

Theoretical and Review Articles // Artículos teóricos y de revisión

- Jesús Gil Roales-Nieto 99-141 Tensión individualismo-gregarismo en la configuración psicológica del ser humano II: arquetipos de yo gregario. [*Individualism-Gregariousness Tension in the Psychological Configuration of the Human Being, II: Archetypes of Gregarious Self.*]
- Lidia Budziszewska 143-162 Hierarchical Classification from Relational Frame Theory: A Review
Jorge Villarroel Carrasco
Enrique Gil

Research Articles // Artículos de investigación

- M. Graça Pereira 165-175 Communication, Forgiveness and Morbidity in Young Adults Involved in a Romantic Relationship.
Liliana Fontes
Margarida Vilaça
Frank Fincham
Eleonora Costa
José C. Machado
- Alma Gabriela Martínez Moreno 177-1846 COVID 19 and Psychological Problems in Mexican Mothers.
Jessica Elizabeth Pineda Lozano
Carmen Alejandrina Virgen Carrillo
María del Rocío Padilla Galindo
Ana Cristina Espinoza Gallardo
- Mariana Coelho 185-196 The Impact of Stigmatizing Experiences and Self-Stigma on Mental Health and Suicidal Behavior: Results from the Community of Portuguese Language Countries.
Henrique Pereira
- Hussein Bharmal 197-210 Evaluation of a Transdiagnostic Group Intervention in a Primary Care Mental Health Service: A Pilot Study.
Roger Moore
Jamie Kelly
- Maria Manuela Peixoto 211-221 Repetitive Negative Thinking, Rumination, Depressive Symptoms and Life Satisfaction: A cross-sectional mediation analysis.
Olga Cunha
- Carlos Eduardo González Cifuentes 223-234 Psychometric properties of the Inventory of Interpersonal Problems-64 in Colombia.
Francisco J. Ruiz

Notes and Editorial Information // Avisos e información editorial

- Editorial Office 237-238 Normas de publicación-*Instructions to Authors*.
Editorial Office 239 Cobertura e indexación de IJP&PT. [*IJP&PT Abstracting and Indexing.*]

ISSN 1577-7057

© 2022 Asociación de Análisis del Comportamiento-MICPSY, Madrid, España

IJP&PT

INTERNATIONAL JOURNAL OF PSYCHOLOGY & PSYCHOLOGICAL THERAPY

EDITOR

Francisco Javier Molina Cobos
Universidad de Almería, España

REVIEWING EDITORS

Mónica Hernández López
Universidad de Jaén
España

Francisco Ruiz Jiménez
Fundación Universitaria Konrad Lorenz
Colombia

ASSOCIATE EDITORS

Dermot Barnes-Holmes
Ulster University
UK

J. Francisco Morales
UNED-Madrid
España

Mauricio Papini
Christian Texas University
USA

Miguel Ángel Vallejo Pareja
UNED-Madrid
España

Kelly Wilson
University of Mississippi
USA

ASSISTANT EDITORS

Francisco Cabello Luque
Adolfo J. Cangas Díaz
Emilio Moreno San Pedro

Universidad de Murcia, España
Universidad de Almería, España
Universidad de Huelva, España

IJP&PT

INTERNATIONAL JOURNAL OF PSYCHOLOGY & PSYCHOLOGICAL THERAPY

Comité Editorial / Editorial Committee

Editor: Francisco Javier Molina Cobos, Universidad de Almería, España

Associate Editors

Dermot Barnes-Holmes, *Ulster University, UK*
Francisco Morales, *UNED, Madrid, España*
Mauricio Papini, *Christian Texas University, USA*
Miguel Ángel Vallejo Pareja, *UNED, Madrid, España*
Kelly Wilson, *University of Mississippi, USA*

Reviewing Editors

Mónica Hernández López, *Universidad de Jaén, España*
Francisco Ruiz Jiménez, *Fund. Univ. Konrad Lorenz, Colombia*
Francisco Cabello Luque, *Universidad de Murcia, España*
Adolfo J. Cangas Díaz, *Universidad de Almería, España*
Emilio Moreno San Pedro, *Universidad de Huelva, España*

Assistant Editors

Former Editors Jesús Gil Roales-Nieto, *Universidad de Almería, España, (2001-2011)*
Santiago Benjumea, *Universidad de Sevilla, España, (2012-2016)*
Miguel Rodríguez Valverde, *Universidad de Jaén, España, (2017)*

Consejo Editorial / Editorial Advisory Board

Yolanda Alonso *Universidad de Almería, España*
Erik Arntzen *University of Oslo, Norway*
M^a José Báguena Puigcerver *Universidad de Valencia, España*
Yvonne Barnes-Holmes *National University-Maynooth, Ireland*
Adrián Barbero Rubio *UNED & MICPSY, Madrid, España*
William M. Baum *University of New Hampshire, USA*
Charles Catania *University of Maryland Baltimore County, USA*
Juan Antonio Cruzado *Universidad Complutense, España*
Victoria Díez Chamizo *Universidad de Barcelona, España*
M^a Paula Fernández García *Universidad de Oviedo, España*
Perry N Fuchs *University of Texas at Arlington, USA*
Andrés García García *Universidad de Sevilla, España*
José Jesús Gázquez Linares *Universidad de Almería, España*
Luis Gómez Jacinto *Universidad de Malaga, España*
Celso Goyos *Universidade de Sao Paulo, Brasil*
David E. Greenway *University of Southwestern Louisiana, USA*
Patricia Sue Grigson *Pennsylvania State College of Medicine, USA*
Steven C. Hayes *University of Nevada-Reno, USA*
Linda Hayes *University of Nevada-Reno, USA*
Phillip Hine *Temple University, USA*
Per Holth *University of Oslo, Norway*
Robert J. Kohlenberg *University of Washington, Seattle, USA*
María Helena Leite Hunzinger *Universidade de Sao Paulo, Brasil*
Julian C. Leslie *University of Ulster at Jordanstown, UK*
Juan Carlos López García *Universidad de Sevilla, España*
Juan Carlos López López *Universidad de Almería, España*
Fergus Lowe *University of Wales, Bangor, UK*
Carmen Luciano *Universidad de Almería, España*
Armando Machado *Universidade do Miño, Portugal*
Jose Marques *Universidade do Porto, Portugal*
G. Alan Marlatt *University of Washington, Seattle, USA*

Ralph R. Miller *State University of New York-Binghamton, USA*
Rafael Moreno *Universidad de Sevilla, España*
Edward K. Morris *University of Kansas-Lawrence, USA*
Lourdes Munduate *Universidad de Sevilla, España*
Alba Elisabeth Mustaca *Universidad de Buenos Aires, Argentina*
José I. Navarro Guzmán *Universidad de Cádiz, España*
Jordi Obiols *Universidad Autónoma de Barcelona, España*
Sergio M. Pellis *University of Lethbridge, Canada*
Ricardo Pellón *UNED, Madrid, España*
Wenceslao Peñate Castro *Universidad de La Laguna, España*
Víctor Peralta Martín *Hospital V. del Camino, Pamplona, España*
M. Carmen Pérez Fuentes *Universidad de Almería, España*
Marino Pérez Álvarez *Universidad de Oviedo, España*
Juan Preciado *City University of New York, USA*
Emilio Ribes Iniesta *Universidad Veracruzana, México*
Josep Roca i Balasch *INEF de Barcelona, España*
Jesús Rosales Ruiz *University of North Texas, USA*
Juan Manuel Rosas Santos *Universidad de Jaén, España*
Jorge Ruiz Sánchez *Universidad de Burgos, España*
Kurt Saltzinger *Hofstra University, USA*
Mark R. Serper *Hofstra University, USA*
Carmen Torres *Universidad de Jaén, España*
Peter J. Urcuoli *Purdue University, USA*
Guillermo Vallejo Seco *Universidad de Oviedo, España*
Julio Varela Barraza *Universidad de Guadalajara, México*
Juan Pedro Vargas Romero *Universidad de Sevilla, España*
Carmelo Visdómine Lozano *SGIP, Ministerio del Interior, España*
Graham F. Wagstaff *University of Liverpool*
Stephen Worchel *University of Hawaii, USA*
Edelgard Wulfert *New York State University, Albany, USA*
Thomas R. Zentall *University of Kentucky, USA*

International Journal of Psychology & Psychological Therapy is a four-monthly interdisciplinary publication open to publish original articles, reviews of one or more area(s), theoretical reviews, or methodological issues, and series of interest to some of the Psychology areas. The journal is published for the *Asociación de Análisis del Comportamiento* (AAC) and MICPSY, and indexed and/or abstracted in:

- Academic Search Complete (EBSCO Publishing Inc.)
- Cabell's Directory (Cabell Scholarly Analytics)
- CLARIVATE-WEB OF SCIENCE (Emerging Sources Citation Index)
- ClinPSYC (American Psychological Association)
- DIALNET (Fundación Dialnet, Universidad de La Rioja)
- DICE-CSIC (Difusión y Calidad de las Revistas Españolas)
- Directory of Open Access Journals (DOAJ)
- EBSCO Information Service
- GOOGLE Scholar Metrics
- IBECs (Índice Bibliográfico Español en Ciencias de la Salud)
- IN-RECS (Index of Impact of the Social Sciences Spanish Journals)
- ISOC (CINDOC, CSIC)

International Journal of Psychology & Psychological Therapy es una publicación interdisciplinaria cuatrimestral, publicada por la Asociación de Análisis del Comportamiento (AAC), abierta a colaboraciones de carácter empírico y teórico, revisiones, artículos metodológicos y series temáticas de interés en cualquiera de los campos de la Psicología. Es publicada por la *Asociación de Análisis del Comportamiento* (AAC) y MICPSY y está incluida en las bases y plataformas bibliográficas:

- Journal Scholar Metrics
- LATINDEX (Sistema Regional de Información en Línea para Revistas Científicas de América Latina, el Caribe, España y Portugal)
- MIAR (Matriz de Información para el Análisis de Revistas)
- ProQuest Prisma Database
- Psychological Abstracts (American Psychological Association)
- PsycINFO (American Psychological Association)
- REBIUN (Red de Bibliotecas Universitarias Españolas)
- RESH (Revistas Españolas de Ciencias Sociales y Humanidades)
- SCIMAGO (SCImago Journal & Country Rank -SCOPUS)
- SCOPUS (Scopus Database Elsevier)

Theoretical and Review Articles // Artículos teóricos y de revisión

Tensión individualismo-gregarismo en la configuración psicológica del ser humano II: arquetipos de yo gregario. [*Individualism-Gregariousness Tension in the Psychological Configuration of the Human Being, II: Archetypes of Gregarious Self.*]..... 99
Jesús Gil Roales-Nieto

Hierarchical Classification from Relational Frame Theory: A Review 143
Lidia Budziszewska, Jorge Villarroel Carrasco, Enrique Gil.

Research Articles // Artículos de investigación

Communication, Forgiveness and Morbidity in Young Adults Involved in a Romantic Relationship 165
M. Graça Pereira, Liliana Fontes, Margarida Vilaça, Frank Fincham, Eleonora Costa, José C. Machado.

COVID 19 and Psychological Problems in Mexican Mothers 177
Alma G. Martínez Moreno, Jessica E. Pineda Lozano, Carmen A. Virgen Carrillo, María R. Padilla Galindo, Ana C. Espinoza Gallardo.

The Impact of Stigmatizing Experiences and Self-Stigma on Mental Health and Suicidal Behavior: Results from the Community of Portuguese Language Countries 185
Mariana Coelho, Henrique Pereira.

Evaluation of a Transdiagnostic Group Intervention in a Primary Care Mental Health Service: A Pilot Study 197
Hussein Bharmal, Roger Moore, Jamie Kelly

Repetitive Negative Thinking, Rumination, Depressive Symptoms and Life Satisfaction: A cross-sectional mediation analysis 211
Maria Manuela Peixoto, Olga Cunha.

Psychometric properties of the Inventory of Interpersonal Problems-64 in Colombia 223
Carlos Eduardo González Cifuentes, Francisco J. Ruiz

Notes and Editorial Information // Avisos e Información Editorial

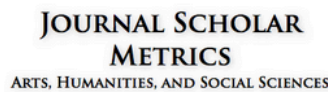
Normas de publicación [*Instructions to Authors*] 237

Cobertura e indexación de *IJP&PT* [*IJP&PT Abstracting and Indexing*] 239

STATEMENTS, OPINIONS, AND RESULTS OF STUDIES PUBLISHED IN *IJP&PT* ARE THOSE OF THE AUTHORS AND DO NOT REFLECT THE POLICY OR POSITION OF THE EDITOR, EDITORIAL COUNCIL OF *IJP&PT*, AND AAC; REGARDING ACCURACY OR RELIABILITY, NO GUARANTEE CAN BE OFFERED OTHER THAN THAT THE PROVIDED BY THE AUTHORS THEMSELVES.

LAS DECLARACIONES, OPINIONES Y RESULTADOS DE LOS ESTUDIOS PUBLICADOS EN *IJP&PT* PERTENECEN EN EXCLUSIVA A LOS AUTORES, Y NO REFLEJAN LA POLÍTICA O POSICIÓN DEL EDITOR, DEL EQUIPO EDITORIAL, NI DEL CONSEJO EDITORIAL DE *IJP&PT*, NI DE LA AAC; EN CUANTO A SU EXACTITUD O FIABILIDAD, NO PUEDE OFRECERSE NINGUNA OTRA GARANTÍA QUE NO SEA LA APORTADA POR LOS PROPIOS AUTORES.

IJP&PT IS INCLUDED IN THE FOLLOWING INDEXING AND DOCUMENTATION CENTERS



Evaluation of a Transdiagnostic Group Intervention in a Primary Care Mental Health Service: A Pilot Study

Hussein Bharmal*, Roger Moore

University of Portsmouth, United Kingdom

Jamie Kelly

West London NHS Trust, United Kingdom

ABSTRACT

Adults with complex mental health difficulties (including those diagnosed with a personality disorder) are often seen in primary care settings with limited access to appropriate psychological therapies. A seven-session group treatment programme, the Coping Skills Workshop (CSW), was developed that combined both Cognitive Behavioural Therapy (CBT) and Dialectical Behavioural Therapy (DBT). The study evaluated the efficacy of a modified version of the CSW. 52 patients (aged 18 years and above) who were under the care of a Primary Care Mental Health Service (PCMHS) in London were referred into the CSW. 26 were randomly allocated to the group treatment programme and 26 to a wait-list control condition (Treatment as Usual; TAU). All participants completed four mental health outcome measures that assessed levels of depression (PHQ-9), anxiety (GAD-7), daily functioning (WS&AS) and general wellbeing (SWEMWBS), at pre- (first session) and post-intervention (end of seventh session). Participants in the wait-list control group completed the measures at similar time intervals. Participants in the treatment condition showed a significant clinical reduction in symptom severity in both PHQ-9 (20%) and GAD-7 (45%) scores alongside an improvement in SWEMWBS scores (17%). In contrast, the TAU group showed a significant deterioration in mental health symptoms at the post-score stage. The findings suggest that the brief transdiagnostic CSW intervention is efficacious and appropriate for individuals with complex mental health difficulties. Further investigation may include populations from different backgrounds and comorbidities.

Key words: coping skills, group transdiagnostic, cognitive behavioural therapy, dialectical behavioural therapy, primary care mental health service.

How to cite this paper: Bharmal H, Moore R, & Kelly J (2022). Evaluation of a transdiagnostic group intervention in a primary care mental health service: A pilot study. *International Journal of Psychology & Psychological Therapy*, 22, 2, 197-210.

Novelty and Significance

What is already known about the topic?

- Research provides robust advantages of using transdiagnostic group psychological interventions informed by DBT and CBT in the NHS Primary Care Mental Health Services.
- Series of outcome measures questionnaires can be useful to monitor the group workshop and review service-users' scores of moving towards recovery.

What this paper adds?

- The implementation of the brief, Coping Skills Workshop has been shown to improve service-users' symptoms of depression and anxiety and general wellbeing.
- The result of this study allows a strengthened awareness of a cost-effective way in providing treatment for mental health.

Around 17.6% of the adult population have common mental health problems of anxiety and/or depression (McManus, Meltzer, Brugha, Bebbington, & Jenkins, 2009). Ninety percent of service users with mental health difficulties are seen in primary care (Fletcher *et alia*, 2009; Shepherd, Cooper, & Brown, 1996). In England, most focus has been placed on providing access to treatment for these common mental health problems (i.e. anxiety and depression).

* *Correspondence:* Hussein Bharmal c/o Dr Roger Moore, Department of Psychology, University of Portsmouth, King Henry I Street, Portsmouth, PO1 2DY, UK. Email: hussein.bharmal@myport.ac.uk // roger.s.moore@port.ac.uk. *Acknowledgements:* The authors would like to thank all the service-users at the West London NHS Trust who took the time to take part in this audit evaluation study.

However, when defining the term 'mental health', we need to take other complex mental health difficulties into consideration. These include conditions such as bipolar disorder, personality disorder, etc. Typically, they account for around thirty to fifty percent of people under primary care services (Naylor, 2020).

Initially, the responsibility for dealing with these service-users falls with GPs, who often feel undertrained or insufficiently experienced to manage these complex mental health issues (Naylor, 2020). Primary Care Mental Health Services act as a way to support GPs to deliver optimal holistic mental health care for these service-users.

The Primary Care Mental Health Service (PCMHS) in West London was developed in 2013 to support service-users in local boroughs with moderate to severe mental health difficulties. The multidisciplinary team (MDT) provides clinics, typically within GP surgeries improves ease of access to treatment (WONCA, 2008). As a result of this, GPs and the PCMHS can form close working relationships, helping to deliver good collaborative care and help service-users to remain well.

Service users seen by the PCMHS are also often unable to access treatment from the Improved Access to Psychological Therapy (IAPT) service as their diagnosis and treatment is too complex (Clark, 2011; Department of Health, 2011; Naylor, 2020). Therefore, a referral is made to PCMHS, as the service supports service-users with a broad range of diagnoses, including, Emotional Unstable Personality Disorder (EUPD) and Bipolar affective disorder.

In terms of available treatments, although antidepressant medications are a common first treatment for mental illnesses, their use is limited by side-effects, poor patient adherence and high relapse risk when medication use is discontinued (Amick *et alia*, 2015). Empirical research has shown that Cognitive Behavioural Therapy (CBT) is as effective as antidepressants (Amick *et alia*, 2015) and has a strong effect on common mental health problems such as depression and anxiety (Cape *et alia*, 2010).

However, evidence of CBT alone for complex mental health difficulties such as Schizophrenia, Bipolar Disorder (BD), Manic episodes and Emotionally Unstable Personality Disorder (EUPD) suggests this approach is limited in terms of its effectiveness (Hofmann *et alia*, 2012). Typically, treatment often needs CBT plus medication treatment -this is especially true for service-users with EUPD (Chiang *et alia*, 2017).

Treatments such as Dialectical Behaviour Therapy (DBT) have been developed and have been found to be effective for treating disorders such as EUPD (Linehan, 1993a, b; Tomlinson, 2018). Studies have shown that service-users who are treated with DBT therapy demonstrate a significant improvement in negative affect and emotional dysregulation along with improvements in wellbeing and control over their environment (Eisner *et alia*, 2017). Other studies have also reported reductions in aggressive behaviours and lower rates of depressive symptoms (Koons *et alia*, 2001; Meygoni & Ahadi, 2012), fewer EUPD symptoms (Uliaszek, Hamdullahpur, Chugani, & Rashid, 2018), reduced hopelessness, and self-harm (Stepp *et alia*, 2008) by the end of treatment. Nevertheless, to be effective, standard DBT therapy in a community public mental health setting, requires a long treatment duration of around 12 months (Flynn *et alia*, 2020a, b).

There are an increasing number of research studies which have considered 'transdiagnostic' psychological treatments that combine aspects of different treatment models to treat a broader range of mental health disorders. Erickson, Janeck, and Tallman (2007) found that Transdiagnostic Cognitive Behaviour Therapy (TD-CBT) in a group format was more effective (with a moderate effect size) compared to a waitlist condition or 'Treatment As Usual' (TAU) condition in reducing symptoms of anxiety.

In a systematic meta-analysis review by Newby, McKinnon, Kuyken, Gilbody, and Dalgleish (2015), transdiagnostic treatments led to significant reductions in both anxiety and depression, along with moderate improvements in quality of life.

These studies show that it is possible to achieve success when treating several disorders simultaneously in a group situation. In addition, group interventions enhance participants' social participation and promote hope through observing the progress with other people (Newbold *et alia*, 2013; Proudfoot, Corr, Guest, & Dunn, 2009) which is a further benefit to be gained from this approach.

Considering the current options available, a brief intervention informed by DBT and CBT within the remit/ operational policy of the PCMHS, would be of considerable benefit. The general aim here is to evaluate the efficacy of a transdiagnostic group treatment programme in PCMHS, incorporating both CBT and DBT therapy -the 'Coping Skills Workshop' (CSW). The CSW was developed by Marinho and Rashed (2015) to treat people with complex mental health difficulties. This early, brief, evidence-based intervention teaches participants effective CBT skills (such as problem solving, goal setting and thought challenging) as well as emotion regulation, interpersonal skills, and mindfulness awareness (from DBT). This aims to help participants cope and decrease their mental illness symptoms (Rowan & Runyan, 2005; Melnyk *et alia*, 2006). The CSW aims to improve each participant's mental health and social and occupational life.

Currently, there is limited evidence on the effectiveness of brief transdiagnostic group treatment programmes offered in primary care settings for service-users with mild to severe mental health difficulties. Specifically, this research will examine whether a modified version of the CSW is an effective intervention to improve service-users' mental health as measured by a series of clinical outcome measures. The 'treatment group' will be compared to participants in a waitlist control. Measures that have already been developed and established will be used to provide a valid pre- and post-treatment comparison. These include: Generalised Anxiety Disorder 7, (GAD-7 by Spitzer, Kroenke, Williams, & Löwe, 2006); Patient Health Questionnaire 9, (PHQ-9 by Kroenke, Spitzer, & Williams, 2001); Working Social and Adjustment scale, (WS&AS by Mundt, Marks, Shear, & Greist, 2002) and the Short Warwick-Edinburgh Mental Well-being Scale, (SWEMWBS by Tennant *et alia*, 2007).

It is predicted that participants in the treatment group (i.e., participants receiving the CSW group-intervention) will show significant clinical improvement and higher wellbeing scores by the end of the treatment compared to the wait-list control group.

METHOD

Participants

All individual participant referrals were reviewed and screened for eligibility (see Table 1) within London Borough of Ealing and Hounslow GP practices. Participants had to be aged at least 18 years old to participate in the intervention. Any referrals that came from other sources, such as secondary care services, were also triaged before being accepted onto the Coping Skills Programme. Only 52 ($M\ age= 42, SD= 15.46$) randomly selected participants between November 2018 and July 2019 were included in this evaluation. There were 32 females (62%) and 20 males. Thirty-seven (71.2%) of those were White (British and Scottish), seven (13.5%) were British Indian, three (5.8%) were British Pakistani and three Spanish (5.8%) and two were British African (3.8%).

Table 1. Inclusion and Exclusion Criteria.

Criteria	Included	Excluded
Participants	Participants need to be registered with a GP in the Boroughs of Hounslow and Ealing.	Participants who have complex needs (e.g. prominent suicide ideation).
Focus	Diagnosed with depression, anxiety, emotionally-unstable personality disorder (EUPD), bipolar affective disorder, psychosis (e.g. paranoid schizophrenia).	Participants who are diagnosed with dementia, eating disorders. Treated by clozapine medication.
Intervention	Can wait up to 28 days to have contact with the PCMHS.	Participants who might be too anxious when participating in group therapy (to avoid placing more distress on such participants). Participants who are unable to use the materials due to impaired concentration/motivation. Participants who do not understand the English language sufficiently to be able to complete the study measures and engage in the group.

Design

A mixed design was used with a between-subjects factor, where participants were allocated to either treatment or a waitlist control condition. Participants in both conditions were asked to complete four self-reported, outcome measures scores (dependent variables) on depression (PHQ-9), anxiety (GAD-7), daily functioning (WS&AS) and positive wellbeing (SWEMWBS) at the first session/week and at the seventh session/week. This allowed comparison of scores over time: pre-to-post intervention (within-subjects factor). The CSW took place face-to-face in an NHS clinic adjacent to a GP clinic.

Instruments and Materials

Ethical approval was reviewed and approved by the NHS West London Trust, Primary Care Mental Health Service as an audit service evaluation report. Around 30-35 participants (due to the maximum room capacity) were given an invitation letter by the PCMHS Trust for the upcoming Coping Skills Workshop (CSW) including dates and timings. The workshops consisted of seven separate sessions which were outlined in the workbook handouts. These workbooks, which were given to the participants at the start of the workshop, also contained some space for 'putting into practice' (homework) tasks. These handbooks included: Managing Unhelpful Thoughts (session 1); Managing Unhelpful Behaviours (session 2); Managing Stress and Worry (session 3); Sleep Management (session 4); Managing Difficult Emotions (session 5); Managing Interpersonal Difficulties (session 6) and Maintaining Wellbeing (session 7). The psychologist taught the sessions using a flipchart and pens. Copies of seven workbook handouts are available from the lead author on request. There was a 10-15 minute break in the middle of the workshop, where participants were provided tea/coffee and biscuits. Before starting each session, participants were asked to complete the four outcome measures scores which are outlined below. For the waitlist control condition, the four outcome measure scores were obtained through contacting participants over the telephone.

Patient Health Questionnaire -9 (PHQ-9; Kroenke *et alia*, 2001). The PHQ-9 is a self-report administered questionnaire for measuring and monitoring symptoms of depression. The scale contains 9 items corresponding to the nine diagnostic criteria for DSM-IV. The patient answers each statement by scoring on a scale of 0 ('not at all') to 3 ('almost everyday'), how troublesome each problem has been during the past two weeks. The

total scores that range from 0-4 indicate minimal depression; 5-9, mild depression; 10-14, moderate depression; 15-19, moderately severe depression; and a score between 20-27 indicating severe depression. The PHQ-9 has shown excellent internal reliability (Cronbach' $\alpha=0.86$), with good construct and convergent validity (Kroenke *et alia*, 2001). *Generalised Anxiety Disorder -7* (GAD-7; Spitzer, Kroenke, Williams, & Löwe, 2006). This self-administered scale consists of 7 items, that assess a generic measure of anxiety severity. Participants were asked to rate, 0-3 (ratings similar to PHQ-9), about how much over the last two weeks they have been bothered by each statement. The total score results from 0-21, with cut-off scores of 5, 10, 15 representing mild, moderate and severe levels of anxiety. The GAD-7 has been shown to have excellent internal consistency (Cronbach' $\alpha=0.92$) and good test-retest reliability ($r=0.83$) with other anxiety scales (Kroenke *et alia*, 2010).

Working Social & Adjustment Scale (WS&AS; Mundt *et alia*, 2002). The five-point WS&AS assesses the impact of an individual's mental health difficulties (daily impairment functioning) on their work, home management, social leisure activities, private leisure activities and relationships. When a participant experiences extreme dysfunction (a score of 8 or higher) on at least three or four domains, they are seen by specialised mental health care services.

Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS; Stewart-Brown *et alia*, 2009). The SWEMWBS scale contains seven items representing four aspects of psychological and eudaemonic (e.g., self-realisation) wellbeing, whilst the last three items cover hedonic (e.g., life satisfaction) wellbeing (Ryan & Deci, 2001). The seven statements are positively worded and are rated on a 5-point Likert-type response scale from 'none of the time' to 'all of the time'. Scores range from 7 to 35. A high score indicates higher positive mental wellbeing over their previous two weeks.

Procedure

The workshops were held at an NHS clinic on Wednesday afternoons. The room and chairs were set up in a circular group layout, as this was found to encourage most effective interaction compared to a rows/classroom arrangement. The flipchart, cups, and biscuits, along with all the handout booklets and the outcome measures scale materials, were all arranged before the session started. Once the room was ready for the group, participants were asked to complete the four outcome measures scores. Thus, the selection process/sample was organized using the 'experience' or 'event-sampling' method, where clients were asked to report and comment on their daily life on multiple occasions over time (Verhagen, Hasmi, Drukker, Van Os, & Delespaul, 2016). Participants were also notified that their scores were confidential and would be anonymized throughout.

All four outcomes' measures scores and the client feedback were recorded in SystemOne (clinical computer programme system). Participants raw completed paper forms were destroyed. The data for the first session and the final seventh session was recorded into a spreadsheet for research purposes (i.e., the current study). This facilitated a comparison to see if the participants, overall, had improved and benefitted from the programme.

For the waitlist control condition, the participants were selected at random from the Trusts' waitlist spreadsheet and only 26 participants were contacted through an office-based telephone. Participants who could not answer the outcome measures, or said that they no longer needed CSW intervention, meant that the next participant was contacted.

Wait-list participants were told that they would be invited into the next cohort. Participants were contacted again at the seventh week to go over the same outcome measures scores. All instructions were standardized and used throughout ensuring consistency and clarity for all 26 participants.

RESULTS

A 2x2 mixed MANOVA was conducted with one between-subjects factor with two levels (condition; treatment vs. waitlist control) and one within-subjects factor with two levels (pre-intervention score vs. post-intervention score). The dependent variables were the four mental health outcome measures scores (PHQ-9, for measuring depression; GAD-7, for measuring anxiety; WS&AS, for measuring participants' daily functioning and SWEMBWS for measuring general wellbeing).

A significant multivariate interaction effect was observed between condition (treatment and waitlist) and intervention time (pre and post), Pillai's $V = .48$, $F(4,47) = 10.95$, $p < .001$, $\eta^2 p = .48$, with a moderate effect size. There was also a significant multivariate main effect of time (within-subjects) on the four outcome measures scales, Pillai's $V = 0.23$, $F(4,47) = 3.45$, $p = .02$, $\eta^2 p = .23$, with a moderate effect size. However, there was a non-significant multivariate main effect between the two conditions (between-subjects), Pillai's $V = .16$, $F(4,47) = 2.22$, $p = .08$, $\eta^2 p = .16$, with a moderate effect size in magnitude.

The significant interaction effect justified 2x2 mixed factorial ANOVAs on the four dependent variables separately –see Table 2.

Table 2. Mean's (SD's) for all four outcome measures scales as a function of client's treatment intervention and control waitlist tested at both pre (1st week) and post treatment (7th week).

Scales	Time ($df = 1,50$)		Condition ($df = 1,50$)		Treatment Condition ($n = 26$)		Waitlist Control Condition ($n = 26$)	
	F	$\eta^2 p$	F	$\eta^2 p$	Pre $M(SD)$	Post $M(SD)$	Pre $M(SD)$	Post $M(SD)$
PHQ-9	10.78*	.18	4.94*	.03	16.73(6.42)	10.85(6.62)	16.12(5.69)	17.92(4.16)
GAD-7	6.55*	.12	8.50*	.15	13.88(5.03)	9.58(5.05)	14.42(4.76)	16.08(4.04)
WS&AS	.68	.01	5.02*	.09	19.27(9.87)	15.38(9.02)	21.54(9.68)	23.12(9.39)
SWEMBWS	7.49*	.13	3.72	.07	34.77(9.72)	42.23(8.34)	33.85(11.04)	34.54(9.44)

Note: * = $p < .05$.

A 2x2 mixed factorial analysis of variance (ANOVA) was conducted (condition, treatment vs. waitlist control; intervention time, pre-post) on the depression (PHQ-9) scores. There was a significant main effect of condition with the treatment group reducing participants severity of the PHQ-9 symptoms more than the waitlist control group (see Table 2). There was also a significant main effect of time with the post-intervention group reducing their depressive symptoms over the seven weeks compared to at the start of the session (see Table 2). Further, there was an interaction effect between condition and time on the depression scale (PHQ-9), $F(1,50) = 38.36$, $p < .001$, $\eta^2 p = .43$ with a medium standardised effect size. It can be seen in Figure 1 that participants who attended all

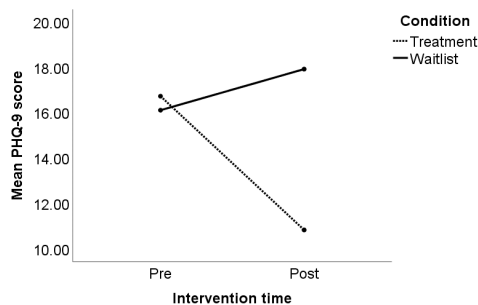


Figure 1. Mean PHQ-9 score as a function of intervention time and condition.

seven sessions of the workshop reduced their depressive symptoms over the seven weeks (post intervention) considerably, compared to the participants in the waitlist condition.

Post-hoc pairwise comparisons (with alpha levels adjusted according to Bonferroni), justified by our interaction effect, showed that participants who completed all seven CSW treatment sessions (postintervention), significantly reduced their depressive symptoms by 5.89 (raw effect size) compared to the start of the intervention ($p < .001$). This was compared to the waitlist group where participants' PHQ-9 scores increased by 1.81 at the end of the seven weeks compared to the beginning of the intervention period ($p = .05$).

Furthermore, a 2x2 mixed factorial ANOVA was conducted (condition, treatment vs. waitlist control; intervention time, pre vs. post) on the anxiety (GAD-7) scores. This analysis revealed a significant main effect of condition where participants who engaged in the CSW treatment intervention significantly reduced their anxiety symptomatology compared to participants in the waitlist control group (see Table 2). In addition, there was a significant main effect of time as participants' symptoms of anxiety significantly improved at postintervention compared to preintervention (see Table 2). These main effects were qualified by a significant interaction effect between condition and time on the GAD-7 scores, $F(1,50) = 33.03$, $p < .001$, $\eta^2 p = .39$, with a small-to-medium standardised effect size. As seen in Figure 2, participants who attended all seven CSW sessions, significantly reduced their anxiety symptoms at postintervention, compared to the waitlist condition.

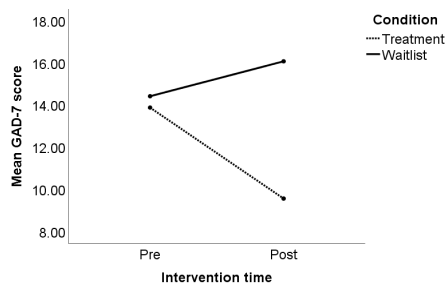


Figure 2. Mean GAD-7 score as a function of intervention time and condition.

Post-hoc pairwise comparisons (with alpha levels adjusted according to Bonferroni) revealed that there was a significant difference between the treatment and waitlist conditions with participants in the CSW treatment group demonstrating significantly decreased anxiety scores (raw effect size of 4.48) after completing the seven sessions ($p < .001$). In contrast, participants in the waitlist control group, showed increased anxiety scores when contacted at the seventh week compared to the first week ($p = .03$), with the raw effect size being negligible (1.65).

General wellbeing scale (SWEMWBS) was analysed with a 2 (Condition: treatment vs. waitlist control) x 2 (Intervention time: pre vs. post) mixed factorial ANOVA analysis. As expressed in Table 2, there was no significant main effect of condition ($p = .06$) on SWEMWBS scores. However, there was a significant main effect of time with participants who completed the seven sessions scoring significantly higher on general wellbeing than at the start of the session (see Table 2). Nevertheless, there was a significant interaction between condition and time on the SWEMWBS scale, $F(1,50) = 5.16$, $p = .027$, $\eta^2 p = .09$, with a medium standardised effect size. This interaction effect indicates that participants

in the treatment condition had improved general wellbeing scores at postintervention, compared to the waitlist condition (see Figure 3).

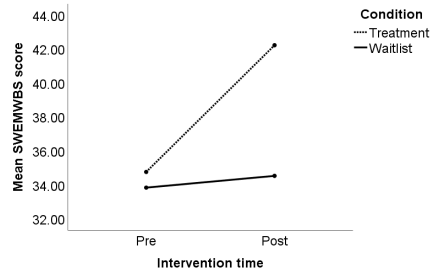


Figure 3. Mean SWEMWBS (general wellbeing scale) score as a function of intervention time and condition.

Post-hoc pairwise comparisons (with alpha levels adjusted according to Bonferroni) indicated that, as hypothesised, participants in the CSW treatment group significantly improved their general wellbeing score considerably by 7.46 at the end of seven weeks intervention ($p = .001$). In contrast, participants in the waitlist control group did not significantly differ in their general wellbeing scores at pre-to-post intervention ($p = .74$), with the raw effect size of the difference being trivial (.69).

Although there was a significant main effect of condition with the CSW treatment group participants scoring improvements on their daily functioning (WS&AS) compared to wait-list controls (see Table 2), there was no significant main effect of intervention time on the WS&AS scores. Additionally, the interaction effect between condition and time was not significant, $F(1,50) = 3.82$, $p = .06$, $\eta^2 p = .07$, with a medium standardised effect size.

Lastly, a multiple regression was conducted using the enter method to predict general wellbeing (SWEMWBS) score from the depression (PHQ-9) and anxiety (GAD-7) scores at postintervention. These variables accounted for a large and statistically significant amount of the variance in predicting SWEMWBS score, $R^2 \text{ Adjusted} = .42$, $F(2, 49) = 19.14$, $p < .001$. However, only the PHQ-9 scale added to the predictive ability of the regression equation at a level which was statistically significant (see Table 3). The negative beta values indicate that reduction in participants' PHQ-9 and GAD-7 scores, both lead to improvements in general wellbeing (SWEMWBS) at postintervention.

Table 3. Individual predictor variables of depression (PHQ-9) and anxiety (GAD-7) measures on wellbeing (SWEMWBS) scale at post-score intervention ($N = 52$).

Variable	<i>B</i>	Standardised <i>B</i>	<i>t</i> value	<i>p</i> level
PHQ-9	-.84	-.55	-2.72	.009
GAD-7	-.21	-.12	-.61	.55

DISCUSSION

The results support the study's main hypothesis: there were significant improvements in symptoms of depression, anxiety, and general wellbeing for the CSW group participants in comparison to wait-list controls at the end of the treatment. Overall, the PHQ-9 scores reduced (by 20%), GAD-7 scores reduced (by 45%) and there was an improvement in SWEMWBS scores (17%). Therefore, the overall effectiveness of the CSW at PCMHs

in improving mental health, wellbeing and functioning is in the medium-to-high range in magnitude. However, the scores in work and social functioning (as measured by the WS&AS) did not appear to show a significant change. Possible reasons for this will be discussed below.

The current findings demonstrate that a brief, seven session, transdiagnostic group programme (that is informed by both CBT and DBT models) can be an effective community treatment intervention and have significant clinical importance for participants with a broad range of mental health difficulties. There was also a significant reduction in symptomatology associated with depression and anxiety, as well as an improvement in general wellbeing (Xia *et alia*, 2011).

There is a large body of research supporting the efficacy of CBT interventions for depression and anxiety (Proudfoot, Corr, Guest, & Dunn, 2009; Spirito *et alia*, 2011; Covin *et alia*, 2008). However, as discussed previously, its utility as a brief, group intervention when treating more complex and comorbid conditions is limited (Hofmann *et alia*, 2012), even though these disorders are frequently encountered in the primary care mental health services (Department of Health, 2011; Van Schaik *et alia*, 2004; Naylor, 2020). The CSW intervention incorporates a core set of CBT-based treatment techniques (such as psychoeducation, graded exposure and cognitive restructuring) but, crucially, also includes core DBT-based strategies (in emotional regulation and interpersonal effectiveness). Empirical research has supported the use of DBT teaching skills during psychological interventions in reducing anxiety symptoms (Arch *et alia*, 2012; Landy, Schneider, & Arch, 2015), depression (Meygoni & Ahad, 2012) and greater reduction in self-harm (Stepp *et alia*, 2008; Neacsiu, Rizvi, & Linehan, 2010). By combining CBT and DBT techniques, the CSW was able to help a broader range of people who may have not been helped by CBT alone (Neacsiu *et alia*, 2014; Ritschel, Cheavens, & Nelson, 2012; Koons *et alia*, 2001).

The current study provides strong evidence that the CSW is an efficacious brief intervention in improving symptoms of depression and anxiety and general wellbeing, for individuals with mental health difficulties in a clinical setting. There is evidence that a transdiagnostic group model can be effectively delivered in a local primary care-based setting which is consistent with previous studies (Powel *et alia*, 2013; Mead *et alia*, 2005; Erickson, Janeck, & Tallman, 2007; Newby *et alia*, 2015; Eisner *et alia*, 2017). Thus, it can be concluded that the CSW approach improves participants' quality of life and their self-esteem overall (Mishna, Kaiman, & Little, 1994).

Furthermore, due to the nature of the CSW intervention (i.e. brief, structured, time-limited, group), this can be a cost-effective way of providing treatment (McDermut, 2001) compared to any other individual psychotherapy interventions (Marziali & Munroe-Blum, 1994). Also, multiple disorders (transdiagnostic) are treated in the same psychotherapy group, servicing a wide range of service-users in need of treatment (Sadock *et alia*, 2014; Rowan & Runyan, 2005). In addition, as the CSW integrates both CBT and DBT therapies, clinicians/psychologists only need to be trained under one manual (McManus *et alia*, 2010; Wilamowska *et alia*, 2010). Therefore, this integrated transdiagnostic therapy could reduce the need for costly professional training and hospitalisation (Phanthunane, Vos, Whiteford, & Bertram, 2011; McCrone, Dhanasiri, Patel, Knapp, & Lawton-Smith, 2008; O'Shea, 2019). This, therefore, increases access to more psychological therapies (Richards *et alia*, 2016; Jerrell *et alia*, 1994) within the primary care service.

Although the present findings provide strong support for the efficacy of the CSW group programme, there are several limitations to the study. Most notably, the study

was not a randomised-controlled trial (RCT). Such an approach compares treatments by randomly assigning participants to conditions without the influence of the researcher/clinician (Essock, Drake, Frank, & McGuire, 2003). However, in this study, participants in both the active and control groups were selected by clinicians in the PCMHS according to suitability for the CSW group programme. This limits our ability to generalise the findings to a broader range of service-users who typically present to mental health services. Therefore, further studies using an RCT design are warranted to further evaluate the efficacy of the CSW approach (Hariton & Locascio, 2018).

Another substantial limitation was the lack of follow-up scores to determine if participant gains were maintained over time, since data were only collected upon completion of the programme (Lubin, Loris, Burt, & Johnson, 1998; Reinholt & Krogh, 2014; Sakiris & Berle, 2019). Therefore, we do not know if recovery rates were sustained over a longer period. Thus, longer-term follow-up is necessary after, say, 2-3 years (following Tucker *et alia*, 1987) in order to evaluate whether the improvement in symptoms seen in service-users can be maintained over time.

The study population invited to attend the workshops was diverse and heterogeneous, since there was a wide range of mental health diagnoses and ethnicities in the group. However, there was some under-representation such as those with high-risk mental health needs (who were not suitable for group intervention) and those service-users who do not speak English were excluded. Future studies should seek to investigate the efficacy of the CSW treatment approach for participants from people with higher risk mental health needs and from those minority populations who avoid seeking social support, before stronger recommendations can be made. Nevertheless, this study was conducted in a working, community-based NHS mental health service/trust, reflecting a 'real-life' pragmatic approach (Zwarenstein & Treweek, 2009).

There was no significant difference in WS&AS (daily impairment functioning) scores when compared at pre-to-post intervention. This may be because there were other factors outside of the scope of the group programme -such as participants' social, housing and work situations- which influenced this variable. Prins and Colleagues (2011) found that participants who engaged in treatment with higher initial depression scores, along with unemployment and lack of social support, are more likely to have moderate or severe symptoms of depression at follow-up and thus, do not change their symptomatology (Östman & Björkman, 2015). It is now common practice to invite social workers to attend the final session of the CSW 'Maintaining Wellbeing', to help those specific issues that were not addressed, enabling individuals to lead meaningful lives (Mental Health Commission, 1998).

Future research could also include a broader range of outcome measures. For example, it may be helpful to include a specific measure for people with symptoms related to personality disorders such as measures of emotional dysregulation (e.g. Difficulties in Emotion Regulation Scale -DERS; (Gratz & Roemer, 2004; Victor & Klonsky, 2016). Additional measures that include self-esteem, self-efficacy, acceptance and interpersonal relationships, and motivation (Rayner & Vitali, 2016) may also provide further, robust information.

In summary, the current study suggests that the brief, transdiagnostic, hybrid (CBT and DBT) coping skills workshop (CSW) is an effective intervention in reducing service-users' mental health symptoms. As a result, participants who completed the intervention reported significant improvements in self-reported outcome measures of depression, anxiety, and general wellbeing scores from pre-to-post intervention, compared to a waitlist control.

To build on the findings of the current study, further investigation is required to understand whether the CSW can be generalised more broadly to different populations and to see if any gains are sustained in the long-term.

REFERENCES

- Amick HR, Gartlehner G, Gaynes BN, Forneris C, Asher GN, Morgan LC, Coker-Schwimmer E, Boland E, Lux LJ, Gaylord S, Bann C, Pierl CB, & Lohr KN (2015). Comparative benefits and harms of second-generation antidepressants and cognitive behavioural therapies in initial treatment of major depressive disorder: Systematic review and meta-analysis. *British Medical Journal*, *351*. Doi: 10.1136/bmj.h6019
- Arch JJ, Eifert GH, Davies C, Vilardaga JCP, Rose RD, & Craske MG (2012). Randomized clinical trial of cognitive behavioural therapy (CBT) versus acceptance and commitment therapy (ACT) for mixed anxiety disorders. *Journal of Consulting and Clinical Psychology*, *80*, 750-765. Doi: 10.1037/a0028310.
- Cape J, Whittington C, Buszewicz M, Wallace P, & Underwood L (2010). Brief psychological therapies for anxiety and depression in primary care: Meta-analysis and meta-regression. *British Medical Journal Medicine*, *8*, 1-13. Doi: 10.1186/1741-7015-8-38
- Chiang K, Tsai JC, Liu D, Lin C, Chiu H, & Chou K (2017). Efficacy of cognitive-behavioral therapy in patients with bipolar disorder: A meta-analysis of randomized controlled trials. *PLoS ONE*, *12*. Doi: 10.1371/journal.pone.0176849
- Clark DM (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience. *International Review of Psychiatry*, *23*, 318-327. Doi: 10.3109/09540261.2011.606803
- Covin R, Ouimet AJ, Seeds PM, & Dozois DJA (2008). A meta-analysis of CBT for pathological worry among clients with GAD. *Journal of Anxiety Disorders*, *22*, 108-116. Doi: 10.1016/j.janxdis.2007.01.002
- Department of Health (2011). *Talking therapies: A four-year plan of action. A supporting document to No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, 1-28. Retrieved from <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH123759>
- Eisner L, Eddie D, Harley R, Jacobo M, Nierenberg AA, & Deckersbach T (2017). Dialectical Behaviour Therapy group skills training for bipolar disorder. *Behaviour Therapy*, *48*, 557-566. Doi: 10.1016/j.beth.2016.12.006
- Erickson DH, Janeck AS, & Tallman K (2007). A cognitive-behavioural group for patients with various anxiety disorders. *Psychiatric Services*, *58*, 1205-1211. Doi: 10.1176/appi.ps.58.9.1205
- Essock SM, Drake RE, Frank RG, & McGuire TG (2003). Randomized controlled trials in evidence-based mental health care: Getting the right answer to the right question. *Schizophrenia Bulletin*, *29*, 115-123. Doi: 10.1093/oxfordjournals.schbul.a006981
- Fletcher J, Bower PJ, Gilbody S, Lovell K, Richards D, Gask L (2009). Collaborative care for depression and anxiety problems in primary care. *Cochrane Database of Systematic Reviews*, Issue 2. Doi: 10.3399/bjgp09X454043
- Flynn D, Kells M, Joyce M, Corcoran P, Hurley J, Gillespie C, Suárez C, Swales M, & Arensman E (2020a). Multisite implementation and evaluation of 12-month standard Dialectical Behavior Therapy in a public community setting. *Journal of Personality Disorders*, *34*, 377- 393. [402]. Doi: 10.1521/pedi_2018_32_402
- Flynn D, Joyce M, Gillespie C, Kells M, Swales M, Spillane A, Hurley J, Hayes A, Gallagher E, Arensman E, Wehrauch M (2020b). Evaluating the national multisite implementation of dialectical behaviour therapy in a community setting: A mixed methods approach. *BMC Psychiatry*, *20*, 235. Doi: 10.1186/s12888-020-02610-3
- Gratz KL & Roemer L (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of Psychopathology and Behavioural Assessment*, *26*, 41-54. Doi: 10.1023/B:JOBA.0000007455.08539.94
- Hariton E & Locascio JJ (2018). Randomised controlled trials -the gold standard for effectiveness research: Study design randomized controlled trials. *BJOG: An International Journal of Obstetrics & Gynaecology*, *125*, 1716. Doi: 10.1111/1471-0528.15199
- Hofmann SG, Asnaani A, Vonk IJ, Sawyer AT, & Fang A (2012). The Efficacy of Cognitive Behavioral Therapy: A Review of Meta-analyses. *Cognitive Therapy and Research*, *36*, 427-440. Doi: 10.1007/s10608-012-9476-1
- Jerrell JM, Hu, T, & Ridgely MS (1994). Cost-effectiveness of substance abuse treatments for the SMI. *Journal of Mental Health Administration*, *21*, 281-295.

- Koons CR, Robins CJ, Tweed JL, Lynch TR, González AM, Morse JQ, Bishop GK, Butterfield NI, & Bastian LA (2001). Efficacy of dialectical behaviour therapy in women veterans with borderline personality disorder. *Behaviour Therapy, 32*, 371-390. Doi: 10.1016/S0005-7894(01)80009-5
- Kroenke K, Spitzer RL, & Williams JBW (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*, 606-613 Doi: 10.1046/j.15251497.2001.016009606.x
- Kroenke K, Spitzer RL, Williams JBW, & Löwe B (2010). The Patient Health Questionnaire Somatic, Anxiety, and Depressive Symptom Scales: a systematic review. *General Hospital Psychiatry, 32*, 345-359. Doi: 10.1016/j.genhosppsych.2010.03.006
- Landy LN, Schneider RL, & Arch JJ (2015). Acceptance and commitment therapy for the treatment of anxiety disorders: A concise review. *Current Opinion in Psychology, 2*, 70-74. Doi: 10.1016/j.copsyc.2014.11.004
- Linehan MM (1993a). *Cognitive-Behavioural Treatment of borderline personality disorder*. New York: Guilford Press.
- Linehan MM (1993b). *Skills Training Manual for treating borderline personality disorder*. New York: Guilford Press.
- Lubin H, Loris M, Burt J, & Johnson DR (1998). Efficacy of psychoeducational group therapy in reducing symptoms of posttraumatic stress disorder among multiply traumatized women. *American Journal of Psychiatry, 155*, 1172-1177. Doi: 10.1176/ajp.155.9.1172
- Marinho F & Rashed R (2015). *Coping Skills Workshop Programme*. Internal West London NHS Trust report: Unpublished.
- Marziali E & Munroe-Blum H (1994). *Interpersonal Group Psychotherapy for Borderline Personality Disorder*. New York: Basic Books.
- McCrone P, Dhanasiri S, Patel A, Knapp M, & Lawton-Smith S (2008). Paying the price: the cost of mental health care in England to 2026. *The British Journal of Psychiatry: The Journal of Mental Science, 184*, 386-392.
- McDermott W (2001). The Efficacy of Group Psychotherapy for Depression: A Meta-analysis and Review of the Empirical Research. *Clinical Psychology: Science and Practice, 8*, 98-116. Doi: 10.1093/clipsy/8.1.98
- McManus F, Shafraan R, & Cooper Z (2010). What does a 'transdiagnostic approach have to offer the treatment of anxiety disorders? *British Journal of Clinical Psychology, 49*, 491-505. Doi: 10.1348/014466509X476567
- McManus S, Meltzer H, Brugha T, Bebbington PE, & Jenkins R (2009). *Adult psychiatric morbidity in England, 2007: Results of a household survey*. Leeds: NHS Information Centre for Health and Social Care.
- Mead N, MacDonald W, Bower P, Lovell K, Richards D, Roberts C, & Bucknall A (2005). The clinical effectiveness of guided self-help versus waiting-list control in the management of anxiety and depression: A randomized controlled trial. *Psychological Medicine, 35*, 1633-1643. Doi: 10.1017/S003329170500560X
- Melnyk BM, Feinstein NF, Alpert-Gillis L, Fairbanks E, Crean, HF, Sinkin RA, Stone PW, Small L, Tu X, Gross SJ (2006). Reducing premature infants' length of stay and improving parents' mental health outcomes with the Creating Opportunities for Parent Empowerment (COPE) Neonatal Intensive Care Unit Program: A randomized, controlled trial. *Paediatrics, 118*, e1414-e1427. Doi: 10.1542/peds.2005-2580
- Mental Health Commission (1998). *Blueprint for mental health services in New Zealand: How things need to be*. Retrieved from http://www.moh.govt.nz/notebook/nbbooks.nsf/0/0E6493ACAC236A394C25678D000BE C3C/%24file/Blueprint_for_mental_health_services.pdf
- Meygoni AKM & Ahadi H (2012). Declining the Rate of Major Depression: Effectiveness of Dialectical Behaviour Therapy. *Procedia - Social and Behavioural Sciences, 35*, 230-236. Doi: 10.1016/j.sbspro.2012.02.083
- Mishna F, Kaiman J, & Little S (1994). Group therapy with adolescents who have learning disabilities and social/emotional problems. *Journal of Child & Adolescent Group Therapy, 4*, 117-131. Doi: 10.1007/BF02548484
- Mundt JC, Marks, IM, Shear MK, & Greist JH (2002). The Work and Social Adjustment Scale: A simple measure of impairment in functioning. *British Journal of Psychiatry, 180*, 461-464. Doi: 10.1192/bjp.180.5.461
- Naylor C (2020). *Mental Health and Primary Care networks: understanding the opportunities Key messages*. Retrieved from <https://www.kingsfund.org.uk/publications/mental-health-primary-care-networks>
- Neacsiu AD, Rizvi SL, & Linehan MM (2010). Dialectical behaviour therapy skills use as a mediator and outcome of treatment for borderline personality disorder. *Behaviour Research and Therapy, 48*, 832-839. Doi: 10.1016/j.brat.2010.05.017
- Neacsiu AD, Eberle JW, Kramer R, Wiesmann T, & Linehan MM (2014). Dialectical behaviour therapy skills for transdiagnostic emotion dysregulation: A pilot randomized controlled trial. *Behaviour Research and Therapy, 59*, 40-51. Doi: 10.1016/j.brat.2014.05.005
- Newbold A, Hardy G, & Byng R (2013). Staff and patient experience of improving access to psychological therapy group interventions for anxiety and depression. *Journal of Mental Health, 22*, 456-464. Doi:

10.3109/09638237.2013.815333

- Newby JM, McKinnon A, Kuyken W, Gilbody S, & Dalgleish T (2015). Systematic review and meta-analysis of transdiagnostic psychological treatments for anxiety and depressive disorders in adulthood. *Clinical Psychology Review*, *40*, 91-110. Doi: 10.1016/j.cpr.2015.06.002
- O'Shea N (2019). *A new approach to complex needs [online]*. Centre for Mental Health website. Retrieved from: www.centreformentalhealth.org.uk/new-approach-complex-needs (accessed on 19 February 2020).
- Östman M & Björkman T (2015). Psychosocial treatment interventions for people with severe mental illness in a community. *International Journal of Psychosocial Rehabilitation*, *19*, 96-105.
- Phanthunane P, Vos T, Whiteford H, & Bertram M (2011). Cost-effectiveness of pharmacological and psychosocial interventions for schizophrenia. *Cost Effectiveness and Resource Allocation*, *9*, 6-13.
- Powell J, Hamborg T, Stallard N, Burls A, McSorley J, Bennett K, Griffiths KM, & Christensen H (2013). Effectiveness of a web-based cognitive-behavioural tool to improve mental well-being in the general population: Randomized controlled trial. *Journal of Medical Internet Research*, *15*, 3-19. Doi: 10.2196/jmir.2240
- Prins MA, Verhaak PFM, Hilbink-Smolanders M, Spreeuwenberg P, Laurant MGH, van der Meer K, van Marwijk HWJ, Penninx BWJH, & Bensing JM (2011). Outcomes for depression and anxiety in primary care and details of treatment: A naturalistic longitudinal study. *BMC Psychiatry*, *11*, 180. Doi: 10.1186/1471-244X-11-180
- Proudfoot JG, Corr PJ, Guest DE, & Dunn G (2009). Cognitive-Behavioural training to change attributional style improves employee well-being, job satisfaction, productivity, and turnover. *Personality and Individual Differences*, *46*, 147-153. Doi: 10.1016/j.paid.2008.09.018
- Rayner M & Vitali D (2016). Short-Term Existential Psychotherapy in Primary Care: A Quantitative Report. *Journal of Humanistic Psychology*, *56*, 357-372. Doi: 10.1177/0022167815569884
- Reinholt N & Krogh J (2014). Efficacy of Transdiagnostic Cognitive Behaviour Therapy for Anxiety Disorders: A Systematic Review and Meta-Analysis of Published Outcome Studies. *Cognitive Behaviour Therapy*, *43*, 171-184. Doi: 10.1080/16506073.2014.897367
- Richards DA, Ekers D, McMillan D, Taylor RS, Byford S, Warren FC, Barrett B, Farrand PA, Gilbody S, Kuyken W, O'Mahen H, Watkins ER, Wright KA, Hollon SD, Reed N, Rhodes S, Fletcher E, & Finning K (2016). Cost and Outcome of Behavioural Activation versus Cognitive Behavioural Therapy for depression (COBRA): A randomised, controlled, non-inferiority trial. *Lancet*, *388*, 871-880. Doi: 10.1016/S0140-6736(16)31140-0
- Ritschel LA, Cheavens JS, & Nelson J (2012). Dialectical Behaviour Therapy in an intensive outpatient program with a mixed-diagnostic sample. *Journal of Clinical Psychology*, *68*, 221-235. Doi: 10.1002/jclp.20863.
- Rowan B & Runyan CN (2005). A primer on the consultation model of primary care behavioural health integration. In LC James & RA Folen (Eds.), *Health psychology series. The primary care consultant: The next frontier for psychologists in hospitals and clinics* (pp. 9-27). Washington DC: American Psychological Association.
- Ryan R.M & Deci EL (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology*, *52*, 141-166. Doi: 10.1146/annurev.psych.52.1.141
- Sadock E, Auerbach SM, Rybarczyk B, & Aggarwal A (2014). Evaluation of integrated psychological services in a university-based primary care clinic. *Journal of Clinical Psychology in Medical Settings*, *21*, 19-32. Doi: 10.1007/s10880-013-9378-8
- Sakiris N & Berle D (2019). A systematic review and meta-analysis of the Unified Protocol as a transdiagnostic emotion regulation-based intervention. *Clinical Psychology Review*, *72*, 101751. Doi: 10.1016/j.cpr.2019.101751
- Shepherd M, Cooper AB, Brown AC, & Kalton GW (1996): *Psychiatric Illness in General Practice*. London, UK: Oxford University Press.
- Spirito A, Esposito-Smythers C, Wolff J, & Uhl K (2011, April). Cognitive-Behavioural Therapy for Adolescent Depression and Suicidality. *Child and Adolescent Psychiatric Clinics of North America* *20*, 191-204. Doi: 10.1016/j.chc.2011.01.012
- Spitzer RL, Kroenke K, Williams JBW, & Löwe B (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, *166*, 1092-1097. Doi: 10.1001/archinte.166.10.1092
- Stepp SD, Epler AJ, Jahng S & Trull TJ (2008). The effect of dialectical behaviour therapy skills uses on borderline personality disorder features. *Journal of Personality Disorders*, *22*, 549-563. Doi: 10.1521/pedi.2008.22.6.549
- Stewart-Brown S, Tennant A, Tennant R, Platt S, Parkinson J, & Weich S (2009). Internal construct validity of the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS): A Rasch analysis using data from the Scottish Health Education Population Survey. *Health and Quality of Life Outcomes*, *7*, 1-8. Doi: 10.1186/1477-7525-7-15

- Tennant R, Hiller L, Fishwick R, Platt S, Joseph S, Weich, S, Parkinson J, Secker J, & Stewart-Brown S (2007). The Warwick-Edinburgh mental well-being scale (WEMWBS): Development and UK validation. *Health and Quality of Life Outcomes*, 5, 1-13. Doi: 10.1186/1477-7525-5-63
- Tomlinson MF (2018). A theoretical and empirical review of Dialectical Behavior Therapy within forensic psychiatric and correctional settings worldwide. *International Journal of Forensic Mental Health*, 17, 72-95. Doi: 10.1080/14999013.2017.1416003
- Tucker L, Bauer SF, Wagner S, Harlam D, & Sher I (1987). Long-term hospital treatment of borderline patients: A descriptive outcome study. *American Journal of Psychiatry*, 144, 1443-1448. Doi: 10.1176/ajp.144.11.1443
- Uliaszek AA, Hamdullahpur K, Chugani CD, & Rashid T (2018). Mechanisms of change in group therapy for treatment-seeking university students. *Behaviour Research and Therapy*, 109, 10-17. Doi: 10.1016/j.bat.2018.07.006
- Van Schaik DJF, Klijn AFJ, Van Hout HPJ, Van Marwijk HWJ, Beekman ATF, De Haan M, & Van Dyck R (2004). Patients' preferences in the treatment of depressive disorder in primary care. *General Hospital Psychiatry*, 26, 184-189. Doi: 10.1016/j.genhosppsych.2003.12.001
- Verhagen SJ, Hasmi L, Drukker M, van Os J, & Delespaul PA (2016). Use of the experience sampling method in the context of clinical trials. *Evidence-based Mental Health*, 19, 86-89. Doi: 10.1136/ebmental-2016-102418
- Victor SE & Klonsky ED (2016). Validation of a Brief Version of the Difficulties in Emotion Regulation Scale (DERS-18) in Five Samples. *Journal of Psychopathology and Behavioural Assessment*, 38, 582-589. Doi: 10.1007/s10862-016-9547-9
- Wilamowska ZA, Thompson-Hollands J, Fairholme CP, Ellard KK, Farchione TJ, & Barlow DH (2010). Conceptual background, development, and preliminary data from the unified protocol for transdiagnostic treatment of emotional disorders. *Depression and Anxiety*, 27, 882-890. Doi: 10.1002/da.20735
- WONCA (2008). What is primary care mental health? WHO and WONCA Working Party on Mental Health. *Mental Health in Family Medicine*, 5, 9-13. Doi: 10.1370/afm.1267.
- Xia J, Merinder LB, & Belgamwar MR (2011). Psychoeducation for schizophrenia. *Cochrane Database of Systematic Reviews*. Doi: 10.1002/14651858.cd002831.pub2
- Zwarenstein M & Treweek S (2009). What kind of randomized trials do patients and clinicians need? *Evidence-Based Medicine*, 14, 101-103. Doi: 10.1136/ebm.14.4.101

Received, February 19, 2022
Final Acceptance, May 10, 2022