Development of cognitive analytic therapy guided self-help for depression (CAT-GSH-D) in NHS Talking Therapies

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Abstract:
There is a lack of patient choice of intervention for those that attend at NHS Talking Therapies (TT) services with a presenting problem of depression. Previous work has seen the development and thorough evaluation of cognitive analytic therapy guided self-help for anxiety (CAT-GSH-A). This paper sets out development process for a sister version for depression called cognitive analytic therapy guided self-help for depression (CAT-GSH-D). The project employed the Medical Research Council (2008) guidelines for developing and evaluating complex interventions. The CAT-GSH-D workbook was developed through a matrix model that included a) identifying the evidence-base; b) identifying appropriate theory; and c) creating a model of the intervention. Three TT staff then rated the CAT-GSH-D workbook using the Scale for Evaluation of Self-Help Guidance for Anxiety Disorders and Depression and their feedback was incorporated into the final version. The CAT-GSH-D workbook has good fidelity to GSH principles and is theoretically grounded in the three-phase (reformulation, recognition and revision) CAT approach.

Keywords:
Cognitive analytic therapy; guided self-help; IAPT

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Introduction

The aim of the NHS Talking Therapies (TT) services (formerly known as The Improving Access to Psychological Therapies) for anxiety and depression is to improve the access to, and delivery of, evidence-based psychological therapies for people experiencing anxiety and depression. The TT programme uses a stepped-care approach with the aim of providing the least restrictive recommended psychological treatment first and then increasing treatment intensity appropriately (Bower and Gilbody, 2005) according to treatment response and risk. Within step-two of these services, low-intensity (LI) interventions for depression, typically underpinned by principles drawn from cognitive behavioural therapy (CBT; National Collaborating Centre for Mental Health, 2019) are recommended and are delivered by psychological wellbeing practitioners PWPs). LI-CBT is offered to people with mild-to-moderate depression (National Institute for Health and Care Excellence; NICE, 2022) as the intervention fits the remit of being brief and least restrictive.

LI-CBT is, to some extent, an effective and durable intervention for those experiencing mild-to-moderate depression in primary care services. LI-CBT is significantly more effective than control conditions (Santoft et al., 2019) with the clinical impact being maintained at least a year after ending (Cuijpers et al., 2010). However, these results found in research may not translate easily into TT services. According to the NHS England (2024) review of their Talking Therapies services, only 47.9% of patient entering LI treatment 'reliably recovered'. Furthermore, the same report showed that approximately 45% of people who began a LI intervention dropped out. As such, whilst CBT-informed LI interventions can be beneficial for some, there are still problems regarding lack of choice, effectiveness, durability, and attrition.

One of the ways suggested to improve outcomes in routine services is to improve better choice of treatments for patients (Windle et al., 2020). To improve the range of possible interventions at step 2 of TT services, Meadows and Kellett (2017) adapted cognitive analytic therapy (CAT) into a guided-self-help (GSH) format for anxiety. CAT-GSH for anxiety has six, 35-minuite, PWP-facilitated sessions which follow the three 'R' CAT approach (reformulation, recognition and revision) embedded in a patient workbook. Reciprocal roles are termed relationship roles in the workbook for ease of understanding and the sequential diagrammatic reformulation is termed the 'roadmap'. In the initial pilot (Meadows & Kellett, 2017) CAT-GSH was acceptable to patients and PWPs, was clinically effective and gains were maintained at follow-up. Wray et al., (2022) investigated treatment acceptability of CAT-GSH with PWPs and found increased treatment choice, collaborative therapeutic relationships, increased insight and the intervention enabling concrete change. Kellett et al., (2023) conducted a large (N=271) patient preference trial of CAT-GSH versus CBT-GSH. Whilst both formats were competently delivered and were clinically efficacious, CAT-GSH was chosen more often (72% v 28%) and CAT-GSH participants differentially attended more sessions and completed more full treatments. CAT-GSH produces both common and distinct change processes when compared to CBT-GSH (Headley et al., 2024).

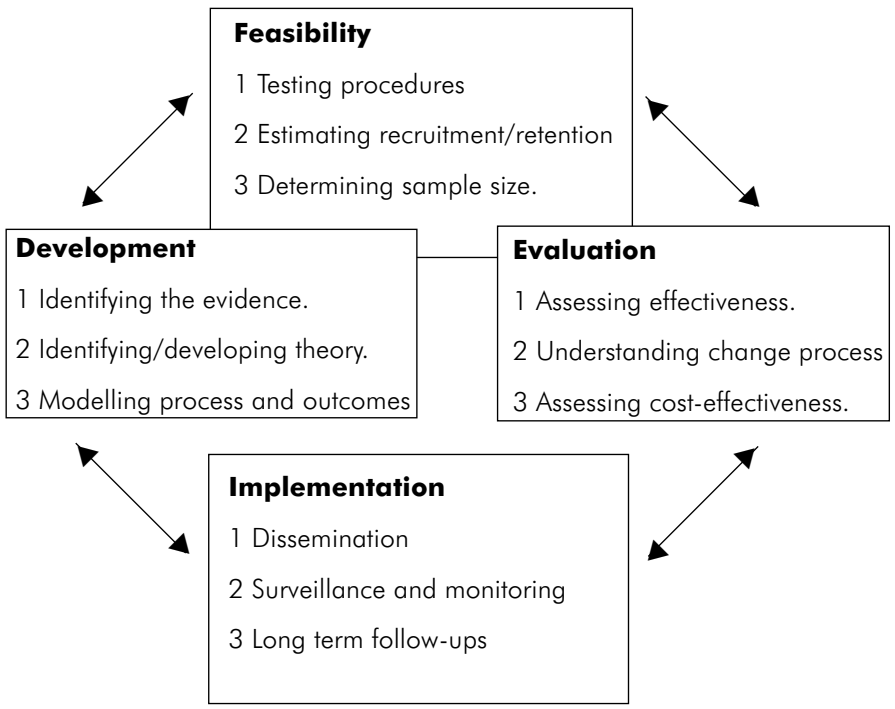
Therefore, whilst the development and evaluation of CAT-GSH for anxiety has been achieved, the development of CAT-GSH for depression has not occurred. Developing a sister CAT-GSH specifically for depression holds the potential for expanding patient choice at step 2 for people attending with depression. This is important because, accommodating patient preference regarding treatment is associated to lower drop-out rates and higher therapeutic alliance compared to patients who either did not get a choice or were allocated to their nonpreferable treatment (Windle et al., 2020).

Method

The Medical Research Council (MRC, 2008) guidelines for developing and evaluating complex interventions directed the process of cognitive analytic therapy guided self-help for depression (CAT-GSH-D) development. Figure 1 set out the four-stage process. This was the process has been previously used to develop both CAT-GSH for anxiety (Meadows & Kellett, 2017) and CBT-GSH (Lovell et al, 2008).

An adapted version of Lovell et al., (2008) and Hardeman et al., (2005) matrix modelling approach was used to develop CAT-GSH-D. This included a) identifying the evidence-base; b) identifying appropriate theory; and c) creating a model of the intervention. Identifying the

Figure 1 Key Elements of the Development and Evaluation Process



Note: Adapted from the Complex Intervention Guide (MRC, 2008)

evidence-base and appropriate theory was completed by defining depression, identifying key components of GSH, identifying key components of CAT, and identifying our target population and related needs. Table 1 outlines the aims, and the exploration methods used. An interview guide developed during the process of reviewing the literature, guided consultations.

Table 1: Methods Used to Develop CAT-GSH Workbook

Exploration Aim	Specific Methods Used
Define depression and its importance	Review qualitative and quantitative evidence which defines depression, people's experiences and its impact.
Identify key components of GSH	Review evidence about the key components of GSH.Hold consultation meeting with qualified and trainee CAT practitioners, alongside NHS Talking Therapies PWPs.
Identify key components of CAT	Review evidence regarding the key components of change within CAT.Consultation meeting with qualified and trainee CAT practitioners, alongside NHS Talking Therapies PWPs.
Identify target population	Review demographics of NHS Talking Therapies services and refer to evidence base.

Note: Adapted table from Lovell et al. (2008) and techniques from Hardeman et al. (2005).

The Matrix Model

Table 2 presents the populated matrix model.

The CAT-GSH-D workbook was adapted based on the feedback to produce a final version. Regarding transparency, an author section at the end of the manual was included. Furthermore, the written content and number of examples was reduced. Table 4 provides an overview of the manual session content and homework.

Development of the CAT-GSH-D workbook

The matrix therefore guided and underpinned the development of the psychoeducational GSH workbook that is the cornerstone of CAT-GSH-D. A trainee CAT practitioner, a PWP, and a team manager of an NHS Talking Therapies service reviewed the workbook. They provided qualitative feedback alongside rating the manual over five criteria using the *Scale for Evaluation of Self-Help Guidance for Anxiety Disorder and*

Table 2: Matrix Guiding the Development of CAT-GSH-D

	Experiences of depression	Barriers to receiving help	Core components of CAT
Systematic Reviews and Research	Depression experienced as emotional, physical, and interpersonal problems stemming from childhood experiences.(Haroz et al., Issakainen & Hanninen, 2014)	Common barriers include stigma, scepticism about treatment, misfitting treatment and unavailable service. Depression-specific barriers include poor motivation, or fearfulness.(Andrade et al., 2013; Mohr et al., 2010; Salaheddin and Mason, 2016)	Three core stages of CAT useful: reformulation, recognition, and revision. Patients valued reformulation tools and associated them to change. Idiosyncratic exits strategies useful.(Sandhu et al., 2017; Tyler and Masterson's, 2011; Westacott, 2010)
Consultation	Not explored	Potential narrative in society is 'just keep going', which could influence a person's opinion about seeking help.Resources within services are limited and patients can feel that pressure (long waiting lists, inconsistent appointments).	Recognition research is underdeveloped yet a useful aspect of CAT. Psychotherapy file may be inaccessible and difficult to translate into GSH. Reformulation letters are difficult to translate into GSH. Considered useful to some clients.
Other Resources	NICE guidelines outlining low mood, loss of interest, and impact on daily functioning.	No relevant findings	Development of 'self' through repeated life experiences. Develops RR and RRP with the aim of coping. Typically, core emotions related to patterns. Understanding procedures as snags, traps, dilemmas. Three stages: reformulation, recognition, and revision. (Ryle and Kerr, 2020)
Included in manual	Emphasis on social functioning and relational expectations alongside low mood and other culturally diverse symptoms. Use of lay language and relevant examples beneficial. Useful to also include in training.	Warm and validating opening to manual, with page dedicated to clear goal setting. It's importance to outline the predicted research effectiveness. Validating people's experience of difficulty accessing services.	Follow three core stages of CAT: reformulation, recognition, and revision. Include tools including target problems; traps, dilemmas, and snags; family tree; timeline; mapping; recognition homework tasks; developing and practice exits; identify new roles (strengths and resilience). Exclude letters and psychotherapy file.

	Client Experience of CAT	Mechanism for Change	CAT and depression
Systematic Reviews and Research	Mixed opinions. Some appreciated the journey, reformulation tools, and developing exits. But could experience difficult emotions. Positive experiences of CAT-GSH for anxiety.(Meadows and Kellett; 2017; Rayner et al., 2010; Tyler and Masterson's, 2011)	Suggested mechanisms of change include development of insight, recognition of processes, understanding proximal development.(Tyler and Mastersons, 2011)	CAT is transdiagnostic and little exploration specifically for Depression
Consultation	Mapping tools important for clients. Important to promote client language.	Recognition of both conscious and unconscious beliefs.	People with a core emotion linked to depression tend to have patterns relating to withdrawing and disconnecting socially. Common snags are dismissing own achievements. Transdiagnostic model with idiosyncratic aims.
Other Resources	No relevant findings	No relevant findings	No relevant findings
Included in manual	Promote own language using relatable examples. Included mapping of patterns and roles.	Promoting development of insight within core stages of CAT.	Input relatable examples for people who experience depression.
	Number of sessions of GSH	**Delivery experience**	**Client and PWPs GSH**
Systematic Reviews and Research	Eight and six sessions of CAT have promising results. Number of sessions not related to GSH outcome.(Gellatly, et al., 2007; Meadows and Kellett, 2017; Wakefield et al., 2021)	GSH have outcome improvements, even with a broad range of delivery (including semi-face-to-face, computer delivered, telephone delivery, internet/emails(Cuijpers et al, 2010; Gellatly et al., 2007)	GSH should include lay language; promote an appropriate and safe space; clearly outline expectations; acknowledge the stigma; individual is central to change. Positive experience of CAT-GSH for anxiety with patients engaged and motivated. CAT-GSH can invite discussion of past trauma during sessions which can

			be difficult for clients and PWPs. Past-present discussion, and therapeutic relations, help develop 'insight' in the client, and this promoted positive change (Khan et al., 2018; Meadows and Kellett; 2017)
Consultation	Typically, fortnightly, and 35-minute sessions in some NHS Talking Therapies services	Typically, face-to-face but could be via tel/video call depending on COVID related restrictions within Talking Therapies services	Not explored
Other Resources	Needs to be feasible for step two NHS Talking Therapies (NICE, 2009)	NHS Talking Therapies uses PWPs to provide their GSH.	No relevant findings
Included in manual	Six sessions	PWPs delivered sessions. Ideally face-to-face but can be delivered via video link depending on COVID restrictions/service user need.	Readability to be identified with consultations. Some of the information identified here standard part of PWPs training and can be discussed in supervision.
	Considerations for people with Learning Disabilities	**Consideration for working with people from different ethnicities**	
Systematic Reviews and Research	Helpful techniques include repeating information, checking in with person, using reasonable adjustments. Other suggestions include creating easy-read material, addressing service issues, changing the pace of therapy.(Dodd et al., 2011)		
Other Resources		Consideration about values and spirituality as part of intervention.(BABCP, 2019)	
Included in Manual	Some of the strategies can be included but it is outside the scope of this research to create an easy-read manual or change the time/ formatting of CAT-GSH.	Whilst not directly incorporated into manual, this is included in supervision and training to discuss application to all areas of person's life impacted by depression	

Table 3: Scores ranges on the Scale for Evaluation of Self-Help Guidance for Anxiety Disorders and Depression

	Scope	Evidence	Engagement	Implementation	Transparency
Range of scores	20, 24, 25	17*, 19, 23	23, 24, 25	18, 20, 18	2, omitted, 3

Note. * one question was omitted

Table 4 Within and between session CAT-GSH-D workbook content and link to the three-phase CAT approach

Session	In-session content	Between-session task
1	Reformulation – Identification of key depression pattern (i.e., a depression dilemma, snag, or depression trap).	Noticing the depression snag, trap or dilemma, complete a family tree, and complete a timeline.
2	Reformulation – identification of origins of depression from past. Introduction to key relational role.	Noticing key depression relational role.
3	Linking past to present. Recognition – writing a depression specific problem statement that makes links from past to present.	Noticing survival patterns developed as a child or adolescent.
4	Revision – creating roadmap and considering exits.	Recognising survival patterns and developing potential depression exits.
5	Revision – developing healthy identity. Identify personal strengths and resilience. New positive relationship role.	Identifying and practicing exits from depression roadmap and developing new positive relationship role.
6	Revision – acknowledging endings. Relapse prevention.	Continuing the work into the rest of life.

Depression (University College London, n.d.). This scale was appropriate because it builds upon practice guidelines (Baguley et al., 2010) and uses broad areas to evaluate GSH. The maximum score was 25 for scope, 25 for evidence, 25 for engagement, 20 for implementation, and 5 for transparency. There are no published psychometric norms for this scale. Table 3 outlines the range and mean rating for scope, evidence, engagement, implementation, and transparency criteria. Readability, clarity, and the compassionate approach of the manual was highly rated. However, reviewers were concerned about the manual's transparency and the large amount of content.

Discussion

This paper has outlined the development of CAT-GSH-D using the MRC treatment development guidelines. This has shown fidelity to that process and the responsivity to the feedback that was provided. This enabled the creation of a CAT-GSH-D patient workbook that was less cluttered, had examples that depression-specific and retained the three-phase transdiagnostic CAT approach. This is the second CAT-informed brief intervention which has been developed to use in NHS Talking Therapies services, alongside Meadows and Kellett's (2017) CAT-GSH for anxiety. The development of CAT-GSH-A and CAT-GSH-D demonstrates the versatility of CAT as an approach, the workbooks still retain the relational focus of CAT and their availability does expand choice in TT services.

However, this has project not been without dilemmas and compromises. Firstly, the MRC (2008) guidelines were used because they were available at the time of development. However, the guidelines have since been updated (Skivington et al., 2021) and other recommendations developed (O'Cathain et al. 2019). One difference between the 2008 guidelines and more recent editions is how the MRC recommendation (2008) places less emphasis on including stakeholders through the development stages. As Racine et al. (2022) demonstrates, including stakeholders (for example, professionals from NHS TT services alongside patient and public involvement; PPI) within in development stages provided key insights which contributed to the final intervention of the workbook. A decision was also taken by the development team to increase the social inclusivity of the CAT-GSH-D workbook through changing some of the images from the CAT-GSH-A workbook. As such, professionals from NHS TT services and CAT trainees were consulted to ensure treatment faithfulness to CAT and GSH and potentially mitigate risks from developing a novel intervention. However, more could have been done such as consulting PPI groups and stakeholders within developing the proposal of the intervention. It is recommended that in future developments of novel interventions stakeholders are involved.

CAT-GSH-D demonstrates the adaptability of CAT as a theoretical model which can be utilised across stepped-care TT services. There is evidence that CAT delivered at step 3 of TT services enabled a recovery rate of 46.4% at end of treatment that increased to 50% at follow-up (Owen et al. 2023). One example of how CAT concepts have been translated into a step-two GSH intervention is the use of reciprocal roles (RR; called relationship roles within the manual). According to Ryle and Kerr (2020), RR are internalised relationship positions that people develop from early life experiences, which can then be internally or externally enacted. Within CAT-GSH for depression, session two introduces RR and builds on the information about historic relationships that the patient and PWP have discussed in session one. The aim is for the patient and PWP to discuss in session and consider what key RR exist in the patients' current close relationships. This 'past-present' focus of CAT-GSH-D makes it distinct from CBT-GSH which works purely in the here and now. Again, differently from CBT-GSH, the CAT-GSH-D workbook also asks the PWP and patient to consider if and when the RR (and RR procedures) occur within the therapeutic relationship during GSH sessions (i.e., an 'enactment' has occurred). This is another example of how CAT's theoretical underpinnings can be incorporated into a step-two GSH intervention and demonstrates CATs versatility in supporting people with mental health difficulties.

However, there were some key dilemmas when developing CAT-GSH-D and translating key tools within CAT to GSH format. For example, the reformulation letter is a tool used within CAT which helps the patient and therapist achieve a preliminary joint understanding (Ryle & Kerr, 2020) and can contribute to improve insight and change to patients (Tyrer & Masterson, 2019). However, this aspect of CAT does not translate well into GSH, due to the increased need for supervision, time and resources. Meadows and Kellet (2017) found that the lack of a reformulation letter did not seem to significantly impact on outcomes within their pilot and both patients and PWPs felt a joint understanding was achieved regardless (Wray et al., 2022). There is deconstruction trial evidence with depression that narrative reformulation does not enhance the effectiveness of CAT (Kellett et al., 2018). Clearly, whilst not all CAT tools are fit-for-purpose in a GSH context, the most important aspect is the workbook being

theoretically grounded and also based upon the three-phase approach to enabling change.

There are several strengths and limitations of this current project. In terms of strengths, diligent steps were taken to ensure that CAT-GSH-D was faithful to both CAT and GSH theoretical underpinnings and also the evidence base for depression. As well as one of the lead researchers being a trained CAT psychotherapist, supervisor and trainer with prior experience of developing CAT-GSH-A, consultations with CAT and GSH experts were completed during and after workbook development. From this advice, alongside critically reviewing the evidence base, CAT-GSH-D was then designed and developed. In terms of limitations, more could have been done to involve experts by experiences and stakeholders. The Scale for Evaluation of Self-Help Guidance for Anxiety Disorders and Depression is currently psychometrically unvalidated and therefore its reliability and validity are open to question. Another limitation was not completing an initial clinical pilot of the CAT-GSH-D workbook. Meadows and Kellett (2017) piloted the CAT-GSH-A workbook with the patients seen by N=3 clinical psychologists with CAT experience.

Conclusion

CAT can be adapted to produce a 6-session GSH intervention for people experiencing mild-to-moderate symptoms of depression for delivery by PWPs in routine TT services. This conclusion was achieved by using the MRC (2008) guidelines for developing and evaluating complex interventions to create CAT-GSH-D, receiving appropriate corrective feedback and also making the workbook more inclusive. Informed decisions were made to continue to include and adapt key concepts of CAT to balance faithfulness of the CAT model with the needs and demands of NHS TT services. The CAT-GSH-D workbook was therefore shortened on this advice to enable better acceptability and usability. What does not differ between CAT-GSH-A and CAT-GSH-D is the *'past-present'* focus and the three-phase approach. CAT-GSH-D needs now to be tested for effectiveness and acceptability in a clinical pilot study. □

References

Andrade, L. H., Alonso, J., Mneimneh, Z., Wells, J. E., Al-Hamzawi, A., Borges, G., Bromat, E., Braffaerts, R., de Girolamo, G., de Graaf, R., Florescu, s., Gureke, O., Hinkov, H., Hu, C., Huang, Y., Hwang, I., Jin, R., Karam, E., Kovess-Masfety, V., Levinson Matschinger, H., O'Neill, S., Posada-Villa, J., Sugar, R., Sampson, N., Sasu, C., Stein, D., Takeshin,a. T., Viana, M., Xavier, M., & Kessler, R. C. (2013). Barriers to mental health treatment: Results from the WHO World Mental Health surveys. *Psychological Medicine*, 44(6), 1303-1317. https://doi.org/:10.1017/S0033291713001943

Bower, P., & Gilbody, S. (2005). Stepped care in psychological therapies: Access, effectiveness, and efficiency: Narrative literature review. *The British Journal of Psychiatry*, *186*(1), 11-17. doi:10.1192/bjp.186.1.11

British Association of Behavioural and Cognitive Psychotherapies. (2019). Improving Access to Psychological Therapies: Black, Asian, and minority ethnic services positive practice guide. https:// lewishamtalkingtherapies.nhs.uk/wp- content/uploads/2021/10/ IAPT-bame-ppg-2019.pdf

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(12), 1943-1957.

Dodd, K., Joyce, T., Nixon, J., Jennison, J., & Heneage, C. (2011). Improving access to psychological therapies (IAPT): Are they applicable to people with intellectual disabilities? *Advances in Mental Health and Intellectual Disabilities*. https://doi.org/ 10.5042/amhid.2011.0110

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? Meta-analysis and meta-regression. *Psychological Medicine*, 37(9), 1217-1228. doi:10.1017/S0033291707000062

Hardeman, W., Sutton, S., Griffin, S., Johnston, M., White, A., Wareham, N. J., & Kinmonth, A. L. (2005). A causal modelling approach to the development of theory-based behaviour change programmes for trial evaluation. *Health Education Research*, *20*(6), 676-687. https://doi.org/10.1093/her/cyh022

Haroz, E. E., Ritchey, M., Bass, J. K., Kohrt, B. A., Augustinavicius, J., Michalopoulos, L., & Bolton, P. (2017). How is depression experienced around the world? A systematic review of qualitative

literature. *Social Science & Medicine*, 183, 151-162. https://doi.org/10.1016/j.socscimed.2016.12.030

Headley, E. (2021). Low intensity guided self-help interventions: Understanding change. (Identification Number: uk.bl.ethos.852137). [Doctoral Thesis, University of Sheffield]. White Rose eTheses Online.

Issakainen, M., & Hänninen, V. (2016). Young people's narratives of depression. *Journal of Youth Studies*, 19(2), 237-250. https://doi.org/10.1080/13676261.2015.1059927

Kellett, S., Bee, C., Smithies, J., Aadahl, V., Simmonds Buckley, M., Power, N., Duggan-Williams, C., Fallon, N., & Delgadillo, J. (2023). Cognitive–behavioural versus cognitive–analytic guided self-help for mild-to-moderate anxiety: A pragmatic, randomised patient preference trial. *British Journal of Psychiatry*, 223(3), 438–445. https://doi.org/10.1192/bjp.2023.78

Khan, N., Bower, P., & Rogers, A. (2007). Guided self-help in primary care mental health: Meta-synthesis of qualitative studies of patient experience. *The British Journal of Psychiatry*, 191(3), 206-211. doi:10.1192/bjp.bp.106.032011

Lovell, K., Bower, P., Richards, D., Barkham, M., Sibbald, B., Roberts, C., Davies, L., Rogers, A., Gellatly, J. & Hennessy, S. (2008). Developing guided self-help for depression using the Medical Research Council complex interventions framework: A description of the modelling phase and results of an exploratory randomised controlled trial. *BMC Psychiatry*, *8*(1), 1-19. https://doi.org/10.1186/1471-244X-8-91

Meadows, J., & Kellett, S. (2017). Development and evaluation of Cognitive Analytic Guided Self-Help (CAT-SH) for use in IAPT services. *Behavioural and Cognitive Psychotherapy, 45(3), 266-284*. doi:10.1017/S1352465816000485

Medical Research Council. (2008). Developing and evaluating complex interventions. *BMJ*. https://mrc.ukri.org/documents/pdf/complex-interventions-guidance/

Mohr, D. C., Ho, J., Duffecy, J., Baron, K. G., Lehman, K. A., Jin, L., & Reifler, D. (2010). Perceived barriers to psychological treatments and their relationship to depression. *Journal of Clinical Psychology*, 66(4), 394-409. https://doi.org/10.1002/jclp.20659

National Collaborating Centre for Mental Health. (2019) The improving access to psychological therapies manual. *National Collaborating Centre for MentalHealth.* https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/NHS Talking Therapies/the-NHS Talking Therapies-manual—final--republished-7-3-18.pdf?sfvrsn=a192d1af_0

National Institute for Health and Care Excellence. (2021). Depression: How common is it? [Clinical Knowledge Summaries]. https://cks.nice.org.uk/topics/depression/background-information/prevalence/

National Institute for Health and Care Excellence. (2021). Depression: How do I diagnose depression? [Clinical Knowledge Summaries]. https://cks.nice.org.uk/topics/depression/diagnosis/diagnosis/

NHS England. (2024, January). NHS Talking Therapies, for anxiety and depression, annual reports, 2022-23. *NHS England.* https://digital.nhs.uk/data-and-information/publications/statistical/nhs-talking-therapies-for-anxiety-and-depression-annual-reports/2022-23#chapter-index

O'Cathain, A., Croot, L., Duncan, E., Rousseau, N., Sworn, K., Turner, K. M., & Hoddinott, P. (2019). Guidance on how to develop complex interventions to improve health and healthcare. *BMJ Open*, 9(8), e029954.

Owen K, Laphan A, Gee B, Lince K. Evaluating cognitive analytic therapy within a primary care psychological therapy service. *British Journal of Clinical Psychology*. 2023 Sep;62(3):663-673. doi:10.1111/bjc.12430.

Racine, E., O Mahony, L., Riordan, F., Flynn, G., Kearney, P. M., & McHugh, S. M. (2023). What and how do different stakeholders contribute to intervention development? A mixed methods study. *HRB Open Research*, 5, 35. https://doi.org/10.12688/hrbopenres.13544.2

Rayner, K., Thompson, A. R., & Walsh, S. (2011). Clients' experience of the process of change in cognitive analytic therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 84(3), 299-313. https://doi.org/10.1348/147608310X531164

Ryle, A., & Kerr, I. B. (2020). Introducing cognitive analytic therapy: Principles and practice of a relational approach to mental health (2nd ed.). John Wiley & Sons.

Salaheddin, K., & Mason, B. (2016). Identifying barriers to mental health help-seeking among young adults in the UK: A cross-sectional survey. *British Journal of General Practice*, 66(651), e686-e692. https://doi.org/10.3399/bjgp16X687313

Sandhu, S. K., Kellett, S., & Hardy, G. (2017). The development of a change model of 'exits' during cognitive analytic therapy for the treatment of depression. *Clinical Psychology & Psychotherapy*, 24(6), 1263-1272. https://doi.org/10.1002/cpp.2090

Santoft, F., Axelsson, E., Öst, L., Hedman-Lagerlöf, M., Fust, J., & Hedman-Lagerlöf, E. (2019). Cognitive behaviour therapy for depression in primary care: Systematic review and meta-analysis. *Psychological Medicine, 49(8), 1266-1274.* doi:10.1017/S0033291718004208

Shine, L., & Westacott, M. (2010). Reformulation in cognitive analytic therapy: Effects on the working alliance and the client's perspective on change. *Psychology and Psychotherapy: Theory, Research and Practice*, 83(2), 161-177. https://doi.org/10.1348/147608309X471334

Skivington, K., Matthews, L., Simpson, S. A., Craig, P., Baird, J., Blazeby, J. M., Boyd, K., Craig, N., French, D. P., McIntosh, E., Petticrew, M., Rycroft Malone, J., White, M., & Moore, L. (2021). A new framework for developing and evaluating complex interventions: Update of Medical Research Council guidance. *BMJ*, n2061. https://doi.org/10.1136/bmj.n2061

Tyrer, R., & Masterson, C. (2019). Clients' experience of change: An exploration of the influence of reformulation tools in cognitive analytic therapy. *Clinical psychology & Psychotherapy*, 26(2), 167-174. https://doi.org/10.1002/cpp.2339

University College London. (n.d.). *Scale for evaluation of self-help guidance for anxiety disorders and depression.* https://www.ucl.ac.uk/pals/sites/pals/files/7_guide_to_evaluating_self-help_materials.pdf

Wakefield, S., Delgadillo, J., Kellett, S., White, S., & Hepple, J. (2021). The effectiveness of brief cognitive analytic therapy for anxiety and depression: A quasi experimental case-control study. *British Journal of Clinical Psychology*, *60*(2), *194-211.* https://doi.org/10.1111/bjc.12278

Windle, E., Tee, H., Sabitova, A., Jovanovi, N., Priebe, S., & Carr, C. (2020). Association of patient treatment preference with dropout and clinical outcomes in adult psychosocial mental health interventions. *JAMA Psychiatry*, 77(3), 294. https://doi.org/10.1001/jamapsychiatry.2019.3750

Wray, A., Kellett, S., Bee, C., Smithies, J., Aadahl, V., Simmonds-Buckley, M., & McElhatton, C. (2022). The acceptability of cognitive analytic guided self-help in an Improving Access to Psychological Therapies service. *Behavioural and Cognitive Psychotherapy*, *50*(5), 493–507. https://doi.org/10.1017/S1352465822000194