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ASSESSING THE TAKE UP AND ACCEPTABILITY OF A SELF-HELP ROOM USED BY PATIENTS AWAITING THEIR INITIAL OUTPATIENT APPOINTMENT

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Abstract. This open study measured the proportion of routine referrals from primary care to a psychiatric sector team with symptoms of anxiety and/or low mood who chose to take up the option of attending a self-help room to use the CBT self-help manual *Mind over mood* during a 6-week waiting list period. It assessed changes in psychological health, dysfunctional attitudes and degree of hopelessness during the period of use of the self-help manual, as well as patient satisfaction with it. Twenty-two of 42 consecutive referrals attended the room (mean 3.55 sessions – *SD* 1.71). The Beck Hopelessness Scale (BHS), the General Health Questionnaire (GHQ), and Dysfunctional Attitudes Scale (DAS), as well as measures of patient participation and satisfaction, were completed at the beginning and end of the 6-week period for those patients who attended the room. All three scale scores fell significantly over the study period, and the DAS and BHS scores at 6 weeks were negatively correlated with the number of sessions attended. The patients generally judged that the self-help intervention was acceptable and effective, and that their knowledge in a number of key areas had been improved. Conclusions regarding effectiveness are limited by the absence of control group data; nonetheless, this study does suggest that the provision of a self-help room containing *Mind over mood* is useful for patients with anxiety and low mood on a waiting list for a psychiatric outpatient assessment.

Keywords: Cognitive behaviour therapy, depression, anxiety, self-help, psychiatry, minimal therapist contact.

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Introduction

Anxiety and depression account for 10% of GP consultations in the U.K. (Goldberg & Huxley, 1980). The boundary between them is not precise and about half of all mental health problems presenting to GPs show features of both anxiety and depression (Paykel & Priest, 1992). There has also been shown to be a large amount of unmet need in the population relating to untreated anxiety and depression (Gask, Usherwood, Thomson, & Williams, 1998). Cognitive Behaviour Therapy (CBT) is an effective treatment for anxiety, panic and depression (Beck, Sokol, Clark, Berchick, & Wright, 1992; Clark et al., 1994; Durham & Allen, 1993; Mattick, Andrews, Hadzi-Pavlovic, & Christiensen, 1990; Kovacs, 1980; Roth, Fonagy, Parry, Target, & Woods, 1996; Teasdale, 1985). Although it has proven effectiveness, CBT is relatively time-intensive and specialist mental health services, to which primary health care teams can refer, have insufficient resources to meet demand or to satisfy the Department of Health stated preference for psychological treatments over drug treatments when outcomes are equivalent (DoH, 1991). In addition, most psychiatric teams have limited access themselves to specialist psychological treatment interventions. There is a need to develop delivery methods that are more time-efficient and less therapist-intensive.

Several written self-help materials have been assessed and shown to be effective (e.g. meta-analyses by Scogin, Bynum, Stephens, & Calhoon, 1990; Gould & Clum, 1993; Marrs, 1995; Cuijpers, 1997). A common criticism of the majority of studies carried out, most notably within the United States, is their recruitment of participants through advertisements, and their use of very broad exclusion criteria. As a result, Cuijpers (1997) argues that the results of these studies cannot be generalized to apply to populations of mental health service patients. Donnan, Hutchinson, Paxton, Grant and Firth (1990), Sorby, Reavley and Huber (1991) and Holdsworth, Paxton, Seidel, Thomson and Shrubb (1996) have evaluated the use of self-help manuals used by GPs in conjunction with other treatments. White (1995) found that a self-help anxiety package offered to patients on a 3-month waiting list to see a clinical psychologist was significantly more effective than ''advice only'' or ''waiting list'' alternatives. Little is known, however, about the potential applicabilitiy of self-help in a general psychiatry setting, particularly when used by patients unsupported by on-going professional contact.

This study aimed to measure the take-up of the CBT self-help manual *Mind over mood* offered to a consecutive sample of primary care referrals of patients with symptoms of depression and/or anxiety referred to an inner city psychiatry service. It also aimed to measure changes in psychological health, dysfunctional attitudes and degree of hopelessness during the use of the self-help manual, as well as patient satisfaction with it.

Methods

Participants

The study participants were 42 consecutive referrals from General Practitioners based at five health centres in Leeds to an inner city psychiatric sector team. This catchment area is characterized by high levels of deprivation (third highest of the 14 MINI indices of the Leeds psychiatric catchment sectors) and also by its proximity to two major universities.

The self-help materials

The self-help resource used in the study was *Mind over mood* by Greenberger and Padesky

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(1995). This book is a structured self-help manual for the treatment of depression and anxiety based on the cognitive behavioural model (CBT). It is just over 200 pages in length but much of this comprises 37 worksheets to be completed by the reader. The manual introduces patients to the differences between thoughts, feelings, mood, and behaviour, and then describes the concept of automatic thoughts and ''Thought Records''. Experiments and action plans are covered as well as the concepts of dysfunctional assumptions and core beliefs. Two chapters also present an overview of the range of symptoms and treatments available for depression and anxiety.

Patient recruitment procedure

The study was ''open'' in design, including consecutively referred patients from primary care with an identified primary problem of anxiety and/or low mood. No control group was used. GP patient referrals are made in writing to the Sector 11 clinical team based at Malham House Day Hospital in Leeds. The team referral form completed by the GP specifies urgency of referral (urgent or routine), includes a short risk assessment, and identifies illiteracy or visual impairment.

Consecutive referrals to CW were assessed for inclusion into the study at the weekly mental health sector team meetings between 15 February and 19 July 1999. The sector team contains two consultants in a job share arrangement and referrals to the second job share partner (Dr V. Deacon) were only included between 19 April and 19 July 1999 due to delay in gaining consent from the GPs involved.

The exclusion criteria were kept to a minimum and were applied at the weekly team referral allocation meeting. All GP referral letters were read out in the meeting, and the multi-disciplinary team decided on the basis of the information available whether the patient was being referred primarily with symptoms of anxiety or depression, and whether they should be excluded from the study because of the following four criteria:

- Urgent referrals.
- Risk of suicide or homicide as stated by the GP referral to the sector psychiatric team.
- Ages below 16 or above 65 (the criteria for the clinical service).
- Illiteracy or marked visual impairment as identified on the referral form.

Each patient included in the study was given the opportunity to use the self-help materials. Patients were offered a short 20-minute interview explaining how to use the self-help materials by GW, a psychiatrist in the team. During this interview, patients were advised to use the materials weekly for one hour during each of the subsequent 6 weeks until their initial appointment with a mental health team practitioner. This routine assessment interview with a health care practitioner was always arranged for 6 weeks after the time of the initial appointment time in the self-help room. A letter inviting the patient to attend both appointments, together with an information sheet outlining the study, was mailed immediately after their allocation to the study. Each allotted session using the book was completed in a self-help room developed by CW that is sited within a psychiatric day hospital and was available between the hours of 9a.m. and 4.30p.m., Monday to Friday. The room contained the *Mind over mood* materials and hourly sessions to use the room were booked by the participants in a diary held by the receptionist. They were encouraged to use the materials at their own pace, and to try to complete the *Mind over mood* worksheets as they read the book. Photocopies of all of the worksheets included in the manual were provided for the patients to take

away with them. No other written materials or professional input were provided to those using the room after their initial 20-minute induction.

Six weeks later, while waiting to be seen by the mental health practitioner, patients were given a second questionnaire by GW. Those patients who failed to attend for their self-help room introductory session were mailed the base-line questionnaire, and subsequently either handed the second questionnaire before their routine assessment interview with a professional 6 weeks later, or were mailed the questionnaire if they failed to attend for this interview.

Measures

Demographic Details (age, gender and marital status) were recorded. Measures included in both questionnaires (base-line and 6 weeks) were:

—GHQ-28 (Goldberg & Hillier, 1979): A well validated and extensively used measure of psychological morbidity, it comprises four sub-scales, measuring somatic symptoms, anxiety and insomnia, social dysfunction and severe depression.

—Dysfunctional Attitudes Scale (DAS) (Weissman, 1979): The DAS measures ''depressogenic schemas'' that are incorporated within Beck's (1976) cognitive model of depression. It was included in the present study in order to assess changes in the dysfunctional thinking often associated with depression and a target area for the CBT approach.

—Beck Hopelessness Scale (BHS) (Beck, Weissman, Lester, & Trexler, 1974): Beck's concept of hopelessness has repeatedly been shown to be a powerful predictor of suicide (Beck, Steer, Kovacs, & Garrison, 1985). The scale is a self-rated questionnaire of 20 statements, each rated by the patient as applying, or not applying, to their life (for more information see Beck & Steer, 1993).

Finally, measures of Patient Expectation with the intervention were measured at baseline, similar in content to measures of Patient Satisfaction measured at 6 weeks. These used 5 or 7-point Likert-style questions and open-ended questions to evaluate attitudes towards the use of the self-help materials (such as their subjective knowledge about the causes and treatment of depression and anxiety).

Analysis

All data were analysed using the Statistical Package for Social Sciences (SPSS for Windows 6.1). Variations among referring health centres and gender differences in self-help room attendance were analysed using chi-square tests; and age differences between attenders and non-attenders by a *t* test. Baseline and 6-week GHQ, DAS, and BHS scores were compared using Wilcoxon signed Rank Tests, which were also used to test for differences in the subjective knowledge of the participants between these two times. Outcome measures were correlated with the number of sessions attended using Spearman's Correlation Co-efficients in order to identify whether those who use the book more show greater gains.

Results

Take-up and comparison of participant characteristics

A total of 89 consecutive patients were referred to the community team during the recruitment period. Forty-seven were excluded from the study because they were urgent referrals,

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judged to be a suicide risk from the referral letter, or had been referred for problems other than anxiety or depression. The remaining 42 referrals were included in the study.

All 42 patients were sent appointment times for the self-help room but only 22 (53%) attended the initial explanatory interview. Twenty of these 22 completed the follow-up questionnaire 6 weeks later, the two who didn't had left the catchment area and could not be traced. Of the 20 referrals who did not attend the self-help room only three returned the baseline questionnaires that were mailed to them (15%), and one of these three withheld consent to be included in the study. The remaining two also completed the 6-week questionnaire but because of the possibility that they were unrepresentative of the group of 20 non-attenders, their questionnaires were not included in the analyses. Only the age, gender, and referring health centre items, which were all recorded on the referral letter from primary care and the attendance at the subsequent outpatient appointment, could therefore be compared between the attending and non-attending groups of referrals.

There was no significant difference in age between the group of referrals who attended (n=22; mean age 28.68, *SD* 11.04) and those who did not attend (n=20, mean age 26.80, *SD* 6.2; 95% CI –7.55 to 3.78, t=–0.671, df=40 on t test). There were also no significant difference in gender proportion between those who used the materials (22.7% male; 77.3% female) and those who did not (45% males and 55% female; Chi square =2.34, p<.10). The referrals who attended the self-help room were much more likely to also attend for their subsequent outpatient appointment (18 of 22 or 81.8%), compared to the self-help non-attenders (10 of 20 or 50%, Chi square = 4.77, 1df, p=.03). The combined attendance rate of the 42 referrals (28 of 42 or 71.4%) is similar to the current Leeds psychiatric outpatient attendance rate of 73%. Some patients continue to attend outpatients so that at present it is not possible to compare the total number of sessions attended between the two groups.

The mean number of sessions attended by the 22 patients who attended their initial introductory session to the self-help room was 3.55 (*SD* 1.71). Two of the 20 patients who completed the second questionnaire (10%) said that they had completed all the worksheets included in *Mind over mood* within sessions, 15 (75%) completed some, and 3 (15%), completed none. Nine (45%) completed some of the worksheets outside of their sessions as homework, the remaining 11 (55%) did not complete any outside.

Outcome measures between baseline and six weeks

The GHQ scores (Likert-scored) dropped significantly between baseline and 6 weeks in those referrals that attended the self-help room (Table 1). The total GHQ scores fell from a mean of 51.4 (*SD* 13.58) to 32.6 (*SD* 13.41), Z=–3.341, p<.001). The Beck Hopelessness Scale (BHS) and Dysfunctional Attitude Scale (DAS) scores were also reduced significantly in those who used the self-help materials over the 6 week period (p<.05 for both measures; see Table 2).

Both the BHS and DAS scores of the 20 attendees at 6 weeks were significantly negatively associated with the number of sessions that they had attended (Spearman's Correlation Coefficient –0.582, p<.01 and –0.456, p<.05 respectively). The BHS scores at baseline were also predictive of the number of sessions that would be attended (Correlation Coefficient –0.431, p<.05). Participants who experienced more hopelessness attended the self-help room significantly *fewer* times. Baseline DAS scores were not significantly correlated with the

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Table 1. Comparison of the GHQ-28 scores of the referrals who used the self-help materials at baseline and at 6 weeks (n=20)

	Baseline		6 weeks		Wilcoxon Signed Ranks Test
	Mean (range)	*SD*	Mean (range)	*SD*	(2-tailed Asymp. significance level)
GHQ Somatic score	13.0 (3–19)	4.65	8.5 (3–16)	3.91	Z = –3.066 (p<.005)
GHQ Anxiety score	14.2 (7–21)	4.52	10.0 (3–20)	4.82	Z = –2.682 (p<.01)
GHQ Social score	13.5 (7–21)	3.28	9.5 (2–19)	4.54	Z = –2.883 (p<.005)
GHQ Depression score	10.7 (1–21)	6.10	4.7 (0–15)	3.75	Z = –3.385 (p<.001)
GHQ Total score	51.4 (23–81)	13.58	32.6 (13–54)	13.41	Z = –3.341 (p<.001)

Table 2. Comparison of the Dysfunctional Attitudes Scale (DAS) and Beck Hopelessness Scale (BHS) scores of the referrals who attended the self-help room at baseline and at 6 weeks (n=20)

	Baseline		6 weeks		Wilcoxon Signed Ranks Test
	Mean (range)	*SD*	Mean (range)	*SD*	(2-tailed Asymp. significance level)
Dysfunctional Attitudes Scale (DAS)	156.2 (87–242)	37.33	141.3 (79–204)	29.96	Z = –2.415 (p<.05)
Beck Hopelessness Scale (BHS)	9.8 (3–20)	4.91	4.9 (1–14)	4.39	Z = –2.413 (p<.05)

subsequent number of sessions attended. The GHQ total scores were also not related to the number of sessions attended, either at base line or at 6 weeks.

Subjective knowledge scores at baseline and six weeks

Table 3 illustrates the mean subjective knowledge scores of the patients who used *Mind over mood*. The patients did not have access to the baseline scores that they had allocated themselves when they subsequently allocated repeat scores at 6 weeks. The scores of every knowledge item increased over the study period to a statistically significant degree (using the Wilcoxon Signed Ranks Test).

Patient satisfaction ratings

At baseline the 22 initial attendees of the room were asked to predict how helpful self-help materials would be for themselves in the treatment of their anxiety and depression. The possible responses were ''helpful – a lot, a little, not much at all, or not sure''. Eleven responded that they were ''not sure'' (50%). Eight thought it would be helpful ''a lot''

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Table 3. Comparison of the levels of subjective knowledge of the referrals who used the self-help materials at baseline and at 6 weeks (n=20)

	Baseline		6 weeks		Wilcoxon Signed Ranks Test
	Mean (range)	*SD*	Mean (range)	*SD*	(2-tailed Asymp. significance level)
Overall knowledge about anxiety and depression (1–7 Likert-style scale)	3.39 (1–5.5)	1.33	4.70 (3–7)	1.08	Z = −3.561 (p<.001)
Knowledge of the causes of anxiety and depression (1–7 Likert-style scale)	3.11 (1–5)	4.78 1.19	(3–7)	0.98	Z = −3.690 (p<.001)
Ability to describe how anxiety and depression affects thinking, behaviour and bodily responses (1–7 Likert-style scale)	3.45 (1–5)	1.34	4.73 (3–7)	1.12	Z = −3.035 (p<.005)
Ability to notice negative thoughts (1–7 Likert-style scale)	3.40 (1–6)	1.33	4.88 (2–7)	1.21	Z = −3.173 (p<.005)
Ability to challenge negative thoughts and seek more moderate thoughts instead (1–7 Likert-style scale)	2.59 (1–6)	37.33	4.03 (2–6)	1.30	Z = −3.325 (p<.001)

(36%), and two predicted that it would be helpful ''a little'' (9%). None of the patients who attended the self-help room predicted that it would not be helpful ''at all'' or ''not much''. At 6 weeks when asked to report how helpful the manual had been, nine (41% of the remaining 20 patients), judged its potential use as ''a lot'', and a further four as ''a little''. Four were not sure. Only three rated the materials as being ''not much'' or ''not at all'' helpful.

At 6 weeks the 20 attenders were asked to rate their overall experience of the self-help materials by choosing one of the five responses: very good, good, bad, very bad or unsure. None chose the ''very bad'' response, two rated it as ''bad'' (10%) and 12 (60%) rated it as ''good'' (9) or ''very good'' (3). Similar responses were given when they were asked to comment on the acceptability of the room. Again no one judged it as ''very unacceptable''. and only two (10%) as ''unacceptable''. Seventeen (85%) rated the experience was ''acceptable'' (13) or ''very acceptable'' (4). One respondent was unsure. When asked to judge the ''overall effectiveness'' of the room, two participants (10%) believed that it was ''not effective''. Eight (40%) responded that it had been ''slightly effective'' and five (25%) ''very effective''. Five (25%) were ''unsure''.

When given a choice of potential responses of ''very easy'', ''quite easy'', ''hard'', ''quite hard'' and ''unsure'', all the 20 responders who completed the second questionnaire described *Mind over mood* as being either ''very easy'' (11 or 55%) or ''easy'' (9 or

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45%) to understand. Twelve (60%) believed that attendance at the self-help room had improved their mood either ''a lot'' (8 or 40%) or ''slightly'' (4 or 20%). Only 6 (28%) patients rated that the book had affected their mood ''not a lot'' (4) or ''not at all'' (2). Two were ''unsure''.

Only one of the 20 attenders responded that they could not recommend *Mind over mood* to be used by others. Nineteen (95%) said they would recommend it. Fourteen (70%) said that they intended to use the book themselves in the future, while six (30%) said that they did not intend to use it again.

Finally, they were asked if they could ''give any suggestions to improve the room''. The most common response (by seven participants) was that there should have been some supervision of the patients whilst they worked on the material: ''I would have appreciated a little discussion about the aspects being learned''.

Discussion

The 52 per cent attendance rate for the self-help room for routine psychiatric referrals with symptoms of anxiety and depression was somewhat lower than found in the three previously mentioned GP-based U.K. studies. It is noteworthy, however, that all of these studies involved additional scheduled face-to-face contact with health professionals (Donnan et al., 1990; Sorby et al., 1991; Holdsworth et al., 1996). Our attendance rate is also lower than the attendance rate achieved in the controlled trial of self-help offered to referrals to a psychology service (White, 1995). Participants in the present study were recommended to attend six times (weekly) prior to their assessment appointment with the mental health care practitioner. In practice, only 10 of the 22 participants who attended their initial self-help room introductory session attended four or more sessions. Looking at other aspects of compliance, only 2 (10%) said that they had completed all the worksheets included in *Mind over mood* within sessions, 15 (75%) completed some, and 3 (15%), completed none. Fewer still (9 or 45%) completed any of the worksheets outside of their sessions as homework. These figures compare with those of Sorby et al. (1991), where only 50% completed their GP prescribed booklet over the study period. Nevertheless, the present study showed that patients believed that they had benefited from the self-help package without adhering to much of its content. A randomized controlled trial would be needed to show whether this subjective viewpoint could be confirmed by improvements in more objective clinical measures.

Although there was no significant difference in terms of the genders of those who did or did not attend the self-help room, it is noteworthy that we are dealing with small numbers and therefore with low power. Of the 14 males in the study, 5 (36%) chose to attend the room compared to 17 of the 28 females (61%) who were included in the study (difference not statistically significant). Although this suggests a possible trend, it is noteworthy that the majority of self-help literature has failed to note a significant gender difference between those choosing to use or not use self-help materials (Scogin et al., 1990; Gould & Clum, 1993; Marrs, 1995; Cuijpers, 1997).

The base-line GHQ and BHS scores reflected a high degree of clinical caseness. The mean BHS score of 9.8 ($SD = 4.91$) is similar to the mean score of 10.2 ($SD = 7.7$) reported by Dyer and Kreitman (1984) in their study of parasuicides admitted to a regional poisons unit. The mean base-line DAS score of 156.2 is also well above both the ''typical depressed

mean score'' of 147 and the ''typical control group mean score'' of 113 reported by Weissman (1979).

Amongst the 20 patients who completed questionnaires at both baseline and 6-week follow-up, the GHQ, BHS, and DAS scores all fell substantially. In view of the absence of a control group, it is not possible to directly ascribe this improvement to *Mind over mood* alone. Multiple other factors such as time, spontaneous recovery, formal and informal supports, and prescription of antidepressant medication are among the other factors that may have contributed to the change observed. However, the significant association between the number of sessions attended and the scores in two of the three outcome measures at 6 weeks, namely the BHS ($p<.01$) and the DAS ($p<.05$) are suggestive of a direct effect of the self-help intervention. Why there was no equivalent association with the GHQ scores is unknown but may be related to the fact that hopelessness and negative automatic thoughts are more specific concepts than the rather vague concept of ''psychological morbidity'' measured by the GHQ. Feelings of hopelessness consequent upon distorted thinking would be particularly expected to be helped by *Mind over mood* that aims to alter unhelpful and negative thinking.

The association between the baseline BHS scores and the subsequent number of self-help room sessions attended is of concern in that it suggests that feelings of hopelessness result in reduced engagement. This is a potential problem of self-help in that feelings of failure from not engaging in an offered treatment may worsen that sense of hopelessness. If a patient views the future as hopeless it may be that they are less likely to take action using self-help materials to alleviate their situation. Self-help may therefore be most suitable for a subset of patients who do not exhibit particularly high levels of hopelessness. The use of measures such as the implementation of a hopelessness scale prior to being offered self-help materials might provide a useful screening measure to identify individuals with particularly high scores who should be offered earlier face-to-face interventions. In view of the influence on compliance shown in this study, the concept of hopelessness is an area that deserves greater evaluation in the field of self-help.

The measures of patient satisfaction generally showed that the participants found the use of *Mind over mood* to be effective at reducing their symptoms, imparting knowledge and improving their ability to carry out tasks. No data are available summarizing the readability statistics of *Mind over mood*; however, the feedback obtained did not suggest that readers had difficulty understanding the content. They generally found the manual itself easy to read and understand. Unfortunately, we do not know the reasons why half of the referrals chose not to try the self-help. It is notable that half of them also failed to attend for their subsequent outpatient appointments, which raises the issue of whether some referrals wished to engage with mental health services at all. It might be the case that self-help is difficult to use for people who are unconfident about or frightened of doing things on their own. It may also have been the case that some of the non-attenders were unable to use a service that was only available during working hours. It is notable, however, that none of the attenders suggested longer opening hours as a way of improving the self-help room intervention. The most common suggestion for improving the service was the provision of some form of professional supervision. Indeed, a trained supervisor might improve compliance and assist with the participants' understanding of the materials. It may have been more cost-effective to simply provide the patients with a copy of *Mind over mood* rather than using valuable space in an allocated room. However, many patients commented that they appreciated space

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and time away from their day-to-day life to stop and reflect on the contents of the manual.

In summary, we found that within an inner city population of consecutive routine primary care referrals with symptoms of anxiety and depression to a psychiatric community team about half chose to use self-help materials based in a self-help room. Most found the use of *Mind over mood* in this context both effective and satisfactory. This study provides findings suggestive of the effectiveness of structured CBT self-help materials. A randomized controlled trial is now required to assess to what extent the improvements found in patients reflected the effectiveness of the book, or other factors such as time or treatment (formal and informal) outside the psychiatric service. In addition, clear models for the use of self-help materials within clinical services need to be developed (Williams, 2001).

References

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.

Beck, A. T., Sokol, L., Clark, D. A., Berchick, B., & Wright, F. (1992). Focused cognitive therapy of panic disorder: A cross over follow-up. *American Journal of Psychiatry*, *147*, 778–783.

Beck, A. T., & Seer, R. A. (1993). *Beck Hopelessness Scale Manual*. Harcourt Brace and Company, San Antonio: The Psychological Corporation.

Beck, A. T., Steer, R. A., Kovacs, M., & Garrison, B. (1985). Hopelessness and eventual suicide: a ten-year prospective study of patients hospitalized with suicidal ideation. *American Journal of Psychiatry*, *145*, 559–563.

Beck, A. T., Weissman, A., Lester, D., & Trexler, L. (1974). The measurement of pessimism: The Hopelessness Scale. *Journal of Consulting and Clinical Psychology*, *42*, 861–865.

Clark, D. M., Salkovskis, P. M., Hackmann, A., Middleton, H., Anastasiades, P., & Gelder, M. G. (1994). A comparison of cognitive therapy, applied relaxation, and imipramine in the treatment of panic disorder. *British Journal of Psychiatry*, *164*, 759–769.

Cuijpers, P. (1997). Bibliotherapy in unipolar depression: A meta-analysis. *Journal of Behavioural Therapy and Experimental Psychiatry*, *28*, 139–147.

DOH (Department of Health) (1991). *Health of the nation*. London: HMSO.

Donnan, P., Hutchinson, A., Paxton, R., Grant, B., & Firth, M. (1990). Self-help materials for anxiety: A randomised controlled trial in general practice. *British Journal of General Practice*, *40*, 498–501.

Durham, R. C., & Allan, T. (1993). Psychological treatment of generalized anxiety disorder: A review of the clinical significance of outcome studies since 1980. *British Journal of Psychiatry*, *163*, 19–26.

Dyer, J. A. T., & Kreitman, N. (1984). Hopelessness, depression, and suicidal intent in parasuicide. *British Journal of Psychiatry*, *144*, 127–133.

Gask, L., Usherwood, T., Thomson, H., & Williams, B. (1998). Evaluation of a training package in the assessment and management of depression in primary care. *Medical Education*, *32*, 190–198.

Goldberg, D. P., & Hillier, V. F. (1979). A scaled version of the GHQ. *Psychological Medicine*, *9*, 139–145.

Goldberg, D. P., & Huxley, P. (1980). *Mental illness in the community: The pathways to psychiatric care*. London: Tavistock.

Gould, R. A., & Clum, A. A. (1993). Meta-analysis of self-help treatment approaches. *Clinical Psychology Review*, *13*, 169–186.

Greenberger, D., & Padesky, C. A. (1995). *Mind over mood: Change how you feel by changing the way you think*. New York: Guilford Press.

Holdsworth, N., Paxton, R., Seidel, S., Thomson, D., & Shrubb, S. (1996). Parallel evaluations of new guidance materials for anxiety and primary care. *Journal of Mental Health*, *5*, 195–207.

Kovacs, M. (1980). The efficacy of cognitive-behavioural therapy for depression. *American Journal of Psychiatry*, *137*, 1495–1501.

Marrs, R. (1995). A meta-analysis of bibliotherapy studies. *American Journal of Community Psychology*, *23*, 843–870.

Mattick, R. P., Andrews, G., Hadzi-Pavlovic, D., & Christiensen, H. (1990). Treatment of panic and agoraphobia: An integrative review. *Journal of Nervous and Mental Disease*, *178*, 567–576.

Paykel, E. S., & Priest, R. G. (1992). Recognition and management of depression in general practice: Consensus statement. *British Medical Journal*, *305*, 1198–1202.

Roth, A., Fonagy, P., Parry, G., Target, M., & Woods, R. (1996). *What works for whom? A critical review of psychotherapy research*. New York: Guilford Press.

Scogin, F., Bynum, J., Stephens, G., & Calhoon, S. (1990). Efficacy of self-administered programs: Meta-analytic review. *Professional Psychology: Research and Practice*, *21*, 42–47.

Sorby, N. G. D., Reavley, W., & Huber, J. W. (1991). Self-help programme for anxiety in general practice: Controlled trial of an anxiety management booklet. *British Journal of General Practice*, *41*, 417–420.

Teasdale, J. D. (1985). Psychological treatments for depression: How do they work? *Behaviour Research and Therapy*, *23*, 157–165.

Weissman, A. N. (1979). The dysfunctional attitude scale: A validation study. Dissertation, University of Pennsylvania. *Dissertation Abstracts International*, *40*, 1389–1390B.

White, J. (1995). Stresspac: A controlled trial of a self-help package for the anxiety disorders. *Behavioural and Cognitive Psychotherapy*, *23*, 89–107.

Williams, C. J. (2001). Ready access to proven psychosocial interventions? The use of written CBT self-help materials to treat depression. *Advances in Psychiatric Treatment*, 7, 233–240.