

Chapter 2

The Self-Help Movement in Mental Health: From Passivity to Interactivity

Introduction

This chapter expands and updates on Norcross' (2006) original proposal to integrate self-help with psychotherapy through the reading of self-help books, autobiographies, and viewing of relevant self-help films. This relatively passive approach can be expanded with active and interactive SH interventions in promotion, prevention, psychotherapy, and rehabilitation through: (1) distance writing (DW) in its various approaches, which will be considered in greater detail in Chapter 3 of this volume, (2) homework assignments, and (3) low-cost approaches to promote physical and mental health. These new approaches suggest a paradigm shift in mental health from traditional individually delivered psychosocial treatment to distance writing (DW) approaches that may mean interacting with participants online without ever seeing them directly (L'Abate, 2008a; 2008b,c).

Since publication of Norcross's proposal a great many evolutionary advances have occurred in the field of MH. Except for community interventions, health promotion, prevention, psychotherapy, and even rehabilitation have been traditionally based on the individually delivered psychosocial treatment paradigm of the last century. In this century, these MH interventions will slowly but inevitably and inexorably change into a DW paradigm in its many interactive forms (L'Abate, 2001a; 2002). This relatively new DW paradigm is based on the increasing use of the Internet, as Norcross notes in his proposal, and in recent advances in the use of homework assignments in prevention, psychotherapy, and rehabilitation, and especially the growth of low-cost approaches to promote physical and MH as discussed in the previous chapter (L'Abate, 2007b).

The utility of the foregoing Internet, distance writing approaches to those suffering from complex and chronic problems is unknown. In many cases where problems are complex and chronic, a structured in-patient environment is often required initially and the need for medication management is likely as well. Additionally, for those who suffer from complex chronic problems (i.e., long-standing/recurring, highly distressing, often accompanied by widespread functional impairment and a lack of social support), a multi-pronged/multi-person treatment is typically recommended. Further, research evidence supports the notion that clinical skill is most

important when treating individuals suffering from serious complex, chronic problems (e.g., Beutler & Clarkin, 1990; Beutler et al., 2003; Beutler & Harwood, 2000; Beutler, Clarkin, & Bongar, 2000; Harwood & Beutler, 2008; Harwood & Beutler 2009).

Whether or not the Internet can provide the conduit necessary for the effective application of clinical skills (including the accurate identification of empirically based principles and strategies of change) and the seamless application of interventions based on these principles and strategies and relevant patient in-session cues is an empirical question; however, it seems that many elements necessary to the successful therapeutic process (close human in-person interaction, accuracy of clinical judgment) based on patient cues are lacking in Internet or distance writing methods. Relatedly, the likelihood that the written word will be less efficient than the spoken word in communication does not augur well for this treatment format among patients with complex and chronic problems. Another concern centers on the formation of a robust therapeutic alliance. More specifically, how strong will the alliance be among patients treated from a distance, and how will ruptures in the alliance be repaired through the Internet and distance writing?

It is unclear if the Internet will improve treatment efficiency or effectiveness (i.e., reduce time in treatment, produce an increase in the likelihood of change and magnitude of change, improve satisfaction with treatment, or if we can identify which patient types/psychiatric disorders respond best, etc.). Likewise, we do not know if these distance treatment methods will prolong the change process in general or among those with more serious psychiatric conditions. Undoubtedly, the Internet and distance writing has application to rural populations and others who are typically underserved (e.g., prison populations, the homebound)—for these reasons, the Internet and distance writing, as well as other forms of self-help treatment require quality investigation into their efficacy, effectiveness, the patient characteristics that suggest these methods are a good match, and the refinement of treatment formats and methods.

The Passive–Active–Interactive Dimension in Self-Help

These terms do not apply solely to participants, they apply more directly to professional helpers, ranging from the reflective “hum, hum” of client-oriented non-directive counseling to the directive stance of behavioral therapists (Kazantzis & L’Abate, 2007). For instance, in defining SH, Norcross (2006) includes reading self-help books and autobiographies and viewing films related to a variety of clinical and non-clinical conditions. Lists about these three approaches include rankings by a large number of psychologists who use them in their professional practices. Additionally, Norcross et al. (2000) compiled a veritable encyclopedia of SH resources available in MH, and there is no reason to replicate them here. Self-help resources identified by Norcross (2006) include books/novels and autobiographies,

Internet resources, and national support groups. The interested reader should consult Norcross (2006) to discover and possibly use that helpful information.

Norcross (2006), even though reporting some of the resources available in the earlier publication (Norcross et al., 2000), did not report on the evidence in support of the ancillary use of these approaches in psychotherapy. The absence of evidence for his proposal seems strangely contrary to the need to support professional practices with evidence rather than with just personal consensus, opinion, or talk. Nonetheless, his 16 practical suggestions to integrate self-help into psychotherapy are right on target and should be heeded by MH professionals who use or plan to use SH information and materials in their clinical, community, and preventive practices. Consequently, we are in Norcross' debt for furnishing an ample and distinct background for his introduction and later expansion and updating in this area. He provided such a completely thorough review of the literature with a full-scale rationale for the introduction of self-help approaches in MH interventions that it is included here in Table 2.1.

Table 2.1 Norcross' (2006) practical suggestions to enhance the effectiveness of self-help approaches

-
1. Enlarge our conceptualization of change mechanisms
 2. Cease devaluing self-help
 3. Broaden the definition of self-help
 4. Capitalize on the multiplicity of self-help benefits
 5. Familiarize yourself with self-help
 6. Assess clients' self-help experiences
 7. Help administer difficult self-help programs
 8. Offer tangible support when linking clients with self-help resources
 9. Recommend research-supported self-help
 10. Rely on professional consensus in the absence of research evidence
 11. Tailor recommendations to the person, not only to the disorder
 12. Recommend self-help for life transitions (as well as disorders)
 13. Employ self-help during waiting periods and maintenance
 14. Address common concerns
 15. Collaborate with self-help organizations
 16. Incorporate self-help methods and referrals into training
-

Shaked (2005), on the other hand, performed an analysis of 10 contemporary best-selling personal SH books published between 1997 and 2002 to assess the degree to which they met both scientific and ethical standards. She used, however, a new and untested instrument to examine its utility in evaluating SH books by both MH professionals and lay readers. A qualitative method, informed by grounded theory, was used to explore and to assess the books. Open coding yielded 33 concepts and 3 categories, namely: scientific rigor, ethical adherences, and book contents. The books were then rated on a 5-point Likert scale, using a new model for content evaluation. Results suggested that most SH books lack empirical support and integrated ethics to a moderate extent. Contents of these books indicated that most were written by authors with doctorates in psychology, who are likely to produce another best seller and did not delineate their theoretical orientation. Religion/spirituality

was salient along with some mention of psychological theories and emphasis on advice-giving. Anecdotes and case studies were not used consistently, nor were questionnaires, other self-assessment exercises, proverbial sayings, or highlighted text. These books were well-organized, although bibliographies and appendices varied in quality. These results indicate the importance of RCT investigations of SH books and other self-help materials or resources.

Note that in this volume we are trying to fulfill Norcross' recommendations as much as possible. Instead of conceiving of SH as connected solely to psychotherapy, as he did, SH is conceived as forming a tier of interventions with characteristics of its own, independent from but intertwined with traditional MH interventions. These characteristics may run hand in hand along a continuum of community and prevention approaches consisting of universal promotions, targeted preventions, necessary psychotherapies, and obligatory rehabilitations, as discussed in the previous chapter; (L'Abate, 1990; 2007b; Mrazek & Haggerty, 1994).

From Passivity to Activity

Self-help interventions may be able to stand alone, depending, for instance, on whether they are directed toward functional populations in mental health promotion, or toward at risk or sub-clinical targeted populations, such as adult children of alcoholics in prevention, or toward clinical or chronic populations in crisis, as in psychotherapy, or injured populations, as in rehabilitation. The introduction of SH approaches in these four categories would produce and obtain a synergistic outcome. SH may, and often should be paired with traditional individually delivered psychosocial interventions; however, SH should demonstrate empirically positive outcome properties of its own before coupling it with any kind of professionally delivered intervention or treatment plan.

No matter how interesting and even absorbing the reading of self-help books, or autobiographies, or viewing films may be, they are *passive* activities. They are based on receptively experienced input and internal processing rather than on the expressive output side of information processing. They do not demand an active involvement and investment on the part of participants; however, therapists may assign interactive, homework assignments, or these self-help approaches can be integrated into the therapeutic process where they demand active participation by the patient. In some cases, these activities may be quite valuable in the pre-contemplative and contemplative phases of any intervention, perhaps encouraging potential participants to seek professional help. During treatment these formerly predominantly passive activities may become a focus of primary involvement in the therapeutic process.

The passive-receptive nature of reading self-help books, autobiographies, and viewing films, for instance, stands in stark contrast to the many studies about the level of active involvement required by therapists as well as by participants for change to occur. The level of activity on the part of therapists and of participants,

for instance, predicts a more positive outcome. More specifically, there is a correspondent relationship between level of activity from both therapist and patient and degree of positive outcome (Bergin & Garfield, 1994; Hubble, Duncan, & Miller, 1999; Snyder & Ingram, 2000). It is logical to extrapolate from the foregoing that the same outcome would be present among self-help mental health interventions. Of course, it all depends on the type of activity we are talking about. Activity per se does not make for a positive outcome (one should never mistake activity for accomplishment). It is important to specify the nature of the activity (positive–negative, frequency, duration, intensity, and satisfaction), how it is prescribed (individually delivered, online, mail, fax, etc.), how it is received by participants, and how it is implemented by both helpers and participants, as defined in the Questionnaire presented in Chapter 1 of this volume.

From Activity to Interactivity

In addition to the three approaches advocated by Norcross that could be considered relatively passive and self-absorbing, there are relatively new advances in the field of SH that require an active and even interactive involvement by both helpers and participants. These advances were not considered in Norcross's otherwise interesting and important proposal. These advances require an "interactive" involvement by participants to become part and parcel of the process of change since they involve participation with actions rather than solely with words (Bohart & Tallman, 1999).

In addition to the ever increasing role of the Internet in providing information to help people in need of greater knowledge about their perceived troublesome conditions, a topic considered briefly by Norcross, there are at least four interactive SH advances that were not covered by Norcross. These advances possess significant implications for the evolutionary progress of MH interventions because they are evidence-based rather than based on the subjective impressions or personal opinions of therapists, let alone participants: (1) the advent of DW as an additional or alternative approach to traditional individually delivered psychosocial interventions, (2) an increase in the use of targeted homework assignments to increase and widen the scope and effect of individual psychosocial treatment interventions, (3) the rise of low-cost approaches to promote physical and MH, and (4) the growth of technology in psychology, psychiatry, and MH (L'Abate & Bliwise, 2009).

Growth in the Use of the Homework Assignments in MH

A taxonomy of counseling goals and methods (Frey & Raming, 1979), based on content analyses and multi-variate taxonomic procedures, produced seven goal clusters. The cluster most relevant to the advances in self-help psychological interventions considered here was "Transfer of Therapy Learning to Outside Situations." The other six clusters are still relevant to MH interventions in general but not to this particular chapter. The primary goal of any MH intervention, whether self-initiated or prescribed, be it in the home, community, school, clinic, or hospital, is to ensure that

whatever positive behaviors or relationships are confronted, considered, and discussed in those settings will generalize to the patient's environment. These are the specific settings that serve to help demonstrate whether any self-help or professional help has been beneficial in a general sense.

In line with this goal, in the last few years the evidence in support of homework assignments to increase transfer of change from the office to the home has grown exponentially (Kazantzis et al., 2005). Administration of homework, for instance, may be minimal in non-directive and psychoanalytical psychotherapies, but achieves much wider applications in most other psychotherapeutic schools, involving a wide range of clinical conditions. The most relevant conclusion that can be made about homework assignments is that they have not received the widespread, systematic applications they deserve as part of mainstream MH practices. Unfortunately, many homework assignments are administered in a helter-skelter fashion without clear goals or prescriptive purposes—the work of Beutler and Harwood (2008), Lambert and Whipple (2008) are notable exceptions to this professionally irresponsible practice.

The last few years have experienced resurgence in the literature about homework assignments involving a variety of populations with both clinical and non-clinical conditions (Kazantzis et al., 2005; Kazantzis & L'Abate, 2007; L'Abate, 1977, 1986; L'Abate & De Giacomo, 2003; L'Abate & McHenry, 1983). Better treatment outcome is associated with specific therapist behaviors (i.e., setting concrete goals, checking to see if the patient understands the assignment, and discussing barriers to completing homework), characteristics of the homework task (i.e., using written reminders of the homework, providing a workbook that contains assignments, due dates, and the materials needed to complete the homework), and client involvement in the discussion and determination of the homework to be completed (Detweiler-Bedell & Whisman, 2005).

Most homework assignments (Kazantzis & L'Abate, 20007) rely in large part on written instructions and, in some cases, writing assignments. Thus far, homework assignments, in spite of their being used by many psychotherapeutic schools, have not produced a model for their systematic administration, perhaps with the exception of Brown-Stanbridge's model (1989) that relies solely on verbal instructions rather than on writing. Nonetheless, the therapeutic potential for homework assignments in MH treatment is immense and in need of full exploitation—after all, homework extends treatment beyond the clinician's office and into the real world. Additionally, therapy time is increased when a patient becomes involved in homework; however, this increase in therapy time does not result in a correspondent increase in treatment costs.

Low-Cost Approaches to Promote Physical and MH

Another advance relevant to the evolution of self-help in MH interventions lies in low-cost approaches to promote physical and mental health (L'Abate, 2007a). These

approaches are based on substantial evidence of positive outcomes in survival and mortality reviewed already in Chapter 1 of this volume.

The major implication of this advance lies in its helping to identify levels and types of functionality for the appropriate administration of homework to strengthen average or even superior functioning in mental health interventions. The large numbers of individuals who can benefit from both promotion and prevention make individually delivered psychosocial interventions unrealistic for a large portion of those in need. Identification of functional and semi-functional populations may prove difficult on the basis of most self-report paper-and-pencil tests available on the market. As already noted in Chapter 1, most psychological tests are designed toward identifying and measuring the type and extent of psychopathology and dysfunctionality with little attention to the measurement of average or superior functioning.

It is important to differentiate between the assessment of functionality based on actual behaviors across contexts (using scales or measures such as the GAF, DSM-IV-TR, 2000; STS-CRF, Fisher, Beutler & Williams 1999; www.innerlife.com, Webpsych, 2009) and the indirect assessment of functionality based on most personality or symptom inventories that tend to focus on pathology. In line with this type of reasoning, an assessment of the activities listed in Table 1.1 was developed to assess behaviors among individuals, couples, and families. The contents of that questionnaire are consistent with the positive psychology movement that emphasizes strengths and sources of resilience rather than the dysfunctional aspects of our lives. This list has not yet been validated, but it is presented as a replicable form that should allow one to determine levels of functioning. Responses to this list would allow the development of a plan to help participants (individuals, couples, families, and groups) with cost-effective and therapeutically effective forms of intervention. Additionally, the foregoing positive-based assessment must be supplemented with measures of pathology/impairment to determine problem severity, complexity, and chronicity.

For instance, participants scoring within the most functional range of scores and without a presenting problem or chief complaint, could be administered any of the self-help activities presented in this volume or any of the non-clinical practice exercises introduced in Chapter 3 of this volume. Participants scoring somewhere in the middle range of scores and presenting with a presenting problem, similar to what might be seen in adult children of alcoholics, could be administered targeted practice exercises directed toward a specific conflict area. Participants scoring at the lowest range of scores with a clinically relevant presenting problem or chief complaint in clear distress could be assigned to individually administered crisis-intervention psychotherapy, with the eventual assignment of self-help approaches relevant to their condition.

Of course, the most professionally responsible method to determine where a patient should enter a stepped-care model of treatment is through clinical interview, reliable and valid measures of diagnosis, distress, and impairment, coupled with measures of resiliency and areas of functionality. For example, patients found to be sub-clinical, with adequate resources and good functioning, are candidates for

prevention-based interventions. Patients with moderate levels of functioning, mild to moderate clinical diagnoses, and some sources of social support may be considered good candidates for self-help interventions that are adjunctive or integral to psychotherapy with various levels of therapist involvement. Finally, patients exhibiting complex, chronic, and severe problems along with high levels of functional impairment and low levels of social support would generally be better served through intensive, longer-term, multi-person, and multi-format psychosocial treatment that may involve pharmacotherapy and various sources of self-help (e.g., AA).

Toward a Technology for MH Interventions

Technology has been a major influence in American society and has become important in most aspects of our lives (Klein, 2007; Marx & Mazlich, 2007). This technology, regardless of whether or not some psychotherapists like it, will continue to exert substantial influence in the directions that clinical psychology, psychiatry, and MH take in general (e.g., www.innerlife.com). The implications of this technology as a revolutionary force in MH will most likely be immense. Biofeedback, virtual reality therapy, working memory training, and transcranial magnetic stimulation, among other interventions, seem destined to supplement or supplant semi-professionals and professionals in administering treatments in ways that were inconceivable heretofore (L'Abate & Bliwise, 2009). The potential ramifications for service delivery provided by technology include enhanced cost-effectiveness, increased access to care, and step-by-step progression from least to most expensive approaches. Possible challenges in the areas of insurance coverage and professional training loom but are not without solution (L'Abate & Bliwise, 2008). These devices will be coupled, on a large scale, with validated SH approaches at some point in the future.

Implications of Recent Advances for MH Interventions

On the basis of the advances summarized above, one admittedly extreme implication relevant to the conduct of MH interventions would consist mainly of administration of written or non-written homework assignments interspersed with rare, infrequent psychosocial treatment sessions. The purpose of these sessions would be four-fold: (1) to check on homework outcomes after completing each assignment or practice exercise; (2) to assign new, relevant homework; (3) to gauge if progress is being made in treatment and determine if adjustments to the treatment plan are indicated; and (4) to make sure that the patient is improving instead of deteriorating. In some cases, these checks could be performed online once the correct identity of participants is assured; however, we suggest that patients periodically visit their treating clinician so a thorough, reliable and valid assessment of progress and patient status can be performed. In other cases, individual treatment sessions interspersed with

homework assignments may be significantly reduced. In the foregoing instance, the valued and expensive presence and talk of a therapist could become contingent on participants completing homework assignments, and therapists can become more available to individually treat severely impaired patients (L'Abate, 2008a,c).

The foregoing might seem preposterous to many MH professionals who value their personal presence and their words. However, it could be argued that because the presence and expertise of the professional is so important, these qualities could be used sparingly and selectively, not just on the basis of words but on the basis of deeds: how well do participants complete prescribed SH homework assignments and how can the therapist's time be better utilized?

A less extreme result of the technological advances relevant to self-help psychotherapeutic interventions involves the already mentioned stepped care approach consisting of successive sieves or stages or steps moving from the least to the most expensive interventions (L'Abate, 1990; 2007c). For instance, after an informed consent form about homework and distance writing is signed by participants, homework could consist first of the most concrete, easy-to-complete behaviors/tasks, including those already existing and listed in Table 1.1. Second, assignments of activities that are the most frequently performed and enjoyed by participants could progress to more difficult and complex homework with workbooks specific to the individual functioning of partners and family members. Individual psychotherapy, for instance, could occur while participants complete practice exercises specific to either individual or relational conflicts or disorders.

Conclusion

The overriding goal of self-help psychotherapeutic interventions is to help assure and increase the generalization of positive behaviors from professional offices or venues to the patient's many environments and contexts. Secondary goals include the following:

1. Improve the effectiveness of treatment(s) by augmentation as an adjunctive form of therapy or to act as an integral component of treatment.
2. Provide for mental and physical health promotion.
3. Reduce the likelihood of relapse.
4. Free up valuable therapist time for those suffering from severe problems.
5. Instill a sense of self-efficacy.
6. Provide for prevention (reduce the likelihood that sub-clinical problems will reach the clinical threshold).
7. Increase the likelihood and magnitude of positive change.
8. Reduce time in therapy and the corresponding cost of treatment.

The likelihood that the foregoing will occur is increased by the administration of homework assignments and a range of relatively low-cost self-help programs or

materials. If self-help materials are to be employed and recommended by a therapist, that clinician should make sure the materials are safe, empirically supported, and relevant to the problem(s) at hand. If there are no available empirically supported self-help materials available for a particular problem and/or patient, then the clinician should make a judgment about assigning what is available. If the decision is to assign, the patient should be fully informed of the lack of empirical support for the self-help procedure being prescribed or suggested. In such cases, if the patient accepts the self-help material, it is important for the therapist to monitor the patient on a regular basis to determine status on functioning, mood, and other indices of mental health.

Generally speaking, if an individual is contemplating self-help psychotherapeutic treatment, they should undergo a clinical intake/diagnostic interview. The reasoning behind this is that most individuals who are considering purchasing a self-help resource are experiencing some sort of distress or impairment—a clinician is able to determine the extent of a problem and assign the appropriate level of care indicated for the individual. That is, a clinician may determine that self-help alone is appropriate; however, this should be accompanied with instructions to contact the therapist if symptoms, functioning, or mood worsen (a referral list should also be provided).

Although not all patients may be able to engage in therapy delivered individually (e.g., cost or time considerations may be prohibitive), low-cost referral, phone check-ins, support groups, and a range of resources are available and with a little creativity and motivation, an acceptable and appropriate treatment plan should be available to virtually all individuals. In the vast majority of cases, we suggest at least minimal therapist involvement, perhaps no less than on a monthly basis, to help ensure that the patient is not experiencing deterioration, to monitor homework or discuss self-help readings, and to make adjustments in treatment if necessary. This should continue until the patient is asymptomatic. Booster sessions may be considered for a period of time following termination, and the therapist should let the patient know that they may return for treatment if the need arises.

Self-Help in Mental Health

A Critical Review

Harwood, T.M.; L'Abate, L.

2010, XXIV, 312 p., Hardcover

ISBN: 978-1-4419-1098-1