

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

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**BEHAVIOURAL AND
COGNITIVE PSYCHOTHERAPY**



**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.

Word count: 186 words

Keywords: Depression, Acceptability, Preference, Self-help

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5 to psychotherapy and antidepressant medication
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7 Marris (1995) defines self-help as “the use of written materials or computer
8 programs ... for the purpose of gaining understanding or solving problems relevant to
9 a person’s developmental or therapeutic needs” (p. 846). Self-help materials typically
10 (1) provide the user with the means to identify their problem by offering information
11 about the symptoms commonly experienced, and (2) offer advice on how to overcome
12 problems, along with techniques for alleviating symptoms, and examples of how to
13 use these techniques. Self-help can be delivered in many formats including books
14 (termed ‘bibliotherapy’) or via the Internet. Self-help can also be offered as either a
15 guided or unguided intervention, where guided self-help involves the patient helping
16 themselves with some form of support from another person (Lucock, Barber, Jones, &
17 Lovell, 2007). Self-help treatments are currently recommended by the National
18 Institute for Health and Clinical Excellence (NICE, 2009) for depression and meta-
19 analyses show that self-help interventions for depression are more effective than no-
20 treatment and comparable to psychotherapies and antidepressants (Cuijpers et al.,
21 2013).
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40 Although the evidence suggests that self-help treatments for depression are
41 relatively effective, less is known about peoples’ attitudes toward self-help
42 treatments; in particular, whether people deem self-help interventions to be an
43 acceptable treatment approach and the extent to which self-help interventions are
44 preferred to other treatment options. Research suggests that patients with depression
45 show a preference for psychotherapy over antidepressants (Raue & Schulberg, 2007)
46 and that patients may benefit more from treatments that they show a preference for
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56 (e.g., Kocsis et al., 2009; Kwan, Dimidjian, & Rizvi, 2010; Lin, et al., 2005; Mergl
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3 et al., 2011; Moradveisi, Huibers, Renner, & Arntz, 2014). Other studies, however,
4
5 have found no impact of patient preference on outcomes (e.g., Leykin et al., 2007;
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7 Moradveisi et al., 2014; Raue, Schulberg, Heo, Klimstra, & Bruce, 2009) and these
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9 discrepancies have led researchers to explore variables, such as beliefs about the
10
11 cause of depression (Dunlop et al., 2012; Khalsa, McCarthy, Sharpless, Barrett, &
12
13 Barber, 2011; Steidtmann et al., 2012), which may moderate the link between
14
15 preference and treatment outcome. Preference has also been linked to engagement
16
17 with treatment. Specifically, there is evidence that treatment preference influences
18
19 initiation of treatment (King et al., 2005; Raue et al., 2009; Raue & Schulberg, 2007),
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21 adherence (Elkin et al., 1999; Raue et al., 2009), attrition (Kwan et al., 2010) and
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23 therapeutic alliance (Iacoviello et al., 2007; Kwan et al., 2010). In short, attitudes
24
25 toward treatment are likely to influence treatment outcomes.
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30 Although we know much about preferences for psychotherapy versus
31
32 antidepressants little research has examined preferences towards self-help treatments
33
34 and how they fare in relation to psychotherapy or antidepressants (Cooper-Patrick et
35
36 al., 1997). There are, however, some studies that can provide indicative evidence.
37
38 Landreville et al. (2001) investigated attitudes towards treatments for depression.
39
40 Participants aged 65 years and over were asked to read one of two descriptions of
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42 depression (either mild to moderate or severe depression) before reading descriptions
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44 of psychotherapy, bibliotherapy, and antidepressant treatments. Participants rated how
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46 acceptable they believed that they would find each of the treatments using the
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48 modified Treatment Evaluation Inventory (Landreville & Guérette, 1998).
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50 Psychotherapy and bibliotherapy were both rated as more acceptable than
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52 antidepressants for treating mild to moderate levels of depression (but not for severe
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54 depression).
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3 Mitchell and Gordon (2007) explored attitudes towards computerised
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5 cognitive behavioural therapy (CCBT) amongst 122 university students, 65% of
6
7 whom had prior or current experience of depression or anxiety. Participants were
8
9 asked to read a brief description of CCBT before rating the treatment in terms of its
10
11 credibility, the expectancy that its use would improve the symptoms of depression and
12
13 the perceived likelihood of using this form of treatment. The findings suggested that
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15 the sample rated CCBT as only ‘somewhat credible’, with moderately low
16
17 expectations for improvement reported. In terms of the participants rating the
18
19 likelihood of using the treatment, only 10% said that they would be likely to choose
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21 this form of treatment as their first choice, with nearly 55% of the sample saying they
22
23 would prefer counselling.
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27 Schneider, Foroushani, Grime, and Thornicof (2014) explored how
28
29 acceptable self-help intervention for depression was deemed to be. $N = 637$
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31 employees, with symptoms of depression, took part in an online CCBT intervention
32
33 for 5 weeks. Prior to the intervention, participants were asked to rate how acceptable
34
35 they would find using CCBT over going to see a GP or psychologist. At the end of the
36
37 intervention they were also asked to rate how acceptable they found the treatment.
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39 Schneider et al. found that, at baseline, 65% of the sample rated CCBT to be equally
40
41 acceptable to seeing a psychologist and 80% of the sample found CCBT as acceptable
42
43 as seeing a GP. There were no significant changes in how acceptable participants
44
45 found the treatments at the end of the study, suggesting that attitudes expressed in
46
47 response to hypothetical scenarios (e.g., “How do you think you would feel...?”)
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49 reflect how people actually feel if they experience the treatment.
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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,

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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.

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3 Landreville and Guérette (1998) principle components analysis with oblimin rotation,
4 identified two components that accounted for 69.36% of the variance. The two factors
5 were labelled “acceptability” (e.g., “*How consistent is this treatment with your*
6 *common sense or everyday notions about what a treatment for depression should*
7 *be?*”) ($\alpha = 0.92$) and “side effects” (e.g., “*To what extent do you think undesirable*
8 *side effects are likely to result from this treatment?*”) ($\alpha = 0.66$). Factor scores were
9 computed for each component. Landreville and Guérette (1998) noted good
10 concurrent validity, internal consistency and test-retest reliability when using the scale
11 to assess treatment acceptability and side effects in relation to treatments for
12 depression.
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25 All participants were then asked to read brief descriptions of all five
26 treatments, which were developed by shortening the detailed treatment descriptions.
27 Participants were asked to rank the five treatments in order of preference. Finally,
28 participants completed a questionnaire, which measured current levels of depression
29 (using the CES-D, Radloff, 1977) and treatment experience (e.g. “If you have
30 suffered from depression, which treatments have you used?”), as well as demographic
31 information (gender, age, ethnic origin, and occupation).
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41 Analysis strategy

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

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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

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

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

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

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3 preferable to antidepressants. Extant research had not, however, explored how
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5 acceptable people find different forms of self-help as an alternative to psychotherapy
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7 and antidepressants. Our findings suggest that psychotherapy remained the most
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9 preferred and most acceptable treatment option. However, guided self-help was
10
11 deemed to be equally acceptable, with the caveat that participants with depression
12
13 rated guided self-help as being less acceptable than non-depressed participants.
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15 Across the sample as a whole, psychotherapy and guided self-help were rated as more
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17 acceptable than bibliotherapy and Internet-based self-help.
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21 The preference for guided over unguided forms of self-help is consistent with
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23 the findings of Mohr, Siddique, Ho, Duffecy, Jin, and Fokuo (2010) who found that
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25 greater interest in receiving mental health treatment was associated with greater
26
27 interest in receiving face-to-face contact. The findings are also consistent with
28
29 findings in relation to anxiety. For example, Sharp, Power, and Swanson (2004) found
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31 that the majority of people on a waiting list for treatment for anxiety disorders chose
32
33 to undertake individual therapy over unguided self-help. Antidepressants and
34
35 bibliotherapy were found to be the least acceptable treatments, with antidepressants
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37 rated as the most likely to have side effects. This latter finding is consistent with
38
39 previous research suggesting that antidepressants are an unpopular treatment option
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41 (Bedi et al., 2000), possibly due to associated side effects (Khawam, Laurencic, &
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43 Malone, 2006).
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47 **Limitations and Future Directions**

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49 **One potential** drawback to the present research is the use of a between sample
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51 design, where participants read just one of five detailed treatment descriptions before
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53 rating how acceptable they would find that treatment. Arguably, it may have been
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55 preferable to have participants read detailed descriptions of all treatments. However,
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3 this was deemed to be overly onerous and not an accurate reflection of how
4 treatments are typically presented to people with depression. The other advantage of
5 randomly allocating participants to treatment over, for example, examining how
6 acceptable actual patients find a treatment that they have been offered, is that
7 potential confounds such as past experience or demographic factors are controlled for.
8 Moreover, the design enabled us to carefully control the amount and nature of
9 information that participants received about each treatment. The present research did,
10 however, also capitalise on a within sample design, where participants read brief
11 descriptions of each treatment and then ranked them in order of preference. The
12 preference data matched the acceptability data, in that both psychotherapy and guided
13 self-help were viewed as the most acceptable and most preferred treatment options. It
14 is, however, worth noting that the information provided in the brief treatment
15 descriptions may not have been detailed enough to provide sufficient information for
16 participants to make an informed decision on preference. In addition, the present
17 research did not consider preferences for the use of combined treatments (e.g.,
18 antidepressant medication and psychotherapy) or the preference for no-treatment or
19 watchful waiting (Dwight Johnson, Apesoa-Varano, Hay, Unutzer, & Hinton, 2013).
20 These might be useful issues to explore in future research.
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43 A second potential limitation is the use of an analogue design, recruiting
44 participants who were not actively seeking treatment for depression. The advantage of
45 this design is that attitudes towards treatments are not clouded by actual help-seeking
46 behaviour. Indeed, no differences were found in ratings of acceptability and perceived
47 side effects between participants with previous treatment experience and participants
48 without. Furthermore, there were few differences between those who had current
49 symptoms of depression and those who did not. Both these findings suggest that our
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3 analogue sample is likely to closely approximate the beliefs of a clinical sample,
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5 which is often the case in the literature that compares clinical and analogue attitudes
6
7 towards treatments for mental health disorders (e.g., Feeny & Zoellner, 2004;
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9 McHugh, Whitton, Peckham, Welge & Otto, 2013). Having said this, further research
10
11 could aim to replicate the present approach in a **treatment-seeking sample**.
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14 **Implications for research and clinical practice**

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16 One of the cornerstones of the stepped-care model is the assumption that the
17
18 treatments that are offered are acceptable to patients (Bower & Gilbody, 2005). As
19
20 such, researchers have begun to explore treatment attitudes and preferences for a
21
22 range of disorders (e.g., Sumner et al., 2014). **Our findings suggest that unguided**
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24 **interventions are less acceptable and less preferable to interventions that contain an**
25
26 **element of personal contact, such as psychotherapy or guided self-help. Researchers**
27
28 **now need to further explore why interventions that contain personal contact are**
29
30 **preferred to unguided interventions. Macdonald, Mead, Bower, Richards and Lovell**
31
32 **(2007) interviewed participants who had received guided self-help for depression and**
33
34 **found that participants reported difficulties engaging with the intervention due to the**
35
36 **symptoms of depression, such as low motivation, or poor concentration. It is possible**
37
38 **that these issues are even more salient for those receiving unguided self-help as they**
39
40 **have no-one to help them to overcome these barriers. In addition, treatments that**
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42 **incorporate personal contact may be perceived to provide more helpful and specific**
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44 **guidance/coaching around the implementation of self-help techniques.**
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50 Finally, given that research suggests that patients allocated their preferred
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52 treatment (out of psychotherapy or antidepressants) are more likely to engage with
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54 that treatment, potentially improving efficacy (e.g., Kwan et al., 2010), future
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56 research might usefully assess whether this is also the case for unguided self-help
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3 interventions. Although less effective than guided self-help (Gellatly et al., 2007),
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5 unguided interventions have been found to be effective for depression (e.g., Cuijpers,
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7 1997), however there are often problems with poor engagement (e.g., Christensen,
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9 Griffiths & Farrer, 2009). Future research needs to assess whether this is due to the
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11 patient feeling that the treatment is unacceptable and/or having a preference for
12
13 another treatment. If this is the case, then possible solutions include; (1) providing
14
15 extra funding to increase the availability of acceptable treatment options, namely
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17 psychotherapy and guided self-help, (2) investigating which forms of support are
18
19 acceptable, as some forms of support are less costly to administer and equally
20
21 effective (in comparison to face-to-face support) such as telephone support (Farrand
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23 & Woodford, 2013), or (3) implementing protocols to boost the acceptability of
24
25 unguided interventions. For example, a large-scale publicity campaign to educate the
26
27 general public in the efficacy of such treatment approaches. The Department of
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29 Health (2013) announced £16 million pounds worth of funding over the next four
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31 years for a campaign against mental health stigma and within this campaign there
32
33 could be scope to promote the use of unguided interventions.
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Running head: HOW ACCEPTABLE IS SELF HELP?

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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

Treatment	Acceptability			Side Effects		
	<i>N</i>	Mean	<i>SD</i>	<i>N</i>	Mean	<i>SD</i>
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

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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 through 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

1
2
3 a person to understand how experiences in the past can unconsciously affect their
4
5 behavior and thinking.

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7 • Cognitive Behavioral Therapy (CBT) can help you to change how you think
8
9 ("cognitive") and what you do ("behavior)". These changes can help you to feel
10
11 better. CBT focuses on the problems and difficulties in the "here and now" instead of
12
13 addressing the causes of your distress or symptoms. CBT looks for ways to improve
14
15 your state of mind by exploring how you currently think about yourself, the world and
16
17 other people and how that affects your reaction to situations.

18
19 • Counseling is sometimes a term used generally to describe all types of therapy,
20
21 however it also refers to a specific type of therapy. Counseling allows a client to talk
22
23 to a trained counselor about a specific problem with the aim of helping the client to
24
25 understand their problem more clearly and come up with their own solutions to deal
26
27 with these difficulties. The role of the counselor is to listen and be non judgmental
28
29 towards the client, providing them with a safe and confidential environment to
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31 discuss their difficulties.

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36 *How do I access these treatments?*

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38 The first step is to discuss how you are feeling with your GP. He or she will then be
39
40 able to refer you to the most appropriate service. You may express a preference for
41
42 the type of talking therapy that you would like to receive. This will be taken into
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44 account when a referral is made, however there may be times when the talking
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46 therapy that you would like is not available or not the right one for the problems you
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48 are experiencing.

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54 *TREATMENT DESCRIPTION 2: Internet administered self-help*

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56 *What is Internet administered self-help?*
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3 In 2010 60% of the UK adult population accessed the Internet every day and many
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5 of us are using the Internet as a means of understanding and treating our own
6
7 health. The NHS Direct website is one of the major sources of health information
8
9 online and it attracts more than 1.5 million visits each month.
10

11 As a result of so many of us using the internet as a source of health information and
12
13 the problems the NHS face in treating depression in convention ways the internet is
14
15 being used to provide self-help treatments for depression.
16
17

18 *Are there different types of Internet administered self-help treatments?*
19

20 Yes, there are many different websites providing self-help for depression, a few are
21
22 outlined below:
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24
25 • Living life to the full (www.livinglifetothefull.com) is an online course that aims to
26
27 provide access to high quality, practical and user-friendly training in practical
28
29 approaches you can use in your own life. The course content teaches key
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31 knowledge in how to tackle and respond to issues/demands that we meet in our
32
33 lives. The course contains modules on issues such as understanding why we feel as
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35 we do, practical problem solving skills, anxiety control, relaxation, overcoming
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37 reduced activity, helpful and unhelpful behaviors, noticing and changing unhelpful
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39 thoughts, healthy living (e.g. sleep, diet and exercise) and staying well. The course
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41 delivers sound, text and video clips as well as short handouts and longer detailed
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43 practical workbooks that develop and build upon the course. The website also offers
44
45 moderated discussion forums that allow course users to swap ideas, information and
46
47 provide support. Nothing on the website is compulsory - you are in control. After
48
49 completing the initial registration process and Session 1, you can choose to
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51 complete as many or as few of the self-help life skills modules as you wish.
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54
55 • MoodGym (<http://www.moodgym.anu.edu.au/>) is an online interactive program
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2
3 designed to help you identify whether you are having problems with emotions like
4 anxiety and depression and learn skills that can help you cope with these emotions.
5
6 MoodGYM is based on two programs that are successful in preventing and treating
7 depression and anxiety. These are: Cognitive Behavior Therapy and Interpersonal
8 Therapy. MoodGym consists of interactive modules that are delivered to you in a
9 specific order. The modules are: feelings, thoughts, de-stressing, and relationships.
10
11 At the end of each module you can apply the material to your own circumstances
12 through a series of activities. As you move through the program, you are presented
13 with information, animated demonstrations, quizzes and “homework” exercises. Your
14 answers to the exercises are recorded in your own workbook, which keeps track of
15 your progress. At the end there is opportunity for you to view this progress and your
16 results.
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29
30 • The Centre for Clinical Interventions (<http://www.cci.health.wa.gov.au/>) website
31 offers free downloadable workbooks that provide self-help guidance for depression.
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33 The depression workbook contains nine modules that cover everything from the
34 symptoms and causes of depression, right through to how to maintain the progress
35 made once you have completed the modules. Specific self-help activities include,
36 behavioral strategies to increase activity levels, how to challenge automatic thoughts
37 that negatively impact upon feelings and finally core beliefs are examined and advice
38 & techniques are given to help the patient confront the core beliefs they hold that
39 may be leading to depression (for example: I’m unlovable).
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49 *How do I access these treatments?*

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

1
2
3 • Overcoming Depression: A five areas approach by Chris Williams. This book
4 contains is a series of structured self-help workbooks for use by people experiencing
5 depression. The course allows access to the cognitive behavior therapy (CBT)
6 approach to treatment. Part one of the book helps the reader to understand why they
7 feel as you do. Part two of the book is all about making changes to the readers life
8 that will help them to overcome their depression. Topics covered include, making
9 changes to do with people and events (such as practical problem solving, being
10 assertive and building relationships with family/friends) making changes to behaviors
11 and activity levels (such as using exercise to boost positive feelings and recognizing
12 helpful and unhelpful behaviors) making changes to negative and upsetting thinking,
13 making changes to things that affect bodily well-being (such as overcoming sleep
14 problems) and finally making changes for the future, which is all about planning for a
15 future that is healthy and free of depression.
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32 • Feeling good: The New Mood Therapy by David Burns. This book describes an
33 approach to mood modification that has a self-help component for those who suffer
34 from depression. Research data is cited that suggests people can learn to control
35 their mood swings and self-defeating behaviors with principles and techniques that
36 the book describes in detail. The author describes dysfunctional thinking that can
37 lead a person into a low mood or prevent them from healing. His theory involves
38 helping the reader develop awareness of the connection between thoughts, feelings
39 and behaviors and then taking active responsibility for identifying automatic thoughts,
40 their distortions and replacing them with a rational response. Throughout the
41 chapters, the author teaches techniques for building self-esteem, handling criticism
42 anger and guilt as well as depression. He also focuses on prevention and personal
43 growth work, skills for coping with stresses of daily living and finally offers advice for
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3 handling suicide.

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5 *How do I access these treatments?*

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7 The reader can purchase self-help books or they are also readily available from
8
9 libraries across the country.
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11 12 13 14 *TREATMENT DESCRIPTION 4: Guided self-help*

15
16 *What is guided self-help*

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18 Guided self-help is provided when a therapist introduces a patient to a range of self-
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20 help tools that they can work through independently, to gain a better understanding
21
22 of the issues that are affecting them. Guided self-help differs from pure self-help as
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24 there is always a trained therapist on hand to provide support to the patient whilst
25
26 they are using the tools. In the UK, guided self-help for depression is provided by
27
28 therapists, who work within the NHS.
29
30

31
32 *Are there different types of guided self-help?*

33
34 Yes, there are a number of guided self-help interventions used by therapists, the
35
36 most commonly used are:

37
38 • The most basic method by which guided self-help is provided, is for the therapist to
39
40 recommend resources for the patient to use or activities for the patient to do.

41
42 Resources can include books, interactive websites, dvd's, cd-roms etc. All of which
43
44 provide information and self-help techniques for the patient to use. Activities that the
45
46 therapist may recommend include, changing your diet, exercising, socializing etc.

47
48 The therapist is on hand to provide support to the patient but they are mainly there to
49
50 guide the patient on their self-help journey by providing the tools they need to help
51
52 themselves recover.
53
54

55
56 • Cognitive restructuring is a guided self-help intervention that seeks to change
57
58
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1
2
3 unhelpful thoughts by identifying, examining and challenging them. A major
4
5 component of depression is negative thinking. Most of the negative thoughts we
6
7 have when depressed are automatic and unhelpful, although they feel believable and
8
9 real at the time. Patients keep a diary in which they identify their unhelpful thoughts.
10
11 Patients then work with their therapist to identify which of their unhelpful thoughts is
12
13 responsible for negative emotions. Once the patient has identified which unhelpful
14
15 thought they wish to work on, they must examine the evidence for and against the
16
17 unhelpful thought. This can be difficult, especially when trying to come up with
18
19 evidence against but the therapist will help the patient by asking them questions like;
20
21 if you had a friend who had this thought what would you say to them to disprove it?
22
23 Once patients have gathered enough evidence for and against the unhelpful thought
24
25 they are able to revise their original thoughts and hopefully come up with an
26
27 alternate thought that is less damaging to their emotional state.
28
29

30
31 • Problem solving is another guided self-help intervention that helps depressed
32
33 patients when their problems initially seem too big to solve. It helps patients consider
34
35 what solutions may exist if they take a systematic and step by step approach to
36
37 solving their problem. Patients begin by outlining the exact problem and breaking it
38
39 down into components. Potential solutions of all kinds, even apparently ridiculous
40
41 ones, are noted down and then analyzed in terms of their strengths and
42
43 weaknesses. The patient then, with the help of their therapist, can choose a solution
44
45 and begin to make a plan of how they will implement this solution. Patients will be
46
47 asked to keep a diary as they begin to put the plan into action. The patient will
48
49 continue to meet with their therapist, who will monitor progress and be on hand to
50
51 choose a new solution should the initial plan fail to solve the problem.
52
53
54

55
56 *How do I access these treatments?*
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3 The first step is to discuss how you are feeling with your GP. He or she will then be
4
5 able to refer you to a therapist who specializes in providing guided self-help.
6
7

8
9
10 *TREATMENT DESCRIPTION 5: Antidepressant medication*

11 *What are antidepressants?*

12
13 Antidepressant medication is a treatment for depression. Antidepressant medications
14
15 are taken in tablet form and they work by increasing the amount of naturally
16
17 occurring chemical messengers in the brain. The brain has many naturally occurring
18
19 chemical messengers. Two of these are called serotonin and noradrenaline. Both
20
21 are important in the areas of the brain that control or regulate mood and thinking. It is
22
23 known that these two chemical messengers are not as effective or active as normal
24
25 in the brain of someone who is depressed. Antidepressants increase the amount of
26
27 these chemical messengers, thus helping to correct the lack of action of the
28
29 messengers and improving mood.
30
31
32

33 *Are there different types of antidepressant medications?*

34
35 Yes, there are a number of different types of antidepressants that may be prescribed
36
37 to you, including:
38
39

40 • Tricyclic antidepressants were among the earliest antidepressants developed.
41
42 Tricyclic antidepressants are effective, but they have generally been replaced by
43
44 other antidepressants that cause fewer side effects. Other antidepressants are
45
46 prescribed more often, but Tricyclic antidepressants are still a good option for some
47
48 people. In certain cases, Tricyclic antidepressants relieve depression when other
49
50 treatments have failed. Tricyclic antidepressants ease depression by affecting
51
52 chemical messengers in the brain (neurotransmitters). These naturally occurring
53
54 brain chemicals are used to communicate between brain cells. Tricyclic
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1
2
3 antidepressants block the absorption (reuptake) of the neurotransmitters serotonin
4
5 and norepinephrine making more of these chemicals available in the brain. This
6
7 seems to help brain cells send and receive messages, which in turn boosts mood.

8
9
10 • Selective serotonin re-uptake inhibitors (SSRIs) are the most commonly prescribed
11
12 antidepressants. SSRIs can ease symptoms of moderate to severe depression, are
13
14 relatively safe and generally cause fewer side effects than other types of
15
16 antidepressants. SSRIs ease depression by affecting chemical messengers
17
18 (neurotransmitters) used to communicate between brain cells. SSRIs block the
19
20 reabsorption (reuptake) of the neurotransmitter serotonin in the brain. Changing the
21
22 balance of serotonin seems to help brain cells send and receive chemical messages,
23
24 which in turn boosts mood. SSRIs are called selective because they seem to
25
26 primarily affect serotonin, not other neurotransmitters.
27
28

29
30 • Mono-amine oxidase inhibitors (MAOIs) were the first type of antidepressant
31
32 developed. MAOIs are effective, but have generally been replaced by other
33
34 antidepressants that are safer and cause fewer side effects. MAOIs generally require
35
36 diet restrictions because they can cause dangerously high blood pressure when
37
38 taken with certain foods. In spite of side effects, MAOIs are still a good option for
39
40 some people. In certain cases, MAOIs relieve depression when other treatments
41
42 have failed. The enzyme monoamine oxidase is involved in removing the
43
44 neurotransmitters norepinephrine, serotonin and dopamine from the brain. MAOIs
45
46 prevent this from happening, which makes more of these brain chemicals available.
47
48 This is thought to boost mood by improving brain cell communication.
49
50

51
52 *How do I access these treatments?*

53
54 Antidepressant medications are only available by prescription from a medical
55
56 profession such as your GP, or Psychiatrist. You will be monitored throughout the
57
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1
2
3 course of your treatment as often the dose or medication will need to be altered to
4
5 treat your depression or ease side effects.
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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 known 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

1
2
3 The Internet is a vast source of knowledge and many of use the Internet as a source
4
5 of health information. As a result of this, the Internet has been used as a way of
6
7 delivering self-help treatments for depression. Many websites provide free
8
9 information on depression and access to self-help techniques. These websites often
10
11 have downloadable workbooks, tutorials and advice on treating depression.
12
13

14 15 16 *Guided self-help*

17
18 In the UK, therapists who work within the NHS often provide guided self-help for
19
20 patients suffering from depression. Guided self-help is often the first step of care
21
22 provided to patients who have decided to seek treatment for their depression.
23
24 Therapists provide the patient with self-help materials (such as books, interactive
25
26 CD-ROMs, worksheets and online resources), which they work though
27
28 independently. The therapist is on hand to offer guidance and support to the patient,
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30 but the majority of the work is down to the patient.
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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;

1
2
3 I couldn't throw off the mood I have developed, a low feeling that seems always to
4 envelop me like a cold, grey blanket. The crying grows worse and by now I am
5 scarcely sleeping. I have started to cry in unexpected places, at inconvenient times.
6
7 One day, I cried at work. I was mortified. I never cry at work. I decided that I must be
8 exhausted, and take a week off. It is the end of June. I spent the days walking
9 around the streets, wearing dark glasses, with tears streaming down my face. I
10 walked for hours every day".

11
12 Participants were asked seven questions about each of the accounts of
13 depression (see Table 1) and asked which of the two accounts they felt best
14 captured the essence of how it feels to be depressed. Participants were then asked
15 to read the treatment descriptions before being asked to answer four questions
16 about each of the longer treatment descriptions (see Table 2) and five questions
17 about each of the brief treatment descriptions (see Table 3).

18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 *Results*

33
34 Table 1 shows that participants rated each of the accounts of depression
35 relatively positively (in the sense that they were easy to read, brought to life the
36 experience of depression and so on). Scores were summed to create an overall
37 score for Helen's account ($\alpha = 0.86$) and David's account ($\alpha = 0.85$). In order to
38 establish whether there were significant differences between the overall mean
39 scores for the two accounts of depression, a repeated measures ANOVA was used.
40
41 Significant differences were observed between the two personal accounts, $F(1,48) =$
42 8.47, $p < .01$, with participants showing a preference for David's account ($M_s = 5.52$
43 and 5.01, $SD_s = 1.04$ and 1.14, for David and Helen's account, respectively). When
44 asked to choose a personal account of depression that best captured the essence of
45 how it feels to be depressed, the majority of participants voted for David's account
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3 (32 participants or 59.3%) rather than Helen's account (17 or 31.5%). Five
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5 participants (9.3%) did not vote. We therefore used David's account of depression in
6
7 the main study.
8

9
10 Table 2 shows that the participants rated the detailed treatment descriptions
11
12 as easy to read and understand, and allowing them to imagine what receiving the
13
14 treatment would be like (i.e., all of the means were below the midpoint of the scale).
15
16 Participants felt that all of the treatment descriptions were slightly biased (i.e., all
17
18 means were above the midpoint of the scale). In order to investigate whether there
19
20 were significant differences between ratings of the different treatments, a series of
21
22 repeated measures ANOVAs were performed, using Bonferroni adjustment to
23
24 correct for multiple tests ($p = 0.01$). No significant differences were observed
25
26 between the five treatment descriptions for any of the four questions ($p > 0.05$ in all
27
28 cases).
29
30

31
32 Table 3 shows that the participants rated the brief treatment descriptions as
33
34 easy to read, easy to understand and allowed them to imagine what receiving the
35
36 treatment would be like (i.e., all means were below the midpoint of the scale). As
37
38 with the detailed treatment descriptions, participants tended to feel that the brief
39
40 treatment descriptions were slightly biased (i.e., all means were above the midpoint
41
42 of the scale). Participants did, however, agree that the brief treatment descriptions
43
44 captured the essence of the longer treatment descriptions (i.e., all means were
45
46 above the midpoint of the scale). In order to investigate whether there were
47
48 significant differences in ratings of the five brief treatment descriptions, a series of
49
50 repeated measures ANOVAs were performed, with Bonferroni adjustment as before.
51
52 Significant differences were observed between the five brief treatment descriptions
53
54 for question 3 only ("How easy was it to imagine what receiving this type of treatment
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3 would be like"?) $F(4, 34) = 3.56, p < 0.01$ (all other $F_s < 2.53, p > .06$. Post hoc
4
5 analysis showed that the brief treatment description for guided self-help ($M = 3.11,$
6
7 $SD = 1.56$) enabled participants to more easily imagine what the treatment would be
8
9 like than the brief treatment description for Internet self-help ($M = 2.37, SD = 1.10$).
10

11 *Conclusion*

12
13
14 The pilot research was able to fulfill its three main aims, which were to
15
16 establish (a) which personal account of depression best captured the essence of
17
18 how it feels to be depressed, (b) whether the detailed and brief treatment
19
20 descriptions were comparable and (c) whether the brief treatment descriptions
21
22 accurately portrayed their longer counterparts. In terms of the personal accounts of
23
24 depression, participants favored David's account and so that is the one that was
25
26 used in the main study. In terms of the full length and brief treatment descriptions
27
28 only one difference was noted, with participants rating the brief treatment description
29
30 for guided self-help as more easily enabling them imagine what the treatment would
31
32 be like than the brief treatment description for Internet self-help.
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Table 1

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

Question	Account 1 (Helen)	Account 2 (David)
	Mean (<i>SD</i>)	Mean (<i>SD</i>)
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 Antidepressants	Bibliotherapy	Internet	Guided
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
1. How easy was the treatment description to read?	2.02 (1.16)	2.76 (1.69)	2.57 (1.36)	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)	2.30 (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)	3.02 (1.37)
4. The treatment description was neutral and unbiased	3.89 (2.13)	3.93 (1.99)	3.83 (1.90)	3.63 (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 Antidepressants	Bibliotherapy	Internet	Guided
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
1. How easy was the description to read?	1.66 (1.30)	1.74 (1.25)	2.03 (1.53)	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)	2.03 (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)	2.37 (1.10)
4. The description was neutral and unbiased	3.74 (2.06)	4.05 (2.05)	4.03 (2.17)	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)	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