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Psychological Therapy for Older People

by

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Thesis for the degree of Doctor of Clinical Psychology

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Abstract

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The evidence-base for psychological therapy for older people is sparse compared to research for working age and young people. This often leads to therapies being intended for working age adults but delivered to older people. To ensure that the delivery of psychological therapy is applicable to the distinct and unique needs of older people, firstly, it is imperative that effectiveness of established therapies is explored specifically in this population. Secondly, it is important to understand therapy experiences and outcomes through the eyes and voices of the older people engaging in therapy. The first paper of this thesis presents a meta-analysis of the effectiveness of Acceptance and Commitment Therapy (ACT) for older people. Through a systematic literature search, 13 studies met our inclusion criteria. Methodological quality was determined using the Standard Quality Assessment Criteria (SQAC) tool. Ten studies were further included in a meta-analysis, which highlighted ACT as a promising treatment option for older people with an overall effect size of g=0.53. However, a cumulative analysis showed a variable effect for ACT in this population over time, suggesting that a true effect has yet to be established and requires further research. The second paper of this thesis explores older people's experiences of psychological therapy. Six participants who were considered by the clinical psychologist delivering therapy to have made positive progress through therapy took part in a semi-structured interview where their experiences of therapy were explored. Interpretative Phenomenological Analysis (IPA) was used to analyse the data. Three main themes emerged which were processing my identity, the powerful therapy relationship and continuing my journey. Two sub-themes for each theme represented important convergence and divergence between participants. The findings present considerations to how therapy is delivered and subsequently received by older people and highlights how therapy outcomes may be deemed successful for this population.

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Research Thesis: Declaration of Authorship

Print name: Laura Prodger

Title of thesis: Psychological Therapy for Older People

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

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Finally, my dad, whose final wish during his battle with cancer is to see me graduate, this is for you.

Abbreviations

ACT ..... Acceptance and Commitment Therapy

CBT ..... Cognitive Behaviour Therapy

CI ..... Confidence Interval

CMA ..... Comprehensive Meta-Analysis

ES ..... Effect Size

g ..... Hedge's g

GET ..... Group Experiential Theme

HRA ..... Health Research Authority

IPA ..... Interpretative Phenomenological Analysis

K ..... Cohen's Kappa

N/A ..... Not Applicable

OP ..... Older People

OPMH ..... Older People's Mental Health Services

PHQ-9 ..... Patient Health Questionnaire Ninth Edition

PRISMA ..... Preferred Reporting Items for Systematic Review and Meta-Analysis

PsycINFO ..... Psychological Information Database

Q ..... Cochrane's Q

RCI ..... Reliable Change Index

RCT ..... Randomised Controlled Trial

SQAC ..... Standard Quality Assessment Criteria

T^2 ..... Tau-squared

Chapter 1 A Meta-Analysis of ACT for Older People

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1.1 Abstract

Objectives: This study aimed to establish the effectiveness of Acceptance and Commitment Therapy (ACT) for an older adult population aged 55 and over.

Method: A random-effects meta-analysis on dependent variables was conducted on all available research through electronic database searching.

Results: 13 studies (480 participants) met the inclusion criteria and 11 had sufficient sample sizes to be included in the analysis. ACT demonstrated an estimated moderate effect (g=0.53) on reducing mental health symptomology in older people pre to post therapy. This effect was found to be moderated by age, with the effect of ACT decreasing as age increased. ACT demonstrated better efficacy for depression (g=0.52) than for anxiety (g=0.42). Studies varied in methodological quality with only four studies including the comparison of a control group and a large range of sample sizes (1-150). A cumulative analysis of publication year highlighted that a true effect is yet to be fully established.

Conclusions: This study provides transdiagnostic exploration of the effectiveness of ACT in older people for reducing mental health symptomology. This adds to the expanding evidence base in this population and highlights ACT as a promising treatment option for older people. However, substantially more research is needed to ascertain the effectiveness of ACT for older people and whether it provides long-term benefits.

Keywords: Acceptance and Commitment Therapy, Older People, Mental Health, Anxiety, Depression

Key points:

- Acceptance and Commitment Therapy demonstrates a moderate estimated effect on reducing mental health symptomology in an older adult population
- Age moderates the effect of ACT treatment efficacy within an older age range

- More evidence is needed to establish a true treatment effect for ACT for older people

1.2 Introduction

1.2.1 Acceptance and Commitment *Therapy*

Acceptance and Commitment Therapy (ACT) is a therapeutic intervention incorporating a range of metaphors, exercises and procedures designed to alleviate human suffering (Hayes et al., 1999). The goal of ACT is for individuals to achieve 'psychological flexibility' by committing to behaviours that enable value-based action (Hayes et al., 2013). Using the six core principles (acceptance, defusion, self as context, contact with the present moment, values and committed action) individuals learn to open-up to difficult thoughts and feelings so that they no longer interfere with living a meaningful life. There is no manualised way in which ACT is delivered, as long as the general principles are consistent with the philosophy and theory (Hayes et al., 1999).

1.2.2 Biopsychosocial Model

Current research has focussed on ACT effectiveness for specific conditions including pain (Hughes et al., 2017; Veehof et al., 2011), depression (Brown et al., 2016; Spijkerman et al., 2016; Wetherell et al., 2016), anxiety Bluett et a;., 2014; Hughes et al., 2017; A-Tjak et al., 2015) and substance misuse (A-Tjak et al., 2015; Lee et al., 2015). The biomedical structure of healthcare services means research tends to focus on diagnosis-driven treatments. However, it is commonly appreciated that health conditions should be looked at through a biopsychosocial lens, considering biological, psychological, and social factors. It has been argued that by ignoring these factors, the NHS is not operating to maximise clinical and economic effectiveness (Wade & Halligan, 2017).

ACT is a transdiagnostic approach, applicable to a range of health difficulties (Hayes & Strosahl, 2005). With its focus not on reducing symptoms, but people living a meaningful life despite symptoms, it aligns with research suggesting older people (OP)

strive for independence accompanied by acceptance of their symptoms (Gabriel & Bowling, 2004) compared to younger people who may strive for independence and recovery (Naughton et al., 2018; Wilberforce et al., 2018).

1.2.3 Older People

OP (65+) make up 19% of the UK's total population (Centre for Ageing Better, 2022) and with people living longer, comorbid and life-limiting conditions are increasing (Maresova et al., 2019). Therapies aimed at reducing symptoms may be less beneficial for chronic conditions. Cognitive Behaviour Therapy (CBT) remains the NICE recommended treatment for most disorders demonstrating effective in OP for depression (Cuijpers et al., 2006; Frazer et al., 2005; Scogin et al., 2005) and anxiety, but less effective than for working aged people (Gould et al., 2012; Kishita et al., 2017), and less effective than ACT for pain (Wetherell et al., 2016). Lower attrition rates have been found in OP undergoing ACT than for younger people undergoing CBT (Wetherell et al., 2011), which may suggest OP are more attuned to the mechanisms underpinning ACT.

OP have been found to have less mental health awareness than younger people (Piper et al., 2018). Generational differences in the way mental health has been conceptualised in past decades has been thought to contribute to this finding (Stowe & Cooney, 2015) as OP have been seen to show a tendency to mask their difficulties (Polacsek et al., 2019). Thus, acceptance and mindfulness practices may be beneficial for OP in helping them understand and tolerate their difficulties.

1.2.4 Available evidence-base

Whilst there is a growing evidence-base for the use of ACT with working aged people (Ost, 2014), this remains limited for OP. The most recent review (Kishita et al., 2017) examining the effectiveness of ACT for OP included pre-post study designs due to the lack

of available Randomised Controlled Trials (RCT's) investigating ACT for OP. This highlighted the sparse comparison in the evidence-base with Kishita et al. (2017) including 10 mixed-method studies and Ost (2014) including 60 solely RCT studies. Within the review, Kishita et al. (2017) examined the effectiveness of ACT and mindfulness-based CBT. Although these two therapies are considered to share common processes, they are disparate therapies, and this makes it difficult to determine the unique effect of ACT on OP.

1.2.5 Research Aims

We aim to provide an up-to-date review of the effectiveness of ACT for OP focussing on all research where validated mental health outcome measures have been recorded pre-post therapy. Although ACT is a transdiagnostic approach, most studies are conducted within healthcare settings where symptom reduction is prioritised (Van Os et al., 2019) and therefore mental health symptomology is our target indicator. Although UK Health services deem OP as 65+, European law considers OP as over 60 (Marcinkowska et al., 2021). Veteran research has shown that veterans who experience PTSD, may retire slightly younger than 60 (Schnurr et al., 2005) and women in China can retire between ages 50-55 (Feng et al., 2019). As retirement is a life transition attributed to OP, we wanted to include this cohort of people. Our scoping search indicated that a minimum age of 55+ would allow for an inclusive, cross-cultural perspective of OP.

1.2.6 Methodological Rationale

A dependent variables meta-analysis (MA) is generally discouraged due to the lack of independence between pre-post therapy scores and lack of control over confounding variables (Cuijpers et al., 2017). However, Kösters (2017) provides contrary rationale for conducting a MA in specific circumstances, particularly when there are few studies which have conducted RCT's, as within this area of research. The paper also argues that even

when reviews have solely used RCT's, high heterogeneity can still be found, which was highlighted in the ACT review on working-age people (Ost, 2014). As such, it is recognised that a lot of effectiveness research uses within group designs and to ignore these would be to ignore a substantial part of the literature. Given that the previous review on ACT for OP conducted a dependent effects MA, we consider a replication of this (excluding the use of mindfulness-CBT) important to ascertain whether the literature in this area is progressing.

To reduce biases in using dependent effect MA the following steps were taken:

- The previous published review (Kishita et al., 2017) was used as a reference point to ensure replicability in this research area with comparable methodology.
- A sensitivity analysis was conducted to explore how results would be impacted by different assumptions given to the correlated variables.
- A combined effect size (ES) was calculated using Comprehensive meta-analysis software (CMA; Borenstein (2022)) to ensure only one ES was used per study to reduce the effect of a type 1 error and is recommended when measuring similar constructs (Van den Noortgate et al. (2013).

These steps allowed for both a narrative synthesis of available evidence, as well as a statistical representation of the state of the available evidence.

1.3 Method

The recommended steps in the Cochrane Handbook for Systematic Reviews (Higgins et al., 2019) was followed. A scoping search was completed on five databases and the protocol was published on Prospero.

1.3.1 Inclusion and Exclusion Criteria

Inclusion and exclusion criteria was established using the Population, Exposure, Outcome (PEO) Framework (Moola et al., 2015) as presented in Table 1-1.

1.3.2 Search Strategy

The search strategy (appendix A) was reviewed by a specialist librarian. Electronic databases were searched including PsycINFO, MEDLINE and Web of Science. Search terms were used for "Acceptance and Commitment Therapy" and for "Older People". Handsearching was conducted on two key journals (Clinical Gerontologist and Aging and Mental Health). Grey literature was searched through PsycEXTRA, Opengrey, ERIC and The Kings Fund. All searches were completed on October 17th 2022, and search term alerts included until December 1st 2022.

1.3.3 Selection of studies

All search results were added to Endnote and duplicates removed. The remainder of search results were added to Rayyan, a systematic review software programme (Ouzzani et al., 2016) to code all eligibility decisions. One researcher (LP) screened all titles and abstracts and a second researcher (SP), not an expert in the field (as recommended to reduce researcher selection bias (Cooper & Ribble, 1989) independently screened 10% of abstracts. Both researchers independently read all full texts and made an eligibility decision. Discrepancies were discussed with a third researcher (WD). Inter-rater reliability

for eligibility decisions was calculated using Cohen's Kappa (Cohen, 1960). Where there was missing information, authors were contacted before making a final decision.

1.3.4 Data Extraction

For eligible studies, key data was extracted including study name, number of participants, intervention description, number of therapy sessions, intervention modality, study setting, treatment target, outcome measure used and descriptive statistics. To minimise data entry errors, two researchers (LP and SP) independently extracted quantitative data from each study.

1.3.5 Risk of Bias

Quality of included studies was assessed using the Standard Quality Assessment Criteria (SQAC; (Kmet et al., 2004)). This is a standardised tool incorporating a 14-item checklist allowing for a quantitative evaluation of each study design, procedure, and quality of reporting. Two researchers (LP & SB) independently scored each included study and computed inter-rater reliability. Disagreements were discussed until a final score was agreed.

1.3.6 Statistical methods

Pre-post ACT intervention mean, standard deviation and sample size were inputted for each study for each outcome measure used to calculate ES. CMA was used to compute ES and complete the MA. If a study completed more than one outcome measure, these were all included and ESs were combined and averaged so only one for each study was used. An analysis of pre-post therapy data was used to gain an overall estimate effect of ACT. A sub-group analysis was conducted on different mental health symptomology (anxiety vs. depression). A separate analysis was performed on studies which included a control group and for studies which repeated outcome measures at a follow-up time point. A funnel plot

and Egger's regression test (Egger et al., 1997) was used to assess symmetry and publication bias. Homogeneity among ESs was assessed using the Q and I-squared statistic (Cochran, 1954; Higgins & Thompson, 2002).

1.4 Results

1.4.1 Study Selection

Database searching yielded 688 results. Duplicates removed and handsearching of two journals and grey literature led to 489 titles and abstracts being screened. 411 records were excluded: 112 did not use ACT as the primary intervention, 101 were not specific to OP, 87 were secondary analysis, 59 did not measure mental health symptomology or use a validated tool, 40 targeted families or caregivers and 12 included participants with cognitive impairments. One report only presented data for the study. 77 studies were read in full, and 64 studies were excluded. Details of exclusions from each database are presented in Figure 1-1.

1.4.2 Methodological Quality

The SQAC (Kmet et al., 2004) tool was adapted for only criteria related to the study designs (appendix B). Studies which included a comparison or control condition were scored out of 24 due to the possibility of random allocation. Case studies were scored out of ten as suggested in guidelines and the remainder were scored out of 22 due to other items being irrelevant for repeated-measure designs. Lower scores were due to small or unequal sample sizes (eight studies), absence of a control group (six studies) and details being omitted around participant recruitment and attrition rates (six studies).

1.4.3 Inter-rater reliability

Eligibility decisions (see appendix C) by two researchers yielded a high inter-rater reliability score for abstract/title screening (k=0.70), full-text screening (k=0.87), data extraction (k=0.99) and for quality assessment (k=0.94).

1.4.4 Study Design

There were differences in how included studies were designed. One study compared outcomes of OP with younger people who had completed a group ACT intervention. One study compared outcomes of a 1:1 ACT intervention with outcomes of a CBT intervention. The remainder of studies were within-subjects designs comparing pre-post treatment effects.

1.4.5 Participants

Of the included studies, there was a total of 480 participants. Participant samples ranged from how they were recruited into the study through different types of health settings. Two studies were from a non-clinical sample, two studies from a veteran specific health service, three studies were recruited in nursing homes, three studies were from primary care services (mild mental health difficulties), and three studies from tier 3 services (complex and longstanding health difficulties, either specialising in mental health or pain). Thus, participants had varying degrees of baseline mental health symptomology scores. Individual study outcomes are presented in Table 1-2. Across studies, age ranged from 63-89 years old, with a mean age of 74. Further characteristics for individual studies are presented in Table 1-3.

1.4.6 Acceptance and Commitment Therapy

All study interventions included the six components of ACT specified by Hayes et al. (2006). However, there were vast differences in intervention lengths. The average number of intervention hours was 184 with a range of 6-1080 total treatment hours. Eight studies compared pre-post scores for individuals who had engaged in an ACT intervention group, and five studies used a 1:1 ACT intervention (two were case studies). Three studies compared an ACT intervention with a control condition. Further intervention

characteristics are presented in Table 1-4. Intervention integrity: the degree to which the intervention closely aligned to ACT principles was measured by five studies. The way in which this was measured differed with some using their own adherence checklist, some recording sessions assessed by a third-party and some discussed with supervisors and in peer groups to ensure individual adherence.

1.4.6.1 Mental Health Symptomology. Of the 13 studies, seven measured anxiety, 12 measured depression and one measured anxiety and depression using a combined outcome measure. Ten of these studies measured mental health as a secondary outcome measure to the primary research aim (Table 1-3).

1.4.6.2 Anxiety. Of the studies focussing on reducing anxiety, six used statistical analysis to examine pre-post mean differences. Of these, four showed a statistically significant reduction in mean anxiety scores. The two studies which did not show statistically significant reductions, participants had low baseline anxiety scores. Of the remaining studies, two were case studies and both demonstrated reliable change, calculated using the reliable change index (RCI) calculation (Jacobson & Truax, 1991). One study (Gould et al., 2021) used RCI, where 45% of participants showed reliable improvement in anxiety scores.

Outcome measures used to assess anxiety symptomology varied among the studies. Four studies used the Generalised Anxiety Disorder Assessment (GAD-7; Spitzer et al., 2006), two studies used the Pain Anxiety Symptoms Scale (PASS-20; McCracken & Dhingra, 2002) and one study used the Depression Anxiety Stress Scale-10 (DASS-10; Halford & Frost, 2021).

1.4.6.3 Depression. Of the studies focussing on reducing depression, nine used statistical analysis to examine pre-post therapy score mean differences. Seven of these showed significant reductions in mean depression scores. The two studies which did not show a significant reduction in depression scores, participants had low scores at baseline. Of the remaining studies, two were case studies, which showed reliable change and one study (Gould et al. 2021) used RCI, with only 3% of participants showing a reliable improvement.

Outcome measures used to assess depression symptomology varied among the studies. Six studies used the Geriatric Depression Scale (GDS; Yesavage, 1988), two used the Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001), one used the DASS-10 (Halford & Frost, 2021), one used the British Columbia Major Depression Scale (BCMDI; Iverson & Remick, 2004), one used the Beck Depression Inventory (BDI; Beck et al., 1961) and one used the Centre of Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977). Thus, a range of outcome measures were used to assess depression symptomology.

1.4.6.4 Acceptance and Commitment Outcome Measurement.

Measurement of participant responses to any of the main principles of ACT were measured by ten studies (some studies used multiple ACT specific outcome measures). Eight studies measured general acceptance and action scores using the Acceptance and Action Questionnaire – II (AAQ II; Bond et al., 2011) and one used the Comprehensive Assessment of Acceptance and Commitment Therapy Processes (CompACT; Francis et al., 2016). Five studies statistically analysed general acceptance and action measures, where no significant differences between mean acceptance and action scores were found pre-post intervention. This indicates that participants outcome measures, designed to demonstrate the main aim of ACT (to be psychologically flexible), did not significantly improve.

Three studies specifically looked at participant's acceptance to pain symptoms using the Chronic Pain Acceptance Questionnaire (CPAQ; McCracken et al., 2004), all finding statistically significant improvement in mean acceptance of pain scores pre-post intervention. This indicates that these participants were more able to accept their symptoms related to pain after an ACT intervention.

Two studies specifically looked at participant's values in relation to pain using the Chronic Pain Values Inventory (CPVI; McCracken & Yang, 2006), with both showing statistically significant improvements in mean values scores, indicating that an ACT intervention improved participants perception of living in line with their values despite their pain symptoms.

1.4.7 Meta-Analysis

A MA was completed on 11 studies, which included all eligible studies excluding the two case studies.

1.4.7.1 Pre-post mean score analysis. ESs varied from no effect (g=0.02) to a large effect (g=0.92). The random effect model (Figure 1-2) showed an overall moderate ES of g=0.53 (95% CI=0.36-0.70) which suggests a significant moderate effect for ACT reducing mental health symptomology ($z=6.03$, $p<0.01$; $T^2=0.05$). There was no significant heterogeneity between the study ESs ($Q(10) = 24.39$, $p<0.01$, $I^2= 60.28$.

1.4.7.2 Publication Bias. A funnel plot (appendix D) showed symmetry in data. Egger's test was not significant ($t(9)=0.99$, $p=0.35$, CI=-5.45-2.12).

1.4.7.3 Sensitivity Analysis. A sensitivity analysis (Table 1-5) was conducted on the estimated pre-post correlation scores. The overall effect changed from medium to small when a correlation score of 0.9 was used. All scores fell on the border of a small-medium effect and therefore the correlation chosen was not considered to impact overall results. Higher pre-post correlations artificially reduce the variance within studies (Van den Noortgate et al., 2013) therefore 0.5 was used.

1.4.8 Additional Analyses

Supplementary analyses were conducted to assess the effect different study designs may have to the effectiveness of an ACT intervention.

1.4.8.1 Mental health. Subgroup analysis found that an ACT intervention showed a moderate effect of g=0.52 (95% CI= 0.34-0.70) when focussing on depression symptomology. This was a significant moderate effect (z=5.77, p<0.01, t^2= 0.04). When focussing on measures of anxiety, the ACT intervention showed a small effect of g=0.42 (95% CI = 0.12-0.72). This was a significant small effect (z=2.72, p<0.01, t^2 = 0.11). Chojak (2021) was removed from this analysis due to measuring anxiety and depression together.

1.4.8.2 Control Group. A separate analysis (Figure 1-3) was conducted for studies including a control condition. Of the four studies included, the random effect model showed that ACT had a significant small effect g=0.36 (95% CI=0.09-0.64) in reducing mental health symptomology when compared to a control group (z=2.60, p<0.01, I^2= 0.00). Heterogeneity was not significant; Q(3) = 2.28, p=0.52, I^2=0.00. A funnel plot (appendix E) showed symmetry in data. Egger's test was not significant (t(2)=0.73, p=0.54, CI=-5.82-8.20).

1.4.8.3 Follow-up. A separate analysis (Figure 1-4) was conducted on studies which used a follow-up time point. Three studies provided three month follow-up data which demonstrated a small ES of g=0.44 (CI:-0.05-0.925). This was not a significant effect (z=1.78, p=0.08, T^2 = 170). One study completed a follow-up analysis at six months, one at nine months and one at 12 months which were excluded due to insufficient data. A funnel plot showed symmetry in data (appendix F) and Eggers Regression test was not significant t(1)=0.53, p=0.690 (CI: -144.29-132.751). There was significant heterogeneity Q(2) = 30.017, p<0.01, T^2= 0.170.

1.4.8.4 Age. Age was shown to moderate the analysis, which accounted for 37.47 % of variance in ESs. A scatterplot (Figure 1-5) shows that ES declines as age increases.

1.4.8.5 Sample Size. A cumulative analysis was completed from largest sample (n=101) to smallest sample (n=5). Smaller samples reduced overall ES (appendix G).

1.4.8.6 Publication year. A cumulative analysis was conducted from earliest (2012) to latest (2021) study. This showed a variable ES over time (appendix H).

1.5 Discussion

1.5.1 Presentation of findings

Overall, ACT yielded a reduction in mental health symptomology for OP with a medium estimated effect. Given the MA methodology used (as already discussed), the ES is prone to bias and may not be robust. Whilst acknowledging this, the ES is comparable to previous reviews (Kishita et al., 2017; Ost, 2014), improving the reliability of these previous findings. Inclusion methods also meant that studies included participants with complexities, such as having severe and enduring mental health conditions, living in residential care settings, and having engaged in previous therapy. It is thus promising that an effect was present, and these characteristics were not statistically found to significantly impact variability in results. This is in comparison to Kishita et al (2017), which found significant heterogeneity among studies. This may suggest that their inclusion of mindfulness-based CBT increases the variability and thus ACT may have different distinctive processes.

1.5.2 Mental Health Symptomology

When considering mental health symptomology, all studies assessed the effect ACT had on anxiety and/or depression. A sub-group analysis on symptomology saw differences between anxiety and depression. The medium effect found for studies which measured depression, suggests that ACT may have promising utility for reducing depression symptomology in OP, which warrants further research. The ES was small for studies which focussed on reducing anxiety. A possible explanation for this discrepancy is the way in which therapy was delivered. Most studies delivered a group intervention. The nature of anxiety, which causes individuals to be hypervigilant in social scenarios (Wells, 1999) is likely to impact one's engagement in a group. OP have been found to show no significant benefit in a group CBT intervention compared to a control condition (Wetherell et al.,

2003). Further research directly comparing 1:1 vs group ACT delivery would allow for further understanding of whether these differences exist in clinical practice.

1.5.3 Limitations

Results were viewed within the context of study limitations of included studies.

1.5.3.1 Methodological quality. When focussing on studies which included a control-condition, the ES reduced to small. Despite these studies using a control group, two were based on small samples and had lower quality assessment scores. A cumulative analysis found that including smaller samples reduced the overall ES. This indicates that using studies of lower methodological quality may give a conservative estimate of ACT effectiveness due to the lack of statistical power to detect a true effect. This also reaffirms our decision to include within subject designs.

Only three of the included studies included longitudinal data and more research is needed to provide robust evidence on the effectiveness of ACT for OP in the longer term. Our cumulative analysis on publication year suggests variable ESs across the years. This highlights that a true effect of ACT has yet to be established for OP. Our review suggests that this is worthy of continuous study to improve the evidence-base and increase the validity of our findings. As most studies did not include a younger comparison group or a control group, it is not possible to ascertain whether there are differences in treatment responses between working-age and OP. More robust methodological studies would allow for this to be explored.

1.5.3.2 Dose of therapy. Despite advancements in ACT research, most studies are conducted on a working age population (Ost, 2014), which may not be comparable to OP, who may employ substantially more compensatory methods to combat more years of lived experience of mental illness (Wetherell et al., 2003).

Treatment hours ranged considerably among our included studies, making it impossible to depict whether treatment length impacts on treatment effect. A moderator analysis showed that the effectiveness of ACT decreased as age increased which may support the need for higher doses of therapy as people age, possibly due to a requirement for more cognitive repetition, as previously reported (Satre et al., 2006). However, this provides only one explanation for the age variance found in the analysis. There was also 63% of variance unaccounted for in the moderator analysis, which suggests more research is needed to understand the other components which may be impacting the effectiveness of ACT for OP.

Conversely, the variance in age may suggest that ACT for people in later older adulthood is not effective. However, only three of the studies included in the MA included participants whose mean age fell above 75 years old, which presents a need for research to be conducted with people in the later stages of older adulthood.

1.5.3.3 Outcome Measurement. Established outcome measurements are currently sub-optimal in establishing valid treatment effects in OP. For example, on the PHQ-9 (Kroenke et al., 2001) a tool used by two of the included studies for assessing the severity of depression, four of the nine items can be attributed to factors related to ageing (such as having little energy and thus sleeping too much, having trouble concentrating and moving or speaking slowly). This may reduce the likelihood of detecting a true reduction in symptoms for OP.

Studies tend to use outcome measures irrespective of age, despite research not demonstrating sensitivity to OP. For example, guidelines on using the BDI specifically stipulates use for ages 13-80 years old (Beck et al., 1961). Yet, one included study (Karlin et al., 2013) aimed to use the BDI to measure depression symptomology with ages up to 90 years old. Symptomology measures are commonly used in clinical practice with OP despite the sparse and conflicting evidence-base (Gee et al., 2010). This presents a critical need to review outcome frameworks for OP to ensure they are appropriate and are representative of what OP want to achieve in therapy. Without such advancements, it is difficult to fully establish the effect of any treatment delivered with OP.

Where eight studies analysed general acceptance scores using the AAQ-II (Bond et al., 2011) and CompACT (Francis et al., 2016), participants did not show a significant improvement in psychological flexibility. When studies specifically focussed on pain acceptance (as per their target symptom), scores significantly improved after the ACT intervention. This suggests that OP may benefit more from ACT when the principles of ACT are targeted to their primary symptoms. OP may thus struggle to generalise the components of ACT to their overall lifestyle. Previous research suggests that OP demonstrate less psychological flexibility overall compared to younger people (Eldesouky & English, 2018) and therefore may need more support to generalise outcomes beyond the intervention target. However, again, this may also suggest that established measures of

ACT are not sensitive to change in OP. For example, the AAQ-II was developed on participants with a mean age of 19 and therefore may not be translatable to OP. More research using ACT specific outcome measures warrants further exploration specifically with OP before they can be used to determine clinical change in this population.

1.5.4 Summary

To our knowledge, this is the first MA focussing on the effectiveness of ACT transdiagnostically with OP and involving a wide range of clinical designs. Results remain promising that ACT may have good utility in reducing mental health symptomology in OP but more robust evidence is required to confidently ascertain this effect in clinical practice, especially in the longer-term.

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1.7 Chapter 1 Appendices

Chapter 1 Appendix A Search Strategy

Database (Host)	Search Strategy		
PsychINFO (EBSCO)	"Acceptance and Commitment Therap*" OR "Third Wave CBT" OR "ACT Therap*" OR "ACT Intervention*" OR "ACT Based Intervention*" OR "ACT Based Therap*" OR "ACT informed Intervention*" OR "ACT Informed Therap*" DE "Acceptance and Commitment Therapy"	rtAND	"Old* People" OR "Old* Adult*" Geriatric* OR Elderly OR 55+ OR 65+ OR "Late*Life" OR Senior* OR Veteran* OR DE "Older Adulthood" OR DE "Geriatric Patients"
Medline (EBSCO)	"Acceptance and Commitment Therap*" OR "Third Wave CBT" OR "ACT Intervention*" OR "ACT Therap*" OR "ACT Based Therap*" OR "ACT Based intervention*" OR "ACT informed Intervention*" OR "ACT Informed Therap*" (MH "Acceptance and Commitment Therapy")	AND	"Old*People" OR "Old* Adult*" OR Geriatric* OR Elderly OR 55+ OR 65+ OR Late* Life" OR Senior* OR Veteran* OR (MH "Aged") OR (MH "Aged, 80 and Over")
Web of Science	"Acceptance and Commitment Therap*" OR "Third Wave CBT" OR "ACT Therap*" OR "ACT Intervention*" OR "ACT Based Therap*" OR "ACT Based Intervention*" OR "ACT informed Intervention*" OR "ACT Informed Therap*"	AND	"Old*People" OR "Old* Adult*" OR Geriatric* OR Elderly OR 55+ OR 65+ OR Late* Life" OR Senior* OR Veteran*
Grey Literature Database			
PsycEXTRA (EBSCO)	Acceptance and Commitment Therapy for Older People		
Opengrey	Acceptance and Commitment Therapy for Older People		
ERIC (ProQUEST)	"Acceptance and Commitment Therap*" OR "Third Wave CBT" OR "ACT Therap*" OR "ACT Intervention*" OR "ACT Based Therap*" OR "ACT Based Intervention*" OR "ACT informed Intervention*" OR "ACT Informed Therap*"	AND	"Old*People" OR "Old* Adult*" OR Geriatric* OR Elderly OR 55+ OR 65+ OR Late* Life" OR Senior* OR Veteran*
The Kings Fund	Acceptance and Commitment Therapy for Older People		
Manual/Hand Searching			
Taylor & Francis Online (Journal: Clinical Gerontologist)	[All: "acceptance and commitment therap*"] OR [All: "third wave cbt"] OR [All: "act intervention*"] OR [All: "act therap*"] AND [in Journal: Clinical Gerontologist]		
Taylor & Francis Online (Journal Aging & Mental Health)	[All: "acceptance and commitment therap*"] OR [All: "third wave cbt"] OR [All: "act intervention*"] OR [All: "act therap*"] AND [in Journal: Aging & Mental Health]		

Chapter 1 Appendix B Quality Assessment Tool (Standard Quality Assessment Criteria (SQAC; Kmet et al, 2004))

Scores are based on agreement between two researchers.

Study: **Alonso-Fernandez et al (2016)**						Comments
Criteria		Yes (2)	Partial (1)	No (0)	N/A	
1	Question/ objective sufficiently described?	2				Clearly outlined in the last paragraph of the introduction
2	Study design evident and appropriate?	2				Design clearly outlined in method section and appropriately answers the study question
3	Method of subject/ comparison group selection or source of information/input variables described and appropriate?	2				Method of selection clearly explained in the method section outlining clearly the inclusion and exclusion criteria and how many participants met this. Participants were randomly assigned to each condition and covered multiple nursing home sites.
4	Subject (and comparison group, if applicable) characteristics sufficiently described?	2				There is a table in the results section that clearly describing the characteristics of both the treatment and comparison group
5	If interventional and random allocation was possible, was it described?	2				Randomisation completed and computer method explained.
6	If interventional and blinding of investigators was possible, was it reported?				N/A	

7	If interventional and blinding of subjects was possible, was it reported?				N/A	
8	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?		1			Missing Results Bias
9	Sample size appropriate?		1			Small sample analysed
10	Analytical methods described/justified and appropriate?	2				Statistical methods clearly explained and appropriate for the data
11	Some estimate of variance is reported for the main results?	2				Standard deviations are reported in the results table and discussion around the bias that may be produced by the comparison group
12	Controlled for confounding?		1			They had a comparison group which is clearly specified with characteristics of the sample. This is described as a control group and is offered as a TAU group but it is not a true control in that participants received some support. Did not measure treatment adherence.
13	Results reported in sufficient detail?	2				Results very clear in how they meet all primary and secondary aims
14	Conclusions supported by the results?	2				Conclusions well supported
Total Score:						21/24

Study: **Campbell et al (2021)**						Comments
Criteria		Yes (2)	Partial (1)	No (0)	N/A	
1	Question/ objective sufficiently described?	2				
2	Study design evident and appropriate?	2				
3	Method of subject/ comparison group selection or source of information/input variables described and appropriate?				N/A	
4	Subject (and comparison group, if applicable) characteristics sufficiently described?	2				Participant well described and demographics clear
5	If interventional and random allocation was possible, was it described?				N/A	.
6	If interventional and blinding of investigators was possible, was it reported?				N/A	
7	If interventional and blinding of subjects was possible, was it reported?				N/A	
8	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?				N/A	
9	Sample size appropriate?				N/A	
10	Analytical methods described/justified and appropriate?				N/A	
11	Some estimate of variance is reported for the main results?				N/A	
12	Controlled for confounding?				N/A	
13	Results reported in sufficient detail?	2				Results well reported
14	Conclusions supported by the results?	2				
					Total Score:	10/10

Study: **Alonso et al (2013)**						Comments
Criteria		Yes (2)	Partial (1)	No (0)	N/A	
1	Question/ objective sufficiently described?	2				Question and objectives clearly defined in the last paragraph of the method section
2	Study design evident and appropriate?	2				Clear and well documented in the methods section
3	Method of subject/ comparison group selection or source of information/input variables described and appropriate?	2				Clearly explained and articulated why the two nursing homes were chosen and how nurses identified participants based on specified criteria
4	Subject (and comparison group, if applicable) characteristics sufficiently described?	2				Characteristics of the sample and the sample setting described
5	If interventional and random allocation was possible, was it described?		1			Randomisation mentioned but method not
6	If interventional and blinding of investigators was possible, was it reported?				N/A	
7	If interventional and blinding of subjects was possible, was it reported?				N/A	
8	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?	2				Well defined and appropriate
9	Sample size appropriate?		1			Sample size small and therefore underpowered but the researchers discuss this and uses non-parametric statistics to account for this. Unclear why 3 people were lost to the analysis.

						Possible publication bias.
10	Analytical methods described/justified and appropriate?	2				Appropriate and transparently reported
11	Some estimate of variance is reported for the main results?	2				This is reported and discussed throughout the results and discussion
12	Controlled for confounding?	2				As much as possible this was documented and analysed and further discussed.
13	Results reported in sufficient detail?	2				Table of results in results section plus commentary. Well documented.
14	Conclusions supported by the results?	2				Discussion supported results and discussed with caution given the small sample size and reporting of potential confounding variables.
					Total Score:	22/24

Study: **Goetz & Hirschorn (2022)**						Comments
Criteria		Yes (2)	Partial (1)	No (0)	N/A	
1	Question/ objective sufficiently described?	2				Clearly outline in the last paragraph of the introduction
2	Study design evident and appropriate?	2				Clearly outlined
3	Method of subject/ comparison group selection or source of information/input variables described and appropriate?		1			It was not clear who referred participants to the group.
4	Subject (and comparison group, if applicable) characteristics sufficiently described?	2				Characteristics of sample and group clearly displayed in the results section
5	If interventional and random allocation was possible, was it described?				N/A	.
6	If interventional and blinding of investigators was possible, was it reported?				N/A	
7	If interventional and blinding of subjects was possible, was it reported?				N/A	
8	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?	2				Clearly articulated and documented
9	Sample size appropriate?		1			Small sample size by nature of it being a quality improvement project. Discusses this as a limitation. Possible publication bias.
10	Analytical methods described/justified and appropriate?	2				Appropriate methods and clearly described
11	Some estimate of variance is reported for the main results?	2				Standard deviations reported and box plot discussed
12	Controlled for confounding?		1			Limited ability to do this due to the design and has some discussion of how factors may

						contribute as well as descriptive characteristics but limited discussion around sub-group analysis. No control group. One of the groups was completed in a different modality (via video)
13	Results reported in sufficient detail?	2				Well Reported
14	Conclusions supported by the results?	2				Balanced and appropriate conclusion
					Total Score:	19/22

Study: **Gould et al (2021)**						Comments
Criteria		Yes (2)	Partial (1)	No (0)	N/A	
1	Question/ objective sufficiently described?	2				Clearly described in the introduction section under main objectives
2	Study design evident and appropriate?	2				Appropriate and clear
3	Method of subject/ comparison group selection or source of information/input variables described and appropriate?	2				Method of selection appropriate and clearly explained
4	Subject (and comparison group, if applicable) characteristics sufficiently described?	2				Characteristics of sample well documented
5	If interventional and random allocation was possible, was it described?				N/A	.
6	If interventional and blinding of investigators was possible, was it reported?				N/A	
7	If interventional and blinding of subjects was possible, was it reported?				N/A	
8	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?	2				Outcomes detailed and appropriate
9	Sample size appropriate?		1			Sample size was appropriate for a feasibility study and this was well documented and referenced. They report the number needed to assess clinical effectiveness in the future and they discuss the reasons for sample size in detail. But small for effectiveness (as the purpose of this study)
10	Analytical methods described/justified and appropriate?	2				Well justified and appropriate
11	Some estimate of variance is reported for the main results?	2				Standard deviations and confidence

						intervals clearly outlined
12	Controlled for confounding?		1			No control group
13	Results reported in sufficient detail?	2				Well documented
14	Conclusions supported by the results?	2				Appropriate conclusions which are well supported and balanced
					Total Score:	20/22

Study: **Jacobs et al (2018)**						Comments
Criteria		Yes (2)	Partial (1)	No (0)	N/A	
1	Question/ objective sufficiently described?	2				Research aims and question clearly outlined in the last paragraph of the introduction
2	Study design evident and appropriate?	2				Appropriate and explained
3	Method of subject/ comparison group selection or source of information/input variables described and appropriate?		1			Selection could not be controlled by the researchers due to the type of study
4	Subject (and comparison group, if applicable) characteristics sufficiently described?	2				Characteristics of the sample and setting described and outlined appropriately in the results section
5	If interventional and random allocation was possible, was it described?				N/A	
6	If interventional and blinding of investigators was possible, was it reported?				N/A	
7	If interventional and blinding of subjects was possible, was it reported?				N/A	
8	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?		1			Outcome measures appropriate and reported but high level of missing data (23.5%). Potential for missing data bias.
9	Sample size appropriate?		1			Sample size was appropriate for the purpose of a feasibility study and discussed the limitations of using the data for judgements of effectiveness (as with the purpose of this research)

10	Analytical methods described/justified and appropriate?		1			Pre-Post reported by details of the between group analyses (between group cohorts) not reported and therefore unclear what was used. Statistical tests performed not reported.
11	Some estimate of variance is reported for the main results?		1			SD's reported but no reports of confidence intervals or discussion around variance
12	Controlled for confounding?		1			Did not have a control condition. Analysis of differences between cohorts detailed clearly
13	Results reported in sufficient detail?		1			Between-group results not reported.
14	Conclusions supported by the results?	2				Well supported and balanced conclusions based on the results
					Total Score:	15/22

Study: **Karlin et al (2013)**						Comments
Criteria		Yes (2)	Partial (1)	No (0)	N/A	
1	Question/ objective sufficiently described?	2				Clearly described in the last paragraph of the introduction
2	Study design evident and appropriate?	2				Appropriate and explained
3	Method of subject/ comparison group selection or source of information/input variables described and appropriate?		1			Unclear how participants were encouraged to take part/referral process
4	Subject (and comparison group, if applicable) characteristics sufficiently described?	2				Characteristics detailed and explained
5	If interventional and random allocation was possible, was it described?				N/A	.
6	If interventional and blinding of investigators was possible, was it reported?				N/A	
7	If interventional and blinding of subjects was possible, was it reported?				N/A	
8	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?	2				Outcomes well defined and appropriate
9	Sample size appropriate?		1			Large overall sample size but uneven group numbers with older people hugely under-represented compared to younger people
10	Analytical methods described/justified and appropriate?	2				Appropriate and reported clearly
11	Some estimate of variance is reported for the main results?	2				Confidence intervals and standard deviations clearly reported
12	Controlled for confounding?		1			Additional analysis completed on characteristics of participants which could account for confounding

						variables but no control condition
13	Results reported in sufficient detail?	2				Reports well supported
14	Conclusions supported by the results?	2				Balanced conclusion based on the results
					Total Score:	19/22

Study: **Roberts & Sedley**						Comments
Criteria		Yes (2)	Partial (1)	No (0)	N/A	
1	Question/ objective sufficiently described?	2				Clearly described purpose of presenting case study
2	Study design evident and appropriate?	2				Study design evident and described in detail
3	Method of subject/ comparison group selection or source of information/input variables described and appropriate?				N/A	
4	Subject (and comparison group, if applicable) characteristics sufficiently described?	2				Subject well described
5	If interventional and random allocation was possible, was it described?				N/A	.
6	If interventional and blinding of investigators was possible, was it reported?				N/A	
7	If interventional and blinding of subjects was possible, was it reported?				N/A	
8	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?				N/A	
9	Sample size appropriate?				N/A	
10	Analytical methods described/justified and appropriate?				N/A	
11	Some estimate of variance is reported for the main results?				N/A	
12	Controlled for confounding?				N/A	
13	Results reported in sufficient detail?	2				Results well described
14	Conclusions supported by the results?		1			Lack of discussion over limitations of the study. The conclusions meet the purpose of the study but would be useful to know how this may advance

						research on a wider scale
					Total Score:	9/10

Study: **Roche (2021)**						Comments
Criteria		Yes (2)	Partial (1)	No (0)	N/A	
1	Question/ objective sufficiently described?	2				Well explained at the end of the introduction
2	Study design evident and appropriate?	2				Appropriate design, detailed clearly
3	Method of subject/ comparison group selection or source of information/input variables described and appropriate?	2				Clearly explained in the method section
4	Subject (and comparison group, if applicable) characteristics sufficiently described?	2				Demographics clearly outlined
5	If interventional and random allocation was possible, was it described?	2				Process of randomisation was clearly explained
6	If interventional and blinding of investigators was possible, was it reported?				N/A	
7	If interventional and blinding of subjects was possible, was it reported?				N/A	
8	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?	2				Outcome measures clearly explained and appropriate
9	Sample size appropriate?	2				Appropriate and supported by power calculations
10	Analytical methods described/justified and appropriate?	2				Thorough and well reported
11	Some estimate of variance is reported for the main results?	2				Clearly included in table in results section
12	Controlled for confounding?	2				Well documented and additional analyses completed on these. Study design accounted for predicted confounding variables
13	Results reported in sufficient detail?	2				well documented results tables but differing numbers in appendix tables.

14	Conclusions supported by the results?	2				Well balanced argument in support of the results
					Total Score:	24/24

Study: **Scott et al (2017)**						Comments
Criteria		Yes (2)	Partial (1)	No (0)	N/A	
1	Question/ objective sufficiently described?	2				Clearly outlined in the final paragraph of the introduction
2	Study design evident and appropriate?	2				Study design evident
3	Method of subject/ comparison group selection or source of information/input variables described and appropriate?		1			Part of routine care and therefore no selection decisions made.
4	Subject (and comparison group, if applicable) characteristics sufficiently described?		1			2 week vs. 4 week
5	If interventional and random allocation was possible, was it described?		1			Not randomly assigned due to service criteria. Participants who were in the 2 week condition also required a physical neuromodulation procedure. This is discussed as limitation within the study.
6	If interventional and blinding of investigators was possible, was it reported?				N/A	
7	If interventional and blinding of subjects was possible, was it reported?				N/A	
8	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?	2				Outcomes well defined and reported
9	Sample size appropriate?		1			Small sample size for two conditions. Data taken from service-level study and therefore no a priori power analysis. Only 50% of participants provided data at follow-up reducing the sample size further.

10	Analytical methods described/justified and appropriate?		1			Analysis reported but combined for both groups and therefore confounding variable of some people receiving neurostimulation and being unclear
11	Some estimate of variance is reported for the main results?	2				SD's reported in tables in the appendix
12	Controlled for confounding?			0		Confounding variables were not controlled for. Lack of randomisation could have confounded variables and sub=group analyses or mediating analyses not performed. Confounding with the comparison of some participants being given a neurostimulation treatment. No Control condition
13	Results reported in sufficient detail?		1			Well reported in results and in appendix but no reports on the between subjects analyses (only statement given)
14	Conclusions supported by the results?	2				Conclusions supported and discusses the limitations with the confounding variables in detail
					Total Score:	16/24

Study: **Witlox et al (2021)**						Comments
Criteria		Yes (2)	Partial (1)	No (0)	N/A	
1	Question/ objective sufficiently described?	2				Well defined in the last paragraph of the introduction
2	Study design evident and appropriate?	2				Clearly defined in the method section
3	Method of subject/ comparison group selection or source of information/input variables described and appropriate?	2				Clearly described and unbiased selection strategy
4	Subject (and comparison group, if applicable) characteristics sufficiently described?	2				Demographics clearly reported in the results section
5	If interventional and random allocation was possible, was it described?	2				Random allocation well described in method section and included random allocation of both participants and practitioners
6	If interventional and blinding of investigators was possible, was it reported?				N/A	
7	If interventional and blinding of subjects was possible, was it reported?				N/A	
8	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?	2				Outcome measures clearly defined and appropriate
9	Sample size appropriate?	2				Sample size appropriate and a priori power calculations discussed
10	Analytical methods described/justified and appropriate?	2				Clearly reported in the results section
11	Some estimate of variance is reported for the main results?	2				Confidence intervals and standard error clearly reported in results tables
12	Controlled for confounding?		1			Demographics reported and analysis completed for baseline

						characteristics. Did not address the different modalities. Also no control condition.
13	Results reported in sufficient detail?	2				Results well reported
14	Conclusions supported by the results?	2				Well supported by the data and a balanced discussion of results
					Total Score:	23/24

Study: **McCracken & Jones (2022)**						Comments
Criteria		Yes (2)	Partial (1)	No (0)	N/A	
1	Question/ objective sufficiently described?	2				Clearly defined and stated in last paragraph of the introduction
2	Study design evident and appropriate?	2				Study design evident and appropriate
3	Method of subject/ comparison group selection or source of information/input variables described and appropriate?		1			Discussed in detail and transparent but as it was part of a service offer, this was not controlled by the researchers. Biased in relation to the speciality service that they used.
4	Subject (and comparison group, if applicable) characteristics sufficiently described?		1			No comparison or control group. Demographics of sample and sample setting provided
5	If interventional and random allocation was possible, was it described?				N/A	.
6	If interventional and blinding of investigators was possible, was it reported?				N/A	
7	If interventional and blinding of subjects was possible, was it reported?				N/A	
8	Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/ misclassification bias? Means of assessment reported?	2				Clear and appropriate
9	Sample size appropriate?		1			Lacks statistical power as discussed in the paper
10	Analytical methods described/justified and appropriate?	2				Appropriate and recorded
11	Some estimate of variance is reported for the main results?	2				Standard deviations reported
12	Controlled for confounding?		1			No control or comparison group

13	Results reported in sufficient detail?	2				Well reported in results section with tables.
14	Conclusions supported by the results?	2				Well balanced and supported conclusions
					Total Score:	18/22

Chapter 1 Appendix C Cohen's Kappa inter-rater reliability calculations

Ratings were interpreted based on 0.81-0.99 yielding a near perfect agreement and 0.61-0.80 yielding a substantial agreement (Cohen, 1960).

i) Inter-rater reliability for data extraction for number of participants, mean and standard deviation for each mental health symptomology measure in each study

Data Extraction		Rater 2 (SP)	
		Yes	*No*
Rater 1 (LP)	*Yes*	*147*	*1*
	No	*1*	*147*

Cohen's Kappa = 0.99 (near perfect agreement (Cohen, 1960)

ii) Inter-rater reliability for quality assessment tool

Quality Assessment		Rater 2 (SB)	
		Yes	*No*
Rater 1 (LP)	*Yes*	*236*	*2*
	No	*2*	*34*

Cohen's Kappa = 0.936 (near perfect agreement (Cohen, 1960)

iii) Inter-rater reliability for eligibility decisions between two researchers

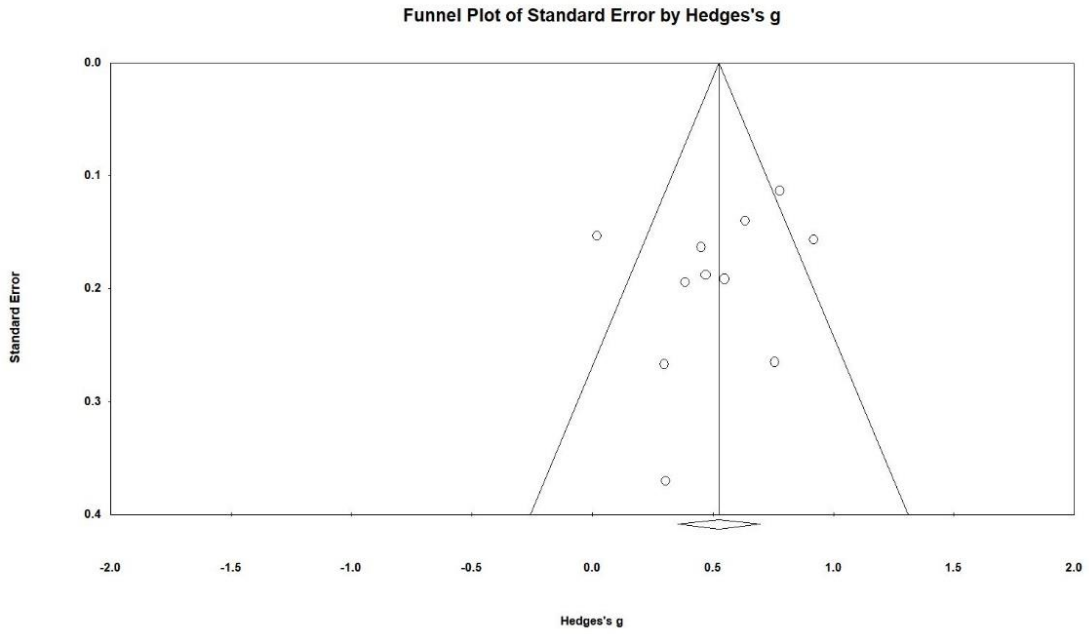
Abstract Screening		Rater 2 (SP)	
		Yes	*No*
Rater 1 (LP)	*Yes*	*6*	*2*
	No	*2*	*42*

Cohen's Kappa = 0.704 (Substantial Agreement)

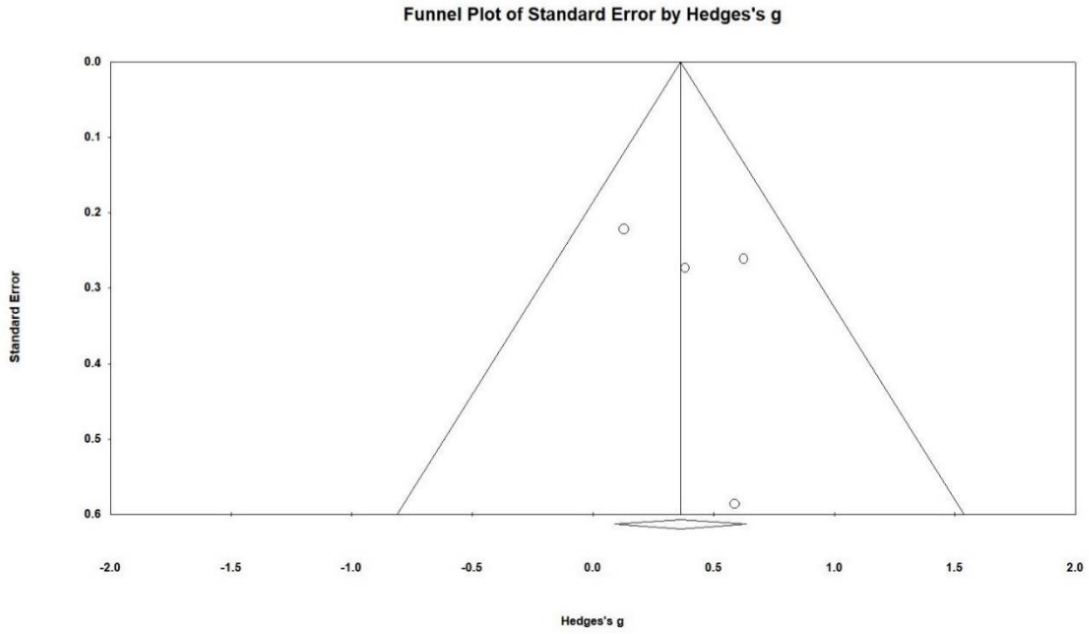
Full Text Screening		Rater 2 (SP)	
		Yes	No
Rater 1 (LP)	Yes	12	1
	No	2	62

Cohen's Kappa = 0.866 (Near Perfect Agreement)

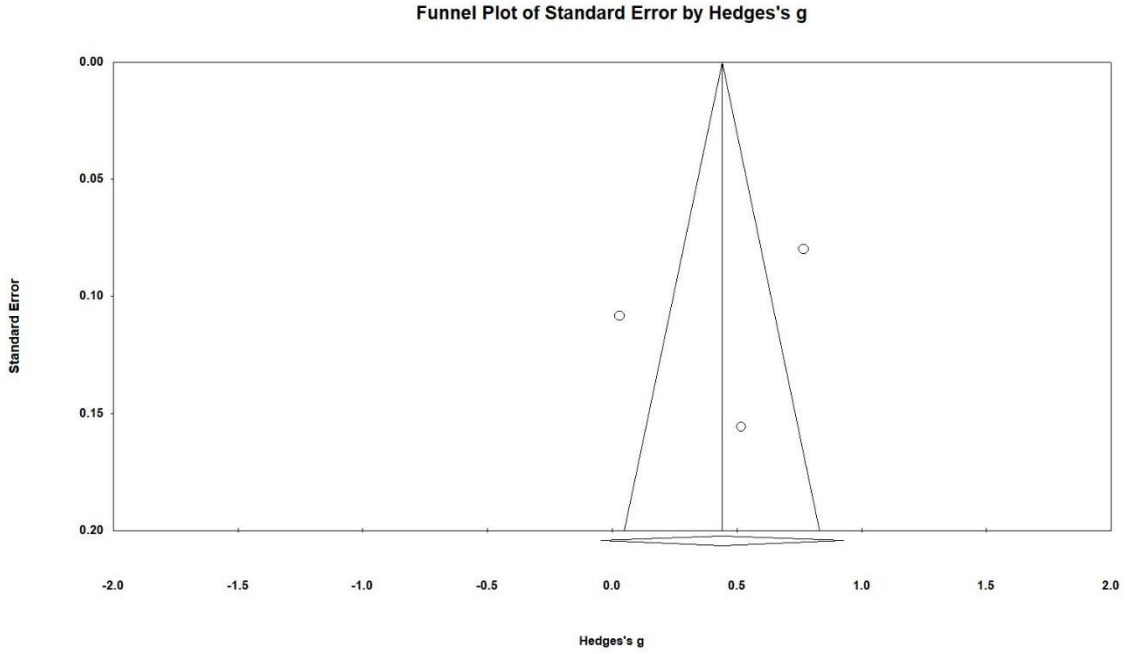
Chapter 1 Appendix D A funnel plot for pre-post mean score analysis



Chapter 1 Appendix E A funnel plot of the studies which included a control arm.

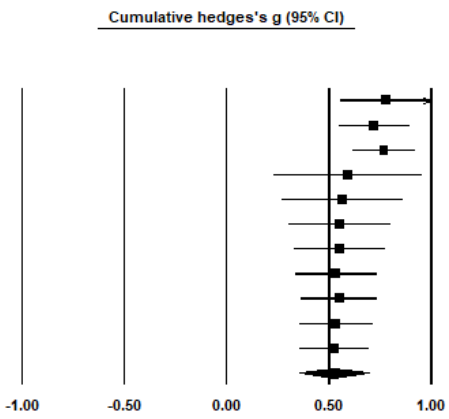


Chapter 1 Appendix F A funnel plot showing studies which included three-month follow-up data using one estimated effect size per study.



Chapter 1 Appendix G A cumulative analysis on included studies from largest sample to smallest sample

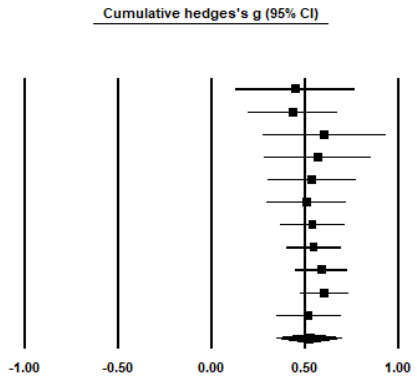
Study name	Outcome	Cumulative statistics						
		Point	Standard error	Variance	Lower limit	Upper limit	Z-Value	p-Value
Witlox et al	Combined	0.779	0.113	0.013	0.557	1.001	6.870	0.000
Scott et al	Depression	0.721	0.088	0.008	0.548	0.894	8.186	0.000
Karlin et al	Depression	0.769	0.077	0.006	0.618	0.919	10.013	0.000
Roche	Combined	0.591	0.184	0.034	0.230	0.952	3.206	0.001
Mccracken & Jones	Combined	0.565	0.150	0.023	0.271	0.859	3.764	0.000
Gould et al	Combined	0.551	0.129	0.017	0.299	0.804	4.283	0.000
Chojak	Anxiety/Depression	0.552	0.112	0.013	0.332	0.772	4.908	0.000
Alonso-Fernandez et al	Combined	0.534	0.102	0.010	0.334	0.734	5.239	0.000
Goetz & Hirshhorn	Depression	0.551	0.095	0.009	0.364	0.738	5.781	0.000
Jacobs et al	Combined	0.534	0.091	0.008	0.357	0.712	5.896	0.000
Alonso et al	Depression	0.525	0.087	0.008	0.354	0.696	6.030	0.000
		0.525	0.087	0.008	0.354	0.696	6.030	0.000



Note: Random Effects

Chapter 1 Appendix H A cumulative analysis on included studies from earliest study to latest study

Study name	Outcome	Cumulative statistics						
		Point	Standard error	Variance	Lower limit	Upper limit	Z-Value	p-Value
Mccracken & Jones	Combined	0.451	0.163	0.027	0.131	0.771	2.762	0.006
Gould et al	Anxiety	0.436	0.123	0.015	0.195	0.676	3.553	0.000
Karlin et al	Depression	0.603	0.167	0.028	0.276	0.930	3.616	0.000
Alonso et al	Depression	0.569	0.147	0.022	0.282	0.856	3.880	0.000
Alonso-Fernandez et al	Combined	0.535	0.120	0.015	0.299	0.771	4.445	0.000
Jacobs et al	Combined	0.509	0.109	0.012	0.296	0.722	4.691	0.000
Scott et al	Depression	0.541	0.087	0.008	0.370	0.713	6.198	0.000
Chojak	Anxiety/Depression	0.548	0.075	0.006	0.401	0.695	7.308	0.000
Witlox et al	Combined	0.589	0.071	0.005	0.449	0.729	8.266	0.000
Goetz & Hirshhorn	Depression	0.602	0.066	0.004	0.472	0.732	9.085	0.000
Roche	Combined	0.520	0.088	0.008	0.348	0.691	5.935	0.000
		0.520	0.088	0.008	0.348	0.691	5.935	0.000



Note: Random Effects

Chapter 1 Appendix I Style Guidelines for Journal of Geriatric Psychiatry

Free Format Submission

"Your manuscript: this should be an editable file including text, figures, and tables, or separate files—whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. Figures should be uploaded in the highest resolution possible. If the figures are not of sufficiently high quality your manuscript may be delayed. References may be submitted in any style or format, as long as it is consistent throughout the manuscript.

Main Text File

Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations;
- The full names of the authors with institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Acknowledgments;
- Abstract structured (Objectives, Methods, Results, and Conclusions);
- 3 – 10 keywords;
- Please provide up to 4 key points – there should be listed after the keywords in the main document.
- Main body: formatted as introduction, materials & methods, results, discussion, conclusion;
- References;
- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below)
- Critical reviews of the literature, including systematic reviews and meta-analyses, 4500 limit. To include Introduction; Content-appropriate headings; Acknowledgements; References; Tables; List of figure captions; List of supporting information legends. Overall combined limit of 6 figures/tables and 150 references."

1.8 Chapter 1 Tables

Table 1-1. PEO Framework for inclusion and exclusion of studies

	Population	**Exposure**	**Outcome**
Inclusion	Participants undergoing an ACT intervention Studies which specifically investigate an older adult population Studies which target the outcomes of participants aged 55+	Studies which administer an ACT Intervention: Interventions must target psychological flexibility through the use of any of the ACT 6 core processes(acceptance, cognitive defusion, being present, self as context, values and committed action)	Studies which use a validated measure to measure mental health symptomology. This was judged by the study reporting psychometrics and/or these being easily available through a basic research search Studies which measure outcomes pre-post therapy Studies which report the effect size or statistics which allow for the effect size to be calculated (i.e. mean and standard deviation)
Exclusion	Participants with a suspected cognitive impairment Studies which involve family/caregiver/staff involvement Participants under 55 Studies which include a broad age range with some participants over 55	Studies where multiple psychological approaches are used in addition to ACT to guide the intervention (such as CBT and CFT)	Studies which report on secondary analysis/data already collated/ Systematic Reviews/Meta Analyses Studies which are not available in the English language

Table 1-2. Individual study outcomes including mean, standard deviation, baseline scores and significance levels

Study	Condition	N	Pre-therapy M (SD)	N	Post-therapy M (SD)	Baseline	Sig change
Alonso-Fernandez et al	Intervention	27	GDS: 10.8 (6.39) PASS: 38.4 (21.91)	27	GDS: 8.9 (5.6) PASS: 28.9 (16.9)	Non-Clinical range for Depression Clinical Range for anxiety	Depression p = 0.05* Anxiety *p=0.01**
	Comparator	26	GDS: 12 (6.87) PASS: 37.3 (23.86)	26	GDS: 11.9 (7.2) PASS-20: 38 (24.2)	Mild range for depression Clinical range for anxiety	Depression *p=0.92* Anxiety *p=0.84*
Campbell et al (2020)	Intervention	1	Raw Score:	1	Raw Score:		Significant RCI
Chojak	Intervention	30	DASS-21: 15.4 (11.23)	30	DASS-21: 9.8 (7.7)	Moderate Range for Depression and Anxiety	*P=0.03**
	Comparator	30	DASS-21: 16.3 (9.8)	30	DASS-21: 16.4 (10.0)	Moderate Range for Depression and Anxiety	*P=0.089*
Alonso et al	Intervention	5	GDS-10: 3.8 (2.3)	5	GDS-10: 3 (1.9)	Clinical range for depression	*p=0.46*
	Control	5	GDS-10: 3 (1.9)	5	GDS-10: 3.6 (2.4)	Clinical range for depression	*p=0.41*
Goetz & Hirschhorn	Intervention		GDS-15: 7.0 (2.9)	17	GDS-15: 4.8 (2.7)	Clinical levels of Depression	*p=0.04**
Gould et al	Intervention	34	GDS-15: 9.8 (3.2) GAI: 15.8 (4.1)	30	GDS-15: 7.8 (4.0) GAI: 13.8 (5.1)	Clinical levels for Depression and Anxiety	RCI used
Jacobs et al	Intervention		GAD: 9.6 (5.8) GDS-15: 8 (3.8)	13	GAD: 8.4 (6.1) GDS: 6.2 (4.6)	Clinical levels for Depression and Anxiety	Depression *p=0.04** Anxiety *p>0.05*
Karlin et al	Intervention	57	BDI-II: 28.4 (11.4)	57	BDI-II: 17.5 (12)	Moderate range for Depression	*P<0.01**
	Comparator	420	BDI-II: 30.3 (10.6)	420	BDI-II: 19.1 (14.3)	Severe range for Depression	*p<0.01**
Robets & Sedley (2015)	Intervention	1	Raw Score:	1	Raw Score:		Significant RCI
Roche	Intervention	41	CES-D: 7.8 (6.3) GAD-7: 2.2 (3.1)	41	CES-D: 7.9 (7.0) GAD-7: 2.1 (3.0)	Low levels of Depression Minimal anxiety	Anxiety *p=0.57* Depression *p=0.46*
	Comparator	40	CES-D: 8.4 (6.8) GAD-7: 2.3 (3.3)	39	CES-D: 8.9 (7.8) GAD-7: 2.9 (4.1)	Low levels of depression Minimal anxiety	Not tested
Scott et al	Intervention	60	PHQ-9: 12.1 (6.4)	60	PHQ-9: 8.3 (5.7)	Moderate range for Depression	*p=<0.01**
Witlox et al	Intervention	150	PHQ-9: 7.0 (4.5) GAD-7: 8.2 (4.3)	101	PHQ-9: 4.1 (4.4) GAD-7: 4.4 (3.9)	Mild range for depression Mild range for anxiety	Depression *p=<0.01** Anxiety *p=<0.01**
	Comparator	164	PHQ-9: 7.92 (4.5) GAD-7: 8.78 (4.3)	121	PHQ-9: 4.8 (4.4) GAD-7: 4.8 (4.0)	Mild range for depression Mild range for anxiety	Depression *p=<0.01** Anxiety *p=<0.01**
McCracken & Jones	Intervention	40	BCMDI: 23.24 (12.5) PASS-20: 39 (21.8)	40	BCMDI: 16.6 (12.8) PASS-20: 30.4 (22.1)	Moderate range for depression Clinical range for anxiety	Depression *p=<0.05** Anxiety *p=<0.01**

Table 1-3. Intervention characteristics including, treatment target, mean age, gender, mental health focus, follow-up data and quality scores

Study	Primary Treatment Target	Mean Age	Gender	Conditions	Mental Health Focus	Mental Health Measure	Follow-up	Quality Score
Alonso-Fenandez et al (2016)	Pain	83	78% Female	ACT vs Control	Anxiety Depression	PASS-20 GDS	N/A	21/24
Campbell et al (2020	Pain	72	Female	Pre & Post	Depression	GDS	N/A	10/10
Chojak (2021)	Non-Clinical	74	70% Female 30% Male	ACT vs control	Anxiety Depression	DASS-21	T1= 4 weeks	22/24
Alonso et al (2013)	Pain	87	67% female 33% male	ACT vs Control	Depression	GDS	N/A	22/24
Goetz & Hirschhorn (2021)	Aging	70	1 Female 16 Male	Pre & Post	Depression	GDS-SF	N/A	19/22
Gould et al (2012)	GAD	75	95% Female	Pre & Post	Anxiety Depression	GAI GDS-15	T1 = 20 week	20/22
Jacobs et al (2017)	Aging	68	100% Male	Pre & Post	Anxiety Depression	GDS – 15 GAD-7	N/A	15/22
Karlin et al (2013)	Depression	68	95% Male 5 % Female	Older vs Younger	Depression	BDI-II	N/A	19/22
Roberts & Sedley (2015)	Anxiety & Depression	89	Male	Pre & Post	Anxiety Depression	HADS GDS	T1 =6 week	9/10
Roche (2021)	Non-Clinical	78	54% Female 46% Male	ACT vs Control	Anxiety Depression	GAD-7 CES-D	3 months	23/24
Scott et al (2017)	Pain	69	38.3% Male	Pre & Post	Depression	PHQ-9	9 months	16/22
Witlox (2021)	Anxiety	63	38.9% Male	ACT vs CBT	Anxiety Depression	GAD-7 PHQ-9	T1 = 3months, 6 months and 12 months	23/24
McCracken & Jones (2012)	Pain	64	62.5% Female	Pre & Post	Anxiety Depression	PASS-20 BCMDI	3 months	18/22

Table 1-4. ACT intervention characteristics for each included study

Study	ACT Number of Hours	Modality	Treatment integrity measured	Treatment Plan Published	Therapist	Treatment Definition
Alonso-Fenandez et al (2016)	1080	Group	No	Yes	Psychologist	Consisted of nine sessions including psychoeducation around the target condition (pain) and incorporated all six components of ACT with descriptions of how this was done.
Campbell et al (2020	7	1:1	No	Yes	Psychologist	Consisted of seven sessions detailing each session in detail with how it related to the case study. The treatment covered all six components of ACT.
Chojak (2021)	Min 240	Group	No	No	Psychologist	Six components of ACT with relevant exercises and metaphors used over 12 modules. Modules included elements of psychoeducation, breathing exercises, listening to a recording and a written exercise. A protocol was used and published in a previous paper.
Alonso et al (2013)	20	Group	No	Yes	Psychologist	Consisted of ten sessions of ACT with a clear treatment plan of how each session focussed on a different aspect of the six components.
Goetz & Hirschhorn (2021)	360	Group	No	Yes	Psychologist	Advertised as a group to "develop skills to handle new challenges. and life transitions in order to live more fully as we get older." It consisted of six sessions, incorporating, and covering the ACT six components.
Gould et al (2012)	16	1:1	Yes	Yes	12 different psychologists	Each session incorporated a specific set of skills, metaphors, experiential exercises, and home practice tasks and incorporated all six components of ACT. The intervention was manualised, and content was pre-determined for most of the sessions.
Jacobs et al (2017)	12	Group	No	Yes	Unspecified	Three 12 session groups were conducted using a protocol which covered all of the six components of ACT with details of the specific skills and metaphors used to demonstrate each component.
Karlin et al (2013)	72	1:1	Yes	Yes	Multiple mental health staff from different professions	Incorporated all six components of ACT and focussed on therapeutic alliances, supporting clients to work on ACT processes and skills. The protocol was designed to be used flexibly to support individual case conceptualisations.
Roberts & Sedley (2015)	6	1:1	No	Yes	Psychologist	Six 1:1 sessions, clearly outlining how each of the six components of ACT were used to support one individual.
Roche (2021)	180	Group	Yes	Yes	2 x Trainee Psychologists	Comprised of two sessions. The first session focused on values and committed action. The second session used the ACT Matrix to explore the remainder of ACT components.
Scott et al (2017)	Min 48	Group	No	No	Multiple clinicians from different professions	Sessions included physical exercise, skills training, and education and incorporated all of the six components of ACT using metaphors and experiential exercises.
Witlox (2021)	Min 255	1:1	Yes	Yes	Mental Health Counsellor/self-study	ACT Blended group included four face to face Sessions and the remainder was online using the ACT 'Living Life to the Full' Protocol.

McCracken & Jones (2012)	Min 97.5	Group	Yes	Yes	Multiple professionals	Treatment methods explicitly aimed at enhancing psychological flexibility and improving daily functioning. All six components were included.

Table 1-5. Sensitivity Analysis on pre-post correlation estimates for the repeated measures analysis

Correlation	Effect Size	Z score	Lower Limit	Upper Limit	P-Value	Effect Description (Cohen, 2013)
0.5	0.53	6.03	0.35	0.70	0.00	Medium
0.6	0.52	5.98	0.35	0.69	0.00	Medium
0.7	0.52	5.91	0.35	0.69	0.00	Medium
0.8	0.51	5.87	0.34	0.65	0.00	Medium
0.9	0.49	5.71	0.32	0.66	0.00	Small

1.9 Chapter 1 Figures

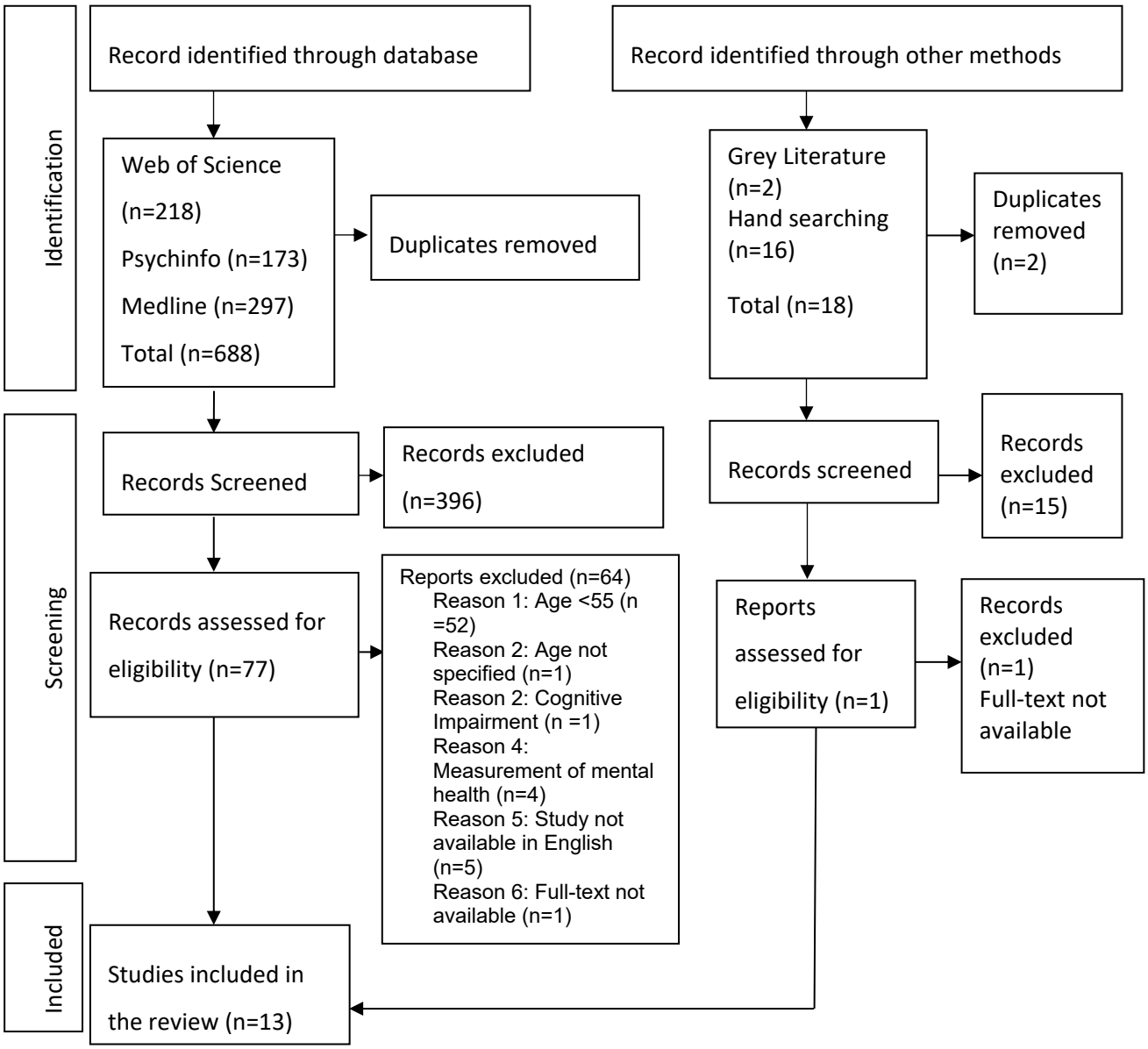
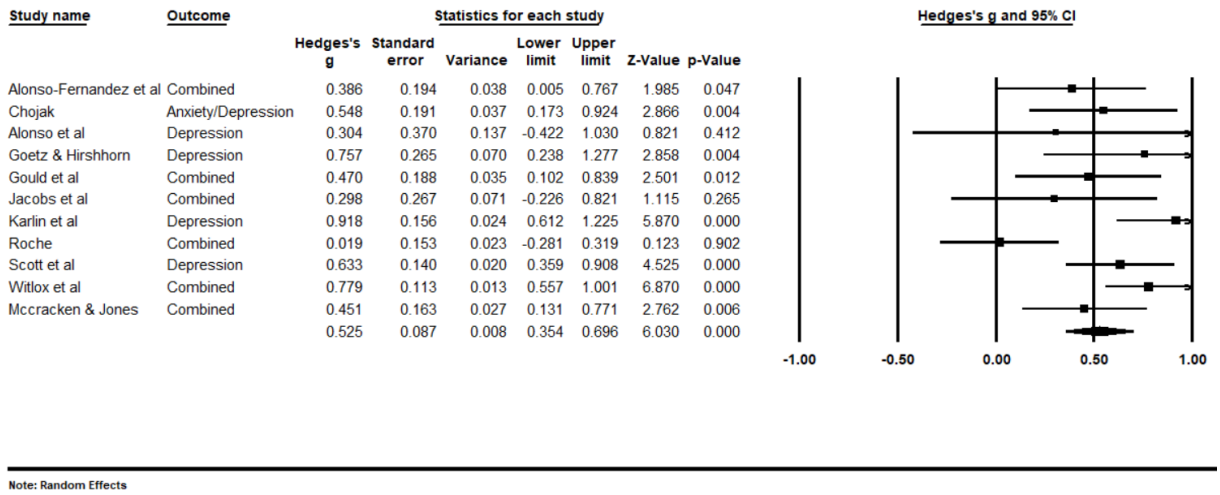


Figure 1-1. PRISMA Diagram (Adapted from Page et al. (2021))



Study name	Outcome	Hedges's g	Standard error	Variance	Lower limit	Upper limit	Z-Value	p-Value
Alonso-Fernandez et al	Combined	0.386	0.194	0.038	0.005	0.767	1.985	0.047
Chojak	Anxiety/Depression	0.548	0.191	0.037	0.173	0.924	2.866	0.004
Alonso et al	Depression	0.304	0.370	0.137	-0.422	1.030	0.821	0.412
Goetz & Hirshhorn	Depression	0.757	0.265	0.070	0.238	1.277	2.858	0.004
Gould et al	Combined	0.470	0.188	0.035	0.102	0.839	2.501	0.012
Jacobs et al	Combined	0.298	0.267	0.071	-0.226	0.821	1.115	0.265
Karlin et al	Depression	0.918	0.156	0.024	0.612	1.225	5.870	0.000
Roche	Combined	0.019	0.153	0.023	-0.281	0.319	0.123	0.902
Scott et al	Depression	0.633	0.140	0.020	0.359	0.908	4.525	0.000
Witlox et al	Combined	0.779	0.113	0.013	0.557	1.001	6.870	0.000
Mccracken & Jones	Combined	0.451	0.163	0.027	0.131	0.771	2.762	0.006
		0.525	0.087	0.008	0.354	0.696	6.030	0.000

Figure 1-2. Random effects model for pre and post data for each study.

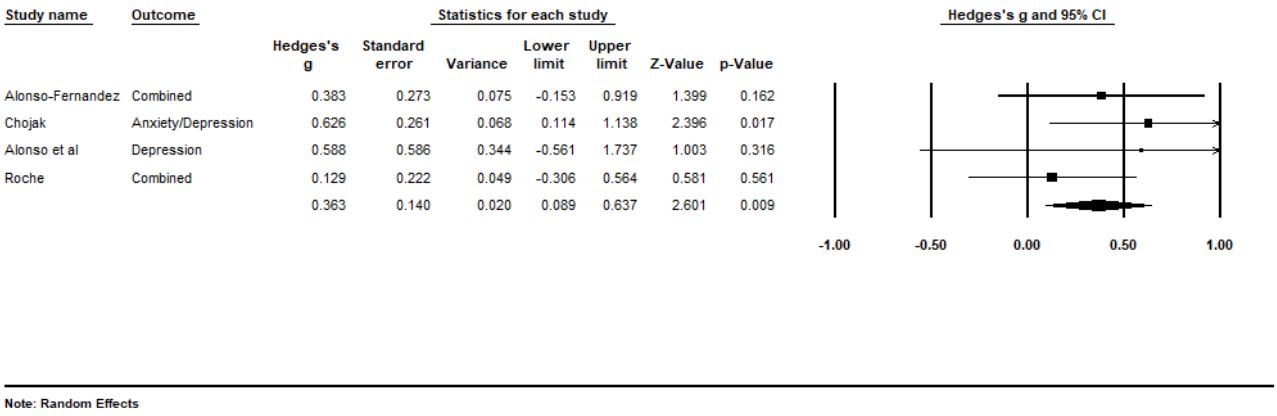


Figure 1-3. Random effects analysis for studies including a control arm with one ES calculated per study

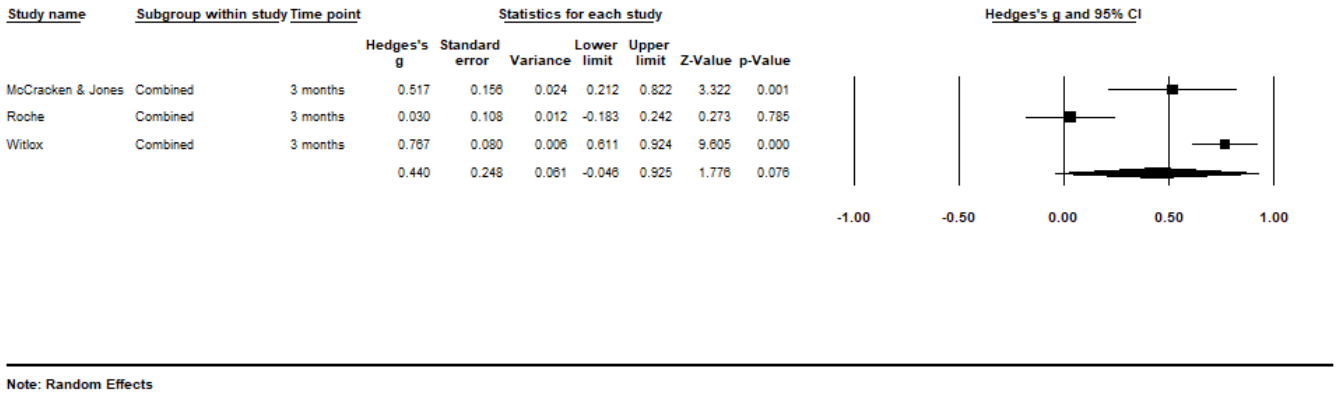


Figure 1-4. Random Effects model for follow-up data combining multiple ES in one given study.

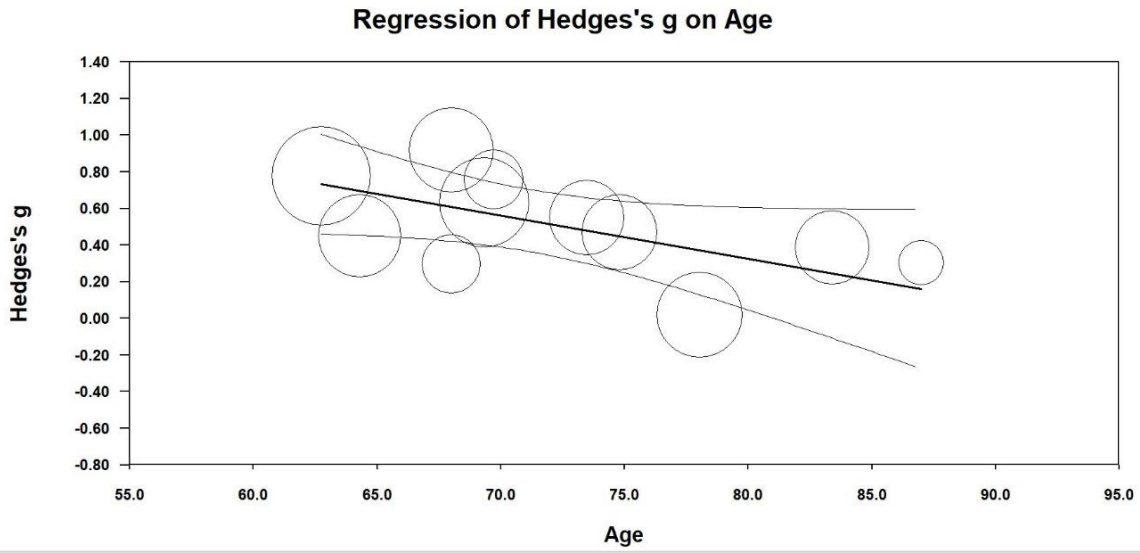


Figure 1-5. Scatterplot showing the regression line and confidence intervals for predicted effect sizes for different ages.

Chapter 2 Older People's Experiences of Psychological Therapy

This paper has been prepared in the format required by the journal, 'Aging and Mental Health'

https://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=camh20

Word Count (Including, tables, figures, and references): 7414

2.1 Abstract

Objective: There is a need to improve and increase psychological treatment for older people. It is currently unclear how and whether therapy should be adapted for this population. This is complicated by outcome frameworks being outdated and underutilised in determining therapy effectiveness for this age group. Older people's voices are imperative in understanding therapy experiences, understanding the mechanisms of positive change and making necessary improvements. **Method:** Six older people (65+), who had received psychological therapy and made positive progress, within a community mental team completed interviews about their experience of therapy. Interpretative Phenomenological Analysis (IPA) was used to analyse results. Methodological quality is highlighted throughout. **Results:** Three group experiential themes were developed (processing my identity, the powerful therapy relationship, continuing my journey), each containing two sub-themes. **Conclusion:** Important insights into how older people experience therapy are highlighted with considerations on how therapy can be sensitive to the unique needs of older people and what may be the determinants of positive progress.

Keywords: older people; psychological therapy; mental health

2.2 Introduction

2.2.1 Older People and Mental Health

With an aging population (Centre for Ageing Better, 2022), there is growing need to focus on healthcare offered to older people (OP). UK health services generally consider OP as over 65 years old. Older adulthood can include life transitions that present unique challenges, such as a change in purpose (Musich et al., 2018), increased social isolation (Dickens et al., 2011), physical health comorbidities (Maresova et al., 2019) and cognitive decline (Murman, 2015). Such factors have led to psychiatric services being criticised for overlooking mental health difficulties as a normal part of aging (Deuter et al., 2016).

Understanding mental health in OP is complex because there are natural aspects of aging which increase the likelihood of someone meeting the suggestive criteria for a mental disorder. For example, on the Patient Health Questionnaire-9 (Kroenke et al., 2001), a commonly used tool for assessing depression severity, four of the nine items can be attributed to factors related to getting older (such as having less energy and thus sleeping more and moving or speaking slower). This presents pitfalls in using traditional tools designed for working age adults to assess OP.

2.2.2 Psychological Therapy for Older People

Psychiatric medication is generally used as the first-line treatment for psychiatric difficulties in OP (Crocco et al., 2017), yet the potential for serious side effects is well established (Lindsey, 2009), with the likelihood and severity of these effects increasing with age and comorbidities (Brooks & Hoblyn, 2007). There is thus argument to increase OP's access to psychological therapies.

There has been limited research on how psychological therapy should be adapted with OP. Laidlaw (Laidlaw et al., 2004) developed an adapted cognitive model

encouraging therapists to focus on cognitions related to physical health and changes in life roles, which has received little additional research external to the primary researchers. Conversely, the Contextual Cohort-Based Maturity/Specific Challenge Model (Knight, 1996) suggests a therapy focus on social differences in relation to specific events that OP have already faced (such as differences in education and historical events) and are currently facing (such as retirement and assisted care). This has been considered useful in supporting the assessment of OP in a variety of settings (Harley & Teaster, 2018; Lehman, 2012; Trevino et al, 2021).

Others argue that therapy adaptations are not required as this assumes an ageist view preventing OP accessing the same services (Warner, 2015) leading some services providing for an 'ageless' population. Whilst it is recognised that therapists are seeing more OP than ever before, they are not always trained in how this may differ from working with older age groups (Laidlaw & McAlpine, 2008).

2.2.3 Psychological Therapy Outcomes

Exploring outcomes in OP's mental health services, predominantly through pre-post therapy questionnaires is challenging. Clinicians do not always find them clinically relevant (Jacobs & Moran, 2010), there is disagreement about what outcomes are most applicable (Kazdin, 2019; Macdonald, 2009; Siette et al., 2021) which is further impacted by questionnaire measures having a sparse, conflicted and out of date evidence-base for OP (Gee et al., 2010). This is problematic for OP's Mental Health (OPMH) services considering outcome measures drive funding (Macdonald & Elphick, 2011). Likewise, patient experience questionnaires have been criticised when adapted to OP because they have a "youthful bias" (Nolan et al., 2001) focussing on recovery and independence, which is not always a priority for OP (Wilberforce et al., 2018). Therefore, there is a need to identify how OP experience psychological therapy to ensure outcomes are valid and

sensitive to the needs of OP which could then also support increases in funding for the growing older population.

2.2.4 Study Rationale

The aim of this study was to explore how OP experience psychological therapy using Interpretative Phenomenological Analysis (IPA). IPA is considered useful in understanding individual psychosocial experiences and building theory (Jedličková et al., 2022).

2.2.5 Research Question

How do OP experience psychological therapy in secondary care mental health services?

2.3 Method

2.3.1 Design

IPA was used to explore the aims of this research. IPA is a qualitative approach used to explore in-depth and subjective experiences of select individuals from an idiographic phenomenology (Larkin et al., 2006).

2.3.2 Epistemology

My epistemological position aligns with that of a social constructionist, where I view social relationships and societal processes as fundamental to understanding human experience. Whilst I held no expectations for what participants may bring to the interviews, I was aware of assumptions I held of OP, which influenced the rationale for this study. I assumed that social transitions would be a critical factor when considering mental health in OP (such as through retirement and changing societal roles e.g., from parent to grandparent, married to widowed etc.). IPA encourages transparency of these assumptions, using the process to highlight and challenge these.

2.3.3 Research Paradigm

There are no set guidelines for approaching IPA, but the philosophical underpinnings of hermeneutics, ideography and symbolic interactionism were important throughout the process. The hermeneutic cycle (the dynamic interaction between researcher and participant) was continually re-visited for sufficient meaning-making of participant experiences (Smith & Osborn, 2003). Ideography was highlighted through the use of one participant's narrative throughout the themes, whilst interweaving convergent and divergent perspectives (Spencer & Ritchie, 2011). Specific questioning during the interviews was used to ensure appropriate understanding of participant experiences, whilst

a reflective log (appendix B) allowed for understanding of my subjective interpretation of participant language.

2.3.4 Ethical Considerations

Ethical approval was obtained from the University of Southampton and from the NHS Health Research Authority (HRA). All participants gave written consent to take part in the study. All participants were given pseudonyms to protect their identity.

2.3.5 Participants and Recruitment

Six participants were purposively recruited from two OP's mental health (OPMH) services in two different NHS trusts. These were secondary-care mental health teams for OP (65+) presenting with severe and enduring mental health difficulties. The number of participants was deemed an appropriate sample to ensure in-depth case-by-case analysis. Participants were selected by clinical psychologists who had delivered therapy, based on the eligibility criteria (Table 2-1). The first three participants referred to the project from each team took part.

All participants were approached by the clinical psychologist who identified their suitability to the project and gave consent to be contacted by the first author. Participants chose whether to participate in a semi-structured interview in person, via videoconference or over the telephone. All participants participated in person in a local NHS setting or in their home. All participants received a £10 voucher as reimbursement for their time.

There were an equal number of participants from the two localities, an equal number of people who identified as male and female, and there was a well-distributed age range. Additional participant characteristics are presented in Table 2-2.

2.3.6 Data Collection

Interviews were conducted by the first author and lasted between 40-70 minutes (mean=55 minutes). Duration of the interview was led by the participant. A topic guide was used for general considerations of what to explore with participants and how to frame complex questions (appendix A). Typical questions included “How did you feel about engaging in psychological therapy?”, “What did you expect from engaging in psychological therapy?”. Each interview varied depending on what each participant brought.

2.3.7 Data Analysis

Each interview was transcribed verbatim by an external transcription service. The process recommended in Smith et al. (2021) was followed. Once all transcripts were individually analysed, transcripts were compared, producing group experiential themes (GETs). These were decided based on prevailing narratives shared by half of participants and therefore could be useful for generally thinking about experiences (Smith, 2011a).

2.3.8 Quality Assurance

Steps were taken to ensure that the four dimensions (sensitivity to context, commitment to rigor, transparency and coherence, and impact and importance) of quality in qualitative research (Yardley, 2000) were demonstrated throughout (appendix C). The write-up phase was influenced by four IPA key quality indicators (Nizza et al., 2021).

2.4 Results

Among the three GETs established, all participants were represented in each (Table 2-4).

2.4.1 Processing my identity

The first GET captured the way participants felt like they were making sense of who they were. Therapy allowed for an exploration of participants identity and how this may have changed throughout their life. Participants suggested that their identity had been shaped by two key subthemes.

2.4.1.1 **Childhood shadows.** Participants tended to use therapy to explore their sense of self and how this may have been influenced by their upbringing. Throughout the interview, Sue described how her childhood experiences influenced her need to constantly be busy, which she now struggled to maintain due to physical health difficulties:

> If I was indoors and sitting doing something but my father came in, I would always get up, because to sit down would look as if I was lazy, which really if you think about it was a bit ridiculous [125-139]

Sue's understanding of her experiences seemed to have surprised her that she had never seen the extent of this influence until therapy.

Although being brought up in a family home with parents and in some cases, siblings, there was physical presence but emotionally, participants described often feeling alone. Cath emphasised this 'you didn't confide in my mother. She'd be the last person you'd confide in. So, you lived alone. Although you were in the house with her and your father and sister, you weren't' [164-169]. Participants tended to speak about holding emotions internally or trying to avoid them. Phil described this similarly to Fran, but his experience of having siblings seemed to give him a feeling of solidarity through their physical presence:

> I asked him, "[brother] I've never seen you cry" and [brother's wife] goes "he cries quite a bit actually". And that really shook me up… I just understood. We never talked about what happened when we were children and all that [822-833]

For Phil, it seemed to have been normalised that emotions were not spoken about, and he came to realise that his brother had learnt to express emotion with his wife, and this was something he was trying to do through therapy.

For some participants, this way of talking about their life with another human felt so unusual that it was initially unhelpful and took time to develop. Phil described how not having these experiences in childhood meant that he did not know how to talk about his life or understand the language that was being used by the psychologist 'I will carry the words because I didn't know them, they weren't understood, and you don't understand what them words mean until they tell you' [1769-1771]. This emphasised how childhood experiences also impacted how some participants felt able to engage with the psychologist.

Overall, participants seemed to realise, through therapy, how earlier experiences were influencing, how they behaved and related to others now. This was considered a valuable part of the therapy experience.

2.4.1.2 **Raised by society.** Therapy was seen to help participants recognise how society was different for them growing up, which could have contributed to their perception of self and experience of mental health. Phil described how, through therapy, he was realising that he was not the only who kept his internal experiences to himself:

> I've known him a long time. He was saying how he grew up and, again, what he was saying to me was what I was receiving. I mean the same thing… his mum and dad you know - there was no one to go to, he had to sort it out himself basically [139-154]

For Phil, therapy gave him the courage to talk about his childhood with his friend, and this was a point of normalisation that this was not just his experience. Even

the closest people in participants life often did not know the reality of the life they lived. Cath similarly explained this experience:

> I'd had a divorce and my auntie said to me "is [ex-husband] going [abroad] with you?" and I said "why would he be going with me, we've been divorced for years" and my mother hadn't told my auntie. That's something you sweep under the carpet. [220-245]

This stressed how some participants were often expected to keep a social façade to protect the way in which their family was viewed. Conversely, for Cath, her goal was not to learn anything new, but to be able to cover up her pain so that she was able to maintain that social façade she had been taught:

> I said to [family member] "I've put the TV on because I hope something will catch my attention and if it catches my attention I'm not thinking about the other thing" …She would discuss it if I wanted to, but I can't see any point [480-506]

Even after therapy, Cath saw no purpose for talking about her emotions. Speaking in therapy felt enough to control her pain again.

For some participants, they recognised how society had contributed to their sense of self as an older person. Fran's fear of seeking help was influenced by negative connotations related to age 'if it's an older adult, they're struggling with one of the nasties, if it's not dementia then it's Parkinson's, so I was very anxious what it may be' [247-252]. For Fran, she expected to have a debilitating illness purely because of her age.

The way old age is viewed in society also impacted on how some participants experienced this life transition. Sue described how society had given her an idyllic view of retirement and when this was not her reality, this impacted her mental health 'being retired is not exactly what I've imagined at all, if anyone thinks when you retire you've got all the time in the world, I haven't got any time in the world' [565-571].

Transitioning to older adulthood for some participants felt like they were no longer part of society. Ben experienced a traumatic incident in the same place he had previously

worked ‘I used to uphold the customs law there, and here’s the police…when you need them, they’re not there’ [563-566]. Ben’s experiences seem to question his sense of being in the world. He used to have purpose and be held in high regard, but now he felt disregarded by the people he used to keep safe.

Overall, participants seemed to have learnt through the process of talking, how their identities and views had been impacted by society.

2.4.2 The powerful therapy relationship

A key facilitator of change seemed to be the safety of the relationship with the psychologist. This relationship appeared to have two key functions which are reflected in the two subthemes.

2.4.2.1 **A temporary friend with boundaries.** The unique characteristics of the psychologist seemed to facilitate a special connection. Sue described her relationship with the psychologist being one that is impossible to re-create:

> If I had any difficulties, I could talk to this person and thought it'd be nice if I had this all the time. Just one person that I could rely on not to think I’m silly… I’ve always felt that if you could find a good friend, a friend that you knew would not disclose things, that would be marvellous. I have gone out of my way to find this special friend, and I had thought I found them, but then they let me down… I’ve got lots of friends, lots of colleagues but they’re not what I would class as I could talk about intimate things with [679-697]

This showed how the psychologist offered a space that promoted safety and non-judgemental listening, which was experienced as a new and welcomed experience. The confides of professional boundaries seemed reassuring to participants. It allowed a contract (whether explicit or not) which facilitated trust. Despite the relationship with the psychologist being temporary, the relationship had permanent effect. Sue explained ‘if I am in a difficulty for whatever reason, I ask myself what would the therapist do? and

usually I come up with something, don't ask me how, but that's how it works with me' [834-842].

Fran similarly spoke about the relationship being special, but the temporary aspect of this connection felt difficult to let go of 'as well as the techniques, it was also the personal support and that was a big loss, so I think I needed, if anything, support over losing [psychologist]' [687-690].

This seemed to be experienced differently amongst male participants. Ben discussed how he valued the relationship, but he felt strong enough for therapy to end 'I keep looking back at the trauma account and seeing what changes we made to it…I don't want to lapse into it – I don't think I will, it was a one-off thing that she's helped me to cure' [777-780]. In this way, the male participants seemed to use the therapy space to 'practice' techniques and then they were able to take what they had learnt back into their lives. Phil discussed how he cried in front of the psychologist 'She knew where I was coming from, definitely, she understood' [913-919]. Within the context of Phil's interview, this felt a fundamental moment of change, where for the first time, he was able to express emotion and feel safe. This allowed him to want to continue this outside of the therapy room.

Leo's relationship with the psychologist was seen differently. He felt a need for connection and company, which he appreciated from the psychologist, but this was not unique to their role 'I looked forward to her coming, but as much as anything, I looked forward to her coming, like I did you this morning. I benefitted in that I wasn't on my own' [247-256].

Social factors offered some divergence in how the relationship could facilitate change. For Leo and Cath, their experience of the therapist differed. These were the only participants who lived alone. They both spoke of not feeling able to talk to family about

their difficulties and did not want to. Leo further expressed that he would not tell his partner or son how he is authentically feeling:

> I don't tell [partner] hardly anything and I don't tell [son]… I always say 'oh I'm fine', I might just say 'I'm not having such a good day today but I'm not too bad, I'll be alright tomorrow' and leave it at that [267-277].

The temporary presence of family seemed to make it possible for both Leo and Cath to mask difficult emotions. All married participants discussed the positive impact of their spouse. Sue described how her husband helps her explore worries 'if I discuss anything with him, he's got good opinions and I follow a lot of what he tells me…he is my best friend' [723-727]. Marriage appeared to facilitate a trusting relationship, that allowed participants to take their experience of talking with the psychologist into their life. This may have also been impacted by age, whereby Cath and Leo were the eldest participants and required support to engage in social activities. Subsequently, the power of the therapeutic relationship for them seemed only to exist in the therapy sessions and not beyond.

For all participants, the boundaries of a non-judgemental, safe space were crucial to facilitate trusting conversations to help participants process their life, but whether this relationship had long-lasting effect may be influenced by external social factors. How participants felt about the relationship ending may also differ depending on gender.

2.4.2.2 The rescue. Therapy was seen by most participants as a need for a helping hand in the 'right direction'. For some participants, there seemed a necessity for someone to help. Fran used a metaphor of being on a boat to describe what she needed from therapy, and this was seen as a 'shining gem' within the transcripts. Gems are idiographic utterances from a participant that shine important and obvious light on the phenomenon (Smith, 2011b). Being 'rescued' seemed pivotal to the aims of the therapeutic process for all participants:

> At the time, an image that comes to mind is of scrabbling to get onboard a boat. Being in the river and in the water, I was just so grateful to have someone to help me climb onboard. It was very immediate. I didn't think in terms of it changing my life, I thought in terms of a rescue, somewhere I could safely explore the things that were overwhelming me…I've always seen water as a dream description of emotion. My nice image is being in a little boat on my own, among the reeds and getting towards the shore, nice little boat [557-590]

This abstract described how the process of therapy felt and the value the psychologist had in pulling Fran to safety and then teaching her to navigate life on her own.

Cath described the extent of how she felt before therapy 'I just felt as though, when you crack something hard and it all shatters. I thought one more little poke and I shall shatter into a million pieces… I stood on that step out there because I couldn't breathe' [573-578]. This need for help was shared with participants, however the rescuing journey was not plain 'sailing' for all. Phil described multiple suicide attempts, yet it was not until the third psychologist, out of four, that he had seen, that change became evident 'That's the first time I've seen any film clips, that was completely different. [Psychologist 3] probably picked up on the fact that I told her about my father and how we got treated' [792-806]. Phil identified that the psychologist listened and found another modality (video clips) to help him see things differently. Thus, the experience of being helped was a process.

Leo was the only participant that did not feel helped 'It's just this sadness, I feel like I could fall down and cry my eyes out for no reason really cause I got everything to live for' [733-737]. All other participants spoke of a processing of their past with the psychologist that had led to a level of acceptance of where they were at. Leo continued to speak about a sadness he did not understand. Considering he was invited to participate in the research as the psychologist judged him to have made positive progress, may suggest a superficial therapeutic relationship as the participant continued to feel stuck.

2.4.3 Continuing my journey

The final GET showed participants perception of therapy as an on-going process, where the two subthemes reflected change that occurred once therapy had ended.

2.4.3.1 Using what I have learnt. Participants spoke about how therapy helped them learn simple things that they could use in everyday life and gave participants dedication to start helping themselves. Fran described how having a cold shower everyday was a change she made through therapy, but spoke about the behaviour not being as important as the inner change she experienced:

> It was nothing to do with the shower, except that I feel strong enough to try it…It was the strength that I lacked, also I got back to having a walk most days, just half an hour, but most days I manage something [738-790]

Fran acknowledged that she was unable to do what she used to and had reached a level of acceptance that she could do other things, but she needed the strength to do this. Leo agreed that the psychologist offered simple changes to his life, which he was continuing, however, he did not feel like these were enough. He was hoping that other people could make the changes he felt he needed. He discussed how if his partner would allow him to live with her, his life would be different:

> She keeps that distance… I've looked up a fold-up bed on the internet and I could stay over there… it would be nice, but she won't have it at the moment… maybe I could get round it sometime, that'd be nice for me [1518-1533]

Leo struggled to accept that he had to live alone, and he did not want to live in residential care. This gave him a different experience to other participants, who could make changes for themselves.

Therapy seemed to give participants confidence to try new things. Phil described how the experience of crying in therapy allowed him to see emotion positively. 'My kids have never seen me cry. But I'm not scared to now…from that I grew strength. I feel that strongly, it makes me a stronger person. It's not bad to cry' [888-894]. The psychologist acted as a 'trial' for how people may respond before trying things outside of the session.

Phil continued to process his past after therapy through having the courage to ask his brothers questions that he never felt able to before 'I would have never asked that question or ever know. He never would have asked me that question but now I'm prepared.' [1729-1745].

Therefore, therapy was seen by some participants as an opportunity to try things out in a safe environment, but fundamental change required effort made after therapy had ended.

2.4.3.2 Accommodating a new me. Participants discussed how therapy helped them to see themselves and their life differently and they began to adapt life to meet this new version of themselves. Fran spoke about feeling more relaxed and able to spend time with friends:

> We've had more social activities than we had in the previous four years put together… very intense socially, not like me at all. I've just been able to let go of that crucial knot of anxiety 'have I got to control it all, have I got to get it right'. I've just been going with the flow. I used to feel that I had to control everything, that if I didn't [husband] wouldn't be

> able to, and now I feel if things go wrong, we won't fall off a cliff. It's a big change [789-814]

Fran highlighted that the changes she experienced differed from her original character and she was able to experience life differently.

Becoming content with the present seemed pivotal for participants who recognised that life brought different challenges to when they were younger. Sue discussed how she realised that she could accommodate her interests, whilst accounting for her physical difficulties. She used to enjoy going abroad cruising, but her husband was concerned about her physical health, so she found new ways to enjoy a holiday 'We decided just to have a break and had a wonderful time, just the two of us. It wasn't because the weather was wonderful, it didn't have to be. That's the sort of thing we'll be doing from now on' [1049-1052].

Cath didn't want to change anything in her life, but therapy helped her tolerate the emotional pain that made her feel like she was suffocating, and she recognised that she was in a state of acceptance that she was the next to die 'If you think of life as a conveyor belt, there isn't anybody in front of me now to fall off the end. So, you're on a conveyor belt and it's jogging along… that's the only way to look at it' [1634-1641]. Cath seemed to speak realistically and with acceptance that this was nature's course.

Conversely, Leo did not experience any changes to his life. He attempted to accommodate his difficulties with loneliness by listening to music and speaking to technology for company, but this was not enough, and was scared of the thought of dying alone:

> It's very simple really, just having somebody around. You know if [partner's] out in the kitchen all morning and I'm in the other room, I'd still be ok. I think I'm a bit scared. I don't know why I haven't been scared much in my life [688-692]

Leo wanted to accept his difficulties and the change in his lifestyle since getting older and to an extent this was happening, however his social environment meant he had limited ability to accommodate a life that felt of value to him. This could suggest that for therapy to support meaningful change outside of the sessions, environmental factors (e.g., social support) need to be considered.

2.5 Discussion

2.5.1 Summary of Findings

Through sharing their experiences, participants uncovered important insights into how therapy was experienced and how this may have facilitated change. Although the three GETs are discussed independently, they all overlap to gain an overall understanding of therapy experiences. Firstly, participants used therapy to process their identity, which was facilitated through the second GET of having a strong connection with the psychologist. This connection with the psychologist allowed participants to make changes through the final GET of continuing with what they had learnt from therapy. The 'shining gem' which provided a succinct commentary of the overall process of therapy as experienced by one participant highlights this overlap. All participants featured in the three GETs indicating strong convergence between participants.

2.5.2 Processing my identity

All participants used therapy to explore their childhood and the way in which society had influenced how they thought about life and subsequently behaved. These were considered essential therapeutic factors in facilitating change. There was a strong narrative among participants to hold their experiences internally and the experience of talking with someone else about these was seen as a new skill. Participants often identified that this was because of the way society taught them to express and feel emotion. Understanding how the process of talking felt for participants may support a need for the length of therapy to be longer for OP to learn how to talk about their life and to begin processing many more years of lived experience.

Understanding early life experiences is already considered key to the work of a therapist to enable a formulation of individual needs (Stangor & Walinga, 2019). This

research suggests that similarly, participants felt that therapy allowed them to process their own life. Using therapy to process their sense of identity and early life experiences accentuates a need for longitudinal formulations, where generational and cohort effects can be acknowledged during psychological assessments. This provides support for incorporating and considering both established adaptation models for OP (Knight, 1996; Laidlaw et al, 2004).

2.5.3 The powerful therapy relationship

All participants discussed the relationship with the psychologist, albeit this was highlighted to have diverse functions. For female participants, the therapy relationship was likened to a friendship, whereby female participants expressed dismay at the relationship ending. Two of the three male participants spoke with acceptance of this relationship ending and discussed using new skills to support them with existing relationships. This supports previous research suggesting that males prefer practical support, whereas females seek out therapies to share their emotions (Liddon et al., 2018). Gender differences may warrant explicit consideration in therapy when working with OP, especially when therapy ends.

Using the therapeutic relationship as a model for change i.e., how to speak differently about one's experiences and to express emotions seemed to be influenced by marriage and social support. The eldest two participants did not want to talk to anyone else about their difficulties and continued to live their life as before. This may have been due to the lack of consistent close relationships. Research has shown that social participation is important to OP (Aroogh & Shahboulaghi., 2020) and a contributor to poor health outcomes (Levasseur et al., 2010). Our study suggests a need to consider social engagement after the therapy ends.

Despite the differences, the therapeutic relationship was considered a safe base for participants to share their experiences. This supports previous research which has found

that the therapeutic relationship may determine therapeutic effectiveness when working with OP (Mace et al., 2017).

2.5.4 Continuing my journey

To continue making progress after therapy, participants indicated two key abilities- to accept the present and the ability to accommodate their difficulties. Some participants alluded to already knowing how their behaviour needed to change, but therapy supported them to gain the inner strength to make these changes. For some participants, this allowed for a change in identity which refutes developmental theories which suggest identity is formed in early adulthood and older adulthood is predominantly a period of reflection (Erikson, 1993).

Participants alluded to experiencing a different type of life as an OP, which may accompany changes to identity. Thus, therapy could be beneficial in helping OP understand that their sense of self can be different depending on the context in which they now find themselves. Where acceptance and accommodation of difficulties were difficult for one participant, this was seen to influence his experience of therapy. This places further importance on supporting environmental changes beyond therapy, such as social connection.

2.5.5 Measuring the effectiveness of psychological therapy

Whilst these findings are specific to a small cohort of OP, the strong convergence in findings, could help future research in informing appropriate outcome measures sensitive to change for OP in OPMH services. Typically, outcome measures have focused on reducing symptomology, but this was not a key theme amongst participants. In contrast, these participants suggest the following as important for positive progress in therapy:

- Strength of the therapeutic relationship

- Feeling safe to discuss early life experiences
- Understanding the development of identity and sense of self
- Understanding emotional experiences
- Acceptance of presenting problems and related emotions
- Ability to use what is learnt in everyday life
- Ability to accommodate difficulties

Further psychometric research would support the generalisability of these findings.

2.5.6 Limitations

Whilst acknowledging the important insights from these study results, we view them within the context of some study limitations.

2.5.6.1 Study recruitment. Participants were recruited due to the psychologist's perception that they had made positive progress. One of the participants did not agree with this perspective. This participant was still included in the analysis. Although his experience was different, his narratives featured within the same GETs highlighting how he valued the same things as other participants despite not feeling they were achieved. Further research focussing on participants experiences when positive progress is not made may ascertain whether convergence in themes still occurs.

Similarly, within the context of Covid-19, one participant engaged in therapy via video. Although this participant's narrative was seen as a 'shining gem' within the GET focusing on the therapeutic relationship, research has shown that video therapy may act as a barrier to establishing rapport (Freytag et al.2022). Further research is therefore necessary to ascertain whether modality of therapy impacts findings.

Although the interviewer's aim was to focus on the most recent episode of therapy, it was clear that participants experienced therapy as a cumulative journey. For one

participant, he spoke primarily of his experience with a psychologist whilst residing in hospital, before continuing therapy in the community with a different psychologist. Thus, length of total psychological experience would have been beneficial to record. Given that participants spoke about the therapy process being new (despite experiencing therapy before) and the participant who had not felt like he had made progress had not experienced therapy before, suggests that therapy length is likely important and requires further exploration.

2.5.6.2 Diagnoses. Information on why participants had engaged in therapy was deemed unnecessary to gain a transdiagnostic sense of how therapy was experienced. For some participants, this information was explicitly given within the interviews and may have contributed to their experience. One participant experienced a single-event trauma, where he sought a specific treatment to help him to process the trauma and once this was completed, he felt better. It would be interesting to compare positive progress experiences with OP in primary care services to see whether mental health severity impacts findings.

2.5.7 Conclusion

Participants provide important insights into their experiences of psychological therapy through exploring their identity, the therapeutic relationship, and generalising what they have learnt into their everyday lives. Developing new psychometric tools from these GETs would provide a novel and idiosyncratic approach to improving outcome measurement in OPMH services.

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2.8 Chapter 2 Appendices

Topic Guide

Topic Focus	**Core Question**	**Prompts/supplementary Questions**
Introduction Question	How did you feel about engaging in psychological therapy?	
Type of Therapy	How did you engage in your most recent therapy?	-Video -Face to Face -Telephone -Mixture What were your experiences of engaging in therapy in this way? Did this affect your experiences in anyway?
Expectations	What did you expect to achieve from engaging in psychological therapy?	-Where did expectations come from? -What information did you have about therapy? -How did psychological therapy meet/alter your expectations? -Cohort Effects
Benefits	How did you feel after engaging in therapy?	-Emotional -Thinking skills e.g. thought challenging -Physical -Relationships -Social -When did you notice these changes? -What did you notice first?
Maintaining Therapy Outcomes	Following your experience of therapy, what is your understanding of how you can maintain these benefits?	-Strategies -Coping skills
Other perspectives	How would other people around you notice you had benefited from psychological therapy?	-Family -Friends -Professionals -Strangers -Who noticed changes first?
Surprises	What unexpected changes have you noticed from engaging in psychological therapy?	-Why do you think this was unexpected?
Anything else?	Is there anything else you would like to tell me about your experiences of engaging in psychological therapy?	

Chapter 2 Appendix B

Abstracts taken from my reflective log when reflecting on Phil's interview and transcript to support the process of GET formation

Phil Interview Reflections

I feel there was something fascinating about his example of not understanding words the psychologist used such as "resonate" which he struggled to say, but later used this word on numerous occasions to describe his experiences. Language was a focal point for this participant, and this made me wonder about the impact of society mean-making using language and how imperative it is to human lives. [Later contributed to the GET of processing my identity and the sub-theme around being raised by society]

Phil Free-coding Reflections

From initially reading the transcript over a few times, before going onto the next stage of experiential statement forming, the same themes were coming to the forefront of my mind:

- The importance of learning to talk about the past, which was something never done before
- The importance of others showing care for you that wasn't felt as a child
- The importance of self-determination to get better
- The importance of other ways of helping rather than the use of speech

Phil – Reflections on his account of therapy (experiencing multiple psychologist's)

I found it interesting that he spoke about getting help from different psychologists during different admissions into hospital and how there wasn't much difference between them. However, it wasn't until the last time that registered because the difference was in himself. He felt a different motivation to get better, although that could have been because the psychologist this time around used a different type of technique – a visual way of understanding him that really stuck for him. [Later contributed to the GET's the powerful therapy relationship and continuing my journey]

Phil - Supervision around experiential statements

We discussed the shared experience of the participant with his siblings – living in the same house, being subjected to the same abuse and despite never talking about it, feeling a sense of comfort that someone had experienced it with him. This bond was unlike any other. My supervisor had gone through the parts of the transcript that spoke similarly about these experiences and shared with me his reflections. From this, we came to an agreement of an experiential theme of – 'unspoken solidarity'. This felt like it captured the participants experience well and this was placed within the PET of 're-writing my story' given that unspoken solidarity had now become spoken given the experience of therapy. [Later contributed to the GET formation of processing my identity]

Phil - Creating personal experiential themes

When I had placed the experiential statements out, they seemed to have a start a middle and an end, with all statements referring to either his childhood – how his age brought his childhood more to light through things like retirement and how his childhood had contributed to his mental health through generational patterns of keeping things private and not being able to acknowledge or express his emotions.

Chapter 2 Appendix C. Table demonstrating the four dimensions of quality (Yardley, 2000) across each project phase

Study Rationale	The topic guide was disseminated to four clinical psychologists working in OP NHS trusts around the country (excluding those involved in the current study) for their perspective on content and appropriateness to the research question. A practice interview was conducted with a clinical psychologist working with OP and a bridling interview was conducted, where the researcher interviewed herself to gain feedback on interview technique, ensure questions were not leading, highlight complexities in questions, and to gain a felt sense of what it is like to be interviewed. This was then reflected on with a supervisor (WD) to overcome any challenges.
Data Collection	To limit the influence of previous participant's interviews prompting the interviewer, participants were interviewed at least one week apart. Throughout the interviews, the interviewer summarised in her own words what the participant had said. This meant participants were given the opportunity to ensure their story was heard as accurately as possible. At the end of the interview, all participants were asked if they would like to speak about anything else that felt important to their experience. The first author listened to parts of each recording to confirm accuracy of transcription.
Data Analysis	Detailed tables and themes were made for each participant to firstly focus on the particular before focussing on shared meanings. Triangulation was used to ensure the quality and validity which included a selection of individual analyses being cross-checked by a supervisor (WD) and external expert in qualitative research (MH). Where the first author struggled to label meaning in individual transcripts, this was reflected on and shared anonymously within an IPA specialist researcher group to gain feedback and re-consider meaning. This is an essential part of the hermeneutic loop, whereby researchers challenge and understand their own assumptions and beliefs in the meaning-making of a participant's shared account in the analysis process.
All Phases	Regular supervision was provided through every phase with the second researcher (WD). These were documented in the reflective log and provided in the audit trails for complimentary perspectives, to highlight influences on interpretation and to reduce offering hierarchical importance to another researcher. Internal auditing was conducted by a second researcher (WD). This was completed through an audit trial, a document offering transparency in decision making across all steps of the project.

Appendix B. Demonstration of key quality indicators as recommended by Nizza et al. (2021)

Quality Indicator	Method
Constructing a compelling, unfolding narrative	Carefully selected quotes were picked to tell the narrative across participants and within a participant. For example; Phil was used to highlight his experience of therapy through all of the GETs beginning with how his childhood had impacted the person he perceived he was, how therapy helped him to process this and how this led to him behaving differently. Whilst doing this, the other participants were interweaved to strengthen shared meaning and to also offer nuanced perspectives of themes.
Developing a vigorous experiential and/or existential meaning	This was articulated through a reflective log, whereby participant meaning-making was understood and interpreted through the interview process, after the interviews, through reading the transcripts and through discussions with a supervisor (WD) and through sharing meaning-making with an expert in IPA (MH).
Close analytical reading of participants words	Each participant's transcript was read and commented on line-by-line. Where important contextual, linguistic or semantic information was conveyed this was highlighted separately. This allowed for the careful selection of quotes to demonstrate experience and a deeper interpretation of participant experience
Attending to convergence and divergence	Themes were carefully considered to offer important convergences, whilst ensuring that divergences were not excluded. A reflective log captured how GETs were constructed to allow for the incorporation of divergence – specifically for one participant (Leo) who's experience of therapy was different to the others yet offered divergence to the overall GET formation.

Chapter 2 Appendix E. Journal style guidelines for Journal Aging and Mental Health

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

Please include a word count for your paper.

A typical paper for this journal should be no more than 7,000 words for quantitative papers and 8,000 words for qualitative papers inclusive of

- figures
- tables
- references
- tables

Appendix excluded.

Any spelling style is acceptable so long as it is consistent within the manuscript.

Please use single quotation marks, except where ‘a quotation is “within” a quotation’.

Please note that long quotations should be indented without quotation marks.

Font

Use Times New Roman font in size 12 with double-line spacing.

Margins

Margins should be at least 2.5cm (1 inch).

Title

Use bold for your article title, with an initial capital letter for any proper nouns.

Abstract

Indicate the abstract paragraph with a heading or by reducing the font size.

Headings

This will show you the different levels of the heading section in your article:

First-level headings (e.g. Introduction, Conclusion) should be in bold, with an initial capital letter for any proper nouns.

Second-level headings should be in bold italics, with an initial capital letter for any proper nouns.

Third-level headings should be in italics, with an initial capital letter for any proper nouns.

Fourth-level headings should be in bold italics, at the beginning of a paragraph. The text follows immediately after a full stop (full point) or other punctuation mark.

Fifth-level headings should be in italics, at the beginning of a paragraph. The text follows immediately after a full stop (full point) or other punctuation mark.”

2.9 Chapter 2 Tables

Table 2-1. Participant inclusion and exclusion criteria for study eligibility

Inclusion Criteria	**Exclusion Criteria**
Participants aged 65+	Those with a suspected cognitive impairment
Previously met the criteria for a secondary-care mental health service	Those who do not have the capacity to consent for themselves
Engaged in a psychological therapy with a clinical psychologist	
Had made positive progress from the beginning to the end of psychological therapy	
Discharged from the psychology team within the last 12 months	

Table 2-2. Characteristics of Participants

Pseudonym	Gender	Age	Ethnicity	Previous experience of psychological therapy (before aged 65)	Previous experience of therapy (over 65)	Modality of therapy received	Duration of most recent therapy
Ben	M	71	White British	No	No	F2F*	1 Year, weekly
Sue	F	79	Scottish	Yes	Yes	F2F	13 weeks, weekly
Phil	M	69	White British/Irish	No	Yes	F2F	1 year, monthly
Fran	F	77	White British	Yes	No	Video	9 months, weekly
Leo	M	87	White British	No	No	F2F	6 months, weekly
Cath	F	87	English	No	No	F2F	4 months, weekly

** Note. F2F – Face to Face*

Table 2-3. IPA recommended steps for analysis (Smith et al., 2021)

Step 1	Read and re-read transcript
Step 2	Reflect on the general meaning-making of the transcript as a whole
Step 3	Make exploratory notes detailing any areas that stand out to the interviewer by reading the transcript line-by-line
Step 4	Construct exploratory statements which define key meanings within sections of the transcript
Step 5	Form personal experiential themes by grouping experiential statements creating key themes across the entire transcript. This was initially completed by hand and then typed into a word document.
Step 6	Compare personal experiential themes across individual transcripts to produce group experiential themes. This was initially completed by hand and continually revisited and revised.

Table 2-4. Prevalence table showing participants who represented each theme

Themes	Prevalence: Participants represented within the theme
GET 1: Processing my identity	(6)
Sub-theme 1: Childhood shadows	Phil, Leo, Sue, Cath (4)
Sub-theme 2: Raised by society	Ben, Fran, Leo, Cath (4)
GET 2: The powerful therapy relationship	(6)
Sub-theme 1: A temporary friend with boundaries	Ben, Sue, Fran, Leo, Cath (4)
Sub-theme 2: The rescue	Sue, Fran, Cath, Phil (4)
GET 3: Continuing my journey	(6)
Sub-theme 1: Using what I have learnt	Ben, Phil, Fran, Leo (4)
Sub-theme 2: Accommodating a new me	Sue, Phil, Fran, Cath (4)

Supplementary Material for Peer-Review

Project Audit Trail

Interview Topic Guide Version 1

Topic Focus	Core Question	Prompts/supplementary Questions
Introduction Question	How did you feel about engaging in psychological therapy?	
Type of Therapy	How did you engage in your most recent therapy?	-Video -Face to Face -Telephone -Mixture What were your experiences of engaging in therapy in this way? Did this affect your experiences in anyway?
Expectations	What did you expect to achieve from engaging in psychological therapy?	-Where did expectations come from? -What information did you have about therapy?
Benefits	What differences in your life did you notice after engaging in psychological therapy?	-Emotional -Cognitive -Physical -Relationships -Social -When did you notice these changes? -What did you notice first?
Other perspectives	How would other people around you notice you had benefited from psychological therapy?	-Family -Friends -Professionals -Strangers -Who noticed changes first?
Surprises	What unexpected changes have you noticed from engaging in psychological therapy?	-Why do you think this was unexpected?
Anything else?	Is there anything else you would like to tell me about your experiences of engaging in	

	psychological therapy?	

Feedback obtained on topic guide

Psychologist 1:

I wonder whether it would be helpful to hear more about how the person came to be referred for therapy – in my experience, very few older people in my service request therapy – they may have compliantly agreed when a psychiatrist/CPN/other suggested it, with little understanding of what it is for or how it could be of use to them. This often shapes how useful therapy may be – those who seek it out are often clearer about what they are after from therapy.

Perhaps also worth considering whether the client was seen in clinic vs home visit. Pre-covid, we typically did home visits which brings lots of positives but also multiple challenges, for client and clinician. However, I wonder whether home visits impact on engagement – I suspect if I expected everyone to see me in clinic my DNA rates would be higher and fewer people would continue the work.

Cohort beliefs will be relevant– when did they grow up? Views re: Institutions and how these impacts on their beliefs about MH input? War time baby – "pull yourself together and get on with it" attitude?

I'm not sure if this will be relevant to your study, but thinking about outcome measures being quite diagnostic / symptom based typically, I wonder if it would be helpful to think about a client's understanding of their MH difficulty pre/post therapy? I.e., did they view it in a medicalised way pre therapy and did that change? I guess I'm thinking about the research about the relationship being the key factor too and how viewing a MH problem from a more psychological than medical perspective might influence their experience of therapy? Sorry, my thoughts aren't fully formed on what I'm trying to say here but I think I use the outcome measures as a bit of a tick box sometimes, aware that they don't always change that much as we might be working on getting a better understanding of a person's difficulties rather than symptom-reduction.

Psychologist 2:

I have looked over the topic guide and feel that it is likely to promote responses that will answer the question. I assume that the questions are intended to be trans-theoretical and therefore the model underpinning the therapy is not being explored? As an IPA thesis person too, I applaud the use of qualitative research to try and get a more robust idea around this issue and will look on for the results as they come out.

Psychologist 3:

It made me think about a pilot we ran for a group therapy using ACT for OP for comorbid physical and mental health issues just before the first covid-19 outbreak. We evaluated this pilot at the end with the participants and the question they were asked to answer was what they thought they've gained from this particular group therapy. One of the tools we used was Thematic Analysis (Braun and Clarke, 2006) and the emerging themes were:

- therapeutic change/gains - participants gave examples of how this was reflected in their thought processes, emotional resilience, meaningful goal setting, realignment with values, general activity and interpersonal communication

- therapeutic process – group dynamics and alliance, therapeutic relationships with facilitators, social element of the group and opportunities for shared humanity experiences (normalisation)
- therapeutic resources (level of structure, support materials, frequency of input, duration of sessions)
- expectations regarding therapy (and towards accessing therapy)

Here are some of the points we asked feedback on:
- clear idea on the purpose of the intervention
- the language used by clinicians was straightforward
- the level of information share was appropriate to individual needs
- the number of sessions was appropriate for individual circumstances
- the length of the sessions was appropriate for individual circumstances
- the balance between assignments/work sheets and reflective process was good
- working psychologically with others was important
- sharing experiences with others was important
- feeling listened to and supported
- being able to understand difficulties and strengths better
- being (more) able to reflect on values and committed actions
- being able to commit more to improving own quality of life
- knowing how to ask for future help when needed
- would recommend psychological therapy to others

(2) We also ran some time ago a SU Feedback Forum where we explored people's experiences referring to their engagement with the psychology service. We used the World Café Method (Brown and Isaacs, 2005) for 5 open ended questions:

- what was your experience of your referral to the psychology service
- what was your experience of psychological sessions
- how easy/ challenging has it been for you to access services
- what was your experience of discharge from the service
- is there anything you would change about your experience

The emerging themes were related to:
- referral pathway (reason for referral, waiting times)
- intervention process (subjective report of therapeutic change/gains, values)
- location and modality of intervention
- expectation of services
- contained endings
- cohort beliefs

(3) Finally, some suggestions from relapse prevention/maintaining progress plans that I usually draw together with SU at the end of their individual therapy:
- what I have learned in therapy
- what was most useful in therapy (it can be a relevant therapeutic link, it can be a specific resource, it can be a trained skill, the therapeutic relationship, etc.)
- what was less helpful in therapy (again, it can refer to content or process)
- how can I work towards maintaining my gains and preventing a relapse
- how can I overcome a relapse or work my way out of a crisis
- what are my strengths and difficulties here and now
- something compassionate to say to my 'old me'
- something encouraging to say to my 'future me'

Psychologist 4:

Sorry I can't be more constructive except to say this looks really good and I am really impressed that you are looking at it from the service user angle – we are currently reviewing what outcomes we use in our OP inpatient service and find them similarly flawed!

Revised Final Interview Topic Guide

Topic Focus	Core Question	Prompts/supplementary Questions
Introduction Question	How did you feel about engaging in psychological therapy?	
Type of Therapy	How did you engage in your most recent therapy?	-Video -Face to Face -Telephone -Mixture What were your experiences of engaging in therapy in this way? Did this affect your experiences in anyway?
Expectations	What did you expect to achieve from engaging in psychological therapy?	-Where did expectations come from? -What information did you have about therapy? -How did psychological therapy meet/alter your expectations? -Cohort Effects
Benefits	How did you feel after engaging in therapy?	-Emotional -Thinking skills e.g. thought challenging -Physical -Relationships -Social -When did you notice these changes? -What did you notice first?
Maintaining Therapy Outcomes	Following your experience of therapy, what is your understanding of how you can maintain these benefits?	-Strategies -Coping skills
Other perspectives	How would other people around you notice you had	-Family -Friends -Professionals

	benefited from psychological therapy?	-Strangers -Who noticed changes first?
Surprises	What unexpected changes have you noticed from engaging in psychological therapy?	-Why do you think this was unexpected?
Anything else?	Is there anything else you would like to tell me about your experiences of engaging in psychological therapy?	

Reflective Log

Bridling interview Reflections

Expectations – I found it difficult in knowing how far to go into previous therapy if they feel expectations came from past experiences of therapy. May be useful to explore whether they felt change came from the current episode of care or it was a continuation of change through multiple experiences of psychological therapy. Whether there were differences in the care that was received from then and until now.

Style of Questioning – I realised that I needed to be cautious about using closed questions. This can be automatic when asking questions. I found I was able to get a much deeper level of enquiry when I was asking open-ended questions. To improve, I should take time to consider my level of response and to feel able to sit with silence to have a period of processing of what the participant has said.

Cohort Effect – This needs to be sensitive with how this is asked. Ways of asking could include how do you think society over time has contributed to your experiences of being in mental health services? [***Explore sensitivity of this subject in supervision prior to interviews]***

How did you feel after engaging in therapy? – I feel that I need to consider literal responses to time. Explore not just directly after a session but in comparison to how someone felt pre having therapy at all. What differences did it make to their life? What would life have looked like if they hadn't engaged in therapy?

Surprises – I need to consider alternative ways of asking this question - has anything surprised you about what you gained from therapy?

I noticed that I need to try to stick to the nuance of what the participant is saying. There is a temptation to follow the topic guide, which may not match what the participant wants to bring and may miss important relevance from the person. Consider what they bring and why they have brought it. Why have they chosen to speak about something, why is that important to them and why did that really matter to their experience of therapy?

Supervision reflections around sensitivity of asking about cohort effects

Reflections around the likelihood of being able to ask about cohort effects naturally and how this should flow from the conversation. Supervisor suggestions when this does not come naturally so that questions feel sensitive:

- You were seen by an older adult psychology service; how did that feel for you?
- Do you think your age was an important factor in how you engaged in therapy? And how you benefited?
- Were there any key events growing up that you feel led to you feeling a certain way about mental health?
- How do you think society shaped your views on mental health growing up?

Practice Interview Reflections with supervisor

- Interesting areas of enquiry – I noticed that I diverted away from the research question at times. I highlight a difference between research vs. therapy i.e. things I may want to know in therapy vs. things that are relevant for this project may differ. It was hard to take the psychologist out of the researcher. Pros and cons of this. Positives around really being present with the client and focussing on what they want to bring. However, be cautious about the purpose of the interview being about how they experienced therapy. I question whether exploring how they experienced mental health may be going off tangent and too in depth of their "problem" of coming to therapy, but in some cases this may be helpful in exploring how therapy helped with their experience of mental health by understanding both of these. I need to be mindful when having this internal debate within the interview (if necessary) on the participants engagement/any signs of uncomfortableness and distress. To be sensitive to their directions. Equally, if this is what they want to discuss, this should not be shut down.
- What do I need to know vs. what am I curious about? Are these the same thing? I was finding myself wondering if I needed to know things for the purpose of the interview (i.e. to get their experience of therapy) or whether I was asking because I was generally interested but it wasn't relevant to the question (how did it feel to experience those panic attacks?) Important to give reflections after the interview to outline when this may be the case. Also, a sign that I am very emersed in my participants experiences.
- Felt repetitive at times, I wanted to tease out more information, but my form of questioning was giving the same answers. Give time between responses to sit with silence and process what has been said before responding as this tended to give a closed question response.
- Try not to validate or assume feeling. For example "that sounds painful" – elicit the feeling from the client. "I'm sensing pain from your answer there, how did it feel for you?"

Interview to analysis reflections per participant

Ben Interview Reflections

I noticed that it was difficult to not untangle the reason for being in therapy.

It was interesting that the participant focussed on his diagnosis and the experiences of mental health/differential diagnosis before trauma and how this may have contributed to progress in therapy this time around. I had tried to not be specific about diagnosis in my questioning, however I appreciated how important this was for this participant and

therefore did further enquire about this. I realised my own biases/therapy stance coming into play here because I tend to dislike diagnostic labels and prefer thinking about a clients experience irrespective of diagnosis. I was able to look past this to use the participants own language and meaning he got from his established diagnoses.

The experiences of being old… I was curious about this and how this participant made sense of this. He discussed how being old meant that he was more likely to experience poor mental health due to the lack of ability to shake things off. He discussed how retirement had a big impact on the way in which he felt he dealt with problems meaning he had more time to think and ruminate about events in his life (both past and present).

I felt after this interview that going forward it would be good to ask participants about length of therapy as this participant felt this really made a difference and that therapy ended at the right time. This may deviate amongst participants who are seen for different lengths of time. To ensure I can think about participants in a homogenous way, it will be worthy to know length of therapy as a standard demographic.

After the interview, I reflected on the duration time. I had anticipated that interviews would last up to 90 minutes, however this interview only lasted 39 minutes. Despite me feeling interested and completely with the participant. A couple of reasons this may not have lasted longer were:

- The participant started to look at his watch around this time. This made me uneasy and like he had come to the end of wanting to talk, so naturally I began to end the interview.
- On occasions, the participant reported not being able to recall certain details of therapy due to the nature of his mental health difficulties and the place he was in at the time.
- The participant said on occasions "that's a good question" before trying to think of how to answer it but for some questions he was unable to give a reason, and this perhaps reflects changes that happen to people without a conscious understanding of the processes that facilitate that change.

Ben Initial reading of transcript reflections

One of the things that struck me as important was his relationship with his wife. This being the precursor to him knowing when he needed support with his mental health, when things between them were difficult and they were having arguments. Within this, there were lots of attitudes around self-blame and him being the reason they fight, leading to him losing her in the past. This also being pertinent for the reason he had gone to therapy and not being able to cope (comparing himself to others, particularly his wife). This was a theme right until the end when we spoke about the future and what he may need to get better, and he responded with that he had been given it all and there was nothing left.

What I also have initially noted is his insightfulness to his difficulties. Understanding that he was unwell and researching what he needed to get better and bringing this to his psychiatrist. My assumption from working in services is that older people may not understand when they are unwell as much as younger people. This participant challenged this assumption.

The participant made a direct comparison to the difference in his age, being classified as an older person and the mental health of someone classified as young. The difference in being able to 'just move on' when you are younger but the additional time of older retired people meaning there is more time for your mind to dwell and ruminate on difficulties that are faced.

Ben Free-coding reflections

One thing I am struggling to find the right words to capture is the participant continuing to bring the question back to his trauma each time. It feels like he is trying to tell me he's feeling better, and therapy is the reason for this, but wanting to highlight that this was a really serious incident, and no-one quite understood how serious it was. I also get a sense that he doesn't understand why people didn't see the severity of it given he nearly died and the 'what if's' of the situation meant things could have been a catastrophe. Because he is still alive and physically ok, people have disregarded his response to the incident that led him to therapy. He wonders if he still held his previous job and hence his position in society whether this would have happened.

This leaves me to interpret what he is saying as psychology gave him someone who understood, who did not disregard this as insignificant, and this led to him thinking about it differently and being able to move on with his life.

Ben Making exploratory notes – reflections

One thing I found surprising about this participant and made me think about my assumptions of older people was his knowledge that he had acquired himself through his own research. He had used the internet to understand what was happening to him. My assumption was that older people may be less likely to use technology and this may be reflective of his age as a younger older person. Within his research of what was needed he made effort to reassure me that he only looks at the 'good' websites and the NHS ones to tell me that he listens to what he should and shouldn't do. Throughout, there is this theme of doing the right thing – looking at the right websites and feeling an injustice to what had happened to him. The woman shouldn't have crashed her car, the police should have listened to him, the ambulance should have been called, he shouldn't need to feel this, the insurance company shouldn't be asking him all these questions and now what he should be feeling and what should he be doing. I wonder if this is specific to older people, these feelings of right and wrong and whether society have encouraged this generation to behave in a certain way and when they don't, they feel guilty or when others don't, they feel angry. Societal rules may therefore lead them feeling a particular way.

I have also tried to write on the transcript and park my own feelings towards his use of being given CBT, and how he knew this was he needed because it is recommended by the NHS. From my own knowledge I know that CBT has utility for older people but can have limited utility. It is the most researched therapy due to funding and there are pros and cons to this, but people will find the research on CBT because it is more readily available, and this participant went into therapy based on this with an assumption that he should get CBT and it should be helpful. It left me wondering how useful this was – was this something that contributed to successful outcomes? And could this have had the opposite effect if he didn't benefit? Even though the participant told me he was having CBT, this was not information I got from the therapist and based on what he achieved in the therapy, it made me wonder if the psychologist may have also used other approaches, especially how the participant is trying to accept what has happened to him. He does not necessarily think about alternatives to the problem but speaks about accepting them as they are. I wonder if this matters to my research question?

Ben - Forming experiential statements reflections

I found it easy to see what parts of the transcript resonated for the participant and were of significance – those in which he delved into for longer and the words which came with non-verbal cues such as sighs and repetition of speak. There was a part that felt important to capture which was when I asked the participant "Despite how uncomfortable it was, you

kept coming each week. What kept you coming back and living through how uncomfortable it was?" and he laughed and said "good question, in short- I don't know". This felt important in the room, but it also took me back to the interview and the feeling in the room. I felt a sense of shock from his voice when I asked that question as if he was saying – you're right, that was difficult, and I kept at it, but I have no idea where I found the strength or why. I found it hard to label this statement, but these reflections have helped me think about this as 'inner strength'. Therapy giving him the inner strength to face his difficulties.

The other experiential statement I struggled to form without just paraphrasing what the participant was saying, was around how he described his age as being a contributing factor to his mental health difficulties. Detailing how as you get older you need more assistance to do things and how you spend more time thinking and ruminating about things. Whereas when you are younger you "just get on with it" as you have a family and a job to focus on. The phrase 'older but not wiser' came to mind and feels like it captures the participants feeling that despite now retiring he feels less equipped to deal with the challenges of life.

Something that I wanted to highlight as a short quote but something that felt very powerful was his reference to the yachting village and the reason this came to mind for him, as where the trauma took place and how he had contributed so much to this society, holding importance there in his job role and now he needs a service back, no-one is there. How unjust that feels and how he feels owed by society. I felt this was very important to his sense of injustice and how he looked back at his life. Something that seems important to this age group also.

Ben - Personal experiential statement reflections

When I was laying the experiential statements out in front of me– they all seemed to cluster around three broad topics. One around how the participant saw himself within society from his upbringing and occupational roles to how he sees himself in the world now. This felt important to understanding how this impacted on his mental health and treatment perception. The second was around feeling a need to talk about his experiences, not knowing how needing to be heard and understood so that he could have help to get better. The third cluster of statements, I felt could have been split up more but overall, they told the complete story of therapy for him from feeling desperate and like things were unbearable to finding ways to manage this, new ways of thinking and feeling to now being present and content with how things are in life. However, understanding that this was a very long and difficult process with his journey being continuous and now having to manage this for himself. These three broad themes were made into the following statements:

1. My place in society

The participant speaks of societal influences on his mental health. From feeling like he cannot seek support because mental health is not as acknowledged as physical health problems. From feeling better that his symptoms can be classified into a recognised disorder (suggesting recognition in society) to feeling like he had served society in his occupation and now he was left to not be cared for, and as if what he had contributed in society no longer matters.

2. Someone to navigate this with

The participant speaks about this episode of mental health difficulties being different to ones he had experienced in the past. He felt a real need to speak about his problems and this was frustrating the people close to him. He felt speaking to a psychologist was the only way to get better.

3. My own journey I must continue

The participant recognised that it was his self-determination that allowed positive change to happen. He was so dominated by his emotions, that he was eager to seek help and it was due to this persistence that he felt he got what he needed. The psychologist was with him, but it was his ability to keep showing up despite it feeling difficult and his ability to recognise when he was doing things that were unhelpful and to change these so that they could be helpful to his recovery.

I feel that there is huge overlap between the last two themes with them both working together, how the psychologist helped him but how he also felt responsible to help himself.

Sue Interview Reflections

I found it difficult in this interview to keep bringing it back to the question relating to the therapy experience because I did not want to invalidate the personal life aspects she was bringing to the interview. I got the impression from her that she did not have a direct answer into what the underlying facilitators of change were. Although she spoke positively about the process, she felt unable to really pinpoint what it was – although gave some suggestions.

I found it hard to gain an understanding of what had changed from therapy because she was unclear of what she noticed in herself before therapy. I got a sense that she did not want to delve too much into the reasons of coming into therapy, so this meant that it was harder to detail those aspects that had changed. I was cautious to be sensitive and respectful to that, as she had the right to be in control of what she spoke about, and this was not a therapy session.

It was also hard not to assume what had changed for her by filling in gaps of her story that she had told. For example, when thinking about what had changed, I felt like highlighting the change from being a private person to now engaging in research about her life being a significant change. However, I did not want to put these words in her mouth. Although, I could see this as something that may have changed, I really felt that this was a value she continued to hold about herself. Her diagnosis of Parkinson's not being seen to the world felt important to her and this seemed to be associated with pride that unless she told people, they would not know.

When she disclosed that she had Parkinson's, I was torn with whether she met the criteria to be a participant due to cognitive changes that can occur as a result. However, due to her diagnosis being 18 years prior and the psychologist referring her because she felt she met the eligibility criteria, I felt it was important to continue. This highlighted the importance of speaking to people without assuming difficulties they have based on the label they possess.

I was interested in her experiences of retirement as a woman. Loss is acknowledged in relation to retirement in older adult services and in the media, but I've always seen this from a male perspective, and I was intrigued by those connections for her also. This led me to wonder whether gender differences (and similarities) are also disregarded when we think about what is important for people.

Another pertinent aspect that I felt came up was the strength of her marriage and how her husband was her safety. This felt very important in her recovery outside of therapy and in feeling like a protective factor.

The choice words of friendship with boundaries also connected with me. It initially felt uncomfortable when she labelled the psychologist as a friend, immediately assuming a loss of boundaries but when I really thought about what she was saying, this made sense in

terms of feeling comfortable to speak to someone else when there is a contract in place for confidentiality and a code of practice where you are under an obligation to be person-centred and non-judgemental. This felt a powerful statement to make.

I caught myself asking double questions a lot and I would like to remind myself to ask a question and leave space to answer it or to think more before I ask a question to avoid this for future interviews.

Sue - Initial Reading Reflections

A huge tendency running through this transcript which I had not picked up on whilst I was in the room with the participant was the need for her to justify all her negative experiences and to put a positive spin on everything. This was particularly important I feel when she speaks about her childhood and her relationship with her father. Although she never explicitly says, I feel she was telling me that the relationship she had with him was challenging and hugely contributed to her mental health difficulties and the way in which she viewed herself. However, this felt too difficult to say out loud and each time she mentions anything negative about her father she immediately catches herself and discusses how also positive those aspects of his personality were, to the degree that she lost the point of the question and asked to be reminded. This did not feel influenced by any cognitive inability but by a psychological block where aspects of trauma felt as though they were surfacing, and she did not want to discuss this.

Another overarching theme whilst reading this back was the loss of occupation and purpose she felt in life. She speaks very proudly of herself and the many things she can do and has achieved in her life and how getting older and experiencing physical ailments has taken this away from her and she struggles to accept that. She implies on numerous occasions that her mind is still the same, but her body does not allow for it to operate in the way that it would like to.

Relationships were a key point for her. She details the relationship with her father as an influence for her needing therapy. She pinpoints the value in the psychologist and her relationship with her as being pivotal to change and the relationship with her husband being the maintaining factor to keeping her well and looking after her. All these relationships she speaks about in a way in which they are all the positive reasons for her getting anywhere in day-to-day life, taking ownerships away from herself at what she's done to help herself get better.

Sue - Methodological Reflections

I felt there were times my interview technique let me down in being able to get the most out of the participant. For example, there was a time where I asked her if she was working (after speaking about the feeling of having a need to let go of tasks at her age). When she said no, there feels like there is more she wants to stay but I moved on to asking her a different question. If I had stuck with this topic, there may have been some useful insights into how this part of her story was impacted or viewed similarly/differently through therapy.

I found there were lots of ways I could enquire more into what she was saying but it was difficult to keep these avenues in mind whilst being fully present with the participant. I thus, feel this made me lose thread of things I wanted to ask at times.

The participant throughout kept saying "What else?" to herself and I felt there was a want to tell me what she thought I wanted to know about. This may, however, been part of her character. There were times I think my questioning took her by surprise because I got more out of her than perhaps, she may have anticipated sharing. This also worried me because I

didn't want her to feel uncomfortable. This meant I was unable to ask curious 'why' questions to things that may have given me a deeper understanding of the participant. For example, when she was talking about friends never knowing about her, it would have been good to ascertain whether that was important to her or why she felt this need. Was it out of embarrassment? It would have been worthy of getting the feeling that accompanied these behaviours. I felt a big pull from being an unbiased researcher wanting to get an answer to my research to feeling sensitive to a person telling a stranger her story and aspects she may not feel comfortable with.

Sue - Free Coding Reflections

I felt that so much this participant said felt important to her that I made a lot of experiential statements. Before I looked at the experiential statements together, I already feel that there is a lot of overlap between them all and I sense a couple of themes standing out. The ones coming to the forefront of my mind already are being a private person, the therapeutic nature of talking, the grief and loss associated with getting older. I feel the same themes presented throughout the interview no matter what question was asked.

Exploratory Notes Reflections

What really stood out for me when thinking about this participant throughout the transcript was hidden meaning. I really noticed how she kept stopping to think, stopping to wonder what she should say, often saying "what else can I tell you", as if she needed to really think about her permissions on what she should divulge. This left me curious about what I could take at face value and what I couldn't. For instance, I was really struck by how she continued a narrative of perfectionism throughout her speech, and I could see how she wanted to give me what I wanted but I also noticed the incongruence in the modality of therapy offered. I was very aware of my positioning as a researcher and how my knowledge as a therapist meant that I knew the modality offered was specifically designed for trauma. This trauma was never explicitly named or spoken about, yet this knowledge I had, was fully conscious in my own mind when reading and listening to her narrative.

Sue - Reflections on creating experiential statements.

I noticed I could create ES's quite easily but grouping them together was difficult. There seemed some overarching themes but there were nuances in the way she spoke about those important aspects of her life that left me torn on whether to create separate themes or sub-themes. For example, whilst she spoke continually throughout the interview about re-establishing herself, it felt important to think about whether I should break this up further by thinking about her body and mind changes, the impact of retirement and finding new ways to find fulfilment in her life.

Although I tried to keep this participant separate from the first one, I couldn't help recognising the commonality with something one of the participants said due to very similar use of wording when describing the progress made in therapy. Both participants spoke about the difficult process of therapy and how they had to work hard at it – uncovering and exposing all aspects of their selves. Due to this I found myself questioning whether I gave it importance because of the commonality I shouldn't be seeking for at this stage. However, I feel this point had been emphasised for both participants.

I likewise struggled with this participants discussion around the importance of marriage and had statements grouped together around marriage and the friendship of the therapist. I have struggled to find an appropriate statement to capture the true meaning of what she is saying. I feel she was saying that her marriage was one of unconditional love and without she would not have the strength to continue, no matter what, her husband is there for advice and support. She speaks about the therapist relationship like this but without the

feeling guilty for it being one-sided and how she trusts her voice and takes it with her wherever she goes. I have no words right now to truly capture this significance in these relationships. This was later reflected on with my supervisor and he got an over-arching sense for companionship and the importance of this.

Sue - Supervision Reflections

I found that speaking about the interview, I could pick out and draw themes from the transcript relevant to the research question. This gives me a more interpretative understanding of the participants experience. For example, throughout the interview she continues to draw from her history and talk about her life – my interpretation of this being that therapy has helped her to make sense of difficult life experiences in a way that now allows her to speak about them and understand how they have contributed to difficulties in her life. Understanding these, allows her to do things differently. However, when taking small parts of individual transcripts, I struggle to highlight my justification for themes.

Sue - PETS

After spending time going back through the ESs, laying them out on the floor and considering my reflections, I felt I could develop three themes to sum up the participants experience well:

1. The weight of the past
2. Unprepared to Age
3. Therapeutic Partnership

Many ESs merged due to similar meaning and these three themes seemed appropriate to fit all ESs within.

The weight of the past

The participant seemed to have a good understanding of how her childhood had contributed to how she was and towards the difficulties she was now facing with her mental health. She described how therapy was a process that allowed her to process this past and look at it from both a positive and a negative lens, with acceptance and understanding.

Unprepared to Age

The participant spoke a lot about her age and how she has to contend with lots of difficult factors related to age. Retirement she describes as having a huge impact on her life and this being the biggest factor to feeling low in mood. She had more time to ruminate on the past and has to contend with multiple comorbid health conditions, which impacts on her ability to engage with the world in the way she would like, having to give up some of her biggest enjoyments.

Therapeutic partnership

The participant spoke about the special connection with the psychologist and how together they developed a trusting relationship that allowed them to explore her past and help her see things differently together.

Phil Interview Reflections

I found this interview tricky with trying to get to the participants answer to the question I had asked. He tended to deviate from the question, and it was not always clear his intention for telling me certain aspects of his story. When I probed this, I got a sense that he was not sure how to articulate some of his experiences. I found that my sense of this was stronger

when he discussed the language barriers he found with the psychologist and how he did not always understand the words that had been used. I became aware of the impact my language had on his understanding of the questions and whether this was not always appropriate for his level of understanding.

I feel there was something fascinating about his example of not understanding words the psychologist used such as “resonate” which he struggled to say, but later used this word on numerous occasions to describe his experiences. I could not help thinking of the research that exists around older people’s ability to understand their own experiences and whether psychology gives them language in being able to articulate the true essence of their experiences. Language was a focal point of this participant, and this made me wonder about the impact of society mean-making using language and how imperative it is to human lives.

On reflection of the interview in its entirety, was the pertinence of two video clips that he watched in therapy, which resonated with his past personal experiences in childhood. I was unclear whether I truly got to the depth of what was so important about these, but my understanding was that these gave him the intrinsic motivation to start working on his recovery and this was something that he continually is reminded of.

Private emotion and retirement were also integral parts of the contribution to mental health difficulties that led to therapy being warranted for this participant and alternative thinking and expression of these was a key drive to positive progress.

Phil - Initial reading of transcript reflections

I found reading this interview different to what I expected. I really found more nuance and depth to the interview than I felt when I was in it. From initially reading the transcript over a few times, before going onto the next stage of experiential statement forming, the same themes were coming to the forefront of my mind:

- The importance of learning to talk about the past, which was something never done before
- The importance of others showing care for you that wasn’t felt as a child
- The importance of self-determination to get better
- The importance of other ways of helping rather than the use of speech

It was interesting that I had found retirement important in the room, yet on reading this back it didn’t seem that retirement was the important part – what it said about him was the important part and how that emphasised other aspects of himself that contributed to his mental health. As if retirement was the thing keeping it all together, but the act of retiring did not feel so pertinent.

What felt powerful reading this transcript was I hadn’t quite felt the significance of the change in this participant until I had re-read the transcript. This was a participant who had gone from going to the tallest building in the city 3 times to end his life, to someone who was now using what he had learnt to help others. He spoke throughout the interview of language being a barrier and not being able to speak to others and not being able to understand the help that had been offered, to now beautifully articulating what had helped him and how he achieved such significant change in his life.

I found it interesting that he spoke about getting help from different psychologists during different admissions into hospital and how there wasn’t much difference between them. However, it was the last time that registered because the difference was in himself. He felt a different motivation to get better, although that could have been because the psychologist

this time around used a different type of technique – a visual way of understanding him that really stuck for him.

Phil - Free coding Reflections

One aspect of this participant's story that I am really struggling to label that keeps coming up is the closeness he shared with his siblings. They look out for one another; they have lived the same past (these shared experiences seem the most important) but they don't share emotions and they don't talk about their shared past. This relationship feels like it needs a unique label that I cannot pinpoint how to label it.

The other aspect of the transcript I struggled to capture a meaning for is his feeling towards his last episode of care, where he now misses the experience, the support, the people he met, the process of change… yet the events that led him to get there were not good. This incongruence he speaks about is powerful but difficult to capture in words.

Phil - Exploratory Notes Reflections

Creating a more thorough analysis line-by-line, the things that came to mind strongly were the participants narrative from start to finish of learning the process of talking. From literally learning the language to use to talk about his emotion. To start this process, non-verbal avenues to connect with him were key. He made continual reference to the validation and normalisation felt when watching two video clips, which were the point at which things completely changed for him and recovery started to happen more readily. The other key aspect that came up for me was the shared childhood experience with his siblings. He feels strongly connected to them, yet nothing is ever shared, emotion isn't spoken about, experience isn't spoken about and his continuous wonderings of why he's ended up so unwell by the weight of his past.

Phil - Experiential Statements Reflections

The participant at the beginning gave lots of different avenues to explore straight away and at the start of the transcript there were lots of turns in phrase being captured by different experiential statements. As the interview progresses, experiential statements became less, and bigger turns of phrase emerged being captured by one over-arching experiential statement.

I felt stuck with capturing the participants experience when discussing his shared experiences with siblings. I thus sought supervision to try and gain external reflection to solve this.

The motivation to get better seemed to come from both intrinsic and extrinsic factors and both seemed equally important for the participant. When only one was present he wasn't getting better and vice versa. This was separated into two statements (finding inner motivation and doing it for the people you care about), although both seem heavily connected to each other.

Phil - Supervision around experiential statements

We discussed the shared experience of the participant with his siblings – living in the same house, being subjected to the same abuse and despite never talking about it, feeling a sense of comfort that someone had experienced it with you. This bond was unlike any other. My supervisor had gone through the parts of the transcript that spoke similarly about these experiences and shared with me his reflections. From this, we came to an agreement on an experiential theme of – 'unspoken solidarity'. This felt like it captured the participants experience well and this was placed within the PET of 're-writing my story' given that unspoken solidarity had now become spoken given the experience of therapy.

Phil - Creating personal experiential themes

When I had placed the experiential statements out, they seemed to have a start a middle and an end, with all statements referring to either his childhood – how his age brought his childhood more to light through things like retirement and how his childhood had contributed to is mental health through generational patterns of keeping things private and not being able to acknowledge or express his emotions. Whilst the middle of his story referred to the therapeutic process, how therapy changed his perception of his past and life, taught him new ways of being in the world and the final part being where he is at now – continuing to learn about himself and taking therapy skills with him but with the confidence to manage this on his own. This left me with the following PETS:

1. Childhood shadows

This related to the participant feeling like he was ruminating on his past life- influenced by retiring. How he realised he had bottled his emotions up because of his past. Therapy helped him to process these things.

2. Re-writing my story

Through therapy, the participant could start to open up about his past – learning how to do this and realise what a difference this would make to him and following this begin acting differently in a way that made him see his life differently.

3. Continuing my journey

The participant spoke about the change in himself being gradual overseeing 4 different psychologists over time. This allowed a gradual learning process, particularly in learning new skills around how to talk about emotion. He continues to push his progress in therapy by processing his past and using the things he has learnt, and he is now using this to help others.

I feel that the re-writing my story and continuing my journey have strong overlapping features because they refer to the feeling of change, although there are subtle differences between the process of change and the characteristics of the change.

Fran - Interview Reflections

I found this participant insightful to her experiences and very open and communicative. I found it easy to clarify meaning with her and she was able to say when I got it wrong, which showed the importance of checking my meaning-making with participants to ensure I have understood correctly. The participant gave numerous helpful statements during the interview, which opened-up several different avenues I could take it. This was the first interview where I felt that the conversation could have different focuses depending on which avenues I decided to go down. My intention was to cover all the potential avenues but as she continued to bring more useful information, I was drawn into more avenues and the previous ones lost place in my mind. Although I was aware that this meant I may be getting responses based on the content I chose to focus on in the moment, I was also aware that I was very much attuned to what she was saying. I felt deeply immersed into her storytelling of her life that this did on occasions mean that important lines of enquiry I wanted to ask about may have been lost.

I felt the interview could have lasted longer but the participant appeared tired, she began losing track of what she was saying, and I deemed it a good place to stop. Once the interview had ended, she reported feeling tired from all the talking, which confirmed my intuition on this.

One of the aspects of this interviews I questioned was how much we spoke about her childhood and at the time I wondered whether we had lost sight of the question. There

were stories she told me of her childhood that were helpful in formulating information about her and I wondered if I was taking a more therapeutic stance as opposed to an interviewer stance during these moment. However, when I caught myself doing this, I brought this back to a question around her experiences of therapy, and this then did feel relevant. For example, when I asked her about aspects of her childhood and how these connect with how she is today, she relayed stories about her childhood which uncovered generational patterns, which she said were imperative to someone understanding her. Without this knowledge, she does not feel heard, and she felt this was important in therapy. In this way, this was helpful for rapport building (so she felt heard) but also so that I could experience what she meant when she described others understanding the generational patterns that contribute to how one may live their life now.

Fran - Methodology Reflections

There had been quite a difference in recruitment with this participant. It had been initially difficult to find a suitable place – due the mental health team not having a central base within the locality she lived in. She had requested to be seen outside of her home and therefore this was explored. It was facilitated with a local GP surgery. The room was changed due to walls being too thin and the interviewer being uncomfortable with asking sensitive questions and recording the interview. This meant there was quite some upheaval. The participant then forgot her appointment and was quite upset that she had forgotten about it and still wished to come on this day. The interviewer was then not informed that the participant had arrived and so wasn't aware how long she had been waiting. I was therefore very aware how this may have affected the participant – who described feeling frustrated and anxious at herself for forgetting the appointment and was flustered by rushing to the location.

There were times, on reflection, through reading the transcription that I could have found out more depth to her responses. For example, she described on a couple of occasions the relationship to the psychologist feeling quite special and when it ended she needed support to get over it. Despite having support after therapy from a mental health relationship, this relationship did not feel like the one with the psychologist. Although I got the sense that this was a felt sense difficult to put into words, I could have clarified this meaning. At the same time, I felt I was asking questions from a therapy perspective (i.e. wondering why she may be the person she is rather than why she experienced therapy in a particular way). This part of the transcript brough this reflection to mind –

"Int: So I'm really interested in how you talk about ehm having to ehm raise your brothers and everything had to be just so and that was your responsibility

P: Yes

Int: and that kind of seeped into your life and son's and I wondered where do you think that came from, where that expectation of yourself came from"

This has given me insight into why older people may come to have the views and opinions they have but perhaps not what their experience is of therapy. Through analysing my transcripts, I may come to realise whether this is an important difference or whether they are intertwined, and the therapeutic nature of my questions may serve some important insights. Through this same part of the transcript the participants has a memory that springs to mind:

"P: My mother nearly died when I was four so maybe that was part of it, and I was very naughty and broke a window (pause)

Int: I wonder why that memory of breaking the window has just come to mind?

P: Yes, why did I? well because I was in disgrace with everybody ehm my my mother has been brought home, but I wasn't allowed to see her. She was so quite ill. Now the idea at the time I couldn't be trusted to just be carried out to see her I think was ludicrous but anyway that' the way they played it. so I didn't see her from the time she was whisked out to the hospital till she came back until after well after until she was completely better but I cried because I couldn't see her. I cried quite more loudly when I still couldn't see her and my 10 year old brother ehm shut me out in the garden and the windows were 4 millimetre glass and I screamed and I punched through the glass and the neighbour who was an ambulance driver drove me to hospital and lectured me all the way about how naughty I was and I was in disgrace with the entire family because the focus should've been on my mother."

Being aware of this memory makes me realise that her experiences during her childhood helped to make sense of generational patterns that are useful for understanding why therapy can be difficult for people. She discusses being punished for showing her emotion and bringing shame on the family. This may be important to understand when therapists are delivering therapy to older people who may have lived a generation of hiding emotion and being punished and judged when expressing them. This was later confirmed with the participant using a clarification question:

"Int: what a different generation that we live in and your experiences of like the war and there is a huge difference in gender and

P: Hmm yes

Int: how women and males are treated differently

P: very differently

Int: and divorce, you can't go to a certain country if you're divorced and how, is do you feel like that is important for people to be aware of in older adult services when you come to therapy?

P: Yes, I think it's the sort of thing that is quite useful to have a handle on"

Fran - Initial reading of transcript reflections

A couple of things really stood out for me reading this transcript for the first time since the interview:

1. The importance of history, society, and culture in understanding how someone sees themselves. For me, this participant had come to therapy with these past experiences and therapy helped her to stop blaming herself for them. To really understand how culture and social norms contributed to her difficulties in life and how she can stop blaming herself for some of her difficult experiences. Something which felt important was the conversations around nationality. She was the only participant that so far knew what ethnicity meant and this felt important given her stories about having an Italian father who was seen as a 'God' and how he did not want a daughter which contributed to how she saw herself as a female in society.
2. Learning new techniques to move forward. Specifically cognitive strategies and being able to understand how her thoughts impact on her behaviour and feelings. Although this wasn't completely new for her, she was able to learn new ways of doing things.
3. The relationship with the psychologist was key and she felt a real sense of loss when this ended. The relationship was something that facilitated change but also caused pain when it finished.

Imagery felt incredibly powerful for this participant. Her metaphor of seeing a boat and wanting to be on that boat but needing a hand to get onboard felt like it said so much about her experience. How the psychologist stopped her from drowning and has allowed her to enjoy being at sea again, taking in the beautiful scenery.

I was also really interested in how she spoke about the NHS and her generation. Growing up in war time, where propaganda was important and how the current news had influenced her decision to not seek help and what treatment would look like. despite not having symptoms of Dementia, she assumed this would be the focus of her treatment.

Fran - Free coding Reflections

I found when I was creating the experiential statements that there were lots of similar ones throughout the transcript. This made me feel that I had interpreted the participant's account well because it was unrevealing the same interpretations throughout. I feel that my use of summarising and clarifying meaning during the interview really helped ensure that the participant was understood correctly. I feel that this participant had an articulate way of understanding her own experiences that made this process feel quite simple.

Fran - Exploratory notes reflections

I found myself stuck on the participants experiences around being taken with her parents at 9 years old to a new country. She discusses how she got a diagnosis of autism, but her parents didn't believe it, so this was never taken seriously. Although the participant now identifies with being autistic, she is grateful for her parents for rejecting this diagnosis because it meant that she attempted and succeeded to live life as a 'normal' being without it forcing her into acting in line with her diagnosis. She speaks about her parents being forced to take her to live with them in another country (instead of leaving her at boarding school with her siblings) and she is grateful that her difficulties forced this. However, I am struggling as a reader to see this as positive, being forced not to feel abandoned by her parents and her seeing this as positive. I also found myself questioning her parents' motive of rejecting the diagnosis – from the participants perspectives this seems to be because they didn't believe the participant had it. I can't help reflect on my other participants narratives around their parents ensuring a certain persona is presented to the world and how a diagnosis may present a problem in the family to the outside world. This left me curious to the participants felt experience of this. I tried to push away my own assumptions to fully immerse myself in how it felt for her irrespective of how it may seem to me as an outsider looking in.

Her whole narrative explains a distrust in mental health services, and this seems important in considering how and why she found psychology a positive experience despite such distrust and negative past experiences. This is likely to say a lot about therapy and its functions.

One thing that made me think about another participant is the way the participant spoke about coming back to therapy in her own mind. She catches herself thinking about techniques in the moment and uses them. I remember Sue saying that when she struggles, she thinks what would my psychologist say and this feels like a joint important component of therapy that ensures the continuation of effort and work to maintain benefits. Feeling connected to something so that it works in the longer-term seems key here.

I feel as this is my fourth participant, the connections with other participants were happening more readily as I was reading through. Another thing which I feel came through more so for the female participants was the connection they felt with the psychologist and how they miss that relationship, and it was more difficult to let go of. This participant

speaks about this (although in jest) as needing support to get over the loss of the psychologist, as if she had a sort of grief reaction to this loss.

Fran - Personal Experiential themes

The experiential statements fitted well together and made 3 main personal experiential statements that I felt captured the participants experience as a whole:

1. The influence of society on who I am

The participant spoke throughout about the influence different societal narratives had on her behaviour. From reading newspapers discouraging her from seeking help from a burdened NHS to being a female growing up, having expectations placed upon her to look after her family, to what it means to be old, experiencing disease and what she 'ought' to be doing in her life.

2. The Helping Hand

The relationship felt powerful and felt the role of a psychologist being different to other professionals offering support. How the participant spoke about feeling heard, something that is a very felt sense and how this closeness due to feeling heard and respected was not replicable with other professionals and was something that she had never felt before. The power in this relationship dynamic gave her the strength to help herself and feel better. However, it is also important to note and how she felt a grieving process when the relationship ended and needed someone else to support her to get over this loss.

3. Continuing a new version of myself

The participant emphasises how the therapeutic process did not end when the therapy ended and how she has had to continue working hard to process her past, continue the things she has found helpful and think about techniques within the sessions which served to help her.

Leo – Interview Reflections

This participant was a lot older, and it felt tricky to connect with him. Firstly, he was partially deaf, and this created a communication barrier at times because he could not always hear what was being said. He also requested to be seen in his own home and therefore, he deviated a lot from the interview to talk and show me things in his house. Although I wanted to follow what was important to him, this was not always relevant to what I was there for. This was also a different experience because of his perception of therapy. Although, he had been referred to the project because his allocated psychologist deemed him to have made positive progress in therapy, he had not felt that he had got much and when I saw him, he reported feeling depressed, which may have affected what he spoke to me about. He was the only person who asked personal questions back to me and I got the sense he was eager for this to be a two-sided conversation. He on numerous occasions asked if I could return to his home to talk to him again, as he had felt much better after my visit.

The general themes I got from him from the interview were that psychological therapy was company for him. The talking aspect was important, but this was not necessarily different from being seen by any other professional. This was impacted by his living context, being the only person, I had seen so far that was widowed and lived alone with no family nearby. Therefore, the professionals going into his home were the only people he saw on a regular basis. Once this ended, he felt that he stooped back into depression, and he describes this being because there was no one around him.

The other important theme I got from him, was the impact company had on him to find inner strength. Being around others helps him to feel safe and motivated him to do the things he needs to. Specifically, the psychologist helped to remind him of the things that are important to his well-being and gave him these reminders to continue to look at once she had left.

Leo - Methodological Reflections

When I initially read this transcript, I did not feel I remembered some of what was said. It made me question whether I was truly present with the participant. I listened to the transcript to familiarise myself with the transcript and listened to this transcript for 40 minutes (longer than I listened to the others). I realised that there were substantial inaccuracies in the transcript. The transcript was therefore re-transcribed by a different transcriber. I wonder if me listening to a larger portion of the transcript led to the increase in emotional connection I had with this participant as described in the initial reading reflections.

Leo - Initial Reading of Transcript Reflections

I found reading this transcript back more emotional than I had anticipated. The strength of the loneliness coming from him was striking and throughout he spoke about his wonderful life, how he should be grateful for all the things he had experienced but also for the things he currently has in life, yet still feeling crippled by depression. What I had not realised when meeting him initially was the emotion of scaredness. When reading this back, I got a huge sense of him feeling scared and not wanting to die alone. In some senses, he seemed to be saying that he was ready to die. He was content with the life he had led and now he was waiting to die, but it scared him that this next transition into death would be alone. He also seemed to feel selfish to think this because he knew, despite feeling lonely, that his death would cause sadness and pain to those that loved him.

I didn't think this transcript would be so relevant due to the content of conversation at times and not feeling relevant to the research question. However, when fully appreciating his narrative within his context, the irrelevant conversation seemed very relevant. It felt as if he was desperate for words, he had lived a private life, a generation where you keep things to yourself and only through poetry, he got to appreciate the human suffering and the trials and tribulations of other people's lives – for which he found inspirational. Poetry was the company he relied on, that spoke to him when there was no-one else in his home.

Although he spoke of the psychologist's company and that her mere presence was important. I wonder if without him knowing that was something really important. The ability for that person to not just be with but to be able to foster these conversations, about death and life transitions of which not everyone feels comfortable.

Leo - Free-coding Notes Reflections

The participant gives a lot of contextual detail around social positioning in society whenever he speaks about people, as if this is something really important to him. I feel he tries to portray a picture of himself being of working-class but having made something of himself by attracting reputable people. He speaks about his partner as if he perhaps would not choose her if life circumstances were different. The emotion of feeling lonely is extremely prominent throughout, being desperate to form connections with others and have people to converse with. He's at a level of acceptance that with his stage of life comes grief of physical capability and a grief of lots of things he used to enjoy. He seems desperate to portray a positive outlook, but it feels as if he is trying to convince himself the most. Trying to desperately highlight the positives to overwrite the loneliness he feels.

The participant speaks about feeling scared, being alone and this appears to be the thought of dying alone. I had not realised at the time of interviewing the true impact losing his wife had on him. He went through a difficult experience losing her and witnessing her go blind and preparing himself for her death. This understandably may have led to him fearing death. What if he experiences something similar? But doesn't have the same support? He speaks about his partner throughout as if he is trying to convince himself that she's good for him but deep down does not understand why she keeps him emotionally distant – and in some ways he does understand why and therefore doesn't want to upset her, but he realises that her approach towards him is part of why he feels lonely but also knows without her he would be even more lonely. It is as if he feels trapped in a no-win situation with her. He speaks about their relationship in what feels like a superficial way – talking about the things she does for him and being grateful for her help whilst spending the rest of the interview discussing the deep connection he has with friends through poetry and through being like-minded.

Leo - Exploratory notes – Line-by-Line

Linguistic coding was prominent throughout this transcript. It felt important to note linguistic differences in how things were said. There were many of time where the sentence at face value was positive such as "wonderful, you are lucky" but this was said with such sadness. The sense of loss felt throughout this transcript is overwhelming despite a lot of the passages of text trying to be hopeful and trying to be positive. The narrative told through the participant followed the same thread throughout. Engaging in psychology was valued company but it did not teach him anything compelling or anything enough to use beyond the session to feel better alone. He awaits the next stage of life, which he understands is death and is apprehensive of how this will happen and what this will look like for him. Depression, which he argues is tiredness, has taken over his life and he struggles to find enjoyment in the things, now that physically he cannot do anymore. He feels lonely and lacking in connection with others.

In keeping with IPA's bottom-up approach, I noticed my mind veering towards some theories as I analysed the transcript. I have written these on the transcript so that I can park them and think about their relevance later on without them influencing my interpretation for this participant. The first one was in relation to family scripts and having a generational learnt behaviour to keep all matters private and not to share emotion. The other theory that came to mind was around the connection of physical health and mental health in older people and how this is difficult to untangle. I am aware that these two things with evidence base behind them were coming up for me and I did not want this perspective to shadow the transcript. However, this may be worthy of attention once I have developed group experiential statements.

Leo - ES Reflections

I found a lot could be collapsed and could have the same meaning. When laid out in front of me, 4 clear and distinct themes emerged. The most prominent was around death, the participant accepting that he is in his last stage of life and being scared of this. Scared of what it will be like, how he will be remembered and what he will leave behind. He speaks as if nothing will help him as death the inevitable last step.

The second prominent theme was centred around loneliness, the participant feeling like he was alone in the world, where people fleet in and out of his home and life but no-one stays and how unbearable this feels.

The third theme featured the participant desperately trying to think positively about his present by reminiscing on the good times he has had in the past and by listing things he

should be grateful for now. However, this felt like a desperate attempt to convince himself that his present was worth living.

The final theme was based around his character, how he views himself and how others view him. This appeared to be important to the participant throughout and what I noticed was the inclusion of mental health around his identity and feeling like he shouldn't be seen this way and how he should feel and how people should see him, whilst at the same time feeling like no-one understands him. He tried to hide his emotions because this is what he has been taught to do by several generations in his upbringing, yet he feels frustrated that no-one truly understands how he feels.

Leo - PETS reflections

The four PETS that I produced were:

1. Someone to care
2. Learnt privacy
3. Convincing myself of a different reality
4. The final stage of life

Someone to care:

The participant speaks throughout about just needing someone to be with him. He is scared of dying alone and feels like a different person in the company of someone else. He even spoke of the happiness he felt since the interviewer had been with him and implying that it no longer mattered who the person was. He spoke throughout about his relationship with his partner being sub-optimal but that he needed to remain grateful for that he had her in his life because he feels incredibly lonely.

Learnt Privacy:

I struggled the most with defining the 'learnt privacy' PET because I felt I wanted to capture the push and pull of wanting to keep things to himself/maintain a good character vs. wanting help from others and not feeling understood. I felt that also in relation to my research question (how do older people experience therapy). I felt this label captured his experience of this push and pull by wanting the psychologist to come and see him as a 'good patient', not wanting to speak badly of her or not do as she says, but at the same time felt it was not working and that it was not helping with the extent of the problems he was feeling.

Convincing myself of a different reality:

The participant speaks throughout the interview about his past, as if he is processing it still. He speaks of difficult times and always ends with a positive spin on the difficult times of his life. i.e., not knowing his parents and not being able to talk to anyone yet having a wonderful childhood. Having lost his wife but it being the best thing for her. He continues to live a life where he struggles particularly with feelings of low mood yet keeps saying "I should be grateful", "I should feel lucky" or "I'm happy to be alive". I don't get a sense that the participant is able to fully articulate how he really feels because that is not the reality he wants to admit.

The final stage of life

The participant acknowledges his age throughout and reflects on his life. There is contentment that he has lived the life he wanted, has had many good experiences and

although is scared is ready to die. He understands that death may be imminent for him, and he is desperate not to experience death alone and wonders how death will treat him.

Cath Interview Reflections

This interview felt different to the others. There was something about the participant's experience, hearing this, that made it feel different. I wondered whether this was the nature of the difficulty which brought her to therapy that felt different, having lost both of her sons in a traumatic incident not too long ago (of which I did not know any further details).

I was curious about why she made it into a severe and enduring mental health service for an event which naturally would cause immense suffering, having never experienced mental health difficulties previously. I knew my job interviewing her was not one of unpicking this but felt this was somewhat relevant in her experiences of psychological therapy. The loss she had experienced meant her experience of life and using coping mechanisms was somewhat different to 'traditional' mental health difficulties despite what diagnosis she may have got to enter such a service (likely depression). My overall sense from this interview was that it was not anything to do with what the psychologist did, but the being with her during an intense emotional process until that intensity reduced. There were no strategies she continued to use nor no answer to what it was that was positive but the having the person coming in the diary each week that gave her purpose. In a lot of ways this was helpful in understanding what it was that she needed. However, the difficulties she experienced felt an important contextual difference.

Her lack of knowing what the positives were or what therapy processes were important felt difficult in the moment and I could feel myself asking clumsy questions and very focussed-led questions (possibly due to me being unconsciously influenced by things brought up previously by other participants) such as the impact of retirement and the impact of age, which were not factors she was bringing. Despite these perhaps biased ways of asking questions, the participant felt able to challenge me and deny any felt experience when I prompted these. Even though I felt I could have been asking led questions due to my experiences from other participants and also due to trying to uncover anything she felt helped in her experience, which she was struggling to find, I felt the biggest emotional connection with this participant. I felt a good rapport and like I had known her for years, which may explain why in the moment I felt able to ask clumsy questions. At the end of the interview off the recording, she told me she wished I lived near her so I could come over for tea and coffee now and again. Despite this being out of the boundaries of my remit, this was something that felt like a 'normal' request from a genuine connection. I felt a sadness that this was the only time we would meet as I said my goodbyes. Given this feeling, I confidently felt immersed in her experience during that interview.

Something she spoke about at the end which I felt was important was the way in which people observe her to be 'strong' and 'independent' and how that frustrated her because that is not how she feels inside. The mask that she wears, and the generational learning of privacy contributed to this feeling. Her voice thus is very important when she speaks of how she feels and with that I felt a pressure to ensure she felt heard in telling her story.

Cath - Initial reading of transcript reflections

I found it powerful reading this transcript back. The way the participant spoke was so articulate and honest about the reality of her situation, talking about emotional topics around death and loneliness in later life. I knew that in the moment of the interview, I had felt clumsy asking some of my questions, however, when reading this back in the transcript the questions did not feel clumsy at all, they also did not feel random or desperate to seek answers but flowed nicely from what she was saying. I realise now, that was my own

worry on reflection from what was an emotional interview covering sensitive topics but, in the moment, I had been attuned to what she was saying.

Although the participant reported not feeling like the type of professional was important to her experience or that she knew what components of the therapy were most useful for her, I found trust centred throughout the transcript. She spoke a lot about how she couldn't speak to family and friends about her difficulties and that they could not be relied upon. There was something about the psychologists that made her feel able to speak openly, made her feel safe, that gave her purpose and she trusted that they were going to come when they said they would and would not let her down. It was as if the predictability and structure of the sessions gave her something to focus on when her emotions felt chaotic and disorganised.

I found it interesting how she spoke throughout about people not understanding how she feels unless they had experienced the same, but she felt understood by the psychologists despite not knowing if they had experienced the same thing.

She also spoke endlessly about her need for privacy and how not even her friends or family truly know her due to never sharing her internal experiences. She gives off an appearance of being a strong independent woman and the grief she experienced meant she could not hide the pain and needed help. Once she could hide it better, it meant she could be independent again and look 'cured' even though she wasn't. It felt like her goal was to be able to hide the pain – different to what you would usually expect from a client whose goal is usually to be able to learn how to manage their pain. Her stage of life seemed important in this goal – having been the same person for many years, not wanting to change, being proud and content with the person she was but needed to get over a bump in the road and was ready for the next stage of life – death.

Cath - Free Coding reflections

It felt that the transcript had a very similar gist throughout the entirety and all parts of the transcript seemed to fit within similar experiential themes. I laid them out and placed them into 6 separate themes; I am back in control, whatever it was it worked, surviving emotional loneliness, putting trust in the right person to listen, reaching an intolerable existence, and surviving the moment. However, when I looked at these, they felt too much like I was paraphrasing her words rather than really capturing the depth of her experience. I kept these how they were and began adding parts of the transcript to capture the experiential themes.

Cath - Exploratory Notes Reflections

I felt that the participant was telling a story of how psychology helped her to feel less overwhelmed and at a crisis point where she didn't know how to survive. She now speaks of a place of not feeling cured but being able to distract from the intensity of her emotions and understand and normalise her experience. She continues to live a life of privacy and portrays a sense of waiting for life to end and get through the days.

Cath - Experiential Statements reflections

There felt a huge overlap in statements when I went through them. One of the things that became apparent at this stage was the participants own coping mechanisms. I felt my professional experience coming into play at this stage of analysis. The participant spoke a lot about emotional avoidance, trying hard to push away the pain and avoiding any conversation about her sons because these remained unbearable. Yet, her experience of psychology was positive because she no longer felt suffocated in her pain. This left me puzzled and wondering how exhausting it must be to continue to push away inevitable

thoughts and feelings every day and how therapies can help not feel an eagerness to do this. However, I got the sense that the participant didn't want to learn alternative or new strategies, her goal was to feel less suffocated, and she was happy to use her own way of coping, but the true value of psychology was having someone with her to find her own way of coping but in the presence of someone else who made her feel less alone in the world. This felt impacted by her lack of family in her life and by her strong view that she cannot share her feelings with any friends or family. The psychologist role thus seemed necessary to be trusting and a listening presence.

Cath - Personal experiential Themes reflections

The experiential statements overlapped hugely and seemed to tell a story of why the participant felt she needed help, what the therapeutic process was like, understanding why she was the way she was and how her age impacts on her view of life. The 4 themes were:

1. **Final stage of life**

The participant gives insight into what it feels like to be at the end stage of life. How she feels abandoned by all family and left to die alone. She ruminates and looks at the past more but is grateful for the life she has had and finds her age is helpful in not having to suffer for much longer. This means she is focussed on living in the here and now and getting through each day rather than thinking about the future because she knows this is death.

2. **The person my generation forced me to be:**

The participant talks about a generation where she holds a strong social façade and her goal in therapy was to be able to maintain this, which had been dropped due to the weight of her pain. She speaks of a life where nothing was spoken about and how she had never had anyone to talk to about her thoughts and feelings. She had always learnt to bottle up her emotions and be able to move on with the difficulties she faced.

3. **A two-way relationship:**

Captures the participants need for a person to listen, to feel understood and to feel heard. This was a relationship she had never experienced in life before. However, she felt safe and like she trusted the psychologist, and this was influenced by the 'professional' understanding that she had. It was a relationship that she felt was directed by her. She maintained her own coping mechanisms and she recognised that these were from her childhood but the relationship with the therapist allowed her to feel less consumed by pain because she had a place to share her feelings and someone to cheer her on in the direction, she wanted to go in.

4. **Desperate for help**

The participant speaks about feeling complete overwhelmed by pain and as if she cannot see any way forward. She has learnt to always deal with things on her own in life, but this time is different, and she doesn't know where to turn and feels a desperation to seek help.

GET Formation

I knew from forming my PETs that there would be overlap in meaning. Lots of things had come to mind that were similar between participants such as the importance of privacy in their generation and the importance of the therapeutic relationship, but I was surprised by the amount of overlap between the participants when I put them all on a page together.

All participants spoke about environmental influences either in the context how society had influenced their thinking of mental health, emotions, and privacy, how they seek help, what illness should like, what retirement should look like or in the context of their childhood experiences and how their family had shaped them as people and how this influenced them in this stage of life.

All participants spoke of the importance of the psychologist in supporting them. The impact of this relationship being paramount to getting better and why this relationship was key. Although one participant (Phil) didn't have this as a theme – within his themes, there were aspects where he did speak about the influence of the psychologist.

When thinking about what would make suitable group experiential themes, I re-visited my research question: How do older people experience psychological therapy?

It was easy to forget the question during the individual analysis phases so that I got a sense of what the participants felt was important and what they brought to the interview (irrespective of my research aim). At this point, I felt it was crucial to remind myself of the research question and as a whole think about how these important aspects for participants answer this question.

Older people seemed to think talking about their past was important in therapy. It was a time of necessary processing. At this stage in their life they found themselves ruminating on the past, which was impacting on their mental health. Lots of factors in their life had meant this was important. Retirement was a common theme amongst participants and how this meant they had lost purpose in life and spent more time thinking about the past.

The relationship was key for older people in therapy, with discussions centred around this being a different type of relationship for most of the participants. One which allowed them to feel heard and understood and a new process of learning to talk about emotions. Feeling the therapeutic nature of talking and its ability to help process life events with another person.

Participants spoke about learning new ways of being and holding themselves responsible for continuing what they have learnt. Some participants expressed this as a process of re-creating themselves. From learning about their past and how their childhood contributed to their development and trying to push away from this or continue to process their life.

1. Processing my created identity

-Childhood
-Society

2. The powerful therapy relationship

-A friend with boundaries
-The rescue

3. Continuing my therapeutic journey

-Processing my life
-A new me

Reflections following Supervisor Audit of Individual GETs and PETs

Discussed how supervisor felt the stage of life has been missed within the GETS. Basing the GETS on prevalence of what was most common amongst most themes left out the importance aspect of later stage of life, particularly for 2 participants. There were 2 participants who experienced therapy differently from others. They did not take anything 'new'. They valued the psychological relationship and someone to talk about private experiences with (something they hadn't had before, as shared with the other participants) but they didn't learn anything in terms of strategies and they were not living life in a different way. 1 of these participants felt talking was enough to allow her to feel differently but no behave differently and the other did not feel or behave differently. Both participants spoke about waiting to die and had accepted that it was nearly "their time". We discussed the importance of being able to capture this nuance. From speaking about it, we also realised how Sue also spoke about getting older and accepting her stage of life, but she had

changed the way in which she was living and was using strategies. We discussed participants characteristics which may have impacted on this difference:

-Sue had a husband who was her best friend and supported her through life

-Sue had received many years of therapy

This may allow us to conclude that participants in their late stage of life may need social support to take changes with them and/or may require a bigger 'dose' of therapy to use and try out new strategies. It may be that therapy needs to be in conjunction with social support with people who live alone.

This made us wonder whether this could be captured as divergence in the third GET or whether a difference sub-theme should be around accommodation, and this could capture the convergence and divergence in how people accommodate their lives from therapy and how this may depend on their social situations.

My supervisor also wondered whether 'connection' was emphasised enough through my sub-themes. He felt this was fundamental to participant experiences and wondered if 'a friend with boundaries' captured this enough. We discussed how through the write-up and allowing a narrative of the themes would help determine this.

Reflections following beginning result write-up

The first two GETs flowed well and quotes sprung to mind immediately, and I was able to demonstrate the GET within the two sub-themes. However, the last GET did not feel like it captured the participants experience enough. Specifically, the sub-theme 'a new me' felt sparse. There was a lack of quotations that I felt really captured the meaning behind this. Conversations previously had in supervision around missing important narratives of Leo and Cath, who had provided divergence to the higher order GET of 'Continuing my journey' felt lost. It felt imperative to capture their different experiences. These did not feel completely different to my GET. Cath had experienced a new way of being, but it was in accepting life as it was, Leo was trying to be a new him, but this was not working, therefore 'accommodating a new me' seemed more prominent and allowed nuance in how participants felt they needed to change or in Leo's case life needed to change to be able to improve.

Individual PETS:

Phil PETs	**ES**	**Example Transcript Quotes**
Childhood Shadows	1. A past of privacy 2. A generation of 'just get on with it' 3. Presenting the accepted version of yourself 4. Retired self, present mind 5. Missed out on life	"Phil: Nothing was ever good enough for him. Like, you know I think he done it deliberately in some ways like erm just to keep on top of you. I mean like, I say we use- we didn't, although he said we had six weeks holiday we weren't allowed to have any children or kids, our friends, we did. But he used to find out sometimes obviously but quite a lot of times he didn't but I mean if he did find out we were in real trouble, so weren't very nice , yeah. But yeah, so erm, well I say- going back to your question, I didn't have an outlet. Went to work and all you was worried about was four on Friday getting erm you know some of your pay pack on you. So we didn't really had no erm (pause) you know, nothing about - well nowadays kids have got

		online, they got that erm option, they can find out, they go online. That's the thing, we didn't have that. Int: And you said a lot about what it was like in your family and how they didn't talk about things like that. Do you think it was like within your family unit or do you think it's an age thing that people don't really at that time didn't speak about their mental health? Phil: Erm, probably every, every week I've met a friend of mine, a lawyer. Use to go football with. He doesn't go now but we were talking about his upbringing and I was saying something about it last week actually because Sunday I said to him, cause we take turns, he phones me or, we yack on about football and all that but I've known him a long time. But anyway, so he was saying how he grew up and yeah, again, what he was saying to me was what I was kind of receiving. I mean the same thing. You know like his mum and dad you know couldn't go- there was no one to go to, he had to sort out himself basically." [96-154] "Int: So are you saying that once you retired, it started making you- Phil: With COVID, the knee, feeling just useless and I just felt and that's what made me feel, got me in this deep black mood. Int: Did it make you start thinking about all that trauma from your past? Phil: yeah it was digging up the past. Int: would you say that's the impact of retirement, was there any other reason that retirement contributed? Phil: I didn't wanna retire but I had to, forced, I don't regret it now but at the time I regret it for a long time. I said that's why I probably snubbed my friends cause I just, I just you know, I'm not (sigh) I suppose it's the way I've been brought up. Was like (sigh) you don't give in if you know what I mean. But I had to give in to it and I didn't like it. Int: When you said that it made you feel you'd given in to something, what was that? Can you tell me a bit more about that? What were you giving in to?

		Phil: Felt like I'd given in too easy. Like to me, it was just too much of an easy option. Before everyone used to see us and think oh they're great kids, they don't do nothing. And you know and they didn't know the story. Funny thing was a few years ago erm I bumped into one of my neighbours in the pub, used to live across the road from us when we was younger and erm, and he said to us "I was always envious of you" like my family "cause you had erm nice cars, always polished and cleaned" and obviously we did that and I said, I said to him "we were envious of you cause your dad like". When we compared things, none of us had it good. We didn't know that. All these years gone by and it wasn't until we met each other in the pub that we found this out. "[1466-1497] "Int: And I noticed that you used the word resonate quite a lot then. And throughout, and you started off by saying that the psychologist was using words that you didn't understand and it wasn't connecting and it just felt like a different language and now you're using that language. Did therapy help you use a different language to understand your life? Phil: I will carry the words because I didn't know them, they weren't understood and people will, because we're older - probably I don't know what kind of people you'll be dealing with but because you're older you don't understand what them words mean. Until, you know until they tell you or you see it, if you see what I mean. Int: And now you're using that language! Phil: (Laughs) Yeah. so yeah, that's the difference I think. I think sometimes you know it's alright using the language tools but I think you gotta go. Cause, don't matter what the age is, I mean if it's younger- you know the younger people then obviously they're gonna understand. Int: Yeah. And you've been quite happily today being like I don't understand what you've just said can you like say something else? But you said at the start when you go to therapy that you didn't feel able to do that. Phil: No. Int: What was it that felt unable to do that?

		Phil: Cause I don't wanna look, like I said cause of erm my upbringing didn't wanna made made to look, to look a fool." [1723-1835] "So when he come with his wife (laughs) cause ob- I didn't know she was coming, she- he come with his wife and I I asked him, I go so "[brother] I've never seen you cry, because when I tell you I haven't seen you cry, neither of us have" (laughs). And she and then goes "he he cries quite a bit actually". And that really shook me up.You know, really (pause) thinking of you know (sigh) oh- that's- (sigh) blew me really, I just understood. Int: What shook you up about it? What was it that surprised you when he said that? Phil: Because I couldn't see him (pause) because, like I said we never talked about what happened when we were children and young and all that.And although we'll bring out certain things, some in- incidents with dad but we , but we, had an incident where my youngest sister one day she spilt all her paint all over the floor and my dad had a fantastic sm- nose for err smell and things and we got everyone in- well we had about five people with hairdryers, washing all the shampoo on there just to keep, take the smell away." [819-853]
Continuing my journey	1. Progress realisation 2. A gradual therapeutic process 3. Becoming unapologetically me 4. Solidarity	"it sounds like you gained so much from kind of that therapy experience, it has really kind of changed all aspects of your life. Was there anything that's been changed that is unexpected that you really didn't expect to happen? Phil: Didn't expect to cry. Think it was just, no way you know. Didn't expect it- yeah and- (pause) and and if, if I am struggling then I can ask someone I know that. Even even with my eldest boy says "Dad, you can phone me any time" and I know that. My dad didn't all the time but it was there when we wanted to you know, cause I suppose that, for me that was showing showing weakness. I should be doing, sort myself out if you see what I mean. I'm the one that's supposed to sort that out. Int: So, you didn't expect to cry, you didn't expect to show your emotions as much as you do. I guess did you, expect any positives? Because you were kind of just going through the motions at the start, did you expect anything good to come out of it?

		Phil: No, not before that third time no. I mean just thinking, something just latched on and then , the co- well, funny enough one night we was talking to nurses and talking about half past one at night, we weren't supposed to but we were. There was a few of us you know and from that, that give us all a kind of bond in there, like, just shows how much they could- they were concerned about us or they wanted to like you know help us and all that, show show so much I mean like, like I say you couldn't ask for no more really they're fantastic they are and I I, both both, all three, was exactly the same. I mean, it it it (sigh) that night I just felt so much and I think well you know we're talking to everyone, everything and you know then they're concerned about you and so you at at times you don't think they are and they are obviously. Yeah and it's nice to know you know." [1545-1610]
Re-writing my story	1. Finding validation 2. A new lens 3. Learning to talk	" Yeah, if it weren't for [clinician 4] and everyone else who's been involved with me, I mean. I I'm I feel that- if I've upset anyone, I've, I do apologise, but I mean but yeah I mean it just shows I mean (sigh) you don't know, you don't know you don't know how much it means. That people were concern- even yourself talking to me now, I mean. It's so much- it means so much. " [1638-1650] "Int: So now it seems that you have more of like a shared experience with your brothers around like your childhood? Phil: Yeah. Int: Do you think that came out of therapy? Phil: Definitely. I mean I would have never asked that question or ever know. you know, he never would have probably asked me that question but now I'm I'm prepared. I don't think we make it like a sort of like a just just, now and again I ask a few things if he want, if he wants to talk we talk, if he don't he won't. Int: So no longer feels like your burden, it's like a shared experience? Phil: Yeah."

		"Phil: But that's, erm, apart from that, like again my kids, I said to you earlier my kids have never seen me cry. But I'm not scared to now. Int: And that seems like something that happened that was really important in the therapy process, that ability to cry in front of someone. Phil: Yeah. you know what, from that I I grew- I grow strength from that. I feel that strongly, it makes me a stronger person. It's not, it's not bad to cry. Int: what was it about crying that made you feel like that? Phil: I suppose realising that the way we're brought up, crying is not a weakness. Int: There's something like therapeutic in that crying itself Phil: Yeah. Int: And was there anything about the therapist reaction that made that feel okay? Phil: I think she knew where I'm coming from definitely. I think she understood." [870-919] "Phil: Um, I think the firs- that's the first time I've seen any err film clips. So that was different, I mean that was completely different, yeah. I think [psychologist] probably picked up the fact, I told her about my father and how we got treated erm and I feel like maybe that's what she'd probably use cause of like the anger" [792-806]

Cath PETs	**ES**	**Example Transcript Quotes**
Final stage of life	Final stage of life The ruminating stage of life Living in the here and now Finding content in	"they're going about their daily business as I did. Cause that's what I'm sitting here thinking, well when I was her age I was in [abroad] doing this, that and the- I didn't have anybody to help me like she has (laughs) all this is going through my mind. And I think yes, well really then you shouldn't moan if you're that age because you've already done all that what she's doing. And her mother is what, 30 years younger than me so when you were her age you were in such and such a place, I'm tryna think where I was (laughs) what I was doing. And I think, so really they're just living their lives the same as you did when you were their

	my own company	age so what are you moaning about?! I'm saying to myself (laughs)." [1439-1456] "You've got- I think, if you think of life as a conveyor belt, there isn't anybody in front of me now is there? To fall off the end. So you're on a conveyor belt and it's jogging along and they're jogging along but they're a long way behind you and you have done all that. And that's the only way to look at it." [1624-1645] "I'm glad I'm this age because that means I've got less time to suffer all this doesn't it, if you see what I mean. So I wouldn't like to be 55 and have that happen to me. So, erm, you mean experience. Well, at 87 I should have had all the experience I need shouldn't I? So You've just gotta call it out and hope it works. So there, there we are." [1572-1583]
The person my generation forced me to be	Holding a strong façade A life on mute A lonely generation	"with my mother, you didn't confide in my mother. I mean she'd be the last person you'd confide in. So you l- you lived alone. Although you were in the house with her and your father and your sister you weren't erm, I th- you naturally think everyone lives like that." [163-176] "I think it's probably a generation of things because I remember I went up to the [region] with a friend of mine who loved to go up there, she couldn't understand a word they said and I remember I'd had a divorce and I think my auntie who's only five years older than me, said in the house, in my mother's house to me "is [ex-husband] going to [abroad] with you?" and I looked at her and said "why would he be going with me, we've been divorced for years" and my mother hadn't told my auntie. That's something you sweep under the carpet (laughs) and she said to my mother, she said "why didn't you tell me?" and my mother said "does anyone want a cup of tea?" So she just ignored everything. That's a classic example". [216-245] "Int: And do you think that's gone through your life? like you just don't tell your family personal details?" Cath: Yes! You just, if you, if you had anything wrong or in trouble, not that there were anything like that I can recall, you didn't, you didn't tell anybody else. And that becomes part of your nature." [264-272]
A two-way relationship	A reliable helping hand A trusting relationship Something to live for	"It it's still a dart and it, you you know you're sort of got a fragile outer coating you know (laughs). It's fragile and I managed to pierce it then and you think oh I've gotta do that hole up now (laughs). But that's the way I look at it." [449-458] "And I said to [family member] "I've put the TV on because I hope something will catch my attention and if it catches

	Powerful process Finding what works for me	my attention I'm not thinking about the other thing" and she said "oh yes I realise that". And she, I mean she does realise that. But she understands but she doesn't, I mean she would discuss it if I wanted to but there's no- I can't see any point." [480-511] "Int: " you were referred to this project in particular because someone felt that you'd made positive progress from the beginning to the end of therapy Cath: Well that's that's true. I think that's quite true, I did get positive things from them. And seeing them and putting it in the diary and knowing they were coming round etc. And yes I did. And I don't see them now and I'm still here. As it were. So, yes it was positive." [556-567] "And, you see people say anytime you want to talk or any time you want to go somewhere just ring me. Now have you tried doing that? You find that they can't do it for some reason. And that's when I get angry, you see. Because I think I've got a car which I can't drive because of my sight. So I've had to ask you who said you could do this. And I don't expect them to drop everything and do it now, I said "could you take me to so and so on Friday?". "Oh no I can't do that because I'm going to" and I sat out there one day, a few weeks ago, I was gonna go the hairdressers and she's only down the road and I think I rang four people up. (Pause) So I had more than two cigarettes that day. And I thought would you credit it, you know they all said they'd do this and they'd do that. All I want them to do is take me to the hairdressers, which will take about 10 minutes. And they can't do it. I'm not saying they weren't, didn't have good reason, but that's what makes you (pause) feel vulnerable and angry. Cause you, you you you're in this position because of you know your sight's going and what have you, and I don't very often ask anybody to do anything and you, then you get angry. Then I get angry. So, so [the psychologist] made me feel a lot better. So it was a good thing that I did that." [609-658] "Cath: Because you didn't feel isolated you see. There was somebody on your case that knew your particulars. Who was coming back next week or the week after or something. So, you didn't look forward to it but it made you feel safe. Int: Was there anything that they did that made you feel safe? Cath: Well no, it just made you feel safe from one visit to the next. So that when they said they weren't coming, but they did come quite a while. And then she said "this is my

		last visit" and I said "oh that's a shame isn't it? Because I've got to quite like you". [749-772]
Desperate for help	Abandoned Consumed by emotional pain	"It was just like being hit on the head with a mallet. Everything just, you can't believe it. I still can't believe it. I still can't believe it. So, I fill my head with other things. Anything, it doesn't really matter what it is." [323-332] "Well, I just felt as though I was erm, when you crack something hard and it all shatters, that's how I felt. I thought one more little poke and I shall shatter into a million pieces. That's how I felt when I rang the doctor up. And err, I stood on that step out there because I couldn't breathe, I had to go outside and I thought what can I do? And I thought I know, I'll go and buy some cigarettes which (laughs) I hadn't smoked for 30 years. So I did. And I had two every morning. Don't have anymore, but I had two in the morning and a cup of tea. And I did that but erm, I mean they got me over that feeling of sort of catastrophe, calamity, and s- you were gonna explode feeling." [572-587] "you get this terrible isolation feeling when you're alone, out on a spit somewhere and there's nowhere anybody anywhere and nobody understands and (pause) and everybody's going about their business which of course they've got a perfect right to do and you could kill them all." [854-861]

Fran PETs	**ES**	**Example Transcript Quotes**
The influence of society on who I am	1. Negative expectations on getting older 2. Letting go of the person I needed to be in life 3. Reflecting on the past 4. A product of society's past	"Yeah and I had to make everybody happy before things were right, everybody and that came from childhood, from having been the one having to get my brothers and my parents all happy and ok before I was safe" [848-852] "I suppose when I read about things, it's usually if it's an older adult, they're struggling with one of the nasties, if it's not dementia then it's Parkinson's so ehm I was very anxious about what it may be , much less anxious now." [247-252] "My brothers were my mother's children, my father wanted a boy, he already got a girl with his first wife. My sister said she hated me since I was born and before because her mother had said 'if it's a girl he won't come back' about my father, don't know why, it doesn't make a lot of sense but anyway, she certainly hated me and my brothers just thought I was a nuisance. My mother said that she was pleased to have a girl but my father wasn't, he wanted a boy. And the family were very male-oriented, and my

		father being Italian and my mother not knowing what being Italian meant, he was the great God, he was the one that earned for the living and other, well she did briefly do things but she didn't have a proper job." [974-991]
The helping hand	1. Grieving the loss of the psychologist 2. Therapeutic partnership 3. Having an alternative perspective on my life 4. Marriage partnership 5. A new experience of help 6. A need to feel heard	"Int: And when you when you kind of agreed to see [name], did you have any expectations of how it may change your life in a positive way Fran: At the time an image that comes to mind is of scrabbling to get onboard a boat. Being in the river and in the water so I was just so grateful to have someone to help me climb onboard. So it was very immediate. I didn't think in terms of it changing my life, if I thought in terms of more of rescue, somewhere where I could safely explore the things that were overwhelming me. And I've always, well as far back as I know I've always seen water as a dream description of ehm of emotion. Int: So you've felt like you're onboard or drowning, is that where you see (interrupted) Fran: At that time yes, yes but my nice image is being in a little boat on my own among the reeds and getting towards the shore, nice little boat (laughs). Int: So when you came into therapy, you were not in this little boat, you were In the sea? Fran: Yes, yes I was overwhelmed by my feelings that I couldn't seem to get a handle on. Int: What did that therapy experience, when you've started engaging, what did that therapy mean to do to help you get onboard? Fran: The non-judgmental is crucial, the safe place to look at things in my past." [557-610] "Int: and when you say you need to continue working hard at things, do you think it's necessary to have someone else do that with you or do you think psychology has given you the power to do it yourself? Fran: Well, I felt the need to have someone with me. I don't know why I feared losing it too quickly before I got sort of solid. Int: Yeah, what do you think would need to have been done for you to feel empowered to be able to do things without someone else being with you?

		Fran: Well, I think having [new support] for a bit ehm offering some of these practical cognitive ways of dealing with things, following on the work that I was doing with [psychologist] is very helpful and I feel as though I turned a corner now and I'm rather chuffed about it. I think if I had stopped immediately after [psychologist] I wouldn't have felt that cause as well as the techniques it was also the personal support and that was a big loss so I think I needed if anything support over losing [psychologist] but having a bridge I fell I'm moving forward now, I've got more strength." [689-695]
Continuing a new version of myself	1. A process of positive change 2. A continued journey of processing life 3. Finding contentment in life as it is now 4. Finding inner strength to do it myself 5. Feeling and behaving differently 6. Seeing my life differently now	"Int: So this cold shower seems quite important in you feeling better in the mornings? Fran: it was nothing to do with the shower, except that I feel strong enough to try it . I think I read in New Scientist probably that they reckon that if you can't get a cold swim, a cold shower is better than nothing but it was the feeling stronger Int: Ok, So I feel like you're saying you kind of know what you need to do to get better but you needed, through therapy to do those things.. Fran: Yes, it was the strength that I lacked , also I got back to having a walk most days, Just half an hour but but most days I manage something. I'm happier ,but that's partially why I feel I've turned the corner. We, this autumn, we've had more social activities than we had in the previous four years put together I think ehm, people visiting, old friends getting in touch and saying 'can we come and see you' , an invitation to go to another old friend in [place] and a holiday on [place] which mattered a lot to us and again meeting old friends there, so very intense socially, not like me at all I feel but I've been I've just been able to let go of that crucial knot of anxiety 'have I got to control it all, have I got to get it right'. I've just been going with the flow." [726-802] "An alternative way of seeing it, yes an alternative view and she offered me simple techniques that I could get my head around like ACE, achievement, closeness, enjoyment for every day and I realised that I really struggled with enjoyment and begun noticing when like this morning I've walked into the dining-room stroke greenhouse and the sun was shining through some glass, coloured glass on the table and I really enjoyed that (laughs). So I

		would've had a moment of enjoyment probably but I wouldn't've registered it in the same way before at all . Int: So when you have those moment now do you automatically find your mind remembering those techniques in therapy? Fran: Yes, yes I do and one that [new support] taught me but [psychologist] prepared the ground was, well actually it was him and me together, because I didn't do what he wanted me to do but I worked out that if I was anxious about something that I could put it on the shelf as a little woolly mouse and come back to it later and sort it out and if it was one that I couldn't sort it was just a ball of wool maybe fairly tangled but I didn't need to sort it out just put it on the shelf (laughs) and sort it and that's actually been quite a powerful thing . It enabled me to let go of a lot of the anxieties, but it was with [psychologist] I got the groundwork for that. Int: So would you say, you mentioned [psychologist] like building this ground, would you say that the work with a psychologist isn't enough, it feels like it's ongoing process Fran: Yes, yes I'm still working at it" [621-670]

Leo PETs	**ES**	**Example Transcript Quotes**
Someone to care	Feeling alone Feeling that someone cares My life feels empty I need whoever is around	"I can't remember experiencing anything one way or other. I think all of it helped me I believe just the phone calls. I can't think of anything, honestly I could guess at something but I can't really remember. I looked forward to her coming but I think it was as much as anything to be. I looked forward to her coming, like I did you this morning and I think I definitely benefitted in some ways that I wasn't on my own." [237-256] "She comes to me regularly and she does my main bed, I can do all my smaller washing and I peg it on clips in my conservatory and ehm I can't get out to the line, I can't put it up you know, it's too much but ehm with the sheets and that so she takes it all home, washes it, airs it, irons it and brings it back . She's so kind to me but ehm she won't let me get close" [691-699] "I'm happy to be alive still, I don't see [name 1] on Thursdays I never do, so it's a rotten day for me but I may, she said on the phone to get me to go, I may have a little

		stroll this afternoon and then I will have an hour sleep. Doctor [name 7] does that you see, but his wife is there, and some days I dash over to [name 1] but I haven't got time to lay down for an hour but I will be today , so I will have a rest today but for you just being here you see I definitely feel better now when you came through that door, So I think I miss company." [1174-1195]
Convincing myself of a different reality	Reinventing the past Positive thinking Accepting my present I must continue to do the things I love Trying to be positive Re-living my own story	"It's just this sadness I just feel like I could fall down and cry my eyes out you know with this and yeah for no reason really cause I got everything to live for. " [733-737] "I often think I'm on my own, I've never met anybody who suffered like this. There are three types isn't there, depression, bipolar and another one and I worked with a chap who had one of the worst three, he was marvellous but he suffered terribly. He died when he was only about sixty, I see his wife occasionally. So he had this or was it manic depression as well, or something but he was worker and he was fun when he messed around and everything but he suffered with this, Poor chap, yeah it must have been terrible Int: So that helped to normalise it for you by knowing P: yeah in a way but I'm more lucky than he was, I'm still here for a start and I do have my evening and I do have the odd days when I'm ok." [1559-1591] "Yeah gosh she was wonderful but she keeps that distance And if I ever did mention anything like I've looked up a bed, a fold-up bed on the internet, and all I would need is a zip up, what they call it, when you get in and a pillow and I could stay over there on Saturday nights cause I go over Saturday evening, I come away like quarter to ten, dark miserable night it would be nice but she won't have it at the moment. Not in a nasty way but maybe I could get round it sometime, that'd be nice for me." [1518-1533]
Learnt privacy	It's difficult to trust other people Holding onto my sense of self Not knowing how to manage emotion	"I always think that I never met anybody, but like she said now there is plenty of people like you around you know so don't worry about that cause I was worried thinking it was just me and I often felt guilty about going to the doctors, I mean you know it's a regular thing cause I felt I was getting in somebody's way you know, so… Int: Oh, you don't like to be a burden people? That's right, yeah that's the thing. I don't tell [partner] hardly anything and I don't tell [my son]. He comes every Monday evening with me here and I always say 'oh I'm fine' you know but I might just say 'I'm not having such a good day today but I'm not too bad, I'll be all right tomorrow' and leave it at that yeah.

		Int: So you try and hide some of your emotions sometimes? Yeah, I do really yeah I do" [256-282] "I said 'oh my eldest boy, my eldest boy has been…'Oh' she said, 'I didn't know'. You see I was working here for years I didn't talk about it, he didn't know what family I had, and even my workmates sometimes I 'I haven't got any family' , you know, yeah I think it's best to keep it out of the way , you get a little bit of jealousy sometimes, I had bits of jealousy trouble over the years and it's never worried me really but I'm sorry for them, you know. Int: So you've always been this private person, do you, where do you think that comes from, in terms of were your family like that or do you think it's like a generational thing? Leo: Yeah, my father was very, yeah he didn't, my father was shot in [country 1] here [points to arm] and finished up just like that the rest of his life, cause they couldn't do anything these days but I remember playing with him one day, I was a little boy, I I've tried to get [points to touching his arm] 'no no' he said 'you can't touch that' and I've never forgot that and my mum told us what happened, he never said anything, he was very quiet, he was a reader as well and a pipe smoker but I didn't really know my parents that much." [306-351]
The final stage of life	I am about to die Life after death My mind is still young Fear of dying	"Or it could be that she could go before me, you know. Int: What do you think would help you living with her? Ehm just it's ehm very simple really, just having somebody around. You know if I, if she's out in the kitchen all morning and I'm in the other room I'd still be ok . Yeah, I think I'm a bit scared. I don't know why I haven't been scared much in my life as you know what I've been through on the end of the football army and working in the factory but ehm but yeah I do I suppose I do worry myself too much possibly but fact that if she's out there and I'm in another room yeah I'd feel somewhat better. Int: Have you always been a worrier or is that new? Uhm I don't know, I don't think so no, I think [name 2] was more a worrier than me cause I'd say to her 'don't do it, it'll happen, you know we'll be ok' . When we were going were going anywhere she'd say 'we'll never get there in time' ehm 'yes we will, we'll get there', or 'look that black cloud is coming over it's gonna rain at night 'no it's not it won't rain' and I was always right in that (both laugh) but I'm not like that. I'm not really a worrier, well I worry about my health now." [682-718]

		"Yeah and I also worry, well I suppose all fathers have to put up with that but [name 3], my [name 3], he's such a good lad and ehm I think probably he could take it better than than most people cause he took his mum very very good as well and [name 4] did. They both were very good. [name 4] did the funeral thing and it was at the, well he's a lecturer anyway but yeah ehm, it's strange" [722-730] "Well the bit of being older is that it's really it's what's going to happen to me I mean I do, last few years I suppose since I've been in this depression has been dreadful, two years now I've had it and tired and whatever it is ehm yeah ehm I I still would like to live on a bit longer but when I've been at my worst I I never thought cause I think I've told you, I've told it 'just take me on' well I felt a bit like that on a couple of times, never suicide but I felt, you know, if this is going to get any worse I will be happy just to drift away" [1160-1171]

Sue PETs	**ES**	**Example Transcript Quotes**
The weight of the past	1. The self I present to others 2. It's painful to get close to people 3. Living a life of secrecy 4. A generation of just get on with it 5. Feeling exposed 6. Painful childhood 7. How society brought me up 8. Never fully trusting others 9. Inadequate self	"Well if I've said certain things to her she'd have just just told me just go and forget about it you know she wouldn't go into it at all ehm (sigh) Int: and how do you see that? Do you see that as a thing that was in your family or do you think it was just like a generational thing. How do you see that? Sue: I think it was a generational thing." [245-271] "Int: You sound like you have a really good understanding of how that followed you through your life in the good and the bad. Do you think psychological therapy helped with that understanding or did you already know that before you engaged? Sue: Oh no I didn't know it, that's come out over the past years. I thought my father was very hard on me. You know, I played with the girls who they didn't know all about this you know. Their father didn't treat them like that. I mean he didn't, he never treated me badly, but he was always, you know, when others wanted me to go out to play I had things to do and to this extent that if I was indoors and sitting doing something but my father came in I would always get up, because to sit down would look as if I was lazy, which really if you think about it was a bit ridiculous but that's the degree that he had on me that I couldn't be judged by doing nothing." [104-139]

Therapeutic partnership	1. Seeing my life through a new lens 2. Feeling like a team 3. A difficult process 4. Therapeutic talking 5. Accepting things as they are 6. No ordinary relationship 7. A new way of living 8. Finding hope	"I did cry a lot on my own and I just wanted it to be resolved. I mean honestly do you think you notice that I've got Parkinson's? Int: No, I didn't notice. And do you think that comes from your ability to, you were saying just then that you noticed you were crying a lot on your own at home, So it really strikes me that you are someone who is very private, you have that diagnosis that no one else knows about that, it is kept within your marriage Sue: Yes Int: and you're crying at home on your own and then suddenly you come weekly to sessions and talking to some stranger about your life. how was that for you? Sue: Terrible. Well, I felt that I was really exposing myself. The only thing that pacified me was that in a hospital things are not discussed with other people so I thought well fairly safe." [501-541] "I think I found it very, maybe because I'm such a private person that I found it quite nice to be able to talk about everything to someone and like a really good friend. I used to feel that you know if I had any problems or difficulties I could talk to this person that I kept seeing and thought it'd be nice if I had this all the time. Just one person, one person that I could rely on or not to laugh or not to think I'm silly or anything like that with." [679-690] Sue: "that's the thing I suppose that there was someone there that I could tell and talk to somebody who wouldn't think anything silly about the things I was asking them, stopped me from crying I suppose and so I've always felt that if you could find a friend, a good friend, a friend that you knew would not disclose things that would be marvellous. Strangely enough I have gone out of my way to find this special friend and I had thought I found them but then they let me down and I know I'm not going to manage this cause I hear about people who have a good friend. I've got lots of friends, lots of colleagues but they're not what I would class as I could talk about intimate things with them." [679-697]
Unprepared to age	1. The cumulative	"I think maybe, when I was working that I really had too much on my plate so now,I must admit, I have to say that being retired is, it is not exactly

	worries of life 2. Age removes autonomy 3. The ruminating mind 4. The deteriorating body 5. The unfulfilling age 6. Retirement fallacy 7. Life halt 8. The friendship of marriage	what I've imagined at all, if anyone thinks when you retire you've got all the time in the world I haven't got any time in the world. [563-571] Int: Do you think retirement had an impact on your mental health? Sue: Yes, if I had had my way and I would have still been single, I would have carried on working. My husband wanted me to stop working… and nevertheless I do think some days, all my friends have got babies, grand grandchildren and it would be nice" [563-621] "well I thought retirement was you know you've got terrible troubles at work when you're working and you resolve them, but then you will be completely free but you're not, well I wasn't I don't know, it's just I had so many other problems and I'm sure it's even worse with people who have children because you know that's always the way. They've always got something wrong that they need sorting. I can't say that retirement you know that you are free of everything and everything in the garden is lovely, it's not." [662-675] "Sue: Going forward, I wish I was young again because I've got Parkinson's I can't drive, I can't dance which is a big big thing for me. I used to love to dance. There is so many things that I can't do anymore and I don't like it. We all have to go through these different phases and my husband he just wants to be with me all the time and I think it is the safest way. We have been in a habit of going cruising and since COVID we haven't been able to do that, I think they're doing it now again but my husband won't go again because they're very crowded in some places and you sit near people and you know this COVID is still rising so he won't go on a cruise so we decided just to have a break. Weeks ago and we went to [location] and we had a wonderful time, just the two of us, and it wasn't because of weather was wonderful, it didn't have to be wonderful and so that's the sort of thing we'll be doing from now on rather than you know organized big affairs." [1014-1043]

<u>All Personal Experiential Statements</u>

Ben:
-My place in society
-Someone to navigate life with

-My own journey I must continue

Sue:
-The weight of the past
-Therapeutic partnership
-Unprepared to age

Phil
-Childhood shadows
-Continuing my journey
-Re-writing my story

Fran:
-The influence of society on who I am
-The helping hand
-Continuing a new version of myself

Leo:
-Someone to care
-Convincing myself of a different reality
-Learnt privacy
-The final stage of life

Cath:
-Final stages of life
-The person my generation forced me to do be
-A two-way relationship
-Desperate for help

Get1: Processing my created identity [changed to processing my identity]	**Get 2: The powerful therapy relationship**	**Get3: Continuing my journey**
Sub-theme 1: Childhood Shadows	Sub-theme 1: A friend with boundaries [Changed to a temporary friend with boundaries]	Sub-theme 1: Using what I have leant
Sub-theme 2: Raised by society	Sub-theme 2: The rescue	Sub-theme 2: A new me [Changed to Accommodating a new me]

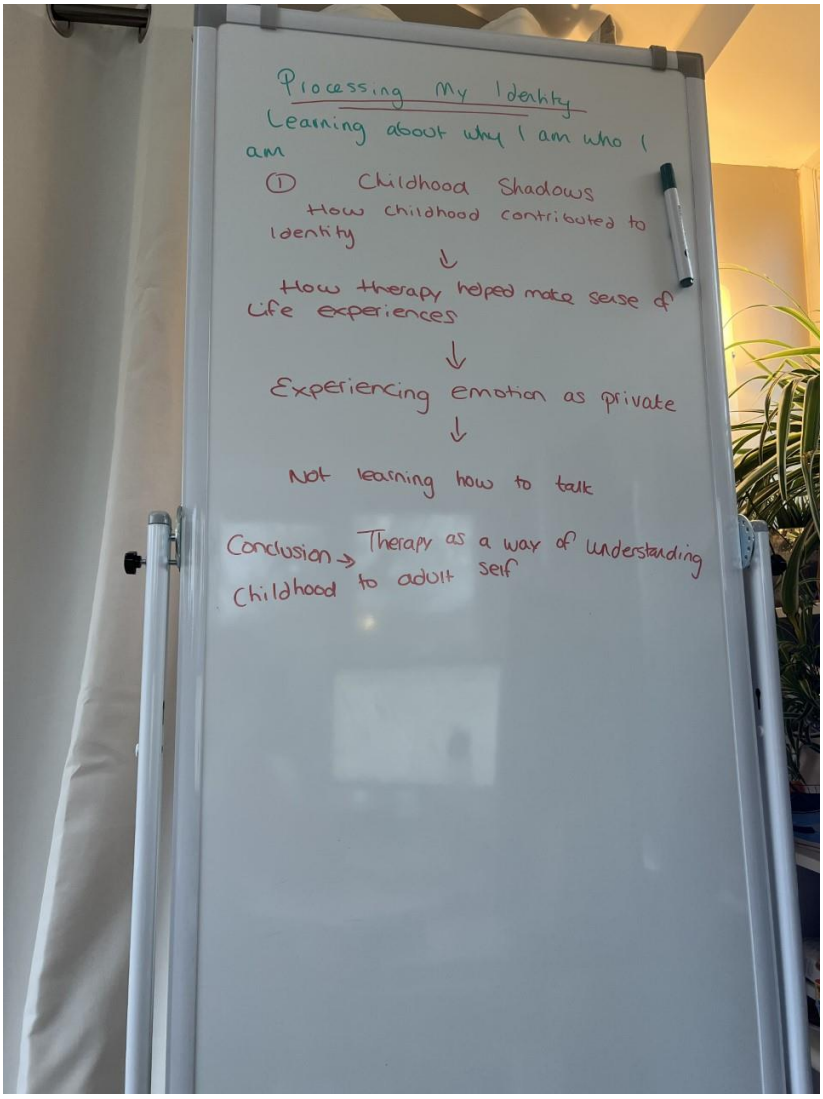
Writing the Narrative

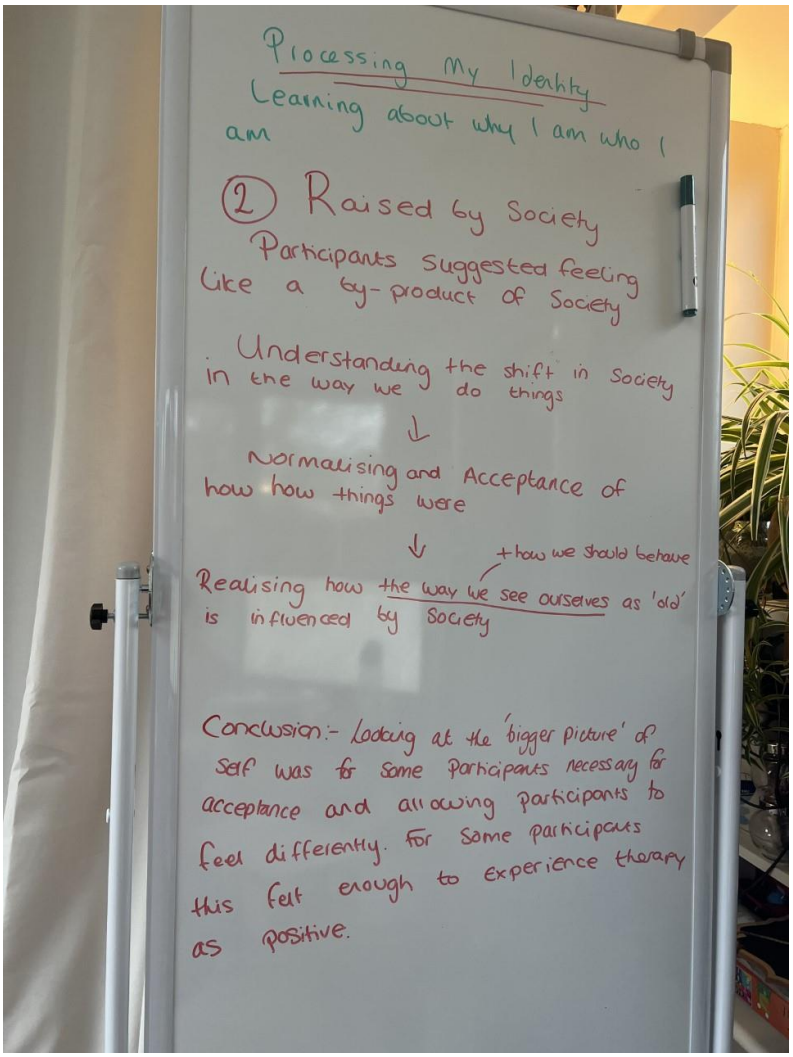
Results Section Reflections

I initially felt writing the results of my thesis project free flowing. I got lost in the words participants were saying. I felt connected to each of the participants in a way that meant I wanted to capture every single nuance that was said. In doing this, I lost sense of the research focus and question. My supervisors gave a helicopter view and external perspective that allowed me to realise that what I had captured was really interesting and

important views from older people, which could relate to multiple questions. What was now important to capture what how these important aspects contributed to their experience of therapy. Which parts of their narrative really highlight this experience and which parts allow us to take their words and really understand and improve therapy experiences. From this, my analysis continues.

Firstly, I changed the first GET. I started to think that this was not about processing a 'created' identity – this was simply processing their identity. The identity that they had pre 65 may have been different to what they had post 65, for reasons explained through therapy. I created a visual map to guide my narrative of this. Specifically, this helped with identifying how quotes captured the overarching theme, how they added a layer to the story and ensured I brought it back to the overarching theme. This helped me to reduce quotes to highlight how they really gave this insight. Instead of just highlighting aspects of childhood, it allowed me to tell the reader why this understanding of childhood was key through therapy. This gave me room to add quotes where the interpretation needed more evidence.

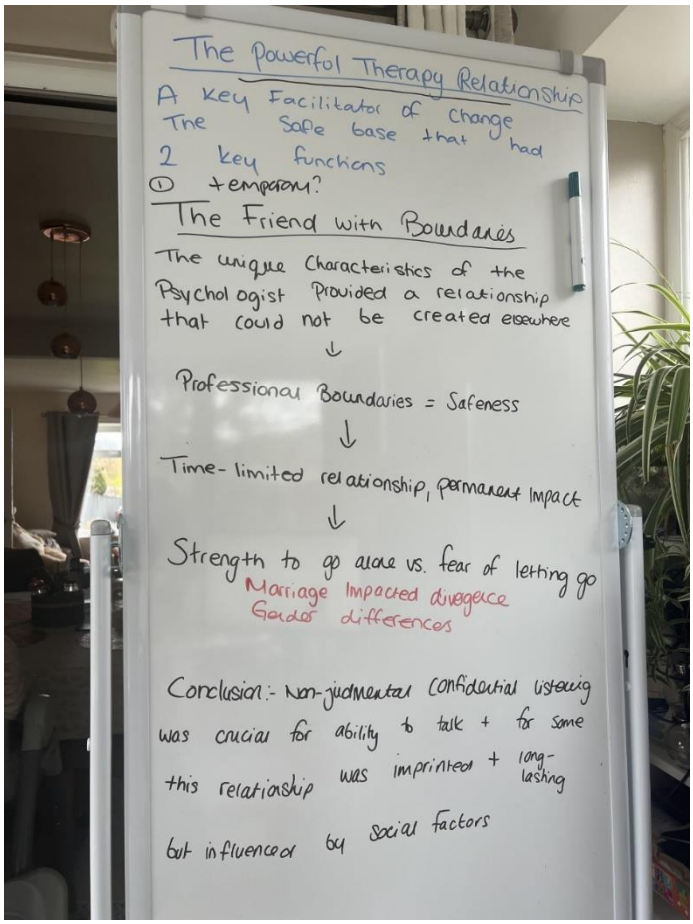


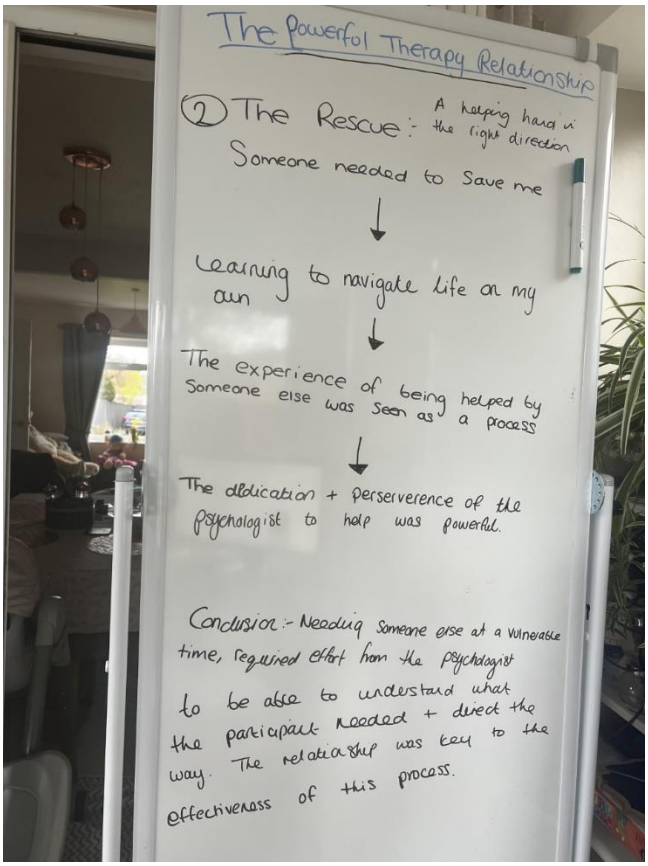


Secondly, I reviewed the 2nd GET and by drawing a map and highlighting what the quotes were saying, this allowed a continuation of the analysis. What became evident was that this GET was the core of the other two. Through this relationship, the first GET was possible and through the therapeutic relationship, the final GET could be achieved. This meant there was overlap in quotes and I used a visual board to decide which GET the quotes spoke of. For example, there was a quote by Phil which showed how crying in the therapy room allowed him to feel differently and meant he was no longer scared to cry. I initially had this in the final GET (continuing my journey) as it was something that allowed him to change from therapy. However, when I reviewed this, it allowed me to see the pertinence of the therapy relationship – how the response from the psychologist had allowed him to feel differently about crying and how the response from the psychologist was pivotal. This was thus moved into the 2nd GET. I added more quotes on marriage to highlight the divergence experienced between participants, which did not seem to be initially clear to the reader.

The final GET felt well placed and flowed well. I made little changes here, apart from reducing quotes to help the reader and also moving some between the 2nd GET.

Overall, I had previously seen the 3 GET's as distinct and this really highlighted how they overlapped and intersected, which fed into my discussion section.


The Powerful Therapy Relationship
A key Facilitator of Change
The Safe base that had
2 key functions
① +empathy?
The Friend with Boundaries
The unique characteristics of the Psychologist provided a relationship that could not be created elsewhere
↓
Professional Boundaries = Safeness
↓
Time-limited relationship, permanent impact
↓
Strength to go alone vs. fear of letting go
Marriage impacted divergence
Gender differences
Conclusion:- Non-judmental confidential listening was crucial for ability to talk + for some this relationship was imprinted + long-lasting
but influenced by social factors


The Powerful Therapy Relationship
② The Rescue :- A helping hand in the right direction
Someone needed to Save me
Learning to navigate life on my own
The experience of being helped by Someone else was Seen as a process
The dedication + perserverence of the psychologist to help was powerful.
Conclusion :- Needing Someone else at a vulnerable time, required effort from the psychologist to be able to understand what the participant needed + direct the way. The relationship was key to the effectiveness of this process.