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Self-Help Therapy

The Science and Business of Giving Psychology Away

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The notion that people can overcome problems through their own efforts was the basis of a social and philosophical movement long before modern book stores had "Self-Help" sections. In its earliest form, "self-help" referred to the coming together of peers who would assist each other independent of professional assistance. Katz and Bender (1976) traced the beginnings of these self-help peer efforts to 19th-century England. The phenomenon of peer self-help groups continues to the present day (Jacobs & Goodman, 1989), with Gartner and Riessman (1977) estimating at least 500 self-help organizations active in the United States two decades ago, a figure that is now dwarfed by hundreds of "chat" groups on the World Wide Web. (See also Chapter 15, for a discussion of the commercialization of self-help through the media.)

Self-help treatment books represent another early form of guidance, available to the public without the involvement of psychologists. Ellis (1977) suggested that the oldest and best-selling self-help text was the Bible, a document that developed without the assistance of mental health professionals. In more recent times, best-selling self-help books continue to be written by authors outside the health professions. Norman Vincent Peale's (1952) *The Power of Positive Thinking* was a best-seller through much of the second half of the 19th century. Peale was a minister, not a

psychologist. At the time of the writing of this chapter, the *Wall Street Journal* (Best selling books, 2000) listed as number 10 on their Nonfiction Best Sellers List *The Art of Happiness* by the Dalai Lama.

Also coincidental to writing this chapter was an article in the January 10, 2000, edition of *Newsweek* titled "Self Help U.S.A." The article observed:

> Since Colonial times, Americans have devoured "success literature," those pragmatic guides to a better life from authors including Ben Franklin, Dale Carnegie. . . . Today they're called self-help books, and they constitute a $563 million-a-year publishing juggernaut. Books are just one avenue to a brand-new you. From seminars to CDs to "personal coaching," the self-improvement industry rakes in $2.48 billion a year, according to the research firm Marketdata Enterprises, which predicts double-digit annual growth through 2003.

Given the enormous popularity of self-help materials and their goal of helping people to help themselves, it is not surprising that psychologists and other health care professionals have provided their share of advice. A text by the physician Samuel Smiles (1881) titled *Self-Help* is an early example. Dr. Smiles (1886) also wrote *Happy Homes and the Hearts That Make Them*, a delightful text that contained chapters on "The Art of Living," "Influence of Character," and "Helping One's Self." Another self-help book more widely known to psychologists is Edmund Jacobsen's (1934) *You Must Relax*. A full accounting of the history of self-help books and influential authors has been provided by Starker (1989).

The explosive growth of do-it-yourself books that dominated the industry in the 1970s was nearly equaled by the development of self-help audiocassettes and videotape programs in the 1980s. A 1988 New York Times article reported that one company, Mind Communications, Inc., sold more than $6 million worth of subliminal tapes in that year, a tenfold increase in sales in just 2 years (Lofflin, 1988). The American Psychological Association also entered the business of developing, marketing, and promoting self-help audiocassettes during this time period, an issue discussed later in this chapter. In the 1990s yet another expansion occurred in the self-help industry as computer programs for self-change were developed (Newman, Consoli, & Taylor, 1997). Self-help over the Internet is the most recently developed avenue for delivering self-administered treatments to the public (Jerome & Zaylor, 2000; Strom, Pettersson, & Andersson, 2000).

The self-help industry has also grown by increasing the scope of issues it addresses. For example, in the area of parenting skills, there used to be general books of advice by authors such as Dr. Benjamin Spock. By the 1980s there were individualized audiotapes that parents could play to children before bedtime for the more specific purposes of eliminating fears or bed-wetting problems, or improving self-esteem. There was a book specifically targeted to help infants with colic (Ayllon & Freed, 1989) and another program directed at issues with toilet training (Azrin & Foxx, 1974). This trend toward greater specificity of focus, coupled with multiple modalities for delivering instructional programs, helps to explain how the self-help movement has become such big business (Lofflin, 1988; Self-help U.S.A., 2000).

PSYCHOLOGY'S CONTRIBUTION TO SELF-HELP DURING THE 1970S

Although the history of self-help spans centuries, it was not until the 1970s that leading academic psychologists became involved to any serious extent in writing and promoting these programs. Lewinsohn wrote on depression (Lewinsohn, Munoz, Zeiss, & Youngren, 1979), Mahoney and Brownell on weight loss (Brownell, 1980; Mahoney & Mahoney, 1976), Heiman and LoPiccolo on sexual dysfunction (Heiman, LoPiccolo, & LoPiccolo, 1976), Coates and Thoresen on insomnia (1977), Lichtenstein on smoking cessation (Danaher & Lichtenstein, 1978), Zimbardo on shyness (1977), and Azrin on habit control (Azrin & Foxx, 1974; Azrin & Nunn, 1977). These individuals and other prominent psychologists contributed to what remains an unprecedented push by academicians to develop self-help therapies (Rosen, 1976a).

At first glance, the involvement of psychologists in the development of self-help materials would seem beneficial. Psychologists who provided advice to the public appeared to be following George Miller's (1969) urgings to "give psychology away" (p. 1074). Miller had used this phrase in his 1969 Presidential Address to the American Psychological Association to clarify what he saw as the major social responsibility of his profession—*to learn how to help people help themselves*. Certainly, this was the spirit of self-help or "do-it-yourself" treatment books in the 1970s—a theme of social consciousness that fit the times.

In line with Miller's urgings, psychologists appeared to be in a unique position to contribute to the self-help movement. By virtue of their training, psychologists were equipped to develop and evaluate the effectiveness of self-help instructional programs. Systematic work in the area had the potential to make available tested self-help therapies that consumers could self-administer or therapists could employ as adjuncts to their office-based interventions. No other professional group combined the skills and expertise that psychologists could bring to bear on the development of these programs. In the most utopian fantasy, psychology would bring a new dawn to the self-help movement, one in which empirically supported materials

were available for specific targeted goals. At an American Psychological Association symposium in 1977, Albert Ellis invited psychologists to imagine the great potential for improved human functioning a set of scientifically researched, written, and periodically revised do-it-yourself manuals could have (Ellis, 1977). This was the enthusiasm that permeated the 1970s when psychologists rushed head-long into the self-help movement.

In addition to numerous self-help programs developed by prominent psychologists, a considerable amount of research was conducted in the 1970s. Glasgow and Rosen (1978, 1982) located 117 studies or case reports from this time period that evaluated behaviorally oriented self-help instructional materials. This constituted a sizeable body of research, for which psychologists are to be commended. Nevertheless, consideration of findings from these studies suggests a number of sobering conclusions, and demonstrates that the task of "giving psychology away" is more complex than initially thought.

THE LIMITS OF SELF-HELP

One important finding that emerged from research in the 1970s was that techniques applied successfully by a therapist were not always self-administered successfully. For example, a study by Matson and Ollendick (1977) evaluated a book titled *Toilet Training in Less Than a Day* (Azrin & Foxx, 1974). The study found that four of five mothers in a therapist-administered condition successfully toilet trained their children, whereas only one of five mothers who used the book in a self-administered condition was successful. This study also revealed that unsuccessful self-administered interventions were associated with an increase in children's problem behaviors and negative emotional side effects between mothers and children. In other words, highly successful interventions based in a clinic or supervised by a therapist did not necessarily translate into a helpful do-it-yourself program. The implications of this finding are apparent. If, for example, 100,000 copies of *Toilet Training in Less Than a Day* were sold and Matson's and Ollendick's (1977) findings applied, then 20,000 children might be expected to benefit from the self-instructional program, an impressive result at extremely low cost. Unfortunately, this seemingly positive outcome would say nothing about the 80,000 parents who might be frustrated, if not angry, because their children were among the 80% who did not respond to the program.

Matson and Ollendick's findings were not unique. Zeiss (1978) conducted a controlled outcome study on the treatment of premature ejaculation. Couples were assigned, on a random basis, to receive either self-administered treatment, minimal therapist contact, or therapist-directed treatment. As in earlier reports by Zeiss (1977) and Lowe and Mikulas

(1975), treatment with only minimal therapist contact was effective. But of six couples who self-administered their treatment in Zeiss's (1978) study, none successfully completed the program.

Yet another demonstration that well-intentioned instructional materials are not necessarily effective was provided in the 1970s. Rosen, Glasgow, and Barrera (1976) found that subjects who were highly fearful of snakes, and able to totally self-administer a written desensitization program, significantly reduced their anxiety reactions. This positive and encouraging outcome was tempered by the additional finding that 50% of subjects in the self-administered condition failed to comply with their program and carry out instructional assignments. Other studies on self-administered fear reduction programs had shown similar problems with compliance. For example, 14 of 29 eligible subjects dropped out in Clark (1973), 5 of 11 dropped out in Marshall, Press and Andrews (1976), and two thirds of subjects failed to complete their program in Phillips, Johnson, and Geyer (1972). Because the compliance/follow-through issue was a major impediment to helping people help themselves, an attempt to increase compliance was attempted by Barrera and Rosen (1977). In this study, phobic subjects were randomly assigned to the original self-administered program used in the 1976 study, or to a revised program with self-reward contracting. The addition of a self-reward contracting module to self-administered desensitization was consistent with self-management efforts promoted at the time (Mahoney & Thoresen, 1974). The results of the study were totally unexpected. As in the 1976 outcome study, 50% of subjects completed the original program and substantially reduced their fears. However, in the revised program, in which self-contracting had been added, the number of subjects who followed the instructions dropped from 50% to 0%. In other words, no subject completed the new and "improved" program. The importance of this unanticipated finding cannot be overemphasized for it clearly demonstrates that *well-intentioned changes in instructional materials can have a significant and negative impact on treatment outcome.* An important corollary to this point is that *the value of a self-help program can only be known by testing the specific content and instructions of that program under the conditions for which it is intended* (Glasgow & Rosen, 1978).

A RUSH TO PUBLISH

How did research findings from the 1970s impact the behavior of psychologists and the marketing of self-help products? Recall that this research supported several conclusions with clear implications for the clinical efficacy of self-help materials. First, the effectiveness of a treatment program under one set of conditions cannot be assumed to generalize to all condi-

tions. Therefore, effective treatments based in a clinic may not yield procedures that can be effectively self-administered. Second, ineffective programs can actually lead to the worsening of a problem. Third, well-intentioned instructional changes can lead to ineffective programs, such that the effect of *any* change in instructional content must be assessed, not assumed.

In the context of these cautionary conclusions drawn from research at the time, Zeiss published an untested revision of his program for premature ejaculators (Zeiss & Zeiss, 1978) despite the finding that no couple successfully administered an earlier draft. Azrin and Foxx (1974), in the face of ample evidence that toilet training was not accomplished in less than a day, contracted with a manufacturer of musical toilet seats and produced a combination program titled *Less Than a Day Toilet Trainer.* Azrin also published a new and untested book under the title *Habit Control in a Day* (Azrin & Nunn, 1977). Rosen, despite findings from well-controlled studies showing follow-through rates as low as 0%, revised his desensitization program yet another time and published *Don't Be Afraid* (Rosen, 1976b).

To appreciate fully these findings within a historical perspective, it can be noted that an earlier text titled *Don't Be Afraid* was published by Edward Cowles in 1941. This older *Don't Be Afraid* differed in content from the *Don't Be Afraid* of 1976, promoting nerve fatigue theories rather than "modern" desensitization. However, without appropriate research, psychologists and consumers cannot know if any advance in the self-treatment of phobic disorders occurred during a quarter of a century. For all we know, the 1941 *Don't Be Afraid* is just as effective, or more effective, compared to any of the well-intentioned drafts developed by Rosen in the 1970s. A similar historical example pertains to the self-help book *Mind-Power* by Zilbergeld and Lazarus (1987). As it turns out, Olston (1903) and Atkinson (1912) published advice books under the same *Mind Power* title. Because all three of these books lack empirical support, it is unknown whether the 1987 publication is any more helpful to readers than its predecessors published eight decades earlier.

In addition to rushing untested programs to market in an effort to "give psychology away," some psychologists (perhaps unwittingly) allowed their programs to be accompanied by unsubstantiated claims. This observation may provide the most dramatic demonstration that commercial factors, rather than professional standards, dominate the marketing of self-help books. Take for example, the 1976 *Don't Be Afraid*, which stated on its book jacket: "In as little as six to eight weeks, without the expense of professional counseling, and in the privacy of your own home, you can learn to master those situations that now make you nervous or afraid" (Rosen, 1976b). Note that research findings are not mentioned to clarify that, at best, 50% of people succeeded at self-administered treatment.

Other examples of claims made by publishers demonstrate the absence of constraint. Consider claims provided on the back cover of *In the Mind's Eye* (Lazarus, 1977), a book that presented cognitive-behavioral strategies that were touted to help the reader "enhance your creative powers, stop smoking, drinking or overeating, overcome sadness and despondence, build self-confidence and skill, overcome fears and anxiety." Lazarus (1977) personally intervened and was able to have the publisher drop these claims at the next printing of the text. But, three years later, Jerome Singer, then the Director of the Clinical program at Yale University, published *Mind Play: The Creative Uses of Fantasy* (Singer & Switzer, 1980), another book presenting cognitive-behavioral techniques. This time, according to the book jacket, a reader could "relax, overcome fears and bad habits, cope with pain, improve your decision-making and planning, perfect your skill at sports and enhance your sex life."

PSYCHOLOGY AND SELF-HELP IN THE 1980s AND 1990s

If the 1970s represented a decade during which psychologists tried to "give psychology away," unencumbered by concerns over the therapeutic value of their gifts, then the following two decades represented a time when marketing strategies were refined, programs proliferated, and data remained sparse (Rosen, 1987, 1993). We found support for this appraisal by logging on to the Web, at *www.amazon.com*, where 137 self-help books were listed for just the letter "A." Among the titles listed by *www.amazon.com* were *A.D.D. and Success, Access Your Brain's Joy Center: The Free Soul Method, Amazing Results of Positive Thinking*, and *The Anxiety Cure: An Eight-Step Program for Getting Well.* There also were many titles with the word "Art," as in *The Art of Letting Go, The Art of Making Sex Sacred,* and *The Art of Midlife.* Findings were similar for the letters B through Z.

We next visited PsychInfo, a search engine on the Web that the American Psychological Association maintains to archive articles from major peer-reviewed journals. In response to the key words "Self-Help Books," we found only 83 references listed for three entire decades, spanning 1970 through 1999. A somewhat more optimistic picture initially presented itself when we used the single key word "bibliotherapy." Here we found 60 records listed for the decade of the 1970s, 207 records listed for the 1980s, and 205 records listed for the 1990s. Such findings suggest a continuing and active interest in self-help materials, with psychologists productively studying and advancing the development of these programs.

Unfortunately, a more detailed inspection of the records was not encouraging. Take, for example, the bibliotherapy references for the time frame of 1990 through 1999. If one *excludes* from the 205 listed references all dissertations, chapters, commentaries, and review articles on the use of

bibliotherapy, and *includes* only controlled studies that actually assessed a self-help book, then the number of references for the entire decade of the 1990s dwindles to 15. This represents a very small number of studies that bear on the thousands of self-help books available at *www.amazon.com* and other retailers. This state of affairs should not come as a surprise. The presence of limited empirical findings on the efficacy of current self-help books extends a finding obtained many years ago by Glasgow and Rosen (1978, 1982). These authors conducted two reviews of the literature on behavioral self-help programs in the late 1970s, and noted that the overall ratio of studies to books dropped from .86 to .59 from the time of the first review to the writing of the second.

At the same time that empirical findings have diminished, statements extolling the virtues of self-help therapies have been on the rise (Ganzer, 1995; Johnson & Johnson, 1998; Lanza, 1996; Quackenbush, 1992; Warner, 1992). In fact, of the 205 references that constituted the 1990s professional literature on bibliotherapy, there were more position papers urging psychologists to use these programs than there were controlled studies on their effectiveness. One author alone contributed 14 such references (Pardeck, 1990a, 1990b, 1990c, 1991a, 1991b, 1992a, 1992b, 1993, 1994, 1996, 1997; Pardeck & Markward, 1995; Pardeck & Pardeck, 1993, 1999).

At the same time that general position papers were arguing for the use of self-help books, several meta-analytic studies demonstrated the general effectiveness of tested programs (Gould & Clum, 1993; Kurtzweil, Scogin, & Rosen, 1996; Marrs, 1995; Scogin, Bynum, Stephens, & Calhoon, 1990). Nevertheless, these publications have added little to the advancement of empirically based self-help interventions. The general conclusion that self-help books can be effective has been known for some time (Glasgow & Rosen, 1978), along with the caution that the value of a particular program can only be known by testing that specific program. Grouping a limited number of extant studies into a meta-analysis provides no empirical basis for evaluating the vast majority of untested programs.

There also came into existence in the 1990s general reviews of self-help books, in the form of consumer guides for the public. The *Authoritative Guide to Self-Help Resources in Mental Health* (Norcross et al., 2000) is the most recent example of this genre. Such reviews are not based on actual outcome studies: Instead, their recommendations are based on personal preferences and/or surveys that poll psychologists on the materials they like to use. Popularity polls among psychologists who use self-help materials in therapist-assisted contexts provide no useful information on the public's ability to self-administer a program at home. This critical point was demonstrated back in the 1970s and was discussed earlier in this chapter. A "1–5 star" rating system provided by opinion surveys falls short of good science, and does not provide a sound basis for consumer confidence.

A FEW POSITIVE DEVELOPMENTS

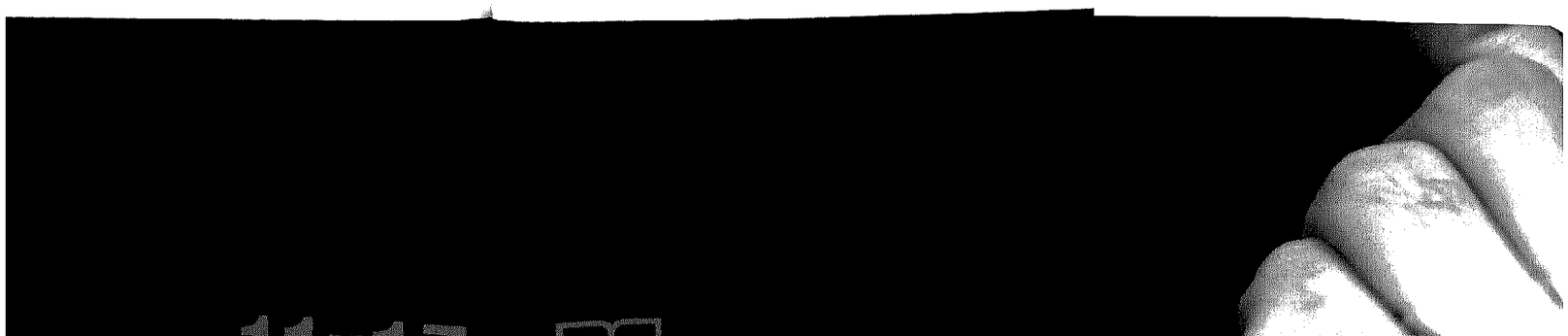
The Debunking of Subliminal Self-Help Tapes

Despite the failure of psychologists to provide an empirical foundation on which to advance the bulk of self-help materials, there have been several positive developments for which psychologists are to be credited. One area in which psychologists have clarified important issues through the conduct of systematic research concerns subliminal self-help programs. These programs started to appear in bookstores in the form of self-help audiotapes in the early 1980s. They shared a common format in that the only consciously perceivable sounds on the tapes consisted of music, ocean waves, and the occasional bird cry. The intended therapeutic effects were purportedly brought about by the unconscious (i.e., subliminal) perception of specific affirmations contained on the tapes. The range of problems that subliminal tapes claimed to alleviate was extensive and included weight loss, memory enhancement, breast enlargement, improvement of sexual function, and relief from constipation.

The notion of technological mind control has always been a popular topic with journalists and the general public (Pratkanis, 1992). Without empirical support, claims of the sort made on behalf of subliminal self-help programs are no better and no different than similar declarations made on behalf of snake-oil over 100 years ago (Young, 1961). Moreover, subliminal self-help tapes are often manufactured in "Research Institutes" owned or staffed by self-proclaimed experts, "doctors," or hypnotists with little or no background in psychology. Not only are the marketing strategies of the subliminal tape industry similar to those of the snake-oil salesmen of yesteryear, the nature of the purported "cure" is similar in that regardless of the problem, there is ostensibly a single, common solution. Subliminal tapes supposedly send a therapeutic message directly to the unconscious, where it quickly transforms the listener's psyche. Similarly, snake-oil could supposedly cure anything from diphtheria to a toothache.

As Koshland (1991) noted, however, the ultimate criterion for resolving a scientific controversy must be the data in a well-run experiment. To the credit of psychologists, it did not take long for researchers to demonstrate that claims of subliminal therapeutic influence were unfounded (cf. British Psychological Society, 1992; Eich & Hyman,1991; Greenwald, Spangenberg, Pratkanis, & Eskenazi, 1991; Merikle, 1988; Merikle & Skanes, 1992; Moore, 1992; 1995; Pratkanis, Eskenazi, & Greenwald, 1994; Russell, Rowe, & Smouse, 1991).

Nevertheless, as with yesterday's critics of snake-oil, today's skeptics of subliminal self-help tapes have not generally been well received. One of us (Moore) was referred to as an "intellectual terrorist" in an advertising brochure by a Michigan manufacturer of subliminal self-help tapes (Mind Communications, 1990). Other critics within the scientific community



have been subjected to personal attacks and insults by defenders of the subliminal tape industry.

Two methods have been used for testing the efficacy of subliminal tapes. As the tapes are designed to bring about improvements of various kinds, the most obvious means of appraising effectiveness would be to look for evidence of improved functioning or enhanced performance. In an innovative study by Pratkanis and colleagues (1994), participants listened daily for 5 weeks to tapes designed to improve either self-esteem or memory. Unbeknownst to the subjects, half of them received tapes that were mislabeled. That is, half the subjects with self-esteem tapes actually listened to tapes designed to improve memory. Similarly half the subjects who thought they had memory tapes were really listening to self-esteem tapes. Pre- and posttest measures of both self-esteem and memory revealed that no improvements in either domain of functioning were brought about by the use of the tapes. Interestingly, participants *believed* that they had benefited from the tapes in a manner consistent with the tapes' labels (and with the manufacturers' claims), even though objective measures showed no such improvements. The investigators thus obtained what they called an *illusory placebo effect*. Participants' expectations of improvement appear to have created the illusion of improvement, even though no improvement actually occurred.

Merikle and Skanes (1992) evaluated subliminal weight loss tapes by recruiting overweight subjects who had a desire to lose weight and who also believed that such tapes could help. Some participants were assigned to a placebo condition in which tapes identical to those in the weight loss condition were used, with the exception that the subliminal affirmations pertained to dental anxiety as opposed to weight loss. The appearance, packaging, and supraliminal materials on the placebo tapes were otherwise indistinguishable from the weight loss tapes. Another group of subjects was assigned to a "wait-list control" condition. All subjects were weighed once a week for 5 weeks. Subjects in all three groups lost about a pound over the 5 weeks, with no evidence of subliminal influences or of placebo effects. It seems likely that simply participating in the study may have made subjects more conscious of weight-related issues. Other investigators have found no evidence that subliminal tapes can improve study skills (Russell et al., 1991) or reduce anxiety (Auday, Mellett, & Williams, 1991).

Another evaluation approach has been to assess the nature of the subliminal auditory signal contained on the subliminal tapes. Although subliminal perception is a valid phenomenon, past research has shown that it occurs only under certain carefully controlled conditions. Subliminal perception is most appropriately defined as a situation in which there is a discrepancy between the viewer's phenomenal experience and his or her ability to discriminate between different stimulus states. Participants are often sensitive to stimuli they claim not to have seen. When required to distinguish between two or more stimuli, subjects can do so with some success, even while professing to be guessing (Holender, 1986). On the other hand, there is little reliable evidence of semantic processing of stimuli that cannot be discriminated (Cheesman & Merikle, 1986). Because stimulus discriminability is a necessary condition for semantic activation and attendant higher-level decision processes (Greenwald, 1992), a failure to demonstrate such discrimination would preclude any effects attributable to the semantic content of a word or message. With respect to subliminal tapes, Merikle (1988) showed that listeners were unable to distinguish a subliminal tape from a placebo control in a forced-choice task. This presence/absence discrimination required a "placebo" tape that was identical to its companion subliminal tape but without any subliminal message. Similarly, Moore (1995) used matched pairs of audiotapes from three different manufacturers and found that subjects could not discriminate between tapes containing ostensibly different subliminal messages. Merikle's and Moore's data are important, for they strongly suggest that no perceptual activity is triggered by the subliminal content of the tapes tested. It should not, therefore, surprise us that no therapeutic benefits have been obtained by any of the evaluation studies mentioned. The signal detection data show that there could never be any therapeutic benefits from such devices because they do not appear to contain a signal that is capable of triggering any perceptual activity—conscious or otherwise.

Of course, research findings have not led to the demise of subliminal audiocassettes, and many can be purchased along with self-help books at *amazon.com*. Nevertheless, the scientific community can take some credit for placing unfounded claims concerning these tapes in proper perspective.

The Evaluation of Self-Help Books

In addition to sound research evaluating the unfounded claims for subliminal self-help tapes, two systematic research programs have demonstrated how self-help books can be evaluated. Scogin and his colleagues (Scogin, Jamison, & Davis, 1990; Scogin, Jamison, & Gochneaur, 1989) have shown that a book on depression (Burns, 1980) can assist older adults with mood problems. Clum and his associates (Gould & Clum, 1995; Gould, Clum, & Shapiro, 1993; Lidran, Watkins, Gould, & Clum, 1995) have assessed a self-help book for the treatment of panic (Clum, 1990) and found support in controlled studies. At the same time, a recent study by Febbraro, Clum, Roodman, and Wright (1999) found that a totally self-administered application of the program was *not* effective, thereby casting

"doubt on the efficacy of bibliotherapy and self-monitoring interventions when utilized absent from contact with a professional who conducts the assessment and monitors treatment compliance" (p. 209). This finding is consistent with previously cited research from the 1970s (Mattson & Ollendick, 1977; Zeiss, 1978), in which effects associated with therapist-assisted programs did not generalize to self-administered conditions, and more recent findings from a meta-analysis (Marrs, 1995), in which the amount of therapist contact was found to moderate outcome for individuals with anxiety problems.

It is highly significant that recent findings have replicated one of the most critical points derived from early research in the 1970s. Once again, it has been demonstrated that *the only way to know the effectiveness of well-intentioned instructional materials, when they are entirely self-administered, is to test those specific materials in the specific context of their intended usage. Psychologists who write self-help materials based on methods they find effective in office settings have no assurance that the public can successfully apply these procedures on their own.*

THE AMERICAN PSYCHOLOGICAL ASSOCIATION AND SELF-HELP

In spite of a few positive developments arising from systematic research efforts, and a better understanding of the potential benefits and limitations of self-help instructional materials, the overall landscape of self-help therapies has not improved over the years. Research findings have not led to the demise of subliminal audiocassettes, and the "Self-Help" section of any local bookstore convincingly demonstrates that untested books of advice flourish. Furthermore, psychologists have contributed to the glut of untested programs more than they have advanced the empirical foundations of self-help.

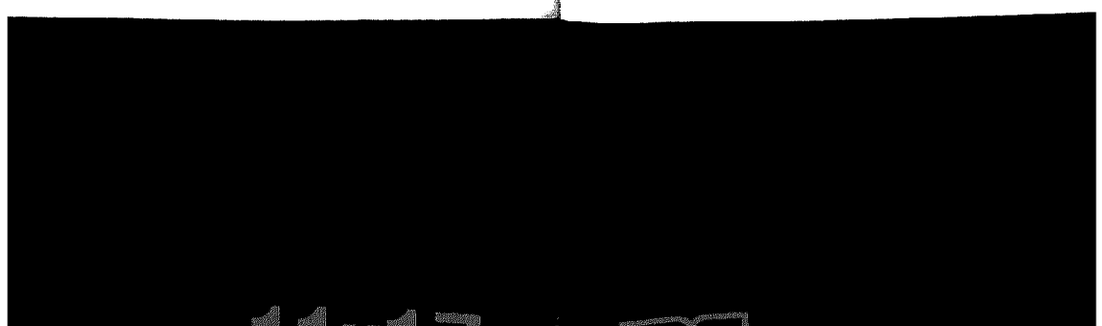
When Miller (1969), more than 30 years ago, urged psychologists to "give psychology away," his admonition was to promote "human welfare" and encourage the systematic development and assessment of effective self-help methods. Miller was not encouraging the headlong rush to market untested materials that has characterized the behavior of most authors over a 30-year period. In one sense, of course, there is nothing wrong with selling programs of advice. Certainly, everyone has the right to market whatever wisdom or guidance they wish to tell the public. On the other hand, psychologists who publish untested programs with misleading titles and unwarranted claims are not meeting professional standards, nor are these individuals applying the science of psychology for the advancement of self-care.

Psychologists who use the status of their profession to promote untested self-help programs provide justification for the public to be skeptical of science (Rosen, 1987, 1993). Robitscher (1980) expressed this concern while addressing a psychiatric audience:

> Every commercial exploitation of psychiatry, large or small, detracts from an integrity that psychiatry needs if it is to have meaning . . . when it becomes commercial, psychiatry dwindles down to a treatment of symptoms and an exploitation of techniques, a pretense of helping another that helps only the self. Many psychiatrists do not approve of the commercialism of psychiatry . . . but almost no psychiatrist speaks out against it. They turn their eyes away to avoid the sight of the money tree being shaken. . . . In the absence of psychiatrists who do not exploit psychiatry, those who do flourish.

There is little indication that the present situation is changing. In the 1970s and 1980s, interested groups within the American Psychological Association (APA) formed Task Forces on Self-Help Therapies. The Task Forces issued recommendations in 1978 and 1990 that suggested the following actions on the part of the APA:

1. Develop a set of guidelines for psychologists similar to the standards that guide developers of psychological test materials. Such guidelines could clarify methodological and outcome evaluation issues pertinent to the adequate development of self-help therapies.
2. Provide to psychologists a list of informational points that should be included in a commercially available self-help program. For example, books would contain a front page that discussed the extent to which the program was evaluated, recommended uses of the program, and reading level of the written instructions.
3. Provide a set of guidelines to aid psychologists who negotiate with publishers. The publication of sample contract clauses could significantly improve the position of psychologists who wish to set limits on claims or other promotional efforts.
4. Develop a short pamphlet to educate the public in the use of self-help therapies. The public could be informed as to how self-help therapies are used as adjuncts to therapist-assisted treatment, or by themselves. The issue of developing realistic expectancies in light of sensationalized claims could be addressed.
5. Consider working in concert with other professional or consumer-advocate groups in an effort to educate the consumer public and possibly develop a review process to review current evidence on self-help programs. In time, it was suggested, standards for establishing a formal "approval seal" might be possible.



The sponsoring groups who originated the Task Forces on Self-Help Therapies did not endorse any of these listed recommendations (Rosen, 1993, 1994). More significantly, the membership of APA was itself, perhaps unwittingly, involved in the development, marketing, and promotion of untested self-help materials. This came about through APA's 1983 purchase of *Psychology Today* and the companion *Psychology Today* Tape Series. By 1985, psychologists on the staff of *Psychology Today* were contracting for new audiotapes to be added to the series. A consumer could order *Personal Impact*, in which "clinical psychologist Cooper helps listeners become aware of and enhance their self-presentation to improve the impact they make on others." Under the catalog section "Becoming More Self-Reliant," the potential consumer was told, "You [can] become a more attractive, appealing person." About *Mental Imagery*, developed by Lazarus, the consumer was told: "Harness the powers of your mind! A noted psychologist explains how to use mental imagery to increase self-confidence, develop more energy and stamina, improve performance and proficiency, cope more effectively, overcome fears, and lose weight." The consumer who ordered one of these untested tapes also received a brochure with the name of the American Psychological Association on the front cover. On the back of this brochure, it stated, "Backed by the expert resources of the 87,000 members of the American Psychological Association, the *Psychology Today* Tape Series provides a vital link between psychology and you." By 1988, the APA Board of Directors had disengaged from *Psychology Today* and sold the magazine to another publisher. Thus, for at least 3 years, the most prominent professional organization representing psychologists actively sought, produced, and promoted untested self-help materials accompanied by unsubstantiated claims that were purportedly backed (without membership approval) by the then 87,000 members. By engaging in these activities, APA not only turned its eyes away from the "money tree" noted by Robitscher (1980), but, for a period of time, APA was itself harvesting the tree's fruits. Further, by developing and marketing untested self-help tapes, APA failed to provide a model or higher standard for its members, some of whom were publishing their own untested programs.

THE FUTURE OF SELF-HELP

In looking to the future, it appears that earlier recommendations to advance psychology's contributions to self-help require modification. These recommendations focused on programs that were likely to be developed by individual psychologists who worked in a specialized area of clinical expertise. The general notion was that the psychologist would assume responsibility for the proper development and assessment of self-help instructional

materials, and that such professional organizations as APA would assist psychologists by providing guidelines for negotiating with publishers, and assist consumers by providing guidelines for how best to choose among available programs. This model for promoting empirically supported self-help materials has failed over the past three decades. An alternative model is needed.

In contrast to an "individualistic" approach to the development and evaluation of self-help materials, a "public health" approach is more likely to advance the efficacy of these programs. Such an approach would employ three of the key characteristics of public health: (1) "transdisciplinarity," (2) an emphasis on the reach and breadth of treatment effects, and (3) attention to the social-environmental context (Abrams et al., 1996; Brownson, Remington, & Davis, 1998; Winett, King, & Altman, 1989). The first of these characteristics, "transdisciplinarity," involves a team of professionals from diverse professions who collaborate to develop a program whose origins are in the project itself, rather than any one individual. Transdisciplinary approaches to self-help are needed because there are multiple factors, in addition to program content, that influence the availability, use, and results of these materials. These factors include marketing considerations, the framing of health messages, literacy and readability, and the family and sociomedical context in which a book is used. Consequently, there is room in the development of self-help programs for contributions from professionals in health communications, marketing, cultural diversity, and other health professions. Consider, for example, the topic of weight loss, one of the single most popular self-help topics. We have learned over the past decades that eating behavior and metabolic outcomes have numerous genetic, physiological, nutritional, exercise, physiology, and social determinants in addition to the core psychological and behavioral processes addressed by psychologists. Research programs that have continuity and address these issues within a broad multidisciplinary perspective stand the best chance of systematically advancing the development of an empirically based self-help weight loss program, as compared to programs developed by individual "leading figure" psychologists who write their well-intentioned but untested books of advice, only to be replaced by the next and most current "authority."

Instead of placing the possibly unreasonable burden on a single author for evaluation of a self-help program, the empirical basis for effective self-help programs will be advanced more rapidly by having programs tested by a variety of individuals, in a variety of settings, and under a variety of conditions. For example, if a national group of educators, family physicians, or researchers were to decide that a given health topic was appropriate for self-help intervention, then members of related professional organizations, clinics, HMOs, or health care systems could coordinate multiple site studies and pool their results. Examples of such multidisciplinary

collaboration are available from the interactions among multiple scientists, including several psychologists, in formulation of the evidence-based guidelines on smoking cessation (Fiore, Jorenby, & Baker, 1997) and development of implementation guidelines by the Agency for Health Care Quality Research (*www.ahqr.gov*).

The second key feature of a public health approach is focus on the breadth and reach of an intervention program (Glasgow, Vogt, & Boles, 1999; Oldenberg, Hardcastle, & Kok, 1997). This perspective is focused on the consumer and can be contrasted with current self-help programs that generally have been developed without thorough consumer input. Self-help programs are more likely to attract and maintain the involvement of users to the extent that the program addresses the concerns and needs of a given group of consumers, and can present information and strategies in a way that makes sense from their worldview, personal model, or illness representation (Hampson, 1996; Leventhal & Diefenbach, 1991). In particular, there is concern regarding whether an intervention reaches those most in need—or only the relatively healthy, affluent individuals who have sufficient time and resources to devote to a program (Conrad, 1987; Glasgow, Eakin, & Toobert, 1996). This concern translates into suggestions for design and distribution of self-help books, and also evaluation criteria. Glasgow and colleagues (1999) suggested that health promotion researchers need to "RE-AIM" their evaluations to explicitly consider the issues of *Reach, Efficacy, Adoption* (within different settings and professionals), *Implementation*, and *Maintenance* of intervention effects. These criteria apply equally well to self-help psychology programs.

The third important characteristic of a public health approach is attention to the social-environmental context. As applied to self-help programs, social context issues include whether instructional materials are used as a stand-alone intervention or are supplemented by therapist or peer contact. We noted previously that some self-help books proved effective when used with therapist support, but not when used alone. It may also be that a book given to patients by their physician or therapist, whom patients understand will check on their progress, may be more effective than one they pick up at a bookstore. Other contextual factors include adjunctive therapeutic modalities such as proactive or reactive telephone support (e.g., Lichtenstein et al., 1996), the use of computer technology or "expert systems" to personalize or tailor intervention (Abrams, Mills, & Bulger, 1999), and an ever-increasing array of other modalities such as the Internet, videotape or CD-ROM materials, and World Wide Web chat rooms. Specification of the conditions under which a self-help program is effective, or not effective, will advance the development of empirically based self-help approaches and lead to development of a more sophisticated "stepped care, matched intervention approach" (Abrams et al., 1996; Brownell & Wadden, 1992) in which an initial assessment recommends conditions of administration likely to be most cost-effective for a given individual.

GUIDELINES FOR PSYCHOLOGISTS AND CONSUMERS

Authors of good will, religious leaders, and health professionals will continue to write books of advice just as they always have done. Nowadays, well-intentioned authors can also expand their advice-giving efforts to audio- and videotapes, and computerized programs. Publishers also will likely continue to promote these instructional materials, as they have done for many years, often accompanying their products with unwarranted titles and claims. Of course, "business as usual" in the self-help industry does not assure us that this year's book of advice will be more effective than last year's best-seller.

In the 1970s, there was a sense of great optimism that the science of psychology was in a unique position to contribute to the advancement of self-help therapies. Recommendations were made to encourage psychologists to use their unique research and clinical skills to develop and promote empirically supported self-help programs. With the wisdom of hindsight and 30 years of experience, we now see that earlier recommendations made to psychologists who wanted to "give psychology away" were overly optimistic. The notion that individual psychologists would carry the burden of assessing and improving their programs, while a professional organization such as the American Psychological Association would assist with supportive guidelines, has not been realized.

It is clear that self-help has not advanced substantially over the past three decades and it is unlikely to advance over the next 30 years if prevailing models are maintained. Unless a new direction is taken, there is no reason to expect that the next *Don't Be Afraid*, published perhaps in the year 2010, will be any more effective than the *Don't Be Afraids* of 1976 and 1941, or that the next *Mind-Power* will be anymore effective than the *Mind Powers* of 1987, 1912, or 1903. It is in this context that we provide guidelines for psychologists who hold an interest in advancing the empirical status of self-help therapies, and recommend a new, broader, and more inclusive approach to the development, use, and evaluation of self-help therapies. Rather than focusing all the responsibility on an individual author of a self-help program, a public health approach to self-help is strongly encouraged. This broader based approach involves the coordinated efforts of health organizations, clinician groups, government agencies, and professional societies. Based upon this approach and the consideration of "who benefits under what conditions," we have developed a checklist of questions (see Table 14.1) to help developers of self-help programs address key issues *before* marketing their programs. This table uses

the RE-AIM framework previously discussed to organize questions under the headings of Reach, Efficacy, Adoption, Implementation, and Maintenance.

The checklist provided in Table 14.1 can also help consumers who are considering adoption of a particular program and want to consider the full range of issues that may affect their selection. However, since the vast majority of current self-help products remain untested, a consumer interested in self-change must follow a few very simple rules. First, the consumer can take comfort in the notion that most self-help products are inexpensive, and, in that regard, there is little harm in buying the product. Next, the consumer should appreciate that claims made for the product are not to be taken seriously unless there is independent empirical evidence in support of the claims. This point is true even when the author of a program is a noted authority within a professional group, such as psychology or psychiatry. Third, the consumer should not feel bad or experience any self-blame if the instructional materials are difficult to apply, or not helpful when applied. Like the 80% of mothers who could not use on their own a toilet training procedure for their children (Matson & Ollendick, 1977), the 100% of males who could not successfully self-administer a program for sexual dysfunction (Zeiss, 1978), the 100% of snake phobics who failed to implement a self-administered desensitization procedure with self-reward contracting (Barrera & Rosen, 1977), and the panic disorder patients who failed to benefit from their self-administered program (Febbraro et al., 1999), the consumer may be dealing with an untested product that simply is not written in a manner that people can use.

In closing, we want to recall the 1977 symposium on Self-Help Therapies that was mentioned earlier in this chapter. At that event, Albert Ellis invited psychologists to imagine the great potential a set of scientifically based do-it-yourself manuals could have. Ellis and others in the 1970s held out a great deal of hope that psychologists would contribute to the development of effective and empirically based self-help programs, thereby fulfilling Miller's (1969) directive to promote human welfare by "giving psychology away." More than three decades later, we continue to support the idealism of the 1970s, and continue to believe that psychologists will play an important role in the development of effective self-help materials. Imagine if you will, to paraphrase Ellis, that a multidisciplinary group of professionals develops self-help programs, educates consumers in their proper use, and continually evaluates and improves these programs in the context of long-term public health projects. It is in this vision of "program-based" methods, rather than "individually authored" products, that the future of an empirically sound self-help movement lies. With a touch of irony for individual authors and their economically motivated publishers, it will be these organizationally based programs that move to the top of best-seller lists.

TABLE 14.1. Guidelines for Developing, Selecting, or Evaluating a Self-Help Program: Questions to Ask

REACH (How broadly applicable is the program?)

1. What percentage of the population having the particular problem, goal, or diagnosis is this program designed to address? Are there subgroups that are more or less likely to participate in this type of program?
2. Are there data on the percentage of individuals who were offered this program who tried it?
   a. If yes, what percentage participated and were they different from those who declined?

EFFICACY (How effective is this program?)

1. Has this program been evaluated? If yes:
   a. Did it do better than a randomized or other type of control condition?
   b. Did the program produce improvements on objective measures of outcome?
   c. Were results reported for all persons who began the program—or only those who liked it and finished?
2. Has the program been evaluated for possible negative or unwanted side effects? If so, what were these?
3. Under what conditions has the program been administered? (Do NOT assume that results will be the same under different conditions.)
   a. Completely self-administered; minimal therapist contact; as a supplement to regular counseling.
   b. What modalities has the program been tested under (e.g., written form; audio- or videotape; computer administered, etc.)?
4. What is the cost of the program—both for purchase and amount of time required relative to other alternative programs?
5. Does the evidence for the program appear to match the claims that are made of it?

ADOPTION (How broadly has the program been used by groups other than the authors—and have the results of these other groups been equally positive?)

1. Is there any information on the range of groups of clinicians, health systems, or researchers who have used or tested the program?
2. Is there any information on the types of professionals or organizations that are likely to use versus not use this program?

IMPLEMENTATION (How easy to use is the program?)

1. What percentage of the initial users of this program complete the program, and how are they different from those who do not?
2. Are there any patient, setting, or procedural considerations for which this program seems to work best?
3. Is there any way to get consultation or technical assistance with the program, if needed?

MAINTENANCE (Does the program produce long-term or lasting results?)

1. What are the longest follow-up assessments that have been conducted, and does the program still seem effective at longer-term follow-ups?
2. Have the organizations or clinicians that have used the program continued to use it?

GLOSSARY

Adoption: The percentage and representativeness of professionals (or medical groups, clinics, health systems, and so on) who will use a given intervention or self-help program.

Bibliotherapy: The use of written materials (e.g., books, manuals) to further a personal goal or therapeutic objective.

Breadth: The range of applicability of a program. In this case, how broad a cross-section of patients and providers will use and benefit from the program.

Compliance: The extent to which a patient follows professional advice. This term has largely been superseded by alternatives such as "self-management," which suggests a more central role for the patient in behavior change (Glasgow & Anderson, 1999).

Program Completion: The percentage and representativeness of persons beginning a program who complete the intervention and follow its recommendations. This term, like "self-management," is preferred to the term "compliance."

Reach: The percentage of persons with a given condition or problem who try a given approach or intervention, and the representativeness of this group of the entire population exhibiting this problem.

Self-Help: The efforts of an individual to achieve behavior change or other personal goals without professional assistance.

Social-Environmental context: The setting in which persons live (their family, neighborhood, cultural group, income level) and in which a program is used (e.g., purchased at a bookstore, used as part of therapy with a professional).

Subliminal: Commonly thought of as referring to the presentation of a stimulus below a threshold of conscious awareness, this term is best defined as a discrepancy between viewers' phenomenal experience and their ability to discriminate among different stimulus states.

Transdisciplinarity: Professionals from a variety of disciplines working together to address a problem.

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15

Commercializing Mental Health Issues

Entertainment, Advertising, and Psychological Advice

NONA WILSON

For many mental health professionals—clinicians, researchers, and professors—the world of television talk shows and mass market self-help handbooks might seem easily dismissed as having little or no relevance to their field of study, in terms of either its current practice or its future direction. Having worked hard to complete academic training, attain professional credentials, and practice within established ethical guidelines, many mental health professionals may be tempted to view the popular "advice industry"—that is, the mass market, commercialized version of professional, psychological expertise—as merely an annoying doppelgänger that is best ignored. Although there certainly are professional grounds for regretting the existence of this shadow presence, ignoring it, I will argue, is much like ignoring a sizable and growing tumor. Not only has the advice industry used the mental health profession as a host to sustain it, but it has metastasized in ways that threaten to displace the profession itself.

The thesis of this chapter is that when psychological expertise and services enter the mass market, they become beholden to marketplace values and strategies. Moreover, as commercialized forms of mental health expertise and services succeed in the mass market, they not only degrade, but ultimately displace, the original upon which they are based. The chapter will consider the convergence of two dominant cultural movements—