Title: Goal setting in group programmes for long-term condition self-management support: experiences of patients and healthcare professionals.

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Abstract

Objective: To examine group facilitators' and participants' experiences of and engagement with goal setting in long-term condition (LTC) self-management group programmes.

Design: We conducted a qualitative mixed method study including 13 interviews with group facilitators, 20 interviews with group participants and content analysis of programme workbooks. Participant interviews explored their goals for managing their condition. Facilitator interviews explored their goals for participants. Data from the three sources were analysed inductively and thematically.

Results: The three themes showed: 1. Participants have personal and meaningful biomedical, social and emotional goals and, facilitators believe these goals to be important and perceive them as integral to increasing motivation and self-responsibility; 2. Facilitators shape participants' goals into pre-determined health behaviour change activities, disregarding social and emotional aspects; and 3. Participant disengagement from the goal setting process and questioning of the value of goal setting was evident.

Conclusions: Patient engagement with goal setting may be less attainable when what matters to people is sidelined to focus on behaviour change goals and self-responsibility. Yet, supporting people to identify and pursue meaningful goals for living with LTCs is more likely to increase engagement and motivation. Stakeholders in group programme development and delivery should review their goal setting activities.

Key words: goal setting, self-management, long-term conditions, group programmes

Introduction

Self-management support is a central component of many national and international policies on long-term condition care (Elissen et al., 2013). Self-management support is defined as an active and collaborative partnership between healthcare professionals (HCPs) and patients, whereby HCPs assist individuals who are managing a long-term condition (Barlow, Wright, Sheasby, Turner, & Hainsworth, 2002; Battersby et al., 2010; Bodenheimer, Lorig, Holman, & Grumbach, 2002; Glasgow, Davis, Funnell, & Beck, 2003; Wagner et al., 2001). Emphasis is placed on the goals, needs, and values of the person living with the long-term condition, rather than the goals of health professionals (Barlow, et al., 2002; Bodenheimer, et al., 2002; Entwistle, Cribb, & Owens, 2018; Wagner, et al., 2001). Most writers articulate that goal setting is a key activity in self-management support for multiple purposes: to help practitioners identify and address what matters to patients and for providing theoretical underpinning and guidance to health behavior change interactions between practitioners and patients (Lenzen, Daniëls, van Bokhoven, van der Weijden, & Beurskens, 2017).

In Australia, the Chronic Disease Strategy states that: "engaging people in the management of their chronic conditions empowers individuals to […] set goals appropriate to their health and social needs and values" (Australian Health Ministers' Advisory Council, 2017, p. 31). Other countries' policies also recommend healthcare professionals implement a collaborative goal setting process that addresses what is important to the individual (Liddy and Mill, 2014; NHS England, 2016).

Goal setting originates from, and has been studied in, the field of organizational psychology. The theory suggests that goal setting supports motivations for action through self-regulation and achieving self-efficacy (Locke and Latham, 2002). Setting goals is thought to be effective because it focusses attention and effort on a desired outcome (Locke and Latham, 2002). It is proposed that if a goal is important to an individual, the goal will be pursued with

higher internal motivation and increased likelihood of achievement (Deci and Ryan, 2000). Goal setting in self-management is informed by self-efficacy theory (Bandura, 1977), a theory of behavioural change and the basis of Lorig's Stanford self-management programmes (Lorig and Holman, 2003). Given this, it is unsurprising that goal setting is regularly included in long-term condition care guidelines and policies as a key tool for health professionals implementing self-management support.

Much health research, however, remains focused on goal setting to encourage people to direct effort and attention on *pre-determined* lifestyle behaviours (Lenzen, et al., 2017). This is exemplified in the proliferation of studies on the effect of goal setting on diet, exercise and disease markers (Chin et al., 2008; Cullen, Baranowski, & Smith, 2001; DeWalt et al., 2009; Estabrooks et al., 2005; Heisler, Vijan, Ubel, Bernstein, & Hofer, 2003; Nothwehr and Yang, 2007; Pearson, 2012; Zgibor et al., 2007). Owens et al. (2017) explored practitioners' measures of success in self-management support and found condition related aspects and maintaining relationships with patients was their main focus (Owens et al., 2017). The personal goal focus that includes individual preferences and social context advocated in policy and theory seems absent in many studies (Holman, Lynch, & Reeves, 2017). The literature exploring the many ways in which the social world shapes health behaviours, particularly with respect to inequalities across demographic factors such as class, gender and ethnicity is also considerable yet, appears unconnected to the individual health-behaviour change focus in the medical literature on goals (Haslbeck et al., 2015).

Group programmes are a common format for providing self-management support for people with long-term conditions (Barlow, et al., 2002; Coster and Norman, 2009). However, there has been limited research attention given to goal setting in the group format. For example, studies evaluating goal setting in programmes such as the Chronic Disease Self-Management Program (Stanford University, 2016) revealed only that participants' feedback was generally

positive, particularly when goals were discussed and followed up (Barlow, Bancroft, & Turner, 2005; Barlow, Edwards, & Turner, 2009; Haslbeck, et al., 2015; Kendall, Foster, Ehrlich, & Chaboyer, 2012; Stone and Packer, 2010). What they did not show, however, was how participants and facilitators approach goal setting, what goals they value and what they think about goal setting. Studies in rehabilitation group settings reveal that there can be a goal mismatch between patients and health professionals (Brown et al., 2014; Pearce et al., 2015). Patients may be reluctant to set goals that are different to health professionals because they fear that this could impact negatively on their future interactions with their health professionals. Given the short-comings of research to-date into goal setting beyond its impact on pre-determined lifestyle behaviours, and that group programmes are a common format of self-management support for people living with long-term conditions, there remains limited understanding of how goal setting is experienced. This includes what goals and aspirations are taken into account in the programmes and how they are enabled by facilitators and perceived by participants. In this exploratory study we examine the experiences of both patients and health professional facilitators of goal setting in group self-management programmes. Our research questions were:

1. What goals did participants attending long-term condition self-management support group programmes have?;
2. What expectations did facilitators have for group programme participation?; and
3. What were the facilitators' and participants' perceptions of goal setting activities in group programmes?

Method

A qualitative approach using multiple methods enabled an examination of how goal setting was perceived, enacted and experienced in group-based self-management support. This study is part of a broader Australian study analysing patient-provider interactions in both group and

one-to-one settings. We undertook interviews with facilitators and participants of group programmes, and analysed the printed materials and workbooks used in group programmes. For this study, our working definition of goals centred around individuals' conscious objectives or aims (Locke and Latham, 2002), desired outcomes (Deci and Ryan, 2000) and expressions of values and preferences (Entwistle and Watt, 2013). We received ethics approval from local area health district and university human research ethics committees. This work was supported by the Australian Research Council under Discovery Project Grant DP150101406.

Sample and recruitment

Participants were people (n=20) attending group programmes and their HCP group facilitators (n=13). The six group programmes selected were chosen because they provided self-management support for chronic obstructive pulmonary disease (COPD), type 2 diabetes, or weight management. These conditions were chosen for several reasons: 1) each is associated with a range of medical, physical, emotional, psychological and social issues for which individuals are expected to self-manage (Kaptein, Fischer & Scharloo, 2014; Powers et al. 2015; Puhl and Heuer, 2010) ; 2) each has group-based programmes in Australia and internationally for supporting individuals to self-manage (Zwerink et al. 2014; Steinsbekk, Rygg, Lisulo, Rise & Fretheim, 2012; Stenberg, Haaland-Øverbya, Fredriksenc & Kvisvik, 2016; Paul-Ebhohimhen and Avenell, 2009); 3) each is relatively prevalent (World Health Organisation (WHO), 2014). While there is some debate, in Australia and internationally, about whether excess weight or obesity should be classified/recognised as a chronic disease or long-term condition or not (Kyle, Dhurandhar & Allison, 2016; Opie, Haines, Ervin, Glenister & Pierce, 2017), it is a major risk factor (and/ or coexists) for a range of long term conditions such as type 2 diabetes, heart disease, stroke and musculoskeletal conditions (WHO, 2014). Programmes were from a range of metropolitan and regional locations and

hospital and community-based settings. Table 1 provides an overview of the programmes. After distributing an information sheet about our study during the course of the programme we invited all group participants and facilitators to participate in an interview. Participants were reimbursed with a gift voucher to compensate them for their time.

Table 1. Overview of the programmes

Location	**Programme focus**	**Facilitators**
Large metropolitan hospital outpatient room	Diabetes type 2	Dietitian
Suburban general practice	Diabetes type 2	Dietitian and EP
Large metropolitan hospital outpatient room	Weight management	Physiotherapist, nurse, psychologist, dietitian
Rural, community hall / hospital meeting room	Weight management/ healthy lifestyle	Dietitian and EP
Large metropolitan hospital outpatient gym	COPD	Physiotherapists
Small metropolitan hospital outpatient gym	COPD	Physiotherapists

Table 2. Group patient participant characteristics

Characteristic	**Number**
Age	
Average	
Diabetes	62
Weight management	49
COPD	69
Overall	59
Range	
Diabetes	31-79
Weight management	27-80
COPD	67-73
Overall	27-80
Median	

Diabetes	69
Weight management	53
COPD	69
Overall	66
Gender	
Female	10
Male	10
Programme focus	
Diabetes (2 female, 4 male)	6
Weight management (5 female, 3 male)	8
COPD (3 female, 3 male)	6
Education level	
School year 10 or below	2
School year 12 or equivalent	7
Trade certificate	5
University degree	5
Not disclosed	1
Employment status	
Employed full-time	2
Casual employment	2
Not currently working	16

Data collection

In-depth, semi-structured interviews were conducted face-to-face (in a mutually agreed location) or by telephone between December 2015 and April 2017. They lasted between 60-90 minutes and were audio-recorded with participants' consent. Interviews occurred around the time of the final group sessions or after programme completion at the convenience of the interviewees. An interview schedule was developed to guide the interviews, based on psychological and sociological understandings of long-term condition self-management (Corbin and Strauss, 1985; Leventhal, Brissette, & Leventhal, 2003), self-management theory (Barlow, et al., 2002; Bodenheimer, et al., 2002), goal setting theory (Deci and Ryan, 2000, 2008) and a review of the qualitative literature (Hughes et al., 2017). Participant interviews included questions to elicit spontaneous talk about their goals about how they manage their condition(s), challenges and aims for attendance at the programme, as well as about their

experiences of goal setting and what goals they had set in the programme. The participants were asked to bring programme workbooks to interviews to facilitate discussion about the goal activities experienced in the programme and the goals they had written (or not) during these activities. Facilitator interviews included questions about how their programme was designed, their perceptions of programme purpose so as to elicit spontaneous talk about their goals for participants, as well as about their stated goals for participants and their experiences of goal setting activities, their roles and their perceptions of group participants. From each programme a set of printed materials and workbooks was obtained from the programme facilitators. The printed materials included presentation slides and other handouts.

Data analysis

The analysis was conducted inductively and thematically using a constant comparative method (Green and Thorogood, 2009). The interview data which were the main focus were organised using qualitative data software (nVivo 11). We conducted multiple readings and team discussions of the interview transcripts to gain familiarity and contextual depth (SH, LS and SL). From the printed group materials, data were extracted where goal setting activities occurred and this was triangulated with the interview data to provide more context and understanding of the programmes and their goal setting activities. From interview data we ascertained what participants and facilitators said about goals and the goal setting activities. A coding framework was developed where text from the three data sources were coded into categories and subcategories. These data were then analysed during which emerging themes and concepts were noted. Analysis and comparison across and within categories were conducted to develop final themes (SH, LS and SL). Differing clinical practice and research backgrounds (SH - pharmacy, LS - psychology and SL – medical sociology) provided diverse perspectives to underpin and ensure the rigour of analysis. Frequent team meetings during

this process included comparison and challenging of individual interpretations, and assumptions were further minimised through review with the broader team (KW - medical sociologist, AR - medical sociologist and SW - behavioural scientist).

Results

The analysis revealed that participants have personal and meaningful social, emotional and biomedical goals. Facilitators believe these goals to be important and perceive them as integral to increasing motivation and self-responsibility. Despite participants having social and emotional goals, facilitators in the programmes worked to shape the participants' goals into pre-determined health behaviour change activities, removing the social and emotional aspects. We found evidence of disengagement from the goal setting process and questioning of the value of goal setting from both participants and facilitators.

These findings are presented below in the following three themes: 1. Participants and facilitators value personal and meaningful goals but for a different purpose; 2. Participants' goals are shaped into pre-determined health behaviour change activities and; 3. Disengagement from the goal setting process.

1. Participants and facilitators value personal and meaningful goals but for a different purpose

Both facilitators and participants emphasised the importance and value of having goals that are personal and meaningful to the person living with and managing a long-term condition. For participants, goals that mattered included aspects of biomedical condition and symptom management, feeling better in themselves and improving physical and psychological health and, being able to do things that are important in everyday life. Similarly, for facilitators, important goals were concerned with what is meaningful to participants and included examples of social goals such as maintaining independent living arrangements and rebuilding

confidence to participate in society, such as catching buses independently and playing with grandchildren. Facilitators and participants both talked about how goals are oriented around social and biomedical facets of individuals' condition management and lives and, in this way, both recognised complexity in participants' goals. Further, both facilitators and participants were strongly of the opinion that 'the social' could not be ignored when managing a long-term condition. The following examples show Bill (participant) forefronting his responsibilities to family when talking about his various health goals and facilitator 1 revealing that she 'always' seeks the goals that matter:

> *It's more for me is just being healthy for my kids, that's the only thing. You know I want to see my daughter get married and all that sort of stuff. I just [...] if I have to inject insulin I will, but if I can push that back and not have to worry about it, then that's even better. [Participant, Bill, male, age 31, diabetes, Site 3]*

> *I always ask them […] what would you say is your main problem […] usually it is their shortness of breath, because it is quite overwhelming and limits everything. But often it'll be something completely random like […] "I've lost my confidence and I don't want to be dependent on my wife anymore" [...] "I want to be able to catch a bus" [Facilitator 1, physiotherapist, Site 1, COPD]*

Despite these commonalities, the purpose of setting personal and meaningful goals differed between participants and facilitators. For facilitators, a key reason was their belief that participants should have 'ownership' over goals to increase motivation and thus achievement in making behavioural changes. They also perceived that having their own goals encouraged participants to take more responsibility for their own health. The link between meaningful goals, increased motivation and taking on responsibility was articulated explicitly by many facilitators:

If they have their own personal goal they're more likely to take on their own self-management. […] if I let them make the goals, they've got the power, they get the confidence that they can do it outside […] they can manage themselves. [Facilitator 9, dietitian, Site 6, weight management]

I think that unless you address what is their major concern, then half the time you're wasting your time. […] what it is that you want to prioritise […] trying to work with what they're interested in and what they're motivated to do something about. [Facilitator 5, dietitian, Site 3, diabetes]

In contrast, participants simply expressed their determination to pursue their goals and to continue to live a full life.

Diabetes is part of my life and it's part of my life forever. I'm not gonna stop diving, I'm not gonna stop travelling, I'm not gonna stop doing what I'm going to do. [Participant, Kevin, male, age 62, Site 3, diabetes]

I'm working hard to try to get off the steroids. I'm really trying hard to do that, that's my goal. And once I get off that I'm going to be trying to get off the methotrexate […] And I'll be determined to do it if I can […] So my determination now is to try to keep as fit as possible, not catch any infections if I can help it, and just do everything I can to stay alive really. [Participant, Deb, female, age 69, Site 2, COPD. Note: this participant had a co-morbid condition which was treated with the medication methotrexate]

2. Participants' goals are shaped into pre-determined health behaviour change activities.

When discussions turned to the activity of goal setting, discordance begins to appear between the ideal of pursuing meaningful goals and the actual goals participants adopted. Facilitators sought to shape (and in doing so narrow) participants' goals towards goals which could lead to discrete and measurable health behavioural change. When talking about goal setting activities in the programmes, facilitators tended to focus on goals being adjusted towards the promotion of lifestyle changes such as increasing exercise, making changes to diet and quitting smoking. To guide group participants towards narrowing their goals, facilitators spoke about educating participants on the benefits of making behavioural changes. They believed that through this education, participants would begin to give more importance or priority to the biomedical aspects of their long-term condition(s) and thus, increase their motivation to pursue goals focused on lifestyle behavioural change. The following quote exemplifies these beliefs:

> *We talk a bit more about goal setting […] working out targeted goals for them […] wanting to educate them and teach them why they should be exercising as well. [Facilitator 7, physiotherapist, Site 2, COPD]*

Facilitators also revealed medical boundaries within which participants were 'free' to set their own goals. For example, in the following two facilitator quotes goal choice is restricted to a choice of a healthy lifestyle change:

> *Definitely what they want to achieve. […] fortunately most of it is somewhat health related, so almost anything and everything can be achieved through some lifestyle change I guess. [Facilitator 12, dietitian, Site 4, diabetes]*

> *Any type of goal that they're wanting to do or they're wanting to sort of aim towards or achieve is fine. It doesn't have to be you know increase your water by three cups a day or you know change from white bread to multigrain bread, it can be anything.*

Whether it's physical or nutrition related or just general health or lifestyle related that's fine. [Facilitator 10, exercise physiologist, Site 6, weight management]

Furthermore, there was a tension evident when participants' goals were seen to be meaningful but, in the view of facilitators their goals were not achievable. For example, facilitators described 'simplifying' the participants' goals or making their goals 'specific' so that they would be 'easier', 'realistic' and 'achievable' for the participant. They saw this as managing what they perceived as the unrealistic expectations of some participants. They spoke of how hard it is for participants to maintain their motivation for behaviour change and that setting easy and simple short-term goals increased the likelihood of achievement and minimised the risk of failure, which they saw as something that they needed to shield participants from.

Set yourself up for success, don't set yourself up for failure, is probably one of the most common terms, or common sentences I say […] Don't set that goal, 'cause that is actually not achievable[...] that's not realistic. [Facilitator 5, nurse, Site 5, weight management]

I try and make them make it [their goal] a little bit more specific. [Facilitator 1, physiotherapist, Site 1, COPD]

The narrow conceptions of goal activities revealed by facilitators were also seen in the examination of the written materials provided to participants in the group programmes. The materials were structured to shape participants' goals towards a narrow and biomedical focus. With titles using variations of the descriptors 'healthy', 'lifestyle', 'diet' and 'exercise', these materials focussed on information, suggestions, guidelines and/or instruction on exercise, diet, healthy lifestyles, the benefits of changing behaviour and the risks of not doing so, and contained activities around these management aspects for participants to complete. The participant workbooks contained goal setting sections for participants to complete during

programme sessions. These goal activities typically contained instructions and examples of types of exercise and diet goals to guide participants in their own goal setting. Missing from the materials were sections on setting meaningful or personal goals. There were no examples of non-biomedical goals such as managing emotions, building confidence or pursuing (or maintaining) valued life roles and activities.

It was apparent that when participants talked about the goals they had set during the group programmes, the social aspects of their overarching goals and aspirations had been stripped away during the programme and were narrowed in on a specific goal focused on the more medicalised aspects of long-term condition management. Like the facilitators, participants expressed (and some had written into their workbooks) goals around diet, condition control and exercise. Overall, participants were vague when speaking about the goals they had set/ written during the programmes, some had not written a goal into their workbooks and others had not brought their workbooks to the interviews. Disengagement from the goal setting process is explored further in Theme 3. Further, participants' discussions of goal setting activities were of activities conducted individually or one-to-one with a facilitator. Group involvement appeared to have been absent and not promoted. In the following quotes, Bill who had previously emphasised family and general health, reveals that in the goal setting activity his focus was now on a weight loss target and Warren recalls the programmes' expectations for setting goals in a group session:

> *I'd love to be about a hundred kilos, I've still got about 15 kilos to go. […] Her [the facilitator] saying, "No, you've lost a little bit of weight, and you're doing all your stuff, and you're on the right track," so that made me feel a bit better. […] that's the big thing, losing weight around the gut and stuff like that. […] the goal thing worked, it's good to write things down. [Participant, Bill, male, age 31, Site 3, diabetes]*

It was setting the goals for the week. Like you say I want to walk 1000 steps in one day or something like that. […] I think what kind of food you gotta eat during the day as well. [Participant, Warren, male, age 33, Site 6, weight management]

3. Disengagement from the goal setting process.

The extent to which facilitators and participants engaged with goal setting activities in programmes varied. In their interviews, facilitators focused on the effects of goal setting on increasing participants' motivation and taking personal responsibility. They viewed goal setting as key to participants achieving health behaviour change (their ultimate aim). Facilitators used goal setting to encourage participants to decide what behaviour change they would pursue.

You can't achieve weight loss without behavioural change, and if you don't have a goal, how are you going to know what your behaviour change is? […] if people don't have a goal I don't know how you would be successful, I don't know how you work on anything if you don't have goals. [Facilitator 5, nurse, Site 5, weight management]

In contrast, the participants were less positive about engaging in setting goals and instead focussed on the difficulties they perceived in achieving the behaviour change goals that were the focus of the programme, particularly after the programme finished. Participants were concerned that once the programme ceased they would no longer receive the support from facilitators and other group participants, as well as access to facilities, resources and the routine of weekly sessions. Participants also foresaw difficulties with trying to implement new goals into their daily lives, alongside other competing work and family demands and priorities:

Goal setting, I would love to be able to. I don't know how I'm going to go. I don't have any like, staying on track like, it's always, [pause] yeah. [pause] It's hard like, because I have full time work, plus full-time study, plus three children. And trying to stick to a goal is going to be hard. [Participant, Monica, female, age 36, Site 6, weight management]

Participants engagement (or lack of) with goal setting also appeared to be associated with conflicts between their determination to achieve goals and their concerns about their ability to do so. Participants talked about the need 'to be disciplined', 'to take responsibility' and 'to persevere'. One participant, Jill, said 'I've got to keep remembering, and I've got to eat the proper foods'. However, conscious of past experiences and envisaging less support after the programme finished, they viewed goal achievement as riding on their own, largely unsupported, choices and actions – it is 'up to me' and 'for my own good'. Participants blamed themselves for what they saw to be their lack of motivation and poor attitude which they believed to be key aspects that they needed to change and, ruminated on the challenge and their prospects:

I have to be disciplined. […] I don't drink alcohol, I don't smoke and the only thing I have is food. We are all striving to get there, I'm trying as hard as I can, you know. [Participant, Kevin, male, age 62, Site 3, diabetes]

I said, "well, how do I fail so that I have to keep coming to the group" you know. Because I think that this is such a support, become such a supportive environment for me that I have concerns about being able to maintain the momentum after here. [Participant, Mark, male, age 68, Site 1, COPD]

What about when it finishes, what are we going to do then? All that eight weeks of exercising and changing our ways of doing things, is that just going to [...] maybe go

chuck in the bin. […] I'm scared that I'm going to go back to my own ways, I admit, I'll probably go back to my own ways. [Participant, Ruby, female, age 27, Site 6, weight management]

There were also examples of explicit disengagement with the goal setting activities from a few participants who questioned the relevance and/or applicability of goal setting to their needs and wants, and who refused to participate. These participants felt that the facilitators' focus was too narrow and simplistic and their 'lifestyle' behaviours and goals were already adequate or at the limits of what they were prepared to change. This suggests a possible negative impact of imposing boundaries on the goals that participants can set whereby goals are shifted away from personal goals and valued activities, and towards specific behavioural change. For example, Gary, who evaded goal setting during sessions, contrasted the goals suggested in the programme (e.g. push ups) with regular (and valued) activities and jobs around the house, which he saw as more engaging.

Get the chainsaws out and chop those things back, rake up leaves. The leaves are coming down […] They're a form of exercise but they're jobs I've got to do. […] they're more my goals than thinking I'll do 14 push-ups or something. They're living goals. [Participant, Gary, male, age 73, Site 2, COPD]

Although facilitators spoke about the importance of goal setting and the need for participants to pursue meaningful goals, some facilitators also questioned the value of goal setting. Facilitators said that goal setting was something to be fitted in around more important components of the programme, such as the education. For other facilitators, there seemed to be a disconnect between goal setting as a programme activity that they spent a lot of time on, and revelations of its limited effectiveness. These facilitators however, unable to explain why goal setting was not effective, appeared destined to continue practicing it in lieu of an

alternative. Facilitator 10 in the following quote sees poor success in goal setting lies with participants' motivation yet, does not consider factors in the goal setting process or the social context within which participants will be enacting their goals.

> *I see so often people write goals or come up with goals whether they're a SMART goal or not but as soon as they walk out that door they lose all motivation […] they go oh that's too hard or it's going to take too much effort or I don't have time. So whether it has become an unrealistic goal, yeah. It's hard to sort of pinpoint what happens in goal setting. [Facilitator 10, exercise physiologist, Site 6, weight management]*

Discussion

This qualitative study captures the views of both facilitators and participants about the goal setting activities in self-management group programmes. Aligning with long-term condition self-management support policy, the group facilitators in our study believed that individuals living with and managing a long-term condition benefited from pursuing personally meaningful goals that are not limited to their conditions and general health, but also extend into broader social and emotional needs and responsibilities. Similarly, the goals of the group participants in our study reflected this diversity. Yet, a disconnect was evident between facilitators' views advocating this belief while providing little in the way of discussion around actually enabling participants to pursue meaningful goals in the programmes. In fact, departing from these ideals, facilitators discussed ways in which they actively shaped the goals of participants to be more closely aligned with what they believed to be most important, namely condition management and exercise and dietary behaviour change. Any goal 'choice' provided to participants, existed within these narrow boundaries, thus stripping the social and emotional aspects out of participants' goals.

Further, facilitators tried to shape the participants' goals (and 'manage their expectations') into simple behaviour change goals that facilitators considered would be 'realistic' and 'achievable'. This appeared to be driven by facilitators' beliefs that they were increasing the likelihood of successful goal achievement and avoiding the risk of failure. Yet, these beliefs diverge from goal theory which proposes that health goals are more likely to be achieved when they are personally meaningful and sufficiently challenging (Deci and Ryan, 2008). In our study, despite facilitators proposing that meaningful goals should be fore fronted for the benefits to motivation and achievement this would provide, pursuing meaningful goals by adopting a broader approach appears to have been overtaken by the imperative to address narrow health behaviours first. The dominance of pre-determined health behaviours in goal setting is well documented (Lenzen et al. 2017, Bodenheimer and Handley 2009). Yet, our data showing tensions between health professionals' conceptualisations and application of goal setting suggests a tension between their willingness to explore broader patient goals and perhaps a professional duty-of-care.

The evidence for the benefits of people with long-term conditions increasing their activity levels and improving diet is not in dispute (Roberts and Barnard, 2005). Most previous research has looked at goal setting for this purpose, namely to encourage patients to take up pre-determined behaviours around activity and diet (Lenzen et al. 2017). Yet, the strategy followed by the facilitators seen in our study of simplifying participants' broader concerns into lifestyle behaviours appears not to have engaged the group participants. For some, the social and emotional realities of their lives remained an ongoing concern to them after the programme. In light of this revelation, the value of providing self-management support that is asocial and decontextualized should be questioned as it is unlikely to engage the things that people value and that could form the basis of goal setting in the everyday lives of people. The 'determinants of health' approach shows that societal organization has a profound and

dynamic effect on both intentional and unintentional health behaviours that should not be ignored when considering the goals of individuals (Short and Mollborn, 2015). Indeed, participants in our study who rejected goal setting as an activity, described in the literature as patient resistance or passivity (Lenzen et al. 2018), were actively questioning of its relevance. Interestingly, participants appeared to expect that the health professional facilitators would propose narrow diet and exercise change for them in the programmes and our overall perception is that goal activities with a broader focus would be novel to them. It would seem that, in the views of the participants, group programmes have not differentiated themselves from other health professional encounters. In our study, seemingly not considered by facilitators in their strategy are the potential risks of goal setting for the purposes of promoting self-responsibility and normative behaviours rather than for the achievement of personally relevant goals (Entwistle and Watt, 2013). For example, the participants in our study spoke of self-blame and guilt over their perceived shortcomings in their motivation to achieve and sustain these goals. This contradicts long-term condition self-management support aims of building self-efficacy and autonomy (Barlow, et al., 2002). Among facilitators there were some who had concerns about the implementation of goal setting activities in the programmes, despite going through the motions, and this perhaps points to structural issues that facilitators are working within, examples being time constraints, rigid programme structures and requirements for biomedical outcomes reporting (Hughes et al., 2018, In press). Other studies however, have revealed that health professionals find forming partnerships with patients challenging and exercising control over patients remains a prominent strategy in goal setting (Mudge et al. 2015, Franklin et al. 2018, Ellis et al. 2017). Poor theoretical application of goal setting may also be a consequence of inadequate training (Hughes et al. 2018, Lenzen et al. 2017, Bodenheimer and Handley 2009).

Participants tended to speak of the value of psychosocial support from facilitators and other participants during the programme, rather than the educational or goal setting aspects. Indeed, it is the ceasing of support at the end of the programme that was of direct concern to many participants. Different models of self-management support where linkages to ongoing support in the participants' communities are provided would address this concern (Holman, et al., 2017; Reeves et al., 2014). Future research in group self-management support programmes may also wish to explore different measures of success than short term behaviour change, such as peer support (Simmons, Bunn, Cohn, & Graffy, 2012).

Strengths and Limitations

The main strength of this study is that it explored goal setting not as an outcome, but as a process, and from the perspective of both group facilitators and group participants. We sampled from multiple contexts, condition types, facilitator professions and participant demographics in order to gain breadth and richness of experience. Analysis of the enactment of goal activities in the group programmes, including the context and purpose for their inclusion in programmes, benefited from triangulation of multiple data sources - the programmes' written materials and the interview data. The written materials cross-validated the finding that goal activities had a pre-determined focus by group facilitators, a finding also consistent with the experiences gleaned from the group participants' interview data..

We accept that participants self-selected and this may mean that other viewpoints were not captured in our data, such as those who dropped out of the programme or were less engaged. Future studies may wish to explore other group programme settings, and formats, where goal setting is included. The conditions in our study are associated with lifestyle behaviours and these are viewed as an important and effective part of management and treatment. This appears to have shaped the perspectives of the facilitators when conducting goal setting as

part of support for self-management in the group programmes. Other long-term conditions where lifestyle behaviours are less critical may have markedly different findings. A further limitation is that only one interview was conducted per participant, and future research may wish to interview at multiple time points before, during and after programmes. People with long-term conditions frequently have co-morbidities that affect treatment, their experience of illness and behaviours however, this was beyond the scope of our study.

Conclusion

Participants' goals are complex, multiple and extend beyond biomedical condition management yet, facilitators are shaping these goals and actively removing the social and emotional aspects. The resultant focus on narrow, condition-management behaviour goals and self-responsibility were of doubtful value to participants and also facilitators. The patient engagement and motivation sought in long-term condition policy and self-management support models may be less attainable when what matters to people is sidelined. Supporting people to achieve broader goals inclusive of psychosocial aspects is a challenge for HCPs. Stakeholders in group programme development and delivery could use the findings of this research to reflect on the process of goal setting activities in their group programmes so they might more closely support participants to identify and pursue goals that are meaningful for living with long-term conditions in the contexts of their everyday lives.

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The authors have no conflicts of interest to disclose.

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