
<td>Phone call at 2, 5 &amp; 8 wks No further detail</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study: Febbraro 1999</td>
<td>Setting</td>
<td>Participants</td>
<td>Recruitment</td>
<td>Groups</td>
<td>Quality</td>
<td>Primary outcome, main findings,</td>
<td>Comment</td>
</tr>
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<td>-------------</td>
<td>--------</td>
<td>---------</td>
<td>-------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Self-Help Intervention</td>
<td>“Coping with Panic” and/or self-monitoring</td>
<td>Participants recruited via advertisements. Only 47 met criteria for panic disorder.</td>
<td></td>
<td>1. Coping With Panic 2. Self-Monitoring 3. Coping with panic + self-monitoring 4. Wait list</td>
<td>All 5 outcome measures had mean &gt; 2SDs.</td>
<td>There were no statistically significant differences between groups on any outcome measures.</td>
<td>Paper reports phase two of study (see Wright 2000 for phase 3).</td>
</tr>
<tr>
<td>Duration</td>
<td>8 wks</td>
<td></td>
<td></td>
<td>98 randomised to 4 groups but data only on 63 completers</td>
<td>Concealment NO</td>
<td>Follow-up 64% (63/98)</td>
<td>Numbers in each group defined as being panic free post treatment: 1. 11/17 2. 8/15 3. 9/13 4. 7/18</td>
</tr>
<tr>
<td>Theory</td>
<td>Coping with panic: CBT Self-monitoring introduced as possible easier alternative</td>
<td></td>
<td></td>
<td></td>
<td>Power Calc NO</td>
<td>Primary Outcome NO</td>
<td>The authors argue that the lack of any treatment effect may be because there is no face-to-face contact with participants. Half of participants did not have panic disorder at randomisation so statistical power would have been reduced.</td>
</tr>
<tr>
<td>Guided or unguided</td>
<td>Unguided – all contact by post</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.7 Results: Depression

Two randomised controlled trials (Table 3.3) and 3 observational studies were identified.

3.71 Randomised Controlled Trials

None of the RCTs that were identified performed well in relation to our specified quality criteria (Table 3.3). Both utilised the book ‘Feeling Good’ as the main therapeutic intervention. The study by Bowman (1995)\textsuperscript{66} is very small (n=32), randomisation is unclear, there is no a priori outcome measure or power calculation, and compliance is reported as low. All these limitations must be borne in mind when interpreting the positive results reported in this paper. Jamison’s (1995)\textsuperscript{75} study and its 3-year follow-up (Smith, 1997)\textsuperscript{76} used a larger (n=80) but also self-selected sample to compare the intervention with a delayed treatment group. As in the previous study randomisation was not concealed, main outcome was not established a priori, multiple outcomes were used, and there is no power calculation. Also, in keeping with the previous study, the authors reported a statistical significant benefit of the intervention for depression with a significant difference also reported at 3 years.

3.72 Observational studies

As with Anxiety disorders the observational studies showed good acceptability for several tools and modalities of delivery. The small (n=20) study by Hannay\textsuperscript{77} showed a modest reduction in GHQ score but also experienced some difficulties when using the intervention of ‘therapeutic writing’. Cristhensen (2002)\textsuperscript{78} used an intervention delivered through the internet. Although little can be inferred in terms of the effectiveness from the results of an observational study, large numbers of people visited the website and approximately half of those who registered completed one or more online assessments. Even though this was a self-selected sample with access to the internet, visitors to the website had high levels of symptomatology according to the questionnaires completed.

3.73 Discussion

The evidence presented here is very weak. Two small randomised trials are included with a number of weaknesses in reporting. The other possibly relevant studies are those identified in the Bower\textsuperscript{79} review. The Holdsworth\textsuperscript{80} study was based in UK primary care and found little evidence of benefit for a self-help book and manual for the GP. There are also computerised CBT trials for depression reported in the Kaltenhaler\textsuperscript{41} review with more encouraging results.

The vast majority of self-help interventions that have been evaluated over recent years are based on CBT. It is of interest to note that Bowman (1995)\textsuperscript{66} also investigated Self Examination Therapy (SET). This intervention was primarily to encourage participants to self-monitor their symptoms. It is a great deal simpler than CBT and showed a similar benefit for the participants, albeit in a very small trial with only 10 subjects in each group.
There is very little evidence here or from the systematic reviews with which to judge the use of self-help materials in depression. It is disappointing that there isn’t a more substantial recent evidence base for using self-help treatments in depression given its public health importance.
### Table 3.3 Recent RCTs of Self-help Interventions for Depression

<table>
<thead>
<tr>
<th>Study: Jamison</th>
<th>Setting</th>
<th>Participants</th>
<th>Groups</th>
<th>Quality</th>
<th>Primary outcome, main findings</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medium</strong></td>
<td>Book:</td>
<td>Various media</td>
<td>Intervention</td>
<td>Concealment</td>
<td>3 main outcome measures HRSD; BDI; SCL-90;</td>
<td>Feeling Good has been extensively studied by the same team &amp; reported in meta-analysis(^{36})</td>
</tr>
<tr>
<td></td>
<td>Feeling Good, David Burns</td>
<td>announcements</td>
<td>N=40</td>
<td>NO</td>
<td>Statistically significant benefit for intervention on all 3 measures.</td>
<td>Three year follow up(^{76}) also reported N=50/80 (62.5%). Treatment gains maintained over three year period but not related to participants returning to read the book</td>
</tr>
<tr>
<td></td>
<td>Subjects</td>
<td>diagnosed by DSM-III-R</td>
<td>Delayed treatment</td>
<td>Follow up to third assessment</td>
<td>Clinically significant improvement: 59% intervention, 13% control.</td>
<td></td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>4 wks</td>
<td>N=40</td>
<td>79% (63/80)</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>treatment and 3 mnth Follow-up</td>
<td></td>
<td>Power Calc</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Primary outcome</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Theory</strong></td>
<td>CBT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Guided or unguided</strong></td>
<td>Read book &amp; complete exercises. Telephoned once a week for less than 10 mins.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study: Bowman 1995</td>
<td>Setting</td>
<td>Participants</td>
<td>Recruitment</td>
<td>Groups</td>
<td>Quality</td>
<td>Primary outcome, main findings,</td>
</tr>
<tr>
<td>-------------------</td>
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<td>-------------</td>
<td>--------</td>
<td>---------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Medium</td>
<td>Book: Feeling Good</td>
<td>Participants recruited via media announcements. Three groups, three time points, pre and posttest and follow up.</td>
<td>Intervention N=10</td>
<td>Concealment NO</td>
<td>Two outcome measures: HRSD, BDI.</td>
<td>Only 25% of “Feeling Good” exercises completed.</td>
</tr>
<tr>
<td></td>
<td>David Burns</td>
<td>Read book &amp; complete exercises. Researcher calls weekly</td>
<td>Self monitor only with self-examination therapy (SET) N=10</td>
<td>Follow up to third time point 90% (27/30)</td>
<td>Statistically significant differences reported for both outcome measures and for both interventions.</td>
<td>SET further explored in generalized anxiety disorder</td>
</tr>
<tr>
<td></td>
<td>Duration 4 wks</td>
<td></td>
<td>Wait list N=10</td>
<td>Power calc NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Theory CBT</td>
<td></td>
<td>Primary outcome NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guided or unguided</td>
<td>Read book &amp; complete exercises. Researcher calls weekly</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.8 Results: Eating Disorders

Existing self-help studies have focussed either on bulimia nervosa (both full and partial syndrome) or binge eating disorder. Some diagnostic and treatment considerations need to be taken into account in interpreting the findings from the studies in this area. The Hay systematic review covering the topic has been criticised for failing to address both disorders separately (Fairburn et al., in press).

Binge Eating Disorder (BED) is included in the appendix in DSM-IV (1994) as a category "deserving further study" rather than as a full syndrome. It is often associated with obesity and those who present to services tend to be obese. In contrast to bulimia nervosa, which without intervention tends to run a chronic course, binge eating disorder tends to remit much more readily without treatment. In a study on the natural course of eating disorders over 5 years (Fairburn, 1999) only 9% still had BED at 5 years, but there was a significant increase in rates of obesity.

3.8.1 Randomised studies on bulimia nervosa and binge eating disorder (BED)

The RCT by Palmer was conducted in an NHS secondary care specialist eating disorder service and included patients with bulimia nervosa, Eating disorders (Not otherwise specified) and BED. It evaluated the book Overcoming Binge Eating comparing self-help with one-off guidance versus waiting list and two types of more intensive guidance (outside the definition used here) given by clinicians experienced in the treatment of eating disorders. There was no statistically significant benefit for the minimal guidance self-help group compared to waiting list. The main improvement seen was in those given face-to-face guidance in the use of the self-help book (4 sessions of 30 mins). The study did not find a statistically significant difference in the number of consultations in secondary care at 12 months follow-up. The small size of the trial reduces the statistical power and so any conclusions about similarity of effects are difficult to sustain.

The other study compared the relative efficacy of fluoxetine and CBT based self-help manual in Bulimia Nervosa. The manual was the author's own and is not publicly available. Both fluoxetine and self-help were effective, and had an additive effect (Mitchell). There were no details provided on the concealment or method of randomisation. The distribution of the main outcome measure, vomiting episodes, was highly skewed. The authors claim to have addressed this problem by using a statistical procedure based on ranks. The result for the self-help manual did not reach conventional levels of statistical significance except for the early 4 week assessment.

The Peterson study was not properly randomised and is discussed under the observational studies section.

3.8.2 Observational studies

The most useful study, Peterson, had three groups and studied Binge Eating Disorder (BED) (Table 3.9). It was not randomised though the authors tried to introduce a certain amount of randomisation once groups had been constructed. In this study participants with
Binge Eating Disorder were given an interesting group based treatment in which a video was watched followed by a group discussion based upon written guidance and a self-help manual. There was no statistical significant difference, though between the self-help format, and a similar format involving a more substantial input from a clinical psychologist. There was no comparison with a waiting list or other treatment as usual control. This study is a longer term follow up of an earlier trial, \(^{48}\), which had a wait list control group, and all three active treatments were significantly better in terms of reducing binges than the wait list control.

Two papers on a single observational study were also identified that studied BED (Table 3.9) \(^{85}\) \(^{86}\). Both report on the use of *Overcoming Binge Eating* \(^{82}\). Telephone guidance is rated by participants as helpful and the book appears to have a positive impact on patients. However, several women also found the book dry and difficult to read. There was no comparison group..

We found one paper \(^{87}\) evaluating the self-help manual *Getting Better Bite by Bite* \(^{88}\) in 28 out-patients with bulimia nervosa. Of 26 patients available at follow-up 4 to 6 weeks later 12 had very much or much improved, 8 somewhat improved, and 6 patients were unchanged. All patients had the option of therapist-aided treatment at follow-up.

We found one uncontrolled observational study \(^{89}\) that evaluated the use of a CD-ROM based interactive multi-media package *Overcoming bulimia: a self-help package* \(^{90}\). Patients with bulimia nervosa improved significantly on key variables of binge eating and self-induced vomiting.

3.83 Discussion

Three of the four RCTs assessing self-help in bulimia nervosa or binge eating disorder reviewed by Hay \(^{56}\), all studied volunteers, limiting the generalisability to NHS-practice. There is also confusion concerning the comparison group reported in this review. The evidence in the systematic review \(^{56}\) comparing pure self-help or self-help with one-off guidance versus waiting-list is inconclusive.

The trials studied here are not sufficient to alter this conclusion. Palmer \(^{81}\) had a combination of participants with Bulimia Nervosa and Binge Eating Disorder. It was a small trial and did not find a statistically significant benefit of self-help with minimal guidance, though they did find a significant benefit of combining four 30 min sessions of guidance with the self-help manual compared to waiting list controls. The Mitchell study \(^{91}\) found a result of marginal statistical significance for their CBT based self-help manual. It is difficult to establish the amount of therapist time involved in this study. There were regular meetings with a research assistant but the authors do not say the content of these meetings. We have assumed that they concentrated on research assessments.

The acceptability of self-help in bulimia nervosa has not been formally studied. However, drop-out rates do seem to be comparable to those from therapist aided-interventions.
There is little indication in the studies about possible implications for service use. One trial concluded that self-help halved the number of sessions needed for a similar clinical outcome. Palmer found no difference in secondary care service use at 1 year despite different degrees of guidance for their self-help intervention. None of the studies identified included a formal health economic evaluation.
<table>
<thead>
<tr>
<th>Study: Mitchell 2001</th>
<th>Setting</th>
<th>Participants</th>
<th>Groups</th>
<th>Quality</th>
<th>Primary outcome, main findings</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-help intervention investigated</td>
<td>Manual, assessed in previous study Mitchell 1990</td>
<td>Recruited from patients being evaluated for Bulimia Nervosa at the Eating Disorders Clinic &amp; from newspaper adverts. Diagnoses by DSM-III for Bulimia Nervosa.</td>
<td>Fluoxetine + self-help n=21</td>
<td>Concealment NO</td>
<td>Primary outcome, vomiting episodes per week. Highly skewed distribution to outcome measure but authors claim this was addressed in analysis.</td>
<td>All patients seen by physician on a regular basis. Patients receiving the manual plus fluoxetine experienced greatest change at both time points for vomiting and binge eating.</td>
</tr>
<tr>
<td>Medium</td>
<td></td>
<td></td>
<td>Fluoxetine only n=26</td>
<td>Follow up Unclear</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Placebo only n=22</td>
<td>Power calc NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Placebo and self-help N=22</td>
<td>Primary outcome YES</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td>16 wks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theory</td>
<td>CBT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guided or unguided</td>
<td>Seen regularly by research assistant but presumed only for assessments. Patients seen by physician to monitor status &amp; medication.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study: Palmer 2002</td>
<td>Setting</td>
<td>Participants</td>
<td>Recruitment</td>
<td>Groups</td>
<td>Quality</td>
<td>Primary outcome, main findings</td>
</tr>
<tr>
<td>-------------------</td>
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</tr>
<tr>
<td>Self-help intervention investigated</td>
<td><strong>Overcoming Binge Eating</strong></td>
<td><strong>Christopher Fairburn</strong></td>
<td></td>
<td>Referrals to specialist secondary care eating disorders service with DSM-IV full or partial Bulimia Nervosa or Binge Eating Disorder. 20% of eligible recruits declined to take part.</td>
<td>Minimal guidance (MG) N=32</td>
<td>Concealment YES by envelope</td>
</tr>
<tr>
<td>Medium</td>
<td><strong>Duration</strong></td>
<td>4 months</td>
<td>Theory</td>
<td>CBT</td>
<td>Face-to-face (FF) guidance (4x30 min) N=30</td>
<td>Follow up 75% (91/121)</td>
</tr>
<tr>
<td>Guided or unguided</td>
<td>Guideline was a brief explanation by therapist of how to use manual.</td>
<td>Telephone guidance (TEL)(4x30 min) N=28</td>
<td></td>
<td>Wait list (WL) N=31</td>
<td>Power Calc NO</td>
<td>Primary outcome YES</td>
</tr>
<tr>
<td></td>
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</tbody>
</table>
3.9 Results: Obsessive Compulsive Disorder

We only identified one observational study that has examined self-help in the treatment of obsessive compulsive disorder\textsuperscript{93}. This investigated a manual provided to the participant who was instructed to read the manual followed by accessing a computerised behavioural treatment for OCD using a touch-tone telephone. This was an uncontrolled study but found a relatively high completion rate. Along with a number of other studies, the authors report the observation that improved compliance with the treatment was associated with a good prognosis. However, this is found in almost all medical interventions\textsuperscript{94} and does not indicate that the treatment was effective.
<table>
<thead>
<tr>
<th><strong>Study: Marks</strong> ⁹³</th>
<th><strong>Setting</strong></th>
<th><strong>Primary outcome, main findings,</strong></th>
<th><strong>Comment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-help intervention investigated</strong></td>
<td><strong>Participants Recruitment</strong></td>
<td><strong>Describe</strong></td>
<td><strong>Acceptability measured by compliance.</strong></td>
</tr>
<tr>
<td>Medium</td>
<td>Manual and touch tone accessed computer</td>
<td>Study 1 Boston &amp; Madison, London</td>
<td>Study 2 London</td>
</tr>
<tr>
<td><strong>BTSTEPS</strong> Duration unclear</td>
<td>Theory</td>
<td><strong>BT</strong></td>
<td>No long term follow up.</td>
</tr>
<tr>
<td><strong>Guided or unguided</strong></td>
<td>In study 2 level of contact with co coordinator increased &amp; subjects proceeded to clinician guided care. Mean time spent = 99 mins</td>
<td>Subjects referred for treatment of OCD; some newspaper advertisements. Assessed for diagnosis of OCD using DSM-III-3 or ICD-10. Subjects in study 2 placed on WL for clinician guided therapy.</td>
<td>Small, uncontrolled trial</td>
</tr>
</tbody>
</table>
3.10 Results: Self-Help Groups

We did not find any references to self-help groups that met our inclusion criteria. However, we did find some studies that have investigated using self-management groups with bipolar disorders as inpatients. There was also some US research examining the participation of service users in self-help groups and any possible influence this might have on outcome. We did not come across any evaluation of the Lorig style Chronic Disease Self-Management Group approach for mental health problems. We were already aware of the manic-depressive fellowship self-management course and the hearing voices network but could not find any empirical study of those interventions delivered in a self-help group format.

In the UK we came across one voluntary organisation Triumph over Phobia (http://www.triumphoverphobia.com/) that runs self-help groups, led by an ex-sufferer and that uses the behavioural model outlined in Living with Fear. At present the approach of Triumph over Phobia has not been evaluated in any formal sense, though the organisation themselves do assess those who attend their groups and routinely measure outcome.

The Depression Alliance (http://depressionalliance.org/) also runs user led groups that use the Chronic Disease model. We are unaware of the content of the groups and think they are very variable in nature. The Manic Depressive Fellowship run a self-management course with the intention of improving people’s skills in self-management.

The Eating Disorders Association (http://www.edauk.com/) has a network of about 50 self-help groups in the UK. We are not aware of the precise model for the self-help groups but they have a good national reputation for providing help and support.

The Hearing Voices network (http://www.hearing-voices.org.uk/) helps to organise self-help groups aiming to help people who experience auditory hallucinations. Part of the aim is to reduce the stigma associated with the experience of hearing voices as well as help people cope with the experience. It is not entirely clear whether these groups would be included in our definition of self-help. One of the aims of the group is to provide support and reduce stigma.
### TABLE 3.6 RECENT OBSERVATIONAL STUDY ON SELF-HELP FOR GENERALISED ANXIETY

<table>
<thead>
<tr>
<th>Study: Finch 99</th>
<th>Setting Participants Recruitment</th>
<th>Primary outcome, main findings, Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-help intervention investigated</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medium</strong></td>
<td>Attacking anxiety multimedia program (audiotapes, videotapes &amp; bibliotherapy options)</td>
<td>Sample from people who had purchased Attacking Anxiety through word of mouth, infomercials or other promotional techniques</td>
</tr>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>6 wks</td>
<td></td>
</tr>
<tr>
<td><strong>Theory</strong></td>
<td>CBT</td>
<td></td>
</tr>
<tr>
<td><strong>Guided or unguided</strong></td>
<td>None. User works through programme</td>
<td></td>
</tr>
</tbody>
</table>
Table 3.7  Recent observational study on self-help for Panic disorder

<table>
<thead>
<tr>
<th>Study: Ost 1998</th>
<th>Setting Participants Recruitment</th>
<th>Groups</th>
<th>Quality</th>
<th>Primary outcome, main findings,</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Help Intervention</strong></td>
<td>Stepped care = Self-help manual then video then group then individual</td>
<td>Non clinical, community setting. Participants had spider phobias only.</td>
<td>Follow-up 63% (65/103) completed first phase Power Calc NO Primary Outcome NO</td>
<td>Non randomised study of a stepped care program in which subjects progressed only if they had not recovered. 38/103 dropped out of the first manual only phase.</td>
<td>Subjects had spider phobias so generalisation to other more severe anxiety disorders uncertain. Perceived credibility of manual treatment most strongly associated with good outcome (p&lt;0.01)</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>Unclear</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Theory</strong></td>
<td>BT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Guided or unguided</strong></td>
<td>The manual phase had no therapist support. Subjects entered the next group if they showed no improvement.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study: Hannay</td>
<td>Setting</td>
<td>Participants</td>
<td>Recruitment</td>
<td>Primary outcome, main findings,</td>
<td>Comment</td>
</tr>
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<td>--------------</td>
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<td>---------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td>Medium</td>
<td>Guidelines for therapeutic writing</td>
<td>Describe</td>
<td>Psychological well being: GHQ12</td>
<td>Small observational study.</td>
</tr>
<tr>
<td></td>
<td>Duration</td>
<td>2 months</td>
<td>6 pts presented with depression; 5 anxiety/depression; 1 anxiety and 8 various other diagnoses.</td>
<td>Baseline GHQ score Mean 7.7 (median 9)</td>
<td>Mixed conditions.</td>
</tr>
<tr>
<td></td>
<td>Theory</td>
<td>Unclear</td>
<td></td>
<td>Posttest GHQ score Mean 5.0 (median 2.5)</td>
<td>Very limited.</td>
</tr>
<tr>
<td></td>
<td>Guided or unguided</td>
<td>GP gives patient leaflet &amp; guidelines.</td>
<td></td>
<td>Concluded that therapeutic writing was acceptable to patients</td>
<td>Very little information on intervention</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study: Blenkiron</th>
<th>Setting</th>
<th>Participants</th>
<th>Recruitment</th>
<th>Primary outcome, main findings,</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medium</td>
<td>Audiotape</td>
<td>Describe</td>
<td>Outcomes investigated.</td>
<td>Very small pilot study. Patients liked tape and found it useful.</td>
</tr>
<tr>
<td></td>
<td>Duration</td>
<td>7 days</td>
<td>Random sample of GPs n=23 in central Leeds invited to participate. 16 agreed from 11 practices. Asked to recruit up to 6 depressed patients with diagnosis of depression.</td>
<td>Levels of anxiety &amp; depression (HAD); attitude &amp; knowledge of depression, motivation and usefulness of intervention (self report measure).</td>
<td>Main outcomes are knowledge &amp; attitudes rather than symptoms.</td>
</tr>
<tr>
<td></td>
<td>Theory</td>
<td>CBT technique</td>
<td></td>
<td>Anxiety &amp; depression not measured posttest.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Guided or unguided</td>
<td>None</td>
<td></td>
<td>Median att score (IQR), 95% CI</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pretest 19(16.5-23)</td>
<td>Posttest 17(14-19.5)</td>
<td>P=0.001</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Audiocassette useful and acceptable to patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study: Christensen</td>
<td>Setting</td>
<td>Participants</td>
<td>Recruitment</td>
<td>Primary outcome, main findings,</td>
<td>Comment</td>
</tr>
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<td>-------------------</td>
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</tr>
<tr>
<td>Self-help intervention investigated</td>
<td>Internet based CBT</td>
<td>MoodGYM</td>
<td>Description</td>
<td>Primary not stated. Aim to measure changes in anxiety &amp; depression symptoms</td>
<td>Uncontrolled trial so outcomes of little value</td>
</tr>
<tr>
<td>Medium</td>
<td>Duration</td>
<td>6m</td>
<td>Theory</td>
<td>CBT</td>
<td>Analysis: regression models for repeated measure data, random effects for individuals. Used STATA-7</td>
</tr>
<tr>
<td>Guided or unguided</td>
<td>2909 registrants, 1503 completed one or more online assessments</td>
<td>Unguided. Work through 5 modules and use workbook</td>
<td>Results: For community registrants who go through programme there is some evidence that anxiety &amp; depression symptoms resolve, associated with progress through modules.</td>
<td>Visitors to this site had higher levels of anxiety &amp; depression than population samples.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Survey design means that cannot be certain that changes are due to computer program. RCT needed</td>
<td></td>
</tr>
</tbody>
</table>
**TABLE 3.9 RECENT OBSERVATIONAL STUDIES ON SELF-HELP FOR BINGE EATING DISORDER**

<table>
<thead>
<tr>
<th>Study: Peterson</th>
<th>Setting</th>
<th>Participants</th>
<th>Groups</th>
<th>Quality</th>
<th>Primary outcome, main findings,</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medium</strong></td>
<td>Manual</td>
<td>Modified from one previously used in studies of the treatment of Bulimia Nervosa (Mitchell et al., 1990; 1993) plus psychoed. video plus topic-based group discussions</td>
<td>Subjects recruited via physician referral &amp; adverts offering free treatment for BED. All diagnosed for BED using DSM-IV</td>
<td>Therapist Led (TL) N=16</td>
<td>Concealment NO not a randomised study</td>
<td>Three outcome measures incorporating objective and subjective binges.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Partial self-help (PSH) N=19</td>
<td>Follow up: 73% (37/51) at 12 months</td>
<td>No significant differences in outcomes observed for any of the groups on 3 “primary” or 5 secondary outcomes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Structured self-help (SSH) N=16</td>
<td>Power calc NO</td>
<td>All 3 main outcomes had mean less than 2 SDs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Primary outcome NO</td>
<td>Improvements in binge eating and associated symptoms maintained through to 12m follow up.</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>8 wks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>22% of the sample sought additional treatment during follow-up.</td>
</tr>
<tr>
<td><strong>Theory</strong></td>
<td>CBT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Guided or unguided</strong></td>
<td>Subjects viewed the video, led their own discussion with provided topics. Homework between sessions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study: Garvin</td>
<td>Setting</td>
<td>Participant Recruitment</td>
<td>Primary outcome, main findings,</td>
<td>Comment</td>
<td></td>
<td></td>
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<tr>
<td>-------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Self-help intervention investigated</td>
<td>Telephone based self-help using a book</td>
<td>Overcoming Binge Eating</td>
<td>Four themes identified relating to participants experience of programme</td>
<td>Small qualitative study. Quantitative results reported in previous paper 103</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medium</strong></td>
<td><strong>Describe</strong></td>
<td><strong>Theory</strong></td>
<td><strong>Guided or unguided</strong></td>
<td><strong>1. Decrease isolation and increase support</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone based self-help using a book</td>
<td>Volunteers from community who met diagnostic criteria DSM-IV for BED</td>
<td>CBT</td>
<td>Telephone call from lay therapist, 30 mins per call</td>
<td><strong>2. Increase knowledge</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overcoming Binge Eating</td>
<td></td>
<td></td>
<td></td>
<td><strong>3. Broaden coping skills</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>4. Improve self esteem</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Paper suggests that evaluation of self-help for the treatment of eating disorders should examine outcomes specific to the goals of minimal interventions eg. Help seeking behaviour.
<table>
<thead>
<tr>
<th>Study: Wells</th>
<th>Setting</th>
<th>Participants</th>
<th>Recruitment</th>
<th>Description</th>
<th>Primary outcome, main findings,</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-help intervention investigated</td>
<td>Telephone based self-help using a book</td>
<td>Volunteers from community who met diagnostic criteria DSM-IV for BED</td>
<td></td>
<td></td>
<td>Pre-post analysis of BMI - no change</td>
<td>6/7 participants rated the telephone support as very helpful.</td>
</tr>
<tr>
<td>Medium</td>
<td>Overcoming Binge Eating</td>
<td></td>
<td></td>
<td></td>
<td>Pre-post analysis of binge-frequency - significant reduction from 11.57 (SD 5.74) to 5.71 (SD 7.37).</td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td>12w</td>
<td></td>
<td></td>
<td></td>
<td>3/7 participants were completely binge-free at 12 weeks</td>
<td></td>
</tr>
<tr>
<td>Theory</td>
<td>CBT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guided or unguided</td>
<td>Phone call from lay therapist. 60 mins per call. Pt had to complete logs daily, weekly summary sheets &amp; follow manual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study: Bara-Carri</td>
<td>Setting</td>
<td>Participants</td>
<td>Recruitment</td>
<td>Main Outcome, Key Findings,</td>
<td>Comment</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>---------</td>
<td>--------------</td>
<td>-------------</td>
<td>-----------------------------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td><strong>Self-help intervention investigated</strong></td>
<td>Multi-media package including CD-ROM, workbooks and audio-tape</td>
<td>Consecutive series of patients with bulimia nervosa recruited from a secondary care specialist eating disorder service</td>
<td>47/60 took up the intervention, 2 further were withdrawn, 39/45 were followed up at 16 weeks. 19/45 completed all 8 sessions. The proportion of patients below DSH-IV threshold for bingeing rose from 18% at pre-treatment to 36% at follow-up, and for vomiting from 30% to 69% respectively.</td>
<td>Patients accessed the CD-ROM treatment in the clinic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medium</strong></td>
<td>Medium</td>
<td>Multi-media package including CD-ROM, workbooks and audio-tape</td>
<td>Multi-media package including CD-ROM, workbooks and audio-tape</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Theory</strong></td>
<td>Theory</td>
<td>CBT</td>
<td>CBT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Guided or unguided</strong></td>
<td>Guided or unguided</td>
<td>Unguided</td>
<td>Unguided</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER FOUR: CLASSIFICATION OF SELF-HELP INTERVENTIONS

4.1 Introduction

Chapters Two and Three have reported the results of our searches of the scientific literature. In addition to the self-help materials that have been subject to more formal evaluation, we also wished to identify those self-help materials that are currently being used irrespective of any evaluation. We therefore carried out a search of some selected voluntary organisations’ websites, publishers’ lists recommended by a panel of experts, local bookstores best-selling publications and finally the Amazon.co.uk website. The purpose of this search was to investigate the types of self-help materials which were more likely to be purchased and used by individual users and to determine which were the most popular. Self-help materials for depression, anxiety, eating disorders, bipolar disorder and schizophrenia, have thus been identified by three different but complementary approaches.

In this section, all the materials that have been identified so far in the report will be brought together and classified. For each psychiatric disorder, the self-help materials will be described. The mode of presentation, whether written, audiovisual or computer based will be noted, as well as whether the material provides structured tasks to engage the user. If the intention of these materials is to engage the reader in activities which can be monitored in some way, then a workbook format, which mirrors educational approaches may be more effective. The description of the intervention will include its appearance, its Flesch score (a measure of reading difficulty) if available, the legibility of its font size, the proportion of text to illustration and the presence of worksheets to be completed by the reader.

We will also indicate the level of evidence for the intervention. We will indicate whether the materials have been included in a systematic review or in any of the more recent randomised controlled trial or observational studies we identified. We will also provide a measure of its “popularity” as judged by its appearance on voluntary organisations’ publications lists, amongst the best selling publications of bookstores or on the Amazon website as a “bestseller”.

4.2 Search Strategy

4.2.1 Voluntary Organisations

We identified seven voluntary groups through asking the practitioners and users represented on the project Steering Group (table 4.1). All of these groups had websites and publication lists. Where there were a large number of publications on the list, the organizations were contacted to establish which materials were most popular. Some of the organizations produced information leaflets. These were excluded and only the materials which explicitly met our criteria for self-help interventions were included.

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression Alliance</td>
<td><a href="http://www.depressionalliance.org">http://www.depressionalliance.org</a></td>
</tr>
<tr>
<td>Eating Disorders Association</td>
<td><a href="http://www.edauk.com">http://www.edauk.com</a></td>
</tr>
<tr>
<td>Hearing Voices Network</td>
<td><a href="http://www.hearing-voices.org.uk">http://www.hearing-voices.org.uk</a></td>
</tr>
<tr>
<td>Manic Depression Fellowship</td>
<td><a href="http://www.mdf.org.uk">http://www.mdf.org.uk</a></td>
</tr>
<tr>
<td>Mental Health Foundation</td>
<td><a href="http://www.mentalhealth.org.uk">http://www.mentalhealth.org.uk</a></td>
</tr>
<tr>
<td>MIND</td>
<td><a href="http://www.mind.org.uk">http://www.mind.org.uk</a></td>
</tr>
<tr>
<td>Triumph Over Phobia</td>
<td><a href="http://www.triumphoverphobia.com">http://www.triumphoverphobia.com</a></td>
</tr>
</tbody>
</table>
4.23 Publisher’s Lists

Two publishing houses were identified by the Steering Group to contact, Sheldon Press and Constable & Robinson. Constable and Robinson produce the Overcoming ... series of books, written by clinicians, based upon CBT and likely to meet our criteria for self-help material. Both publishers were contacted and produced a list of relevant publications.

In addition, the Amazon.co.uk website was searched for each condition, entering the condition name and self-help, for example depression and self-help. The results were then sorted using the “bestseller” option, though we have doubts about the validity of this option in selecting the best selling books.

We attempted to obtain national data on best-selling self-help books but this proved prohibitively expensive. We therefore asked two local high street bookshops in Bristol (Waterstone’s and Blackwells) to produce a list of their bestsellers under the heading “popular psychology” for the period June 2001-June 2002. This was the category most likely to include self-help materials for the conditions in which we were interested. The publications were then screened so that only those that fulfilled our definition of self-help were included.

4.24 Other search strategies

We also asked a panel of experts their views on materials most recommended to patients, and we also referred to a survey of self-help materials most frequently recommended by therapists. 106

4.3 Results

4.31 Popular self-help books

Table 4.2 presents the list of self-help materials, type and source, excluding materials which have been empirically evaluated and have already been discussed previously. Where there were a number of books presented, the top ten were chosen. It was not possible to assess the validity of these figures as indicative of bestsellers nationally.

Nine books were identified for depression. Of these, Climbing Out of Depression 107, and Gilbert’s Overcoming Depression 108, were identified via voluntary organisations’ websites and high street bookstores or Amazon, giving an indication that these might be the materials most commonly accessed by sufferers of depression. Gilbert’s Overcoming Depression 108 also featured on the top ten list of therapists, indicating its popularity with users and professionals. Mind Over Mood 109 sold well in one of the local bookstores but was also the most popular book with therapists 28.

Five books and one audio cassette were identified for anxiety. Three of these feature on MIND’s website. Two books were identified for OCD, one through Amazon and one through one of the publishers. Five books were identified for panic. Of these, Overcoming Panic 110, was mentioned on the MIND website, was an Amazon “bestseller” and is one of a series run by the publishers advocating a CBT based approach.

Five books were identified for eating disorders. Of these, three are for anorexia nervosa, one for bulimia nervosa and binge eating disorder combined and one for bulimia nervosa. Bulimia Nervosa: a CBT programme, 111, has only recently been published but appears on the Amazon list. Overcoming Anorexia Nervosa: a self-help guide using CBT, 112, features on the Eating Disorders association website, Amazon and is one of a range of CBT based approaches published by Constable & Robinson.
Of the three books identified for bipolar disorder, *Inside Out* features on two voluntary organisations’ websites. For schizophrenia, *Accepting Voices and Hearing Voices* were mentioned on the MIND website.

### TABLE 4.2 – POPULAR SELF-HELP MATERIALS BY PSYCHIATRIC DISORDER

#### Depression

<table>
<thead>
<tr>
<th>Self-help Material</th>
<th>Type</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Climbing Out of Depression - a practical guide for sufferers, S. Atkinson</td>
<td>Book</td>
<td>MIND*, Depression Alliance, Amazon</td>
</tr>
<tr>
<td>Overcoming Depression, P. Gilbert</td>
<td>Book</td>
<td>Blackwells bestsellers, Waterstone's top 50, Depression Alliance</td>
</tr>
<tr>
<td>Overcoming Depression, R. Gillett</td>
<td>Book</td>
<td>Manic Depression Fellowship, MIND*</td>
</tr>
<tr>
<td>Mind Over Mood, D. Greenberger</td>
<td>Book</td>
<td>Blackwells bestseller, Experts list*</td>
</tr>
<tr>
<td>Depression, D. Rowe</td>
<td>Book</td>
<td>Depression Alliance*, Eating Disorders Association</td>
</tr>
<tr>
<td>Trickett S. Coping with Anxiety &amp; Depression, S. Trickett</td>
<td>Book</td>
<td>Sheldon Press Bestseller</td>
</tr>
<tr>
<td>Overcoming depression &amp; MD - a whole person approach, P Wider</td>
<td>Book</td>
<td>Amazon</td>
</tr>
<tr>
<td>Luciani Self coaching how to heal anxiety &amp; depression, J. Luciani</td>
<td>Book</td>
<td>Amazon (can also download)</td>
</tr>
</tbody>
</table>

#### Anxiety

<table>
<thead>
<tr>
<th>Self-help Material</th>
<th>Type</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overcoming Social Anxiety and shyness: a self-help guide using CBT, G. Butler</td>
<td>Book</td>
<td>MIND*, Amazon</td>
</tr>
<tr>
<td>Learn to relax, M. George</td>
<td>Book, cassette</td>
<td>MIND*</td>
</tr>
<tr>
<td>Overcoming Anxiety, H. Kinnerley</td>
<td>Book</td>
<td>MIND*, Amazon</td>
</tr>
<tr>
<td>Painfully shy: how to overcome social anxiety, B. Markaway</td>
<td>Book</td>
<td>Amazon</td>
</tr>
<tr>
<td>Triumph over shyness: conquering shyness &amp; social anxiety, M. Stein</td>
<td>Book</td>
<td>Amazon</td>
</tr>
<tr>
<td>Pass through Panic - freeing yourself from anxiety &amp; Fear, C. Weeke</td>
<td>Audiotape</td>
<td>Amazon</td>
</tr>
</tbody>
</table>

#### Obsessive Compulsive Disorder

<table>
<thead>
<tr>
<th>Self-help Material</th>
<th>Type</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why Does everything have to be perfect? Understanding OCD, L. Sackman</td>
<td>Book</td>
<td>Amazon</td>
</tr>
<tr>
<td>Understanding Obsessions and Compulsions, F. Tallis</td>
<td>Book</td>
<td>Sheldon Press</td>
</tr>
</tbody>
</table>

#### Panic

<table>
<thead>
<tr>
<th>Self-help Material</th>
<th>Type</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting Control, L. Baer</td>
<td>Book</td>
<td>Triumph over Phobia (ToP)</td>
</tr>
<tr>
<td>Overcoming Panic, D. Silove</td>
<td>Book</td>
<td>MIND*, Amazon</td>
</tr>
<tr>
<td>The Panic Book, N. Phillips</td>
<td>Book</td>
<td>Triumph over Phobia (ToP)</td>
</tr>
<tr>
<td>Coping Successfully with panic attacks, S. Trickett</td>
<td>Book</td>
<td>Sheldon Press</td>
</tr>
<tr>
<td>Living with Fear, I. Marks</td>
<td>Book</td>
<td>Mental Health Foundation, ToP, Waterstone's top 50</td>
</tr>
</tbody>
</table>

#### Eating Disorders

<table>
<thead>
<tr>
<th>Self-help Material</th>
<th>Type</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorexia Nervosa: your questions answered, J. Buckroyd</td>
<td>Book</td>
<td>Mental Health Foundation, Amazon</td>
</tr>
<tr>
<td>Bulimia Nervosa &amp; Binge Eating Disorder - a guide to recovery, P. Cooper</td>
<td>Book</td>
<td>Eating Disorders Association, Mental Health Foundation</td>
</tr>
<tr>
<td>Bulimia Nervosa: a CBT Programme for Clients, M. Cooper</td>
<td>Book</td>
<td>Amazon</td>
</tr>
<tr>
<td>Anorexia - the wish to change, A.H.Crisp</td>
<td>Book</td>
<td>Eating Disorders Association (EDA)</td>
</tr>
<tr>
<td>Overcoming Anorexia Nervosa - a self-help guide using CBT, C. Freeman</td>
<td>Book</td>
<td>EDA, Amazon, publisher’s recommendation</td>
</tr>
</tbody>
</table>

#### Bipolar Disorder

<table>
<thead>
<tr>
<th>Self-help Material</th>
<th>Type</th>
<th>Source</th>
</tr>
</thead>
</table>
4.32 Self-help materials that have been evaluated

Table 4.3 presents the materials which have been identified from our search of the scientific literature and have been subject to empirical evaluation. We also indicate which materials were also identified during the search of voluntary groups and publishers’ lists.

For depression, *Feeling Good* \(^{122}\) has been evaluated in three systematic reviews \(^{37;38;55}\) and two subsequent RCTs \(^{66;75}\) we identified. This book is also recommended by therapists but does not appear on any of the voluntary organizations websites nor on any of our other lists. This is possibly indicative of its American origins. The same is likely for *Control Your Depression* \(^{123}\) which has also been included in the same three reviews but not subsequently subjected to more recent trials and not recommended in the UK.

One book, *Managing Depression & Anxiety* \(^{124}\) was included in one systematic review \(^{54}\) and also appears on the Mental Health Foundation website, possibly reflecting its UK origins. The audiocassette *Coping with Depression* sponsored by the Royal College of General Practitioners and Royal College of Psychiatrists \(^{125}\) has not been evaluated in randomised controlled studies.

*Beating the Blues* produced by Ultrasis, has been subjected to systematic review \(^{126}\) and is mentioned on the Mental Health Foundation website. This programme is currently being marketed for use in primary care.

For anxiety, *Stresspac* is offered in two formats, a manual and a computerized version. Both have been included in systematic reviews \(^{54;127}\). *Coping with Panic* \(^{71}\) is another American self-help intervention which has been extensively reviewed \(^{37;67;68;70}\) but does not appear on any of the UK voluntary organizations websites nor bestseller lists.

For bulimia nervosa (*Getting Better Bit(e) by Bit(e)* \(^{128}\) and binge eating, (*Overcoming Binge Eating*, \(^{82}\) ) have been included in one systematic review \(^{56}\). The latter has also been evaluated in bulimia nervosa in one recently completed randomized controlled study RCT \(^{81}\). Both of these are also to be found on the websites of the Eating Disorders Association and Mental Health Foundation, and *Getting Better, Bit(e) by Bit(e)* features on the top ten list of CBT therapists. A multi media CD-ROM treatment (*Overcoming bulimia: a self-help package* \(^{90}\) has been piloted in bulimia nervosa in one observational study \(^{89}\).

No materials for either bipolar disorder or schizophrenia have been empirically evaluated.

<table>
<thead>
<tr>
<th>Schizophrenia</th>
<th>Self-help Material</th>
<th>Type</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepting Voices, M. Romm</td>
<td>Book</td>
<td>MIND*</td>
<td></td>
</tr>
<tr>
<td>Hearing voices: a common human experience, J. Watkins</td>
<td>Book</td>
<td>MIND</td>
<td></td>
</tr>
<tr>
<td>Zucker Goldstein Family Involvement in the treatment of schizophrenia</td>
<td>Book</td>
<td>Manic Depression Fellowship, MIND*</td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 4.3 – AVAILABLE SELF-HELP MATERIALS EMPIRICALLY TESTED BY CONDITION**
### Depression

<table>
<thead>
<tr>
<th>Self-help Material</th>
<th>Type</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beating the Blues, Ultrasis</td>
<td>Computer based CBT</td>
<td>Systematic review (Kaltenhaler et al), MHF website</td>
</tr>
<tr>
<td>COPE (ST Solutions)</td>
<td>Computer based CBT</td>
<td>Systematic review (Kaltenhaler et al),</td>
</tr>
<tr>
<td>Overcoming Depression, (CALIPSO, Leeds Innovations)</td>
<td>CD-ROM package</td>
<td>Systematic review (Kaltenhaler et al),</td>
</tr>
<tr>
<td>Feeling Good, David Burns</td>
<td>Book</td>
<td>Systematic review (Gould et al; Marrs; Cuijpers). RCT (Jamison; Bowman) Recommended by therapists</td>
</tr>
<tr>
<td>Control your depression, Lewinsohn</td>
<td>Book</td>
<td>Systematic review (Gould et al; Marrs; Cuijpers).</td>
</tr>
<tr>
<td>Coping with depression, RCGP/RCP</td>
<td>Audio</td>
<td>Observational study (Blenkiron)</td>
</tr>
<tr>
<td>Managing Depression &amp; Anxiety, N. Holdsworth</td>
<td>Book</td>
<td>Systematic review (Bower et al) also on MHF website</td>
</tr>
</tbody>
</table>

### Anxiety

<table>
<thead>
<tr>
<th>Self-help Material</th>
<th>Type</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stresspac, J. White</td>
<td>Manual &amp; multimedia</td>
<td>54,129</td>
</tr>
</tbody>
</table>

### Panic

<table>
<thead>
<tr>
<th>Self-help Material</th>
<th>Type</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coping with Panic, G. Clum</td>
<td>Book</td>
<td>37,342/358,70</td>
</tr>
<tr>
<td>FearFighter</td>
<td>Computerised CBT. Internet version being piloted</td>
<td>130</td>
</tr>
</tbody>
</table>

### Eating Disorders

<table>
<thead>
<tr>
<th>Self-help Material</th>
<th>Type</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overcoming Binge Eating, C. Fairburn</td>
<td>Book</td>
<td>Hay56, also on Eating Disorders Association (EDA) and Mental Health Foundation (MHF) website</td>
</tr>
<tr>
<td>Getting better bit(e) by Bit(e), U. Schmidt</td>
<td>Book</td>
<td>Hay56 also on EDA and MHF website Recommended by therapists</td>
</tr>
<tr>
<td>Overcoming Bulimia</td>
<td>Computer</td>
<td>89</td>
</tr>
</tbody>
</table>

### 4.4 Classification of self-help materials by condition

This section collates the information from the previous tables and describes the nature of the self-help intervention.

#### 4.4.1 Depression

Table 4.4 summarises the self-help interventions identified for depression. Three books are identified which give specific instructions for tasks and contain a large number of questionnaires and forms for the reader to complete. All use a CBT model. Both *Mind Over Mood* and Williams *Overcoming Depression: a five areas approach* are A4 size, with a large number of worksheets and activities for the reader to engage in. Only one of the three, *Coping With Depression*, has been evaluated in randomised controlled trials. *Mind over Mood* and Williams *Overcoming Depression* have accompanying notes or a training manual for the health care practitioner. Both these books also have linked training courses for health care practitioners and *Overcoming Depression* provides a series of training CD ROMs to support staff use of the materials.
Three books were identified which are also CBT based but though there is some instruction and
guidance for the reader, are primarily descriptions of the cognitive behavioural approach with some
helpful advice. The publications do contain a handful of questionnaires but the main point of the book is
in the text. Of these, *Feeling Good*, 122 has been subjected to the most research 37;38;66;75;133. However, the
reading age, as indicated by the Flesch score, is higher than *Mind Over Mood*109 and *Overcoming
Depression: a five area approach* 131 and the presentation is less in keeping with a contemporary
educational format. *Feeling Good* is still recommended frequently by therapists. There is also a more
modern version of *Feeling Good* by the same author, *The Feeling Good Handbook* 134 with more
worksheets, larger print and less dense text. Gilbert’s *Overcoming depression*, 108 is a popular book in the
UK, highly recommended by therapists yet it is one which has not been studied empirically.

Three computer programs are currently being introduced into practice in the UK and have been included
in the Kaltenhaler review 135. These use a multi media approach to engage the user in problem solving
activities. These are Beating the Blues (www.ultrosis.com, Stresspac (jim.white@glacomeng.scot.nhs.uk)
and Overcoming Depression: A Five Areas Approach (www.calipso.co.uk).

Other self-help books were identified which do not conform to a CBT model but which encourage
psychological change. None of the three books identified has been empirically evaluated despite their
apparent popularity.

One audiocassette was identified which had been tested in an observational study136. This was not readily
available for potential users.
### Table 4.4 Classification of Self-Help Materials for Depression

#### a) Written, workbook format, based on CBT

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
</table>
| **Control Your Depression, Peter M. Lewinsohn et al**  
   Revised May 1992  
   Publisher Simon & Schuster Books  
   Legibility, lines double spaced, font 11, text broken up into manageable paragraphs. Worksheets, exercises with examples. Extra worksheets in appendix, not UK A4 | **Level of evidence**  
   RCT  
   **Availability**  
   In print, has to be ordered from USA  
   **Therapist input**  
   Can be used alone or as resource for group, Instructor’s manual available. | American publication.  
   No recent evidence of effectiveness. Tested extensively by one team in America. A Coping with Depression course, designed for use in self-help groups, has been developed to support individuals working through the book. |
| **Mind over Mood**  
   Dennis Greenberger and Christine Padesky  
   Printed 1995, no revisions  
   Publisher, Guildford Press,  
   Legibility, font 12, text broken by plenty of worksheets with examples. Each chapter summarized. Extra worksheets in the appendix | **Level of evidence**  
   No trials reported  
   Recommended by therapists*  
   **Availability**  
   High Street bookstores, internet  
   **Therapist input**  
   No explicitly stated but indicates that the book is to be used in conjunction with therapy | This is one of the newer self-help books. It is larger than most of the others in this review. The worksheets are clear and readers encouraged to use them. It is designed to encourage therapists to use it as an adjunct to therapy, there is a clinician’s guide |
| **Overcoming Depression**  
   Chris Williams  
   Published 2001 by Arnold  
   Legibility, text broken by cartoons, clear headings, bullet points and instructions rather than continuous text. Ten workbooks, with a concluding section on managing depression for professionals and a section on motivation for the user. Each workbook summarized. Developed in collaboration with practitioners. Avoids traditional CBT terms. | **Level of evidence**  
   No trials reported  
   **Availability**  
   High Street bookstores, internet  
   **Therapist input**  
   Suggested that each workbook could be followed by a review of ten minutes with a health care practitioner. | Similar to Mind Over Mood but the presentation is different, with less text and it is designed to engage the reader immediately. Clear explanation of how the book can be used by the individual and professional. Accompanying notes for practitioners in the book. Training course has been developed. Training CD-ROMs for practitioners are available. Same materials as Calipso, Overcoming depression self-help CD-ROM. |

#### b) Written, some worksheets, activities for reader, based on CBT

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
</table>
| **Feeling Good - the new mood therapy, David D. Burns.**  
   Revised edition October 5th 1999, Publisher Avon Books  
   **Size -**  
   Legibility – font size 10, dense text, no illustrations.  
   Some worksheets, mostly text | **Level of evidence**  
   RCT  
   Recommended by therapists  
   **Availability**  
   High Street bookstores, internet  
   **Therapist input**  
   Potentially none | Widely cited and referred to on voluntary organisations websites. Author is American.  
   Also available, The Feeling Good Handbook by the same author. This is much more in line with contemporary self-help material, larger print size, the book is bigger, and there are more exercises to complete, with self-help assignments at the back. |
| **Overcoming Depression,** Book, 368 pages, Flesch | **Level of evidence** | This is an extremely popular |
Paul Gilbert  
Revised 2000  
Publisher, Constable & Robinson Ltd  

<table>
<thead>
<tr>
<th>Name</th>
<th>Score</th>
<th>Size</th>
<th>Legibility</th>
<th>Chapters</th>
<th>Exercises</th>
<th>Worksheets</th>
<th>Tension Chart</th>
<th>Availability</th>
<th>Therapist Input</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing Anxiety &amp; Depression Nicholas Holdsworth</td>
<td>12.8</td>
<td>-</td>
<td>Mostly text, font size 12, chapters summarized, key points and exercises. Some worksheets, with extra forms at the back of the book.</td>
<td>12 chapters</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>High Street bookstores, internet</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Booklet, 44 pages</th>
<th>Level of evidence</th>
<th>Availability</th>
<th>Therapist input</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCT</td>
<td>Mental Health Foundation</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Beating the Blues Ultrasis</th>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interactive multi-media programme designed for use in primary care setting, with practitioner assessment and progress review each week. Video, graphics and voice sequences to engage user. Eight modules completed weekly.</td>
<td>Level of Evidence</td>
<td>RCT</td>
<td>This has been tested in a RCT. The NICE report indicates that further evidence of effectiveness is not necessary. Installation in other community setting is currently being investigated</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CALIPSO (Overcoming Depression) Leeds Innovations</th>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD-ROM package developed to provide training to postgraduate health care workers in the field of mental health. Subsequently been developed for use as a form of CBT for depression</td>
<td>Level of Evidence</td>
<td>No trial reported</td>
<td>Same Material as Overcoming Depression self-help workbook.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>抑郁症 - the way out of your prison Dorothy Rowe</th>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Book, 239 pages, information, no worksheets or exercises.</td>
<td>Level of evidence</td>
<td>No trials reported, Depression Alliance*</td>
<td>Dynamic model but not CBT. Popular book, featuring on voluntary organizations websites and on local high street bookshop shelves.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>doi:10.4103/0014-0665.177102</th>
<th>Level of evidence</th>
<th>Availability</th>
<th>Therapist input</th>
</tr>
</thead>
<tbody>
<tr>
<td>No trials reported, Depression Alliance, MIND, Eating Disorders Assoc</td>
<td>High Street bookstores, internet</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No trials reported</th>
<th>Local bookshops survey*</th>
<th>Recommended by therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression Alliance</td>
<td>High Street bookstores, internet</td>
<td>None</td>
</tr>
</tbody>
</table>

| Depressive state. Some Christian influence, uses imagery to take individual through steps to get out of depressive state. | Level of evidence | No trials reported, Depression Alliance* | Some Christian influence, uses imagery to take individual through steps to get out of depressive state. |

<table>
<thead>
<tr>
<th>Level of evidence</th>
<th>Availability</th>
<th>Therapist input</th>
</tr>
</thead>
<tbody>
<tr>
<td>No trials reported</td>
<td>High Street bookstores, internet</td>
<td>None</td>
</tr>
</tbody>
</table>
Table 4.5 presents the self-help interventions identified for anxiety, panic, phobia and OCD. For these conditions, no self-help interventions written and in a workbook format were identified.

Four books were identified which engaged the reader in activities and exercises. None had been subjected to research, except Living with Fear which has been compared to computer and therapist administered behaviour therapy but not waiting list. However, even this study was not included in our review as the level of therapist intervention exceeded our criterion. Three of the books are produced by the same publishing house and are part of a range of self-help materials using a CBT approach to promote independence.

One attractively produced book, Learn to Relax uses visualization and relaxation techniques to promote psychological change. Unfortunately, we have been unable to obtain some of the self-help interventions. Of these, two are of particular interest. StressPac by Jim White of Glasgow is a manual, audiocassette or computer package for anxiety which has been investigated using a randomized controlled trial and included in the systematic review by Kaltenhaler. We are still awaiting confirmation of its availability and use. George Clum’s Coping with Panic has also been investigated in the US using randomised controlled trials, though the methodology of these was poor. The book is not readily available here in the UK.
### Table 4.4 Classification of Self-help materials for Anxiety, Panic, Phobia, OCD

**a) Written, workbook format, based on CBT**

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
</table>
| **Living with Fear**  
Isaac Marks  
Published 1978, McGraw-Hill | Book, 283 pages, Flesch score 14.1  
Font size 12, mostly text and information, final chapter self-help exercises and worksheets. | Level of evidence  
No trials reported.  
Availability  
Triumph over phobia (ToP)  
Therapist input  
None but is used by ToP in user-led self-help groups. | This book has been extensively supported and used by Triumph Over Phobia. |
| **Overcoming Anxiety: a self-help guide using CBT**  
Helen Kinnerley  
Published 1997, Constable & Robinson | Book, 170 pages, no available Flesch score.  
Font size 12, mostly text, broken by boxes which contain exercises or examples to illustrate points in the text. Final chapter for extra worksheets. | Level of evidence  
No trials reported.  
Availability  
High street bookstores, internet  
Therapist input  
None | One of range of CBT books produced by publisher. |
| **Overcoming Social Anxiety & Shyness**  
Gillian Butler  
Published 1999, Constable & Robinson | Book, 233 pages, no available Flesch score.  
Font size 12, mostly text, reader encouraged to undertake activities. Extra worksheets in appendix. | Level of evidence  
No trials reported.  
Availability  
High street bookstores, internet  
Therapist input  
None | One of range of CBT books produced by publisher. |
| **Overcoming Panic – a self-help guide using CBT**  
Derrick Silove and Vijaya Manicavasagar  
Published 1997, Constable & Robinson  
ISBN 1854877011 | Book 135 pages, no Flesch score available.  
Font size 12, text with monitoring sheets and activities, Extra monitoring sheets in the appendix | Level of evidence  
No trials reported.  
Availability  
High street bookstores, internet  
Therapist input  
None | One of range of CBT books produced by publisher. |

**b) Written, some worksheets, activities for reader, based on CBT**

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
</table>
| **Living with Fear**  
Isaac Marks  
Published 1978, McGraw-Hill | Book, 283 pages, Flesch score 14.1  
Font size 12, mostly text and information, final chapter self-help exercises and worksheets. | Level of evidence  
No trials reported.  
Availability  
Triumph over phobia (ToP)  
Therapist input  
None but is used by ToP in user-led self-help groups. | This book has been extensively supported and used by Triumph Over Phobia. |
| **Overcoming Anxiety: a self-help guide using CBT**  
Helen Kinnerley  
Published 1997, Constable & Robinson | Book, 170 pages, no available Flesch score.  
Font size 12, mostly text, broken by boxes which contain exercises or examples to illustrate points in the text. Final chapter for extra worksheets. | Level of evidence  
No trials reported.  
Availability  
High street bookstores, internet  
Therapist input  
None | One of range of CBT books produced by publisher. |
| **Overcoming Social Anxiety & Shyness**  
Gillian Butler  
Published 1999, Constable & Robinson | Book, 233 pages, no available Flesch score.  
Font size 12, mostly text, reader encouraged to undertake activities. Extra worksheets in appendix. | Level of evidence  
No trials reported.  
Availability  
High street bookstores, internet  
Therapist input  
None | One of range of CBT books produced by publisher. |
| **Overcoming Panic – a self-help guide using CBT**  
Derrick Silove and Vijaya Manicavasagar  
Published 1997, Constable & Robinson  
ISBN 1854877011 | Book 135 pages, no Flesch score available.  
Font size 12, text with monitoring sheets and activities, Extra monitoring sheets in the appendix | Level of evidence  
No trials reported.  
Availability  
High street bookstores, internet  
Therapist input  
None | One of range of CBT books produced by publisher. |

**c) Computer or multi media, based on CBT**

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
</table>
| **Learn to Relax**  
Mike George  
Published 1998, Duncan Baird  
Legibility, font size 10, text broken by pictures, etchings and spiritual quotes. Encourages reader to | Level of evidence  
No trials reported.  
Availability  
MIND  
Therapist input  
None | This book would appeal to a particular audience who were used to undertaking forms of relaxation exercises. Also available in cassette form. |

**d) Written, encourages psychological change, activities for reader.**

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
</table>
| **Learn to Relax**  
Mike George  
Published 1998, Duncan Baird  
Legibility, font size 10, text broken by pictures, etchings and spiritual quotes. Encourages reader to | Level of evidence  
No trials reported.  
Availability  
MIND  
Therapist input  
None | This book would appeal to a particular audience who were used to undertaking forms of relaxation exercises. Also available in cassette form. |
undertake activities, creative visualization.

e) **Audiocassette**

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

f) **Awaiting Final Classification**

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Painfully shy: how to overcome social anxiety</td>
<td>Book, 265 pages</td>
<td>Amazon bestseller</td>
<td></td>
</tr>
<tr>
<td>Triumph Over Shyness: conquering shyness &amp; social anxiety</td>
<td>Book, American, also available as an e book to download from Amazon. Synopsis from Amazon. Offers information on where &amp; how to seek professional help. Presents pointers to reader to overcome phobia e.g. positive self-talk.</td>
<td>Amazon bestseller</td>
<td></td>
</tr>
<tr>
<td>Pass through panic – freeing yourself from anxiety &amp; fear</td>
<td>Audiocassette, American. Synopsis from Amazon A recording of an eight-part radio programme originally broadcast in 1967, addresses panic disorders, depression &amp; agoraphobia</td>
<td>Amazon bestseller</td>
<td></td>
</tr>
<tr>
<td>Stresspac</td>
<td>Manual &amp; audiocassette or computer package.</td>
<td>Systematic review141</td>
<td></td>
</tr>
<tr>
<td>Getting Control</td>
<td>Book, American, hard to get hold of</td>
<td>Triumph over phobia</td>
<td></td>
</tr>
<tr>
<td>Coping with Panic</td>
<td>Book, American, hard to get hold of</td>
<td>Systematic review67 RCT 67;68;70</td>
<td></td>
</tr>
<tr>
<td>The Panic Book</td>
<td>Book</td>
<td>Triumph over phobia</td>
<td></td>
</tr>
<tr>
<td>Coping Successfully with Panic Attacks</td>
<td>Book</td>
<td>Sheldon press</td>
<td></td>
</tr>
<tr>
<td>FearFighter</td>
<td>Computer package</td>
<td>Systematic review141</td>
<td></td>
</tr>
<tr>
<td>BT STEPS</td>
<td>Voice Interactive computer programme</td>
<td>Mental Health Foundation, Triumph over Phobia</td>
<td>Addresses Obsessive Compulsive Disorder</td>
</tr>
<tr>
<td>Why Does Everything Have to be perfect</td>
<td>Book</td>
<td>Amazon bestseller</td>
<td></td>
</tr>
<tr>
<td>Understanding obsessions and Compulsions</td>
<td>Book</td>
<td>Sheldon Press</td>
<td></td>
</tr>
<tr>
<td>FearFighter</td>
<td>Computer based self exposure therapy</td>
<td>Systematic review142</td>
<td></td>
</tr>
</tbody>
</table>
4.43 Eating Disorders

Two books were identified which conform to a workbook format and are therefore likely to encourage the reader to engage in the activities. *Bulimia Nervosa – a CBT programme for clients*[^11] has recently been published and is yet to be evaluated. *Anorexia Nervosa: the wish to change*[^121] was mentioned on the Eating Disorders Association website.

Four books were identified which used a CBT approach and gave practical advice for the reader to use. Of these, *Getting better Bite by Bite and Overcoming Binge Eating*[^82] have been included in the systematic review by Hay[^56]. The latter has also been evaluated in one recent randomised controlled trial[^81]. These interventions are also identified on two voluntary organisations’ websites, the Eating Disorders Association and the Mental Health Foundation and are readily available at bookstores and on the internet.

A new computer based package for Bulimia Nervosa has recently been developed[^89] but we came across no other computer based interventions. Two interventions were identified which encourage psychological change, but both of these books appear to provide more information than encourage the reader to undertake activities.

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
</table>
| **Bulimia Nervosa – a cognitive therapy programme for clients**  
*Myra Cooper et al*  
Published 2000, *Jessica Kingsley Ltd*  
Book, 244 pages, no Flesch score available.  
Font size 12, text with worksheets, activities and examples. | **Level of evidence**  
Amazon  
**Availability**  
High Street bookstores, internet  
**Therapist input**  
None or in conjunction with therapy | This book has only been recently published and not evaluated in trials.  
Follows patterns of contemporary self-help materials, with educational format. |
| **Anorexia Nervosa – the wish to change**  
*A.H. Crisp et al*  
Book, 89 pages, no Flesch score available.  
Font size 12, text with exercises and monitoring sheets. Short chapters, bullet points, cartoons | **Level of evidence**  
Voluntary organization website Eating Disorders Assoc  
**Availability**  
High Street bookstores, internet  
**Therapist input**  
None | A workbook, with educational format. |

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
</table>
| **Overcoming Binge Eating**  
*Christopher Fairburn*  
1995, published by *Guildford Press*  
ISBN 089862961  
Book, 204, Flesch score unavailable.  
Font size 12, mostly text, broken by diagrams. Part 1 mainly information, part 2, the self-help program. Contains monitoring sheets | **Level of evidence**  
RCT  
Voluntary organization website Eating Disorders Assoc, (EDA)  
**Available**  
High Street bookstores, internet | Classical CBT, highly structured.  
Evaluated for use in the treatment of bulimia nervosa and binge eating disorder |
<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
</table>
| **Overcoming Bulimia Williams et al**  
Leeds Innovations  
[www.calipso.co.uk](http://www.calipso.co.uk) | Computer CD ROM. Eight sessions, each lasting approximately 45 minutes | Level of evidence  
Expert recommendation | Recent open study completed at eating disorders centers in London & Leicester show promising take-up, drop out and clinical improvement with reduced vomiting & binging.  
High user acceptability. |
| **Anorexia Nervosa – a survival guide for families, friends and sufferers. Janet Treasure**  
Published 1997, Psychology Press.  
This book is aimed at sufferers, their families, carers and has sections for each. The section for the anorexic provides information, with some guidance for self-help strategies. | Level of evidence  
Open Study | Although this book has self-help section, it is mostly used with therapy |
| **Anorexia Bulimia Julia Buckroyd**  
Font size12. Mostly text and | Level of evidence  
first published 1996. information with short section on self-help strategies where to access professional help.

e) Audiocassette

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
</table>

f) Awaiting Final Classification

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
</table>

How to Cope with Bulimia J Gomez

4.44 Bipolar Disorders

Two publications were identified. *Overcoming Mood Swings* written by Jan Scott, an expert in mood disorders and focuses on self-monitoring and self-management plans. *Inside Out* is a small booklet published by the Manic Depressive Fellowship which encourages the reader to self-monitor and recognize extremes of mood. It appears on the MIND list.

4.45 Schizophrenia

There were no self-help interventions identified which were based on CBT in workbook format, with worksheets or computer or multimedia packages. One book was identified which promoted psychological change but the majority of the text was information giving only.

<table>
<thead>
<tr>
<th>Table 4.6 Classification of self-help materials for Bipolar Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a) Written, workbook format, based on CBT</strong></td>
</tr>
<tr>
<td><strong>Self-help material</strong></td>
</tr>
<tr>
<td>Description of intervention</td>
</tr>
<tr>
<td>Rating</td>
</tr>
<tr>
<td>Comment</td>
</tr>
</tbody>
</table>

| **b) Written, some worksheets, activities for reader, based on CBT** |
| **Self-help material**                                      |
| Description of intervention                                |
| Rating                                                      |
| Comment                                                     |

| **c) Computer or multi media, based on CBT**                |
| **Self-help material**                                      |
| Description of intervention                                |
| Rating                                                      |
| Comment                                                     |
**Inside Out Manic Depression Fellowship**
No available trials reported. **Availability**
MIND
**Therapist input**
None
This short booklet provides reader with information and some activities to encourage self-monitoring and management, but no depth or detail.

**d) Written, encourages psychological change, activities for reader.**

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
</table>

**e) Audiocassette**

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
</table>

**f) Awaiting Final Classification**

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living without depression &amp; Manic Depression: a workbook for maintaining mood stability ME Copeland</td>
<td>Book</td>
<td>Amazon</td>
<td></td>
</tr>
<tr>
<td>Living with Depression &amp; manic Depression: self-help strategies Mary Ellen Copeland</td>
<td>Audio cassette</td>
<td>Amazon</td>
<td></td>
</tr>
<tr>
<td>New Hope for people with Bipolar Disorder Jan Fawcett</td>
<td>Book, 342 pages. Synopsis from Amazon. This book uses a dimensional approach to expel the myths &amp; fears surrounding this illness. It also discusses treatment options and offers compassionate and insightful suggestions.</td>
<td>Amazon</td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 4.7 CLASSIFICATION OF SELF-HELP MATERIALS FOR SCHIZOPHRENIA

**a) Written, workbook format, based on CBT**

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**b) Written, some worksheets, activities for reader, based on CBT**

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**c) Computer or multimedia, based on CBT**

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**d) Written, encourages psychological change, activities for reader.**

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
</table>
| Hearing Voices: a common human experience  
John Watkins  
Published 1998, Hill of Content.  
Font size 12, mostly text and information. Outlines some strategies for coping with voices. | Level of evidence No trials reported. Recommended by MIND Availability MIND Therapist input None | Not based on CBT, mostly information. |
|                   |                             |        |         |
| e) Audiocassette  |                             |        |         |

**f) Awaiting Final Classification**

<table>
<thead>
<tr>
<th>Self-help material</th>
<th>Description of intervention</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 4.5 Discussion

We found a wide range of self-help materials for most of the psychiatric disorders we included though often there was little scientific work to investigate their effectiveness.
Self-help interventions for depression and anxiety have been investigated for a number of years, though as discussed above the evidence to support their use is still rather weak. Self-help in eating disorders is a relatively recent development but there is increasing research in this area now. There is less available for the more severe disorders, but even here there are also signs of an increasing production of self-help materials for people with bipolar disorder and schizophrenia.

Self-help materials take on a variety of styles and formats and have varying production values. The most recent innovation are the computer based programs. There has also been a change towards a more interactive, educational format, though the newer books have not been evaluated. The newer self-help books are well produced but we considered that there is an opportunity for publishers to use illustrations and better design to make them more attractive to members of the public.

There were a number of instances where self-help materials that had been investigated using randomised controlled trials were not available here in the UK. In part this might have been because the self-help intervention had been developed in the US. But there has also been a trend in the past for individual investigators to develop their own self-help materials without the assistance of a publisher or other organisation that would enable them to be easily available to members of the public.

We also identified a number of apparently popular self-help books that were not based upon the CBT model. These books had not been evaluated but they are potentially helpful. By improving understanding and insight, such books could be a useful form of self-help. Investigating other psychological models in a self-help format may be of value.
CHAPTER FIVE DISCUSSION

5.1 Summary of findings

Self-help interventions have been developed and investigated over the past 20 yrs. Much of the research has been performed in the USA but there is also some more recent work carried out in other Western countries. Despite the quantity of research performed, most of the studies that have been identified were severely limited and poorly executed. Though it is common for systematic reviews to identify weaknesses in the literature, the studies we have identified are weak even by that benchmark. It is also striking that a relatively limited range of interventions have been studied.

The weaknesses of the literature are as follows:

1. Small size of trials leading to an increased possibility of publication bias, unsuccessful randomisation and wide confidence intervals.
2. Poor reporting quality of trials and inappropriate analysis. Hardly any studies met the CONSORT criteria for reporting randomised trials. Many of the conclusions made by authors and reviewers are of dubious statistical validity.
3. Many studies have not studied clinical populations. For example, it may be impossible to generalise from studies in a student population to the NHS context. Students are familiar with the idea of independent study and self-help approaches may be much less acceptable and have poorer adherence in NHS clinical populations.
4. There have been relatively few independent evaluations of self-help materials. Most materials have been directly evaluated by those who devised them.
5. The interventions were almost all based on cognitive behavioural therapy for anxiety, depression, bulimia nervosa or binge eating disorder. There is little or no empirical data on which components of the self-help intervention might help patients and whether the cognitive, behavioural or any other elements are critical.
6. The degree of additional guidance from a health care practitioner that might be necessary for any clinical benefit has not been established in the existing literature. Almost all the current trials have included some guidance, often from the team involved in developing the self-help materials.
7. There has been no systematic investigation of the possibility that self-help materials might be harmful when used outside a clinically supervised context.
8. The economic implications of a widespread adoption of self-help materials has not been studied.
9. There has been little empirical study of the clinical or sociodemographic characteristics that might be associated with a good response to a self-help approach.

Given these weaknesses it is important to summarise what conclusions can safely be drawn. Firstly, that most studies have reported a significant benefit of self-help materials, based upon a CBT approach, for depression, anxiety, bulimia nervosa and binge eating disorders when given in the context of a clinical assessment and some
degree of monitoring. Much of the monitoring has been as a result of the research protocol but might be a critical element of the intervention.

What is less certain is whether this evidence is of sufficient rigor to recommend the use of self-help materials. The possibility of harm has not been empirically studied and is probably relatively remote as long as the patient is still given the opportunity to pursue other therapeutic options if the self-help approach proves unsuccessful. Given the weakness of the evidence it is probably wise to only recommend self-help materials when given in a clinically supervised context and when alternative therapeutic options will be recommended if self-help proves unacceptable or ineffective.

The final observation concerns the absence of any evidence in a number of areas. We could not find any empirical study of self-help interventions for schizophrenia and bipolar disorder or anorexia nervosa. Likewise, the use of self-help groups to deliver self-help materials has not been studied. We have noted that self-help materials that are not based upon CBT have not been formally evaluated, despite widespread sales and anecdotal evidence suggesting that some patients find them useful. Finally, there has been little investigation of the likely economic costs or benefits of using self-help materials.

5.2 Methodological Limitations & Strengths of the Review

5.2.1 Search Strategy and identifying relevant literature

We have adopted a pragmatic approach towards searching the literature for studies on self-help materials. We were aware of previous systematic reviews and so decided our first step would be to carry out a systematic review of the existing systematic reviews. In effect we have relied upon the search strategy adopted by the 7 reviews we identified. Some of the older reviews had poor search strategies, and the three oldest only searched databases with a North American bias. It is possible therefore that some of the older especially European literature might not have been detected. However, we do not think this has introduced an important bias though it might have contributed to some publication bias in those reviews as well as our own.

Following the systematic review of systematic reviews we then carried out a focused literature search in a few key areas: recent articles since 1990 for depression, anxiety and eating disorders, schizophrenia and bipolar disorder and self-help groups. We also tried to identify any studies adopting a qualitative methodology in this area. Once relevant studies had been identified we have summarised the studies but were unable to perform any quantitative summary of the findings. This was a limitation largely imposed by the variability and quality of the reporting in the constituent studies. Our search strategy was probably less effective at identifying observational studies and qualitative work. Nevertheless we think it unlikely there are any major omissions.

Despite these limitations we have carried out thorough literature searches and adopted a reliable method of identification. The abstracts were checked by two people and data extractions was performed independently by two people and any disagreements resolved by discussion. We have therefore incorporated almost all the relevant literature in this review. We can be confident that any single large RCT as not been omitted.
We chose to restrict our search to a limited number of psychiatric disorders. Other conditions may have had some useful self-help approaches which we would not have identified using our search strategy. For example, post-traumatic stress disorder can be treated using cognitive behavioural techniques. Self-help might also have been studied in victims of early trauma and those who repeatedly self-harm.

5.22 Systematic review of systematic reviews

We have conducted a thorough search for systematic reviews and have included all those that we think are currently available. We know of two ongoing systematic reviews; of bibliotherapy for depression and computerised CBT for depression and anxiety (NEAL) being carried out under the auspices of the Cochrane Collaboration Depression, Anxiety and Neurosis group. One might suppose that problems such as publication bias would be less of a problem when reviewing systematic reviews.

The results of the systematic reviews were not presented in a way that enabled us to perform a quantitative synthesis. The early systematic reviews were poor from a modern perspective and gave few details about the constituent studies. More recently, focused reviews with improved methodology have been performed with a more relevant aim. The Bower et al review was restricted to studies that recruited within a primary care setting, though it could be criticised for summarising studies with possibly diverse diagnostic groups, including chronic fatigue. Their conclusion that further research is needed within UK primary care seemed well supported.

We chose the comparison between self-help and “treatment as usual” as the most important question to address. The reviews often included other comparisons and in particular comparisons with more intensive treatment. We chose the comparison with Treatment as usual on the grounds that most of these self-help treatments seem appropriate for use in primary care or where specialist psychotherapies are either unavailable or subject to a long wait.

The systematic reviews almost all concentrated on clinical outcomes. Only the Kaltenhaeler review included a section on the economic consequences of computerised CBT. This analysis was based primarily upon empirical data from the as yet unpublished Proudfoot et al study on Beating the Blues.

5.23 RCTs and observational studies

We identified a number of more recent studies but on balance, these did not appear to address any of the deficiencies identified from the systematic reviews. Most of the trials were small and described poorly. There was little information on concealment of randomisation and the statistical analysis was inappropriate in many instances. The majority of studies had numerous outcome measures. A number of these studies also recruited by means of media campaigns and the generalisability of these studies to NHS clinical settings is uncertain.

Despite some detailed and focussed searching of electronic databases, we did not identify any studies of self-help in schizophrenia or bipolar disorder. The observational studies we identified were almost all uncontrolled (except ) and contributed little to any evaluation of effectiveness. We failed to identify any projects that carried out any
qualitative work in relation to self-help interventions except for one study on eating disorders. Though it should be acknowledged that it is often difficult to carry out electronic searches for qualitative studies in medicine. Finally, there was very little useful information on self-help groups for mental health problems and no real data on their possible effectiveness.

5.24 Other Search Strategies

There are a wide range of “self-help” books that are currently available in print. We also identified the self-help materials that are currently recommended by the key voluntary organisations. There was often little overlap between the books currently recommended or were popular according to booksellers and those self-help materials that had been subjected to evaluation. What is striking is that almost all the self-help interventions that have been investigated are based upon cognitive behavioural interventions. Many of the books currently marketed as “self-help” do not fulfil our own criteria for self-help. This might be because we have implicitly taken a cognitive behavioural orientation towards this work. Perhaps self-help books based upon different models of therapy such as psychodynamic, interpersonal or systemic therapy do not require the structured and methodological “workbook” format that is needed for CBT. These books have not been subject to randomised evaluation but may be helpful for many individuals with mental health problems.

What was apparent from this last exercise is the popularity of self-help in a general sense and the widespread recognition within the voluntary sector and by commercial publishers of the public’s desire for information and self-help for mental health problems.

5.3 The nature of self-help interventions

5.3.1 Self-help books

Most of the interventions that we identified are in written format, books with or without self-help exercises and worksheets. The older material tends to be in a more conventional book format. Some of the books such as Burns’ *Feeling Good*, tend to provide advice and suggestions for action but these are often buried in large quantities of text. There is an increasing trend to use modern educational production standards for the more recent texts. For example, *Mind over Mood* and Williams’ *Overcoming Depression* are large format and also allow the forms to be photocopied by the readers. These texts are large format and full of questionnaires and worksheets that can be completed. There is a logical progression in these books so that each exercise relies to a certain extent on what has gone before.

Very few of the more modern formats have been studied empirically. However, there is no reason to suppose that the older books on CBT are any more effective than the modern ones. Many professionals are now recommending the newer, large format self-help books to their patients. If there were sufficient evidence from previous studies to support the idea that self-help books based upon CBT principles were effective in depression, anxiety and eating disorders, it would appear illogical to use the empirical evidence to support one publisher’s version of a CBT self-help book against another’s. To a certain extent the attractiveness of the book will also be an individual matter for
the reader. For example, some people like the more “American” style of *Mind over Mood*, but others dislike the “upbeat” approach. Providing people with a range of suitable books would seem a more sensible approach and would allow individual choice. This argument could also be applied to other media including computerised CBT.

In the future it is likely that there will be a continuing evolution in how CBT materials are presented in a self-help format. For example, at present the books are not illustrated in colour or printed on glossy paper. It is possible that publishers will choose to improve the quality of production
d and make them more attractive to the potential readership. In order to make recommendations it is therefore helpful to have some principles upon which any future publications can be based.

At our present state of knowledge we would suggest that if self-help books are recommended, that these books should be based upon CBT, include case vignettes, have a large format with worksheets that can be easily photocopied or removed and should have a modest reading age. A large typeface also can help readability. On the other hand, some potential users might prefer a more discrete publication to read in public areas. As argued above, there is an opportunity to develop more attractively produced self-help books, though these would be more expensive to buy. Further research on the presentation and format of self-help materials would be extremely valuable and qualitative methods may be particularly useful to address these issues.

5.32 Audio, video

There has been relatively little evaluation of audiotape or videotape self-help materials when used alone. In the main they have been used as a supplement to written material. In principle these methods would appear to be more acceptable to individuals who do not read very much. We could not find any studies about preferences of format but it is likely that different individuals will have preferences for different ways of presenting CBT material.

5.33 Computer based and Multi-media Self-help

There is increasing interest in the possibility of using computers to administer cognitive behavioural self-help packages. The quality of the production has changed along with the technology and some of the packages are multimedia, in the sense that they include video clips as well as providing forms and questionnaires. This area, of computerised CBT (CCBT) was the subject of a very recent review commissioned by the HTA program (Kaltenhalter
d) that came to a familiar conclusion for systematic reviews – that the evidence was encouraging though perhaps not quite sufficient to recommend widely. However, some of the more recent RCTs that have evaluated CCBT are of a much higher methodological quality than some of the older studies carried out on written material.

In principle, the computerised format may be suitable for individuals who are not keen on working through books or who have lower levels of literacy. On the other hand, most homes do not have access to multi-media personal computers and this would reduce the availability. In the Proudfoot et al trial of CCBT, only 62% finished the treatment that was provided on a PC in their GP surgery but this is not markedly different from the
few other studies that have reported completion rates for written self-help materials when recruitment has been based in primary care (Bower).

5.34 Self-Help Groups

There was surprisingly little evaluation of self-help groups and the use of self-help materials in self-help groups for mental health problems. Kate Lorig in the USA is associated with developing a model of self-help in which users might incorporate self-help materials within a self-help group and led by someone with the condition. This was originally developed and evaluated in relation to arthritis but has been generalised under the heading of the Chronic Disease Self-Management Course. This has the advantage of being a potentially empowering means of delivering an intervention which incorporates the professional perspective in the self-help material.

These self-help groups were excluded from the current review as they require more lay time than we had originally set for our inclusion criteria. We had set a limit of 5 hours lay time for inclusion in the review. Nevertheless these are interesting and potentially important methods of delivering self-help interventions.

We have already mentioned (Section 3.10) some of the voluntary sector organisations that run self-help groups. These include, Triumph over Phobia, the Manic Depressive Fellowship, the Eating Disorders Association and the Hearing Voices network.

There are also a large number of other self-help groups that are currently operating in the UK. For example in the Bristol area alone, the local MIND has identified 19 voluntary sector organisations that run self-help groups. Virtually nothing is known about how they operate, who attends and their relationship with statutory services. Many might be providing unstructured support but some might also be using self-help materials. Further research into the content and nature of the work done by self-help groups in the voluntary sector would usefully complement more formal evaluation of self-help materials.

5.35 Supporting psychological theory

Almost all the self-help materials that have been evaluated have been based upon cognitive behavioural therapy (CBT). CBT covers a range of approaches and is usually taken to include behavioural therapy without a specific cognitive element. The self-help approach fits well with CBT. In therapist administered CBT, there is an expectation on the patient to carry out “homework” tasks and to develop skills to manage situations and symptoms themselves. The therapist therefore incorporates an educational role in their approach.

We came across two other approaches. Self-monitoring is not primarily based upon a cognitive or behavioural theory but could work by improving motivation to change behaviour. The second approach was therapeutic writing. The underlying theoretical approach is based upon the idea of improving insight and by exposure to painful or distressing topics.

We did not find any evaluation of self-help that met our definition (Section 3.10) and was based upon more psychodynamic approaches. It is possible that our definition of
self-help excluded any psychodynamic evaluation as our definition of self-help was based in part upon the kind of model that is used in CBT. However, we think it unlikely that we have missed such interventions in our searches. It is more likely that self-help approaches fit less well with the psychodynamic approach that puts much more emphasis upon the relationship between client and patient as a therapeutic agent.

There were a few self-help books that appeared to be based more upon psychodynamic or interpersonal approaches. One of the most popular in the UK is Dorothy Rowe’s “Depression: a way out of your prison”\(^ {115} \). This kind of approach with more emphasis upon interpersonal factors could be helpful in improving insight even if it doesn’t provide the kind of practical or behavioural advice common in the CBT based books. The popularity of this kind of approach perhaps reflects its potential usefulness. The current enthusiasm for CBT is derived mainly from the availability of empirical evidence but alternative approaches may also be effective even if there is little evidence to support any benefit. For example, the recent results from counselling trials appear to suggest a benefit of more interpersonal based psychotherapies for neurotic disorders within primary care\(^ {148,149} \).

5.36 Self-help for Severe Mental Illness

We found little written material on self-help for people with schizophrenia or bipolar disorder. We identified some books on self-help for bipolar disorder based upon cognitive behavioural principles\(^ {143} \).

The Manic-Depressive Fellowship (http://www.mdf.org.uk) runs a Self Management Training Programme whose aim is to “equip participants to develop new strategies, monitor mood states, link thoughts, feelings and behaviours, and develop an alertness to mood variations. All of the group facilitators are themselves experienced self-managers.” The main approach is to identify possible trigger factors for illness and increase awareness of mood changes. The idea is to give the individuals extra skills to help them manage their illness. It was excluded from our review as a “self-help” intervention as the time involvement (six 2.5 hour sessions) was over our self-imposed limit. We found no reference for any evaluation of this programme.

The Hearing voices network also run groups that are designed to help people come to terms with voices but also to develop new skills to help manage them. The degree of professional involvement varies in such groups. In some cases the groups are run as group therapy along cognitive behavioural lines.

There has been increasing interest in studying cognitive behavioural approaches towards both schizophrenia and bipolar disorder\(^ {136} \). Given the evidence for effectiveness\(^ {11} \) of CBT for schizophrenia it is likely that there will be increasing interest in developing self-help materials, following the experience of CBT for depression and anxiety. Providing self-help materials for people with schizophrenia and bipolar disorder in a self-help group format might be a useful approach, particularly for those with severe mental illness who are often in contact with services and familiar with group approaches.

Given these possible developments it is worth noting that adherence to treatments provided by professionals is poor amongst many service users with severe mental
illness. Insight into illness can be impaired at times. Self-help interventions are also of potential value to carers as well as users and this might be especially so for carers of people with more severe disorders. This might be relevant for Standard 7 of the National Service Framework.

5.37 Characteristics of subjects

A number of studies recruited via adverts or from student populations. Generalisability to UK primary or secondary care might therefore be difficult. One would expect that subjects recruited by advertisement might have less severe disorders. However, this possible limitation has in many, though not all studies, been addressed by requiring participants to exceed a measure of severity or reach certain diagnostic criteria.

Of more concern is the possibility that recruitment by adverts or from student populations would improve the acceptability and adherence to the self-help approach. Students might be more familiar with the educational model adopted by most self-help approaches and may therefore show a better response. Respondents to adverts might also be particularly motivated to follow a course. In the UK clinical setting, the situation might be quite different. Some sections of the population do not read very widely. One might also suppose that elderly people who have had little formal education might find the self-help approach more difficult. The characteristics of those subjects who find the self-help approach acceptable and can adhere to the program needs to be investigated, though such studies are difficult to carry out. It seems likely that different types of self-help resources will suit different patient groups.

5.4 Effectiveness

5.41 Clinical outcomes

It would seem premature to base any widespread adoption of self-help materials in the UK on the current studies. One particularly important question that we think inhibits the widespread adoption of self-help materials is that the amount and nature of any professional guidance to ensure effectiveness is unknown. There is an increasingly held viewpoint that some amount of professional advice is needed to use these materials. In other words, the adoption of self-help materials would probably require additional training of professional or ancillary staff. Implementing such a programme of education and training would have important logistical and economic costs. At present, it is difficult to see how this could be justified. We discuss the possibility of harm below.

It is easy to draw the conclusion that “further research is needed” and that self-help interventions based upon a cognitive behavioural approach might be of benefit in depression, anxiety disorders, binge eating disorder and bulimia nervosa. Is the current evidence good enough to justify widespread implementation? The limitations of this evidence have been listed above and in particular the likelihood of publication bias is high and the studies are often too small and poorly reported. Almost all the interventions have also been directly evaluated by people who have developed or have a vested interest in the success of the intervention. There is no large randomised controlled trial by an independent group that meets modern expectations for reporting, with an adequate follow-up and is based in the kind of setting generalisable to UK primary care.
Despite these shortcomings we are inclined to conclude that these approaches can be effective. We are less certain that we have a realistic and accurate view of how much better these might be and whether they would be effective without a certain degree of informed clinician support for their use. There might therefore be some difficulty in supporting a wholehearted policy that NHS Direct or general practitioners should recommend certain publications or programs. Any clinical recommendation should emphasise that there is some uncertainty about the effectiveness of this approach and that some people might not benefit. Of most importance is that any potential user for self-help approaches is advised to consult a clinician for additional treatment if the self-help approach is unsuccessful.

5.42 Potential for harm

The evidence we have summarised does not support the view that the self-help materials that have been evaluated lead directly to harm in the context of the published trials. Despite this there are still probably two main sources of potential harm.

First, people might use self-help materials for conditions that are not appropriate. For example, self-help for a different diagnosis might be used or self-help for a very severe form of disorder that would require specialist treatment. Related to this is the possibility that a patient would start or persist with self-help when a referral to professional might be more appropriate.

This kind of harm has not been investigated by the studies we have identified. Almost all have screened subjects with some kind of standardised or diagnostic assessment. Some of the US studies that recruited by advertisement appeared to exclude a large number of subjects at this stage but they do not provide much information on why those subjects were excluded or whether it would have mattered if those subjects had used the self-help materials.

We do not think this source of harm is particularly likely. Some of the self-help books include an introductory section on the diagnosis of the target condition so that readers should be able to tell whether the book is appropriate for their mental health problem. In addition, there is a great deal of overlap between symptoms and syndromes of depression and anxiety and almost everyone with an eating disorder also reports symptoms of depression and anxiety. This phenomenon, that has come to be called comorbidity, indicates that for most conditions this will not be an important clinical concern. Perhaps of more concern is the possibility that someone with a very severe depression that requires urgent treatment persists with use of self-help materials and avoids seeking help.

The second possible harm concerns the disillusionment that might result if a patient uses self-help material but does not benefit from that approach. The unsuccessful use of self-help materials might discourage them from seeking help from professionals. Some of the self-help materials do not explain that there are alternative or more intensive versions of cognitive therapy available and that if the self-help approach does not prove successful then further professional help can be sought. Particularly in disorders such as depression, or where low self-efficacy is an important clinical issue, an unsuccessful outcome for self-help might lead to delays or prevent further therapy. It would also be
important for self-help materials to have an initial section with assessments designed to
give the reader some indication about whether they should seek professional advice.

The randomised trials did not investigate the possibility of harm because of delayed
treatment. At first sight it is difficult to know how this possibility could be evaluated. What is probably important, particularly given the weak evidence for effectiveness, is that self-help materials are given with the message to consult professionals for further help if they prove unacceptable or ineffective.

The possibility of harm might be greater for more severe disorders such as schizophrenia, bipolar disorder or anorexia nervosa. The consequences of delayed treatment might be much more serious for both the patient and family members. The need for a ongoing clinical contact in parallel with any self-help interventions would seem particularly important.

5.43 Risks and benefits

On balance the benefits probably outweigh the risks but there needs to be clear guidance about the use of self-help packages if these are to be incorporated into management plans. Ideally, individuals need to be assessed before embarking on a recommended course of self-help and monitored to ensure that any appropriate treatment is given following a self-help course. It is probably reasonable, in view of the poor evidence for effectiveness, to encourage the use of self-help within a clinically supervised setting.

Within the policy framework of the NHS plan, it is essential that the promotion of self-help is not seen as being at odds with the requirements to monitor and evaluate the provision of health care. This will mean that user groups must be involved in developing services with PCTs and engaged with the process of clinical governance.

5.44 Cost and quality of life

Costs have not been examined in any detail in the systematic reviews or clinical trials that we have identified though we are aware of the economic analysis from the Proudfoot et al Beating the Blues trial. The review of computerized CBT addressed the issue of costs and also had the Proudfoot results available. They argued that CCBT could not be thought of as an alternative to therapist administered CBT as there are long waiting lists at present in the UK. In other words, if CCBT became available it would be an additional treatment on top of any face to face psychotherapy that was provided and would be an extra cost for the NHS. They estimated that the costs would be in the order of £100-£200 per person and might account for some £200-300m if implemented on a national scale.

There are of course various other possibilities. Improved recovery would also presumably have some benefits on consultation rates in primary care and use of other services. CCBT, or for that matter any of these self-help materials, could be used as a possible first “step” in a stepped care programme. In that case there might be a saving in the use of antidepressants or therapist administered CBT as some people would recover on the CCBT before requiring medication.
Any future evaluations of self-help materials should attempt to evaluate the economic impact in NHS settings. It is likely, though, that self-help materials will be an additional cost to the NHS but might lead to improved clinical outcomes and patient satisfaction.

5.45 Influence of therapist type and time on outcome

We defined self-help in this paper as requiring less than one hour of professional time. The studies of self-help have almost all included some professional input. It is almost inevitable that research studies will also include contact between the researchers and participants and this might have some bearing on the understanding of the purpose of the self-help materials and how to use them. One study did attempt to carry out the whole research study by post, and though there are a number of alternative explanations for the negative result they found, it is possible that some degree of explanation and ongoing guidance is necessary before self-help will be effective. There were many instances where it proved difficult to find out what contact occurred between the subject and whether the contact was concerned with carrying out research assessments or explaining the self-help materials.

There is no real empirical data on whether therapist contact improves outcomes. Marrs in the systematic review found there was an increasing effect size as the duration of therapist contact increased for studies investigating self-help in anxiety disorders. There is an increasing consensus within the field that some degree of contact is necessary, but there is less consensus about what this contact should include. For example, it could be provided by different people: professional, ex-user, trained non-professional workers. It could consist primarily of telephone contact rather than face-to-face meetings. Frequent very short appointments might be better than longer ones at the beginning or end of the course.

We have not considered the issue of whether self-help materials can reduce the amount of time in conventional therapist administered treatments. Our impression is that almost all cognitive behaviour therapists are using self-help materials as part of their clinical work. There is another research agenda in how these can be most effectively used and how they can lead to the use of therapist time most effectively within the session.

5.5 Acceptability and adherence

5.51 Service users and members of public

The studies we identified did not systematically examine the acceptability of the interventions. This question has been investigated in relation to pharmacological interventions by examining drop-outs from treatment. Adherence to self-help materials is also quite difficult to estimate, even if the participants have continued to complete the research assessments. There is very little information that could be generalised to a UK primary care setting. One of the few studies that reported usable information was that of Proudfoot et al where 100 of 267 potential participants refused to take part and only 62% of the randomised subjects allocated to computerised CBT completed the course.

Some work on the acceptability of self-help manuals has been reported in eating disorders. Just over half (57%) read more than half the manual and 43% completed at least 2 exercises. In a randomised study of binge eating disorder, only 6% of
subjects in the pure self-help group completed the entire program, compared to 68% of subjects in the guided self-help condition. Further work on dropouts and lack of adherence could be performed on the existing literature but this would be severely limited by the unusual nature of participants in RCTs. There is a widespread scepticism amongst clinicians that many people are able or willing to independently embark and complete the work required by a self-help approach. Investigating the extent to which participants will complete the self-help course and carry out the tasks would be an important question to ask in future research. Such research might also be a cheaper method of determining how the format of self-help interventions might be improved and optimised.

For clinicians, it would be ideal to have some idea of which patients are more likely to find the self-help approach more acceptable and more beneficial. Perhaps the important principle would be to provide some choice. For example, one could have a similar CBT approach in book form, as computerised CBT or provided as a user-led self-help group. Flexibility in the amount of professional contact could also vary between individuals. To ask all these related questions by means of randomised controlled trials with clinical outcomes may be impracticable in the short run and to a certain extent will have to rely upon clinical experience and studies designed with intermediate outcomes (such as adherence) or using qualitative methods.

5.52 Professionals

The development of self-help materials has come primarily from professionals involved in CBT. There is also widespread use of self-help materials by professionals who use CBT in secondary care. We know less of their use by other professionals in secondary care or in primary care. Our impression is that they are not widely used and it is in these settings that benefit is most likely. Without empirical study it is difficult to know why self-help materials are not more widely used. We suspect that part of this is that their use has not been disseminated and that the professionals are uncertain about how to use them or how to respond to patients if they raise any queries. Dissemination of the possible value of self-help, together with recommended materials should probably be supplemented by brief (1 or 2 session) training courses so that professionals feel more confident in their use. We are only aware of additional training resources for health care practitioners that have been developed for two self-help manuals.

5.6 Usefulness in the UK healthcare system

5.61 Stepped care approach

There is increasing interest in applying the principles of “stepped care” to current primary care based treatments of depression. There have been successful evaluations of this approach in the US. Stepped care attempts to mimic the usual clinical approach in which more acceptable interventions are given first, leading on to more expensive or more difficult approaches only if the patients have not responded to the simpler approach. Another important element of the stepped care approach as implemented is that it incorporates an approach in which the disorder is actively managed and ensures that patients who are not getting better are not allowed to disappear or stop attending the doctor. Stepped care is based upon two premises. First, that different patients will
respond to different intensities of treatment. Second, that there is no sure way of
deciding beforehand which patients will respond to what intensity of treatment.

Self-help interventions would seem to be a very useful foundation for a stepped care
approach. One could also envisage a stepped care program including a more supervised
self-help intervention as a second step in the intervention. Incorporating self-help within
the stepped care model would also address concerns about the possible harm that might
result if patients were discouraged from seeking further help if self-help had proved
unsuccessful. The integration of self-help interventions into a stepped care programme
would also have implications for the environment in which therapies are delivered.
There has been some pilot work using resource rooms in primary care in which books,
pamphlets and CD-ROMs could be made available.

5.62 NHS Direct

The potential for recommending self-help interventions fits within the philosophy of a
modern NHS. Organizations such as NHS Direct and Walk in Centres led by nurses are
designed to provide information, encourage self-management and advise on self-care.
Clinical guidelines for the management of depression could incorporate advice on
suitable self-help materials as well as incorporating advice that would minimise harm.
For example, going to see the GP following use of self-help interventions.

At the present state of knowledge it is probably inadvisable that NHS Direct or Walk in
Centres provide a general recommendation to use self-help materials for depression,
anxiety, bulimia nervosa or binge eating disorder. At present, there is insufficient
evidence to support the effectiveness of completely unguided use of self-help materials.
As argued above, it is probably wise that self-help materials are used and given in the
context of some degree of clinical oversight. If NHS Direct or Walk in Centres do
provide advice on self-help materials, these should be accompanied by an unambiguous
message that these may not be beneficial for everyone and that their general practitioner
should be consulted if the problems are not resolved or their condition is sufficiently
severe.

5.63 Implications for role of professionals and skills of professionals

If self-help interventions are to be used more widely, professional attitudes and
knowledge will need to be assessed. We suspect that some of the professional reluctance
to use these materials result not only from lack of an awareness of their existence but
also uncertainty about how to use them and a nervousness of being asked questions by
patients based upon the material that might be difficult to answer. Experienced
cognitive behavioural therapists are enthusiastic users of self-help materials, but
professionals less familiar with the model tend not to use them.

Simple training courses or books on how to use self-help for professionals are being
developed and would be an important element in disseminating self-help materials.
Such training would also involve learning how to assess appropriately and support
individuals in self-directed learning. The role of the professional would be to guide and
support and only to intervene when necessary. Such a program has been developed for
mental health teams in the use of self-help in Glasgow - the SPIRIT course.
There is also potential for using relatively unskilled professionals in helping to administer and encourage the use of self-help materials. It could be a role for the new Graduate Mental Health Worker that is being introduced under the National Service Framework for Mental Health. Training and education of self-help materials is likely to improve effectiveness but given the considerable resources that could be used it would be important that this aspect of self-help is properly evaluated in a UK context.

5.64 User led self-help groups

There is great potential for incorporating self-help materials within user led self-help groups. The Living with Long Term Illness project recognised this and places this initiative within the move to increase the use of patient expertise. The current initiatives within the voluntary sector could be encouraged in the context of more formal evaluations of effectiveness and reassurance concerning matters of clinical governance. Provision of support from users together with a model of care with empirical backing would seem a particularly powerful combination. Such groups could also be run within the statutory sector by employing users to run self-help groups. As always the training and support of the group leaders would be a crucial element if such initiatives were to be successful. Though this sounds a promising and innovative idea, there is at present no empirical evidence to support the use of either voluntary or statutory sector resources to develop such a service.

5.7 Recommendations

5.71 Recommendations for clinical practice

1. There should be increased professional awareness of the potential value & limitations of self-help materials. This would be particularly important for primary health care teams and secondary care workers without specific CBT skills.
2. Service users are encouraged to discuss self-help materials they are using with professionals they consult and professionals should routinely ask about their use.
3. Brief education in the use of self-help materials should be available for interested primary care and secondary care health workers. The duration and nature of the education should be tailored to the needs of the professional group. This training could also be made available to the new Graduate Mental Health Workers recommended by the National Service Framework.
4. Recommendation of self-help materials should be based upon the best evidence available and a set of objective criteria. This would enable new materials to be included in any recommendation as long as they fit those criteria. Trial evidence that supports a particular publisher’s output should lead to recommendations that summarise the principles behind those materials.
5. The statutory sector should actively engage with the self-help movement in the voluntary sector in order to provide advice and support on the use of self-help materials.
6. NHS direct could provide advice on recommended self-help texts and CD Roms but also emphasise that patients should consult their doctor both before and after using these materials if there condition is sufficiently severe.
5.72 Recommendations for research

1. There is still a need to investigate the effectiveness of self-help approaches for depression, anxiety and bulimic type eating disorders within a pragmatic trial in UK primary care. Any new trial should be large and carried out independently of the manufacturers of the self-help approach. It could be argued that self-help should be evaluated in the context of a stepped care model.

2. The extent and nature of guidance that might be needed to ensure self-help materials are effective has not been established.

3. We do not know the characteristics of the people that are willing and able to follow and complete a self-help course. Different people might prefer different media. Such information might enable clinicians to best predict which patients might have a better outcome with self-help materials. The acceptability and use of self-help materials in people of ethnic minorities would be valuable.

4. There are still questions about the best way of providing self-help materials. There is a move towards a more educational format but these have not been evaluated. There is scope for qualitative studies on the appearance and ease of use of self-help materials to help improve the formats.

5. At present we do not know the nature of the “active” ingredients in self-help and whether self-help based upon other models, apart from CBT, might be effective.

6. Further development and evaluation of self-help interventions for people with bipolar disorder and schizophrenia are required.

7. Development and evaluation of user-led self-help groups is required. More knowledge of current self-help groups and their mode of operation and relationship with the statutory sector would provide important background for any developments in that area.

8. All evaluations should, of course, include an economic analysis.
STATEMENT OF INTERESTS

Judy Proudfoot (Beating the Blues), Chris Williams (Overcoming Depression) and Ulrike Schmidt (Getting Better Bite by Bite) have all developed self-help materials.
EXECUTIVE SUMMARY
Self-help interventions have been developed and investigated over the past 20 yrs. Much of the research has been performed in the USA but there is also some more recent work carried out in other Western countries. Despite the quantity of research performed, many of the studies that have been identified have been severely limited and poorly executed. Though it is common for systematic reviews to identify weaknesses in the literature, the studies we have identified are weak even by that benchmark. It is also striking that a relatively limited range of interventions have been studied.

For the purposes of this expert paper we proposed that self-help approaches are characterised by two particular features. First, that they either require no or only “minimal” practitioner input. We defined this as one hour or less of professional face-to-face time and up to six 15 minute telephone calls. For non-professional guidance we will allow “guided self-help” with up to 5 hours of non-professional time allocated. The second criterion we adopted was the requirement that self-help includes instruction on how the user can improve their skills to cope and manage their difficulties. Though this criterion is difficult to define precisely, it intends to exclude books that just provide information and a few words of advice.

We identified self-help materials using three methods. First, we identified all the systematic reviews that have included self-help interventions. Second, after this process we carried out a focussed systematic research of more recent literature not included in the systematic reviews and in areas where no literature had been identified. Finally we identified self-help materials that are currently recommended in the UK or widely purchased by searching websites, contacting publishers, voluntary organisations and bookstores.

The weaknesses of the literature are as follows:

1. Small size of trials leading to an increased possibility of publication bias, unsuccessful randomisation and wide confidence intervals.
2. Poor reporting quality of trials and inappropriate analysis. Hardly any studies met the CONSORT criteria for reporting randomised trials. Many of the conclusions made by authors and reviewers are of dubious statistical validity.
3. Many studies have not studied clinical populations. For example, it may be impossible to generalise from studies in a student population to the NHS context. Students are familiar with the idea of independent study and self-help approaches may be much less acceptable and have poorer adherence in NHS clinical populations.
4. There have been relatively few independent evaluations of self-help materials. Most materials have been directly evaluated by those who devised them.
5. The interventions were almost all based on cognitive behavioural therapy for anxiety, depression, bulimia nervosa or binge eating disorder. There is little or no empirical data on which component of the self-help intervention might help patients and whether the cognitive, behavioural or any other elements are critical.
6. The degree of additional guidance from a health care practitioner that might be necessary for any clinical benefit has not been established in the existing literature. Almost all the current trials have included some guidance, often from the team involved in developing the self-help materials.
7. There has been no systematic investigation of the possibility that self-help materials might be harmful when used outside a clinically supervised context.
8. The economic implications of a widespread adoption of self-help materials has not been studied.
9. There has been little empirical study of the clinical or sociodemographic characteristics that might be associated with a good response to a self-help approach.

Given these weaknesses it is important to summarise what conclusions can safely be drawn. Firstly, that most studies have reported a significant benefit of self-help materials, based upon a CBT approach, for depression, anxiety, bulimia nervosa and binge eating disorder when given in the context of a clinical assessment and some degree of monitoring. Much of the monitoring has been as a result of the research protocol but might be a critical element of the intervention.

What is less certain is whether this evidence is of sufficient rigor to recommend the use of self-help materials. The possibility of harm has not been empirically studied and is probably relatively remote as long as the patient is still given the opportunity to pursue other therapeutic options if the self-help approach proves unsuccessful. Given the weakness of the evidence it is probably wise to only recommend self-help materials when given in a clinically supervised context and when alternative therapeutic options will be recommended if self-help proves unacceptable or ineffective.

The final observation concerns the absence of any evidence in a number of areas. We could not find any empirical study of self-help interventions for schizophrenia and bipolar disorder. Likewise, the use of self-help groups to deliver self-help materials has not been studied. We have noted that self-help materials that are not based upon CBT have not been formally evaluated, despite widespread sales and anecdotal evidence suggesting that some patients find them useful. Finally, there has been little investigation of the likely economic costs or benefits of using self-help materials.

**Recommendations for Clinical Practice**

1. There should be increased professional awareness of the potential value & limitations of self-help materials. This would be particularly important for primary health care teams and secondary care workers without specific CBT skills.
2. Service users are encouraged to discuss self-help materials they are using with professionals they consult and professionals should routinely ask about their use.
3. Brief education in the use of self-help materials should be available for interested primary care and secondary care health workers. The duration and nature of the education should be tailored to the needs of the professional group. This training could also be made available to the new Graduate Mental Health Workers recommended by the National Service Framework.
4. Recommendation of self-help materials should be based upon the best evidence available and a set of objective criteria. This would enable new materials to be included in any recommendation as long as they fit those criteria. Trial evidence that supports a particular publisher’s output should lead to recommendations that summarise the principles behind those materials.
5. The statutory sector should actively engage with the self-help movement in the voluntary sector in order to provide advice and support on the use of self-help materials.

6. NHS direct could provide advice on recommended self-help texts and CD Roms but also emphasise that patients should consult their doctor both before and after using these materials if there condition is sufficiently severe.

**Recommendations for research**

1. There is still a need to investigate the effectiveness of self-help approaches for depression, anxiety and eating disorders within a pragmatic trial in UK primary care. Any new trial should be large and carried out independently of the manufacturers of the self-help approach. It could be argued that self-help should be evaluated in the context of a stepped care model.

2. The extent and nature of guidance that might be needed to ensure self-help materials are effective has not been established.

3. We do not know the characteristics of the people that are willing and able to follow and complete a self-help course. Different people might prefer different media. Such information might enable clinicians to best predict which patients might have a better outcome with self-help materials.

4. There are still questions about the best way of providing self-help materials. There is a move towards a more education format but these have not been evaluated. There is scope for qualitative studies on the appearance and ease of use of self-help materials to help improve the formats.

5. At present we do not know the nature of the “active” ingredients in self-help and whether self-help based upon other models, apart from CBT, might be effective.

6. Further development and evaluation of self-help interventions for people with bipolar disorder and schizophrenia are required.

7. Development and evaluation of user-led self-help groups is required. More knowledge of current self-help groups and their mode of operation and relationship with the statutory sector would provide important background for any developments in that area.

8. All evaluations should, of course, include an economic analysis.
REFERENCES

Reference List


5. Broadhead WE, Blazer D, George L, Tse C. Depression, disability days and days lost from work. *JAMA* 1990;**264**:2524-8.

Ref Type: Serial (Book,Monograph)


Ref Type: Report


Ref Type: Serial (Book,Monograph)


Ref Type: Report


Ref Type: Report


Ref Type: Report


Ref Type: Personal Communication


Ref Type: Computer Program


Ref Type: Report


Ref Type: Report


Ref Type: Report

Ref Type: Report

Ref Type: Report


APPENDIX

Search Strategy for Systematic Reviews of self-help (Medline)

Database: Medline <2002 to August Week 3 2002>

Search Strategy:

1. exp eating disorders/ (650)
2. exp anorexia nervosa/ (195)
3. exp bulimia/ (151)
4. exp mood disorders/ (2436)
5. exp bipolar disorder/ (581)
6. exp neurotic disorder/ (48)
7. exp depression/ (1274)
8. exp depressive disorder/ (1775)
9. exp seasonal-affective disorder/ (42)
10. exp adjustment-disorders/ (29)
11. exp anxiety/ (946)
12. exp anxiety-disorders/ (1468)
13. exp agoraphobia/ (34)
14. exp panic disorder/ (176)
15. exp phobic disorders/ (174)
16. exp panic/ (28)
17. exp stress disorders, -post traumatic/ (579)
18. exp obsessive-compulsive disorder/ (223)
19. exp affective symptoms/ (141)
20. exp stress psychological/ (1898)
21. exp mental disorders/ (18469) 
22. exp mood disorder/ (0)
23. exp obsessive behavior/ (20)
24. exp compulsive behavior/ (145)
25. exp schizophrenia/ (1544)
26. exp psychotic disorders/ (557)
27. (agoraphob: or acrophob: or acraphob:).mp. (75)
28. (claustrophob: or worry: or worried or worries).mp. (285)
29. (vertigo or shyness).mp. (263)
30. social phob:.mp. (98)
31. (generalised anxiety or generalized anxiety).mp. (110)
32. ((free-floating or free floating) adj anxiety).mp. (3)
33. ophidiophob:.mp. (0)
34. health anxiety.mp. (9)
35. (depression: or depressed or depressive:).mp. (6362)
36. (dysthmi: or dythmi:).mp. (1)
37. cyclothym:.mp. (10)
38. ((episodal or paroxsymal) adj anxiety).mp. (0)
39. depressive disorder.mp. (1265)
40. neurotic disorder.mp. (4)
41. psychological stress.mp. (101)
42. anxiety.mp. (2892)
43. (phobia: or phobic).mp. (215)
44. manic depression.mp. (7)
45. neuros:.mp. (2294)
46. psychos:.mp. (2257)
47. psychological stress.mp. (101)
48. (post traumatic stress disorder or post-traumatic stress disorder or PTDS).mp. (122)
(obsessive compulsive disorder or obsessive-compulsive disorder or OCD).mp. (280)
eating disorder.mp. (137)
anorexia.mp. (522)
(bulimia or bulimia).mp. [mp=title, abstract, cas registry/ec number word, mesh subject heading] (196)
(mood or affective or panic or anxiety or stress or bipolar or phobic) adj (attack: or reaction: or symptom: or disorder:)).mp. (1541)
or/1-53 (28204)
exp bibliotherap:/ (6)
exp compact disc/ (56)
exp book:/ (0)
exp video record:/ (609)
exp video tape/ (0)
exp tape recorder/ (0)
exp internet/ (2283)
exp CD-I/ (5)
exp audiovisual aid:/ (1436)
(book or books or booklet or leaflet: or pamphlet: or guide or guides).mp. (2812)
(self adj (help or technique: or instruction or management or care or administration)).mp. (672)
patient education.mp. (2392)
(non directive or non-directive counsel::).mp. [mp=title, abstract, cas registry/ec number word, mesh subject heading] (8)
((self-help or self-help) adj guide:).mp. (0)
((self-help or self-help) adj manual:).mp. (3)
(videotape adj (self-help or self-help)).mp. (0)
((audio cassette or audio-cassette) adj (self-help or self-help)).mp. [mp=title, abstract, cas registry/ec number word, mesh subject heading] (0)
bibliotherapy.mp. (11)
videorecording.mp. (2)
tape-recorder.mp. (8)
(compact disk or compact disc).mp. (12)
internet.mp. (2592)
(computer adj (package or assisted or aid or aided learning)).mp. (453)
(cd or cd-rom).mp. (3572)
educational material.mp. (21)
((self-help or self-help) adj manual:).mp. (3)
(minimal contact adj therapy).mp. (0)
or/55-81 (13397)
54 and 82 (1061)
workbook.mp. (15)
worksheet.mp. (10)
interactive.mp. (688)
questionnaire.mp. (5892)
(self completion or self-completion).mp. (28)
(self evaluation or self-evaluation).mp. (56)
patient diary.mp. (4)
health status.mp. (2331)
(measure: or scale:).mp. (55370)
quality of life.mp. (4746)
user acceptability.mp. (4)
user satisfaction.mp. (21)
(self adj (help or technique: or instruction: or management or care or administration)).mp. (675)
or/84-96 (64038)
83 and 97 (486)
Search Strategy for Self-Help interventions for Schizophrenia (Medline)

Database: Medline <2002 to August Week 3 2002>
Search Strategy:
-----------------------------------------------
1 exp schizophrenia/ (1544)
2 exp paranoid disorders/ (24)
3 schiz:.mp. (2445)
4 hebephren:.mp. (3)
5 oligophreni:.mp. (1)
6 psychotic:.mp. (850)
7 psychoses.mp. (432)
8 psychoses.mp. (97)
9 tardivi:.mp. (75)
10 akathisi:.mp. (55)
11 exp bibliotherapy/ (6)
12 (self adj (help or technique or instruction or management or
   managed or care or administer or administered)).mp. (1124)
13 self-help.mp. (116)
14 self-help group.mp. (23)
15 ((self-help or self-help) adj (video or videotape)).mp. (0)
16 ((self-help or self-help) adj (audiotape or audio-tape)).mp.
   (0)
17 or/1-10 (3094)
18 or/11-16 (1129)
19 randomized-controlled trial.pt. (8276)
20 controlled clinical trial.pt. (1233)
21 random allocation/ (1647)
22 double blind method.mp. (3179)
23 randomized-controlled-trials/ (3262)
24 single blind method.mp. (533)
25 single blind method/ (533)
26 clinical trial.pt. (15326)
27 exp clinical trials/ (7571)
28 (clin: and trial:].ti,ab. (7902)
29. \(((\text{singl: or doubl: or tripl: or trebl:}) \text{ and (blind: or mask: or dummy:)})\).mp. [mp=title, abstract, cas registry/ec number word, mesh subject heading] (3582)
30. placebos/ (499)
31. (control: or prospectiv: or volunteer:).ti,ab. (67631)
32. random:.ti,ab. (17400)
33. research design/ (1700)
34. comparative study/ (34241)
35. exp evaluation studies/ (20217)
36. follow up studies/ (10785)
37. prospective studies/ (9575)
38. experimental methods/ (0)
39. experimental design/ (1700)
40. experimentation/ (0)
41. followup studies/ (10785)
42. posttreatment followup/ (0)
43. treatment outcomes/ (0)
44. longitudinal studies/ (1889)
45. comparative study.mp. (34468)
46. or/19-45 (127558)
47. 17 and 18 and 46 (7)
48. limit 47 to english language (6)
49. limit 48 to human (6)
50. remove duplicates from 49 (6)
51. from 50 keep 1-6 (6)
Data extraction sheets for Review of Systematic reviews

**SELF-HELP INTERVENTIONS FOR MENTAL HEALTH**

**IN/OUT FORM – SYSTEMATIC REVIEWS**

ID No 

Assessor_____ (e.g. GL) Date: ______________ 

1. Bibliographic details

Reference: Journal________________________________________ Year_______

Volume_______(e.g. 271) Pages_____ - _______(e.g.1940-1947)

First author________________ (e.g. Dieppe P)

Title: __________________________________________________________________________

_________________________________________________________________________________

1. Is this a systematic review? (an overview of primary studies which use explicit & reproducible methods to identify the studies & record the content)  yes  no

2. Is at least one of the following covered in the review (Schizophrenia, Anxiety, Depression, Eating Disorder, Bipolar Disorder, OCD) yes  no

3. Are studies of self-help intervention(s) included yes  no

4. Is therapist contact time limited in any of the included studies? yes  no

If yes, is this defined as <1hr prof. < 5hrs non-prof. ? yes  no
Conclusion

IN OUT For Discussion

Not IN but useful references

Comments

Inout_form3/14/03/02
ASSESSING THE QUALITY OF PUBLISHED SYSTEMATIC REVIEWS

SELF-HELP INTERVENTIONS FOR MENTAL HEALTH (SECOND DRAFT)

ID No

Assessor_____ (e.g. GL)

1. Bibliographic details

Reference: Journal________ (e.g. JAMA)    Year________(e.g. 1994)
            Volume_______(e.g. 271)    Pages______- _______(e.g.1940-1947)

First author____________________(e.g. Dieppe P)

Title: ____________________________________________________________

SECTION ONE:

1. Research question / objectives

   Is there a clearly defined review question ?  ☐ yes  ☐ no

2. Inclusion and exclusion criteria for primary studies

   Are there clearly defined inclusion / exclusion criteria  ☐ yes  ☐ no

   Was there more than one observer involved in selecting studies ?  ☐ yes  ☐ no

3. Search strategy

   Is the search strategy clearly described ?  ☐ yes  ☐ no

   Did the search strategy include electronic databases  ☐ yes  ☐ no

      If yes, how many different databases ? _________

      Which databases?

                                    ___________________________________
                                    ___________________________________

   Are the keywords given ?  ☐ yes  ☐ no
What years were covered? _______ - _______ (e.g. 1985-1995)

Where language restrictions specified? ☐ yes ☐ no
If yes, describe __________________________________________

Did the search include

- a search for unpublished material? ☐ yes ☐ no
- a search of reference lists? ☐ yes ☐ no
- a hand search of journals? ☐ yes ☐ no
- conference abstracts, theses or other ‘grey’ literature? ☐ yes ☐ no
- material obtained from licensing authorities? ☐ yes ☐ no
- material obtained from pharmaceutical companies? ☐ yes ☐ no
- trial registers? ☐ yes ☐ no
- consultations with experts? ☐ yes ☐ no

4. Identified studies

Is there a list of included studies? ☐ yes ☐ no
Is there a list of excluded studies? ☐ yes ☐ no
Did the list of identified studies include unpublished material? ☐ yes ☐ no
conference abstracts or other ‘grey’ literature? ☐ yes ☐ no
non-English language journals? ☐ yes ☐ no

Brief description of included study designs

____________________________________________________________________
____________________________________________________________________

Characteristics of intervention and control groups

____________________________________________________________________
____________________________________________________________________

____________________________________________________________________
5. Data extraction / collection

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were primary investigators contacted for unpublished data?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Was there more than one data extractor for each study?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Was the data extraction process blinded?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>If yes, describe</td>
<td>-----</td>
<td></td>
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<tr>
<td>Was the analysis based on individual patient data?</td>
<td>yes</td>
<td>no</td>
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</table>

6. Quality assessment

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<tr>
<td>Quality assessment used</td>
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<td>no</td>
</tr>
<tr>
<td>Method used:</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td>Previously published instrument (unadapted)</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Adaptation of published instrument</td>
<td>yes</td>
<td>no</td>
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<tr>
<td>Own criteria/ method</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Checkist of individual items</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Scale resulting in summary score</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Was there more than one assessor?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Was assessor blind to:</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td>journal</td>
<td>yes</td>
<td>no</td>
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<tr>
<td>authors</td>
<td>yes</td>
<td>no</td>
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<td>results</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>sponsors</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>For the RCTs were the following key domains assessed?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Concealment of treatment allocation</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Blinding of outcome assessment</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Withdrawals and dropouts</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Were observational studies assessed for quality?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Was quality incorporated into the analysis</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>If yes, how?</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td>Trials of low quality excluded</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>
Stratified analysis (thresholds) 
Quality weights for pooling 
Regression analysis by quality 

Section Three:
7. Analysis and presentation of results

Descriptive data only 

If data were presented:

Was a fixed effects model used? 
Was a random effects model used? 
Test of heterogeneity? 
Intention to treat? 
Characteristics of individual studies shown? 
Graphical presentation of individual results? 
Exploration of heterogeneity?
  meta-regression? 
  funnel plot? 
  pre-specified subgroup analysis? 
  (state which groups)

post-hoc sub-group analysis? 
  (state which groups)

cumulative meta-analysis? 
L’Abbé plot? 
other?

Possibility of multiple publications addressed?
Sensitivity analysis?  ⚫ yes  ⚫ no

- by trial quality  ⚫ yes  ⚫ no
- by study size  ⚫ yes  ⚫ no

Other

Are sufficient data available for re-analysis?  ⚫ yes  ⚫ no

2. Results

No of trials in primary analysis:  

Sample size of smallest trial:  

Sample size of largest trial:  

Primary outcome  

Results (specify measure: OR/RR/HR, confidence interval, P value) for treatment vs control

3. Interpretation and conclusions

- Limitations of primary studies discussed?  ⚫ yes  ⚫ no
- Limitations of review discussed?  ⚫ yes  ⚫ no
- Results interpreted in terms of other available evidence?  ⚫ yes  ⚫ no
- Practical and specific clinical recommendations made?  ⚫ yes  ⚫ no
- Future specific research agenda proposed?  ⚫ yes  ⚫ no
- Ongoing trials listed?  ⚫ yes  ⚫ no

4. Sponsorship/Funding

- Pharmaceutical industry?  ⚫ yes  ⚫ no
- Government?  ⚫ yes  ⚫ no
- Charity?  ⚫ yes  ⚫ no
None?  

Other? ________________________________

5. General comments about the quality of the review:
### List of relevant individual studies extracted from review of systematic reviews

<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Int. / control</th>
<th>modality</th>
<th>Problem</th>
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<td>Allen 1973</td>
<td>Treatment of test anxiety by group administered and self administered relaxation and study counselling</td>
<td>Study counseling &amp; relaxation training (group or ind); study counseling (group or ind) vs control (attention focusing, testing or minimal contact)</td>
<td>BT</td>
<td>Test anxiety</td>
<td>Scogin</td>
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<td>Allen 1989</td>
<td>Videotaped modeling &amp; film distraction for fear reduction in adults undergoing HBO therapy</td>
<td>Videotape (v control)</td>
<td>BT</td>
<td>Fear</td>
<td>Scogin Gould Marrs</td>
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<td>Baker 1973</td>
<td>Self directed sensitization for acrophobia</td>
<td>Audiotape (v audiotape plus therapist)</td>
<td>BT</td>
<td>Acrophobia</td>
<td>Gould Marrs</td>
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<td>Brown 1984</td>
<td>A psychoeducational approach to the treatment of depression:</td>
<td><em>Coping with Depression Course</em> (group v individual tutoring v phone contact v wait-list control)</td>
<td>CBT</td>
<td>Depression</td>
<td>Scogin Gould Marrs</td>
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<td>Study</td>
<td>Intervention</td>
<td>Outcome Measures</td>
<td>Methodology</td>
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<td>Chalder 1997</td>
<td>Self help treatment of chronic fatigue in the community: a RCT</td>
<td>Self help booklet vs control</td>
<td>CBT</td>
<td>Chronic fatigue</td>
<td>Bower</td>
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<td>Clark 1973</td>
<td>Case histories and shorter communications</td>
<td>Self directed desensitization vs therapist admin desensitization vs control</td>
<td>BT</td>
<td>Snake phobia</td>
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<td>Cotler 1970</td>
<td>Sex differences and generalization of anxiety reduction with automated desensitization and minimal therapist interaction</td>
<td>Audiotape (4 treatment groups balanced for therapist-client sex differences v controls).</td>
<td>BT Desensitization</td>
<td>Snake phobia</td>
<td>Scogin Marrs</td>
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<td>Donnan 1990</td>
<td>Self help material for anxiety: a RCT in general practice</td>
<td>Audiotape &amp; booklet (Flesch score 71) vs normal treatment control</td>
<td>?CBT</td>
<td>Anxiety</td>
<td>Bower</td>
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<td>Donner 1969</td>
<td>Automated group desensitization for test anxiety</td>
<td>Audiotape (3 groups, therapist v self v wait list control)</td>
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<td>Scogin Marrs</td>
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<td>Reference</td>
<td>Study Description</td>
<td>Intervention</td>
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<td>Condition</td>
<td>Author</td>
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<td>Gould 1993</td>
<td>The use of bibliotherapy in the treatment of panic a preliminary investigation</td>
<td>Bibliotherapy <em>Coping with Panic (Clum 1990)</em> vs wait-list control vs individual therapy</td>
<td>CBT</td>
<td>Panic disorder and mild agoraphobia</td>
<td>Gould</td>
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<td>Jarmon 1972 (thesis)</td>
<td><em>No clear indication of amount of therapist input</em></td>
<td>Differential effectiveness of RET bibliotherapy, bibliography and attention-placebo in the treatment of speech anxiety</td>
<td>RET</td>
<td>Speech anxiety</td>
<td>Marrs</td>
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<td>Kahn 1968</td>
<td>Desensitization with minimal therapist contact</td>
<td>Therapist desensitization vs self administered desensitisation</td>
<td>BT</td>
<td>Phobia (mixed)</td>
<td>Scogin</td>
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<td>Keller 1975</td>
<td>Effects of a program in rational thinking</td>
<td>Therapist supported RET programme using <em>A guide to rational living (1975)</em></td>
<td>RET</td>
<td>Anxiety</td>
<td>Marrs</td>
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<td><strong>involvement</strong></td>
<td><strong>on anxieties in older persons</strong></td>
<td>vs control</td>
<td><strong>Kirsch 1979</strong></td>
<td><strong>Self desensitization &amp; meditation in the reduction of public speaking anxiety</strong></td>
<td><strong>Desensitisation relaxation manual (v desensitization meditation manual v meditation manual v no treatment)</strong></td>
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<td><strong>Kupshik 1999</strong></td>
<td><strong>Assisted bibliotherapy: effective, efficient treatment for moderate anxiety problems</strong></td>
<td><strong>Written material plus three levels of therapist support</strong></td>
<td>CBT</td>
<td><strong>Desensitisation</strong></td>
<td><strong>Anxiety</strong></td>
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<td><strong>Lang 1970</strong></td>
<td><strong>A psychophysiological analysis of fear modification using an automated desensitization procedure</strong></td>
<td><strong>Audiotape for automated desensitization (v therapist admin programme v no treatment control)</strong></td>
<td>BT Desensitisation</td>
<td><strong>Phobia (mixed)</strong></td>
<td>Scogin Marrs</td>
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<td><strong>Loeb 2000</strong></td>
<td><strong>Guided and unguided self-help for binge eating</strong></td>
<td><strong>Overcoming Binge Eating (Fairburn 1995)</strong> Unguided vs guided self-help</td>
<td>CBT</td>
<td><strong>BED</strong></td>
<td>Hay</td>
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<td><strong>Marshall 1976</strong></td>
<td><strong>A self administered program for public speaking anxiety</strong></td>
<td><strong>Manual for self admin desensitization ( v therapist admin v manual only v manual +check v manual +attention placebo v attention placebo v no treatment)</strong></td>
<td>BT Desensitisation</td>
<td><strong>Public Speaking Anxiety</strong></td>
<td>Scogin Gould Marrs</td>
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<td>McClaskey 1970</td>
<td>Bibliotherapy with emotional disturbed patients: an experimental study</td>
<td>Didactic Bibliotherapy or creative bibliotherapy (Used with psychotherapy) vs two control groups</td>
<td>??</td>
<td>Emotional disturbance??</td>
<td>Marrs</td>
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<td>Moss 1977</td>
<td>Self-directed contact desensitisation</td>
<td>Manual based on Rimm &amp; Masters (1974) treatment procedure. Four groups, self-directed (friend); self-directed (stranger); therapist directed contact desensitization; attention control.</td>
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<td>Peterson 2000</td>
<td>Predictors of treatment outcome for binge eating disorder</td>
<td>CBT vs self treatment manual, followed up by 16 wks CBT</td>
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<td>Case histories &amp; shorter communications</td>
<td>Booklet &amp; minimal contact (v booklet &amp; therapist v no treatment)</td>
<td>BT Desensitisation</td>
<td>Social anxiety</td>
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<td>Pitkow 1980</td>
<td>Effects of RET</td>
<td>RET vs RET + RET bibliotherapy vs RET</td>
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<td>(thesis)</td>
<td>RET bibliotherapy and psychodynamically orientated psychotherapy on adjustment in adult clinical patients</td>
<td>REC plus placebo bibliotherapy vs psychodynamically orientated psychotherapy</td>
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<td>Register 1991</td>
<td>Stress inoculation bibliotherapy in the treatment of anxiety</td>
<td>Manual based on <em>Allen &amp; Zotlow (1980)</em> behavioural interventions for alleviating test anxiety: four groups. Phone contact treatment; no contact treatment; wait list control; no contact wait list control.</td>
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<td><em>Phone contact mean 3 mins per week x 3 weeks</em></td>
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<td>Rosen 1976</td>
<td>A controlled study to assess the clinical efficacy of totally self administered systematic desensitization</td>
<td>Therapist administered desensitization programme (v manual &amp; record v manual, record &amp; minimal contact v placebo control)</td>
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<td>Desensitisation using <em>Don't be afraid: a program for overcoming fear and phobias</em> Prentice Hall (1976) cited in Glasgow 1978</td>
<td>Snake phobia</td>
<td>Scogin, Gould, Marrs</td>
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<td>Rosen 1977</td>
<td>A two year follow up on systematic desensitization with data pertaining to the external validity of laboratory fear assessment</td>
<td>Post treatment assessment of subjects participating in 1976 study (see table of papers included in more than one review)</td>
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<td>Marrs</td>
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<td>Schelver 1983</td>
<td>The effects of self administered CT on</td>
<td>Self admin CT using <em>A new guide to rational living</em> (v self admin attention</td>
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<td>Study</td>
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<td>Description</td>
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<td>Schmidt 1983</td>
<td>Amount of therapist contact &amp; outcome in multidimensional depression treatment program</td>
<td>131 page self help therapy manual (contact with therapist individual or small group or large group v self admin v wait list control)</td>
<td>BT CBT Assertion training</td>
<td>Depression</td>
<td>Gould Marrs Cuijpers</td>
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<td>Scogin '89</td>
<td>Comparative efficacy of CT and behavioural bibliotherpay for mildly and moderately depressed older adults</td>
<td>CT using Control your depression (v BT using Feeling Good v delayed treatment control)</td>
<td>CT BT</td>
<td>Depression</td>
<td>Gould Marrs Cuijpers</td>
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<td>Scogin 1985</td>
<td>Memory skills training, memory complaints and depression in older adults</td>
<td>Manual (described in paper) immediate treatment group and wait list control</td>
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<td>Scogin 1990</td>
<td>Two year follow up of bibliotherapy for depression in older adults</td>
<td>Post treatment assessment of participants in 1989 study (see table of papers included in more than one review)</td>
<td>CBT BT</td>
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<td>Cuijpers</td>
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<td>Scogin '87</td>
<td>Bibliotherapy for depressed older adults: a self help alternative</td>
<td>Cog bibliotherapy using Feeling Good plus weekly telephone by therapist (v control bibliotherapy using Man's Search for Meaning plus weekly telephone contact)</td>
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<td>Gould Cuijpers</td>
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<td>Selmi 1990</td>
<td>Computer</td>
<td>CBT computer programme designed by</td>
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<td>Design/Intervention</td>
<td>Outcome Measure</td>
<td>Authors</td>
<td>Conclusion</td>
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<td>Sorby 1991</td>
<td>Self-help programme for anxiety in general practice: a controlled trial of an anxiety management booklet</td>
<td>Booklet written by authors plus conventional treatment vs conventional treatment only.</td>
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<td>Treasure 1996</td>
<td>Sequential treatment for bulimia nervosa incorporating a self-care manual</td>
<td>CBT vs self treatment manual, <strong>Getting Better Bit(e) by Bit(e)</strong> followed by 16 wks CBT</td>
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<td>White 1995</td>
<td>Stresspac: a controlled trial of a self-help package for the anxiety disorders</td>
<td><strong>Stresspac: available from Psychological Corporation</strong> vs advice only vs no intervention</td>
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<td>Generalised anxiety disorder</td>
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<td>Wollersheim 1991</td>
<td>Group treatment of unipolar depression: a comparison of supportive, bibliotherapy and delayed treatment groups</td>
<td>Bibliotherapy using <strong>Bye, bye blues: overcoming depression</strong> (v coping therapy v supportive therapy v delayed treatment)</td>
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<td>Bowers 1993</td>
<td>Use of computer administered CBT with depressed patients</td>
<td>RCT, computerized package (Overcoming Depression) vs therapist led CBT vs treatment as usual</td>
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<td>Carr 1988</td>
<td>Supervised exposure treatment for phobias</td>
<td>Comparative study, self exposure versus therapist led CBT</td>
<td>Self exposure</td>
<td>Phobias</td>
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<td>Grime (diiseratation)</td>
<td>An open randomized study to compare the effects of a computerized CBT programme (Beating the Blues) plus conventional care vs conventional care alone, on absence from work due to anxiety, depression or stress</td>
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<td>CBT</td>
<td>Depression, anxiety</td>
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<td>Jones</td>
<td>CBT for anxiety: difficulties in carrying out a randomized trial and lessons learned</td>
<td>RCT, anxiety management package based on StressPac versus treatment as usual vs book</td>
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<td>Klein</td>
<td>A brief internet based treatment for panic disorder</td>
<td>RCT, internet based CBT programme vs self monitoring</td>
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<td><strong>Newman</strong></td>
<td>Comaprison of palmtop computer assisted brief CBT to CBT for panic disorder</td>
<td>Palmtop computer CBT programme vs therapist led CBT vs relaxation tape</td>
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<td><strong>Osgood Hynes</strong></td>
<td>Self edministered psychotherapy for depression using a telephone eccessed computer system plus booklets</td>
<td>Open cohort trial, psychotherapy using treatment booklets &amp; telephone calls to a computer aided interactive voice response system (COPE)</td>
<td>psychotherapy</td>
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<td><strong>Proudfoot</strong></td>
<td>The development &amp; beta test of a computer therapy programme for anxiety &amp; depression; hrdles &amp; preliminary outcomes</td>
<td>Multimedia programme (Beating the Blues)</td>
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<td><strong>Proudfoot</strong></td>
<td>Computerised interactive multimedia CBT reduces anxiety and depression in general practice: a randomized</td>
<td>Beating the Blues vs treatment as usual</td>
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<td>Anxiety and or depression</td>
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<td>Computer administered CBT for depression</td>
<td>Computerised CBT vs therapist led CBT vs wait list control</td>
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<td>Shaw</td>
<td>Lessons from pilot tests of computer self help for agora/clausrophobia and panic</td>
<td>Self exposure &amp; relaxation (FearFighter)</td>
<td>Self exposure</td>
<td>Agoraphobia, clausrophobia and panic</td>
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<td>Smith</td>
<td>Computer delivered modeling of exposure for spider phobia: relevant versus irrelevant exposure.</td>
<td>RCT, self exposure using interactive animations – compares three variations of the same programme</td>
<td>Self exposure</td>
<td>Spider phobia</td>
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<td>Cognitive behavioural computer therapy for the anxiety disorders</td>
<td>CBT (based on StressPac written materials)</td>
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<td>anxiety</td>
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<td>Wright (poster)</td>
<td>Controlled trial of computer assisted CBT for depression</td>
<td>Multi media learning programme vs therapist led CBT vs waitlist control</td>
<td>CBT</td>
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Data extraction sheets for randomised controlled trials and observational studies

**SELF-HELP INTERVENTIONS FOR MENTAL HEALTH IN/OUT FORM RCTS**

ID No

Assessor____ (e.g. GL) Date: _____________

1. Bibliographic details

Reference: Journal________________________________ Year________
            Volume_______ (e.g. 271) Pages_____ - _______ (e.g. 1940-1947)

First author________________ (e.g. Dieppe P)

Title: ____________________________________________________________________________________

Is subject's diagnosis/problem:

- Schizophrenia  yes
- Anxiety yes
- Depression yes
- Eating disorder yes
- Bipolar disorder yes

**Intervention(s):**

- Therapist time within protocol guidelines? yes no

**Study Type:**

- RCT? yes
- Observational? yes
- Qualitative? yes
- Other? yes describe ____________________________

Conclusion: yes IN yes OUT yes For Discussion
Assessor_____(e.g. GL)       Date: ____________       First
author____________________(e.g. Dieppe P)

Title:

__________________________________________________________________________

__________________________________________________________________________   Year_______

Volume______(e.g. 271)   Pages____- ______(e.g.1940-1947)   Study design
RCT   ☑ Observational ☑ Qualitative ☑

Condition: Schizophrenia ☑ Anxiety ☑ Panic Disorder ☑ OCD ☑ Dysthymia ☑
Depression ☑ Eating disorder ☑ Bipolar disorder ☑

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<th>Therapist Contact Time</th>
<th>Setting Participants</th>
<th>N</th>
<th>Comparison Group eg: wait list</th>
<th>Medium</th>
<th>Main findings as in paper, Qual</th>
<th>Qual 1</th>
<th>Qual 2</th>
<th>Qual 3</th>
<th>Rating</th>
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<td>Medium</td>
<td>Per wk</td>
<td>Describe</td>
<td></td>
<td></td>
<td>Eg. Book, audiotape, video, combination, CD-ROM, Other</td>
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<td>Psych theory</td>
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<td>Guided or unguided</td>
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<td>Ie: nature of therapist role</td>
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<td><strong>Expectations of user</strong></td>
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<td>I.e: what user is expected to do.</td>
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Qual 1 = concealment  
Qual 2 = F/up rate >80%  
Qual 3 = primary outcome stated with a priori power calculation