

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

**The effectiveness and cultural compatibility of a
guided self-help cognitive-behaviour programme for
Asian students in New Zealand**

A thesis presented in partial fulfilment of the requirements for
the degree of Masters of Arts in Psychology at
Massey University, Albany,
New Zealand

Kai-Chi Katie Lee

2014

Abstract

With more Asian migrants and students coming to New Zealand, there is a need to provide psychological interventions that is both effective and culturally compatible. Even though Cognitive Behaviour Therapy (CBT) has been shown to be an effective intervention in the treatment of depression and anxiety, few researches have examined the effectiveness of CBT with Asian populations outside the United States. Furthermore, no research has been identified that looked at the effectiveness of low intensity CBT with Asians in New Zealand. From an emic perspective, the cultural values and principles in which interventions were developed in, warranted that it be tested with other cultures to determine if its effectiveness was cross-cultural.

The purpose of the study was to fill the gap by examining the effectiveness and cultural compatibility of a guided self-help, low intensity CBT programme, Living Life to the Full (Williams, 2007), for students of Asian descent in New Zealand. A sample of 11 East Asian and Southeast Asian participants was recruited from universities and language school around the Auckland area. Quantitative measures were administered throughout the 8 weeks of the programme, and qualitative feedback was obtained at the end of the programme. Results supported the effectiveness of the programme, in the reduction of depression and anxiety, and the improvement of quality of life, adjustment and participants' understanding of stress and low mood. In addition, participants found the programme culturally compatible and beneficial. The findings supported the suitability of the low intensity CBT programme for use with the Asian population.

Asian immigrants and students experience unique stressors and problems associated with adjusting to a new culture. Low intensity CBT helps to remove the barriers of stigma and reluctance to seek help, by providing a more accessible form of psychological interventions that is effective and culturally compatible with the Asian population.

Acknowledgements

My appreciation goes out to my supervisor, Dr. Mei Wah Williams, for your guidance and feedback throughout this process. Thank you for helping me focus and gain clarity with the scope of my research, and for your attention to detail with revisions of this thesis.

I want to acknowledge my family, who have given me their support and encouragement from afar. Thank you for always believing in me and my abilities. I am truly blessed with more than I could ask for.

Special thanks to the incredible team at Equip. The work you do is so vital, and often under-appreciated. You have been wonderful support workers for me, and I want to thank you for all your support. I want to acknowledge my colleagues in the Rimu Room, you make work fun! Thank you Des for your amazing support, I truly appreciate it.

To my friends in New Zealand, thank you for keeping me sane throughout this time. Christina, thank you for taking care of me and making sure I'm well-fed. Your efforts do not go unnoticed. Abby, thank you for sharing your procrastination tips with me. Our Thursday thesis sessions have kept me on track and helped me enjoy this process.

And most of all, thank you to the One Above, for sustaining me and giving me joy throughout this time. In everything, may you be glorified.

Table of Contents

Abstract.....	ii
Acknowledgements.....	iii
Table of Contents.....	iv
List of Figures.....	viii
List of Tables.....	ix
CHAPTER 1: Introduction.....	1
CHAPTER 2: Mental Health through the Lens of Culture.....	3
How important is culture?.....	3
The New Zealand context.....	4
Mental health in New Zealand.....	4
Asian in New Zealand.....	5
Difference between the East and West.....	5
Influences and values of Chinese culture.....	6
Cultural explanation and responses for mental health problems.....	6
Problems with immigration for Asians in New Zealand.....	7
Stigma and shame: barriers to accessing help.....	8
International students of Asian descent.....	9
Expectation for academic success.....	10
Loss of social support.....	10
Poor adjustment.....	11
Reluctance to seek help.....	11
Summary.....	11
CHAPTER 3: Cognitive Behaviour Therapy and its Use with Asians.....	13
History of CBT.....	13
Principles of CBT.....	13
Using CBT with Asians.....	14
Principles of CBT are transferable.....	15
Modifications to CBT.....	16
Summary.....	17
CHAPTER 4: Low Intensity CBT.....	18
The need for Low Intensity CBT.....	18
Principles of LI-CBT.....	19
Benefits of LI-CBT.....	19
Challenges to LI-CBT.....	20

Suitable client characteristics for LI-CBT	20
Types of LI-CBT.....	21
Guided self-help versus unguided self-help.....	21
Internet-based verses book-based	22
Individuals versus group-based.....	23
The empirical evidence for Low-Intensity CBT.....	23
HI-CBT versus LI-CBT	24
Guided versus unguided self-help.....	24
Modes of LI-CBT delivery	25
Living Life to the Full.....	25
Summary	26
CHAPTER 5: Present study.....	28
Research rationale.....	28
Research aim.....	28
Research hypotheses	28
CHAPTER 6: Method.....	30
Participants.....	30
Inclusion/exclusion criteria.....	30
Design	30
Procedure	31
Recruitment.....	31
Screening questionnaire	31
Informed consent	31
Intervention.....	32
Measures	33
Patient Health Questionnaire 9 (PHQ-9).....	34
Generalised Anxiety Disorder 7 (GAD-7)	34
World Health Organisation Quality of Life Questionnaire (WHOQOL-BREF)	35
Student Adaptation to College Questionnaire (SACQ)	36
Understanding stress and low mood (UndSLM).....	36
Client Satisfaction Questionnaire 8 (CSQ-8).....	37
Semi-structured interview	37
CHAPTER 7: Results	38
Part I. Preliminary Data Screening	38
Missing data.....	38
Normality.....	39

Outliers.....	39
Part II: Effectiveness of the guided self-help programme	39
Group's scores across time	39
Depressive and anxiety symptoms	39
Quality of life.....	40
Adjustment to studying.....	41
Understanding of stress and low mood.....	42
Individuals' scores across time	43
Clinical significance.....	43
Comparing sample means	45
Part III: Cultural compatibility of the guided self-help programme	47
Participant satisfaction.....	48
Semi-structured interview	48
Helpful aspects of the programme	48
Recommend to friends	50
Meeting expectations	50
Facilitator support	51
Less relevant parts of the programme	51
Cultural compatibility	52
Resolving problems	53
Help seeking behaviour.....	54
Family influence	55
CHAPTER 8: Discussion.....	56
Summary of aims and findings	56
Hypothesis 1: Group ratings on the outcome measures would improve over time.....	56
Hypothesis 2: Individual participants' scores would improve at a clinically significant level and when compared to sample means.....	57
Hypothesis 3: Participants would be satisfied with the programme and find it suitability and cultural compatible.....	58
Satisfaction.....	58
Suitability	59
Cultural compatibility	60
Limitations of the study	62
Measures	62
Language proficiency.....	63
Social desirability.....	63

Self-referred	63
Small sample	64
Extraneous variable.....	64
Recommendations for future research	65
Implications for clinical practice.....	66
Conclusion	67
References.....	69
Appendix A: Programme Posters and Flyers in English and Mandarin	87
Appendix B: Screening Questionnaire.....	89
Appendix C: Information Sheet.....	90
Appendix D: Consent Form	93
Appendix E: Patient Health Questionnaire 9 (PHQ-9)	94
Appendix F: Generalised Anxiety Disorder 7 (GAD-7)	95
Appendix G: Understanding stress and low mood (UndSLM).....	96
Appendix H: Client Satisfaction Questionnaire 8 (CSQ-8)	97
Appendix I: Semi-structured Interview Questions.....	98
Appendix J: Outliers by Participant, Measure and Time, with the Participant's Score and the Group Mean Score on the Corresponding Measure.....	99

List of Figures

- Figure 1 The decrease in mean scores on the PHQ-9 and GAD-7 at baseline and across the 8 weeks of the programme
- Figure 2 The increase in mean scores on the WHOQOL-BREF subscales at baseline, week 4 and week 8
- Figure 3 The increase in mean scores on the SACQ subscales at baseline and week 8
- Figure 4 The increase in mean scores on the UndSLM at baseline and week 8
- Figure 5 The mean change on the PHQ-9 and GAD-7 for the clinical and non-clinical groups at baseline and week 8

List of Tables

Table 1	The self-help materials used in this study, with the week the booklet was presented, the name of the booklet, and the topic the booklet covered
Table 2	The mean, standard deviation, t-score, degree of freedom, and two-tailed p-value for the scores at baseline and week 8 across all the WHOQOL subscales
Table 3	The mean, standard deviation, t-score, degree of freedom, and two-tailed p-value for the scores at baseline and week 8 across all the SACQ scales
Table 4	Participants' PHQ-9 and GAD-7 scores at baseline (pre) and week 8 (post) with an indication of clinical significance
Table 5	Comparing sample means with participants' scores across the four WHOQOL-BREF subscales at baseline and week 8
Table 6	Comparing sample means with participants' scores across the five SACQ scales at baseline and week 8

Chapter 1

Introduction

Psychology as a discipline was birthed in Europe and was further developed in the United States. Psychological theories and principles of practice are largely based upon Euro-American values, in which autonomy and independence are valued (Williams, Foo, & Haarhoff, 2006). However, these values are not shared by all people. For Asians, especially, value is placed on relationships and fulfilling family obligations over individual desires. When delivering therapy, it is important to consider the client's culture in understanding and treating the problems. Modifications to Western-developed psychotherapies are needed, so that ethnic minorities can also benefit.

Cognitive Behaviour Therapy (CBT) was developed by Beck in the 1960s (Beck, 1963, 1964) and has grown in popularity due to its effectiveness and cost-efficiency. Therapists using CBT help their clients gain more control by identifying and changing unhelpful thinking and behaviours. There is ample evidence to suggest that CBT is an effective intervention equal to or above the effects of medication alone in treating mental health (Robinson, Berman & Neimeyer, 1990). To improve access, a guided self-help programme has been developed by Dr. Chris Williams, called *Living Life to the Full* (Williams, 2007). This low intensity programme teaches life skills in response to the demands of everyday life.

There is a gap in the literature in examining the use of CBT with the Asian population (Sandil, 2006). Although modifications to CBT have been suggested to better meet the needs of Asian clients (such as Hwang, Wood, Lin & Cheung, 2006; Chen & Davenport, 2005), these studies were mostly conducted with Asians in the United States. Moreover, no studies have been identified that examine the effectiveness of low intensity CBT programmes with the Asian population. Due to differing culture values and practices, research is needed to test whether the interventions, which were developed in the Western context, is also effective and suitable for the Asian population. The purpose of the present study is to fill the gap by examining the effectiveness and cultural compatibility of a guided self-help CBT programme for Asian students in New Zealand.

To gain an understanding of the cultural compatibility of the programme, this thesis will start in Chapter 2 with the overview of how culture influences perceptions of mental health, in particular, the impact culture has on Asian international students' adjustment to studying in New Zealand. In chapter 3, an introduction of Cognitive Behaviour Therapy is provided, with a look at how it fits with Asians in therapy. Next, low intensity CBT is examined in chapter 4, with a focus on the programme used for this research, *Living Life to the Full*. The aims and

hypotheses of the present study are specified in chapter 5. The methods will be presented in chapter 6, followed by the quantitative and qualitative results in chapter 7. This paper ends with the discussion in chapter 8, outlining the findings, limitations and implications of this study.

Chapter 2

Mental Health through the Lens of Culture

This chapter gives an overview of mental health in the New Zealand context, starting with a broad view of the importance of culture. The values of Asian culture influences people's interpretation and treatment of mental health. With the increase of Asians in New Zealand, their mental health and specific challenges to immigration are addressed. Moreover, we take a closer look into the experiences of international students and the challenges they face.

How important is culture?

Culture is defined as the set of values, beliefs, customs and social behaviour that are shared amongst a particular people or society (Merriam-Webster, 2014). Researchers and practitioners differ in their perception of the extent to which culture influences individuals' mental health. The Universalists believe that theories are universally applicable to all peoples (Maxie, Arnold, & Stephenson, 2006). This etic approach is based on the assumption that disorders are caused and presented in the same way by all people, therefore, treatment for disorders do not need to be modified for different cultural groups (Hall, 2001; Alvidrez, Azocar, & Miranda, 1996). The etic approach is problematic as it is not sensitive to cultural differences, and tends to favour the culture of which the theory was developed, namely the Euro-American culture.

In contrast to the Universalists belief that all theory and practice can be applied to all people, the Contextualists highlight the significance of the cultural context that shapes individuals. The emic approach acknowledges the heterogeneity within ethnic groups, and the factors that lead to these differences, including gender, age, socio-economic status (Alvidrez et al., 1996). Hall (2001) stated that to group ethnic minorities into broad categories without specifying its characteristics is a methodological flaw in research. The emics believe culturally relevant modifications are need for psychological interventions as Western therapy outside of its context is not appropriate for use with non-Westerns (Sue & Sue, 1999).

With the ease of inter-country movement and cities becoming more multi-ethnic, it is even more important for culture to be considered during therapy. Multi-cultural therapy is considered the fourth force in psychology, stemming from the practice of psychodynamic, behavioural and humanistic approaches (Westbrook, Kennerley, & Kirk, 2011). Culture determines people's help seeking behaviour and level of scepticism towards the health care

system (Anderson et al., 2003). Therapists need to consider the cultural values and characteristics of their clients in order to deliver culturally appropriate, beneficial therapy.

The New Zealand context

New Zealand is becoming increasingly diverse. In 2013, 74% of the country's population were European, 14.9% Maori, 11.8% Asian and 7.4% were Pacific peoples (Statistics New Zealand, 2014). The diversity was even more pronounced in Auckland, with the population being 56.5% European, 18.9% Asian, 14.4% Pacific peoples and 11.1% Maori (Statistics New Zealand, 2006). The Asian population almost doubled in size since 2001 and projections show that ethnic minorities in New Zealand will continue to grow, with Asians numbering 790,000 by 2026. With the changing faces of New Zealand, providing culturally appropriate therapy is now more important than ever. There is a call for improved availability and access to mental health services for Asians living in New Zealand (Mehta, 2012).

Mental health in New Zealand

Mental health is prevalent in New Zealand, with 20.7% of the population experiencing some type of mental health disorders in the past 12 months. Within the fifth of the population, 31.7% of problems were considered mild, 45.6% moderate and 22.7% severe (Wells et al., 2006). The most common presenting problems were anxiety, depression and/or stress (Fitzgerald, Galyer, & Ryan, 2009). Only 39% of people with a mental disorder had visited health services in the last 12 months and the most common reason for delaying help seeking was the belief that the problem would get better by itself (Mental Health Foundation, 2014). This attitude is most common with younger people and may be most problematic, as 16 to 24 year olds have the highest rate of mental illness and are less likely to seek help for mental health problems (Mental Health Foundation, 2014).

Public mental health services have previously focused their resource and funding for treatment of the most severe mental health problems. The emphasis is now moving towards treating mild to moderate mental health problems using brief interventions (Fitzgerald et al., 2009). As with elsewhere in the world, the demand for brief, cost-effective, solution-based, and empirically-supported interventions is coming from individuals, as well as government agencies and the health insurance industry (Merrick & Dattilio, 2006). The limited funding poses a challenge for psychologists to deliver effective intervention in four to six sessions (Lyons & Low, 2009).

Psychologists are meeting the demand by providing brief therapies, with CBT being the most common (Merrick & Dattilio, 2006). Its effectiveness in reducing psychological symptoms

and relapse rates for a range of disorders has been supported by research (Butler, Chapman, Forman & Beck, 2006). Furthermore, CBT provides a framework that allows for idiosyncrasy and is flexible in treating individuals, couples and families of diverse cultural backgrounds. Clients are asking specifically for CBT as they know of its effectiveness and see its brief sessions as an affordable option (Merrick & Dattilio, 2006).

Asian in New Zealand

Asians coming to New Zealand face a lot of problems with immigration. Before addressing these issues, we need to first explore the context of Asian culture, so we can better understand the problems Asians immigrants face. 'Asian' is too broad a label and does not acknowledge the diversity of the many ethnic, cultural and racial groups that would be encapsulated under that category. This section starts with the broad concepts that differentiate Asian culture from Western culture. Later, we take a closer look at the Chinese culture with its varying influences and resulting values that shape people's perceptions of mental health. The problems that immigrants face when they move to New Zealand heighten the risk of mental illness. Lastly, international students face similar problems to immigrants, on top of academic pressures. The stigma of mental illness and people's reluctance to seek treatment are issues that need to be addressed.

Difference between the East and West

People of the East are raised with a different value system to those of the West (Yip, 2005). The most noticeable culture difference is the Western focus on individualism and the Eastern value for collectivism (Yang, 2011). In Western culture, the self is upheld and emphasised. The ability to self-assert is seen as integral to developing one's worth. Children are taught from a young age to express their feelings and protect their rights. In contrast to this, people of the East restrain their emotions and desires. Desires and wants are to be neutralised, or at least moderated. Peace is achieved through quieting the mind through self-control, and Eastern people tend to be more passive in social situations (Williams et al., 2006). The value of collective harmony is greater than individuals' rights; therefore, conflict aversion is more desirable than self-assertion (Yang, 2011). Responsibility to the group is stronger than the need for independence (Chen & Davenport, 2005). Individuals are expected to sacrifice their own desires and wants for the betterment of the family. Self-worth and identity is linked more closely with interpersonal relationships than with individual achievements (Yip, 2005). In Asian cultures, the traits of assertiveness, creativity and independence are not emphasised or encouraged (Hall, 2001).

Influences and values of Chinese culture

The above values are all reflected in the collective societies in China. Chinese culture is influenced by Confucianism, Taoism and Buddhism, where family, academic achievement and emotional restraint are highly valued. Chinese family members rely heavily on one another for support, to the point of being perceived as enmeshed by outsiders (Williams et al., 2006). There is a hierarchical structure to the family, with fixed gender-determined roles for its members (Mondia, Hichenberg, Kerr, Eisenberg, & Kissane, 2012). Deference is shown to the older generation, particularly the patriarch of the family (Chen & Davenport, 2005). Decisions are made for children, even into late adolescence (Williams et al., 2006). Children are expected to show filial piety, or respect and obligation to their parents (Hsu & Wang, 2011). The importance of the family is reflected by how the Chinese introduce themselves; the family name comes before their first name, demonstrating the emphasis on family identity over individual identity (Chen & Davenport, 2005). It is therefore more crucial to protect the family name, above individual honour and reputation.

The children's role is to gain academic success and to bring honour to the family. There is high expectation and value placed on school achievement. Due to the vast number of the population, there is intense competition between students to become the top of the class. These efforts are to ensure that, in the future, individuals are able to secure high-status careers, which is believed to guarantee a successful and happy life (Chen & Davenport, 2005). Individuals are motivated by seeing their achievements not just for themselves, but bringing honour to the family. Parents use guilt and shame to motivate children to excel (Chen & davenport, 2005). This level of emphasis on academic achievement heightens the stress and anxiety experienced by Chinese students.

Individuals from Chinese society are taught from a young age to suppress their emotions. The expression of strong emotions, both positive and negative, unbalances the collective harmony (Chen & Davenport, 2005). Having emotional difficulties is perceived as bringing shame to the family (Mondia et al., 2012). Physical affection and praise are rarely expressed. Instead, parents express their pride for their child's academic achievement indirectly by speaking of the child's achievements to friends or relatives in front of the child (Sue, 1997). Self-control, discipline and restraint of emotions are highly valued in Chinese culture. These influences and values affect how mental health is perceived and responded to.

Cultural explanation and responses for mental health problems

Paralleling the emic position, the explanations for mental illness are largely shaped by cultural influences. From a traditional Chinese medicine perspective, mental illness is the

imbalance of bodily processes (Yip, 2005). The harmony between nature and the individual is disrupted as the mind is cluttered with desires and strong emotions (Chen & Davenport, 2005). To overcome this, one needs to free their mind of burdens and wants. Similarly, Confucianism teaches that mental health comes from a purified mind, disciplined manner and restrained emotions (Chen & Davenport, 2005). As physical health and mental health are perceived to be interconnected, psychosocial problems are somatised (Yip, 2005), and traditional Chinese medicine is often used to treat mental illnesses (Williams et al., 2006). For serious mental illnesses, the cause is attributed to fate and regarded as predetermined (Cheung, 1986). Often, patients are called to accept the fate of their present situation (Yip, 2005).

Due to beliefs that mental health problems may be due to an imbalance of bodily processes, cluttering of the mind, or punishment from god, Asian immigrants do not readily seek psychological interventions for treating mental illness (Williams & Cleland, 2007). Preference is given to self-help methods, herbal medicine, traditional healing (e.g. acupuncture, meditation, fortune telling), rather than accessing mental health services (Foo, 2007). The family is relied on heavily, including close relatives and friends for extra support (Cheung, 1986). Even if specialised help is sought, Chinese people may continue to receive treatment from Chinese herbalists, for tonics that can strengthen the body and the mind (Yip, 2005).

Problems with immigration for Asians in New Zealand

Asian immigrants living in New Zealand face several challenges due to the change in culture. The following section is summarised into problems occurring within the family and outside the family. For families that immigrated together, the different rates of acculturation between family members increase the intergenerational tensions that occur (Mondia et al., 2012). Younger members adapt to host culture and accept its values more readily than their parents (Chen & Davenport, 2005). For example, showing filial piety is expected from Chinese parents, however, the emphasis on personal choice of Western society may cause conflict within the family. Individuals need to balance the wishes and expectations of the family with their own individual desires.

Looking at social and environmental factors, families are removed from their usual extended support systems and need to re-establish themselves socially and economically. Amongst Korean immigrants, the change in environment dramatically affects their self-care, decreases their involvement in leisure, and increases the barriers to getting paid work (Kim & Nayar, 2012). Immigrants experience a loss of autonomy and sense of worth due to the disruption in their work (Kim & Nayar, 2012), and this contributes to poorer mental health. The process of accessing support may be difficult, as they do not have the prior knowledge to navigate through the different health services of their host country. On top of that,

discrimination based on ethnicity makes adjusting to a new culture more difficult, and this was reportedly experienced by a fifth of Asian migrants (Williams, Graham, & Foo, 2004). Their inability to communicate in English can limit their educational and employment opportunities, and this can be a source of trial and frustration. For those coming from countries of political unrest, the process of immigration may be traumatic and discriminating (Ngai, Latimer, & Cheung, 2001; Williams et al., 2004). The stress of immigration and living with a minority status impacts negatively on their adjustment and mental health (Eyou, Adair, & Dixon, 2000). Immigrants experience high levels of mental health problems, such as post-traumatic stress disorder, depression, anxiety and emotional distress (Ho, Au, Bedford, & Cooper, 2003), but are often reluctant to seek mental health treatment.

Immigrants' experience and level of adjustment are key indicators for mental health development and treatment. Eyou and colleagues (2000) found that Chinese adolescent immigrants who were integrated into New Zealand culture had higher self-esteem than their peers who were separated or marginalised. Similarly, well-adjusted individuals experienced fewer mental health problems than their less-adjusted peers (Hong, Morris, Chiu, & Benet-Martinez, 2000). The level of acculturation also determines how likely immigrants are to access health services, after controlling for age, gender, and health status (Anderson et al., 2003).

The presentation of the above issues does not mean to say all immigrants experience these problems. Even amongst immigrants of the same country, people have different experiences of immigration, depending on the person's age, gender, identification with home/host culture, geographic area, socioeconomic status, language ability, level of acculturation, ethnic-racial identity, experiences with discrimination and perceived minority status (Alvidrez et al., 1996; Foo, 2007; Yip, 2005). These experiences determine their perception of the causes of mental health and the type of treatment sought (Williams et al., 2006).

Stigma and shame: barriers to accessing help

Amongst the Chinese community, there is a lack of understanding and strong stigmatisation of mental illness. The high value of preserving the collective harmony means that disruption to this peace, in the form of mental health problems, is suppressed. The Mandarin word for 'mental illness' has a connotation of 'insanity' in Chinese culture. Therefore, families deny the occurrence of mental illness in the family (Williams et al., 2006). On top of this, there is a dominant cultural belief that "one's dirty laundry should not be dried in public" (Banks, et al., 2006). To have mental health problems is to bring disgrace and shame to the family name. This serious 'loss of face' prevents people from admitting to emotional problems (Yip, 2005). If problems are discussed, they are likely to be attributed to an external cause and presentation is

likely to be somatised (Foo, 2007; Zaroff, Davis, Chio, & Madhavan, 2012). Biological or spiritual explanations are more acceptable than psychological explanations of mental illness (Williams et al., 2006), and relational issues are expressed more readily than individual emotional distress (Chen & Lewis, 2011). Distress is expressed somatically with an emphasis on bodily sensations (Zaroff et al., 2012).

Due to the stigma associated with mental illness, Asian migrants are less likely to seek help from mental health services. East Asians often hold a negative view of therapy and are resistant to help seeking behaviours (Chen & Lewis, 2011). A study found Asian Americans had more negative help-seeking attitudes and greater mental health stigma than European Americans (Masuda & Boone, 2011), and the stigma predicted help-seeking attitudes. Even though the prevalence of mental illness are the same for Asians as well as New Zealanders, Asians are under-represented in psychiatric wards and only 3.2% of secondary mental health and addiction service users are Asians (Ho et al., 2003; Ngai et al., 2001; Ministry of Health, 2013). Their low involvement in mental health services gives the false perception that Asians are mentally robust and do not have mental illnesses (Williams et al., 2006). They are also less likely to self-refer to mental health services, but when they do, the problem is likely to be severe, and crisis intervention is needed (Ho et al., 2003; Williams et al., 2004). Treatment is likely to be terminated prematurely, before full recovery (Williams et al., 2006). Feedback from Asian service users indicated that they were dissatisfied with the waiting time and the lack of health information available in public services (Ngai et al., 2001).

International students of Asian descent

International students make up a significant percentage of the student body in New Zealand universities. In 2011, there were 19,321 international students studying at New Zealand universities, of which Chinese ($n = 6,199$), South Koreans ($n = 1,055$) and Japanese ($n = 938$) students were the largest contributors (Education Counts, 2013). As universities gain a large percentage of their revenue from international students (Ministry of Education, 2012), it is to the interest of the study institutions to offer services that keep students healthy and attending classes. University services need to recognise the unique challenges of international students, and offer aid to those who are struggling (Fritz, Chin, & DeMarinis, 2008).

International students face unique challenges on top of what is normally experienced by immigrants to New Zealand. As mentioned above, immigrants often struggle with language difficulty, limitations to education and employment, lack of social support, adjustment difficulties and discrimination. Addition to this, international students face academic pressures, financial problems, poor health, loneliness, interpersonal conflicts, problems with developing

personal autonomy, and adjusting to new educational and social systems (Baker & Siryk, 1986; Bean, 1982; Church, 1982). For Asian students, language difficulty is a greater issue compared to international students from other countries (Fritz et al., 2008). It is noted that 41% of international students studying in Australia were experiencing substantial levels of stress, due to homesickness, culture shock or discrimination (Russell, Rosenthal, & Thomson, 2010). These stressors contribute to poor mental health (Yip, 2005), whilst international students identify fewer resources to cope with these stressors (Kaczmarek, Matlock, Merta, Ames, & Ross, 1994). The following section highlights specific struggles of Asian international students that differ from domestic students, including the expectation for academic success, loss of social support, poor adjustment, and reluctance to seek help.

Expectation for academic success

International students usually have strong academic skills and are highly motivated. For Asian students, the opportunities for immigration do not come easily and it is with great difficulty that families are able to send their child overseas to study. Being able to go overseas is perceived as superior to staying behind as there are more opportunities overseas for a better life (Williams et al., 2006). With the sacrifices made by parents to send their child overseas, there is more expected of them in return. In Chinese culture, there is already an expectation for children to succeed academically, and the pressure is even greater for students studying overseas. The pressure and expectation to succeed comes not just externally from the family, but the value has become internalised (Foo, 2007). Failure to do so would bring shame and “loss of face” to the family. This need to succeed carries greater weight for Asian students and creates more stress for the individual.

Loss of social support

International students leave their established support systems behind and must learn new ways of relating to the education and social systems of their host country. They struggle with loneliness and the challenge of re-establishing themselves (Yip, 2005). In the process of forming new social supports, Asian students tend to form friendships with others from the same country (Abe, Talbot, & Geelhoed, 1998). Surdam and Collins (1984) found that these individuals who socialise only with other international students are less adjusted compared to those who form friendships with local U.S. students. This is important to note, as the lack of social adjustment impacts negatively on academic performance (Rienties, Beausaert, Grohnert, Niemantsverdriet, & Kommers, 2012). Similarly, a New Zealand study found that international tertiary students were less socially competent compared with domestic students (Brown & Daly, 2005). This can be a particularly trying time as Asian students had previously relied more on familial support than international students from other cultures.

Poor adjustment

In a review conducted by Zhang and Goodson (2011), psychosocial adjustment of international students were predicted by stress, social support, English proficiency, country of origin, length of time in the United States, acculturation, social interaction with locals, self-efficacy, gender and personality. Baker and Siryk (1989) measured students' adjustment by using their Student Adaptation to College Questionnaire. Adjustment was measured using four subscales: academic, social, emotional-personal and institutional attachment. As a whole, international students were found to score lower on social adjustment (Rienties et al., 2012) and institutional attachment (Kaczmarek et al., 1994) than domestic students. For Asian international students, in particular, they were less academically and socially adjusted (Rienties & Tempelaar, 2013), and less institutionally attached (Abe et al., 1998), compared with other international students. Even though these studies were conducted in the United States and the Netherlands, the evidence showed that international students, in particular Asian students, have a more difficult time adjusting to university life than other students. This lack of adjustment affects Asian international students' participation in university life and enjoyment of the study experience, which negatively impacts on their mental health.

Reluctance to seek help

International students' excellence in academic work, coupled with their low usage of counselling services, gives the impression that they are emotionally robust and well-adjusted individuals (Boyer & Sedlacek, 1988; Kaczmarek et al., 1994). However, their low presentation in healthcare settings is more possibly due to their reluctance to seek help, rather than their superior mental health. Delay in accessing help may be due to stigma (Masuda & Boone, 2011), unfamiliarity with the healthcare system, or reluctance to reveal to parents or health professionals about their struggles for fear of 'losing face' (Ngai et al., 2001). Cost of the service was also a barrier identified by Thais for accessing primary health care services in New Zealand (Seesaengnom, Parackal, & Ho, 2012). Surdam and Collins (1984) reported that it was difficult for international students to seek assistance on issues other than those related to immigration and finances. Some students with a history of mental illness may be reluctant to disclose of their problems for fear of jeopardising their chance of studying overseas. The delay in help-seeking could exasperate these problems and lead to poorer mental health.

Summary

Culture is a powerful force that subconsciously shapes how we interpret and respond to the world. It is becoming clear that people cannot be treated as a homogenous group, but there must be recognition for idiosyncrasy based on individuals' background and experiences. Due to

the cultural interpretation and stigma around mental health, Asians are reluctant to seek help for treatment. With more Asian immigrants and students coming into New Zealand, health care services need to provide culturally compatible interventions that are evidence-based and effective. This is addressed in the next chapter with the use of Cognitive Behaviour Therapy with the Asian population.

Chapter 3

Cognitive Behaviour Therapy and its Use with Asians

This chapter will provide a brief introduction to Cognitive Behaviour Therapy, looking at the history of its formation and the principles that form its practice. Then, a closer look is taken on the use of Cognitive Behaviour Therapy with the Asian population, with some of the principles fitting well with Asian culture, while others need to be modified.

History of CBT

Cognitive Behaviour Therapy (CBT) as it is known today did not have a single origin, but its development is with the contribution of many great minds. The most significant contributors were Ellis (1962) with rational emotive behaviour therapy, Wolpe (1958) with behaviour therapy, and Beck (1963, 1964) with cognitive therapy. The 'Beckian' model of CBT has become more dominant since the 1970s and its influence continues to spread. Its empirical focus, integrative practices and cost-effective approach has made CBT the most utilised theoretical orientation amongst psychotherapists around the world (Merrick & Dattilio, 2006).

Principles of CBT

CBT operate from a principle of interacting systems of cognition, emotion, behaviour, physiology and environment. These systems are more commonly referred to as the Five Part Model (Padesky & Mooney, 1990). The parts are interconnected and each part affects the other parts, thus improvement in one area will lead to improvement in the other areas. *Cognitions* are the thoughts, beliefs and interpretations we give to our situations. Situations do not directly affect our emotional reaction, but it is the meaning we give to these situations that produces a certain emotional response (Beck, 1964). The job of the therapist is to educate and encourage their clients to adjust their maladaptive cognitions, and learn new ways of coping (Chen & Davenport, 2005). Improvements in emotional states could also be achieved by changing our behaviour, such as exercising more and being more assertive. The focus of CBT sessions is on current processes that maintain the problem, rather than past or unconscious processes of problem development. Using the Five Part Model, unhelpful thinking and behaviour are identified and replaced with more adaptive alternatives.

CBT sessions are characterised by collaboration and skill acquisition. Collaboration upholds the client as the expert in their life and experiences, whilst the therapist is the expert in psychological intervention. Together, the client and therapist work to resolve unhelpful

behaviours and thoughts. The skills acquired in session are put into practice in homework tasks to encourage learning and generalisation of the skills. A collaborative approach is needed for homework tasks to increase adherence to the plan (Wright, Williams, & Garland, 2002). Clients gain valuable insight and control over their situation with the practice of these skills. Collaboration helps to empower clients by respecting their agency, although a didactic approach may be necessary when the therapist is giving information about a disorder or treatment. Therapists need to be mindful of the degree to which clients expect and can accept collaboration in therapy, especially when the client is of another culture. Clarification of roles and expectations at the beginning of a therapeutic relationship can be helpful to minimise future confusion and for the therapist to adjust their approach to meet client's needs (Chen & Lewis, 2011).

Using CBT with Asians

There is a gap in the literature in examining the use of CBT with the Asian population (Sandil, 2006). Hall (2001) noted that even though CBT is an empirically supported therapy for treating depression, anxiety and stress, more research is needed to determine whether empirically supported therapies are effective for use with ethnic minorities. Hall found a lack of empirical support for culturally sensitive therapy, as well as a lack of inclusion of ethnic minorities in the testing of the efficacy of empirically supported therapies. This gap has important implications as psychologists of ethnic minority clients do not know the most effective intervention for treating this demographic. Furthermore, ethnic minorities may avoid seeking help or end treatment prematurely if they perceive a lack of understanding from psychologists (Hall, 2001). Reports have found Asians are unfamiliar with Western models of care and prefer alternate interventions that incorporate spirituality, balance and holistic health (Te Pou, 2010).

Despite a lack of empirical support, the popularity for the use of CBT for Asian populations cannot be denied. An adaptation of Beck's Five Part Model for Chinese clients was presented at the inaugural International Asian Health Conference in New Zealand (Williams et al., 2004). Chinese culture, values and practices were integrated into Beck's model and the model served to explain the contributing factors to the development of mental illness for Chinese clients. Similar work was also presented at the First Asian Cognitive Behaviour Therapy Conference in May 2006 in Hong Kong. Over 150 presentations were made on the theme of Evidence-based Assessment, Theory and Treatment (Merrick & Dattilio, 2006). At both of these conferences, approval of the adaptation of CBT for Chinese clients was recognised. It is important to note that most of the research involving Asians was conducted in

highly-individualistic countries (e.g. United States of America) and research written in languages other than English may not be accessible.

A particular study of note is one conducted by Williams et al. (2006), in which CBT was adapted for use with an elderly Chinese woman with generalised anxiety disorder. CBT was found to be an appropriate framework for working with Chinese people, as an effective conceptualisation of problem could be made using an adapted Five Part Model. Despite limited improvements in outcome measures, the Five Part Model helped the client understand the nature of her problem and feel more in control of her life. The client remained in therapy for a longer period than expected despite her initial reluctance to be exposed to a novel treatment approach. Lin (1994) found the median duration of therapy for Chinese mental health patients was 8 sessions even when the therapist was matched on ethnicity and language. Williams et al. concluded that CBT was useful in treating Chinese people, although cultural considerations are needed to fully understand the clients' problems and to provide appropriate treatment.

Principles of CBT are transferable

There are a number of principles and practice of CBT that make it transferable for use with Asians. To be a suitable and effective intervention, the framework of therapy has to fit with the expectations of the client. CBT is a non-judgemental approach, and the Five Part Model can be tailored to incorporate idiographic factors and meet individual needs. The model is flexible enough to be able to integrate cultural factors, such as the impact of immigration, somatic complaints and interpersonal relationships. Matching the expectations and preferred approach that Asians have of psychotherapy, CBT is evidence-based, structured, explicit, problem-focused, present-focused, action-oriented, and short-term (Foo, 2007; Williams et al., 2006). Its psycho-educational approach in teaching new coping skills to manage distress is empowering and promotes self-help.

There are aspects of Chinese culture that parallels with the cognitive principle of CBT. A famous Confucius proverb says, *Life is really simple, but we insist on making it complicated*. This highlights that it is our perception that determines our reaction, matching the CBT principle of our cognition determining our reaction, rather than the situation determining our reaction (Chen & Davenport, 2005).

The structure of CBT helps with Asians' tendency for lower tolerance to ambiguity. The preference for structure and practical, immediate solutions is also the practice of CBT. Asians expect to play the patient role, while the therapist is deemed as the doctor. Therapists are respected, as one holding the knowledge and expertise (Chen & Davenport, 2005). Teaching concepts and strategies in a didactic manner would enhance the perceived therapist effectiveness

(Chen & Davenport, 2005). The cultural value of holding deference to authority can be used for greater therapeutic effectiveness.

The emphasis Asians place on value-for-money and practicality facilitates their adherence to completing homework tasks. Homework is an integral part of CBT, as it is used to enhance therapeutic collaboration and ensure skills are transferred into everyday life (Kazantzis, Deane, Ronan, & L'Abate, 2005). As noted in Lyons and Low (2009), homework is important for the client to take on the responsibility for change, explore alternative ways of thinking and behaving, and it also provides a measure for change. The emphasis on value-for-money and preference for brief sessions with quick symptom relief means Chinese clients are motivated to complete homework and expect quick gains (Williams et al., 2006).

Modifications to CBT

For effective therapy, CBT places emphasis on the principle of collaboration. At first glance, it may seem that using a more didactic approach with Asians does not fit with collaboration, as it is not working together with the client towards therapeutic goals. However, Asian clients do not expect this level of collaboration, but would prefer a more directive approach, with the therapist as the authoritative expert (Williams et al., 2006). To be more directive does not deviate from the CBT principle of collaboration, as collaboration can be thought of as understanding clients' expectations and needs, and working within the format the client finds most comfortable and familiar (Williams et al., 2006; Foo, 2007). In this way, to assume a more directive, action-oriented, and didactic approach is to work collaboratively with Asian clients' expectations. Clients are more trusting of their therapist and better therapeutic alliance can be developed if the therapist is more directive (Williams et al., 2006). Therapists need to be aware that their suggestions may carry more weight and are more influential. Similarly, the seemingly non-directive process of Socratic questioning, in which the client is guided by the therapist to discover and challenge dysfunctional beliefs, is counterproductive, as the questioning style does not conform to Asian perceptions of therapists as experts, and the therapist loses credibility with each question asked (Chen & Davenport, 2005). Also, Asian clients may focus on getting the 'right answer' rather than exploring their thoughts and beliefs, as the questioning style intended. Instead of asking a question, therapists can ask the client to provide a rationale for their thoughts or behaviour. Using 'sentence stem' is another effective technique, in that the client is asked to complete a sentence. For example, the therapist asks "If I don't get top marks on this exam....", and wait for the client to complete the sentence. More accurate information can be elicited in this way, rather than directly asking a question (Chen & Davenport, 2005).

Due to the hierarchical nature of Asian culture, clients expect to be told what to do (Chen & Davenport, 2005). They are familiar with the professional offering solutions and they may not realise they need to actively participate in their recovery (Williams et al., 2006). Furthermore, the deference to authority means clients may be reluctant to disagree with their therapist (Chen & Davenport, 2005). To counter these expectations, therapists can educate clients on the therapy process, highlighting that the therapist is the expert in therapy, and the client is the expert in his or her life (Chen & Davenport, 2005). The client needs to understand that their input is needed throughout the therapeutic process in order for problems to be resolved.

Summary

Cognitive Behaviour Therapy is a popular treatment with its brief, structured sessions, fitting well with the expectations of Asian clients. Its flexible framework and collaborative approach eases the adaptation to other cultures. While more research is needed outside of the United States to understand CBT's application and effectiveness, it may be that low intensity CBT can be utilised for Asians to receive psychological intervention without experiencing the stigma attached to attending therapy sessions. The accessibility of low intensity CBT is addressed in more detail in the next chapter.

Chapter 4

Low Intensity CBT

To improve the psychological wellbeing of the general public, there has been a move to provide more accessible forms of support in a more economical manner. Society suffers when the demand for therapy exceeds supply and people end up on waiting lists for therapy. One way of increasing access to therapy is by reducing the contact time of interventions, so that treatment can be offered to more people. There is a need for more flexibility in how therapy is delivered, so that more can benefit. The following section outlines the various forms of Low Intensity CBT (LI-CBT) and its potentials, pitfalls and empirical evidence. The section concludes with a look at the LI-CBT programme, Living Life to the Full, which is used for this study.

The need for Low Intensity CBT

Despite the effectiveness and wide use of CBT, there are a number of barriers for accessing service. Traditionally, CBT is delivered for 12-20 weeks, in one hour face-to-face appointments. However, for some, to make time for therapy once a week requires arrangements for travel, childcare, and time off work (Bennett-Levy, Richards & Farrand, 2010). The effort and cost needed for this commitment to CBT may be too great a barrier. Stigma around accessing mental health services may also deter those from seeking help. Even when people do decide to seek help, the shortage of qualified psychotherapists means people end up on long waiting lists and only those in high criticality are given priority. This prevents those who are just under the clinical threshold from gaining the help they need. These barriers make it difficult for intervention to be provided at early onset of mental health issues, where gains would be greatest.

The concern for greater accessibility of mental health services has led to the development and government funding of the Improving Access to Psychological Therapies (IAPT) programme in the UK (Department of Health, 2008). The IAPT programme started in 2006, with a goal of providing evidence-based psychological therapies to more people (IAPT Programme, 2014). CBT was the most commonly used IAPT intervention that met the National Institute of Health and Care Excellence (NICE) treatment guidelines. IAPT seeks to address the unmet demand for psychotherapies, mainly in treating depression and anxiety in primary care settings.

IAPT distinguishes between two types of CBT, high intensity and low intensity. High Intensity CBT (HI-CBT), or traditional CBT, is delivered to clients with more complex and perpetuating problems, whereas Low Intensity CBT (LI-CBT) targets mild to moderate depression and anxiety. HI-CBT is provided by qualified professionals, such as nurses and

psychologists. LI-CBT is facilitated by Psychological Wellbeing Practitioners, or para-professionals, who do not need a professional qualification to deliver the service. HI-CBT sessions are longer, typically 12 to 20 sessions, depending on severity and diagnosis (Gyani, Shafran, Layard, & Clark, 2013). LI-CBT has fewer sessions with minimal contact between therapist and client, making intervention more economical and accessible. NICE recommends a stepped care model of service, in that clients are first offered LI-CBT, with those failing to respond to treatment being stepped up to HI-CBT and receiving more intensive treatment (IAPT Programme, 2014). LI-CBT is not considered a “lesser than” intervention to HI-CBT. For some, the flexibility of LI-CBT is more appealing than HI-CBT (Marks & Cavanagh, 2009). Lovell and Richards (2000) highlighted that there is no empirical basis for the delivery style of traditional CBT. LI-CBT attempts to answer to this, by delivering evidence-based practice, in an evidence-based approach.

Principles of LI-CBT

In LI-CBT, the materials are seen as central to the intervention, rather than an addition to therapy (Richards, 2010). Low intensity practitioners provide guidance and support, but it is the materials that teach the CBT concepts and skills (Bennett-Levy et al., 2010). In the UK, self-help materials are recommended for early treatment of mild and moderate depression (NICE, 2004). Clients are taught self-management skills to apply to their daily situations and progress is monitored by outcome measures (Williams & Garland, 2002). Between-session homework and evaluation of progress is a major part of LI-CBT (Bennett-Levy et al., 2010). In determining what level of therapy a client requires, a guiding principle is to minimise the burden placed on clients whilst maximising the potential positive clinical outcome (Sobell & Sobell, 2000). Depending on the level of the presenting problem, the intervention chosen should pose the least restriction whilst still achieving positive outcomes (IAPT Programme, 2014).

Benefits of LI-CBT

Low intensity CBT has a number of benefits over traditional, HI-CBT. Already mentioned, LI-CBT is an effective, evidence-based intervention, that is more accessible, cost-effective and flexible (Bennett-Levy et al., 2010). LI-CBT reduces the stigma and discrimination attached to mental health, as it allows access to interventions without being involved in the mental health sector (Williams, 2001). The general public is more accepting of self-help approaches than using medication or psychotherapy (Jorm et al., 1997). More privacy can be provided to LI-CBT clients as receiving intervention can be done without leaving the home. This removes the potential barriers of physical, psychological, social, environmental and economic factors that often make attending clinic appointments challenging (Lovell, 2010). The

lack of cost and time restraints allow for greater access by the general public. Also, LI-CBT allows for people who have not reached the threshold to qualify for HI treatment to target the problem early before it exasperates. Service users are able to choose the type of intervention, according to their preference. They can also determine their own pace of treatment and this provides a sense of control for their health (Williams, 2001). For example, self-paced, internet-based interventions offer flexibility in how frequently service-users access help. LI-CBT is presented in simplistic terms that are more easily-understood by the general public (reading age is 12 years), as opposed to the more technical language of traditional CBT (reading age is 17 years; Williams & Garland, 2002). Moreover, the effectiveness of the intervention continues after the sessions end, as the CBT materials can be readily accessed (Westbrook et al., 2011).

Challenges to LI-CBT

Despite its strengths, LI-CBT has many shortcomings. From the professional perspective, there is a concern that LI-CBT delivery will not be able to uphold the professional quality established by HI-CBT (Williams & Martinez, 2008). As LI practitioners do not need a professional qualification, their training and supervision to delivery LI-CBT is of paramount importance. Also, LI practitioners need to have the confidence and experience to handle client safety issues and confidentiality concerns. There is a concern that failed treatment using LI-CBT materials may prevent clients from seeking help in the future and dilute the potential benefits of HI-CBT (Williams & Martinez, 2008). Also, a major criticism of LI-CBT is that the manualised materials do not provide the intensity and flexibility needed by some clients (Williams & Martinez, 2008).

As with all self-help interventions, attrition is a major issue. Cuijpers, Donker, van Straten, Li and Andersson's (2010) review found that drop-out rate was indeed higher for guided self-help compared to face-to-face HI-CBT, although the difference was not significant. Practitioners are concerned that the reduced therapist contact can be problematic for LI-CBT (MacLeod, Martinez, & Williams, 2009). Reflecting the need for practitioner contact, Gellatly et al.'s (2007) review found guided self-help as the only effective form of self-help. However, it is unclear whether the effect was due to therapist contact. The factors that contribute to the effectiveness of guided self-help need to be investigated with future research.

Suitable client characteristics for LI-CBT

There are particular client characteristics that need to be considered when using LI-CBT. Practitioners considered higher motivation, commitment, self-efficacy and lower rates of hopelessness as traits that service users need for better outcomes in using LI-CBT (MacLeod et al., 2009; Williams, 2001). Usually, clients with milder problems would be recommended for

LI-CBT, compared to clients with more enduring and complex problems. Clients whose problems are too severe, or have physical causes will not see as much benefit from LI-CBT. Improvements were greater for clients who self-referred, compared to mental health referrals (Mataix-Cols, Cameron, Gega, Kenwright, & Marks, 2006). Clients who are younger with high socio-economic status and education are more likely to have successful outcomes with self-help treatment (Schmidt & Miller, 1983). Having an internal locus of control also predicts better clinical outcomes (Mahalik & Kivlighan, 1988).

Types of LI-CBT

LI-CBT is a new and growing intervention amongst evidence-based psychological treatments (Bennett-Levy et al., 2010). While it is still forming, Bennett-Levy et al. (2010) proposed a working definition of low intensity as the low usage of specialist therapist time, usage in a cost-effective way, and high access to the population. Low usage of specialist's time can be achieved by seeing more than one client at the same time, or by seeing them for fewer/shorter sessions. This allows the intervention to be more cost-effective and more people are able to access the support.

LI-CBT comes in a number of forms, including guided self-help, unguided (pure) self-help, internet-based interventions, and group CBT. Amongst these forms of delivery, written self-help materials are the most commonly used amongst therapists (Keeley et al., 2002). There are also different ways consumers can be supported, including telephone, email, face-to-face, or text messaging. These variations in delivery allow more people to access help in a way that they choose. The preference for the type of delivery is associated with the individual's learning style (Williams & Martinez, 2008). The effectiveness of the intervention depends on clients' expectations and preferences. Some may be more inclined to use internet-based CBT over face-to-face sessions (Marks & Cavanagh, 2009), while another study has shown the opposite preference (Klein & Cook, 2010). The issue, therefore, is not that one mode is superior to the other, but that clients should be able to choose a modality that matches their preference. In the section below, we will look at the most common forms of LI-CBT.

Guided self-help versus unguided self-help

The biggest distinction between the modes of LI-CBT delivery styles is guided and unguided self-help. Guided self-help is delivered in-person or via the internet, with the service user being supported by a low intensity practitioner, using self-help materials over 5-8 sessions (Lovell, Richards & Bower, 2003). Interactions with the practitioner can be through face-to-face, over the phone, through email or text messaging, depending on service users' preference.

Unguided self-help uses internet-based or book-based interventions without the support of the facilitator, allowing more flexibility and control for the service user.

There are some drawbacks to both modes of delivery. For guided self-help, considerations need to be taken when using phone, email or text messaging modes of contact, as the lack of non-verbal cues in communication can lead to misunderstanding between service user and facilitator (Richards et al., 2006). In certain situations, certain populations are unable or unwilling to access guided self-help. Some prefer anonymity, while others live in remote areas with limited access to services. For these individuals, self-help books or internet-based interventions may be the only way they can access interventions (Bennett-Levy et al., 2010). For internet-based interventions, unguided programmes have poorer completion rates and weaker clinical effectiveness compared with guided self-help (Cavanagh, 2010). In one study, only 56% of participants completed a full course of unguided, internet-based intervention (Waller & Gilbody, 2009). Despite the drawbacks, unguided, internet-based programmes are able to be accessed by more people than guided self-help, which is limited by the number of available facilitators.

Internet-based verses book-based

There are a vast amount of self-help materials on the internet and in book form. It is often difficult to choose between what is available, much less find materials that are evidence-based and effective (Richards & Farrand, 2010). A distinction is made between self-help and psycho-education materials, as the former provides not just information, but also self-management skills for presenting problems (Williams, 2001). Psycho-education information alone is an ineffective form of self-help. The general public are less familiar with internet-based interventions and have lower expectations of its effectiveness, and, therefore, tend to prefer book-based materials (Murray et al., 2003). For both modes, readability of the materials and participants' prior perceptions about the mode of delivery can affect the rate of attrition and needs to be carefully considered when selecting interventions. Whereas the information presented in self-help books can be converted to an internet-based version, the benefit of internet-based interventions is the incorporation of media and audio pieces that enhances information delivery. These alternative modes of delivery are especially important for service users with limited grasp of the English language. Client's literacy level needs to match the materials that are used. For those that struggle with reading and attention, audio or visual materials can be used (Williams & Martinez, 2008).

Individuals versus group-based

LI-CBT can be delivered in individual and group formats. The CBT skills that are used are similar in both settings, with a focus is on the CBT materials. Group-delivery is more cost-effective than individual-delivery as information is delivered to many people at the same time. The major advantage for group-delivery is that participants can learn from and share ideas with each other, a component that is not available with individual-delivery (Chellingsworth, Williams, McCreath, Tanto, & Thomlinson, 2010). There is also a sense of belonging that comes from groups, as participants realise they are not alone in their struggles. Group delivery is also more cost-effective, as more people are receiving the intervention at the same time (Brown et al., 2011).

Despite its benefits, there are several challenges to group-delivered CBT (Chellingsworth et al., 2010). Support through groups is less flexible with timing and location, as groups run at a specific time and place. Getting sufficient number of participants to begin a group, finding an available, competent facilitator, and hiring a space that would accommodate the participants are all logistical considerations that could make group-delivery challenging. Also, it is just as difficult to retain participants for groups as it is for individuals. Arguably, stigma would be a greater issue for groups as there are more people involved and anonymity is less secure. Individual-delivery tends to be favoured over group-delivery (Brown et al., 2011). Moreover, with more people involved, it would be more difficult to manage the interaction between the participants, ensuring that people have a turn in speaking and disruptive behaviour is minimised. Individual-delivery, on the other hand, allows individual concerns to be addressed and delivery can be catered to individual abilities. The flexibility in time and the confidentiality of individual interventions is often more feasible and valuable to service users.

The empirical evidence for Low-Intensity CBT

Even though the effectiveness of traditional CBT has been well documented with strong empirical evidence (Butler et al., 2006; Tolin, 2010; Rush, Beck, Kovacs & Hollon, 1977; Evans et al., 1992; Paykel et al., 1999), the literature and research around low intensity CBT is still under development. LI-CBT is a new form of intervention, developed less than a decade ago, and is still much contained in the UK. However, evidence has begun to emerge on the effectiveness of guided self-help interventions and its use has been incorporated into the NICE guidelines. The following section will outline the comparison between traditional CBT and LI-CBT, and the various delivery modes of LI-CBT.

HI-CBT versus LI-CBT

Traditionally, CBT is delivered for 12-20 weeks, one hour face-to-face appointments. However, there is no empirical basis for this delivery style (Lovell and Richards, 2000). With a move towards more cost-effective interventions, there is a need to not only deliver evidence-based practice, but in an evidence-based approach. Most studies find evidence to suggest that guided self-help and traditional CBT have comparable effects (Jacobson et al., 1996; Lovell et al., 2003; Cuijpers et al., 2010). While these studies do not suggest a superiority of LI-CBT to HI-CBT, the findings does differ from therapists' perceptions, as self-help was considered less effective to therapist treatment (Keeley et al., 2002). This difference in perception of therapists and actual research findings warrants more research to clarify the effectiveness of this relatively new technique.

While the evidence indicates no differences between LI-CBT and HI-CBT, there is some empirical evidence emerging that support the shorter and more focused delivery style of LI-CBT (Whitfield & Williams, 2003). Barkham et al., (1996) found that the improvement in CBT treatment plateau after eight sessions. There is value then, in offering LI-CBT as a more economical and equally effectiveness intervention to traditional CBT. LI-CBT can be more widely accessed, allowing more people to benefit from it, and some tend to prefer this form of treatment (Jorm et al., 1997).

Guided versus unguided self-help

There is strong evidence to suggest the effectiveness of guided self-help over unguided self-help. Reliable recovery rates were significantly higher among those who received guided self-help compared to those who received unguided self-help (Gyani et al., 2013). The guidance component of self-help CBT has also been under research. Gellatly et al.'s (2007) review using meta-analysis and meta-regression found guided self-help as the only significant moderator of effective outcomes in depressive clients using self-help. Interestingly, the level of support need only be minimal monitoring and encouragement. Gellatly et al. found that the effectiveness of this form of CBT was irrespective of the number of sessions offered and the facilitator's training and background. This finding differed from previous research that found therapist input had no additional benefits on top of self-help treatment (Williams, 2001). Moreover, for those who were stepped up to HI-CBT after unsuccessful LI-CBT intervention, a significantly higher proportion had received unguided self-help (54.5%) compared to a lower proportion who received guided self-help (25.7%; Gyani et al., 2013). This finding suggests the inferiority of unguided self-help to guided self-help.

Evidence for the effectiveness of guided self-help is clearer for the treatment of depression than it is for anxiety. This difference is reflected in the NICE guidelines, in that

guided self-help is recommended for the treatment of depression, but not unguided self-help (NICE, 2009). For anxiety, both forms of self-help were recommended (NICE, 2011). However, it was acknowledged that there is less evidence for the effectiveness of unguided self-help for the treatment of anxiety. Gyani et al. (2013) also supported this differentiation using logistic regression analyses. Depressive patients receiving guided self-help was more likely to reliably recover than those who received unguided self-help. For anxiety, the reliably recovery rates were comparable between guided and unguided self-help. However, results for this research did not control for the number of sessions the participants undertook, whether guided or non-guided self-help. Therefore, it is unclear whether the effect was due to the guidance of a practitioner or the number of sessions completed.

Modes of LI-CBT delivery

It is difficult to determine the superiority of one mode of LI-CBT delivery over another, as there is insufficient research to allow for this conclusion. Evidence vary across the different modes of delivery and with different psychological problems. However, it is possible to determine the effectiveness of internet-based, book-based and over-the-telephone delivery styles. For internet-based interventions, it was found to be effective and clinical significant for treating anxiety in Australia (Mewton, Wong, & Andrews, 2012). However, only 55.1% of the participants completed the unguided six lessons. For depression, book-based self-help materials are at least as effective as internet-based interventions (Gellatly et al., 2007). Anderson et al., (2005) found evidence for unguided, book-based LI-CBT to be an effective intervention, although the evidence was based on studies that were small and of low quality. For internet-based and book-based intervention, guided self-help was found to be more effective than unguided approaches (Spek et al., 2007; Barak, Hen, Boniel-Nissim, & Shapira, 2008; Hirai & Clum, 2006). Face-to-face LI-CBT was only superior to over-the-telephone interventions for more severe cases, whereas the effects were comparable for lower severity cases (Hammond et al., 2012). There is insufficient evidence to determine a clinically significant difference between individual guided self-help and group-guided self-help. However, some evidence suggests a favouring of the latter in reducing depression symptoms at 1-month follow-up (NICE, 2004). There is not yet any study on the effectiveness of text messaging as a form of guided self-help, or how frequently the support needs to be for guided self-help interventions to be effective (Andersson & Carlbring, 2010).

Living Life to the Full

The current study examines the effectiveness of a LI-CBT programme developed by Dr. Chris Williams, of Glasgow University (Williams, 2007). The programme was named Living

Life to the Full (LLTTF) and teaches life skills to enable the users to fully engage and meet the demands of everyday life (Williams, 2007). The rationale for LLTTF is to provide rapid, cost effective, accessible and evidence-based treatment to people with less severe problems. The content covers the Five Part Model and teaches strategies to change altered thinking, feelings, behaviours, and physical symptoms. The programme uses language that is more easily understood for the community setting, without deviating from the traditional CBT approach (Williams & Garland, 2002). The programme is presented in colourful booklets that are short and well-designed. This layout greatly aids concentration and is more easily digestible than traditional CBT workbooks (Boyle, Lynch, Lyon, & Williams, 2011). The programme can be used with or without the support of a para-professional, accessed on the internet or in book form, and conducted individually or in group format. It includes media and visual aids that enhance the learning of the CBT concepts.

The LLTTF programme has been adapted for use with different demographics. Boyle and colleagues (2011) examined the use of LLTTF for adolescents in the UK. Of 280 students in secondary school and their teachers, they found the intervention was well-received. The LLTTF was also tested for group delivery in the community. A randomised controlled trial found LLTTF to be effective in improving depression, anxiety and social functioning (Williams, Morrison, McConnachie, & McClay, 2014). The programme has also been used for Black and Minority Ethnic women in a classroom setting (Lloyd & Abdulrahman, 2011). They found that 100% of respondents agreed or strongly agreed that the classes had been helpful. Unfortunately, being a newly developed programme, the research conducted using LLTTF is limited and support for the effectiveness of the programme is still accumulating. Furthermore, LLTTF has only been used and tested in the UK. It is important, therefore, to expand its use and determine the effectiveness and suitability of the LI-CBT programme outside these contexts. The current research took LLTTF to New Zealand and examined its use with Asian students.

Summary

Despite the effectiveness and popularity of CBT, obstacles, such as access, cost and stigma, may stop people from seeking help. More accessible forms of CBT, named low-intensity CBT have been developed to teach life skills in response to the demands of everyday life (Williams, 2007). The treatment of mild to moderate levels of depression and anxiety has been shown to be effective with low intensity, guided self-help interventions. The various modes of delivery provide more flexibility and privacy for the user, the latter of which is especially important for Asian clients. Given the difference in value and culture in which the LI-CBT programmes was developed, it is important to examine its usefulness when applied to the

Asian population. This study adds to the research by testing the effectiveness and cultural compatibility of a guided self-help programme for Asian students in New Zealand.

Chapter 5

Present study

This chapter provides the rationale, aims and hypotheses for the present study.

Research rationale

Even though CBT has been shown to be an effective intervention in the treatment of depression and anxiety, few researches have examined the effectiveness of CBT with Asian populations outside the United States. Furthermore, no research has been identified that looked at the effectiveness of LI-CBT with Asians in New Zealand. With the increasing migration of Asian students into New Zealand's educational institutions, the mental health concerns of this group need to be addressed. As people respond differently to treatment, the cultural fit of the LI-CBT programme need to be tested for this particular population.

Research aim

As mentioned previously, the purpose of the study was to fill the gap by examining the effectiveness and cultural compatibility of a guided self-help CBT programme amongst students of Asian descent in New Zealand. This was achieved, firstly, by assessing effectiveness of the programme on measures of depression, anxiety, quality of life, adjustment and understanding of stress. Secondly, the cultural compatibility of the programme was explored using a client satisfaction measure and semi-structured interview. A better understanding of the participants' experience of the programme will be identified through feedback during the interview.

Research hypotheses

Hypothesis 1: It was hypothesised that, as a group, the ratings on the outcome measures would improve over time. The interest is on the effectiveness of the whole programme, based on the scores from pre-intervention to post-intervention. More specifically, it is predicted that participants' total scores on the:

- Patient Health Questionnaire 9 (PHQ-9; Spitzer, Kroenke, & Williams, 1999) would decrease, indicating a reduction in depressive symptoms
- Generalised Anxiety Disorder 7 (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006) would decrease, indicating a reduction in anxiety symptoms

- World Health Organisation Quality of Life Questionnaire (WHOQOL-BREF; WHOQOL Group, 1994) would increase, indicating an improvement in perceived quality of life
- Student Adaptation to College Questionnaire (SACQ, Baker and Siryk, 1989) would increase, indicating an improvement in adjustment to studying
- Understanding stress and low mood (UndSLM; Williams, 2007) would increase, indicating an improvement in participants' understanding of the concepts taught in the programme

Hypothesis 2: On the individual participants' level, it was hypothesised that the improvements of participants' scores on depression (PHQ-9; Spitzer et al., 1999) and anxiety (GAD-7; Spitzer et al., 2006) would be clinically significant. Additionally, comparisons with sample means from other studies would show an improvement in scores on quality of life (WHOQOL-BREF; WHOQOL Group, 1994) and adjustment (SACQ; Baker and Siryk, 1989; i.e. participants would score under the mean before the intervention, and above the mean after the intervention).

Hypothesis 3: It was hypothesised that participants would be satisfied with the programme provided, based on positive ratings on the Client Satisfaction Questionnaire 8 (CSQ-8; Larsen, Attkisson, Hargreaves, & Nguyen, 1979). A high satisfaction rating would indicate a high suitability and cultural compatibility of the programme for the study's sample.

Chapter 6

Method

This chapter presents the method for the present study, specifying the participants, design, procedure, intervention, and measures.

Participants

There were 13 participants recruited for this study, 11 of whom completed the 8 weeks programme. Data from the two participants who dropped out were excluded from analysis. The ages of the participants ranged from 20 to 29 years ($M = 23.8$, $SD = 3.2$) and had lived in New Zealand for 2 to 28 years ($M = 7.9$, $SD = 8.6$). Participants were 63.6% male ($n = 7$) and 36.4% female ($n = 4$). There were 4 participants from China, 2 from Malaysia, 2 from the Philippines, and 1 each from Taiwan, Vietnam and Cambodia. It is important to note for later discussion that 63.6% of the participants were of Chinese descent ($n = 7$). In terms of their level of study, 54.6% were undergraduates in New Zealand universities ($n = 6$), 18.2% were postgraduates ($n = 2$), and 27.3% were either in language schools or enrolled in internships ($n = 3$). Participants were asked what problems they would like help with on the screening questionnaire; stress was identified by 81.8% of the participants ($n = 9$), low mood by 54.6% ($n = 6$), anxiety by 54.6% ($n = 6$), sleeping problems by 27.3% ($n = 3$), and other problems that the participants specified were social life and general sadness.

Inclusion/exclusion criteria

Interested students were screened for suitability based on country of origin, indication of some level of mental illness, no risk to self and others, and absence of substance abuse, psychosis and borderline personality disorder. Students from outside of East Asian or Southeast Asian countries were excluded, as it was important to retain a sample that had a relatively similar cultural background, in order to draw conclusions that were generalisable and for the data to be comparable to other cultural studies. The other exclusion criteria were used as the programme was designed for mild to moderate levels of mental illness. Only students who fitted the criteria and responded within the deadline were included in the study. Students who did not meet the criteria were given contact numbers of other health care services they could access.

Design

This study tested the effectiveness of the Living Life to the Full (LLTFF; Williams, 2007) programme in improving depression, anxiety, quality of life, adjustment and

understanding of stress. Given the normal distribution of the data and the use of continuous level scaling of the measures, the use of parametric statistics was employed. The interest of the study is on the effectiveness of the LLTTF programme as a whole, therefore, paired samples t-tests were used to analyse the difference between mean scores at baseline and week 8 across all the measures. Descriptive statistics were used to describe clinical significance, to make comparisons with sample means, and to determine client satisfaction. Statistical analyses were performed using SPSS[®] version 21.0 (SPSS Inc., Chicago, IL, USA) for Windows[®]. Qualitative data obtained from the semi-structured interviews were summarised and presented under relevant themes. The combination of quantitative and qualitative data was to provide meaningful and rich information, and to enhance the understanding of the overall analysis. Ethics approval for this study was obtained through the Health and Disability Ethics Committee (ref: 13/STH/86).

Procedure

Recruitment

The posters and flyers advertising the study were printed in English and Mandarin (refer to Appendix A). The advertisements were distributed in the libraries, classrooms, and common rooms, of the universities and language schools in the Auckland area. Participants were also recruited from university student clubs and by word of mouth. The email address of the researcher was given on the advertisements for students to enquire about the study.

Screening questionnaire

Students who responded to the advertisements were emailed the screening questionnaire (see Appendix B). As previously mentioned, the questionnaire asked about potential participants' age, country of origin, number of years in New Zealand, presenting problems, risk to self and others, previous diagnosis and ability to commit to the 8-week programme. If the participant criteria were met, a meeting was arranged at a convenient location to conduct the initial assessment.

Informed consent

Suitable candidates were emailed the information sheet (Appendix C) and consent form (Appendix D) to look through before the initial interview. During the initial interview, the researcher highlighted topics that were expected to be of high concern for people from Asian culture (e.g. voluntary participation, confidentiality, and protection of information). Also, it was explained that the programme is self-help oriented, rather than therapy-based. The participants were also made aware that the programme is run in fulfilment of a Masters thesis and that the

researcher is also the facilitator of the study. All participants signed a consent form before proceeding with the initial assessments. Obtaining informed consent took between 5 to 15 minutes. Those who agreed to participate commenced the programme a week after.

Intervention

The 8-week LLTTF programme was developed by Dr. Chris Williams (2007) of Glasgow University. The programme used basic Cognitive Behaviour Therapy principles and techniques to teach life skills to meet the demands of everyday life. The programme was presented in nine colourful booklets with differing topics (refer to Table 1). Each week, the participants were given a different book, with the exception of the first session when the LLTTF guide book was also given. The programme included a video, which was played during the first session, explaining the interaction of the Five Part Model. Sessions were held in the university student centre meeting rooms, study rooms in the university or local libraries, and quiet, local cafes. To allow for comparison of results, the facilitator adhered to the script and delivered the content in a consistent manner.

Table 1

The self-help materials used in this study, with the week the booklet was presented, the name of the booklet, and the topic the booklet covered

Week	Name of booklet	Topic
1	<i>Write all over your bathroom mirror</i>	A guide to using LLTTF
1	<i>Why do I feel so bad?</i>	Explaining the Five Part Model
2	<i>I can't be bothered doing anything</i>	Increasing pleasurable activities
3	<i>Why does everything always go wrong?</i>	Changing negative thinking
4	<i>I'm not good enough</i>	Increasing confidence and self-esteem
5	<i>How to fix almost everything</i>	Breaking down problems and making plans
6	<i>The things you do that mess you up</i>	Changing unhelpful behaviour
7	<i>Are you strong enough to keep your temper?</i>	Handling anger
8	<i>10 things you can do to make you feel happier straight away</i>	Practical tips to boost mood

Note. Booklets are from Chris Williams (2007) Living Life to the Full programme

The delivery of this study had been carefully considered to fit with the nature and values of this particular sample. LLTTF was originally designed for group-delivery of up to 16 people. However, as mentioned in chapter 4, group delivery limits the flexibility for the session to be tailored to individual needs and beliefs (Chellingsworth et al., 2010). The group setting also makes it more difficult to disclose beliefs that may be perceived as shameful (Tucker & Oie, 2007). The avoidance of shame is particularly important in Asian culture, given their reserved nature and the stigma around mental illness (Yip, 2005). After careful cultural considerations, it

was speculated that participants would appreciate the privacy of individual sessions. This would allow participants to be more open and transparent in their discussions, thus, benefiting more from the programme. The developer of the programme was contacted to ascertain whether the booklets would be suitable for use with individuals. The researcher was given permission to run the programme on a one-to-one basis, similar to the LLTTF online format.

Before the programme was delivered to the participants, the facilitator studied the LLTTF scripts for each module and pilot studies were conducted with a volunteer in the same age bracket and cultural background as the participants in this study. At the beginning of each session, a brief review of last week's session and the homework task was conducted. The facilitator then went through that week's booklet and explained the concepts in a friendly and engaging manner. The skills were directly put into practice using the session worksheets. Homework tasks involved planning what the participant wanted to do for the week, ensuring that the goals were useful, specific and realistic. Self-review of the homework task was encouraged. The sessions were conducted once a week, with session times ranging from 25 to 65 minutes, with an average time of 40 minutes.

Some modifications for running of the programme were made to fit with the one-to-one format. Parts of the programme that involved group exercises were omitted. As all the materials were in the books and it was presented to individual participants, computer slides and posters were not used. The anxiety control training was omitted due to limited time. The session times were also shorter than that would be required for a group format. At times, the facilitator would use Mandarin to explain the concepts that participants had difficulty understanding. To ensure comparability between participants, the facilitator limited tailoring the programme to the individuals, except when checking for current mental state at the beginning of each session. The facilitator is of Chinese descent and spoke Mandarin at times during the session if it helped to clarify the content.

Measures

The measures that were used for this study assessed depression, anxiety, quality of life, adjustment, understanding of stress and low mood, and client satisfaction. All the measures were paper-and-pencil self-report instruments. The measures were all suitable for community, rather than clinical, use. The initial assessment included all of the measures, excluding client satisfaction evaluations, and took between 10 to 50 minutes to complete, with an average of 26 minutes. Subsequent assessments at the end of each session took 3 to 7 minutes to complete. The final assessment took 15 to 25 minutes to complete. The LLTTF pack included individual session evaluations that were used as feedback for the facilitator and were not used for further

analysis. A semi-structured interview was conducted at the end of the programme to determine the relevance of the programme for this particular population. The following section outlines the measures used for the study and its psychometric properties.

Patient Health Questionnaire 9 (PHQ-9)

The PHQ-9 (Spitzer et al., 1999, see Appendix E) consisted of nine questions correlating to the depression diagnostic criteria in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV, American Psychiatric Association, 2000). It was a measure developed and recommended for screening depression in the primary care setting and is also used as the standard measure across primary mental health practices in New Zealand (Nease & Malouin, 2003; Lyons & Low, 2009). The PHQ-9 is a valid and reliable measure for depression in health care settings, as well as in the general population (Kocalevent, Hinz, & Brahler, 2013). It has also been identified as a useful tool for monitoring treatment progress (Chen, Huang, Chang, & Chung, 2006) and is effective in detecting clinical change over time (Lowe, Kroenke, Herzog, & Grafe, 2004; Titov et al., 2011). The PHQ-9 showed good internal consistency in other studies (Cronbach's $\alpha = .87$, Kocalevent et al., 2013; $\alpha = .74$ and $.81$ pre- and post-treatment, respectively, Titov et al., 2011), and also had good internal consistency with this study ($\alpha = .89$). Participants responded on the 4-point Likert scale, indicating 0 = *not at all*, 1 = *several days*, 2 = *more than half the days*, 3 = *nearly every day*. PHQ-9 scores ranged from 0 to 27, with 5 levels of severity: minimal (total score: 1-4), mild (total score: 5-9), moderate (total score: 10-14), moderately severe (total score: 15-19), and severe (total score: 20-27). A cut-off score of 10 is considered clinically significant in detecting major depression (Spitzer et al., 1999; Arroll et al., 2010). For this study, the PHQ-9 was administered at baseline and every week of the programme to determine changes in depressive symptoms.

Generalised Anxiety Disorder 7 (GAD-7)

The GAD-7 is a seven-item questionnaire reporting anxiety severity over the past two weeks (Spitzer et al., 2006, see Appendix F). In a systematic review, GAD-7 showed good criterion validity for sensitivity (89%) and specificity (82%) for detecting generalised anxiety disorder at the threshold score of 10 (Kroenke, Spitzer, Williams, & Lowe, 2010). It is also moderately good at screening for panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%), and post-traumatic stress disorder (sensitivity 66%, specificity 81%; Kroenke, Spitzer, Williams, Monahan, & Lowe, 2007). Data from randomised controlled trials found the GAD-7 to be sensitive to change and had a one-factor structure (Dear et al., 2011). The GAD-7 had good reliability, construct validity and procedural validity in a study carried out in 15 primary care clinics (Spitzer et al., 2006). It had adequate internal consistency in other studies (Cronbach's $\alpha = .79-.91$; Dear et al., 2011), and

was very good for this study ($\alpha = .88$). Participants responded on the 4-point Likert scale, indicating 0 = *not at all*, 1 = *several days*, 2 = *more than half the days*, 3 = *nearly every day*. GAD-7 scores ranged from 0 to 21, with 4 levels of severity: minimal (total score: 0-4), mild (total score: 5-9), moderate (total score: 10-14), and severe (total score: 15-21). The cut-off score of 10 was recommended for detection of generalised anxiety disorder (Kroenke et al., 2010). For this study, the GAD-7 was administered at baseline and every week of the programme to determine changes in anxiety symptoms.

World Health Organisation Quality of Life Questionnaire (WHOQOL-BREF)

Quality of life is defined by the World Health Organisation as an individual's perception of their place in life, in the context of their culture and value systems, and in relation to their aspirations, expectations, standards and concerns (WHOQOL Group, 1994). The WHOQOL-BREF is a 26-item, shortened version of the WHOQOL-100. It is divided into 4 domains of physical, psychological, social and environment subscales, with two general items that are examined separately (WHOQOL Group, 1998). The scores were transformed to a 100-point scale to allow comparisons between domains and with the WHOQOL-100. Four types of response format using 5-point Likert scales were used throughout the instrument, with higher scores indicating better quality of life. Respondents indicated their perception of quality of life over the past 2 weeks.

With testing over 23 countries, WHOQOL-BREF showed good psychometric properties of reliability and validity (Skevington, Lotfy, & O'Connell, 2004). Significant discriminant validity was found for each domain in the total population. Internal consistency across the total sample was adequate, except for the social domain, which showed marginal consistency ($\alpha = .82$ for physical, $\alpha = .81$ for psychological, $\alpha = .80$ for environment, and $\alpha = .68$ for social). The Cronbach alpha coefficients for this study were moderate, with .59 for the physical subscale, .82 for psychological subscale, .83 for the relationship subscale, and .65 for the environment subscale. The measure also demonstrated good validity for use in cross-cultural settings, and has been translated into 30 languages (World Health Organisation, 1998). Adapted versions of WHOQOL-BREF has been approved for usage with New Zealand's general population, Chinese medical students, and Taiwanese mothers (Krageloh et al., 2013; Zhang et al., 2012; Gau et al., 2010, respectively). Permission for using the WHOQOL-BREF in this study was obtained from The WHOQOL Group. This study used the WHOQOL-BREF at baseline, week 4 and week 8 of the intervention.

Student Adaptation to College Questionnaire (SACQ)

The SACQ was developed by Baker and Siryk (1989) to measure students' adjustment to college. It is a 67-item questionnaire, using a 9-point Likert scale, ranging on a continuum from *applies very closely to me* to *doesn't apply to me at all*. The higher the score, the better adjusted the student is. The results of a meta-review showed that the scores on the SACQ were a good predictor of students' grades and retention at college (Crede & Niehorster, 2012). A translated version consisting of 28 items had been used to assess adjustment for Chinese students (Tao, Dong, Pratt, Hunsberger, & Pancer, 2000). Adjustment is considered multifaceted, therefore the measure was divided into 4 subscales: Academic Adjustment with 24 items ($\alpha = .81$ to $.90$), Social Adjustment with 20 items ($\alpha = .83$ to $.91$), Personal-Emotional Adjustment with 15 items ($\alpha = .77$ to $.86$), and Institutional Attachment with 15 items ($\alpha = .85$ to $.91$; Dahmus, Bernardin, & Bernardin, 1992). As a whole, the SACQ demonstrated good internal consistency ($\alpha = .92$ to $.95$; Dahmus et al., 1992) and high concurrent validity (Beyers & Goossens, 2002). In the current study, the Cronbach alpha coefficient was $.89$ for the full scale, $.88$ for the academic subscale, $.72$ for the social subscale, $.83$ for the emotional subscale, and $.82$ for the attachment subscale. The full scale score is not to be interpreted in isolation, but was designed to be interpreted with the four subscales (Baker and Siryk, 1989). The Academic Adjustment subscale measured the extent a student copes with educational demands. The Social Adjustment subscale measured the extent a student copes with interpersonal demands. The Personal-Emotional Adjustment subscale measured the extent a student experiences psychological distress and somatic problems. The Institutional Attachment subscale measured the commitment a student has to their institution. For this study, the SACQ was administered at baseline and at the end of the programme.

Understanding stress and low mood (UndSLM)

This questionnaire was included in the LLTTF pack (Williams, 2007, see Appendix G), and measured participants' understanding of stress and low mood. The UndSLM consisted of 8 questions, corresponding to each of the 8 modules of LLTTF. The questionnaire was rated on a 5-point Likert scale, ranging from 1 = *very poor*, 2 = *poor*, 3 = *okay*, 4 = *good*, and 5 = *very good*, with higher scores indicating better understanding of the concepts and its effects. No studies could be identified that has tested the psychometric properties of this measure. For this study, the Cronbach alpha coefficient was $.87$, showing good internal consistency. This questionnaire was administered at the baseline and at the end of the programme.

Client Satisfaction Questionnaire 8 (CSQ-8)

The CSQ-8 measured clients' perceived satisfaction with the intervention they received (Larsen et al., 1979, see Appendix H). The measure consisted of 8 questions, rated on a 4-point Likert scale. Scores ranged from 8 to 32 with higher scores indicating greater satisfaction with the intervention. The measure was used widely and suitable for research and evaluation (Perreault, Leichner, Sabourin, & Gendreau, 1993). The measure has high internal consistency (Cronbach's $\alpha = .93$) and good criterion and construct validity (Attkisson & Zwick, 1982). The Cronbach's alpha of this study was .89, demonstrating very good internal consistency. The CSQ-8 was administered at the end of the programme.

Semi-structured interview

A semi-structured interview was conducted at the conclusion of the intervention. The interview inquired of participants' experience, perceived helpfulness, and cultural compatibility of the programme (refer to Appendix I). Additional questions were asked depending on the participants' responses, with a focus on the cultural background of the participants. Interview time ranged from 9 to 42 minutes, with an average time of 20 minutes.

Chapter 7

Results

This chapter presents the results of this study. Firstly, preliminary data screening was conducted to determine the type of statistical analysis that would be appropriate for the data. Then, the two aims of the study were examined in depth. Quantitative results of the five measures (PHQ-9, GAD-7, WHOQOL-BREF, SACQ, and UndSLM) were analysed across time to determine the effectiveness of the programme. Then, individuals' scores were assessed for clinical significance and against the population norms. The suitability of the programme was evaluated using descriptive analysis of the CSQ-8. Lastly, the qualitative data from the semi-structured interview were summarised under common themes.

Part I. Preliminary Data Screening

The raw data was screened and cleaned following the instructions provided in Pallant (2011), so as to ensure accurate input and to fulfil assumptions before analyses were performed. Additionally, reliability analyses using Cronbach's alpha was conducted and these results were reported in the Method section under each of the measures used. The following section provides information about missing data, test of normality, and outliers.

Missing data

Missing data was found for individuals, as well as on measure items. The data collected from participants who did not complete the 8-week programme ($n = 2$) was excluded from analysis, as the comparison would be meaningless. One of the participants had moved to another city after week 4, while another discontinued studying as she became employed after week 2, and therefore, no longer meeting the criteria of the study. At week 4, missing data was found on a participant's WHOQOL-BREF questionnaire. It was clear that this was accidental, as the measure was printed double-sided, and the participant had neglected to turn the page over, thus had left the entire second page blank. Unfortunately this error was detected too late and could not be reversed. Minimal missing data were also found on two of the measures, the WHOQOL-BREF and SACQ. For these incidences, the missing item was replaced by the individual's mean score on the corresponding subscale, according to the user manual instructions of the measures (World Health Organisation, 1998; Baker and Siryk, 1989).

Normality

The Shapiro-Wilk test of normality was used, as suggested for small samples (Malkovich & Afifi, 1973), to determine if the difference between scores at baseline and week 8 were normally distributed. Deviation from normal distribution was identified by a p -value smaller than .05. All the differences between the two times were normally distributed ($p > .05$), except for the SACQ attachment subscale ($p = .03$). Given that the skewness and kurtosis were in the normal range, the scores on the SACQ attachment subscale were not transformed.

Outliers

Minimal outliers were found in the data. Of note were participant 10's scores, reporting fewer occurrences of anxiety and depression, and higher quality of life and adjustment, compared to the other participants. Contrastingly, participant 13 reported more symptoms of anxiety and depression, and poorer quality of life and understanding of stress and low mood, than the other participants. As the differences between the mean and 5% trimmed mean of these measures were minimal, the outliers were not excluded. Appendix J shows the outliers by the participant, the measure and time in which the outlier occurred, the score of the outlier, and the mean and standard deviation of that measure for all the participants.

Part II: Effectiveness of the guided self-help programme

In this section, the effectiveness of the programme was analysed statistically using the scores of the PHQ-9, GAD-7, UndSLM, WHOQOL-BREF and SACQ. First, the analysis was performed across time for the total sample using the total scores. Then, individual scores were examined for clinical significance on the PHQ-9 and GAD-7, and against sample means for the WHOQOL-BREF and SACQ.

Group's scores across time

It was hypothesised that the total scores of the full sample would improve over time, in that the total scores on the PHQ-9 and GAD-7 would decrease, and the total scores on the WHOQOL-BREF, SACQ and UndSLM would increase. As we are interested in the effectiveness of the programme as a whole, the difference between pre-intervention (baseline) scores and post-intervention (week 8) scores were analysed using paired samples t-tests.

Depressive and anxiety symptoms

This study measured depressive and anxiety symptoms using the PHQ-9 and GAD-7, respectively. Paired samples t-tests were conducted to evaluate the impact of the LLTTF

programme on the PHQ-9 and GAD-7. There was a statistically significant decrease in PHQ-9 scores from baseline ($M = 10.55$, $SD = 5.47$) to week 8 ($M = 3.36$, $SD = 2.77$, $t(10) = 4.68$, $p = .001$ (two-tailed)). The mean decrease in PHQ-9 scores was 7.18 with a 95% confidence interval ranging from 3.76 to 10.61. The eta squared statistic (.69) indicated a large effect size. For the GAD-7, the same was found with a statistically significant decrease in GAD-7 scores from baseline ($M = 10.45$, $SD = 4.59$) to week 8 ($M = 3.18$, $SD = 2.71$, $t(10) = 6.07$, $p < .0005$ (two-tailed)). The mean decrease in GAD-7 scores was 7.27 with a 95% confidence interval ranging from 4.60 to 9.95. The eta squared statistic (.79) indicated a large effect size. Looking at Figure 1, the decrease in mean scores can be seen across baseline and the 8 weeks of the programme on both the PHQ-9 and the GAD-7.

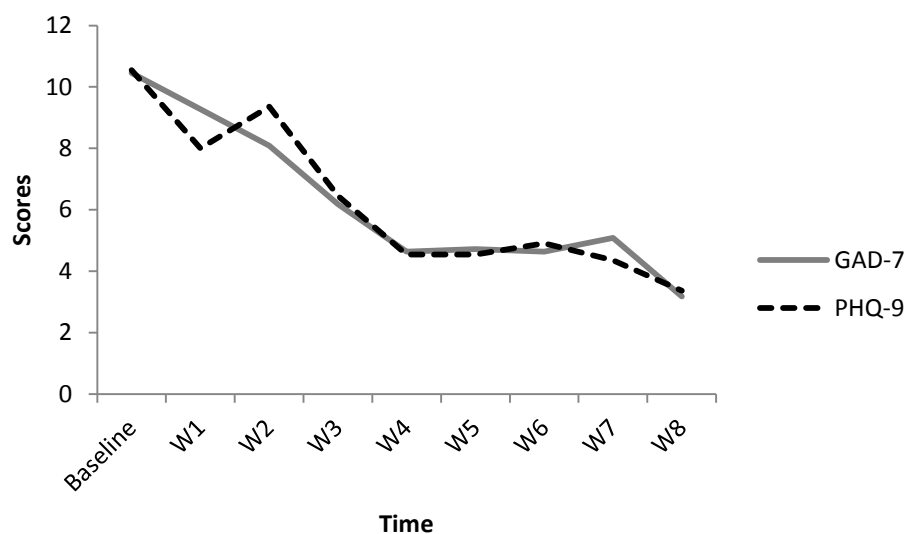


Figure 1. The decrease in mean scores on the PHQ-9 and GAD-7 at baseline and across the 8 weeks of the programme.

Quality of life

This study measured participants' perceived quality of life using the WHOQOL-BREF. The total scores of the whole sample was analysed across the four subscales: physical, psychological, relational and environmental. Using paired samples t-tests, there was a statistically significant increase in quality of life rating on all of the subscales from baseline to week 8. The mean, standard deviation, t -score, degree of freedom, and two-tailed p -value for the scores at baseline and week 8 across all the subscales are presented in Table 2. The eta squared statistic for all the subscales showed a large effect size (physical subscale = .53, psychological subscale = .76, relational subscale = .56, environmental subscale = .34). The increase in quality of life scores can be seen from the visual inspection of Figure 2.

Table 2

The mean, standard deviation, *t*-score, degree of freedom, and two-tailed *p*-value for the scores at baseline and week 8 across all the WHOQOL subscales

WHOQOL subscale	Time	Mean	SD	Mean change	Interval range*	<i>t</i> -value	df	<i>p</i> -value
Physical subscale	Pre	65.36	9.81					
	Post	78.55	14.07	13.18	4.37 - 21.99	-3.33	10	.008
Psychological subscale	Pre	53.55	15.53					
	Post	72.73	12.85	19.18	11.67 - 26.70	-5.69	10	.000
Relational subscale	Pre	49.36	22.96					
	Post	66.55	18.82	17.18	6.51 - 27.86	-3.59	10	.005
Environmental subscale	Pre	61.45	14.62					
	Post	71.64	14.94	10.18	.08 - 20.29	-2.25	10	.049

Note. *Interval range is of a 95% confidence interval

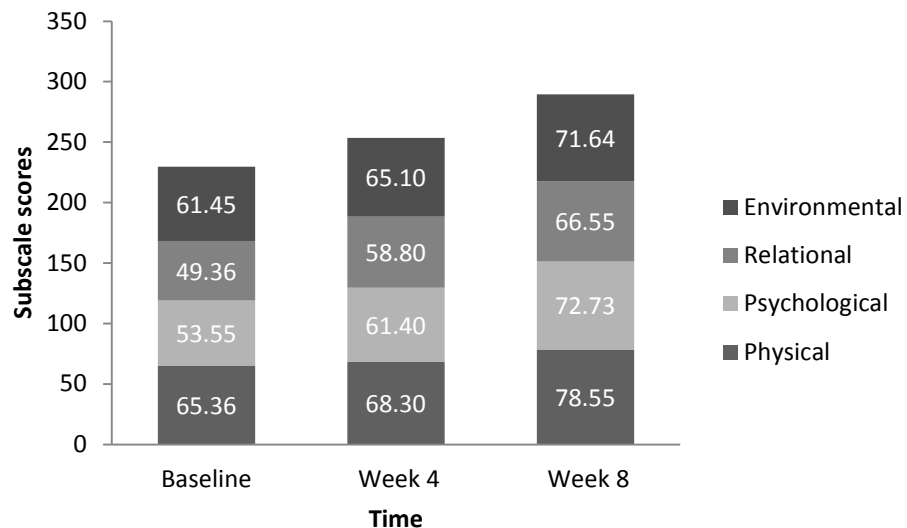


Figure 2. The increase in mean scores on the WHOQOL-BREF subscales at baseline, week 4 and week 8.

Adjustment to studying

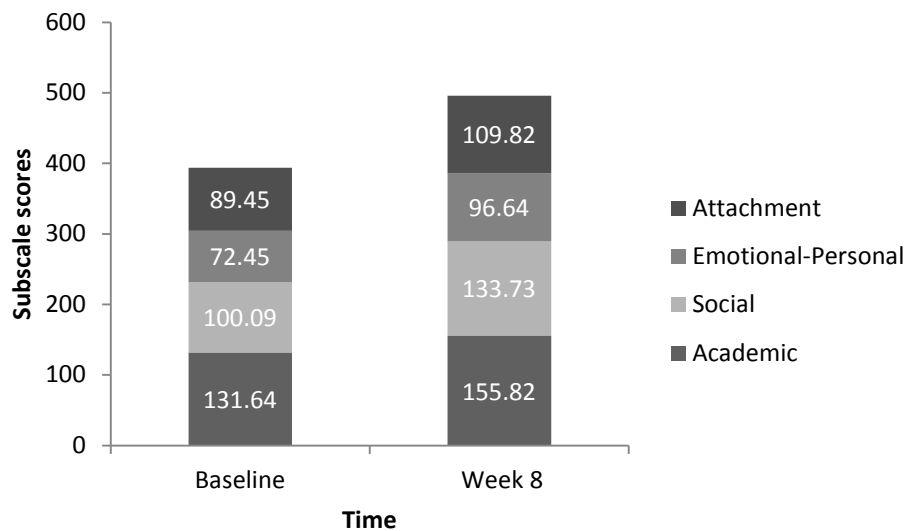
Participants' adjustment to studying was measured with the SACQ. Paired samples *t*-tests were conducted to evaluate the impact of the LLTTF programme on the group mean of the full scale, and the 4 subscales (academic, social, emotional, and attachment). For all the scales, there were statistically significant increases in scores from baseline to week 8. The mean, standard deviation, *t*-score, degree of freedom, and two-tailed *p*-value for the scores at baseline and week 8 across all the scales are presented in Table 3. The eta squared statistic for all the SACQ scales showed a large effect size (full scale = .80, academic subscale = .64, social subscale = .65, emotional subscale = .70, attachment subscale = .68). The increase in adjustment scores can be seen from the visual inspection of Figure 3.

Table 3

The mean, standard deviation, *t*-score, degree of freedom, and two-tailed *p*-value for the scores at baseline and week 8 across all the SACQ scales

SACQ scales	Time	Mean		Mean change	Interval range*	<i>t</i> -value	df	<i>p</i> -value
		Mean	SD					
Full scale	Pre	355.91	84.19					
	Post	448.27	69.32	92.36	59.56 – 125.17	-6.27	10	.000
Academic subscale	Pre	131.64	28.96					
	Post	155.82	28.85	24.18	11.54 - 36.82	-4.26	10	.002
Social subscale	Pre	100.09	30.63					
	Post	133.73	24.16	33.64	16.25 - 51.02	-4.31	10	.002
Emotional subscale	Pre	72.45	21.58					
	Post	96.64	22.24	24.18	13.00 - 35.36	-4.82	10	.001
Attachment subscale	Pre	89.45	21.75					
	Post	109.82	15.33	20.36	10.57 - 30.16	-4.63	10	.001

Note. *Interval range is of a 95% confidence interval



Note. SACQ subscales scores total up to full scale score

Figure 3. The increase in mean scores on the SACQ subscales at baseline and week 8.

Understanding of stress and low mood

A paired samples *t*-test was conducted for the UndSLM questionnaire. There was a statistically significant increase in scores from baseline ($M = 24.91$, $SD = 4.42$) to week 8 ($M = 33.73$, $SD = 3.52$, $t(10) = -10.78$, $p < .0005$ (two-tailed)). The mean increase in scores was 8.82 with a 95% confidence interval ranging from 7.00 to 10.64. The eta squared statistic (.92) indicated a large effect size. Figure 4 shows the increase in UndSLM mean score from baseline to week 8.

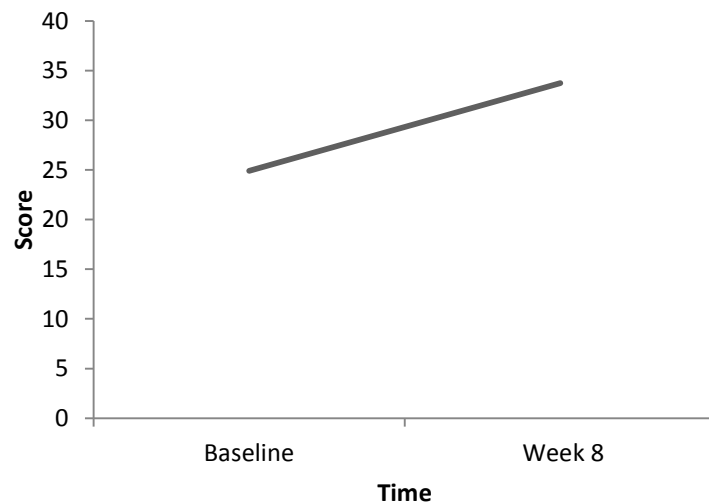


Figure 4. The increase in mean scores on the UndSLM at baseline and week 8.

Individuals' scores across time

Participants' total scores were examined individually for clinical significance on the PHQ-9 and GAD-7, and against the sample means established by other studies for the WHOQOL-BREF and SACQ. Only the baseline and week 8's scores were used to determine the effectiveness of the programme.

Clinical significance

Statistical significance does not necessarily mean the difference is of practical or clinical value (Jacobson & Truax, 1991). Measuring clinical significance is needed to determine if the change in scores is meaningful. A criterion suggested for clinical evaluation of the PHQ-9 and GAD-7 is the decrease in more than 5 on the total score (Kroenke, Spitzer and Williams, 2001). Comparing participants' scores at pre-intervention (baseline) and post-intervention (week 8), 63.6% ($n = 7$) had a clinically significant reduction in depressive symptoms, and 72.7% ($n = 8$) had a clinically significant reduction in anxiety symptoms. Although there were clinically significant decreases in PHQ-9 and GAD-7 scores, the large standard deviations indicate the high variability of scores. Table 4 lists the actual scores of the participants at baseline and week 8, and whether the decrease in scores was of clinical significance.

Clinical significance could also be evaluated by determining the number of participants who started the programme with clinical levels of depression and anxiety, and ending the programme at a non-clinical level. For this evaluation, the criterion of a score of 10 was used, with scores above 10 being in the clinical category, and scores below 10 being in the non-clinical category (Spitzer et al., 1999; Arroll et al., 2010; Kroenke et al., 2010). At the beginning

of the programme, 54.5% ($n = 6$) scored in the clinical range of the PHQ-9, and 63.6% ($n = 7$) scored in the clinical range of the GAD-7 (see Table 4). By the end of the programme, all of the participants were under the clinical cut-off level (i.e. scores were under 10) on both the PHQ-9 and GAD-7.

Table 4

Participants' PHQ-9 and GAD-7 scores at baseline (pre) and week 8 (post) with an indication of clinical significance

Participant	PHQ-9 (pre)	PHQ-9 (post)	Clinical significance	GAD-7 (pre)	GAD-7 (post)	Clinical significance
1	8	0	Y	6	2	N
2	8	1	Y	9	1	Y
3	4	1	N	8	2	Y
4	17	8	Y	16	2	Y
6	10	6	N	12	9	N
8	8	3	Y	14	4	Y
9	20	3	Y	14	4	Y
10	2	3	N	0	0	N
11	15	6	Y	10	3	Y
12	14	0	Y	12	1	Y
13	10	6	N	14	7	Y
Mean (SD)	10.55(5.47)	3.36(2.77)		10.45(4.59)	3.18(2.71)	

Note. PHQ-9 scores ranged from 0 to 27, with 5 levels of severity: minimal (1-4), mild (5-9), moderate (10-14), moderately severe (15-19), and severe (20-27). GAD-7 scores ranged from 0 to 21, with 4 levels of severity: minimal (0-4), mild (5-9), moderate (10-14), and severe (15-21).

Using the same criterion of a clinical cut-off level at 10-points, greater gains were found for those who started the programme with moderate to severe levels of depression and anxiety. The data was examined by dividing the participants into clinical and non-clinical groups (i.e. those who scored above 10 at baseline and those who scores below 10). The mean change of the PHQ-9 score was greater for the clinical group ($M = 9.5$, $SD = 5.24$) than the non-clinical group ($M = 4.4$, $SD = 3.58$). On the GAD-7 scale, the same was also found with a larger mean change of the clinical group ($M = 8.86$, $SD = 3.53$) compared to the non-clinical group ($M = 4.5$, $SD = 3.42$). Looking at Figure 5, the participants who started the programme with more severe ratings of depressive and anxiety symptoms achieved more gains (i.e. greater reduction in scores) by the end of the programme, as indicated by the steeper slope on the graph, compared to those who began the study with milder levels of depression and anxiety.

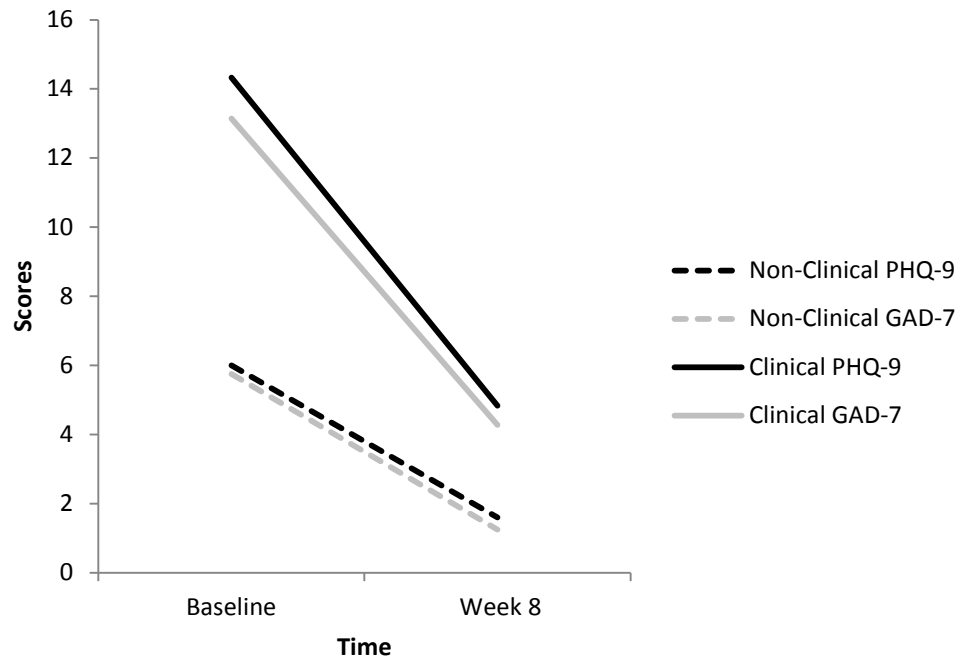


Figure 5. The mean change on the PHQ-9 and GAD-7 for the clinical and non-clinical groups at baseline and week 8.

Comparing sample means

Sample means outlined in other studies were used as a standard of comparison for the scores of this study's participants. For the WHOQOL-BREF, the means from Hawthorne, Herrman, and Murphy (2006) were used as their sample was also drawn from the community and was in the same age bracket (20 to 29 year olds) as our sample. Hawthorne et al.'s study sample had a mean of 85.4 ($SD = 10.9$) on the physical subscale, 71.4 ($SD = 17.5$) on the psychological subscale, 72.9 ($SD = 18.8$) on the social subscale and 74.3 ($SD = 14.0$) on the environmental subscale. When these means were compared to our sample, none of the participants scored above the mean at baseline on the physical subscale, but 36.4% did at week 8 ($n = 4$). On the psychological subscale, 9.1% scored above the mean at baseline ($n = 1$), compared to 63.6% at week 8 ($n = 7$). On the relational subscale, 18.2% scored above the mean at baseline ($n = 2$), compared to 45.5% at week 8 ($n = 5$). On the environmental subscale, 36.4% were above the mean at baseline ($n = 4$), compared to 54.5% at week 8 ($n = 6$). As a whole, the psychological subscale at week 8 was the only mean score that scored above the mean ($M = 72.73$, $SD = 12.85$, see Table 5).

Table 5

Comparing sample means with participants' scores across the four WHOQOL-BREF subscales at baseline and week 8

Time	Participant	Physical	Psychological	Relational	Environmental	
Baseline	1	81	56	69	75*	
	2	63	56	56	81*	
	3	69	63	81*	50	
	4	56	44	31	38	
	6	63	69	25	63	
	8	56	44	69	75*	
	9	75	44	50	50	
	10	81	88*	81*	75*	
	11	56	44	25	44	
	12	63	50	31	69	
	13	56	31	25	56	
		Mean (SD)	65.36(9.81)	53.55(15.53)	49.36(22.96)	61.45(14.62)
	Week 8	1	81	75*	75*	56
2		88*	69	75*	88*	
3		94*	81*	94*	75*	
4		69	81*	69	56	
6		63	81*	44	81*	
8		81	69	69	75*	
9		88*	81*	81*	69	
10		81	88*	75*	75*	
11		56	56	56	63	
12		100*	75*	69	100*	
13		63	44	25	50	
		Mean (SD)	78.55(14.07)	72.73*(12.85)	66.55(18.82)	71.64(14.94)

Note. *Participant's score was above the means found in Hawthorne et al.'s (2006) study

Moving to the SACQ, the sample means from Abe et al.'s (1998) study was chosen as the standard for comparison, as their sample had more similar features to our study. Of the 59 international students in their sample, 61.7% were Asian, with mean scores of 385.64 ($SD = 63.48$) on the full scale, 142.58 ($SD = 26.27$) on the academic subscale, 107.42 ($SD = 22.96$) on the social subscale, 84.39 ($SD = 16.86$) on the emotional subscale, and 86.33 ($SD = 19.05$) on the attachment subscale. Compared to Abe et al.'s means, 36% of our sample scored above the full scale mean at baseline ($n = 4$), increasing to 82% at week 8 ($n = 9$, see Table 6). The same increase was found from 27% ($n = 3$) to 64% ($n = 7$) on the academic subscale, 36% ($n = 4$) to 82% ($n = 9$) on the social subscale, 18% ($n = 2$) to 73% ($n = 8$) on the emotional subscale, and 55% ($n = 6$) to 91% ($n = 10$) on the attachment subscale. As a whole, the attachment subscale was the only scale at baseline that scored above the means in Abe et al.'s study. At week 8, all five scales were above the means. Compared to the population norms provided by the developer

of the measure (Baker & Siryk, 1989), it is interesting to note that participant 3's score on the emotional subscale increased dramatically, starting at 16 percentile and ending the programme at 92 percentile. This participant's scores on the other SACQ subscales only increased marginally.

Table 6

Comparing sample means with participants' scores across the five SACQ scales at baseline and week 8

Time	Participant	Full scale	Academic subscale	Social subscale	Emotional subscale	Attachment subscale	
Baseline	1	404*	141	122*	78	113*	
	2	397*	153*	104	91*	92*	
	3	408*	144*	128*	78	104*	
	4	281	109	77	52	61	
	6	311	126	65	70	79	
	8	378	135	99	79	100*	
	9	306	125	79	65	68	
	10	547*	194*	161*	122*	130*	
	11	284	96	80	60	82	
	12	352	137	122*	41	93*	
	13	247	88	64	61	62	
		Mean (SD)	355.91 (84.19)	131.64 (28.96)	100.09 (30.63)	72.45 (21.58)	89.45* (21.75)
	Week 8	1	523*	186*	156*	109*	126*
2		511*	183*	135*	124*	121*	
3		458*	147*	125*	120*	107*	
4		439*	162*	127*	90*	96*	
6		399*	140	118*	72	112*	
8		392*	127	90	110*	95*	
9		449*	167*	142*	91*	99*	
10		562*	202*	165*	125*	132*	
11		385	116	146*	67	113*	
12		485*	167*	164*	88*	124*	
13		328	117	103	67	83	
		Mean (SD)	448.27* (69.32)	155.82* (28.85)	133.73* (24.16)	96.64* (22.24)	109.82* (15.33)

Note. *Participant's score was above the means found in Abe et al.'s (1998) study

Part III: Cultural compatibility of the guided self-help programme

To fulfil the second part of the research aim, the cultural compatibility of the programme was examined and reported in this section. The descriptive data from the CSQ-8 is presented, followed by a detailed review of the cultural compatibility, suitability and participants' experience of the programme.

Participant satisfaction

The CSQ-8 was administered at the end of the programme to assess the participants' satisfaction. The results confirmed the hypothesis that participants' would have a positive rating on the CSQ-8, indicating high satisfaction with the programme. As is common with client satisfaction ratings (Brannan, Sonnichsen, & Heflinger, 1996), a negative skew of $-.90$ was found on the total score. As a whole, the participants' mean score ranged from 3.00 to 4.00 ($SD = .00$ to $.64$). Overall, the participants were satisfied with the service they had received.

Semi-structured interview

Feedback regarding the cultural compatibility, suitability and experience of the participants were explored during individual semi-structured interviews at the end of week 8. All interviews were tape-recorded and transcribed. The interview questions can be found in Appendix I. The following section is organised into three parts: helpful aspects, less relevant parts and cultural compatibility of the programme. Each section includes a summary of the findings, with supporting statements extracted from the interviews.

Helpful aspects of the programme

In general, the participants found the programme helpful in meeting their needs. It made a positive impact on their lives and they learnt skills that were beneficial presently and in the future. The programme allowed the participants to examine why they felt or thought a certain way, and "provided the tools" to change the way they feel and think. The participants identified that they gained greater insight into their reactions in different situations. Several participants acknowledged that their life had become "better", whether they believed the effects were due to the programme or not. One participant summed it up by saying, "I think it was all very helpful, because I enjoyed coming here every week and I learnt different things every week".

There were varying needs that were met, as the participants had different struggles coming into the programme. Participants identified problems, such as studying, sleeping difficulties, socialising, general low mood and lack of energy, all of which had reportedly improved by the end of the programme. One participant recognised that she "was in a bad situation, and needed to change". The availability of a free programme also made it more acceptable. While some novel ideas were introduced, many participants said the programme acted as a reminder to use the strategies and reinforced prior knowledge. It provided a guideline and a scientific, formalised approach to overcoming problems. Knowing that there was a structured method to solving problems came as a relief to some. One participant said, "once you know you have some method to solve this problem, you are not afraid. Because before I'm just

worried that I don't have a method. I was very worried. But now I have some useful things". Although it had been helpful, the programme did not fully resolve all of the participants' issues, as was noted by one participant who experienced mild depression, "I'm quite appreciative of this programme to help me to handle this situation by myself. I just felt like I was tired every day every morning, and I felt like I couldn't walk out of this dark hole and couldn't concentrate on anything. I can't say I'm walking out of it, but I can say, I'm managing it".

Out of all the topics that were covered by the programme, changing perspectives was one of the most useful skills that was identified by the participants. The problems themselves may not have changed, but participants reported that their response has changed and their mood has lifted. Some participants found week 3's session about changing cognition particularly helpful, as the strategy 'to label a bad thought' would stop them feeling worse. This contrasted with the opinion of two of the participants, who found the session overly simplistic and inadequate in helping them change their negative thoughts.

Many participants valued the planning and practicality of the programme. They were able to prepare and be intentional about what they wanted to achieve. The participants were able to use the planner to think of a goal they had decided for themselves, and to put the skills they learnt into practice straight away. The application of skills and the planning process was highlighted by many participants. Similarly, breaking down a plan into smaller pieces, analogous of eating an elephant by cutting it into smaller chunks, was a vivid and helpful strategy recalled by many participants. Taking the time to formulate a plan and problem solving, instead of using trial and error, helped participants feel more in control of their problems and less overwhelmed by the whole picture. Practical suggestions given in the last session, such as eating breakfast, exercising and eating healthy, were noted as helpful.

Certain parts of the programme were mentioned as helpful, although less frequently. Participants liked the Five Part Model, and most understood its parts and how they interacted. They could see that there were things they could do to make themselves feel better, and that is by changing their behaviour and thinking. They appreciated that the programme provided a "formalised" and "easy to remember" approach to understanding how their feelings were linked to their thinking and behaviour. The video played during the first session was vividly recalled by a few participants. Some identified themselves as the lady in the video, who was ignored by her friend. Their response was "immediately I think, maybe she doesn't like me. But then I remembered, oh, that's not true. That's a bad thought, that's a lie. That's not true. She was probably just busy". The session about self-esteem helped participants realise they don't have to "aim for perfection", but that it is important to be able to accept oneself. Some recalled that one needed to *act* confident to *become* confident.

Recommend to friends

All the participants said they would recommend this programme to their friends, although their reasons varied. In asking how the participants would introduce the programme to their friend, it gave an indication of what they found to be the most helpful aspect of the programme. Some participants introduced the programme by saying it would help them overcome stress, change how they think, or boost their mood. The programme taught “skills that helped people to help themselves”. Specific issues that the programme helped with included dealing with exam stress, planning their career, and improving their social life. Having someone to talk to and make plans with was valuable. The programme was helpful in general, although two of the participant noted that they would not know if others would find it helpful.

“I would recommend it. A lot of people would come in with, I guess like me, I was quite sceptical of what it could do for me. And then you know after the first session I was still quite sceptical with what I thought was the basicness of it, how the everyday strategies were like, nothing new. Basic is the wrong word, but, you know, common sense. If people can get over that and know that it is just reinforcing you to use those things that would help. I would recommend it to people. But I don’t know how other people will take it, because I went from being sceptical about it, to thinking, you know, this is actually pretty good. But also, for someone who is as seasoned as myself, it still helped for me to admit to faults and stuff, it actually helps you be a better person. As confident as I am, I’ve learnt strategies to help me deal with things, making me even more confident”.

Meeting expectations

Participants came into the programme with different sets of expectations. Most of the participants’ expectations were met, however, one identified that the programme was not as helpful as they would expect and the programme did not add to their knowledge. This particular client was expecting the programme to be more “problem-focused” and found the predetermined topic of the manualised sessions to be irrelevant to their current situations. For others, the programme exceeded their expectations, with one noting that the self-directed approach was unexpected, in a positive way.

“I thought you were going to be intentional in changing me into the way you want me to be. I just thought it would be an educational session, like the psychologist tells you stuff and you do it. But it was the other way around, that’s why I was surprised, because it was more, guidance rather than telling me. It makes embracing the programme easier. I mean the books were about you, fixing your life, making you feel happy, and things you

can easily do. And when you make plans, I get to choose what the plans are and how easy they are, so that helps”.

Another participant came expecting that the programme was going to be life-changing, and eventually accepted that there was no magic cure to life’s problems, instead the programme provided a collection of strategies to help with problems.

“To be honest, I thought, you go in, thinking it was going to help my sleep. And I was waiting for the silver bullet, and I realised after a while, after the first session, you think, eh, is that all. But then you realise, no, it’s actually good and it’s going to help me. Because I guess there’s no silver bullet to life, no magic pill. I was expecting an awesome strategy that is going to solve my problems, but I guess life isn’t that simple. It’s like putting simple little things together, as one. Tool to help you with life issues”.

Facilitator support

Several participants noted the benefits of having facilitator support, which was interesting as this topic was unsolicited. To have someone to talk to and to feel supported was invaluable. It was helpful for participants to be able to discuss and make plans with the facilitator. One participant suggested that “the relationship is built on trust”, and if that rapport were not present, he “did not think this programme can help”. Although one participant noted that it felt “weird” opening up to someone, they gradually felt more comfortable. It was also motivating to have someone recognise their progress and reminding them of their achievements. One participant reflected on how the programme would be if it was run without a facilitator, “if I was given this programme online. I don’t think it’d be as effective, to be honest. The strategies, the goal will be straightforward, but having that person to remind you or to discuss things with helps a lot. And then, it’s also having someone noticing your progress as well”.

Less relevant parts of the programme

There were parts of the programme that participants felt were less helpful. Parts of the programme were not relevant to some participants who did not struggle with anger or low confidence. Additionally, one participant noted that the Five Part Model was too theoretical, and did not see how it applied in reality. The programme introduced some novel ideas that one participant would find difficult to do, such as writing a happy list, making a smoothie, eating porridge, and heavy breathing. Whether this was due to the cultural difference or individual preference of the participant was difficult to determine, as the participant was unsure themselves.

Two of the participants felt that the programme explained concepts in overly simplistic terms and the skills taught were too basic and common sense. This was particularly noted for

their inability to change their negative thoughts, as was the dominant struggle of these two participants, and the problem is still unresolved by the end of the programme. One of the participants identified that he would benefit more from high-intensity CBT, where his beliefs to the negative thoughts could be examined in depth. He expressed his frustration at not being able to resolve his negative thoughts.

“Even till now, it’s still a challenge and it’s still my single biggest challenge. Just changing the way I think, and I totally get it, the concept makes sense, you just have to think differently, but I guess at the same time as well, this programme or the way it was presented kind of dumbs it down a bit. I can say, it’s not that simple, like it’s said in the book. It’s the kind of things you’ve told yourself in the past, but if it were that simple, and you can stop thinking like that, then everyone would be fine and happy. So I felt that it was useful, but still at the same time, it didn’t bring anything new to the table. Because ultimately what happens is, it happens inside your mind and no one can change the way I think, other than me, and so I don’t think there are really any magical ways that it can happen”.

Furthermore, he expressed how important it is to change his negative thinking, yet how impossible it seemed to him.

“Well that’s the crux of it, isn’t it. Your first thought needs to be different and the book says, “why don’t you think like that?” Well, you don’t think like that because it’s not your human instinct, clearly. Clearly, your human instinct thinks that person just ignored me, they don’t address the *how* you do that. I have a problem with the way that I think. A lot of the time my first instinct is that negative, this tells me the first thing I should think is think positive. If it was that easy, sure, I would do it, but that’s the crux of it. How do you do that? I still don’t know, to this day”.

Cultural compatibility

All of the participants felt that the programme fitted well with their culture and there was no conflict. The programme gave enough flexibility to be applied to other cultures. The Chinese culture and the New Zealand culture were perceived to be “similar” by several participants. As one participant noted, emotions are the same across cultures, “happy is happy” in any context. Culture was not seen as an issue, but commitment to the programme was the key, as one participant said, “these books, its more improving yourself, so if people actually commit in the programme they can actually change their life. It’s not because we’re Asian or Caucasian, I don’t think that’s really related. If people actually committed, it should be ok”. Some participants found that the programme taught strategies that they had learnt previously.

Three of the participants, who were Chinese, had learnt similar strategies from self-help books, friends and family. These concepts included, breaking a problem into smaller pieces, telling yourself you are good enough, talking to friends and family, and exercising more. It was highlighted that the programme would be helpful to Kiwi Asians who experience an “identity crisis”, ones who do not feel they completely “fit” into either culture. However, the benefit of this bicultural status was the ability to “mix the best of both worlds and make it work”. While all of the participants found the programme culturally compatible to their Asian upbringing, aspects of their cultures that impacted on mental health were highlighted.

Resolving problems

Participants identified that they did not have adequate ways of dealing with their problems, prior to coming into the programme. Often, participants tried to ignore the problem, isolating themselves and hiding away. “I just try to keep everything inside and let time heal me” was the strategy employed by one participant. However, “putting it aside” was not helpful, as the problem was not being addressed. One participant mentioned using alcohol and comfort eating as a way to cope. Another participant identified the effect of the masculine culture in how problems were handled. He noted, “especially with males, it’s just ‘harden up man, get over it’. I think if I didn’t come to these sessions, it probably would have just blown up at some point. These are like little air vents releasing stress, pressure and anxiety instead of building it up and in one big episode, and you might go bang”.

The way Asian society handles psychological problems is perceived to be different to New Zealand society. One participant noted that, in China, where it is highly competitive, people do not have as much time to care and offer help to those they see struggling. A Filipino participant said depression is not recognised in their culture, and that their people are “in denial” about their problems, turning to religion to solve their issues. Taking time to reflect and make a plan seemed foreign to one Malaysian participant, who said “in my culture, you just harden up and move on with it. You just ignore it and move on, but this programme teaches something different. In my culture, they would see this as a bit feminine, a bit weird, in fact, to do so much self-introspection and then come up with plans.” He gave insight into how his culture taught him to face barriers, and even though he was able to overcome, it often left him unhappy and tired. “It’s almost like you’re doing things the hard way. Like the only approach you have is to hammer it and it’s tiring after a while. Because you know the Asian way is to do things the tried and true way. It’s very rigid. You don’t have innovation, or try different ways”.

Help seeking behaviour

Participants identified differing degrees of openness in expressing mental health concerns. Several participants noted that Asians are more reserved, and tend not to express their emotions, as they need to be “polite” and they try to “figure out the problems by themselves”. One participant identified that Chinese people were not comfortable in expressing their feelings, especially negative feelings. Help-seeking was expressed by a number of participants as a sign of weakness. The inadequacy of not being able to handle one’s problems was evident in a participant’s comment, stating that she just “want to feel like I am strong enough, I don’t need this kind of help”.

Stigma around seeking mental health services explained why people keep quiet about mental illness. There is a “shame” associated with asking for help. One participant said “I didn’t want anyone to know and pretty much nobody knew”. Another participant expressed that “I’m afraid people will not want to be friends with me. In our culture, if you have some psychological problem, it’s a very big thing. They think you’re crazy or something. So I don’t want to tell people”. After going through the programme, one participant was more open to using professional counselling services offered at work. Acknowledging the stigma, he said, “if you seek help, you’re weak and useless, but actually as weak as you are, or as stable as you are, I think it would actually help”.

What added to participants’ reluctance to seek help was the portrayal of positive images of Kiwi Asians’ mental wellness in the media. Asians in New Zealand were perceived as “mentally stable”, as they have the “lowest crime rate” and are the “high achievers in school”. The high achiever image made it particularly difficult for one participant to seek help.

“I kind of used to think I would be good enough to deal with these sorts of problems myself. Basically conquer anything that I had in the past. And that was probably the biggest things, that image and that expectation and I felt like I was letting myself down, like I’d lost, because I had to get help from someone else”.

Two of the participants acknowledged that they had sought professional help in the past. One of the participants noted that Chinese people seldom sought professional help for mental illnesses, and the price for seeing a psychologist was high. She recalled that her experience was negative, as the counsellor she sought was not professionally trained and she found it unhelpful. She resorted to finding strategies online, but had not experienced much improvement. Due to the “language barrier”, she has not sought help in New Zealand. The other participant had sought help in New Zealand, but also did not recall a positive experience from the help received.

The lack of follow up meant that he did not receive adequate intervention from community mental health services. He acknowledged that he eventually resolved his issues on his own.

Family influence

The family was identified as a major influence to how problems arose and how it was handled. Asian students were expected to follow their parents' wishes and not have their own opinion. Because elders were meant to be respected, one participant withdrew from speaking up, and she started hiding away and isolating herself. Another participant tried talking to her parents about her anxiety, but expressed that her "parents can't understand. They said I have everything. You're not worried about your studies, and you don't have financial pressure, 'why do you have this kind of problems' "? However, another participant got the opposite response and was encouraged by their mother at an early age to talk to her, so they can solve the problem together. As he got older, he stopped talking to his mother about his issues, especially as they were in China and unable to help him. This participant kept silent about his issues, even from his wife, as he perceived she would not be able to understand why he struggled with depression.

A couple of participants identified that their parents did not explicitly teach them how to deal with psychological issues. "Even simple things like chill out, go for a walk, none of that has been mentioned. I picked up the skills here and there growing up. Nothing was taught. You just deal with it yourself". Asian parents did not express negative emotions, and one participant reflected that he would not know how his parents dealt with stresses and anxieties, as they kept any trace of it hidden. He himself also kept his emotions hidden from people, and prefers to withdraw socially. He perceived that to seek help for this programme was to "expose" oneself.

It was mentioned that Asian parents were more protective of their children and managed their child's affairs, even into young adulthood. One participant noted that due to the One-Child Policy in China, children were well protected and very "self-centred". They were shielded from failures and when they experienced the "real world", they often had difficulty adjusting. This was especially evident when interpersonal conflict arose, only-children had difficulty taking the other person's perspective and seeing their contribution to relational problems. It was "the way they were brought up, with all the attention of the parents and grandparents. They don't need to think about others".

Chapter 8

Discussion

This chapter presents the discussion for this study. First, the aim and findings according to the hypotheses are summarised. Then, the limitations are discussed, followed by the recommendations for future research, and the implication for clinical practice. The chapter ends with the conclusion of the study.

Summary of aims and findings

The aim of this study was to fill the gap in the literature by examining the effectiveness and cultural compatibility of the Living Life to the Full (Williams, 2007) programme for Asian students. Hypotheses for this study were tested with a sample of 11 East Asian and Southeast Asian participants, studying in New Zealand. The Living Life to the Full guided self-help programme was found to be effective in reducing depressive and anxiety symptoms, and increasing quality of life, adjustment, and understanding of stress and low mood. In addition, participants found the programme culturally compatible and beneficial. The findings supported the suitability of the low intensity CBT programme for use with the Asian population.

Hypothesis 1: Group ratings on the outcome measures would improve over time.

The hypothesis for an improvement in outcome measures was supported, with statistically significant results found on all the outcome measures and its corresponding subscales, indicating an improvement in wellbeing from the start of the programme, to the end of the 8 weeks programme. Compared to their state of wellbeing at baseline, the participants reported significantly lower rates of depression and anxiety at the end of the programme. Participants' perceived quality of life on each of the subscales had significantly improved at the end of the programme, indicating an improvement in physical, psychological, relational and environmental quality of life. Participants' adjustment to studying had also reportedly improved overall, as indicated by the significant increase in scores on the SACQ full scale. In addition, participants reported better academic adjustment, social adjustment, emotional-personal adjustment, and more attachment to their study institution, at the end of the programme. Finally, participants had a better understanding of the concepts and effects of stress and low mood by the end of the programme. By all accounts, the results displayed statistically significant differences, in favour of the effectiveness of the programme for Asian students in New Zealand. These improvements are important, as Asian international students often experience more pressure for academic success (Foo, 2007), loss of social support (Brown & Daly, 2005),

loneliness and poorer mental health (Yip, 2005), homesickness, culture shock and discrimination (Russell et al., 2010).

Hypothesis 2: Individual participants' scores would improve at a clinically significant level and when compared to sample means.

The results partially supported the hypothesis of participants' improvements at a clinically significant level. Clinical significance was found for 63.6% of the participants for depression, and 72.7% for anxiety, according to the criterion of a decrease in more than 5 on the total score (Kroenke et al., 2001). This indicated that the majority of the participants had a reduction in depression and anxiety that was clinically significant. Using the criterion of a clinical cut-off level at the score of 10, there were 54.5% of the participants in the clinical depression range and 63.6% in the clinical anxiety range at the beginning of the programme. By this criterion, the programme had been effective as all the participants were in the non-clinical levels of depression and anxiety by the end of the programme. It is interesting to note that those who started the programme with more severe levels of depression and anxiety had greater gains from the programme, compared to those with less severe levels. This finding can be expected as the participants in the latter group started the programme with fewer depressive and anxiety symptoms, so the gain they could achieve would be less substantial than those who started the programme with more severe problems.

Using sample means from other studies as a standard of comparison for participants' scores, some improvements were found that partially supported the hypothesis. For quality of life using Hawthorne et al.'s (2006) means, participants reported improvements for physical, psychological, relational and environmental quality of life, with psychological quality of life being the most improved (9.1% scored above the mean at baseline, compared to 63.6% at week 8). This is promising as the LLTTF programme is a psychological intervention that teaches life skills that can be applied to all areas of life (Williams, 2007), and would be expected to especially help with psychological quality of life. Even though participants began the programme with poorer quality of life, compared to the participants in Hawthorne et al.'s study, improvements were shown with about half of the participants scoring above the mean, indicating a similar rating of quality of life as the participants in Hawthorne et al.'s study.

Comparing student adjustment with Abe et al.'s (1998) sample, the participants reported better adjustment only for institutional attachment at the start of the programme. By then end of the programme, the participants reported better overall adjustment, academic adjustment, social adjustment, emotional adjustment, and was more institutionally attached. This indicated that the participants had shown improvement in their adjustment to studying in New Zealand, which is significant given that international students were found to have poorer adjustment compared to

domestic students (Rienties et al., 2012; Kaczmarek et al., 1994), and this was especially true of Asian international students (Rienties & Tempelaar, 2013; Abe et al., 1998).

The anomaly of finding was found for one of the participants, using individual scores inspection. For this participant, their emotional adjustment had risen dramatically from the beginning to the end of the programme, while other aspects of their adjustment had only a slight change. This is an unusual finding as this particular participant had strongly expressed in the interview that they did not find the programme helpful in changing the way they thought, the programme was not as helpful as they had expected and it did not add to their prior knowledge. Their reported improvement in emotional adjustment may be due to social desirability bias, or an overcompensation to indicate how well they were doing, by no input of the programme. While the genuineness and cause of the participant's high emotional adjustment score at the end of the programme is uncertain, they were explicit in stating that it was not due to the effects of the programme.

Hypothesis 3: Participants would be satisfied with the programme and find it suitability and cultural compatible.

Satisfaction

From the feedback elicited at the end of the programme, the hypothesis for participant satisfaction of the programme was supported. The participants reported that the programme had been helpful in meeting their needs, including problems with studying, sleeping, socialising, low mood and lack of energy. The programme had a positive impact and gave tools that helped participants change how they think and feel. Insight and overall improvement of wellbeing were reported by participants. Instead of waiting for the magic cure, the application of these life skills were what participants identified as helpful for improving their mental health. Participants found it a relief to know they now had a guideline to help resolve their issues. Of the strategies that were taught, changing thoughts and making plans were the two most helpful and frequently mentioned. Participants were able to quote the strategies taught in the programme (e.g. "it's just a bad thought" when recognising an unhelpful thought pattern, "how do you eat an elephant? One piece at a time" for breaking down big problems and solving it one bit at a time). This was an encouraging sign that the participants had used and learnt the skills that were taught. Another sign of participant satisfaction was that all of the participants reported they would recommend the programme to their friends.

It is noteworthy to mention that facilitator support was spontaneously reported by participants as an important component to the programme. Several participants mentioned the value of having someone to talk to, who noticed their progress and motivated them to use the skills taught. One participant noted that they did not think the programme would have been as

effective if it did not come with facilitator support. These reports matched research that found guided self-help more effective than unguided interventions (Gyani et al., 2013). The therapeutic relationship was what made interventions effective (Whitfield and Williams, 2003), allowing clients to openly discuss their problems.

Of the 13 participants that started the programme, 11 of them completed the 8 weeks programme. Even for the participants who did not continue the programme, one had moved outside of the research area and another stopped studying, thus no longer meeting the inclusion criteria. This low rate of attrition (15.4%) may be credited to the effects of guided intervention, as unguided self-help programmes are susceptible to high attrition (Eysenbach, 2005; Cavanagh, 2010; Waller & Gilbody, 2009). Also, it may have helped that the facilitator was of the same race and age bracket as the participants. Sue and Sue (1999) found that clients who have therapists of their own ethnicity, speaking the same language, attend more sessions than those unmatched in ethnicity and language. Facilitator support was especially valuable for this sample of Asian students, as supportive relationships are important for international students' psychological and academic adjustment (Leung, 2001).

Suitability

Despite the overall satisfaction of the programme, there were parts of the programme that participants did not find suitable or helpful. While most of the participants reported that the programme had met or even exceeded their expectations, one participant felt the programme did not meet their needs. This participant found the programme's manualised delivery too restricting. A more intensive intervention was needed for this participant, and was probably what they had expected to receive. As the programme was conducted for research, there were certain limitations that the facilitator needed to adhere to, in that the facilitator limited the variability in delivery of the programme, so as to ensure the findings were comparable. This had limited the flexibility of the programme, had it not been for research purposes. Another participant stated that even though the programme was helpful in building up their confidence, it did not eliminate other problems or help them change their thoughts.

The LLTTF programme was carefully designed so as to use everyday language that did not contain psychological jargon (Williams et al., 2014). This was reflected by the participants, who found the concepts readily acceptable and easy to understand. However, the parsimonious explanations were reportedly inadequate and overly simplistic for two of the participants. Another participant gave the opposite evaluation, in that they found the Five Part Model too theoretical and impractical. The mixed responses, with some participants finding the content too simplistic and others finding it too complex, was also echoed by the respondents of Boyle et al.'s study (2011). Additional information or more practical explanations could be provided to

add to the gaps in the programme and address these varied responses. Boyle et al. suggested using problem-solving and adaptation of the programme to meet the specific needs of the participants.

Cultural compatibility

The hypothesis of cultural compatibility of the programme was supported with this sample. It was predicted that some level of cultural-compatibility of the programme would be identified, especially as the programme was run on a one-to-one basis, allowing for idiosyncratic adaptations to each participant. Also, the programme was delivered in an educational and didactic manner, which fitted with the preference and expectations of Asian people (Chen & Davenport, 2005). All of the participants identified a high sense of cultural compatibility with the programme. While some novel ideas were introduced, some of the concepts were already known by a few participants. Beyond findings of compatibility, participants reported different way that their culture resolves problems and seeks help. In addition, the importance of family influence was highlighted.

Participants identified that they did not have adequate ways of dealing with their problems, preferring to ignore the issue or hide away. Some participants identified that this reaction was due to family expectations of children remaining quiet and obedient. Seeking professional help was hindered by the language barrier and the perceived ineffectiveness of psychological interventions. For the majority of the participants, seeking help was seen as a sign of weakness. Asians were perceived to be reluctant and uncomfortable with expressing their emotions. To be unable to handle their problems was perceived as shameful and the stigma around mental health kept those who were struggling silent. The participants' responses echoed findings from previous research around Asians' reluctance to seek help (Masuda & Boone, 2011). Leibowitz (2010) found that ethnic minorities would only risk the shame associated with help seeking when the problems become severe. These perceptions appeared more self-imposed, rather than externally-imposed, as the participants did not recall incidences when they were shamed for having mental health problems. The cultural value of self-restraint of emotions may have become internalised (Foo, 2007). There was only one incidence that was recalled by a participant whose parents stated that they could not understand why she struggled with emotional issues. Family supportiveness in emotional problems varied amongst the participants, with some parents offering support, while others neglected to offer help.

The positive portrayal of Asian in the media added to participants' reluctance to seek help, as it was seen as breaking the stereotype of Asians as high achievers, who were mentally stable. Their low involvement in mental health services gave the false perception that Asians are mentally robust and do not have mental illnesses (Williams et al., 2006). This stereotype was

noted by a male participant, who also spoke of the male culture's response to mental health to just 'get over it'. Men tend to value self-reliance and do not see the benefits of 'talking' about a problem (Leibowitz, 2010). Despite the participants' reported reluctance to seek help, their voluntary participation in this study may indicate that they found the low intensity programme more acceptable and less stigmatising than more intensive psychological interventions (Williams, 2001).

Families have a strong influence on shaping the child. Asian parents were described as protective and over-involved. Due to the expectation that parents have control over children's education and decisions, Chinese children may be seen as dependent and lacking maturity, compared to their peers in Western society (Sue & Sue, 1999). One participant noted the effects of China's One-Child Policy, with children growing up with all the attention of the family and becoming very self-centred. They are shielded from failures and have difficulty overcoming opposition once they leave the family's embrace. It can be expected that children growing up in this protective environment will have more difficulty adjusting, dealing with conflict and relational issues in later life. The One-Child Policy was implemented in 1979, and there is still a lack of research to determine the social and emotional effects of this change in society.

An unexpected finding that arose from the interviews was the lack of socialisation that the participants received from their families in dealing with emotional problems. This may seem to contradict the image of family closeness usually associated with Asian families (Mondia et al., 2012). Despite this impression, two of the participants spoke strongly against their parents neglecting to teach coping strategies or showing any sign of emotionality in the family. What is surprising is that these participants had been in New Zealand the longest, compared to the other participants. Moreover, their immediate families lived in New Zealand, whereas the other participants' families were living in their country-of-origin. These two participants were also ones that reported more severity in depression and anxiety at the beginning of the programme. This seemed incongruent to previous research that found students who had spent a longer time in their host country had better adjustment to the culture, as they were more familiar with the local systems and had better grasp of the English language (Abe et al., 1998), thus experiencing less mental health issues related to adjusting to a new country (Hong et al., 2000). A possible explanation for these two participants' poor mental health is that their upbringing in New Zealand contrasted with their parents' upbringing in Asian countries, and therefore, they may experience more cultural discrepancy and conflict with their family (Mondia et al., 2012), compared to other participants who had grown up in Asian countries and had recently moved to New Zealand.

Limitations of the study

The findings of this study needs to be interpreted within the context of some limitations, namely the cultural appropriateness of the measures used, language proficiency of the participants, social desirability of the responses, motivation of self-referred participants, limitations of small sample, and other extraneous variables.

Measures

Although all of the measures used in this study were suitable for community populations, they had not been tested for use with Asian populations, which make interpretation of the data less valid. For example, in evaluating clinical significance using a PHQ-9 score of 10 as the clinical cut-off point recommended by most studies, Inagaki et al. (2013) identified that the cut-off point may be lower for Asians, as they are less expressive and reluctant to report problems, due to the value of self-control and restraint of emotions (Foo, 2007). Moreover, Asians tend to express somatic symptoms more readily than psychological symptoms (Chen & Davenport, 2005), and Western-developed measures may not be sensitive to these somatic symptoms of mental health. To have the cut-off point at 10, which may be higher than what Asians would tend to report, would mean those reporting under this level are not recognised as severely depressed and may not receive the necessary treatment. Inagaki et al. suggested a much lower cut-off point at 4 or 5 PHQ-9 score, in order to have a high detection rate for major depressive disorders amongst Asians.

A lack of normative data for the WHOQOL-BREF and SACQ makes interpretation of the findings difficult. Other than concluding that the programme was found to be effective for our sample, it is not possible to conclude where our sample sits in relation to the population. It is also not possible to determine clinical significance without normative data. Culturally specific normative data are needed in order for comparative results to be accurate (Zaroff et al., 2012). For the WHOQOL-BREF comparisons with this study, Hawthorne et al.'s (2006) mean scores were used for comparison as the age bracket of the samples matched. Also, the comparison SACQ data from Abe et al.'s (1998) study did not comprise entirely of Asian international students. At current, the SACQ manual has established norms by gender and year in university (Baker & Siryk, 1989), however, these are based on samples from the United States and do not distinguish between ethnicities. The sample means used for comparison with this study were unmatched for ethnicity, and therefore the comparative results need to be interpreted with this consideration in mind.

Language proficiency

The content of the programme was presented in English, which is not the first language for the majority of the participants in this study. Although the facilitator was present during the sessions to explain the terms, in Mandarin if necessary, and the concepts were simple, the lack of language proficiency may have limited participants' understanding and ability to express themselves. This may have affected the feedback they gave during the interview and their reports on the measures. It is uncertain whether all of the participants fully comprehended the questions asked in the measures, especially for the SACQ, which was developed in the United States, and contained idioms that some participants were unfamiliar with and enquired about. For example, "loneliness for home is a source of difficulty for me", and "sometimes my thinking gets muddled up too easily". Abe et al. (1998) also found their international students sample may have had difficulty understanding questions such as "lately, I have been feeling blue and moody a lot", and "I haven't been mixing too well with the opposite sex lately." This lack of English fluency may cause the burden of assessments to be greater for our sample, especially for the initial assessment, when a couple of participants took 50 minutes to complete, with an average of 26 minutes.

Social desirability

As with all self-reported subjective measures, the findings are susceptible to social desirability bias (Nederhof, 1985). This is especially true for the Asian sample, as their cultural value to avoid shame would make them reluctant to reveal personal information that would jeopardise this (Williams et al., 2006; Bond & Smith, 1996). Also, their high value to maintain collective harmony may make them hesitant to reveal what they really thought about the programme, but tell the facilitator what they think she wants to hear (Jones, 1983). Some level of social desirability bias was suspected in the aforementioned incidence of one participant's dramatic increase in emotional adjustment, although they were explicit during the interview that they did not find the programme helpful. Interpretation of the data needs to be in light of the cultural values of the participants.

Self-referred

Participants of this study were self-referred and therefore likely to be highly motivated and see more improvements with the intervention (Mataix-Cols et al., 2006). However, Gyani et al. (2013) found that self-referrals did not predict reliable recovery, but it does facilitate therapeutic outcomes. This may explain the improvement in scores for this study.

Small sample

Usually small sample sizes would limit the power of the analysis. However, all the statistical analyses detected a significance difference at a p -value of .05, indicating that the differences in the scores were large enough to be detected. Moreover, Isaac and Michael (1981) asserted that small samples were more appropriate for exploratory research, such is this study. The sample was drawn from Asian students studying in the Auckland area, and participants came in with presenting problems that were similar to what would be expected of the general public, with stress, low mood and anxiety being the most prevalent issues reported (Fitzgerald et al., 2009). Most of the participants hold values that were shaped by their Asian upbringing, although this was not explicitly tested for, it was communicated through the interview. This would allow some level of generalisation of the findings between this sample and Asian immigrants living in New Zealand.

Extraneous variable

The lack of a control group and follow up study makes it unclear whether the improvements were due to the effect of the programme or extraneous variables. By simply being part of the programme may have made the participants more attune to their symptoms. Moreover, the participants were aware that they were part of the facilitator's research. The belief that they are getting better may account for improvements, rather than the effectiveness of the actual intervention, as explained by placebo studies (Kaptchuk, 2002). Having someone monitor their progress could be enough of a motivator to change behaviour and thoughts, as evidenced by the Hawthorne Effect (Franke & Kaul, 1978). This may also explain the superior effectiveness of guided self-help programmes, compared with unguided programmes (Gyani et al., 2013).

During the 8 weeks of the programme, external events could have affected participants' responses on the measures. For example, participants had reported visa issues, relationship break ups, and emotional break downs during the 8 weeks. The resolution of these problems may be due to passage of time and a natural resolution, rather than the effectiveness of the intervention. However, some participants did attribute their symptom relief to the intervention. As all the participants were students, the semester progression with varying times for assignments and exams would create higher levels of stress during those times. This was somewhat moderated for as the participants' started the programme at different times, with the last participant starting 3 and a half weeks after the first participant.

Recommendations for future research

Further investigation is needed as this study had several limitations. Even though confounding variables to do with individual participants were minimised as this study used a within-subject design, other extraneous variables could be avoided if a randomised control group were used. It was helpful to limit the effects of semester progression as the participants' starting times were staggered. A follow up session would be beneficial to establish whether the treatment effects were sustained over time. Future research can increase the validity of the findings by using a control group, staggered start, and follow up session.

More research is needed to develop culturally appropriate interventions and measures for Asians. Hall (2001) called for psychotherapies for ethnic minorities to be both empirically supported and culturally sensitive. This is the only study that has used the LLTTF programme with East Asian and Southeast Asian students. There were no studies found which examined whether Asians preferred individual or group therapy, although a study has found group therapy to be effective for Chinese immigrants when compared to controls (Shen, Alden, Sochting, & Tsang, 2006). As the LLTTF programme can be delivered online, in group or one-on-one, it would be interesting to determine the format that Asians would prefer and how effective the differing delivery styles were. Cultural adaptations for low intensity CBT programmes have not yet been established, although Mandarin versions of LLTTF materials are currently being developed by Dr. Chris Williams (personal communication, April 5, 2013), and this version may be more appropriate for those with limited grasp of the English language. However, the effectiveness of these materials will need to be established.

Appropriate guidelines need to be developed for using the measures with Asians and international students. The PHQ-9 and GAD-7 need to establish a clinical cut-off score that would be accurate and appropriate for use with Asians, in order for screening for depression and anxiety to be valid and sensitive for this population. Guidelines for interpreting the WHOQOL-BREF scores need to be provided to enable comparisons between study samples and population norms. Moreover, norms need to be established for using the SACQ with international students. Although the SACQ has been found to be appropriate for use with international students (Abe et al., 1998), the lack of norms for this group make comparative data difficult to interpret. Generalisation to other cultures and the validity of the findings are limited by this. It is expected that the adjustment scores for international students would differ from domestic students, as they face different challenges, and would have a different set of norms. On a national level, New Zealand has far fewer choices of universities compared to the United States, and this would also affect the SACQ institutional attachment scores for students in New Zealand.

Implications for clinical practice

This study not only fills the gap in literature for its use of low intensity CBT with Asians, but it has practical implications in identifying a psychological intervention that is effective and culturally compatible with Asians. Due to the stigma and limited access associated with attending psychotherapy sessions, low intensity CBT approaches serve as an alternate, yet effective intervention for those with mild to moderate levels of depression and anxiety. Low intensity CBT materials can be widely distributed, are easy to access, and more economical (Williams et al., 2014). The focus is on prevention and teaching life skills, rather than illness intervention. The increased use of these low intensity CBT materials would help to improve the quality of care provided in the community. Having said that, the suitability and usefulness of low intensity CBT is limited by the severity of mental health problems and the willingness for the public to access these materials. The participants in this study who had more severe levels of depression reported less benefit from the programme. Severe levels of mental health are more adequately treated with high intensity CBT interventions (Gyani et al., 2013). It is important to ensure the intensity of psychological interventions are matched with the individual's needs, as negative experiences of ineffective and culturally inadequate interventions can cause people to doubt the effectiveness of psychological help and would deter them from seeking help again (Leibowitz, 2010). Practitioners need to be aware that Asians tend to have a lower rate of help seeking and they are under-utilising the services allocated to them (Williams & Cleland, 2007). Strategies need to be established to minimise the potential barriers to access. Due to the stigma and shame associated with mental health, when Asians do seek help, it is important to emphasis confidentiality and to reduce the feelings of shame and guilt associated with receiving help (Chen & Davenport, 2005). People should be encouraged to see that caring for their mental health is just as important as their physical health (Leibowitz, 2010). As Kumar, Tse, Fernando and Wong (2006) argued, there is a need for more research into the specific mental health needs of Asians in New Zealand and how to address them. Practitioners can bridge the gap of those experiencing mental illness and those seeking help, by providing low intensity CBT as a more accessible and less stigmatising alternative to psychotherapy (Leibowitz, 2010).

Given the increase of Asian students coming to New Zealand and the specific needs and difficulties experienced by international students, university counselling centres need to be prepared to encounter issues that may be outside their normal scope of practice. Asians have difficulty adjusting to New Zealand culture and face more discrimination, as they are not able to visually 'blend' into White society due to their distinct physical features (Williams & Cleland, 2007). Practitioners need to provide culturally appropriate interventions in a culturally appropriate manner (Anderson et al., 2003). It starts with an awareness of one's own cultural influences and an appreciation of the differences of other's culture (Banks et al., 2006).

Although Asians tend to prefer a more directive, practical approach in therapy, it is important not to stereotype, but to consider the individual needs and experiences of the client (Hwang, 2011; Sue & Sue, 1999; Chen & Davenport, 2005; Foo, 2007). As this study found, ethnicity match with the facilitator may have been a factor to the high retention rate. When providing interventions, clients who have therapists of their own ethnicity, speaking the same language, would attend more sessions than those unmatched in ethnicity and language (Sue & Sue, 1999).

Universities can run programmes to help students better adjust to host culture and university life. Social groups that can foster supportive social relationships need to be encouraged, as these are important for international students' psychological and academic adaptation (Leung, 2001). Those with well-established and healthy social supports were found to have better adjustments when studying (Crede & Niehorster, 2012).

Conclusion

This study investigated the effectiveness and cultural compatibility of a guided self-help programme, Living Life to the Full, for the sample of 11 Asian students in New Zealand. This was the first study that examined the LLTTF programme with a focus on Asians. Low intensity CBT is a relatively new initiative, allowing better access to psychological interventions for the general public, and evidence for the effectiveness of guided intervention approaches are accumulating. It was important to test the effectiveness of the programme for usage with participants from an Asian culture as the programme was developed in the United Kingdom. From an emic perspective, the cultural values and principles in which the programme was developed in, warranted that it be tested with other cultures to determine if its effectiveness was cross-cultural. The programme proved to be effective in reducing depression and anxiety, and improving quality of life, adjustment and participants' understanding of stress and low mood. The majority of the sample had shown a reduction in depression and anxiety that constituted clinical significance. The WHOQOL-BREF and SACQ need to establish population norms suitable for Asians, to allow for further comparisons. Participants were satisfied with the programme and it helped to resolve some of the problems participants came in with, although a couple of the participants found the concepts in the programme over-simplistic. Facilitator support was identified as a valuable component to the programme. As a whole, all of the participants reported that the programme was culturally compatible. Participants identified differences in the way Asian culture responded to mental health problems and noted the importance of family influence. With more Asians immigrants and students coming to New Zealand and experiencing problems adjusting to the culture, perhaps the increased promotion and use of low intensity CBT programmes would remove the barriers of stigma and reluctance

to seek help, by providing a more accessible form of psychological interventions, that is effective and culturally compatible with the Asian population.

References

- Abe, J., Talbot, D. M., & Geelhoed, R. J. (1998). Effects of a peer program on international student adjustment. *Journal of College Student Development, 39*(6), 539-547.
- Alvidrez, J., Azocar, F., & Miranda, J. (1996). Demystifying the concept of ethnicity for psychotherapy researchers. *Journal of Consulting and Clinical Psychology, 64*(5), 903-908.
- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR, 4th ed. Text Revision*. Washington, DC: American Psychiatric Association.
- Anderson, L., Lewis, G., Araya, R., Elgie, R., Harrison, G., Proudfoot, J., Schmidt, U., Sharp, D., Weightman, A., & Williams, C. (2005). Self-help books for depression: how can practitioners and patients make the right choice? *British Journal of General Practice, 55*, 387-392.
- Anderson, L., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E., Normand, J., & the Task Force on Community Preventive Services (2003). Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine, 24*, 68-79.
- Andersson, G., & Carlbring, P. (2010). Using different communication channels to support internet interventions. In J. Bennett-Levy, D. A. Richards, P. Farrand, H. Christensen, K. M. Griffiths, D. J. Kavanagh, B. Klein, M. A. Lau, J. Proudfoot, L. Ritterband, J. White & C. Williams (Eds.), *Oxford Guide to Low Intensity CBT Interventions* (pp. 269-274). New York: Oxford University Press.
- Arroll, B., Goodyear-Smith, F., Crengle, S., Gunn, J., Kerse, N., Fishman, T., Falloon, K., & Hatcher, S. (2010). Validation of PHQ-2 and PHQ-9 to screen for major depression in the primary care population. *Annals of Family Medicine, 8*(4), 348-353.
- Attkisson, C. C., & Zwick, R. (1982). The client satisfaction questionnaire: Psychometric properties and correlations with service utilization and psychotherapy outcome. *Evaluation and Program Planning, 5*, 233-237.

- Baker, R. W., & Siryk, B. (1989). *Student Adaptation to College Questionnaire (SACQ)*. Los Angeles: Western Psychological Services.
- Banks, C., Choumanivong, C., Hauraki, J., Kazantzis, N., Stewart, M., Taufa, P., & Tse, S. (2006). Therapy across cultures: A clinical round table discussion about working with people from cultures other than your own. *New Zealand Clinical Psychologist*, 16(3), 18-23.
- Barak, A., Hen, L., Boniel-Nissim, M., & Shapira, N. (2008). A comprehensive review and meta-analysis of the effectiveness of internet-based psychotherapeutic interventions. *Journal of Technology in Human Services*, 26, 109-160.
- Barkham, M., Rees, A., Stiles, W. B., Shapiro, D. A., Hardy, G. E., & Reynolds, S. (1996) Dose-effect relations in time-limited psychotherapy for depression. *Journal of Consulting and Clinical Psychology*, 64, 927-935.
- Bean, J. (1982). Student attrition, intentions, and confidence: Interaction effects in a path model. *Research in Higher Education*, 17, 291-321.
- Beck, A.T. (1963). Thinking and depression, 1: Idiosyncratic content and cognitive distortions. *Archives of General Psychiatry*, 9, 324-333.
- Beck, A.T. (1964). Thinking and depression, 2: Theory and therapy. *Archives of General Psychiatry*, 10, 561-571.
- Bennett-Levy, J., Richards, D. A., & Farrand, P. (2010). Low intensity CBT interventions: a revolution in mental health care. In J. Bennett-Levy, D. A. Richards, P. Farrand, H. Christensen, K. M. Griffiths, D. J. Kavanagh, B. Klein, M. A. Lau, J. Proudfoot, L. Ritterband, J. White & C. Williams (Eds.), *Oxford Guide to Low Intensity CBT Interventions* (pp. 3-18). New York: Oxford University Press.
- Beyers, W., & Goossens, L. (2002). Concurrent and predictive validity of the Student Adaptation to College Questionnaire in a sample of European Freshman students. *Educational and Psychological Measurement*, 62, 527-538.
- Bond, R., & Smith, P. B. (1996). Culture and conformity: A meta-analysis of studies using Asch's (1952b, 1956) line judgment task. *Psychological Bulletin*, 119, 111-137.

- Boyer, S. P. & Sedlacek, W. E. (1988). Noncognitive prediction of academic success for international students: A longitudinal study. *Journal of College Student Development*, 29, 218-223.
- Boyle, C., Lynch, L., Lyon, A., & Williams, C. (2011). The use and feasibility of a CBT intervention. *Child and Adolescent Mental Health*, 16(3), 129-135.
- Brannan, A. M., Sonnichsen, S. E., & Heflinger, C. A. (1996). Measuring satisfaction with children's mental health services: Validity and reliability of the satisfaction scales. *Evaluation and Program Planning*, 19(2), 131-141.
- Brown, J.C., & Daly, A.J. (2005) *Intercultural contact and competencies of tertiary students. New Zealand Journal of Educational Studies*, 40, 85-100.
- Brown, J. S. L., Sellwood, K., Beecham, J. K., Slade, M., Andiappan, M., Landau, S., Johnson, T., & Smith, R. (2011). Outcome, costs and patient engagement for group and individual CBT for depression: A naturalistic clinical study. *Behavioural and Cognitive Psychotherapy*, 39, 355-358.
- Butler, A. C., Chapman, J. E., Forman, E. M., Beck, A. T. (2006). *The empirical status of cognitive-behavioral therapy: A review of meta-analyses*. *Clinical Psychology Review*, 26(1), 17-31.
- Cavanagh, K. (2010). Turn on, tune in and (don't) drop out: engagement, adherence, attrition, and alliance with internet-based interventions. In J. Bennett-Levy, D. A. Richards, P. Farrand, H. Christensen, K. M. Griffiths, D. J. Kavanagh, B. Klein, M. A. Lau, J. Proudfoot, L. Ritterband, J. White & C. Williams (Eds.), *Oxford Guide to Low Intensity CBT Interventions* (pp. 227-233). New York: Oxford University Press.
- Chellingsworth, M., Williams, C., McCreath, A., Tanto, P., & Thomlinson, K. (2010). Using CBT-based self-help classes to deliver written materials in Health Service, further education and voluntary sector settings. In J. Bennett-Levy, D. A. Richards, P. Farrand, H. Christensen, K. M. Griffiths, D. J. Kavanagh, B. Klein, M. A. Lau, J. Proudfoot, L. Ritterband, J. White & C. Williams (Eds.), *Oxford Guide to Low Intensity CBT Interventions* (pp. 215-223). New York: Oxford University Press.
- Chen, H. M., & Lewis, D. C. (2011). Approaching the "resistant:" Exploring East Asian international students' perceptions of therapy and help-seeking behaviour before and

after they arrived in the United States. *Contemporary Family Therapy*, 33, 310-323.

- Chen, S. W.-H., & Davenport, D. S. (2005). Cognitive-behavioral therapy with Chinese American clients: Cautions and modifications. *Psychotherapy: Theory, Research and Practice*, 42, 101-110.
- Chen, T. M., Huang, F. Y., Chang, C., & Chung, H. (2006). Using the PHQ-9 for depression screening and treatment monitoring for Chinese Americans in primary care. *Psychiatric Services*, 57(7), 976-981.
- Cheung, F. M. C. (1986). Psychopathology among Chinese people. In M. H. Bond (Ed.), *The psychology of Chinese people* (pp. 170-212). Hong Kong: Oxford University Press.
- Church, A. T. (1982). Sojourner adjustment. *Psychological Bulletin*, 91, 540-572.
- Crede, M., & Niehorster, S. (2012). Adjustment to college as measured by the Student Adaptation to College Questionnaire: A quantitative review of its structure and relationships with correlates and consequences. *Educational Psychology Review*, 24, 133-165.
- Cuijpers, P., Donker, T., van Straten, A., Li, J., & Andersson, G. (2010). Is guided self-help as effective as face-to-face psychotherapy for depression and anxiety disorders? A systematic review and meta-analysis of comparative outcome studies. *Psychological Medicine*, 40, 1943-1957.
- Dahmus, S., Bernardin, H. J., & Bernardin, K. (1992). Student adaptation to college questionnaire. *Measurement and Evaluation in Counseling and Development*, 25(3), 139-142.
- Dear, B. F., Titov, N., Sunderland, M., McMillan D., Anderson, T., Lorian, C., & Robinson, E. (2011). Psychometric comparison of the Generalized Anxiety Disorder Scale-7 and the Penn State Worry Questionnaire for measuring response during treatment of generalised anxiety disorder. *Cognitive Behaviour Therapy*, 40(3), 216-227.
- Department of Health. (2008). *IAPT implementation plan: National guidelines for regional delivery*. Retrieved from www.iapt.nhs.uk

- Education Counts (2013). *International students in New Zealand*. Retrieved from http://www.educationcounts.govt.nz/__data/assets/pdf_file/0017/115028/Exchange-Rates-and-International-Student-Enrolments-in-NZ-2003-2011.pdf
- Ellis, A. (1962). *Reason and emotion in psychotherapy*. New York: Lyle Stewart.
- Evans, M. D., Hollon, S. D., DeRubeis, R. J., Piasecki, J. M., Grove, W. M., Garvey, M. J., & Tuason, V. B. (1992). *Differential relapse following cognitive therapy and pharmacotherapy for depression*. *Archives of General Psychiatry*, 49(10), 802-808.
- Eyou, M. L., Adair, V., & Dixon, R. (2000). Cultural identity and psychological adjustment of adolescent Chinese immigrants in New Zealand. *Journal of Adolescence*, 23(5), 531-543.
- Eysenbach, G. (2005). The law of attrition. *Journal of Medical Internet Research*, 7, e11
- Fitzgerald, J., Galyer, K., & Ryan, J. (2009). The evaluation of a brief mental health therapy initiative in primary care: Is there a role for psychologists? *New Zealand Journal of Psychology*, 38(1), 17-23.
- Franke, R. H., & Kaul, J. D. (1978). The Hawthorne Experiences: First statistical interpretation. *American Sociological Review*, 43, 623-643.
- Fritz, M. V., Chin, D., & DeMarinis, V. (2008). Stressors, anxiety, acculturation and adjustment among international and North American students. *International Journal of Intercultural Relations*, 32, 244-259.
- Gau, B-S., Chen, Y-C., Lo, L-H., Chang, M., Chao, Y-M., Chiang, B-L., & Yao, G. (2010). Clinical applicability of the World Health Organisation Quality of Life scale Brief version (WHOQOL-BREF) to mothers of children with asthma in Taiwan. *Journal of Clinical Nursing*, 19, 811, 819.
- Gellatly, J., Bower, P., Hennessy, S., Richards, D., Gilbody, S., & Lovell, K. (2007). What makes self-help interventions effective in the management of depressive symptoms? Metaanalysis and meta-regression. *Psychological Medicine*, 37, 1217–1228.

- Gyani, A., Shafran, R., Layard, R., & Clark, D. M. (2013). Enhancing recovery rates: Lessons from year one of IAPT. *Behaviour Research and Therapy*, *51*(9), 597-606.
- Hall, G. C. N. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical and conceptual issues. *Journal of Consulting and Clinical Psychology*, *69*(3), 502-510.
- Hawthorne, G., Herrman, H., & Murphy, B. (2006). Interpreting the WHOQOL-BREF: Preliminary population norms and effect sizes. *Social Indicators Research*, *77*, 37-59.
- Hammond, G. C., Croudace, T. J., Radhakrishnan, M., Lafortune, L., Watson, A., McMillan-Shields, F., & Jones, P. B. (2012). Comparative effectiveness of cognitive therapies delivered face-to-face or over the telephone: An observational study using propensity methods. *PLOS One*, *7*(9), e42916.
- Hirai, M., & Clum, G. A. (2006). A meta-analytic study of self-help interventions for anxiety problems. *Behavior Therapy*, *37*, 99-111.
- Ho, E., Au, S., Bedford, C., & Cooper, J. (2003). *Mental Health Issues for Asians in New Zealand: A Literature Review*. Waikato, New Zealand: Mental Health Commission.
- Hong, Y. Y., Morris, M. W., Chiu, C. Y., & Benet-Martinez, V. (2000). Multicultural minds: A dynamic constructivist approach to culture and cognition. *American Psychologist*, *55*(7), 709-720.
- Hsu, W. S., & Wang, C. D. C. (2011). Integrating Asian clients' filial piety beliefs into solution-focused brief therapy. *International Journal of Advanced Counselling*, *33*, 322-334.
- Hwang, W. C. (2011). Cultural adaptations: A complex interplay between clinical and cultural issues. *Clinical Psychology, Science and Practice*, *18*, 238-241.
- Hwang, W. C., Wood, J. L., Lin, K. M., Cheung, F. (2006). Cognitive-behavioral therapy with Chinese Americans: Research, theory and clinical practice. *Cognitive and Behavioral Practice*, *13*, 293-303.
- IAPT Programme (2014). *IAPT: Improving Access to Psychological Therapies*. Retrieved from <http://www.iapt.nhs.uk/iapt/>

- Inagaki, M., Ohtsuki, T., Yonemoto, N., Kawashima, Y., Saitoh, A., Oikawa, Y., Kurosawa, M., Muramatsu, K., Furukawa, T. A., & Yamada, M. (2013). Validity of the Patient Health Questionnaire (PHQ)-9 and PHQ-2 in general internal medicine primary care at a Japanese rural hospital: A cross-sectional study. *General Hospital Psychiatry, 35*, 592-597.
- Isaac, S., & Michael, W. B. (1981). *Handbook in research and evaluation: A collection of principles, methods, and strategies useful in the planning, design, and evaluation of studies in education and the behavioral sciences* (2nd ed.). San Diego, California: EDITS Publishers.
- Jacobson, N. S., Dobson, K. S., Traux, P.A., Addis, M. E., Koerner, K., Gollan, J. K., Gortner, E., & Prince, S. E. (1996) A component analysis of cognitive behavioural treatment for depression. *Journal of Consulting and Clinical Psychology, 64*, 295–304.
- Jacobson, N. S., & Truax, P. (1991). Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*(1), 12-19.
- Jones, E. L. (1983). The courtesy bias in South-East Asian surveys. In M. Bulmer & D. P. Warwick (Eds.), *Social Research in Developing Countries* (pp. 253-260). London: UCL Press.
- Jorm, A., Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., Pollitt, P. (1997). “Mental health literacy”: a survey of the public’s ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia, 166*, 182-186.
- Jorm, A. F., Korten, A. E., Jacomb, P. A., Rodgers, B., Pollitt, P., Christensen, H. and Henderson, S. (1997). Helpfulness of interventions for mental disorders: beliefs of health professionals compared with the general public. *British Journal of Psychiatry, 171*, 233–237.
- Kaczmarek, P. G., Matlock, G., Merta, R., Ames, M. H., & Ross, M. (1994). An assessment of international college student adjustment. *International Journal for the Advancement of Counselling, 17*, 241-247.

- Kaptchuk, T. J. (2002). The placebo effect in alternative medicine: Can the performance of a healing ritual have clinical significance? *Annals of Internal Medicine*, *136*(11), 817-825.
- Kazantzis, N., Deane, F. P., Ronan, K. R., & L'Abate, L. (Eds.). (2005). *Using homework assignments in cognitive behaviour therapy*. London: Routledge, Taylor & Francis Group.
- Keeley, H., Williams, C., & Shapiro, D. A. (2002). A United Kingdom survey of accredited cognitive behaviour therapists' attitudes towards and use of structured self-help materials. *Behavioural and Cognitive Psychotherapy*, *30*, 193-203.
- Kim, H., & Nayar, S. (2012). The experiences of Korean immigrants settling in New Zealand. In A. Sobrun-Maharaj, F. Rossen, S. Parackal, S. Nayar, E. Ho, D. Newcombe, Y. Ratnasabapathy, J. Hand, & S. Ameratunga (Eds.). *Social Environment, Migration, and Health Proceedings of the Fifth International Asian and Ethnic Minority Health and Wellbeing Conference* (pp. 19-30). Auckland, New Zealand: University of Auckland.
- Klein, B., & Cook, S. (2010). Preferences for e-mental health services amongst an online Australian sample. *Electronic Journal of Applied Psychology*, *6*(1), 27-38.
- Kocalevent, R. D., Hinz, A., & Brahler, E. (2013). Standardization of the depression screener Patient Health Questionnaire (PHQ-9) in the general population. *General Hospital Psychiatry*, *35*, 551-555.
- Krageloh, C. U., Kersten, P., Billington, D. R., Hsu, P. H-C, Shepherd, D., Landon, J., & Feng, X. J. (2013). Validation of the WHOQOL-BREF quality of life questionnaire for general use in New Zealand: confirmatory factor analysis and Rasch analysis. *Quality of Life Research*, *22*, 1451-2457.
- Kroenke, K., Spitzer, R. L., & Williams, J. B. W (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*, 606-613.
- Kroenke, K., Spitzer, R.L., Williams, J.B., Monahan, P. O., & Lowe, B. (2007). Anxiety disorders in primary care: Prevalence, impairment, comorbidity, and detection. *Annals of Internal Medicine*, *146*(5), 317-325.

- Kroenke, K., Spitzer, R. L., Williams, J. B. W., & Lowe, B. (2010). The patient health questionnaire somatic, anxiety, and depressive symptom scales: a systematic review. *General Hospital Psychiatry, 32*, 345-359.
- Kumar, S., Tse, S., Fernadndo, A., & Wong, S. (2006). Epidemiological studies on mental health needs of Asian population in New Zealand. *International Journal of Social Psychiatry, 52*(5), 408-412.
- Larsen, D.L., Attkisson, C.C., Hargreaves, W.A., and Nguyen, T.D. (1979). Assessment of client/patient satisfaction: Development of a general scale, *Evaluation and Program Planning, 2*, 197-207.
- Leibowitz, J. (2010). Improving access to low intensity interventions for ethnic minority communities. In J. Bennett-Levy, D. A. Richards, P. Farrand, H. Christensen, K. M. Griffiths, D. J. Kavanagh, B. Klein, M. A. Lau, J. Proudfoot, L. Ritterband, J. White & C. Williams (Eds.), *Oxford Guide to Low Intensity CBT Interventions* (pp. 567-575). New York: Oxford University Press.
- Leung, C. (2001). The psychological adaptation of overseas and migrant students in Australia. *International Journal of Psychology, 36*(4), 251-259.
- Lin, J. C. H. (1994). How long do Chinese Americans stay in psychotherapy? *Journal of Counseling Psychology, 41*, 288-291.
- Lloyd, M., & Abdulrahman, A. I. (2011). *Equally Connected Report 13: Living Life to the Full*. NHS Health Scotland: Equality Team.
- Lovell, K. (2010). Supporting low intensity interventions using the telephone. In J. Bennett-Levy, D. A. Richards, P. Farrand, H. Christensen, K. M. Griffiths, D. J. Kavanagh, B. Klein, M. A. Lau, J. Proudfoot, L. Ritterband, J. White & C. Williams (Eds.), *Oxford Guide to Low Intensity CBT Interventions* (pp. 273-280). New York: Oxford University Press.
- Lovell, K., & Richards, D. (2000) Multiple Access Points and Levels of Entry (MAPLE): ensuring choice, accessibility and equity for CBT services. *Behavioural and Cognitive Psychotherapy, 28*, 379-391.

- Lovell, K., Richards, D.A., & Bower, P. (2003). Improving access to primary mental health care: uncontrolled evaluation of a pilot self-help clinic. *British Journal of General Practice*, 53, 133-135.
- Lowe, B., Kroenke, K., Herzog, W., & Grafe, K. (2004). Measuring depression outcome with a brief self-report instrument: Sensitivity to change of the Patient Health Questionnaire (PHQ-9). *Journal of Affective Disorders*, 81, 61-66.
- Lyons, R., & Low, P. (2009). Brief psychological therapy in primary care: The psychologist's challenge. *New Zealand*, 38(1), 24-31.
- MacLeod, M., Martinez, R., & Williams, C. (2009). Cognitive behaviour therapy self-help: Who does it help and what are its drawbacks? *Behavioural and Cognitive Psychotherapy*, 37, 61-72.
- Mahalik, J. R., & Kivlighan, D. JR. (1988). Self-help treatment for depression: Who succeeds? *Journal of Counselling Psychology*, 35, 237-242.
- Malkovich, J. F., & Afifi A. A. (1973). On tests for multivariate normality. *Journal of the American Statistical Association*, 68(341), 176-179.
- Marks, I. M., & Cavanagh, K. (2009). Computer-aided psychological treatments: Evolving issues. *Annual Review of Clinical Psychology*, 5, 121-141.
- Masuda, A., & Boone, M. S. (2011). Mental health stigma, self-concealment, and help-seeking attitudes among Asian American and European American college students with no help-seeking experience. *International Journal of Advanced Counselling*, 33, 266-279.
- Mataix-Cols, D., Cameron, R., Gega, L., Kenwright, M., Marks, I.M. (2006). Effect of referral source on outcome with cognitive-behavior therapy self-help. *Comprehensive Psychiatry* 47, 241-245.
- Maxie, A. C., Arnold, D. H., & Stephenson, M. (2006). Do therapists address ethnic and racial differences in cross-cultural psychotherapy? *Psychotherapy: Theory, Research, Practice, Training*, 43(1), 85-98.
- Mehta, S. (2012). Health needs assessment of Asian people living in the Auckland region. In A.

Sobrun-Maharaj, F. Rossen, S. Parackal, S. Nayar, E. Ho, D. Newcombe, Y. Ratnasabapathy, J. Hand, & S. Ameratunga (Eds.). *Social Environment, Migration, and Health Proceedings of the Fifth International Asian and Ethnic Minority Health and Wellbeing Conference* (pp. 131-137). Auckland, New Zealand: University of Auckland.

Mental Health Foundation of New Zealand (2014). *Mental health quick statistics*. Retrieved from <http://www.mentalhealth.org.nz/page/128-mental-health-quick-statistics>

Merriam-Webster (2014). *Culture*. Retrieved from <http://www.merriam-webster.com/dictionary/culture>

Merrick, P. L., & Dattilio, F. M. (2006). The contemporary appeal of cognitive behaviour therapy. *New Zealand Journal of Psychology*, 35(3), 117-119.

Mewton, L., Wong, N., & Andrews, G. (2012). The effectiveness of internet cognitive behavioural therapy for generalised anxiety disorder in clinical practice. *Depression and Anxiety*, 29, 843-849.

Ministry of Education (2012). *Exchange Rates and International Student Enrolments in New Zealand 2003-2011*. Wellington: Ministry of Education.

Ministry of Health (2013). *Mental Health and Addiction: Service use 2009/10*. Wellington: Ministry of Health.

Mondia, S., Hichenberg, S., Kerr, E., Eisenberg, M., & Kissane, D. W. (2012). The impact of Asian American value systems on palliative care: Illustrative cases from the family-focused grief therapy trial. *American Journal of Hospice and Palliative Medicine*, 29(6), 443-448.

Murray, K., Pombo-Carril, M. G., Bara-Carril, N., Grover, M., Reid, Y., Langham, C., Birchall, H., Williams, C., Treasure, J., & Schmidt, U. (2003). Factors determining uptake of a CD-ROM-based CBT self-help treatment for bulimia: patient characteristics and subjective appraisals of self-help treatment. *European Eating Disorders Review*, 11, 243-260.

Nease, D. E. J., & Malouin, J. M. (2003). Depression screening: a practical strategy. *The Journal of Family Practice*, 52(2), 118-126.

- Nederhof, A. J. (1985). Methods of coping with social desirability bias : A review. *European Journal of Social Psychology*, 15(3), 263-280.
- Ngai, M. M. Y., Latimer, S., & Cheung, V. Y. M. (2001). *Final report on healthcare needs of Asian people: Surveys of Asian people and health professionals in the North and West Auckland*. Auckland, New Zealand: Asian Health Support Service, Waitemata District Health Board.
- NICE (2004). *Depression: management of depression in primary and secondary care*. London: National Institute for Clinical Excellence.
- NICE (2009). *Depression in adults with a chronic physical health problem: Treatment and management: Clinical Guideline 91*. London: National Institute for Health and Clinical Excellence.
- NICE (2011). *Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: Management in primary, secondary and community care: Clinical Guideline 113*. London, UK: National Institute for Health and Clinical Excellence.
- Padesky, C. A., & Mooney, K. A. (1990). Presenting the cognitive model to clients. *International Cognitive Therapy Newsletter*, 6, 13-14.
- Pallant, J. F. (2011). *SPSS Survival Manual: A step by step guide to data analysis using SPSS*. Crows Nest, NSW: Allen & Unwin.
- Paykel, E. S., Scott, J., Teasdale, J. D., Johnson, A. L., Garland, A., Moore, R., Jenaway, A., Cornwall, P. L., Hayhurst, H., Abbott, R., & Pope, M. (1999) Prevention of relapse in residual depression by cognitive therapy: A controlled trial. *Archives of General Psychiatry*, 56, 829–835.
- Perreault, M., Leichner, P., Sabourin, S., & Gendreau, P. (1993). Patient satisfaction with outpatient psychiatric services: Qualitative and quantitative assessments. *Evaluation and Program Planning*, 16, 109-118.
- Richards, D. (2010). Low Intensity CBT. In M. Mueller, H. Kennerley, F. McManus, & D. Westbrook (Eds.). *The Oxford guide to surviving as a CBT therapist*. Oxford: Oxford

University Press.

- Richards, D. A., & Farrand, P. (2010). Choosing self-help books wisely: sorting the wheat from the chaff. In J. Bennett-Levy, D. A. Richards, P. Farrand, H. Christensen, K. M. Griffiths, D. J. Kavanagh, B. Klein, M. A. Lau, J. Proudfoot, L. Ritterband, J. White & C. Williams (Eds.), *Oxford Guide to Low Intensity CBT Interventions* (pp. 201-207). New York: Oxford University Press.
- Richards, D. A., Lankshear, A. J., Fletcher, J., Rogers, A., Barkham, M., Bower, P., Gask, L., Gilbody, S., & Lovell, K. (2006). Developing a U.K. protocol for collaborative care: a qualitative study. *General Hospital Psychiatry, 28*, 296-305.
- Rienties, B., Beusaert, S., Grohnert, T., Niemantsverdriet, S., & Kommers, P. (2012). Understanding academic performance of international students: the role of ethnicity, academic and social integration. *Higher Education, 63*, 685-700.
- Rienties, B., & Tempelaar, D. (2013). The role of cultural dimensions of international and Dutch students on academic and social integration and academic performance in the Netherlands. *International Journal of Intercultural Relations, 37*, 188-201.
- Robinson, L. A., Berman, J. S., & Neimeyer, R. A. (1990). Psychotherapy for the treatment of depression: A comprehensive review of controlled outcome research. *Psychological Bulletin, 108*, 30-49.
- Rush, A.J., Beck, A.T., Kovacs, M., & Hollon, S.D. (1977). Comparative efficacy of cognitive therapy and pharmacotherapy in the treatment of depressive outpatients. *Cognitive Therapy & Research, 1*, 17-37.
- Russell, J., Rosenthal, D., & Thomson, G. (2010). The international student experience: Three styles of adaptation. *Higher Education, 60*(2), 235-249.
- Sandil, R. (2006). Cognitive behavioral therapy for adolescent depression: implications for Asian immigrants in the United States of America. *Journal of Child and Adolescent Mental Health, 18*, 27-32.

- Schmidt, M. M., & Miller, W. R. (1983). Amount of therapist contact and outcome in a multidimensional depression treatment program. *Acta Psychiatrica Scandinavica*, *67*, 319–332.
- Seesaengnom, D., Parackal, S., & Ho, E. (2012). Utilisation of and barriers to accessing primary health care services in New Zealand: A cross-sectional survey of Thai adults living in Auckland. In A. Sobrun-Maharaj, F. Rossen, S. Parackal, S. Nayar, E. Ho, D. Newcombe, Y. Ratnasabapathy, J. Hand, & S. Ameratunga (Eds.). *Social Environment, Migration, and Health Proceedings of the Fifth International Asian and Ethnic Minority Health and Wellbeing Conference* (pp. 114-125). Auckland, New Zealand: University of Auckland.
- Shen, E., Alden, L., Sochting, I., & Tsang, P. (2006). Clinical observations of a Cantonese cognitive-behaviour treatment program for Chinese immigrants. *Psychotherapy: Theory, Research, Practice, Training*, *43*, 518-530.
- Skevington, S. M., Lotfy, M., & O'Connell, K. A. (2004). The World Health Organisation's WHOQOL-BREF quality of life assessment: Psychometric properties and results of the international field trial. *Quality of Life Research*, *13*, 299-310.
- Sobell, M. B., & Sobell, L. C. (2000). Stepped care as a heuristic approach to the treatment of alcohol problems. *Journal of Consulting and Clinical Psychology*, *68*, 573-579.
- Spek, V., Cuijpers, P., Nyklicek, I., Riper, H., Keyzer, J., & Pop, V. (2007). Internet-based cognitive behaviour therapy for symptoms of depression and anxiety: a meta-analysis. *Psychological Medicine*, *37*, 319-328.
- Spitzer, R.L., Kroenke, K., & Williams, J.B. (1999). Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. *Journal of the American Medical Association*, *282*(18), 1737-1744.
- Spitzer, R.L., Kroenke, K., Williams, J.B., & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine*, *166*, 1092-1097.

- Statistics New Zealand (2006). *Ethnic groups in New Zealand*. Retrieved from <http://www.stats.govt.nz/Census/2006CensusHomePage/QuickStats/quickstats-about-a-subject/culture-and-identity/ethnic-groups-in-new-zealand.aspx>
- Statistics New Zealand (2014). *2013 Census QuickStats about Culture and Identity*. Wellington, New Zealand: Statistics New Zealand.
- Sue, D. (1997). Counseling strategies for Chinese Americans. In C. C. Lee (Ed.), *Multicultural issues in counseling: New approaches to diversity* (2nd ed., pp. 173–187). Alexandria, VA: American Counseling Association.
- Sue, D. W., & Sue, D. (1999). *Counselling the cultural different: Theory and practice* (3rd ed.). New York: John Wiley.
- Surdam, J. & Collins, J. (1984). Adaptation of international students: A cause for concern. *Journal of College Student Personnel*, 240-245.
- Tao, S., Dong, Q., Pratt, M. W., Hunsberger, B., & Pancer, S. M. (2000). Social support: Relations to coping and adjustment during the transition to university in the People's Republic of China. *Journal of Adolescent Research*, 15, 123-144.
- Te Pou (2010). *Building evidence for better practice in support of Asian mental wellbeing: An exploratory study*. Auckland, New Zealand: Auckland Uni Services.
- Titov, N., Dear, B. F., McMillan, D., Anderson, T., Zou, J., & Sunderland, M. (2011). Psychometric comparison of the PHQ-9 and BDI-II for measuring response during treatment of depression. *Cognitive Behaviour Therapy*, 40(2), 126-136.
- Tolin, D. F. (2010). *Is cognitive-behavioral therapy more effective than other therapies?: A meta-analytic review*. *Clinical Psychology Review*, 30(6), 710-720.
- Tucker, M., & Oie, T. (2007). Is group more cost effective than individual CBT? The evidence is not solid yet. *Behavioural and Cognitive Psychotherapy*, 35, 77-91.
- Waller, R., & Gilbody, S. (2009). Barriers to the uptake of computerised cognitive behavioural therapy: a systematic review of the quantitative and qualitative evidence. *Psychological Medicine*, 39, 705-712.

- Wells, J. E., Oakley Browne, M. A., Scott, K. M., McGee, M. A., Baxter, J., & Kokaua, J., (2006). Prevalence, interference with life and severity of 12 month DSM-IV disorders in Te Rau Hinengaro: The New Zealand Mental Health survey. *Australian and New Zealand Journal of Psychiatry*, 40, 845-854.
- Westbrook, D., Kennerley, H., & Kirk, J. (2011). *An introduction to cognitive behaviour therapy: Skills and applications* (2nd ed.). London: Sage.
- Whitfield, G., & Williams, C. (2003). The evidence base for cognitive-behavioural therapy in depression: delivery in busy clinical settings. *Advances in Psychiatric Treatment*, 9, 21-30.
- WHOQOL Group (1994). Development of the WHOQOL: Rationale and current status. *International Journal of Mental Health*, 23, 24–56.
- WHOQOL Group (1998). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychological Medicine*, 28, 551–558.
- Williams, C. (2007). *Living life to the full*. Retrieved from <http://www.fiveareas.com>
- Williams, C. (2001). Use of written cognitive-behavioural therapy self-help materials to treat depression. *Advances in Psychiatric Treatment*, 7, 233-240.
- Williams, C., & Garland, A. (2002). A cognitive-behavioural therapy assessment model for use in everyday clinical practice. *Advances in Psychiatric Treatment*, 8, 172-179.
- Williams, C., & Martinez, R. (2008). Increasing access to CBT: Stepped care and CBT self-help models in practice. *Behavioural and Cognitive Psychotherapy*, 36, 6675-683.
- Williams, C., Morrison, J., McConnachie, A., & McClay, C-A. (2014). *A randomised controlled trial of a community based group guided self-help intervention for low mood and stress*. Edinburgh: Chief Scientist Office.
- Williams, M. W., & Cleland, A. M. M. M. T. (2007). Asian peoples in New Zealand: Implications for psychological practice. In I. M. Evans, J. J. Rucklidge, & M. O'Driscoll (Eds.), *Professional practice of psychology in Aotearoa New Zealand* (pp. 85–102). Wellington: New Zealand Psychological Society.

- Williams, M. W., Foo, K. H., Haarhoff, B. (2006). Cultural considerations in using cognitive behaviour therapy with Chinese people: A case study of an elderly Chinese woman with generalised anxiety disorder. *New Zealand Journal of Psychology*, 35(3), 153-162.
- Williams, M. W., Graham, E. Y. H., Foo, K. H. (2004). A modified cognitive behavioural therapy model for working with Chinese people In S. Tse, A. Thapliyal, S. Garg, G. Lim, & M. Chatterji (Eds.), *Proceedings of the Inaugural International Asian Health Conference: Asian health and wellbeing, now and into the future* (pp. 209- 222). New Zealand: The University of Auckland, School of Population Health.
- Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford University Press.
- World Health Organisation (1998). *WHOQOL User Manual*. Geneva: World Health Organisation.
- Wright, B., Williams, C., & Garland, A. (2002). Using the Five Areas cognitive-behavioural therapy model with psychiatric patients. *Advances in Psychiatric Treatment*, 8, 307-315.
- Yang, Y. (2011). The challenge of professional identity for Chinese clinicians in the process of learning and practicing psychoanalytic psychotherapy: The discussion on the frame of Chinese culture. *The International Journal of Psychoanalysis*, 92, 733-743.
- Yip, K-S. (2005). Chinese concepts of mental health: Cultural implications for social work practice. *International Social Work*, 48(4), 391-407.
- Zhang, J., & Goodson, P. (2011). Predictors of international students' psychosocial adjustment to life in the United States: A systematic review. *International Journal of Intercultural Relations*, 35, 139-162.
- Zhang, Y., Qu, B., Lun, S., Wang, D., Guo, Y., & Liu, J. (2012). Quality of life of medical students in China: A study using the WHOQOL-BREF. *Public Library of Science*, 7(11), 1-9.

Zaroff, C. M., Davis, J. M., Chio, P. H., & Madhavan, D. (2012). Somatic presentations of distress in China. *Australian and New Zealand Journal of Psychiatry*, 46(11), 1053-1157.

Appendix A: Programme Posters and Flyers in English and Mandarin

Printed in colour



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

FREE Programme for East-Asian students!



Want to feel happier, become more active, sleep better, and generally feel more in control of your life?

A guided self-help programme is being run as part of my Masters research. These will teach key life skills to help overcome low mood and other common difficulties.

Individual sessions run for 8 weeks starting August/September 2013 and are free of charge for participants.

For more information, please contact Kxxxx at xxxxxxx@gmail.com



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKĒNGA TANGATA

FREE Programme for East-Asian students!

提供給亞洲學生免費輔導



Want to feel happier, become more active, sleep better, and generally feel more in control of your life?

你想要活得更快樂，更有精神，睡得更好，更能掌握自己的生活嗎？

A guided self-help programme is being run as part of my Masters research. These will teach key life skills to help overcome low mood and other common difficulties.

我在找尋想要克服情緒低落，焦慮等等困擾的人來參予我的碩士研究

Individual sessions run for 8 weeks starting August/September 2013 and are free of charge for participants.

這8個禮拜的一對一輔導課程，完全免費，教你如何克服生活上的挑戰

For more information, please contact Kxxx at xxxxxx@gmail.com

有任何問題請和我聯絡

Appendix B: Screening Questionnaire

What is your age: _____

What country are you from: (select your answer in **bold**)

- China
- Taiwan
- Hong Kong
- Japan
- Korea
- Other. Please specify: _____

How many years have you been in New Zealand: _____ years

I would like help with my: (select multiple answers in **bold**)

- Low mood
- Anxiety
- Stress
- Sleeping problems
- Physical health problems
- Other. Please specify: _____

Are you at risk to yourself or others? (select your answer in **bold**)

- Yes
- No
- I'm not sure

Have you been diagnosed with any of the following: (select your answer in **bold**)

- Substance abuse
- Psychosis
- Borderline personality disorder

Can you commit to an 8-week programme? (select your answer in **bold**)

- Yes
- No

Appendix C: Information Sheet



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

Guided self-help CBT Research Study

Information Sheet

You are invited to take part in research using a low intensity CBT programme. Before deciding if you want to be involved in the research, please read the following information carefully so that you fully understand the nature of the research project and your rights should you choose to participate.

What is the study about?

Cognitive Behaviour Therapy (CBT) is a talking psychotherapy that research has shown to be effective for many different problems, such as anxiety, depression, and stress. CBT emphasises the importance of how you think about yourself, situations, the world and other people.

During times of distress, people think differently about themselves, others and the world. CBT practitioners help each person identify and change their unhelpful thinking and behaviour. The end result is often that the person feels better about themselves, for example less anxious and less depressed.

Low intensity CBT and the use of CBT self-help materials, is an innovative and evidence-based intervention that is being used with successful results in England, Scotland and Canada. It is different to traditional CBT as the emphasis is on the self-help materials themselves, and support for working through the materials is provided by a 'paraprofessional' or Psychological Wellness Professional. Low intensity CBT provides helpful strategies which can be used by most people to help them overcome their difficulties with symptoms of mild anxiety and depression.

This research aims to examine the effectiveness of CBT guided self-help. In particular we are interested in knowing if peoples' thoughts, feelings, and behaviours change after the low intensity CBT intervention. In addition, we would like to know if these changes impact on your quality of life and adjustment to university life. This research is run for the purposes of a Masters thesis. The researcher will also be acting as the facilitator of the programme.

Who can take part?

To participate in this research, you need to be 18 or over, and be experiencing symptoms of depression or anxiety. You will need to have sufficient skills in reading, writing and speaking English and must not meet diagnostic criteria for substance

abuse, psychosis or borderline personality disorder. You must also be able to keep yourself safe from harm. Additionally, as the study is focused on the effectiveness of the intervention for Asian students, participants need to be from an Asian country, such as China, Taiwan, Hong Kong, Japan or Korea.

What would I have to do?

If you agree to participate you will receive a comprehensive psychological assessment, followed by 8-weeks of face-to-face sessions of CBT. The sessions will be provided by the facilitator, who will be a trained paraprofessional. The sessions will last between 30-45 minutes, once a week. Questionnaires will be completed each week and should take no longer than 15 minutes. An interview will be conducted at the end of the programme to get your feedback and evaluation. The interview will be sound recorded to ensure the information is being captured.

There will be no charge involved.

How will the study benefit me?

CBT is an effective therapy for individuals with anxiety and depression, because what it teaches you is how your thoughts affect your behaviours, and how some simple techniques can help you gain control over these issues. One of the main benefits for you is a greater self-awareness of how to deal with issues that may lead to anxiety and depression and how to deal with them more effectively.

Will my information remain confidential?

Yes. All your information will remain confidential at all times as part of standard procedures within the Centre for Psychology.

- Research data will only be accessed by the researcher and clinical supervisor
- The reports will not contain material which could identify you
- All data will be kept locked.
- Files will be stored in a separate location from the identifying information

Your rights as a participants:

If you choose to take part in the research, you have the right to:

- Withdraw from the study at any time;;
- Decline to take part in this study, knowing this will not have any impact on what services I receive;
- Decline to answer any particular question;
- Ask any question about the study at any time during participation;
- Be given a summary of the findings of the study once it has been completed if you request it

- Ask for the recorder to be turned off at any time during the interview

Questions or concerns:

If at any time you have questions or concerns about this study, you are welcome to contact Dr Mxx Wxxxxx, Phone (09) 414 xxxx, extension xxxxxx.

If you have any questions about any issues pertaining to Maori in this study, regardless of your own ethnicity, you are welcome to contact Dr Lily George, Postdoctoral Research Fellow at the Research Centre for Maori Health and Development, phone (09) 414 0800 extension 41594.

If you have any queries or concerns regarding your rights as a participant in this study you may wish to contact a Health and Disability Advocate, telephone 0800 555 050 Northland to Franklin.

What happens from here:

You will have the opportunity to ask any questions before you agree to take part and begin your assessment. If you do not wish to take part then you will still be able to receive the programme.

This study has received ethical approval from the Health and Disability Ethics Committee, Ref: 13/STH/86

Thank you for reading this information sheet.

Appendix D: Consent Form



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

Guided self-help CBT Research Study

Participant Consent Form

This consent form will be held for a period of ten (10) years

- I have read the information sheet for this study and have had the details explained to me. My questions about the research have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given contact details to use in case I have future questions about the study.

- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time.

- I agree to provide information to the researchers on the understanding that this will be confidential. The information I supply will only be used for the purpose of the study. All information will be treated confidentially within the Centre, subject to the ethical guidelines on the limits of confidentiality provided by the Psychological Society of New Zealand's Code of Ethics, as per the Privacy Act (1993).

- I agree to the interview, at the end of the programme, being sound recorded.

- I have had adequate time to consider whether or not to take part in this study. I agree to participate in this study under the conditions set out in the Information Sheet.

Signature.....Date

Full Name (printed).....

Appendix E: Patient Health Questionnaire 9 (PHQ-9)

Developed by Spitzer, Kroenke, & Williams, 1999

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix F: Generalised Anxiety Disorder 7 (GAD-7)

Developed by Spitzer, Kroenke, Williams, & Lowe, 2006

GAD-7				
Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems? <i>(Use "✓" to indicate your answer)</i>	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

Appendix G: Understanding stress and low mood (UndSLM)

Developed by Williams, 2007

Your current understanding about stress and low mood

Please answer the following questions to summarise how you see your own current level of knowledge.

1. Your ability to understand how low mood and stress affect you

Very poor	Poor	Okay	Good	Very good
1	2	3	4	5

2. Your ability to plan activities to boost how you feel

Very poor	Poor	Okay	Good	Very good
1	2	3	4	5

3. Your ability to respond positively to your negative thinking

Very poor	Poor	Okay	Good	Very good
1	2	3	4	5

4. Your ability to plan ways to boost your confidence

Very poor	Poor	Okay	Good	Very good
1	2	3	4	5

5. Your ability to overcome practical problems in your life

Very poor	Poor	Okay	Good	Very good
1	2	3	4	5

6. Your ability to overcome unhelpful behaviours in your life that are worsening the way you feel

Very poor	Poor	Okay	Good	Very good
1	2	3	4	5

7. Your ability to overcome problems of anger and irritability in your life

Very poor	Poor	Okay	Good	Very good
1	2	3	4	5

8. Your ability to do things that make you feel happier and healthier

Very poor	Poor	Okay	Good	Very good
1	2	3	4	5

Appendix H: Client Satisfaction Questionnaire 8 (CSQ-8)

Developed by Larsen, Attkisson, Hargreaves, & Nguyen, 1979

CSQ-8
CLIENT SATISFACTION QUESTIONNAIRE

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. *Please answer all of the questions.* We also welcome your comments and suggestions. Thank you very much, we really appreciate your help.

CIRCLE YOUR ANSWERS

1. How would you rate the quality of service you have received?

4	3	2	1
<i>Excellent</i>	<i>Good</i>	<i>Fair</i>	<i>Poor</i>

2. Did you get the kind of service you wanted?

1	2	3	4
<i>No, definitely not</i>	<i>No, not really</i>	<i>Yes, generally</i>	<i>Yes, definitely</i>

3. To what extent has our program met your needs?

4	3	2	1
<i>Almost all of my needs have been met</i>	<i>Most of my needs have been met</i>	<i>Only a few of my needs have been met</i>	<i>None of my needs have been met</i>

4. If a friend were in need of similar help, would you recommend our program to him or her?

1	2	3	4
<i>No, definitely not</i>	<i>No, I don't think so</i>	<i>Yes, I think so</i>	<i>Yes, definitely</i>

5. How satisfied are you with the amount of help you have received?

1	2	3	4
<i>Quite dissatisfied</i>	<i>Indifferent or mildly dissatisfied</i>	<i>Mostly satisfied</i>	<i>Very satisfied</i>

6. Have the services you received helped you to deal more effectively with your problems?

4	3	2	1
<i>Yes, they helped a great deal</i>	<i>Yes, they helped somewhat</i>	<i>No, they really didn't help</i>	<i>No, they seemed to make things worse</i>

7. In an overall, general sense, how satisfied are you with the service you have received?

4	3	2	1
<i>Very satisfied</i>	<i>Mostly satisfied</i>	<i>Indifferent or mildly dissatisfied</i>	<i>Quite dissatisfied</i>

8. If you were to seek help again, would you come back to our program?

1	2	3	4
<i>No, definitely not</i>	<i>No, I don't think so</i>	<i>Yes, I think so</i>	<i>Yes, definitely</i>

Appendix I: Semi-structured Interview Questions

1. What impact has the course had on your life? What's one thing you'd take from the course?
2. What expectations did you have coming in to the programme?
3. How relevant was the programme in meeting your needs ? Did it help you deal more effectively with your problems?
4. What worked well for you? What was useful/helpful?
5. What could be improved? Not helpful/dislike?
6. What would you like more/less of?
7. Does it fit with your cultural understanding?
8. What changes would you recommend for the programme to better meet your cultural needs?
9. Are there other ways of dealing with problems in your culture that wasn't mentioned in the books?
10. If someone asked you whether you'd recommend the course, what would you say?
11. Any other feedback?

Appendix J: Outliers by Participant, Measure and Time, with the Participant's Score and the Group Mean Score on the Corresponding Measure

Participant	Measure	Time	Score	Mean (SD)
10	GAD-7	Baseline	0	10.45(4.59)
10	PHQ-9	Week 4	0	4.55(2.21)
10	WHOQOL (psy)	Week 8	88	72.73(12.85)
10	SACQ (acad)	Baseline	194	131.64(28.96)
10	SACQ (emo)	Baseline	122	72.45(21.58)
13	GAD-7	Week 5	15	4.73(4.31)
13	PHQ-9	Week 5	13	4.55(3.59)
13	UndSLM	Week 8	24	33.73(3.52)
13	WHOQOL (rela)	Week 8	25	66.55(18.82)
11	GAD-7	Week 4	10	4.64(2.77)
11	PHQ-9	Week 4	8	4.55(2.21)
6	GAD-7	Week 8	9	3.18(2.71)
3	WHOQOL (rela)	Week 8	94	66.55(18.82)