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RESEARCH ARTICLE

Types and mechanisms of idiographic change during guided self-help for anxiety

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Abstract

Objectives: To compare idiographic change during two formats of guided self-help (GSH); cognitive-behavioural therapy guided self-help (CBT-GSH) and cognitive analytic therapy guided self-help (CAT-GSH).

Design: Qualitative inductive thematic analysis.

Methods: Semi-structured interviews with *N* = 17 participants with a reliable change outcome on the GAD-7 after completing GSH for anxiety. Changes were categorised and themes extracted.

Results: No differences between CAT-GSH and CBT-GSH were found regarding types of change reported. The five overarching themes found were *personal qualities of success, enlightenment through understanding, specific tools and techniques, changes to relationships and tailoring support*. Four themes maximally differentiated between the two different types of GSH; CAT-GSH enabled relational insight and change whilst CBT-GSH enabled better understanding of anxiety, new coping techniques and supportive relationships.

Conclusions: Both common and model-specific factors contribute to patient change during GSH. Whilst all forms of GSH are grounded in the psychoeducational approach, separate theoretical foundations and associated methods facilitate different types of ideographic change.

KEYWORDS

change mechanisms, cognitive analytic therapy, cognitive-behavioural therapy, guided self-help, qualitative

INTRODUCTION

Low-intensity (LI) therapies have been developed to respond to the growing need for efficient and effective interventions to meet increasing clinical demand (Shafran et al., 2021). LI interventions are followed by more intensive interventions when there is lack of responsivity (Bower & Gilbody, 2005). This 'stepped-care' approach is advocated by the National Institute for Health and Clinical Excellence (NICE) for the treatment of depression and anxiety disorders (NICE, 2009, 2011). The Improving Access to Psychological Therapies (IAPT) programme was commissioned to deliver these NICE guidelines and so scaled-up and systematised stepped-care principles to a national level in England, and particularly created and recruited a new workforce (i.e., psychological wellbeing practitioners [PWPs]) to deliver LI interventions. The IAPT programme has recently been renamed as *NHS Talking Therapies for Depression and Anxiety*.

Guided self-help (GSH) is a practitioner-supported, brief and psychoeducational type of LI treatment that is typically based on CBT principles and can be delivered over the phone, over the internet, in groups or in a one-to-one format (Wakefield et al., 2021). The self-help is guided by a practitioner, due to the evidence that GSH outperforms pure self-help (Gellatly et al., 2007). The durability of change enabled by GSH has been shown to be questionable (Ali et al., 2017), as has the poor acceptability of the approach for some (Chan & Adams, 2014). Service guidelines strongly advocate offering a choice of intervention to patients in order to increase acceptability, and potential effectiveness and durability (CSIP, 2008). In response, Meadows and Kellett (2017) developed a manualized GSH version of cognitive analytic therapy (CAT). The evidence base for CAT-GSH shows that the intervention is adherent to GSH philosophy, creates low dropout rates, is clinically effective and durable (Meadows & Kellett, 2017), is an acceptable intervention for practitioners to deliver (Wray et al., 2022) and is equally efficacious to CBT-GSH (Kellett et al., 2023).

Researchers have been trying to unpick the change process during psychotherapy for many years and numerous models have been developed and tested (Altman et al., 2020). However, such research has tended to be on traditional psychotherapy approaches. There is therefore only a small evidence base concerning the change processes within LI therapies, despite the ubiquity of the use of these brief interventions in services across the globe (Delgadillo, 2018). Macdonald et al. (2007) identified gaps between patients' pre-treatment expectations and their actual experiences of GSH (e.g., being surprised about the amount of effort required in completing the homework set by the practitioner). Lillevoll et al. (2013) identified three dimensions contributing to positive change during GSH; active patient engagement, therapist guidance and sound psychoeducational content. Examining participants' experiences of internet-delivered GSH for depression (Bendelin et al., 2011) found similar evidence of the motivational experience of LI treatment, how the patient interacts with the psychoeducational materials, attitudes towards the approach and the skills/knowledge attained through the intervention.

Whilst routine outcome monitoring is valuable in assessing effectiveness of the interventions delivered in routine services, these measures are, by definition, exclusively nomothetic (Lloyd et al., 2019). People attend for help due to their recognition that there is a need to change and translating this motivation into idiographic goal attainment is a valid and complimentary evaluation of the effectiveness of an intervention (Lloyd et al., 2019). The current project took a nomothetic and ideographic approach towards understanding how two differing versions of GSH created change. The project used nomothetic outcome measures to identify effective GSH interventions and then used qualitative methods to explore idiographic change processes during two different types of GSH (i.e., CBT-GSH versus CAT-GSH). This study therefore had following questions: (1) what are the similarities and differences in the types of idiographic change experienced during effective CBT-GSH and CAT-GSH and (2) are the mechanisms of change different during effective CBT-GSH and CAT-GSH?

METHOD

Ethics and design

Ethical approval was obtained (IRAS: 240751). The qualitative study was nested within a partially randomised patient preference trial (PRPPT) examining the efficacy and clinical durability of two differing types of manualized GSH (CAT-GSH versus CBT-GSH) for anxiety disorders delivered at step 2 of an IAPT service (see Kellett et al., 2023 for full descriptions). The trial was registered (NCT: 03730532) and study protocol published (Kellett, Bee, et al., 2021; Kellett, Simmonds-Buckley, et al., 2021). In a PRPPT, the outcomes from two (or more) interventions are compared, whereby participants are given the choice between the interventions (and then receive their preference), and when participants do not have a strong preference then they are allocated to an intervention by traditional randomisation (Kowalski & Mrdjenovich, 2013). During the Kellett, Bee, et al. (2021); Kellett, Simmonds-Buckley, et al. (2021) trial, patient preference was supported by psychoeducation being provided at research screening interviews concerning the approach and style of each GSH intervention, so that participants could make an informed choice of GSH. A total of $n = 271$ eligible participants were recruited; 19 (7%) were allocated to treatment via randomisation. In the preference cohort, 181 (72%) preferred and received CAT-GSH and 71 (28%) preferred and received CBT-GSH. All participants provided consent for participation. Qualitative and quantitative data were collected concurrently, and the study used a concurrent nested design where qualitative data was prioritised and quantitative data strengthened findings from the thematic analysis. A critical realist position was adopted, assuming that whilst data are reflective of reality, it does require interpretation to identify and highlight the underlying structures (Willig, 2013).

Treatments

GSH interventions were delivered by qualified PWPs under clinical supervision. CAT-GSH followed a structured 6–8 session treatment protocol supported by a detailed client workbook (Meadows & Kellett, 2017). The six sessions are (1) 'identifying the current patterns of my anxiety' (2) 'identifying the roots of my anxiety' (3) 'linking my past to my present' (4) 'making a roadmap of my problems and to making exits' (5) developing a new, healthy and more flexible me' and (6) endings and preparing for the future. CBT-GSH followed the treatment as usual IAPT structured 6–8 session anxiety treatment protocol and associated client workbooks for anxiety (Richards & Whyte, 2011). CBT-GSH helps the client to identify and change unhelpful thought patterns about the self, others and the world around them; increase positive activity and teaches techniques and skills to cope with anxiety. Kellett, Bee, et al. (2021); Kellett, Simmonds-Buckley, et al. (2021) reported that CBT-GSH and CAT-GSH differed in the following ways: (a) CBT-GSH works primarily with the here-and-now, (b) CAT-GSH works with the past and the here-and-now, (c) CBT-GSH does not make active use of the therapeutic relationship, (d) CAT-GSH does work within the therapeutic relationship, (e) CAT-GSH is based on a dialogical and relational theoretical model, (f) CBT-SH is based on a cognitive-behavioural theoretical model. During the trial, the validated six-item LI treatment competency scale (LITC) was used to assess GSH treatment competency, where a score of ≥18 defines competent GSH (Kellett, Simmonds-Buckley, et al., 2021). One randomly selected session was audio-recorded per participant. Sessions were first rated by a rated by a trained independent rater and then by two teams of expert PWP raters, with three PWPs in each team. Interrater reliability ranged between 0.85–0.99. The LITC score was 19.34 (SD 2.85) for CAT-GSH and 19.94 (SD 2.92) for CBT-GSH. The competency scores did not differ between the types of GSH ($t(92) = 1.20$, $p = .584$).

Recruitment into qualitative study and procedure

A purposive sample of participants drawn from the PRPPT was recruited. At 8-week follow-up, participants achieving 'reliable change' (i.e., a reduction of 4 points or more) on the pre-post GAD-7 score via the established IAPT criteria (National Collaborating Centre for Mental Health, 2021) were invited to an additional interview. Whilst thematic saturation can be reached after 6–12 interviews when using thematic analysis to develop meaningful themes from a homogenous sample (Guest et al., 2006), due to the presence of two treatment groups in the trial, a larger sample was sought. The final sample consisted of $N = 17$ participants (i.e., $n = 10$ CAT-GSH and $n = 7$ CBT-GSH) and Table 1 contains their demographic information. Number of sessions attended ranged from 4 to 8, with an average of 5.76 sessions attended by thirteen women and four men, the majority ($n = 15$) being white British.

Measures

Generalised Anxiety Disorder Scale (GAD-7; Spitzer et al., 2006); a 7-item, self-report anxiety scale used widely across mental health services that assesses anxiety symptoms. Items are rated from 0 (not at all) to 3 (nearly all the time). GAD-7 scores of 5, 10 and 15 represent cut-off for mild, moderate and severe anxiety and scores need to drop by 4 or more for change to be reliable. Change scores were calculated using GAD-7 screening versus last treatment session scores. The GAD-7 has high internal consistency (Cronbach's $\alpha = 0.92$), high test–retest reliability ($r = 0.83$), and good convergent validity against the Beck Anxiety Inventory ($r = 0.72$; Spitzer et al., 2006).

Client Change Interview (Elliott, 2011); an approximately 60-minute semi-structured interview that investigates what patients have found helpful about their psychotherapy (Hjeltnes et al., 2016; McElvaney & Timulak, 2013) and so was adapted to make it fit-for-purpose for the GSH context. Questions focused on the changes that participants had observed during GSH, what was helpful or unhelpful and what they believed had caused the changes. Numerical ratings (1–5) were made

TABLE 1 Participant demographic information.

ID	Gender	Age	Ethnicity	Type of GSH	GAD-7 change score	Preference/ randomised
1	Female	68	White – British	CBT-GSH	16	Randomised
2	Female	39	White – British	CAT-GSH	9	Randomised
3	Female	53	White – British	CAT-GSH	8	Randomised
4	Male	33	White – British	CAT-GSH	11	Randomised
5	Male	51	White – British	CBT-GSH	9	Randomised
6	Female	19	White – British	CAT-GSH	7	Randomised
7	Female	51	White – British	CAT-GSH	12	Randomised
8	Female	19	White – British	CAT-GSH	9	Randomised
9	Female	33	White – British	CBT-GSH	5	Randomised
10	Female	19	Pakistani	CBT-GSH	14	Randomised
11	Male	27	Not Stated	CBT-GSH	16	Randomised
12	Male	35	White- British	CAT-GSH	9	Randomised
13	Female	41	White – British	CAT-GSH	9	Randomised
14	Female	56	White – British	CAT-GSH	12	Randomised
15	Female	54	White – British	CBT-GSH	14	Randomised
16	Female	53	White – British	CAT-GSH	19	Randomised
17	Female	35	White – British	CBT-GSH	9	Randomised

of how important changes were, how likely it was that these changes would have occurred without the GSH and how expected changes were. The Change Interview does not assume that the change described is caused by the intervention and therefore excludes changes unrelated to the intervention (Elliott, 2008).

Analyses

Data analysis took part in two stages: first, the analysis of change ratings and secondly, qualitative analysis using inductive thematic analysis (Boyatzis, 1998). Figure 1 summarises the analytic stages. During stage one, participant reported changes that had occurred during their GSH were rated based on how important each change was, how likely it was that the change would have occurred without the GSH and how much the change was expected. This enabled a number count of the type of changes created by the GSH to be created and ratings to be an index of the personal impact. Appendix S1 report the full

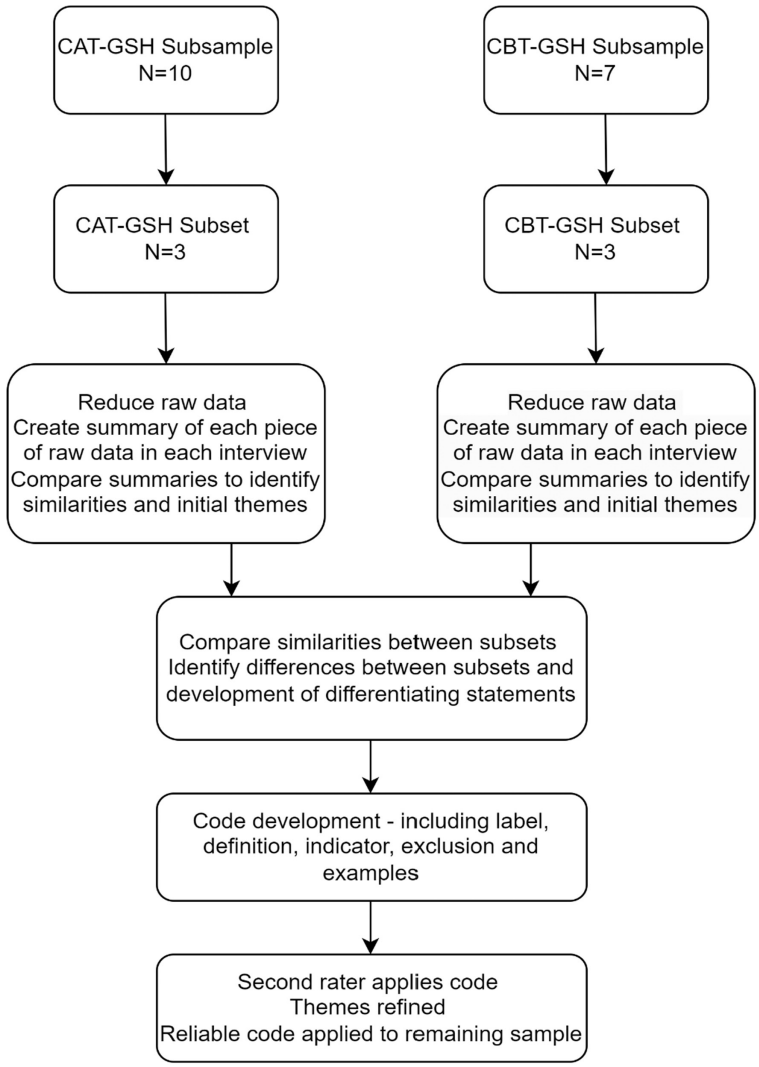

FIGURE 1 Summary of the analytic process.

change dataset split by type of GSH. Changes were categorised into cognitive, behavioural, emotional, or relational change by two raters and there was a high level of coding agreement ($k = .942$, $p < .001$). Associations between type of GSH and changes reported were analysed using chi-square and where assumptions were violated (i.e., more than 20% of expected cells <5 for analyses >2 × 2) the Likelihood Ratio statistic was reported. Comparisons of change rating scores between CAT-GSH and CBT-GSH were analysed using Mann-Whitney U tests. During stage two, $n = 17$ interviews were digitally recorded, transcribed verbatim and analysed.

The nine-stage process of inductive thematic analysis (Boyatzis, 1998) that was used enabled themes to be identified that differentiated between the two treatment groups. The first author (EH) immersed themselves in the data, reading and listening to interviews several times. The overall sample was split by treatment group and outline summaries were developed for a subset of data (three transcripts for each group) in each subsample. Similarities within each subset were identified and initial themes developed. Themes were compared to identify similarities between the two subsets and where differences were present, a set of differentiating statements were developed. To enhance reliability, a second researcher (CB), applied the code to 30% of raw data (Boyatzis, 1998) and codes were refined or dropped when agreement was poor. Interrater agreement was calculated from six transcripts and there was high levels of agreement ($k = .87$; $p < .001$).

Knowing that the researcher acts as an active agent in the production of knowledge makes reflexivity an integral component within each stage of the qualitative research process (Trainor & Bundon, 2020). The lead researcher (EH) therefore kept a reflexive journal throughout the research process and had regular supervision to increase awareness to the potential influence of preconceived beliefs during the analysis process, notably, the lead researchers' alignment to analytic therapy models in their own clinical practice. Interpretations were regularly discussed with research colleagues to ensure transparency (a reflexive statement can be found in Appendix S2). To enhance rigour of the analytic process, an additional step was added to the nine-step method outlined by Boyatzis (1998).

RESULTS

Stage one

Across the entire sample, 73 idiographic changes were reported and Table 2 summarises these changes. There was no association between GSH version and type of change (X^2 (3, $n = 73$) = .94, $p = .816$), but those receiving CAT-GSH were more likely to be surprised by the changes achieved during the intervention ($U = 379.50$, $z = -2.88$, $p < .001$).

Stage two

Five overarching themes were found, with four themes maximally differentiating between the two differing versions of GSH. Table 3 outlines these themes and subthemes. Four subthemes maximally

TABLE 2 Changes identified during each type of GSH.

Type of idiographic change	CBT-GSH	CAT-GSH
Behavioural	13	13
Emotional	3	5
Relational	5	8
Cognitive	10	16
Total	31	42

TABLE 3 Themes and subthemes with differentiating statements.

	Themes and subthemes	Differentiating statements
1	**Personal qualities of success**	
1a	The therapist as a relatable guide	
1b	The client as an active agent of change	
2	**Enlightenment through understanding**	Understanding why vs understanding what
3	**Specific tools and techniques**	Looking inwards to move forwards vs. using techniques
4	**Relationships**	
4a		Relational change and insight vs relational support
4b		Transformation of the self-self-relationship
5	**Tailoring support**	

differentiated between the mechanisms of change experienced during CAT-GSH ($n = 10$) versus CBT-GSH ($n = 7$). The association between differentiating themes and intervention type was significant for relational change/insight vs support (X^2 (1, $n = 49$) = 23.07, $p < .001$); understanding why vs what (X^2 (1, $n = 28$) = 28, $p = <.001$) and looking inwards to move forwards vs using applying techniques (X^2 (1, $n = 75$) = 26.13, $p = <.001$). Table 4 contains a summary of the number of key differentiating statements between the two types of GSH.

THEME ONE: PERSONAL QUALITIES FOR SUCCESS

This theme captured how the personal qualities of both the PWP and the patient contributed to change throughout the GSH intervention. The conscious effort made by the patient to change and a range of personal skills and qualities from both the patient and the PWP were seen to contribute to success.

The practitioner as a relatable guide

Personal qualities of the PWP, such as being warm, reassuring and empathic were said to be crucial in facilitating a safe place to explore difficult experiences during GSH. Many felt that the personal connection and similarities they shared with their PWP, helped to create an environment for positive change

> *P10:* I thought what was helpful was the fact that my therapist was from an ethnic minority, so that in itself i think was helpful because it was like, she comes from a background where she understands family circumstances and other family relationships that are harder for us to manage given that our family dynamics are a bit different.

> *P8:* because my therapist in this instance was younger, I felt less like I was being patronised. rather than talking to a therapist it felt like i was talking to a friend.

The PWP was referred to as a guide with authority and knowledge to help patients' move towards recovery and someone who was critical for change.

> *P16:* I couldn't quite connect the dots until I was speaking to the therapist and doing the exercises.

TABLE 4 Summary of subthemes differentiating CAT-GSH completers from CBT-GSH completers.

		All participants ($n=17$)		CAT-GSH ($n=10$)		CBT-GSH ($n=7$)	
Subtheme	**Differentiating statements**	**No. of statements**	**% pts**	**No. of statements**	**% pts**	**No. of statements**	**% pts**
2	Understanding why vs. understanding what						
	Understanding why	16	47	16	80	0	0
	Understanding what	12	29	0	0	12	71
3	Looking inwards to move forwards vs. using new techniques						
	Looking inward to move forwards	35	70	33	100	2	29
	Using new techniques	40	94	15	90	25	100
4a	Relational insight and change vs. supportive relationships						
	Relational insight and change	35	65	30	80	5	42
	Supportive relationships	14	35	2	10	12	71
4b	Transformation of self-self relationship	16	41	16	70	0	0

The patient as an active agent of change

Participants in both types of GSH talked about their personal efforts to recover. Participants worked hard to make the GSH successful, even when this had an emotional cost. Participants showed dedication in putting skills into practice, working on their progress in between sessions and after therapy had ended.

> *P9:* I've set a reminder in my phone to remind me to sit down on my own in a quiet space with the material and go over the things.

> *P15:* I did read the modules which I've kept the link to, so if anything happens in the future I can go through the ABCs.

Participants were given the opportunity to put skills learnt in the sessions into practice through implementing new coping methods into real-life situations. Participants spoke about the need to implement the skills in real life learnt during GSH sessions and some felt that the increased stress of doing this acted as a test that demonstrated how effective the intervention had been in real life.

> *P16:* … the whole of society changed during that time and people's situations and that in itself helped me sit and evaluate certain things but definitely both of them coming together helped.

Several of the participants spoke of the emotional burden of engaging in the GSH, and this was spoken about as being essential and something they were willing to go through in order to overcome anxiety and enable personal change.

> *P6:* The first three weeks were very hard. You know, having to go back over a lot of stuff that you've been through, it wasn't necessarily the nicest of times to have to talk about it again, but it had to be talked about. I recognise that it was something that had to be done….

In addition to a willingness to experience the emotional burden of change, many participants reported needing to overcome preconceived beliefs and uncertainty about GSH.

> *P8:* When you think of counselling you think of cold, someone sat there with a clipboard and they're judging you.

Despite their apprehension, participants showed a commitment to persevere, a willingness to stay open-minded and give the GSH a chance. This personal quality of being open-minded and committed meant that, in all cases, the GSH they received surpassed their expectations.

> *P15:* I was a bit apprehensive because, you know, you don't want to root out something in a dark corner that you've hidden away or something… but it was totally different than what I thought it was going to be, a much better experience.

THEME TWO: ENLIGHTENMENT THROUGH UNDERSTANDING

Both CBT-GSH and CAT-GSH participants reported that developing a better understanding of their anxiety contributed to their recovery. The key difference between the two versions of GSH was understanding 'why' during CAT-GSH versus understanding 'what' during CBT-GSH. The CBT-GSH

participants spoke about the importance of better understanding what anxiety was, through the psychoeducational content.

> *P15:* I learnt some things that I was doing were completely typical of people with anxiety disorder and it made me feel less of a one off or less alone, I just had classic symptoms….

CAT-GSH participants spoke about understanding anxiety in a different way, as they reported learning about the origins of their anxiety from specific past events, experiences, or relationships. They reported therefore being able to understand why they experienced anxiety in the first place, in addition to also learning more about what anxiety was through the psychoeducation.

> *P3:* t was helpful, definitely, just knowing where this anxiety was stemming from and being able to pick different things out made it easier to know that it wasn't just happening without a reason….

THEME THREE: SPECIFIC TOOLS AND TECHNIQUES

Participants described how they were able to overcome anxiety. The key difference between the approaches seemed to be looking inward to move forwards during CAT-GSH versus learning and using new techniques during CBT-GSH. CBT-GSH participants spoke about learning specific and active techniques to manage anxieties, and these included writing down anxieties, grounding, breathing or thought challenging.

> *P10:* One was literally writing down what is it that's actually making me anxious and basically breaking it down into the options that it could have been, or the options that did happen but then breaking those down into, say, how bad it could have been and kind of rating it.

CAT-GSH participants also discussed techniques, however these were secondary to an initial more internal process of recognition and looking for the origins of anxieties, before then engaging in coping skills.

> *P16:* If I hadn't gone for low intense therapy I don't think I would have looked at my own analysis and how I process bad situations… I just think 'I can't cope'… that would be the first thing I would have said instead of stopping and thinking, you will cope with this, you have coped with this and what can I do about it?

THEME FOUR: RELATIONSHIPS

"Relational insight and relational change vs. relational support"

The key difference between the approaches was the relational insight and relational change facilitated by CAT-GSH, versus the relational support of CBT-GSH. Both groups reflected on relationships, but CAT-GSH participants spoke of gaining insight into their relationships and also how relationships contributed to the maintenance of their problems. CAT-GSH participants reported developing a better understanding of relational dynamics. In addition to this insight, CAT-GSH participants spoke more often about the changes that had occurred within their relationships due to the GSH.

> *P12:* So now I understand the way she thinks or reacts to stuff I'm saying to her and what's coming back at me. A better understanding of that and I can deal with it appropriately, which hopefully makes her a bit happier without realizing it.

> *P14:* …with the therapy I was beginning to see that there's a relationship to how I've been brought up and the way you're taught things and how it carries as an adult…I was beginning to pick up on things that weren't quite right in the relationship with my mum….

Relationships were still mentioned by CBT-GSH participants, but the focus here was on how their relationships had helped alongside the therapy in being supportive or in facilitating change.

> *P1:* …he'd get ready and come with me, he didn't want me to go out walking alone so, he was very very much part of the recovery….

Transformation of the relationship with self

Several of the CAT-GSH participants discussed changes that had taken place in relation to perceptions of themself, for example, changes to their identity. This was often associated with the re-processing of past experiences, or the re-framing of previous adversity into current personal growth. This subtheme was not present in the CBT-GSH sample.

> *P15:* By talking to somebody else about it I realized that yes, it's a horrible thing that happened to me but it wasn't my fault and the fact that I've been able to be strong enough to just pick myself up and carry on after, you know, is amazing. So rather than thinking 'oh my god why me?' I was thinking 'jeez, I managed to carry on'.

THEME FIVE: TAILORING SUPPORT

Being offered the 'correct' level of scaffolding, including the number of sessions, level of guidance or having future access to support helped participants to feel better able to change. Where this balance was not quite right, some participants experienced aspects of the intervention more negatively, for example, some felt that they needed more support from the PWP.

> *P14:* I was questioning myself, am I doing this right?… I did get there but sometimes there were a few times where I was unsure if I was doing it correctly… I just needed that little bit more guidance.

Most participants expressed that they would have preferred more sessions, but acknowledged that they had had 'enough' GSH to make a difference.

> *P5:* if it's effective in a short period of time it doesn't need to be longer.

Some felt that more flexibility in how they received the GSH could have been helpful

> *P6:* I feel like being able to spread your sessions out a little bit as well, I think when I was doing it there was that pressure of trying to do it every week, kind of thing, but still being able to have the opportunity to take a week or two break if you need to because you've got other stuff going on.

For many, the knowledge that they could access further support in the future was helpful, as this made them feel less alone at the end of the GSH, and seemed to provide a sense that they were still being 'held' by the service.

> *P14:* she did say "if ever you get bad again, you can just ring up and we'll see you again", so that helps the fact that if things start going wrong I can go back. You know, that's there if I need it.

DISCUSSION

This study explored what idiographic changes are made during two differing formats of GSH, when a nomothetic outcome measure (i.e., GAD-7) suggested an effective intervention had occurred. The study used the rigorous qualitative methodology and allowed for a structured analysis with a validated code book in patients that had met diagnostic criteria for the presence of an anxiety disorder, due to their participation in a research trial, and who were competently treated. Inductive analysis yielded five overarching themes and four subthemes and four of the themes maximally differentiated between the change process of two GSH interventions. There were differences in the mechanisms of change facilitated by the differing GSH interventions, but clearly also change processes that were common to both. In line with Wampold's (2015) contextual model, change was brought about through factors common to both interventions including positive therapeutic relationships, the development of an explanation of anxiety and positive behavioural change in the form of new techniques. The results do not suggest that either version of GSH was superior to the other, but highlights that the differing clinical methods facilitated change in different ways. Because patients attend for help with problems that are personal them, they generally have positive attitudes to idiographic measurement and any associated analyses of change (Frumkin et al., 2021).

There was a differentiating theme between the two versions of GSH of "understanding why vs understanding what." The 'why' is best summarised as insight during CAT-GSH and the 'what' as impact of anxiety psychoeducation during CBT-GSH. Recipients of CAT-GSH found the exploratory process key to creating idiographic change. Increased insight regarding the origins and maintainers of problems during CAT has been previously reported (Balmain et al., 2021) and this mirrors the experience of receiving other analytically based therapies (Nilsson et al., 2007). No less important was the impact of psychoeducation when receiving CBT-GSH. This is line with cognitive-behavioural tradition where insight relates to understanding the role cognitions play in distress and also the manner in which thoughts, feelings and behaviours interact (Timulak & McElvaney, 2013). The understanding 'why' theme from the CAT-GSH participants is important, particularly because one of the patient complaints that has been raised about CBT-GSH (Macdonald et al., 2007) is that people are often seeking insight into the 'cause' of their current emotional problems, whereas CBT-GSH is largely concerned with symptom resolution.

The 'looking inwards to move forwards vs using techniques' theme shares similarities with evidence when CBT has been compared with analytically informed psychotherapies. For example, Nilsson et al.'s (2007) found high intensity CBT participants described change as occurring due to the introduction of specific change methods and this would be the 'using techniques' subtheme in the current study. Llewelyn et al. (1988) found that CBT participants identified with the 'problem solution' approach of CBT as facilitating change, and this was different to the process of 'awareness building' by those receiving exploratory therapy. Whilst those receiving CAT-GSH reported learning and applying anxiety management techniques to a similar extent as CBT-GSH participants, these were more dependent on an initial process of looking inwards to enable understanding as to why the anxiety was present in the first place. The use of techniques in CBT-GSH fits with the Lillevoll et al. (2013) study where patients

noted that they used internet-delivered LI-CBT to acquire new depression management skills and then used these skills to manage mood in the real world.

There was a key distinction between the two interventions regarding how *changing relationships* supported change. During CAT-GSH this change mechanism seemed to be a process of relational insight, relational change and particularly change to the self-to-self relationship (i.e., the way in which a person talks to and treats themself). No equivalent theme was reported during CBT-GSH. This suggests that CAT-GSH enables a reparative process of the self that enables better anxiety management. The fifth CAT-GSH session centres on the construction of new reciprocal roles and therefore this would have involved a self-to-self reciprocal role relationship that was based on compassion, support and encouragement and so on. The contribution of relationships was different for those receiving CBT-GSH in that participant's emphasised the importance of having access to interpersonal support. This mechanism is akin to the 'client extra-therapeutic factors' reported by Lambert (1992) and highlights the importance of interpersonal support whilst CBT-GSH is underway.

Despite GSH having minimal contact time with the PWP (6–8 sessions of 35-munute duration), the therapeutic relationship and influence of the practitioner was important across both versions of GSH. Participants spoke frequently of the vital role that the PWP played in their recovery, particularly when they were able to relate to the practitioner on a more personal level (i.e., similar age, being a parent, from similar cultural backgrounds). This in line with similar findings from therapeutic alliance literature, where collaborative connections with the therapist positively influence outcomes (Orlinsky et al., 2003) and again underlines why GSH tends to be more indicated then pure self-help (Gellatly et al., 2007). This finding also emphasises the competency of building of effective therapeutic alliances early during these very brief and structured GSH interventions (Kellett, Simmonds-Buckley, et al., 2021). Previous research on the change process during CAT found that early and explicit efforts at collaboration were a significant theme (Rayner et al., 2011).

There was strong emphasis on the participant's own qualities in being open, willing and committed to engaging in the GSH, whether through making the decision to engage in the LI intervention despite apprehension, or actively practising techniques between the sessions. This is akin to Bendelin et al. (2011) study that emphasised the need for patient motivation to engage with the LI-CBT materials. GSH therefore seems inappropriate where there is high patient ambivalence, or when the patient is in the precontemplation stage of change (Prochaska & DiClemente, 2005). Another participant quality that enabled change was willingness to process distressing past events and tolerate associated emotions. The CAT-GSH participants particularly spoke about re-evaluating past traumas and making sense of difficult past personal events and relationships. This process was absent from the CBT-GSH group because the method is based on the here-and-now and therefore exploration of the past is not encouraged. CAT-GSH has a 'past-present' focus (Wray et al., 2022) and therefore this type of work is possible. It is noticeable that the duration of each CAT-GSH session meant that this work was achieved in a relatively brief time frame. This therapeutic work also clearly created a high emotional load and mirrors the Balmain et al. (2021) results where CAT participants reported feeling strong emotional reactions during sessions, but felt this emotional labour was tolerable and worthwhile. Some participants spoke of having negative beliefs or perceptions about GSH before starting the intervention and some did not expect the GSH to work. The expectations of therapy literature consistently finds that positive expectations lead to good outcomes (Rutherford et al., 2010). However, the current findings suggest that having willingness to give GSH a chance, despite apprehension, was helpful and important for change. Where participants felt that the intervention was flexible to their needs and wishes this was found to be beneficial. This parallels findings by Amos et al. (2019) who found that personalising GSH was more effective compared to a more overly regimented approach. Whilst GSH is a manualised approach, there are ample opportunities to match and fit the approach to the person, and the materials should always be appropriately personalised (Norcross & Wampold, 2011).

Limitations and further research

There are a number of limitations to the current research. Perhaps the largest limitation was the sample size and larger studies would be useful in the future. The data was drawn from interviews and future studies should take a process analysis approach and try to identify when change processes are occurring during real time therapeutic conversations during differing versions of GSH. Completing studies with patients that do not find GSH helpful would be just as valuable as studies with those that have found the approach helpful. Assessing the durability of idiographic changes would be useful, as would studying how these prevent relapse, particularly given the evidence of the ease with which patients relapse following LI interventions (Ali et al., 2017). The study's inclusion criteria of a reliable change on the GAD-7 could arguably have been made more rigorous by making this a reliable and clinically significant change (Jacobson & Truax, 1991). Participants were mostly white British and female and a wider sampling frame would have been helpful. PWP competence scores were not available for all participants in this sample. More CAT-GSH participants were interviewed than CBT-GSH due to over recruitment in the CAT-GSH arm of the original trial (Kellett et al., 2023) and this possibly influenced the themes identified. The sample was limited to anxiety and types and mechanisms of change may differ in the context of different diagnoses; further research might seek to replicate this study using different clinical populations and differing versions of GSH. Evidence of how specific treatment modules within therapies influence idiographic outcomes has started to happen and needs to continue (Frederick et al., 2023).

Implications and recommendations for clinical practice

Creation and progress ratings of idiographic goals are an important compliment to nomothetic routine outcome monitoring (Cooper & Xu, 2023). There is a need to develop CAT-GSH for depression. Eliciting and meeting patient preferences should be the clinical culture of psychological services, as the style of the therapy needs to be matched to the needs of the patient (Kellett et al., 2023). Additional screening for readiness and motivation for change, specifically for GSH where there is a great emphasise placed on personal effort, may prove useful to identify ambivalence or where readiness or motivation is low and risk of dropout high. A key consideration from this study is how to better select patients for CAT-GSH. In terms of treatment allocation then the use of methods drawn from precision medicine are indicated, so that patients can be better matched to the GSH intervention which is most likely to create change. For example, the *personalised advantage index* (PAI) could be used to identify those patients who benefit more from CAT-GSH than CBT-GSH, as this is advantageous when there are two comparably effective treatments to choose from (Friedl et al., 2020). These precision medicine approaches remove patient preferences and so a more nuanced approach would be to present the PAI results to the patient, then provide them with the psychoeducation about the interventions and then allocate based on based on resultant patient preference. That would be an example of a truly informed choice. The current study also prompts an update of the psychoeducation about CAT-GSH and CBT-GSH, so that it is also now emphasised that CAT-GSH helps people to better understand 'why' and CBT-GSH would be a better option when people want to better understand the 'what' of how to implement change.

Conclusions

The idiographic change process during GSH has not been extensively studied and an idiographic approach is important to maintain in clinical services that are increasingly reliant on nomothetic routine outcome monitoring (Tilden, 2020). This study has highlighted that both common and model-specific factors are present and facilitate positive outcomes. CAT-GSH enabled an exploration of internal processes and relationships, whereas CBT-GSH provided better understanding of anxiety and offered techniques to cope. Common to both versions of GSH was a therapeutic

environment where support was tailored, participants felt supported and connected to their practitioner and participants were active in the change process. These findings suggest that change mechanisms are neither common nor specific during GSH, but more likely an integration of both. Further research is clearly indicated particularly given the scale at which LI interventions are now being delivered in routine services.

AUTHOR CONTRIBUTIONS

Emma Headley: Conceptualization; investigation; writing – original draft; methodology; formal analysis; project administration; data curation. **Stephen Kellett:** Conceptualization; investigation; funding acquisition; writing – review and editing; methodology; project administration; supervision. **Charlotte Bee:** Project administration. **Jess Lancashire:** Project administration. **Vikki Aadahl:** Project administration. **Claire Bone:** Project administration; writing – review and editing. **Niall Power:** Project administration; formal analysis.

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CONFLICT OF INTEREST STATEMENT

None.

DATA AVAILABILITY STATEMENT

The data and the analysis are available from the corresponding author on request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

Appendix S1.

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APPENDIX A

TABLE OF THE CHANGE RATINGS IN CAT-GSH AND CBT-GSH

Changes identified and ratings					
			Ratings		
ID	Changes identified	Change category	Change was unexpected (5 = completely unexpected)	Change would have occurred without therapy (5 = change would not have happened without therapy)	Change was important (5 = change was very important)
CBT-GSH					
1	Better able to cope with stressful things	Cognitive	4	2	5
	Stopped worrying about what hasn't happened yet	Cognitive	5	2	5
	Calmer whilst driving	Emotional	4	2	5
	Using breathing techniques	Behavioural	4	2	5
5	Reduced feelings of panic	Emotional	4	1	4
	No longer putting things off	Behavioural	4	1	4
	Being able to see things from a different angle	Cognitive	4	2	4
	Improved concentration	Cognitive	1	1	4
9	Change in my negative thinking	Cognitive	2	1	4
	Reviewing the therapy workbook to keep in touch with thoughts and feelings	Behavioural	4	2	3
	More open with my partner	Relational	4	1	4
	More assertive in my relationships at work	Relational	3	2	5
	Better understanding and management of social anxiety	Behavioural	4	2	4
10	Taking a step back	Cognitive			
	Reduction in overworking	Behavioural	4	4	5
	Increased self-care	Behavioural	4	1	4
	Reduce caffeine intake	Behavioural	5	3	5
	Increased activities	Behavioural	4	1	3
11	Being more open with other people	Relational	5	1	5
	Better outlook on life/ anxiety	Cognitive	2	3	3
	More active	Behavioural	4	1	4
	Better understanding of myself	Cognitive	2	1	4

Changes identified and ratings					
			Ratings		
ID	Changes identified	Change category	Change was unexpected (5 = completely unexpected)	Change would have occurred without therapy (5 = change would not have happened without therapy)	Change was important (5 = change was very important)
15	Less clingy with my partner	Relational	3	3	4
	Being able to use the shower/bath	Behavioural	2	4	4
	Change in thoughts about being able to breathe	Cognitive	1	4	4
	Generally less panicky	Emotional	4	1	4
17	Writing down worries	Behavioural	2	4	5
	Grounding using senses	Behavioural	5	1	5
	New job	Behavioural	2	4	3
	More open with family members	Relational	3	2	5
	Recognising unhelpful thinking patterns	Cognitive	4	2	5
CAT-GSH					
2	Less self-critical	Cognitive	3	3	4
	Taking time out for myself	Behavioural	4	1	4
	Listening to myself and acting on my own advice	Behavioural	2	2	5
3	Feeling like myself again	Emotional	5	1	5
	Taking a step back	Cognitive	5	1	5
	Improved relationships with son	Relational	5	1	5
	Having the desire to do things again	Emotional	3	1	5
	Not dissecting everything	Cognitive	5	1	5
	Not worrying all the time	Cognitive	5	1	5
	Separating work and personal life	Cognitive	5	1	5
4	Looking after myself better	Behavioural	2	1	5
	Improved self-awareness	Cognitive	3	1	5
	Overcoming negative thoughts	Cognitive	5	2	5
	Completing tasks and not napping	Behavioural	5	1	5
6	Increased self-care	Behavioural	4	2	4
	Taking a step back	Cognitive	4	1	4
	Less self-critical	Cognitive	5	1	4
	More confident in myself	Emotional	4	1	5

Changes identified and ratings

ID	Changes identified	Change category	Ratings		
			Change was unexpected (5 = completely unexpected)	Change would have occurred without therapy (5 = change would not have happened without therapy)	Change was important (5 = change was very important)
7	Feeing more worthy	Emotional	5	1	5
	Starting a new job	Behavioural			
	Being more open in my relationship with my husband	Relational	5	2	5
	Better relationship with my kids	Relational	5	1	5
8	Change in outlook – focus on positive	Cognitive	4	1	5
	See myself as survivor not a victim	Cognitive	5	1	5
	Increased positive activity	Behavioural	3	2	5
	Less self-critical	Cognitive	5	1	5
12	Change in relationship with my wife	Relational	5	1	5
	Not overthinking things at work	Cognitive	1	1	4
13	More open and assertive	Relational	5	1	5
	Increased self-care	Behavioural	5	2	5
	Relaxing more	Behavioural	5	1	5
	Not getting caught up in other people's problems	Relational	5	1	5
14	Having insight into difficult relationship with mum, thinking about patterns between the past and present	Cognitive	3	2	5
	Can better manage my relationship with my mum	Relational	3	1	5
	More self-confident	Emotional	3	1	5
16	Taking a step back	Cognitive	4	1	5
	No longer think everything is my fault	Cognitive	4	1	5
	Positive change in relationship	Relational	5	2	5
	Sharing my feelings at work	Behavioural	4	1	5
	No longer avoid doing things	Behavioural	4	1	5
	Being kinder to myself	Behavioural	5	2	5
	Taking time to relax	Behavioural	4	2	5

Note: CAT-GSH, Cognitive Analytic Therapy Guided Self-Help; CBT-GSH, Cognitive-Behavioural Therapy Guided Self-Help; Pt, participant.