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CORRESPONDENCE

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To the Editor:

In a recent issue of *Psychological Medicine*, Mead *et al*. (2005) present interesting findings that suggest that their model of guided self-help does not provide any additional benefits to patients waiting for psychological therapy. This has obvious implications for the many NHS services that offer assisted and non-assisted self-help to people waiting for psychological therapy or as an alternative to psychological therapy. Therefore, their findings should be closely scrutinized.

One major concern is that the patients included in the study are more severe than would be appropriate for an assisted self-help programme. The general idea is to offer self-help as an alternative to conventional therapy for people with mild disorders. However, the average CORE-OM scores for the patients assigned to guided self-help is 1·98 (0·64). The cut-off scores for 'caseness' are 1·19 for men and 1·29 for women (Barkham *et al*. 2005). The mean score for NHS primary- and secondary-care settings is 1·81 (Evans *et al*. 2003; Barkham *et al*. 2005). In the Primary Care Service in which we work and where we routinely offer assisted self-help, the mean CORE-OM score at the assessment is 1·48 (0·62). It seems to us then, that the level of severity in this sample is very high, perhaps much higher than the self-help approach is likely to be helpful for. It is possible, and perhaps even likely, that people who are less disabled are able to make much more use of the self-help material and show greater improvement.

While on this point, there are disconcertingly large differences between the mean CORE-OM scores for the guided self-help and control groups (1·98 and 1·87 respectively). The authors cite an article by Roberts & Torgerson (1999) who themselves argue that differences in baseline characteristics should only be analysed if there are grounds to suspect that the randomization procedure has not been properly conducted. However, the point to note here is that the baseline differences exist for one of the dependent variables as well as some of the co-variables, which should have been investigated. Moreover, the article by Roberts & Torgerson (1999) should not be seen as research 'guidelines', but rather as an interesting debate appearing in the Education and Debate section of the *British Medical Journal*.

A further problem has to do with the nature of their self-help programme: it appears to involve some sort of 'one-size-fits-all' approach to a variety of psychological disorders – that is, that they used the same manual for a variety of psychological problems. At best, the article provides an indication of the lack of effectiveness of their idiosyncratic self-help programme, but the findings should not be generalized to all assisted self-help programmes that occur across the NHS. Common sense suggests that any treatment programme should be matched to the presenting problem. This, after all, is what we do in therapy.

The authors do acknowledge this problem and suggest that the results obtained in the guided self-help group may have been more impressive if presenting problems were matched with appropriate self-help programmes, but concluded that this would have made their study inapplicable since it is a 'poor reflection of current practice'. The issue then, is not so much about the efficacy of guided self-help but more about their current practice. In the service in which we work, we provide self-help material for five common psychological disorders. Trained assistant psychologists are available to guide clients through these manuals; an approach which may be more representative of other services.

Only 52% of the guided self-help group seem to comply fully with their self-help programme and this figure is based on the three quarters

of the sample who provided adherence data, suggesting that it may be lower. It would be interesting to do a further analysis according to the rate of compliance. Our guess is that the results for those who complied with the guided self-help programme may be more impressive.

Their conclusion is that the guided self-help group show no additional benefits to the waiting-list group, because both groups show similar improvements. A number of studies have suggested that waiting-list samples often improve over the duration of the wait (Arrindell, 2001; Posternak & Miller, 2001). However, something that the authors of the study fail to acknowledge is that the improvement achieved through assisted self-help may be far more robust than the improvements that occur 'spontaneously' (Subotnik, 1972). This idea is supported by another study: Westbrook (1995) randomly allocated patients to two groups: one included patients who had attended a detailed intake interview and were offered self-help advice and the other group were simply placed on the waiting list without an assessment. Here, too, having an assessment before the start of the wait was the clear preference for clients, whether or not they were in the assessment group. Significantly, although there were no measurable differences at the start or end of therapy, the assessment group were far less likely to report a relapse 12 months after therapy. [Interestingly, a study by Quiring *et al*. (2002) provides evidence that the time between referral and the start of CBT can have implications for the rate of relapse 12 months after therapy, with longer waits being associated with lower rates of relapse.] The study, then, would be much more interesting if they considered the long-term benefits (and perhaps this is being done). Therefore, it could be that the article does not report any additional benefits for the self-help group because these additional benefits are only measurable much later on.

Finally, the patients who completed the assisted self-help programme reported being satisfied with it. This could have been explored more fully: perhaps they felt satisfied precisely because they felt more able to cope with their problems in the future rather than because they experienced any immediate benefit. And patients who feel that they have actively participated in the process of recovery are likely to feel more empowered, which is a very desirable outcome. Sometimes patients are wiser than their researchers.

Declaration of Interest

None.

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The Authors' reply:

The letter from Young and colleagues usefully reiterates the importance of careful interpretation of studies. We have no major disagreement with many of the points they raise, but feel that some of their points should be viewed as testable hypotheses rather than statements of fact.

We agree that our paper reports on the clinical effectiveness of one particular model of guided self-help (GSH) only. The patients included in our trial were of a severity that would routinely receive conventional psychological therapy, and the study shows that GSH may be inappropriate for this patient group. Although Young *et al*. focus on the severity of patient symptoms, there are many alternative reasons for the lack of effect observed, including the nature of the guidance offered, the skills and training of the facilitators, the nature of the materials used and the expectancies of patients on a waiting list.

It is a reasonable proposition that patients with less severe symptoms might benefit more from GSH, but it is also possible that such patients would fail to demonstrate benefit from *any* intervention beyond those improvements that would be expected over time within a control or usual care group (Friedli *et al*. 1997). The effectiveness of GSH for milder problems is an empirical question, and one that has yet to be answered definitively. It is noteworthy that ours is one of two recent UK studies that have now failed to demonstrate the effectiveness of GSH (Richards *et al*. 2003). The evidence used by NICE in its recent depression guidelines is based on studies conducted in USA settings with volunteer populations (Scogin *et al*. 1987, 1989; Bowman *et al*. 1995; Jamison & Scogin, 1995), which may be associated with higher effects than studies from more clinically representative settings (Churchill *et al*. 2002). Our study does not prove that *all* models of GSH are ineffective, and there may be a role for GSH in prevention (Willemse *et al*. 2004), maintenance and relapse prevention, or as part of collaborative care models. However, the need to provide an evidence base remains.

Although our data did show some evidence of difference in CORE scores between intervention and control groups at baseline, the analyses of outcome were adjusted for baseline values, and CORE was not the defined primary outcome.

Young *et al*. make a number of incorrect assumptions about our treatment manual and procedures. While patients in our trial all used a single GSH manual, this did contain distinct sections relating to a number of different behavioural and cognitive strategies for both anxiety disorders and depression. Moreover, the assistant psychologists were trained to link the particular nature of the patient's problem with specific, appropriate therapeutic techniques. We thus feel the difference between our trial intervention and Young *et al*.'s service may have been overstated here.

Intention-to-treat analyses are the gold standard in RCTs. Although an analysis of compliers may well have shown a larger effect, the potential for bias in such analyses means that the interpretation of such a finding would be problematic. We are not aware of any data that would suggest that the levels of compliance in our programme were so high as to be unrepresentative of routine practice of guided self-help.

We have collected data at 9 months, but the waiting-list design means that such outcomes are confounded by other psychological therapy and cannot provide a rigorous test of the effect of GSH *per se*. We agree that satisfaction is an important outcome, but decision-makers need to be aware that this may be the limit of benefit from GSH in this population.

In conclusion, we would agree that our study does not suggest that all provision of GSH is ineffective. However, the evidence base for all GSH interventions requires far more development and we hope our results will lead to the more effective targeting of this model of care towards patients who are most likely to benefit. Whether the true reason for the lack of effect in our trial is patient expectations, the nature of the guidance, the self-help materials, patient severity or a combination of these factors is currently unknown. As stated in the paper, we are currently developing a new GSH intervention using the Medical Research Council 'complex interventions' framework, and we hope that our results will serve as an impetus to others to conduct further research in this area.

Declaration of Interest

None.

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