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PROFESSIONAL DOCTORATE IN COUNSELLING PSYCHOLOGY

“Older Adults’ Experience of Psychological Therapy”

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***A Portfolio submitted to meet the criteria for the
Degree of Doctor of Psychology (DPsych)***

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London

4th November 2013



**THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN
REDACTED FOR DATA PROTECTION/CONFIDENTIALITY
REASONS:**

pp 172-198:	Section C. Client study: A complex case of an older adult's experiences of insomnia and depression.
p 228:	Appendix 1. Field notes.
pp 231-232:	Appendix 4. Field notes.
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Finally and definitely not least, I would like to dedicate this thesis to my children for their unconditional love and support all through my career as a Psychologist.

Monday, 4th November 2013

AUTHOR'S DECLARATION

To Whom It May Concern:

I, Maureen McIntosh declare that this thesis, which is submitted to meet the criteria for the degree of Doctor of Psychology (DPsych) entitled "*Older Adults' Experience of Psychological Therapy*", is an original study carried out through my own research. All the results and conclusions drawn are from this study unless otherwise acknowledged in the text and references. I also give my permission that City University (London), can use this dissertation to be copied without further referring to me, only single copies to be used for the objective of study according to the usual requirements of City University (London).

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ABSTRACT

The portfolio examines the older adult experience of psychological therapy.

The research study is from the older adult perspective and it provides a rich narrative and strengthens theory and practice links. This research explored older adult service users' retrospective accounts of Psychological Therapy within a secondary care service. The aim was to enhance the knowledge base and understanding of what is known about older adults' subjective experiences of the processes involved when receiving Psychological Therapy. A qualitative methodology was chosen to allow the older adult participants to express their thoughts and feelings using unstructured interviews. The Grounded Theory analysis revealed categories and themes which produced a theory that explains the process of therapy. Nine older adult participants volunteered to take part and a grounded theory analysis of the data yielded a core category of '*moving towards equanimity*'. The category can be understood as contributing to the older adult participants regaining emotional stability, mental calm and balance.

Within the Professional Practice section the case study features the complexity of the therapeutic work with an older adult who experienced depression and insomnia. The case examines the flexibility in the use of the therapeutic model and the core skills required within a strong therapeutic relationship which helped the older adult hold onto hope.

The final part of the portfolio is a critical review about older adults and the therapeutic alliance. The review examines studies that have explored this extensive research area to raise awareness of the factors that influence the development of the alliance with older adults.

INTRODUCTION TO THE PORTFOLIO

Section A: Preface

Ageing is an important feature of “diversity” and there are a lack of journal articles within Counselling Psychology publications that draw attention to process issues and what is similar or divergent “across the lifespan” (Werth et al, 2003, p.806). It is widely acknowledged that Psychological therapies (Gatz, 2007; Laidlaw et al, 2003; Andrew, Fisk & Rockwood, 2012; Garner, 2003) can support the mental well-being of older adults. Psychology services are trying to make a difference to older adults against a background of debate on the subject of ageing. Research about Psychologists’ understanding of the client experience enhances theory to practice links (Llewellyn & Hardy, 2001).

The following sections illustrate different but related aspects of working with older adults therapeutically. In section B this original piece of process research examines how older adults experience therapy which can advance Psychologists’ knowledge and skills of what older adults expect from therapy from their perspective. In Section C the case study draws on my clinical experience of working with older adults and it reflects on my clinical judgement, treatment interventions and the therapy relationship. The case highlights how the generational factors, co-morbidity of physical health problems, psychological health and risk issues were managed when unexpected events occurred during the course of the therapeutic work. Finally, section D critically reviews the literature about older adults and the therapeutic alliance. This topic of the therapy alliance is an expansive area of study and it is considered to be central for change in therapy to take place (Norcross & Hill, 2004; Bordin, 1979). Critically reviewing the influences on the alliance when working with this client group allows Counselling Psychologists to adapt their way of working to align themselves to what older adults’ needs are.

Section B – Research study

This section is about research that used a Constructivist Grounded Theory method to explore Older Adults Experience of Psychological Therapy. It has four chapters that include the: Introduction, Methodology, Findings and Discussion. The Introduction begins with a broad view of the discourse, statistics about ageing within the UK, psychological provision for older adults and existing research about their experience of therapy. The literature highlights that there is still inequalities to accessing mental health services (Age Concern, 2006). Changes within some government policies have expanded the service for Improving Access to Psychological Therapy to redress this disparity (Department of Health – DOH, 2012).

Chapter one also incorporates an overview of quantitative and qualitative research that examines the older adult experience of Psychological Therapy and what those studies contribute to clinical practice. The gaps in research demonstrate that more qualitative studies are needed to describe the process of therapy for all client groups (Llewellyn & Hardy, 2001) and in particular for older adults where there is less research (Katz & Mishler, 2003). The research aims at the end of this chapter highlights where this study is located and the importance of studies exploring the subjective experiences of older adults in therapy.

In chapter two, qualitative methodology and the constructivist grounded theory methods are described to show the appropriateness of the research question, design, strategy and analysis of the data in the exploration of the older adults' viewpoint. The reflexive stance of the researcher and the inter-dependence between the researcher and participant in the co-construction of meaning regarding the participant's experience (Charmaz, 2006) is also featured.

In chapter three the findings of this research study explains the process of therapy for these participants and the theory that emerged from the data. Four categories and nineteen sub-categories show the journey through therapy and the relationship with the core category of 'moving towards

equanimity'. This chapter also features quotes to highlight the participants' voice and illustrates links with the researcher's interpretations.

In the fourth chapter the discussion draws on existing literature about the older adult participants' self-identity and how negative life events and other challenges during this developmental stage impacted on the participants causing distress and instability. The extant research presented elucidates on how the older adult is helped back to emotional balance within a supportive therapeutic relationship that takes account of the whole person. After the fourth chapter the reflexivity section will explore the researcher's personal, epistemological and methodological perspective of the research process. This is an important part of conducting qualitative research because it demonstrates where, as a researcher, I am positioned and identifies my underlying assumptions and how this may have impacted upon the research (Kaskett, 2012). Within this section I have used my journal to reflect on the methodological issues that arose to give some thought to my views about the research partnership with the participants and the overall process.

Section C: Professional Practice

Chapter five expands on the theory to practice links of working with older adults. This case study was chosen to demonstrate the complex work that I do as a Counselling Psychologist with older adults. The case illustrates how depression, insomnia and suicidal ideas were worked on therapeutically with the older adult client. The Cognitive Behavioural therapy (CBT) model was used flexibly and it was also formulation driven. The therapy alliance was also central to managing the risk issues that developed within therapy. Supervision was a key support throughout the work and when reformulating about the client's needs. The rationale for reviewing the case and introducing a mindfulness approach alongside the cognitive behavioural model is also discussed.

Section D – Critical Review

A Critical review of older adults and the therapeutic alliance was undertaken to highlight the factors that are relevant for this client group. The therapeutic alliance is a significant area of research within psychotherapy because it examines the different factors which influence the development of the therapeutic relationship. Although it is an under-researched area from the perspective of how to work with alliance issues and older adults, the review examines the current and past research to highlight what is important to know when working with older adults in therapy in order to create a robust working relationship.

DOCTORAL RESEARCH

Older Adults' Experience of Psychological Therapy

CHAPTER 1

INTRODUCTION

There is a wealth of knowledge psychologists can learn about the older adult's subjective view of therapy through process research (Llewellyn & Hardy, 2001). Thus, clinical practice can be enhanced as the Counselling Psychologist connects with the older adult's experience through increased awareness (Elliott and James, 1989).

However, there are mixed attitudes within society regarding old age. Unhelpful ideas about ageing can contribute to the "neglect and exclusion" of many older adults by constructing a view of them as being a burden to society (Stephen & Flick, 2010, p.644). Nevertheless, it is acknowledged that we live in an ageing society and current debates about the ageing population, in the United Kingdom (UK) shows there were 1.7 million more people over 65 than in previous years (Office of National Statistics - ONS, 2012). Furthermore, future estimates for 2035 predict that older adults (65+) will represent 23% of people within the UK (ONS, 2012). There is also an emphasis on the impact of dementia on communities and future implications for service provision within the National Health Service (NHS). For example, reports that there are "36 million people worldwide...without a formal diagnosis" of dementia sends a powerful message about the potential challenges that are to come (World Alzheimer, 2011, p.2). In this current climate the NHS has redesigned the mental health provision for older adult services to account for these changes within this population.

Delivering Psychological Therapy to older adults has become a government priority with the expansion of their Improving Access to Psychological Therapies (IAPT) to include older adults (DoH, 2012). The British Psychological Society (BPS, 2006) has also set out what psychology services should be providing for older adults, to support their mental health. Despite these improvements, the evidence still highlights disparities in health provision and

access to mental health services (Royal College of Psychiatrists - RCPSYCH, 2013; DOH, 2004). Gatz (2007) argues that the difficulty for older adults, who have psychological problems, is being able to secure a referral to a Psychologist. For older adults who see their General Practitioner (GP) about “depression” (RCPSYCH, 2013, p.60) only half are referred onto specialist services (Age Concern, 2007). As older adults can experience variability in the care they receive (Clark et al, 2003), health professionals’ should be assisted to make an early assessment and refer older adults on to the most appropriate service (RCPSYCH, 2013).

A number of additional initiatives for service providers have been put into place, such as “The Mandate” policy where the Government instructs the NHS to give an enhanced service for patients (DoH, 2012, p.3). There is a further emphasis stating it is crucial for older adults to receive “...dignified and compassionate care” within the NHS (DoH, 2011, p.2).

In order for older adult services to provide care to the elderly that maintains their dignity, the perspectives of older adults need to be heard. Mulholland (2011) acknowledges that hearing the client’s viewpoint is one of the many NHS targets considered to be important for clients to have a say in developing services (National Health Service Quality Improvement Scotland - NHS QIS, 2006). Furthermore, the National Institute for Health and Clinical Excellence (NICE) suggested that more research is needed within the communities where people live (Thornicroft et al, 1998). Fudge et al (2007) conducted research on user involvement and reported that older adults want to take part in studies that have a direct impact on the delivery of services and implementation of policy.

Thus, the importance of psychologists conducting studies about the client’s experience of therapy (Stone & Elliott, 2011) can also bring a wealth of knowledge that highlights their story (Bonsmann, 2010). The utility of research that gives the client perspective about

psychological therapy is important. It means that their feedback can be incorporated into “service planning and implementation” (Howse et al, 2005, p.63).

Psychological therapies

Obstacles such as ageist barriers and a more medical perspective have led to therapy for older adults trailing behind that of younger client groups (Hepple, 2004). However, psychology for older adults is shown to be effective (Gatz, 2007; Laidlaw & Baikie, 2007). Psychological Therapy offers a variety of therapeutic approaches that help older adults cope with problems in life, and is also considered an important intervention that compliments medication (Evans & Reynolds, 2006).

For some older adults ageing can be arduous due to the gradual progression of illnesses that they experience (Knight, 2004). Research demonstrates that proven psychological models enhance the mental well-being of older adults (Pinquart et al, 2006; Woods, 2003). Using talking therapies, the Psychologist helps the older adult converse about their problems. Woods (2003) suggested that the differences for psychologists who provide a specialist service are the factors that continually challenge older adults in their everyday life. Therefore, adjusting therapy accordingly may be necessary (Knight, 2004) for some older adults.

Entering into therapy can give people the opportunity to experience independence, feel capable and offer a sense of connectedness to others (Ryan & Deci, 2000). Therefore, conducting process research about what the older adult thought about therapy, how it affected them and what took place in the room, can help clinicians address their psychological needs successfully (Werth et al, 2003).

Process research

It is asserted that methods based solely on observable facts are too limiting for exploring client experiences as it hides topics such as “power and privilege”, due to the structured procedures used (Pfaffenberger, 2006, p.336).

Researching “psychological therapeutic process” takes account of what happens in the therapeutic encounter and the procedures that help to transform the individual (Llewellyn & Hardy, 2001, p.2). This type of study investigates the influences and reciprocal actions between client and therapist (Greensberg and Pinsoff, 1986) highlighting the interpersonal context and how it is understood by both parties (Llewellyn & Hardy, 2001).

Llewellyn and Hardy (2001, p.2) suggest that “process research” within therapy falls into three main categories: the first being “exploratory” research which is used to explain the phenomenon under study and what happens in the session; then “hypothesis testing” which demonstrates the connection with “process and outcome” and lastly, “theory development” identifies the changes that take place within the person due to the therapeutic process (Llewellyn and Hardy, 2001, p.1). To understand the components that create such “rich interactions” studies need to uncover what takes place in therapy (Llewellyn and Hardy, 2001, p.2).

Process research is a way for psychologists to stay informed about interpersonal factors in clinical practice (Llewellyn and Hardy, 2001; Orlinsky, Grawe, and Parks, 1994). However, there is a paucity of qualitative research which is considered to be apposite when specifying the elements (Rennie, 1994b; Morrow, 2005) within the person’s experience of therapy. Using qualitative methods allows the researcher to take an emic position when making sense of the participants’ perspective (Maione & Chenail, 1999).

Quantitative and mixed methods studies about client experiences

The “hypothesis-testing” approach explores the relationship between therapy “process and outcome” (Llewellyn & Hardy, 2001, p.6). There has been a substantial contribution using this approach to show the importance of the therapeutic relationship as a medium for change (Orlinksy & Howard, 1986; Bachelor & Horvath, 1999).

There is a large amount of quantitative research methods used to investigate therapeutic models (Gatz, 2007), for instance Cognitive Behavioural Therapy (CBT), (Lund et al, 2013; Barrowclough et al, 2001), systemic therapy (Ward et al, 2007) and psychodynamic psychotherapy (Rossborough, Luptak & McLeod, 2013). Yet, there are more research studies about older peoples’ experience of CBT, which may not fully examine all aspects of the older adult experience of therapy (Gatz, 2007).

‘Hypothesis-testing’ (Llewellyn & Hardy, 2001, p.6) research does not offer a sense of how the interventions work with “co-morbidity” (Gatz, 2007, p.53). In addition, there will also be differences in the way practitioners deliver therapy in their clinical work, when compared to the findings of “Randomized Control Trials” (Gatz, 2007, p.53). Therefore, conducting research that emphasises practice-theory links to demonstrate the components that lead to change is more helpful for psychologists (Smith & Grawe, 2003).

Arean et al (2003, p.9) argue that research about psychotherapy and older adults is dominated by “RCT’s” (Randomized Control Trials). For example Barrowclough et al (2001, p.761) demonstrated that “CBT is effective” and retained by older adults who presented with anxiety one year post-treatment. Moreover, Gum et al (2006, p.14) conducted an “RCT” on the choice of interventions by older adults’ with depression. They proposed that older

adults'prefer therapy instead of medicines and are likely to be pro-active when seeking treatment if they have been informed as to what is available. This indicates that having a choice is of some significance to them (Gum et al, 2006).

Barrowclough et al, (2001) and Gum et al (2006) suggest from their respective studies that therapy is what older adults'want and benefit from, which is useful. Therefore, understanding what therapy means to older adults'would extend this area of research further. Expanding on the issues that concern older adults have also been derived from mixed methodologies which offers a way to transverse both quantitative and qualitative methods.

Wittink et al, (2008) used a mixed-methods approach to investigate the older adults' perspective of "moderate depression" (Wittink et al, 2008, p.1176). There were nineteen older adult participants who were asked questions about their mood for the "quantitative" stage of the research (p.1176). For the qualitative part the participants were interviewed about their perspectives on "depression" and the data was examined for recurrent ideas (Wittink et al, 2008, p.1176). The authors concluded that participants found the GP's correct evaluation of the problem helpful (Wittink et al, 2008). However, they felt there was a lack of understanding with regard to low mood and other circumstances that related to their situation (Wittink et al, 2008).

There are implications' regarding how illness is understood as it is important if treatment interventions are to be effective (Wittink et al, 2008). Thus, if older adults perceive that professionals do not fully comprehend their difficulties (Howse et al, 2005, p.63) it may reduce the effectiveness of the treatment (Quinn, 2008). A study's methods should not obscure vital information that pertains to the participant (Gallegos, 2005) instead the research design should be applicable to the type of data to be collected (Elliott & Lazenbatt, 2005).

Quinn (2008) also conducted a study to explore what older adults think about psychological problems. She used a mixed methods design to gather more detailed accounts about their stance regarding mental health problems and their perspectives on receiving treatment from a “psychologist or psychiatrist” (Quinn, 2008, p.6). Her findings demonstrated that personal experience, being able to adjust emotionally, becoming older and coping with difficulty does impact on older adults beliefs about mental health problems (Quinn, 2008).

It is important to hear the perspective of older adults who come to therapy so their viewpoints and the meanings of their experiences are better understood (Willig, 2001). In the following mixed method study hearing about the efficacy of therapy in advance helped older adults decide to commence treatment. It also encouraged them to feel a sense of “hope” about what could be gained at the end of the process (Woodhead, Ivan & Emery, 2012, p.162).

Woodhead, Ivan and Emery (2013, p.260) continued their research into why older adults “engage in psychotherapy”. Their data suggested the main reasons for seeking therapy were: the gains participants saw within those who experienced therapy and because they wanted to develop new ways to manage their “depression” (Woodhead, Ivan and Emery, 2013, p.267). These findings were also influenced by older adults’ experience of mental health interventions in the past (Woodhead, Ivan & Emery, 2013). They conclude that developing more methods that prepares older adults who have never experienced therapy before can help to reduce obstacles, enhance “psychotherapy engagement”; whilst managing beliefs and attitudes about the process (Woodhead, Ivan & Emery, 2013, p.271).

The aforementioned studies produced interesting findings about how older adults make sense of the challenges they face and the importance of being understood by the systems they come into contact with. Therefore, it is useful to develop alternative perspectives on ageing given that older adults are individuals in their own right, and should not be judged just by their age

alone, if quality services are to be provided to them (Howse et al, 2005). Research that can make sense of the client experience can produce new learning (Bonsmann, 2010) and improve the level of support they receive.

Although quantitative and mixed methods approaches bring new knowledge about older adults' experiences, therapy models and emotional difficulties; there is less emphasis on the subjective experience that would offer a more "descriptive approach" to exploring what occurs in therapy (Lewellyn & Hardy, 2001, p.3).

What can be helpful about qualitative methodologies is that they offer a richness of data which is beneficial to furthering understanding about what older adults require from talking therapies. Therefore, when Psychologists study the older adult client's experiences of therapy it can help all professionals involved in their care to become more cognisant of their needs and perceptions (Bonsmann, 2010; Howe, 1996).

Qualitative Research and the client experience

The "meaning," of a person's lived experience is best communicated through the use of qualitative methodology (Rennie, 2004, p.37). The approach encompasses principles that purport to be supportive and accepting of "client agency" (Rennie, 2004, p.49) so they can achieve their goals (Lee, 2004). It is well-known among theorists and practitioners of therapy that the therapeutic alliance (Norcross & Hill, 2004) is a "vehicle for change" (Laughton-Brown, 2010, p.6). Therefore, it can be helpful to understand the quality of interaction between the older adult and the therapist, where the process can be captured through qualitative research methods (Llewellyn & Hardy, 2001). Rayner et al (2011, p.299) report that the "client and therapist" perception of the therapeutic process can differ in perspectives (Elliott & Shapiro, 1992; Helmeke & Sprenkle, 2000). Hence, including older adults in

research means that their personal stories can be studied and this can be empowering to them (Wenger, 2003).

Bonsmann (2010, p.31) used “narrative methods” to promote an understanding of the participant’s experience of therapy. Her aim was not to seek veracity about the experience, instead to give an explanation about the relationship (Macran et al, 1999) within the therapeutic environment. The findings showed that examining the clients’ experience draws out the many elements about the “therapy process” (Bonsmann, 2010, p.41). Bonsmann (2010) described that participants’ stories highlighted issues such as “congruence, pacing, power, boundaries and ethics” (Bonsmann, 2010, p.31). She suggests that clients’ narratives can teach “Counselling Psychologists” (p.41) how to provide a service that is useful to the client. Bonsmann (2010) concludes that her findings indicate that the participants simply wish for a “space” to talk about their experiences (p.42).

Nelson and Quintana (2005, p.345) point to the usefulness of the “constructivist-interpretive” framework and qualitative methods that allows the participant to identify what is their concern rather than predestine the concepts. Heath (2011) used a grounded theory method to explore how older adults experienced group therapy and the processes that takes place within that context. Her study established that participants’ experience of “change” highlighted a core category of “Counteracting Forces” that helped them gain knowledge and experience acceptance as they felt heard in group therapy (Heath, 2011, p.29). “Counteracting forces” can be explained as the interaction that took place between the “person, societal factors and within group” therapy contributing to the participants “experience of change” (Heath, 2011, p.33).

The discourse about therapy outcomes is a question that has a powerful influence on the research, theory and practice within the field of therapy (Ward et al, 2007). Castonguay et al (2006) observed that the therapy alliance is central to the work therapists and clients do. It has been argued that in order for therapy to be of benefit to the individual certain conditions need to be present, where the type of interaction between the therapist and client moves the process forward (Kivnick & Kavka, 1999).

Psychologists working with older adults can offer a different insight into the complex world of the older adult, with qualitative research highlighting the specific experience of the individual (Abad-Corpa et al, 2010). Exploring process in therapy cannot be underestimated because of the meaning for older adults, as it positions the client in “their social and cultural settings” (Katz & Mishler, 2003, p.35). It is therefore important that researchers select procedures that are receptive to the situation under study. This allows the meanings to be elucidated within the stories that are told, thereby conveying how the persons’ experiences are “organized and change over time...” (Katz & Mishler, 2003, p.36).

The research question

The existing research featured in this introduction highlight the need for more studies that reflect the process of therapy for older adults. This will be the remit of the current study. The research question of what is the older adults’ experience of psychological therapy examines the processes within therapy. The therapeutic work and what takes place between a Psychologist and client can be complicated to unravel, with some aspects that remain hidden unless the process is fully explored (Polkinghorne, 1999).

The older adult's perspective helps Psychologists acquire information that only the individual would have "privileged access" to (Elliott & James, 1989, p.445). It also "gives voice" (Willig, 2001, p.12) to individuals who can often encounter difficulties with being heard.

Additionally, this research will be an opportunity for older adults who often experience age discrimination (Age Concern, 2006) to talk about their experience of receiving therapy. Process research that is geared towards extrapolating information on the older adult's journey in therapy can enhance a psychologists' existing knowledge base (Elliott, 1983) as well as add to a body of research that highlights a gap pertaining to this particular clinical group (Atwal & Calwell, 2005).

This research will demonstrate how the particular needs of older adults are understood and worked with in a therapeutic context. This type of study connects well with "clinical practice" (Llewellyn & Hardy, 2001, p.14) and can be used as a procedural approach to look more closely at the therapy journey (Smith & Grawe, 2003). The research will examine the "dynamic interactive process" and the specialist way of working with older adults (Llewellyn & Hardy, 2001, p.15) from the older adults' viewpoint.

In addition to comprehending the older adult's attitudes and beliefs about the therapy process, a theory will be developed from the qualitative data capturing the valuable elements of therapy. A qualitative research methodology that specifies a set of principles and procedures with unstructured interviews will allow the older adult the flexibility they require to re-count what they consider to be important. The research will "re-construct" the meaning (Mills et al, 2006, p.26) using a constructivist grounded theory method (Charmaz, 2006). Examining the participants' stories and this allows for the construction of a theory that represents the prominent processes within the categories that emerge (Willig, 2001).

In chapter two of the methodology I have set out the principles and procedures which guided this constructivist grounded theory about the older adults' experience of therapy.

CHAPTER 2

METHODOLOGY

An Introduction to the Methodology Chapter

This chapter features discussions on how the research question was developed; the research aims, the design in addition to a brief history about grounded theory and the different versions. There will be particular consideration given to the constructivist approach and choice of methodology. The researcher used a reflexive stance to contemplate what the influences were on the method (Kaskett, 2012). Finally, the chapter sets out the research strategy, procedures and analysis including debates around quality issues that relate to qualitative research, permitting the reader to appraise the quality standards utilized in this study (Charmaz, 2006). The reflexivity section is located after chapter four examining how the researcher's positioning may have influenced the decisions taken during the research process (Kaskett, 2012).

The Research Question

For the research question to be effective, consideration was given to assess whether the methodology could answer the question, about what is the older adults' experience of psychological therapy. The researcher agrees with Arobotto and Shaw's (2006, p.17) assertion that "qualitative methods in psychology are designed to embrace the messiness of human existence". Green and Britten (1998) state that the methodology and the research question need to be in accord and in this current study the methods take account of the complexity of the lived experience. The research question evolved from a discussion with my clinical manager, a Consultant Clinical Psychologist, who has worked with older adults for

more than twenty five years. The conversation was about my plan to undertake research with older adults. She suggested that my clinical practice as a Counselling Psychologist could be turned into a question asking how older adults experience processes within therapy (Harper, 2008). I hoped the knowledge gained would be of benefit to the delivery of psychological therapies for older adults (Mruck & Gunter, 2007), and that the experience for the participants who agreed to share their story would be a valuable and positive one.

As a Practitioner Psychologist, I considered what other motivating factors had contributed to my decision to explore this area. One factor that is ever present within the National Health Service (NHS) is a culture where performance indicators often become the driving force behind good clinical outcomes. My clinical experience of working with older adults is that the therapeutic process has richer meanings that go beyond numerical data (Curry et al, 2009). I hoped to capture that in my research and learn how they experienced that process to enhance clinical practice. I was aware that qualitative studies can offer a way to substantiate psychological therapies being of benefit for older adults, as research currently suggests (Woods, 2003; Knight, 2004); whilst demonstrating how the client incorporates such changes within their own “biography” (Green & Britten, 1998, p.1231).

I reflected upon my starting point as I gave some thought to the title of my research; *Older Adults’ Experience of Psychological Therapy*. I recalled that an Occupational Therapy colleague taking an interest in my research topic commented that the research question was broad implying that it was not specific enough. I had constructed a scenario in my researcher’s mind of the participants taking the lead in describing what aspects of their experience of therapy they wanted to share and I was curious about what their stories might reveal. Therefore, I decided to loosely frame the research question (*Can you tell me about your experience of therapy, and what was that like for you?*), to capture the “emic”

perspective (Wilson Scott & Howell, 2008, p.3) and allow the participants to speak openly about their subjective experiences.

Using this approach, can help build knowledge about the processes involved in therapy, and how older adults experience what Psychologists do, which in turn can help deepen understanding about their experience and improve the practitioner's effectiveness during treatment (Elliott, 1989).

Research Aims

The research study had three aims. Firstly, to increase understanding and knowledge about the processes involved in the older adults' therapeutic experience. Secondly, understand the participants' attitudes and beliefs about the therapeutic process. Finally, develop a theory that offered an explanation of the participants' experience.

Research Design

The research is situated within the Constructivist Grounded Theory tradition, which is part of the grounded theory framework. This paradigm suggests that the researcher is also part of the process of "reconstructing" the meaning from the participants' experiences (Mills et al, 2006, p.26). The researcher found that this conceptual framework gave rich significance to the stories told by the older adult participants, it drew out complex issues that seemed important to them (Mills et al, 2006). The mutual exchange between the participant and researcher helped the research process and provided a theory that allowed their story to be depicted (Mills et al, 2006).

A Brief History: Grounded Theory

The grounded theory framework arose from deliberations about research during the “1920s and 1930s”, when conversations about developing a different method that examined human beings commenced (Denzin & Lincoln, 2000, p.1). Theorists from the “Chicago School” explored whether qualitative research could be used to enquire about everyday life (Denzin & Lincoln, 2000, p.1). The discourse paved the way for a co-construction of knowledge, experience and meanings attributed to that reality (Denzin & Lincoln, 2000). Grounded theory originated with the work of Glaser and Strauss (1967) and represents a paradigm that has expanded and progressed since its inception in the 1960s (Glaser and Strauss, 1967). What this framework offers is an alternative perspective which suggests that social behavior could be accounted for and discovered through research (Suddaby, 2006).

These methods focused on a path that incorporated distinct stages from the generation of codes observed in the data, to concepts and how they relate to each other, which then lead to a core category. Finally, a model is produced that elucidates the processes of the experience under study and its meaning (Locke, 2001). This inductive method moves from the individuals’ accounting of events to general conclusions, in order to generate and develop a theory that is grounded in the data (Glaser and Strauss, 1967). Qualitative methods are of interest to Psychologists as it increases what is understood and the meanings people attribute to their experiences. (Willig, 2001).

Kelle (2005, p.8) described the divergent positions about “coding” models that accounted for Glaser and Strauss developing their own perspectives. Under discussion in this section are three traditions from the Grounded theory paradigm. These different examples of grounded theory “exist on a methodological spiral” (Mills et al, 2006, p.24). This figurative expression illustrates how grounded theory has developed from the traditional inclinations of Glaser and

Strauss (1967) and the evolved method of Strauss and Corbin (1990, 1998) to a constructivist model (Charmaz, 2006).

Firstly, the 'Classic' grounded theory (Glaser & Strauss, 1967; Glaser 1978; 1998), combines both "positivism and pragmatism" (Charmaz, 2006, p.6-7). Moreover, early-grounded theorists were influenced by proponents of symbolic interactionism (Puddephatt, 2006). The premise of this sociological perspective is that people respond to events in their life because they have meaning to them. Moreover, the interpretation of the social interactions influences the meaning they attribute to their experience (Duckett, 2007).

Secondly, the 'Evolved' method (Strauss & Corbin's, 1990, 1998) used intricate methods to analyze the data, whilst acknowledging the theory stemmed from the participants' social and cultural experiences indicating a "relativist" position (Mills, Bonner and Francis, 2006, p.27).

However, although the constructivist model is also described as relativist in its leanings, the method highlights the significance of the relationship that develops between the researcher and participant and includes both voices (Charmaz, 2006). For example a key aspect of the constructivist framework is that of partnership (Charmaz, 2006) where the reconstruction of the story takes place (Charmaz, 2006).

Charmaz, (2003, p.269) draws attention to the notion that constructivist research can enhance what can be known about a person's "subjective experience" as well as explain its meaning. Furthermore, Mills, Bonner and Francis (2006) contend that the factors which distinguish the classic, evolved and constructivist frameworks, are concerned with the differing perspectives on veracity. Furthermore, the classic version posits that truth is waiting to be found unexpectedly (Glaser, 1978). However, Charmaz (2006, p.59) disputes this claim by reminding grounded theorists that codes and categories develop from an "emerging process".

Choice of Methodology

To be considered a scientist-practitioner, Counselling Psychologists are encouraged to conduct research that demonstrates the evidence for what they do, particularly with respect to clinical outcomes (Whiston & Campbell, 2010). There are two distinct paradigms that offer perspectives on how people behave; an interpretive stance tries to comprehend the behavior, whilst positivist approaches seek to offer an explanation through prognosticating the results (Willig, 2001).

Quantitative approaches cannot fully explore process issues as they employ systematic procedures to identify causality (Willig, 2001). Moreover, quantitative methods incorporate ontological views that do not connect to the exploration of a clients' subjective experience of therapy quite as well as qualitative methods, as personal experience is not made of fixed or linear properties, but is in fact changeable (Howe, 1996).

Psychologists are interested in understanding process to learn how to meet the person's needs. In this study of older adults' experiences in therapy, I found that to fully comprehend the subjective meanings within the older adult experience it was necessary to be a part of the process. This captured some of the subtleties in the language and emotions when the older adult re-told their stories.

Additionally, studying older adults' experiences is efficacious (Hoyt & Bhati, 2007), because psychologists will learn more about their clients and this can be used to improve practice. Therefore, building a theory through qualitative methods about the processes involved in that experience is beneficial to the psychologist and older adult. The epistemology of this study is based on the subjective experience of the older adult, thus the importance of that experience is relative to how the individual interprets the life events in question.

In conclusion, the choice of methodology was appropriate so that a comprehensible account of the story is given, thus placing the spotlight on the client perspective.

Research Strategy

Ethical Approval

Ethics approval was received from the Research Ethics Committee within the Psychology Department at City University (Appendix 12) and the Local Ethics Committee within the National Health Service (NHS - Appendix 13). Permission to conduct this research in the NHS was sent to the local committee who scrutinize all aspects of the research to ensure patient safety. All the correct protocols were complied with as instructed by the Research and Development Department within the respective Foundation Trust where access was sought.

Additionally, approval from the NHS Foundation Trust also allowed access to the patient database known as RiO, which is an electronic patient record database where confidential patient information is held safely (Appendix 14).

All NHS research is guided by the Department of Health (DoH) framework for Research Governance (DoH, 2005). This study also followed standards set out by The British Psychological Society (BPS) Code of Human Research Ethics (BPS, 2010). These standards ensured that participants who took part were treated ethically (Korchin & Cowan, 1982; Ceci, Peters & Plotkin, 1985; Bruce, 1990).

Constructivist Grounded Theory Methods

A qualitative approach was utilized with the use of unstructured interviews for collecting data. The method of data analysis was taken from the constructivist grounded theory framework (Charmaz, 2006). The method of data collection and analysis was concurrent, as Charmaz (2006) believes, moving between the method of collecting and analyzing data helps the researcher to avoid becoming inundated and lose focus. Thus, adopting this style of collecting and analyzing the data was more robust than using a more condensed method (Willig, 2001).

This mode of data collection and analysis also helped the researcher to refrain from making “conceptual leaps” (Charmaz, 2006, p.48); and ensured that this analytical process moved toward a grounded theory that incorporated “theoretical sampling” and the saturation of the categories (Charmaz, 2006, p.48).

An essential part of this paradigm is an emphasis on the process the researcher and the participants enter into, in addition to the researchers’ interpretation derived from the data (Charmaz, 1995b). Constructivists acknowledge the intrinsic nature of the research relationship and how it brings to light the interconnected elements of the phenomenon through dialogue and a shared understanding about knowledge and its meaning (Mills et al, 2006). Charmaz (2006) elaborated on what it means to create together, when she refers to the use of tacit definitions to represent the participants’ experience.

PROCEDURES

Ethical Considerations

Some authors support the view that it is valuable to include the voice of marginalized groups, so that they can be represented within research (Beauchamp et al, 2002), which underlines the significance of studies on older adults that can be empowering to them (Reed, Weiner &

Cook, 2004). Moreover; it is ethically important to consider the complex issues that may arise when exploring the experiences of this vulnerable group. The researcher considered the vulnerability factors before approaching older adults who had completed a course of therapy, following mental health problems (Liamputtong (2007).

Due to my clinical work there was an awareness of the significance of managing the unpredictability of what could occur if the participant became distressed in therapy. Therefore, I took ethical responsibility to look after the welfare of the participants' (Liamputtong (2007) by monitoring their well-being, staying engaged throughout and observing their progress during and after the interview (Dickson-Swift, 2005). I remained ethically accountable for protecting the participants from harm due to the highly emotive nature of their stories (Dickson-Swift, 2005). Strategies such as the use of ongoing assessments of ethical issues were employed, to shield both participant and researcher. This enabled the "psychological well-being" of the participants to be a priority consistently throughout the study (Banister et al, 1994, p.152), ensuring the research conformed to accepted standards that are responsive to the ethical dilemmas that could surface during the interviews (DoH, 2005; BPS, 2010).

When I considered the boundary between Researcher-Psychologist some thought was given to the potential blurring of boundaries between my role as a Counselling Psychologist and my researcher position. Patton (1990, p.334) suggests holding the demands that exist in the "dual roles" of researcher and psychologist can be complex, as this method relies upon the interaction within the research relationship (Mills et al, 2006). Patton (1990, p.334) draws our attention to "empathic neutrality" but this notion is not in keeping with the epistemology of the researcher. As a result this was not used to manage the complexities that lie within managing these two roles. When Pattons' (1990) position is contrasted with Granfanaki

(1996) the latter author suggests that a researcher can be involved with the participants' narrative whilst remaining impartial to the subject matter. Moreover, being a researcher can be viewed as holding an advantageous position (Granfanaki, 1996) that allows for the exploration of aspects within the participants' life experiences.

In view of the very nature of qualitative methodology being based on engaging with the phenomenon under study, impartiality was not used to manage the two roles (McGourty, Farrants, Pratt & Cankovic, (2010). Instead the researcher used self-awareness to maintain boundaries; in fact this helped me to be more mindful that I remain within the researcher position.

The older adult participants were informed in writing and verbally that the researcher was also a psychologist conducting a study about their experience of therapy, and also that the interview was for research purposes and not psychological therapy. The assessment of risks with regard to the probability of difficult issues resurfacing was an additional ethical problem considered before, during and after data collection (McLeod, 1994; Magi Sque, 2000).

During the interview process there were times when the participants' stories touched upon areas that were very emotive for them. The researcher remained open, sensitive and aware when the participants' were upset, which was assessed and the situation was managed responsively by asking the older adults if they wanted to continue, so that their safety was maintained. Furthermore, the researcher offered empathic support when required by participants (Pope, 1991). Being thorough and open throughout the research process placed the participants' well-being at the centre of the study. The researcher duly noted from the outset how other qualitative researchers had dealt with their own ethical problems by encompassing key merits of, "flexibility and deep engagement" in order to create a "good

research alliance” and keep the older adult participants’ safe (May, 1989; Grafanaki 1996, p.335).

Informed Consent

Sin (2005) posited that consent is not just a task that is performed on one occasion rather it should be sought at differing points throughout the research process. Ethical dilemmas are inherent within research and hence, giving the participants full disclosure about the study, verbally and through the patient information sheet at the outset helps to minimize any distinctions in power that could impact upon the research relationship (Banister et al, 1994). In addition, acknowledging the issue can be helpful in preventing any mis-use of such power (Banister et al, 1994).

Informed consent was sought from all the participants by providing written information about the purpose, with advantages and disadvantages of participation to ensure they fully understood what the invitation meant for them (Dickson-Swift, 2005). Participants’ were sent a covering letter (Appendix 15) as an introduction to the study and a participant information sheet (Appendix 16) that disclosed what was involved in the research. Some of the participants telephoned the researcher prior to giving their consent as suggested in the covering letter, so they could obtain additional information about the research. The consent form (Appendix 17) incorporated information about confidentiality in order to reassure the participants they had the option to withdraw at any time throughout the research process (Christians, 2005).

Participants could also choose how much information they divulged during the interview and for the tape to be stopped at any time so they could take a moment to assess whether they wanted to continue or move the topic forward in a different direction (Banister et al, 1994).

The consent form explained that the identity of the participants would be anonymized and the researcher would also take responsibility for destroying the audiotapes once the interview had been transcribed.

Confidentiality

The issue of confidentiality and anonymity is important, particularly when researching vulnerable groups (Christian, 2005). Hence, the protection of the participants' identity was ensured during written communication for this thesis. For example, the transcribed data was saved on an encrypted Universal Serial Bus (USB) according to the guidelines that require confidential information be kept safely (Data Protection Act, 1998). Eight of the nine interviews were conducted in the older adult participants' home, as was their preference.

Only one participant chose to come to the researchers' office. Anonymity was maintained as the office had a therapy room usually used for an outpatient clinic or as an interview room for other service meetings. Therefore, it was not necessary to disclose the details about the participant to other staff members.

Sampling Strategy

A purposive sampling strategy was employed to select the participants for this research study (Patton, 1990). Morse (2007, p.232) talked about the researcher choosing participants that represent the area under study and sampling a "demographically homogenous" group of people in order to manage the dissimilarity in explanations that could arise. However, Laidlaw's (2003) framework expands on the idea of within group variations due to "cohort beliefs" (Laidlaw, 2003, p.33; Smyer & Qualls, 1999). This is where older adults who have been exposed to particular "shared experiences" adopt the same convictions (Laidlaw, 2003,

p.33; Smyer & Qualls, 1999). In this study the participants were born in three different time frames bringing particular cultural experiences from that generation (Table 1, p.38).

The participants were chosen because their stage of life and their age, was a criterion that made them an important source of knowledge (Mays, 1995), that contributed specifically to the aims of the research (Greenhalgh & Taylor, 1997). Variables such as the gender and ethnic background of the participants are mentioned in the demographics section to add context. Although these areas are important, in that contextual factors influence how individuals construct and make sense of their experience of life (Charmaz, 2000; Guba & Lincoln, 1994), the selection of this sample was voluntary and guided by three main criteria.

It is noteworthy that when considering the issue of recruitment, Feldman et al (2008) assert that procedures may need to be revised to take account of populations that are difficult to recruit from, as some research studies may not adequately represent the diversity of cultures within society. The next part of this section features a description about the inclusion criteria that were used to choose this sample.

Inclusion Criteria

The first criterion was that participants were over the age of 65. The second criterion was for the participants' to have completed a course of Psychological therapy at least six to twelve months prior to the data collection delivered by a qualified Psychologist or a Trainee Psychologist who was supervised by a Chartered Psychologist whilst on placement. Thirdly, participants with Dementia or other types of organic cognitive impairment were not included in this study due to the possible impact on the quality of the information collected. The researcher checked the client records to ensure that participants had not been re-referred back to the service and to establish that they met the inclusion criteria. Each participant gave a

retrospective account of their journey through therapy. This type of sampling placed an emphasis on understanding the participants' experience rather than trying to generalize the findings as in a quantitative method (Charmaz, 2006).

The Participants

The participants were recruited from the Psychology services within three older adult community mental health teams, in an area of a large English city. A sample size of nine older adult participants were interviewed by the end of the analysis, by which time the analytical categories had become saturated; meaning that nothing new surfaced from the data (Guest et al, 2006; Charmaz, 2006). Eight female participants and one male participant volunteered to be interviewed. Their ages ranged from 68 – 82 years with a mean age of 74.88 years, from three “age-specific generations” (Smyer & Qualls, 1999; Laidlaw et al, 2003, p.33). The participants' ethnic orientations were: White British, Greek-Cypriot and White Jewish (Appendix 8).

Table 1: The Participants' demographics

Variable	N (9)
<u>Gender</u>	
Male	1
Female	8
<u>Age range</u>	
68 – 69	2
71 – 79	5
82	2
<u>Ethnicity</u>	
White British	7
White Jewish	1
Greek-Cypriot	1

Recruitment

The participants were recruited using the database of discharged therapy clients from three Older Adult Psychology Services within an NHS Foundation Trust. The researcher was given approval from the Trust to access the electronic patient database known as RiO. The IT department emailed RiO lists of discharged clients seen by the Psychology service to the researcher. In addition, the researcher had password protected authorization to access the RiO system to gather more details about whether the discharged clients met the inclusion criteria.

The RiO lists provided by the IT department were extensive, but not all the information was up to date. This led the researcher to cross check the discharged client files to ensure the information was accurate and to confirm that the participants met the criteria to take part in the study. This aspect of the process was extremely time-consuming. These time factors were managed by trying to establish protected research time, whilst the researcher worked full-time as a Psychologist.

The research focused on participants who were discharged from the service approximately six to twelve months before the data was collected. Following discussions with senior psychologists and a review of the literature, the time frame was deemed suitable, as it was not too soon after the completion of therapy to raise unprocessed feelings (McLeod, 1994; Magi Sque, 2000) and additionally, not too far back for details of their therapeutic experience to be forgotten.

Some of the discharged clients on the RiO lists did not meet the inclusion criteria because they had either: passed away, were only seen for an assessment, had been re-referred back to the service or had some form of cognitive impairment. The participants' were recruited in an ethically sensitive manner and the researcher was aware of participant safety when

conducting research, due to the vulnerable nature of the participants taking part (Magi Sque, 2000). A research database for the study was kept to record the details of the participants contacted and their response to the invitation to take part in the research. Appendix 18 is an example of the information that was kept securely (Data Protection Act, 1998).

The discharged clients were sent a covering letter (Appendix 15) that introduced the researcher and the study. The research pack also included the participant information sheet (Appendix 16) together with a consent form (Appendix 17) and a stamped addressed envelope. All the information gave details about the study and the patient information sheet was presented in the format of the most frequently asked questions. The researcher was aware that a number of older adults can experience sensory impairments such as visual loss. Whilst seeking NHS ethics approval the researcher's first template of the patient information sheet was in a larger font and the information was quite detailed. However, the ethics committee felt the information should be condensed to two pages which meant the font size was smaller and the information succinct.

After sending three rounds of research invitations to the first group of potential participants (n=23) from the list of discharged clients, four participants agreed to take part in the study and they were sent an appointment letter (Appendix 19). One of the participants who initially gave consent to take part decided at the beginning of the interview that she did not want the interview to be audio-taped. The research design stipulates that all interviews must be audio-taped; therefore the interview was not included in the study.

The researcher found it difficult to recruit older adult research participants which caused considerable delay. Mody et al (2008, p.2346) argued that there are a number of obstacles that impact on recruiting older adults to research studies namely, "health, social, and cultural barriers", in addition to "informed consent" factors. The authors (Mody et al, 2008) propose a

framework to address the complex areas that need to be considered when recruiting older adults for research. Patel, Doku, and Tennakoon (2003) add that being from an older age group is one of ten elements that can hinder recruiting participants to a study.

For context, the reader should be aware that at this stage during the research, the recruitment came to a standstill for nine months between the third and fourth interviews, due to a lack of older adult volunteers. The study was at risk of not being completed and this was of some concern to the researcher and her supervisor. After reviewing the lack of participants with the supervisor, a contingency plan was discussed. At that time the recruiting of older adults was only taking place in one locality; consequently this was changed to widen the search for participants geographically to include two further local Psychology services for older adults within the same Foundation Trust. This decision gave the research a new lease of life and the researcher felt hopeful that the study would be completed. It can be argued that managing the unpredictability of dilemmas occurring within “real world” studies (Robson, 1993, p.3) is an aspect that is inherent in this type of research context.

Moreover, as well as widening the search for volunteers a change in approach was used when the researcher contacted potential participants. For example, one research invitation was sent, then the researcher waited approximately between 14 to 20 days (ie: the time frame depended on when the researcher could secure protected time during working hours), then a follow-up telephone call (Bell, 1999) was made if a telephone number was available. Sending out two invitations instead of three, together with the follow-up call helped to keep this part of the research process moving as the researcher worked through the list of potential participants and sent out research letters.

For example, when the researcher telephoned a discharged client the researcher introduced herself and asked if they had received the research information. There were occasions when a

relative caring for the older adult would answer the telephone or a member of staff, if the older adult lived in a care facility and they would decline on behalf of the older adult (eg: if the older adults' situation had changed and they could not take part in the study). If no one answered the telephone, a second round of research invitations was sent, and if no reply was received, the researcher did not contact the participants again, instead the researcher moved onto a new group of names on the RiO list. A record was kept on the research database of all the contacts that were made to potential participants. In total 82 discharged clients were contacted, this figure included three participants who were contacted by an intermediary (Clinical Psychologist) from the locality where the participants were known to the team, so consent could be given for their details to be passed onto the researcher.

One participant told the intermediary that she had changed her mind after initially agreeing to be contacted. No contact was made with that participant and only two older adults from that locality volunteered and gave consent to take part.

When the researcher received a consent form from a participant they were offered an interview based on the order in which the consent form was received. For example when a participant sent their consent form back they were assigned an ID number *psy 01* and so forth by the researcher. An appointment letter was then sent to the participant detailing when and where the research interview would take place.

If the consent form stipulated that the participant declined to take part, a letter (Appendix 20) was sent to acknowledge receipt of the form to decline taking part (ie: sometimes the discharged client would telephone or send a letter to decline). The researcher thanked them for making contact to specify their preference not to take part. The letter also informed them that they had been removed from the study's research database.

Follow-up Telephone Calls

Bell (1999) suggests that following up the initial research invite to the participant with a telephone call maybe required to clarify any questions the participant may have. Another reason for telephone contact is to improve the likelihood that participants will take part. Patel et al (2003) contend that this process can facilitate a higher number that agree to participate in being interviewed over the phone. The researcher's study had a different rationale for making an informal telephone call to discharged clients. The telephone call was made or another letter was sent to see if the participants received all the information and to explain what the focus of the study would be if the participant wanted more details. I would usually make the follow-up telephone call only if a phone number was available, if there was no number another letter was sent. Typically, during the telephone call, the researcher would introduce herself and then ask if the participant had received the invitation about the study. The researcher was aware at all times that her tone of voice and inquiries should not create any pressure to take part in the study. For example the researcher would say: My name is Maureen McIntosh and I wondered if you received the information with regard to my research study, about older adults' experience of psychological therapy. I would then wait to hear the person's response. Their responses varied between asking more about the study, declining to take part by choosing to give an explanation or not elaborating. On some of these occasions they would consent to take part.

Whatever their response I acted accordingly, appropriately and ethically, whilst being mindful of how I might be perceived during the telephone conversation. After every telephone contact I would document the call, reflecting on my experience in my journal. In retrospect it was important for me, as the researcher to feel confident that I had managed the

situation ethically. What follows are three examples of what took place when telephone contact was made during the recruitment phase of the study.

Firstly on one occasion, the wife of *psy 12* called the researcher to say that her husband was in hospital with a broken hip and also had dementia; therefore he could not take part in the study. The researcher thanked her for telephoning and confirmed that a letter would be sent to confirm he had been removed from the research database. On another occasion, the researcher received a telephone call from the daughter of *psy 29* explaining that her mother has memory problems and could not take part in the study.

Lastly, in a third example the reader is directed to appendix 11 where the researcher demonstrates how an unexpected event during the recruitment and interview stages was managed, by both the participant and researcher.

Data Collection: The interviews

In a review of health research, Fudge et al (2007) claimed that older adults want to take part in research especially if the outcome of the study leads to policy change. Interviewing older adults may bring challenges similar to or in some cases different to other groups of participants; for example there maybe sensory impairment which must be managed appropriately so older adults are not excluded from research (Gubrium & Holstein, 2003). Furthermore interviews that use a format that is too rigid in structure, can direct participants to the interviewer's notion of what may seem significant, instead of obtaining more subjective comprehension of the older adult experience of therapy (Knight, 2002).

The interviews in this study were unstructured, which Hammersley and Atkinson (1995) contend is an appropriate tool that requires the least input from the researcher. The researcher was mindful of how both she and the participant could affect each other and this was

monitored throughout the interviews by observing changes during the interview process. The researcher was observant about whether the participant felt comfortable to continue by ensuring there was no negative impact from the interview (Underwood et al, 2010). For example by enquiring with the participant how they were feeling and whether they would like to continue or pause. Moreover, the unstructured interview kept the participants' voice at the centre of the dialogue. Also, face to face interviewing gave the researcher an opportunity to assimilate information that featured textured conversations, allowing for prompting and interaction with the older adult participants in a way that questionnaires may not have encapsulated (Knight, 2002).

The relationship that developed during the interview placed the emphasis on the language and actions of the participants (Mills et al, 2006). The researcher managed power issues within the research relationship by adhering to the constructivist epistemology which advocates that research should be dedicated to keeping the focus on the participant (Mills et al, 2006).

Hall and Callery (2001) discuss the importance of the research relationship for being attentive to how both parties interact, can add a level of trustworthiness to the processes involved in the creation of data. It has been stressed that "trust" is an important component in the research relationship that has several dimensions, which need to be negotiated with the participant (Cartwright & Limondri, 1997, p.233). Additionally, an awareness of relational issues can also highlight the role of "power" and how important it is to monitor how data is represented (Hall & Callery, 2001, p.258).

In qualitative interviews the participant exercises the most influence when they express their story. In the study the participants talked about their experience of Psychological Therapy and the researcher decided to frame the research question loosely (Appendix 3), whilst also assisting through encouragement and prompts (Corbetta, 2003). The questions developed

when the subject matter became more evident during the analysis, and questions were asked during the interview to elucidate responses given by the participants' (Wood & Griffiths, 2007; Charmaz, 2006). The researcher worked meticulously to put judgment to one side by actively listening to the participants' story using an unstructured questioning style that empowered them to talk freely about what they wanted to share (Holloway et al, 2001).

This strategy created a context whereby the participants' voice (Willig, 2001) could be heard throughout the research process (Mishler, 1991) and recognized through contact between the participant and researcher, which helped the "reciprocal shaping" of the data to take place (Mills et al, 2006, p.9). This meant that both parties created the conversations through their mutual dependence, one upon the other (Mills et al, 2006) to develop an understanding of the older adult's lived experience. The value of this style of communication was both parties constructed the meaning within the story (Mills et al, 2006). This style of relating conveys that there is agreement and secondly, that the position of the researcher is also important within the methodology (Mills et al, 2006).

The interviews took place in the participants' home or an interview room within a local community facility where the researcher was based. The interviews were audio taped and the length of time for each interview ranged between 50 – 90 minutes. The time frame of each interview was influenced by how much each participant wanted to talk.

After each interview the researcher updated her field notes on what was observed to capture the processes that occurred before, during and after the interview (Charmaz, 2006). The material generated from the interviews was transcribed and a constructivist grounded theory analysis was applied to the interviews to create categories by comparing all the aspects constantly (Glaser & Strauss, 1967; Dyer, 2006). The interaction of the researcher with the data facilitated the end result of theory development (Charmaz, 2006).

A copy of the transcribed material was offered to the participants so they could check through what was transcribed from the audio-tapes, and then they could choose what information they wished to include in the study. Another reason for offering the transcribed data was so that the participants have an opportunity to view how the researcher has represented their experience in the written word (Banister et al, 1994; Liamputtong, 2007). Only three participants requested a copy of their transcribed interview and all participants asked for feedback of the results of the study. A summary of the findings will be sent to them after the oral examination of this Doctorate portfolio.

Debriefing the participants

It is good research practice to offer the participants support if there are issues they want to discuss that result from the study. At the end of the interviews the researcher checked with each participant about how they had experienced the process to ensure that they were not distressed by issues that had arisen in the interview (Banister et al, 1994). In the event, the participants all reported that they felt the interview went well and they had not become negatively affected by the study. The researcher reminded them that they could contact their General Practitioner (GP) for additional support, as they had already given permission for their GP (Appendix 21) to be notified in the original research contract. The participants were also advised that they could contact their local community mental health service if they needed support (Appendix 22).

Data Analysis Strategy

The research design and method of analysis is a retrospective study based on the principles that reality is a co-construction, where the researcher is active in the development of meanings with the participant (Charmaz, 2006). The theory that developed was derived from

this process and can be considered to be context specific, influenced by events past and present, also cultural and social variables (Charmaz, 2006). In this section the researcher describes the different aspects that needed to be considered during the analysis, and then a detailed description of the procedures that followed with examples to illustrate the process.

Theoretical sensitivity

Theoretical sensitivity increases an awareness of the meaning within the data regarding, what happened during therapy and how it was experienced (Glaser, 1978; Strauss & Corbin, 1998). The process is about reflecting on what is revealed in the data by taking a variety of positions that illuminate and shape the ideas (Charmaz, 2006), which lead to the researcher becoming more sensitive to what was exposed when analyzing the stories.

Another aspect of becoming sensitized to existing theories is the prerequisite of some academic programs for a research proposal to include a literature search. Henwood and Pidgeon (2003, p.138) put forward the notion of “theoretical agnosticism” where the researcher shows good judgment over the literature that exists, rather than concluding that a concept is certain when it cannot be demonstrated (Mills et al, 2006).

For this study the researcher conducted a small literature review for the purpose of the proposal but this did not hinder my ability to be curious and creative, which is needed for developing theory grounded in the data (Charmaz, 2006). The researcher used methods such as memo writing and constant comparison to keep the focus on what emerged from the data. The researcher also asked questions of the memos, codes and categories, by constantly comparing data.

The initial coding produced many codes with the advantage of moving the researcher closer to meeting the four evaluative criteria (“*credibility, originality, resonance and usefulness*”)

espoused by Charmaz, (2006, p.182). I will elaborate on how the study met the evaluative criteria in the discussion (chapter 4).

Quality Issues and Evaluation criterion

Although the criteria deliberations (Elliott & Lazenbatt, 2005) go beyond the scope of this chapter, it raises interesting arguments about how the criteria should be related to the method used by the researcher, so that the study is executed correctly (Elliott & Lazenbatt, 2005). Benoliel (1996) asserts that for a study to be considered as grounded theory research the application of the method must be central to the process. The key aspects such as “concurrent data collection, constant comparative analysis, theoretical sampling and memos” ensure the study is credible (Elliott & Lazenbatt, 2005, p.48).

A number of sources were used to increase the credibility (Charmaz, 2006) of this research through triangulation (May & Pope, 1995). The researcher asked two Clinical Psychologists, one Health Psychologist and one Counselling Psychologist to examine the choices that were made during the analytical process to improve the “rigour and transparency” within the study and implant an “audit trail” (Bowen, 2009 p.305). The codes and categories were audited to confirm whether there was consensus with the researcher’s interpretations.

Other authors have commented on how vital it is for the researcher to demonstrate reflexivity with the conclusions made at differing points during the process (Mauthner & Doucet, 2003). Reflexivity allows the participants’ experiences to be represented accurately and keep the researcher’s interpretations on track. The significance for this study was that “rigor” increased (Hall & Callery, 2001, p.259) and any potential threats to the quality of what was constructed was avoided, to further deepen the honesty of the results (Mays & Pope, 1995).

The method of triangulation added to how the participants' story was perceived and enhanced the ideas coming through about the data which created a space to think about the data from different perspectives (Banister et al, 1994). By corroborating the methods used in this study it helped the researcher to not impose her own perspectives onto the data, but instead ensure theory expansion was grounded in the data (Elliott, et al, 1999).

In addition, Elliott and Lazenbatt (2005, p.48) place some emphasis on how to strengthen qualitative findings in their paper on *'How to recognize a quality grounded theory research study'*. Seale (1999) proposes that the researcher ask participants to check their transcripts or the findings to manage any mis-interpretation. However, Elliott and Lazenbatt (2005) argue this would involve adding another procedure that needed analysis, and they also state that the researcher can choose whether to utilize this strategy. Seale's (1999) view was highlighted in Elliott and Lazenbatt's paper (2005); that researchers should not become too dependent on conventional validation procedures which is an interesting idea. Seale (1999) upholds a notion similar to the concept of variation (Charmaz, 2006), which is that the researcher should be prepared to amend the findings as new information emerges. Elliott and Lazenbatt (2005) conclude that the constant comparison and theoretical sampling methods integral to the grounded theory process could be viewed as sufficient to increase the research's trustworthiness.

Research memos

Research memos were written from the outset of the analysis (Appendix 9). It had become an important function from the initial coding stage to completion of the analysis. The research memos described what was observed in the data and the early memos were compared to later ideas and categories to check the themes and concepts that emerged. The descriptions moved to an abstract level as it took account of the context that influenced the participants' stories.

This was significant to ensure the abstractions were derived from the data (Mills et al, 2006). Memos can demonstrate the “analytical lens” the researcher uses and what sense was made of the data (Mills et al, 2006, p.12). This method provided an opportunity to gather ideas for “theoretical sampling” so that the researcher could build the story analytically in order to develop a theory grounded in the participants’ experience (Elliott & Lazenbatt, 2005, p.51). Writing memos kept the researcher connected to all aspects of the research journey. Being transparent in this way allows the audience to determine how the meaning was “reconstructed into theory” (Mills et al, 2006, p.11). Furthermore, memos are a way of acknowledging a variety of complex determinants that can impact on the researchers’ interpretation; which is revealed through writing and represented in the final version of the story (Mills et al, 2006).

Research Journal and Field notes

Keeping a journal and field notes throughout the analytical process to reflect on the researcher’s experience gave a transparent and trustworthy account of the process. To be invited into the participants’ life to discuss their experiences of the therapeutic process meant that from the outset the researcher-participant interaction was discussed and determined by the context (Hand, 2003). These methods gave the researcher the opportunity to write about judgments, power issues and how this was experienced. A biography of each participant’s life story was written in order to further examine what the researcher remembered (Appendix 10, Biographies). The biographies show how writing freely helped the researcher position herself differently in relation to what was talked about and what emerged.

Data Analysis Procedure

Using open coding is a process that allows the researcher to clarify what is taking place with the participants’ experience by asking questions about what can be seen in the data. In the

study, codes were constructed and placed into categories to represent the data (Charmaz, 2006). The researcher was able to use open coding to “reflect action” and keep the participants’ language and voice at the centre of developing a conceptual theory (Charmaz, 2006, p.48). This helped to contain the researcher so that the theories which exist are not imposed on the data (Charmaz, 2006).

Line by line coding was used in the first stage of analysis where the researcher took each line of the transcript and explored the content. This worked well due to the large amount of codes present (Charmaz, 2006). For example, within interview nine (psy 44) featured below in table A, the researcher asked herself questions, as suggested by Charmaz (2006) about what was happening in the data. Using the participants’ “in vivo” codes helped the researcher stay close to and maintain the participants’ “meanings and actions” (Strauss & Corbin, 1998; Charmaz, 2006, p.55).

Table A.

<u>Transcript line no: 296</u>	<u>Line by line code</u>
<u>Quote</u> - ‘in vivo’ code	<i>First stage of analysis</i>
It could be I mean me life got disrupted didn’t it? (psy 44, l. 296)	Life got disrupted

The researcher wrote a corresponding research memo exploring what this statement could be referring to, which underscores another procedure in the analysis. Memos are a contemplative method that allows the researcher to reflect on their account of the data and promote the descriptive categories to a “theoretical level” by turning them into concepts (Mills et al, 2006, p.11). An early memo about the quote and line by line code featured in Table A was written, and is illustrated in Table B:

Table B.

Early Memo: 19/06/2010 (psy44) Open coding stage: <u>Life got disrupted</u> Shock (<i>written in red pen</i>). The significance of the unexpected, negative life event that came suddenly and caused devastation. She tries to make sense of the trauma and loss.

The constant comparative method (Glaser & Strauss, 1967) formed another part of the analysis and is central at each stage of the analysis. It is an iterative process that requires the researcher to move back and forth, taking one set of data through a “constant comparative analysis” (Elliott & Lazenbatt, 2005, p.50). Charmaz (2006) explains that by comparing units of the interview material with other aspects of the data, the researcher can identify whether what emerges is alike or dissimilar. This procedure played an important part at various levels of the analysis. It took a great deal of time to examine the accounts given by each participant with events from the interview and then subsequent interviews (Charmaz, 2006). The process of comparing and coding is aimed at “constructing abstractions” (Charmaz, 2006, p.181). This means to explain ideas that have formed from the codes, by bringing together the qualities of that idea (Charmaz, 2006). This procedure connects the concepts with the data and subsequent associations are then made to sizeable matters later in the process (Charmaz, 2006).

The next stage of analysis was focused coding where the researcher looked for recurrent themes leading to further exploration in subsequent interviews (Charmaz (2006). At this stage, the researcher decided not to use axial coding (Strauss, 1987; Strauss & Corbin, 1990; 1998). Axial coding is a means of relating “categories to subcategories”, which stipulates the

“properties and dimensions” (Charmaz’s, 2006, p.60). Charmaz (2006, p.61) exhorts that it is not necessary to use axial coding if the researcher wanted to use uncomplicated principles and accommodate the experience of uncertainty by instead tracking “leads” observed in the data.

The main purpose of focused codes was to locate the early tentative codes from the first stage of the analysis (Charmaz, 2006). Properties refer to the characteristics of the category and the dimension to the “range” of that property (Adams, Lunt & Cairns, 2008, p.141). These two aspects of the method helped the researcher gain knowledge about what the category signified for the participant (Charmaz, 2006). Table C is an example of focused coding. The method required the researcher to choose the earlier codes that emerged most often and place them into categories (Charmaz, 2006) whilst continually refining such categories through the process of constant comparison. Moreover, it was important to be aware of assumptions and remain open to alternative perspectives.

Table C.

<u>Sub-Category</u>	<u>Focused code</u>	<u>Quote</u>
<i>Responding to an existential crossroad</i>	Finding life got disrupted	It could be I mean me life got disrupted didn't it? (psy 44; line, 296)

The focused codes that developed through this stage of the process helped the researcher to become more aware of being drawn in certain directions that opened up the topic to further questions (Charmaz, 2006). This enabled the researcher to produce categories for further analysis. The ideas that developed lead to more questions being asked about the data; which yielded a rich representation that allowed the researcher to be more responsive and not to enforce preconceived ideas onto the data (Charmaz, 2006).

The researcher's interpretation as illustrated in table D demonstrates what was observed as the data progressed to "analytic categories" and the concepts from which the older adult participants' experiences were revealed (Charmaz, 2006, p.3).

Table D:

<u>CATEGORY</u>	<u>SUB CATEGORIES</u>	<u>DIMENSIONS</u>	<u>PROPER-TIES</u>	<u>CODES</u>	<u>QUOTES</u>
<i>Sensing continuity and discontinuity within an ageing 'self'</i>	<i>Responding to an existential crossroad</i>	Distress...trauma	Breach	Finding life got disrupted	It could be I mean me life got disrupted didn't it? 44, 296

Throughout the analysis the researcher created space, by stepping back and writing down more ideas about the data using memos.

Theoretical coding

The researcher used theoretical coding following the development of focused codes to assemble the stories analytically (Glaser, 1978). Theoretical codes demonstrate the formation of relationships, which can be thought of as an explanation of what emerged during the analysis, and thus to be incorporated into a "theory" (Charmaz, 2006, p.63).

The researcher examined the categories that emerged from the data and compared them with written memos using "clustering" (Charmaz, 2006, p.86) in order to incorporate the data and memos into a theoretical model (Charmaz, 2006) of the older adult experience of therapy.

This meant noting the categories then drawing lines or arrows that linked different categories, delineate the property in the categories and how they are related (Charmaz, 2006). This helped to organize the codes and create a narrative portrait of the relationships from quotes to

the categories to understand the processes involved (Charmaz, 2006). This stage of analysis enabled the researcher to free herself, by getting in touch with her originaive ability so that particular events in the data could be viewed in different ways (Charmaz, 2006). Appendix 23; is a conceptual memo that developed around contextual factors that led to participants receiving psychological therapy.

Willig (2001, p.26) talks about research being a “creative” undertaking and the procedures utilized should be beneficial to answer the “research question”. Charmaz (2006, p.135) also explains that varying techniques can be useful, but it should not be seen as a “mechanical process”. Such advice helped the researcher explore and ask more of the data by remaining open to what emerged (Charmaz, 2006).

Charmaz (2006, p.178) further posits that:

“Researchers can draw on the flexibility of grounded theory without transforming it into rigid prescriptions concerning data collection, analysis, theoretical leanings, and epistemological positions”.

Managing variations within the process

A complex case can occur when the participants’ experience is the reverse of the “majority” view within a study (Morse, 2007, p.240). When subsequent interviews do not reproduce the same fluctuation in their experience of the process this is called a negative case. Morse (2007) suggests that this raises some interesting questions about what may have contributed to this disparity. Morse (2007) also argued that if the case is deemed an extreme deviation from the views expressed by the other participants then it should be disregarded.

Charmaz (2006, p.109) expands on this notion of “variation” by explaining that in her study about experiencing physical health problems, she noticed the way in which the individual

lived with the problem can be different and change over time. This created a deviation from how she originally interpreted the data (Charmaz, 2006). Charmaz described (2006) how she decided to go back and scrutinize the category again, then she used theoretical sampling to explore the issue in further interviews. This highlighted the complex nature of that category; it also helped to improve her understanding of the phenomenon. Charmaz (2006, p.109) advised that if this occurs, the researcher should “focus on certain actions, experiences, events or issues” instead of the participant as such. After analyzing her findings Charmaz (2006) incorporated another category into the process that offered an explanation for the degree of difference. The researcher used this guidance when examining the phenomenon of *‘barriers to the alliance’*, and this analysis led to the creation of two sub-categories that represented a variation within that category (eg: generational and typical barriers to the alliance).

Theoretical sampling

In order to develop a theory that possessed depth represented the participants’ story and accounted for the changes experienced by older adults who had psychological therapy, it was important that the researcher utilized competent procedures (Morse, 2007). Part of that process involved theoretical sampling as it refined the categories and strengthened the findings (Charmaz, 2006).

It also brought together the data and analysis at different stages in the process, and as the theory took form it helped the researcher to examine clues by comparing the content of the research memos with what was observed from the data (Charmaz, 2006).

The researcher continued to interview participants to clarify categories (Charmaz, 2006, p.107, Glaser, 1978). This method was used to improve the “categories and properties” by

examining relevant data, as sampling in this way has the capacity to detail the “variation, consistency and contradictions” within the data (Kumar et al, 2003, p.143).

This process helped the categories become clearer and formed a substantive theory that linked the emergent ideas and the data (Charmaz, 2006). For example after the fourth interview the researcher remained curious about what had emerged regarding psy 15’s experience of not finding the psychologist helpful. The fifth interview with psy 20 highlighted the importance of the therapeutic relationship and how the participants experienced the psychologist differently. By the end of the analysis after the categories were saturated, an additional component within the sub category highlighted the quality of the participants’ therapeutic relationship and the barriers which emerged. This demonstrated the complexity of the processes involved in that category.

The researcher checked that the consistency within the theoretical framework was grounded in the data and therefore represented the participants’ story by returning to the categories and constantly comparing the data (Charmaz, 2006).

Theoretical Saturation

Theoretical saturation was achieved through “sorting” and seeing how the categories related to each other (Morse, 2007, p.239), so that a point was reached where no new information was revealed and thus assembling new data would not be productive (Charmaz, 2006). When no new data emerged the researcher moved to the writing stage.

Determining the Core Category

Expanding the storyline gave some ordination to grouping the categories which helped connect the conceptual patterns (Charmaz, 2006) to the “central phenomenon” (Wilson Scott, 2004, p.123). This accounted for the story of older adults’ experience of psychological

therapy. The research analysis explicated the processes that formed a theoretical model (Strauss, 1987; Strauss & Corbin, 1998; Charmaz, 2006) of how the ideas shaped during the research process explained the relationships between the categories. Diagrams used in this study added an extra dimension that helped to produce a model on the experience of therapy (Charmaz, 2006).

The core category of **‘moving towards equanimity’** represented what was central to the participant’s experience of therapy and drew the four main categories and nineteen sub categories together to give meaning to their stories. The use of the participants’ language kept the core category grounded in the data and allowed the researcher to “construct abstractions” whilst connecting those concepts to the interview material (Charmaz, 2006, p.181). Furthermore, the final stage in the analysis offered an explanation of older adults’ experience of psychological therapy.

A more detailed theoretical explanation of the core category is presented in the findings (Chapter 3).

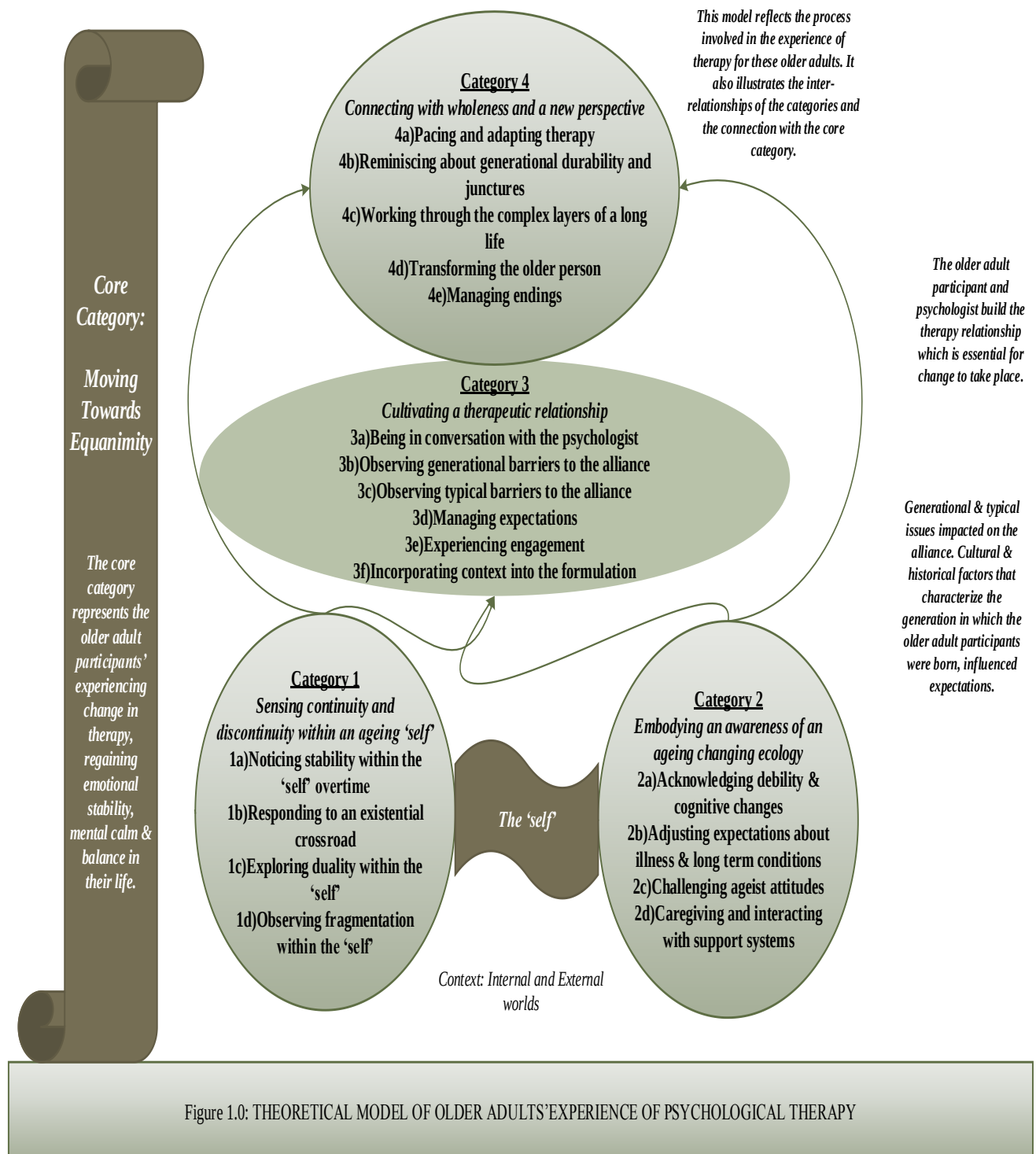
CHAPTER 3

FINDINGS

This chapter features the findings and emergent theory from the Constructivist grounded theory study on older adults' experience of psychological therapy. Firstly, there will be an explanation of the core category of **moving towards equanimity**. Secondly, the integrated theory is summarized and a diagram is displayed in *figure 1* on pg. 62, to provide a representational explanation and understanding of the processes involved. Thirdly, four categories and nineteen sub-categories are detailed to expand on the properties and dimensions (*Appendix 6 - Coding table & Appendix 7- Categories and Sub-categories*) moreover, quotes have been used from the transcripts to add context to the evaluation of these findings. These findings demonstrate how the categories that emerged from the data represent a theoretical conceptualization about the older adult participants' story and illustrate the unifying function within it, in addition to detailing the inter-relationships and conceptual patterns (Charmaz, 2006).

The participants have been given pseudonyms (*Appendix 8*) to maintain their confidentiality. Finally, it is important to note that the core category is just one explanation of how I have made sense of the data. It is recognized within the research community that research findings are open to refutation and others may interpret these outcomes differently. I have also used different terminology ie: 'the self', self-concept and sense of self; interchangeably throughout this thesis to refer to the individuals' personal identity where the process encompasses the participants' perception of a "past", present "and future self" (Corbin & Strauss, 1988, as cited in Abernathy, 2008, p.201).

Therefore, I propose that the explanation of the older adult participants' account of their therapeutic experience is a resonant, retrospective biography.



CORE CATEGORY: MOVING TOWARDS EQUANIMITY

CATEGORY 1: Sensing continuity and discontinuity within an ageing 'self'

CATEGORY 2: Embodying an awareness of an ageing changing ecology

CATEGORY 3: Cultivating a therapeutic relationship

CATEGORY 4: Connecting with wholeness and a new perspective

The Core Category

The core category of 'moving towards equanimity' can be understood as the older adult participants experiencing change during psychological therapy. This helped them acquire self-understanding and moved them towards regaining emotional stability, mental calm (The Free Dictionary) and balance in their life. The therapeutic work helped the older adult participants resolve the disruption within the 'self', caused by significant negative life events. As a consequence, the older adult was able to move along a dimension from imbalance to balance.

The first category explains the impact upon the 'self' when unpredictable negative events occur and how these happenings contributed to destabilizing the older adults' internal world, causing discontinuity to their sense of self.

Negative events can be thought of as the "stressful life circumstances" (Moos et al, 2006, p.2) that occur in the present and the older adult struggles to cope with. For many older adults who have experienced living through world war two for instance or other types of traumatic histories from long ago, many have held onto painful memories deep within for all of their life (Davis, 2013; McCarthy & Davis, 2003; Hiskey et al, 2008). More recent challenging

experiences can interact with traumatic events that have happened long ago in the past (Macleod, 1994). Experiences that have taken place more recently in the older adult's life such as "retirement, loneliness, comorbid psychiatric illness," and physical health problems that are challenging can "re-activate" (Macleod, 1994, p.625) past trauma memories within the older adult and impact on how they manage "developmental tasks" during this stage of life (McCarthy & Davis, 2003, p.146).

The older adult's traumatic history can lay dormant because they have found their own way to cope throughout their life. A metaphor by an older adult who lived through the Holocaust illustrates this process and likens this un-awakened trauma to "stones in a pond" (Davis, 2013, p.46), that are sometimes obscured from view.

The connection between these historical distressing experiences and more recent stressful negative events are the attributes within these challenging life events, because they possess similar elements to that of the original trauma (Gordon, 2010; Scurfield, 1984). For instance, the older adult may experience "being alone", feeling "mis-understood, being isolated, devalued" and uncertain of what lies ahead (Gordon, 2010, p.8) which may trigger unresolved feelings and painful memories from the past that can create instability within. Depression can also leave the older adult exposed to a re-surfacing of trauma as the negative trajectory of depressive illness connects the older adult back to disturbing (Dunbar & Lishman, 1984), unprocessed events (Lang, 1977; 1979) and opens "past wounds" (Gordon, 2010, p.8) no longer held together by "protective and defensive mechanisms" (Macleod, 1994, p.626) due to the challenges of old age (Macleod, 1994; Pary, Turns & Tobias, 1986).

At the beginning of therapy the older adult brought a 'sense of continuity and discontinuity within their ageing 'self' (Sneed & Whitbourne, 2005). There was recognition of continuity into old age by these participants which is also a notable formal developmental theory

(Erikson, 1968) that suggests older adults are aware of their sense of self over time. The calm and balance of the older adult participants' inner world became challenged by the crisis which ensued. These issues contributed to the development of mental health problems as they tried to cope with these difficulties. The older adult participants dealt with the crisis and they coped as best they could, and these reactions created further psychological instability, which blocked an equanimous response. The older adult participants faced multiple physical and mental health challenges, in addition to loss and a shifting self-concept, all of which had repercussions on their autonomy and resilience. These problems led to conflicting ideas about how they perceived themselves and life, as they struggled to re-balance the 'self' and cope. Coming to therapy was an opportunity to explore the dichotomy and fragmentation within the older adult participants' now vulnerable sense of 'self'.

The second category is about the older adult participants 'embodying an awareness of an ageing changing ecology'. Like the first category, this explicates the affect upon the 'self'. Embodying is about how these older adults showed what ageing and change meant for them because of their interpretation of that experience. What takes place is an awareness of their experience of ageing due to the interaction between their internal and external ecology because of the challenges they face. This category further illustrates how these conjunctures at that stage in their life, while combined with the ageing process was an important factor in how they responded and made sense of their experiences. The participants and psychologists acknowledged issues of being frail, cognitive changes and trying to adjust to the challenges of long term conditions that these older adults faced. The specialist psychological support also consisted of an awareness of a changed 'self', in an ecology where ageist attitudes exist.

Furthermore, the skill of the psychologist is also connected to understanding the contextual factors where multi-level systems of care giving and support play a role in the older adult participants' life and how these systems are experienced by older adults.

The uniqueness of the therapeutic work with the older adult participants is predicated upon the third category being in place, when the older adult participant and psychologist 'cultivate a therapeutic relationship'. The therapeutic work is about how they both engaged with the realities presented in the first two categories that reflect the emotional complexity in the older adults' internal and external worlds. Within the therapy space there is that recognition of the richness of a long life already lived, and the reality of the life in the present moment despite obstacles and uncertainty about the length and quality of life in the future. In the therapeutic encounter, there is acknowledgement that the older adult brings a particular historical knowledge, wisdom and values from a previous generation. Moreover, there are also cohort differences inter-generationally. Being in the therapy room with the older adult, the psychologist brought specialist knowledge and expertise about the ageing process, in addition to a contextual understanding of the different environments in which older adults live. This helped guide the participants towards developing greater stability.

Moving towards equanimity also meant that the therapeutic relationship with the older adult needed to be nurtured through a therapeutic conversation, so that the participants' main concerns could be explored. The therapy relationship empowered the participants to take responsibility as this is part of the process of change in therapy.

The therapy process brought some challenges to this collaboration and there were generational and typical barriers to the therapeutic alliance. For example 'generational barriers to the alliance' influenced what was understood due to the assumptions, expectations, beliefs, and experiences held by the older adult as well as the psychologist, which restricted

the fluidity in building the alliance. Additionally, 'typical barriers to the alliance' were evoked within the older adult participants because understandably they found talking within therapy difficult. Consequently, 'managing expectations' became an important stage in building the therapeutic alliance. This was in order to clarify the limitations of psychological therapy, think about the possibilities in relation to the older adults' therapeutic goals and to work through the difficulties that arose during the building of the therapeutic relationship. Collaboration meant that the older adult could then 'experience engagement' with the psychologist, so that they could work together 'incorporating context into the formulation' which brought a deeper understanding of the subjective experiences of the participants.

Lastly, the fourth category depicts the journey towards achieving equanimity that helped the older adult to evolve, develop and gradually change as they 'connected with wholeness and a new perspective'. Within this stage of therapy, the psychologist 'paced and adapted' the sessions according to the individual needs of the older adult. The therapeutic conversations included 'reminiscing about generational durability and junctures'. The function of this exploration was to acknowledge the resilience of previous generations and how the older adults experienced these historical events, as well as the stories passed on through their families. The psychologist took into account the pain, distress and trauma within the participants' stories as they negotiated how they would join together to 'work through the complex layers of a long life'. Experiencing psychological therapy helped to 'transform the older person' so that they regained emotional stability. The older adults were aware they had survived and moved forward from a challenging situation because they could own that they felt better and were coping with life again. As therapy drew to a close 'managing endings' was acknowledged by both parties to be a time of loss and some sadness. At this stage in the

therapy journey, the older adult and psychologist both took time to reflect upon the work and also take responsibility for the sense of hope regarding the changes that had taken place.

In summary, experiencing therapy gave these older adult participants a sense of control, which helped them feel more resilient, grounded, and connected to a new perspective. Moving toward equanimity led to them being different, having balance, developing “composure” (The Free Dictionary) and a re-integrated sense of wholeness, as they had learnt how to keep hold of the ‘self’ through a more equanimous frame of mind.

The next section includes a more detailed explanation of each of the categories and subcategories. Furthermore, the quotes used vary and I have chosen them to exemplify the phenomenon that was studied (Morse, 2007).

**Category one: Sensing continuity and discontinuity within
an ageing 'self'**

- 1a) Sub-category: Noticing stability within the 'self' over time
- 1b) Sub-category: Responding to an existential crossroad
- 1c) Sub-category: Exploring duality within the 'self'
- 1d) Sub-category: Observing fragmentation within the 'self'

The older adult participants spoke about the negative life events that left them with a fragmented 'self' causing a discontinuity within their internal world. Their experiences influenced the way they viewed themselves and their environment, as they embodied an internalised 'sense of continuity and discontinuity within their ageing 'self''. The participants talked about their awareness of the continuity within, that ranged from childhood into old age, which gave the older adult's lived experiences added meaning.

The participants' were aware of a sense of self changed by these negative circumstances. The participants spoke of experiencing traumatic life events and the threat to their physical and emotional worlds which disrupted their sense of continuity and revealed a 'self' in distress. Dealing with loss was a significant factor as they saw important aspects of their life change, and the stress of which brought them to the edge of their coping capacity.

These older adults were 'responding to an existential crossroad' where the intensity of their difficulties reduced their sense of control over the 'self'.

The psychological distress left them unable to sustain equanimity and move forward with their lives' in a meaningful way. The participants recognised the contradictions in their usual way of being and their understandable reactions to very difficult problems indicated that these negative life experiences had altered their sense of self, generated strong emotions that

left them feeling overwhelmed and troubled. There was a real sense of internal conflict and loss when the older adults re-told their story about how the psychological impact created a ‘duality within the self’. As the older adults faced this dichotomy, they struggled to cope and make sense of their experiences because of the shifting views of the ‘self’ that interfered with their mental stability.

Their story conveyed a process of a disintegrating ‘self’ that was in distress, losing control and created an incongruence that disconnected the older adults from their resilient self. This left them emotionally unsteady and breaking down. The participants explained that the impact reduced their ability to ‘hold’ them self together which caused ‘fragmentation within the self’. The older adults’ experiences led to them receiving psychological therapy to cope with the discontinuity such life changing events brought about.

1a) Sub-category: Noticing stability within the ‘self’

Stability during the older adults’ lifetime allowed the participants to hold onto a sense of self as they remembered the person they were before and who they are now:

Margaret described how she embodied an awareness of youth within her mind, whilst the outward appearance of an ageing ‘self’ was juxtaposed with childhood memories:

If I let all the grey come through and everything I’d be an old lady. I’m young in my mind. (psy 02: 660)

Margaret further displays the sociable and extravert nature that is characteristic of her self-identity.

...don’t want to talk to anybody and I talk to everybody. If I saw you down the road I might say nice day a bit cold ain’t it, I might not know you at all, but that’s the person I was from a little girl; friendly... (psy 02: 30-31)

Christina expressed her certainty regarding her sense of who she is and how some of her experiences have contributed to her self-knowledge and confidence:

...married, tell you things, tell you who I am. I know who I am, I don't want nobody to tell me I'm happy, clever or anything I know myself. (psy 15: 60-61)

Angela described how proud she was that she could hold onto particular attributes that are central to how she sees herself:

...intelligent and articulate is kind of one of the three pluses for me and I think that's why [I] hang onto that the way I do. (psy 24:235)

1b) Sub-category: Responding to an existential crossroad

When the older adult participants found their life disrupted by negative events that interfered with the flow of their existence, it was difficult for them to cope with the crisis. The breach was significant and lead to the participants not coping. Understandably their experiences caused an internal struggle and they were unable to take an equanimous approach to these difficulties. With the 'self' left uncontained and distressed from the trauma of their experiences the older adults lost a sense of balance and feeling of being grounded.

Christina described the moment she experienced a traumatic loss because of the pressure placed on her to have an abortion:

...was (...) because of what I've done and because I wanted children. And because I was pregnant they have to bring me something, tablets to take it away, I take them, I don't know. After that really I never been happily, I (pray) myself why I listen to him and I shouldn't of marry. But didn't have any choice years back it's (...) now. I've never been happy all my life, you know, things just really (...) from that it's (...) ... (psy 15:21-25)

Christina remembered that she was given tablets that took away her pregnancy, she indicated how difficult that decision was and the regret and sense of guilt that maintained her unhappiness.

For **Sally** the impact of the depression was keenly felt:

Yes, yes, yes, yes. I was annoyed really with myself that it really got a hold of me like that...[context: the depression] (psy 20: 430)

She described her helplessness when faced with depression again. Sally talked about how disappointed she was with herself that the depression had caught her unawares.

Helen explained how the mental health problems she experienced made it too difficult for her to cope. She described being aware that she was no longer in control of herself:

...because I could not hold myself... (psy 25: 257)

In the quote she indicated her realization that she did not feel self-contained, which suggested that she had reached an existential crossroad where a decision needed to be made.

Melody talked about the day that she went out shopping with her husband, a routine task they would usually do together:

*...crashed into a 4x4 and I don't know no more he died at the wheel with a heart attack and
xxxx...(psy 44: 14)...It could be I mean me life got disrupted didn't it? (psy 44:296)*

The impact of the trauma was evident as the crash in which her husband died so tragically, changed her life completely; leaving her questioning what could have happened.

1c) Sub-category: Exploring duality within the 'self'

The psychological impact of the presence of duality within the 'self' rested along a dimension from rejecting to accepting the 'self', which gave rise to conflict in the older adults' internal world. The participants' story is one of a changed 'self' because of particular life events they faced, which left them with doubts that influenced their self-perception and undermined their ability to cope. The participants experienced this anti-thesis as a threat to the integrity of the 'self', and such threats caused instability in the older adults' mental state, thus moving the participants further away from equanimity.

Julie indicated what the experience of a dichotomous 'self' felt like:

*...thinking I don't know what to do. It's very difficult to stand up and say actually this is not
selfish...(psy 07: 60)*

The uncertainty within her internal world left her not being able to assert herself, to voice her own disquiet.

Julie continued to examine opposing views of herself and the situation:

...also not feeling myself to be sufficiently worthwhile to say, I'm okay this is nothing to do with me...(psy 07: 105)

Her description of feeling inadequate and unimportant makes it more difficult for her to have a voice, and step back.

While **Angela** expressed that there are some parts of herself that she accepts implying that there are parts she rejects. These opposing ideas are held together by an overarching “theory” that helped her hold onto a view of herself that she could own:

...analysis and so on, understanding of it even maybe. But it doesn't, doesn't all that help and as far as accepting myself is concerned well there are bits of me that I accept and think of okay. In theory overall I think I'm I feel myself to be a good human being and for me I think that's important cause I think people should be human beings and I think there is a lot less ...(psy 24: 142-144).

Angela denotes how she functioned with duality and a threat to the ‘self’ that presented difficulties which led to her coping by concealing parts of the ‘self’ that she struggled to accept:

...covering up and I somehow managed to, but that's getting more difficult and so. I mean every so often it's kind of a joke...(psy 24:49)

Margaret explained that she was aware of being effected by her distressing experiences. This had caused her to re-evaluate her self-perception and consider that she is both ‘weak’ and ‘tough’. Whilst others, she says, are surprised that the negative events caused a change within her, implying that others had difficulty accepting that there had been a change:

...always been so tough they can't believe there's weakness in me, they can't believe me. (psy 02: 7)

1d) Sub-category: Observing fragmentation within the ‘self.’

The fragmentation of resources within the ‘self’ distanced the participants from equanimity. The consequences of experiencing disintegrating resources meant that the older adults understandably could not cope with these negative life experiences and the disruption reduced the older adults’ ability to utilize their resilient self. The participants experienced emotional instability, negative thoughts, worry, fear, disappointment, anxiety, depression, loss and attempted suicide as they struggled to re-balance the ‘self’.

Peter felt unable to find peace of mind as the worry about having cancer impacted on his sleep.

He signified how relentless the worry was when he stated “*your brain is going 24 hours a day*”:

I don't suppose even you would know what it's like you know your brain is going 24 hours a day and somehow or the other you have to try and stop that even for a little while and the only way you can stop it is to get to sleep, you can't get to sleep because it's on your brain. (psy 03:122)

Margaret described that experiencing stress at 72 was too much to cope with:

Stress, I'm nearly 72, I really don't need it I've been through hell the last few years. (psy 02: 602)

Melody was too afraid to walk past her front door because she feared intruders and this left her feeling vulnerable and unsafe:

...scared to pass me front door, I thought somebody was kept coming in. I kept trying, locking it, trying... (psy 44: 28)

Angela observed the destructive nature of the fragmenting 'self' that left her experiencing mental health problems at a late age accompanied by suicidal ideation leading to further disintegration:

...suicidal, what you call it, feeling coming into to me. Sometimes I can sit there and say hey.....(psy 25:206)

Because I spent xx years, I didn't know anything about mental health until I was xx years of age and it was just a complete breakdown that brought me into the mental health. I had one...(psy 25: 275-276)

Margaret looked back to the moment she took an overdose to cope with her difficulties. Her fragmented self is clear to see:

And honestly that's what killed me and that is that day when I took all those pills – they weren't sleeping pills they were anti-depressants tablets. It was all in my xxxx of my xxx, they were in there and I locked myself in and I took one after the other, after the other. I thought in my mind I want to go to sleep, I want to wake up; it's a bad dream and it's finished. And I took one after the other; I took a load of them they were in the xxxx. (psy 02: 777-781)

She talked about the way in which she took the pills and her state of mind, about her hopes that she could pause, sleep, then wake up and so her distress would be all over.

Category two: Embodying an awareness of an ageing changing ecology

2a) Sub-category: Acknowledging debility & cognitive changes

2b) Sub-category: Adjusting expectations about illness & long term conditions

2c) Sub-category: Challenging ageist attitudes

2d) Sub-category: Care giving and interacting with support systems

The older adult participants talked about the many challenges they faced and their explanations demonstrated that they ‘embodied an awareness of an ageing changing ecology’. The older adults’ sense of self was influenced by unexpected negative life events which impacted on the way the older adult participants interacted with their environment, and this was a barrier to a more “adaptive response” (Fillit & Butler, 2009, p. 350) whilst also preventing equanimity from being established.

The multiple contexts that the older adult participants were located within reflected the different circumstances that influenced their lives and the meanings they gave to it. All these systems that related to their physical health, mental health, community and social care were brought into the therapy room. The older adult participants had witnessed a ‘self’ that had changed many times within all these contexts, and they experienced being treated differently. They were aware that they needed different coping strategies to manage the ‘self’ thus ‘acknowledging debility and cognitive changes’, in conjunction with a normal ageing process. These experiences they faced were juxtaposed with further difficulties of ‘adjusting expectations about illness and long term conditions’. Another context in which the older adult participants were situated was within the communities where they lived. These older adults

had some knowledge of the contributory factors when ‘challenging ageist attitudes’, and the unhelpful discourses that included stereotypical negative assumptions about older adults. Such attitudes and power differentials from parts of society meant the older adult experienced this as a threat to the stability of the ‘self’, which maintains social exclusion, and a vulnerable sense of self that contributes to their invisibility.

The participants’ story reflected a change in the sense of self over time as they aged, in addition to the limits placed on their health. The older adults talked about being reliant on ‘caregiving and interacting with support systems to help them continue to live their lives. They spoke about the support being varied and the impact that a lack of support had upon their life, as well as the importance of having reliable systems that offered support when they needed it.

In the therapeutic environment, there was awareness from both the psychologist and participant that being an older adult was complex and multi-layered. The therapeutic conversations needed to incorporate generational differences in the older adults’ worldview, to understand what the participants required from the psychologist. Moreover, this was necessary in order to grasp a fuller understanding about the needs of the older adult to reintegrate the ‘self’ and fulfil the journey towards a sense of mental calm, which is the essence of equanimity.

2a) Sub-category: Acknowledging debility and cognitive changes

‘Acknowledging debility and cognitive changes’ meant that the participants began to notice and understand the consequences of this period of health related change and its impact. The participants’ observations of having to live with debility and cognitive changes existed on a dimensional range from mild to severe.

Melody described the impact of not being in control of her physical health and external environment:

...gets xxxxx strokes you know. I didn't know I was doing it and I left me front door wide open and...(psy 44: 40)

She recounted how she began to interact differently in her home, she was unaware at the time of leaving her door open and how vulnerable this made her.

Sally indicated that it was difficult to remember the detail of what occurred last year:

I don't really know, can't put a finger on its last year now you know which you forget especially at my age. I suppose just there to listen, you know there's not really much I can say. (psy 20: 21-22)

Sally had interpreted the forgetfulness as an expectation of her age.

In contrast, **Angela** felt “worried” about the changes in her memory:

...really worried about my memory, short term memory in particular but long term is not so hot either and so I had these...(psy 24: 29)

She described that something had altered which she interpreted as her cognitive processes being less effective than they used to be.

For **Margaret** ageing meant that she did not get better in the same way as before:

[Look] when you're old I don't heal up easily, it gives me needles and it will go down me, yeah. (psy 02: 412)

Her conviction suggested that the belief about the rate in which she expected to heal would be thought of as the norm because of her age.

2b) Sub-category: Adjusting expectations about illness and long term conditions

The older adult participants had to adjust their expectations about the illnesses and long term conditions they faced. These medical conditions ranged from coping with cancer to managing multiple medications to maintain their health.

Sally incorporated taking warfarin into her daily routine:

And I'm on warfarin and I take the warfarin 6 o'clock at night that's those over there (she points to where she keeps them) but I'm on so many pills now you know. (psy 20: 203-204).

Sally talked about how she takes warfarin at a particular time and how this is one of a variety of medications she had to take.

Margaret had just begun her cholesterol medication in addition to medicine for her thyroid and blood pressure:

[All I] take is thyroxin, blood pressure, cholesterol. I only just started on cholesterol I've never known it before but I've just started on it and I had a blood test last week and I've got to go and check it, how it is I don't know - God all in one year...(psy 02: 608-610).

She described that as part of routine medical checks she now manages her long term conditions by going to the Doctor's surgery to have her health monitored. She signified a sense of astonishment at all her health related problems happening within one year.

Margaret goes onto add that in many ways the long terms conditions are an expected part of her life given her age:

And yet, underactive thyroid what I would expect to have at my age, bit of blood pressure it's acceptable at my age and now I've just found out that I might have a bit of cholesterol (she giggles as she said that). (psy 02: 761-763).

Whilst **Peter's** expectations seemed to suggest that he was looking forward to a life without medical problems:

Because you get to my age and you think you're going to have a good life (he chuckles) – you get rheumatism, you get arthritis, you get, you get that. I try to (enjoy) myself which I do, I must admit. (psy 03:194-196).

Instead he faced the challenge of being diagnosed with a long term condition. He revealed a positive attitude when he explained that he tried to still enjoy himself.

Peter applied a similar attitude to the odds that were given to him when he discussed the outcome of undergoing chemotherapy treatment for cancer:

And she said if you didn't have it, chemo, 50:50 chance it would come back, I said okay... (psy 03:182).

Melody had found her own way of adjusting to the knowledge that her long term condition would result in death:

It's just one of those things; you've got to die with something I mean I'm going to die with that. (psy 44: 285-286)

Her comment embodied layers of meaning entwined within a language that suggests an acceptance of something she cannot change.

2c) Sub-category: Challenging ageist attitudes

Within the wider community there are discourses that take place about older adults that can be perceived as being excluding. Some of the assumptions held about the elderly by parts of society are challenging for older adults. The participants described how they experienced this loss of power and the impact upon their personal identity. The participants attempted to challenge ageist perspectives, while confronting discrimination and other negative points of view. The participants actively rejected preconceptions that purported to define them just by their age. How the participants came to identify themselves was fundamental to their recovery and equanimity.

Peter remembered that when he went to the Doctor about his medical problem he was informed that the symptoms were because of his age:

Yeah, you see it all started with the Doctor that was the first thing, with prostate cancer you keep wanting to go for a wee, then you've got to go 5 minutes, 10 minutes and nothing's happening and then you're told it's your age and I said okay then. Then we went out to xxxxx then we were all sitting out on the beach and I said na something's wrong I keep wanting to go to the toilet, I said this is wrong and when we came home I went back to see him. He said this (..), I said no you didn't you told me it was just me age, then he starts giving me a letter for the hospital and in the middle of it he told me what I had (...) they can't say the other thing to you and (...) I can't believe it, that was to me a year wasted a complete year. (psy 03: 209-216).

Although Peter initially accepted what his Doctor told him he later questioned it. He challenged the Doctors ageist account of what was discussed. Peter was then sent for tests and the results were given to him and he expressed his shock about having prostate cancer and his disappointment that the mis-diagnosis meant he had lost a year when he received no treatment.

Margaret wanted to preserve some dignity when she asked for privacy in the bathroom:

...in the bathroom could I have a shower she said no, I said I'll just wash quickly. I said could you please turn your back on me I said I'm not being funny and I am an old lady and I'm not use to having people around me. (psy 02: 554-556).

She tried to remind the person of the generational differences and her expectation for some respect but she was not listened to.

Helen also spoke about being ignored and the generational differences in the way younger people and older adults are treated:

...anywhere. If you've got a younger person with ya behind that counter will be the person that will go with the younger person and ignore the older person. (psy 25: 553-554)

Helen's experience was that more attention was paid to the young person that accompanied her and the description she gave was of being discriminated against.

Both Helen and Angela demonstrated how they stood up against ageist assumptions.

Angela was reminded of an occasion when she felt classified in an undignified way and her response suggested that she may have experienced this as dehumanizing:

...was that he was just treating me as one of your general xxxxx geriatrics and I didn't feel as though I came into that category... (psy 24:9).

Helen was aware that ageism needed to be challenged wherever older adults are; in order to help people acknowledge that in society human beings have the capacity to behave in ageist ways:

Ageism, the places that we go is where ageism is already there but when they've seen what we've done they've picked up on it and gone oh, oh, oh course we do that and it's... (psy 25:550-551)

2d) Sub-Category: Care giving and interacting with support systems

The participants faced health and social changes that restricted their ability to care for themselves, as they became more dependent on others to support them. The older adult participants found they needed different levels of ‘care giving and interaction with support systems’ to help them be as independent as possible.

Support systems varied and the participants indicated that they experienced these systems in ways that were disempowering and non-sustaining when there was a lack of reliable support. When the participants felt disempowered, it created instability for the older adult as they were deprived of the chance to have influence over the ‘self’, and what took place within their lives.

In contrast, systems that were experienced by the older adult participants as positive interactions, allowed them to feel sustained, supported and therefore empowered. The participants brought all of these complexities about how they experienced being an older adult to therapy. The psychologist needed to work with the participants to understand the emic perspective and move the older adult towards equanimity. Understanding how the participants adjust to the interactional patterns and dynamics of support systems was important, as this helped to increase the older adults’ sense of connectedness between their internal and external worlds.

Peter recounted that he heard nothing from his Doctors for some months and spoke about how he experienced this absence of communication:

Couldn't, what was going on, I think I was left for about 6 months not knowing from a to b and then I had to go to, because I was under two Doctors at xxxxxxxx and then I went to the other... (psy 03: 78-79).

His remark demonstrates how confusing it felt not hearing from his Doctors regarding treatment for his cancer. Peter indicated that he was not sure of what plan his Doctors' had for him, which created more uncertainty.

Peter's previous quote is contrasted with his experience of being supported and feeling more connected, which had a powerful effect upon his sense of belonging, which helped him to feel less alone living with cancer:

I've sat and thought everyone in this room as got cancer. So you talk to one another and you know that's how I looked at things, I thought you're not the only one, you think you are and then you walk into a room of say 20 people and so a lot of them were in there with scarves on and all that and you start chatting to them and you feel that you're not the only one there's plenty. (...) (The last word of this sentence was said in a whisper). (psy 03:163-167).

Alice explained that she did not feel well and no one listened to her:

...xxxxx xxxx and I just didn't feel well, but no one was listening, Doctor included. None of them would...(psy 41:76).

Alice chronicled another occasion where she felt overlooked and the context that she was in failed to meet her needs:

Yes, it was a xxxx, it was terrible. No stimuli, the shower door was broken and was left open when I was washing, my dignity was completely ignored. I was forced to get up even though I didn't want to; I was made to go into the lounge without any real comfortable chairs to sit on, nothing to do, just people sitting in their chairs just rocking backwards and forwards. Now that to me was the worst thing you could have done to me, fortunately I was going to transferred to xxxxxxxx to the xxxx (psy 41: 91-95).

She experienced the environment as appalling where she was not treated with dignity. Her account is rather striking as she expressed how disempowered she felt. Alice remembered the impact upon her sense of self and feeling unsupported. She portrayed a sense of relief when she was moved to a different place where she experienced a more supportive milieu.

The older adult participants described what it meant to them to experience support that met their needs in ways that kept them connected with the 'self'.

Peter explained how the encouragement from his Doctor helped him but there were times he felt uncertain whether he was doing things correctly:

It kept me together and he was saying you're doing the right thing, but you don't know what you're doing in a sense and I'm thinking I'll go for a walk and I used to go fishing years and years ago. (psy 03: 104-105).

Having carers three times a day helped **Melody** feel supported at home which she appreciated, but she also noticed the difference when the carer was not there. Her remark indicated she was aware of being less independent and more isolated without a carer coming to help her:

Yeah, but I have a carer three times a day here. It's alright when she's here, it's when she's gone and at the moment I can't get out much and the matron's been getting in touch with (long pause as she tries to remember) Oh God what is it. Is it Age Concern or Help the Aged? (psy 44:52-54).

Category three: Cultivating a therapeutic relationship

- 3a) Sub-category: Being in conversation with the psychologist
- 3b) Sub-category: Observing generational barriers to the alliance
- 3c) Sub-category: Observing typical barriers to the alliance
- 3d) Sub-category: Managing expectations
- 3e) Sub-category: Experiencing engagement
- 3f) Sub-category: Incorporating context into the formulation

‘Cultivating a therapeutic relationship’ with the older adult participants became an important foundation from which to engage with the therapy work, so that both the participants and psychologist could make sense of the difficulties and move toward equanimity.

Psychological therapy comprised of an iterative quality, where the therapeutic relationship became a vehicle by which the participants could move back and forth reflecting introspectively when talking with the psychologist. The importance of the therapy relationship was central to the process of change. The therapeutic journey for the older adults coalesced particular stages that commenced with a conversation with the psychologist, where barriers to the alliance both generational and typical needed to be worked through so that the older adult participants felt safe enough to engage and share their main concerns. Moreover, managing expectations, engagement and also the incorporation of the formulation formed this part of the older adults’ journey through therapy.

For these older adult participants ‘being in conversation with the psychologist’ rested upon a dimension of communication and the dialogue contributed towards the building of a working

alliance. However, when trying to negotiate a shared understanding, barriers arose which meant there were obstructions within the communication which caused some restrictions.

When ‘observing generational barriers to the alliance’ there was an awareness of generational differences that influenced the expectations and assumptions of the participant. Becoming dependent upon the psychologist was not an easy undertaking for the older adults. The participants spoke about being born into a generation where coping with difficulty was expected to be managed in a different way. The participants reflected upon talking therapy being unfamiliar and not being available in ‘those days’, which indicated that talking about problems would have been handled within communities through other means. As the participants’ continued to look back, they spoke about being born in a different time and their story conveyed a powerful sense of a cultural past context and discourses that were part of shaping their life experiences.

In that therapeutic space it was important to be aware of ageist beliefs and unhelpful assumptions so that the participants’ felt heard and understood; because assumptions and a lack of transparency contributed to inhibiting disclosure. The participants’ also revealed that they experienced ‘typical barriers to the alliance’ and these defences and resistance became a blockade to talking. Furthermore, these barriers are characteristically universal for many client groups where attempts are made to avoid upsetting feelings.

Both the older adult participants and psychologist became aware of the influence of such barriers due to the effect upon decisions regarding what and when the older adults would talk about their issues in therapy. There was acknowledgement that these difficulties were arduous, and that changing a deep rooted issue that had been within the ‘self’ since childhood was not an easy part of the ‘self’ to open up. This was because of the emotional pain entwined within the complex layers of the ‘self’.

Both the older adult participants and psychologist had to work through these barriers in order for therapy to progress. Thus, ‘managing expectations’ became a way for the psychologist and older adult to resolve the problems at this stage of the work. This entailed talking through what the participant expected, what the psychologist heard and what would be offered in therapy. This kind of transparency within the relationship helped trust develop in the psychologist, the therapy process and enhanced the experience of therapy for the older adults which helped them feel more settled about the process.

Through the genuineness that emerged from the collaborative encounter, the older adults were helped to ‘experience engagement’ through the therapy relationship. Trust was embodied within the relationship and was an essential element in the process. Moreover this contributed to the participants’ experience of power in the therapeutic relationship. The older adults portrayed how the reliability of the psychologist encouraged them to engage and depend upon the psychologist. This collaboration happened ‘naturally’ because of the connection they experienced within the relationship that embodied qualities of congruence that aids good communication.

Metaphorically, it was like opening a door to an important visitor who you want to interact with. Therefore ‘letting’ the psychologist ‘in’ was about being open to the possibilities of something different. The older adults’ story gave a sense of calm about the reciprocity that existed in the therapy relationship which allowed for the giving and receiving of help to occur.

The therapy relationship ‘incorporated context into the older adult formulation’ to develop a shared understanding, through clarification of the meanings within the older adults’ experiences. During the exploration of the older adults’ story developing a formulation was a collaborative process so that understanding of the patterns that kept the participants stuck and experiencing discontinuity in the ‘self’ was talked about and understood. Coming together to

examine what was going on helped the older adult participants to recognize what factors contributed to the maintenance of the problems they faced at this stage in their life. Negotiating agreement about the formulation moved the older adult participants along in their journey toward equanimity, so they benefitted from the therapeutic work.

3a) Sub-category: Being in conversation with the psychologist

Talking to the psychologist was about having a space to talk about how the older adult participants felt.

Margaret explained that it was about talking to someone about the problems she faced:

[It] was someone to talk to and discuss your problems with. (psy 02:15).

Sally described how the conversation allowed her to tell the psychologist what she felt:

Oh yes, yes in conversation I was telling her how I felt and it just gradually came back. But....(psy 20:50).

The process of talking allowed the issues of concern to be brought back into her awareness.

Feeling listened to was an important factor that helped the participants' to communicate.

Margaret articulated that she noticed the importance of being listened to and her explanation suggested that she felt heard by the psychologist.

What stands out to me is that you can talk about it and they can listen to you, because like I say (psy 02:309)

Angela expands on the impact of talking upon her internal world:

...expressing some of my concerns and unhappiness and things. And I found that therapeutic in itself and after quite a long...(psy 24:89).

Talking helped Angela to go deeper into herself and locate what troubled her and she experienced this process as restorative.

Seeing a psychologist at the moment when they needed to talk was highlighted by the participants.

Helen recounted:

[But to] have that psychologist come along at that time, so that was good (psy 25:246).

...timing was excellent because I was very, very negative really negative. I didn't wanna live, I didn't wanna do this, I didn't wanna do, don't talk to me your rubbish. And I was sort of...(psy 25:248-249).

Her appreciation that the psychologist was available at the right time points to how significant the psychology referral was to her because of how pessimistic she felt.

Sally remembered that the psychologist came to see her when she was in hospital and how that was a very helpful experience to have a psychologist come and talk to her in that context:

[the...] lady that used to talk to me in hospital was very helpful. (psy 20: 19).

Sally explicated what it meant to have someone to talk to:

Yes, yes we need company I suppose and that kind of thing. ... (psy 20:437).

Talking therapy was experienced as a relationship that offered support during therapy.

3b) Sub-category: Observing generational barriers to the alliance

Generational barriers to the alliance indicated that the older adult participants and the psychologist had particular ways of viewing the issues brought to therapy. Assumptions can be held by the psychologist about the needs of older adults. Additionally, the life experiences the participants had are shaped by cultural and historical factors that characterize the generation in which they were born (Lazarus & DeLongis, 1983).

These attitudes may not have been in the psychologists' or participants' conscious awareness all the time, but they had the power to influence and create blocks within the alliance if they were not acknowledged and worked through with the older adult.

Christina illustrated that the psychologist did not help her:

He didn't help me, tell me how to, he just told me how to go out and make friends (...) I know everything about this. I have enough experience to know about that. (psy 15: 236-237).

The tone of Christina's account symbolized the difficulties to the alliance when there are blocks in communication and understanding. The participants' expression suggested that she expected something different from the psychologist. Instead the participant was given information about how to make friends and increase her social activities. It is well documented that often older adults can become isolated and integrated mental health services have access to resources that can help older adults feel more socially included. The participant indicated that this issue was not of immediate concern to her.

Christina stated that her main issue was her distress that began because of the generational factors that pertained to that time:

...pay the rent (...) in those times were different a long time ago. I am suffering because I live in that time (...) (psy 15:120).

Her narrative brings to mind that she lived in a time when life was different and the rules that governed that period contributed to how much she suffered.

Angela expounded another generational barrier to the alliance as she chronicled that being alive for a long time influenced how much she believed therapy could help her get better:

Yes, but again just thinking about it now how it formulates itself with me is that what it comes down to is that it's all my fault that I can't be cured and that's a very, it probably goes back to when I was 6 or 7 or 8. So that I think that I have lived for a very long time with a lot of very negative feelings about myself and so in a way not responding to treatment is another stick to beat myself with and there's been lots of those throughout the years.(psy 24: 128-131).

Angela blamed herself for not getting better in the past and she talked about knowing that it stemmed from her childhood. The strength of feeling expressed by the participant demonstrated the view that living a long life with difficult feelings about the 'self' contributed to how she approached the alliance with the psychologist.

3c) Sub-category: Observing typical barriers to the alliance

Typical barriers in the alliance were common factors that are present when the participants and psychologist were building the therapeutic alliance, leading to intrapersonal issues that obstructed the participants' self-expression. Barriers were ways in which the participants shielded themselves from talking about painful memories and the consequences meant that their freedom to express their concerns was temporarily curtailed. The participants were aware of the impact that revealing aspects of their story would have on them, and so they prepared themselves in readiness to share with the psychologist.

Certain conditions needed to be in place for the participants to express themselves freely, for example: trust, empathy, reciprocity, feeling listened to, being understood and also an awareness of power within the therapy relationship. These and other elements add richness to

the therapeutic interaction which are necessary so that barriers between the older adult participants and psychologist can be worked through.

Christina described the barrier of how painful it felt to tell her story:

Yes, yes it was quite painful I never say anything to (...)... (psy 15: 92).

Helen sounded clearer in her own mind about the process involved in talking and how particular types of conversations exist on different pathways:

Because there's different (roads) to that, I'm not going to start bringing up things that [really affect me]. ... (psy 25: 130).

This participant referred to the process involved in talking and how she chose to limit what and when an issue was spoken about, depending on the situation.

Helen indicated that telling her story was restricted during the building of the therapy alliance despite the knowledge and skills that the therapist possessed:

Yeah it is, you're not going to straight away meet somebody even though they are a psychologist you're not going to meet them straight away and talk like I am now. (psy 25: 139-140).

The participant points to phases which are implicit, but also explicit within talking therapy, that signifies how the pace of what was spoken about develops.

Christina recollected that the blocks to the alliance, sometimes meant that speaking to the psychologist was “*difficult*”. The participant contrasts this with the research process and the freedom of expression she experienced during the interview:

Sometimes it was difficult really; I speak to you more freer. I didn't speak to him more free. I.....(psy 15: 429-430)

3d) Sub-category: Managing expectations

Working through the blocks that arose in the alliance allowed for a trusting and transparent relationship to unfold, that also embodied hope. This meant issues about the therapeutic process, the limitations of the work and confidentiality could be clarified and expectations managed. The participants came to therapy because they wanted to gain something from the process.

Angela described the attitude that she brought to therapy:

...to be right. I think it would be impossible to meet with a psychologist and for you to think this is not going to work for me...(psy 24:313).

She explained that it would be difficult to have doubts that the therapy would not be beneficial.

Whilst **Sally** spoke about taking a similar attitudinal position in her approach to therapy:

Well you know if you think something is not going to be good for you, you just don't do it...(psy 20: 470).

Christina had doubts about herself and what to expect from the psychologist:

I don't know how I was going to do it (...) how I was going to do it (...) (heart) you understand that, I didn't know how he was going to help me. ... (psy 15: 246-247).

She reflected some uncertainty about her own ability to move forward and this was paralleled as she wondered about the psychologists' capacity to help her. Having an understanding of what was going to happen seemed to be expressed by Helen too, which demonstrates that the therapeutic process was experienced by the participants has unpredictable.

3e) Sub-category: Experiencing engagement

'Experiencing engagement' is about the deep connection between the psychologist and the participants as they built a therapeutic relationship. This component allowed the older adult to share, learn about and recognise patterns of behaviour that maintained the presenting problems. The nucleus within the process of engagement is trust and this was essential for the participants to collaborate and open up to the psychologist. This meant a bond was sustained within an authentic understanding, reliable relationship, that created a safe space to talk and encourage hope. Some of the qualities of the relationship were expressed by the participants as being listened to, feeling understood, connecting with the psychologist, freedom of self-expression, choices and trusting the psychologist. This helped them work towards finding a resolution to their problems. Engagement was an important factor for the client to feel safe enough to disclose their concerns. Through trust, openness and transparency the therapy alliance was strengthened. There was something about the genuineness of the authentic relationship that helped the participants and psychologist develop good communication.

Peter felt that the psychologist listened as he shared his worries:

Well, if you've got any worries you know that someone is there to listen to you...(psy 03: 201).

Trusting the psychologist helped Helen and Alice share more of their story:

Helen explained:

I got to trust her and then I started bringing out, giving more, you know. (psy 25: 146).

The participant developed trust in the psychologist over time and this helped her to share more in therapy.

Alice:

...came out, poured everything I felt so comfortable with her (she drank a little water) I was able to pour it all out. ...(psy 41: 107-108).

This participant evoked a vivid account of her own journey of self-expression and how talking to the psychologist flowed. Additionally, she also felt at ease with the psychologist which helped the process move forward.

The participants spoke about the “persona” of the psychologist and that there was something intrinsic within the psychologist that allowed them to develop trust. This notion indicates that they trusted the psychologist intuitively and this allowed them to trust the process, which suggests that the therapeutic process, the participants and the psychologist are all interlinked.

Alice:

...they will have to find somebody else, but I didn't force myself it had to come naturally, it had to come naturally it did. ... (psy 41: 233-234).

The participant remembered that the therapy relationship developed “*naturally*” and the process was not ‘*forced*’.

Helen:

...[her] approach to me, her persona. You can tell people by movements. (psy 25:163).

Through her observations the participant learned something about the character of the psychologist that was fundamental.

Alice:

I don't know; she's got a particularly good persona and you can trust her you know she's not..... (psy 41:226).

The character of the psychologist met with the participant's approval and this told Alice that she could be trusted.

Helen:

I think it was about the relationship with the psychologist. I felt I could trust her and I...(psy 25: 160).

This participant added how the quality of the relationship helped her build trust in the psychologist.

Angela:

Yes I would think so I mean I think that, but I suppose that obviously this kind of theme the chemistry does need [to be right] ... (psy 24: 312).

The participant draws a link with experiencing a helpful therapy relationship with the rapport, and the special connection that gradually evolved.

Alice:

I feel if you don't let somebody in that you can trust don't have the help, don't let them in. ...(psy 41: 220).

Oh yes it's a two way street two of you have to play your part, you and the psychologist and.....(psy 41:318).

Taking responsibility was an important factor when the participants decided to accept psychological therapy. Alice illustrates the relationship of mutual dependence that existed between the participant and psychologist.

3f) Sub-category: Incorporating context into the formulation

Incorporating context into the formulation was about developing a shared understanding of the participants' circumstances, in readiness to grasp the meaning of their difficulties. Developing a formulation together was not an easy transition for the participants, and the capacity to discern what was going on was blocked at times by protective barriers that formed layers of meaning between how the difficulties were perceived and what was eventually owned. During this stage both the psychologist and participants became accustomed to each other's style of interaction as they developed confidence in the therapy process, so they could collaborate and explicate the older adult participants' problems.

Formulation and reformulation was about making sense of what was going on in the participants' internal and external worlds, so that the interventions generated would help the participants move toward equanimity. The strong partnership that unfolded was created through good communication and flexibility in the therapy relationship. The collaborative aspect was also able to withstand negotiation and clarification, as the older adult participants began recognizing patterns that had a bearing on their lives.

Helen was able to track her difficulties back to her past and her relationship with her mother:

...going from me mother and me mother's death and all in between there, what was happening....(psy 25:202).

The loss she experienced when her mother passed away was significant and she connected the reverberations of that loss to the impact of other events in her life.

Sally also had an understanding of the mental health problems she experienced:

No not really, not when you're children you don't really do you, but I was so so upset. I had sisters with me, xxx sisters with me, younger than me so I felt a bit more responsible for them as well you know. But hmmh over the years you know when I had xxx babies I finished up with post-natal depression. Although I hadn't had many attacks it was really deep depression; yeah the young ...(psy 20:15-18).

The participant's recollections of these events originating in her childhood, she understood as a “*really deep depression*”. She traced it back to the war and how she felt at that time during the evacuation. Formulating about what had happened helped **Sally** to take another perspective:

...looking back how upset I was; you know what I mean. It might have affected me different at that time being a child. (psy 20:233-234).

Her exploration allowed her to reconnect with her childhood experience and make sense of the understandable developmental impact.

It was difficult for **Margaret** to make sense of the problems that brought her to therapy:

I don't even know what happened, I think its stress related had a lot to do with it (psy 02: 405).

Her words suggest that she was unaware, in that moment about the cause of her predicament.

Eventually she reasoned, rather insightfully: “*I think its stress...*”

Angela elaborated about her depressive illness and showed an awareness of the blocks to using what is already known to her, to move forward:

Well I think, I think one of the problems is for a very long time I thought that, I understood a lot of the reasons why I might be depressed and as I say they go back a very long way. But understanding or any way being able to explain why they're there doesn't remove the depression for me. I think I've always been very aware and conscious of what's been going on in my head but the awareness doesn't seem to me to move me forward in anywhere. (psy 24: 112-115).

The participant acknowledged that she had thought about her problems “...for a very long time...” and she was able to gather explanations about the depression. She indicated the extent of these problems and just knowing these facts still does not help her. She adds that awareness about what is happening in her mind does not eliminate the barrier, which illustrated that changing is not a linear process but an emotionally complex one.

In contrast **Helen** was able to explain her thought process in making sense of what the patterns meant and how her alternative perspective helped her to consider other ‘possibilities’:

Well, I found it helpful because some of the things that she said you know; left me with the impression that yeah it's a possibility of what was going on in my mind at the time. And not... (psy 25:7-8).

The participants' insight illustrates that she began to reconsider what was happening within her internal world.

By being open to the process, **Helen** reflected her enthusiasm for what she had learnt as patterns that had been buried for a long time were now visible giving her choices in how to respond:

...it was brilliant, it brought out what I for years have never realised that there was a circle.....(psy 25: 201).

Category four: Connecting with wholeness and a new perspective

- 4a) Sub-category: Pacing and adapting therapy
- 4b) Sub-category: Reminiscing about the generational durability and junctures
- 4c) Sub-category: Working through the complex layers of a long life
- 4d) Sub-category: Transforming the older person
- 4e) Sub-category: Managing endings

‘Connecting with wholeness and a new perspective’ was about the older adult participants coping better with the ‘self’ and life again. Understanding the ‘self’ in therapy helped them become emotionally stable. What the older adults learnt helped them to reintegrate their sense of self because they were able to take a new perspective in relation to themselves and their life situation. Their experience of the therapy process supported them to perceive the ‘self’ differently and their confidence seemed embodied within a calm reassurance that they had reached a point where they felt whole again. Furthermore, this demonstrated the capacity of these older adult participants to develop and move forward with equanimity.

Particular elements needed to be in place before the participants felt able to work through their main concerns within the therapeutic relationship which was used in the fulfilment of change. The therapy work consisted of ‘pacing and adapting therapy’ for the complex work with the older adult. While therapy progressed it was modified where necessary to account for physical frailty, sensory impairment, memory problems, mobility issues and other health related difficulties. These challenges were in the therapy room with the psychologist and older adult participants therefore, adapting therapy allowed both parties to incorporate these

issues into the work to meet the needs of the participant. Furthermore, pacing therapy was important because it gave the older adult participants time to open up and process what was going on. The length of the sessions also helped to take pressure from the therapy experience so they did not feel they needed to ‘pour’ all their concerns out at once because the older adults felt able to express themselves in their own time.

The therapeutic space also allowed time for the participants to ‘reminisce about generational durability and junctures’ they had learnt and experienced in their lifetime, which reignited memories of cultural history (Lazarus & DeLongis, 1983). The participants had a strong sense of themselves as an older person in the present, and also an equally strong sense of the generational events and the quality of enduringness of their past when they told their story. The time afforded to the older person in therapy seemed to allow that deep connection within the relationship so that the older adult could feel truly understood. The participants spoke in various ways about the long length of time they have lived and this awareness, from the older adult and the psychologist was acknowledged within the therapeutic relationship; as well as just being present with that shared reality.

The therapeutic conversations with the older adult participants drew back to remembering other aspects of the past while ‘working through the complex layers of a long life’. This connected stories of loss, punishment and their childhood to reveal the distress that these unprocessed experiences had caused. The participants’ commitment to therapy was based on trusting the psychologist and the process. Hence the participants’ perception of and interaction with the psychologist helped them to listen and notice the skills that were used to move them forward and work through the pain, loss and disappointment of what happened to them.

The psychologist acted as a bridge between where the older adult participants' were within the 'self' and where they wanted to be. Moreover, within the containing therapeutic relationship, the psychologist held the older adult together whilst helping to connect the participant to their resilient and equanimous 'self'. The uniqueness within the collaborative interaction with the older adult was the specialist skills the psychologist brought to understanding the needs of an 'ageing self', whilst still seeing the person, with all of their history, decades of learning, wisdom and years of life; in addition to all the challenges and changes that they were facing.

As the older adult participants' self-understanding developed, they felt more empowered to reconnect to their core strengths and resilience. The therapy relationship was fundamental to the participants' experience of care and learning in therapy that incorporated feedback which assisted them in reaching a turning point because the process of therapy 'alerted' them to the patterns that were going on within their internal and external world. The older adults spoke about how they came to understand the unhelpful patterns of behaviour and how they were relating to them.

The therapy encounter helped empower the participants to face these problems, and helping them to find different ways to respond by having the opportunity to observe their internal world as they became more aware of aspects of the 'self'. The timing of the psychologists' interpretations consisted of a shared formulation that helped the older adult to consider who they were before the negative life event. This led to a period of reassessment of their self-identity and life story as they worked through with the psychologist the conflicts as they reconciled the split parts of 'the self'. Hence, talking to the psychologist helped the older adult to track their experiences and develop a life script that made sense of what had

happened to them. This also shed light on the dominant stories that had become familiar to them, and the many views of the 'self' that had been constructed in their life time.

The older adult participants' commitment to the therapy work and their recognition of their role in the process of change helped them to contemplate a future where 'the self' was supported to change, whilst they also took responsibility for that process. As the older adults' developed a more positive attitude about the 'self' they regained control and balance which helped them cope better and take a different view of themselves. The therapy process was about locating equanimity through acceptance as they invested hope in the psychologist and themselves.

At this stage, the participants had adjusted to an emotionally stable way of being that contributed to 'transforming the older person' and they began changing, coping and feeling better. They also felt encouraged that they had 'pulled through' and reconnected to equanimity within the 'self'.

The older adults had learnt to work through an internal struggle and reintegrate those parts of the 'self' that had been shattered by negative life events that had left them changed, blurring their self-identity. Learning to be more compassionate was important, as this contributed to helping them take a new perspective. This new position helped them to appreciate that they had choices and autonomy that allowed the older adult to move from discontinuity within the 'self' to a transformed and equanimous 'self'.

Having arrived at the end of therapy the older adult participants had changed to a reintegrated sense of self that allowed them to find balance, experience being capable again because they felt safe and emotionally stable. The therapy process provided the participants with what they needed to feel whole again. The participant's willingness to work with the psychologist and

recognize that change was possible demonstrated that these older adults stayed open to the therapeutic process. The strength of the therapy relationship helped the participants to negotiate and ‘manage endings’ and although this stage of therapy understandably brought about feelings of loss and sadness, it also gave the older adult participants a sense of hope and optimism. The older adult participants indicated that they had achieved a good ending and this was based on a partnership of trust which was encompassed in the knowledge that what they had experienced was something life changing, that moved them towards equanimity.

4a) Sub-category: Pacing and adapting therapy

The participants’ identified the importance of time and patience in how sessions were paced this helped them to feel contained, so that the therapy space was experienced as safe enough for them to talk. Adapting therapy also helped the participants understanding of their difficulties as the interventions were tailored and accounted for the participants’ individual needs.

Alice explained how impressed she was by the length of the therapeutic contract:

Well as I say 16 weeks, it’s quite a lot it’s not 5, 6 weeks and then being dumped. Because it...(psy 41:324).

The participant compared “16 weeks” to a shorter period of “5, 6 weeks”, she goes onto infer that having less sessions would be experienced as being abandoned.

Having time to talk gave the participants an opportunity to decide whether there was enough trust in the therapy relationship for them to share their concerns.

Helen revealed some cautiousness in how she approached talking with the psychologist:

Yeah it is, you're not going to straight away meet somebody even though they are a psychologist you're not going to meet them straight away and talk like I am now. ... (psy 25: 139-140).

The participant contrasted talking with the researcher and opening up during the interview with being different with a psychologist. Her guardedness implied that protecting herself until she was ready to talk was a way to manage the therapy process.

Alice revealed that she evaluated how long she would have to talk about her difficulties:

Well I thought if going to help I've got the time, I don't have to pour it all out... (psy 41: 330)

The participant weighed up the usefulness of therapy which helped her to feel reassured that she did not have to say everything that worried her at the same time.

The participants appreciated the way the psychologist used diagrams to construct an understanding of the complex issues connected to the problems they experienced.

Alice explained that she felt “*comfortable*” enough to ask for further clarification from the psychologist as they made sense of these patterns:

Yes, I felt comfortable that if I didn't quite understand what she was trying to say, I would say xxxxxx I'm sorry I don't quite understand what it is that you are trying to say. She could perhaps rephrase it but in a different way and she would do a lot of diagrams. (psy 41: 343-345).

The participant's account demonstrated a collaborative relationship where a shared understanding was important. The psychologist showed her flexibility in the way she worked with the participant so therapy could be adapted by “*rephrasing it but in a different way...*” by illustrating this new understanding through the use of “*diagrams*”.

The shared understanding led to new insights and explanations about patterns that influenced the participants' internal and external worlds.

Alice:

Yes, she'd (...) diagrams some (...) the negative and the positive. The negative – hate, neglect, (hurt) emotions, my feelings; the other side was cope, love and trying to balance the two. (psy 41: 347-348).

4b) Sub-category: Reminiscing about generational durability and junctures

Remembering how strong prior generations were in withstanding the cultural events of that time brought back powerful images about family members coping with many challenges:

Peter reflected upon the happy times being interrupted by the war:

(...) we were all happy and then the war, so we go through the war, he was evacuated then...(psy 03:414).

The participant presented a sequence of events that was experienced as “*happy*” followed by a significant disruption.

For **Sally** she was clear in her mind that the impact of being evacuated had remained with her for seventy one years:

...cause of my depression was when I was evacuated as a child; I was 11 years old which I was at an...(psy 20: 10).

And during those times (“*in them days*”) **Sally** did not have access to medication or mental health services for her depression:

...the first time I had depression after my babies I never had any medication or anything in them days I...(psy 20: 51).

The participants remembered family members who also experienced war.

Peter talked about his father and three brothers:

...we're a big family (...) my father was in the 1914 war he's the (...) he obviously survived. I had xxx brothers go in the other war, 2nd world war and xxxx of them came home. (psy 03:448-450).

He highlights a striking memory about his father surviving that First World War. His timeline continued into the Second World War, when he talked about his brothers' return.

Contextual factors that consisted of the norms and laws of a past generation were experienced in different ways.

Christina referred to how “different” it was living “a long time ago”:

...pay the rent (...) in those times were different a long time ago. I am suffering because I live in that time (...) (psy 15:120).

The participant goes onto explain that she suffered and she indicated that this experience was related to the time in which she was born. Her story evokes an image of powerlessness and oppression because of the cultural expectations of that period.

4c) Sub-category: Working through the complex layers of a long life

The participants struggled to cope with past traumas, uncertainty about the present and the future which led to them feeling stuck and experiencing mental distress. They talked to the psychologist about the disruptive impact on their life and the destabilizing effect on the sense of 'self'.

Emotionally complex layers of distressing difficult issues were worked through in therapy, and connected the participants with the emotional pain of unprocessed feelings.

Angela expressed the depth and longevity of her problems:

...buried inside of me, piling up for years and years about all sorts of things but this was something quite different, but it was.....(psy 24:101).

The participant denotes that these difficult experiences were hidden within the 'self' and had been building up for some time about many complex matters.

Talking about these experiences in therapy was felt to be traumatic initially. **Alice's** remark emphasized the intensity of that experience:

Very much so, very much. The first couple of times I found extremely traumatic, the first two.....(psy 41:141).

Christina found it difficult to talk about her past with the psychologist:

Well, certainly it was difficult to answer to the psychologist back; I was thinking all the time you know (to ask) but hmm, I'm telling the truth. ... (psy 15: 5-6).

Her use of the word “*certainly*” suggested that there was no doubt in her mind that it was hard to give an “*answer to the psychologist*”.

Difficulty sharing painful feelings is universal within therapy, but eventually the strong alliance allowed the participants and psychologist to connect with the pain in the participants’ story:

Christina was able to reveal the sadness within:

she is saying). (...) how he treated me (...) we have a lot of things but something inside me feel sad... (psy 15:313).

And **Alice** spoke about the disappointment and loss of not having a good enough childhood experience:

...always felt I never had the childhood other people had and I've always regretted that. I think that... (psy 41:369).

4d) Sub-category: Transforming the older person

The participants reflected on the change they had observed within the ‘self’ that helped them to adjust to their life. The change indicated a difference in their attitude towards themselves and a sense that they felt better. This new perspective embraced both past, present and future selves with a compassionate stance that embodied balance and courage.

Margaret’s acknowledgement that she had experienced a difficult time brings with it a realization that she had processed those experiences and found a way to adjust to them:

I’ve been through a terrible, terrible time. But I know I’m very strong, but. (psy 02: 744).

Christina owned that the situation is different now and so is she:

It reminds me it’s different, I’m different. (psy 15: 533).

Peter described that he had a breakthrough:

...it was the circle that you was in and you had to find your own way out. (psy 03:11)

The participant explained how stuck he felt and how the journey through therapy helped him reconnect with his resilient ‘self’ and find a way through his difficulty.

The participants had noticed a shift in their thinking to an alternative way of viewing themselves and life circumstances.

Alice spoke of how therapy helped her change her perspective:

...and she made me see myself in a completely different light. The way she worked with me and made.....(psy 41:143).

The participant was aware that she changed due to the therapy relationship. She described the change in her self-perception which indicated the impact was profound.

Therapy also helped **Alice** show self-compassion:

...main thing is (...) you got to start learning to love yourself, give yourself a hug every now and again. ...(psy 41: 145).

The participant reflected on how she is “learning to love” and comfort herself, by being kind and generous to herself.

Julie was cognizant of what could happen if she does not take care of herself:

It is merely getting rid of the impact on yourself of it, cause after all – as you know, it’s you suffers...(psy 07: 367).

She identified that removing the consequences of the difficulty from the ‘self’ is one way to protect the ‘self’.

The participants were able to live with the knowledge that past negative events had intruded upon their life.

Margaret explained that:

...to me it's scarred me. But I was getting, I was living with it, I was really living with it. (psy 02: 73).

The participant was aware of a change within the 'self' that was a reminder of what she had been through, holding this in mind she could own that she "*was living with it*" and coping.

Alice illustrated this point when she explained how well she had adjusted:

Oh feeling better, coping a lot more, not crying as much, not punishing myself, not punishing...(psy 41:213).

The participant's description sets out a number of components that developed during her experience of psychological therapy that led to equanimity, which also underlined the cultivation of a compassionate self.

The participants took responsibility for their part in the process of change.

Christina simply explained what she wanted to achieve for herself:

I wanted to change. (psy 15:525).

Julie's understanding of the therapy process helped her to move forward and was embedded in the knowledge that 'finding balance' meant that she had connected to equanimity:

... I suppose it does, yes I suppose it does. It's a matter of finding a balance isn't it...(psy 07: 301).

The participant depicted that now she was able to connect to wholeness by stepping back and observing:

...this is what you say by keeping myself as the whole person and the outside of what's going on of the other side. (psy 07: 106-107).

4e) Sub-category: Managing endings

'Managing endings' represented the end of the therapeutic journey for the older adult participants. Ending therapy brought up feelings of loss for the participants and it could be surmised that this would be mirrored by the psychologist too. Ending therapy was the culmination of all the hard work the participants and psychologist had invested into the therapy relationship. This stage of therapy also incorporated a sense of hope about recovery, as the older person became reunited with wholeness and equanimity.

Helen acknowledged her feelings about the end of therapy:

...being playful). Yeah, it was the best thing actually I was so sad when it came to an end. (psy 25: 238).

The participant showed her appreciation as she described how she benefited from the experience of psychological therapy. Her gratitude is juxtaposed with feelings of sadness that therapy had come to an end.

Alice signified how fearful she felt about ending with the psychologist:

I was frightened that I may not see her again and I might panic. I told her, I wrote a letter to...(psy 41:249).

The participant examined her feelings and her words denote that parting brought up some uncertainty about coping. There was recognition of the shared responsibility both the participant and the psychologist took in managing these feelings.

Margaret indicated her sense that during the ending process she could cope:

Yeah when he said I was okay and he was moving on, I was okay. (psy 02: 425)

The participant owned that she was better and there was an agreement with the psychologist that the work had concluded.

Moving towards equanimity was the experience of these older adult participants, as they detailed what informed them that they had achieved balance and a sense of calm within the ‘self’.

Alice explicated what made her more aware that therapy was now complete:

I think that really put the final finishing touches to it for me and if the staff were beginning to understand and know what was happening, I think I could cope with it. (psy 41 :254-255).

The participant talked about “*the final finishing touches*” being an indicator that she continued to feel supported and understood after therapy ended. The participant expressed how knowing this was powerful enough and reassuring of itself.

For **Sally** “*nothing new*” was taking place in her life at that time, and she declared that this was due to her “*age*”:

[nothing new] happening in my life at my age. I just see my sisters and all that but I was on the mend and I was discharged from the hospital and so I didn’t see her any more. (psy 20: 132-133).

The participant’s approach to the ending of therapy implied that the rhythm and routine of her life had returned and she was no longer caught at the existential crossroad that brought her into therapy. Her communication has power because it elicits meanings about the older adult participants’ now restored, whole again with equanimity.

In the next and concluding chapter I have deliberated on the connection to formal theories regarding psychological therapy with older adults and the relationship to the conceptual categories identified in this thesis. I will also show how the conclusions are linked to Charmaz's (2006) evaluative criteria, to further demonstrate how this research met the quality standards of a constructivist grounded theory study. Additionally, the methodological limitations, future research considerations and the impact of this study's findings upon clinical practice with older adults will be contemplated.

CHAPTER 4

DISCUSSION

This chapter discusses the conceptual categories and processes involved in the older adult experience of psychological therapy. The subjective accounts in this study offer some insights about their particular stage of life and how negative life events created distress but were resolved during psychological therapy.

The chapter begins by exploring the formal theories for the main categories yielded during the analysis that illustrate links with the findings of this study. I will examine the literature on self-identity (Polkinghorne, 1999; Erikson, 1968; Mead, 1913; Charmaz, 1983; 1995), continuity theory (Atchley, 1989) and how a person's sense of a coherent self can be interrupted by "narcissistic injury" (Atiq, 2006, p.54) causing a discontinuity within the 'self' (Corbin & Strauss, 1988, p.201). I will also highlight the impact of these experiences upon the older person whilst they are facing a number of physical, cognitive and emotional challenges that coincide with their developmental life stage. Moreover, I will reflect on the importance of the therapeutic relationship and how the older adult experiences it within their sense of self. Finally, general consideration is given to the process of working through difficult emotional issues within an authentic therapy relationship (Atiq, 2006).

In the next section I will present the emergent theory of 'moving towards equanimity' that lead to a transformation within the older adult, and a re-connection to their equanimous 'self' is elaborated upon.

I would like to draw the reader's attention to the interchangeable use of terms such as psychological therapy, psychotherapy and therapy throughout this chapter, which is defined here as “...*deepening the client's self-understanding as the means for overcoming distressing symptoms*” (Polkinghorne, 1999, p.1429). This chapter does not include debates about the application of psychological models of therapy for older adults; however consideration is given to theories which offer perspectives predominantly on the subjective experience for older adults and the therapeutic process.

The ‘self’ has been conceptualized by many different authors (James, 1890, Erikson, 1968; Rogers, 1951; Maslow, 1954) who draw our attention to the complexity of peoples’ beingness. Atiq (2006) asserts that older adults come to therapy with issues regarding their self-respect and personal worth. Moreover Atiq (2006, p.54) suggests that “bio-psychosocial losses” connected to their age and reduced resources are what the therapist works with.

The events people experience in life are not separate from ‘the self’ (Whiton-Calkins, 1915), in fact it is contended that the person’s “story has the power to provide life with meaning” (Polkinghorne, 1991, p.145). Polkinghorne (1991, p.135) discusses a person’s sense of self at length in his paper on “*Narrative and Self-Concept*” where he ponders on how the ‘self’ is “constructed within an unfolding autobiography” that integrates life’s happenings.

McLeod (1997) suggests the story a person tells about themselves is their own private way of identifying who they are.

Both James (1890) and Erikson (1968) also viewed a person’s self-identity as being comprised of thoughts and feelings based on the individual’s interaction with their environment (Bosma et al, 2005). A person’s self-identity gives them a sense of coherence

(Mathieson & Stam; Mead, 1934) and in Mead's theory the 'self' is conceptualized as the person perceiving themselves, whilst observing themselves in their mind (Mead, 1913). Erikson (1968) also remarked upon a similar process when he talked about the development of the 'self' as possessing constancy, meaning that the person has an ongoing recognition of the self, suggesting the sense of self is both "stable and changeable" (Markus & Wurf, 1987, p.45). Other authors concur with this notion of continuity within the 'self' and they argue that it can facilitate good psychological health (Maslow, 1954; Rogers, 1951; Knight, 2004); as it provides the person with direction and a sense that their life has purpose (Suh, 2002).

The findings of this study showed the older adult participants had a continuous sense of self as they looked back at who they were before the negative events in their lives took place. The participants' expressed a sense of themselves from their childhood into old age, and they could name particular attributes that defined them as an individual. Margaret spoke of qualities that demonstrated an awareness of the physiological signs of ageing such as having grey hair, whilst maintaining a view of herself as still being 'young in her mind'.

However, the psychosocial composition of the older adult participants' lived experience showed how distressing and traumatic events posed challenges to the 'self' on many levels (Aldwin and Gilmer, 2004). This appeared to cause discontinuity where their self-perception had changed as they incorporated the losses and being unwell into their self-identity (Abernathy, 2008). Polkinghorne, (1991) suggests it is the explanation individuals give themselves that informs them what life events mean. Existing theories about the 'self' and the consequences of painful life experiences highlight that a person can encounter a loss of self (Charmaz, 1983; 1995) due to a "biographical disruption" (Bury, 1982, p.171) that

contributes to the older adult not coping (Atiq, 2006) with distressing and unexpected shifts in their life.

Butler (1967) argues that the challenges older adults face regarding their physical health triggers an awareness of “frailty” that contributes to a “new identity” as an older adult (as cited in Fillit & Butler, 2009, p. 349). Fillit and Butler (2009, p.348) suggest that when the older adult views the impact of being frail as a threat it causes a “frailty identity crisis”, which is the psychological reaction to this difficulty. Bury’s (1982, p.171) influential work on the impact of “chronic illness” in younger adults with “rheumatoid arthritis” showed that they sustained a disrupted ‘self’, which he described as an occurrence that “weakened” their sense of self. Similarly, experiencing stress can cause disintegration within the individuals’ perception of their life story (Polkinghorne, 1991).

Early life experiences where the needs of the child have not been met also shape the self-identity (Kohut and Wolf, 1978) which can create “vulnerability” within the older adult (Atiq, 2006, p.54). This is due to the older adult not receiving the resources within the ‘self’ to manage disruptions from negative life events (Atiq, 2006). Woods (2003, p.131) also holds the view that unresolved losses experienced in the older adults’ past can contribute to “depression” in the later years of a person’s life.

In the findings of this study the concepts drawn from the analysis were rooted in emotionally painful life experiences that contained qualities regarding how unexpected emotional difficulties converge on peoples’ lives, preventing them from moving forward. Davies (2013, p.48) posits that for older adults “trauma re-activation” can be triggered when they are facing difficult life events. Alice expressed that looking back she did not experience a good enough

childhood where she was entitled to receive an “accepting-confirming mirroring” (Kohut and Wolf, 1978, p.413) relationship that she could imitate, that would validate and build her self-worth. Alice also talked about the childhood trauma that disrupted her early development, by preventing her from uniting with the “idealized” significant other that was meant to meet her childhood needs (Kohut and Wolf, 1978, p.413). The participants’ story reflected the trauma and how they experienced their life as being disrupted which created a changed ‘self’, with less resources for coping (Mathieson and Stam, 1995, as cited in Abernathy, 2008).

For an older adult issues of loss can be experienced more often during this period of their life. The effect upon the ‘self’ has been described as “narcissistic injuries” (Atiq, 1989, p.54) that harm the ‘self’. It is also contended that a person’s sense of self is the outcome of their biography (Gergen & Gergen, 1988) so when the ‘self’ is disrupted, the individuals’ psychological well-being can lead to a discontinuity that divides the “past and the future self” (Corbin & Strauss, 1988, p.201). Lazarus and DeLongis (1983, p.246) suggest that it is the importance of the negative life event within the “continuity” of the older adult’s “life and not age alone” that needs to be considered. The interpretation of the negative experience is influential and this impacts on how the older adult adjusts (Lazarus & DeLongis, 1983).

Identity adjustment was also reviewed in an article about “*Models of the Ageing Self*” (Sneed & Whitbourne, 2005, p.375) where various theoretical approaches were examined to understand how the older adults’ identity adapts to the many difficulties that the ‘self’ is confronted with.

This study revealed how the difficulties posed to the ageing ‘self’ caused the participants to doubt whether they could overcome their problems, as they had come to believe that they

could no longer manage the life crisis. The participants had noticed that the untoward circumstances had changed them because it had disrupted the continuity within their ageing 'self' and this brought them to an existential crossroad. At this crossroad the older adult participants' were distressed and overwhelmed by their experiences, which left them stuck and they explained that they could no longer 'hold' the 'self' together.

Janoff-Bulman, (1992, as cited in Abernathy, 2008) maintains that a person can experience a crisis as menacing to the 'self', and this can challenge their suppositions about what they regard to be familiar and certain about their life and environment. The older adult participants experienced internal conflicts that left them struggling to cope as they became more emotionally unstable; indicating that they had lost control of the 'self' (Charmaz, 1983; 1995). As a consequence when the disharmony ensued the participants' inner world fragmented.

Peter spoke about this experience vividly as he remembered that he did not have any peace of mind because his 'brain' was distressed 'twenty four hours a day'. Margaret was also experiencing the self-disintegrating results of stressful life events as 'hell'. Furthermore, she explained that this was made more intolerable because she was '72' years of age.

The ageing process comprises of different aspects that include biology, psychology and social factors, the comprehension of which can be multifaceted (Aldwin & Gilmer, 2004). The participants in this study were situated in a number of different contexts that weaved complex systems into their ecology. This experience shifted their attention onto health, community and social care issues; which featured aspects of normal ageing (Knight, 2004), in addition to unexpected occurrences. These challenges meant that the participants' ageing 'self' had to

adjust to these demands as well as to the distressing life events that eventually led to them experiencing psychological therapy.

Knight (2004, p.5) offers an age-specific model that incorporates the view espoused in the 1970s which put the emphasis on “normal ageing” rather than focusing on the losses during the ageing process. Knight’s (2004, p.5) framework known as the “contextual, cohort-based, maturity, specific-challenge model (CCMSC)”, acknowledges that as older adults age they are more likely to face difficulties regarding “chronic illness and disability”.

Furthermore, Atchley (1989, p.183) also put forward a theory about “normal ageing” and continuity that highlights how a person evolves over time and within their individual context. Atchley (1989, p.184) emphasized how older adults use “adaptive choices” that help them to plan and cope with shifts in their life course, whether that is experienced within their inner or outer worlds. However, he argues that employing “adaptive strategies” would be difficult for those older adults who need support to live their lives independently (Atchley, 1989, p.184).

The participants in this study spoke about such challenges and expressed an embodied awareness that frailty and cognitive changes were now a part of their ecology. Their experience of an ageing changing self also meant that they had to become accustomed to some of their physical health problems being managed pharmacologically. These adjustments led to them changing their expectations as they tried to come to terms with a variety of long term conditions. Peter remembered that he was looking forward to a ‘good life’ in his old age and now he must adjust to having arthritis. Sally had a particular time of the evening when she took her warfarin medication; which she had managed to make an important part of her

everyday routine. Melody was also accepting of the long term condition that could one day take her life away, she commented, that she would “die” from that illness eventually.

The participants also experienced discrimination due to their age and this arose in varied situations and influenced their interactions with others. Stereotypical ageist assumptions were experienced by the older adult participants as excluding (Age Concern, 2006).

Ageist attitudes that are held by some within society have been described as:

“...a constriction that rearranges power relations...When ageing, people may gain or lose parts of themselves; however, with ageism, people are shaped into something that is always less” (Cooper, 1986; Perkins, 1992, p.413).

The participants talked about fighting for their right to dignity and to be heard and seen as a person instead of being placed into a category that depersonalizes them and only acknowledges their age, leaving their personal identity invisible. They described the impact of being treated differently on their self-esteem, when generational assumptions made by younger people discriminate against the older person and marginalize them further (Charlesworth & Greenfield, 2004).

In this study, Helen described her experience of the young shop assistant assuming that it was appropriate directing their attention to the younger person who accompanied Helen and how angry she felt. Ageism can also be demonstrated by older adults, termed “internalized ageism”, meaning when an older adult feels as though therapy cannot be effective for them due to their age (Charlesworth & Greenfield, 2004, p.413).

The participants explained that being treated in ageist ways triggered particular feelings and attitudes within them that empowered them to confront these viewpoints. Notwithstanding,

they dealt with ageist assumptions by voicing their concerns, whilst being aware that older adults are not always listened to because in fact, as the participants pointed out ‘ageism is everywhere’.

As people age, they can encounter physical health problems (Knight, 2004) that can leave them requiring support in various forms, from carers who provide personal and domestic care (Roe, Whattam, Young & Dimond, 2001), to joining social groups to reduce their social isolation, in addition to increased medical care (Knight, 2004). Experiencing physical health problems can contribute to the older adult looking within and viewing themselves as frail and dependent on others as they become more aware of a changed sense of self (Charmaz, 1983).

Adapting to changes where additional support is needed to maintain independence can be felt by older adults in different ways. Peter found that the support he received from his Doctors’ left him feeling uncertain about his prognosis. In order to take control of the situation he became pro-active and he challenged ageist assumptions until he received care that met his needs. Having timely, reliable support was expressed by the participants’ as life sustaining. Melody indicated that when her carers visit and support her she experiences this in positive ways; however she is aware of how much she depends on the care at those times when she is not in receipt of it.

When a person experiences ill-health they try to connect with who they were before they became unwell, to bring “past” and “present” together to understand what the experience means (Williams, 1984, p.179). For the older adult participants in this study they experienced crisis and complexity within the context of their internal and external worlds which reduced their resilience and they could not cope. Abernathy (2008, p.201) argued that when an individual begins therapy their psychological problems have disrupted their “agency”, meaning that the person no longer has control over their plans, goals and intentions due to

restrictions in their life (Lee, 2004). These older adults had experienced significant losses that brought an awareness of a changed ‘self’ as they adjusted to their role as clients (Quinn, 2008) that understandably had difficulty coping with life in the way they used to.

A therapeutic relationship is a central aspect to working with a client’s distressing problems (Norcross, 2002; Beck, 1995; Richards, 2011) and contributes to the process of change within therapy (Laughton-Brown, 2010). The older adult participants were able to share their concerns with the psychologist by having therapeutic conversations about their problems. The aim of the conversations was to move the older adults towards equanimity by bringing the story of the ‘self’ to a unified whole (Polkinghorne, 1991). Experiencing a good working alliance allowed the older adult to re-integrate the ‘self’, so that their balance, calm and sense of “continuity” within the story of their life could be renewed (Williams, 1984, p.178).

McLeod (2009, p.6) described what is distinctive about the act of coming together for the therapist and client. He implied that this is a reciprocal interaction and a:

“...private conversation arising from the intention of one person to reflect on and resolve a problem in living and the willingness of another person to assist in that endeavour”.

His statement illustrates the particular connections needed for there to be a real sense of harmony (Omylinska-Thurston & James, 2011) that helps the client feel heard and understood, whilst constructing the meaning of their experiences (Charmaz, 2006). The participants’ expressed that having someone to talk to about their problems helped them feel heard. Angela reflected on the depth of her ‘unhappiness’ and how sharing her story helped her to feel calm as she experienced it as ‘therapeutic’. The building of the working alliance

with older adults' had some generational and typical barriers to overcome before engagement could take place. Generational differences exist between older adults born in different periods in time and this influences their experience due to the dissimilar historical context (Knight, 2004). This is of importance to psychologists, who would need to work flexibly whilst taking account of the older person's "unique history" (Lazarus & DeLongis, 1983, p.245), so that both parties can adjust to these factors (Knight, 2004).

Christina talked about the suffering she experienced being born during a time when the cultural expectations were different. She indicated that in the initial stages of therapy when cultivating a therapeutic relationship this generational barrier was a block to her feeling heard and understood by the psychologist. The analysis showed that it is important to work through such barriers for therapy to progress.

Research also shows that there are a greater number of older adults who are living with trauma from their childhood when compared to older adults with current trauma experiences (Bottche; Kuwert; Knaevelsrud, 2012). Angela expressed how aware she was of her problems which began in childhood and she talked about living with these negative views of herself for a long time. When working with issues such as these it was important for the psychologist to be mindful of the "context" in which the individual is located (Knight 2004; Appleton & Martin, 2012, p.6) in order to have a better understanding of the older adult. Appleton and Martin (2012, p.11) explained how they used "life review work" during therapy with an older adult to create an understanding of the circumstances of their experience. In addition they used normalcy as reassurance that they had understandably acted in that way as a response to adversity (Appleton and Martin, 2012).

Typical barriers within the working alliance can arise for older adults; wherein emotional defenses, ambivalence (Appleton & Martin, 2012) and attachment issues in old age

(Cookman, 2005) are common factors that need to be worked with in the development of the therapy relationship. The stress from negative life events may be experienced as “emotionally painful”, leaving the person overwhelmed by their own “suffering” (Bolger, 1999, p.343). Psychologists are trained to help people in emotional distress to “work through” (Bolger, 1999, p.342) their problems in a safe therapeutic space, where the offer of support and relief from their difficulties can be experienced. The participants in this study acknowledged how painful (Rennie, 1985b) it was to talk about aspects of their story and they indicated that trusting the psychologist, whilst having time and a safe space to talk was very important to the building of the therapeutic alliance.

Managing the expectations of therapy helped the participants to examine what therapy could offer them and also gave the psychologist an opportunity to clarify aspects that might be assumed on both sides. Expanding the therapeutic conversation in this way allowed trust and hope to build but it also provided an opportunity to work through doubts that may have arisen. Angela and Sally talked about bringing an attitude to therapy where they felt it was important to believe the psychologist could help. In contrast, Christina was able to express her uncertainty about the therapeutic process and wondered how the psychologist would be able to help her. It tends to be the case that issues of transference can arise within therapy and therefore should be worked through (Garner, 2003; Castonquay et al, 2006).

Transference (Weiner, 2009) and countertransference (Katz and Geneway, 2002) are an expected aspect of the therapeutic work that goes beyond the model used by the therapist. Transference can impede the interaction between the older adult and the psychologist because it can impact on the collaborative nature of the working alliance. Invariably, the therapist and client may or may not have an awareness of some of the past “relationship histories” brought

into this process that can act on the alliance and how it forms itself (Katz and Geneway, 2002, p.327).

In Jan Weiner's book (2009, p.70) entitled *'The Therapeutic Relationship; Transference, Countertransference, the Making of Meaning'*, she cites Carl Jung's evocative statement:

Emotions are contagious because they are deeply rooted in the sympathetic system . . . any process of an emotional kind immediately arouses a similar process in others. . . . Even if the doctor is entirely detached from the emotional contents of the patient, the very fact that the patient has emotions has an effect on him. And it is a great mistake if the doctor thinks he can lift himself out of it. He cannot do more than become conscious of the fact that he is affected.

C. G. Jung, "The Tavistock Lectures"

Jung reflects on how coming together to form a therapy relationship is a complex undertaking, laden with emotionality. An awareness of these factors so that it can be talked about is also part of truly, being with the older adult; that is, to be fully present with all that "illness, pain and loss" in order to connect together on the journey towards equanimity (McBee, 2003, p.257; Garner, 2003).

In this study Helen spoke about how a rupture in the alliance led to uncertainty about whether the trust with the psychologist could be rebuilt; whilst triggering feelings that left a lingering doubt in her mind. She described that it was unexpected when the psychologist shared confidential information with others following a risk issue that arose during therapy. The impact made her question whether she could trust others and the issue suggests that ethical principles were experienced by the participant as a breach of trust.

The British Psychological Society, in their policy on the *Code of Ethics and Conduct* (2009, p.11) have produced good practice guidelines which posit that Psychologists should:

...“Restrict breaches of confidentiality to those exceptional circumstances under which there appears sufficient evidence to raise serious concern about:

- (a) the safety of clients;
- (b) the safety of other persons who may be endangered by the client’s behaviour; or
- (c) the health, welfare or safety of children or vulnerable adults.”....

In this study the safety of the older adult was the issue that needed to be negotiated in collaboration with the participant. Working to heal the rupture (Safran et al, 1990) helped to rebuild the therapy relationship. They were able to reset the therapy agreement by talking about what had taken place (Egan, 2007); so that power could be re-established through openness (Yalom, 2002) and joining together in managing expectations.

One of the quintessential aspects in building the therapy relationship, that creates a “therapeutic bond” (Hunter, 2012, p.179) between the older adult and therapist, starts with the therapy connection. Hunter (2012) described in her grounded theory research that examined this process from the therapists’ perspective where she located the following main areas: “Empathic resonance, role investment, mutual affirmation, satisfaction and risks of working with trauma” (Hunter, 2012, p.182-185). The author concludes that both therapist and client made an “empathic connection” with some degree of emotional depth, furthered by a mutual respect and a shared commitment to the therapy process (Hunter, 2012, p.189).

In this study, the older adult participants’ trust in the therapy relationship helped strengthen and deepen the engagement. The relationship felt genuinely natural for Helen and Peter because of the guidance they received. The participants expressed how the style of the

psychologist helped them to communicate their concerns as the rapport and reciprocity deepened.

When the participants engaged in constructing together the formulation, both psychologist and participant incorporated contextual factors that took account of the older adults' history and different life circumstances (Appleton & Martin, 2012). The telling of the older person's narrative can often mean parts of the story come to light in the present that might not have been available to the older adult at the time of the trauma (Appleton & Martin, 2012).

In this study the analysis indicated that the adult participants were able to connect to past losses deep within their childhood experience which helped make sense of longstanding difficulties they had endured. The process of examining difficult emotions associated with painful events was a complex, emotional commitment that was laden with defenses to protect the older adult from further pain. However, the strength of the therapy relationship helped them draw out patterns and this part of the process revealed choices to the older adult whilst they moved towards embracing equanimity.

The participants described how they connected with wholeness and a new perspective during therapy. They found that the pace and adaptations made by the psychologist helped them talk because they felt safe within the therapy environment. The pace and quality of the sessions helped the participants open up and gave them some sense of control about what they wanted to share. The collaborative relationship meant the older adults felt comfortable, understood and accepted by the therapist. They were able to acknowledge together the importance history, events and strength when they reminisced on the influence of past generations. Furthermore

remembering the past was a reminder of the cultural restrictions of that time and how they experienced it.

Atiq (2006, p.54) reminds therapists working with older adults that when the person has come to therapy with a sense of self that has experienced discontinuity, they often look to the therapist who may be from a different generation to show their “approval”. Atiq (2006) argues that when this is given by the therapist, the older adult feels as though they are reconnected to a part of themselves that is in its original functioning state of capableness (Lazarus, Groves, Newton & Brief, 1984). Being in therapy can offer the older adult balance to “restore self-continuity” (Newton et al, 1986; Smyer et al, 1990, as cited in Hyer et al, 2004, p.280). So, it is within the therapy relationship that the older adult participants’ developed an alternative view of themselves. Garner (2003, p.540) contends that the process of change for older adults in therapy is often about “acceptance and equanimity” about the restrictions within life that cannot be altered. During therapy, the participants found that they could tolerate the difficult aspect of talking about painful feelings as they worked through the multi-layered stories within their lived experience.

The participants felt supported by the Psychologist as they transformed, and so felt empowered and able to take responsibility for their life. As therapy unfolded the participants’ showed they were coping emotionally and psychologically. The data indicated that the participants felt better and could manage their lives differently. The older adults spoke about their experience of a breakthrough and how they could see themselves in a ‘different light’. The participants’ developed self-compassion and loving kindness towards themselves and they indicated that the therapeutic process created an inner change within the ‘self’ as they had learnt how to “make-meaning” (Astin & Keen, 2006, p.4) of their experiences. They

acknowledged and accepted that although their experiences had changed them they were now living with what had happened and were able to see every day “as a gift” (Astin & Keen, 2006, p.2), which suggested that they had connected with equanimity.

Managing endings for the participants was about coming to an agreement regarding how to say goodbye. In therapy the older adult participants changed and the process helped them see that they had survived, adjusted to the unexpected challenges and thus, had rediscovered their resilient ‘self’ (Ma, 2012). Having “identity balance” enables the person to adapt when they are confronted with difficulty whilst holding onto a coherent ‘self’ (Sneed & Whitbourne, 2005, p.384).

Equanimity has a number of definitions that feature within different areas such as spirituality, religion, mindfulness. One such meaning is the ability of the individual to perceive a “silver lining” when experiencing problems in addition to “psychological or spiritual well-being and optimism (Astin & Keen, 2006, p.2). Andrew, Fisk and Rockwood (2012, p.1351) propose that there are substantive theories within ‘psychology’ that sees the “work of aging” as being a process of “aging with equanimity” (Erikson & Erikson, 1997, as cited in Andrew et al, 2012, p.1351). The notion of age and how it relates to equanimity is about how older adults make sense of this phase of their life. It is also argued by Astin and Keen (2006) that equanimity has a quality that captures the emotional inner world of the person. Moreover, the meta-characteristics of equanimity include a sense of “calm, peacefulness, centeredness, self-transcendence and compassion” (Astin & Keen, 2006, p.2).

The phenomenon studied in this research produced an emergent theory that saw the older adult participants learn in therapy how to ‘move towards equanimity’ so they could embody emotional stability, mental “calm” (Astin & Keen, 2006, p.2) and a re-balanced sense of self. The participants’ experience of psychological therapy took them along a path where they were able to locate their resilient and compassionate self as they learnt to connect to wholeness.

In the last part of this chapter I will discuss the evaluative criteria, methodological limitations, future research and implications for clinical practice.

The Evaluative Criteria

Charmaz’s (2006) four evaluative criteria guided this research and was used as a measure of whether the quality standards were met. The first criterion states that the findings should be “credible” (Charmaz, 2006, p.186). The dual role of being a psychologist who works with older adults added to my awareness and familiarity with the phenomena under study as a researcher. Furthermore, constant comparing of the data allowed me to refine the categories to an abstract level of understanding so that the emergent theory could be attributed to the experience of these older adult participants.

The second criterion asks whether the study could be described as having “originality” and what does this offer to older adult research (Charmaz, 2006, p.182). During the course of doing this research project and discussions with psychologists and academics that specialize in working psychologically with older adults, I have become aware of the paucity of research that examines the therapeutic processes involved in this complex work with older adults. My research “extends” the knowledge base about working with older adults as it offers a subjective account of how therapy is experienced (Charmaz, 2006, p.182). Moreover, the

importance of such rich accounts goes beyond theoretical models and outcome measures. Instead, it is simply about the older adult in a therapy room with a psychologist and being transformed within the therapeutic relationship.

The third criterion is “resonance” which means the study needed to be a good account of the participants’ story to allow the implicit meanings to become evident (Charmaz, 2006, p.182).

The findings of this research demonstrated that with the support of the psychologist the process led to many gains that enabled the participants to stay encouraged and hold onto hope. The participants achieved emotional stability and a sense of calm due to their willingness to work with the psychologist and recognize that change was possible. The meaning inherent within the data is that, experiencing therapy helped to move the participants towards equanimity and this contributed to their recovery and the unity they wanted again in their life.

The final criterion is whether this study is ‘useful’ and brings “knowledge” that is beneficial in the participants’ daily life, whilst having potential for further research (Charmaz, 2006, p.183). There is utility within this research for older adults because it demonstrates that learning (Seligman, 1998) to respond to the unexpected problems and challenges in life with equanimity was achievable for these older adults. Future studies could build on this research to examine the process of therapy for older adults, in addition to taking account of other differing factors that can influence therapy such as: ethnic origin, gender differences, sexual orientation as well as spirituality. Exploring these aspects may help deepen psychologists’ understanding of the older adult in therapy yet further.

Methodological Limitations

There are some methodological limitations within this study to consider. The older adult participants were recruited as a purposive sample, where their age and the course of Psychological therapy they undertook were key elements that met the inclusion criteria for this study. Therefore, the transferability of these findings would not be appropriate for generalization (Charmaz, 2006) due to the contextual factors that apply specifically to the older adult participants' situations (Goulding, 2002). Furthermore, my comprehension and interpretation of the data was taken from the perspective that emerged while analysing the older adults' accounts and it is understood that the reader or another researcher may take a different view (Boyd & Gumley, 2007).

There were also difficulties recruiting older adult participants to the study and this issue would need to be explored further in future research to ensure greater involvement from older adults who are from differing cultural contexts. The numbers of ethnic minority participants that took part was very low and only two female participants came from other racial backgrounds compared to the majority who were White-British. The researcher was also aware that the gender ratio of 8:1 represented more female volunteers.

Feldman et al (2008) argues that the same procedures cannot be applied to everyone. Therefore, the methods that are used for embarking on research are not always suitable because it excludes whole communities from taking part. Moreover, it would be important to consider "a flexible recruitment" procedure that could help to increase research engagement with older adults in general and those from ethnic minorities (Feldman et al, 2008, p.473).

Future research considerations

The older adults' experience of Psychological therapy is important both "practically and theoretically" (Elliott & James, 1989, p.461) given the ageing population and how this will impact on areas such as "economics, health, social status and social support" (Garland, 2005, p.13). Therefore, it follows that more qualitative studies would bring detailed information about what older adults think and need, to prepare future services for the demands ahead.

Elliott and James (1989, p.461) suggest that research exploring therapy experience needs to include the "client perspective" as the psychologists' understanding of the client is the cornerstone of the therapeutic work. During the course of the data collection the participants' raised other interesting topics, which were not directly related to the research question. A variety of issues relating to inequality of access to psychological therapy, ageism within society, disability, discrimination and sexual orientation arose during the interviews. These topics appear to be of importance to the older adult participants and could be revisited in future research. Finally, the interesting area of mindfulness practice (McBee, 2003); 'equanimity and spirituality' (Astin & Keen, 2006) and mindfulness approaches more broadly (Kabat-Zinn, 1990; Williams & Penman, 2011) in relation to working with older adults is another important avenue for older adult research.

Implications for clinical practice

There are implications for Psychologists and other clinical practitioners who offer therapy to older adults regarding the emergent theory. Moving towards equanimity represents the reflections these older adults' and what exemplifies the "process and outcome" of therapy for them (Gumley & Schwannauer, 2011, p.237).

It also highlights how complex factors such as “psychological problems...interact with stressful life events, culture and context” (Gumley & Schwannauer, 2011, p.237).

The Psychologist is in a position where they can offer support to the older adult in therapy, when their sense of self can no longer cope in the way it once used to. This facilitates a process that sees the older adult receiving help to “go on with life nevertheless” (Garland, 2005, p.13). The participants in this study examined their story in conversation with the psychologist in order to develop some self-understanding so they could learn how to manage the challenges they faced. The findings of their subjective experience embody rich accounts which indicate that older adults can “produce new narratives in new contexts” (Lars-Christer Hyden, 1997, p.52). The existing literature about older adults also demonstrates that they benefit from psychological therapy (Woods, 2003; Atiq, 2006) where change does take place (Clark & Mishler, 1992).

Older adults tend to perceive changes in their “self-concept” as being greater “subjectively” rather than “objectively” (Bengston et al, 1985, p.55). This means the psychologist will always need to inquire into their perspective in order to comprehend the older adults’ story to help them find a solution. The older adult participants’ in this study indicated that they experienced the process of receiving psychological therapy as helpful, further facilitated by the willingness of the psychologist to tailor their knowledge and expertise to correspond with their needs. Through an “empathic connection” (Hunter, 2012, p.189) “misperceptions about ageing” (Knight, 2004, p.55) can be clarified. Other issues in relation to their stage of life such as experiencing an ageing ‘self’, loss, low mood, anxiety, debility, memory problems, support systems and self-worth can also be explored as part of the older adults evolving sense of self (Knight, 2004).

Implications for psychologists are that by fully understanding the impact of psychological problems on ‘the self’, interventions can be targeted more effectively in therapy (Garland, 2005). The Psychologist provides a life belt by giving “coherence” that helps the older adult discover “meaning and a renewed sense of self” (Abernathy, 2008, p.205). Woods (2003, p.131) argues that for psychologists who work with this client group, the “life-span developmental approach” (Kraaij and de Wilde, 2001), is important as the clients’ difficulties may go beyond the presenting problem.

Within a trusting and confiding therapy relationship the story of how the older adult has managed in the past, can hold rich information (Woods, 2003) about their resilient nature. Moreover, the collaboration between the older adult and psychologist in this study meant the individual’s “whole ‘self’” (Rodgers, 2002, p.7) was taken into account to help them to move toward their equanimous ‘self’.

The researcher is aware that what makes a qualitative study distinctive is the detailed attention given to the participants’ experience. This allows psychologists’ to gain some insight into what therapy felt like for them.

In conclusion, I agree with Elliott and James (1989) when they suggest the emergent conclusions that are derived from qualitative studies can be applied in the psychologist’s therapy work by making them aware of different aspects of the older adults’ inner and outer worlds; to promote what takes place in the therapeutic encounter from the older adults’ point of view.

The next part of this thesis will feature the reflexivity section.

Reflexivity Section

Personal Reflexivity

As the author of this study I recognize my part in writing about the journey taken with the older adult participants, and the meanings that developed from the process. The style of presentation in this study included the many identities of the researcher (Charmaz & Michell, 1996) and was written in an academic style. I referred to myself in the third person as the researcher and also in the first. Banister (1994, p.161) advocates that it is preferable when writing about a qualitative study to write in “the first person” because it accentuates the epistemological underpinnings of the methodology, whilst also allowing the author to take ownership of the study.

I am a Chartered Counselling Psychologist and I have worked with older adults for over ten years. My role as a Practitioner Psychologist gives me the opportunity to listen and appreciate the life stories told by older adult. Making the decision to embark upon this Constructivist Grounded Theory research about older adults’ experiences of psychological therapy came about because I wanted to deepen my understanding of the processes involved during therapy from the client’s perspective.

The service where I am based is situated within a culturally diverse community, with many socio-economic problems. This context and the social location within my own race and culture have influenced this research. My ecology places me within an ethnic minority culture where historically some people have been marginalized, stereotyped and are often faced with social injustice. The juxtaposition with my professional role as a Counselling Psychologist and what that affords is to some extent a more privileged position within the National Health

Service (NHS). However, this is a changing picture due to the current austerity measures and current business model being adopted in most NHS Foundation Trusts.

The sense of privilege that is assigned to my profession does not necessarily match with some of the negative, stereotypical, societal discourses that are espoused about Black and ethnic minorities. The aforementioned factors influenced how I perceive social inequalities, and this has motivated me to contribute to changing attitudes that are intolerant of difference, privately and through my clinical work, in response to what has been expressed by the older adults who come into contact with the Psychology service.

Stephen and Flick (2010) have discussed their view of some of the negative discourses about older adults and they refer in their journal paper to Nelson's (2002) position that in part, the discussions within society about older adults are being fuelled by an ageist rhetoric that still perceives older adults in pessimistic ways. The hope is that this research will give a sense of the person and the unique qualities of those who took part, so that stereotypical perspectives do not permeate the often limited services that are provided for older adults.

Epistemological Reflexivity

The framework used in this study was directed by the ontological and epistemological position that the researcher holds (Mills et al, 2006). Charmaz (2006, p.10) asserts that theory is "constructed" from the data, because researchers exist in the environments where they conduct their examinations by "interacting with people, perspectives and research practices". This point is true of the researcher who works with older adults delivering Psychological therapy. Charmaz (2006, p.130) describes that the extent to which a study can be said to be "constructivist or objectivist" is dependent on how much of the study incorporates the main features of the paradigm in question. Therefore, after careful consideration of the approaches

put forward by classic and evolved theorists, I learned that perhaps those methods could be too limiting for this study. I reasoned that because the constructivist framework took account of the “position of mutuality”, this study could then incorporate a method which could demonstrate the reciprocity within the researcher-participant relationship (Mills et al, 2006, pg.8). Charmaz (2006) contends that encompassing the points of view of the researcher and the participant establishes that knowledge is created by working together.

The aforementioned deliberations influenced the researchers’ decision to use Constructivist Grounded Theory methods to inquire and learn more about the older adult participants’ experience of psychological therapy. In this interpretive study I attempted to understand what the older adult participant’s experience was from the standpoint that meaning is constructed mutually as the research process emerges (Mills et al, 2006). It was through this interaction with the participants, and subsequently refining those categories that an understanding of those experiences was reached (Charmaz, 2006).

For example, in a segment taken from the transcript of the second interview and the field notes [Appendix 1] I found this interview interesting and I was curious about what the analysis would reveal. The participants’ openness during the interview played an important role, and his relaxed, calm style was engaging. I allowed him to speak and I used prompts to guide the research interview, which was preferable so he could tell his story. Furthermore my approach was to be confident in my skill as a researcher so that the focus remained on the interaction with the participant. These aspects allowed both the participant and researcher to work together to make sense of the narrative as it unfolded.

His story (psy 03) explained how the news that he had cancer had sent his world into a circle that he tried to regain control of. With the help of Psychological therapy he eventually found a way out of those difficulties. The use of the participants’ words during the analytical stage

was important as it kept the findings grounded in the data (Charmaz, 2006). This study incorporated partnership into the research design, where both participant and researcher shared responsibility for engaging with the aims of the study. A segment of the transcript from the third interview (appendix 2) illustrates how the researcher and participant worked together to make sense of his experience. The interview flows well as both parties enter into a conversational rhythm to clarify the meanings embedded in the language about his lived experience. This kind of collaboration contributed to the “reconstruction” of the participant’s story, to convey an interpretation of the context using their language (Mills et al, 2006, p.9).

The epistemological perspective of the researcher influenced the decision about how the research question was framed and this connects with the ontology of the method that was used (Annells, 1996). Thus, in this study the choice of method and the researcher’s position, concerning how knowledge is acquired through co-construction and the interaction with the participant is apposite (Mills et al, 2006).

In conclusion, using qualitative methodology is relevant to evidence based practice, because the process facilitates an examination of “the attitudes, beliefs and preferences” of the participant (Green & Britten, 1998, p.1230). Therefore in that respect, the objective of this study was met.

The Constructivist Grounded Theory perspective was congruent with my personal and professional position and embodied aspects of the therapeutic process, in which the client and the therapist develop a shared understanding of the problem and collaborate together. Similarly, constructivists’ central idea is about the theory emerging from the data because it is a construction of that reality which has been studied (Charmaz, 2006). Therefore, by making use of this constructivist approach I am acknowledging the subjective experiences of

both participant and researcher by recognizing that “multiple truths and realities” exist within the co-construction of this study (Mills et al, 2006, pg.9; Charmaz, 2006).

Methodological Reflexivity

Kasket, (2012) argues that being reflexive is also about the methodology and what factors may have influenced the decisions taken during the study. She further posits that discussion about these issues demonstrates that the researcher was aware and took appropriate action to maintain quality standards in the study (Kasket, 2012). The expertise that the researcher brought to this process is well documented in the professional reflexivity section. The researcher had a number of roles (eg: researcher, psychologist, writer) throughout this process and it was clear that maintaining boundaries in relation to these positions was an important undertaking even during the writing up phase of the study. The researcher’s role is central to the method and how it was operationalized, thus making it crucial to take account of any bias going into the process because of its bearing on the interpretation of the data. It was therefore necessary throughout to stay firmly grounded in the language of the participant (Mills et al, 2006).

One of the assumptions I acknowledged in the research was about Psychological Therapy being a positive experience for all older adults who go through therapy. This assumption stems from my professional role as a Practitioner Psychologist. Although in reality each client that comes to therapy is an individual with their own history and particular factors that are of concern to them. The researcher knows that not every client will have a positive experience and there are a variety of variables, factors and barriers that can impact on the client-therapist relationship.

When I reflected on the assumption about therapy being a positive experience, I was aware of the issues within the NHS regarding performance targets, outcome measurement and the pressure on Psychologists to prove that they are effective in delivering interventions that benefit service users. To balance expertise, with what is unknown and what emerges from the data whilst continuing to stay open, felt like a difficult balance to hold at times during the research process. Stiles (1993, p.598) discussed the notion of “empowerment” and he said that research should aim to strengthen participants’ meanings. He goes on to say that “constructing interpretations” that promote “participants interests rather than...vested interests” is a way to manage the “ethical” matters that may arise (Stiles, 1993, p.598). The researcher was aware that assumptions such as wanting to achieve a purely positive outcome would affect how the data could be understood. Thus, being diligent in ensuring that the focus of this study stayed connected to developing theory from the experiences of older adult participants was key in maintaining the integrity of this research.

Charmaz (2006, p.16) also talked about “sensitizing” concepts where an interest in a topic could direct the researcher to make specific enquiries thereby potentially calling into question the quality of what is revealed in the data. Charmaz, (2006, p.17) added that the ideas already known about the area of study should be regarded as “points of departure” to widen impressions, rather than restrict them.

Mills et al (2006, p.10) described the researcher as comprising of many “selves” which should be held in mind and the reflection utilized to express any “underlying assumptions”. The researcher used a journal throughout and wrote memos that helped to keep a track of her thoughts about the data (Mills et al, 2006).

Conducting this research study changed how I came to view my role as a Psychologist, because it gave me a rich experience of how some older adults perceive the therapy that

Psychologists' deliver. Just having the chance to hear what was important to the participants helped me to connect with their narrative even more and the impact increased my knowledge and improved my clinical practice.

Reflection on the Field notes and Transcripts

Nine anonymized transcripts were produced from the audio-taped interviews used in this study. Burman (1994, p.57) discusses the influence on the interviewer when transcribing the raw data into text, and suggests that the "experience and memory" of what took place during the research interview are important. She further explains that writing notes about the experience of researching in the field is beneficial, because it aids transparency, which can unveil whether the researcher holds any suppositions that have influenced the interpretation of the data (Burman, 1994). Furthermore, using memos is another method that can manage researcher bias (Elliott & Lazenbatt, 2005). The researcher kept field notes that captured her thoughts and feelings about the interview and the participant; in order to convey their experience. Wilkinson (1988, p.495) asserts that the researcher should be reflexive and engage in a prolonged inquiry into the procedures that are used in the study so that the "assumptions, values and biases" can be known.

Reading through my field notes and journal I am reminded of how much I wanted my first interview to go smoothly (Appendix 5). Recruiting participants to the study was extremely slow and I felt concerned for how much this was affecting me. However, I was well prepared for the interview and I was focused on how to be present during the interview process for the participant.

Upon my arrival at psy 02's home, in the first interview, I did not anticipate that the carpenter would be working in another part of the house and hammering in the background. There were

a few telephone interruptions from a relative checking that the participant was alright. The participant was warm, friendly and eager to share her story in its entirety, before we began talking about her experience of psychological therapy. I was aware that it was difficult to bring the participant back to the research question at times, which left me experiencing the process has a little chaotic at first and I blamed my skills as an interviewer. It seemed important to use prompts to guide the interview and I did not feel I should try and control the content, because it was important for the participant to speak freely.

As I relaxed more into the interview it just seemed to flow, in retrospect it did proceed well enough and the participant appeared at ease, which is illustrated in the transcript segment by her openness about her feelings. In fact, when transcribing the material I observed how well the researcher and participant collaborated to make sense of her story. In the transcript segment [Appendix 5] the participant talked about a loss of confidence from the person she used to know herself to be and how she fought to reconnect to the confident individual she was before. It is interesting that by the end of the interview I was also able to connect to my own confidence as the interviewer and take that into subsequent interviews. Reflecting on the first interview in my field notes, I tried to keep the interview question in sight as much as possible, whilst maintaining the partnership that is central to the research relationship.

Another example of the research partnership refers to my impression during the follow-up telephone conversation with psy 15. The unexpected situation that arose before she consented allowed us to work together, thereby strengthening that research partnership [Appendix 11]. Her story was one of survival through something very traumatic. She expressed herself well, as she described what was difficult about telling the Psychologist about her life. Her narrative gave a rich context and a deeper understanding of her experience. I felt drawn to her in my

role as a researcher to support her in the re-telling of her story, which I experienced as a positive interaction.

When transcribing the material I experienced a connection with the data and the ideas about the meanings flowed, and consequently I put them into memos. There are three strands that formed key elements within the extract and segment that are featured. Firstly, in her re-telling of her story the participant described her sense of powerlessness as a consequence of the life events that were difficult to cope with. Secondly, a similar description is revealed as she talked about how she experienced Psychological therapy with the Psychologist. Finally, her collaborative relationship with the researcher seemed to produce the opposite effect when contrasted with the two previous strands, which may have been due to a sense that both parties were attuned and this enabled the participant to be empowered.

Researcher Reflexivity

In retrospect at the start I was an inexperienced grounded theorist and the journey through this creative process was challenging, but rewarding too. I learnt to stay motivated, trust in myself as a grounded theorist; trust the data and the research process too. This study enabled me to accept that anxiety can accompany learning something new, especially if it is of great personal and professional importance.

Despite the many obstacles that arose, the process lead to my growth as a person, practitioner, researcher and author. In conclusion, I recognize and can identify with the notion of a changed ‘self’ that the participants spoke about, albeit from different contexts, I gained more confidence which ultimately enabled the writing of this study to be completed.

REFERENCES

- Abad-Corpa, E., Gonzalez-Gil, T., Barderas-Manchado, A.M., De La Cuesta-Benjumea, C. Monistrol-Ruano, O., Mahtani-Chugani, V. & Martinez-Hernandez, A. (2010). Research protocol: a synthesis of qualitative studies on the process of adaptation to dependency in elderly persons and their families. *BioMed Central Geriatrics*, 10, 58-62. Available on: <http://www.biomedcentral.com/1471-2318/10/58> (Accessed: 08/05/2011)
- Abernathy, B.E. (2008). *Who am I now? Helping trauma clients find meaning, wisdom and a renewed sense of self*. In *Counseling Interventions Celebrating Vistas' fifth anniversary*. Eds. Walz, G. R., Blener, J.C., Yep, R.K. Counseling Outfitters, LLC. American Counseling Association.
- Age Concern (2006). *UK Inquiry into Mental Health and Well-Being in Later Life*. Coordinated by Age Concern. www.ageconcern.org.uk
- Age Concern. (2007). *Improving Services and Support for Older People with Mental Health Problems*. The Second Report from the UK Inquiry into Mental Health and Well-Being in Later Life. Age Concern, 133 Audit Commission. *Forget Me*
- Aldwin, C.M. & Gilmer, D.F. (2004). *Health, Illness and Optimal Aging*, Thousand Oaks, CA: Sage.
- Andrew, M. K., Fisk, J. D. & Rockwood, K. (2012). Psychological well-being in relation to frailty: a frailty identity crisis? *International Psychogeriatrics*, 24(8), 1347-1353.
- Anells, M. Grounded Theory Method: Philosophical Perspectives, Paradigm of Inquiry, and Postmodernism. *Qualitative Health Research*, 379-393.
- Arean, P.A., Cook, B.L., Gallagher-Thompson, D., Hegel, M.T., Schulberg, H.C. & Schulz, R. (2003) Guidelines for Conducting Geropsychotherapy Research. *American Journal Geriatric Psychiatry*, 11, (1), 9-16.
- Appleton, C. & Martin, C. (2012). Dreamcatching: Using an integrative approach to manage chronic PTSD in an older adult. *PSIGE Newsletter*, no. 120, 5-17.
- Aroboto, T. & Shaw, R. (2006). Why we use qualitative methods in psychology. *Qualitative Methods in Psychology*, 2, 17-18.
- Astin, A.W. & Keen, J. P. (2006). Equanimity and Spirituality. *Religion & Education*, 33(2), 1-8.
- Atchley, R. C. (1989). A Continuity Theory of Normal Aging. *The Gerontologist*, 29(2), 183-190.
- Atiq, R. (2006). Common Themes and Issues in Geriatric Psychotherapy. *Psychiatry*, [June], 53-56.
- Atwal, A. & Caldwell, K. (2005). Older People: the enigma of satisfaction surveys. *Australian Occupational Therapy Journal*, 12-16.
- Bachelor, A. & Horvarth, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S.D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 133-178). Washington, DC: American Psychological Association.
- Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative Methods in Psychology: A Research Guide*. Buckingham. Open University Press.

REFERENCES

- Barrowclough, C., King, P., Colville, J., Russell, E., Burns, A. & Tarrier, N. (2001). A Randomized Trial of the Effectiveness of Cognitive Behavioral Therapy and Supportive Counseling for Anxiety Symptoms in Older Adults, *Journal of Consulting and Clinical Psychology*, 69(5), 756-762.
- Beauchamp, T.L., Jennings, B., Kinney, E.D. & Levine, R.J. (2002). Pharmaceutical Research involving the homeless. *Journal of Medicine and Philosophy*, 27, (5), 547-564. (cited in Liamputtong (2007), p.25, op cit).
- Beck, J.S. (1995). *Cognitive therapy: Basics and Beyond*. New York: The Guildford Press.
- Bell, J. (1999). *Negotiating access: Ethics and the problems of 'inside' research*. In J. Bell (Ed.) *Doing your research project: A guide for first-time researchers in education and social science*. (3rd edn) (pp.37-47). Buckingham: Open University Press. (cited in Matthiesen & Richter (2007), p.145, op cit).
- Bengston, V.L., Reedy, M.N. & Gorden, C. (1985). *Ageing and self-conceptions: Personality processes and social contexts*. In J.E. Birren & K. W. Schaie (Eds.), *Handbook of the psychology of aging* (2nd ed., pp. 544-593). New York: Van Nostrand Reinhold. (cited in Knight, (2004), p.55, op cit).
- Benoliel, J.Q. (1996). Grounded theory and nursing knowledge. *Qualitative Health Research*, 6, (3), 406-428. (cited in Elliott & Lazenbatt (2005), p.49, op cit).
- Bolger, E.A. (1999). Grounded Theory Analysis of Emotional Pain. *Psychotherapy Research*, 9(3), 342-362.
- Bonsmann, C. (2010) What do clients have to say about therapy? *Counselling Psychology Review*, vol.25, (4), 31-45.
- Bosma, H. & Kunnen, E.S. (2005). *Identity and Emotion: Development through self-organisation*. Cambridge University Press.
- Bottche, M., Kuwert, P. & Knaevelsrud, C. (2012). Post-traumatic stress disorder in older adults: An overview of characteristics and treatment approaches. *International Journal of Geriatric Psychiatry*, 27, 230-239.
- Bowen, G. A. (2009). Supporting a grounded theory with an audit trail: an illustration. *International Journal of Social Research Methodology*, 12(4), 305-316.
- Boyd, T. & Gumley, A. (2007). An experiential perspective on persecutory paranoia: A grounded theory construction. *Psychology and Psychotherapy: Theory, Research and Practice*, 80, 1-22.
- British Psychological Society. (2010). *Code of Human Research Ethics*. www.bps.org.uk
- British Psychological Society. (2009). *Code of Ethics and conduct: guidance published by the ethics committee of the British Psychological Society*. www.bps.org.uk
- Bruce, M.L., Seeman, T. E., Merrill, S. S. & Blazer, D. G. (1994). The impact of depressive symptomatology on physical disability: MacArthur Studies of Successful Aging, *American Journal of Public Health*, 84, 1796-1799. (cited in Wittink et al, (2008), p.1174, op cit).
- Burman, E. (1994). *Interviewing*. In Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative Methods in Psychology: A Research Guide*. Buckingham. Open University Press. Pp.49-71.

REFERENCES

- Butler, R.N. (1967). Research and clinical observations on the psychologic reactions to physical changes with age. *Mayo Clinical Process*, 42: 596-619. (cited in Fillit & Butler (2009), p.349, op cit).
- Bury, M.R. (1982). Chronic illness as disruption. *Sociology of Health and Illness*, 4, 167-182.
- Castonguay, L. G., Constantino, M.J. (2006). The Working Alliance: where are we and where should we go? *Psychotherapy: Theory, Research, Practice, Training*, 43(3), 271-279.
- Charlesworth, G. & Greenfield, S. (2004). Overcoming Barriers to collaborative conceptualization in cognitive therapy with older adults. *Behavioural and Cognitive Psychotherapy*, 32, 411-422.
- Charmaz, K. (1995b). *Grounded theory*. In J. Smith, R. Harre & L. V. Langenhove (Eds.), *Rethinking methods in psychology* (pp. 26-47). London: Sage Publications.
- Charmaz, K. (2000). *Grounded theory: Objectivist and constructivist methods*. In N. Denzin & Y.
- Charmaz, K. (1995). The Body, Identity, and Self: Adapting To Impairment. *The Sociological Quarterly*, 36, 657-680.
- Charmaz, K. (1983). Loss of self: a fundamental form of suffering in the chronically ill, *Sociology of Health and Illness*, 5, (2), 168-195.
- Charmaz, K. & Mitchell, R.G. (1996). The myth of silent authorship: Self, substance, and style in ethnographic writing. *Symbolic Interaction*, 19, (4), 285-302. (cited in Mills et al, (2006), p. 12, op cit).
- Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. London: Sage.
- Christian, C.G. (2005). *Ethics and Politics in qualitative research*. Pp. 109-164. In *The Sage Handbook of Qualitative Research*, 3rd edition, edited by N.K. Denzin and Y.S.Lincoln. Thousand Oaks, CA: Sage. (cited in Liamputtong (2007), p.33, op cit).
- Clark, J.A. & Mishler, E. G. (1992). Attending to patients' stories: reframing the clinical task. *Sociology of Health and Illness*, 14(3), 344-371.
- Clarke, A., Hanson, E, J. & Ross, H. (2003). Seeing the person behind the patient: enhancing the care of older people using a biographical approach, *Journal of Clinical Nursing*, 12: 697-706.
- Cookman, C. (2005). Attachment in older adulthood: concept clarification. *Journal of Advanced Nursing*, 50(5), 528-535.
- Cooper, B. (1986). *Voices: On becoming old women*. In J. Alexander (Ed.), *Women and aging: An anthology by women* (pp. 47-57). Corvallis, OR: Calyx. (cited in Perkins & Tice, (1994), p.443, op cit).
- Corbetta, P. (2003). *Social Research Theory, Methods and Techniques*. (pp.264-283). London: Sage.
- Corbin, J. & Strauss, A. (1988). *Unending work and care: Managing chronic illness at home*. San Francisco. Jossey-Bass. (cited in Abernathy, (2008), p.201, op cit).
- Curry, L.A., Nembhard, I.M. & Bradley, E.H. (2009). Qualitative and Mixed Methods Provide Unique Contributions to Outcomes Research. *Qualitative and Mixed Methods Research*, 119, 1442-1452. Downloaded from <http://circ.ahajournals.org> on 1/11/2013.

REFERENCES

- Data Protection Act (1998). *Records Management*. Information Commissioners Office. Department of Health.
- Davies, S. (2013). Stones in the pond: Late life effects of psychological trauma. *Clinical Psychology Forum*, 250, 46-48.
- Denzin, N., & Lincoln, Y. (2000). *The discipline and practice of qualitative research*. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 1-28). Thousand Oaks: Sage Publications.
- Department of Health (2004). *Patient and Public Involvement in health. The Evidence for policy implementation*. London: Department of Health. www.gov.uk/
- Department of Health (2005). *Research governance framework for health and social care: second edition*. London: Department of Health. www.gov.uk/
- Department of Health (2012). *The Mandate from the Government to the NHS Commissioning Board: April 2013 – March 2015*. London: Department of Health. www.gov.uk/
- Department of Health (2011). *The Operating Framework for the NHS in England 2012/13*. London: Department of Health. www.gov.uk/
- Dickson-Swift, V. (2005). *Undertaking sensitive health research: The Experiences of Researchers*. Unpublished Doctoral thesis, Department of Public Health, School of Health and Environment, LA Trobe University, Bendigo, Australia. (cited in Liamputtong (2007), p.23, op cit).
- Duckett, S. (2007). Symbolic Interactionism. *PSIGE Newsletter*, No. 101, Oct. The British Psychological society.
- Dunbar, G.C. & Lishman, W. A. (1984). Depression, recognition, memory and hedonic tone: a signal detection analysis. *British Journal of Psychiatry*, 144, 376-382. (cited in Macleod (1994), p. 630, op cit).
- Dyer, C. (2006). *Research in Psychology: A Practical Guide to Methods and Statistics*. Oxford: Blackwell.
- Eagan, G. (2007). *The skilled helper: A problem-management and opportunity development approach to helping* (8th ed.). Belmont, CA: Thompson Higher Education. (cited in Richards (2011), p.59, op cit).
- Elliott, R. & Shapiro, D.A. (1992). *Client and therapist as analysts of significant events*. In S.G. Toukmanian & D.L. Rennie (Eds.), *Psychotherapy process research: Paradigmatic and narrative approaches* (pp. 163-186). London: Sage Publications.
- Elliott, R. & James, E. (1989). Varieties of client experience in Psychotherapy: An analysis of the literature. *Clinical Psychology Review*, vol. 9, 443 – 467.
- Elliott, R. (1983). Fitting Process Research to the Practising Psychotherapist. *Psychotherapy: Theory, Research and Practice*, 20, 47-55. (cited in Booth et al (1997), p.176, op cit).
- Elliott, N. & Lazenbatt, A. (2005). How to recognise a ‘quality’ grounded theory research study. *Australian Journal of Advanced Nursing*, 22, (3), 48- 52.

REFERENCES

- Erikson, E. (1968). *Identity: Youth & Crisis*. New York. Norton
- Erikson, E. H. & Erikson, J.M. (1997). *The Life Cycle Completed*. New York. Norton (cited in Andrew et, al (2012), p.1351, op cit).
- Evans, C. & Reynolds, P. (2006). Survey of the provision of psychological therapies for older people, *Psychiatric Bulletin*, 30, 10-13.
- Feldman, S., Radermacher, H., Browning, C., Bird, S. & Thomas, S. (2008). Challenges of recruitment and retention of older people from culturally diverse communities in research, *Ageing & Society*, 28, 473-493.
- Fillitt, H. & Butler, R. (2009). The Frailty Identity Crisis. *Journal of American Geriatrics*, 57, 348-352.
- Fudge, N., Wolfe, C.D.A. & McKevitt (2007). Involving older people in health research. *Age and Ageing*, 36, 492-500.
- Gallegos, N. (2005). Client perspectives on what contributes to symptom relief in psychotherapy: A Qualitative Outcome Study. *Journal of Humanistic Psychology*, 45 (3), 355-382.
- Garland, J. (2005). Facing up to ageing. *PSIGE Newsletter*, 92, 13-15.
- Garner, J. (2003). Psychotherapies and older adults. *Australian and New Zealand Journal of Psychiatry*, 37, 537-548.
- Gatz, M. (2007) Commentary on Evidence-Based Psychological Treatments for Older Adults. *Psychology and Aging*, vol.22 (1), p.52-55.
- Gergen, K., & Gergen, M. (1988). *Narrative and the self as relationship*. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (pp. 17-56). San Diego, CA: Academic Press. (cited in Abernathy, (2008), p.200, op cit).
- Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. Chicago: Aldine. (cited in Charmaz (2006), p. 4, op cit).
- Glaser, B. (1978). *Theoretical sensitivity*. Mill Valley CA: Sociology Press. (cited in Charmaz (2006), p. 63, op cit).
- Glaser, B. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley. CA: Sociology Press (cited in Charmaz (2006), p. 63, op cit).
- Gordon, R. (2010). Ageing, dementia and adult survivors of childhood sexual assault. *Australian Institute of Family Studies*, 6 – 13. Available on line: www.aifs.gov.au/acssa/pubs/
- Goulding, C. (2002). *Grounded Theory: A Practical Guide for Management, Business and Market Researchers*. Sage, London.
- Grafanaki, S. (1996). Symposium: How research can change the researcher: the need for sensitivity, flexibility and ethical boundaries in conducting qualitative research in counselling/psychotherapy. *British Journal of Guidance and Counselling*, 24(3), 329-338.
- Green, J. & Britten, N. (1998) Qualitative research and evidence based medicine. *British Medical Journal*, 316, 1230-1232. Available at online: <http://bmj.com/cgi/content/full/316/7139/1230#BIBL> (Accessed: 30/05/1998).

REFERENCES

- Greenberg, L. S. & Pinsoff, W. M. (1986). *The psychotherapeutic process*. New York: Guilford Press.
- Greenhalgh, T. & Taylor, R. (1997). How to read a paper: Papers that go beyond numbers (qualitative research). *British Medical Journal*, 315:740–743. [PubMed: 9314762]
- Guba, E. G., & Lincoln, Y. S. (1994). *Competing paradigms in qualitative research*. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117).
- Gubrium, J. F. & Holstein, J. A. (2003). [eds.]. *Ways of Aging*. Boston: Blackwell.
- Guest, G., Bunce, A. & Johnson, L. (2006). How Many Interviews Are Enough? An Experiment with Data Saturation and Variability. *Field Methods*, 18, (1), 59-82.
- Gum, M.A., Arean, A. P., Hunkeler, E., Tang, L., Katon, W., Hitchcock, P., Steffens, C.D., Dickens, J. & Unutzer, J. (2006). Depression Treatment Preferences in Older Primary Care Patients. *The Gerontologist*, 46(1), 14-22.
- Gumley, A. & Schwannauer, M. (2011). Editorial: *Psychology and Psychotherapy, Psychology and Psychotherapy: Theory, Research and Practice*, 84, 237-238.
- Hall, W.A. & Callery, P. (2001). Enhancing the Rigor of Grounded Theory: Incorporating Reflexivity and Relationality. *Qualitative Health Research*, 11(2), 257-272. Available at online: <http://qhr.sagepub.com/content/11/2/257> (Accessed: 29/12/2010)
- Hammersley, M. & Atkinson, P. (1995) *Ethnography: Principles in Practice*, (2nd Ed.), pp 263-287, London, Routledge. (cited in Knight (2002), p. 52, op cit).
- Hand, H. (2003). The mentor's tale: A reflexive account of semi-structured interviews. *Nurse Researcher*, 10, 15-27. (cited in Mills et al (2006), p.9, op cit).
- Harper, D. (2008). Clinical Psychology. In C. Willig & W. Stainton-Rogers (2008) (Eds). *The Sage Handbook of Qualitative Research in Psychology*. (pp. 430-454). London: Sage.
- Heath, J. (2011) A process of counteracting forces: A grounded theory investigation of group therapy with older adults. *PSIGE Newsletter*, 115, 27-40.
- Henwood, K. & Pidgeon, N. (2003). *Grounded theory in psychological research*. In P.M. Camic, J.E. Rhodes, & L. Yardley (Eds), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp.131-155). Washington, DC: American Psychological Association. (cited in Charmaz (2006), p.138, op cit).
- Helmeke, K. B., & Sprenkle, D.H. (2000). Client's perceptions of pivotal moments in couples' therapy: A qualitative study of change in therapy, *Journal of Marital and Family Therapy*, 26, 469-483.
- Hepple, J. (2004). Psychotherapies with Older People: an Overview. *Advances in Psychiatric Treatment*, 10, 371-377.
- Hiskey, S., Luckie, M., Davis, S. & Brewin, C. R. (2008). The Emergence of Posttraumatic Distress in Later Life: A Review. *Journal of Geriatric Psychiatry and Neurology*, 21, 232 – 241. Available online: <http://anp.sagepub.com/>

REFERENCES

- Holloway., I. & Fulbrook, P. (2001). Revisiting qualitative inquiry: Interviewing in nursing and midwifery research. *NT Research*, 6, 539-550. (cited in Mills et al (2006), p.10, op cit).
- Howe, D. (1996). Client experiences of counselling and treatment interventions: a qualitative study of family views of family therapy. *British Journal of Guidance and Counselling*, 24, (3), 367-375.
- Howse, K., Ebrahim, S. & Gooberman-Hill, R. (2005). Help-avoidance: why older people do not always seek help, *Reviews in Clinical Gerontology*, 14, 63-70
- Hoyt, W.T. & Bhati, K.S. (2007). Principles and practices: An Empirical Examination of Qualitative Research. *Journal of Counselling Psychology*, 54, (2), 201-210.
- Hunter, S. V. (2012). Walking in sacred spaces in the therapeutic bond: Therapists' Experiences of Compassion Satisfaction Coupled with the Potential for Vicarious Traumatization. *Family Process*, 51(2), 179-192.
- James, W. (1890). *The Principles of Psychology*. New York: Dover Publications.
- Janoff-Bulman, R. (1992). *Shattered assumptions: Toward a new psychology of trauma*. New York: Free Press. (cited in Abernathy, (2008), p.201, op cit).
- Joseph, S. (2011) Changing How We Think About Psychological Trauma. Trauma is not an illness. *Psychology Today*. Available on line: www.psychologytoday.com/
- Kabit-Zinn, J. (1990). *Full Catastrophe living, using the wisdom of your body and mind to face stress, pain and illness*. Random House. New York.
- Kasket, E. (2012). The counselling psychologist researcher. *Counselling Psychology Review*, 27(2), 64-73.
- Katz, A.M. & Mishler, G. (2003). Close encounters: exemplars of process-oriented qualitative research in health care. *Qualitative Research*, vol. 3 (1): 35-56. <http://qhr.sagepub.com/content/3/1/35> (Accessed: 29/12/2010)
- Katz, R.S. & Genevay, B. (2002). Our patients, Our Families, Ourselves. The Impact of the Professional's Emotional Responses on End-of-life Care. *American Behavioral Scientist*, 46(3), 327-339.
- Kelle, U. (2005). "Emergence" vs. "forcing" of empirical data? A crucial problem of "grounded theory" reconsidered. *Forum, Qualitative Social Research*, 6(2). Art.27, paragraphs 49 & 50.
- Knight, B.G. (2004). *Psychotherapy with Older Adults*. (3rd ed.) London: Sage.
- Knight, P. (2002). *Small Scale Research*. (pp. 49-72). London: Sage.
- Kivnick, H. Q. & Kavka, A. (1999). *It takes two: Therapeutic Alliance with Older Clients*. In M. Duffy (Eds.), *Handbook of Counseling and psychotherapy with older Adult*. pp. 107-131. New York: Wiley & Sons.
- Kohut, H. & Wolf, E.S. (1978). The Disorders of the Self and their Treatment: An Outline. *The International Journal of Psychoanalysis*, 59, 413-425.
- Kraaiji, V. & De Wilde, E. J. (2001). Negative life events and depressive symptoms in the elderly: a lifespan perspective. *Aging & Mental Health* 2001, 5(1): 84-91 (as cited in Woods (2003), p.131, op cit).

REFERENCES

- Kumar, S., Little, P. & Britten, N. (2003). Why do general practitioners prescribe antibiotics for sore throat? Grounded theory interview study. *British Medical Journal*, 326, 138-144.
- Laidlaw, K., Thompson, L.W., Dick-Siskin, L. & Gallagher-Thompson, D. (2003). *Cognitive Behaviour Therapy with Older People*. Chichester. John Wiley & Sons.
- Laidlaw, K. & Baikie, E. (2007). Psychotherapy and Demographic Change: Why psychotherapists working with older adults need to be aware of changing demographics now. *Nordic Psychology*, 59(1), 45-58.
- Lang, P. J. (1977). Imagery in therapy: an information processing analysis of fear. *Behavior Therapy*, 8, 862-886. (cited in Macleod (1994), p. 630, op cit).
- Lang, P. J. (1979). A bio-informational theory of emotional imagery. *Psychophysiology*, 16, 495-512. (cited in Macleod (1994), p. 630, op cit).
- Laughton-Brown, H. (2010). Trust in the therapeutic relationship: Psychodynamic contributions to counselling psychology practice, *Counselling Psychology Review*, 25, (2), 6-11.
- Lazarus, R.S. & DeLongis, A. (1983). Psychological Stress and Coping in Aging. *American Psychologist*, 245-254.
- Lazarus, L.W., Groves, L. & Newton, N. (1984). Brief Psychotherapy with the elderly: A review and preliminary study of process and outcome. In: Lazarus LW (ed). *Clinical Approaches to Psychotherapy with the Elderly*. Washington, DC: American Psychiatric Press, 16-35. (cited in Atiq, (2006), p.54, op cit).
- Lee, C. (2004). Agency and Purpose in narrative Therapy: Questioning the Postmodern Rejection of Meta narrative. *Journal of Psychology and Theology*, 32, (3), 221-231.
- Liamputtong, P. (2007). *Researching The Vulnerable: A guide to Sensitive Research Methods*. London: Sage.
- Llewellyn, S. & Hardy, G. (2001). Process Research in understanding and applying Psychological Therapy. *British Journal of Clinical Psychology*, 40, 1 – 20.
- Locke, K. (2001). *Grounded theory in management research*. Thousand Oaks, CA: Sage.
- Lund, H. G., Rybarczyk, B.D., Perrin, P. B., Leszczyszyn, D. & Stepanski, E. (2013). The Discrepancy between Subjective and Objective Measures of Sleep in Older Adults Receiving CBT for Comorbid Insomnia. *Journal of Clinical Psychology*, 69(10), 1108-1120.
- Ma, M. (2012). On Learning Resilience and Equanimity. *Psychology Today*. Available on line: www.psychologytoday.com/
- Macleod, A. D. (1994). The reactivation of Post-Traumatic Stress Disorder in Later Life. *Australian and New Zealand Journal of Psychiatry*, 28, 625 – 634. Available on line: <http://anp.sagepub.com/>
- Macran, S., Ross, H., Hardy, G.E. & Shapiro, D.A. (1999). The importance of considering clients' perspectives in psychotherapy research. *Journal of Mental Health*, 8, 325-337.
- McCarthy, G. & Davies, S. (2003). Some implications of Attachment Theory for understanding Psychological functioning in old age: An illustration from the long-term psychological effects of World War Two. *Clinical Psychology and Psychotherapy*, 10, 144-155. Available on line: www.interscience.wiley.com

REFERENCES

- Magi-Sque, M. (2000). Researching the Bereaved: An Investigator Experience. *Nursing Ethics*, 7, (1), 23-34. (cited in Liamputtong (2007), p.23, op cit).
- Maione, P. V. & Chenail, R. J. (1999). *Qualitative inquiry in psychotherapy: Research on the common factors*. In *The Heart and Soul of Change: What Works in Therapy*. Hubble, Mark A. (Ed.); Duncan, Barry L. (Ed.); Miller, Scott D. (Ed.); pp. 57-88. Washington, DC, US: American Psychological Association.
- Markus, H. & Wurf, E. (1987). The dynamic self-concept. *Journal of Personality and Social Psychology*, 51, 858-866. (cited in Batory, (2010), p.45, op cit).
- Maslow, A. H. (1954). *Motivation and Personality*. New York: Harper & Brothers. (cited in Suh, (2002), p.1378, op cit).
- Mathieson, C. M., & Stam, H. J. (1995). Renegotiating identity: Cancer narratives. *Sociology of Health and Illness*, 17(3), 283-306. (cited in Abernathy, (2008), p.201, op cit).
- Mauthner, N.S. & Doucet, A. (2003). A Reflexive Accounts and accounts of reflexivity in qualitative data analysis. *Sociology*, 37, (3), 413-431. In A. Bryant & K. Charmaz (2007) (Eds). *The Sage Handbook of Grounded Theory*. (pp. 417-435). London: Sage.
- May, K.A. (1989). *Interviewing techniques in qualitative research: concerns and challenges*. In: J. Morse (Ed.) *Qualitative Nursing Research: Contemporary Dialogue*, pp. 171-182 (Rockvill, MD, Aspen). (cited in Grafanaki, (1996), p.335, op cit).
- Mays, N. & Pope, C. (1995). Qualitative research: Rigour and qualitative research. *British Medical Journal*, 311, 109-112.
- McBee, L. (2003). Mindfulness Practice with the Frail Elderly and their Caregivers. *Topics in Geriatric Rehabilitation*, 19(4), 257-264.
- McGourty, A. J., Farrants, J., Pratt, R. & Cankovic, M. (2010). Taking your participants home: Self-care within the research process. *Counselling Psychology Review*, 25(4), 65-72.
- McLeod, J. (1997). *Narrative and Psychotherapy*. London: Sage.
- McLeod, J. (1994). *Doing Counselling Research* (2nd ed). London: Sage.
- Mead, G.H. (1934). *Mind, Self and Society*. (Eds.) C. W. Morris, Chicago: University of Chicago. (cited in Charmaz, (1983), p.170, op cit).
- Mead, G.H. (1913). The Social Self [1]. *Journal of Philosophy, Psychology and Scientific Methods*, 10, 374-380. Available on line: An internet educational resource developed by C. D. Green, York University, Toronto, Ontario. Available on line: <http://psychclassics.yorku.me/Mead/self.htm>
- Mills, J., Bonner, A. & Francis, K. (2006). Adopting a constructivist approach to grounded theory: Implications for research design. *International Journal of Nursing Practice*, 12, 8-13.
- Mills, J., Bonner, A. & Francis, K. (2006). The Development of constructivist Grounded Theory. *International Journal of Qualitative Methods*, 5(1), 25-35.
- Mishler, E. (1991). *Research Interviewing: Context and Narrative*. Harvard, MA, USA: Harvard University Press. (cited in Mills et al (2006), p.10, op cit).

REFERENCES

- Mody, L., Miller, D. K., McGloin, J. M., Freeman, M., Marcantonio, E. R., Magaziner, J. & Studenski, S. (2008). Recruitment and Retention of Older Adults in Aging Research. *Journal of the American Geriatrics Society*, 56(12), 2340-2348.
- Moos, R. H., Brennan, P. L., Schutte, K. K. & Moos, B. S. (2006). Older adults' coping with negative life events: common processes of managing health, interpersonal, and financial/work stressors. *International Journal of Aging Human Development*, 62(1), 39-59. Available on line: www.ncbi.nlm.nih.gov
- Morse, J. M. (2007). *Sampling in Grounded Theory*. In A. Bryant & K. Charmaz (2007) (Eds.), *The Sage Handbook of Grounded Theory* (pp. 201-216)
- Morrow, S. L. (2005). Quality and Trustworthiness in Qualitative Research in Counseling Psychology. *Journal of Counselling Psychology*, 52(2), 250-260.
- Mruck, K. & Gunter, M. (2007). *Grounded Theory and Reflexivity*. In A. Bryant & K. Charmaz (2007) (Eds.), *The Sage Handbook of Grounded Theory*. (pp. 515-538). London: Sage.
- Mulholland, P. (2011). Service user satisfaction questionnaire of NHS Tayside Psychological Therapies Services of Older People, *Psige Newsletter*, no.115, April 2011.
- Nelson, M. L. & Quintana, S. M. (2005). Qualitative Clinical Research with children and adolescents. *Journal of Clinical Child and Adolescent Psychology*, 34(2), 344-356.
- Nelson, T. D. (Ed). (2002). *Ageism: Stereotyping and prejudice against older persons*. Cambridge, MA: MIT Press (cited in Stephen & Flick, (2010), p.644, op cit).
- Newton, N. A., Brauer, D., Gutmann, D. L., & Grunes, J. (1986). Psychodynamic therapy with the aged: A review. *Clinical Gerontologist: The Journal Of Aging And Mental Health*, 5(3-4), 205-229 (cited in Hyer et al, (2004), p.280, op cit).
- NHS Quality Improvement Scotland (2006). *Patient Focus and Public Involvement Framework*. Edinburgh & Glasgow: NHS QIS. www.audit-scotland.gov.uk
- Norcross, J.C. & Hill, C. (2004). Empirically Supported Therapy Relationships. *The Clinical Psychologist*, 57(3), 19-24.
- Norcross, J.C. (2002). *Psychotherapy relationships that work* (Ed.). New York: Oxford University Press.
- Office for National Statistics (2012). *Population ageing in the United Kingdom, its Constituent Countries and the European Union*. www.statistics.gov.uk
- Omylinska-Thurston, J. & James, P. E. (2011). The therapist's use of self: A closer look at the processes within congruence, *Counselling Psychology Review*, 26(3), 20-31.
- Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behaviour change* (4th ed., pp. 270–375). New York: Wiley.
- Orlinsky, D. E., & Howard, K. I. (1986). Process and outcome in psychotherapy. In S. L. Garfield & A.E. Bergin (Eds.), *Handbook of psychotherapy and behaviour change* (3rd ed., pp. 311–381). New York:Wiley.

REFERENCES

- Pary, R., Turns, D. M. & Tobias, C. R. (1986). A case of delayed recognition of post-traumatic stress disorder, *American Journal of Psychiatry*, 143, 941. (cited in Macleod (1994), p. 625, op cit).
- Patel, M. X., Doku, V. & Tennakoon, L. (2003). Challenges in Recruitment of Research Participants. *Advances in Psychiatric Treatment*, 9, 229-238.
- Patton, M.Q. (1990). *Qualitative Evaluation and Research Methods* (2nd ed), London. Sage. (cited in Grafanaki, (1996), p. 334, op cit).
- Perkins, K. (1992). Psychosocial implications of women and retirement. *Social Work*, 37, 526-532. (cited in Perkins & Tice, (1994), p.443, op cit).
- Perkins, K. & Tice, C. (1994). Suicide and older adults: The strengths perspective in practice. *Journal Of Applied Gerontology*, 13(4), 438-454. doi:10.1177/073346489401300407
- Perlman, H. H. (1979) *Relationship. The heart of helping people*, Chicago: University of Chicago Press.
- Pfaffenberger, A.H. (2006) Critical issues in therapy outcome research. *Journal of Humanistic Psychology*, 46, (3), 336-351. Available at online: <http://qhr.sagepub.com/content/46/3/336> (Accessed: 29/12/2010)
- Pinquart, M., Duberstein, P. R., & Lyness, J.M. (2006). Treatments for later-life depressive conditions: a meta-analytic comparison of pharmacotherapy and psychotherapy. *American Journal of Psychiatry*, 163, 1493-1501.
- Polkinghorne, D.E. (1991). Narrative and Self-Concept. *Journal of Narrative and Life History*, 2 & 3, 135-153.
- Polkinghorne, D.E. (1999). Traditional research and psychotherapy practice. *Journal of Clinical Psychology*, 55, 1429-40.
- Pope, K.S. (1991). *Dual relationships in psychotherapy, ethics and behaviour*, 1, pp.21-34. (cited in Grafanaki, (1996), p.355, op cit).
- Puddephatt, A.J. (2006). Special: An Interview with Kathy Charmaz: On Constructing Grounded Theory, *Qualitative Sociology Review*, 2(3), 5-20.
- Quinn, K. M. (2008). Research Prize Winner – Older peoples’ attitudes to mental illness, *PSIGE Newsletter*, No. 105, 4 - 18
- Rayner, K., Thompson, A.R. & Walsh, S. (2011). Clients’ experience of the process of change in cognitive analytic therapy, *Psychology and Psychotherapy: Theory, Research and Practice*, 84, 299-313.
- Reed, J., Weiner, R. & Cook, G. (2004). Partnership with older people- moving towards making the rhetoric a reality. *International Journal of Older People Nursing, in association with the Journal of Clinical Nursing*, 13(3a), 3-10.
- Rennie, D.L. (1985b). *The functions of the narrative in psychotherapy*. Paper presented at Fourth Annual Human Science Research Conference, Edmonton, Alberta. (cited in Elliott & James, 1989, p.460, op cit).
- Rennie, D.L. (1994b). Clients’ deference in psychotherapy. *Journal of Counseling Psychology*, 41, 427-437.

REFERENCES

- Rennie, D. L. (2004). Anglo-North American Qualitative Counselling and Psychotherapy Research. *Psychotherapy Research*, 14, (1), 37-55.
- Richards, C. (2011). Alliance ruptures: Etiology and resolution, *Counselling Psychology Review*, 26(3), 56-62.
- Robson, C. (1993). *Real World Research*. Chichester. Wiley & Sons.
- Roe, B., Whattam, M., Young, H. & Dimond, M. (2001). Elders' perceptions of formal and informal care: aspects of getting and receiving help for their activities of daily living, *Journal of Clinical Nursing*, 10, 398-405.
- Rogers, C. (1951). *Client-Centred Therapy: Its Current Practice, Implications, and Theory*. Houghton Boston. Mifflin.
- Rodgers, B. (2002). An Exploration into the Client at the Heart of Therapy: A qualitative perspective, *Person-Centered and Experiential Psychotherapies*, 2(1), 19-30.
- Roseborough, D. J., Luptak, M., McLeod, J. & Bradshaw, W. (2013). Effectiveness of Psychodynamic Psychotherapy with Older Adults: A Longitudinal Study. *Clinical Gerontologist*, 36, 1-16. Downloaded on 31/10/13.<http://dx.doi.org/10.1080/07317115.2012.731476>
- Royal College of Psychiatrists. (2013). *Whole-person care: from rhetoric to reality Achieving parity between mental and physical health*. www.rcpsych.ac.uk/usefulresources/publications/
- Ryan, R.M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55(1), 68-78. (cited in Pfaffenberger, (2006), p.338, op cit).
- Rayner, K., Thompson, A.R. & Walsh, S. (2011). Clients' experience of the process of change in cognitive analytic therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 84, 299-313.
- Safran, J. D. McMain, S., Crocker, P. & Murray, P. (1990). Therapeutic Alliance Rupture as a therapy event for empirical investigation. *Psychotherapy*, 27(2), 154-164.
- Scurfield, R.M. (1984). *Post trauma stress assessment and treatment overview and formulation*. In: Figley CR, ed. *Trauma and its wak*. New York: Brunner/Mazel, 237. (cited in Macleod (1994), p. 626, op cit).
- Seale, C. (1999). *The quality of qualitative research*. London: Sage. (cited in Elliott & Lazenbatt, (2005), p.51, op cit).
- Seligman, M. P. (1998). Treatment becomes Prevention & Treatment. *Prevention & Treatment*, 1(2), ArtID 1e.
- Sin, C. H. (2005). Seeking Informed Consent: Reflections on Research Practice. *Sociology*, 39(2), 277-294. Available at: <http://qhr.sagepub.com/content/39/2/277> (Accessed: 29/12/2010)
- Smith C. E, & Grawe, K. (2003). What Makes Psychotherapy Sessions Productive? A New Approach to Bridging the Gap Between Process Research and Practice, *Clinical Psychology and Psychotherapy*, 10, 275-285.
- Smyer, M. A. & Qualls, S. H. (1999). *Aging and mental health*. Malden: Blackwell Publishing.

REFERENCES

- Sneed, J.R. & Whitbourn, S. K. (2005). Models of the Aging Self. *Journal of Social Issues*, 61(2), 375-388.
- Stephens, C. & Flick, U. (2010). Health and Ageing – Challenges for Health Psychology Research, *Journal of Health Psychology*, vol. 15(5), 643-648.
- Stiles, W.B. (1993). Quality control in Qualitative Research. *Clinical Psychology Review*, 13, 593-618.
- Stone, C. & Elliott, R. (2011). Clients' experience of research within a research clinic setting. *Counselling Psychology Review*, 26(4), 71-84.
- Strauss, A. (1987). *Qualitative analysis for social scientists*. Cambridge, UK: Cambridge University Press. (cited in Charmaz, (2006), p.60, op cit).
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research* (1st ed.). Thousand Oaks, CA: Sage. (cited in Charmaz, (2006), p.60, op cit).
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing founded theory* (2nd ed.). Thousand Oaks, CA: Sage. (cited in Charmaz, (2006), p.60, op cit).
- Suddaby, R. (2006). From the editors: What grounded Theory is not. *Academy of Management Journal*, 49, 633-642.
- Suh, E.M. (2002). Culture, Identity Consistency, and Subjective Well-Being, *Journal of Personality and Social Psychology*, 83, (6), 1378 – 1391.
- The British Psychological Society. (2006). *Briefing paper 5, Commissioning Clinical Psychology Services for older people, their families and other carers*. The BPS. Leicester.
- The Free Dictionary by Farlex. Available at: <http://www.thefreedictionary.com/equanimity> (Accessed: 03/08/2010)
- Thornicroft, G., Wykes, T., Holloway, F., Johnson, S. & Szmulker, G. (1998) From Efficacy to effectiveness in community mental health services. PRiSM Psychosis study 10. *British Journal of Psychiatry*, 173, 423-427. (cited in Burns & Priebe (2004), p.189, op cit).
- Underwood, M., Satterthwait, L.D. & Bartlett, H. P. (2010). Reflexivity and Minimization of the Impact of Age-Cohort differences between researcher and research participants. *Qualitative Health Research*, 20(11), 1585-1595. Available at: <http://qhr.sagepub.com/content/20/11/1585> (Accessed: 29/12/2010)
- Ward, M.R., Linville, D. C. & Rosen, K. H. (2007). Clients' perceptions of the Therapeutic Process: A Common Factors Approach. *Journal of Couple & Relationship Therapy*, 6(3), 25-42.
- Wenger, G. C. (2003). *Interviewing older people*. In J.A. Holstein & J. F. Gubrium (2003). (Eds). *Inside Interviewing, New Lenses, New Concerns*. (pp.111-130) London: Sage.
- Weiner, J. (2009). *The Therapeutic Relationship: transference, countertransference and the making of meaning*. University Press. Texas.
- Werth Jr, J. L., Kopera-Frye, K., Blevins, D. & Bossick, B. (2003). *The Counselling Psychologist*, vol.31, (6), 789-814.

REFERENCES

- Whiton-Calkins, M. (1915). The self in scientific psychology. *The American Journal of Psychology*, 26(4), 495-524.
- Whiston, S.C. & Campbell, W.L. (2010) Randomized Clinical Trials in Counselling: an Introduction. *Counselling Outcome Research and Evaluation*, 1(1), 8-18. <http://qhr.sagepub.com/content/1/1/8> (Accessed: 29/12/2010)
- Williams, G. (1984). The Genesis of Chronic illness: Narrative Re-construction, *Sociology of Health and Illness*, 6(2), 175 – 200.
- Williams, M. & Penman, D. (2011). *Mindfulness a practical guide to finding peace in a frantic world*. Piatkus. London.
- Willig, C. (2001) *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham. Open University Press.
- Wilson Scott, K. (2004) Relating Categories in Grounded Theory Analysis: Using a Conditional Relationship Guide and Reflective Coding Matrix. *The Qualitative Report*, 9, (1), 113-126. Available online at: <http://www.nova.edu/ssw/QR/QR9-1/wilsonscott.pdf>
- Wilson Scott, K. & Howell, D. (2008) Clarifying Analysis and Interpretation in Grounded Theory: Using a Conditional Relationship Guide and Reflective Coding Matrix. *International Journal of Qualitative Methods*, 7, (2), 1-15. Available online at: www.nova.edu
- Wittink, M.N., Dahlberg, B., Biruk, C. & Barg, F. K. (2008). How older adults combine medical and experiential notions of depression, *Qualitative Health Research*, 18, (9), 1174-1183.
- Woods, B. (2003). What's so different about Older People? *Clinical Psychology and Psychotherapy*, 10, 129-132.
- Wood, R.T. A. & Griffiths, M.D. (2007). A qualitative investigation of problem gambling as an escape-based coping strategy. *Psychology and Psychotherapy: Theory, Research and Practice*, 80, 107-125.
- Woodhead, L. E., Ivan, I. I. & Emery, E. E. (2012).An exploratory study of inducing positive expectancies for psychotherapy. *Aging and mental Health*, 16, 162-166.
- Woodhead, L. E., Ivan, I. I. & Emery, E. E. (2013). Impact of Older Adults' Experience With Psychotherapy on Treatment Engagement. *Clinical Gerontologist*, 36, 260-273.
- World Alzheimer Report (2011). *Executive Summary. The benefits of early diagnosis and intervention*, Alzheimer's Disease International. www.alz.co.uk/worldreport2011
- Yalom, I. (2002). *The Gift of Therapy*. London: Piatkus Books. (cited in Richards (2011), p.59, op cit).

Section C

Professional Practice – Client Study

A Complex Case Study of an Older Adult's Experiences of Insomnia and Depression

Section D

Critical Review

Older Adults and the Therapeutic Alliance

Chapter 6

A Critical Literature Review

Title: Older Adults and the Therapeutic Alliance

Aims: This critical review aims to show that differences exist when developing an alliance with older adults (Knight, 2004).

Objectives: The review will begin with a brief background about the therapy alliance, secondly, there will be a discussion about the interaction between physical illness and psychological health for older adults (Knight, 2004). Thirdly, an overview of the research about the therapy alliance, and lastly the myriad of relational systems connected to the older adult, such as: transference, counter transference and ruptures will be considered (Prasko et al, 2010, Garner, 2003; Safran & Muran, 1996; Knight, 2004).

Rationale: By increasing awareness about how to manage alliance issues in clinical practice it can lead to a meaningful therapy encounter, so that a genuine connection with the older person can fortify the therapeutic relationship (Kivnick and Kavka, 1999).

This review features terms that will be used interchangeably throughout this chapter, such as the therapeutic alliance, and the therapeutic relationship. In addition the term therapist will be utilized to refer to the person who delivers psychological therapy.

The sources for this critical review are taken from databases and resources that include: *PsycInfo*, *PsycARTICLES*, *Psychology and Behavioral Sciences Collection via Ebscohost* (1,485 articles), *Scopus* (1,691 articles), and *Web of Knowledge* (118, 400 articles).

Search terms such as: *therapeutic alliance*, *older adults*, *psychology*, *psychotherapy*, *relationship* and *therapeutic relationship* were used. These databases were chosen because they hold peer reviewed studies that address the topic in question. This critical review features published research over the past 33 years (1980 – 2013) pertaining to the aforementioned terms and age group (65+) to examine how the topic has evolved. Some refining of the sources that relate to psychology and psychotherapy journals, also countries

(*United Kingdom, United States and Canada*) was conducted because they have the largest number of cited articles. The results produced 123 research articles. On further inspection of those studies not all the participants were over 65 (eg: some studies included respondents in their mid-40s or 50s) and some research featured both older and younger (eg: 18 – 70) respondents in their sample. Therefore, the studies which have been selected for discussion will include adults as well as older adults. The critical review begins with a brief background about the topic area.

Background

The therapeutic relationship has its roots within “psychoanalysis” but it is central to and applicable across all models (Fluckiger, 2012, Herzoug et al, 2010; Bordin, 1979, p.253; Batchelor & Horvath, 1999). Research about the therapeutic alliance is a vast well-researched area of psychotherapy and it is considered to be central to the “change process” for all client groups (Bordin, 1979, p.252; Castonguay et al, 2006; Gelso & Carter, 1985; Norcross & Hill, 2004; Owen et al, 2013; Norcross & Hill, 2011).

The therapy relationship is one aspect of the “common factors”, which are the elements of various therapy models that are effectual (Grencavage & Norcross, 1990, p.372; Messer, 2002). Hyer et al (2004) argue that despite the wealth of evidence pertaining to this important topic there is less research about the older adult experience of the therapeutic alliance. Hyer et al (2004) contend that in spite of insufficient studies the therapy alliance has been a consistent part of therapy for elders.

The interaction between physical illness and psychological health

The life events that older adults face bring complexity and co morbidity to the therapeutic work for example “frailty, losses, dependency, fear of death and survivor guilt” can be experienced as an attack on the older adult’s sense of identity (Hyer et al, 2004, p.280). Andrew, Fisk and Rockwood (2012, p.1351) conducted a correlation study about the impact of “frailty” on the older person. They found an interesting phenomenon where older adults experience “a frailty identity crisis” (Fillit & Butler, 2009, p.351) that impacts on their psychological health because the emotional and physical health changes are experienced as a catastrophe (p.1347).

“Frailty” is a broad term that encompasses a number of problems that can impact on older adults to restrict their mobility and ability to function in their usual way (Mhaol’ain et al, 2012, p.1266). In a quantitative study from the Republic of Ireland the link between “frailty, anxiety and depression” was examined (Mhaol’ain et al, 2012, p.1265). Five hundred and sixty five older adult participants were placed in three conditions (pre-frail, frail and robust) where measurements of depression and anxiety were rated (Mhaol’ain, 2012 et al). The results demonstrated that older adults in the “frail” conditions showed increased scores of “anxiety and depression” (Mhaol’ain et al, 2012, p.1271). The authors concluded that “frailty” is a key factor for determining older adults who are likely to worsen psychologically (Mhaol’ain et al, 2012, p.1265). They recommend that older people who present with these issues should be assessed as their results suggest that their mental well-being could be compromised (Mhaol’ain et al, 2012, p.1271).

Mhaol’ain et al (2012, p.1272) posit that although this area is under researched they recognise that due to the study’s “cross-sectional” method they can only state what was observed

because of the poor research design that restricts generalizability. However, this study's strength is that it does highlight an important area that draws attention to the needs of older people and the preventative measures, such as the use of psychological therapy to ameliorate their mental well-being. There is the potential that in therapy the development of the alliance can renew and bring harmony to the older person's inner world which would be of immense value to them (Newton et al, 1986). Fillit and Butler (2009, p.351) suggest that the therapeutic relationship can help older people who experience "frailty" to feel heard and understood which can lead to more helpful ways for them to adjust.

Hyer et al (2004) claim that the alliance has a powerful influence when working with the older adults. Therefore, understanding the reciprocal "emotional engagement" between the therapist and client and its applicability in the therapy environment is important (Sexton et al, 1996, p.471). Older adults who experience engagement within the therapy relationship during the early sessions gain relief from their presenting problems (Hyer et al, 2004). The relationship develops from a position of mutual understanding (Safran & Muran, 2000) and generates a momentum within the work that has been described as possessing distinctive aspects (Samstag, 2002). These facets capture that sense of the individual (Duncan, 2002) within the therapy relationship which is especially important for the psychology of the older adult; in light of the impact of the life changes that they experience.

OVERVIEW

Theoretical perspectives about the alliance

Studies have examined the therapy relationship to understand how the alliance functions within approaches such as cognitive behavioural therapy [CBT] (Castonquay, Constantino & Holtforth, 2006), family therapy (Ward et al, 2007), psychodynamic therapy (Nuetzel, Larsen, Prizmic, 2007), couple therapy (Knoblch-Fedders, Pinsof & Mann, 2004) and a variety of clinical presentations, client groups and contexts (Kivnick & Kavka, 1999).

Bordin (1979, p.253) explained that the alliance incorporates a triple element that includes “...an agreement on goals, an assignment of task...and the development of bonds”. These aspects focus on the reciprocal action that happens in the therapy relationship (Marmar et al 1986; Hill, 2004). The ‘working alliance inventory’ (Horvath & Greenberg, 1989) was developed from Bordin’s (1979, p.254) framework of how the therapy relationship develops and includes components such as “liking and trust”. Bordin (1979, p.254) posits that if the work is to go beyond the defended layers of the client’s internal world extended “bonds of trust and attachment” are necessary.

Research has explored the impact of the relationship from differing theoretical perspectives to gain a deeper understanding about aspects that influence the alliance, and how that relates to outcome (Hill, 1994, Gaston et al, 1998). Some studies are quite clearly defined by the client group, type of model, and presenting problem (Kivnick & Kavka, 1999) because the focus is on outcome rather than process (Llewelyn and Hardy, 2001). Imel et al (2013, p.154) argue that there is a move to unravel the link between the “alliance and outcome”.

A comparative research design was used by Gaston et al (1998) with one hundred and twenty older adults (60+) who experienced depression. The aim was to examine the therapy relationship using different models (brief dynamic therapy, behavioural therapy and cognitive therapy), there was also a group where the intervention was deferred. The researchers were interested in whether the therapy relationship would be linked to the type of intervention and if the results of therapy would produce improvements for the participants. Psychologists delivered 16 – 20 individual sessions and questionnaires were used at regular intervals to measure the progress (Gaston et al, 1998).

The findings showed that an enhanced therapy relationship was demonstrated in the brief dynamic and cognitive groups (Gaston et al, 1998). Gaston et al (1998) argue that this was due to how those models encourage self-reflection from the client (Gaston et al, 1998) which the older adults benefitted from. In the behavioural group, Gaston et al (1998) found that it was difficult to identify what particular elements influenced the therapy relationship. The findings also showed that the therapy relationship was monitored and it increased during the course of the work; although this was changeable across different stages in therapy (Gaston et al, 1998). A limitation within the results was claimed by Gaston et al (1998) regarding the ratings and how they may have been unfairly prejudiced, because those assessing the data specialised from a “dynamic” perspective (Gaston et al, 1998, p.203).

The authors point to the quality of the results and they also recommend that the study is repeated to gather more robust evidence (Gaston et al, 1998). The strength of the study is that the sample includes older people and its findings suggest benefits from therapy that included self-reflection (Gaston et al, 1998). However, a weakness of this research is that the results are insufficient to draw conclusions about how the therapeutic interventions and the alliance

produce benefits. This is due to the unreliable ratings given by the assessors that have produced questionable results because of the suggestion of “bias” (Gaston et al, 1998, p.203).

However, the question about a link between the therapy model and alliance is continually being asked about this type of research (Ardito & Rabllino, 2011). Gelso and Carter (1985, p.156) suggest that Carl Rogers (1957) has contributed to studies about the development of the therapy relationship by highlighting the “facilitative conditions”. These include the characteristics of “empathy, warmth and acceptance” (Hyer et al, 2004, p.276) which are seen as important for the client to be restored back to health (Batchelor & Horvath, 1999). Furthermore, Gelso (2010, as cited in Hill, 2010, p.589) put forward the idea that studies about the “real relationship”, regarding the “clients’ attachment” in therapy; is another avenue for exploring “a way of being” with the client that can build on the current alliance research.

Measuring the alliance

Research has also explored what therapists bring to the alliance (Batchelor & Horvath, 1999), which relates to “interpersonal influences” to examine how the client views the therapist (LaCrosse, 1980, p.320; Batchelor, 1995; Imel et al, 2013).

Imel et al (2013, p.154) examined whether it would be helpful to assess the therapy relationship with a “patient-alliance measure”. They looked at whether “patient-rated measures” are trustworthy enough to evaluate the therapists’ ability to maintain the therapy relationship (Imel et al, 2013, p.154). This was a quantitative study featuring the discharged caseload of two groups of providers (“93 therapists from independent practice (IP) and 72 therapists from a non-profit clinic (HMO”) who had worked with adults (Imel et al, 2012, p.154). The findings showed that the questionnaire relating to the clients’ views of the

alliance was found to be a dependable measure (Imel et al, 2012). Also the therapists' differences in "alliance scores" was minor which suggests that the participants were prone to develop robust therapy relationships (Imel et al, 2012, p.163).

Therapists who developed an alliance at the beginning of the work were able to sustain that at the end of therapy which indicates their level of competency (Imel et al, 2013). There was also a large difference ("best and worse alliance" scores) in the evaluations from the IP group which could be due to clinicians with increased "variability" in how they practice therapy (eg: either being given the "best and worse alliance" scores) choosing to practice privately (Imel et al, 2013, p.163). This difference in the scores for the IP group matches the author's second hypothesis which stated that the IP group are not as uniform in their clinical practice when contrasted with the therapists from the HMO setting (Imel et al, 2013).

However, the authors acknowledge that the differing evaluations given about the therapists may have been affected by the "complexity" of the cases that the therapist had seen (Imel et al, 2013, p.163). This is an "unmeasured bias", which could arguably be considered to be a weakness of the analysis (Imel et al, 2013, p.163). Another weakness was the data collection methods where the cases used in the study are drawn from a depositary of closed files. It is also claimed that due to the amount of participants (total $n=4471$) in the study the results are "generalizable" to clinical therapeutic practice (Imel et al, 2013, p.163). Imel et al (2013) explain that the shortcoming was because they had no influence in how the data was gathered. Thus, despite the large number of participants the bias mentioned by Imel et al (2013) does introduce a deficiency that impacts on the quality of the results. Further research could expand on the reason for the development and maintenance of a strong therapy alliance.

Client and therapist factors

Imel et al (2013, p.155) pointed to “gender, age and the client history” for being factors that can impact on the complexity within the therapy work. There are various ways that the alliance can be assessed and the evidence suggests that the client’s evaluation of the therapeutic relationship is an effective forecast about the results of therapy (Horvath & Symonds, 1991).

Research about characteristics of the therapist and client, in addition to the role these aspects have in the therapy alliance during the initial appointments was explored by Rosen et al (2012). Some research studies describe the process of therapy as a “phasic process” (Eames & Roth, 2000, p.421) and Sexton et al (1996) argues that the first appointment is where the therapist and client begin to build an alliance. Moreover, Gaston et al (1998) suggests that the alliance does vary at different stages in therapy.

In Rosen et al’s (2012) mixed methods approach they investigated whether the characteristics of the therapists and client would affect the congruence within the relationship at the beginning of therapy. It was argued by the researchers that measurements of “social identity” such as “race”, gender and “age” are important elements that interplay with the alliance (Rosen et al, 2012, p.185). The participants (over 18) and clinicians were from different racial backgrounds (“black, white & Latino”) and they studied the quality of the alliance from “114 videotaped” first therapy appointments (Rosen et al, 2012, p.185). The analysis of the data was determined by collecting quantitative and qualitative information in the same period. Also the qualitative method was used to examine disparities in the session (Rosen et al, 2012).

The findings demonstrated that “race”, gender and “age” (Rosen et al, 2012, p.193) are important in the initial session. Unfortunately, the authors do not specify clearly the reasons

for this interpretation, for instance, they contend the elements (“ethnic matching”) measured are “significant”, then they stipulate that the result has “partial support” (Rosen et al, 2012, p.193) which is inconclusive. The results also showed that when there is homogeneity in the age of both parties the relationship was more effective (Rosen et al, 2012, p.193). The authors conclude that by addressing the needs of the therapy relationship from the beginning of the encounter it will lead to harmony within the interaction (Rosen et al, 2012).

A weakness of this study is that there was insufficient detail in some of the findings, for example the authors could not say decisively what the similarity in age signifies that made the relationship more effective. However, they do speculate upon cohort factors that helped both parties to feel they had a similar perspective (Rosen et al, 2012). For example the client and therapist may have experienced being part of historical and “cultural” events that influenced the “generation” (Rosen et al, 2012, p.193) where they are both located; that influence what they had in common. Rosen et al (2012, p.194) contend that one explanation of the limits within their study are related to the methods used which lacked “randomization” which prevents them from drawing conclusions. The authors acknowledge the difficulty in putting forward what constitutes a congruent relationship, especially when the person’s unique approach and diversity play a part in their subjective position of what that means (Rosen et al, 2012).

Interestingly, often younger therapists (Knight, 2004) work with older adults and this can raise conflicting feelings within the client and therapist about how they negotiate a shared understanding of each other when the generational divide is often so wide. However, the supposition from Rosen et al (2012) that age is an aspect that influences the alliance is useful for the younger therapist when attempting to build a strong relationship. The younger therapist can adapt the way they work with older adults, so that there is an understanding of

the older adults' "unique history", which can be a helpful way to strengthen the connection (Lazarus & DeLongis, 1983, p.245).

A similar study to Rosen et al (2012) carried out by Taber et al (2011, p.379) used a "correlation" study about "personality congruence" (p.378) with 32 pairs of "clients and therapists" (p.377). The objective was to assess whether there would be an association with a positive therapeutic relationship. Their findings showed that the participants developed a connection with the therapist in the initial therapy sessions (Taber et al, 2011). They concluded that compatibility in character does have a function in the therapy relationship because it allows the person to experience being heard and understood by the therapist (Taber et al, 2011).

The authors have indicated that more research in this area could be beneficial and they have identified a number of weaknesses in their study (Taber et al, 2011). Taber et al (2011) are cautious about the interpretation of these results because it is a "correlational" study and therefore they cannot prognosticate beyond these findings (Taber et al, 2011, p.379). Also the therapists were trainees and so Taber et al (2011) indicate their uncertainty about whether the results are confounded. For example Taber et al (2011, p.380) acknowledge that being in training still demonstrates that the "trainee counsellors" can build a connection (Mallinckrodt & Nelson, 1991) with the client, however their ability to attend to "goals and tasks" may have been compromised because they do not possess all the competencies as yet (Taber et al, 2011, p.380). Taber et al (2011) recommend further research to recruit more participants using a purposive sample of qualified clinicians. Although they are tentative about their results the client and therapist factors are a fruitful area for further study (Taber et al, 2011).

Some of the studies (Rosen et al, 2012; Taber et al, 2011) featured thus far have explored particular characteristics about the person and how particular qualities can influence the alliance which is an aspect of the “common factors” reviewed by Grencavage and Norcross (1990, p.372) as very pertinent. One of the elements from their review is a sense of “expectancy and hope” to get better (Grencavage & Norcross, 1990, p.374) that the client experiences from the relationship. This aspect is congruent with one of the therapist factors to “cultivate hope” and the anticipations of the client (Grencavage & Norcross, 1990, p.374) which suggests that harmony is needed in the alliance to meet that objective. Hope is important when working with older adults as often they can experience a sense of “powerlessness” (Snyder, Michael & Cheavens, 1999, p.182) from the challenges they are trying to cope with. Within the therapy relationship adopting a sense of “care” for the older adult (Hyer et al, 2004, p.277) is also essential because it encapsulates and models that sense of “hope” they need to achieve their intentions (Snyder, Michael & Cheavens, 1999, p.182).

Defining the components within the alliance

The body of research about the alliance and what components are most influential is extensive. A review of studies about the specific conditions that need to be present for therapy to progress well showed that “collaboration” is a principal feature within the alliance (Norcross & Hill, 2004, p.19). Hatcher and Barends (1996, p.1331) concur that only one aspect of the alliance, namely “confident collaboration” is significant because it shows how much the client perceives they will improve. “Confident collaboration” is at the heart of the therapy work that the client and therapist are engaged in and this element is about how much the client is “confident and committed” to the therapeutic work (Hatcher and Barends, 1996, p.1331). It also encapsulates the clients’ view of the work as being “purposeful” which helps

the person remain dedicated and hold onto the belief of a “positive” outcome (Hatcher and Barends, 1996, p.1332).

Andrusyna et al (2001) disagrees with the idea that one factor defines the alliance. In their study they examined the sensitivity of the instruments that assess qualities within the therapy relationship using a CBT model and the “working alliance inventory” (Horvath & Greenberg, 1989, p.223). Andrusyna et al (2001) set out to evaluate Bordin’s (1979) framework to see if it described what is meant by the therapy relationship in CBT (Andrusyna et al, 2001). Using quantitative methods they examined the audio video tapes of 94 depressed adults who received CBT (Andrusyna et al, 2001) in the second appointment. Only one session was selected to reduce the likelihood of the results from therapy confounding the assessment of the relationship (Andrusyna et al, 2001). Independent observers listened to the tapes then rated them without any identifiable information on the tapes (Andrusyna et al, 2001).

Their findings suggested that the therapy relationship element of the alliance was separate from the “goals and tasks” (Andrusyna et al, 2001, p.173) strands that are shown in Bordin’s (1979) approach. Andrusyna et al (2001, p.173) claim that the findings suggest that the instruments assessing the alliance should assess these variables differently. The authors’(Andrusyna et al, 2001) reasoned that Bordin’s (1979) framework indicates that the three facets are connected as opposed to a single constituent (Andrusyna et al, 2001). They argue that the interpretation of these findings demonstrate that one set of elements [“goal, task and confidence bond”] should be examined aside from the “relationship” aspect (Andrusyna et al, 2001, p.177). This suggestion is because the latter assesses “interpersonal” issues (Andrusyna et al, 2001, p.177).

The main shortcoming of this study are the methodological limits due to the way the data was collected. Andrusyna et al (2001) acknowledge that only being able to hear what was happening in the session would have omitted other ways of seeing how the therapist and client would have interacted. Also they used a brief scale ("*Working Alliance Inventory shortened, observer-rated version*") to assess the qualities of the therapy relationship, thus providing insufficient details about particular aspects of the alliance because of the poor data collection method (Andrusyna et al, 2001, p.173). This would thereby render the findings less accurate (Andrusyna et al, 2001).

There is an underestimation by Andrusyna et al (2001) of the significance of the therapy relationship element within Bordin's (1979) model and how it functions together with the other two strands. Andrusyna et al (2001, p.177) have neglected to consider how necessary the emotions and other factors that are embedded within the therapeutic relationship drive the "goals and tasks". Without that genuine emotional connection that takes place between the client and therapist the therapeutic work will not progress. The therapy alliance has been depicted as "the ordinarily good relationship" that is needed if both parties are to agree a plan of action (Brown & Pedder, 1991, p.54). Moreover, Brown and Pedder (1991) indicate the complex emotional, psychological and physical undertaking that happens when collaborating. Andrusyna et al (2001) do recommend that reproduction of their study should include an extended questionnaire about the alliance which is a helpful suggestion. There is also some recognition by Andrusyna et al (2001) that exploring the alliance is more intricate than they had presumed.

The research into the alliance demonstrates that the subject matter is constantly evolving and generates many questions about the qualities that help the client and therapist to connect. Although some of the American studies (Gaston et al, 1998; Taber et al, 2011; Rosen et al,

2012; Andrusyna et al, 2001, Imel et al, 2013) evaluated in this review show some methodological weaknesses the various subjects they researched would benefit from further study.

Taber et al's (2011, p.378) interest in "personality congruence" is similar to Rosen et al's (2012) in as much as it examines the "identity" characteristics of the individual and how that relates to the therapy relationship (Taber et al, 2011, p.376) . Andrusyna et al's (2001) reconsideration of the instrument to assess elements in the alliance seemed to produce more queries than answers. All studies tend to have some limitations and perhaps that is how progress in the research community develops. Unfortunately, these studies demonstrate that the main challenge was the poor data collection methods that suggest the evidence is questionable.

Thus, there is a paucity of research specifically on older adults and the alliance moreover it would be necessary to conduct studies with the elderly in order to draw more evidence based conclusions. However, anecdotal evidence from clinical practice suggests that for older adults the initial engagement is important for the alliance to build and also congruence can aid good communication. In addition to the characteristics of the therapist and older adult which can also be influential.

In the next part of this review there will be a discussion about the many considerations that beset the therapist and older adult in clinical practice, which need to be negotiated in order for the alliance to develop.

The Myriad of Relational Systems

The older adult can be located within many different systems and depending on their particular circumstances the interactions within health, social care, family systems, community systems and friendship networks can give rise to complex emotions. Transference has been described as “*the redirection of feelings from the client to therapist*” and “*countertransference are the feelings from the therapist*” towards the client (Prasko et al, 2010, p.189). These experiences take place because the client and therapist notice external and internal issues within their lived experience that remind them about an event in their past (Prasko et al, 2010). These subjective recollections resonate with the person bringing about comparable responses that occurred in the past (Goin, 2005, Prasko et al, 2010, p.189). Knight (2004) argues that with older adults the therapist should be aware that “transference” (p.69) can emanate from differing parts of the older person’s lived experience. Garner (2003) suggests that if these issues are not managed it can interfere with the therapy work.

Transference

There are times when the same “relationship script” the older adult may have used with others in their life takes place within therapy and in their everyday life (Knight, 2004, p.69). When the therapist behaves in the same way the client experienced in the past, nothing new is learnt (Knight, 2004).

The older adult client can associate the therapist with another significant relationship namely, the “child, grandchild, parent, spouse or a social authority figure” (Knight, 2004, p.70). Whomever the therapist represents for the client there is an opportunity to “interpret the transference” (Knight, 2004, p.71). For example, Knight (2004, p.72) suggests that in therapy “grandchildren” can hold a perfect position within the client’s mind or may be; in contrast the

“grandchild” may represent a “negative transference” where the older adult client may feel on the periphery of the family system and alone. Trying to make sense of how the client perceives what is being triggered within; by talking it through can strengthen the therapeutic bond (Knight, 2004) and move therapy forward.

Countertransference

The prominent theorist Charles Gelso (as cited in Hill, 2010, p.589) a central figure within the research on the therapeutic relationship explained in an interview with Hill (2010, p.589) that “counter transference” could be viewed as “the enemy or ally”. Countertransference can impact on the quality of the relationship, where the conversations within therapy give rise to particular feelings within the therapist. Biggs (1989, p.43) argues that “resistance” to working therapeutically with older adults is connected to the therapist’s own gloomy attitudes (Knight, 2004) about the work not being beneficial for the person because they are older. The reality for the therapist and society in general is that the particular life experiences that older adults encompass such as “illness and disability” and the loss of close relationships might feel quite challenging for some therapists to manage routinely (Knight, 2004, p.68).

Biggs (1989) and Knight (2004, p.68) both address the patterns of expectations when “younger therapists” are challenged by the issues that the older adult client may bring; as they may not have expected to have to manage such issues at that point in their own stage of life (Knight, 2004). Moreover, it can be the case that some therapists may feel conflicted because they are facing similar experiences in their personal lives. For instance there may be a relative that has received a diagnosis of dementia, or who maybe depressed and working with a client with those presentations might create boundary issues. During the course of supervision and using self-reflection can be a useful support at those times (Constonguay et al, 2006).

Working with older adults the therapist begins to learn about how life was for the older person many generations ago (Knight, 2004). For therapists this experience brings into sharp focus the limitations in living and where they could be if they were on a similar life trajectory; which can bring insight but also some unease (Knight, 2004).

In a review of the therapists' stance regarding working with older adults Woolfe (1998) highlights a number of areas around why some therapists feel "resistance" (p.142). For instance (Woolfe, 1998) "fear of dependency" (p.143) and "anxiety about death" (p.144) can arise when thinking about delivering therapy to older people. Woolfe (1998) described that these issues are connected to beliefs where the therapist may view the work with older adults as not worth investing in because the problem they present with is viewed as unalterable (Kapur & Pearce, 1987). Gelso argues (as cited in Hill, 2010) that if the therapist is self-aware and in touch with their internal issues then the countertransference can help the therapist make sense of the person in useful ways (Hill, 2010, p.589).

A UK study by Atkins and Lowenthal (2004) also discovered fears and countertransference issues in the therapists who participated in their qualitative research about how they experience delivering therapy to elders. The authors used a "heuristic method" to understand the participants' experience (qualified therapists - "6 females & 1 male, aged 45 to 72"), using unstructured interviews to explore the therapists' sense of the work (Atkins & Lowenthal, 2004, p.496).

The findings suggested that the therapists' experiences raised a number of personal and professional questions, feelings and thoughts about working with older people. For example: *"perceptions of old age and ageism; boundaries and settings; changes to practice; culture and experiences; awareness of time; loss; decline and mortality; and parents and children"*

(Atkins & Lowenthal, 2004, p.493). Atkins and Lowenthal's (2004) findings indicate that the participants thought deeply about the older adult clients and how the challenges they face effect their lives.

The participants were also mindful of managing their own "anxiety and fears" regarding "ageing and loss" through a reflective process that allowed them to be more cognizant of the intrapersonal issues that arose (Atkins and Lowenthal, 2004, p.508). The participants' expressed their sense of loss and fears through an awareness of the proximity either to that of the older adults' story or the fear it brought up within them as they drew parallels with their clients (Atkins & Lowenthal's, 2004). Working with older adults' raised different concerns and emotions that created some anxiety and fear as the participants reflected on themselves or ageing relatives.

The participants also contemplated on loss issues that impacted on the older person (Atkins & Lowenthal's, 2004).

For instance (a quote from a participant): *"When you are older it is a reality and their contemporaries are beginning to die and that can involve perhaps a parent and with these large families a couple of their brothers or sisters and I think that's an awful lot of loss for people in 6 years and 'What's that like?' Whatever age, whatever the reasons for death, what that feels like and what it means to them. Loss is in the foreground, present"* (Atkins & Lowenthal, 2004, p.502).

Additionally, Atkins and Lowenthal (2004) found that the participants' stance of being accepting of the older adults' individual qualities was another way for the participants to adjust to the challenges faced when working with older adults. Moreover, being flexible, adapting the therapy work, being open to experience and letting go of unhelpful frames of reference that serve to confine the older adult within a rigid, negative, ageist, structure was also incorporated by the participants (Atkins & Lowenthal, 2004).

Atkins and Lowenthal (2004, p.508) produced an interesting study and they claim that the aim of the study was not to create a theoretical framework of therapy with elders; instead they

wanted to increase “awareness”. This is a qualitative study and the results are specific to the participants and demonstrate their subjective experience of working with older adults. Atkins and Lowenthal (2004) also acknowledge their background in the field of psychology and this would have contributed to how much reflexivity played a part in their study. However, being “reflexive” is important when examining the position of the researcher (Atkins and Lowenthal’s, 2004, p.508). Reflexivity is a vital area within qualitative research and it shows good practice when the researcher can reflect on how they managed the process (Kaskett, 2012).

Ruptures in the therapeutic relationship

Safran et al (1990, p.154) discussed the impact when blocks in therapy that are due to “alliance ruptures” shifts the condition of the therapy relationship and how that can interrupt progress. Obstacles to maintaining that alliance are often threatened when a breach contributes to a diminished therapeutic alliance (Safran & Muran, 1996).

Managing “ruptures” (Safran & Muran, 1996, p.447) by talking with the older adult client is a helpful way to work with those barriers. Therapists who experience these issues in the therapy context are advised to use reflexive and reflective practices (Constonguay et al, 2006). Safran et al (1990) and other researchers suggest that utilizing “meta-communication” (p.159) when “rupture markers” (p.157) are indicated. Having that conversation about what is taking place heals the breach and reintroduces the harmony when the issue is worked through (Safran et al, 1990).

Thus, there are many gains from understanding how the alliance is experienced by the older adult client and therapist; also ensuring that therapist’s work towards keeping that “positive

bond” within the relationship can contribute to a robust therapy interaction (Castonguay et al, 2006, p.272).

Conclusion

The research presented in this critical review suggests that there are many aspects to investigate in order to comprehend the therapeutic alliance and the impact on clinical practice. The review demonstrated that there is a plethora of different studies exploring aspects of the “common factors” (Grencavage & Norcross, 1990, p.372), combinations within these elements and how this relates to specific diagnosis, client groups, therapy approach, client/therapist characteristics and stage of therapy (Sexton et al, 1996; Rosen et al, 2012).

There appears to be less research on the process involved in building and sustaining the alliance relationship with the older person that could have practical applicability in therapy (Hyer et al, 2004; Kivnick & Kavka, 1999). When research has a narrow focus it tends to omit the detail that is required for the results to be useful within the therapy encounter (Llewellyn & Hardy, 2001).

A number of the studies featured in this review had methodological problems that suggest the findings are questionable (Gaston et al, 1998; Taber et al, 2011; Rosen et al, 2012; Andrusyna et al, 2001, Imel et al, 2013). However, those same studies do acknowledge the limitations of the conclusions that can be drawn; they also make helpful suggestions for future research which can only build the knowledge base about the therapy alliance further. As a consequence it has been highlighted that more responsive measures are needed to capture what is taking place in the therapy relationship so that accurate evaluations can be made (Andrusyna et al, 2001).

Castonguay, Constantino and Holtforth (2006) suggest that therapists should incorporate alliance questionnaires routinely in their clinical work so that the calibre of the relationship can be assessed. Even though the client and therapists appraisal of the relationship can be based on different elements (Rosen et al, 2012; Horvath & Bedi, 2002); therapists prefer to evaluate the alliance themselves based on their clinical experience of knowing their clients (Castonguay, Constantino and Holtforth, 2006).

Another aspect is the benefit of qualitative studies (Atkins & Loewenthal, 2004) that highlight how the process of therapy with an older adult is experienced by the therapist using reflective and reflexive skills; moreover, studying the clinical work in this way “sensitizes” the therapist to the needs of the client (Elliott and James, 1989, p.461).

Research demonstrates that building the alliance happens from the first meeting, which has clinical implications for the way therapists and clients engage (Horvath & Bedi, 2002; Sexton et al, 1996). Establishing the therapy alliance should be about adjusting therapy to the needs of the individual (Norcross & Wampold, 2011). Adapting therapy for older adults becomes more central to the work because of “cognitive slowing” (Hyer et al, 2004, p.278) which can interfere with how some older adults engage with the therapy work.

Invariably the therapist and client are working with the complexity of the person’s lived experience, that means that the therapist needs to take the position “to be with” the client (Garner, 2003, p.540). Knox and Cooper (2011) suggest that although the therapeutic journey can be variable, there will be instances of “connectedness” (p.63) which demonstrates “relational depth” (p.64). In the therapeutic environment both parties are responding to what is provoked in the other, which can create process issues such as “transference and counter transference” (Prasko et al, 2010, p.189; Knight, 2004). Working with those incongruities in

the relationship helps to manage “alliance ruptures” and strengthen the relationship (Safran et al, 1996, p.447).

The therapy relationship with an older adult needs additional reciprocity when compared to other client groups (Molinari, 1996). The reasons for this relate to the age of the therapist and the importance of fully comprehending the cultural background the older adult is located within (Molinari, 1996). The relationship that emerges when the older adult and the therapist rely on one another in this way, is one of sharing and interdependence (Molinari, 1996) that is beneficial to both client and therapist.

Thus, the awareness by therapists about what can alter the alliance with the older adult is of significance. The therapy alliance is important for a genuine connection to be made and this requires flexible working with the older adult so that therapy can be experienced as beneficial to their psychological well-being (Fillit & Butler, 2009).

REFERENCES

- Andrusyna, P. T., Tang, T. Z., DeRubeis, R. J. & Luborsky, L. (2001). The Factor Structure of the Working Alliance Inventory in Cognitive-Behavioral Therapy. *The Journal of psychotherapy Practice and Research*, 10, 173-178.
- Andrew, M. K., Fisk, J. D. & Rockwood, K. (2012). Psychological well-being in relation to frailty: a frailty identity crisis? *International Psychogeriatrics*, 24(8), 1347-1353.
- Ardito, R. B. & Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: historical excursus, measurements, and prospects for research. *Frontiers in Psychology*, 2(270), 1-11.
- Atkins, D. & Lowenthal, D. (2004). The lived experience of psychotherapists working with older clients: An heuristic study, *British Journal of Guidance and Counselling*, 32(4), 493-509.
- Batchelor, A. (1995). Clients' Perception of the Therapeutic Alliance: A Qualitative Analysis. *Journal of Counseling Psychology*, 42(3), 323-337.
- Bachelor, A. Horvath, A. (1999). *The Therapeutic Relationship. In The heart and soul of change: What works in therapy.* Hubble, Mark A. (Ed.); Duncan, Barry L. (Ed.); Miller, Scott D. (Ed.); Washington, DC, US: American Psychological Association, pp. 133-178.
- Biggs, S. (1989). Professional Helpers and Resistances to work with Older People. *Ageing and Society*, 9(1), 43-60.
- Bordin, E. S. (1979). The Generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice*, 16(3), 252-260.
- Brown, D. & Pedder, J. (1991). *Introduction to Psychotherapy: An Outline of Psychodynamic Principles and Practice.* (2nd Ed.). Routledge. London.
- Butler, R. (1975). *Why survive? Being old in America.* New York: Harper & Row. (cited in Perkins & Tice, (1994), p.443, op cit).
- Castonguay, L. G., Constantino, M.J. (2006). The Working Alliance: where are we and where should we go? *Psychotherapy: Theory, Research, Practice, Training*, 43(3), 271-279.
- Duncan, B. L. (2002). The legacy of Saul Rosenzweig: The Profundity of the Dodo Bird. *Journal of Psychotherapy Integration*, 12, 32-57.
- Eames, V. & Roth, A. (2000). Patient attachment orientation and the early working alliance – a study of patient and therapist reports of alliance quality and ruptures. *Psychotherapy Research*, 10(4), 421-434.
- Fillitt, H. & Butler, R. (2009). The Frailty Identity Crisis. *Journal of American Geriatrics*, 57, 348-352.
- Garner, J. (2003). Psychotherapies and older adults. *Australian and New Zealand Journal of Psychiatry*, 37, 537-548
- Gaston, L., Thompson, L., Gallagher, D., Cournoyer, L. G. & Gagnon, R. (1998). Alliance, Technique, and their Interactions in Predicting outcome of Behavioral, Cognitive, and Brief Dynamic Therapy. *Psychotherapy Research*, 8(2), 190-209.

REFERENCES

- Gelso, C.J. & Carter, J.A. (1985). The Relationship in Counseling and Psychotherapy: Components, Consequence, and Theoretical Antecedents. *The Counseling Psychologist*, 13(2), 155-243.
- Grencavage, L. M. & Norcross, J.C. (1990). Where are the commonalties among the therapeutic common factors? *Professional Psychology: Research and Practice*, 21(5), 372-378.
- Fluckiger, C., Wampold, B. E., Del Re, A. C., Symonds, D. & Horvath, A. O. (2012). How Central Is the Alliance in Psychotherapy? A Multilevel Longitudinal Meta-Analysis. *Journal of Counseling Psychology*, 59(1), 10-17.
- Hatcher, R.L. & Barends, A. W. (1996). Patients' view of the alliance in psychotherapy: Exploratory factor analysis of three alliance measures. *Journal of Consulting and Clinical Psychology*, 64(6), 1326-1336.
- Herzoug, A. G., Hoglend, P., Havik, O.E. & Monsen, J. T. (2010). Development of working alliance over the course of psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 83, 145-159.
- Hill, C. (1994). What is the Therapeutic Relationship? A Reaction to Sexton and Whiston. *The Counseling Psychologist*, 22(1), 90-97.
- Hill, C. (2010). Charles Gelso: The "Real" Person. *The Counseling Psychologist*, 38(4), 567-599.
- Horvath, A. O. and Bedi, R. P. (2002). "The alliance" in *Psychotherapy Relationships that work: Therapist contributions and Responsiveness to Patients*. In (ed.). [pp.37-69] J. C. Norcross (New York: Oxford University Press.
- Horvath, A. O. & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal Counseling Psychology*, 36, 223-233.
- Horvath, A. O. & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: a meta analysis. *Journal Counseling Psychology*, 38, 139-149.
- Hyer, L., Kramer, D. & Sohnle, S. (2004). CBT with older people: alterations and the value of the therapeutic alliance. *Psychotherapy, Theory, Research Practice, Training*, 41(3)276-291.
- Imel, Z. E., Hubbard, R.A., Rutter, C.M. & Simon, G. (2013). Patient-Rated Alliance as a Measure of Therapist Performance in Two Clinical Settings. *Journal of Consulting and Clinical Psychology*, 81(1), 154-165.
- Kapur, R. & Pearce, M. (1987). Group psychotherapy with the elderly, *British Journal of Psychotherapy*, 3, (4), 289-296. (cited in Woolfe, (1998), p.142, op cit).
- Kasket, E. (2012). The counselling psychologist researcher. *Counselling Psychology Review*, 27(2), 64-73.
- Kivnick, H. Q. & Kavka, A. (1999). *It takes two: Therapeutic Alliance with Older Clients*. In M. Duffy (Eds.), *Handbook of Counseling and psychotherapy with older Adult*. pp. 107-131. New York: Wiley & Sons.
- Knight, B.G. (2004). *Psychotherapy with Older Adults*. (3rd ed.) London: Sage.
- Knobloch-Fedders, L. M., Pinsof, W. M. & Mann, B.J. (2004). *The Formation of the Therapeutic Alliance in Couple Therapy*. *Family Process*, 43(4), 425-442.

REFERENCES

- Knox, R. & Cooper, M. (2011). A state of readiness: An Exploration of the Client's Role in Meeting at Relational Depth. *Journal of Humanistic Psychology*, 51(1), 61-81.
- LaCrosse, M. B. (1980). Perceived Counselor Social Influence and Counseling Outcomes: Validity of the Counselor Rating Form. *Journal of Counseling Psychology*, 27(4), 320-327
- Llewellyn, S. & Hardy, G. (2001). Process Research in understanding and applying Psychological Therapies. *British Journal of Clinical Psychology*, 40, 1 – 20.
- Mallinckrodt, B. & Nelson, M. L. (1991). Counselor Training Level and the Formation of the Psychotherapeutic Working Alliance. *Journal of Counseling Psychology*, 38(2), 133-138.
- Markowitz, J. C. & Weissman, M. M. (2004). Interpersonal psychotherapy: principles and applications. *World Psychiatry*, 3(3), 136-139.
- Marmar, C. R., Weiss, D. S. & Gaston, L. (1989). Toward the validation of the California Therapeutic Alliance Rating System. *A Journal of Consulting and Clinical Psychology*, 1(1), 46-52.
- Messer, S. B. (2002). Let's Face Facts: Common factors are more potent than specific therapy ingredients. *Clinical Psychology: Science and Practice*, 9(1), 21-25.
- Mhaolian, A.M., Wei Fan, C., Ramero-Ortuno, R., Cogan, L., Cunningham, C., Kenny, R. A. & Lawlor, B. (2012). Frailty, depression and anxiety in later life. *International Psychogeriatrics*, 24(8), 1265-1274.
- Molinari, V. (1996). Current *approaches to therapy with elderly clients*. In *The Hatherleigh guide to psychotherapy* (pp.192-213). New York: Haworth Press.
- Morrow, S. L. (2005). Quality and Trustworthiness in Qualitative Research in Counseling Psychology. *Journal of Counselling Psychology*, 52(2), 250-260.
- Norcross, J.C. & Hill, C. (2004). Empirically Supported Therapy Relationships. *The Clinical Psychologist*, 57(3), 19-24.
- Norcross, J.C. & Wampold, B.E. (2011). Evidence-Based Therapy Relationships: *Research conclusions and Clinical Practices*. *Psychotherapy*, 48(1), 98-102.
- Nuetzel, E.J., Larsen, R. J. & Prizmic, Z. (2007). The Dynamics of Empirically Derived Factors in the Therapeutic Relationship. *Journal of the American Psychoanalytic Association*, 55, 1321-1353.
- Owen, J., Reese, R. J., Quirk, K. & Rodolfa, E. (2013). Alliance in action: A new measure of clients' perceptions of therapists'. *Psychotherapy Research*, 23(1), 67-77.
- Prasko, J., Diveky, T., Grambal, A., Kamaradova, D., Mozny, P., Sigmundova, Z., Slepecky, M. & Vyskocilova, J. (2010). Transference and Countertransference in *Cognitive Behavioral Therapy*. *Biomedical Papers of the Medical Faculty*, 154(3). 189-198.
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95-103 (cited in Gelso & Carter (1985), op cit).

REFERENCES

- Rosen, D. C., Miller, A.B., Nakash, O., Halperin, L. & Algeria, M. (2012). Interpersonal Complementarity in the Mental Health Intake: A Mixed-Methods Study. *Journal of Counseling Psychology*, 59(2), 185-196.
- Safran, J. D. & Muran, C. J. (1996). The Resolution of Ruptures in the Therapeutic Alliance. *Journal of Consulting and Clinical Psychology*, 64(3), 447-458.
- Safran, J. D. McMain, S., Crocker, P. & Murray, P. (1990). Therapeutic Alliance Rupture as a therapy event for empirical investigation. *Psychotherapy*, 27(2), 154-164.
- Safran, J. D. & Muran, C. J. (2000). *Negotiating the Therapeutic Alliance: A Relational Treatment Guide*. New York: Guildford Press.
- Samstag, L. W. (2002). The common versus unique factors hypothesis in psychotherapy research: did we misinterpret Rosenzweig? *Journal of Psychotherapy Integration*, 12, 58-66.
- Sexton, H. C., Hembre, K. & Kvarme, G. (1996). The Interaction of the Alliance and Therapy Microprocess: A Sequential Analysis. *Journal of Consulting and Clinical Psychology*, 64(3), 471-480.
- Snyder, C. R. M., Scott T. & Cheavens, J. S. (1999). Hope as a psychotherapeutic foundation of common factors, placebos, and expectancies. In Hubble, Mark A. (Ed); Duncan, Barry L. (Ed); Miller, Scott D. (Ed), (1999). *The heart and soul of change: What works in therapy*, (pp. 179-200). Washington, DC, US: American Psychological Association, xxiv, 462 pp. doi: [10.1037/11132-005](https://doi.org/10.1037/11132-005)
- Taber, B.J., Leibert, T.W. & Agaskar, V. R. (2011). *Psychotherapy*, 48(4), 376-380.
- Ward, M.R., Linville, D.C. & Rosen, K. H. (2007). Clients' Perceptions of the Therapeutic Process: A Common Factors Approach. *Journal of couple & Relationship Therapy*, 6(3), 25-43.
- Woolfe, R. (1998). Therapists' attitudes towards working with older people, *Journal of social work practice*, vol.12, (2), 141-147.

APPENDICES

Appendix 2

Segment from the Second interview transcript [psy 03, line 283 – 310]

R I think knowledge is power and I think what you've done is you've definitely educated yourself about your condition in order to – I don't know – cope with it.

P Yeah.

R That's what it sounds like anyway.

P Yeah, you got a (lift). That I'm not worried about now cause that 6 months was the key thing I didn't know what was happening; now I (never not) know what's happening.

R Now that that's at some distance in your mind...

P ...finish with.

R Yeah. Do you often feel, get a little bit down or low and use the strategies you were taught in psychology...

P ...that's one thing I don't do, go down like I used to, like I did – no way.

R Can you tell me a little bit more about why you're staying on a kind of even keel ...

P ...even keel. I think it's because I know I'm gonna have treatment, I'm not gonna be left and you almost control it, so you don't have to worry about it after that 6 months when I did worry about it. It's because I was left, nothing was being done. That's when a lot of people get (frighten) but you can have this treatment.

R How would you say therapy has helped you make sense of that experience and that difficulty that you had and how is it still helping you now?

P I think it's because you talk to the Doctors that you're under and you can explain things to them and see if you're doing the right, like I say, doing the right thing. Then they reassure you you're (...).

R It's as though you're saying that that guidance through that time...

P ...that period

R ...is really, really important in keeping you and even though you're not formally in therapy at the moment, are you still using that as a way of supporting yourself and telling yourself you're doing the right thing, as a way of supporting yourself.

P Yeah.

R To keep looking forward.

Appendix 3

The research question:

The researcher decided to frame the research question loosely and using prompts as appropriate to allow the participants to speak openly about their experience.

Q: Can you tell me about your experience of therapy, and what was that like for you?

Prompts and themes were also used to guide the interview.

Appendix 6

Coding Table

CORE CATEGORY: MOVING TOWARDS EQUANIMITY

4 Categories and 19 Sub-categories

(v.9) - 1st Sept 2013

<u>CATEGORY</u>	<u>SUB- CATEGORY</u>	<u>DIMENSION</u>	<u>PROPERTY</u>	<u>CODE</u>	<u>QUOTE</u>
<i>Category 1: Sensing continuity and discontinuity within an ageing 'self'</i>	<i>1a) Noticing stability within the 'self' over time</i>	<i>Childhood.....old age</i>	<i>Sense of self</i>	Noticing I'm young in my mind	660 - If I let all the grey come through and everything I'd be an old lady. I'm young in my mind. (psy 02)
		<i>Childhood.....old age</i>	<i>Sense of self</i>	Knowing who I am	60-61: ...married, tell you things, tell you who I am. I know who I am, I don't want nobody to tell me I'm happy, clever or anything I know myself. (psy 15)
		<i>Childhood.....old age</i>	<i>Sense of self</i>	Knowing that's the person I was from a little girl	30-31:- ...don't want to talk to anybody and I talk to everybody. If I saw you down the road I might say nice day a bit cold ain't it, I might not know you at all, but that's the person I was from a little girl; friendly... (psy 02)
		<i>Childhood.....old age</i>	<i>Sense of self</i>	Being intelligent and articulate	235-...intelligent and articulate is kind of one of the three pluses for me and I think that's why hang onto that the way I do. (psy 24)
	<i>1b) Responding to an existential crossroad</i>	<i>Distress...trauma</i>	<i>breach</i>	Bringing tablets to take it away	21-25:... was (...) because of what I've done and because I wanted children. And because I was pregnant they have to bring me something, tablets to take it away, I take them, I don't know. After that really I never been happily, I (pray) myself why I listen to him and I shouldn't of marry. But didn't have any choice years back it's (...) now. I've never been happy all my life, you know, things just really (...) from that it's (...)... (psy 15)

<u>CATEGORY</u>	<u>SUB- CATEGORY</u>	<u>DIMENSION</u>	<u>PROPERTY</u>	<u>CODE</u>	<u>QUOTE</u>
Category 1: Sensing continuity and discontinuity within an ageing 'self'	1b) Responding to an existential crossroad	<i>Distress...trauma</i>	<i>breach</i>	Finding it got hold of me	430 - Yes, yes, yes, yes. I was annoyed really with myself that it really got a hold of me like that...[context: the depression] (psy 20)
		<i>Distress...trauma</i>	<i>breach</i>	Dying at the wheel	14- ...crashed into a 4x4 and I don't know no more he died at the wheel with a heart attack and xxxx...(psy 44)
		<i>Distress...trauma</i>	<i>breach</i>	Finding me life got disrupted	296 - It could be I mean me life got disrupted didn't it? (psy 44)
		<i>Distress...trauma</i>	<i>breach</i>	Finding I could not hold myself	257-...because I could not hold myself...(psy 25)
	1c) Exploring duality within the 'self'	<i>Rejecting.... Accepting</i>	<i>Anti-thesis</i>	Finding it's very difficult to stand up	60- ...thinking I don't know what to do. It's very difficult to stand up and say actually this is not selfish...(psy 07)
		<i>Rejecting.... Accepting</i>	<i>Anti-thesis</i>	Finding [I'm] not feeling myself to be sufficiently worthwhile	105-...also not feeling myself to be sufficiently worthwhile to say, I'm okay this is nothing to do with me...(psy 07)
		<i>Rejecting.... Accepting</i>	<i>Anti-thesis</i>	Having bits of me that I accept	142-144:... analysis and so on, understanding of it even maybe. But it doesn't, doesn't all that help and as far as accepting myself is concerned well there are bits of me that I accept and think of okay. In theory overall I think I'm I feel myself to be a good human being and for me I think that's important cause I think people should be human beings and I think there is a lot less ...(psy 24)

<u>CATEGORIES</u>	<u>SUB-CATEGORIES</u>	<u>DIMENSIONS</u>	<u>PROPERTIES</u>	<u>CODES</u>	<u>QUOTES</u>
Category 1: Sensing continuity and discontinuity within an ageing 'self'	1c) Exploring duality within the 'self'	<i>Rejecting.... Accepting</i>	<i>Anti-thesis</i>	Covering up	49- ...covering up and I somehow managed to, but that's getting more difficult and so. I mean every so often it's kind of a joke...(psy 24)
		<i>Rejecting.... Accepting</i>	<i>Anti-thesis</i>	Seeing they can't believe there's a weakness in me	7- ...always been so tough they can't believe there's weakness in me, they can't believe me. (psy 02)
	1d) Observing fragmentation within the 'self'	<i>Imbalance... ...Balance</i>	<i>distress</i>	Being scared to pass me front door	28- ...scared to pass me front door, I thought somebody was kept coming in. I kept trying, locking it, trying... (psy 44)
		<i>Imbalance... ...Balance</i>	<i>distress</i>	Knowing your brain is going 24 hours a day	122- I don't suppose even you would know what it's like you know your brain is going 24 hours a day and somehow or the other you have to try and stop that even for a little while and the only way you can stop it is to get to sleep, you can't get to sleep because it's on your brain. (psy 03)
		<i>Imbalance... ...Balance</i>	<i>distress</i>	Feeling coming into me	206- ...suicidal, what you call it, feeling coming into to me. Sometimes I can sit there and say hey.....(psy 25)
		<i>Imbalance... ...Balance</i>	<i>distress</i>	Having a complete breakdown	275-276: Because I spent xx years, I didn't know anything about mental health until I was xx years of age and it was just a complete breakdown that brought me into the mental health. I had one...(psy 25)
		<i>Imbalance... ...Balance</i>	<i>distress</i>	Feeling stress, I'm nearly 72	602 - Stress, I'm nearly 72, I really don't need it I've been through hell the last few years. (psy 02)

<u>CATEGORIES</u>	<u>SUB-CATEGORIES</u>	<u>DIMENSIONS</u>	<u>PROPERTIES</u>	<u>CODES</u>	<u>QUOTES</u>
Category 1: Sensing continuity and discontinuity within an ageing 'self'	1d) Observing fragmentation within the 'self'	<i>Imbalance...</i> <i>...Balance</i>	<i>distress</i>	Taking all those pills	777-781: And honestly that's what killed me and that is that day when I took all those pills – they weren't sleeping pills they were anti-depressants tablets. It was all in my xxxx of my xxx, they were in there and I locked myself in and I took one after the other, after the other. I thought in my mind I want to go to sleep, I want to wake up; it's a bad dream and it's finished. And I took one after the other; I took a load of them they were in the xxxx. (psy 02)
Category 2: Embodying an awareness of an ageing changing ecology	2a) Acknowledging debility & cognitive changes	<i>Mild.....severe</i>	<i>physiological</i>	Finding when you're old I don't heal up easily	412 – [Look] when you're old I don't heal up easily, it gives me needles and it will go down me, yeah. (psy 02)
		<i>Mild.....severe</i>	<i>physiological</i>	Finding I didn't know I was doing it	40-...gets xxxxx strokes you know. I didn't know I was doing it and I left me front door wide open and...(psy 44)
		<i>Mild.....severe</i>	<i>physiological</i>	Forgetting especially at my age	21-22: I don't really know, can't put a finger on its last year now you know which you forget especially at my age. I suppose just there to listen, you know there's not really much I can say. (psy 20)
		<i>Mild.....severe</i>	<i>physiological</i>	Being worried about my memory	29- ...really worried about my memory, short term memory in particular but long term is not so hot either and so I had these...(psy 24)
		<i>Mild.....chronic</i>	<i>management</i>	Taking warfarin	203-204: And I'm on warfarin and I take the warfarin 6 o'clock at night that's those over there (<i>she points to where she keeps them</i>) but I'm on so many pills now you know. (psy 20)

<u>CATEGORIES</u>	<u>SUB-CATEGORIES</u>	<u>DIMENSIONS</u>	<u>PROPERTIES</u>	<u>CODES</u>	<u>QUOTES</u>
<i>Category 2: Embodying an awareness of an ageing changing ecology</i>	<i>2a) Acknowledging debility & cognitive changes</i>	<i>Mild....chronic</i>	<i>management</i>	Having [a] 50:50 chance	182- And she said if you didn't have it, chemo, 50:50 chance it would come back, I said okay...(psy 03)
		<i>Mild....chronic</i>	<i>management</i>	Taking thyroxin, blood pressure, cholesterol	608 – 610: [All I] take is thyroxin, blood pressure, cholesterol. I only just started on cholesterol I've never known it before but I've just started on it and I had a blood test last week and I've got to go and check it, how it is I don't know - God all in one year...(psy 02)
		<i>Mild....chronic</i>	<i>management</i>	Getting arthritis	194-196: Because you get to my age and you think you're going to have a good life (he chuckles) – you get rheumatism, you get arthritis, you get, you get that. I try to (enjoy) myself which I do, I must admit. (psy 03)
	<i>2b) Adjusting expectations about illness & long term conditions</i>	<i>Mild....chronic</i>	<i>management</i>	Expecting to have at my age	761-763: And yet, underactive thyroid what I would expect to have at my age, bit of blood pressure it's acceptable at my age and now I've just found out that I might have a bit of cholesterol (she giggles as she said that). (psy 02)
		<i>Mild....chronic</i>	<i>management</i>	Knowing I'm going to die with that	285-286 - It's just one of those things; you've got to die with something I mean I'm going to die with that. (psy 44)
	<i>2c) Challenging ageist attitudes</i>	<i>Inclusion... ...exclusion</i>	<i>confront</i>	Saying I am an old lady	554-556: ...in the bathroom could I have a shower she said no, I said I'll just wash quickly. I said could you please turn your back on me I said I'm not being funny and I am an old lady and I'm not use to having people around me. (psy 02)

<u>CATEGORIES</u>	<u>SUB-CATEGORIES</u>	<u>DIMENSIONS</u>	<u>PROPERTIES</u>	<u>CODES</u>	<u>QUOTES</u>
<i>Category 2: Embodying an awareness of an ageing changing ecology</i>	<i>2c) Challenging ageist attitudes</i>	<i>Inclusion...</i> <i>...exclusion</i>	<i>confront</i>	Ignoring the older person	553-554: ...anywhere. If you've got a younger person with ya behind that counter will be the person that will go with the younger person and ignore the older person. (psy 25)
		<i>Inclusion...</i> <i>...exclusion</i>	<i>confront</i>	Going where ageism is already	550-551: Ageism, the places that we go is where ageism is already there but when they've seen what we've done they've picked up on it and gone oh, oh, oh course we do that and it's... (psy 25)
		<i>Inclusion...</i> <i>...exclusion</i>	<i>confront</i>	Telling me it was just me age	209-216: Yeah, you see it all started with the Doctor that was the first thing, with prostate cancer you keep wanting to go for a wee, then you've got to go 5 minutes, 10 minutes and nothing's happening and then you're told it's your age and I said okay then. Then we went out to xxxxx then we were all sitting out on the beach and I said na something's wrong I keep wanting to go to the toilet, I said this is wrong and when we came home I went back to see him. He said this (.), I said no you didn't you told me it was just me age, then he starts giving me a letter for the hospital and in the middle of it he told me what I had (...) they can't say the other thing to you and (...) I can't believe it, that was to me a year wasted a complete year. (psy 03)
		<i>Inclusion...</i> <i>...exclusion</i>	<i>confront</i>	Treating me as one of your general xxxxx geriatrics	9- ... was that he was just treating me as one of your general xxxxx geriatrics and I didn't feel as though I came into that category...(psy 24)

<u>CATEGORIES</u>	<u>SUB-CATEGORIES</u>	<u>DIMENSIONS</u>	<u>PROPERTIES</u>	<u>CODES</u>	<u>QUOTES</u>
<i>Category 2: Embodying an awareness of an ageing changing ecology</i>	<i>2d)Caregiving and interacting with support systems</i>	<i>Disempower...empower</i>	<i>Non-sustained</i>	Being left	78-79: Couldn't, what was going on, I think I was left for about 6 months not knowing from a to b and then I had to go to, because I was under two Doctors at xxxxxxxx and then I went to the other...(psy 03)
		<i>Disempower...empower</i>	<i>Non-sustained</i>	Finding my dignity was completely ignored	91-95: Yes, it was a xxxx, it was terrible. No stimuli, the shower door was broken and was left open when I was washing, my dignity was completely ignored. I was forced to get up even though I didn't want to; I was made to go into the lounge without any real comfortable chairs to sit on, nothing to do, just people sitting in their chairs just rocking backwards and forwards. Now that to me was the worst thing you could have done to me, fortunately I was going to transferred to xxxxxxxx to the xxxx (psy 41)
		<i>Disempower...empower</i>	<i>Non-sustained</i>	Finding no one was listening	76-...xxxxx xxxx and I just didn't feel well, but no one was listening, Doctor included. None of them would...(psy 41)
		<i>Disempower...empower</i>	<i>sustainment</i>	Talking to one another	163-167: I've sat and thought everyone in this room as got cancer. So you talk to one another and you know that's how I looked at things, I thought you're not the only one, you think you are and then you walk into a room of say 20 people and so a lot of them were in there with scarves on and all that and you start chatting to them and you feel that you're not the only one there's plenty. (...) (the last word of this sentence was said in a whisper). (psy 03)

<u>CATEGORIES</u>	<u>SUB-CATEGORIES</u>	<u>DIMENSIONS</u>	<u>PROPERTIES</u>	<u>CODES</u>	<u>QUOTES</u>
Category 2: Embodying an awareness of an ageing changing ecology	2d) Caregiving and interacting with support systems	<i>Disempower...</i> <i>....empower</i>	<i>sustainment</i>	Keeping me together	104-105: It kept me together and he was saying you're doing the right thing, but you don't know what you're doing in a sense and I'm thinking I'll go for a walk and I used to go fishing years and years ago. (psy 03)
		<i>Disempower...</i> <i>....empower</i>	<i>sustainment</i>	Having a carer three times a day	52-54: Yeah, but I have a carer three times a day here. It's alright when she's here, it's when she's gone and at the moment I can't get out much and the matron's been getting in touch with (long pause as she tries to remember) Oh God what is it. Is it Age Concern or Help the Aged? (psy 44)
Category 3: Cultivating a therapeutic relationship	3a) Being in conversation with the psychologist	<i>Communication...</i> <i>...no communication</i>	<i>dialogue</i>	Having someone to talk to	15- [It] was someone to talk to and discuss your problems with. (psy 02)
		<i>Communication...</i> <i>...no communication</i>	<i>dialogue</i>	Telling her how I felt	50 - Oh yes, yes in conversation I was telling her how I felt and it just gradually came back. But....(psy 20)
		<i>Communication...</i> <i>...no communication</i>	<i>dialogue</i>	Standing out to me is that you can talk	309 - What stands out to me is that you can talk about it and they can listen to you, because like I say(psy 02)
		<i>Communication...</i> <i>...no communication</i>	<i>dialogue</i>	Expressing some of my concerns and unhappiness	89-...expressing some of my concerns and unhappiness and things. And I found that therapeutic in itself and after quite a long...(psy 24)
		<i>Communication...</i> <i>...no communication</i>	<i>dialogue</i>	Needing company	437-Yes, yes we need company I suppose and that kind of thing. ...(psy 20)
		<i>Communication...</i> <i>...no communication</i>	<i>dialogue</i>	Having that psychologist	246- [But to] have that psychologist come along at that time, so that was good. (psy 25)

<u>CATEGORIES</u>	<u>SUB-CATEGORIES</u>	<u>DIMENSIONS</u>	<u>PROPERTIES</u>	<u>CODES</u>	<u>QUOTES</u>
Category 3: Cultivating a therapeutic relationship	3a) Being in conversation with the psychologist	<i>Communication...</i> <i>...no communication</i>	<i>dialogue</i>	Timing was excellent	248-249: ...timing was excellent because I was very, very negative really negative. I didn't wanna live, I didn't wanna do this, I didn't wanna do, don't talk to me your rubbish. And I was sort of...(psy 25)
	3b) Observing generational barriers to the alliance	<i>restrict...</i> <i>....unrestricted</i>	<i>obstruction</i>	Telling me how to	236-237 He didn't help me, tell me how to, he just told me how to go out and make friends (...) I know everything about this. I have enough experience to know about that. (psy 15)
		<i>restrict...</i> <i>....unrestricted</i>	<i>obstruction</i>	Living for a long time	128-131:Yes, but again just thinking about it now how it formulates itself with me is that what it comes down to is that it's all my fault that I can't be cured and that's a very, it probably goes back to when I was 6 or 7 or 8. So that I think that I have lived for a very long time with a lot of very negative feelings about myself and so in a way not responding to treatment is another stick to beat myself with and there's been lots of those throughout the years.(psy 24)
		<i>restrict...</i> <i>....unrestricted</i>	<i>obstruction</i>	Suffering because I live in that time	120- ...pay the rent (...) in those times were different a long time ago. I am suffering because I live in that time (...) (psy 15)
	3c) Observing typical barriers to the alliance	<i>restrict...</i> <i>....unrestricted</i>	<i>obstruction</i>	Remembering it was quite painful	92 - Yes, yes it was quite painful I never say anything to (...)...(psy 15)
		<i>restrict...</i> <i>....unrestricted</i>	<i>obstruction</i>	Finding I didn't speak to him more free	429-430: Sometimes it was difficult really; I speak to you more freer. I didn't speak to him more free. I.....(psy 15)
		<i>restrict...</i> <i>....unrestricted</i>	<i>obstruction</i>	Bringing up things that [really affect me]	130- Because there's different (roads) to that, I'm not going to start bringing up things that [really affect me]. (psy 25)

<u>CATEGORIES</u>	<u>SUB-CATEGORIES</u>	<u>DIMENSIONS</u>	<u>PROPERTIES</u>	<u>CODES</u>	<u>QUOTES</u>
Category 3: Cultivating a therapeutic relationship	3c) Observing typical barriers to the alliance	<i>restrict...</i> <i>....unrestricted</i>	<i>obstruction</i>	Finding you're not going to meet them straight away	139-140: Yeah it is, you're not going to straight away meet somebody even though they are a psychologist you're not going to meet them straight away and talk like I am now. (psy 25)
	3d) Managing expectations	<i>Trust....no trust</i>	<i>hopes</i>	Thinking this is not going to work for me	313- ...to be right. I think it would be impossible to meet with a psychologist and for you to think this is not going to work for me... (psy 24)
		<i>Trust....no trust</i>	<i>hopes</i>	Feeling I didn't know how he was going to help me	246-247: I don't know how I was going to do it (...) how I was going to do it (...) (heart) you understand that, I didn't know how he was going to help me. ... (psy 15)
		<i>Trust....no trust</i>	<i>hopes</i>	Thinking something is not going to be good	470-Well you know if you think something is not going to be good for you, you just don't do it... (psy 20)
	3e) Experiencing engagement	<i>dis-connecting...</i> <i>...Connecting</i>	<i>authentic</i>	Listening to you	201- Well, if you've got any worries you know that someone is there to listen to you... (psy 03)
		<i>dis-connecting...</i> <i>...Connecting</i>	<i>authentic</i>	Trusting her...I started bringing out, giving more	146- I got to trust her and then I started bringing out, giving more, you know. (psy 25)
		<i>dis-connecting...</i> <i>...Connecting</i>	<i>authentic</i>	Finding the chemistry does need [to be right]...	312- Yes I would think so I mean I think that, but I suppose that obviously this kind of theme the chemistry does need [to be right]... (psy 24)
		<i>dis-connecting...</i> <i>...Connecting</i>	<i>authentic</i>	Letting somebody in that you can trust	220- I feel if you don't let somebody in that you can trust don't have the help, don't let them in. ... (psy 41)
		<i>dis-connecting...</i> <i>...Connecting</i>	<i>authentic</i>	Feeling I could trust her	160- I think it was about the relationship with the psychologist. I felt I could trust her and I... (psy 25)

<u>CATEGORIES</u>	<u>SUB-CATEGORIES</u>	<u>DIMENSIONS</u>	<u>PROPERTIES</u>	<u>CODES</u>	<u>QUOTES</u>
<i>Category 3: Cultivating a therapeutic relationship</i>	<i>3e) Experiencing engagement</i>	<i>dis-connecting...</i> <i>...Connecting</i>	<i>authentic</i>	Pouring everything I felt so comfortable with her	107-108: ...came out, poured everything I felt so comfortable with her (she drank a little water) I was able to pour it all out. ... (psy 41)
		<i>dis-connecting...</i> <i>...Connecting</i>	<i>authentic</i>	Finding it had to come naturally	233-234: ...they will have to find somebody else, but I didn't force myself it had to come naturally, it had to come naturally it did. ... (psy 41)
		<i>dis-connecting...</i> <i>...Connecting</i>	<i>authentic</i>	Saying it's a two way street	318- Oh yes it's a two way street two of you have to play your part, you and the psychologist and..... (psy 41)
		<i>dis-connecting...</i> <i>...Connecting</i>	<i>authentic</i>	Experiencing her persona	163- ...[her] approach to me, her persona. You can tell people by movements. (psy 25)
		<i>dis-connecting...</i> <i>...Connecting</i>	<i>authentic</i>	Having a particularly good persona	226- I don't know; she's got a particularly good persona and you can trust her you know she's not..... (psy 41)
	<i>3f) Incorporating context into the formulation</i>	<i>Agree.....disagree</i>	<i>understanding</i>	Thinking I don't even know what happened	405 - I don't even know what happened, I think it's stress related had a lot to do with it. (psy 02)
<i>Category 3: Cultivating a therapeutic relationship</i>	<i>3f) Incorporating context into the formulation</i>	<i>Agree.....disagree</i>	<i>understanding</i>	Seeing it was really deep depression	15-18: No not really, not when you're children you don't really do you, but I was so so upset. I had sisters with me, xxx sisters with me, younger than me so I felt a bit more responsible for them as well you know. But hmmh over the years you know when I had xxx babies I finished up with post-natal depression. Although I hadn't had many attacks it was really deep depression; yeah the young... (psy 20)

<u>CATEGORIES</u>	<u>SUB-CATEGORIES</u>	<u>DIMENSIONS</u>	<u>PROPERTIES</u>	<u>CODES</u>	<u>QUOTES</u>
<i>Category 3: Cultivating a therapeutic relationship</i>	<i>3f) Incorporating context into the formulation</i>	<i>Agree.....disagree</i>	<i>understanding</i>	Understanding what was happening	202-...going from me mother and me mother's death and all in between there, what was happening.....(psy 25)
		<i>Agree.....disagree</i>	<i>understanding</i>	Being able to explain	112-115: Well I think, I think one of the problems is for a very long time I thought that, I understood a lot of the reasons why I might be depressed and as I say they go back a very long way. But understanding or any way being able to explain why they're there doesn't remove the depression for me. I think I've always been very aware and conscious of what's been going on in my head but the awareness doesn't seem to me to move me forward in anywhere. (psy 24)
		<i>Agree.....disagree</i>	<i>understanding</i>	Recognising what was going on	7-8: Well, I found it helpful because some of the things that she said you know; left me with the impression that yeah it's a possibility of what was going on in my mind at the time. And not...(psy 25)
		<i>Agree.....disagree</i>	<i>understanding</i>	Affecting me different at that time	233-234: ...looking back how upset I was; you know what I mean. It might have affected me different at that time being a child. (psy 20)
		<i>Agree.....disagree</i>	<i>understanding</i>	Having never realised	201- ...it was brilliant, it bought out what I for years have never realised that there was a circle.....(psy 25)
<i>Category 4: Connecting with wholeness and a new perspective</i>	<i>4a) Pacing and adapting therapy</i>	<i>Minimal... ...extensive</i>	<i>Modify</i>	Knowing you're not going to meet them straight away and talk	139-140: Yeah it is, you're not going to straight away meet somebody even though they are a psychologist you're not going to meet them straight away and talk like I am now. ...(psy 25)
		<i>Minimal... ...extensive</i>	<i>Modify</i>	Saying 16 weeks, it's quite a lot	324- Well as I say 16 weeks, it's quite a lot it's not 5, 6 weeks and then being dumped. Because it...(psy 41)

<u>CATEGORIES</u>	<u>SUB-CATEGORIES</u>	<u>DIMENSIONS</u>	<u>PROPERTIES</u>	<u>CODES</u>	<u>QUOTES</u>
Category 4: Connecting with wholeness and a new perspective	4a) Pacing and adapting therapy	<i>Minimal... ...extensive</i>	<i>Modify</i>	Thinking I've got the time	330- Well I thought if going to help I've got the time, I don't have to pour it all out... (psy 41)
		<i>Minimal... ...extensive</i>	<i>Modify</i>	Rephrasing it	343-345: Yes, I felt comfortable that if I didn't quite understand what she was trying to say, I would say xxxxxx I'm sorry I don't quite understand what it is that you are trying to say. She could perhaps rephrase it but in a different way and she would do a lot of diagrams. (psy 41)
		<i>Minimal... ...extensive</i>	<i>Modify</i>	Having diagrams	347-348: Yes, she'd (...) diagrams some (...) the negative and the positive. The negative – hate, neglect, (hurt) emotions, my feelings; the other side was cope, love and trying to balance the two. (psy 41)
	4b) Reminiscing about generational durability and junctures	<i>Generation... ...generation</i>	<i>Cultural history</i>	Going through the war	414-(...) we were all happy and then the war, so we go through the war, he was evacuated then...(psy 03)
		<i>Generation... ...generation</i>	<i>Cultural history</i>	Remembering the 1914 war	448-450: we're a big family (...) my father was in the 1914 war he's the (...) he obviously survived. I had xxx brothers go in the other war, 2 nd world war and xxxx of them came home. (psy 03)
		<i>Generation... ...generation</i>	<i>Cultural history</i>	Living in that time	120- ...pay the rent (...) in those times were different a long time ago. I am suffering because I live in that time (...) (psy 15)
		<i>Generation... ...generation</i>	<i>Cultural history</i>	Finding I never had any medication	51...the first time I had depression after my babies I never had any medication or anything in them days I...(psy 20)
		<i>Generation... ...generation</i>	<i>Cultural history</i>	Being evacuated	10 - ...cause of my depression was when I was evacuated as a child; I was 11 years old which I was at an...(psy 20)

<u>CATEGORIES</u>	<u>SUB-CATEGORIES</u>	<u>DIMENSIONS</u>	<u>PROPERTIES</u>	<u>CODES</u>	<u>QUOTES</u>
Category 4: Connecting with wholeness and a new perspective	4c) Working through the complex layers of a long life	<i>Unprocessed....</i> <i>...Processed</i>	<i>Distress</i>	Being extremely traumatic	141- Very much so, very much. The first couple of times I found extremely traumatic, the first two.....(psy 41)
		<i>Unprocessed....</i> <i>...Processed</i>	<i>Distress</i>	Being buried inside	101- ...buried inside of me, piling up for years and years about all sorts of things but this was something quite different, but it was.....(psy 24)
		<i>Unprocessed....</i> <i>...Processed</i>	<i>Distress</i>	Feeling I never had the childhood	369- ...always felt I never had the childhood other people had and I've always regretted that. I think that...(psy 41)
		<i>Unprocessed....</i> <i>...Processed</i>	<i>Distress</i>	Feeling sad	313- ...she is saying). (...) how he treated me (...) we have a lot of things but something inside me feel sad...(psy 15)
		<i>Unprocessed....</i> <i>...Processed</i>	<i>Distress</i>	Finding [it] difficult to answer	5-6: Well, certainly it was difficult to answer to the psychologist back; I was thinking all the time you know (to ask) but hmm, I'm telling the truth. ...(psy 15)
		<i>Unprocessed....</i> <i>...Processed</i>	<i>Distress</i>	Bringing up things that [really affect me]	130- Because there's different (roads) to that, I'm not going to start bringing up things that [really affect me]. (psy 25)
	4d) Transforming the older adult	<i>Instability...</i> <i>....Stability</i>	<i>Adjustment</i>	Knowing I'm very strong	744- I've been through a terrible, terrible time. But I know I'm very strong, but. (psy 02)
		<i>Instability...</i> <i>....Stability</i>	<i>Adjustment</i>	Learning to love yourself	145- ...main thing is (...) you got to start learning to love yourself, give yourself a hug every now and again. ...(psy 41: 145)
		<i>Instability...</i> <i>....Stability</i>	<i>Adjustment</i>	Feeling it's scarred me.....I was living with it	73- ...to me it's scarred me. But I was getting, I was living with it, I was really living with it. (psy 02)

<u>CATEGORIES</u>	<u>SUB-CATEGORIES</u>	<u>DIMENSIONS</u>	<u>PROPERTIES</u>	<u>CODES</u>	<u>QUOTES</u>
Category 4: Connecting with wholeness and a new perspective	4d) Transforming the older adult	<i>Instability...</i> <i>....Stability</i>	<i>Adjustment</i>	Finding your own way out	11- ...it was the circle that you was in and you had to find your own way out. (psy 03)
		<i>Instability...</i> <i>....Stability</i>	<i>Adjustment</i>	Keeping myself as the whole person	106-107: ...this is what you say by keeping myself as the whole person and the outside of what's going on of the other side. (psy 07)
		<i>Instability...</i> <i>....Stability</i>	<i>Adjustment</i>	Getting rid of the impact	367- It is merely getting rid of the impact on yourself of it, cause after all – as you know, it's you suffers...(psy 07)
		<i>Instability...</i> <i>....Stability</i>	<i>Adjustment</i>	Seeing myself in a completely different light	143-...and she made me see myself in a completely different light. The way she worked with me and made.....(psy 41)
		<i>Instability...</i> <i>....Stability</i>	<i>Adjustment</i>	Feeling better, coping a lot more	213- Oh feeling better, coping a lot more, not crying as much, not punishing myself, not punishing.....(psy 41)
		<i>Instability...</i> <i>....Stability</i>	<i>Adjustment</i>	Finding a balance	301-... I suppose it does, yes I suppose it does. It's a matter of finding a balance isn't it...(psy 07)
		<i>Instability...</i> <i>....Stability</i>	<i>Adjustment</i>	Wanting to change	525- I wanted to change. (psy 15)
		<i>Instability...</i> <i>....Stability</i>	<i>Adjustment</i>	Reminding me I'm different	533- It reminds me it's different, I'm different. (psy 15)
	4e) Managing endings	<i>Despair...</i> <i>...optimism</i>	<i>Hope</i>	Finding I was okay	425 -Yeah when he said I was okay and he was moving on, I was okay. (psy 02)
		<i>Despair...</i> <i>...optimism</i>	<i>Hope</i>	Being on the mend	132-133: [nothing new] happening in my life at my age. I just see my sisters and all that but I was on the mend and I was discharged from the hospital and so I didn't see her any more. (psy 20)

<u>CATEGORIES</u>	<u>SUB-CATEGORIES</u>	<u>DIMENSIONS</u>	<u>PROPERTIES</u>	<u>CODES</u>	<u>QUOTES</u>
<i>Category 4: Connecting with wholeness and a new perspective</i>	<i>4e) Managing endings</i>	<i>Despair... ...optimism</i>	<i>Hope</i>	Finding I was so sad	238- ...being playful). Yeah, it was the best thing actually I was so sad when it came to an end. (psy 25)
		<i>Despair... ...optimism</i>	<i>Hope</i>	Being frightened that I may not see her again	249- I was frightened that I may not see her again and I might panic. I told her, I wrote a letter to...(psy 41)
		<i>Despair... ...optimism</i>	<i>Hope</i>	Putting the final finishing touches to it	254-255: I think that really put the final finishing touches to it for me and if the staff were beginning to understand and know what was happening, I think I could cope with it.(psy 41)

Appendix 7

4 Categories and 19 Sub-categories

CORE CATEGORY: MOVING TOWARDS EQUANIMITY

(v.9) - 1st Sept 2013

CATEGORY	SUB-CATEGORY	SUB-CATEGORY	SUB-CATEGORY	SUB-CATEGORY	SUB-CATEGORY	SUB-CATEGORY
<i>Sensing continuity and discontinuity within an ageing 'self'</i>	1a) Noticing stability within the 'self' over time	1b) Responding to an existential crossroad	1c) Exploring duality within the 'self'	1d) Observing fragmentation within the 'self'	(blank)	(blank)
<i>Embodying an awareness of an ageing changing ecology</i>	2a) Acknowledging debility & cognitive changes	2b) Adjusting expectations about illness & long term conditions	2c) Challenging ageist attitudes	2d) Caregiving and interacting with support systems	(blank)	(blank)
<i>(3) Cultivating a therapeutic relationship</i>	3a) Being in conversation with the psychologist	3b) Observing generational barriers to the alliance	3c) Observing typical barriers to the alliance	3d) Managing expectations	3e) Experiencing engagement	3f) Incorporating context into the formulation
<i>(4) Connecting with wholeness and a new perspective</i>	4a) Pacing and adapting therapy	4b) Reminiscing about generational durability and junctures	4c) Working through the complex layers of a long life	4d) Transforming the older person	4e) Managing endings	(blank)

Appendix 8

Participants' demographics and pseudonyms

PSEUDONYMS	GENDER	ID	AGE	ETHNICITY
Margaret	Female	02	71	White British
Peter	Male	03	74	White British
Julie	Female	07	68	White British
Christina	Female	15	76	Greek Cypriot
Sally	Female	20	82	White British
Angela	Female	24	79	White British
Helen	Female	25	69	White British
Alice	Female	41	73	White Jewish
Melody	Female	44	82	White British

Appendix 9

Research Memos

This section gives a selection of the 157 plus memos written during the analysis of the data and includes a storyline memo.

Core Category memos

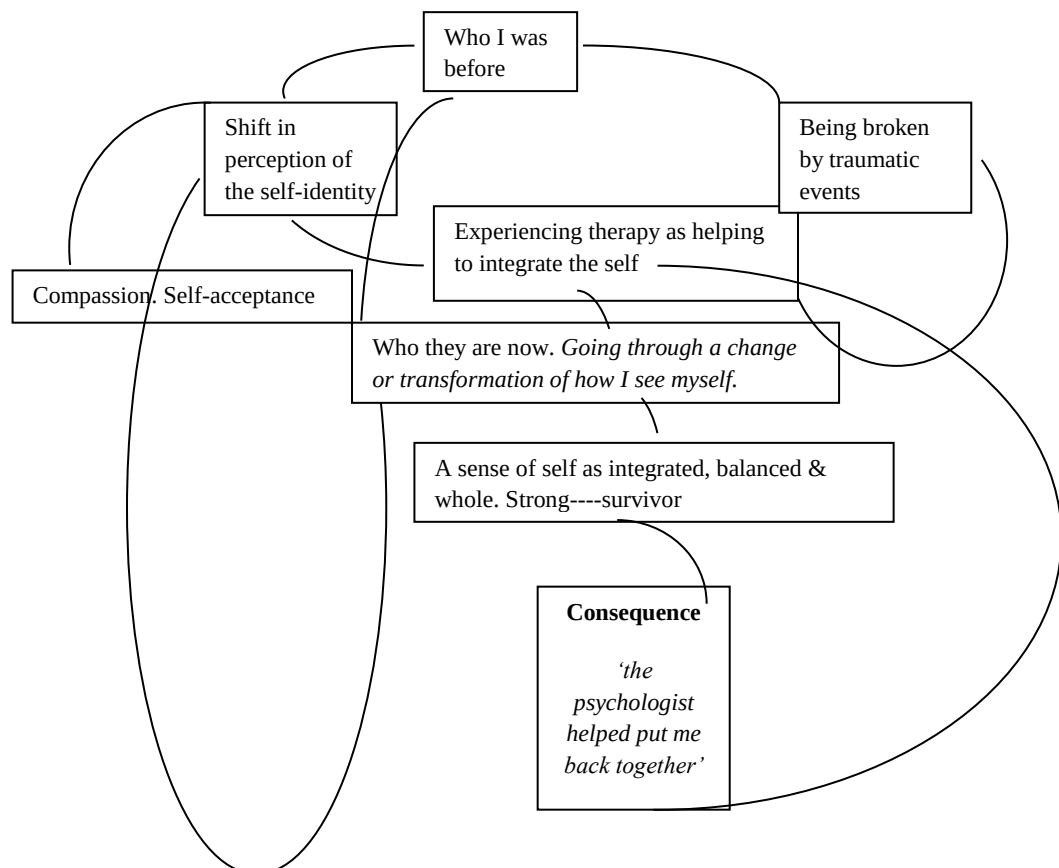
Memo 27: Early Memo -03/08/2010

Equanimity

This is a concept used in religion. Is it used to describe older adults, resilience in... (*Equanimity defined – on-line as peace of mind and abiding calmness*). In a sense a persons' development. For older adults [this] harnesses resilience despite the reality, they are still managing to adapt to life's challenges (eg: 'I'm depressed but somehow I'm functioning'). A struggle going on between getting well and adapting and getting on in their lives. She can hold onto these aspects of herself as being temporal – she can be depressed but function and get on with things....

Memo 69: Early Memo -21/08/2010

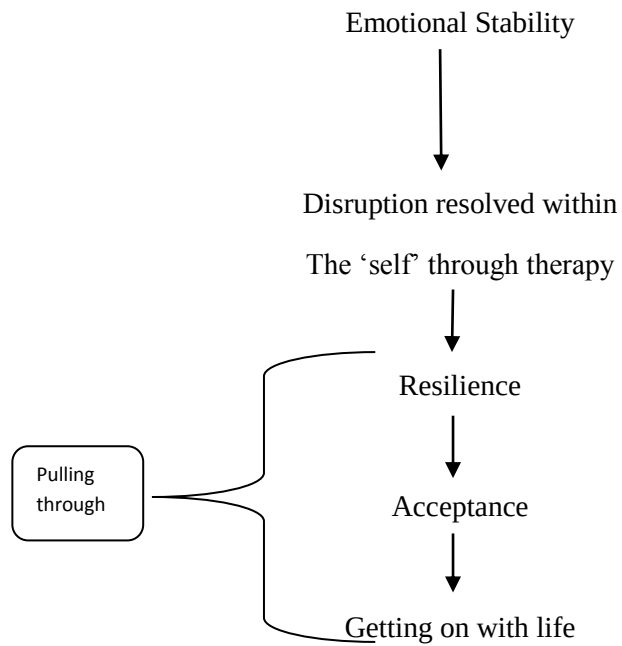
Preliminary framework to think about the emerging categories



Core Category memos

Memo 151: Advanced memo – 29/06/2013

Equanimity



Core Category memos

Storyline memo: Working towards equanimity with the older person - 15/07/2013

The core category working towards equanimity with the older person can be thought about as the participants experiencing the process of psychological therapy has helping them work towards regaining emotional stability, mental calm and balance in their life. Helping them to resolve the disruption within the 'self' caused by significant negative life events. There is a temporal order in how the sub-categories inter-relate and connect with the core category. At the beginning of therapy the older person brings an internalised sense of continuity and discontinuity within their aged self. There is a recognition of who they are from childhood into old age, which suggests that the older person is aware of their sense of self because they notice stability within the aged 'self' over time. The unpredictability of life brought negative events that had an emotional and psychological impact upon the older persons' sense of who they are. The calm and balance of their inner worlds became challenged by the crisis which contributed to negative coping reactions and the development of mental health problems for the older person.

The trauma and distress created a breach in how they responded to the existential crossroad within the aged 'self', which maintained the disruption, preventing the older person from coping with their difficulties with equanimity. The participants faced multiple challenges, loss and a shifting self-concept which impacted on the participants' autonomy that led to conflicting ideas about themselves. The consequences meant that they were struggling to re-balance themselves and cope with life. Coming to therapy was an opportunity to explore the duality within the aged 'self' and the anti-thesis between accepting and rejecting the 'self'. Additionally, coming to therapy was the beginning of the older person's journey that moved the participants along a dimension from imbalance to balance; from fragmentation within the aged 'self' and distress to wholeness by the end of therapy and a more equanimous frame of mind.

The uniqueness of the therapy work with the older person consisted of an embodied awareness of an ageing changing ecology, both the participant and psychologist engaged with this reality which indicated the emotional complexity within the participants internal and external worlds. The ageing process brings with it a changing sense 'self' and the older adult participants come to therapy with many different challenges which need to be taken account of within the therapeutic relationship. Acknowledging debility and cognitive changes during the ageing process was important if therapy was to meet the needs of the older person. Within the therapy space there is that awareness of the richness of a long life that has already been lived and the reality of life in the present despite all the obstacles.

Core Category memos

Storyline memo: Working towards equanimity with the older person - 15/07/2013

In the therapeutic encounter there is acknowledgement that the older person brings particular historical knowledge and values from a previous generation. In that therapy space the psychologist can bring specialist knowledge and understanding about ageing, contextual understanding of the environments in which older people live. The participants talked about the many challenges they face by acknowledging debility and cognitive changes during the ageing process. The older person embodies the awareness that they are facing changes that indicate a normal ageing process, added to which they try to re-balance by adjusting their expectations about illness and long term conditions. Within the communities in which older people live they try to challenge ageist attitudes even though there are variations of whether this is experienced personally or if it is observed within their environments, there is acceptance that it exists. Within the wider community the discourses that take place about older people, the assumptions about who they are and how they are viewed by some parts of society pose many challenges that leave the participants striving to be heard and given a voice rather than to remain invisible. Increasingly as the participants' age and there are limits placed on their health, they become reliant on caregiving and they interact with support systems to help them continue to live their lives as independently as they can. Although support can vary and the participants talked about the impact that a lack of support has upon their life.

The participants bring all of these issues into the therapeutic environment; there is awareness from both the psychologist and participant that being an older person can be complex and multi-layered. Within therapy working towards equanimity meant cultivating a therapeutic relationship with the older person to nurture a collaboration through a therapeutic conversation whilst exploring the participants' main concerns. Therapy comes with some challenges and typically an individual from which ever client group may find talking difficult, and therefore there will [be] variations within this process. The barriers that interfere with the building of an alliance can also be influenced by generational factors, assumptions from both the older adult client as well as the therapist. Managing expectations is an important stage in building the alliance in order to clarify together the limitations and work through the blocks that [interfere] in the working relationship. Talking therapy comprises of an iterative quality, where the therapeutic relationship became a vehicle by which the participants could move back and forth reflecting introspectively, through talking with the Psychologist.

Core Category memos

Storyline memo: Working towards equanimity with the older person - 15/07/2013

The relationship became an important foundation from which to engage with the therapy work to help the older person make sense of their difficulties. The nature of therapy incorporates particular aspects and phases for the older adult to be able to work through their problems, communicating, interacting and listening to the psychologist.

Engaging in the therapy work helped the older adult in their journey towards balance and psychological stability that lead to changes in their sense of self. They learned to perceive them self in a new way by adjusting to their current situation because they remembered their strengths and developed a flexible approach toward themselves and their situation.

The journey towards achieving equanimity within their lives helped them to evolve, develop, [and] gradually change by connecting with wholeness and a new perspective. Experiencing psychological therapy had reminded them that they had survived and moved forward from a challenging situation and they acknowledged they were feeling better and coping better with life. Achieving equanimity can be understood as the older adult participants developing an alternative perspective which led them to feel different, have self-compassion, a sense of calm, harmony and a reintegrated sense of wholeness.

Category one memos

Memo 1: Early Memo -24/11/2008

Mixed view of 'self'

The image of a past 'self' changing, the way she views herself differently from before and others may also see her differently. She perceives herself as an intelligent person and being an achiever through staying motivated because she has always been a hard worker. The self was split between wanting to live and wanting to die, she has chosen her family and now she wants to live. Mixed view of her sense of self now and who she was in the past, trying to hold onto that resilience of before, but wondering how others may see her, questioning if they see her differently. She was trying to keep herself together by staying connected to her family.

Memo 36: Early Memo -03/08/2010

Not Coping

About experiencing a relapse, dealing with traumatic experiences (different processes such as unpacking the trauma – what ...or the precipitating factors). There's something about how the client responds to trauma, how the psychologist works with that, the client may be left feeling 'all is gone' and start avoiding people, worrying, helpless, suicidal (quite strong) feeling frustrated – this leading to depriving themselves and being in denial about not coping, the spiral – 'I did not hold myself' a loss of control. Coping with the role of carer also has its own pressure which creates communication problems, loss of freedom & feeling like a parent.

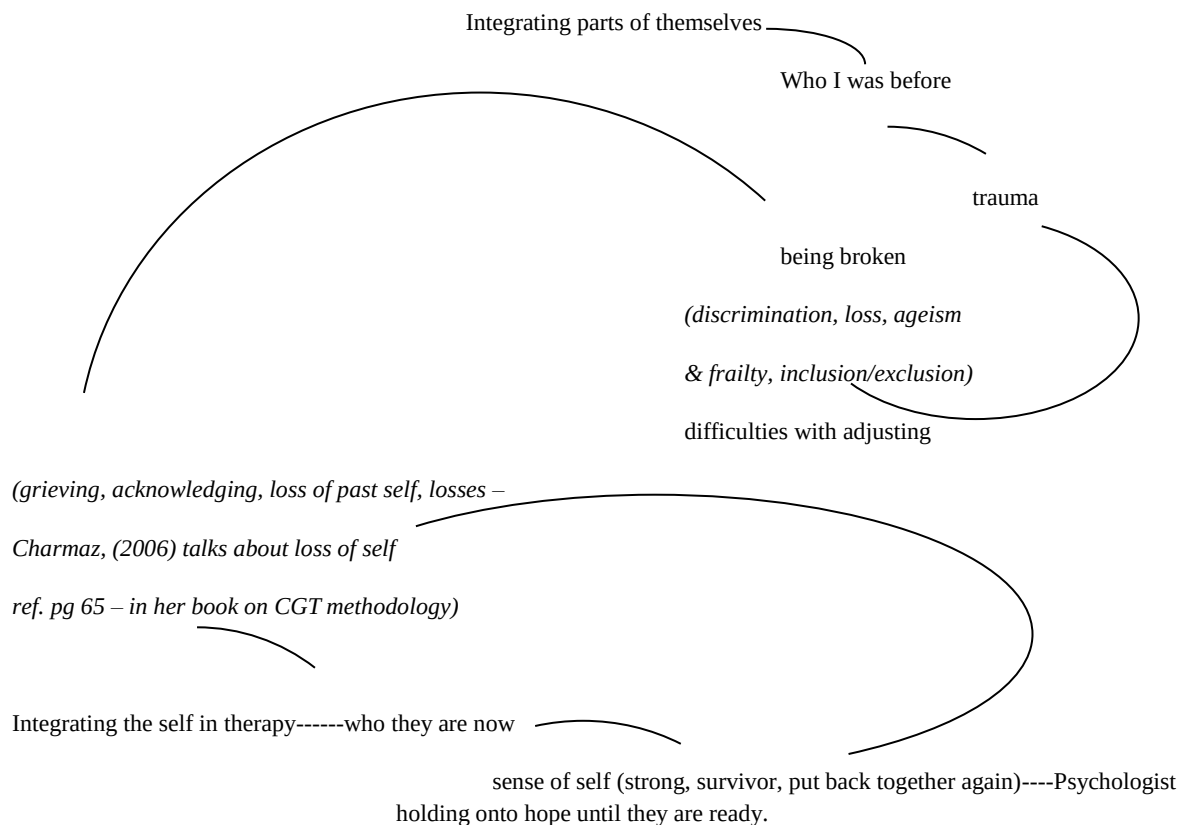
Category one memos

Memo 26: Early Memo – 03/08/2010

Shifting self-concept

Trauma-----helpless & dependent-----work through conflict/pain-----move forward-----sense of being different but the same

This is who I was before-----this is who I am now



Category one memos

Memo 37: Early Memo -05/08/2010

A broken self-identity

The client broken by traumatic events – Explain the concept of broken/metaphor – examples in the data when clients have said or implied this about themselves in their life story. The psychologist offers/ the psychologist helps to repair – (unpack meaning) the client's fragile self-identity. Is it a similar process to healing/faith in the psychologist to help? Rebuild – (unpack meaning) the shattered self. [Concealment-----display (dimension/interesting is it relevant????)]

Memo 75: Conceptual Memo – 19/09/2010

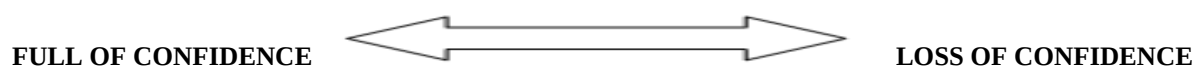
Experiencing a broken self

The participants spoke of experiencing traumatic life events and the threat to their physical and emotional worlds left their lives disrupted and they found themselves in distress. Dealing with loss was a significant factor for them as they saw important aspects of their life had been destroyed. The stress of which brought them to the edge of what they could cope with. They explained that they did not feel in control and they expressed disparaging views about themselves, an image came to mind of a disintegrating 'self', fragmented, disconnected, unsteady then breaking down. The distress of their experiences left them lost and without the ability to 'hold' them self together.

Memo 105: Advanced Memo – 14/04/2013

Contradiction – past/present

The participant has a sense that she was a person that was full of confidence in the past – she is presented with another contradiction about her sense of self.

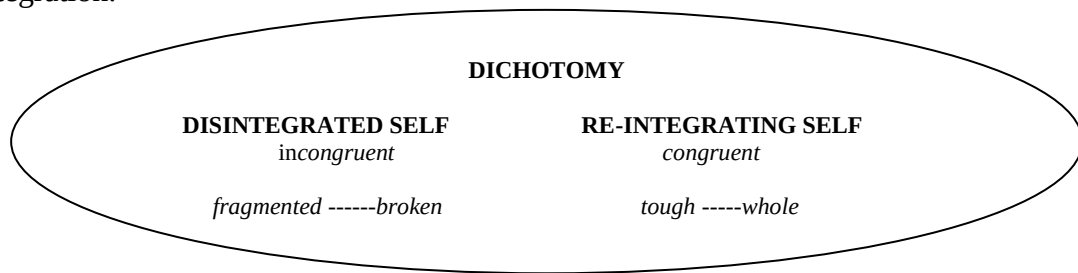


Category one memos

Memo 102: Advanced Memo – 14/04/2013

Disintegrating self --- Re-integrating self

Distressed, losing control and unable to be her usual self, she conveys in her story a process of disintegration.



Memo 132: Advanced Memo – 15/06/2013

Contrasting ‘self’

Anti – thesis – what’s happening in therapy when participants present the ‘self’ ???

Juxtaposition.

Memo 141: Advanced Memo - 22/06/2013

Dichotomy of the ageing, changing ‘self’

The participants’ story is one of a changed ‘self’I kept coming back to this notion of this change within the person something had changed – she had lost her husband tragically and she was alone, she changed from being independent to becoming more dependent on services, she felt depressed being alone, cognitive changes, wandering, memory loss, anxiety – so many factors and issues in the therapy room to keep in mind and hold onto for and with the participants.

Category one memos

Memo 144: Advanced Memo - 23/06/2013

Finding life got disrupted

This [is] about the life events that interrupt the flow of life. The disruption caused trauma/distress that was significant and it led to them not being able to cope with life and themselves. The changes the disruption caused was felt quite acutely and caused a dichotomy within the 'self' (strong----weak). This and other conflicts have arisen throughout the data – coping and resilience and acceptance so that this normal understandable reaction to life events can be dealt with in therapy. In therapy the psychologist and participant work together to bring equanimity, balance ---- reconnecting the participants with a sense of themselves and the support they need to help them to cope again with life. The therapy relationship empowers the participants to take responsibility again and this is part of the process of change in therapy for older adults'.

Category one: Storyline memo – 09/07/2013

Internalising a sense of continuity and discontinuity within the aged self

Being from a different generation brings memories of how life was in the past, during a time when significant events such as the two world wars and being evacuated impacted on them and the previous generation. Their experience of being from that time takes them to a place where they contemplate the differences between then and now and how they have lived a long time. They embody knowledge and life experience that is different to younger generations, a way of viewing them self and the world. The participants recognise the 'self' over time which allows for continuity of the self in a changing world. When their life is disrupted with negative events that interrupt the flow of the participants' existence, the disturbance is experienced as trauma and distress, which is significant enough to lead to the participants not coping with life or them self. The psychological impact creates a dichotomy within the participants that raises a conflicting sense of self, which interferes with that sense of constancy in the self-identity, causing a fragmented self-perception. Remembering the person they were before allowed the participants to remind them self of who they are, they enter into a review of their life story and what defined them as individuals. The participants' experiences have left them struggling to cope, they had become disconnected from the 'self' and this experience created mental instability. This psychological distress contributed to them feeling unable to keep their life together.

Category two memos

Memo 7: Early Memo -07/02/2010

Having a sense of being different

Ageing? Needing different coping strategies to manage her depression or prevent it from starting.

Memo 8: Early Memo - 07/02/2010

Age, power, having a voice

Feeling that she has power for her age and this may have something to do with how assertive she has been in her life and standing up for herself. Being older she hasn't come up against anything 'not agreeable'. Even though she may not have experienced ageism she knows that some older adults feel they are not listened to.

Memo 13: Early Memo -07/04/2010

Ageism

Institutional ageism in mental health organisations. Ageism in society, people discriminate, there is stigma, negative assumptions, ignorance and a lack of education about older adults. Negative outcomes – being invisible, implicit messages, being ignored, being treated as though they lack capacity to think, make decisions and have choices. Challenging ageism – making herself visible, being heard, constantly reminding people that they are there (“I said I am here”).

Memo 33: Early Memo - 03/08/2010

Social Inclusion/Exclusion

About empowerment and ageing/frailty and challenging ageist assumptions.

Being a problem-----It not being a problem

How does social inclusion connect with autonomy? Age and frailty

Social exclusion-----social inclusion

(a dimension, eg: the process of autonomy)Taking responsibility-----acceptability

Category two memos

Memo 61: Early Memo -13/08/2010

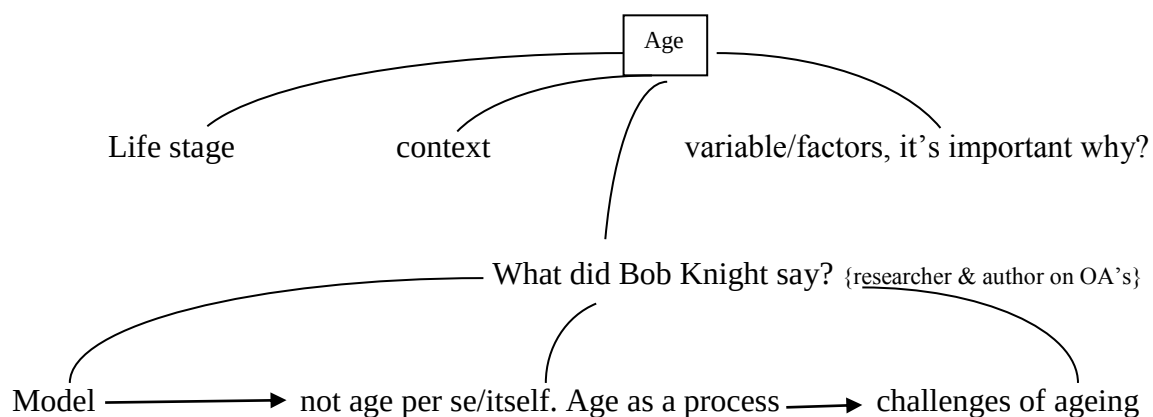
Being a different generation and living with age & frailty (was a diagram, see narrative below)

- Do a free thinking memo on what this category is about? Is it about adjustment issues???
- Generational issues --- life stories---context (struggles, memories – good/bad, the past)
- Generational issues and age are different processes.
- Age: Acceptance (*'I've done all my living in the past'*)
- Age: what does it mean to be an OA? (*'You're a long time dead'*)
- Age: Frailty – how I live with frailty, it's relevant to the client group, but was it relevant in their experience of therapy?
- Age: Frailty – Loss of the individual – increase in vulnerability – I have to rely on others? – I'm not strong enough?

Memo 74: Early Memo -08/09/2010

Age

Are we defined by our age? Or our experiences regardless of age? How does our age affect how we respond to events?



Note: My supervisor had said that loss is loss but for someone at a particular stage in their life may be tackled differently and need more support. (*Nostalgia defined: yearning for the past in an idealised form. Remembrance of one's childhood the good old days of a few generations back*).

Category two memos

Memo 77: Conceptual Memo - 19/09/2010

The person's changing perceptions and changing over time

Being from a different generation presented challenges for the participants and these generational factors revealed differing representations of young and old. Adjusting to ageing meant that they needed to adapt during this period of change. Their views of living with frailty and physical health changes was located within various stereotypical assumptions of ageing. Challenging ageism was acknowledged as being a way of coping with their experiences. They found themselves confronting discrimination and negative assumptions in everyday life, as they disagreed with the opinion that being a particular age defines who you are, as though that is the sum of everything there is to know about a person.

Memo 109: Advanced Memo – 26/05/2013

What's unique about older adults' in therapy?

Older adults' have and bring so many different challenges into the therapy room. When you are sat opposite an older person there is an awareness of the richness of a life that is being lived despite all the challenges of:- Physical health/frailty, Cognitive/memory problems, Isolation/loneliness, Vulnerability, Power issues, Ageism, Generational factors, Independence/dependence, Receiving support/coping, Accepting support, An ageing self. There is age not the number but all of that life in one space – so much of the past is in that therapy room.

Category two memos

Memo 127: Advanced Memo – 14/06/2013

Many contexts

Context is about the circumstances that the participants' are in that impact/influence their lives and the meanings that they derive from it. ~Thinking about systems and context. All of the different contexts in the therapy room:

- Social context
- Gender
- Generational context
- Social care
- Home life
- Cultural context
- Family context
- Friendships
- Past life history
- Physical health
- Mental health
- Ageing self
- Changing self

The participants are witnessing a 'self' that has changed many times and is still changing within all these contexts.

Memo 157: Advanced Memo - 01/09/2013

Ageing changing 'self'

What makes this process different for older adults is their stage of life and the expectations, assumptions and particular challenges they face and how that influences therapy. The life stage, the context and the meanings the participants' give to their experience and how the psychologist works with the participants' to move them forward so they can cope with life again.

Category two: Storyline memo – 09/07/2013

Embodying awareness of an ageing changing ecology

The participants talked about the many challenges they face by acknowledging debility and cognitive changes during the ageing process. The older person embodies the awareness that they are facing changes that indicate a normal ageing process, added to which they try to re-balance by adjusting their expectations about illness and long term conditions. Within the communities in which older people live, they try to challenge ageist attitudes even though there are variations of whether this is experienced personally or if it is observed within their environments, there is acceptance that it exists. Within the wider community the discourses that take place about older people, the assumptions about who they are and how they are viewed by some parts of society pose many challenges that leave the participants striving to be heard and given a voice rather than to remain invisible. Increasingly as the participants' age and there are limits placed on their health, they become reliant on caregiving and interact with support systems to help them continue to live their lives as independently as they can. Although support can vary and the participants talked about the impact that a lack of support has upon their life. The participants bring all of these issues into the therapeutic environment; there is awareness from both the psychologist and participant that being an older person can be complex and multi-layered.

Category three memos

Memo 2: Early Memo -25/10/2009

Fear of not coping, age, therapy and power issues

Fear of not coping – in what way? What would that mean to the person? Do other participants talk about not coping and if so is it different or the same? Interesting how [the] view of aging seems to be linked with fragility, a loss of strength, identity? I could think of it under a theme of loss. What does the context of ageing offer to other participants? Therapy can feel deskilling for the participants, it can be more de-skilling to an older adult. Is there a generational factor about how they experience therapy? Issues of power – losing power? Holding onto power? Regaining Power? What about resilience and strength – connected to power? Rising from adversity – strength? Power?

Memo 5: Early Memo - 07/02/2010

Helping yourself vs “Needing Company”

“Needing company” or needing support from someone to help with the depression. What did psy 20 mean? Is there a struggle with accepting help (“you’ve got to pull yourself out of ...”), could be that it was important to rely on herself in the first instance. Does having company mean collaborating with someone to pull you through? Self-reliant – taking responsibility for her own needs. It’s difficult for her to let go of some of that responsibility and become dependent on the therapist??? Is that due to age? Is it because it’s her first time experiencing talking therapy?

Category three memos

Memo 9: Early Memo-15/02/2010 & 27/03/2010

Experiencing the Psychologist

(15/2) - Trust and confidentiality. Wanting to share confidential information with the psychologist. Difficulty trusting 'when confidentiality has been broken. The psychologist apologised and the therapeutic relationship was repaired ("we got over it"). But the trust issue 'stayed with' the participant.

(27/3) - Having a good relationship with the psychologist, strong relationship before confidentiality broken due to risk issues. The relationship could withstand this crisis because it had a strong alliance foundation.

Memo 19: Early Memo -13/06/2010

Therapeutic relationship

Trust is embodied in the therapeutic relationship and it is a crucial ingredient. The consequence of this being in place is that the participant feels better and this is a sign that the client is getting the best out of psychology.

Memo 21: Early Memo -02/07/2010

Experiencing therapy the negative

Defences, doubts, hopes, denial, ambivalence, uncertain, experiencing resistance, being resistant to change – adjustment difficulties – experiencing obstructions –therapy may not be for everyone.

Memo 24: Early Memo -03/08/2010

Therapist's assumptions

Therapist assumptions about the needs of the older person (eg: the person just needs a daycentre) can leave older adults' not feeling understood and heard and this limits what the client shares with the psychologist. Assumptions inhibit disclosure.

Category three memos

Memo 31: Early Memo -03/08/2010

Generational factors linked with age and frailty

The imposing limitations, eg: indirect experience and what they bring into therapy – a time when they had to conform to a particular way of living, such as not working, being at home, not using contraception, not having a choice as to who to marry, Tooutside of one's cultural expectations, the evacuee's process. [They] might influence their expectations – talking about your feelings not past generations, this generation – perhaps about adjusting to keeping problems to yourself or priest or another neighbour or a professional. Stiff upper lip might be an unrealistic expectation if they feel they have to show strength, may not be open to therapy and support is important for their recovery, eg: psychologist, psychiatry, signposting. Despite all the 'stuff' they bring in, have to work with it as it influences how they see the psychologist and the therapy, we have to work with these challenges. You have to be aware of the generational factors/ageing and frailty that may be played out in the therapy room – *psy 20* – described basically that she has already lived. Her negative interpretation of her age – doesn't view herself as having a future, I've lived my life (82 years), switched off her expectations, accept loss.

Memo 34: Early Memo -03/08/2010

Experiencing therapy

[An] older adults comes into therapy and may be in denial about the problem and also limit what is talked about, this could be an indication that they are not ready to take responsibility. So the psychologist helps the older adult to explore different aspects of the story, develop/strengthen engagement by being reliable and regular/consistent. This makes therapy predictable, less anxiety provoking because the client may be struggling with uncertainty.

Category three memos

Memo 35: Early Memo -03/08/2010

Having an alliance

[The] psychologist offers resources to the client and through that process - the step between resources and the client taking responsibility, the steps/ ingredients that need to be in place before the client can take that step. Having an alliance [is] necessary to move the client from the resources to taking responsibility. Crosses all models, approaches, the therapeutic relationship needs to be in place before change can happen---- engagement, trust, being listened to, [and] expertise – in order to deliver the resources. Confidentiality is part of that – can't trust the psychologist if you don't know the limits of confidentiality. Beginning therapy about having time to talk about problems, not feeling pressurised – you don't let people in, you don't let it work – that needs time. The ending of therapy about loss, feeling sad that it's come to an end, perhaps an indication of how much has been invested – experiencing the therapist's style of interacting and knowing that the psychologist is right, eg: having confidence in the psychologist's skills, and that develops as you create a partnership then good communication. Good communication is about feeling understood, psy 15 felt a similarity with the process to the researcher-participant and client-therapist. Particular predictors in therapy seem to be a good relationship [and also] between participant and researcher. So there are different pathways in the relationship between the participant and the therapist-client (eg: I'm not talking to you as in therapy – different roads to that, she wasn't going to start bringing up things).

Memo 40: Early Memo-05/08/2010

The therapeutic relationship

What are the therapeutic ingredients that have helped older adults rebuild their self-identity? What are the ingredients within their experience of therapy that lead to them becoming resilient? The main element is the therapeutic relationship [universal] without this alliance nothing takes place. *Context:* within the therapeutic relationship particular impacts are experienced, so the context [of] the relationship becomes the condition [where] these impacts/outcomes [take place], without the relationship the client doesn't get to experience therapy in a beneficial way.

Category three memos

Memo 65: Early Memo -14/08/2010

The middle phase of psychological therapy

Remember – The therapeutic relationship is the beginning, middle and end and it's about being authentic, and acceptance of the psychologist---accepting the problems.

Memo 78: Conceptual Memo - 19/09/2010

The therapeutic relationship with the psychologist was valuable

Therapy progresses due to the development of a therapeutic relationship with the participant. Some of the qualities of that relationship was expressed by the participants as being listened to, feeling understood, connecting with the psychologist, freedom of self-expression, choices and trusting the psychologist to help them work towards finding a resolution to their problems. Engagement through building is an important factor for the client to feel safe enough to disclose their concerns. Through trust, openness and transparency the therapy alliance is strengthened. There is something about the genuineness of that authentic relationship that helped the participants and psychologist develop good communication.

Memo 81: Advanced Memo – 24/11/2012

Communication

The process of therapy is about communication. Talking to the psychologist and the participant may hold back, not sharing everything ('he didn't help me with the pain'). Is this about barriers such as defenses, resistance, [and] not acknowledging feelings? Is the barrier about not working through the pain? Awareness – psychologist and client.

Category three memos

Memo 86: Advanced Memo – 25/11/2012

Persona

Two participants talked about the psychologist having a “particularly good persona and you can trust her”). They talked about the psychologist, something about the psychologist that allowed them to trust the process. Interesting that the participants didn’t really know anything about what that process would be like before they embarked on this journey. But for them the “persona” of the psychologist indicated that they could trust them. It makes me think that the process and the psychologist are interlinked. The skill of the psychologist to make the process work. The psychologists’ persona (define: identity/role) embodies trust. It’s about the psychologist’s persona embodying trust and the client, trusting her letting her in, the client being open, a willingness to give it a go, to have trust you have to have a therapy relationship. Trusting means she’s not going to let you down – reliable, the client feels comfortable with the psychologist and the psychologist and the participant “gelled” – a sense of connectedness, and that came “naturally” – it organic. The persona symbolizes something to the participant that there is something right about the psychologist. The psychologist’s persona embodies: trust, comfort and reliability.

Memo 87: Advanced Memo – 25/11/2012

Engagement

The reliability of the psychologist encourages engagement. What is this about?

- Connection / gel
- It comes naturally /it’s like it’s organic
- Co-operation/collaboration this helps the participants’ pick themselves up and cope differently

Without co-operation therapy cannot work and the client is stuck or goes back down.

Category three memos

Memo 93: Advanced Memo – 25/11/2012

The therapy relationship

....‘it’s a two way street’ – reciprocal, both of you have roles to play. What does this consist of? Letting you talk and getting feedback/constructive. Sometimes the feedback wasn’t pleasant to hear, it was difficult but the strength of the therapy relationship helped her through that part of the process “it became positive”.

Memo 106: Advanced Memo – 22/04/2013

Experiencing therapy

Age issues OA’s bring to therapy. Adapting therapy to meet their needs. Note to self: take a step back and embed that practice in research (supervisor’s suggestion). Go through each line and interpret (ie: frailty). Position self as the expert. Consider uniqueness – generational issues, ageing is always present throughout the process – stage of life and resilience. Remember the person ‘I’ was before and coming to terms with the experience of ageing are part of the same process. Take the data from description to abstraction. Remember variability in how the participants’ experience the therapeutic relationship. The therapeutic connection the alliance, what does it mean? Be specific. Re-think therapy relationship, is age a barrier to connecting? What are the other barriers? Therapists’ have different ways of working. What adapting therapy for OA’s?

Category three memos

Memo 108: Advanced Memo – 25/05/2013

“Speaking to you differently”

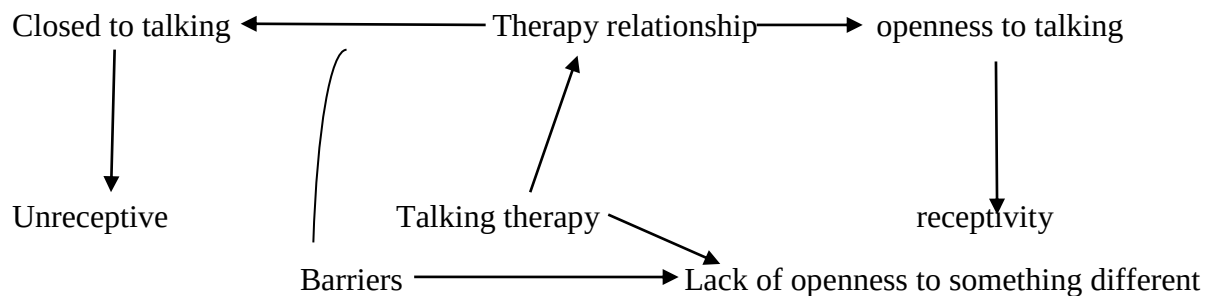
Differences and similarities in talking to the researcher and the psychologist she worked with. ‘What is this a process of? What is this variation in telling/talking to the psychologist vs researcher?’ The questions Charmaz would ask of the data. [Psy 15, 214-215] –“To you I could say anything, I speak to you different, I tell you more than I tell him (the participant is referring to the psychologist she worked with). Feeling as though she could say anything to the researcher – something about feeling free to talk indicates no barriers, trust and a real empathic connection with the researcher, which helped the participant to open up and share her story. The participant reflects on the interaction with the researcher that allowed her to feel she could speak differently, something about the relationship being quite central to the process for the participant and for clients in general. We know that the therapy relationship is the structure that supports, it embodies, it is a medium by which change takes place. Within this structure the participant-researcher relationship could help the participant tell more of their story. Telling more could be understood as the communication that takes place. There are different levels/ degrees to telling/talking. Tell more / less of the story. Different levels of engagement ‘empathic engagement’. It appears that therapy not being helpful was about the blocks that can be experienced during therapy and gets played out in the therapeutic relationship. From what the data is saying there are particular conditions that need to be in place for the participant to be able to speak freely. The participant’s interaction with the researcher is quite telling as it seems to describe some of the ingredients that were missing from the therapy relationship which prevented the participant from speaking freely. I know that the researcher-participant relationship is different from the participant-psychologist relationship, but there are some overlaps- ie: trust, power, feeling comfortable, engagement, telling/talking, understanding, reciprocity, the quality of the interaction, choosing what to say.

Category three memos

Memo 114: Advanced Memo – 27/05/2013

Being receptive to therapy

Being receptive to therapy, taking to the process of therapy, not every client will take to talking. Something about being open to the process. A number of barriers can prevent this openness to therapy – prior experiences, preconceptions about therapy – more importantly the therapy relationship is central [in] helping / facilitating this process. What are the variations within this process that can interfere with its progress or facilitate it for older adults’?



Memo 121: Advanced Memo – 01/06/2013

Trust

Central to engagement within therapy. It is the heart of the process and the nucleus of the therapeutic relationship.

Memo 122: Advanced Memo – 02/06/2013

Reciprocity

What is taking place during the therapy relationship, something about ‘mutuality’ – in the encounter there is an exchange that takes place during the talking that is beneficial to both parties, a sharing of something that both the psychologist and participant need. It’s about how that (needing to help & needing help) is negotiated and operationalized.

Category three memos

Memo 131: Advanced Memo – 15/06/2013

Having Chemistry

Having chemistry is a process and it's about the therapy relationship. It's about talking together. It embodies qualities of balance/equilibrium, congruence, mutuality, a bond, a connection, which allows good communication – having a conversation. But to do this the participant must feel comfortable, understood, it's about having rapport (harmony in the relationship). It's about being attuned.

Memo 138: Advanced Memo - 19/06/2013

Developing a formulation with the participants

Creating and sharing a formulation is a collaborative process so that understanding of the patterns that kept the participants stuck can be discussed. Coming together to explore what is going on, helped the participants to recognize the signs and identify what factors contributed to maintaining the problems they faced. The psychologist offered guidance and both the participants and psychologist learnt, and deepened their understanding of the issues. As their awareness unfolded it opened up possibilities that the participants would improve and cope with their emotional world.

Memo 153: Advanced Memo - 30/06/2013

Reciprocity

Reciprocity in the therapy relationship. Both participant and the psychologist are wanting something from the other person. Something about giving and receiving in therapy. Both want feedback, both want to understand how the process is going for the other. The strength of the therapy relationship keeps them connected.

Memo 155: Advanced Memo - 30/06/2013

Trust

This is about connecting with the psychologist in the therapy relationship, by 'letting her in'. It's like opening a door to an important visitor who you are wanting to interact with. Letting the psychologist in is about getting the benefits of the therapeutic work.

Category three: Storyline memo: Cultivating a therapeutic relationship with the older person -09/07/2013

Being in conversation with the psychologist the participants could begin to share their difficulty. The importance of the therapeutic relationship is central to changing in psychological therapy and as with relationships, trying to negotiate a shared understanding would undoubtedly give rise to barriers that contribute to inhibited disclosure, therefore managing expectations would be a key feature during this part of the process. For the participants feeling listened to and understood meant that they could experience engaging 'empathically'. Positive qualities that moved the process forward is the necessity of being open to the process in order to build a strong therapy relationship. Trusting the psychologist was essential to the process so that the participant could feel safe enough to disclose their concerns. Through the trust and transparency that emerged the psychologist used a person centred approach to help the participants experience a genuine collaborative encounter.

Category Four memos

Memo 10: Early Memo -27/03/2010

Making sense of problems

Therapy helping her to think about what was going on in her mind. Understanding patterns of behaviour, the therapist helped her to understand unhelpful patterns she had never noticed before and now she can 'relate' to the patterns and there's awareness.

Memo 11: Early Memo -27/03/2010

Experiencing therapy

It's not easy expressing feelings. Therapy 'alerts' her to other things she needed to take into account. Therapy acting like a mirror reflecting what she may not see in her blindside.

Memo 12: Early Memo -03/04/2010

Psychology empowering participants

Psychology empowers participants to face there problems, teaching them different ways to respond to particular problems, giving them the tools. The more resources they have they can choose ways to respond that are not negative and self-defeating. Psychology kept the participants going – sustaining.

Category Four memos

Memo 14: Early Memo - 09/04/2010

Changing things – ‘self’

Developing my thoughts about earlier memos and thoughts about the participants’ feelings about ‘the self’. One participant said it’s virtually impossible to change – she had no self-belief and it felt ‘insurmountable’, a huge obstacle. What was the obstacle to change? She appeared to function by presenting a public face that was strong, together and doing well. Whilst hiding her private face from the world which was less motivated, not doing well and avoidant. Struggling to reconnect and reconcile the split in those parts of ‘the self’. The relationship with the Psychologist helped her to focus on her needs and main concerns. The interaction needs to be right; the chemistry has to be reasonable. Sounds like through the therapeutic relationship something life changing took place that is based on trust – she explained that ‘I can’t meet with a psychologist with doubt and think this isn’t going to work for me’. Sounds like a commitment to the work and a recognition of her part in the process of change. She can contemplate a future where ‘the self’ is supported to change, something about her willingness to take some responsibility for that process.

Memo 17: Early Memo -09/06/2010

Acceptance

Psychology offers something. Choices, ways of being despite your experiences. Psychology offers different ways of seeing the ‘self’, learn to manage the conflict, [and] the internal struggle. It gives options and helps to integrate those parts of the ‘self’ that have been shattered by traumatic events that have left the older adult participants changed, blurring their identity and sense of who they were, who they are meant to be now and who they can be in the future. Learning to ‘love’ the self and be ‘kinder’ was important, helping them see an alternative.

Memo 18: Early Memo -12/06/2010

Internal conflict with the self-identity

Negative and positive dimensions in the ‘self’, trying to re-balance the two aspects and reduce the pressure of the negative aspect. When the negative part dominates the participants go downhill and they do not feel right within their own mind. When the positive aspects of the ‘self’ regain control it has the power to rebalance the self and the participants cope better and have a different view of themselves. Psychology helps the participants to find harmony through acceptance and a positive outcome.

Category Four memos

Memo 20: Early Conceptual Memo – 19/06/2010

Self-Identity and Psychological Therapy

I developed my thoughts after looking through a diagram about accessing therapy and exploring the self-identity. Reflecting on the past and how 'life got disrupted', self-perceptions about personal identity, being strong, a fighter and having self-belief. Listening to the psychologist helped her to fight her depression. Instead of struggling with the disruptions, she can cope with life again, she used strategies in therapy that pulled her through her difficulties, coping statements that soothed her ('never mind') and helped her to develop a compassionate voice that moved her forward. Change happened in therapy and the psychologist pulled her through, rebuilding the shattered sense of trust in her own ability through encouragement to get over it. Her sense of self is rebuilt and she can own that she has resilience because she has become self-accepting.

Memo 22: Early Memo -02/07/2010

Deprivation, loss of self, not coping

This is the start of therapy, the loss of self and the participants' not coping – a response to traumatic events. Change takes place in therapy and the participant feels listened to by the psychologist. The therapeutic alliance is about trust, where the work can take place and the psychologist helps the participant rebuild their sense of self. The style of the psychologist to listen, understand and be patient [which] strengthens the rapport between them.

Memo 25: Early Memo -03/08/2010

Autonomy

Being proactive and doing something about the situation which involves having choices and having choices is part of having personhood/self/identity. There is something about them being able to identify with themselves, that they have the capacity (experiences or built in therapy) to make different choices. Imagery – someone coming into therapy – broken – through therapy relationship the psychologist helps the person find themselves in a different way – being put back together again, a sense of ownership, '...know who I am'. In order to get to this, need to recognise unhelpful patterns so they can change this. In order to do this, would have to develop a positive self-concept and have confidence about yourself, feel strong enough.

(Re: discrimination/trauma/losses) Broken-----Being capable

Autonomy is about moving from being broken to being capable (ie: allowing oneself to move to developing a sense of 'personhood' through making choices, developing a positive self-concept and being confident about oneself.

Category Four memos

Memo 28: Early Memo -03/08/2010

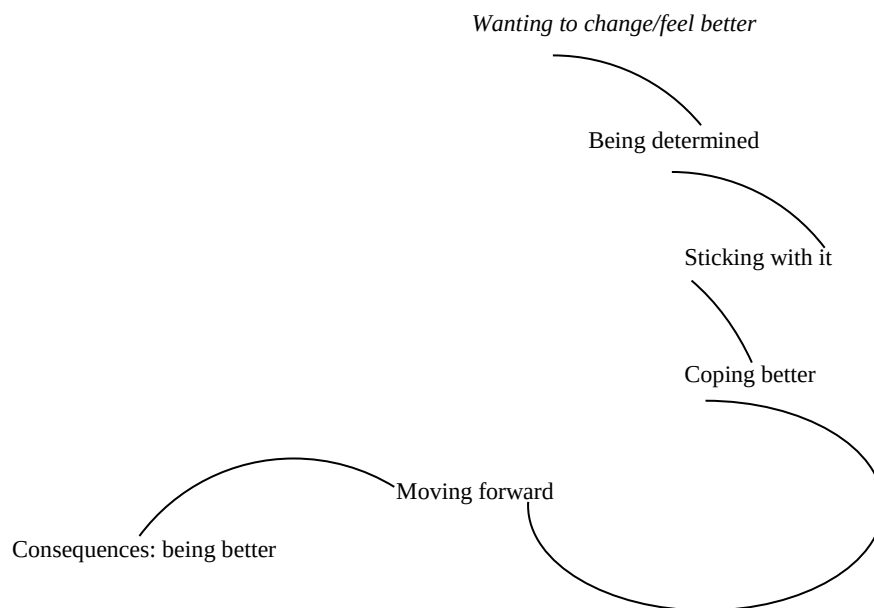
Observing one's internal world

Trying to make sense of their experiences; why they are stuck, exploring regrets, feelings of guilt, anger, shame, having an awareness of difficult emotions. Trusting the psychologist to name them, the skill of the psychologist to pick up on that and reflect it back to that. I wonder if your blaming yourself is the client willing to hear that?

Memo 29: Early Memo – 3/8/2010

Getting there through changing

A realisation that they've come from something, winning, coping better, they don't hurt so much – you feel better, moving forward. In order to make that happen they have to want to change, they have to fight for that – 'I'm winning' – the journey becomes about determination, not giving up, sticking with it.



Category Four memos

Memo 38: Early Memo -05/08/2010

Personhood and identity

Can personhood be lost? / can the psychologist help replace/rebuild parts of the client's 'self' disrupted by negative life events? Psy 41- talked about the psychologist stripping her down emotionally. I wonder about the psychologist taking the client back in time so that she can relate to her an earlier self (strength and resilience), not just the traumatised parts of the self/identity.

Memo 39: Early Memo -05/08/2010

Resilience

'The ability to recover quickly' (The Free Dictionary) from setbacks. Metaphor – interesting 'elasticity' (The Free Dictionary) the ability to spring back quickly into 'shape' (The Free Dictionary) – the psychologist helps the client get back into shape after the negative life event has disrupted their equilibrium, that balance of mind and emotions leaving the person incapable of being able to help themselves.

Memo 42: Early Memo -05/08/2010

Turning Point

Introducing a positive internal dialogue which is about rebuilding the client's self-identity (sometimes – voices from the past – if only....my life could have been different. Concealing fear – consequences.

Memo 44: Early Memo -11/08/2010

Ways of coping – coming into therapy

Creating boundaries. Interesting (07) 'keeping yourself as a whole person' – is this what the psychologist is helping the client to do –WHOLE –implies something about a broken/fragmented individual who isn't coping and the psychologist trying to rebuild the client into a whole person that can function and who is accepting of themselves.

Memo 47: Early Memo -11/08/2010

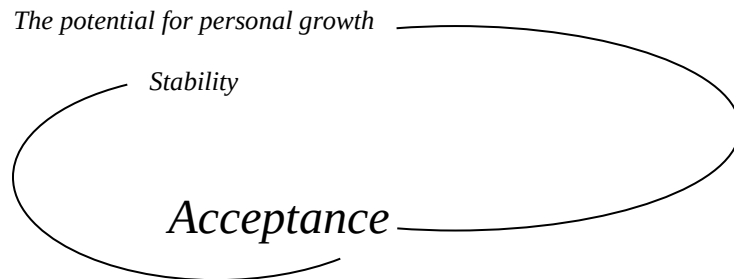
'Winning' by changing direction

What's this about? Moving forward

Category Four memos

Memo 49: Early Memo – 11/08/2010

Being Resilient



Category Four memos

Memo 52: Early Memo -12/08/2010

Turning point

This was when the client wants change, wants to be better -----Is this also about their willingness to take responsibility?

Memo 54: Early Memo -12/08/2010

Life got disrupted

This is about the trauma (“I had a happy marriage, crash bang, never mind”). Disruptions in life – negative life events (precipitating factor)

Quotes:

I was crazy (psy 25)

I didn't notice I was going down (psy41)

I could not hold myself (psy25)

Process

The psychologist holds the client temporarily in therapy, until the client is ready and resilient enough to do this again. It's about rebuilding the self-identity.

Category Four memos

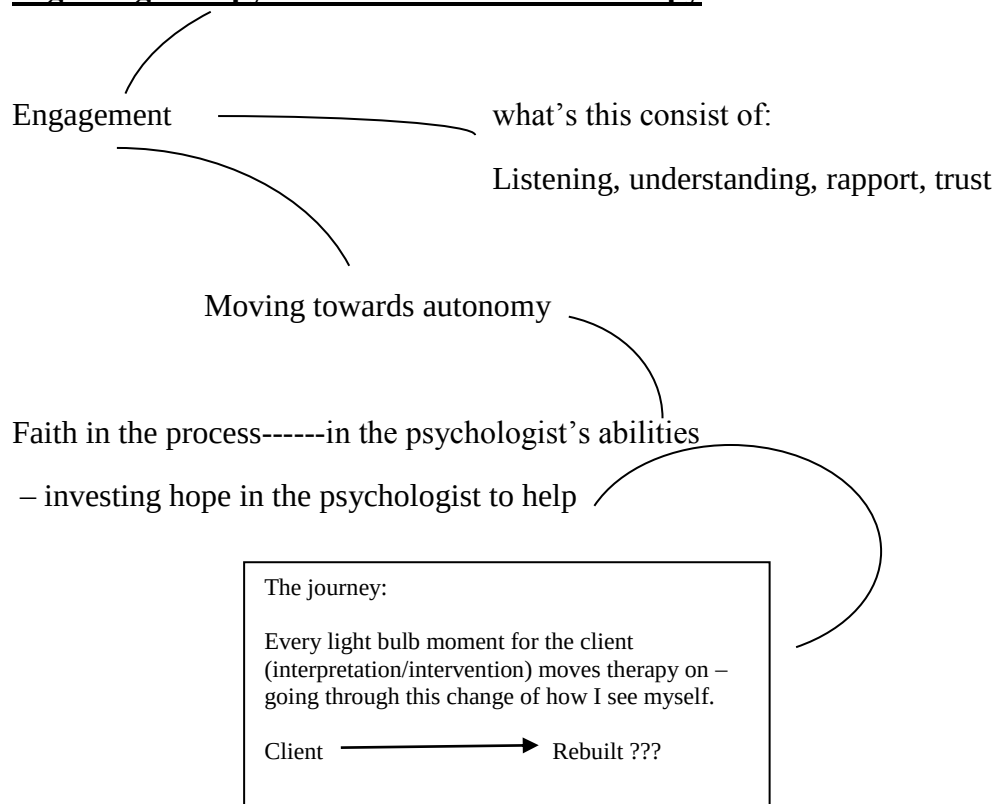
Memo 60: Early Memo -13/08/2010

Observing one's internal world

The process through autonomy. Becoming aware of aspects of the 'self'. The psychologist offers timing interpretation and formulation.

Memo 63: Early Memo -13/08/2010

Beginning therapy ----- End of therapy



Memo 66: Early Memo -14/08/2010

The ending phase of psychological therapy

...experiencing a good ending – this is about the therapeutic relationship.

Category Four memos

Memo 72: Early Memo -07/09/2010

An integrated sense of self

Having psychological therapy provided an alternative that contributed to an integrated sense of self and seeing things in a different light (psy 41): [what is this about?]

- Change
- Knowing I was okay (psy 02)
- Personal growth to achieve resilience
- Getting a breakthrough and seeing that there was an alternative

Memo 76: Conceptual Memo - 19/09/2010

‘The person before you would not believe’

Contemplating who they were before following the trauma led to a period of reassessing their self-identity and life story as they struggled with conflict and also wanting to feel better. Tracking their experiences seemed to help them develop a life script to make sense of their experiences and reflect on particular aspects of the past. This shed some light on some of the dominant stories that had become familiar to them, and the many views of ‘self’ that had been constructed in their life time. Remembering and holding onto positive aspects of them self was a way for them to reconnect with a past ‘self’ that had resilient qualities and this reminded the participants about a period of stability that they recognized but had lost touch with temporarily. Working with the psychologist was a way for the participants to tentatively move towards changing how they saw their present and future selves through remembering the past.

Memo 79: Conceptual Memo - 19/09/2010

The psychologist pulled “me” through and helped me find my way

The support given by the psychologist gave the participants a chance to have someone to talk to and receive help. This presented them with the opportunity to develop strategies, such as positive self-talk and having other resources, being ‘pulled through’ was how the participants experienced being supported and encouraged to move forward. It brings to mind something about being transformed because the participants were empowered to take responsibility and help themselves to stay well. Learning to be self-accepting was an influential turning point to stay[ing] motivated. For the participants letting go of unhelpful patterns was about changing, stepping back so they could feel more balanced and find an alternative [way] to view the ‘self’ and their situation.

Category Four memos

Memo 80: Conceptual Memo – 19/09/2010

“Seeing myself in a different light”

The participants expressed that having psychological therapy assisted them in getting a breakthrough and seeing that there was an alternative. By breaking through their difficulties they achieved personal growth because they had survived and reconnected to their resilience. Moving forward and being different allowed them to rebuild and restore their life. Their confidence in themselves was embodied within a calm, reassurance of knowing they were okay and [this] helped the participants experience self-belief. Having arrived at the end of therapy the participants had changed to a reintegrated sense of self that allowed them to find balance, experience being capable again because they felt safe and stable. The therapy process provided the participants with what they needed to feel whole again. Rebuilding the participant’s sense of self; provided them with an opportunity to take ownership of how they saw themselves. This helped them become reacquainted with who they are now. It makes me think about older adults as being survivors, fighting through and adjusting to some of life’s unexpected challenges whilst still having to live with some of the consequences of those life events. Having an integrated sense of self was something they worked towards and gained when they experienced psychological therapy. The participant’s willingness to work with the psychologist and recognize that change was possible demonstrated that these older adults stayed open to the therapeutic process. Experiencing psychological therapy helped to transform their broken sense of self and contribute to them seeing themselves “in a completely different light”.

Category Four memos

Memo 84: Advanced Memo – 25/11/2012

Choices

...the psychologist giving an alternative and helping the client work through the pain, loss and disappointment. The participant recognizes the signs of becoming unwell. The psychologist teaches and guides the older adult to recognize the patterns and gives them choices about how to cope with that????

Memo 85: Advanced Memo – 25/11/2012

Feeling better

What does feeling better look like? The therapy relationship, the importance of that – the “catalyst” (Perlman, 1979, p.2) to change, psy 41 said, “*I let her in, I let her into me*”. This is the benefit of the work a central ingredient is trust, that’s the power within the therapy relationship, central to the process involved in the client experience.

Category Four memos

Memo 90: Advanced Memo – 25/11/2012

Endings and coping

Worries over how to cope without therapy ‘I dreaded the last one’. Staff consultation happened and the psychologist shared her understanding and it helped staff support the participant better and so the participant was reassured – a good ending. She knows she’ll be okay.....‘that really put the final finishing touches to it... I think I could cope with it. Something about the psychologist passing on the trust, reliability and responsibility to the client and staff. Is this about containment?

Memo 94: Advanced Memo – 25/11/2012

Pacing

It’s about opening up, talking, learning and processing what’s going on. Talking is difficult at the beginning and it takes time to open up to the psychologist. It takes at least three session. It can take 5/6 weeks before talking begins. Pacing is about giving the participant time to talk, taking the pressure off from ‘pouring’ it out all at once and so it’s about the length of therapy. ‘I can do it in my own time’.

Memo 95: Advanced Memo – 25/11/2012

Sharing power within the therapy relationship

They were able to disagree, to step back and think about it and come back and talk about it. The therapy experience needs to share power, the strength of the therapy relationship is when the participant feels empowered to express themselves freely “I felt comfortable”.

Category Four memos

Memo 107: Advanced Memo – 25/05/2013

The psychologist acts as a bridge between

The psychologist acts as a bridge between where the participants' are at and where they want to be.

Distress-----Feeling better

Conflicted self-----wholeness

Disrupted self-----integrated self

Not coping-----coping

No support-----feeling supported

The psychologist holds the participant together until they can do that for themselves. The psychologist connects the participant to their resilient self. The skill of the psychologist to understand the whole of the older person, with all of that history, wisdom and years of life. What's central is the understanding of that ageing self with all the challenges and changes that they are facing. An awareness of all these aspects whilst still seeing the person.

Memo 110: Advanced Memo – 27/05/2013

Self-understanding

The participants' bring a great deal of knowledge about themselves into therapy – 60, 70, 80, 90 years of knowing themselves and developing their own resources and ways of coping that help them to pull through their difficulties. This sense of themselves in part helps them to ride the waves of life and develop insights about the patterns that keep them stuck. Often these insights help them to be pro-active in the management of some of their concerns. Self-understanding is what psychologists' try to help their clients develop so that changes that benefit the client can take place. When OA's receive therapy they bring many decades of learning into that therapy room. Working within that reality is important in order to empower the client and reconnect them with their core strength.

Memo 113: Advanced Memo – 27/05/2013

Different stages in therapy

The process of therapy being like a journey that you both begin together, something happens in the middle stages where the core of the work is done - learning, strengthening of the clients' resources, reconnecting them with their sense of who they are by empowering them to take charge of their lives again. The ending is a readiness to cope again – “on the mend”, describes a process that is not yet complete – on going – the difference is the client feels able to continue the rest of the journey without therapy.

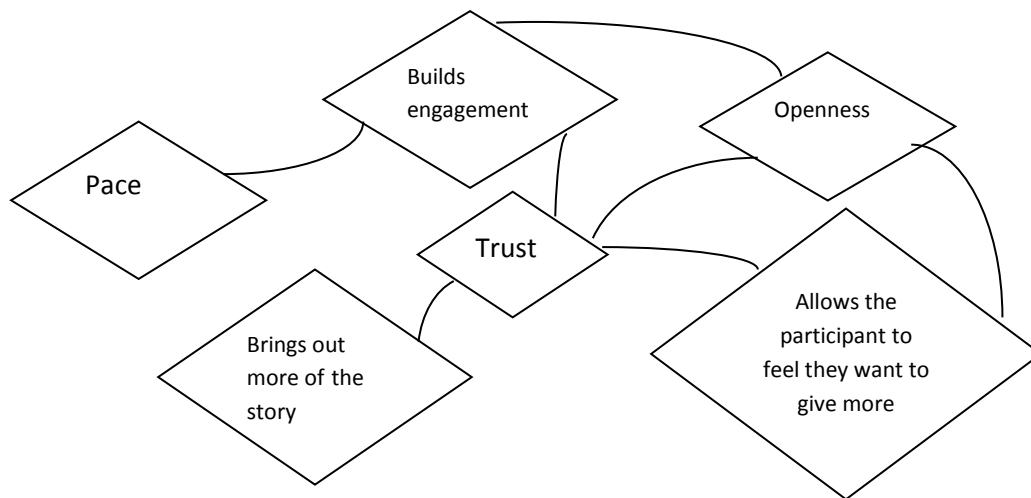
Getting better ('on the mend') —————> feeling better —————> being better

Category Four memos

Memo 117: Advanced Memo – 01/06/2013

Pacing the talk/degrees within talking

When – what's that about??? Is it about building trust or a bond with the psychologist – this is connected with the therapeutic relationship so the pace of the therapy work is important – the rate of movement contributes towards creating a safe space for the client. The pace of the session contributes to the engagement that needs to take place between participant and psychologist.



Memo 120: Advanced Memo – 01/06/2013

Adapting therapy

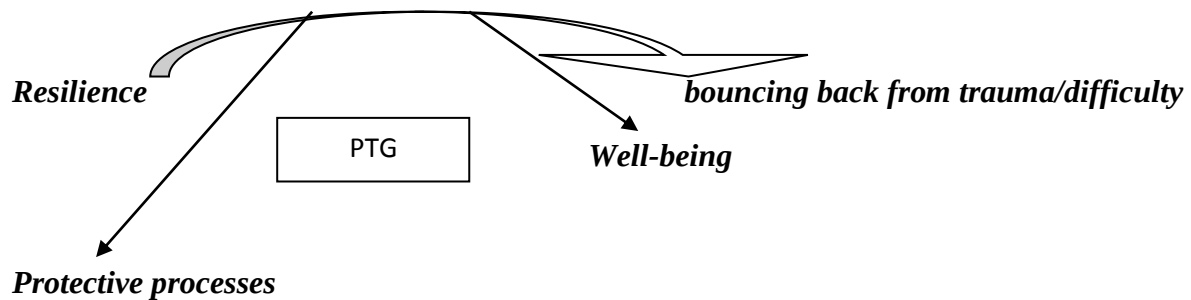
Therapy mirrors what the participants are struggling with/within themselves and the psychologist works with the issues that challenge them. Whilst doing therapy those issues that are challenging (ie: physical frailty sensory problems, memory and all sorts of issues) are in the room with the psychologist and participant because of the challenges the psychologist is constantly adapting therapy to take these issues into account.

Category Four memos

Memo123: Advanced Memo – 02/06/2013

Resilience

It makes me think of what else drives this process. It's about recovery and how the participant adjusts so they can cope with life again. I'm wondering about post traumatic growth [PTG] (Joseph, 2011).



Memo 124: Advanced Memo – 09/06/2013

Engagement and the therapeutic relationship

There is a strong sense of the relationship, a real connection between the psychologist and the participant that allowed the participant to share, learn and recognize patterns of behavior that kept them stuck. The participants had a strong sense themselves as an older person and an awareness of how older adults' can be discriminated against and are treated as if they are invisible. Pacing sessions seemed important in helping the client tell their story. The timing seemed to allow that deep connection and for the participant to feel understood.

Memo 129: Advanced Memo – 14/06/2013

Living for a very long time

The participant spoke about how she has lived for a very long time with a lot of very negative feelings about [her] self. There is an awareness from the participant and the psychologist, I would think that the participant has 'lived for a very long time'. The participant brings all this knowledge and life experience into the room. The participants' are unique in that respect, so from the beginning the age of the person is there, but it is not the only issue in the room (The person: mental health, physical health, culture, frail self, ageing self etc).

Category Four memos

Memo 140: Advanced Memo - 19/06/2013

Endings

Coming to an agreement about therapy ending is a process that is negotiated with the participants. Achieving a good ending is about qualities that developed during the building of the alliance and based on the partnership of trust. The participants expressed their fears and sadness when therapy came to an end, but this was encompassed in the knowledge that what they had experienced was something life changing.

Memo 142: Advanced Memo - 22/06/2013

Kindness and Compassion

The participants' found a way to think better of them self. Coming to terms with the 'self' so the disruption is resolved – the participant is helped to resolve this dis-inequity caused by the fragmentation of the 'self' that was not coping post disruption. What does this kindness and compassion towards the 'self' mean?

Renewing, re-integration ←————→ Therapy relationship

Memo 143: Advanced Memo - 22/06/2013

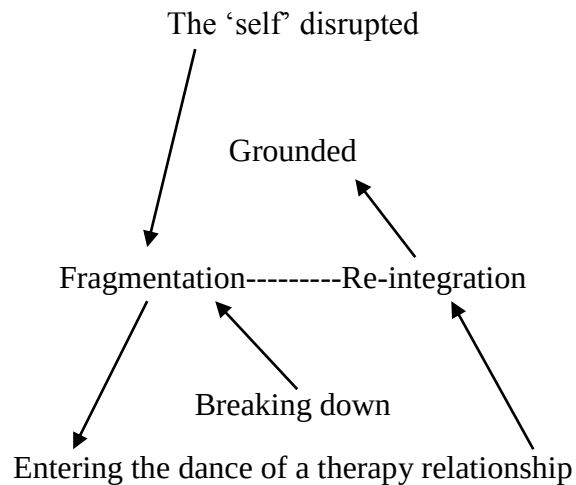
Changing and being different

Reconnecting with that sense of who they are and what the person wants to change. Being different is about wanting to change despite the pain of the past. Where does the change take place? Changing within, making myself more happy leads to freedom from the suffering and pain. Freedom is about acceptance, the participants' can't change the past, therefore changing within is about 'going my own way', finding my own way.

Category Four memos

Memo 146: Advanced Memo - 25/06/2013

'Self'



.....I think I had thought that this is about how the psychologist and participants were able to communicate together about the participants' experience and bring a new understanding to their situation.

Memo 152: Advanced Memo - 29/06/2013

Working through

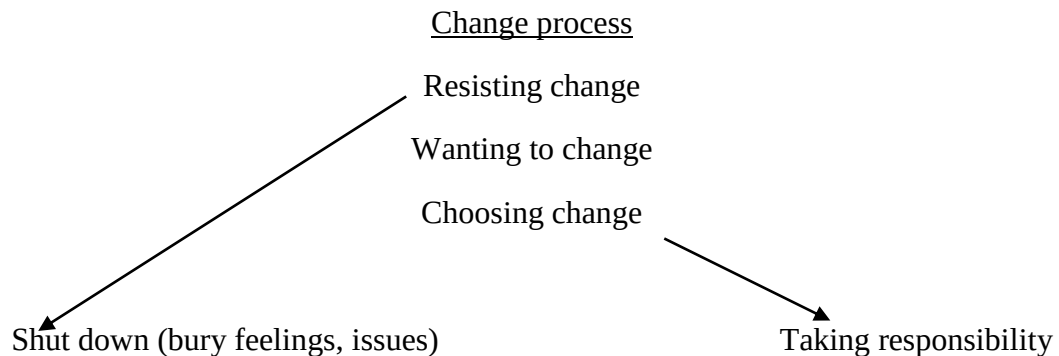
Working through the pain and difficulty, the therapy journey lead to insight and awareness.

Category Four memos

Memo 154: Advanced Memo - 30/06/2013

Taking Responsibility

It's about using choices to decide what you want ----- choosing to get better, choosing to change. To do that the participants' take a different perspective.



Category Four: Storyline memo – 09/07/2013

Embracing wholeness and compassion within

Particular elements are needed to be in place before the participants felt able to talk, which permitted the therapeutic relationship to be used as a vehicle for change. The therapy work consisted of formulating to make sense of experiences so that they could develop a shared understanding. The participants noticed that the psychologist paced and adapted therapy to meet their needs as this was important because they were talking about and working through difficulty. The conversations drew back to remembering the past that connected to stories of loss, punishment and their childhood. The participants' commitment to therapy was based on trusting the psychologist and the process, hence the participants' perception of the psychologist helped them to listen and notice the skill of the psychologist. These factors were fundamental to the participants' experience of care in therapy. Receiving feedback and learning in therapy contributed to them reaching a turning point where they began changing, coping and feeling better, they felt encouraged that they were 'pulling through' and finding that balance. The therapy relationship allowed the participants to negotiate and manage endings, although it brought about feelings of sadness, the participants were at a point where they felt they could manage. By the end of therapy the process helped to foster self-belief within the participants so they can cope with life again. Helping the participants to relocate their resilience. This is an aspect that is utilised within the therapeutic relationship to empower the client to take a different position. Coping with life again is about recovery so that they can connect with a sense of achievement through the choices they make by being pro-active because this gives a sense of purpose. Resilience demonstrates the flexible nature of the older person to come back from difficulty and learn from experience as they develop strategies to hang onto accomplishments with courage.

Appendix 11

Ethical Issues and managing unexpected events during the research process

The researcher sent out an invitation to psy 15 about the study (including the patient information sheet and consent form) on 26/10/2009. A follow-up telephone call was made to the participant on 13/11/2009 and during that conversation psy 15 asked questions about the research, before agreeing to take part in the study. Before the call ended the researcher enquired about how the signed consent form would be returned to the researcher; because there were three days between the telephone call and the day of the interview (16/11/2009). Psy 15 explained that she would give the form to the researcher before the interview started and my impression was that the telephone conversation went well.

Before the interview began the researcher clarified with the participant about the consent form and I checked with the participant to see if she had understood the information included in the patient information sheet. This is in line with Sin (2005, p.290) who suggested that consent should be sought at varying points during the research process to check whether the participant would like to continue. It was at that point that the participant informed the researcher that she could only read in her own language (Greek-Cypriot) but not in the English language. During the follow up telephone conversation the participants' verbal communication was in English, and there was no indication given at that time whether the participant was unclear about any aspect of the research. The researcher remembers that psy 15 showed curiosity and a keen interest to take part in the study during that telephone conversation.

Appendix 11 (cont'd)

We agreed that I would read the patient information sheet (PIS) and the consent form to her before she made a decision to take part. This unexpected occurrence before the interview was managed by both parties and it also gave the participant another opportunity to decline, if she so wished. The researcher was aware that the participant could have experienced that moment where a decision needed to be made, as pressurizing. Therefore, every opportunity (eg; reading the PIS to the participant, leaving time for questions and checking in with psy15) was given to the participant to take her time to consider whether to consent or not. Again, the researcher noted that same keen interest to take part and share her story as psy 15 had conveyed during the follow-up telephone call. The interview began when the participant signed the consent form.

In extract 3 of the field notes and a segment of the transcribed data about psy 15 (Appendix 4), I reflect upon my experience of the interview. I take the view that there was some sense of the quality within the collaboration during that in-depth interview. Perhaps it could be described as an example of how much the participant felt heard during that partnership. I wrote in my journal – 16/11/2009 *'I conducted the research interview with psy 15 and it felt very positive. Interestingly, she was able to give me a detailed account of what makes it difficult to talk to the Psychologist'*.

Appendix 12

(Note: this is a typed and redacted example of the original letter)

City University

London

Friday, 22 February 2008

NHS Research Ethics Committee

RE: XXXXXXXXX Older Adult Service Users Experiences of Psychological Therapy

Dear Colleagues

I am writing to confirm that the above research proposal has been reviewed and discussed with the applicant. It is deemed to be of significant scientific merit. I am satisfied that the ethical considerations have been taken into account and that the proposed responses to dealing with these are appropriate.

I am of the opinion that this project is methodologically sound and has the potential to lead to significant discovery and that the candidate is well placed to deliver these.

I support the ethical approval of this project.

Yours sincerely

Dr Malcolm Cross

PhD C.Psychol AFBPS

Head of the Department of Psychology

Appendix 13

NHS ETHICS APPROVAL

(Note: this is a typed and redacted example of the original letter showing only page 1 of 3 as this states that the research has approval)

Full title of study: Older Adult Service Users Experiences of Psychological Therapy:
A Qualitative Study.

REC reference number: XXXXXXXX

Thank you for your letter of 30 April 2008, responding to the Committee's request for further information on the above research [and submitting revised documentation], subject to the conditions specified below.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation [as revised].

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements.

Appendix 14

NHS FOUNDATION TRUST APPROVAL

(Note: this is a typed and redacted example of the original letter)

Re: Older adult service users' experiences of psychological therapy: a qualitative study

Thank you for sending confirmation of your approval from the ethics committee and submitting your proposed research project, which has now been assessed by the Trust Research Management Group.

I am now happy to inform you that the XXXXXXXXXX Trust has approved this study, therefore NHS Indemnity will extend to any negligence that might occur as a result of or during the course of this project. Should any untoward events occur, it is **essential** that you contact your Trust supervisor and the R&D Office immediately. If patients or staff are involved in an incident, you should also contact the Assurance department via Incident.Reporting@XXXXXXXXX.nhs.uk

Please note that all NHS and social care research is now subject to the DoH Framework for Research Governance. If you are unfamiliar with the standards contained in this document, or the Trust policies that reinforce them, you can obtain details from the R&D Office or from the DoH Internet site (www.doh.gov.uk).

You must inform the R&D Office if your project is amended and you need to re-submit it to the ethics committee or if your project terminates. This is necessary to ensure that your indemnity cover is valid and also helps the office to maintain up to date records.

Yours sincerely,

Appendix 15

Research Invitation Covering Letter

Version date: 13/02/08

City University London
School of Social Sciences
Psychology department
Northampton Square
London
EC1V 0HB

Date:

Dear (*participant's name*):

My name is Maureen xxxxxx and I am a Chartered Counselling Psychologist within XXXXXX Trust. This letter is an invitation for you to consider taking part in a study about Older Adults experiences of Psychological Therapy that I am conducting as part of my Doctorate in Psychology at City University under the supervision of Professor Peter Ayton and XXXXXX.

The purpose of this study, therefore, is to explore your experience of therapy in an Older Adult Psychology service, in order to increase our knowledge and understanding of what is known about your experiences of the therapeutic process. It may have been nine to twelve months ago since you were discharged from the Psychology service and the aim will be to talk to you about that experience. Participation in this study is voluntary and I would like to assure you that this study has been reviewed and received ethics clearance through the Research Ethics Committee within the Psychology Department at City University and the Ethics Committee within the National Health Service. However, the final decision about participation is yours. If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact me on xxxxxx.

I hope that the results of my study will be of benefit to all those directly involved in the study, other Older Adults, the Psychology Service, as well as those in the broader research community.

I very much look forward to speaking with you and thank you in advance for your assistance in this project.

Yours sincerely,

Chartered Counselling Psychologist and Chief Researcher

Appendix 16

THE PARTICIPANT INFORMATION SHEET

City University London
School of Social Sciences
Psychology Department
Northampton Square
London
EC1V 0HB

1. Study Title

Older Adult Service Users Experience of Psychological Therapy.

- 2. Invitation:** You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends, relatives and your GP if you wish. You can ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.
- 3. What is the purpose of the study?** The purpose of this study is to allow you to express your thoughts and feelings about your experience of Psychological Therapy. It is hoped that your views can contribute to the growth of a better 'quality' service for older adults. Older adults have a significant role to play in how Psychology services are shaped and delivered; therefore, gathering feedback from you could lead to us providing a more efficient service that meets the needs of older adults within this community. In order to expand the professions knowledge of the older adult experience it is important to listen to what you and other older adults think about their experience of Psychology so that we can understand what therapy was like for you.
- 4. Why have I been chosen?** It is up to you to decide whether or not to take part. The aim is to look at your experiences of Psychological therapy; the study is about what you experienced. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form.
- 5. What will happen to me if I take part?** It will involve an interview of approximately 60 – 90 minutes in length and you may discuss anything you feel is relevant to the topic. I can come and visit you at home or I can arrange access to a quiet room at xxxxxx if you prefer. You may decline to answer any of the interview questions if you so wish. Further, you may decide to withdraw from this study at any time without any negative consequences by advising the researcher. With your permission, the interview will be audio recorded to facilitate collection of information, and later transcribed for analysis. Shortly after the interview has been completed, I will send you a copy of the transcript to give you an opportunity to confirm the accuracy of our conversation and to add or clarify any points that you wish. All information you provide is considered completely confidential. Your name will not appear in any thesis or report resulting from this study, however, with your permission anonymous quotations may be used. Data collected during this study will be kept in a locked filing cabinet, and the tapes will be destroyed once transcribed. Only researchers associated with this project will have access.
- 6. What do I have to do?** You will only be asked to discuss your experiences of Psychological therapy; the study is about what you experienced.
- 7. What are the possible disadvantages and risks of taking part?** Discussing your experiences may raise painful feelings because of the delicate nature of the topic. The researcher will be open and sensitive to what you are talking about and your safety is ensured. The researcher will assess and help with whatever arises and reassurance will be given when needed. The researcher will also be contactable by phone at the Psychology service (telephone number) where she is based if extra support is needed.

Appendix 16 (cont'd)

THE PARTICIPANT INFORMATION SHEET

8. **What are the possible benefits of taking part?** It is hoped that the interview will be helpful because it gives you a chance to talk about your experiences and your contribution will allow other professionals working in this area to understand what it is like for an older adult to have gone through Psychological Therapy. It can be an empowering experience for some older adults to have an opportunity to talk about such experiences. It can also help the Psychology Service to provide better quality services that match the needs of older adults.
9. **What happens when the research study stops?** When the research is over you will no longer have to share your experiences with the researcher by way of an interview. You will be thanked for your participation in the study and if you request it, feedback about the results of the study can be provided.
10. **What if something goes wrong?** If you wish to complain about any aspect of the way you have been approached or treated during the course of this study please contact: *Professor Malcolm Cross, Director of Dpsych Programme, City University London, School of Social Sciences, Psychology Department, Northampton Square, London, EC1V 0HB*. He will be able to give you advice about the complaints mechanisms that may be available to you.
11. **Will my taking part in this study be kept confidential?** With the exception of material that infringes on the law all information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it. Confidentiality will be maintained with the following exceptions: If material comes to light to assist the researcher to act within the law concerning child protection and with the researchers' legal obligation to report anyone that is at risk, because of the researchers' duty of care to all concerned.
12. **What will happen to the results of the research study?** The results of the research study will be used in the researcher's Professional Doctorate in Psychology Thesis. If you request feedback about the results of the study it can be provided.
13. **Who is organizing and funding the research?** No external funding is being given towards this research which is organized by the researcher. The study is also closely supervised by City University and an External Examiner.
14. **Who has reviewed this study?** This study has been reviewed and received ethics clearance through the Research Ethics Committee within the Psychology Department at City University and the Ethics Committee within the National Health Service.
15. **Contact for further information.** You can contact the researcher (Maureen McIntosh) on:
xxxxxxxxxx

Appendix 17

CONSENT FORM

I have read the information presented in the information letter about a study into Older Adults Experiences of Psychological Therapy being conducted by Maureen McIntosh, Chartered Counselling Psychologist from xxx xxxxx Foundation Trust, studying at City University in London. I have also read the Patient Information Sheets; I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.

I am aware that my interview will be audio recorded to ensure an accurate recording of my responses. I am also aware that excerpts from the interview may be included in the thesis and/or publications to come from this research, with the understanding that the quotations will be anonymous. I am aware that the researcher will take responsibility for any tapes authorized by this form and she will ensure that strict confidentiality is maintained and tapes will be destroyed once transcribed. I was informed that I may withdraw my consent at any time without penalty by advising the researcher.

I understand that this study has been reviewed by, and received ethics clearance through, the Research Ethics Committee within the Psychology Department at City University and the Ethics Committee within the National Health Service. I was informed that if I have any comments or concerns resulting from my participation in this study, I may contact the Director of the course, Professor Malcolm Cross at: City University London, School of Social Sciences, Psychology Department, Northampton Square, London, EC1V 0HB

With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.

☐ YES ☐ NO

I agree to have my interview audio recorded.

☐ YES ☐ NO

I agree to the use of anonymous quotations in any thesis or publication that comes of this research.

☐ YES ☐ NO

Participant Name: _____ (Please print)

Participant Signature: _____

Signature of Researcher _____ (Please print)

Researcher Signature: _____

Date: _____

Appendix 18

Examples of the Research Database of the participants who were contacted

(For confidentiality reasons some details have been anonymized, eg:xxxx).

Consent given		Consent declined	
Participant's Name	Xxxxxx	Participant's Name	Xxxxxx
ID	Psy 15	ID	Psy 22
Consent given	Yes	Consent given	No
Date of Birth	Xxxxxx	Date of Birth	Xxxxxx
Psychologist	Xxxxxx	Psychologist	Xxxxxx
Date of Discharge from the service	Xxxxxx Xxxxxxx	Date of Discharge from the service	Xxxxxx Xxxxxx
Start of therapy	Yes (16.11.09)	Start of therapy	/
GP letter sent	26.10.09	GP letter sent	15.01.10
1 st invite sent	13.11.09	1 st invite sent	/
Follow-up call	/	Follow-up call	/
2 nd invite sent	No	2 nd invite sent	/
Interpreter needed	/	Interpreter needed	25.01.10
Declined to take part	Yes	Declined to take part	/
Inclusion criteria met	/	Inclusion criteria met	/
Exclusion criteria met	/	Exclusion criteria met	Letter received saying this participant does not want to take part.
Reasons for not taking part		Reasons for not taking part	

Appendix 19
Appointment Letter

Version date: 13/02/08

City University London
School of Social Sciences
Psychology department
Northampton Square
London
EC1V 0HB
Date:

Dear *(participant's name)*

You were kind enough to express an interest in my research study about Older Adults Experiences of Psychological Therapy and I am writing to arrange a convenient time to meet with you.

I will visit you at your home on....., at

I do hope that this is a convenient time and date, if not I can re-schedule another day that we can meet.

I look forward to seeing you on that day.

Yours Sincerely,

Chartered Counselling Psychologist and Chief Researcher

APPENDIX 20

Acknowledgement letter of declined consent

Private & Confidential

Dear XXXXXXXX,

Thank you for contacting me regarding my study about Older Adults experiences of Psychological Therapy and your request not to participate.

I can confirm that I have removed you from my research database.

Many thanks.

Yours sincerely

Chartered Counselling Psychologist and Chief Researcher

APPENDIX 21

Letter to the General Practitioner (GP)

Date

Dear Dr xxxxxxxxxxxx,

My name is Maureen McIntosh and I am a Chartered Counselling Psychologist within xxxxxxxxxxxxxxxx. This letter is informing you, with the participant's permission, that your patient (**NAME**) as agreed to take part in a study about Older Adults Experiences of Psychological Therapy that I will be conducting (DATE). This is part of my Doctorate in Psychology at City University under the supervision of Professor Malcolm Cross xxxxxxxx.

The purpose of this study is to explore their experience of therapy in an Older Adult Psychology service, in order to increase our knowledge and understanding of what is known about their experiences of the therapeutic process. It would have been nine to twelve months ago since their discharge from the Psychology service and the aim will be to talk together about that experience. Participation in this study is voluntary and this study has been reviewed and received ethics clearance through the Research Ethics Committee within the Psychology Department at City University and the Ethics Committee within the National Health Service.

If you have any questions regarding this study, or would like additional information to, please contact me on xxxxxxxxxxxxxxxx

I hope that the results of my study will be of benefit to all those directly involved in the study, other Older Adults, the Psychology Service, as well as those in the broader research community.

Yours Sincerely,

Chartered Counselling Psychologist and Chief Researcher

APPENDIX 22

Post Interview clinical support

The participants were informed that they could contact their GP if they needed further support following the interview. They were also informed that they could contact the local Community Mental Health Team (the telephone number for the service was on the letter sent to the participants).

APPENDIX 23

Memo 75: Conceptual Memo – 19/09/2010

Experiencing a broken self

The participants spoke of experiencing traumatic life events and the threat to their physical and emotional worlds left their lives disrupted and they found themselves in distress. Dealing with loss was a significant factor for them as they saw important aspects of their life had been destroyed. The stress of which brought them to the edge of what they could cope with. They explained that they did not feel in control and they expressed disparaging views about themselves, an image came to mind of a disintegrating 'self', fragmented, disconnected, unsteady then breaking down. The distress of their experiences left them lost and without the ability to 'hold' them self together.

APPENDIX 24

Client Case Study Consent Form

I have read the information presented in the information letter about a study into Older Adults Experiences of Psychological Therapy being conducted by Maureen McIntosh, Chartered Counselling Psychologist from xxxxxx, studying at City University in London. I have also read the Patient Information Sheets; I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.

I am aware that this case study will feature within the researcher's Doctorate in Psychology about Older Adults experiences of Psychological Therapy. I am also aware that excerpts from the Psychological work may be included in the thesis and/or publications to come from this research, with the understanding that the quotations will be anonymous. I am aware that the researcher will take responsibility for this information and she will ensure that strict confidentiality is maintained and the information will not, under any circumstances, contain names or identifying characteristics. This consent form is to be retained by the researcher and kept secure. At the completion of the study it will be destroyed in a secure fashion. I was informed that I may withdraw my consent at any time without penalty by advising the researcher.

I understand that this study has been reviewed by, and received ethics clearance through, the Research Ethics Committee within the Psychology Department at City University and the Ethics Committee within the National Health Service. I was informed that if I have any comments or concerns resulting from my participation in this study, I may contact the Director of the course, Professor Malcolm Cross at: City University London, School of Social Sciences, Psychology Department, Northampton Square, London, EC1V 0HB

With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.

☐ YES ☐ NO

I agree to the use of anonymous quotations in any thesis or publication that comes of this research.

☐ YES ☐ NO

Participant Name: _____ (Please print)

Participant Signature: _____

Signature of Researcher _____ (Please print)

Researcher Signature: _____

Date: _____

Appendix 25

Client Case Study Information Sheet

City University London
School of Social Sciences
Psychology Department
Northampton Square
London
EC1V 0HB

1. Study Title

Older Adult Service Users Experience of Psychological Therapy.

- 2. Invitation:** You are being invited to allow the researcher to write a confidential case study about the therapeutic work you undertook with the researcher. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends, relatives and your GP if you wish. You can ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.
- 3. What is the purpose of the study?** The purpose of this case study is to highlight clinical interventions in which the researcher has been a primary participant. The case study will explore the skills and knowledge required to be a reflexive scientist-practitioner. Older adults have a significant role to play in how Psychology services are shaped and delivered; therefore, gathering feedback from you could lead to us providing a more efficient service that meets the needs of older adults within this community. In order to expand the professions knowledge of the older adult experience it is important to listen to what you and other older adults think about their experience of Psychology so that we can understand what therapy was like for you.
- 4. Why have I been chosen?** It is up to you to decide whether or not to take part. The case study will explore the skills and knowledge required to be a reflexive scientist-practitioner. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form.
- 5. What will happen to me if I take part?** The researcher will write a confidential case study about the therapeutic work. The researcher will take responsibility for this information and she will ensure that strict confidentiality is maintained and the information will not, under any circumstances, contain names or identifying characteristics. This consent form will be retained by the researcher and kept secure. At the completion of the study it will be destroyed in a secure fashion. You may withdraw your consent at any time without penalty by advising the researcher.
- 6. What are the possible benefits of taking part?** It is hoped that the interview will be helpful because it gives you a chance to talk about your experiences and your contribution will allow other professionals working in this area to understand what it is like for an older adult to have gone through Psychological Therapy. It can be an empowering experience for some older adults to have an opportunity to talk about such experiences. It can also help the Psychology Service to provide better quality services that match the needs of older adults.
- 7. What happens when the research study stops?** You will be thanked for your participation in the study and if you request it, feedback about the results of the study can be provided.
- 8. What if something goes wrong?** If you wish to complain about any aspect of the way you have been approached or treated during the course of this study please contact: *Professor Malcolm Cross, Director of Dpsych Programme, City University London, School of Social Sciences, Psychology Department, Northampton Square, London, EC1V 0HB.* He will be able to give you advice about the complaints mechanisms that may be available to you.
- 9. Will my taking part in this study be kept confidential?** With the exception of material that infringes on the law all information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it. Confidentiality will be maintained with the following exceptions: If material comes to light to assist the researcher to act within the law concerning child protection and with the researchers' legal obligation to report anyone that is at risk, because of the researchers' duty of care to all concerned.
- 10. What will happen to the case study?** The case study will be used in the researcher's Professional Doctorate in Psychology Thesis. If you request feedback about the results of the study it can be provided.

Appendix 25 (cont'd)

Client Case Study Information Sheet

11. **Who is organizing and funding the research?** No external funding is being given towards this research which is organized by the researcher. The study is also closely supervised by City University and an External Examiner.
12. **Who has reviewed this study?** This study has been reviewed and received ethics clearance through the Research Ethics Committee within the Psychology Department at City University and the Ethics Committee within the National Health Service.
13. **Contact for further information.** You can contact the researcher (Maureen McIntosh) on:
xxxxxxxxxx