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Guided self-help in a brave new world

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Abstract

CBT self-help (SH) offers an accessible and efficient way to treat common mental disorders. The evidence-based SH movement now has an important foothold in the healthcare arena. This article surveys the emergence of SH at a particular social and historical junction, and summarises key lessons from experimental and practice-based studies.

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At the turn of the 20th century, when psychology was a nascent discipline, Freud famously stated that the objective of psychotherapy was to transform pathological misery into ordinary unhappiness.[1] Such a glum picture seems fitting against a canvas of Victorian-era moral repression and wet war-paint from continental conflicts that would spill again in the coming decades. At the time, the yoke of human misery that had long been delegated to the clergy was shifting to different patriarchal figures: experts in medicine and psychology. Fast forward a century, and ideas about emotional suffering have changed dramatically. Human misery is seen as a quantifiable aspect of health, mental health professionals are no longer the sole arbiters of expertise, and the tools of their trade are now available to the masses. Psychological self-help has come of age in a historical junction where societal norms about individual freedom, social justice, and neoliberalism converge. Its narrative is attuned with today's ideals in Western society: misery can be fixed by science, the individual can aspire to live a fulfilling life, and the key to unlock happiness is a commodity available in the marketplace.

From a sociological perspective, the broadly defined self-help movement is facilitated by prevailing cultural narratives. But unlike the peer support, coaching and inspirational self-improvement literatures, self-help (SH) based on principles of cognitive behavioural therapy (CBT) gains traction from its impressive scientific credentials. Nearly forty years ago, Glasgow and Rosen[2] reviewed over 60 studies and case reports in which SH manuals based on principles of behaviour therapy were applied to phobias, smoking, childhood behavioural problems and other issues. They concluded that SH seemed potentially efficacious but further validation was required in clinical populations, with appropriate control conditions, longer follow-up,

and attending to predictors of treatment outcome. Since then, numerous studies heeding these recommendations have been documented in over thirty reviews and meta-analyses, covering themes such as (self-administered) bibliotherapy,[3] guided SH,[4-5] technology assisted SH,[6-7] and guided SH to prevent the onset of mental health problems.[8] There is now compelling evidence from over 50 controlled trials that CBT-based SH interventions are efficacious, particularly in relieving the acute-phase symptoms of depression and anxiety disorders and in preventing –or at least delaying– their onset. However, several important caveats are worth considering.

The efficacy of guided SH interventions has been shown to be comparable to that of individual CBT for several psychological and somatic problems.[6] By implication, SH is highly *efficient*, considering its low intensity (brief), low cost (delivered by trained coaches or lay volunteers), flexible (delivered in person, by internet, telephone, or groups) and accessible (didactic) nature. However, pooled effect sizes favouring SH over other control groups vary widely from small (e.g., ~*Hedges g* = 0.20) to moderate (~g = 0.70) in different meta-analyses, with typically moderate indices of heterogeneity. From this we can deduce that the effects of SH interventions vary considerably, raising the need to understand the factors that might account for such variability.

Some methodological explanations are that employing certain types of control groups (e.g., waitlist), inadequate concealment of random allocation, and recruiting participants from community (vs. clinical) settings tends to yield more favourable results. This observation has been raised to temper the enthusiasm with which technology-assisted SH has been promoted, since several trials of internet CBT (iCBT) have tended to recruit participants

via social media and estimates from clinical samples show more modest effect sizes.[4,7] Furthermore, low adherence to iCBT is increasingly recognised as an obstacle,[7] which suggests that clinical management is necessary in some cases. The consensus in clinical guidelines is that offering guided SH is preferable to unsupported SH, but this view is contested by others, since the type and intensity of support necessary to attain clinical improvement appears to vary across diagnoses.[5] For example, panic disorder is highly responsive to bibliotherapy, but adjunctive support is indicated for insomnia, binge eating disorder and unipolar mood disorders. Furthermore, emerging studies suggest that minimal levels of support (e.g., brief telephone contact) are comparable and possibly more effective than face-to-face guided SH. Minimal support plausibly enhances adherence to the treatment model by minimising patient-dropout and therapist-drift into unspecific or supportive counselling. Indeed, recent applications of highly structured large-group psychoeducational CBT delivered with minimal interaction between facilitators and participants yielded effect sizes that are comparable to those reported in meta-analyses of guided SH.[9]

Following the large-scale dissemination of guided SH in countries like England, Australia and Canada, practice-based studies have generated new insights about its effectiveness and limitations in routine care. Despite the standardised nature of guided SH, the effectiveness of treatment is partly influenced by the facilitator,[10] with some attaining exceptional results even if they apply the same SH model as their peers.[9] Possible explanations may be due to differences in competence and treatment-adherence among facilitators. Replicated findings in different services have also revealed a predictable pattern of treatment response.[9-10] Patients with early gains (e.g., reliable improvement) during the first 4 sessions of guided SH have the best

chance of attaining full remission of symptoms, and those who do not improve by session 6 are most likely non-responders. This observation of an *optimal dose* of treatment (4 to 6 sessions) can inform clinicians' decisions to rapidly escalate non-responders to more intensive treatments, or to extend the length of treatment for early responders in order to maximize their chance of recovery. Although this trial-and-error approach is an efficient way to assess the benefits of SH in individual cases, the advent of personalized and precision medicine research has led to important advances. Replicated studies have found that patients with specific combinations of features (e.g., severe depression plus personality disorder traits and socioeconomic disadvantages) have a high probability of dropout and poor outcomes in guided SH interventions, whereas they tend to respond favourably to more intensive psychological therapy.[11] This evidence suggests that matching patients to treatments (guided SH vs. high intensity therapy) could be an optimal way to use scarce resources in public healthcare systems. The importance of judicious treatment-matching and outcome monitoring is accentuated by the fact that very few controlled trials of SH have followed participants for 12 months or longer. Meta-analytic reviews that favour acute-phase SH interventions have reported significantly smaller effect sizes at 12 months' follow-up,[4] consistent with practice-based evidence that approximately 53% of guided SH completers relapse within the first year (mostly within 6 months) of treatment completion.[12] Taken together, these findings suggest that treatment outcomes could be improved by matching patients to treatments/therapists, using routine outcome measures to monitor progress during the acute-phase, and applying interventions to prevent relapse during the continuation-phase after initial remission of symptoms.

Based on the current state of the art, SH deserves a place at the table of healthcare interventions in a brave new world of evidence-based treatment, public ownership of knowledge and rapidly evolving technologies. It is also clear that SH has not yet deposed the role of traditional psychotherapy, at least in the treatment of more complex cases, those with recurrent disorders, and conditions like anorexia nervosa, post-traumatic stress disorder or obsessive-compulsive disorder. But these two treatment models should be seen as complementary from a population-based and stratified care perspective. In particular, SH has a unique role to play in the area of prevention, and its potential is yet to be fully realised in supporting the well-being of populations such as students, young people in social care, elderly people, people with chronic illnesses, armed forces, etc. It also has the potential to reach people in need of treatment but who might not otherwise seek formal medical or psychological input. This issue of *BJPsych*, for example, features a remarkable study by Williams et al[13] in which lay volunteers offered group SH interventions for depression in community venues, in a highly effective way. Such interventions have a tremendous impact on access to care and an important social function in the translation of scientific ideas and de-stigmatisation of mental health problems.

By the same token, it is prudent to recognise that prevailing cultural ideals also permeate the subtext of SH interventions which promise to enable people to “live their life to the full”, or to “beat the blues”. This modern optimism and cultural primacy of the individual are palpable in the new marketplace of (largely unregulated) well-being apps and internet programmes that boldly promise solutions to most human misfortunes. This over-optimistic stance does not seem so pernicious until we realise that it blurs the boundaries between psychopathology and ordinary unhappiness,

which is often influenced by wider cultural, relational, and socioeconomic determinants. A cautionary tale can be found in the proliferation of commercial *mindfulness* products that offer solutions to miscellaneous health, interpersonal and occupational problems, commodifying a watered-down version of Eastern philosophy with tenuous links to science. The evidence-based SH movement has undoubtedly stamped an enduring footprint in the field of mental healthcare; its future advancement and integrity hinge on its commitment to scientific rigour, cautiousness, and ideological impartiality.

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