Additional file 1

Supplementary section 1. Baseline characteristics

Table S1. Characteristics of participants at baseline, by randomised care model.

Characteristic	PCBH (n = 36)	PCBH+GSH (n = 39)	Total (N = 75)
Data availability			
Background questionnaire missing	3 (8.3%)	2 (5.1%)	5 (6.7%)
Gender			
Men	17 (51.5%)	18 (48.6%)	35 (50.0%)
Women	16 (48.5%)	19 (51.4%)	35 (50.0%)
Age, years			
Mean (SD)	38.6 (14.9)	35.0 (12.2)	36.7 (13.5)
Range	18-71	19-69	18-71
Relationship status			
Married/cohabiting/in a stable relationship	22 (66.7%)	23 (62.2%)	45 (64.3%)
Divorced or widowed	3 (9.1%)	3 (8.1%)	6 (8.6%)
Single	6 (18.2%)	8 (21.6%)	14 (20.0%)
Other	2 (6.1%)	3 (8.1%)	5 (7.1%)
Highest education			
Compulsory school	1 (3.0%)	1 (2.7%)	2 (2.9%)
Upper secondary or adult education	11 (33.3%)	10 (27.0%)	21 (30.0%)
College/university	19 (57.6%)	26 (70.3%)	45 (64.3%)
Other	2 (6.1%)	0 (0.0%)	2 (2.9%)
Employment status (multiple responses)			
Employed/self-employed/studying	29 (87.9%)	33 (89.2%)	62 (88.6%)
On sick leave/disability pension	1 (3.0%)	2 (5.4%)	3 (4.3%)
Jobseeking	0 (0.0%)	3 (8.1%)	3 (4.3%)
Retired/early retirement	3 (9.1%)	1 (2.7%)	4 (5.7%)
Homemaker	0 (0.0%)	0 (0.0%)	0 (0.0%)

Characteristic	PCBH (n = 36)	PCBH+GSH (n = 39)	Total (N = 75)
Parental leave	0 (0.0%)	2 (5.4%)	2 (2.9%)
Other	1 (3.0%)	1 (2.7%)	2 (2.9%)
Current work/study level			
0%	4 (12.1%)	3 (8.1%)	7 (10.0%)
25%	0 (0.0%)	0 (0.0%)	0 (0.0%)
50%	0 (0.0%)	3 (8.1%)	3 (4.3%)
75%	2 (6.1%)	2 (5.4%)	4 (5.7%)
100%	27 (81.8%)	29 (78.4%)	56 (80.0%)
Self-rated economic situation			
Very bad or bad	2 (6.1%)	3 (8.1%)	5 (7.1%)
Neither good nor bad	7 (21.2%)	8 (21.6%)	15 (21.4%)
Good or very good	24 (72.7%)	26 (70.3%)	50 (71.4%)

Values are n (%) unless otherwise indicated. Percentages for baseline characteristics use participants with available background-question data: PCBH, n = 33; PCBH+GSH, n = 37; total, n = 70. The missing-data row uses all randomised participants as its denominator. Participants could select more than one employment status, so those percentages do not sum to 100%. Age is presented as mean (SD) and range. PCBH = Primary Care Behavioral Health; GSH = guided self-help.

Supplementary section 2. Algorithm to support the clinicians' assessment.

An algorithm, previously used in two studies (1,2) but modified for the purpose of this study, was used to assist clinicians in their assessments. The purpose was to help guide treatment decisions by offering insights into which problem areas could be most significant for the patient and if there were any contraindications to initiate structured treatment with GSH.

In addition to the questionnaires detailed under Measures, BASS4 was used to collect the patient's responses to vignettes containing concise descriptions of each problem area targeted by GSH in the study. Two vignettes also cover descriptions used to disqualify patients from GSH treatment: life problems and distress due to medical conditions. Patients were asked to rate their level of recognition within each problem area (A) and the importance of addressing each area (B). The clinician was then instructed to add 15 points to the vignette problem rated as most important and 10 points to the second most important. Subsequently, the rating for each vignette's question A was multiplied by question B, resulting in a score between 0–16 for each problem area. Moreover, scoring above the cut-off on a given symptom-specific questionnaire (see Supplementary Section 6 and Table S4) added 10 points for the respective problem area, while scoring below the cut-off yielded 0 points. The cut-offs for each scale were set by the research group specifically for the purpose of the algorithm, which is to inform the clinician about possible treatment themes rather than to provide a diagnosis.

Scores normally ranged from 0 to 41. The theoretical maximum was 51 when the same problem area was selected as both most and second-most important. Although there is no formal cut-off score, a higher score suggests a higher likelihood of the patient experiencing a particular problem. High scores on the domains of life problems and distress due to medical conditions were seen to indicate that GSH was not the most suitable option, especially if none of the GSH problem areas reached comparable levels. The AUDIT-C and pain scores as well as the patient's stated reason for seeking help were interpreted separately to alert clinicians to potential issues that could affect the suitability of GSH as a treatment option, even if one or more problem areas received high points in the algorithm.

Supplementary section 3. Retrospective classification of GSH suitability in the PCBH arm.

To identify patients that were randomised to the contextual assessment but might have been suitable for GSH if that had been an option, a retrospective assessment model has been developed. This model is based on the assessment procedure for clinicians in the study, with the crucial distinction that only questionnaire data inform the categorisation. This includes data from the automated algorithm described above, as well as information provided in the CRF that could be assumed to be presented at the patient's first visit. To compensate for the lack of information provided face-to-face by the patient and the absence of questionnaires measuring the burden of life problems or somatic illness, 10 points were added to the life problems and medical distress domains if the patient scored 12 or higher on those. This cutoff was chosen as it would indicate that the patient rated these vignettes as highly relatable and important to work with. The retrospective assessment involved four steps:

1. Patients clearly unsuitable for GSH were identified based on their stated reasons for seeking help and the clinicians' notes in the CRF. Patients deemed unsuitable for GSH were excluded from the analysis group.

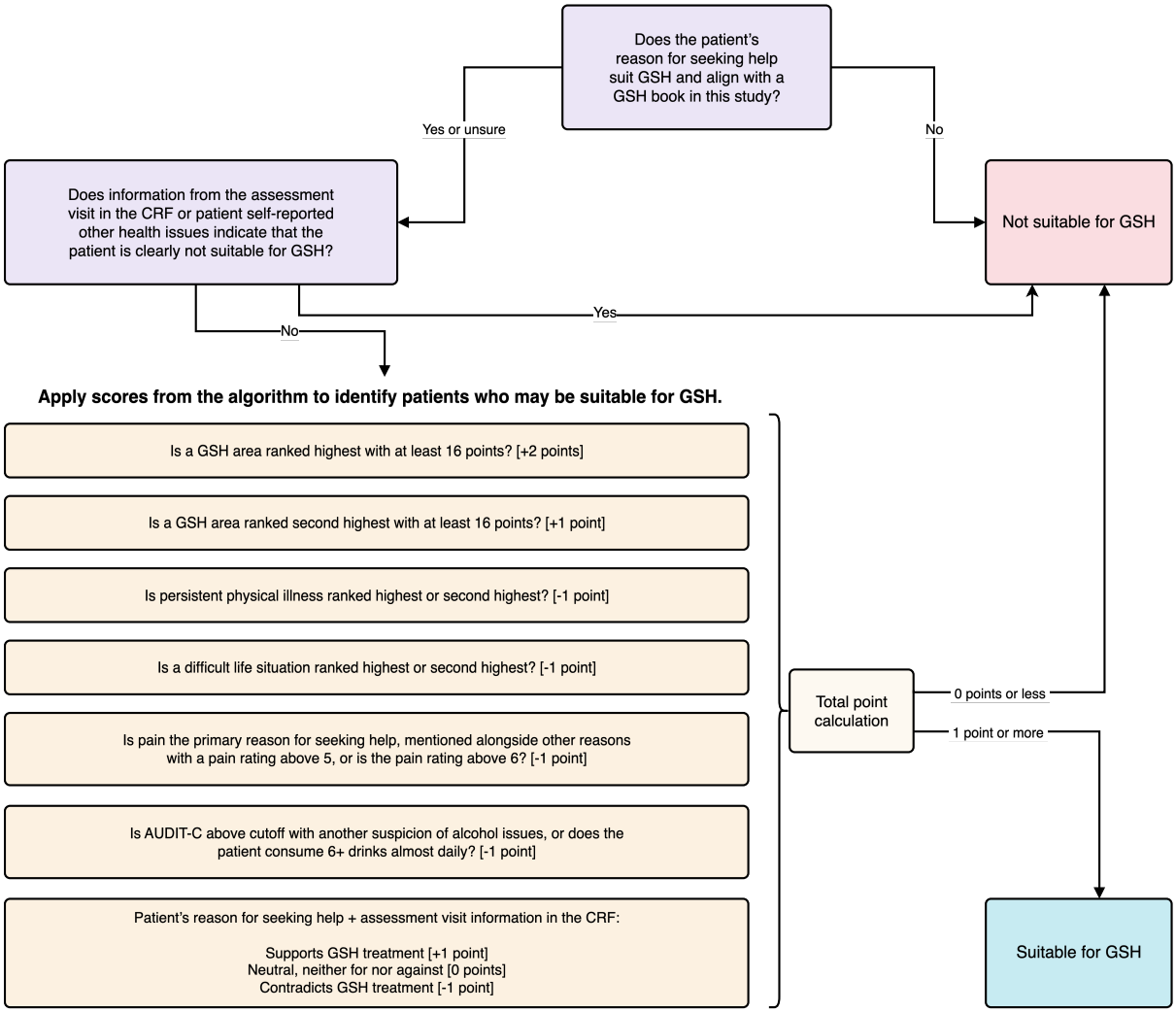
   This step was operationalised using both a strict and a more permissive classification. To give an example, in the permissive condition a participant stating that they are "feeling down" after a difficult divorce would be rated as suitable for GSH, as behavioural activation is presumed to be effective regardless of the cause of the depressive symptoms. However, under the strict condition, the same example would be considered unsuitable due to the presumption that the participant would have too much of a need to process their divorce with the therapist. The strict classification was used to define the GSH-suitable BI subgroup in the primary preliminary-effect analysis as it performed better (see Table S2).

2. Patients potentially suitable for GSH were evaluated using specific scoring criteria, incorporating results from the automated algorithm, AUDIT-C scores, and the 1-item pain scale. Points were added for high scores in GSH-relevant problem areas, while deductions were made for high scores in non-relevant domains or indications of substance abuse or pain that may interfere with treatment. Those deemed unsuitable were excluded from the analysis group.

Table S2. Overview of performance of the strict vs. permissive rules for retrospective suitability assessment.

Classification	Suitable in PCBH	Agreement in PCBH+GSH	False positives	False negatives
Strict	17/36 (47%)	23/36 (64%)	9/36 (25%)	4/36 (11%)
Permissive	26/36 (72%)	21/36 (58%)	12/36 (33%)	3/36 (8%)

Fig. S1. Overview of how algorithm data informed the retrospective categorisation of suitable and unsuitable for GSH.



Supplementary section 4. Vignettes used in the screening algorithm.

The following vignettes, translated from Swedish, were used in the screening algorithm.

Depression

“Most of us feel down from time to time. Sometimes, this feeling becomes deeper and more persistent, which we often label as depression. The reasons for feeling down or depressed vary widely and manifest differently from person to person. Life changes, such as losing significant people or activities that once brought us joy, often trigger feelings of sadness. It’s also common to feel down due to other issues like sleep problems, anxiety, pain, or difficult life circumstances.

When feeling depressed, it’s typical to lose interest in activities we used to enjoy. Things that once brought pleasure may no longer evoke positive feelings. We may find ourselves caught in repetitive thoughts and rumination about problems. Self-doubt, guilt, and negative thoughts about life are common. Thoughts about death and the meaninglessness of life may also surface. Despite thinking a lot, clarity of thought diminishes, and attention and energy levels decline. Decision-making becomes challenging, and it’s hard to find motivation for tasks we know we should do. Feeling physically drained and becoming passive are also common experiences.”

Worry and anxiety

“It’s normal to feel anxious before important events or when faced with challenging situations in life. Anxiety can help us anticipate and prepare for different scenarios. But for some, anxiety takes up too much space in daily life. Constant worry, often stronger than justified, can revolve around work, family, health, or fear of something bad happening. Worries can shift depending on life circumstances. Instead of helping us cope, anxiety becomes a persistent discomfort and limitation. It can feel challenging to control and drains both time and energy. Relationships may suffer, especially if we frequently seek reassurance from loved ones about our worries. Despite awareness of excessive worrying, it can be difficult to stop.

Feeling down or overly sensitive is common when perceiving life as problematic or threatening. Stress may persist even when life’s actual demands are manageable. Anxiety can also lead to sleep problems and physical symptoms such as muscle tension and pain.”

Panic attacks and panic disorder

“Experiencing a panic attack involves suddenly and inexplicably feeling intense physical and emotional discomfort. The anxiety response is similar whether triggered by a specific fear like spiders or social situations, but panic disorder refers to when these feelings arise unexpectedly and without a clear cause. With panic disorder, there’s also a fear of the physical sensations themselves, often leading to concerns about dying, fainting, or losing control. Sometimes, the fear of having another panic attack can itself trigger one.

Typical physical symptoms include rapid heartbeat, difficulty breathing, chest pressure, dizziness, and trembling, alongside other uncommon and unpleasant bodily sensations. During a panic attack, there is a profound sense of fear and overwhelming discomfort.

It's common for those who've experienced panic attacks to begin avoiding places or situations associated with them. This often includes public transport, enclosed spaces, or being alone. Many individuals also develop safety habits such as drinking water, taking medication, or ensuring they're always with someone else. These avoidance behaviours can significantly impact daily life, sometimes severely limiting what individuals feel capable of doing."

Social anxiety

"For those experiencing social anxiety, being the centre of attention entails profound discomfort. There's often a fear of potentially embarrassing oneself or being scrutinised by others. It's common to feel like all eyes are on you in social settings, which makes it challenging to stay present.

When experiencing this discomfort, the body also reacts. Blushing, sweating, dry mouth, dizziness, and difficulty concentrating are typical responses. Stuttering and trembling can easily occur. Sometimes, there's a fear of specific reactions such as stuttering, shaking hands, blushing, or experiencing a mental block.

Some devise their own strategies for managing social situations. They may participate in social gatherings but find them immensely stressful. Those affected by social anxiety may also begin to limit themselves in both personal and professional realms due to the overwhelming discomfort or perceived difficulty in handling it. This often occurs despite genuinely desiring more involvement in various social contexts. Feeling restricted in this way often leads to feeling sad or down as well."

Stress-related problems

"Experiencing stress means perceiving something as a potential threat, triggering our fight-or-flight response. Our attention sharpens, and our body prepares for physical exertion. While stress can be helpful in short bursts, ongoing intense stress beyond the usual challenges of life can be detrimental to our well-being. Common triggers for stress reactions include trying to manage too many responsibilities simultaneously or feeling overwhelmed by demands at home or work. Stressful situations where we feel powerless, have insufficient time, or lack a structured daily routine also contribute.

It's common to fall into negative cycles where we prioritise tasks over self-care (such as leisure, maintaining relationships, rest, and sleep) to stay productive, or to dwell on stressors. This can lead to both physical and mental fatigue. Persistent body tension, headaches, and stomach aches are common symptoms, and maintaining concentration and making decisions becomes challenging. If someone experiences multiple stressors over an extended period without adequate recovery and suffers from poor sleep, they may develop severe symptoms and feel completely exhausted."

Sleep problems

“Experiencing sleep problems means consistently having difficulty sleeping for an extended period. Sometimes, these issues have clear causes like high stress, children waking during the night, or working shifts. However, sleep problems can also persist without an obvious reason. In such cases, it’s particularly important to address sleep specifically.

The most common sleep problems involve either not getting enough sleep or having sleep patterns that don’t align with desired times or duration. It can mean taking a long time to fall asleep, waking frequently during the night, or waking up too early.

After prolonged periods of sleep disturbance, daily functioning is often impaired. Concentration becomes challenging, irritability increases, and one may feel more emotionally detached. Sleep and mental well-being influence each other; other mental health issues often worsen sleep quality, while inadequate sleep can further impair overall well-being.”

Illness anxiety

“Occasionally worrying about one’s health is common. Illness anxiety, also known as hypochondria, involves an excessive fear of having or developing a serious illness like cancer, heart disease, MS, or other severe conditions. This fear persists over time and significantly impacts quality of life. Anxiety may be triggered, for example, by reading about diseases or noticing new sensations in the body. It’s common to experience symptoms that are associated with the feared illness.

Many people with illness anxiety seek medical attention much more frequently than others. However, some may instead avoid anything related to illness, such as medical facilities, and may not seek care even when necessary. Relationships with close family members can also be affected negatively, especially if seeking their support during times of heightened anxiety. Long-term illness anxiety can lead to increasing frustration and often feelings of sadness. If fear of illness recurs frequently, it can interfere with daily activities and gradually lead to greater passivity.”

Obsessive compulsive disorder

“Obsessive-compulsive disorder (OCD) consists of both obsessions and compulsions.

Obsessions are recurring, unwanted thoughts that persistently intrude. Common themes include fear of contamination or dirtiness, harming others, something terrible happening, or something else that is deeply distressing to the individual. Obsessions are often followed by compulsions, which are actions taken to reduce the discomfort caused by the obsessions.

Sometimes, compulsions are directly linked to the obsession, such as excessive washing due to a fear of contamination, or repeatedly checking the stove out of fear it might cause a fire at home. In other cases, the compulsion may not have an obvious connection, like excessive arranging or organising to alleviate anxiety from the obsessions. Compulsions can also involve attempts to suppress or control the obsessions, often revolving around feelings of having done something wrong or being somehow abnormal.

OCD causes significant distress as individuals can become trapped in prolonged cycles of obsessions and compulsions throughout each day. Many people start avoiding situations that trigger their obsessions, which can greatly limit their daily lives and activities."

Persistent physical illness

"Long-term physical ailments can include conditions such as diabetes, asthma, cardiovascular issues, gastrointestinal disorders like ulcerative colitis and Crohn's disease. It also encompasses neurological conditions such as MS, Parkinson's disease, or complications post-stroke, as well as diseases like cancer. Chronic pain conditions, whether with or without a clear cause, fall into this category, along with conditions like tinnitus or IBS (irritable bowel syndrome).

Living with these conditions over time profoundly impacts daily life. It often leads to limitations in independent living, increased reliance on others for assistance, and reduced ability to work as before, which can lead to social isolation. Engaging in meaningful activities becomes more challenging, significantly affecting overall quality of life. In daily routines, thoughts and attention frequently revolve around managing symptoms rather than focusing on positive aspects of life."

A difficult life situation

"Sometimes, people seek help because their life situation has become too challenging. Overwhelming problems may include a significant responsibility for children or other family members needing care without any possibility of respite. Other examples are financial difficulties, loneliness and lack of social support network, or issues and dissatisfaction within family or love life. It can also involve significant workplace problems, such as work overload, poor working conditions, or conflicts at work. The presence of threats and violence in close relationships or having relatives with substance abuse problems are other common reasons why the life situation feels unmanageable. It is not uncommon for several different problems to contribute to making the overall life situation difficult to manage."

Supplementary section 5. GSH materials.

All texts used in this study have been used in prior studies, either as GSH or standalone text treatments delivered online. All of these treatments are available in print in Swedish, with the exception of the GSH texts on depression and generalised anxiety. For these, texts from previously evaluated internet-based treatments were printed in book form. In the early stages of the study, an evidence-based self-help book on managing relationship problems was initially included to broaden the relevance of GSH. However, ethical concerns arose regarding the assessment of potential contraindications, such as intimate partner violence, when the patients' partners were not present. As such, it was removed before any patients were assigned this form of GSH.

Table S3. Overview of GSH texts and treatment strategies.

Problem area	GSH text	Evaluated in	Main treatment components
Depression	Self-printed, based on internet-based treatment	Hedman et al. (3)	Values-based behavioural activation
Generalised anxiety disorder	Self-printed, a reworked version of Wadström (4) previously used in an internet-based treatment	Andersson et al. (5)	Exposure-based strategies to extinguish worry
Illness anxiety disorder	Hedman et al. (6)	Axelsson et al. (7), Salomonsson et al. (8)	Exposure to illness anxiety-provoking stimuli, mindfulness
Social phobia	Furmark et al. (9)	Hedman et al. (10), Salomonsson et al. (8)	Cognitive restructuring, behavioural experiments
Panic disorder	Carlbring & Hanell (11)	Hedman et al. (12), Salomonsson et al. (8)	Cognitive restructuring, interoceptive and in vivo exposure, breathing retraining
Obsessive-compulsive disorder	Asplund & Rosengren (13)	Salomonsson et al. (8)	Exposure with response prevention
Adjustment and exhaustion disorder	Kompetenscentrum psykisk ohälsa, Gustavsbergs vårdcentral, Region Stockholm (14)	Lindsäter et al. (15), Salomonsson et al. (8)	Increasing recovery, behavioural activation, values identification, exposure
Insomnia	Jernelöv (16)	Kaldo et al. (17), Salomonsson et al. (8)	Stimulus control, sleep restriction

Supplementary section 6. Self-report questionnaires and cut-offs.

Abbreviated patient-rated scales were used to assess symptoms of common mental health disorders: PHQ-4 (18) for depression and anxiety symptoms, PDSS-SR-2 (19) for panic disorder, Mini-SPIN (20) for social anxiety disorder, ISI-2 (21) for insomnia and AUDIT-C (22) for alcohol consumption. For OCD, stress, exhaustion disorder, illness anxiety disorder, and pain, factor analytic item-reduction and sensitivity-to-change analyses from previous trials identified 2-3 key items from the PSS-4, SMBQ, OCI-R, and SHAI (23–26). Pain was assessed using a 10-point Likert scale. Due to the small sample size in this pilot trial, a general symptom index was calculated from all items.

Table S4. Overview of self-report questionnaires, including minimum and maximum scores and cut-off points.

Self-report questionnaires	Min-max	Cut-off
AUDIT-C (The Alcohol Use Disorders Identification Test-Concise)	0–12	3/4[1]
BBQ (Brunnsviken Brief Quality of Life Questionnaire)	0–96	N/A
CSQ-4 (items 2, 5, 7, and 8 from the Client Satisfaction Questionnaire, CSQ-8)	4–16	N/A
GAD-2 (Generalized Anxiety Disorder 2-item)	0–6	2
General symptom index (Calculated from all symptom scales)	0–1	N/A
ISI-2 (Insomnia Severity Index 2-item)	0–8	4
Mini-SPIN (Social Phobia Inventory – Abbreviated Version)	0–12	5
OCI-R-3 (Obsessive Compulsive Inventory – Revised, 3-item)	0–12	2
Pain (One-item rating from 0 to 10)	0–10	N/A
PCBH satisfaction 9-item	0–45	N/A
PDSS-SR-2 (Panic Disorder Severity Scale 2-item)	0–8	2
PHQ-2 (Patient Health Questionnaire 2-item)	0–6	2
PSS-2 (Perceived Stress Scale 2-item)	0–8	5
SHAI-3 (Short Health Anxiety Inventory 3-item)	0–9	3
SMBQ-2 (Shirom-Melamed Burnout Questionnaire 2-item)	0–12	8
WHODAS-12 (WHO Disability Assessment Schedule 2.0)	0–48	N/A
WHODAS-8 (WHO Disability Assessment Schedule 2.0, Psychosocial factor)	0–32	N/A

Note. Cut-offs set specifically for the purpose of the algorithm.

[1] The cut-off is set to 4 for men and 3 for women.

Supplementary section 7. Calculation of the general symptom index.

The general symptom index was calculated from all symptom scales measuring symptoms that were targeted by guided self-help (GSH) treatments. AUDIT-C and the pain scale were excluded from this index, as substance abuse and pain were not targeted by the GSH treatments. Each scale score was normalised to a value between 0 and 1 by dividing it by the maximum score on the respective scale. The general symptom index was determined by calculating the average of all the normalised symptom scales at each measurement point. As there were two symptom scales measuring similar constructs of stress and exhaustion, an average score was calculated from these.

Supplementary section 8. Satisfaction and adverse events questions.

8.1 PCC satisfaction questions.

Each item is rated 0-5 on the scale [Never true, Very rarely true, Sometimes true, Often true, Almost always true, Always true].

1. I feel that my problems are taken seriously at my primary care centre.
2. I feel that the people providing my care genuinely care about me.
3. During visits, the person I meet shows an interest in my life situation and how I am doing.
4. The people providing my care suggest ways to help me.
5. My primary care centre has the resources needed to give me the help I need.
6. The care I receive is gradually helping me improve.
7. I know what I can do to help those providing my care help me.
8. The people providing my care and I share the same understanding of my condition.
9. I would recommend the care I receive to other patients with similar problems.

8.2 Adverse events, 3-item version.

“The following questions are asked to determine if the care, treatment, or wait for care or treatment you received has led to any unwanted events or effects. The purpose here is to find out if the treatment you received has caused any short- or long-term side effects, or if you have deteriorated or experienced other unwanted effects while waiting for treatment. You can describe as many unwanted events or effects as you wish in free text.

1. During the course of your treatment, have you experienced any unwanted events or effects that you believe are due to the treatment? Or, while waiting for treatment, have you experienced any unwanted effects or deterioration? [Yes, No]

2. Describe the unwanted events or effects. Also indicate when during the treatment or waiting period these events/effects occurred, how often they occurred, and how long each event/effect lasted. [Free text]

3. How negatively do you believe these unwanted events or effects impacted your well-being when they occurred? [Did not affect me at all, Affected me slightly negatively, Affected me moderately negatively, Affected me very negatively]”

8.3 Adverse events, 9-item version.

“The following questions are asked to find out if the care, treatment, or waiting for care or treatment you have received has led to any adverse events or effects. The aim here is to determine if the treatment you received can cause any short- or long-term side effects, or if you have worsened or experienced other adverse effects while waiting for treatment. You have the opportunity to provide detailed information on two adverse events or effects. If you

have experienced more than two adverse events or effects, describe the two that have had the greatest negative impact on your well-being and use the lines at the bottom to describe other adverse events and adverse effects.

1. During the course of treatment, have you experienced any adverse events that you believe are due to the treatment or received any adverse effects from the treatment? Or have you experienced any adverse effects or deterioration while waiting for treatment? [Yes, No]
2. Describe the adverse event or adverse effect. Also specify when during the treatment/waiting period these events/effects occurred, how often they occurred, and how long each event/effect lasted. [Free text]
3. How negatively do you believe these adverse events or adverse effects affected your well-being when they occurred? [Did not affect me at all, Affected me slightly negatively, Affected me moderately negatively, Affected me very negatively]
4. How related do you perceive the adverse event to be to the treatment you received or the fact that you were waiting for treatment? [Unrelated, Probably unrelated, Possibly related, Probably related, Related]
5. During the course of treatment, have you experienced any additional adverse events that you believe are due to the treatment/waiting period or received any adverse effects from the treatment/waiting period? [Yes, No]
6. Describe the adverse event or adverse effect. Also specify when during the treatment/waiting period these events/effects occurred, how often they occurred, and how long each event/effect lasted. [Free text]
7. How negatively do you believe these adverse events or adverse effects affected your well-being when they occurred? [Did not affect me at all, Affected me slightly negatively, Affected me moderately negatively, Affected me very negatively]
8. How related do you perceive the adverse event to be to the treatment you received? [Unrelated, Probably unrelated, Possibly related, Probably related, Related]
9. If during the course of treatment or waiting period you have experienced any additional adverse events that you believe are due to the treatment or received any adverse effects from the treatment or waiting period, describe them here. Specify when these events/effects occurred, how often they occurred, how long each event/effect lasted, how negatively they affected your well-being then, and how negatively they affect your well-being now. [Free text]”

Supplementary references

1. Hallgren M, Kraepelien M, Öjehagen A, Lindefors N, Zeebari Z, Kaldo V, et al. Physical exercise and internet-based cognitive-behavioural therapy in the treatment of depression: randomised controlled trial. Br J Psychiatry J Ment Sci. 2015 Sep;207(3):227–34. doi:10.1192/bjp.bp.114.160101 PubMed PMID: 26089305.

2. Kraepelien M, Blom K, Lindefors N, Johansson R, Kaldo V. The effects of component-specific treatment compliance in individually tailored internet-based treatment. Clin Psychol Psychother. 2019;26(3):298–308. doi:10.1002/cpp.2351 PubMed PMID: 30650232; PubMed Central PMCID: PMC6635903.

3. Hedman E, Ljótsson B, Kaldo V, Hesser H, El Alaoui S, Kraepelien M, et al. Effectiveness of Internet-based cognitive behaviour therapy for depression in routine psychiatric care. J Affect Disord. 2014 Feb;155:49–58. doi:10.1016/j.jad.2013.10.023 PubMed PMID: 24238951.

4. Wadström O. Sluta älta och grubbla : lättare gjort med kognitiv beteendeterapi (KBT) : en bok om hur oro och ältande fungerar och hur man kan komma tillrätta med det. [Linköping]: Psykologinsats; 2017.

5. Andersson E, Hedman E, Wadström O, Boberg J, Andersson EY, Axelsson E, et al. Internet-Based Extinction Therapy for Worry: A Randomized Controlled Trial. Behav Ther. 2017 May;48(3):391–402. doi:10.1016/j.beth.2016.07.003

6. Hedman E. Tänk om jag är sjuk! : fri från hälsoångest med kognitiv beteendeterapi. Stockholm: Natur & kultur; 2016.

7. Axelsson E, Andersson E, Ljótsson B, Björkander D, Hedman-Lagerlöf M, Hedman-Lagerlöf E. Effect of Internet vs Face-to-Face Cognitive Behavior Therapy for Health Anxiety: A Randomized Noninferiority Clinical Trial. JAMA Psychiatry. 2020 Sep 1;77(9):915–24. doi:10.1001/jamapsychiatry.2020.0940 PubMed PMID: 32401286; PubMed Central PMCID: PMC7221860.

8. Salomonsson S, Santoft F, Lindsäter E, Ejeby K, Ljótsson B, Öst LG, et al. Stepped care in primary care – guided self-help and face-to-face cognitive behavioural therapy for common mental disorders: a randomized controlled trial. Psychol Med. 2018 Jul;48(10):1644–54. doi:10.1017/S0033291717003129

9. Furmark T, Holmström A, Sparthan E, Carlbring P, Andersson G. Social fobi - social ångest : effektiv hjälp med KBT. Stockholm: Liber; 2019.

10. Hedman E, Andersson G, Ljótsson B, Andersson E, Rück C, Mörtberg E, et al. Internet-based cognitive behavior therapy vs. cognitive behavioral group therapy for social anxiety disorder: a randomized controlled non-inferiority trial. PloS One. 2011 Mar 25;6(3):e18001. doi:10.1371/journal.pone.0018001 PubMed PMID: 21483704; PubMed Central PMCID: PMC3070741.

11. Carlbring P, Hanell Å. Ingen panik : fri från panik- och ångestattacker i 10 steg med kognitiv beteendeterapi. Stockholm: Natur & Kultur; 2018.

12. Hedman E, Ljótsson B, Rück C, Bergström J, Andersson G, Kaldo V, et al. Effectiveness of internet-based cognitive behaviour therapy for panic disorder in routine psychiatric care. Acta Psychiatr Scand. 2013 Dec;128(6):457–67. doi:10.1111/acps.12079 PubMed PMID: 23406572.

13. Asplund M, Rosengren EL. Fri från tvång : steg för steg med kognitiv beteendeterapi : [en självhjälpsbok]. Stockholm: Natur & kultur; 2012.

14. Kognitiv beteendeterapi för stress- och utmattningsproblematik: En självhjälpsbehandling. Stockholm: Kompetenscentrum psykisk ohälsa, Gustavsbergs vårdcentral, Region Stockholm; 2019.

15. Lindsäter E, Axelsson E, Salomonsson S, Santoft F, Ejeby K, Ljótsson B, et al. Internet-Based Cognitive Behavioral Therapy for Chronic Stress: A Randomized Controlled Trial. Psychother Psychosom. 2018;87(5):296–305.

16. Jernelöv S. Sov gott! : råd och tekniker från KBT. Stockholm: Wahlström & Widstrand; 2008.

17. Kaldo V, Jernelöv S, Blom K, Ljótsson B, Brodin M, Jörgensen M, et al. Guided internet cognitive behavioral therapy for insomnia compared to a control treatment - A randomized trial. Behav Res Ther. 2015 Aug;71:90–100. doi:10.1016/j.brat.2015.06.001 PubMed PMID: 26091917.

18. Kroenke K, Spitzer RL, Williams JBW, Löwe B. An ultra-brief screening scale for anxiety and depression: the PHQ-4. Psychosomatics. 2009;50(6):613–21. doi:10.1176/appi.psy.50.6.613 PubMed PMID: 19996233.

19. Forsell E, Kraepelien M, Blom K, Isacsson N, Jernelöv S, Svanborg C, et al. Development of a very brief scale for detecting and measuring panic disorder using two items from the Panic Disorder Severity Scale-Self Report. J Affect Disord. 2019 Oct 1;257:615–22. doi:10.1016/j.jad.2019.07.057

20. Connor KM, Kobak KA, Churchill LE, Katzelnick D, Davidson JR. Mini-SPIN: A brief screening assessment for generalized social anxiety disorder. Depress Anxiety. 2001;14(2):137–40. doi:10.1002/da.1055 PubMed PMID: 11668666.

21. Kraepelien M, Blom K, Forsell E, Hentati Isacsson N, Bjurner P, Morin CM, et al. A very brief self-report scale for measuring insomnia severity using two items from the Insomnia Severity Index - development and validation in a clinical population. Sleep Med. 2021 May 1;81:365–74. doi:10.1016/j.sleep.2021.03.003

22. Bush K, Kivlahan DR, McDonell MB, Fihn SD, Bradley KA. The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. Ambulatory Care Quality Improvement Project (ACQUIP). Alcohol Use Disorders Identification Test. Arch Intern Med. 1998 Sep 14;158(16):1789–95. doi:10.1001/archinte.158.16.1789 PubMed PMID: 9738608.

23. Warttig SL, Forshaw MJ, South J, White AK. New, normative, English-sample data for the Short Form Perceived Stress Scale (PSS-4). J Health Psychol. 2013 Dec 1;18(12):1617–28. doi:10.1177/1359105313508346

24. Lundgren-Nilsson Å, Jonsdottir IH, Pallant J, Ahlborg G. Internal construct validity of the Shirom-Melamed Burnout Questionnaire (SMBQ). BMC Public Health. 2012 Jan 3;12:1. doi:10.1186/1471-2458-12-1 PubMed PMID: 22214479; PubMed Central PMCID: PMC3307433.

25. Österman S, Axelsson E, Lindefors N, Hedman-Lagerlöf E, Hedman-Lagerlöf M, Kern D, et al. The 14-item short health anxiety inventory (SHAI-14) used as a screening tool: appropriate interpretation and diagnostic accuracy of the Swedish version. BMC Psychiatry. 2022 Nov 14;22(1):701. doi:10.1186/s12888-022-04367-3

26. Foa EB, Huppert JD, Leiberg S, Langner R, Kichic R, Hajcak G, et al. The Obsessive-Compulsive Inventory: development and validation of a short version. Psychol Assess. 2002 Dec;14(4):485–96. PubMed PMID: 12501574.