

REVIEW ARTICLE

Why is self-help neglected in the treatment of emotional disorders? A meta-analysis

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ABSTRACT

Background. Although the burden of emotional disorders is very high, mental health care is only available to a minority of patients. The literature suggests that self-help strategies, both bibliotherapy and self-help groups alike, are effective for various, less serious complaints but it is unclear whether available data support a role for self-help in treatment protocols for patients with clinically significant emotional disorders.

Method. We searched the literature with a focus on ‘anxiety’ and/or ‘depressive disorder’. Standardized assessment of diagnosis or symptoms and randomized controlled trials were inclusion criteria for a meta-analysis.

Results. The mean effect size of self-help (mainly bibliotherapy) *v.* control conditions is 0.84, and 0.76 for follow-up; the effect sizes of self-help *v.* treatment are –0.03 and –0.07 respectively. A longer treatment period is more effective.

Conclusions. Bibliotherapy for clinically significant emotional disorders is more effective than waiting list or no treatment conditions. The dearth of studies on self-help groups for emotional disorders does not permit an evidence-based conclusion concerning the effects of self-help groups. No difference was found between bibliotherapy and psychiatric treatment of relatively short duration.

INTRODUCTION

This study explores the effectiveness of self-help strategies for treatment of patients suffering from remittent and chronic disabling mood and anxiety disorders. Lifetime diagnoses of anxiety and depression show extensive co-morbidity (Mineka *et al.* 1998). Nearly half (47%) of those meeting lifetime criteria for major depression also met criteria for a co-morbid anxiety disorder (Regier *et al.* 1998).

The World Bank has reported that mental disorders account for 9.1% of the world total global disease burden, with 22.4% of that burden

residing in established market economies, and half of that due to emotional disorders (Andrews, 1998). The indirect costs to society of depression are estimated at seven times the direct costs of depression, half of the total amount attributed to all mental disorders (Stoudemire *et al.* 1986). Yet, strategies for prevention, risk factor reduction and effective treatment of people with emotional disorders do not seem to have been adequately implemented. A disproportionate amount of treatment effort is spent on people with chronic psychoses compared with those suffering from emotional disorders (Andrews, 1998). The Camberwell Needs for Care Survey concluded that only 28% of the need for depression treatment and only 13% of the need for anxiety treatment is ever met

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(Bebbington *et al.* 1997). The established mental health care system does not have the resources to meet the extensive need for care of people with anxiety and depressive disorders. The kind of shortfall between what is on offer and what is necessary can be filled by alternatives cost-effectively (Lovell & Richards, 2003). Such an alternative might include self-help strategies because of their *a priori* presumed low costs. However, is there any evidence that self-help will be effective as an alternative for the treatment of clinically relevant emotional disorders?

Self-help groups and bibliotherapy are the two main self-help strategies. Each has its own history of development, methodology, research strategy and relationship with professionals. Self-help groups are voluntary associations of persons with similar problems which are controlled by their own members and not by professionals (Humphreys & Rappaport, 1994). Professionally led 'support groups' should not be confused with self-help groups. Self-help through naturally evolved or specially created 'lay' groups and networks represents the oldest and most widely spread system of care for 'human ills' (Katz, 1981). Self-help groups arise in society when certain needs are not met by formal health care organizations (Lieberman, 1990). Well-known examples include the Alcoholics Anonymous groups and self-help programmes for eating disorders. Research on these groups and programmes is mainly the preserve of the field of sociology and generally concerns case histories based on anecdotal evidence. Only a few studies have contained systematic comparison testing hypotheses (Katz, 1981). In the 1980s and 1990s, self-help strategies were developed for the general support of patients and relatives in addition to the regular treatment of somatic or psychiatric disorders. Some controlled trials examined the effectiveness of this kind of supportive self-help groups (Barlow *et al.* 1999). Bibliotherapy, as defined by Marrs (1995), relies on written texts, computer programs or audio/video-recorded material for the purpose of understanding or solving problems concerning a person's development or in meeting their therapeutic needs. It became a focus of interest for professionals in the 1970s. Several meta-analyses were published, including randomized as well as non-randomized

controlled effectiveness studies. Our current focus is specifically on bibliotherapy and self-help groups for patients with emotional disorders (anxiety and depression). What do reviews and meta-analyses tell us about the effectiveness of self-help in this patient population?

Four reviews by Glasgow & Rosen (1978), Trojan (1989), Kurtz (1990) and Lieberman (1990) support self-help as a useful component in the treatment of psychiatric patients. Self-help manuals are reported as being effective for several phobic anxieties (Glasgow & Rosen, 1978). Members of self-help groups have reported the reduction of disease-related stress and increased competence and social activation (Trojan, 1989). Studies of local peer mutual-aid networks have reported reduced symptomatology and use of professional services (Kurtz, 1990). However, from a methodological point of view, the quality of the studies, all published before 1990, is rather unsatisfactory, at least those reviewed by Trojan (1989) and Lieberman (1990).

Five meta-analyses of self-help strategies have been published, four concerning bibliotherapy and one on self-help groups. Mean effect sizes (ES) for bibliotherapy (Scogin *et al.* 1990*a*; Gould & Clum, 1993; Marrs, 1995; Cuijpers, 1997) range from 0.53 to 0.96 for various target problems, ranging from 'minor' problems (assertion skills, study skills, parental skills, difficulties with sleep, sex, and memory) to potentially clinical disorders (depression, anxiety, habit disorders). The effects on anxiety and mood disturbances fell within this range (Gould & Clum, 1993; Marrs, 1995). Differences between self-administered and therapist-administered treatments were non-significant (Scogin *et al.* 1990*a*; Marrs, 1995; Cuijpers, 1997). Only one meta-analysis (Barlow *et al.* 1999) examined studies of self-help groups but no conclusions can be drawn concerning emotional disorders. However, most studies of the meta-analyses included subjects who suffered from relatively 'minor' problems recruited by the media or students, while a few were randomized clinical trials. These reviews and meta-analyses do not permit conclusions on the effectiveness of self-help for patient populations with clinically significant emotional disorders. It was therefore decided to perform a meta-analysis that only included randomized controlled trials

concerning emotional disorders which were likely to disturb all areas of social functioning.

METHOD

Objective

To examine whether the reported effectiveness of self-help strategies (bibliotherapy and self-help groups) would hold true for clinically significant emotional disorders by testing the hypothesis that self-help strategies are (1) as effective as treatment by professionals, and (2) more effective than no treatment, and, if sufficient data are available, whether the results are modified by (1) the length of treatment or follow-up, or (2) the severity of the illness.

Inclusion criteria

Randomized controlled trials that used symptom measures or a psychiatric diagnosis and compared bibliotherapy or self-help group with placebo or waiting list conditions and usual treatment conditions. Studies of mild emotional disorders were excluded, such as simple phobias which do not affect broad areas of social functioning. The diagnosis was based on a structured clinical interview for assessment of a DSM or ICD diagnosis or on assessment scales using a cut-off score to establish caseness. Insufficient data to allow meta-analytical pooling was cause for exclusion. Trials exclusively concerning children and adolescents were excluded. Self-help was defined as a therapeutic intervention for self-treatment administered through group meetings (self-help groups) or bibliotherapy, mainly independent of professionals. We restricted the self-help strategies to include those that were found to be relevant in the reviews and meta-analyses referred to because the exclusive objective of this study was whether the reported results would also apply to clinically significant emotional disorders.

Methods of the review

Screening of the studies, quality assessment and data extraction were performed by the first author. Any doubt about inclusion was discussed with the co-authors. Study quality was assessed according to the Delphi criteria list for the quality assessment of randomized controlled trials for conducting systematic reviews (Verhagen *et al.* 1998).

Literature search

In total, the meta-analyses referred to concerned a comprehensive search in electronic databases, databases of dissertation and psychological abstracts, reference lists and hand searches of relevant journals, covering the literature from the 1970s to the 1990s, using the keywords 'self-help', 'self-treatment', 'self-help group' and 'bibliotherapy', including 118 studies on bibliotherapy and 26 on self-help groups. We performed an additional search for the 1990–2000 period in Medline, PsychINFO and the Cochrane Library, not restricting for language, using the same keywords as above and adding 'randomization' and 'anxiety or depressive disorder' according to the objective of the study, selecting for randomized controlled trials and clinically relevant psychiatric disorders. This resulted in another 28 hits for bibliotherapy and 7 for self-help groups. The total sample encompassed 179 studies, including two studies of German language. The titles and abstracts of the studies were screened for first orientation on inclusion criteria. Of the 179 studies, 34 studies, all concerning emotional disorders, were selected for detailed examination on the inclusion criteria, 18 of which were subsequently excluded, see the Appendix (on p. 13) for excluded studies and exclusion reasons. Only 16 studies met all criteria, including one study of German language (Rosner *et al.* 1999). Two studies (Scogin *et al.* 1990*b*; White, 1995) reported on the same population of former studies (Scogin *et al.* 1989; White, 1998) and were thus pooled. Therefore, our meta-analysis comprised 14 studies: 13 on bibliotherapy (8 new studies not included in previous meta-analyses) and one on self-help groups (new). Nine concerned mood disorders, four anxiety disorders and one both. The self-help conditions and the treatment conditions were mainly based on cognitive behavioural principles. Patients were adult and elderly persons with depression or anxiety disorders recruited by press announcement ($n=9$) or from referrals to mental health care facilities ($n=5$). Nearly two-thirds of the studies concerned patients with chronic conditions or patients with a prior treatment history having had previous treatment. Diagnosis was based on a structured clinical interview for assessment of a DSM-III, DSM-III-R or ICD-10

Table 1. *Meta-analysis on the effectiveness of self-help in the treatment of emotional disorders: study characteristics*

No.	Study	Diagnosis	Inclusion	Recruitment	Illness duration	Age (years)	Measures
1	Al-Kubaisy <i>et al.</i> 1992	Phobia	ICD-10; FTPQ ≥ 20	Referred patients	> 14 years	18–60	FTPQ avoid/fear; FQ Total
2	Bright <i>et al.</i> 1999	Major depression; Dysthymia	SCID	Media	All previously treated	21–72	BDI; HRSD
3	Brown & Lewinsohn, 1984	Unipolar depression	RDC	Media	± 9 years	16–65	BDI; CES-D
4	Landreville & Bissonette, 1997	Unipolar depression	IDD	Media; referred patients	± 10 years disability	≥ 55	GDS; BDI
5	McNamee <i>et al.</i> 1989	Panic disorder with agoraphobia	SCID	Referred patients	Mean 12 years; range 2–40	29–60	Phobic target; Global phobia
6	Rosner <i>et al.</i> 1999	Unipolar depression	HRSD > 16	Media	—	22–76	BDI
7	Schelver & Gutsch, 1983	Social anxiety	SADS upper 15%	Students	> 1 year	Students	SADS; FNE; State (STAI)
8	Schmidt <i>et al.</i> 1983	Unipolar depression	RDC	Media	80% prior treatment	$M = 42$	BDI; SDS; MMPI-D; DACL
9	Scogin <i>et al.</i> 1987	Unipolar depression	HRSD ≥ 10	Media	—	≥ 60	HRSD; GDS; BDI
10	Scogin <i>et al.</i> 1989	Unipolar depression	HRSD ≥ 10	Media	—	≥ 60	HRSD; GDS
11	Selmi <i>et al.</i> 1990	Unipolar depression	RDC	Media	> 6 months	Adults	BDI; HRSD; SCL-90-R depr.
12	Tyrer <i>et al.</i> 1993	Dysthymia; Panic disorder; GAD	SCID	Referred patient	Previously treated	17–76	HADS depression/anxiety
13	White, 1995	Anxiety disorders	ADIS-R	Referred patient	> 2 years	$M = 38$	HAD-anxiety
14	Wollersheim & Wilson, 1991	Unipolar depression	DSM-III; MMPI-D $T \geq 70$	Media	50% previously treated	22–68	BDI; MMPI-D; SDS

No., Research number; **Diagnosis:** GAD, Generalized Anxiety Disorder; **Inclusion:** FTPQ, Four Target Phobia Questionnaire; SCID, Structured Clinical Interview for DSM-III-R; RDC, Research Diagnostic Criteria; IDD, Inventory to Diagnose Depression for DSM-III-R; HRSD, Hamilton Rating Scale for Depression; SADS, Social Avoidance and Distress Scale; ADIS-R, Anxiety Disorder Interview Schedule – Revised; **Measures:** FTPQ avoid/FTPQ fear = Self-report/observer-rated Four Target Phobias (FTPQ) avoid/fear; FQ, Self-report Fear Questionnaire (FQ); BDI, Self-report Beck Depression Inventory; HRSD, Observer-rated Hamilton Rating Scale for Depression; CES-D, Self-report Centre for Epidemiologic Studies Depression Scale; GDS, Self-report Geriatric Depression Scale; Phobic tar/Global ph, Observer-rated phobic target and global phobia; SADS, self-report Social Avoidance and Distress Scale; FNE, Self-report Fear of negative Evaluation Scale; State (STAI), Self-report State or Trait Anxiety Inventory; SDS, Self-rating Depression Scale; MMPI-D, Self-report Minnesota Multiphasic Personality Inventory Depression scale; DACL, Self-report Depression Adjective Checklist; SCL-90-R d., Self-report Hopkins symptom Checklist depression scale; HADS anx/depr, Self-report Hospital Anxiety and Depression Scale.

diagnosis ($n=9$) or on assessment scales using a cut-off score for inclusion ($n=5$). Details can be found in Table 1 for study characteristics and Table 2 for study conditions and post-treatment and follow-up results.

Quality of included studies

Nine items were assessed in accordance with the Delphi list (Verhagen *et al.* 1998). All studies were randomized controlled trials in concordance with the inclusion criteria. Concealment procedure of treatment allocation was only reported in one study (Tyrer *et al.* 1993). Three studies did not adequately report baseline data (Schelver & Gutsch, 1983; Selmi *et al.* 1990; Wollersheim & Wilson, 1991). All were active treatment conditions, which are almost impossible to blind for patient and caregiver. Three studies reported assessor blinding (McNamee *et al.* 1989; Al-Kubaisy *et al.* 1992; Tyrer *et al.* 1993). Point estimates and measures of variability were presented for the primary outcome measures. Only three studies included intention-to-treat analyses (Tyrer *et al.* 1993; White, 1995; Rosner *et al.* 1999). One study (Tyrer *et al.* 1993) scored the highest possible score for active intervention trials (7 out of 9 items of the Delphi list). Three studies (Schelver & Gutsch, 1983; Selmi *et al.* 1990; Wollersheim & Wilson, 1991) scored low (2 or 3 items of the Delphi list), insufficiently describing baseline similarity of the samples of the compared conditions, in contrast with the remaining studies which achieved moderate scores (4 or 5 items of the Delphi list).

Statistics

A meta-analysis aims to integrate a large number of results (Glass *et al.* 1981). Effect sizes are defined as the standardized mean difference (g) between a treatment group and a control group in terms of an outcome variable. Here ' d ' is the corresponding unbiased effect size estimator. We used the computer program META, version 5.3, developed by Schwarzer (1989).

The observed variability in sample estimates of effect size is partly due to variability in the underlying population parameters and partly due to sampling error. Therefore, assuming heterogeneity in the study set, a 'random effects model' (Hedges & Olkin, 1985; Schwarzer,

1989), was applied. A test of homogeneity serves to examine whether the separate effect sizes can be considered as being samples from a common population of effect sizes. Data are homogeneous if 100% of the observed variance is explained by sampling error, which is desired. When only a percentage can be explained by sampling error, this suggests that the observed differences in the results of individual studies might be caused by factors other than change. Control for moderator variables is then necessary.

Publication bias influences the reliability of population effect sizes. We computed a 'fail safe n ' (Orwin, 1983) to estimate the number of studies with non-significant results that would be required to convert a significant meta-analytic finding into a non-significant one. Nearly all the studies included reported more than one outcome measure. To avoid disproportionate weighting of the studies with more measures, multiple outcome measures were averaged to obtain one effect size per treatment comparison in each study according to Scogin *et al.* (1990a) and Marrs (1995). Several studies compared a number of contrast groups. For each of these, the mean effect size was calculated. Post-treatment and follow-up comparisons were made, if available. A sensitivity analysis was performed to control for the influence of self or rater-assessment on the mean effect size estimate.

The analysis included 16 post-treatment comparisons of self-help *v.* control conditions (placebo/waiting list) and 16 self-help *v.* contrast treatment conditions. Five follow-up comparisons could be made with placebo conditions, 9 for the contrast treatment conditions. Details can be found in Table 2 for study conditions and post-treatment and follow-up results.

RESULTS

The results are summarized in Table 3. The mean effect size of the self-help *v.* control conditions comparisons is 0.84 [95% confidence interval (CI)=0.65–1.02; $n=490$]. A test for homogeneity shows that 100% of the variance can be explained by sampling error, which indicates that differences between samples are absent. A total of 50.8 studies would be necessary in order to reduce the effect size to 0.20 indicating absence of effect (Orwin's fail safe n).

Table 2. Meta-analysis on the effectiveness of self-help in the treatment of emotional disorders: study conditions, post-treatment (T1) and follow-up period (T2), and results

No.	Conditions (n)	Comparison	T1	dT1	T2	dT2
1	(1) Bibliotherapy (n=26). Behavioural therapy principles, manual: <i>Living with Fear</i> (Marks, 1980). Additional 6 × 60-min instruction sessions.	1 v. 2	8	0.92	14	1.00
	(2) Control condition (n=25). Relaxation audiotape. Additional 6 × 60-min instruction sessions.	1 v. 3	8	-0.28	14	-0.18
	(3) Treatment condition (n=25). 6 × 60-min instruction sessions and 9 × 90-min sessions, clinician accompanied exposure plus self-exposure.					
2	(1) Self-help group (n=13). Mutual support group, informal exchanges, focused on interpersonal insight and disclosure.	1 v. 3	10	0.01		
	(2) Self-help group (n=14). Cognitive behavioural principles; 90-min sessions, weekly, manual: <i>Feeling Good</i> (Burns, 1989). No additional contact, except for one peer, who have had training managing the manual.	1 v. 4 2 v. 3	10 10	-0.15 0.44		
	(3) Treatment condition (n=22). Mutual support group, informal exchanges, focussed on interpersonal insight and disclosure, lead by professionals.	2 v. 4	10	0.24		
	(4) Treatment condition (n=18). Group cognitive behavioural therapy; 90-min sessions, weekly, manual: <i>Feeling Good</i> (Burns, 1989), lead by professionals.					
3	(1) Bibliotherapy (n=14). Cognitive behavioural therapy principles, manual: <i>Control Your Depression</i> (Lewinsohn, 1978). Additional one session initially, subsequent phone-contact 10–35 min, 12 sessions.	1 v. 2 1 v. 3	8 8	0.43 -0.00	12	-0.21
	(2) Control condition (n=11). Delayed treatment control, waiting list.	1 v. 4	8	0.11	12	0.36
	(3) Treatment condition (n=25). Cognitive behavioural therapy, manual: <i>Control Your Depression</i> (Lewinsohn, 1978); class tutoring, 12 sessions.					
	(4) Treatment condition (n=13). Cognitive behavioural therapy, manual: <i>Control Your Depression</i> (Lewinsohn, 1978); individual tutoring.					
4	(1) Bibliotherapy (n=10). Cognitive behavioural principles, manual: <i>Feeling Good</i> (Burns, 1989). Additional maximal 15-min phone-contact once a week.	1 v. 2	4	0.30		
	(2) Control condition (n=13). Delayed treatment control, waiting list. Additional maximal 15-min phone-contact once a week.					
5	(1) Bibliotherapy (n=9). Cognitive behavioural therapy principles, manual: <i>Living with Fear</i> (Marks, 1980). Additional 12-min phone-contact, weekly 8 weeks and 2-weekly for 4 weeks.	1 v. 2	12	1.05	32	1.10
	(2) Control condition (n=9). Relaxation audiotape. Additional 12-min phone-contact, weekly 8 weeks and 2-weekly for 4 weeks.					
6	(1) Bibliotherapy (n=10). Cognitive behavioural therapy principles, manual. Additional 20-min phone-contact, weekly, non-directive, by non-professionals.	1 v. 1 1 v. 3	20 20	-0.06 0.09		
	(2) Treatment condition (n=18). Cognitive behaviour therapy, manual, weekly.		20			
	(3) Treatment condition (n=12). Focussed expressive therapy, manual, weekly.					
7	(1) Bibliotherapy (n=11). Cognitive therapy principles (Ratio-Emotive Therapy), manual: <i>A New Guide of Rational Living</i> (Ellis & Harper, 1961). Additional initial phone-contact, interview and orientation meeting.	1 v. 2 1 v. 3	5 5	0.94 0.35		
	(2) Control condition (n=12). No-treatment control. Additional initial phone-contact, interview and orientation meeting.					
	(3) Control condition (n=12). Self-administered attention placebo condition: <i>Man's Search for Meaning</i> (Frankl, 1959). Additional initial phone-contact, interview and orientation meeting.					
8	(1) Bibliotherapy (n=12). Cognitive behavioural therapy principles, manual. Additional initial contact, the first treatment week and a phone-contact in week 4 to offer encouragement and answer client questions.	1 v. 2 1 v. 3	8 8	1.41 -0.21	18 18	0.26 -0.25
	(2) Control Condition (n=10). Delayed treatment control, waiting list. No treatment contact.	1 v. 4	8	-0.02	18	-0.10

Table 2 (cont.)

No.	Conditions (n)	Comparison	T1	dT1	T2	dT2
	(3) Treatment condition (n = 11). Cognitive behavioural therapy, individual, manual.	1 v. 5	8	0.88	18	0.48
	(4) Treatment condition (n = 11). Cognitive behavioural therapy, 2 small groups, 90-min sessions, weekly, manual.					
	(5) Treatment condition (n = 12). Cognitive behavioural therapy, large group, 90-min sessions, weekly, manual.					
9	(1) Bibliotherapy (n = 9). Cognitive behavioural therapy principles, manual: <i>Feeling Good</i> (Burns, 1989). Additional 10-min phone-contact, weekly, supportive.	1 v. 2 1 v. 3	4 4	1.34 0.83	8	-0.28
	(2) Control condition (n = 8). Delayed treatment control, waiting list.					
	(3) Control condition (n = 8). Self-administered attention placebo condition: <i>Man's Search for Meaning</i> (Frankl, 1959). Additional 10-min phone-contact, weekly, supportive.					
10	(1) Bibliotherapy (n = 19). Behavioural therapy principles, manual: <i>Control Your Depression</i> (Lewinsohn, 1986). Additional phone-contact, weekly.	1 v. 3 2 v. 3	4 4	0.34 1.05		
	(2) Bibliotherapy (n = 21). Cognitive behavioural therapy principles, manual: <i>Feeling Good</i> (Burns, 1980). Additional phone-contact, weekly.					
	(3) Control condition (n = 21). Delayed treatment control, waiting list.					
11	(1) Bibliotherapy (n = 12). Cognitive behavioural therapy principles, interactive computer program, 6 sessions. Additional initial and at the end of a session; on request while the patient was interacting with the computer.	1 v. 2 1 v. 3	10 10	1.26 0.14	18 18	1.67 0.12
	(2) Control condition (n = 12). Delayed treatment control. No treatment.					
	(3) Treatment condition (n = 12). Cognitive behavioural therapy, 6 sessions, manual.					
12	(1) Bibliotherapy (n = 40). Psycho-education, self-help treatment package and relaxation tape. Additional 15-min sessions in weeks 0, 1, 2, 4, 6.	1 v. 2 1 v. 3	10 10	1.10 -0.42		
	(2) Control condition (n = 26). Placebo pills.					
	(3) Treatment condition (n = 80). Cognitive behavioural therapy, 1-h sessions in weeks 0, 1, 2, 4, 6.					
13	(1) Bibliotherapy (n = 21). Cognitive behavioural therapy principles and psycho-education, self-help anxiety management package (Stresspac) and relaxation tape. Additional one 30-min session.	1 v. 2 1 v. 3	12 12	0.99 0.70		
	(2) Control condition (n = 21). Waiting-list control.					
	(3) Control condition (n = 20). Placebo, 30-min session, advice on ways of coping with anxiety.					
14	(1) Bibliotherapy (n = 8). Cognitive behavioural therapy principles, manual: 'Bye bye blues: overcoming depression' (Wollersheim, 1980). Additional initial contact in the first treatment week, once midway the treatment, and a final contact.	1 v. 2 1 v. 3	11 11	0.36 0.36	37	0.05
	(2) Control condition (n = 8). Delayed treatment control.	1 v. 4	11	0.31	37	-0.25
	(3) Treatment condition (n = 8). Cognitive behavioural therapy, weekly 2-h sessions.					
	(4) Treatment condition (n = 8). Supportive therapy, weekly 2-h sessions.					

No., Research number; T1, T2 in weeks; dT1 = d post-treatment; dT2 = d follow-up, whereas d = unbiased standardized mean difference, a positive sign means that the effect size 'd' of the self-help condition is greater than the effect size of the control condition; a negative sign means that the difference is in the opposite direction.

The mean effect size of the self-help v. contrast treatment conditions comparisons is -0.03 (95% CI -0.20 to 0.14; n = 543). A test for homogeneity shows that 100% of the variance is attributable to sampling error.

The follow-up mean effect size for the self-help v. control conditions comparisons is 0.76 (95% CI 0.09-1.42; n = 130). The wide

confidence interval might include a clinically unimportant advantage to self-help. The test for homogeneity indicates that 35.9% of the variance can be explained by sampling error and 64.1% by population variance. Cluster analysis distinguished two clusters at a 5% level of significance. Therefore, two studies were re-analysed. Study 8 (Schmidt & Miller, 1983)

Table 3. *Meta-analysis on the effectiveness of self-help in the treatment of emotional disorders: summary of the results*

Comparison conditions	Number of comparisons	<i>n</i>	Effect size difference	95% Confidence interval	Orwin's fail safe <i>n</i>	Test for homogeneity (%)
Total study sample (14 studies):						
Clinically significant emotional disorders						
Self-help v. control condition post-treatment	16	490	0.84	0.65 to 1.02	50.8	100
Self-help v. contrast treatment post-treatment	16	543	-0.03	-0.20 to 0.14		100
Self-help v. control condition follow-up	5	130	0.76	0.09 to 1.42		35.9
Self-help v. contrast treatment follow-up	9	236	-0.07	-0.33 to 0.19		100
Subsample (8 studies):						
Severity of disease defined as (1) prior treatment, or (2) illness duration > 2 years						
Self-help v. control condition post-treatment	8	288	0.88	0.65 to 1.12	27	100
Self-help v. contrast treatment post-treatment	9	373	-0.15	-0.36 to 0.06		100
Self-help v. control condition follow-up	3					
Self-help v. contrast treatment follow-up	6	181	-0.03	-0.32 to 0.27		100

revealed an opposite pattern of effects on the Self-report Social Avoidance and Distress Scale (DACL) on the one hand and the three measures of depression on the other. Since depression is a main focus of this study, the DACL could have been excluded giving an increased average mean difference between trial arms. Study 9 (Scogin *et al.* 1987) had several weaknesses: (1) a very small sample size ($n=24$) was randomized to three conditions; (2) baseline differences between group characteristics were found, for instance on the Self-report Geriatric Depression Scale (GDS); (3) the contrast 'placebo' manual could have been of therapeutic value; (4) an unusually short treatment and follow-up period (1 month) was used. We conclude that the inclusion of the DACL in study 8 and the study characteristics of study 9 may account for the heterogeneity between the studies. Correction for the mean average of study 8 and exclusion of study 9 would increase the mean effect sizes of the meta-analysis of the self-help v. control conditions comparisons, and of the follow-up mean effect sizes as well.

The follow-up comparisons of self-help with contrast treatment conditions revealed a mean effect size of -0.07 (95% CI -0.33 to 0.19 ; $n=236$; where 100% of the variance could be explained by sampling error), implying that there is no difference between the effect of self-help and contrast treatment during follow-up.

Does treatment or the follow-up period modify the results? The treatment period varied

between 4 and 12 weeks for 16 self-help v. control conditions comparisons with a median of 8 weeks. The average mean difference for comparisons of a short treatment episode (4 weeks: $n=5$; 5 weeks: $n=2$) is 0.74 ; for 8 weeks ($n=3$) it is 0.92 and for more than 8 weeks (10 weeks: $n=2$; 11 weeks: $n=1$; 12 weeks: $n=3$) it is 0.91 . A treatment period of 8 weeks or more seems to be somewhat more effective than a shorter treatment period.

Does severity of illness influence the results? A subset of 8 studies (Schmidt & Miller, 1983; Brown & Lewinsohn, 1984; McNamee *et al.* 1989; Al-Kubaisy *et al.* 1992; Tyrer *et al.* 1993; White, 1995; Landreville & Bissonette, 1997; Bright *et al.* 1999) reported on referred patients, people who had had prior treatment or whose illness had lasted more than 2 years. Eight post-treatment and only 3 follow-up comparisons were available for self-help v. placebo control conditions, and there were also 9 post-treatment and 6 follow-up comparisons for self-help v. contrast treatment conditions. The mean effect size of the self-help v. placebo control conditions comparisons is 0.88 (95% CI 0.63 – 1.12 , $n=288$). A test for homogeneity indicated that 100% of the variance could be attributable to sampling error. Orwin's fail safe n reveals that 27 new studies are needed to reduce the effect to 0.20 . Three follow-up comparisons are too few for re-analysis. However, the mean effect sizes are 1.15 , 0.28 and 0.43 , indicating a positive trend. The post-treatment mean effect

size of the self-help *v.* contrast treatment conditions comparisons is -0.15 [95% reliability interval (RI) = -0.36 to 0.06 , $n=373$]. A test for homogeneity indicated that 100% of the variance could be attributed to sampling error. The mean effect size of the self-help *v.* contrast treatment conditions follow-up comparisons is -0.03 (95% RI -0.32 to 0.27 , $n=181$). A test for homogeneity indicated that 100% of the variance could be attributed to sampling error.

Are the results affected by whether outcomes are self-rated or not? Mood and anxiety affect cognitive functioning and therefore might bias self-assessment. Study 4 (Landreville & Bissonette, 1997) found a moderate to high correlation between participants' and significant other persons' ratings. We examined differences in the estimated mean effect sizes for self *v.* rater-assessed measures by analysing all studies ($n=6$) using self and rater-assessed measures. Five studies (Schelver & Gutsch, 1983; Scogin *et al.* 1987, 1989; Selmi *et al.* 1990; Al-Kubaisy *et al.* 1992) reported a post-treatment self-help *v.* control conditions comparison and two (Al-Kubaisy *et al.* 1992; Bright *et al.* 1999) a post-treatment self-help *v.* contrast treatment conditions comparison. We recalculated outcomes for post-treatment self-help *v.* waiting list (or placebo) conditions. The mean effect size of 6 comparisons ($n=197$) is 0.69 for self-assessment and 1.40 for rater assessment, a significant difference ($T=2.84$; $p<0.005$). Exclusion of self-rated assessments would therefore improve the overall results of self-help.

DISCUSSION

This meta-analysis shows a robust effect for bibliotherapy as a self-help treatment for emotional disorders such as anxiety and depression which might be chronic and remitting. Bibliotherapy is significantly more effective than placebos or waiting lists ($ES=0.84$) and may be as effective as professional treatment of relatively short duration ($ES=-0.03$). The effect size is remarkably similar to those reported in previous meta-analyses on self-help (ranging from 0.59 to 0.96), all except one concerning miscellaneous targets, mainly minor problems for samples recruited by media advertisements. Our effect size equals the results of cognitive therapy in

depressed patients ($ES=0.82$; Gloaguen *et al.* 1998) and is larger than the effect size of antidepressants ($ES=0.50$; Joffe *et al.* 1996).

The methodological limitations of our study are the restrictions of the search and the quality of the trials included. We presumed the searches of former meta-analyses to be comprehensive, covering the literature from the 1970s to the 1990s, and performed an additional search for the 1990–2000 period in several electronic databases. However, systematic reviews based on a search of the English language literature accessible in the major bibliographic databases will often produce results that are close to those obtained from reviews based on more comprehensive searches free of language restrictions. The search was not restricted to the English literature, which is important in psychiatry. Controlling for the influence of unpublished trials (Orwin's fail safe n), 50.8 studies with non-significant results would need to be found in order to reduce the effect size to absence of effect. It is unlikely that a more comprehensive search would profoundly alter the results. Moreover, hard to locate and unpublished trials may be of lower quality and bias the meta-analysis (Egger *et al.* 2003). In contrast to previous meta-analyses on bibliotherapy, a strong aspect of the study was the restriction to randomized trials. However, trials in which concealment is either inadequate or unclear (lack of information), as was the case in most of the studies included, yield larger estimates of treatment effects compared with trials in which authors report adequately concealed treatment allocation (Schultz *et al.* 1995). Most studies did not blind the assessor or include intention-to-treat analysis, which can bias the results as well. Sensitivity analyses of these aspects were not performed because of the small number of studies. Further limitations included the small sample sizes, the relatively short duration of treatment of 4–20 weeks (the acute phase of treatment only according to APA guidelines) and the restriction to mainly bibliotherapy, usually based on the principles of cognitive behavioural treatment. Strong aspects of the study include the inclusion criteria and the results of sub-analyses. Inclusion was restricted to populations of adults with established emotional disorders. Disorders such as arachnophobia and acrophobia, which are unlikely to be of

clinical significance, were excluded. Referral for psychiatric treatment as a method for recruitment and chronic duration of illness do not seem to have affected the results, as shown by a sub-analysis of eight studies with patient populations with a duration of illness of more than two years and/or previous treatment. This subset produced a similar result ($ES=0.88$). The significantly higher effect size for observer-rated assessments as compared to self-reports adds to the strength of our meta-analytical findings. The five meta-analyses on self-help mentioned earlier concerned patient populations mainly based on media recruitment and all conclude that self-help modalities for these 'pre-clinical' patients are effective. In our sub-analysis of referred patients we found a similar effect size for a specified clinical population. This suggests that any potential bias of recruitment method is of minor importance. Because there is a lack of information about loss of social functioning due to psychiatric disorder, we confined our conclusion to a clinical population of emotional disorders of potentially severe outcome. More trials need to be performed on this subject. Hopefully new trials will perform adequately and report concealment of randomization. The development of the standardizing meta-analysis methodology and quality assessment of trials and the rapidly extending hand-searched database of randomized controlled trials in the Cochrane Library would make it worthwhile starting a meta-analysis on bibliotherapy according to the methodology of the Cochrane Library with periodically performed updates. We found only one study on self-help groups. The effectiveness of self-help groups for emotional disorders still remains under-researched in controlled studies. What is the reason for this? The history of the twentieth century reveals two different developments. Patients who were dissatisfied with mental health care initiated self-help groups. These were studied by sociologists with their own methodology but not explored by controlled studies (Katz, 1981). Self-help groups did not enter the field of evidence-based medicine. Bibliotherapy, developed as therapeutic manuals by psychologists and psychiatrists, became a subject of randomized controlled studies as an alternative for professional treatment. It is generally felt to be unethical to refer patients to self-help when

treatment by professionals is called for. Nevertheless, self-help groups do have an important role to play in mental health care. Data from the National Comorbidity Survey reveal that the self-help sector was used in conjunction with other sectors of outpatient mental health care facilities in 63% of cases (Kessler *et al.* 1994). Kessler *et al.* (1994) suggest that the systematic incorporation of self-help groups as part of a comprehensive treatment programme could reduce the number of visits to mental health professionals.

Cost-effectiveness was not the object of the studies included in this or earlier meta-analyses. They do, however, suggest that bibliotherapy and self-help groups will be of interest in this respect. Further research in this area is necessary. This also applies to the long-term effects of bibliotherapy. Like other types of treatment, bibliotherapy or self-help groups may not suit or benefit all patients. Therefore, research is needed on patient characteristics predicting outcome.

Two more issues deserve to be mentioned. First, psycho-education is part of many treatment strategies. This may be considered as a kind of bibliotherapy, for example Lewinsohn's 'Coping with depression' course, containing 12 sessions and 2 booster sessions (Lewinsohn *et al.* 1986). According to Cuijpers (1998), Lewinsohn's course is an effective treatment for unipolar depression and useful in an active outreach approach for people recruited by media who might not otherwise seek treatment. Second, how effective are trained volunteers or lay workers in using specific treatment models as paraprofessionals? Christensen & Jacobson (1994) concluded that paraprofessionals usually produce effects that are greater than those of control conditions and comparable to those of professional therapists. A controlled study (Bright *et al.* 1999) suggests that paraprofessionals are as effective as professionals in reducing the symptoms of depressed patients by cognitive-behavioural group therapy. It seems a worthwhile avenue to study the effects of courses led by paraprofessionals. Training lay people in giving courses on how to use therapeutic manuals is an interesting field for future exploration.

Is it time for doctors to reconsider their professional role in the treatment of emotional

disorders? Do psychiatrists underestimate the value of the acquisition of knowledge by patients? Do psychiatrists and psychotherapists overestimate the importance of the therapeutic relationship and of their own level of experience? The results of our meta-analysis suggest that these are issues that need more attention from researchers.

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REFERENCES

- Al-Kubaisy, T., Marks, I. M., Logsdail, S., Marks, M. P., *et al.* (1992). Role of exposure homework in phobia reduction: a controlled study. *Behavior Therapy* **23**, 599–621.
- Andrews, G. (1998). The burden of anxiety and depressive disorders. *Current Opinion in Psychiatry* **11**, 121–123.
- Barlow, S. H., Burlingame, G. M., Nebeker, R. S. & Anderson, E. (1999). Meta-analysis of medical self-help groups. *International Journal of Group Psychotherapy* **50**, 53–69.
- Bebbington, P. E., Marsden, L. & Brewin, C. R. (1997). The need for psychiatric treatment in the general population: the Camberwell Needs for Care Survey. *Psychological Medicine* **27**, 821–834.
- Becu, M., Becu, N., Manzur, G. & Kochen, S. (1993). Self-help epilepsy groups: an evaluation of effect on depression and schizophrenia. *Epilepsia* **34**, 841–845.
- Bright, J. I., Baker, K. D. & Neimeyer, R. A. (1999). Professional and paraprofessional group treatments for depression: a comparison of cognitive-behavioral and mutual support interventions. *Journal of Consulting and Clinical Psychology* **67**, 491–501.
- Brown, R. A. & Lewinsohn, P. M. (1984). A psychoeducational approach to the treatment of depression: comparison of group, individual, and minimal contact procedures. *Journal of Consulting and Clinical Psychology* **52**, 774–783.
- Burns, D. D. (1980, 1989). *Feeling Good*. Signet/New American Library: New York.
- Christensen, A. & Jacobson, N. S. (1994). Who (or what) can do psychotherapy: the status and challenge of nonprofessional therapies. *Psychological Science* **5**, 8–14.
- Cuijpers, P. (1997). Bibliotherapy in unipolar depression: a meta-analysis. *Journal of Behavior Therapy and Experimental Psychiatry* **28**, 139–147.
- Cuijpers, P. (1998). A psychoeducational approach to the treatment of depression: a meta-analysis of Lewinsohn's 'coping with depression' course. *Behavior Therapy* **29**, 521–533.
- Egger, M., Jüni, P., Bartlett, C., Holenstein, F. & Sterne, J. (2003). How important are comprehensive literature searches and the assessment of trial quality in systematic reviews? Empirical study. *Health Technology Assessment* **7**, 1–76.
- Ellis, A. & Harper, R. A. (1961, 1971). *A Guide to Rational Living*. Prentice-Hall: Englewood Cliffs, NJ.
- Frankl, V. (1959, 1963). *Man's Search for Meaning*. Pocket Books: New York.
- Glasgow, R. E. & Rosen, G. M. (1978). Behavioral bibliotherapy: a review of self-help behavior therapy manuals. *Psychological Bulletin* **85**, 1–23.
- Glass, G. V., McGaw, B. & Smith, M. L. (1981). *Meta-analysis in Social Research*. Sage Publications: Beverly Hills.
- Gloaguen, V., Cottraux, J., Cucherat, M. & Blackburn, I. M. (1998). A meta-analysis of the effects of cognitive therapy in depressed patients. *Journal of Affective Disorders* **49**, 59–72.
- Gould, R. A. & Clum, G. A. (1993). A meta-analysis of self-help treatment approaches. *Clinical Psychological Review* **13**, 169–186.
- Hedges, L. & Olkin, I. (1985). *Statistical Methods for Meta-analysis*. Academic Press: Orlando, FL.
- Humphreys, K. & Rappaport, J. (1994). Researching self-help/mutual aid groups and organizations: many roads, one journey. *Applied & Preventive Psychology* **3**, 217–231.
- Jerrell, J. M., Hu, T. & Ridgely, M. S. (1994). Cost-effectiveness of substance disorder interventions for people with severe mental illness. *Journal of Mental Health Administration* **21**, 283–297.
- Joffe, R., Sokolov, S. & Streiner, D. (1996). Antidepressant treatment of depression – a meta-analysis. *Canadian Journal of Psychiatry* **41**, 613–616.
- Kassinove, H., Miller, N. & Kalin, M. (1980). Effects of pretreatment with rational emotive bibliotherapy and rational emotive audiotherapy on clients waiting at community mental health center. *Psychological Reports* **46**, 851–857.
- Katon, W., Von Korff, M., Lin, E., Walker, E., Simon, G. E., Bush, T., Robinson, P. & Russo, J. (1995). Collaborative management to achieve treatment guidelines. Impact on depression in primary care. *Journal of the American Medical Association* **273**, 1026–1031.
- Katz, A. H. (1981). Self-help and mutual aid: an emerging social movement? *Annual Review of Sociology* **7**, 129–155.
- Keller, J. F., Croake, J. W. & Brooking, J. Y. (1975). Effects of a program in rational thinking on anxieties in older persons. *Journal of Counseling Psychology* **22**, 54–57.
- Kelly, J. A., Murphy, D. A., Bahr, G. R., Kalichman, S. C., Morgan, M. C., Stevenson, L. Y., Koob, J. J., Brasfield, T. L. & Bernstein, B. M. (1993). Outcome of cognitive-behavioral and support group brief therapies for depressed, HIV-infected persons. *American Journal of Psychiatry* **150**, 1679–1686.
- Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., Wittchen, H. & Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. *Archives of General Psychiatry* **51**, 8–19.
- Kuhns, M. L. (1997). Treatment outcomes with adult children of alcoholics: depression. *Advanced Practice Nursing Quarterly* **3**, 64–69.
- Kurtz, L. F. (1990). The self-help movement: review of the past decade of research. *Social Work with Groups* **13**, 101–115.
- Landreville, Ph. & Bissonette, L. (1997). Effects of cognitive bibliotherapy for depressed older adults with a disability. *Clinical Gerontologist* **17**, 35–55.
- Lang, P. J., Melamed, B. G. & Hart, J. (1970). A psychophysiological analysis of fear modification using an automated desensitization procedure. *Journal of Abnormal Psychology* **76**, 220–234.
- Lewinsohn, P. M., Munoz, R. F., Youngren, M. A. & Zeiss, A. M. (1978, 1986). *Control Your Depression*. Prentice-Hall: Englewood Cliffs, NJ.
- Lieberman, M. A. (1990). A group therapist perspective on self-help groups. *International Journal of Group Psychotherapy* **40**, 251–279.
- Lovell, K. & Richards, D. (2003). Multiple Access Points and Levels of Entry (MAPLE): ensuring choice, accessibility and equity for CBT services. *Behavioural and Cognitive Psychotherapy* **728**, 379–391.
- Marks, I. M. (1980). *Living with Fear*. McGraw-Hill: New York.
- Marrs, R. W. (1995). A meta-analysis of bibliotherapy studies. *American Journal of Community Psychology* **23**, 843–870.
- McClaskey, H. (1970). Bibliotherapy with emotionally disturbed patients: an experimental study. *Dissertation Abstracts International* **31**, 5205A.
- McNamee, G., O'Sullivan, G., Lelliot, P. & Marks, I. (1989). Telephone-guided treatment for housebound agoraphobics with

- panic disorder: exposure vs. relaxation. *Behavior Therapy* **20**, 491–497.
- Minaka, S., Watson, D. & Clark, L. A. (1998). Comorbidity of anxiety and unipolar mood disorders. *Annual Review of Sociology* **49**, 377–412.
- Monti, P. M., Fink, E., Norman, W., Curran, J., Hayes, S. & Caldwell, A. (1979). Effect of social skills training groups and social skills bibliotherapy with psychiatric patients. *Journal of Consulting and Clinical Psychology* **47**, 189–191.
- Orwin, R. G. (1983). A fail-safe N for effect size in meta-analysis. *Journal of Educational Statistics* **8**, 157–159.
- Regier, D. A., Rae, D. S., Narrow, W. E., Kaelber, C. T. & Schatzberg, A. F. (1998). Prevalence of anxiety disorders and their comorbidity with mood and addictive disorders. *British Journal of Psychiatry* **173**, 24–28.
- Robinson, P., Katon, W., Von Korff, M., Bush, T., Simon, G., Lin, E. & Walker, E. (1997). The education of depressed primary care patients: what do patients think of interactive booklets and a video? [see comments]. *Journal of Family Practice* **44**, 562–571.
- Rosner, R. F. U., Beutler, L. E. & Daldrup, R. (1999). Depression-sverläufe in unterschiedlichen Psychotherapieformen. Modellierung durch Hierarchische lineare Modelle (HLM) [Course of depression in different psychotherapies. An application of hierarchical linear models]. *Zeitschrift fuer Klinische Psychologie. Forschung und Praxis* **28**, 112–120.
- Salaberria, K. & Echeburua, E. (1998). Long-term outcome of cognitive therapy's contribution to self-exposure *in vivo* to the treatment of generalized social phobia. *Behavior Modification* **22**, 262–284.
- Schelver, S. R. & Gutsch, K. U. (1983). The effects of self-administered cognitive therapy on social-evaluative anxiety. *Journal of Clinical Psychology* **39**, 658–666.
- Schmidt, M. M. (1980). Amount of therapist contact and outcome in a multimodal depression treatment program. *Dissertation Abstracts International* **42** [08-B], 3441.
- Schmidt, M. M. & Miller, W. R. (1983). Amount of therapist contact and outcome in a multidimensional depression treatment program. *Acta Psychiatrica Scandinavica* **67**, 319–332.
- Schultz, K. F., Chalmers, L., Hayes, R. J. & Altman, D. G. (1995). Empirical evidence of bias. Dimensions of methodological quality associated with estimates of treatment effects in controlled trials. *Journal of the American Medical Association* **273**, 408–412.
- Schulze, M., Osen, B. & Hand, I. (1997). Verhaltenstherapeutische Kurzzeit-Gruppentherapie zur Versorgung von Patienten mit Angststörungen in der primärärztlichen Praxis. *Verhaltenstherapie* **7**, 5–13.
- Schwarzer, R. (1989). *Meta-analysis Programs*. Freie Universität: Berlin.
- Scogin, F., Bynum, J. & Stephens, G. (1990a). Efficacy of self-administered treatment programs: meta-analytic review. *Professional Psychology: Research and Practice* **21**, 42–47.
- Scogin, F., Hamblin, D. & Beutler, L. (1987). Bibliotherapy for depressed older adults: a self-help alternative. *Gerontologist* **27**, 383–387.
- Scogin, F., Jamison, C. & Davis, N. (1990b). Two-year follow-up of bibliotherapy for depression in older adults. *Journal of Consulting and Clinical Psychology* **58**, 665–667.
- Scogin, F., Jamison, C. & Gochneaur, K. (1989). Comparative efficacy of cognitive and behavioral bibliotherapy for mildly and moderately depressed older adults. *Journal of Consulting and Clinical Psychology* **57**, 403–407.
- Scogin, F., Storandt, M. & Lott, L. (1985). Memory-skills training, memory complaints, and depression in older adults. *Journal of Gerontology* **40**, 562–568.
- Selmi, P. M., Klein, M. H., Greist, J. H., Sorrell, S. P. & Erdman, H. P. (1990). Computer-administered cognitive-behavioral therapy for depression. *American Journal of Psychiatry* **147**, 51–56.
- Stoudemire, A., Frank, R., Hedemark, N., Kamlet, M. & Blazer, D. (1986). The economic burden of depression. *General Hospital Psychiatry* **8**, 387–394.
- Telch, M. J., Schmidt, N. B., Jaimez, T. L., Jacquin, K. M. & Harrington, P. J. (1995). Impact of cognitive-behavioral treatment on quality of life in panic disorder patients. *Journal of Consulting and Clinical Psychology* **63**, 823–830.
- Trojan, A. (1989). Benefits of self-help groups: a survey of 232 members from 65 disease-related groups. *Social Science and Medicine* **29**, 225–232.
- Tyrer, P. (1996). Diagnostic anomalies in social phobia. *International Clinical Psychopharmacology* **11** (suppl. 3), 29–33.
- Tyrer, P., Seivewright, N., Ferguson, B., Murphy, S. & Johnson, A. L. (1993). The Nottingham study of neurotic disorder. Effect of personality status on response to drug treatment, cognitive therapy and self-help over two years. *British Journal of Psychiatry* **162**, 219–226.
- Verhagen, A. P., de Vet, H. C. W., de Brie, R. A., Kessels, A. G. H., Boers, M., Bouter, L. M. & Knipschild, P. G. (1998). The Delphi list: a criteria list for quality assessment of Randomized Controlled Clinical Trials for conducting systematic reviews developed by Delphi consensus. *Journal of Clinical Epidemiology* **51**, 1235–1241.
- White, J. (1995). Stresspac: a controlled trial of a self-help package for the anxiety disorders. *Behavioural and Cognitive Psychotherapy* **23**, 89–107.
- White, J. (1998). 'Stresspac': three year follow-up of a controlled trial of self-help package for anxiety disorders. *Behavioural and Cognitive Psychotherapy* **26**, 133–141.
- Wollersheim, J. P. (1980). Bye bye blues: overcoming depression. Missoula, MT: Unpublished MS, University of Montana.
- Wollersheim, J. P. & Wilson, G. L. (1991). Group treatment of unipolar depression: a comparison of coping, supportive, bibliotherapy and delayed treatment groups. *Professional Psychology: Research and Practice* **22**, 496–502.

APPENDIX**Meta-analysis on the effectiveness of self-help in the treatment of emotional disorders: excluded studies and reasons of exclusion**

Study	Reason for exclusion by absence of
1 Becu <i>et al.</i> 1993	Randomized controlled design
2 Jerrell <i>et al.</i> 1994	Anxiety or depression symptom measures
3 Kassinove <i>et al.</i> 1980	Anxiety or depression symptom measures
4 Katon <i>et al.</i> 1995	Self-help comparison condition
5 Keller <i>et al.</i> 1975	Assessment of a diagnosis or cut-off score to establish caseness
6 Kelly <i>et al.</i> 1993	Self-help comparison condition
7 Kuhns, 1997	Assessment of a diagnosis or cut-off score to establish caseness
8 Lang <i>et al.</i> 1970	Assessment of a diagnosis or cut-off score to establish caseness
9 McClaskey, 1970	Anxiety or depression symptom measures
10 Monti <i>et al.</i> 1979	Anxiety or depression symptom measures
11 Robinson <i>et al.</i> 1997	Self-help comparison condition
12 Salaberria & Echeburua, 1998	Self-help comparison condition
13 Schmidt, 1980	Assessment of a diagnosis or cut-off score to establish caseness
14 Schmidt & Miller, 1983	Self-help comparison condition
15 Schulze <i>et al.</i> 1997	Self-help comparison condition
16 Scogin <i>et al.</i> 1985	Assessment of a diagnosis or cut-off score to establish caseness
17 Telch <i>et al.</i> 1995	Self-help comparison condition
18 Tyrer, 1996	Anxiety or depression symptom measures