

Chapter 5. Qualitative study

5.1. Chapter overview

This chapter is presented as an unpublished manuscript that pertains to the third study, which involved qualitative research as part of a multiphase research design. Semi-structured interviews were conducted with eligible patient-practitioner dyads to investigate patients' and MSK practitioners' experiences and beliefs regarding the role of CFs by exploring their interpretations during LBP consultations. The manuscript begins with a succinct introduction and rationale for the qualitative research. It then provides an explanation of the materials and methods used to recruit participants, as well as to collect and analyse the data. Subsequently, the main results are presented, elucidating four themes and their corresponding sub-themes, accompanied by illustrative participant quotes. Lastly, the manuscript discusses the findings within the context of the existing literature and reflects on the strengths and limitations of the research. The chapter concludes with additional reflections that are presented to discuss the researcher's characteristics and how they may have influenced the data collection and interpretation.

5.2. Unpublished manuscript

The following section presents a manuscript that has been drafted for submission to a peer-reviewed journal as part of the integrated thesis format. Consequently, the formatting adheres to the author guidelines and differs from the traditional chapters of this thesis. The key differences relate to the in-text citations (i.e., numbered), line spacing, paragraph formatting, and headings. Please note that the in-text citations will be included in the main reference list at the end of the thesis rather than at the end of this manuscript.

***“Being a guide for patients to show them a journey out of back pain”:
Exploring patients’ and musculoskeletal practitioners’ experiences
of contextual factors during consultations for low back pain***

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Introduction

Musculoskeletal (MSK) conditions are a substantial contributor to disability globally [1], with low back pain (LBP) being the leading cause [2,3]. Chronic, non-specific LBP (cLBP) involves symptoms such as pain and reduced physical functioning which persists for 12 or more weeks, often without a known pathoanatomical cause [4]. Clinical guidelines recommend conservative treatments (i.e., non-invasive, non-surgical, and non-pharmacological) such as self-management approaches, exercise, and physical/manual therapies [5,6]. However, treatments for non-specific LBP are limited to managing pain and its consequences, [4] resulting in modest symptom relief [7].

Alongside recommended treatments for MSK pain, contextual factors (CFs) may simultaneously influence patients’ clinical outcomes [8,9]. Evidence suggests CFs could contribute to a sizeable proportion of analgesic responses in MSK pain, after considering spontaneous remission [10]. Di Blasi et al. [11] characterised CFs

into five useful domains: (1) patient's characteristics/beliefs; (2) practitioner's characteristics/beliefs; (3) patient-practitioner relationship; (4) treatment characteristics; and (5) treatment setting/environment. CFs therefore encompass social, psychological, and physical dimensions of clinical interactions which are capable of activating physiological and psychological responses [12,13].

Manipulating CFs can stimulate positive (placebo) or negative (nocebo) effects arising from the patient's perception and interpretation of contextual information surrounding medical treatments [12,13]. Endogenous neuroanatomical and neurochemical systems are implicated in placebo analgesia and nocebo hyperalgesia with links to cognitive and affective processes related to the judgement of meaning and context [13–15]. Optimising CFs during clinical practice has the potential to modulate MSK pain [10,12,16] presenting a salubrious approach to improve clinical outcomes [10,12,15,17] which could enhance the effectiveness of current treatments [7,12]. Moreover, harnessing CFs may be a promising adjunct to augment conservative treatments for cLBP [18].

Translational research has been highlighted as an important focal area by various placebo researchers [16,19–21]. Increasingly there is implicit consensus that placebo/nocebo effects are enmeshed with social interactions and subjective interpretations of meaning [22–24] and more recently, embodied, or enactive cognition – dynamic interactions between individuals and their environment [25]. However, placebo studies have become partially detached from the public sphere, omitting patients', and to a lesser extent, practitioners' perspectives [23]. Although symptom improvement is a common treatment outcome, it is unclear which elements

of the therapeutic encounter are perceived as important or impactful by patients and their MSK practitioners.

Previous qualitative studies on LBP have focused on the psychosocial impact, access to information and treatment, patients' need for a clear diagnosis, and partnerships with practitioners [26–30]. In focus group discussions, patients with cLBP expressed their preference for empathetic and knowledgeable practitioners who could provide clear explanations of their symptoms [31]. Another study revealed that participants perceived LBP as threatening because it was difficult to make sense of [32]. While these studies provide important insights into patients' experiences, their primary emphasis has revolved around patients' beliefs concerning illness and treatment, as well as the dynamics of the therapeutic relationship. Accordingly, there is limited research exploring the experiences of both patients and MSK practitioners across all five CF domains during clinical practice.

Notably, two national Italian surveys ($n = 558$ physical therapists; $n = 1,112$ patients) [33,34] examined the knowledge and awareness of CFs during clinical practice. The authors of both surveys recommended further research to investigate patients' and practitioners' perceptions of CFs to gain a more comprehensive understanding of their role in clinical practice [33,34]. Accordingly, this study aims to draw on the experiences of patient-practitioner dyads to provide deeper insights regarding the perceived importance of CFs during LBP consultations. This may also help to describe potentially therapeutic aspects of healthcare interactions and identify whether there may be perceived synergistic action between the CF domains.

Materials and methods

In this study, the Consolidated Criteria for Reporting Qualitative Research (COREQ) [35] guided the reporting to ensure key methodological aspects were included.

Study aim

This study aimed to explore both patient's and practitioner's experiences following private care (i.e., non-NHS) consultations in the UK for a recent episode of recurring or persistent LBP. The aim was to separately interview the same dyad (i.e., both the patient and their MSK practitioner) using online or telephonic semi-structured interviews to discuss and explore each individual's experience of the same healthcare interaction and the extent to which CFs were involved. The research objective was to better understand the perceived importance and perceived influence of CFs during private care treatment for cLBP. Thus, this study will seek to address the following research question: *What are the views of patients and practitioners on their experiences of LBP consultations and to what extent are CFs involved?*

Study design

Qualitative methods are appropriate and useful to explore participants' perspectives in a non-directive and open manner. A qualitative methodology was used to explore participations experiences of CFs during cLBP treatment and was located within a pragmatic paradigm. Pragmatism is orientated towards practical problem-solving for real-world social situations, with the purpose of creating knowledge to facilitate change or improvement (i.e., it has utility) [36]. Pragmatists focus on human experiences, recognising they are inseparable from situations and contexts and may involve investigating the problem from different perspectives [37]. Thematic

analysis was selected as the analytical approach for this study because of its adaptability in capturing broader themes and perspectives, in line with the study's aim and pragmatic approach. This method allows for an inductive exploration of themes based on data relevance, facilitating a nuanced understanding of the role of CFs in private care treatment for cLBP. This approach was preferred over interpretative phenomenological analysis and grounded theory, which prioritise individual experiences and theory development respectively. Exploring the knowledge and experiences of underrepresented yet influential participants may be useful to understand how CFs may be optimally harnessed during clinical practice.

Participant recruitment

This study recruited six participants, organised into three patient-practitioner dyads ($n = 6$), but all semi-structured interviews were conducted separately. Each dyad was recruited from privately-owned clinics located in England. This approach was influenced by a preceding Delphi study, where the majority of panellists expressing interest in CFs were MSK practitioners in private practice [38]. Moreover, considering the ongoing strain on NHS services during the Covid-19 pandemic and the limited integration of Chiropractors, Osteopaths, and Sports Therapists within the NHS, their involvement in this study was not feasible. These factors played a role in shaping this decision. Accordingly, eligible practitioners included qualified, private practice MSK therapists, namely Chiropractors, Physiotherapists, Osteopaths, and Sports Therapists, who provided treatment to patients with cLBP in the UK. MSK practitioners were recruited first, and following informed written consent, they assisted with identifying potentially eligible patients.

The inclusion criteria for patient participants were: adults (18–65 years), with a history of non-specific, cLBP (i.e., symptoms persisting for at least three months), with no signs of neurological symptoms, cognitive impairment, nor indications of an underlying pathology/serious illness, nor a recent physical trauma/surgery. New or returning patients attending an initial assessment or follow-up appointment either via telephone, face-to-face, or virtually were eligible to take part. All participants were required to be able to converse in English, and have access to the internet via a computer, laptop, tablet, or smartphone.

The study recruited practitioner participants through multiple channels, including social media (e.g., Facebook, Twitter, LinkedIn), email invitations, and professional networks. These networks were instrumental in disseminating research invitations and flyers, which outlined the study's general information. Interested and eligible practitioners were asked to contact the interviewer (BS) via email. Snowballing through word-of-mouth referrals also played a role in recruitment.

Interested practitioners received an information sheet to review. After providing written informed consent, practitioners were emailed guidance documents to assist with introducing the study to eligible patients. Eligible patients were recruited through the help of participating practitioners. Practitioners were required to complete an agreement form before approaching eligible patients, but they were not required to obtain their patient's written consent. The interviewer was solely responsible for obtaining informed consent from participants.

Participating practitioners were responsible for screening eligible patients, advertising the study (e.g., invitations, flyers, posters), and providing general information during the initial approach. Patient posters and flyers provided an overview of the study including Frequently Asked Questions (FAQs). The posters/flyers emphasised the confidentiality of patient information and assurances that their ongoing treatment would not be affected by participating in the study. Interested patients were given the option to scan a QR code to access the information sheet or they received a flyer/invitation including the interviewer's contact details. Participating practitioners did not share patient contact details with the research team. All participants were offered a £15.00 voucher as a token gesture for their involvement in the study.

Ethical considerations

Prior to data collection, the study received ethics approval from Bournemouth University's Research Ethics Panel (**Ethics ID: 33506**). Participation in the study was entirely voluntary, and participants had the right to withdraw at any time without penalty. No coercion or deception was used during the study, and participant quotes were anonymised to maintain confidentiality. All participants were debriefed after the study and received a summary of the findings.

Ethical considerations in dyadic research were addressed through a careful participant engagement process. Gatekeepers were not required to obtain or request written consent from any prospective participant (either practitioners or patients). Their role was to assist in identifying eligible participants on the researcher's behalf, provide general information about the research, and, if the individual expressed

preliminary interest, distribute a research invitation/flyer. Gatekeepers served the role of advertising the study and were not expected to complete the recruitment process (i.e., facilitate the signing of an agreement form). The process of obtaining informed written consent was solely managed or facilitated by the researcher (BS).

Since it was possible that a patient participant might disclose perceived unprofessional, unsatisfactory care, or misconduct by their practitioner during an interview, precautionary protocols were in place in accordance with ethical requirements. The researcher had prior training in basic and advanced counselling techniques and possessed the requisite interpersonal skills to manage upset/distressed participants, treat them with empathy, respect their dignity, and determine whether it was necessary to terminate an interview and associated recording. Participants were not required to respond to any questions they felt uncomfortable answering. The interviewer was responsible for emailing the patient information explaining how to lodge a complaint if such a disclosure was made once an interview was completed (or terminated). Doing so was entirely at the patient's discretion and was handled according to the respective clinic's internal procedures.

If the reported misconduct was alleged to be severe (e.g., dangerous, abusive, etc.) or in instances where it was either unclear or ambiguous, the researcher would anonymously disclose the nature of the alleged misconduct to the supervisory team to help make an adjudication. The supervisory team included two Physiotherapists (CC and CK), who were also able to determine whether this information should be anonymously disclosed to the Clinical Director, without identifying the patient or practitioner, so corrective action could be taken if necessary, or to simply refer the

patient to the clinic's complaint handling process if initially recruited via the Clinical Director. However, if the practitioner was recruited in their individual capacity, then after consulting with the supervisory team, the patient would have been provided with suitable information to lodge a complaint with the practitioner's respective regulatory body (e.g., General Chiropractic Council). Notably, there were no disclosures of serious practitioner misconduct during the interviews.

All discussions or correspondence concerning the alleged misconduct would not have included identifying information about either the practitioner or the patient (e.g., relevant excerpt from an anonymised transcript or a verbal/written summary of the perceived misconduct). Since these were private care patients, they would also have been entitled to change healthcare providers if preferred. Overall, ethical considerations were paramount, with measures in place to protect participant confidentiality and ensure appropriate handling of disclosures.

Excerpts from the practitioner and patient information sheets below highlight that prospective participants were informed of the protocol regarding disclosures of perceived misconduct.

“Please note that if your patient discloses that they believed they received improper or unprofessional care from you, then this information may be anonymously disclosed to the research supervisors to determine whether your patient should be provided with information to lodge a formal complaint. If you were recruited through your Clinical Director then this information will also be anonymously disclosed to them to ensure corrective action is taken if necessary. However, this will be done anonymously without disclosing either your or your patient's name or identifying features. If you have any concerns or unanswered questions about this, please discuss these with the researcher.”

“Please note that if you tell the researcher about unsatisfactory or unprofessional care during the interview, this information may be anonymously disclosed to the research supervisors as well as the Clinical Director (where appropriate) to ensure corrective action is taken if necessary. You may also be provided with information about how to lodge a formal complaint via email after the interview has taken place. However, none of your personal details will be shared with these individuals ensuring your anonymity will be protected.”

Anonymity was emphasised, ensuring confidentiality for all parties involved. The participant agreement forms further reiterated these protocols, with participants acknowledging their understanding and consent to the outlined procedures as indicated below:

“If a patient of mine discloses unsatisfactory or unprofessional care to the researcher during their interview, then:

- *Details of this may be anonymously disclosed to the research supervisors (and the Clinical Director if recruited through them) so corrective action may be taken if necessary.*
- *However, my and my patient’s identity or identifying features will not be revealed to these parties.*
- *My patient may also be provided with information to lodge a complaint should they wish to do so.”*

“I understand that if I tell the researcher about unsatisfactory or unprofessional care during the interview, then:

- *Details of this may be anonymously disclosed to the research supervisors, and the Clinical Director where appropriate, so corrective action may be taken if necessary.*
- *However, my identity or identifying features will not be revealed to these parties.*
- *I may also be provided with information to lodge a formal complaint if I wish to do so.”*

Copies of the information sheets, and agreement forms are included in Appendix III.

Study context

All data collection took place remotely because of the requirements for social distancing to mitigate and reduce participants' risks or exposures during the Covid-19 pandemic. The study involved private care patients and MSK practitioners based in England. It is worth noting that Covid-19 regulations frequently changed during this period.

Data collection

Ethics approval was obtained prior to practitioner recruitment commencing in January 2021, with data collection concluding in December 2021. Interviews were conducted between May and November 2021 and were arranged at a convenient date and time for participants using a semi-structured interview guide (see Appendix III). All interviews (25–30 minutes) were conducted using online platforms by a single interviewer (BS). BS is a female, international postgraduate student with an MSc in Health Psychology, prior experience as a face-to-face counsellor, and has experienced persistent pain for more than 20 years. BS had no prior relationship with the study participants.

The interview guide was developed by considering relevant literature, along with preliminary findings of a prior systematic review [18] and Delphi-study conducted by the authors [38], which informed the primary aim and research question for this qualitative study. Furthermore, targeted consultations involving three patient volunteers provided feedback on the initial design of patient interview guide and the recruitment process. Targeted consultations involve real-world research users with relevant lived experiences [39]. Volunteers were recruited

through Bournemouth University's *Public Involvement in Education and Research* (PIER) partnership. MSK practitioners also provided insights on the changing research landscape, considering Covid-19's impact at the time.

All participants had the option to complete an online pre-interview task (5–10 minutes) before their scheduled interview (see Appendix III). The task requested basic demographic information to ensure that inclusion criteria were met and asked participants to share important moments or experiences during their recent appointment. The purpose of this task was to help reduce recall bias since virtual interviews were not conducted immediately following LBP consultations. One patient chose not to complete the task. Participants' notes were screenshared during interviews to help them elaborate on their earlier responses. Participants had the option to turn their web camera on or off, but only the audio was digitally recorded. All participants provided written consent to be audio recorded, and data were stored in accordance with General Data Protection Regulation requirements. Only BS and the interviewee were present during the interviews. Field notes were taken during and after the interviews. BS introduced herself as a postgraduate research student, and participants were informed that the research was part of an ongoing PhD project.

Data analysis

Data analysis followed the six key phases of thematic analysis described by Braun and Clarke [40]. Using qualitative data analysis software (NVivo, version 12) ensured transparency and provided an audit trail. The patients' and practitioners' interview data were analysed separately, using an inductive approach. During the first phase, BS transcribed the audio recordings verbatim. Thereafter repeated

readings of transcripts and re-listening to audio recordings were conducted to ensure familiarity with the data and immersion in its depth and breadth [40]. In the second phase, initial codes were generated to capture key ideas and concepts in the data. Codes were reviewed during the third phase whilst searching for patterns, connections, and relationships. Thereafter, codes were grouped into preliminary themes based on their relevance to the research question and salience, as outlined by Braun and Clarke [40].

In the fourth phase, BS reviewed the themes, and CK, a qualified physiotherapist with extensive experience in qualitative research, independently cross-checked codes against the participants' transcripts to ensure that the developing themes accurately represented and supported patients' experiences. In the fifth phase, the themes and corresponding sub-themes were named and defined based on their characteristics and supporting data [40]. The research team critically discussed these initial findings to verify the credibility of the themes.

The same analysis process was then repeated for the practitioner data. During the third and fourth phases, CK also independently cross-checked the codes and initial themes to validate that the practitioner themes were converging with the patient analysis. In the fifth phase, the identified themes were redefined to reflect both patients' and practitioners' experiences and confirm that the data supported them. The research team critically discussed these initial findings to verify the credibility of the themes. The last analysis phase involved writing up the analysis including selecting vivid and compelling examples from the data and linking the findings back to the research question and literature [40].

Results

Participant demographics

Fourteen MSK practitioners in private practice, consisting of 11 Chiropractors, two Sports Therapists, and one Osteopath, consented to take part in this study. However, only three practitioners from different MSK clinics in England were able to recruit one patient with cLBP each, resulting in three patient-practitioner dyads. These three dyads participated in separate online interviews ($n = 6$) to discuss their experiences of private consultations for cLBP. Table 1 presents a summary of participants' characteristics.

Table 1. Overview of participants' characteristics

Patients' Characteristics ($n = 3$)				
Pair	Pseudonyms	Gender	Age Range	Duration of LBP symptoms
1	Amelia	Female	30-34 years	Approximately 7 years
2	Beth	Female	35-39 years	Approximately 2 years
3	Chloe	Female	18-24 years	Approximately 5 years
Practitioners' Characteristics ($n = 3$)				
Pair	Pseudonyms	Gender	Age Range	Years of clinical experience
1	Alexander	Male	30-34 years	Approximately 10 years
2	Ben	Male	30-34 years	Approximately 4 years
3	Charles	Male	25-29 years	Approximately 4 years

Overview of themes

Four key themes reflecting patients' and MSK practitioners' experiences during LBP consultations emerged from the thematic analysis: (1) journey with LBP; (2) quality of the relationship; (3) shared journey to recovery; and (4) quality of the treatment space. Each of these main themes is accompanied by two corresponding sub-themes, which are presented below with relevant quotes for illustration.

Theme one: Journey with LBP

This theme encompasses patients' and practitioners' experiences of unpacking the journey with LBP that each patient had navigated for several years. The theme has two salient sub-themes: (a) the negative impact of LBP, and (b) prior negative treatment experiences.

Negative impact of LBP

All three patients described how reoccurring LBP symptoms had negatively impacted their daily lives, often for extended periods of time. Deleterious impacts included work absences, being unable to sleep comfortably, pursue meaningful activities, or perform everyday movements and exercise without experiencing pain which also affected their emotional well-being.

I was bed bound for about a week ...I was really struggling with the most basic of things... over the last two years it's declined to the last month, really bad pain! I've really struggled to exercise... I can't physically do it because the pain is too much. ...to be able to just sleep, and actually turning one swift move, from one side to the other, would just be amazing!

[Amelia, Female, 30-34 years]

Practitioners appeared to be aware of their patient's journey and the negative impact of LBP on their lives. Practitioners allowed patients to share their story from the beginning and described starting initial consultations by just listening. They made a conscious effort to pay attention to and prompt patients to share their experiences and acknowledge their difficult journeys, instead of focusing exclusively on diagnostic information. Practitioners took time to appreciate the adverse impact LBP symptoms were having on important aspects of their lives, along with considering previous treatment experiences to gain a clearer understanding of each patient's LBP journey.

...it's saying their story, but then obviously throughout that, acknowledging that story, so I'm not just looking like I'm looking for parts that are just of diagnostic value, but also of value to the patients. I'm thinking through in my head, 'Okay, what are these valuable parts within this patient's journey?' ...having an understanding of what's not just a biomechanical problem, but what's going on in their life around them

[Ben, Chiropractor, Male, 30-34 years]

Prior negative treatment experiences

A range of factors were mentioned as contributing to prior negative treatment experiences which resulted in patients expressing frustration and a lack of trust in healthcare practitioners. Amelia and Chloe had protracted LBP journeys, lasting around seven and five years, respectively, before seeking treatment from Alexander and Charles. Both patients felt there was a lack of a clear or credible explanation which allowed them to make sense of their LBP experiences during previous consultations. For instance, throughout Chloe's journey, practitioners offered differing LBP explanations, but as her symptoms persisted, these explanations were no longer considered credible.

...originally she thinks I slipped a disc, but it went back in on its own. For me, that didn't make sense. ...I know you shouldn't look up things, but I was looking up things about slipped discs and stuff, and it just didn't add up to what she was saying. ...I just didn't feel comfortable with her and what she was saying.

[Chloe, Female, 18-24 years]

Amelia felt her previous practitioner lacked good communication skills and failed to treat her as a person. After that initial consultation, she experienced an increase in disabling symptoms and relied on prescribed pain medication to regain basic mobility, despite expressing her dislike for analgesics.

...the Chiropractor didn't communicate with me; he kind of almost just put me in these positions, didn't tell me what he was doing, no communication, no [explanation of] what was wrong, no thoughts on what could be the problem, what could have caused this? ...I remember leaving there thinking that was just something I never, ever want to experience again; it was just absolutely hideous!

[Amelia, Female, 30-34 years]

Chloe's LBP journey involved several consultations with public and private practitioners and described two additional factors contributing to her prior negative treatment experiences. Firstly, she was dissatisfied with the lack of effective reassurance she received primarily because her LBP symptoms did not improve during the timeframes practitioners had indicated.

... they [GP] said, "Oh it's just a bruised coccyx, you'll be fine." ...about six weeks later, it was really bad still, and it was getting worse... I booked an appointment back with the GP and then they just gave me like pain relief and said, "Take that", and that was all... Then I got put on the waiting list for the NHS physio, and he gave me exercises for four weeks and said, "If you carry on doing these exercises, you'll be fine basically", which ended up not happening.

[Chloe, Female, 18-24 years]

Secondly, Chloe was frustrated with the lack of personalised advice she received regarding her valued activity (i.e., dancing) during prior consultations. She felt it was either disregarded entirely or the given advice was illogical which made her doubt the practitioner's knowledge/expertise.

...when I had gone to the other places, I kind of, just thought because they disregarded it [dancing], and they didn't really have any advice.

...it was the aspect of them turning around and saying a year and a half off [dancing], to me, seemed very, it was over exaggerated... It made me feel like they didn't actually know [what they were talking about]...for me to just go back weekly for a year and a half of them telling me I can't dance still, so they could get money basically.

[Chloe, Female, 18-24 years]

Interestingly, since Charles and Alexander had taken an interest in listening to their patient's LBP stories, they were able to identify and then tailor their responses to each patient's previously unmet needs. Both practitioners took their patient's pain experiences seriously, responded by validating those experiences, and providing appropriate reassurance. Whilst listening to Chloe's LBP journey for instance, Charles was acutely aware of how important dancing was to her and

recognised she had received unsatisfactory advice from previous practitioners which he aimed to address.

...she was a dancer, all different types of dancing, very passionate about it. ...I've never known anyone to be told to take that kind of duration of time off, which must have conveyed quite a sense of severity ...there was a lot of reassurance required and trying to break down messages that she had been given...

[Charles, Chiropractor, Male, 25-29 years]

Alexander was aware of Amelia's prior negative experience and made a concerted effort to create a calm, safe space by encouraging her to share her story. He thought it was important to validate her prior negative experience, express empathy, and provide reassurance because he recognised Amelia might be feeling uneasy about seeking treatment again.

...it made me more aware that okay, I'm gonna put a bit more effort into projecting a bit more of a calming, welcoming energy... I just encouraged her to share a bit more about that and just made sure to really validate it ...I think that allowed her to feel safe ...I emphasised that I'd explain everything; "I'm not going to do anything without letting you know and making sure you're okay, so you're involved in that".

[Alexander, Chiropractor, Male, 30-34 years]

In both cases, the current practitioners demonstrated to patients that in addition to recognising the impact of LBP on their lives, their voices were heard, and their stories were important. Exploring each patient's journey, whilst acknowledging their prior experiences, and attending to patient's individual needs appeared to be pivotal for building a solid foundation to establish a therapeutic relationship during the first appointment together.

Theme two: Quality of the relationship

This theme captures the perspectives of patients and practitioners regarding the importance of the quality of the relationship between them, which was shaped by their interactions during LBP consultations. Two key sub-themes emerged in relation to the establishment of a therapeutic relationship: (a) person-centred approach, and (b) practitioners' attributes and attitudes.

Person-centred approach

A person-centred care approach was perceived as beneficial in developing a good-quality relationship during LBP consultations. Patients described feeling heard and understood when practitioners made time to listen to their experiences. Doing so helped patients feel more confident in their practitioner's ability to help, which was important for developing the therapeutic relationship.

...I could tell he was fully, fully listening to me, but more importantly understanding me. ...he was just constantly reiterating what I was saying, which made me feel like, okay (a) he is listening, and (b) he understands; which are two very important things when you want to get something sorted.

[Amelia, Female, 30-34 years]

Practitioners also thought it was important to demonstrate they were actively listening by not interrupting, giving patients time to share, paraphrasing, or reflecting on their experiences so patients felt heard and understood. Practitioners also demonstrated person-centredness through expressing genuine empathy, offering encouragement, using open-ended questions or motivational interviewing skills to support the development of a good-quality relationship.

...basically, just start listening to start with. I think it's important initially, just so they feel heard, and I'm not just interrupting straightaway and asking things I need to know; it's so they can say their story. ...maybe I can make her feel heard, by me talking about it and saying, "Oh, it must be difficult in that situation, because they don't understand what you're going through...". So, giving her,

kind of support, through having those conversations. I think it was useful for me, but particularly to the patient.

[Ben, Chiropractor, Male, 30-34 years]

The manner in which practitioners explained their initial findings allowed patients to develop a clearer understanding of their LBP symptoms which helped to effectively reassure them by reducing health-related anxieties. Patients thought the use of diagrams, models, or videos was useful to understand their LBP.

...he had like, a plastic back, and he showed me what I done, where I've done it, and he took me through each step. ...then I knew exactly where, and how, and what, which is always helpful. ...it's not always good when it's about your health, to be in the unknown. ...it's quite nice to know exactly what is going on... it made me feel completely at ease which is always good.

[Beth, Female, 35-39 years]

Likewise, practitioners reported offering clear, credible, and reassuring explanations by utilising visual aids to support patients' understanding. Since patients had thought explanations were absent or nonsensical during previous consultations, these practitioners addressed an essential need in a person-centred way. Practitioners were also mindful of inadvertently exacerbating their patient's concerns by avoiding visual indicators which might signify serious illness.

...I just use a skeletal diagram basically, focusing on the spine. There's no broken, red bits anywhere. ...that's what I showed her beforehand... And then, we go back to that diagram, and I'll say, "Yep, that's what we found there...that's where the problem is".

[Alexander, Chiropractor, Male, 30-34 years]

Practitioners also acknowledged the inter-connection between physical and socio-emotional factors which helped them individualise their approach. Through adopting person-centred practices, practitioners were able to recognise and begin to address cognitive or emotional factors potentially exacerbating patient's symptoms. For instance, after carefully considering Chloe's circumstances, Charles recognised

possible psychosocial factors influencing her pain expectations. Providing a multi-dimensional explanation of pain was perceived as challenging but beneficial to address Chloe's LBP-related anxiety. Charles emphasised the importance of first establishing trust before introducing information that may contradict unhelpful or misinformed pain-related beliefs because of the risk of undermining the relationship or appearing to invalidate her pain experiences.

...[Chloe's] older sister is a long-term back pain sufferer, and I have no doubt that seeing her sister's experience with back pain probably influenced her expectations and fears... the last thing I want to risk is sounding dismissive about their pain... it is a delicate conversation ...she was getting better at the point that I introduced this psychosocial stuff ...by then they trust you enough to maybe say things that contradicts beliefs that they have previously held. ...I usually recommend the Lorimer Moseley Ted talk after and follow it up ...when I'm having the conversation with them, they're probably hopefully taking that on board a bit more, because I know them, and I'm making it more relatable to them.

[Charles, Chiropractor, Male, 25-29 years]

Chloe thought the personalised explanation together with the pain science video was beneficial. This knowledge enabled Chloe to reinterpret her pain experiences and reduce fearful responses which did not appear to impair the therapeutic relationship.

...he's just said that because I've been very wary of it, that a lot of it has become psychological, which I totally understand because I would feel one twinge of pain and be like, "Oh my God I can't do this, it's bad!" Whereas it's not actually... I think is a good thing that I've understood that now.

[Chloe, Female, 18-24 years]

Patients also found it helpful when practitioners discussed and reviewed their goals by exploring valued activities. Revisiting these goals throughout their treatment and working together towards their goals seemed to strengthen the relationship.

...going through, I guess what my main goals are, which again was something really important to me. ...why do I want to get this sorted? Where do I want to be? What am I trying to achieve? ...I found that really helpful.

[Amelia, Female, 30-34 years]

Practitioners also focused on understanding patient's goals and their capacity to engage in valued activities in a person-centred way. Practitioners considered this important for creating a trusting relationship and described discussing barriers, using empathy, exploring patient's motivation and self-efficacy, whilst acknowledging and encouraging their progress.

...those goals, those underlying factors is something I put a real focus on, trying to understand with patients. I think it's really key to get that trust and rapport going. ...then just affirming the progress she had made. I really wanted to kind of boost her motivation and self-esteem ...I could see she had that motivation. I really wanted to elicit that, really draw it out, and, and cement it...

[Alexander, Chiropractor, Male, 30-34 years]

Although less salient, another person-centred approach involved practitioners clearly explaining the consultation and treatment. Patients found it useful because it put them at ease, helped manage their expectations, and assisted in building trust.

...because he makes you like thoroughly understand what he's doing, why he's doing it.

[Chloe, Female, 18-24 years]

He went through what was going to happen in the consultation, but also reassuring that nothing will happen without you knowing. ...which again put me at ease completely!

[Amelia, Female, 30-34 years]

To ensure mutual understanding, practitioners noted that it was useful to clarify the consultation process, so patients knew what to expect. Actively considering the patient's perspective promoted the development of a good-quality relationship.

...explain what I'm going to do on the day. ...it's giving them a map of what we're doing within the consultation so they're not just being led through it, and wondering what's next and will they get treatment or not? It's kind of pre-answering some questions they might have ...It's explaining some answers as I go along. So, explaining what I'm looking for as well.

[Ben, Chiropractor, Male, 30-34 years]

Through adopting a person-centred approach, practitioners could identify and respond to patient's individual needs which cultivated trusting therapeutic relationships.

Practitioners' attributes and attitudes

During LBP consultations, patients expressed positive impressions of their practitioners, which helped establish trust in their practitioner's expertise and supported the development of a good-quality relationship. From the patients' perspectives, important practitioner attributes and attitudes included being kind, calm, welcoming, friendly, professional, and knowledgeable.

He was very professional, very calm, very kind... I've met people, and you think, 'Oh, you don't really know what you're doing,' but I never had that impression, and he was completely professional ...it's good to feel safe with the person who is dealing with your back, because your back is very important.

[Beth, Female, 35-39 years]

Amelia and Chloe's initial impressions were also influenced by others' positive experiences of care through word-of-mouth referral or online reviews. Others' experiences may have been important because both were dissatisfied with their previous treatment. These patients' impressions of their practitioners' supportive attributes and professional expertise were partly informed by personal and vicarious experiences.

...anything I buy, I'm always Googling you know. Is this good? What are people saying about it? What experience have they ever had? ...then read the reviews online, and they were just glowing! Alexander's particular name, his name kept coming up...in the glowing, glowing reviews.

[Amelia, Female, 30-34 years]

Equally, practitioners emphasised the importance of developing the therapeutic relationship from the outset. Practitioners described being attentive to

verbal and non-verbal cues and tried to display caring and compassionate attitudes. Empathy was an important attribute that practitioners consistently demonstrated. An empathic approach was perceived as a valuable in addressing patients' multifaceted needs and cultivating the therapeutic relationship.

...[empathy] is really important. ...I felt like she didn't really experience any empathy before, any consideration of her point of view, and actually found that quite a traumatic experience. ...it was really trying to calm her anxiety down, make her feel safe, make her feel respected, you know reassure her that I was going to take it slow, and tell her what's going on. ...she's been very clear that she's much happier this time, and she feels a lot safer, and she has that trust, and that she feels respected and listened to.

[Alexander, Chiropractor, Male, 30-34 years]

Notably, Amelia described feeling trust and a sense of partnership because she felt respected, reassured, and supported. She acknowledged Alexander's attitude was distinctly different from her previous experience since he focused on fostering trust to build the therapeutic alliance.

...I already was feeling that trust for him. ...this isn't like that guy that I saw before, this is a totally different situation. ...building trust is on my terms, I'm kind of in control of that, almost like a partnership... That's what it felt like, and that's what it has felt like since. It's a partnership, it's a two-way thing.

[Amelia, Female, 30-34 years]

Practitioners recognised that by engaging with patients in a holistic way, they were providing both physical care and psychosocial support which was useful in building and maintaining trusting relationships.

...you build a social relationship with a patient ...talk about how she'd been getting on day-to-day and some of the work stresses, and things like that ...I think we've developed quite a good relationship... Some people are not always able to talk to other people about those things. ...having someone to talk to...it can be a useful part of it [the treatment], since we know that low back pain isn't just affected by biomechanical parts.

[Ben, Chiropractor, Male, 30-34 years]

Although practitioners reflected on their own physical attributes, this seemed less relevant to patients. Initially, practitioners perceived the use of medical masks as a communication barrier believing it affected their ability to build patient rapport. Practitioners described adjusting by paying additional attention to non-verbal cues such as their patient's eyes, vocal tone, posture, and body language.

...masks were a difficult one to get used to, because we're used to trying to read people's expressions and things. ...there's so much communication involved in what we do, both in terms of what we're conveying, and what we're interpreting....so much of what we receive is body language, and facial expressions, and tone of voice... [wearing masks] made it difficult in terms of building rapport.

[Charles, Chiropractor, Male, 25-29 years]

The sub-themes highlight the shared recognition of patients and practitioners regarding the importance of person-centred practices and effective interpersonal communication in establishing a positive and high-quality relationship during LBP consultations.

Theme three: Shared journey to recovery

This theme describes the shared journey towards recovery between patients and practitioners during LBP consultations. Two sub-themes were identified: (a) shaping recovery expectations, which included assessments, care plans, and prognosis; and (b) treatment credibility and expectations.

Shaping recovery expectations – assessments, care plans, and prognosis

Patients described undergoing thorough physical examinations during their initial consultation and found it helpful when practitioners highlighted functional improvements following regular physical assessments. Sharing symptom changes appeared to serve as a positive indicator to patients of their progress during their

recovery journey.

...I had to bend to the side, to the back, and moving my leg, and it was just seeing how the movement of them and what sort of restriction was there. ...I know the positions I need to be in, to know how well it was going. So yeah, it was good.

[Beth, Female, 35-39 years]

Practitioners also focused on regularly sharing positive observations regarding noticeable changes in physical functioning including activities of daily living during consultations. By doing so practitioners aimed to instil a sense of optimism or hope by reassuring patients that they were heading in the right direction and were on the road to recovery.

...you can demonstrate even subtle changes early on, whether those be objective in terms of, just seeing how someone's moving slightly differently, or orthopaedic tests, or strength, or anything like that, or subjective, how she's feeling... you can demonstrate that they are helpable. I really, jump on that straight away, with a long-term patient, I can say, "Right, we know that you respond to this, we know it's going to get there, and we can see improvements, and this is a helpable issue..."

[Charles, Chiropractor, Male, 25-29 years]

All three patients described a tapered treatment plan which seemed to be important for them to establish a sense of moving towards recovery. Patients found it helpful when the next steps in their care plan were clear since this was perceived as useful for managing recovery expectations. Interestingly, attending fewer LBP appointments appeared to be interpreted as an indicator of progress for some.

...for the first three weeks, I saw him twice a week, and then it went to once a week, and then, once every other week. It was good, because it meant that I was recovering... it meant that my back was progressing, and he was happy with the progress that was going on and how well it was healing.

[Beth, Female, 35-39 years]

Practitioners mentioned adopting a tapered care plan but thought that regular assessments and reviews were important to evaluate their patient's recovery journey. Clearly explaining care plans assisted in managing their patient's recovery

expectations. Evaluating how patients were responding guided practitioners in adjusting initial treatment plans.

...I start by treating someone slightly more intensively, and then gradually and progressively, as they're feeling better, I reduce the frequency ...with a view of really assessing her after those first four sessions, to actually make sure that she's improving... I need to know if something needs to change

[Charles, Chiropractor, Male, 25-29 years]

Other ways practitioners attempted to create positive recovery expectations may not have been as noticeable to patients. Practitioners described using a 'hands-on' approach during all physical assessments and thought it was important to explain what they were evaluating along with sharing their findings. More importantly, practitioners were acutely aware of explaining findings in a manner which helped normalise patient's experiences of distressing symptoms without exacerbating their fears and concerns to support positive but realistic recovery expectations.

...explaining that, "Okay, this is what we usually look for, this is what I found", but without catastrophising certain movements...if the range of motion was extremely limited, I'd put a context for that and I'll say, "and that's quite normal if you've got back pain" ...if there is a chance that a patient could become worried about a particular movement not being good enough, I'm reassuring them and saying, "Oh, this is temporary, once muscle spasm tends to go down, then you'll get the normal range back".

[Ben, Chiropractor, Male, 30-34 years]

Additionally, practitioners focused on providing an optimistic prognosis during the report of findings whilst also allaying patient's fears to help manage their recovery expectations. Practitioners mentioned carefully choosing their words, reassuring patients, and emphasising positive aspects too (e.g., no signs of damage or serious pathology, good hip/knee range of motion). Practitioners actively avoided terminology with negative connotations such as damaged, degenerated, advanced, severe, slipped, or bulging discs because they were mindful of how their words might influence patients' perceptions or create unnecessary distress. Similarly, they

tried to avoid statements which might appear to dismiss, downplay, or negate patient's pain experiences. Softer and simpler language was used to inhibit fear or alarm. For example, framing LBP as "a muscle and joint problem" or using terms like irritation/sensitisation instead of compressed/trapped nerves. Practitioners expressed confidence in their ability to help, whilst emphasising that their patient's LBP was routine and treatable with some mentioning previous successful cases. Although practitioners' views differed about offering a mechanical diagnosis, they all thought it was important to provide clear, non-technical explanations first and focused on decreasing patient's anxiety.

...patients say, "my bad disc", "I've got a disc problem here", "I've been told my facet joints are damaged or degenerated" ...patients imagine that something is there, and it's there still, and it will always be there in their back, for the rest of their life. And it's almost like an entity that they keep with them, almost in terms of how they conceptualise it. And that's what I don't want to do. ...I'll try and keep the language a lot simpler, in an attempt to avoid that happening

[Ben, Chiropractor, Male, 30-34 years]

"...this is a case I see a lot. And we get really good results, so I'm confident that you're in the right place, and confident we can help, and the good thing is as well, there's nothing else more serious going on." ...I wanted her to really feel like this is good news... I wanted to make sure every part of it could reduce down the anxiety.

[Alexander, Chiropractor, Male, 30-34 years]

Since patients had expressed a clearer understanding of their LBP symptoms, they did not seem to be too concerned with receiving a clinical label. Interestingly, both Amelia and Chloe believed their recovery journey would take time and found it helpful that their expectations had been appropriately managed during LBP consultations.

...he didn't try and sell me the world; he didn't try and sell me a quick fix ...my expectations of this is [it is] going to be a bit of a journey, I'm aware of that, it's going to take a bit of time, and that's okay; I found that really, really helpful.

[Amelia, Female, 30-34 years]

Although practitioners aimed to positively shape patients' recovery expectations, they recognised the importance of providing a realistic view of the journey too.

I explain beforehand, how it's a non-linear path to recovery...I set the expectation, so that it doesn't panic them, when inevitably they do have good and bad days, which I find helps.

[Charles, Chiropractor, Male, 25-29 years]

Treatment credibility and expectations

Patients held positive perceptions regarding a range of treatments received during LBP consultations. Physical and manual therapies were viewed as credible treatments for ameliorating persistent symptoms. Notably, patients thought following prescribed exercises were helpful and important to their recovery journey. Exercise seemed to be conceptualised as a tool for keeping their back loose and/or regaining strength. Moreover, Chloe thought the personalised advice combined with adaptive exercises were useful for her recovery which had previously been unsatisfactory during earlier treatment.

...there were exercises, so you started off with, sort of movement exercises, and then strengthening exercises. They don't take very long, they're not very difficult. ...some of the exercises would keep my back loose, and some were for strengthening, like the muscles in my back. The exercises have helped, and I felt the difference as well ...I just really did the treatment and I stuck with the exercises

[Beth, Female, 35-39 years]

Patients also expressed positive treatment expectations regarding how different therapies might address specific issues contributing to their LBP symptoms. Patients believed manual or physical therapies released tension, increased blood flow, reduced muscle spasms, addressed inflammation, and improved mobility which was thought to be beneficial to their recovery. Patients described these treatments as

painless, comfortable, or quite pleasant even if they experienced some apprehension initially.

...he was really clear on, kind of, what the acupuncture does in terms of the blood flow. ...where I have the pain in that lower disc, is inflamed and everything around it is stressed, and trying to protect it. ...as it does that, it's super tense, which is then causing that mobility issue. So really clear on how the acupuncture can help that ...then on the flip side what some of those alignments can do ...and how that can almost free up, once that, blood flow has been introduced a little bit more, so, I was really clear on what those things would do for me, which is good.

[Amelia, Female, 30-34 years]

...he like electrocuted it, and manipulated it, and I did some exercises and then he sent me some exercises that I need to do. ...he put his little machine on my back, and that was it really, I didn't feel it at all. It was just sending like electrodes fastened to my back to put my disc where it should be, and to help with the muscles around it and the inflammation.

[Beth, Female, 35-39 years]

All practitioners in the study provided Chiropractic treatment, which was viewed as an effective therapy for managing LBP. However, practitioners also expressed concerns about patients becoming overly reliant on manual therapy and thought this could be unhelpful in the long-term. To support patients in their recovery journey, practitioners emphasised the importance of self-management techniques such as heat therapy, progressive activity/exercise programmes, and individualised advice.

...just being a guide for patients, and for her in particular, to show them a journey out of back pain... All the self-management techniques, like using heat, being more active, having conversations about days when she was less active ...giving a structured way to be active ...manual therapy helps with the pain part, which then has a knock-on effect, of the function improving, but it doesn't strengthen muscles... That's up to the patient. ...it's building that into the consultation, to avoid that reliance. We want them to have ways that they can control it and improve their function.

[Ben, Chiropractor, Male, 30-34 years]

Patients appeared satisfied with their LBP treatment since there was nothing different they would have preferred. More importantly, patients conveyed optimistic

attitudes about their recovery. For example, Beth said, “*my recovery has been really good actually*” and seemed confident about self-managing her LBP. Chloe and Amelia noted symptom improvements and expressed hope about their recovery.

It's definitely not as frequent, it's definitely not as bad, and there's less symptoms than what I used to have ...I think the way he's gone around it has been very useful to me ...Now I do [feel there is hope]. I haven't in the past five years.

[Chloe, Female, 18-24 years]

Optimistic, is the right word. ...I feel so open to this. I just feel open, and optimistic, because I trust him.

[Amelia, Female, 30-34 years]

During interviews, practitioners reflected on their journey with each patient and expressed that they were also satisfied with the treatment they provided.

...I find it hard to look back at what I would see as a very successful case of someone with chronic back pain that hadn't gotten better for a long, long time and say that I would have done anything differently.

[Charles, Chiropractor, Male, 25-29 years]

Theme four: Quality of the treatment space

This theme captures the views of both patients and practitioners on the significance of the quality of the treatment space during LBP consultations. Two sub-themes emerged, namely (a) patients feeling safe, and (b) physical aspects of the clinic.

Patients feeling safe

A sense of feeling safe was an essential aspect related to the quality of the treatment space. This appeared to be important since patients were attending face-to-face consultations during the Covid-19 pandemic. These hygiene protocols helped patients to feel safe and comfortable during LBP consultations and allay underlying anxieties.

...Covid restrictions were put into place. I had to wait in the car, and he came out and checked my temperature with a like gun thing, and washed my hands, with sanitising gel, and then when I was leaving, I had to do the same. I knew that when I left, he cleaned the sofa, which means before I got there, he cleaned from the last person, so I didn't have to worry...

[Beth, Female, 35-39 years]

...they had some procedures in place: which is you wait outside; you're called in; my temperature was taken; I was asked to hand sanitise... Everything just felt safe.

[Amelia, Female, 30-34 years]

Creating a feeling of safety by ensuring Covid-19 hygiene guidelines were purposely and consistently adhered to, not only because it was expected, and safe practice, but because practitioners recognised that high cleanliness standards were important to maintaining a good quality treatment space. Besides using personal, protective equipment (PPE) such as medical masks and scrubs, other measures included screening patients, minimising contact, spacing appointments, welcoming patients outside, and adapting treatment and waiting areas to minimise patients' exposures.

...PPE, Perspex screens behind reception, knee operated sinks, you know hand sanitiser all over the place... essentially PPE and cleaning measures which already had to be pretty good ...in terms of the layout of the clinic, everything's much the same, except with the necessary precautions taken. And perhaps things like initially spacing out appointments...

[Charles, Chiropractor, Male, 25-29 years]

A feeling of safety was also expressed by patients in the way staff made them feel at ease. Reception staff were notable in this role by being welcoming, friendly, polite, and approachable.

I met with two front of house people and they're just so welcoming, and friendly, and polite... if businesses realised how much impact receptionist, or front of house staff, makes people's experiences... I think they would invest more in those people because, it already just put me at ease straight away!

[Amelia, Female, 30-34 years]

...the lady at the desk is always smiling and cheery... that always helps to have someone who is approachable and friendly.

[Beth, Female, 35-39 years]

Similarly, one of the practitioners appeared to be aware of the importance of having a friendly and welcoming face as soon as patients entered the clinic and highlighted that this was an intentional aspect of the practice to ensure patients felt at ease.

...the front desk staff, who are a fantastic team, are very friendly, very welcoming, really go out of their way to put people at ease.

[Alexander, Chiropractor, Male, 30-34 years]

Physical aspects of the clinic

The second aspect which contributed to a sense of a high-quality treatment space, from the patients' perspectives, were physical aspects of the clinic. For example, displaying practitioners' photographs and credentials in reception, separate/private treatment areas, and windows/natural light which appeared to create a positive impression.

It [the clinic] was lovely, so when you go up the stairs, you go through the doors and on the left-hand side there's a little table, and it shows the picture of the people that work there... and there was a little report, these are the people who work there, and what their qualifications were, their history of the job... because then you know who you're dealing with almost.

[Beth, Female, 35-39 years]

Only one of the practitioners described the interior design and décor as an important feature of the clinic, which had been carefully considered and intentionally designed so patients would feel relaxed and at ease during their appointments. He highlighted features which helped to create a clean and professional treatment space such as using natural colours schemes and artwork instead of anatomy posters to try de-medicalise the clinic.

...we've gone out of our way to make it not too medical, we want it looking clean and professional ...we've got like natural colours, so it's not stark whites ...we've got a little bit more curated artwork... I've got a couple of anatomy posters, but a lot less than there used to be. ...sorta gone for the bare minimum, I don't want it to be too clinical. I want it to be a place where they can come in and feel they can relax.

[Alexander, Chiropractor, Male, 30-34 years]

The sub-themes of feeling safe and physical aspects of the clinic illustrate how the quality of the treatment space is an important factor in creating a positive environment of care for patients during LBP consultations.

Thematic map

Figure 1 below provides a conceptual overview of the study's results, illustrating the relationships between the four main themes and corresponding sub-themes.

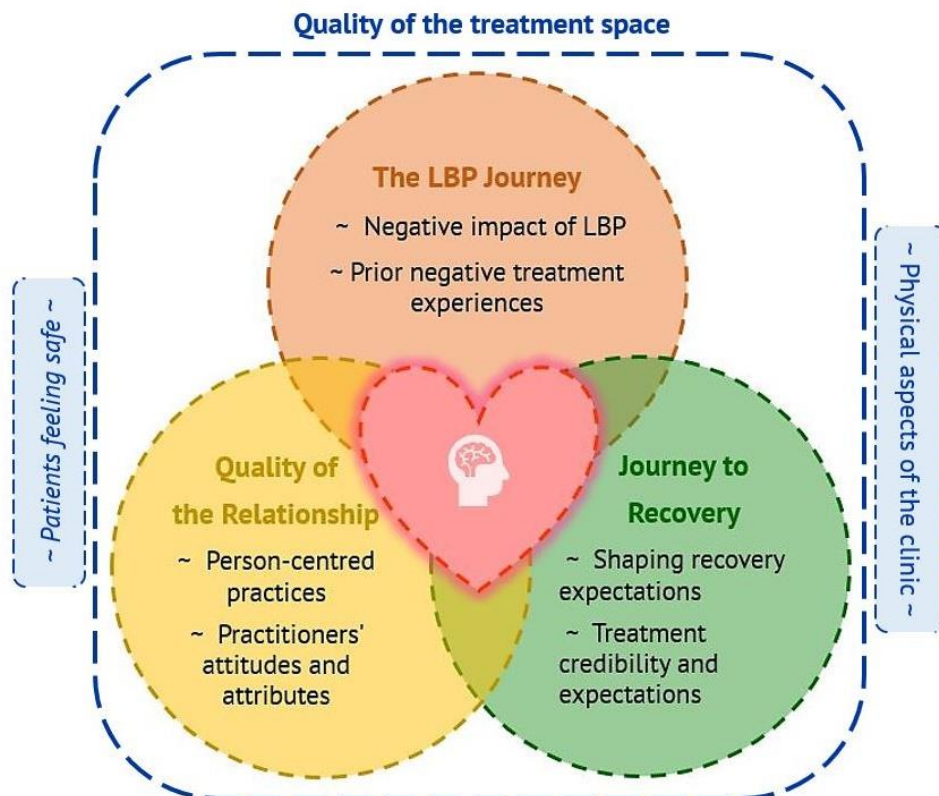


Figure 1. Thematic schema illustrating main themes and sub-themes and their inter-relatedness

The diagram illustrates that at the heart of LBP consultations is the MSK practitioner. The heart-shaped icon symbolises their compassionate mindsets which shaped their care approach. The dashed lines represent the permeating nature of practitioners' beliefs which were infused in key elements of these consultations as depicted by each circle.

Practitioners' values, characteristics, and beliefs played a crucial role in shaping their approach during LBP consultations. Practitioners' philosophy of practice enabled them to gather essential information, explore critical aspects of each patient's journey, identify patients' previously unmet needs, as well as establishing trust and an initial rapport. Practitioners' person-centredness and interpersonal communication skills were key in establishing trusting therapeutic relationships, ensuring patients felt supported, empowered, and engaged in the shared journey to recovery.

Practitioners also recognised the importance of tailoring treatment to address patients' complex needs which guided patients' treatment and recovery expectations. Practitioners' beliefs and characteristics coloured the nature of each interaction, leading to genuine connections with each patient. Finally, the treatment environment played an important role in creating a receptive, clean, and safe space for patients, which formed a supportive foundation for enriching the quality of communication. These CFs were interwoven into LBP consultations and were valuable to patients' positive experiences.

Discussion

Summary of the findings

This research aimed to draw on the experiences of UK patient-practitioner dyads to provide deeper insights regarding the perceived importance and role of CFs during LBP consultations. The results highlight four key findings. Firstly, MSK practitioners' characteristics and beliefs emerged as beneficial CFs which shaped the quality of patient-practitioner interactions during LBP consultations which is a novel finding. Secondly, meaningful treatment characteristics positively influenced patients' treatment and recovery expectations such as articulating an optimistic prognosis, demonstrating functional progress, and establishing the credibility of treatments. Collaborative goal setting, tailored advice, and personalised graded activities were also perceived as beneficial treatment characteristics which helped address patients' needs. Thirdly, qualities of the treatment environment including high hygiene standards and friendly, approachable support staff helped reinforce patients' experiences of a safe and welcoming space. Lastly, practitioners described actively leveraging CFs during private care consultations for patients experiencing cLBP with the intention of positively influencing emotions and perceptions to support their recovery.

Perceived importance of CFs during LBP consultations

Role of MSK practitioners' characteristics and beliefs

MSK practitioners' characteristics and attitudes towards patients emerged as beneficial CFs by shaping the development of a good-quality relationship. Practitioners recognised the complexity of each patient's LBP journey instead of solely focusing on diagnostic information. Each patient's LBP journey was highly

individualised with an intricate array of adjunctive factors. Giving patients an opportunity to recount their LBP experiences together with practitioners' ability to elicit valuable information was pivotal in identifying patients' multifaceted needs. How practitioners made use of person-centred practices, whilst validating patients' experiences were a notable feature across participants' LBP consultations. These person-centred practices involved MSK practitioners actively listening to patients' stories by not interrupting, expressing empathy, offering encouragement, using open-ended questions, and summarising/reflecting which helped patients feel heard and understood, consequently building trust. Participants recognised excellent interpersonal communication skills were essential for building trust which was instrumental for cultivating therapeutic relationships.

Patient's individual preferences, prior experiences, and expectations can positively or negatively influence clinical outcomes [22,41] and affect the magnitude of the response during MSK rehabilitation [42]. Since patient-practitioner interactions shape patients' experiences and expectations, actively listening to appreciate the value of a patient's story could be considered a therapeutic intervention in its own right [43,44]. Meaningful conditions for creating a safe environment include being present and receptive whilst listening to a patient's journey to identify prominent needs and concerns which supports the therapeutic relationship [45]. Presence is the cornerstone of effective clinical engagements, whilst receptiveness provides the framework for gathering pertinent information [45]. MSK practitioners in the current study demonstrated presence and receptiveness during LBP consultations which helped support the therapeutic relationship. MSK practitioners who actively listened and demonstrated an

understanding of their patient's journey were then able to individualise their care approach which highlights key aspects of person-centred practices.

Adopting a person-centred approach to develop a strong therapeutic relationship establishes the recovery context which positively shapes patients' expectations [8,9]. Person-centred communication skills such as active listening, paraphrasing, empathy, offering encouragement, and humour has previously been associated with an improved therapeutic alliance which positively influences clinical outcomes [41,42,46]. A good-quality patient-practitioner relationship strengthens the therapeutic alliance [47] which can positively influence pain and physical functioning outcomes in patients with LBP [48,49]. Similarly, person-centred communication that enhances the therapeutic alliance is an influential CF associated with pain improvements during cLBP treatment [18].

Patients in this study reported forming positive impressions of their MSK practitioners and valued practitioners who were kind, calm, welcoming, friendly, professional, and knowledgeable. Patients' positive experiences also built confidence in their practitioners' expertise, which cultivated good-quality relationships. Practitioners emphasised the importance of developing a therapeutic relationship from the outset by being attentive to verbal and non-verbal cues and consistently demonstrating empathy.

Positive body language to demonstrate warmth and friendliness, along with expressing genuine empathy or concern, and an authentic interest in the patient cultivates a strong therapeutic relationship [8]. The effects of positive and empathic

communication have also been associated with improved pain intensity outcomes [50]. Using open body-language such as eye-contact, smiling, a warm tone of voice, along with higher perceived competence and professionalism modulates patients' pain [51]. Findings from a recent Delphi-consensus survey revealed that UK MSK practitioners believed their own traits and mindsets could be deliberately harnessed to influence outcomes during cLBP rehabilitation [38]. Practitioner attributes that were perceived as being influential included attentiveness, kindness, calmness, compassion, genuineness, honesty, creating a caring atmosphere, and prioritising patients to build trust [38]. Practitioners intentionally used positive body language and effective reassurance to strengthen the patient-practitioner relationship, which was regarded as the most important CF during cLBP treatment [38]. It is therefore important for MSK practitioners to engage in person-centred practices to enhance the therapeutic relationship [52] since patients may feel invalidated, dehumanised, or experience distress during negative clinical interactions [53]. Furthermore, practitioners' attitudes, together with their verbal and non-verbal behaviours, have the potential to influence patients' pain experiences [51,54]. For instance, focused receptivity involves actively considering patients' verbal and non-verbal behaviour to acquire insights into their physical and psychological circumstances [45].

In this study, MSK practitioners recognised the complex nature of patients' LBP experiences and acknowledged the importance of addressing cognitive and emotional factors potentially exacerbating their symptoms. To provide patients with clear, credible, and reassuring LBP explanations, practitioners used visual aids and sometimes offered multi-dimensional explanations of pain to address LBP-related anxiety. Notably, practitioners emphasised the importance of establishing trust

before introducing information that could contradict unhelpful or misinformed pain-related beliefs, as this could undermine the therapeutic relationship or invalidate the patient's experiences. This aligns with the findings of Bunzli et al. [32] where patients needed to make sense of their pain.

In their study, participants believed LBP was unpredictable, intense, and uncontrollable which made it feel threatening and difficult to understand [32]. Diagnostic uncertainty left participants fearful and unsure of how to manage their threatening pain experiences [32]. Patients want comprehensive and personalised LBP explanations that extend beyond a diagnostic label [31]. This information helps patients understand reasons for their pain which enables them to engage in treatment-related decisions more effectively [31]. Using negative language during an educational LBP video negatively affected healthy participants' anxiety levels and their illness beliefs in a recent randomised controlled trial [55]. Person-centred education to address unhelpful or misinformed illness beliefs is an important CF which may improve outcomes in conservative cLBP treatment [18]. Collectively, these findings highlight the benefits of offering illness and pain-related information to support patients in understanding factors contributing to their LBP. Doing so can contribute to the reduction of emotional distress (e.g., anxiety), subsequent catastrophising, and fear-avoidant behaviour, where the first two factors have been consistently associated with poorer clinical outcomes [56].

Patients' previous negative treatment experiences were attributed to practitioners' poor communication and interpersonal skills, and a lack of clear or credible explanations of their LBP, leading to increased anxiety, frustration, and

mistrust. Amelia's negative and enduring memory of her initial treatment experience underscores the importance of MSK practitioners not only treating patients' physical symptoms, but equally recognising and addressing their cognitive and emotional needs. An absence of person-centred practices may prolong LBP experiences, increase symptom severity, and delay future treatment-seeking, particularly in cases where trust was not established, as illustrated by Amelia's case. By providing psychosocial support alongside physical care, practitioners can engage with patients in a holistic manner, to build and maintain a trusting relationship. Overall, this key finding highlights the clinical significance of person-centredness and the integrated management of LBP in fostering a positive therapeutic relationship. The attributes and attitudes of these practitioners were instrumental in achieving this clinical goal. The role of their credibility, professionalism, genuineness, and congruent communication approach was influential in building trusting therapeutic relationships in this study.

Meaningful treatment characteristics

In this study, practitioners conducted comprehensive physical examinations during LBP consultations, ruled out serious illness/injury, and regularly shared observations of noticeable improvements in physical functioning, including activities of daily living. This positive feedback served as an indicator of progress, instilling a sense of optimism and reassuring patients they were on the right track. Practitioners focused on offering an optimistic prognosis, while being mindful of exacerbating patients' anxiety by avoiding pessimistic language. Clearly communicating the next steps in the treatment plan helped manage patients' recovery expectations. For some patients, attending fewer appointments was seen as a sign of progress, emphasising the

importance of establishing a sense of moving towards recovery.

Practitioners' words or choice of phrases can have a significant and enduring impact on patients' LBP beliefs, including their expectations for recovery [57,58]. Low recovery expectations are considered a strong predictor of poor clinical outcomes in patients with non-specific LBP [59]. Using appropriate reassurance combined with a positive prognosis can positively influence patients' beliefs regarding current and future LBP episodes which could have beneficial effects [57]. Consultations that include a complete examination process, including history taking and physical assessments, can be considered simple interventions [60], as touch is a recognised CF [12] capable of relieving pain [61,62]. In a cohort of patients experiencing LBP for the first time, the examination process had small but significant effects on pain intensity, pain catastrophising, fear-avoidance, mobility, and physical sensitivity [60]. MSK practitioners in the current study recognised the importance of a comprehensive physical examination for building credibility in their skills and initial treatment recommendations, and regularly reviewed and reassessed patients to evaluate their recovery journey and adjust the treatment plan. Regular reassessments helped patients understand the progress they were making which was reassuring. Additionally, frequent reassessments were important in establishing the credibility of the treatment, as patients could see that the practitioners were actively monitoring and adjusting their treatment plan based on their changing needs.

Patients expressed positive views of various LBP treatments, such as exercise and manual or physical therapies (e.g., acupuncture, massage), which they perceived as credible and painless for ameliorating persistent symptoms. Prescribed exercises

were seen as important for LBP recovery and were conceptualised as a tool for keeping the back loose and/or regaining strength. Patients also believed that manual or physical therapies alleviated tension, improved blood flow, reduced muscle spasms, addressed inflammation, and improved mobility. More importantly, they held positive expectations for therapies that were believed to address physiological issues contributing to their LBP. Interestingly, practitioners' beliefs and expectations about different therapies, and how these were communicated, appeared to influence patients' expectations and perceptions. While all practitioners provided chiropractic treatment, they were cautious about patients solely relying on manual therapy and stressed the importance of self-management techniques like heat therapy, progressive exercise, and personalised advice for long-term recovery. All patients were satisfied with their treatment and believed it was improving their LBP symptoms and overall well-being.

Patients' experiences in this study are consistent with the key treatment characteristics identified in previous research which shaped patients' beliefs about LBP treatments [31]. These characteristics include a treatment approach that is deemed credible and administered by a trustworthy practitioner, has proven effectiveness in achieving relevant goals, is perceived as appropriate for the patient's individual situation and diagnosis, and is considered safe and accessible [31]. The current study's findings were also aligned with a recent scoping review that showed patients preferred and believed in the effectiveness of manual therapy for LBP [63]. In a recent qualitative study, patients did not believe exercise was a common feature of manual therapy, but an important component of their long-term self-management plan [64]. Exercise was conceptualised as a protective factor to prevent future LBP

episodes. The perceived benefits were typically linked to biomechanical mechanisms indicative of possible misconceptions or misinterpretations regarding the rationale practitioners provided for engaging in exercise [64]. Similarly, patients in the current study expressed comparable views as they appeared to focus on the physical benefits only. It is also possible that patients may have simply viewed it as “medical exercise” since practitioners framed it as a self-management approach.

Other meaningful treatment features identified in the current study included using collaborative goal setting, providing personalised advice, and tailoring graded activities which helped to address patients’ previously unmet needs. Recurring failures in achieving functional goals and unsuccessful treatments may result in patients feeling unable to make ‘sensible’ LBP management decisions [32]. During physiotherapy, demonstrating person-centeredness involves providing personalised treatment, maintaining open communication, educating patients, and working towards patient-defined goals [65]. Thus, practitioners’ specialised knowledge, interpersonal skills, and confidence are key in supporting and empowering patients [65]. Likewise, the current study suggested MSK practitioners aimed to foster collaborative relationships with patients to help them achieve their goals and address barriers limiting activity levels. Practitioners consistently used person-centred approaches to tailor treatment to address patients’ needs and manage their recovery expectations.

Patient’s treatment expectations are a recognised prognostic factor in MSK pain [66,67] which shape patient’s pain experiences [68]. Expectations for pain relief can influence physical functioning and pain intensity outcomes in patients with LBP

[69,70]. A recent systematic review identified verbal suggestions and physical or visual cues as key CFs that influence patients' recovery expectations and perceptions of treatment effectiveness [18]. A meta-analysis found that interventions designed to influence patients' expectations had small but positive effects on chronic pain and suggested that combining different types of expectations could enhance these effects [71]. Chen et al. [54] found that patients' pain intensity was influenced by practitioners' expectations of treatment success, which were communicated through subtle cues like facial expressions and non-verbal behaviour during simulated clinical interactions. In the present study, practitioners used a range of approaches to shape patients' expectations. These included physical, visual, and verbal cues, as well as emphasising symptom improvements and explaining beneficial treatment features to establish its credibility. These findings suggest that practitioners were impactfully shaping patients' recovery and treatment expectations during LBP consultations.

Qualities of the treatment setting

Adherence to hygiene protocols and high cleanliness standards, together with friendly and approachable reception staff contributed to patients feeling safe and comfortable during LBP consultations, particularly during the Covid-19 pandemic. Private treatment areas, displaying practitioner credentials, and intentional design choices (e.g., artwork, natural colour schemes) also contributed to positive patient experiences by creating a relaxing and comfortable space.

The care environment plays an important role in influencing patients' safety, pain experiences, mood, anxiety, stress, and satisfaction with care [72,73,74].

Healthcare environments that prioritise patients' physical safety (e.g., preventing infection, falls, medical errors) and psychological well-being and security are essential for promoting optimal healing [72,73]. Cleanliness can increase patients' sense of safety [75,76] and welcoming design choices may help reduce anxiety [77]. The organisation of space is also important, such as features which support social interactions and communication [78], accommodate patients with mobility issues, and facilitate personal space and privacy [77,79]. Inadequate privacy can affect healthcare interactions as patients may be hesitant to share sensitive information or experience a loss of dignity during physical examinations [79,80]. Respecting patients' need for privacy and dignity is therefore important to facilitate open and honest communication and prevent dehumanising experiences.

Considering qualities of the healthcare environment presents an avenue where Clinical Directors, Estates personnel, or public health providers could potentially implement modest changes to influence patient satisfaction, mood, and clinical outcomes. For example, basic communication skills training for frontline staff can put patients at ease and reduce perceived barriers to accessing care. Design features that promote relaxation and healing include using natural lighting, nature-related views or artwork, plants/flowers, water features, relaxing, soft music, or reducing unpleasant noises. Additionally, comfortable temperatures, pleasant aromas, and soothing colour schemes can create a calming effect. Research has shown that these design features have a positive impact on patient outcomes [12,72,74].

While the healthcare environment has been shown to be important for supporting patients' healing and well-being, there is limited evidence regarding which design features are most effective or how different elements may interact [79,81]. Nevertheless, there is an opportunity to apply person-centred design principles in MSK clinics and outpatient rehabilitation facilities. Before making significant changes, it may be worthwhile to conduct a user-needs-analysis to evaluate clinical employees' and patients' views and ensure subsequent changes create the desired atmosphere while also addressing staff and patients' needs. Since the impact of the environment may be influenced by other CFs, an integrated approach considering multiple CFs is likely to be more effective in promoting positive clinical interactions and outcomes.

Leveraging CFs during LBP consultations

The preceding themes and overarching findings collectively illustrate how CFs were instrumental in positively shaping LBP consultations and shifting patients' mindsets towards a more optimistic or hopeful outlook. These MSK practitioners and their patients recounted numerous experiences where CFs were used during clinical practice. Practitioners described actively leveraging CFs with the intention of positively influencing patients' emotions and mindsets to subsequently influence patients' clinical outcomes.

However, these practitioners' interest in CFs, and their ability to implement them during LBP consultations may not reflect the skills and awareness of other MSK practitioners in different settings or countries. A key recommendation of this study is for MSK education providers to incorporate current knowledge on CFs and

their potential to induce placebo and nocebo effects into their curriculum. Solely emphasising the acquisition of biomedical knowledge and technical skills may result in a failure to enhance MSK practitioners' understanding, competence, and confidence in applying essential psychosocial skills. Such skills may complement and augment manual and physical therapies particularly during the rehabilitation of patients with non-specific persistent LBP.

To enhance MSK practitioners' clinical practice, adopting an “enactive-biopsychosocial approach” could be a useful framework [43]. The traditional biopsychosocial (BPS) model is often interpreted as either a relationship-centred approach or in terms of multi-factorial illness contributors, but these two interpretations are not mutually exclusive and can be integrated to address misapplications and theoretical limitations of the traditional BPS model during MSK care [43]. An enactive-biopsychosocial approach involves considering the embodied experience of the patient, the context in which the patient is situated, and the social and cultural factors that may influence their condition [43]. This enactive approach may help MSK practitioners develop a more complete understanding of their patients' experiences which may help tailor treatments to meet patient's individual needs.

Strengths and limitations

It is important to note the potential for researcher subjectivity since the interviews and primary analysis were conducted by the same researcher (BS). The data presented represents the researcher's interpretation of participants' perceptions. However, steps were taken to ensure the credibility and trustworthiness of the

findings. Firstly, CK (a qualified physiotherapist with extensive experience in qualitative research) independently cross-checked sections of the text and transcripts during the thematic analysis by verifying and comparing codes and themes. The research team also reviewed and discussed emergent themes to verify their credibility. This cross-checking process generated constructive discussions and novel insights which helped refine the interpretations. To ensure the accuracy of the findings, member-checking was employed to confirm that they aligned with the participants' perspectives and experiences. Although participants received a summary of the findings to verify their credibility, no additional feedback was received. Finally, the interviewer used field notes to engage in reflexivity during data collection and analysis to critically reflect on potential biases and underlying assumptions.

The interviewer used bracketing during the interviews to minimise the potential influence of her prior knowledge regarding participants' experiences with their MSK practitioners, and vice versa. The interviewer refrained from disclosing any prior information during individual interviews to maintain participant confidentiality and ensure interviews would not deleteriously affect pre-existing patient-practitioner relationships. This approach aimed to maintain the integrity of the interview process and preserve the authenticity of participants' responses. Future studies considering interviewing patient-practitioner dyads may wish to use separate interviewers for each cohort to further mitigate potential influences and enhance methodological rigor.

Another limitation of the study pertains to the relatively small and homogenous sample, which was influenced by challenges encountered during patient recruitment amidst the Covid-19 pandemic. Out of the 14 practitioners who agreed to participate, 11 were ineligible since none of their patients expressed interest in the study. Despite providing practitioners with written guidelines to assist with identifying eligible patients and making an initial approach, this task deviated from their routine practice, presenting difficulties for some practitioners. As a result, the sample was smaller than anticipated. Recruiting patients in clinics immediately after their consultations might have been beneficial for improving patient involvement.

Separately interviewing patient-practitioner dyads might have influenced the recruitment dynamics. Eligible practitioners could have perceived this approach as potentially threatening because of possible concerns about patients making disclosures that could be perceived as undesirable or compromising. The ethical considerations outlined in the participant information sheet regarding such disclosures may have affected practitioners' willingness to introduce the study to prospective patient participants. Consequently, practitioners may have inadvertently biased the patient sample, possibly only referring successful rehabilitation cases for inclusion.

A pilot phase for the interview schedules could have improved the study's rigour. Since it was not possible to interview patient-practitioner dyads immediately after their consultations, an optional pre-interview task was provided. The aim of the task was to allow participants to reflect on their consultations before the interview to reduce recall bias to some extent. This task may have been more appropriate for busy

practitioners, as it provided an opportunity to refer to their clinical notes, reflect on a specific patient, or help clarify the interview's focus. However, the optional tasks were not consistently completed by all participating patients. It is therefore unclear whether the elicited information improved data quality.

The interviewing process, including the style, interviewer's attributes, and prior knowledge of CF literature, may have influenced the data collected. Practitioners may have been inclined to provide socially desirable responses by sharing positive aspects while potentially withholding unfavourable information. The interviewer acknowledges the inherent challenges faced by MSK practitioners in navigating the delicate balance between clinical reasoning and fostering patient engagement. Similar challenges were encountered by the interviewer, while actively listening and following the interview guide without interrupting the participant's flow of thought or appearing overly abrupt. Exclusively using electronic interactions also posed challenges, particularly during audio-only interviews, where positive body language and eye contact could not be conveyed, which potentially affected the establishment of good interpersonal connections. Technical issues like unstable internet connectivity arose during one interview. Collectively, these factors may have affected participation rates (e.g., "Zoom fatigue") and the quality of interviews. Finally, a nominal participation incentive was offered, which may have influenced the patient participation.

Despite these limitations, this study provides a valuable contribution to the growing body of research on the importance of considering CFs during MSK care. The involvement of both MSK practitioners and patients provides a unique

perspective on the implementation and experience of CFs during LBP consultations. Another strength relates to the involvement of practitioners and patients during the research design phase which may have helped ensure the research was relevant and applicable to the real-world context. The thick description of participants' experiences might be useful to MSK practitioners interested in incorporating CFs into clinical practice. Furthermore, this study demonstrates the complex interplay between CF domains during clinical practice which is important for furthering translational research and knowledge of CFs. Lastly, the study illustrates the importance of incorporating a broader range of skills, particularly psychosocial skills, in MSK education and clinical practice, as well as the potential for person-centred design in MSK clinics to support positive patient outcomes.

Conclusion

In summary, this study has explored both patients and MSK practitioners' experiences of CFs during private care consultations for cLBP in the UK. Preliminary insights suggest that CFs are intricately embedded in LBP consultations and play a pivotal role in shaping patient-practitioner relationships and patients' expectations. Important CFs identified in this study include practitioners' attributes and their attitudes towards patients, the quality of their interpersonal communication supporting the therapeutic relationship; tailoring features of the treatment to address patients' physical, cognitive, and emotional needs; together with creating a safe and welcoming treatment environment for patients with cLBP.

5.3. Additional reflections

I (BS) conducted all six semi-structured interviews, transcribed, and analysed the data during this qualitative study. Considering qualitative research involves the collaborative construction of meaning, there are several personal factors that may have influenced the research process. These factors could have affected data collection, coding, analysis, and subsequent interpretation, as outlined below.

I am a female, South African postgraduate student with master's degrees in Health Psychology (King's College London) and Psychology (Wits University, Johannesburg). I have a strong interest in theories related to contextual factors, placebo/nocebo effects, pain perception, health behaviour, and coping. It is also important to acknowledge my background includes prior experience as a face-to-face counsellor and, more notably, my personal journey with persistent pain for more than two decades, which has shaped my understanding of these topics. I also have personal experience with chronic kidney disease (CKD) and asthma, further shaping my perspectives on long-term health-related conditions. Consequently, my positionality, experiences, beliefs, and methodological approach may have influenced the research process and findings.

As a South African student conducting research in the United Kingdom (UK), my cultural background may have influenced my perspective on persistent pain within a different cultural and healthcare context. My limited exposure to the NHS and UK private practice settings (except for MSK clinic observations) may have impacted my understanding of the healthcare context. Additionally, my limited exposure to the UK culture may have made it less likely for me to recognise nuanced cultural responses and beliefs, potentially leading to omissions in my interpretation of the data. However, my academic training in Psychology has equipped me with a comprehensive understanding of factors influencing pain experiences. Moreover, my experience as a face-to-face counsellor has equipped me with essential skills in active listening and empathetic engagement with individuals facing diverse challenges. The interplay of my academic training, experience as a counsellor, and my own health journey may have influenced how I approached this research.

I am mindful of the potential biases introduced by my personal health-related experiences which may have impacted data interpretation. These previous experiences have influenced my awareness of the challenges faced by individuals managing long-term health conditions and the importance of person-centred healthcare. Given my experiences, I recognise that I may hold certain preconceptions related to persistent pain. For example, I may have a

heightened sensitivity to certain aspects of the participants' experiences that resonated with my own journey. It is possible that my own journey could have influenced how I interpreted certain aspects of the participants' experiences and potentially led to a deeper emotional connection with their experiences. I recognise that my experiences could have shaped my perceptions and assumptions during data collection and analysis. Likewise, my understanding of pain and contextual factors might have shaped how I engaged with participants, influenced my assumptions about their experiences, and data analysis. Moreover, the pragmatic methodological approach might have led me to prioritise practical implications and the utility of the research outcomes.

This awareness prompted me to be vigilant about potential presumptions and take necessary steps to minimise their impact on the research outcomes. Throughout the research process, I remained committed to continuously challenging my assumptions and engaging in self-reflection. I aimed to critically examine how my journey might have influenced my interactions with participants and the data analysis. Engaging in self-reflection allowed me to ensure that my interpretations were not unduly influenced by my personal experiences. I have tried to use reflexivity as a tool to evaluate my responses and thought processes throughout the research. By being transparent about these potential biases and taking steps to address them, I aimed to enhance the research's credibility.

Throughout the data collection process, I remained reflexive about my positionality and methodological approach and their potential influence on the interviews. My awareness of the influence of contextual factors, coupled with pragmatism, may have guided how I crafted interview questions and engaged with participants. As the sole interviewer with no prior relationship with the study participants, I tried to establish trust and a good rapport that facilitated authentic conversations while maintaining a professional demeanour. I aimed to approach each participant with an open mind and tried to avoid imposing my own beliefs on their experiences. I made efforts to create a safe and comfortable space for participants to share their stories without feeling judged or misunderstood. My goal was to create a supportive environment that encouraged participation.

I was also attentive to the power dynamics inherent in the researcher-participant relationship and tried to minimise any potential influence on their responses. My background in Psychology and experience as a counsellor may have influenced my ability to recognise and empathise with their experiences, potentially shaping the dynamics of the interactions. I remained attuned to the power dynamics that could arise during interviews. I aimed to ensure a flexible and adaptive approach to cater to participants' unique experiences while

also addressing the research objectives. However, it is also important to recognise that my presence as an interviewer may have inadvertently shaped participants' responses and the depth of their disclosures.

During the data analysis phase, my background knowledge of relevant theories and pragmatism as a methodological approach may have influenced the identification and interpretation of patterns and themes. Furthermore, I have prior experience as a market researcher and have analysed qualitative data within that context. I am aware that the analytical processes in market research may not always be as rigorous or systematic as required for empirical insights. To address this, I have been careful to follow procedural steps during the analysis process, aiming to enhance the rigor and credibility of the findings. During data analysis, I actively engaged in self-reflection to identify any preconceptions that may have influenced my interpretations to ensure analytical decisions were driven by the data rather than my assumptions. Through field notes, member checking, and seeking feedback from my supervisory team, I aimed to maintain transparency and rigor in the analysis process. Nonetheless, my background and experiences may still have influenced my understanding and interpretations of the data.

Throughout the research process, I upheld ethical principles, adhering to guidelines for research involving human participants. I ensured that all participants were fully informed about the research objectives and obtained informed consent before commencing with the interviews. Additionally, to protect their identities, all participants were given pseudonyms during data analysis and reporting. Confidentiality was maintained, and participants were empowered to withdraw from the study without consequence.

In conclusion, my positionality and experiences may have influenced this qualitative research. Throughout the study, I have endeavoured to address potential biases to enhance the credibility and trustworthiness of the findings. My overarching goal has been to approach this research with transparency, reflexivity, and ethical integrity. By acknowledging my positionality and biases, I encourage readers to critically engage with the research to foster a deeper understanding of the study's insights.

Examples to demonstrate the reflexive aspects of the qualitative study have been extracted from the field notes and are presented in Appendix III.