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INVESTIGATION INTO PARTICIPANT EXPERIENCES OF GUIDED SELF-HELP INTERVENTIONS FOR DEPRESSION

Section A: Participant experiences of cognitive-behavioural therapy guided-self-help interventions for depression: a meta-synthesis of qualitative studies

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Section B: A qualitative exploration and comparison of experiences of change following a guided-self-help cognitive CBT or MBCT intervention for depression

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Statement of Covid-19 Impact

In early 2020, at the start of the Covid-19 pandemic, I was in the final stages of planning my MRP project. I had a proposal approved from the university and had received provisional approval from NHS ethics. In addition to this, I had designed an intervention for the purposes of the research, created a workbook and had prepared all the materials including a consent form and information sheet for the project.

The pandemic caused significant disruption to the plans for the MRP as the source population was based within a neurorehabilitation ward within a general hospital. Lockdown restrictions led to a number of substantial changes to be imposed in a very short space of time. Most of the service users were discharged from the unit to prepare for the first wave of COVID patients, and many of the nursing and therapies staff were redeployed to other wards. In addition, all non-COVID research was suspended by the trust, and external visitors, including myself, were prohibited from entering the hospital site.

As a consequence of these changes, it became unfeasible to carry out the research as planned, and, as time went on it became clear that the situation would not return to 'normal practice' for some time. Despite extensive discussion with my supervisors in an attempt to adapt the project, there was no practical way of continuing. I therefore had to find a new MRP project and begin the proposal process from scratch. I have included examples of my work for the original MRP in Appendix V to demonstrate the work that had gone into the original project. This has been included as the original project provided some valuable opportunities to learn and develop competencies that were not available in the second project (notably, developing a research project from scratch, preparing an NHS ethics and HRA submission, and designing an intervention and its associated materials).

Summary

Section A: Presented here is a meta-synthesis of the current literature investigating participant experiences of guided self-help interventions for depression. A total of twelve studies were included within the review which were assessed to be of medium to high quality. Methodological limitations included a lack of author reflexivity and relatively homogenous samples. Findings from the review suggested a range of experience across participants with the perceived suitability and acceptability of the guided self-help intervention playing an important role. Participants largely perceived the guidance offered to be a helpful factor particularly where the supporter was flexible and able to form a good therapeutic alliance. The findings of the review are discussed in light of the limitations and recommendations for future research and implications for clinical practice are discussed.

Section B: Presented here is a qualitative study investigating the comparative experiences of participants attending either a guided self-help intervention based on cognitive behavioural therapy (CBT-GSH) or mindfulness based cognitive therapy (MBCT-GSH). Twenty-four participants took part in a semi-structured interview within one month of completing the guided self-help intervention. Interviews were analysed using template analysis, a form of thematic analysis, and presented within the results as a series of themes and sub-themes. The findings discuss the experiences of participants of a novel MBCT-GSH and an established CBT-GSH intervention within clinical settings. Key limitations, directions for future research and implications for clinical practice are discussed.

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Section A: Literature Review

Participant experiences of cognitive-behavioural therapy guided-self-help interventions for depression: a meta-synthesis of qualitative studies

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Abstract

Introduction

Increasing access to evidence-based and acceptable interventions whilst improving outcomes for individuals living with experiences associated with depression is an important item on the political agenda. Whilst there is a growing body of literature into the efficacy of cognitive behavioural therapy guided self-help (CBT-GSH) interventions for depression, there is limited understanding of how participant's experience such interventions. This review set out to synthesise the available qualitative research findings exploring participant experience of CBT-GSH interventions and to consider the perceived helpful and unhelpful aspects of such interventions.

Methods

The search strategy included five databases with search terms spanning four key areas; CBT, depression, guided self-help and qualitative studies. Twelve studies reporting on ten samples were identified and quality assessed. Following this, a thematic analysis was carried out following the steps of Thomas and Harden, (2008).

Results

The meta-synthesis resulted in three meta-themes and nine sub-themes. Key themes included 'process of change', 'guidance' and 'suitability'. Findings suggested that experiences of the intervention varied across study and intervention. Methodological limitations of studies included lack of author reflexivity, homogeneity of samples and limited reporting of results in two studies.

Conclusion

This meta-synthesis suggests that experiences of CBT-GSH for depression are varied, with a range of facilitators and barriers identified. An important component appears to be how suitable and acceptable an individual finds the intervention to meet their needs and fit into their lifestyle. Further research into experiences of more diverse populations and novel GSH interventions would be useful.

Introduction

Depression is a prevalent mental health difficulty, with an estimated lifetime prevalence of 10% in the general UK population (Kessler & Bromet, 2013). Although experiences of depression will differ depending on an individual and their circumstances, key difficulties include a lack of pleasure in activities and/or low mood, in addition to other feelings such as loss of interest, guilt and/or low motivation (American Psychiatric Association, 2013). Offering therapy options early for individuals with symptoms of depression can benefit both the individual and society (Griffiths & Christensen, 2006) and therefore, increasing access to timely evidence-based interventions has been on the National Health Service (NHS) and global agenda for many years (Alderwick & Dixon., 2019; NHS., 2014).

Guided self-help (GSH) interventions have provided one way to bridge the gap between an increased demand for therapy and long waiting times (Bennett-Levy, 2010). These interventions offer a way to deliver evidence based therapies in a timely and cost-effective manner by combining the use of self-help materials (e.g. a book) with guidance, typically offered by a professional. This combination means that GSH interventions require less therapeutic input than traditional face to face therapies and guidance can be delivered by more junior clinicians (e.g. graduates or mental health practitioners). GSH based on cognitive behavioural therapy (CBT-GSH) is a well-researched and recommended therapy option for mild to moderate depression in England (Cujipers et al., 2010; NICE, 2009).

CBT-GSH interventions for depression

CBT-GSH uses key principles from traditional CBT interventions which are rooted within the cognitive model (Beck, 1967) with influences from behavioural theory (Westbrook et al., 2011). Cognitive theory assumes that an individual's emotions and behaviours are directly related to how they perceive a situation (Beck,1967). A branch of behavioural theory,

learning theory, assumes that behaviours that result in a positive affect can have a reinforcing quality (Bandura, 1977). Cognitive behavioural theory is therefore rooted in the notion that there is a cyclical nature between thoughts, behaviours and emotions (Westbrook et al., 2011). CBT and CBT-GSH interventions aim to support individuals to understand and gain techniques to adapt thought processes and behaviour patterns, essentially supporting them to become their own therapist. In contrast to traditional CBT, CBT-GSH offers limited guidance from a clinician, which is of a facilitative and supportive nature, and the individual completes a large proportion of the learning and psycho-education components on their own with the use of self-help materials. Again, this differs from pure self-help where individuals are given no guidance beyond the self-help material.

Within England, CBT-GSH is often offered as a first therapy option within the NHS for depression for adults. This is typically offered as a self-help booklet, accompanied by four to six sessions led by a psychological wellbeing practitioner (PWP) delivered over the telephone or face-to-face (Bennett-Levy et al., 2010). However, there are different designs of CBT-GSH interventions for depression which differ across format of self-help materials, guidance and the duration (Bennett-Levy et al., 2010). Self-help materials can be delivered online, via a smart-phone application or in a book/booklet (Benett-Levy et al., 2010). Guidance can differ across amount of guidance offered, format of guidance and the qualifications of the individual offering the support (Bennett-Levy et al., 2010).

Evidence base for CBT-GSH for depression

Research on CBT-GSH interventions for depression is largely focussed on quantitative research. Evidence has suggested efficacy, feasibility and acceptability of CBT-GSH for depression (Cuijpers et al., 2010; Gellatly et al., 2007). Research has implied that these interventions can be as effective as traditional face-to-face CBT (Cuijpers et al., 2010). The amount of guidance has been suggested to have an impact on efficacy, with those

receiving more experiencing a greater change than those receiving less (Johansson et al., 2012). Whilst there is a strong evidence base for the usefulness of GSH interventions, it cannot be overlooked that drop-out rates for these interventions can be high (Mohr et al., 2010). This suggests that whilst the intervention may be suitable for some, it may not be suitable for others.

Whilst quantitative research can make a useful contribution to the evidence base of psychological interventions, it has been argued that the reliance on self-report, symptom-based measures does not allow for the capturing of service user experience (Braakmann, 2015). Qualitative studies that explore individual experience of interventions can provide additional value in investigating an intervention (Donovan, 2002). Service user feedback is a crucial and valued element to providing person-centred care (Omeni et al., 2014). Including service user experience within research encompasses the NHS values of 'everybody counts' and 'compassion' by attempting to understand unique and differing experiences and to give service users a voice (Department of Health., 2015; British Psychological Society 2010). While qualitative research does not aim to be generalisable to the whole of the population, it can provide in depth understanding of experience of process which could lead to refinement and improvement of interventions (Ahmad et al., 2019). Therefore, it is important to understand how service users experience these interventions.

Service User Experience of CBT-GSH

A number of reviews have synthesised qualitative literature on participant experiences of different low-intensity (not specifically GSH) CBT interventions across a range of presentations. A review on service user experiences of primary care support for depression attempted to create an explanatory framework to support the implementation of CBT-GSH interventions for depression (Khan et al., 2007). The review revealed a number of themes which lead to recommendations including a consideration of individual circumstances and

experiences of depression, the acceptability of the setting where the intervention will take place and the importance of engaging with an individual's own understanding of their difficulties related to depression (Khan et al. 2007).

Other reviews have investigated participant experiences of digital health interventions (Patel et al., 2020) and computerised CBT interventions for common mental health difficulties including but not limited to depression (Knowles et al., 2015). Both of these reviews included CBT interventions delivered as purely self-help and with added guidance. Results suggested participant initial views of the interventions could impact engagement (Patel et al., 2020). In addition, guidance offered and ability to personalise interventions to participants' needs were seen as valuable aspects of the interventions (Patel et al., 2020). Knowles et al (2015) suggested that the privacy and control that comes with computerised CBT interventions was a key facilitator to engagement.

Rationale for the current review

Existing reviews appear to be of good quality and offer an important contribution to the evidence base. However, no review has yet investigated qualitative literature investigating CBT-GSH interventions for depression in isolation. Previous reviews have grouped findings across different models (CBT, healthcare), presentations (anxiety, depression) and self-help format (guided, non-guided). CBT-GSH interventions for symptoms of anxiety differ to those for symptoms of depression (Westbrook et al., 2011) and research suggests that non-GSH interventions can produce less favourable outcomes than self-help interventions with clinician support (Johnson & Anderson, 2012). These different formats of intervention may result in different experiences for participants and therefore warrant independent investigation.

Aims

This study critically synthesised and appraised the existing qualitative literature investigating individual experiences of CBT-GSH for adults with clinical symptoms of

depression. The review aimed to answer the questions: what are the experiences of those taking part in CBT-GSH interventions for depression and what are perceived helpful and unhelpful aspects of such interventions?

The review included all formats of CBT-GSH for depression regardless of methods of delivery for the self-help and guidance elements. This could provide insight into aspects of CBT-GSH interventions for depression that are valued by participants and areas that they feel could be improved. The review may help to ascertain whether valuable aspects and areas for improvement are common across interventions regardless of delivery format. Findings could contribute to the current evidence base and may provide information to support the development and clinical applications of CBT-GSH for depression.

Methods

Review design

This review adopted a meta-synthesis approach, an umbrella term used for methods to systematically review qualitative research (Dixon-Woods et al., 2006). In order to meet the aims of the review, a thematic synthesis methodology was selected. Thematic synthesis was derived from thematic analysis (Braun & Clarke., 2006) and is suited to reviewing research investigating participants' opinions and experiences (Barnett-Page & Thomas, 2009). The review adopted a critical realist epistemology, which assumes that whilst there is an objective reality, our knowledge of this reality is shaped by our experiences and beliefs (Barnett-Page & Thomas, 2009).

Search terms and strategy

This review adopted a pre-planned search strategy with preliminary searches completed on Google Scholar and Psychinfo to confirm that there were no existing reviews of qualitative studies on CBT-GSH for depression. Main searches were completed on MEDLINE, PubMed, Psychinfo, Web of science and CINAHL. Searches were completed on

the 12th of May 2021 and included English-language scholarly and peer-reviewed journal articles from inception to May 2021. Search terms covered four categories as detailed in Table 1 with full inclusion criteria detailed in Table 2. Search terms were restricted to titles and abstracts. Screening was completed by the trainee which included the removal of duplicates, screening by title, abstract and finally the whole paper of remaining studies was read. The reference lists of included studies were searched to identify any further suitable studies.

Table 1.

Summary of search terms

Search Category	Summary of terms
GSH	'self-help' OR 'GSH' OR 'computer' OR 'app' OR 'audio' OR 'book' OR 'telephone' OR 'internet' OR 'online' OR 'phone' OR 'e-therap*' OR 'user-led' OR 'patient-led' OR 'PWP-led' OR 'therapist-led' OR 'guided'
Low mood	depression' OR 'low mood' OR 'depressive'
CBT	'CBT' OR 'eCBT' OR 'iCBT' OR 'behav* activation' OR 'cognitive therap*' OR 'cognitive behav* therap*' OR behav* therap*
Qualitative	'qualitative' OR 'thematic' OR 'process evaluation' OR 'grounded theory' OR 'IPA', 'experience' OR 'acceptability' OR 'mixed-methods'

Table 2.

Inclusion criteria

Inclusion criteria	Exclusion criteria
English language Published in a peer reviewed journal Community, primary and secondary care interventions Participants aged over 18 with clinical depression Self-help intervention with 'guidance' or 'support' Qualitative studies Studies with a significant qualitative element embedded in a larger scale study	Multiple mental health difficulties examined and not separated in results No guidance offered Guidance offered is representative of a full course of therapy

Studies were excluded where multiple mental health difficulties were included, and different CBT interventions used (for example CBT for anxiety or CBT for psychosis) and not separated within the results section. This is because this study was investigating participant experiences of CBT interventions for depression only. In addition, studies were included where the CBT intervention had been adapted to support individuals from specific groups if all the core aspects of CBT for depression were included.

Quality Appraisal

The role and appropriate method of quality appraisal for qualitative research is debated (Garside, 2014; Thomas & Harden, 2008; Yardely, 2000). This study adopted a 'sensitivity analyses' in order to consider the potential impact of study quality on the findings of the review (Thomas & Harden., 2008). In this method, the contribution of lower quality studies to the review conclusions, meta-themes and sub-themes are considered after the meta-synthesis has taken place (Thomas & Harden, 2008).

Quality appraisal was conducted by the trainee using the Critical Appraisal Skills Programme (CASP) checklist for qualitative research (CASP, 2018; Appendix A) as recommended within the enhancing transparency in reporting the synthesis of qualitative research framework (ENTREQ; Tong et al., 2012). The measure includes ten questions which consider the reporting quality and appropriateness of methods used across the sample, data collection, data analysis and results (CASP., 2018).

Analysis

The trainee completed a bracketing interview with a peer prior to the analysis phase of this project in order to promote rigour and consider potential bias that could impact results (Appendix B).

Once data were collected and quality appraised, the study followed the steps of thematic synthesis as outlined by Thomas and Harden (2008). Deciding on the material to extract as 'data' from primary studies can be complicated when dealing with qualitative research due to the different methods of analysis and reporting styles of authors (Sandelowski & Barroso, 2002). For the purpose of this study, all information within the results sections of the papers were treated as data to be extracted. This decision was made as it is in line with the steps of thematic synthesis (Thomas & Harden, 2008) and due to the different reporting styles of the included studies which use different qualitative methods and differing quantities of raw data (quotations) in the results sections.

Analysis included a first stage of inductive line by line coding of the full results sections of included papers. This resulted in a series of 'free codes' which were presented in a list. Next, 'free codes' were organised and grouped together based on similarities and organised into a hierarchical tree structure with the addition of new descriptive themes to capture the meaning of the groups of codes (Thomas & Harden, 2008; Appendix C). Analytical themes were then created by analysing the descriptive themes in relation to the aims of the review and were discussed in supervision (Thomas & Harden, 2008; Appendix D). At this stage the sensitivity analysis took place. Those studies that were rated lowest quality by the CASP (studies with the most amber and red ratings), were assessed to ensure that none of the final themes were generated only by these studies.

Structure of the review

This review followed the ENTREQ framework (Tong et al., 2012). A summary of included studies is first provided followed by a critical appraisal as guided by the CASP (2018). Next, the results from the thematic synthesis are described and discussed in relation to the current literature. Finally, implications for clinical work and future research are discussed bearing in mind the limitations of the review.

Results

Summary of studies

The PRISMA diagram in Figure 1. illustrates the screening process. Twelve papers were included within the meta-synthesis which are summarised in Table 3. Amongst the included papers, two sets of two papers comment on the same sample derived from an RCT. Richards et al. (2016) and Richards et al. (2018) present findings from different open-ended questionnaires used in the same RCT (Richards et al., 2015). Lillevoll et al., (2013) examined experiences and Wilhelmsen et al., (2013) examined motivation to persist from the same interview data. Although both of these studies were analysing the same data, new themes emerged within each write-up that were relevant to the review, and therefore they were included. Therefore this review reports on twelve papers derived from ten samples.

The papers included in the meta-synthesis were completed in high income countries including Norway, Sweden, England, Canada, Ireland and Switzerland. All studies included participants with mild to moderate depression, however, two studies included individuals with post-natal depression (Pugh et al., 2015) and heart failure and depression (Lundgren et al., 2018). These studies were included as the interventions were well described and included all key components of CBT-GSH.

Studies differed in the format of CBT-GSH intervention offered. Most self-help materials were delivered over the internet (n=10), with one study using written materials (Haller et al., 2019) and one using a smartphone application (Ly et al., 2015). The guided part of the intervention was delivered over the telephone (n=3), via e-mail (n=5), face to face (n=3) or a blend of telephone and e-mail (n=1). The majority of papers used semi-structured interviews and included small sample sizes ranging from 6-36 participants. Two papers used qualitative questionnaires and had larger sample sizes of 88-288 participants (Richards et al., 2016; Richards et al., 2018). Data were collected immediately after the intervention (n=4), after

each intervention session (n=1), after six months (n=1) or not explicitly stated (n=2). Three studies included varying timeframes of 0 -12 months (Lundgren et al., 2018, Haller et al., 2019) and 0-36 months post-intervention (Holst et al., 2017). A range of analysis methods were used, including thematic analysis (n=5), phenomenological analysis, (n=2), systemic text condensation (n=1), qualitative content analysis (n=1), constant comparison (n-1) and descriptive interpretive qualitative analysis (n=1). One study did not explicitly state the qualitative analysis method used (Lundgren et al., 2018).

Figure 1. PRISMA Diagram

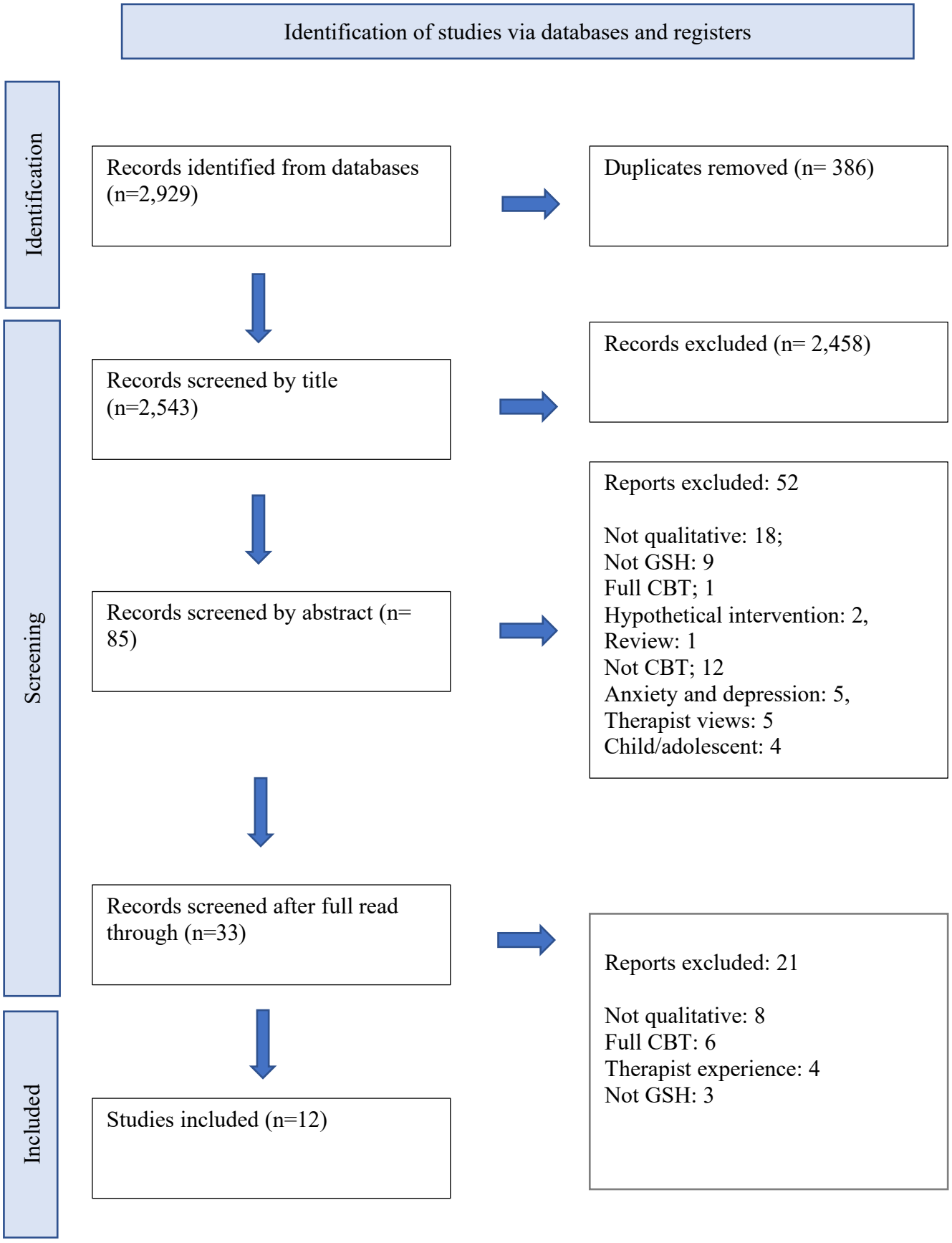

Table 3:

Summary of included studies

Study Title	Author, year	Study Location	Aims	Depression and RCT inclusion criteria	Intervention and 'guided' element	Sample	Data Collection	Analysis method
Towards a conceptual framework of the working alliance in a blended low-intensity cognitive behavioural therapy intervention for depression in primary mental health care: a qualitative study	Doukani et al., 2020	Four primary care services, UK	To understand participant experiences of a blended intervention for depression in primary care as applied to a conceptual model of working alliance	Depression measure: A score of 4 or above on the Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001) Qualitative inclusion (if recruited from RCT): Completion of at least one module of online CBT	Six 30 minute sessions of low intensity CBT for depression delivered by a PWP supplemented by five online sessions using an online programme, MoodBuster.	Nineteen participants recruited from an RCT sample. RCT sample recruited from primary care services. Age range (19-67) Mean 34.47 31% female White British 63.1%, Black/African/Caribbean/Black British 5.3% Asian or Asian British 21% Mixed or multiple ethnic group 5.3% Other 5.3%	Semi-structured interviews using a schedule developed for the study. Participants invited to study two weeks after the intervention took place.	Thematic analysis

						Intervention completers 63.2%		
Cognitive behaviour therapy (CBT) for depression by computer v.s. therapist: Patient experiences and therapeutic processes.	Gega et al., 2013	England, UK	To explore participant experiences of telephone GSH v.s. guided computerised CBT	Depression measure: Mild to moderate depression as determine by the ICD-10 interview Not recruited from RCT	Computerised CBT for six weeks completed in a GP surgery with an introduction and debrief each session by a therapist.	Six participants recruited from GP surgeries. Age range 19-33 (mean 22) 33.3% female No comment on ethnicity 33.3% non-completers Opportunistic sample.	Semi-structured interviews using the Change Interview Data collected at the end of therapy, or at the point of drop-out.	Thematic analysis
"Unrigging the support wheels" - A qualitative study on participants' experiences with and perspectives on low-intensity CBT	Haller et al., 2019	Switzerland	To explore participant experiences with low-intensity telephone delivered CBT.	Depression measure: A score of 16-25 on the PHQ9 Qualitative inclusion (if recruited from RCT): Due to time constraints the first fourteen participants completing the RCT were invited	CBT GSH with telephone appointments with a clinical psychologist.	Thirteen participants recruited from a RCT. RCT participants recruited from GP surgeries and newspaper advertisements Age range (26-79) 87% female	Semi-structured interviews with an interview schedule developed for the study Time from intervention to interview varied from 0-12 months.	Qualitative content analysis

						No comment on ethnicity One non completer (only one person from the whole RCT had dropped out) Opportunistic sample		
Patients' experience of a computerised self-help program for treating depression- a qualitative study of internet mediated cognitive behavioural therapy in primary care	Holst et al., 2017	Sweden	Explore participants experiences of computerised CBT GSH	Depression measure: Mild to moderate depression as measured by the Montgomery Åsberg Depression Rating Scale – self rating version (MADRS-S; Montgomery & Asberg, 1979) Qualitative inclusion (if recruited from RCT): All participants who completed the	Self-help CBT computer intervention supplemented by e-mails and three phone calls from a therapist.	Thirteen participants recruited from an RCT sample. RCT participants recruited from primary care services. Age 27-68 (mean 41) 53% Female 92% participants identified as Swedish. No further information given on ethnicity. No comment on including drop-outs. Participants	Semi-structured interview or focus group. Time from intervention to interview varied from 0-36 months.	Systemic text condensation

				RCT were invited.		invited on completion of the RCT.		
Patient experience of computerised therapy for depression in primary care	Knowles et al., 2015	England, UK	To explore participant experiences of computerised CBT with a focus on engagement and acceptability.	Depression measure: PHQ9 (Kroenke et al., 2001) score of 10 and above Qualitative inclusion (if recruited from RCT): The first 80 participants that completed the RCT were invited. Due to time constraints.	Self-help CBT computer intervention using Beating the Blues or Mood Gym supplemented by weekly telephone calls over 8 weeks by a technician, with the aim of offering motivation and technical support	Thirty-six participants recruited from an RCT sample via convenience sampling. RCT sample recruited from GP practices. Age range 29-69 (mean age 51) 72% Female 94% White British, 6% 'Other White background' Engagement tracked by logging in to the programme. Range 0-18 times (mean 6.3 times).	Semi-structured interviews with an interview schedule developed for the study. Participants invited to interview after the intervention, however no detail given on how long after the intervention the interview was conducted.	Constant comparison
Patients' experiences of helpfulness in guided internet-based treatment	Lillevoll et al., 2013	Norway	To explore participant's experiences of participants experiences of a	Depression measure: A score of 14-29 on the Beck Depression Inventory (BDI;	MoodGYM - an online CBT self-help course consisting of five modules supplemented by 20-	Fourteen participants recruited from an RCT sample. RCT sample	Semi-structured interview developed for the study	Phenomenological analysis

for depression: qualitative study of integrated therapeutic dimensions			guided computerised CBT intervention	Beck et al., 1996) indicating mild to moderate depression. Qualitative inclusion (if recruited from RCT): All participants invited to participate at the end of RCT in a debrief session	30 minute face to face sessions with a psychologist with limited CBT training. Session number varied on individual need. On average participants were offered one session per module.	recruited from GP surgeries and two outpatient mental health clinics. Strategic sample across age, gender and non-completers. 64% female 21% non-completers Age range 18-63 (mean 36.1) No other demographics given	Data collected at final intervention session.	
Patient experiences of web-based cognitive behavioural therapy for heart failure and depression: qualitative study	Lundgren et al., 2018	Sweden	To explore the experience and meaning derived of individuals participating in a web based intervention for depression amongst individuals with heart failure	Depression measure: A score of more than 5 on the PHQ-9 (Kroenke et al., 2001). Cut off was severe levels of depression indicative of inpatient admission. Qualitative study inclusion: all	Seven module online CBT intervention for individuals with depression and heart failure, supplemented by weekly written feedback from a mental health nurse and an option of text message support.	Thirteen participants recruited from an RCT. Individuals with an outpatient appointment or recent hospital admission with a diagnosis of heart failure and at least mild symptoms of depression were recruited via letter.	Semi-structured telephone interviews developed for the study. Interviews conducted 0-12 months after the intervention ended.	Unclear - suspected thematic analysis

				participants who had taken part in at least one CBT-GSH intervention		Purposive sample of participants who actively used the intervention. Age range 41-80 (median 69). No further information on age Female 30.7% No information given on ethnicity. No comment on whether drop-outs were included.		
Experiences of a guided smartphone-based behavioural activation therapy for depression: a qualitative study	Ly et al., 2015	Sweden	To explore the views and experiences of participants taking part in a guided smartphone self-help behavioural activation intervention for low mood.	Depression measure: A score of more than 5 on the PHQ9 (Kroenke et al., 2001). Qualitative inclusion (if recruited from RCT): All participants	Eight week smartphone behavioural activation intervention supplemented by weekly personalised e-mails and motivational text messages from a therapist who had completed clinical training.	Twelve participants recruited from an RCT sample. Strategic sample to cover difference experiences of the intervention (negative, neutral, positive).	Semi-structured interviews using an interview guide prepared for the study. Recruited through newspapers. Collected 6 months after	Thematic analysis

				taking part in the RCT eligible.		50% female Age range 20-59 (Mean 37.9) Mixture of positive, neutral and negative experience. No comment on ethnicity. 16% of included participants dropped out of the intervention	the intervention.	
Client experiences of guided internet cognitive behaviour therapy for postpartum depression: a qualitative study	Pugh et al., 2015	Canada	Understand experiences of women with postpartum depression completed a guided internet delivered CBT depression intervention	Depression measure: Score of ten or more on the Edinburgh Postnatal Depression Scale (Cox et al., 1987). Qualitative study inclusion: all participants who had taken part in at least one CBT-GSH intervention	Adapted seven-module CBT depression intervention delivered over the internet supplemented by weekly e-mails from an assigned therapist.	24 women with postpartum depression recruited from a RCT. RCT participants recruited through media recruitment (radio, tv, newspaper). 100% Female 92% Caucasian 8% 'other' (not specified) Age not reported Only those that completed the	Open-ended questionnaire written for the study. Data collected after the final session of the intervention.	Thematic analysis

						intervention were included.		
Acceptability, satisfactions and perceived efficacy of "Space from Depression" an internet delivered treatment for depression	Richards et al., 2016	Ireland	To explore participants experiences of a CBT-GSH intervention for depression.	Depression measure: Score of 14-29 on the BDI-II (Beck et al., 1996) Qualitative study inclusion: those that took part in at least module of the CBT-GSH intervention	Eight-module CBT-GSH intervention delivered over the internet. Guidance delivered by a 'supporter' with training in delivering feedback on the CBT-GSH intervention. Feedback was delivered via e-mail after each module.	281 participants recruited from an RCT sample recruited from a national depression charity in Ireland. 75% female Age range 18-63 (mean 38.10) No information given on ethnicity. Participants included if they had completed at least one question on the Satisfaction with Treatment measure. No information given on drop-out.	Open-ended questionnaire delivered at the end of the 8-week intervention. The Satisfaction with Treatment measure (Richards et al., 2013) which included 13 open-ended qualitative questions Data collected immediately after intervention.	Thematic analysis
Significant events in an Internet-delivered (Space	Richards et al., 2018	Ireland	To gain insight into the therapeutic processes within	Depression measure: Score of 14-29 on the BDI	Eight-module CBT-GSH intervention delivered over the internet. Guidance	88 participants recruited from an RCT sample. Participants were	Helpful Aspects of Therapy (HAT)	Descriptive 22counselling22

from Depression) intervention for depression			a GSH intervention for depression	(Beck et al., 1996) Qualitative inclusion (if recruited from RCT): those that took part in at least module of the CBT-GSH intervention	delivered by a 'supporter' with training in delivering feedback on the CBT-GSH intervention. Feedback was delivered via e-mail after each module.	recruited from a national depression charity in Ireland. 74% female Age 21-66 (mean 37.93) No information given on ethnicity.	questionnaire - qualitative questions only. Data collected after each intervention session.	qualitative analysis
Motivation to persist with internet-based cognitive behavioural treatment using blended care: a qualitative study	Wilhelmsen et al., 2013	Norway	To explore participant's motivation to continue an intervention combining internet self-help and therapist support	Depression measure: A score of 14-29 on the BDI (Beck et al., 1996) indicating mild to moderate depression. Qualitative inclusion (if recruited from RCT): All participants invited to participate at the end of RCT in a debrief session	MoodGYM - an online CBT self-help course consisting of five modules supplemented by 20-30 minute face to face sessions with a psychologist with limited CBT training. Session number varied on individual need. On average participants were offered one session per module.	Fourteen participants recruited from an RCT sample. RCT sample recruited from GP surgeries and two outpatient mental health clinics. Age 22-51 (mean 34.6) 64% female 21% non-completers No other demographics given	Semi-structured interviews with an interview guide created for the study. Invited to interview at the end of the therapeutic intervention, however the timeframe was not explicitly stated.	Phenomenological hermeneutics

						Began as an opportunistic sample but changed to a strategic sample after ten interviews to include an even spread of gender and completers/non-completers		

Methodological Critique

This section provides a summary and critique of the literature included within this review. The CASP (2018) was used as a guide to aid the critique, and a traffic light system was used to rate studies. Table 4. provides a brief overview of scoring and Appendix E provides a more extensive summary of the quality appraisal process.

Aims and method

All of the studies included within this review included a clear statement of study aims. Eight of the studies aimed to assess the experiences of participants following a CBT-GSH intervention for depression. Four studies had a more specific focus such as investigating participant motivation (Wilhelmsen et al., 2013), the working alliance (Doukani et al., 2020) acceptability and satisfaction (Richards et al., 2016) and significant events (Richards et al., 2018) as related to CBT-GSH interventions. Qualitative methods were assessed as appropriate for all included studies.

Research Design and Sampling

Research designs appeared appropriate in relation to the aims of the research. Richness of the justification of this varied across the studies. Recruitment was generally well described and justified. Almost all of the studies were embedded within RCTs (n = 11). Of the studies embedded within RCTs, four studies included a stratified sample. Two studies stratified across age, gender and treatment completion (Lillevoll et al., 2013; Wilhelmsen et al., 2013), one on experience of therapy (Ly et al., 2015) and one on engagement with the intervention (Lundgren et al., 2018). Three studies included all participants that had completed qualitative questionnaires within an RCT (Pugh et al., 2015; Richards et al., 2016; Richards et al., 2018). Two studies provided little detail about how participants were selected from the RCT (Doukani et al., 2020; Holst et al., 2017) and two studies included opportunistic samples (Gega et al., 2013; Haller et al., 2019). An opportunistic sample could introduce some bias as

it may attract those who had a more positive outcome from therapy or those who were more motivated.

While the CASP does not specifically ask about the demographics of samples, it felt important to consider this within the critique. Some studies included narrow age ranges however there was a broad representation across all studies with the mean age of the samples varying from 22-51. One study provided the age range only which was 41-80 (Lundgren et al., 2018) and one study did not include age within the demographics (Pugh et al., 2015). Study samples ranged from 30.7% female (Lundgren et al., 2018) to 87% female (Haller et al., 2019). One study included females only as the target sample was women with postnatal depression (Pugh et al., 2015). Most studies commented on and included participants who dropped out of the intervention, with the exception of three studies (Lundgren et al., 2017; Pugh et al., 2015; Richards et al., 2016). Not including drop-outs may provide a positively biased view of the intervention. Only four studies commented on the ethnicity of samples (Pugh et al., 2015; Knowles et al., 2015; Holst et al., 2017; Doukani et al., 2020). With the exception of one study (Doukani et al., 2020) the ethnicity of samples was largely homogenous with participants identifying as predominantly white, which can limit the generalisability of results.

Table 4.

Quality assessment of studies

Methodological quality criteria	Studies											
	Doukani et al., 2020	Gega et al., 2013	Haller et al., 2019	Holst et al., 2017	Knowles et al., 2015	Lillevoll et al., 2013	Lundgren et al., 2018	Ly et al., 2015	Pugh et al., 2015	Richards et al., 2016	Richards et al., 2018	Wilhelmsen et al., 2013
Aims												
Method												
Design												
Sample												
Data collection												
Reflexivity												
Ethical considerations												
Data analysis												
Findings												
Research value												

Table Key: Green - met criteria, Amber - criteria partially met, Red - criteria not met

Data collection

Overall, data collection methods were appropriate and well described. Most studies used semi-structured interviews, with three studies using questionnaires with open ended questions (Pugh et al., 2015; Richards et al., 2016; Richards et al., 2018). Benefits of semi-structured interviews may include the ability to ask follow-up questions, to enable elaboration around key areas and a more in depth exploration of participant experience (Silverman, 2013).Whereas, open ended questionnaires can be completed privately and may facilitate more open and honest feedback (Patton, 2014). Many studies did not discuss data saturation, however, small sample sizes were acknowledged as a limitation and justified within these studies.

Reflexivity and Ethical Issues

Reflexivity and ethical issues reflect the two areas that scored the lowest across the studies when reviewed with the CASP (2018). Very few authors critically examined their role and potential bias in the design of the studies. In some studies, the authors referred to quality assurance practices that were completed in order to minimise bias, such as bracketing interviews, inclusion of service users in the design of the study and multiple coders in the analysis process, however further details and reflection on the impact of the researcher were not given. It has been argued that journal space can make it challenging to adequately demonstrate researcher reflexivity, however due to the potential influence a researcher's views can have on interpreting qualitative results failure to do this can reduce the credibility of research findings (Dodgson., 2019).

The consideration and discussion of ethical issues was an area that was frequently lacking within the descriptions of studies. Again, this could be due to space limitations in journals, however discussion of measures to prevent harm such as debriefs would have been valuable.

Data analysis, findings and value

Analysis methods were justified and mostly well described across studies. The most common method was thematic analysis (n=5). One study did not label the analysis method, however it described the process thoroughly (Lundgren et al., 2018). Findings were generally well presented across studies. Two studies included limited amounts of quotes within the results section which could limit the reader's understanding of results (Gega et al., 2013; Holst et al., 2017). Studies considered implications for future research and provided valuable contributions to the evidence base.

Summary

Overall, the studies included within the review were of medium to good quality. All designs, data collection and data analysis methods were assessed as appropriate. A key weakness in two studies (Gega et al., 2013; Holst et al., 2017) was limited raw data to support research findings within the results section. Due to the dearth of literature within this area, no studies were excluded on quality. As Table 5 demonstrates, none of the meta-themes within the meta-synthesis rested solely on any of the lower rated studies and were all backed up by other studies included within the review.

Table 5.

Meta-themes, sub-themes and quotes

Meta-theme	Sub-theme	Papers Present	Exemplary Quotes
Process of change	Acquisition of new knowledge	9 Gega et al., 2013 Haller et al., 2019 Lillevoll et al., 2013 Lundgren et al., 2018 Ly et al., 2015 Pugh et al., 2015 Richards et al., 2016 Richards et al., 2018 Wilhelmsen et al., 2013	"The treatment made me more aware for sure. I was clearly more aware of my situation and what I could do to feel better." (Ly et al., 2015, p.64)
	Active change	10 Doukani et al., 2020 Gega et al., 2013 Haller et al., 2019 Lillevoll et al., 2013 Lundgren et al., 2018 Ly et al., 2015 Pugh et al., 2015 Richards et al., 2016 Richards et al., 2018 Wilhelmsen et al., 2013	"To just do something, not wait until you're motivated, it's hard at first but very rewarding when you finish it" (Richards et al., 2018, p.40)
	CBT psychoeducation and tools	8 Gega et al., 2013 Haller et al., 2019 Lillevoll et al., 2013	"The modules 4 and 5 [cognitive modules] have been most useful for me personally. [These modules helped me to] recognise the 'typical negative thoughts' I was having and practicing to change them to more positive ones is a great coping strategy" (Pugh et al. 2015, p.214)

		Lundgren et al., 2018 Ly et al., 2015 Pugh et al., 2015 Richards et al., 2016 Richards et al., 2018	
Guidance	Added value	11 Doukani et al., 2020 Gega et al., 2013 Haller et al., 2019 Holst et al., 2017 Knowles et al., 2015 Lillevoll et al., 2013 Lundgren et al., 2018 Ly et al., 2015 Pugh et al., 2015 Richards et al., 2016 Richards et al., 2018	"Without human support…there would be no real push on to finish and complete the course" (Richards et al, 2016) "An app is like a machine, it's not personal at all. I think it's good to have some elements of talking to a human about this kind of thing because I think you want reassurance as well, which you wouldn't get from an app" (Doukani et al., 2020, p. 6)
	Therapeutic relationship	8 Doukani et al., 2020 Gega et al., 2013 Haller et al., 2019 Holst et al., 2017 Lillevoll et al., 2013 Lundgren et al., 2018 Richards et al., 2016 Richards et al., 2018	"I thought it (relationship with therapist) was really good! She didn't make me feel judged in any way. She was very accommodating" (Lillevoll et al., 2013) "I simply felt comfortable and felt like I was being in safe hands in terms of having the feeling that I could open up without it getting to anyone or someone making fun" (Haller et al., 2019, p.6)
	Encouraging motivation	10 Doukani et al., 2020 Gega et al., 2013	"I had a therapist who called me and checked how I had proceeded and pushed me a bit and said, 'come on go through this chapter until tomorrow, I'll call you back

		Haller et al., 2019 Holst et al., 2017 Knowles et al., 2015 Ly et al., 2015 Pugh et al., 2015 Richards et al., 2016 Richards et al., 2018 Wilhelmsen et al., 2013	then'. I needed someone to push me because I had a problem with sitting down and getting things done" (Holst et al., 2017, p.49) "It was good to have a deadline [the consultation], which required me to be organised" (Wilhelmsen et al. 2013, p.5)
Acceptability and suitability	Relevance	11 Doukani et al., 2020 Gega et al., 2013 Haller et al., 2019 Knowles et al., 2015 Lillevoll et al., 2013 Lundgren et al., 2018 Ly et al., 2015 Pugh et al., 2015 Richards et al., 2016 Richards et al., 2018 Wilhelmsen et al., 2013	"Well, so little by little, when I could only identify with the character that was not depressed, then it like became more and more…it was almost as if I felt myself getting annoyed by those modules. And I decided that this here stuff doesn't give me anything" (Lillevoll et al., 2013, p.10). "I didn't relate to any of the examples because they weren't the same problems as I was having" (Gega et al., 2013, p.223)
	Flexibility and accessibility	9 Haller et al., 2019 Holst et al., 2017 Knowles et al., 2015 Lillevoll et al., 2013 Lundgren et al., 2018 Ly et al., 2015 Pugh et al., 2015 Richards et al., 2016 Richards et al., 2018	"If I wanted to sit down and do it at two in the night or five in the morning or in the middle of the day then this was fine I could choose when to carry out my exercises […] it is an advantage to be able to do it at a time of my choice. (Lundgren et al., 2018, p.7) "It was difficult to find time for this. I'm struggling to find time to do everything. There is so much that has to be done, that most things get done half-heartedly" (Wilhelmsen et al., 2013, p.5)

	Wilhelmsen et al., 2013	
Privacy v.s. solitary	9 Doukani et al., 2020 Gega et al., 2013 Haller et al., 2019 Holst et al., 2017 Knowles et al., 2015 Lundgren et al., 2018 Pugh et al., 2015 Richards et al., 2016 Richards et al., 2018	"Yes, this I would recommend, namely that one can be completely open there is no need to feel observed or analyzed or monitored in any way-instead it all takes place behind a screen" (Lundgren et al., 2018, p.8). "I would have liked a sample situation for the trigger cycle. I was a bit stumped with it to begin with and still don't know if I've done it right" (Richards et al., 2018, p. 43).

Results from thematic synthesis

The results from the thematic synthesis will be discussed below. Three meta-themes emerged from the text and nine sub-themes. Meta-themes included 'process of change', 'guidance' and 'acceptability and suitability'. Table 5 provides a summary of meta-themes, themes and example quotes. Following the meta-synthesis, a sensitivity analysis was completed to ensure that no themes were derived solely from lower quality papers. Table 5 demonstrates that this was not the case, with all sub-themes being evident in several studies, therefore the sensitivity analysis did not deem it necessary to prioritise certain findings over others.

Meta-theme 1. Process of change

This meta-theme includes information given by participants when describing key changes that they noticed during and after the GSH interventions. This theme includes three sub-themes; acquisition of new knowledge, active change and active ingredients.

Acquisition of new knowledge

Participants from nine papers described the therapeutic value of new knowledge they had gained from the guidance and the self-help aspects of the intervention. Participants described learning about common symptoms of depression as a normalising process which allowed them to become more accepting and less blaming of themselves (Lillevoll et al., 2013; Gega et al., 2013). Knowledge brought an awareness of symptoms of depression which was described as faciliatory to self-reflection, enabling participants to consider thoughts and feelings more objectively (Ly et al., 2015; Pugh et al., 2015; Gega et al., 2013; Lundgren et al., 2018). Participants described experiencing a feeling of being in control and an ability to deal with challenges as they arise (Pugh et al., 2015). Many discussed feeling like they had an understanding of how to facilitate change (Richards et al., 2018; Pugh et al., 2015; Gega et al., 2013). For some this brought a sense of hope for the future (Lillevoll et al., 2013;

Richards et al., 2016). However, although this was not frequently reported in studies, some participants reported finding the information given as nothing new and 'common sense', suggesting that they expected something more from the intervention (Gega et al., 2013).

Active change

In addition to the acquisition of new knowledge, participants frequently discussed their role as an active agent within the therapeutic process. Some described the process of therapy as a shift from a passive to a more active state (Richards et al., 2018). Participants discussed a process of 'learning by doing' whereby activities taught them the relationship between behaviour, thoughts and well-being (Ly et al., 2015). Others were surprised by how active they needed to be within the therapy and came to recognise that the knowledge gained from the intervention needed to be turned into action (Gega et al., 2013).

Participants in four papers discussed this process of active change as a key motivator and reinforcer. For some, engaging activities was reinforcing, in that as they noticed positive change, it became easier to engage with the process (Ly et al., 2015). Others described the process of making positive changes for themselves as a form of relief (Lillevoll et al., 2013), increased hope for the future (Pugh et al. 2015) and gave more motivation and control (Wilhelmsen et al., 2013). The description of taking action as a positive process was also present for some individuals who did not find the intervention useful on the whole (Lillevoll et al., 2013; Wilhelmsen et al., 2013). Rather, the act of 'doing something' appeared to be a positive step regardless of outcome.

CBT-GSH was described by some as a catalyst for change, with participants in five papers describing it as the 'first step' or a move in the right direction, rather than the complete package. Participants discussed that they experienced a small amount of control within this early stage of self-help (Lundgren et al., 2018) and for others it was a step in the right direction, but not sufficient as a therapy on its own (Ly et al., 2015). Participants

recognised that engaging in CBT is part of an active continuous process that needs to continue outside of the therapy in order to maintain change (Haller et al., 2019).

CBT psychoeducation and tools

Participants from eight papers described specific CBT strategies they used as a result of the intervention. In five studies participants talked about feeling that they had a 'tool kit' or had developed coping strategies that taught them to cope in challenging situations (Lundgren et al., 2018; Gega et al., 2013; Ly et al., 2015; Richards et al., 2016; Richards et al., 2018).

Participants from six studies discussed changing the relationship with their thoughts as a result of the intervention. This included becoming more flexible in thinking (Lillevoll et al., 2013) paying deliberate attention to thoughts (Haller et al., 2019) and using thought challenging to reflect and reframe cognitions (Gega et al., 2013; Richards et al., 2016; Richards et al., 2018). However, some participants described the process of interacting and dissecting thoughts as distressing (Knowles et al., 2015). Participants in three studies discussed the benefits of behavioural activation, describing an ability to 'break the cycle' (Lillevoll., 2013) and a learning that small activities each day can generate change (Ly et al., 2015). However, participants from one paper described how low mood symptoms could get in the way of engaging with behavioural activation, which increased stress (Richards et al., 2018).

Meta-theme 2. Guidance

When describing the interventions, many participants commented on the guidance they received. This meta-theme encapsulates conversations around the guidance offered and includes three key themes: added value, therapeutic relationship and encouraging motivation.

Added value

The perception of guidance offered differed across participants and papers. The papers discussed the added value of support, whilst recognising that satisfaction varied across participants. Individuals from four papers described both telephone and e-mail delivered guidance as an essential or vital part of the intervention. Some participants felt that the intervention would not have been successful without the support of a therapist (Ly et al., 2015; Doukani et al., 2020 & Holst et al., 2017, Wilhelmsen et al., 2013). It was suggested that support was more important at the beginning of therapy whilst learning and understanding content (Haller et al, 2019) and as a way to manage the large workload of the intervention (Holst et al., 2017). Whilst these papers suggested that therapist support was valued and important, some participants favoured the combination of therapist and self-help rather than the therapist only (Doukani et al., 2020; Haller et al., 2019). Participants discussed that feedback sessions allowed for sense making and to deepen the learning and understanding of content provided on the self-help platform. Having this space encouraged self-reflection (Pugh et al., 2015), offered another perspective on difficulties (Haller et al., 2019) and enabled participants to take the written information and apply it to their own lives (Lillevoll et al., 2013).

Six papers reported that participants felt that the support offered was not enough, or that they were hoping for more support. This was primarily across the studies that offered e-mail support or optional telephone support rather than scheduled telephone or face to face sessions. These participants discussed that receiving support via e-mail was sometimes frustrating as they could not ask follow-up questions (Ly et al., 2015; Gega et al., 2013) and there was a preference for ‘real time’ support (Holst et al., 2017; Ly et al., 2015; Gega et al., 2013; Doukani et al., 2020; Lundgren et al., 2018). Some participants felt that with minimal therapist support, it opened opportunity for misunderstanding and doubts in how they were

interacting within the therapy and lead to a lack of motivation (Gega et al., 2013, Knowles et al., 2015). Others described the process as lonely and missing continuity (Lundgren et al., 2018; Ly et al., 2015; Richards et al, 2016).

Therapeutic relationship

Participants from eight papers discussed the importance of a collaborative working relationship, with trust and non-judgemental listening. For some, non-judgemental listening from the therapist was validating and enabled them to talk freely and generate trust within the relationship (Haller et al., 2019; Richards et al., 2016; Doukani et al., 2020; Lillevoll et al., 2013). Having a face to face meeting at the beginning of therapy before telephone calls facilitated trust between participants and therapists (Haller et al., 2019). For others, trust was developed through the knowledge that they were working with a qualified professional who had knowledge of depression (Wilhelmson et al., 2013; Lillevoll et al., 2013; Haller et al., 2019). However, for some, the short consultations served as a barrier to opening up (Wilhelmsen et al., 2013).

Participants discussed important characteristics of the therapist which included being approachable, containing, accepting, friendly, positivity, supportive, caring and empathetic (Doukani et al., 2020, Gega et al., 2013, Haller et al., 2019; Holst et al., 2017). These qualities allowed participants to feel listened to and validated. Those who had more challenging experiences described the therapist as too rigid and found a lack of real time contact un-containing (Lundgren et al., 2018; Knowles et al., 2015, Gega et al., 2013). Many studies offering e-mail or very limited support reported that some participants wanted real time support and more contact with a therapist (Lundgren et al., 2018, Ly et al., 2015; Pugh et al., 2015, Richards et al.,2016; Richards et al., 2018).

Encouraging motivation

Ten of the papers discussed the role of the feedback or guidance as a key motivator that enabled engagement with the self-help aspects of the course. Some discussed how the therapist feedback helped to counteract a low motivation that comes with depression (Holst et al., 2017). Participants who received both e-mail support and/or telephone guidance reported that the support brought an accountability which ensured that they completed the tasks (Doukani et al., 2020; Gega et al., 2013; Ly et al., 2015; Lundgren et al., 2018). However, some of those receiving minimal support reported that this was not powerful enough and they wished for telephone or face to face support (Gega et al., 2013; Knowles et al., 2015; Lundgren et al., 2018). For some, this resulted in a lack of motivation, avoidance of challenging tasks and at times a disengagement in the therapy. Others found that they received motivation and encouragement from external sources such as family support and increasing social interactions (Wilhelmsen et al., 2013). Some individuals that received telephone support also reported that at times the minimal support was demotivating (Doukani et al., 2020).

Meta-theme 3. Acceptability and suitability

An important meta-theme running through the studies was the acceptability and suitability of the intervention. This meta-synthesis has included papers that investigate GSH interventions with varying levels of support. Satisfaction with the intervention was not unanimous across the type or amount of guidance. However, it appeared to be more dependent on the acceptability and suitability of the type of support for the individual.

Relevance

The importance of the relevance of therapy was highlighted within ten studies. It was important for participants that this therapy felt relevant and suitable for their needs and this was a key motivator and supporter of engagement. Some participants described experiencing

recognition and support when aspects of the content seemed relevant and validating of their experiences (Lillevoll et al., 2013; Lundgren et al., 2018; Gega et al., 2013; Knowles et al., 2015). However, other participants experienced a mismatch in the content of the programme and their perceived difficulties, which led to frustration and a lack of new learning (Lillevoll et al., 2013; Lundgren et al., 2018; Gega et al., 2013; Knowles et al., 2015). Participants in one paper described feeling 'too well' or 'too ill' in contrast to the examples given which made it difficult to engage in the therapy (Lundgren et al., 2018). Some found it easier when there were suggestions built into the intervention that suited them, rather than needing to tailor the intervention to meet their needs (Ly et al., 2015 Gega et al., 2013) and others described being more accepting of irrelevant content where they felt that there were at least some aspects of the course which suited their needs (Lillevoll et al., 2013, Pugh et al., 2015).

An important factor that seemed to relate closely to the relevance of the programme was the ability for the programme to be tailored to suit ones participants' needs, thus making it more relevant. Participants described the ability to 'pick and choose' the most relevant chapters or modules as a useful way to get more out of the intervention (Pugh et al., 2015; Lillevoll et al., 2013; Lundgren et al., 2018; Wilhelmson et al., 2013; Ly et al. 2015). Many participants talked about the importance of the therapist in increasing the relevance and personalising the intervention (Haller et al., 2019; Doukani et al., 2020), whereas others wished that they had more therapist support to help them to tailor it to their needs (Pugh et al., 2015; Gega et al., 2013; Ly et al., 2015). All the papers where participants suggested more therapist time to help with tailoring the intervention were from interventions with e-mail guidance only.

Flexibility and accessibility

The ability to fit the intervention into one's everyday life appeared to be an important factor determining the suitability of the GSH interventions. Participants in nine studies

commented on the flexibility and accessibility of the intervention. Many found the flexibility to choose when to engage with the self-help material a useful aspect of the intervention (Wilhelmsen et al., 2013, Pugh et al., 2015, Richards et al., 2016), as this allowed individuals to fit it in around competing demands and pick the right time to engage (Wilhelmsen et al., 2013). For some, they found using the telephone a useful way to adapt the intervention to family life (Haller et al., 2019) and others enjoyed the portability of the intervention and the ability to access it from anywhere (Holst et al., 2017; Ly et al., 2015). Some participants who received e-mail support reported that not having scheduled appointments felt relaxing and it was useful being able to decide how much time to dedicate to the intervention (Holst et al., 2017). However, the flexibility of the intervention was challenging for some, as they found that it became easy to avoid (Richards et al., 2016; Lundgren, Holst et al., 2017), and some found it difficult to find a suitable place to complete the work (Holst et al., 2017). Participants in one paper described that this became easier when they created set times to complete the intervention whereas others found it difficult to engage (Richards et al., 2018). Some felt that this intervention was not suitable for those with more significant symptoms of low mood due to the flexibility and the motivation needed to engage (Holst et al., 2017; Knowles et al., 2015).

A few participants found that the intervention was not in fact that flexible due to the amount of time and commitment that was needed to fully engage. The intervention was described by some as time consuming (Richards et al., 2018). However, others felt that the intervention was ‘time saving’ as you could pick and choose which modules to complete (Lundgren et al., 2018). Participants in three papers described the fast pace of the intervention as too demanding and a difficulty maintaining the discipline when receiving less input from a therapist (Pugh et al., 2015; Holst et al., 2017; Lundgren et al., 2018). Everyday factors were

described as a barrier to engaging with the intervention schedule (Wilhelmsen et al., 2013; Richards et al., 2016; Lundgren et al., 2018).

Privacy v.s. solitary

Participants views differed on the minimal therapist support. Individuals from six papers commented on how completing work from their own home created a space of privacy and safety. For some, the perceived distance and anonymity enabled more open and honest conversations without a fear of judgement (Pugh et al., 2015; Lundgren et al., 2018). The act of writing thoughts down on internet programmes, rather than voicing them made the therapy more accessible and easier to engage in for participants from one paper (Holst et al., 2017). Some of those having guidance on the telephone found that the perceived distance between themselves and the therapist enabled more choice around what they wish to disclose (Haller et al., 2019). Whilst a number of participants discussed being able to access the therapy from somewhere safe and from the comfort of their own home (Haller et al., 2019; Doukani et al. 2020), others found that they missed the transition time of travelling to and from a therapist's office which enabled for preparation and debrief on the lead up to and after sessions (Haller et al., 2019).

A proportion of participants felt left alone during the intervention and that they did not have enough support (Knowles et al., 2015; Holst et al., 2017; Gega et al., 2013; Richards et al., 2018; Doukani et al., 2020). For some, not having someone to answer questions led to confusion and a lack of clarity with the content and what was expected from them (Holst et al., 2017; Gega et al., 2013; Richards et al., 2018) those with limited support discussed how it felt difficult not being able to clarify with a person (Gega et al., 2013; Richards et al., 2018). However, for others, this time alone was important for consolidating information and reflecting on learning (Gega et al., 2013; Doukani et al., 2020).

Discussion

This review set out to synthesise the existing qualitative literature that explores participant experiences of CBT-GSH for depression. The aims were to understand participant experiences of such interventions and to explore what was perceived by participants to be helpful or unhelpful aspects of such interventions. The meta-synthesis included twelve publications reporting on ten samples. Below the results from the review will be discussed in relation to the aims and the existing literature.

Summary of findings

Findings from the meta-synthesis revealed three meta-themes and nine sub-themes. Perceived helpful aspects within the theme 'process of change' were related to generating an awareness of one's difficulties, becoming motivated by activity and acquiring techniques to deal with difficulties. Perceived unhelpful aspects included not acquiring new knowledge, not enough change and emotional challenges to engaging with the materials. These findings fit in with current literature within psychotherapy more broadly which discuss the important combination of common (therapeutic skills) and specific factors (model specific) in the process of change (Garfield, 1997). Previous research has suggested that the therapeutic relationship is an important factor which determines good outcomes (Hovarth et al., 2011). The results from this review suggest a trusting therapeutic relationship supported engagement, whereas those receiving e-mail support frequently commented that they hoped for more support. Model specific aspects in this study were highlighted as re-evaluating the accuracy of thoughts and behavioural activation, the two key components within CBT (Westbrook et al., 2011). The current review also highlighted participants recognition of their role as an active agent within the therapeutic process. Previous literature has acknowledged the client as a neglected 'common' factor within the therapeutic process (Bohart & Tallman, 2010) and the role of self-help material in enabling new knowledge and allowing individual's

to essentially become their own therapist (Bendelin et al., 2011; Gerhards et al., 2011). The role of the self as an active agent can be seen across therapeutic models (Bohart & Tallman, 2010) however, CBT-GSH interventions generally require more input from the individual than traditional face-to-face therapy (Bennett-Levy et al., 2010). One common difficult aspect that was frequently cited within this study was the ability to afford the time that was expected of participants which may be a result of the extra input required within GSH interventions.

Perceived helpful aspects of the guidance offered included having space for reflection and clarification, accountability and generating motivation. Short consultations, inflexible modes of support (e.g. e-mail) and a therapist who did not personalise the intervention appeared to be unhelpful aspects of the guidance offered. Quantitative research suggests guidance increases efficacy of CBT self-help interventions (Johnson & Anderson, 2012), however the findings from this review suggest that for some participants the CBT-GSH is more acceptable and helpful when there is a certain amount of guidance and active dialogue, rather than written feedback.

Previous research has suggested that the extent to which an individual engaged in the intervention had a direct impact on satisfaction with the intervention (Bendelin et al., 2011). The findings from the current review suggest that some participants believe that guidance can be a vital component to encourage engagement. In addition, the present review suggests that telephone and face to face support may be more useful for some individuals where motivation is a challenge, with some of those receiving e-mail support requesting real-time support, more support and more motivation to engage with the therapy. This is in line with previous reviews which suggest that some individuals receiving no guidance with digital health interventions discussed being unclear on the content, dissatisfied with the support offered and disengaged with treatment more frequently (Patel et al., 2020; Knowles et al., 2014).

'The fit' of the intervention appeared to be an important factor for engagement and/or satisfaction with the therapy and was dependent on a number of factors. Participants who recognised themselves within the CBT-GSH intervention or felt that the information was relevant to their needs seemed to be more motivated and engaged within the intervention. This supports previous research which suggests individuals respond more positively to self-help materials which include narratives that echo their difficulties (Macdonald et al., 2007; Patel., 2020).

Some participants enjoyed the ability to complete the intervention where they wanted and felt this added an element of privacy. However, others felt that they missed contact and were left feeling alone and that they did not have enough support, leading to confusion, lack of clarity and lack of motivation. This finding supports current literature which suggests flexibility of the intervention can be useful to some and not for others (Patel, 2020). Patel (2020) reported that participants appeared to find the flexibility more challenging when not receiving any guidance at all. In addition, the relevance of the intervention to an individual's difficulties was particularly important in this study.

Limitations of the review

With the exception of one study (Gega et al., 2013) all of the studies included within this review were derived from large RCT samples. However, all but two studies (Richards et al., 2016; Richards et al., 2018) included small sample sizes. It cannot be assumed that the views narrated within this review are representative of all individuals who had taken part within the CBT-GSH interventions within the RCT. Whilst this is important to recognise, this review did not aim to provide generalisable results, rather to provide rich information of individual participant accounts to help build an understanding of how these CBT-GSH interventions are experienced.

Whilst the included studies reported negative, difficult and unhelpful aspects of the CBT-GSH intervention the overall narrative of the included studies, with exception of one study (Gega et al., 2013) was largely positive. Whilst this could be reflective of participant experiences it is important to note that methodological factors could influence this. Nine of the included studies collected their data via interview, conducted by a member of the research team. It could be that participants felt that they needed to portray a more positive account of their experiences to the interviewer due to their involvement in the support offered. However, a strength of the papers included in the review is that most papers included some participants who had dropped out of therapy. Although these numbers were limited, the voices of those that potentially found the CBT-GSH most challenging or unsuitable may have been included in some way.

The included studies reported on different demographics, predominantly age and gender. However, few studies reported on the ethnicity of participants included. Those that did report on ethnicity, reported a relatively homogenous sample with the majority of participants identifying as ‘white’. Evidence based therapies draw on the current evidence base to offer interventions for the general population (NICE., 2009). It is therefore important to include samples within research that represent that whole population, for this reason, it would have been useful to have a clearer picture of the cultural diversity of the samples.

Research Implications

As aforementioned, limited numbers of individuals who had dropped out of the CBT-GSH interventions were included however the experiences of these participants were largely grouped together with treatment completers within the analysis. Further research that compares and contrasts experiences of those who remained on the CBT-GSH intervention and those who disengaged could provide useful information about what aspects of the interventions are helpful or unhelpful across these groups.

Research into the CBT-GSH experiences of individuals from different cultural backgrounds, socio-economic status and education level could provide useful information to support the understanding of ways these interventions are useful and where they can be improved. The inclusion of representative samples including those from different cultures and backgrounds is an identified gap within the quantitative evidence base (Fordham et al., 2021) therefore further quantitative research into the effectiveness, feasibility and acceptability of such interventions across different groups would be an important area for further research. CBT-GSH interventions may not be a useful intervention for certain populations due to an emphasis on reading, required access to the internet or phone and/or the westernised concepts included within CBT. Further research into accessible, cost-effective interventions for different populations would be useful.

Finally, qualitative research into existing and new interventions can provide valuable information such as perceived barriers and facilitators to engagement and an indication of the variability of experiences whilst ensuring that service users have a voice within research. Therefore, further qualitative research into already existing and emerging therapies for depression and other common mental health difficulties alongside efficacy studies would be recommended.

Clinical Implications

The findings from this study have highlighted the importance and value of the guidance included within CBT-GSH interventions. This is a view backed up by quantitative findings which suggest self-help therapies delivered over the internet are more effective with the addition of guidance (Johansson & Anderson, 2012; Richards & Richardson., 2012). Views appeared to differ about the usefulness of different forms of guidance, those that received minimal guidance, on the whole appeared less satisfied with the support. Whilst this won’t be the case for each person, it would be recommended for services to consider

including telephone and/or face to face guidance alongside GSH interventions and to discuss facilitators and barriers to this with participants prior to the intervention.

Participants appeared to do well when they felt that the interventions were relevant and/or tailored for their needs. Prior to offering CBT-GSH interventions a comprehensive assessment of difficulties should be completed and participant's goals considered. Individuals offering guidance during GSH interventions could also discuss the service user's wishes for the intervention and consider together what will help them to get the most out of the intervention.

Conclusions

In contrast to the large amount of quantitative literature investigating CBT-GSH interventions for depression, there have been comparatively few studies seeking to explore the views and experiences of the individuals taking part in such interventions. This meta-synthesis aimed to explore and synthesise the available qualitative literature. In total, twelve studies were included within a thematic synthesis. This resulted in three themes and nine sub-themes capturing participants experiences of the CBT-GSH interventions for depression and included; process of change, guidance and acceptability and suitability. Within these themes both helpful and unhelpful aspects of CBT-GSH interventions were discussed.

As a whole, the results from this study suggest that experiences of CBT-GSH are contrasting and suggest that these interventions may be more acceptable and suitable for some than others. In addition, the results suggest that a range of different variables can facilitate or hinder one's engagement and satisfaction. Further research may wish to explore qualitative experiences of CBT-GSH intervention across different populations and to investigate participant experience of novel and existing interventions.

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Section B: Empirical Paper

A qualitative exploration and comparison of experiences of change following a GSH CBT or MBCT intervention for depression.

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Abstract

Introduction

Conducting qualitative research into service user experience of existing and emerging interventions for depression is an important aspect of delivering person centred care and understanding key facilitators, barriers and experience of change, or no change, in order to adapt new and existing interventions to meet the needs of those receiving them. This study aimed to explore participant experiences of a CBT guided-self-help intervention and a novel MBCT guided-self-help intervention.

Methods

This qualitative study interviewed twenty-two participants using a semi-structured interview schedule which asked about experiences of change, lack of change, attributions of change and helpful or unhelpful aspects of the therapy. Interviews were analysed using template analysis and narratively compared to scope out any key differences in experiences within and between the interventions.

Results

The results covered four key themes which included ‘getting onto the course’, ‘perceived change’, ‘guided self-help’ and ‘ingredients for change’. Key differences between the interventions included a change in interaction with thoughts and emotions, the time commitment of the course and the key elements of the course individuals found useful. Overall, participants appeared to identify similar helpful and unhelpful aspects of the course regardless of intervention.

Conclusions

The results from this study suggest varied experiences across intervention which can be largely depended on individual circumstance. Further research with more diverse samples would be recommended.

Introduction

Depression is characterised by low mood and/or lack of pleasure in addition to other experiences such as guilt, difficulties sleeping and/or lack of motivation (American Psychiatric Association, 2013). With an estimated UK lifetime prevalence of 10%, (Kessler & Bromet, 2013) depression is a common difficulty and can significantly impact an individual's relationships, employment and quality of life (Department of Health, 2008). Whilst the diagnostic categorisation of depression is contested (Jacob, 2009), this terminology has been adopted throughout this study as the interventions explored were delivered within National Health Service (NHS) primary care settings. As these settings offer evidence-based therapies which utilise the diagnostic category it appeared appropriate to adopt this definition. This decision will be revisited in the discussion section of this paper.

Primary care support for depression

Offering early intervention for depression can be beneficial at both an individual and societal level (Griffiths & Christensen, 2006) and therefore the NHS launched Improving Access to Psychological Therapies (IAPT) to provide evidence based psychological therapies in a timely manner (Department of Health, 2008). IAPT offers interventions in a 'stepped care model' which aims to offer the least intrusive intervention based on individual needs (NICE, 2009). This typically involves guided self-help (GSH) supported by a Psychological Wellbeing Practitioner (PWP) (Step 2), followed by longer face-to-face interventions where needed (Step 3). Whilst there are a range of different therapy options recommended at Step 3 (National Collaborating Centre for Mental Health., 2018), cognitive behavioural therapy guided self-help (CBT-GSH) is the main intervention offered at Step 2. There's evidence that CBT-GSH can be helpful for people experiencing depression (Bower et al., 2013; Coull & Morris, 2011; Cuijpers et al., 2010), however, IAPT data has shown modest rates of reliable change and therapy completion rates at Step 2 (Health and Social Care Information Centre.,

2020; Chan & Adams., 2014), which could suggest that for some people CBT-GSH might not be the right fit. Offering a choice of intervention options for individuals with symptoms of depression is recommended within NICE guidance (NICE., 2009) and is in line with the NHS values of 'respect and dignity' and 'everyone counts' (Department of Health., 2015). In addition, lack of therapy choice is a suggested barrier to engaging and remaining in therapy (Curran et al., 2019). It is therefore important to consider other interventions which could be offered within a GSH format to increase choice at Step 2. One option could be mindfulness-based cognitive therapy (MBCT), an evidence-based therapy typically offered in a group format across eight-weekly sessions (Teasdale et al., 2000).

MBCT was originally designed as a therapeutic intervention to support individuals who suffer from recurrent depression. It has a strong evidence base within this area (Kuyken et al., 2016) and is a recommended intervention for individuals at a higher risk of recurrent depression within NICE guidance (NICE., 2009). Due to the efficacy of MBCT, studies have also assessed the effectiveness of MBCT for individuals with current depression and have shown that this can be an effective treatment option (Goldberg et al., 2019). Although research in this area is in its infancy, some preliminary studies have suggested positive outcomes from MBCT offered as a GSH intervention for individuals with symptoms of depression (Taylor et al, 2014; Ly et al, 2014). Whilst CBT-GSH and MBCT-GSH are similar in format of delivery and their roots in cognitive theory, the way this theory is used differs and therefore may be experienced differently by service users.

CBT and MBCT theory and mechanisms of change

CBT is rooted in the notion that our behaviour can have a direct impact on our thoughts and emotions, and the way that we think and interpret situations can have an impact on our responses and actions (Westbrook et al., 2011). This relationship between thoughts, feelings, body sensations and behaviours is thought to be reciprocal and potentially

reinforcing. CBT focusses on teaching clients how to identify 'thought distortions', enabling change through the ability to discriminate between thoughts and reality, and encourages clients to engage in activities that will allow for a balance in life and bring about a sense of enjoyment and achievement (Westbrook et al., 2011).

Whilst MBCT draws on elements of cognitive theory, an important distinction is its roots within Buddhist meditation practice and the addition of mindfulness (Kabbat-Zinn et al., 1992) . Mindfulness refers to the ability to pay attention, non-judgementally in the present moment (Kabat-Zinn et al., 1992). MBCT focusses on mindfulness practice to bring about an increased awareness of present moment experiences (such as thoughts, feelings and body sensations) which is thought to allow individuals to consciously choose how to respond in situations rather than triggering a more habitual reaction (Kabat-Zinn., 2009). In the 'doing' and 'being' modes model, Segal et al. (2018) suggested a key mechanism of change in MBCT is moving from a position of 'doing', where one thinks about the past and future, to a position of 'being', where one is non-judgementally fully present in the moment.

The mechanisms of change detailed above are mechanisms specific to CBT and MBCT. Psychotherapy research more generally suggests that there is a combination of common (across model) and specific (model specific) factors which can bring about change (Mulder et al. 2017). However, the interplay of these factors in CBT and MBCT are not fully understood (Cujipers., 2019). Investigating participant experience of change through qualitative research is one way researchers have attempted to further understand the role of mechanisms of change.

Participant experience of change

Qualitative psychotherapy research suggests that participants can experience therapeutic change both as a gradual process due to accumulating contributing factors and as a more immediate process defined by key 'aha' moments within therapy (Carey et al., 2007;

Higginson & Mansell., 2008). A change in perspective, actions, behaviours and feelings have been highlighted as some ways participants label and perceive change (Carey et al., 2007; Higginson & Mansell., 2008). Participants have described new knowledge as a faciliatory mechanism to promote a shift from hopelessness to awareness (Higgson & Mansell., 2008). This can come about through developing techniques to manage difficulties or through conversations in therapy which make the change mechanism more difficult to pinpoint (Clarke et al., 2004). In addition, the therapeutic relationship has been highlighted as an important factor in relation to participant experience of change (Amos et al., 2018; Curran et al., 2019). The reduced therapist contact within GSH interventions may result in a different experience for participants in relation to traditional face to face therapy.

Participant experience of CBT-GSH and MBCT-GSH

As reviewed in Section A of this paper, qualitative studies investigating CBT-GSH have demonstrated that participants have diverse experiences of these interventions. A theme across studies investigating participant experience of CBT-GSH is the role of the therapist as a motivating agent. Some participants reported that they needed more support, felt lonely and found the course demanding whilst others found the course suitable and beneficial (Holst et al, 2017). Only one study has assessed participant experiences of CBT-GSH for depression in isolation using a self-help book (Haller et al., 2019). A key theme was the importance of the individual as an active agent within the therapy, with those taking a more active role experiencing more self-reported positive change (Haller et al., 2019).

Fewer studies have investigated the qualitative experience of MBCT interventions, with most research focussing on traditional MBCT delivered as a face to face 8-week course (Malpass et al., 2012). One study has investigated the facilitators and barriers of a self-help MBCT intervention (Banjeree et al., 2017) which cited time consuming practices, dealing

with negative thoughts and self-criticism as barriers to engagement, whereas facilitators included increased control over thoughts and options to take part in shortened practices.

The present study

To the best of the trainee's knowledge, no studies have yet investigated participant experience of MBCT-GSH or compared these with participant experiences of a CBT-GSH as offered within a UK IAPT setting. To date, the focus of CBT and MBCT research has been disproportionately quantitative. Whilst quantitative research plays an important role in the development of evidence-based therapies, including the experiences and views of service users is an important aspect to developing interventions and offering person-centred care (British Psychological Society, BPS, 2010).

This study will explore participants experience of change, lack of change and consider barriers and facilitators to engagement. Looking at similarities and differences between MBCT-GSH and CBT-GSH could help to identify whether facilitators and barriers or attributions of change are common across the GSH interventions or specific within the modality (CBT/MBCT). This could shed light on any differences in outcome as observed within a recent RCT in which this study is embedded (Strauss et al., 2020). Findings from this study could be used to consider important elements in the training of PWPs, modify aspects of the interventions to facilitate engagement and minimise barriers within IAPT settings whilst also providing recommendations for further research.

Aims

The aim of the current study is to investigate comparative experiences of a CBT-GSH intervention in comparison to a MBCT-GSH intervention when offered to individuals with symptoms of mild or moderate depression in an IAPT service, focussing on experiences of change.

Research Questions

1. What were participants' experiences of change, if any, following a CBT-GSH and MBCT-GSH intervention?
2. What are the similarities and differences in experiences of change, or no change, between those receiving a CBT-GSH or CBT-GSH intervention?
3. What did the participants attribute any change to?
4. Were there differences or similarities in attribution of any reported change across the two interventions?
5. What are the perceived facilitators and barriers of engaging in the interventions?
6. Is there a difference in facilitators and barriers across interventions?

Methods

Study Context

This study took place within a randomised controlled trial (RCT) investigating the efficacy of a MBCT-GSH intervention versus a CBT-GSH intervention for mild and moderate depression (Strauss et al., 2020). Participants were recruited from ten England IAPT services and randomised to an intervention after being stratified according to IAPT service location and Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001) score. Participants received a self-help book based on either CBT (Williams, 2017) or MBCT (Teasdale et al., 2014) with the addition of six, thirty-minute, PWP sessions for guidance and support. The sessions were conducted either face-to-face or over the telephone based on current practice within the IAPT setting and participant preference (National Collaborating Centre for Mental Health., 2018). The RCT findings are currently under embargo, prior to publication as is usual in such studies to ensure that findings are peer reviewed before they are made more widely available. The current study took place at the end of the RCT, after participants had completed the intervention and the second set of outcome measures. The

trainee joined the research team in January 2021, once data collection was complete and interviews had been transcribed.

Design

This study adopted a qualitative methodology to enable a deeper understanding of participants' experiences of each intervention. Structured interviews were conducted individually with participants using an adapted Change Interview schedule (Appendix G; Elliott et al., 2008) and analysed using template analysis (Brooks et al., 2015). This study adopted a critical realist epistemological position, which accepts that although there is an objective reality, people's experiences of this may differ depending on their past experiences and their expectations (Barnett-Page & Thomas, 2009). Please see Appendix H for a further epistemological statement.

Participants

Of the 410 participants in the RCT, twenty-four participants attended an interview. Data for two participants were not able to be transcribed due to recording quality. Data for twenty-two participants, eleven from each arm, were included in the study. The study aimed to include participants who had both engaged and dropped out of the interventions. Despite a concerted effort to recruit those who had dropped out of the intervention, none of those participants agreed to take part.

Participants were recruited via opportunistic sampling from individuals in the RCT sample (Strauss et al., 2020) who had expressed interest and given consent to attend a qualitative interview. As participants were recruited from the RCT the same inclusion and exclusion criteria applied, these are detailed in Table 1.

Table 1.

Inclusion/Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
A score of 10 or more on the PHQ9 Aged 18+ Sufficient literacy skills to read and understand self-help materials Meet diagnostic criteria on the revised Clinical Interview Schedule (CIS-R) for a primary diagnosis of a depressive episode, mixed anxiety and depression, or non-specified mild neurotic disorder	Score 20+ on the PHQ9 Score 4+ on CIS-R suicidality scale Express strong preference (5/5) for either CBT or MBCT intervention

Participant numbers were determined on pragmatic grounds. A minimum of twelve participants has been recommended for studies using forms of thematic analysis (Braun & Clarke, 2006). Whilst pre-determining sample size can bring limitations as data saturation cannot be guaranteed, a smaller sample size can enable richer analysis (Sandelowski., 1995). This is a similar approach used within other studies examining participant experiences of GSH interventions as demonstrated in Section A in this paper.

Participant information by study arm is detailed in Table 2. The reliable change column highlights where there was an increase or decrease of 6 or more points on the PHQ9 (Kroenke et al., 2001) score from pre to post intervention, a score difference that is seen to indicate a significant change in IAPT (Health and Social Care Information Centre, 2020). Further demographic information is given in Table 3 alongside the RCT demographics. The sample within this study is broadly representative of the demographics within the RCT.

Table 2.

Participants

Pseudonym	Study Arm	Sessions Attended	PHQ9 Pre	PHQ9 Post	Reliable change
George	CBT	6	22	10	Reliable improvement
Sarah	CBT	4	15	2	Reliable improvement
Francis	CBT	6	16	4	Reliable improvement
Hannah	CBT	3	13	4	Reliable improvement
Harry	CBT	6	13	9	None
Sebastian	CBT	5	12	8	None
Helena	CBT	6	12	2	Reliable improvement
Michael	CBT	6	17	11	Reliable improvement
James	CBT	6	10	3	Reliable improvement
Georgia	CBT	6	20	3	Reliable improvement
David	CBT	6	22	13	Reliable improvement
Alice	MBCT	6	17	13	None
Rachel	MBCT	5	16	2	Reliable improvement
Mark	MBCT	6	6	2	None
Megan	MBCT	6	10	4	Reliable improvement
Beatrice	MBCT	6	15	9	Reliable improvement
Sam	MBCT	6	13	21	Reliable decline
Sophie	MBCT	6	15	4	Reliable improvement
Sandra	MBCT	4	18	3	Reliable improvement
Alexa	MBCT	4	11	1	Reliable improvement
Brian	MBCT	6	15	0	Reliable improvement
Grace	MBCT	4	12	9	None

Table 3.

Participant demographics from current study and RCT

Demographics	Total. N (%)	RCT Total N (%)
Age	Median 34 Range 18-81	Median 35 in MBCT arm Median 32 in CBT arm
Gender		
Male	9 (40%)	152 (37%)
Female	13 (59%)	251 (61%)
Identify as other terms	0 (0%)	3 (2%)
Ethnicity		
Asian/Asian British	1 (4.5%)	17 (4.1%)
Black/African/Caribbean/Black British	2 (9%)	15 (3.7%)
Mixed	0 (0%)	20 (4.9%)
White British/White Irish	17 (77%)	351 (85.6%)
Any other white background	2 (9%)	5 (1.2%)
Prefer not to say	0 (0%)	2 (0.5%)
Marital Status		
Single	6 (27%)	168 (41%)
Married/Civil Partnership	14 (64%)	208 (50.7%)
Separated/Divorced	2 (9%)	31 (7.6%)
Prefer not to say	0 (0%)	3 (0.7%)
Sexual Orientation		
Heterosexual	20 (90%)	356 (87%)
Gay	2 (10%)	16 (3.9%)
Education Level		
GCSE	5 (22.7%)	82 (20%)
A-level	6 (27.3)	116 (28.2%)
University level	11 (50%)	200 (48.8%)
No educational qualification	0 (0%)	8 (1.5%)

Measures

Interviews followed an adapted Change Interview schedule (Elliott et al., 2008; Appendix G), a widely used semi-structured interview aimed at exploring participants' experiences of change during a psychological intervention (Clarke et al., 2004; Gega et al., 2013). The original change interview (Appendix F) was adapted to include a question about difficulties prior to the therapy and any remaining difficulties after therapy to examine the extent of perceived change or lack of change. The adapted interview consisted of nine

question areas which explored what changes, if any, participants noticed over the course of therapy, the extent of the changes they noticed and what they attributed any changes to. They also explored resources and/or lack of resources which enabled or hindered engagement in therapy, helpful and problematic aspects of the therapy and future suggestions.

This provided a structure which enabled the interviewer to explore participants' experience of change across both interventions, whilst remaining flexible enough to enable elaboration and reflection on different aspects both within and between intervention arms. In addition, the interview probes both for positive and negative experiences of therapy in an attempt to work against a potential assumption that psychotherapy interventions will promote positive change (Elliot, 2002). Finally, the interview asks about external influences and non-therapy factors which enables a broader understanding of participant's experiences and an ability to situate the therapy experience within a wider context (Elliott, 2012; Dreier, 2008).

Service user consultation

A Lived Experience Advisory Panel (LEAP) consisting of six individuals with experience of IAPT, including participants from a pilot RCT (Strauss et al., 2018) met before the submission of the NHS ethics application. During the meetings the Change Interview (Elliott et al., 2008) was discussed and an additional question was added to include participant suggestions. A member from the panel, a Lived Experience Consultant (LEC), delivered the interviews and gave consultation during the analysis phase of the project.

Procedure

On enrolment to the RCT, participants were given an information sheet (Appendix I) and a consent form (Appendix J). Details of the qualitative interviews were given within the information sheet, and permission to be contacted for the interview was given on the consent form. Participants were contacted by the LEC after they had completed the intervention and

second set of outcome measures. The interview took place within a month of the final intervention session.

Interviews were held over telephone, audiotaped and averaged 42 minutes. They were delivered by an experienced LEC with training in qualitative interviewing, participants were aware of the researcher's lived experience. This decision was made to facilitate discussion and to remove any pressure participants may feel by being interviewed by a member of the research team that they were in contact with during the intervention. The interview schedule was used as guide, allowing for the use of follow up questions to enable participants to expand on different areas that were important to them (Rubin & Rubin, 2004). On completion of data collection, transcripts were transcribed verbatim by three research assistants.

Ethical considerations

Ethical approval was granted by the Health Research Authority and NHS ethics (Appendix K) to which the trainee was added on 11/01/2021. During recruitment, participants were given an information sheet (Appendix I) and consent form (Appendix J). At this time, participants were provided with information for local support services or how to get in contact with the research team should they need any further support. Participants were given a code and data were kept anonymous during the analysis process. All participants were given a pseudonym for this report, and demographic information has been displayed separately in order to protect participants' identities. Participants were reminded that this study was voluntary and that they could withdraw at any time. Following the interview, the interviewer and participant had a debrief and the interviewer contacted the participants in the next few days to provide further opportunity for any questions or support. A summary of results was prepared for the ethics panel (Appendix L) and participants (Appendix M) on study completion.

Data Analysis

Data were analysed using template analysis (TA), a form of thematic analysis that employs a hierarchical coding structure to guide analysis (Brooks et al., 2015). TA is thought to be an appropriate form of analysis for studies with larger data sets and those taking a critical-realist epistemological position (King et al., 2012). TA allows the use of *a priori* themes to inform the initial coding template (King et al., 2012), enabling the trainee to use selected questions from the interview protocol to inform coding, whilst remaining open to new emerging themes within the data (Brooks et al., 2015). Using an *a priori* coding structure enabled the trainee to look for similarities and differences between the two sets of data whilst still allowing codes to emerge inductively from the data. TA allows for multiple levels of coding, which means that sub-theme categories can become more detailed and specific. An in-depth analysis with multiple levels of coding suited this study, as it allowed for subtle differences across participant accounts to be analysed.

Analysing the transcripts

Data analysis was completed following the steps outlined by Brooks et al. (2015). First, a flexible, tentative, initial template was constructed using *a priori* codes selected from the Change Interview template (King et al., 2012; Appendix N). Second, the trainee familiarised themselves with the accounts to be analysed by reading through the entire dataset. Usually a smaller amount of data would be read (Brooks et al., 2015) however, due to the trainee not completing the interviews, this method was chosen to enable them to become immersed in the data. Third, five interviews from the dataset were highlighted and inductively coded line by line next to the initial coding template (Appendix O). Fourth, where codes from the transcript did not fit into existing *a priori* themes on the template, this was written down. At the end of analysing the sub-set, written notes were re-visited and used to update the template to create a second draft (Appendix P). Fifth, the trainee, supervisor and LEC met to discuss

emerging themes and changes made to the template. The supervisor and LEC had coded two interviews from the subset prior to this meeting. Sixth, the trainee completed and coded a further five interviews next to the updated coding template and repeated step three and four. At this stage, the template was 'finalised' and applied to the entire data set, including those interviews already preliminarily coded (Appendix Q). A master spreadsheet was created on Microsoft Excel where the template was listed and coding for each separate interview was added in separate columns (Appendix R). Although this template was finalised it remained flexible should new themes emerge. No new themes emerged at this point. In the final coding template, seven of the twenty-five *a priori* codes remained, this included two themes and five sub-themes.

Comparing treatment arms

Data from both arms were analysed together using the same template. This decision was made as participants were asked the same questions in the Change Interview it was likely similar topics would be covered. However, the template remained flexible to the emergence of new themes from each arm. After primary analysis was completed, the transcripts were labelled according to arm. Mind maps were used to lift the data from the template and consider the best way to represent the findings within the results (King., 2012). Within the mind maps notes were added to describe which arm each code originated from (Appendix S). Conversations regarding similarities and differences across the arms occurred and were agreed on in supervision. Differences across the arms appeared in the content of the codes (including both *a priori* and emerging codes) rather than the codes themselves. Therefore, it was decided that the results from both arms would be discussed collectively with space given to discuss any similarities and differences within the themes. As this was a qualitive study the results were compared descriptively, definitive conclusions were not drawn.

Reflexive Positioning

A bracketing interview was completed prior to analysis (Appendix T) and the researcher kept a reflexive diary throughout the process (Appendix U). These measures are in line with quality assurance guidance to encourage the reflexivity of the researcher and to reduce potential biases and assumptions going into the study (Mays & Pope, 2000).

The trainee has two years of experience delivering CBT-GSH interventions in IAPT as a PWP in addition to personal experience of CBT-GSH interventions as a service user. The trainee recognises that there are both benefits and challenges to offering GSH interventions within primary care settings. Whilst they have seen that these interventions can be beneficial for individuals, there are also situations where such interventions do not support individuals in the best way. The trainee was not involved in interviewing and remained blind to intervention arm. Whilst these approaches could facilitate a sense of separation and objectivity to the transcripts, it was recognised that the trainee's past experiences and current views could influence the development of themes. With this in mind, quality assurance checks were taken in order to ensure rigour and enhance the reliability of the results.

Quality assurance Checks

Two members of the research team (supervisor and LEC) reviewed the trainee's coding of two transcripts and the first and final coding templates. Review meetings were held where discrepancies were resolved through discussion and consideration of impact on the final results. The use of *a priori* themes were carefully considered within these meetings and attention was given where *a priori* themes were not capturing the corresponding codes and where new codes needed to be added (King et al., 2012).

The researcher remained blind to the quantitative results from the RCT throughout all stages of this project in order to reduce biased interpretation of results (Moore et al., 2015). The researcher remained blind to intervention arm during coding of interviews. However,

during the process of reading and analysing the transcripts participants sometimes described which intervention they received. Each transcript was analysed independently, so if one interviewee revealed their intervention group, this did not affect analysis of other interviews. The researcher became unblinded after initial analysis to assess similarities and differences between interventions.

Results

Table 4 provides a summary of the four overarching themes and thirteen sub-themes derived from analysis. Due to space, attention will be given to themes that are particularly relevant to the research questions, that tell us something new or where there were differences observed in responses between the two interventions. The purpose of this is not to draw definitive conclusions across interventions, rather to provide a narrative to highlight some key similarities and differences that emerged from the text.

Table 4.

Themes and sub-themes

Overarching theme	Subtheme	Comment on similarity/difference
Getting onto the course	Reasons for seeking support	No difference
	Expectations	No difference
Perceived change	Change of focus	More prominent in MBCT-GSH group MBCT-GSH focus on present moment CBT-GSH focus on self
	Awareness and control	Difference in dealing with thoughts CBT-GSH 'challenging' thoughts MBCT-GSH take a step back and allow thoughts to pass
	Lack of change	No difference
	Change in relationships	No difference
Guided self-help	Time commitment	MBCT-GSH described mindfulness practice as time consuming CBT-GSH described self-help book as time consuming
	Support and guidance	No difference
	Self-help book	CBT-GSH arm describing this as time consuming, otherwise no difference

Ingredients for change	The individual	No difference
	External factors	No difference
	Course content	Different useful aspects of each course identified
	Therapeutic factors	No difference

Getting onto the course

This theme covers narratives where participants described key difficulties and motivations for getting onto the course and consists of two sub-themes.

Reasons for seeking support

Participants from both arms described difficulties that led them to seek support including anxiety, low mood, low self-esteem, frustration and anger. Others described situational factors such the loss of a loved one, work difficulties and loneliness. Participants also described key motivations including being more present with children and partners, and to come off of medication.

Expectations

Participants described hoping to have support with the above difficulties. Many discussed not knowing what to expect from the course and approaching it with an open mind. Others described modest expectations as they did not feel that a book would help them. These expectations did not differ across intervention or reliable change outcome.

Perceived change

This theme focusses on changes that participants noticed during and/or after the intervention and consists of four subthemes.

Change of focus

MBCT-GSH participants discussed a change of focus to the present moment and to their body whilst still noticing their thoughts.

"Focussing on the current job at hand, you know, I've been able to focus on things better than I used to be able to…you can recognise the thought patterns…let those ones slide and then just appreciate the thing that you're doing at this moment in time" Rachel, MBCT-GSH

Whilst participants from the CBT-GSH arm briefly discussed a shift of focus back onto themselves, this theme was much less prominent or rich in data in comparison to the MBCT-GSH arm.

"*What's really helpful is that I've brought the focus back to myself and my health" Hannah, CBT-GSH*

Awareness and control

A perceived increase in awareness and control in managing challenges, thoughts and emotions was frequently discussed. Participants from both interventions described an increased awareness of 'triggers', how they respond and increased awareness of what helps.

"Understanding the links between all the different areas and how one impacts upon another and how that kind of starts you on that downwards cycle and understanding that all you have to do is stop one area to stop all the other areas, that was very empowering actually because it made me realise 'oh you know I can actually stop this if I want to" Helena, CBT-GSH

Narratives described a new-found sense of control, allowing individuals to interact with thoughts and emotions differently. This included noticing difficult thoughts and emotions and an ability to accept, tolerate or interact with them with increased confidence. The way participants described dealing with their thoughts differed across intervention. CBT-GSH participants described challenging thoughts and thinking "more rationally", whereas

MCBT-GSH participants discussed the ability to take a step back and allow difficult thoughts and emotions to pass.

"I am in a place where I embrace my emotion and try to understand it, try to find the trigger, try to find a solution and try to make a more permanent solution, so if I'm sad, what can I do to be more permanently happy? What triggered my emotion? Why do I feel this way? I've started to analysise my thoughts in a more healthy way" George, CBT-GSH

"It's a bit of a revelation around you know, your mind, and how it works and how, you know the negative connotations that we can put in there and actually you know, distancing yourself from those or, you know, putting those to one side and realised that just because you think something, doesn't necessarily make it true" Rachel, MBCT-GSH

Across both arms participants described an awareness over what they can do to improve mood which resulted in active change and engagement in new activities.

Lack of change

A few participants found that certain difficulties continued after the intervention, with many describing that the 'underlying problem' remained. Experiences and descriptions differed across participants, but not intervention. Those who discussed a lack of change were largely amongst the participants whose PHQ-9 (Kroenke et al., 2001) scores did not reduce reliably. A couple of participants described feeling that the course helped with some difficulties, however external factors resulted in lower mood. However, there was discussion of underlying difficulties remaining amongst some of those whose scores did meet reliable change, with some reporting that although the difficulties are there, they feel more able to address these difficulties.

"*You know, all the issues and problems are still there but, you know, I think it's like learning how to, how to look at them or how to cope with them is the key" David, CBT-GSH*

Change in relationship

Participants discussed being more present within family, romantic and social relationships and making new friends. One of the most frequently discussed relationships was a change in relationship with themselves, which included making more time for themselves, being kinder to themselves and regaining a part of themselves they had lost. These descriptions did not differ across intervention.

"I mean there's a strong sense of, I'm actively kinder to myself and even though I know when I'm in situations where I should've done differently that is something I'm actively stopping and thinking a bit, stopping and appreciating it a bit better…objectively" Sandra, MBCT-GSH

Guided self-help

This theme covers information discussed by participants when referring to the GSH aspects of the intervention, including the guidance from the PWP and self-help book. This theme contains three sub-themes; time commitment, support and guidance and self-help.

Time Commitment

The time commitment of the GSH course was seen as a challenge for many participants. All MBCT-GSH participants described the mindfulness exercises as time consuming. Some participants recognised the time consuming nature but found ways to fit it into their lives (for example, choosing the shorter exercises or allowing themselves to miss some exercises).

"I struggled with the time commitment, particularly when I got to the point of having to do the 3-minute exercises every day….it just doesn't fit in with normal life. I very rarely managed to do both the breathing and meditation in a day" Mark, MBCT-GSH

This theme was less present amongst CBT-GSH participants however, some commented on difficulties with making time to read the book.

"It's been quite difficult to find time to sit down and read the book with sort of everything that's been going on with work, and sort of family. So it's kind of a sort of a more the time issue that anything else." Harry, CBT-GSH

Support and guidance

Many participants commented on the importance and value of PWP sessions. Helpful aspects included motivation, accountability and focus, which participants described as facilitators to engagement. Useful PWP traits included compassion, non-judgemental listening and kindness. To many, it was beneficial when PWPs took a genuine interest and a personalised approach which involved applying the material to the participant's experiences, and spending time on what was important to the participant.

"Being able to talk through and reflect back on with somebody, your feelings and your thoughts around it and your experiences, that was a big part of it, cause I think you could do the book without having the feedback I don't think it would have been have as beneficial to me" Rachel, MBCT-GSH

For some, the limited sessions made it difficult to build a therapeutic alliance which impacted the content that could be discussed within sessions. It was suggested that more PWP input would be beneficial and further increase motivation and engagement. Two

participants described finding the PWP sessions too rigid or scripted which led to the experience feeling impersonal.

"*I'll say, "oh well that made me feel really bad" and they'll say "aha that's the trigger!" and I say "well no that happened before and it was fine". You know, it felt at times like we were ticking boxes" James, CBT-GSH*

One participant described difficulties related to cultural differences and was left feeling like they had to adapt to the intervention, rather than the intervention being adapted for them.

"I had to try and change my explanation of how I felt about something….I was tamping down my desire to be fully expressive….and feeling like I needed to be more polite" Sebastian, CBT-GSH

Perhaps surprisingly, given the different stance the PWPs were asked to take in the two interventions, differences between the CBT-GSH and MBCT-GSH were not obvious from the participants' accounts.

Self-help Book

There were mixed views and experiences reported in relation to the self-help aspect of the course. Motivation was seen as key to being able to engage with the self-help aspect of the course and individuals discussed how symptoms of low mood would often get in the way of this. There were times where individuals felt that they were left on their own with the material and described a lack of clarity about what they should be doing in between sessions.

"*Sometimes it wasn't clear if I should be reading everything, cause like in the workbook there's lots of little quotes…if I had direction on whether I should be reading every single last bit that would have helped" Sandra, MBCT-GSH*

Some participants found the self-help aspect helpful, with space between PWP sessions described as a space to think and put suggestions into action. Others found the book encouraging in the way that they could personalise it and dip in and out where they felt was appropriate. Individuals also discussed that this helped with fitting it into their schedules.

"One thing was…because you could pick and choose in the book it felt quite personalised… I didn't have to read through the whole thing it was like right what area is of most concern, let's work on that and then you know, take the tools from that" Helena, CBT-GSH

Ingredients for change

This theme covers factors that participants attributed any change too and aspects that were perceived as supporting, or not supporting, change. This theme includes 'the individual', 'external factors', 'course content' and 'therapeutic factors'. All of the below themes, with the exception of course content, differed across participant, but not intervention.

The individual

The extent to which the course 'fit' an individual appeared to be an important contributor to how useful participants found either intervention. Some people enjoyed reading and learning and felt that this interest was something that enabled them to get more out of the course. This was also linked to a level of intelligence that some people felt was needed to engage in not only the reading but also the psychoeducation aspects of the course.

"I like to study and read, and sort of analyse things. I think having sort of the personal ability and also like doing that helped me to sort of sit down at the nook and study it and really get into it in that way" Francis, CBT-GSH

Many described a determination and perseverance that enabled them to see the course through to the end. For some, perseverance was described as a personality trait, whereas for others it was generated from external factors such as noticing the impact of low mood on others and wanting to repair relationships. Individuals who did not describe perseverance, motivation or commitment often described this as a limitation.

External Factors

External factors were frequently discussed as enabling change including medication, changing job, sunny weather and challenges which resolved themselves during the course. Those taking medication often found it difficult to ascertain whether the course or medication was more useful. For some, they felt medication was needed for them to feel able to engage in the course.

"I have changed jobs like three times, I have rehabilitated that into kind of my routine in (location), which I has just come back from being away. It's also summer which makes this huge difference to my mood and things like that." Alice, MBCT-GSH

A frequently discussed external factor was the ability to afford time. Having time off work, a partner to do chores, a flexible job and no children were all factors which supported individuals to take the time to complete the course. For others, multiple commitments were described as a barrier to engaging with the therapy.

"*I work full time, I found it quite difficult to, as much as I was trying, to dedicate enough time between the session to really look at the chapter of the book and really sort of het into that with all the things of daily life that happens in between". Francis, CBT-GSH*

Course content

Course content was discussed as a factor that enabled change. Similarities across the two interventions included participants describing that they had a tool-box and gaining techniques to help them to manage mood.

MBCT-GSH participants most commonly discussed the mindfulness exercises as a tool to overcome spiralling thoughts, to take a step back and a useful way to make time for themselves. The most frequently discussed of these was a three-minute breathing exercise.

"I think practicing mindfulness itself has definitely had an impact because, as I've said before, the whole practice is just being far more present, not being caught up in my sort of internal narrative" Mark, MBCT-GSH

Those on the CBT course discussed the 5-areas as a way to understand themselves and as a tool to evaluate a situation. Participants also discussed learning to take control and engage in activities that they enjoy as well as thought challenging as a way to turn into their thoughts and create new explanations.

"The most helpful thing has been trying to sort of change the way I think about things….I can sit down and think about it logically" Harry, CBT-GSH

Within both interventions, aspects of course content were sometimes experienced as distressing. This was particularly challenging when reading the self-help book and trying to engage in difficult materials on their own. Participants spoke to the difficulty of facing their thoughts and emotions after trying to supress them for some time. However, within these accounts it was apparent that there were perceived helpful aspects to engaging with distressing content for some participants.

*"Some of the thoughts that came into my mind during the working with difficulty meditation were a little bit painful, but then it was helpful to think about them so I don't think it was negative" Beatrice, MBCT-**GSH***

Therapeutic Factors

A key factor in enabling change appeared to be an understanding and non-judgement from others. This was obtained from different sources, such as employers, partners, friends, GPs, PWPs and family members.

"I had amazing support from my family around me…nobody judged me, everybody let me be" Georgia, CBT-GSH

Many participants discussed the 'normalising' of their symptoms as a helpful factor that made them feel less alone with their experiences. Most frequently, this was discussed in relation to the self-help books from both interventions. Participants described benefitting from friends, partners, PWP self-disclosure and colleagues sharing experiences from when they felt low. Of those who did not discuss having close friends and family, some suggested that intervention peer support groups would be a helpful addition that would make them feel more supported and engaged with the intervention.

"Depression has symptoms and it's not…there's not something wrong with me. It's just, you know, I think that one is quite, that was quite [a] big realisation from working through the book, that actually it's not…it's not me, it's just something that I struggle with" Megan, MBCT-GSH

Discussion

This study aimed to explore participants' experiences of CBT-GSH and MBCT-GSH interventions, including experiences of change, facilitators and barriers to engaging with the

intervention, and any comparative or contrasting experiences between the interventions. Whilst some narratives differed across arms, an interesting finding was that perceived changes, difficulties and helpful aspects of the course were largely similar regardless of the intervention received. In some instances perceived changes differed across intervention, which could be assumed given MBCT-GSH and CBT-GSH focus on different mechanisms of change (Segal et al., 2018; Shapiro et al.,2006 ; Westbrook et al., 2011). A key difference was participant's descriptions of how they relate to thoughts, whereby those in the CBT arm looked at thoughts critically and rationally and those in the MBCT arm detached from the thoughts and allowed them to pass. These findings are in line with the key mechanisms of change within CBT and MBCT (Segal et al., 2018; Westbrook et al., 2011). However, both of these changes appeared to result in an increased awareness and control over thoughts. This fits in with existing literature which suggests both CBT and MBCT attempt to alleviate depression through a changed relationship with thoughts rather than changed content (Segal et al., 2018).

Regardless of outcome scores, all participants discussed some positive change. Whilst this could be indicative of the data collection method and participants feeling obliged to give positive feedback, this fits in with previous research that suggests that quantitative outcome is not fully indicative of a person's experience of therapy (De Smet et al., 2019). Quantitative research has suggested an alleviation of depression symptoms following CBT and MBCT (Cujipers et al., 2010; Ly et al., 2014) however, this study, in line with previous qualitative research has shown potential for other positive change from GSH interventions such as awareness, perceived control, increased in activity, improved relationships and a changed relationship with the self (Patel et al., 2020).

The PWP seemed to be a source of motivation within both interventions. Motivation appeared to play an important role within the intervention due to the active role participants are expected to take. A key symptom of depression is low motivation (APA., 2013), and participants discussed grappling with this and finding it difficult to self-motivate without the help of the PWP. Previous research has supported this where service users have described guidance within self-help interventions as a vital component to support engagement (Ly et al., 2015). This also supports quantitative research which suggests guided self-help is more effective than pure self-help (Johnson & Anderson, 2012). In addition, participants in this study highlighted the importance of common factors across the interventions, including the therapeutic relationship and qualities of the PWP. The importance of the therapeutic alliance has been highlighted within previous quantitative research (Ackerman & Hilsenroth., 2003; Elliott et al., 2018) and qualitative research (Knowles et al., 2014). Interestingly, participants discussed how some of the therapeutic factors such as normalisation and non-judgemental listening could come from a range of sources including their own support system rather than the PWP and self-help book alone.

Some participants reported distress during the MBCT and CBT interventions. Previous literature has suggested that distressing aspects of therapy are common and can be an important enabler of change (Schermuly-Haupt et al., 2018) whereas other research suggests that for a small number, negative effects can have a lasting impact (Crawford et al., 2016). Participants within this study largely discussed times of distress as part of a therapeutic journey rather than detrimental.

Previous studies into guided and non-guided self-help interventions have highlighted that the way participants engage with the interventions has an important impact in experience of the intervention (Haller et al., Patel et al., 2020). Whilst this did not come up within this

study, participants discussed some key factors which made engagement difficult. One key barrier was the time needed to fully engage; a finding frequently cited within other qualitative research as explored within Section A of this paper. The current study highlighted the role of systemic factors such as an individual's support network and life circumstances in motivation and ability to engage. Whilst MBCT and CBT theory (Beck et al., 1967; Westbrook et al., 2011; Segal et al., 2018) tend to focus on the person, this study has demonstrated that external factors also play an important role in the process of change. This suggests that whilst MBCT-GSH and CBT-GSH may be suitable for an individual's presentation, it may not be suitable for those who do not have a support system around them or the ability to afford the time to fully engage. Previous literature has highlighted the importance of social factors in motivation to engage with GSH interventions (Wilhelmson et al., 2013) and social status and family situation on the ability to engage with therapy in psychotherapy research more generally (Curran et al., 2019).

Limitations

This research was not designed to be generalisable to the rest of the population, but to provide a snapshot of participant experiences of two GSH interventions. The sample size was small and it therefore cannot be assumed that the voices heard within the results are representative of the whole population. However, including the voices of service users in the evidence base for new and existing interventions is an important aspect of offering person-centred care (BPS., 2010) and can provide rich descriptions and important information which can influence the implementation of such therapies.

Recruitment for this study was focussed on a self- selected RCT sample which may represent a more motivated sample of the population. Whilst the use of opportunistic sampling will reduce the possibility of a representative sample being obtained, the sample

within this study did not differ greatly in demographics in relation to the RCT. Nevertheless, the sample included was young (mean age 32), well-educated and predominantly White British, therefore the experiences of those from different ethnicities, older populations and those from different educational and social backgrounds were not well represented.

This study was a secondary analysis with archival interview data from participants who had taken part in an RCT. Therefore, the participants included had met a set of previously determined inclusion and exclusion criteria and further information could not be gathered. History of previous depressive episodes is unknown for the participants included within this sample, which is a limitation of the study. As discussed previously, MBCT was originally created as a therapy for recurrent depression and therefore may be experienced differently by those experiencing a first episode of depression rather than recurrent depression. In addition, whilst treatment preference was assessed prior to selection for the RCT it was not reassessed at recruitment for this qualitative study. Whilst participants with a very strong (5/5) preference for either intervention were excluded from the study, those with preferences ranging from 1-4 out of 5 were included, which meant participants could have had varying levels of preference for the intervention they received. This data would have been useful to accompany the results, as whilst research is conflicted in this area, some research has suggested that treatment preference can influence engagement and outcome with the intervention (Winter & Barber, 2013).

Only those who had attended three or more sessions agreed to take part in this study. Without including the voices of those who dropped out of the intervention, it is likely that the sample collected are of those that had a more positive experience. With that being said, the sample included participants attending three to six sessions, and reliable improvement, reliable decline and no change indicating some variation in experience.

The data collection method of single interviews at the end of therapy relied on retrospective accounts of the therapy process. Individuals may not always have a good understanding of what lead to change or prevented it. In addition, giving retrospective accounts may mean individuals are influenced by outcomes of therapy and may not be representative of how experience and opinion of therapy can change over time (Williams & Healy., 2001). Whilst it may have been helpful to complete interviews at different stages of therapy, doing so could have interfered with the RCT aspect of the wider study, increased burden on participants and further reduced the sample size to those most motivated.

This study relies on a diagnostic categorisation of depression (APA, 2013). This is contested due to questions around the reliability and validity of the construct of diagnosis and the generalising of individual's experiences into a catch all term (Pickersgill., 2013). Whilst diagnosis can be problematic, this study was embedded within the NHS which provides evidence based therapies according to diagnosis. This study set out to capture the voices of individuals accessing services and highlight the variety of experience, both positive and negative, associated with therapies for individuals experiencing depression.

Future research

The data within this study only shows individuals who took part and attended at least three sessions. Further qualitative research into CBT-GSH and MBCT-GSH interventions amongst participants who drop-out of therapy would be useful. As MBCT-GSH is a novel intervention further quantitative efficacy research and research into mechanisms of change would make a useful contribution. Future qualitative research exploring participant experiences of GSH interventions across a broader range of diversity characteristics including age, ethnicity and education level is needed. This should include exploration of potential adaptations to support engagement across different groups. In addition, this study suggested

that participants found therapeutic qualities within their support system which helped them with the guided self-help aspect of the course. Further research into the value of systemic factors on the ability to engage with GSH interventions would be useful, including an exploration of how to support those with less external support.

Implications

The fit of both the CBT-GSH and MBCT-GSH appeared to be important within this study. Due to the time commitment and motivation needed to participate, participants appeared to feel more able to engage with the intervention where they have the ability to afford time. It would be recommended that PWPs take time to discuss the intervention, what it will entail and make the time commitment clear. Exploring potential facilitators, barriers and ways to support motivation with the individual prior to the intervention would be recommended. This could include a consideration as to whether it is the right time to engage. PWP support appeared to be an important factor that encouraged engagement within the intervention and it would therefore be recommended to retain this support rather than offering interventions as purely self-help. In addition, PWPs could be encouraged to personalise the interventions to an individual's circumstances. Finally, support groups and extra PWP sessions could be considered, particularly for those with a limited support system.

Conclusion

This study qualitatively assessed twenty-two participant's experiences of an MBCT or CBT intervention. Whilst the study suggests some potential differences in the mechanisms of change between the two interventions, it also implies the importance of non-specific factors such as the therapeutic relationship. This study has also suggested the importance of 'the fit' of a GSH intervention, highlighting the importance of an individual's personal circumstances, personality and support system in facilitating engagement. It is recommended that further

qualitative research be completed within diverse primary care settings for both MBCT-GSH and CBT-GSH interventions.

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Appendices

Appendix A: Critical Appraisal Skills Programme for Qualitative Studies

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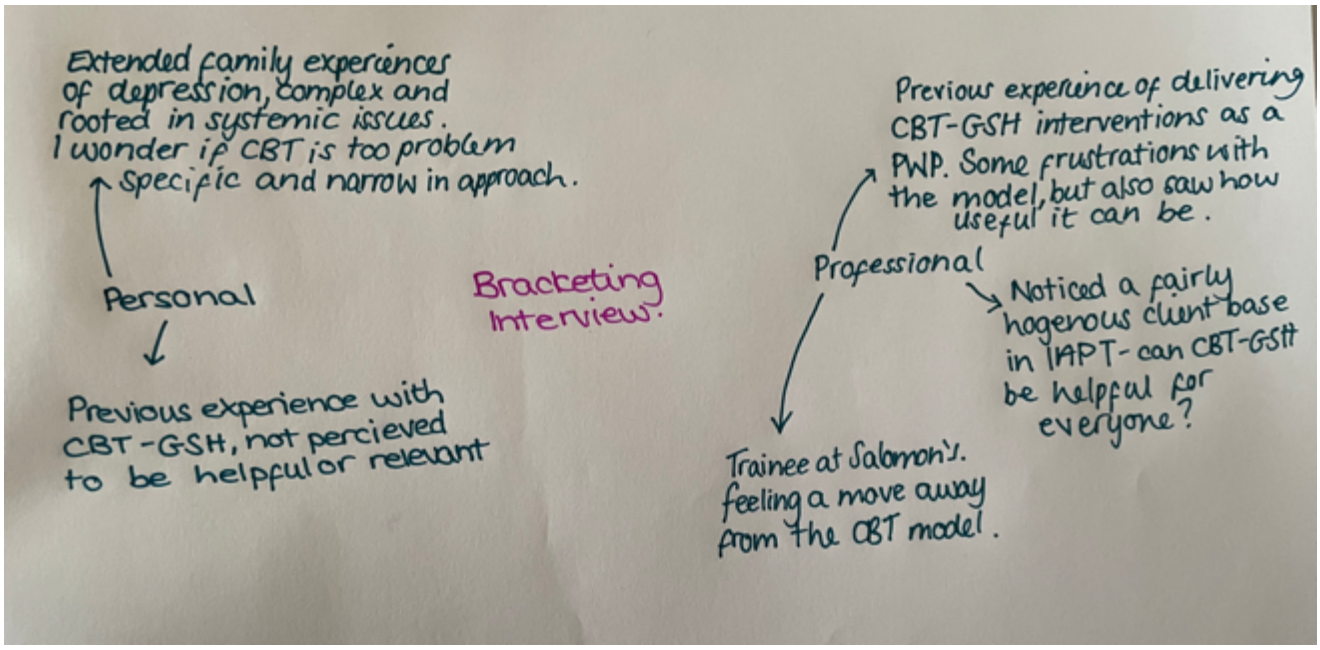
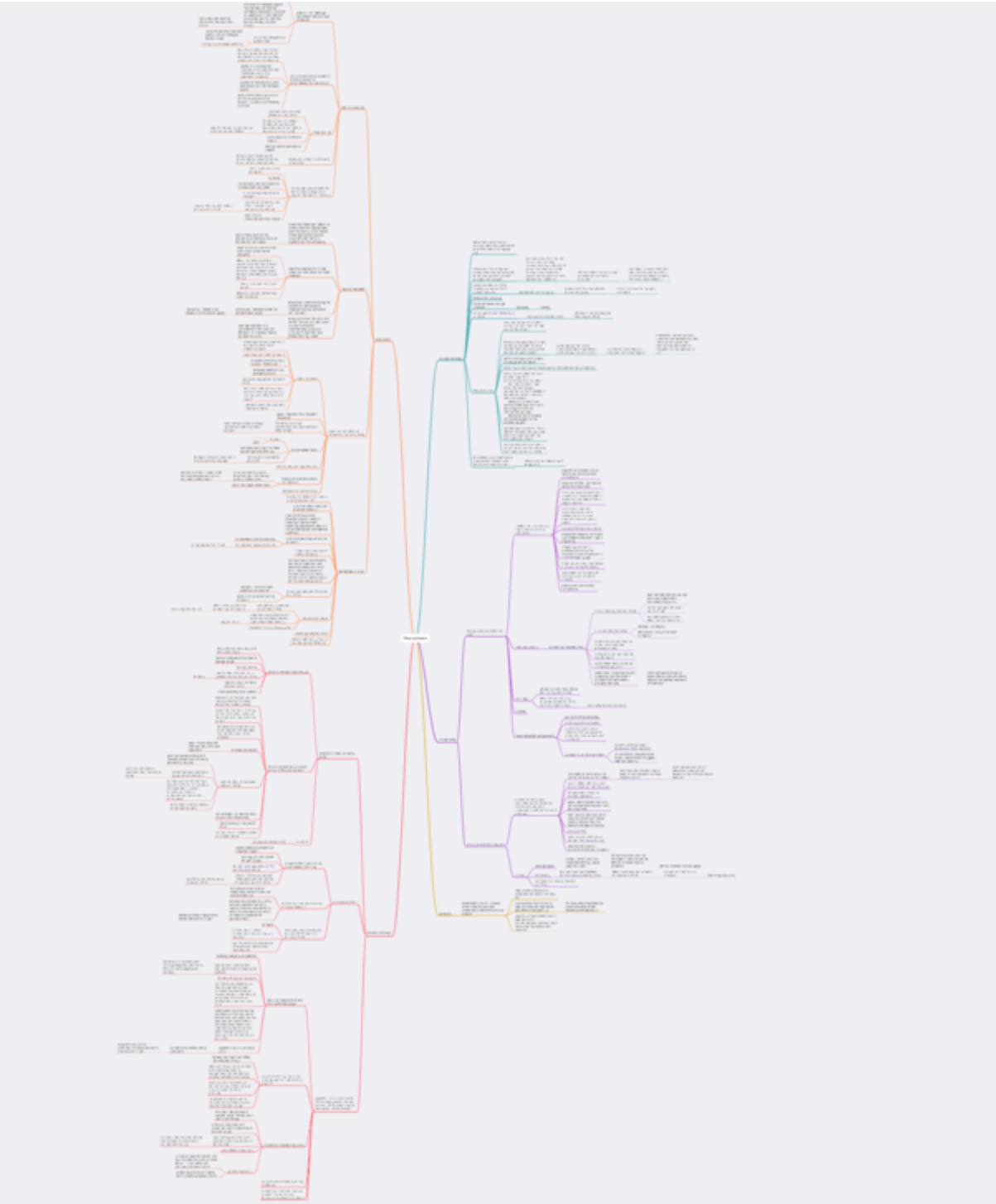
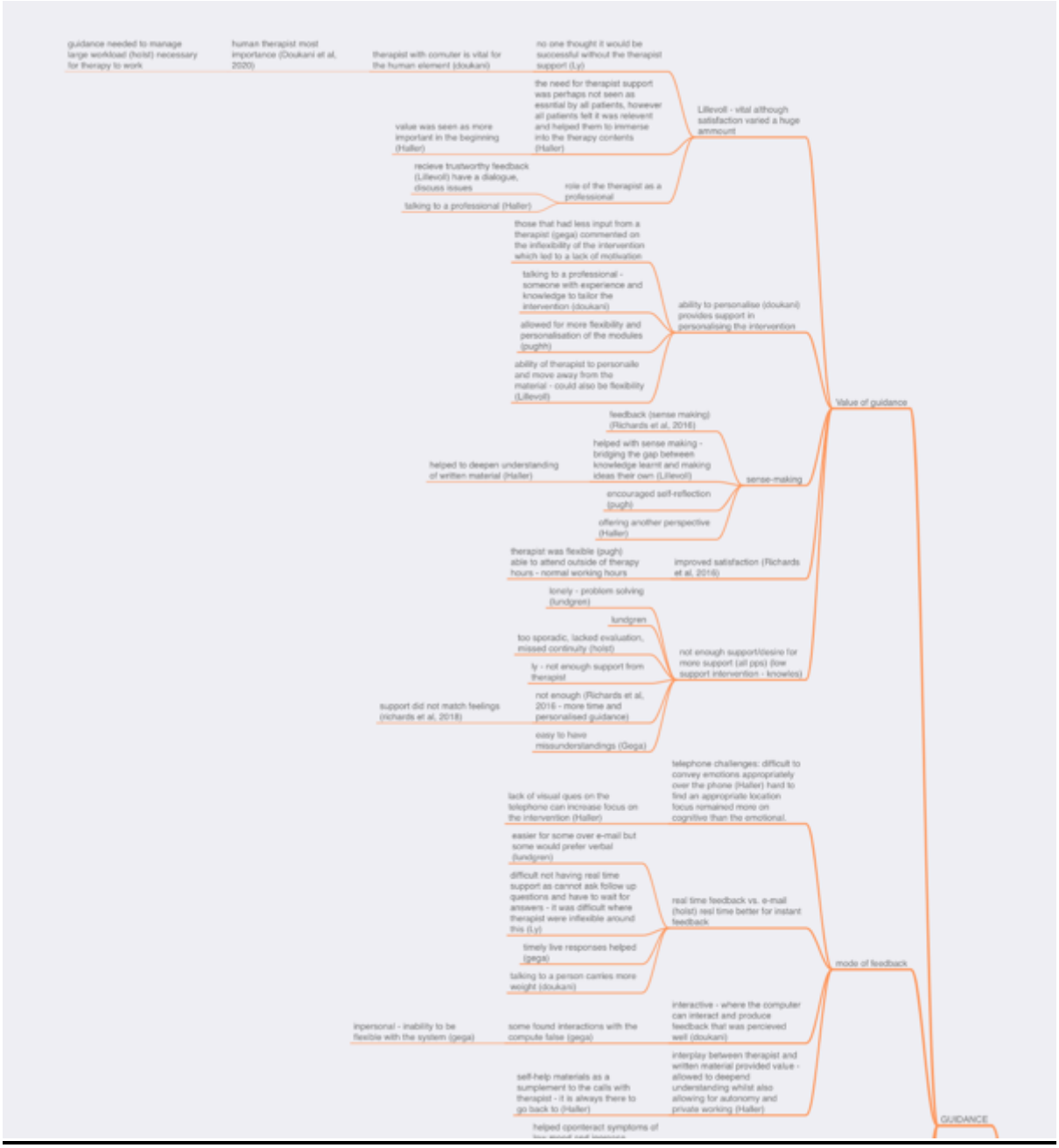
Appendix B: Bracketing interview for Section A

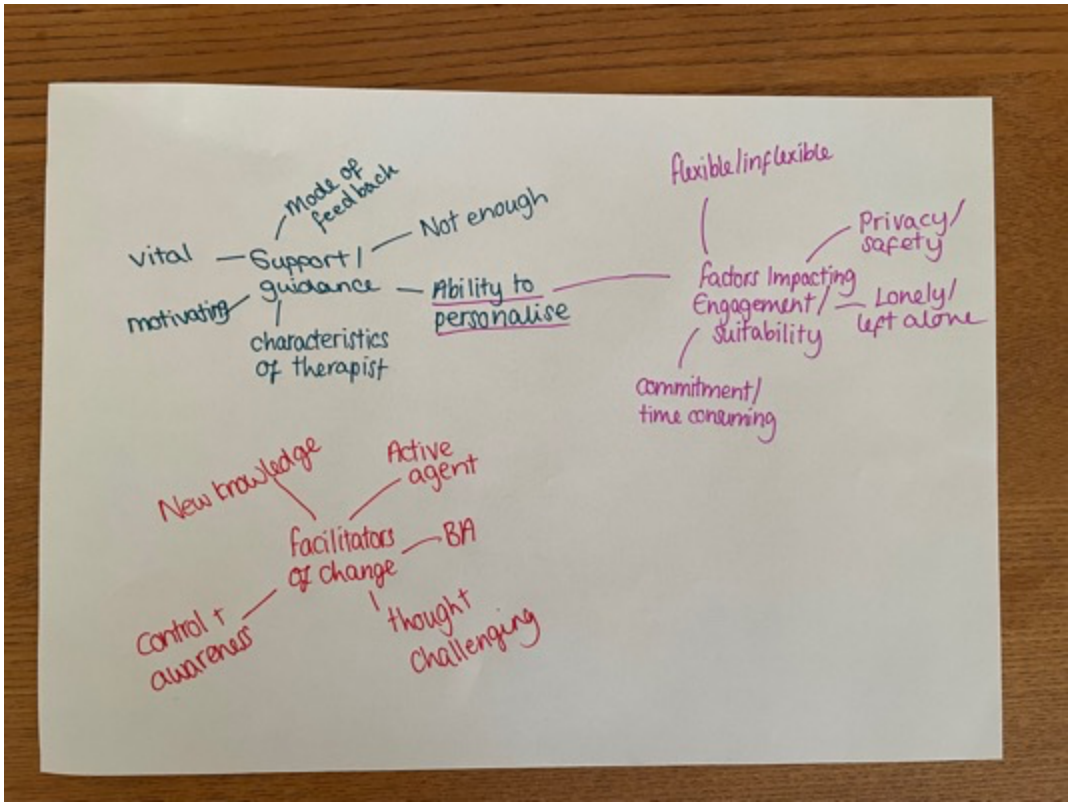


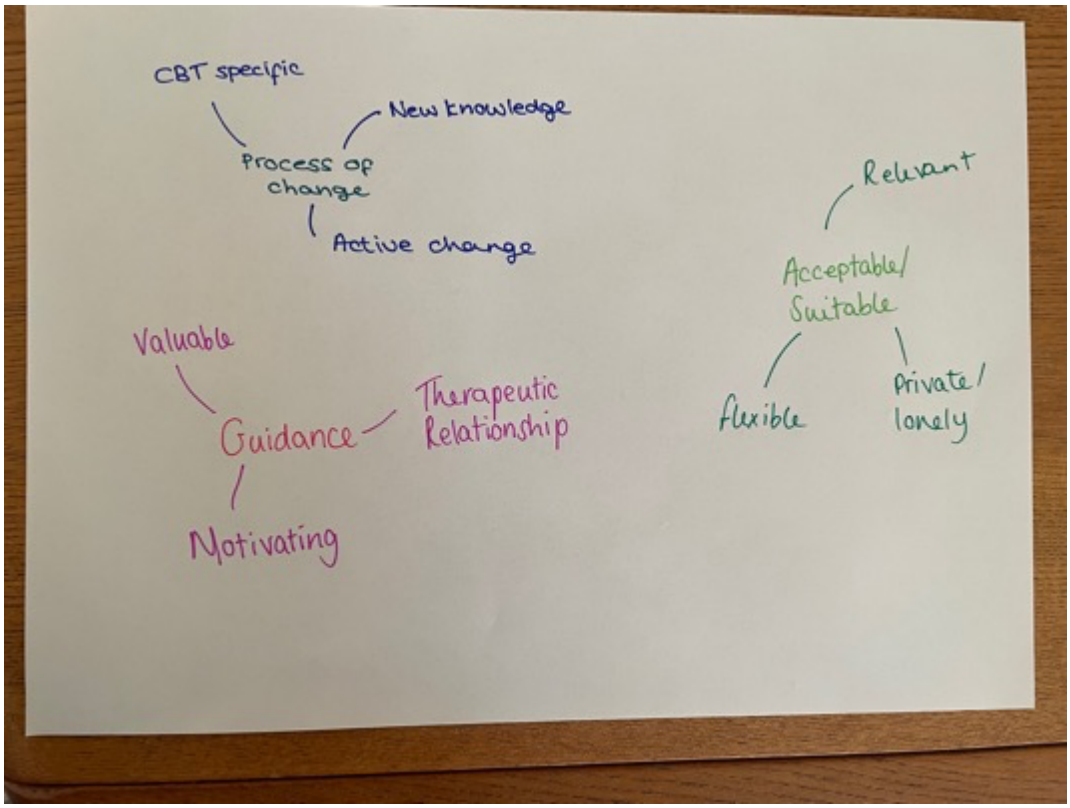
Appendix C: Snapshots of examples of free codes being organised into a hierarchical tree structure for Section A




guidance needed to manage large workload (holst) necessary for therapy to work
human therapist most importance (Doukani et al, 2020)
therapist with comuter is vital for the human element (doukani)
no one thought it would be successful without the therapist support (Ly)
the need for therapist support was perhaps not seen as essntial by all patients, however all patients felt it was relevent and helped them to immerse into the therapy contents (Haller)
Lillevoll - vital although satisfaction varied a huge ammount
value was seen as more important in the beginning (Haller)
recieve trustworthy feedback (Lillevoll) have a dialogue, discuss issues
role of the therapist as a professional
talking to a professional (Haller)
those that had less input from a therapist (gega) commented on the inflexibility of the intervention which led to a lack of motivation
talking to a professional - someone with experience and knowledge to tailor the intervention (doukani)
ability to personalise (doukani) provides support in personalising the intervention
allowed for more flexibility and personalisation of the modules (pughh)
ability of therapist to personalie and move away from the material - could also be flexibility (Lillevoll)
Value of guidance
feedback (sense making) (Richards et al, 2018)
helped with sense making - bridging the gap between knowledge learnt and making ideas their own (Lillevoll)
helped to deepen understanding of written material (Haller)
sense-making
encouraged self-reflection (pugh)
offering another perspective (Haller)
therapist was flexible (pugh) able to attend outside of therapy hours - normal working hours
improved satisfaction (Richards et al, 2018)
lonely - problem solving (lundgren)
lundgren
too sporadic, lacked evaluation, missed continuity (holst)
not enough support/desire for more support (all pps) (low support intervention - knowles)
ly - not enough support from therapist
support did not match feelings (richards et al, 2018)
not enough (Richards et al, 2018 - more time and personalised guidance)
easy to have missunderstandings (Gega)
telephone challenges: difficult to convey emotions appropriately over the phone (Haller) hard to find an appropriate location focus remained more on cognitive than the emotional.
lack of visual ques on the telephone can increase focus on the intervention (Haller)
easier for some over e-mail but some would prefer verbal (lundgren)
difficult not having real time support as cannot ask follow up questions and have to wait for answers - it was difficult where therapist were inflexible around this (Ly)
real time feedback vs. e-mail (holst) real time better for instant feedback
timely live responses helped (gega)
talking to a person carries more weight (doukani)
mode of feedback
impersonal - inability to be flexible with the system (gega)
some found interactions with the compute false (gega)
interactive - where the computer can interact and produce feedback that was percieved well (doukani)
interplay between therapist and written material provided value - allowed to deepend understanding whilst also allowing for autonomy and private working (Haller)
self-help materials as a sumplement to the calls with therapist - it is always there to go back to (Haller)
GUIDANCE

Appendix D: Examples of the process of developing analytical themes for Section A





Appendix E: Quality Assessment of studies for Section A

Appraisal Criteria	Studies											
	Doukani et al, 2020	Gega et al, 2013	Haller et al, 2019	Holst et al, 2017	Knowles et al, 2015	Lillevoll, 2013	Lundgren et al, 2018	Ly et al., 2015	Pugh et al, 2015	Richards et al, 2016	Richards et al, 2018	Wilhelmsen et al, 2013
Was there a clear statement of the research?	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Is a qualitative methodology appropriate?	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Was the research design appropriate to address the aims of the research?	**Partial** Design chosen was appropriate. This was not justified.	**Yes** Appropriate method, brief justification of its selection.	**Partial** Appropriate method, however, this was not justified.	**Yes**	**Yes** Appropriate design to address research design.	**Yes**	**Partial** Appropriate method, however, this was not justified.	**Yes**	**Partial** Appropriate method, however, this was not justified.	**Yes** Appropriate design and brief justification given.	**Yes**	**Yes**
Was the recruitment strategy appropriate to the aims of the research?	**Yes** However, did not discuss why these participants were most relevant.	**Yes** Did not discuss why these participants were most relevant.	**Yes** Did not discuss why these participants were most relevant.	**Yes** No comment on why they were relevant	**Yes** Participant selected from RCT sample via convenience sampling. Recruitment method well described.	**Yes** However, did not describe why these PPs were relevant.	**Yes** Recruitment strategy appropriate to aims. Did not discuss why some did not take part.	**Yes** Recruitment strategy appropriate to aims. Did not discuss why some did not take part.	**Yes** Recruitment strategy appropriate to aims. Did not discuss why sample was relevant	**Yes** Participants selected from RCT sample.	**Yes**	**Yes** No comment as to why participants were relevant.

Was the data collected in a way that addressed the research issue?	**Yes** Discussed adequately including information on data saturation.	**Yes** No discussion of saturation. Setting not justified.	**Yes** No discussion of saturation. Setting not justified	**Yes** No comment on saturation	**Yes** Setting described, not justified. Data collection method well described and justified. Saturation discussed.	**Yes** Data saturation not discussed.	**Yes** Data saturation not discussed.	**Partial** Saturation not discussed. Rationale for location not discussed. Reported that recordings were used but no comment on how (e.g. tape, video).	**Partial** No comment on saturation. No comment on justification of the method.	**Partial** Data collection method clear and briefly justified. It was unclear whether those that dropped out were given the questionnaire, or if only those who had completed the intervention were included. No comment on data saturation and setting not justified.	**Yes** However, no comment on saturation of data.	**Yes** No comment on saturation
Has the relationship between the researcher and participants been	**No** No discussion of this	**Partial** Good discussion of quality assurance measures. No	**Yes** Information given on interviewer relationship to participants	**Partial** Researcher did not complete interviews. Discussion of	**No** No information given on their own role.	**Partial** Acknowledgement of need and use of a bracketing interview	**Yes** This was well considered within the methods	**Partial** Data quality assurance briefly discussed little	**Partial** Some consideration given to quality assurance, little	**No** No comment on researcher's own role.	**No** No discussion or reflexivity	**Yes** Researcher commented on role as a health worker and

adequately considered?		discussion of researchers impact on this		bracketing interview, no further information given.		with no further comment	and discussion.	reflexivity from author	reflexivity from researcher.		from researcher.	reflected on this briefly.
Have ethical issues been taken into consideration?	**Partial** Method of consent well described. No discussion of ethical approval.	**Partial** Ethical approval obtained, discussion of process of consent. No discussion on how effects of the study may have been managed.	**Partial** Ethical approval obtained, discussion of process of consent. No discussion on how effects of the study may have been managed.	**Partial** Ethical approval obtained, discussion of process of consent. No discussion on how effects of the study may have been managed.	**Partial** Ethical approval obtained, discussion of process of consent. No discussion on how effects of the study may have been managed.	**No** Mention of some information given to participants but no mention of ethical approval outside of a reference to the RCT	**Yes**	**No** Ethics not adequately discussed	**Partial** Ethical approval obtained, discussion of process of consent. No discussion on how effects of the study may have been managed.	**No** No comment on ethics. Study embedded within RCT and reader referred to RCT protocol for further information .	**Yes**	**Partial** Ethical approval obtained, discussion of process of consent. No discussion on how effects of the study may have been managed.
Was the data analysis sufficiently rigorous?	**Partial** Well described method of analysis and quality assurance. Good amount of quotes given to demonstrate findings. No reflexivity from researcher in terms of	**Partial** Comment of how data was selected from the original sample to demonstrate the analysis proves Own role not examined	**Partial** Good explanation however no reflexivity from researcher	**Yes** Brief mention of researcher impact on analysis.	**Partial** In depth discussion of analysis given. Sufficient data given to support findings. No consideration given on researcher's own role in analysis.	**Partial** No consideration of impact of self in the analysis process	**Partial** Data analysis method was not explicitly defined it is not clear what method was used. Otherwise, the method and process of data analysis was clear and well	**Partial** No consideration of self in analysis process	**Yes** Well described.	**Yes** Description of analysis process. Consideration given to how themes were derived for thematic analysis. Information given on how data was selected for results.	**Partial** Detailed description of analysis. Not much examination of potential of own bias within data analysis.	**Partial** Not much examination of own bias within data analysis.

	their role in analysis.						explained. Researchers role and impact on analysis was considered.			Brief information given on researcher's role in analysis.		
Is there a clear statement of findings?	**Yes** Well described.	**Partial** Findings reported with little input of quotations and short descriptions of findings.	**Yes**	**Partial** Findings reported with little input of quotations and short descriptions of findings.	**Yes** Explicit reporting of findings. Consideration given for and against arguments. Findings discussed in relation to research question. No comment credibility of findings, however this was partially discussed in methods. Limitations briefly discussed.	**Yes**	**Yes**	**Partial** There is not much discussion before and against arguments	**Yes**	**Partial** Explicit reporting of findings. Consideration given for and against arguments. Findings discussed in relation to research question. No comment credibility of findings, however this was partially discussed in methods. Limitations briefly discussed.	**Yes**	**Yes**
How valuable is the research?	**Yes**	**Yes**	**Yes**	**Yes**	**Yes** Findings placed within the context of current	**Yes**	**Yes**	**Partial -** No suggestion of future research, little	**Yes**	**Yes** Findings placed within the context of current	**Yes**	**Yes**

					literature, further research recommendations given. Consideration given to underrepresented populations and recommendations for further research given.			suggestion of implications for practice.		literature, further research recommendations given. Consideration given to underrepresented populations and recommendations for further research given.		

Appendix F: Original Change Interview

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Appendix G: Adapted Change Interview

Date: ..... ID code: .....

Change Interview for LightMind 2

(Adapted from Elliott, 2006)

Interview Strategy: This interview works best as a relatively unstructured empathic exploration of the client's experience of the self-help course. Think of yourself as primarily trying to help the client tell you the story of his or her the self-help course so far. It is best if you adopt an attitude of curiosity about the topics raised in the interview, using the suggested open-ended questions plus empathic understanding responses to help the client elaborate on his/her experiences. Thus, for each question, start out in a relatively unstructured manner and only impose structure as needed. For each question, a number of alternative wordings have been suggested, but keep in mind that these may not be needed.

- Ask client to provide as many details as possible
- Use the "anything else" probe (e.g., "Are there any other changes that you have noticed?"): inquire in a non-demanding way until the client runs out of things to say

Introduction given to clients: After the self-help course, clients are asked to come in for an hour-long semi-structured interview. The major topics of this interview are any changes you have noticed since the self-help course began, what you believe may have brought about these changes, and helpful and unhelpful aspects of the self-help course. The main purpose of this interview is to allow you to tell us about the self-help course and the research in your own words. This information will help us to understand better how the self-help course works; it will also help us to improve the self-help course. This interview is audio-recorded for later transcription. Please provide as much detail as possible.

Interview Schedule:

1. ***Changes***: [about 10 min]
1a. What changes, if any, have you noticed in yourself since the self-help course started? *(Interviewer: Reflect back change to client and write down brief versions of the changes for later. If it is helpful, you can use some of these follow-up questions: For example, Are you doing, feeling, or thinking differently from the way you did before? What specific ideas, if any, have you gotten from the self-help course so far, including ideas about yourself or other people? Have any changes been brought to your attention by other people?)*

1b. Has anything changed for the worse for you since the self-help course started?

i. .....
ii. .....
iii. .....
iv. .....
v. .....

1c. Is there anything that you wanted to change that hasn't since the self-help course started?

i. .....
ii. .....
iii. .....
iv. .....

Date: ..... ID code: .....

v. .....

2. ***Change Ratings***: [about 10 min] (Go through each change and rate it on the following three scales:)
2a. For each change, please rate how much you expected it vs. were surprised by it? (Use this rating scale:)

(1) Very much expected it
(2) Somewhat expected it
(3) Neither expected nor surprised by the change
(4) Somewhat surprised by it
(5) Very much surprised by it

2b. For each change, please rate how likely you think it would have been if you hadn't done the self-help course? (Use this rating scale:)

(1) Very unlikely without the self-help course (clearly would not have happened)
(2) Somewhat unlikely without the self-help course (probably would not have happened)
(3) Neither likely nor unlikely (no way of telling)
(4) Somewhat likely without the self-help course (probably would have happened)
(5) Very likely without the self-help course (clearly would have happened anyway)

2c. How important or significant to you personally do you consider this change to be? (Use this rating scale:)

(1) Not at all important
(2) Slightly important
(3) Moderately important
(4) Very important
(5) Extremely important

	Expected it? (1-5)	Likely? (1-5)	Importance? (1-5)
Change 1:			
Change 2:			
Change 3:			
Change 4:			
Change 5:			

3. ***Attributions***: [about 5 min] In general, what do you think has caused the various changes you described? In other words, what do you think might have brought them about? (Including things both outside of the self-help course and in the self-help course)

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.....

.....

.....

Date: ..... ID code: .....

4. ***Helpful Aspects***: [about 10 min] Can you sum up what has been helpful about the self-help course so far? Please give examples. (For example, general aspects, specific events)

.....

.....

.....

.....

5. ***Resources***: [about 5 min]
5a. What personal strengths do you think have helped you make use of the self-help course to deal with your problems? (what you're good at, personal qualities)

.....

.....

.....

.....

5b. What things in your current life situation have helped you make use of the self-help course to deal with your problems? (family, job, relationships, living arrangements)

.....

.....

.....

.....

6. ***Problematic Aspects***: [about 5 min]
6a. What kinds of things about the self-help course have been hindering, unhelpful, negative or disappointing for you? (For example, general aspects. specific events)

.....

.....

.....

.....

6b. Were there things in the self-help course which were difficult or painful but still OK or perhaps helpful? What were they?

.....

.....

.....

.....

Date: ..... ID code: .....

6c. Has anything been missing from your treatment? (What would make/have made the self-help course more effective or helpful?)

.....

.....

.....

.....

7. ***Limitations***: [about 5 min]
7a. What personal limitations do you think have made it harder for you to use the self-help course to deal with your problems? (things about you as a person)

.....

.....

.....

.....

7b. What things in your life situation have made it harder for you to use the self-help course to deal with your problems? (family, job, relationships, living arrangements)

.....

.....

.....

.....

8. ***Suggestions***. [about 5 min] Do you have any suggestions for us, regarding the research or the self-help course? Do you have anything else that you want to tell me?

.....

.....

.....

.....

9. ***Final reflections*** [about 5-10 minutes] on the self-help course:

9a) What were the main issues or difficulties you were experiencing *before* you started the self-help course?

.....

.....

.....

Date: ..... ID code: .....

.....

9b) To what extent have these issues or difficulties changed since undertaking and completing self-help course?

.....

.....

.....

.....

9c) How do you live with these issues or difficulties now? Have you noticed any differences in how you live with these issues or difficulties since completing the self-help course?

.....

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.....

.....

Appendix H: Epistemological Position Statement

There is ongoing debate about the appropriate philosophical position for qualitative studies that are embedded within RCTs (Bonell et al., 2018; Marchal et al., 2013). Marchal et al. (2013) argue that qualitative projects derived from RCT samples are embedded in positivist ideals, because they are based on assumptions that there is an objective reality that can be measured. Similarly, Bonell et al. (2018) argue that RCTs investigating social interventions are rooted within the realist paradigm. Pawson (1997) argues that realist evaluation of qualitative data can be used to understand change or lack of change, and effectiveness or ineffectiveness of interventions investigated within RCTs. This project was embedded within an RCT and therefore leans toward a realist position; however, the project aims to assess and interpret the narrative experiences of participants which will require a more critical lens.

This study therefore took on a critical realist epistemological position, which accepts that although there is an objective reality, people's experiences of this may differ depending on their past experiences and their expectations (Barnett-Page & Thomas, 2009). This includes the researcher, and so critical realist approaches acknowledge the important role of the researcher in interpreting participants' accounts and not simply taking them at face value. This epistemological position fits with the exploratory qualitative design of the study. Although template analysis is not wedded to a particular epistemological position, it has been argued that the use of a priori themes within this method fits within a realist or critical realist epistemology (King et al., 2015). As a trainee, I believe that service users have real experiences, and that intervention can lead to real changes. This reflects my realist ontology. However, I am also aware that the real world may be experienced and interpreted differently by different people.

Appendix I: Information Sheet

LightMind 2

Participant Information Sheet

Low-Intensity Guided Help Through MINDfulness

Participant Information Sheet 07 February 2019 Version 7.0

[redacted]

Would you like to take part in this research study? Before you decide, it is important for you to understand why the research is being done and what it would involve. Please take time to read the following information carefully and discuss it with friends, relatives, your care team and your GP if you wish. Ask us if there is anything that is not clear or if you would like more information (please see our contact details at the end of this document). Please take time to decide whether or not you wish to take part.

Reading this Participant Information Sheet does not mean that you will automatically be eligible to take part in this study.

The [redacted] have reviewed and approved this study.

LIGHTMind 2: Low-Intensity Guided Help Through MINDfulness.
Participant Information Sheet 07 February 2019 Version 7.0
REC Reference Number: 17/LO/0596

Brief summary

We are investigating two kinds of supported self-help courses with people experiencing symptoms of depression. We hope to involve 410 people in this research. Half of these people will be asked to follow a supported cognitive behaviour therapy (CBT) self-help course and half will be asked to follow a supported mindfulness-based cognitive therapy (MBCT) self-help course. Both courses will use a book as a guide. Everyone will have regular support sessions (by phone or face-to-face) with a mental health practitioner to support them during the course.

Each self-help course lasts for 8 weeks but you will be given 16 weeks to complete the course. We will follow participants up six months after the course has ended.

There is more information about the study on the next few pages. Please take your time to read about the study and if you have any questions you can call or email the research team(see contact details on the last page).

What is the purpose of the study?

What is Cognitive Behaviour Therapy?

Cognitive behaviour therapy (CBT) explores the links between our thoughts, feelings and behaviour and aims to help us to change negative thinking and unhelpful behaviours that can maintain depression. CBT self-help courses are effective for people experiencing depression and supported CBT self-help is recommended for use in the NHS for people experiencing mild to moderate symptoms of depression.

What is Mindfulness-Based Cognitive Therapy?

Mindfulness is the capacity to notice and accept our current experience (thoughts, feelings, body sensations) and respond to our experiences in a way that is helpful. Mindfulness-based cognitive therapy (MBCT) adds mindfulness meditation practice and principles to cognitive therapy. MBCT is effective in preventing depression coming back and in reducing symptoms of depression.

This Study

There is growing evidence that supported use of self-help MBCT materials might be helpful for people experiencing mild or moderate symptoms of depression. However, to date, there is no high quality research evaluating the benefits of supported self-help MBCT. This study will evaluate the effectiveness of supported self-help MBCT in comparison to supported self-help CBT.

Expenses and Reimbursements

If you take part in the study you will receive a £20 gift voucher to reimburse you for the time involved in completing the questionnaires at the start of the study, after you have finished the self-help workbook and again 6 months later. You will also be reimbursed for any travel expenses involved in completing the questionnaires.

Why have I been invited?

We want to speak with you because we understand that you experience symptoms of depression and because you scored within a certain range on a self-report measure

of depression. You do not need to have a background in CBT or MBCT to take part in this study.

We want to recruit 410 people, half will be offered supported self-help MBCT and the other half will be offered supported self-help CBT. Participants will be randomly selected to receive either MBCT or CBT self-help. You cannot choose which type of self-help you receive.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you decide not to take part this will not affect the care you receive.

If you decide to take part you will be asked to sign a consent form and you will be free to withhold any personal information or to withdraw at any time, without giving a reason and without this affecting the care you receive.

If you do decide to take part we will ask you not to use any other psychological interventions during the course of the study. This will help us to tell how effective each self-help course has been.

What would taking part involve?

First, you will either meet with a member of the research team or speak by phone for about 30-45 minutes to complete a consent form and eight questionnaires online or on paper, whichever you prefer. The nine tick-box questionnaires will ask you:

1. About your recent experiences of depression
2. About your quality of life
3. How mindful you are in everyday life
4. About your self-compassion
5. About your sense of personal control
6. About what you expect from the treatment you will receive and which treatment you would prefer to receive

The member of the research team can support you to complete these questionnaires by reading out the questions or you may prefer to complete them on your own. As well as the questionnaires the member of the research team will ask you some questions about your age, gender, ethnicity etc. and about any medication you are currently taking. This meeting can happen over the phone, or you can choose to meet the research team member in person at a place and time convenient for you.

After you have completed these questionnaires, you will be allocated at random to either receive the self-help MBCT course or the CBT self-help course. When you have been allocated to an intervention, you will receive a copy of the allocated self-help book from the research team.

What will happen when I receive the self-help book?

A member of the research team will arrange the first of six appointments with a mental health practitioner, named a Psychological Wellbeing Practitioner (or PWP), which may be by phone or face-to-face. During these appointments a mental health practitioner will help guide you through the 8-week self-help course. The MBCT book is a guide that you are asked to engage with during the self-help course, it contains a

CD with mindfulness practice tracks for you to use. The CBT book explains CBT and provides exercises for you to carry out. Each course will take up to an hour a day of your time, depending on what is possible for you, including time for reading the self-help book, completing exercises and consultation with the mental health practitioner who will support you during the course. These support sessions will last approximately half an hour each and can be arranged at a time convenient for you. With your consent, the support sessions may be audio recorded for research purposes. If you would prefer for the sessions not to be recorded this is fine, and you can still take part in the study.

What happens when I have completed the course?

When the self-help course is finished you will be asked to complete a similar set of questionnaires that you completed in your first meeting. Again, rather than meeting face to face, this can be done online or the questionnaires can be posted to you if you prefer. This should take around 20-30 minutes. Completing these will help us to find out about how helpful each self-course has been.

Six months after the end of the course we will ask you for a final time to complete the questionnaires online or by post. This should take around 20-30 minutes. The member of the research team involved with organising your post-intervention and follow-up assessments will be unaware of which self-help course you completed (CBT or MBCT) and it is important that you do not reveal this information to them.

After completing the 16-week follow-up questionnaires, we would also like to interview 40 people over the phone about their experiences of their self-help course and we will audio record these interviews. Once we have interviewed 40 people this part of the study will be over and so you may or may not be invited to take part in a telephone interview. If you do decide to take part in a telephone interview, you will be asked about your experiences of the course including what might have changed during the course and what you might have found helpful or unhelpful. This interview should take no longer than 1 hour.

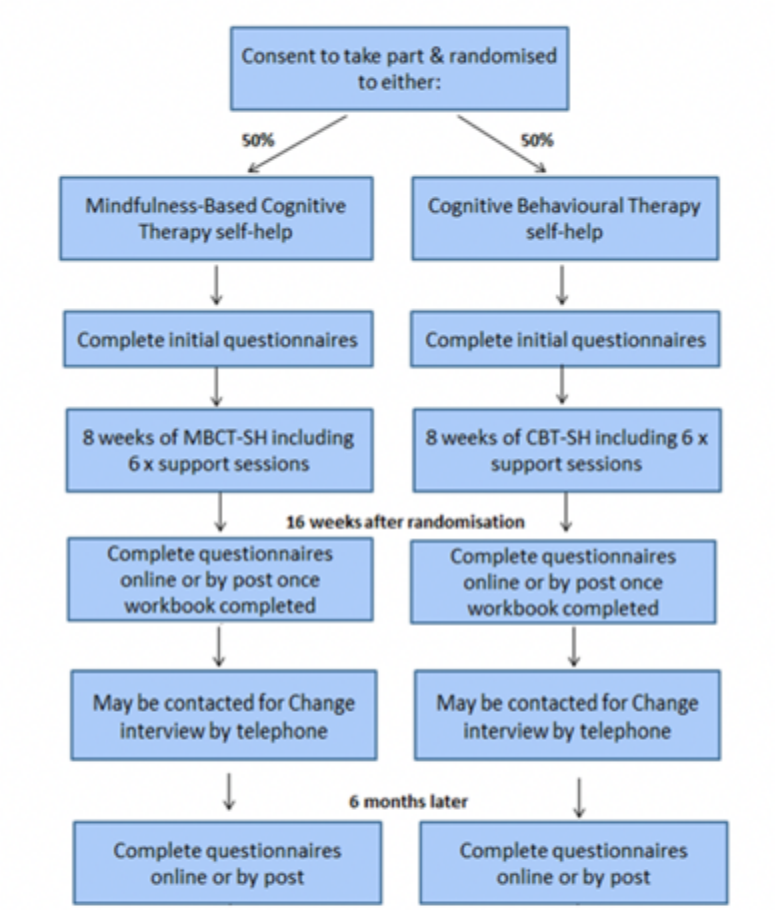
Once the study has ended we are interested in conducting follow-on studies looking at longer term outcomes. You will have the optional opportunity to consent for us to contact you after the study has ended for the purpose of longer term follow-up.

Where will I have to go?

The meetings with the member of the research team at the beginning of the study will take place at a convenient location for you such as your GP surgery or your home. The cost of travelling to this meeting will be reimbursed to you. If you prefer, these meetings can be performed over the phone.

The following flow chart illustrates what happens if you decide to take part in the study:

Flow Chart of Study Pathway



What are the advantages and disadvantages of taking part?

The MBCT self-help course is a type of self-help that is not routinely provided in the NHS because it has not been researched in a high quality study. For this reason we do not know whether or not it will be helpful. By taking part in the study you will be helping us to learn if this course is helpful for depression and this will help primary care services when they are planning what to offer.

Thinking about our thoughts and feelings and reflecting on our experiences with depression can be helpful, although it can also sometimes feel difficult. The mental health practitioner who provides support will be experienced in helping people who have symptoms of depression. You will also be free to access help from your GP, should you wish, and to stop the self-help course and to drop out of the study.

Confidentiality

[redacted] Trust is the sponsor for this study based in the United Kingdom. We will be using information from you and your medical records in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. [redacted] will keep identifiable information about you for 1 year after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

[redacted]

[NHS site] will collect information from you and your medical records for this research study in accordance with our instructions.

[NHS site] will use your name, and contact details to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Individuals from [redacted] NHS Foundation Trust and regulatory organisations may look at your medical and research records to check the accuracy of the research study. [NHS site] will pass [redacted] NHS Foundation Trust who will have access to information that identifies you will be people who need to contact you to about the research study or audit the data collection process. The people who analyse the information will not be able to identify you and will not be able to find out your name, or contact details.

[NHS site] will keep identifiable information about you from this study for 1 year after the study has finished.

If you consent, members of the research team will have access to your medical notes in order to gather information relevant to the study and your GP will be informed that you are taking part. You are free not to give this consent and still take part in the study.

This study complies with data protection laws. All information that is written or audio recorded during the course of assessment meetings will be kept strictly confidential and stored securely. Members of the research team will have access to these records. This information will be coded and have your name and address removed so that you cannot be recognised from it. Monitors or auditors from regulatory authorities

or from the host NHS Trust may have access to personal data during the study for the purpose of auditing the study.

With your consent, anonymised data (with your name and other identifying information removed) may be shared with other research teams for the purposes of future research. You are free not to give this consent and still take part in the study.

The research team have an obligation to share information if they have concerns about your personal safety or about the safety of other people.

If you would like to find out more about why and how patient data is used in research, please visit the Understanding Patient Data website.

https://understandingpatientdata.org.uk/what-you-need-know

What will happen to the results of the study?

The results of this study will be written-up by the July 2020 and submitted to a national psychology journal. You can choose to receive feedback on the results of the study. No-one will be identified in any publication.

Who has reviewed the study?

The study has been reviewed and approved by the Research and Development Department within your local NHS Trust. It has also been reviewed by a NHS Research Ethics Committee.

Next Steps

If you are interested in taking part in the study please allow yourself at least 24 hours to consider your decision before contacting the research team or before asking for a member of the research team to contact you. This is to ensure that you have had time to consider your decision.

Your contact name for the study is:

Name of your Research Team contact: xxxxxxxxx

If you would like to take part in the study, or to find out further information please call a member of the research team on xxxxx xxxxxx or xxxxxxxxxxx or email xxxxxxxx at

The research lead for the study is:

Insert Principal investigator details
Name
Address
Telephone
Email

If you are harmed by taking part in this research study, there are no special compensation arrangements. If you are harmed by someone's negligence, then you may have grounds for a legal action, but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you. You may also [redacted]

If you decide to participate in the study you will be given a copy of this information sheet and a signed consent form to keep.

On behalf of the LIGHTMind 2 study team, thank-you for taking the time to read this information sheet.

Appendix J: Consent form

Insert Local Headers

Participant Identification Number: ____ /____ ____ ____

CONSENT FORM

Title: LightMind 2: *Low-Intensity Guided Help Through Mindfulness; A Randomised Controlled Trial Comparing Supported Mindfulness-Based Cognitive Therapy Self-Help to Supported Cognitive Behavioural Therapy Self-Help for Adults Experiencing Depression*

[redacted]

		Please initial box
1	I confirm that I have read and understand the Participant Information Sheet dated 07/02/2019 (version 7) for the above study and have had the opportunity to ask questions.	☐
2	I understand that my participation is voluntary and that I am free to withhold personal information or to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected.	☐
3	I understand that if I choose to withdraw from the study, any information I have already completed will be kept by the research team.	☐
4	I understand that relevant sections of my medical notes and data collected during the study, may be looked at by regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	☐
5	I give permission for members of the research team to access my medical notes for the purposes of the study. This information will be treated with confidence.	☐
6	I give permission for findings from the study to be written up for publication. Any publication will not identify me.	☐
7	I understand that in the event that I disclose information which may indicate new risk to myself or others, the researcher will be obliged to follow Trust risk procedures that may require release of my personal data.	☐
8	*I give permission for my GP to be informed about my participation in this study.	☐
9	*I give permission for a telephone interview, which may be conducted after my therapy sessions have completed, to be audio recorded.	☐
10	*I give permission for my sessions with the Psychological Wellbeing Practitioner therapist to be audio recorded.	☐

11	*I give permission for non-identifiable data to be shared with other research teams for research purposes.	☐
12	*I give permission for members of the research team to contact me after this study has ended for follow-on studies exploring longer term follow up.	☐
13	I agree to take part in the above study	☐

Name of participant..... Date..... Signature.....

Researcher..... Date..... Signature.....

* *Consenting to these statements is optional. If you do not consent to these statements you can still take part in the study.*

Please tick this box if you would like to receive a copy of findings from the study ☐
If you would like a copy of findings please indicate if you would like these by post ☐ or by email ☐

Email address.....

When completed, 1 for patient; 1 for researcher site file (original), 1 for health records

Appendix K: NHS Ethics

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Appendix L: Summary letter to NHS ethics

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Appendix M: Summary letter to participants

A qualitative exploration and comparison of experiences of change following a guided-self-help cognitive CBT or MBCT intervention for depression

Background: Investigating new therapy options for individuals experiencing depression is important in order to increase service user choice. As experience of depression and therapy can be different for each person, it is important to understand how existing and new interventions are experienced in order to make improvements.

Aims: This study aimed to explore the comparative participant experiences of a CBT guided-self-help intervention or an MBCT guided-self-help intervention.

Method: Twenty-two participants took part in an interview, twelve of whom had completed a CBT guided-self-help intervention, and twelve a MBCT guided-self-help intervention. Results were analysed qualitatively in order to produce key themes which emerged from the interviews. These themes were then compared to see if there were any differences in experience between the two therapies.

Results: The results produced four themes and thirteen sub-themes. Below the themes are in bold with sub-themes below.

Getting onto the course Reasons for seeking support Expectations	**Guided Self-Help** Time commitment Support and guidance Self-help book
Perceived change Change of focus Awareness and control Lack of change Change in relationship	**Ingredients for change** The individual External factors Course content Therapeutic factors

Description of themes and sub-themes:

Getting onto the course. Participants listed key reasons for taking part in the course which included difficult emotions such as low mood and also key motivations including wanting to be more active in relationships and wanting to come off medication. There was a range of expectations for the course including expectations to feel better, no expectations and relatively low expectations that the course would be useful.

Perceived change: Everybody talked about some changes that were noticed. This included a change of focus to the present moment (MBCT) or themselves (CBT), a feeling of awareness and control which came from new knowledges and how to deal with thoughts and a change in relationships both with others and with themselves. Some participants noticed that there were some difficulties that remained or certain aspects they wanted help with that were not covered by the course.

Guided self-help: Participants discussed key aspects of guided self-help. One key area was the time commitment expected from both MBCT and CBT, many people found the course time consuming and at times a challenge to fit in. The PWP sessions were seen as some as a way to improve motivation. There were different responses to the self-help book. Some found this useful, however other's struggled to fit in time to read and to find motivation to engage with this aspect.

Ingredients for change: Participants talked about key aspects that helped with engagement with the intervention. Individuals discussed some characteristics that helped to engage in the course such as perseverance and an open-mind. For others, key aspects of low mood and low motivation made the course challenging. Individuals listed a number of factors that helped bring about change that were not due to the course such as medication, family, change in circumstances and the weather. It also seemed that having support from another person (family, friend, PWP) was an important factor which helped individuals to engage more fully with the course.

Conclusions: Overall, the accounts from both interventions were similar. Key differences included the techniques that individuals found useful and the way participants dealt with thoughts.

Implications

- Services should assess whether GSH interventions seem appropriate based on an individual's circumstances
- Services should describe fully what GSH involves, including the time commitment, and give service users space to ask questions
- Services should discuss best ways to support the individual prior to starting a GSH intervention
- PWPs to take time to personalise interventions and discuss an individual's needs

Appendix N: Initial coding template

1. Perceived change
    a. Change for better
    b. Change for worse
    c. Desired change not realised
    d. No change
2. Attributions
    a. Course
    b. Non-course
3. Helpful aspects of course
    a. General
    b. Specific
4. Resources
5. Problematic aspects of course
    a. General
    b. Specific
6. Difficult aspects of course
    a. General
    b. Specific
    c. Missing aspects of therapy
7. Limitations
8. Suggestions for improvement
9. Difficulties
    a. Prior to course
    b. Difficulties changed since course
    c. Current difficulties

Appendix O: Example of initial inductive coding on a transcript
Participant screening number has been blanked out.

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Appendix P: Example of updated coding template

Key: Black = *a priori codes* Blue = *second draft codes*

1. Perceived change
    a. Overarching change
    b. Behaviour
    c. Emotion
    d. Cognition
    e. General
    f. Desired change not realised
2. Attributions
    a. Course
        i. Self-help materials
        ii. PWP
    b. Non-course
        i. Medication
        ii. Circumstances
        iii. Support from others
3. Helpful aspects of course
    a. General
    b. Specific
4. Resources
    a. Personal strengths
    b. Social network
    c. Work
    d. Role of PWP
5. Problematic aspects of course
    a. General
    b. Specific
6. Difficult aspects of course
    a. General
    b. Specific
    c. Missing aspects of therapy
7. Limitations
    a. Personal strengths
    b. Social network
    c. Work
    d. Other professionals
    e. Role of PWP
8. Suggestions for improvement
    a. PWP
    b. Content
9. Difficulties
    a. Prior to course
    b. Difficulties changed since course
    c. Current difficulties
10. Role of medication
11. Role of GP

Appendix Q: Final coding template

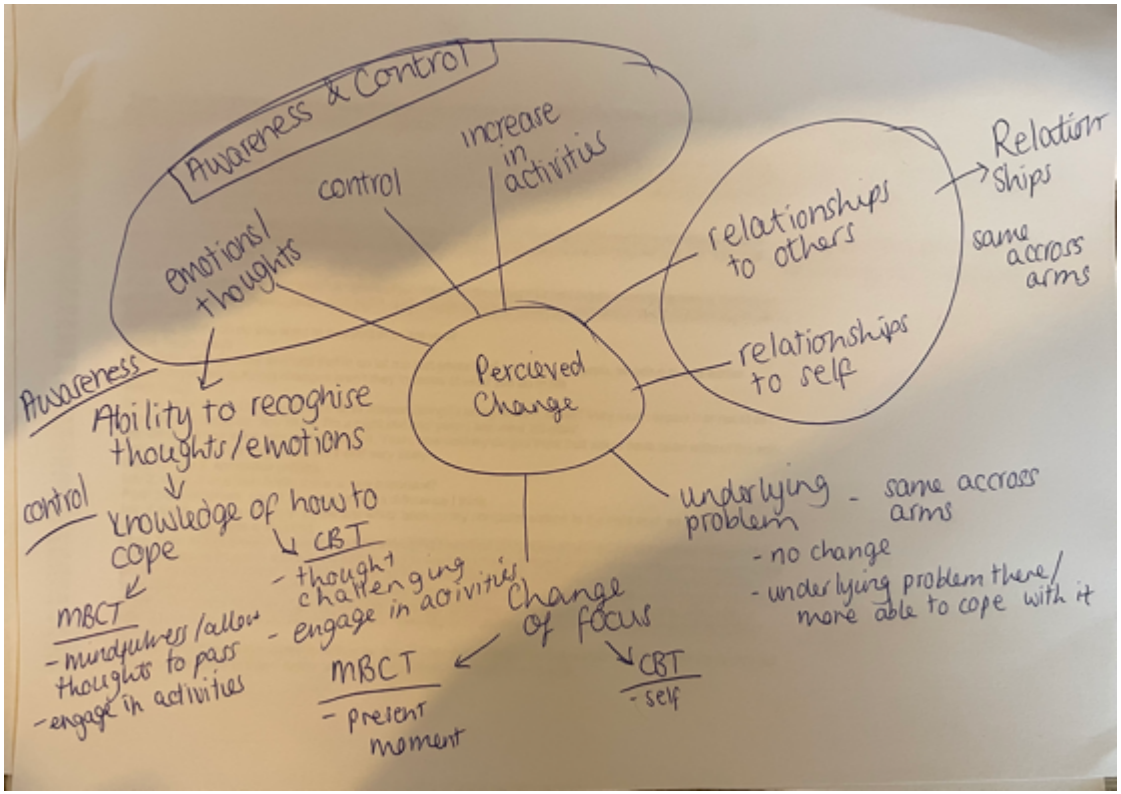
Key: Black = *a priori codes* Blue = *second draft codes* Green = *final draft codes*

1. Pre course
    a. Challenges prior to the course
    b. Expectations for therapy
    c. Motivations to engage
2. Changes
    a. New knowledge
        i. Behaviour change
        ii. Change in emotion
        iii. Change in thinking
        iv. Control
    b. Focus
        i. Self
        ii. Present moment
    c. Emotions
        i. Positive change
        ii. No change
    d. Dealing with thoughts
        i. Thought challenging
        ii. Taking a step back
    e. Change in relationships
        i. Social
        ii. Family
    f. Relationship with self
    g. Hope for change not realised
3. Attributions
    a. Course
        i. PWP
        ii. Self-help materials
    b. Circumstantial change
        i. Job
        ii. Family
        iii. Social life
    c. External factors
        i. Role of medication
        ii. Weather
        iii. Able to make time
    d. Existing knowledge
4. Course qualities
    a. Useful aspects of course
    b. Difficult aspects of course
    c. Suggestions for improvement
5. Facilitators/barriers
    a. Personal
        i. Facilitators
        ii. Barriers
    b. Support network
        i. Facilitators
        ii. Barriers

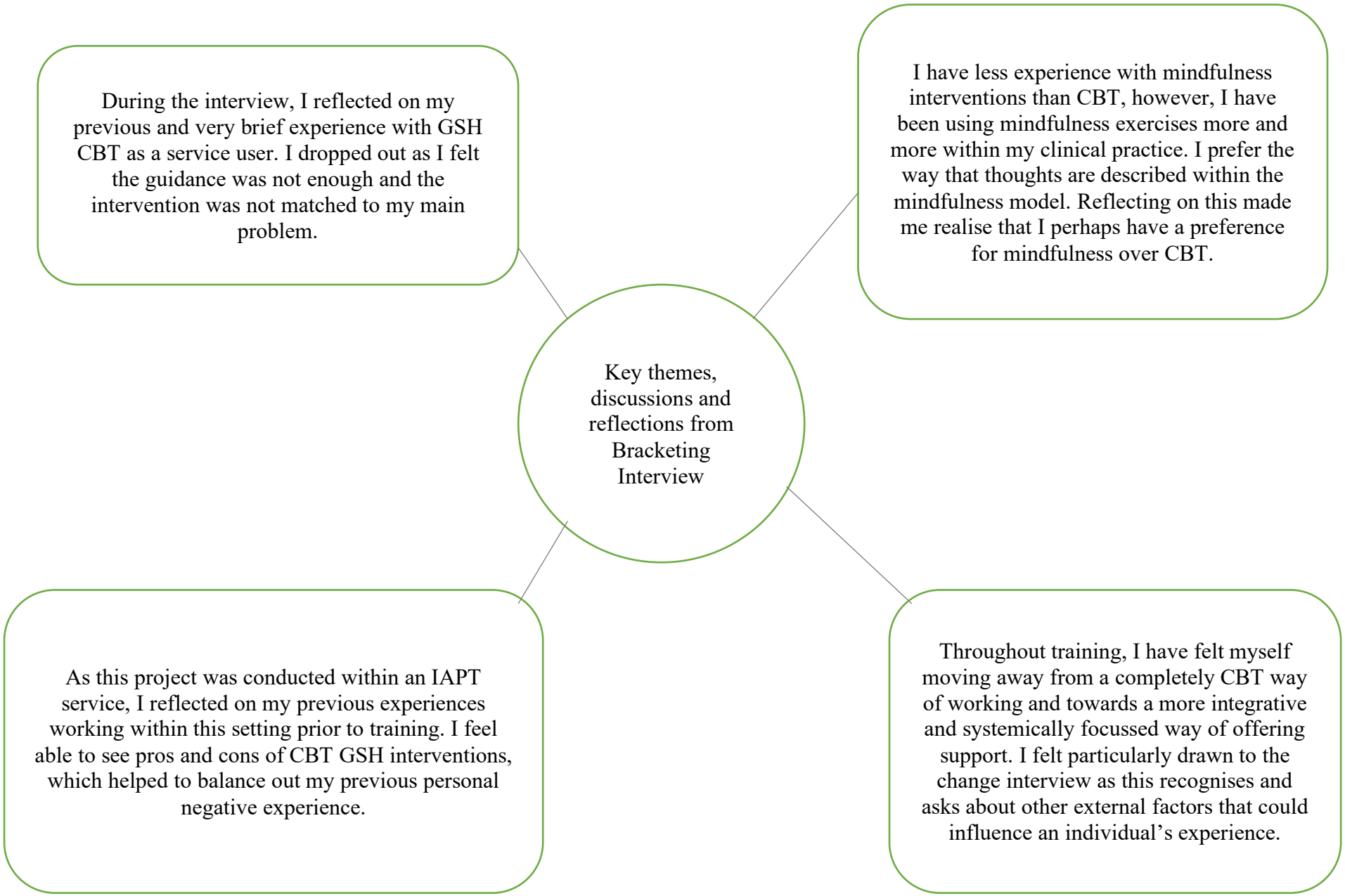
c. Professionals (e.g. G.P./PWP)
    i. Facilitators
    ii. Barriers
d. Commitments
    i. Facilitators
    ii. Barriers

Appendix R: Example of coding master spreadsheet with coding template

Appendix S: Example mind maps leading to final theme development


Awareness & Control
control
increase in activities
emotions/ thoughts
Awareness
Ability to recoghise thoughts/emotions
control
knowledge of how to cope
MBCT
- mindfulness /allow thoughts to pass
- engage in activities
CBT
- thought challenging
- engage in activities
Perceived Change
relationships to others
relationships to self
Relationships
same across arms
underlying problem - same across arms
- no change
- underlying problem there/ more able to cope with it
Change of focus
MBCT
- present moment
CBT
- self

Appendix T: Bracketing interview for Section B



Appendix U: Examples of research diary

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Appendix V: Examples of quotes corresponding to themes

Overarching theme	**Subtheme**	**Quotes MBCT**	**Quotes CBT**
Getting onto the course	Reasons for doing the course	"The main reason I started was to find a coping mechanism for what I thought….basically to deal with depression and anxiety" Mark "I have been dealing with anxiety for a few years, and depression as well more recently" Sophie	"I was feeling very low….and the other thing is I couldn't sleep at all" George "It was grief, financial worries and depression, I guess as well. Not being able to come to terms with everything that had happened in such a short period of time" David "Very low self-esteem, and really bad anxiety, panic attacks" Helena
	Expectations	"I was really open-minded about the LightMind course….I didn't think that I would feel any different reading a book and going to a meeting, but it has" Alexa	"I mean I had a pretty good understanding of what the course would and wouldn't be, before I went into it. I am aware of what a CBT self-help course looks like,, so I didn't have overly high expectations of you know it's going to change my life in huge significant ways" James
Perceived change	Change of focus	"The fact of switching off and having some quiet time, focussing on the here and now" Brian	" I've been worrying about everybody else and keeping busy and keeping occupied and then work and this, that and the other and then I took a little bit of time to actually focus on me" David, CBT
	Awareness Control	"I feel a lot more prepared in some ways for the effect of anxiety and depression and, and I think I have matured a lot emotionally" Alice "I am much more aware of…I think just awareness…I am sort of much more aware of my	"I have started to analyse my thoughts and the way I work in a more deeply intricate way, so I do understand a lot more my body function and the way I process my emotions and thoughts now than a few months ago or before the CBT course started" George

Guided self-help		thought, that they are just thoughts…and that has led me to react to situations much better and being calmer, it has made me gravitate towards situations that I enjoy" Sophie "I am a lot less troubled with some of the sort of, some of the thoughts with my depression and anxiety that I was….this was one of the key things for me throughout learning about mindfulness….bringing yourself back into the now, and focussing on what you are doing and bringing your brain out of that sort of this preoccupied thinking about the past and the future, and a lot of abstract worries" Mark "I felt that I am able to, if I am having a difficult situation, or like if I feel frustrated or if I think about a memory for me particularly ruminate-rumination on things I - maybe how I've acted in the past or whatever, I'm able to - if that comes in my mind I'm able to just sort of appreciate that I'm having a memory that I'm not happy - an unpleasant experience put it that way. I can appreciate that at the time and just stand back and look at it for what it is" Sandra	"So I've been able to bring more readily to front of mind things that might help me to immediately get through moments of panic or moments of low feeling or low emotion" Sebastian "I think having a better understanding of how everything is linked together. So sort of, what drives my low mood and then how that effects not only mentally but also physically: And then understanding how to listen to my body a bit more and understand what is happening" Harry
	Lack of change	"I need counselling for grief and anger. And I kind of haven't received that, and I haven't processed any of that sadness that is there, and I also…what I really wanted to work on was myself as a being" Alice	"I was hoping that, I suppose, the frustration and the, you know, shortness of temper would dissipate a bit, I definitely think it has, but I'm, I think this is more of a long term thing, I don't think this is something that you can switch off overnight" David
	Relationships	"yeah and looking forward to social events more than I did before" Beatrice	"I want to groom, I want to shower, I want to shave, I want to have a cup of coffee, I want to, you know have good experiences of doing good and nice things to and

		"It's more natural for me to took good care of myself, have more sort of respect myself" Sophie	for myself and it has made me able to, it has given me a better perspective" David, CBT "I'm not hiding away, I used to turn my phone off and ignore messages cause I just didn't want to talk to anyone, that's not the case anymore so yeah" Sarah
	Support and guidance	"Having phone calls helped, it made me stick to it a bit more" Grace ""When they are looking for a nugget of something that ticks one of the boxes…so I feel sometimes I would say something and then my supervisor [PWP] would be like "oh, so you are kind of feeling this: and it's like well, not really but if that's your box on your form then I guess" Alice.	"so it's just like cultural difference…I had to try and change my explanation of how I felt about something…in distress or despair it's frustrating to have to translate something that seems so simple" Sebastian "I also think that having the sessions with the PWP also helped a little bit kind of giving a sense of accountability to it as well" James
	Self-help book	"I did lack motivation most of the way through it, I didn't stick to the other things so that was a bit like shameful and demotivating" Grace. "working through the self-help book has definitely given me the tools to recognise that maybe I am not feeling so good" Megan	"the lack of face-to-face interaction, self-help I know is…self-help, it's also, like that's one of the things that it lacks drastically which is part of the reason why I really wanted to have some face-to-face interaction" Sebastian "there's too many things going on in my head to be able to focus on that [the book], whereas being led into a question or led into an exercise by someone and motivated through that would have been easier" David

	Time commitment	"I found it a lot to do…to even work out when was the best time of day to do 10 minutes meditation for me cause I can't do it in the evening cause I'll fall asleep, and these were often asking 45 minutes plus journaling tasks with all these other things, so I found it, at first I was quite determined, so yeah I found like I couldn't keep it up so it wasn't going to work with me, like the treatment wasn't going to work because I couldn't do it to a T, sort of thing" Sandra "it was quite a lot of work. I think it was very structured, it was….so the structure of….on every second day you need to do this exercise and every other day then you do this one….I found that really just cold because that's not….that wasn't practical for me, and you know, I have had to try and adapt it to my…family and work wise….to be able to do what I could do when I could do it, and I think that was….I sometimes in the beginning felt a little bit of guilt if I wasn't doing it exactly right, but I just thought, I have to go it the best I can do it" Mark "I think I'm more disappointed with myself than anything in the course. I didn't fully appreciate; I think at the start of the eight-week period that there would need to be such a high commitment of time to it." Brian	"Yeah so I think sort of work is a big one just in terms of sort of the stressful nature of my job, and sort of difficulty in being able to put aside a regular time to sort of go through the book" Harry. "I've been telling myself and encouraging myself not to give up on the treatment, which is something I've wanted to do many times, because sometimes I was getting a little bit you know, I didn't have time to do it" George
Ingredients for change	The individual	"Even though I found it a bit of a struggle to start with, certainly some of the things that I was being led through were, as I said, very alien, but I've persevered with it" Sam	"I'm intelligent so being able to read and understand and take things in very quickly, I think that's very helpful cause there was never a point where I was going 'what I don't understand', I was able to understand it. I think if I

		"I think I am very determined as a person. In general behaviour I am very stubborn" Alice	had any issues with understanding…it would be a lot less effective" Helena "When I start something I'll want to finish it" Alexa
	Therapeutic factors	"learning it's a lot more common than I thought it was" Mark The book has done me more help, just because I have realised that there's not only me who feels a certain way that I feel at times….like it's normal, that it's okay to feel that way, and everyone goes through it" Alexa	"Talking to friends who have similar experiences who have gone through similar things. So, who are also experiencing depression or low mood or been on antidepressant medication and just being able to talk to them about sort of what they have gone through and how they cope with it/ But having sort of calls of this is what I am going through then having that support, so I have those friends who are just checking in". Harry. "My wife has her experiences, she kind of goes through things like I do and she's very understanding and kind of knows what it's like, so we're quite good at supporting each other" James
	External factors	"I tend to think it is the increased dose of medication that has helped me to move out of this period of depression" Brian "I had time out at Christmas which helped" Mark	"Sort of just from a day-to-day point of view how busy I am, although I'm working part-time sort of every other moment when I'm not working I'm sort of dealing with small children and running a household and that sort of, business made it hard because you to do the self-help course I had to prioritise myself" Helena I've been more positive, I still think I need a little more time to see whether that is the weather changing or me

			doing new things or the CBT entirely I think it's a little bit of both" George
	Course content	"I use the body scan each night and it helps me get to sleep. I used to really struggle with sleep" Grace "The meditation I have found very good, if anything happens when I am feeling anxious I'll just take myself away and just spend some quiet time with myself, five, ten minutes….having persevered with it, it does help, yeah" Mark Focussing on it and writing it down and capturing that thought with it just kind of…for me, it kind of sent me into like a big spiral. The more I was, I was spending time and capturing those thoughts and thinking about it, the more it made me think about it even more so…that kind of thing didn't help me" Sam	"the most helpful thing has been trying to sort of change the way I think about things….I can sit down and think about it logically" Harry Yeah the five areas diagram, and then having that tool with me to then sort of se e how that changed" Harry "it's been very useful naming what I'm doing like "oh I'm catastrophising" Helena "Having to try and think of things that I didn't want to think of, like memories in the back of my mind or emotions I didn't want to deal with….so, all of those things were really painful experiences in a way because I was not ready to talk about, but I would say through CBT I am now a lot more comfortable thinking about those thoughts, talking about them and I've even mentioned a lot of these to some friends and family, not all of it, but making my way there" George "I can't think of anything specific but I think generally, you know, the realisation of how dark things had been and had become, was quite a shock and that was kind of a big wake-up call" David "I think the most painful thing is when you, cause when you feel down the way that you do you never really want to talk about you problem, I found the really difficult painful thing was opening up about the things that really get to you and accepting them, but again positive at the

			same time because I was able to vent about it and get the help I needed” Sarah

Appendix W: Demonstration of work completed for original MRP

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