Doctoral Thesis:

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

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Doctorate in Clinical Psychology

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# Word Count Statement

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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

Firstly, I would like to express my gratitude to the participants of this study. I am extremely thankful to my field supervisor, Dr Suzi Curtis, who has ensured that the research process was as smooth as possible. I am also extremely thankful to the NHS clinical psychology service, including the secretaries and clinicians, who have all invested time and effort in supporting me during the recruitment process. Secondly, I am thankful to my friends and family who have supported me through motivational words, delivering food parcels, and by giving me space yet always a message or telephone call away. My biggest thanks and admiration goes towards my friends who I am privileged to be on clinical training with. They are my most valued resource and without them, nothing would be possible. Thirdly, I am especially grateful to my placement supervisor, Dr Jen Davies, who has always been a listening ear, and has shown me care and compassion beyond the work of the placement. I am thankful to my mentor, Dr Steve Field, for all the humour, and more importantly for being a key figure in my professional development over the last three years. Finally, I want to express my deepest gratitude to my research supervisor, Dr Ian Smith, who has supervised my research projects throughout clinical training. Ian has been nurturing, motivating, and above all he has never stopped believing in me.
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Section One: Literature Review

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

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Prepared for submission to Journal of Psychosomatic Research¹

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, LTCs are defined as health conditions that currently cannot be cured, for example heart conditions, diabetes, pulmonary diseases and cancer. LTCs can sometimes be controlled by medication, however these conditions are often degenerative and life-limiting.

The latest published report from the Department of Health (DOH) 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. Australia has described this issue as their "biggest health challenge" 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. 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. Worldwide, an average of 9.3-23% of people with LTCs, across 60 countries, report co-morbid depression. There is a marked decrease in quality of life for people with LTCs, and experiences of depression and/or anxiety has been documented as both a cause and consequence of physical ill health.

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. People with co-morbid LTCs and mental health difficulties are also more likely to develop further chronic diseases. 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. 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 and may reduce their motivation to stabilise the condition. In a research study carried out by Dignity in Dying, 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.

**Barriers to accessing mental health services**

The associations between emotional and physical wellbeing are suggested in literature and in practice (e.g.). Alongside pharmacological treatment, The National Institute for Health and Care Excellence (NICE) 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, and 85% of people with diabetes do not have access to psychological services. 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 and stigma can be internalised which leads to lower self-worth and poorer self-management. 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. 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. 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 despite service users reporting interest in accessing mental health support. 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.

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, diabetes (e.g.) and COPD (e.g.). Furthermore, mindfulness-based interventions for chronic pain
(e.g.\textsuperscript{31}), and acceptance-commitment therapy for heart disease (e.g.\textsuperscript{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.\textsuperscript{33}), the benefits of mindfulness-based interventions following stroke and transient ischemic attack (e.g.\textsuperscript{34}), and the perceived value of mind-body practices for people living with human immunodeficiency virus (HIV; e.g.\textsuperscript{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\textsuperscript{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.\textsuperscript{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\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{43} Metasyntheses are regarded by the National Health and Medical Research Council\textsuperscript{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.\textsuperscript{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.\textsuperscript{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) tool47, 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 200348, 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).
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, including one study that combined this with grounded theory principles; two studies used a grounded theory informed analysis; one study used Interpretative Phenomenological Analysis; one used qualitative content analysis; one used narrative analysis; and two studies did not note the specific analysis method. Sample size ranged from 10-30. The age ranged from 18-85, although three studies did not report a range. Mean and median ages were not calculated as one study 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\textsuperscript{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\textsuperscript{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\textsuperscript{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)\textsuperscript{64} was used to assess the strengths and weaknesses of the selected articles. The use of CASP\textsuperscript{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.\textsuperscript{65} Instead the author used the CASP\textsuperscript{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\textsuperscript{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.\textsuperscript{66,67}
The initial two screening items on the CASP\textsuperscript{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.\textsuperscript{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\textsuperscript{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\textsuperscript{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\textsuperscript{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\textsuperscript{49} guidelines.

There are many epistemological stances that can inform approaches to conducting systematic reviews\textsuperscript{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. 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 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. 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. 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, 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.\textsuperscript{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\textsuperscript{56,62} included a discussion of the therapists' qualities which were highly valued by participants with LTCs. There were many qualities, including warmth, genuineness\textsuperscript{57}, supportiveness, attentiveness\textsuperscript{59}, and demonstrating understanding and empathy\textsuperscript{61}, which were key qualities that were important to participants. The therapist was a ‘listening ear’\textsuperscript{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).\textsuperscript{61} In addition, a trusting, non-judgmental, and
positive therapeutic relationship relieved the participants' sense of burden 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). Attachment theory was discussed by the authors of one study, 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 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. However, there appears to be a delicate balance which therapists navigate. The authors of one study 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, "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).

Theme two: therapy was a safe and neutral space. Three articles 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). 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). 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.\textsuperscript{57} In addition, Gerskowitch et al.\textsuperscript{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.\textsuperscript{57,58} In their study, Dennison et al.\textsuperscript{52} discussed how participants who were more unsatisfied with their social support gained more positive experiences in therapy. Dennison et al.\textsuperscript{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.\textsuperscript{51,52,55,58-63} Prior to receiving therapy, many participants
were "holding things in" and "hanging on" (p.597)\textsuperscript{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.\textsuperscript{61} Aspects of therapy such as setting goals, collaborative working\textsuperscript{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).\textsuperscript{62} Although some participants noticed no improvement in physical symptoms despite increased emotional wellbeing\textsuperscript{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).\textsuperscript{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.\textsuperscript{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).\textsuperscript{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).\textsuperscript{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\textsuperscript{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).\textsuperscript{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. From the outset, accessing therapy allowed participants to feel more empowered and more in control of their difficulties. 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. 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). 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). 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) and in turn felt an increased sense of mastery, "those [counselling sessions] changed me forever. It has changed my mental attitude... everything" (p.600). 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). However, three studies 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).\textsuperscript{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.\textsuperscript{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)\textsuperscript{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,\textsuperscript{56} "I had mobility problems, so seeing me at home was the only option" (p.57).\textsuperscript{57} Conversely, some people preferred to be seen at the hospital as it was seen as a ‘safe space’\textsuperscript{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).\textsuperscript{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). In addition, Angel et al. 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 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. 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). This view was supported by the findings of MacCormack et al., 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. Two articles 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 condition13 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. 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. 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.). 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. Clarkson's model of positive therapeutic relationships described that therapists who demonstrate "unconditional acceptance" (p.136) elicit open responses and trust from the service user. Clarkson's model 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. This finding is consistent with the results from Lambert's study of factors which influenced therapeutic outcome. Lambert's 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 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 as a reduced quality of life, which can include a negative impact on a person's wellbeing and perceived burden on friends and family. Research has suggested that burden can be caused by many factors associated with living with a LTC, including physiological side-effects of medication, psychosocial consequences, and reduction on quality of life. The NICE guidance 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, 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. Acceptance of a physical health condition can have a positive influence on the emotional and physical wellbeing of people with LTCs. The findings of this meta-ethnography can be understood in the context of Bartley et al.'s three circles model, where the 'circle of pain' illustrates the distress and anxiety which people with LTCs often experience. Bartley et al.'s '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\(^8\), people can experience hope, optimism and a reduction in isolation.\(^9\) 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\(^9\) 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\(^8\), 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\(^\), 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\(^6\) scores (Table 2) indicated that the studies included in this meta-ethnography were of varying quality. Nekolaichuk et al.'s\(^5\) 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\textsuperscript{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.\textsuperscript{95,96} Another weakness is that many of the studies\textsuperscript{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.\textsuperscript{97}). Nonetheless, this meta-ethnography did not exclude studies on the basis of low CASP\textsuperscript{64} scores, as it was important to consider all literature about the topic area. Furthermore, studies which had higher quality findings (e.g.\textsuperscript{51}) were reflected in the synthesis more than studies with less reported detail (e.g.\textsuperscript{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.\textsuperscript{98} As people living with LTCs have additional physical health needs which impact on their daily activities\textsuperscript{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.\textsuperscript{63} If service users had prior negative experiences or attitudes of help-seeking, they are less likely to access further healthcare services.\textsuperscript{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\textsuperscript{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.\textsuperscript{101} Alternatively, psychological therapists can coordinate 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.\textsuperscript{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\textsuperscript{63}, a
secondary care rehabilitation programme, specialist psychology services, specialist health services specifically for the health condition, a primary care mental health service, a general hospital, and a charity for the health condition. 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. As recommended by The King's Fund, 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. 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 researched the experiences of CBT. While CBT is the recommended therapeutic model for people with co-morbid psychological and physical health difficulties, there is growing evidence to suggest that other therapy approaches, such as SFBT, can achieve good outcomes in this population. As previously discussed, Lambert's 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.
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.
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http://dx.doi.org/10.3402/qhw.v9.24420.


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


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


Figure 1

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

- Titles and abstract (where available) reviewed for all potentially relevant papers.
  - Total = 4064
  - MEDLINE = 756
  - PsycINFO = 591
  - CINAHL = 1238
  - Academic Search Complete = 703
  - PubMed = 41
  - EMBASE = 344
  - Web of Science = 391

- Duplicates removed (n = 815)

- Records screened (n = 3249)
  - 3205 records excluded due to not meeting the inclusion and exclusion criteria

- Full-text articles assessed for eligibility (n = 44)
  - 31 full-text articles excluded due to not meeting the inclusion and exclusion criteria

- Studies included in qualitative metasynthesis (n = 13)
Table 1

*Summary of articles included for meta-ethnography*

<table>
<thead>
<tr>
<th>Article</th>
<th>Research Aims</th>
<th>Therapeutic modality</th>
<th>Methodology: method of data collection and analysis</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angel, Jensen, Gonge, Maribo, Schiottz-Christensen and Buus (2012)(^{63})</td>
<td>To understand the service user experiences of counselling.</td>
<td>Counselling</td>
<td>Semi-structured interviews, as part of a previous randomised clinical trial</td>
<td>Sample size: n = 20 &lt;br&gt; Ages: 46.9 (mean); unspecified range &lt;br&gt; Gender: 13 female; 7 male &lt;br&gt; Setting: hospitals, Denmark &lt;br&gt; Type of long-term health condition: low back pain</td>
</tr>
<tr>
<td>Berg, Raminani, Greer, Harwood and Safren (2008)(^{61})</td>
<td>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.</td>
<td>Cognitive behavioural therapy</td>
<td>Semi-structured interviews, as part of a previous randomised controlled crossover trial</td>
<td>Sample size: n = 14 &lt;br&gt; Ages: 43.93 (mean); 31-53 (range) &lt;br&gt; Gender: 1 female; 13 male &lt;br&gt; Setting: USA &lt;br&gt; Type of long-term health condition: HIV</td>
</tr>
<tr>
<td>Bremander, Bergman and Arvidsson (2009)(^{58})</td>
<td>To understand the service user experiences of a multimodal treatment with a cognitive approach.</td>
<td>Cognitive approach</td>
<td>Interviews</td>
<td>Sample size: n = 16 &lt;br&gt; Ages: 46 (mean); 24-64 (range) &lt;br&gt; Gender: 13 female; 3 male &lt;br&gt; Setting: hospital, Sweden &lt;br&gt; Type of long-</td>
</tr>
<tr>
<td>Authors</td>
<td>Study Objective</td>
<td>Methodology</td>
<td>Sample Size</td>
<td>Ages</td>
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<tr>
<td>Carr, Smith and Simm (2014)</td>
<td>To gain an understanding of how service users perceived solution-focused brief therapy.</td>
<td>Solution-focused brief therapy, Semi-structured interviews, Inductive thematic analysis</td>
<td>n = 11</td>
<td>51.4</td>
</tr>
<tr>
<td>Dellasega, Añel-Tiangco and Gabbay (2012)</td>
<td>To understand how service users responded to motivational interviewing with regards to behaviour change.</td>
<td>Motivational interviewing, Focus group discussion, as part of a previous randomised controlled trial, Interpretative Phenomenological Analysis</td>
<td>n = 19</td>
<td>61.1</td>
</tr>
<tr>
<td>Dennison, Moss-Morris, Yardley, Kirby and Chalder (2013)</td>
<td>To understand the process of change in service users who received cognitive behavioural therapy.</td>
<td>Cognitive behavioural therapy, Telephone interviews, as part of a previous randomised controlled trial, comparing cognitive therapy</td>
<td>n = 30 (15 received CBT, 15 received supportive listening)</td>
<td>43.5</td>
</tr>
<tr>
<td>Study</td>
<td>Objective</td>
<td>Method</td>
<td>Sample Size</td>
<td>Sample Characteristics</td>
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<tr>
<td>Gerskowitch, Norman and Rimes (2015)\textsuperscript{53}</td>
<td>To understand the experiences of service users who received cognitive behavioural therapy by a trained psychological therapist in a primary care psychology service.</td>
<td>Cognitive behavioural therapy</td>
<td>One-to-one interviews</td>
<td>Sample size: n = 11</td>
</tr>
<tr>
<td>MacCormack, Simonian, Lim, Remond, Roets, Dunn and Butow (2001)\textsuperscript{57}</td>
<td>To understand how service users experienced cognitive behavioural therapy and relaxation therapies.</td>
<td>Cognitive behavioural therapy, relaxation therapies</td>
<td>Telephone interviews</td>
<td>Sample size: n = 14</td>
</tr>
<tr>
<td>Mikocka-Walus, Gordon, Stewart and Andrews</td>
<td>To explore the views of service users who received psychotherapy.</td>
<td>Psychotherapy</td>
<td>Semi-structured interviews</td>
<td>Sample size: n = 12</td>
</tr>
<tr>
<td>Reference</td>
<td>Study Objective</td>
<td>Type of Intervention</td>
<td>Methodology</td>
<td>Sample Size</td>
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<tr>
<td>Morgan, Cousins, Middleton, Warriner-Gallyer and Ridsdale (2016)</td>
<td>To explore the views of service users who received behavioural intervention, including pre and post-therapy perspectives.</td>
<td>Behavioural intervention</td>
<td>Semi-structured interviews, as part of a previous feasibility trial</td>
<td>Sample size: n = 20</td>
</tr>
<tr>
<td>Nekolaichuk, Turner, Collie, Cumming and Stevenson (2013)</td>
<td>To understand service users' satisfactions and dissatisfactions with counselling.</td>
<td>Counselling</td>
<td>Focus group approach</td>
<td>Sample size: n = 23</td>
</tr>
<tr>
<td>Study</td>
<td>Methodology</td>
<td>Findings</td>
<td>Sample Size</td>
<td>Ages</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
<td>----------</td>
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</tr>
<tr>
<td>Nekolaichuk, Turner, Collie, Cumming and Stevenson (2013)</td>
<td>To explore the meaning of attachment and mindfulness-based cognitive therapy with service users who had not benefited from conventional pain treatment.</td>
<td>Cognitive therapy</td>
<td>Semi-structured interviews</td>
<td>A phenomenological analysis with a focus on meaning</td>
</tr>
<tr>
<td>Ward, Hogan, Stuart and Singleton (2008)</td>
<td>To explore service users' experiences of psychological interventions, including cognitive behavioural therapy, person-centred, psychodynamic, and integrative/eclectic approaches.</td>
<td>Cognitive behavioural therapy, person-centred therapy, psychodynamic therapy, integrative approaches</td>
<td>Interviews</td>
<td>Thematic analysis following grounded theory principles</td>
</tr>
</tbody>
</table>
Table 2

*CASP scores of the articles selected for the meta-ethnography*

<table>
<thead>
<tr>
<th>Study</th>
<th>Research design</th>
<th>Sampling</th>
<th>Data collection</th>
<th>Reflexivity</th>
<th>Ethical issues</th>
<th>Data analysis</th>
<th>Findings</th>
<th>Value of research</th>
<th>Total score</th>
<th>Strengths of the article</th>
<th>Weaknesses of the article</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angel et al. (2012)</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>19</td>
<td>Sample interview questions were provided. Detailed explanation of the methodology.</td>
<td>No details of the authors’ reflexive position.</td>
</tr>
<tr>
<td>Berg et al. (2008)</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>17</td>
<td>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).</td>
<td>No details of the research design. Findings did not always relate to the research aims.</td>
</tr>
<tr>
<td>Bremander et al. (2009)</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>19</td>
<td>Authors discussed transparently how data collection and analysis took place. Authors explicitly outlined ethical considerations.</td>
<td>Authors did not comment on reflexivity, but acknowledged unfamiliarity with the psychological approach. Findings were described but not critiqued fully.</td>
</tr>
<tr>
<td>Carr et al. (2014)</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>19</td>
<td>Epistemological stance was discussed in relation to the research design. Discussed how findings could be expanded to focus on other service user groups.</td>
<td>No further discussion around ethical issues aside from approval from the ethics committee.</td>
</tr>
<tr>
<td>Dellasega et al.</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>15</td>
<td>Research bias and influence were taken into account</td>
<td>No details given about how consent and</td>
</tr>
<tr>
<td>Study</td>
<td>Research design</td>
<td>Sampling</td>
<td>Data collection</td>
<td>Reflexivity</td>
<td>Ethical issues</td>
<td>Data analysis</td>
<td>Findings</td>
<td>Value of research</td>
<td>Total score</td>
<td>Strengths of the article</td>
<td>Weaknesses of the article</td>
</tr>
<tr>
<td>-------</td>
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<td>--------------------------</td>
</tr>
<tr>
<td>(2012)</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>19</td>
<td>account during data analysis.</td>
<td>confidentiality issues were discussed with focus group participants. Findings were described briefly and at times irrelevant to research aims.</td>
</tr>
<tr>
<td>Dennison et al. (2013)</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>19</td>
<td>Sampling strategy was extensively reported. Authors detailed the methodological problems that arose and how these were resolved.</td>
<td>Brief mention of research design. No discussion around the reflexive positions of authors.</td>
</tr>
<tr>
<td>Gerskowitz et al. (2015)</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>18</td>
<td>Authors discussed their reflexive positions as both practitioners and researchers.</td>
<td>Brief mention of the recruitment strategy. Findings were not distinguished between participant groups.</td>
</tr>
<tr>
<td>MacCorr mack et al. (2001)</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>18</td>
<td>Authors extensively discussed the methodology. Discussed implications for cancer care.</td>
<td>No discussion around the relationship between the researchers and participants.</td>
</tr>
<tr>
<td>Mikocka-Walus et al. (2013)</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>16</td>
<td>Sampling was explored in detail. Authors commented on their reflexive stance as researchers and health practitioners.</td>
<td>Authors could offer explanation of why the design and data collection methods were chosen. Only one theme was presented.</td>
</tr>
<tr>
<td>Morgan et al. (2016)</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>15</td>
<td>Authors presented findings in a detailed manner which answered the research questions.</td>
<td>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.</td>
</tr>
<tr>
<td>Study</td>
<td>Research</td>
<td>Sampling</td>
<td>Data Collection</td>
<td>Reflexivity</td>
<td>Ethical Issues</td>
<td>Data Analysis</td>
<td>Findings</td>
<td>Value of Research</td>
<td>Total Score</td>
<td>Strengths of the Article</td>
<td>Weaknesses of the Article</td>
</tr>
<tr>
<td>-----------------------</td>
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<td>-------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Nekolaic huk et al.</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>23</td>
<td>Most aspects of the research were justified and explained. Implications for clinical practice and how this research contributes to the evidence base was discussed.</td>
<td>Authors could explain in more detail how their positions may have influenced the research outcomes.</td>
</tr>
<tr>
<td>(2013)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peilot et al.</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>20</td>
<td>Authors provided detailed explanations of the methodology. Findings related directly to research questions.</td>
<td>No inclusion of the researcher's role in the interviews. Authors could expand on how findings relate to policies.</td>
</tr>
<tr>
<td>(2014)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward et al.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>15</td>
<td>Findings directly related to the research questions. Implications for practice was discussed.</td>
<td>Authors offered no explanation to why the research design was chosen. Little explanation of the analysis process was given.</td>
</tr>
<tr>
<td>(2008)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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<td></td>
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</table>
### Themes extracted from reviewed articles

<table>
<thead>
<tr>
<th>Article</th>
<th>Themes synthesised from individual articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angel et al. (2012)(^{63})</td>
<td>Integrating explanations into daily life; Generating resources; Unsuccessful responses</td>
</tr>
<tr>
<td>Berg et al. (2008)(^{61})</td>
<td>General experience; Participants' feedback about the core intervention modules; Participants' perspectives about their ability to participate; Participants' reactions to the patient-therapist relationship</td>
</tr>
<tr>
<td>Bremander et al. (2009)(^{58})</td>
<td>Changing one's life plan; Changing one's perception of life; Managing one's life</td>
</tr>
<tr>
<td>Carr et al. (2014)(^{51})</td>
<td>Psychologist on my side; Looking forwards not backwards; Importance of communication about and during the therapy; Owing the therapy</td>
</tr>
<tr>
<td>Dellasega et al. (2012)(^{59})</td>
<td>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</td>
</tr>
<tr>
<td>Dennison et al. (2013)(^{52})</td>
<td>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</td>
</tr>
<tr>
<td>Gerskowitch et al. (2015)(^{53})</td>
<td>Making connections between physical symptoms and mood, thoughts or activities; Sharing experiences and feeling understood; Reflections on treatment experience</td>
</tr>
<tr>
<td>MacCormack et al. (2001)(^{57})</td>
<td>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</td>
</tr>
<tr>
<td>Mikocka-Walus et al. (2013)(^{60})</td>
<td>Psychotherapy and its efficacy in managing psychological symptoms and IBD</td>
</tr>
<tr>
<td>Morgan et al. (2016)(^{54})</td>
<td>Prior perceptions and expectations of treatment; Experience of the therapy; Content, delivery and changes</td>
</tr>
<tr>
<td>Nekolaichuk et al. (2013)(^{55})</td>
<td>Distress and the Need for Support; Challenges to Service Access; The Therapeutic Encounter</td>
</tr>
<tr>
<td>Peilot et al. (2014)(^{62})</td>
<td>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</td>
</tr>
<tr>
<td>Ward et al. (2008)(^{56})</td>
<td>Experiences in counselling of people with ME; Reflections on the nature of the relationship with the counsellor; Reactions to counselling; Perceived benefits of counselling</td>
</tr>
</tbody>
</table>
### Higher order themes derived from reviewed articles

<table>
<thead>
<tr>
<th>Synthesised themes</th>
<th>Original articles</th>
<th>Themes extracted from original articles</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Concept one: the therapist and space mattered more to me than the psychological model</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The therapists’ qualities which led to positive relationships</td>
<td>Berg et al. (2008)</td>
<td>Participants’ reactions to the patient-therapist relationship</td>
</tr>
<tr>
<td></td>
<td>Bremannder et al. (2009)</td>
<td>Changing one's perception of life</td>
</tr>
<tr>
<td></td>
<td>Dellasega et al. (2012)</td>
<td>Being heard and responded to as a person; Encouragement and empowerment through empathy; Coaching rather than critiquing</td>
</tr>
<tr>
<td></td>
<td>MacCormack et al. (2001)</td>
<td>Therapist qualities; An experienced and caring professional</td>
</tr>
<tr>
<td></td>
<td>Mikocka-Walus et al. (2013)</td>
<td>Psychotherapy and its efficacy in managing psychological symptoms and IBD</td>
</tr>
<tr>
<td></td>
<td>Peilot et al. (2014)</td>
<td>Feeling empowered when learning to let go and leave things behind</td>
</tr>
<tr>
<td></td>
<td>Ward et al. (2008)</td>
<td>Reflections on the nature of the relationship with the counsellor; Perceived benefits of counselling</td>
</tr>
<tr>
<td>Therapy was a safe and neutral space</td>
<td>Dennison et al. (2013)</td>
<td>Tuning in and sharing thoughts and feelings</td>
</tr>
<tr>
<td></td>
<td>Gerskowitch et al. (2015)</td>
<td>Sharing experiences and feeling understood</td>
</tr>
<tr>
<td></td>
<td>MacCormack et al. (2001)</td>
<td>General therapy impressions/what's helpful; Individual versus family involvement; Relational/being with' experience; A unique space for exploring and discussing</td>
</tr>
<tr>
<td><strong>Concept two: therapeutic processes facilitated discovery and change</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy prompted change in LTC management</td>
<td>Angel et al. (2012)</td>
<td>Generating resources; Integrating explanations into daily life</td>
</tr>
<tr>
<td></td>
<td>Berg et al. (2008)</td>
<td>General experience</td>
</tr>
<tr>
<td></td>
<td>Bremannder et al. (2009)</td>
<td>Changing one's life plan</td>
</tr>
<tr>
<td></td>
<td>Carr et al. (2014)</td>
<td>Looking forwards not backwards; Importance of communication about and during the therapy; Psychologist on my side</td>
</tr>
<tr>
<td></td>
<td>Dellasega et al. (2012)</td>
<td>Collaborative action planning and goal setting; Nonjudgmental accountability</td>
</tr>
<tr>
<td></td>
<td>Dennison et al. (2013)</td>
<td>Buying into therapy</td>
</tr>
<tr>
<td>Study</td>
<td>Content</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>Mikocka-Walus et al. (2013)</td>
<td>Psychotherapy and its efficacy in managing psychological symptoms and IBD</td>
<td></td>
</tr>
<tr>
<td>Nekolaichuk et al. (2013)</td>
<td>Distress and the Need for Support</td>
<td></td>
</tr>
<tr>
<td>Peilot et al. (2014)</td>
<td>Building an understanding of one's body and symptoms; Finding meaning in life with pain</td>
<td></td>
</tr>
<tr>
<td>Carr et al. (2014)</td>
<td>Owning the therapy</td>
<td></td>
</tr>
<tr>
<td>Dennison et al. (2013)</td>
<td>Achieving personally valued changes; Learning and enacting explicit strategies for living with MS</td>
<td></td>
</tr>
<tr>
<td>Gerskowitch et al. (2015)</td>
<td>Reflections on treatment experience</td>
<td></td>
</tr>
<tr>
<td>Morgan et al. (2016)</td>
<td>Experience of the therapy; Prior perceptions and expectations of treatment</td>
<td></td>
</tr>
<tr>
<td>Nekolaichuk et al. (2013)</td>
<td>The Therapeutic Encounter</td>
<td></td>
</tr>
<tr>
<td>Ward et al. (2008)</td>
<td>Experiences in counselling of people with ME</td>
<td></td>
</tr>
</tbody>
</table>

### Concept three: the barriers to engagement

<table>
<thead>
<tr>
<th>Study</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angel et al. (2012)</td>
<td>Unsuccessful responses</td>
</tr>
<tr>
<td>Berg et al. (2008)</td>
<td>Participants' feedback about the core intervention modules; Participants' perspectives about their ability to participate</td>
</tr>
<tr>
<td>Gerskowitch et al. (2015)</td>
<td>Making connections between physical symptoms and mood, thoughts or activities; Reflections on treatment experience</td>
</tr>
<tr>
<td>MacCormack et al. (2001)</td>
<td>Home versus hospital visits</td>
</tr>
<tr>
<td>Nekolaichuk et al. (2013)</td>
<td>Challenges to Service Access</td>
</tr>
<tr>
<td>Ward et al. (2008)</td>
<td>Reactions to counselling</td>
</tr>
<tr>
<td>Bremander et al. (2009)</td>
<td>Managing one's life</td>
</tr>
<tr>
<td>Dennison et al. (2013)</td>
<td>Experiencing ongoing benefits</td>
</tr>
<tr>
<td>Morgan et al. (2016)</td>
<td>Content, delivery and changes</td>
</tr>
<tr>
<td>MacCormack et al. (2001)</td>
<td>Session format and follow up</td>
</tr>
<tr>
<td>Peilot et al. (2014)</td>
<td>Feeling empowered when learning to let go and leave things behind</td>
</tr>
</tbody>
</table>
Appendix 1-A

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

<table>
<thead>
<tr>
<th>Database</th>
<th>Date Searched</th>
<th>Searchable Years</th>
<th>MeSH Terms</th>
<th>Search Limits Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDLINE</td>
<td>6th October 2016</td>
<td>1999-2016</td>
<td>1. (MH &quot;Psychology&quot;) OR (MH &quot;Psychological Techniques&quot;) OR (MH &quot;Models, Psychological&quot;) OR (MH &quot;Interview, Psychological&quot;) OR (MH &quot;Resilience, Psychological&quot;) OR (MH &quot;Psychology, Social&quot;) OR (MH &quot;Psychology, Experimental&quot;) OR (MH &quot;Psychology, Applied&quot;) OR (MH &quot;Adaptation, Psychological&quot;) OR (MH &quot;Transference (Psychology)&quot;) OR (MH &quot;Self Psychology&quot;) OR (MH &quot;Psychology, Clinical&quot;) OR (MH &quot;Practice (Psychology)&quot;) OR (MH &quot;Psychological Trauma&quot;) OR (MH &quot;Anticipation, Psychological&quot;) OR (MH &quot;Unconscious (Psychology)&quot;) OR (MH &quot;Psychoanalytic Therapy&quot;) OR (MH &quot;Cognitive Therapy&quot;) OR (MH &quot;Behavior Therapy&quot;) OR (MH &quot;Aversive Therapy&quot;) OR (MH &quot;Couples Therapy&quot;) OR (MH &quot;Narrative Therapy&quot;) OR (MH &quot;Family Therapy&quot;) OR (MH &quot;Relaxation Therapy&quot;) OR (MH &quot;Gestalt Therapy&quot;) OR (MH &quot;Functional Behavior, Psychology&quot;) OR (MH &quot;Person-Centered Therapy&quot;) OR (MH &quot;Psychiatric Somatic Therapies&quot;) OR (MH &quot;Mind-Body Therapies&quot;) OR (MH &quot;Anger Management Therapy&quot;) OR (MH &quot;Psychological Phenomena and Processes&quot;) OR (MH &quot;Acceptance and Commitment Therapy&quot;)</td>
<td>&quot;Boolean/Phrase&quot;, &quot;English Language&quot;</td>
</tr>
</tbody>
</table>
"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

<table>
<thead>
<tr>
<th>PsycINFO</th>
<th>7th October 2016</th>
<th>2002-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. DE &quot;Chronic Illness&quot; OR DE &quot;Chronicity (Disorders)&quot; OR DE &quot;Chronic Fatigue Syndrome&quot; OR DE &quot;Physical Illness (Attitudes Toward)&quot; OR DE &quot;Chronic Pain&quot; OR DE &quot;Chronic Obstructive Pulmonary Disease&quot; OR DE &quot;Terminally Ill Patients&quot; OR DE &quot;Physical Disorders&quot; OR DE &quot;Myasthenia &quot;Boolean/Phrase&quot;, &quot;English Language&quot;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Gravis" OR DE "Multiple Sclerosis" OR DE "Lupus" OR DE "Dysthmic 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...
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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 "Cushing 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


6. DE "Qualitative Research"

Search Field: 4 AND 5 AND 6
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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}
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 "Ocular Neoplasm,

EXPERIENCES OF THERAPY FOR PEOPLE WITH LTCS

1-67
"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
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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
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**EXPERIENCES OF THERAPY FOR PEOPLE WITH LTCS**
## Appendix 1-B

### Summary of databases searched using free text search.

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Search Field: 1 AND 2 AND 3
Appendix 1-C

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Types of article

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

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Prepared for submission to Journal of Psychosomatic Research

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\cite{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). Section one of this thesis identified that a number of countries, including the UK, USA and Australia, 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%. The World Health Organization 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. 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. 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. Not only does psychological intervention improve quality of life for people with LTCs, there is evidence to suggest better functional capabilities post-therapy and improved
physical health outcomes and reduce medication use. Moreover, findings from de Lusignan et al. 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 and Department of Health 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 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 recommends Cognitive Behavioural Therapy (CBT) as the preferred psychological intervention. Sage et al.'s '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. ) 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 (COPD) and chronic heart failure, there are recommendations to offer psychological support, although they do not specify a particular type of therapeutic modality. However, the NICE guidance 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, anxiety experienced by people with HIV, and quality of life for people with skin diseases. 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 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. There is also evidence to show that the effectiveness of CBT is mixed, as Coventry and Gallatly 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.), 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 identified that investigating therapeutic change can provide insight into how people
experience therapy. Understanding exactly which components of therapy are effective and the processes of change can provide a deeper understanding to what matters to SUs. 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). 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. 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. 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. SF therapy can be applied to a broad range of distresses experienced by people with LTCs, as a number of the techniques focus on empowering the person to be independent, to identify inherent resources and to encourage future-orientated goals. The NHS England Personalised Care and Support Planning framework 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. 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, 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. 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 and hopelessness for the future.

As aforementioned, the only NICE guidance in existence for people with LTCs suggests the use of CBT. Although there is research which suggests that CBT is an efficacious therapy model (e.g.) 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, and CBT’s adaptability for use with people with an increasingly wide range of mental health difficulties. 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. 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\textsuperscript{50,51}, and children and adolescents experiencing distress.\textsuperscript{52} Although there is a dearth of research studying SF therapy for people with LTCs, one recent study\textsuperscript{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.\textsuperscript{35} Further exploration of how SF therapy is experienced can be beneficial in understanding how aspects of the intervention can be useful.\textsuperscript{35} Moreover, Dellasega et al.\textsuperscript{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\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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. 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. 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. As Coyle 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. Edwards and Potter 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. All interviews were transcribed verbatim with transcript conventions (Table 3) using the framework provided by Edwards and Potter. 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.

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.

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. 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. 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. 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

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

<table>
<thead>
<tr>
<th></th>
<th>Practitioner</th>
<th></th>
<th>SU</th>
<th>↑yeah</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>so you've kept that going even though</td>
<td>14</td>
<td>↑yeah</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>you've had these distress behind the scenes but from [your grandchild's] point of view</td>
<td>16</td>
<td>↑yeah</td>
<td></td>
</tr>
</tbody>
</table>

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). 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)*
When SUs talked about themselves negatively, these accounts were at times made stronger and more convincing using the *rhetoric of argument*.\textsuperscript{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).\textsuperscript{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*
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*, 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. 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 might 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)*
Su's spoke about interpersonal conflicts.

These conflicts placed restrictions on goal construction.

Practitioners did not focus on these conflicts (de-contextualisation). Instead, they focused on the SUs' goals.

Construction of alternative goal.

Figure 3. Processes of discourse three: de-contextualising

This discourse typically began with SUs describing their conflicts with other people. Su's 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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SU</td>
</tr>
<tr>
<td>2</td>
<td>Practitioner</td>
</tr>
<tr>
<td>3</td>
<td>SU</td>
</tr>
<tr>
<td>4</td>
<td>Practitioner</td>
</tr>
<tr>
<td>5</td>
<td>SU</td>
</tr>
</tbody>
</table>
Practitioner: tell me what you ↑do ↓do

SU: you mean in the house and stuff

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

SU: >I don't think I am living well with it though<

Practitioner: ok

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

Practitioner: wow

SU: if nothing else I do do that >you know I'll hoover up and I'll tidy round<

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

SU: yeah

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

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. 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). 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 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. Trope 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.

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 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." Andrew responded, "so you'd love to actually physically be out and about and is it does it only count 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 notice<." 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)*
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 deep down I tend to believe the [specialist doctor] who did the ↓erm angiogram ↑who told me everything was alright 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 incorrect< and I'm/ I'm sticking with what [the specialist] had said

2 Practitioner  you haven't actually looked so you've got the evidence of the [specialist doctor] that looked

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 before (: ) 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 enzymes being up
and then they go out they have to keep me for 24 hours and ↑that's not a
heart attack

<table>
<thead>
<tr>
<th></th>
<th>Practitioner</th>
<th>SU</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
<td>yes</td>
</tr>
</tbody>
</table>
| 5 | SU           | that's probably (.). these muscle spasms which- coronary artery spasms
which says (.). but I/ I say I/ I um I- I just- I just still feel as vulnerable
and as stupid 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 like 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 family (.). you're determined to bring the
logical 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 tell you that or what would
you notice |
| 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 about it at all 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 loved life I absolutely (.). ↑loved being with my
family and being retired and everything that life has to offer |
| 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 instead |
| 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 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, 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, 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 determination and the fact that you'll see through what you do is some of your strengths.

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 tiny bit... what 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 before 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. Practitioners 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, 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\textsuperscript{73}, Narrative Therapy\textsuperscript{74}, Systemic Family Therapy\textsuperscript{75}, and CBT.\textsuperscript{76} For example, the use of \textit{attributional semantics}\textsuperscript{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.\textsuperscript{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. 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. ). 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. 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, 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 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 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 research was when people were guided by practitioners to develop alternative goals and to be able to progress towards these goals. Although Elliott's 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 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 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 and there are usually high attrition rates in participation. As the exploration of LTCs can evoke thoughts and emotions around mortality, managing participants' and researchers' distress can be complex. 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. 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. 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\textsuperscript{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\textsuperscript{36}, and setting appropriate goals\textsuperscript{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.\textsuperscript{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.\textsuperscript{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\textsuperscript{95}, and also when clients do not understand or agree with goals.\textsuperscript{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\textsuperscript{97} and are advantageous in maximising the clinical outcomes for SUs.\textsuperscript{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.
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https://doi.org/10.1023/A:1026629024866.
Table 1

*Demographic of participants*

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<th>Gender</th>
<th>Age</th>
<th>Health Condition (as reported by SUPS)</th>
</tr>
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<tr>
<td>Andrew (PP)</td>
<td>Male</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Clare (PP)</td>
<td>Female</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Rachel (PP)</td>
<td>Female</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Natalie (PP)</td>
<td>Female</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Beth (SUP)</td>
<td>Female</td>
<td>20s</td>
<td>Ehlers-Danlos hypermobility syndrome</td>
</tr>
<tr>
<td>Debbie (SUP)</td>
<td>Female</td>
<td>50s</td>
<td>Lymphoma; rheumatoid arthritis</td>
</tr>
<tr>
<td>Faz (SUP)</td>
<td>Male</td>
<td>70s</td>
<td>Arthritis</td>
</tr>
<tr>
<td>Jackie (SUP)</td>
<td>Female</td>
<td>40s</td>
<td>Fibromyalgia</td>
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<td>Male</td>
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<td>Bowel Cancer</td>
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<td>60s</td>
<td>Cancer</td>
</tr>
<tr>
<td>Sharon (SUP)</td>
<td>Female</td>
<td>60s</td>
<td>Fibromyalgia</td>
</tr>
<tr>
<td>Bill (SUP)</td>
<td>Male</td>
<td>70s</td>
<td>Coronary artery spasms/variant angina</td>
</tr>
</tbody>
</table>
Table 2

*Participant dyads*

<table>
<thead>
<tr>
<th>Practitioner Participants</th>
<th>Service User Participants</th>
<th>Dyad number</th>
</tr>
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<tbody>
<tr>
<td>Andrew</td>
<td>Debbie</td>
<td>Dyad 1</td>
</tr>
<tr>
<td></td>
<td>Matt</td>
<td>Dyad 2</td>
</tr>
<tr>
<td></td>
<td>Sue</td>
<td>Dyad 3</td>
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<td>Rachel</td>
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<td>Jackie</td>
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<tr>
<td>Natalie</td>
<td>Sharon</td>
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</table>
Table 3

Transcript conventions

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

[^59]: This reference is not provided in the text.
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 her 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 mental 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:::<[laughing]

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 person I used to be type of thing (.)(.) not as strong as ah::: (.)(.) not as able to as able to (.)(.) I sometimes feel as though I'm drifting from them a little bit

3 Practitioner m:

4 SU erm:: (.)(.) (.)(.) yeah just ah (.)(.) ↓sometimes I sometimes sometimes I just (.)(.) don't see the point 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 reason to be down ↑here today>

5 Practitioner yes

6 SU ↓you know that's er: (.)(.) (.)(.) you know that's I've put that in my thing there you know er (.)(.) what you know why why am I here (.)(.) what use am I (.)(.) what you know what's er (.)(.) (.)(.) what help am I to my family type of thing do you know do you know just ↑low 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 busy

15 Practitioner yes

16 SU >type of thing< you know just ah: sometimes it's trying to take it like small step at a time just to <try do a little bit more each day>

17 Practitioner yes

18 SU (beginning of extract 2 in text) 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 not who you are |
| 28 (end of extract 2 in text) | SU | no 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 love to be telling me |
| 32 | SU | I'd love to be telling you that I was (.). earning more money providing more for my family er getting fitter getting stronger I suppose that's the \[\] |
| 33 | Practitioner | yes |
| 34 | SU | \[\]. (.). just feels though ↓sometimes wasting away a little bit you know (.). |
| 35 | Practitioner | what would you love to notice instead |
| 36 | SU | not 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 | \[\]. (.). (.). ↑just being happier [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 pain doesn't help (.) if you're in pain 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 pain and you have to cope with the pain (.) 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 coping 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 some way and like I said the pain isn't was bad as it was last 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 surprised that things have have changed 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 ↑have 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 believe that there would be I did not believe that it would be but I have come through 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 you know you pick up and erm you know start to get it ↓start feeling a little bit better

| Practitioner | 26 | a bit bit a time approach rather than thinking too big |
| SU | 27 | ↓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 some people tend (.) ↑to not look down on me but (.) sniff attitudes 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 got (.) 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 pain but

6. Practitioner: m: m:

7. SU: you know and on other days you just (.) you just physically 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 scooter

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 fight ↓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 you don't know (.) <you know what my circumstances are but but how I or (.) how 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 walk as far as I can

22. Practitioner: wow

23. SU: I do 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 expertise 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 angry 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 >you should be doing this and you should be doing that< (.↓I find it quite hard to express exactly (.↓you know what I do do
34  Practitioner    mm
35  (beginning of extract 3 in text)  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
36  Practitioner    m: m:
37  SU    but then she doesn't realise
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 helps out in a big way then that's what I'll do
56  Practitioner    yes yes so it's important to you to make a difference to him it sounds like
57  SU    I wanna help
59  Practitioner    yeah
60  SU    that's what I wanna/ I wanna try and help the best 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 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
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 worst 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 (.) where would you say generally speaking <things are at the moment>

2 SU er:: (.) I'd say (.) about five

3 Practitioner about half 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 was 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 positive attitude

10 SU yep erm and the (.) exercise 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 tiny bit (.) I'm not saying what would take you up a eight or a nine but even the slightest
thing can be a five and a half (.). what 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 before when we were talking about this getting out of bed thing |
| 19 | Practitioner | ok yeah |
| 20 | SU | maybe I can increase that to a five and a half by trying (.). 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 ↑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 small 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 aim 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 build up |
| 27 | Practitioner | yeah and ok so 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 confident 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 will stick to because I know it's gonna help me in the long run |
| 37 | Practitioner | ok yeah |
| 38 | SU | if I can start off with small things and build them up but even like down to smoking (.). which is quite a big thing is that I tried for years (.). on and off but I did 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 I won't slide 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 do do it (.). I do see it through |
Section Three: Critical Appraisal

The importance of discourse in clinical psychology practice

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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 was a representation of how the social constructionist stance can be utilised in research. As opposed to a positivist view where there are 'truths' to scientifically falsify, 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. Although quantitative research is more easily generalised, the findings from qualitative research can be transferable to other contexts and settings, and can contribute to systematically conducted meta-syntheses, which is regarded by the National Health and Medical Research Council 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 explain that researchers tend to enter a field of research with preconceptions of what the research will likely find. In Malterud's essay, she argued that these preconceptions, previous personal and professional experiences and motivations of the researcher, can likely bias how the research is undertaken. Malterud 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\textsuperscript{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.\textsuperscript{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 epistemology20, 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.\textsuperscript{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\textsuperscript{26} to purposefully elicit agreement or acceptance resembles the principles of Motivational Interviewing\textsuperscript{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.\textsuperscript{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.\textsuperscript{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\textsuperscript{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 outlines that "discourse analysis is more than just a methodology - it is a philosophy, a way of being" (p. 1). In her essay, Morgan 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\textsuperscript{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.\textsuperscript{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\textsuperscript{34} and deconstructing the underlying assumptions of diagnoses.\textsuperscript{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\textsuperscript{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.\textsuperscript{37} Harper\textsuperscript{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, but the research process can also influence the researcher’s views of the study. 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. This is in contrast with a structured assessment-formulation-intervention approach 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


19. Carr SM, Smith IC, Simm R. Solution-focused brief therapy from the perspective of


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
Full Set of Project Data

☐ 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 PI’s 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 filler 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 familiar 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 SRFT 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):

<table>
<thead>
<tr>
<th>Student 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title: Forename/Initials Surname</td>
</tr>
<tr>
<td>Miss Joanna Cheng</td>
</tr>
<tr>
<td>Address: Clinical Psychology, Furness College</td>
</tr>
<tr>
<td>Lancaster University</td>
</tr>
<tr>
<td>Lancaster</td>
</tr>
<tr>
<td>Post Code: LA1 4YG</td>
</tr>
<tr>
<td>E-mail: <a href="mailto:j.cheng1@lancaster.ac.uk">j.cheng1@lancaster.ac.uk</a></td>
</tr>
<tr>
<td>Telephone: 01524582070</td>
</tr>
<tr>
<td>Fax:</td>
</tr>
</tbody>
</table>

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):

<table>
<thead>
<tr>
<th>Academic supervisor 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title: Forename/Initials Surname</td>
</tr>
<tr>
<td>Dr Ian Smith</td>
</tr>
<tr>
<td>Address: Clinical Psychology, Furness College</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Student(s)</th>
<th>Academic supervisor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student 1</td>
<td>Miss Joanna Cheng</td>
</tr>
<tr>
<td></td>
<td>Dr Ian Smith</td>
</tr>
</tbody>
</table>

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: j.cheng1@lancaster.ac.uk
- * Personal E-mail: j.cheng1@lancaster.ac.uk
- Work Telephone: 01524592282
- * Personal Telephone/Mobile: [Obfuscated]
- Fax: 01524592282

* This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.

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 HR/AR&D reviewers that is sent to the CI.
A5-1. Research reference numbers. Please give any relevant references for your study:

Applicant's/organization's own reference number, e.g. R & D (if available):
Sponsor’s/protocol number:
Protocol Version:
Protocol Date:
Funder's reference number:
Additional reference number(s):

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organization 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 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 or other office (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 (PPs) are recruiting service users for the project, they will ensure that potential service user participants (SUPs) 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 and LTCs can be used to improve 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 SUPs request, and that the SU can pause 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 diagnostic 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, 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.

| §. PURPOSE AND DESIGN OF THE RESEARCH |

A7. Select the appropriate methodology description for this research. Please tick all that apply.
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 societally 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
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.
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.

<table>
<thead>
<tr>
<th>intervention or procedure</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>Seeking informed consent</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>months</td>
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<tr>
<td>Recording the interview</td>
<td>2</td>
<td>1</td>
<td>SF practitioner,</td>
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*Initially, Joanna Cheng, Trainee Clinical Psychologist will carry out this procedure via post. If no response is received, the participant will carry this out in the health service.*

**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 interview/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 mispractice 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 SUSs 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 SUSs, age, health condition (for SUSs), 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 SUSs) 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 SUS 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 RIS 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
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 materials). 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 with 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.

A35-1. 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 interpreter)?

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 is 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.

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**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, fax numbers, 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 be 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 as the Lancaster University policy on data storage (http://www.lancaster.ac.uk/ehs/research/doctoral_study/dotlnsps/ehs/researchandsafety/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.

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?

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<tr>
<td>Dr</td>
<td>Bill</td>
<td>Selwood</td>
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</table>

Post: Professor, Programme Director, Doctorate in Clinical Psychology, Lancaster University

Qualifications: PhD

Work Address: Division of Health Research
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:*

- [x] Peer reviewed scientific journals
- [x] Internal report
- [x] Conference presentation
- [x] Publication on website
- [ ] Other publication
- [ ] Submission to regulatory authorities
- [x] 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.

Participants 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 SUs) 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 (Pinepoli & 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.

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<td>Dr</td>
<td>Suzi</td>
<td>Curtis</td>
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<tr>
<th>Post</th>
<th>Clinical Psychologist</th>
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<td>Qualifications</td>
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A64. Details of research sponsor(s)

A64-1. Sponsor

<table>
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<tr>
<th>Lead Sponsor</th>
<th>Commercial status:</th>
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<td>Status:</td>
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<tr>
<td>○ NHS or HSC care organisation</td>
<td>Commercial status:</td>
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<td>○ Academic</td>
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<td>○ Pharmaceutical industry</td>
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<td>○ Medical device industry</td>
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<td>○ Local Authority</td>
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<td>○ Other social care provider (including voluntary sector or private organisation)</td>
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If Other, please specify:
Contact person

Name of organisation: Lancaster University
Given name: Diane
Family name: Hopkins
Address: [Redacted]
Town/city: Lancaster
Post code: LA1 4YT
Country: UNITED KINGDOM
Telephone: 01524 592338
Fax: [Redacted]
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 A94-1)? 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
A68-1. Give details of the lead NHS R&D contact for this research:

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Details can be obtained from the NHS R&D Forum website: [http://www.rfforum.nhs.uk](http://www.rfforum.nhs.uk)

A69-1. How long do you expect the study to last in the UK?

- Planned start date: 01/09/2016
- 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
Full Set of Project Data

- 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.

A75. 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.

A75.1. 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.

- [ ] 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 design of the research? Please tick box(es) as applicable.

- [ ] NHS indemnity scheme will apply (protocol authors with NHS contracts only)
- [X] 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 conduct of the research?

- [X] 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.

**A79.** 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.

<table>
<thead>
<tr>
<th>Investigator identifier</th>
<th>Research site</th>
<th>Investigator Name</th>
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<tbody>
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<td>IN1</td>
<td></td>
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<td>NHS site</td>
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<td></td>
<td>Non-NHS site</td>
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<tr>
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<tr>
<td>Organisation name</td>
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</tr>
<tr>
<td>Full Set of Project Data</td>
<td>IRAS Version 5.3.1</td>
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<tr>
<td>Address</td>
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<tr>
<td>Post Code</td>
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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

<table>
<thead>
<tr>
<th>Stage</th>
<th>Procedure</th>
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<tbody>
<tr>
<td>1</td>
<td>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.</td>
</tr>
<tr>
<td>2</td>
<td>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.</td>
</tr>
<tr>
<td>3</td>
<td>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</td>
</tr>
<tr>
<td>4</td>
<td>The inclusion/exclusion criteria, introductory letter, PIS, consent form and guidance for SUP recruitment will be distributed and explained to PPs.</td>
</tr>
<tr>
<td>5</td>
<td>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.</td>
</tr>
<tr>
<td>6</td>
<td>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.</td>
</tr>
<tr>
<td>7</td>
<td>The recording will be transcribed verbatim by the Chief Investigator, and the audio will be shared with the Research Supervisor to aid the analysis</td>
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</table>
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 are 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**

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<tr>
<td>Prepare and submit IRAS/R&amp;D form along with research protocol and research materials</td>
<td>May-August 2016</td>
</tr>
<tr>
<td>Recruitment of participants (after ethical approval)</td>
<td>Summer-Autumn 2016</td>
</tr>
<tr>
<td>Data collection</td>
<td>Summer-Autumn 2016</td>
</tr>
<tr>
<td>Data analysis</td>
<td>ASAP (September - December 2016)</td>
</tr>
<tr>
<td>Submit thesis</td>
<td>May 2017</td>
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<tr>
<td>Submit papers for publication</td>
<td>End of July 2017</td>
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<tr>
<td>If accepted, submit final accepted manuscript to research coordinator</td>
<td>Once paper is accepted.</td>
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References


"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.
"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: [REDACTED]  
Telephone: [REDACTED]

IRAS Project ID: 207169  
Title: Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions.
“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.

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 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: _____________________

_________________________________
"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.
"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.

<table>
<thead>
<tr>
<th>Name of Participant</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Researcher</td>
<td>Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

IRAS Project ID: 207169
Title: Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions.
"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
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 ___________
"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,  

[Redacted]
**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 indicate ‘Yes’ to (f), please provide your preferred contact details:

IRAS Project ID: 207169
Title: Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions.
"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:

IRAS Project ID: 207169
Title: Constructing preferred future and resource conversations through solution-focused discourses with people with long-term physical health conditions.
Appendix 4-D

NHS Research Ethics Committee approval letter

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:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
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</thead>
<tbody>
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<td>1</td>
<td>26 October 2016</td>
</tr>
<tr>
<td>Other [Demography Form PP Version]</td>
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<td>3</td>
<td>26 October 2016</td>
</tr>
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</table>

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
<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [EL &amp; PL 2016-17]</td>
<td></td>
<td>20 July 2016</td>
</tr>
<tr>
<td>GP/consultant information sheets or letters [Guidance For Practitioners]</td>
<td>2</td>
<td>24 August 2016</td>
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<td>IRAS Application Form [IRAS_Form_31082016]</td>
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<td>31 August 2016</td>
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<tr>
<td>IRAS Checklist XML [Checklist_26102016]</td>
<td></td>
<td>26 October 2016</td>
</tr>
<tr>
<td>Letter from sponsor [Joanna Cheng IRAS sponsorship letter]</td>
<td></td>
<td>12 August 2016</td>
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<td>Other [PN 2016-17]</td>
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<td>Other [Schedule of Events IRAS Project ID 207169]</td>
<td>1</td>
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<tr>
<td>Other [Statement of Activities IRAS Project ID 207169]</td>
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<tr>
<td>Other [Demography Form PP Version]</td>
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<td>26 October 2016</td>
</tr>
<tr>
<td>Participant consent form [Consent Form PP Version]</td>
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<td>26 October 2016</td>
</tr>
<tr>
<td>Participant information sheet (PIS) [Participant Information Sheet PP Version]</td>
<td>2</td>
<td>24 August 2016</td>
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<tr>
<td>Research protocol or project proposal [Research protocol]</td>
<td>5</td>
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<tr>
<td>Summary CV for Chief Investigator (CI) [CV Joanna Cheng]</td>
<td></td>
<td>17 August 2016</td>
</tr>
<tr>
<td>Summary CV for supervisor (student research) [Ian Smith research CV 26022016]</td>
<td></td>
<td>26 February 2016</td>
</tr>
</tbody>
</table>

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

[Redacted]

REC Assistant

E-mail: [Redacted]

Copy to: Dr Diane Hopkins

[Redacted]

A Research Ethics Committee established by the Health Research Authority
Appendix 4-E

Health Research Authority approval letter

Health Research Authority

Miss Joanna Cheng
Clinical Psychology
Furness College
Lancaster University
Lancaster
LA1 4YG

09 December 2016

Dear Joanna Cheng

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.
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](http://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](http://www.hra.nhs.uk), and emailed to [hra.amendments@nhs.net](mailto: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](http://www.hra.nhs.uk).

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](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.
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]
### Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

<table>
<thead>
<tr>
<th>Document</th>
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<th>Date</th>
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<td>Contract/Study Agreement [Schedule of Events]</td>
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<td>20 July 2016</td>
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<tr>
<td>IRAS Checklist XML [Checklist_26102016]</td>
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<td>2</td>
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<td>Summary CV for Chief Investigator (CI) [CV Joanna Cheng]</td>
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<tr>
<td>Summary CV for supervisor (student research) [Ian Smith research CV 26022016]</td>
<td></td>
<td>26 February 2016</td>
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</tbody>
</table>
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: 

<table>
<thead>
<tr>
<th>Section</th>
<th>HRA Assessment Criteria</th>
<th>Compliant with Standards</th>
<th>Comments</th>
</tr>
</thead>
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<tr>
<td>1.1</td>
<td>IRAS application completed correctly</td>
<td>Yes</td>
<td>No comments</td>
</tr>
<tr>
<td>2.1</td>
<td>Participant information/consent documents and consent process</td>
<td>Yes</td>
<td>No comments</td>
</tr>
<tr>
<td>3.1</td>
<td>Protocol assessment</td>
<td>Yes</td>
<td>No comments</td>
</tr>
<tr>
<td>4.1</td>
<td>Allocation of responsibilities and rights are agreed and documented</td>
<td>Yes</td>
<td>The Sponsor has submitted a Statement of Activities and Schedule of Events. The Sponsor is not intending to use any other agreements with sites.</td>
</tr>
<tr>
<td>4.2</td>
<td>Insurance/indemnity arrangements assessed</td>
<td>Yes</td>
<td>Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the</td>
</tr>
<tr>
<td>Section</td>
<td>HRA Assessment Criteria</td>
<td>Compliant with Standards</td>
<td>Comments</td>
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<td>---------------------------------------------------------------</td>
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<td>--------------------------------------------------------------------------</td>
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<tr>
<td>4.3</td>
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<td>Yes</td>
<td>The study is not funded.</td>
</tr>
<tr>
<td>5.1</td>
<td>Compliance with the Data Protection Act and data security issues assessed</td>
<td>Yes</td>
<td>No comments</td>
</tr>
<tr>
<td>5.2</td>
<td>CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed</td>
<td>Not Applicable</td>
<td>No comments</td>
</tr>
<tr>
<td>5.3</td>
<td>Compliance with any applicable laws or regulations</td>
<td>Yes</td>
<td>No comments</td>
</tr>
<tr>
<td>6.1</td>
<td>NHS Research Ethics Committee favourable opinion received for applicable studies</td>
<td>Yes</td>
<td>REC Favourable Opinion (with additional conditions) was issued on 26 October 2016. The REC acknowledged conditions were met on 26 October 2016.</td>
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<td>6.2</td>
<td>CTIMPS – Clinical Trials Authorisation (CTA) letter received</td>
<td>Not Applicable</td>
<td>No comments</td>
</tr>
<tr>
<td>6.3</td>
<td>Devices – MHRA notice of no objection received</td>
<td>Not Applicable</td>
<td>No comments</td>
</tr>
<tr>
<td>6.4</td>
<td>Other regulatory approvals and authorisations received</td>
<td>Not Applicable</td>
<td>No comments</td>
</tr>
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</table>

**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...
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 IRAS project ID 207169. 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.
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 do not intend 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

<table>
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<tr>
<th>RDI Ref No</th>
<th>RDI-207169-B</th>
<th>REC Ref</th>
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<tr>
<td>IRAS ID</td>
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<td></td>
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<tr>
<td>Title</td>
<td>Preferred future &amp; resource through SFBT with people with LTCs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Trust (Site)</td>
<td>[Redacted]</td>
<td>[Redacted]</td>
<td>[Redacted]</td>
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</tbody>
</table>

Thank you for submitting the above named research study to [Redacted] 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 [Redacted].


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

[Redacted], RDI Manager