Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology

June 2017

Doctoral Thesis:

The mechanisms of psychological therapy with people with long-term physical health conditions

Joanna Cheng

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Word Count Statement

Thesis Section	Text	Tables, figures, references and appendices	Total
Abstract	286	0	286
Literature Review	7,976	16,296	24,272
Research Paper	7,959	8,279	16,238
Critical Appraisal	3,718	936	4,654
Ethics Section	5,912	2,708	8,620
Totals	**25,851**	**28,219**	**54,070**

Abstract

This thesis comprises a literature review, a research paper and a critical appraisal of the research process.

Qualitative literature was systematically reviewed using a meta-ethnography, with the aim of understanding how people with long-term physical health conditions (LTCs) experience psychological therapies. Thirteen articles were identified. Six themes emerged from the synthesis: i) 'therapists' expertise and empathic approach led to positive relationships'; ii) 'therapy was a safe and neutral space'; iii) 'therapy prompted change in LTC management'; iv) 'psychological awareness reduced isolation and increased control'; v) how physical ill health interacts with being able to participate in therapy'; and vi) 'time-limited therapy did not always match service users' illness trajectory'. The findings were discussed in relation to the values of psychological therapy for people with LTCs and the current way services are delivered to people experiencing co-morbid mental health difficulties.

The research paper comprised a qualitative study using a Discursive Action Model approach, which aimed to develop an understanding of how practitioners and service users construct resources and preferred futures within solution-focused therapy sessions. Eight participant dyads were recruited, formed by pairs of practitioners and service users. Data were collected via audio recordings. Four discourses were highlighted: i) 'practitioners' use of assumptions drew out resources'; ii) 'explicit commentaries construct change'; iii) 'de-contextualising for goal construction'; and iv) 'removing the blame, effort and failure'. The results highlighted the discursive mechanisms which enabled construction of resources and

goals. The trans-theoretical applicability of the discourses, clinical implications and recommendations for future research were discussed.

The critical appraisal discusses the importance of discourse in clinical psychology practice. The drivers behind conducting this thesis, strengths and weaknesses of the study, and lastly reflections on future practice in clinical psychology were offered.

Declaration

This thesis records the work undertaken for the Doctorate in Clinical Psychology at Lancaster University's Division of Health Research. The work presented here is the author's own, except where due reference is made. The work has not been submitted for the award of a degree elsewhere. The authors have no competing interests to report.

Name: Joanna Cheng

Signature:

Date:

Acknowledgements

Contents

Section Two: Research Paper

Section Three: Critical Appraisal

Section One: Literature Review

The experiences of psychological therapy with people with long-term health conditions

Joanna Cheng

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Correspondence should be addressed to:

Joanna Cheng

Department of Clinical Psychology,

Faculty of Health and Medicine,

C16 Furness Building,

Lancaster University,

Lancaster,

Lancashire, United Kingdom

LA1 4YG

E-mail: j.cheng1@lancaster.ac.uk

Tel: +44 1524 592970

Prepared for submission to *Journal of Psychosomatic Research*[1]

---

[1] Please note this manuscript is prepared in line with the author guidance for *Journal of Psychosomatic Research* (see Appendix 1-C), therefore the SAGE Vancouver referencing style will be adhered to. However, the Lancaster University word limit will be followed instead of the journal's word limit.

Abstract

Objective: Mental health difficulties are often experienced by people living with long-term physical health conditions (LTCs). As the drive to improve psychological outcomes for this population increases, research into the effectiveness of psychological interventions becomes more important. This meta-ethnography aims to understand how people with LTCs experience psychological therapy.

Methods: Studies that focused on participants' experiences of therapies were selected. Thirteen articles were identified from systematic searches of seven academic journal databases. Studies were rated by quality to determine their strengths and weaknesses, then synthesised to look for emerging themes.

Results: Six themes within three higher-order concepts emerged from the synthesis. The therapeutic process was a safe and neutral space where participants began a journey of self-evaluation. As a result of therapy, participants gained increased psychological awareness and were able to address their negative views of self, which supported them to manage their LTC differently. However, this population continues to face barriers to engaging fully in therapy.

Conclusion: Psychological interventions are extremely valuable to people living with LTCs. As there is no dominant service model in the UK for how psychological services are delivered, the current evidence base and services would benefit from further research into service user experiences, including experiences of a range of therapy models.

Introduction

The prevalence of mental health in long-term physical health conditions

Over the past decade there has been an increased academic and clinical focus on the co-morbidity of mental health difficulties in people living with long-term health conditions (LTCs). According to the Mental Health Network of The NHS Confederation[1], LTCs are defined as health conditions that currently cannot be cured, for example heart conditions, diabetes, pulmonary diseases and cancer.[2] LTCs can sometimes be controlled by medication, however these conditions are often degenerative and life-limiting.[3]

The latest published report from the Department of Health (DOH)[3] estimated that over 15 million people in England are living with a LTC, and an estimated 30% of this population may also have co-morbid mental health difficulties.[4] Australia has described this issue as their "biggest health challenge" (p.1)[5] due to seven million of their population living with at least one LTC. In the United States of America (USA), 25% of adults have multiple chronic conditions.[6] In addition, the American Psychological Association reports that mental health difficulties, such as depression and anxiety, are higher in people with LTCs in comparison to the general population.[7] Worldwide, an average of 9.3-23% of people with LTCs, across 60 countries, report co-morbid depression.[8] There is a marked decrease in quality of life for people with LTCs[9], and experiences of depression and/or anxiety has been documented as both a cause and consequence of physical ill health.[10]

The importance of psychological wellbeing

Psychological wellbeing is an important factor for people with LTCs. Living with a LTC with co-morbid mental health difficulties can increase the risk to a person's emotional

and physical wellbeing, such as higher rate of unemployment and mortality.[1] People with co-morbid LTCs and mental health difficulties are also more likely to develop further chronic diseases.[5] LTCs are complex by nature due to many different factors, including the impact on the individual's lifestyle and the requirement of changing one's coping style.[11] As people have to adjust to a new lifestyle dictated by their condition, the increased stress can lead to the development or exacerbation of mental health difficulties. People with LTCs are also living with the fact that a full recovery is impossible; hopelessness can undermine their ability to cope with difficulties[12] and may reduce their motivation to stabilise the condition.[13] In a research study carried out by Dignity in Dying[14], it was found that out of 760 suicides in Britain, approximately 300 people who ended their lives were also terminally ill. Moreover, the experience of mental health difficulties played a significant role in people with suicide ideation.[15]

Barriers to accessing mental health services

The associations between emotional and physical wellbeing are suggested in literature and in practice (e.g.[16]). Alongside pharmacological treatment, The National Institute for Health and Care Excellence (NICE)[17] recommends the use of psychological interventions for people with LTCs and explicitly calls for health professionals to "establish disease burden by talking to people about how their health problems affect their day-to-day life" (p.10). In spite of this, it is estimated that the vast majority of people with LTCs are not receiving mental health support. For example, Macmillan reported that 60% of people with cancer who experience depression do not receive any support for depression[18], and 85% of people with diabetes do not have access to psychological services.[19] Two factors which are associated with poor uptake of mental health services in people with LTCs are: i) the stigma of having a

mental health difficulty, ii) the limited resources and/or training in general physical health services to provide psychological care.

The negative image of having a LTC affects individuals externally and internally; relationships can change as a result of the increased need for practical support[20] and stigma can be internalised which leads to lower self-worth and poorer self-management.[21] Acquiring particular LTCs can create specific feelings of self-blame. For example, as chronic obstructive pulmonary disease (COPD) is primarily caused by tobacco smoking, individuals often experience feelings of disgrace and marginalisation from their personal networks and from society, due to the stigmatisation of COPD as a self-inflicted condition.[22] People facing LTCs may be treated differently and sometimes negatively; they may face discrimination due to the LTC, and they may feel stigmatised by society, which can lead to experiences of shame and reluctance in seeking help.[23] The second factor that may prevent people with LTCs from accessing mental health support is differing service approaches to managing co-morbid LTCs and mental health difficulties. Psychological support is rarely addressed as part of routine medical care[24] despite service users reporting interest in accessing mental health support.[25] People with LTCs and psychological needs may find that the latter go unmet due to difficulties in care co-ordination, perceived stigmatisation, and limited psychological awareness in general medicine.[26]

The current evidence base

There are numerous studies investigating the effects of psychological therapy for people with specific LTCs. The utility of cognitive behavioural therapy (CBT) has been widely researched across a range of health conditions, including cancer (e.g.[27,28]), diabetes (e.g.[29]) and COPD (e.g.[30]). Furthermore, mindfulness-based interventions for chronic pain

(e.g.[31]), and acceptance-commitment therapy for heart disease (e.g.[32]) both have an established evidence base. There are also a number of systematic literature reviews that have focused on questions relating to specific health conditions, such as the experiences of psychosocial interventions for colorectal cancer (e.g.[33]), the benefits of mindfulness-based interventions following stroke and transient ischemic attack (e.g.[34]), and the perceived value of mind-body practices for people living with human immunodeficiency virus (HIV; e.g.[35]). There continues to be a dearth of research on other therapeutic modalities, such as the experiences of receiving solution-focused brief therapy (SFBT) for LTCs. Despite being recommended by NICE guidance for treatment of some LTCs[36], SFBT and other therapies have not yet been researched in a way which promotes recommendations as a therapeutic modality.

While there is a large amount of quantitative research evidence relating to psychological outcomes in by people with LTCs (e.g.[37,38]), a number of systematic reviews have also highlighted that the existing evidence is relatively weak. For example, in a review of randomised controlled trials (RCTs) of chronic spinal pain, when physical and psychological interventions were combined, small effect sizes were observed[39], which suggests that although the findings were statistically significant, the success of the interventions were marginal. There are other drawbacks to quantitative data, such as the lack of narrative experiences behind service users' responses and the lack of rich and detailed information from participants.[40]

The psychological experiences of living with a LTC are arguably similar across different health conditions, regardless of people's individual cultures and social backgrounds. Qualitative research suggests that people living with a health condition experience common

themes around hopelessness, a breakdown of familial relationships and increased suicidal thoughts.[41,42] Therefore, it cannot be ignored that there are commonalities in the psychological experiences of people living with LTCs, regardless of the health condition. To date there is no published research on how people with a range of LTCs experience psychological therapies. Understanding how living with a LTC can impact on individuals' psychological wellbeing may mean that those with rare conditions, or where there is a lack of research into a specific condition, are still represented in the evidence base.

In order to improve both the psychological and physical health outcomes for people with LTCs, it is essential to understand their personal experiences, views and attitudes towards psychological interventions. A qualitative meta-ethnography can provide further and alternative insights into service users' experiences through a rigorous collation and synthesis process.[43] Metasyntheses are regarded by the National Health and Medical Research Council[44] as the highest level of evidence; the use of these reviews could describe the current progress, identify inconsistencies and gaps in the evidence case. This form of evidence collates a range of interview responses from participants and therefore presents a stronger case to make recommendations for future service developments and research.[45] Using qualitative research to understand service users' views about psychological interventions can lead to identification of what truly matters to service users, which can inform the understanding of healthcare quality and can drive service improvement.[46]

The current meta-ethnography

This meta-ethnography aims to develop an understanding of how people with LTCs experience psychological interventions. Rather than focusing on a specific health condition, this study will include all LTCs in order to capture a range of experiences to develop an

understanding on commonalities or differences. Therefore, this study will be the first of its

kind; the findings will contribute to the understanding of how service users' perceive the role

of psychology in the management of physical healthcare, including any positive or negative

views, and if psychological support has led to any change. By providing evidence of the

impact experienced by service users, it may contribute to service developments in both

mental health and medical health services, and will help inform health professionals of the

needs of this population.

Method

Searching for studies

Seven databases were searched to identify potential articles to be reviewed. The search for articles was divided into two stages, to ensure that articles were reviewed systematically. In consultation with the Academic Supervisor and support from a specialist librarian, in the first stage (see Appendix 1-A) all databases were searched using MeSH, subject, permuted or thesaurus terms, with the exception of Web of Science where users may only use free text search. The search strategy was formed based on the SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) tool[47], a search strategy tool which allows the sensitivity of search terms to be adjusted to maximise the retrieval of relevant articles. The terms "psychological therapy", "chronic illness" and "qualitative research" were entered into the search individually to be mapped onto MeSH or thesaurus terms. Once thesaurus terms were selected, a Boolean search of all terms were combined to produce the search results.

The second stage (see Appendix 1-B) involved searching all the databases again, this time using a free text search. This was completed to check whether articles were excluded due to not being mapped to thesaurus terms in the hosting database. For example, "qualitative research" was added to the MEDLINE thesaurus of index terms in 2003[48], therefore qualitative articles prior to this date may have been missed during the stage one search.

Inclusion and exclusion criteria

Articles were selected for review based on the following inclusion criteria: i) articles published in English, due to lack of translation resources; ii) articles published in peer-

reviewed journals, for quality assurance; iii) research which studied the experiences of psychological therapies; iv) research which used qualitative methods and analyses; v) the analysis to be derived from first person accounts from adults with a LTC.

Articles were excluded if they focused on: i) psychological therapies which involved minimal therapist involvement, such as self-help/self-management programmes, peer support groups and computerised cognitive behavioural therapy interventions; ii) research where the purpose of the therapy was not to alleviate distress, for example feasibility studies and studies where the research aim focused solely on compliance with other interventions; iii) research where all participants received group therapy instead of individual therapy; iv) research where psychological therapy was not the main focus, such as studies into art combined with narrative therapy; v) research which did not use an inductive data-driven approach. To illustrate, Zeligman and Barden's study[50] explored the use of narrative therapy for individuals with HIV, but this article was excluded as they provided a descriptive case example rather than synthesising and analysing participants' experiences. As this meta-ethnography is the first attempt to review the current topic, it was important to ensure that a complete representation of the literature was presented.

Study selection

A hand search of the references from articles to be included in the review identified no further studies meeting the inclusion or exclusion criteria. Additionally, systematic reviews identified from the initial search were also checked and no additional studies meeting the criteria were found. Moher et al. 's[49] flow diagram was adapted to show the search strategy (see Figure 1).

FIGURE 1 HERE

The titles and abstracts, where available, were read for all search results. The inclusion and exclusion criteria were used to remove or retain articles. Where this was unclear, full-text articles were obtained and read to fully assess eligibility for review.

Characteristics of the selected studies

Thirteen articles were identified which met the eligibility criteria for review. All were published between 2001-2016. Table 1 outlines a summary of the articles included. The articles described research which involved participants from the USA, United Kingdom (UK), Canada, Australia, Denmark and Sweden. Eleven studies used one-to-one interviews with participants, and two studies used focus group approaches. Analysis methods were varied: five studies used thematic analysis[51–55], including one study that combined this with grounded theory principles[56]; two studies used a grounded theory informed analysis[57,58]; one study used Interpretative Phenomenological Analysis[59]; one used qualitative content analysis; one used narrative analysis[60]; and two studies did not note the specific analysis method.[61,62] Sample size ranged from 10-30. The age ranged from 18-85, although three studies did not report a range.[55,59,63] Mean and median ages were not calculated as one study[57] did not report a mean and no studies reported a median. Participants were recruited from hospitals, outpatient care, specialist health clinics and psychological services. All participants had a diagnosis of a LTC.

TABLE 1 HERE

Dennison et al.'s[52] study explored the experiences of service users, who were assigned to either CBT or supportive listening. As this meta-ethnography aims to understand the experiences of psychological therapy, only the findings which related to participants who received CBT were analysed. Berg et al.'s[61] study examined service users' perspectives on CBT and medical adherence, therefore only the findings related to distress rather than compliance were analysed. In Gerskowitch et al.'s[53] study, participants received either low-intensity guided self-help, participation in a mindfulness-based stress reduction (MBSR) group or 1:1 high-intensity cognitive behavioural therapy. Articles that used group therapy would be excluded from this meta-ethnography, therefore only the low-intensity guided self-help and 1:1 high-intensity cognitive behavioural therapy experiences were analysed.

Quality assurance

The Critical Appraisal Skills Programme (CASP)[64] was used to assess the strengths and weaknesses of the selected articles. The use of CASP[64] allows researchers to critically consider the quality and interpretive strength of articles. As there is no established guidance around sufficient quality of qualitative research, however, this evaluation tool was not used to exclude articles based on scores.[65] Instead the author used the CASP[64] framework to develop an understanding of the relative strengths and weaknesses of each article, which informed how much or little it may contribute to the interpretations. Using the CASP[64] as a tool where the author can critically consider the research findings in context rather than as part of an exclusion process also fits into the author's social constructionist stance where contexts are formed through the process of ongoing interaction, and that these contexts should not be judged by objective means.[66,67]

The initial two screening items on the CASP[64] ensure that the study aims were conveyed and an appropriate qualitative methodology was employed; all articles met the screening criteria. A four-point rating scale developed by Duggleby et al.[68] served as a framework to rate the further eight questions, where a maximum score of 24 could be awarded. The points given at evaluation are as follows: 0 points = no report on a particular issue; 1 point = weak justification for a particular issue; 2 points = issue addressed but provided no elaboration; 3 points = the particular issue was extensively justified and explained. Table 2 shows the CASP[64] scores, which will be used to weigh up the data in accordance with each criterion.

TABLE 2 HERE

Analysis and synthesis of studies

Noblit and Hare's[43] stepped guidance was used to frame the data extraction and synthesis process. This approach allows researchers to thoroughly synthesise a collection of studies by interpreting participants' experiences, comparison of accounts across studies and developing higher-order themes and concepts, while maintaining the integrity of the original studies. As this approach is widely recognised as the established method for conducting meta-ethnographies[69], it was used to meet the aim of this study. The reporting standard of this meta-ethnography is framed by The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) and PRISMA Explanation and Elaboration[49] guidelines.

There are many epistemological stances that can inform approaches to conducting systematic reviews[70]; this meta-ethnography was approached from a social constructionist perspective. Social constructionism represents the idea that an individual's accounts and

experiences are formed by their contexts, such as social, cultural and socio-economical contexts.[71] As the study aims to understand how people with LTCs individually experience psychological therapy, the author developed themes and concepts based on the synthesis of participants' accounts.

Noblit and Hare's[43] guidance begins with identifying the research (step one) and searching for literature (step two), which were outlined above.

Step three - first reading of articles. The original articles were read with attention paid to identifying initial themes that were relevant to the current research question. Accompanying quotations and contextual issues were collated with summaries of the data. Articles were read in chronological order according to publication date, in order to minimise potential bias or influence from the author.[43] Table 3 outlines the data drawn from original articles for further synthesising.

Step four - decide how the studies are related to each other. With the initial themes in mind, an understanding was developed of how these related to each other. Summarised data from the studies were printed, cut up and separated from the original articles to form a blind process for the author, where commonality was the only factor that determined grouping into emerging themes.

Step five - translating studies into one another. During this stage, constant comparisons were made between emerging themes, checking for subtle common concepts. Emerging themes which were found to have a key concept in common were grouped to form synthesised themes. Once synthesised themes emerged, these were checked against the

original articles to ensure representation of the summary, synthesis and quotations were accurate.

Step six - synthesising translations or themes into higher-order themes that representatively encompass the meaning in the individual articles. The synthesised data and author's interpretations were analysed to examine how each theme contributed or competed with each other. Higher-order themes were checked against the original articles to maintain accuracy. Table 4 shows the process of how the data from original studies became synthesised themes, which contributed to higher-order themes.

TABLE 3 HERE

TABLE 4 HERE

Statement of reflective position

In qualitative research it is important to acknowledge that the researcher's reflexivity takes a central role and how the researcher can influence the data.[72] As the author of this meta-ethnography, I acknowledge that I am conducting this research using a social constructionist stance, where my views of the data and the interpretation process were shaped by the reports from participants, rather than attempting to seek a pre-determined phenomena within participants' reports. Maintaining a mindful approach that both researchers and participants co-construct the outcomes of the research[73], I understand that my clinical interests of working with people with LTCs have motivated me to conduct this meta-ethnography. It was ensured that my pre-existing experiences did not form a bias or

influenced the research through regular supervision with my Academic and Field

Supervisors.[74]

Results

Three higher-order concepts were identified from the synthesis of the articles: i) the therapist and space mattered more to me than the psychological model; ii) therapeutic processes facilitated discovery and change; iii) the barriers to engagement. Two themes were identified within each of the three concepts, forming a total of six themes.

Concept one: the therapist and space mattered more to me than the psychological model

This concept concerns how the participants' experiences of therapy influenced the therapeutic relationship and the perceived usefulness of therapy. While synthesising the selected articles, the author noticed that no specific therapeutic models were mentioned by participants. In one article, MacCormack et al.[57] found it difficult to distinguish which therapy model participants received as they never mentioned what their therapist 'did' but talked about the power of 'being'. It seems that 'being with' someone at a time of distress was more important than 'doing'.

Theme one: therapists' expertise and empathic approach led to positive relationships. Seven of the reviewed articles[56–62] included a discussion of the therapists' qualities which were highly valued by participants with LTCs. There were many qualities, including warmth, genuineness[57], supportiveness, attentiveness[59], and demonstrating understanding and empathy[61], which were key qualities that were important to participants. The therapist was a 'listening ear'[56] which allowed participants to talk openly; "even if it was something that was very personal, he made me feel so comfortable... as soon as I came in the door, I could start sharing it with him" (p.276).[61] In addition, a trusting, non-judgmental, and

positive therapeutic relationship relieved the participants' sense of burden[60] which in turn fostered hope, "I was able to talk and relate to her and trust her... she helped me to want to keep going" (p.56).[57] Attachment theory was discussed by the authors of one study[62], where therapy was seen as a secure base which strengthened and empowered participants. This was particularly poignant as the majority of the participants within this study[62] required time to gain trust due to previous traumatic experiences. Participants' view of their therapist as a nurturing and secure attachment figure, where they can feel safe and supported, seemed to have opened the possibility for participants to build positive therapeutic relationships. It was helpful for participants to know that their therapist had prior experience of providing intervention to somebody with the same LTC.[56,57] However, there appears to be a delicate balance which therapists navigate. The authors of one study[57] discussed how service users appreciated seeing therapists as human beings rather than someone in an expert position, and argued that empathy and being connected to one another led to a more positive therapeutic relationship. Conversely, when therapists were perceived to have limited experience of specific health conditions, they were viewed negatively[56,60], "I was really cross after three sessions, she didn't have a very good understanding of my illness, I gave her a book!" (p.77).[56]

Theme two: therapy was a safe and neutral space. Three articles[52,53,57] discussed the safeness and neutrality of the therapeutic space. Participants valued talking to somebody in a neutral position who was not a family member or a friend, as they felt that it would place burden on others, "they have got their own lives... when you keep talking to your family they get a bit 'oh, here we go again'" (p.8).[53] If participants were concerned about upsetting their family members, then having a chance to talk about their LTC to someone independent could mean they can "get it off [their] chest" and "not hold back about anything" (p.56).[57] The

authors of one article highlighted that although family and friends were emotionally available for the participants, the therapy context allowed participants to disclose deeper and more upsetting experiences.[57] In addition, Gerskowitch et al.[53] discussed that talking to friends and family about their symptoms could evoke fear, shame and stigma, in which the therapy space allowed them to feel validated and understood. Talking in a safe and neutral space facilitated a reduction in stigma, which allowed participants to talk more deeply about issues, explore the meaning of their LTC and were able to open up to family members.[57,58] In their study, Dennison et al.[52] discussed how participants who were more unsatisfied with their social support gained more positive experiences in therapy. Dennison et al.[52] speculated that the participants' perceptions of LTCs as enduring and requiring tolerance is challenged in the therapeutic space, where learning to cope outside of the therapy room became a main goal for participants. Through therapy participants learnt the value of talking as a safe strategy and led them to begin sharing their difficulties with others.

Concept two: therapeutic processes facilitated discovery and change

This concept explored the ways in which therapy led to participants looking inwardly into their own management of the LTC. Through this self-evaluation, participants were able to make changes in their daily lifestyles. As participants began to view their LTC from a different perspective, their sense of isolation reduced and in turn, perceived control of their condition increased.

Theme three: therapy prompted change in LTC management. Change as a result of therapy was discussed in nine articles.[51,52,55,58–63] Prior to receiving therapy, many participants

were "holding things in" and "hanging on" (p.597)[55], and only sought counselling when they reached a breaking point or became emotionally paralysed. Participants found that intervention facilitated them to take a different perspective, and promoted self-evaluation of their management of the LTC, which lessened their depression symptoms.[61] Aspects of therapy such as setting goals, collaborative working[51,59,62], and understanding the mind-body link had prompted participants to challenge themselves to move from uncertainty to being in a place where they are able to better manage their LTC, "I must face it [now]... and understand it" (p.6).[62] Although some participants noticed no improvement in physical symptoms despite increased emotional wellbeing[60], many participants commented on the useful aspects on therapy which facilitated change, "[keeping a diary] has been very instructive – to be able to look at the past week's activities... When we got to Thursday and I had done something out of the ordinary" (p.789).[63] Therapy influenced people not only emotionally, but also in what they did practically to manage their LTC, such as exercising and rediscovering previous hobbies.[63] It seems that psychological intervention legitimised participants' problems and provided highly valuable resources which were useful for the future management of the LTC, "I do not know what I would have done without it" (p.1998).[58] As well as feeling equipped to manage their health, it appears that participants also felt a boost in their confidence as a result of the psychological intervention, "I don't think I would have been able to make it if I hadn't have felt, the confidence that I got when I'd finished with [psychologist]" (p.387).[51] However, when participants lacked understanding about the nature of the therapeutic process, they perceived this as not being the 'right fit'. For example, in Dennison et al.'s[52] study, some participants disliked aspects of therapy, such as the requirement to complete paperwork and the perceived negative terminologies. These participants did not report benefits, "I didn't want to continue [because] I didn't think I...[was] the right person for it or... agreeing with it, I didn't like it at all." (p.981).[52]

Theme four: psychological awareness reduced isolation and increased control. Six articles discussed the concept of psychological awareness and how this may have influenced isolation and sense of control.[51–56] From the outset, accessing therapy allowed participants to feel more empowered and more in control of their difficulties.[51] Within therapy, participants gained psychological knowledge and awareness of how the LTC was interacting with their emotional wellbeing. At times, this increase of psychological awareness has allowed participants to make changes and feel differently. For example, participants who used therapy to focus on the solution rather than the problem found that this strategy increased their confidence.[51] Moreover, the skills of challenging negative thoughts were helpful in bolstering self-awareness and self-efficacy in managing the LTC, "a thought will come into my head now and I can get rid of it as quickly as it came in" (p.984).[52] These participant accounts conveyed a sense of control over their health condition as well as their emotional wellbeing. As participants continued to deepen their psychological understanding through therapy, they began to question their own negative views of self, "I am looking for permission from somebody... [to] give myself a break" (p.600).[55] Gaining deeper understanding of their experiences seemed to be highly valuable to participants, who began to feel less isolated, "the [psychologist] enlightened me, made me feel more free" (p.599)[55] and in turn felt an increased sense of mastery, "those [counselling sessions] changed me forever. It has changed my mental attitude... everything" (p.600).[55] Moreover, when participants faced their negative views of self this appears to have lessened the self-stigma they previously perceived, "I was less ashamed to tell people I was ill, or I was less prejudiced against having ME" (p.10).[53] However, three studies[52,54,56] described the barriers to gaining psychological understanding. Some participants reported that certain aspects of therapy were challenging and became difficult to use, "unless you're really seriously taking time to sit down and analyse it... it's

quite hard to consciously separate thoughts and feelings" (p.4).[54] It seems that when people

are not on board with the therapeutic model it could be a barrier to developing psychological

awareness.

Concept three: the barriers to engagement

The experience of not being able to fully engage in therapy is discussed in this

concept. Practical difficulties associated with physical ill health, attitudes towards aspects of

therapy and the amount of appointments appeared to be barriers to participation.

Theme five: how physical ill health interacts with being able to participate in

therapy. Six articles discussed the aspects of therapy which may have created barriers for

participants in relation to their LTCs.[53,55–57,61,63] Due to poor health, many participants across

the articles found aspects of therapy difficult, such as the location of therapy and appointment

time schedules. Participants commented on the rigidity of appointment times, "cancer and its

support shouldn't be nine to five" (p.597)[55], which suggests that the times when participants

required most support was when their therapist was unavailable. Many participants preferred

to be seen at home rather than at hospital due to practical difficulties,[56] "I had mobility

problems, so seeing me at home was the only option" (p.57).[57] Conversely, some people

preferred to be seen at the hospital as it was seen as a 'safe space'[57], this seems to have been a

very personal preference which was dictated by the individual's physical and emotional

needs, in particular their physical health condition at the time, "I think illness was the only

thing that kept me from being [there]" (p.276).[61] Participants also found that other aspects of

their LTC became obstacles to engaging with therapy. Some participants found that logging

activity on paper was at times tiring, complicated and time-consuming, "I don't think that I always followed through with it, and in a way, it kind of made me feel bad about myself" (p.275).[61] In addition, Angel et al.[63] found that participants felt guilty when they were not able to physically complete homework tasks, which could lead to self-blame and stigmatisation of having a LTC. This contrasts with the findings in the theme 'therapy was a safe and neutral space', where participants felt able to address the stigma. It seems that the positive aspect of setting up a safe space may be under threat if unachievable goals were set. Furthermore, some participants commented that approaches were not holistic enough. This was illustrated in Gerskowitch et al.'s[53] study where participants found therapy lacked an integrative approach that considered diet and nutrition, which are important to people who are aiming towards living well with LTCs.

Theme six: time-limited therapy did not always match service users' illness trajectory. This theme emerged from issues discussed in five articles.[52,54,57,58,62] Although participants felt that the number of therapeutic sessions received was helpful, many expressed the need for ongoing support, "I tried to sit down and think about what was going on... but I didn't know what to do with it cos I needed someone to talk to" (p.986).[52] This view was supported by the findings of MacCormack et al.[57], where participants expressed that the timing of therapy did not always coincide their physical health treatment, "I think I would've preferred [the sessions] to go on at least another two, or until I'd completed chemo[therapy]" (p.57). Some participants felt terrified about moving on without the support of a therapist, although others felt eager to test their new skills independently.[58,62] Two articles[54,57] noted that follow-up telephone contact was valued by participants, which seemed to be a helpful way of communicating to people that support is there when they require it in the future.

Discussion

Current findings

The aim of this meta-ethnography was to understand how people with a range of LTCs experienced psychological therapy. The synthesis of thirteen articles led to an emergence of six themes within three higher-order concepts. Firstly, most participants valued their therapist as someone who was impartial, empathic and experienced in the field of physical health. Therapy was a neutral space where participants felt safe to disclose their innermost thoughts and feelings. Once in the therapy room, issues were discussed which participants did not feel able to talk about with family members and friends. However, when the therapist was perceived as lacking knowledge of the specific health condition, some participants felt angry and frustrated. Secondly, the conversation within the therapy room prompted participants to evaluate how they managed their LTC. This increase in psychological awareness allowed participants to challenge their own negative evaluations of self, which they reported reduced isolation and increased a sense of control. However, if participants were not committed to the principles of the therapeutic model, they experienced the tasks and language to be blaming and negative. For these participants, psychological awareness and change were not mentioned within the articles. Finally, the importance of person-centred therapy was highlighted, particularly within this clinical population where many physical health factors may prevent people from engaging fully in therapy.

Living with a degenerative and life-limiting health condition can be extremely isolating, where people often feel unable to open up to others about the impact of the condition[13] and unable to talk about their feelings without reservations.[75] Talking to a therapist in a non-judgemental and contained setting allowed participants to relate to their

therapist as an 'outsider' in relation to their personal networks, which developed into a sense that their burdens were being lifted through the therapeutic process. The notion of forming therapeutic relationships in a human-to-human manner, rather than an expert-patient manner, has been documented by Rogers who advocated for person-centred therapy.[76] Rogers found that people who accessed psychology services viewed their therapeutic relationship as meaningful and important, which was a driver in achieving positive clinical outcomes.[76] The therapist being experienced as an outsider is evidenced in research into other clinical populations who are also marginalised by their life-long conditions (e.g.[77]). The neutral position of the therapist and the therapeutic space symbolised an area of safety and detachment where participants felt able to engage in an honest conversation about their feelings.[77] Clarkson's model of positive therapeutic relationships[78] described that therapists who demonstrate "unconditional acceptance" (p.136) elicit open responses and trust from the service user. Clarkson's model[78] further explained, "the psychotherapist facilitates the patient to have new experiences with real relationships and real people, to begin to trust and expect such relationships " (p.68), which connects with the current findings that many participants proceeded to share their difficulties with family members after experiencing a positive relationship with the therapist. Although participants discussed aspects of the work which was suggestive of a particular therapeutic model, it is important to note that none of the participants within any of the thirteen articles named the therapeutic model, even though some researchers had explicitly outlined these to the participants. It seems that neither the name of the model or the techniques used mattered to participants, and conversely how it was delivered by the therapist, how it was tailored, and whether or not the model was appropriate to the person's needs, were more important.[79] This finding is consistent with the results from Lambert's[80] study of factors which influenced therapeutic outcome. Lambert's[80] study showed that the therapeutic modality only influenced 15% of change, while common factors such as

warmth, empathy and a positive therapeutic relationship was responsible for 30% of psychological change. Lambert[80] argued that the therapeutic relationship is a major component which predicts positive clinical outcomes, and he asserted that clinicians must form a positive therapeutic relationship as a foundation in their endeavour to support people with mental health difficulties.

The therapeutic process appeared to have lifted the burden which was experienced by participants prior to seeing their therapist. Burden is characterised by The King's Fund[9] as a reduced quality of life, which can include a negative impact on a person's wellbeing[81] and perceived burden on friends and family.[53,60] Research has suggested that burden can be caused by many factors associated with living with a LTC, including physiological side-effects of medication[82], psychosocial consequences[83], and reduction on quality of life.[84] The NICE guidance[17] on offering psychological invention for people with LTCs specified that disease burden must be established. Treatment burden can become extremely overwhelming for individuals, and as it is a highly subjective experience[85], the impact of burden can be expressed in different ways and across a range of situations in the person's daily life. The reflective nature of therapy can often encourage people to look inward and evaluate their lives; this increased cognition can lead people to pursue their goals and construct meaning into their daily activities.[86] Acceptance of a physical health condition can have a positive influence on the emotional and physical wellbeing of people with LTCs.[87] The findings of this meta-ethnography can be understood in the context of Bartley et al.'s three circles model[88], where the 'circle of pain' illustrates the distress and anxiety which people with LTCs often experience. Bartley et al.'s[88] 'circle of practice' argued that psychological therapy can allow people to achieve mindful awareness of their health condition through addressing the thoughts, feelings and actions, and eventually moving to the 'circle of presence' where people

have more clarity of their circumstances and appreciate the richness of their experiences. Through better engagement and less use of avoidance strategies[89], people can experience hope, optimism and a reduction in isolation.[90,91] The findings suggest that through therapy, individuals can address the burden which may lessen isolation and in turn encourage a sense of mastery and agency[92] which paves the way for increased control of their LTC.

Limitations of the study

It is important to note that even though the studies included for this review were carried out in six countries (UK, USA, Canada, Sweden, Denmark and Australia), all were conducted in developed countries. Although countries are contextually unique from one another, the author of this review continues to be curious about how people with differing cultural beliefs would perceive the experience of living with a LTC and how psychological intervention may differ for them. In the findings of a study conducted in Taiwan[93], which explored the spiritual aspects of living with cancer, the individuals' LTCs were not openly discussed and instead, spiritual interventions were often sought by family members to decrease the rate of physical health deterioration. As health beliefs and attitudes vary widely between different cultures[94], it is important that in the current multicultural society that healthcare services have the cultural competencies to explore how each cultural group experience living with LTCs.

The CASP[64] scores (Table 2) indicated that the studies included in this meta-ethnography were of varying quality. Nekolaichuk et al.'s[55] study yielded a high score of 23 out of a possible 24, as many aspects of the research such as the methodology, analysis and

the implications of the research were justified and explained in detail. Many of the studies[51,54,56,57,59] did not offer sufficient commentary on the ethical issues of the recruitment strategy or the effects of participation. People living with a LTC are on various stages of illness and recovery, and many people may not have had the opportunity to participate due to the state of their condition.[95,96] Another weakness is that many of the studies[51,52,54,57,58,62,63] did not explicitly state the reflexivity issues of the research. Critically understanding one's own role as a researcher and how potential bias could influence the study is particularly important within this topic area, where participants may discuss topics which can be difficult to engage with. Previous studies has shown that sometimes researchers have found it difficult to immerse themselves in topics about mortality and death due to their own personal reactions towards it, which has created barriers in conducting research impartially with others (e.g.[97]). Nonetheless, this meta-ethnography did not exclude studies on the basis of low CASP[64] scores, as it was important to consider all literature about the topic area. Furthermore, studies which had higher quality findings (e.g.[51]) were reflected in the synthesis more than studies with less reported detail (e.g.[59]).

Clinical implications

The findings of this meta-ethnography have implications for how services and therapies are delivered and the issue of generic versus specialist mental health services for people with LTCs.

Firstly, across the studies participants alluded to a mismatch between their personal coping strategies and how the therapy was delivered. Practical barriers to attending therapy

can hinder engagement, may discourage individuals from attending therapy, and could risk an increase in drop-out rate.[98] As people living with LTCs have additional physical health needs which impact on their daily activities[9], healthcare services that do not take into account these difficulties may risk further marginalisation and stigmatisation of people with LTCs. Furthermore, when therapeutic modality or tasks within therapy do not match with people's goals, it can create frustration and negativity. For participants whose physical health condition limited their ability to complete written homework tasks, this unmet goal had reinforced their sense of disgrace and guilt.[63] If service users had prior negative experiences or attitudes of help-seeking, they are less likely to access further healthcare services.[99] The effort both the therapist and service user had contributed in tackling stigma and prompting better management of the LTC are at the risk of being jeopardised if the therapeutic tasks and goals are incongruent with what the service user can realistically carry out. In a RCT study on imagery-based behavioural intervention delivered to people with cancer[100], the authors found that in addition to participants' regular therapist contact, weekly telephone contact from the therapist to encourage participants to practice strategies at home resulted in improvements in participants' quality of life. Moreover, using a telephone support approach in psychological therapy has been found to reduce the disadvantages of people not living near therapy location and people who were too unwell to travel.[101] Alternatively, psychological therapists can co-ordinate treatment planning with primary care physicians such as GPs and medical team colleagues, who may have regular contact with service users and thus may be in a better position to explore barriers to engagement in psychological therapy.[102]

Secondly, the summary table (Table 1) which outlines the demography of participants show that therapy was received from a range of services, which can affect how people engage with psychological therapy. The studies recruited from a hospital occupational clinic[63], a

secondary care rehabilitation programme[58], specialist psychology services[51,55], specialist

health services specifically for the health condition[52,54,59], a primary care mental health

service[53], a general hospital[60], and a charity for the health condition.[56] As all participants had

received psychological therapy within these services, it shows that there is no single

established pattern of service delivery at present. For example, the current findings show that

the offer of time-limited therapy and the lack of flexibility within services has been found to

be a weakness of current service provision.[52,56–58,62,63] As recommended by The King's Fund[9],

a joint approach between general health and mental health services means that therapy can

maximise its effectiveness and reduce the use of services for individuals. Without a

collaborative approach and joint decision-making between service users and therapists, there

is a risk of therapeutic ruptures occurring.[103] It is therefore important that services are

streamlined in their approach to ensure that people with LTCs receive a uniform model of

care which is of paramount importance to their mental and physical wellbeing.

Recommendations for future research

The meta-ethnography would have been more broadly applicable if there were more

studies that focused on how participants experienced different therapeutic models. The

majority of the included studies[52–54,56–58,61,62] researched the experiences of CBT. While CBT

is the recommended therapeutic model for people with co-morbid psychological and physical

health difficulties[104], there is growing evidence to suggest that other therapy approaches, such

as SFBT, can achieve good outcomes in this population.[36] As previously discussed,

Lambert's[80] finding of common factors skills shown by therapists as the most influencing

predictor of clinical outcomes suggest that it is important to consider how components of

another therapy model can contribute to improvements in psychological wellbeing for people

with LTCs. Moreover, as highlighted in the findings and clinical implications, many participants experienced practical barriers to engagement such as the use of homework tasks within a cognitive-behavioural framework, which further suggests the need to explore how people with LTCs experience other therapeutic models. Future research that explores the service users' acceptability towards components of therapy, such as homework tasks and practical issues, will develop our understanding of how psychological therapy could be more effective in improving engagement from people with LTCs. A quantitative research design using self-report questionnaires can allow researchers to measure rates of acceptability and therapeutic change. For example, participants' ratings of a certain component of their therapy could be measured in combination with ratings of perceived improvement in wellbeing, which would extend the findings of this research.

It also remains unclear exactly how psychological interventions facilitate people to address their negative views of self and reduce self-stigma. Findings from this meta-ethnography have shown that talking to a therapist led to a more compassionate view of the self, however it is difficult to ascertain if this change of view happened during the course of the therapy or retrospectively. A qualitative research design using a form of discourse analysis to record therapeutic dyads of service users and therapists would provide insight into how and when the change happened, and who facilitated this change between the service user and therapist. Discourse analysis will be particularly useful in this context as it enables the researcher to study how people discuss and make sense of their circumstances.[105]

Conclusion

The experience of receiving psychological support in relation to having a physical health condition has been shown to be complex and also extremely valuable. The safe and neutral therapy space was particularly important for participants. Participants underwent a journey of self-evaluation and increased psychological awareness, which led to a difference in how they managed their LTC. There were indications on the demands placed on how psychological services are provided in partnership with physical health services, such as the need to provide more holistic and integrated care. Despite the lack of a dominant service model of how to deliver this care, the findings in this meta-ethnography show that psychological support is undoubtedly valued by people living with LTCs, and highlights the opportunity for services to continue offering additional therapy models to suit the needs of this population.

References

1.   The NHS Confederation. *Investing in emotional and psychological wellbeing for patients with long-term conditions*. London, http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Investing in emotional and psychological wellbeing for patients with long-term condtions 16 April final for website.pdf (2012).

2.   Ross D, Bedroussian A, Charuworn A, et al. *An Unhealthy America: The Economic Burden of Chronic Disease Charting a New Course to Save Lives and Increase Productivity and Economic Growth*. Santa Monica, CA, https://www.sophe.org/Sophe/PDF/chronic_disease_report.pdf (2007).

3.   Department of Health. *Long Term Conditions Compendium of Information: Third Edition*. Leeds, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf (2012).

4.   Cimpean D, Drake RE. Treating co-morbid chronic medical conditions and anxiety/depression. *Epidemiol Psychiatr Sci*. 2011; 20: 141–50, http://dx.doi.org/10.1017/S2045796011000345.

5.   Australian Institute of Health and Welfare. *Chronic disease - Australia's biggest health challenge*. Canberra: AIHW, http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129547726 (2014).

6.   Ward BW, Black LI. State and Regional Prevalence of Diagnosed Multiple Chronic Conditions Among Adults Aged ≥18 Years - United States, 2014. *MMWR Morb Mortal Wkly Rep*. 2016; 65: 735–8, http://dx.doi.org/10.15585/mmwr.mm6529a3.

7.   American Psychological Association. Psychologists' Role in Treating Persons with a

Chronic Illness. *American Psychological Association*,

http://www.apa.org/about/gr/issues/health-care/chronic.aspx (2016).

8. Moussavi S, Chatterji S, Verdes E, et al. Depression, chronic diseases, and decrements

    in health: results from the World Health Surveys. *Lancet (London, England)*. 2007;

    370: 851–8, http://dx.doi.org/10.1016/S0140-6736(07)61415-9.

9. Naylor C, Parsonage M, McDaid D, et al. *Long-term conditions and mental health:*

    The cost of co-morbidities. London,

    http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-

    conditions-mental-health-cost-comorbidities-naylor-feb12.pdf (2012).

10. Department of Health. *Long-term conditions positive practice guide*,

    http://www.iapt.nhs.uk/silo/files/longterm-conditions-positive-practice-guide.pdf

    (2008).

11. Drageset S, Lindstrøm TC, Underlid K. 'I just have to move on': Women's coping

    experiences and reflections following their first year after primary breast cancer

    surgery. *Eur J Oncol Nurs*. 2016; 21: 205–211,

    http://dx.doi.org/10.1016/j.ejon.2015.10.005.

12. Breitbart W. Identifying patients at risk for, and treatment of major psychiatric

    complications of cancer. *Support Care Cancer*. 1995; 3: 45–60,

    http://dx.doi.org/10.1007/BF00343921.

13. Turner J, Kelly B. Emotional dimensions of chronic disease. *West J Med*. 2000; 172:

    124–8, http://dx.doi.org/10.1136/ewjm.172.2.124.

14. Dignity in Dying. *A Hidden Problem: Suicide by Terminally Ill People*. London,

    http://www.dignityindying.org.uk/wp-

    content/uploads/2014/10/FOI_report_A_Hidden_Problem.pdf (2014).

15. Latha KS, Bhat SM. Suicidal behaviour among terminally ill cancer patients in India.

Indian J Psychiatry. 2005; 47: 79–83, http://dx.doi.org/10.4103/0019-5545.55950.

16.   The King's Fund. *Long-term conditions and multi-morbidity*,

http://www.kingsfund.org.uk/time-to-think-differently/trends/disease-and-

disability/long-term-conditions-multi-morbidity (2016).

17.   National Institute for Health and Care Excellence. *Multimorbidity: clinical assessment*

and management management,

https://www.nice.org.uk/guidance/ng56/resources/multimorbidity-clinical-assessment-

and-management-1837516654789 (2016).

18.   Macmillan Cancer Support. *Worried Sick: the Emotional Impact of Cancer*. London,

http://www.macmillan.org.uk/documents/getinvolved/campaigns/campaigns/impact_of

_cancer_english.pdf (2006).

19.   Diabetes UK. *Minding the gap: The provision of psychological support and care for*

people with diabetes in the UK. London,

https://www.diabetes.org.uk/Documents/Reports/Minding_the_Gap_psychological_re

port.pdf (2008).

20.   Hasson F, Spence A, Waldron M, et al. Experiences and needs of bereaved carers

during palliative and end-of-life care for people with chronic obstructive pulmonary

disease. *J Palliat Care*. 2009; 25: 157–163, https://search-proquest-

com.ezproxy.lancs.ac.uk/docview/214200316?accountid=11979.

21.   Kato A, Fujimaki Y, Fujimori S, et al. A qualitative study on the impact of internalized

stigma on type 2 diabetes self-management. *Patient Educ Couns*. 2016; 99: 1233–

1239, http://dx.doi.org/10.1016/j.pec.2016.02.002.

22.   Halding A-G, Heggdal K, Wahl A. Experiences of self-blame and stigmatisation for

self-infliction among individuals living with COPD. *Scand J Caring Sci*. 2011; 25:

100–107, http://dx.doi.org/10.1111/j.1471-6712.2010.00796.x.

23.   Guttman N, Salmon CT. Guilt, fear, stigma and knowledge gaps: ethical issues in

        public health communication interventions. *Bioethics*. 2004; 18: 531–52,

        http://dx.doi.org/10.1111/j.1467-8519.2004.00415.x.

24.   Pagé MG, Kovacs AH, Irvine J. How do psychosocial challenges associated with

        living with congenital heart disease translate into treatment interests and preferences?

        A qualitative approach. *Psychol Health*. 2012; 27: 1260–70,

        http://dx.doi.org/10.1080/08870446.2012.667099.

25.   Kovacs AH, Saidi AS, Kuhl EA, et al. Depression and anxiety in adult congenital heart

        disease: predictors and prevalence. *Int J Cardiol*. 2009; 137: 158–64,

        http://dx.doi.org/10.1016/j.ijcard.2008.06.042.

26.   Griffiths J, Ewing G, Rogers M. 'Moving swiftly on.' Psychological support provided

        by district nurses to patients with palliative care needs. *Cancer Nurs*. 2010; 33: 390–

        397, http://dx.doi.org/10.1097/NCC.0b013e3181d55f9b.

27.   Beatty L, Koczwara B. An effectiveness study of a CBT group program for women

        with breast cancer. *Clin Psychol*; 2010; 14: 45–53, 10.1080/13284207.2010.500307.

28.   Greer S. CBT for emotional distress of people with cancer: some personal

        observations. *Psychooncology*. 2008; 17: 170–3, http://dx.doi.org/10.1002/pon.1205.

29.   Esbitt SA, Batchelder AW, Tanenbaum ML, et al. 'Knowing that you're not the only

        one': Perspectives on group-based cognitive-behavioral therapy for adherence and

        depression (CBT-AD) in adults with type 1 diabetes. *Cogn Behav Pract*. 2015; 22:

        393–406, http://dx.doi.org/10.1016/j.cbpra.2014.02.006.

30.   Kunik ME, Veazey C, Cully JA, et al. COPD education and cognitive behavioral

        therapy group treatment for clinically significant symptoms of depression and anxiety

        in COPD patients: a randomized controlled trial. *Psychol Med*. 2008; 38: 385–96,

        http://dx.doi.org/10.1017/S0033291707001687.

31.   Veehof MM, Trompetter HR, Bohlmeijer ET, et al. Acceptance- and mindfulness-based interventions for the treatment of chronic pain: a meta-analytic review. *Cogn Behav Ther*. 2016; 45: 5–31, http://dx.doi.org/10.1080/16506073.2015.1098724.

32.   Goodwin CL, Forman EM, Herbert JD, et al. A pilot study examining the initial effectiveness of a brief acceptance-based behavior therapy for modifying diet and physical activity among cardiac patients. *Behav Modif*. 2012; 36: 199–217, http://dx.doi.org/10.1177/0145445511427770.

33.   Hoon LS, Chi Sally CW, Hong-Gu H. Effect of psychosocial interventions on outcomes of patients with colorectal cancer: a review of the literature. *Eur J Oncol Nurs Off J Eur Oncol Nurs Soc*. 2013; 17: 883–891, http://dx.doi.org/10.1016/j.ejon.2013.05.001.

34.   Lawrence M, Booth J, Mercer S, et al. A systematic review of the benefits of mindfulness-based interventions following transient ischemic attack and stroke. *Int J Stroke*. 2013; 8: 465–474, http://10.0.4.87/ijs.12135.

35.   Donald G, Lawrence M, Lorimer K, et al. The meaning and perceived value of mind-body practices for people living with HIV: A qualitative synthesis. *JANAC J Assoc Nurses AIDS Care*. 2015; 26: 660–672, http://dx.doi.org/10.1016/j.jana.2014.11.010.

36.   National Institute for Health and Care Excellence. *Improving Supportive and Palliative Care for Adults with Cancer*. London, https://www.nice.org.uk/guidance/csg4/resources/improving-supportive-and-palliative-care-for-adults-with-cancer-773375005 (2004).

37.   Farver-Vestergaard I, Jacobsen D, Zachariae R. Efficacy of psychosocial interventions on psychological and physical health outcomes in chronic obstructive pulmonary disease: a systematic review and meta-analysis. *Psychother Psychosom*. 2015; 84: 37–50, http://dx.doi.org/10.1159/000367635.

38.   Apóstolo J, Bobrowicz-Campos E, Rodrigues M, et al. The effectiveness of non-
       pharmacological interventions in older adults with depressive disorders: A systematic
       review. *Int J Nurs Stud*. 2016; 58: 59–70, http://10.0.3.248/j.ijnurstu.2016.02.006.

39.   O'Keeffe M, Purtill H, Kennedy N, et al. Comparative Effectiveness of Conservative
       Interventions for Nonspecific Chronic Spinal Pain: Physical,
       Behavioral/Psychologically Informed, or Combined? A Systematic Review and Meta-
       Analysis. *J Pain*. 2016; 17: 755–774, http://dx.doi.org/10.1016/j.jpain.2016.01.473.

40.   Britten N. Qualitative interviews in medical research. *BMJ*. 1995; 311: 251–3,
       http://www.jstor.org.ezproxy.lancs.ac.uk/stable/29728175.

41.   Erlangsen A, Stenager E, Conwell Y. Physical diseases as predictors of suicide in older
       adults: a nationwide, register-based cohort study. *Soc Psychiatry Psychiatr Epidemiol*.
       2015; 50: 1427–1439, http://dx.doi.org/10.1007/s00127-015-1051-0.

42.   Greydanus D, Patel D, Pratt H. Suicide risk in adolescents with chronic illness:
       implications for primary care and specialty pediatric practice: a review. *Dev Med Child
       Neurol*. 2010; 52: 1083–7, http://dx.doi.org/10.1111/j.1469-8749.2010.03771.x.

43.   Noblit GW, Hare RD. *Meta-Ethnography: Synthesizing Qualitative Studies*. Newbury
       Park, CA: SAGE Publications, Inc, 1988.

44.   National Health and Medical Research Council. *NHMRC Levels of Evidence and
       Grades for Recommendations for Developers of Clinical Practice Guidelines*,
       https://www.nhmrc.gov.au/_files_nhmrc/file/guidelines/developers/nhmrc_levels_grad
       es_evidence_120423.pdf (2009).

45.   Shaw RL. Identifying and Synthesizing Qualitative Literature. In: Harper D,
       Thompson AR (eds) *Qualitative Research Methods in Mental Health and
       Psychotherapy: A Guide for Students and Practitioners*. John Wiley & Sons, Ltd.,
       2012, pp. 10–22.

46. Pope C, van Royen P, Baker R. Qualitative methods in research on healthcare quality. *Qual Saf Health Care*. 2002;11: 148–52, http://dx.doi.org/10.1136/QHC.11.2.148.

47. Cooke A, Smith D, Booth A. Beyond PICO. *Qual Health Res*. 2012; 22: 1435–1443, http://dx.doi.org/10.1177/1049732312452938.

48. Shaw RL, Booth A, Sutton AJ, et al. Finding qualitative research: an evaluation of search strategies. *BMC Med Res Methodol*. 2004; 4: 5, http://dx.doi.org/10.1186/1471-2288-4-5.

49. Moher D, Liberati A, Tetzlaff J, et al. Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Med*. 2009; 6, http://www.prisma-statement.org/2.1.2 - PRISMA 2009 Checklist.pdf.

50. Zeligman M, Barden SM. A Narrative Approach to Supporting Clients Living with HIV. *J Constr Psychol*. 2015; 28: 67–82, http://10.0.4.56/10720537.2013.854185.

51. Carr SM, Smith IC, Simm R. Solution-focused brief therapy from the perspective of clients with long-term physical health conditions. *Psychol Health Med*. 2014; 19: 384–91, http://dx.doi.org/10.1080/13548506.2013.824594.

52. Dennison L, Moss-Morris R, Yardley L, et al. Change and processes of change within interventions to promote adjustment to multiple sclerosis: Learning from patient experiences. *Psychol Heal*. 2013; 28: 973–992, http://dx.doi.org/10.1080/08870446.2013.767904.

53. Gerskowitch C, Norman I, Rimes KA. Patients with medically unexplained physical symptoms experience of receiving treatment in a primary-care psychological therapies service: A qualitative study. *Cogn Behav Ther*. 2015; 8, http://dx.doi.org/10.1017/S1352465815000235.

54. Morgan M, Cousins S, Middleton L, et al. Patients' experiences of a behavioural intervention for migraine headache: a qualitative study. *J Headache Pain*. 2016; 17: 1–

7, http://dx.doi.org/10.1186/s10194-016-0601-5.

55. Nekolaichuk CL, Turner J, Collie K, et al. Cancer patients' experiences of the early phase of individual counseling in an outpatient psycho-oncology setting. *Qual Health Res*. 2016; 23: 592–604, http://dx.doi.org/10.1177/1049732312470567.

56. Ward T, Hogan K, Stuart V, et al. The experiences of counselling for persons with ME. *Couns Psychother Res*. 2008; 8: 73–79, http://10.0.4.56/14733140801972760.

57. MacCormack T, Simonian J, Lim J, et al. 'Someone who cares:' a qualitative investigation of cancer patients' experiences of psychotherapy. *Psychooncology*. 2001; 10: 52–65, http://dx.doi.org/10.1002/1099-1611(200101/02)10:1%3C52::AID-PON489%3E3.3.CO;2-M,

58. Bremander A, Bergman S, Arvidsson B. Perception of multimodal cognitive treatment for people with chronic widespread pain-changing one's life plan. *Disabil Rehabil*, 2009; 31: 1996–2004, http://dx.doi.org/10.3109/09638280902874139.

59. Dellasega C, Añel-Tiangco RM, Gabbay RA. How patients with type 2 diabetes mellitus respond to motivational interviewing. *Diabetes Res Clin Pract*. 2012; 95: 37–41, http://10.0.3.248/j.diabres.2011.08.011.

60. Mikocka-Walus AA, Gordon AL, Stewart BJ, et al. 'Just to get it off my chest': Patients' views on psychotherapy in inflammatory bowel disease. *Couns Psychother Res*. 2013; 13: 227–234, http://10.0.4.56/14733145.2012.730540.

61. Berg C, Raminani S, Greer J, et al. Participants' perspectives on cognitive-behavioral therapy for adherence and depression in HIV. *Psychother Res*. 2008; 18: 271–280, http://10.0.4.56/10503300701561537.

62. Peilot B, Andréll P, Samuelsson A, et al. Time to gain trust and change--experiences of attachment and mindfulness-based cognitive therapy among patients with chronic pain and psychiatric co-morbidity. *Int J Qual Stud Health Well-being*. 2004; 9: 24420,

http://dx.doi.org/10.3402/qhw.v9.24420 .

63.   Angel S, Jensen LD, Gonge BK, et al. Patients' interpretations of a counselling

        intervention for low back pain: A narrative analysis. *Int J Nurs Stud*. 2012; 49: 784–

        792, http://dx.doi.org/10.1016/j.ijnurstu.2012.01.010.

64.   CASP UK. *Critical Appraisal Skills Programme (CASP) Systematic Review Checklist*.

        Oxford, www.casp-uk.net/ (2013).

65.   Sandelowski M, Barroso J. Classifying the findings in qualitative studies. *Qual Heal*

        Res. 2003; 13: 905–23, http://dx.doi.org10.1177/1049732303253488.

66.   Thorne S, Jensen L, Kearney MH, et al. Qualitative Metasynthesis: Reflections on

        Methodological Orientation and Ideological Agenda. *Qual Health Res*. 2004; 14:

        1342–1365, http://dx.doi.org/10.1177/1049732304269888.

67.   Conner CT. Social Problems: The Limits and Strengths of the Social Constructionist

        Perspective. *Symb Interact*. 2014; 37: 618–620, http://dx.doi.org/10.1002/symb.125.

68.   Duggleby W, Holtslander L, Kylma J, et al. Metasynthesis of the hope experience of

        family caregivers of persons with chronic illness. *Qual Health Res*. 2010; 20: 148–58,

        http://dx.doi.org/10.1177/1049732309358329.

69.   Bondas T, Hall EOC. Challenges in approaching metasynthesis research. *Qual Health*

        Res. 2007; 17: 113–21, http://dx.doi.org/10.1177/1049732306295879.

70.   Barnett-Page E, Thomas J. Methods for the synthesis of qualitative research: a critical

        review. *BMC Med Res Methodol*. 2009; 6, http://dx.doi.org/10.1186/1471-2288-9-59.

71.   Creswell JW, Miller DL. Determining Validity in Qualitative Inquiry. *Theory Pract*.

        2000; 39: 124–130, http://dx.doi.org/10.1207/s15430421tip3903_2.

72.   Gilgun J. Reflexivity and Qualitative Research. *Curr Issues Qual Res*. 2010; 1: 1–8,

        http://www.scribd.com/doc/35787948/Reflexivity-and-Qualitative-Research.

73.   Lynch M. Against Reflexivity as an Academic Virtue and Source of Privileged

Knowledge. *Theory, Cult Soc*. 2000; 17: 26–54,

http://dx.doi.org/10.1177/02632760022051202.

74.   Boyatzis RE. *Transforming qualitative information: Thematic analysis and code development.* Thousand Oaks, CA: SAGE Publications, Inc, 1998.

75.   Gaab EM, Owens RG, MacLeod RD. Primary caregivers' experiences living with children involved in pediatric palliative care in New Zealand. *Vulnerable Child Youth Stud*. 2013; 8: 1–9, http://dx.doi.org/10.1080/17450128.2012.720396.

76.   Rogers CR. The necessary and sufficient conditions of therapeutic personality change. *J Consult Clin Psychol*. 1992; 60: 827–832, http://dx.doi.org/10.1037/0022-006X.60.6.827.

77.   Gifford C, Evers C, Walden S. What's it like to work with a clinical psychologist of a specialist learning disabilities service? Views from people with learning disabilities. *Br J Learn Disabil*. 2012; 41: 114–120, http://dx.doi.org/10.1111/j.1468-3156.2012.00730.x.

78.   Clarkson P. *The Therapeutic Relationship*. 2nd ed. London: Wiley-Blackwell, 2003.

79.   Howgego IM, Yellowlees P, Owen C, et al. The therapeutic alliance: the key to effective patient outcome? A descriptive review of the evidence in community mental health case management. *Aust N Z J Psychiatry*. 2003; 37: 169–83, http://dx.doi.org/10.1046/j.1440-1614.2003.01131.x.

80.   Lambert MJ. Implications of outcome research for psychotherapy integration. In: Norcross JC, Goldstein MR (eds) *Handbook of Psychotherapy Integration*. New York: Basic Books, 1992, pp. 94–129.

81.   Demain S, Gonçalves A-C, Areia C, et al. Living With, Managing and Minimising Treatment Burden in Long Term Conditions: A Systematic Review of Qualitative Research. *PLoS One*. 2015; 10: e0125457,

http://dx.doi.org/10.1371/journal.pone.0125457.

82.   Kerr NM, Patel HY, Chew SS, et al. Patient satisfaction with topical ocular

hypotensives. *Clin Experiment Ophthalmol*. 2013; 41: 27–35,

http://dx.doi.org/10.1111/j.1442-9071.2012.02823.x.

83.   Baylor CR, Yorkston KM, Eadie TL, et al. The psychosocial consequences of BOTOX

injections for spasmodic dysphonia: a qualitative study of patients' experiences. *J

Voice*. 2007; 21: 231–47, http://dx.doi.org/10.1016/j.jvoice.2006.01.007.

84.   Jordan S, Philpin S, Warring J, et al. Percutaneous endoscopic gastrostomies: the

burden of treatment from a patient perspective. *J Adv Nurs*. 2006; 56: 270–281,

http://dx.doi.org/10.1111/j.1365-2648.2006.04006.x.

85.   Sav A, Kendall E, McMillan SS, et al. 'You say treatment, I say hard work': treatment

burden among people with chronic illness and their carers in Australia. *Health Soc

Care Community*. 2013; 21: 665–674, http://dx.doi.org/10.1111/hsc.12052.

86.   van Donkersgoed RJM, de Jong S, Pijnenborg GHM. Metacognitive Reflection and

Insight Therapy (MERIT) with a Patient with Persistent Negative Symptoms. *J

Contemp Psychother*. 2016; 46: 245–253, http://dx.doi.org/10.1007/s10879-016-9333-

8.

87.   Casier A, Goubert L, Gebhardt WA, et al. Acceptance, well-being and goals in

adolescents with chronic illness: a daily process analysis. *Psychol Health*. 2013; 28:

1337–1351, http://dx.doi.org/10.1080/08870446.2013.809083.

88.   Bartley T, Bates U, Bartley T. The Three Circle Model: A Formulation of MBCT for

Cancer (MBCT-Ca). In: *Mindfulness-Based Cognitive Therapy for Cancer*. Chichester,

UK: John Wiley & Sons, Ltd, pp. 354–363,

http://doi.wiley.com/10.1002/9781119960041.ch15 (2011).

89.   Yurkovich EE, Lattergrass Hopkins I, Rieke S. Health-Seeking Behaviors of Native

American Indians With Persistent Mental Illness: Completing the Circle. *Arch Psychiatr Nurs*. 2012; 26: e1–e11, http://dx.doi.org/10.1016/j.apnu.2011.11.002.

90.   McCreaddie M, Payne S, Froggatt K. Ensnared by positivity: A constructivist perspective on 'being positive' in cancer care. *Eur J Oncol Nurs*. 2010; 14: 283–290, http://dx.doi.org/10.1016/j.ejon.2010.03.002.

91.   Holtz CS, Sowell R, Velasquez G. Oaxacan Women with HIV/AIDS: Resiliency in the Face of Poverty, Stigma, and Social Isolation. *Women Health*. 2012; 52: 517–535, http://dx.doi.org/10.1080/03630242.2012.690839.

92.   Goldzweig G, Hasson-Ohayon I, Alon S, et al. Perceived threat and depression among patients with cancer: the moderating role of health locus of control. *Psychol Health Med*. 2016; 21: 601–607, http://dx.doi.org/10.1080/13548506.2016.1140902.

93.   Lin H, Bauer-Wu S. Psycho-spiritual well-being in patients with advanced cancer: an integrative review of the literature. *J Adv Nurs*. 2003; 44: 69–80, http://dx.doi.org/10.1046/j.1365-2648.2003.02768.x.

94.   Steinberg SM. Cultural and religious aspects of palliative care. *Int J Crit Illn Inj Sci*. 2011; 1: 154–6, http://dx.doi.org/10.4103/2229-5151.84804.

95.   Harris FM, Kendall M, Bentley A, et al. Researching experiences of terminal cancer: a systematic review of methodological issues and approaches. *Eur J Cancer Care (Engl)*. 2008; 17: 377–386, http://dx.doi.org/10.1111/j.1365-2354.2007.00880.x.

96.   Entwistle V, Tritter JQ, Calnan M. Researching experiences of cancer: the importance of methodology. *Eur J Cancer Care (Engl)*. 2002; 11: 232–237, http://dx.doi.org/10.1046/j.1365-2354.2002.00344.x.

97.   Crocker JC, Beecham E, Kelly P, et al. Inviting parents to take part in paediatric palliative care research: a mixed-methods examination of selection bias. *Palliat Med*. 2015; 29: 231–40, http://dx.doi.org/10.1177/0269216314560803.

98.   Mohr DC, Hart SL, Howard I, et al. Barriers to psychotherapy among depressed and nondepressed primary care patients. *Ann Behav Med*. 2006; 32: 254–258, http://dx.doi.org/10.1207/s15324796abm3203_12.

99.   Steginga SK, Campbell A, Ferguson M, et al. Socio-demographic, psychosocial and attitudinal predictors of help seeking after cancer diagnosis. *Psychooncology*. 2008; 17: 997–1005, http://dx.doi.org/10.1002/pon.1317.

100.   Freeman LW, White R, Ratcliff CG, et al. A randomized trial comparing live and telemedicine deliveries of an imagery-based behavioral intervention for breast cancer survivors: reducing symptoms and barriers to care. *Psychooncology*. 2015; 24: 910–918, http://dx.doi.org/10.1002/pon.3656.

101.   Chambers SK, Morris BA, Clutton S, et al. Psychological wellness and health-related stigma: a pilot study of an acceptance-focused cognitive behavioural intervention for people with lung cancer. *Eur J Cancer Care (Engl)*. 2015; 24: 60–70, http://10.0.4.87/ecc.12221.

102.   Mackenzie LJ, Carey M, Sanson-Fisher R, et al. A cross-sectional study of radiation oncology outpatients' concern about, preferences for, and perceived barriers to discussing anxiety and depression. *Psychooncology*. 2015; 24: 1392–1397, http://dx.doi.org/10.1002/pon.3806.

103.   Safran JD, Muran JC, Eubanks-Carter C. Repairing alliance ruptures. *Psychotherapy (Chic)*. 2011; 48: 80–7, http://dx.doi.org/10.1037/a0022140.

104.   National Institute for Health and Care Excellence. *Depression in adults with chronic physical health problem: recognition and management*. Manchester: NICE, https://www.nice.org.uk/guidance/cg91 (2009).

105.   Horton-Salway M. The Construction of M.E.: The Discursive Action Model. In: Wetherell M, Taylor S, Yates SJ (eds) *Discourse as Data: A Guide For Analysis*.

London: SAGE Publications, 2001, pp. 147–188.

Figure 1

PRISMA diagram for inclusion of articles in the current meta-ethnography
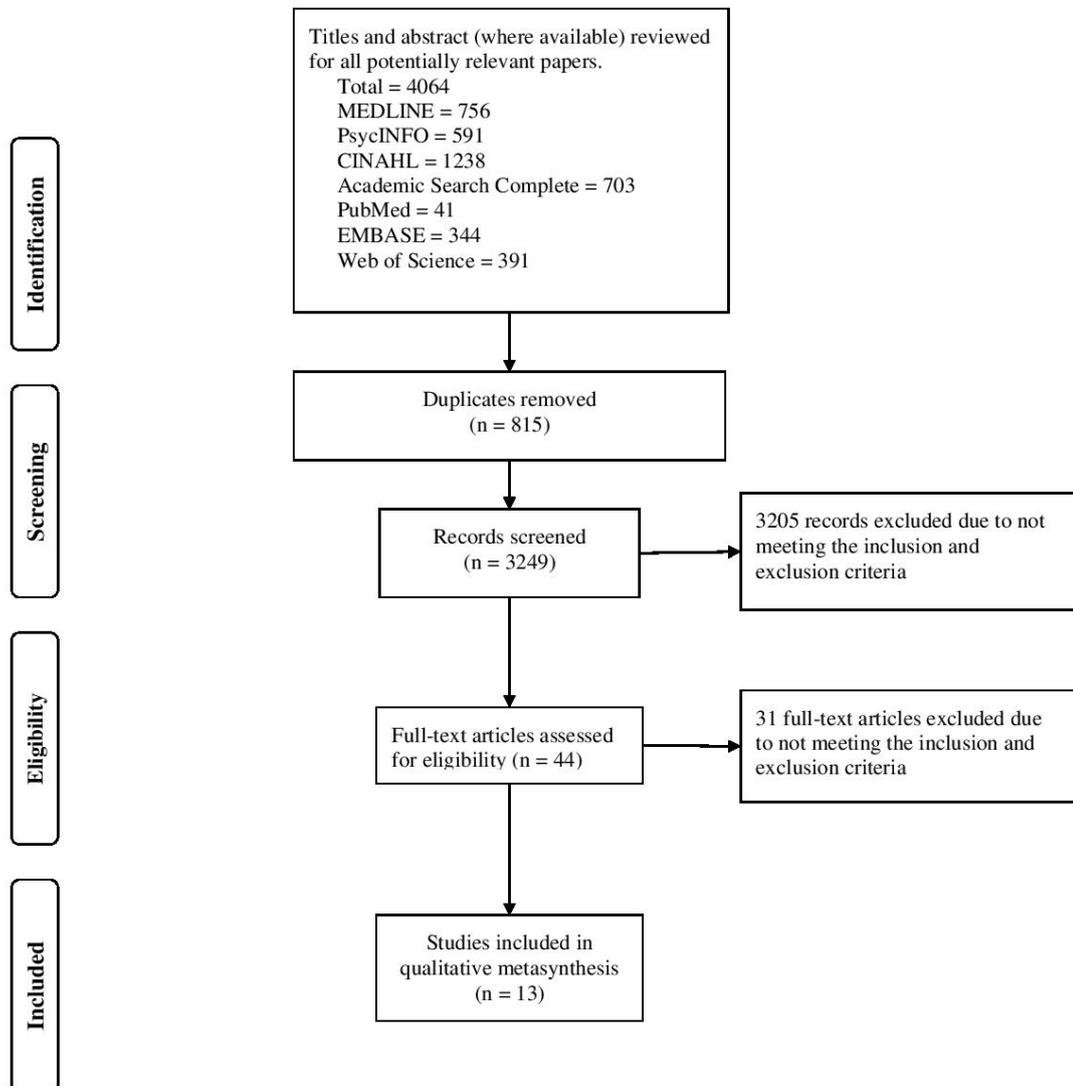
Table 1

Summary of articles included for meta-ethnography

Article	Research Aims	Therapeutic modality	Methodology: method of data collection and analysis	Participants
Angel, Jensen, Gonge, Maribo, Schiottz-Christensen and Buus (2012)[63]	To understand the service user experiences of counselling.	Counselling	Semi-structured interviews, as part of a previous randomised clinical trial Narrative analysis	Sample size: n = 20 Ages: 46.9 (mean); unspecified range Gender: 13 female; 7 male Setting: hospitals, Denmark Type of long-term health condition: low back pain
Berg, Raminani, Greer, Harwood and Safren (2008)[61]	To identify how to increase efficiency in delivering intervention. To explore the views of service users who received cognitive behavioural therapy for medical adherence and depression.	Cognitive behavioural therapy	Semi-structured interviews, as part of a previous randomised controlled crossover trial Unspecified inductive analysis	Sample size: n = 14 Ages: 43.93 (mean); 31-53 (range) Gender: 1 female; 13 male Setting: USA Type of long-term health condition: HIV
Bremander, Bergman and Arvidsson (2009)[58]	To understand the service user experiences of a multimodal treatment with a cognitive approach.	Cognitive approach	Interviews Grounded theory	Sample size: n = 16 Ages: 46 (mean); 24-64 (range) Gender: 13 female; 3 male Setting: hospital, Sweden Type of long-

				term health condition: chronic widespread pain
Carr, Smith and Simm (2014)[51]	To gain an understanding of how service users perceived solution-focused brief therapy.	Solution-focused brief therapy	Semi-structured interviews Inductive thematic analysis	Sample size: n = 11 Ages: 51.4 (mean); 35-85 (range) Gender: 7 female; 4 male Setting: clinical health psychology department, UK Type of long-term health condition: service users experienced either Parkinson's disease, cancer, chronic pain, lung disease or hepatitis B.
Dellasega, Añel-Tiangco and Gabbay (2012)[59]	To understand how service users responded to motivational interviewing with regards to behaviour change.	Motivational interviewing	Focus group discussion, as part of a previous randomised controlled trial Interpretative Phenomenological Analysis	Sample size: n = 19 Ages: 61.1 (mean); unspecified range Gender: 9 female; 10 male Setting: outpatient care, USA Type of long-term health condition: type 2 diabetes mellitus
Dennison, Moss-Morris, Yardley, Kirby and Chalder (2013)[52]	To understand the process of change in service users who received cognitive behavioural therapy.	Cognitive behavioural therapy	Telephone interviews, as part of a previous randomised controlled trial comparing cognitive	Sample size: n = 30 (15 received CBT, 15 received supportive listening) Ages: 43.5 (mean); 24-64

			behavioural therapy with supportive listening Inductive thematic analysis	(range) Gender: 23 female; 7 male Setting: outpatient care, UK Type of long-term health condition: multiple sclerosis
Gerskowitch, Norman and Rimes (2015)[53]	To understand the experiences of service users who received cognitive behavioural therapy by a trained psychological therapist in a primary care psychology service.	Cognitive behavioural therapy	One-to-one interviews Inductive thematic analysis	Sample size: n = 11 Ages: 50 (mean); 19-60 (range) Gender: 8 female; 3 male Setting: primary care mental health team, UK Type of long-term health condition: chronic pain (n = 6); chronic fatigue syndrome (n = 2); fibromyalgia (n = 3)
MacCormack Simonian, Lim, Remond, Roets, Dunn and Butow (2001)[57]	To understand how service users experienced cognitive behavioural therapy and relaxation therapies.	Cognitive behavioural therapy, relaxation therapies	Telephone interviews Grounded theory	Sample size: n = 14 Ages: no mean age provided; 30-72 (range) Gender: 10 female; 4 male Setting: Australia Type of long-term health condition: cancer
Mikocka-Walus, Gordon, Stewart and Andrews	To explore the views of service users who received psychotherapy.	Psychotherapy	Semi-structured interviews Qualitative content analysis	Sample size: n = 12 Ages: 45.5 (mean); 21-76 (range)

(2013)[60]				Gender: 6 female; 6 male Setting: inflammatory bowel disease service in hospital, Australia Type of long-term health condition: Crohn's disease
Morgan, Cousins, Middleton, Warriner-Gallyer and Ridsdale (2016)[54]	To explore the views of service users who received behavioural intervention, including pre and post-therapy perspectives.	Behavioural intervention	Semi-structured interviews, as part of a previous feasibility trial Thematic analysis	Sample size: n = 20 Ages: 43 (mean); 18-75 (range) Gender: 14 female; 6 male Setting: headache specialist clinics, UK Type of long-term health condition: clinically diagnosed migraine
Nekolaichuk, Turner, Collie, Cumming and Stevenson (2013)[55]	To understand service users' satisfactions and dissatisfactions with counselling.	Counselling	Focus group approach Inductive thematic content analysis	Sample size: n = 23 Ages: 53 (mean); unspecified range Gender: 19 female; 4 male Setting: psycho-oncology department in a cancer centre, Canada Type of long-term health condition: breast cancer (n = 7); genitourinary

				cancer (n = 5); metastatic cancer (n = 3); unspecified type of cancer (n = 8)
Nekolaichuk, Turner, Collie, Cumming and Stevenson (2013)[62]	To explore the meaning of attachment and mindfulness-based cognitive therapy with service users who had not benefited from conventional pain treatment.	Cognitive therapy	Semi-structured interviews A phenomenological analysis with a focus on meaning	Sample size: n = 10 Ages: 44 (mean); 32-60 (range) Gender: 9 female; 1 male Setting: referrals for psychiatric assessments, Sweden Type of long-term health condition: fibromyalgia (n = 1); chronic wide spread pain (n = 3); whiplash trauma (n = 5); chronic regional pain (n = 1)
Ward, Hogan, Stuart and Singleton (2008)[56]	To explore service users' experiences of psychological interventions, including cognitive behavioural therapy, person-centred, psychodynamic, and integrative/eclecti-c approaches.	Cognitive behavioural therapy, person-centred therapy, psychodynamic therapy, integrative approaches	Interviews Thematic analysis following grounded theory principles	Sample size: n = 25 Ages: 44 (mean); 23-65 (range) Gender: 21 female; 4 male Setting: community third sector groups, UK Type of long-term health condition: myalgic encephalomyelitis (also referred in some literature as chronic fatigue

syndrome)

Table 2

CASP scores of the articles selected for the meta-ethnography

Study	Research design	Sampling	Data collection	Reflexivity	Ethical issues	Data analysis	Findings	Value of research	Total score	Strengths of the article	Weaknesses of the article
Angel et al. (2012)[63]	3	3	3	0	2	3	3	2	19	Sample interview questions were provided. Detailed explanation of the methodology.	No details of the authors' reflexive position.
Berg et al. (2008)[61]	0	3	3	2	2	3	2	2	17	Reflexivity was considered by pretesting interview schedules with the authors' colleagues. Some consideration of individuals with psychiatric disorder that may compromise capacity to consent (e.g. the diagnosis of a learning disability).	No details of the research design. Findings did not always relate to the research aims.
Bremander et al. (2009)[58]	1	3	3	1	3	3	2	3	19	Authors discussed transparently how data collection and analysis took place. Authors explicitly outlined ethical considerations.	Authors did not comment on reflexivity, but acknowledged unfamiliarity with the psychological approach. Findings were described but not critiqued fully.
Carr et al. (2014)[51]	3	3	3	1	1	3	3	2	19	Epistemological stance was discussed in relation to the research design. Discussed how findings could be expanded to focus on other service user groups.	No further discussion around ethical issues aside from approval from the ethics committee.
Dellasega et al.	3	3	3	2	0	2	1	1	15	Research bias and influence were taken into	No details given about how consent and

Study	Research design	Sampling	Data collection	Reflexivity	Ethical issues	Data analysis	Findings	Value of research	Total score	Strengths of the article	Weaknesses of the article
(2012)[59]										account during data analysis.	confidentiality issues were discussed with focus group participants. Findings were described briefly and at times irrelevant to research aims.
Dennison et al. (2013)[52]	1	3	3	0	3	3	3	3	19	Sampling strategy was extensively reported. Authors detailed the methodological problems that arose and how these were resolved.	Brief mention of research design. No discussion around the reflexive positions of authors.
Gerskowitch et al. (2015)[53]	3	1	2	3	2	3	2	2	18	Authors discussed their reflexive positions as both practitioners and researchers.	Brief mention of the recruitment strategy. Findings were not distinguished between participant groups.
MacCormack et al. (2001)[57]	3	3	3	0	0	3	3	3	18	Authors extensively discussed the methodology. Discussed implications for cancer care.	No discussion around the relationship between the researchers and participants.
Mikocka-Walus et al. (2013)[60]	1	3	1	3	2	3	1	2	16	Sampling was explored in detail. Authors commented on their reflexive stance as researchers and health practitioners.	Authors could offer explanation of why the design and data collection methods were chosen. Only one theme was presented.
Morgan et al. (2016)[54]	1	3	3	0	1	3	3	1	15	Authors presented findings in a detailed manner which answered the research questions.	Authors commented very little on the research design. No statement of reflexive position given. Authors did not discuss findings in relation to policy or future research.

Study	Research design	Sampling	Data collection	Reflexivity	Ethical issues	Data analysis	Findings	Value of research	Total score	Strengths of the article	Weaknesses of the article
Nekolaichuk et al. (2013)[55]	3	3	3	2	3	3	3	3	23	Most aspects of the research were justified and explained. Implications for clinical practice and how this research contributes to the evidence base was discussed.	Authors could explain in more detail how their positions may have influenced the research outcomes.
Peilot et al. (2014)[62]	3	3	3	0	3	3	3	2	20	Authors provided detailed explanations of the methodology. Findings related directly to research questions.	No inclusion of the researcher's role in the interviews. Authors could expand on how findings relate to policies.
Ward et al. (2008)[56]	1	2	3	2	1	1	3	2	15	Findings directly related to the research questions. Implications for practice was discussed.	Authors offered no explanation to why the research design was chosen. Little explanation of the analysis process was given.

Table 3

Themes extracted from reviewed articles

Article	Themes synthesised from individual articles
Angel et al. (2012)[63]	Integrating explanations into daily life; Generating resources; Unsuccessful responses
Berg et al. (2008)[61]	General experience; Participants' feedback about the core intervention modules; Participants' perspectives about their ability to participate; Participants' reactions to the patient-therapist relationship
Bremander et al. (2009)[58]	Changing one's life plan; Changing one's perception of life; Managing one's life
Carr et al. (2014)[51]	Psychologist on my side; Looking forwards not backwards; Importance of communication about and during the therapy; Owning the therapy
Dellasega et al. (2012)[59]	Nonjudgmental accountability; Being heard and responded to as a person; Encouragement and empowerment through empathy; Collaborative action planning and goal setting; Coaching rather than critiquing
Dennison et al. (2013)[52]	Tuning in and sharing thoughts and feelings; Learning and enacting explicit strategies for living with MS; Buying into therapy; Achieving personally valued changes; Experiencing ongoing benefits
Gerskowitch et al. (2015)[53]	Making connections between physical symptoms and mood, thoughts or activities; Sharing experiences and feeling understood; Reflections on treatment experience
MacCormack et al. (2001)[57]	General therapy impressions/what's helpful; Therapist qualities; Individual versus family involvement; Home versus hospital visits; Session format and follow up; Relational/'being with' experience; A unique space for exploring and discussing; An experienced and caring professional
Mikocka-Walus et al. (2013)[60]	Psychotherapy and its efficacy in managing psychological symptoms and IBD
Morgan et al. (2016)[54]	Prior perceptions and expectations of treatment; Experience of the therapy; Content, delivery and changes
Nekolaichuk et al. (2013)[55]	Distress and the Need for Support; Challenges to Service Access; The Therapeutic Encounter
Peilot et al. (2014)[62]	Finding meaning in life with pain; Feeling empowered when learning to let go and leave things behind; Building an understanding of one's body and symptoms
Ward et al. (2008)[56]	Experiences in counselling of people with ME; Reflections on the nature of the relationship with the counsellor; Reactions to counselling; Perceived benefits of counselling

Table 4

Higher order themes derived from reviewed articles

Synthesised themes	Original articles	Themes extracted from original articles
Concept one: the therapist and space mattered more to me than the psychological model		
The therapists' qualities which led to positive relationships	Berg et al. (2008)[61]	Participants' reactions to the patient-therapist relationship
	Bremander et al. (2009)[58]	Changing one's perception of life
	Dellasega et al. (2012)[59]	Being heard and responded to as a person; Encouragement and empowerment through empathy; Coaching rather than critiquing
	MacCormack et al. (2001)[57]	Therapist qualities; An experienced and caring professional
	Mikocka-Walus et al. (2013)[60]	Psychotherapy and its efficacy in managing psychological symptoms and IBD
	Peilot et al. (2014)[62]	Feeling empowered when learning to let go and leave things behind
	Ward et al. (2008)[56]	Reflections on the nature of the relationship with the counsellor; Perceived benefits of counselling
Therapy was a safe and neutral space	Dennison et al. (2013)[52]	Tuning in and sharing thoughts and feelings
	Gerskowitch et al. (2015)[53]	Sharing experiences and feeling understood
	MacCormack et al. (2001)[57]	General therapy impressions/what's helpful; Individual versus family involvement; Relational/'being with' experience; A unique space for exploring and discussing
Concept two: therapeutic processes facilitated discovery and change		
Therapy prompted change in LTC management	Angel et al. (2012)[63]	Generating resources; Integrating explanations into daily life
	Berg et al. (2008)[61]	General experience
	Bremander et al. (2009)[58]	Changing one's life plan
	Carr et al. (2014)[51]	Looking forwards not backwards; Importance of communication about and during the therapy; Psychologist on my side
	Dellasega et al. (2012)[59]	Collaborative action planning and goal setting; Nonjudgmental accountability
	Dennison et al. (2013)[52]	Buying into therapy

	Mikocka-Walus et al. (2013)[60]	Psychotherapy and its efficacy in managing psychological symptoms and IBD
	Nekolaichuk et al. (2013)[55]	Distress and the Need for Support
	Peilot et al. (2014)[62]	Building an understanding of one's body and symptoms; Finding meaning in life with pain
Psychological awareness reduced isolation and increased control	Carr et al. (2014)[51]	Owning the therapy
	Dennison et al. (2013)[52]	Achieving personally valued changes; Learning and enacting explicit strategies for living with MS
	Gerskowitch et al. (2015)[53]	Reflections on treatment experience
	Morgan et al. (2016)[54]	Experience of the therapy; Prior perceptions and expectations of treatment
	Nekolaichuk et al. (2013)[55]	The Therapeutic Encounter
	Ward et al. (2008)[56]	Experiences in counselling of people with ME
Concept three: the barriers to engagement		
How physical ill health interacts with being able to participate in therapy	Angel et al. (2012)[63]	Unsuccessful responses
	Berg et al. (2008)[61]	Participants' feedback about the core intervention modules; Participants' perspectives about their ability to participate
	Gerskowitch et al. (2015)[53]	Making connections between physical symptoms and mood, thoughts or activities; Reflections on treatment experience
	MacCormack et al. (2001)[57]	Home versus hospital visits
	Nekolaichuk et al. (2013)[55]	Challenges to Service Access
	Ward et al. (2008)[56]	Reactions to counselling
Time-limited therapy did not always match service users' illness trajectory	Bremander et al. (2009)[58]	Managing one's life
	Dennison et al. (2013)[52]	Experiencing ongoing benefits
	Morgan et al. (2016)[54]	Content, delivery and changes
	MacCormack et al. (2001)[57]	Session format and follow up
	Peilot et al. (2014)[62]	Feeling empowered when learning to let go and leave things behind

Appendix 1-A

Summary of databases searched using MeSH, subject, permuted or thesaurus terms.

Database	Date Searched	Searchable Years	MeSH Terms	Search Limits Applied
MEDLINE	6th October 2016	1999-2016	1. (MH "Psychology") OR (MH "Psychological Techniques") OR (MH "Models, Psychological") OR (MH "Interview, Psychological") OR (MH "Resilience, Psychological") OR (MH "Psychology, Social") OR (MH "Psychology, Experimental") OR (MH "Psychology, Applied") OR (MH "Adaptation, Psychological") OR (MH "Transference (Psychology)") OR (MH "Self Psychology") OR (MH "Psychology, Clinical") OR (MH "Practice (Psychology)") OR (MH "Psychological Trauma") OR (MH "Anticipation, Psychological") OR (MH "Unconscious (Psychology)") OR (MH "Psychoanalytic Therapy") OR (MH "Cognitive Therapy") OR (MH "Behavior Therapy") OR (MH "Aversive Therapy") OR (MH "Couples Therapy") OR (MH "Narrative Therapy") OR (MH "Family Therapy") OR (MH "Relaxation Therapy") OR (MH "Gestalt Therapy") OR (MH "Functional Behavior, Psychology") OR (MH "Person-Centered Therapy") OR (MH "Psychiatric Somatic Therapies") OR (MH "Mind-Body Therapies") OR (MH "Anger Management Therapy") OR (MH "Psychological Phenomena and Processes") OR (MH "Acceptance and Commitment Therapy") 2. (MH "Chronic Disease") OR (MH "Hepatitis, Chronic") OR (MH "Pancreatitis, Chronic") OR (MH "Bronchitis, Chronic") OR (MH "Renal Insufficiency, Chronic") OR (MH "Fatigue Syndrome, Chronic") OR (MH	"Booleon/Phrase", "English Language"

| | | | "Hepatitis D, Chronic") OR (MH "Hematoma, Subdural, Chronic") OR (MH "Leukemia, Myelomonocytic, Chronic") OR (MH "Leukemia, Neutrophilic, Chronic") OR (MH "Jaundice, Chronic Idiopathic") OR (MH "Kidney Failure, Chronic") OR (MH "Hepatitis C, Chronic") OR (MH "Hepatitis B, Chronic") OR (MH "Leukemia, Myeloid, Chronic-Phase") OR (MH "Leukemia, Lymphocytic, Chronic, B-Cell") OR (MH "Polyradiculoneuropathy, Chronic Inflammatory Demyelinating") OR (MH "Pulmonary Disease, Chronic Obstructive") OR (MH "Ophthalmoplegia, Chronic Progressive External") OR (MH "Multiple Sclerosis, Chronic Progressive") OR (MH "Acute-On-Chronic Liver Failure") OR (MH "Leukemia, Myelogenous, Chronic, BCR-ABL Positive") OR (MH "Leukemia, Myeloid, Chronic, Atypical, BCR-ABL Negative") OR (MH "Headache Disorders") OR (MH "Leukemia, Prolymphocytic, T-Cell") OR (MH "Prostatitis") OR (MH "Leukemia, Myeloid") OR (MH "Q Fever") OR (MH "Polychondritis, Relapsing") OR (MH "Paroxysmal Hemicrania") OR (MH "Leukemia, Myeloid, Accelerated Phase") OR (MH "Hepatitis, Autoimmune") OR (MH "Hashimoto Disease") OR (MH "Eosinophilic Esophagitis") OR (MH "End Stage Liver Disease") OR (MH "Angina, Stable") OR (MH "Retroperitoneal Fibrosis") OR (MH "Arthritis, Juvenile")

3. (MH "Qualitative Research")

Search Field: 1 AND 2 AND 3 | |
| PsycINFO | 7th October 2016 | 2002-2016 | 1. DE "Chronic Illness" OR DE "Chronicity (Disorders)" OR DE "Chronic Fatigue Syndrome" OR DE "Physical Illness (Attitudes Toward)" OR DE "Chronic Pain" OR DE "Chronic Obstructive Pulmonary Disease" OR DE "Terminally Ill Patients" OR DE "Physical Disorders" OR DE "Myasthenia | "Booleon/Phrase", "English Language" |

Gravis" OR DE "Multiple Sclerosis" OR DE "Lupus" OR DE "Dysthymic Disorder"

2. DE "Physical Disorders" OR DE "Chronic Obstructive Pulmonary Disease" OR DE "Lupus" OR DE "Chronic Fatigue Syndrome" OR DE "Sexually Transmitted Diseases" OR DE "Parkinson's Disease" OR DE "Chronic Pain" OR DE "Chronic Illness" OR DE "Kidney Diseases" OR DE "Picks Disease" OR DE "Menieres Disease" OR DE "Lyme Disease" OR DE "Cerebral Small Vessel Disease" OR DE "Tay Sachs Disease" OR DE "Sickle Cell Disease" OR DE "Celiac Disease" OR DE "Addisons Disease" OR DE "Leukoencephalopathy" OR DE "Muscular Disorders" OR DE "Infectious Disorders" OR DE "Heart Disorders" OR DE "Cardiovascular Disorders" OR DE "Myasthenia Gravis" OR DE "Multiple Sclerosis" OR DE "Dysthymic Disorder" OR DE "Parkinsonism" OR DE "Immunodepression" OR DE "Gynecology" OR DE "Geriatric Patients" OR DE "Extrapyramidal Symptoms" OR DE "Endocrine Disorders" OR DE "Encephalopathies" OR DE "Encephalitis" OR DE "Dyskinesia" OR DE "Dysexecutive Syndrome" OR DE "Dysarthria" OR DE "Diabetes Mellitus" OR DE "Diabetes Insipidus" OR DE "Coronary Prone Behavior" OR DE "Bradykinesia" OR DE "Autosome Disorders" OR DE "Angina Pectoris"

3. (((((((((((((((((((DE "Heart Disorders") OR (DE "Diabetes" OR DE "Gestational Diabetes" OR DE "Type 2 Diabetes" OR DE "Diabetes Mellitus" OR DE "Diabetes Insipidus" OR DE "Metabolic Syndrome" OR DE "Endocrine Disorders")) OR (DE "Hypertension" OR DE "Essential Hypertension")) OR (DE "Hepatitis" OR DE "Toxic Hepatitis" OR DE

"Liver Disorders")) OR (DE "HIV")) OR (DE "AIDS")) OR (DE "Irritable Bowel Syndrome")) OR (DE "Osteoporosis")) OR (DE "Arthritis" OR DE "Rheumatoid Arthritis")) OR (DE "Back Pain" OR DE "Somatoform Pain Disorder" OR DE "Complex Regional Pain Syndrome (Type I)")) OR (DE "Migraine Headache")) OR (DE "Multiple Sclerosis")) OR (DE "Multiple Sclerosis")) OR (DE "Angina Pectoris")) OR (DE "Blood and Lymphatic Disorders" OR DE "Blood Pressure Disorders" OR DE "Cerebrovascular Disorders")) OR (DE "Immunologic Disorders" OR DE "Guillain-Barre Syndrome" OR DE "Cardiovascular Disorders" OR DE "Blood and Lymphatic Disorders" OR DE "Somatoform Disorders" OR DE "Genital Disorders" OR DE "Endocrine Sexual Disorders" OR DE "Cerebrovascular Disorders" OR DE "Skin Disorders" OR DE "Pituitary Disorders" OR DE "Musculoskeletal Disorders" OR DE "Lung Disorders" OR DE "Liver Disorders" OR DE "Heart Disorders" OR DE "Genetic Disorders" OR DE "Chromosome Disorders" OR DE "Atypical Disorders" OR DE "Vision Disorders" OR DE "Eye Disorders" OR DE "Encephalitis" OR DE "Celiac Disease" OR DE "Viral Disorders" OR DE "Thyroid Disorders" OR DE "Physical Disorders" OR DE "Pharyngeal Disorders" OR DE "Parathyroid Disorders" OR DE "Muscular Disorders" OR DE "Movement Disorders" OR DE "Metabolism Disorders" OR DE "Menstrual Disorders" OR DE "Male Genital Disorders" OR DE "Lipid Metabolism Disorders" OR DE "Joint Disorders" OR DE "Infectious Disorders" OR DE "Gynecological Disorders" OR DE "Gastrointestinal Disorders" OR DE "Feeding Disorders" OR DE "Endocrine Disorders" OR DE "Digestive System Disorders" OR DE "Congenital Disorders" OR DE "Bronchial Disorders" OR DE "Bone Disorders" OR DE "Blood Pressure Disorders" OR DE "Bacterial Disorders" OR DE "Autosome Disorders" OR DE "Autonomic Nervous System Disorders" OR DE "Allergic Disorders" OR DE "Allergic

Skin Disorders" OR DE "Adrenal Gland Disorders" OR DE "Tourette Syndrome" OR DE "Dyspraxia" OR DE "Dysphonia" OR DE "Tay Sachs Disease" OR DE "Restless Leg Syndrome" OR DE "Myasthenia Gravis" OR DE "Muscular Dystrophy" OR DE "Multiple Sclerosis" OR DE "Irritable Bowel Syndrome" OR DE "Hypothyroidism" OR DE "Cystic Fibrosis" OR DE "Cushings Syndrome" OR DE "Crying Cat Syndrome" OR DE "Cornelia De Lange Syndrome" OR DE "Chronic Illness" OR DE "Cerebral Palsy" OR DE "Bradykinesia" OR DE "Athetosis" OR DE "Arteriosclerosis" OR DE "Anosognosia" OR DE "Addisons Disease")) OR (DE "Cancer Screening" OR DE "Terminal Cancer" OR DE "Human Papillomavirus" OR DE "Metastasis" OR DE "Melanoma" OR DE "Neoplasms")) OR (DE "Arrhythmias (Heart)" OR DE "Heart Disorders")) OR (DE "Connective Tissues" OR DE "Connective Tissue Cells")) OR (DE "Fibromyalgia")) OR (DE "Osteoporosis")) OR (DE "Tuberculosis" OR DE "Pulmonary Tuberculosis")

Search Field: 1 OR 2 OR 3 = 4

5. DE "Relaxation Therapy" OR DE "Psychodynamic Psychotherapy" OR DE "Freudian Psychoanalytic School" OR DE "Adlerian Psychotherapy" OR DE "Jungian Psychology" OR DE "Debriefing (Psychological)" OR DE "Structural Family Therapy" OR DE "Conversion Therapy" OR DE "Health Care Psychology" OR DE "Forensic Psychology" OR DE "Schema Therapy" OR DE "Dialectical Behavior Therapy" OR DE "Strategic Family Therapy" OR DE "Rational Emotive Behavior Therapy" OR DE "Online Therapy" OR DE "Emotion Focused Therapy" OR DE "Family Therapy" OR DE "Aversion Therapy" OR DE "Acceptance and Commitment Therapy" OR DE "Transpersonal Psychology" OR DE "Social Psychology"

OR DE "Self-Psychology" OR DE "Positive Psychology" OR DE "Individual Psychology" OR DE "Humanistic Psychology" OR DE "Gestalt Psychology" OR DE "Cross Cultural Psychology" OR DE "Cognitive Psychology" OR DE "Coaching Psychology" OR DE "Clinical Psychology" OR DE "Applied Psychology" OR DE "Abnormal Psychology" OR DE "Relationship Therapy" OR DE "Personal Therapy" OR DE "Exposure Therapy" OR DE "Cognitive Therapy" OR DE "Cognitive Behavior Therapy" OR DE "Brief Relational Therapy" OR DE "Psychological Engagement" OR DE "Psychological Development" OR DE "Experimental Psychology" OR DE "Counseling Psychology" OR DE "Systematic Desensitization Therapy" OR DE "Solution Focused Therapy" OR DE "Reality Therapy" OR DE "Progressive Relaxation Therapy" OR DE "Narrative Therapy" OR DE "Multisystemic Therapy" OR DE "Mind Body Therapy" OR DE "Insight Therapy" OR DE "Gestalt Therapy" OR DE "Eye Movement Desensitization Therapy" OR DE "Existential Therapy" OR DE "Computer Assisted Therapy" OR DE "Behavior Therapy" OR DE "Affirmative Therapy" OR DE "Rehabilitation Counseling" OR DE "Psychodynamics" OR DE "Emotional Adjustment" OR DE "Psychoanalysis" OR DE "Motivational Interviewing" OR DE "Interpersonal Psychotherapy" OR DE "Individual Psychotherapy" OR DE "Psychosocial Rehabilitation" OR DE "Community Mental Health" OR DE "Biopsychosocial Approach" OR DE "Behavior Analysis" OR DE "Adaptation" OR DE "Therapeutic Community" OR DE "Sociotherapy" OR DE "Sleep Treatment" OR DE "Mental Health Program Evaluation"

6. DE "Qualitative Research"

Search Field: 4 AND 5 AND 6

CINAHL	7th October 2016	1989-2016	1. (MH "Fatigue Syndrome, Chronic") OR (MH "Leukemia, Myeloid, Chronic") OR (MH "Leukemia, Lymphocytic, Chronic") OR (MH "Renal Insufficiency, Chronic") OR (MH "Pulmonary Disease, Chronic Obstructive") OR (MH "Terminally Ill Patients") OR (MH "Critically Ill Patients") OR (MH "Critical Illness") OR (MH "Kidney Failure, Chronic") OR (MH "Hepatitis, Chronic") OR (MH "Hematoma, Subdural, Chronic") OR (MH "Chronic Pain") OR (MH "Chronic Pain (NANDA)") OR (MH "Lung Injury") OR (MH "Pancreatitis, Chronic") OR (MH "Ophthalmoplegia, Chronic Progressive External") OR (MH "Hepatitis C, Chronic") OR (MH "Hepatitis B, Chronic") OR (MH "Chronic Periodontitis") OR (MH "Chronic Pain Control (Saba CCC)") OR (MH "Chronic Pain (Saba CCC)") OR (MH "Bronchitis, Chronic") OR (MH "Acute-On-Chronic Liver Failure") OR (MH "Invasive Pulmonary Aspergillosis") OR (MH "Uveitis, Intermediate") OR (MH "Heart Failure") OR (MH "Thyroiditis, Autoimmune") OR (MH "Kearns-Sayre Syndrome") OR (MH "Eosinophilic Esophagitis") OR (MH "Cryopyrin-Associated Periodic Syndromes") OR (MH "Arthritis, Juvenile Rheumatoid") 2. (MH "Neoplasms") OR (MH "Neoplasms, Germ Cell and Embryonal") OR (MH "Neoplasms, Ductal, Lobular, and Medullary") OR (MH "Prostatic Neoplasms, Castration-Resistant") OR (MH "Hematologic Neoplasms") OR (MH "Neoplasms, Glandular and Epithelial") OR (MH "Neoplasms, Cystic, Mucinous, and Serous") OR (MH "Meningeal Neoplasms") OR (MH "Neoplasms, Adnexal and Skin Appendage") OR (MH "Pharyngeal Neoplasms") OR (MH "Neoplasms, Multiple Primary") OR (MH "Vulvar Neoplasms") OR (MH "Neoplasms, Connective and Soft Tissue") OR (MH "Peripheral Nervous System Neoplasms") OR (MH "Infratentorial Neoplasms") OR (MH "Anus Neoplasms") OR (MH "Bile	"Booleon/Phrase", "English Language"

| | | | Duct Neoplasms") OR (MH "Pelvic Neoplasms") OR (MH "Neoplasms, Complex and Mixed") OR (MH "Genital Neoplasms, Female") OR (MH "Colorectal Neoplasms, Hereditary Nonpolyposis") OR (MH "Otorhinolaryngologic Neoplasms") OR (MH "Neoplasms, Second Primary") OR (MH "Carcinoma, Lobular") OR (MH "Neoplasms, Nerve Tissue") OR (MH "Neoplasms, Bone Tissue") OR (MH "Hypothalamic Neoplasms") OR (MH "Femoral Neoplasms") OR (MH "Abdominal Neoplasms") OR (MH "Neoplasms, Unknown Primary") OR (MH "Breast Neoplasms, Male") OR (MH "Oropharyngeal Neoplasms") OR (MH "Vaginal Neoplasms") OR (MH "Supratentorial Neoplasms") OR (MH "Stomach Neoplasms") OR (MH "Prostatic Neoplasms") OR (MH "Palatal Neoplasms") OR (MH "Neoplasms, Squamous Cell") OR (MH "Neoplasms, Basal Cell") OR (MH "Hypopharyngeal Neoplasms") OR (MH "Head and Neck Neoplasms") OR (MH "Colonic Neoplasms") OR (MH "Cervix Neoplasms") OR (MH "Thyroid Carcinoma, Anaplastic") OR (MH "Trophoblastic Neoplasms") OR (MH "Colorectal Neoplasms") OR (MH "Gestational Trophoblastic Neoplasms") OR (MH "Sebaceous Gland Neoplasms") OR (MH "Parotid Neoplasms") OR (MH "Neuroectodermal Tumors, Primitive") OR (MH "Neoplasms, Vascular Tissue") OR (MH "Vascular Neoplasms") OR (MH "Uveal Neoplasms") OR (MH "Tongue Neoplasms") OR (MH "Adrenal Gland Neoplasms") OR (MH "Biliary Tract Neoplasms") OR (MH "Bladder Neoplasms") OR (MH "Bone Marrow Neoplasms") OR (MH "Brain Neoplasms") OR (MH "Breast Neoplasms") OR (MH "Bronchial Neoplasms") OR (MH "Conjunctival Neoplasms") OR (MH "Esophageal Neoplasms") OR (MH "Eyelid Neoplasms") OR (MH "Lung Neoplasms") OR (MH "Muscle Neoplasms") OR (MH "Orbital Neoplasms") OR (MH "Paranasal Sinus Neoplasms") OR (MH "Maxillary Neoplasms") OR (MH "Soft Tissue Neoplasms") OR (MH | |

"Urogenital Neoplasms") OR (MH "Nose Neoplasms") OR (MH "Lip Neoplasms") OR (MH "Odontogenic Tumors") OR (MH "Uterine Neoplasms") OR (MH "Ovarian Neoplasms") OR (MH "Neoplasms, Radiation-Induced") OR (MH "Kidney Neoplasms") OR (MH "Intestinal Neoplasms") OR (MH "Retinal Neoplasms") OR (MH "Neoplasms, Neuroepithelial") OR (MH "Neoplasms, Muscle Tissue") OR (MH "Neoplasms, Mesothelial") OR (MH "Neoplasms, Hormone-Dependent") OR (MH "Neoplasms, Fibrous Tissue") OR (MH "Neoplasms, Gonadal Tissue") OR (MH "Neoplasms, Fibroepithelial") OR (MH "Neoplasms, Adipose Tissue") OR (MH "Cervical Intraepithelial Neoplasia") OR (MH "Urethral Neoplasms") OR (MH "Urologic Neoplasms") OR (MH "Ureteral Neoplasms") OR (MH "Thyroid Neoplasms") OR (MH "Thymus Neoplasms") OR (MH "Thoracic Neoplasms") OR (MH "Testicular Neoplasms") OR (MH "Splenic Neoplasms") OR (MH "Spinal Neoplasms") OR (MH "Spinal Cord Neoplasms") OR (MH "Skull Neoplasms") OR (MH "Skin Neoplasms") OR (MH "Sigmoid Neoplasms") OR (MH "Salivary Gland Neoplasms") OR (MH "Retroperitoneal Neoplasms") OR (MH "Respiratory Tract Neoplasms") OR (MH "Rectal Neoplasms") OR (MH "Pleural Neoplasms") OR (MH "Pituitary Neoplasms") OR (MH "Peritoneal Neoplasms") OR (MH "Penile Neoplasms") OR (MH "Parathyroid Neoplasms") OR (MH "Pancreatic Neoplasms") OR (MH "Nervous System Neoplasms") OR (MH "Mouth Neoplasms") OR (MH "Mediastinal Neoplasms") OR (MH "Mandibular Neoplasms") OR (MH "Liver Neoplasms") OR (MH "Laryngeal Neoplasms") OR (MH "Jejunal Neoplasms") OR (MH "Jaw Neoplasms") OR (MH "Ileal Neoplasms") OR (MH "Heart Neoplasms") OR (MH "Gingival Neoplasms") OR (MH "Gastrointestinal Neoplasms") OR (MH "Gallbladder Neoplasms") OR (MH "Facial Neoplasms") OR (MH "Eye

| | | | Neoplasms") OR (MH "Endometrial Neoplasms") OR (MH "Endocrine Gland Neoplasms") OR (MH "Ear Neoplasms") OR (MH "Duodenal Neoplasms") OR (MH "Digestive System Neoplasms") OR (MH "Cranial Nerve Neoplasms") OR (MH "Central Nervous System Neoplasms") OR (MH "Cecal Neoplasms") OR (MH "Bone Neoplasms") OR (MH "Neoplasm Regression, Spontaneous") OR (MH "Carcinoma, Ductal, Breast") OR (MH "Neoplasm Invasiveness") OR (MH "Neuroectodermal Tumors, Primitive, Peripheral") OR (MH "Neuroectodermal Tumors") OR (MH "Nerve Sheath Tumors") OR (MH "Multiple Endocrine Neoplasia Type 2b") OR (MH "Multiple Endocrine Neoplasia Type 2a") OR (MH "Multiple Endocrine Neoplasia Type 1") OR (MH "Multiple Endocrine Neoplasia") OR (MH "Squamous Cell Carcinoma, Cervix") OR (MH "Carcinoma, Small Cell") OR (MH "Carcinoma, Renal Cell") OR (MH "Cancer Patients") OR (MH "Cancer Survivors") OR (MH "Carcinoma, Transitional Cell") OR (MH "Carcinoma, Squamous Cell") OR (MH "Carcinoma, Non-Small-Cell Lung") OR (MH "Carcinoma, Adenoid Cystic") OR (MH "Meningeal Carcinomatosis") OR (MH "Neuroendocrine Tumors") OR (MH "Lymphatic Vessel Tumors") OR (MH "Carcinoid Tumor") OR (MH "Antigens, Tumor") OR (MH "Renal Cell Carcinoma, Metastatic") OR (MH "Rehabilitation, Cancer") OR (MH "Carcinoma, Papillary") OR (MH "Carcinoma, Islet Cell") OR (MH "Carcinoma, Hepatocellular") OR (MH "Carcinoma, Ductal") OR (MH "Carcinoma, Basal Cell") OR (MH "Carcinoma in Situ") OR (MH "Seminoma") OR (MH "Pinealoma") OR (MH "Esthesioneuroblastoma, Olfactory") OR (MH "Hereditary Breast and Ovarian Cancer Syndrome") OR (MH "Granulosa Cell Tumor") OR (MH "Neoplastic Syndromes, Hereditary")

Search Field: 1 OR 2 = 3 | |

| | | | 4. (MH "Desensitization, Psychologic") OR (MH "Adaptation, Psychological") OR (MH "Models, Psychological") OR (MH "Behavior Therapy") OR (MH "Psychological Theory") OR (MH "Cognitive Therapy") OR (MH "Therapy, Computer Assisted") OR (MH "Couples Counseling") OR (MH "Psychology, Social") OR (MH "Psychology, Clinical") OR (MH "Psychology, Applied") OR (MH "Psychological Well-Being") OR (MH "Psychological Processes and Principles") OR (MH "Positive Psychology") OR (MH "Health Psychology") OR (MH "Support, Psychosocial") OR (MH "Validation Therapy") OR (MH "Simple Relaxation Therapy (Iowa NIC)") OR (MH "Family Therapy (Iowa NIC)") OR (MH "Family Therapy") OR (MH "Acceptance and Commitment Therapy") OR (MH "Transference (Psychology)") OR (MH "Unconscious (Psychology)") OR (MH "Reinforcement (Psychology)") OR (MH "Regression (Psychology)") OR (MH "Recognition (Psychology)") OR (MH "Psychology") OR (MH "Psychological Well-Being (Iowa NOC)") OR (MH "Psychological Techniques") OR (MH "Conditioning (Psychology)") OR (MH "Cognitive Therapy (Iowa NIC)") OR (MH "Psychotherapy, Group") OR (MH "Psychotherapy")

5. (MH "Qualitative Studies")

Search Field: 3 AND 4 AND 5 | |
| Academic Search Complete | 10th October 2016 | 1991-2016 | 1. DE "REMOTIVATION therapy" OR DE "RATIONAL emotive behavior therapy" OR DE "PASTORAL psychology" OR DE "TOKEN economy (Psychology)" OR DE "FEELING therapy" OR DE "BEHAVIOR therapy for older people" OR DE "FILIAL therapy" OR DE "CUE exposure therapy" OR DE "BOWENIAN family therapy" OR DE | "English Language" |

| | | | "GROUP practice in clinical psychology" OR DE "SOCIAL psychology -- Textbooks" OR DE "PSYCHOLOGY -- Study & teaching -- Evaluation" OR DE "REALITY therapy" OR DE "SOLUTION-focused brief therapy" OR DE "IMAGO relationship therapy" OR DE "PSYCHOLOGY -- Practice" OR DE "PATHOLOGICAL psychology in literature" OR DE "COUNSELING psychology -- Vocational guidance" OR DE "DEFENSE mechanisms (Psychology) -- Testing" OR DE "ATTRIBUTION (Social psychology) -- Testing" OR DE "PSYCHOANALYSIS & folklore" OR DE "SOMATOTYPES -- Psychological aspects" OR DE "HIV infections -- Diagnosis -- Psychological aspects" OR DE "PSYCHOLOGY & biography" OR DE "INTIMACY (Psychology) & work" OR DE "PSYCHOLOGICAL research personnel" OR DE "MOTIVATION (Psychology) -- Testing" OR DE "RETROACTIVE interference (Psychology)" OR DE "FAMILY constellations (Therapy)" OR DE "CLINICAL psychology -- Study & teaching (Graduate)" OR DE "INTERVIEWING in psychology" OR DE "PSYCHOLOGY -- Cross-cultural studies" OR DE "PSYCHOLOGY & the humanities" OR DE "EVIDENCE-based psychology" OR DE "HELPLESSNESS (Psychology) in literature" OR DE "MINORITIES in psychology" OR DE "GESTALT therapy in literature" OR DE "SCHEMA-focused cognitive therapy" OR DE "PERSONAL construct therapy" OR DE "PSYCHIATRIC somatic therapies" OR DE "SOLUTION-focused therapy" OR DE "COGNITIVE-analytic therapy" OR DE "RESILIENT therapy" OR DE "GESTALT therapy" OR DE "COUNSELING psychology -- Periodicals" OR DE "COUNSELING psychology -- Study & teaching" OR DE "TRANSFERENCE (Psychology) in literature" OR DE "BEHAVIORISM (Psychology) in literature" OR DE "COUNSELING psychology -- Practice" OR DE "INDIVIDUATION (Psychology) in literature" OR DE | |

"PSYCHOLOGY -- Study & teaching -- History" OR DE "PATHOLOGICAL psychology -- Study & teaching" OR DE "COUNSELING psychology -- Methodology" OR DE "CLINICAL psychology -- Methodology" OR DE "EMOTIONS (Psychology) & cognition -- Research" OR DE "IMAGERY (Psychology) -- Therapeutic use" OR DE "ADJUSTMENT (Psychology) -- Testing" OR DE "AFFECT (Psychology) -- Research" OR DE "OPERATIONAL psychology" OR DE "ADAPTABILITY (Psychology) -- Testing" OR DE "PATHOLOGICAL psychology -- Cross-cultural studies" OR DE "PERSONAL construct theory" OR DE "SINGLE-session psychotherapy" OR DE "MORITA psychotherapy" OR DE "PROJECTIVE techniques"

2. (((((((((((DE "ASTHMA -- Pathophysiology" OR DE "ASTHMA -- Popular works" OR DE "ASTHMA -- Periodicals" OR DE "ASTHMA -- Psychological aspects" OR DE "ASTHMA -- Congresses" OR DE "ASTHMA in old age" OR DE "ASTHMA -- Mortality") OR (DE "RESPIRATORY agents industry" OR DE "OBSTRUCTIVE lung diseases -- Alternative treatment" OR DE "OBSTRUCTIVE lung diseases -- Pathophysiology" OR DE "RESPIRATORY disease nursing" OR DE "CHRONICALLY ill -- Care -- Congresses" OR DE "CHRONICALLY ill -- Social conditions" OR DE "CHRONIC care model" OR DE "SARS (Disease)" OR DE "GUM disease -- Etiology" OR DE "SEXUALLY transmitted diseases -- Prevention -- Law & legislation" OR DE "AIDS (Disease) -- Immunological aspects" OR DE "PITUITARY diseases -- Complications" OR DE "MILIARIA (Disease)" OR DE "DISEASE clusters" OR DE "CEREBROVASCULAR disease -- Nutritional aspects" OR DE "HEART diseases -- Law & legislation" OR DE "CENTRAL nervous system -- Diseases -- Complications" OR DE "AIDS (Disease) &

| | | | mass media" OR DE "PARKINSON'S disease -- Etiology" OR DE "HEART diseases -- Environmental aspects" OR DE "HEART diseases -- Social aspects" OR DE "AIDS (Disease) -- Mortality" OR DE "AIDS (Disease) -- Vaccination" OR DE "CHRONICALLY ill older women" OR DE "AIDS (Disease) literature" OR DE "SARS (Disease) -- Psychological aspects" OR DE "AIDS (Disease) -- Transmission -- Law & legislation" OR DE "AIDS (Disease) -- Nutritional aspects" OR DE "AIDS (Disease) -- Prevention -- Religious aspects" OR DE "AIDS (Disease) -- Statistics" OR DE "ORAL diseases -- Immunological aspects" OR DE "SCLEROTIUM diseases" OR DE "NERVOUS system -- Diseases -- Periodicals" OR DE "AIDS (Disease) education (Secondary)" OR DE "SARS (Disease) -- Epidemiology" OR DE "CEREBROVASCULAR disease -- Patients -- Functional assessment" OR DE "PARKINSON'S disease -- Patients -- Family relationships" OR DE "SEXUALLY transmitted diseases -- Law & legislation" OR DE "CROHN'S disease -- Alternative treatment" OR DE "DEFICIENCY diseases -- Prevention" OR DE "HEART valve diseases -- Etiology" OR DE "RESPIRATORY diseases -- Immunological aspects" OR DE "SARS (Disease) -- Etiology" OR DE "HTLV diseases -- Treatment" OR DE "LYME disease -- Immunological aspects" OR DE "AIDS (Disease) in literature" OR DE "THROAT diseases -- Hospitals" OR DE "PELVIC inflammatory disease -- Prevention" OR DE "AIDS (Disease) -- History" OR DE "NERVOUS system -- Diseases -- Immunological aspects" OR DE "KIDNEY diseases in pregnancy" OR DE "ENDOCRINE gland diseases in pregnancy" OR DE "CARDIOVASCULAR diseases -- Psychological aspects" OR DE "CELIAC disease -- Nutritional aspects" OR DE "AIDS (Disease) -- Moral & ethical aspects" OR DE "CARDIOVASCULAR diseases -- Nutritional aspects" OR DE "INTESTINAL diseases -- Nutritional aspects" OR DE | |

| | | | "INCURABLE diseases -- Hospitals" OR DE "AIDS (Disease) -- Social aspects" OR DE "CARDIOVASCULAR diseases -- Periodicals" OR DE "AIDS (Disease) in old age" OR DE "IMMUNOLOGIC diseases in pregnancy" OR DE "HEART diseases -- Psychological aspects" OR DE "AUTOIMMUNE diseases in pregnancy" OR DE "DEFICIENCY diseases -- Diagnosis" OR DE "EYE -- Diseases -- Diagnosis -- Equipment & supplies" OR DE "AIDS (Disease) -- Epidemiology" OR DE "PARKINSON'S disease -- Age factors" OR DE "MENIERE'S disease -- Research" OR DE "INTESTINAL diseases -- Immunological aspects" OR DE "CORONAVIRUS diseases -- Immunological aspects" OR DE "PARKINSON'S disease -- Patients -- Functional assessment" OR DE "AIDS (Disease) in women" OR DE "AIDS (Disease) in pregnancy" OR DE "AIDS (Disease) -- Diagnosis" OR DE "AIDS (Disease) -- Complications" OR DE "HEART diseases -- Immunotherapy" OR DE "AUTOIMMUNE diseases -- Congresses" OR DE "AIDS (Disease) -- Transmission" OR DE "AIDS (Disease) -- Treatment" OR DE "AIDS (Disease) -- Research" OR DE "AIDS (Disease) -- Psychological aspects" OR DE "AIDS (Disease)" OR DE "BRONCHOALVEOLAR lung cancer" OR DE "PLEUROPULMONARY blastomas" OR DE "HEART -- Interventional radiology" OR DE "HEART -- Cytopathology" OR DE "HIV wasting syndrome" OR DE "ORBIVIRUS infections" OR DE "AIDS-related complex" OR DE "HIV infections -- Transmission" OR DE "AIDS patients")) OR (DE "HEART abnormalities -- Psychological aspects" OR DE "CONGESTIVE heart failure -- Alternative treatment")) OR (DE "DIABETES -- Pathophysiology" OR DE "DIABETES -- Complications -- Alternative treatment" OR DE "OLDER diabetics")) OR (DE "HYPERTENSION -- Genetics -- Research" OR DE "HYPERTENSION -- Nutritional aspects" OR DE "HYPERTENSION -- | |

			Congresses")) OR (DE "HEPATITIS viruses -- Ecology" OR DE "HEPATITIS -- Alternative treatment")) OR (DE "HIV infections -- Diagnosis -- Psychological aspects" OR DE "HIV-positive persons -- Psychology" OR DE "HIV-positive persons" OR DE "HIV infections -- Transmission")) OR (DE "MULTIPLE sclerosis -- Physical therapy")) OR (DE "TUBERCULOSIS & literature" OR DE "TUBERCULOSIS -- Nursing" OR DE "CONGENITAL, hereditary, & infantile tuberculosis" OR DE "INTESTINES -- Tuberculosis")) OR (DE "HEART diseases -- Social aspects" OR DE "HEART diseases -- Psychological aspects")) OR (DE "CYSTIC fibrosis -- Nutritional aspects" OR DE "CONGENITAL cystic adenomatoid malformation of lungs")) OR (DE "CEREBRAL palsy -- Treatment -- Research")) OR (DE "CANCER clusters" OR DE "CANCER patients -- Biography" OR DE "BRAIN cancer -- Etiology" OR DE "CANCER (Crustacea)" OR DE "INTEGRATIVE oncology" OR DE "URINARY organs -- Cancer -- Congresses" OR DE "GENITOURINARY organs -- Cancer -- Congresses" OR DE "MEDULLARY breast cancer" OR DE "PROSTATE cancer -- Nutritional aspects" OR DE "CUTANEOUS breast cancer" OR DE "THYROID cancer -- Etiology" OR DE "CANCER -- Nutritional aspects -- Congresses" OR DE "CANCER patients in literature" OR DE "OVARIAN cancer -- Congresses" OR DE "CANCER genetics -- Congresses" OR DE "CANCER -- Diagnosis -- Congresses" OR DE "GENITALIA -- Cancer -- Prevention" OR DE "COLON cancer -- Nutritional aspects" OR DE "CANCER -- Exercise therapy" OR DE "BREAST cancer -- Law & legislation" OR DE "LUNGS -- Cancer -- Statistics" OR DE "CANCER -- Information services" OR DE "BLADDER cancer -- Congresses" OR DE "CANCER prevention -- Needs assessment" OR DE "CANCER -- Eclectic treatment" OR DE "THROAT -- Cancer -- Treatment" OR DE "GASTROINTESTINAL cancer --	

			Congresses" OR DE "CANCER diagnostic equipment industry" OR DE "BRCA genes" OR DE "ONCOLOGY -- Nomenclature" OR DE "AIDS malignancies" OR DE "TRICHILEMMAL carcinoma" OR DE "JUVENILE polyposis syndrome" OR DE "KRUKENBERG tumors" OR DE "PLEUROPULMONARY blastomas") 3. DE "EDUCATION -- Qualitative research" Search Field: 1 AND 2 AND 3	
PubMed	11th October 2016	1809-2016	(("Qualitative Research"[Mesh]) AND "Chronic Disease"[Mesh]) AND (((("Acceptance and Commitment Therapy"[Mesh] OR "Couples Therapy"[Mesh] OR "Relaxation Therapy"[Mesh] OR "Mind-Body Therapies"[Mesh] OR "Anger Management Therapy"[Mesh] OR "Reality Therapy"[Mesh]) OR ("Psychotherapy"[Mesh] OR "Psychotherapy, Psychodynamic"[Mesh] OR "Imagery (Psychotherapy)"[Mesh] OR "Psychotherapy, Rational-Emotive"[Mesh] OR "Psychotherapy, Multiple"[Mesh] OR "Psychotherapy, Group"[Mesh] OR "Psychotherapy, Brief"[Mesh] OR "Cognitive Therapy"[Mesh])) OR ("Virtual Reality Exposure Therapy"[Mesh] OR "Narrative Therapy"[Mesh] OR "Psychoanalytic Therapy"[Mesh] OR "Person-Centered Therapy"[Mesh] OR "Gestalt Therapy"[Mesh] OR "Marital Therapy"[Mesh] OR "Family Therapy"[Mesh] OR "Behavior Therapy"[Mesh] OR "Distance Counseling"[Mesh])) OR "Counseling"[Mesh])	"English Language"
EMBASE	12th October 2016	1974-2016	1. chronic disease/ 2. anger management therapy/ or aversion therapy/ or behavior therapy/ or client centered therapy/ or cognitive behavioral therapy/ or cognitive therapy/ or family therapy/ or gestalt therapy/ or narrative therapy/ or reality therapy/ or systemic therapy/	No search limits applied

			3. qualitative analysis/ or qualitative research/ Search Field: 1 AND 2 AND 3	
Web of Science	Did not use MeSH, subject, permuted or thesaurus terms (see Table 2).			

Appendix 1-B

Summary of databases searched using free text search.

Database	Date Searched	Searchable Years	MeSH Terms	Search Limits Applied
MEDLINE	12th October 2016	1972-2016	1. [psychological therap*] OR [psychological intervention*] OR [cognitive behavioural therapy] OR [cognitive behavioral therapy] OR	"English", "Academic Journals", "Adult"
PsycINFO	12th October 2016	1958-2016	[CBT] OR [psychotherap*] OR [solution focused therap*] OR [solution focused brief therap*] OR [narrative therap*] OR [family therap*]	"English", "Academic Journals", "Adulthood"
CINAHL	12th October 2016	1981-2016	[psychological counsel*] OR [systemic therap*] OR [systemic family therap*] OR [motivational interviewing] OR [cognitive analytic therap*]	"English", "Academic Journals", "Adult"
Academic Search Complete	10th October 2016	1983-2016	OR [psychodynamic therap*] OR [person centred therap*] OR [mindfulness] OR [dialectical behavior therap*] OR [dialectical behaviour therap*] OR [relaxation] OR [eye movement*] 2. [long term health condition*] OR [long term condition*] OR [chronic health condition*] OR [chronic condition*] OR [chronic disease*] OR [life limiting condition*] OR [life limiting illness*] OR [life limiting disease*] OR [chronic illness*] OR [asthma] OR [chronic fatigue syndrome] OR [kidney disease*] OR [chronic obstructive pulmonary disease] OR [COPD] OR [chronic pain] OR [heart failure] OR [angina] OR [arthritis] OR [sick cell disease] OR [diabetes] OR [endometriosis] OR [epilepsy] OR [hypertension] OR [hepatitis] OR [hiv] OR [aids] OR [inflammatory bowel disease] OR [irritable bowel disease] OR [irritable bowel syndrome] OR [low back pain] OR [migraine] OR [multiple sclerosis] OR [oseteoarthritis] OR [parkinsons disease] OR [parkinson's disease] OR [Autoimmune disorder*] OR [lung disease*] OR [cancer]	"English", "Academic Journals"

			OR [Cardiac arrhythmia*] OR [cerebral palsy] OR [Crohn's disease] OR [Coeliac disease] OR [Connective tissue diseases] OR [Coronary heart disease] OR [Cystic Fibrosis] OR [digestive condition*] OR [Endocrine disorder*] OR [Fibromyalgia] OR [coagulation disorder*] OR [Lung fibrosis] OR [lupus] OR [Osteoporosis] OR [Peripheral vascular disease*] OR [Tuberculosis] 3. [grounded theory] OR [narrative] OR [phenomenolog*] OR [thematic analysis] OR [qualitative*] Search Field: 1 AND 2 AND 3	
PubMed	Did not use free search terms (see Table 1).			
EMBASE	12th October 2016	1974-2016	1. "psychological therap*" OR "psychological intervention*" OR "cognitive behavioural therapy" OR "cognitive behavioral therapy" OR "psychotherap*" OR "solution focused brief therap*" OR "narrative therap*" OR "family therap*" "psychological counsel*" OR "systemic therap*" OR "systemic family therap*" OR "motivational interviewing" OR "cognitive analytic therap*" OR "psychodynamic therap*" OR "person centred therap*" OR "mindfulness" OR "dialectical behavior therap*" OR "dialectical behaviour therap*" OR "relaxation" 2. "long term health condition*" OR "long term condition*" OR "chronic health condition*" OR "chronic condition*" OR "chronic disease*" OR "life limiting condition*" OR "life limiting illness*" OR "life limiting disease*" OR "chronic illness*" OR "asthma" OR "chronic fatigue syndrome" OR "kidney disease*" OR "chronic obstructive pulmonary disease" OR "COPD" OR "chronic pain" OR "heart failure" OR "angina" OR "arthritis" OR "sick cell disease" OR "diabetes" OR	"Use Boolean Terms", "Human", "Journal Article" Search fields applied to Title and Abstract.

			"endometriosis" OR "epilepsy" OR "hypertension" OR "hepatitis" OR "hiv" OR "aids" OR "inflammatory bowel disease" OR "irritable bowel disease" OR "irritable bowel syndrome" OR "low back pain" OR "migraine" OR "multiple sclerosis" OR "oseteoarthritis" OR "parkinsons disease" OR "Autoimmune disorder*" OR "lung disease*" OR "cancer" OR "Cardiac arrhythmia*" OR "cerebral palsy" OR "Crohn's disease" OR "Coeliac disease" OR "Connective tissue diseases" OR "Coronary heart disease" OR "Cystic Fibrosis" OR "digestive condition*" OR "Endocrine disorder*" OR "Fibromyalgia" OR "coagulation disorder*" OR "Lung fibrosis" OR "lupus" OR "Osteoporosis" OR "Peripheral vascular disease*" OR "Tuberculosis" 3. qualitative Search Field: 1 AND 2 AND 3	
Web of Science	12th October 2016	Not included in database	Same as PsycINFO, MEDLINE, CINAHL and Academic Search Complete free search terms.	Boolean search, "Journal Article", "English", "Research Areas: Psychology"

Appendix 1-C

Journal of Psychosomatic Research author guidelines

Your Paper Your Way

We now differentiate between the requirements for new and revised submissions. You may choose to submit your manuscript as a single Word or PDF file to be used in the refereeing process. Only when your paper is at the revision stage, will you be requested to put your paper in to a 'correct format' for acceptance and provide the items required for the publication of your article.
To find out more, please visit the Preparation section below.

Introduction

Types of article

Full Length Papers

Full length research papers will not normally be more than 4000 words in length (Introduction through Discussion) and will preferably be shorter. Submission of a paper to the Journal of Psychosomatic Research will be held to imply that it represents original research not previously published (except in the form of an abstract or preliminary report), that it is not being considered for publication elsewhere, and that if accepted by the Journal of Psychosomatic Research it will not be published elsewhere in the same form in any language without the consent of the Publisher. Major papers of topical content will be given priority in publication. **Please note that this journal does not publish animal studies.**

Short Reports

The journal welcomes short reports, which may be either preliminary communications or brief accounts of original research. Short Reports must not exceed 1500 words and should include no more than 2 tables and 30 references. The journal does not publish case reports.

Editorials

The Editors welcome suggestions for editorials which give personal and topical views on subjects within the journal's area of interest. They should not normally exceed 1500 words, excluding references and should have no more than 20 references.

Review Articles

Review papers are normally 4000-5000 words (Introduction through Discussion). Authors are advised to consult one of the Editors with an outline before submitting a review.

Letters to the Editors

These normally refer to articles previously published in the journal. The Editors are also willing to consider letters on subjects of direct relevance to the journal's interest, including research letters. Letters should not exceed 1000 words, including references. Where appropriate, they should begin with a reference to the published article that is the subject of the letter. Research letters should be submitted as 'Letters to the Editors'

Special Articles

These may be invited by an editor or submitted after discussion with an editor. Special articles are designed to provide an analysis of a topic of particular interest to readers of the journal and are more extensive in scope than an editorial. They should not primarily be a commentary on an article previously published in the journal, which would be better addressed in a letter or editorial.

Other Papers

The Editors welcome suggestions for other types of papers, such as conference reports, accounts of major research in progress and interviews with senior research workers. These should not be submitted without prior consultation with an editor.

Contributions for the European Association for Psychosomatic Medicine (EAPM) pages

These should generally not exceed 1000 words, excluding references. Contributions for the EAPM pages must not have an abstract. Topics covered in these pages should be of interest to EAPM members and may be focused on innovations and developments in clinical services in specific European countries, updates on important developments in specific European countries, contributions related to the EAPM, papers focusing on historic topics, etc. Results of scientific research should not be submitted to the EAPM pages, since these require peer-review. Contributions for the EAPM pages are not peer-reviewed but subject to editorial approval. EAPM In case of doubt about the suitability of a subject, please contact the European editor or the EAPM section editor at jpsychores@elsevier.com

Contact details for submission

Journal of Psychosomatic Research
Editorial Office
E-mail:jpsychores@elsevier.com

Submission checklist

You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details.

Ensure that the following items are present:

One author has been designated as the corresponding author with contact details:
• E-mail address
• Full postal address

All necessary files have been uploaded:
Manuscript:
• Include keywords
• All figures (include relevant captions)
• All tables (including titles, description, footnotes)
• Ensure all figure and table citations in the text match the files provided
• Indicate clearly if color should be used for any figures in print
Graphical Abstracts / Highlights files (where applicable)
Supplemental files (where applicable)

Further considerations
• Manuscript has been 'spell checked' and 'grammar checked'
• All references mentioned in the Reference List are cited in the text, and vice versa
• Permission has been obtained for use of copyrighted material from other sources (including the Internet)
• Relevant declarations of interest have been made
• Journal policies detailed in this guide have been reviewed
• Referee suggestions and contact details provided, based on journal requirements

For further information, visit our [Support Center](#).

 Before You Begin

Ethics in publishing

Please see our information pages on [Ethics in publishing](#) and [Ethical guidelines for journal publication](#).

Human and animal rights

If the work involves the use of human subjects, the author should ensure that the work described has been carried out in accordance with [The Code of Ethics of the World Medical Association](#) (Declaration of Helsinki) for experiments involving humans; [Uniform Requirements for manuscripts submitted to Biomedical journals](#). Authors should include a statement in the manuscript that informed consent was obtained for experimentation with human subjects. The privacy rights of human subjects must always be observed.

All animal experiments should comply with the [ARRIVE guidelines](#) and should be carried out in accordance with the U.K. Animals (Scientific Procedures) Act, 1986 and associated guidelines, [EU Directive 2010/63/EU for animal experiments](#), or the National Institutes of Health guide for the care and use of Laboratory animals (NIH Publications No. 8023, revised 1978) and the authors should clearly indicate in the manuscript that such guidelines have been followed.

Declaration of interest

All authors are requested to disclose any actual or potential conflict of interest including any financial, personal or other relationships with other people or organizations within three years of beginning the submitted work that could inappropriately influence, or be perceived to influence, their work. [More information](#).

Submission declaration

Submission of an article implies that the work described has not been published previously (except in the form of an abstract or as part of a published lecture or academic thesis or as an electronic preprint, see '[Multiple, redundant or concurrent publication](#)' section of our ethics policy for more information), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere including electronically in the same form, in English or in any other language, without the written consent of the copyright-holder.

Changes to authorship

Authors are expected to consider carefully the list and order of authors **before** submitting their manuscript and provide the definitive list of authors at the time of the original submission. Any addition, deletion or rearrangement of author names in the authorship list should be made only **before** the manuscript has been accepted and only if approved by the journal Editor. To request such a change, the Editor must receive the following from the **corresponding author**: (a) the reason for the change in author list and (b) written confirmation (e-mail, letter) from all authors that they agree with the addition, removal or rearrangement. In the case of addition or removal of authors, this includes confirmation from the author being added or removed.
Only in exceptional circumstances will the Editor consider the addition, deletion or

rearrangement of authors **after** the manuscript has been accepted. While the Editor considers the request, publication of the manuscript will be suspended. If the manuscript has already been published in an online issue, any requests approved by the Editor will result in a corrigendum.

Reporting clinical trials

All reports on clinical trials submitted for publication should include a completed Consolidated Standards of Reporting Trials (CONSORT) flow chart. Please refer to the CONSORT statement website at   http://www.consort-statement.org for more information. This journal has adopted guidelines on clinical trial registration of the International Committee of Medical Journal Editors (ICMJE) which require, as a condition of consideration for publication of clinical trials, registration in a public trials registry. Trials must register at or before the onset of patient enrolment. The clinical trial registration number should be included at the end of the abstract of the article. For this purpose, a clinical trial is defined as any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects of health outcomes. Health-related interventions include any intervention used to modify a biomedical or health-related outcome (for example drugs, surgical procedures, devices, behavioural treatments, dietary interventions, and process-of-care changes). Health outcomes include any biomedical or health-related measures obtained in patients or participants, including pharmacokinetic measures and adverse events. Further information can be found at   http://www.icmje.org.

Reporting on other types of research studies

It is also recommended that authors submitting other types of articles (non-trials) follow the appropriate reporting guidelines for the type of study being reported (http://www.equator-network.org/resource-centre/library-of-health-research-reporting/reporting-guidelines/).

- Systematic reviews and meta-analyses of randomized trials and other evaluation studies: PRISMA
- Systematic reviews and meta-analyses of observational studies: MOOSE
- Studies of diagnostic accuracy: STARD
- Observational studies: STROBE

Copyright

Upon acceptance of an article, authors will be asked to complete a 'Journal Publishing Agreement' (see more information on this). An e-mail will be sent to the corresponding author confirming receipt of the manuscript together with a 'Journal Publishing Agreement' form or a link to the online version of this agreement.

Subscribers may reproduce tables of contents or prepare lists of articles including abstracts

for internal circulation within their institutions. Permission of the Publisher is required for resale or distribution outside the institution and for all other derivative works, including compilations and translations. If excerpts from other copyrighted works are included, the author(s) must obtain written permission from the copyright owners and credit the source(s) in the article. Elsevier has preprinted forms for use by authors in these cases.

For open access articles: Upon acceptance of an article, authors will be asked to complete an 'Exclusive License Agreement' (more information). Permitted third party reuse of open access articles is determined by the author's choice of user license.

Author rights
As an author you (or your employer or institution) have certain rights to reuse your work. More information.

Elsevier supports responsible sharing

Find out how you can share your research published in Elsevier journals.

Role of the funding source

You are requested to identify who provided financial support for the conduct of the research and/or preparation of the article and to briefly describe the role of the sponsor(s), if any, in study design; in the collection, analysis and interpretation of data; in the writing of the report; and in the decision to submit the article for publication. If the funding source(s) had no such involvement then this should be stated.

Funding body agreements and policies

Elsevier has established a number of agreements with funding bodies which allow authors to comply with their funder's open access policies. Some funding bodies will reimburse the author for the Open Access Publication Fee. Details of existing agreements are available online.
After acceptance, open access papers will be published under a noncommercial license. For authors requiring a commercial CC BY license, you can apply after your manuscript is accepted for publication.

Open access

This journal offers authors a choice in publishing their research:

Open access
• Articles are freely available to both subscribers and the wider public with permitted reuse.
• An open access publication fee is payable by authors or on their behalf, e.g. by their research funder or institution.

Subscription

• Articles are made available to subscribers as well as developing countries and patient groups through our <u>universal access programs</u>.

• No open access publication fee payable by authors.

Regardless of how you choose to publish your article, the journal will apply the same peer review criteria and acceptance standards.

For open access articles, permitted third party (re)use is defined by the following <u>Creative Commons user licenses</u>:

Creative Commons Attribution-NonCommercial-NoDerivs (CC BY-NC-ND)

For non-commercial purposes, lets others distribute and copy the article, and to include in a collective work (such as an anthology), as long as they credit the author(s) and provided they do not alter or modify the article.

The open access publication fee for this journal is **USD 3300**, excluding taxes. Learn more about Elsevier's pricing policy: <u>https://www.elsevier.com/openaccesspricing</u>.

Green open access

Authors can share their research in a variety of different ways and Elsevier has a number of green open access options available. We recommend authors see our <u>green open access page</u> for further information. Authors can also self-archive their manuscripts immediately and enable public access from their institution's repository after an embargo period. This is the version that has been accepted for publication and which typically includes author-incorporated changes suggested during submission, peer review and in editor-author communications. Embargo period: For subscription articles, an appropriate amount of time is needed for journals to deliver value to subscribing customers before an article becomes freely available to the public. This is the embargo period and it begins from the date the article is formally published online in its final and fully citable form. <u>Find out more</u>.

This journal has an embargo period of 12 months.

Elsevier Publishing Campus

The Elsevier Publishing Campus (<u>www.publishingcampus.com</u>) is an online platform offering free lectures, interactive training and professional advice to support you in publishing your research. The College of Skills training offers modules on how to prepare, write and structure your article and explains how editors will look at your paper when it is submitted for publication. Use these resources, and more, to ensure that your submission will be the best that you can make it.

Language (usage and editing services)

Please write your text in good English (American or British usage is accepted, but not a mixture of these). Authors who feel their English language manuscript may require editing to eliminate possible grammatical or spelling errors and to conform to correct scientific English may wish to use the English Language Editing service available from Elsevier's WebShop.

Submissions

The Journal of Psychosomatic Research utilizes a web-based submission and peer review system. Authors should submit their manuscripts, with figures and tables, electronically at the journal Web site: https://www.evise.com/evise/jrnl/JPSYCHORES. Complete instructions are available on the Web site.

The journal reviews all material that it receives. Approximately 50% of manuscripts are rejected after pre-review by an editor, typically after consultation with another member of the editorial staff or an external peer reviewer. This is done so as to allow authors whose manuscripts would almost certainly be rejected after peer review to submit the work elsewhere with as little delay as possible. Common reasons for rejection at this stage are insufficient originality, low priority of interest to the journal and clear quality deficits. We attempt to reach an initial decision on all articles that go through full peer review within 90 days of submission. Approximately 25% of submitted manuscripts are ultimately accepted for publication.

 Preparation

Manuscripts should conform to the uniform requirements known as the 'Vancouver style' (International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. N Engl J Med 1997; 336:309-315). The Editors and Referees attach considerable importance to a succinct and lucid prose style and well organized tables. Authors whose native language is not English are advised to seek help before submission. Statistical procedures should be clearly explained.Manuscripts should conform to the uniform requirements known as the 'Vancouver style' (International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. N Engl J Med 1997; 336:309-315). The Editors and Referees attach considerable importance to a succinct and lucid prose style and well organized tables. Authors whose native language is not English are advised to seek help before submission. Statistical procedures should be clearly explained.

NEW SUBMISSIONS

Submission to this journal proceeds totally online and you will be guided stepwise through the creation and uploading of your files. The system automatically converts your files to a single PDF file, which is used in the peer-review process.

As part of the Your Paper Your Way service, you may choose to submit your manuscript as a single file to be used in the refereeing process. This can be a PDF file or a Word document, in any format or lay-out that can be used by referees to evaluate your manuscript. It should contain high enough quality figures for refereeing. If you prefer to do so, you may still provide all or some of the source files at the initial submission. Please note that individual figure files larger than 10 MB must be uploaded separately.

References

There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent. Where applicable, author(s) name(s), journal title/book title, chapter title/article title, year of publication, volume number/book chapter and the pagination must be present. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted at proof stage for the author to correct.

Formatting requirements

There are no strict formatting requirements but all manuscripts must contain the essential elements needed to convey your manuscript, for example Abstract, Keywords, Introduction, Materials and Methods, Results, Conclusions, Artwork and Tables with Captions.

If your article includes any Videos and/or other Supplementary material, this should be included in your initial submission for peer review purposes.

Divide the article into clearly defined sections.

Figures and tables embedded in text

Please ensure the figures and the tables included in the single file are placed next to the relevant text in the manuscript, rather than at the bottom or the top of the file.

REVISED SUBMISSIONS

Use of word processing software

Regardless of the file format of the original submission, at revision you must provide us with an editable file of the entire article. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier). See also the section on Electronic artwork.

To avoid unnecessary errors you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your word processor.

Cover letter

Each manuscript should be accompanied by a Cover Letter. In addition to a brief description of the article being submitted and its relevance to likely readers of the journal, the Cover Letter should include a statement that (1)authors of this article had access to all study data, are responsible for all contents of the article, and had authority over manuscript preparation and the decision to submit the manuscript for publication, (2) that all listed authors have approved of the submission of the manuscript to the journal, and (3) an explanation of the relationship of the submitted paper to any other published, submitted or proposed papers reporting the same or overlapping data. You may submit the completed letter online.

Title Page

This should contain (a) the title of the article; (b) a short running head; (c) name of department where the work was conducted; (d) names of the each author with highest academic degree; (e) name, address, phone and fax of author responsible for correspondence and to whom requests for reprints should be addressed.

Structured Abstract

This should be subdivided under the headings **Objective, Methods, Results, and Conclusion** and should not exceed 250 words.

Keywords

Up to six keywords should be listed in alphabetical order after the abstract. These terms should optimally characterize the paper to facilitate choice of peer reviewers.

Article Structure

The text should be divided into sections with main headings: Introduction, Method, Results and Discussion and, in total, these sections should not normally be greater than 4000 words in length.

Acknowledments

Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. Acknowledgements must include mention of any source of funding outside the basic funding of the host institution (see *Role of the funding source* above). List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof

reading the article, etc.).

Tables

Number tables consecutively in accordance with their appearance in the text. Place footnotes to tables below the table body and indicate them with superscript lowercase letters. Avoid vertical rules. Be sparing in the use of tables and ensure that the data presented in tables do not duplicate results described elsewhere in the article.Each should be on a separate sheet, numbered consecutively in Roman numerals.

Figures

Each should be on a separate sheet, and numbered consecutively. Captions should be on a separate sheet. The number of illustrations should be kept to a minimum. Colour illustrations are not normally acceptable. Authors may be asked to support the costs of colour reproduction.

Competing Interest Statement

All manuscripts should include a competing interests declaration that should be in the following format:

'All authors have completed the Unified Competing Interest form at http://www.icmje.org/coi_disclosure.pdf and declare that(1)[authors] received support from [name of company or other competing interest] for the submitted work;(2)[authors] have [specify relationships] with [name of companies or other competing interests] in the past three years that could be perceived to constitute a conflict of interest;(3)spouses, partners, or children of [authors] have [specified] financial relationships that may be relevant to the submitted work; and(4)[authors] have [specify type of relationship] non-financial interests that may be relevant to the submitted work. 'If there are no competing interests to report, the authors should state, 'The authors have no competing interests to report'.

Appendices

If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

Graphical abstract

Although a graphical abstract is optional, its use is encouraged as it draws more attention to the online article. The graphical abstract should summarize the contents of the article in a

concise, pictorial form designed to capture the attention of a wide readership. Graphical abstracts should be submitted as a separate file in the online submission system. Image size: Please provide an image with a minimum of 531×1328 pixels (h $\times$ w) or proportionally more. The image should be readable at a size of 5×13 cm using a regular screen resolution of 96 dpi. Preferred file types: TIFF, EPS, PDF or MS Office files. You can view Example Graphical Abstracts on our information site.

Authors can make use of Elsevier's Illustration and Enhancement service to ensure the best presentation of their images and in accordance with all technical requirements: Illustration Service.

Highlights

Highlights are mandatory for this journal. They consist of a short collection of bullet points that convey the core findings of the article and should be submitted in a separate editable file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point). You can view example Highlights on our information site.

Abbreviations

Keep abbreviations to a minimum and avoid their use in the abstract. Spell out each abbreviation in the text the first time that it is used. Ensure consistency of abbreviations throughout the article.

Formatting of funding sources

List funding sources in this standard way to facilitate compliance to funder's requirements:

Funding: This work was supported by the National Institutes of Health [grant numbers xxxx, yyyy]; the Bill & Melinda Gates Foundation, Seattle, WA [grant number zzzz]; and the United States Institutes of Peace [grant number aaaa].

It is not necessary to include detailed descriptions on the program or type of grants and awards. When funding is from a block grant or other resources available to a university, college, or other research institution, submit the name of the institute or organization that provided the funding.

If no funding has been provided for the research, please include the following sentence:

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Footnotes

Footnotes should be used sparingly. Number them consecutively throughout the article. Many word processors build footnotes into the text, and this feature may be used. Should this not be the case, indicate the position of footnotes in the text and present the footnotes themselves separately at the end of the article.

Electronic artwork

General points
• Make sure you use uniform lettering and sizing of your original artwork.
• Preferred fonts: Arial (or Helvetica), Times New Roman (or Times), Symbol, Courier.
• Number the illustrations according to their sequence in the text.
• Use a logical naming convention for your artwork files.
• Indicate per figure if it is a single, 1.5 or 2-column fitting image.
• For Word submissions only, you may still provide figures and their captions, and tables within a single file at the revision stage.
• Please note that individual figure files larger than 10 MB must be provided in separate source files.
A detailed guide on electronic artwork is available.
You are urged to visit this site; some excerpts from the detailed information are given here.
Formats
Regardless of the application used, when your electronic artwork is finalized, please 'save as' or convert the images to one of the following formats (note the resolution requirements for line drawings, halftones, and line/halftone combinations given below):
EPS (or PDF): Vector drawings. Embed the font or save the text as 'graphics'.
TIFF (or JPG): Color or grayscale photographs (halftones): always use a minimum of 300 dpi.
TIFF (or JPG): Bitmapped line drawings: use a minimum of 1000 dpi.
TIFF (or JPG): Combinations bitmapped line/half-tone (color or grayscale): a minimum of 500 dpi is required.
Please do not:
• Supply files that are optimized for screen use (e.g., GIF, BMP, PICT, WPG); the resolution is too low.
• Supply files that are too low in resolution.
• Submit graphics that are disproportionately large for the content.

Color artwork

Please make sure that artwork files are in an acceptable format (TIFF (or JPEG), EPS (or PDF), or MS Office files) and with the correct resolution. If, together with your accepted article, you submit usable color figures then Elsevier will ensure, at no additional charge, that these figures will appear in color online (e.g., ScienceDirect and other sites) regardless of whether or not these illustrations are reproduced in color in the printed version. **For color reproduction in print, you will receive information regarding the costs from Elsevier**

after receipt of your accepted article. Please indicate your preference for color: in print or online only. Further information on the preparation of electronic artwork.

Illustration services

Elsevier's WebShop offers Illustration Services to authors preparing to submit a manuscript but concerned about the quality of the images accompanying their article. Elsevier's expert illustrators can produce scientific, technical and medical-style images, as well as a full range of charts, tables and graphs. Image 'polishing' is also available, where our illustrators take your image(s) and improve them to a professional standard. Please visit the website to find out more.

Figure captions

Ensure that each illustration has a caption. A caption should comprise a brief title (**not** on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

References

These should be numbered consecutively in the text in the order in which they are first mentioned and be so denoted in the list. Their form should be that adopted by the US National Library of Medicine, as used in the Index Medicus and as recommended in Huth EJ, Medical Style and Format.

Reference links

Increased discoverability of research and high quality peer review are ensured by online links to the sources cited. In order to allow us to create links to abstracting and indexing services, such as Scopus, CrossRef and PubMed, please ensure that data provided in the references are correct. Please note that incorrect surnames, journal/book titles, publication year and pagination may prevent link creation. When copying references, please be careful as they may already contain errors. Use of the DOI is encouraged.

A DOI can be used to cite and link to electronic articles where an article is in-press and full citation details are not yet known, but the article is available online. A DOI is guaranteed never to change, so you can use it as a permanent link to any electronic article. An example of a citation using DOI for an article not yet in an issue is: VanDecar J.C., Russo R.M., James D.E., Ambeh W.B., Franke M. (2003). Aseismic continuation of the Lesser Antilles slab beneath northeastern Venezuela. Journal of Geophysical Research, http://dx.doi.org/10.1029/2001JB000884i. Please note the format of such citations should be in the same style as all other references in the paper.

Web references

As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

Data references

This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.

Reference management software

Most Elsevier journals have their reference template available in many of the most popular reference management software products. These include all products that support Citation Style Language styles, such as Mendeley and Zotero, as well as EndNote. Using the word processor plug-ins from these products, authors only need to select the appropriate journal template when preparing their article, after which citations and bibliographies will be automatically formatted in the journal's style. If no template is yet available for this journal, please follow the format of the sample references and citations as shown in this Guide.

Users of Mendeley Desktop can easily install the reference style for this journal by clicking the following link:
   http://open.mendeley.com/use-citation-style/journal-of-psychosomatic-research
When preparing your manuscript, you will then be able to select this style using the Mendeley plug-ins for Microsoft Word or LibreOffice.

Reference formatting

There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent. Where applicable, author(s) name(s), journal title/book title, chapter title/article title, year of publication, volume number/book chapter and the pagination must be present. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted at proof stage for the author to correct. If you do wish to format the references yourself they should be arranged according to the following examples:

Reference style

Text: Indicate references by number(s) in square brackets in line with the text. The actual authors can be referred to, but the reference number(s) must always be given.
Example: '..... as demonstrated [3,6]. Barnaby and Jones [8] obtained a different result ....'
List: Number the references (numbers in square brackets) in the list in the order in which they appear in the text.
Examples:
Reference to a journal publication:
[1] J. van der Geer, J.A.J. Hanraads, R.A. Lupton, The art of writing a scientific article, J. Sci. Commun. 163 (2010) 51–59.
Reference to a book:
[2] W. Strunk Jr., E.B. White, The Elements of Style, fourth ed., Longman, New York, 2000.
Reference to a chapter in an edited book:
[3] G.R. Mettam, L.B. Adams, How to prepare an electronic version of your article, in: B.S. Jones, R.Z. Smith (Eds.), Introduction to the Electronic Age, E-Publishing Inc., New York, 2009, pp. 281–304.
Reference to a website:
[4] Cancer Research UK, Cancer statistics reports for the UK.
http://www.cancerresearchuk.org/aboutcancer/statistics/cancerstatsreport/, 2003 (accessed 13.03.03).
Reference to a dataset:
[dataset] [5] M. Oguro, S. Imahiro, S. Saito, T. Nakashizuka, Mortality data for Japanese oak wilt disease and surrounding forest compositions, Mendeley Data, v1, 2015.
http://dx.doi.org/10.17632/xwj98nb39r.1.

Journal abbreviations source

Journal names should be abbreviated according to the [List of Title Word Abbreviations](#).

Video

Elsevier accepts video material and animation sequences to support and enhance your scientific research. Authors who have video or animation files that they wish to submit with their article are strongly encouraged to include links to these within the body of the article. This can be done in the same way as a figure or table by referring to the video or animation content and noting in the body text where it should be placed. All submitted files should be properly labeled so that they directly relate to the video file's content. In order to ensure that your video or animation material is directly usable, please provide the files in one of our recommended file formats with a preferred maximum size of 150 MB. Video and animation files supplied will be published online in the electronic version of your article in Elsevier Web products, including [ScienceDirect](#). Please supply 'stills' with your files: you can choose any frame from the video or animation or make a separate image. These will be used instead of standard icons and will personalize the link to your video data. For more detailed instructions please visit our [video instruction pages](#). Note: since video and animation cannot be embedded in the print version of the journal, please provide text for both the electronic

and the print version for the portions of the article that refer to this content.

Supplementary material

Supplementary material can support and enhance your scientific research. Supplementary files offer the author additional possibilities to publish supporting applications, high-resolution images, background datasets, sound clips and more. Please note that such items are published online exactly as they are submitted; there is no typesetting involved (supplementary data supplied as an Excel file or as a PowerPoint slide will appear as such online). Please submit the material together with the article and supply a concise and descriptive caption for each file. If you wish to make any changes to supplementary data during any stage of the process, then please make sure to provide an updated file, and do not annotate any corrections on a previous version. Please also make sure to switch off the 'Track Changes' option in any Microsoft Office files as these will appear in the published supplementary file(s). For more detailed instructions please visit our artwork instruction pages.

AudioSlides

The journal encourages authors to create an AudioSlides presentation with their published article. AudioSlides are brief, webinar-style presentations that are shown next to the online article on ScienceDirect. This gives authors the opportunity to summarize their research in their own words and to help readers understand what the paper is about. More information and examples are available. Authors of this journal will automatically receive an invitation e-mail to create an AudioSlides presentation after acceptance of their paper.

After Acceptance

Online proof correction

Corresponding authors will receive an e-mail with a link to our online proofing system, allowing annotation and correction of proofs online. The environment is similar to MS Word: in addition to editing text, you can also comment on figures/tables and answer questions from the Copy Editor. Web-based proofing provides a faster and less error-prone process by allowing you to directly type your corrections, eliminating the potential introduction of errors.
If preferred, you can still choose to annotate and upload your edits on the PDF version. All instructions for proofing will be given in the e-mail we send to authors, including alternative methods to the online version and PDF.
We will do everything possible to get your article published quickly and accurately. Please use this proof only for checking the typesetting, editing, completeness and correctness of the text, tables and figures. Significant changes to the article as accepted for publication will only

be considered at this stage with permission from the Editor. It is important to ensure that all corrections are sent back to us in one communication. Please check carefully before replying, as inclusion of any subsequent corrections cannot be guaranteed. Proofreading is solely your responsibility.

Offprints

The corresponding author will, at no cost, receive a customized Share Link providing 50 days free access to the final published version of the article on ScienceDirect. The Share Link can be used for sharing the article via any communication channel, including email and social media. For an extra charge, paper offprints can be ordered via the offprint order form which is sent once the article is accepted for publication. Both corresponding and co-authors may order offprints at any time via Elsevier's Webshop. Corresponding authors who have published their article open access do not receive a Share Link as their final published version of the article is available open access on ScienceDirect and can be shared through the article DOI link.

Additional information

Author Inquiries

Visit the Elsevier Support Center to find the answers you need. Here you will find everything from Frequently Asked Questions to ways to get in touch.
You can also check the status of your submitted article or find out when your accepted article will be published.

Section Two: Research Paper

Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions.

Joanna Cheng

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Correspondence should be addressed to:

Joanna Cheng

Department of Clinical Psychology,

Faculty of Health and Medicine,

C16 Furness Building,

Lancaster University,

Lancaster,

Lancashire, United Kingdom

LA1 4YG

E-mail: j.cheng1@lancaster.ac.uk

Tel: +44 1524 592970

Prepared for submission to *Journal of Psychosomatic Research*[1]

---

[1] Please note this manuscript is prepared in line with the author guidance for *Journal of Psychosomatic Research* (see Appendix 3), therefore the SAGE Vancouver referencing style will be adhered to. However, the Lancaster University word limit will be followed instead of the journal's word limit.

Abstract

Objective: People living with long-term physical health conditions (LTCs) often experience co-morbid mental health difficulties. Although current guidance recommends psychological therapy, there is little understanding of the specific elements of therapy which promote individuals' wellbeing. Research suggests that identifying personal resources can lead people to set achievable goals[1,2], which are activities of key importance for people with LTCs. Solution-Focused (SF) therapy which focuses on strengths, resources and goals may therefore be an efficacious approach for this population. This study aims to understand how people with LTCs construct preferred futures and resources with their practitioners in a SF therapy session.

Methods: Eight participant dyads, comprised of SF practitioners and service users with LTCs, were recruited. The methodology and analysis was undertaken using a Discursive Action Model (DAM) informed approach. The therapy sessions were audio-recorded and transcribed verbatim with DAM transcript conventions.

Results: Four discourses were highlighted within the data: practitioners' use of assumptions drew out resources; explicit commentaries construct change; de-contextualising for goal construction; removing the blame, effort and failure.

Conclusion: The study found discursive mechanisms within SF therapy which led to effective construction of resources and goals. However, these mechanisms are not specific to the SF approach and therefore can be applied trans-theoretically to further benefit people with LTCs. Future studies using a discourse methodology in other therapeutic models would provide insight into the transferability of these mechanisms.

Introduction

Psychological interventions for people with long-term health conditions

As awareness of mental health and physical health co-morbidity increases, there is a growing drive to provide psychological interventions to people with long-term physical health conditions (LTCs).[3–5] Section one of this thesis identified that a number of countries, including the UK[6], USA[7] and Australia[8], in which a large proportion of people with LTCs are known to experience mental health difficulties. Living with a LTC can increase the chances of developing mental health difficulties by 20-50%.[9] The World Health Organization[10] states that if depression becomes chronic for people with LTCs, it may lead to further physical disability over time. Furthermore, research findings from Moussavi et al.[11] showed that people with LTCs and co-morbid mental health difficulties rated their physical and emotional health to be worse in comparison to people who experienced depression or LTCs alone. Living with a LTC can negatively affect people in a number of ways, and arguably the co-morbidity of mental health may mean that people's physical health also deteriorates.

The view that people with LTCs should be offered psychological support, and that doing so can have a positive influence on their management of LTCs, has been substantiated by a large amount of research. For example, Graham et al.[12] found that people who received Acceptance and Commitment Therapy demonstrated increased seizure-control in epilepsy and better disease self-management. Within a physical health context, psychological interventions can support individuals to recognise how emotional distress can impact negatively on physical health management and therefore learn different ways of coping with their LTC.[13] Not only does psychological intervention improve quality of life for people with LTCs, there is evidence to suggest better functional capabilities post-therapy[14] and improved

physical health outcomes[1,15] and reduce medication use.[16] Moreover, findings from de Lusignan et al.[17] showed that referrals to psychological services could reduce patients' self-admissions into accident and emergency services. It is therefore clear that receiving psychological intervention can benefit people with LTCs in multiple ways. Offering psychological support can be regarded as part of a person's holistic care, improving both emotional and physical wellbeing.

Current guidance on psychological interventions for LTCs

As research into the associations between psychological and physical wellbeing increases, national bodies in the UK such as the Mental Health Foundation[18] and Department of Health[19] have recognised the link and have argued that mental health needs to be integral to the public health agenda. For example, The King's Fund[4] identifies depression and anxiety to be the most commonly experienced mental health difficulties for people with LTCs. The National Institute for Health and Care Excellence (NICE) guidance for co-morbid LTCs and depression[20] recommends Cognitive Behavioural Therapy (CBT) as the preferred psychological intervention. Sage et al.'s[13] 'CBT for Chronic Illness and Palliative Care' handbook explains that people vary in the way they cope with distress, where focusing on the 'here-and-now', can allow people to practically manage thoughts, feelings, and behaviours and thus prompts change in how the person manages their LTC. The previously stated research (e.g.[11,14,16]) shows that there are commonalities of experience across people who live with LTCs, yet currently there is no other published NICE guidance for other co-morbid mental health difficulties, including anxiety. Within NICE guidance for specific LTCs, such as for chronic obstructive pulmonary disease[21] (COPD) and chronic heart failure[22], there are recommendations to offer psychological support, although they do not specify a particular type of therapeutic modality. However, the NICE guidance[23] for supporting people with

cancer recommends the use of Solution-Focused Brief Therapy as an additional intervention approach to CBT.

The efficacy of CBT

There is a large amount of evidence suggesting the effectiveness of CBT for people with a range of LTCs, such as sleeplessness in people diagnosed with cancer[24], anxiety experienced by people with HIV[25], and quality of life for people with skin diseases.[26] However, there is also evidence to suggest that CBT may not be effective for a number of people with LTCs. For example, a systematic review of controlled trials by Farrand and Woodford[27] showed that CBT had limited effectiveness for people with LTCs experiencing either depression and anxiety. Another study found that CBT treatment effects were not statistically significant for people with cancer.[28] There is also evidence to show that the effectiveness of CBT is mixed, as Coventry and Gallatly[29] found that, for people with COPD, CBT was effective for depression but not for anxiety. While it is unclear why CBT may be helpful for some people and not others, the findings from section one of this thesis suggest that elements of the therapeutic approach, such as managing homework tasks, may not meet the needs of people with LTCs. Furthermore, although randomised controlled trials (RCTs) have shown examples of how CBT can be efficacious for illness-related mental health distress (e.g.[30,31]), the evidence shows that CBT was only effective for a proportion of the sample, albeit a large proportion, which suggests that the rest of the participants may benefit from receiving an alternative therapeutic modality.

What matters to people living with LTCs

Studies of how change in therapy occurs date back to the 1980s, when Greenberg[32] identified that investigating therapeutic change can provide insight into how people

experience therapy. Understanding exactly which components of therapy are effective[33] and the processes of change can provide a deeper understanding to what matters to SUs.[34] A number of studies which investigated how people with LTCs perceive psychological interventions have identified that setting appropriate goals and working collaboratively with the therapist were regarded as important to service users (SUs).[35–37] When therapy was used as a space to identify SUs' personal resources and different ways of coping with difficult situations, it enabled people to feel better equipped to manage their health.[1,2] Based on the findings of these studies it can be concluded that working together with the therapist to identify personal resources, which then can lead to the therapist and SU to set achievable goals, are likely to be activities of key importance for people living with LTCs.

Solution-Focused therapy as an alternative therapeutic modality

Solution-Focused (SF) therapy is an approach that focuses on identifying personal resources, goals which matter to the person, and solutions to their problems.[38,39] These therapeutic principles are different to those found in CBT, which focuses on the problems, erroneous thinking patterns and negative impacts on the person's behaviour.[13] SF therapy can be applied to a broad range of distresses experienced by people with LTCs[40], as a number of the techniques focus on empowering the person to be independent, to identify inherent resources and to encourage future-orientated goals.[41] The NHS England Personalised Care and Support Planning framework[42] states that clinical practice should focus on individuals' best hopes and draw on their skills to work towards a solution, rather than using a problem-focused approach to managing care. The principles of SF practice are therefore in line with these guidelines and are pertinent to supporting SUs to live well beyond therapy.[43] Although clinical practice and research demonstrate the efficacy of the therapeutic approaches, the specific mechanisms of how therapeutic techniques lead to improved mental health requires

better understanding. Studying the mechanisms of SF therapy and how they contribute to psychological wellbeing would be worthwhile and valuable for developing the understanding of what works in mental and physical health wellbeing more broadly.

In a microanalysis study of therapy content comparing CBT and SF therapy[44], it was found that discussion of negative issues was significantly higher in CBT. Conversely, SUs who received SF therapy discussed more positive and empowering topics.[44] This style of therapy which focuses on goals, achievements and the future can be hugely beneficial to people living with LTCs, who may experience struggles with adaptation to their health condition[45] and hopelessness for the future.[46]

As aforementioned, the only NICE guidance in existence for people with LTCs suggests the use of CBT.[20] Although there is research which suggests that CBT is an efficacious therapy model (e.g.[24–26]) this may be influenced by factors which make CBT lend itself to be more easily investigated through quantitative research designs, which in turn produce findings which are more generalisable. These factors include an emphasis on outcome measures within CBT, the use of a modular, step-by-step approach[47], and CBT's adaptability for use with people with an increasingly wide range of mental health difficulties.[48] As CBT is regarded as the dominant therapy model due to its efficacy being well-supported by the evidence-base, it is important to acknowledge that the therapeutic style and the focus on negative content may not meet the needs of everyone with LTCs.[49] Meanwhile, SF therapy's principles which focuses on strengths and resources may be an alternative therapy approach for people with LTCs.

The current evidence base

SF therapy is seen to be beneficial in other clinical populations, such as adults with mental health difficulties[50,51], and children and adolescents experiencing distress.[52] Although there is a dearth of research studying SF therapy for people with LTCs, one recent study[35] highlighted a number of positive experiences when this approach was used. For example, the identification of resources allowed people to cope with upcoming difficulties, to initiate change autonomously, and to achieved a sense of hope for the future.[35] Further exploration of how SF therapy is experienced can be beneficial in understanding how aspects of the intervention can be useful.[35] Moreover, Dellasega et al.[36] supports further research into innovative interventions for people with LTCs, in the hope that people presenting with complex and multiple needs may benefit from approaches which are different from those currently offered.

The use of discursive psychology

Discourse analysis (DA) was first introduced within social psychology[53], which studies the function and nature of linguistic and textual data. Within psychology, discursive approaches views language as a person's tool to construct psychological and social reality, rather than viewing language as a direct reflection of a person's reality.[53] As the approach assumes that language is understood through social processes in which there are no objective truths to uncover, it is argued that DA is aligned to social constructionism.[54]

There are many forms of discourse analysis, such as critical discursive psychology, Foucauldian discourse analysis and discursive psychology; the latter is most closely associated with the work of Potter and Edwards.[55] As a qualitative methodology, discursive psychology can be used to highlight people's constructions of their worlds through language

use. Using discourse analysis for this study would be particularly helpful in order to provide a deeper understanding of how people identify resources and goals within therapy. A core assumption of discursive psychology is that language is used to convey social functions through a variety of strategies.[54] In contrast to conversational analysis which is concerned with linguistic organisations and details of utterances, discursive psychology focuses on the social organisation of talk and highlights how discourses are shared across conversations.[54]

The current study

The present research aims to develop an understanding of how people with LTCs construct preferred futures and resources with their practitioners in an initial SF therapy session. Many of the studies in section one of this thesis comment on the weaknesses of the interview approach to qualitative data collection, noting that participants were keen to focus on the successes and shortcomings of the intervention (e.g.[1,36]). Conversely, conducting a qualitative study using therapy recordings can capture what actually takes place in therapy and therefore provide deeper understanding of how therapeutic change occurs. As SF therapy pays close attention to the language used by practitioners and SUs, analysing the therapy content through an approach informed by DA will build upon the knowledge of how SF practice can support people to identify desired outcomes and adapt to their health condition. It is hoped that the results of this study will support developments in guidance and service delivery.

Method

Participants

This study recruited two sets of participants; practitioners who provided SF therapy (referred to as 'practitioner participants'; PP) and 'service user participants' (SUP). In total, twelve participants (see Table 1) took part in the study, forming eight practitioner and SU dyads (see Table 2). The Chief Investigator recruited PPs through a NHS clinical health psychology service; SUPs were identified by the PPs, and both recruitment strategies followed their respective inclusion and exclusion criteria.

TABLE 1 HERE

TABLE 2 HERE

The inclusion criteria for PPs were: practitioners offering an initial therapy session to a SU with a LTC using a SF approach; and practitioners who carried out therapy in English. Exclusion criteria: practitioners who do not have the capacity to consent to participation in this study. Practitioners were not excluded based on job experience or professional qualification. Inclusion criteria for SUPs: adults from age 18; people who were starting therapeutic work that used SF approaches; people who communicated in English; and people with any LTC, which could be defined by service access or self-identification. No potential SUPs were excluded on the basis of their LTC as this study aimed to capture a range of experiences and aimed to identify SF principles across a variety of health conditions. Exclusion criteria for SUPs: people who were receiving therapy but not engaging in SF

approaches and people who did not have the capacity to consent to research. PPs' capacity to consent was determined by the Chief Investigator, and SUPs' capacity was determined by the PP using the same procedure (see Guidance for Practitioners in Appendix 4-C). Based on the health conditions reported by SUPs, purposive sampling was used for this study as it aimed to gain a range of experiences from people experiencing different health conditions.[56] PPs were asked to recruit no more than three SUs to form separate dyads, to ensure that data was collected from a variety of SF practitioners.

Design

This study used a qualitative research design where the data comprised audio recordings of SF practice. Data were analysed using a Discursive Action Model (DAM) informed approach, following the framework by Potter, Edwards and Wetherell.[57] As a particular type of discursive psychology approach, DAM studies how people talk about their experiences and how they make sense of their environment; this approach is widely used in the context of health psychology, medicine and self-help groups.[58] As Coyle[54] stated that the "preferred form of text within discursive psychology is a naturally occurring one" (p.105), the data for this current study were collected through a more naturalistic and contextually-grounded approach of using audio recordings of live therapy, rather than collating data derived from interviews with participants.

Procedure

The initial stages of recruitment involved attending service meetings to raise awareness of the research project and to distribute recruitment materials to potential PPs who met the inclusion/exclusion criteria. Recruitment materials (Appendix 4-C) were distributed via the administrator and the Field Supervisor so that the Chief Investigator did not have the

details of any potential PPs prior to giving their formal consent to involvement. While the Chief Investigator did not anticipate practitioners lacking capacity to consent, this procedure was carried out to confirm this and to ensure that PPs understood the importance of determining informed consent from SUPs.

SUPs were recruited by PPs through sending the relevant research materials along with their routine initial appointment letter, which ensured that SUPs received the information and had over 24 hours to consider their participation in the research. Potential SUPs were able to formally accept or decline the research participation either before the initial appointment or at the start of the appointment, where PPs provided an overview of the project, information about confidentiality and the right to withdraw from the research. PPs assured that declining or withdrawing from the research did not affect the therapeutic process. If SUPs formally decided to participate, their capacity to consent was assessed by the practitioner before the consent and demography forms were signed.

At the end of the appointment, PPs explained to SUPs that their involvement in the research was complete, but they would continue with the care as offered by their practitioners. Both PPs and SUPs were given contact details of the Chief Investigator, the Academic Supervisor and the Research Director if any concerns were raised. No further contact was made with participants unless they indicated that they wished to receive a summary of the research.

Analysis

The data were analysed using a DAM framework.[57] Edwards and Potter[59] described DAM as allowing researchers to study how life events are described, the constructive nature

of individuals' reports, and how cognitive states are attributed. Used widely in social psychology, the DAM framework can re-conceptualise psychological experiences which are expressed through discourses.[58] All interviews were transcribed verbatim with transcript conventions (Table 3) using the framework provided by Edwards and Potter.[59] All transcripts were analysed to identify common and powerful discourses which were relevant to the research questions. For the purposes of the results, examples from two transcripts will be used to illustrate each of the discourses identified.

TABLE 3 HERE

The DAM model is separated into three elements which guide the analysis (Table 4). First, the researchers focus on 'Action' which investigates what participants do during their interactions with others. During this step, the researcher also seeks to understand how participants assign causes to events through their accounts. Second, the 'Facts and Interests' are analysed. This element of the model seeks to understand how participants construct their own accounts, how they react to the accounts of others, and how they balance these potentially differentiating views. Third, 'Accountability' is investigated. Participants' agendas and personal accountability are analysed to determine how concepts such as blame and responsibility occur. Implications of these accounts were also studied, which may contribute to the overarching narrative of the conversation.

TABLE 4 HERE

Statement of reflective position

Conducting qualitative research requires the researcher to take a reflexive stance and to consider how the researcher's experiences can influence the analysis and interpretation of the data.[60] It is important to acknowledge that I have professional and personal interests of working with people with LTCs, which prompted me to take a mindful approach that this research can be a product of personal views and experiences.[61] The use of a reflective journal to document my personal feelings, and sharing these with the Academic Supervisor through regular supervision ensured that pre-existing perceptions did not influence the analysis of the research.[62] I acknowledge that I view the world and operate on a social constructionist stance. The epistemological viewpoint is particularly important for me as I believe that a person's understanding of the world, their experiences and their construction of language are shaped by social processes. How people experience their LTCs and psychological therapy is central to my clinical interests, which contributed to the drive of undertaking this study.

Ethics

This research study and the accompanying ethics application were approved by the NHS Research Ethics Committee (Appendix 4-D) and the Health Research Authority (Appendix 4-E). Although demographic information was collected, all participants were given a pseudonym to protect anonymity and therefore no personally identifiable information was used within this report. The author approached the research materials mindfully as both practitioners and SUs were recruited as participants; to ensure that the research materials were accessible to SUs of varying ranges of literacy abilities, their respective materials were designed in an easily understandable format with feedback sought from people who used services from the University's Public Involvement Network. Separate materials were developed for practitioners which were also checked by the Field Supervisor to ensure that all

information was clear, particularly as practitioners also acted as recruiters as well as
participants.

Results

The analysis focused on how SUs and practitioners constructed discourses about
resources and preferred futures through SF conversations. Analysis was divided into two
sections, to answer each of the research questions in turn (see Appendix 2-B for extended
extracts).

Research question one: construction of resources, skills and strengths

Within this section, two discourses are considered: 'practitioners' use of assumptions
drew out resources' and 'explicit commentaries construct change'.

Discourse one: practitioners' use of assumptions drew out resources (figure 1)
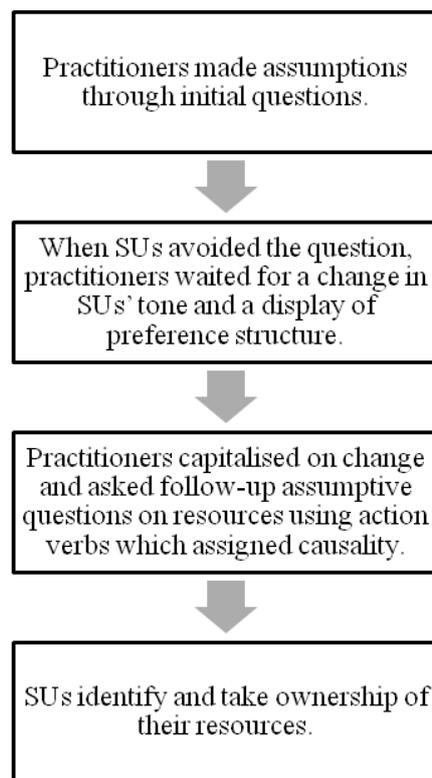
Figure 1. Process of discourse one: assumptions

Practitioners asked assumptive questions in a variety of ways to elicit different types of resources from SUs.

Extract 1 - Andrew and Debbie

1	Practitioner	how would [your grandchild] know today that this had done you good (.) how would she know that [you were] on form [today] (.) <u>really</u> on form
2	SU	she wouldn't i-it's just that I love her to bits
3	Practitioner	so are you (.) you'll just be just the ↑same[?]
4	SU	(.) yeah
5	Practitioner	so what are you already doing <u>well</u> with [your grandchild] even despite everything you've been through the things that we talked about today what are you already doing <u>well</u>
6	SU	I/I'm just her Nan
7	Practitioner	yes
8	SU	I'm just there for her (.) if she needs me
9	Practitioner	yes
10	SU	↑I mind her when I need to so I'm just her Nan
11	Practitioner	yes
12	SU	>I'm just a normal person to her I'm just her Nan ↑who loves her

		very much and I think she's loves me as well [smile]<
13	Practitioner	so you've kept that going even though
14	SU	↑yeah
15	Practitioner	you've had these <u>distress</u> behind the scenes but from [your grandchild's] point of view
16	SU	↑yeah

When practitioners ask questions with assumptive elements, these can be seen as implicit propositions that fulfil a *validation function.*[63] A validation function, within the context of a conversation, is when a person purposefully constructs an utterance with the purpose of eliciting agreement or acceptance (p.98).[59] In relation to this discourse, this can lead SUs to accept and validate the practitioner's propositions as well as their own opinions and memory of their resources. One way in which practitioners asked assumptive questions about resources involved the use of an external perspective. For example, in extract 1 Andrew (practitioner) asked Debbie (SU) how her grandchild would describe her qualities. In doing so, Andrew makes the assumption that Debbie has resources, and deploys the use of an external source to confirm this (line 1). Another way practitioners asked questions was through directly enquiring how multiple people contributed to the SU's resources, such as when Clare (practitioner) asked about Beth's (SU) resources and how she navigated life with an LTC, as well as emotional distress, with her family; "what is it that helps you all get through what is it about the family that (.) that rises to these challenges?".

At times SUs avoided answering such questions (e.g. lines 2, 6 and 8, extract 1), which can be seen as an attempt to terminate the conversation about resources. On these occasions, practitioners waited for a change in the SU's intonation ("↑I mind her when I need to"; line 12) which signalled that the SU was considering a change in topic. In addition, practitioners appeared to be listening out for the SU to display a *preference structure* (p.52)[59], a discursive structure of utterance which is used when the speaker is signalling agreement or

compliance. When a preference structure is displayed (lines 10 and 12), the person's speech tends to be more fluent and less marked by hesitation (p.52)[59].

When such a structure is displayed by the SU in combination with an intonation signalling a change in topic, the practitioner then tended to ask a further assumptive follow-up question (line 13). Within these follow-up questions, practitioners used different types of verbs, such as "you've kept" and "going" (line 13). Their usage can be seen through the lens of *attributional semantics*[64], where the verbs can infer meaning and causality to a certain person within a conversation. These follow-up questions appeared to fulfil the purpose of eliciting additional resources from the SU or clarifying those identified in the previous question(s). By using action verbs, practitioners frequently assigned agency to the SU and invited them to accept this assignation of agency. At other times, practitioners' use of action verbs instead assigned causality to external sources of support, such as when Clare (practitioner) used "helps" and "rises" to enquire about Beth's (SU) family. However, this alternative strategy was also successful, as SUs could then comment on their access to external support systems: "well my dad- is my rock" (Beth), in relation to how this contributed to their own coping resources.

Once causality or agency was assigned to the SU, they took on the role of an agent and were able to attribute changes to their own personal action within the subsequent conversation. This resulted in SUs fully engaging in the conversation about resources and taking ownership of their qualities.

Discourse two: explicit commentaries construct change (figure 2)
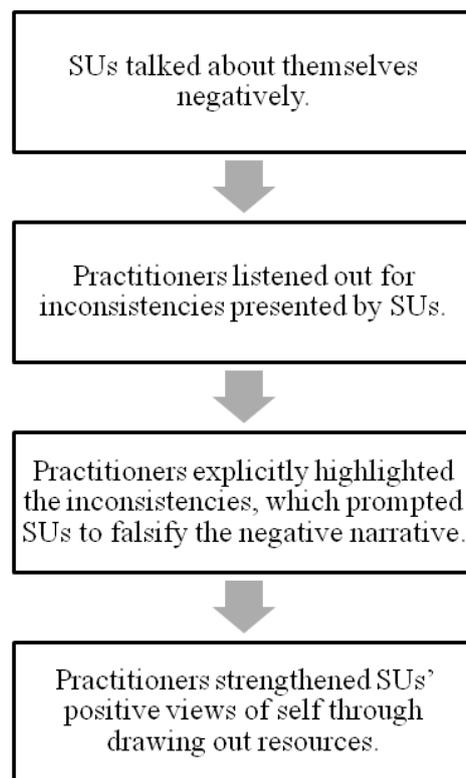
Figure 2. Process of discourse two: explicit commentaries

When SUs talked about themselves negatively, these accounts were at times made stronger and more convincing using the *rhetoric of argument.*[65,66] This is a device which operates through presenting something in a logical-sounding and impersonal language structure, which hides the speaker's partiality and draws a conclusion that appears rational, therefore making it hard for others to challenge (p.135)[59]. As DA is generally used to study texts, examples of *rhetoric of argument* tend to be more explicit in these formats. However, in a therapy session these conversation devices are likely to be deployed more subtly as the context is more collaborative. Therefore, although the rhetorical arguments were present within the transcripts, they were more implicit.

Extract 2 - Andrew and Matt

1	SU	you know that's er: (.) (.) I do I get very tired er::m (.) >I feel it's probably cos I've had done quite< a- I haven't done any exercise in the last three years since I've been (.) (.) <u>poorly</u> you know
2	Practitioner	mm
3	SU	it's really hard doing a bit more (.) I'll go to gym or something
4	Practitioner	sometimes you are saying whenever I think of doing some exercise I'd lie down til the thought goes away
5	SU	yeah
6	Practitioner	in some way you've said something like that but it sounds like that <u>might</u> be something you would be pleased to notice if you're doing a bit more exercise that's more like you is it
7	SU	yeah I do that and I think I'd like to do a bit more exercise (.) (.) ↑almost cos it yeah especially with the taxi it's a sedentary lifestyle anyway
8	Practitioner	you know that's right so you know the cliche of taxi drivers
9	SU	yeah yeah ↑with a burger
10	Practitioner	I was gonna say eating rubbish [laugh] but that's <u>not</u> who you are
11	SU	<u>no</u> no [laugh]

In extract 2 shows Matt (SU) describing to Andrew (practitioner) how he was not able to exercise as he was fatigued from physical illness (line 1). When SUs presented inconsistent narratives, an opportunity was created for practitioners to rebut such constructions. For example, a SU might argue that they are a negative person, but followed with briefly presenting themselves in a more positive way ("I'll go to the gym or something"; line 3). This appeared to be an implicit communication of resistance to take the full blame or responsibility for accepting the negative narrative of themselves. In another example, Faz (SU) reported to Rachel (practitioner): "when you're in pain so you can't be the life and soul of the party… and [then you can't] go party[ing] like I used to (.) which I'm in pain and you have to cope with the pain."

Once the inconsistency was noticed by the practitioner, they began to highlight these inconsistencies through *footing*[67], a form of talk which describes how either through verbatim reporting or summarising the gist of a conversation, a person can be encouraged to recognise that there are doubtful or questionable elements within their speech act.[68] For example,

Rachel responded to Faz, "yes so you're in a better place than you were"; and Andrew responded to Matt, "in some way you've said something like that but it sounds like that <u>might</u> be something you would be pleased to notice if you're doing a bit more exercise that's more like you is it" (line 6, extract 2). This drew the SU's attention towards their own contradictory narrative and switched the focus from the SU's own memory of themselves as negative, to a focus of considering their recall accuracy (line 7).

Practitioners' rebuttals through reflective commentaries therefore questioned the SU's strongly presented narrative of a negative self by drawing their attention to the narrative of a positive self. Practitioners strengthened this engagement by asking SUs through assumptive style questioning (Rachel: "you don't think about the pain as much so something is happening instead?") of what resources they already possessed which could have contributed to these positive views.

Research question two: construction of the preferred future and goals

This section discussed two discourses: 'de-contextualising for goal construction', and 'removing the blame, effort and failure'.

Discourse three: de-contextualising for goal construction (figure 3)
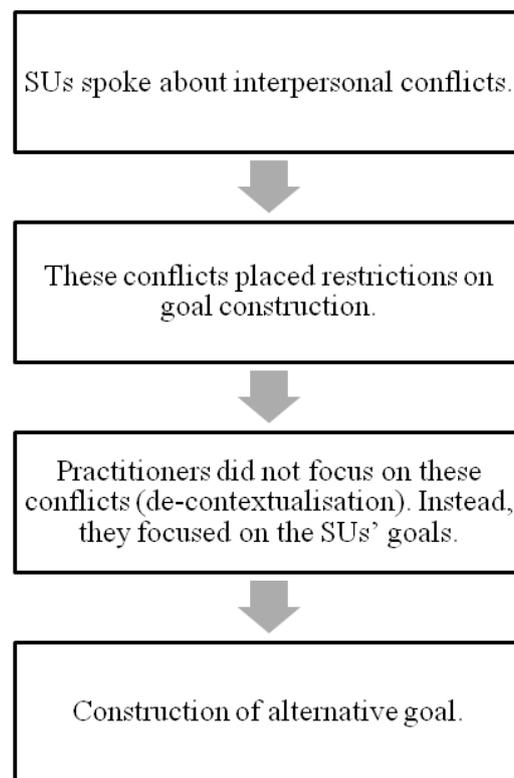
Figure 3. Processes of discourse three: de-contextualising

This discourse typically began with SUs describing their conflicts with other people. SUs presented the conflict as their primary focus rather than how the conflicts could be resolved, which restricted the potential for conversations about goals to take place. For example, at the start of Rachel (practitioner) and Jackie's (SU) therapy session (extract 3), Jackie has fibromyalgia and described how another health professional she had talked to did not realise the ways Jackie undertook physical activity.

Extract 3 - Rachel and Jackie

1	SU	and obviously doesn't understand me circumstances and I know she's only here to do a job but sometimes I think (.) she thinks I need to help myself
2	Practitioner	m: m:
3	SU	but then she doesn't realise
4	Practitioner	all the things you ↑do ↓do
5	SU	yeah

6	Practitioner	tell me what you ↑do ↓do
7	SU	dyou mean in the house and stuff
8	Practitioner	yeah: tell me the ways you've found to try and (.) erm I guess live well with this condition the ways what do you do
9	SU	>I don't think I am living well with it though<
10	Practitioner	ok
11	SU	I feel like- I'm constantly in pain and I'm constantly tired but then on the other hand I do do the washing up and do the ironing I make sure I do that
12	Practitioner	wow
13	SU	if nothing else I do do that >you know I'll hoover up and I'll tidy round<
14	Practitioner	yeah yeah cos those things are important to you to be able to do those to spend energy on those kinda things is that
15	SU	yeah
16	Practitioner	>is that right in your world in your kind of world in your life that's that's a good use of your< energies
17	SU	well ↑I think so

After listening to the SUs' accounts of the interpersonal conflicts, practitioners chose to remove focus from these conflicts by setting them aside and instead focused on the SU's aims. This removed the context of the disagreement and the restriction from the conversation. For example, Rachel began asking Jackie to clarify the tasks which she did undertake (line 6). In relation to the DAM, Jackie's reports can be seen to be rhetorically organised to undermine alternative accounts.[59] Within this discourse, Rachel demonstrated that she was listening to Jackie's account of conflict (line 2), then asked Jackie, "tell me what you ↑do ↓do" (line 6). Rachel appeared to have deployed a strategy called *attribution management* (p.123).[59] Attribution management refers to the discursive element where person X is factually reporting an event, which can incorporate the person's own agenda or concerns, and person Y separates this relationship between fact and rhetoric.

In relation to this discourse, practitioners appeared to utilise attribution management to separate the rhetoric of remembered conflict from the SU's goals. By asking questions

without reference to the interpersonal conflicts ("tell me the ways you've found to try and...

live well with this condition the ways what do you do"; line 8), practitioners led SUs to take a

broader view of their aims. In doing so they were encouraging SUs to make *high-level*

construals, which are a conceptualisation of the future at a more abstract and less context-

driven level. Trope and Liberman's construal-level theory[69] details how construals of this type

lead people to view events globally instead of becoming entangled with contextual factors.

High-level construals are described as a psychological distance which enables a person to

study the bigger picture and are able to focus on the prominent elements within a complex

situation.[69] Trope[70] argues that when people are making high-level construals, they are less

likely to be distracted by what took place within situations, which increases their chances to

achieve their goals. Conversely, when people adopt low-level construals they tend to think

more concretely about a situation and may focus on minor details. In relation to this

discourse, utilising low-level construals may be unhelpful to SUs as it means that they are

focused on the details of the conflict rather than evaluating the situation from a distance and

from a less context-driven level.[69]

     As the conflict was no longer the central focus of the conversation, the opportunity

then arose for the SU's aims to become the focus instead (lines 11 and 13). Without the

restrictions imposed by descriptions of the conflict situation, SUs appeared to be able to

concentrate on their goals during the subsequent conversation and hence were better able to

take responsibility over the construction of their goals (lines 14-17).

     At times, practitioners included the people mentioned in the conflict (i.e. as involved

parties) but without repeating the circumstances around the interpersonal conflict. For

example, in Andrew's (practitioner) therapy session with Sue (SU), she reported that her husband had a lack of interest in participating in activities with her, "I want to be able to <u>get</u> out and <u>do</u> things and and he's now saying ↓oh well can't leave the dog at home so ↑he's now blaming anything." Andrew responded, "so you'd love to actually physically be out and about and is it does it only <u>count</u> if it's with [your husband] or be out and about on your own is that >is that something you'd also be pleased to <u>notice</u><." This appeared to be the practitioners' attempts to demonstrate that they had listened to the SUs' accounts and that all the presented information, including the conflict, was taken into account. In addition, this maintained the involved parties' position within the conversation but de-contextualised and removed the elements of conflict.

Discourse four: removing the blame, effort and failure (figure 4)
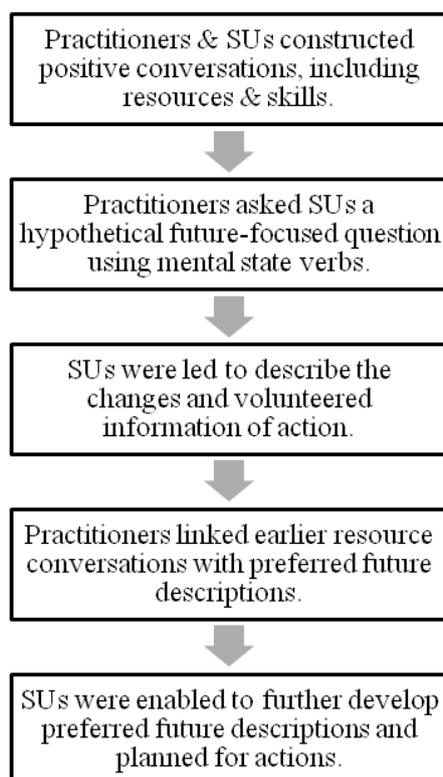
Figure 4. Processes of discourse four: removing blame, effort and failure

Toward the end of the therapy sessions, practitioners asked SUs a future-directed

question which had specific characteristics: they had a hypothetical element and used mental

state verbs (related to *attributional semantics* seen in discourse one).

Extract 4 - Clare and Bill

1	SU	er:m >well because like I say< I know <u>deep</u> down I tend to believe the [specialist doctor] who did the ↓erm angiogram ↑who told me everything was <u>alright</u> erm (.) the doctor who was an associate of the specialist (.) erm he did I/ I don't he/ he read the notes erm and I don't think he >you know as far as I'm concerned he was <u>incorrect</u>< and I'm/ I'm sticking with what [the specialist] had said
2	Practitioner	you haven't actually <u>looked</u> so you've got the evidence of the [specialist doctor] that <u>looked</u>
3	SU	yes yes yeah so [the specialist doctor] looked and they said everything was ok (.) erm but it's/ it's the- it's the erm (.) I think it's just the vulnerability of/ of not worth whereas <u>before</u> (.) I knew I was fixed >so

		to speak< and ↓now I don't feel as though I am that that it could happen (.) and it has happened a few times I've been in hospital two or three times because but/ but I have/ I have figured that out (.) was that when I've had pains in my chest and I've the GTN spray which they give ya >which I don't take very often< erm it has made me faint I thought it was the heart attack getting worst (.) but the guys that came said it's probably your GTN it makes you it affects you/ it makes me pass out erm and that's happened three times (.) erm but the ambulance crew sorted that out they'd taken me in but it's only my <u>enzymes</u> being up and then they go out they have to keep me for 24 hours and ↑that's not a heart attack
4	Practitioner	yes
5	SU	that's probably (.) these muscle spasms which- coronary artery spasms which says (.) but I/ I say I/ I um I- I- I just- I just still feel as vulnerable and as <u>stupid</u> as I fee:l (.) by/ by erm having this lack of confidence not driving and I'm not I just-
6	Practitioner	you wanna go this way [movement noise]
7	SU	yeah that's what I'd <u>like</u> to get out of it
8	Practitioner	so if you're- if you're a say <about half way now> and that's because obviously you've always been a confident person
9	SU	yeah
10	Practitioner	you've got the support of your <u>family</u> (.) you're determined to bring the <u>logical</u> brain in and go forwards
11	SU	yeah
12	Practitioner	<what would tell you um SU> that let's say/ say/ say you >came back next time or some time in the near future you say to yourself< ↑ah (.) things are a little bit better (.) what would <u>tell</u> you that or what would you <u>notice</u>
13	SU	if I could get through a day without thinking about dying [laugh] cos I do think about it maybe eight to ten times a day >just comes over me<
14	Practitioner	so if you didn't think <u>about it at all</u> where would you be
15	SU	erm if I didn't think about it at all I'd be back where I was I'd be nine out of ten >ten out of ten<
16	Practitioner	you'd be back [as a confident person]
17	SU	yeah cos I've always <u>loved</u> life I absolutely (.) ↑loved being with my family and being retired and everything that <u>life has to offer</u>
18	Practitioner	yeah
19	SU	you know I'm not I'm not erm everything was great
20	Practitioner	<the first that you'd notice is thinking less about ↑dying>
21	SU	yeah
22	Practitioner	yes what would you be thinking <u>instead</u>
23	SU	oh >where we're going today what we're gonna do where will we take the kids out you know the children out erm< just/ just those/ those type of things I wonder if I'll make a few bobs today [laugh] yeah

In extract 4 the practitioner asked "what would you notice [between now and next session]?" (line 12). Rather than using action verbs, in this case practitioners chose to use mental state verbs (e.g. "notice") which had the effect of removing responsibility from the person to take direct action (and also removed any perceived blame for not having taken any action). In addition, rather than presenting these future-directed questions as a task, such as "what will you do between now and next session," practitioners engaged SUs in a thought experiment of the changes they would like to observe rather than asking them to be active in making changes. The effect of this was to further contribute to the characteristic of removing the possibility of failure on the SU's part. For example, when Clare asked Bill "so if you didn't think about it at all where would you be" (line 14), the use of the mental state verbs ("think", "where") engaged Bill in a thought experiment and prompted him to volunteer information of action, where he would not be thinking about death and instead he would be thinking of spending time with his family (line 17). It is seen within this discourse that the hypothetical nature of the question removes the possibility of failure, and the mental state verbs remove the responsibility to take any action. When used in combination, they removed the effort for the person to take action.

On the rare occasion where a practitioner did use an action verb (e.g. "tell") this was always in addition to a mental state verb ("notice"; line 12). While this combination had the effect of placing some responsibility on the SU, the use of the mental state verb softened the overall level of responsibility, thus maintaining the overall question as an observation rather than a task. Asking questions with a combination of action and mental state verbs appears to have increased the likelihood of SUs imagining changes that could take place.

Edwards and Potter[59] argue that most utterances involve attributing accountability and agency to a person. Within this discourse, practitioners' future-directed questions had the opposite effect of removing accountability and agency.

Although practitioners removed any requirement for action from the SU through the way they framed their questions, which allows space for ideas and outcomes, SUs appeared nevertheless to volunteer to make actions. In doing so they may well have been behaving according to the *maxim of quantity*[71], an assumed cooperative principle which describes how within a conversation, a person should offer only as much information as required on a subject, and nothing more. However, as there was no requirement for the SU to respond with action, a void was left after the practitioner asked the future-focused question. As there was still a conversational expectation to provide further information as a response to the practitioner's question (lines 14 and 16), the SU then seemed to fill the void by volunteering information related to making an action. This can also be seen as a fulfilment of the *maxim of relevance*[71], which rules that a person must offer information that is relevant and pertinent to the discussion.

Once SUs volunteered their intended actions, practitioners then linked the resources which had been elicited earlier within the therapy session with the SUs' preferred future, which was elicited from the future-directed question. For example, Clare said to Bill, "the first that you'd notice is thinking less about ↑dying" (line 20) which made a reference to the earlier constructed resources of Bill being a confident and logical person (lines 5-11). In another example, Natalie (practitioner) demonstrated this link between resources and preferred futures by saying to Sharon (SU), "great to hear that you'll try it out tomorrow that's

fantastic and I'm sure that by the sounds of it that kind of <u>determination</u> and the fact that

you'll <u>see</u> through what you do is some of your <u>strengths</u>."

After a link was made between resources and preferred futures, SUs were enabled to

further develop these descriptions of preferred futures and plan for action. For example, after

Natalie (practitioner) asked Sharon (SU) a future-directed question ("what would help you go

up that scale [of your mood] a <u>tiny</u> bit... <u>what</u> would make it go from five to five and a half

[out of ten]"), Sharon responded: "maybe something that you sa- (.) that we sa- (.) that we

broached on <u>before</u> when we were talking about this getting out of bed thing... <put that plan

into place that actual> small thing." Within SF therapy, this is a *miracle question,* a goal-

directed approach. Practitioner*s* appeared to have used the resource conversations to imply

that the SU had agency in the situation, which led to an increase in confidence and

willingness to construct a preferred future. Here, it is seen that SUs were driven to take an

instrumental action[72], an action sequence where a person considers various means to achieve

a goal, and then applies this reasoning as an expectation of attaining these goals. In relation to

this discourse, SUs' awareness of their resources were taken into consideration to evaluate

whether or not they could expect to achieve their goals, and as practitioners linked resources

and preferred futures, SUs appeared to have rationally calculated that these goals were a

realistic expectation, thus leading to an increase in confidence and willingness to carry out

the instrumental action of constructing a preferred future. This appeared to have strengthened

the SU's interest in developing the descriptions of preferred futures and motivated them to

plan for actions related to their preferred future (Sharon: "it's a challenge that [goal] (.) I like

challenges I suppose").

Discussion

Current findings

      This study aimed to develop understanding of how people with LTCs construct preferred futures and resources with their practitioners through SF conversations. Discourse one described practitioners' use of assumptive style questioning to draw out the inherent resources which SUs had, which led SUs to identify and take ownership of these resources. Discourse two considered the function of explicit and reflective comments made by practitioners in relation to SU's reports, which turned implicit communications of change into explicit descriptions of resources. Discourse three described the way practitioners removed restrictions to de-contextualise SUs' conflicts to elicit preferred futures. Finally, discourse four described practitioners' future-focused questions which removed the effort for SUs to pursue goals, and through inferential linking to resource conversations, enabled SUs to construct preferred futures.

The trans-theoretical applicability of discursive mechanisms

      The current study found a number of discursive mechanisms within practitioners' and SUs' speech which led to constructions of resources and preferred futures. Although this research has highlighted the discursive mechanisms which were operating within the SF therapy model, their applicability is not limited to a single model. Many elements of the discourses are similar to the techniques found in Motivational Interviewing[73], Narrative Therapy[74], Systemic Family Therapy[75], and CBT.[76] For example, the use of *attributional semantics*[64] in discourse four to remove the blame, responsibility, and effort for SUs to take any action can be seen as a technique in Narrative Therapy, where therapists practice from a motive-less and decentred position.[77] The current findings suggests that there are discursive

overlaps between therapeutic modalities and therefore these mechanisms are arguably trans-theoretical and so could be used to develop other models of therapy.

The current findings highlighted that discursive mechanisms which were found within SF therapy sessions, contribute to the current understanding of what is efficacious within therapy. One of the most valued aspects of clinical psychology practice is the emphasis placed on utilising the breadth and depth of psychological therapies.[78] As such, a key finding emerging from research of therapeutic outcomes is the importance of integrated therapies. A number of studies have suggested that therapy which incorporates elements from more than one model can demonstrate positive clinical outcomes for SUs (e.g.[79–81]). The practice of integrated therapy is in congruence with the view that therapy should be holistic, person-centred, and tailored to the needs of SUs.[42,82] As aforementioned, the discursive mechanisms highlighted in this study are deployed in a range of therapeutic models, and therefore these mechanisms can be used to develop integrationist approaches. Furthermore, as eclecticism is the most commonly reported theoretical orientation[83], and the flexibility of utilising different approaches is highly valued in clinical psychology practice, the current findings can add to the implementation of integrative therapy which furthers the drive to deliver person-centred care.

The findings of this study also extend the current knowledge of processes in therapeutic change. Greenberg[32] argued that identifying, describing, and explaining the processes which lead to therapeutic change are highly valuable in contributing to knowledge of how psychological therapies should be delivered. In Elliott's[84] research, he found that a major 'helpful event' within therapy was when practitioners provided new information to increase insight, awareness, and cognitive restructuring. Another 'helpful event' found in

Elliott's[84] research was when people were guided by practitioners to develop alternative goals and to be able to progress towards these goals. Although Elliott's[84] findings relate directly to the discourses around resources and goals, other processes were observed. Not only did practitioners within this study increase SUs' awareness of resources, discursive techniques were deployed to argue for SUs' ownership of these resources, which were inherent to the SU rather than a newly-acquired set of skills developed within the therapy session. The current findings arguably add strength to the above research of therapeutic processes. Additionally, the present study provides richness through highlighting the details of how change processes operate within therapy, as it is data-driven rather than interpretative. Overall, this provides new insight which existing research does not offer.

Many researchers have suggested that the common factors shared between therapeutic practices lead to positive clinical outcomes (e.g.[85,86]). In a study of therapeutic processes, Lambert[87] found that the common factors were responsible for 30% of change, whereas the model of the therapy was only associated with 15% of therapeutic change. More recently, Clarkson's[88] model of positive therapeutic relationships supports this finding; she explained that a therapeutic relationship should include a foundation of the following common factors: "unconditional acceptance", "being human", "agreed goals" and "empathy" (p.136). It is now well established from a variety of studies that it is not the techniques which therapists use, but the common factors which affect therapeutic change. The current findings extend the evidence-base around common factors through identifying the most effective discursive elements of therapy which led to therapeutic change. These mechanisms should be integrated into therapeutic practice, as this study has shown them to be efficacious for constructing resources and preferred futures for SUs.

Strengths and limitations of the study

As one of the aims was to understand how preferred futures, including goals, were constructed between practitioners and SUs, recording only the first SF therapy session between each pair is a limitation of the study. Although the findings highlight the discursive mechanisms involved in the construction of goals, the scope to record subsequent therapy sessions would provide greater insight into the transferability of these constructions between therapy sessions and whether or not these discursive mechanisms were successful in eliciting change in the long-term.

There are ethical issues around conducting research with people with LTCs[89] and there are usually high attrition rates in participation.[90] As the exploration of LTCs can evoke thoughts and emotions around mortality[91], managing participants' and researchers' distress can be complex.[92] Although there can be difficulties with recruiting participants from a LTC population, using an innovative methodological approach such as the one used in this study can reduce the emotional demands placed on participants and researchers.[93] The use of audio recordings of the therapy sessions can be seen as a relative strength as it avoids creating undue distress and is arguably more naturalistic and ecologically valid. Themessl-Huber et al.[94] recommended that this method should be used more frequently as their research found that not only did recording therapy sessions reduce ethical risks, but it also had no significant effect on the therapy content or the decisions made.

Clinical implications

The discursive mechanisms highlighted within this study are trans-theoretical and may support people with LTCs to identify resources and goals regardless of the therapeutic modality offered by services. Clinical guidance such as The NHS England Personalised Care

and Support Planning framework[42] supports the view that therapy should enable SUs to utilise their resources, then move to draw out the person's best hopes, allowing them to find solutions and ways of managing their LTC. Moreover, research suggests that identifying resources, being better able to cope with difficult situations[36], and setting appropriate goals[35] are valued highly by people with LTCs. As aforementioned, the current findings identified the most effective discursive elements of therapy, therefore practitioners providing psychological therapies to people with LTCs should consider adopting the discursive mechanisms within their therapeutic sessions to enhance positive clinical outcomes. For example, when practitioners ask goal-related questions they can ensure that these questions are hypothetical and involve the use of mental state verbs, so as to avoid the possibility of failure and responsibility. In this study it was shown that by removing these elements, SUs were successfully prompted to volunteer to take actions.

Furthermore, the discursive mechanisms highlighted in this study can be found in other therapeutic models and are in line with the evidence from change process research (e.g.[84]). The processes which enable SUs to make steps towards change can contribute to a positive therapeutic relationship, and are now well established from a variety of studies as the most important factor in psychological therapy (e.g.[86,87]). Several lines of evidence suggest that there are factors which can lead to therapeutic ruptures, such as a lack of collaboration between therapists and clients[95], and also when clients do not understand or agree with goals.[88,96] The findings of the current research suggests that practitioners should consider utilising more integrationist therapy approaches, such as a combination of techniques from different therapeutic models, which are in line with current guidance of person-centred practice for people with LTCs[97] and are advantageous in maximising the clinical outcomes for SUs.[98]

Recommendations for future research

As the current study focused on initial therapy sessions where goals and resources were proposed, recording the subsequent therapy sessions would be helpful to further our knowledge of how resources were utilised and where goals were achieved over the course of the therapy. A qualitative research design which replicates the current methodology would preserve the integrity of recording live therapy sessions, and would also utilise the DAM approach in exploring how language and communication lead to the construction of goals and resources over time.

Future research should focus on studying other therapeutic models using DA to provide insight into the transferability of the discursive mechanisms highlighted in this study. As these mechanisms were found to be effective elements of therapy, studies into other modes of therapy using DA could contribute to the current understanding. Through either observing the use of similar discursive mechanisms within other models of therapy, or finding the deployment of different discursive techniques, these results could strengthen the current findings or be combined with the mechanisms identified in the current study to develop a new, integrated therapy approach.

Conclusion

The construction of resources and goals between practitioners and people with LTCs has been shown to be multifaceted. Practitioners used a number of discursive mechanisms to elicit resources and preferred futures from SUs. The discursive mechanisms highlighted in this study are not limited to SF practice and can be seen in the techniques of other therapeutic modalities, thus the discursive mechanisms may have trans-theoretical applicability. This

research study shows that the discursive mechanisms within therapy highlights the

opportunities for development in medical and clinical psychology interventions.

References

1.   Angel S, Jensen LD, Gonge BK, et al. Patients' interpretations of a counselling intervention for low back pain: A narrative analysis. *Int J Nurs Stud*. 2012; 49: 784–792, http://dx.doi.org/10.1016/j.ijnurstu.2012.01.010.

2.   Bremander A, Bergman S, Arvidsson B. Perception of multimodal cognitive treatment for people with chronic widespread pain-changing one's life plan. *Disabil Rehabil*. 2009; 31: 1996–2004, http://dx.doi.org/10.3109/09638280902874139.

3.   Nikcevic A V., Kuczmierczyk AR, Bruch M. *Formulation and Treatment in Clinical Health Psychology*. Hove, East Sussex: Routledge, 2006.

4.   Naylor C, Parsonage M, McDaid D, et al. *Long-term conditions and mental health: The cost of co-morbidities*. London, http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf (2012).

5.   HM Government and Department of Health. *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. London, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf (2011).

6.   Cimpean D, Drake RE. Treating co-morbid chronic medical conditions and anxiety/depression. *Epidemiol Psychiatr Sci*. 2011; 20: 141–50, http://dx.doi.org/10.1017/S2045796011000345.

7.   Ward BW, Black LI. State and Regional Prevalence of Diagnosed Multiple Chronic Conditions Among Adults Aged ≥18 Years - United States, 2014. *MMWR Morb Mortal Wkly Rep*. 2016; 65: 735–8, http://dx.doi.org/10.15585/mmwr.mm6529a3.

8.   Australian Institute of Health and Welfare. *Chronic disease - Australia's biggest*

health challenge. Canberra: AIHW,

http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129547726 (2014).

9.   Goodwin RD, Davidson KW, Keyes K. Mental disorders and cardiovascular disease

among adults in the United States. *J Psychiatr Res*. 2009; 43: 239–46,

https://doi.org/10.1016/j.jpsychires.2008.05.006.

10.   World Health Organization. *World Health Statistics 2007*. Geneva, Switzerland,

http://www.who.int/gho/publications/world_health_statistics/whostat2007.pdf (2007).

11.   Moussavi S, Chatterji S, Verdes E, et al. Depression, chronic diseases, and decrements

in health: results from the World Health Surveys. *Lancet (London, England)*. 2007;

370: 851–8, http://dx.doi.org/10.1016/S0140-6736(07)61415-9.

12.   Graham CD, Gouick J, Krahé C, et al. A systematic review of the use of Acceptance

and Commitment Therapy (ACT) in chronic disease and long-term conditions. *Clin

Psychol Rev*. 2016; 46: 46–58, https://doi.org/10.1016/j.cpr.2016.04.009.

13.   Sage N, Sowden M, Chorlton E, et al. *CBT for Chronic Illness and Palliative Care*.

Chichester: John Wiley & Sons, Ltd., 2008.

14.   Zhang W, Wu H-X, Zhong H, et al. Psychological and behavioral intervention

improves the quality of life and mental health of patients suffering from differentiated

thyroid cancer treated with postoperative radioactive iodine-131. *Neuropsychiatr Dis

Treat*. 2016; 12: 1055, https://doi.org/10.2147/NDT.S105460.

15.   Farver-Vestergaard I, Jacobsen D, Zachariae R. Efficacy of psychosocial interventions

on psychological and physical health outcomes in chronic obstructive pulmonary

disease: a systematic review and meta-analysis. *Psychother Psychosom*. 2015; 84: 37–

50, http://dx.doi.org/10.1159/000367635.

16.   McGillion M, Arthur H, Victor JC, et al. Effectiveness of Psychoeducational

Interventions for Improving Symptoms, Health-Related Quality of Life, and

Psychological well Being in Patients with Stable Angina. *Curr Cardiol Rev*. 2008; 4: 1–11, https://doi.org/10.2174/157340308783565393.

17.   de Lusignan S, Chan T, Parry G, et al. Referral to a new psychological therapy service is associated with reduced utilisation of healthcare and sickness absence by people with common mental health problems: a before and after comparison. *J Epidemiol Community Health*. 2012; 66: e10, https://doi.org/10.1136/jech.2011.139873.

18.   Mental Health Foundation. Long-term physical conditions and mental health | Mental Health Foundation, https://www.mentalhealth.org.uk/a-to-z/l/long-term-physical-conditions-and-mental-health (2015, accessed 7 April 2016).

19.   Department of Health. Talking therapies: A four-year plan of action. *Department of Health*; 1–28, http://www.iapt.nhs.uk/silo/files/talking-therapies-a-four-year-plan-of-action.pdf (2011).

20.   National Institute for Health and Care Excellence. *Depression in adults with chronic physical health problem: recognition and management*. Manchester: NICE, https://www.nice.org.uk/guidance/cg91 (2009).

21.   National Institute for Health and Care Excellence. *Chronic obstructive pulmonary disease in over 16s: diagnosis and management*, https://www.nice.org.uk/guidance/cg101/resources/chronic-obstructive-pulmonary-disease-in-over-16s-diagnosis-and-management-35109323931589 (2010, accessed 17 April 2017).

22.   National Institute for Health and Care Excellence. *Chronic heart failure in adults: management*, https://www.nice.org.uk/guidance/cg108/resources/chronic-heart-failure-in-adults-management-35109335688901 (2010, accessed 17 April 2017).

23.   National Institute for Health and Care Excellence. *Improving Supportive and Palliative Care for Adults with Cancer*. London,

https://www.nice.org.uk/guidance/csg4/resources/improving-supportive-and-palliative-care-for-adults-with-cancer-773375005 (2004).

24.   Garland SN, Johnson JA, Savard J, et al. Sleeping well with cancer: a systematic review of cognitive behavioral therapy for insomnia in cancer patients. *Neuropsychiatr Dis Treat*. 2014; 10: 1113–24, https://doi.org/10.2147/NDT.S47790.

25.   Clucas C, Sibley E, Harding R, et al. A systematic review of Interventions for anxiety in people with HIV. *Psychol Health Med*. 2011; 16: 528–547, https://doi.org/10.1080/13548506.2011.579989.

26.   Chan MF, Chua TL. The effectiveness of therapeutic interventions on quality of life for vitiligo patients: a systematic review. *Int J Nurs Pract*. 2012; 18: 396–405, https://doi.org/10.1111/j.1440-172X.2012.02047.x.

27.   Farrand P, Woodford J. Effectiveness of Cognitive Behavioural Self-Help for the Treatment of Depression and Anxiety in People with Long-Term Physical Health Conditions: a Systematic Review and Meta-Analysis of Randomised Controlled Trials. *Ann Behav Med*. 2015; 49: 579–593, https://doi.org/10.1007/s12160-015-9689-0.

28.   Campbell CL, Campbell LC. A systematic review of cognitive behavioral interventions in advanced cancer. *Patient Educ Couns*. 2012; 89: 15–24, https://doi.org/10.1016/j.pec.2012.06.019.

29.   Coventry PA, Gellatly JL. Improving outcomes for COPD patients with mild-to-moderate anxiety and depression: A systematic review of cognitive behavioural therapy. *Br J Health Psychol*. 2008; 13: 381–400, https://doi.org/10.1348/135910707X203723.

30.   Johnson JA, Rash JA, Campbell TS, et al. A systematic review and meta-analysis of randomized controlled trials of cognitive behavior therapy for insomnia (CBT-I) in cancer survivors. *Sleep Med Rev*. 2016; 27: 20–28,

https://doi.org/10.1016/j.smrv.2015.07.001.

31. Sharpe L, Gittins CB, Correia HM, et al. Problem-solving versus cognitive restructuring of medically ill seniors with depression (PROMISE-D trial): study protocol and design. *BMC Psychiatry*. 2012; 12: 207, https://doi.org/10.1186/1471-244X-12-207.

32. Greenberg LS. Change process research. *J Consult Clin Psychol* 1986; 54: 4–9.

33. Llewelyn S, Hardy G. Process research in understanding and applying psychological therapies. *Br J Clin Psychol*. 2001; 40: 1–21, http://dx.doi.org/10.1348/014466501163436.

34. Elliott R. Psychotherapy change process research: realizing the promise. *Psychother Res*. 2010; 20: 123–35, http://dx.doi.org/10.1080/10503300903470743.

35. Carr SM, Smith IC, Simm R. Solution-focused brief therapy from the perspective of clients with long-term physical health conditions. *Psychol Health Med*. 2014; 19: 384–91, http://dx.doi.org/10.1080/13548506.2013.824594.

36. Dellasega C, Añel-Tiangco RM, Gabbay RA. How patients with type 2 diabetes mellitus respond to motivational interviewing. *Diabetes Res Clin Pract*. 2012; 95: 37–41, http://10.0.3.248/j.diabres.2011.08.011.

37. Peilot B, Andréll P, Samuelsson A, et al. Time to gain trust and change--experiences of attachment and mindfulness-based cognitive therapy among patients with chronic pain and psychiatric co-morbidity. *Int J Qual Stud Health Well-being*. 2014; 9: 24420, http://dx.doi.org/10.3402/qhw.v9.24420.

38. Dolan Y. What is Solution-focused Therapy? - Institute for Solution-Focused Therapy, http://www.solutionfocused.net/what-is-solution-focused-therapy/ (2015, accessed 23 February 2017).

39. de Shazer S. *Clues: Investigating Solutions in Brief Therapy*. New York: Norton, 1988.

40.   Burns K. *Focus on solutions : a health professional's guide*. Second Edi. Solutions

          Books, 2016.

41.   de Shazer S, Dolan Y, Korman H, et al. *More than Miracles: The State if the Art if

          Solution-focused Brief Therapy*. New York: Routledge, 2007.

42.   Person Centred Care/Coalition for Collaborative Care/Medical directorate. *NHS

          England Personalised Care & Support Planning Handbook - Executive Summary*.

          Leeds, https://www.england.nhs.uk/wp-content/uploads/2016/04/exec-summary-care-

          support-planning.pdf (2016, accessed 25 February 2017).

43.   Royal College of General Practitioners. *Stepping forward. Commissioning principles

          for collaborative care and support planning*. London,

          http://www.rcgp.org.uk/~/media/Files/CIRC/Quality-Improvement/RCGP-Stepping-

          Forward-2016.ashx.%0A (2015).

44.   Jordan SS, Froerer AS, Bavelas JB. Microanalysis of positive and negative content in

          solution-focused brief therapy and cognitive behavioral therapy expert sessions. *J Syst

          Ther*. 2013; 32: 46–59, https://doi.org/10.1521/jsyt.2013.32.3.46.

45.   Drageset S, Lindstrøm TC, Giske T, et al. Women's experiences of social support

          during the first year following primary breast cancer surgery. *Scand J Caring Sci*.

          2016; 30: 340–348, https://doi.org/10.1111/scs.12250.

46.   Breitbart W. Identifying patients at risk for, and treatment of major psychiatric

          complications of cancer. *Support Care Cancer*. 1995; 3: 45–60,

          http://dx.doi.org/10.1007/BF00343921.

47.   Richards D, Whyte M. *Reach Out. National Programme Student Materials to Support

          the Delivery of Training for Psychological Wellbeing Practitioners Delivering Low

          Intensity Interventions*. 3rd ed.,

          https://cedar.exeter.ac.uk/media/universityofexeter/schoolofpsychology/cedar/docume

nts/Reach_Out_3rd_edition.pdf (2011).

48.   Salkovskis PM. *Frontiers of cognitive therapy*. New York: Guilford Press, 1996.

49.   Whalley B, Hyland ME. One size does not fit all: motivational predictors of contextual

        benefits of therapy. *Psychol Psychother*. 2016; 82: 291–303,

        https://doi.org/10.1348/147608309X413275.

50.   Theeboom T, Beersma B, Van Vianen AEM. The differential effects of solution-

        focused and problem-focused coaching questions on the affect, attentional control and

        cognitive flexibility of undergraduate students experiencing study-related stress. *J

        Posit Psychol*. 2016; 11: 460–469, https://doi.org/10.1080/17439760.2015.1117126.

51.   Carrera M, Cabero A, González S, et al. Solution-focused group therapy for common

        mental health problems: Outcome assessment in routine clinical practice. *Psychol

        Psychother Theory, Res Pract*. 2016; 89: 294–307, https://doi.org/10.1111/papt.12085.

52.   Wells K, McCaig M. The Magic Wand Question and Recovery-Focused Practice in

        Child and Adolescent Mental Health Services. *J Child Adolesc Psychiatr Nurs*. 2016;

        29: 164–170, https://doi.org/10.1111/jcap.12159.

53.   Potter, J, Wetherell, M. *Discourse and Social Psychology: Beyond Attitudes and

        Behaviour*. London: SAGE Publications, 1987.

54.   Coyle A. Discourse Analysis. In: Lyons E, Coyle A (eds) *Analysing Qualitative Data

        in Psychology*. London: SAGE Publications, 2007.

55.   Potter, J. *Represeting Reality: Discourse, Rhetoric and Social Construction*. London:

        SAGE Publications, 1996.

56.   Jupp V. Purposive Sampling. *The SAGE Dictionary of Social Research Methods*,

        http://srmo.sagepub.com/view/the-sage-dictionary-of-social-research-

        methods/n162.xml (2006, accessed 24 September 2015).

57.   Potter J, Edwards D, Wetherell M. A Model of Discourse in Action. *Am Behav Sci*.

1993; 36: 383–401, https://doi.org/10.1177/0002764293036003008.

58.   Horton-Salway M. The Construction of M.E.: The Discursive Action Model. In:
        Wetherell M, Taylor S, Yates SJ (eds) *Discourse as Data: A Guide For Analysis*.
        London: SAGE Publications, 2001, pp. 147–188.

59.   Edwards D, Potter J. *Discursive Psychology*. London: SAGE Publications, 1992.

60.   Gilgun J. Reflexivity and Qualitative Research. *Curr Issues Qual Res*. 2010; 1: 1–8,
        http://www.scribd.com/doc/35787948/Reflexivity-and-Qualitative-Research.

61.   Lynch M. Against Reflexivity as an Academic Virtue and Source of Privileged
        Knowledge. *Theory, Cult Soc*. 2000; 17: 26–54,
        http://dx.doi.org/10.1177/02632760022051202.

62.   Boyatzis RE. *Transforming qualitative information: Thematic analysis and code
        development.* Thousand Oaks, CA: SAGE Publications, Inc, 1998.

63.   Edwards D, Middleton D. Joint remembering: constructing an account of shared
        experience through conversational discourse. *Discourse Process*. 1986; 9: 423–459,
        http://dx.doi.org/10.1080/01638538609544651.

64.   Brown R, Fish D. The psychological causality implicit in language. *Cognition*. 1983;
        14: 237–273, http://dx.doi.org/10.1016/0010-0277(83)90006-9.

65.   Potter J, Wetherell M. Accomplishing attitudes: facts and evaluation in racist
        discourse. *Text - Interdiscip J Study Discourse*. 1988; 8: 51–68,
        http://dx.doi.org/10.1515/text.1.1988.8.1-2.51

66.   Antaki C, Leudar I. Claim backing and other explanatory genres in talk. *J Lang Soc
        Psychol*. 1990; 9: 279–92, http://dx.doi.org/10.1177/0261927X9094004.

67.   Goffman E. Footing. *Semiotica*. 1979; 25: 1–30,
        http://dx.doi.org/10.1515/semi.1979.25.1-2.1.

68.   Wooffitt RC. 'I was just doing X... when Y': Some inferential properties of a device in

accounts of paranormal experiences. *Text - Interdiscip J Study Discourse.* 1991; 11: 267–288, http://dx.doi.org/10.1515/text.1.1991.11.2.267.

69.   Trope Y, Liberman N. Construal-level theory of psychological distance. *Psychol Rev.* 2010; 117: 440–63, https://doi.org/10.1037/a0018963.

70.   Trope YL. Construal Level Theory. In: Van Lange PK (ed) *Handbook of Theories of Social Psychology.* Washington, D.C.: Sage Publications Ltd, 2012, pp. 118–134.

71.   Grice HP. Logic and conversation. In: Cole P, Morgan J (eds) *Syntax and Semantics 3: Speech acts.* New York: Academic Press, 1975.

72.   Weber M. The Nature of Social Action. In: Runciman W. (ed) *Weber: Selections in Translation.* Cambridge: Cambridge University Press, 1991.

73.   Miller WR, Rollnick SR. *Motivational Interviewing: Preparing People for Change.* 2nd ed. New York: Guilford Press, 2002.

74.   White M. *Maps of Narrative Practice.* New York: W.W. Norton and Company, 2007.

75.   Anslow K. Systemic family therapy using the reflecting team: the experiences of adults with learning disabilities. *Br J Learn Disabil.* 2014; 42: 236–243, https://doi.org/10.1111/bld.12048.

76.   Mueller M, Kennerley H, McManus F, et al. *Oxford Guide to Surviving as a CBT Therapist.* New York: Oxford University Press, 2010.

77.   White M. Decentred practice. In: *Narratives of Therapists' Lives.* Adelaide, South Australia: Dulwich Centre Publications, 1997, pp. 200–216.

78.   Gardner D. Working with Personality Disorder. In: Beinart H, Kennedy P, Llewelyn S (eds) *Clinical Psychology in Practice.* Chichester: Blackwell Publishing Ltd, 2009, pp. 236–247.

79.   Back SE, Killeen T, Foa EB, et al. Use of an Integrated Therapy With Prolonged Exposure to Treat PTSD and Comorbid Alcohol Dependence in an Iraq Veteran. *Am J*

Psychiatry. 2012; 169: 688–691, https://doi.org/10.1176/appi.ajp.2011.11091433.

80.   Withers MC, Nelson TS. A Method for Creating Individualized Practice-Based

Evidence. *J Fam Psychother*. 2015; 26: 210–225,

https://doi.org/10.1080/08975353.2015.1067533.

81.   Zentman MD. Integrated couple therapy: A family developmental approach to the

treatment of couples incorporating psychoanalytic and systemic models. In: Carson

DK, Casado-Kehoe M (eds) *Case studies in couples therapy: Theory-based*

approaches. New York: Routledge, 2011, pp. 357–367.

82.   The Health Foundation. *Person-centred care made simple. What everyone should*

know about person-centred care. London,

http://www.health.org.uk/sites/default/files/PersonCentredCareMadeSimple.pdf (2014,

accessed 19 January 2016).

83.   Gurman A. Integrative couple therapy. In: *Clinical handbook of couple therapy*. New

York: Guilford Press, 2008, pp. 31–72.

84.   Elliott R. Helpful and nonhelpful events in brief counseling interviews: An empirical

taxonomy. *J Couns Psychol*. 1985; 32: 307–322, https://doi.org/10.1037/0022-

0167.32.3.307.

85.   Leibert TW, Dunne-Bryant A. Do Common Factors Account for Counseling

Outcome? *J Couns Dev*. 2015; 93: 225–235, https://doi.org/10.1002/j.1556-

6676.2015.00198.x.

86.   Howgego IM, Yellowlees P, Owen C, et al. The therapeutic alliance: the key to

effective patient outcome? A descriptive review of the evidence in community mental

health case management. *Aust N Z J Psychiatry*. 2003; 37: 169–83,

http://dx.doi.org/10.1046/j.1440-1614.2003.01131.x.

87.   Lambert MJ. Implications of outcome research for psychotherapy integration. In:

Norcross JC, Goldstein MR (eds) *Handbook of Psychotherapy Integration*. New York: Basic Books, 1992, pp. 94–129.

88. Clarkson P. *The Therapeutic Relationship*. 2nd ed. London: Wiley-Blackwell, 2003.

89. LeBlanc TW, Wheeler JL, Abernethy AP. Research in end-of-life settings: an ethical inquiry. *J Pain Palliat Care Pharmacother*. 2010; 24: 244–50, https://doi.org/10.3109/15360288.2010.493579.

90. Addington-Hall J. Research sensitivities to palliative care patients. *Eur J Cancer Care*. 2002; 11: 220–4, http://dx.doi.org/10.1046/j.1365-2354.2002.00343.x.

91. Payne S. Resilient Carers and Caregivers. In: Monroe B, Oliviere D (eds) *Resilience in Palliative Care*. Oxford: Oxford University Press, 2009, pp. 83–97.

92. Dunning T, Duggan N, Savage S, et al. Diabetes and end of life: ethical and methodological issues in gathering evidence to guide care. *Scand J Caring Sci*. 2013; 27: 203–211, https://doi.org/10.1111/j.1471-6712.2012.01016.x

93. Harris FM, Kendall M, Bentley A, et al. Researching experiences of terminal cancer: a systematic review of methodological issues and approaches. *Eur J Cancer Care (Engl)*. 2008; 17: 377–386, http://dx.doi.org/10.1111/j.1365-2354.2007.00880.x.

94. Themessl-Huber M, Humphris G, Dowell J, et al. Audio-visual recording of patient–GP consultations for research purposes: A literature review on recruiting rates and strategies. *Patient Educ Couns*. 2008; 71: 157–168, https://doi.org/10.1016/j.pec.2008.01.015.

95. Watson JC, Greenberg LS. Alliance ruptures and repairs in experiential therapy. *J Clin Psychol*. 2000; 56: 175–86, http://dx.doi.org/10.1002/(SICI)1097-4679(200002)56:2%3C175::AID-JCLP4%3E3.0.CO;2-5.

96. Sufran JD, Muran JC. *Negotiating the therapeutic alliance: A relational treatment guide.* New York, US: Guilford Press, 2000.

97.   The NHS Confederation. *Investing in emotional and psychological wellbeing for patients with long-term conditions*. London, http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Investing in emotional and psychological wellbeing for patients with long-term condtions 16 April final for website.pdf (2012).

98.   Fraenkel P, Pinsof WM. Teaching Family Therapy-Centered Integration: Assimilation and Beyond. *J Psychother Integr*. 2001; 11: 59–85, https://doi.org/10.1023/A:1026629024866.

Table 1

Demographic of participants

Participant Pseudonym	Gender	Age	Health Condition (as reported by SUPS)
Andrew (PP)	Male	N/A	N/A
Clare (PP)	Female	N/A	N/A
Rachel (PP)	Female	N/A	N/A
Natalie (PP)	Female	N/A	N/A
Beth (SUP)	Female	20s	Ehlers-Danlos Hypermobility Syndrome
Debbie (SUP)	Female	50s	Lymphoma; Rheumatoid Arthritis
Faz (SUP)	Male	70s	Arthritis
Jackie (SUP)	Female	40s	Fibromyalgia
Matt (SUP)	Male	50s	Bowel Cancer
Sue (SUP)	Female	60s	Cancer
Sharon (SUP)	Female	60s	Fibromyalgia
Bill (SUP)	Male	70s	Coronary Artery Spasms/Variant Angina

Table 2

Participant dyads

Practitioner Participants	Service User Participants	Dyad number
Andrew	Debbie	Dyad 1
	Matt	Dyad 2
	Sue	Dyad 3
Clare	Beth	Dyad 4
	Bill	Dyad 5
Rachel	Faz	Dyad 6
	Jackie	Dyad 7
Natalie	Sharon	Dyad 8

Table 3

Transcript conventions[59]

Symbol	Meaning
[ ]	Start and end of overlapping speech
(.)	Pause which is hearable but too short to measure
/	A break in the voicing of sound
: or ::	Elongations of previous sound. The more colons, the longer the elongation.
Underlining	Emphasis
↑↓	Marked rises and falls of intonation (pitch).
- (hypen)	Abrupt stop
> (greater than) < (less than)	Mark changes in rate of speech. E.g. the cat then >rushed out into the road, without even looking< and that's when I hit it.

Table 4

The discursive action model[59]

Action
1. The focus is on action, not cognition.
2. Remembering and attribution become, operationally, reportings (and accounts, description, formulations, versions) and the inferences that they make available.
3. Reportings are situated in activity sequences such as those involving invitation refusals, blamings and defences.
Fact and Interest
4. There is a dilemma of stake or interest, which is often managed by doing attribution via reports.
5. Reports are therefore constructed/displayed as factual by way of a variety of discursive techniques.
6. Reports are rhetorically organised to undermine alternatives.
Accountability
7. Reports attend to the agency and accountability in the reported events.
8. Reports attend to the accountability of the current speakers' action, including those done in reporting.
9. The latter two concerns are often related, such that 7 is deployed for 8, and 8 is deployed for 7.

Appendix 2-A

Journal of Psychosomatic Research author guidelines

Please see the journal guidance located in Appendix 1-C.

Appendix 2-B

Extended extracts from analysed transcripts

Discourse one - example transcript of focal example (Clare and Beth)

1	SU	so it's been quite difficult because::: ↓can't really explain it without labelling ↑erm basically- the- someone died and my mum and it's my grandma (.) and we hadn't seen her for twenty years until last year (.) and so I've only met her (.) I'm only twenty one so I've only known her for a year until she died (.) and there's a sister involved (.) and the sisters seen them for the last twenty years and it was <u>her</u> fault why why they didn't talk for twenty years but she doesn't want she didn't want Mum to get that involved and ug::h:::::
2	Practitioner	m::
3	SU	I think she's::- I don't want to sound awful- but I think she's having a <u>mental</u> breakdown of some sort because:: she accused me and my sister off giggling at at the funeral which is not something we'd/ do we would do so >now my family's not talking kind of thing<
4	Practitioner	hm::: (.) m::::: (.) so difficult tensions kinda thing - yeah↓ (.) so ↑how are you all (.) what is it that helps you all get through what is it about the family that (.) that rises to these challenges
5	SU	er::::
6	Practitioner	or what - what/ what/ what/ helps- erm-
7	SU	well my dad - is my rock kinda thing
8	Practitioner	yeah
9	SU	>cos if I'm struggling cos I do a lot of chasing trying to get consultants<
10	Practitioner	yeah
11	SU	if I'm getting nowhere he joins in >sorts it out somehow< [laugh]
12	Practitioner	he backs you up (.) makes calls
13	SU	yeah (.) all of a sudden >I'm like yeah didn't get I can't I can't get an appointment for this person then he rings them up and goes I've got you on for next week and I'm like:::<
14	Practitioner	[laughing]
15	SU	why (.) why (.) does it take you to ring them up
16	Practitioner	>is he the mafia or something< [laugh]
17	SU	yeah [laugh] (.) well usually we throw in the word ↑do we need to get the MP involved and that's kinda it so ↓cos we have done that a couple of times
18	Practitioner	↓yeah
19	SU	so
20	Practitioner	↓>yeah yeah yeah<
21	SU	erm so yeah
22	Practitioner	yeah so he's (.) he's a real support (.) and he's quite a sorter sounds like
23	SU	yeah

Discourse two - extended extract 2 (Andrew and Matt)

1	Practitioner	↑how would [your wife] describe your qualities then
2	SU	↑oh I don't know [laugh] er::: not really good at the moment I don't think probably (.) don't know what's er (.): I don't feel as though I'm the <u>person</u> I used to be type of thing (.)(.) not as <u>strong</u> as ah::: (.)(.) not as able to as <u>able</u> to (.) ah:::: (.) I sometimes feel as though I'm <u>drifting</u> from them a little bit
3	Practitioner	m:
4	SU	erm:: (.) (.) (.) yeah just ah (.) (.) ↓sometimes I sometimes sometimes I just (.) don't see the <u>point</u> you know just (.) just stay in bed stay in bed all day long and just (.) I don't know whether I don't know if that's depression or/or what it is but I just don't I just sometimes wake up thinking <what's the point of today you know what's the <u>reason</u> to be er: down ↑here today>
5	Practitioner	yeah
6	SU	↓you know that's er: (.) (.) (.) you know that's that's I've put that in my thing there you know er (.) what you know why <u>why</u> am I here (.) <u>what</u> use am I (.) what you know what what's er (.) (.) what <u>help</u> am I to my family type of thing dyou know dyou know just ↑<u>low</u> really
7	Practitioner	yes
8	SU	that I just er (.) (.) that there's a tough note there's bad >pretty low days< er::m
9	Practitioner	yes yes
10	SU	↑having said that I have been feeling a little bit bit better so the last couple of months you know since the since I made the appointment type of thing
11	Practitioner	yeah
12	SU	yeah I have been a bit bit
13	Practitioner	>what have you noticed<
14	SU	just er that (.) (.) (.) I think it's more that I've been able to (.) make myself a little bit more <u>busy</u>
15	Practitioner	yes
16	SU	>type of thing< you know just ah: sometimes it's trying to take it like <u>small</u> step at a time just to <try do a <u>little</u> bit more each day>
17	Practitioner	yes
18 (beginning of extract 2 in text)	SU	you know that's er: (.) (.) I do I get very tired er::m (.) >I feel it's probably cos I've had done quite< a- I haven't done any exercise in the last three years since I've been (.) (.) poorly you know
19	Practitioner	m:
20	SU	it's really hard doing a bit more (.) I'll go to gym or something

21	Practitioner	sometimes you are saying whenever I think of doing some exercise I'd lie down til the thought goes away
22	SU	yeah
23	Practitioner	in some way you've said something like that but it sounds like that might be something you would be pleased to notice if you're doing a bit more exercise that's more like you is it
24	SU	yeah I do that and I think I'd like to do a bit more exercise (.) (.) ↑almost cos it yeah especially with the taxi it's a sedentary lifestyle anyway
25	Practitioner	you know that's right so you know the cliche of taxi drivers
26	SU	yeah yeah ↑with a burger
27	Practitioner	I was gonna say eating rubbish [laugh] but that's <u>not</u> who you are
28 (end of extract 2 in text)	SU	<u>no</u> no
29	Practitioner	who are you
30	SU	[laugh] I don't know
31	Practitioner	on a good day you know for the sake of argument sat here in just a few weeks time and you're telling me that things are moving in the right direction what would you <u>love</u> to be telling me
32	SU	I'd love to be telling you that I was (.) <u>earning</u> more money <u>providing</u> more for my family er getting <u>fitter</u> getting stronger I suppose that's the
33	Practitioner	yes
34	SU	er::: (.) just feels though ↓sometimes <u>wasting</u> away a little bit you know (.)
35	Practitioner	what would you love to notice instead
36	SU	<u>not</u> to be wasting away [laugh]
37	Practitioner	↑what would you notice instead
38	SU	↑er:: working working hard ah: (.) (.) <being able to give more to my family>
39	Practitioner	right
40	SU	er::m (.)(.)(.) ↑just being <u>happier</u> [laugh] that's all ↓that's all
41	Practitioner	yes
42	SU	that's all

Discourse two - example transcript of focal example (Rachel and Faz)

1	SU	yeah and the <u>pain</u> doesn't help (.) if you're in <u>pain</u> it well you're not happy when you're in pain so you can't be the life and soul of the party you know and not go party like I used to be (.) which I'm in <u>pain</u> and you have to cope with the <u>pain</u> (.) and it's difficult to cheer up sometimes like me wife said >oh cheer up you but she forgets you know<
2	Practitioner	yeah
3	SU	>just cos I'm sat there< doesn't mean I'm not in pain you know what I mean
4	Practitioner	yeah it's a invisible
5	SU	yeah you know I am still in pain but I'm just <u>coping</u> in pain you know
6	Practitioner	yes yes
7	SU	that's the difference really I'm in pain it doesn't make you happy it ↓doesn't make you a happy person by any means
8	Practitioner	yes yes yes so you're in a better place than [you were]
9	SU	[last year]
10	Practitioner	initially last year and you know that because erm
11	SU	I don't think it's bad thoughts
12	Practitioner	you don't it's bad thoughts
13	SU	not now I don't but initially
14	Practitioner	what stuff dyou think instead now then
15	SU	what do
16	Practitioner	like what so you don't think the bad thoughts as much so something is happening instead
17	SU	well these tablets must've worked (.) possibly working you know in <u>some</u> way and like I said the pain isn't was bad as it was <u>last</u> year but I did first go to the centre (.) ↓when my daughter first recommended me to see the people ↑so in that respect >I'm better than I was last year< so in that way I don't think as as many ↑suicidal thoughts you know because there's there's nothing really to feel suicidal about if if you're coping as you are so >that's how I am really<
18	Practitioner	so so there's a bit of a story of coping already gone on down this journey kinda thing erm are you <u>surprised</u> that things have have <u>changed</u> a bit
19	SU	yeah::
20	Practitioner	cos the pain is still there [isn't it]
21	SU	[oh yeah yeah] well surprised yeah I didn't think there was a ↓way out out of the ↓tunnel (.) so I didn't think I would ever get better every better than I was but I ↑<u>have</u> got a bit better so in that respect it's good
22	Practitioner	yeah yeah so sometimes there's hope and change even when you can't see it at the time
23	SU	yeah I didn't <u>believe</u> that there would be I did not believe that it would be but I have come <u>through</u> quite a lot and erm so >I am full of arthritis that's the problem<
24	Practitioner	yes
25	SU	I've have a few operations on things and when you're really really bad you know trying to recover from ↓operations and you're down there

		you don't think you can but ↑gradually gradually you know you pick up and erm you know start to get it ↓start feeling a little bit better
26	Practitioner	so a bit bit a time approach rather than thinking too big
27	SU	it's like sort of a gradual thing

Discourse three - extended extract 3 (Rachel and Jackie)

1	SU	yeah I suppose so- I mean I/ yeah I am (.) I'm/ I'm trying (.) sniff but <u>some</u> people tend (.) ↑to not look down on me but (.) sniff <u>attitudes</u> towards me with what I've got it's a bit like(.) you know ↑just get up and get on with it
2	Practitioner	m:
3	SU	if I could I would
4	Practitioner	m: m: yes yes that approach d doesn't work with a condition like what you've <u>got</u> (.) you can't just do >more and more and more<
5	SU	no cos otherwise (.) you know (.) on a good day- you know it's good (.) on/ on you know still in <u>pain</u> but
6	Practitioner	m: m:
7	SU	you know and on other days you just (.) you just <u>physically</u> can't can't do anything
8	Practitioner	m: m: ↑what what does a good day look like
9	SU	(.) erm (.) >like yesterday was a nice day< when [my husband] was off we just went for a walk and I was in me <u>scooter</u>
10	Practitioner	oh yeah (.)you got one of those
11	SU	well it was like or not leave the house
12	Practitioner	ah::
13	SU	and then [the health professional] was saying you should be walking you should be doing this but it's/ it's ok to say that- but sometimes I think like I/ I have had to <u>fight</u> ↓me whole life
14	Practitioner	yes
15	SU	so (.) I don't need people saying to me >well you know you should trying you should be doing this and doing that <
16	Practitioner	m:
17	SU	and I think well >it's ok for you to sit back and say that but <u>you</u> don't know (.) <you know what my circumstances are but but how I or (.) <u>how</u> I work (.) I don't just go home and sit there all day
18	Practitioner	m:
19	SU	and do nothing
20	Practitioner	m: m:
21	SU	I/ I try I <u>walk</u> as far as I can
22	Practitioner	wow
23	SU	I <u>do</u> what I can
24	Practitioner	wow
25	SU	so
26	Practitioner	wow
27	SU	I just
28	Practitioner	so in many ways (.)you yeah you definitely have <u>expertise</u> in

		your ↑own life (.)↓you know you've figured out some things that help and things that don't help so much
29	SU	yeah
30	Practitioner	and you've got a lot of knowledge bout that
31	SU	yeah I/ I get <u>angry</u> though I mean I like [the health professional] and she's nice but ↓>I feel like she talks a bit down to me<
32	Practitioner	mm
33	SU	you know well >you should be doing this and you should be doing that< (.) I find it quite hard to express exactly (.)you know what I <u>do</u> do
34	Practitioner	mm
35 (beginning of extract 3 in text)	SU	and obviously doesn't <u>understand</u> me circumstances and I know she's only here to do a job but sometimes I think (.) she thinks I need to help myself
36	Practitioner	m: m:
37	SU	but then she doesn't <u>realise</u>
38	Practitioner	all the things you ↑do ↓do
39	SU	yeah
40	Practitioner	tell me what you ↑do ↓do
41	SU	dyou mean in the house and stuff
42	Practitioner	yeah: tell me the ways you've found to try and (.) erm I guess live well with this condition the ways what do you do
43	SU	>I don't think I am living well with it though<
44	Practitioner	ok
45	SU	I feel like- I'm constantly in pain and I'm constantly tired but then on the other hand I do do the washing up and do the ironing I make sure I do that
46	Practitioner	wow
47	SU	if nothing else I do do that >you know I'll hoover up and I'll tidy round<
48	Practitioner	yeah yeah cos those things are important to you to be able to do those to spend energy on those kinda things is that
49	SU	yeah
50	Practitioner	>is that right in your world in your kind of world in your life that's that's a good use of your< energies
51 (end of extract 3 in text)	SU	well ↑I think so
52	Practitioner	yeah yeah yeah
53	SU	cos I think well [my husband] needs his shirts for work so I've thats the least I can do
54	Practitioner	yes
55	SU	and that <u>helps</u> out in a big way then that's what I'll <u>do</u>
56	Practitioner	yes yes so it's important to you to make a difference to him it sounds like
57	SU	I wanna <u>help</u>
59	Practitioner	yeah
60	SU	that's what I wanna/ I wanna try and help the <u>best</u> I can

61	Practitioner	yeah
62	SU	and even me daughters and me grandkids like (.) about three weeks ago me daughter she went away overnight and I stayed and I had the kids- for her
63	Practitioner	wow
64	SU	↓you know three boys between ten and six
65	Practitioner	wow
66	SU	it was hard work but (.) it was worth it >I was glad I did it<

Discourse three - example transcript of focal example (Andrew and Sue)

1	SU	↑sounds like I'm putting all the blame on him and (.) erm I am and I'm not
2	Practitioner	mhm
3	SU	I mean I don't- I want to be able to get out and do things and and he's now saying ↓oh well can't leave the dog at home so ↑he's now blaming anything
4	Practitioner	↑what things would you love to go out and do
5	SU	↑well I've got a pushbike
6	Practitioner	yeah
7	SU	and I'd like us to get pushbikes and go for a cycle (.) or something like that which we ↑did do one time ↓erm I think he was I think he he borrowed me daughters bike at the time
8	Practitioner	mhm
9	SU	and then he borrowed er: son in law's bike (.) erm but he wanted it back
10	Practitioner	mhm
11	SU	because he was trying to train get up to his bike so so (.) >he now hasn't got one he's got a racing bike but he won't use it< so ↓I just feel I'm hitting my head against a brick wall sometimes
12	Practitioner	so you'd love to actually physically be out and about and is it does it only count if it's with john or be out and about on your own is that >is that something you'd also be pleased to notice<
13	SU	well I go out on the bike on me own last time I went out on me pushbike by myself <I got a text message from me granddaughter saying where's your helmet> [laugh]
14	Practitioner	ah::
15	SU	↑she put me off and I still gotta got a get a helmet [laugh]
16	Practitioner	so let's really nail this ↑would you be pleased to notice >again this is all about< what matters to you isn't it and making sure that we're going the right direction (.) would you be pleased to notice in then next few weeks if you went and bought a helmet
17	SU	I supposed I could I should do really
18	Practitioner	I'm not saying >I'm not advising< you I was asking you a question
19	SU	>I should do then I could actually get out on the bike< but again would be erm if he's out as well I'll again would be leaving the dog
20	Practitioner	yeah so it's it sounds it's not panacea so you'll still be working around his movements etc

21	SU	yeah
22	Practitioner	and <u>clearly</u> you're a very <u>logical</u> woman and your <u>logic</u> here is to there'll be times when he's in when >therefore you could go out on your bike<
23	SU	↑yeah yeah
24	Practitioner	and
25	SU	rather than using the car
26	Practitioner	right
27	SU	cycle to the village
28	Practitioner	right
29	SU	cos it's only about a mile away (.) ↑I mean I walk there I walk the dog up the other day
30	Practitioner	↑did you
31	SU	>yeah walked him to the village<

Discourse four - example transcript of focal example (Natalie and Sharon)

1	Practitioner	good [laugh] erm so let me ask you a few more questions if that's ok so imagine we draw like a scale (.) if you want from zero to ten (.) so imagine zero is the <u>worst</u> things have ever ever been (.) in terms of your symptoms (.) in terms of how you feel about them and how you feel about yourself so ↓that's like the lowest things have ever been and (.) ↑ imagine ten is I guess maybe that miracle day in which everything you're able to do everything you want to do and you may still have some of the symptoms some of the pain but actually you know (.) looking good (.) <u>where</u> would you say generally speaking <things are at the moment>
2	SU	er:: (.) I'd say (.) about five
3	Practitioner	about <u>half</u> way
4	SU	yep
5	Practitioner	yeah right (.) so what makes it five then and not (.) a four or three or two
6	SU	well a couple of months ago it <u>was</u> a four or a three or a two
7	Practitioner	ok yep yep
8	SU	but because of (.) this positivity and this enjoyment(.) it's got it up to a five
9	Practitioner	right so something what's/ what's making it a five is your <u>positive</u> attitude
10	SU	yep erm and the (.) <u>exercise</u> is kind of freeing my body a bit from the pain
11	Practitioner	so (.) >basically the things that you're doing< helping you at the moment to be a five
12	SU	yeah
13	Practitioner	yeah brilliant (.) <anything else makes it a five>
14	SU	erm no not that I can think of
15	Practitioner	yeah so those are the main things >erm I guess my next question Sharon is< what would help you go up that scale a <u>tiny</u> bit (.) I'm not saying what would take you up a eight or a nine but even the <u>slightest</u>

		thing can be a five and a half (.) <u>what</u> would make it go from five to five and a half
16	SU	at this moment
17	Practitioner	m:
18	SU	erm (.) maybe something that you s- (.) that we s- (.) that we broached on <u>before</u> when we were talking about this getting out of bed thing
19	Practitioner	ok yeah
20	SU	maybe I can <u>increase</u> that to a five and a half by <u>trying</u> (.) now to <put into place put that plan into place that actual> small thing of getting out of bed before I get out of bed thinking ↑hang on you're not going oh oh oh oh ↑you don't need to do that (.) ↑you just need to get out of bed
21	Practitioner	yeah
22	SU	so maybe have to take it up it's a <u>small</u> thing but (.) er but if it brings that up if it helps >it doesn't matter does it<
23	Practitioner	absolutely no
24	SU	so I think that's what I'm gonna <u>aim</u> for that little thing [laugh]
25	Practitioner	[laugh] I think that's fantastic I think that's really good I think yeah I mean you know one little thing at the time then (.) >you can go up that scale won't you< so start yeah start with the simple little thing and it sounds like you made a bit of a plan there for yourself
26	SU	yeah and maybe <u>build</u> up
27	Practitioner	yeah and ok so that that's fantas- >dyou think that's something you could do sometime soon<
28	SU	yeah ↑tomorrow
29	Practitioner	brilliant I'd love to hear that (.) great erm ok so again >using a scale we'll do like scales< so from zero to ten (.) ten being the maximum zero being minimum (.) how <u>confident</u> are you that you're gonna do that tomorrow
30	SU	ten
31	Practitioner	oh you're a hundred percent confident
32	SU	↑I am
33	Practitioner	oh right [laugh] why's that
34	SU	oh yeah because once I (.) ↑for myself if I say <I'm going to do something> (.) I give it a go
35	Practitioner	ok yeah
36	SU	might not always stick to/ well something like this (.) I <u>will</u> stick to because I know it's gonna help me in the <u>long run</u>
37	Practitioner	ok yeah
38	SU	if I can start off with small things and build them up but even like down to <u>smoking</u> (.) which is quite a big thing is that I tried for years (.) on and off but I <u>did</u> about 15 years ago stopped smoking (.) I've done things like getting to >weight watchers slimming world< I do once I'm focused I will do it and <u>I won't slide</u> but then once I get to my weight (.) or whatever I'm like I'm ok now and the weight comes back on (.) ↑so when I decide I'm going to do something I <u>do</u> do it (.) I do see it through

Section Three: Critical Appraisal

The importance of discourse in clinical psychology practice

Joanna Cheng

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Correspondence should be addressed to:

Joanna Cheng

Department of Clinical Psychology,

Faculty of Health and Medicine,

C16 Furness Building,

Lancaster University,

Lancaster,

Lancashire, United Kingdom

LA1 4YG

E-mail: j.cheng1@lancaster.ac.uk

Tel: +44 1524 592970

Introduction

This critical analysis will explore my experience of discursive psychology in relation to my personal and professional values, the research process, and the importance of discourse in clinical practice. Firstly, the findings of the research paper will be summarised. Secondly, my epistemological position, values and passion for this clinical population will be discussed. Thirdly, the strengths and limitations of the study will be offered. Fourthly, future directions in research and how research has influenced practice will be discussed. The final section outlines my reflections on how this thesis process has shaped my continuing practice in clinical psychology.

Summary of findings

The aim of this thesis was to understand how resources and preferred futures were constructed by service users (SUs) and practitioners using a Solution-Focused (SF) therapy approach. The findings show how a number of discursive mechanisms contributed to the construction of resources and preferred futures. Discourse one showed that practitioners made assumptions through questioning about the inherent resources that SUs had. These assumptive style questions invited SUs to consider their own resources which ultimately led to SUs taking an ownership of them. In discourse two, practitioners listened out for inconsistencies in SUs' speech, and once this was noticed, communicated these inconsistencies back through commentaries to elicit changes in the SU's views of themselves. In discourse three, practitioners de-contextualised the interpersonal conflicts presented by SUs by focusing on the person rather than on the conflicts, to enable the development of goal construction conversations. By focusing solely on what the SU wanted, it was possible for practitioners to start constructing alternative goals with the SU. Discourse four showed that practitioners asked future-focused questions which removed blame, responsibility and effort,

and by linking resources constructed earlier in the therapy session with the future-focused

question, SUs' confidence and motivation to construct a preferred future increased.

Developing my values and an epistemological position

The drivers which led me to conduct my thesis in long-term conditions

I have always concentrated my academic assignments and research projects on topics

which will have a beneficial impact for people who use mental health services and bear

directly on clinical psychology practice. For my Service-Related Project (SRP) I was

extremely excited to conduct a research study on how service users (SUs) experience the role

of clinical psychologists within Learning Disability (LD) services. The findings of this

research study were that SUs did not fully understand the role of clinical psychologists,

leading to misunderstandings and difficulties in ending therapy. As a result, I was driven to

create an easy-read information booklet for people with LD which explains the role of a

clinical psychologist. This booklet was published by the Division of Clinical Psychology

within the British Psychological Society[1], and I am proud that this booklet was driven by the

clinical implications identified in my SRP, and that it has made a difference to services and

SUs. The motivation to conduct this thesis in LTCs stems from my continuing interest in

involving SUs in research, and researching to directly benefit SUs.

In addition, my developing passion for working with people with long-term physical

health conditions (LTCs) was shaped by my placements in child health, adult health, adult

palliative care, paediatrics LD and my specialist placement in paediatric oncology and HIV.

While I engaged with the research literature and had theoretical knowledge of how people

with LTCs often experience mental health difficulties[2,3], working therapeutically with people

who are living with LTCs provided me with a deeper level of understanding of how having a health condition can affect many areas of their lives. Through my clinical experience I have learnt that psychological therapy should be led by the needs of the SU, especially in this clinical population where the SU's physical health plays a key role in whether they can or cannot engage fully in therapy.[4,5] Within health sciences, research and clinical practice do not exist in isolation and instead, research and clinical practice are influenced by one another, which further shapes public policy and service development.[6] Through this understanding of how research can heavily shape clinical practice, it has become a personal and professional endeavour to continue working clinically with people with LTCs and to focus on research where SUs are central to the topic.

Developing my epistemological position

Over the course of clinical psychology training I have realised my epistemological stance as a social constructionist. After receiving a teaching session on epistemology in the induction block of training, I began to research epistemological views in mental health. Hacking's essay[7], *Making Up People,* argued that mental health problems are labels created by people rather than 'real' scientific entities waiting to be discovered. This was a particularly resonating argument for the starting stages of my career. Hacking[7] emphasised that it is the language and descriptions used by people which ultimately form these labels, and that although these labels do not disable a person, the way society reacts and uses these labels are what causes impacts on people.[8] These discussions fitted naturally with my developing values and formed the belief that people are shaped by their experiences of the world, including their social, economical and cultural contexts, which drives my interest in undertaking research using a qualitative methodology.

In particular for the thesis, the use of discursive psychology to analyse the language used to describe life events and how people construct their reports[9] was a representation of how the social constructionist stance can be utilised in research.[10] As opposed to a positivist view where there are 'truths' to scientifically falsify[11], conducting qualitative research with a social constructionist epistemology can help us identify how particular phenomena happen and can provide a richness of experience which is lacking in quantitative research.[12] Although quantitative research is more easily generalised[13], the findings from qualitative research can be transferable to other contexts and settings[14], and can contribute to systematically conducted meta-syntheses, which is regarded by the National Health and Medical Research Council[15] as the highest level of evidence.

However, there were several considerations borne in mind when I conducted this qualitative research. Although I was motivated to learn how people with LTCs build resilience, strengths and goals while continuing to live with their health condition, it was of paramount importance that this viewpoint did not bias the findings of the research. Giorgi and Giorgi[16] explain that researchers tend to enter a field of research with preconceptions of what the research will likely find. In Malterud's essay[14], she argued that these preconceptions, previous personal and professional experiences and motivations of the researcher, can likely bias how the research is undertaken. Malterud[14] added that these issues can be mitigated as the researcher develops reflexivity, which is of paramount importance in qualitative research. Using the discursive action model (DAM) methodology and analysis was a new experience for me, and in conjunction with only studying the data at a discursive level, this brought upon unexpected emotional reactions. For example, within my reflective journal I wrote:

"Something interesting is happening to me. I am analysing Clare (practitioner) and

Beth's (SU) transcript, separating them into how the SU construct resources, and how

they construct preferred futures. When I first transcribed and applied the coding

conventions, I noticed that Beth was very 'stuck'. As I'm analysing using the DAM

framework, using language, I find that I am emotionally reacting to what Beth is

saying. Clare's effort to elicit goals were repeatedly dismissed by Beth. I am

empathising with both Beth and Clare here, but I didn't have this thought when I

transcribed verbatim, only when I applied coding conventions. I can see these

mapping onto my value system - I strongly stand against the notion of accepting the

status quo. I will need to discuss this with [Academic Supervisor] to ensure these

thoughts doesn't cloud my analysis."

In relation to the above reflections, initially I believed that there were no resources or

preferred futures constructed within the therapy session. However, after recognising that

these beliefs may be connected to my own feelings and values, I documented these in my

reflective journal and postponed this section of the analysis while I sought supervision with

the Academic Supervisor. Malterud[14] argued that the involvement of multiple researchers can

strengthen the value of qualitative study, "not for the purpose of consensus or identical

readings, but to supplement and contest each others' statements" (p. 484). Furthermore, as

reflexivity within qualitative research involves continuous awareness, repeatedly refining our

views and discussing these with co-researchers can provide insight to how one's current

position may impact on the research.[17] Within the supervision session, my Academic

Supervisor reminded me that the meaning behind the words (i.e. the SU's intentions to pursue

or not pursue goals) was not the focus of the research, and rather it was how the conversation

around goals was side-stepped by the SU, and how the practitioner responded to this, which

should be the focus of this analysis. Through this experience I learnt that when using DAM, it is important to consider the accounts of participants from the perspective of a discursive researcher rather than from an interpretive perspective. The regular research supervision was highly valuable in guiding the research, maintaining integrity within research practice, and increasing awareness of researching with a social constructionist epistemology.

The strengths and limitations of the current study

Transferability of the findings

At the initial stages of the study, there was the consideration of expanding the recruitment to reach more clinical health psychology services. However, it was established before the ethics submission that there are few clinical health psychology services that solely use SF therapy. Contact was made with other clinical psychologists and practitioners who worked with people with LTCs, however the response was that they rarely used SF therapy as a sole therapeutic modality, and often they used SF techniques in conjunction with other therapeutic modalities. Although SF therapy is recommended in some clinical guidance (e.g.[18]), and has been found in research to be efficacious for people with LTCs (e.g.[19]), it may not be provided as widely in comparison to other therapeutic models. There are a number of factors for this, such as its alignment with a social constructionist epistemology[20], which is less commonly researched through randomised control trials in comparison to therapeutic modalities with a more structured and positivist stance.

A relative strength of this study, however, was the wide range of health conditions which were reported by the SU participants. Health conditions ranged from cancer, rheumatic conditions, cardiac conditions and connective tissue disorder. As seen in the Literature

Review, many of the reviewed articles focused on the experiences of psychological therapy from SUs with a single type of health condition. For example, Bremander, Bergman and Arvidsson's[21] sample comprised of SUs with chronic pain, and in Mikocka-Walus et al.'s[22] study, all participants experienced Crohn's disease. Although there is value to conducting research within a specific health population, for example an increased rationale to use the research findings to develop service delivery for a specific group of the population, there is evidence to suggest that research findings in LTCs do not only benefit people with a specific type of LTC but can be transferable to other types of LTCs. There are commonalities in the psychological experiences of people living with LTCs, such as experiences of hopelessness, increase in suicidal thoughts and breakdowns in relationships.[23,24] Therefore, in the current research where we recruited people living with a range of LTCs, it is hoped that the findings will be transferable to other contexts and could be representative of people with LTCs as an overall population.

The finding of trans-theoretical discursive mechanisms

In the initial stages of conducting this study, I envisaged that the findings would hopefully contribute to the efficacy of SF therapy for people with LTCs through showing how SF therapy can elicit resources and goals for people with LTCs, in a similar way that the results of Carr, Smith and Simm's study[19] did. It was an enriching experience to understand how resources and preferred futures were constructed within SF conversations, but in addition, it was particularly exciting to find that discursive elements highlighted within this study were not exclusive to SF therapy but can be seen in other types of psychological therapy.

The assumptive style questions which practitioners used to elicit the inherent resources in SUs (discourse one) are similar to the assumptions of unique outcomes in Narrative Therapy.[25] In Narrative Therapy, practitioners assume that there are exceptions to the person's problems, and they implicitly enquire about moments when the problem did not occur. For example, a question to elicit unique outcomes within Narrative Therapy could be: "tell me about a time when [this problem] got you to do... and somehow you stopped it from being as bad as usual?" Moreover, the discursive element of using assumptions through the deployment of a validation function[26] to purposefully elicit agreement or acceptance resembles the principles of Motivational Interviewing[27], where practitioners identify and evoke the intrinsic motivation of change within SUs. In discourse two, the use of reflective and explicit commentaries constructed a change in SUs' negative views of self. This is similar to the use of reflecting teams within Systemic Family Therapy, in which a group of observers listen to the therapeutic session and explicitly communicate their reflections, including what they have witnessed, to the family who are in the therapy session.[28] The use of de-contextualisation as a tool to remove the conflict as the central focus of the conversation (discourse three) is similar to the externalisation technique in Narrative Therapy.[29] The purpose of externalisation in Narrative Therapy is to objectify the problem and remove the conflation of the person and their problem; viewing the person as a separate entity from their context was observed to be similar to the discursive mechanism highlighted in discourse three. Furthermore, practitioners' deployment of a future-focused question to remove responsibility, blame and effort in discourse four is arguably the same as the principle of being 'neutral reporters' who ask questions without motives within Narrative Therapy.

In Franklin et al.'s[30] systematic review of the therapeutic processes within SF therapy, it was found that specific types of SF co-construction techniques, such as strength-orientated

techniques, yielded improved clinical outcomes for participants. In light of the findings within this study, it is argued that not only do the highlighted discursive mechanisms demonstrate the effectiveness of certain aspects of SF conversations, but also that these mechanisms are trans-theoretical and can be applied in other therapeutic modalities. Although the findings show that the discursive mechanisms were successful in constructing resources and preferred futures in people with LTCs, these mechanisms may also be beneficial to people experiencing mental health difficulties, with or without LTCs. The discursive mechanisms can be applied in a broad range of health contexts and can be incorporated into other therapeutic modalities to maximise the opportunity for people to improve their wellbeing. This leads to the need for further research using discourse analysis to study other therapeutic models in order to provide insight into the transferability of these mechanisms. Alternatively, practitioners providing psychological therapies to SUs can adopt the use of the discursive mechanisms highlighted in this study to evaluate the usefulness of these mechanisms, and if these mechanisms bring about similar sequences of conversations.

The impact of research on practice

As I began adopting the perspective of discursive psychology, I found myself viewing clinical and everyday conversations differently. I began noticing the nuances in people's speech, including the intonations, pauses and changes in rate of speech. Previously these speech acts were placed as secondary in importance as I focused on interpreting people's meanings, however since conducting the analysis for this thesis, I started to question why certain discursive strategies were deployed by others. Morgan[31] outlines that "discourse analysis is more than just a methodology - it is a philosophy, a way of being" (p. 1). In her essay, Morgan[31] argues that discursive psychology is not only a study of talk, it also

challenges psychological phenomena through interpreting repertoires, ideological dilemmas and subject positions.

Within clinical psychology, discourse analysis has influenced the way language is considered. In Avdi and Georgaca's[32] critical review, they found that discourse analytic studies has been used to provide a deeper understanding to a number of clinical processes, including: how meaning is transformed within therapy; how agency, responsibility and blame are negotiated between practitioners and SUs; the role of practitioners and how they shape SUs' accounts; and the roles of power and resistance within therapy. This demonstrates that the use of discourse analysis within clinical psychology can allow research to focus on the way language is used to construct reality and how language is used functionally by people to achieve interpersonal goals.[33] The findings suggests that understanding the principles of discourse can inform how therapy can be delivered and how certain discursive mechanisms can alter the therapeutic experiences of SUs. Moreover, discourse analysis has been applied as a critical method of understanding the history behind clinical categories[34] and deconstructing the underlying assumptions of diagnoses.[35] Discourse analysis is therefore able to be used in a variety of ways to understand how concepts are constructed within clinical psychology, which can benefit both services and people who use services. Moreover, Harper[36] studied the way mental health difficulties are constructed in a range of public texts, including policy and media texts, and how subjectivity has influenced the way in which mental health is portrayed. Using discourse analysis within clinical psychology has shown that dominant categories and practices can be deconstructed, and by highlighting the constraints of these assumptions, it can open the opportunities for alternative concepts and practices.[37] Harper[38] argues that discourse analytic findings can inform novel interventions and may contribute to the drive to find other methods of practice, which can be offered in

addition to dominant and well-established therapy models. These studies further suggest that discourse analysis is an advantageous method in providing a rich understanding of mental health at both service and public levels, and can enhance clinical work, which can influence clinical psychology practice.

Within my current clinical practice, as well as noticing how people construct versions of events, I have combined this new discursive knowledge with the practice of interpreting meaning, which seems to contribute to my understanding and formulations. Often in qualitative research there is the recognition that the researcher's experiences can influence the research[39], but the research process can also influence the researcher's views of the study.[40] From my experience of transferring discursive psychology ideas from a research context to a clinical context, and the realisations which followed, I have become curious as to how using a discursive methodology has influenced other researchers who also engage in clinical practice. This curiosity could be a potential research question and may inform future research focused on the reflexivity of research in clinical psychology, and whether the experience impacts on clinical psychology practice.

In my research, only initial therapy sessions were recorded for analysis. The Academic Supervisor, Field Supervisor and myself were confident in only recording the initial therapy sessions as resources and preferred futures tend to be the focus of SF conversations from the outset.[41] This is in contrast with a structured assessment-formulation-intervention approach[42] where strengths and goals are often not explored until the intervention stages. However, as one of the research questions was to explore how preferred futures are constructed within SF conversations, I remained curious about how these

constructions unfolded in subsequent therapy sessions and was aware of my thoughts around 'what's next?'. In my reflective journal, I wrote:

> "I wonder what happens next? I wonder how these SUs, who have worked so hard already in their first ever session with the practitioner, took these SF conversations forward? SF therapy must seem so different to them compared to their views or experiences of 'traditional' therapy. I know some of the SUs said to the practitioner that they liked it, but I can't help but think about how they will get on with it in the long-term, and whether the difficulties experienced by the participants in my Literature Review were repeated or resolved."

Although recording subsequent therapy sessions was outside the scope of this thesis, future research using a DAM approach to record further therapy sessions would provide insight into how the discursive strategies unfold between therapy sessions. With particular focus on discourse four (*'removing the blame, effort and failure'*), where SUs were driven to volunteer effort and commitment to noticing change between therapy sessions, future research which focuses on how this driver is enacted in the SUs' lives could provide insight into the efficacy of these discursive techniques within therapy.

Final reflections

I undertook this research to further my understanding of how SUs navigate psychological therapy and how they build strengths, resilience and resources to cope in difficult circumstances. Over the course of completing this thesis, there were a number of occasions where my abilities and resources were tested and placed under extreme pressure.

As I reflected on this research process, I realised that my journey through this thesis is not dissimilar to the journey which SUs embark on as they begin and progress with therapy. The SUs and I were at parallel stages of learning new concepts, being concerned about our limits, pushing through these limits and eventually growing in awareness and understanding. This process has encouraged me to continue building resilience, and to find the resources which helped me cope during difficult times. Within clinical psychology practice, I often observe SUs beginning a journey of acquiring resources, uncovering inherent strengths and ultimately growing. This thesis process has been uplifting and challenging, and in the last 18 months I have gained new perspectives in what matters to SUs, the difficulties faced by SUs and practitioners, and the importance of research in practice. These new learning experiences have influenced my work in my specialist paediatric placement, and will continue to contribute to the development of my values beyond clinical practice. The experience of using discursive psychology as a research methodology has helped me to mature personally, through which I have learnt to apply my motivation and face my own self-critic rather than avoiding difficult matters. I felt hugely privileged to have conducted research which gives voice to both SUs and practitioners, and I am glad to have focused the research in a LTC context which will continue to shape my professional and personal identity in clinical psychology.

References

1.   Cheng J, Smith IC. *What is a clinical psychologist? Easy-read information booklet.*

        British Psychological Society, https://www.bps.org.uk/system/files/user-files/Division

        of Clinical Psychology/public/DCP What is clin psy.pdf (2017).

2.   Goodwin RD, Davidson KW, Keyes K. Mental disorders and cardiovascular disease

        among adults in the United States. *J Psychiatr Res*. 2009; 43: 239–46,

        https://doi.org/10.1016/j.jpsychires.2008.05.006.

3.   Zhang W, Wu H-X, Zhong H, et al. Psychological and behavioral intervention

        improves the quality of life and mental health of patients suffering from differentiated

        thyroid cancer treated with postoperative radioactive iodine-131. *Neuropsychiatr Dis

        Treat*. 2016; 12: 1055, https://doi.org/10.2147/NDT.S105460.

4.   MacCormack T, Simonian J, Lim J, et al. 'Someone who cares:' a qualitative

        investigation of cancer patients' experiences of psychotherapy. *Psychooncology*. 2001;

        10: 52–65, http://dx.doi.org/10.1002/1099-1611(200101/02)10:1%3C52::AID-

        PON489%3E3.3.CO;2-M.

5.   Dennison L, Moss-Morris R, Yardley L, et al. Change and processes of change within

        interventions to promote adjustment to multiple sclerosis: Learning from patient

        experiences. *Psychol Health.* 2013; 28: 973–992,

        http://dx.doi.org/10.1080/08870446.2013.767904.

6.   Grady PA. Creating a healthier tomorrow through research, practice, and policy. *Nurs

        Outlook*. 2010; 58: 268–271, https://doi.org/10.1016/j.outlook.2010.07.007.

7.   Hacking I. Making up people. In: Heller TC (ed) *Reconstructing individualism:

        Autonomy, individuality and the self in Western thought*. Redwood City, CA: Stanford

        University Press, 1986, pp. 222–236.

8.   Oliver O, Sapey B. *Social work with disabled people*. Basingstoke: Palgrave

       Macmillan, 2009.

9.   Edwards D, Potter J. *Discursive Psychology*. London: SAGE Publications, 1992.

10.   Coyle A. Discourse Analysis. In: Lyons E, Coyle A (eds) *Analysing Qualitative Data*

       in Psychology. London: SAGE Publications, 2007.

11.   Burr V. *Social Constructionism*. 2nd ed. London: Routledge, 2003.

12.   Britten N. Qualitative interviews in medical research. *BMJ*. 1995; 311: 251–3,

       http://www.jstor.org.ezproxy.lancs.ac.uk/stable/29728175.

13.   Leung L. Validity, reliability, and generalizability in qualitative research. *J Fam Med*

       Prim Care. 2015; 4: 324–7, http://dx.doi.org/10.4103/2249-4863.161306.

14.   Malterud K. Qualitative research: standards, challenges, and guidelines. *Lancet*. 2001;

       358: 483–488, https://doi.org/10.1016/S0140-6736(01)05627-6.

15.   National Health and Medical Research Council. *NHMRC Levels of Evidence and*

       Grades for Recommendations for Developers of Clinical Practice Guidelines,

       https://www.nhmrc.gov.au/_files_nhmrc/file/guidelines/developers/nhmrc_levels_grad

       es_evidence_120423.pdf (2009).

16.   Giorgi A, Giorgi B. Phenomenology. In: Smith JA (ed) *Qualitative psychology: A*

       practical guide to research methods. London: SAGE, 2003, pp. 25–50.

17.   Berger R. Now I see it, now I don't: researcher's position and reflexivity in qualitative

       research. *Qual Res*. 2015; 15: 219–234, https://doi.org/10.1177/1468794112468475.

18.   National Institute for Health and Care Excellence. *Improving Supportive and Palliative*

       Care for Adults with Cancer. London,

       https://www.nice.org.uk/guidance/csg4/resources/improving-supportive-and-palliative-

       care-for-adults-with-cancer-773375005 (2004).

19.   Carr SM, Smith IC, Simm R. Solution-focused brief therapy from the perspective of

clients with long-term physical health conditions. *Psychol Health Med*. 2014; 19: 384–91, http://dx.doi.org/10.1080/13548506.2013.824594.

20. Bannink FP. Solution-Focused Brief Therapy. *J Contemp Psychother*. 2007; 37: 87–94, https://doi.org/10.1007/s10879-006-9040-y.

21. Bremander A, Bergman S, Arvidsson B. Perception of multimodal cognitive treatment for people with chronic widespread pain-changing one's life plan. *Disabil Rehabil*. 2009; 31: 1996–2004, http://dx.doi.org/10.3109/09638280902874139.

22. Mikocka-Walus AA, Gordon AL, Stewart BJ, et al. 'Just to get it off my chest': Patients' views on psychotherapy in inflammatory bowel disease. *Couns Psychother Res*. 2013; 13: 227–234, http://10.0.4.56/14733145.2012.730540.

23. Erlangsen A, Stenager E, Conwell Y. Physical diseases as predictors of suicide in older adults: a nationwide, register-based cohort study. *Soc Psychiatry Psychiatr Epidemiol*. 2015; 50: 1427–1439, http://dx.doi.org/10.1007/s00127-015-1051-0.

24. Greydanus D, Patel D, Pratt H. Suicide risk in adolescents with chronic illness: implications for primary care and specialty pediatric practice: a review. *Dev Med Child Neurol*. 2010; 52: 1083–7, http://dx.doi.org/10.1111/j.1469-8749.2010.03771.x (2010).

25. White M. *Maps of Narrative Practice*. New York: W.W. Norton and Company, 2007.

26. Edwards D, Middleton D. Joint remembering: constructing an account of shared experience through conversational discourse. *Discourse Process* 1986; 9: 423–459.

27. Miller WR, Rollnick SR. *Motivational Interviewing: Preparing People for Change*. 2nd ed. New York: Guilford Press, 2002.

28. Vetere A, Dallos R. *Working Systemically with Families: Formulation, Intervention and Evaluation*. London: Karnac, 2003.

29. Morgan A. *What is Narrative Therapy?: An easy-to-read introduction*. Adelaide, South Australia: Dulwich Centre Publications, 2000.

30. Franklin C, Zhang A, Froerer A, et al. Solution Focused Brief Therapy: A Systematic Review and Meta-Summary of Process Research. *J Marital Fam Ther*. 2017; 43: 16–30, https://doi.org/10.1111/jmft.12193.

31. Morgan A. Discourse Analysis: An Overview for the Neophyte Researcher. *J Heal Soc Care Improv*. 2010; 5: 1–7, https://www.wlv.ac.uk/media/wlv/pdf/Discourse-analysis-Dr-A--Morgan.pdf.

32. Avdi E, Georgaca E. Discourse analysis and psychotherapy: A critical review. *Eur J Psychother Couns*. 2007; 9: 157–176, http://dx.doi.org/10.1080/13642530701363445.

33. Georgaca E, Avdi E. Evaluating the talking cure: The contribution of narrative, discourse and conversation analysis to psychotherapy assessment. *Qual Res Psychol*. 2009; 6: 233–247, http://dx.doi.org/10.1080/14780880802146896.

34. Blackman L. *Hearing voices: Embodiment and experience*. London: Free Association Books, 2001.

35. Gillett G. A discursive account of multiple personality disorder. *Philos Psychiatry Psychol*. 1997; 4: 213–222, https://muse-jhu-edu.ezproxy.lancs.ac.uk/article/28189.

36. Harper DJ. Storying policy: Constructions of risk in proposals to reform UK mental health legislation. In: Hurwitz B, Skultans V, Greenhalgh T (eds) *Narrative research in health and illness*. London: BMA Books, 2004, pp. 397–413.

37. Parker I, Georgaca E, Harper D, et al. *Deconstructing psychopathology*. London: Sage Publications Inc., 1995.

38. Harper D. Discourse analysis. In: Slade M, Priebe S (eds) *Choosing methods in mental health research: Mental health research from theory to practice*. London: Routledge, 2006, pp. 47–67.

39. Boyatzis RE. *Transforming qualitative information: Thematic analysis and code development.* Thousand Oaks, CA: SAGE Publications, Inc, 1998.

40.   Gilgun J. Reflexivity and Qualitative Research. *Curr Issues Qual Res*. 2010; 1: 1–8, http://www.scribd.com/doc/35787948/Reflexivity-and-Qualitative-Research.

41.   Burns K. *Focus on solutions : a health professional's guide*. Second Edi. Solutions Books, 2016.

42.   Sage N, Sowden M, Chorlton E, et al. *CBT for Chronic Illness and Palliative Care*. Chichester: John Wiley & Sons, Ltd., 2008.

Appendix 4-A

NHS Research Ethics Committee application

Full Set of Project Data   IRAS Version 5.3.1

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
Preferred future & resource through SFBT with people with LTCs

1. Is your project research?

◉ Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product

○ Clinical investigation or other study of a medical device

○ Combined trial of an investigational medicinal product and an investigational medical device

○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice

○ Basic science study involving procedures with human participants

○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology

◉ Study involving qualitative methods only

○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)

○ Study limited to working with data (specific project only)

○ Research tissue bank

○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?   ○ Yes ◉ No

b) Will you be taking new human tissue samples (or other human biological samples)?   ○ Yes ◉ No

c) Will you be using existing human tissue samples (or other human biological samples)? ○ Yes ◉ No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

☑ England
☐ Scotland

☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

◉ England

○ Scotland

○ Wales

○ Northern Ireland

○ This study does not involve the NHS

---

4. Which applications do you require?

IMPORTANT: If your project is taking place in the NHS and is led from England select 'IRAS Form'. If your project is led from Northern Ireland, Scotland or Wales select 'NHS/HSC Research and Development Offices' and/or relevant Research Ethics Committee applications, as appropriate.

☑ IRAS Form
☐ Confidentiality Advisory Group (CAG)
☐ National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D Offices in Northern Ireland, Scotland and Wales the CI must create NHS/HSC Site Specific Information forms, for each site, in addition to the study wide forms, and transfer them to the PIs or local collaborators.

For participating NHS organisations in England different arrangements apply for the provision of site specific information. Refer to IRAS Help for more information.

Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?

○ Yes   ◉ No

---

5. Will any research sites in this study be NHS organisations?

◉ Yes   ○ No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out research e.g. NHS Support costs) for this study provided by a NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC), NIHR Patient Safety Translational Research Centre or a Diagnostic Evidence Co-operative in all study sites?

Please see information button for further details.

○ Yes   ◉ No

Please see information button for further details.

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

○ Yes   ◉ No

The NIHR Clinical Research Network provides researchers with the practical support they need to make clinical studies happen in the NHS e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form (PAF) immediately after completing this project filter question and before submitting other applications. Failing to complete the PAF ahead of other applications e.g. HRA Approval, may mean that you will be unable to access NIHR CRN Support for your study.

6. Do you plan to include any participants who are children?

◯ Yes ⦿ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

◯ Yes ⦿ No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

◯ Yes ⦿ No

9. Is the study or any part of it being undertaken as an educational project?

⦿ Yes ◯ No

Please describe briefly the involvement of the student(s):
This study is being undertaken as part of the Chief Investigator's doctoral thesis.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

⦿ Yes ◯ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

◯ Yes ⦿ No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

◯ Yes ⦿ No

Integrated Research Application System
Application Form for Research involving qualitative methods only

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Preferred future & resource through SFBT with people with LTCs

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions.

A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title	Forename/Initials	Surname
	Miss	Joanna	Cheng
Address	Clinical Psychology, Furness College		
	Lancaster University		
	Lancaster		
Post Code	LA1 4YG		
E-mail	j.cheng1@lancaster.ac.uk		
Telephone	01524592970		
Fax			

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
DClinPsy Doctorate of Clinical Psychology

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title	Forename/Initials	Surname
	Dr	Ian	Smith
Address	Clinical Psychology, Furness College		

	Lancaster University
	Lancaster
Post Code	LA1 4YG
E-mail	i.smith@lancaster.ac.uk
Telephone	01524592282
Fax	

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Miss Joanna Cheng	☑ Dr Ian Smith

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

◉ Student

◯ Academic supervisor

◯ Other

A3-1. Chief Investigator:

	Title Forename/Initials Surname
	Miss Joanna Cheng
Post	Trainee Clinical Psychologist
Qualifications	BSc Psychology
	PGCert Evidence-Based Psychological Treatment
Employer	Lancashire Care NHS Foundation Trust
Work Address	Clinical Psychology, Furness College
	Lancaster University
	Lancaster
Post Code	LA1 4YG
Work E-mail	
* Personal E-mail	j.cheng1@lancaster.ac.uk
Work Telephone	
* Personal Telephone/Mobile	█████████
Fax	

* This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.

	Title	Forename/Initials	Surname
	Dr	Diane	Hopkins
Address	Research Services		
	B14 Furness College		
	Lancaster University, Lancaster		
Post Code	LA1 4YT		
E-mail	ethics@lancaster.ac.uk		
Telephone	01524592838		
Fax			

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):

Sponsor's/protocol number:

Protocol Version:

Protocol Date:

Funder's reference number:

Project website:

Additional reference number(s):

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

◯ Yes   ⦿ No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

The title of the research project is: "Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions." The primary research question is: how do people with long-term physical health conditions construct preferred futures and resources with their practitioners in an initial solution-focused therapy session? 8-12 participant dyads will be recruited from the ██████████████████ ██████████ in ████████████████████████████. All service-users (SU) who have a long-term condition (LTC) and are receiving solution-focused approaches will be invited to participate. With consent from the SUs, therapeutic sessions between SUs and the therapist will be audio recorded as data. The practitioners will also be participants, forming a dyad with SUs. The study, including the write-up, will aim to finish in May 2017. This study will be analysed using a Discursive Action Model informed method.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

Consent:
Prior to the initial appointment, practitioners and service users will receive recruitment materials, including a Participant Information Sheet (PIS) and Consent Form. The Chief Investigator will assess the practitioners' capacity to consent to participate in the study. As practitioner participants (PP/s) are recruiting service users for the project, they will ensure that potential service user participants (SUP/s) have the capacity to consent to the study using the same procedure as the Chief Investigator. A guidance will be provided to practitioners to outline how to determine capacity to consent. This guidance is developed by the Chief Investigator with the Research Supervisor, following guidelines of the Mental Capacity Act. Participants are directed to the Chief Investigator's contact details in the recruitment materials if they have any additional questions.

Risks, burdens and benefits:
There are no direct benefits to the participants. This research project hopes to develop understanding of how SFBT conversations and their stated therapeutic techniques operate in practice. This study also hopes to add to the evidence base for qualitative studies of SFBT and LTCs.

As participants will not be interviewed, there should no distress as a direct result of the research. It will be stated in the PIS that practitioners can stop the recording at any time at the SU's request, and that the SU can pause/stop the recording process should they want to discuss issues that they do not want to be included in the data analysis. Henry et al. (2015) showed that recording clinical sessions for research had no significant effect on discussions around depression symptoms, preventive health, and depression diagnosis; depression treatment recommendations; visit length; visit difficulty. Finally, the details of the Chief Investigator and the Academic Supervisor will be given if participants wanted to withdraw from the study or make a complaint.

In a typical initial therapeutic session using solution-focused conversations, it will be made clear that the focus of the conversation will be around psychological wellbeing relating to the service user's physical health problem. The practitioner may ask the service user about their main problems, which can include mental health difficulties associated with their physical health issues. The practitioner may focus on times when the problem has not been around in the same way, and may ask the service user if they noticed any changes in the way they approach their issues. Possible resources and strengths may be explored, which may lead to conversations around change and preferred futures. The therapeutic session may also discuss the service user's interests and hobbies in order to build rapport. Therapeutic goals may be discussed during the initial session.

Confidentiality:
The Chief Investigator hopes to collect a minimal amount of personally identifiable information at the recruitment stage. For PPs, it will collect their name and the service they work for. For SUPs, it will collect their name, age, gender and type of LTC. All personally identifiable information will be anonymised. All electronic and paper copies of data will be stored securely. Electronic data will be stored on the Chief Investigator's personal file on the University server. All electronic data will be encrypted and text documents will also be password-protected. With consent from the participants, health services may request to access the anonymised transcripts for future research. All participants are given the opportunity to state in the consent form whether or not they agree for their anonymised transcripts to be used in future research. The transcripts will be stored securely in an password protected and encrypted electronic server for ten years after completion of the research project, where they will be destroyed in accordance of the Data Protection Act (1998). All of the above are outlined explicitly in the PIS and the Consent Form.

Conflict of interest:
There are no issues around conflict of interest.

Participants will be given the contact details of the Chief Investigator and the Academic Supervisor should they wish to receive a feedback of the results from the research project.

---

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply:*

☐ Case series/ case note review

☐ Case control

☐ Cohort observation

☐ Controlled trial without randomisation

☐ Cross-sectional study

☐ Database analysis

☐ Epidemiology

☐ Feasibility/ pilot study

☐ Laboratory study

☐ Metanalysis

☑ Qualitative research

☐ Questionnaire, interview or observation study

☐ Randomised controlled trial

☐ Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

The principal research question is: how do people with long-term physical health conditions construct preferred futures and resources with their practitioners in an initial solution-focused therapy session?

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

There is a high co-morbidity of LTCs and mental health difficulties (Naylor et al., 2012). People are 20-50% more likely to experience depression if they have a LTC (Goodwin, Davidson, & Keyes, 2009); depression is likely to become chronic, which leads to increased disability over time (World Health Organization, 2007). The Mental Health Foundation recognises that physical and mental health are inextricably linked, and advocates that mental health should become an integral part of the public health agenda (Mental Health Foundation, 2015).

Solution-focused brief therapy (SFBT) focuses on identifying personal resources, strengths and meeting the service users' desired outcomes. Currently, SFBT is a recommended therapeutic modality in the NICE guidance for supporting adults with cancer (National Institute for Health and Care Excellence, 2004), alongside Cognitive Behavioural Therapy (CBT). Most guidelines for improving psychological wellbeing in LTCs regard CBT as the 'gold standard' intervention, however it may not be suitable for everyone (Whalley & Hyland, 2009). Offering SFBT as an alternative approach will give SUs choice, and allow therapists more versatility in their practice. CBT is recommended in the NICE guidance for managing depression in chronic health conditions (National Institute for Health and Care Excellence, 2009). However, in Farrand and Woodford's (2015) systematic review of CBT randomised controlled trials for people with LTCs, there was a small effect size for the treatment of depression and anxiety in people with LTCs, suggesting that CBT is not meeting some needs of people with LTCs. Campbell and Campbell (2012) found that CBT treatment effects were not statistically significant for people with cancer. There is a need for alternative therapeutic options for people with LTCs. Carr, Smith and Simm (2014) found that people with LTCs who engaged in SFBT reported a number of positive experiences, such as the identification of strengths and resources to cope with difficult situations.

Although Carr, Smith and Simm (2014) investigated how people with LTCs feel about SFBT, there is little evidence to show how these are socially constructed in the therapeutic process. This research hopes to find out how the SU and the practitioners use SF conversations to construct preferred futures and resources. Identifying these processes will allow us to deepen our understanding of how SF conversations allow people adapt to health conditions, which will be a valuable resource for SUs and services.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research*

participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.

The research project will be a qualitative study as it will be collecting the recorded therapeutic sessions of participants. A discursive psychology informed approach will be used to guide this research, as I hope to seek out and conceptualise the patterns of how SF conversations are used to construct preferred futures and narratives about resources which could support people to adapt to LTCs. Potter, Edwards and Wetherell's (1993) techniques in Discursive Action Model theory will be used to inform the design and analysis of this project.

The recruitment process will begin following the ethics approval. The Chief Investigator will attend team meetings to talk about the project, and will ask practitioners to wait at least 24 hours after the meeting so that they have had time to consider the research before agreeing to give consent for involvement. The Field Supervisor and/or team administrators distribute research materials to practitioners on behalf of the Chief Investigator. Once the consent form is received, the Chief Investigator initiates contact with the practitioners to assess capacity to consent. Practitioners who decide to participate in the research will be referred to as 'practitioner participants' (PP) in this document. PPs will be given the inclusion and exclusion criteria where they can decide which of their SUs may be eligible for the study. PPs are given the recruitment materials to distribute to SUs. SUs' capacity to consent will be measured by PPs using the same prodecure. If SUs agree to participate, they will be referred to as 'SU participants' (SUP) in this document. A pair of PP and SUP will form a participant dyad.

All participants will receive the following recruitment materials:
- An Introductory Letter
- A Participant Information Sheet
- Consent Form
In addition, PPs will receive a 'Guidance for Practitioners' document.

Potential participants will receive a freepost envelope as part of the materials, where they can return their expression of interest reply slip. The participant's involvement with the research project begins at this stage. The recording will take place within the therapeutic session. The Chief Investigator will have no further contact with participants unless participants choose to contact them or if arrangements were made to feedback the project results.

The recruitment period will run up to seven months, where transcription and analysis will take place alongside data collection. The research project will aim to complete in May 2017.

The design and research materials have been developed with input from service-user groups.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

☐ Design of the research

☐ Management of the research

☐ Undertaking the research

☑ Analysis of results

☐ Dissemination of findings

☐ None of the above

Give details of involvement, or if none please justify the absence of involvement.
All recruitment materials have been developed with input from clinical psychologists and service users of psychological therapy services. The members of the Lancaster University Public Involvement Network were able to view and comment on the presentation, language and standard of the research materials. Their feedback has been incorporated into the materials, where changes were made to better suit the needs of people who receive services. At the start of the recruitment, both PPs and SUPs are asked to indicate whether or not they would like to receive a summary of the research. Participants are asked to leave contact details so they can be contacted to arrange this process. No personally identifiable data of other participants will be shared.

---

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

- ☐ Blood
- ☐ Cancer
- ☐ Cardiovascular
- ☐ Congenital Disorders
- ☐ Dementias and Neurodegenerative Diseases
- ☐ Diabetes
- ☐ Ear
- ☐ Eye
- ☐ Generic Health Relevance
- ☐ Infection
- ☐ Inflammatory and Immune System
- ☐ Injuries and Accidents
- ☑ Mental Health
- ☐ Metabolic and Endocrine
- ☐ Musculoskeletal
- ☐ Neurological
- ☐ Oral and Gastrointestinal
- ☐ Paediatrics
- ☐ Renal and Urogenital
- ☐ Reproductive Health and Childbirth
- ☐ Respiratory
- ☐ Skin
- ☐ Stroke

Gender: Male and female participants

Lower age limit: 18   Years

Upper age limit: Years

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

The inclusion criteria for service user participation will be: adults from age 18 (no upper age limit); people who are beginning therapeutic work with a SF approach; people who are able to communicate in English; people with any long-term physical health condition, where the condition can be defined by the service access or by self-identification.

The inclusion criteria for practitioner participation will be: practitioners who are offering solution-focused conversations to service users; practitioners who are carrying out the session in English.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

The exclusion criteria for service user participation will be: people who are in therapy but are not having SF conversations; people that do not have capacity to consent to taking part in the research.

The exclusion criteria for practitioner participation would be if they do not have capacity to consent to taking part in the research.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.

2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?

3. Average time taken per intervention/procedure (minutes, hours or days)

4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Seeking informed consent	2	0	2 months	Initially, Joanna Cheng, Trainee Clinical Psychologist will carry out this procedure via post. If no response is received, the practitioner will carry this out in the health service.
Recording the interview	2	2	1 month	SF practitioner, ███████████████████

A21. How long do you expect each participant to be in the study in total?

Involvement with the study will begin as the Chief Investigator receives informed consent. Depending on individual practitioners' availability, SUs vary in how quickly they are seen for their initial appointment. The therapeutic sessions will be recorded, however the precise date of when this occurs is dependent on the SU's availability for therapy. As only the first therapeutic session is recorded, participants will be involved with the project until the end of this first session.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

SUs will be offered their routine care, therefore any potential risks and burdens will not be a direct result of the study. If there is any distress as a direct result of the research, for example, if SUs or practitioners are distressed by the presence of the audio recording equipment, then they can be stopped immediately. Finally, the details of the Chief Investigator and the Research Supervisor will be given if participants wanted to withdraw from the research or make a complaint.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

⦿ Yes   ◯ No

If Yes, please give details of procedures in place to deal with these issues:

In the event that malpractice was brought to light in the recordings, it will be discussed with both the Academic and Field Supervisors immediately and advice will be sought on the most appropriate way to proceed, and the manager of the service within which the practitioner works will be informed. Service user participants will be receiving exactly the same care they would do were they not participating in the research. This means that in the event that a service user discloses information that suggest they may cause harm to themselves or others, the practitioner will follow the service guidance on management of risk, which may include breaking confidentiality and notifying other agencies, including the safeguarding teams of the service and local authorities. If practitioner participants discloses information that suggest they may cause harm to themselves or others, the Chief Investigator will discuss this with both the Academic and Field Supervisors immediately to seek advice and promptly take any necessary action to prevent or minimise harm.
In all of the instances above, confidentiality to participate in the research project may be broken and this is outlined in the Participant Information Sheet for service users and practitioners.

A24. What is the potential for benefit to research participants?

The research project hopes to benefit the services which SUs and participants receive. The project will help practitioners and clinical psychologists to understand how solution-focused conversations can generate topics around preferred futures and resources. This will allow practitioners and service providers to identify another psychological intervention that they can offer, other than CBT.

A26. What are the potential risks for the researchers themselves? *(if any)*

As the Chief Investigator will not be meeting participants for this research, there are no potential risks for the researcher. There will be no lone working issues.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used? *For example, identification may involve a disease register, computerised search of social care or GP records, or review of medical records. Indicate whether this will be done by the direct care team or by researchers acting under arrangements with the responsible care organisation(s).*

The research project will collect the SUPs', age, health condition (for SUs), the name of their practitioner and preferred contact method. The preferred contact method will only be provided by the participants if they indicated that they would like to receive a summary of the research. For PPs, only their name, the service they work for and their preferred contact method (conditions as the same as above) will be obtained. Identifiable information will only be obtained by the Chief Investigator if participants choose to share this.

All personally identifiable information will be anonymised in the transcripts and reports. Participants will be asked to choose a pseudonym which will be represented in all transcripts and write-ups of the project. Participants' ages and health condition (if they are SUs) will only be used for demographic reporting in the write-up, and no precise date of birth will be obtained throughout the study. Participants' contact details, real names and their matching pseudonym will be stored in an encrypted and password-protected file and will only be seen by the Chief Investigator. This file will only be used if a participant wishes to withdraw from the study after the interview, and so the appropriate audio recording and transcript can be tracked and deleted. If the PP wishes to withdraw from the study, this will automatically withdraw the SUP from the study as analyses of one half of a dyad would not be possible. The file and all audio recordings will be deleted after the study is finished. The transcripts will be stored securely by Lancaster University, in a password-protected and encrypted electronic server for ten years after completion of the research project, where they will be destroyed in accordance of the Data Protection Act (1998). All of the above are outlined explicitly in the PIS and Consent Form.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

◯ Yes ⬤ No

Please give details below:

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

◯ Yes ⬤ No

A29. How and by whom will potential participants first be approached?

The Chief Investigator will have no access to personal information of potential participants prior to participants opting in to the study.

Practitioner participants: Potential PPs who fulfil the inclusion/exclusion will be sent research materials by the Field

Supervisor and/or team administrators, on behalf of the Chief Investigator. Potential PPs will be given an Introductory Letter, PIS and Consent Form. The research aims and methodology will be explained. If practitioners agree to participate, they will formally become PPs and recruit SUPs.

SU participants: SUs who fulfil the inclusion/exclusion criteria will be approached by their practitioners who are offering solution-focused therapeutic approaches. Potential SUPs will be given an Introductory Letter, PIS and Consent Form. If SUs agree to participate, they will become formally recruited SUPs.

All participants can contact the Chief Investigator directly to discuss or opt in to the study. The Chief Investigator will have no access to participants' contact details prior to this.

A30-1. Will you obtain informed consent from or on behalf of research participants?

◉ Yes   ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

Informed consent will be gained from all participants.

For PPs, the capacity to consent will be assessed by the Chief Investigator once the consent form has been returned. The Chief Investigator will ensure that PPs can understand the information, retain the information, weigh the information to inform decision-making, and communicate their decision. This is in accordance to the Mental Capacity Act (2005). PPs will be made aware that they will be assessing the capacity of SUPs using the same procedure. PPs will assess capacity at the beginning of the therapeutic session.

An Introductory Letter, PIS and Consent Form will be distributed to potential participants. All materials are written in a size 12 font to aid understanding. The SUP version of materials are adapted to be understood by people with a lower reading age so that it is inclusive to all potential participants, regardless of educational background or cognitive ability. When potential participants contact the Chief Investigator to opt in or ask questions, the Chief Investigator will explicitly give opportunities for queries around consent.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

◉ Yes   ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

The recruitment period will run for seven months. Potential participants can take part any time during this window, as long as they are attending their first appointment from psychological services. The Chief Investigator will stop recruitment after the sample size limit is reached.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? *(e.g. translation, use of interpreters)*

All research information is written in size 12 font and 1.5 spaced so that potential participants are not crowded with text. The formatting of all written materials are the same to ensure consistency. All SUP materials are written with attempts to remove as much jargon as possible, and also written in an easy to understand format so that the research is inclusive to people of all abilities. As stated in the inclusion criteria, only therapy conducted in English will be considered for participation, therefore all participants must have understanding and communication competencies in the English language. An audio recorded version of the recruitment materials can be given to participants who have difficulty reading or have limited literacy levels.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

- ⦿ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.
- ◯ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.
- ◯ The participant would continue to be included in the study.
- ◯ Not applicable – informed consent will not be sought from any participants in this research.
- ◯ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

If the participant loses capacity to consent during the study, the participant will be withdrawn from the study. No further contact will be made regarding the study and no new information will be collected. Subject to ethical approval, the research project may retain data that was collected whilst the participant was able to give informed consent.   All data will continue to be anonymised. All personal identifiable information will be deleted in line with the procedures following the right to withdraw.

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)? *(Tick as appropriate)*

- ☐ Access to medical records by those outside the direct healthcare team
- ☐ Access to social care records by those outside the direct social care team
- ☑ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☑ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☑ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☑ Use of audio/visual recording devices
- ☐ Storage of personal data on any of the following:

  - ☐ Manual files (includes paper or film)
  - ☐ NHS computers
  - ☐ Social Care Service computers
  - ☐ Home or other personal computers
  - ☐ University computers
  - ☐ Private company computers
  - ☐ Laptop computers

Further details:
Storage of data, including electronic and paper copies, will be in compliance with Lancaster University regulations for research data storage.

Consent forms will be scanned to an electronic pdf format. All paper copies with personally identifiable information will be destroyed through disposal in NHS Trust confidential shredding bins. Electronic pdfs of consent forms will be encrypted, password-protected and stored in the Chief Investigator's personal file space on the University server via Virtual Private Network.

The audio recorder will not be encrypted but will be deleted from the recorder as soon as the audio files are transferred to a password protected computer. In the meantime the audio recorder will be stored securely in a locked filing cabinet. All audio recording files will encrypted and password-protected and will be stored on the University server. These will be deleted after the study has finished.

All transcripts will be stored securely in a locked filing cabinet for ten years after completion of the study. They will be destroyed in accordance of the Data Protection Act (1998).

A file containing participants' pseudonyms and real names and contact details will be encrypted, password-protected and stored on the University server. This will be deleted after the study has finished.

A37. Please describe the physical security arrangements for storage of personal data during the study?

Personal data will be stored electronically on the Chief Investigator's personal file on the University server. No personal information will be stored on computers. The file store will be encrypted.

A38. How will you ensure the confidentiality of personal data? *Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

The Chief Investigator will follow the NHS Code of Confidentiality (2003) as well a the Lancaster University policy on data storage (http://www.lancaster.ac.uk/shm/study/doctoral_study/dclinpsy/onl inehandbook/ethics_and_data_storage_advice/).

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

The Chief Investigator will have access to data containing participants' personal information. The Academic Supervisor will have access to one therapy recording and to anonymised data in order to provide supervisory support during data collection and analysis. Field Supervisors will also have access to anonymised data to support data analysis.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

The data generated by the study will be analysed by the Chief Investigator at their home address. Input will be obtained from the Academic Supervisor. The analysis of paper files will be kept in a locked cabinet. Electronic files will be password-protected and encrypted, which will be stored in the Chief Investigator's personal file on the University server.

A42. Who will have control of and act as the custodian for the data generated by the study?

	Title	Forename/Initials	Surname
	Dr	Bill	Selwood
Post	Professor, Programme Director, Doctorate in Clinical Psychology, Lancaster University		
Qualifications	PhD		
Work Address	Division of Health Research		

	Furness College, Lancaster University
	Lancaster
Post Code	LA1 4YG
Work Email	b.sellwood@lancaster.ac.uk
Work Telephone	01524593998
Fax	

A43. How long will personal data be stored or accessed after the study has ended?

◉ Less than 3 months

◯ 3 – 6 months

◯ 6 – 12 months

◯ 12 months – 3 years

◯ Over 3 years

A44. For how long will you store research data generated by the study?

Years: 10
Months:

A45. Please give details of the long term arrangements for storage of research data after the study has ended. *Say where data will be stored, who will have access and the arrangements to ensure security.*

All data will be stored electronically by Lancaster University DClinPsy Research Coordinator in the long term. Data that will be stored long term are consent forms, interview transcripts and coded data produced during analysis. All data will be encrypted and transferred securely to the Research Coordinator using a secure file transfer software. The Research Coordinator will save the files in a password-protected file space on the University server. The Chief Investigator will send an email to the Research Coordinator with the password for encrypted files, the end date of the study and the year the data should be destroyed.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

◯ Yes   ◉ No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

◯ Yes   ◉ No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

◯ Yes   ◉ No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

◯ Yes   ⦿ No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50-1. Will the research be registered on a public database?

⦿ Yes   ◯ No

Please give details, or justify if not registering the research.
The Chief Investigator aims to publish this research project after completion, which may appear on public databases.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

☑ Peer reviewed scientific journals
☑ Internal report
☑ Conference presentation
☑ Publication on website
☐ Other publication
☐ Submission to regulatory authorities
☑ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
☐ No plans to report or disseminate the results
☐ Other (please specify)

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

The Chief Investigator will collect the following data for the research project which will constitute as personally identifiable data: name, age, contact details and health condition (if they are SU participants); name, the service they work for and contact details (for practitioner participants). The participant's name will be replaced with a pseudonym, which will be represented in all transcripts, coded data from analysis, draft reports, the published report and all further documentations. The participant's age and health condition will not be anonymised; however their date of birth will not be collected at any point of the research project and therefore will not be identifiable. The participant's contact details will not be used beyond the analysis phase; they will be retained so that participants can be contacted if they indicated a preference to receive a summary of the report.

A53. Will you inform participants of the results?

⦿ Yes   ◯ No

Please give details of how you will inform participants or justify if not doing so.

A summary sheet of the findings will be produced. This will be sent to participants who indicated that they would like to receive this.

The results will also be disseminated to other interested groups, such as service-user groups and services, to communicate the purpose and findings of the study as well as sharing the contribution of participants.

Participant's information sheet outlines that the research project will be published with all personally identifiable information anonymised.

5. Scientific and Statistical Review

A54-1. How has the scientific quality of the research been assessed? *Tick as appropriate:*

☐ Independent external review

☐ Review within a company

☐ Review within a multi−centre research group

☑ Review within the Chief Investigator's institution or host organisation

☑ Review within the research team

☑ Review by educational supervisor

☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
The quality of the research will be assessed by the Academic Supervisor and Field Supervisors. They will assess the quality of the all research materials, the interview schedule, the manner of how the interview was conducted, coded analysis, draft reports and the final report. The research will also be reviewed by the Lancaster University Examinations Board and the Lancaster University DClinPsy Research Team.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size: 24
Total international sample size (including UK): 24
Total in European Economic Area: 24

Further details:
The minimal sample size is eight dyads (formed by PPs paired with SUPS), with a maximum of 12 pairs; total of 24 participants. A psychological study of family therapy using a Discursive Action Model had a sample of nine videotaped sessions (Pinelopi & Eleftheria, 2015), which this research hopes to match. The maximum sample size is 12 pairs/24 participants due to time constraints of the Chief Investigator, whilst also ensuring the size is sufficient enough to increase the likelihood of it being published in the identified journal.

Purposive sampling will be used for this study as it aims to recruit a variety of people in different circumstances.

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

As this research project is a qualitative study, it does not require power analysis. The relatively small sample size would allow for meaningful and rich data to be generated. The initial purposive sampling would be appropriate for this research project as it aims to gain a range of accounts from people with LTCs.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by

which the data will be evaluated to meet the study objectives.

This research project will be using a Discursive Action Model (DAM) informed analysis. DAM, as a type of discursive psychology, allows researchers to understand the relationship between language and knowledge, and how people make sense of what is happening (Edwards & Potter, 1992). As this research hopes to develop an understanding of how people with LTCs construct preferred futures and resources through solution-focused conversations, DAM will allow the research to seek out the linguistic discourses of people's therapeutic interaction and social reality (Coyle, 2007). The raw data will be transcribed. Line by line coding will be used to identify actions, facts and interests, and accountability (Edwards and Potter, 1992).

All analysis will be conducted manually by the Chief Investigator. Input and feedback will be obtained from the Academic Supervisor to check the codes and categories to ensure that the Chief Investigator has not over-represented or missed aspects of the data.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title	Forename/Initials	Surname
	Dr	Suzi	Curtis
Post	Clinical Psychologist		
Qualifications	████		
Employer	████████████████		
Work Address	████████████████		
	██████		
	████		
Post Code	████		
Telephone	██████		
Fax			
Mobile			
Work Email	██████		

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status:
○ NHS or HSC care organisation
◉ Academic
○ Pharmaceutical industry
○ Medical device industry
○ Local Authority
○ Other social care provider (including voluntary sector or private organisation)
○ Other

Commercial status:

If Other, please specify:

Full Set of Project Data   IRAS Version 5.3.1

Contact person

Name of organisation Lancaster University
Given name   Diane
Family name   Hopkins
Address   ██████████████████   ████████████
Town/city   Lancaster
Post code   LA1 4YT
Country   UNITED KINGDOM
Telephone   01524592838
Fax
E-mail   ethics@lancaster.ac.uk

Is the sponsor based outside the UK?
○ Yes   ◉ No

*Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a
legal representative established in the UK. Please consult the guidance notes.*

A65. Has external funding for the research been secured?

☐ Funding secured from one or more funders

☐ External funding application to one or more funders in progress

☑ No application for external funding will be made

What type of research project is this?

◉ Standalone project

○ Project that is part of a programme grant

○ Project that is part of a Centre grant

○ Project that is part of a fellowship/ personal award/ research training award

○ Other

Other – please state:

**A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other
than a co-sponsor listed in A64-1) ?** *Please give details of subcontractors if applicable.*

○ Yes   ◉ No

**A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another
country?**

○ Yes   ◉ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the

reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

Title Forename/Initials Surname

Organisation
Address

Post Code
Work Email
Telephone
Fax
Mobile

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 01/06/2016
Planned end date: 31/05/2017
Total duration:

Years: 0 Months: 11 Days: 31

A71-1. Is this study?

◉ Single centre

◯ Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

☑ England

☐ Scotland

☐ Wales

☐ Northern Ireland

☐ Other countries in European Economic Area

Total UK sites in study

Does this trial involve countries outside the EU?
◯ Yes   ◉ No

A72. Which organisations in the UK will host the research? *Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

☑ NHS organisations in England   1

☐ NHS organisations in Wales

☐ NHS organisations in Scotland

☐ HSC organisations in Northern Ireland

☐ GP practices in England

☐ GP practices in Wales

☐ GP practices in Scotland

☐ GP practices in Northern Ireland

☐ Joint health and social care agencies (eg community mental health teams)

☐ Local authorities

☐ Phase 1 trial units

☐ Prison establishments

☐ Probation areas

☐ Independent (private or voluntary sector) organisations

☐ Educational establishments

☐ Independent research units

☐ Other (give details)

Total UK sites in study: 1

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

◯ Yes   ⦿ No

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

The Chief Investigator will receive regular supervision from the Academic Supervisor and the Field Supervisor. A research contract has been agreed and arrangements for monitoring and auditing the conduct of the research is as follows:

The Chief Investigator will have monthly contact, including supervision, with the Academic Supervisor and Field Supervisor. The contacts will be a mixture of emails, telephone conferences or face-to-face meetings, depending on the agenda of the contact.

A76. Insurance/ indemnity to meet potential legal liabilities

Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

---

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the <u>design</u> of the research? *Please tick box(es) as applicable.*

<u>Note:</u> Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the <u>conduct</u> of the research?

<u>Note:</u> Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☑ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☐ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

○ Yes   ● No   ○ Not sure

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For NHS sites, the host organisation is the Trust or Health Board. Where the research site is a primary care site, e.g. GP practice, please insert the host organisation (PCT or Health Board) in the Institution row and insert the research site (e.g. GP practice) in the Department row.*

Investigator identifier	Research site	Investigator Name
IN1	● NHS site ○ Non-NHS site	Forename ▆▆▆ Middle name Family name ▆ Email ▆▆▆▆ Qualification (MD...) ▆▆▆▆ Country ▆▆▆
	Country: England	
	Organisation name ▆▆▆▆	

Address ▇▇▇▇▇▇

▇▇▇▇▇▇▇▇▇▇

Post Code ▇▇▇▇

Appendix 4-B

Research protocol

Research Protocol for NHS Ethics Application

Title: Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions.

Name of applicant: Joanna Cheng
Trainee Clinical Psychologist
Doctorate in Clinical Psychology
Furness College
Lancaster University
Lancaster
United Kingdom
LA1 4YG

Names of Supervisors:
Research Supervisor: Dr Ian Smith
Senior Clinical Tutor
Doctorate in Clinical Psychology
Furness College
Lancaster University
Lancaster, LA1 4YG

Field Supervisors: Dr Suzi Curtis
Clinical Psychologist
████████████████████

Affiliations: Trainee Clinical Psychologist, Lancaster University & Lancashire Care NHS Foundation Trust

Version number: 5
Date: 24 August 2016

Introduction

This research project aims to develop an understanding of how people with a long-term physical health condition (LTC) construct preferred futures and resources with their therapists using solution-focused conversations. More than 15 million people in the United Kingdom are living with a LTC (Department of Health, 2011). Living with a LTC can significantly impact on many areas of a person's mental wellbeing, including a change in identity, roles, relationships and self-worth. There is a high co-morbidity of LTCs and mental health difficulties (Naylor et al., 2012). People are 20-50% more likely to experience depression if they have a LTC (Goodwin, Davidson, & Keyes, 2009); depression is likely to become chronic, which leads to increased disability over time (World Health Organization, 2007).

Over the last few decades there has been an increasing movement recognising the importance of psychosocial wellbeing and the influence it has in health and illness (Nikcevic, Kuczmierczyk, & Bruch, 2006). 'No health without mental health' (HM Government and Department of Health, 2011), a UK cross-government strategy, states that "good mental health and resilience are fundamental to our physical health" (p.5), which suggests that the improvement of psychological wellbeing will allow people to manage and cope better with LTCs. The Mental Health Foundation (2015) recognises that physical and mental health are inextricably linked, and advocates that mental health should become an integral part of the public health agenda.

Cognitive-behavioural therapy (CBT) is recommended in the NICE guidance for managing depression in chronic health conditions (National Institute for Health and Care Excellence, 2009). CBT has shown effectiveness in a wide range of health conditions (e.g. Chan & Chua, 2012; Clucas et al., 2011; Garland et al., 2014). However, there is also evidence that suggests that CBT has limited effectiveness for people with LTCs. In Farrand and Woodford's (2015) systematic review of CBT randomised controlled trials for people with LTCs, there was only a small effect size detected for the treatment of depression and anxiety, suggesting that CBT is not meeting some needs of people with LTCs. Furthermore, in a systematic review of CBT for people with chronic obstructive pulmonary disease, significant treatment effects were found for depression but not for anxiety (Coventry & Gellatly, 2008), indicating that there is a need for alternative therapeutic options for people with LTCs.

Solution-focused brief therapy (SFBT) is a recommended therapeutic modality in the NICE guidance for supporting adults with cancer (National Institute for Health and Care Excellence, 2004). SFBT focuses on identifying personal resources, strengths and meeting the service-users' (SU/s) desired outcomes (de Shazer, 1988). In a recent study, people with long-term health conditions who engaged with SFBT reported a number of positive experiences, such as the identification of strengths and resources to cope with difficult situations, the ability to initiate change autonomously, and the approach allowed them to achieve a sense of hope for the future (Carr, Smith, & Simm, 2014). Although CBT for LTCs is well supported by the evidence-base, the style and therapeutic focus may not be suitable for everyone (Whalley & Hyland, 2009). Offering SFBT as an alternative

approach will give SUs choice, and allow therapists more versatility in their practice.

Understanding how solution-focused (SF) practice could be beneficial for people with LTCs may contribute to the efficacy of this approach, which may support developments in guidance and service delivery. More importantly, understanding how SF practice can support people to identify desired outcomes and adapt to their health condition would be a valuable resource for the SUs and psychologists working with this clinical population.

The main aims of this research project is: how do people with LTCs construct preferred futures and resources with their practitioners in an initial SF therapy session?

Method

Participants

The study will have two sets of participants; practitioners who use SF practice, 'practitioner participants' (PP) and SUs, 'service user participants' (SUP). The study will aim to recruit 8-12 sets of participant dyads. Practitioners are able to recruit more than one SU. However, to collect a range of data, no more than three SUs per practitioner would be recruited. Purposive sampling will be used for this study as it aims to recruit a variety of people in different circumstances. SUs will be recruited from psychological therapy services for people with LTCs where

SF practice is provided. SUs will not be excluded based on their LTC as this study hopes to identify SFBT principles across a range of conditions.

The inclusion criteria for practitioner participation: practitioners offering SF conversations to SUs; practitioners who are carrying out the session in English. The exclusion criteria will be practitioners who cannot give informed consent. Practitioners will be not excluded on the basis of experience. The inclusion criteria for service user participation: adults from age 18; people who are beginning therapeutic work with a SF approach; able to communicate in English; any LTC, where the condition can be defined by the service access or by self-identification. The exclusion criteria will be: people who are not having SF conversations; people that do not have capacity to give informed consent.

Design

This will be a qualitative study examining audio recordings of routine clinical practice. This study will be using a Discursive Action Model (DAM) informed approach, drawing on the techniques described by Potter, Edwards and Wetherell (1993) DAM is a particular type of discursive psychology approach that studies how people talk about and make sense of their current situations, and is widely used in the context of medicine, health psychology and self-help groups (Horton-Salway, 2001). Coyle (2007) argues that the "preferred form of text within discursive psychology is a naturally occurring one" (p. 105). Therefore, collecting data through audio recording of the therapy session is more realistic and contextually-grounded.

Materials

PPs and SUPs will each receive the following:

- Introductory Letter

- Participant Information Sheet (PIS)

- Consent Form

In the Consent Form participants are asked if they wish to receive a summary of the research, and if they are willing for the NHS Trust to safely store the audio recording for future research purposes. Participants are asked to leave an email address or phone number so they can be contacted to arrange this process. No personally identifiable data of other participants will be shared.

Procedure

Stage	Procedure
1	The Chief Investigator will approach PPs initially through attending team meetings in the healthcare service to raise awareness of the study. The Chief Investigator will then distribute the research materials to PPs meeting the inclusion and exclusion criteria via the Field Supervisor and/or team administrators. This ensures that the Chief Investigator does not have the details of potential PPs.
2	PPs will have over 24 hours to decide whether or not they would like to participate in the study. Once the PPs return the consent form, the Chief Investigator will make contact to discuss the study further.
3	Capacity to consent to the interview will be assessed at this stage. The PIS will be used to assess understanding, whether or not participants could

	retain the information, and whether or not they can weigh the information as part of the decision-making process, and to facilitate the communication of their decision. PPs will be made aware that they will use the same procedure to ensure informed consent is received as they recruit SUPs.
4	The inclusion/exclusion criteria, introductory letter, PIS, consent form and guidance for SUP recruitment will be distributed and explained to PPs.
5	The SUP versions of the documents will be sent to SUs along with their initial appointment invitation letter by the PPs. SUPs will therefore have over 24 hours to consider whether or not they would like to be involved with the research. SUs are given the opportunity to respond to practitioners prior to the initial appointments to indicate willingness or decline to participate. SUs have the opportunity to contact the Chief Investigator if they have any further questions. If no response was received, the SF practitioner will ask the SUs at the beginning of the initial appointment, where they will have the opportunity to agree or decline.
6	Before the session commences, SF practitioners will verbally give a brief overview of the project aims and explain confidentiality and the right to withdraw. Informed consent will be assessed by the PP at the start of the session. No demographic or personally identifiable details will be obtained unless SUs return the consent form. Practitioners will use audio recording equipment to record the sessions, and explain that this will be transcribed by the Chief Investigator.
7	The recording will be transcribed verbatim by the Chief Investigator, and the audio will be shared with the Research Supervisor to aid the analysis

and interpretation process. The audio recordings and transcripts will be stored electronically with encryption and password protection. The transcripts will be stored securely on an electronic server by the university. All files will be stored for ten years after completion of the research project, where they will be destroyed in accordance of the Data Protection Act (1998).

Analysis

As this research hopes to develop an understanding of how people with LTCs construct preferred futures and resources through solution-focused conversations, DAM will allow the research to seek out the linguistic discourses of people's therapeutic interaction and social reality (Coyle, 2007).

Practical Issues

Lancaster University DClinPsy will cover the costs of the paperwork. A research mobile number will be provided should participants wish to ask any questions. Lancaster University DClinPsy will also provide audio recording materials. Audio recordings and transcripts will be stored securely at my home address. All electronic materials are stored with in an encrypted folder on a password protected computer. All transcripts will be anonymised, password protected and encrypted. With consent from the participants, NHS services may request the anonymised transcripts from Lancaster University DClinPsy for future research.

Ethical Concerns

As this study is recruiting participants from psychological therapy services that provide SFBT, SF approaches is offered to all SUs on a routine basis and therefore participation to the research will not mean SUs would be excluded from their usual care. It will be stated in the PIS that practitioners can stop the recording at any time at the participants' request, and that the participants can pause/stop the recording process should they want to discuss issues that they do not want to be included in the data analysis. Henry et al. (2015) showed that recording clinical sessions for research had no significant effect on discussions around the therapeutic process. It will be outlined explicitly that the research project is separate to usual therapeutic process, and if they wish to decline or withdraw from the study, it will not affect the care they receive or influence the therapeutic relationship.

Capacity to consent and informed consent will be gained from all participants prior the formal participation to the research. Initially, consent is gained and assumed when participants returns the consent form with agreement and signed to express that they understood the research as outlined in the PIS. The Chief Investigator will then assess PPs' capacity to consent before the research proceeds. As practitioners are also recruiters, they will be responsible for assessing SUs' capacity to consent to the study. The Chief Investigator may not meet the SUP, therefore capacity to consent will be ensured by advising PPs to refer to national guidance for capacity to consent to research. If SUPs appear to not have capacity to consent in the initial appointment, their consent form will be invalidated and they will be removed from the study.

To protect the all participants' personally identifiable information, they will be asked to choose a pseudonym which will be used on transcripts and the written report. No personally identifiable information will be included in the written report. A password protected and encrypted file of the participants' actual names and their pseudonym will be kept by the Chief Investigator, should the participants wish to withdraw from the research project after the recording took place; this file will not be shared with anyone and will be destroyed after the research has completed.

Timescale

ACTION	DATE
Prepare and submit IRAS/R&D form along with research protocol and research materials	May-August 2016
Recruitment of participants (after ethical approval)	Summer-Autumn 2016
Data collection	Summer-Autumn 2016
Data analysis	ASAP (September - December 2016)
Submit thesis	May 2017
Submit papers for publication	End of July 2017
If accepted, submit final accepted manuscript to research coordinator	Once paper is accepted.

References

Carr, S. M., Smith, I. C., & Simm, R. (2014). Solution-focused brief therapy from the perspective of clients with long-term physical health conditions. *Psychology, Health & Medicine*, *19*(4), 384–91. http://doi.org/10.1080/13548506.2013.824594

Chan, M. F., & Chua, T. L. (2012). The effectiveness of therapeutic interventions on quality of life for vitiligo patients: a systematic review. *International Journal of Nursing Practice*, *18*(4), 396–405. http://doi.org/10.1111/j.1440-172X.2012.02047.x

Clucas, C., Sibley, E., Harding, R., Liu, L., Catalan, J., & Sherr, L. (2011). A systematic review of Interventions for anxiety in people with HIV. *Psychology, Health & Medicine*, *16*(5), 528–547. http://doi.org/10.1080/13548506.2011.579989

Coventry, P. A., & Gellatly, J. L. (2008). Improving outcomes for COPD patients with mild-to-moderate anxiety and depression: a systematic review of cognitive behavioural therapy. *British Journal of Health Psychology*, *13*(Pt 3), 381–400. http://doi.org/10.1348/135910707X203723

Coyle, A. (2007). Discourse Analysis. In E. Lyons & A. Coyle (Eds.), *Analysing Qualitative Data in Psychology*. London: SAGE Publications.

Data Protection Act. (1998). Retrieved from http://www.legislation.gov.uk/ukpga/1998/29/data.pdf

de Shazer, S. (1988). *Clues: Investigating Solutions in Brief Therapy*. New York: Norton.

Department of Health. (2011). *Ten things you need to know about long term conditions.* Department of Health, Richmond House, 79 Whitehall, London SW1A 2NJ, UK, dhmail@dh.gsi.gov.uk. Retrieved from http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Healthcare/Longtermconditions/tenthingsyouneedtoknow/index.htm

Farrand, P., & Woodford, J. (2015). Effectiveness of Cognitive Behavioural Self-Help for the Treatment of Depression and Anxiety in People with Long-Term Physical Health Conditions: a Systematic Review and Meta-Analysis of Randomised Controlled Trials. *Annals of Behavioral Medicine : A Publication of the Society of Behavioral Medicine*, *49*(4), 579–93. http://doi.org/10.1007/s12160-015-9689-0

Garland, S. N., Johnson, J. A., Savard, J., Gehrman, P., Perlis, M., Carlson, L., & Campbell, T. (2014). Sleeping well with cancer: a systematic review of cognitive behavioral therapy for insomnia in cancer patients. *Neuropsychiatric Disease and Treatment*, *10*, 1113–24. http://doi.org/10.2147/NDT.S47790

Goodwin, R. D., Davidson, K. W., & Keyes, K. (2009). Mental disorders and cardiovascular disease among adults in the United States. *Journal of Psychiatric Research*, *43*(3), 239–46. http://doi.org/10.1016/j.jpsychires.2008.05.006

Henry, S. G., Jerant, A., Iosif, A.-M., Feldman, M. D., Cipri, C., & Kravitz, R. L. (2015). Analysis of threats to research validity introduced by audio recording clinic visits: Selection bias, Hawthorne effect, both, or neither? *Patient Education and Counseling*, *98*(7), 849–56.

http://doi.org/10.1016/j.pec.2015.03.006

HM Government and Department of Health. (2011). *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. London. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

Horton-Salway, M. (2001). The Construction of M.E.: The Discursive Action Model. In M. Wetherell, S. Taylor, & S. J. Yates (Eds.), *Discourse as Data: A Guide For Analysis* (pp. 147–188). London: SAGE Publications.

Mental Health Foundation. (2015). Long-term physical conditions and mental health | Mental Health Foundation. Retrieved April 7, 2016, from https://www.mentalhealth.org.uk/a-to-z/l/long-term-physical-conditions-and-mental-health

National Institute for Health and Care Excellence. (2004). *Improving Supportive and Palliative Care for Adults with Cancer*. London. Retrieved from https://www.nice.org.uk/guidance/csg4/resources/improving-supportive-and-palliative-care-for-adults-with-cancer-773375005

National Institute for Health and Care Excellence. (2009). *Depression in adults with chronic physical health problem: recognition and management*. Manchester: NICE. Retrieved from https://www.nice.org.uk/guidance/cg91

Naylor, C., Parsonage, M., McDaid, D., Knapp, M., Fossey, M., & Galea, A. (2012). *Long-term conditions and mental health: The cost of co-morbidities*. London. Retrieved from http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

Nikcevic, A. V., Kuczmierczyk, A. R., & Bruch, M. (2006). *Formulation and Treatment in Clinical Health Psychology*. Hove, East Sussex: Routledge.

Potter, J., Edwards, D., & Wetherell, M. (1993). A Model of Discourse in Action. *American Behavioral Scientist*, *36*(3), 383–401. http://doi.org/10.1177/0002764293036003008

Whalley, B., & Hyland, M. E. (2009). One size does not fit all: motivational predictors of contextual benefits of therapy. *Psychology and Psychotherapy*, *82*(Pt 3), 291–303. http://doi.org/10.1348/147608309X413275

World Health Organization. (2007). *World Health Statistics 2007*. Geneva, Switzerland. Retrieved from http://www.who.int/gho/publications/world_health_statistics/whostat2007.pdf

Appendix 4-C

Recruitment Materials

Doctorate in Clinical Psychology | Lancaster University

Version 2, 24.08.16

"Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions."

Introductory Letter for Practitioners

Dear practitioner,

I am a Trainee Clinical Psychologist with the Lancaster University Doctorate in Clinical Psychology. I am focusing my doctoral thesis on physical health psychology, specifically to develop an understanding of how solution-focused conversations can facilitate people in this clinical population to adapt to their health conditions. This is an invitation to participate in the study; you have been invited as you offer solution-focused brief therapy (SFBT) to service users.

The documents, 'Participant Information Sheet for Therapists' and 'Guidance for Therapists', tells you more about the study. Please return the 'Consent Form' to me via the pre-paid envelope if you would like to take part in this study. You are also welcome to contact me if you have any questions.

Thank you,

Chief Investigator: Joanna Cheng

IRAS Project ID: 207169
Title: Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions.

Doctorate in Clinical Psychology | Lancaster University

"Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions."

Introductory Letter for Service Users

Dear service user,

This is an invitation to take part in a research study. You have been sent this letter as you are starting your first therapy session with your practitioner. This study aims to understand how a particular type of therapy helps people with long-term physical health condition.

The 'Participant Information Sheet' tells you more about the study. As this letter was sent / given to you by your practitioner, I do not have your contact details and your information remains confidential. Please return the 'Consent Form' to your practitioner if you would like to take part in this study. You are also welcome to contact me if you have any questions.

Thank you,

Joanna Cheng
Trainee Clinical Psychologist
Lancaster University Doctorate in Clinical Psychology

E-mail: ▮▮▮▮▮▮▮▮▮▮▮
Telephone: ▮▮▮▮▮▮▮▮▮

IRAS Project ID: 207169
Title: Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions.

Doctorate in Clinical Psychology | Lancaster University

"Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions."

Participant Information Sheet for Practitioners

Dear practitioner,

My name is Joanna Cheng and I am conducting this research for my thesis at the Lancaster University Doctorate in Clinical Psychology.

What is the study about?

The purpose of this study is to find out how preferred futures and resources are constructed with solution-focused conversations between the service user and the practitioner.

Why have I been approached?

You have been approached because we aim to recruit practitioners who use solution-focused approaches and the service users that will be receiving the therapeutic session, forming a participant dyad.

Do I have to take part?

No. It is completely up to you to decide whether or not you take part.

What will I be asked to do if I take part?

If you decide you would like to take part, you would be asked to complete the Consent Form. As you are formally recruited as part of a participant dyad, your capacity to provide informed consent will be assessed by myself. You would be asked to send the recruitment information to 1-3 service users who are receiving their first appointment with you, who will be informed to reply to you directly to indicate willingness to participate. At the start of the first appointment, you will be assessing service users' capacity to consent, explain confidentiality and the right to withdraw. This information is included in the 'Guidance for Practitioners' document. You will be provided an audio recorder to record the appointments.

Will my data be confidential?

- Personally identifiable information will be kept confidential, however the content of the sessions, such as quotations, will be reported anonymously.

- The only exceptions to keeping this confidentiality would be if anything you said on the recording made us concerned that there was malpractice or other risk of harm to yourself or others. In those circumstances the Chief Investigator would discuss this issue with her supervisors and may need to break confidentiality in order to prevent or minimise the risk.

- The data collected for this study will be stored securely. The audio recording and the typed version of the therapy session (transcripts) will be encrypted and kept in a password-protected computer. Only researchers will have access to this data.

- Audio recordings will be destroyed and deleted after the end of the study.

- At the end of the study, hard copies of the Consent Form will be scanned electronically, all paper formats will be destroyed.

- The transcript will be made anonymous by removing any identifying information. Anonymised direct quotations from the transcript may be used in the reports or publications from the study, so your name will not be attached to them. Quotations will be used in a way to minimise the chance where participants are identifiable. If you consent to make your anonymised transcripts available for future research, only this transcript will be shared

with the healthcare services who has made the request, and no personally identifiable information will be given.

What will happen to the results?

The results will be summarised and reported in a thesis and will be submitted for publication in an academic or professional journal. The study will also be disseminated to people who use services, and to professionals and stakeholders of the Doctorate in Clinical Psychology.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the Chief Investigator.

Are there any benefits to taking part?

There are no direct benefits to participants. However, this study will help practitioners, psychologists and services find out more about how solution-focused practice is regarded by service users, and how solution-focused practice allows them to shape their preferred future. I also hope that this research could be used to share best practice and to add to the SFBT and physical health psychology literature, which has always had a predominant focus on CBT.

What if I change my mind?

You may wish to change your mind about participation, even after you have agreed to participate. In this event, I can remove your recording and notes within two weeks after the recording took place. After these two weeks I will not be able to do this; after this point your data will have been pooled with data from other participants, which will make it difficult to remove individual participants' data.

Who has reviewed the project?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been

reviewed and given a favourable opinion by London – Bromley Research Ethics Committee.

What do I do if I want to take part?

Please complete and return the Consent Form directly to me. After I receive this, I will contact you directly to discuss the next steps of the research process.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the Chief Investigator: Joanna Cheng, ██████████████████████████████████

Thank you for taking the time to read this information sheet.

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

███████████████████████

Telephone number: █████████████████████

Email: ██████████████████

███████████████

███████████████████████

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

███████████████████████

Telephone number: ██████████████████

Associate Dean for Research Email: ███████████████████

██████████████

██████████████

██████████████

██████████████

Doctorate in Clinical Psychology | Lancaster University

Version 2, 24.08.16

"Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions."

Participant Information Sheet for Service Users

Dear service user,

My name is Joanna Cheng and I am conducting this research for my thesis at the Lancaster University Doctorate in Clinical Psychology.

What is the study about?
I am interested to find out what it is like for you to live with a health condition and how a specific type of psychological therapeutic approach, solution-focused brief therapy could be helpful.

Why have I been approached?
You have been approached because you have been offered a solution-focused therapy appointment by a practitioner.

Do I have to take part?
No. It is completely up to you to decide whether or not you take part.

IRAS Project ID: 207169
Title: Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions.

What will I be asked to do if I take part?

If you decide you would like to take part, you can complete the Consent Form and give this to your practitioner. If you agree to take part, your therapy will be audio recorded. You can ask for this to be stopped at any time. All you need to do is to attend the appointment as you would usually attend other health appointments. You will not be asked any special questions or be asked to do anything different. Your practitioner will not do or ask anything different from what they would usually ask you. The recording will start after the practitioner has introduced the research, and will stop at the end of the session.

Will my data be confidential?

- Personally identifiable information (e.g. your real name) will be kept confidential, however the content of the sessions, such as quotations, will be reported anonymously.

- The only exceptions to keeping this confidentiality would be if anything you said on the recording made us concerned that there was malpractice or other risk of harm to yourself or others. In those circumstances the Chief Investigator would discuss this issue with her supervisors and may need to break confidentiality in order to prevent or minimise the risk.

- The data collected for this study will be stored securely. The audio recording and the typed version of the therapy session (transcripts) will be encrypted and kept in a password-protected computer. Only researchers will have access to this data.

- Audio recordings will be destroyed and deleted after the end of the study.

- At the end of the study, hard copies of the Consent Form will be scanned electronically, all paper formats will be destroyed.

- The transcript will be made anonymous by removing any identifying information. Anonymised direct quotations from the transcript may be used in the reports or publications from the study, so your name will not be attached to them. Quotations will be used in a way to minimise the chance where participants are identifiable. If you consent to make your anonymised transcripts available for future research, only this transcript will be shared

with the healthcare services who has made the request, and no personally identifiable information will be given.

What will happen to the results?

The results will be summarised and reported in a thesis and will be submitted for publication in an academic or professional journal. The study will also be disseminated to people who use services, and to professionals and stakeholders of the Doctorate in Clinical Psychology.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the Chief Investigator.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part.

What if I change my mind?

You may wish to change your mind about participation, even after you have agreed to participate. In this event, I can remove your recording and notes within two weeks after the recording took place. After these two weeks I will not be able to do this; after this point your data will have been pooled with data from other participants, which will make it difficult to remove individual participants' data.

Who has reviewed the project?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by ████████████████████████

What do I do if I want to take part?

Please complete and return the Consent Form directly to your practitioner. Your practitioner will pass on the form to myself. When you attend your first appointment, your practitioner will discuss the next steps of research process before beginning the routine clinical session. If you would like to speak to me directly about the study, please do not hesitate to contact me.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher:

Joanna Cheng, ███████████████████████████████

Thank you for taking the time to read this information sheet.

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

████████████████████████████

Telephone number: ████████████████████

Email: ████████████████

████████████████

██████████████████████

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

████████████████████████████

Telephone number: ████████████████

Associate Dean for Research Email: ████████████████

████████████████

████████████████

████████████████

████████████████

If you wish to speak to someone from the service about the therapeutic session you received, which you feel do not relate to the research, you may contact the Patient Advice and Liaison Service (PALS).

To find your nearest PALS office via the internet, please use the following web address: http://www.nhs.uk/Service-Search/Patient-advice-and-liaison-services-(PALS)/LocationSearch/363

You can also ask your GP surgery, hospital or phone NHS 111 for details of your nearest PALS.

Doctorate in
Clinical Psychology | Lancaster
University

"Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions."

Consent Form for Practitioners

We are asking if you would like to take part in a research project that explores how preferred futures and resources are constructed between the practitioner and service user in solution-focused conversations.

Before you consent to participating in the study we ask that you read the 'Participant Information Sheet' and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the Chief Investigator,

Joanna Cheng, ██████████████████████████

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study	
2. I confirm that I have had the opportunity to ask any questions and to have them answered.	
3. I understand that the therapeutic session will be audio recorded and then made into an anonymised written transcript.	
4. I understand that audio recordings will be kept until the research project has been examined.	
5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	
6. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication.	
7. I understand that the information from the therapeutic session will be	

pooled with other participants' responses, anonymised and may be published.	
8. I consent to information and quotations from the therapeutic session being used in reports, conferences and training events.	
9. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished.	
10. I understand that I have been provided opportunity to indicate whether or not the healthcare service can request the anonymised transcripts for future research purposes.	
11. I consent to take part in the above study.	

Name of Participant_____ Signature_____ Date _____

Name of Researcher _____Signature _____Date _____

IRAS Project ID: 207169
Title: Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions.

Doctorate in Clinical Psychology | Lancaster University

"Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions."

Consent Form for Service Users

We are asking if you would like to take part in a research project that explores how preferred futures and resources are constructed between the practitioner and service user in solution-focused conversations.

Before you consent to participating in the study we ask that you read the 'Participant Information Sheet' and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the Chief Investigator,

Joanna Cheng, ███████████████████

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study	
2. I confirm that I have had the opportunity to ask any questions and to have them answered.	
3. I understand that the therapeutic session will be audio recorded and then made into an anonymised written transcript.	
4. I understand that audio recordings will be kept until the research project has been examined.	
5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	
6. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication.	
7. I understand that the information from the therapeutic session will be	

pooled with other participants' responses, anonymised and may be published.	
8. I consent to information and quotations from the therapeutic session being used in reports, conferences and training events.	
9. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished.	
10. I understand that I have been provided opportunity to indicate whether or not the healthcare service can request the anonymised transcripts for future research purposes.	
11. I consent to take part in the above study.	

Name of Participant_____ Signature_____ Date _____

Name of Researcher _____Signature _____Date _____

Doctorate in
Clinical Psychology | Lancaster University

"Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions."

Guidance for Practitioners

Dear practitioners,

Thank you so much for participating and helping me collect data for the thesis. This guidance will outline the inclusion/exclusion criteria and the procedure for recruiting service users.

Inclusion criteria:

- Adults from age 18.

- People who are beginning therapy with a solution-focused approach.

- People with any long-term physical health condition.

- People who are able to communicate in English.

Exclusion criteria:

- People who are in therapy but are not having solution-focused conversations

- People that do not have capacity to consent to taking part in the research.

Please send the following documents to service users, along with their initial appointment invitation letter:

1. An Introductory Letter

2. A Participant Information Sheet

3. Consent Form

IRAS Project ID: 207169
Title: Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions.

The Participant Information Sheet will explain that the consent form will be returned directly to you. Service users were informed that they can contact me directly if they had any questions.

Please refer to the following checklist at the initial appointment:

- Introduce the study by referring to the Participant Information Sheet, service users' version.
- If you did not receive any indication of agreement or declination to the study prior to the appointment, please ask the service user to consider the study, using the Participant Information Sheet as an outline.
- Assess whether or not the service user has the capacity to consent to the study by checking: i) the service users' understanding of the research; ii) whether or not the service user can retain the information; iii) whether or not the service user can weigh the information to make a decision; and iv) whether or not the service user can communicate their decision.
- If the service user agrees, ask to sign the Consent Form & Demography Form
- Ensure that the service user understands that the recording can be stopped at any time.
- Begin audio recording.

If you have any questions about the study, please contact the Chief Investigator: Joanna Cheng, ███████████████████████████

Doctorate in
Clinical Psychology | Lancaster
University

"Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions."

Demography Form for Service Users

Please complete the following questions which provides the researchers basic demography information about participants. If you have any questions or queries before signing the consent form please speak to the Chief Investigator, Joanna Cheng, ██████████████████████████████████

(a) Age:
(b) Please provide a pseudonym (fake name) that you would like to be referred as in the study:
(c) Please indicate the health condition(s) you experience:
(d) Have you ever had solution-focused therapy or any other type of talking therapy before? **Yes / No** If you answered 'Yes', please indicate if possible what the talking therapy was called:

Please continue overleaf.

(e) Please indicate the name of the practitioner that has offered you the current therapeutic session:

(f) Would you like to receive a summary of the research? **Yes / No**

(g) Would you be willing for the following institutions to request the anonymised written transcripts from Lancaster University for future research purposes only?
i) Lancaster University Doctorate in Clinical Psychology research: **Yes / No**
ii) NHS Trusts: **Yes / No**

If you indicates 'Yes' to (f), please provide your preferred contact details:

Doctorate in
Clinical Psychology | Lancaster
University

"Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions."

Demography Form for Practitioners

Please complete the following questions which provides the researchers basic demography information about participants. If you have any questions or queries before signing the consent form please speak to the Chief Investigator, Joanna Cheng, ███████████████████████████████

Please complete the following details:

(a) What service do you work for?
(b) Please provide a pseudonym (fake name) that you would like to be referred as in the study:
(c) Would you like to receive a summary of the research? **Yes / No**
(d) Would you be willing for the following institutions to request the anonymised written transcripts from Lancaster University for future research purposes only? i) Lancaster University Doctorate in Clinical Psychology research: **Yes / No** ii) NHS Trusts: **Yes / No**

If you indicates 'Yes' to (c), please provide your preferred contact details:

Appendix 4-D

NHS Research Ethics Committee approval letter

NHS
Health Research Authority

Telephone:

> Please note: This is an acknowledgement letter from the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

26 October 2016

Miss Joanna Cheng
Clinical Psychology, Furness College
Lancaster University
Lancaster
LA1 4YG

Dear Miss Cheng

Study title:	**Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions.**
REC reference:	**16/NW/0721**
IRAS project ID:	**207169**

Thank you for submitting your response on the 26 October 2016. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 26 October 2016

Documents received

The documents received were as follows:

Document	Version	Date
Other [Consent Form SUP Version]	3	26 October 2016
Other [Demography Form SUP Version]	1	26 October 2016
Other [Demography Form PP Version]	1	26 October 2016
Participant consent form [Consent Form PP Version]	3	26 October 2016

Approved documents

The final list of approved documentation for the study is therefore as follows:

A Research Ethics Committee established by the Health Research Authority

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [EL & PL 2016-17]		20 July 2016
GP/consultant information sheets or letters [Guidance For Practitioners]	2	24 August 2016
IRAS Application Form [IRAS_Form_31082016]		31 August 2016
IRAS Application Form XML file [IRAS_Form_31082016]		31 August 2016
IRAS Checklist XML [Checklist_31082016]		31 August 2016
IRAS Checklist XML [Checklist_26102016]		26 October 2016
Letter from sponsor [Joanna Cheng IRAS sponsorship letter]		12 August 2016
Letters of invitation to participant [Introductory Letter PP Version]	2	24 August 2016
Other [PN 2016-17]		01 August 2016
Other [Introductory Letter SUP Version]	2	24 August 2016
Other [Consent Form SUP Version]	2	24 August 2016
Other [Participant Information Sheet SUP Version]	2	24 August 2016
Other [Schedule of Events IRAS Project ID 207169]	1	26 August 2016
Other [Statement of Activities IRAS Project ID 207169]	1	26 August 2016
Other [Consent Form SUP Version]	3	26 October 2016
Other [Demography Form SUP Version]	1	26 October 2016
Other [Demography Form PP Version]	1	26 October 2016
Participant consent form [Consent Form PP Version]	3	26 October 2016
Participant information sheet (PIS) [Participant Information Sheet PP Version]	2	24 August 2016
Research protocol or project proposal [Research protocol]	5	24 August 2016
Summary CV for Chief Investigator (CI) [CV Joanna Cheng]		17 August 2016
Summary CV for supervisor (student research) [Ian Smith research CV 26022016]		26 February 2016

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

16/NW/0721	Please quote this number on all correspondence

Yours sincerely

████████████

████████████
REC Assistant

E-mail: ████████████████████

Copy to: Dr Diane Hopkins

                    ████████████

                    ████████████████

Appendix 4-E

Health Research Authority approval letter

NHS
Health Research Authority

Miss Joanna Cheng
Clinical Psychology
Furness College   Email: ▮▮▮▮▮▮
Lancaster University
Lancaster
LA1 4YG

09 December 2016

Dear Joanna Cheng

Letter of HRA Approval

Study title: Constructing preferred future and resource conversations
                               through solution-focused discourses with people with long-
                               term physical health conditions
IRAS project ID: 207169
REC reference: 16/NW/0721
Sponsor   Lancaster University

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England
The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read** *Appendix B* **carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities

- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.

- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

IRAS project ID	207169

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators"*, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

IRAS project ID	207169

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please email the HRA at hra.approval@nhs.net. Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **207169**. Please quote this on all correspondence.

Yours sincerely

███████████

Assessor

Email: ██████████████

Copy to: *Dr Ian Smith, Lancaster University [Academic Supervisor]*
            ███████████████

            Dr Diane Hopkins, Lancaster University [Sponsor Contact]
            ███████████████

            ██████████████████████████ *[Lead NHS R&D Contact]*
            ███████████████

IRAS project ID	207169

Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

Document	Version	Date
Contract/Study Agreement [Schedule of Events]	1	05 December 2016
Contract/Study Agreement [Statement of Activities]	1	05 December 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [EL & PL 2016-17]		20 July 2016
GP/consultant information sheets or letters [Guidance For Practitioners]	2	24 August 2016
IRAS Application Form [IRAS_Form_31082016]		31 August 2016
IRAS Application Form XML file [IRAS_Form_31082016]		31 August 2016
IRAS Checklist XML [Checklist_31082016]		31 August 2016
IRAS Checklist XML [Checklist_26102016]		26 October 2016
Letters of invitation to participant [Introductory Letter PP Version]	2	24 August 2016
Other [Insurance Certificate - 2016-17]		01 August 2016
Other [Introductory Letter SUP Version]	2	24 August 2016
Other [Participant Information Sheet SUP Version]	2	24 August 2016
Other [Consent Form SUP Version]	3	26 October 2016
Other [Demography Form SUP Version]	1	26 October 2016
Other [Demography Form PP Version]	1	26 October 2016
Participant consent form [Consent Form PP Version]	3	26 October 2016
Participant information sheet (PIS) [Participant Information Sheet PP Version]	2	24 August 2016
Research protocol or project proposal [Research protocol]	5	24 August 2016
Summary CV for Chief Investigator (CI) [CV Joanna Cheng]		17 August 2016
Summary CV for supervisor (student research) [Ian Smith research CV 26022016]		26 February 2016

IRAS project ID	207169

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, *participating NHS organisations, capacity and capability* and *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Name: ▇▇▇▇▇▇▇
Tel: ▇▇▇▇▇▇▇
Email: ▇▇▇▇▇▇▇▇▇▇

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The Sponsor has submitted a Statement of Activities and Schedule of Events. The Sponsor is not intending to use any other agreements with sites.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the

IRAS project ID	207169

Section	HRA Assessment Criteria	Compliant with Standards	Comments
			activities expected of them for this research study.
4.3	Financial arrangements assessed	Yes	The study is not funded.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	REC Favourable Opinion (with additional conditions) was issued on 26 October 2016.\n\nThe REC acknowledged conditions were met on 26 October 2016.
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

There is one site type participating in this study. Study activity is the same at all participating NHS organisations as detailed in the protocol.

Please note that the remit of HRA Approval is limited to the NHS involvement in the study. Research activity undertaken at non-NHS sites is therefore not covered and the research team should make appropriate alternative arrangements with relevant management at these organisations to conduct

IRAS project ID	207169

the research there.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at ███████████████████. The HRA will work with these organisations to achieve a consistent approach to information provision.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

Participating NHS organisations in England **be expected to formally confirm their capacity and capability to host this research**.

- Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capacity will be confirmed is detailed in the *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* section of this appendix.

- The Assessing, Arranging, and Confirming document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

The sponsor has confirmed that a Local Principal Investigator will be required, and has already been identified at the participating site.

GCP training is not a generic training expectation, in line with the HRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

The sponsor has confirmed that all study activities will be undertaken by local staff who have a contractual relationship with the relevant organisation. Therefore no honorary research contracts or letters of access are expected for this study.

IRAS project ID	207169

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

The applicant has indicated that they <u>do not intend</u> to apply for inclusion on the NIHR CRN Portfolio.

Appendix 4-F

Research Support Officer sponsorship documents

Applicant name: Joanna Cheng
Division: DHR

12 August 2016

Dear Joanna,

Re: Constructing preferred future and resource conversations through solution-focused discourses with people with longterm physical health conditions.

The University of Lancaster undertakes to perform the role of sponsor in the matter of the work described in the accompanying grant application. As sponsor we assume responsibility for monitoring and enforcement of research governance. As principal investigator you will confirm that the institution's obligations are met by ensuring that, before the research commences and during the full term of the grant, all the necessary legal and regulatory requirements are met in order to conduct the research, and all the necessary licenses and approvals have been obtained. The Institution has in place formal procedures for managing the process for obtaining any necessary or appropriate ethical approval for this grant. Full ethical approval must be in place before the research commences and should be reviewed at all relevant times during the grant.

Yours sincerely,

PP ███████████████████
Associate Dean for Research
Chair Faculty of Health and Medicine Research Ethics Committee.

CC ████████████, Secretary to FHMREC

Appendix 4-G

NHS Trust Research Development & Innovation Department approval letter

Miss Joanna Cheng
Lancaster University
Clinical Psychology
Furness College
Lancaster
LA1 4YG

1st February 2017

Dear Miss Joanna Cheng

RDI Ref No	RDI-207169-B	REC Ref	16/NW/0721
IRAS ID	207169		
Title	Preferred future & resource through SFBT with people with LTCs		
NHS Trust (Site)			

Thank you for submitting the above named research study to ▉▉▉▉▉▉▉▉▉▉▉▉▉▉▉▉
▉▉▉▉▉▉▉ Research Development & Innovation Department (RDI) for Confirmation of Capacity & Capability (RDI Permission).

I am pleased to inform you that the RDI review is now complete and you may accept this letter as formal RDI Permission that this study can be conducted at ▉▉▉▉▉▉▉▉▉▉▉▉▉▉▉▉▉▉▉▉▉▉

This permission is granted on the understanding that the study will be performed to the standards outlined in the Research Governance Framework for Health and Social Care – second edition 2005.
www.gov.uk/government/uploads/system/uploads/attachment_data/file/139565/dh_4122427.pdf

I would like to take this opportunity to wish you every success with this research. Please do not hesitate to contact me if you have any queries.

Yours sincerely

▉▉▉▉▉▉▉▉▉▉▉, RDI Manager