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Impact of support on the effectiveness of written cognitive behavioural self-help: A systematic review and meta-analysis of randomised controlled trials

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HIGHLIGHTS

- Written CBT self-help results in a medium effect size.
- Effectiveness did not vary by type of support.
- Effectiveness may vary by mental health condition with different types of support.
- Larger effect sizes were associated with higher baseline severity for depression.
- There were a number of significant clinical and methodological moderators.

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ABSTRACT

Cognitive behavioural therapy self-help is an effective intervention for a range of common mental health difficulties. However the extent to which effectiveness may vary by type of support — guided, minimal contact, self-administered — has not been extensively considered. This review identifies the impact of support on the effectiveness of written cognitive behavioural self-help and further explores the extent to which effectiveness varies across mental health condition by type of support provided. Randomised controlled trials were identified by searching relevant bibliographic databases, clinical trials registers, conference proceedings and expert contact. 38 studies were included in the meta-analysis yielding a statistically significant overall mean effect size (Hedges' $g = -0.49$). Overall effect size did not significantly differ by type of support ($Q = 0.85$, $df = 2$, $p = 0.65$) (guided: Hedges' $g = -0.53$; minimal contact: Hedges' $g = -0.55$; self-administered: Hedges' $g = -0.42$). For guided and self-administered types of support, planned comparisons revealed a trend for effect size to vary by mental health condition and for guided CBT self-help the modality of support was significant ($Q = 6.32$, $df = 2$, $p = 0.04$), with the largest effect size associated with telephone delivery (Hedges' $g = -0.91$). Additional moderator analysis was undertaken for depression given the number of available studies. Regardless of higher baseline levels of severity the effect size for minimal contact was greater than for guided support. Greater consideration should be given to the potential that type of support may be related to the effectiveness of written cognitive behavioural self-help and that this may vary across mental health condition. Findings from this systematic review make several recommendations to inform future research.

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1. Introduction

Attempts to increase access to evidence based psychological therapies for common mental health problems are resulting in a paradigm shift in the way cognitive behavioural therapy (CBT) is delivered (Bennett-Levy et al., 2010). This shift is away from the delivery of face-to-face 'high intensity' CBT by experienced and specialist mental health professionals towards the inclusion of low intensity CBT (Bennett-Levy & Farrand, 2010). On the basis of the developing evidence base CBT self-help is currently emerging as a key low intensity CBT intervention for the treatment of depression (Anderson et al., 2005; Cuijpers, 1997; Gellatly et al., 2007); anxiety (Hirai & Clum, 2006; van Boeijen et al., 2005); anxiety and depression (Couell & Morris, 2011; Cuijpers, Donker, van Straten, Li, & Andersson, 2010; Van't Hof, Cuijpers, & Stein, 2009); insomnia (van Straten & Cuijpers, 2009); bulimia nervosa and binge eating disorder (Stefano, Bacaltchuk, Blay, & Hay, 2006; Sysko & Walsh, 2008). Several of these meta-analyses however have highlighted limiting CBT self-help for use amongst patients presenting with symptoms of mild to moderate severity only (Couell & Morris, 2011; Van't Hof et al., 2009).

CBT self-help commonly takes the form of books, computerised cognitive behavioural therapy (cCBT), audiotape and videotape (Hirai & Clum, 2006; Marks, Cavanagh, & Gega, 2007) with written formats the most commonly employed (McKenna, Hevey, & Martin, 2010). To overcome potential difficulties concerning lack of knowledge or motivation that may be encountered when using CBT self-help (Bendelin et al., 2011) support may also be provided, which can be face-to-face, by telephone or based around e-mail (Bennett-Levy et al., 2010). The content of such support often takes the form of a practitioner providing information regarding the CBT self-help approach alongside regular updates to monitor progress. Large differences however exist in the amount and nature of support being provided. This can vary from no support being provided at all, to infrequent 'check-ins' to regular scheduled support sessions, whereby the practitioner may also support the patient in making recommendations about use of the self-help materials or support problem solving in the event the patient is struggling (Carlbring & Andersson, 2006).

A taxonomy has been developed (Glasgow & Rosen, 1978) to help classify variations in the nature and type of support that may be provided for CBT self-help. This taxonomy distinguishes between three types of support — *self-administered*, in which the patient uses the self-help materials exclusively on their own with the exception of contact for data collection purposes only; *minimal contact* in which the patient relies upon the self-help materials but has irregular, often non face-to-face contact with a practitioner and *therapist administered* in which the patient receives regular and scheduled meetings with a practitioner whose role is to support them using the self-help materials (Glasgow & Rosen, 1978). This taxonomy has recently been updated within a literature review of technology-assisted self-help for depression and anxiety to better account for the wider variations in the type of support provided across studies (Newman, Szkodny, Llera, & Przeworski, 2011).

Unfortunately the application of a taxonomy used to specify the nature of support being provided for CBT self-help has been poorly adopted within research studies and highlights wider criticisms regarding the reporting of intervention content in published research (Abraham & Michie, 2008; Michie & Abraham, 2004). This makes it difficult to reach conclusions regarding the extent to which support for self-help may be impacting upon effectiveness. For example, several systematic reviews examining CBT self-help have adopted support as a moderator and highlighted a strong association between support and effectiveness (Andersson & Cuijpers, 2009; Gellatly et al., 2007; Hirai & Clum, 2006; Spek et al., 2007; van Straten & Cuijpers, 2009). However within these systematic reviews the moderator analysis compared supported against self-administered self-help which fails to take account of the wide variations regarding content and type of support (Glasgow & Rosen, 1978; Newman et al., 2011). Consequently it becomes difficult to reach conclusions regarding the optimal level of support to provide.

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