

Self-Help: Towards the Next Generation

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Abstract. In the UK, recent guidelines on the treatment of depression and anxiety recommend CBT-based self-help materials as one important component of services. However, despite being based on specific CBT techniques or “empirically grounded interventions”, early optimism has been dented by data from recent studies that have cast doubt on the effectiveness of the current generation of these materials. As a consequence, it may be necessary to consider that other factors may contribute to the overall magnitude of CBT effects. Indeed, it is logically inconsistent to argue that specific factors are pre-eminent in CBT whilst maintaining that delivery via therapists is more likely to be effective than self-help. The contribution of “common factors” that operate in personal therapeutic encounters, for example, therapist responsiveness and the patient-therapist alliance, may be one possible overlooked reason for the reduced effectiveness of self-help materials. The development of the next generation of self-help materials, therefore, may benefit from the testing of materials that combine common and specific factors, including specific measurement of the strength of common factors and their relationship to clinical outcomes. We discuss a model of such common factors and suggest how they could be incorporated into the next generation of CBT based self-help materials.

Keywords: Self-help, depression, anxiety, common factors, cognitive behavioural therapy, NICE.

Background

Self-help as a method of alleviating the distress caused by mental health problems is an idea that is gaining increasing prominence. Clinical guidelines recently issued by the National Institute for Health and Clinical Excellence (NICE) recommend the use of self-help techniques in the treatment of panic disorder, generalized anxiety disorder and mild depression (National Institute for Clinical Excellence, 2004a, 2004b). This emphasis on self-help is consistent with other recent policy initiatives: for example, the National Service Framework (NSF) for Mental Health (Department of Health, 1999) is underpinned by the principles of involving service users in the delivery of care and of accessibility to services (Lewis et al., 2003). Both of these principles are extremely relevant to self-help.

However, defining self-help is not without difficulty and is an area of considerable debate. Depending on one’s viewpoint, self-help definitions can include a collection of highly specific psychological treatment materials delivered alone or with minimal support (Lewis et al., 2003), places to go and people to see outside the “official” treatment agencies in order to receive peer affirmation and support (Rogers and Elliot, 1997), and a series of generic supportive strategies

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for living (Faulkner and Layzell, 2000). According to Lewis et al. (2003), even if self-help is defined as therapeutic information, it should do more than merely give information and advice. Its success depends on a dynamic interaction between materials and users so that they are able to set their own goals, learn relevant skills and understand how to protect against relapse. Even from a professional's point of view, therefore, self-help includes elements of patient empowerment and is regarded by many as a sophisticated intervention in its own right rather than as merely a cheaper variant of care by professionals (Richards, 2004).

Nonetheless, it would be inappropriate to ignore the need for cost-effective and accessible forms of mental health care, particularly for the common problems of depression and anxiety. In England, the recent 5-year review of the NSF for Mental Health acknowledged that the availability of psychological services has increased (Department of Health, 2004), although "long waiting lists remain in many places" (p. 72). The review recommended that the National Institute for Mental Health in England (NIMHE) "explore ways of expanding the availability of talking treatments". These would be likely to include "self-help technologies" (p. 72).

Furthermore, patients who are diagnosed with depression and anxiety in primary care are likely to represent only a proportion of people with these disorders in the wider community (Goldberg and Huxley, 1980). In a recent survey of adults carried out by the Office for National Statistics (ONS) about 1 in 6 were assessed as having a neurotic disorder in the week before interview (164 cases per 1000 adults) (Office for National Statistics, 2001). The most prevalent was mixed anxiety and depressive disorder, with 88 cases per 1000 adults. It seems reasonable to argue that if more accessible forms of care were available, more of this group would access and receive treatment through a greater range of routes, beyond the traditional GP referral. Given this level of need and the dearth of trained staff to provide effective psychological therapies, it is clear that the NSF review's recommendations regarding the increase in self-help availability should be addressed as a matter of urgency.

Cognitive behavioural therapy and the content of self-help

Cognitive behavioural therapy (CBT) researchers have a half-century-long tradition of revolt against the notion that psychotherapy is an art that can only be learnt through experiencing psychotherapy oneself. Equally, in contrast to other therapy models, CBT has rejected the idea that the central focus and agent of change in psychotherapy should be the relationship between practitioner and patient. This has led to the development of a set of "empirically grounded clinical interventions" (Salkovskis, 2002, p. 4), acknowledging the roles of theory, empiricism and the scientist-practitioner (Barlow, Hayes and Nelson, 1984). CBT has developed through both "big-" and "small-science", from single case experimental designs to randomized controlled trials. Even at the level of individual therapy, Beck and colleagues highlight the emphasis in CBT on "empirical investigation" involving both the patient and the therapist (Beck, Rush, Shaw and Emery, 1979, p. 7).

This approach to psychological therapy has furnished the modern cognitive behavioural therapist with an array of specific techniques and approaches that the scientific method has shown to be effective. Examples include exposure for phobias, cognitive restructuring for depression, and cognitive behavioural interventions for people with psychosis. This emphasis on science has, of course, been fundamental to the success of CBT and has led to CBT being the most frequently supported evidence-based psychological treatment in clinical guidelines, the recent NICE guidelines being an example of this (National Institute for Clinical

Excellence, 2004a, 2004b). CBT researchers and practitioners regard its “specific factors”, i.e. its “empirically grounded clinical interventions” as the reason for this success. As such, these specific techniques are generally held to possess their own independent therapeutic agency; that there is a direct and strong relationship between techniques and patient recovery.

It is precisely because of this belief in the independent agency of specific CBT techniques that they have been prime candidates for translation into self-help formats. This translation has been aided by the fact that many of these techniques are very clearly described and have often been manualized as part of their development and testing. As a consequence, the majority of current self-help materials have CBT techniques as their main therapeutic content. Indeed, the NICE evidence-based guidelines on depression and anxiety recommend CBT-based self-help (National Institute for Clinical Excellence, 2004a, 2004b). Most self-help manuals and computer-based programmes try to disseminate these specific CBT techniques to a wide audience of potential patients. They are used during CBT by the majority of therapists (Keeley, Williams and Shapiro, 2002) and as interventions in their own right (Lovell et al., 2003; Richards, Lovell and McEvoy, 2003).

However, uncertainty exists over the effectiveness of the current generation of self-help technologies. Despite early enthusiasm and accompanying optimistic studies (Cuijpers, 1997; Bowman, 1997), more recent reviews, whilst conceding that the available research generally concludes that self-help is beneficial, raise concerns over the quality of this research (Bower, Richards and Lovell, 2001; Lewis et al., 2003; Kaltenthaler, Parry and Beverley, 2004). For example, Lewis et al. (2003) express doubt as to “whether this evidence is of sufficient rigor to recommend the use of self-help materials” (p. 99). Given these concerns, one could argue that this earlier research has given an over optimistic impression of the effectiveness of current technologies, since it is well acknowledged that “poor trial design makes treatments look better than they really are” (Moore and McQuay, 2000, p. 1). These concerns have been reinforced by recent rigorously conducted randomized controlled trials that have been equivocal about the benefits of self-help (Richards, Barkham et al., 2003; Mead et al., 2005). Despite increased patient satisfaction, both these studies found no significant clinical advantage for self-help compared to usual care when guided self-help delivered by practice nurses in primary care was compared to usual treatment by General Practitioners alone (Richards, Barkham et al., 2003) or when it was delivered by psychology assistants to patients awaiting psychological therapy compared to those who remained untreated on the waiting list (Mead et al., 2005).

If the critical reviews of the evidence base, supported by these later studies, are to be believed, there are a number of candidate variables to account for weaker effects, including such things as context and setting. We will argue that the therapeutic impact of CBT may be attributable to more than the application of specific empirically grounded techniques, and that one potential element that might explain the apparent failure of the current generation of self-help methods to fulfil their early promise may be the lack of attention paid to “common factors” present in therapist assisted CBT in the development of self-help materials. It may be that the effects of self-help can be enhanced by delivering it in a context where such common factors can contribute to overall effects.

Common factors

As a consequence of the prominence given to techniques or “specific factors”, cognitive behaviour therapists have traditionally placed less emphasis than other schools on factors

common to all types of psychotherapy. However, there is considerable interest and a large body of research on the so-called “common factors” in psychotherapy, interest that can be traced back to a seminal paper published in 1936 (Rosenzweig, 1936). Rosenzweig noted that all forms of psychotherapy achieved successes. He argued, therefore, that there are unrecognized factors that operate in any therapeutic situation that contribute to the success of the therapy. He further argued that these unrecognized factors operate in apparently different forms of psychotherapy and that it is having these in common that makes therapies equally successful. More recently, researchers have argued that as much as 30% of the improvement in psychotherapy is due to common factors, in contrast to a supposed 15% contribution that can be attributed to specific techniques (Lambert and Barley, 2002).

Much of the research on common factors has centred on the therapeutic relationship. Researchers have defined specific elements of this relationship and examined to what extent they contribute to therapeutic outcome. A recent extensive review of the literature on this topic included elements on factors such as empathy and the alliance between therapist and patient (Norcross, 2002). Common factors were examined to determine how each one correlated with the outcome of therapy. The authors found strong correlations between certain relationship elements and therapy outcome: these were the alliance (Horvath and Bedi, 2002), cohesion in group psychotherapy (Burlingame, Fuhriman and Johnson, 2002), empathy (Bohart, Elliot, Greenberg and Watson, 2002) and goal consensus and collaboration (Tryon and Winograd, 2002). It is, of course, possible to argue that the case for the therapy relationship having a causal link to outcome is far from proven. Current research only shows a correlation between the two and it is difficult to see how research could be designed that would prove a causal link (Norcross, 2002). Elements of the therapeutic relationship would be difficult to manipulate as independent variables. However, this body of evidence does warrant consideration in terms of its general applicability to CBT and its specific role in self-help.

CBT and the therapeutic relationship

In 1979, Beck et al. (p. 45) described the therapeutic relationship as the “context” in which specific techniques are applied. Twenty-five years later, Goldfried (2004) echoed this view and described the relationship as “like the anesthesia that allows for a surgical procedure to be performed” (p. 98). This is in sharp contrast to other schools of psychotherapy that view the relationship as central to a patient’s recovery. However, recent researchers have suggested that, even in cognitive therapy, there may be an association between the therapy relationship and the outcome, independent of the relationship between outcome and specific CBT techniques (Waddington, 2002; Ilardi and Craighead, 1994; Safran and Segal, 1996).

We do not argue that CBT practitioners neglect the building of strong therapeutic relationships with their patients. Indeed, Beck noted that “slighting the therapeutic relationship” i.e. minimizing its importance, was a common problem amongst trainee therapists (Beck et al., 1979, p. 27). On the contrary, a competent CBT practitioner is good at not only applying the appropriate techniques, but also at building relationships with patients. However, by attributing all the outcome of CBT to the effect of specific technical aspects of CBT it may be that CBT is neglecting an important element of its effectiveness. Ironically, many experimental studies in CBT have implicitly recognized this by randomizing patients to attention controls as placebo conditions to control for some of these factors. These studies have frequently found that some patients improve markedly in these groups (e.g. Marks, Lovell, Noshirvani, Livanou and

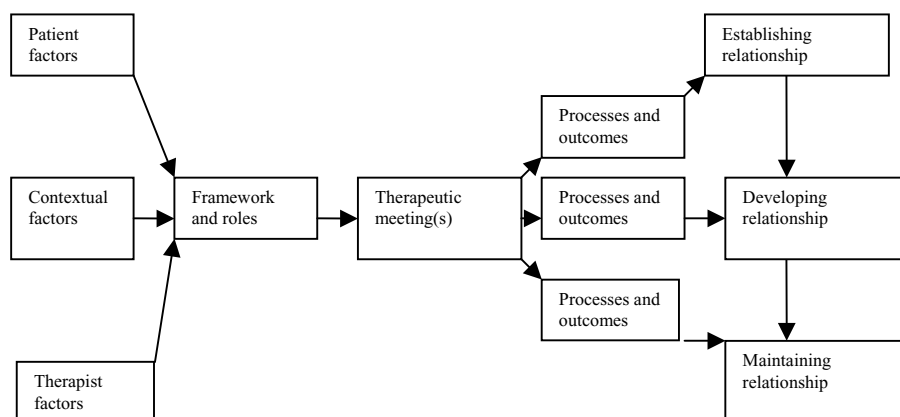


Figure 1. Conceptual map of therapist patient interaction (reproduced with permission from Barkham et al., 2003)

Thrasher, 1998; Elkin, 1994). These “placebo” effects, therefore, may actually be reflecting the independent agency of common factors.

The above reflections lead to the following question. Is the lesser effectiveness of self-help a consequence of CBT being implemented without “anaesthesia” or because the independent therapeutic effect of common factors is being removed from this mode of CBT delivery? It is logically inconsistent to argue that specific factors are pre-eminent in CBT whilst maintaining that delivery via therapists is more likely to be effective than self-help. If specific CBT factors are the main agent of change, their context and delivery mode should be inconsequential.

Therapist-patient interactions and CBT

If one accepts that common factors present in the interaction between patient and therapist play an important role in the effectiveness of CBT – as they are thought to do in other psychotherapies – it is necessary to identify these factors and attempt to incorporate them into self-help, thereby increasing the likelihood that self-help will approximate more to the effectiveness of traditional CBT. In the same way that the alliance between therapist and patient is valued by patients as one of their most important mediators of therapeutic effect (Horvath and Bedi, 2002), there is evidence that common factors are equally important to patients in guided self-help. For example, in a qualitative study of a guided self-help clinic (Rogers, Oliver, Bower, Lovell and Richards, 2004) many patients did not use technique-based attributions of success, even where limited amounts of common factors (in terms of contact with a self-help facilitator) were available. Instead, many patients used interpersonal attributional concepts, regarding their improvements as a consequence of “having somebody to talk to” (p. 44).

A recent review of measures of therapist-patient interactions (TPI) in mental health settings developed a conceptual map of this subject area (see Figure 1). The authors identified three developmental processes as necessary for the provision of an effective therapeutic relationship: “establishing a relationship”, “developing a relationship” and “maintaining a relationship”. The

Table 1. Objectives of the three stages in the therapist-patient relationship and the role of common and CBT specific factors

	Objectives	Common factors	CBT specific factors
Establishing the relationship	Positive expectancies; Hope; Patient engagement	Empathy, warmth and genuineness; Negotiation of goals; Collaborative framework; Guidance	Assessment of patient; Formulation; Establishing therapist competence
Developing the relationship	Commitment; Trust in therapist; Openness to therapy	Developing a secure base; Feedback; Responsiveness	Education; Rationale giving; Initiating treatment
Maintaining the relationship	Satisfaction; Alliance; Emotional processing; Clinical improvement; Preventing drop out	Rupture repair; Flexibility and responsiveness	Specific treatment techniques; Problem solving; Relapse prevention

map also detailed key “processes” that therapists use to achieve “objectives” for each phase. The authors assumed that although therapy progresses through these phases, the therapist might need to use processes from different phases in a single session, or at times across the whole course of therapy.

Several of the processes cited, for example “exploration of aspects of the patient-therapist relationship” are more relevant to other schools of psychotherapy than CBT: a CBT practitioner would not recognize maintaining a therapeutic relationship as an objective of therapy *per se*. With this caveat in mind we have adapted this map to reflect traditional CBT practice (see Table 1). The relationship phases are retained and mapped against processes and objectives that are particularly relevant to CBT. We have renamed the processes as “common factors” to contrast them with specific CBT techniques or factors. We have then matched these specific factors to the phases of relationship building during which they are mostly employed.

This revised map highlights the common factors employed during therapist delivered CBT and the next step is, therefore, to consider how they could be incorporated into self-help materials. The concept may be counter-intuitive but we aim to demonstrate that this approach will provide scope for improving the materials currently available. Although the detail is outside the scope of this paper, there are also lessons that can be learnt from other disciplines. For example, the design of self-help materials can be seen as similar to designing open learning materials: both face the challenge of motivating people to continue, to complete homework assignments, and to fit activities into busy schedules. A brief glance at the open learning literature reveals an interest in designing materials that can show empathy with students, are broken into manageable chunks, and allow some flexibility of use (Race, 1993). A recent paper about preventing dropout from open learning emphasizes the importance of marketing programmes appropriately to avoid a gap between student expectations and experiences that can lead to student attrition (Yorke, 2004). Much of this thinking can be seen as the application of common factors to distance learning educational materials and parallels our own concerns to incorporate common factors more explicitly into self-help.

We will now consider each of the phases in the provision of an effective therapeutic relationship in relation to the incorporation of common factors into self-help.

Establishing the relationship

Perhaps the primary objective in the early stages of building a therapeutic relationship is that the patient will return for further appointments. Achieving patient engagement is as critical for the success of self-help materials as it is for traditional therapy. Other objectives include generating positive expectations of therapy and encouraging the patient to have a sense of hope about the outcome.

Although empathy, warmth and genuineness are usually considered as skills deployed in personal relationships, it may be possible for self-help materials to display these characteristics. Material can appear to have been produced by a concerned individual, who can prove that they understand the patient's difficulties by accurately and simply describing what their feelings are likely to be. The type of language used can convey warmth and caring. The use of accessible language can signify genuineness of intent, as can a sense of respect for the patient's suffering. Indeed, it may be possible for self-help materials to have a "personality", and this can contribute to the building of a relationship with the user.

The interactive negotiation of goals may seem to be a process that would be difficult to replicate in self-help. However, materials can use techniques to enable patients to think about their aims and write them down, including using examples of the kind of goals that might and might not be possible. The materials can even provide suggestions for measurement of progress and dates at which progress could be assessed. The idea of reviewing progress, and thus encouraging patients to tailor their use of the materials accordingly, leads to the requirement that materials can be used in a non-linear way. A good analogy is to compare a self-help manual to the kind of instruction manual that comes with a video or television; the user only reads the sections that they need (Holdsworth and Paxton, 1999). This requirement will also be relevant to incorporating other common factors into self-help and will be discussed in more detail below.

Building a collaborative framework means generating faith in the methods that will be employed and gaining commitment to working towards the goals that the patient has set. Clear information about how therapy will work and how the patient will progress is vital to building this framework. This type of information can also provide guidance to the patient as to how they might feel at the different stages of therapy. Other important guidance could include tips on dealing with common stumbling blocks to progress.

Developing the relationship

Once the relationship has been established, the key objective is to ensure that the patient feels committed to participating in therapy. CBT can be arduous and requires substantial patient commitment. As noted above, completion of CBT homework by patients has been shown to be a critical determinant of clinical outcome (e.g. Burns and Nolen-Hoeksema, 1992). Gaining patient commitment to consistent and regular extra-therapeutic homework activity is crucial in both therapist mediated and self-help CBT.

Barkham et al. (2003) cite the development of a secure base as one of the processes important in this phase. They state, "the aim in the therapeutic relationship is to develop a base from which patients feel secure and able to explore their problems productively" (p. 14). There are two elements to this secure base: patients need to feel "safe" with their therapist as well as confident about the treatment techniques that will be used. Generating confidence in

treatment techniques involves giving a rationale for the interventions to be used so that the patient can understand the purpose of various exercises. This type of information giving can be employed in self-help materials. Other useful techniques might be sections with “frequently asked questions” that anticipate the kind of questions that are often asked in therapy. The use of case studies can help patients see what can be achieved, which can also inspire confidence in CBT techniques.

Generating a sense of safety with the therapist might appear to be more of a challenge for self-help. However, as we argue above, self-help materials can have a personality and can appear to be produced by a caring individual who is knowledgeable and experienced. Descriptions of the support that the materials can offer will also help to generate a sense of safety. Self-help should also create opportunities for patients to personalize materials (a concept used in the development of open learning materials), increasing their ability to act as a secure base.

There is also a challenge in ensuring that self-help materials are appropriately responsive to patients. Stiles, Honos-Webb and Surko (1998) define responsiveness as “behaviour that is affected by emerging context” (p. 439). It is clear that self-help materials could never be acutely responsive on a “moment-to-moment” basis, but they can still be responsive to emerging context through being used in a non-linear way. Patients need to be able to identify their own needs and then be able to find the relevant material, linking to the idea of reviewing progress introduced above.

Giving feedback is important at this stage of the relationship. For example, the use of simple behavioural activation techniques can provide feedback to reinforce some of the therapy messages. Some early success will also build confidence in the treatment being proposed.

Maintaining the relationship

Skills crucial to maintaining a successful therapeutic relationship include repairing “ruptures” in the relationship and being responsive to the changing requirements of the patient. The most concrete example of a rupture is where a patient drops out of therapy in an unplanned manner. It should be remembered that retention is a problem for psychological therapies in general, with reports of between 17 and 40% of patients dropping out from both trials and routine clinical practice (Churchill et al., 2001; Aubrey, Self and Halstead, 2003). Although it has been noted that in terms of the broader definition of self-help, “dropping out” is a somewhat counter-intuitive concept (since “most health care is self-care” (p. S23) (Coulter and Elwyn, 2002), problems of concordance with specific psychological self-help programmes are significant, even in the case of computer based self-help programmes that have been explicitly designed to try and minimize this (Proudfoot et al., 2003, 2004).

This is clearly a very challenging area for the development of self-help materials and it is likely that many patients will require one-to-one support as they progress. At this stage it becomes increasingly difficult to see how self-help materials alone could adequately respond to these challenges. Some form of interpersonal guidance sitting alongside self-help materials might be needed to encourage patients to continue and deal with any problems.

However, there are potential ways in which materials can anticipate difficulties and attempt to provide strategies against possible ruptures in the relationship. As discussed above, materials can be designed in a non-linear fashion so that patients have places to turn to if they are experiencing difficulties. The use of “appointments” within self-help materials could be

considered as a way to generate commitment and sections might be included on how to recommence therapy if a rupture has occurred. Honesty about possible setbacks (and how these can be overcome) may help to counter some difficulties.

Conversely, one might also argue that self-help has distinct advantages over traditional therapy in preventing ruptures in terms of accessibility. If materials are structured in a flexible way, they can answer the questions and fears that arise in the middle of the night, as well as during office hours. Patients can also undertake therapy at times convenient to them, without having to worry about, for example, taking time off work. They are also easier to pick up again after a rupture, whereas rearranging therapy might be more difficult.

Conclusions

The challenge of meeting the need for treatment of depression and anxiety is well recognized. Self-help materials have the potential to contribute to meeting this need. However, recent research has cast doubt on the effectiveness of the current generation of these materials. One potential reason for this might be the lack of explicit attention paid to reproducing the “common factors” present in CBT therapy within self-help materials. The development of the next generation of self-help materials, therefore, may benefit from the testing of materials that combine common and specific factors, including specific measurement of the strength of common factors and their relationship to clinical outcomes. Given that self-help is a core component of the NICE Guidelines for anxiety and depression (National Institute for Clinical Excellence, 2004a, 2004b), such research and development is urgently required to meet the aspirations and the assertions of both these guidelines and the NSF for mental health (Department of Health, 1999), aimed as they are at improving the desperately poor availability of psychological therapies in the UK at the current time.

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