A PORTFOLIO OF ACADEMIC, THERAPEUTIC PRACTICE AND RESEARCH WORK


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Submitted to the University of Surrey in partial fulfilment of the Practitioners Doctorate in Psychotherapeutic and Counselling Psychology.

July 2010
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To ensure the confidentiality of all clients and research participants, pseudonyms have been used in the place of actual names throughout the portfolio. Furthermore, all information which may identify an individual has been changed.
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Acknowledgements

Above all others I would like to thank my parents. They taught me how to inquire, challenge, respect and most importantly to persevere. They have been supportive financially, emotionally and practically. I wish to express my gratitude to my clinical supervisors who I feel have been instrumental to my learning, as well as to the course team who have supported and nurtured my growth as a Counselling Psychologist. I am grateful to all those I have encountered throughout my training as peers, friends and colleagues for their individual contributions. I also wish to acknowledge the privilege I have felt with each individual who has shared an aspect of their lives with me, either as client or research participant. My special thanks go to Dr Phil Anderson, whose passion for working with older adults was inspiring, and who enabled my research projects. I would also like to thank my therapist, who listened to me and accepted me. He made my therapy a very powerful experience that I continue to draw on. I offer a wide and far researching thank-you to all my friends and family, but closer to home a heart felt thank-you to my wonderful partner, who has been my rock, and my Jasmine Lilly who brought it all to life.
Portfolio Abstract

This portfolio comprises of three dossiers, academic, therapeutic and research which have been compiled in partial fulfilment of the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology. The academic dossier contains three essays. The first discusses the factors that affect the therapeutic relationship when working with older adults. The second explores psychodynamic conceptualisations of the effect aggressive fathers can have on the development of their daughters. The third presents a conceptualisation of vomit phobia from a cognitive behavioural perspective. The therapeutic dossier contains details of the placements undertaken as part of the doctoral training, and a clinical essay which outlines my development as a Counselling Psychologist by drawing on the clinical experience and my personal growth throughout the training. The research dossier is comprised of three discrete pieces of research which are inter-related by the theme of psychotherapy with older adults. The first piece is a literature review on existential therapy with older adults. It outlines the advantages of offering existential psychotherapy to older adults. It incorporates models of aging, research on the subjective factors that affect well-being and research on existential therapy with older adults. The second piece of research was an investigation into the experience of individual therapy for older adults, using Interpretative Phenomenological Analysis (IPA). Four main themes emerged from the data entitled: 'The beginning', 'The therapeutic relationship', 'Discussing key issues' and 'The ending'. The third piece of research investigated the group processes in therapy with older adults. A localised theory was generated which related to the core category of 'Counteracting Forces'. This contained three main sub-categories of Group Process, Individual Process and Societal Process. For each process a counteracting force is believed to operate. Overall the portfolio aims to demonstrate my development as a practitioner, integrating theory and practice, as well as attending to my personal development.
Introduction to the Portfolio

This portfolio comprises of a selection of academic, clinical and research papers submitted in partial fulfilment of the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. This portfolio contains three separate dossiers which reflect the wide range of material that I have engaged with throughout my training. The papers reflect my academic and clinical interests and demonstrate my evolving competencies. The purpose of this introduction is to orientate the reader to the different parts of this portfolio and to link these parts together and to my own personal development. Although this portfolio is mainly related to my development in training, I feel it is also important to introduce myself and the key points that led me to commence my training.

Personal Introduction

The first point was my decision to study psychology at the University of Bath. This was based on my combined interests of Politics, Biology and Chemistry which I studied for A-Levels. Psychology appealed because it was asking intriguing questions, and there still seemed to be so much that was 'unknown'. It was also a combination of my scientific and humanistic interests. Although I considered a career in psychology, I did not have aspirations to be a psychologist, either when I entered or when I left university. However, on reflection my involvement in Nightline, a student listening service, for the three years I was at university demonstrates my interest and commitment to providing a space for people experiencing distress. The work at the listening service opened my eyes to a world different to that which I had so far experienced. As a listener I felt that I was in a very honoured position of being able to be with people, and that the connection we made either over the telephone or face to face was the vital element in the alleviation of distress. At this time in my life my
interest in psychology and my interest in providing support for people appeared to be quite distinct from each other.

My choice of career after leaving university was not related to psychology or listening, and I did not gain that much satisfaction from it. I started volunteering with The Samaritans, a free support line for people considering or actually taking their own lives, or generally experiencing distress or despair. I found the experiential training very thought provoking and emotionally stirring. It started the process of self-examination and self-reflection which has been advanced in my counselling psychology training. It was also my first encounter with considering ethical and legal issues which had profound implications. The Samaritans is an organisation founded on the respect for the individual whatever their reason for distress, with the listener being accepting and non-judgmental. On occasions this was difficult, but I valued these important underpinnings. Whilst at The Samaritans, my interests as listener and psychologist started to merge. I started to read more about experiences of distress and mental health concerns, mainly through reading autobiographies. I was also fortunate to be able to attend the annual conference which comprised of three days of seminars, workshops and public addresses. I found this so fascinating, enjoyable and stimulating that I started to think about a career change.

The appeal of counselling psychology for me was the approach it took in understanding people and their experiences, which aligned with my role as a Samaritan. I felt the attention it paid to the relationship was important, as my experience lay in the being with people, connecting as two equals, with one being there for the other. I valued the respect that it had for people, whilst also providing the opportunity to be a scientist and going beyond the listening role.
Academic Dossier

The academic dossier consists of three essays that reflect an area of interest or a clinical presentation that I was trying to understand more at the time of writing.

The first essay presented is entitled: 'Discuss the factors that may affect the therapeutic relationship when working with older adults'. My interest arose in this subject area from a lifespan development module. It marks my first step in researching psychotherapy with older adults. The essay discusses social segregation and social categorisation and how this can lead to stereotyping. It also discusses issues of transference and how all these impact on the therapeutic relationship.

The second essay presented explores the fascinating but neglected area of the influence of aggressive fathers on their daughter's development. Two clients with whom I was working psychodynamically, presented with similar relationships with their fathers. The essay is entitled: 'Walking on eggshells: Working with clients who had aggressive fathers'. The essay explores the different theoretical positions of Freud, Klein, Winnicott and Bowlby and finishes with a discussion on how working with this issue impacts on the therapeutic relationship.

The third essay presented explores the presentation of vomit phobia or emetophobia. It is entitled: 'Understanding human distress: A theoretical essay on vomit phobia'. I was inspired to explore this dimension of human distress, as a client, with whom I was working with Cognitive Behavioural Therapy (CBT), presented with this concern. I was intrigued, because superficially it could have been approached as a simple phobia, using behavioural experiments, with little thought being paid to the therapeutic relationship. However, I feel that my approach as a Counselling Psychologist (in training), paying attention to the phenomenology, meaning making and issues of power and control provided a
therapeutic space where a person with vomit phobia was able to understand and change. Although the main therapeutic stance was of CBT, this was mainly due to placement expectations and the fact that CBT features most prominently in the literature. However, what happened in the therapy room was more than graded exposure and cognitive challenging and this is explored in the essay.

**Therapeutic Practice Dossier**

The therapeutic section of this portfolio includes a brief of overview of the three placements that I completed as part of my training as a Counselling Psychologist. In summary, these include a primary care service based at a GP centre, a tertiary psychotherapy department and a geographically located primary care service. For each placement a synopsis is given detailing the orientation, typical client presentations and types of supervision.

This section also contains a personal account of my professional development, provided in my Final Clinical Paper. The paper outlines my development as a Counselling Psychologist by drawing on the clinical experience and my personal growth throughout my years of training.

**Research Dossier**

The research section of this portfolio is comprised of three discrete pieces of research which are inter-related by the theme of psychotherapy with older adults.

It is in keeping with the philosophical stance of counselling psychology to be open to what brings someone to research a subject, so as to be aware of how our interests and our experiences affect the interpretative framework. Therefore I will take this opportunity to detail my interest in older adults and ageism. My interest in older adults started due to my close relationships with my grandparents. As I
grew up I started to become aware of one of my grandmother’s anxieties. When I started my training as a counselling psychologist, I started to reflect on why psychological intervention was not offered to her. I was motivated to conduct research into psychotherapy with older adults as a means to justify the provision of services, not for my grandmother, as unfortunately it is too late for her, but for what I could see as an important unmet need. I also had a very positive role model in my grandfather who was an astute, intelligent and very capable man. It was part of the family narrative, told with admiration, how he had retired three times, and eventually stopped working in his mid-eighties. I remember the speech he gave at his ninetieth birthday party which was clear, witty and heartwarming. Maybe he was exceptional, but I doubt he was the exception, and to view this man as ‘less worthy’ of a psychological intervention due to his age seemed wrong.

This led me to think about ageism, and how institutionalised it is. I then started to reflect on my own experiences of ageism, but this time in reverse, of being ‘too young’ and how it made me feel angry, frustrated, sad, and unjustly attacked. I was also aware of my father experiencing ageism when he was made redundant at 49, and how he found it hard to get further employment due to his age. He now works for a Japanese company which values the knowledge and expertise that he has, and it is interesting how our culture seems to disregard the potential advantages found with older age. I found it fascinating that prejudice due to age was so pervasive, especially as other types of discrimination are seen to be condoned.

The initial literature review was entitled: ‘How can existential therapy help older adults?’ Having developed an interest in existential psychotherapy, I was interested in whether it would be particularly suitable for older adults, given its focus on phenomenology and existential concerns. The research on existential therapy was limited and only from the United States of America. Due to this
apparent gap in the literature I felt the subject was worthy of further exploration, especially with the potential for empirical research.

My first piece of empirical research investigated the experiences of individual therapy for older adults, using Interpretative Phenomenological Analysis (IPA). I did consider researching the experiences of existential therapy, but I thought more open and explorative research was more suitable. From this four main themes emerged from the data about the experience of therapy: the beginning, the therapeutic relationship, discussing key issues and the ending. A finding which I found interesting related to the loneliness of older adults. I became curious as to whether therapy in a group format may help with the loneliness felt by the older adults. From this, the second piece of empirical research investigated the group processes in therapy with older adults. A localised theory of what processes occur in group therapy with older adults was generated. This related to the core category of 'Counteracting Forces', which contained three main sub-categories: Group Process, Individual Process and Societal Process. For each process a counteracting force is believed to operate. Overall the findings add new insight by incorporating participants' outside experiences into the group processes, highlighting how group processes lead to individual change and providing a contextual basis.

Conclusion

This portfolio is the culmination of research, academic and therapeutic work towards a Practitioner Doctorate in Counselling Psychology. It aims to demonstrate to the reader how I have developed as a practitioner, integrating theory and practice as well as attending to my own personal development.
Academic Dossier

Introduction to Academic Dossier

The academic dossier includes three essays that were submitted during my counselling psychology training. These papers are eclectic in nature and offer an insight into the diverse topics covered as part of the training. The first essay explores the factors that affect the therapeutic relationship when working with older adults. The second paper explores the effect of aggressive fathers on the development of their daughters. Clinical examples are used to illustrate the key issues. Finally, the third essay considers working with and conceptualising vomit phobia as a form of human distress. A clinical example is used to highlight the experience of a client in therapy.
Essay 1: Discuss the factors that may affect the therapeutic relationship when working with older adults.

Introduction

The term ‘older adults’ can be defined by many different chronological ages and does not have a specific age bracket, unlike ‘children’, who are under the age of 18. In much of the literature, the exact age definition of an older adult is absent (Slater, 1995; Stokes, 1992; Stuart-Hamilton, 1996). In the UK, adults over the age of 65, the legal retirement age for males, can be considered to be older adults, and this is the definition used in the essay. The exact chronological age of older adults does not need a detailed definition, as the essay will show that the factors that influence the therapeutic relationship between a psychologist or psychotherapist with older adult clients relate to societal and family influences.

The essay will discuss how social segregation and social categorisation can result in people perceiving themselves to be different from people of other age groups, which in turn can lead to an ‘us and them’ distinction. This distinction and limited interaction may mean it is harder for the therapist to empathise with the older client, which in turn affects the working alliance. This differentiation can result in the therapist being more reliant on social stereotypes, and these in turn will impact on the therapeutic alliance if they are not within the therapist’s self awareness. The impact of stereotypes can affect the therapist’s perceptions of the client, therapist’s behaviour and client’s behaviour. The therapist may also rely on his or her own family interactions, to connect with the older adult, which can lead to parental and grandparental transference. The impact of the existential threat of the older person to the therapist and the resulting anxiety will also be discussed. It is recognised that there are many influences that affect the therapeutic relationship and those factors that can be controlled by the therapist and can lead to an improvement in the relationship will be discussed in this
essay. The conclusion will emphasise how it is important that the therapist is self-aware, and aware of the external factors that affect the therapeutic relationships, in order to make the therapy more effective.

'Us and them' differentiation.

Two ways in which 'us and them' differentiation can occur is through the processes of age categorisation and social age segregation. Age categorisation, as defined by Bytheway (2005) is how people are classified into different age cohorts e.g. 40s, 50s, 60s or age categories e.g. child, adolescent, adult, and elderly. The process of classifying people by their age cohort or age category emphasises the differences between the groups, and the similarities within the groups. It is recognised that age categorisation can be useful in aiding psychologists to understand the factors that are relevant to certain age groups, but it is the over emphasis on differences which leads to distorted stereotypes.

"Defining older people as a homogenous group is problematic, it can lead to stereotypical and stigmatising perceptions of what old age is, attracting negative attitudes to later life. Nevertheless, evidence suggests that some in the older age bracket are subject to particular stressors and physical changes that can adversely affect their mental health (Clarke, 2005, p. 290).

Hagestad and Uhlenburg (2005) divided social age segregation into three types: institutional, spatial and cultural age segregation. Institutions in western societies segregate people, for example children in schools, adults in work, and older people in specifically designed retirement homes or villages. There are aged-based entry restrictions for each of these institutions. Spatial age segregation is when lifestyle and routine separate individuals, as people of different ages do not occupy the same locations at the same time. The two segregations highlight how there are not the opportunities for face to face interaction between people of
different ages, particularly outside the family unit. When there is interaction, communication can be affected by cultural age segregation highlighting how people of different ages have different cultures, which influences the language spoken, and this difference in language will further increase the barriers in communication. Overall categorisation and segregation prevent people of different ages from interacting. This can result in therapists relying on social stereotypes or family members when relating to clients.

Stereotypes of older people

Stereotypes can have a negative effect on the therapeutic relationship in three ways. Firstly they can distort the therapist's perception of the client (Biggs, 1989). They can also affect the therapist's behaviour and the client's behaviour. There are many stereotypes, both positive and negative of older adults (Kite et al., 2005) but Sneed and Whitbourne (2005) have proposed that six main stereotypes exist. These are particularly relevant to this essay as they concern the health, roles and relationships of older people and therefore have a direct impact on the therapeutic encounter.

1. Older adults are lonely and lacking close friends and family.
2. Older adults have higher rates of mood disorders than younger adults.
3. Older adults are rigid and unable to cope with the declines associated with aging.
4. Older adults become increasingly like each other with each passing year.
5. Older adults are sick and dependent.
6. Older adults are cognitively and psychologically impaired.

Although Sneed and Whitbourne (2005) have argued there is insufficient evidence to support these stereotypes and they challenge their validity, the implications of these stereotypes are far reaching, and can distort the perception the therapist has of the client, and the client's self perceptions.
“The labelling of a person as ‘old’ carries so much force that everyone including the elder forgets the individual with specific strengths and a history of accomplishments who is hidden within the image of the stereotypical ‘older person’.” (Knight, 1986, p. 92).

Therefore if a therapist were to hold these assumptions about an older adult client, this would have a negative effect on the therapeutic relationship, as it would be based on distorted perceptions, and not on the actual client and their presenting problems. Indeed, Woolfe and Biggs (1997) found that therapists lowered expectations about what could be achieved and were less likely to challenge defences when working with older adults. This is likely to change the nature of the relationship, in that it would be a more supporting or friendship based relationship, rather than a therapeutic one that has a focus on change.

Social stereotypes can affect the therapeutic relationship by influencing the therapist’s behaviour, in particular the language and the way they interact with the older client. Although Knight (1986) recommends that therapists should speak slower and more clearly to older clients, if this is not at the appropriate level to the client’s needs, then it could have a negative effect on the therapeutic relationship, if, for example, the client perceives the therapist to be patronising. Nelson (2005) found that the stereotype that all older people have deficits in cognitive abilities leads to patronising language. This included over accommodation; being overly polite, speaking louder, slower, in a higher pitch, playing down serious thoughts concerns and feelings, and using ‘baby talk’; simple words and sentences with exaggerated intonation. Research found that the older adults regarded the patronising language as disrespectful, condescending and humiliating (Giles et al., 1994). Therefore, if a therapist started using patronising language and thereby insulting the client, this would
seriously affect the working alliance as the client would not feel understood by the therapist and may have negative feelings such as anger and resentment towards the therapist.

Social stereotypes and patronising language can have a further effect on the client in terms of learned dependence. Baltes (1995) found that older adults in institutions learnt to become dependent in order to gain certain advantages, for example attention and social contact. It may be that the therapist also encourages certain behaviours of dependency by not challenging the stereotypes of older adults. The therapist also needs to be aware that the client may become dependent on therapy for social contact and therefore resist the therapeutic process of change in order to continue the contact (Knight, 1986). In this way the relationship is negatively affected as it is not therapeutic in providing positive change, but is actually destructive by promoting dependency and neglecting the client's ability to control their environment in an active rather than passive way.

Transference and Counter Transference

In addition to the therapeutic relationship being influenced by stereotypes, Knight (1986) has proposed that transference and counter transference issues also impact upon it. The transference issues include the therapist as the client's child, grandchild, parent, or spouse at a younger age. These issues are important to consider as they have an effect on the therapeutic relationship, but counter transference will be discussed further as the therapist is responsible for bringing it into the relationship and therefore it is under his or her control.

"Counter transference represents the therapist's perception of a relationship with the client, that is not based in the reality of the relationship or the client's actual characteristics" (Knight, 1986, p.131).
Knight (1986) has proposed that there are two types of counter transference specifically when working with older adults; parental and grandparental. This is where the client is seen to be similar to the therapist's own mother, father or grandparents, and the effect on the therapeutic relationship will depend on the therapist's relationships with their parents and grandparents. It is likely to cause the greatest influence if the family relationship is particularly negative with unresolved conflicts, or conversely if it is idealised. The effects can be an over commitment to client change, irrational anger, and issues of control in the session. Counter transference feelings may prevent the therapist from viewing the relationship between the client and their children objectively, or from the client's perspective. Knight (1986) presents examples of where the counter transference can distort clinical judgement, as the client's symptoms are minimised and not given a diagnosis. Supporting this, Cuddy et al. (2005) found that mental health professionals frequently fail to notice depression in older adults. Therefore counter transference influences the therapeutic relationship as the therapist is being influenced by factors that are not presented by the client.

Existential Threat

Knight (1986) also noted that when working with older adults, some therapists avoided discussing end of life issues and he believes this was due to the therapists' own discomfort. The Terror Management Theory proposed by Martens et al. (2005) has developed this and suggested that older adults present an existential threat for all individuals who do not consider themselves to be old.

"Negative attitudes and behaviours directed toward elderly people can be explained in large part by people's own fears about aging and death" (Martens et al., 2005, p. 223-224).
The basis of the theory is that all humans have a conscious or subconscious anxiety about death and the associated physical deterioration of the human body. Research by Martens et al. (2005) found self-reported negative attitudes toward the older adults were positively correlated with fears about death, suggesting that the negative attitudes stem from concerns about the similarity between oneself and elderly individuals. This substantiates the creation of an 'us and them' distinction discussed earlier.

The impact of the death anxiety is most likely to have an effect on the therapeutic relationship if, for example, a client wanted to discuss the issues surrounding death, but the therapist was not open to explore these due to his or her own fears. Conversely, there may be an over involvement from the therapist who subconsciously needs to discuss their own anxieties, while this is not an issue for the client (Knight, 1986). This can impact the therapeutic relationship, as a good working alliance is only formed when the client can discuss all issues and can direct the focus of the therapy (Mearns & Thorne, 1999).

Although Martens et al. (2005) does provide evidence that death anxiety affects attitudes towards older adults, the research was based on general opinions of older adults, rather than asking about influential figures, friends or family. It also focused on the negative side of death and physical deterioration and it may be that older adults who are physically enabled with a good quality of life are positive role models and therefore can relieve the death anxiety by showing a future self that is not fearful.

Conclusions.

In summary, the essay has discussed how age categorisation and social segregation can create an 'us and them' distinction particularly with older adults. This leads to social stereotypes which can distort the therapists' perceptions of
the client, as well as the client's self-perceptions. It can also influence the
behaviour of the therapist in terms of patronising language, and the client in
terms of learned dependence. In addition, the therapeutic relationship is also
affected by transference and counter transference, which can lead to a distortion
of the therapists' clinical judgement. Furthermore the existential threat presented
by the client can lead the therapist to feel anxious about aging which affects the
therapeutic relationship if death, as an issue, is ignored or over emphasised.

It is acknowledged that there are many factors that affect the therapeutic
relationship, but the factors discussed are specifically relevant when working with
older adults as they are based on ageist prejudices which are the most socially
condoned and institutionalised forms of prejudice (Nelson, 2002). Therefore they
may not be in the forefront of the therapist's consciousness as factors that affect
the therapeutic relationship, compared to prejudices that are based on explicit
differences such as race, gender and sexuality.

"The relationship is one in which both partners are prone to the projections,
distortions, prejudices and misunderstandings which occur in all relationships."
(Du Plock, 1997, p. 84).

When prejudices are accepted by both the therapist and the client, they are not
challenged. Therefore it is important to raise awareness of the ageist
assumptions, stereotypes and anxieties, as this will help in building the working
alliance. Once a factor is in the awareness of the therapist, it can then be left
outside the relationship, bracketed (Du Plock, 1997), or brought into the
relationship to be discussed (Jacobs, 1999), depending on the type of therapy
being offered.

In conclusion, building the therapeutic relationship into a working alliance is a
prime aim of therapy. When either the client or the therapist perceive themselves
to be different from the other, it is important that the therapist works on showing empathy and understanding to build the therapeutic relationship. Using strategies such as mentioning important historic periods in the client’s life can do this with older adult clients (Knight, 1989). More importantly being aware of the stereotypes, prejudices and anxieties that can damage the relationship is vital.
References


Essay 2: Walking on eggshells: Working with clients who had aggressive fathers.

Introduction

This essay will discuss the impact of aggressive fathers on daughters. Two clinical examples of female clients who have aggressive fathers will be used to explore how their fathers impacted on their childhood, and contributed to their current problems. A brief description is given of each client in Appendix A. Theoretical models will be discussed, including those of Freud (1905), Klein (1928), Winnicott (1950) and Bowlby (1973). The effects on the therapeutic relationship will also be discussed. The clients' experiences will be used to illustrate the effect their aggressive fathers had on their lives. The focus will also be on the expression of aggression, which is experienced as a critical and hostile interaction, or emotional abuse (Rutter, 1990). The effects of physical and sexual abuse are beyond the scope of this essay.

Miss G: 'I can't imagine sitting Dad down saying you are the only one where I feel like I am walking on eggshells when I am around you'

Mrs F: 'I just want to be able to discuss things and be honest with my Dad and I asked him, why does it always feel as though I was treading on egg shells with you?'

Freud

Freud (1905, 1923) originally conceived the oedipal conflict through self reflection on his childhood and proposed that it was a conflict that had to be resolved by all children.

'Freud found the libidinal relations to the parents to be the centre and the
In short, the conflict centres on how a son accepts his father into his relationship with his mother. In the maturation process the child begins to realize that his mother has a sexual relationship with the father outside her relationship with the son. Freud proposed that the conflict for boys is that they want to murder their father, so they can have an exclusive relationship with their mother, but then feel guilt for their feelings and fear that their father will castrate them. Resolution comes from identifying with the father, and changing the relationship with mother so it is less close.

The original emphasis of the theory was on men, however, the oedipal complex in women has also been developed by Lampl de Groot (2000). She proposed that it starts for girls when they realize the anatomical differences between themselves and boys, the fact they do not have a penis, and they assume that they have been castrated. The first phase of the oedipal complex is to accept the fact she has been castrated and the second phase is to identify herself with the lost love object, her mother, and to put her father in that place, thus passing into the positive oedipal situation (Lampl de Groot, 2000). If the father does not act as a love object for the female child, she may try to return to her former position with the mother as the primary love object. This would be the case if the father was hostile or aggressive; therefore the effect of an aggressive father for girls may mean that the oedipal conflict cannot be fully resolved.

Formulation

Miss G found her father overtly disparaging and critical. This may have made it difficult to move her libidinal desires from her mother to her father for two reasons. Firstly, he did not offer the love and caring needed for this to occur, and
secondly there was a fear that her father would attack her mother if she left. This might explain why Miss G is locked into a pattern of relating to her father where on the one hand she is constantly trying to please him, e.g. with choice of career and partner, but on the other hand constantly feels angry at him for his critical behaviour.

For Mrs F the relationships with her parents were more tempestuous, but it can be hypothesized that to some extent she was able to resolve the oedipal complex, moving her libidinal desires away from her mother to focus on her father, as she described siding with her father against her mother. This process may have been aided when her younger sister was born. However, Mrs F description of both parents as having periods of anger may mean that each parent would alternate as her love object and she did not have a stable relationship with either parent. This pattern is still repeating, as since the birth of her son she has been in contact with her father and not her mother.

**Klein**

Klein (1928) placed the start of the oedipal complex at weaning, when the mother frustrates the oral desires of the child.

‘I regard the deprivation of the breast as the most fundamental cause of turning to the father’ (Klein, 2000, p.103).

Klein believed the motive to possess the father as a love object came from envy and hatred against the mother for taking away the breast; she also proposed that it came at an earlier age than Freud had proposed. In addition, Klein thought that due to the oedipal complex, females experience great anxiety about their womanhood, in a similar way that men fear castration, and this leads to increased control over the oedipal impulses. This suggests that where there is aggression from the father, this may lead to denial or fear about womanhood in daughters.
Indeed, when Mrs F described experiencing her period for the first time, she said that

'I was upset, I did not want to become a woman. I found it difficult as I was getting bigger breasts and experiencing moods.'

Within the psychodynamics of the family, when a girl’s father does become an important primary person, it is within the context of a bisexual relational triangle. A father’s behaviour and family role and a girl’s relationship to him are crucial to her ability to form a heterosexual relationship (Chodrow, 2000). It is too simple to follow this argument to propose that aggressive fathers cause homosexual daughters, but both Miss G and Mrs F have disrupted relationships with their partners.

Formulation

Mrs F went through a period of spending thousands of pounds using her husband’s credit card, which could be viewed not as traditional passive feminine behaviour but of masculine activity and an act of castration by stealing her husband’s money (Chodrow, 2000). In this way, although in a heterosexual relationship Mrs F is behaving in an aggressive and masculine way. It could be that her father’s aggression prevented Mrs F from identifying with her mother’s femininity and therefore her own, or she may be copying her mother’s aggressive behaviour.

Miss G retains a close relationship with her mother, visiting her daily and constantly worrying about her well-being. She is concerned about her current partner’s wish to buy a house with her and therefore form a stable relationship. She was unable to commit to a previous partner of seven years in a similar way. She adamantly states that she does not want children. Although she is not homosexual, prioritizing her mother’s needs above those of her partner and her
own, may indicate that being in a heterosexual relationship with the associated expectations of commitment and children causes her anxiety.

In support of this theory, research by Burgner (1985) found that when fathers were absent in the first years of life, the patients were impaired in their capacity to separate from their primary object, and remained ambivalently attached to their mother. This in turn affected their sexual identity and their self confidence in their adult roles as partners and parents. It can be hypothesized that fathers who are absent by virtue of their aggression, could produce a similar reaction. Overall, acquisition of second object is of crucial significance in the ability to form mature object relations (Gaddini, 1976).

The oedipal conflict has been maintained as one of the primary theories on psychodynamic literature although the emphasis has moved away from the libidinal desire for the mother and towards the importance of triangulation for the development of the self.

**Winnicott**

Winnicott focused more on the role of the father in a child’s development. He stated that the first role of the father was to support the mother in caring for her baby and to enable the mother to provide a holding environment without unnecessary impingements (Winnicott, 1968). The father is also important for meeting the needs of the mother, which are independent from those of the child. If the father is not able to provide the mother with needs for comfort, strength and sexual pleasure, then the child, who is in a symbiotic relationship, will try to meet the needs of the mother. Later in the child’s development, the father is needed for the child to develop a sense of self. The relationship with the mother is still felt as merged, whereas the interactions with the father are felt to be separate. It is from the father that children can first learn about a human being that is
different. He proposed that it is through the father that children learn about relationships that include love and respect without idealization (Winnicott, 1981). Therefore, the father is needed for the child to break away from the dependant and close relationship with the mother and for a sense of self to develop. This theory is conceptually different to the oedipal complex, as it focuses on the formation of self, rather than a reaction of libidinal desires.

Formulation

Miss G’s lack of closeness to her father probably deprived her of an early experience of another person, with different interests, and as separate from herself. This is likely to have led to an undeveloped sense of self, independent from her mother. It can be seen that the mother has remained a primary love object, and this unity has become a threat to self hood. This may explain why Miss G has been unable to pursue a career without feeling overwhelming anxiety and self doubt.

‘I went to see the manager who told me that I would be able to go as far as I want to go in (work), but I just had this terrible fear of failing.’

In the same respect, Mrs F also appears to have low self worth and self doubt, especially in the workplace.

‘It has left me feeling so low about myself. I just have no confidence, when I was working at my old job.’

Winnicott (1950) also considered the role of aggression, particularly the child’s aggression towards the mother, although his ideas differed from Klein’s. He proposed that in the early stages of development when the ‘me’ and ‘not me’ are being established, it is the aggressive component which is needed for the ‘not me’ to be felt as external. This is important as a certain amount of aggression is needed to make the sense of self, separate to the mother. It could be that if the
father is aggressive towards the mother, the child does not feel they can be aggressive as well, and therefore they moderate their aggression by not becoming independent.

Formulation

This appears to be the scenario between Miss G and her parents. She fears the father's attacks on her mother, and herself, and is also unable to express her anger at her mother.

'I get really resentful towards her, I think why do I have to listen to this, and it makes me angry towards my Dad as well.'

Whether this is a repetition of how she felt as a child has not been explored in analysis.

For Mrs F, her behaviour seems a lot more complex as she has been aggressive with her mother, seeking independence, but then also plays a reconciliatory role.

Winnicott believed that aggression is part of the primary expression of love and if aggression is lost at an early stage of emotional development, there is also some degree of loss of the capacity to love, and to make relationships. Mrs F's relationship with her partner seems to contain cycles of conflict and love as it did with her father. For Miss G, as her therapist, I am left wondering to what extent she loves her partner. The affect of an aggressive father can therefore be seen to effect the ability of a person to express their aggression and love to their mothers. This restricts their development of an independent sense of self, and also their ability to love a partner.

Bowlby

Attachment theory, originating from the work of Bowlby (1973, 1988, 1990)
stresses how attachments to parents, both the primary caregiver and the secondary carer (usually the father), is also important for the development of the child. Attachment theory differs from the theories already presented, with respect that it does not view either sexuality or aggression as driving forces of development (Fonagy, 2001), but highlights the need for attachment as a basic need it it's own right. Anger is however recognized as a natural response of the child to a threat to the attachment relationship, and serves to strengthen the relationship (Bowlby, 1973).

The relationship to father is important especially when the mother is unavailable to the child, through separation, illness, or birth of another child. Both clients experienced ‘unavailable mothers’ to differing degrees when they were younger. Mrs F reported that her mother had post natal depression when she was born and was on medication due to suicidal ideation. Miss G described incidences of her mother’s depression in adulthood, suggesting that she may have suffered depression when Miss G was a child. Miss G also had three older siblings who would have been competition for her mother’s attention. Therefore the attachment to a secondary caregiver would increase significance, and the effects of aggression would be more critical.

Research by Lyons- Ruth et al. (1999) found that frightened and frightening behaviour predicted disorganized attachment in infants. This suggests that the aggressive behaviour of fathers, may contribute to a disorganized attachment style. Overall, a disorganized attachment in early life can lead to relational disturbances in later childhood, e.g. bullying, which are felt to be a sense of interpersonal incompetence, and also problems with affect regulation and social cognitive skills in adult life. Both Miss G and Mrs F were bullied at school, and felt that it affected their happiness.
Miss G: ‘Occasionally they would say a comment about my nose that would knock me back into place, like I had no right to be popular’

Mrs F: ‘There was a time at school as well where I was forced into stealing by one of the girls who was bullying me. I didn’t want to do it, but she made me.’

The therapeutic relationship

The therapeutic relationship is the vehicle for previous relationships to be re-enacted through transference and counter transference (Clarkson, 2003). The client will treat the therapist as though they are her mother, father, and other key figure in their lives. For example, Lampl de Groot (2000) noted that with two female clients, a positive homosexual transference was formed, where the therapist represented the mother as a love object.

When there are issues of aggression with the father, the client may perceive the therapist as aggressive or critical. Or conversely, the client may act in aggressive ways, which may lead the therapist to act in a controlling or refraining manner (Lansky, 2001). The two clients have expressed their anger at me in very different ways. Miss G has cancelled sessions and made degrading remarks about our relationship. Her resistance in forming an attachment with me may mirror the lack of relationship she has with her father. Mrs F has turned up late to sessions, and tried to extend the boundary of the end of the sessions. This may mirror how her relationships contain both love and hate.

In terms of the counter transference, with Miss G, I have found it difficult not to criticize her, thereby taking up the role of father. I also feel hurt by the fact she is not always open with her thoughts and feelings, maybe in the same way as her father. Mrs F has pushed my patience, but invokes less angry feelings within me,
and I have noticed a tendency for me to treat her differently to other clients. The therapeutic relationship is vital to the success of therapy (Clarkson, 2003) and aggression in early childhood will mean that aggression is also a feature of the therapeutic relationship. Therefore, awareness of the dynamics that can prevent a rupture in the relationship is important.

Conclusion

The role of the father in development is very important, as recognized by Freud (1905), Klein (1928), Winnicott (1950) and Bowlby (1973). The development of an infant or child can be affected when their relationship with their father is not healthy. This essay has concentrated on the more subtle affects of fathers, rather than the more profound affects of physical violence and incest, because both clients believe that their aggressive fathers significantly impacted their lives. ‘Inadequate fathers don’t have to be drunk (..) or violent. They can do a pretty thorough job by being overbearing, critical and stamping on any attempts their (children) make to be independent’ (Phillips, 1993, p. 182).

The essay explored how the father plays a role to resolve the oedipal complex, to form a transition from mother to father, providing the foundations for future heterosexual relationships. The father also prevents enmeshed relationships, where the child would feel the need to provide for the mother. There is also an idea that the separation from the symbiotic relationship with mother is needed to provide a concrete sense of self. Aggression expressed by the father affects the child’s ability to become independent. Attachment also forms a fundamental part of healthy development, and aggression on the part of the attachment figure can lead to relational disturbances.

This essay has considered two female clients, whose relationships with their fathers meant they constantly felt they were ‘walking on eggshells’. Their
symptoms and problems are different, due to the vast differences in their early environments, but there are key similarities. It is valuable to have a wide range of theories to examine client histories, as this offers the advantage of the client looking at their experiences through different lenses, to find which resonates and therefore helps them understand their childhood experiences.
Appendix A: Brief descriptions of the client.

Miss G

Client Profile:

Miss G is a 36 year old white woman who is currently living with her boyfriend, and running her own business. She attends sessions well dressed in a casual style, with some but minimal make up. She is the youngest of 4 siblings, her oldest sister being 50 and her youngest brother being 46. Her parents are in their late 70's.

Presenting Problems

Miss G was referred with dysmorphophobia. She suffers from low self esteem and lacks confidence especially in pursuing a career. She is constantly worried about the well-being of her mother, and fears that her parents will die shortly.

Background History

Miss G described her Dad as attacking and critical, 'a dominating man who belittles people'. Her mother is kind and caring, and has 'put up' with her father either silently or in a passive way. She was unhappy at school where she was bullied about her nose. In 1997 she had a rhinoplasty, but is not happy with the result.

Miss G is currently in a relationship of 4 years with a man 10 years her junior. They do not live together but spend nights together intermittently during the week. Previously she was in a relationship for seven years, but did not live with
her partner. When they separated, her boyfriend married someone shortly afterwards and Miss G became depressed.

Mrs F

Client Profile:

Mrs F is a 34 year old white woman who is married and has an 18 month son. She is not currently working but prior the birth of her son she was working in an accountancy company. She dresses smartly and is articulate.

Presenting Problems

Mrs F was referred by her GP as she had diagnosed herself with ADHD having read an article that had described symptoms that fitted her own. These included: problems with her memory, impulsiveness, blank spells and trances that affect her concentration. She also reports feeling anxious and finds herself reacting angrily to everyday situations.

Background History

Mrs F said she hated her childhood and was ‘totally nervous and lacked confidence’. She described a childhood where she was either on good terms with her mother or her father. She described her father as verbally and emotionally aggressive, although she said that he was never physically aggressive. She said he was a controlling man, who would do cruel things when angry like destroying her toys. She thought that her mother was jealous of her, and would inspect her shopping bags.
Mrs F said that she was bullied in secondary school. She was forced to steal from other children in the class as she was threatened physically by another girl.

**Personal Relationships**

Mrs F described her relationship with her husband as strained. She has had difficulties as she finds herself constantly lying to him and has previously accumulated several thousands of pounds of debt using his credit card. She said that she does not respect his property and can become very jealous when he is with his daughter by another marriage, or buys himself things.

After 10 years without contact, Mrs F initiated contact with her father when she found out she was pregnant. She reported that the relationship is slowly rebuilding, but she finds it difficult to trust him. Mrs F was not in contact with her mother when she first started therapy, as she had found her over controlling in how she cared for her son. However, she re-contacted her after she had found out that her mother had had a stroke. She is not currently in contact with her sister who is five years younger.
References


Introduction

This essay will present an understanding of vomit phobia from the cognitive behavioural perspective. It will be illustrated with client consultations from my clinical placement. Firstly a clinical presentation of vomit phobia will be given, followed by a comparison of behavioural and cognitive approaches and two case studies of behavioural therapy. A cognitive behavioural model will also be presented and this essay will highlight significant areas that are not covered by the model, so as to provide a more integrated understanding of vomit phobia. This will be followed by a discussion of the influence of the therapeutic relationship in therapy. Overall the essay aims to provide a clear and comprehensive understanding for counselling psychologists and other clinicians working with vomit phobia.

Clinical Presentation of Vomit Phobia

Vomit phobia, also described as emetophobia, is the fear of vomiting. This can either relate to the individual vomiting themselves, being in the presence of other people vomiting, or vomiting in the presence of others. Prevalence ranges between 1.7% and 3.1% of the population for men, and between 6% and 7% for women (Overveld et al., 2007). The Diagnostic and Statistical Manual of Mental Disorders (APA, 2000), rated vomit phobia under ‘Specific Phobia (Other Type)’. There is little understanding about the predisposing factors, but there is often a trigger incident around the age of 8, and the early onset follows a chronic course with little periods of remission (Lipsitz et al., 2001).
The majority of information about people with vomit phobia has come from research on self-diagnosed individuals, recruited through self help groups, or from case study reports. Therefore to gain understanding of this phobia, comparisons have been made to other anxiety disorders. Two research surveys by Lipsitz et al. (2001) and Veale & Lambrou (2006) have been key to providing information about the experience of vomit phobia, and they have been combined and summarised below.

**Specific Features**

Individuals with vomit phobia experience extreme fear or terror when they encounter vomit, either from other people vomiting, or vomiting themselves. In addition, they reported feeling nauseous, either every day, or every other day. The thought of vomit is anxiety provoking, so much so that individuals often use excessive avoidance and safety behaviours to manage their anxiety. Avoidance behaviours included avoiding illegal substances, being around drunks, fairground rides, people who are ill, boats, holidays abroad, travel by aeroplane and public transport, drinking alcohol, crowded places, eating from buffets, visiting others in hospital, visiting pubs, eating in restaurants and using public toilets. They also avoided specific foods, including meat, chicken and shell fish, foreign meals, diary products, eggs, and pre-cooked foods. Safety behaviours included locating escape routes, taking medication, sucking antacids/mints, repeatedly checking the sell by date of food, washing hands excessively, repeating a word or action to prevent vomiting, excessive cleaning and washing of food.( Lipsitz et al., 2001; Veale & Lambrou, 2006).

As well as affecting their everyday functioning, the vomit phobia affected their life patterns. Lipsitz et al. (2001) found that almost half of all females in the research avoided or delayed becoming pregnant. Moreover, Veale & Lambrou (2006) found a small percentage (5.3 %) reported having terminated a pregnancy due to
their phobia. The presenting concerns of my client, Ms G, exemplify the presentations of vomit phobia.

Ms G. was a 45 year old white lady who had diagnosed herself with vomit phobia, as she reacted with extreme fear when encountering any situation relating to vomit. She was not able to remember any specific incidents when she was younger that may have instigated her phobia, but she did remember being told off for being sick by her grandmother around the age of 4. She also reported that she vomited as a young baby when she was given warm milk, and her parents had to feed her with cold milk. She described a ‘trigger’ incident at age 10, when she went by bus on a school trip, and several of the children had travel sickness. This she found unbearable as she could not escape. Ms G. has not married nor had children due to her fear of vomiting. She lives with her partner of 17 years who is very supportive. The vomit phobia had significantly impacted on her relationships with her partner, parents and friends, as she avoids any interaction with them if they are ill, and has a restricted social life. She works with horses, which she enjoys, and commented that they are unable to vomit. She has several dogs, but is unconcerned by their vomit. Her main motivation for coming to therapy was to overcome her avoidance of hospitals as her parents are elderly, and she wants to be able to visit them if they become ill. In addition, she had a breast cancer scare last year, and she believed she would have refused chemotherapy as it would have induced vomiting. For one homework task I asked Ms G to rate all the things she avoided due to her vomit phobia. She remarked that this was amazingly insightful, as she completed 2 sides of A4, and could have continued. She fitted the criteria described above as she avoided all illness, transport, and restricted her diet e.g. rice pudding and porridge as to her they vaguely resemble vomit. She had also started to avoid lifts and pregnant women, 'just in case'.
Similarities with panic disorder

The avoidance and safety behaviours are characteristic of panic disorder, but there is also overlap in the cognitive processes of selective attention and vigilance (Veale & Lambrou, 2006). Thorpe and Salkovkis (1995) also found increased frequency of catastrophic cognitions relating to ability to cope, similar to panic disorder. In addition to vomit fears per se, there was also fear of the accompanying panic (Craske, 1991). Furthermore, as with panic attacks, individuals with vomit phobia also find themselves in a vicious circle, where the nausea, as a symptom of anxiety, is misinterpreted as impending vomit, and therefore a fear reaction intensifies the nausea (Veale & Lambrou, 2006).

Similarities with obsessive compulsive disorder (OCD).

The presentation of vomit phobia also has similarities with OCD, in particular, recurrent checking, specific rituals in cooking, and the fear of contamination (Lipsitz et al., 2001). There is also an over-inflated sense of responsibility in their belief about the degree of influence they have in their ability to prevent themselves from vomiting, by the regular checking of sell by dates of food products, monitoring the health of others, or by washing their hands excessively (Veale & Lambrou, 2006).

Similarities with social phobia

There is also an overlap with social phobia in as much that a minority of individuals reported shame about vomiting in front of others (Veale & Lambrou, 2006). Furthermore, there was a heightened sensitivity to the opinions of others, and many hold beliefs that people will negatively evaluate them if they are sick, and this evaluation is catastrophic (Boschen, 2007).
Comparison between behavioural and cognitive approaches to phobia

Cognitive Behavioural Therapy (CBT) combines theory and practice from the two schools, however their theoretical bases, mechanisms for change and therapeutic interventions, although often overlapping, can be seen as discrete.

Behavioural theories are based on associative and specific learning experiences, e.g. classical conditioning. Therapeutic approaches aim for clients to 'unlearn' their associations (Craske & Rowe, 1997). Behavioural theories are be criticised in their accuracy of conceptualising phobias, when specific traumatic incidents are not recalled, as is often the case with vomit phobia. In comparison, cognitive approaches recognise patterns of thinking that are concerned with perceived harm or danger. Unconscious and conscious interpretations are assumed to generate anxiety; and therapy aims to correct the processes via conscious reasoning (Craske & Rowe, 1997). Behaviour therapies are mainly based on exposure or systematic desensitisation, using habituation and extinction. Cognitive therapies have tended to use exposure situations to challenge these thoughts. It is in the specifics of therapy that cognitive and behavioural therapies begin to overlap. Overall, direct exposure is considered to be the most effective intervention for specific phobias (Matthews, 1978), but this can pose a challenge for vomit phobia as there are ethical issues about inducing vomit in clients (Davidson et al., 2008).

Research on therapy with vomit phobia.

There is limited research on therapy with vomit phobia. One of the first was a case study by McFayden and Wyness (1983) who described a simulation of in vivo exposure. They had previously tried providing 'simulated vomiting' using the sounds of vomiting. As this was unsuccessful, they endeavoured to make the situation more realistic. This entailed a therapist running into a session with
minestrone soup and tinned rice in his mouth and being 'sick' into a sink in a room where the client was standing. This happened approximately 10 times per session, and over the course of five weeks the therapist was 'sick' in different locations. At the follow-up the client reported less anxiety, reduced avoidance and more confidence in dealing with uncomfortable situations and had been symptom-free for over a year. This seems to be a creative albeit excessive solution in providing in vivo exposure, and the authors recommend this approach for all specific phobias. It would interesting to explore what other processes were occurring other than habituation. I wonder about the surreal nature and maybe humorous experience generated by a man running into a room with soup and pudding in his mouth! I will address this later when discussing the therapeutic relationship.

Following on from this study, Phillips (1985), presented a study of therapy using an exposure method of recorded simulations, based on the theory that with repeated or prolonged exposure the fear will gradually reduce. Seven participants, with fear of themselves or others vomiting, had group therapy for 1 hour each week over 8-13 sessions. In each session they were exposed to a filmed sequence of vomiting which lasted 4 minutes. There were seven sequences, with a person coming closer to the camera in each sequence and then sound being added. Overall, the therapy significantly reduced the symptoms of phobia for all the participants, and a follow-up assessment six months later showed no return of phobia symptoms. This research seemed to be original and beneficial, and it would have been interesting to learn more about how the group processes facilitated the change process. For example, Phillips commented that “during the first session one patient had to be persuaded by the group to stay in the room” (Phillips, 1985, pg. 47). This may imply a process of universality and group cohesiveness (Yalom, 1970).
It is interesting to note that both studies detailed a process of being less fearful of others vomiting, whereas people with vomit phobia primarily fear themselves vomiting (Lipsitz et al., 2001). It may be that individuals have been able to adapt or apply the context to themselves, as all participants reported less fear related to themselves vomiting.

A CBT formulation

The most comprehensive and detailed model of vomit phobia has been proposed by Boschen (2007). The theory behind Boschen's model is in line with Veale and Lambrou (2006), as he drew on the overlap with panic disorder, social phobia and OCD. A full diagrammatic model is given by Boschen (2007, pg 413) but in summary he proposes that following a trigger, which could either be of bodily cues, situations linked to vomit, or vomit related thoughts, there are two distinct phases, the acute and maintenance phase. Prior to this there are the predisposing factors of high general anxiety, vulnerability and a predisposition to anxiety being expressed via somatisation, in particular feelings of nausea. This seems to be a unique contribution and may explain why some people develop a phobia and while others do not.

The acute phase comprises of three sections: an interpretation that bodily cues are an indication of vomit, an increased arousal and the somatisation of anxiety related to nausea. The maintenance phase comprises of four sections: hypersensitivity to bodily cues, worry about future vomiting, avoidance, and failure to gather disconfirming evidence. Within the maintenance phase there are two feedback loops. The first that worry leads to hypersensitivity, which in turn leads to the person noticing bodily symptoms which results in fear. The second is the avoidant behaviour, which prevents the person learning that feelings of nausea and fear, do not lead to vomiting. The conceptualisation of an acute and
maintenance phase with feedback loops follows the CBT understanding of other anxiety disorders e.g. panic disorder (Wells, 1997).

The model by Boschen (2007) also produced formulation based therapeutic interventions including exposure, cognitive restructuring, distraction and arousal management, all of which are keystones of cognitive behavioural therapy. As yet, there has been no research on using the model suggested by Boschen (2007), and it would be interesting to see how it compares to traditional behavioural therapy.

A critique of the CBT model

The model, although convincing, lacks the emotional and physical awfulness of vomiting. I ask the reader to think about the last time they vomited and think about the experience. If you can remember it and connect to it, that’s what’s missing. The model provides a space for the fear, but not for the awful experience of vomiting. Unlike a fear of spiders or heights, vomiting is an awful and particularly distressing experience for the majority of people, and it is important to remember this when working with someone who has vomit phobia. I believe it was therapeutic for me to validate the awfulness of vomiting for Ms G, so as not to minimise her experiences.

Leading on from the awful, is the disgusting. This is an area that has been explored by Overveld et al. (2008) following Boschen’s (2007) model. They found that people with vomit phobia had significantly higher levels of disgust propensity (how quickly someone experiences disgust), and disgust sensitivity (how negatively someone evaluates the disgust experience) and these can be linked to the predisposing factors of Boschen’s model. In particular they found that disgust sensitivity was correlated with vomiting phobia, but they could not conclude whether it was an epiphenomenon or a causal relationship. This means
that research participants with vomit phobia were different to the participants with panic disorder and a non-clinical control group in terms of how they experienced and evaluated disgust. This insight into the disgust element adds realness to the Boschen model which lacked the emotions related to vomit.

The exploration of disgust formed part of the therapy with Ms G. Vomit was compared with other human bodily excretions as well as animal faeces and animal vomit. All these varied in the degree to which they disgusted her, but she was particularly disgusted by the sensation of the liquid vomit coming out of her mouth. There was something quite powerful in discussing a topic that is normally avoided, the disgusting elements of our world. The exploration started the process of decreasing avoidance and helped identify where the phobia was located, it also raised questions about why other disgusting excretions were not feared. It was also therapeutic to think about what vomit actually is, undigested food and stomach acid, in order to allow Ms G to consider different views of vomit.

Another important research finding by Davidson et al. (2008) was that people with a phobia of vomiting had a higher internal locus of control, suggesting that they also have a fear of losing control, and that the phobia is reflective of an underlying problem. Overall they found that people with vomit phobia considered general and personal aspects of their lives, especially health related issues, to be under their control. They hypothesised that individuals with vomit phobia, who believe that events are under their control, may find it difficult when this control is relinquished during the act of vomiting, and this creates the phobia. Vomiting can be experienced as an extreme loss of control. Indeed, Andrews (1992) described it as a 'violent bodily reflex'. There are indications of loss of control in Boschan’s model, e.g. worrying, avoidance and safety behaviours, but it may be helpful to practitioners to make the issue of control more explicit in therapy. Understanding how this loss of control is distressing for some individuals, and incorporating it
into a conceptualization and discussing it within therapy, could potentially be advantageous for clients. It is unfortunate that given the onus on control, Veale & Lambrou (2006) found no difference in the number of times participants believed they had vomited compared to the control group. Therefore, in reality the use of safety and avoidant behaviours had not reduced the likelihood of themselves vomiting.

Control was a major issue with Ms G who was generally very controlled in her life, but also in her own exposure outside the therapeutic space. I made several suggestions about videos she could watch, but she found ‘a suitable one’ by herself. After watching a video of someone vomiting, having been induced by a natural drug, she was able to understand that her anxiety was less about the vomit, but more about the anticipatory fear just before she, or someone else would vomit. This can be understood as the fear before loosing control. She described how she would try to regain control, by eating smaller portions when in situations where there might be vomit, so that a minimal amount of liquid could come up, and the vomiting would be reduced to retching, which was more bearable for her. We also spoke about the reasons why people are sick, and reframed it as an inbuilt safety mechanism of the body. Ms G could relate to this as horses cannot vomit, and are therefore more at risk if they eat a poisonous substance. It appeared that integrating vomiting as a bodily response, as part of her, allowed Ms G to experience her own vomiting as something coming from her, and thereby not out of her control.

The Therapeutic Relationship

The models and the previous research have provided insight, but there is an absence of any discussion about the role of the therapeutic relationship. The therapeutic relationship is very important within CBT (Gilbert & Leahy, 2007), and the quality of the therapeutic relationship is related to therapeutic outcome.
Therefore it is important to discuss potential ruptures to the relationship. The relationship in CBT is often conceptualised as a 'collaborative empiricism' or working alliance, where the client and therapist work together to facilitate positive change (Beck et al., 1979). However, this relationship could be ruptured, as the issue of control is very significant for people with vomit phobia, as found by Davidson, et al. (2008). As discussed, control was a significant issue for Ms G, and she had to trust me and the model in order for her to be able to begin to lose elements of her control, and to begin to feel comfortable. An example would be homework tasks, aimed at reducing avoidance and safety behaviours. Although we worked collaboratively, the agreed task would often be modified by her, thus under Ms G’s control again. It was important that we were able to reflect on the difficulty of losing control in therapy, and how the issue of control was reflected in our relationship. This provided her with insight into her typical ways of relating.

Another important factor is the therapist’s own aversion to this subject matter. I had very strong feelings of nausea, before, during and after the sessions. Although I did not at any time believe I was going to vomit, I found this a reaction to exploring vomit in great detail! My own physical feelings helped me gain insight into what Ms G may feel on a daily occurrence, but it could have led to my avoidance during therapy or surface level exploration. This may also be mirrored by the comment in the McFayden and Wyness (1985) article:

“It may be some time after therapy before you can enjoy rice pudding and minestrone soup!” (pg 176).

I believe they are commenting about their own feelings of nausea and maybe the intrinsically natural fear about having to vomit. It is worthy to note that vomit is one of the few universally accepted disgust stimuli (Rozin, et al., 2000) and the therapist and client being able to share the disgust, may enable the client to cope
without fear. I am also aware that I used humour as a means to stay with the material presented, and this built rapport between us. However, other clients might react differently and feel that it trivialises their distress. Therefore attention has to be paid to the relationship and the therapist’s reactions to the material.

A Final Consideration

From a psychodynamic perspective, a phobia is a symbolic representation of an unconscious anxiety (Kamil, 1970). Barber and Luborsky (1991) proposed that therapy addressing only overt symptoms may at times be insufficient. They believe where a client is psychologically minded and disinclined towards behavioural therapy, as were 90% in the research by Lipsitz et al. (2001), psychodynamic psychotherapy might be ‘the best choice’ (Barber and Luborsky, 1991). It is pertinent to be open to other conceptualisations, especially as research has found that change is facilitated through the therapeutic relationship, and developing alternative ways of thinking, regardless of the type of therapy (Wiser et al., 1996).

Conclusion

In summary, vomit phobia is a chronic and very distressing condition affecting all aspects of a person’s life. Understanding of vomit phobia has been through the lens of specific phobia with comparisons being made to panic disorder, social phobia and OCD. Traditionally vomit phobia has been ‘treated’ using behavioural therapy, in particular systematic desensitisation. Boschen (2007) has proposed a CBT formulation which at first seems comprehensive, but lacks the element of disgust and the issue of control. Also missing from the formulation is the role of the therapeutic relationship, which will be affected by the therapist’s possible aversion to the subject matter and the issue of control. It is also important to be
aware of the meaning of the phobia, and drawing on psychodynamic theory can be advantageous.

This essay has been to some extent written from a psychopathological perspective, mainly due to the stance of CBT. However, the literature on disgust proposes that it is a universal phenomenon, and my own reaction to the discussion of vomit concurs with this. The literature also suggests that although vomit phobia is a diagnosis, it is mainly identified as a problem by the people experiencing it, as they believe the phobia to adversely affect their everyday functioning. Indeed, the majority of the research is based on self-diagnosed participants. Vomit phobia is definitely a response where the symptoms of distress, disgust, avoidance and safety behaviours are on a continuum, as they affect all of us to varying degrees.
References


Therapeutic Practice Dossier

Introduction to the Therapeutic Practice Dossier

The therapeutic practice dossier contains an overview of the three placements that I have completed as part of my training as a Counselling Psychologist. Details are provided of the therapeutic practice and the professional responsibilities. They are followed by the Final Clinical Paper which contains a personal account of my professional development, drawing on clinical experiences and my own personal growth.
First year clinical placement: A primary care service in a GP centre.

*November 2005 - July 2006*

My first year clinical placement was situated in a GP clinic in South London. The service was managed by a Counselling Psychologist, and comprised of myself, another trainee Counselling Psychologist and an independent Counselling Psychologist who was employed on an *ad hoc* basis to run groups.

The primary care service served a diverse range of people in terms of ethnic origin, occupational status and socio-economic status. It offered short-term psychological therapy (approx. six sessions) for clients aged 18-65 years who presented with mild to moderate psychological difficulties. The service accepted referrals from the GP service and clients were assessed by the Counselling Psychologist. Clients were primarily offered short term therapy of six sessions, although this could be increased to 20 sessions if this was considered appropriate.

My theoretical orientation was person-centred, but I also integrated ideas from other therapeutic modalities. My clinical work encompassed a diverse range of psychological problems including mild to moderate depression and anxiety, Post Traumatic Stress Disorder, childhood issues and employment issues. I was supervised by the Counselling Psychologist, both individually and with the other trainee. During this placement a logbook was kept and process reports and client studies were written. Additional responsibilities included attending client assessments with the lead Counselling Psychologist and co-facilitating a 6 week course which focused on using CBT techniques to manage anxiety and depression.
Second year clinical placement: An NHS Psychotherapy Department.

October 2006 - July 2007

My second year clinical placement was within a Psychotherapy Department of an NHS Mental Health Trust, which operated from two hospitals. The Psychotherapy Department was formed of three Consultant Adult Psychotherapists, a Group Psychotherapist and three Psychiatrists. The department head was a Psychiatrist.

The department offered tertiary care to those referred by GPs, Community Mental Health Teams, and other secondary services. The clients usually presented with moderate to severe psychological difficulties including, depression, anxiety, and personality disorders. The difficulties were relatively longstanding and previous psychological interventions, or medication, had not helped. Clients were offered individual or group psychodynamic psychotherapy. The individual therapy was usually offered for one to two years; however, some clients were offered shorter term therapy of 6 months, if this was considered appropriate. The groups usually ran for a period of a year, and specialist groups for young adults and adults with personality disorder were also available.

My clinical work was mid to long term and the length of therapy varied from five to ten months. The clients presented with a range of issues including personality disorder traits, compulsive lying, derealisation symptoms, self harm and relationship problems. These were also accompanied by depression and anxiety, which affected their everyday functioning. I practiced psychodynamically, using ideas from Freud, Klein, Winnicott and Bowlby. I received supervision from two supervisors, one individually, and one with another trainee. During this placement a logbook was kept and two process reports were written.
During this placement I attended weekly group management meetings and clinical presentation meetings. I presented clients on two occasions. I also had the opportunity to attend ward rounds of the psychiatric ward at the hospital, led by a Consultant Psychiatrist and the opportunity to observe Electric Convulsive Therapy.
Third year clinical placement: A primary care service provided by an NHS Mental Health Trust.

October 2008 - June 2010

My third year placement was part-time over two years and was within a primary care service run by an NHS Mental Health Trust. The service was responsible for six geographical clusters which included one city and 3 towns. There was a main office for administration and therapeutic work and seven GP surgeries where assessments and clinical work were carried out. The service was managed by a Consultant Clinical Psychologist, and comprised of a Counselling Psychologist, who was my supervisor, a Clinical psychologist and three Counsellors. There were six other trainees on placement and three Assistant Psychologists.

The service was for people with mild to moderate depression and anxiety, but was open to a diverse range of presenting problems. Clients gained access to the service, firstly by GP referral, and then by opting in through completing a self assessment questionnaire. This was followed by an assessment appointment to decide on the treatment option which included counselling, computerised CBT, individual CBT, or Anxiety and Depression Groups. This was based on the stepped care model of NICE guidelines.

I was mainly responsible for providing individual Cognitive Behavioural Therapy to clients with mild to moderate depression and anxiety. The number of sessions ranged from short term (3-6) to longer term (20 sessions), depending on presenting problems which included depression, anxiety, panic, social anxiety, health anxiety, Post Traumatic Stress Disorder, Body Dysmorphic Disorder and specific phobias. I also conducted client assessments within the service, which involved treatment planning and referring clients to other services where
appropriate. I facilitated and co-facilitated three groups dealing with anxiety, and one group dealing with depression, with, on average 15 people per group. I received supervision from a Counselling Psychologist on a weekly basis. During this placement a logbook was kept and two process reports were written.
Final Clinical Paper

*I soon realized that no journey carries one far unless, as it extends into the world around us, it goes an equal distance into the world within.*

~Lillian Smith

The training to become a Counselling Psychologist has been a journey, with adventures into new worlds that have been exciting, fulfilling, challenging and frustrating. I am using this paper to reflect on the experience and to explore the parts of my training which helped me develop as a Counselling Psychologist. I will draw on my experiences with clients who I feel have touched me and changed an element of my practice. I will not have a chance to discuss them all, so will bring in the ones where the experiences have been the most profound. Details of clients presented have been changed and anonymised to protect their confidentiality. I will reflect on my own personal development, and also my role as supervisee, client and researcher. I will also use this paper to draw on psychological theories that have been instrumental to my development.

The first steps of my journey to become a Counselling Psychologist started with choosing to do an undergraduate degree in Psychology. Although interesting and enjoyable, I often felt that psychologists were studying themselves as though they were another animal, and I wanted to explore the key aspects of discovering what makes us human. Ironically, the closest I came was in a module on Artificial Intelligence, and it was here that I came across Eliza, a computer program who ‘performed’ therapy (Weizenbaum, 1966). I was struck with how this was possible, especially as I was involved with ‘Nightline’, the student counselling service at the university.
I think my desire to understand people and what makes us human fuelled my wanderlust, and I travelled on two occasions after leaving university. The first was to Israel for 5 months, and the second to South America, Australia and South Korea in a 'gap year'. These amazing experiences helped me as I was increasingly becoming disillusioned with my career in market research. I started voluntary work with The Samaritans in 2001, mainly because at my local train station there was a big advertising hoarding asking 'Have you come to the end of the line?' and I thought 'Yes!' I found the work at The Samaritans extremely rewarding and it awoke my passion in trying to understand peoples' experiences and distress, so much so that I decided to apply for a change of career as a Counselling Psychologist. This is a decision I have not regretted, and one which has changed my life. The influence of my placements, supervisors and service requirements have each affected my practice profoundly, and in order to discuss my development in the clearest way these experiences will be presented chronologically.

**Entering a new world- A humanistic encounter**

I started my first days on the course as an eager traveller hungry for the sights and smells and experiences of a foreign land. I was keen and ready to learn the language which seemed like a foreign tongue to my years in business.

My first year placement was in a primary care setting seeing people for six sessions. I found that I had a natural affinity to the Rogerian assumptions, the core conditions and the idea of an interplay between the process of self actualising and conditions of worth struck an accord with my own beliefs about growth (Rogers, 1951, 1959). Maybe it was also a reflection of my own personal situation and striving for growth by starting the course. I also found the ideas of
Clarkson (2003) on the therapeutic relationship hugely influential. They helped me think of the relationship as a tool and as an entity in its own right, which went beyond the listening role at The Samaritans. The placement involved working with people from different cultural backgrounds and I found the existential notion of bracketing assumptions and working from the client’s frame of reference very useful when I was faced with differences I did not understand and or fully appreciate (Spinelli, 2003).

To begin with I found the emotional exposure of the work very difficult. I often felt overwhelmed with the sadness, hopelessness and helplessness. I experienced particular difficulties in hearing one distressing story in an assessment which was themed with assault, betrayal and hopelessness. After the session I cried uncontrollably, and luckily I was supported by a fellow trainee. That experience helped me think about how I needed to learn to cope with my feelings, and I started to explore and reflect on my own experiences through personal therapy in order to prevent my personal responses to the client’s story interfering in the relationship. In that way personal therapy was invaluable in my first year, and it felt like a guiding hand on my journey. It also helped me realize that I was also a person in the relationship, and my own attempt at resolving issues was part of the therapy process.

In a similar way I felt disheartened by cancellations and non attendance and I also had a blow to my confidence when in the same week, two clients did not want to meet with me again after a first meeting. Due to my high anxiety related to starting the course, with the demands and expectations that accompanied the placement, I think my attachment style was often ‘preoccupied’ (Fraley et al., 2000). It was through supervision at placement and at university that I started to think about the client, their presenting problems, and how they communicated their distress. I was then able to realize how important it was to think about the client and not to focus on my perceived inadequacies.
Starting therapy myself was a challenging experience and allowed me to gain empathy for my clients. I can vividly remember my first meeting with my therapist. I was tricky, testing and aloof, playing games designed to test him. I liked his response, and slowly started to trust him. I think I acted in this way as my usual coping mechanism for difficult issues has been to ignore their significance or the pain. Faced with the prospect of having to discuss these issues in therapy, I was very anxious and I still wanted to avoid, so my attachment style to my therapist was probably 'fearful-avoidant' (Frealey et al., 2000). This first hand insight helped prepare me for my initial meetings with clients.

One of the clients, Mrs V¹, was a 30 year old lady who had been a victim of child abuse, and more recently an armed robbery which had triggered a psychotic episode. I found the literature on trauma from a humanistic perspective to be invaluable (Lewis-Harman, 1998, Speirs, 2001). I am aware that using research and literature in part stems from my anxiety about working with clients, but also understanding and knowing more about traumatic incidents helped me 'be' with my clients. This was an instance where I was able to redress my limited experience in a positive way, and provide a valuable therapeutic experience to my client.

I felt privileged to have a supervisor who enabled me to open my thinking to other ideas. I felt much supported with one of my clients, Ms S², a 39 year old lady who had been victim of childhood sexual abuse and was currently suffering from low mood and relationship difficulties. My supervisor introduced me to the Drama Triangle (Karpman, 1968) of Victim, Rescuer and Abuser, which seemed prevalent in the sessions, with my position fluctuating between Rescuer and Abuser. Understanding these dynamics enabled me to respect and stay

¹ Also in Appendix.
² Also in Appendix
alongside my client so that she could disclose in her own time. In addition, the humanistic principles of meeting the client where they are, with respect, were particularly important for this client and they enabled her to explore the abuse with me.

Another client which influenced my learning was Ms A³, a 53 year lady who presented with symptoms of ‘hypochondria’. She brought up very strong feelings in me including annoyance and dislike, especially when she acted like a child who needed to be taken care of. At other times, I would be left feeling confused and slightly numb after her sessions. I was really helped when my supervisor started to explore with me the basics of transference and counter-transference and in particular projective identification (Ogden, 1979). I also started to read more about the psychodynamic interpretations (Szasz, 1988; Shaw, 1990; Griffith & Griffith, 1994; Jonson, 1994), which helped me to understand her presenting distress from a different perspective. I feel something really important happened with this client in terms of my development of using the relationship. Ms A made a request at the beginning of therapy to use an upright office chair, rather than the lower therapy chairs due to her ‘bad back’. I usually moved the chairs around before the session, but one week I did not remember until after she had come into the room. This invoked a lot of feelings in her about ‘not being loved’ which stemmed from her childhood. I felt that being able to discuss this between us was a key turning point for her, but also a key learning experience for me in my understanding of using the therapeutic relationship and how open discussion of what occurs between the therapist and the client can aid the therapeutic process.

By the end of the first year I was ‘hooked’ on my journey. The reading around certain areas of psychodynamic literature, coupled with our compelling psychodynamic lectures left me wanting to know more.

³ Also in Appendix
Encountering another new world- A psychodynamic experience

Any confidence or competence I thought I had in therapy was blown away when I started my second year. It reminded me of the time when, having spoken Spanish for 4 months in Ecuador, Peru and Bolivia, I went to Argentina. I did not understand a word and nobody understood me! The accent on the language was too dramatic a shift for me. In the same way the expectation and understandings from a psychodynamic perspective was like encountering another new world.

At first, entering my second year placement at a Psychotherapy Department, I felt enormous pressure to conform to the ‘foreign cultural traditions’. These I felt pervaded every aspect of therapy, from the greeting in the corridor which included suppressing my natural tendency to smile when saying hello and blanking any genial conversation. Part of this was due to the close supervision, where entire transcripts from the sessions were explored, and every detail was critiqued. There was nowhere to hide. I also wanted to embrace a strict psychodynamic approach so as to gain a fuller understanding.

I found the supervision and the expectations difficult at first, and I felt straight-jacketed in the interpretations and interventions I was ‘expected’ to make, particularly because I was wary of interpreting everything as transference. Paradoxically, the literature I was reading was expansive and enlightening. Supervision sessions encouraged exploration and conjecture, whereas my therapy sometimes felt bound and staid. Trying to resolve the ‘split’ and integrating the supervision into my therapy was the quest for the year and I became more skilled at offering interpretations linked to the insights I had gained through supervision and self-reflection.
Another related challenge was the role of the therapist as a 'blank screen'. I could understand the logic behind the argument, but I sometimes felt like it jeopardised the relationship and it conflicted with my humanistic conceptualisations of the therapeutic relationship. I felt that because I was not being 'me', I found it hard to be consistent. I was pretending to be a blank screen, an actor, but not a very good one. I used my own therapist (a Jungian analyst) to help me. I could readily relate to his warmth and compassion and I started to imitate him and think about what he would say in situations. He was also very compassionate in my time of 'crisis' and even offered me an extra session at no charge. This was very valuable for me as I felt that he was genuinely concerned for me, and his flexibility responded to my needs, for which I was grateful. I felt that I had to adapt the blank screen for me as a Trainee Counselling Psychologist, rather than as a strict psychoanalyst.

A turning point for me was 8 weeks into therapy with one client. Mrs F\(^4\) was a 32 year old married woman who had a two year old son. Her presenting difficulties included relationship difficulties and low mood. Mrs F's father had been verbally abusive in her childhood and she had adapted by placating or lying to him. She had also formed a similar pattern of relating with her husband, who would become aggressive, and controlling, only for Mrs F to lie about her actions. I felt that I had formed a good relationship with Mrs F, and I felt she was being open and honest. Her sessions were usually late afternoon, but at midday I got a call from the receptionist to say that Mrs F was very distressed and waiting for me in reception. I went to see her and she had her son with her in a pushchair. She told me how she was desperate to see me, but that her friend had let her down, so she did not have a baby sitter. She wanted to bring her son into the therapy session. I felt stuck. I knew it was not a good idea to bring in her son, and yet I felt that she would not return if I said no. It was a test. I asked her to come back at the normal time with her son. The therapy session was used to demonstrate to

\(^4\) Also presented in an academic essay.
her how having her son in the room was not conducive to therapy, to which she agreed, having experienced the difficulty. I felt that allowing her this experience prevented the transference of me being the dominating father from appearing and so preserved the relationship. Instead we stood alongside each other in a position of 'not knowing' (Casement, 1985). It was difficult presenting my justifications in supervision as I was doing the opposite to what I 'should' be doing. I was acting on my instincts as to what I thought was the best thing to do, yet I knew it would be thought 'wrong' by my supervisor and I did not have the theoretical justification. Later, I found that Alexander (1956) had recommended a controversial practice of analysts behaving in a way that did not support the patient's transference reactions. He believed this created a 'corrective emotional experience' which could lead to personal gains in individual therapy. Indeed, we often discussed this incident in therapy to explore the 'real' versus 'projected' relationship between us. I believe this experience was a turning point, not only for my client, but also for myself as it allowed me to experience an intense understanding of transference. It also gave me confidence that I would do 'the best' for my client and that I was attuned to her needs and responding appropriately. Although on this occasion I worked with the transference differently, I was also able to embrace it with other clients, which will be discussed below.

Working as a pregnant therapist in my second year was also extremely interesting. Although I wanted to mention it to my clients, this was not considered appropriate by the psychodynamic literature (Goodwin, 1980), or my supervisors as I would be bringing my own material. They believed the disclosure was unnecessary as the end date of therapy was not affected by the pregnancy. Working as a pregnant therapist brought up a lot of counter-transference feelings, but it also heightened my feelings of empathy, connection and focusing on the therapeutic dyad, whilst still being aware of a 'third party' (Maat & Vandersyde, 1995). I did however sometimes find it hard to separate out my own reactions
from my counter transference. For instance, with a Mr B, a male client who presented with binge eating, I felt compelled to eat before and after seeing him. I am still sceptical over whether it was counter-transference or was it my response to seeing a client around lunchtime whilst being pregnant!

Negative transference reactions are common in clients with a pregnant therapist (Maat & Vandersyde, 1995; Rubin, 1980; Underwood & Underwood, 1976) and they were particularly apparent with Mrs B5, a 70 year old lady who presented with symptoms of dysmorphia and low mood. She had married in her thirties to a man who had children by a previous marriage. She longed for children, but was not able to conceive, as her husband had developed fertility problems. She adopted a young boy aged 5, and experienced considerable difficulties bringing him up. Now as an adult, they still had a strained relationship. Mrs B spent considerable time ruminating over not being able to have children of her own, and how things might have been different. I was about 2 months pregnant when I started therapy with Mrs B, and I expressed concern about being pregnant and working with her presenting distress. My supervisor believed it might be therapeutic in itself. I found it very difficult to form a relationship with her, although she did attend every session. The sessions were filled with themes of envy, jealousy, and hatred and she often criticised my ‘training status’. It may have been that she unconsciously knew that I was pregnant. It was a testing but enriching encounter and I feel I developed more as a therapist. I feel part of the therapeutic benefit was for her to experience attacking, without retaliation (Winnicott, 1971). She proved to be one of my most challenging clients, as working with the negative transference directed at me was difficult and strongly contrasted to the positive perspective of humanistic philosophy.

Moreover, it was interesting working with Mrs B, as she was considered to be an ‘older adult’ and my research interest was individual therapy with older adults.

5 Also in Attachment.
Other members of my team were reticent about working with her, but I jumped at the chance. I felt it was an enriching experience to be working and researching in the same area, and there was a two way process where I gained insight into my research through my client and vice versa.

Overall, by the end of the placement I was thoroughly invigorated by the psychodynamic therapy. But I made the therapy work for me. I did it as a Counselling Psychologist and not as a trainee analyst. I felt that I worked with the transference but also allowed my clients to connect with me as an individual. I truly valued the time for self reflection, both considering my own issues, my clients distress, and different theoretical points of view.

**Divergent travelling- Worlds apart**

It was difficult for me to leave my Counselling Psychology journey because a part of me felt like something precious was being taken away from me. Maybe it related to the fact that my friends, with whom I had shared so many trials and tribulations were also continuing without me. On reflection my development as a psychologist is intertwined with my own personal development and this has been enormously affected by my learning and becoming a mother during the course. I feel that my journey continued as there were many parallels with learning to become a mother and learning to become a therapist. There were many experiences where the theoretical changed to the experiential, which had also occurred with my clients.

I have a vivid memory when my daughter was 3 months old. It was 2 am, and I had been up many times during the night. She was screaming, but did not want food, winding, or sleep. I took a resigned breath, not knowing what to do, and sat back in my rocking chair, just breathing deeply and humming. She settled and
stared into my eyes. That's when I thought 'so this is holding'. It all seemed to fit into place. My experiences with my young daughter added to my belief in my ability, especially in holding distress (Bion, 1967; Winnicott, 1958). It also enriched my understanding and experience of connecting with another, and how it is a dynamic and evolving process.

The 'year away' turned out to be less of a dramatic loss. I was still involved in the course, working on research, reading different theories, and applying for placements. In fact it turned out to have many gains. I feel the skills that I developed as a mother and the insight I gained meant that on returning to my final year, I was more grounded and enlightened. I was also more interested in thinking about attachment theories and the effect of early childhood experiences. It gave me a different perspective on object relations (Klein, 1975). My psychodynamic supervisor kindly sent me 'The child, the family and the outside world', (Winnicott, 1964) which linked psychodynamic theory to the practicality of life. Maybe that's why my third placement started as a process of integration.

**Hang on - maybe it's not worlds apart - A cognitive behavioural challenge and the start of integration.**

I can remember being in a remote village in South Korea, meeting an old lady selling fruit at the side of the road. We both conversed in our own languages, not understanding the other's speech, but communicating through facial gestures, body movements and intonations. It was a significant experience of connecting. We were both worlds apart, but together in our humanness and there was something special in our relationship which transcended language.

Although apprehensive about starting my journey again, I really enjoyed the cognitive behavioural model. It added clarity, where the psychodynamic theory
had provided mystique. Working part time, I had the luxury of being able to take things a bit slower, so I did not feel the pressure to suddenly become 'competent'.

When I reflect on the two years of work at a primary care mental health service, I am struck at how many patients I have seen. I have found the service where I am working to be more boundaried in some ways, but more flexible in others. For example, I have felt restricted by the number of sessions I can offer, and to whom I can offer individual therapy. However, I was encouraged to be more accommodating to clients needs when arranging therapy times, frequencies and session lengths. I have found the opportunity to conduct assessments very rewarding, and it has helped me focus my formulating and conceptualising skills so that after 45 minutes, I am able to feedback my opinions to the client for further discussion. I feel it is important for clients to feel understood and for our relationship to be containing and immediate. To some extent where I have been lacking in depth due to the type of service, I have made up in breath of presenting concerns.

I adapted more readily to the collaborative way of working compared to the blank screen approach. I drew a lot on humanistic principles which are so important in establishing a relationship. I felt that the conceptual models (e.g. Wells, 1997) were interesting and useful for clients, but I always found it beneficial to present them as ideas to work with rather than a rigid framework. I found that I was equally informed by the narrative, symbolic, relational and transferential dimensions of the relationship. One aspect that I found to be very informative was the use of paper and pen in the sessions and the homework. It was a really useful tool to reflect on the presenting problems with clients. For one client, Mrs Y, who presented with symptoms of Body Dysmorphic Disorder, the amount of paper generated between us was voluminous. I reflected on how this might have been a reaction to the fact that she felt uncomfortable with me looking at her, and

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6 Also in Appendix.
working with paper reduced her anxiety. This allowed a discussion on her core beliefs of not being 'good enough', which was a key part of the therapy.

The level of integration in my practice, and the way the relationship was used has been dependent on the client and to what extent they present with relational difficulties. The work with Ms G\textsuperscript{7} who presented with a specific phobia was very different to Mr D, a recovering substance abuser with social anxiety and paranoid thoughts. Furthermore, I worked for 20 sessions with Mrs K\textsuperscript{8} who presented with complex trauma and symptoms of PTSD. Although I worked mainly within a CBT context, I was mindful of the psychodynamic approaches that emphasize understanding the meaning of the events, as well as the importance of the relationship to provide a different experience to the trauma (Levy & Lemma, 2004). I feel that I was able to work competently using the cognitive behavioural model, as a Counselling Psychologist, whose attention to the relationship, both as a necessary pre-requisite for therapy (Beck et al., 1979) but also as the medium for change is paramount (Castonguay et al., 1996; Robinson et al., 1990).

I feel the group work I have conducted as part of the placement has provided me with a key part of my development. To begin with I co-facilitated with my supervisor whose vibrancy and passion filled me with awe. Although in subsequent groups I wanted to emulate her, I had to find my own style. My own learning as a facilitator ran alongside my research of interviewing older adults who had attended groups. In particular the reported helpfulness of seeing that 'we are not the only ones' was a frequent message from participants. Facilitating groups developed my confidence, and by the end of the placement I was leading groups and supporting assistant psychologists who were my co-facilitators.

\textsuperscript{7} Also presented in an academic essay.
\textsuperscript{8} Also in Attachment.
Personal Development

The quote at the start of this text illustrates how alongside my professional development as a Counselling Psychologist there has also been personal growth. It is fair to say that with each client and the meaningful connection that accompanies it, there has been also an area of self reflection. For some clients there has been considerable overlap between their presenting concerns and my own. For others the differences between us have been equally interesting. In the same way considering a client’s story in depth with the family narratives, meanings and contexts has also led me to reflect on my own story and how it is affected by the stories of my family, friends and culture. Alongside the depth of history, is the depth of emotion. Before I started the course, intense feelings could be difficult to hold and had to be dissipated. Now I can find the strength to own and hold my own feelings, as well as others. I also feel enlightened about understanding my own behaviour, especially in close relationships and how it is based on early significant relationships. This journey was helped enormously by my own personal therapy, but also by the group interactions at university. It is also impossible to separate from my personal life which ran alongside the course. Great emphasis is placed on the use of self within Counselling Psychology and I feel there has definitely been movement in the ‘Johari windows’ of self awareness (Luff & Ingham, 1955) and definitely more to come. Therapy is always going to be influenced by the therapists’ ways of thinking and therefore it is an important to look at resonance and to be open to blind spots for the sake of the client and the relationship.

An Emergent Identity.

My identity has changed throughout the course. I started by describing myself as a student, not even a psychology graduate, maybe reflecting the uncertainty I
was entering. I then tentatively started to use the label 'Trainee' only really adopting it in my last 2 years when I firmly became a Counselling Psychologist in Training. I feel my identity as a Counselling Psychologist has in part been developed through the encountering and working with different conceptualizations as well as the critical stance taken towards knowledge and assumptions.

The wealth of experience I gained through three different placements has allowed me to immerse myself in different theoretical orientations, and so I can appreciate their strengths and limitations, an approach advocated by Safran and Messer (1997). However, I have found it difficult to ignore or discard insights acquired through learning. I found it challenging to let go of my humanistic principles in the psychodynamic year and I found it impossible to bracket my psychodynamic understanding in the CBT years. Now I would find it problematic not to use collaborative working and behavioural experiments from CBT when appropriate. This is where I feel integration takes place, in the practicalities of therapy and the uniqueness of every therapeutic relationship. I feel it is helpful to keep asking myself 'what is happening between me, this client, in this situation, at this time?' By incorporating separate perspectives from different models I feel that I can move beyond the boundaries of a single approach, and that I am not being inhibited by ideology (Bloch, 1988).

As a Counselling Psychologist I feel the role of 'Scientist-Practitioner' has formed part of my identity. Whilst acknowledging that it can take many forms (Lane & Corrie, 2008), my role as a researcher, exploring the experiences of older adults in both individual and group therapy, has contributed to this. Being a researcher is not a novel experience for me, but I developed it using more rigorous qualitative methodologies. The research has been a more involved and less abstract process, relating directly to the experience of therapy which I was trying to understand. My decision to use two qualitative methodologies was a step
away from my identity as a market researcher towards my identity as a Counselling Psychologist.

I think there has always been a part of me that has wanted ‘to do’ in therapy. That impulse to help others in distress at The Samaritans led me to want to ‘do’ more than listen. But as I became more experienced, I realised the doing was through the being with clients. I feel this was crystallized with CBT when the opportunity was presented to do more, so I focused on ‘being with’ more. Overall I am in agreement with Bloch (1982) that psychotherapy is an intricate blend of art and science. That leads me to incorporate the scientist, researcher and artistic practitioner into my identity.

Journeys will continue, and I go forward with an open mind as to where I will travel next. Working with older adults would offer new opportunities, and I am considering advancing my knowledge and practice in Systemic and Acceptance and Commitment Therapy. My wanderlust to visit far away lands has been replaced by a deep satisfaction of working on a relational level with clients, and the ever changing landscapes that arise between us.
References


Introduction to the Research Dossier

This research dossier consists of three pieces of work which are linked together by the theme of psychotherapy with older adults. The first piece is a literature review which outlines the advantages of offering existential psychotherapy to older adults. It incorporates models of aging, research on the subjective factors that affect well-being and research on existential therapy with older adults. The second piece is a qualitative study that explores the experiences of older adults in individual therapy and uses Interpretative Phenomenological Analysis. The third piece is a qualitative study that explores the processes in group therapy with older adults. A Grounded Theory methodology was used and a localised theory is presented. All three pieces discuss the implications for counselling psychologists and allied healthcare professionals.
Can existential therapy help older adults? A literature review.

Abstract

The increasing aging population in the UK and the accompanied need for psychotherapy was impetus to explore whether existential psychotherapy can benefit older adults. Firstly, models of aging were reviewed, and it was found that subjective factors can contribute significantly to the well-being of older adults. In particular, having meaning in life and a spiritual connection are important. Secondly, the availability of psychotherapy to older adults was reviewed and it was found that Government initiatives to address the inequality of provision has generally been unsuccessful and furthermore, there was an absence in offering existential psychotherapy to older adults. Existential psychotherapy was therefore reviewed, highlighting three contributions it can make to working with older adults. These are the conceptualisation of ‘four world views’, a concern with existential issues, and a non-pathologising attitude to old age. Finally research on existential psychotherapy with older adults was reviewed, which explored how finding meaning in life is important. The review highlighted that there has not been any research conducted in the UK on existential psychotherapy with older adults. Research questions which could address this deficit were suggested.
Introduction

In order to explore whether existential therapy can help older adults, it is first necessary to define both existential therapy and older adults. Existential therapy refers to many different therapeutic practices, which focus on how people experience their world, and how the experiences relate to existential issues (see Cooper, 2003 for a description of different existential therapies). This literature review draws on the British School of Existential Analysis, the American Existential Humanistic Approach, and the work of Frankl (1969). Although there are ideological differences, each can make a valuable contribution to working with older adults. Older adults can be defined as those over the age of 65, a critical age for the division of services within the NHS, although an age definition is often absent in the literature, (Slater, 1995; Stokes, 1992; Stuart-Hamilton, 1996).

There are a number of reasons for reviewing this area. First of all, within England the older adult population is growing and Government statistics predict that by 2025 the number of 80 year olds in the population will increase by a half and the over 90s will have doubled (Department of Health, 2001). This is an important age group to recognise, as the over 85s consume five times more NHS resources compared to 16-44 year olds (Department of Health, 2001). Secondly, referral rates to psychotherapy services for people over the age of 65 were disproportionately low, with only 1 per cent of over 75s being referred (Murphy, 2000). However, there are now Government initiatives to provide more therapy that is tailored to their needs (National Service Framework for Older People, Department of Health, 2005). Lastly, existential therapy is not one of the dominant types of therapy offered by the NHS, but it does have key contributions that could potentially benefit older adults.
This review considers the older adult population and in particular the challenges they face. It outlines research investigating the psychotherapy available to older adults. The gerontology research that overlaps with existential theory will be reviewed to highlight the possible ways that existential therapy can contribute to the work with older adults. The research includes quantitative and qualitative methodologies as well as case studies and has mainly originated in the UK, USA or western Europe, so cultural influences will be minimal. Finally, areas where further research is needed will be detailed.

1. An overview of the literature on older adults

The challenges faced by older adults encompasses a wide range of issues including changes in employment status (Coleman, 1999), changes in role in the family (Molgaard, 1994), loss of friends and family (McDougall, 1995) and physical and psychological functioning (Albert & Killiany, 2001). All these challenges can affect the mental well-being of an individual. Statistics from the Department of Health (2001) state that around 10-15% of the population aged 65 or over have depression, with severe states of depression affecting about 3-5% of older people. Also dementias affect 5% of the total population aged 65 and over, rising to 20% of older adults aged 80 and over. Sneed and Whitbourne (2005) summarized the position of older adults when they stated that that older adults are faced with numerous physical, psychological and social role changes that challenge their sense of self and capacity to live happily.

These factors that can affect the happiness of an individual can occur at any age. There is a debate in the literature detailed by Ruth and Coleman (1996) regarding the extent to which these life events happen more in the later years of an adult’s life. They concluded that older adults are no less able to cope than younger adults with stressful life events. Supporting this, Tornstam (1992) found no empirical support that old age is more stressful than earlier periods of life.
Indeed there is evidence to suggest that daily hassles seem to show a stronger correlation to physical and psychological well-being than major life events in the elderly (Landrevill & Vezina, 1992). Overall, Clarke (2005) proposed that defining older people as a homogenous group is problematic because it can lead to stereotypical and stigmatising perceptions, which attract negative attitudes. Nevertheless, he provides evidence that suggests that some older adults are subject to particular stressors and physical changes that can adversely affect their mental health. Therefore, old age can be a time of psychological and physical well-being, where older adults can enjoy a good quality of life and it may just be a pervasive stereotype that old age is related to decline.

Furthermore, Knight (1996) has argued that there is a continued maturity throughout the lifespan, with increasing cognitive complexity (the capacity to understand argument, social change and an appreciation that people hold different points of view), and emotional complexity (better comprehension and control of emotional reactions). This is an important consideration when thinking about psychotherapy with older adults.

The literature on the models of aging also offers an insight into older adults and there are several psychological models which have put different perspectives on how people age. One of the most influential models on lifespan development has been proposed by Erikson (1963). It placed old age as the eighth stage in a person’s life, where there is a crisis between integrity and despair. This model suggests that to solve the crisis the person must reach a stage where they accept and value themselves and the situation they find themselves in. This model presents the older adult as creating meaning in their life and becoming satisfied through valuing themselves, accepting the frailty of life and ultimately death. Research by Nehrke et al. (1980) can be seen to support this proposition. When they measured life satisfaction, locus of control and self concept they found the older participants were more satisfied with their lives and this implied they had
reached the resolution of the personality crisis. Although this activity of creating meaning in life is important when considering if existential therapy can help older adults, imposing set stages within a person’s life can be critiqued for enforcing rigidity onto a person’s experience.

In support of this understanding, Piaget’s model of intellectual development proposed that emotional and cognitive development becomes increasingly complex in older age (Piaget, 1950). Also, Tornstam (1994) formulated the notion of ‘gero-transcendence’, a maturational process in which people become more occupied with philosophical reflections. This was supported by research that explores the reflections related to meaning in older adults (Reker, 2004; Reker & Fry, 2003; Reker et al., 1987). These models both present older people as more inward, reflecting and in a period of ‘meaning making’ in their lives. This is a key factor when considering whether existential therapy can help older adults.

Another influential model is that of ‘successful aging’ proposed by Baltes and Baltes (1993). It is based on the premise that successful aging is a process involving three components: selection, optimization and compensation, which are components of adaptation that depend on the personal and societal circumstances. This model is an optimistic view of aging that stresses the potential of individuals to adapt as they age. It is based on adaptation or behavioural plasticity that does not imply a specific outcome but it is an objective measure of preparedness for dealing with demands. It is biologically orientated and focused on behavioural changes that would allow an individual to adapt to their environment. They believe the subjective indicators, for example, quality of life and well-being are necessary but not essential for an adequate definition of successful aging.

There seems to be a separation between models that focus on the philosophical
aspects of creating meaning in life (Erikson, 1963) and the behavioural adaptation (Baltes & Baltes, 1993), which minimizes the importance of these subjective factors. The psychological literature appears to lack a cohesive model that addresses both the subjective and objective factors that affect happiness in older adults.

Much research focuses on subjective factors and Coleman (1999) argues that the dominant mode of thinking within gerontology emphasises the importance of the subjective experience

‘One cannot judge quality of life on the basis of externally assessed health or environmental parameters without taking into account people’s own individual evaluations, which in turn reflect their goals, commitment and meaning systems’ (Coleman, 1999, p. 49).

However, there are often no set criteria to measure the subjective experience, which makes it a complex area to research. Terms such as happiness, quality of life, life satisfaction, well-being, or absence of depression or anxiety are used in empirical research and the lack of clarity on their meanings make comparisons difficult. There is even a debate regarding the conceptualisation in psychology of the subjective measures. Ryff (1989) argues that psychologists have conceptualised well-being too narrowly, focusing primarily on current happiness and that other aspects such as purpose in life (i.e. having goals and a sense of direction) and that personal growth (i.e. having a feeling of continued development) are also important in well-being. The term psychological well-being which encompasses notions of happiness, purpose in life and personal growth will be used in this review as it offers a broad definition. It is also compatible with an existential viewpoint that stresses the experiences of an individual, who is faced with choice and development. As existential therapy is based on subjective experience of well-being this indicates that existential therapy can potentially benefit older adults.
In addition to the subjective factors of quality of life, there is much empirical research to suggest spirituality and making meaning in life affects the aging of an individual. Fry (2000) found that existential measures of personal meaning, religiosity and spirituality had a greater contribution to psychological well-being in older adults than demographic variables, social resources, physical health or negative life events, which have been traditional indicators. The results replicated and extended the work of previous studies suggesting a strong link between religiosity and successful coping with the challenges and stresses of old age (Ai et al., 1998; Idler & Kasl, 1992; Levin, 1995; Maton & Wells, 1995; Pargament, 1997).

More recent research also supports this view. Moremen (2005) conducted qualitative research to explore issues of meaning and spirituality in older women. The main themes that arose were: a need to feel connected; spiritual questioning; existential angst and thoughts about death and dying. It suggested that spiritual questioning, independent of organised religion, significant loss or impending death is a natural part of the aging process as one approaches the end of the lifespan, which is in tune with Erikson's model of aging. Therefore there is substantial theory and research to support the view that spirituality or self reflection in a meaning making process is an important contributor to the psychological well-being of older adults.

This review has highlighted that a significant proportion of older adults experience difficulties, and that there are many problems associated with old age. However older adults do achieve psychological well-being. The contribution of psychotherapy to support this achievement is now considered followed by an examination of the particular relevance of an existential approach.
2. Psychotherapy with older adults

From the review of the literature it is apparent that there has been a historical neglect in terms of providing psychotherapy to older adults (Hepple et al., 2002). Rivlin (1995) maintains that the stereotype that older adults are ‘a lost cause’ has led to a mistaken perception of old people and this in turn has led to ageist policies. Hepple et al. (2002) have commented that despite the increasing pool of evidence to support their effectiveness, psychological interventions are not widely available to older adults in the United Kingdom. They propose that firstly, this is because there is a lack of guidance on how to apply psychological theory to therapeutic work with older adults. Secondly, problems in later life are viewed by professionals as biological rather than psychological and therefore there is a preference towards medication rather than psychotherapy. The National Service Framework for Older People (Department of Health, 2005) aimed to eradicate age discrimination towards older adults in the NHS, and since 2004 there have been initiatives to ensure that older people with mental illness have improved access to the services available to younger adults.

Despite the Government initiatives, research by Cuddy et al. (2005) found that older people were more likely to be given drugs than psychotherapy, and more likely to be given Cognitive Behavioural Therapy (CBT) than psychodynamic psychotherapy. Woods and Roth (1996) when reviewing the therapies available to older adults concluded there was little research into the efficacy of treatments for older adults. It reported that data from case studies and open trials indicated that methods used in treating younger adults can be applicable to older people, though treatment may proceed at a lower pace, and similar findings were also found by Brammer (1984). However more recently, Hepple et al. (2002) reviewed the literature on psychotherapies for older adults and proposed that psychodynamic therapy, CBT, systemic therapy, interpersonal therapy and cognitive analytic therapy all have significant benefits and have worked well with
older adults. However, this review did not mention humanistic therapies, including existential and person centred therapy. It did discuss the features that make an individual suitable for different types of therapy and advocated a tailored approach, showing a movement towards acknowledging the benefit of psychotherapy for older adults, albeit using a restricted range of therapies.

Coleman (1994) provided evidence that many older people in western society lack the encouragement and an audience to ‘tell their story to’. These are occasions that would help older people to reaffirm their identity, and could relieve their psychological distress. Furthermore, research by Hagberg (1995) suggested that the life-history report is a significant indicator of well-being in later life. It is a key point to note that the importance of retelling past experiences to improve psychological well-being has been recognized in existential psychotherapy (Lantz, 1998; Lantz & Raiz, 2004).

A review of the literature on the psychotherapy available to older adults shows the majority of articles mentioned CBT and psychodynamic psychotherapy with a limited amount on humanistic or existential psychotherapy. This is not unusual in itself as it is also a reflection of the dominant therapies offered to all adults. However, given the stated importance of meaning making and spirituality in older age, there appears to be a lack of provision of tailored therapy to individual needs. The contribution that existential psychotherapy can make when working with older adults will now be reviewed.

3. Existential Therapy

As stated in the introduction, there is no one school of existential therapy and furthermore, existential therapists have spent much of their energies rejecting an all encompassing theory or system (Cooper, 2003). Even within the British School of Existential Analysis, there are two prominent members with different

‘Existential philosophy is concerned with the nature of humanity, with its existence in the modern world, and with the meaning of this existence to the individual. Its focus is on the individual’s most immediate experience, his or her own experience and the experiencing of this existence (Patterson, 1986, p.420)

In accordance with this, existential psychotherapy focuses on a phenomenological approach to therapy that involves being with the client to experience their world. Due to its theoretical and philosophical underpinnings it would seem that existential therapy can contribute to the process of improving psychological well-being in older adults. Supporting this McDougall (1995) proposes that existential psychotherapy is particularly appropriate for the ‘boundary situations' faced by older adults, e.g. retirement and illness. This review examines three unique contributions that existential theory and therapy have to offer which can specifically benefit the work with older adults. These include; the understanding that a person has four ways of experiencing the world and within this an understanding of the self in a social context, the emphasis on existential concerns and the non-pathologising of old age. Each contribution will be discussed incorporating literature on older adults and aging.

3.1. Four World Views

The German philosopher Heidegger originally conceptualized the idea of ‘being-in-the-world' as a way of understanding people and how they interacted with the world (van Deurzen & Arnold-Baker, 2005). This concept was applied by the German psychiatrist Binswanger (1946) who felt that using this concept of 'being-in-the-world' gives human existence a structure and was a viable alternative to
the medical model which categorized people according to a pathology. His ideas that there are three world views of the physical, social and personal, were championed and explained further by May (1983). They have since been elaborated by van Deurzen (2002) from the British School of Existential Analysis who also introduced the fourth world view of spirituality. This is explained succinctly,

‘existentially a person’s world relations define her sense of self and the self is the centre-point of a person’s entire network of physical, social, personal and spiritual world relations (van Deurzen, 2002, p.166)

Overall, existential therapy provides an opportunity for a person to come to terms with their world and their life. To explain these concepts more fully each component of the four world views will be reviewed and linked with current research, with the aim of providing a better understanding of whether existential therapy can help older adults.

‘Umwelt’ / World around
This describes the natural world with its physical, biological dimension, where a person is likely to behave in an instinctual manner. It includes attention to bodily and physical sensations from internal and external sources, issues of body image, physical fitness or weakness, and attitude towards food, sex and all parts of the natural world (van Deurzen, 2002).

One of the foremost parts of the physical world is the human body. The body is instrumental in determining how a person comes into contact with the world. As a person ages, the body changes, and older age can often be accompanied by an increased prevalence of physical illness and a reduction in being able to perform physical activities. The experience of changes in the body challenges beliefs about who we are, about who the world requires us to be and about the world’s response to being (Spinelli, 1997). One aspect of the body is the effect of physical illness on the older adult. Research by Evans et al. (1991) found that
physical illness can lead to depression in older adults, which in turn can lead to secondary physical problems. In the literature there also appears to be a link between physical activity and self efficacy and depression. Langan and Marotta (2000) found a positive correlation between performance of physical activity and self efficacy. Recent quantitative research has shown a link between physical activity and quality of life, in part by increasing self efficacy and self esteem (Elavsky et al., 2005; McAuley et al., 2006). Research by Davis-Berman (2001) also pointed to a link between self efficacy and depression, with physical efficacy being a strong predictor of depressive symptoms. Goldenberg (2005) has theorized that the body threatens a person’s self efficacy by reminding them that they have to face death. As existential therapy pays attention to the physical world of older adults and in particular to the body with issues of disability, physical illness and ability to carry out exercise, existential therapy could help individuals gain insight on how these factors can affect their being in the world.

'Mitwelt' / World of others
This describes the social world of human relationships and interactions, which are primarily those of public, everyday encounters. An individual’s experiences are embedded in a social, political and cultural environment which affects actions, feelings and thoughts (van Deurzen, 2002).

There is a body of research on how social support can improve well-being (Berkman & Syme, 1979; Coi & Wodarski, 1996) which provides clear evidence that fewer social support resources leads to higher levels of depression and suicidal ideation (Vanderhorst & McLaren, 2005). This area is well recognised as influential to psychological well-being and therefore existential therapy does not offer a unique contribution in this area. However, existential theory can contribute valuable insight into the experience of older adults as it emphasises the importance of the social context and the social construction of meaning. Existential psychotherapists aim to understand the social context of a person,
and how culture influences their perception of who they are. This is particularly pertinent for older adults as they are likely to have experienced different world views as children and this can result in an experience of alienation and isolation as society has changed (May, 1983).

Rodin and Langer (1980) have shown how negative beliefs and stereotypes in society about aging can be adopted by older adults and integrated into their self systems, which in turn affects their behaviour. In addition, Sneed and Whitbourne (2005) have discussed how not only do older adults have to overcome normative physical, psychological and social role changes that challenge their sense of vitality and positive regard, but also there is a plethora of negative and ageist stereotypes that are abound in our youth oriented culture. Therefore it is important to understand the social world of an older adult and how this affects their view of themselves. This has been effectively summarised by Knight (1986):

'The labelling of a person as ‘old’ carries so much force that everyone, including the elder, forgets the individual with specific strengths and a history of accomplishments who is hidden within the image of the stereotypical ‘older person’.' (Knight, 1986, p. 92)

Research has challenged traditional assumptions of old age by showing the societal constructions of old age. Ruth and Coleman (1996) argue that age differences in research are due to the cohorts being researched and these do not reflect ontogenetic age changes. In particular, Dannefer and Perlmutter (1990) contest that there are only a few psychological aging effects that are general to all individuals, irrespective of social contexts, and this statement has been supported by the empirical research of McCrea and Costa (1998) that found no change in character traits over time. Indeed, research by Katzko et al. (1998) found cultural differences in the self concept of elderly people between Spanish
and Danish older adults. Furthermore, Reker et al. (1987) studied the
differences on key life attitudes on different ages, but believed these only
reflected that there were age differences rather than age changes per se.
Therefore the research has shown how society can influence how an older adult
can perceive themselves, and the influences are not grounded to the actual
experience of aging. As existential therapy is aware of the effect of the
environment on the individual there is more opportunity to challenge views that
are detrimental and untrue to the individual.

'Eigenwelt' / World of Self and Intimate relations
This term is used to describe the private world of intimacy with self and others.
The inner world includes feelings, thoughts, character traits, objects and people
in as much as these are identified as your own (van Deurzen, 2002).

There has been much research into the self concept of older adults, although the
research is based on different conceptualisations that may contrast sharply with
the existential notion. However, it is useful to consider this work as it does offer
insight into the 'world of self' of older adults, because how an older adult relates
to him or herself is crucially important.

Markus and Herzog (1991) argue that the role of the self concept is important in
aging as positive functioning depends on whether people can find ways to sustain
an overall positive view of themselves.

'The self-concept, particularly self-esteem, and conceptually related
characteristics such as personality traits, aspirations and age identification
have been persistently linked to psychological well-being'. (Markus &
Herzog, 1991, p.128)

It may be that older adults need to be able to fit together their changing
perceptions of self, and research by Holahan (1988) has found that older adults
who are able to do this are more satisfied with their lives. Qualitative research
supporting this by Bausch (1997) examined how low income women defined themselves. It found that the women did not think of themselves in stigmatising terms, but defined themselves as ‘fortunate’ or ‘blessed’. Therefore the ability to see oneself in a positive way affects well-being.

When considering if existential therapy can help older adults it is important to note that the research shows that issues of ‘self’ are significant to well-being and that existential therapy complements this as it focuses on issues of the self and the self in relation to others (van Deurzen, 2002). However, the literature has not tackled the self from an existential perspective which proposes;

‘Self construct is grounded in relation and can only be said to be real in so far as it is that which reflects and is reflected in any given experience’ (Spinelli, 1994, p.347).

Spinelli (1994) defines three key points with regards to the existential vision of the self

- The self is a product of relational experience.
- The self can only be viewed as a relational construct.
- The self has plasticity and undergoes constant reinterpretation, especially when aspects are denied or disowned.

The existential perspective on self can add extra depth to other concepts of self, and this in turn might have a positive impact in therapy. Take for example the research by Holtzclaw (1985). It proposed that older adults need a positive self concept based on experience, not on the judgement of others, in order to be fulfilled and the opportunity for transcending one’s experience and integrating the various roles from their lives must be present. An existential perspective would argue that a person will always be influenced by others, but a focus on the other world views would be a way around the negative judgement of others thereby allowing the transcendence and integration to occur.
As well as the relationship to self, which will always be within a social context, interpersonal and intimate relationships are also included. Intimate relationships can include relationships with a partner, family, non family and caregivers. Indeed, Takahashi et al. (1997) in a study of older adults in Japan, found that older adults well-being was not affected by whether the relationships were with family members or non family members, but those who did not have relationships had a lower score in subjective well-being. The extent to which the findings in Japan can be applied to older adults in the UK needs to be considered. Research by Piercy (2001) found that relationships between older adults and non family caregivers are frequent in the United States and were satisfying to both the care giver and the care receiver. In addition Moyer (1992) found that sibling relationships among the elderly can assume crucial importance in the lives of older adults. Furthermore, Antonucci et al. (2001) found that both marital relationships and friendships can have both positive and negative aspects, and that the well-being of older adults is affected by these with respect to the fact that supportive relationships can help older people meet the challenges of aging.

Sexual activity is a major aspect of intimacy in relationships, but there has been relatively little about sexuality among older people. For example the National Survey of Sexual Attitudes and Lifestyles (2001) was restricted to people under the age of 60. However, there has been research on how physiological, psychosocial and cultural influences can impact on the sexuality of older adults (Zeiss & Kasl-Godley, 2001). Furthermore, the presence of chronic pain in a partner was shown to challenge intimacy in close relationships, but also those in intimate relationships can cope more effectively with chronic pain (Roberto, 2001). In addition, when researching the satisfaction with physical intimacy of elderly care giving couples, Svetlik et al. (2005) found that loss in relationship intimacy affected older adults in the same way as younger adults. It can be seen that intimate and close relationships are important for the well-being of older adults, and this is also recognised by existential therapy.
'Uberwelt' / Spiritual dimension

This describes a spiritual dimension of beliefs and aspirations where the person is likely to refer to values beyond oneself and make sense of their existence. It can represent the religious element of a person's existence or their values and ideals, as everybody has an implicit world view with a philosophy or ideology (van Deurzen, 2002).

As mentioned earlier, spirituality is an important factor in the psychological well-being of older adults. Fry stressed the significance of the spiritual world view, as a major contributor to psychological well-being of older adults living in communities and institutions (Fry, 2000), as well as following the loss of a spouse (Fry, 2001). Other complementary research by Golsworthy and Coyle (1999) substantiates this when they found that following the loss of a spouse, the spiritual beliefs were important for older adults to make meaning of their loss. The importance of the spiritual world in old age is further highlighted by the fact that higher spirituality predicts lower loneliness in older adults (Walton et al., 1999). In addition, the importance of spirituality when working with older adults has led to the introduction of Spiritual Life Review as a counselling technique for older adults (Lewis, 2001). Therefore existential theory has a significant contribution to offer psychotherapy as it is able to work explicitly with the issues of spirituality, which are significant issues for older adults. Graften (2000) has called for more research on incorporating spirituality into the therapeutic process, and this might be answered if existential psychotherapy is practised and researched more with older adults.

Summary of the existential concept of the four world views.

The unique way that existential theory conceptualizes the self into four dimensions allows for previous research on the importance of physical factors
(e.g. the physical body), personal factors (e.g. self concept and intimate relationships), social factors (e.g. social support networks and ageist stereotypes) and spirituality to be incorporated rather than excluded when considering the well-being of older adults. As stated the self concept is important to psychological well-being and therefore the focus of existential therapy on this area is clearly relevant. This is important because the worlds of older adults may be particularly dominated by the medical model if there are health complications. The existential approach focuses on clarifying a person’s view on life and living, and the conceptualisation of four worlds can help when there is an irresolvable problem in one area, which can often accompany old age. For example, focusing on spiritual issues can bring freedom from despair and ego centrism resulting from physical pain and suffering (Lukas, 1992). However, due to existential therapy’s acceptance of the spiritual aspects of life, the recent research that prioritises the importance of spirituality and meaning making can be incorporated into therapeutic practise.

Furthermore, existential therapy is able to encompass the psychological models of aging, particularly those which incorporate a spiritual reflection of meaning making aspect (Erikson, 1963) or the plasticity of behaviour (Baltes & Baltes, 1993). Existential theory acknowledges that humans are active individuals and that self awareness is critical for satisfaction in life. It may be that all types of psychotherapy would to some extent incorporate the different models of aging, but the existential therapy's emphasis on understanding the individual's context is an important difference. Its theoretical contributions can assist in the further development of a model of aging that can encompass the huge array of experiences and situations that affect the experience of being an older adult. Counselling psychologists should consider the implications of existential theory, in order to increase their repertoire of knowledge when working with older adults.
3.2. *Existential issues: the meaning of life and ultimate concerns.*

People are able to create meaning and order in spite of apparent chaos and absurdity (Frankl, 1969) and a primary aim of existential psychotherapy is to enable this process (van Deurzen-Smith, 1997). Brammer (1984) cites the work of Frankl (1977) that meaning must be extracted from the present moment, not promises of past or future hopes, to fill the 'existential vacuum'. This vacuum is a deficit of sustaining values and it is experienced as emptiness, loneliness, meaninglessness and dissatisfaction.

The quantitative research of Reker (Reker, 2004; Reker & Fry, 2003; Reker et al., 1987) has provided useful insights into the 'meaning-making' of older adults. It has described personal meaning as the belief that life has purpose and coherence, and has developed quantitative measures to explore this and other variables. Earlier work of Reker et al. (1987) investigated life attitudes and well-being of five age groups. Interestingly, they found that believing the future has meaning, believing that there is a purpose in life and believing that they have control over life predicted psychological and physical well-being with all age groups. In addition, older respondents report high levels of life satisfaction compared with middle aged and younger respondents. Overall, the findings show that the future having meaning, a purpose, and control in life are associated with positive mental and physical health, whereas lack of meaning adversely affects psychological well-being. This suggests that a therapy which focuses on exploring future meaning, life purpose and life control, such as existential therapy, would benefit older adults and improve their psychological well-being.

Further research found that there were no significant differences between younger and older adults, when six different scales of meaning were measured (Reker & Fry, 2003) or when a personal meaning index was used (Reker, 2004). The findings from this research can be interpreted in a number of ways. On the
one hand younger and older adults may be similar in terms of their making meaning in life. On the other hand, it might be that the quantitative scales are either not sophisticated enough to be able to measure the differences, or another epistemology would be more appropriate. The existential theory advocates a phenomenological approach to understanding a person's experience, and it may be that this type of investigation would show differences between younger and older adults. However, the important issue to take from this research is that finding meaning does contribute to the psychological well-being of older adults and that existential therapy, which acknowledges this importance, can offer the opportunity for older adults to perceive their existence in a more fulfilling way (Frankl, 1977).

The existential perspective can offer a further contribution to this discussion due to the prominence it places on 'ultimate concerns' i.e. death, freedom, isolation and meaninglessness. A focus on these four ultimate concerns was originally derived from the work of Tillich (1962), and has been expanded by Yalom (1980). However, other schools engage with more concerns (van Duerzen & Arnold Baker, 2005). These concerns are applicable to all people but can be considered particularly salient for older adults due to the lifespan stage they are at and the changes that occur in later life, as reviewed earlier. Furthermore, how a person copes with or adjusts to these concerns can affect their psychological well-being (McDougall, 1995).

A study by Levine et al. (1984) has particular implications for this review, as it described how carers of people with dementia face existential concerns of death, isolation, freedom and meaninglessness and discussed therapeutic and behavioural options to help the carer cope with each of these concerns. This study illustrated how a focus on four existential concerns can give insight into the problems that people face, that initially appear to need medical or practical interventions, but in fact require a therapeutic approach.
Of the concerns mentioned above, the issue of death will be expanded as death is one of the most important issues in existential psychotherapy (van Deurzen & Arnold Baker, 2005). McDougall (1985) has stated that reactions to loss and death are major developmental tasks needing resolution, and if a person can confront the possibility of death, the encounter can alter the patient's life perspective and promote a truly authentic immersion in life. Although therapists might think that the issue of death will automatically be a concern for older adults, Williams (1990) found that death itself was less of a concern for older people who were more concerned about long, disruptive or unexpected illness. Therapeutic work with older adults should not be equated solely with death, and as this literature review has shown, there are many other issues that affect older adults. The existential perspective is able to offer a unique contribution as it is concerned about how people live, knowing that they are going to die and that being and living, involves being towards death (Strasser, 2005).

Furthermore existential psychotherapists have a unique contribution to therapy as they are encouraged to be comfortable with existential concerns. This suggests that the therapeutic encounter within an existential framework would be less affected by the therapists' existential concerns. Knight (1986) noted that many therapists avoided discussing end of life issues when working with older adults. In addition, the Terror Management Theory by Martens et al. (2005) proposed that older adults present an existential threat for all individuals who are not in touch with their own fears about aging and death, and where this is present in therapists may cause barriers in psychotherapy. In this respect, existential therapists may be best placed to help older adults, although it is acknowledged that there will always be individual differences amongst therapists and the extent they feel comfortable talking about death. These last two sections have commented on links between empirical work and explicit existential perspectives. There is also a potential implicit contribution.
3.3. The non-pathologising of old age.

Existential theory takes a non-pathologising stance towards existence and hence calls for therapists to understand clients in a non-pathologising manner. It accepts that the 'givens' in people's lives are socially constructed and therefore the theory distances itself from the labels of symptoms and cures. Instead it focuses on being in the world with the client, a phenomenological approach where the therapist aims to bracket their own assumptions and prejudices (Spinelli, 1994). It is through this phenomenological approach that existential therapy might offer a valuable contribution to working with older adults. This is because it does not focus on the challenge or issue per se, but what it means to the person. By exploring the meaning or experience of the challenge this allows a self reflection and options for change, that might not be possible with more traditional therapies i.e. CBT.

The negative stereotypes that older adults are faced with has been commented on earlier. Stressing this further du Plock (1997) has highlighted how stereotypes are embraced, not only because their narrowness offers a sense of certainty about who we are, but also limits a person's ability to be open to what life brings. Therefore as existential therapists aim not to pathologise or be influenced by stereotypes, they are likely to be able to challenge the self concepts which are pervasive in western society that might not be valid for the individual, and thereby introduce the possibility of different self systems, that may in turn lead to improved psychological well-being of older adults.

4. Research on existential therapy with older adults.

This review has outlined three potential benefits for using existential psychotherapy with older adults. To recap these are; attention to the four world
views, openness to ultimate concerns and the importance of meaning making and the non-pathologising of old age. However there is a paucity of research describing existential therapy with older adults, which could imply the therapy is not being undertaken or that it is not being researched. Within the current evidence based ethos of the NHS, existential therapy is unlikely to be advocated unless there is research into its efficacy, effectiveness and the contributions it can make towards the psychological well-being of older adults.

The major contribution to the research and practice of existential psychotherapy with older adults has come from United States. Lantz and Gomia (1995) described work undertaken with older adults, where the therapeutic task in existential psychotherapy was broken down into three stages. Each stage has a focus on 'meaning potentials', which are the things that provide meaning in a person's life and can be related to relationships, roles and activities. The first task was to identify the client's meaning potentials that the therapist can respect and honour. In the middle stage activities are used to help the client think about what they can do to make their life more meaningful now and in the future, and to recollect and honour what made their life meaningful in the past. The third stage was an evaluation and ending of therapy. Three clients were presented in order to illustrate the stages. It needs to be noted here that therapists in Britain are likely to reject notions of stages and techniques within existential therapy (Spinelli, 1994) as this is based on assumptions that the experience of therapy and the stages encountered can be standardised for all individuals, which contradicts the view that each individual is unique.

Lantz (1998) explored recollection as a curative process in existential psychotherapy. He cited the theory of Frankl (1969), who proposed that reminiscence and recollection of past events and meaning potentials can be a helpful way of shrinking the clients' existential vacuum. It also illustrated the importance of using art, dream reflection, poetry and photography in helping
clients uncover repressed meaning and meaning potentials in the unconscious.

Lantz and Raiz (2004) presented case studies of older adult couples who had received existential psychotherapy. It highlighted four activities of 'holding', 'letting', 'mastering' and 'honouring', to help couples overcome existential concerns and existential pain. Holding refers to the use of the relationship to bring existential concerns and pain to the conscious awareness. Telling is the use of the therapeutic experience to disclose and talk to the therapist and the partner. Mastering is a way of finding a sense of mastery and control over the existential pain. Finally, honouring refers to the healing process of noticing meaning potentials in the future and the present. Honouring can also refer to reminiscence therapy which was discussed earlier. Case studies were presented to demonstrate the common existential issues of couple work with older adults, but the process of the four activities was not described or explained. In addition, a quantitative evaluation supported the use of existential therapy with older adults, although a limitation was noted as the therapy was tailored to the needs of the couples, no standard approach was received.

Overall the three articles above provide a detailed account of how existential therapy with older adults may be qualitatively different to other types of psychotherapy. The research has an overarching theme of honouring what can make a person's life meaningful, particularly looking to the past to provide a grounding. However, the research seems to be ad hoc in nature, and does not develop a process or theory. Another point to note is that the research has come from the United States, and many of the assumptions made, i.e. stages in therapy and ideas of the unconscious, contradict the ideologies within the United Kingdom. However, there is limited literature from the UK and only one case study was found (Roberts, 2005), but it did not significantly contribute to the discussion of whether existential therapy could help older adults.
Research by Garrow and Walker (2001) offers a contribution when discussing if existential therapy can help older adults, as it described existential group therapy with older adults. The existential group therapy was found to be valuable as it assisted group members in finding meaning in their lives. The group was also found to facilitate social support and improved coping with grief, loss, chronic illness and death. The issues of death, freedom, isolation and loneliness were discussed with a positive outcome. It was concluded that the existential group therapy provided an open atmosphere for the older adults to freely discuss their fears and concerns and it also provided opportunities for restoring and maintaining meaningful social interaction.

Research on existential psychotherapy with older adults is required in order to justify support for the provision of existential psychotherapy with older adults in an NHS context. More empirical and process orientated research needs to be carried out, especially within the UK to make a valid argument for its provision.

Conclusion

The fields of gerontology and existential psychotherapy were encountered as two separate areas. This literature review has endeavoured to weave them together in order to explore the ways that existential therapy can potentially help older adults.

Firstly it was explored how old age can accommodate both positive and negative experiences. Models of aging were discussed, and it was found that subjective factors can contribute significantly to the well-being of older adults. In particular having meaning in life and a spiritual connection are important. Secondly, the availability of psychotherapy to older adults was explored. It found that Government initiatives to address the inequality of provision had been unsuccessful and there was a notable absence in offering existential
psychotherapy to older adults.

Following this, existential psychotherapy was reviewed, highlighting three contributions it can make in working with older adults. The four world views of an individual include the physical, social, intimate and spiritual. All are important for older adults, and moreover the attention paid to the spiritual world by the existential model complements the research that spirituality is important to psychological well-being. It was also speculated how the world views might contribute to a more definitive model of aging.

The influence of finding meaning in life on the well-being of older adults was reviewed, as was the existential concerns of death, isolation, freedom and meaninglessness. Overall it could be argued that as existential therapy encompasses these issues, it can potentially benefit older adults. The attempt by existential therapists not to pathologise old age was seen as beneficial as the rejection of stereotypes of older age offers a more open framework from which to work.

Finally research from the United States on existential psychotherapy with older adults was reviewed. It explored how existential psychotherapy with older adults was beneficial due to its focus on how people find meaning in life. The review highlighted how there was an absence of research originating from the UK on existential psychotherapy with older adults. Therefore the review highlighted gaps in the literature that could be addressed by research, which includes the following research questions:

A. Does existential psychotherapy with older adults improve their quality of life?
B. Is existential therapy with older adults more effective than traditional therapies?
C. How do older adults experience existential psychotherapy?
This review has revealed the potential for counselling psychologists to use existential therapy either in its entirety or as part of an integrated approach when working with older adults. However, although the review has linked research to theory, there is a need to empirically test the extent to which these links are more than just speculation. Overall, existential therapy aims to help people to find ways to live as happily as they can with old age, death and all the other issues that life presents. It is about making sure there is quality of life and psychological well-being up until death. These ideas are also of fundamental importance within counselling psychology and therefore counselling psychologists can benefit from being aware of the ways in which existential therapy can help older adults.
References


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Appendix A: Personal Reflections

Reasons for topic

There are several personal reasons why I wanted to explore this topic. The most longstanding comes from when I was working at the Samaritans. There was one older lady who was very depressed and would often phone at 5am, because she wanted to talk about how she found her life meaningless and how she wanted to die. I often felt helpless when talking to her as I was at a loss as to what to say. I was aware that I faced these feelings because of her age, rather than her situation, as I did not feel hopeless when talking to younger people, as I could rely on my belief that life changes and positive events can happen. In addition, I think that the ageism in society both against the young and the old has been in the back of my mind for a while, but it was brought to the fore when I started my first placement where I was told that counselling in the primary health trust was not available for people over the age of 65. I was shocked by this, and thought that this group of people could gain a lot from short term counselling, but were being sidelined.

I became interested in the existential model of psychotherapy from reading Yalom, but before attending university I had found the work of Jean-Paul Satre very interesting. I found some of the theoretical concepts very intriguing, and I wanted to find out more. I was very surprised when I could not find much literature on existential therapy or issues with older adults, and this led me to explore the issue further.

Personal investment and commitment

Originally when I first started, I wanted to volunteer for an organisation that works with older adults, to gain more first hand experience. I contacted Age Concern,
but unfortunately due to my timetable, I was not able to take up the volunteer opportunities they had available. I had been speaking to my Grandmother about some of the experiences and challenges she was facing, which has been enlightening. Particularly, we had spoken about the changes she had to go through, which involved moving from the area she had lived in for the past 40 years, to a warden assisted flat. This posed many problems as she found the socialising difficult after living a solitary lifestyle for 10 years, after my Grandfather died. We have discussed religion to some extent, but mainly I was interested in how my Grandmother had no fear of death, and just appears to be living day to day.

The effect on how I have interpreted the literature

I recognise that I am particularly interested in the literature that focuses on the ageist arguments, although I have had to force myself to get off the 'bandwagon' to critique its usefulness. Another factor, has been that I have enjoyed reading certain authors of existential work more than others, e.g. Yalom and Spinelli. However, I have had to force myself to engage in more difficult texts and ideas in order to gain a broader understanding of the philosophy.

Reflections of data collection process

The data collection process was less about searching through articles found on databases, and was more about following reference trails in books and journals, which was frustrating, as well as interesting. When searching data this way it is difficult to know if any conflicting data has been missed.

How interpretative framework has shaped the analyses

I have been explicit throughout the literature review when interpreting research
findings so that they fit within the four world views, or under the ultimate concerns. It might be the case that not all the research can fit ‘nicely’ into the four world views. My aim was to make an attempt to fit the vast body of research on older adults into different categories to offer another perspective rather than to prove conclusively that the existential perspective was the only way. Other than that I have been quite open to the arguments and conflicting research in the literature.

The affect of having explored the topic

Since exploring the research topic, I have grown more interested in existential psychotherapy. I cannot say that my enthusiasm to work with older adults has increased, as the issues still remain abstract, as all of my clients have been under the age of 60. However, I would say that old age does seem less of a mystery and more ‘normal’. I am left with a desire of wanting to be wise now, rather than having to wait until old age, which may be more than 50 years.

Overall, as a psychologist from outside the existential school, I believe existential therapy can offer a valuable contribution to working with older adults.
Appendix B: Contribution Notes for Journal
The Division of Counselling Psychology publish a quarterly journal, the Counselling Psychology Review (CPR).

Notes for Contributors

Submissions
The Editorial Board of Counselling Psychology Review invites contributions on any aspects of counselling psychology. Papers concerned with professional issues, the training of counselling psychologists and the application and practice of counselling psychology are particularly welcome. The Editorial Board would also like to encourage the submission of letters and news of forthcoming events.

Academic and Practitioner submissions
Manuscripts should be typewritten, double spaced with 1" margins on one side of A4 paper. Each manuscript should include a word count at the end of each page and overall. Sheets should be numbered. On a separate sheet include author's name, any relevant qualifications, address, telephone number, current professional activity and a statement that the article is not under consideration elsewhere and has only been submitted to Counselling Psychology Review. As academic and practitioner articles are refereed, the rest of the manuscript should be free of information identifying the author. Authors should follow The Society Guidelines for the Use of Non-Sexist Language contained in the booklet Code of Conduct, Ethical Principles and Guidelines. Four copies of the manuscript should be submitted with a large s.a.e. A copy should be retained by the author.

Bibliographic references in the text should quote the author's name and the date of publication thus: Davidson (1999).

Academic submissions only
All academic submissions must include an abstract. The abstract should be no longer than 250 words (depending on the length of the paper). It needs to be double spaced, on a separate sheet and headed 'Abstract'. The British Psychological Society's Style Guide provides the following information on writing abstracts:
The purpose of the abstract is to allow the reader to assess the content of the article prior to reading the full text. In addition to appearing immediately below the author’s name, the abstract will be used for indexing and information retrieval by such services as Psychological Abstracts. It should, therefore, be written so that it can be understood independently of the body of the paper (p.6).

Proofs of academic and practitioner articles are sent to authors for the correction of typesetting errors only. The Editor needs the prompt return of proofs. Contributors should enclose a 3.5" disk (either DOS or Mac format) with the document saved both in its original word-processing format and as an ASCII file. All diagrams and other illustrations should be saved in their original format and as a TIFF or an EPS.

Other submissions

Book reviews, letters, details about courses and notices of forthcoming events are not refereed but evaluated by the Editor. However, book reviews should conform to the general guidelines for academic articles. Contributors should enclose two hard copies.

Submissions should be sent to:
Heather Sequeira, Editor, at heathersequeira@onetel.com
An exploration into how older adults experience psychotherapy.

Abstract

This paper reports a qualitative study that examines the experiences of eight older adults (people over the age of 65) who had previously received psychotherapy. Although quantitative measures of experience and effectiveness are available, there has been a scarcity of research into the phenomenology of psychotherapy for this cohort. The study explored their experiences using semi-structured interviews, and transcripts were analysed using Interpretative Phenomenological Analysis (IPA). Four main themes emerged from the data about the experience of therapy: the beginning, the therapeutic relationship, discussing key issues and the ending. The study can be seen as a valuable contribution to research on older adults and will aid clinicians to gain a greater understanding of the dynamics existing in the therapy room.
An exploration into how older adults experience psychotherapy.

Introduction

The experiences of older adults who have received psychotherapy is an important and interesting area of research because there have been relatively few studies assessing the impact of psychotherapy with this population and there have been a scarcity of studies in which clients have been asked about their experiences. Amongst those over the age of 65, (the criteria for division of services within the NHS) people who have gained access to psychological services within this cohort are a minority, (Cuddy et al., 2005), despite an increasing pool of evidence that supports the effectiveness of such services (Hepple et al., 2002).

Rivlin (1995) described the lack of psychotherapy services available to older adults as an 'historical neglect'. However, the Government has sought to redress this inequality in service provision, which has largely been due to age discrimination, through the National Service Framework (Department of Health, 2005). It introduced initiatives to ensure that older people with mental illness have the same access to services. The age discrimination in service provision to older adults can be traced back to Freud (1905) who believed psychoanalysis was unsuitable for people over the age of fifty. It was still viewed as endemic within the NHS in 2000 by Murphy (2000). It can be seen that there is an issue regarding the service provision to older adults and alongside this it is important to decide what services to provide.

A review of therapies available to older adults conducted by Woods and Roth (1996) concluded there was little research into the efficacy of treatments. It only reported that methods used in treating younger adults could be applicable to older people. However, this suggestion disregards the fact that older adults have
specific and different needs compared to younger adults. These relate to changes in life transitions, empowerment issues and physical, mental and social losses (Orbach, 2003).

A comprehensive review by Hepple et al. (2002) provided greater depth on the application of different psychotherapies with older adults. They proposed that psychodynamic, cognitive behavioural, systemic, interpersonal and cognitive analytic therapies all had significant benefits and have worked well with older adults. The review paid attention to the particular needs of older adults and considered their life-stage (Britton & Woods, 1999) and changes to physical health, social identity and changes in power dynamics (Hepple et al., 2002).

However, missing from the literature was an exploration into how older adults experience therapy and in particular the aspects of therapy which they find beneficial. This focus has the potential to highlight which processes are the most beneficial in meeting the specific needs of this client group.

Investigating the experience of older adults will provide insight into the key aspects that make psychotherapy a beneficial experience. Heath (2006) reviewed the literature on psychotherapy with older adults and suggested that there are certain key factors that should be present within the therapeutic encounter in order to provide older adults with a positive and beneficial experience of therapy. Of most important to note is the therapist holding a non-judgmental and non-ageist attitude towards old age. Woolfe and Biggs (1997) found that therapists held ageist assumptions about a client’s propensity to change, dependent on their age. Therefore the therapist’s attitude could impact on the client’s experience of therapy.

In addition, how older adults experience psychotherapy may be related to the client’s ability to discuss their concerns as well as the therapist’s availability to
listen to them. Research has shown that existential concerns including finding meaning in life and contemplating death are significant concerns for older adults (Garrow & Walker, 2001; Lantz & Gomia, 1995; Lantz & Raiz, 2004). However, Knight (1986) noted that many therapists either avoid discussing end of life issues when working with older adults, or over emphasized them. Supporting this, Martens et al. (2005) proposed that older adults present an existential threat, or an uncomfortable confrontation with the reality of death for therapists, and that this may cause barriers in psychotherapy, which would impact on the older adult’s experience of psychotherapy. Heath (2006) proposed that integrating existential psychotherapy into the therapist’s theoretical framework could be a way of improving the therapeutic experience of older adults. Therefore, another important issue is the importance of exploring whether older adults experience any difficulties discussing existential concerns including death, with their therapists, and whether this contributed to a positive or negative experience of therapy.

Overall the research will address the above issues by asking: How do older adults experience psychotherapy? The research aims to explore how older adults experience psychotherapy, focusing on the positive and negative experiences of the therapy and the topics that were discussed. As the experience of therapy is sensitive and highly complex, it is best understood through qualitative methodology, which is more concerned with meaning, sense making and understanding the subjective experience (Willig, 2001). A qualitative understanding of the client’s experience would enlighten existing quantitative assessments of therapy. It will also provide clinicians with valuable data regarding aspects of the therapy that are valued, beneficial or detrimental to the therapeutic experience. The study will explore the extent to which the experience of therapy was affected by the factors identified in the literature, but will also be open to listen to the ‘clients’ stories’, to gain a greater richness of what the experience is like and how it can be understood.
Interpretative Phenomenological Analysis (IPA) will be used as it is well suited for exploring the meaning that experiences hold for participants (Smith & Eatough, 2007). IPA endeavours to understand the experience from the point of view of the individual, and so this first hand account of the experience of therapy will provide a valuable contribution to the literature. Participants will be interviewed individually using semi-structured interviews in order to generate rich data (Smith & Eatough, 2007).

**Personal Reflections**

I became interested in older adults due to the strong opinions and perspectives I had encountered by clinicians and non-clinicians about the characteristics of older adults and attitudes towards working with this client group. The research followed a literature review I conducted on whether existential therapy could help older adults, and from this the next step was an empirical study into the experiences of therapy. When I discussed my research whilst working in the NHS, I encountered a range of reactions from the dismissive to the passionate and supportive! One psychiatrist was supportive of the research as he was frustrated by the lack of psychological services in the area. He commented that there was only one psychologist for three CHMTs, whose main work was cognitive testing. Postcode rationing still seems to be rife within the NHS. Overall, both the positive and negative opinions I faced filled me with passion to carry out the research.

**Method**

**Recruitment Procedure**

Ethical approval was obtained from COREC, the Surrey and Borders Partnership Trust Research and Development Committee and University of Surrey School of Human Sciences Ethics committee. (See Appendix A).
The sample was recruited using two procedures. The first used a local NHS service provider of psychotherapy to older adults. Psychologists and Psychiatrists in the services contacted current and previous service users to enquire if they would be willing to take part. If they agreed, the researcher contacted them by letter, giving more details about the research and then telephoned a few days later to check their eligibility and to arrange an interview time. The second procedure included placing posters in environments that are frequently attended by older adults, including GP centres and social clubs. Participants opted into the research by telephoning the researcher. At this point their eligibility was checked and an interview time arranged. They were then sent a letter giving details about the research and confirming the interview time and date.

The information letter (See Appendix B) allowed participants to engage in an informed risk assessment for themselves as it detailed what they were required to do, the location, and length of the interview, clarification of confidentiality and emphasised their to the ability to withdraw at any stage. This information was also given before the interview and the participants were asked to sign a consent form before the start of the interview process (See Appendix C), in accordance with the guidelines advocated by Coyle and Olsen (2005).

Research Instrument.
The data were collected by conducting a semi-structured interview with eight participants. The individual interviews aimed to provide a confidential and safe setting where participants would feel free to explore their experiences. It was also appropriate logistically as many of the participants had mobility problems so the interviews were conducted in their homes.
Interview Schedule

The interview schedule (See Appendix D) was developed by including questions that asked about the participants' experience of psychotherapy with further prompts to include the key issues considered as important to older adults identified by Heath (2006). The interview schedule began by asking questions about what led the client to enter therapy and gained information on the referral process and how many sessions they attended. They were asked about the therapist and how they experienced therapy. Further questions asked about the subjects they discussed and their ability to talk openly in therapy. To end they were asked to summarize their experience. The interview schedule was purposefully left open, and used as a tool to encourage participants to talk. The data collection process was conducted within the framework of basic counselling interactions, which has the dual purpose of collecting data and containing any distress participants may experience by offering empathy, genuineness and unconditional positive regard (Coyle & Olsen, 2005).

The schedule was developed by seeking comments from the research supervisor and tested by conducting a pilot interview. The pilot interview was transcribed and reviewed by both the researcher and research supervisor, and minor amendments were made that aided the interview schedule to elicit more information.

Participants

All participants were aged 65 or over and had attended psychotherapy, conducted by a Psychiatrist, Psychologist, Psychotherapist or a Counsellor. This included all types of 'talking' therapy but did not include befriending services or creative forms of therapy e.g. art therapy. All participants had been offered a minimum of six and had attended a minimum of three sessions. The participants were either in therapy or had finished within the last six months.
The recruitment of participants did not include quotas on age groups, sex, marital status, accommodation or ethnicity, as the breakdown of those receiving therapy by these criteria was not known. Furthermore, as the existing population is relatively small, enforced quotas would have limited the number of respondents recruited.

Eight participants were interviewed, and the sample was relatively homogeneous as is recommended for the analytic strategy of IPA (Smith, 2004). There was a relatively broad age range from 67-86 years (Mean age = 76.25). All respondents were from a white British background. Five participants lived independently and three lived in warden-assisted accommodation. However, only one male participant was recruited and out of the eight participants, six were recruited from one CMHT, one from a Psychiatric Service and one had opted into the research independently.

Table 1: Participants' Details.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Marital status</th>
<th>Seen by</th>
<th>Duration of therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr A</td>
<td>77</td>
<td>Married</td>
<td>Psychologist</td>
<td>1 year</td>
</tr>
<tr>
<td>Ms B</td>
<td>67</td>
<td>Divorced</td>
<td>Psychologist</td>
<td>1 year</td>
</tr>
<tr>
<td>Mrs C</td>
<td>73</td>
<td>Married</td>
<td>Psychologist</td>
<td>8 sessions</td>
</tr>
<tr>
<td>Mrs D</td>
<td>84</td>
<td>Married</td>
<td>Psychologist</td>
<td>4 sessions</td>
</tr>
<tr>
<td>Mrs E</td>
<td>66</td>
<td>Widowed</td>
<td>Psychologist</td>
<td>4 sessions</td>
</tr>
<tr>
<td>Ms F</td>
<td>75</td>
<td>Divorced</td>
<td>Psychotherapist</td>
<td>10 months</td>
</tr>
<tr>
<td>Mrs G</td>
<td>86</td>
<td>Widowed</td>
<td>Psychiatrist/ Psychologist</td>
<td>3 years/ 3 months</td>
</tr>
<tr>
<td>Ms H</td>
<td>82</td>
<td>Divorced</td>
<td>Psychologist</td>
<td>6 months</td>
</tr>
</tbody>
</table>
Analytic Approach
The data were analysed using Interpretative Phenomenological Analysis (IPA) (Smith 1996a; Smith, Flowers & Osborn, 1997; Smith, Jarman & Osborn, 1999). The approach explored the participants' experience from their own perspective and was both phenomenological and interpretative. The assumptions underlying the epistemology stress the importance of the experience and this complements the research question, which seeks to explore the phenomenology of the therapy.

All the interviews were recorded and then transcribed by the researcher. During the transcribing process the researcher kept a record of thoughts and ideas that came to mind. The analysis involved re-reading the transcripts several times with an aim of getting 'a feel' for the interviews. One transcript (Appendix E) was identified as containing the most varied data and a left hand margin analysis was conducted to identify the issues being discussed and the initial thoughts of the researcher. Notes and questions were made on the language the participant used, meanings within the data, and these highlighted convergences or contradictions in the story of the participant. This was then repeated with the other transcripts. A right hand margin analysis was conducted on the first transcript which transformed notes and ideas into more specific themes. The themes were an attempt to understand psychologically the notes made in the left hand margin. In order to keep the themes grounded in the data, the researcher constantly questioned 'where is this theme in the data?' In addition, the issues and themes were discussed with the research supervisor to check they were explicit in the data and to conjecture alternative insights. Afterwards, right hand margin analysis was conducted on the rest of the transcripts and care was taken to ensure that the themes were consistent with and could be illustrated by the data. The data were 'reduced' by establishing connections between the preliminary themes, amalgamating themes and incorporating data into different themes. This produced superordinate and sub themes. Finally, the superordinate and sub themes were collected in a table and ordered to produce a
logical and coherent narrative. Overall the analysis was an iterative process and the researcher moved back and forth between the stages detailed above.

IPA recognizes that the research and data analysis is influenced by the researcher's own perspective of the world and their interaction with the participants (Willig, 2001). Therefore it needs to be made explicit to the reader that the main researcher is a Counselling Psychology Trainee who has an interest in older adults and existential issues, and the research supervisor is a non-practising psychologist with an interest in older adults. Personal reflections have been provided to make my interpretative framework explicit. During the analysis the researcher endeavoured to remain open to what the data brought and interpretations were checked by both researchers for any undue influence of the primary researcher's interpretative framework and preconceived thoughts.

The traditional criteria of evaluating quantitative research e.g. objectivity and replicability, cannot be applied to qualitative research, as it contradicts the aims of subjectivity and the phenomenological experience of a discrete group of individuals (Elliott, Fisher, & Rennie, 1999; Smith, 1996b; Touroni & Coyle, 2002). Instead, Yardley (2000) has suggested alternative criteria for qualitative research, with the essential characteristics being: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. The findings will be illustrated by extracts from the interviews in order for the reader to access transparency and coherence. Discussion of the analysis and previous research will be included so as to enhance the understanding of the data. In addition, the analysis section will be followed by an overview and consideration will be given to the practical and theoretical implications and will give recommendations for further research, thereby demonstrating the importance and impact of the research.

\[9\]

\[9\] In the quotations empty brackets indicate where material has been omitted and ellipsis points (...) indicate a pause in speech. The therapist's name has been substituted with (the therapist) and pseudonyms have been used to protect the confidentiality of the participants.
Personal Reflections

Despite my interest in older adults, my experience of working with people over 65 is limited. I found that the interview process challenged me personally, and made me realise how many stereotypes I was holding. For example I remember commenting to a friend that not one of the participants had offered me biscuits during the interview. Although said in jest, it revealed to me some of my expectations. I was also shocked at how young some of the participants looked. Although I knew they were over 65, some of them appeared a lot younger, and coupled with their youthfulness and exuberance it seemed wrong that they should be classified into older adult services.

However, I must admit I also felt frustrated in many of the interviews, as many participants did not answer the questions directly, but instead often rambled and went off the subject. One participant wanted to discuss her nephew’s dyslexia and not the therapy. I found this very challenging as I had a conflicting agenda of wanting a story to unfold, but also to address specific issues. From the frustration I felt I was also able to understand the ageism I had encountered, and it made me appreciate how skilled the therapists were. For many of the clients I felt that their stories were about triumph over adversity, and I was struck by how many of them were looking to the future and gaining meaning in their lives, albeit in a different way to my meaning making. I believe this may have affected my interpretative framework by focusing on the benefits of therapy.

Findings

The analysis of the data revealed a variety of themes that will be presented so as to tell the experience of the therapy as a narrative, in order to make the data accessible to the reader. Firstly the experience of entering therapy, followed by the relationship with the therapist and the issues discussed, and finally the experience of ending therapy.
Table 2: Superordinate and Sub themes from the analysis

<table>
<thead>
<tr>
<th>Superordinate Theme</th>
<th>Sub Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>The experience of entering therapy</td>
<td>Referral process</td>
</tr>
<tr>
<td></td>
<td>Process of starting therapy</td>
</tr>
<tr>
<td>The experience of the therapeutic relationship</td>
<td>Talking as a process</td>
</tr>
<tr>
<td></td>
<td>Key elements in the relationship</td>
</tr>
<tr>
<td></td>
<td>Therapist characteristics</td>
</tr>
<tr>
<td>The experience of discussing key issues</td>
<td>Explicit versus underlying issues</td>
</tr>
<tr>
<td></td>
<td>Loneliness</td>
</tr>
<tr>
<td></td>
<td>Death and the future</td>
</tr>
<tr>
<td></td>
<td>Meaning in life</td>
</tr>
<tr>
<td>The experience of ending therapy</td>
<td>The process of ending</td>
</tr>
<tr>
<td></td>
<td>Perceptions of success</td>
</tr>
<tr>
<td></td>
<td>Ongoing contact</td>
</tr>
</tbody>
</table>

**The experience of entering therapy**

The process for starting therapy was different for each client, due to the reasons they had been referred and the referral process; therefore it is difficult to draw out commonalities in the experience. Two of the participants had actively sought
psychological help after a distressing experience and both had received psychotherapy or counselling before. For all the others psychotherapy was a new experience. Some had been referred by their GP, due to their presenting problems.

Ms B: 'I had a rather distressing time over Christmas and my son asked me to get help... I went to see my GP eventually to ask for help'

A few had been referred by a psychiatrist following a consultation regarding a physical condition e.g. memory loss or a stroke. One participant was offered psychotherapy after having found no relief for chronic depression from medication. All participants had a unique story about what brought them to psychotherapy and this remained with them throughout the experience.

The participants' perceptions about their own problems and preconceptions and prior knowledge also impacted on the beginning of therapy. The majority were open to the experience and were compliant with the process, following the advice recommended by the health professionals.

Mrs E: '(the psychiatrist) knew that I had gone through a rough time and he suggested that perhaps I should see a psychologist and I said yes by all means'.

However, there were some participants who were resistant to psychotherapy, as the concept of resolving problems by talking seemed alien and contradicted with their way of coping.

Mrs D: 'At one point I said I couldn't see any point in talking to him about it really, I couldn't see what it could do. I am an old lady, we never talked about things when we were younger, there wasn't any counselling and I couldn't see the point of it to start with.'
This may reflect attitudes within this cohort who have lived with a ‘stiff upper lip’ ethos in terms of dealing with difficulties, or the ambivalence about the ability of ‘only talking’ may reflect that for this age group therapy is a relatively new approach (Orbach, 2003). Also affecting the start of therapy were perceptions of what it means to have to receive help and the associated feeling invoked of shame about weakness.

*Mrs D:* ‘I always felt that people who had to tell people everything and get them to work out their problems were a bit lilly- livered, not able to sort things out for themselves, needed a crutch if you like to get over anything’.

This is supported by research which found that feelings of being a burden, shame and an inability to share experiences affected the start of therapy and were particularly significant issues for older adults (Timms & Blampied, 1985).

Therefore the data raised the issue that it is important to be aware of how clients feel about starting therapy, as preconceptions often affect client expectations and experiences of therapy, as also found by other research (Taylor & Loewenthall, 2001; Toukmanian & Rennie, 1992). It appears that all participants were able to overcome any initial concerns or anxieties and form a relationship with the therapist.

**The experience of the therapeutic relationship**

From the analysis of the data, the most benefit the older adults derived from the therapeutic experience was from the interaction with the therapist and the therapeutic relationship. The importance of the therapeutic relationship can further be divided into three subthemes; the importance of talking as a process, key elements within the relationship and the therapist characteristics.
Talking as a process

At the most fundamental level, participants found the opportunity to talk to someone immensely beneficial. It was the interaction on a one-to-one, personal basis, where they were able to talk freely which was particularly valued by the participants.

Mrs C: ‘I didn’t cry so much when (therapist) was visiting me. I didn’t get so depressed because I could talk to him. Yes it was somebody I could talk to (...) I looked forward to him coming simply because I could talk to him’.

Mrs E: ‘It’s just talking that really helps you’.

Supporting this, where one respondent only experienced a limited amount of interaction with the therapist, this contributed towards a negative experience of psychotherapy.

Mrs G: ‘I used to come out absolutely fuming as he never talked and that doesn’t help with me at all. I can’t just keep on, letting it all come out, I need the back and to.’

On a deeper level, being understood and being able to talk openly and not to be judged was remarked as contributing to the positive experience.

Mrs B: ‘I feel relaxed when I come here, I feel like I could say anything to him, if I wanted to, I could say anything’.

Mrs H: ‘She is a good listener and it is obvious from the answers she gives me that she has understood things from my point of view’.
Key elements in the relationship

The process of talking was aided by key elements existing in the relationship, which include trust and acceptance. It was important for participants to feel that they could trust their therapist and the therapist viewed them as an individual and beyond the label of an 'older person' who had emotional difficulties.

Mrs H: ‘I trust (the therapist) absolutely’.

Mrs D: ‘(the therapist) did take me seriously, (and) didn’t think I was a wimp or a silly old lady.’

Mrs C: ‘(therapist) didn’t make you feel as if you were a nuisance’.

None of the participants mentioned that the therapist treated them differently because of their age.

Ms B: ‘No I think that whatever age you were (the therapist) would be exactly the same’.

In fact, the connection between the therapist and participant seemed to transcend age differences, so many did not encounter it as an issue at all. This appears to be due to a combination of the genuineness of the therapist and the participants also not labelling themselves as an ‘older adult’.

Mrs E: ‘He didn’t speak to me as though I was an old person, or as if I was a young person. He just spoke to me as a person, and that is how I felt with him’.
One participant was angry by the institutional classification of the services, as she found it ageist, but did not find this reflected in the therapist's attitude towards her.

*Mrs G:* 'The notice they have outside, 'Psychiatry of Old Age' I have grumbled about that loads of times... That really did get me to the stomach. I did get pretty incensed about that. (But) no it didn't come into (the relationship).'

For another participant however, the experience of psychotherapy was affected by the client's opinions of seeing a therapist younger than herself. This may have reflected a participant's anxiety of the therapist not being robust enough or a personal preference based on subjective experiences.

*Ms F:* 'I really do need someone who is older. I never sorted that out but I need to feel comfortable'.

The type of relationship between the client and therapist was commented on, and generally it was experienced as largely informal and on first name terms.

*Mrs E:* 'It was just chatting really, very simple words, nothing spectacular'.

*Mr A:* 'We got on very well together, we had a Christian name association.'

This seemed to aid the relationship by allowing the participants to feel that they could talk openly. The relationship with the therapist was experienced as more intimate and relaxed compared to relationships with other health professionals, where formality and distance were experienced.
Mrs C: ‘You get used to doctors that are up there somewhere. I could never talk easily to them. They always seemed to be in such a hurry, that you don’t want to ask questions’.

Entwined within the relationship and aiding the process of talking were the characteristics of the therapist themselves.

**Therapist Characteristics**

When the participants were asked to describe their therapist, typical descriptors include ‘good listener’, ‘kind’, ‘nice’, ‘cheerful’ and ‘understanding’. However, the therapists’ positive characteristics included holding a professional opinion and being knowledgeable.

Mrs C: ‘(the therapist) was saying that there are more depressed elderly people or there are as many as younger people... he knows what he is talking about.’

The therapists were also experienced as giving advice and direction. This was most appreciated when the clients felt that it was aligned with their own situation, and when this was the case it seemed to enhance the therapy.

Ms H: ‘(the therapist) always gives me and advises me in a very calm way... like a friend. Be able just to tell her and then she would say ‘don’t you think’, then the rest comes out of that, and it is nice’.

However, the therapist’s directiveness caused discomfort for one participant when it was not thought to be appropriate, but she felt obliged to follow it unconditionally.
Ms F: ‘She has me doing things...she suggested I do this and I did it without thinking... she suggested I speak to (friend) I thought I don’t want to go there.’

The therapists were also experienced as challenging, but in a way that benefited the clients.

Ms B: ‘I find it easy to communicate with him. That doesn’t mean he doesn’t challenge me, but he does so in a very kind and a very understanding way’.

It was also felt to be helpful when the clients were able to accept themselves and their problems.

Mrs E: ‘I suddenly felt, why shouldn’t I do that, why shouldn’t I do this.....he made me think yeah, why shouldn’t I’.

Overall the experience of the interaction within the relationship led to feelings of empowerment, where the participants were able to tackle the issues that were affecting them.

Mrs H: ‘She takes me new energy to go on after that and new ideas that I can follow.’

It may have been that the therapists were aware or were practising age affirmative counselling, whereby therapists actively affirm older adults and empower them (Orbach, 2003), or their style and characteristics had a similar effect.

It is interesting to note that the analysis of the data revealed that the main benefit
felt by the participants came from a relationship that is open to them being able to talk freely and to an attentive person. The three core conditions as proposed by Rogers (1951) of congruence, empathy and unconditional positive regard are aligned to this, as participants mentioned how the therapist was experienced as being kind, understanding and a good listener. Rogers (1990) also proposed that the quality of the relationship is the most important factor for therapeutic change. However, consideration also needs to be paid to the social environment of older adults. In western society where there is social segregation of older adults (Hagestad & Uhlenberg, 2005) and lack of availability and opportunities for older adults to tell their story (Coleman, 1994) as well as pervasive negative stereotypes (Sneed & Whitborne, 2005), the non-ageist and affirming attitude of the therapist may be felt to be even more beneficial.

Furthermore if old age is a time which requires individuals to find value and accept themselves (Erikson, 1963) or re-affirm their identity (Coleman, 1999), it appears that the therapeutic relationship can provide a place to address these concerns. This is supported by research by Antonucci et al. (2001) that found that supportive relationships helped older people meet the challenges of ageing. In addition, Takahashi et al. (1997), found a positive correlation between well-being and close relationships with family and non family members. Therefore the availability of an understanding relationship by itself and what the relationships can facilitate are both important.

Overall the main experience of therapy was about the process of talking and who they were talking to. Nevertheless, consideration does need to be paid to the extent the relationship will offer ongoing benefits as research by Holtzclaw (1985) found that older adults need a positive self concept based on experience, not on the judgement of others. Therefore, the ongoing gain from therapy needs to be considered if the participants face future negative experiences. It is possible that discussion of key issues may have a longer lasting benefit, and as will be shown,
the issues discussed by the participants did impact on the experience of therapy.

**Personal Reflections**

I found it extremely interesting that within the interview, many participants described and discussed their experiences of the Second World War with me. I think I often underestimate how important this experience is to their personal history and how they perceive themselves. It also highlighted to me the importance they placed on having someone to talk to and the pleasure they gained from re-telling their experiences to me.

**The experience of discussing key issues.**

From the analysis of the data, there appears to be a distinction between issues that were explicitly addressed within the therapy and those which were often more underlying issues, which occasionally were not addressed. As this varied for each person it may reflect more the extent to which the participant rather than the therapists were able to deal with them.

On the whole participants felt more comfortable talking about the challenges they faced either relating to the presenting problem that brought them into therapy or the situations they were finding difficult in their day to day life. Relationship problems and issues regarding friends and family were also discussed.

*Mrs D:* 'It was about an aftermath of a fall that I had'.

*Ms F:* 'Mostly what I discussed were the problems I have with my daughters and the difficulty I had with the man'.

The analysis revealed differences in the extent to which the participants
discussed their past or focused more on the present and future. This may have been due to the therapist directing therapy or reflecting the main concerns of the participants. It is worth bearing in mind that research on existential psychotherapy has shown that retelling past experiences leads to improved psychological well-being (Lantz, 1998; Lantz & Raiz, 2004). Therefore the experience of therapy is likely to be influenced by the issues that are discussed.

From listening to the participants and from analysis of the data, it can be hypothesised that the topics discussed masked underlying existential concerns, which may or may not have been dealt with explicitly within psychotherapy. The existential concerns include loneliness, death and the future and having meaning in life. Furthermore these were sometimes interwoven with the client's own spiritual beliefs.

Loneliness

Loneliness appeared to be an underlying factor mentioned by nearly all of the participants and not just affecting those living by themselves. The fact that loneliness was so prevalent is in line with research that found that loneliness affects around one third of the elderly population and is a serious health endangering problem for 10% (Forbes, 1996). The loneliness was described as an upsetting and uncomfortable feeling that affected their inner state of being, and was affected by the situational circumstances of a declining social interaction and changed social and family relationships.

Ms H: ‘But the biggest thing with me is loneliness. I have got one very good friend that comes to see me once a week... There is no one except for her. Everyone is out of work and you never see them'.
The majority attributed their low mood or depression to their loneliness. It is interesting to note that research has found that although loneliness and depressiveness correlate with each other in older people, they are discrete phenomena (Young, 1982) and this should be borne in mind by therapists.

Although loneliness was a common feeling, only two of the participants discussed their feelings in therapy directly.

Mrs E: 'I do get lonely on my own at times, but that is something that you have to come to terms with anyway really.
I: Was that something you were able to discuss in therapy?
Mrs E: ‘Yes it was, it makes you sort of think differently.’

Mrs C: ‘The loneliness is terrible’.
I: And were you able to discuss this with (therapist)?
Mrs C: ‘Oh yes, I could talk about anything, and I could feel comfortable about it.’

The discussion in therapy appears to be beneficial in helping the clients come to terms and live with their loneliness. For some participants the loneliness was discussed as an underlying concern when relationships with friends and family were discussed. For one participant, with limited social interaction, the therapist encouraged them to be more active socially, although this was not well received.

Mrs G: ‘I don’t want to go out, not the places where (the therapist) wants me to go.’

It is important to recognize that the psychotherapy seemed to play a part in helping to relieve the feelings of loneliness, by providing a structured time for the
people to talk. During the course of therapy many reported that they would look forward to the sessions.

Mrs E: ‘I would have an appointment to go and see him and yes I would look forward to go and see him, because I always felt better after I saw him.’

This relates to the issue discussed earlier that the therapy provided the participants with a place to talk. Research by Tikkainen and Heikkinen (2005) found that a common feature of loneliness is a perceived lower level of togetherness in social interactions. This feeling of loneliness and how it was felt to be impacted by meaningful social connection, may explain why the relationship with the therapist was so important and beneficial to the clients.

Even though the therapy contributed in a multitude of ways to relieve the loneliness, it seems that the participants still had to face their changed social roles, and there was felt to be a resignation to their ‘place’ in society. For a few of the women, it was the change in role from parent to grandparent and therefore no longer being the centre of the family.

Mrs B: ‘With my eldest son (...) it has been difficult to talk to him, but he has his own life. They have little families now. I feel that I have got to get myself on and get myself sorted’.

Despite loneliness being discussed in therapy, either explicitly or implicitly, and the structure of therapy helping to tackle their feelings, there seemed to be a feeling of hopelessness from the participants about their situation, which could not be ‘solved’ by the therapy. These findings correspond to research that found loneliness can carry a stigma that affects the behaviour of people who feel lonely (Weeks, 1994). Therefore therapists should be aware of underlying issues and
difficulty clients may face in talking about issues due to the perceived shame or lack of opportunity to change.

**Personal Reflection**

The issue of loneliness arose and was apparent to me from the very start, as most of the participants were very willing to take part. The interview was the highlight of their day, or even their week, as they would not be meeting to talk to anyone else. The overwhelming feelings of loneliness I felt during the interviews have definitely impacted on my interpretation of the data as I was more sensitive to identifying it in the notes and themes. I felt that it was one of the most important issues to be highlighted.

**Death and the future**

In a similar vein to loneliness, discussion about death and the future varied between participants. For some, attitudes towards death and dying were explored because it related explicitly to the presenting problems i.e. where one participant had had a near fatal fall.

*Mrs D:* ‘(The therapist) sort of got round to the fact that I was of this age and I perhaps thought about death more than you do when you are young, and it all sort of came in on top of me’.

In addition, attitudes towards death were also discussed when relating to the participant’s own fears of death or having to face the reality of dying. Also fears or reactions to the loss or potential loss of a partner or friends were addressed.

*Mrs D:* ‘When you are younger you are looking ahead all the time, when you are older you are inclined to look backwards. And when something
happens like a fall or something, you wonder and think, will I see my great grandson go to school'.

However, the extent to which the participants were able to discuss openly their own views depended on the individual and often they remained under the surface.

Mrs C: ‘I prefer not to think about it. I am hoping that when my time comes, I will just go to sleep and not wake up. I try not to think about all the suffering that happens.’

For others, the issue of death and dying was not considered and the participants were encouraged to look forward to their future in an optimistic mood and constructive plans they were making for example holidays or excursions. Only for one participant was the exploration of death actively avoided by the therapist.

Mr A: ‘(therapist) used to think that if I can block out all there miserable thoughts, thoughts of death and that sort of thing, that I could manage to get out of this situation.’

The fact that there is no one overriding pattern about the discussion of death from the data is an interesting finding in itself, and is supported by research which found that responses to the contemplation of or confrontation with death are extremely varied and do not conform to a set pattern, even among older persons (Feifel, 1956, 1969). The responses from the clients could be interpreted that they are having different emotional reactions to death (Kubler-Ross, 1969). Therefore it is not straight-forward to suggest that psychotherapy will be more beneficial for clients if there is a discussion about their feelings towards death (Knight, 1986). However, research suggests that there is a need for health professionals to communicate end of life issues with their patients (Vandrevala et
al., 2002), and the data suggest that for each person this may be encountered in a specific way. Therefore therapists need to be flexible about the way they communicate, and to be open to the client’s feelings about death.

It is important to consider here that the findings may be limited by the fact that the sample was relatively ‘young’, with only three of the participants over the age of 80. Therefore consideration about death may be less of an issue for most of the participants interviewed.

For some participants their religious and spiritual beliefs were part of the discussions about death and the future, but these were explored only when the client brought them to therapy and were particularly significant to them.

I: Did you talk about the future?
Mrs H: Yes we must have done, because my basic thinking is that God leads us on according to what he wants us to do.’

The analysis indicated that spirituality and religion played an important part for some participants, especially when thinking about death and meaning in life. Where spirituality was important to the participants and discussed, it contributed to a beneficial experience of therapy. However, only a minority of the participants had strong spiritual or religious beliefs, and this challenges the research that found religiosity and spirituality had a greater contribution to psychological well-being in older adults than demographic variables, social resources, physical health or negative life events (Fry, 2000). However, this study also reflects the findings of the research by Crossley and Slater (2005) that in spite of increasing emphasis upon spirituality in the psychological literature, issues relating to spirituality are regularly overlooked within the therapeutic setting. For one participant although her spiritual beliefs were important, they had not been explored in therapy.
Ms F: ‘I certainly believe in a higher power, because if I didn’t believe it I would certainly be dead today’.

I: ‘Is this something you have discussed with your therapist?’

Ms F: ‘No not really, it is something I have always kept within (organisation)’.

Therefore therapists need to be aware of spiritual concerns but not to inappropriately place too much emphasis on them. Supporting this, Graften (2000) has called for more research on incorporating spirituality into the therapeutic process and this seems particularly salient for older adults.

**Meaning in Life**

Whilst the exploration around death was tangible for some, enquiring about how clients found meaning in life was experienced more subtly. It seemed that the therapists often encouraged the participants to discuss their hobbies or interests and participants spoke about those things which gave them meaning, which often centred on involvement with family or friends. It can be interpreted that the therapist could have been leading an affirmation process whereby the participants reconnect with meaningful aspects in their lives rather than contemplating a lack of meaning.

Ms H: ‘I desperately want to go on living, because I have got 4 children and 4, and, in June I have 5 grand children, so that is why I want to be alive, there is so much to live for.’

For those who had problems finding meaning in their life they described feelings of boredom and frustration.
Mrs A: 'the psychiatrist) said you should be making plans for the next 5 years, well I get bored to desperation as there is nothing for me to do. (...) I get bored to exasperation, knowing what I can really do with the rest of the time I have got left.'

It has been proposed that discussions about boredom and frustration can reflect an existential vacuum, where people feel they have no purpose or meaning in life (Frankl, 1969).

The extent to which challenges and issues confronted in later life were either dealt with explicitly or managed more through current issues depended very much on the participant. The analysis indicated that the psychotherapy was experienced as manageable and did not cause the clients to feel overwhelmed by philosophical and existential concerns. This contradicts the notion formulated by Tornstam (1994) of 'gero-transcendence' (a maturational process in which people become more occupied with philosophical reflections) as the participants discussed more symptom specific or everyday issues. This is significant as research shows that for older adults daily hassles show a stronger correlation to physical and psychological well-being than major life events (Landrevill & Vezina, 1992). The findings perhaps indicate that for some older adults existential concerns can be dealt with, or that they manifest themselves in people's daily life hassles. Therefore, in therapy, older adults are perhaps likely to benefit from talking about everyday problems, rather than a direct philosophical discussion about existential concerns.

The experience of ending psychotherapy.

There were differences in how the process of ending psychotherapy was experienced in itself and whether the therapy was deemed to have been
successful or not. For many participants the issue of availability of ongoing contact was a concern.

Process of ending

For some the therapy came to a natural end, when presenting problems had been felt to have been fully addressed.

*Mrs D:* ‘But I got over it and I thought well that’s it. I will just go the rest of the way on my own’.

*Mrs E:* ‘It got to a point that the last time I went I was thinking to myself I don’t need to go any more, which was nice’.

For others, the ending was experienced as abrupt, which caused one participant to feel distressed. There was also confusion for some about the reasons for ending, which was experienced as upsetting or confusing. Overall it seems that when clients did not feel in control of the ending this contributed to a negative experience.

*Mrs C:* ‘The last time (therapist) said I won’t be coming any more and I was like boo hoo (crying)’.

*Mrs G:* ‘A month ago (therapist) said to me the next one is the last one. ( ) she doesn’t tell me why, I am just left with all this’.

Within the process of ending, some participants wanted more therapy, either to continue for the ongoing contact or to overcome a specific problem.
Mrs B: ‘(The therapist) said that he will give me six sessions on the behavioural part (for OCD), but he hasn’t said that this is final… that is stressful actually’.

However, with the theme of continuing, arose the feeling of not being entitled to treatment, and this may reflect how older adults can take on the negative stereotypes about how they are less ‘valuable’ than younger adults (Nelson, 2005).

Mrs B: ‘I do realise that it is quite an expensive treatment, but it has been helpful at the moment, he is the only one I can talk to about it. So without being greedy or anything, I am happy to continue to a level where I feel so much better’.

Perceptions of success

As the main benefit was derived from having an opportunity to talk and being involved in the therapeutic relationship, success was mainly felt to be the ability they could continue or engage in their lives more. However, success was based on a personal level and did mean different things to each participant.

Mrs H: ‘I will be delighted when it comes to an end, in that it will mean that I am whole again…When you are whole, you are able to help other people and you are able to get on with your life.’

However, the success of therapy was questioned or the positive experience of the relationship was criticised when clients still found themselves with unresolved difficult experiences. There was frustration at the therapy as it was not able to change past events and so therefore was felt to be useless.
Mr A: '(the therapist) tried to do his best and I liked talking to him. The thing is that it goes back many years, and these things that bother me and come back into my mind have gone, and what can you really do about them?'

Ongoing contact

Many participants valued the offer by the therapist to regain contact if they experienced further problems. It appears to be felt as continuing the connection between the therapist and the client, and maybe this defends against feelings of loneliness.

Mrs E: 'He said "I don’t think you need to see me any more but if you want to you can. You can always call me up", which is a nice thing to have in the background if you feel low'.

The data revealed how the experience of ending was as unique for the participants as the experience of starting. However, where the ending was felt to be appropriate by the participant, it was experienced more satisfactorily. It is important to note that the ending of therapy and the loss of the therapeutic relationship were felt to be particularly painful by some participants, and this has been due to the repetition of the feelings associated with previous losses (Lendram, 2004). Therefore the therapist needs to be aware of the importance to the client of ending therapy, in order to help the experience of therapy remain positive.

The ending also seemed to bring up issues of power and control in life, especially when the therapists were unclear about the boundaries of the sessions. It may be that this reflected the confused nature of the participants, or it may be that for
older adults clarity about the framework of the sessions is more important (Orbach, 2003).

The importance of having ongoing contact available is also interesting and confuses the issue of the need for a clear worked through ending. It may be that the offer of ongoing contact is more symbolic and a defence against the anxiety of loneliness. However, it implies that the clients still have needs that were not met or addressed in therapy, or that the grappling and exploration of existential issues is a continual process that cannot be 'solved' by therapy but remains until the ultimate end (McDougall, 1995).

**Personal Reflections**

I had a feeling when interviewing the participants that I was encroaching on an almost sacred experience with the therapist. I sometimes felt I was asking someone 'what did you discuss with your priest in confession?'. I found all the participants were open, but they were more comfortable discussing with me tips and techniques, or less personal scenarios they had talked about. When trying to explore deeper issues, the participants were more general and vague as though talking about the experience and sharing would take away the value they placed on it. At times I found this frustrating as I felt important points were just out of my reach. However, I remained respectful of their right to withhold telling me about their experience. I found that offering empathy and staying with sensitive subjects enabled the participants to speak more freely. I wonder if my age may have influenced their openness as their opinions of me may have been affected by a 'grandchild transference' (Knight, 1986), or it might have been due to the cultural norms of this generation.
Overview and Implications

In summary, the participants experienced therapy as very beneficial and very positively which supports the movement towards providing more psychotherapy services for older adults. The data lead us to believe that psychotherapy, where there is a focus on the relationship and a non-ageist attitude of the therapist, is best placed to help older adults. It is interesting to note that there has been a move towards age affirmative counselling (Orbach, 2003) when working with older adults, due to the discrimination within western society. This seems to mirror a trend for other minority and discriminated groups, e.g. gay and lesbian clients (Mair & Izzard, 2001; Milton & Coyle, 2003). It would be interesting to research whether psychotherapy is experienced more positively when an age affirmative approach is specifically used.

The data contradict the representations of older adults as inward looking individuals who seek to distance themselves from society (Cumming & Henry, 1961), as the participants were seeking interaction and often felt lonely and isolated. This aligns with the proposed suggestion of Maddox (1964) that activity and not disengagement is the secret to successful aging to which psychotherapy can play a part. However, it is important that the findings are interpreted, considering the sample, as older adults are not a homogeneous group (Clarke, 2005) and therefore broad generalisations are not viable.

Furthermore, it seems that there is still a gap between what an individual faces as they are aging and what is discussed in therapy e.g. feelings of loneliness. It does not appear that the therapist’s characteristics or the openness of the relationship prevent the issues from being discussed, even though research has found that the therapist’s own death anxiety and transference issues can affect the openness of the relationship (Atkins & Loewenthal, 2004). It may be more to do with the personal barriers of the individual and expectations or preconceptions
about what they can bring. This may reflect the society where subjects such as
death and purpose in life may be felt to be taboo (Vandrevala et al., 2002).

There may be reasons why therapists do not push these issues further. They
may believe that it would be unethical to push subjects that the client does not
bring to therapy. This was found by Crossley and Salter (2005) when looking at
why spiritual concerns were not discussed in therapy. Alternatively, time or
resource restrictions mean that there was not space to bring it in. From a
different tangent it could be inferred that existential concerns were tackled by the
discussions in psychotherapy of daily life issues which made it easier and more
manageable to think about meaning and purpose in life, rather than a direct
philosophical questioning. If this is the case, then it is important that therapists
take seriously what is discussed by the client and not taken at a superficial level
and to be aware that there may be deeper underlying meanings that relate to
existential concerns. Further research into the discussion of existential concerns
within psychotherapy would be interesting to clarify this situation.

It is worth considering that the methodology of individual interviews, may have
limited the amount of discussion on existential concerns as the taboo of
discussing these topics may have persisted. A focus group with participants of
similar ages may have provided a more open environment for discussion about
existential concerns, due to the support and availability of people having similar
experiences. This was found to be the case with existential group therapy for
older adults (Garrow & Walker, 2001). It is also important to consider the effect a
'young' trainee has when asking older adults about their therapy. It is possible
that an older researcher may yield different results, as the participants may relate
differently to them.

It is also worthy to note, that due to the social isolation of older adults combined
with increased feelings of loneliness, group therapy may be more beneficial for
older adults, than individual therapy (Scrutton, 1989). Research by Garrow and Walker (2001) on existential group therapy with older adult participants found that group therapy was beneficial for participants to find meaning in their lives; it improved coping with grief, loss and death and facilitated social support. Therefore research into how group therapy is experienced and the issues participants are able to discuss may reveal interesting findings, especially in comparison with this study.

Personal Reflections

The discussion brings into question the purpose of psychotherapy in our society. Is it provided by the NHS for people to discuss how aging affects them, or should it be focused on specific problems? Put another way, should the NHS be providing psychotherapy that tackles feelings of loneliness, concerns with death and reactions to aging, if there are not the opportunities for these to be addressed in wider society? To some extent I feel that the problems faced by many older people are due to society, and therefore the means of addressing the problems should be done through societal change, rather than the use of psychotherapy. However, I am aware that utopia is not possible!

Overall, I have found the process of research challenging and interesting. I feel that I have gained a lot from the data about how older adults experience therapy, and the intrigue of further questions that need answering keeps the area alive for me.
References


Appendix A. Ethics Approval Documentation
Dear Miss Heath

Full title of study: How do older adults experience psychotherapy?
REC reference number: 07/Q1803/8

Thank you for your letter of 19 February 2007, responding to the Committee’s request for further information on the above research and submitting revised documentation.

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 approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

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<th>Document</th>
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An advisory committee to the South East Coast Strategic Health Authority
### Research governance approval

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

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With the Committee's best wishes for the success of this project,

Yours sincerely,

[Signature]

Dr Roger Wheeler
Chair

Email: Julie.Knowles@nhs.net

An advisory committee to the South East Coast Strategic Health Authority

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174
Julia Heath  
Department of Psychology – PsychD  
University of Surrey  

12 March 2007  

Dear Julia  

Reference: 112-PSY-07  
An exploration into how older adults experience psychotherapy  

Thank you for your submission of the above proposal.  

The School of Human Sciences Ethics Committee has given a favourable ethical opinion.  

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the School Ethics Committee.  

Yours sincerely  

[Signature]  

Dr Kate Davidson
Dear Participant,

Thank you for agreeing to participate in the research we discussed over the phone. Please take time to read the following information.

Research

The research aims to understand how people experience psychotherapy. For example:

- what they thought about their therapist,
- the topics they discussed
- things that were helpful
- things that were unhelpful interview.

The interview will last approximately 45 mins, depending on how you find the questions. It will be conducted by myself, Julia Heath, a Counselling Psychologist in training.

The interview will also be taped and then transcribed. All recordings and transcripts will be kept securely in a locked location that is only accessible by the researcher. Verbatim quotations may be used in the report to illustrate issues raised, but everything you say will reported anonymously and will be kept confidential. All personal information will be kept separately in accordance with the Data Protection Act.
Disclosure of Abuse in Therapy

The research aims to understand both positive and negative experiences of therapy. If you discuss any experience that could be interpreted as abusive, the interview will stop, and relevant parties will be informed, so as to protect your safety and others.

Consent Form

You will also be required to sign a consent form before the interview to show you have understood the information and you have agreed to take part. You will be able to withdraw from the research at any stage.

Thank you for agreeing to take part in the research. To confirm, we are meeting at your home address on Date and Time.

If for any reason you are no longer able to participate, please call me to let me know by calling 01483 686981.

I look forward to meeting you.

Yours Sincerely

Julia Heath
Counselling Psychologist in training

Thank you very much for taking time to participate in the study. Your participation is very much appreciated.
Appendix C. Information sheet and Consent Form
INFORMATION SHEET

Title of Project: An exploration into how older adults experience therapy

Name of Researcher: Julia Heath

Dear Participant,

Thank you for agreeing to participate in the interview. Please take time to read the following information and feel free to ask any questions.

The interview will take last for approximately 45 minutes and will be an open discussion on how you experienced therapy. I will be asking you some questions, but it is mainly an opportunity for you to talk. I would really appreciate your open and honest opinions about your experience of therapy. There are no right or wrong answers and all your answers will remain confidential.

The interview will be recorded, and your comments might be highlighted within a report. However, everything you say will be anonymised so that it is not possible to identify you. What you say will not affect your access to further treatment.

If at any point you would like to withdraw, you are free to do so, without any implications. If you discuss any experience that could be interpreted as abusive, the interview will stop and what you have said will not be included in the research. I am ethically obliged to inform relevant parties about your experience, so as to protect your safety and others, and this will be done sensitively, and protecting your confidentiality as much as possible.
Results of the study

The interview will be transcribed, excluding any personal identifying information. The tape and transcript will be stored in a secure place. All tapes will be deleted upon completion of the research. All of your responses will be kept strictly confidential and will be used solely for the purposes of the research. The transcribed data from the discussion will be included in the research report, which will be read by University Staff, and may be published.

If you find that you become distressed at any time during the interview, please mention this and we will stop. If after the interview you feel affected in any way by the material discussed during your interview, please seek support from somebody you are close to. If you would like, I can phone you the next day. You might also find it helpful to use a confidential listening service.

Samaritans: 08457 90 90 90

Mind: 08457 660 163.

Please contact your GP, if you wish to be referred to further counselling or psychotherapy services within the NHS.

Alternatively, Age Concern offers a free counselling service. Please contact Joy Hunter on 01483 446628

Age Concern Guildford
Rex House
William Road
Guildford
GU1 4QZ
01483 503414

Many thanks

Julia Heath
Trainee Counselling Psychologist
CONSENT FORM

1. I confirm that I have read and understood the information given to me about the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from the University of Surrey or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

4. I agree to my GP being informed of my participation in the study

5. I consent to the use of audio taping with the possible use of anonymous verbatim quotation.

6. I agree to take part in the above study.

______________________________  ______________________________  ______________________________
Name of Participant             Date                        Signature

______________________________  ______________________________  ______________________________
Name of Interviewer            Date                        Signature

When completed, 1 for client file and 1 for researcher file.
Appendix D. Interview Schedule
1. Can you tell me a bit about the talking therapy you went to?
   - Prompt for type of therapy
   - Was it individual, group, family or couple
   - How did they gain access
   - Where was it
   - How many sessions they attended.

2. Can you tell me a bit about the therapist/ counsellor?
   - What words would you use to describe them
   - How did they make you feel
   - Probe for if there was ageism

3. Overall how would you describe the experience?
   - Do you think that it helped?
   - Do you find you have more or less meaning in life then before?
   - What do you think about the future? How has this changed from when you were younger?

4. What subjects did you discuss in therapy?
   - Did you discuss religion, death, intimate relationships, body and the disease, environment.
   - How did you experience that?
   - What could have made it easier, better?
   - What was it that made it difficult?

5. Were you able to talk freely with the therapist?
   - Were there issues you thought you could not bring up?
   - Did you find the therapist directive e.g. gave advice or suggestions? How was that?

6. Can you tell me what the positive things were about psychotherapy?
7. Can you tell me what the negative things were about psychotherapy?
8. Are there any other things you would like to bring up?
9. Check how participant feels and they are ok to finish the interview.
Appendix E: Transcript of Interview
Transcript of interview with Ms H.

INTERVIEWER: Just to start off can you tell me a bit about the therapy you had. Was it with (therapist name), who did you see?
MS H: In the first place I saw a consultant, a man who has gone now and I can’t remember his name.
INTERVIEWER: Was he is a psychiatrist?
MS H: Yes, but he is retired now. And he then referred me to (therapist), and also to a speech therapist as well, and also to a brain, I have a brain scan. I think that is all.
INTERVIEWER: How long are you seeing (therapist) for?
MS H: This is where I can’t remember. Memory is a thing which is wrong for me now. I can’t retain things very easily. It must be nearly two years I would think, but I am not sure now. And then sometimes more often than others, it just depends.
INTERVIEWER: Sometimes, would you see her once a week, but sometimes, a bit rarer?
MS H: Yes yes, usually, in the beginning it was once a week, but later on, it was getting was a month, then I think in the last, recently I have actually been finding it necessary to talk more, in roughly the last 4 months. Now it is about every two weeks.
INTERVIEWER: So it is continuously changing?
MS H: Yes I also see another consultant, and her name is (name) erm, I think she is a professor. I can’t remember her name, I will have to look it up.
INTERVIEWER: Don’t worry about the name. Can you remember what led up to you seeing the psychiatrist, what led to the referral?
MS H: In the very first place? Because I was getting very concerned, I was actually, was erm, concerned about my memory. I was very concerned about it in the first place because people were saying to me, that everyone has a bad memory, but in the end I think it is a little more than that. Even (therapist) said not to be so concerned about it at the moment. Even then I know that my memory is not as it should be. Which may be about the stroke, a residual of the stroke. But recently, my memory is not so good and I think I have been having tests done, I had to done and it gone less again.
INTERVIEWER: When you meet up with (therapist), do you talk about your memory, or is the therapy focused on how you are feeling?
MS H: When I talk to (therapist), she has encouraged me to talk about me, not my memory.
INTERVIEWER: Ok
MS H: Which means that, obviously its all reticent really.
INTERVIEWER: Were you finding that you were feeling low because of your memory?
M; Yes, yes I was. I think it will be around November last year. Because I am having so much pain, and also because decisions were not being made about the future and the trouble with the back pain and my neck as well. But then in the end, the medication I was given in January wasn't quite right and then my GP increased it and that made it even worse, and then in the end, (specialist), do you need her name? (INTERVIEWER: No). She found another one, so the last month has been lovely.
INTERVIEWER: You said that (therapist) encouraged you to talk about yourself. Can you remember what you talked about?
MS H: I think in general what was going on at the moment about my pain levels, erm and things like erm, erm. I don’t know love, I really can’t remember, things that are relevant about what is going on at the time. I can’t really recall. Sometimes it is about family, some days what I am doing or the things going on, and I think like, how my also kind of how my finding it hard to pray these days. Well I was finding it hard to pray which is usual for me because it is part of my life, and getting very tired as well.
INTERVIEWER: Can you tell me a bit more about when you were talking about how you find it hard to pray. What sort of things did you explore?
MS H: I am really, I am, not really. No I can’t now, it is something that has gone now because I think I would think probably erm, my chemistry of my brain was not as it should be really, because I think I did a lot of sleeping, no motivation, erm, couldn’t work things out from the point of view of
making decisions, I usually belong to a lot of people, different kind of groups, social, social work, but I didn’t, I couldn’t cope with that at all. It is fine now, well it is a lot better anyway.

INTERVIEWER: Did you find that you were able to bring up anything that you wanted in the therapy?

MS H: Oh yes, very much so.

INTERVIEWER: How would you describe (therapist)?

MS H: How I would describe (therapist)? I am sorry to take a few minutes. Well what I like to say, I want to say it in professional terms, yes she is a very good, she is a listener, that is the word I am looking for, she is a good listener, and it is obvious from the answers that she gives me during the conversation that she has understood things from my point of view, as well as being able to point me in the right direction. I have the highest regard for her, and I would be very lost without her. I think she is professional and she is, and I think of her as a friend, but she is very professional, and I think she is a remarkable lady.

INTERVIEWER: You said that she was able to think about you from your point of view but then also point you in the right direction?

MS H: Yes, that is right.

INTERVIEWER: So you feel really understood by her?

MS H: Yes absolutely.

INTERVIEWER: And you said there was a conversation, would you say it was interactive with her?

MS H: Yes, very much so.

INTERVIEWER: And how did you find that?

MS H: It was that interaction which made it so good. I mean obviously because I have been a nurse, and I understand some of these things anyway, she made me feel professional myself, but very nice, but when you are feeling very, not coping very well, it would be dreadful if someone made you feel even worse. But the way she did things for me and helped me, I do very much respect her. And she makes me feel respected as well which is nice.

INTERVIEWER: You say that she treated you as a fellow professional, it sounds like you felt she had a lot of respect when she was talking to you?

MS H: Yes, yes. Whether she had I don’t know, but I felt it. Understood, understood and sympathy.

INTERVIEWER: You felt like she understood you.

MS H: Well I think she understood the pain, she understood or what I am thinking about you know.

INTERVIEWER: Would you say that was beneficial for you?

MS H: Essential, absolutely essential. Very much so.

INTERVIEWER: How did you feel when you were with her?

MS H: Relaxed, very very relaxed, new energy and then she takes me new energy to go on after that and new ideas that I can follow.

INTERVIEWER: So it seems that as well as listening she was also giving you advice and directions.

MS H: Oh yes.

INTERVIEWER: What did you think about the advice and the directions?

MS H: Well because I had absolute respect for her, then I would take on board the things she indicated, like relaxing a bit more.

(interruption)

INTERVIEWER: We were thinking about the advice she gave you.

MS H: Well you see I can remember now, relaxing was one of them. It was relevant for every time. About the prayer, she said why don’t you go back to church again, it may help you. Things that were very important to me, should would encourage me back into my own thought. It was very good really.

INTERVIEWER: It sounds like she helped you get in touch with yourself again.

(interruption)

INTERVIEWER: Where were we?
MS H: We were saying how she encouraged me to go back into my life.
INTERVIEWER: That was it. Did you feel that she ever gave you suggestions that weren't relevant?
MS H: No no it was very much in line with what was relevant for me.
INTERVIEWER: And it seems like you spoke about many different things, about religion, pain and your social groups, how did you find talking about these different areas.
MS H: It was so good to talk to someone who listened and gave me advice.
INTERVIEWER: And did you feel that she accepted your religion and spirituality?
MS H: Very much so, she didn't tell me what to do, she made me consider what was right for me through my own thought, but she led me to where I wanted to be, but it was my own thought. She never said about anything that was, she didn't sort of go along the lines, of you should do that, or it would be good if you did that, it was suggestions, based on she knows me. She knows me very well.
INTERVIEWER: Did you ever talk about the meaning that you have in your life. What you take out of life?
MS H: I am not understanding what you mean by that. You mean what is the point of life?
INTERVIEWER: Yes, those sort of questions.
MS H: Oh yes, but then you it wouldn't be said in that way because, I have so much, I have such a wonderful life really, I have family and all the rest of it, it is very unusual for me to get low, when I got the depression it was quite a shock to me really. But I am frightened about my lack to remember things because it is very important to me to keep going and have a normal life if I can. But also I knew (therapist) would tell me if it is going down, and I need to know that, because of trust. I trust her absolutely and want to know exactly what is going on.
INTERVIEWER: So it is important having the trust.
MS H: Absolutely, if I have got something going wrong, if it is going to be Alzheimer's, or if it is going to be more trouble related to my stroke, if I get more senility or that kind of thing, I do want, I trust her to tell me sorry, you know, it is worse, but then I know she would say right, we can do certain things. At the moment anyway.
INTERVIEWER: And when you were talking about things, was it made mainly about what was going on for you at the time.
MS H: Yes yes, we started in the first place talking about things that, about me and my life and what I had done in my life. We did that in the beginning but that was a long time ago now. My childhood, my divorce, and that kind of thing. Yes. But it sort of, I had to explain that to her and I think and then we moved on once that was done. It doesn't need to be said again.
INTERVIEWER: And did you talk about the future as well?
MS H: Yes we must have done, because I live my basic thinking is that God leads us on according to what he wants us to do, so therefore, we never know where we are going to be led and what we are going to do. It is quite exciting really. Knowing that, once you accept that you are led by a living Christ, then for me if you believe that, you go on in confidence that he is going to guide me bit by bit to his purposes, not for anything else.
INTERVIEWER: Having these believes seems quite, seems to give you strength, both calming but strengthening at the same time.
MS H: Well it must do, but I did not believe in them just to make a, I don't believe these things so that I can feel comforted, I do think that this is what I actually think that our search for God, because you have to use that as a word, because we don't know what God is, he is a spirit, but it is the essence, that's a reason for living as far as I am concerned, I always have been since I was 18.
INTERVIEWER: When you were finding it difficult to pray, was it hard to carry on living as well?
MS H: No no because, the trouble is if you are trying to, when you have this kind of belief, it is a two way channel, accepting that what I believe, and if I believe certain things and the way I do things, then part of that is being able to sit down and worship God, pray, meditate, all these things. But when I had this awful black, then I really couldn't think of going to worship in the church, it would break me down. I would cry and I don't want people to know that. I mean (therapist) said why not? I mean it is as if taking part of my relationship with God is cut off as I
am not able to keep in touch, but I don’t ever doubt that he goes on caring for me. And his love and his spirit is around me all the time. And when I can’t, other people pray for me, and I will pray for them, so it is different.

INTERVIEWER: It seems that you talked a lot about your religious and spiritual beliefs, and within that did you talk about how you felt towards dying and death?

MS H: Oh yes obviously. Oh yes, but I mean, I don’t like the thought of how I am going to die, but for me death, I will carry on living. For me I live every day, every minute that, am I going to have another stroke? Am I going to have another major operation, well, you don’t know if you will come out of it or not. So death is a reality and it is part of life. Yes of course I don’t like the thought. I desperately want to go on living. Because I have got 4 children and 4 and in June I have 5 grand children, so that is why I want to be alive, there is so much to live for.

INTERVIEWER: Did you talk about your relationships with your children and grandchildren?

MS H: Oh yes, I mean it is just part of me. Yes yes.

INTERVIEWER: And is there anything that (therapist) could have done to make it easier for you to talk about different things.

MS H: Yes, we have, she knows that I get anxious about my daughter and her partner, but that was a little while ago really. But if I was feeling really anxious about her then we would talk about it, it is just when it comes into my mind.

INTERVIEWER: Is there anything that (therapist) could have done to make it less difficult to talk about things?

MS H: No none, she would make it better for me.

INTERVIEWER: She would make it easier to talk?

MS H: Yes she always gives me and advises me in a very calm way, not calm in a very, like a friend. Be able to just tell her and then, you know when you say don’t you think, then the rest comes out of that, and it is nice.

INTERVIEWER: So it is the way she frames the questions and the way she listens?

MS H: Yes I am not aware of it at all, it is just talking to a very very, I was going to say loving, but a kindly person.

INTERVIEWER: Ok, do you feel that with (therapist) that she would have treated you differently if you were younger?

MS H: Oh no, I have no idea, oh no I have no idea at all.

INTERVIEWER: Did you feel that she was relating to you in a particular way because of your age?

MS H: Oh no definitely not. I think that she would always deal with somebody as a person, as they, whatever their age, whatever, you just know.

INTERVIEWER: So in a way you felt she was being quite genuine towards you?

MS H: I am absolutely sure of it. Very much so. I have no doubt about that. She has a calling I think, yes she has obviously got a calling to heal people by her, the person she is. Also she has the, like you have, the skills of your trade, but the person you are and the way you, it is obvious to me that she is a very caring lady, it shows in what she does.

INTERVIEWER: It seems that it has been and is a very positive experience for you

MS H: Oh yes

INTERVIEWER: Was there anything negative about the experience?

MS H: No nothing at all. Nothing at all.

INTERVIEWER: Ok

MS H: No definitely no. No no, the only thing for me that are negatives are of I don’t go to her. She is a, I mean obviously that is the negative for me, as a person.

INTERVIEWER: So thinking about that, would you say it is a negative thing that the therapy has to come to an end?

MS H: No, no I will be delighted when it comes to an end, in that it would mean that I am whole again for the moment. I will be whole again. No I think, otherwise it is like, stop smoking. If you don’t need it more, then you will need it later on. I don’t think it is like that. When you are whole you are able to help other people and you are able to get on with your life, so that is good. The
only negative thing is that she is a very nice, I hate that word, nice, a very special lady, and that's nice.

INTERVIEWER: Ok, I think I have come to the end of my questions now. Is there anything else you wanted to say before we finish.

MS H: No no, thank you very much for coming out, I hope it is useful.

INTERVIEWER: Yes, and how are you feeling?

MS H: Yes, I hope I have been able to answer the questions.

INTERVIEWER: Yes you have, thank you.
The Counselling Psychology Review

The Division of Counselling Psychology publish a quarterly journal, the Counselling Psychology Review (CPR).

Notes for Contributors

Submissions
The Editorial Board of Counselling Psychology Review invites contributions on any aspects of counselling psychology. Papers concerned with professional issues, the training of counselling psychologists and the application and practice of counselling psychology are particularly welcome. The Editorial Board would also like to encourage the submission of letters and news of forthcoming events.

Academic and Practitioner submissions
Manuscripts should be typewritten, double spaced with 1" margins on one side of A4 paper. Each manuscript should include a word count at the end of each page and overall. Sheets should be numbered. On a separate sheet include author's name, any relevant qualifications, address, telephone number, current professional activity and a statement that the article is not under consideration elsewhere and has only been submitted to Counselling Psychology Review. As academic and practitioner articles are refereed, the rest of the manuscript should be free of information identifying the author. Authors should follow The Society Guidelines for the Use of Non-Sexist Language contained in the booklet Code of Conduct, Ethical Principles and Guidelines. Four copies of the manuscript should be submitted with a large s.a.e. A copy should be retained by the author.

Bibliographic references in the text should quote the author's name and the date of publication thus: Davidson (1999).

All references should be listed at the end of the text and should be double spaced in APA style. A guide to the presentation of references using the APA style is given in The British Psychological Society Style Guide, available at £3.50 per copy from The British Psychological Society, St Andrews House, 48 Princess Road, East, Leicester LE1 7DR, UK.

Low-quality artwork will not be used. Graphs, diagrams, etc., should be supplied in camera-ready form. Each should have a title. Written permission should be obtained by the author for the reproduction of tables, diagrams, etc., taken from other sources.

Academic submissions only
All academic submissions must include an abstract. The abstract should be no longer than 250 words (depending on the length of the paper). It needs to be double spaced, on a separate sheet and headed 'Abstract'. The British Psychological Society's Style Guide provides the following information on writing abstracts:
The purpose of the abstract is to allow the reader to assess the content of the article prior to reading the full text. In addition to appearing immediately below the author's name, the abstract will be used for indexing and information retrieval by such services as Psychological Abstracts. It should, therefore, be written so that it can be understood independently of the body of the paper (p.6).

Proofs of academic and practitioner articles are sent to authors for the correction of typesetting errors only. The Editor needs the prompt return of proofs. Contributors should enclose a 3.5" disk (either DOS or Mac format) with the document saved both in its original word-processing format and as an ASCII file. All diagrams and other illustrations should be saved in their original format and as a TIFF or an EPS.

Other submissions
Book reviews, letters, details about courses and notices of forthcoming events are not refereed but evaluated by the Editor. However, book reviews should conform to the general guidelines for academic articles. Contributors should enclose two hard copies.

Submissions should be sent to:
Heather Sequeira, Editor, at heathersequeira@onetel.com

Abstract

Previous research into group therapy with older adults has tended to focus on effectiveness rather than addressing participants' experiences and what they found meaningful. This study aimed to investigate and explore participants' experiences of group therapy and the processes occurring, with a view to producing a localized theory. A grounded theory methodology was used and semi structured interviews were conducted with eight older adults who had previously participated in group therapy. The data were subjected to grounded theory analysis that produced a core category of 'Counteracting Forces'. Within this, the three main sub-categories were Group Process, Individual Process and Societal Process. For each process a counteracting force is believed to operate. Overall the findings add new insight by incorporating participants' outside experiences into the group processes, highlighting how group processes lead to individual change and specifically focusing on emotions. By incorporating societal processes, the findings are also given a contextual basis. Recommendations are offered for practice and further research.
Introduction

The exploration and understanding of group processes is important because it explains how and why group therapy is efficacious. There are significant clinical implications in identifying the process variables that make groups more therapeutic. These therapeutic factors are an essential part of group processes and research has found a direct link between therapeutic factors and outcomes (Castonguay et al., 1996; Corey & Corey, 2002; Oei & Browne, 2006). The group process can be considered comparable to the relationship in individual therapy, which has been found to be the best predictor of outcome (Mearns & Cooper, 2005). To date, there has been very little research on the processes in group therapy with older adults (people aged 65 years and above).

This introduction will first discuss older adults as a unique population, as a precursor to considering why group process in older adults should be different to younger adults. It will also overview research on group therapy with older adults before identifying a significant gap in the literature.

Older Adults as a ‘special’ population.

Older adults are not a homogenous population, but individuals who are faced with numerous physical, psychological and social role changes that can challenge their sense of self and capacity to live happily (Sneed & Whitbourne, 2005). In particular, the stage of ‘late adulthood’ is characterized by specific changes, including retirement (Coleman, 1999), increased decline in physical and cognitive abilities (Albert & Killiany, 2001), changes in relationships to children and family (Molgaard, 1994), and increased likelihood of death of a close friend or family
These factors have a profound impact on well-being as mental health problems are present in 40% of those aged 65 or over who attend their G.P., in 50% of older adult inpatients in general hospitals and in 60% of residents in care homes (Healthcare Commission, 2009).

In addition to the diverse array of changes to social, economic and physical areas encountered in later years, lifespan developmental models also add a contribution to our understanding of the unique position many older adults are facing. Erikson's (1950) developmental model proposed that the challenge in late adulthood is one of 'ego integrity versus despair'. He proposed a process where on the one hand a person in their later years either begins to accept their life, and the responsibility they had and this leads to little regret, or they begin to fear death and feel despair as they do not have the time to direct their life in a more satisfying direction. Other models highlight behavioural changes including Disengagement Theory (Cumming & Henry, 1961) and Successful Aging (Baltes & Baltes, 1993). It is important to specifically study group therapy of older adults as it can be seen that the challenges they face are varied and significantly different to those for younger age groups.

**Group Therapy with Older Adults.**

Group therapy with older adults has been popular since the Second World War (Kalson, 1982). There are many types of group therapy including; psychodynamic, encounter groups, remotivation, reality orientation, age integrated life crises group therapy, behaviour modification and reinforcement therapy, attitude therapy, milieu therapy, self-image therapy, reality therapy and resocialisation therapy (see Burnside, 1978; Kalson, 1982). The 1980's saw an increase in research showing the effectiveness of group psychoanalytic approaches with older adults (Leszcz, 1990; Porter, 1991). More recently there has also been an increase in group cognitive behavioural therapy (CBT), with
research to demonstrate its effectiveness (Beutler et al., 1987; Leung & Orrell, 1993). Interestingly, research by Steuer et al., (1986) compared group psychodynamic and group CBT with older adults and found both modalities to be equally effective. This is an interesting finding as it suggests that it is the group, as opposed to the therapy type, which is the key therapeutic factor, as is the relationship with individual therapy (Mearns & Cooper, 2005). More will be said on this later. Group cognitive therapy has also been found to be effective for older adults with depression (Yost et al., 1986). Overall, there is research into the effectiveness of different therapy groups with older adults, although it does not appear to be comprehensive and detailed. In comparison there appears to be a scarcity of research into the processes within the older adult therapy groups. Therefore, the important question that needs to be addressed is not whether groups are working, but why they are working.

*Group processes with older adults.*

The study of group processes with older adults draws on existing group process theories e.g. Yalom (1970), Cooper and Mangham, (1971), Tuckerman (1965) and Rogers (1970). However, it is recognised in the literature that there will be differences with older adults, due to the 'special' characteristics of this group. Burnside (1978) highlighted that support, encouragement and empathy need to predominate, and tends to focus on the role of the group leader. Other research focused on the social aspect of the group and these will be discussed below.

Research on group effectiveness with older adults by Thomas and Martin, (1992), highlighted three areas where there were therapeutic processes. They proposed that groups provided opportunities for restoring and maintaining meaningful social interaction. Secondly groups provide increased opportunity for intimacy and friendships for older people who often suffer from isolation. Finally they offer support for sharing common losses, concerns and experiences.
This is supported by research on outpatient group treatment for older adults showing increased sociability and ease of interpersonal relationships over a six month period (Liederman & Green, 1965). They believed that putting a geriatric patient into a group was a first step in taking them out of isolation. This is further developed by the theory of Goldfarb (1971) who proposed that the very act of putting people into groups is in itself a social act and that group therapy affects intrapsychic functioning by improving interpersonal relationships and increases self-esteem, self-confidence, sense of purpose and pleasure.

The use of existential group therapy with older adults was explored by Garrow and Walker (2001). They presented an excerpt from a therapy session where they identified processes related to existential concepts dealing with death anxiety, meaninglessness, freedom and isolation. In addition, they also found that the group provided a sense of community and belonging, which helped participants to develop new ways of coping and to discover the importance of their own uniqueness. Similar findings by Weiss (1994) found that both cognitive and life therapy groups in a long term care setting provided participants with a sense of meaning and purpose. Therefore it can be questioned whether it is the type of therapy provided or the group experience which provides the increased meaningfulness for the participants.

Whereas the research mentioned appears to be discussing processes on the macro level, innovative research by Lankin et al. (1982) reveals more about what happens within the groups. When comparing group behaviours in non-therapy 'helping groups' of older adults (65-80 years old) and younger adults (18-22 years old), they found that there were significant differences between the groups. In particular they found the older adults in the group had increased self-disclosure and talked with relative ease about loneliness, fears of abandonment, problems of widowhood and feelings of rejection and vulnerability. In addition they
described the flow of the older adult group as almost continuous, from disclosure to reassurance or advice, a tranquil sharing followed by a comforting response. In comparison, for the younger adults the flow was disjointed and there were significant periods of silence. Overall, these differences in the interactions between members in the two age groups lends support to the idea that group processes with older adults need to be studied separately, and cannot be assumed to be the same as for younger adults.

The reflections on an analytic psychotherapy group with older adults also substantiate these findings. Canete et al. (2000) found that 'normal' processes of competitiveness, rivalry and aggression were absent, and instead there was a preoccupation with belonging and maintaining internal group harmony. They concluded that key issues in old age (e.g. dependency, loneliness, social discrimination, helplessness and despair) are better explored in a group as there is opportunity to experience interdependency, belonging and acceptance without shame.

The research above is insightful and enlightening, but it has all originated from researchers’ observations of these groups, or by the participants using quantitative measures. Woods and Roth (1996) noted that in both the Steuer et al. (1987) and Beutler et al. (1986) studies, mentioned previously, beneficial changes related to group cognitive therapy were particularly noted on the self reports, rather than on the observer-rated scales. This indicates that the participant's experience is a better indicator of change than an observer's assessment. Arguably, what is missing from the literature is an account of what is occurring in the group which originates from the participant’s perspective, i.e. what the participants’ experienced and what they found meaningful.

Thus, this research will hopefully re-address the imbalance by asking: What processes in group therapy with older adults lead to change? The research aims
to investigate and explore the participants' experiences of group therapy. Moreover the research aims to use the participants accounts to develop a localised theory of the experiences of older adults in group therapy, as a previously constructed theory is absent from the literature. It is hoped that a theory stemming from the group participants' perspectives could inform the field of psychotherapy and counselling psychology. The objective is to add to the theoretical basis of group dynamics and psychology.

For this purpose, the research will adopt a qualitative perspective as it attends to the key factors of context (Coyle, 2007) and it gives a 'voice' to older adults, which is important as the voices of many in this cohort are seldom heard. More specifically grounded theory will be used as it has been found to be a valuable tool for examining therapeutic processes (Wooley et al., 2000). Traditionally grounded theory is used when relatively little is known about the phenomenon under investigation, but even though group processes have been extensively studied, even amongst older adults (Burnside, 1978), previous research has tended to be from observers and group facilitators, rather than the group participants. Furthermore, grounded theory was designed to construct theoretical explanations of social processes (Glaser & Strauss, 1967), and as this has not been addressed in the literature, it was thought to be the most appropriate methodology.

A constructionist version of grounded theory will be employed, (Charmaz, 1990, 2006) which has evolved from the original conceptualisation by Glaser and Strauss (1967). This version proposes that categories and theories are constructed by the relationship between the researcher, the participants and the wider world, rather than emerging from the data. Furthermore, the method of grounded theory acknowledges that the researcher's decisions, questions, and background all shape the research process and therefore any theory constructed offers an 'interpretive portrayal' and not an exact picture (Charmaz, 2006, p. 10).
It is fundamental that the researcher's beliefs are explicit, so as to contextualise the findings, personal reflections will be used throughout this report.

The data will be collected individually as this creates a potential to generate rich data and should produce higher response rates considering the mobility issues of the participants (Payne, 2007). Semi-structured interviews will be used, and are considered relevant for grounded theory as the questions are purposefully open to encourage the participants to talk (Charmaz, 2006).

**PERSONAL REFLECTIONS**

I am a Trainee Counselling Psychologist who has an interest in older adults, and I believe that they are often subjected to ageism both in terms of service provision, and also in therapists' attitudes towards a potential to change. I have previously conducted research into the experiences of older adults in individual therapy and a literature review on existential therapy with older adults. I am an advocate for research to provide evidence for more services that can help older adults. Although I have not worked within an older adult service, I do have some experience of working with people individually over the age of 65. I also have experience of facilitating groups of adults aged 18 and over, some of which have included people over the age of 65. In addition, I have been part of an experiential group as part of my training. Facilitating and participating in a group has made me aware of the processes that occur. I am mindful that many of the participants in the groups that I facilitated have spoken about how
beneficial it was to see other people in the same situations as themselves.

Method

Ethical Considerations

Prior to recruiting participants, ethical approval for the research was obtained from COREC, the Surrey and Borders Partnership Trust Research and Development Committee and the University of Surrey School of Human Sciences Ethics committee. (See Appendix A).

Literature Review

The undertaking of a literature review prior to conducting research is debated (Hawker & Kerr, 2007). However, as a research proposal was needed for course requirements and the aforementioned ethics committees, the researcher reviewed the literature on group therapy and individual therapy with older adults, before the data collection process. A further literature review was undertaken following the data analysis which focused more on the findings.

Participants

The participants were people over the age of 65 who had attended group psychotherapy within the last 3 months. The participants were not selected on their official diagnosis or other specific characteristics, e.g. gender or relationship status, but only by virtue of the fact they had attended the group. This follows Glaser's (1992) position that the relevance of variables will emerge from the data
analysis and should not be assumed in advance. A requirement was that the participants must have attended at least half of the sessions, in order to provide sufficient exposure to the therapy. Furthermore, participants were recruited if they were able to talk about their experience in a coherent manner, screening out those who were confused or emotionally unstable. The reasons for this were twofold, firstly to protect those who could be deemed vulnerable and secondly to ensure that the data were of high quality. The screening was a subjective process conducted by a psychologist.

Participants were recruited to the study from a Community Mental Health Team for Older Adults. A lead clinical psychologist identified people who had attended group therapy 3 months prior to the research starting, or were currently attending group therapy. For those who had completed therapy, the psychologist contacted them by telephone to ask if they were willing to participate in the research. If they were currently attending a group, they were asked by the group therapists if they would participate in research.

The recruitment procedure for this study followed the principles of theoretical sampling (Charmaz, 2006, pp. 96-115). This is a process which develops from the initial sampling start point and seeks to gather more data to elaborate and refine categories that have emerged from the analysis. This technique allows the researcher to construct full and robust categories and to clarify the relationships between categories. In this study the interview schedule was adapted on three occasions to collect further data that could follow the development of emerging theoretical categories.

Overall 28 people were asked to participate, out of which 8 agreed to be interviewed. The participants were from three groups, two which used Cognitive Behavioural Therapy (CBT) and one which used Narrative Therapy (NT). Each group ran for eight weeks and formed part of the services provided by a day
centre. There were also other therapy groups including Art Therapy and Physiotherapy, as well as other group activities. This has an implication for the data, as the Psychotherapy was not provided as a discrete intervention. See Table 1 for characteristics of the sample. Pseudonyms have been given to protect the anonymity of the clients.

Table 1: Participant Details

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age</th>
<th>Relationships</th>
<th>Therapy Group</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valerie</td>
<td>Female</td>
<td>69</td>
<td>Single</td>
<td>CBT</td>
<td>White-British</td>
</tr>
<tr>
<td>Jill</td>
<td>Female</td>
<td>77</td>
<td>Divorced</td>
<td>NT</td>
<td>White-British</td>
</tr>
<tr>
<td>Dierdre</td>
<td>Female</td>
<td>79</td>
<td>Widowed</td>
<td>CBT</td>
<td>White-Other</td>
</tr>
<tr>
<td>Rita</td>
<td>Female</td>
<td>75</td>
<td>Widowed</td>
<td>NT</td>
<td>White-British</td>
</tr>
<tr>
<td>Sheila</td>
<td>Female</td>
<td>70</td>
<td>Single</td>
<td>CBT</td>
<td>White-British</td>
</tr>
<tr>
<td>Lilly</td>
<td>Female</td>
<td>83</td>
<td>Widowed</td>
<td>CBT</td>
<td>White-British</td>
</tr>
<tr>
<td>Rose</td>
<td>Female</td>
<td>82</td>
<td>Married</td>
<td>NT</td>
<td>White-British</td>
</tr>
<tr>
<td>Barbara</td>
<td>Female</td>
<td>68</td>
<td>Married</td>
<td>CBT</td>
<td>White-British</td>
</tr>
</tbody>
</table>
All the participants were female, and their ages ranged from 69-83 (Mean age = 75.4). The participants were all white and all but one was British. To this extent the group can be considered homogenous, however, their presenting problems and background history were unique.

Procedure

Participants who agreed to the research were sent a letter detailing the study, and what was expected of them. The information letter (See Appendix B) allowed the participants to personally engage in an informed risk assessment as it detailed what they were required to do, the location and length of the interview, clarification of confidentiality and anonymity and highlighted to the ability to withdraw at any stage. They were then telephoned by the researcher to confirm that they were still happy to participate, and to arrange a date, time and location. The participants were given another information sheet and consent form regarding the research before the interview started (See Appendix C). At the end of the interview the participants were de-briefed. This procedure followed with the guidelines advocated by Coyle and Olsen (2005).

The length of the interviews ranged from 45 to 80 minutes. The interviews were digitally recorded and the researcher transcribed each interview, taking approximately 1 hour to transcribe 10 minutes of speech.

Interview Schedule

The interview schedule was initially designed by the researcher, based on her previous experience and reading of the literature (See Appendix D). Following theoretical sampling, the schedules were subjected to two amendments through the data collection process. The first amendment included a question regarding connecting to others in the group. A memo written after one interview is included
as it highlights the themes of the participant and feelings of the researcher (see Appendix Dii & Diii). The second amendment focused more on understanding change, how the experience of the group changes over time, and how individuals changed as a result of being in the group. A memo written during an analysis stage highlights the key questions arising for the interviewer (see Appendix Div & Dv).

**Analysis**

The grounded theory method of Charmaz (2006) was employed to analyse the data. To start with the researcher familiarized herself with the data, by reading and re-reading the transcripts. Then for each transcript the process of ‘Initial Coding’ was conducted whereby codes were generated which describe the data and create units of analysis which capture actions and processes. The codes were annotated in the left hand margin. A brief process of ‘Focused Coding’ was employed which developed more conceptual codes. After the first three interviews were coded, the data was discussed with the research supervisor and changes were made to the interview schedule.

A further 3 interviews were conducted, transcribed and read. After the initial coding was completed, the transcripts were compared for similarities and differences. The focus coding process was developed further, refining and modifying the codes in a constant comparative process. From the six interviews, an attempt was made at ‘Axial Coding’, whereby the distinct initial codes were brought together under category and sub category headings and links were made between them. The codes, categories and relationships were again discussed with the research supervisor and further amendments were made to the interview schedule. Throughout the process of data analysis, and after the interviews, the researcher wrote memo’s on personal reflections and emerging perspectives, which informed the process.
A further interview was conducted, transcribed and read. After initial and focused coding, all the transcripts were compared and contrasted. With seven transcripts the process of 'Theoretical Coding' was started, whereby theoretical codes were generated and the relationships between the codes were developed. This led to theoretical categories. A tentative theory was discussed between the research and research supervisor. Another interview was conducted and the analysis detailed above was followed.

As the final interview did not identify any new theoretical insights or reveal new properties of the core theoretical category, theoretical saturation was deemed to have been achieved (Charmaz, 2006; Stern, 2008.) The theory was developed and refined by returning to the data and through discussions with the research supervisor which provided further insights into the data. Overall the grounded theory analysis was an iterative process moving between coding, conceptualising, and re-conceptualizing the data.

Credibility of the research

The evaluation of qualitative research and in particular grounded theory cannot be from the traditional criteria of a positivist perspective that demands objective findings or replicable outcomes. This is because these criteria contravene the purpose of this study, which is to construct an interpretation of participants' accounts. Instead, Yardley (2000) has suggested criteria for assessing the validity of qualitative research by highlighting the desirable characteristics of: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. The results section will present extracts from the transcripts, so that the reader can assess the transparency and coherence of the study. The other criteria for assessing the research will be presented in the discussion.
PERSONAL REFLECTIONS

It is pertinent to note that I, as the researcher, had an influence on the participants' accounts. Many of them allied me to the Trainee Clinical Psychologist who had conducted two of the groups. They were all aware of my title as 'psychologist', and therefore this may have prevented more negative views of the group being reported.

The experience of meeting and interviewing the participants was very enlightening. As I went to many of their homes, it gave me greater insight into their lives and relationships. Sitting in a chair in their lounge, I felt I could take in their environment and momentarily put myself in their shoes.

I felt that I was able to use my skills as a Trainee Counselling Psychologist when interviewing the participants, in terms of providing a safe and containing space, as well as offering empathetic responses, and summaries to make sure I was within the participant's frame of reference. With a couple of the participants I found the interviews very difficult, as they did not seem to be able to answer my questions without wandering off track and discussing something which I thought was irrelevant. One of the first interviews I transcribed, I debated whether to include in the transcript parts which were tangential. I did, and during the analysis I started to think about why this person was telling me that piece of information at
that point in time, a reflection I also often use in my therapeutic practice. That led me to think in more depth about what the participants were telling me about their experiences in life and having been in a group. I was then able to look at the data from different angles. For example, one participant told me about the problems she was having with her hearing aids. What transpired was that she is unable to make contact with people by telephone, so increasing her isolation.

Interviewing one of the early participants I felt a sense of her empowerment when I was with her. This seemed to come from her learning about coping strategies and developing new understandings. This empowerment seemed to provide a new lease of life. The positive energy contradicts messages in society about older people’s capacity to learn and to change. It ignited my passion to challenge the ageist assumptions and discriminating attitudes that are so pervasive in our society. However, not all the stories I heard were uplifting, some were about struggles, disappointments and painful life histories. Many of the participants were socially isolated, and did not leave their homes, unless it was to go to a day centre. Although sometimes I felt sad to hear their stories, I also admired the storyteller’s resilience and strength. It must be difficult to tackle all the changes that are faced with old age, not having the solid base of a happy childhood to fall back on. This impacted my interpretation in that I reflected on the need and
opportunity for support and holding when people are faced with difficulties.

Overall I am aware that listening to the stories of older adults made me want to make sure that their voices and views were heard by others. Maybe it is a reaction to their isolation, or the fact that the experience of the group was so positive, and the participants felt very appreciative of the experience. The atmosphere described in the groups seemed very open, empathetic and nurturing. The participants also seemed to have a lot of respect for each other, the space and the group therapists. This led me to examine the data to see what in particular was happening in the group to create this special environment.

Results

Albeit all participants varied in demographical backgrounds the data yielded various commonalities. One single core category emerged from the data: the process of counteracting forces. The process of counteracting forces can be seen as an umbrella term, which encompasses the subcategories of group, individual and societal processes. These three dimensions of the process of counteracting forces are dynamic and interacting. For clarity a visual representation is presented in Figure 1. The core category and the sub categories will be presented in turn.

10 In the quotations empty brackets with ellipsis points (…) indicate where material has been omitted. The therapist's name has been substituted with (the therapist).
Core Category: Counteracting Forces

The core category of counteracting forces was developed from an exploration into why the change described by individuals was happening. It arose from the participants' discussions about how the group provided a place to learn new skills, be listened to, and accepted by others, compared to the difficulties they experienced outside the group. Many participants mentioned how they experienced a change within themselves, as a direct consequence of being in the group. The extract from Sheila illustrates how individuals experienced a change within themselves.

Sheila: I know since being on the group that I can change. Whereas before I would react to something, now I can act more positively because of the things I have learnt in the group.

Participants also reported seeing other group member's change.

Barbara: We could actually see quite a change in one of the gentlemen who came over the weeks. I mean the first time he came he was so on edge that he would have to walk around every 5 minutes or have to walk outside. Over the weeks he got a lot better, and he was able to sit still and listen. And when he came into the group he smiled rather than not, so it was obviously helping him quite a lot.

This in itself fostered Barbara's belief in the group.

Barbara: It was quite encouraging, thinking that he was obviously getting a lot better than he had been.
Figure 1

COUNTERACTING FORCES

Experiences outside the group
- Mental decline
- Physical decline
- Environment
- Social relationships

Experiences inside the group
- Learning
- Acceptance
- Encouragement
- Not the only one

GROUP PROCESS

INDIVIDUAL PROCESS
- Distressing Feelings
  - Loneliness
  - Worthlessness
  - Hopelessness

Enabling Feelings
- Connecting
- Self-confidence
- Optimism

SOCIETAL PROCESS
- Expectations
  - Traditional
  - Institutional


Sub Category: A Group Process

Changes in the participants are best understood by considering what the group was providing compared to what the individual was experiencing in their lives. In a simplistic way it can be seen as a 'see saw' effect, with the overall positive experiences of the group, balancing out the negative experiences outside the group, a positive counteracting force.

Experiences outside the group.

To fully appreciate the change experienced by the individual, and how the group process aided this change, it is first important to understand the experiences of the participants outside the group, which have been divided into mental decline, physical decline, environment, and social others.

Mental Decline
All participants mentioned a problem affecting their mental well-being or a decline in their mental ability. Some had suffered from what they had termed 'breakdowns', whereas others specifically mentioned either depression or anxiety.

Valerie: All the stress caused me to have a breakdown.

Physical Decline
In addition, participants were also experiencing a decline in their physical health, either due to a gradual deterioration, or through chronic disease, such as arthritis. Some participants had also had cancer.

Rose: I have had a very bad time because of my back. (....) I can't walk I am having trouble walking.
**Environment**
A couple of participants mentioned having problems where they live, or finding a new home presenting difficult challenges compared to the place where they had lived for the majority of their adult lives.

*Sheila: Since I moved here, there is a small council estate at the back, I have had horrendous problems with youngsters, and we had to get police involved. I had to get the gate installed, because they pulled the side gate off.*

**Social Others**
Relationship difficulties also affected a number of the participants, including single, co-habiting and married participants. Participants spoke about tensions with children and siblings, some of which were long-standing.

*Lilly: My sister had upset me by writing nasty letters. It didn’t cause [the depression], but it didn’t help at all.*

Many participants experienced multiple difficulties.

**Experiences inside the group.**

In contrast to the experiences outside the group, participants spoke about how the group provided learning, acceptance, encouragement and a feeling of being ‘not the only one’.
Learning
Although participants were from both Narrative Therapy and CBT groups, they all spoke about what they had learnt in the group. This included understanding about their experiences, concepts, explanations and origins. Also included were tools and techniques, which many described as 'coping strategies'. Valerie’s comments illustrated how this was experienced as very helpful and beneficial.

Valerie: It taught me a lot of things that would help... It taught me not to be quite so anxious. It taught me that when I panic, which I do frequently, it taught me to slow my breathing down again, and how to think things through and not to be so frightened of everything (...). The person who was talking said how they coped with it, and then you think I can use that coping mechanism for myself.

The learning aspect of the group seemed to provide a purpose for the group, which allowed for other group process to operate (acceptance, encouragement and 'not the only one') and in turn, these processes were instrumental to the learning of the content.

Acceptance
Nearly all participants spoke about how accepted they felt in the group. They valued the fact that other members respected and did not judge what they said, and that they were listened to, without being 'ridiculed' or 'put down'. For many, the group provided a new experience of being able to listen to others, and also having the opportunity to speak, and be listened to. The simplicity of this was summarized by Jill: 'they listened, that was the main thing'. This was added to by the therapeutic frame laid out by the therapists which included confidentiality and respect for others. The extract below from Rose illustrates how being open about an attempted suicide, and the subsequent acceptance was very powerful.
Rose: Because they didn’t judge me for what I had done, they understood. I mean I couldn’t understand it myself.

In addition, the acceptance from the group decreased her worry about talking.

Rose: They were really kind. (...) I discovered that it is good to talk, to get it out in the open, and that’s what I was doing towards the end. And feeling easy about it, and not worrying about it.

Furthermore, she was also able to accept the other people in the group.

Rose: I was never sorry to hear what they had to say and I never judged them for it because I didn’t think I should.

Encouragement
Acceptance by others can be viewed as an implicit process which contrasts to the explicit process of encouragement. Participants described others as kind, and offering praise, encouragement, and congratulating each other on achievements. For Sheila the group provided a different experience to that outside the group.

Sheila: I think one of the biggest things I found was the encouragement, not just from (therapists) but from the other people in the group. I was always told you are no good at anything, you will never do anything. And for someone to say you are a nice person, or the ideas that you have are good, thank you for contributing to the group, was quite an eye opener for me, that I could actually do anything that was any good.
It appears that the nearness of the group, with the acceptance and encouragement from others provided a positive contrast to other social relationships outside the group, either current or past.

Not the only one
The phrase ‘Not the only one’ was mentioned by the majority of participants, and alluded to by the others. At first it was about being in a group where others were also suffering, and that initial realization that other people are in the same situation. However, the experience of sharing and disclosure added a deeper dimension of being able to feel for other people and to acknowledge that their own experiences had affected them. The experience of ‘not being the only one’ also reduced the shame and stigma the participants felt with ‘being ill’. This will be discussed later. The extract below illustrates how for one participant, the group interaction, and sharing of personal information helped her to feel less alone in the world.

Jill: There were one or two, one of them seemed to be quite a lot like myself. When we were expressing things, she would refer to what I said. (....)Otherwise you feel, or I always felt that I’m the only one with this. Then you suddenly realize that you are not the only one. That helps you. Well it helped me (....). It was a bit of a comfort to see that you are not alone.

It can be considered that ‘not being the only one’, led to a process of normalisation, whereby participants moved from a position of seeing themselves as different and alone, to seeing themselves as similar and connected to others. This was aided by the learning and understanding of explanations for their distress.
From the data analysis it became apparent that the counteracting force of the group process was only one dimension where there was change. There was also a corresponding change within the participants. The memo below illustrates how this emerged from the data

Memo: Being accepted and encouraged by others reduced shame, added to this the process of normalization and connecting led to empowerment.

Sub category: An Individual Process

For each participant there was a different degree of change, and the feelings of each individual were unique to that person, and largely depended on their personal circumstances. However, this does not distract from the finding that there was a counteracting force of positive, more enabling emotions within the individual, resulting from the group experience, which balanced the distressing feelings felt before starting the group.

Distressing feelings within the self.

Participants described how they felt before they started the group and they linked it to the experiences encountered outside the group. The feelings can be categorized into loneliness, worthlessness, and hopelessness.

Loneliness
For the majority, the problems in their environment and difficulties in relationships led the participants to feel lonely. Even though some participants had partners or close family relationships, they still spoke about how they did not feel able to talk about their problems, as illustrated below:
Sheila: There are friends you can share things with and friends that you wouldn’t. If you are feeling a bit down, I never phone anyone and say I am feeling really rough, I’m in a lot of pain and I can’t cope today.

For another participant, the loneliness was a consequence of the shame related to having a ‘mental illness’.

**Worthlessness**

The analysis suggested that many participants experienced feelings of worthlessness or uselessness. For Barbara these had emerged from her decreased ability, either due to physical disability, or as a result of her mental distress.

*Barbara: At one stage I couldn't write a shopping list or think straight enough to think about what I would need, so I was pretty useless for a while.*

For Jill, it was a long standing feeling which had affected her throughout her life.

*Jill: I would do anything for anybody else but nothing for me. A worthless feeling I suppose.*

**Hopelessness**

For many participants, there was a feeling of being overwhelmed, or not seeing an end to their problems. This came over as a feeling of hopelessness. For some it was about not being able to do the activities they had previously enjoyed. Interestingly, for Rose the group had helped lift her mood, but then her continued disability after an operation again altered her perception about her situation.
Rose: I got on so well, and everything was looking up, and then I had the treatment, and I thought I would be fine and pick up the pieces again, but I can't.

This illustrates the dynamic nature of the counteracting forces at work for an individual, and how even if there is change from being in a group, the external forces can still add pressure on an individual.

Enabling feelings within the self.

The group therapy was reported by participants to change the feelings they had about themselves and their situations. These enabling feelings include connectedness, self confidence and optimism.

Connectedness

A feeling of connectedness, both to others in the group due to its social nature and also to themselves, appears to be counteracting the feeling of loneliness and isolation.

Lilly: When you are that bad you can't get interested in things (...). I like being with other people you see. (...). I missed seeing people.

The opportunity of the group to meet others and connect with others was valued by the group. Participants spoke about how the group 'gelled' or how they got to know each other 'very well'. Some participants considered others in the group to be newly formed friends. Overall being with others in a more intimate way and especially being with others who had similar concerns provided a new and enriching experience. For many the process of connecting to others was a gradual change, as they were often cautious at the beginning of therapy.
Rose: It was good as I keep things to myself a lot. I am not a very outgoing person. I was surprised as I felt very relaxed about being in the group, talking to them. Talking about myself. They all took an interest in you. We all sort of took an interest in each other. To me, we got to know each other very well in such a short space of time.

This extract illustrates the change within Rose, as she was able to talk more, due to the interest that the group members showed in each other.

Self Confidence
All but one of the participants mentioned an increase in self confidence, and they related it to an increased feeling of control over their symptoms, with new coping tools, or through finding their own voice.

Valerie: I think it has changed me. I think it has given me more confidence in myself, and also I wouldn’t be so afraid of going out into a situation. So it has given me a little bit of self confidence. I must be able to think more of myself, because I have always regarded this mental illness that I have got as something to be ashamed of and now I don’t get that anymore, as now I can see that a lot of people have it as well as me.

This quote illustrates how Valerie’s confidence has grown through the group situation, but in addition that connecting to others has helped decrease the shame she felt related to her 'mental illness'. For Lilly her confidence grew directly from seeing that she was not by herself.

Lilly: It gave me more confidence to think that you are not on your own.
Therefore, there appears to be a link between ‘self confidence’ and ‘not the only one’.

Optimism
The group therapy also seemed to foster a sense of optimism in the future, probably intrinsically linked to the change and the increase in self confidence. This can be described as a feeling of optimism.

Sheila: I think it has made me feel a lot more positive, yes a lot more positive. And it has given me a new way of coping with different situations, and actually whereas in the past I might not have bothered, now I will tackle something.

Overall it appears that the positive enabling feelings counteract the negative feelings, with a shift from isolation to connectedness, from worthlessness to self confidence, and from hopelessness to optimism.

Sub category: A Societal Process

This third layer of a counteracting force materialized with less precedence than the other two layers, but still needs to be considered as it provides an enriching understanding of the counteracting forces that exist on a societal level. The participants' views on mental health and talking about problems or concerns were balanced by the views of the health professionals working in the hospitals and day centres.
Traditional Social Influences

For many of the participants, they had cultural and societal beliefs about talking to others. There were shared beliefs about not talking to others, not burdening others, particularly children (Jill: 'putting on young shoulders').

Dierdre: *These people have enough problems of their own, and you don't go there and tell them your problems.*

Participants also spoke about their history of 'mental illness' and how their first experience of treatment was not focused on talking, but rather using 'those awful shock treatments' (Lilly) – Electric Convulsive Therapy (ECT) or medication. The traditional medical model of the participant's distress seemed to mirror the cultural expectations of not talking about problems.

Current Social Influences

In comparison, the therapy group appeared to counteract this, not only in terms of the participants being expected to talk about their problems, but also with a new perspective from the institution of a psychological explanation of human distress. Rita summarized this eloquently.

*Rita: I feel that it was the first time that I had been in a hospital where everybody had gone out of their way to try and treat us as people, or to try and discover what the causes were, rather than just giving out pills. (…) Holistic. Dealing with the whole person. I felt (the therapy) was much more of an aim to do that, rather than just heaping out pills.*

The participants changed their views, were willing to open up to talk about themselves, and they came to believe in the benefit of it. They moved away from
their cultural beliefs towards the institutional beliefs based on the positive experiences within the group. This can be viewed as another counteracting force.

The relationships between the processes

The three processes; group, individual and societal are dynamic and all interact with each other. It has been outlined above how the experiences within the group all interplay with each other e.g. with acceptance and encouragement aiding learning, and vice versa. Furthermore there is a link between the experiences within the group and how this counteracts the feelings within the individual. The theory has mainly been able to link the processes at a general level, whilst presenting the idea of a counteracting force within each process. From the data a direct link was constructed between ‘Not the only one’ and ‘self-confidence’, however other direct links were not able to be constructed.

Discussion

This study was carried out in order to understand older adults’ experiences of group therapy and to examine the processes within the group. The emergent results can be constructed into a localized theory which proposes that counteracting forces occur on three levels of process: the group, the individual and societal. Furthermore, the participants spoke about how elements of these processes interacted and led them to experience a change. Each process will be discussed in more detail relating it to the literature.

Group Process

The findings on the ‘positive experiences within the group’ have the most overlap with the current literature. Research by Fuhriman and Burlingame (1990)
identified six factors unique to group therapy. These were: vicarious learning (improvement in response to another participant’s experiences), role flexibility (participant as both help seeker and help provider), universality (realizing others are struggling with similar problems), altruism (offering support and encouragement to others), family re-enactment (the group resembling the participant’s family of origin) and interpersonal learning (learning from interactions with other participants). Apart from the factor of family re-enactment, there is a conceptual convergence with parallels emerging from this grounded theory analysis and from the above study. There are also parallels with the extensive study on group process by Yalom (1970), who proposed ten curative factors in group processes. This study differs in the fact that four factors were identified as the most significant: learning, acceptance, encouragement and seeing others with similar concerns (‘not the only one).

The importance of learning has also been found by other research. Weiss (1994), linked learning to providing a sense of meaning and purpose in life. There is also support for the importance of acceptance (Canete et al., 2000) and encouragement (Burnside, 1978). The concept ‘not the only one’ is well established in the literature as it is analogous to universality (Yalom 1970; Foulkes, 1964). It has been found to be a key component in self help groups (Llewelyna & Haslett, 1986).

It is interesting to compare this study to research by Oei and Browne (2006). They measured the effect of five group variables: cohesion, leader support, expressiveness, independence and self discovery on outcome, and found expressiveness was the most highly correlated. All the variables, apart from cohesion, can be viewed as solitary, especially when contrasted to the experiences identified by the study (learning, acceptance, encouragement and not the only one), which indicate more of a connection between the participants. Therefore the study suggests that processes which involve a unity between the
participants may be better predictors of outcome. This proposal is in line with the research by Lankin et al. (1982) which observed that older adult groups were more sharing and comforting than younger adult groups. Moreover the importance of unitary is also supported by the research of Canete et al. (2000), who found that older adult groups were preoccupied with belonging and maintaining group harmony. It is interesting to consider whether these processes are due to older age or generational differences, and this could be an area for further research.

Research to date has just been from the perspective of researchers and group facilitators. As this research has come from the perspective of the group participants, a new dimension has been added to the understanding of group processes with older adults. This is the effect of the participants’ experiences outside the group. Although the literature has recognized the adverse environmental conditions for older adults which include ageism (Nelson, 2005); and isolation (Hagestad & Uhlenberg, 2005); the influence of the adult’s experiences outside the group have not been explicitly considered in how they affect group processes. It is almost as though participants are seen to leave their ‘outside lives’ at the door when entering the therapy room. This study has conceptualized how the outside experiences directly affect the processes within the group. It can be seen that giving a voice to the participants has allowed a new theoretical consideration to group processes, as their experiences outside the group can be seen to influence the processes inside the group.

**Individual Process**

The emergence of an individual change process operating within a therapy group adds a novel dimension to the literature in two ways. Firstly it directly links individual change to group therapy, and it also highlights the importance of the participants’ emotions.
Group therapy research has focused more on how the group changes, rather than on how the individual changes within the group (Lewin, 1947; Tuckerman, 1965). The literature does not provide substantial accounts of how group processes affect the individual. Goldfarb (1971) proposed that interpersonal relations increase self esteem and self confidence. Similarly, Yalom (1970) made the link between group cohesiveness and self esteem, proposing a group’s influence on self esteem is a function of its cohesiveness. There are parallels between these proposals and the research finding that ‘not the only one’ is linked to self confidence. Moreover this study is also more detailed in providing a greater insight into the change within the individual.

Traditional group process theories have also focused more on changing interactions between group members and the change in their behaviours (Smith, 1980). Discussion regarding the participant’s emotional change is not found in the literature. Indeed, when examining the differences between individual and group therapy processes Holmes and Kivlingham (2000) found that ‘emotional awareness – insight’ was not a prominent part of group psychotherapy processes. However, the literature concerning older adults is different. Lankin et al. (1982) found that older adults had increased self disclosure, particularly regarding loneliness and feelings of rejection and vulnerability, when compared with younger groups. Similarly Canette et al. (2000) found that key issues discussed by older adults were dependency, loneliness, helplessness and despair. Therefore emotions and emotional change appears to be a main part of group therapy with older adults in this research. It is interesting to question whether the emotional focus with older adults is due to the methodology, which gave the participants an opportunity to discuss their emotions, or if these processes indicate a specific process in older adults. This could be investigated by further research.
Overall this research adds a new insight into the emotional change experienced by participants as a result of attending the group. By using a methodology which focused on the participants' views, it readdressed the imbalance in the literature by making participants' feelings central to the process of change.

Societal Process

Similarities emerged between the literature and the research with the attitudes older adults had towards talking about their concerns. The older adults' views on self expression and mental health due to generational influences has been noted extensively by Orbach, (2003). She comments on prevailing attitudes to such situations in society as being 'pull yourself together' and adopting 'a stiff upper lip'.

Interplay between Group, Individual and Societal Processes

The theory presented does not propose stages or hierarchies, instead it proposes a constant interplay of factors, with cycles happening uniquely for each individual, and on three different levels. It presents a different theory of change compared to the more traditional ideas which focus more on processes as the group develops (Bion, 1961; Rogers, 1970). The theory brings a new dimension to traditional approaches on group therapy, as it contextualises the group processes within the society, and so presents an alternative and more holistic viewpoint. Overall the theory of counteracting forces gives a novel insight to address how and why groups are beneficial for older adults.

Clinical Implications

Group therapy seems to be an appropriate intervention on two levels. The first being a cost effective therapy where the population is large and the resources are
limited (Leung & Orrell, 1993). But more importantly, the format of the group itself appears to provide additional benefits, especially considering the range of concerns such as physical and mental decline, social relations and hostile environments. This theory, by virtue of the fact that it found beneficial changes in individuals, supports the provision of group therapy for older adults.

The theory is also an important consideration to aid group therapists to conceptualize the processes that lead to change. It might alter therapists' interventions that stress support and acceptance and feedback from the other participants on progress and alternative strategies. It can facilitate the development of creating a positive environment within the group, by focusing on the features of learning, acceptance and encouragement. In this way, it will encourage therapists to think beyond what is being 'discussed' in the theoretical perspective.

**Evaluation of Credibility**

Overall the study can satisfy the criterion for evaluating qualitative research laid out by Yardley (2000). It has demonstrated sensitivity to context by relating the study to current research and theoretical literature, as well as considering and placing the context of the participants as central to the emergent theory. The presentation of participants' extracts and researcher memos as well as using a rigorous methodology has demonstrated the criteria of commitment and rigour and transparency and coherence. Finally the unique theoretical contribution of this study coupled with the implications for the wide variety of clinicians (e.g. psychologists, group therapists, occupational therapists) who facilitate in group therapy with older adults, has demonstrated the criteria of impact and importance.
Limitations

The theory constructed can be seen to reflect the accounts of eight older white women, who were visitors to a day centre. The main limitation of the research is that it has produced a tentative and localised theory, which cannot be transferred to other groups, especially those with differences in participants' characteristics, service provision or type of therapy. It is possible however, that this research could form part of a wider 'survey of voices', with research being conducted with different samples to produce a more detailed account (Steibbins, 2006). Despite the limitations of the research it is hoped that the concept of counteracting forces will enhance psychologists' and group therapists' understanding of the therapeutic factors in groups of older adults.

PERSONAL REFLECTIONS

I am disappointed that I was not able to observe any groups with older adults, to be able to witness first hand the dynamics and processes. I think I would have found it an enriching experience, and it may have brought me closer to the data. Unfortunately due to the policies at the service, it was not possible.

The grounded theory methodology has highlighted to me the importance of considering the context of individuals. In particular the wider social context which individuals face, in terms of economic, political and cultural influences, both past and present. In this respect the Grounded Theory methodology allows for a more explanatory understanding of the experience being investigated and so therefore it goes beyond the description of the IPA study I had previously carried
out. For example, Jill experienced the group very positively and it appeared she went into the group motivated and enthusiastic, as it was a dramatically different approach to her distress compared to her experiences of ECT and psychiatric inpatient hospitalisations. The Grounded Theory methodology allowed these previous experiences of interventions to be considered in understanding the experience of the therapy group. I feel that as a researcher, I was able to use my creativity and intuition as part of the research process and therefore consider the 'why' as well as the 'how'. This created a unique contribution to understanding group experiences and therefore seems to be a more worthwhile endeavour than the IPA investigation, which was largely descriptive, as I felt I could not become so involved in the process of understanding the data.

I found that both the Grounded Theory and IPA methodologies were limited in respect that they relied heavily on the use of language for participants to describe their experiences. For some, this was very difficult. In the interview with Barbara she was able to talk about concrete examples, i.e. change in another group member, but found it more difficult to talk about her feelings and thoughts of being in a group, interacting with others, or thinking about her own distress. This may have been due to the culture she grew up in, which discouraged talking about concerns, but it also may reflect that it is difficult for some people to use language or words adequately to describe
their experiences. This was not the case for all the participants, but for both the Grounded Theory and IPA methodologies, there might be limitations in what is reported to the interviewer based on ability to articulate complex and deep thoughts and feelings.

Continuing from this, the role of language also needs to be considered in that both Grounded Theory and IPA methodologies rely on the representational validity of language (Willig, 2008). However, language can be seen to play a role in constructing an experience as the words people use are integral in their understandings. This is not fully acknowledged in the methodologies.

Overall, I have enjoyed the experience of meeting and discussing the therapy with older adults, both individual and group experiences. I really appreciated their effort and thoughtfulness made by the participants in the interviews and I feel that qualitative methodologies allow the rich and complex experiences to be understood, albeit through my personal lens in the interpretation of the data.
References


Appendix A: Ethical Approval
04 March 2009

Miss Julia L L Heath
Trainee Counselling Psychologist (Psych D)
University of Surrey
Department of Counselling Psychology
University of Surrey
Guildford
GU2 7XH

Dear Miss Heath

Full title of study: An investigation of the processes in group therapy with older adults that lead to change.

REC reference number: 09/H0803/2

The Research Ethics Committee reviewed the above application at the meeting held on 25 February 2009.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to submit the Site-Specific Information Form to any Research Ethics Committee. The favourable opinion for the study applies to all sites involved in the research.

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. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.
Approved documents

The documents reviewed and approved at the meeting were:

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<td>GP/Consultant Information Sheets</td>
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Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegr6up@nres.npsa.nhs.uk.

This Research Ethics Committee is an advisory committee to London Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.
With the Committee's best wishes for the success of this project

Yours sincerely

Dr Christine Heron
Chair
Email: recwandel@stgeorges.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments
"After ethical review – guidance for researchers"

Copy to: Mrs Marion Steed
13th March 2009

Dear Julia

Reference: 316-PSY-09
Title of Project: An investigation of the processes in group therapy with older adults that lead to change

Thank you for your submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has given favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Yours sincerely

Dr Adrian Coyle
Dear {Name},

We would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. You have been selected for this study because you have recently had group therapy with the Older People Mental Health Service. The research is part of a Doctoral Level Research Project aimed at exploring people's experiences of group therapy. Therefore your views would be most welcomed and will contribute to improving the services available.

Research

The research aims to understand how people experience group therapy. For example:

- what they thought about the group,
- the topics they discussed
- whether there was anything they found helpful
- whether there was anything they found unhelpful
- Whether they have noticed any change since being in the group.

What is required of you?

The interview will last approximately 45 minutes, depending on how you find the questions. It will take place either in your own home, at Farnham Road Hospital or at the University of Surrey, depending which is the most convenient for you. It will be conducted by myself, Julia Heath, a Counselling Psychologist in training.

The interview will also be tapped and then transcribed, but everything you say will be anonymous and confidential. If you would like to review the transcript of the interview, this can be arranged. All personal information will be kept separately in accordance with the Data Protection Act, which means only myself and the university supervisor will have access to it.

Ethical Approval

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity.
This study has been reviewed and given favourable opinion by Wandsworth Research Ethics Committee.

Consent Form

You will also be required to sign a consent form before the interview to show you have understood the information and you have agreed to take part. You will be able to withdraw from the research at any stage, without giving a reason. This will not affect the standard of care you receive.

Your GP will be informed

We would like to inform your GP of your participation in the research to ensure a continuity of care. We will ask for you to give your consent to this at the start of the interview.

It is up to you to decide if you agreed to take part in the research. We will describe the study again and go through this information sheet before the interview. I will contact you shortly to arrange a convenient date time, and location to meet. If for any reason you do not want to participate, please call me to let me know on 01483 686931.

I look forward to meeting you.

Yours Sincerely

Julia Heath
Counselling Psychologist in training
Appendix C: Second Information Letter and Consent Form.
Dear {Name},

Thank you for agreeing to participate in the interview. Please take time to read the following information and feel free to ask any questions.

The interview will take last for approximately 45 minutes and will be an open discussion on how you experienced therapy. I will be asking you some questions, but it is mainly an opportunity for you to talk. I would really appreciate your open and honest opinions about how you experienced group therapy. There are no right or wrong answers and all your answers will remain confidential. If at any point you would like to withdraw, you are free to do so, without any implications.

The interview will be recorded, and your comments might be highlighted within a Doctorate report. However, everything you say will be anonymised so that it is not possible to identify you. What you say will not affect your access to further treatment.

Results of the study

The interview will be transcribed, excluding any personal identifying information. The tape and transcript will be stored in a secure place. If you would like to review the transcript of the interview, this can be arranged. All tapes will be deleted upon completion of the research. All of your responses will be kept strictly confidential and will be used solely for the purposes of the research. The transcribed data from the discussion will be included in the research report, which will be read by University Staff, and may be published.
The Interview

If you find that you become distressed at any time during the interview, please mention this and we will stop. If after the interview you feel affected in any way by the material discussed during your interview, please seek support from somebody you are close to. Alternatively you can phone some voluntary organizations:

Samaritans: 08457 90 90 90
Mind: 08457 660 163

Informed GP

We would like to inform your GP to ensure continuity of care. There is a section on the consent form to indicate this.

If you have any questions, please feel free to ask at any time. I hope that you enjoy participating in this research,

Yours Sincerely

Julia Heath
Counselling Psychologist in Training
Patient Identification Number for this trial:

CONSENT FORM

Title of Project: What processes in group therapy lead to change in older adults?

Name of Researcher: Julia Heath

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from the University of Surrey or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

4. I agree to my GP being informed of my participation in the study.

5. I agree to take part in the above study.

__________________________  ________________  ____________________
Name of Participant       Date             Signature

When completed, 1 for client file and 1 for researcher file.

Thank you very much for taking time to participate in the study. Your participation is very much appreciated.
Appendix D- Interview Schedules and Memos.
Appendix D i: Interview Schedule version 1

1. Can you tell me a bit about the group therapy you went to?
   • Why were you referred?
   • What were your initial thoughts about attending?
   • How many sessions did you attend?
   • What did you do in the group?

2. What was it like being in the group?
   • Did you feel you were able to talk freely?
   • What was it like being with other people?
   • How did being in the group make you feel?
   • What was your relationship like with the therapist?
   • What was your relationship like with other group members?

3. What subjects did you discuss in therapy?
   • How did you find discussing these subjects?
   • Was there anything missed from the subjects discussed?

4. Would you mind explaining to me about your condition?
   • Can you tell me what has happened to your condition since you went into the group?
   • IF MENTION CHANGE: Is there something in particular about the group that helped the change?
   • Please clarify/ expand.

5. Are there any other things you would like to add to what you have already said?

Check how participant feels and they are ok to finish the interview.
Appendix D ii: Memo written after the interview with Jill.

The group provided a place to gain trust and confidence. In addition the group demonstrated that she was not alone or 'the only one'. The main benefit for her was getting in contact with bottled up feelings. There was something about being with others and hearing their stories that allowed her to do this. The group also gave her the ability to care for others, which seemed to counter her feelings of being worthless. The process of the group seems to be about reconnecting and unburdening and the group cohesion provided a space for being listened to and embodied a challenge to her isolation.

NOTE: It is important to explore the idea of being connected to others in more detail.
Appendix D iii: Interview Schedule version 2

1. Can you tell me a bit about the group therapy you went to?
   • Why were you referred?
   • What were your initial thoughts about attending?
   • How many sessions did you attend?
   • What did you do in the group?

2. What was it like being in the group?
   • Did you feel you were able to talk freely?
   • What was it like being with other people?
   • How did being in the group make you feel?
   • What was your relationship like with the therapist?
   • What was your relationship like with other group members?

3. How important do you think being connected to others is, if at all?

4. What subjects did you discuss in therapy?
   • How did you find discussing these subjects?
   • Was there anything missed from the subjects discussed?

5. Would you mind explaining to me about your condition?
   • Can you tell me what has happened to your condition since you went into the group?
   • IF MENTION CHANGE: Is there something in particular about the group that helped the change?
   • Please clarify/ expand.

6. Are there any other things you would like to add to what you have already said? Check how participant feels and they are ok to finish the interview.
Appendix D iv: Memo written during analysis.

Although on the surface there was a learning of concepts, terminology, tools and techniques. The importance of the group seems to be about the process of learning and what flowed between the members and facilitators. It appears that the learning of the group was instrumental and/or a pre-requisite to the group process. All which are needed for change to be possible. This leads me to question: What happened in the groups as they developed? How did the individuals change?
Appendix D v: Interview Schedule version 3

1. Can you tell me a bit about the group therapy you went to?
   - Why were you referred?
   - What were your initial thoughts about attending?
   - How many sessions did you attend?
   - What did you do in the group?

2. What was it like being in the group?
   - Did you feel you were able to talk freely?
   - What was it like being with other people?
   - How did being in the group make you feel?
   - What was your relationship like with the therapist?
   - What was your relationship like with other group members?

3. What was it like when you first started coming to the group?

4. Now you have experienced the group, how do you see yourself now and in the future?

5. It seems like coming to the group has .....? Can you tell me more about that?

6. How important do you think being connected to others is, if at all?

7. What subjects did you discuss in therapy?
   - How did you find discussing these subjects?
   - Was there anything missed from the subjects discussed?
8. Would you mind explaining to me about your condition?
   - Can you tell me what has happened to your condition since you went into the group?
   - IF MENTION CHANGE: Is there something in particular about the group that helped the change?
   - Please clarify/ expand.

9. Are there any other things you would like to add to what you have already said?

Check how participant feels and they are ok to finish the interview.
Appendix E - Guide for Authors: Journal of Aging Studies.
Journal of Aging Studies: Guide for Authors

Introduction

The Journal of Aging Studies features scholarly papers offering new interpretations that challenge existing theory and empirical work. Articles need not deal with the field of aging as a whole, but with any defensibly relevant topic pertinent to the aging experience and related to the broad concerns and subject matter of the social and behavioral sciences and the humanities. The journal emphasizes innovations and critique - new directions in general - regardless of theoretical or methodological orientation or academic discipline. Critical, empirical, or theoretical contributions are welcome.

Contact details for submission

Authors are requested to submit complete manuscripts in MS Word to the Editor, Jaber F. Gubrium via e-mail sent to: gubriumi@missouri.edu

Subject line should read JAS Submission.

Ethics in Publishing

For information on Ethics in Publishing and Ethical guidelines for journal publication.

Conflict of interest

All authors are requested to disclose any actual or potential conflict of interest including any financial, personal or other relationships with other people or organizations within three years of beginning the submitted work that could inappropriately influence, or be perceived to influence, their work.

Submission declaration

Submission of an article implies that the work described has not been published previously (except in the form of an abstract or as part of a published lecture or academic thesis), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere including electronically in the same form, in English or in any other language, without the written consent of the copyright-holder.

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Language and language services

Please write your text in good English (American or British usage is accepted, but not a mixture of these). Authors who require information about language editing and copyediting services pre- and post-submission

Preparation

Use of wordprocessing software

It is important that the file be saved in the native format of the wordprocessor used. The text should be in single-column format. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. In particular, do not use the wordprocessor’s options to justify text or to hyphenate words. However, do use bold face, italics, subscripts, superscripts etc. Do not embed "graphically designed" equations or tables, but prepare these using the wordprocessor's facility. When preparing tables, if you are using a table grid, use only one grid for each individual table and not a grid for each row. If no grid is used, use tabs, not spaces, to align columns. The electronic text should be prepared in a way very similar to that of conventional manuscripts. Do not import the figures into the text file but, instead, indicate their approximate locations directly in the electronic text and on the manuscript. See also the section on Electronic illustrations. To avoid unnecessary errors you are strongly advised to use the "spell-check" and "grammar-check" functions of your wordprocessor.

Article structure

Subdivision - unnumbered sections
Divide your article into clearly defined sections. Each subsection is given a brief heading. Each heading should appear on its own separate line. Subsections should be used as much as possible when cross-referencing text: refer to the subsection by heading as opposed to simply "the text".

Essential title page information

• **Title.** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.

• **Author names and affiliations.** Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name, and, if available, the e-mail address of each author.

• **Corresponding author.** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address.**

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Abstract

A concise and factual abstract is required. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separately from the article, so it must be able to stand alone. For this reason, References should be avoided, but if essential, then cite the author(s) and year(s). Also, non-standard or uncommon abbreviations

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should be avoided, but if essential they must be defined at their first mention in the abstract itself.

**Keywords**

Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, “and”, “of”). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

**Abbreviations**

Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

**Acknowledgements**

Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

**Footnotes**

Footnotes should be used sparingly. Number them consecutively throughout the article, using superscript Arabic numbers. Many wordprocessors build footnotes into the text, and this feature may be used. Should this not be the case, indicate the position of footnotes in the text and present the footnotes themselves separately at the end of the article. Do not include footnotes in the Reference list.

**Electronic artwork**

*General points*

- Make sure you use uniform lettering and sizing of your original artwork.
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- Only use the following fonts in your illustrations: Arial, Courier, Times, Symbol.
- Number the illustrations according to their sequence in the text.
- Use a logical naming convention for your artwork files.
- Provide captions to illustrations separately.
- Produce images near to the desired size of the printed version.
- Submit each figure as a separate file.

**Figure captions**

Ensure that each illustration has a caption. Supply captions separately, not attached to the figure. A caption should comprise a brief title (not on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

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Number tables consecutively in accordance with their appearance in the text. Place footnotes to tables below the table body and indicate them with superscript lowercase letters. Avoid vertical rules. Be sparing in the use of tables and ensure that the data presented in tables do not duplicate results described elsewhere in the article.
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Citation in text
Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either "Unpublished results" or "Personal communication" Citation of a reference as "in press" implies that the item has been accepted for publication.

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As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

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Please ensure that the words 'this issue' are added to any references in the list (and any citations in the text) to other articles in the same Special Issue.

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List: references should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters "a", "b", "c", etc., placed after the year of publication.

Examples:
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Reference to a book:
Reference to a chapter in an edited book:

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Appendix F: Transcript of Interview with Sheila
INTERVIEWER: Can you tell me why you were referred to the group?

SHEILA: Well I was going to the centre, I had a CPN coming to the house, there were so many things going on, and I had just moved here. {Name} the CPN thought that she couldn’t help me so she got {Psychologist’s name} to come. {Name} came and she immediately said I want you to go to the {Day} Centre this week, because I was very very low. I have had a lot of problems with youngsters since moving here, with the police involved, financial problems, and major operations with cancer and things and I had gotten very low, I got sent to the day centre at {location} and I was there when they decided to do the group. Unfortunately I missed three as I was back in hospital. I missed the first two, and one other, so unfortunately I was not able to do the whole group, but {centre manager}, decided who she thought would benefit from the group that {Psychologist} and {Occupational Therapist} were running together. So that’s how I was invited to go but as I say I was back in hospital so I missed the beginning bit. It was quite difficult to get into the group, as they had already done the basics at the beginning, but even so. I have to keep on referring back to the literature because there was so much to remember. You don’t remember much I am afraid when you are not feeling too good.

INTERVIEWER: So what was the group about?

SHEILA: It was a small group, there weren’t many of us 6-7. {Psychologist} and {Occupational Therapist} would talk a bit. Cognitive Behavioural Therapy. They would talk and then we could join in, or they would ask us ‘what do you think about this?’, ‘How would you cope with this situation?’. So it was us participating after they had discussed the topic for the day. Or part of it. But it was based on cognitive behavioural therapy.

INTERVIEWER: How often did you participate in the group?

SHEILA: I found it very helpful, especially, obviously different people have different problems and have different ways of coping with things. It was great having the support of other people in the group and seeing that you are not the only one who wasn’t coping with something. And you got ideas from other members in the group apart from {Psychologist} and {Occupational Therapist} about how to cope with different things. We became quite a close knit group because obviously it is very confidential. I found it really helpful, as I say I learnt so much, but they had to cram it into a certain number of weeks. We felt we needed more time. It seemed a bit rushed each week, but we all joined in. Every week we had the opportunity to. We were either asked outright, ‘Sheila what do you think?’ or you could just volunteer to speak if you wanted to, and we all did. It was really good. It wasn’t just them up the front and we could all join in and listen, we could all join in and we all did. And it was just such encouragement. At the end we all had a letter, and the last week, the week before the last week, we were asked to think of something positive we had seen in each person in the
group in how we thought they had changed. And the last one we had we went around the group, and it was just so interesting to see what other people could see in you, but what you couldn’t see in yourself. It was very very good, but we all wished that it had gone on for a little bit longer, not forever, but a little bit.

INTERVIEWER: Do you think you needed time to digest what had been said to you.

SHEILA: We also thought that, and {Psychologist} bless her did say that ‘I will have time to talk to you next week, to talk to each one of you’, but she never did have the time, so even if something did come up, you didn’t really have the time. It wasn’t her fault as she didn’t have the time, she really did have so much to get through. So it would have been nice to be able to spend some time.

INTERVIEWER: Just with her?

SHEILA: Just with her, because she said 'next week I will be able to spend some time with each one of you', but she never did have the time. That never materialised. So it was generally just a group thing all the time. All of us and I mean all of us felt that we could have done with another 2-3 weeks, not longer, just another 2-3 weeks. Because every week we learnt something new, and you can see all the paper work here. And at the beginning the terminology Cognitive Behavioural Therapy, I had never heard of it, so there was a lot, a lot to learn.

INTERVIEWER: It’s interesting what you were saying about the support of the group, can you tell me a bit about that?

SHEILA: The support. Oh dear, that’s difficult. That’s probably more as we got into the group. I can just see it they had a board with sheets of paper, and {Psychologist} and {Occupational Therapist} would share what they were going to do that week. And they would say, ‘does that come under behaviour, or your feelings or your thoughts?’ And you could just answer ad lib, and it was really interesting if some of us came up with the right answer and if you did, you could congratulate each other. People with depression often have very low self esteem, so we could encourage each other, and it was fun. There was a lot of fun in it. Nobody had to share anything really deep if they didn’t want to, and in fact there wasn’t time. It was more about how to cope with and how to change your thought patterns. And what you can change and what you can’t. Because I am in a lot of pain, I spend a lot of time in bed, so I keep this on the side of the bed. And I can just keep on referring to it. Because I can’t remember all that we did! And as I say I missed three weeks anyway. I missed some of it, but it was very very good, and having the encouragement from other members in the group, apart from {Psychologist} and {Occupational Therapist}.

INTERVIEWER: It sounded as though you congratulated each other if you got things right?

SHEILA: We did, we did. We had a laugh on the third or fourth week, say I said something came under feeling, and it was wrong, then we would just laugh, you could just be normal or natural and it didn’t matter if you got things wrong. They
would encourage you to think, now does the situation, whatever it is, feeling, the answer is just one word, I feel..... Yes we did encourage each other, and if someone did answer, and they felt upset because they had said the wrong thing, we just encouraged them. Within the group it was very much encouraging each other through the whole thing. And a bit of laughter if we got things wrong! Which we did, because a lot of things we had never heard of before, all the categories. They drew a diagram of a hot cross bun, you have the 4 things there, and you had to remember which came under which, and of course we got it wrong at the beginning and it is good to have it written down for you. There were things we did ourselves as well.

INTERVIEWER: Did you feel like you were able to talk freely?

SHEILA: Yes. Very much so, we were really put at ease, and a lot of it came from {Psychologist}, and {Occupational Therapist}, but {Occupational Therapist} is the OT and she is there all the time. She was so enthusiastic they way she would put things across to us, and also she would say, not like preaching at us, but saying how she would have got something wrong in what we were trying to do until she took the course. She was more like one of us, even though she was teaching us as well, but she was more like one of us, and you didn't feel like you were in a classroom. I felt completely at ease. And if you didn't feel well that day, you didn't have to say anything, you could just sit quietly, which is very important as some days you don't feel too good. Most of the time, we did have one in the group who talked too much, and that was quite difficult. But then that might well be her problem, and it did get under quite a few of our skins half the time. {Psychologist} had to get really firm, but no I found it very very good, but perhaps it could have gone on a little bit longer. We couldn't have gone over more.

INTERVIEWER: You said that you talked but sometimes it wasn't that deep. Did you bring some of the deeper issues to the group?

SHEILA: It was more general, no-body went into anything really deep. We only had one man in the group, and he had recently spilt up from his wife, and he wasn't coping with it, and he found it difficult to be on his own. But he didn't go into it. He spoke like that, but not a lot.

(Break in transcript).

INTERVIEWER: It sounds like one of the things you found as beneficial was that people were in the same position as you. You mentioned the fear of failure and the difficulties in the mornings.

SHEILA: Yes, with the mornings, I can't say that I feel very down, but I have had ME for 23 years, and that makes you feel very tired and not too good in the mornings, and some of them would feel really sick and nauseous in the mornings, and that some of them would share. And yet another lady who is suffering from depression feels absolutely fine in the morning. Now she shared that, but she
was the only one who didn’t have difficulty in the morning, I think everybody else did.

INTERVIEWER: Was there a specific thing that happened that you found particularly helpful or unhelpful?

SHEILA: There was a lot that was helpful, a terrific amount in the group. I think one of the biggest things I found was the encouragement, not just from {Psychologist} and {Occupational Therapist}, but from other people in the group. Because like a lot of people I suffer from… I was always told you are no good at anything, you will never do anything and everything like this. And for someone to actually to say you are a nice person, or the ideas you have got are good, you know thank you for contributing to the group, what ever it would be that week was quite an eye opener for me, that I could actually do anything that was any good.

INTERVIEWER: So it seems it might have been more in the smaller things than the big things.

SHEILA: The big things?

INTERVIEWER: Like the thank you for your contribution.

SHEILA: I think we took something out of the group every week, and we learnt something every week, and little things throughout the day now will bring back something from the group. I can’t think of a specific situation now, but things will arise, and something that you have learnt in the group will now help you come with that situation. Until you actually come to it. But before the group you probably wouldn’t be able to, but now you can, as you have learnt a different way of coping with the situation.

INTERVIEWER: So how would you say you have changed since being on the group, how has it affected your depression?

SHEILA: I think it has made me feel a lot more positive, yes a lot more positive. And it has given me a new way of coping with different situations, and actually whereas in the past I might have not bothered, now I will tackle something. I mean just a small thing, which for me wasn’t because it was so annoying, since I moved here, there is a small council estate at the back. I have had horrendous problems with youngsters, and we had to get police involved. I had to get the gate installed, because they pulled a side gate off. Then I had problems with the back, with their dog tied up and barking all day, well I dealt with that last year, and then new neighbours moved in this side and they have a dog and bark bark, but this time, and it was while I was doing the group, I thought I can do something about this, so I wrote to them, I didn’t go round, because it is difficult when you are on your own, and I said could they please do something about the dog, and they have, and I dealt with it in a nice way. And they have been having really late getting drunk at night in the garden and the noise has been horrendous and they picked up on it during the course and they said how great it was that I was able to do it and they said how I wasn’t able to do it before I went on the course. So
that's just to give you a rough idea, and there have been many other things as well. I suppose getting more confidence in myself that I can do more, um.

INTERVIEWER: And what's boosted your confidence?

SHEILA: I don't know. It is the different way of learning to do things, and the encouragement from {Psychologist} and the people in the group who, its just the silly little things of 'oh that was a good idea'. I mean it is a combination of a lot of things and realising that you are not the only one that feels like you are feeling, and that in itself stops you from feeling like a terrible failure. Because other people, some who feel worse than you do, so it's difficult to really put into words. I know since being on the group that I can change. Whereas before I would react to something, now I can act more positively because of the things that I have learnt in the group. But that just happens throughout the day. This is really difficult.

INTERVIEWER: No it's really good. You mentioned confidentiality; can you tell me more about that?

SHEILA: This course was on depression, but there is another course on anxiety. We have had 2, and the first week {Occupational Therapist} said do you have anything to add, and there were two of us from the depression group and both of us said it would be nice to make sure what is said within the group remains confidential, and {Occupational Therapist} said, yes that is a good idea. Because it does make you feel that if you need to, or the opportunity arises that you can say something. And if you share something about yourself that it isn't going to go outside, you hope. You feel safe, so the confidentiality is very important, and the fact that we encourage each other in the group, it doesn't just come from {Occupational Therapist}. We had one lady there from the anxiety who is very quiet and she has said some lovely things, and it was lovely seeing her face when you said 'that was a super idea'. Her face lit up and it was brilliant.

INTERVIEWER: And how did it feel for you?

SHEILA: It felt good to help someone else. We have gelled as a group. It's just a pity it didn't go on for a few more weeks and we all thought that. But {Psychologist} said she would take note of that, because she felt that in a way it was a bit rushed, and it would have been beneficial to have a few more weeks. We could have gone over things a bit more, perhaps in a bit more depth. I mean often we were rushing towards the end because it was lunchtime. We were often late into lunch, because often as the weeks went by we were chatting more and more amongst ourselves, and we got to know one another as well, so we felt more at ease. I don't know what the others were like for the first two, whether they just sat there and didn't say a word.

INTERVIEWER: Outside the group have you stayed in contact with anyone?

SHEILA: Well they are still there. I see them at the centre. I am in contact, there were a number of people coming from {town}, so I am in contact with some of them. One of them just lives just down from {Street Name}, she is an elderly lady
and I see her. And I gave another one a lift to see her daughter this morning. She has just left the group, so yes I am in contact with the ones that live round here.

INTERVIEWER: How would you compare the individual with the group therapy?

SHEILA: Different, very different. Not very different but different, because with {Name}, the 1 to 1, there were so many issues when I first saw her that she wanted to take one at a time, and we still haven't finished the main ones, but that was right to deal with more deeper things than it would have been in the group, because there would have not have been time. If every person had wanted to share something really deep, you wouldn't have been able to get through the course. You wouldn't be able to do it.

INTERVIEWER: You never would have had your lunch either!

SHEILA: No! We were late most weeks actually, well the last ones in. Especially towards the end, because we were enjoying it, and we did have a laugh. Especially when we got it wrong, and we had this board up and we had to guess where to put things. They had cards with words and things on. It was good, and you felt more relaxed as the weeks went by. I wouldn't mind doing it again.

INTERVIEWER: It sounds like as the weeks went on and you got more relaxed, would you say your mood lifted, or was it not linked so directly?

SHEILA: Oh yes, because you felt like you were actually getting somewhere, you felt like you were actually doing something that would help you get on with your day to day life. I mean some of the things we knew, but some of them I didn't. I mean some of the things I will forget, I mean my memory is not as good as it used to be, however much you want to remember. But certainly different, much different now. But then I am still going to the centre. What it will be like when I stop going there and I am back on my own, with what I have to cope with physically and that. Yes I can put into practise some of the things I have learnt! And how many lies I tell myself, this is what I learnt as well, by being negative, and all along there is no need to be. Like with feeling negative, somebody in the group would help one another by saying look, you have done this and you have done that. We helped one another in the group.

INTERVIEWER: Like challenging?

SHEILA: Yes, like challenging, to help one another. If they said, 'I can't do this or that', they would say 'yes you can'. If somebody had said something the previous week, and somebody had remembered we would say well you have done this, so you can do that. So it was very much once we were gelling. Which was good, because it helps you to encourage one another. But that does take a few weeks. If you put a group of strangers together, well some of us might have known each other a little bit if we had sat together in the lounge, but not in a group format.

INTERVIEWER: So it seems the individual work you did was a bit more in depth?

SHEILA: Definitely
INTERVIEWER: And you talked about your childhood but the group seemed to help because it was all people in the same boat, mucking in and helping each other, challenging,

SHEILA: And coping with everyday things. I personally feel that a one to one is the place where you discuss more personable things, where you might get upset with what you are discussing, depending what it is with a group of people. And I felt things that had happened to me, right from a child, wouldn't have been fair, for other people to have heard, or to know as it might upset them, so there are things that you talk about on a one to one with a psychologist rather than in a group. I'm not just talking about feeling negative or having problems in the morning, there is more in depth things about that you need to talk about as a one to one, but there is still a lot that you can learn in a group. And how to manage your time, that was something else that we learnt. Because a lot of people when they are depressed have not got the energy and don't want to do anything, and one week we spent discussing during this next week, see if you can do something you have not done for a long time. It might be something silly, like try to clear a room, or start to tidy something, but not to try and do the whole thing, to break your life down into small little things, rather than trying to do too much. I found that helpful as well. I mean I am restricted physically, but if I start say 30 minutes of something, then I am really chuffed as I have done something. I mean I moved into here 2 years ago, and I have still not unpacked, partly because I have had all the problems with the youngsters and I thought that I would have to move again, so I stopped unpacking. And also when you become depressed you just have not got the energy. And also I am on morphine patches as I am in so much pain. It’s doubly difficult to do anything now, so if I do something I am really pleased with myself, and I have learnt that through the group. Then we went back the next week, and she asked, ‘have you been able to do anything?’ and all of us had. And each one of us to the person that was talking said ‘gosh that’s great’ and that builds you up to hear it from somebody else. So that’s how we helped one another. I hope you are getting the idea. It’s really difficult.

INTERVIEWER: And it seems it builds you up because it is people similar to you, rather than the psychologist, or the OT-the professions. It’s your peers.

SHEILA: Well even some of the things, she would liken herself to some of the things, she would say if she is tired and overstretched and doesn’t want to do something, she says that she has learnt to pace herself, and she said everybody can do it. The lady that was very quiet never went out. Well she very rarely went out, and she started to go out, and we were so thrilled for her, and because we were excited and thrilled, it thrilled her. And that was the thing that we were able to do. You wouldn’t have got that if you weren't in a group, and that was good. It’s really good. There is a place for groups, but perhaps for not very in depth. Perhaps there is a group that is held, but this was more on behaviour and how to cope. I mean you have your thoughts, but how to change you attitude, to how you reacted to the thoughts that you had, is more what we have learnt. I don’t know if
this is helping, I hope it is, because I have learnt so much through this week I mean these weeks.

INTERVIEWER: And how would you say this combined with going to the centre and seeing people there as well? Do you think it added to the effect of the group?

SHEILA: Well I am in another group now, so there is input there. I am thinking about when I actually leave. Because it has changed so much, there is very little staff there. {Manager} retired 10 years early, so it is so boring now apart from this one group, so I am thinking when this anxiety group finishes which is in 10 weeks I might, because last week I thought I can't stand this anymore, its not nearly as good. But apparently they are not given the funding. So it's a bit dire there at the moment, but it is a lifeline to have when you are going through things. I mean {Manager} was really good. He would notice if you were a bit down or something, and they weigh you occasionally, and one week he said how are you, and I said I am really struggling to keep going and he got me to see Dr {Name} who I had never seen and there was a lifeline there if you were feeling rough, but that has gone as they are not replacing {Manager}. Unless it bucks up a bit, then you are on your own. I mean I have a CPN, but she said I can't help you, you need to see someone else, and I will be lumbered with her, and I don't like her attitude. So what will happen, I will have to cope on my own, well I have all my life, and hopefully remember what I have done in the groups. But there is no talk of them wanting me to leave yet.

INTERVIEWER: I was just wondering, you spoke about being on your own, and being by yourself, and yet the group was able to offer you meaningful contact with others.

SHEILA: The group was good. I have got lots of friends, I have got lots of friends, but there are friends you can share things with and friends that you wouldn't. If you are feeling a bit down, I never phone anybody and say I am feeling really rough, I'm in a lot of pain and I can't cope today. I mean it has been a lifeline for me going to the centre and on the course. In fact {Occupational Therapist} came to me after the last one and said to me, 'was that a bit all flustered today?'. Something was going on and it wasn't a good week, but we shall see what it is like next week. But I think they are all under a lot of pressure as they haven't got the staff. I have got to keep going over all of this paperwork.

INTERVIEWER: You said that you would never phone up your friends and say I am feeling rough, or down. Is that something you would have said in the group?

SHEILA: That did come up, I think that it may have been the last week, I learnt many years ago not to. I mean there are friends that I share with, but unfortunately they do not live locally. So I do share with some friends, they live in Cornwall, and Suffolk. One friend knows that I am going, but I wouldn't go around telling anyone else. Perhaps that's where I am wrong and I said to the group, I have never ever had anyone there for me ever, I have always had to be the strong one, right from a child, because I have always learnt that there isn't
anyone there for you. When you have wanted somebody there is nobody there so.

INTERVIEWER: And were you able to say to the group, I am feeling really rough today? Or I am in a lot of pain?

SHEILA: You could say it, I probably might have said, although {Psychologist} or {Occupational Therapist} a couple of times said ‘you are not feeling too good are you?’ and I said ‘no, I am in a lot of pain’ and just left it at that. Next week they would say ‘how are you?’. When you have an ongoing illness, you just don’t keep talking about it, you just get on with life. I have two little dogs, they are in my bedroom, and I take them out twice a day even if I am in a lot of pain. And they kept bringing that up, they said ‘you keep on doing it’ and I said ‘I know!, because I enjoy it’. It takes an awful lot to set me back, but I know that I can switch like that, and be bright one day, and not to good the next. But hopefully with all these new things, which I said I keep at the side of my bed, and I do refer to them. And that’s the idea of having the paper work that you can refer to it, because they said I don’t expect you to remember everything we are talking about. So it’s good to have, plus the worksheets we have done ourselves, so weeks they said we have some homework for you, which is good! But it was encouraging the whole time. The group each week was encouraging, which was good, really good. I hope this has been of help to you?

INTERVIEWER: Yes it has been brilliant. Thank you very much. Is there anything else you would like to add?

SHEILA: No that’s it.

INTERVIEWER: Are you ok to finish it there?

SHEILA: Yes