Help yourself to CBT: Investigating clinically significant change in a low intensity programme for low mood

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The aim of the research was to examine the clinical significance of a low intensity cognitive-behavioural guided self-help programme for a community sample of individuals experiencing depression and low mood. The intervention was provided either face-to-face or over the telephone depending on the participant's preference. The study used a two-group repeated measures naturalistic design. Participants were assessed weekly during the six-week programme, with follow-up assessments at six and twelve weeks. Thirteen participants completed the programme. Low mood was measured by the nine-item Patient Health Questionnaire (PHQ-9), and quality of life was measured by the short form Quality of Life and Enjoyment Questionnaire (QLES-SF). Results showed a clinically significant reduction in depressive symptoms and increase in quality of life ratings. The results provide preliminary support that a cognitive-behavioural guided self-help programme can benefit people experiencing low to moderate levels of depression.

Keywords: depression; low-intensity; cognitive behavioural interventions; clinical significance

Depression is a widespread and debilitating condition. It is estimated that depression will be the second highest disease-causing burden in the world by 2020 (World Health Organization, 1992). In New Zealand, depression is experienced by as many as 20% of women and 10% of men during their lifetime, and has an overall lifetime prevalence rate of 16% (Oakley Browne, Wells, Scott, & McGee, 2006). The proportion of Māori presenting with depression is substantially greater than New Zealand European, with nearly one in three experiencing major depressive disorder at some point in their lives (Baxter, 2008). The personal cost of depression includes significant clinical morbidity, increased mortality (particularly from suicide), diminished functioning, and decreased quality of life (see Barge-Schaapveld, Nicolson, Berkhof, & deVries, 1999; Hays, Wells, Sherbourne, Rogers, & Spritzer, 1995; Klerman & Weissman, 1992; Ustün, 1999).

Despite the prevalence, severity, and the negative impact of depression, it is treatable. There are successful evidence-based interventions available, including medication, psychosocial interventions, and psychotherapies such as cognitive behavioural therapy (CBT) (Beck, 1963, 1964; Beck, Rush, Shaw & Emery, 1979).

However, because of the high demand for mental health services and a lack of resources, only the most complex and chronic cases are typically accepted in treatment. Extensive waitlists, insufficient number of practitioners, and/or costs associated with therapy means psychological interventions are inaccessible for people who could potentially benefit from psychotherapy, i.e., those with mild to moderate levels of depression and anxiety. Therefore, those who would benefit the most from psychotherapy are the least likely to receive it, and those with the most severe conditions (such as severe clinical depression, bipolar disorder) and the least responsive to psychotherapy receive it; thus further exacerbating the problem of waitlists (Williams & Chellingsworth, 2010).

These problems have led to the recent development of low intensity interventions. Low intensity refers to the low usage of specialist therapist time (Bower & Gilbody, 2005), or the usage of the therapist's time in a cost-effective way. The primary purpose of low intensity cognitive behavioural interventions (LI-CBI) is to increase access to evidence-based psychological therapies on a community-wide basis, using the "minimum level of intervention necessary to create maximum gain" (Bennett-Levy & Farrand, 2010, p. 8). As the conceptual underpinnings of LI-CBI have already been discussed by Haarhoff and Williams (2017) in this issue, the principles will not be repeated here.

One example of LI-CBI is self-help. Self-help can play an important role in increasing the client's sense of control over and understanding of their mental health, thereby preventing relapse, reducing the amount of time spent in therapy, and increasing motivation (Keeley, Williams, & Shapiro, 2002). Self-help materials have come to be seen both as psychological interventions in their own right and as an adjunct to therapist-delivered care (Improving Access to Psychological Therapies [IAPT], 2010). As an intervention, self-help involves the delivery of materials that employ different media-based format, such as printed materials, digital, or web-based programmes. Whatever the means of delivery, self-help materials aim to increase the users' knowledge about a particular problem and equip them with skills to better self-manage their difficulties (Williams, 2003). For example, bibliotherapy and internet-delivered CBT for social anxiety have been shown to be effective as pure self-help models (Furmark et al., 2009).

Pure self-help, however, has been found to have high dropout rates and many do not complete the programme

(Waller & Gilbody, 2009). A seminal review by Gellatly et al. (2007) demonstrated that practitioner support led to significantly improved outcomes compared to the use of self-help on its own. For all self-help interventions, they found a medium effect size but when the analysis focused on guided self-help studies only, this increased to a large effect size. This suggests that guided self-help may be more effective than the provision of information alone.

In a practitioner-support model, the practitioner takes the role of an encouraging and supportive figure who introduces the self-help materials, monitors the individual's progress, and reviews his/her outcomes. Compared to traditional therapy, Papworth, Marrinan, Martin, Keegan, and Chaddock (2013) reported guided self-help is less intensive, requires fewer contact hours, and is cost-effective. Birchall and Palmer (2002) believed it could potentially be empowering for clients as well. The use of guidance can facilitate the implementation of high-quality evidence-based treatment and act as a step up to more intensive treatment if required.

A number of studies have demonstrated substantial improvements in mental health symptoms using guided self-help models (Ghaderi & Scott, 2003; Hirai & Clum, 2006; Priemer & Talbot, 2013; Williams et al., 2013; Williams & Whitfield, 2001). Currently, low intensity interventions are recommended by the National Institute for Health and Care Excellence (NICE; 2004, 2009) in their clinical guidelines for treatment of sub-threshold (mild to moderate) depression and anxiety disorders. Initial results suggest that this approach to treatment have similar findings to that of traditional face-to-face type therapies (Cuijpers, Donker, van Straten, Li, & Andersson, 2010). Low intensity interventions have been successfully implemented through the Ministry of Health initiatives in England, Scotland, and Canada (e.g., IAPT (Clark, 2013); STEPs (White, 2008); Bounce Back: Reclaim your Health (Canadian Mental Health Association, 2012). The New Zealand Ministry of Health (2008) has identified the need for a stepped care approach to the mental health system, recommending that low intensity

interventions, such as self-help books, treatments delivered over the internet, and brief interventions be available for people with mild to moderate mental health problems.

The delivery of supported low intensity treatments typically employs a variety of flexible and accessible formats. Although face-to-face contact is part of this, the use of other modalities such as telephone, the internet, and social media are increasingly used to increase access and choice. These options support the delivery of low intensity interventions due to its capacity to overcome many of the physical, social, and economic barriers that prevent access to mental health services (Bee et al., 2008; Lovell, 2010; Mohr et al., 2005). The barriers may include remoteness from mental health facilities, having to travel long distances, an inability to attend treatment due to cost, work, childcare, or other emergencies.

The study's primary aim was to investigate the clinical effectiveness of a guided self-help LI-CBI for people experiencing low mood. Two forms of guided support were provided; face-to-face and over the telephone. The second aim of the study was establish the clinical significance, rather than just the statistical significance, of the observed change in low mood symptoms. Statistical significance is typically used to establish the effectiveness of an intervention. However, it would be of great value to consider the clinical significance of change as well. In traditional outcome research, the results are often aggregated, masking individual differences. This provides little or no information regarding the variability of responses both within and between individuals (Blampied, 2001; Jacobsen & Truax, 1991). For example, a statistically significant treatment effect does not make it clear whether some individuals have not changed or have even deteriorated in the treatment group. In contrast, the focus of clinical significance is to examine whether the intervention resulted in any change for the individual client in terms of their functioning and everyday life (Blampied 2001; Kazdin, 2003). In a stepped care approach to treatment, examining clinical significance can be particularly useful because it signals when clients have achieved clinically

significant change in their status and no longer require treatment, or whether a step up in treatment is needed. For the study, a two-way repeated measures, naturalistic research design was used.

Method

Participants

To be included in the study participants needed to be between 18 and 65 years of age, experiencing depressive symptoms or low mood and to be proficient in reading and writing English. They were also advised that in order to participate in the study, they could not have any major hearing or sight impediments, any major mental health diagnosis (such as substance dependency, psychosis), and any imminent risk of harm to self or others. A key focus of the study was to make the intervention readily accessible to people in the community and, therefore, there were no restrictions on gender, ethnicity, or medication use.

A total of 48 people applied to take part in the larger *Help Yourself to CBT* study via a specifically designed website, indicating their preference to participate either in a group or an individual-based guided self-help project. Twenty-six people registered for the individual support: 18 for face-to-face support and eight for telephone support. Seven withdrew prior to the baseline measures being taken, leaving 19 participants who attended the initial session. Thirteen participants completed the programme, which consisted of four support sessions over the six week programme. Six participants dropped out of the programme (five in the face-to-face condition and one in the telephone condition). The reasons for dropping out were the programme not meeting the expectations, and/or inappropriateness of the modality for the participant's needs.

The results are based on the 13 participants who completed the programme. The sample consisted of 11 females and two males, with a range of ages (mean age = 41, *SD* = 11, range = 25–64). The majority of the sample identified their ethnicity as New Zealand European (69%). Two participants identified as British and one as Macedonian. Fifty four per cent of the

sample were married or in a relationship, and over half (62%) were employed either in full- or part-time positions. Seventy-seven per cent of participants had received previous therapy, ranging from talking therapy only to in-patient treatment. Three participants (23%) were currently taking antidepressant medication for their problems.

Measures

All authors of the measures utilised were contacted regarding weekly use and this was deemed appropriate.

Patient Health Questionnaire Depression Scale (PHQ-9)

The PHQ-9 (Kroenke, Spitzer, & Williams, 2001) is a 9-item self-report measure of depression that assesses both diagnostic criteria and severity of depression. Participants are asked to identify how often they have been troubled by these symptoms in the past two weeks on a 4-point scale (0 "not at all"; 1 "more than half the days"; 2 "several days"; 3 "nearly every day"). with a maximum score of 27. The authors suggested cumulative scores of 5, 10, 15 and 20 be used as cut-off points to indicate "mild", "moderate", "moderately severe" and "severe" depression respectively. Cronbach's alpha coefficient for the measure was $\alpha = .89$.

Quality of Life Enjoyment and Satisfaction Questionnaire-Short Form (QLES-SF)

This is a 16-item short form of the QLES questionnaire (Endicott, Nee, Harrison, & Blumenthal, 1993). It measures quality of life on the domains of physical health, subjective feelings, leisure activities, social relationships, general activities, satisfaction with medication, and life satisfaction. Participants are asked to rate how satisfied they have been over the last week on a 5-point scale from 1 ("very poor") to 5 ("very good"). The QLES-SF scale has a cut-off value of 50.70 where participants are termed "Functional" if their scores exceed this value, or "Impaired" if their scores are below this value (Eisen et al., 2006). Cronbach's alpha coefficient for the measure was $\alpha = .94$.

Client Satisfaction Questionnaire (CSQ-8)

The CSQ-8 (Larsen, Attkisson, Hargreaves, & Nguyen, 1979) is a short version of the original 18-item CSQ that enquires about participants' opinions and conclusions regarding the services they have received. The anchors for the responses differ according to the question, but all are based on a 4-point scale, with higher scores pertaining to greater satisfaction. Examples of items include "How satisfied are you with the amount of help you have received?" (1 ["quite dissatisfied"]; 2 ["indifferent or mildly dissatisfied"]; 3 ["mostly satisfied"]; 4 ["very satisfied"]), and "Have the services you received helped you to deal more effectively with your problems?" (1 ["no, they seemed to make things worse"]; 2 ["no, they didn't help"]; 3 ["yes, they helped somewhat"]; 4 ["yes, they helped a great deal"]). The maximum CSQ-8 score is 32. The measure was administered only at the end of the programme.

Overcoming Depression and Low Mood Programme

Overcoming Depression and Low Mood: A Five Areas Approach (ODLM; Williams, 2012) is a self-help book that uses the principles of low intensity CBT to treat depression and low mood. The ODLM is in its third edition and contains 16 "workbooks" within a single bound book. The workbooks are based on the "five areas" model, similar to Greenberger and Padesky's (1995) five-part model. This framework provides a structure to address the range of problems and difficulties that clients may face in the following domains: environment (life situation, relationships and practical problems), cognitions (altered thinking), emotions (altered mood), physiology (altered physical symptoms) and behaviour (altered behaviour). ODLM is designed to be used either in a pure self-help format or as a guided self-help with support provided by a practitioner.

As the book is the main component of intervention for low mood and depression, the workbooks aim to be accessible, requiring a reading age of 11–14 years, and the content is presented as jargon-free as possible. The choice of which workbook to use is what is termed a "learner-led" approach where

the workbooks can be completed in any order, after an initial module that helps the person identify his/her particular problem areas. A final exit workbook teaches effective strategies for relapse prevention. Each workbook includes a "Putting into Practice" (homework) plan to encourage application in everyday life.

Procedure

For the study, the self-help programme was delivered in a guided support framework over six weeks. Guided support was provided either face-to-face (FTF) or over the telephone (T), depending on the participant's choice. In the registration process participants were asked to choose how they wanted their self-help support to be delivered. Participants were informed about the study and asked for informed consent. To provide the baseline data, the participants were sent the PHQ-9 and QLES-SF via email to complete one week before the initial session, and then completed the same measures at the beginning of the initial session; providing two baseline data. Over the period of the six week programme, the measures were emailed each week to the participants via a link that was active for that week. The weekly data was collected for further analyses outside the scope of this article (Montagu, 2015). For the purpose of this article, the first baseline, the final week of the programme, and follow up scores were used in the analysis. Two follow-up points at six and 12 weeks' post-intervention were included to investigate if changes were sustained over time. The researcher was able to view and track the progress of the participants on a weekly basis. A total of nine data points were obtained for the PHQ-9 and the QLES-SF.

At the initial session the participants were oriented to the five areas model and the ODLM workbooks. In conjunction with the practitioner, the participants chose the problem areas they wished to work on. The workbooks most relevant to these problems were identified and the participants worked on these during the six weeks. Participants were given a copy of Williams's (2012) ODLM free of charge.

The participants were given a total of four support sessions (30-40 minutes each) over a six-week period

of the study. In the support sessions, the practitioner reviewed the homework, addressed possible difficulties in using the workbooks, provided support and encouragement, and set the pace for the workbook use. The final session focused on relapse prevention strategies. The first two support sessions were held a week apart, with the remaining support sessions a fortnight apart. Support protocols provided by Chris Williams for both FTF and T support conditions were used for the current study. The support sessions were provided by the researcher, after she received training and supervision in the use of the ODLM self-help CBT programme for people experiencing depression and low mood.

All face to face (FTF) and telephone (T) sessions were carried out at the Centre for Psychology, Massey University, Albany. Ethical approval for the study was obtained from the Health and Disability Ethics Committee (CEN/11/09/051).

Data Analysis

Clinically significant change is defined as the score at which the probability of coming from a clinical and non-clinical distribution is equal. Scores below this point are classified as the non-clinical range. Clinically significant change requires that a person is above the cut-off pre-treatment (i.e., is in the clinical range) but below this at post-treatment. Reliable change is where the change in scores must be greater than what could be due to the inherent reliability of the measure. A reliable change index (RCI) was calculated using estimates from clinical and non-clinical population distributions (means and standard deviations) for the measures from the clinical pre-treatment scores and estimates of internal reliability from the current study, and the non-clinical distribution from original validation studies (Kroenke et al., 2001; Stevanovic, 2011). Thus:

$$RCI = \frac{M_2 - M_1}{\sqrt{2}(s_1\sqrt{1-r_{xx}})2}$$

where:

M_2 and M_1 are the clinical and non-clinical distribution means

s_1 is the standard deviation of the clinical distribution at intake

r_{xx} is the internal reliability

(Cronbach's alpha) of the measure used

The pre-treatment internal reliability estimates, using Cronbach's coefficient alpha, for the PHQ-9 (α =.89) and the QLES-SF (α =.94), and the standard deviations were used in the RCI calculation. On the basis of these data, reliable and clinically significant change (RCSC) criteria were calculated.

Results

Depression

Table 1 presents a summary of the level of severity for depression on the PHQ-9 for each participant at baseline, end of the programme, and at the 12-

Table 1
Summary of Changes on the Patient Health Questionnaire Depression Scale (PHQ-9) for the Face-to-Face and Telephone Support Conditions (N=13)

Participant's ID	Severity at baseline	Severity at end of programme	RCSC End of programme Yes/No	Severity at 12week FU	RCSC 12week FU Yes/No
Face To Face (n=7)					
3	Moderate	Mild	Y	Mild	Y
4	Moderately severe	Moderate	N	Mild	Y
6	Mild	Mild	N	Mild	N
8	Moderate	Mild	Y	Mild	Y
9	Moderate	Mild	Y	Mild	Y
10	Severe	Moderately severe	N	Mild	Y
12	Moderately severe	Moderately severe	N	Mild	Y
Telephone (n=6)					
13	Moderate	No depression	Y	No depression	Y
14	Moderately severe	No depression	Y	No depression	Y
15	Moderately severe	Mild	Y	Mild*	Y*
17	Moderately severe	Mild	Y	Mild	Y
18	Mild	Mild	N	Mild	N
19	Mild	No depression	N	No depression	N

Note. Categories of severity are 0–4 is no depression, 5–9 mild, 10–14 moderate, 15–19 moderately severe, and 20 severe depression. FU=follow-up; RCSC=reliable and clinically significant change.
* 6 weeks' follow-up data was only available for this client.

week follow-up. The RCSC for the individuals are also shown.

For the FTF group at baseline, all participants were experiencing some level of depression with severity ranging from mild to severe. Over half of the group were in the mild to moderate range (57%), with the remaining participants experiencing moderately severe to severe levels of depression. By the end of the programme, 71% (n=5) showed a

reduction in depression severity from their baseline score, although two remained with moderately severe depression. Thus 43% achieved RCSC at the end of the programme. As can be observed in Table 1, at the 12-week follow-up point, all participants were in the mild range for depressive symptoms, and RCSC was demonstrated for six out of the seven participants from baseline to follow-up. The one participant that did not show any RCSC started the programme with mild depressive symptoms and remained at this level for the duration of the study period.

In the telephone support group, the initial baseline measures indicated 50% of the participants had moderately severe depression, with the remaining having mild to moderate depression. At end of the programme, all but one showed a reduction in their level of depression although all were in the mild to no depression level; thus 67% of the participants demonstrated RCSC. At the follow-up stage, all participants maintained the progress they had made at the end of the programme. The two participants who did not demonstrate clinical change had comparatively lower

levels of depression at baseline.

Quality of Life

Table 2 presents a summary of RCSCs for the QLES-SF. With the exception of participant 6, all FTF participants had baseline QLES-SF scores that would be classified as Impaired (Endicott, Nee, Harrison, & Blumenthal, 1993). By the end of the programme, five participants (71%) had reached the Functional level, and this translated into a positive RCSC index. By the 12-week follow-up, only one participant remained in the Impaired group; this same client was also the most severely depressed of this group at the start of the programme.

Participants in the telephone (T) condition had higher quality of life scores at baseline compared to the FTF group (see Table 2). Only three (50%) of the participants in the T condition were in the Impaired range, and by termination all six participants (100%) had reached the Functional level. Those that increased to a Functional level at the end of treatment demonstrated RCSC and furthermore, this was maintained at the 12-week follow-up, with the exception of participant 15. This participant did not complete the 12-week follow-up measures but did provide one at six-week follow-up, and as can be seen the score

reverted to the Impaired range.

To determine if there were any statistical differences between certain demographic characteristics at baseline and follow-up (where applicable) for the outcome measures the Mann-Whitney U tests were used. Participants in both conditions (FTF and T) were combined for the analyses. There were no significant statistical differences between males and females in baseline or follow-up scores on depression and quality of life.

For those participants using medication during the programme, significant differences were found across all outcome measures at 12 weeks' follow-up, but not at baseline. However, these differences were not in the expected direction. Those using medication had a significantly higher

depression score at 12 weeks' follow-up (Md=5.50, n=4) compared to those not using medication (Md=2, n=8), U=4.5, z=1.98, p=.048, r=.57. Furthermore, participants using medication had a significantly lower median score of quality of life at 12 weeks' follow-up (Md=60.5) in comparison to those not on medication (Md=75), U=3, z=-2.23, p=.026, r=.64.

The effect size (ES) was calculated using Cohen's d which represents the size of the difference between means, and ranges from small (0.2), medium (0.5), and large (0.8). The ES for those that completed the programme in both support conditions are shown for the PHQ-9 and QLES-SF in Table 3.

Table 3

Effect Size* for the Face-to-Face and Telephone Support Conditions on the Patient Health Questionnaire (PHQ-9) and Quality of Life Enjoyment and Satisfaction Questionnaire (QLES-SF)

	Condition	End of programme	12 weeks' follow-up
PHQ-9	Face to face	1.12	2.01
	Telephone	1.60	2.80
Quality of Life	Face to Face	1.29	2.89
	Telephone	1.08	1.97

*Cohen's d

Table 2

Summary of Changes on the Quality of Life Enjoyment and Satisfaction Questionnaire (QLES-SF) for the Face-to-Face and Telephone Support Conditions *(N=13)*

Participant's ID	Baseline	End of programme	RCSC End of programme Yes/No	12 week FU	RCSC 12 week FU Yes/No
Face to Face (n=7)					
3	Impaired	Functional	Y	Functional	Y
4	Impaired	Functional	Y	Functional	Y
6	Functional	Functional	N	Functional	N
8	Impaired	Functional	Y	Functional	Y
9	Impaired	Functional	Y	Functional	Y
10	Impaired	Impaired	N	Impaired	N
12	Impaired	Impaired	N	Functional	Y
Telephone (n=6)					
13	Impaired	Functional	Y	Functional	Y
14	Functional	Functional	N	Functional	N
15	Impaired	Functional	Y	Impaired*	N*
17	Impaired	Functional	Y	Functional	Y
18	Functional	Functional	N	Functional	N
19	Functional	Functional	N	Functional	N

Note. Functional and impaired correspond to above or below the cut-off of 50.70 respectively (Eisen et al., 2006). FU=follow-up; RCSC=reliable and clinically significant change.
* 6 weeks' follow-up data was only available for this client.

For the PHQ-9, both support conditions demonstrated a large ES at the end of the programme, and this increased at follow-up. Similar results were shown for the QLES-SF for both conditions; in that large ES were demonstrated at the end of the programme, and this increased at follow-up.

Participant Satisfaction with the Programme

Each participant's score on the CSQ-8 is shown in Figure 1. The scores ranged from 20 to 32, with the average score being 28. The high level of rating showed the participants were satisfied with the programme.
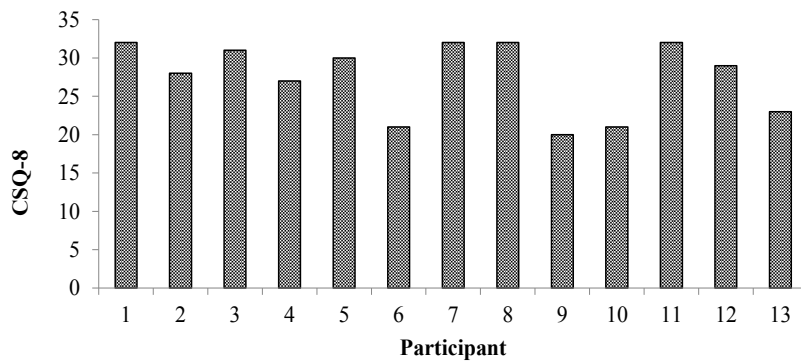
Figure 1. Client Satisfaction Questionnaire (CSQ-8) scores for each participant

Discussion

The aim of this study was to investigate the clinical significance of a guided self-help treatment programme *Overcoming Depression and Low Mood* (Williams, 2012) for individuals in the community experiencing low mood. Conventional statistics typically used in treatment outcome research enables pre- and post-treatment differences to be investigated, but provides little information about the clinical significance of the changes. Thus reliable and clinically significant change (RCSC) methodology was used in this research. RCSC has a number of advantages: the reliable change index (RCI) sets the criteria for determining whether the magnitude of observed change is spurious (attributable to measurement error), and the RCSC determines the clinical meaning of the observed change. Employing these criteria, the results showed there were improvements in symptoms of depression and quality of life for the participants.

Overall, of those who completed the programme, seven of the 13 participants (54%) demonstrated RCSC in depression as measured by the PHQ-9 by the end of the programme, and this increased to 10 participants (77%) by 12 weeks' follow-up. Eleven participants (85%) showed clinically significant change in quality of life scores as measured by the QLES-SF at the end of the programme and this was the same at 12 weeks' follow-up. These findings highlight the magnitude of clinical change that was experienced by participants across the duration of the programme and, furthermore, not only the maintenance of these gains at the follow-up period, but also the number of individuals who may not have achieved clinical change by the end of the programme, but did so at the follow-up points. These results indicate that on an individual level, change was clinically meaningful over this time and the effect sizes were strong. It needs to be noted that participants who initially scored low on symptom measures (i.e., in the non-clinical range) were not able to demonstrate RCSC across time as a result of the criteria. For example, in this study there were three individuals who scored in the mild range for depression who improved over the course of the programme and although they did not meet criteria for RCSC, it is likely this change was significant on an individual level. In an RCT or research study that focused on pre-post change only, these changes would have been lost.

The measure of client satisfaction administered to participants post-programme indicated that the guided self-help programme was well received. Participants were similarly satisfied with the guided self-help programme, whether they had received face-to-face or over-the-telephone support. These results are in agreement with the literature that suggests telephone guidance is just as effective at reducing levels of depression as face-to-face guidance (e.g. Hammond et al., 2012). New Zealand has a large rural population and access to mental health services is not easily available. The positive finding from the telephone support group would suggest that this mode of support could be useful when face-to-face contact is not possible, providing mental health for those suffering mild-moderate levels of depression.

Qualitative feedback was also gained from participants post-programme (including some who had dropped out). While the majority of the feedback was positive, reflecting the self-report CSQ-8 measure, information about what participants liked or did not like about the programme was obtained. One participant reported that the book was at times too simple, and that the material did not answer his questions, leading to him feeling frustrated. Some noted that the programme didn't sufficiently address all their needs, and that it was difficult to put the skills into practice, particularly due to having to focus on other events going on in their life. Participants also noted particular workbooks were useful, such as "Overcoming Anxiety and Avoidance "and "Doing Things to Boost How You Feel". Others noted the biggest hurdle to seeking help for their recovery was a lack of funds and appreciated the provision of the workbooks free of charge. The literature notes that cost is a prohibitive factor in people being able to access mental health services, and that the cost-effectiveness of unguided and guided self-help may be an avenue in which people can access such help (Scogin, Hanson, & Welsh, 2003).

This study contributed some important observations associated with clinical outcomes of low-intensity delivered mental health care. It has provided initial evidence that a guided self-help CBT programme can improve mental outcomes for a community-based population, with minimal input and cost. This is true for those experiencing mild to moderate symptoms, but also for those with more severe levels of depressive symptoms. Some studies have questioned the suitability of self-help interventions for those with severe depression (e.g. McKendree-Smith, Floyd, & Scogin, 2003). However, the current study found that participants who were initially classified as moderately severe or severely depressed made clinically significant improvements on outcome measures of depression.

This research project also reflects a new trend in mental health services, which is to offer a variety of supportive interventions (e.g., face-to-face and telephone options), as not all consumers will engage with one type of service. Further, this study attempted to reduce to a minimum the criteria placed on individuals receiving LI-CBI in order to validate the premise of making psychological interventions as available

as possible. These aspects are in keeping with the rationale for why low intensity interventions were developed; to increase access to treatment for those requiring it (Bennett-Levy & Farrand, 2010). Thus the design of the current study reflected the way in which empirical research is being conducted in that it represents cases typically found in clinical settings, such as using a self-referred community sample with a comorbidity of disorders. The results and its application may be more suitable to clinical practice rather than that of a randomised control research sample.

Having highlighted the strengths of this research, it is important to remember that no study is without its limitations. The small sample size or the lack of a sufficient number of baseline period (e.g., three baseline points) limits the generalisability of the results.

Employing participants who self-select through media advertisements has its criticisms. As Gellatly et al. (2007) noted significantly higher effect sizes are generally reported compared to those from a clinical population. Individuals who self-refer may have higher motivation levels and different demographic characteristics to clients who are referred from a primary care setting (Coull & Morris, 2011). It is noted, however, that the IAPT initiative now encourages self-referrals to low intensity interventions as less sessions are required for successful outcome, thus reducing the cost and length of interventions needed (Clark, 2016; Freeston, 2016).

Overall there was a relatively high level of attrition in this study (37%), although this figure is similar to other low-intensity studies and traditional CBT research (Bilich, Deane, Phipps, Barisic, & Gould, 2008; Wierzbicki & Pekarik, 1993). It was pleasing to note there was considerably less attrition in the telephone condition (14%) compared to the face-to-face condition (42%). Previous studies also demonstrated lower levels of attrition in tele-psychotherapy than face-to-face interventions (e.g., Mohr, Vella, Hart, Heckman, & Simon, 2008; Palmer, 2002). A potential explanation for the lower attrition rates is that telephone use may reduce the barriers arising from transportation problems, lack of services in the area, childcare problems, lack of time, and social stigma (Parsonson & Stokes, 2012). Furthermore, by allowing participants to choose their mode of support may have increased the accessibility and acceptability of the intervention than if participants had been randomised to a particular support condition. This is likely to increase participants' engagement and adherence to the programme.

An additional limitation is that the researcher was also the facilitator of all of the face-to-face and telephone support sessions. This could lead to an unintentional bias towards a positive finding, thus future research should look towards employing an LI therapist that is independent of the researcher role.

The LI-CBI programme, however, is not part of a stepped care model of delivery, as in England for example. This meant that participants who did not improve with the LI intervention were unable to be "stepped up" if required, and is a serious limitation of the study. In order to effectively deliver LI-CBI, the New Zealand mental health system would need to be structured in a way that facilitates referral to higher intensity care if needed.

In summary, this study provides preliminary evidence of the effectiveness in the clinical significance of a guided self-help programme for a community sample of New Zealanders. This study is one of the first of its kind to be implemented within a New Zealand population, and the results are promising and indicate further research should be conducted in this area. Furthermore, this research supports the New Zealand Ministry of Health's (2012) initiative to implement a stepped care system within the primary mental health sector, and suggests that these new methods of mental health support are likely to be well received by New Zealanders.

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Conflicts of Interest

The authors declare no conflicts of interest.

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