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Older Person's Mental Health: Considerations for Psychological Practice

by

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Thesis for the degree of Doctor of Clinical Psychology

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Abstract

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The first chapter of this thesis is a qualitative evidence synthesis via meta-ethnography, exploring the views of psychological professionals working with older people. A search was conducted via relevant databases and a total of 10 qualitative studies met inclusion criteria. Six themes, or third-order constructs, were developed from the aggregated findings. These are presented in the context of the original studies, with professionals' age, stage of training, and cultural background considered for accordance and divergence between the studies' findings. Implications are discussed, which suggest an increase in older person psychology is much needed during professional training, supported with adequate supervision. Tighter inclusion criteria, i.e., by way of professional group or country, may have served in providing specificity and relevance for specific psychological organisations.

The second chapter reports a qualitative study exploring the views, perspectives, and experiences of older people with depression and their contemplations of meaning and purpose in life. Five older patients of older person community mental health teams contributed to the data via semi-structured interviews. Data was analysed via Interpretative Phenomenological Analysis. Three themes were developed: Living a Full Life; Developing the Self; and, Connecting Past, Present, and Future. Relationships with family, friends, and wider community were established as important for continued meaning and purpose, as was the continuation of learning and self-development. Time, in terms of perspectives of the future and regret from the past was seen differently by those at varying points along the depression trajectory. Again, a tighter inclusion criteria is commented on as a point for future research given the divergence of participants' current level of depression within the sample. Implications for policy and practice are discussed.

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Research Thesis: Declaration of Authorship

Print name: Megan Denne

Title of thesis: Older Person Mental Health: Considerations for Psychological Practice

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signature: ..... Date: 3rd September 2023

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This research is dedicated to the generous participants who shared their time, experiences, and wisdom with me. You taught me an awful lot; I hope I did you justice.

Definitions and Abbreviations

First order constructs..... Professionals' accounts of their experiences working with OP

Second order constructs..... The studies' authors interpretations (i.e., themes and concepts) of professionals' accounts

Third order constructs ..... The interpretations of the synthesis research team

Psychological professionals..Clinical psychologists; Cognitive Behavioural Therapists, Psychological Wellbeing Practitioners; Counsellors, Child and Adolescent Psychotherapists; Counselling Psychologists; Forensic Psychologists; Health Psychologists; Systemic Family Therapists, Adult Psychotherapists; Children's Wellbeing Practitioner; Education Mental Health Practitioner; Mental Health and Wellbeing Practitioners; and, Youth Intensive Psychological Practitioners. The psychotherapist professional roles included those practicing Art Therapy, including Music Therapy, as these are established psychological interventions as recognised by the BACP.

Chapter 1 Clinicians' views and experiences of working therapeutically with older adults: A qualitative synthesis

1.1 Abstract

Background. Recovery rates depict the benefit of older people (OP) receiving psychological intervention. Whilst initiatives exist to improve OP's access to psychological services, there remains an unplugged gap between service demand and service provision, in part due to the low rate of psychological professionals specialising in OP mental health.

Objective. This meta-ethnography focusses on the role of the professional in exploring this gap.

Method. A systematic literature search via key databases identified 10 relevant papers for inclusion in the synthesis. This was performed via Noblit and Hare's seven phases of meta-ethnography.

Results. Six third-order constructs were developed, which were contextually balanced with professionals' own age, level of training, and country/ culture of practice.

Conclusion. The provision of psychological services would benefit via training programmes incorporating a specific older person module supported by relevant clinical placements. Effective supervision of trainees and young therapists is imperative for supporting and encouraging a new generation of psychological professionals working in this field.

PROSPERO registration number: CRD42022352162

Keywords: Meta-ethnography; psychological professionals; views and experiences; older adults

1.2 Introduction

Widely documented is the prevalence of mental health challenges in the older population, which have been made more pronounced by the COVID-19 pandemic (Zaninotto et al., 2022). Although older people's (OP) mental health problems are lower in prevalence than younger cohorts (National Centre for Social Research, 2021), the occurrence of poor mental health changes with age, with common mental health difficulties affecting 15-20% of adults in their 60s-70s rising to more than 30% for those in their late 80s (National Centre for Social Research, 2021). Further, early treatment of psychological problems is identified as an important factor for minimising the risks of chronic illness in later years (Poole & Steptoe, 2018).

Fortunately, the effectiveness of standard psychological treatment is encouraging, with recovery rates for common mental health problems comparable to, and sometimes exceeding, those of a younger cohort (Baker & Kirk-Wade, 2023), yet OP do not access psychological therapy at the same rate (O'Donnell et al., 2021), some reasons for which lie on the side of the professional. Previous research has highlighted clinicians conceptualising depression as an inevitable stage of aging and therefore querying the suitability of therapy (Frost et al., 2019). OP's hesitancy to access therapy has also been assumed as a disinterest in psychological approaches (Hannaford et al., 2019); indeed, this has been acknowledged to account for why some OP do not access psychological services, due to seeing their needs best met by self-reliance and independent means (Hannaford et al., 2019).

Across recent years, a range of initiatives have been implemented to improve OP's access to therapy. These have been implemented in the form of specific OP priority workstreams, such as those developed by the British Association for Counselling and Psychotherapy (BACP, 2020), along with the far-reaching NHS Long Term Plan, which seeks to provide improved integrated services for co-morbid needs often experienced within the older population (NHS, 2019).

Yet, the gap between service need and actual service provision remains unplugged. Less documented in official initiatives is the low rate of psychological professionals (hereon referred to as 'professionals') working with OP and specialising in gerontology (American Psychological

Association, APA, 2018); if continued this will likely have ramifications for meeting the mental health needs of the future older population. Official APA review data (APA, 2018) depicts the current and projected psychologist supply and demand for 2015-2030. Demand is established as current patterns of service use balanced with estimated changes in the demographics of the population; supply is determined by the number of qualified active psychologists, new entrants, workforce patterns, and migration patterns. Across all age groups, the largest increase in projected demand relates to the older patient group, with a required 54% increase in full-time equivalents to meet the projected demand.

Whilst aforementioned initiatives exist to encourage and streamline OP's access to psychological care, the growing older client base means that a psychological workforce lacking in specialist training may struggle to match this demand. Systematic reviews of OP's attitudes towards psychological therapy exist elsewhere (see Nair et al., 2020), and serve in providing a critical, yet one-sided, part of the picture detailing OP accessing and receiving treatment for psychological difficulty. Such previous reviews are diluted in terms of their mixed focus of mental health treatment more generally (i.e., self-management, medication). This paper aims to investigate factors surrounding the psychological professional in order to enhance understanding of how the psychological workforce can be effectively equipped for working with an aging population.

1.2.1 Rationale for meta-ethnography

Gaining the first-hand perspective of professionals who have worked with OP has offered insight into understanding the low rate of professionals specialising in geropsychology. Yet there remains to exist a synthesis of qualitative research in this area, which may serve in informing professionals when working, or considering working, with OP, along with highlighting key points for policy and training considerations. The research question therefore for this study is: what do the combined findings from qualitative research inform about professionals' experiences and views of working therapeutically with OP?

Chapter 1

The aim of this study is to synthesise and interpret existing qualitative literature of professionals' perspectives on working psychologically with OP. This will be undertaken via the application of Noblit and Hare's (1988) seven phase meta-ethnography, to first synthesize the perspectives and experiences of professionals, followed by the production of new interpretations. An ethnographic approach will assist in moving beyond an aggregation of findings and towards the production of new conceptual understandings of professionals' experiences of working with OP (Noblit & Hare, 1988).

1.3 Method

The eMERGE criteria (France et al., 2019) was reviewed as part of a check of reporting quality. Where possible, their reporting guidance was used to incorporate the seven stages of the framework as subheadings for this review, merged with conventional journal paper headings (see Table 1).

1.3.1 Phase 2: Deciding what is relevant - Search strategy

The search strategy was comprehensive, in that all available studies, of sufficient quality, were sought to be included in the review. The following definition was used when searching the literature: 'Papers whose primary focus is professionals' views of working therapeutically with OP'. Papers also had to be written in English language (either original version or officially translated) and published between 1980 and 2022.

1.3.1.1 Search processes

Search terms were developed via various scoping searches and consultation with a University of Southampton Research Librarian (see Appendix A). The search was conducted via three databases, as per recommendation for doctoral level systematic reviews: PsycINFO (via EBSCO), MEDLINE (via EBSCO), and Web of Science Core Collection. A further database search for grey literature via OpenGrey, The British Library (including a search via EThOS for theses published online) and The Cochrane Library was conducted. These databases were chosen as they also publish material potentially relevant to the aims of the review. Contents of key journals were hand searched. All references were uploaded to Covidence for the screening phase. 70 duplicates were automatically identified, reviewed by the author prior to removal.

1.3.1.2 Selecting primary studies

Eligibility for inclusion in the review was considered with reference to the SPIDER framework (Sample, Phenomena of Interest, Design, Evaluation, and Research Type; see Cooke et al., 2012).

Table 1

Seven Stages of Meta-ethnography

Phase	Description of stage	Exampled in paper
1. Getting started	Context and rationale for meta-ethnography; explaining the meta-ethnography	Introduction
2. Deciding what is relevant	Search strategy and process: search-terms; inclusion and exclusion criteria; quality checking	Methods
3. Reading included studies	Reading and data extraction: noting metaphors, concepts, and themes	Methods
4. Determining how studies are related	Comparing the studies - 1st order construct development	Methods
5. Translating studies into one another	Preserving the context - 2nd order construct development	Results
6. Synthesising translations	Overarching concepts - 3rd order construct development	Results
7. Expressing the synthesis	Summary of findings; strengths, limitations, reflexivity; recommendations	Discussion

See Table 2 for inclusion/ exclusion criteria in relation to the SPIDER framework. Regarding the sample, it was decided that including trainees and qualified professionals would provide the multiplicity required for a full picture of psychological working with OP. Specifically, those qualified and with experience of working were deemed to be in a position to offer insights gained from actual lived experience. On the other hand, trainees/ those without experience of OP may serve in providing perspective on the barriers and considerations of the work.

1.3.1.3 Outcome of study selection

The author was responsible for inclusion/ exclusion decisions. Initial title and abstract screening yielded 18 studies for full-text screening (see Figure 1). An external reviewer reviewed a random subset of 20% to corroborate inclusion decisions. Two papers were not available and could not be sourced by the UoS library. Frequent reasons for rejection at the full-text screening included the qualitative enquiry focussed on evaluations of psychological interventions for OP, the sample not

consisting of psychological professionals, and studies utilising a mixed-methods design. This resulted in 10 papers for the quality appraisal phase (see Table 3).

1.3.1.4 Quality appraisal

This review sought to only include studies that were of a certain quality, both in terms of methodology and relevance of output (see Campbell et al., 2011). The Critical Appraisal Skills Programme (CASP) provides a manageable framework for quality assessment and is much endorsed by qualitative researchers (see Dixon-Woods et al., 2006). That said, the research team appreciated the role of intuition in quality appraisal, and so referred to key points identified by

Table 2

Inclusion and Exclusion Criteria in Relation to SPIDER Framework

SPIDER domain	Inclusion	Exclusion
Sample	Psychological professionals, in training and qualified (see definition)	Non-psychological professionals or mixed sample where view of psychological professionals cannot be separated from rest of sample
Phenomenon of Interest	Working psychologically with OP, which could be either direct lived experience or presumptions/ estimations of this	Psychological work was not main modality of working
Design	Form of interviews, focus groups, field studies, observations or other qualitative methods that explored the experiences and perspectives of clinicians	Opinion pieces and policy papers
Evaluation	Views, experiences, attitudes, or perspectives of psychological professionals	Evaluations/ appraisals of therapies, psychological initiatives for OP population
Research	Primary research that was qualitative in nature were included.	Non-qualitative (i.e., quantitative, or mixed methods), non-primary/ secondary design (i.e., previous systematic reviews/ meta-analyses/ qualitative syntheses)
Date	1980-2022	Pre-year 1980
Language	Papers are written/ translated into English	Non-English written papers

Toye and colleagues (2013). These being: the importance of conceptual clarity (CC; i.e., how clearly has the author provided theoretical insight? Can I "see the wood through the trees"?); and interpretative rigour (IR; i.e., what is the context of the interpretation?). It was decided that relevance of findings was to be considered alongside methodological strength, and that studies would not be eliminated based on methodological weakness alone, particularly as lack of reporting does not necessarily infer poorly conducted research (see Campbell et al., 2011). These considerations combined with CASP provided a solid framework to undertake quality assessment (see Table 2). Quality appraisal was undertaken by the author. Following this, a random subset (20%) of two papers were reviewed by an external reviewer to check agreement. Level of agreement between the reviewers was found to be satisfactory (i.e., the appraisal resulted in a very similar quality score), meaning no papers were removed from inclusion in the synthesis following this.

Figure 1

PRISMA Flow Diagram of Search Results

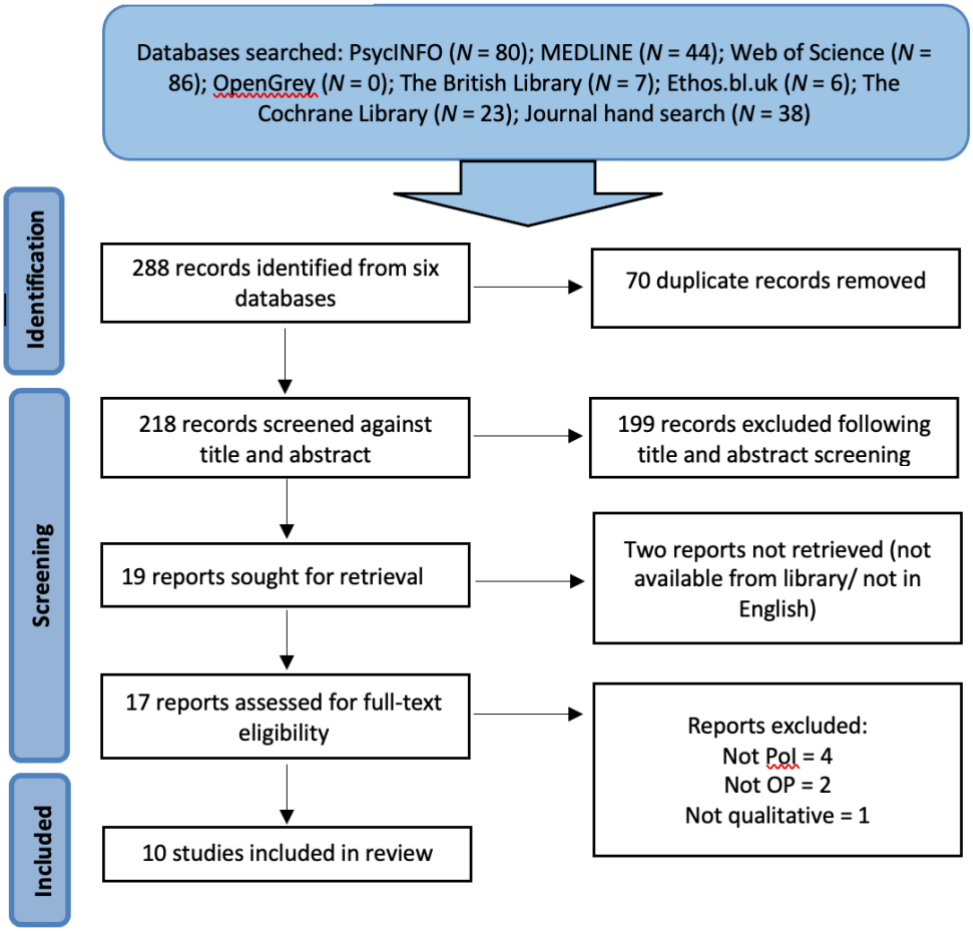


Table 3

Quality Appraisal of Primary Studies

Study	1	2	3	4	5	6	7	8	9	10	CC	IR	T
1. Santiago	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12
2. Engelskirger	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12
3. Lederman & Shafler	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12
4. Rawle	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12
5. Bennett	✓	✓	✓	✓	✓	n/c	✓	✓	✓	✓	✓	✓	11
6. Boschann et al.	✓	✓	✓	✓	✓	✓	n/c	✓	✓	✓	✓	✓	11
7. Morante et al.	✓	✓	✓	n/c	✓	✓	n/c	✓	✓	✓	✓	✓	10
8. Watts*	✓	✓	✓	✓	✓	n/c	✓	n/c	✓	✓	X	✓	10
9. Kapeloni & Glover	✓	✓	✓	n/c	n/c	✓	n/c	n/c	✓	✓	✓	✓	8
10. Atkins & Lowenthal	✓	✓	✓	✓	n/c	n/c	n/c	✓	X	✓	✓	✓	8

Note. ✓ = satisfied; X = not satisfied; n/c = not clear; CC = Conceptual Clarity; IR = Interpretative Rigour; T = Total score

***** Only themes relating to counsellors and psychologists were examined

1.3.2 Phase three: Reading included studies

Selected papers were read and re-read to become familiar with the key concepts and metaphors. An Excel spreadsheet (design of which was based on Sattar et al.'s 2021 worked example) was constructed to organise the raw data – i.e., the first and second order constructs – within the studies. It is important to specify our definitions of first, second, and third order constructs, as these can vary in the meta-ethnography literature (see definitions list).

1.3.3 Phase four: Determining how the studies are related

A list of themes from each paper were compiled together under the name of each study (see Appendix B). Mostly, this involved copying over the exact wording (or nearly exact) of theme names. In other cases, theme names were elaborated to ensure the essence of the theme was captured in the list of themes; this was done in the circumstance where "bucket labels" had been assigned to themes, which overlook the underlying meaning of the contributing codes (see Braun

and Clarke, 2019). Based on their common concepts, themes were clustered into relevant categories.

Table 4

Study Characteristics

Study	Stated aim	Participant characteristics	Time working with OP	Data collection	Analytic approach
1. Santiago, 2013 US	Describe millennial counsellors' experiences and perceptions of aging and provision of gerocounselling	Eight millennial counsellors in training (all female; aged 30 and below)	Not stated	Focus groups and individual interviews (all participants)	Glauser and Strauss' Constant Comparison
2.Engelskirger, 2017 US	Examination of clinical psychology graduates' experience of empathic failure during OP psychotherapy	Seven trainees of DClinPsych or MSc in Social Welfare (six female; one male; aged 25–36)	1-4 years	Descriptive Phenomenology informed interviews	Descriptive Phenomenology
3. Lederman & Shefler, 2022 Israel	Obtain information about therapists' identification and management of ageist biases in psychotherapy	14 psychotherapists (11 female; three male; aged 42-71 years)	10-41 years (not OP specific)	Semi-structured interviews	Grounded Theory
4. Rawle, 2022 US	Obtain in-depth contextual information from individuals working clinically with older patients in long-term care settings	10 licensed psychologists (eight female; two male)	3.5-17 years	Semi-structured interviews	Content Analysis
5. Bennett, 2002 US	Uncover transferential themes experienced by younger clinicians	Seven qualified supervisors to psychotherapy trainees	Not stated; selected for "expertise in geropsychology"	Semi-structured interviews	Grounded Theory (Strauss & Corbin)
6. Boschann et al., 2022 Germany	Explore the experiences and perceptions of young psychotherapists working therapeutically with OP	20 trainee psychotherapists (14 women; six men; aged 27-35)	3 months (at least)	Semi-structured interviews	Grounded Theory
7. Morante et al., 2020 Australia	Identify and explore psychologists' perceptions of nuanced clinical issues in psychotherapy with OP	13 clinical psychologists (four male; nine female; aged 30-69)	1.5-20 years	Semi-structured interviews	Braun and Clarke's Thematic Analysis
8. Watts, 2007	Examine psychological professionals' differing regards to their perceptions, experiences, and beliefs of aging	Four licensed psychologists and four counsellors (seven female; one male; aged 34-64)	2.5-23 years	Semi-structured interviews	Phenomenological Analysis
9. Kapeloni & Glover, 2022 Republic of Ireland	Identify and make meaning of therapists' experience working with OP	10 counsellors or psychotherapists (eight female; two male; aged 40-70)	3-25 years	Semi-structured interviews	Heideggerian Hermeneutic Phenomenology
10. Atkins & Loewenthal, 2004, England	Highlight factors consequential from therapists' experiences of working with OP to understand barriers	Eight psychotherapists trained to at least diploma level in psychodynamic or integrative therapy (six female; two male; aged 45-72)	Not stated	Unstructured interviews	Heuristic Approach

1.4 Results

1.4.1 Phase five: Translating studies into one another

Themes and concepts from all papers were summarised in order of quality, starting with the highest scoring paper (Santiago, 2013) to the lowest scoring paper (Atkins & Lowenthal, 2004). In practice, this involved the themes and concepts of study one compared and contrasted with each other, with reference to the study's context. Findings of study two developed these descriptions; a summary of its themes and how the findings diverge from paper one was added to the working document. This was continued until all 10 papers had been summarised and descriptively aggregated together, producing a synthesis of the primary authors' interpretations. A translations table was created, which clustered second order constructs in one column, supported with first order constructs (i.e., quotes to illustrate the author's interpretations) in an adjacent column (see Appendix B). These were grouped under descriptor headings, which fed into the development of third order constructs in phase six.

Reflexivity and monitoring researcher bias were practised in this stage and those subsequent. The research team discussed theme development, sharing personal and established meanings of certain concepts i.e., ageism, prejudice, cohort effects, in order to arrive at a mutual agreement of how to begin conceptualising third order constructs.

1.4.2 Phase six: Synthesising the translations

Translations were synthesised via reciprocal and refutational approaches (see Noblit & Hare, 1988); this section presents the researchers' interpretations, in the context of the original authors' interpretations and original data (see Table 4). Numbers correspond to study names in Table 3. The process was iterative: papers were consistently revisited to ensure first and second order meanings were preserved and reflected in the researchers' third order interpretations.

1.4.2.1 Suitability for Psychotherapy

There were differing views on OP's suitability for psychotherapy; for some, the question of whether OP can access psychological mindedness was evident in some accounts, with qualified professionals questioning whether they recognise "an inner world or know there is an option to speak it" (3). Divergent to this was the view of millennial counsellors, who described OP's life experiences providing greater self-awareness, meaning openness to the therapeutic process (1). Qualified professionals spoke of working with OP as "not so much different to work with younger clients – just that some things seem a bit sharper", alluding to an awareness of diverging values and experiences as a result of cohort effects (10).

Further, unsuitability for psychotherapy could be based on the conception that OP prefer medical professionals, "like a psychiatrist" (2), to discuss psychological matters. Young professionals admitted to never having contemplated working with OP, as "isn't that what social workers do?" (1).

Within some accounts, ageist beliefs seemed strongly contextualised to the therapists' age. Older supervisors commented that their young supervisees perceived OPs as frail, and this acting as a barrier to being challenged in therapy (5; 6). A group of young clinicians identified their avoidance of "taboo" topics, such as sexual desire, was maintained due to assumptions "that older people don't have sexual feelings" (5). For some, maintaining these blocks was a well-meaning, yet restricting, 'respect for elders' adage, which was perceived to be stronger in the context of a larger therapist-client age gap. This was not limited to younger therapists only; cultural context could be a consideration for professionals' openness in discussing personal topics, given that Israeli therapists' spoke of their prominent "stereotypes lurking at the door", which shaped assumptions of what should and should not – "like sexuality" – be talked about (3).

Seemingly, there are risks of professionals having a, or condoning their clients', nihilistic view, accepting that psychological change is no longer possible or worthwhile when end of life is near (6). Another paper depicted therapists embracing that a push for progress may not be suitable, and instead accepting a focus of "making the most of living with what is" (10). Given OP's

varying needs, an integrative model with therapist flexibility is imperative; more positive accounts saw groups of professionals owning their responsibility to "try different angles" and being open to "see where it goes" (7), if facing resistance for change.

For this construct in particular, study dates were considered as contextual factors, in that they incur cohort effects: the sample of a 2002 study (5) differs by twenty years to that of a 2022 study (6). Interestingly however, the reciprocal or refutational relationship between the studies' findings did not appear time related.

1.4.2.2 The Expansive Role of the OP Psychotherapist

Professionals working with OP are assumed to have an advocacy role for their older clients (1;4;7;8), in terms of ensuring their access to psychological therapy (1; 7; 8) and confronting ageist stereotypes within the wider societal culture (4; 8; 10). Prioritising the empowerment of older clients was prioritised as "the biggest thing" in some accounts (5; 8), so long as there is the initial personal drive for change (3). Clinical work with OP can be seen as an opportunity to be creative and flexible, utilizing "out of the box treatment" (4). Drawing on the client's "wealth of insight" (8) was identified as a key therapeutic tool, encouraging clients to reflect on past experiences to create new meanings. Socratic questioning (7) and reminiscence therapy (8) were provided as specific approaches for clients to use their accrued wisdom for solving current problems. Some therapists stated that, although stories are a privilege to hear, too much time spent reminiscing can distract from progress (7), indicating there is a line to be had between past and present focus.

Ethical issues specific to an older client group, such as elder abuse and euthanasia, were described by some as specific considerations for practice (7; 8). Specifically, the balance between "putting aside judgement approval or disapproval" (7) on euthanasia, whilst ensuring the client had full understanding of the personal, familial, and legal ramifications is key for maintaining therapeutic alliance whilst fulfilling a responsible role (7). The importance of supervision and systemic working was highlighted by qualified psychologists (7) indicating that regardless of clinicians' experience, information sharing around delicate ethical issues is paramount.

1.4.2.3 Therapist as Parent vs. Therapist as Child

Accounts spoke of the common experience of transference and countertransference. For some, as the client gets "closer to the end, like a child is closer to the beginning", professionals described this triggering the therapist to adopt the parental role (9). In contrast, others assume the role of the child (8; 10), with the older client reminiscent of a parent or grandparent (5; 10), occasionally leading to overfamiliarity with the client (2). These cross processes seemingly occurred regardless of professional age or stage of qualification, although there was some alignment between therapists' assumptions of older patients as vulnerable (9) and frail (5) leading to the therapists in a parent role, whereas older clients reminiscent of a therapists' older relative may lead to a child role. Openness to transferences taking place is critical to therapy and therapeutic alliance; this was discussed in the context of direct therapist-client discourse (9) and during supervision (5).

1.4.2.4 Psychotherapists' Readiness to Work with Older People

There was a call for an increase in specialist OP psychotherapy training (1; 2; 5; 9). A global increase in the older population, and therefore increase in demand for mental health services, sets the context for this message from participants. Specifically, a "who am *I*?" response (5) depicts the struggle younger professionals may have in owning their expertism when working with older adults (1; 5). Aforementioned themes of implicit societal customs around respect for OP seemingly come into play here, some of which are cemented by OP's prejudices of their therapist being many years their junior and therefore not qualified to impart psychological advice; experienced clinicians identified their younger supervisees facing criticism due to "age or lack of experience" (5; 8).

1.4.2.5 Working (Cautiously) with the System

Team working was described as a critical factor for addressing OP's diverse needs (4; 7). For professionals working in a hospital, a balance was stressed between adhering to the ethical responsibility of information sharing, yet on a need-to-know basis due to diagnoses

"misinterpreted by the nursing staff" (7). Offering the least amount of information necessary as part of handover was discussed as a viable option. Better yet, psychological in-house training for medical staff may serve in more effectively reducing cross-wired communication (5).

Professionals' interactions with families were appreciated as opportunities for effective systemic working (4; 10) but caveated with the need for caution where families do not have the perceived best interests for their older relative (7; 8).

1.4.2.6 Confronting Death and Endings Comes with Experience

Working with older people comes the inherent acknowledgement of death and loss (1; 4; 6; 8; 9; 10), these being both primary (i.e., "it would be more likely I'd lose that person", 1) and secondary (i.e., "the loss of loved ones…independence… role as a caregiver", 4) experiences. Whilst most therapists spoke of death with an open, accepting attitude, a sample of millennial counsellors (1) and supervisors of younger therapists (5) reflected on the perceived emotional risks of clients nearing end of life, and a generalised fear of death blocking important existential discussions (5). These varying attitudes appear contextualised by therapist age; younger professionals feared the emotional impact of losing a client, and this risk being elevated working with OP (1). Older professionals however spoke of their work offering an opportunity to confront existential matters, and that acceptance of their own ageing permitted an openness to ask 'life's big questions' (4; 10).

Culture seemingly contributed to how therapists' handled loss; a sample of American psychotherapists described how "there is nothing more feared in this culture… than sick people" (5) and that with this comes young trainees wanting to distance themselves from mortality and ill health. For those working or originating outside of Western culture, such as a therapist working within a Native American community, the painful emotional process was supported by the wider community coming together (4). Within the same sample, an Asian American therapist commented on her surprise that OP are an "underserved population", noting that they are not taken care of in the same way as in her home culture where they are "respected and take[n] care of" (4).

Table 5

First, Second, and Third Order Constructs from the Ten Studies

Third order constructs	Second order constructs	First order constructs
Suitability for Psychotherapy	- Challenges with psychological language, psychological mindedness, and introspection (3) - PP don't work with OP (1) and OP prefer medics anyway (2) - Younger professionals feel awkward with the "taboo" topics (3; 5; 6); the confidence for this comes with years of experiences (4) - Change is futile anyway (6) - Making the most of living with what is (10) - If it's not working, try a different angle (7)	*Many of them don't know they have an inner world or they don't know that there is an option to speak it and somebody would care ... When this is the experience, their communication is very concrete, and it's very difficult for the therapist* (3)
The Expansive Role of the OP Professional	- Empowering the person first, advocating second (1; 4; 7; 8; 10) - Using wisdom as a therapeutic tool (7; 8) - Openness to distinctive ethical issues and refraining on judgement (7; 8) -	*[They've] been on this planet for 75–80 years and they've gained a wealth of insight and wisdom and experience that I haven't got… I just simply tap into that…I simply use Socratic questioning with them…they start to answer their own questions…* (7)
Therapist as Parent vs. Therapist as Child	- Clients' vulnerability triggers a parental reaction (9) - Therapist viewed as the child (8; 10) - Caretaker transference (5; 10) - Over-familiarity leading to empathic failure (2)	*The older they get, they need to be treated as an infant. That's it! It triggers the parental response in us…because they are closer to the end, like a child is closer to the beginning.* (9)
Psychotherapists' Readiness to Work with OP	- Feeling underprepared (5, 8) and inadequate to work with OP (1, 5) - Need for training (1, 2, 5, 8)	*I just don't feel prepared to work with older people* (1)
Working (cautiously) with the System	- Diverse needs call for MDT working (4) - Information sharing should be a need-to-know basis (7; 10) - Including the family in a team approach (4; 10) - Balancing family involvement with clients' best interests (8)	*It should really be a shared role, not only among families and friends but also among different providers and different systems. It needs to be a team approach.* (4)
Confronting Death (comes with experience)	- Acceptance and being present (8; 9; 10) - Talking about death is part of the work (4; 8; 9) - Acknowledging death and feeling vulnerable (1; 5; 10) - Loss comes in many forms (4; 8, 10) - Experiencing loss through the OP (8; 9)	*It shouldn't be that hard to just hold someone's hand and say, "What are you proud of in your life? Are you okay? Are you scared?"* (4)

Note. Numbers correspond to study names in Table 3.

1.5 Discussion

1.5.1 Phase seven: Expressing the synthesis

This section summarises the key findings of the syntheses, along with evaluative points and researcher reflexivity, concluding with recommendations for clinical practice and educational contexts.

Via application of the methods of meta-ethnography, studies exploring psychological professionals' considerations and experiences of working with OP have been synthesised to form new interpretations and a line of argument conceptualisation, therefore achieving the initial established aims.

Consistent with the literature, OP's suitability for psychotherapy was presented as a key consideration across many of the accounts, which depicted divergent perspectives. OP's life history and years lived were identified as ways to make the work more reflexive and meaningful, and complimentary for deriving meaning and problem solving for present day challenges, a. Other accounts reflected the enduring stereotype of OP having cognitive inflexibility. The studies' contextual factors were emphasised here, with age of therapist and cultural norms holding some contextual weight for the presence of ageist stereotypes; year of study, and therefore specific cohort effects, did not play such a role.

A refutational synthesis collated the divergent views on transference. Whilst specific themes of transference are beyond the scope of this review, it was identified that professionals' specific assumptions of OP as vulnerable and frail lead to their parent role, whereas older clients reminiscent of a therapists' older relative may lead to a child role. In some accounts the direction of transference seemingly had some bearing on the trend of how adaptive clinicians were in navigating death and loss: those who avoided talking about death tended to be therapists who assumed the child role, whereas therapists who reported acceptance of death were those experiencing transference as a parental figure, suggesting that the parental role brings a responsibility of managing difficult circumstances. Indeed, those who presented more ease

around death saw the value in 'the time for therapy of silence' (Kübler-Ross, 1997), where structured therapeutic techniques are no longer of relevance.

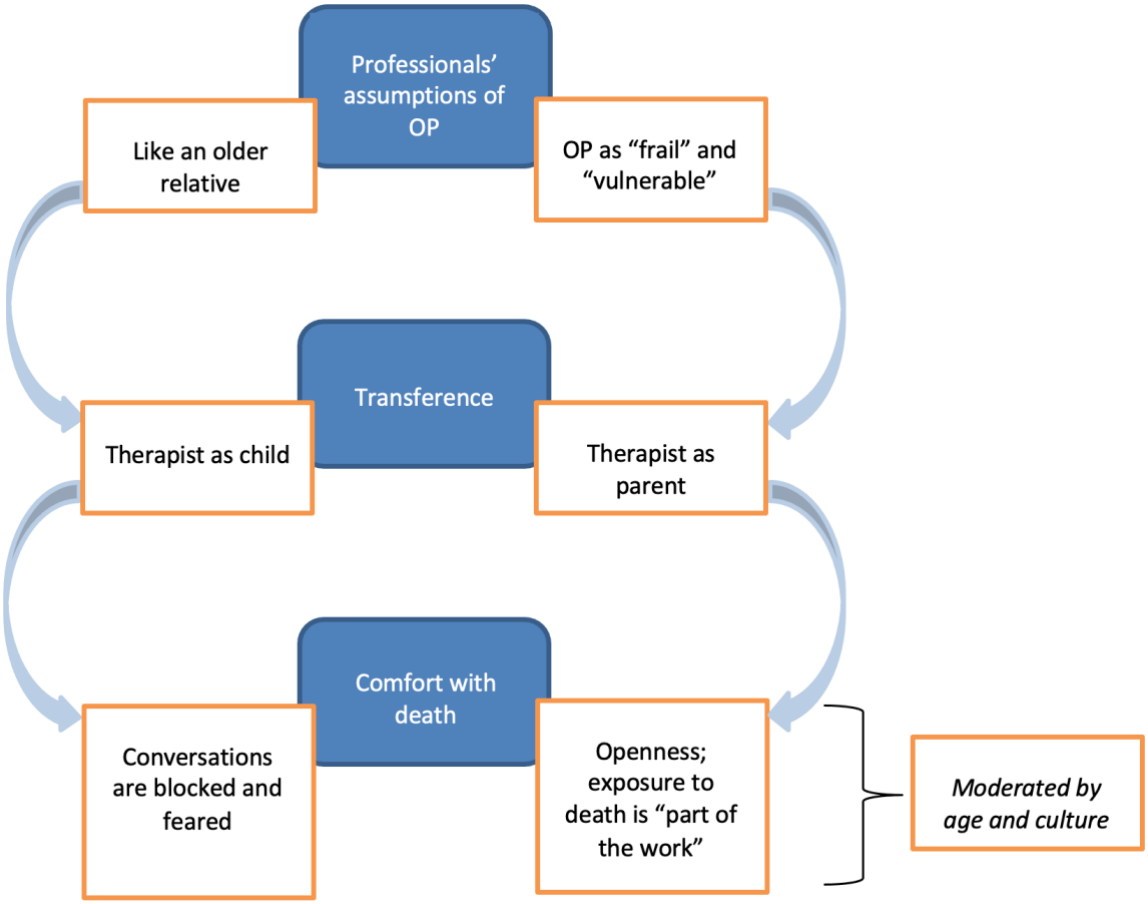
The synthesis of 10 relevant papers presents a line of argument which represents the inter-relationship between a select few third order interpretations (see Figure 2). Notably, these are interpretations that represent factors surrounding the professional and their relationship with older clients: professionals' assumptions of OP, transference and countertransference, and professionals' comfort with death. The line of argument model incorporates the interweaving nature between factors discussed in the previous paragraph, along with consideration of how professionals' assumptions of OP effect the direction of transference, and subsequently their ease at which they can manage death and loss within their work. This final factor is considered within the model to be moderated *somewhat* by age and culture of the professional. Papers capturing the views of non-Western professionals (Rawle) identified the openness these professionals had with death and loss, compared with, for example, American professionals (i.e., Bennett). More pronounced was an influence of professionals' age on managing death and loss, with papers that represented the views of younger professionals depicting the struggle and discomfort surrounding these issues, compared with those representing older professionals, where there was a perceived sense of ease and openness to existential matters.

1.5.1.1 Strengths, limitations, and reflexivity

The meta-ethnographic approach created a synthesis of professionals' perspectives that are "greater than the sum of its parts" (Barnett-Page & Thomas, 2009 p.2), whilst being comprehensively developed utilising established systematic processes (i.e., CASP) and worked examples (i.e., Sattar et al. 2021). The broad scope of this review means that a range of voices – by way of professionals' therapeutic approach and training, stage of career, cultural background – were included in the synthesis; the findings potentially hold relevance for a wide range of psychological professionals working with older groups.

Figure 2

Line of Argument Depicting a Conceptual Model of Factors Surrounding the Professionals



This in itself brings a limitation to the specificity of findings, given the diverse training programmes and necessary qualifications required for working in divergent health systems. On reflection, a more specific inclusion criteria may have served for application of the findings and a tighter focus for synthesising the findings into a line of argument.

Of course, the views collated here are only one side of the story for exploring OP relationship with psychological therapy; to provide a well-rounded account of this relationship, these findings should be interpreted alongside published reviews of OP's views and attitudes (see Nair et al. 2020).

1.5.1.2 Recommendations

Accounts contributed to important implications for adequately preparing therapists for working with older clients, such as a need for training to address trainees' feelings of inadequacy

in this line of work; this was found across the range of study dates, indicating that training programmes are still somewhat lacking in their dedication to OP psychology. To address this, training programmes would likely benefit from embedding a specific OP module within the syllabus, ideally with suggestions of how lifespan-based competencies can be met when a specific OP placement cannot be provided. How this is implemented will depend on the context of each institution; it is evident that specific training requirements are established in the UK (see BPS, 2006), USA (see Pikes Peak Model, Knight et al., 2009), and other countries. Equally, supervisors should be skilled in advising their young and in-training supervisees how to confidently express their professionalism in the circumstance of older clients having doubts of their proficiency.

Family involvement is encouraged to maximise opportunity for well-rounded care, but should be approached with caution given clinicians', rare but significant, concerns of family members taking advantage of their older relatives. Further, systemic work should not be assumed as always essential given the potential for caregiver burden to have deleterious effect on the older clients' therapeutic outcomes (Martire et al., 2008). Consulting guidelines such as Mottaghipour and Bickerton's (2005) Family Pyramid of Care is recommended for incorporating the family in clinical practice.

1.5.2 Conclusion

This meta-ethnography highlights some key considerations for psychological professionals working with OP. We view these findings as just one side of the story of delivering and access of psychological therapy with older clients. It is acknowledged that a -wide inclusion criteria may have diluted the specificity of the findings for application with specific psychological professional groups. Future qualitive syntheses could focus on particular groups of professionals (i.e., by way of stage of training, cultural background) to better understand specific factors relevant to these groups.

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Chapter 2 "When you get to a certain age you are no good to man or beast": Meaning and purpose in life in later years and implications for clinical practice

2.1 Abstract

Background. Meaning in life (MiL) and purpose in life (PiL) are recognised to have a protective aspect against depression. Older people can have a certain susceptibility to losing sense of MiL and PiL due to compromises and losses associated with aging. The primary aims of this study were to: i; explore how older people with depression connect to MiL and PiL, and any relation these constructs may have with experiences of depression, and ii; develop insight into the role of psychological intervention to develop MiL and PiL in later life.

Methods. A qualitative, phenomenological design via semi-structured interview was utilised to obtain personal accounts from five older people with lived experience of depression. Participants had recently received psychological therapy under a community mental health team in the south of England. Interviews were audio recorded and transcripts were analysed via Interpretative Phenomenological Analysis.

Results. Three group experiential themes were identified: Living a Full Life; Developing the Self; and, Connecting Past, Present, and Future. Participants deemed developing and maintaining connections with people and communities around them an important aspect for guiding them through depression. (Re)discovery of personal strengths was identified as an important aspect to a continued meaning by some, whilst others explained depression as a block to this. Participants referred to the thread of time, rumination, and, for some, the futility of goals in later years.

Conclusion. Older people used MiL and PiL interchangeably and made little to no differentiation between the concepts. Each theme presents policy and clinical implications for older people experiencing depression.

Chapter 2

Key words: Purpose in life; meaning in life; older person psychology; Interpretative

Phenomenological Analysis

2.2 Introduction

Well established in the existential literature is the essentiality of meaning in life (MiL) and purpose in life (PiL) in relation to psychological and physical health. Viktor Frankl's work positions meaning and purpose as essential for achieving complete emotional well-being (Frankl, 1969). This in turn avoids what he termed an 'existential vacuum', characterised by boredom, apathy, and eventually depression (Thorne & Henley, 2005), which inspired the development of logotherapy, an approach centred around the necessity of a quest for meaning. Since this seminal piece of work, MiL and PiL have been appreciated as key tenants for understanding the thriving and suffering of adults in later years. Given the increase in life expectancy, it is imperative that psychological understanding and practice continues to develop for the older person population.

2.2.1 Defining meaning and purpose in life

There are various definitions for MiL and PiL within the literature, with some authors conflating the two (e.g., Steger et al., 2009). In this work, we refer to two separate definitions, which correspond with those clarified by Reker and colleagues (1987) and Sharma and Bluck (2022). That is, MiL is the *consideration for one's existence and larger aspirations*. By PiL we refer to *externally oriented intentions and goals initiated and set out to be achieved*.

2.2.2 The contribution of meaning and purpose to wellbeing

Empirical investigation to assess the contribution of MiL and PiL to human wellbeing has had promising outcomes. As initially proposed by Frankl (1959), MiL has been identified as a critical component for navigating stressful life experiences (Vos et al., 2015); similarly, increased PiL shows strong recovery properties following difficult life events, due to the role purpose plays in cognitive reappraisal and avoiding rumination (Schaefer, 2013). More specifically, both MiL and PiL have been identified as key factors in reducing depression symptomology (Bowling & Iliffe, 2011). These benefits, along with Frankl's own development of logotherapy, have led to the development of meaning-oriented therapies, which show great improvements for people with physical illness (Vos et al., 2015) and older clients with depression (Bowling & Iliffe, 2011). Indeed,

Public Health Scotland (n.d.) now emphasise the importance of purpose and meaning in achieving a state of mental well-being and the National Institute for Health and Care Excellence (n.d.) specify older people's participation in meaningful activity as a quality standard for care homes.

2.2.3 Theory

According to Frankl's theory, humans have a primary and universal motive to search for meaning and without pursuit or attainment of this, we experience psychological consequences of apathy, boredom, and meaninglessness (Frankl, 1959). Frankl's proposition that purpose provides a 'way out' of challenging hardships suggests PiL may provide enhanced resilience to its possessor. Whilst traditional models of successful aging call on a multitude of factors for the pursuit of global health in later years, such theories can bypass the importance of resilience (Rowe & Kahn, 1997; Bowling & Iliffe, 2011) *and* the importance of the spirit. Indeed, Frankl and scholars alike emphasise the spiritual dimension, deemed an integral aspect of logotherapy and quest for meaning and purpose (Xu, 2010). Therefore, we conceptualised a person's sense of MiL and PiL as essential internal resources, that buffer challenging life experiences, such as depression, and form part of the drive towards complete psychological and spiritual health.

2.2.4 Rationale for the research

Older people's susceptibility to losing their sense of MiL and PiL has been indicated in the qualitative literature. Previous research indicates that loss of purpose and meaning is implicated in older people's perceptions that living life beyond a certain point of old age may be futile, despite no identified diagnosis of depression (Van Wijngaarden, 2015). For those with depression, logotherapy has been evidenced as an effective intervention for reducing depressive symptoms via the discovery of meaning (Kim & Choi, 2020). Yet, qualitative research remains to exist that explores older people's conceptualisations of MiL and PiL, in the context of their depression, and whether recipients of psychological therapy view therapy as engaging them to contemplate meaning and purpose. Accordingly, the current study deliberately focusses on this group.

The aim of this research is to investigate how older people with depression make sense of MiL and PiL in their later years. Secondly, enquiry into whether and how psychological therapy contributes to older people's conceptualisation of MiL and PiL will also be pursued.

2.3 Methods

2.3.1 Design

This study utilised qualitative methodology with interpretative phenomenological analysis (IPA) as the core approach. The theoretical underpinnings of IPA are grounded in phenomenology, (double) hermeneutics, and ideography (Smith et al., 2022), and so it was considered that the individuals' experiences, or sense-making, communicated in their own terms, will be interpreted through the researcher, with the researcher paying close attention to self-reflexivity (Finlay, 2008). This involved the research team considering their prior experiences working with older people; strategies to operationalise reflexivity are detailed in subsequent sections. The consolidated criteria for reporting qualitative research (COREQ) were referred to for quality checking (Tong et al., 2007).

2.3.2 Participants, sampling, and recruitment

The participants were selected purposively in order to form a sample that held views and experiences relevant to the studied phenomenon (Creswell & Poth, 2018). The recruitment sites, two Older Person NHS Mental Health Services (OPMH) in the south of England, were chosen for convenience. The author's supervisor acted as a gatekeeper to psychologists at one site due to this being her place of work at the time. The author had worked at the second site during a clinical placement.

The author was introduced to the team, with email follow-up providing recruitment materials for psychologists to review the eligibility criteria. Purposive sampling involved the psychologists discussing the research with their patients (see Appendix D), at their discretion of them meeting eligibility criteria (see Table 6). If interested, information sheets were provided (see Appendix E). Following candidates' expression of interest, the author contacted potential participants via telephone in order to ascertain that participants were eligible to participate and fit the homogenous criteria for the sample. If appropriate, verbal consent was attained and a time was arranged for the interview to take place.

Five participants contributed to the interview data (see Table 7). Malterud and colleagues' (2016) five dimensions of information power suggested a target of eight participants (see Appendix C). This figure was not reached due to recruitment challenges. The sample consisted of one male and four females, all White British. There was diversity in terms of treatment status, in that two participants had recently finished sessions with their psychologist, whilst the other three were in an active phase of therapy. All participants had been or were married, yet there was diversity in participants' relationship situation; two were widowed, two were divorced, and one was living with their spouse. All participants had children and were living independently.

2.3.3 Data collection

Semi-structured interviews took place between November 2022 and February 2023. These were conducted by the lead author and lasted from 30 to 75 minutes. Interviews were audio recorded.

The interview schedule (see Appendix F) was developed by the author, and further refined following feedback from the supervisor team, and an expert by experience (EbE).

Table 6

Inclusion and Exclusion Criteria for Participation

Inclusion criteria	Exclusion criteria
Aged 67 or over	Current high risk of suicide at time of recruitment and/or interview
Had a current or very recent diagnosis of depression (DSM-V criteria)	Current psychotic episode (DSM-V criteria)
Recognition that they have experienced depression and able to reflect on this	Diagnosis of a dementia or identified memory problem according to professional judgement
Under the care of a mental health service and engaged or recently engaged in psychological therapy	
Deemed well enough to participate by themselves and their lead professional	
Have capacity to consent	
Have a good understanding of English	

Sections pertaining to MiL and PiL were influenced by the wider literature, specifically, Reker and Peacock's (1981) measure for assessing multidimensional attitudes towards life (Life Attitude Profile; LAP). Item wording of the LAP was closely analysed and served, in part, as a basis for the interview questions. The sequencing of questions was designed to regard the comfort of participants (Smith & Osborn, 2003), and open questions were chosen to obtain views and build rapport, followed by probing on more specific issues (Pietkiewicz & Smith, 2014). Funnelling was considered as a way of managing bias in the construction of the questions, which was particularly important for section D – experiences of psychological therapy – due to potential assumptions surrounding impact of psychological therapy on MiL, PiL, and symptoms of depression.

Face-to-face, one-off, interviews were arranged with four participants; one participant was interviewed via phone due to her own preferences. In person interviews took place within a private clinic room in the participants' local OPMH centre, or in a private room on the University of Southampton campus (author's place of study). Participants attended the interviews alone. Participants gave written informed consent at the time of the interview or were sent the consent form (see Appendix G) in advance with an addressed envelope to return the form to their local OPMH, in the case of the telephone participant. Participants were given a £20 voucher as a thank you for participating. Participants were provided with a debrief statement (see Appendix H) and the opportunity to ask questions.

2.3.3.1 Input from experts by experience

To ensure participant documentation was appropriate, one current older patient with lived experience of depression was recruited to review all of the study documents. Feedback was discussed by the research team and incorporated in the final versions of documents.

2.3.4 Data analysis

The author undertook IPA for the data analysis (Smith et al., 2022). Data was analysed inductively, with close attention paid to the participants' accounts – both in terms of what is said and what is not said. Following full professional transcription, transcripts were read, and audio recordings

Table 7

Participant Characteristics

Participant name*	Sex	Age	Ethnicity	Treatment status**	Partner status	Children	Living situation
Frank	Male	69	White British	Past	Partner - cohabiting	Yes	Independent
Susan	Female	73	White British	Active	Divorced	Yes	Independent
Diana	Female	69	White British	Past	Widowed	Yes	Independent
Victoria	Female	78	White British	Active	Divorced	Yes	Independent
Frieda	Female	82	White British	Active	Widowed	Yes	Independent

* Pseudonym name

** Intervention with a clinical psychologist as part of care under mental health team

listened to, to begin the sustained engagement with the text (step 1). Exploratory noting of the whole transcript detailing (un-censored) points of interest was noted on the right margin (step 2).

Next, experiential statements were constructed (step 3) and made on notes stuck on the left-hand margin. These captured the researcher's interpretations of the accounts at a broader level, whilst still remaining localised to the participants' narrative. These emerging themes were listed together on a separate sheet and considered for how they cluster together according to conceptual similarity (step 4; see appendix I). Themes started to cluster together, with some emerging as personal experiential themes; these were named, consolidated, and organised into a table (step 5). This stage was iterative in terms of ensuring that this sense-making of themes reflected the primary data, i.e., the participants' own words, and could be revisited for further refinement depending on incoming data. These five steps were then repeated for all individual cases (step six). Once all transcripts had been analysed, the account-wide personal experiential themes were organised into group experiential themes or GETs (step 7). These final themes were chosen on the basis of how richly representative they are, along with prevalence, within the participants' accounts.

2.3.5 Researcher reflexivity

We are an all-female research team working in the field of clinical psychology. The author is a clinical psychology trainee; the project supervisors are clinical psychologists working clinically and in academic posts.

Our age means that we do not yet have *direct, personal* experience of the phenomenon under investigation – depression and contemplations of meaning and purpose in later life. Yet, the inception of the project idea is based on the synthesis of the author's experiences in her personal and working life. At a similar time of reading Frankl's work, the researcher worked therapeutically with older people experiencing depression. She noted her clients' recurring questions and doubts surrounding meaning and purpose, which strongly resonated with Frankl's teaching.

Undoubtedly, subjectivity will be present in the findings, given the difficulty of divorcing personal influence on the qualitative process (Tong et al., 2007). Indeed, such influences are to be acknowledged and appreciated. Measures were taken, however, for subjectivity to influence the methodology and presentation of findings. These are laid out in the following section.

2.3.6 Trustworthiness of findings

Lincoln and Guba's (1986) criteria for assessing trustworthiness of qualitative research, along with the development of an audit trail (Koch, 1994) were practised as follows.

Transferability was operationalised through the provision of descriptions contextualising the interviews – specifically, the service and participant demographics – to allow the generalizability from the target site to further settings (Bloomberg & Volpe, 2008).

Dependability was demonstrated through the audit trail which involved the author writing memos to record initial conceptualisations of participants' accounts (Lincoln & Guba, 1986), having just recorded the interview, and were used as a starting point, as these interpretations developed during the coding stage and theme development.

2.3.7 Ethical Approval

This research was granted full NHS ethics approval from the NHS Research Ethics Committee (22/WA/0185) and the Health Research Authority (IRAS Project ID 313946). The study was also reviewed and approved by the University of Southampton Ethics and Research Governance committee (submission ID 70464.A1).

2.4 Results

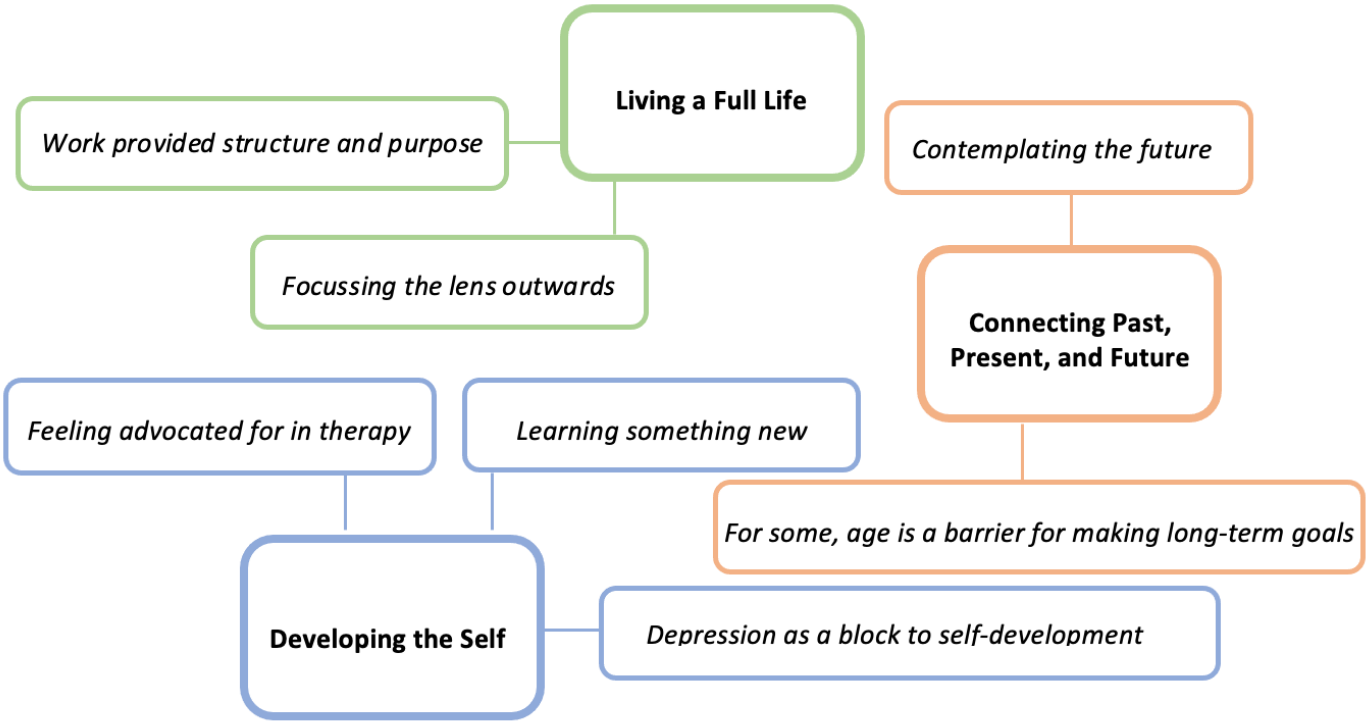
Three Group Experiential Themes (GETs) were developed: Living a Full Life, Developing the Self, and Connecting Past, Present, and Future. All three themes were represented in each of the five accounts. See Figure 3 for a diagrammatic formulation of the three GETs and subthemes illustrating relationships and overlap between the themes, as depicted by their proximal position to each other.

2.4.1 Living a full life

The first GET captures participants' consideration for living a meaningful and purposeful life as one of *fullness*, which they spoke of being constructed by the connections they, or their family, have created with people around them. Having meaningful occupation, discussed in the form of work, was spoken of as a highly positive aspect of participants' lives, in terms of providing structure and incentive, thus contributing to their overall sense of purpose.

Figure 3

Diagrammatic Formulation of GETs and Subthemes



2.4.1.1 Focussing the lens outwards

Participants alluded to the creation and maintenance of connection with others in different ways. Diana spoke of her felt sense, guided by her religious beliefs, that people have come into her life, and it is her purpose to serve them:

> "I have to think that Him upstairs puts people in my way to give me that little bit of hope, that little bit of purpose, that little bit of … well-being, to keep me going on" – Diana

Here, she speaks of the motivation and energy that's derived from helping others and the feeling of purpose she gets from this. Helping and connecting with others was echoed in Frank's account also:

> "I phoned him and he said, "Oh I'm so glad you've phoned me up," and we had a little chat and then I'll text them so, you know, "you can phone me anytime", he said, "Yeah, I know". And like he phoned me, I phoned them …That's our contact. And I've got strength from that." – Frank

After a number of years in and out of an inpatient ward, Frank saw the utility of his experience of depression – as "something I can use". We see him here describing the lasting effects of making connections with other patients on the ward, and how his ability to have true empathy with others helps foster these connections. Similarly, Diana, who, like Frank, considered herself as "on the other side" of depression, spoke of the importance of bringing real, authentic understanding of mental health that can be limited in professional services:

> "You reach out to the mental health but I think … unless they have had that experience it seems very text-booky. You can read up about it but there is nothing so … liberating than if you have been through it and you can say I have got to the other side." - Diana

All of the participants were parents and grandparents, yet only one spoke of their parental role as a consideration for their sense of purpose and meaning. Susan, spoke of the bi-directional importance in her grandmother-granddaughter relationship; her granddaughter represents a beacon of hope and joyfulness whilst she continues to battle depression:

"But she is my purpose in life at the moment because she represents to me all that is fun" - Susan

Victoria made a unique contribution in her comments about her parents' talent in the performing arts and involvement in societies and organisations during their times of parenthood. This created a sense of lives filled with fullness and variety, and ultimately "*a pretty happy life because they were so involved in everything"* (Victoria).

Frieda, who was still in a spell of depression, would frequently refer to feeling confused or uncertain, specifically around not knowing how she could connect with others and be part of their network, despite her having the intention to do so - "if I can help somebody, I will do". This uncertainty of purpose was echoed in Diana's account, who although was feeling better, reflected on her experiences during the depression and thinking she "has nothing left to give".

2.4.1.2 Work provided structure and purpose

Across the accounts, participants spoke of their experiences during their work lives and the experience of these coming to an end in relation to their depression. For Victoria, her busy and demanding job meant she was kept preoccupied away from being consumed by her depression – "I didn't have five minutes really to think about what you're feeling". The end of this work, therefore, meant losing something which motivated her to get up each day and coincided with a more pronounced period of depression.

"I didn't have this incentive to get up and go to work, and once you're at work you're stimulated by everything that is going on."- Victoria

This was a similar experience for Frank, who spoke of his injury at work coupled by COVID-19 leading to him having to give up work. He spoke of these changes to his physical health and loss of work as the start of his spiral into depression:

"That's the start of it really … it got worse and worse, and, in the end, I had to retire" - Frank

Diana explicitly spoke about her views on the continued impact for good she can have in a work environment, yet how these are overlooked due to pervasive societal beliefs about older people's limited contribution to a workforce:

> "there is this concept within the workforce and even now I struggle with it because I still think my brain is quite active, so it is like you are stereo-typed – when you get to a certain age you are no good to man or beast." – Diana

2.4.2 Developing the self

In the second GET, we see participants reflect on the importance of continued learning and personal development. This was perceived more as a gradual unfolding and evolution of the self, as opposed to ticking off achieved goals. For those still in a bout of depression, participants described their symptoms as a major barrier to this. Positively, participants reflected on their self-development through the lens of therapy and described how the relationship with their psychologist was helpful in promoting their agency and developing confidence.

2.4.2.1 Learning something new

Finding new challenges and realising their capacity to grow and develop was deemed an important aspect to a continued meaning and purpose by some participants. During one of his stays on an inpatient ward, Frank started to develop the confidence to facilitate a poetry group. This experience taught him something new about himself: in previous public speaking occasions earlier in life he would shy away from these opportunities. Now in his later years, he has overcome an anxiety and can speak in front of others, going to show 'it's never too late to learn':

> "I'm not scared of standing in front of people anymore, I would never have done that before" - Frank

Taking an active stance to personal development was mirrored in Diana's account. After recognising her passion for learning, she took the decision to continue this and enrol on a college course:

> "I love learning, so it has given me a purpose to contact college, to do what I want to do" - Diana

Susan contributed her profound experience of coming to understand and accept her daughter's sexual orientation as a lesbian. Her new understanding was interpreted as a transcending experience which meant personal development in her understanding of family relationships:

"my daughter, she's gay, and that sort of gave me a lot of purpose in the fact that it was a whole new experience to me" - Susan

2.4.2.2 Depression as a block to self-development

Some participants reflected on the inhibiting effect depressive symptoms can have on drive and making changes for the better. Frieda spoke of invitations from others to socialise, but not wanting to go due to difficulties in motivating herself and any glimpses of a lift in mood feeling futile. She spoke of this being her "own fault" due to her difficulties in motivation, thus perpetuating her belief of being an "awful" and "terrible person" who "is not very strong":

"I think it's my own fault though. I think it's getting motivated to do things, you know. It's not as if I don't get offered out or something … but I don't really want to go so I think that's my own fault" - Frieda

Victoria's account highlighted the friction between feeling most comfortable by herself in her own home and the pressure of getting out of the house, potentially indicative of a cultural expectation that the 'good life' is one of busyness and activity:

"Well, I should be doing a lot more than I am, but I tend to be at ease … more when I'm at home on my own which is not right. I should be doing other things." – Victoria

Frank spoke about the loop of a relapse, in terms of making small improvements and getting well enough by "doing what he needed to do" to be discharged from the ward but then relapsing again. Eventually, he broke free of this by digging deep and learning how to help himself:

"the second time I was going through the motions, I was doing what I had to do. The nurse said the same thing, and I'm thinking 'you know what? I've got to learn from this'" - Frank

2.4.2.3 Feeling advocated for in therapy

The role of their psychologist and therapy itself seemed paramount to participants' feelings of empowerment and agency. Diana spoke of her experiences in therapy helping her to set boundaries with other people which allowed her to say no to others and discovering what's best for her.

> "she has given me options [by] learning to set boundaries … giving yourself space and doing the things I want to do" – Diana

Susan reflected on the importance of time during her sessions, this being for her to work things through with her psychologist, whom she believed had good intuition and an appreciation for hearing her story:

> "I never felt that she was rushing me to get to the bits she needed to get to … she let me talk" - Susan

2.4.3 Connecting past, present, and future

Throughout their accounts, participants reflected on the thread of time in their sense-making of experiences of depression, purpose and meaning. In the final GET, we see them reflect on the role of goals at certain life stages, and the divergence of their future perspectives in context of their current experience of depression.

2.4.3.1 For some, age is a barrier for making long-term goals

For those still experiencing depression, goals were a difficult concept, potentially due to the perception of these being more appropriate for younger age. Victoria spoke of the distance between her current self and past younger self; she perceived that back then, she had choices to consider for the life in front of her:

> "It's not like when you're younger – 'what are you going to be?', you don't know, do you, when you're that young where you want to be going" - Victoria

For Susan, goals of a smaller kind, like household chores, were met with a feeling of futility; despite a feeling of having got it done, she couldn't see past there being little point in it. In her account, she reflected a very similar message to that of Victoria's:

> "When you're younger … you decide what you want to do and how you're going to get on in life and this, that and the other. But when you like, with me, personally, I just think to myself, "Well, I'm coming to the end of my life. I haven't really got any goals" – Susan

Frank reflected a different stance in his account. He spoke of planning, determination, and a 'will to meaning' in achieving his goal of improved physical health via a commitment to a physiotherapy programme.

> "I said 'I know what I'm going to have to do, and I'm going to do it', which I did do" - Frank

2.4.3.2 Contemplating the future (in spite of the past)

Throughout some accounts, participants contemplated their future as a daunting prospect, such as Susan who spoke of her future vision being stripped away from depression:

> "But I don't look far ahead anymore because the depression has taken that away from me." - Susan

Frieda alluded to her past life being one of fullness, activity, and prospects for the future, yet this feeling seemed very separate to the one she lives now. Having a life worth *loving* seemed to be one where the future was in front of her.

> "I loved life then … you look forward to all the different things … they're [children] going to get married and have grandchildren, and holidays and things like that" - Frieda

Victoria spoke of the resentment she feels towards her ex-husband, whose decisions contributed to her difficult financial situation, another stress factor for her being able to contemplate a fruitful future.

> "you get to this age, and you think, heaven knows, I haven't got much in the bank … I just felt very resentful of all that, and I still do" Victoria

Similar tones of '*stuckness'* were echoed in Frieda's account, who spoke of the lack of differentiation between one day to the next, and how life for her is a matter of waiting for the next chapter of death:

> "To me, one day rolls into the next and there's no... well, I would say I'm in the waiting room in the place that I am, I'm in the waiting room." - Frieda

Diana spoke of the nature of rumination, and how it can pull you back into regret and remorse but moving on *with time* regardless. There was an essence of how purpose and meaning may act as a buffer from the impact of difficult circumstances and increase the likelihood of effectively managing depression.

> "you can always look back at what you could have done, should have done, … the world doesn't stop still, and it still keeps evolving so you do have to have this purpose, this meaningful life." Diana

2.5 Discussion

2.5.1 Summary of findings

Our first theme, 'Living a Full Life', outlines the role participants identified for themselves in connection to others. Some, most notably those who were somewhat relieved of depression, spoke of the development of their responsibility to serve, accompany, or support others. The role of social connection and devotion in developing meaning and purpose has been found in evaluations of meaning-based interventions for older people (Kim & Choi, 2020), and serves as a practical point for supporting older people's connection with the communities, both familial and wider societal, around them.

Intrapersonal responsibility is another key finding, reflected in our second theme – 'Developing the Self'. Some participants spoke of their agency in striving to improve their lives and generating the motivation for getting better. Indeed, a discovery, or re-discovery of strengths appeared a salient asset in this process, which is a central objective to logotherapy interventions (Kim & Choi, 2020). There were reflections of Frankl's teaching surrounding the ability of choosing one's attitudes in any given circumstance, revives freedom and dignity, and ultimately serves in personal meaning making (Frankl, 1959). Where people still felt trapped by depression, summoning the motivation to find meaning and purpose felt uncertain.

In 'Connecting Past, Present, and Future', we saw participants contemplating the future, both with unease and apathy as well as enthusiasm and readiness. Purpose and meaning were interpreted as acting as a buffer of negative events, therefore equipping these participants with a positive outlook for what the future may hold. Indeed, those who have a strong felt sense of purpose has been shown to provide a resilience effect from negative life events (Schaefer et al., 2013). Conversely, the judgements and assumptions about the futility of goals in older age darkened and dampened these participants' future vision, with some of the sample seemingly playing the waiting game until death. This disconnection with life has been explored in the qualitative literature, with one of its key constituents depicted as 'a pain of not mattering' (Van Wijngaarden et al., 2015), which we conceptualise as a loss or decline in perceived purpose. The

implications of these findings are incredibly important in the most existential sense, given the association between disconnection with life and a longing for life to end (Van Wijngaarden et al., 2015).

2.5.2 Strengths and limitations

We see our sample as yielding a high level of information power (Malterud et al., 2016) and therefore provided rich data to illustrate older people's experiences of depression and their sense-making of meaning and purpose. The sample's focussed inclusion criteria are in agreement with IPA's commitment to an idiographic focus in understanding a person's specific meaning in a specific context (Pietkiewicz & Smith, 2014). That said, tighter inclusion criteria surrounding how recent participants had accessed psychological therapy may have enhanced the specificity of the findings; "recently engaged" was left at the discretion of the professionals, therefore may have led to variability within the sample. Tightening this may have contributed to richer data for understanding the (changing) roles of meaning and purpose at various stages of the depression experience. This therein holds a suggestion for future research. Alternatively, the author appreciates that an alternative qualitative methodology, such as narrative analysis may have been suited to accommodate for the heterogenous features within the sample. It is appreciated also that the sample is relatively small as a result of recruitment challenges coupled with time constraints for the project.

The author was careful in appreciating and reflecting on her lived experiences and position and the effects of these on the methodological and analytical process, particularly those relating to prior clinical work with older clients which partially inspired the research question. Whilst it was appreciated that at a foundational level IPA cannot, nor does it set out to, achieve a genuine and complete first-person account, and therefore the account is always subject to a co-construction between participant and researcher (Larkin et al., 2008), reflexive practices monitored researcher influence. These included those elaborated on previously, such as memoing and collaboration with the supervisory team to support the cross-checking of the researcher's interpretations and how these contributed to theme development.

Additionally, whilst the idea for the research question was rooted in the researcher's clinical experience, the development of the study was relatively distant from the participant population. It is worth crediting the role of public and patient involvement in places, yet more could have been done on the co-production of this project (such as, at the recruitment and analysis phase) in order to enhance the relevance and acceptability for the older person community (Ennis & Wykes, 2013). We also acknowledge the limited relevance the findings may have for non-White British older populations, particularly given the variation in how differing cultures perceive old age (Gire, 2019).

2.5.3 Clinical implications

The findings of this study derive a number of implications for clinical practice and policy (see Table 8). We make suggestions for change to enhance older people's connection, socialisation and sharing of mental health experiences, which could be addressed by the provision of community groups and services. This feels particularly important in the current, post-COVID era when the effects of service rollback and closure are still experienced by a group already vulnerable to isolation and challenges with service access (Zaninotto, 2022). Psychological professionals have a role in encouraging their older clients' engagement in these groups.

Our findings suggest that older adults' appetite for learning does not stop when they reach a certain age: we encourage the provision of educational classes and psychologists to use their clinical training to help their clients discover their core values as motivation for self-development, which can be supported via use of core behaviour change techniques in the context of depression (i.e., behavioural activation).

2.5.4 Conclusions

The findings of this study illustrate the sense-making and experiences of older people in relation to meaning and purpose in life. There are a number of clinical and policy-based implications that can be derived which may have relevance for older people's experiences along the trajectory of depression. Ultimately, psychologists should feel equipped in using their established clinical skills for encouraging conversations around MiL and PiL with their older

clients, with the hope of an improved understanding, and ultimately treatment, of depressive symptoms.

Table 8

Clinical and Policy Implications for Facilitating Older Clients' Meaning and Purpose

Theme	Suggestions for change	How should this be delivered/ encouraged?
Living a Full Life	Connection, socialisation, sharing of mental health experiences	Policy: Provision of community-based groups and meaning-oriented groups (NHS) for older people; these are shaped and assisted by EbE input. Professionals: Emphasis on encouraging older clients to engage with groups and community initiatives.
Developing the Self	Skills, opportunities to learn, engaging in values-based activities, feeling supported by professional	Policy: Development/provision of OP-specific skills/ educational classes. Professional: Use of Socratic techniques (see Frankl, 1986) and ACT-based principles to understand values underpinning meaning and purpose; psychological professionals use therapeutic alliance to advocate for clients.
Connecting Past, Present, and Future	Motivation, development of positive future orientation, managing rumination	Professional: Use of BA principles to encourage motivation and setting of small goals; mindfulness techniques for motivation.

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Appendix A Example of Search Terms for psycINFO

Search ID #	Search terms
S1	TI ("elderly people" OR "older adult*" OR "age* over 65" OR "older patient*" OR "elderly patient*") OR AB ("elderly people" OR "older adult*" OR "age* over 65" OR "older patient*" OR "elderly patient*")
S2	DE "Older Adulthood"
S3	TI (experience* OR view* OR attitude* OR perspective* OR perception* OR opinion* OR thought*) OR AB (experience* OR view* OR attitude* OR perspective* OR perception* OR opinion* OR thought*)
S4	DE "Experiences (Events)"
S5	DE "Psychotherapist Attitudes" OR DE "Psychologist Attitudes" OR DE "Counselor Attitudes"
S6	TI (clinician* OR therapist* OR psychologist* OR counsel#or OR psychotherapist) OR AB (clinician* OR therapist* OR psychologist* OR counsel#or OR psychotherapist)
S7	DE "Therapist Trainees" OR DE "Psychotherapists"
S8	TI ("psychological therap*" OR "psychological treatment*" OR "psychological intervention" OR psychotherapy OR counsel*)) OR (AB ("psychological therap*" OR "psychological treatment*" OR "psychological intervention" OR psychotherapy OR counsel*) NOT TX ("occupational therap*" OR "physical therap*")
S9	DE "Client Centered Therapy" OR DE "Transactional Analysis" OR DE "Solution Focused Therapy" OR DE "Self Psychology" OR DE "Schema Therapy" OR DE "Psychodrama" OR DE "Primal Therapy" OR DE "Network Therapy" OR DE "Narrative Therapy" OR DE "Grief Counseling" OR DE "Gestalt Therapy" OR DE "Feminist Therapy" OR DE "Existential Therapy" OR DE "Cognitive Behavior Therapy" OR DE "Autogenic Training" OR DE "Psychotherapy" OR DE "Individual Psychotherapy" OR DE "Brief Psychotherapy" OR DE "Psychodynamic Psychotherapy" OR DE "Analytical Psychotherapy" OR DE "Supportive Psychotherapy" OR DE "Adlerian Psychotherapy" OR DE "Integrative Psychotherapy" OR DE "Humanistic Psychotherapy" OR DE "Ericksonian Psychotherapy" OR DE "Eclectic Psychotherapy" OR DE "Interpersonal Psychotherapy" OR DE "Group Psychotherapy" OR DE "Geriatric Psychotherapy" OR DE "Expressive Psychotherapy" OR DE "Experiential Psychotherapy"
S10	TI (qualitative OR ethnograph* OR phenomenol* OR ethnonurs* OR grounded theor* OR “purposive sample” OR hermeneutic* OR heuristic* OR semiotics OR “lived experience*” OR “life experience*” OR “cluster sample” OR “action research” OR “observational method” OR “content analysis” OR “thematic analysis” OR “constant comparative method” OR “field stud*” OR “theoretical sample” OR “discourse analysis” OR “focus group*” OR “ethnological research” OR ethnomethodolog* OR interview*) OR AB (qualitative OR ethnograph* OR phenomenol* OR ethnonurs* OR grounded theor* OR “purposive sample” OR hermeneutic* OR heuristic* OR semiotics OR “lived experience*” OR “life experience*” OR “cluster sample” OR “action research” OR “observational method” OR “content analysis” OR “thematic analysis” OR “constant comparative method” OR “field stud*” OR “theoretical sample” OR “discourse analysis” OR “focus group*” OR “ethnological research” OR ethnomethodolog* OR interview*)
S11	DE "Qualitative Methods" OR DE "Thematic Analysis" OR DE "Focus Group" OR DE "Interpretative Phenomenological Analysis" OR DE "Grounded Theory" OR DE "Focus Group Interview"
S12	S1 OR S2 *(Pot 1: Older people)*
S13	S3 OR S4 OR S5 *(Pot 2: Phenomenon of interest)*
S14	S6 OR S7 *(Pot 3: Professional)*

S15	S8 OR S9 *(Pot 4: Therapy)*
S16	S10 OR S11 *(Pot 5: Research type)*
S17	S12 AND S13 AND S14 AND S15 AND S16

Appendix B Phase 4: Determining how the studies are related

Lists of themes/ concepts

Santiago, 2013. Exploring Millennial Generation Counselor Trainees' Perceptions of Aging and their Understanding of Counseling Older Adults: A Qualitative Study of Student Perspectives

1. I just never really thought about counselling old people: Social workers working with older people, not psychological professionals
2. Counselling older adults is "too hard": No experience of old age meaning not able to relate to old age; OP are difficult to communicate with
3. Older adults resist the idea of talking to a counsellor: the stigma of receiving psychological support persists in older generations
4. Counselling interventions don't really work with old people: therapeutic work is limited with OP; OP have greater self-awareness and so are therefore great candidates for psychological input
5. It's always good to understand clients across the lifespan: The benefits of working with OP goes both ways – understanding one's own aging family; understanding OP compliments a fully systemic view of the family; consideration for OP needs greater advocacy – and psychological professionals bear this responsibility
6. I just don't feel prepared to work with older people: educational training programmes are not equipping professionals to adequately treat the older population; educational providers/ lecturers seem disinclined or uncomfortable talk about counselling OP; End-of-life issues are a particularly neglected area of training; specialist training is required for working with OP
7. I don't want to counsel older clients who are gonna die on me – working with OP could mean facing the death of a client
8. I don't want to get pegged as the counsellor who works with older people – being assigned as the OP psychology professional would be limiting
9. I just don't see myself working with old people but I sure hope a counselor is willing to talk to me when I get old – Thinking forwards about how one might be treated…; Attitudes are culturally contextualised – depending on their home culture, therapists may have varying attitudes of working with OP.

Engelskirger, 2017: Psychotherapy Trainees' Empathic Failures with Older Adults

1. Empathic failure due to therapist countertransference: overfamiliarity with the client having been reminded of a family member; OP's preference for a medical doctor undermines the young therapist; feeling bruised and taking hesitance to commence work personally
2. Empathic failure due to insufficient therapeutic alliance: divergent identities (in age and other demographic) create a gap in alliance

Lederman & Shefler, 2022: Psychotherapy with older adults: Ageism and the therapeutic process

1. Maintaining openness to change while acknowledging limitations: Older adults are more concrete and rigid patients than younger adults – difficulty in acknowledging their inner world and speaking the psychological language
2. Therapeutic change and development are possible and related to the patient's personality and motivation for change – it's not age that matters for change to occur, it's personality and motivation to change (which are regardless of age); it's a privilege to work with older adults
3. Ageism has an effect on both the therapist and the patient
4. Dealing with ageism by overcoming fear of aging and death and trying to see the patient as a person and not just as an older adult

Rawle, 2022. How does working in longterm care settings with older adults impact psychologists' attitudes towards aging

1. Part of a system/ team – working within an MDT is especially important for older adult working; the team approach goes beyond just the professional setting – working like a team with the family makes a difference too
2. Creative interventions and outlook on progress – the importance of professionals feeling comfortable to talk about "taboo" topics; focussing on the here and now, as well as appreciating that OP will engage in rumination; death and dying is part and parcel of the work; usual expectations for therapeutic progress need to be curbed; OP psychologists don't just do psychology
3. Healthy aging and heterogeneity in older adulthood – the older population are bleakly overgeneralised; Ageism/ infantilization have sinister effects
4. Misconceptions about aging and eldercare as gloomy and depressing – work with older adults can impart major life lessons for the therapists; ageist stereotypes are culturally rooted and way off the mark for some
5. Understanding loss – as a result of death, changing circumstances, changing identity, changing ability.

Bennett, 2002. The Therapist's Transference: Younger Therapists Working with Older Adults

1. Death Anxiety – both in terms of the therapists' own and finding uncomfortable talking with their older adults
2. Vulnerability Transference – seeing what we assume as a projected image of ourselves can interfere with the clinical work
3. Sexuality – ageist stereotypes interfere with talking about sexual matters
4. Frailty – these can be culturally based (see spreadsheet)
5. Caretaker transference – the therapist seeing the client as a parent/ grandparent role; personal experiences of seeing family age act as an archetype for aging (and these can be inaccurate for the client)
6. Feelings of inadequacy – not having the right to give OP advice; the age difference threatening the feeling of expertise/ owning the position of authority/ being the expert; being prepared (with the help of supervision) to challenge ageism from older clients
7. Role confusion – working with OP involves a multi-pronged, diverse set of responsibilities and professional roles

Boschann et al., 2022. How Young Psychotherapists Experience Working with Older Patients

1. Respectful and Admiring Attitude: Older people have gone through so much, and have so much to draw from; transference/ countertransference; it's difficult to criticize older clients
2. Caring and Supportive Attitude: Older adulthood is a time of loss therefore older people need to be looked after
3. Doubtful Attitude: It's hard to argue with a nihilistic attitude when the end is in sight
4. Open Attitude: Working with older adults can mould one's overarching view of older adults; when there are only a few years left (of life) it's better to work on stability
5. Treatment Setting: Inpatient settings are tougher environments than community

Morante et al., 2020. "It's Not How Old You Are, It's How You Are Old": Australian Clinical Psychologists' Experiences of Working with Older Adults

1. Older Adults' Access to Psychotherapy: OPs' readiness for psychological input – their psychological mindedness
2. Therapy with Older Adults is the Same but Different: It's not how old you are it's how you are old – i.e., the older adult population is heterogenous and cannot be lumped under the umbrella of 'aged'; working behaviourally may be more effective than cognitively
3. Therapy with Older Adults is the Same but Different: Working systemically – Managing confidentiality issues can be complicated
4. Therapy with Older Adults is the Same but Different: Wisdom as a Therapeutic Tool – older people have a whole life of resources to draw from
5. Therapy with Older Adults is the Same but Different: Talkin' bout their generation – working with OP can involve socializing them to psychology (as opposed to the medical model); some older-old adults may not know the remit of psychological professionals; trauma is common-place with older adults but they may not express it
6. The Highs and Lows of Working with Older Adults – listening to their stories can be a privilege, but a distraction from the work; work with OP provides a future lens for what's meaningful in life; "you make of aging what you put into it"; there are specific ethical issues to be aware of working with this population

Watts, 2007. An examination of professional practitioners' perceptions and experiences in providing services with older adults: A qualitative study

1. Work with OP is about empowering them to make decisions and advocate for themselves [first four themes collapsed into one]
2. Work with OP is rewarding
3. Practitioners assumed an advocate role for their older clients - The responsibility of the psychologist is to work with the person first, wider network second
4. Listening to older clients' stories - Hearing someone's past helps acknowledge one's own present biases; Attaching meanings with reference to the past helps address current difficulties
5. Stories give meaning and create a sense of purpose for older adults - The quest for meaning goes both ways: professionals find relevance in the stories of their clients
6. Reminiscence used as a treatment intervention

7. Dissatisfaction with time constraints
8. Barriers to mental health care services
9. Practitioners' struggles against callous treatment of older clients' aging issues
10. The aging process: Psychological / developmental models can help us understand the aging process; It's not how old you are, it's how you are old
11. Myriad of losses - Preparedness and acceptance of loss is key for working with OP; The professional cannot (yet) relate to the level of loss experienced by their older client, therefore cannot yet help transcend the losses
12. Psychologists have a role to mobilize social change re ageist attitudes
13. Unhelpful attitudes of family - Work with OP involves having to face conflicting pressures between consent to having the family involved and the perceived best interests of the older client
14. Unpleasant situations with caregivers
15. The toll of Alzheimer's Disease
16. Depression as a confounding factor – depression lasts longer in OA; Depression goes undetected/ undiagnosed in older patients - symptoms of depression are normalised as just signs of aging?
17. Touched by older clients' pain - Experiencing loss through the client's life before in one's own life; In a position of influence but sometimes without power - role of the family
18. Therapists sensitized about their own issues of death and dying - Working with suicidal patients involves close monitoring; Older adulthood is full with loss and change and adapting to this can be difficult / A change in physical ability can be the trigger for suicidal thinking/ acting
19. Participants' own spirituality affected by working with older clients: Death and dying prompts clinicians to access or confront their own relationships with spirituality, which can cause difficult feelings of transference
20. Older clients saw the therapist as their child - Welcoming and being aware of the possibility of transference; Transference is "inevitable"
21. Therapists struggled to contain their countertransference reactions
22. A need for academic training in aging curriculums across disciplines
23. An urgent need for clinical experience - A new generation of older patients brings with it their own cohort effects and specialist
24. There is nothing like personal experience learned from their own family members

Kapeloni & Glover, 2022. Encountering older adults in psychotherapy: The lived experience of therapists working with older adults in Ireland

1. Coping with Sadness: Sadness as a result of secondary loss is common in this line of work; mourning for all the things having gone wrong in life with older clients
2. Coping with Vulnerability: therapists in a parent role - the client is "closer to the end, like a child is closer to the beginning" which triggers the parental response (countertransference); A warmer approach is needed
3. Coping with Dying and Death: Acceptance of death; Working outside the box with death; Death is uncomfortable and leads to normal standards of work slipping/ changing
4. Coping with Aging: Older therapists empathising with their aging clients

Atkins & Lowenthal, 2004. The lived experience of psychotherapists working with older clients: An heuristic study.

1. Perceptions of old age and ageism: working with OP isn't that different to working with younger clients; it's important to be aware of stereotypes of aging and how to challenge these
2. Boundaries and settings are important considerations: nursing home visiting and being part of a team, but caution around confidentiality
3. Changes to practice: adjusting and accounting for physical disabilities; having a different mind-set for the expected outcomes of therapy
4. Culture and experiences: variations between therapist and clients' cohort effects, and how this may be evidenced in language.
5. An awareness of time
6. An awareness of loss: most clients have experienced multiple losses – not just around death
7. Decline and mortality: There is a closeness to death that is more significant than working with younger clients – wary of countertransferences
8. Parents and children: Countertransferences associated with older clients feeling like parents; wanting to make things better in own relationship with parent

Appendix C Phase 5: Translating studies into one another

Translations Table

Descriptor (broad thematic headings)	First order data	Second order data/ themes
Confronting death, loss, and existential questions Third order construct? – Confronting and managing death comes with years of experience	*. . . there's more acceptance I think on my part when older people go. I'm quite accepting of death when it comes after a long life . . .* *It shouldn't be that hard to just hold someone's hand and say, "What are you proud of in your life? Are you okay? Are you scared?" It's harder to have that conversation with a young person but it's not hard to have it with someone as they're older.* *There's a lot of grief and loss in this population. Not just with the loss of loved ones, but the loss of their independence, the loss of their role as a caregiver to their kids, the loss of their job. They retired. They don't know what to do with themselves. They lost their identity. All kinds of loss and usually that's a trigger.* *Loss of a sense of purpose and loss of role from retirement, loss of the identity they got from their jobs and certainly loss of the active person they used to be, so loss of health, loss of mobility, loss of contact with other people and loss of partners, loss of friends, of people dying around them and occasionally loss of children and siblings*	Acceptance and being present (Kapeloni & Glover, 2022) Talking about death and dying is part of the work, Rawle "I don't want to counsel older adults who are gonna die on me" Santiago 2002 Loss comes in many forms – as a result of death, changing circumstances, changing identity, changing ability, Rawle Experiencing loss through the client, Watts An awareness of loss: most clients have experienced multiple losses – not just around death; Decline and mortality: There is a closeness to death that is more significant than

		working with younger clients – wary of countertransferences
Working with the System	*I work with doctors, nurse practitioners, and nurses and PT and OT and the pharmacists. So, it's a very integrative kind of situation. Rawle, 2022*	MDT working is key for addressing diverse needs, Rawle, 2022
	. . . especially in an aged-care facility or hospital you lose a lot of privacy and so it was really important that I kept a lot of the stuff they said private so I'd have my own psychology files and then information I put into an aged-care facility computer was very minimal like "worked on this strategy, please encourage them to use it to help reduce panic," we just translated what was important for staff to know . . . that's a really important ethical issue, that the psychologist doesn't pass on information that will be misinterpreted by the nursing staff. (Participant 11) – Morante	But – strike a balance between following ethical responsibilities and offering information that would be beneficial– Morante et al., 2020
	"There is a lot of caregiver burnout, but that is a society problem. We tend to delegate all caregiving responsibilities to one person, it's usually the daughter, and usually that person has to step up to do it. It should really be a shared role, not only among families and friends but also among different providers and different systems. It needs to be a team approach."	Support in a larger context - the team approach goes beyond just the professional setting – working like a team with the family makes a difference too (Rawle, 2022)
	One thing that tears me apart is seeing my clients abandoned by their family members, and then having to bring these same people into therapy to discuss their loved one's well-being... boy, what a struggle! In all honesty, I don't want to deal with them in making serious decisions on their loved ones behalf, because I feel that they are not concerned... they only want their property and bank accounts!	But – Conflicting pressures between consent to having the family involved and perceived best interest of the client, and being compromised in

	There is also a thing about confidentiality with elderly people that I find very difficult. Often they live in warden assisted places and you get the warden ringing up and saying "They are drunk and I'm very worried about them", I won't discuss this with somebody else apart from the client and the GP and you get a lot of animosity from warden if you won't disclose.'	terms of what can be done - Watts, 2007 Boundaries and settings are important considerations: nursing home visiting and being part of a team, but caution around confidentiality (Atkins & Lowenthal)
Transference and Countertransference Third order construct: Therapist as parent vs therapist as child. OR Patient as parent vs patient as child	*. . . I went in very gently, like he was hard of hearing, but I remember it was nearly instinctual. I remember treating him like a kid, the older adult . . . I was just nurturing him in a way that was nearly kind of over-humanistic . . . I just remember thinking, that the older they get, they needed to be treated as an infant. That's it! It triggers the parental response in us, very strongly . . . because they are closer to the end, like a child is closer to the beginning.* *I have experienced many transference issues in working with clients, which has been respectful on both the client and my part... and there were times when I have been looked on as being beautiful and young... and I have also had my older clients tell me that I reminded them oftheir daughters, granddaughters, or nieces who were sometimes mean to them. So what I do is have them to share whatever they feel or think... good and the bad and we talk about it.* *And then also I think that there was a lot of countertransference between her, because she also reminds me of my mom, and so like, it's frustrating to me because some of the behaviors she does, my mom does as well. And so like, in some ways, like my mom, I would just treat my mom, like, you know what*	Therapists in a parental role - the client is "closer to the end, like a child is closer to the beginning" which triggers the parental response (Kapeloni & Glover, 2022) But – Older clients saw the therapist as their child – and being open about this in therapy (Watts) Caretaker transference – younger therapist seeing the client as parent/ grandparent (Bennett, 2002) Empathic failure due to therapist

	mom, like whatever, [Inaudible] and I'll talk to you later. – Engelskirger *'With an older client my counter transference is certainly partly parental but it is also partly to the older client as my parent and my sense of wanting to take care of them, having something to do with wanting to take care of my own parents. The feeling that I wanted to be the child, treat the older person as the parent.'*	countertransference: overfamiliarity with the client having been reminded of a family member (Engelskirger, 2017) Countertransferences associated with older clients feeling like parents; wanting to make things better in own relationship with parents (Atkins and Lowenthal)
The expansive role of the OP psychologist	*I think the biggest thing that we need to do is to help change our older patients' way of thinking... If this fails, we should be part of the programs that serve them and advocate for those older patients who really need support...* *Consider out of the box treatment instead of just upping medications. For example, photo therapy with a patient who has seasonal affective disorder* *. . . the challenge was trying to put aside my approval or disapproval [of euthanasia] and just work with her around what she wanted to do and why and helping her think through the ramifications for her family and potential legal ramifications . . . rather than talking about how it was going to be done, it was really thinking about her own understanding and making sure she was clear about that, and that way it was not for me to judge in any way or get into the ins and outs and what that meant for me in terms of any ethical or legal issues. . .* *These are people that have been on this planet for 75–80 years and they've gained a wealth of insight and wisdom and experience that I haven't got even*	Practitioners assume an advocate role for their older clients, but work with the person first for them to make autonomous decisions, wider network second (Watts) Progress in clinical work can look different – it is useful for the therapist to generate a flexible definition for clients (Rawle) Elder abuse and euthanasia as distinctive ethical issues (Morante; Watts) & without warning giving up and committing suicide (Watts) Using wisdom as a therapeutic tool – the OP are an expert of their own lives (Morante et al., 2020); the therapist can use these

	at my age and I just simply tap into that and a lot of the time I simply use Socratic questioning with them . . . they start to answer their own questions . . .	opportunities for OP to draw on experiences to create new meanings and solve their own problems (Watts, 2007)
	I do find with them that it must be a warmer approach, a more human approach, I can't be very clinical. And I don't know how you think of this ethically, but, for some of my older clients, I make them a cup of tea. Because it took a lot out of them [to come], they's nervous, they treat me like a doctor. And you must work with them on the fact that they are not in here with somebody who has authority over them, they are in charge.	Coping with vulnerability with a "warmer, more human approach" (Kapeloni and Glover 2022)
	It's very different working with an older population than with an adult population or a younger population where you basically see people who have emotional problems or mental health problems, but not accompanied with a visible health condition.. . . I think the countertransference takes the form o f "I don't want to be that close. I want to distance a little bit.". . . There is something about illness that is difficult for all of us to deal with when we are there to deal with the mental health component. Yet of course with an aging population if that depression can be dealt with the course of the illness is going to be different___ One of the things the literature talks about is that depression in older adults is often unrecognized and not treated. I can see why when therapists are reluctant to work with people if there is an illness.	Working with physical and emotional ill health (Bennett)
Suitability for Psychology/ Therapy Incorporate ageism and prejudices here	*I don't really put much thought into counseling older adults…I mean isn't that what social workers do?*	Counsellors don't work with OP; counselling interventions don't really work with old

	Whenever I'm trying to explore any emotions, and like connecting with her past, she becomes very, like, angry with me, that like that's not my job to do that. And that it like, one time she said, if I wanted to explore my past, I would go to an M.D., I wouldn't talk to you. Like a psychiatrist.	people (Santiago, 2013) OP resist the idea of talking to a counsellor (Santiago, 2013); OP's preference for a medical doctor undermines the young therapist; feeling bruised and taking hesitance to commence work personally (Engelskirger, 2017)
	Many of them don't know they have an inner world or they don't know that there is an option to speak it and somebody would care ... When this is the experience, their communication is very concrete, and it's very difficult for the therapist. There are younger patients who are also concrete, but the feeling is often nevertheless different.	Older adults are more concrete and rigid patients than younger adults – difficulty in acknowledging their inner world and speaking the psychological language (Lederman & Shefler, 2022) and psychological mindedness in question with OP/ are they ready? (Morante et al., 2020) It's difficult to criticize older adults (Boschann et al., 2022)
	I think there is an ageism going on that that's not something older people are interested in or anything that they have thoughts or feelings about. Maybe with a younger patient you might explore the sexual aspect of the relationship, where if you have someone who is older it seems like supervisees are less likely to even engage a thought about that aspect of the relationship. I'm not just talking about whether or not they are actually having sex but all the things that go along with having sex. There is a certain assumption that older people don't have sexual feelings	Assumption that OP are not sexual - talking about "taboo" topics i.e., sexuality, needs to happen (Bennett, 2002; Rawle, 2022)

	Younger therapists see the elderly as sort of helpless, sort of fragile and helpless... The[new]therapist sort of worries or tends to think that they might not have the inner resources to deal with exploring painful issues. They sort of tend to see them as weak when in fact the opposite may be true.	Frailty – younger therapists assume frailty of their older clients (Bennett, 2002; Boschann)
	"The aging population is also our most diverse population. So, I get to work with such a wide range of different people, and I really value diversity and I think it's really important to talk about." - Rawle	But - OP have greater self-awareness and so are therefore great candidates for psychological input (Santiago et al., 2013)
	I think older adults are a lot more knowledgeable about themselves, too, than kids and adolescents know about themselves. They come to know themselves so well that they can probably bring a lot more to the table when it comes to counseling them. A counselor might have to do more digging for if it was for someone else younger.	Healthy aging and heterogeneity in older adulthood, bleak overgeneralizations are pervasive but inaccurate (Rawle, 2022)
	Perhaps that's also my image of old age. So—I don't know—because when you are older than 80 years somehow, what does life still have in store for you? So, somehow, I noticed that it was always difficult for me to argue against it, but also to really convey more confidence, because I thought, well, sometimes you can't really argue it away.	It's hard to argue with a nihilistic attitude when the end is in sight (Boschann et al., 2022)
	. . . be willing to try different angles, if something doesn't work it's not because the person is hopeless, like try to figure out something that might work for that person, I feel like I have to really try my best and see where it goes.	But – if something's not working then try a different angle (Morante)

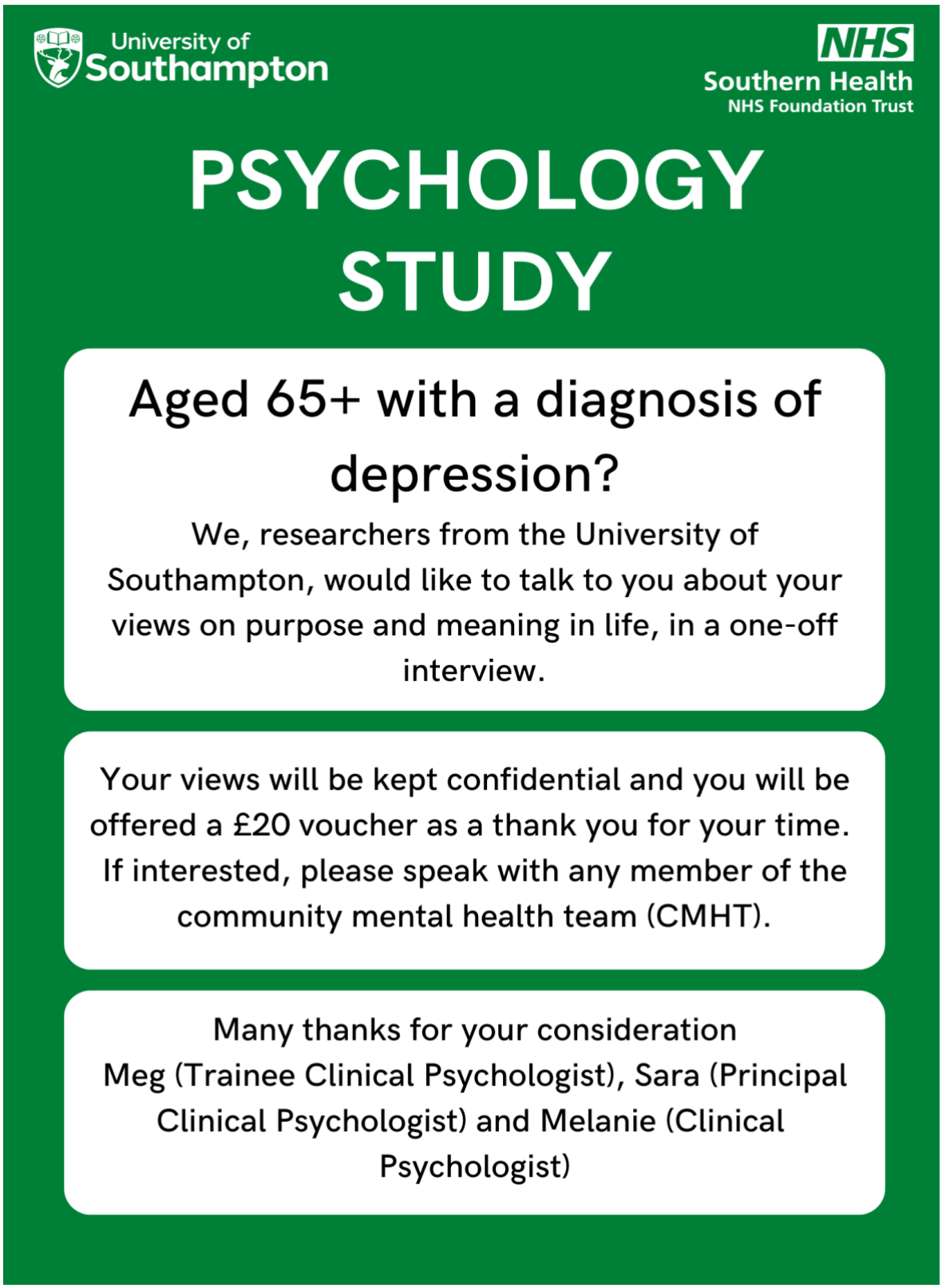
Clinicians' readiness to work with OP	*The people I have supervised individually . . . struggle with the issue of being younger and sort of "who am I as a young therapist to be talking with an elderly person about their experience given that it is so far from my own?". .. the kind of difficulty o f feeling entitled of having a position to talk with them about their emotional and psychological experiences - Bennett* *I had an 83-year-old patient, which I felt was like a young adolescent .... you have to come without any prejudice, therapy (with older adults) is not different than with any other age groups. To see the older patient as weak is coming from anxieties and countertransference. There is a lot of respect in seeing a human being in front of me. When he is sitting in front of me, I don't see an older man; I see libido, I see passion for life.*	I just don't feel prepared to work with older people (Santiago, 2013) A need for academic training in aging curriculums across disciplines (Watts, 2007) An urgent need for clinical experience - A new generation of older patients brings with it their own cohort effects and specialist (Watts, 2007) Feelings of inadequacy - not having the right to give OP advice; the age difference threatening the feeling of expertise/ owning the position of authority/ being the expert; being prepared (with the help of supervision) to challenge ageism from older clients (Bennett, 2002) Ageism can be confronted by being open and going beyond assumptions of old age – Lederman and Shefler, 2022 It would be inappropriate from a younger person to discuss sexual issues

		with an older person (Bennett, 2002)

Appendix D Information Power Calculation

To shape and justify sample size, the five dimensions of Information Power has been applied, as per guidance from Malterud et al. (2016). These include: (1) Aim of the study; (2) Sample specificity; (3) Use of established theory; (4) Quality of dialogue; (5) Analysis strategy. This suggests a relatively small sample is required, given that the aim of the study is narrow and focussed on older people with depression and their sense making of a specific phenomenon. Sample specificity is therefore dense as the sample will only include participants who hold characteristics highly relevant for the aim of the study. Further, there is theoretical grounding to the study, and it is envisaged that the quality of dialogue will be relatively strong, as the lead researcher has recent experience working with older people with depression and will be familiarised and confident with the interview schedule. Analysis will be cross-case, therefore requiring a range of experiences (i.e., participants) to develop the data. On balance, the proposed sample size is eight participants.

Appendix E Recruitment Poster



Appendix F Participant Information Sheet

Participant Information Sheet

Study Title: Making Sense of Purpose in Life and Meaning in Life in Later Years: Implications for Clinical Practice

Researcher: Meg Denne
ERGO number: 70464

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others, but it is up to you to decide whether or not to take part. If you are happy to participate you will be asked to sign a consent form.

What is the research about?
I am a trainee clinical psychologist in my third year of training for my doctorate in clinical psychology at the University of Southampton. This research project forms part of my thesis project undertaken for my training. My supervisors and I are interested in exploring older people's perspective of purpose in life (PiL) and meaning in life (MiL) in relation to their experiences of depression, and if psychological therapy has contributed to their MiL and PiL. By PiL, we refer to the goals and intentions people make throughout their lifetime. By MiL, we refer to people having an appreciation for why they have lived and making sense of their being. We hope to investigate this area in order to understand this potential relationship better and to potentially inform the development of psychological therapy for older people.

The Sponsor for this research project is the University of Southampton, who are funding the project. This project is in collaboration with the NHS, who are the recruitment site for recruiting participants.

Why have I been asked to participate?
You have been invited to participate as you are over the age of 67 who is experiencing an episode of depression and are under the care of an older person's community mental health team (OP-CMHT). Your care co-ordinator has already approached you to talk about the research and has passed on your contact details to us so that we can see if you would like to participate. We are aiming to recruit eight participants in total.

What will happen to me if I take part?

Before the Interview

If you choose to take part, you will be invited to participate in a one-off interview with the lead researcher. This will be arranged between yourself and the researcher to take place at a time and location convenient for you, and in line with government guidelines for COVID-19 at the time of the interview. It may be possible for this to be at your OP-CMHT clinic, or via a video conferencing platform. Before the interview takes place, you will be asked to sign a consent form which will confirm that you are happy to take part in the study.

The Interview

It is expected that the interview will last for around one hour. During the interview, the researcher will ask you questions centred around your experience of depression, your understanding of PiL and MiL, and whether you relate these concepts to your mental health. These questions will have been prepared in advance in collaboration with people who have had depression in the past.

After the Interview

There will be opportunity for you to ask the researcher questions about the study before and after the interview, and at the time of arranging the interview. You will not be contacted again by the researcher after the interview; however, we can send a summary of the results to you via post or email if you would like us to, so that you can see the key findings from this research. If there are any concerns regarding your participation in the study, you can discuss these with your care co-ordinator CCO.

The research project will last until all eight interviews have been completed, analysed, and included in the write-up as part of the researcher's thesis.

Consent and Data Storage

The interview will be audio recorded so that it can be transcribed at a later date by professional transcribers external to the university. This is so that we can explore the key themes within the data and therefore answer our research questions. Consent to being audio recorded is therefore a requirement for participation and will be included as one of the points on the consent form that you will be asked to sign if you would like to participate. It should be noted that audio files of the interviews will be securely stored on the researcher's University OneDrive account until they have been transcribed; they will be deleted following this. The audio files will be kept for approximately three months.

Are there any benefits in my taking part?

As a gesture of thanks for your participation, you will be given a £20 voucher. Your participation also contributes to improving our understanding of the research topic and informing psychological therapies for older people.

Are there any risks involved?

We do not perceive any risks with participation. However, we understand that talking about mental health can be a sensitive topic and potentially cause distress. This is why we will be informing your care co-ordinators about your involvement so that they can offer support following the interview, if you feel this is needed. Further, the researcher undertaking the interviews is trained in providing psychological therapy and can therefore offer support at the time of the interview. If you find the interview too uncomfortable, you are free to withdraw from the study at the time of or during the interview.

What data will be collected?

Data collected for this study will include the audio recording of the interview; the interview transcript; participant characteristics (e.g., age, gender, ethnicity); consent forms; and contact details (your name, contact number, email/ address). This will be collected by the researcher and accessed only by the research team (the researcher and her two supervisors).

Will my participation be confidential?

Your participation and the information we collect about you during the course of the research will be kept strictly confidential. There are limits to confidentiality, such as in the circumstance of information shared with the researcher that suggests risk to yourself or others. In this instance, information will need to be shared with the relevant agencies, such as with your care co-ordinator and safeguarding teams. In addition, we will let your GP/ lead healthcare professional know that you are taking part in the study.

The audio recordings of the interview will also be sent to professional transcribers; however, these will be named under your non-identifiable code and care will be taken to ensure they do not break anonymity.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Data will be linked by a non-identifiable unique code, that bears no resemblance to your personal information (e.g., P01). This means that the data will be pseudonymised, as we will use this code to link your data together (the audio recording until deleted, interview transcript, consent form, participant characteristics and contact details). These codes will be kept on a password protected spreadsheet, and only members of the research team will be able to access them.

As mentioned, the audio recording will be securely deleted once it has been transcribed. During this transcription phase, all identifiable information will be removed. Up until the point of deletion, audio files will be stored on the researcher's University OneDrive account. All other files will be password protected, known only to the research team, and stored on this OneDrive account for the duration of the project, except for the contact details list which will be stored on the researcher's NHS laptop. Contact information will be stored securely until June 2023, to allow opportunity for the researcher to share the written report with the participants. Following this, contact information will be destroyed. Your consent form will be kept in a locked cabinet, accessible only to the research team. The data (apart from the audio recording and contact information) will be stored for 10 years, which is in keeping with recommended guidelines for research data management.

Quotations from the interviews will be used in the write-up of the findings as these will represent the key themes within the data. However, only basic demographic information such as participant age and gender will accompany these quotes and all identifiable information (such as names of people and places) will be removed. Therefore, any quotes from your interview that may be included in the write-up will not contain identifiable information.

Do I have to take part?

No, it is entirely up to you to decide whether or not to take part. You can decide to take part at the initial discussion with the researcher or you can have some time to consider whether to participate or not, and the researcher can call to discuss this with you at another time. We ask that you let the researcher know at the latest of 30th November 2022 so that you can be included in the research. If you decide you want to take part, you will need to sign a consent form to show you have agreed to take part.

To confirm, there is no obligation to take part in this research and your care or treatment will not be affected depending on whether you decide to take part or not.

What happens if I change my mind?

You have the right to change your mind and withdraw at any time without giving a reason and without your participant rights or routine care being affected. This includes during the interview and after the interview. However, withdrawal of your data can only happen up until the point that it is anonymised.

If you change your mind before the interview, you should contact the researcher on their email (email address provided at the end of this document). Any data collected up until this point will be withdrawn from the study.

If you decide during the interview that you would like to withdraw from the study, you can inform the researcher there and then. The audio recording will be deleted, and any other data collected until this point will be withdrawn from the study.

If you decide after the interview that you would like to withdraw from the study, you should contact the research on their email. If you decide that you would like to withdraw your data, you have three weeks following the interview to notify the researcher of this. If your data has been anonymised, we will keep the information about you that we have already obtained for the purposes of achieving the objectives of the study only.

If you decide to withdraw from the study at any point, you will be asked to complete a sign a form to confirm this decision, which the researcher will sign as well.

What will happen to the results of the research?
As explained, this research forms part of the researcher's thesis for their doctoral qualification. The results will therefore be written up within their thesis. As per the University of Southampton's Data Management Policy and Open Access Policy, the data and write-up of the thesis will be submitted to the University of Southampton Institutional Repository. Open Access means that the research can reach wider audiences with fewer barriers for people accessing and reading the research. Further, sharing the data from this study allows the data to be re-used in future research therefore reducing the effort of duplicating another study like this one.

There are no plans to deposit the research data anywhere else. It is possible that the thesis will be edited to a shortened manuscript for publication in a professional journal.

Whilst the research data will be made available, your personal details will remain strictly confidential. Research findings made available in any reports or publications will not include information that can directly identify you without your specific consent.

If you have any concerns or queries regarding what will happen to the results of this research, you should get in touch with the researcher/ a member of the research team via the email provided at the end of this document. If you wish to file a complaint regarding the management of your data, then please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Where can I get more information?

Lead researcher: Meg Denne – md3n20@soton.ac.uk
Primary supervisor: Dr Sara Carr – sara.carr@southernhealth.nhs.uk
Secondary supervisor: Dr Melanie Hodgkinson - m.j.hodgkinson@soton.ac.uk

What happens if there is a problem?
If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions. Please do contact us via email or phone numbers below.

Lead researcher: Meg Denne – md3n20@soton.ac.uk
Primary supervisor: Dr Sara Carr – sara.carr@southernhealth.nhs.uk
Secondary supervisor: Dr Melanie Hodgkinson - m.j.hodgkinson@soton.ac.uk

If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Patient Advice and Liaison Service (PALS; Dorset HealthCare University NHS Foundation Trust)
Tel: 0800 587 4997
Email: **dhc.pals@nhs.net**

Data Protection Privacy Notice
The University of Southampton conducts research to the highest standards of research integrity. As a publicly funded organisation, the University has to ensure that it is in the public interest when we use personally identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

Southern Health NHS Foundation Trust will keep identifiable information about you from this study for 10 years after the study has finished.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you for taking the time to read this information sheet and considering taking part in the research.

Appendix G Development of the Interview Schedule

Topic Guide

A. Experiences of Depression

1. Can you tell me about your experience of depression?
   1a/ prompt. What did it mean to you that you were diagnosed with/ have a diagnosis of depression? How did that feel for you at the time?
2. What does the word depression mean to you? (Lawrence et al., 2006)
   2a/ prompt. Do you consider depression to be illness or mental health condition?

B. Purpose in Life

I'm curious to know what you think about purpose and having purpose in life – by this I mean the goals and intentions people make throughout their lifetime. Can you tell me about your thoughts on purpose, and if this is something you've discovered in your lifetime? [the following act as prompts for this broad question]

1. Do you feel you've had/ continue to have clear goals in your life?
2. Have you discovered, either recently or sometime in the past, a satisfying life purpose? Can you tell me about that?
3. Are you living, or have you lived, the kind of life you wanted to live?

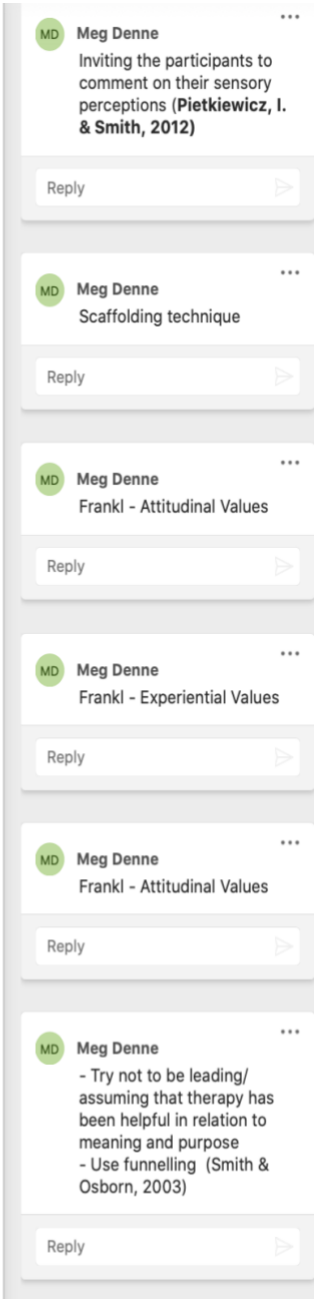
C. Meaning in Life

The next section refers to meaning in life – by this I mean people having an appreciation for why they have lived and making sense of their being. I'm interested to know if this is something you've considered, and how you find meaning in your life?
[the following act as prompts for this broad question]

1. Do you have a sense of who you are as a person? How have your experiences in life or encounters with others shaped this?
2. Thinking about your experience of depression, or other hardships over your lifetime, how, if at all, has that shaped your understanding of the real meaning of life?
3. Do you look forward to the future?

D. Therapy/psychology in relation to understanding of MiL & PiL

1. What have your experiences been of psychological therapy?
2. In what way has psychological therapy developed your understanding of your meaning and purpose in life?
3. How have these experiences in turn effected your mental health/ symptoms of depression?



Appendix H Participant Consent Form

Study title: Making Sense of Purpose in Life and Meaning in Life in Later Years

Researcher name: Meg Denne
ERGO number: 70464
Participant Identification Number:

Please initial the boxes if you agree with the statements:

I have read and understood the information sheet (V1.2 18.07.2022) and have had the opportunity to ask questions about the study.	
I understand my participation is voluntary and I may withdraw at any time for any reason without my participation rights being affected.	
I understand that my data can be withdrawn up until the point of anonymisation, at which point it will be included in the analysis for the study.	
I consent to being audio-recorded for the purpose of data collection and understand the use and management of this data.	
I understand that quotations from my interview may be used within the write-up of the findings, but that all identifiable information will have been removed prior to this use and that basic demographic information only will accompany these quotations.	
I agree to take part in this research project and agree for my data to be used for the purpose of this study.	
I agree for my data to be re-used in future research as part of the Open Access Policy.	

Name of participant (print name) ……

Signature of participant…….

Date…….

Appendix I Debriefing Statement

Project Title: Making Sense of Purpose in Life and Meaning in Life in Later Years**:** Implications for Clinical Practice

Debriefing Statement (V1 08.04.2022)

ERGO ID: 70464

The aim of this research was to explore the experiences of older people with depression and how they make sense of meaning in life (MiL) and purpose in life (PiL). Your data will help our understanding of any relationship between depression and MiL and PiL and how psychological therapy contributes to developing meaning and purpose. Once again, the results of this study will not include your name or any other identifying characteristics. The research did not use deception; you were made aware of each stage of the study and the true intention of your participation. You may have a copy of this summary if you wish, along with a summary of the research findings once the data has been analysed and written up.

If you have any further questions please contact me, Meg Denne, on md3n20@soton.ac.uk.

Thank you for your participation in this research.

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the University of Southampton Head of Research Integrity and Governance (023 8059 5058, rgoinfo@soton.ac.uk).

If you have experienced any distress during your involvement in this study, and you feel it would be helpful to discuss this with a professional, you can contact your care therapist Isabella Wesson on 07825 858850.

Appendix J Ethics Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Melanie Hodgkinson
Room 3091 Building 44
University of Southampton
Southampton
SO17 1BJN/A

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

22 July 2022

Dear Dr Hodgkinson

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Making Sense of Purpose in Life and Meaning in Life in Later Years: Implications for Clinical Practice**
IRAS project ID:	**313946**
Protocol number:	**70464 (ERGO)**
REC reference:	**22/WA/0185**
Sponsor	**University of Southampton**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

UNIVERSITY OF Southampton

ERGO II – Ethics and Research Governance Online https://www.ergo2.soton.ac.uk

Submission ID: 70464.A1
Submission Title: Making Sense of Purpose in Life and Meaning in Life in Later Years: Implications for Clinical Practice (Amendment 1.1)
Submitter Name: Meg Denne

The Research Integrity and Governance team have reviewed and approved your submission.

You may only begin your research once you have received all external approvals (e.g. NRES/HRA/MHRA/HMPPS/MoDREC etc or Health and Safety approval e.g. for a Genetic or Biological Materials Risk Assessment).

Appendix K Example of Step 4 of IPA

Participant Two

A. DEPRESSION EFFECTS OUTLOOK

Life in a depression means living day to day – to an extent

Depression stripped her of her future vision
"I don't look far ahead anymore because depression has taken that away from me"

Depression clouds any enthusiasm for having goals and hope for something different
"With how I am now… it's been such a long time, three and a half years now, being like this, I've just lost hope. I just don't see goals or anything like that because I just think is this just going to be going on" – pg. 5

Past the point of long-term goals

Making and working towards goals and aspirations was for earlier in life
"This is a very funny situation because when you're younger and that, you decide what you want to do and how you're going to get on in life and this, that, and the other"

She recognises she could have goals, but these feel futile pg. 5
"If I did it [house chores], that would ease, that would form a purpose, you know? And I'll have done it. But I just don't see the point in it"

B. FOCUSSING THE LENS OUTWARDS

Having faith in granddaughter – who provides lightness and joyfulness
"She represents to me all that is fun" pg. 4

and when this happens it lifts her out of depression
"she comes in every night for her tea. She sort of gets me going, you know? I can't possibly be in depression when I'm around her. She just lifts my mood really, really much" pg. 4

Serving others can be a found purpose – helping others/ them through tough times
"My daughter and her partner have split up … So, therefore, I have a goal more than ever because I do more babysitting while [my daughter] works" pg. 4

Having an identity as a nan to her granddaughter (she represents something/ someone)
"The way she [granddaughter] talks to me, you know? She sees me as her nan"

Goals around herself feel futile *(same quote as in '*She recognises she could have goals, but these feel futile pg. 5'***)***

Pushing beyond and transcending her current circle of understanding – having new experiences (understanding her daughter's sexual orientation)
"Yeah, I mean I think one thing that's helped quite a bit meaning is my daughter, Sarah, she's the youngest, 33, 34, I don't know. Yeah, she's gay. And that sort of gave me a lot of sort of purpose in the fact that it was a whole new experience to me." Pg4