Examining self-guided internet-delivered cognitive behavior therapy for older adults with symptoms of anxiety and depression: Two feasibility open trials


1. Introduction

Epidemiological surveys indicate that the rates of anxiety and depression tend to be lower in older adults. However, these surveys also indicate that approximately 8% and 3% of adults over 65 years of age still meet formal diagnostic criteria for depression and anxiety disorders, respectively (Byers et al., 2010; Gum et al., 2009; Pirkis et al., 2009). This is significant given that the number of adults over 65 is projected to increase in the coming decades and given these conditions compound the effects of physical comorbidities (Katon et al., 2007; Braam et al., 2005).

There is considerable evidence for the efficacy of psychological treatments, such as cognitive behavior therapy (CBT), for older adults with anxiety and depression (Scogin et al., 2005; Nordhus and Pallesen, 2003; Ayers et al., 2007; Gould et al., 2012; Wetherell et al., 2005). However, research indicates that the proportion of older adults seeking and receiving evidence-based treatment for anxiety and depression is low (Australian Bureau of Statistics, 2007; Troller et al., 2007). This has led several researchers to examine internet-delivered cognitive behavior therapy (iCBT) for older adults (i.e., 60 years and older) with anxiety and depression as a way of overcoming barriers to traditional face-to-face treatments and increasing access to evidence-based treatment (Dear et al., 2013; Spek et al., 2007; Zou et al., 2012; Dear et al., in press; Titov et al., in press). For example, two recent randomized

Keywords: Anxiety, Depression, Geriatric, Online therapy, Self-guided, Cost and utility analysis

Abstract

Self-guided internet-delivered cognitive behavior therapy (iCBT) has considerable public health potential for treating anxiety and depression. However, no research has examined the use of self-guided iCBT, that is, treatment without contact with a clinician, specifically for older adults. The aim of the present study was to undertake a preliminary examination of the acceptability, efficacy and health economic impact of two entirely self-guided iCBT programs for adults over 60 years of age with anxiety and depression. Two separate single-group feasibility open trials of self-guided iCBT were conducted, the Anxiety Trial (n = 27) and the Depression Trial (n = 20), using the control groups of two randomized controlled trials. The online treatment packages consisted of five online educational lessons, which were delivered over 8 weeks without clinical contact. Participants rated the interventions as acceptable with more than 90% reporting the course was worth their time and more than 70% of participants completing at least 3 of the 5 lessons within the eight weeks. Significant reductions on measures of anxiety (Generalized Anxiety Disorder 7-item; GAD-7) and depression (Patient Health Questionnaire 9-item; PHQ-9) were observed from pre-treatment to post-treatment in both the Anxiety Trial (GAD-7 Cohen’s d = 1.17; 95% CI: 0.55 to 1.75) and the Depression Trial (PHQ-9 Cohen’s d = 1.06; 95% CI: 0.33 to 1.73). The economic analyses indicated that there was statistically significant improvement in health-related quality of life compared to baseline and marginally higher costs associated with treatment for both the Anxiety Trial ($69.84; 95% CI: $4.24 to $135.45) and the Depression Trial ($54.98; 95% CI: $3.84 to $106.12). The results provide preliminary support for the potential of entirely self-guided iCBT for older adults with anxiety and depression and indicate larger scale and controlled research trials are warranted.

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controlled trials of iCBT provided with regular clinician guidance found significant improvements in symptoms of anxiety and depression (Cohen’s ds > 1.0) among adults over the age of 60 compared with a Waitlist-Control Group (Dear et al., in press; Titov et al., in press). Moreover, these trials found the improvements in symptoms to be maintained at a 12-month follow-up and found the interventions to be cost-effective at common willingness-to-pay thresholds.

There is now strong meta-analytic evidence for iCBT treatments for anxiety and depression in adults generally (Andersson and Cuijpers, 2009; Andrews et al., 2010; Cuijpers et al., 2009). Importantly, the findings of these meta-analyses have suggested that iCBT treatments provided with weekly clinician-guidance may achieve better clinical outcomes than iCBT provided in self-guided formats, that is, where no regular contact with a clinician is provided (Andersson and Cuijpers, 2009; Cuijpers et al., 2009). However, since these meta-analyses, several clinical trials have produced clinical results that are more encouraging of self-guided iCBT treatments (Berger et al., 2011; Furmark et al., 2009; Leykina et al., in press). For example, one study found no differences in clinical outcomes between self-guided and clinician-guided iCBT for adults with depression (Berger et al., 2011) and another found no differences for adults with social anxiety disorder (Furmark et al., 2009). Another trial (n = 257) examined self-guided iCBT for symptoms of anxiety and depression and found large clinical effects (Cohen’s ds > .80) consistent with those obtained in clinician-guided treatments, particularly among participants with comorbid anxiety and depression and where automatic emails were provided (Titov et al., 2013, 2014). These more recent studies are encouraging and highlight the public health potential of well-developed self-guided treatments for anxiety and depression among older adults to date.

The present study sought to explore the efficacy, acceptability and health economic impact of self-guided iCBT for older adults with anxiety and depression using two separate single group open trials. To do this, the present study employed the Waitlist Control-Groups from two previous randomized controlled trials (RCTs; Dear et al., in press; Titov et al., in press), where the control groups were provided with self-guided iCBT. It was hypothesized that: (1) participants would report significantly reduced symptoms of anxiety and depression at post-treatment; (2) these reductions in symptoms would be maintained at 3-month follow-up, and (3) the self-guided iCBT treatment would reduce costs and improve health-related quality of life.

2. Method

2.1. Design

The present study reports the pre-treatment to post-treatment and 3-month follow-up data of two delayed-treatment Waitlist Control Groups from two previous RCTs examining iCBT treatments for older adults with symptoms of anxiety (Dear et al., in press) and depression (Titov et al., in press), respectively. These Waitlist Control Groups were provided access to the iCBT treatment programs after the Treatment Groups had completed treatment. However, rather than receiving weekly contact with a Clinical Psychologist, participants in the Waitlist Control Groups were provided access to the iCBT treatment programs in an entirely self-guided format; that is, without contact with a Clinical Psychologist.

2.2. Participants

Interested older adults applied online to participate in the initial RCTs via an established website (www.eentreclinic.org) after reading details about the studies. Sixty-two participants were allocated to the Waitlist-Control Groups from the two initial RCTs; forming the Anxiety Group open trial and the Depression Group open trial reported here. The inclusion criteria were: (i) resident of Australia; (ii) at least 60 years of age; (iii) have been assessed by a GP or specialist to rule out obvious physical causes for their symptoms. An initial additional criterion was that applicants have a total score ≥10 on the Patient Health Questionnaire-9 Item (PHQ-9; Kroenke et al., 2001) or ≥8 on the Generalized Anxiety Disorder-7 Item Scale (GAD-7; Spitzer et al., 2006). However, this criterion was later removed due to the considerable number of applicants who did not meet this criterion in the initial RCTs. No formal criteria for symptoms were required thereafter; however, all participants had to self-report difficulties with anxiety or depression and want to participate in treatment. The exclusion criteria were: (i) currently participating in CBT; (ii) using illicit drugs or consuming more than three standard drinks/day; (iii) diagnosed with schizophrenia or bi-polar disorder; (iv) experiencing severe symptoms of depression (defined as a total score >19 or responding >2 to Question 9 (suicidal ideation) on the PHQ-9); and (v) if taking medication for anxiety or depression, not being on a stable dose of medication for at least one month. Details of participant flow are shown in Fig. 1.

Fifty-four of the 62 participants from the Waitlist Control Groups of the initial RCTs completed the pre-treatment questionnaires and were eligible to participate in the present study. The demographic characteristics and diagnostic composition of the sample are shown in Table 1. The study was approved by the Human Research Ethics Committee (HREC) of Macquarie University, Sydney, Australia and the trials were registered on the Australian and New Zealand Clinical Trials Registry (ANZCTR) as ACTRN12611000929909 and ACTRN12611000927921.

2.3. Measures

2.3.1. Patient Health Questionnaire-9 Item (PHQ-9; Kroenke et al., 2001)

The PHQ-9 comprises 9 items measuring symptoms of major depressive disorder based on the DSM-IV criteria for depression. A total score of 10 on the PHQ-9 has been identified as an important threshold for identifying DSM-IV congruent depression, with increasing scores indicating greater symptom severity (Kroenke et al., 2001). The PHQ-9 has good internal consistency (Titov et al., 2011) and is sensitive to change (Kroenke et al., 2010). The psychometric properties of the PHQ-9 have been examined and found to be satisfactory in older adults (Phelan et al., 2010).

2.3.2. Generalized Anxiety Disorder 7-Item Scale (GAD-7; Spitzer et al., 2006)

The GAD-7 is a 7-item measure sensitive to the symptoms of GAD, social phobia and panic disorder with increasing scores indicating greater severity of symptoms. The GAD-7 has good internal consistency (α = .79–.91) and good convergent and divergent validity with other anxiety and disability scales (Spitzer et al., 2006; Dear et al., 2011). A total score of 8 on the GAD-7 has been shown to be the optimum sensitive and specific threshold for the possible presence of an anxiety disorder (Kroenke et al., 2007). One recent study has found the GAD-7 to be sensitive to symptoms of GAD among older adults; however, the lower cut-off score of 5 is recommended (Wild et al., in press).

2.3.3. Mini International Neuropsychiatric Interview Version 5.0.0 (MINI; Sheehan et al., 1998)

The MINI is a brief diagnostic interview developed to determine the presence of current Axis-I disorders using DSM-IV diagnostic criteria. It has excellent inter-rater reliability (κ = 0.88–1.00) and adequate concurrent validity with the Composite International Diagnostic Interview (CIDI; World Health Organization, 1990). The MINI was administered in the present trials by two trained and experienced Clinical Psychologists (JBZ & CNL) under the supervision of two Senior Clinical Psychologists (BFD & NT).
2.3.4. EuroQol-5 Dimensions-5 Levels (EQ-5D-5L; Herdman et al., 2011)

The EQ-5D-5L is a standard and widely used measure of health-related quality of life (Brazier, 2007; Herdman et al., 2011). It comprises 5 items, which enquire about 5 dimensions of health: mobility, self-care, usual activities, pain and discomfort, and anxiety and depression. Responses to the five dimensions are weighted and summed to create a total score between 0 (i.e., indicating deceased) and 1 (i.e., indicating full-health). The EQ-5D-5L has been shown to have good convergent validity with the World Health Organization 5-item Well Being questionnaire (Janssen et al., 2013). EQ-5D-5L scores were converted into utility values using an algorithm for the Australian population (Norman et al., 2013). Then quality-adjusted life years (QALYs) were calculated using the time-weighted average of the utility scores (Glick, 2007).

2.4. Interventions

Participants were provided access to the Managing Stress and Anxiety Course (n = 32) or the Managing Your Mood Course (n = 22) based on their principal symptoms reported during assessment. These interventions are described in detail elsewhere (Dear et al., in press; Titov et al., in press), but both are structured online interventions, which encourage participants to learn and practice core CBT psychological skills. Participants complete these interventions over an 8 week period and both interventions are comprised of 5 online lessons, 5 lesson summaries and homework assignments, regular automatic emails and several detailed case-studies, which participants follow through the Course. Both Courses follow the same structure, where lessons 1, 2, 3, 4, and 5 are available at the beginning of weeks 1, 2, 4, 5, and 7, respectively. Both Courses also introduce and teach the same core skills, except that one focuses on the application of the skills to manage anxiety and the other focuses on the application of the skills to manage depression. These courses provide age-appropriate case stories and examples of skill use; however, the presentation of therapeutic information and the teaching of the psychological skills was not modified and is identical to the general iCBT courses they were based on (see Dear et al., in press; Titov et al., in press). All material is presented in both a didactic form (i.e., text based instructions and information) and a case-enhanced learning form (i.e., where educational stories are used to demonstrate the application of skills and problem resolution). Based on previous research supportive of the importance of automatic emails (Titov et al., 2013; Titov et al., 2014), both interventions were provided with automatic emails, which notified participants of new material, prompted participants to view unread materials, encouraged progress through the programs and normalized the difficulties in learning new skills and managing symptoms.

2.5. Statistical analyses

2.5.1. Clinical analyses

All analyses were conducted using SPSS version 22. Participants who did not start treatment were not included in any analyses. Mixed-models analyses, employing an autoregressive covariance structure, maximum likelihood estimation and pre-treatment scores as a covariate, were used to analyze changes on the symptom measures. These mixed models analyses were run separately for the overall samples and for the clinical subsamples; defined as those participants scoring \( \geq 10 \) on the PHQ-9 or \( \geq 8 \) on the GAD-7 at pre-treatment. The mixed-models approach is consistent with intention-to-treat analytic approaches under the assumption that data is missing at random. Effect
sizes (Cohen’s $d$) and 95% confidence intervals were calculated for within-group effects based on the observed means. The following criteria of clinical significance were used. First, reliable improvement was calculated using standard procedures for determining reliable change (Jacobson & Truax, 1991), which take into account the improvement being employed. Specifically, a participant was deemed to have made a reliable improvement if they scored above the total cut-off at pre-treatment (i.e., $\geq 8$ on the GAD-7 or $\geq 10$ on the PHQ-9) and their symptoms improved by a reliable amount; that is, more than 5.20 or 3.53 on the PHQ-9 and the GAD-7, respectively (Gyani et al., 2013). Second, reliable recovery was determined to have occurred if a participant scored above the clinical cut-off at pre-treatment, made a reliable improvement, and scored below the clinical cut-off at the post-treatment or follow-up time point of interest (Gyani et al., 2013). Importantly, these analyses were calculated separately for the PHQ-9 and the GAD-7 and for each trial with baseline observations being carried forward as a conservative approach for controlling for missing data.

### 2.5.2. Economic analysis

The economic analysis was conducted from the perspective of the national health provider in Australia. Data on health-related resource use and health-related quality of life (HRQoL) was collected at baseline, week 8 (i.e. end of treatment) and 3-months post-treatment. Individual patient-level costs were calculated as the product of healthcare resource use and relevant unit costs for: (1) primary and secondary health care consultations and admissions, (2) use of anti-depressant and anxiolytic medications, and (3) resource use associated with the iCBT treatment provided. Resource use was valued using costs from the Medicare Benefits Schedule (Australian Government Department of Health and Ageing, 2013) and the Pharmaceutical Benefits Scheme (Australian Government Department of Health, 2013). Patient-level HRQoL was measured using the EuroQol EQ-5D-5L questionnaire (Herdmann et al., 2011; Brazier, 2007). EQ-5D scores were converted into utility values using a valuation algorithm for the Australian population (Norman et al., 2013). Changes in costs and health effects (measured in terms of HRQoL) were estimated as the difference between post-treatment time points (i.e., 8 weeks and 3 months, respectively) and pre-treatment values and then summarized for each treatment arm. Difference in costs and benefits was tested using paired t-tests for each group using 10,000 bootstrapped samples.

### 3. Results

#### 3.1. Treatment satisfaction

Of the participants providing feedback about the course in the Anxiety Trial ($n = 22$), 20/22 (90%) indicated that they were very satisfied or mostly satisfied with the course, 22/22 (100%) indicated that it was worth their time and 21/22 (95%) indicated that they would recommend the course to a friend. Similarly, of the participants providing feedback about the course in the Depression Trial ($n = 14$), 11/14 (78%) indicated that they were very satisfied or mostly satisfied with the Course, 13/14 (92%) indicated that it was worth their time and 14/14 (100%) indicated that they would recommend the course to a friend.

#### 3.2. Symptom outcomes for overall samples

Means, standard deviations and effect sizes for the overall samples are shown in Table 2. For the Anxiety Trial, the mixed-models analyses revealed significant effects for Time on the GAD-7 ($F_{2, 43} = 15.70, p < .001$) and PHQ-9 ($F_{2, 43} = 20.50, p < .001$). Pairwise comparisons revealed that, on both measures, scores reduced significantly from pre-treatment to post-treatment ($p < .001$), but not from post-treatment to 3-month follow-up ($p$ range: .166 to .342).

Similarly, for the Depression Trial, mixed-models analyses revealed significant effects for Time on the PHQ-9 ($F_{2, 37} = 12.90, p < .001$) and GAD-7 ($F_{2, 30} = 3.76, p = .034$). Pairwise comparisons revealed that scores reduced significantly from pre-treatment to post-treatment on the PHQ-9 and GAD-7 ($p$ range: $.001$ to .031), but not from post-treatment to 3-month follow-up ($p$ range: .841 to .918).

#### 3.3. Symptom outcomes for clinical subsamples

Means, standard deviations and effect sizes for the clinical sub samples are shown in Table 2. For the Anxiety Trial, the mixed-models analyses revealed significant effects for Time on the GAD-7 ($F_{2, 24} = 11.01, p < .001$) and PHQ-9 ($F_{2, 22} = 24.63, p < .001$) for the clinical sub samples on each measure. Pairwise comparisons revealed that, on both measures, scores reduced significantly from pre-treatment to post-treatment ($p < .001$), but not from pre-treatment to 3-month follow-up ($p$ range: .271 to .335).

Similarly, for the Depression Trial, mixed-models analyses revealed significant effects for Time on the PHQ-9 ($F_{2, 14} = 11.01, p < .001$) and GAD-7 ($F_{2, 14} = 21.07, p < .001$) for the clinical sub samples on each measure. Pairwise comparisons revealed that scores reduced significantly from pre-treatment to post-treatment on the PHQ-9 and GAD-7 ($p < .001$), but not from post-treatment to 3-month follow-up ($p$ range: .375 to .985).
### 3.4. Clinical significance

The proportions of participants reporting reliable improvement and reliable recovery are shown in Table 3. For the Anxiety Trial, 70% of participants reported a reliable improvement and more than 47% reported having made a reliable recovery on the GAD-7 at post-treatment. Similarly, in the Depression Trial, 40% of participants reported a reliable improvement and 33% reported a reliable recovery on the PHQ-9 at post-treatment.

### 3.5. Economic analyses

The mean costs in the Anxiety Trial (including the intervention cost) were $69.84 more per participant over the eight week treatment period (95% bias corrected CI: $4.24 to $135.45) compared to the pre-treatment costs for the same period in the same group (Table 4). However, at three-month follow-up, there was no statistically significant cost difference compared to the pre-treatment costs. The utility scores evaluated using the EQ-5D-5L were statistically significantly higher at eight weeks (estimate: 0.07; 95% bias corrected CI: 0.00 to 0.15) and at 3-month follow-up (estimate: 0.17; 95% bias corrected CI: 0.08 to 0.26) compared to baseline. These findings suggest that iCBT is associated with higher costs during the treatment period and results in higher health-related quality of life, which is primarily attributable to improvement in the anxiety/depression score in the EQ-5D-5L questionnaire.

### 4. Discussion

The current study extends previous research and provides a preliminary examination of the acceptability, efficacy and health economic impact of two self-guided iCBT interventions for older adults with anxiety and depression. It was hypothesized that (1) participants would report significantly reduced symptoms of anxiety and depression at post-treatment, (2) these reductions in symptoms would be maintained at 3-month follow-up, and (3) the self-guided iCBT treatment would reduce costs and improve health-related quality of life. These hypotheses were supported. Moderate to large within-group effect sizes were observed on measures of anxiety and depression in both trials, which were maintained at 3-month follow-up. Moreover, in both groups, there were statistically significant improvements in health-related quality of life compared to baseline and there were marginally higher

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### Table 2

Means, standard deviations and effect sizes (Cohen’s d) for the observed and estimated marginal means for each trial.

<table>
<thead>
<tr>
<th>Overall sample</th>
<th>Anxity Trial</th>
<th>PHQ-9</th>
<th>Depression Trial</th>
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<td>Pre Post 3-Month follow-up</td>
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<td>7.25 (4.60)</td>
<td>4.88 (3.76)</td>
<td>4.86 (4.61)</td>
<td>7.25 (4.17)</td>
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### Table 3

Proportions reporting reliable improvement and reliable recovery.

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<th>Estimated means</th>
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<td>13.29 (3.54)</td>
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Note. Baseline observations were carried forward for missing data. A person was deemed to have made a reliable improvement if they scored above the total cut-off at pre-treatment and their symptoms improved by a reliable amount. A person was deemed to have reliably recovered if they scored above the clinical cut-off at pre-treatment, made a reliable improvement, and scored below the clinical cut-off at the post-treatment or follow-up time point of interest. GAD-7: Generalized Anxiety Disorder 7-item. PHQ-9: Patient Health Questionnaire 9-item.
costs incurred during the treatment period. However, the cost of providing treatment was relatively low.

The results of the present study are encouraging regarding the potential of self-guided iCBT interventions for older adults with anxiety and depression. The results are broadly consistent, in terms of clinical efficacy, with recent trials examining clinician-guided iCBT interventions for older adults with symptoms of anxiety and depression (Dear et al., in press; Titov et al., in press), which found similarly large within-group effect sizes (Cohen’s d = 1.0) from pre-treatment to post-treatment and large effect size differences (Cohen’s d > 1.0) between treatment and control groups at post-treatment. The results are also consistent with several recent trials exploring purely self-guided iCBT interventions, which have managed to obtain similar clinical outcomes without clinician guidance (Berger et al., 2011; Furmark et al., 2009; Titov et al., 2013; Titov et al., 2014). It is important to note that the results of these previous trials and the current trials contrast to meta-analytic reports (Andersson and Cuijpers, 2009; Andrews et al., 2010; Cuijpers et al., 2009), which have indicated superior results for trials involving regular clinician guidance over those without contact. Unfortunately, to date, there is a relatively limited empirical basis for understanding what factors might be leading some self-guided trials to obtain encouraging results where others have not (Titov et al., 2013; Andersson and Titov, 2014). However, one large recent trial indicated that, regular automatic emails facilitate iCBT adherence and facilitate treatment outcomes in adults with comorbid anxiety and depression (Titov et al., 2013; Titov et al., 2014). Similar automatic emails were included in the present trials and may have contributed to the encouraging outcomes.

Despite the outcomes, caution is needed when interpreting the findings of the present trials. First, being single-group feasibility open trials without direct comparison groups, no conclusions about clinical efficacy or cost-effectiveness can be made. Further research involving direct comparison groups is needed to draw conclusions about the efficacy of self-guided iCBT for older adults, both compared with no treatment and clinician-guided iCBT. Second, while more than 85% of participants met diagnostic criteria for an anxiety or affective disorder, it is important to note that some participants did not meet diagnostic criteria and participants were not required to report clinical level symptoms of anxiety or depression (i.e., symptoms above clinical cut-offs) in order to participate. Third, the samples were comprised of a young cohort of older adults (average age = 65.3 and 66.6; SDs = 5.33 and 3.71; range = 60 to 81) and an internet-treatment seeking sample that consented to participate in self-guided iCBT. It is, therefore, unclear how the results might generalize to older cohorts of older adults and those who might present to face-to-face treatments or who want clinician contact. Fourth, the present study employed the control groups of two previous RCTs and, while attrition was low, it is unclear what effect this may have had on the obtained results. Unfortunately, because of this, the present study does not provide data about the acceptability or potential rates of uptake were self-guided iCBT to be disseminated to the public. Lastly, it is not clear from the present trials what factors might contribute to the good clinical outcomes observed. Indeed, little is known generally about the participant, treatment and other factors leading to positive treatment effects in self-guided iCBT treatments (Baumeister et al., in press) and, therefore, much more research is needed.

Overall, the present results highlight the potential of self-guided iCBT treatments for older adults with anxiety and depression, and the cost and quality of life outcomes of the internet delivery of evidence-based psychological treatment. Caution is needed in interpreting the results of the present study, however, these promising results indicate that large replication studies involving direct comparisons with control groups are warranted. Further research is also needed to understand the participant and treatment factors associated with good clinical outcomes in self-guided iCBT treatments.

Disclosures

N Titov and B Dear are authors and developers of the Managing Stress and Anxiety Course, but derive no personal or financial benefit from it. N Titov, B Dear and B Klein are funded by the Australian Government to develop and provide a free national internet and telephone-delivered treatment service, the MindSpot Clinic (www.mindspot.org.au), for people with anxiety and depression.

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References


### Internet Interventions

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#### Subject Classifications

#### Additional Title Details

#### Publisher & Ordering Details

#### Online Availability
Examining self-guided internet-delivered cognitive behavior therapy for older adults with symptoms of anxiety and depression: Two feasibility open trials


Highlights

- Few older adults with symptoms of anxiety and depression seek psychological treatment.
- Self-guided and Internet-delivered cognitive behavior therapy (iCBT) has potential for older adults.
- This study examined the feasibility of self-guided iCBT for older adults.
- Large clinical improvements were found in symptoms of depression.
- Evidence of the cost-utility of self-guided iCBT was also found.

Abstract

Self-guided internet-delivered cognitive behavior therapy (iCBT) has considerable public health potential for treating anxiety and depression. However, no research has examined the use of self-guided iCBT, that is, treatment without contact with a clinician, specifically for older adults. The aim of the present study was to undertake a preliminary examination of the acceptability, efficacy and health economic impact of two entirely self-guided iCBT programs for adults over 60 years of age with anxiety and depression. Two separate single-group feasibility open trials of self-guided iCBT were conducted, the Anxiety Trial (n = 27) and the Depression Trial (n = 20), using the control groups of two randomized controlled trials. The online treatment packages consisted of five online educational lessons, which were delivered over 8 weeks without clinical contact. Participants rated the interventions as acceptable with more than 90% reporting the course was worth their time and more than 70% of participants completing at least 3 of the 5 lessons within the eight weeks. Significant reductions on measures of anxiety (Generalized Anxiety Disorder 7-item; GAD-7) and depression (Patient Health Questionnaire 9-item; PHQ-9) were observed from pre-treatment to post-treatment in both the Anxiety Trial (GAD-7 Cohen’s d = 1.17; 95% CI: 0.55 to 1.75) and the Depression Trial (PHQ-9 Cohen’s d = 1.06; 95% CI: 0.33 to 1.73). The economic analyses indicated that there was statistically significant improvement in health-related quality of life compared to baseline and marginally higher costs associated with treatment for both the Anxiety Trial ($69.84; 95% CI: $4.24 to $135.45) and the Depression Trial ($54.98; 95% CI: $3.84 to $106.12). The results provide preliminary support for the potential of entirely self-guided iCBT for older adults with anxiety and depression and indicate larger scale and controlled