Assertiveness and Healthy Boundaries: Guided Self-Help Programme: Practitioner Guide

THE TALKING THERAPIES UK PRACTITIONER GUIDES



Assertiveness and Healthy Boundaries: Guided Self-Help Programme: Practitioner Guide

Delivering the programme as guided self-help

A practitioner guide · 7 contacts · to accompany the workbook

TALKING THERAPIES UK

First edition · 2026

Published by Talking Therapies UK, talkingtherapies.co.uk.

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First edition, 2026.

This guide accompanies the Assertiveness and Healthy Boundaries: Guided Self-Help Programme programme on the Talking Therapies UK self-help platform and its workbook. It is drawn from the programme and is kept current with it: whenever the programme changes, the guide is set again.

Revision 6. This printing was set on 7 November 2026 from the programme as it stood that day.

A note on clinical responsibility. This guide supports qualified practitioners delivering guided self-help within their competence, their supervision and their organisation’s policies. It does not replace clinical judgement, and its thresholds are guidance: where your service’s policy differs, follow your service’s policy.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

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How to use this guide

This guide is for qualified practitioners who support clients through the Assertiveness and Healthy Boundaries: Guided Self-Help Programme programme as guided self-help: a short supported contact after each of its 7 modules, with the client working through the programme or its workbook in between.

Part 1 says who the programme is for. Part 2 covers what every contact needs: your part in guided self-help, how to structure a contact, how to review each kind of worksheet, what to do when the work is not being done, how to adapt the programme, the check-ins and when to step up, and risk. Read Parts 1 and 2 before you begin with a client.

Part 3 has a chapter for each contact, to read before that contact: what the client has read in the module, a plan, how to review the week's worksheets with their answers. Part 4 covers ending the work, supervision, and the checklist.

The guide follows the programme as it stands on the platform, so its plans name the programme's own modules, teaching and worksheets, and it is set again whenever the programme changes.

What this guide covers

- Who the programme suits, how to assess for it, and when it is not enough on its own
- Your part in guided self-help, and how to structure each contact
- For each of the 7 contacts: what the client has read, a plan, and the worksheets with their answers
- Keeping the work going, adapting the programme, the check-ins and stepping up, and risk at every contact
- Ending well, supervision, and a checklist for delivering the programme as designed

PART 1

Before you start

Who the programme is for, and how to decide whether it suits a client.

In this part

- Chapter 1, Who the programme is for: who it suits, how to assess for it, and when it is not enough on its own

CHAPTER 1

Who the programme is for

This step-2 equivalent guided self-help programme draws on the robust evidence base of Cognitive Behavioural Therapy, Acceptance and Commitment Therapy and skills-based approaches such as assertiveness training and Dialectical Behaviour Therapy. It helps participants understand the psychology of assertiveness, develop practical communication tools, and learn how to set and protect personal boundaries. The programme is designed for NHS delivery and can be completed in weekly 30-minute sessions.

What the programme covers

1. Understanding Assertiveness and Boundaries
2. Your Rights and Personal Values
3. Thoughts that Block Assertiveness
4. Communication Skills: I-Statements and Active Listening
5. Setting and Maintaining Boundaries
6. Managing Conflict and Emotional Regulation
7. Relapse Prevention and Ongoing Practice

Who it suits

- Adults whose difficulties are of mild to moderate severity on assessment, in the area the programme addresses.
- Clients who want to work on the difficulty themselves between contacts, and can set aside time each week to read and to complete the worksheets.

- Clients who can read and write in English, or who have the support to do so.

When it is not enough on its own

- Current risk to self or others, including thoughts of ending their life with any plan or intent: assess and manage the risk first, under your service's policy.
- Severe difficulties on assessment, including a PHQ-9 of 20 or more or a GAD-7 of 15 or more: offer high-intensity therapy, or deliver the programme only alongside it.
- Psychosis, mania, or drug or alcohol dependence that is not being treated.
- A previous course of guided self-help that did not help, where the reasons have not changed.

PART 2

Delivering it well

How guided self-help works and what your part in it is: structuring each contact, reviewing the worksheets, keeping the work going, adapting it, the check-ins, and risk.

In this part

- Chapter 2, Guided self-help and your part in it: what guided self-help is, what the research says about support, and what your role is and is not

CHAPTER 2

Guided self-help and your part in it

What guided self-help is

Guided self-help pairs a structured programme, which the client works through on their own, with brief, regular contact with a trained practitioner. The programme carries the teaching: it explains the difficulty, teaches the skills, and sets the practice for each week. Your task is to help the client use it. In Assertiveness and Healthy Boundaries: Guided Self-Help Programme that means 7 contacts of about thirty minutes, one after each module, by telephone, video or in person, with the client reading the module and completing its worksheets in between.

This division of labour is what makes guided self-help efficient, and it is also where it most often goes wrong. A practitioner who re-teaches each module in full turns a thirty-minute contact into an under-powered therapy session and leaves no time for the client's own practice, which is where change happens. A practitioner who asks only "How did it go?" leaves the client alone with the hardest parts. The contact plans in Part 3 are built to avoid both: most of each contact is spent on what the client did, what they learned from doing it, and what they will do next.

What the research says about support

Self-help is not a lesser treatment when it is supported. Cuijpers and colleagues (2010) pooled the studies that had compared guided self-help directly with face-to-face psychotherapy for depression and anxiety disorders, and found no significant difference in effect between the two, at the end of treatment or at follow-up. Farrand and Woodford (2013) pooled randomised trials of written cognitive behavioural self-help, found it effective for anxiety and depression, and examined how the support offered alongside it relates to its effect.

Two practical conclusions follow for your contacts. The support needs to be regular and planned, booked in advance and kept, rather than offered when the client asks for it. And it needs to be about the client's use of the programme, rather than a parallel conversation about everything else in their week.

Your part, and its limits

Roth and Pilling (2008) set out the competences needed to deliver cognitive and behavioural therapies well, distinguishing the generic competences of any good therapeutic work (engaging the client, building and keeping a working alliance, ending well) from those specific to an approach. In guided self-help the generic competences carry most of the weight. Your part has five elements:

1. Engage the client and keep the alliance: warmth, interest in the client's own words and examples, and reliability, so that contacts happen when agreed and start and end on time.

2. Review the practice: look at what the client did, with their permission, and help them draw out what they learned from it.

3. Solve problems: when the practice did not happen or did not help, find out why, and agree a smaller and clearer next step.

4. Monitor outcome: score the check-ins with the client, compare them over time, and act on the stepping-up guidance in Chapter 7.

5. Keep the work safe: ask about risk at every contact, and know what you will do with the answer (Chapter 8).

What the role is not matters as much. It is not an assessment of the whole person, a formulation of their history, or open-ended therapy. When a client brings something that needs more than the programme can offer, such as a trauma history that is beginning to surface, a relationship in crisis, or a worsening of their difficulties, acknowledge it, record it, and decide with the client and your supervisor whether a different step of care is needed, rather than stretching the contacts to hold it.

The stance that helps

Clients who do well in guided self-help tend to describe a practitioner who was interested, who noticed the effort they had made, and who was clear about what came next. Specific recognition ("You filled in the diary on five days, including the Thursday you said was the worst of the week") does more than general reassurance. Curiosity about what got in the way ("What was happening on the two days the diary stayed empty?") does more than encouragement to try harder. And a clear, small plan at the end of each contact, written down by the client in their own words, does more than a long list of good intentions.

The stance in a cognitive behavioural programme

Cognitive behavioural work rests on collaborative empiricism: the client and the practitioner treat the client's beliefs and patterns as ideas to be tested rather than facts to be argued with. In brief contacts this means asking more than telling, and turning disagreement into an experiment ("What would you expect to happen if you tried it this week? How could we find out?"). Keep a light written

record of what the client has learned in their own words, so that each contact builds on the last.