Attitudes and preferences towards self-help treatments for depression in comparison to psychotherapy and antidepressant medication

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Abstract

Background: Self-help is an effective treatment for depression. Less is known, however, about how acceptable people find different self-help treatments for depression.

Aims: To investigate preferences and attitudes toward different self-help treatments for depression in comparison to psychotherapy and antidepressants.

Methods: N = 536 people who were not actively seeking treatment for depression were randomly assigned to read about one of five treatment options (bibliotherapy, Internet-based self-help, guided self-help, antidepressants, or psychotherapy) before rating how acceptable they found the treatment. Participants also ranked the treatments in order of preference.

Results: Psychotherapy and guided self-help were found to be the most acceptable and preferred treatment options. Antidepressants and bibliotherapy were found to be the least acceptable treatments, with antidepressants rated as the most likely to have side effects. Preference data reflected the above findings – psychotherapy and guided self-help were the most preferred treatment options.

Conclusions: The findings highlight differences in attitudes and preferences between guided and unguided self-help interventions; and between self-help interventions and psychotherapy. Future research should focus on understanding why unguided self-help interventions are deemed to be less acceptable than guided self-help interventions for treating depression.

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Keywords: Depression, Acceptability, Preference, Self-help

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Marrs (1995) defines self-help as "the use of written materials or computer programs ... for the purpose of gaining understanding or solving problems relevant to a person's developmental or therapeutic needs" (p. 846). Self-help materials typically (1) provide the user with the means to identify their problem by offering information about the symptoms commonly experienced, and (2) offer advice on how to overcome problems, along with techniques for alleviating symptoms, and examples of how to use these techniques. Self-help can be delivered in many formats including books (termed 'bibliotherapy') or via the Internet. Self-help can also be offered as either a guided or unguided intervention, where guided self-help involves the patient helping themselves with some form of support from another person (Lucock, Barber, Jones, & Lovell, 2007). Self-help treatments are currently recommended by the National Institute for Health and Clinical Excellence (NICE, 2009) for depression and meta-analyses show that self-help interventions for depression are more effective than no-treatment and comparable to psychotherapies and antidepressants (Cuijpers et al., 2013).

Although the evidence suggests that self-help treatments for depression are relatively effective, less is known about peoples' attitudes toward self-help treatments; in particular, whether people deem self-help interventions to be an acceptable treatment approach and the extent to which self-help interventions are preferred to other treatment options. Research suggests that patients with depression show a preference for psychotherapy over antidepressants (Raue & Schulberg, 2007) and that patients may benefit more from treatments that they show a preference for (e.g., Kocsis et al., 2009; Kwan, Dimidjian, & Rizvi, 2010; Lin, et al., 2005; Mergl

et al., 2011; Moradveisi, Huibers, Renner, & Arntz, 2014). Other studies, however, have found no impact of patient preference on outcomes (e.g., Leykin et al., 2007; Moradveisi et al., 2014; Raue, Schulberg, Heo, Klimstra, & Bruce, 2009) and these discrepancies have led researchers to explore variables, such as beliefs about the cause of depression (Dunlop et al., 2012; Khalsa, McCarthy, Sharpless, Barrett, & Barber, 2011; Steidtmann et al., 2012), which may moderate the link between preference and treatment outcome. Preference has also been linked to engagement with treatment. Specifically, there is evidence that treatment preference influences initiation of treatment (King et al., 2005; Raue et al., 2009; Raue & Schulberg, 2007), adherence (Elkin et al., 1999; Raue et al., 2009), attrition (Kwan et al., 2010) and therapeutic alliance (Iacoviello et al., 2007; Kwan et al., 2010). In short, attitudes toward treatment are likely to influence treatment outcomes.

Although we know much about preferences for psychotherapy versus antidepressants little research has examined preferences towards self-help treatments and how they fare in relation to psychotherapy or antidepressants (Cooper-Patrick et al., 1997). There are, however, some studies that can provide indicative evidence. Landreville et al. (2001) investigated attitudes towards treatments for depression. Participants aged 65 years and over were asked to read one of two descriptions of depression (either mild to moderate or severe depression) before reading descriptions of psychotherapy, bibliotherapy, and antidepressant treatments. Participants rated how acceptable they believed that they would find each of the treatments using the modified Treatment Evaluation Inventory (Landreville & Guérette, 1998). Psychotherapy and bibliotherapy were both rated as more acceptable than antidepressants for treating mild to moderate levels of depression (but not for severe depression).

Mitchell and Gordon (2007) explored attitudes towards computerised cognitive behavioural therapy (CCBT) amongst 122 university students, 65% of whom had prior or current experience of depression or anxiety. Participants were asked to read a brief description of CCBT before rating the treatment in terms of its credibility, the expectancy that its use would improve the symptoms of depression and the perceived likelihood of using this form of treatment. The findings suggested that the sample rated CCBT as only 'somewhat credible", with moderately low expectations for improvement reported. In terms of the participants rating the likelihood of using the treatment, only 10% said that they would be likely to choose this form of treatment as their first choice, with nearly 55% of the sample saying they would prefer counselling.

Schneider, Foroushani, Grime, and Thornicoft (2014) explored how acceptable self-help intervention for depression was deemed to be. $N = 637$ employees, with symptoms of depression, took part in an online CCBT intervention for 5 weeks. Prior to the intervention, participants were asked to rate how acceptable they would find using CCBT over going to see a GP or psychologist. At the end of the intervention they were also asked to rate how acceptable they found the treatment. Schneider et al. found that, at baseline, 65% of the sample rated CCBT to be equally acceptable to seeing a psychologist and 80% of the sample found CCBT as acceptable as seeing a GP. There were no significant changes in how acceptable participants found the treatments at the end of the study, suggesting that attitudes expressed in response to hypothetical scenarios (e.g., "How do you think you would feel…?") reflect how people actually feel if they experience the treatment.

The Present Research

Although the studies described above provide insight into how acceptable people find different self-help treatments for depression, a number of important questions remain unanswered. First, no study to date has compared how acceptable people find different types of self-help. The present research will examine attitudes toward and preferences for guided self-help, unguided bibliotherapy, and unguided Internet-based self-help. The research will also investigate how acceptable people find traditional treatments (namely, psychotherapy and antidepressants), in order to provide a comparison. Second, research to date has focused on how acceptable people find different treatments, but has not yet explored treatment preferences. Specifically, if peoples' first choice of treatment is unavailable (e.g., there is a long waiting list for psychotherapy), then it is currently unclear what treatment they might prefer instead. Pressures on health services mean that this question is significant. The present research, therefore, also asked participants to rank treatments in order of preference. We also measured current levels of depression and previous treatment experience to investigate whether they influence attitudes and preferences.

Method

Sample

Staff and students at a large University in the UK were emailed an invitation to take part in a study examining attitudes toward treatments for depression. As we were interested in attitudes towards treatments that are not clouded by actual help-seeking behaviour, we sought to recruit an analogue sample who were not actively seeking treatment for depression. No inclusion/exclusion criteria were set in terms of level of depression or diagnosis. $N = 536$ participants responded. Participants were aged between 17 and 76 years ($M = 29.90$, $SD = 12.57$) and 65.11% were female,

53.73% were students, and 57.46% were White British. Participants' mean score on the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) was 26.75 (*SD* = 13.64), indicating relatively high levels of depression (Radloff, 1991).

Procedure

Participants who agreed to take part in the study were asked to read a brief description of depression and a personal account of how it feels to be depressed.[1] Participants were then randomly allocated to read a detailed description of one of five treatment for depression: psychological therapy, antidepressants, guided self-help, bibliotherapy or Internet-based self-help. Each description contained information regarding what the treatment involved, what the different treatment subtypes were (e.g., examples of the different types of psychotherapy available) and how the treatment could be accessed.[2]

Once participants had read the detailed treatment description, they rated how acceptable they found the treatment using a modified version of the Treatment Evaluation Inventory (TEI: Kazdin, 1980; Landreville & Guérette, 1998). The TEI was modified to measure how acceptable people find different treatments for depression and consisted of nine questions (e.g. "*How acceptable would you find this treatment for treating your depression?*" and "*To what extent do you think there might be risks in undergoing this kind of treatment?*"). In line with the findings of

[1] The description and personal account were 276 words in length and were taken from the website of the mental health charity, Mind (Stewart, 2010). Pilot research suggested that the account brought to life the experience of depression and accurately reflected how it feels to be depressed. Further details of this pilot research, along with the materials used are available in the supplementary materials.

[2] The descriptions of psychological therapy and antidepressants were taken from the UK mental health charity, Rethink (Rethink, 2012a, 2012b). These documents were edited to make them shorter and they were used as a template for the descriptions of the self-help treatments. Pilot research suggested that the treatment descriptions portrayed what the treatment involved and reflected what receiving the treatment would be like. Further details of this pilot research, along with the descriptions used are available in the supplementary materials.

Landreville and Guérette (1998) principle components analysis with oblimin rotation, identified two components that accounted for 69.36% of the variance. The two factors were labelled "acceptability" (e.g., *"How consistent is this treatment with your common sense or everyday notions about what a treatment for depression should be?"*) ($\alpha = 0.92$) and "side effects" (e.g., *"To what extent do you think undesirable side effects are likely to result from this treatment?"*) ($\alpha = 0.66$). Factor scores were computed for each component. Landreville and Guérette (1998) noted good concurrent validity, internal consistency and test-retest reliability when using the scale to assess treatment acceptability and side effects in relation to treatments for depression.

All participants were then asked to read brief descriptions of all five treatments, which were developed by shortening the detailed treatment descriptions. Participants were asked to rank the five treatments in order of preference. Finally, participants completed a questionnaire, which measured current levels of depression (using the CES-D, Radloff, 1977) and treatment experience (e.g. "If you have suffered from depression, which treatments have you used?"), as well as demographic information (gender, age, ethnic origin, and occupation).

Analysis strategy

One-way between-groups multivariate analyses of variance (MANOVA) was used to investigate differences in ratings of acceptability and side effects between the five treatment descriptions, and to investigate the impact of current levels of depression and treatment experience on ratings of acceptability and side effects. A Friedman test was used to investigate differences in preference ratings, with Wilcoxon sign-ranks tests used for post-hoc comparison.

Results

How Acceptable are Treatments for Depression?

Table 1 shows the average levels of acceptability and side effects for each of the five treatment options. Perceptions of both acceptability, F (4, 531) = 18.97, $p <$ 0.01, eta^2 = 0.13, and side effects, F (4, 531) = 18.19, $p < 0.01$, eta^2 = 0.12, differed between treatments. Pairwise comparisons with Bonferroni adjustment revealed that psychotherapy and guided self-help were rated as the most acceptable treatments. There was no significant difference in how acceptable participants rated psychotherapy and guided self-help ($p = 0.30$). Psychotherapy and guided self-help were, in turn, rated as significantly more acceptable than antidepressants, bibliotherapy, and Internet-based self-help ($p < 0.01$).

In terms of perceived side effects, pairwise comparisons with Bonferroni adjustment revealed that antidepressants were rated as significantly ($p < 0.01$) more likely to have side effects than psychotherapy that, in turn, was deemed to have significantly more side effects than bibliotherapy, guided self-help and Internet-based self-help. There were no differences in perceived side effects between any of the other self-help interventions (ps < 0.05).

Does Current Depression or Treatment Experience Influence how Acceptable People Find Treatments?

Radloff (1991) proposed that scores of 16 or higher on the CES-D scale indicate the presence of depression symptoms. In the present sample 64.74% of participants scored above this cut off point. Table 1 shows how acceptable participants found each of the five treatments separately for those with and without symptoms of depression. There was only a statistically significant difference in ratings between those with and without symptoms of depression for guided self-help, F(1, 85) = 7.72, p = .01, eta^2 = 0.08. Depressed participants rated guided self-help as

being significantly less acceptable than did participants without symptoms of depression. There were no differences in acceptability or side effects between participants with and without symptoms of depression for the remaining treatments (Fs < 2.99, *ns*).

Table 1 also shows levels of acceptability and side effects associated with each of the five treatments for participants who had previous experience of the treatments versus those who did not. A series of one-way between-groups MANOVAs revealed no statistically significant differences between those with and without treatment experience on the combined dependent variables (Fs < 2.61, *ns*).

Which Treatments for Depression do Participants Prefer?

Table 2 shows participants preferences for the five different types of treatment. There were significant differences between the mean rank scores for the five brief treatment descriptions (X^2 = 853.34, p < 0.001). Post-hoc comparisons showed that psychotherapy was preferred to all other treatments; guided self-help (z = -14.23, p < 0.01, antidepressants (z = -16.79, p < 0.01), bibliotherapy (z = -18.55, p < 0.01), and Internet-based self-help (z = -18.99, p < 0.01). Guided self-help was preferred to antidepressants (z = -4.53, p < 0.01), bibliotherapy (z = -10.79, p < 0.01), and Internet-based self-help (z = -14.77, p < 0.01). Antidepressants were preferred to bibliotherapy (z = -4.38, p < 0.01) and Internet-based self-help (z = -8.31, p < 0.01). Finally, bibliotherapy was preferred to Internet-based self-help (z = -6.09, p < 0.01).

Discussion

To investigate peoples' attitudes toward self-help treatments for depression, the present research compared perceptions of three types of self-help with psychotherapy and antidepressants. Consistent with the findings of other research (e.g., Raue & Schulberg, 2007), psychotherapy was rated as more acceptable and

preferable to antidepressants. Extant research had not, however, explored how acceptable people find different forms of self-help as an alternative to psychotherapy and antidepressants. Our findings suggest that psychotherapy remained the most preferred and most acceptable treatment option. However, guided self-help was deemed to be equally acceptable, with the caveat that participants with depression rated guided self-help as being less acceptable than non-depressed participants. Across the sample as a whole, psychotherapy and guided self-help were rated as more acceptable than bibliotherapy and Internet-based self-help.

The preference for guided over unguided forms of self-help is consistent with the findings of Mohr, Siddique, Ho, Duffecy, Jin, and Fokuo (2010) who found that greater interest in receiving mental health treatment was associated with greater interest in receiving face-to-face contact. The findings are also consistent with findings in relation to anxiety. For example, Sharp, Power, and Swanson (2004) found that the majority of people on a waiting list for treatment for anxiety disorders chose to undertake individual therapy over unguided self-help. Antidepressants and bibliotherapy were found to be the least acceptable treatments, with antidepressants rated as the most likely to have side effects. This latter finding is consistent with previous research suggesting that antidepressants are an unpopular treatment option (Bedi et al., 2000), possibly due to associated side effects (Khawam, Laurencic, & Malone, 2006).

Limitations and Future Directions

One potential drawback to the present research is the use of a between sample design, where participants read just one of five detailed treatment descriptions before rating how acceptable they would find that treatment. Arguably, it may have been preferable to have participants read detailed descriptions of all treatments. However,

this was deemed to be overly onerous and not an accurate reflection of how treatments are typically presented to people with depression. The other advantage of randomly allocating participants to treatment over, for example, examining how acceptable actual patients find a treatment that they have been offered, is that potential confounds such as past experience or demographic factors are controlled for. Moreover, the design enabled us to carefully control the amount and nature of information that participants received about each treatment. The present research did, however, also capitalise on a within sample design, where participants read brief descriptions of each treatment and then ranked them in order of preference. The preference data matched the acceptability data, in that both psychotherapy and guided self-help were viewed as the most acceptable and most preferred treatment options. It is, however, worth noting that the information provided in the brief treatment descriptions may not have been detailed enough to provide sufficient information for participants to make an informed decision on preference. In addition, the present research did not consider preferences for the use of combined treatments (e.g., antidepressant medication and psychotherapy) or the preference for no-treatment or watchful waiting (Dwight Johnson, Apesoa-Varano, Hay, Unutzer, & Hinton, 2013). These might be useful issues to explore in future research.

A second potential limitation is the use of an analogue design, recruiting participants who were not actively seeking treatment for depression. The advantage of this design is that attitudes towards treatments are not clouded by actual help-seeking behaviour. Indeed, no differences were found in ratings of acceptability and perceived side effects between participants with previous treatment experience and participants without. Furthermore, there were few differences between those who had current symptoms of depression and those who did not. Both these findings suggest that our

analogue sample is likely to closely approximate the beliefs of a clinical sample, which is often the case in the literature that compares clinical and analogue attitudes towards treatments for mental health disorders (e.g., Feeny & Zoellner, 2004; McHugh, Whitton, Peckham, Welge & Otto, 2013). Having said this, further research could aim to replicate the present approach in a treatment-seeking sample.

Implications for research and clinical practice

One of the cornerstones of the stepped-care model is the assumption that the treatments that are offered are acceptable to patients (Bower & Gilbody, 2005). As such, researchers have begun to explore treatment attitudes and preferences for a range of disorders (e.g., Sumner et al., 2014). Our findings suggest that unguided interventions are less acceptable and less preferable to interventions that contain an element of personal contact, such as psychotherapy or guided self-help. Researchers now need to further explore why interventions that contain personal contact are preferred to unguided interventions. Macdonald, Mead, Bower, Richards and Lovell (2007) interviewed participants who had received guided self-help for depression and found that participants reported difficulties engaging with the intervention due to the symptoms of depression, such as low motivation, or poor concentration. It is possible that these issues are even more salient for those receiving unguided self-help as they have no-one to help them to overcome these barriers. In addition, treatments that incorporate personal contact may be perceived to provide more helpful and specific guidance/coaching around the implementation of self-help techniques.

Finally, given that research suggests that patients allocated their preferred treatment (out of psychotherapy or antidepressants) are more likely to engage with that treatment, potentially improving efficacy (e.g., Kwan et al., 2010), future research might usefully assess whether this is also the case for unguided self-help

interventions. Although less effective than guided self-help (Gellatly et al., 2007), unguided interventions have been found to be effective for depression (e.g., Cuijpers, 1997), however there are often problems with poor engagement (e.g., Christensen, Griffiths & Farrer, 2009). Future research needs to assess whether this is due to the patient feeling that the treatment is unacceptable and/or having a preference for another treatment. If this is the case, then possible solutions include; (1) providing extra funding to increase the availability of acceptable treatment options, namely psychotherapy and guided self-help, (2) investigating which forms of support are acceptable, as some forms of support are less costly to administer and equally effective (in comparison to face-to-face support) such as telephone support (Farrand & Woodford, 2013), or (3) implementing protocols to boost the acceptability of unguided interventions. For example, a large-scale publicity campaign to educate the general public in the efficacy of such treatment approaches. The Department of Health (2013) announced £16 million pounds worth of funding over the next four years for a campaign against mental health stigma and within this campaign there could be scope to promote the use of unguided interventions.

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Table 1

Mean Levels of Treatment Acceptability and Side Effects by Treatment Condition for the Whole Sample and by Symptoms of Depression and Treatment Experience

	Acceptability			Side Effects		
Treatment	*N*	Mean	*SD*	*N*	Mean	*SD*
Psychotherapy	96	0.59	0.87	96	0.10	0.94
No depression symptoms	23	0.77	0.89	23	-0.06	0.97
Depression symptoms	60	0.61	0.87	60	0.15	0.96
No experience of treatment	25	0.66	0.84	25	0.18	1.05
Experience of treatment	43	0.62	0.84	43	0.00	0.92
Guided self-help	99	0.33	0.95	99	-0.07	0.92
No depression symptoms	27	0.76	0.93	27	-0.18	0.84
Depression symptoms	60	0.17	0.91	60	-0.05	0.95
No experience of treatment	2	0.26	1.03	2	0.03	0.81
Experience of treatment	71	0.01	0.99	71	-0.31	1.01
Bibliotherapy	104	-0.27	1.03	104	0.37	1.01
No depression symptoms	25	-0.49	0.93	25	-0.46	1.13
Depression symptoms	70	-0.09	1.03	70	-0.40	0.99
No experience of treatment	13	-0.18	1.15	13	-0.05	1.04
Experience of treatment	61	0.26	0.96	61	-0.40	0.88
Internet-based self-help	111	-0.26	0.95	111	-0.16	0.97
No depression symptoms	29	-0.24	0.98	29	-0.16	0.89
Depression symptoms	71	-0.32	0.92	71	-0.16	1.04
No experience of treatment	7	-0.41	1.08	7	-0.02	1.18
Experience of treatment	63	-0.30	0.86	63	-0.09	0.74

Antidepressants	112	-0.27	0.92	112	0.65	0.87
No depression symptoms	17	-0.24	0.87	17	0.42	0.89
Depression symptoms	77	-0.21	0.95	77	0.61	0.87
No experience of treatment	25	-0.16	1.04	25	0.54	0.98
Experience of treatment	48	-0.34	0.89	48	0.71	0.91

Table 2

Mean Preference Ratings for the Whole Sample

Treatment	Mean	*SD*
Psychotherapy	1.77	1.25
Guided self-help	3.25	1.40
Antidepressants	3.76	1.86
Bibliotherapy	4.23	1.27
Internet-based self-help	4.68	1.32

Supplementary materials 1: Description of depression

Depression is a serious mental illness that is characterized by a number of unpleasant symptoms. These symptoms include a low depressed mood which is constantly present every day, a lack of interest and pleasure in activities that used to be enjoyed, changes in weight and/or appetite, insomnia or hypersomnia (excess sleep), psychomotor agitation (which is a series of unintentional and purposeless motions that stem from mental tension and anxiety including pacing around a room, wringing one's hands and other similar actions), tiredness and a lack of energy, feelings of worthlessness or inappropriate guilt, an impaired ability to concentrate or indecisiveness and, most seriously, recurrent thoughts of death. A person who is depressed does not necessarily suffer from all of these symptoms, but generally 5 or more symptoms are present for more than two weeks.

Supplementary materials 2: Personal account of depression

"I felt detached from the world around me. All emotions – love, affection, anger – were gone. Actually, I can't say I had no emotions, I did, but they all seemed desperately negative. Most involved fear. Fear that I would never escape the condition. I was so scared of being alone with my thoughts. At night, everything seemed so bleak. I couldn't concentrate on anything; I couldn't read or watch TV. I couldn't relax or unwind. Sleep seemed impossible – so many thoughts were racing through my mind. I would spend hours fantasizing about ways of killing myself. Everything to do with everyday life seemed like such hard work. I simply didn't have the energy to go to work, to see friends, to shop, cook or clean. It all seemed pointless! What was the point in eating, when I didn't even want to be alive?"

Supplementary materials 3: Detailed Treatment descriptions

TREATMENT DESCRIPTION 1: Psychological therapy

What is psychological therapy?

Many people find that psychological therapies, sometimes referred to as 'talking treatments', 'counseling or psychotherapy', are useful for the treatment of depression. With the help of a trained professional, clients are encouraged to talk through the problems associated with their depression. Therapy can also allow you to explore the factors involved in making you ill in the first place and what keeps you from recovering. Therapy can also help you to deal with a specific traumatic experience such as bereavement. Therapy is usually undertaken though one-to-one sessions with a trained therapist or can be held as a group. There are also non-talking based psychological therapies such as art therapy. The number of sessions required depends on the type of therapy, the nature of the illness and what is available if the therapy is accessed on the NHS. Therapy usually last around 1-2 hours per session for an average of 16 weeks, although the duration of therapy required depends on the type of therapy sought and the extent of the depression.

Are there different types of psychological therapies?

Yes, there are a number of different types of psychological therapies available, including:

• Psychodynamic psychotherapy is one of the longest established therapies and is a term that covers therapy of an analytical nature. It is a form of in-depth therapy that focuses on the unconscious and past experiences and the effects they have on current behavior and thinking. The client is encouraged to talk about childhood relationships and experiences during the sessions. The aim of the therapy is to help

a person to understand how experiences in the past can unconsciously affect their behavior and thinking.

• Cognitive Behavioral Therapy (CBT) can help you to change how you think ("cognitive") and what you do ("behavior)". These changes can help you to feel better. CBT focuses on the problems and difficulties in the "here and now" instead of addressing the causes of your distress or symptoms. CBT looks for ways to improve your state of mind by exploring how you currently think about yourself, the world and other people and how that affects your reaction to situations.

• Counseling is sometimes a term used generally to describe all types of therapy, however it also refers to a specific type of therapy. Counseling allows a client to talk to a trained counselor about a specific problem with the aim of helping the client to understand their problem more clearly and come up with their own solutions to deal with these difficulties. The role of the counselor is to listen and be non judgmental towards the client, providing them with a safe and confidential environment to discuss their difficulties.

How do I access these treatments?

The first step is to discuss how you are feeling with your GP. He or she will then be able to refer you to the most appropriate service. You may express a preference for the type of talking therapy that you would like to receive. This will be taken into account when a referral is made, however there may be times when the talking therapy that you would like is not available or not the right one for the problems you are experiencing.

TREATMENT DESCRIPTION 2: Internet administered self-help

What is Internet administered self-help?

In 2010 60% of the UK adult population accessed the Internet every day and many of us are using the Internet as a means of understanding and treating our own health. The NHS Direct website is one of the major sources of health information online and it attracts more than 1.5 million visits each month.

As a result of so many of us using the internet as a source of health information and the problems the NHS face in treating depression in convention ways the internet is being used to provide self-help treatments for depression.

Are there different types of Internet administered self-help treatments?

Yes, there are many different websites providing self-help for depression, a few are outlined below:

• Living life to the full (www.livinglifetothefull.com) is an online course that aims to provide access to high quality, practical and user-friendly training in practical approaches you can use in your own life. The course content teaches key knowledge in how to tackle and respond to issues/demands that we meet in our lives. The course contains modules on issues such as understanding why we feel as we do, practical problem solving skills, anxiety control, relaxation, overcoming reduced activity, helpful and unhelpful behaviors, noticing and changing unhelpful thoughts, healthy living (e.g. sleep, diet and exercise) and staying well. The course delivers sound, text and video clips as well as short handouts and longer detailed practical workbooks that develop and build upon the course. The website also offers moderated discussion forums that allow course users to swap ideas, information and provide support. Nothing on the website is compulsory - you are in control. After completing the initial registration process and Session 1, you can choose to complete as many or as few of the self-help life skills modules as you wish.

• MoodGym (http://www.moodgym.anu.edu.au/) is an online interactive program

designed to help you identify whether you are having problems with emotions like anxiety and depression and learn skills that can help you cope with these emotions. MoodGYM is based on two programs that are successful in preventing and treating depression and anxiety. These are: Cognitive Behavior Therapy and Interpersonal Therapy. MoodGym consists of interactive modules that are delivered to you in a specific order. The modules are: feelings, thoughts, de-stressing, and relationships. At the end of each module you can apply the material to your own circumstances through a series of activities. As you move through the program, you are presented with information, animated demonstrations, quizzes and “homework” exercises. Your answers to the exercises are recorded in your own workbook, which keeps track of your progress. At the end there is opportunity for you to view this progress and your results.

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

How do I access these treatments?

Treatment is accessed via the Internet and thus requires a computer or other device that is able to go online.

TREATMENT DESCRIPTION 3: Bibliotherapy

What is bibliotherapy?

Bibliotherapy is basically books to help people solve problems. The use of literature can be used to help people cope with emotional problems, mental illnesses, or changes that have occurred in their lives. As a result of the change, it promotes personality and developmental growth. Bibliotherapy provides a sensitive way for a practitioner to guide reading to help an individual understand themselves and the environment, learn from others, and possibly find solutions to their problems.

Are there different types of bibliotherapy?

Yes, there are numerous amounts of self-help books for depression, three of the best-regarded are:

• Overcoming Depression: A self-help guide using cognitive behavioral techniques by Paul Gilbert. This book, written by an expert in the field of depression, uses cognitive-behavioral principles to provide a structured self-help treatment. Part One of the book helps the reader to gain an understanding of depression and its causes. Part Two provides the reader with guidance on managing their depression. It focuses on increasing activity levels, breaking problems into manageable steps and looks briefly at sleep management, diet, exercise and alcohol/drugs. It moves on to an exploration of the role of thoughts and feelings, and teaches the reader to identify and challenge thoughts that may contribute to low mood, giving particular focus to overcoming self-blaming and self-critical thoughts. The importance of developing inner compassion is highlighted, as a means of reducing signals to the body to produce a depressed response. Part Three looks at particular problems associated with depression, such as the need for approval, guilt, shame, anger, assertiveness, disappointment and perfectionism.

• Overcoming Depression: A five areas approach by Chris Williams. This book contains is a series of structured self-help workbooks for use by people experiencing depression. The course allows access to the cognitive behavior therapy (CBT) approach to treatment. Part one of the book helps the reader to understand why they feel as you do. Part two of the book is all about making changes to the readers life that will help them to overcome their depression. Topics covered include, making changes to do with people and events (such as practical problem solving, being assertive and building relationships with family/friends) making changes to behaviors and activity levels (such as using exercise to boost positive feelings and recognizing helpful and unhelpful behaviors) making changes to negative and upsetting thinking, making changes to things that affect bodily well-being (such as overcoming sleep problems) and finally making changes for the future, which is all about planning for a future that is healthy and free of depression.

• Feeling good: The New Mood Therapy by David Burns. This book describes an approach to mood modification that has a self-help component for those who suffer from depression. Research data is cited that suggests people can learn to control their mood swings and self-defeating behaviors with principles and techniques that the book describes in detail. The author describes dysfunctional thinking that can lead a person into a low mood or prevent them from healing. His theory involves helping the reader develop awareness of the connection between thoughts, feelings and behaviors and then taking active responsibility for identifying automatic thoughts, their distortions and replacing them with a rational response. Throughout the chapters, the author teaches techniques for building self-esteem, handling criticism anger and guilt as well as depression. He also focuses on prevention and personal growth work, skills for coping with stresses of daily living and finally offers advice for

handling suicide.

How do I access these treatments?

The reader can purchase self-help books or they are also readily available from libraries across the country.

TREATMENT DESCRIPTION 4: Guided self-help

What is guided self-help

Guided self-help is provided when a therapist introduces a patient to a range of self-help tools that they can work through independently, to gain a better understanding of the issues that are affecting them. Guided self-help differs from pure self-help as there is always a trained therapist on hand to provide support to the patient whilst they are using the tools. In the UK, guided self-help for depression is provided by therapists, who work within the NHS.

Are there different types of guided self-help?

Yes, there are a number of guided self-help interventions used by therapists, the most commonly used are:

• The most basic method by which guided self-help is provided, is for the therapist to recommend resources for the patient to use or activities for the patient to do. Resources can include books, interactive websites, dvd's, cd-roms etc. All of which provide information and self-help techniques for the patient to use. Activities that the therapist may recommend include, changing your diet, exercising, socializing etc. The therapist is on hand to provide support to the patient but they are mainly there to guide the patient on their self-help journey by providing the tools they need to help themselves recover.

• Cognitive restructuring is a guided self-help intervention that seeks to change

unhelpful thoughts by identifying, examining and challenging them. A major component of depression is negative thinking. Most of the negative thoughts we have when depressed are automatic and unhelpful, although they feel believable and real at the time. Patients keep a diary in which they identify their unhelpful thoughts. Patients then work with their therapist to identify which of their unhelpful thoughts is responsible for negative emotions. Once the patient has identified which unhelpful thought they wish to work on, they must examine the evidence for and against the unhelpful thought. This can be difficult, especially when trying to come up with evidence against but the therapist will help the patient by asking them questions like; if you had a friend who had this thought what would you say to them to disprove it? Once patients have gathered enough evidence for and against the unhelpful thought they are able to revise their original thoughts and hopefully come up with an alternate thought that is less damaging to their emotional state.

• Problem solving is another guided self-help intervention that helps depressed patients when their problems initially seem too big to solve. It helps patients consider what solutions may exist if they take a systematic and step by step approach to solving their problem. Patients begin by outlining the exact problem and breaking it down into components. Potential solutions of all kinds, even apparently ridiculous ones, are noted down and then analyzed in terms of their strengths and weaknesses. The patient then, with the help of their therapist, can choose a solution and begin to make a plan of how they will implement this solution. Patients will be asked to keep a diary as they begin to put the plan into action. The patient will continue to meet with their therapist, who will monitor progress and be on hand to choose a new solution should the initial plan fail to solve the problem.

How do I access these treatments?

The first step is to discuss how you are feeling with your GP. He or she will then be able to refer you to a therapist who specializes in providing guided self-help.

TREATMENT DESCRIPTION 5: Antidepressant medication

What are antidepressants?

Antidepressant medication is a treatment for depression. Antidepressant medications are taken in tablet form and they work by increasing the amount of naturally occurring chemical messengers in the brain. The brain has many naturally occurring chemical messengers. Two of these are called serotonin and noradrenaline. Both are important in the areas of the brain that control or regulate mood and thinking. It is known that these two chemical messengers are not as effective or active as normal in the brain of someone who is depressed. Antidepressants increase the amount of these chemical messengers, thus helping to correct the lack of action of the messengers and improving mood.

Are there different types of antidepressant medications?

Yes, there are a number of different types of antidepressants that may be prescribed to you, including:

• Tricyclic antidepressants were among the earliest antidepressants developed. Tricyclic antidepressants are effective, but they have generally been replaced by other antidepressants that cause fewer side effects. Other antidepressants are prescribed more often, but Tricyclic antidepressants are still a good option for some people. In certain cases, Tricyclic antidepressants relieve depression when other treatments have failed. Tricyclic antidepressants ease depression by affecting chemical messengers in the brain (neurotransmitters). These naturally occurring brain chemicals are used to communicate between brain cells. Tricyclic

antidepressants block the absorption (reuptake) of the neurotransmitters serotonin and norepinephrine making more of these chemicals available in the brain. This seems to help brain cells send and receive messages, which in turn boosts mood.

• Selective serotonin re-uptake inhibitors (SSRIs) are the most commonly prescribed antidepressants. SSRIs can ease symptoms of moderate to severe depression, are relatively safe and generally cause fewer side effects than other types of antidepressants. SSRIs ease depression by affecting chemical messengers (neurotransmitters) used to communicate between brain cells. SSRIs block the reabsorption (reuptake) of the neurotransmitter serotonin in the brain. Changing the balance of serotonin seems to help brain cells send and receive chemical messages, which in turn boosts mood. SSRIs are called selective because they seem to primarily affect serotonin, not other neurotransmitters.

• Mono-amine oxidase inhibitors (MAOIs) were the first type of antidepressant developed. MAOIs are effective, but have generally been replaced by other antidepressants that are safer and cause fewer side effects. MAOIs generally require diet restrictions because they can cause dangerously high blood pressure when taken with certain foods. In spite of side effects, MAOIs are still a good option for some people. In certain cases, MAOIs relieve depression when other treatments have failed. The enzyme monoamine oxidase is involved in removing the neurotransmitters norepinephrine, serotonin and dopamine from the brain. MAOIs prevent this from happening, which makes more of these brain chemicals available. This is thought to boost mood by improving brain cell communication.

How do I access these treatments?

Antidepressant medications are only available by prescription from a medical profession such as your GP, or Psychiatrist. You will be monitored throughout the

course of your treatment as often the dose or medication will need to be altered to treat your depression or ease side effects.

Supplementary materials 5: Brief treatment descriptions

Psychological therapy

With the help of a trained therapist, clients are encouraged to talk through the problems associated with their depression. Therapy can also allow the client to explore the factors involved in making them ill in the first place and what keeps them from recovering. Therapy sessions usually last between 1-2 hours for an average of 16 weeks, although this varies depending on the severity of the depression.

Antidepressant medications

Are taken in tablet form and work by increasing the amount of naturally occurring chemical messengers in the brain. It is know that chemical messengers are not as effective or active as normal in the brain of someone who is depressed. Antidepressants increase the amount of these chemical messengers, thus helping to correct the lack of action of the messengers and improving mood.

Bibliotherapy

The definition of bibliotherapy is simplified to basically books that help people solve problems. The use of literature can be used to help people cope with emotional problems, mental illnesses, or changes that have occurred in their lives. Bibliotherapy provides a sensitive way for a practitioner to guide reading to help an individual understand themselves and the environment, learn from others, and possibly find solutions to their problems.

Internet administered self-help

The Internet is a vast source of knowledge and many of use the Internet as a source of health information. As a result of this, the Internet has been used as a way of delivering self-help treatments for depression. Many websites provide free information on depression and access to self-help techniques. These websites often have downloadable workbooks, tutorials and advice on treating depression.

Guided self-help

In the UK, therapists who work within the NHS often provide guided self-help for patients suffering from depression. Guided self-help is often the first step of care provided to patients who have decided to seek treatment for their depression. Therapists provide the patient with self-help materials (such as books, interactive CD-ROMs, worksheets and online resources), which they work though independently. The therapist is on hand to offer guidance and support to the patient, but the majority of the work is down to the patient.

Supplementary materials 6: Description of pilot research

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

Participants and Procedure

The pilot study recruited 54 postgraduate students studying in the Psychology department at the University of Sheffield. The sample was made up of 42 females (77.8%) and 12 males (22.2%). Participants were emailed a link to an online questionnaire, which took around 20 minutes to complete. Ethical approval for the preliminary study was granted alongside the main study from the University of Sheffield.

Participants read two different accounts of depression (one referring to 'Helen', the other referring to 'David') in a counterbalanced order. David's account is presented above (see Supplementary materials 2), while Helen's account was as follows:

"I was tired all the time and not normal fatigue but bone-weary exhaustion. I slept as if I had been knocked unconscious and struggle to wake in the morning, dragging my leaden limbs through the day. I was always cold; my fingers white and numb even during the summer, when I kept a heater going full blast. If I got too cold, I would find it almost impossible to get warm again and have to resort to lying in a bath with the hot water running. My arms and legs ached constantly, so painfully that, at times, I take painkillers every four hours. I felt constantly low and depressed;

I couldn't throw off the mood I have developed, a low feeling that seems always to envelop me like a cold, grey blanket. The crying grows worse and by now I am scarcely sleeping. I have started to cry in unexpected places, at inconvenient times. One day, I cried at work. I was mortified. I never cry at work. I decided that I must be exhausted, and take a week off. It is the end of June. I spent the days walking around the streets, wearing dark glasses, with tears streaming down my face. I walked for hours every day".

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

Results

Table 1 shows that participants rated each of the accounts of depression relatively positively (in the sense that they were easy to read, brought to life the experience of depression and so on). Scores were summed to create an overall score for Helen's account ($\alpha = 0.86$) and David's account ($\alpha = 0.85$). In order to establish whether there were significant differences between the overall mean scores for the two accounts of depression, a repeated measures ANOVA was used. Significant differences were observed between the two personal accounts, $F(1,48) = 8.47$, $p < .01$, with participants showing a preference for David's account (Ms = 5.52 and 5.01, SDs = 1.04 and 1.14, for David and Helen's account, respectively). When asked to choose a personal account of depression that best captured the essence of how it feels to be depressed, the majority of participants voted for David's account

(32 participants or 59.3%) rather than Helen's account (17 or 31.5%). Five participants (9.3%) did not vote. We therefore used David's account of depression in the main study.

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

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

would be like"?) $F(4, 34) = 3.56$, $p < 0.01$ (all other Fs < 2.53, $p > .06$. Post hoc analysis showed that the brief treatment description for guided self-help ($M = 3.11$, SD = 1.56) enabled participants to more easily imagine what the treatment would be like than the brief treatment description for Internet self-help ($M = 2.37$, $SD = 1.10$).

Conclusion

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

Table 1

Descriptive Statistics for the 7 Questions assessing the Personal Accounts of Depression

Question	Account 1 (Helen) Mean (*SD*)	Account 2 (David) Mean (*SD*)
The account was easy to read	4.90 (1.81)	5.57 (1.91)
The account brought to life the experience of depression	5.25 (1.33)	5.62 (1.33)
The account fitted my understanding of how it might feel to be depressed	5.22 (1.38)	5.78 (1.14)
The account made me realise the severity of depression	4.96 (1.48)	5.60 (1.36)
The account made it easy for me to imagine that I was depressed	4.35 (1.81)	4.61 (1.80)
The account highlighted a number of the symptoms of depression	5.02 (1.59)	5.67 (1.05)
The account made it easy for me to imagine how depression would affect my day-to-day life	5.13 (1.50)	5.56 (1.29)

Note. All questions were answered using a 7-point Likert scale where 1 = strongly disagree and 7 = strongly agree

Table 2

Descriptive Statistics for the Five Treatment Descriptions

Question	Psychotherapy Mean (*SD*)	Antidepressants Mean (*SD*)	Bibliotherapy Mean (*SD*)	Internet Mean (*SD*)	Guided Mean (*SD*)
1. How easy was the treatment description to read?	2.02 (1.16)	2.76 (1.69)	2.57 (1.36)	2.34 (1.55)	2.38 (1.23)
2. How easy was it to understand what this treatment involved?	2.42 (1.22)	2.66 (1.36)	2.61 (1.15)	2.57 (1.43)	2.30 (1.03)
3. How easy was it to imagine what receiving this type of treatment would be like?	2.64 (1.38)	3.30 (1.62)	2.98 (1.34)	2.81 (1.23)	3.02 (1.37)
4. The treatment description was neutral and unbiased	3.89 (2.13)	3.93 (1.99)	3.83 (1.90)	3.68 (1.81)	3.63 (1.93)

Note. All questions were answered using 7-point Likert scales. For questions 1 – 3, 1 = extremely easy and 7 = extremely difficult, while for question 4, 1 = strongly disagree and 7 = strongly agree

Table 3

Descriptive Statistics for the Five Brief Treatment Descriptions

Question	Psychotherapy Mean (*SD*)	Antidepressants Mean (*SD*)	Bibliotherapy Mean (*SD*)	Internet Mean (*SD*)	Guided Mean (*SD*)
1. How easy was the description to read?	1.66 (1.30)	1.74 (1.25)	2.03 (1.53)	1.61 (1.20)	1.71 (1.35)
2. How easy was it to understand what this treatment involved?	2.24 (1.26)	2.18 (1.52)	2.53 (1.45)	2.45 (1.39)	2.03 (1.33)
3. How easy was it to imagine what receiving this type of treatment would be like?	2.55 (1.35)	2.79 (1.56)	3.11 (1.49)	3.11 (1.56)	2.37 (1.10)
4. The description was neutral and unbiased	3.74 (2.06)	4.05 (2.05)	4.03 (2.17)	3.92 (2.25)	3.61 (2.52)
5. The description captured the essence of the longer description	4.76 (1.91)	4.75 (1.70)	4.76 (1.76)	4.78 (1.86)	5.46 (1.48)

Note. The response scales for questions 1 – 4 were as above and for question 5, 1 = strongly disagree and 7 = strongly agree