Joint position statement on the NICE guideline for anxiety

Organisational signatories

Age UK, Caroline Abrahams, Charity Director
Association of Child Psychotherapists (ACP), Kate England, Interim Co-Chair & Director of Community Matters
Association of Christians in Counselling (ACC), Kathy Spooner, Chief Executive Officer
Association for Dance Movement Psychotherapy UK (ADMPUK), Vicky Karkou, Director of the Research Centre for Arts and Wellbeing
Association for Psychoanalytic Psychotherapy in the Public Sector (APPPS), Jeremy Clarke CBE, Chair
British Association for Counselling and Psychotherapy (BACP), Dr Phil James, Chief Executive
British Association of Arts Therapists (BAAT), Claire Louise Vaculik, Chair of the Board of Directors
British Association for Drama Therapists (BADth), Amy Mackay, Chair
British Association for Music Therapy, Andrew Langford, Chief Executive
British Psychoanalytic Council (BPC), Greg Ross-Sampson, Chief Executive
British Psychoanalytic Association (BPA), Ora Dresner, President
British Psychological Society (BPS), Roman Raczka, President
Centre for Mental Health, Andy Bell, Chief Executive
College of Mental Health Partnership (CMHP), Karen Shuker, President

College of Sexual and Relationship Therapists (COSRT), Dr. John Dodd, CEO
European Association for Psychotherapy (EAP), Cătălin Zaharia, President
Human Givens Institute (HGI), Graeme Layzell, HGI Board Member
IFS UK Research Group, Dr Richard Colley and Dr Maike Klein, Co-Directors
Institute of Health Visiting (IHV), Alison Morton, CEO
London Friend, José Veiga, Counselling Manager
Men's Minds Matter, Nigel Sanderson, Lived Experience Expert & Co-Director
MHFA England and the Association of Mental Health First Aiders, Sarah McIntosh, Chief Executive
Mental Health Matters, Jane Hughes, CEO
Mental Health UK, Brian Dow, CEO
Mind, Dr Sarah Hughes, Chief Executive
MindOut LGBTQ Mental Health Services, Peter Nesbitt, Charity Director
National Counselling and Psychotherapy Society (NCPS), Jyles Robillard-Day, Chief Executive
Psychotherapy and Counselling Union (PCU), Richard Bagnall-Oakeley, Executive Committee at PCU
Rethink Mental Illness, Mark Winstanley, CEO
Social Anxiety Alliance UK, Neil Greening, Chair
Society for Psychotherapy Research UK (SPR UK), Biljana van Rijn, UK Chapter President
Southdown, Emma McDermott, Head of Partnerships
Student Minds, Dom Smithies, Head of Influencing & Communications
The Minded Institute, Heather Mason (MA, MA, MSc, 500-YT, C-IAYT), Founder and Director
UK Association for Gestalt Practitioners (UKAGP), Ruth Nightingale, Chair
UK Association for Humanistic Psychology Practitioners (UKAHPP), Jo Molle, Chair
UK Council for Psychotherapy (UKCP), Jon Levett, Chief Executive

Individual signatories

Dr. Irena Bezić, EAP outgoing President, PhD, Lecturer, Clinical Supervisor, ECP Psychotherapist
José Castilho, EAP incoming President, MSc Psychoanalytical Psychotherapy, Lecturer, Clinical Supervisor, ECP Psychotherapist
Professor Divine Charura MBE, Professor of Counselling Psychology, York St John University
Richard Davis, Lecturer in Counselling, University of Cumbria
Ed Fellows, Senior Complex Trauma Psychotherapist, South London and Maudsley NHS Foundation Trust, UKCP Accredited
Professor Mary Hanley, Co-Director of the Centre for Neurodiversity and Development, Durham University
Professor Dr. Michael P. Hengartner, Professor of Clinical Psychology (or Research Group Leader), Kalaidos University of Applied Sciences, Zurich, Switzerland
Dr. Trish Hobman, Associate Head of Counselling, School of Education, Language and Psychology, York St John University
Patricia Hunt, EAP Past President, Chair of the Ukrainian and European Psychotherapy Alliance, Clinical Supervisor, ECP Psychotherapist

Professor Vicky Karkou, Director of the Research Centre for Arts and Wellbeing at Edge Hill University
Professor Del Loewenthal, Emeritus Professor of Psychotherapy and Counselling, University of Roehampton
Dr. Amy Pearson, Assistant Professor in Psychology, Centre for Neurodiversity and Development, Durham University
Dr Felicitas Rost, Lecturer in Psychology and Counselling at The Open University
Tom Warnecke, EAP General Secretary, Integrative Psychotherapist, Clinical Supervisor, ECP Psychotherapist
Cătălin Zaharia, EAP President, ECP Psychotherapist, Senior Psychiatrist, Health Care Manager - Biomedical Engineering

Document prepared by (and correspondence to):
Ellen Dunn, UK Council for Psychotherapy (UKCP)
Paige Wilson, UK Council for Psychotherapy (UKCP)
Email: research@ukcp.org.uk

Background

The National Institute for Health and Care Excellence (NICE) produces recommendations for care in the NHS. The NICE Guideline for Generalised Anxiety Disorder and Panic Disorder in Adults (hereafter shortened to the NICE anxiety guideline) was initially published in 2011. Only minor changes have been made since its original publication. According to the NICE website, the anxiety guideline will only be updated if there is 'new evidence that is likely to change the recommendations.' Despite surveillance reviews being periodically conducted, there has yet to be a substantive update to the anxiety guideline resulting from these reviews.

Anxiety is a significant public health issue. According to a 2023 survey by the Mental Health Foundation, 60% of UK adults have experienced anxiety that interfered with their daily lives over a two-week period.[i] In 2022-23, NHS Talking Therapies received 498,650 presenting complaints of either anxiety or stress related disorders.[ii] Of those, 253,649 were specifically presenting complaints of generalised anxiety disorder, and 35,122 were presenting with mixed anxiety and depressive disorder. The number of people experiencing and seeking treatment for common mental health conditions like anxiety have increased sharply in recent years, and NHS mental health services have struggled to keep pace to deliver timely, high-quality care to every person in need of support. There are significant resourcing issues that need to be addressed in mental healthcare that will be costly, such as increased funding, expanding the workforce, and improving in-patient care.[iii]

Ensuring that people can access appropriate and effective treatment will alleviate some of the pressures faced by services. While NHS Talking Therapies are hitting the target for people receiving their first treatment appointment within six or 18 weeks of referral, only 53% finish their course of treatment and 47% reliably recover.[iv][v] Updating the NICE guideline in line with our asks will allow services to deliver a range of effective treatments to those experiencing anxiety, facilitating their engagement and recovery. The effect of this is a reduced need for further treatment, allowing people to move faster through the system and freeing up capacity for other patients.

Improving mental health outcomes and provision will also deliver benefits for individuals, communities and society. It is estimated that mental ill health costs £300bn every year, through economic losses like unemployment and sickness absences and human costs like reduced quality of life and premature mortality.[vi] As government research shows there are over a million people who could enter the labour market if their health improved[vii], guaranteeing that everyone can access effective treatment for generalised anxiety and panic disorder will support a system where people, the NHS, and the economy can flourish.

Summary of Serious Concerns

Based on an in-depth review of the current anxiety guidelines conducted by the research team at the UK Council for Psychotherapy (UKCP), we are deeply concerned that their current state is limiting the quality and variety of care available to patients accessing care for generalised anxiety disorder and panic disorder in NHS Talking Therapies.

The primary concern is the lack of a meaningful update since the anxiety guidelines were published over a decade ago. Many strides in mental health and anxiety treatment have been made in this time, none of which have been included in the guideline. Furthermore, the evidence review used to determine the recommendations for treatment has significant methodological issues. Finally, there is a lack of patient choice, which has negative repercussions for service provision.

Based on these concerns, **a revision of the whole guideline** is necessary. This must be done following a multi-step review that allows a representative range of stakeholders to give feedback in a meaningful way, accepts a wider evidence base, and provides timely opportunities for those involved to comment on any updates before publishing. If the guideline is not updated significantly, patients seeking treatment for generalised anxiety and panic disorder will continue to experience a lack of patient choice, restricted treatment options, and services that are not designed with accessibility in mind. **We are calling for the following amendments to be made:**

1. The guideline must be brought up to the standard of the NICE depression guideline. This includes keeping the diagnostic criteria consistent, clarifying recommendations for comorbid depression and anxiety, and providing clearer guidance for clinicians.

2. Accessibility for marginalised or hard-to-reach populations needs to be properly addressed in the guideline. This includes uptake and access to services, and adaptations for cultural competence once accessing treatment.

3. Methodological issues must be rectified in an evidence review of the guideline. This includes:
    - establishing consistent criteria for establishing efficacy
    - including studies with mixed anxiety populations that better reflect the real-life presentations of anxiety
    - accurately classifying interventions
    - including a wider range of evidence when establishing efficacy, including service user perspectives, long-term research, and practice-based research
    - updating research priorities to reflect the current anxiety research landscape

4. Patient choice must be integrated into recommendations. A collaborative approach to decisions about treatments between patients and clinicians should be included. A wider range of high intensity talking therapies and other mandated professions such as Music Therapy, Art Therapy and Dramatherapy need to be recommended for patients to have a genuine choice between types of therapy.

This position statement outlines in detail below the basis for each of these required amendments.

1. The guideline must be up to the standard of the updated depression guideline

The NICE Guideline for Depression in Adults was updated in 2022 after a significant review process that involved three stakeholder consultations on updated drafts of the guideline. Key changes made to the depression guideline in 2022 include: the removal of the stepped-care model, the integration of collaborative language throughout, and the expansion of patient choice to include more talking and creative therapies available to patients.

Our primary concerns are the contradiction between the recommendations for comorbid anxiety and depression in the NICE depression and anxiety guidelines, outdated references to diagnostic criteria, and the availability of clear guidance in different formats for clinicians.

Given that depression and anxiety are the most frequent presenting complaints that NHS Talking Therapies addresses, it is vital that the guidelines complement each other. However, the anxiety guideline in comparison falls short in several key areas. Currently there is a contradiction between the guidelines between how treatment of comorbid depression and anxiety is addressed. The depression guideline recommends that, when a person has an anxiety disorder and comorbid depression, the clinician should consider treating the anxiety disorder first. However, the anxiety guideline recommends that whichever is more severe should be treated first. This discrepancy needs to be addressed urgently to provide clarity for clinicians.

Due to the outdated nature of the anxiety guideline, its sole reference to diagnostic criteria is the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-IV), which was released in 1994. There is no mention of the most recent DSM-V, released in 2013, or the other main diagnostic system International Classification of Diseases-11 (ICD-11), which is referenced in the NICE guideline for depression. The NICE depression guideline cites both the DSM-V and the ICD-11. NICE's own Clinical Knowledge Summaries reference the ICD-11 in guidance regarding generalized anxiety disorder, so it is unclear why it is omitted in the guideline itself[viii]. Therefore, both the DSM-IV and ICD-11 should be included in the document, and a study using the ICD as diagnostic criteria should not be a reason to exclude an otherwise high-quality study.

The newest version of the NICE depression guideline also provides clear, easily understandable guidance for clinicians in several different formats, including visual summaries and a decision support tool. These resources assist clinicians in making informed decisions and helps guide readers towards key aspects of the longer guideline document. In comparison, the NICE anxiety guideline does not provide any visual summaries or decision support tools for clinicians. Therefore, we are asking for NICE to include this as part of the revised anxiety guideline.

2. The guideline must address accessibility for marginalised populations

The anxiety guideline neglects to include information about access barriers for people from ethnic minority backgrounds and other hard-to-reach populations. While NICE invite people to comment on the impact of guidance on health inequalities as part of their principles and stakeholder input is invited as part of ongoing surveillance reviews, concerns are frequently dismissed. Appropriate accommodations for minoritised populations are only briefly mentioned in terms of language issues in the guideline rather than more substantive accommodations. For example, details on navigating language barriers and adapting care to be culturally competent are absent. In comparison, the

updated NICE depression guideline includes several sections detailing how to navigate language or communication difficulties, and how to improve access to services, particularly with regards to stigma or discrimination.

Patients that have the worst health outcomes are often from one or more of these groups, so it vital that the healthcare provision does not further entrench systemic patterns of health inequality[ix]. For example, Black adults receive the lowest treatment rates of any ethnic group despite experiencing higher rates of mental illness, and one in seven LGBT people have avoided mental health treatment for fear of discrimination[xxi]. Research has found that the likelihood of racially-minoritised people seeking mental health care is affected by stigma, individual understanding of mental health distress, the competence of mental health professionals, and their perception of service accessibility[xii]. A review of NHS Talking Therapies services identified the need for better understanding of interpreters and their role in providing mental health care[xiii]. As difficulties in access are similar when individuals seek support in mental health services for various conditions, **incorporating information on navigating language barriers and delivering culturally competent care is an essential aspect of any guideline that works for all service users, including those from marginalised populations[xiv].** The omission of barriers to access will therefore mean that some affected by anxiety will not have equitable access to care, impacting their quality of life and chance of recovery. This demonstrates why it is essential that the anxiety guideline is updated to be consistent with other NICE guidelines that reflect barriers to treatment, ensuring adequate provision for similar groups to those highlighted in the depression guidelines, such as specific ethnic minority communities, people who are homeless, or asylum seekers[xv].

3. The guideline evidence review must rectify methodological issues

This coalition of stakeholders is calling for a full revision of the anxiety guideline, including an updated evidence review that addresses the following serious methodological issues. The following methodological issues are deviations from common scientific practice.

Over the course of the past twelve years, there have been significant developments in mental health research, including pertaining to the treatment of generalised anxiety disorder, co-morbid anxiety and depression, and panic disorder. It is therefore highly concerning that NICE, upon conducting several surveillance reviews, has not meaningfully integrated any new research into their guidelines**. A combination of restrictive criteria on the type of study population, how efficacy is defined, how interventions are classified, and the narrow types of studies that are considered, has led to over a decade's worth of mental health research being excluded from consideration.**

At present, NICE frequently excludes studies that are conducted in mixed populations, where both anxiety and depressive symptoms are present. However, the actual presentation of anxiety frequently accompanies depression, and indeed NHS Talking Therapies reported over 35,122 primary presentations of comorbid anxiety and depression disorder in 2022-23. Excluding high-quality studies that have mixed populations is not reflective of the real-life presentation of anxiety, which frequently presents alongside depressive symptoms[xvi].

Furthermore, the exclusion of mixed populations is not consistent across surveillance reviews. In 2015, NICE excluded a high-quality Cochrane review[xvii] on the effectiveness of psychodynamic psychotherapy in treating anxiety. However, in a 2020 surveillance review[xviii], all new CBT studies under consideration were from mixed populations. It is an essential principle of scientific integrity that reasons for exclusion are applied consistently.

The current classification of interventions is also of concern. Several types of therapy are grouped as CBT, which oversimplifies the evidence base and obscures the effectiveness of other distinct approaches. Of most concern is metacognitive therapy being labelled as CBT, which is not consistent with the wider research literature[xix]. This misclassification was highlighted to NICE by a stakeholder in a 2015 surveillance review. In their response, NICE described this concern as "not a priority area" and declined to update the guideline.

Furthermore, criteria for determining the efficacy of different treatments are inconsistent across interventions. Much of the evidence review is based on comparative studies, which compare results between two or more interventions. Routinely, when findings indicate a no statistically significant difference in outcomes between the two recommended interventions (CBT and applied relaxation), this is considered as evidence *in favour* of CBT or applied relaxation. However, when studies comparing interventions that are not currently recommended find no statistically significant difference in outcomes between two types of other therapies, this is considered as evidence *against* the other therapies.

For example, in a study comparing relaxation therapy and CBT, parity of outcomes between the two is deemed sufficient to conclude efficacy.

> "Limited evidence suggests there is no difference between relaxation therapy and CBT for people with GAD or panic disorder, but that CBT is superior when effectiveness is based on pooled effects estimates from mixed anxiety disorder populations." (2020 Surveillance review, appendix A: abstract review)

Despite there being little difference in outcomes between relaxation therapy and CBT, applied relaxation is one of the primary recommended interventions. This is in contrast to a

study comparing psychodynamic therapy with anxiety management training and non-directive therapy. While studies also found little statistical difference in outcomes, this was used as a rationale to exclude psychodynamic therapy instead.

> "The limited evidence shows no statistically significant difference between psychodynamic therapy and an active comparison (anxiety management training). The limited High-intensity psychological interventions evidence did not show statistically significant differences in relative effectiveness between psychodynamic therapy and non-directive therapies. Therefore, no recommendations for psychodynamic therapy in the treatment of GAD can be made.' Full Clinical Guideline CG113 (7.9.3)

This is despite NICE's own inclusion of a randomised controlled trial (RCT) study that found overall similar outcomes for the primary outcome measure between psychodynamic therapy and CBT.

> "Both CBT and short-term psychodynamic psychotherapy yielded significant, large, and stable improvements with regard to symptoms of anxiety and depression. No significant differences in outcome were found between treatments in regard to the primary outcome measure.[xx]"

Interventions must be treated consistently with regards to what qualifies as evidence in favour of efficacy. At present, this is not the case, and the bias towards already recommended interventions needs to be adequately addressed in any further evidence review.

The evidence review is over-reliant on only one type of scientific method, and neglects to include other high-quality evidence in different methodologies and study designs. As recognised by NICE[xxi] and the Cochrane Collaboration[xxii], good practice for developing guidelines includes drawing on a variety of evidence types, including qualitative, case study, practice-based, and cohort studies. It is also essential that service-user perspectives, expert testimony, and clinical judgment are taken into account when developing the guideline. At present, while there are occasional instances in which an expert testimony or service-user perspective is included, their experiences do not meaningfully contribute to formation of the guideline. For example, when one topic expert provided feedback that older people and people from different ethnic minority backgrounds found IAPT services unacceptable or difficult to access, NICE responded that "no evidence was found that suggested IAPT services were unacceptable or difficult to access for BAME groups or older people."[xxiii]

Long-term research following up on outcomes after a trial has ended has been neglected, which discounts treatments that are effective over a longer period. Many types of therapy aim to elicit psychological improvement over a longer time frame, and excluding long-term studies thereby discounts the true effectiveness of these interventions. Understanding how the current recommended treatments of CBT and applied relaxation impact patients long-term is also essential to ensuring that these interventions are effective beyond a limited period of time.

Including long-term research is also a vital aspect of parity of esteem between NICE physical and mental health guidelines. NICE guidelines for long-term physical conditions such as epilepsy and asthma examine treatment outcome data over 1-10 years. Thus, the evaluation of treatments for anxiety must meet the same standards as guidelines for long term physical conditions.

Finally, the research priorities detailed in the anxiety guideline are out of step with the current field of mental health research. For example, the guidelines' fourth recommendation, suggests further research on chamomile and gingko, instead of the societal determinants of health or long-term, large-scale research into different types of talking therapies, which is increasingly focus of current mental health research.

4. The guideline must provide a genuine choice of talking therapies

The anxiety guideline lacks the collaborative approach to treatment recognised in the depression guideline. The depression guideline contains guidance for clinicians about discussing with patients their prior experiences with anxiety, previous treatment options patients found helpful, what factors they think are contributing to their anxiety, and what they hope to gain from treatment. Including this collaborative approach in the anxiety guideline is an essential part of ensuring that there is parity between the anxiety and depression guidelines. As acknowledged by NICE[xxiv] and the larger research community, shared decision making is an essential aspect of providing high-quality support for patients[xxv].

Additionally, as recognised by NICE in the guideline for depression, and across the mental health field, patient choice is vital[xxvi]. Allowing patients a choice between therapy types has been shown to lead to better outcomes for those seeking mental health support from the NHS[xxvii,xxviii]. This essential principle of care needs to be integrated into future versions of the anxiety guideline.

Instead, the current version of the anxiety guideline is highly limiting for patient choice of therapy. Low-intensity or step two non-pharmaceutical interventions are required to be

based on CBT treatment principles. This effectively limits the low intensity therapies to a CBT-based model of treatment only. High-intensity or step three interventions only offer two talking therapies, CBT and applied relaxation.

The focus on CBT is significantly limiting not only the patient's ability to choose between different options of treatment but also restricts the number of treatment options clinicians are able to offer. Additionally, both the high-intensity therapy treatments are categorised as symptom-focused or problem-oriented therapies[xxix,xxx]. Providing other therapies is essential, to allow those with anxiety from a more complex underlying cause, such as childhood-based trauma, to access the support they need.

Other talking and creative therapies besides CBT and applied relaxation have been shown to be effective in treating anxiety[xxxi,xxxii,xxxiii,xxxiv,xxxv,xxxvi,xxxvii].Addressing the methodological issues in the evidence review, as discussed above, will allow for the consideration high-quality evidence on other therapies and their inclusion in a revised guideline.

Conclusion

Without adequately addressing the above concerns with the anxiety guideline, we are concerned that the quality of NHS mental health support provision for anxiety will be negatively affected. Because of the impact NICE guidelines have on UK and international policy, it is of the utmost importance that the issues with this guideline in its current form are addressed. We urge NICE to conduct a comprehensive review of the guidelines that addresses the problems outlined above and allows for meaningful stakeholder feedback throughout the guideline development process.

[i] Mental Health Foundation. (2023). *Mental Health Awareness Week Mental Health Awareness Week*. https://www.mentalhealth.org.uk/sites/default/files/2023-05/MHF-UK-Uncertain-times-Anxiety-in-the-UK-and-how-to-tackle-it-MHAW-2023-report.pdf

[ii] NHS. (2024, January 16). *NHS Talking Therapies, for anxiety and depression, Annual reports, 2022-23*. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/nhs-talking-therapies-for-anxiety-and-depression-annual-reports/2022-23

[iii] British Medical Association. (2025, December). *Mental health pressures in England*. [Online] Available at: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/mental-health-pressures-data-analysis [Last accessed 16.12.2025].

[iv] NHS England. (2025). *NHS mental health dashboard Q1 2025/26*. [Online] Available at https://www.england.nhs.uk/publication/nhs-mental-health-dashboard/#heading-1 [Last accessed 16.12.2025].

[v] NHS England. (2025). *NHS Talking Therapies for anxiety and depression, Annual report*. [Online] Available at Microsoft Power BI [Last accessed 16.12.2025].

[vi] Centre for Mental Health. (2024). *The economic and social costs of mental ill health*. [Online] Available at https://www.centreformentalhealth.org.uk/publications/the-economic-and-social-costs-of-mental-ill-health/ [Last accessed 16.12.2025].

[vii] Department for Work and Pensions and Government Social Research. (2025) *Work aspirations and support needs of health and disability customers*. [Online] Available at Work aspirations and support needs of health and disability customers: Interim findings - GOV.UK [Last accessed 16.12.2025].

[viii] NICE. (2023, February). *When Should I Suspect Generalized Anxiety Disorder?* NICE. https://cks.nice.org.uk/topics/generalized-anxiety-disorder/diagnosis/diagnosis/

[ix] Office for Health Improvement and Disparities. (2022). *Health disparities and health inequalities: applying All Our Health*. [Online] Accessible at Health disparities and health inequalities: applying All Our Health [Last accessed 31.07.2025].

[x] Bansal, N., Karlsen, S., Sashidharan, S, P., Cohen, R., Chew-Graham, C, A., and Malpass, A. (2022). Understanding ethnic inequalities in mental healthcare in the UK: A meta-ethnography. *PLoS Medicine*. 19(12). https://doi.org/10.1371/journal.pmed.1004139.

[xi] Stonewall. (2018). *LGBT in Britain – Health (2018*). [Online] Available at https://www.stonewall.org.uk/resources/lgbt-britain-health-2018 [Last accessed 31.07.2025].

[xii] Alam, S., O'Halloran, S., & Fowke, A. (2024). What are the barriers to mental health support for racially-minoritised people within the UK? A systematic review and thematic synthesis. *the Cognitive Behaviour Therapist*, *17*, e10.

[xiii] *Ethnic Inequalities in Improving Access to Psychological Therapies (IAPT) Full report Prepared by the NCCMH on behalf of the NHS Race and Health Observatory*. (2023). https://www.nhsrho.org/wp-content/uploads/2023/10/Ethnic-Inequalities-in-Improving-Access-to-Psychological-Therapies-IAPT.Full-report.pdf.

[xiv] Carrier, J. D., Gallagher, F., Vanasse, A., and Roberge, P. (2022). Strategies to improve access to cognitive behavioral therapies for anxiety disorders: A scoping review. *PloS One*. 17(3). e0264368. https://doi.org/10.1371/journal.pone.0264368.

[xv] Bristow, K., Edwards, S., Funnel, E., Fisher, L., Gask, L., Dowrick, C., and Chew Graham, C. (2011). Help Seeking and Access to Primary Care for People from "Hard-to-Reach" Groups with Common Mental Health Problems. *International Journal of Family Medicine*. 2011. 490634. https://doi.org/10.1155/2011/490634.

[xvi] Kalin, N. H. (2020). The critical relationship between anxiety and depression. *American Journal of Psychiatry*, *177*(5), 365-367.

[xvii] Abbass, A. A., Kisely, S. R., Town, J. M., Leichsenring, F., Driessen, E., De Maat, S., Gerber, A., Dekker, J., Rabung, S., Rusalovska, S., & Crowe, E. (2014). Short-term psychodynamic psychotherapies for common mental disorders. *The Cochrane database of systematic reviews*, *2014*(7), CD004687. https://doi.org/10.1002/14651858.CD004687.pub4

[xviii] *Appendix A, Surveillance of generalised anxiety disorder and panic disorder in adults (NICE guideline CG113)*. 2020. https://www.nice.org.uk/guidance/CG113/documents/surveillance-review-proposal

[xix] Callesen, P., Reeves, D., Heal, C., & Wells, A. (2020). Metacognitive therapy versus cognitive behaviour therapy in adults with major depression: a parallel single-blind randomised trial. *Scientific reports*, *10*(1), 7878.

[xx] Leichsenring D Sc, F., Salzer, S., Jaeger, U., Kächele, H., Kreische, R., Leweke, F., ... & Leibing D Sc, E. (2009). Short-term psychodynamic psychotherapy and cognitive-behavioral therapy in generalized anxiety disorder: a randomized, controlled trial. *American Journal of Psychiatry*, *166*(8), 875-881.

[xxi] *3 Evidence | NICE health technology evaluations: the manual | Guidance | NICE*. (2022, January 31). Www.nice.org.uk. https://www.nice.org.uk/process/pmg36/chapter/evidence-2

[xxii] Noyes, J., Popay, J., Pearson, A., Hannes, K. & Booth, A. (2011). Qualitative research and Cochrane Reviews. In J. Higgins & S. Green (Eds.), *Cochrane Handbook for Systematic Reviews of Interventions (version 5.1.0)* (chapter 20). The Cochrane Collaboration.

[xxiii] *2019 surveillance of generalised anxiety disorder and panic disorder in adults (NICE guideline CG113)*. (n.d.). https://www.nice.org.uk/guidance/CG113/documents/surveillance-review-proposal

[xxiv] NICE. (2023). *Shared Decision Making*. National Institute for Health and Care Excellence; NICE. https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making

[xxv] NHS England. (2019). *NHS England: Shared decision making*. Www.england.nhs.uk. https://www.england.nhs.uk/personalisedcare/shared-decision-making/

[xxvi] *Depression in Adults - Patient Choice Evidence Review* (2022). National Institute for Health and Care Excellence https://www.nice.org.uk/guidance/ng222/evidence/i-patient-choice-pdf-400716158868

[xxvii] Devilly, J., and Borkovec, T (2000) Psychometric properties of the credibility/ expectancy questionnaire

[xxviii] Davidson, L., Roe, D., Stern, E., Zisman-Ilani, Y., O'Connell, M., & Corrigan, P. (2012). If I choose it, am I more likely to use it?. *International Journal of Person Centered Medicine*, *2*(3), 577-592.

[xxix] Institute for Quality and Efficiency in Health Care. (2022, June 2). *Cognitive Behavioral Therapy*. National Library of Medicine. https://www.ncbi.nlm.nih.gov/books/NBK279297/

[xxx] Hayes-Skelton, S. A., Roemer, L., Orsillo, S. M., & Borkovec, T. D. (2013). A Contemporary View of Applied Relaxation for Generalized Anxiety Disorder. *Cognitive Behaviour Therapy*, *42*(4), 292–302. https://doi.org/10.1080/16506073.2013.777106

[xxxi] Cuijpers P, Sijbrandij M, Koole SL, Andersson G, Beekman AT and Reynolds III CF (2013). The efficacy of psychotherapy and pharmacotherapy in treating depressive and anxiety disorders: A meta-analysis of direct comparisons. *World psychiatry*, *12*(2), 137-148.

[xxxii] Barkowski S, Schwartze D, Strauss B, Burlingame GM and Rosendahl J (2020). Efficacy of group psychotherapy for anxiety disorders: A systematic review and meta-analysis. *Psychotherapy Research*, *30*(8), 965-982.

[xxxiii] Bressi C, Porcellana M, Marinaccio PM, Nocito EP and Magri L (2010). Short-term psychodynamic psychotherapy versus treatment as usual for depressive and anxiety disorders: a randomized clinical trial of efficacy. *The Journal of nervous and mental disease*, *198*(9), 647-652.

[xxxiv] Milrod B, Leon AC, Busch F, Rudden M, Schwalberg M, et al (2007). A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder. *American Journal of Psychiatry*, *164*(2), 265-272.

[xxxv] Wright D and Abrahams D (2015). An investigation into the effectiveness of Dynamic Interpersonal Therapy (DIT) as a treatment for depression and anxiety in IAPT. *Psychoanalytic Psychotherapy*, *29*(2), 160-170.

[xxxvi] de Witte M, Aalbers S, Vink A, Friederichs S, Knapen A, Pelgrim T, Lampit A, Baker F A, van Hooren S (2025). Music therapy for the treatment of anxiety: a systematic review with multilevel meta-analyses. *eClinicalMedicine*, 84.

[xxxvii] Bradt J, Dileo C, Myers-Coffman K, Biondo J (2021). Music interventions for improving psychological and physical outcomes in people with cancer. *The Cochrane Database of Systematic Reviews,* 10(10).