

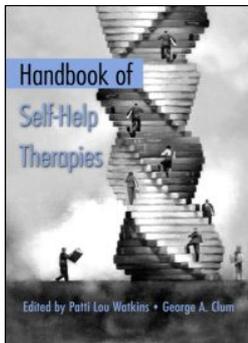
This article was downloaded by: 10.3.98.14

On: 24 Apr 2017

Access details: *subscription number*

Publisher: *Routledge*

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: 5 Howick Place, London SW1P 1WG, UK



Handbook of Self-Help Therapies

Patti Lou Watkins, George A. Clum

Self-Help Interventions

Publication details

<https://www.routledgehandbooks.com/doi/10.4324/9780203935439.ch3>

George A. Clum

Published online on: 28 Nov 2007

How to cite :- George A. Clum. 28 Nov 2007 ,*Self-Help Interventions from: Handbook of Self-Help Therapies* Routledge.

Accessed on: 24 Apr 2017

<https://www.routledgehandbooks.com/doi/10.4324/9780203935439.ch3>

PLEASE SCROLL DOWN FOR DOCUMENT

Full terms and conditions of use: <https://www.routledgehandbooks.com/legal-notices/terms>.

This Document PDF may be used for research, teaching and private study purposes. Any substantial or systematic reproductions, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The publisher shall not be liable for an loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

CHAPTER 3

Self-Help Interventions

Mapping the Role of Self-Administered Treatments in Health Care

GEORGE A. CLUM

The last 30 years have witnessed the publication of a torrent of books aimed at transforming the average American citizen into a successful business and financial entrepreneur who is at once thin, muscular, fit, free of illness and disease, and content with life. This transformation is to be achieved at the hands of none other than the average citizen herself, for the vehicle that will provide this metamorphosis is the self-help book or program in the hands of this same citizen. In the health arena, this change guru might be someone who has personally overcome disease or disorder or who has systematized an approach whose change formula will help sufferers overcome their deficiencies. The number of books dedicated to this enterprise has expanded to the point where the *New York Times* provides a separate rating system of the most successful. Clearly, the self-help book has become a major factor in the domain of self-improvement.

The assumption of the majority of these books is that the success stories detailed within will provide the motivational prod to stir the consumer to action and that, once so stirred, the technology advocated will be employed and the intended change produced. The extrapolated message is obvious: "I've been able to do it. Follow my formula and you will too!" or "I've shown that this formula has transformed others. Use it and transform yourself!" Almost without exception, the purveyors of change have failed to examine whether

their formula has in fact been read, understood, digested, and implemented, much less whether that implementation has produced the intended change. The author's obligation terminates with the provision of the formula.

More determined or more responsible purveyors of change have begun to ask, and attempt to answer, a series of questions related to their formulas. Who reads, watches, or listens to their message? Is receiving the message sufficient to produce change or must the formula for change actually be applied? What level or degree of application is sufficient to produce change? Are all parts of the formula equally important or even relevant? Can the reader, for example, identify more personally relevant segments, apply only those segments, and experience a level of change identical to that produced by someone who has digested and applied all segments? Are multiple formulae equally successful—do readers simply need a formula and any formula will do?

The present chapter begins by examining similarities and differences in the process encountered in accessing the more general health system and in accessing the self-help arena. A number of discrepancies are noted between how self-help materials are typically accessed and utilized and how the general health system works, discrepancies that may be cause for concern. One of those discrepancies in the self-help arena involves the lack of formal diagnosis prior to selecting a self-help remedy. Trends in the scientific study of self-help are then examined to provide insights into how this area is growing and where deficiencies may lie. Next examined is the overall effectiveness of self-help materials, as revealed in meta-analytic studies summarizing their effectiveness. In this section, estimates of the overall effectiveness of self-help approaches are examined as assessed by dropout rates, treatment outcome comparing self-help to both wait-list and therapist-administered treatments, and long-term outcomes. Where possible, specific comparisons are made between effectiveness rates for self-administered treatments and therapist-administered treatments for specific disorders. Next addressed was the place of self-help treatments in the health arena. In this context we examine the conditions under which self-help treatments could be used as a stand-alone treatment and when their use as an adjunctive treatment should be recommended. Specific approaches to stepped-care models are examined as part of this debate. The chapter concludes by examining the importance of assessment of change for answering a variety of questions on overall treatment effectiveness and changes in treatment tactics linked to expected rates of change for target problems.

Parallels to Help-Seeking in the Health Arena

In the health arena, people seek help when things go wrong—they feel bad (symptoms), notice that something has changed in how their body functions

(signs), or receive information that their symptoms or signs deserve further examination. If the object of their attention is behavior—smoking, eating, drinking—individuals usually do not consult experts to diagnose the problem, though their attention may be aroused if someone has labeled their behavior “addicted” or the consequences of their behavior “obese.” Problem definition, as this phase is called, can be either self- or other-identified. If the problem in question requires specific definition, the sufferer may seek an expert opinion to provide a diagnosis. In the mental health arena, diagnosis is a complex process that involves not only definition of the identified signs and symptoms, but also definition of additional/accompanying conditions, officially termed comorbid conditions, that may contribute to, complicate, and be associated with the presenting problem that prompted the health search. The process of accurately defining the target problem(s) has been largely ignored in the self-help domain and is a major source of concern for both researchers and authors of self-help materials. Self-help programs designed to treat depression, for example, assume that the problem to be targeted is indeed depression and not another physical disorder with a symptom picture similar to depression. Obviously, a self-administered change program applied by an individual to a problem that does not exist will not work and is also likely to have unintended consequences—not receiving treatment for the disorder that does exist, for example. Individuals who suffer from severe levels of the disorder in question or who have complicating comorbid conditions, e.g., substance dependence *and* depression, may not realize that the self-help program being employed was never intended to be applied to individuals with their level of disorder.

Once a problem is diagnosed, the health expert may turn her attention to what causal factors are involved. At the molar level, this determination might include examining the individual’s history for evidence of significant losses or stressors or conducting a lab test to determine thyroid function. The medical treatment recommended would hinge on the formulation of what was causing the depression. Differences in causal formulations also exist within the psychological domain. While professionals are aware of these differences and may prescribe different treatments depending on these formulations, purveyors of self-administered therapies typically advocate for one specific approach. Discriminations between causal agents are considered unimportant or their importance is ignored. This one-size-fits-all approach is applied indiscriminately by the consumer who is likely unaware that different formulations exist. If improvement does not follow upon application of the program, the user is likely to conclude “The program is worthless!” or “I’m worthless for failing to make the program work for me,” as opposed to the determination that “This program was not designed for my specific needs.”

44 • Handbook of Self-Help Therapies

In the health arena, once a specific treatment for the specific problem is applied, its effectiveness is evaluated. Simply put, the sufferer and the health expert determine whether change occurs. This phase of the intervention is often incorporated into many self-help programs. Various self-administered assessment instruments are often provided and the consumer is encouraged to assess his progress, or lack thereof, on a regular basis. What is not known in the self-help arena is what happens to those people who have not responded to the self-help program. Do they abandon it? Do they try harder? Do they jettison that approach and call their physician or seek other professional services? Information on the fate of failed self-helpers would be useful in recommending changes to the self-administered treatment protocols.

Positioning Self-Help Treatments in the Health Arena

In one sense, the people have voted and self-help materials occupy a place of prominence in the pantheon of treatments for mental health problems. According to Amazon.com, 81,796 self-help books were available to help negotiate life's shoals as of October 2006. Advice on how to deal with specific problems included 522 books on depression, 398 on anxiety, and 425 on various addictions. Children merited 1429 self-help books of their own. One book proclaimed that it was the last self-help book one would ever need. The very fact that so many choices exist is part of the problem because there is little in the way of guidance to help individuals decide which books might be useful for their particular problem, much less specific data on which are effective and which are not.

Were it known which books were effective, a related issue involves how to position self-help materials in the health arena. One possibility is to offer such materials as an alternative to or as an adjunct to professional advice and help. In this scenario, self-help materials would be used very much as they are today. That is, authors would offer various forms of advice, which would be purchased in the marketplace and utilized with various levels of success. Used in this way, self-help programs are only an informal part of the health system, whose impact is difficult, if not impossible, to gauge.

Another approach is to offer self-help materials more formally, as part of the overall process of evaluation and diagnosis by primary and secondary health professionals. Used in this way, individuals with yet-unidentified specific problems would enter the health care system seeking help for signs or symptoms of concern. A formal evaluation would then be conducted and individuals assigned to an appropriate treatment, in some cases a stand-alone self-administered treatment (SAT), in others a therapist-enhanced SAT, in still others treatment provided by a professional. Improvement (or not) would be carefully monitored to determine whether

the SAT was proving effective. Essentially, all of the SATs examined in this book utilized this approach. Because all SATs were examined as part of a study, a formal evaluation was conducted to determine whether individuals met the criteria for inclusion in the study. Only then were they assigned to an SAT condition, wherein they were carefully evaluated at, minimally, posttreatment. In a very real sense, what we know about the effectiveness of SATs is based totally on individuals who have received SATs within this model.

Patterns in the Study of SAT Effectiveness

Next examined was the growth of treatment outcome studies of the effectiveness of SATs over the last 30 years. An increase in the number of outcome studies was expected for several reasons: (a) Attention was drawn to the study of the effectiveness of SATs by Glasgow and Rosen's (1978) and Rosen's (1987) articles on the need for such studies as well as the dearth of studies conducted up to the time their papers were written; (b) several meta-analyses (Gould & Clum, 1993; Marrs, 1995) were written, also publicizing the importance of and need for such studies; (c) the growth of the number of books and tapes on self-help approaches was growing rapidly; and (d) a rapid increase in the use of the Internet by the public and a rapid increase in the number of self-help approaches available on the Internet all pointed to the need for such studies.

To illustrate whether this expected proliferation of studies materialized, we examined the references for a number of review and meta-analytic-review studies for eight different target problems (an approach admittedly not leading to an exhaustive review of the literature). We grouped these studies in 5-year increments for the last three decades. These results are shown in Table 3.1. A number of trends stand out in this table. The most obvious trend is that, in spite of an increase in the number of such studies in recent years, there has clearly been no proliferation of research in this area. This conclusion accords with that of (Chapter 2 in this text), who argue that the case for the effectiveness of most self-help offerings in the health arena simply has not been made. There has, however, been a clearly increasing trend in the number of such studies, with a doubling in each successive decade over the previous decade. This increase in controlled outcome studies does seem to have been spurred by the high-profile reviews of this research area. The number of controlled evaluations of Internet-based interventions, on the other hand, has been limited.

A second trend to be seen in the completed studies is that researchers are increasingly willing to evaluate SATs for more difficult mental health problems. For example, studies on the effectiveness of SATs for eating

46 • Handbook of Self-Help Therapies

Table 3.1 Summary of the Number of Controlled Studies Evaluating SATs for Specific Target Problems Over a 30-Year Period

Target problem	5-Year period					
	75–79	80–84	85–89	90–94	95–99	00–04
Eating disorders			1	3	10	12
Sexual dysfunctions	5	4	3			1
Insomnia	1		1	2	2	3
Problem drinking			2	1	3	8
Cigarette smoking		2	1	2	9	1
Depression		3	2	2	6	5
Anxiety disorders	3	1	3	8	7	6
Childhood problems	1	1	1	3	6	1
Totals	10	11	14	21	43	37

disorders has increased greatly in the last decade, this in spite of the fact that eating disorders have been considered difficult to treat and sufferers both resistant to talk about their problems and to take action to change them. In a similar vein, problem drinking and depression both have seen a significant increase in the number of studies that have evaluated the effectiveness of SATs. The belief that therapists must be employed to overcome low levels of motivation of these target populations is being challenged by the success of the evaluated programs. The type of anxiety disorders being targeted has also shifted. In the early part of this 30-year period, speech anxiety and phobias were the target problems. More recently, panic disorder, agoraphobia, obsessive–compulsive disorder, and posttraumatic stress disorder have all been targeted, mostly successfully. This willingness to tackle mental disorders of known difficulty has consistently been preceded by the development of an effective treatment approach that is delivered by a therapist. This sort of progression makes sense, because the technology for delivering treatments already exists and simply awaits the development of content shown to be effective.

Effectiveness of Self-Administered Treatments

The determination of whether SATs are effective must be approached by providing answers to several questions and by drawing parallels to the psychotherapy outcome literature. Recent answers to the question of whether psychotherapy is effective have specified the importance of comparing specific treatments with different control groups, including

wait-list (WL) and placebo (PL) controls, and the determination of whether specific treatments for any given disorder or problem yield different outcomes than do other treatments. In the domain of SATs, the questions addressed to date include: (a) whether SATs are more effective than no treatment or WL; and (b) whether SATs are equivalent to treatments offered in individual or group therapy formats (hereafter referred to as therapist-directed treatments [TDTs]). Other questions addressed are whether more individuals drop out of SATs as compared to TDTs and whether any improvements realized are stable over time. A further question is whether effectiveness rates differ depending on the type of problem that is being addressed.

To begin to answer these questions, the literature was examined for meta-analytic summaries of the effectiveness of SATs and TDTs, both for the general outcome literature and for specific disorders/problems. Meta-analytic summaries were chosen for comparison because they offer the best hope of making valid comparisons. These comparisons were further standardized by examining only those effect sizes (ESs) that compared SATs and TDTs to no treatment or WL groups, a decision necessitated by the almost exclusive use of such comparison groups in studies of the efficacy of SATs.

The first question addressed is whether individuals who enter studies that evaluate the effectiveness of SATs do not tolerate the approach being offered and drop out of treatment. Such dropouts could occur for a variety of reasons, including preference for seeing a live therapist or taking medication, failure to see the relevance of the selected SAT to the identified problem, a desire to sample the material rather than consume it in its entirety, or unwillingness to comply with assorted exercises offered in the self-help material. Rosen, Glasgow, and Barrera (1976) identified a number of examples of study participants who failed to conduct exercises, complete the entire treatment package, or dropped out of the study altogether. The question of compliance and how it relates to outcome will be addressed in a later section. The question of what the frequency of study dropouts is from SATs, however, was evaluated by Gould and Clum (1993) in a set of 40 studies. These authors reported that, in the studies that presented such information, the dropout rate was 9.7% for individuals receiving the SAT and 8.6% for individuals in the control condition. This estimate is comparable to the dropout rate of 10% of treated individuals and 9.2% of controls reported by Shapiro and Shapiro (1983) in their meta-analysis of psychotherapy studies where treatment was administered by a therapist. These results indicate that SATs are well-tolerated within the context of outcome studies in which individuals are formally enrolled.

A more recent analysis of dropout rate in SATs was conducted by Hirai and Clum (2006) for individuals seeking help for anxiety problems. These authors reported a dropout rate of 12.3% for individuals in SATs during the treatment period. Individuals dropped out while in the control conditions at somewhat higher rates, with 11.3% of individuals in WL groups, 13.4% in placebo groups, and 18.0% in minimal treatment groups dropping out during the intervention phase of the study. These results support the contention that participation in SATs is well tolerated and that individuals perceive the viability of the approach being offered.

The next question addressed concerns the level of treatment effectiveness of SATs. Several comprehensive meta-analyses have been conducted of the SAT literature, with overall estimates of effectiveness as measured by ESs for comparisons of SATs and WL/no treatment controls ranging from .57 (Marrs, 1995) to .87 (Gould & Clum, 1993). Given that SATs that have been empirically examined almost exclusively utilized cognitive-behavioral treatment (CBT) approaches, prudence requires that the above results be compared with the general effectiveness of CBT treatments delivered by trained experts. Bowers and Clum (1988) conducted such a meta-analytic study, evaluating 69 treatment studies that compared the effectiveness of therapist-administered CBTs to a placebo or attention-control group, with a subset of 40 studies that also utilized a no treatment or WL control. The overall ES comparing TDTs to WL was .76, while the overall ES comparing TDTs to placebo controls was .55. The estimates of ESs from the two general meta-analyses of SATs compare favorably with these estimates of effectiveness for TDTs. Several caveats exist for these comparisons. The Bowers and Clum study was conducted using treatments available 10 years prior to those evaluated in the meta-analytic summaries of SAT effectiveness. Given that SATs are based on standard CBT treatments for various disorders, improvements in treatments could be expected over that 10-year period. Such improvements would then be mirrored in the SATs, which, even when self-administered, could prove superior to older, less sophisticated approaches. In addition, summaries of treatments not aggregated by type of problem may pose additional problems. Gould and Clum (1993), for example, found that treatment effectiveness varied by type of target sample, with anxiety problems being more effectively treated with SATs than depression or habit disturbances. A more valid comparison, therefore, would examine the effectiveness of SATs and TDTs for the same type of target problem.

Accordingly, we next compared treatment effectiveness for different diagnostic groups/target problems. Table 3.2 summarizes these comparisons. An examination of the ESs for SATs indicates that the treatment effects may be described as highly variable, varying from small to large,

Table 3.2 Comparisons of Summary ESs for SATs and TDTs for Specific Types of Target Problems at Posttreatment

Target problem	Type of treatment approach	
	SATs	TDTs
Posttraumatic stress disorder	.45	1.26
Panic disorder/agoraphobia	.56	.87
Generalized anxiety disorder	.92	.82
Depression	.83	.73
Smoking	1.28	1.88
Alcohol abuse	.15	.37

using a standard for ESs developed by Wolf (1986). Thus, SATs are effective for a wide variety of mental health problems, when compared to WL controls, but this effectiveness varies in degree. Moreover, variations in the level of effectiveness mirror somewhat closely variations for TDTs for similar problems. For example, as indicated in Table 3.2, the lowest ESs, whether therapist-directed or self-administered, are for alcohol abuse problems, while the highest ESs are for smoking cessation. Moderate treatment effects are found for both TDTs and SATs for most of the anxiety disorders and depression.

A more accurate determination of whether SATs have approximately the same level of effect or are substantially less effective than TDTs comes from direct comparisons between these two venues in the same study. In these comparisons, more confidence can be placed in the outcomes because individuals with similar levels of the target problem are being treated in both groups. Fewer studies have been conducted that permit these types of comparisons. When they do exist, however, they are instructive. Hirai and Clum (2006), for example, evaluated such comparisons in individuals with various anxiety problems. In these comparisons, TDTs were clearly more effective for specific phobias, social anxiety, posttraumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD). Similar outcomes were found for panic disorder/agoraphobia and test anxiety. Differences in effectiveness between the two venues were also reported by van Lankveld (Chapter 9 in this text) in the treatment of sexual dysfunctions. van Lankveld reports equal efficacy between SATs and TDTs for problems of premature ejaculation but more efficacy for TDTs for problems of orgasmic dysfunction, especially in women.

Also lacking in the SAT effectiveness literature are follow-up studies that evaluate the duration of treatment effects. In the general meta-analysis by Gould and Clum (1993), only 12 of 40 studies conducted follow-up

assessments in a form that allowed the determination of ESs. The ES for those 12 studies was .53, a moderate effect, and compares with an Es of .66 for these same 12 studies at posttreatment. These results suggest that the treatment effects were fairly stable, with some attenuation of the level of improvement. The stability of outcomes varies by type of target problem. Fairly stable results over time exist for social skills and headaches, variable results for smoking, and attenuation of treatment gains for weight loss and depression. Such comparisons are based on very few studies, however, and must be considered tentative. More recent meta-analyses of specific subsets of problems have yielded more reliable results, although based on a limited number of studies. Of 24 studies that compared the effectiveness of SATs to WL controls in the treatment of anxiety disorders, only 7 examined efficacy in a follow-up period. Of studies that compared SATs and TDTs in this same meta-analysis, 11 of 17 studied the comparative effects in a follow-up period. Hirai and Clum (2006) reported that treatment effects tended to be stable in the follow-up period and that differences between SATs and TDTs narrowed. Van Lankveld (Chapter 9 in this text), on the other hand, found that the effects of SATs for sexual dysfunctions tended to be short-lived, with problems in orgasmic dysfunction and pain during sexual activity reverting to levels extant prior to the start of treatment. Again, a caveat must be issued, as most of the SATs studied to date have used very brief follow-up periods to determine the stability of outcomes, with maximum periods infrequently exceeding 6 months.

In summary, individuals who enter treatment studies knowing that one of the approaches offered might be an SAT have dropout rates similar to those for individuals who enter treatment studies knowing that they will either be placed in a TDT or a control condition. Once assigned to an SAT, individuals tend to remain in treatment. For those individuals who complete SATs, outcomes are in the moderate range when compared to WL or placebo but tend to be somewhat less when compared to a TDT. This latter conclusion varies depending on the type of target problem, however, with SATs equivalent to TDTs for some disorders.

Moreover, relapse rates after treatment suggest that the effects of many SATs are stable. Once again, however, stability of effects varies depending on the type of problem being addressed.

Integrating SATs in the Delivery of Treatments for Health Problems

The principle question to be addressed here is whether any SATs have demonstrated sufficient efficacy to warrant their prescription for dealing with any health problems. A related question is how SATs are to be used in the treatment armamentarium—only adjunctively with other treatments

offered by a professional, as a first step in a stepped-care approach, or as a stand-alone treatment. Also critical is the question of whether the most familiar approach to using SATs should be employed (i.e., prescribing an empirically validated book, tape, or Web-based intervention) or whether modifications should be recommended in how SATs are utilized (e.g., with regular therapist follow-up and only in the context of an established health care system).

Arguably, those SATs that have shown empirical equivalence to TDTs can be recommended as stand-alone treatments. SATs that are effective compared to WL but less effective than TDTs, on the other hand, would be considered the first step in a stepped-care approach. Stepped-care can be defined as “lower-cost interventions (that) are tried first, with more intensive and costly interventions reserved for those insufficiently helped by the initial intervention” (Haaga, 2000, p. 547). Cognitive behavioral treatment approaches, especially when delivered in group format, have been found to be more cost-efficient for panic disorder (PD) than pharmacologic interventions (Otto, Pollack, & Maki, 2001). Thus, stepped-care interventions might involve SATs alone, SATs in combination with individual or group therapy interventions, psychotherapy alone, and pharmacologic agents. In a special section published in the *Journal of Consulting and Clinical Psychology* devoted to examining stepped-care approaches to psychotherapy, a series of experts recommended SATs or SAT-augmented treatments for generalized anxiety disorder (GAD; Newman, 2001), PD (Otto et al., 2001), eating disorders (Wilson, Vitousek, & Loeb, 2001), and alcohol problems (Sobell & Sobell, 2000).

While SATs have been found effective for a number of diagnosable problems, solutions for implementing their use in stepped-care approaches have yet to be resolved. One approach would be to develop predictive models for who responds to SATs, TDTs, and pharmacotherapies. Differential assignment to these treatments would require different predictive models, a requirement that may prove elusive, given Otto et al.’s (2000) experience with predicting treatment response in individuals with PD. These authors report that severity and comorbidity predict outcome regardless of the treatment venue.

In contrast, Sobell and Sobell (2000) recommend an approach in which assignment to venue of treatment is based on clinical judgment and would include such variables as severity of the problem, the presence of suicide ideation, and the patient’s preferences for and biases toward treatment. Decisions to continue or change treatment approaches would be based on evaluations that reflect progress or not. The requirement of involving experts from the beginning of treatment has the added benefit of ensuring that the recommended treatment approach fits the problem definition.

When used adjunctively to individual or group-administered treatments, SATs have another benefit; i.e., they can be used once treatment is over as a reference guide for what to do in case of setbacks or relapse. This approach would reduce therapist time requirements and provide support for the individual's efficacy for solving the problem alone.

Feedback Approaches for Enhancing Outcome

SATs, whether delivered via books or computer-assisted programs, often incorporate continuous assessments to check on progress or the lack of progress. Stepped-care approaches require the use of constant monitoring to determine whether progress is occurring or whether a shift to more traditional treatments is required. As examined to date, SATs have utilized assessments to provide feedback to the individual being treated and to the individual conducting the study to assist with treatment planning.

Feedback mechanisms regarding the progress of individuals in treatment serve to enhance treatment outcome (Chapter 4 in this text). This is true whether the feedback is provided to the individual in treatment or to the therapist working with the individual. In both cases, the mechanisms for producing change are likely similar. Feedback to the individual in treatment informs the individual of her progress, or lack thereof. If informing the individual of progress, feedback serves as both a reward and as information that the individual is acting in ways to produce treatment gains. If informing of lack of progress, feedback serves to motivate and to help the individual change direction and attempt other approaches. Feedback to the therapist may have similar effects. This possibility was explored in a study by Lambert, Hansen, and Finch (2001), who compared the results of a simple feedback system that used color-coding to identify progress and to make simple change-no-change in treatment plan recommendations. Therapists who received such feedback produced more cases with clinically significant change than did therapists not receiving feedback. Other therapist feedback systems have similar goals but their effectiveness has not been evaluated. Ideas regarding how to use feedback in SATs can be gleaned from research on feedback with TDTs.

In spite of the lack of validating data, Lambert (2001) identified a beginning trend to evaluate individual treatment progress as an approach likely to enhance psychotherapy outcomes. In his discussion of this important area, he noted that psychotherapy outcome research has evolved from efficacy research, which establishes differential treatment outcomes for specific modalities under controlled conditions, to effectiveness research, which establishes the effectiveness of various treatment approaches on the front lines, where treatment is being accomplished with individuals of complex

diagnostic configurations. More recently, assessing treatment outcomes has been expanded to include evaluating the progress of individuals, in comparison to predicted pathways based on normative data.

In one such model, reported on by Lueger, Howard, Martinovich, Lutz, Anderson, and Grissom (2001), individuals were compared to three dosage levels of outcome and three phases of outcome to determine where they were in terms of psychotherapeutic progress. Howard, Kopta, Krause, and Orlinsky (1986) reported that 50% of patients improved after 8 sessions, 75% improved after 26 sessions, and 85% reached an asymptote after 60 sessions. Variability in this pattern was produced by variations in diagnoses, symptoms, and interpersonal problems. The rate of patient improvement was slower in a study by Anderson and Lambert (2001), who reported that 50% of patients needed 13 sessions of psychotherapy before reporting clinically significant change. Using a phase model to describe how therapy progresses, Howard, Lueger, Maling, and Martinovich (1993) reported three distinct phases—increases in subjective well-being (remoralization), symptom reduction (remediation), and recovery of life functioning (rehabilitation). Improvement in remoralization occurred mostly around the 2nd session, remediation around the 6th session, and life functioning around the 10th session. Deviations from this progression have been linked to less successful treatment outcomes.

Feedback systems such as described in these studies of psychotherapy processes have not been systematically incorporated into therapist-assisted treatments or SATs. The potential for doing so, however, is considerable. Self-help books frequently include a variety of assessment devices with instructions to chart progress on a regular basis. A variety of online programs exist that conduct basic assessments that help individuals identify the types of problems they may have, with recommendations to check such assessments with their therapist or to proceed to the online treatment. Online assessments are capable of much more, given that repeat assessments are relatively easy to perform, as are graphs illustrating change over time. As an example, panicsolutions.com offers a real-time feedback report for individuals who want to evaluate their pre- and posttreatment panic profile and compare themselves to individuals who have completed a self-administered treatment program. Because this assessment incorporates evaluations of the principle symptom domains of PD, coping strategies, and efficacy for performing coping strategies, users of the program can evaluate themselves on factors predictive of and representative of treatment change. Therapists who utilize this system can receive regular updates on their clients' progress. Roodman (1996), in an unpublished study, evaluated a feedback system based on this profile and delivered either in person, by a therapist, or by mail. When compared to assessment only, differential

improvement was found for the feedback groups on frequency of full and limited-symptom panic attacks.

Using established assessments for different disorders, the effectiveness of SATs could be examined and rates of change compared. As with the studies completed for TDTs, such assessments could help determine whether change continues to occur or whether an asymptote has been reached. Decisions could then be made to utilize another self-help modality or to switch to a TDT or pharmacologic agent. Participants in the program would also have access to such data and could be a part of the decision process.

Summary and Conclusions

The present chapter began with an evaluation of the scope of self-help approaches to problems of medical and psychological relevance in present-day American society. While the use of various self-help approaches is both undeniable and vast, much less information is available on the effectiveness of these approaches. One of the chief difficulties encountered in examining the role of SATs for reducing health problems in our society is that no information exists as to how individuals identify the problems to be addressed, whether the identified problems exist in a form that can be targeted by SATs, how or whether such self-help vehicles are utilized, and whether any change takes place.

As an alternative to the way in which SATs are currently consumed, an alternative approach was identified, one that parallels how SATs have been evaluated in the scientific literature. In this approach, SATs are considered to have a potentially important role in society's overall approach to health problems. Such a role recognizes the treatment validity of some approaches and calls for the development and testing of others. Critical to the employment of such approaches is the formal diagnostic process that typifies the medical/psychological treatment process when individuals access formal health care modalities. It is not expected that such an approach would replace the current way in which self-help treatments are used, but rather that it would augment the current approach.

For SATs to be incorporated into the current health system, it must first be established that they are in fact effective. Also requisite is the determination of the level of effectiveness. Accordingly, the literature on effectiveness was selectively sampled to provide a sense of the levels at which effectiveness has been tested and the levels of effectiveness so far established. Generally speaking, the number of studies is still low but the frequency with which such approaches are being examined is accelerating. Evidence collected so far paints a picture of a small cadre of approaches

validated for a growing number of specific health problems. Furthermore, the evidence suggests that the approaches targeted to date are well tolerated, moderately effective, and generally stable in their effects. Moreover, an examination of the outcome studies that have been conducted leads to the inevitable conclusion that the only information available on effectiveness exists in the context of studies completed after both a thorough evaluation of the problem to be addressed and careful monitoring of the progress found.

Next addressed was the use of SATs in a stepped-care approach to medical and psychological problems. The stepped-care approach, when applied to SATs, is basically a conceptualization of the possible roles SATs could have relative to other treatment approaches. The recommendation was made that SATs could be a valuable first step when their validity has been established and when they are clearly inferior to TDTs. SATs would have alternate treatment status when they were found equivalent to TDTs in treatment effect. Regardless of the history of effectiveness determined in past studies, an important feature of the stepped-care approach is continuous monitoring of the individual's progress for the approach selected. Regular monitoring of treatment progress is considered essential to the determination of treatment effectiveness in the community setting, having established treatment efficacy in controlled studies.

Another approach for the use of continuous assessment of SAT effectiveness was found in a set of studies used to establish norms for change in mental health problems, regardless of the psychological treatment approach employed. This approach seeks to identify common processes across theoretically different treatment approaches as well as to identify typical time periods for patient involvement in each of those processes. While not yet employed in SAT research, the promise exists for finding common therapeutic elements as well as for estimating the time required for various types of change using SATs.

Chapter Points

- The first step in addressing health problems within the health care system is diagnosis, a step often omitted in seeking self-administered solutions to problems.
- Also missing in the application of self-help remedies is an understanding of specific connections between causal factors and the identified problem, a gap that may reduce successful treatment of the problem.
- The place of SATs in the total approach to health delivery systems is largely undefined. The current role of SATs is largely informal,

with neither access nor use tied to diagnosed problems, except when recommended by a health care professional.

- More formal integration of SATs into the health care system is possible. The extant body of empirical literature evaluating the effectiveness of SATs illustrates how formal incorporation of such approaches might work.
- Empirical studies of the effectiveness of SATs has been increasing, as have investigations of more difficult and complex mental health problems.
- The effectiveness of SATs has been demonstrated for a number of different problems, while the level of effectiveness parallels that for TDTs. SATs will continue to be used informally but also might be formally incorporated into the health care system as both stand-alone treatments and as the first step in stepped-care approaches.
- The formal use of SATs requires ongoing assessment of progress, a procedure that both enhances outcome and improves the likelihood of selecting the best treatment approach.

References

- Anderson, E. E., & Lambert, M. J. (2001). A survival analysis of clinically significant change in outpatient psychotherapy. *Journal of Clinical Psychology, 57*, 875–888.
- Bowers, T., & Clum, G. A. (1988). The relative contribution of specific and non-specific treatment effects: analysis of placebo-controlled behavior therapy research. *Psychological Bulletin, 103*, 315–323.
- Bradley, R., Greene, J., Buss, E., Deetra, L., & Westen, D. (2005). A multi-dimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry, 162*, 214–227.
- Cuijpers, P. (1997). Bibliotherapy in unipolar depression: A meta-analysis. *Journal of Behavior Therapy and Experimental Psychiatry, 28*, 139–147.
- Glasgow, R. E., & Rosen, G. M. (1978). Behavioral bibliotherapy: A review of self-help behavior therapy manuals. *Psychological Bulletin, 85*, 1–23.
- Gould, R. A. & Clum, G. A. (1993). A meta-analysis of self-help treatment approaches. *Clinical Psychology Review, 13*, 169–186.
- Haaga, D. A. F. (2000). Introduction to the special section on stepped care models in psychology. *Journal of Consulting and Clinical Psychology, 68*, 547–549.
- Hirai, M., & Clum, G. A. (2006). A meta-analytic study of self-help interventions for anxiety problems. *Behavior Therapy, 37*, 99–111.
- Howard, K. I., Kopta, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose effect relationship in psychotherapy. *American Psychologist, 51*, 159–164.
- Howard, K. I., Lueger, R. J., Maling, M. S., & Martinovich, Z. (1993). A phase model of psychotherapy outcome: Casual motivation of change. *Journal of Consulting and Clinical Psychology, 61*, 678–685.

- Lambert, M. J. (2001). Psychotherapy outcome and quality improvement: Introduction to the special section on patient-focused research. *Journal of Consulting and Clinical Psychology, 69*, 147–150.
- Lambert, M. J., Hansen, N. B., & Finch, A. E. (2001). Patient focused research: Using patient outcome data to enhance treatment of fear. *Journal of Consulting and Clinical Psychology, 69*, 159–172.
- Lueger, R. J., Howard, K. I., Martinovich, Z., Lutz, W., Anderson, E. E., & Grissom, G. (2001). Assessing treatment progress of individual patients using expected treatment response models. *Journal of Consulting and Clinical Psychology, 69*, 150–159.
- Marrs, R. W. (1995). A meta-analysis of bibliotherapy studies. *American Journal of Community Psychology, 23*, 843–870.
- Mitte, K. (2004). A meta-analysis of the efficacy of psycho- and pharmacotherapy in panic disorder with and without agoraphobia. *Journal of Affective Disorders, 88*, 127–145.
- Mojica, W. A., Suttorp, M. J., Sherman, S. E., Morton, S. C., Roth, E. A., Maglione, M. A., et al. (2004). Smoking-cessation interventions by type of provider: A meta-analysis. *American Journal of Preventive Medicine, 26*, 391–401.
- Newman, M. G. (2000). Recommendations for cost-offset model of psychotherapy allocation using generalized anxiety disorder as an example. *Journal of Consulting and Clinical Psychology, 69*, 549–556.
- Otto, M. W., Pollack, M. H., & Maki, K. M. (2000). Empirically supported treatments for panic disorder: Costs, benefits and stepped care. *Journal of Consulting and Clinical Psychology, 69*, 556–564.
- Robinson, L. A., Berman, J. S., & Neimeyer, R. A. (1990). Psychotherapy for the treatment of depression: A comprehensive review of controlled outcome research. *Psychological Bulletin, 108*, 30–49.
- Roodman, A. A. (1996). *A test of the effects of assessment and feedback on individuals with panic attacks*. Unpublished master's thesis, Virginia Tech., Blacksburg, VA.
- Rosen, G. M. (1987). Self-help treatment books and the commercialization of psychotherapy. *American Psychologist, 42*, 46–51.
- Rosen, G. M., Barrera, M., & Glasgow, R. E. (2007). Good intentions are not enough: Reflections on past and future efforts to advance self-help. In P. L. Watkins & G. A. Clum (Eds.) *Handbook of self-help therapies* (pp. 25–39). New York: Routledge.
- Rosen, G. M., Glasgow, R. E., & Barrera, M. (1976). A controlled study to assess the clinical efficacy of totally self-administered systematic desensitization. *Journal of Consulting and Clinical Psychology, 44*, 208–217.
- Shapiro, D., & Shapiro, D. (1983). Comparative therapy outcome research: Methodological implications of meta-analysis. *Journal of Consulting and Clinical Psychology, 51*, 42–53.
- Sobell, M. B., & Sobell, L. C. (2000). Stepped care as a heuristic approach to the treatment of alcohol problems. *Journal of Consulting and Clinical Psychology, 69*, 573–580.
- van Lankveld, J. J. D. M. (1998). Bibliotherapy in the treatment of sexual dysfunctions: A meta-analysis. *Journal of Consulting and Clinical Psychology, 66*, 702–708.

58 • Handbook of Self-Help Therapies

- Westen, D., Novotny, C. M., & Thompson-Brenner, H. (2004). The empirical status of empirically-supported therapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin*, *130*, 631–663.
- Wilson, G. T., Vitousek, K. M., & Loeb, K. L. (2000). Stepped care treatment for eating disorders. *Journal of Consulting and Clinical Psychology*, *69*, 564–573.
- Wolf, F. M. (1986). *Meta-analysis. Quantitative methods for research synthesis*. Beverly Hills, CA: Sage.