DOCTORATE IN CLINICAL PSYCHOLOGY

Assignment/Assessment: Major Research Project

Title: **Adapting Cognitive Behavioural Therapy Interventions for Anxiety or Depression to Meet the Needs of People with Long-term Physical Health Conditions**

Keywords: Anxiety, depression, guided self-help, long-term conditions

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Statement of academic probity and professional practice:

"I certify that all material in this assignment which is not my own work has been identified and properly attributed. I have conducted the work in line with the BPS DCP Professional Practice Guidelines."

Submitted in partial fulfilment of requirements for the Doctorate Degree in Clinical Psychology, University of Exeter

DOCTORATE IN CLINICAL PSYCHOLOGY

Assignment/Assessment: Literature Review.

Title: Adapting Cognitive Behavioural Therapy Interventions for Anxiety or Depression to Meet the Needs of People with Long-term Physical Health Conditions: A Narrative Review.

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Abstract

People with long-term physical health conditions (LTCs) have an increased risk of depression or anxiety. There is an emphasis on mental health services adapting their practice to offer evidence-based psychological interventions to people with LTCs and comorbid mental health problems. However there is limited evidence to inform practice around how to adapt interventions to best meet these needs. This systematic review with narrative analysis synthesises the available evidence around how cognitive-behavioural therapy interventions for anxiety and depression have been adapted. Adaptations relating to content, delivery and acceptability for people with LTCs conditions are suggested. Further research is needed to investigate the appropriateness of adapted interventions in mental health services.

Keywords: Adaptations, Cognitive-behaviour therapy, Long-term conditions

Highlights[1]

- Professionals may be guided by whether the person has a physical or cognitive impairment as a result of their LTC.
- Adaptations to content include recognising the interaction between the LTC and anxiety and/ or depression; addressing illness related cognitions that contribute to excess disability; and adjusting expectations to increase re-engagement in valued activities
- There is a need to further explore acceptability of interventions for people with LTCs. Psychological interventions may be more acceptable if offered as part of physical health care

[1] As per Journal's Notes for Authors

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Adapting Cognitive Behavioural Therapy Interventions for Anxiety or Depression to Meet the Needs of People with Long-term Physical Health Conditions: A Narrative Review.

Approximately 46% of people with a mental health condition have a co-morbid long-term physical health condition (LTC; Naylor et al., 2012). Co-morbidity may exacerbate the perceived severity of symptoms of both conditions, and increase distress and service use (Hiller & Fichter 2004; Yates et al., 2004). However, treatment typically only focuses on the LTC rather than the mental health condition (Department of Health [DH], 2012a; Turner & Kelly, 2000).

Mental health services are required to increase access to evidence-based psychological interventions for people with LTCs (e.g. DH, 2008, 2012b). However, people with LTCs face a number of barriers to accessing psychological interventions compared to the general population (DH, 2008). For example, the LTC may impact on the practical commitments of participation (Andrykowski & Manne, 2006; Coventry & Gellatly, 2008), or the contents of the intervention may be not be considered appropriate (Hind et al., 2010), which could increase attrition rates (Fitzpatrick, Simpson & Smith, 2010).

NICE (2009) guidance recommends low and high intensity cognitive-behaviour therapy (CBT) as delivered within a stepped care approach for people with LTCs: These should be adapted by considering duration, frequency and length of sessions, and by integrating the mental health care with physical health care.

However, there is limited evidence of effective psychological interventions in people with LTC's because co-morbid LTCs are typically an exclusion criterion in mental health

research (Creed, 1997; Harpole et al., 2005). For example, the NICE (2009) guidance, included only three studies of guided self-help in people with co-morbid LTCs, and these reported a moderate but non-significant effect: This finding was replicated in a meta-analysis examining the effectiveness of guided self-help specifically in individuals with LTCs (Farrand & Woodford, submitted). One hypothesis for these results is that the content of standard interventions are not appropriate for people with LTCs (Hind et al., 2010). Research suggests that it may be important to adapt CBT interventions to integrate both the physical and mental health condition in the formulation and treatment plan (Piette, Richardson, & Valenstein, 2004). For example, people with LTCs may have realistic illness-focused negative thoughts related to loss of role or abilities, therefore traditional cognitive restructuring approaches may need tailoring (Church, 1998; Cole & Vaughan, 2005; Hind et al., 2010).

In summary, there may be a need to consider the acceptability of psychological interventions for people with LTCs, in terms of content as well as practicalities around delivery. To date there has not been a synthesis of the evidence related to whether the types of adaptations should vary across different LTCs. This review used systematic search techniques with a narrative method (Pace, Thwaites, & Freeston, 2011) to synthesise the ways CBT interventions for anxiety and depression have been adapted for people with LTCs. This is an exploratory approach and does not seek to critically evaluate quality or effectiveness of studies (Andrykowski & Manne, 2006).

Aims

A systematic search of the literature was completed to address the following aims:

- To identify how CBT interventions for anxiety and depression have been adapted for people with LTCs
- To identify how adapted interventions vary across LTCs
- To identify ways to improve acceptability of adapted interventions for people with LTCs.

Method

Search Strategy

Medline, EMBASE, PsychINFO, CINAHL and ISI Web of Science were searched from 1966 to October 2012. The search strategy was developed based on familiarisation with the literature and thesaurus searches of alternative keywords (Appendix B). A search to identify CBT interventions for anxiety and depression was conducted and combined with key terms for identifying adaptations. These results were combined with the search strategy for LTCs. The search was limited to articles published in English.

Study Selection

Titles and abstract were independently reviewed for potential relevance. To improve reliability, a co-researcher also screened 100 titles, and 120 of the retained paper's abstracts. Disagreements were discussed to guide later decision making, the paper was retained if consensus was not achieved. Relevant references within included papers and excluded systematic reviews were followed up.

Participants were required to be aged over 18, with clinical anxiety and/or depression with a co-morbid LTC: Studies were required to report use of a standardised screening

instrument for assessment of clinical depression and/or anxiety. All clinical and non-clinical settings were eligible.

The review was restricted to non-communicable diseases, which are the leading cause of death in the world (WHO, 2011). It was decided to exclude conditions that may be identified under the term of "medically unexplained symptoms" as these symptoms may reflect more of a functional rather than organic basis.

There were no methodological restrictions. Articles were required to report the details of either an implemented or planned protocol of an adapted CBT intervention for anxiety or depression in people with LTCs. Articles were excluded where there was insufficient information about the adaptations made, and where the primary aim was to prevent rather than treat psychological difficulties, or to manage symptoms of the LTC. Qualitative studies that explored the acceptability of the interventions were also retained.

Data Analysis

A narrative synthesis was used to summarise and integrate the information related to adaptations to practice.

Results

A total of 3569 unique titles were identified (See Appendix C). One hundred and sixty eight full articles were screened for eligibility. Fifty seven articles are included in this review (Appendix D; Details of excluded studies are reported in Appendix E).

Study Characteristics.

All studies focused on reduction in symptoms of depression, with or without anxiety. Only one study focussed on clinical anxiety alone (Eiser, West, Evans, Jeffers, & Quirk, 1997).

Most studies recruited participants from physical health care settings: A few studies were conducted by psychological services within medical settings (e.g. Greer, Moorey & Baruch, 1991; Scholey & Woods, 2003). No studies were conducted within mental health services.

Information about the adapted interventions are reported in Appendix D.2. Three interventions used computerised CBT (cCBT). Twenty-nine studies delivered CBT individually either face-to-face (n=20), by telephone (n=4), or through a combination of both. In the EnRICHD trial (e.g. The ENRICHD investigators, 2001) participants initially received face-to-face sessions with a choice of continuing with face-to-face or group option. Ten interventions, one of which also offered in between telephone contact, were delivered through groups. Groups may confer additional benefits for people with LTCs through decreasing isolation and allowing comparison to others (Bottomley, 1998).

Intensity of interventions varied. Interventions typically ranged between eight to twelve sessions. Group length varied from 1-2.5 hours (mode= two hours): Individual sessions lasted 50 to 60 minutes.

Relevance of CBT techniques for people with LTCs

Cognitive techniques. A range of cognitive techniques were reported including thought monitoring, thought stopping, cognitive restructuring coping self-statements and cognitive reattribution. Adjuvant Psychotherapy (Moorey & Greer, 1989) which has a specific focus on understanding the patient's attributions about their cancer, and their coping styles was used in five studies (Bottomley, 1998; Bottomley, Hunton, Roberts, Jones & Bradley, 1997; Greer et al., 1991; Greer et al., 1992; Moorey et al., 1998). Focusing on overcoming unhelpful or inaccurate illness attributions is helpful because these can lead to excessive disability and greater depressive symptoms (Dobkin, Allen & Menza, 2007). Participants reported that learning cognitive restructuring skills was particularly helpful (Beatty & Koczwara, 2010),

Behavioural techniques. A number of studies focused on the need to either engage the person in previously valued activities, or to focus on new areas of life that are not affected by the LTC (e.g Hind et al., 2010; Hopko et al., 2008; Vriezekolk et al., 2012). Behavioural approaches aimed to overcome avoidance or increase pleasurable activities (e.g. Stanley, Veazey, Hopko, Diefenbach, & Kunik, 2005). Behavioural activation may be particularly relevant for people with LTCs who may have initially withdrawn from or avoid activities due to the impact of their LTC (Hopko et al., 2008). Fear-based imaginal exposure (Stanley et al., 2005) was also used to practise coping with events; this may benefit those who avoid situations due to fears about exacerbating symptoms. Interviews found that participants in a cancer group perceived active behavioural components to be beneficial (Bottomley, 1998).

Relaxation was used in a number of studies (n=20) as a coping skill to reduce stressors and symptoms which may relate to both physical and mental health conditions. It may also address somatic complaints and sleep disturbances (Dobkin, Allen, & Menza, 2006).

***Problem solving*.** Problem solving was applied in 22 interventions and was considered the main CBT technique within seven interventions (e.g. Nezu, Nezu, Felgoise, McClure, & Houts., 2003.). Problem solving provided a structure for people to engage with activities or overcome their own specific problems typically related to the impact of the LTC (Nezu, et al., 2003).

How have CBT interventions been adapted?

Resources. To increase relevance, a number of interventions were supported by written information developed for the specific LTC, which included examples of people with that LTC (e.g. Cully, Paukert, Falco, & Stanley, 2009). Many of these were adapted from manuals developed for older adults, due to the higher prevalence of LTCs in older adults (e.g. Boeschoton et al., 2012). One self-help manual, tailored to coping with depression and the LTC, was used across COPD and Diabetes Mellitus (Horn et al., 2007) suggesting that it may be possible to use self-help material which generalises across LTCs.

Integration of physical and emotional difficulties. Depression and anxiety were typically viewed as a reaction to the LTC. When supporting people with LTCs, a common theme was to deliver an initial session teaching how thoughts, behaviours and mood interact with the LTC (e.g. Cully et al., 2009; Kunik et al., 2001; Stanley et al., 2005). Van Eijk and colleagues (2004) argued that it is necessary to explore with the patient how the LTC

contributes to changes in personal and social function as part of the intervention for mental health problems.

Participants were supported to distinguish between complaints related to the LTC and those related to the emotional and behavioural consequences of the LTC (Hyninnen, Bjerke, Pallesen, Bakke, & Nordhus, 2010; Lamers et al. 2006; van Eijk et al., 2004). A guiding principle was to highlight the excess disability caused by depression or anxiety, which was reversible, and to emphasise rebuilding valued roles and activities (e.g. Dobkin et al., 2007; Hopko et al. 2008; Scholey & Woods, 2003).

A number of studies integrated CBT techniques for self-managing the LTC as part of the intervention (e.g. Cully et al. 2009; Piette et al., 2011; van Bastelaar et al., 2008). Alternatively, there may be benefits in delivering separate self-management interventions alongside the psychological interventions as part of a multidisciplinary intervention (Horn et al., 2007; Kootker, Fasotti, Rasquin, van, & Geurts, 2012; Korstjens et al., 2011).

Format of delivery.

Flexibility of contacts. A qualitative exploration of MS patients who used standard cCBT interventions highlighted that their physical condition made it difficult to attend one-hour sessions (Hind et al., 2010). Participants benefit from a flexible intervention approach in order to respond to patient need, for example in response to crises or burden of fluctuating symptom (The Enrichd Investigators 2001; Stanley et al., 2005).

Adaptations to delivery included number of sessions, session length, and amount of content covered per session (Hyninnen et al.2010; Dobkin et al., 2006). For example, the EnRichd study designed the intervention to reduce participation burden by adjusting the pacing of treatment goals and homework and through shorter and more frequent sessions

(The Enrichd Investigators, 2001). Most interventions offered weekly appointments, with some allowing for greater contact depending on need. Alternatively, van Eijk and colleagues (2004) spaced sessions 2-3 weeks apart to enable session content to be applied in everyday life.

Telephone delivery was used to overcome barriers to attendance resulting from the LTC (e.g. Boeschoton et al., 2012; Mohr et al. 2005; Steel, Nadaeu, Olek, & Carr, 2007), or practical considerations around how to deliver increased access to care in an applied setting (Mohr et al., 2005; Piette et al., 2011).A few studies were also delivered face to face in people's homes (The Enrichd Investigators, 2000; Lamers et al., 2006). Users of an online intervention valued that it could be followed from home and offered flexibility around participation (Van Bastelaar, Pouwer, Cuipers, Twisk, & Snoek, 2008).

Enhancing use of social support. Intervention outcomes may be enhanced by including the person's significant others within the sessions, and engaging them as a co-therapist (e.g. Dobkin et al. 2006; Nezu et al., 2003; Rasquin, Van de Sande, Praamstra, & van Heugten., 2009). Utilising the support system around the person can increase coping with the condition, help monitor realistic expectations, and enhance acquisition and application of learned techniques in everyday life (Dobkin et al. 2006, 2007; Nezu et al., 2003).

To What Extent Have Adaptations to Interventions Varied Across LTCs?

Studies tended to be condition specific, although some did consider generalisability. For example Lamers and colleagues (2006) recognised the need to examine whether an adapted intervention could be generic across conditions: They included participants with Diabetes Mellitus a gradual progressive condition compared to COPD, a gradual relapsing

condition. Relevant guidance for adapting practice could be based on whether the LTC has a physical and/or cognitive impact.

Physical impact.

***Burden*.** It may be necessary to consider the safety of behavioural interventions (Freedland et al., 2007), for example checking with the medical professionals that behavioural activation is safe for the person.

***Modifying expectations*.** People with LTC's may no longer be able to manage previously enjoyed activities or function as independently. Adjusting expectations of the self, or modifying activities was identified as a key component due to physical limitations or to avoid worsening of LTC symptoms (e.g. Heslop, Baker, Stenton, & Burn, 2009; Stanley et al., 2005). Pacing of activities which provide pleasure and accomplishment may need to be modified to emphasise completing activities when able and minimising intensive activities when the LTC fluctuates (Dobkin et al., 2007; Stanley et al. 2005).

Flexible coping strategies. Hopko and colleagues (Hopko & Colman, 2010; Hopko et al., 2008) included an acceptance based philosophy (Hayes, Strosahl & Wilson, 1999) to reengage people in values and valued goals. Restructuring can be applied to thoughts and behaviour which can be modified, with acceptance of aspects that cannot (Hopko et al.2008; Vriezekolk et al. 2012). The idea of acceptance versus change may be particularly important to promote successful reengagement in activities when working with certain LTCs, for example with progressive conditions (Beatty & Koczwara, 2010) or fluctuating conditions (Vriezekolk et al., 2012).

Cognitive impairments.

Delivery considerations. Working with certain neurological conditions requires the practitioner to consider adaptations around cognitive deficits, for example, with stroke (Lincoln et al., 1997, Rasquin et al., 2009), dementia (Scholey & Woods, 2003) and Parkinson's Disease (Feeney Egan, & Gasson., 2005). Where there are cognitive deficits, the therapist may need to take a more active role to overcome memory problems (Scholey & Woods, 2003); present the information in a structured format with less or simplified information. (Rasquin et al., 2009; Lnicoln et al, 1997; Kootker et al., 2012); regularly review content and elicit summaries (Feeney et al., 2005; Scholey & Woods, 2003); and include a significant others to enlist their co-operation (Dobkin et al., 2006).

Intervention techniques. For patients with moderate to severe cognitive impairments, the focus may shift from the process of challenging cognitions to less cognitively demanding strategies, such as relaxation (Dobkin et al., 2007) or writing coping statement that can be readily used (Scholey & Woods, 2003).

Informing Acceptability of Interventions.

As described above, a common approach used to meet the needs of the study population was to integrate an information session on the interaction between the particular LTC and thoughts, feelings, behaviours. Specific LTC focused texts were also used to support the interventions.

A number of studies reported the use of the Client Satisfaction Questionnaire (CSQ; Larsen, Attkisson, Hargreaves, & Nguyen, 1979) as a measure of intervention satisfaction (e.g. Cully et al., 2009; Hyninninen et al., 2010; Hopko et al. 2008, Kunik et al., 2001).

However this measure provides limited information about what types of adaptations are seen as necessary and acceptable.

The social support element of groups may be particularly valuable to people with LTCs. An exploration of acceptability of a work-book based group intervention revealed that participants with cancer reported that the social opportunity to communicate with other cancer patients was particularly beneficial (Beatty & Koczwara, 2010). Social support enabled participants to observe similar experiences and problems in others; this helped them learn that they were not alone and decreased perceived isolation (Fitzpatrick, et al., 2010; Vriezekolk et al., 2012). Within cCBT interventions, patient videos for sharing stories and skills were seen as a key part for increasing acceptability and meeting this social comparison need (van Bastellaar, Cuijpers, Pouwer, Riper, & Snoek, 2010).

Participants with multiple sclerosis (MS) who used standard cCBT felt that the content did not legitimise their grief over losses resulting from their MS, and perceived that one of the packages used inappropriate case material for people with MS (Hind et al., 2010). One strategy for improving acceptability involves the inclusion of people with LTCs in the development of the intervention, for example to advise on components that are considered inappropriate, in need of improving, or missing (van Bastellaar et al., 2008). However, few studies reported how the contents of the interventions were developed, or explored the acceptability of interventions.

Another strategy for improving personal relevance of the intervention was by providing participants the choice of whether to focus on developing coping skills for self-managing the LTC or for addressing the mental health problem, for example cognitive restructuring (Cully et al., 2009). Patient choice was also promoted by negotiating the amount

of time to spend on topics, length of session, and whether these were supported in person or over phone (Cully et al. 2009).

Willingness of therapists to focus on physical as well as mental health concerns appears to alleviate patient concerns about receiving mental health treatment (Cully et al. 2009). Alternatively, barriers to attending mental health services may be overcome by integrating psychological therapies' within normal outpatient care (Heslop et al. 2009). Embedding psychological interventions in primary-care services may be beneficial because nurses have experience working with LTCs, and patients are used to visiting these setting for management of their LTC (van Eijk et al., 2004). Training of physical health-care professionals, for example nurses, to deliver brief interventions may be a feasible solution to services (Lamers et al., 2006) because the dual training enables them to distinguish psychological from physical symptoms and to direct treatment as appropriate (Heslop et al., 2009).

Discussion

It is important that psychological practitioners understand how to adapt practice to a wide variety of LTCs conditions because the prevalence of people with LTCs, particularly those with three or more LTCs, is predicted to increase (DH, 2012b; Uijen & van de Lisdonk, 2008). Adapting interventions to include how the physical and psychological conditions interact may provide a more acceptable fit for people with LTCs (Cully et al., 2009).

The review sets out a number of considerations around how to adapt CBT interventions to meet the needs of people with LTCs. Decisions about what to adapt may be informed by whether the LTC has a cognitive or physical impact. Considerations about how

to overcome barriers related to attendance, and implementation of intervention techniques are discussed. Appropriate modifications include location and setting of sessions, the way strategies are presented and implemented, and flexibility due to fluctuations in the LTC (White, 2000).

A key adaptation relates to helping people to understand the link between their LTC and mood. A number of included studies recognised how the attributions a person makes about their LTC can lead to excess disability (Dobkin et al., 2006; Savard et al., 2006). Adapting practice may include helping the person to modify inaccurate illness related beliefs, and to adjust expectations of their abilities in response to their LTC, particularly with fluctuating LTCs (Dobkin et al., 2006; Savard et al., 2006; Stanley et al., 2005).

Social support, either through involvement in a group or by including a significant other in the intervention, was often a key component of the intervention (Beatty & Koczwara, 2010; Dobkin et al., 2006). It would be important to consider how this need would be addressed when people with LTCs are supported one-to-one, particularly where there is minimal contact with the supporting professional (Hind et al., 2010).

The review identified that embedding psychological interventions within physical health services, and offering choice around whether to focus on physical or emotion management may confer additional benefits for people with LTCs. It is suggested that professionals with dual training may be better able to identify excess disability related to psychological not physical symptoms (Heslop et al., 2009).

Limitations

A number of studies were excluded because the intervention focused on prevention not treatment, or was applied in populations that did not have clinical anxiety or depression. Furthermore, the search strategy aimed to identify only articles that explicitly cited reasons for their adaptations to the intervention either in terms of acceptability, content or delivery, therefore this review does not cover all CBT interventions applied to people with LTCs. The inclusion of these studies may have offered further recommendations for adaptations

Implications

The majority of research has been carried in physical health rather than mental health settings. However, "No Health without Mental Health" calls upon the Improving Access to Psychological Therapies (IAPT) services to respond to the gap in service provision. This review provides information to inform clinicians about relevant adaptations. However, therapists need the skills to address the experience of living with a LTC whilst delivering the essential components of CBT (White, 2000). This may pose particular challenges to the professional in the mental health settings without experience working with LTCs. An area for further research is to explore whether people with LTCs, and the professionals who support them in mental health services, perceive adapted CBT interventions to be acceptable (Lewis, Pearce, & Bisson, 2012).

It was not possible to present condition specific recommendations based on the number of studies retained. Research is needed to investigate whether it is possible to develop a generic adapted approach for working with a variety of LTCs. Low-intensity psychological interventions such as guided self-help interventions typically involve minimal therapist

contact (Gellatly et al., 2007), and may be particularly relevant for people with LTCs due to their flexibility around delivery which increases their accessibility (NICE, 2009). The review found little research into the use of low-intensity interventions with LTCs, and where written information was provided, this tended to be adapted for a specific LTC. No studies have attempted to use adapted self-help across a variety of LTCs. Other than Hind and colleagues' study (2010), no attempt has been made to investigate the use of standard self-help with people with LTCs.

Conclusion

This review summarises adaptations to practice that may be relevant to mental health professionals supporting people with LTCs. Participants were typically recruited from medical settings, with the interventions applied to a specific LTC. There is a gap in the literature about how to adapt practice within mental health settings. Research is needed to determine whether a generic intervention or framework could be applied within mental health services, such as IAPT, to guide practitioners who may encounter a variety of LTCs. Furthermore, there is a need to consider whether delivering psychological interventions within mental health services is acceptable to people with LTCs.

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Appendix A: Notes for Authors

Source: Clinical Psychology Review (n.d). *Guide for Authors*. Retrieved from http://www.elsevier.com/journals/clinical-psychology-review/0272-7358/guide-for-authors

-  **Preparation**

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Appendix B: Medline Search Strategy*

Table 1.

Search Strategy

Population[3]	Intervention	Study limiters
1. ("Long term" OR longterm OR long-term OR ongoing OR "on-going" OR "on going" OR mild OR moderate OR severe OR chronic OR persistent).ti,ab 2. ((condition* OR disease* OR illness OR illnesses OR problem OR problems OR pain OR disorder)).ti,ab 3. (1 ADJ3 2).ti,ab 4. ("physical-problem" OR "health-problem" OR "medical-problem").ti,ab 5. CHRONIC PAIN/ 6. CHRONIC DISEASE/ OR PULMONARY DISEASE, CHRONIC OBSTRUCTIVE/ OR INFLAMMATORY BOWEL DISEASES/ 7. (("cerebrovascular-accident" OR stroke OR "myocardial-ischemia" OR "coronary disease"	17. (((individuali?e OR individuali?ed OR adjust OR adjusted OR adjustment OR adjusting OR alter OR altered OR alteration OR amend OR amendable OR amended OR amendment OR tailor OR tailorable OR tailored OR personal OR personalised OR personalized OR change OR changed))).ti,ab	27. (Humans[Mesh] 28. English[lang]))

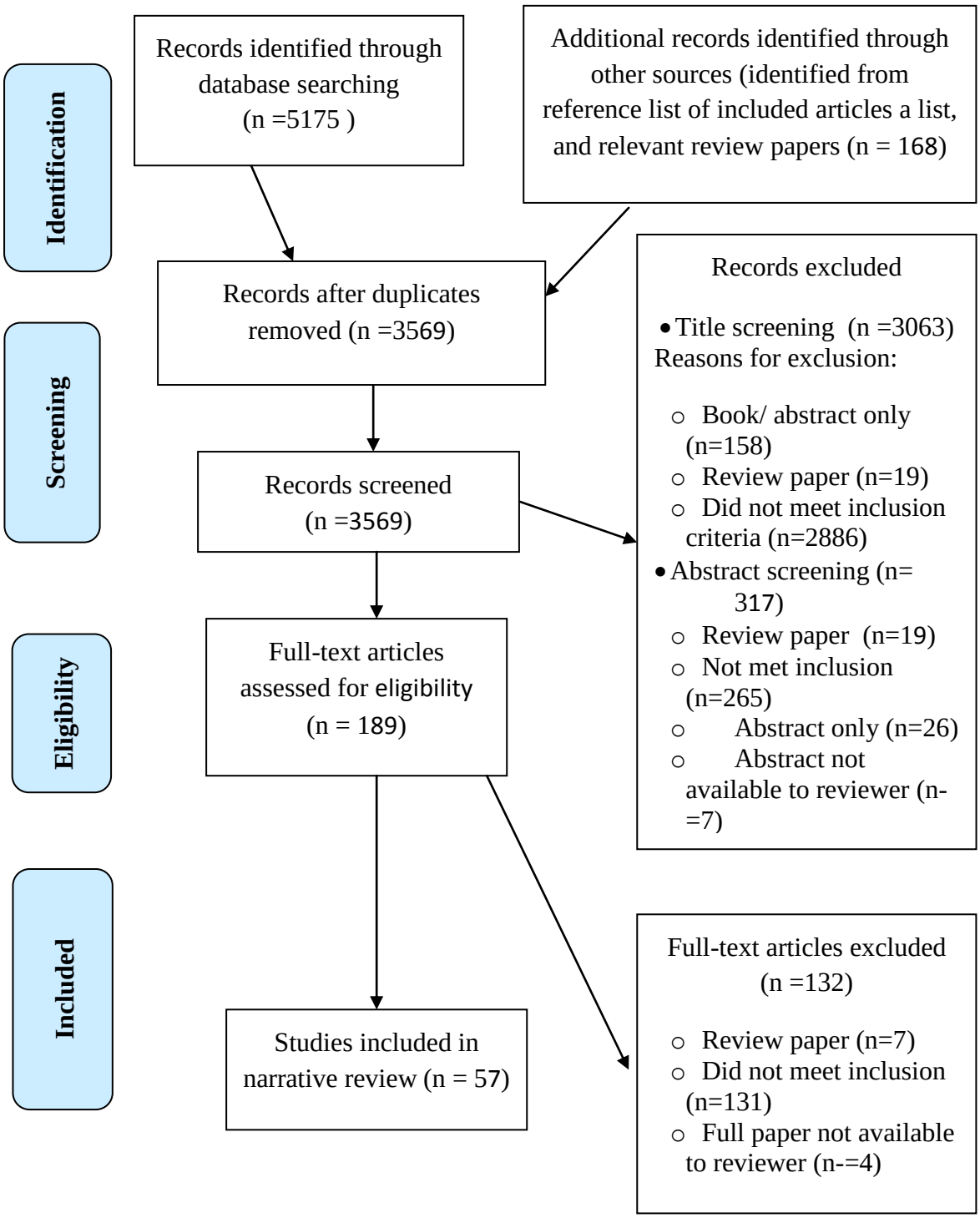
[3] Review was restricted to non-communicable disease after the search strategy

Population[3]	Intervention	Study limiters
OR hypertension OR diabetes OR diabetic OR diabetes-mellitus OR arthritic OR arthritis OR rheumatic OR rheumatism OR rheumatoid OR osteoporosis OR fibromyalgia OR asthma OR asthmatic OR "chronic obstructive pulmonary disease" OR "COPD" OR emphysema OR "degenerative disease" OR neurodegenerative OR "chronic fatigue syndrome" OR menorrhagia OR endometriosis OR "irritable bowel syndrome" OR HIV OR neoplasm OR "congestive heart failure" OR cancer*)).ti,ab 8. 3 OR 4 OR 5 OR 6 OR 7		
9. ((depression OR depressed OR dysphoria OR dysthymia OR dysthymic OR "dysthymic disorder" OR anxiety OR anxiousness OR anxieties OR anxious OR panic OR phobia OR phobic OR fear OR worry OR worries OR agoraphobia OR	29. ("anxiety management" OR "behaviour modification" OR "behavior modification" OR psychoeducation* OR psycho-education* OR self-help OR self-manage* OR self-care OR selfhelp OR selfcare OR selfmanage OR bibliotherapy	

Population[3]	Intervention	Study limiters
agoraphopic OR melanchol* OR "low mood" OR "obsessivecompulsive" OR "obsessive-compulsive")).ti,ab 10. (((obsessive OR obsessional) AND (personality OR personalities OR compulsive OR compulsion))).ti,ab 11. DEPRESSION/ 12. DYSTHYMIC DISORDER/ 13. ANXIETY/ OR SOCIAL ANXIETY DISORDERS/ OR ANXIETY DISORDERS/ OR GENERALIZED ANXIETY DISORDER/ 14. DEPRESSIVE DISORDER/ OR DEPRESSIVE DISORDER, MAJOR/ OR DEPRESSIVE DISORDER, TREATMENT-RESISTANT/ 15. 9 OR 10 OR 11 OR 12 OR 13 OR 14	OR manual OR manualise* OR manualize* OR booklet OR "written material").ti,ab 30. (cognitive OR behaviour* OR behavior* OR cognitivebehavio?r* OR cognitive-behavio?r*).ti,ab 31. (therapy OR therapies OR psychotherapy OR psychotherapies).ti,ab 32. "CBT".ti,ab 33. COGNITIVE THERAPY/ 34. BEHAVIOR THERAPY/ 35. 17 OR 20 OR 21 OR 22 OR 23	
16. 8 AND 15	36. 17 AND 24	
	37. 16 AND 25	29. 26 AND 27 AND 28

- Search strategy was adapted for other databases.

Appendix C. Flow Diagram of Screening Process



Source: Adapted from Moher , Liberati, Tetzlaff, Altman, & The PRISMA Group (2009)

Appendix D Details of included studies

Appendix D.1: Studies Included in the Analysis

Table 2.

Study details

Paper	**LTC[a]**	**Mood disorder[b]**	**Diagnostic measure/s[c]**	**Recruitment[d]**	**Intervention Design**	**Intervention group[e]**
Beatty & Koczwara (2010)	Breasr Cancer	A/ D	DASS-21	Clinical	Case series	n= 5 (3 with A, 3 with D) F=5 Age= range 45-63
Bottomley 1998) & Bottomley, Hunton, Robers, Jones, & Bradley, 1997)	Mixed Cancer	A/ D	HADS	Clinical	Non-RCT	n=9 F=9 Age=50.5(11 .4)
Boeschoten et al. (2012)	MS	A/D	BDI-II CIDI HADS	Clinical	Pilot study (before-and after)	n=44 F=34, M=10 Age 45
Chambers et al. 2009)	Cancer	A/D	BSI-18	Non-clinical	RCT	n=140 (protocol)
Cully et al. (2009)	Congestive Heart Failure and/or chronic obstructive pulmonary disease (COPD)	A/D	BDI-II STAI	Clinical	Case series	N=3 M=3 Ages 61, 62 & 78
Cully et al. (2010) Adjusting to Chronic Conditions Using Education, Support, and Skills (ACCESS)	Congestive Heart Failure &/ COPD	A/D	BDI-II STAI	Clinical	Before and After study	n=23 M=22), F=1 Age=71.44 (8.23)
Davidson et al. (2010) COPES trial	Acute coronary syndrome	D	BDI	Clinical	RCT	n=80 F=43, M=37 Age 59.3 (10.6)
Dobkin, Allen & Menza (2006)	PD	D	Met DSM-IV criteria (not stated how assessed)	Not specified	Before and After study	n=3 M=2, F=1 Age 52, 60, 76

Paper	**LTC[a]**	**Mood disorder[b]**	**Diagnostic measure/s[c]**	**Recruitment[d]**	**Intervention Design**	**Intervention group[e]**
Dobkin et al. (2007)	PD	D	Met DSM-IV criteria (not stated how assessed	Clinical	Before and After study	n=15 M=7, F=8 Age 48-78
Eiser, West, Evans, Jeffers, & Quirk (1997)	COPD	A	HADS	Clinical	case-control study	n=12 M= 4, F= 8 Age= 73 (range 60-80)
ENRICHD Trial (Berkman et al., 2003; Carney et al., 2994; ENRICHD 2000, 2001; Saab et al., 2009)	MI	D	DISH	Clinical	RCT	n=781 Face-to-face therapy only, F= 348, M=433 Age= 61.3 n=356 group plus Face-to-face Therapy F=138, M=218 Age=58.7
Feeney et al., (2005)	PD	A/D	BDI-II MINI	Non-clinical	Before and After study	n=4 M=2, F=2 Age= 44-81
Fitzpatrick et al. (2010)	PD	A/D	DASS-21	Non-clinical	Qualitative IPA study	n=12 (9 with clinical levels) M=7, F=5 66.3 (7.3)
Freedland et al. (2009).	Coronary artery bypass	D	DISH	Clinical	RCT	n=41 F=23. M= 18 Age= 62(11)
Greer, et al.(1992)	Mixed cancer	A/ D	HADS	Clinical	RCT	n=72 F=52. M=51 Age= 51(13.6)
Greer, Moorey & Baruch,. 1991	Mixed cancer	A/ D	HADS	Clinical	Before and After study	n=44 M=14, F=30 Age 47.9 (range 17-77)
Heslop et al. (2009)	COPD	A,D	HADS	Clinical	Before and After study	n=10 M=5, F=5 Age=68

Paper	**LTC**[a]	**Mood disorder**[b]	**Diagnostic measure/s**[c]	**Recruitment**[d]	**Intervention Design**	**Intervention group**[e]
						(range 57–80).
Hind et al. (2010)	MS	D	BDI	Clinical	Qualitative Framework analysis	Beating the Blues (n=8_ M=2, F=6 43 (range 30–61) MoodGym (n=9) M=2, F=7 47 (range 36–51)
Hopko et al. (2011)	Breast cancer	A/D	HANDS ADIS-IV HRSD BDI-II BAI CES-D	Clinical	RCT	N=80 F=80 BA n=42 Age=56.4 (11.1) PS n=38 Age= 54.3 (11.2)
Hopko et al. (2008)	Mixed Cancer	D	ADIS-IV HRSD BDI-II BAI	Clinical	Before and After study	n=13 F=11, M=2 Age=52.2 (10.9)
Hopko & Colman (2010)	Breast cancer	D, A	ADIS-IV HRSD BDI-II BAI	Clinical	Case series	n=2 F=2 Age- 31 and 66
Horn et al. (2007)	Cardiovascular disease (diabetes mellitus, COPD,)	D	PHQ-9; MINI	Clinical	RCT	Approx. n=126 Protocol
Hyninnen et al. (2010)	COPD	A/ D	BDI-II, BAI, SCID	Clinical	RCT	n=25 M=14, F=11 Age 59.3 (7.6)
Kootker, Fasotti, Rasquin, van, & Geurts (2012	Stroke	D	HADS	Clinical (Rehabilitation setting Self-referral)	RCT	N/A (proposal)

Paper	**LTC[a]**	**Mood disorder[b]**	**Diagnostic measure/s[c]**	**Recruitment[d]**	**Intervention Design**	**Intervention group[e]**
Korstjens et al., 2011	Cancer (mixed)	A/D	HADS	Clinical	RCT	n=76 F=66, M=10 Age= 47.8 (10.5)
Kunik et al., 2001	COPD	A	GDS BAI	Clinical and non-clinical	RCT	n=21 M= 83% of total sample N=48) Age= 71.3(5.9)
Lamers et al., (2006)	Diabetes Mellitus (DM) type II COPD	D	PHQ-9 MINI HRDS	Clinical	RCT	DM: n = 184; COPD: n = 177) Not stated
Lincoln et al., (1997)	Stroke	D	BDI HADS	Clinical	Single case experimental design	n=19 M=8, F=11 Age=67.1 (13.8)
Lustman et al., 1998a; Lustman et al., 1998b)	Diabetes Mellitus type II	D	BDI	Clinical & Non-clinical	RCT	n=20 F=12, M= 8 Age 53.1(10.5)
Mohr, Boudewyn, Goodkin & Epstein., (2001) & Mohr, Hart, & Goldberg (2003);	MS	D	BDI	Clinical & non-clinical	RCT	n=22 F=43, M= 17(of total sample) Age=44.6(10 .3)
Mohr et al., (2000)	MS	D	SCL—90 HDRS SCID	Clinical	RCT	n=16 F= 10 ,M=6 Age= 42.6)12.8)
Mohr et al. (2005; also described in Beckner, Vella, Howard & Mohr, 2007)	MS	D	SCID HDRS BDI-II	Clinical & Non-clinical		N=62 Age 48.6 (9.2) F=47, M=15
Moorey et al., (2009)	Cancers	A/D	HADS	Clinical	RCT	n=45, Age 65(12.6)
Adjuvant Psychological Therapy	Cancers	A/D	HADS	Clinical	RCT	n= 25 F=35, M-=12 (of total

Paper	**LTC[a]**	**Mood disorder[b]**	**Diagnostic measure/s[c]**	**Recruitment[d]**	**Intervention Design**	**Intervention group[e]**
Moorey et al. (1998)						sample) Age= 51 (13.45)
Nezu, Nexu, Felgoise, McClure, & Houts., 2003	Cancers	D	BSI HRSD	Clinical	RCT	n=45 (PS) F= 30, M=15 Age= 49.18 n=43 (PS with SS) F= 27Age=45.8 1
Petrak et al. (2010)	Diabetes Mellitus type II	D	PHQ-9 SCID	Clinical	RCT	Age= range 65-85 (Study protocol)
Piette et al. (2011)	Type II Diabetes Mellitus	D	PHQ-9 BDI	Clinical and non-clinical	RCT	n=145 Age 55.1(9.4) F=74, M=71
Rasquin, Van de Sande, Praamstra, & van Heugten (2009)	Stroke	D	SCL-90-R BDI-II	Clinical	Case series	n=5 F=4, M=1 Age= range39-54
Rhee et al. (2000)	RA	D	CES-D SCL-90-R AIMS	Clinical	RCT	N=47 Age=60 (median, total of sample)
Savard et al. (2006)	Breast cancer	D	HADS BDI SCID	Clinical	RCT	n= 21 F= 21 Age= 51.47 (8.05)
Scholey & Woods (2003)	Dementia	D	GDS	Clinical	Case series	n=7 Age= 57-83 F=4, M=3
Serfaty et al. (2010)	Cancers	A,D	HADS	Clinical	RCT	N=19 Age 54(11.3) M=1, F= 18
Sharplin et al., (2010)	Cancers	A/ D	BDI-II STAI	Non-clinical	Prospective Before and After study	n=25 F=22, M=3 Age=

Paper	**LTC**[a]	**Mood disorder**[b]	**Diagnostic measure/s**[c]	**Recruitment**[d]	**Intervention Design**	**Intervention group**[e]
						52(10.2)
CBT-RADAR Stanley et al., (2005)	COPD	A/ D	BAI BDI-II SCID	Clinical	Case series form RCT	n=5 (2 did not meet clinical criteria) M=5 Age= range 54-80
Steel et al., (2007)	Hepatobiliary Cancer	A/ D	CES-D STAI	Clinical	RCT	n=6 F= 2, M=4 Age= 58 (range 39-84)
Van Bastelaar et al. (2008; 2010)	Diabetes mellitus II	D	CES-D CIDI	Clinical & non-clinical	RCT	n=255 F=155, M=100 Age= 50(12)
Van Eijk et al. (2004)	Tyoe II diabetes Mellitu COPDs	D	PHQ-9 MINI HRSD	Clinical	Before and After study	n= 27 (diabetes =15, COPD=7) F=16, M=11 Age= >60
Vriezekolk et al., (2012)	Rheumatic disease	A/ D	IRGL	Clinical	Before and After study	n=25 (no further details)

[a] A= Anxiety, D= Depression

[b] Diagnostic measures: ADIS-IV= Anxiety Disorders Interview Schedule–IV1 (Brown, Di Nardo, & Barlow, 1994); AIMS = Arthritis Impact Measurement Scales (Meenan, Gertman, Mason &, Dunaif, 1982); BAI= The Beck Anxiety Inventory (Beck & Steer,1993); BDI= Beck Depression Inventory (Beck, Ward, Mendelson , Mock, & Erbaugh, 1961); BDI-II= Beck Depression Inventroy-II (Beck, Steer & Brown, 1996); BSI= Brief Symptom Inventory (Derogatis, 1993); BSI-18= Brief Symptom Inventory (Derogatis, 2000); CES-D= The Center for Epidemiological Studies of Depression Scale (Radloff, 1977); CIDI= Composite International Diagnostic Interview (WHO, 1990) ; DASS-21= Depression Anxiety and Stress Scales (Lovibond & Lovibond, 1995); DISH= Diagnostic Interview and Structured Hamilton protocol (Hamilton et al., 2002);GDS= Geriatric Depression Scale (Stiles, & McGarrahan, 1998); HADS= Hospital Anxiety and Depression scale. (Zigmond &

Snaith, 1983); HRSD= Hamilton Rating Scale for Depression (Hamilton, 1960); HANDS= Harvard National Depression Screening scale (Baer et al., 2000); IRGL= General Health and Lifestyle questionnaire (Huiskes, Kraaimaat, & Bijlsma, 1990); MINI= Mini International Neuropsychiatric Interview (Sheehan et al., 1998); PHQ-9= Patient Health Questionnaire-9 (Kroenke, Spitzer & Williams, 1998); SCID= Structured Clinical Interview based upon the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (First, Spitzer,Gibbon, & Williams, 1995); STAI = State-Trait Anxiety Inventory (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983); SCL-90-R =The Symptom Checklist-90–Revised (Derogotis, 1977)

[c] Clinical= e.g. recruited through physical health care settings; Non-clinical= e.g. advertisement, community recruitment, support services

[d] F= Female, M= Male. Unless stated, Mean age reported with Standard Deviation in brackets where available.

Appendix D.2: Adaptations to Included Studies

Table 3.

Adaptations to included studies.

Paper	CBT interventions [1]	Delivery Format	Number of sessions (weekly unless stated)	Length of sessions (mins)	Reason for inclusion	Contents	Delivery	Acceptability
Beatty & Koczwara (2010)	AT, CR, RP, RT Other	Group	10	120	Acceptability	Coping and acceptance Enhanced social support		
Bottomley 1998) & Bottomley, Hunton, Robers, Jones, & Bradley, 1997)	CR, RT, AS	Group	8	90	Content Acceptability	Booklets and leaflets written for cancer patients		
Boeschoten et al. (2012)	PS	cCBT	5	120	Content Acceptability	Provided information about LTC and its psychosocial consequences. Adjusted text and examples for LTC		Used Client Satisfactory Questionnaire (CSQ)
Chambers et al. 2009)	PS, CR, SS, Other	Telephone	5	60	Delivery Content Acceptability	Option of choosing to focus on LTC related topics (e.g. pain) If relevant.	Telephone delivery	Option of focusing on LTC
Cully et al. (2009) & Cully et al. (2010) ;	BA, CR, RT, PS	Face-to-face & Telephone	6 & 3 telephone booster calls.	Face-to-face= 50 Telephone = 10-15	Content Delivery Acceptability	LTC specific educational brochures Focused on LTC related issues	Telephone boosters Shorter sessions Also web-based	Choice of modules Used CSQ Stated interventions as feasible and

Adjusting to Chronic Conditions Using Education, Support, and Skills, [ACCESS]						.	resources Aimed to overcome potential barriers to care	acceptable by de-emphasising mental health and emphasising overall improvements e.g. quality of life
Davidson et al. (2010) COPES trial	PS	Face to face or Telephone	Weekly reviewed at 8 weeks (total not stated). Frequency adapted depending on progress and individual preference	30-45	Acceptability Delivery		Collaborative care Stepped care	Choice of treatment (PS or antidepressant) Satisfaction with care only significant compared to care as usual at 9 months
Dobkin et al. (2006)	RT, BA, SH, CR Other	Face-to-face	12- to 14-session (caregivers separate 3-4 sessions)	(Not stated)	Content Delivery	Focus on excess disability, with depression as reversible, increase contact with environmental reinforcers and modify expectations of self and abilities. Compensate for memory loss (see Delivery)	Fewer topics, simplified material, presented in different formats (written, oral, audiotape) Sessions with caregivers to reinforce skills	Reports patients and caregivers found intervention acceptable
Dobkin et al. (2007)	BA, SH, CR, RT, Other	Face-to-face	10-14 & separate 3-4 caregivers sessions (Reviewed after 8 weeks)	45-60min	Content Delivery	(As above in Dobkin et al., 2006) Emphasis on RT to address somatic symptoms, anxiety and sleep problems; sleep hygiene; and pacing when well Compensate for memory	As above (in Dobkin et al. (2006)	

						loss (see Delivery)		
Eiser et al., (1997)	RT Other	Group (n=5-6)	6	90	Content	Discussed physical symptoms and impact of LTC on quality of life. Explained link between anxiety and breathlessness		
ENRICHD Trial (Berkman et al., 2003; ENRICHD 2000, 2001; Saab et al., 2009)	BA, CR,PS, RP, RT Other SS, AT Other	Face-to-face & group	<6 months Group= 12 weeks Face-to-face median = 11	Individual = 60 Group= 120	Content And Delivery`	Focused on social context of problems; included focus on personal values and goals	Option of a group Delivered in clinic or patients home	
Feeney et al., (2005)	CR, RP	Group	8 & 1-month follow up,	60	Delivery		Adapted to allow less in-session writing	
Fitzpatrick et al. (2010)	Mindfulness Based Cognitive Therapy	Group	8	150	Acceptability	.		Instructed not to take part in exercises if not able Authors state positive results indicate acceptable intervention with Parkinson's disease
Freedland et al. (2009).	Stress management BA, PS, CR, RP	Face-to-face & Telephone contacts as needed	12	50-60	Delivery Content	Techniques modified for cardiac patients (not explained beyond ensuring medically safe)	Frequency adapted according to severity. Brief contacts between sessions	
Greer et al. 1991	PS, CR, BA, RT Other	Face-to-face	6	60	Content, delivery	CBT focus on recognising meaning and impact of LTC	Option of involving significant other	

And Greer et al., 1992 Adjuvant Psychological Therapy								
Heslop et al. (2009)	BA, CR, GS, RT Other	Face-to-face	*X*=4 (range 2–13).		Content Delivery	Emphasis on pacing and achievable goals	Brief 4 sessions focused on COPD issues of breathlessness and pacing Delivered by respiratory nurse with dual training	Suggest delivering in primary care overcomes stigma of attending mental health services
Hind et al. (2010)	Beating the Blues & MoodGym Packages (details not stated)	cCBT	Beating the Blues= 8 MoodGym= 5	60	Acceptability			Explored perceptions of acceptability of standard cCBT Considerations around adapt session length, need for human contact from a therapist to reduce isolation, help set goals and apply techniques. Content needs to acknowledge how LTC interacts with depression
Hopko et al. (2011)	BA intervention: (BA, Ex, RT, AT) OR PS	Face-to-face	8	60	Content	Information on understanding link between LTC and depression. Exposure to experience of diagnosis and life with the LTC Acceptance versus change emphasis throughout		

	intervention					intervention to change areas that can be controlled or modified.		
Hopko & Colman (2010)	CR, CS, RT, TS, Ex, PS, SH	Face-to-face	9	60	Content Acceptability	Focus on values and life goals Exposure to experience of diagnosis and life with the LTC		Used CSQ
Hopko et al. (2008)	BA, CS, CR, Ex, PS RT, SH,. TS, ,	Face-to-face	9	1hr	Content Acceptability	Focus on values and life goals Exposure to experience of diagnosis and life with the LTC Mindfulness relaxations		Used CSQ
Horn et al. (2007)	PS (Self-help book: RT, SH, CR Other)	Face-to-face	6-12x sessions over 22 weeks	60(initial) 30 (follow ups)	Content Delivery Acceptability	Self-help manual tailored to coping with depression and LTC. Included RT, exercise, dietary and SH because these problems are increased for people with LTCs	Multidisciplinary approach (MDT)	Choice of whether receive antidepressant
Hyninnen et al. (2010)	BA, CR, Ex, SH	Group (n=4-6)	7	120	Content Delivery	Information about link between mood, and excess disability. Focus on reducing excess disability	Cut number of sessions and components. Increased session length	
Kootker, Fasotti, Rasquin, van, & Geurts (2012)	BA, CR, GS, RP, RT	Face-to-face	13-16 sessions over 4 months.	60 (with 10-15 minute break)	Delivery Content	Discussed grief over losses	Improved communication techniques for population MDT to help achieve goals Concrete,	

							accessible support	
Korstjens et al., 2011	GS, PS, RT	Group (n=8-12)	12 Concurrent twice per week exercise	120	Content Delivery	Problem solving approach developed for cancer patients. Explored experiences of LTC	Integrated with physical rehabilitation.	
Kunik et al., 2001	CST, Ex, RT, ST,	Group (n=6-10) Weekly telephone support Workbooks Audiotapes	1 group session Follow up weekly telephone calls over 6 weeks	120	Content Delivery	Education about role of anxiety and depression in LTCs	Brief intervention Telephone support Workbooks and audiotapes	
Lamers et al., (2006)	PS, GS, Thought monitoring	Face-to-face	<10 sessions in <3months	(not stated)	Content Delivery Acceptability	Explores illness related cognitions and links illness to mood and behaviour. Address excess disability	Delivered at home Minimal contact	Evaluation of satisfaction was high
Lincoln et al., (1997)	AS, BE, CR Other	Face-to-face	<10 sessions in 3 months	Not stated	Delivery		States adapted to take account of stroke, e.g. print size of diaries	
Lustman et al., 1998a; Lustman et al., 1998b)	BA, PS, CR	Face-to-face	10	1hr	Delivery		Delivered alongside a condition self-care education program	
Mohr, Hart, & Goldberg (2003); Mohr et al., 2001)	Not specified (see Mohr et al., 2000)	Face-to-face	16	50 min	Delivery Content	(see Mohr et al. 2000)	Delivered alongside LTC management skills	
Mohr et al., (2000)	AS, CR, GS, Other.	Telephone	8	50mins	Content Delivery	Supported with a workbook based on adapted manualised model for use with older adults to	Adapted manual to include visual aids, improved structure, remind	

						increase suitability: Optional modules	participants of topics covered Telephone to overcome barriers	
Mohr et al. (2005; also reported in Beckner, et al., 2007)	CR, BA. PS	Telephone	16	50 min	Delivery	(see Mohr et al., 2000)	(see Mohr et al., 2000)	
Moorey et al., (2009)	Description of staff training	Face-to-face	*X* =5.7		Content Delivery	Based on cancer specific book.	Trained palliative care professionals to deliver as part of hospice care	
Moorey et al. (1998)	PS	Face-to-face	*X* =10 (4-16, < 4 months	(not stated)	Content	Adjuvant psychological Therapy developed specifically for cancer	Option of sessions with significant other	
Nezu et al., 2003	PS	Face-to-face or	10 Sessions (*X* =12-13 weeks)	90	Content Delivery	Problem solving self-help manual specific for LTC.	Significant other acts as co-therapist and provides social support. Therapist individualises the approach	
Petrak et al. (2010)	PS, BA, CR Thought control Increase physical activity Social skills	Group (n=4-8)	12 weeks, followed by monthly for a year.	120	Content	Workbook specific for LTC, based on text for older adults with type 2 diabetes. Supported		
Piette et al. (2011)	Not described	Telephone	12 (Followed by 9	(not stated)	Content, Delivery	Integrated with physical activity due to link with	9 month monthly follow up	

			monthly booster sessions).			depression and diabetes outcome	Trained nurses Telephone increased access	
Rasquin et al (2009)	BA, CR, RT	Face-to-face & Telephone	8. & Twice a week telephone	1	Content Acceptability	Based on intervention for chronic disease, modified to account for cognitive deficits. Supported with a LTC relevant workbook	Variety of delivery formats	Feasibility questionnaire identified perceptions about the interventions
Rhee et al. (2000)	RT, PS, SS Other	Group	10 3-monthly follow-up for 15 months.	120	Content	Integrated enhancement of social support, pain management and CBT. Delivered based on assumption stress management would affect depression and pain.		
Savard et al. (2006)	BA, CR, GS, RP	Face-to-face	8 With 3 weekly booster sessions; not state duration)	60-90	Content Delivery	Cognitive therapy adapted for people with cancer. Aim to develop optimistic but realistic outlook. BA took into account the persons physical abilities e.g. focus on sense of accomplishment over leisure activities. Modify inaccurate illness cognitions. Increase use of short-medium and long-term goals.	Booster sessions every 3 weeks due to variable nature of condition.	
Scholey & Woods (2003)	Not described.	Face-to-face	8 sessions	(not stated)	Content Delivery	Discussion of diagnosis and how this related to cognitive changes Illness beliefs	More active role of therapist in agenda setting Summarise	

						Discussion of loss of abilities and fears about the future Creation of alternative thoughts rather than challenging.	material Need to be flexible, patient and tolerant if homework not competed	
Serfaty et al. (2010)	Not specified	Face-to-face	Up to 8 over 10 weeks. *X* =5.4 (3.1).	1	Content	Standard CBT but linked to illness beliefs, experience and impact, Included recognition of the social impact and spiritual/existential aspects		
Sharplin et al., (2010)	MBCT intervention	Group (n=13 and 12)	8 Mindfulness practice 6 out of 7 days)	120 (optional 3 hr follow-up after 6 weeks) 45 mins per day	Acceptability	Mindfulness of breath, present focus and acceptance		Assessed acceptability related to incorporation into daily life and barriers Benefits of peer group setting and from incorporating mindfulness techniques into life Not connect with "depression" terms
Stanley et al., (2005; CBT-RADAR)	BA, CR, Ex, PS, SH, RT, TS	Group	8	60	Content	Emphasise link between LTC and mood and how these lead to avoidance. And safety behaviours. Recognised impact of illness on abilities. Replace previously enjoyed activities with less physically demanding but enjoyable activities.	Focus on modifying of previously enjoyed activities in response to physical limitations	Reported satisfaction with intervention

Steel et al., (2007)	Not specified	Face-to-face & telephone follow-up	3-4 face-to-face & 5-6 telephone sessions in 6months	(not stated)	Content Delivery Acceptability	Choice of content related to physical or psychological condition	Delivery face to face as well as over telephone. Supported with written & audiotape information	Choice to promote relevance
Van Bastelaar et al. (2008; 2010)	AT, BA, , CR, RP , RT	cCBT plus minimal email support & Internet forum access	8	60	Content Delivery Acceptability	Integrated physical with psychological focused option of topics	Access to support forum to access specific topics of interest Followed from home and allowed flexibility	Adjusted intervention to match needs of diabetes population based on research, experience and expert panel Use video examples of patients struggling with LTC and depression and how to use skills. Users desire diabetes-oriented approach.
Van Eijk et al. (2004)	PS Other	Face-to-face	2-6	X =570	Content Delivery Acceptability	Integrates self-management of LTC:	Delivered by nurses as part of standard care. Nurses can help distinguish between problems related to LTC and those related to psychological consequences of LTC	Judged as worthwhile and effective by patients and deliverers. Intervention deliverers emphasised need for greater flexibility in number of visits.
Vriezekolk et al., (2012)	CR, Ex, GS, PS, AT, RP, Other	Group (n=5-8) alternated	CBT= 12 over 16 weeks	90	Content Delivery Acceptability	Address impact and fluctuating nature of LTC Focus on acceptance or	Group increases social support MDT program	Satisfaction with intervention and found it useful to help

		with Face-to-face	3x 2hr sessions attended by spouse			change and flexible coping Social skills training to facilitate generalisation of skills. Integrated with physical therapy and occupational theray	Inclusion of significant other in 3 sessions	coping.

[1] Intervention techniques include activity scheduling (AS), assertiveness training (AT), behavioural activation (BA), behavioural experiments (BE),coping self-statements/ self-instructional training (CS), cognitive restructuring (CR), exposure (imaginal or in-vivo; Ex), goal setting (GS), problem solving (PS), relapse planning (RP), relaxation training (RT), sleep hygiene (SH), TS (thought stopping): "Other" refers to additional techniques not classed within these labels, e.g. communication skills, anger management.

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Appendix E: Details of Excluded studies

Appendix E.1 Excluded Full Articles

Table 4.

Reasons for exclusion

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Albus et al., (2011)			x				
Allen, Shah, Nezu, Nezu, Ciambrone, Hogan, & Mor (2002)		x					
Alter et al. (1996)			x				
Altshuler, Rosenbaum, Gordon, Canales & Avins (2012)			x				

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Ames et al., (2011)				x			
Andersen et al. (2004)			x				
Angell et al. (2003)			x				
Antoni et al. (2009)		x					
Antoni et al. (2001)		x					
Antoni et al. (2012)				x			
Applebaum, Blanchard, Hickling, & Alfonsom (1988)	x						
Askey-Jones, Silber, Shaw, Gray, & David (2012)				x			
Badger, Braden,	x		x				

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Longman, & Mishel (1999)							
Barsky et al. (2010)	x			x			
Bayliss, Edwards, Steiner, & Main (2008)			x				
Beatty, Koczwara, Rice & Wade (2010)		x					
Beatyy, Koczwara, & Wade (2011)		x					
Beatty, Oxlad, Koczwara, & Wade (2010)	x						
Boesen et al. (2011)			x				

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Bottomley (1997)					x		
Boyle & Ciccone (1994)							x
Broomfield et al. (2011)					x		
Brothers, Yang, Strunk, & Andersen (2011)			x	x			
Brown, Munford & Munford (1993)			x				
Budin et al. (2008)		x	x				
Burg et al., (2008)			x				
Calfas, Kaplan, & Ingram (1992)	x						

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Carpenter, Stoner, Schmitz, McGregor, & Doorenbos (2012)		x					
Chambers, Foley, Galt, Ferguson & Clutton (2012)	x						
Chernyak et al. (2009)			x				
Cipher, Clifford, & Roper (2007).	x						
Cluver, Schuyler, Frueh, Brescia, & Arana (2005)				x			
Cocker, Bell, &	x						

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Kidman (1994)							
Cowan, Pike, & Budzynski (2001)	x		x				
Craig, Hancock, Dickson, & Chang (1997)	x						
Crawford & McIvor (1987)		x		x			
Cundey & Frank (1995)					x		
Cully, Graham, Stanley, Kunik (2007)				x			
Davis (1986)		x					

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
de Godoy, & de Godoy (2003)				x			
Didjurgeit, Kruse, Schmitz, Stuckenschneider, & Sawicki (2002)			x				
Dinkel et al. (2012)		x					
Dreisig, Beckmann, Wermuth, Skovlund, & Bech, (1999)		x					
Dolbeaut et al. (2012)	x	x					
Edelman, Bell, & Kidman. (1999)				X			

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Edelman, Lemon, Bell, & Kidman (1999)				x			
Ell et al. (2011)			x				
Emery, Schein, Hauck, & MacIntyre (1998)	x	x	x				
Evans, & Connis (1995)	x			x			
Evers, Kraaimaat, van Riel, & de Jong (2002)		x					
Fawzy (1999)					x		
Foley, Baillie, Huxter, Price, & Sinclair (2010)		x					

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Forman, & Lincoln (2010)	x	x					
Frizelle et al. (2004)		x	x				
Garnefski, Kraaij, & Schroevers (2011)						x	
Gignac (2003)			x				
Gilmer, Walker, Johnson, Philis-Tsimikas, & Unutzer (2008)			x				
Golden & Gersh (1990)			x				
Goldstein, McAlpine, Deale, Toone, &	x						

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Mellers (2003)							
Greer & Moorey (1997)					x		
Grossman et al. (2010)				x			
Grover, Kumaraiah, Prasadrao, & D'Souza (2002)	x		x				
Guthrie (1996)					x		
Hambridge, Turner, & Baker (2009)							x
Harpole et al. (2005)							
Hegel et al. (2002)			x			x	
Henderson et al (2012)			x				

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Henry, Wilson, Bruce, Chisholm, & Rawling (1997)			x				
Hirsh, Sears, & Conti (2009)		x					
Hopko, Bell, Armento, Hunt, & Lejuez (2005)			x				
Hopko, Robertson, & Carvalho (2009)				x			
Hosaka, Sugiyama, Tokuda, & Okuyama . (2000)		x					
Hunkeler et al. (2000).						x	

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Ibrahim et al. (1974).		x					
Katon (2003)			x				
Katon et al. (2002)						x	
Katon et al. (2006)			x				
Katon et al. (2004)			x				
Kemp, Corgiat, & Gill (1992)							x
King & Kennedy (1999)		x					
Kishi & Kathol (1999)						x	
Kunik et al. (2005)	x						
Kunik et al. (2008)			x				

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Laperriere et al. (2005)			x				
Larcombe & Wilson (1984)				x			
Leibing, Pfingsten, Bartmann, Rueger, & Schuessler, (1999)						x	
Lewin, Coulton, Frizelle, Kaye, & Cox (2009)	x						
Lincoln & Flannaghan (2003)				x			
Lisansky & Clough (1996)	x	x					

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Luskin, Reitz, Newell, Quinn, & Haskell (2002).			x				
Lustman, Clouse, & Freedland (1998)			x				
Lustman, Griffith, & Clouse (1997)			x				
Maisiak, Cain, Yarbro, & Coates (1981)			x				
Mannix et al. (2006)			x				
May et al. (2009)	x						
McLaughlin et al. (2005)	x						

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Morrison, Johnston, MacWalter, & Pollard (1998)		x					
Moss-Morris et al. (2009)	x	x					
Moss-Morris, McCrone, Yardley, van Kessel, Wills, & Dennison (2012)	x						
Moynihan, Bliss, Davidson, Burchell, & Horwich (1998)	x						
Mynors-Wallis, Gath,						x	

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Lloyd-Thomas, & Tomlinson (1995)							
Naverette-Naverette et al. (2010)		x	x				
Nezu, Nezu, Houts, Friedman, & Faddis (1999)			x				
O'Leary, Shoor, Lorig, & Holman (1988)	x	x					
Parker et al. (1995)	x						
Penedo et al. (2004)		x					
Penedo et al. (2006)	x	x					

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Pradhan et al. (2007)			x				
Rahe, Ward, & Hayes (1979)			x				
Reme et al., (2011)			x				
Rigby, Thornton, & Young (2008)		x					
Rodgers, Khoo, MacEachen, Oven, & Beatty (1996)							x
Rybarczyk, Gallagher-Thompson, Rodman, Zeiss, Gantz, & Yesavage (1992).					x		

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Sandgren, McCaul, King, O'Donnell, & Foreman (2000)			x				
Sharpe, Allard ,& Sensky (2008)				x			
Sharpe, Sensky, Timberlake, Ryan, Brewin, & Allard (2001)	x						
Sherwood et al. (2011)	x	x					
Sirey, Raue, & Alexopoulos (2007)	x						
Sloman (2002)			x				

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Smeulders, van Haastregt, van Hoef, van Eijk, & Kempen (2006)	x						
Stanley et al. (2009)						x	
Stanton (2005)			x				
Stiefel et al. (2008)			x				
Teri & Gallagher-Thompson (1991)			x				
Trask, Paterson, Griffith, Riba, & Schwartz (2003)				x			
Turner et al. (2011)			x				

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Unutzer at al., 2002			x				
Van den Berg, Gielissen, Ottevanger, & Prins (2012)		x					
Van der Ven et al. (2005)	x						
Van der Ven et al. (2005)	x						
Visschedijk, Collette, Polman, Pfennings, & Van der Ploeg, (2004)	x	x					
Watt & Cappeluz (2000)			x				

	Reasons for Exclusion						
Authors	Not primarily for treatment of anxiety/ depression	Not required to have clinical anxiety/ depression	Not adapted (for LTC) CBT intervention	Insufficient details about intervention/ adaptations	Review not intervention	Not non-communicable LTC	Full text not available
Willemse, Smit, Cuijpers, & Tiemens (2004)		x					
Williams, Katon, Lin, Noel, Worchel, & Cornell (2004)				x			
Wong, Chau Kwok, & Kwan (2007)		x	x				
Wood & Mynors-Wallis (1997)				x			

Appendix E.2: References of excluded studies

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