



Older adults' experiences of psychotherapy

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

- pp 101-108:** 3.2. **Part 2:** Introducing the narrators and their narratives.
- pp 241-277:** **Part 3.** Professional Practice: "If at the end of therapy your client takes away one word, let that word be choice". A client study using an existential approach.

Table of Contents

Acknowledgments	8
Declaration	9
Preface	10
 PART 1 – DOCTORAL RESEARCH.....	 19
<i>Older women’s stories of counselling: A narrative study</i>	
Abstract	20
 1. CHAPTER ONE – INTRODUCTION.....	 21
Overview.....	21
1.1 Definitions	21
1.1.1 ‘Older adult’	21
1.1.2 ‘Counselling’	23
1.2 Psychological difficulties amongst older adults	26
1.2.1 Depression	26
1.2.2 Anxiety disorders	28
1.2.3 Loneliness and social isolation.....	29
1.2.4 Impact of retirement	30
1.3 Psychological theories of later life	30
1.3.1 Erikson’s lifespan model	31
1.3.2 The loss-deficit model.....	32
1.3.3 The contextual, cohort-based, maturity, specific challenge (CCMSC) model.....	33
1.4 Mental health provision for older adults	34
1.5 Low prevalence of counselling amongst older adults.....	36
1.5.1 Under-provision of counselling for older adults	37
1.5.2 Low uptake amongst older adults	41
1.6 Older adults’ decision to enter into counselling.....	47
1.7 Older adults’ experiences of counselling	50
1.8 Rationale and aims of the study	51
1.8.1 Hearing the stories of former clients: Analysing the narratives of six older women’s counselling experiences	51
1.8.2 Aims of the study.....	52
1.8.3 My story: motivational factors for the present study	53
1.8.4 Relevance to counselling psychology	55

2. CHAPTER TWO – METHODOLOGY	58
Overview.....	58
2.1 The role of paradigm	59
2.1.1 Ontological position.....	60
2.1.2 Epistemological position.....	61
2.2 Qualitative methodology.....	63
2.2.1 Rationale for qualitative methods.....	63
2.2.2 Methods considered.....	64
2.2.3 The context of narrative research: philosophical underpinnings and overview	65
2.2.4 Narrative interviewing	70
2.2.5 Recruitment of participants.....	76
2.2.6 Audio recording	80
2.2.7 Transcription.....	80
2.3 Ethical considerations.....	81
2.3.1 Informed consent	82
2.3.2 Debriefing	83
2.4 Explanation and rationale for narrative analysis.....	84
2.4.1 Rationale for narrative analysis	84
2.4.2 Langdridge’s critical narrative analysis (CNA).....	85
2.5 Reflexivity	96
3. CHAPTER THREE – NARRATIVE ANALYSIS.....	99
Overview.....	99
3.1 Part 1: A critique of the illusion of subjectivity	99
3.2 Part 2: Introducing the narrators and their narratives	101
3.3 Part 3: Synthesis	108
3.3.1 Expectations	109
3.3.2 Keeping up appearances.....	116
3.3.3 Taking opportunities.....	120
4. CHAPTER FOUR – DISCUSSION.....	132
Overview.....	132
4.1 Summary of findings, relationship to existing literature and their implications.....	132
4.1.1 Expectations and attitudes towards engaging in counselling.....	133
4.1.2 Keeping up an appearance of stoicism	137
4.1.3 Taking opportunities: Referrals, client agency and emotional distress.....	141

4.2	Methodological challenges	153
4.2.1	Dual roles as researcher/ practitioner	153
4.2.2	Ethics of interpretation.....	154
4.2.3	Establishing validity	155
4.2.4	Anonymity and ‘giving voice’	156
4.3	Evaluation of the study.....	156
4.3.1	Limitations	156
4.3.2	Avenues for future research.....	160
4.3.3	Final reflections	161
4.4	Conclusion	162
4.5	References.....	165
5.	APPENDICES	189
5.1	Appendix 1: Ethics release form	190
5.2	Appendix 2: Recruitment flyer.....	196
5.3	Appendix 3: Participant information sheet	198
5.4	Appendix 4: Consent form	200
5.5	Appendix 5: Narrative interview schedule.....	202
5.6	Appendix 6: Resource sheet	205
PART 2 – PUBLISHABLE PAPER	207	
<i>Opening up in a safe place: A narrative analysis of older women’s experiences of counselling</i>		
PART 3 – PROFESSIONAL PRACTICE	241	
<i>“If at the end of therapy your client takes away just one word, let that word be choice”; A client study using an existential approach</i>		
Overview.....	242	
1. THE INTRODUCTION TO THERAPY	242	
1.1	Biographical details of the client and rationale for choice of case	242
1.2	Presenting problems, aims for therapy and rationale for theoretical orientation.....	244

1.3	Referral and context of the work.....	245
1.4	Therapeutic contract	246
1.5	Formulation of the problem	246
2.	THE DEVELOPMENT OF THERAPY	248
2.1	Overview of the basic principles of existential therapy and their implementation in the current case.....	248
2.2	The therapeutic relationship and process.....	256
2.3	Challenges in the work and use of supervision	258
3.	THE CONCLUSION OF THERAPY AND DISCUSSION	260
3.1	The therapeutic ending.....	260
3.2	Discussion: The existential therapy framework and evaluation of the work.....	261
3.3	Learning about myself as a therapist	269
	References	271

List of Tables and Figures: Doctoral Research

Figure 1:	Research questions, paradigmatic issues and methodological approach	59
Figure 2:	Langdridge's (2007) model of critical narrative analysis	88
Figure 3:	Overarching themes and corresponding subthemes	109
Table 1:	Example of initial coding phase (Clare)	89
Table 2:	Example of second coding phase (Clare)	91

List of Tables and Figures: Publishable Paper

Figure 1:	Langdridge's (2007) model of critical narrative analysis	217
Figure 2:	Overarching theme and corresponding subthemes	221
Table 1:	Example of initial coding phase (Emily)	218
Table 2:	Example of second coding phase (Emily)	219

To my family, for their endless love and support

'Life as a therapist is a life of service in which we daily transcend our personal wishes and turn our gaze toward the needs and growth of the other. We take pleasure not only in the growth of our patient but also in the ripple effect—the salutary influence our patients have upon those whom they touch in life.'

Irvin D. Yalom, *The Gift of Therapy* (2001)

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Declaration

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Preface

This doctoral portfolio comprises three pieces of work, each reflecting aspects of the knowledge, skills and reflexive insights gained through the course of my counselling psychology training. At the heart of the portfolio is the concept of meaning-making thus a phenomenological perspective permeates the work. Part 1 presents a narrative research study of six former older female clients' decision to enter into counselling and their experiences of counselling. For the purposes of this thesis, 'older clients' refers to people aged 65 and above. Part 2 is a paper intended for publication focusing on one particular theme: *Opening up in a safe place*, which emerged from the larger research study. Part 3 presents an account of my therapeutic work with an older, male gay client embedded in an existential framework to psychotherapy. The portfolio has been entitled 'Older adults' experiences of psychotherapy' as Part 1 and Part 2 focus on the psychotherapeutic experiences of older *female* clients whilst Part 3 examines the psychotherapeutic work with an older *male* client. Each of the three parts and their connection to each other will be discussed below.

Use of the terms 'Counselling' and 'Psychotherapy'

In the current portfolio, the terms (psychological) 'counselling' and 'psychotherapy' have been used interchangeably for three main reasons which will be briefly explained. Firstly, as Arbuckle (1967) argues, counselling and psychotherapy are in all essential respects identical. The kinds of issues that draw people to use counselling and psychotherapy are often very similar. Secondly, the aims of both counselling and psychotherapy are similar. Both can be seen as an attempt to allow the client to build up resources to live in more healthy, meaningful and satisfying ways, and to develop self-awareness. Thirdly, a high degree of respect for the autonomy of the client is a basic principle in both counselling and psychotherapy. In both, there is an understanding that the client brings with them the potential needed to successfully achieve their aims (COSCA, 2004).

However, it is worth noting that there has been considerable debate over the difference between counselling and psychotherapy (McLeod, 2003). It could be argued that though the terms 'counselling' and 'psychotherapy' have similar meanings with considerable overlap, there are some distinctions between the two. It could be claimed that whilst counselling typically focuses on helping people cope with current circumstances, psychotherapy tends to address long-standing and

deep-seated personal problems (Martin, 2015). In other words, whilst counselling focuses on present day issues, psychotherapy provides a longer-term approach for issues which arise from past experiences, often rooted in childhood or adolescence. However, this is not as clear cut as it once may have been. It could be argue that the intensity and depth of therapeutic work can be just as great in counselling as in psychotherapy (COSCA, 2004).

It appears that the trend is for recognising the similarities between counselling and psychotherapy. This trend is reflected in the increasing pressure towards joint bodies representing both fields of practice. Perhaps counsellors and psychotherapists are basically doing the same kind of work, using identical approaches and techniques, but are required to use different titles in response to the demands of the agencies that employ them (McLeod, 2003).

In my clinical experience, counselling may be offered in certain circumstances as part of the psychotherapy process and a counsellor may work with clients in a psychotherapeutic way. This is supported by the British Association for Counselling and Psychotherapy which argues that to differentiate between counselling and psychotherapy is out of step with research and other developments in the field of the psychological therapies (BACP, 2013). Based upon these reasons and for the purposes of this portfolio the terms 'counselling' and 'psychotherapy' have been used interchangeably.

The three parts of the portfolio and their connection to each other

The empirical research study presented in Part 1 entitled *Older women's stories of counselling: A narrative study* draws on a narrative approach to address two research questions: 'How do older women construct their decision to enter into counselling?' and 'How do older women construct their experience of counselling?'.

Worth highlighting is that the original research questions, prior to the recruitment of participants, were 'How do older *adults* construct their decision to enter into counselling?' and 'How do older *adults* construct their experience of counselling?' as the study was open to older men and women. The literature review in Chapter One Introduction follows this original path. However, during recruitment, only women responded thus the study evolved into focusing on the counselling experiences of older women.

This lack of response from older men could be explained by the differential take-up rate of counselling services in men and women (Murray et al., 2006; Scher, 1981; Vacha-Haase, 2010) which is worthy of a research study in its own right. Many older men have a negative image of psychotherapy, seeing it as shameful and indicative of weakness (Twining, 1996). Indeed, Vacha-Haase (2010) highlights that overcoming negative stereotypes about psychotherapy in the older male population is a particular challenge, especially for men raised within traditional gender roles with narrow views of masculinity.

Consequently, six former female clients of a mental health charity's counselling service narrated their stories of therapy. They were encouraged to voice personally meaningful experiences whilst imposing their own style and structure. The aim was to illuminate how narrators constructed their stories in an interview context and why the stories were narrated in the way they were. Narrative analysis of the data facilitated the use of different interpretative lenses to explore the various facets of the narratives. The study assumes that the stories of counselling generated were co-constructions between participants and myself. Given its interactional basis, narrative becomes a collaborative enterprise – the joint product of narrator and listener (Holstein & Gubrium, 2012). Reflexivity was therefore a vital aspect of each stage of the research process.

Part 2 presents the theme of *Opening up in a safe place*, intended for publication in the *Journal of Counseling Psychology*. This theme emerged from the larger doctoral thesis exploring older women's counselling experiences. This theme was not reported in the larger study due to length constraints. Furthermore, it was felt that this theme warranted a separate publication as it highlights an important facet of older women's counselling experiences with practical implications for counselling psychology practice. The *Journal of Counseling Psychology* is a peer-reviewed academic journal, published by the American Psychological Association. This journal was selected for a number of reasons. Firstly, it is a high impact publication with a broad professional readership. Secondly, it publishes, amongst other subjects, theoretical and empirical articles on multicultural aspects of counselling and counselling interventions. Thirdly, the journal pays particular attention to empirical studies on the evaluation and application of counselling interventions and the applications of counselling with diverse and underrepresented populations. Arguably, older women are underrepresented, especially in mental health services.

The literature indicates that older clients are underrepresented in the caseload of many counsellors (Goudie, 2010).

The client study in Part 3 illustrates the therapeutic work conducted with an older, male gay client using an existential approach. 'Harry' presented with mild depression and anger management difficulties. Struggling with his sexual identity and relationships, he described himself as feeling 'lost' in the world and in search of meaning. The existential framework to psychotherapy highlights an exploration of clients' 'being in the world', thus contextual factors were considered. The socio-historical context in which Harry grew up advocated that homosexuality was unacceptable and should be conceptualised as a mental illness. Understandably, this discourse had been internalised thus perpetuating feelings of shame. Internalised homophobia means that there is a high probability of gay clients feeling devalued and worthless (Marshall, 2004).

The client study illustrates the developing therapeutic relationship and the challenges that were met throughout the 20 weeks of therapy. It has been suggested that counselling psychologists are distinguished from other psychologists as their focus is on relationships and process (Rawson, 2012 as cited in Florance, 2012). Rawson advocates that counselling psychology implies empowerment and liberation. These two concepts are at the heart of existential therapy, hence another way the approach fits well with the principles of counselling psychology. The existential framework also ties in with the portfolio's overarching theme of meaning-making. As Yalom (1980) highlights, we are all meaning-seeking creatures thrown into a meaningless universe. Harry used therapy to explore his meaning-making processes. Furthermore, issues of older age and sexuality were explored. As a reflective practitioner, an attempt was made to identify my own views on older age and relationships as well as homosexuality.

The three pieces of work are connected in three main ways. Firstly, they aim to illuminate the lived psychotherapeutic experiences of former older clients. Indeed, the ethos of counselling psychology is to place the individual client's unique subjective experience at the very heart of theory and practice (Strawbridge & Woolfe, 2003). Secondly, they consider the wider historical and cultural context in understanding individual's experiences of therapy. There is an effort to understand human experience within the context of the social world that we inhabit.

It could be argued that older adults and homosexuals are considered marginalised groups in society facing stereotyping and discrimination. Both ageism and homophobia can be seen as attitudes that contain powerful fears or resist within ourselves (Richards, 2011). The challenge of ageing that we all face may be significantly exacerbated if we are gay or lesbian. Older gay individuals are, for example, twice as likely to be single and live alone than their heterosexual peers and four times as likely to have no children (often a significant element of comfort, care and dependency in later life for older parents) (Age UK, 2005).

Counselling psychology has a history of interest in issues of social injustice, the manifestations of power and the importance of giving voice to the oppressed (Milton, 2014). Indeed, counselling psychology training and ethical guidelines make explicit our commitment to work in ways that recognise social contexts and discrimination. British Psychological Society (BPS) ethical guidelines teach us to work always in ways that empower clients and also demonstrate the high standards of anti-discriminatory practice appropriate to the pluralistic nature of society today (BPS, 2001). As counselling psychologists, it is important to have an understanding of how wider cultural narratives and prejudices may be influencing a person's meaning-making and emotional distress. These wider discourses are likely to impact on the therapeutic work. In this portfolio, cultural narratives of ageism and homophobia were considered thus contextualising individuals' experiences.

Thirdly, importance was placed upon therapist and researcher reflexivity. Reflexivity is central to counselling psychologists in research and clinical practice. Reflexivity was therefore woven throughout the portfolio. An effort has been made to demonstrate how my identity, background and status as a trainee counselling psychologist may have impacted upon the research and therapeutic process.

My relationship with my grandmother was one of the main inspirations for this project. Although we live in different countries, our bond is unshaken by time and distance. As a child I would stay with her in Greece and be captivated by the stories she narrated of her own childhood, the war and the people and experiences that have brought joy to her life. It was through these stories that I came to know my grandmother and the life she had lived. The stories also provided an insight into my grandmother's values, beliefs and struggles, all of which shaped the person she had become. The tales she told were a glimpse of a different generation, a world with its own traditions and priorities. She has always been a wellspring of strength, dignity and compassion to me. Yet, the concept of therapy was unfamiliar to her as she

was brought up in a generation and culture of self-sufficiency and keeping struggles within the family.

In the current portfolio, the term 'generation' is understood as a group of people defined by age boundaries—those who were born during a certain era. In other words, generation is understood as people within a delineated population who experience the same significant events within a given period of time (Pilcher, 1994). A generation could be defined as the aggregate of all people born over a span of roughly twenty years. It could be argued that members of a generation are shaped in lasting ways by the eras they encounter as children and young adults thus they also tend to share some common beliefs and behaviours, including culture, values, civic engagement, and family life (Life Course Associates, 2015). A generation might have its own memories, language and habits.

However, generation lengths are not certain and keep evolving. Their beginning and endpoints are approximations. Moreover, the variations within generations can be large. Mindful that a generation encompasses a diversity of social class, background and attitudes towards emotions, in the research study presented in the current portfolio, attention was paid to each narrator's unique story of counselling.

The experience of completing this doctoral portfolio has helped shape my professional development in a number of ways. Perhaps most noticeably it has further developed my professional research skills. Although I had research experience from my undergraduate and masters degrees, creating a doctoral level piece of empirical research has stretched me both academically and personally. For two years, I have inhabited the world of narrative research which was new territory for me. Whilst the power of storytelling has always fascinated me, applying this to research was a bridge between the creativity and freedom of the construction of stories and the scientific rigour involved in eliciting, analysing and writing up narrative research in a way that has useful implications for counselling psychology practice.

In addition, the process of completing this portfolio has helped improve my clinical practice. I am now mindful of some of the reasons older women may have negative preconceptions of psychotherapy and how to engage older female clients who may be unfamiliar with the concept or process of therapy. Furthermore, through this work my subconscious assumption of an asexual older age was challenged. In my previous clinical work with older clients, issues of sexuality and sex were not

discussed. This may have been due to the client not considering this relevant to their problems or perhaps I was not facilitating an environment in which these issues could be explored. Working on this portfolio has helped me become more comfortable in engaging in a discussion about an older client's experiences of sexuality. Working with an older gay client in particular has brought my attention to the (often false) assumption of heterosexuality in older clients. I now appreciate the difficulties these clients may have in revealing their sexual orientation to me as a therapist.

In writing this portfolio, the two main concepts that have been strengthened in me as a trainee counselling psychologist are choice and curiosity in oneself during therapy. The starting point of my clinical work with every client is to foster curiosity in themselves and with time hopefully help the individual to become cognisant of a world of choice and possibility.

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Part 1 – Doctoral research

Older women's stories of counselling:

A narrative study

Abstract

There is a plethora of literature on older adults and psychological counselling. The literature reveals many assumptions and opinions of healthcare professionals and academics regarding older adults' decision to enter into counselling or not and advice on how counselling should be conducted with older adults. Yet, there is an absence of the voices of older people in narrating their counselling encounters. This qualitative study explored how six older women constructed their decisions to enter into counselling and their experiences of counselling. Although the study was open to both older men and women, only women expressed an interest in participating. Narrative interviews were therefore conducted with former female clients of a mental health charity aged between 66 and 74. Interviews elicited individuals' stories of counselling and a critical narrative analysis approach was used to examine each narrator's story.

From this analysis, three overarching themes and corresponding subthemes emerged across the six narratives. Accounts highlighted the significance of generational and cultural factors in narrators' expectations of counselling and subsequent decision to enter into therapy. Narrators revealed long-standing patterns of projecting an outward image of wellbeing whilst struggling to manage difficult circumstances and emotions. This was often linked to generational attitudes of self-sufficiency, independent problem solving and emotional reticence. Narrators also worried about burdening loved ones with their problems. Decisions to enter into counselling were constructed within this context of emotional isolation.

Furthermore, findings highlighted the significance of people or services influencing narrators' access to counselling. Counselling was constructed as an opportunity to focus on hearing one's own thoughts, without outside voices impeding. Narrators also constructed identities from passive patients at the start of counselling to emerging active agents of change both in the therapeutic context and in their wider lives. Dominant cultural narratives of mental health problems and counselling were also discussed with reference to narrators' stories. The implications of the study's findings for referrers and counselling psychology practice were explored.

1. Chapter One – Introduction

Overview

This chapter will explore the literature in the field of older adults' decision to enter into counselling and their experience of psychological counselling. The aim is to demonstrate how there are gaps in the current literature which the current study intends to address. By doing so the decision to pursue these areas will be explained, arguing why the topic of older adults' counselling experiences is an area worth investigating and in particular, using a narrative approach.

This chapter will begin by exploring definitions of 'older adult' and 'counselling' and explain how they are understood in the current project. A review of the literature on psychological difficulties amongst older adults will follow. Psychological theories of later life will be critically evaluated, explaining how each suggests working with older people in a particular therapeutic way. There will be a discussion about the mental health provision for older adults followed by an exploration into the low prevalence of counselling amongst older people attributed to both under-provision of services and low uptakes. A critical review of studies into older adults' decision to seek counselling and experiences of counselling will follow.

At the end of this review of the literature my rationale for the current study will be presented. The aims of the project will be outlined and motivational factors in the choice of this topic will be highlighted. The chapter will conclude with an explanation of why it is believed that this topic and the narrative approach employed are congruent and relevant to counselling psychology.

1.1 Definitions

1.1.1 'Older adult'

According to the World Health Organization (WHO, 2007), most countries have selected a chronological age of 60 or 65 as a definition of 'older person'. This age is chosen because it tends to be the age when most people in developed countries retire. In the late nineteenth century, Otto Von Bismarck chose the chronological age of 65 as the retirement point even though very few working adults in Germany

reached that age. Neugarten (1974) distinguished between the young-old (65–80) and the old-old (80+). Yet, it is important to highlight that ‘older age’ is a broad age band of 30 or so years with a diversity of life experiences and life stages (Woods & Roth, 2005).

Chronological ageing as a social and historical construct has diverse meanings in different countries and in different societies and cultures. Anthropology has shown how concepts of ‘old age’ vary between different individualist and collectivist cultures. Philpot (1986) compared traditional and modern attitudes towards older people in Japan and found that the roots of respect for older people were contained within Japanese culture and religion. Despite the rapid development of industrialisation and urbanisation, respect for elders has remained. Old age has still retained a certain authority and respect. Thus the quality of life that older people experience is often determined by social attitudes and values. As ageing is both a physiological and social process, it is worth noting that while ageing in a physical sense is inevitable, how we as individuals respond to this process is culturally and socially defined (Phillipson, 1998).

Chronological ageing is particularly misleading regarding mental health, except in the case of dementia. Although some mental health problems seem to increase with age, this does not mean that they are inevitable consequences of ageing. Whilst recognising the complexities of defining ‘old age’, for the purposes of this study the term ‘older adults’ will be used, referring specifically to adults aged 65 and above, influenced by Libman’s (1989) definition of ‘old age’. This is also consistent with guidelines from the Department of Health and current literature (Knight, 2004; Patrick, 2006).

The justification for focusing on older adults in the current study is supported by literature suggesting that older people have unique needs and warrant separate research. Woods and Roth (2005) argue that the anticipated response to psychological intervention by older adults cannot be assumed to be the same as that of younger adult samples.

1.1.1.1. Increasing life expectancy

Part of the reason for choosing to focus on older adults in the present study was that the proportion of older people across the world is increasing at a faster rate than any other population group. This is due to both decreasing fertility rates and increasing life expectancy rates (United Nations Population Fund, 2005). Those over retirement age currently make up 18 per cent of the ageing population. Indeed, the numbers of people over 80 will increase by half and those over 90 will double by 2025 (Department of Health, 2001).

This increase in life expectancy, mainly in the developed world, is due to cultural changes shaping science, technology and wide-scale behaviour. Advances in medicine and biology have given us vaccines and antibiotics, and the development of sanitation systems, as well as better lifestyles and nutrition. All of these factors have been successful in preventing infectious and parasitic diseases causing premature deaths. This increase in the age of the population has implications; one being the mental health provision for people aged 65 and above. This means that there is likely to be an increasing number of people receiving mental health interventions in older age. Indeed, growing numbers of older people imply a need for increased attention from counselling and therapy professionals (O’Leary & Barry, 2006).

1.1.2. ‘Counselling’

The term ‘counselling’, when referenced within Psychology, is often used interchangeably with ‘psychotherapy’ (British Association for Counselling and Psychotherapy – BACP, 2013). No single, consensually agreed definition of either psychological counselling or psychotherapy exists in spite of many attempts across the decades.

For the purpose of this thesis, a clear definition of counselling was needed to ensure that the participants had indeed engaged in psychological counselling with a trained or in- training therapist. Unfortunately, ‘counsellor’ and ‘psychotherapist’ are not protected titles by law. This means that legally anyone can call themselves a counsellor or psychotherapist without having to prove they belong to a regulating body or that they are professionally qualified to conduct therapy. Fortunately, moves are underway to make these protected titles, and for these professions to join the

Health and Care Professions Council (HCPC) register, a statutory regulator of 308,000 health and care professionals from 16 professions in the United Kingdom.

Understanding of the term counselling in the current study is taken from the BACP (2013) and *The Sage Handbook of Counselling and Psychotherapy* (2006). The BACP defines counselling and psychotherapy as:

Umbrella terms that cover a range of talking therapies. They are delivered by trained practitioners who work with people over a short or long term to help them bring about effective change or enhance wellbeing.’

The Sage Handbook of Counselling and Psychotherapy (Feltham, 2006, p. 3) offers a more thorough definition:

Counselling and psychotherapy are mainly, though not exclusively, listening-and-talking based methods of addressing psychological and psychosomatic problems and change, including deep and prolonged human suffering, situational dilemmas, crises and developmental needs, and aspirations towards the realisation of human potential.

Counselling is not a unitary framework; it is used to denote a varied set of techniques employed to address a wide range of problems (Roth & Fonagy, 2006). Regardless of the theoretical model employed by the counsellor, the relationship between the client and the counsellor is often intended to be one of equals. Classically, it is strongly influenced by client-centred ideas of empathy, warmth and genuineness. Though these remain important, more recently counselling has developed as an integrative approach combining a range of therapeutic orientations (Roth & Fonagy, 2006).

The last 15 years has seen the emergence of a substantial body of literature on the application of psychological therapy and counselling models with older people (See Evans & Garner, 2004; Hill & Brett, 2004; Knight, Kelly, & Gatz, 1992; O’Leary, 1996; Terry, 1997). The increasing focus on evidence-based approaches and treatment outcomes (NICE guidelines; Cochrane Collaborations) more frequently includes older populations within the sampled populations or targets research and reviews specifically at them (Hill & Brett, 2004).

In his book *Counselling Older People*, Scrutton (1999) highlights that the objective is to help the person to live more happily, with less stress and in greater harmony with others. Counselling is not concerned with 'doing things' for people but enabling people to do things and make choices for themselves. Scrutton stresses the importance of older peoples' need to see themselves as individuals who have the capacity to make their own decisions. He claims that many older people need to be empowered. He argues that too many older people are too accepting of ageist stereotypes concerning what they can and should do 'at their age'. He emphasises that too rarely do older people insist that they want more from life and feel empowered to go in search of it.

There are many schools of psychotherapy including person-centred, cognitive behavioural, psychodynamic, interpersonal, existential, integrative and reminiscence therapy. Due to length constraints each approach will not be described. Explanations of these models and discussions of differences and similarities between them can be found in Feltham's (1995) book. It could be argued that all therapies share common themes of establishing a supportive optimistic relationship, examining disorders, addressing conflict and ambivalence, repairing interpersonal or intrapsychic deficits and restructuring defences (Yesavage & Karasu, 1982). Amongst others, cognitive-behavioural therapy (CBT), interpersonal therapy (IPT), and brief focal dynamic therapy have been shown to be used with success in older clients (Baldwin et al., 2003; Kennedy, 2000; Knight, 1999).

Participants in the current study had undergone counselling at a mental health charity in the south of England that offers a wide range of therapeutic approaches, depending upon the training of the therapist. In order to safeguard the anonymity of participants, the charity and its location will not be named. For the purposes of this study the therapeutic model used was not of primary concern as the focus was on the subjective narrative accounts of participants' encounters of counselling. The presence or absence of reference to the therapeutic model used in sessions was revealing in itself when analysing the narratives.

1.2 Psychological difficulties amongst older adults

The literature suggests that the main difficulties faced by older people are loss in all its manifestations: loneliness, depression, anxiety, anticipation of death, insomnia and cognitive decline including dementia (Hepple, Pearce & Wilkinson, 2002; O'Leary & Barry, 2006; Orbach, 1996; Wolpert, 2011). The following section will focus on the most prevalent psychological difficulties amongst older adults namely depression, anxiety disorders, loneliness, social isolation and the impact of retirement.

1.2.1 Depression

While dementia may have become a dominant culture image of older age, depression is actually more prevalent. Whereas the prevalence of dementia is about 5% in the over 65s rising to 20% for those over 80, depression is much more common in the younger age band of older people. Depression is the most common mental health condition in people aged 65 affecting 22% of men and 28% of women (Thomas, 2013). Depression in older people is essentially no different to depression at any other age. However, research has consistently found that the highest rate of symptoms is in the 65-plus age group (O'Leary, 1996). This means that more than two million people over the age of 65 in England have symptoms of depression (Wolpert, 2011). Depressed older people are also less likely to endorse affective symptoms and more likely to display cognitive changes, somatic symptoms, and loss of interest than are depressed younger people (Fiske, Loebach Wetherell, & Gatz, 2009).

Factors contributing to depression in older age include multiple and chronic physical illness and cognitive impairment. Some groups are at higher risk of depression for example, older South Asians (Rait, Burns, & Chew, 1996) and depression occurs in 40% of care home residents but often goes undetected (Godfrey, 2005). The environment of residential homes for older people is often under-stimulating, and being moved to a residential facility can be disruptive, can entail a loss of previous surroundings and may mark a loss of personal control and autonomy. Indeed, the fear of losing independence is common in this age group and loss of independence in general can trigger mental health problems.

When a person becomes dependent this can lead to hurt pride, anxiety and depression. Scrutton (1999) astutely highlights that when disability happens

suddenly, perhaps through illness or an accident, we are aware of the likely emotions that may accompany it. Yet, when it arises through the gradual process of ageing, we often fail to recognise the equal significance given to that loss. Depression often causes suffering, family disruption, worsens the outcomes of many medical illnesses, and increases disability and mortality (Alexopoulos, 2005; Blazer, 2003).

Depression has been a major focus of therapeutic research investigations with older adults and studies show that suicide among older people accounts for a third of the yearly total. A study by Conwell, Duberstein and Caine (2002) indicates that the rate of suicide amongst older adults warrants significant concern and highlights the need for intervention to address the prevalence of mood disorders in this age group. It has been suggested that ongoing assessment of suicidal ideation is important because the rate of suicide is highest in older adults, compared with that of any other age group (American Association for Geriatric Psychiatry, 2004).

Depression is often associated with hopelessness and negative expectations about the future (Beck, 1967; Beck, Rush, Shaw, & Emery, 1979). In extreme situations, the loss of significant people can lead to loss of the will to live. Many older people do not recognise their depression. They are told or they believe that it is a symptom of normal ageing or part of a physical illness. It could be argued that depression in older people is too often viewed as a medical problem rather than an emotional or social one. This is perhaps due to the dominance of the biological or organic model in old-age psychiatry and neuropsychology which has tended towards 'brain-based' rather than 'psyche-based' explanations of distress in later life (Hepple, 2004). Indeed, the imaging and charting of deficits takes priority over any meaningful dialogue about shared existential fears between professional and patient (Hepple, 2004).

Perhaps as a result of this, many older people prefer to present physical rather than emotional reasons for their state of mind. The depressed mind can have a devastating effect upon the functioning of the body including psychosomatic illnesses. Depressed people may have aching limbs, but the depression itself may either highlight the pain or actually give rise to it. There is research to suggest that depressive symptoms and a lack of social support increase functional impairment and also increase the loss of independence (Hays, Saunders, Flint, Kaplan, & Blazer, 1997).

1.2.2 Anxiety disorders

Anxiety disorders include generalised anxiety disorder (GAD), phobias, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD). The study of anxiety disorders in older adults has historically been neglected. Epidemiological studies of psychopathology in later life have concentrated on depression and dementia, while anxiety disorders have received far less attention (Flint, 2005; Beekman et al., 1998). However over the past fifteen years there has been more research into the prevalence, nature and consequences of anxiety in people aged 65 and above. A systematic search of articles published from 1980–2007 of older adults in a community sample, using the Medline, Web of Science and PsycINFO databases, was conducted (Bryant, Jackson & Ames, 2008). Articles were selected for this review if they reported the prevalence of anxiety disorder in general, or of anxiety symptoms, or of individual anxiety disorders. This yielded 49 articles for inclusion. Results indicated that feelings of anxiety were quite common – reported by up to 24% of participants – but anxiety disorders, were much rarer varying from 2.4% to 15%. However, in this particular review, the methodologies used in the studies were so variable as to make comparisons difficult.

GAD is reported to be the most common anxiety disorder in older adults (Ames et al., 2007; Beekman et al., 1998). OCD, panic disorder and PTSD are the least prevalent of the anxiety disorders in older people. This is reflected in the small number of studies generated by Medline and PsycINFO searches when using the terms OCD (17), panic disorder (23) and PTSD (38), restricting the search to the 65-plus age group. The exception to this was the rather high figure for sub-case levels of what the AGE CAT [a computerised diagnostic system for use with the Geriatric Mental State (GMS), a semi-structured interview for use with older people] terms ‘obsessional neurosis’, found in London. The authors reported that this is a statistically significant difference (Copeland et al., 1987), but did not offer suggestions as to why this may be. There has also been a significant level of clinical interest in PTSD, because the survivors of the Second World War and the Holocaust are now well into older age.

Anxiety can cause considerable subjective distress (Ayers, Sorrell, Thorp, & Wetherell, 2007), reduce life satisfaction (Brenes et al., 2005) and increase the risk for the onset of disability, even in high-functioning older adults (Seeman et al., 1995). It also increases the risk of mortality, both from suicide (Allgulander & Lavori, 1993) and physical, especially cardiovascular diseases (van Hout et al., 2004). Yet

unfortunately, anxiety continues to be under-recognised and therefore under-treated in older people (Forsell & Winblad, 1998; van Hout et al., 2004).

1.2.3 Loneliness and social isolation

Loneliness and social isolation are often used interchangeably in a vague and ill-defined manner to indicate how individuals evaluate their overall social network and levels of engagement (Cattan, White, Bond, & Learmouth, 2005). Loneliness can be said to describe the state in which there is a gap between the individual's actual and desired level of social engagement and as such is inherently subjective. Social isolation, on the other hand, refers to the level of integration of individuals and groups into their wider social environment (Victor, Scambler, Bond, & Bowling, 2004).

For many older adults, relationships that have accumulated during the lifespan may be lost. Spouses, friends and siblings pass away around a surviving older person, making the person prone to the aggregating effect of loneliness, grief and sometimes survivor's guilt. Older adults are increasingly dealing with bereavement, death, and facing their own mortality. It is also important to highlight that many people over 65 are carers for their partners. Caring for a partner who is becoming increasingly frail can contribute to individuals' social isolation and feelings of loneliness.

A loneliness and isolation evidence review carried out by Age UK in 2010 highlighted that befriending schemes have proved one of the more effective services for combating both isolation and loneliness, but they are best used in conjunction with other services. Group activities and exercise were suggested to be particularly useful in helping older people out of loneliness and isolation. Despite the lack of concrete evidence on the prevention of loneliness, there is a body of research on loneliness itself. The Growing Older (GO) project (2001) had isolation and loneliness as one of its 25 themes. In GO findings professor Victor, found that seven per cent of older people were often lonely and 31% were sometimes lonely. In addition to prevalence, Victor found that loneliness is a dynamic concept and varies across the life course. She emphasises that the relationship between isolation and loneliness is a complex one, involving social contact, health (physical and psychological), and mood. Poor physical and mental health were found to be associated with loneliness and isolation. Yet, due to its very nature, it may be difficult to accurately quantify and assess levels of loneliness and social isolation in older adults.

1.2.4 Impact of retirement

There has been a fairly widely held view that retirement is an event that can trigger ill health, with both physical and psychological problems (Minkler, 1981). However, there are now a number of studies which suggest that the transition into retirement may not in itself cause damage to an individual's health or well-being (Fonseca & Paúl, 2004; Jaeger & Holm, 2004). Rather, it is the particular circumstances which lead to retirement and in which retirement is experienced that influence mental health. Macro-social phenomena such as pension systems and societal norms regarding retirement are relevant. So are micro-social factors for example, whether retirement is entered into voluntarily, individual financial circumstances, family relationships and social networks, and how these factors interact with social class, gender and ethnicity (Moffatt, 2009).

Retirement can have a major impact on the mental health of people in later life. For some it means a time of freedom from the grind of employment, the child-rearing years and other responsibilities. As explained above, in some cultures reaching old age might mean increased social status (Philpot, 1986). However, for others it may lead to loss of status, a perceived reduced role in life and less contact with friends and colleagues. Other impacts of retirement may be loss of financial stability and leaving work may lead to a loss of the sense of belonging and may trigger a sense of loss of purpose in life.

At the same time, it is important to highlight that there is evidence to suggest that some older people are more content than in mid-life. Blazer (2010) cites three main reasons for this: positive optimisation, wisdom – 'expert knowledge' and better emotion regulation strategies that have been developed throughout the life course.

1.3 Psychological theories of later life

There are various psychological theories of ageing and later life which have been modified throughout the years. The following section will present three key models, namely Erikson's lifespan model, the loss-deficit model and the contextual, cohort-based, maturity, specific challenge model. There will be a review of how each model conceptualises and accounts for psychological difficulties and therefore suggests working psychotherapeutically with older adults.

1.3.1 Erikson's lifespan model

Psychologist and psychoanalyst Erikson's (1982) psychosocial theory of development is a theory of human development, growth and maturation from birth to old age. This model sets out eight stages of psychosocial development: infancy (0–2): trust vs. mistrust, toddlerhood (2–4): autonomy vs. shame, preschool (4–5): initiative vs. guilt, childhood (5–12): industry vs. inferiority, adolescence (13–19): identity vs. role confusion, young adulthood (20–39): intimacy vs. isolation, middle adulthood (40–64): generativity vs. stagnation and late adulthood (65+): integrity vs. despair. The model emphasises the transition through these stages over the lifespan. The way in which a person experiences any particular stage influences future success or lack of success in mastering the next stage of development (Erikson, 1982).

The theory proposes that during late adulthood there is a dichotomy of integrity/despair. During this time many people who have achieved what was important to them, look back on their lives and feel great accomplishment and a sense of ego integrity. Conversely, those who had a difficult time during middle adulthood may look back and feel a sense of despair. According to this theory, successful completion of each stage results in a healthy personality and the acquisition of basic virtues. The virtue associated with this eighth stage is 'wisdom'. Basic virtues are characteristic strengths, which the ego can use to resolve subsequent crises.

One of the main strengths of Erikson's model is its acknowledgement that development continues throughout the life cycle. Professor of psychology and life-story theorist McAdams (1999) supports this model however, he questions whether the stages must be regarded as sequential and only occurring in the age ranges suggested. For example, the theory claims that the search for identity occurs in adolescence, however it could be argued that there are times in later life when one is searching for identity. Furthermore, ego integrity is an issue which can develop repeatedly in any stage of adult development (Melia, 1999). Moreover, the theory could be criticised for not addressing the challenges an older person may face in terms of physical changes, social roles and the cultural challenges of a youth-oriented culture (Sneed & Whitbourne, 2005).

In a posthumously published edition of *The Life Cycle Completed* (1997), Joan Erikson, Erikson's widow and collaborator, proposed an extension to the theory in

the form of a ninth stage which applies to people in their 80s and 90s. During this stage individuals strive to transcend the everyday limitations of human experience and knowledge, instead confronting their own ageing self and seeking a more universal understanding of life. Her explication of this new stage drew extensively on Tornstam's (2005) theory of gerotranscendence, which suggests a potential stage of development in 'extreme' old age where, rather than emphasising decrements in physical capacity, there is a focus on continued growth in dimensions such as spirituality and inner strength. In this ninth stage an individual is thought to be motivated to resolve past difficulties in preparation for death. Resolution of these difficulties are thought to result in a feeling of worth as well as a sense of harmony and peace (Erikson & Erikson, 1997). However, this image of old age as a time of peace and harmony may obscure the real problems and insecurities felt by many older individuals.

1.3.2 The loss-deficit model

This model of ageing was illustrated by Knight (2004), a professor of gerontology and psychology. The model portrays the normative course of later life as a series of losses and the typical response as depression. The common beliefs and attitudes that accompany this model can be summarised like this: ageing, fragility and illness are basically synonymous and inevitable, thus should be accepted as the norm, along with the emotional distress people experience in older age (Knight, 2004). Consequently, these beliefs and attitudes inform the approaches toward working with adults, viewing therapy for older adults as assisting in their adjustment to the natural losses of later life (O'Leary & Barry, 2006).

Scrutton (1999) believes that the losses inherent in ageing mean that older people present with a repeating cycle of social distress, involving worthlessness, inadequacy, fear and vulnerability. There is support for the idea that emergent themes in work with older clients frequently revolve around loss (O'Leary, 1996; Thomas, 2013). Scrutton's psychological treatment plan would be to deal with developmental deficits, negative emotions, emotional repression, failing health and death; in other words, to learnt to accept and cope with loss. However, it could be argued that by focusing only on acceptance and coping, the loss-deficit model limits the possibility of optimising functioning and improving life experience.

1.3.3 The contextual, cohort-based, maturity, specific challenge (CCMSC) model

Knight (2004) advocates a different view on ageing, criticising the loss-deficit model for failing to recognise that loss is not unique to older adults, but rather can occur throughout life. Consequently, illness and disability should not be normalised as typical and inevitable for the ageing process as the model suggests.

As an alternative, Knight proposes the contextual, cohort-based, maturity, challenge-specific model arguing that it brings greater understanding to the multiple factors contributing to older adults' worlds. This model helps to explain the way in which some older individuals seem to, in spite of their losses, report general well-being and overall positive emotions. This model addresses the adaptability of older people to changes which occur in old age, or who in Erikson's terminology have 'achieved integrity'.

Knight's model recognises that multiple co-existing factors contribute to the experiences of ageing. He suggests that 'expert knowledge' gained through life, work, and family encounters reflects a valuable gain through maturation. He offers information about older people in the areas of intelligence, personality and emotional development and life satisfaction. For Knight, these are the sources of their strength as they cope with the challenges of loss, and this strength leads to proven fewer cases of depression (Knight, 2004). The CCMSC model therefore proposes that older adults display greater maturity than younger adults but may also be facing some of the most difficult challenges of adulthood.

Cohort differences are explained by membership in a birth-year-defined group that is socialised into certain abilities, beliefs, attitudes and personality dimensions that will stay stable as the group ages and that distinguishes that cohort from those born earlier and later (Knight, 2004). The model suggests that the fact that individuals are members of earlier-born cohorts should be recognised and incorporated into the psychotherapeutic process. Knight advocates that as part of understanding the older adult client, the therapist needs to explore the client's base of experience as a member of a particular cohort.

Rich sources of material for understanding older adult clients' ideas about self and others include their perceptions of the historical events that influenced their life and what values were most important to members of their cohort. In order for therapists

to have a greater understanding of the cultural attitudes of this time, an awareness of the values and attitudes of those who experienced World War II may be helpful. The model highlights that a genuine willingness to learn and a display of understanding the importance of values of an older adult client will help bridge the gap between cohorts.

The model further asserts that the social context will influence older adults' experiences and that therefore their environmental realities should be considered in psychotherapy; for example, whether a person lives at home alone, with family or in a nursing home. Moreover, unlike the loss-deficit model, the CCMSC model recognises the specific nature of challenges thus differentiates the issue from ageing itself. Approaching psychotherapy with older adults with this recognition in mind brings a more comprehensive understanding to life changes, and respects the diverse and specific nature of experiences influencing a client's reality (Knight, 2004). Although the model outlines important differences between older and younger adults in therapy, similarities often outweigh differences between the groups as the process of psychotherapy unfolds.

The above three models offer different insights into what it means to be an older adult and how to best work therapeutically with this client group. However, another perspective is that models for working therapeutically with older adults is unnecessary. Atkins and Loewenthal (2004) argue that a question arises as to whether therapists actually need any models to work with older adults or whether working in a phenomenological manner adequately meets their needs.

1.4. Mental health provision for older adults

The National Service Framework for Mental Health applies only to people below the age of 65 which is arguably a clear form of discrimination. It has therefore been left to the National Service Framework for Older People to deal with mental health. The National Service Framework for Older People specifies the promotion of mental health and psychological care.

Yet things have been slow to develop in some NHS Trusts. In a poignant article in *Therapy Today* (Patrick, 2006) the author highlights that there are no ring-fenced funds to deal with the number of suicides among older people (a third of the yearly total). There are also no ring-fenced funds to deal with the one person in six who develops depression after age 65. Both of these events indicate a missed

opportunity for mental health support. In primary care settings, it has been proposed that counselling should be available to clients as a first-choice intervention in mild to moderate depression (Baldwin et al., 2003). There is evidence to suggest that in moderate to severe depression, counselling in combination with an antidepressant agent produces better outcomes than does either treatment alone (Baldwin et al., 2003).

Despite there being many over 65s 'taking on the world' there are others who present possible problems for counselling services for example, mobility difficulties, fifty-minute fatigue, faltering concentration, deafness, visual impairment and physical illness. Patrick (2006) suggests that this might explain why current dealings with older people seem to remain medical in tone. She suggests that input tends to concentrate mostly on pharmacological treatment of both the physical and mental health problems of ageing, and an attempt to encourage socialisation as the cure-all for the perceived problems of old age.

In his illuminating book, *You're Looking Very Well; The Surprising Nature of Getting Old* (2011), Wolpert argues that there is considerable evidence of discrimination against older people in healthcare, with staff disbelieving older people's accounts of their medical or clinical symptoms, or with these being disregarded as a natural condition of their age. He reports that fewer than 10% of older people with clinical depression are referred to specialist mental health services compared with about 50% of younger adults with mental health and emotional problems (Wolpert, 2011).

Fortunately, an initiative originating from Better Government for Older People (BGOP) in the UK, *Moving Out Of The Shadows* (MOOTS), was set up to 'harness the voices of older people who experience a range of mental health problems, to inform and influence future policy, practice and experiences' (Bowers, Eastman, Harris & Macadam, 2005, p. 1). Furthermore, Mind's (2005) *Access All Ages* campaign helped raise awareness of the mental health needs of the older population. It highlighted services' cut-offs, lack of treatment choice, age discrimination by GPs, lack of suicide prevention policy, high levels of electroconvulsive therapy (ECT) and diagnosis failure.

Interestingly, Patrick (2006) claims that the problem is that many therapists may not be trained to work with older adults. An exception to this is the clinical psychology training programme which includes an older adults' placement. Other trainee therapists, including trainee counselling psychologists, may complete their training

with little or no experience of working with older adults which, amongst other things, may be a professional disadvantage when seeking employment. During my own counselling psychology training, teaching on the psychological development of older adults and corresponding skills for therapy were largely absent. It could therefore be argued that trainee counselling psychologists may be lacking a more holistic view of psychological development over the lifespan. In fact, lifespan psychologists have allocated specific tasks to old age. On the other hand, one could contend that older adults have problems common to all age groups and therefore viewing older adults as a separate group is unnecessary.

My own belief, based on clinical practice, is that clients should be treated equally, regardless of age; however, it is important to have an understanding of cohort and generational issues relating to a person's age. This helps to provide a context for the client's presenting issues and allows the therapist to appreciate how the client's wider sociocultural background may be influencing their understanding of their problems and their engagement with therapy.

1.5 Low prevalence of counselling amongst older adults

The National Service Framework for Older People specifically cites counselling as having an important role to play in the treatment of depression (Rainsford, 2002). Yet counselling amongst older adults is less prevalent compared to other age groups with older clients underrepresented in the caseloads of many counsellors (Goudie, 2010; Murphy, 2000).

This low prevalence is demonstrated in referral rates in the NHS. Figures show 36,000 referrals for NHS counselling among those aged 15 to 19, 194,000 referrals among those in their 20s, 179,000 among those in their 30s, 168,000 among those in their 40s and 111,000 among patients in their 50s. Yet, among those in their 60s there were 48,000 referrals, and among those in their 70s, less than 17,000 referrals were made (Health and Social Care Information Centre, 2009). The literature suggests that this low prevalence can be explained in two main ways: the under-provision of counselling for older adults and low uptakes (i.e., many older adults choosing to not enter into counselling). A discussion of these two explanations follows.

1.5.1 Under-provision of counselling for older adults

Clinical psychologist, Pilgrim (1997) believes that the problem lies in older people being overlooked by therapists in comparison to younger adults. Common mental health problems like depression and anxiety tend to be under-recognised and under-treated in primary care settings (Goudie, 2010). It had been argued that a possible reason for this is ageism on the part of the referrer (Ford & Sbordone, 1980). Pilgrim (1997) proposes that older people are often considered by professionals to be fixed in their functioning and thus lack the capacity for change. In fact, Freud believed that psychoanalysis (and other forms of therapy) was not suitable for people over fifty years of age as exemplified in the following quotation:

Near or above the age of fifty the elasticity of mental processes on which the treatment depends, is as a rule lacking. Old people are no longer educable.

(1905, p. 255)

Freud's opinion led to a belief that older people could not change or were not psychologically minded. Freud was 49 at the time of writing this and lived to be 82, during which period his supposedly 'inelastic' mental processes went through many creative changes in the reshaping of his theories (Orbach, 1996). Unfortunately, the idea that therapeutic change is impossible in older adults persists among some healthcare professionals today. Some believe that therapy for the young is more valuable because older people have fewer years to live which may contribute to their aversion in using psychotherapy with this population (Woods, 2003).

A survey of the prevalence and availability of psychological therapy in departments of psychotherapy in the UK concluded that compared with younger people, the provision of services to older people is woefully lacking, with only a small number receiving therapy (Murphy, 2000). A postal questionnaire was sent to one hundred psychotherapy departments within the UK in an attempt to gauge the use of psychotherapy services by older patients. Of the respondents, 88% felt that the needs of older people for psychotherapy were not met as well as those of younger people in their catchment areas. Respondents highlighted the lack of referrals of older people to psychotherapy services.

Respondents drew attention to poorly resourced departments that had identified the need for more psychotherapy input for older adults but lacked the resources to address it. Of the respondents, 66% felt that they would be unable to meet the

needs of older adults within their present resources. Of the 24% who felt that this was possible, a number commented that this would only remain the case if the present low level of referrals was maintained. Many respondents related their anxiety about seeking referrals of older people to their own lack of experience in treating this group and a need for further training.

This large-scale study was useful in highlighting that psychotherapy for older people is often a scarce resource mainly due to lack of resources. Moreover, it added to knowledge in the field by offering practical suggestions for improving services including that the psychotherapy needs of this age group need to be considered in service planning. It further advocated that all professionals need educating about the availability and applicability of the psychotherapies for the older patient.

However, the survey could be criticised for not addressing the provision of psychotherapy within old age psychiatry departments. It could also be argued that a postal questionnaire lacks sufficient depth of responses and did not allow respondents to elaborate on their answers or for the researchers to check their understanding of responses provided. For example, interviews would have allowed the researchers to delve deeper into respondents' anxieties about seeking referrals of older people and perhaps obtain more insightful data on respondents' views on further training.

Another survey by Collins, Katona and Orrell (1997) looked at the attitudes of GPs to referral of older people with depression for psychological treatments. A questionnaire was developed and used in a national survey and data was collected from five catchment areas in the UK. An interesting aspect of the study was that it investigated the backgrounds of the GPs. They found that female GPs particularly favoured counselling and that experience in psychiatry was associated with selection of CBT. However, despite positive intentions little referral activity was forthcoming. Ninety-three per cent of GPs reported that they would consider referring an older person for psychological therapies but only 44% had actually done so. One in three GPs showed a lack of knowledge of the range of interventions available and the indications for choosing a particular psychological therapy.

The results suggest that GP training and further education should emphasise psychological therapies, particularly for GPs without psychiatry experience. This should make referrals more appropriate, ensure more effective use of services and improve patient care. The questionnaire added to knowledge by including a section

for comments in which GPs reported that a lack of local clinical psychology services and long waiting lists deterred them from making referrals. However, the use of a survey to assess attitudes to referral of older people with depression did not allow the researchers to investigate why female GPs favoured counselling. Moreover, this method of data collection did not allow for GPs to express how they felt their backgrounds influence their course of treatment for older adults with depression. In the current study, interest lay in whether participants' stories of their decision to enter into counselling featured their GPs or whether their emotional difficulties were not disclosed to or picked up by their doctors.

In support of the above study, Garner (2002) highlighted that older people are offered psychotherapies significantly less than younger ones and yet outcome is comparable, sometimes better, than for younger patients. Perhaps more financial resources are invested in treating younger people as they are seen to have the ability and time to change. If this is the case, it is arguably evidence of healthcare ageism with discriminatory practices against older people.

Scrutton (1999) questions why when a young person reaches adolescence and has difficulties at home or school, then we assume that they require help, and we are keen to provide it, but when older people reach old age the assumption is that they do not require help. Perhaps there is an assumption that older people do not require counselling; that ageing brings with it an easy ability to express personal feelings and needs. Maybe there is an image of old age as a time of peace and tranquility which obscures the real problems and insecurities felt by many older individuals.

Yet the apparent neglect of counselling older people may be found deep within the human psyche. Scrutton (1999) suggests that the problem is that there are no answers to old age, no cures and no reassurances that can prevent the ageing process. Consequently, we may feel powerless and in order to ease our own anxiety we withdraw from older people. We choose not to confront their feelings of profound loss, loneliness, rejection and despair, or indeed the death and bereavement that are common in older age. Relating to older people can be a demanding task, especially for those who see in their experience a reflection of themselves and their future. Scrutton suggests that rather than engage with older people it is easier to deny their needs. Perhaps we prefer to accept their (often false) reassurances and hide behind our defence mechanisms. Maybe it is the easiest way for both parties to cope with loss and pain.

The good news is that more recently steps have been taken to improve provision. Improving Access to Psychological Therapies (IAPT) for older adults is one of the six core commitments of the IAPT four year plan set out in 2011. This followed an adult psychiatric morbidity survey which assessed prevalence of depression among people aged 65+ at eighteen per cent when in initial data only five per cent of people in IAPT services were over 65 years.

1.5.1.1 Ageism

Ageism is a term coined by Butler (1969), used to describe stereotyping, prejudice, and discrimination against individuals or groups because of their age (Associated Press, 2004). Ageism can be directed at all age groups but it is older people who arguably experience it most pervasively and acutely, with older age frequently being portrayed as inevitably a period of deficit, decline and illness (Knight, 2004). Butler (1969) claims that 'daily we are witness to, or even unwitting participants in, cruel imagery, jokes, language, and attitudes directed at older people' (Associated Press, p. 1). Such negative stereotypes have social, psychological, and physiological consequences. Old-ageism can be seen 'as reflecting a deep-seated uneasiness on the part of the young and middle-aged; a personal revulsion to and distaste for growing old, disease, disability; and a fear of powerlessness, uselessness and death' (Butler, 1969, p. 243).

It is important to note that whilst all counsellors will have encountered young and possibly middle adulthood, few will have had first-hand experience of late adulthood (Scrutton, 1999). This brings the advantage that clients can be responded to without interference from the counsellor's direct experience of this stage, but also increases the scope for counsellors to fall foul of unsubstantiated stereotypes concerning later life. Furthermore, countertransference issues are important to consider when working with older adults (Knight, 1996; Sprung, 1989). Twining (1996) suggests that clients in late adulthood bring with them the reminder, *memento mori* – remember you will die – thereby forcing counsellors to face their own inevitable ageing and the risks and fears it brings of disability and dependency. Recognition of the powerful impact of social and internalised ageism becomes essential for psychotherapists when approaching the conversation of ageing. This recognition is integral to the process of working with clients, especially if they are perceived as or see themselves to be 'older adults' (Twining, 1996).

1.5.2 Low uptake amongst older adults

Whilst acknowledging under-provision of services and ageism, even when counselling is made available, certain groups of people are less likely to claim it as a right. One of these groups is older people, with or without private means (Patrick, 2006). Uptake of counselling in older adults is less than other population groups.

Scrutton (1999) highlights the resistance to counselling and counsellors by some older people in the UK. A major obstacle to overcome is that of the stigma of mental health problems. It could be argued that this stigma is especially strong in this age group and thus people are less likely to seek out help from mental health services.

Older men are particularly reticent in engaging with counselling services and disclosing emotional distress due to associating counselling with personal inadequacy (Murray et al., 2006; Scher, 1981). Even when men realise they are depressed or have another problem, they are less likely than women to see a mental health professional (Mahalik, Good & Englar-Carlson, 2003). As mentioned in the Preface, this may explain why, despite the current study being open to older men and women, only women responded.

In a qualitative study on primary care professionals' perceptions of depression in older people, thirty professionals including GPs, nurses and counsellors working in eighteen South London primary care teams were interviewed about their perceptions of depression in older people (Murray et al., 2006). The GPs reported that older patients rarely mentioned psychological difficulties, but the nurses felt that older people were less inhibited in talking to them about non-medical problems.

The study highlights that many older people were perceived to regard symptoms of depression as a normal consequence of ageing as suggested by the loss-deficit model. Further, the study was useful in highlighting cultural variations in illness beliefs. The attribution of symptoms in particular were thought to profoundly influence the help-seeking behaviour of older people from minority ethnic groups. The primary care professionals reported that many older people regard depression as a 'sign of weakness' and the perceived stigma of mental illness was widely recognised as a barrier to seeking help.

The study was helpful in illuminating differences in disclosure to GPs and nurses. It suggests that some older patients may not think it appropriate to mention non-physical problems in a medical consultation with their GP but may feel more

comfortable discussing these issues with a nurse. These are important findings which call for further research into older adults' willingness to disclose non-medical problems to different healthcare professionals and the reasons for these differences in behaviour. This may shed light on how attitudes towards GPs inhibit older adults' disclosure of psychological difficulties which may present a barrier in accessing psychological treatments.

However, the study relied on healthcare professionals' impressions and opinions of their patients which inevitably presents a bias. Also, the sample of participants was taken from South London, arguably a very narrow urban area thus findings are unlikely to represent the experiences of primary care professionals from other areas of the UK. Moreover, the study only focuses on one mental health problem, depression, thus failed to investigate primary care professionals' perception of anxiety, bereavement or other emotional difficulties experienced by many older adults (Beekman et al., 1998; Bryant, Jackson & Ames, 2008).

In the current study, one of the aims was to investigate narrators' journeys into counselling including whether they disclosed their emotional difficulties to a healthcare professional such as their GP or whether they self-referred to the mental health charity's counselling service. Interest lay in narrators' decision to seek counselling and how their attitudes towards healthcare professionals inhibited or enabled access to therapy. Unlike Murray et al.'s (2006) study, the present study was not limited to experiences of depression but to all emotional and personal difficulties which brought the narrators into counselling.

Scrutton (1999) claims that some older people may be opposed to the very idea of counselling and may associate it with psychological or mental illness. After all, counselling is a relatively new concept that did not exist when older people were young. The era in which individuals grow up, become adults, and establish careers and families exerts a shaping influence that interacts with other personal characteristics to affect the perception of psychological distress and of mental health treatment (Knight, Kelly, & Gatz, 1992).

In support of this, Knight (1999) claims that contemporary older adults have little familiarity with the process or benefits of psychotherapy. He believes that older adults are generally unaware that psychotherapy is an available option, as well as an adjunct to medication. Without adequate education, psychotherapy may be viewed as 'just talking', rather than a 'talking and thinking through emotions or

problems' process that consists of client-identified goals. Historically, the current older adult population has been discouraged from expressing their emotions. Therefore, sharing feelings or discussing issues with a therapist needs to be explained as an acceptable form of treatment.

It has been suggested that more education of older people is needed about the treatment options available to reduce the stigma of mental health problems and to increase the number of older individuals who seek and benefit from treatment (Sirey, et al., 2001).

A mixed methods study by Kunkel and Williams (1991) revealed the differing expectations of psychotherapy between younger and older clients. Quantitative and phenomenological research methods were used as they were simultaneously applied to expectations about counselling in one hundred older adults and one hundred gender- and ethnic-matched university students. Participants completed the Expectations About Counselling-Brief Form (EAC-B) questionnaire with appended demographic items, and also participated in semi-structured group interviews.

A thematic analysis of interview data revealed that the older adults expressed little confidence and reliance on counselling services. The findings suggested that self-reliance and stoicism were abiding themes for the participants, which mitigated the older adult seeking psychological therapy. The study also found that many older people might be part of a cohort that views counselling as irrelevant and contrary to life experience. In order to counteract this, the authors recommend that those undertaking counselling with older clients should accommodate the individual's need to feel empowered and autonomous whilst encouraging growth. The authors also advocate therapists talking to older clients to understand common elements of specific age cohorts whilst remaining sensitive to individual differences. The study's strength lies in applying two methodological perspectives thus was able to compare qualitative and quantitative data obtained. Moreover, matching younger and older participants for gender and ethnicity reduced the potential differences caused by these factors. Yet, the study could be criticised for using group interviews rather than individual interviews as some participants may not have been as honest in a group setting and responses may have been influenced by other group members. Moreover, the study neglected to explain the clear rationale for comparing university students (young adult respondents) and older adults whilst making no reference to those aged in-between. Similarly to Kunkel and Williams' (1991) study, one of the

aims of the current study was to investigate older adults' expectations of counselling but using a more in-depth analytic process which included an analysis of themes amongst other qualitative interpretative lenses.

In support of Kunkel and Williams' (1991) findings, Wetherell et al. (2004) undertook a survey of younger and older adults (over age 60) who had utilised primary care services. They found that older individuals were 25% less likely to undertake counselling. The responses from the survey indicate that older adults were more likely than younger adults to hold a belief in self-reliance that could limit their willingness to accept treatment from mental health services. The study also outlined that older individuals believed that through greater life experience they may have gained a sense of self-efficacy for problem solving and were therefore more likely to feel that they could work through difficulties themselves. The authors advocate that educational messages should be given to older adults to help improve understanding of counselling services.

Further research has highlighted the complexities in regard to older adults attending psychotherapy services. Hayslip, Schneider and Bryant (1989) undertook a study focusing on older women's perceptions of counsellors of the same gender. Ninety-six women served as pseudo-clients in an analogue study in which they were presented with counselling vignettes. They found that the participants would have perceived younger counsellors more positively when discussing intimate topics, whilst preferring older counsellors for discussion of less intimate issues. This perhaps highlights the complexity of the issue of older clients not readily disclosing emotional difficulties. However, criticism could be levelled at this study for using artificial scenarios rather than obtaining phenomenological data of real counselling encounters. Nevertheless, the study was helpful in highlighting the counsellor's gender and age in older women's disclosure of intimate topics which informed the current study. In the present study, attention was paid to how stories of counselling included the counsellor's age and gender and the narrator's interpretation of these factors during their counselling process.

In the aforementioned study by Murray et al. (2006), older men were particularly reluctant to disclose emotional distress to primary care professionals despite being more vulnerable to severe depression and suicide than older women. Men in particular may associate counselling with personal inadequacy and regard it as undermining self-sufficiency and personal autonomy (Scher, 1981). Some have a negative image of therapy, seeing it as shameful and indicative of weakness

(Twining, 1996). Independent problem solving is an important value in older generations (Zank, 1998).

Vacha-Haase (2010) highlights that emotional isolation and overcoming negative stereotypes about psychotherapy in the older male population is a particular challenge, especially for men raised within traditional gender roles with narrow views of masculinity. Many older people do not normally demand attention and will not come forward readily to request counselling support (Scrutton, 1999).

Non-disclosure of emotions and emotional isolation were investigated in a qualitative study by MacDonald and Morley (2001). Thirty-four people referred to an NHS psychotherapy department were given a modified form of Oatley and Duncan's (1994) emotion diary which included questions about whether each recorded emotion had been subsequently disclosed to anyone. One week later the diaries were collected and participants interviewed. Interviews focused, among other things, on reasons for non-disclosure of recorded emotional experiences. The results indicated that a majority of the emotional incidents recorded in the diaries were not disclosed (68%). Qualitative analysis of the interview data revealed that non-disclosure and emotional isolation were related to the anticipation of negative interpersonal responses to disclosure in addition to more self-critical factors including shame. The study suggested that these factors could inhibit people from seeking professional help.

Although the study could be criticised for its small sample size, the use of an emotion diary was a creative method of data collection which allowed the researchers to obtain rich and insightful written data from participants. This informed the current study as attention was paid to the mention of shame and whether narrators' decisions to enter into counselling made reference to emotional isolation and a perceived lack of people in their lives whom they felt they could disclose emotional difficulties to. However, perhaps the study would have been more credible if participants were asked to keep a diary over a longer period of time. It could be argued that one week is not a sufficient amount of time to accurately gauge whether participants experienced and disclosed certain emotions. Participants may have not had the time or opportunity to disclose their emotions within a one week time frame.

Furthermore, low uptakes of counselling amongst older adults may be attributed to fear of change or the belief that change is not possible 'at their age'. These beliefs may be reinforced by ageist stereotypes. There may also be cultural differences in

accepting counselling, for example, O'Leary (1996) discussed Irish reticence. Van Etten (2006) highlights that to improve the rate of psychotherapy use among older adults, stigma surrounding psychiatric treatment, as well as misconceptions that older adults are incapable of change, must be unlearned and eliminated. She believes that disorders such as depression, anxiety, and complicated bereavement must be considered psychiatric illnesses rather than normal consequences of ageing.

Fortunately, steps have been taken to raise awareness of and reduce stigma around counselling and mental health problems. Age UK's website is useful in providing information on talking treatments and highlights how older people as a group are drastically under-represented as users of counselling services. The charity supports the idea that this might be because there has been a stigma attached to seeing a therapist. The website provides links to local NHS mental health services and explains how a visit to the GP is often the first step towards receiving help. Indeed, some branches of Age UK offer in-house counselling and group therapy. Increased education and awareness is likely to result in future generations of older people being more psychologically minded.

It is important to highlight other sources of support for older people which could mean that counselling is not needed. Regular exercise has been shown to help reduce depression in older people (Barbour & Blumenthal, 2005). Also, culture, particularly religious traditions, can exert a strong influence on psychological wellbeing among older people. A study exploring quality of life (Higgs et al., 2005) found that religion among older people from ethnic minority communities was a strong provider of emotional support in times of stress. Religious beliefs helped the individual maintain a sense of self, identity and continuity, and thus reinforced positive wellbeing. Furthermore, being part of a religious community could help some people feel less isolated by providing a sense of belonging and increased socialisation, which could function as protective factors against psychological distress.

In support of this, a quantitative study was conducted comparing older adults' help-seeking from clergy to help-seeking from other sources of formal mental health services (Pickard & Tang, 2009). Data were from the Naturally Occurring Retirement Community Demonstration Project in America (N=317). Multinomial logistic regression was used to compare sources from which help was sought. The results indicated that older adults sought help from clergy more frequently than from other

formal sources. Interestingly, the study proposed that the increasing older population and the attendant crisis in mental health services might best be addressed through public-private partnerships in which mental health professionals assist clergy in identifying problems and making appropriate referrals to mental health services.

1.6 Older adults' decision to enter into counselling

According to Knight (2004), older adults seek therapy for the same reasons that younger adults do, including depression, anxiety, self-understanding and problems with friends and family. However, it could be argued that older clients may come into therapy with more inaccurate expectations about the nature of therapy than younger clients. There are still older adults who equate mental health services with inpatient hospitalisation for long periods of time. In fact, these misperceptions may be major barriers for older people in seeking therapy or establishing a relationship with their therapist (Knight, 2004). Yet, research shows that attitudes are changing as people want to find solutions without medication and associated side-effects (Rainsford, 2002).

This attitude was reflected in the results of a quantitative study in which two hundred participants aged 65 and older rated the acceptability of three different treatments for geriatric depression: (a) cognitive therapy, (b) cognitive bibliotherapy, and (c) antidepressant medication (Landreville, Landry, Baillargeon, Guérette, & Matteau, 2001). Findings highlighted that cognitive therapy and cognitive bibliotherapy were equally acceptable and more acceptable than antidepressant medication for patients presenting mild to moderate symptoms. However, cognitive therapy was more acceptable than both cognitive bibliotherapy and antidepressant medication for patients presenting severe symptoms.

This study is helpful in illuminating the fact that although antidepressant medication remains the predominant approach to treating geriatric depression this does not appear to reflect the preference of older adults themselves. These results are in line with other studies' findings on the topic (Lundervold & Lewin 1990; Rokke & Scogin, 1995) in showing that psychological treatments are considered by older adults as more acceptable than antidepressant medication for the treatment of geriatric depression. However, this study does not explain why cognitive therapy was rated more positively than medication. Moreover, the authors only examined the

acceptability of treatments separately. It could be argued that a single therapeutic approach is not sufficient to effectively treat geriatric depression. Future studies could compare the acceptability of various treatment combinations with that of the same treatments used separately.

A German study (Zank, 1998) also investigated the opinions and fears of eighty-four older individuals concerning psychotherapy. A random sample of community-dwelling older people in Berlin was drawn. Seven per cent reported they had undergone psychotherapeutic treatment and 46% said that they knew someone who had been treated by a psychotherapist. A questionnaire was distributed that consisted of three scales: prejudices against psychotherapy, sharing problems with others, and fears of psychotherapy. In order to test the hypothesis that there are cohort differences due to societal changes, the sample was divided into younger elderly (age ≤ 73 , $N=43$) and older elderly (age ≥ 74 , $N=41$). A multivariate analysis was computed with age group as the independent variable and prejudices, sharing problems, and fears as the dependent variables. Results showed that older adults were often fearful of undertaking psychotherapy. Findings also revealed that prejudices and fears were higher in the older elderly as compared to the younger elderly but the mean scores of these variables were moderate, which means that prejudices and fears were not as high as expected.

This study was useful in demonstrating a relatively high, and for younger elderly cohorts an increasing, acceptance of psychological treatment. However, findings were limited due to the solitary use of a questionnaire to collect data. This did not allow for a more in-depth qualitative assessment of participants' opinions and perspectives of psychotherapy, which could have produced new insights that were not covered in the questionnaire. From a phenomenological stance, it could be argued that research employing the sole use of questionnaires is an artificial creation by the researcher, as it is asking only a limited amount of information which consequently restricts participants' responses.

Furthermore, in Zank's (1998) study only three scales were used. It could therefore be argued that there is a level of researcher imposition, meaning that when developing the questionnaire, the researcher makes their own decisions and assumptions as to what is and what is not important. As a consequence the questionnaire may be missing something that is of significance. Nevertheless, valuable information was taken for the current study. The three areas of prejudices against psychotherapy, sharing problems with others, and fears of psychotherapy

were included as prompts in the present study's interview schedule. The aim was to gain insight into peoples' decision to enter into counselling, including possible preconceptions and concerns (see Appendix 5, p. 203–204 for the interview schedule).

Another insightful study which looked at people's decision to enter into therapy was presented by Gurin, Veroff and Feld (1960) in their summary of *Americans View Their Mental Health* study. This was a quantitative study in which a nationwide interview survey was administered. The authors proposed a three-stage process that people go through before seeing a psychotherapist. The first stage identifies the problem as psychological rather than physical or a moral deficiency. They suggest that some people do not classify the problem at all but simply try not to think about it. In the study, this stage of the decision process was affected by age; that is, older people were less likely than younger people to label the problem as psychological.

The second stage is deciding to seek help. Having defined the problem as psychological, many people decide to work it out for themselves or wait for the problem to disappear. The third stage is the decision to seek professional help. The study suggests that having decided to seek help, many people will go to a physician or buy a self-help book rather than see a counsellor. This is an illuminating proposal, especially in terms of explaining why some older adults may not seek professional help. However, the study was carried out in the 1960s and there has been much more public awareness of psychological interpretations of problems over more recent decades.

Yet, more recent research has tended to support the finding that older adults are not so much reluctant to use mental health services as they are unable to identify the problems as being psychological and thus seek specialty mental health services (Colenda et al., 2003). The implication is that a major task of mental health professionals working with older people is to educate them to correctly identify problems that are psychological in nature.

Following an extensive literature review, it was found that there is limited research into older people's decision to enter into counselling and no research investigating this area using a narrative approach. Consequently, one of the aims of the current study was to address this absence by eliciting the stories of six older former clients' journeys into counselling.

1.7 Older adults' experiences of counselling

Within cognitive-behavioural approaches, the term 'therapy education' is often used (Gallagher-Thompson & Thompson, 1996), referring to the responsibility of the therapist to inform the older client about psychotherapy. Nordhus, Nielsen and Kvale (1998) find this term especially relevant with regard to the older client's expectations about psychotherapy. They suggest that some patients may have the belief that psychologists are an extension of their physician. When referred to psychotherapy by their primary care physician, they may enter therapy with a fairly constricted medical definition of their difficulties. In addition, it may come as a surprise that the therapist offers weekly appointments and that help is being provided in a rather unfamiliar way, compared with earlier treatment experience. Identifying and addressing a client's expectations about psychotherapy may of course be relevant for younger adults as well. But in terms of maximising therapeutic effect with older adults, the authors suggest that a careful discussion of the client's expectations and an explanation of the limits of therapy were central elements in establishing the therapeutic relationship.

An insightful qualitative study of older adults' encounters with psychological counselling in Canada (Hunter, 2011) addressed the limitations of current geropsychological research, theory and practice and identified the counselling needs of this growing population. The study was influenced by a culture-specific approach that emphasised the importance of attending to the uniqueness of cultural groups from the perspective of the members of those groups in the refinement of psychological theory, research and practice (Arthur & Collins, 2005). Furthermore, the study answered a call to include clients' perspectives in enhancing multicultural competences of counsellors (Pope-Davis et al., 2002). A strength of the study was its mixed gender sample comprising of six women and four men over the age of 65 who had undergone psychological counselling as an older adult. This allowed for a comparative analysis of gender similarities and differences in participants' encounters with psychological counselling. Another advantage of the study was that participants ranged in age from 67 to 89 years old, thus included the young-old (65-80) as well as the old-old (80+) (Neugarten, 1974).

A narrative analysis was conducted using interview data of older adults' stories concerning the overarching question: 'What are older adults' experiences with psychological counselling?' Results captured meaningful counselling experiences. The study highlighted the value of psychological counselling and shed light on the

importance of promoting competent counselling for older clients. The focus was on participants expressing the competencies and skills they felt counsellors should have. However, the study could be criticised for using the term 'psychological counsellor' very broadly. Some participants described experiences with counselling psychologists while others had worked with mental health social workers, psychiatrists, and master's level counsellors. This raises a question regarding the extent to which the experiences of participants in psychological counselling can be attributed to differences in training perspectives of the different mental health professionals.

Similarly, the present study also aimed to elicit and analyse the narratives of older former clients' counselling experiences but the focus was on the experiences of former clients in the UK. Unlike the Hunter (2011) study, all participants in the current study received psychological counselling from a trained or in-training psychotherapist at a mental health charity in the south of England. Furthermore, as well as eliciting the narrative accounts of people's overall encounters of counselling, the current study also focused on the narrative accounts of older former clients' decisions to enter into counselling including motivations and expectations.

1.8 Rationale and aims of the study

1.8.1 Hearing the stories of former clients: Analysing the narratives of six older women's counselling experiences

Embarking on the literature review for this study revealed an absence of the voices of older former clients in narrating their counselling experiences. The literature revealed many assumptions and opinions of healthcare professionals and academics regarding why older people choose to enter into counselling or not and how counselling should be conducted with older people. Yet, it failed to represent the perspectives and stories told by older individuals regarding their personal counselling encounters. Furthermore, apart from the aforementioned Canadian study (Hunter, 2011) there is a lack of research using a narrative approach to gain insight older adults' experiences of counselling.

Consequently, the current study aimed to fill this gap by eliciting and analysing the narrative accounts of six older women regarding their decision to enter into counselling and their experiences of counselling. As Riessman (2008) highlights, narratives invite us as listeners to enter the perspective of the narrator. The study therefore aimed to give voice to former clients and analyse how stories were used to construct experiences of counselling.

1.8.2 Aims of the study

The aim was to elicit and analyse participants' stories of counselling by exploring the way these experiences were constructed during the research interview. Attention was paid to the functions the individual narratives served i.e. what message or point was being conveyed to me as their audience.

As mentioned in the Preface, the original research questions were 'How do older *adults* construct their decision to enter into counselling?' and 'How do older *adults* construct their experience of counselling?' as the study was open to older men and women. However, in light of subsequent recruitment in which only women responded, the study evolved into focusing on the counselling experiences of older women.

The present study therefore aimed to address the following two research questions:

1. How do older women construct their decision to enter into counselling?
2. How do older women construct their experience of counselling?

Particular attention was paid to the wording of the two research questions: 'How do older women *construct* their decision to enter into counselling?' and 'How do older women *construct* their experience of counselling?'. My choice of the word 'construct' relates to narrative research in which there is an assumption that narrators build/construct stories to convey their experiences. As Langdridge (2007, p. 130-131) states, 'we work to *construct* meaningful narratives for ourselves' and arguably for others'. Willig (2013, p. 133) also claims that through *constructing* narratives about their lives, people make connections between events and interpret them. Willig (2013, p. 133) highlights that 'researching narratives can tell us much about the ways in which people construct meaning in (and for) their lives'.

The word 'construct' was purposely chosen instead of 'make' or 'have' as it was felt that this was most suited to the aims of the present narrative study. In narrative research, interviewers encourage narrators to construct stories of their experiences with the aim of accessing not only the content of the stories but also how they are assembled and conveyed to the interviewer as their audience.

In the current study, at the beginning of the interviews, narrators were encouraged to construct their stories of counselling in their own ways, focusing on whatever was considered personally meaningful and important. The aim was to analyse not only the content of the stories but how these stories were constructed and expressed to me as their audience (i.e., the tone, function and how issues of identity were presented). For these reasons, it was felt that the word 'construct' was appropriate.

'The truths sought by narrative researchers are narrative truths, not historical truths' (Spence, 1982). Indeed, the aim of narrative inquiry is not to find one generalisable truth but to 'sing up many truths' (Byrne-Armstrong, 2001, p. 112). As a narrative orientation to the data was employed, the historical accuracy of participants' accounts was not a priority. Instead, emphasis was on understanding how and why the stories were being told in the way they were.

The theoretical underpinning of narrative inquiry is the belief that 'telling a story about oneself involves telling a story about choice and action' (Rice & Ezzy, 1999, p. 126). Since narrative accounts were being elicited, narrative analysis was chosen as the most suitable way to make sense of the interview data. Attention was paid to content and structure whilst maintaining the holistic integrity of the story. There was an assumption that the narratives produced were co-constructed by the narrators and myself, therefore interactions in the interview context were included in the analysis.

1.8.3 My story: Motivational factors for the present study

My interest in this project stems from my personal and professional curiosity in older peoples' relationship with counselling. Over the past decade I have worked with older adults in a variety of settings including in a private care home as a support worker, on an inpatient stroke ward as an assistant clinical psychologist, at a counselling service within a GP practice and at a mental health charity as a trainee counselling psychologist. These experiences have developed my interest in older people's meaning-making in seeking and engaging with counselling. Throughout the

years, I have encountered mixed attitudes from older people regarding their perceptions of counselling. These have ranged from viewing counselling as self-indulgent, unnecessary, for the 'mad' or for the younger generation to counselling being seen as invaluable in helping manage emotional distress and improve quality of life.

Whilst on placement at the mental health charity, there was an increase in older adult referrals to the counselling service. As explained above, there is generally a low prevalence of counselling amongst older people compared to other age groups. One of the purposes of this study was to shed light on the expectations of the six participants prior to engaging in counselling, with the aim of exploring older adults' current perceptions of seeking help in the form of counselling. Curiosity about why the participants chose to engage in counselling and how they narrated the stories of their encounters drove the current study.

Furthermore, as a relatively young (aged 28) trainee counselling psychologist, I was curious about whether age or other characteristics such as gender, social class, ethnicity and the therapeutic model used in sessions were important factors in the participants' stories. Whilst acknowledging that due to the small sample size results are not generalisable, insight into participants' experiences of counselling could enhance understanding of whether there are common issues that emerge for older adults. As therapists, this information could help us work more effectively with this client population.

Another motivational factor for this topic was age discrimination in mental health services and the need for further attention, so that services developed for working adults are available to older adults on the basis of need, not age. Unfortunately, older people do not have access to the range of mental health services available to younger adults despite having the same, and often greater, need (Anderson, 2007).

A further interest in the project arose from my fondness of narrative inquiry. The psychologist within me finds storytelling a fascinating part of human nature. Stories or narratives have been shared in every culture as a means of education, cultural preservation and instilling moral values. People of all ages tend to love stories; whether in the form of a news story, a film, a novel or a Christian or Buddhist parable. For a brief period we immerse ourselves in another world whilst attaching our own meaning to the story.

Stories can bring events to life and as narrative is a use of language that is traditional and learnt from a young age, it is often easily memorable. Many of us grow up listening to and reading stories that stimulate the imagination and teach us important life lessons. My attention to and memory for stories used in teaching is much stronger than in other modes of delivery. When we tell stories, our verbal and non-verbal communication changes, making language easier to understand. Bruner (1990) claims that we learn about the social world most easily in narrative form and it is often how we recall, recount and anticipate experience.

That stories appear so often supports the view of some theorists that narratives are one of the natural cognitive and linguistic forms through which individuals attempt to order, organise and express meaning (Mishler, 1986). As Riessman (1993), a central proponent of the adoption of narrative methods within social sciences highlights, narrative is a basic human way of making sense of the world – we lead storied lives. Maybe stories are just data with a soul (Brown, 2010).

1.8.4 Relevance to counselling psychology

Counselling psychology principles are based upon humanism in which there is a belief that every person has their own unique way of perceiving and understanding the world and that the things they do only make sense in this light. Counselling psychology draws upon and seeks to develop phenomenological models of practice i.e. based on the way one perceives and interprets events (BPS, 2013). Therefore, the unique subjective experience of an individual client has been placed at the very core of counselling psychology theory and practice (Strawbridge & Woolfe, 2003).

The current thesis is relevant to counselling psychology in three main ways. Firstly, the study aims to illuminate older women's subjective and unique experiences of counselling. Interest lies in understanding the lived experiences of participants and how those encounters are interpreted and told. This is congruent with the humanistic and phenomenological values of counselling psychology.

Secondly, narrative inquiry is highly congruent with the ethos of counselling psychology. Narrative approaches to research arguably provide the space for people to tell their stories in the same way that counselling psychologists encourage clients to relay their personal stories in therapy. Therefore, both the narrative researcher and the counselling psychologist aim to understand not only the content of stories but what meaning this holds for the individual and how the stories are told.

Both are audiences for the narrator whilst at the same time mindful of their influence in shaping the story.

Building on this, it could be argued that the core of therapy is the process in which the client comes to tell, and then re-author, a personal narrative. Indeed, a growing psychotherapeutic movement uses narrative research to help clients rewrite or better understand their life stories (Doan & Parry, 1994; Friedman & Combs, 1996; Hermans-Jansen, 1995; White & Epsen, 1990).

In support of this, McLeod (1997) proposes that all therapies are therefore narrative therapies and that the counselling experience can be understood in terms of telling and retelling stories. Davy (2010) agrees that all talking therapies are narrative in which a person experiencing a dilemma or distress tells a therapist stories about their past, present and possible futures. Through their responses, the therapist promotes elaboration and reflection on some kinds of stories more than others. If the story is not heard, then the therapist and the client are deprived of the most effective and mutually involving mode of discourse open to them.

Allowing participants to provide narrative accounts of their experiences can help to redress some of the power differentials inherent in the research enterprise (Elliot, 2005). A frequently cited book on narrative inquiry is Mishler's (1986) *Research Interviewing: Context and Narrative*. He argues that paying attention to the stories that respondents tell potentially leads to a radical re-examination of the standard practices adopted in qualitative interview research. Mishler emphasises the need to understand that the discourse of the interview is jointly constructed by the interviewer and the interviewee. Both counselling psychologists and narrative researchers aim to create a collaborative relationship, reflecting on their own role in the interactive process. For this reason, both narrative researchers and counselling psychologists acknowledge the importance of reflexivity.

Thirdly, as counselling psychologists it is important for us to be curious about a client's decision to attend counselling and investigate whether it was indeed the decision of the individual, their GP or their family. If we are serious about providing the best service for our clients, we must listen to their feedback and be continuously improving the way we work with each client group. We cannot always know if our clients are benefiting from therapy, we have blind spots too. It is therefore good practice for therapists to regularly ask clients how they feel therapy is progressing (Lambert, 2007). However, some clients may feel uncomfortable expressing

dissatisfaction to their therapists. Therefore, perhaps we are more likely to obtain honest feedback when former clients are invited to share their experiences by an independent researcher.

2. Chapter Two – Methodology

Overview

In this chapter the ontological and epistemological choices made within the study will be outlined and justified. There will be an explanation of how these are congruent with my research questions, choice of data collection and analysis. All research adopts a position on politics, power, values and truth, even if that adoption sneaks into the research unannounced (Burman & Whelan, 2011). Explicitly engaging with epistemological issues allowed for the clarification of my position on the key questions of values, power and truth. The assumption of a philosophical stance on how one knows (and therefore investigates) reality determines the researcher's role and positionality before their participants (Banister, 2011).

Qualitative research questions identify the phenomenon that the researcher wants to investigate. They point us in the direction without predicting what we may find. Leading qualitative methods researcher in psychology, Willig (2013), suggests that good qualitative research questions tend to be process-oriented. They ask *how* something happens. Indeed, it is the research questions that guide the entire research process. As highlighted in the introductory chapter, the current study was motivated to answer the following research questions:

1. How do older women construct their decision to enter into counselling?
2. How do older women construct their experience of counselling?

The ontological and epistemological positions were determined by the above research questions. These positions in turn guided my choice of data collection and analysis. The following diagram, **Figure 1**, outlines the research questions, paradigmatic issues and the main methodological choices made in the current study which are discussed in this chapter.

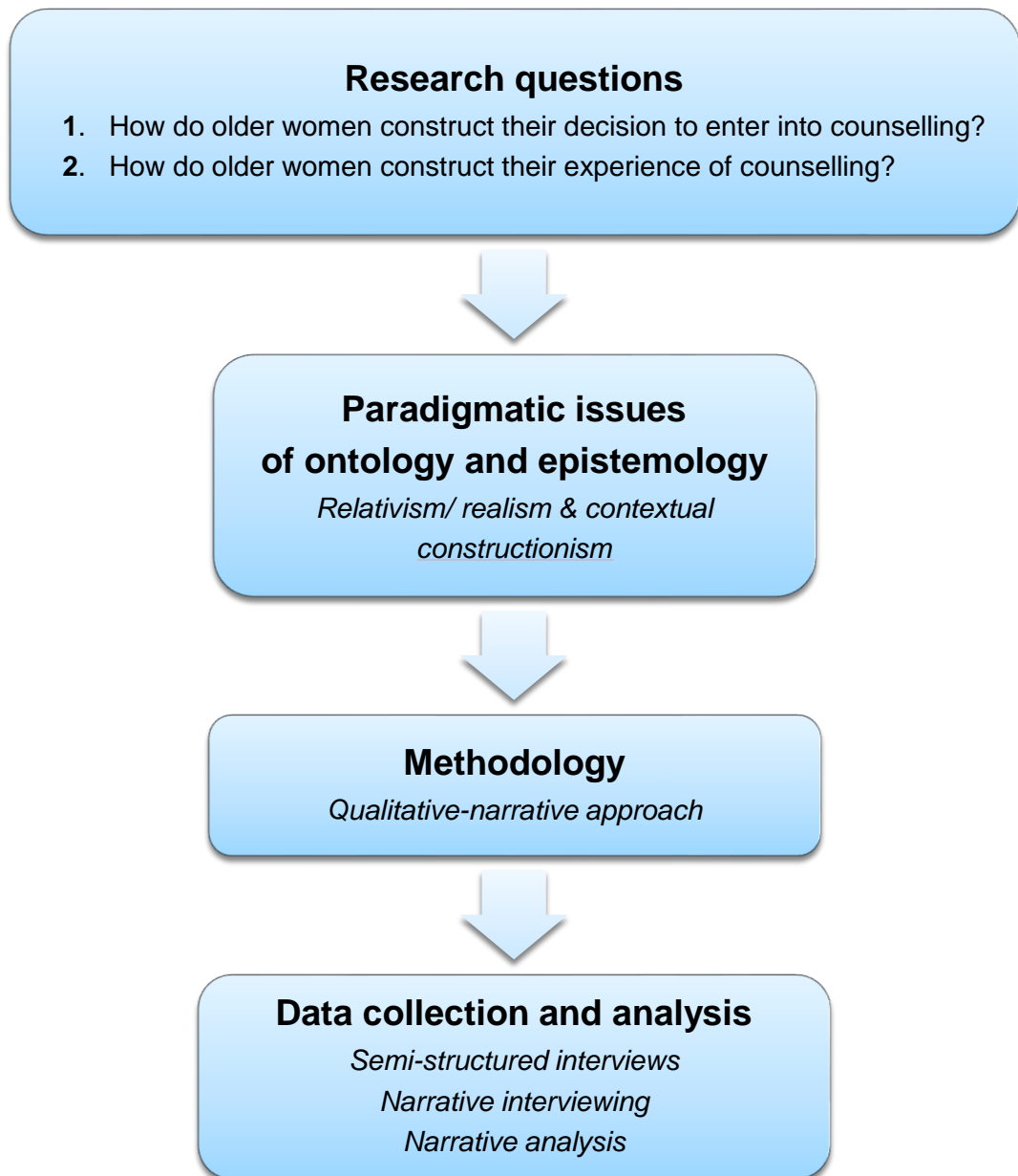


Figure 1: Research questions, paradigmatic issues & methodological approach

2.1 The role of paradigm

Guba and Lincoln (1994) define paradigm as ‘the basic belief system or worldview that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways’ (p. 105). In this manner, the paradigm chosen by the researcher plays an important role in influencing the direction the research takes (Guba, 1990; Phillips, 1987), and as Guba and Lincoln (1994) explain, provides answers to three fundamental research questions:

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1. Ontology: What is the form and nature of reality and what can be known about this reality?
 2. Epistemology: How can this ontological reality be obtained or captured by the research?
 3. Methodology: Which methods are best to generate answers to questions posed taking into consideration epistemological and ontological positions?

2.1.1 Ontological position

Ontological positions can be described as ‘realist’ and ‘relativist’ (Willig, 2013). A realist ontology maintains that the world is made up of structures and objects that have cause-effect relationships with one another. A relativist ontology, by contrast, rejects such a view of the world and maintains instead that the world is not an orderly, law-bound place. A relativist ontology questions the ‘out-there-ness’ of the world and draws attention to the diversity of interpretation that can be applied to it (Willig, 2013). Relativism therefore assumes that there is no absolute truth as truth is relative based on subjective values according to differences in perceptions. It assumes that everything is constructed in the mind of the individual and is therefore changeable.

The ontological position adopted in this study stands in the middle of realism and relativism. There is an assumption that the phenomenon of counselling is real and ‘out there’ in the social world, whilst at the same time assuming that each participant experienced this real phenomenon through their own unique lens. There is the supposition that there may be multiple realities but these realities are context-bound by the interview setting. The stories that were narrated to me in the interview context may be different to the stories narrated in other settings or narrated at different points in time. Therefore, it is assumed that the narrative accounts gathered in the present study are not static representations of experiences. Stories are always crafted for an audience and as Parker (2005) highlights, we can never know that someone we interviewed has really let us hear their story.

As the researcher, I viewed myself as a central figure in the research process, inevitably influencing every aspect of the study. I was mindful that I partly constructed the findings based on my interactions with narrators and my subjective interpretation of the data. Interpretations usually mean that the interpreter brings to light aspects of the object which are not immediately obvious but will help her

understand better what it may be about. In line with Willig (2013), I believe that interpretation is an essential and arguably unavoidable part of narrative research because, without some form of interpretation, I would not have been able to make sense of the large and complex data.

2.1.2 Epistemological position

Epistemology is a branch of philosophy concerned with the nature and scope of knowledge. It is often referred to as a theory of knowledge. Thinking, talking and writing about one's own epistemological commitments encourages reflexivity, which in turn helps us to specify the status and limitations of our knowledge claim (Willig, 2013). The type of knowledge I aimed to produce was phenomenological. Interest lay in the lived counselling experiences of participants and the stories they told of these experiences.

As I was drawing from a narrative approach to research, the epistemological positions commonly adopted by narrative researchers were considered. Due to the emphasis on language and culture, some narrative researchers adopt a social constructivist epistemology. This epistemological standpoint draws attention to the fact that human experience, including perception, is mediated historically, culturally and linguistically (Willig, 2013). Other narrative researchers emphasise the lived experience of the individual which is regarded as holding some degree of coherence and continuity, and thus adopt a critical realist epistemology (e.g., Crossley, 2000). Critical realist research assumes that we cannot gain a mirror image of reality as it is mediated by our interpretation of it.

Based on the research questions and aims of the study, the epistemological position adopted in the current project stands in the middle of social constructionism and critical realism and can be defined as contextual constructionism. 'Contextualism' assumes that knowledge is grounded in individuals' meaning in different contexts. Contextual constructionist research is based upon the assumption that all knowledge is necessarily contextual and standpoint-dependent. This means that results will vary according to the context in which the data was collected and analysed, furthermore that different insights can be generated about the same phenomenon (Madill, Jordan & Shirley, 2000).

A contextual constructionist epistemology was adopted as there was an assumption that knowledge is necessarily local, provisional and situational (Jaeger & Rosnow,

1988), but that there is such a thing as a phenomenon of counselling and that this same phenomenon can be fruitfully approached by using different perspectives (Madill et al., 2000). Jaeger and Rosnow (1988) put forward that human activity does not happen in isolation but rather in the context of the socio-historical and cultural environment. 'Human actions are embedded in a context of time, space, culture and the local tacit rules of conduct' (Jaeger & Rosnow, 1988, pp. 4–5). This means that knowledge discovered in the research interview context and in the analytic process reflects both participants and my own perspectives.

A contextual constructionist epistemology is suited to narrative research as the narratives people tell are likely to be influenced by wider cultural narratives as well as their audience. As Riessman (2008, p. 8) highlights, 'stories do not just fall from the sky, they must always be considered in context as storytelling occurs at a historical moment with its circulating discourses and power relations'. Moreover, the local context of the storytelling must be considered i.e. who the audience is who receives the story and how this might influence the type of story being told.

In the current study there is an assumption that knowledge is influenced by the person's own experiences of the world and that this is also context-dependent. Contextual constructionism is suited to this study as it suggests that the participant and the researcher are both active, interpretative beings in the context of their worlds (Madill et al., 2000).

Contextual constructionism sees all accounts as imbued with subjectivity. In the current study it is assumed that there is a real phenomenon of counselling which the six participants experienced in their own subjective ways and that the interview context was a real social environment in which narratives were constructed. Furthermore, it is assumed that the interview context, including my presence as researcher and the setting of the mental health charity, is likely to have influenced participants' constructions of their counselling narratives. Moreover, as contextual constructionism views the researcher's interpretations as being context-dependent, importance is placed upon researcher reflexivity which will be discussed towards the end of this chapter.

2.2 Qualitative methodology

It was felt that the methodology most suited to my epistemological stance and research questions was that of qualitative methods. The following section will introduce this methodology before outlining its justification and use within the present study.

Qualitative researchers tend to be concerned with the quality and texture of experience, rather than with the identification of cause-effect relationships (Willig, 2013). For this reason, qualitative research is often referred to as interpretative research. Interviews are the most widely used methods of eliciting the viewpoint of participants for qualitative analysis. The accounts and arguments elicited through the use of qualitative methods have the potential to provide unexpected insights into factors which may not have been considered by the researcher.

Qualitative methodologies are especially well-suited to explore particular situations and experiences of individuals. In this respect some qualitative methodologies can be viewed as akin to traditional clinical practice. As in the clinician-client relationship, central importance is often attached to the interaction between the researcher and the participants (Yardley, 2000). As a trainee counselling psychologist, the client-therapist relationship is at the heart of my clinical practice. For this reason, the use of qualitative methods was congruent with my own values and belief system.

2.2.1 Rationale for qualitative methods

Qualitative methods were chosen for the current study as the focus was on the individual's perspective, taking fully into account the ways in which the phenomenon of counselling was expressed in a particular location (Orford, 1992). In this study, the location was the interview setting. The accounts of counselling were retrospective as participants were asked to talk about an experience which had occurred months prior to the interview. Furthermore, some participants had encountered more than one course of counselling. This meant that the details of the counselling process and feelings experienced may have faded into memory. However, as explained above, the primary aim was not to gain a factually accurate account of the process of counselling but rather an understanding of how participants constructed and attributed meaning to their experience.

Furthermore, as the aim was to generate textual rather than numerical data, it was necessary to use a method of data collection that permitted participants to express themselves in ways that were not constrained and dictated by the research (Marks & Yardley, 2004). The objective of the study was to elicit and analyse rich, descriptive narrative accounts therefore qualitative methods were suitable.

2.2.2 Methods considered

In determining the qualitative method that would best facilitate the exploration of older women's decision to enter into counselling and their experiences of counselling, interpretative phenomenological analysis (IPA) and discourse analysis were considered. The rationale for rejecting these methods in the current study in favour of narrative analysis will briefly be presented.

2.2.2.1 Interpretative phenomenological analysis

IPA aims to capture the quality and texture of lived experience yet makes explicit that the phenomenological analysis generated by the researcher is always an interpretation of the participant's experience. Smith (1997, p. 189) characterises this method of analysis as 'an attempt to unravel the meanings contained in... accounts through a process of interpretative engagement with the texts and transcripts'. This facilitates a process of enabling the researcher to identify themes within and across the data.

Although this analytic method would have allowed for a level of analysis exploring the content of the text, unlike narrative analysis, it would have broken down the accounts told thus losing the holistic integrity of the stories of counselling. Eliciting stories from participants regarding their counselling experiences and using narrative analysis to analyse these stories meant that my gaze turned to the function, tone and issues of identity as well as the themes. Thus arguably, providing a more holistic form of analysis. Unlike IPA, narrative analysis allowed for the exploration of *how* as well as *why* accounts were told in the way they were thus gaining insight into the social or psychological functions of participants' accounts. Furthermore, narrative analysis allowed for the exploration of the influence of broader socio-cultural narratives on participants' accounts thus adopting a wider lens compared to IPA.

2.2.2.2 Discourse analysis

Discourse analysis is a broad and diverse field, including a variety of approaches to the study of language (Wetherell, Taylor, & Yates, 2001). It is assumed that language constructs social reality rather than mirroring it. There are many similarities between discourse and narrative analysis including a focus on the function of accounts and attention to contextual factors. However, in the current study the aim was to encourage creativity and freedom in the construction of accounts through eliciting unique stories. Narrative analysis enabled the exploration of different facets of the narratives – the stories within the stories and the characters of these stories. It would have been unlikely to achieve this through discourse analysis.

2.2.3 The context of narrative research: philosophical underpinnings and overview

The current study drew from a narrative orientation to research as the aim was to analyse how older women construct their decision to enter into counselling and their experience of counselling. In order to describe the narrative approach, I feel it is important to outline its philosophical roots. The phenomenological movement and the emergence of phenomenological psychology will be outlined. This focuses on people's lived experiences and how those experiences are told. The following section will also briefly explain what is meant by the term hermeneutics which underpins narrative analysis.

2.2.3.1 Phenomenological psychology

Phenomenological psychology is an approach to psychology that draws directly on the phenomenological tradition of philosophy. Phenomenology is the study of human experience and the way in which things are perceived as they appear to consciousness (Spinelli, 2008). Phenomenology is the given name to the philosophical movement beginning with Edmund Husserl (1859–1938) and then developed by Martin Heidegger (1889–1976). This movement had a huge influence on many disciplines including psychology. The phenomenological psychology focus is on people's perceptions of the world with an emphasis on what is experienced and the way it is experienced.

Understanding perceptions and experiences involves the researcher engaging in a series of processes designed to generate rich descriptions of people's lived

experiences of the world. With this comes recognition of the way the researcher may have preconceptions about a topic and the importance of reflecting upon these and bracketing them off as much as possible.

Hermeneutics

Hermeneutics (from the Greek messenger of the gods, Hermes) is the theory, art and practice of interpretation, originally the interpretation of texts. Heidegger began the hermeneutic turn in phenomenological philosophy by emphasising how all understanding involves interpretation. Hermeneutic phenomenology is therefore concerned with interpretation designed to grasp the understanding of a research participant. Thinking hermeneutically encourages us to be aware of the preconceptions we bring to our research. Indeed, philosopher Gadamer (1975) emphasised the historically and culturally situated nature of all understanding and the need to reflect upon this. The increasing interest in hermeneutics in phenomenology has led to the development of phenomenological narrative methods of data analysis which were employed in the current study (Langdridge, 2007).

2.2.3.2 Definition and features of a narrative

Narrative inquiry is rooted in phenomenological psychology and involves hermeneutics in order to extract meaning from a text. The term 'narrative' comes from the Latin verb *narrativus*, which means 'telling a story' (Oxford Dictionary, 2006). Therefore, the terms 'story' and 'narrative' are synonymous and often used interchangeably.

Riessman (1993) highlights that the exact definition of a narrative is open to debate among researchers. Within the realm of narrative research in psychology, Riessman (2008, p. 6) offers a working definition for narrative as 'long sections of talk – extended accounts of lives in context that develop over the course of single or multiple interviews'. Another definition proposed by Murray (2003, p. 113) is that narrative is 'an organised interpretation of a sequence of events [which] involves attributing agency to the characters in the narrative and inferring causal links between the events'. Riessman and Quinney (2005) highlight that what distinguishes narrative from other forms of discourse can be focused in terms of sequence and consequence. Events are selected, organised, connected and evaluated as meaningful for a particular audience, and hence the focus of analytic attention on how and why events are storied.

Crossley (2000) and Murray (2003) propose that the function of narration in bringing order and coherence to our lives may become all the more relevant and pronounced when faced with non-normative or disruptive experiences that rupture expectation, as we strive to regain a sense of control and make sense of events. It could be argued that people tend to seek counselling in times of distress, upheaval or when struggling with disruptive experiences.

Narrative in the human sciences could therefore be defined provisionally as discourses with a clear sequential order that connect events in a meaningful way for a definite audience and thus offer insights about the world and/or people's experience of it (Hinchman & Hinchman, 1997). This definition is helpful as it stresses three key features of narratives. Firstly, that they are temporal/chronological, secondly that they are meaningful, and thirdly that they are inherently social in that they are produced for a specific audience. A brief description of these three features will follow.

Temporality within narrative

Aristotle, in *Poetics* (384–322 BCE), described a story as having a beginning, middle and an end. It is the chronology of events within a narrative that distinguishes it from a description. However, it could be argued that defining a narrative as something with a beginning, middle and end raises the question of whether what is being focused on is a kind of 'defensive' structure in which the actual disorganisation of everyday life (its beginning, *muddle* and end) is being denied (Emerson & Frosh, 2004, p. 8).

Meaning of narrative

The evaluation is crucial for establishing the point or meaning of a story (Elliot, 2005). A number of authors have argued that the evaluation is socially the most important component of the narrative (Linde, 1993; Polanyi, 1985). In a conversational setting, for example, the narrator must guard against the 'so what?' response to a story. This is accomplished by providing an adequate evaluation of the events that have been recounted (Polanyi, 1985). It is the evaluation that conveys to an audience how they are to understand the meaning of the events that constitute narrative, and simultaneously indicates what type of response is required. While the speaker can be understood as responsible for producing a narrative with

an acceptable evaluation, the audience must collaborate by demonstrating that the evaluation has been understood.

It could be argued that the very telling of a narrative represents an evaluative act. It suggests that certain events and decisions are reportable by virtue of their significance. Perhaps this indicates that the fact that the narrators in the current study chose to participate in a project requiring them to tell their stories of counselling meant that they felt their stories were worth telling.

Audience and social context

Many authors with an interest in narrative have highlighted the importance of the context of this telling and the role of the listener in the construction of narratives (Bernstein, 1997; Gubrium & Holstein, 1998; Holmes, 1997). Oral narratives presuppose an audience, or as Plummer (1995, p. 20) articulates 'stories can be seen as joint actions'. At the most basic level, an individual will need the conversational space to tell a story to another and the co-operation of a conversational partner. When someone begins to tell a story, the other conversational participant gives the storyteller privileged access to the floor (Coates, 1996; Sacks, 1992). The listener therefore immediately becomes an active co-participant in the recounting of a narrative.

In addition, any speaker in an interaction needs to decide how best to communicate their message and in making this decision will attempt to take into account what the listener can reasonably be expected to know (Brown, 1995). In the current study, narrators were aware of my status as a trainee counselling psychologist who had worked at the charity as an honorary therapist. Narrators were therefore likely to have assumed my knowledge of counselling and this would have inevitably influenced how much detail and explaining was included in the narratives.

2.2.3.3 The 'narrative turn'

Over the past 20 years there has been a dramatic increase in interest in narrative among those adopting qualitative approaches to research. Narrative inquiry has expanded rapidly across the social sciences. Researchers have taken the 'narrative turn' to documenting and understanding the discursive complexity of accounts. Thus storytelling probably represents the future direction for a great deal of phenomenologically informed work (Langdridge, 2007). Both Riessman (2008) and

Chase (2005) pointed to the important role played by liberation movements in voicing the stories of marginalised groups, especially in the 1960s and 1970s.

The civil rights, feminist and gay movements were pivotal to this shift (Chase, 2005). Commonalities in stories of discrimination created group belonging and set the stage for collective action (Riessman, 2008). Feminist scholars in particular, resisted the notion that personal narratives were merely informational. They became interested instead in subjects as active narrative agents exploring subjective meanings formerly silent or unrecognised. Today, many researchers are turning to narrative because the stories reveal truths about human experience (Riessman, 2008). Indeed, narratives are useful in research precisely because storytellers interpret the past rather than reproduce it.

2.2.3.4 Aims and assumptions in narrative research

The aims and assumptions of a narrative orientation to research will be outlined including how these have guided and informed the course of the current study. The term 'narrative psychology' emerged to capture the spirit of humanist alternatives to the demeaning image of human beings in traditional laboratory-experimental research, and to find a way of representing the stories people tell about themselves (Crossley, 2000).

Narrative psychology assumes that people are reflective and natural storytellers who make their experiences meaningful by telling stories about them (Silver, 2013). Narrative research therefore aims to produce knowledge about how people weave their experiences into meaningful stories. This focus on the ways in which people construct meaning in their lives (Willig, 2013), as opposed to simply examining such meanings, contributed to my choice of a narrative approach over one based solely in interpretive phenomenology.

Mishler (1986) convincingly argues that participants' storytelling tendencies are sometimes suppressed by interviewers' interruptions. In traditional qualitative interviewing, stories may go unrecorded or discarded in the analysis as irrelevant digressions. At the heart of the current study was the elicitation of personally meaningful stories, enabling participants the freedom to narrate their stories of counselling imposing their own style and structure.

2.2.4 Narrative interviewing

Researchers wishing to 'give voice' to marginalised groups have often chosen interviews as their preferred method of data collection (Goodley, 2000). It could be argued that in British culture older people are a marginalised group, particularly in terms of receiving mental health services (Pilgrim, 1997; Wolpert, 2011). As the study's aim was to elicit stories, narrative interviewing provided the narrators with the opportunity to become active participants within the research process by selecting what they believed to be the most salient information. It is important to highlight that narrative interviewing is not a set of techniques, nor is it necessarily 'natural'. But rather, it offers a way for investigators to forge dialogical relationships and greater communicative equality (Riessman, 2008).

Data was collected during a single interview with each participant lasting approximately 90 minutes. Several authors suggest that 90 minutes is the optimal length for a qualitative research interview (Hermanowicz, 2002; Seidman, 1998). This was a suitable amount of time to allow for in-depth responses but not too long to tire narrators or risk loss of concentration. Semi-structured interviews were employed as they enabled me to delve into the position and comments of the interviewees (Burman, 1994). This format facilitated the consistency of a series of predetermined questions whilst allowing the flexibility of asking the questions in any order, to leave questions out or introduce new questions or prompts in light of the stories being told.

Authors such as Riessman (1990) and Mishler (1986) have each emphasised that interviewees are likely to provide narratives in the context of interviews about their experiences, unless the structure of the interview itself or the questioning style of the interviewer suppresses such stories. They argue that most people like telling stories and with little encouragement will provide narrative accounts of their experiences in research interviews. Mishler (1986) explicitly links the notion of obtaining narratives in interviews to the aim of empowering respondents as he succinctly explains:

Various attempts to restructure the interviewer- interviewee relationship, so as to empower respondents, are designed to encourage them to find and speak in their own 'voices'. It is not surprising that when the interview situation is opened up in this way, when the balance of power is shifted, respondents are likely to tell 'stories'. (pp. 118–199).

This illuminating quotation suggests the natural inclination people have to tell stories. It also raises a wider question about the possible power imbalance in society, silencing marginalised groups by not listening to their thoughts, opinions and feelings about their experiences of mental health services. It could be argued that when left to 'flow', people's narratives could reveal unconscious paths of association. These pathways are defined by emotional motivations, as opposed to rational intentions (Wilkinson, Joffe & Yardley, 2004).

In contrast to the view that narratives will emerge naturally during interviews, some authors have described situations in which they have failed to obtain narratives from respondents even though this was the primary aim of the interview. This raises questions about the most effective ways of encouraging respondents to provide detailed storied accounts of their experiences in interviews. Chase (1995) claims that we are most likely to succeed in eliciting narratives from participants when we ask simple questions that clearly relate to their life experience.

Hollway and Jefferson (2000) described their unsuccessful attempts to obtain narrative responses in their pilot interviews for a study on the fear of crime. They critiqued their own study by stating that although their interview questions were open-ended and framed in everyday language, they were too focused on the interests of the researcher and were not broad enough to allow respondents to provide the detailed narrative accounts they were hoping to elicit. Furthermore, their study did not focus on a particular incident. They used their own unsuccessful pilot experience to suggest that the best interview questions for narrative interviews invite participants to talk about specific times and situations.

Following these suggestions, the aim of the present study was to focus on participants' most recent experience of counselling at a mental health charity. Although this involved asking participants to talk about an event that happened over the course of weeks or months, it is a specific encounter, confined to a particular duration in time and took place in a specific place.

Furthermore, Mishler (1986) highlights the importance of paying attention to the role of the interview context in shaping the narrative, as narratives do not occur in isolation, but as a result of an interaction between researcher and participant. However, Parker (2005) cautions against the claim to have established rapport with interviewees. He claims that it overlooks the fact that the account given of what went on in the interview is necessarily one-sided. He argues that what is of interest is not

our mistaken idea that we have established rapport, but our attention to the moments when the relationship breaks down and what we make of it. Throughout the interview process I was mindful of the interview setting of the mental health charity and my presence as a relatively young, white, trainee counselling psychologist in relation to responses given.

Note-taking was avoided during the interviews as this would have interfered with eye-contact, non-verbal communication and attention to the subtleties of interaction. However, notes of my personal feelings immediately after each interview added richer material to the process of analysis. For example, following an interview with a particular participant I felt proud to be in my profession. The narrator's story of counselling was one of restitution. Her experience of counselling had enabled her to get back in touch with the core of who she was. During analysis, I realised that one of the functions of her narrative was to praise counsellors and the work they do. This inevitably had an impact on my feelings as a therapist and the positive impact the profession can have on people's lives.

2.2.4.1 The interview schedule

A good way to obtain detailed and comprehensive accounts from interviewees is to express ignorance (Willig, 2013). With this in mind, interviewees were encouraged to state the obvious and therefore give voice to otherwise implicit assumptions. The aim was to elicit narratives and gently bring interviewees back to the research questions if they had gone off topic. This was a delicate balance to strike. I was mindful of not steering narrators away from talking about what was personally meaningful. I knew that allowing this space may help generate novel insights, so following Langdridge's (2007, p. 69) advice, interrupting was minimised unless a participant wandered 'completely off the subject and seemed unlikely to return.'

Interviews began by asking participants to voice their reasons for agreeing to be interviewed. It was hoped that this might shed light on why each participant wanted to tell their story and the meaning this held for them. Participants were invited to tell their stories in whatever way they felt appropriate. Questions and prompts were used to ensure my research questions were being addressed. The questions were designed to be personal and engaging, showing my interest and curiosity, human-to-human. As the intention was to elicit narratives, standardised questions were kept to a minimum. One of the strengths of narrative interviewing is that it gives

participants much more central control in shaping the agenda. As Parker (2005) highlights, the best research enables surprising things to happen.

Towards the end of the interview process, five constructivist questions were asked to delve even deeper into participant's meaning-making of their counselling experience and as an attempt to elicit creative responses. "W" questions (beginning with "what", "why" or "when") only give a certain level of depth and often elicit a pre-packaged, easily retrievable response. In contrast, constructivist or 'workshop' questions are more creative and often surprise interviewees, encouraging deeper reflection in order to construct a response. For example, participants were asked "If your story of counselling were to be made into a film or book, what genre would it be, for example would it be a drama, comedy, tragedy, adventure, horror? And why?" and "Would there be a turning point in the film or book?" (See Appendix 5, p. 203–204, for the interview schedule). In designing part of the interview schedule I drew from McAdams' (1993) narrative interview protocol, particularly in asking narrators to think about their experience in terms of a book and identifying turning points.

It is worth noting however, that as Riessman (2008) suggests, the specific wording of a question is less important than the interviewer's emotional engagement and degree of reciprocity in the conversation. During interviewing, my focus was on being present and responding to the stories rather than blindly following the list of set questions.

2.2.4.2 Skills used to elicit a story

Some participants narrate extensive stories about their lives with very little encouragement from the interviewer. Conversely, other participants are reluctant to speak; the very openness of the narrative interview may invite suspicion and anxiety, leading to brief answers and long pauses (Murray, 1997). It was important for the participants to feel that their stories were valued. This can be difficult as some participants may feel that their stories are not worthy of research investigation. Indeed, during the telephone screening interviews, one participant expressed her worry that she "may not be of any use" to me, suggesting that she felt her story was not worthy of investigation. Perhaps by saying she may not be of "use" to me she was giving herself an object status. How narrators positioned themselves during the interview was of interest in the current study and therefore included in analysis.

With some encouragement and validation of her experience, she proceeded to open up in depth about her encounter during the course of the interview. Perhaps presenting one's experience in the context of an academic research interview can feel intimidating to some people, particularly if they are not from an academic background themselves. Maybe there is a perceived pressure to be very interesting, articulate or have something remarkable to say. Measures were taken to reassure narrators that I was interested in any experience they had, positive or negative. At the beginning of the interview, narrators were reassured that there were no right or wrong answers; that the purpose of the study was exploratory.

Fortunately, times are changing and the narrative turn in social sciences reflects broader changes in society. The public display of personal stories has increased the legitimacy of personal storytelling. Older people are especially receptive to the extended narrative interview. It would appear that their very position in the life course provides them with a perspective to look over their lives. Freeman (1997) suggested that later life is the narrative phases *par excellence*. In later life one has gained a certain distance from the life one has lived making it possible to size up events and draw connections over time. As in my case, the researcher will often be younger thus the older person may feel more comfortable about taking control of the interview.

Researchers and their communicative competencies are the main instrument of collecting data (Oppenheim, 1992). My main challenge was to facilitate storytelling. Riessman (2008) highlights that creating possibilities in research interviews for extended narration requires investigators to give up control. On Riessman's advice, I followed narrators down 'their trails', encouraging participants to speak in their own way, which shifts power in interviews. Although relations of power are never equal, the disparity is diminished. As Riessman highlights, genuine discoveries about a phenomena can come from 'power-sharing' (p. 24).

As a trainee counselling psychologist the use of self is a skill that has been developed through my training programme. Rogers' (1961) core conditions have been embedded in me and were used to be a more in-tune and effective interviewer. Echoing Rogers' (1961) core conditions of empathy, congruence and unconditional positive regard, McAdams (1993) suggests that the listener should not adopt an advisory or judgemental role. Instead s/he should serve as an 'empathic and encouraging guide and affirming sounding board' to the narrator's story (p. 254). Mindful of using active listening skills such as paraphrasing and reflecting

back content and feeling, I believe this helped clarify understanding both for myself and for the narrators.

Participants were encouraged to feel as comfortable and relaxed as possible with ice-breakers such as the offering of tea/coffee and biscuits prior to the interview. This hopefully created a welcoming environment and was a small token of offering something in return for their participation.

2.2.4.3 The co-construction of a story

It is generally acknowledged in the human sciences that ‘the researcher does not *find* narratives but instead participates in their creation’ (Neander & Skot, 2006, p. 297). Given its interactional basis, narrative becomes a collaborative enterprise – the joint product of narrator and listener (Holstein & Gubrium, 2012). In the current study, the stories produced were viewed as co-constructions. The question regarding the relative contribution of the different participants in shaping a narrative is an ongoing challenge facing the narrative researcher in collecting and analysing narrative accounts (Camic, Rhodes, & Yardley, 2009).

My role in the co-construction of each narrator’s story was conceptualised in two main ways. Firstly, minimal encouragers allowed narrators to continue at length whilst I made a conscious effort to limit interrupting, even though some responses did not appear to be directly answering the interview questions. I followed what Mishler (1986, p. 74) describes as ‘a general rule for conversationalists’, mindful that a story was being told and my role of facilitating storytelling. Narrators were allowed to ‘hold the floor’ beyond the limits of a usual turn to see what story would naturally unfold. In facilitating storytelling, my listening and questioning in particular ways will have inevitably shaped the stories being told.

Secondly, I was the audience to whom the narrators were presenting themselves and their experiences in a particular light. Narrative accounts were therefore developed for me, a young, white, female trainee counselling psychologist and researcher. Had participants been recounting their counselling experiences to friends or family, the stories narrated may have had a different texture and served different functions. Furthermore, in line with a contextual constructionist epistemology it was assumed that the co-construction of each story was affected by the context in which it was produced. Five interviews took place in counselling rooms in the mental health charity and one took place in the participant’s home.

2.2.4.4 Piloting

Piloting refers to the process of designing and trying out questions and procedures before official data collection (Langdridge, 2007). This was important for numerous practical and ethical reasons. Piloting helped not only with the wording and clarity of interview questions but also with the ordering of question sequences. It also helped me practise my interviewing techniques thus increasing confidence during official data collection. One of the primary benefits of piloting was fine-tuning my skills of eliciting a story in a way that would feel comfortable for all involved and would ensure that the research questions were being answered.

Interview questions were piloted on three friends and two family members of ages ranging from 27 to 68 years. Three 'pilotees' had undergone counselling so questions were exactly the same. For the other two, the 'experience of counselling' was replaced with 'university experience' but the format and aim of the interview remained the same. 'Pilotees' were encouraged to be completely honest about aspects of the process that were not clear or they did not feel comfortable with. Constructive criticism was encouraged and as I already had a close relationship with the 'pilotees', the feedback provided was direct and helpful suggestions were offered. Furthermore, piloting enabled the rehearsal of audio-recording skills in order to ensure optimal clarity and volume of recordings.

By engaging in this process, it was found that the five constructivist questions required people to take much more time to think about how they would form a response. Some of the initial interview questions were changed following feedback that they were too difficult or abstract. All 'pilotees' reported that a 60 to 90 minute timeframe was an appropriate duration for the interview process and all described the experience of participating as positive.

2.2.5 Recruitment of participants

The study was open to older men and women however only women responded. As stated in the Preface, this lack of response from older men could be explained by the differential take-up rate of counselling services in men and women (Murray et al., 2006; Scher, 1981; Vacha-Haase, 2010). Many older men have a negative image of psychotherapy, seeing it as shameful and indicative of weakness (Twining, 1996). Indeed, Vacha-Haase (2010) highlights that overcoming negative stereotypes about psychotherapy in the older male population is a particular

challenge, especially for men raised within traditional gender roles with narrow views of masculinity. Consequently, the study evolved into focusing on the counselling experiences of older women.

Regarding sample size, there are no set guidelines stipulating the amount of participants needed for narrative research. Narrative inquiry often focuses on the experiences of one or a few participants rather than those of a larger group. One of its goals is to 'give voice' to those whose stories have been previously unheard in educational research (Chase, 2005). Studying a small sample in depth is advised due to the often extended narrative accounts provided by participants and the in-depth nature of narrative analysis.

For the purposes of this study, six female participants were recruited. This was a suitable sample size allowing for an in-depth analysis of each narrative account whilst at the same time exploring whether there were any commonalities across narrators' accounts. Participants were all 'young-old' (Neugarten, 1974) females aged between 66 and 74 years. Four were of British origin, one was Cuban and one was Jamaican.

The BPS Code of Human Research Ethics (2010) advises that recruitment of participants for a given study should apply exclusion criteria which protect the health and wellbeing of participants. Below is a list of the inclusion and exclusion criteria used in the current study:

Inclusion criteria:

- Men and women aged 65 and over at the time of starting counselling
- Have had at least one course of counselling (therapeutic model and duration can vary)
- Fluent in English. As the method of data collection was narrative interviewing, it was imperative that participants were able to express themselves fully within their narratives. For ethical reasons, non-native English speakers were not excluded. However, intelligible English was vital for the purposes of transcription and analysis.

Exclusion criteria:

- Attending counselling or any other psychological treatment at the time of interview. The aim was to gain insight into participants' overall experiences of the counselling process following its completion
- Severe cognitive, language or communication difficulties that could interfere with the ability to understand the nature and purpose of the study, follow the interview questions and respond in an intelligible way. This was an ethical issue highlighting the importance of participants' ability to give informed consent. These abilities were assessed informally during the telephone screening interviews by judging how prospective participants engaged in conversation and responded to preliminary questions.

2.2.5.1 Recruitment process and material

Participants were recruited through a mental health charity which will not be named to ensure confidentiality. The reason for choosing to recruit through this organisation was threefold. Firstly, I had worked on placement at this particular charity which provided me with first-hand knowledge of how the organisation works and the nature of counselling received by clients. Clients attend one-to-one weekly counselling sessions for up to 20 sessions. The duration of therapy is negotiated between the therapist and client. Therapeutic models vary depending upon the training of the therapists. They include person-centred, CBT, existential, psychodynamic and integrative. Some of the counsellors and psychologists at the charity are in training but receive regular clinical supervision. Due to my pre-existing association with the charity I had a good working relationship with the counselling service manager who was interested in the study and offered to assist with recruitment.

Secondly, this organisation was specifically chosen because the counselling service only accepts people who chose to attend counselling and are not forced by law. Clients can self-refer or be referred by their GP or other service. For the purposes of the study it was important that participants had chosen to attend counselling as one of the aims was to elicit a narrative account about their decision to engage in therapy in the first place. However, this does not necessarily mean that people wanted to attend counselling as they may have felt pressurised to attend by family or felt obliged to follow the advice of their GP. Thirdly, this particular mental health

charity was chosen as it has a policy of accepting adult clients of all ages, including people aged 65 and above.

The charity's counselling service manager agreed for the Head of Administration to send out letters to a random selection of 22 former clients aged 65 and over who had received counselling within the last year. It was thought that people who had undergone counselling more recently would be in a better position to recall their experiences. Enclosed in the letter was the research information sheet providing prospective participants with details of the nature of the study, the terms of confidentiality and the right to withdraw from the study (see Appendix 3, p. 199, for the information sheet).

In addition, permission was gained from the counselling service manager to display a recruitment flyer in the waiting room. The flyer and letters provided prospective participants with a choice between contacting me via email or by telephone. In the recruitment material the terms 'older people', 'mature', 'elderly' or 'seniors' were avoided as people may not have identified themselves with these labels (see Appendix 2, p. 197 for the recruitment flyer). Out of these 22 former clients, six women responded expressing an interest in participating in the study.

2.2.5.2 Telephone screening interviews

Once these six women had made contact with me, brief telephone screening interviews were set up. The rationale for these preliminary interviews was three-fold. Firstly, to ensure prospective participants fully understood the nature of the study and their role in it and secondly, to ensure that they met the criteria for the study. Thirdly, the screening interviews gave prospective participants the opportunity to ask any questions they had about the project. One woman asked where the interviews would be conducted as this determined whether she would be able to participate. Due to poor mobility she did not feel comfortable travelling outside of her area. The interview was therefore carried out in a quiet room in the mental health charity, which was ideal for her.

During the screening interviews, I clarified that I did not work for the charity and that the study was not part of a service evaluation. Participants were asked where they would prefer to be interviewed. I suggested in a quiet room at the charity, at City University, at their home or at a local library. All participants preferred to be interviewed in a quiet room at the charity, stating that the location was convenient and familiar. The one exception to this was a participant who preferred to be

interviewed at her home due to difficulty with mobility. As this involved visiting a participant's home, measures were taken to safeguard myself. I arranged to telephone my sister following the interview and she was informed of the participant's address and advised to contact the police if contact had not been made within three hours.

2.2.6 Audio recording

With the written informed consent of participants, the interviews were audio-recorded for two main reasons. Firstly, to obtain an objective record of everything that had been said as words may have been missed or misinterpreted during the interview process. Secondly, recording allowed me to listen back to the interviews several times for the purpose of transcription and analysis of the data. Recording is now generally considered to be good practice in all qualitative interviewing (Hermanowicz, 2002). Without tape-recording, all kinds of data are lost: the narrative itself as well as moments of laughter and sighing. In particular, if the interview is understood as the site for the production of meaning and the role of the interviewer is to be analysed alongside the accounts provided by the interviewee, it is important to capture the details of the interaction (Elliott, 2005).

2.2.7 Transcription

Rather than understanding the transcription process as occurring prior to analysis, it is more appropriate to understand it as part of the analytic process (Gee, 1999; Silverman 1993; Wengraf, 2001). Indeed, analysis cannot be easily distinguished from transcription (Riessman, 1993). There was a movement back and forth between transcribing and developing understanding. It could be argued that the act of transcription is an interpretative practice, carrying evaluative connotations (Gergen, 1994). There are different ways in which an interview can be transcribed. As the current study was interested in not only the content but also the subtleties of communicative interaction between myself as interviewer and the interviewees, words as well as the way in which they were spoken were documented.

Each transcript was read in an active way, listening to the recording and rereading the transcripts to immerse myself in the data. The recordings were then transcribed verbatim. There was an attempt to preserve as much detail as possible from the conversation both in terms of words, paralinguistics and silences to add further clarity and accuracy. This included documenting false starts, repetition, non-lexical

utterances such as ‘umms’ and ‘errs’. Emphases in speech were marked by underlining words (e.g., he), capital letters were used to indicate an increase in volume (e.g., AND) and degree signs indicated a decrease in volume (e.g. °but°). Square brackets indicated when there had been other things going on such as [laughter] or a [sigh]. Furthermore, words I was unsure about were bracketed and empty brackets were used to indicate that a word was not heard e.g., (). An effort was made to create a comprehensive record of narrators’ words and actions to ensure that as little as possible was ‘lost in translation’.

2.3 Ethical considerations

The term ‘ethical’ is used to describe the issues that relate to the relationship between the researcher and the research participants and the impact of the research process on those individuals. Ethics has grown in importance over recent years in the social sciences. However, some of this growth has not been so welcome. A growth in the litigation culture, along with a growing paranoia about the fragility of humanity, particularly of older adults, may be reinforcing negative stereotypes. The following quotation captures my ethos about ethics throughout the current study:

The wisest know that the best they can do...is not good enough. The not so wise, in their accustomed manner, choose to believe that there is no problem and that they have solved it. (Malcolm, 1990, p. 162, as cited by Josselson, 1996).

My priority throughout the research process was the protection and safety of participants. Ethical considerations are a necessary part of the research process in order to consider and minimise any potential harm to participants (Parker, 1994). At the same time I was aware that it would be impossible to create a research project that eliminated all ethical dilemmas and issues. No formal, institutional code can resolve all ethical problems and no research design is ethically neutral. It was therefore felt that the most responsible course of action was to critically analyse the study and identify as many ethical issues as possible and address them to the best of my ability.

The study gained ethical approval by the Research and Ethics Committee of the School of Arts and Social Sciences at City University London (see Appendix 1, p. 191–195, for ethics release form) and all BPS ethical guidelines were adhered to,

including assuring participant anonymity, confidentiality and the right to withdraw from the study (Code of Human Research Ethics, BPS, 2010). No deception was involved in the research and there was no identifiable physical or psychological risk for participants. In the letter sent out by the charity, all participants received an information sheet outlining the aims of the study and their role in it (see Appendix 3, p. 199, for information sheet). During the screening interviews, it was explained that the data provided would be discussed with my research supervisor and therefore complete confidentiality could not be guaranteed.

2.3.1 Informed consent

Written informed consent was obtained, including permission to audio-record the interviews for transcription (see Appendix 4, p. 201, for the consent form). Informed consent indicates that participation is knowledgeable and voluntary and that participants can withdraw from the research at any time (LaRossa, Bennett & Gelles, 1981). Participants were informed of their right to withdraw their data from the research up to one week following the interview date, without having to provide a reason. Time was allowed for participants to reflect upon their involvement following the interview and decide whether they still wanted their data to be used.

Participants were informed that the primary aim of the study was not to gather information on the *content* of the counselling sessions but rather to find out how the *process* of counselling was experienced. In practice, participants did talk about the content of their counselling sessions. It appeared that they wanted to share their experience in context by explaining their reasons for attending counselling and disclosing some of the problems they were facing including the background to these problems.

Moreover, the effort to empower participants and the study of their responses as narratives were closely linked. They are connected through the assumption that one of the ways through which individuals make sense of and give meaning to their experiences is to organise them in narrative form. Mishler (1986) asserts that through their narratives people may be moved beyond the text to the possibilities of taking action. That is, to be empowered is not only to speak in one's own voice and to tell one's own story, but to apply the understanding arrived at to action in accord with one's own interests.

Indeed, one participant shared that the process of telling her counselling story had brought up questions about her marriage. She subsequently requested a copy of the audio-recording of the interview explaining that she wished to listen back to herself and review her decision to stay with her husband. She was therefore provided with a copy of the recording after she agreed that the copyright belonged to me and that the recording would be purely for her own use. This challenges the usual notion that research methods are neutral, that is, merely technical instruments for recording and describing reality that do not in themselves change reality. All methods have consequences. The form and content of interviews affect respondents in ways that we as researchers could never predict (Mishler, 1986).

2.3.2 Debriefing

During debriefing participants were invited to ask any questions they had following the interview. They were also asked how they felt following the interview, assessing whether they felt emotionally disturbed by the process. Participants were given a resource sheet with organisations they could contact if they experienced difficulties following the interview (see Appendix 6, p. 206, for the resource sheet). Fortunately, none of the participants showed signs of distress following the interview process.

In line with the Data Protection Act 1984, audio recordings were kept in a locked filing cabinet until the data had been transcribed to ensure participant confidentiality. Transcriptions were kept on a password-secure computer. Furthermore, pseudonyms were used in the report of this study to ensure anonymity. Participants chose their own pseudonyms. This was a small way of allowing participants more input into the research process.

Despite all the ethical guidelines in research, Brinkmann and Kvale (2008) caution against the practice of ethics as rule-following. Ethical dilemmas will surface throughout the research process, requiring the researcher to remain ethically attuned throughout. Instead of simply learning the ethical rules for the treatment of participants in psychological research, I strived to adopt ethical research behaviour by developing the ability to sense, judge and act in an ethical manner (Brinkmann & Kvale, 2008). This included using my skills as a trainee counselling psychologist to sense and respond to early signs of discomfort or distress during the interviews. The aim was to be ethically mindful at every stage of the research process from the conception of the research questions to the write up.

2.4 Explanation and rationale for narrative analysis

'Narrative analysis' is an umbrella term for methods of analysing a story from texts (Riessman, 2008). There are a wide variety of definitions of what constitutes a narrative and an equally wide variety of approaches to the analysis of these narratives (Riessman, 1993). Narrative analysis therefore comes in many forms, with different authors favouring different conceptualisations of 'a story' and having different foci of interest. For instance, Gergen regards the self-narrative as 'a linguistic implement constructed and reconstructed by people in relationships' (Gergen & Gergen, 1983, p. 156), whereas McAdams argues that it is 'the story is inside of us' (McAdams, 1993, p. 12).

Narrative analysis does not involve uncovering objective truth (Stephenson & Kippax, 2008). It operates on the assumption that the story becomes true because it is meaningful to the person telling it, rather than the story being meaningful because it is true. It could be argued that when people experience events in their lives, they try to make sense of them through the process of creating stories. Every method of analysis provides a different way of knowing phenomena, and therefore each leads to unique insights and knowledge. In narrative analysis, attention shifts to the details – how and why a particular event is storied and what this can reveal about the phenomena under investigation (Riessman, 2008).

2.4.1 Rationale for narrative analysis

In explaining my choice of narrative analysis in the current study I will refer back to the two research questions:

1. How do older women construct their decision to enter into counselling?
2. How do older women construct their experience of counselling?

Interest lay in eliciting stories of counselling in order to analyse *what* stories were told and *how* they were told. In other words, to answer the research questions, participants' stories were analysed in terms of content and structure. Narrative analysis was fitting as it investigates how and why events are storied, not only the content of the stories, in order to allow researchers 'to think beyond the surface' (Riessman, 2008, p. 13). The current study aimed to gain an insider's perspective of not only what was said, but also how it was said and why. This method of analysis therefore enabled me to ask various questions of the data and apply a range of

interpretative lenses to the narratives in order to fully answer the research questions.

There are no standard procedures for carrying out narrative analysis. However, Langdridge (2007), as well as Hiles and Čermák (2008), have formulated helpful guidelines. They recommend that the researcher apply a range of interpretative perspectives to the narrative. This means working through the text repeatedly, asking different questions of the data. Different methods have different strengths and weaknesses, so in deciding which model to use, I returned to my research questions for guidance. Having examined several methods of analysis including Frank's (2012) dialogical narrative analysis and McAdam's (1993) life stories narrative analysis, Langdridge's (2007) model of critical narrative analysis (CNA) was chosen. The next section explains this analytic method and its justification for use in the current study.

2.4.2 Langdridge's critical narrative analysis (CNA)

2.4.2.1 The process of CNA

Psychologist Darren Langdridge built primarily on the work of philosopher Paul Ricoeur to develop a model of critical narrative analysis. As Langdridge (2007) explains, Ricoeur sought to provide a framework for reading text that is built on the fundamentals of phenomenological philosophy while also engaging with hermeneutics. Ricoeur (1984) argues that in narrative, new meaning comes about through the synthesis of elements into a coherent whole. He claims that stories are constructed to make sense of our lived experience through the organisation of disparate elements into meaningful wholes.

Building on this, Langdridge (2007) translated Ricoeur's philosophy into a practical methodology, which applies phenomenological analysis to narrative accounts. Langdridge explains that his approach shares much in common with other forms of narrative analysis (such as that by Dan McAdams, Michael Murray and Donald Polkinghorne), but with some key differences. There is an emphasis on identifying narratives and examining them for function, tone and thematic content. Also, there is a 'critical moment' where the researcher employs imaginative hermeneutics of suspicion. Here the researcher moves beyond a simple focus on the apparent, and using critical engagement with a social theory, interrogates his or her own way of viewing the topic as well as the narratives.

Langdridge's model incorporates six stages, but he is keen to emphasise that none should really be seen as discrete. The aim of CNA is the synthesis of a variety of analytic tools, to better enable the analyst to work critically with the data and to shed light on the phenomenon (Langdridge, 2007). For this reason, the model is presented in the form of a circle, emphasising its cyclical nature and showing the potential for iteration. This cyclical process is demonstrated in **Figure 2** (p. 88). In the following section, the model will be presented as I applied it.

In Stage 1 'A critique of the illusions of subjectivity', a reflexive engagement formed the basis of analysis. This stage involved thinking through my background and experience and the impact this might have had on the questions being asked and the data that I helped produce (Langdridge, 2007). This entailed turning the hermeneutic, the method of interpretation, on myself first and foremost. Heidegger (1927) and Ricoeur (1981) both argue that even when we attempt to bracket our preconceptions we speak from somewhere. Langdridge (2007) emphasises the importance of recognising this in our research and how this must itself be subject to critique. This encouraged me as researcher to view my own subjectivity as inevitably involved in the research process and therefore important to reflect upon. The recordings were then listened to several times and impressions of what was going on for the narrators, for me, and between us as the narratives unfolded were noted.

Stage 2 of the model 'Identifying narratives, narrative tone, and rhetorical function' involved looking for distinct stories within the text, and identifying the tone and function. Tone is concerned with the overall emotional flavour of the narrative (Murray, 2003) for example, optimistic/pessimistic. I assessed the tone of each narrative from both the content of the stories and the style of narrativisation. Attention was also paid to shifts in tone throughout the stories. Langdridge (2007) explains that the tone may provide important insights into the meanings being expressed.

This second stage also involved identifying the psychological and social functions of the narrative, for example to justify, persuade, praise, criticise or to pass on a message. Furthermore, I searched for how particular narratives were drawing on wider cultural and generational narratives, and the implications of these for the story being constructed. Indeed, narrative researchers are increasingly committed to viewing narratives as forms of action (Wortham, 2001). The narrator actively constructs narrative reality to achieve particular descriptive ends. The factual

accuracy of the narratives therefore took a back seat to what was socially accomplished through storytelling (see Holstein & Gubrium, 2000; Lincoln, 2000).

Stage 3 of the model, 'Identities and identity work', involved an analysis of how the self was brought into the narrative. A narrative identity is a 'sense of selfhood for ourselves and others' (Langdrige, 2007, p. 130). Ricoeur (1991) believes that life is in search of a narrative. That is, our identities are constructed through the stories we tell. Hence, the self is brought into being through the stories we construct. Langdrige however, suggests that the narratives we have access to are limited by the world we inhabit, and therefore the identities we can construct are limited by the wider social context in which we live. As Ricoeur (1991, p. 437) eloquently states 'we learn to become the narrator of our own story without completely becoming the author of our life'.

Identity work involved examining how the six narrators presented their actions, values and opinions in ways that defined their identity. This stage therefore involved asking questions such as 'what kind of person does this particular narrative construct?' and 'how does this relate to the topic of counselling experiences?' This is echoed in Riessman's (2008) description of dialogical/performance narrative analysis in which attention is paid to how selves are performed for a particular audience. She suggests that we are constantly composing impressions of ourselves and projecting a definition of who we are that we test out with others.

Stage 4 involved identifying key themes and subthemes, and the relationship between them. Joffe (2012) suggests that a theme refers to a specific pattern of meaning found in the data. This stage is therefore named 'Thematic priorities and relationships'. Langdrige (2007) highlights the importance of not breaking down the text too much in this process. Instead the aim was to identify key themes without losing sight of the overall narrative. The text was therefore worked through line by line, paragraph by paragraph and notes were made in the margins of emerging key ideas. Following this, ideas were organised into clusters of meaning based on commonalities. After generating the clusters, the themes were worked through, and it was decided if they were distinct or whether they could be collapsed into one category. The text was returned to several times whilst I engaged in a cyclical process of refining categories and examining the relationships between them.

Stage 5 was the critical stage in which there was a critique of the text by subjecting it to a *hermeneutic of suspicion*¹ grounded in social theory. This involved seeking to identify ‘meaning hidden beneath the surface and in need of unmasking’ (Langdrige, 2007, p. 49). Langdrige (2007, p. 136) borrows from Ricoeur (1981) in highlighting that ‘we always have a view from somewhere’. Not only are we physically situated and contingent but also socially and culturally situated and contingent (Ricoeur, 1981 as cited in Langdrige, 2007). Langdrige argues that we can try to bracket off our preconceptions and recollect meaning from the text, but this will always be imperfect.

Finally, in Stage 6 ‘Synthesis’, all the stages were brought together to generate an overall interpretation to write up the findings.

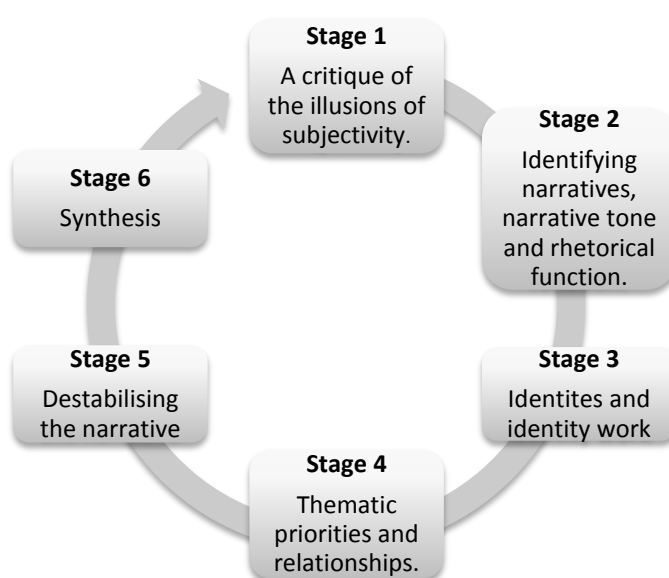


Figure 2: Langdrige’s (2007) model of critical narrative analysis

¹ A term coined by Paul Ricoeur (1970)

Exemplar

An exemplar segment of a participant's (Clare) transcript has been included in this section as a means to demonstrate how the data was coded and analysed. This particular segment was chosen as it includes a section which made it directly into the presentation of key themes in Chapter Three. This part has been included within the thesis in order to provide transparent evidence to the reader in regards to the process followed. This section is presented in two tables. **Table 1** below presents on the left hand side the segments of the transcript and on the other is the initial coding that was assigned to these pieces of data. The first phase of coding was conducted on a line-by-line basis which meant that I became fully immersed in the analysis of the data.

Table 2 represents the second coding phase in which the initial codes highlighted in **Table 1** have been reduced in order to make the most sense of the vast amount of data provided in the transcripts. This facilitated the categorising of data which led to the development of key themes.

Table 1: *Example of initial coding phase*

C: And you cannot love someone who is a bully...and I find that the only way to cope is to be detached, look upon him as a sad case really. We've been married twelve years, coming up thirteen this November and I've already made up my mind, if he gets beyond being able to look after, I will certainly get him into a home, I won't...I'm not going to have that stress. Erm he's not a loving person and I don't feel loving, he's killed any of that a long time ago, I don't feel loving towards him. It did hurt me to think what I'd done, married someone like him, made such a big mistake having been single	<ul style="list-style-type: none">- justification for not loving husband- detachment as a coping strategy- reaching caring limits-self-care in carer role-No loving feelings towards husband-Marriage was a big mistake
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<p>for such a long time and had opportunities but didn't want to settle down when I had the children.</p> <p>L: So there's a sense of regret of marrying your husband, a bully who you feel detached from?</p> <p>C: Yeah, but thank god I've got good friends to spend time with when I'm out of the house. I have a friend who's a counsellor, she lives a bit further out, bereavement she does mainly, but she has some health problems. We do meet occasionally but I don't go into anything really. I just feel she has so much on her plate. And I like to make a nice time of it really with her. I do tend to consider other people's feelings before my own sometimes. I'm very aware of doing that. I think it's perhaps not wanting to rock the boat or just to keep things pleasant. I think that's why I found talking to a stranger in counselling so good, I'd definitely recommend it to people, especially people like me who feel stuck; I made the decision to go, people shouldn't feel ashamed.</p>	<p>- children put before romantic relationships</p> <p>- good friends outside of the house</p> <p>-friend has own problems</p> <p>-doesn't want to burden her</p> <p>-puts others before self</p> <p>-wants to keep things pleasant</p> <p>-counsellor being a stranger is 'good'</p> <p>-would recommend counselling for others</p> <p>-challenges stigma of attending counselling</p>
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To further demonstrate and provide clarity in regards to the interpretations which were made, I will explain how I arrived at these codes by providing examples. The code '**detachment as a coping strategy**' was decided upon based on the following sentence, "*and I find that the only way to cope is to be detached*". In this sentence the words 'cope' and 'detached' were the main units of meaning that led to deciding on this code. The code '**puts others before self**' was based upon the following sentence, "I do tend to consider other people's feelings before my own sometimes".

The code **‘counsellor being a stranger is good’** was decided upon based on the sentence “I think that’s why I found talking to a stranger in counselling so good”. In this sentence the words “talking to a stranger” “in counselling” and “good” were the main units of meaning that lead to deciding on this code. The code **‘challenges stigma of attending counselling’** was based on the narrator’s use of the words ‘shouldn’t’ and ‘feel ashamed’. The remaining codes drawn from this segment of transcript have followed a similar process of interpretation.

After conducting this stage of the analysis, the early codes were grouped into key categories which formed the basis of the emergence of key themes. These are presented on the right hand side of the transcript in **Table 2** below. In this second stage, there was also an analysis of narrative tone, social or psychological function of the narrative, identity (i.e., how the self is presented and how the narrator draws on wider cultural narratives). For clarity and ease of understanding each of these interpretative lenses have been highlighted in a different colour. Analyses of these are presented on the left hand side of the transcript below.

Interpretative lenses:

Tone

11

Function

Figure 1

Identity

100

Drawing on wider cultural narratives

Table 2: *Example of second coding phase*

<p>Presents self as victim of bullying</p> <p>Determined tone</p>	<p>C: And you cannot love someone who is a bully...and I find that the only way to cope is to be detached, look upon him as a sad case really. We've been married twelve years, coming up thirteen this November and I've already made up my mind, if he gets beyond being able to look after, I will certainly get him into a home,</p>	<p>- detachment as a coping strategy</p>
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<p>Blames husband for her feelings</p> <p>Tragic tone</p> <p>Being a mother came first</p> <p>Shift in tone- becomes optimistic</p> <p>Sees herself as considerate/ selfless/ self-aware</p>	<p>I won't...I'm not going to have that stress.</p> <p>Erm he's not a loving person and I don't feel loving, he's killed any of that a long time ago, I don't feel loving towards him.</p> <p>It did hurt me to think what I'd done, married someone like him, made such a big mistake having been single for such a long time and had opportunities but didn't want to settle down when I had the children.</p> <p>L: So there's a sense of regret for marrying your husband, a bully who you feel emotionally detached from?</p> <p>C: Yeah, but thank god I've got good friends to spend time with when I'm out of the house. I have a friend who's a counsellor, she lives a bit further out, bereavement she does mainly, but she has some health problems. We do meet occasionally but I don't go into anything really. I just feel she has so much on her plate. And I like to make a nice time of it really with her. I do tend to consider other people's feelings before my own</p>	<p>-self-care as carer</p> <p>-Loveless marriage</p> <p>-children put first</p> <p>-good friends</p> <p>-doesn't want to burden friend</p>
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<p>Optimistic tone</p> <p>Advocates counselling</p> <p>Sees self as stuck</p> <p>Wider cultural narrative of feeling ashamed of attending counselling</p>	<p>sometimes. I'm very aware of doing that. I think it's perhaps not wanting to rock the boat or just to keep things pleasant. I think that's why I found talking to a stranger in counselling so good, I'd definitely recommend it to people, especially people like me who feel stuck; I made the decision to go, people shouldn't feel ashamed</p>	<p>-counsellor being a stranger is good</p> <p>-would recommend counselling for others</p> <p>-challenges stigma of attending counselling</p>
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From this example, the reader can see that the initial fifteen codes have been reduced down and the key codes are beginning to become established through the analytic process. This example of coding produces many different codes, however after the process of making categories and refining the analysis, not all of these codes are directly illustrated in the final overarching themes and subthemes. Instead they have been consumed by other more accurate and descriptive codes during the development of categories. One specific section from this transcript did make it directly into the results section as a quote to support a theme:

“We do meet occasionally but I don't go into anything really. I just feel she has so much on her plate. And I like to make a nice time of it really with her. I do tend to consider other people's feelings before my own sometimes. I'm very aware of doing that. I think it's perhaps not wanting to rock the boat or just to keep things pleasant.”

This quote is used in Chapter Three of the thesis to demonstrate the theme of 'Burdening others', which is a subtheme of the overarching theme 'Keeping up Appearances'. In this section the narrator refers to not wanting to burden her friend with her own emotional problems. She was concerned that her friend had enough of her own difficulties and felt that by disclosing her marital problems she would be overwhelming her thus preferred to 'keep things pleasant'. Furthermore, the narrator felt that she was in an unhappy marriage that she had chosen to stay in and

therefore could not justify burdening her friend with her troubles. Woven through the presentation of the key themes and subthemes in Chapter Three will be a discussion of the narratives' tone, function, presentation of self and how wider cultural discourses influenced the stories told.

2.4.2.2 Justification for the use of CNA

The rationale for choosing Langdridge's CNA in the current research is fourfold. Firstly, there is an in-built reflexive stage (Stage 1). The model encouraged me to look at my preconceptions about the topic of older women and counselling. As a trainee counselling psychologist and qualitative researcher this appealed to me, as reflexivity is valued both in terms of clinical practice and research. Reflexive engagement is arguably an integral part of qualitative research, as this involves subjective interpretation of the data inevitably influenced by the researcher's position and status.

My position as a trainee counselling psychologist and young, white woman would have inevitably influenced my behaviour in the research interviews, and my interpretation of the data. It was therefore important to choose a method of analysis that would encourage me to reflect upon my own beliefs, assumptions, background, experience, and characteristics, and how they may have impacted on the research process. Reflexive engagement was particularly pertinent in the current study as I had first-hand experience of conducting counselling with older women, and therefore inevitably had preconceptions about the attitudes older women have towards counselling and their engagement with it.

Secondly, this model encourages the researcher to investigate how particular narratives draw on wider cultural narratives and the implications of these for the stories being constructed (Langdridge, 2007). This was congruent with the study's epistemological position of contextual constructionism, which assumes that all knowledge is necessarily contextual and standpoint-dependent. Contextual constructionism assumes that human activity does not happen in isolation but rather in the context of a socio-historical and cultural environment. As Jaeger and Rosnow (1988) highlight, human actions are embedded in a context of time, space, culture, and the local tacit rules of conduct.

Drawing on wider cultural and generational narratives was particularly relevant to the current study. Wider cultural and generational narratives of older age, emotional distress and psychotherapeutic input could be significantly influential in peoples'

engagement with therapy, both in terms of their decision to enter into counselling and their experiences of the counselling process. Arguably, psychological counselling is a western concept, influenced by wider narratives of the medical model (Jensen, 2006). Therefore, the sociocultural discourses around what counselling entails, is likely to impact on how it is used.

Thirdly, it is important to highlight that Langdridge's model includes aspects of other methods of narrative analysis, but its key distinguishing feature is the inclusion of a 'critical moment', where an attempt is made to interrogate the text, using aspects of social theory as a hermeneutic of suspicion. This makes this method of narrative analysis particularly suitable for researchers interested in conducting work on topics which are embedded with issues of power and politics (Langdridge, 2007).

As the focus of the current study was on the stories of older former clients' decision to enter into counselling and their stories of counselling, it suited this method. Older people are arguably a marginalised group in society, particularly in terms of receiving mental health interventions (Pilgrim, 1997; Wolpert, 2011). As highlighted in the introductory chapter, depression and anxiety in older people continue to be under-recognised and under-treated in primary care settings (Goudie, 2010; Murphy, 2000; Pilgrim, 1997; Wolpert, 2011), with possible ageism amongst healthcare professionals affecting referral rates (Ford & Sbordone, 1980). Indeed, older clients are underrepresented in the caseload of many counsellors (Goudie, 2010). Older people are often overlooked by therapists in comparison to younger adults. Furthermore, older adults are often considered by professionals to be fixed in their functioning and thus lack the capacity for change (Pilgrim, 1997).

Fourthly, Langdridge's model allowed me to gain an overall view of the topic to see what participants talked about rather than focusing on one particular aspect of the narrative. CNA enabled the exploration of different facets of the topic, by applying several interpretative lenses to highlight what may be important to know and what may be important for future research in the area of older women and counselling.

2.5 Reflexivity

During transcription, I found myself listening to certain segments several times before every word could be deciphered. Although frustrating at times, as Riessman (1993) suggests, the laborious task of transcribing allowed me to start thinking about how the data could be analysed. Whilst transcribing the interview data, I kept a notebook of my own thoughts, impressions and memories of the interactions. This information proved to be helpful when formally engaging in analysis.

Three invaluable resources were used in conducting this study. Firstly, I kept a reflexive journal of my emotions, thoughts and impressions immediately following each research interview. This was useful in jogging my memory of each narrator and their story when writing up the study. In particular, it was helpful in recalling the emotional impact each narrativisation had on me, information that was subsequently used during analysis to interpret the function and tone of each story.

Secondly, halfway through the project a fellow trainee and I decided to set up a 'thesis update' email group, which another three classmates joined. The group was used for each member to set individual weekly thesis goals and report back on progress. This proved to be incredibly useful in providing extra motivation, emotional support and helped reduce feelings of researcher isolation.

A third valuable resource was attending talks and presentations at the Thomas Coram Research Unit on narrative approaches to research. These were organised by NOVELLA (Narratives of Varied Everyday Lives and Linked Approaches), which is a national centre for research methods node. This is a platform on which researchers from various disciplines, present and discuss their narrative research. This provided an invaluable insight into a narrative orientation to making sense of data which gave me the opportunity to clarify my understanding of ways to carrying out narrative analysis. The centre also enabled me to be part of a narrative research community by facilitating meetings with like-minded researchers and sharing ideas.

Attending these talks encouraged me to engage more deeply with reflexive analysis. Reflexive analysis is a means by which the researcher acknowledges the centrality of their position in influencing the research process and its interpretations (Alvesson & Sköldberg, 2000; Finlay & Gough, 2003; Parker, 1994; Willig, 2013).

The following personal reflexive account is an attempt to tell my own story and the influence it may have had on the research process. In doing so, three key questions will be addressed (derived from Willig's (2013) definition of personal reflexivity), in order to explore the aspects of my identity relevant to this research:

1. Who am I as a person?
2. Who am I in relation to the research topic?
3. Who am I as a researcher?

1) Who am I as a person?

In answering this question I will draw upon my background, values and beliefs. I am a 28-year-old female, British-Greek trainee counselling psychologist at City University in London. Originally from Manchester, I have lived in both the UK and Greece. It is my impression that in both countries, stigma around mental health problems and seeking professional help is still prevalent. I feel proud and privileged to be part of a profession that humanises emotional distress and helps people develop curiosity in themselves to ultimately uncover what is personally meaningful.

As a trainee counselling psychologist the relationship I form with clients and attention to process is central to my work. My aim is to facilitate a space for my clients' voices and stories to be heard, mindful that some stories may be told for the first time in therapy. This aspect of my professional identity permeates across all areas of the research, and thus illustrates the personal significance of counselling psychology values included within the study.

2) Who am I in relation to the research topic?

My interest in older people and counselling began whilst working as a support worker in a private care home during the summers of my psychology undergraduate degree. In the under-stimulating environment of the care home, I found that the residents would openly tell me stories of their lives and about how they were feeling. Unfortunately, many would have no-one else to talk to as visits from relatives became increasingly sparse. At the time, none of the residents were offered (or were even aware of) counselling despite some clearly struggling emotionally.

A few years later, during my MSc in Psychology I chose several counselling-related modules (counselling skills, introduction to CBT, counselling and psychotherapy)

which I thoroughly enjoyed. Alongside studying for my masters, I worked as an assistant clinical psychologist on a stroke ward. Part of my role was conducting therapy for post-stroke depression and anxiety, mainly with older adults due to the higher prevalence of stroke in this age group. For some, therapy was unfamiliar but many patients would soon use the therapy to help with not only their adjustment to life after stroke but also to talk about other, long-standing aspects of their lives. This highlighted for me that for many older people, their first contact with psychological therapy is following a physical impairment and is often by chance. I was fortunate to work on one of the few stroke wards in the UK that offered regular counselling.

3) Who am I as a researcher?

In terms of my identity as a student and researcher, I graduated in 2006 with a BA in Psychology and went on to complete an MSc in Psychology in Manchester. Whilst completing my masters, I worked on a stroke ward that had recently introduced a peer support group for in-patients. This was the first of its kind in the UK and so I chose to investigate the group for my masters' dissertation. Qualitative methods were employed to interview members on their lived experiences of the group. Qualitative methods and the ethos of counselling psychology are highly compatible with my personal values and belief system, and for me personally, is a far more satisfying means of conducting research as rich material is generated.

My age, gender, academic background and work experience will all have inevitably influenced the interview interactions as well as the interpretation and analysis of the data. Taking each of the aforementioned personal aspects into account, I am aware that the research study is simultaneously (and paradoxically) restricted and liberated by my outlook, experiences, skills and background.

3. Chapter Three – Narrative analysis

Overview

This chapter presents the findings obtained through a critical narrative analysis of the interview data. There are three parts to the chapter which represent a synthesis of the findings obtained. Part 1 is a reflexive critique of my own subjectivity in relation to the topic, which was foundational to data analysis, as explained in the methodology chapter. In Part 2, following Langdridge's (2007) recommendation, the six narrators and their narratives will be introduced. This forms part of the analysis that Langdridge refers to in Stage 2 of his Critical Narrative Analysis as 'identifying narratives'. Although it was important to highlight the heterogeneity of individual experience in the six narrative accounts, there were overarching themes that wove through the six narratives. In Part 3, these themes will be presented, including a discussion of tone, function and how identity is presented in relation to each theme. Interwoven in the presentation of these themes will also be an analysis using social theories of age and generation as 'hermeneutics of suspicion'. Knight's (2004) contextual, cohort-based, maturity, specific challenge (CCMSC) model and Erikson's (1982) psychosocial theory of development described in the introductory chapter will be drawn upon as interpretative lenses to uncover 'meaning hidden beneath the surface' (Langdridge, 2007, p. 49).

3.1. Part 1: A critique of the illusion of subjectivity

In contemplating writing this reflexive engagement, it was helpful to remember Ricoeur's words 'we always have a view from somewhere' (Ricoeur, 1981, as cited in Langdridge, 2007) in relation to our research topic. This encouraged a reflection on my own motivations, positioning and thoughts around the topic of older women and counselling and how this shaped my listening and questioning. It was important to make explicit my thoughts about the topic prior to analysis as these would have inevitably influenced my interpretation of the data and the subsequent knowledge produced.

Throughout the research process I became aware of my motivation to 'give voice' to what I considered a marginalised group in society, particularly in terms of receiving mental health services. This view developed both from a literature review on the

topic as well as from my personal experiences of working with older adults in varied contexts. As a support worker in a care home and as an assistant psychologist on an NHS stroke ward, I witnessed many older people struggle emotionally and this being dismissed as 'normal' due to their age. This attitude is represented by the loss-deficit model of ageing which views fragility, illness and emotional distress as a natural consequence of older age (Knight, 2004; O'Leary & Barry, 2006). It is my belief that this attitude is dangerous as older people are unlikely to seek help for emotional and psychological distress if there is an assumption that distress should be accepted as an inevitable result of older age. If these views are adopted by healthcare professionals and internalised by older people, individuals over the age of 65 may miss out on mental health care. This in turn could lead to deterioration in their emotional and psychological wellbeing.

Whilst motivated by 'giving voice' to older people, I was mindful of not positioning these individuals as 'vulnerable' or 'fragile' and in need of protecting, as suggested by the loss-deficit model. This would have been patronising, inaccurate and feeding into ageist stereotypes. In exploring my attitudes, I realised that I was theoretically drawn to Knight's (2004) CCMSC model. The model emphasises that older age is potentially a period of great satisfaction with people drawing strength from factors such as life experience. This theory of older age resonates with my own beliefs, particularly in challenging the view that emotional distress in later life should be accepted as the norm.

This made me wonder about the impact this attitude might have on the way I planned to interpret the data. Would I subconsciously focus on the positive experiences of participants' counselling stories? Would my function be to advocate counselling for older women? Once I became aware of the risk of my motivations obscuring my view of individual's stories, I tried to diverge from adopting such a strong position. Instead, an attempt was made to 'bracket off' (as much as possible) my own polemic views to really hear the stories being told.

Mindful that stories are always crafted for an audience (Parker, 2005), I wondered what version of their stories narrators presented to me. As Parker (2005) highlights, what is of interest is not if participants have told us their 'real' story, but what version they have chosen to tell us and why. With this in mind, I wondered how my presence as a white, trainee counselling psychologist in my twenties and having worked for the mental health charity influenced the construction of stories. Perhaps I was positioned by narrators as being affiliated with or even representing the charity

or counselling profession and therefore seen as biased. This may have inhibited the narrativisation of negative aspects of experiences or feelings towards the counsellor.

3.2. Part 2: Introducing the narrators and their narratives

In this part, an overview of each narrator's unique story will be presented which includes contextual details of the narrators. This constitutes the 'identifying narratives' part of the analytic process as outlined in Stage 2 of Langdridge's (2007) CNA model. It is also hoped that providing contextual information on each person will help place the narrative into a wider socio-historical context. In presenting each narrative account, the main themes, functions, tone and issues of identity will be discussed.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

3.3. Part 3: Synthesis

This section examines the three overarching themes and corresponding subthemes which emerged across the six narratives. Woven through the presentation of these themes will be a discussion of tone, function and identity. Furthermore, Knight's (2004) CCMSC model and Erikson's (1982) psychosocial theory of development will be used as interpretative lenses. This highlights the influence of the social context whilst still remaining true to the phenomenological perspective of each narrator (Langdridge, 2007). The aim was to present the themes whilst privileging the voices of the narrators thus not losing sight of each narrator's story. For this reason, extended narrative extracts of narrators' voices as well as my own have been included. These are interspersed with my interpretations. For clarity and to concisely illustrate the study's main findings, the following diagram, **Figure 3**, outlines the overarching themes and corresponding subthemes which emerged from the analysis. The three overarching themes have been viewed as independent of each other and will therefore be examined separately below.



Figure 3: Overarching themes and corresponding subthemes

3.3.1. Expectations

This overarching theme illustrates narrators' expectations and preconceptions of counselling and how these influenced their decisions to enter into counselling. The subtheme of *Influence of cultural attitudes* illuminates how perceived cultural attitudes towards seeking professional help shaped the narrators' beliefs about what it meant to engage in counselling and what counselling entailed. The subtheme of *Influence of generational factors* sheds light on how generational perspectives towards mental health problems and seeking outside help were embedded in the psyches of some of the narrators. Narrators described how their family backgrounds influenced their attitudes towards expressing emotion and their hesitancy in taking up counselling. Narrators compared their expectations to their experiences of counselling.

3.3.1.1. Influence of cultural attitudes

It was evident that the narrators' ideas about entering into counselling were heavily influenced by perceived cultural attitudes towards mental health problems and seeking professional help. Half of the narrators expressed an apprehension in attending therapy. They described feeling either cynical or hesitant largely based upon preconceptions which were attributed to negative cultural attitudes and beliefs about seeking professional help. In narrating the decision to enter into counselling, Macy highlighted what she considered the British cultural attitude towards the word 'counselling'. This made her question whether she should give herself permission to accept professional help:

Lydia: Could you tell me the story of your decision to enter into counselling in the first place?

Macy: Yes, first of all it is a dirty word, you know

Lydia: Mmm

Macy: WE'RE BRITISH FOR GOD'S SAKE, PULL YOURSELF TOGETHER!

Macy's immediate response to my question was to state that counselling is a "dirty" word, suggesting it is a taboo subject in our culture. This implies a social stigma towards seeking counselling which was evident in Macy's narrative. The stigma associated with counselling could perpetuate feelings of shame in seeking out professional help. In narrating her decision to enter into counselling, Macy expressed her hesitance and attributed this to a perception in British culture that seeking professional help is indicative of being "weak" as we "should" be able to manage life's challenges. She related this to ideas about being "British", suggesting an emotional reticence. Perhaps this also suggests that there is a dominant cultural narrative that by being British one should be self-sufficient and have the ability to problem-solve autonomously.

Macy's voice is loud, as indicated by the capital letters, suggesting the forceful tone of this command. Direct speech is also used, as though she is adopting the voice of society or British culture. This could also reflect the voice of people she knows. For example, elsewhere in her narrative Macy tells a side story of her neighbour instructing her to "just pull yourself together":

"And there's still a lot of that about [laughs], our next door neighbour's a bit like that. We've had a succession of horrid things happen, you know, contemporaries dying of cancer, our son's marriage breaking up, you know whatever and she said '*Just pull yourself together!*' I'd give anything to pull myself together! What do you think I don't..."

Macy expressed the frustration and lack of empathy felt when given this advice. The last sentence tails off perhaps indicating exasperation in speech, possibly making it difficult for her to bring her experience to language. The tone was exasperated as Macy highlighted the unhelpfulness of such advice and the pressure she felt to be able to cope alone with emotional distress.

This cultural attitude towards life's adversities and emotional distress was presented as negatively impacting on her expectations of counselling. There was an expectation that her counsellor would also tell her to "just pull yourself together". Direct speech is used to illustrate her anticipated response from her counsellor:

"NOW WE KNOW ABOUT THESE THINGS, AND FOR GOD'S
SAKE YOU KNOW YOU'RE PROBABLY GOING BATTY
ANYWAY BUT DON'T WORRY, and I was terrified."

This captures Macy's internalised soliloquy (Athens, 1994; Ezzy, 1998) referring to conversations one has with oneself or imagined others. Macy's adoption of the anticipated voice and tone of her counsellor is loud and authoritative. There was an expectation that her counsellor would take on the position of 'expert', prescribing solutions and telling her she is "probably going batty". This suggested that she would be seen as "mad" or "demented", a fear that is referred to elsewhere in her narrative. There may also be an assumption that one must be "batty" to be referred for counselling.

Macy revealed the medicalised associations she had had of counselling, perhaps reflecting the dominant medical tone of dealings with older adults in healthcare (Patrick, 2006).

"It was unexpected. Because, I thought it was going to be white coats []
And there was this pretty young thing, very relaxed, actually interested to
help [] and the ambiance of the room was lovely."

Macy expressed surprise that her counsellor was not wearing a "white coat", attire that is usually associated with a medical doctor. Instead, she was met with someone who was "relaxed" and "interested to help", suggesting a more human, personable experience. Her narrative also highlighted the importance of the physical environment of the counselling room, describing it as unexpectedly "warm, welcoming and not exerting itself". This helped reduce initial feelings of anxiety.

Macy's expectations of counselling were largely negative and based on cultural misconceptions about the meaning attached to therapy and what the process entails. Relatedly, Emily's narrative highlighted a lack of knowledge around counselling. She suggested that more education is needed to improve understanding of counselling services. Her proposed solution was for free counselling to be offered to the public at least once:

Emily: I think at least once in life people should have counselling and it should be free for them to realise that it is important and also for them to have more knowledge of it.

Lydia: Why do you think it's important for everyone to have counselling?

Emily: Because everybody has issues, everybody has problems; life is not easy, and people, you see some people are ignorant and some people are unaware of things. I think people should have, I don't know how to put it, but for people to recognise what counselling is. And then it's certainly their choice, to do it or not. But it should be offered at least once.

One of the functions of Emily's narrative was to advocate counselling and pass on the social message that it is a valuable service that everyone, regardless of financial status, should be offered. She used her own positive experience to promote counselling for others. Life as difficult was normalised but emphasis was placed upon the element of choice people should have in taking up therapy.

3.3.1.2. Influence of generational factors

All six narrators were born during or soon after World War II. Generational attitudes towards discussion of mental health problems and seeking help were interwoven through the narratives. As Knight's (2004) CCMSC model suggests, it is important to understand the values and attitudes of the cohort individuals belong to. This may impact on beliefs regarding mental health, seeking professional help and expectations of counselling, including the role of the client. With Knight's model as an interpretative lens, I was mindful that counselling is a relatively new concept and was not easily available when the narrators were young. The era in which individuals grow up, become adults, and establish careers and families exerts a shaping influence that interacts with other personal characteristics to affect the perception of psychological distress and of mental health treatment (Knight, Kelly, & Gatz, 1992). Narrators spoke about expectations of self-sufficiency and learning to hide or avoid undesirable emotions. Particularly during childhood and adolescence, narrators referred to a sense of shame and feeling of inadequacy in openly expressing emotional or psychological distress. These beliefs were linked to narrators' ambivalence about accepting counselling. Macy attributed her doubts about the efficacy of counselling to generational attitudes:

“I thought, if I go, I might think it’s an old lot of hogwash or whatever [] I suppose I’d been indoctrinated by a generation of you know ‘pull yourself together’.”

She attributed the expectation that she should be able to cope alone to being “indoctrinated” by her generation. This perhaps highlights the perceived power of generational attitudes on personal beliefs. Again, she referred to the pressure to “pull yourself together” which was repeated with a tone of frustration throughout her narrative. Despite these negative expectations of counselling, Macy was prepared to “give it a go” and discover for herself whether benefit could be gained.

The narrativisation of the significance of generational factors and more specifically cohort differences also formed a large part of Kate’s story. Whilst disclosing feeling like an “outsider” amongst her ex-colleagues, Kate highlighted the difference in culture and attitudes between wartime babies such as herself and the post-Second World War baby boomers:

“I’d had children early and these were people for whom the pill had come along and you could live together, and you didn’t have to be married.”

As Knight (2004) suggests, rich sources of material for understanding older adults ideas about self and others include their perceptions of the historical events that influenced their life and what values were important to members of their cohort, as opposed to those born earlier or later.

Kate: I think for a lot of older people, there might be two things, we weren’t demonstrative, you didn’t let your feelings out so people in my age group, but not the decade later.

Lydia: So for your generation?

Kate: For my generation, you didn’t cry at funerals you maintained your dignity, you didn’t run to the state to help you out if you got yourself in financial difficulties, you were self-sufficient. [] And now there are two generations of people who have never needed to have that level of self-sufficiency because the state has been there.

Kate explicitly stated her perception of the differences between generations in attitudes towards emotional expression and seeking outside support. This difference in attitude impacted upon her sense of being understood by her younger counsellor. She doubted whether someone who was “decades younger” could empathise with her 50 years experience of caring for a disabled child.

Some of the narrators compared their experiences of counselling to their childhood backgrounds. They spoke of how their upbringing influenced their attitudes towards seeking help outside of the family and expressing emotion. A lack of understanding of mental health problems whilst they were growing up was highlighted. A large part of Macy’s narrative was dedicated to explaining this connection. Her narrative takes on a tragic tone as she narrates the story of how the Second World War prevented the development of a bond with her solidier father:

“My father was away for most of the war. I was born in the middle of it. [] Until 1946 I didn’t see him until I was practically four [] and we never, ever developed a relationship. He hadn’t a clue how to talk to a small child [sighs].”

Macy’s narrative explained how the wider socio-political situation she was born into impacted upon her upbringing. As Knight (2004) suggests, it is important to understand individuals’ experiences and meanings attached to World War II and how this may have shaped an understanding of their background, themselves and their distress. Macy believed that due to the war, her father was physically and emotionally absent. This meant that her emotional needs were not fully met as a child. Her father was described as stern, expressing little emotion. Her mother was portrayed as overcompensating for the “horrors of the war” and her father’s absence by becoming overprotective of her:

“I wasn’t building bravery into my life, because she protected me too much, quite understandably. [] Through counselling I could see my mother’s strong love but it was a bit suffocating.”

Macy expressed using counselling to formulate her problems. Having had a “suffocating” mother, Macy believed that she did not learn to be brave and take risks in life. Macy told a tale of not being understood by her parents and attributed this to a generational attitude of not speaking of the anxiety and depression she suffered from:

“My mother and father [] didn’t stand a chance of understanding it because it wasn’t allowed, nobody had addressed it, you know, I was seen as weak, and he [father] didn’t know how to handle it. And my mother knew to encourage my lack of confidence, he [father] found it difficult and thought she was bowing to my inadequacies. He thought I needed to pull myself together! And the one thing I wanted to do is pull myself together!”

Macy emphasised a generational attitude towards mental health problems by claiming they were not “allowed” to be shown whilst she was growing up. As a result she was viewed as “weak” and inadequate. There was a belief that her father thought she should have been able to manage her emotions. The intolerance of emotional expression demonstrated by her father formed part of the ambivalence towards engaging with counselling. Elsewhere in the narrative, Macy explained that counselling helped her to better understand her parents and appreciate how their own generational values shaped their attitudes towards mental health issues and expression of emotional vulnerability.

At the same time, Macy acknowledged that beliefs about mental health and emotional expression have progressed:

“So, in the end, I still didn’t want to do it because still my father’s attitude was there but I actually had a smoother path, it was all the rave by the time I got to it! [laughs].”

There was an acknowledgement of a change in wider cultural perceptions of counselling which played a large part in her decision to enter into therapy. By stating it was “all the rave”, Macy implies that there was an emerging discourse of acceptance in seeking counselling when she was considering it:

“So, by the time I got to think about going, I still had a bit of my dad in me ‘Oh pull yourself together’ and I was aware then that things had changed, because there used to be the mentality of ‘they’ll just talk a lot of daftness to you’ and that they [counsellors] were freaks.”

Whilst acknowledging the influence of her father’s discouraging attitude towards seeking support, Macy was mindful that there was no longer a discourse of illegitimacy around counselling. Related to her previous expectation that counselling might be an “old lot of hogwash”, she was able to state that perceptions of

counsellors as just talking “daftness” and being “freaks” was an outdated perspective.

“But you’ve actually become far more important, because a lot of people are carrying a lot of depression I’ve come to the conclusion.”

Macy revealed her relatively recent recognition of the prevalence of depression and counsellors’ important role in this. Kate’s narrative also referred to the lack of emotional expression whilst growing up as a “wartime baby”:

“I wasn’t cuddled as a child. My mother was a good, kind, stern Christian woman and we didn’t do demonstrative.”

It was evident from Kate’s narrative that expression of emotional vulnerability was unfamiliar to her, having been brought up in a family environment in which undesirable emotions were suppressed. Kate’s use of the word “we” suggests that this restraint of emotional demonstration was the family norm. She related her family’s attitude of ignoring difficult emotions to describing her family’s response to her disabled son:

“Yes, as I say his father rejected him. My mother was OK but she wouldn’t discuss his difficulties because she was of a generation where you didn’t have people in the family who weren’t quite 100% intellectually so that was never discussed.”

Despite single-handedly caring for her disabled son and struggling emotionally, her expectation of herself to be self-reliant and “a copier” had been embedded in her since childhood. Suppressing her emotions and projecting an outward image of managing had become ingrained. This surface image of coping emotionally is discussed in the following section.

3.3.2. Keeping up appearances

This overarching theme illustrates narrators’ projection of an image of emotional well-being and “coping” with life’s adversities. The women spoke about how they had emotionally isolated themselves by presenting a façade of not needing support. Vulnerabilities, fears and emotional distress were often hidden from family and friends. The subtheme of *Maintaining an image* refers to narrators’ stories of upholding an outward image of wellbeing and coping whilst internally suffering.

Hidden vulnerable parts had not been shared due to shame or fear that others would not understand their problems. Some narrators spoke about having shaped an identity of strength and resiliency. They feared that this identity would be lost if their struggle was revealed. In some cases this was linked to generational attitudes of self-sufficiency and independent problem solving. The subtheme of *Burdening others* illuminates how one of the functions of emotionally isolating oneself was to avoid impinging upon family and friends. This was linked to some narrators' decisions to engage with counselling as they chose to confide in a counsellor rather than "burden" family and friends.

3.3.2.1. Maintaining an image

Knight's (2004) CCMSC model highlights the importance of older people's social context and environmental realities when attempting to understand their difficulties. Kate's social reality for the majority of her life had been to prioritise caring for her disabled son. She revealed the discrepancy between her internal and external states:

"I staggered on through this life of mine, feeling that I've appeared to cope but also [brief pause], I should say knowing that I appeared to cope °feeling that I hadn't really°."

Kate corrected herself by emphasising that she knew she had given others the impression that she was coping. Her voice became quieter at the end of this sentence and took on a more reflective tone. My interpretation was that admitting that she had not been coping was still something she was adjusting to. Kate revealed that her identity as a strong, autonomous mother was challenged when she began seeking professional help. Yet, the fear of reaching crisis point overrode this. She subsequently decided to seek professional support: "Instead of suppressing it, I let it show." Although Kate was able to allow herself to be supported by professional services, she still felt the pressure to maintain her constructed identity with family and friends:

Kate: And it's too late now for me to present any other me to people who have known me for 10, 20, 30, 40, 50 years.

Lydia: Mmm

Kate: Because they'd think, you know [pause]

Lydia: That's how they see you? You feel the need to keep that going?

Kate: Yes, maintain that.

Lydia: Maintain that perception?

Kate: Up to a point, I don't actually care if people see, what you might call a softer side of me, but I don't want to be taken advantage of.

Kate claimed that it was "too late" to change the perception people had of her, implying that they would struggle to adjust to seeing her in a different light. Kate's narrative described the development of a "softer side" to her identity following counselling, allowing her to get in touch with her vulnerability and letting her feelings show. However, here she expressed her concern that by showing this side to others she could be taken advantage of. It appears that Kate's belief was that letting down her guard and allowing others to see her pain might open her up to exploitation. Perhaps her identity of self-sufficiency and pattern of concealing emotions functioned as defenses against manipulation from others.

Clare was also concerned about revealing another facet of herself, which would mean her friends seeing her in a different light:

"I'm quite a strong person, I don't think they like to see me needy, needing somebody so it's best to keep out. [] Sometimes they don't want to know you have problems."

It is implied that her friends see her as a strong person which she identified with. However, Clare assumed that her friends did not want to see her as "needing somebody". This appeared to serve the function of justifying her choice to maintain the image of coping. In the context of her wider narrative, this resulted in emotional isolation. Clare reflected upon her pattern of not allowing her true self to be seen:

"I find when I'm down, I don't reach out, you become inward and it's afterwards you think, 'well why didn't you phone so and so?'"

Emily also spoke about her reluctance to let herself be known:

"I'm a very open person but it gets to the point when I don't talk to people a lot about my situation, it's not their fault."

Emily takes responsibility for presenting an image of managing and therefore not allowing herself to be supported by others. She claimed that although she is an “open person”, disclosing her daughter’s and her own mental health problems is particularly difficult and therefore often avoided.

3.3.2.2. Burdening others

Some narrators felt the need to ‘keep up appearances’ of coping due to worry about burdening family and friends with their problems. There was a sense of guilt in unloading their troubles onto loved ones, which was constructed as selfish. Using Knight’s (2004) model as an interpretative lens, the social context of the narrators and how this was brought into the narratives was considered. Emily revealed that although she lived with her youngest daughter, she did not want to burden her:

“I live with my other daughter, but I don’t want to overwhelm her, she’s young, she’s 27 and she’s been through quite a lot.”

Despite there being times when Emily felt overwhelmed, her priority was to protect her youngest daughter. In the context of Emily’s narrative, it is clear that, as a mother, she felt guilty for not being able to “fix” her eldest daughter’s mental health problems. Believing that she had “failed” one daughter, she strived to shield her youngest child from her own emotional distress.

Clare also spoke about not wanting to burden others whilst describing meetings with a friend:

“We do meet occasionally but I don’t go into anything really. I just feel she has so much on her plate. And I like to make a nice time of it really with her. I do tend to consider other people’s feelings before my own sometimes. I’m very aware of doing that. I think it’s perhaps not wanting to rock the boat or just to keep things pleasant.”

It is evident from Clare’s narrative that she puts other people’s needs before her own. Being in an unhappy marriage, time with friends was precious and therefore treated as an opportunity to have a “pleasant” time. This meant that she avoided disclosing her husband’s abusive behaviour and her consequent feelings of depression to friends. My interpretation was that there might have been elements of shame or fear of judgement from others. For Clare, it was less complicated to ‘keep

up appearances', pretending that she was happy. She felt that it was a bad situation she had chosen to stay in and therefore could not justify burdening others.

3.3.3. Taking opportunities

This overarching theme related to narrators' expressions of feeling they were presented with opportunities both to engage in counselling and opportunities within the counselling process which they took advantage of. The subtheme of *Gatekeepers* illuminates the narrators' access to therapy and the people or services influencing this decision. For some narrators, their GPs were presented as pivotal characters in their access to counselling although antidepressants were offered as a first resort. Although four out of the six women self-referred to the charity, their decision to do so was heavily influenced by other services. The subtheme of *Listening to oneself* refers to narrators' constructions of counselling as an opportunity to focus on hearing one's own thoughts, without outside voices impeding. The subtheme of *Control and responsibility* focuses on the narrators' constructed identities from passive patients at the start of counselling to emerging active agents of change.

3.3.3.1. Gatekeepers

In the current study, gatekeepers are understood as being people or services that have control of individual's access to counselling. This could be through the information they hold which is disseminated to others or through their act of referring to psychological services.

In narrating their decision to enter into counselling, two of the narrators reported accessing counselling through their GPs. Their GPs were presented as key characters in their stories, influencing their attitudes and ideas about their mental health concerns and informing them of the availability of counselling. Macy was worried about approaching her GP regarding her depression and anxiety as she feared being viewed as "demented":

“Well, my great fear is that the doctor will say ‘well actually she’s demented’ and this worried me to bits, you know, I’m actually going potty.”

Developing dementia or “going potty” was a concern Macy had and feared it being confirmed by her doctor. Elsewhere in the narrative, she revealed that she was

convinced that her doctor would think she's "completely bats" which increased her anxiety and meant that she postponed approaching her GP for weeks. It was evident that there was a discourse about being written off as "demented" and Macy feared the consequences of this. Despite this worry, Macy's despair and subsequent need for support took precedence, thus she finally decided to approach her GP as a first point of contact:

"I went to him and said you know, chin on the floor, I just can't hack it, I'm terrified all of the time [sighs]. So he put me on Prozac for a bit which did absolutely nothing and I sort of struggled on and in the end I went and said, you know, there must be something wrong with me and he said no, it's actually a gene. I don't know that I believe that but this sort of depressive erm oh anxiety, apparently some people are more prone to it than others and it's to do with your genes. I don't know, but whatever it is it's a buggar! [laughs]."

In narrating this encounter, Macy's tone began as sad and slightly frustrated. She highlighted her desperate state and emphasised how antidepressants were offered as a first and only resort initially and did "absolutely nothing" to alleviate her symptoms. The fact that the Prozac did not reduce her symptoms impacted on her self-perception, leaving her feeling inadequate and confirming her belief that there must be something intrinsically 'wrong' with her. Macy struggled to name her reasons for attending counselling, describing her condition as "this sort of depressive erm oh anxiety" or "this thing", perhaps reflecting the confusion around her mental state. She highlighted her GP's biological aetiology of her problem attributing her distress to a "gene". It appeared that her GP drew from a biomedical model of mental distress by stating as a fact that she was suffering from an inherited illness that was treatable with medication.

Although Macy's GP was a powerful, influential character in her story, she positioned herself as an active agent, suspicious of her doctor's explanation. This is reflected in her statement "I don't know that I believe that". Towards the end of the account, her tone became more light-hearted claiming that "whatever it is, it's a buggar" which was accompanied with laughter. Perhaps the function of this was to lighten the mood following the intensity inherent in her description of the prescription anti-depressants. Despite not being fully convinced of her doctor's biological explanation of her distress, she highlighted that he enabled her to not feel ashamed:

“My GP was the first person who said ‘don’t be ashamed, it’s an illness and you’ve inherited it. So I was allowed by the doctor, not to feel ashamed.”

Macy’s use of the word “allowed” suggested she felt the need to be given permission to not feel ashamed. Perhaps this coming from a medical authority figure made it valid in Macy’s world. Following an unsuccessful course of antidepressants and having “struggled on”, she returned to her GP who subsequently suggested counselling. Macy highlighted feeling anxious and depressed so thought “why not try it?” Her GP was presented as a supporting character and gatekeeper to counselling, informing her of its availability and making the referral to the mental health charity.

Clare’s GP also acted as gatekeeper to counselling and indeed noticed her low mood without her mentioning it. Clare explained that she made an appointment with her GP to investigate a physical health problem:

“I can’t remember what I went for but he picked up that I was probably looking low.”

During the consultation, her doctor “picked up” on her low mood and asked questions about how she had been feeling. Clare explained that she was asked about the existing emotional support in her life:

“Have you anyone you can talk to and share?” And I said there isn’t really. I mean I’ve made a lot of friends, I know a lot of people but they’re not people you want to discuss a lot of your personal stuff with, I have tried that but it’s not a good idea because people like to talk behind your back.”

In the context of Clare’s narrative, she had confided in friends in the past and had been betrayed. She had therefore learnt not to trust friends with “personal stuff”. Like Macy, Clare’s GP offered antidepressants as a first resort. She emphasised that this was refused as she did not want to “go down that route”. Her GP subsequently suggested counselling. Clare spoke about her enthusiasm to take this opportunity:

“I felt yes! I’m going to do that, I need someone that I can talk to, that I can trust and feel safe with and to unburden a lot of this stuff.”

In the context of Clare's narrative, which emphasises her abusive husband and a mistrust of friends, Clare's search for someone she could "trust" and feel "safe" with was of particular significance. Once her GP offered a referral to the charity's counselling service, she was determined to take up the opportunity as a support that she not only wanted, but needed.

The other four narrators self-referred to the charity. Out of these four, three had gatekeepers who made the narrators aware of the availability of counselling at the charity. Melanie was the only narrator who knew about the counselling service and accessed it independently. As an ex-health visitor she had referred people to therapy services therefore was familiar with issues of access.

Alison was under the care of a substance misuse service key worker at the time of self-referring to the charity. It appeared that her key worker informed her of the availability of counselling at the charity and actively encouraged her to make contact:

"I was going to a place [] it was called substance misuse, that's for alcohol and drugs, and I was on the books so to speak there and I was seeing somebody there, this lady and I think she mentioned [charity's name] and she said phone and make the appointment."

Although Alison agreed it would be a good idea to engage in counselling she kept postponing making contact with the charity:

"So I kept dithering so she said 'well focus on phoning [charity's name]' and she said 'do it before I see you next week'. [] She said 'It doesn't matter when you do it, even if it's the last day coming up to seeing me she said, you know, do it and I got home and did it that evening.'"

From this account, it appears that Alison was given a deadline to contact the charity. In the context of Alison's wider narrative, perhaps she was encouraged to engage with counselling before she felt ready. After only four or five sessions she relapsed and was hospitalised for alcoholism.

Emily also accessed counselling at the charity through the gatekeeper of the charity's carers' support group. As explained earlier, she had knocked on the charity's door and was greeted by a member of staff to whom she explained her situation. This led to a referral to the charity's carers' support group.

“Yes, that’s how desperate I was. And very kindly this woman came out and I just talked, and talked to her and explained the situation and she suggested the carers’ support group. So I started coming to [charity’s name] because carers have a meeting, and I didn’t know that.”

It was through attending the group that she was made aware of the availability of individual counselling sessions at the service which led to a self-referral:

“I went there and then I started knowing that they do counselling because I was very lucky that they had started to give counselling to people and because I know what counselling does, I wrote to see whether I could have counselling.”

The tone is optimistic and animated as she explained being “very lucky” to have access to counselling. Her previous experience many years ago, albeit at a different service, had been appraised as enlightening. Consequently, when informed that she could re-engage she was keen to take advantage of the opportunity.

Likewise, Kate accessed counselling through other services. Following her narrativisation of an “extremely difficult” period caring for her son and feeling she was on the cusp of being overwhelmed, she decided to contact social services:

“Instead of suppressing it I let it show. I took myself to social services and required help.”

This was presented as a turning point in Kate’s narrative as it was the first time that she had sought support from professional services. This led to a carer’s assessment, which she described as not amounting to anything. Her tone was frustrated as she explained that she was yet to see the report. She therefore presented herself as taking control of the situation and discovering a charity carers’ support group to which she self-referred:

“And I also went to the carers’ support place where I was more genuinely very upset, I mean I wasn’t either controlling it or showing it, it, it just began to come out.”

Like Emily, it was through a carers support group that Kate became aware of the availability of counselling at the mental health charity:

“It was suggested under the umbrella of ‘things for carers’. And for the first time, someone had focused on me as being a carer, which is a label I’ve formally repudiated.”

Emily had not previously accessed professional services as she had been in denial about her son’s disability, an insight which was reached through counselling. Her reticence to identify herself as a carer meant that she had not been aware of available support including counselling.

3.3.3.2. Listening to oneself

All of the narratives highlighted the women’s identities as carers and/or devoted mothers and wives. These roles often involved dedicating much time, energy and emotion to looking after family members, sometimes at the expense of their own wellbeing. Prioritising or even connecting with their own emotional needs was an unfamiliar concept to some. The narrativisation of difficult, confusing family relationships permeated the narratives. In some cases, life narratives had been interrupted by family members’ problems which meant that the narrators’ needs had been neglected. In this context, counselling was constructed as an opportunity to listen to oneself and attend to one’s internal world, without outside voices impeding. According to Knight’s model (2004), expert knowledge gained through life, work and family experience reflects a valuable gain through maturation. It appeared that the narrators believed this and thus some of them explicitly stated their ability to tap into their inner resources during the counselling process.

Emily talked about how she was too enmeshed in her daughter’s problems to recognise the impact it was having on her:

“My other daughter sent me one day to a friend of mine to stay all day because [says whilst smiling] I guess I looked so bad [laughs]; I didn’t realise it because I was so involved with my daughter’s problem.”

The tone was light-hearted and humorous as Emily smiled and laughed about neglecting herself, which to me felt somewhat incongruent. The tone soon became more serious as Emily explained that she was out of touch with herself and had consequently reached the point at which she was scared for her own mental health:

“My mind started working so much that I couldn’t restore my mind. [] My thoughts were one after another, one after another °I thought I was going

to be mentally ill myself because I never thought I was going to feel like that° [sighs]. I realised that I wasn't well. I was so ill I couldn't concentrate on my yoga because my mind wanted to do yoga, but at the same time wanted to cook, at the same time wanted to do this..."

Emily wanted to let me know the extent of her feelings of being out of control and the accompanying fear. The tone was anxious and her speech became faster, reflecting her narrated state of feeling uncontained. Emily's speech trailed off, as if re-experiencing the exasperation felt at the time. She sighed loudly, indicating feeling overwhelmed and needing to catch her breath. Following this description of her mental state, counselling was constructed as a place of containment, enabling more control and clarity of thoughts:

"So counselling helped me get on track, back to my own self and hear what I was saying."

Emily's narrative moved from an expression of her inability to "restore" her mind, to counselling helping her to get "back to my own self". She revealed that there was nowhere else in her life where she could "hear" what she was saying. Melanie also spoke about listening to herself both in the context of her hopes for counselling and her experience:

"It was a feeling that it's probably about time I sat and talked to somebody about how I felt, and to hear what I'm saying because things go round and round and round in your head but you never actually come up with answers."

The repetition of "round" perhaps indicates the futility of trying to make sense of her thoughts alone prior to counselling. Perhaps the act of sitting down in counselling was an opportunity to ground herself, thus facilitating the interruption of the cyclical movement of her thoughts. Melanie revealed that listening to herself facilitated the acknowledgement of her emotions:

"I thought counselling helped when I'm talking, to listen to myself, what I'm saying, whether I'm homing into how I really feel and what I wanted to say."

Like Emily, the focus was on listening to herself and only being able to do so in the presence of another. Perhaps this suggests that having to articulate her thoughts to

the counsellor helped Melanie listen to what she was saying. Listening to oneself was constructed as a way to identify what was deemed important.

Likewise, Macy constructed counselling as an opportunity to allow time for herself, enabling her to see through a different lens. The absence of time and space dedicated to talking about oneself was highlighted suggesting it was a luxury in her world:

“It’s quite nice to sit and talk about oneself for an hour, you know, you never get a chance anywhere else. And by doing so, I began to see things holistically.”

Similarly, Kate’s narrative of counselling emphasised the importance of carving out time on a regular basis to focus on herself. She used this as an opportunity to connect with her suppressed “despair”, “anger” and “resentment” borne from sacrificing her life to care for her son. Erikson’s (1982) psychosocial theory of development could help to interpret Kate’s experience. The theory proposes that during late adulthood there is a dichotomy of integrity/despair. During this time people who have achieved what was important to them, look back at their lives and feel great accomplishment and a sense of ego integrity. Conversely, those who had difficulty during middle adulthood may look back and feel a sense of despair. It could be that Kate was looking back at her life and the difficult time she had been through and felt despair as she had dedicated her life to her son. Although she wanted to let me know that she loved him dearly, perhaps there was a sense of loss of the life she could have had, as she explains, “that was my life”. Her counselling experience was narrated within this context:

“It was a place I could go once a week where I would be allowed to talk about me and how I feel and how difficult I’m finding things.”

Kate appeared to be suggesting that she felt she was given permission to talk about herself and her difficult feelings during counselling. In the context of her wider narrative, in particular her family upbringing and generational attitudes towards emotional expression, this is a permission she had not previously felt. Kate elaborated on how counselling was a time to make sense of her experiences, without outside voices impeding:

“It was still time for me, not impinged on by other people’s requirements of me, [] I needed to be exploring the very negative experiences of the

past twelve months to find out why the situation so nearly became insupportable.”

Kate elaborated on the process of counselling, revealing her positioning of the counsellor:

“The funny thing is, a lot of the time in counselling you’re talking to yourself for your own benefit but you can’t do it sitting alone. [] It’s a funny thing isn’t it? And sometimes it can be intensely irritating that the other person communicates so little. But it’s better because you can’t just sit facing an empty chair and get counselling [laughs].”

The tone was light-hearted and animated which contrasted with the tragic, sad tone dominating Kate’s narrative. Like Emily, Kate felt that the process of listening to oneself needed to be facilitated by another person. Kate constructed counselling as “talking to yourself for your own benefit” suggesting that it is a space providing an opportunity to engage in a constructive dialogue with oneself. The counsellor was positioned as an “irritating” passive presence but one that was essential for introspection. Kate seemed to be implying that she would have preferred more input from her counsellor. Perhaps it was particularly difficult for Kate to be vulnerable with someone who was not equally sharing a part of themselves.

3.3.3.3. Control and responsibility

In relation to the aforementioned theme of ‘Expectations’, more than half of the narrators had inaccurate preconceptions about the nature and process of counselling. There was a medical discourse of expecting to be “cured” or be prescribed solutions to problems. Perhaps this reflected the medical tone that had dominated their treatment by healthcare professionals. Counselling was constructed as helping narrators to develop a sense of agency, strengthening a belief in their own control of both the therapeutic process and their difficulties. Counselling was presented as an opportunity to see themselves and their problems through a different lens. As the stories unfolded, narrators’ identities appeared to shift from passive patients/recipients of therapy to active agents of change. The women constructed counselling as facilitating acceptance of responsibility for their emotions and a relinquishment of responsibility for others’ problems.

Melanie explained that she learnt to have control over her thoughts about her troubled relationship with her daughter and her subsequent ways of coping. This problematic relationship was Melanie's main reason for attending counselling:

"Maybe I wasn't of that impression before I started, but having gone through it and realising that a lot of it is down to myself, and how I see things and how I cope with things and to help me come to a decision."

Melanie's narrative portrayed counselling as helping her realise that she had choices in how to respond to her daughter, including setting up boundaries. Through the counselling process, she realised that the answers would not be provided by her counsellor, which helped develop her own sense of agency:

"I just expressed how I was feeling and suggestions, I knew were not going to be forthcoming; that it was really up to me to make the decisions."

Melanie spoke about how she felt she was ultimately responsible for making therapy work hence took on an active role in shaping the sessions to meet her needs:

"So, it was me who sort of created the sessions in a way."

Likewise, Macy reflected upon her change in perspective towards her anxiety and depression. Following years of searching for an external solution, Macy praised her counsellor for helping her acknowledge that there would be no "quick fix" and that she was ultimately the creator of her own mood:

"She helped me realise, that there was no cure. It was my control of it."

This realisation was daunting at first. Recognising that she was ultimately in control of her own thoughts and subsequent feelings leading to anxiety and depression challenged her initial reassuring belief that her counsellor would be able to "fix" her:

"It set me back a bit and then I thought well, I'm not going to get all the answers but think of the things you did do and that helped."

Macy took responsibility for the progress made during counselling and although leaving counselling not completely transformed, she highlighted developing a more realistic view of her mental health problems. Her position towards her emotional distress changed from passive recipient searching for external answers to assuming responsibility and viewing herself as an active agent of change.

Emily's narrative was often chaotic and disordered as she explained a sense of lack of control in her relationship with her daughter. Counselling was constructed as a beacon of hope, helping to make sense of her relationship. This made her feel more in control and not lose sight of herself in the chaotic family context. Instead of remaining a passive recipient of her daughter's behaviour, Emily also developed a sense of self as an active agent of change. However, these two identities interchanged throughout her narrative. She explained how counselling enabled her to understand the reasons she could not help, thus alleviating some of the guilt felt:

Emily: When I came to counselling and I talked it's like it reminded me of things that have happened and think about why I cannot help, it's not because I'm not able to help, it's not like I don't want to help, it's not that I'm a bad mother, it's nothing to do with that. I realised that in my case it's circumstances [sighs] and there's nothing I can do. I cannot change it because it's not up to me either. My daughter is 31 as well and she has to do part of it. Because sometimes I get so involved that I forget that part.

Lydia: So you take on all the responsibility and blame yourself?

Emily: Yes, it's like a train going a hundred miles and then suddenly derails [laughs] and then somebody has to come and put it back [laughs].

Emily wanted to let me know that her inability to help her daughter was not because she did not want to help or because she was a "bad mother", perhaps indicating that this was an identity she had been struggling with. My impression was that her narrative functioned to reassure herself that the situation was out of her control. By highlighting her daughter's adult age perhaps she is providing further reasons for the relinquishment of responsibility. At this point I interject to clarify my own understanding and as an attempt to highlight the theme of responsibility which I felt was emerging from the narrative.

The tone became more light-hearted as Emily likened her mental state to that of a fast train. The simile of a fast train appeared to reflect her mental state of continuous stress until she reached crisis point and lost control indicated by the derailment of

the train. Her counsellor was depicted as the person who helped her get “back on track”.

The theme of control dominated Clare’s narrative. A large part of her story was dedicated to explaining her reasons for attending counselling, namely her intermittent depression which she attributed to her controlling husband:

“He had to be the boss, in control and organised me that way as well you know.”

Clare felt trapped in her unhappy marriage but felt ambivalent and guilty about separating. Within the wider narrative of her marriage, counselling was constructed as facilitating a dialogue about the lack of control felt and whether she wanted to change this. Clare presented counselling as helping her to take back some control by giving her the confidence to contact a solicitor:

“During counselling, I did make the step to go to a solicitor actually to get some advice about °you know, if I was to make a move°, where I stood and everything.”

Clare’s voice quietened as she spoke about the possibility of separating from her husband. Perhaps this reflected her ambivalent feelings and doubting herself, which permeated the narrative. At the time of the research interview, Clare was living with her husband but shared that counselling had encouraged her to set boundaries around his behaviour. This had strengthened her sense of agency in her relationship thus reducing feelings of depression.

In constructing their decision to enter into counselling and their experience of the process, all six narrators explicitly or implicitly highlighted issues of stigma around mental health problems, preconceptions of the nature and process of counselling and issues of access and agency. These will be discussed in the following chapter together with the implications of these findings for referrers and counselling psychology practice.

4. Chapter Four – Discussion

Overview

This concluding chapter of the research will begin by summarising the study's findings and their implications, including how they fit into the existing literature and their applicability to referrers and counselling psychology practice. This will be followed by a review of the methodological challenges faced and how these were navigated through. The current study will be critically evaluated, highlighting limitations and avenues for future research. The chapter will close with a final reflexive engagement with the research process and concluding thoughts.

4.1 Summary of findings, relationship to existing literature and their implications

The main overarching themes which emerged from the interview material were 'Expectations', 'Keeping up appearances' and 'Taking opportunities'. These themes will be discussed within the context of existing literature in the field and with reference to implications for referrers and counselling psychology practice. Adopting a contextual constructionist epistemology allowed me to appreciate how the narrators' stories of their engagement with counselling did not happen in isolation but rather in the context of a socio-historical and cultural environment (Jaeger & Rosnow, 1988). This enabled the exploration of how the narrators' drew on wider cultural narratives of mental health and counselling.

Langdridge's (2007) CNA model was compatible with contextual constructionism as it enabled the use of Knight's (2004) CCMSC model and Erikson's (1982) psychosocial theory of development as interpretative lenses. This shed light on wider contextual and cohort issues in working with older clients and how they impact on attitudes and beliefs about mental health and therapy. Incorporating an understanding of the socio-historical backgrounds of older clients into clinical practice could help us appreciate and address systemic and individual barriers to therapy and strengthen the therapeutic alliance.

4.1.1 Expectations and attitudes towards engaging in counselling

In constructing their decision to enter into counselling, narrators' expectations were predominantly negative with medical preconceptions. A dominant medical discourse of treatment influenced the narratives told. Ideas about being 'cured' or 'fixed' by an expert were reflected in the women's language, for example, Kate's reference to "doses" of counselling. The stories of narrators' expectations and subsequent hesitancy about engaging with counselling were largely shaped by cultural and generational factors.

These findings support the existing literature on the topic presented in Chapter One of the current research study. The literature indicates a dominant medical tone of dealings with older adults in healthcare and the suggestion that many older adults believe that psychologists are an extension of their physician (Patrick, 2006; Kvale, 1998). The narrators' ideas about being 'cured' supports the aforementioned literature highlighting that some older clients may enter therapy with a fairly constricted medical definition of their difficulties and that it may come as a surprise to them that help is being provided in a rather unfamiliar way compared to earlier treatment experiences (Nordhus, Nielsen & Kvale, 1998).

Dominant cultural narratives about mental health problems as indicative of weakness and inadequacy permeated narrators' stories. These wider narratives exacerbated feelings of ambivalence and shame about engaging with counselling. For example, Macy expressed her hesitance about attending counselling and attributed this to a perception in British culture that seeking professional help is indicative of being "weak" as we "should" be able to manage life's challenges. This also emerged in Murray et al.'s (2006) study in which primary care professionals believed that many older people regard depression as a 'sign of weakness'. Findings from the present study also strengthen the conclusion drawn from the Murray et al. (2006) study which was that the stigma of mental health problems presents a barrier to seeking help. The current thesis therefore advocates van Etten's (2006) recommendation that to improve the rate of psychotherapy use amongst older adults, stigma surrounding psychiatric treatment needs to be eliminated.

In the present study, individual narratives reflected wider cultural and generational attitudes towards mental health problems and the expectation to 'cope' with life's

adversities. Macy attributed the expectation that she should be able to cope alone to being “indoctrinated” by her generation. This perhaps highlights the perceived power of generational attitudes on personal beliefs. Findings from the present thesis are in line with Riessman’s (2008) proposition that stories are social artefacts, revealing as much about society and culture as they do about the narrator.

The current thesis highlights that a major obstacle to overcome is that of the stigma of mental health problems. This is consistent with Scrutton’s (1999) claim that prejudiced beliefs about mental health are especially strong in older age groups and thus people are less likely to seek out help from mental health services. He claims that some older people may be opposed to the very idea of counselling, associating it with mental illness. This view is supported by Lebowitz and Niederehe (1992) who state that the stigma of mental health problems is especially strong in older adults who tend to associate mental health problems with personal failure.

Social stigma around mental health problems and seeking professional help compounded feelings of shame and inadequacy for several narrators. In some cases this meant that seeking ‘outside’ professional support was postponed. For example, Macy referred to a dominant cultural narrative that by being British one should be self-sufficient and be able to “pull yourself together”. This was an attitude she expected from her “white-coat”-wearing counsellor. This highlights some older people’s misconception of the nature and process of counselling which is supported by existing literature (Knight, 1999; Scrutton, 1999). As highlighted in the literature review, many older adults have little familiarity with the process or benefits of psychotherapy and may associate it with mental illness (Knight, 1999; Scrutton, 1999). Indeed, the literature suggests that there are still older people who equate mental health services with inpatient hospitalisation for long periods of time (Knight, 2004).

Older individuals may have beliefs that limit their willingness to accept talking treatments for mental health problems such as a fear of stigma or fear of being viewed as “mad” or “batty” by the counsellor, as reflected in Macy’s narrative. As suggested by the narrators in the current study, perhaps the implication of this is that more education is required to improve understanding of counselling services in order to help older people make an informed choice about engaging in it. For example, Emily’s narrative highlighted a lack of knowledge around counselling. This supports findings from Knight (1999) indicating that many older people are unaware that psychotherapy is an available option, as well as an adjunct to medication.

Increased awareness of mental health problems is likely to challenge negative stereotypes and normalise therapeutic interventions. Findings from the current study support the aforementioned literature emphasising the importance of explaining to older adults the nature and process of counselling and their active role as clients as oppose to medical patients (Goudie, 2010). As highlighted in the literature review, without adequate education, psychotherapy may be viewed as 'just talking', rather than a 'talking and thinking through emotions or problems' process that consists of client-identified goals (Knight, 1999).

For some narrators, engaging with counselling also conflicted with generational attitudes towards mental health problems and emotional expression. This was linked to childhood upbringings around the time of the Second World War in which undesirable emotions were often suppressed and mental health problems were dismissed or unrecognised. For example, Macy believed that due to the war, her solidier father was physically and emotionally absent. Her father was described as stern, expressing little emotion thus Macy learnt to associate expression of emotion with shame. Narrators' generational values of self-sufficiency and independent problem solving led to ambivalent feelings about engaging with counselling.

Findings from the current thesis support Kunkel and Williams' (1991) conclusions that self-reliance and stoicism mitigate older adults seeking psychological therapy. The ambivalence in entering into counselling felt by some of the narrators due to an expectation of self-sufficiency echoes current literature in the field. As highlighted in the literature review, the era in which individuals grow up, become adults, and establish careers and families exerts a shaping influence that interacts with other personal characteristics to affect the perception of psychological distress and of mental health treatment (Knight, Kelly, & Gatz, 1992).

Narrators in the current study were torn between their dual identity of individuals who were struggling emotionally and an identity of stoicism that they had grown up with. Drawing from Knight's (2004) model, the implication of these findings is perhaps for therapists to be mindful of older adults' hesitancy in engaging with counselling and apprehension about emotional expression by appreciating their wider socio-historical contexts.

As counselling psychologists it is important to have an understanding of cohort and generational issues relating to a person's age. This provides a context for the issues the client presents, enabling the therapist to appreciate how the client's wider

sociocultural background may be influencing their understanding of their problems, previous attempts at recovery and their meaning-making and engagement with therapy.

Embedded attitudes and possible shame in seeking counselling is likely to impact on clients' initial engagement in the therapeutic process as shown in Kate's narrative. Expressing emotional vulnerability may be unfamiliar to some older adults. It is also important to remember that counselling is a relatively new concept that did not exist when the narrators were young. Findings suggest that therapists may be in a better position to help clients if they learnt about the specific cultural and historical context of the older client, thus adding a layer of insight when working with this age group.

Findings from the current study support the research of Kvale et al. (1998), which claims that in order to maximise the therapeutic effect with older clients, a careful discussion of the client's expectations and an explanation of the limits of psychotherapy is central in establishing the therapeutic relationship. Of course this is important for clients of any age but perhaps particularly important for older people who due to generational differences may be unfamiliar with the process of therapy, psychological interpretations of problems and emotional expression (Gurin, Veroff & Feld, 1960; Knight, 2004).

Furthermore, it may be useful for therapists to reflect upon how generational and age differences between themselves and their clients may be impacting on their clients' sense of being understood. For example, Alison commented that "I don't mean to criticise, I just felt that she [counsellor] possibly was too young". Likewise, Kate felt that having a counsellor who was "decades younger" reduced her sense of being understood. Clients may not initiate this conversation therefore therapists could use prompts if they suspect this may be a barrier to therapy and the formation of a therapeutic relationship.

Gergen and Gergen (1983) emphasise the broader importance of studying narratives. Their analysis is less concerned with the content of specific narratives but with the functions that the processes of creating narratives serve in social life. They argue that narratives are the basis for making experiences meaningful and as a consequence, can be used to support efforts to engender social change. In the current study, one of the main functions of the narrators' stories was to challenge stigmatisation of mental health problems. For example, Macy's narrative criticised

the social stigma around mental health difficulties and seeking professional help. In addition, her narrative functioned to advocate counselling amongst older people based on her own positive experience. Indeed, personal stories of counselling were used to advocate acknowledgement and acceptance of emotional distress and seeking therapeutic input.

Moreover, in Macy's narrative there was an acknowledgement of a change in wider cultural perceptions of counselling which played a large part in her decision to enter into therapy. Macy highlighted an emerging discourse of acceptance in seeking counselling at the time she was considering it. These findings are supported by research presented in the literature review indicating that attitudes are changing as people want to find solutions without medication and their associated side effects (Rainsford, 2002). There is research suggesting that CBT is more acceptable to older adults than anti-depressant medication to treat depression (Landreville, Landry, Baillargeon, Guérette, & Matteau, 2001).

This movement is also demonstrated in the aforementioned initiative originating from Better Government for Older People (BGOP) in the UK, *Moving Out Of The Shadows* (MOOTS), which was set up to 'harness the voices of older people who experience a range of mental health problems, to inform and influence future policy, practice and experiences' (Bowers, Eastman, Harris & MacAdam, 2005, p. 1). Furthermore, Mind's (2005) *Access All Ages* campaign helped raise awareness of the mental health needs of the older population. Both of these are likely to have contributed towards the emerging discourse of acceptance of counselling in the older adult population. This developing change in attitudes towards mental health and seeking psychotherapeutic input meant that the six women in the current study sought and engaged in counselling.

4.1.2 Keeping up an appearance of stoicism

Almost all the narrators in the current study spoke about maintaining an image of stoicism and resiliency with family and friends in the face of life's adversities. Fear of judgement from others regarding their emotional distress appeared to mirror wider cultural attitudes towards mental health problems and emotional expression. Findings from the current thesis are consistent with results from the aforementioned study by MacDonald and Morley (2001) which suggested that shame is a strong factor in emotional isolation and non-disclosure of people struggling with emotional and personal experiences. The authors revealed that for their participants, non-

disclosure and emotional isolation was also related to the anticipation of negative interpersonal responses to disclosure. They suggested that these factors could inhibit people from seeking professional help.

For example, in the present study Macy shared feelings of inadequacy, which perpetuated a sense of shame resulting in non-disclosure. Another reason for keeping others at a distance through the projection of emotional wellbeing was the assumption that other people would not understand or empathise with the narrators' struggles. The distance narrators had created between themselves and others meant that vulnerabilities, fears and emotional distress were often hidden from family and friends. For instance, Kate felt the pressure to maintain her constructed identity of resilience with family and friends as she believed it was "too late" for her to "present any other me". Her main concern was that people would take advantage of her if she shared her vulnerable side. Likewise, Emily chose not to share her emotional distress with her family "because they get scared" of mental health problems as they do not understand them. This societal stigma of mental health problems is shown in the research and literature (Murray et al., 2006; Scrutton, 1999; Sirey, et al., 2001). For Kate and Emily, the consequence of the pressure felt to maintain an appearance of stoicism was emotional isolation which maintained feelings of anxiety and depression.

An image of stoicism may also be presented to GPs by older women, which could prove to be a barrier to accessing psychological support. For this reason GPs (and other healthcare professionals with the power to refer to mental health services) might therefore be advised to be curious about older women's emotional wellbeing when they present with physical health problems.

In some cases mental health problems and emotional distress may only be detected through a patient attending an appointment for a physical health problem as exemplified in Clare's narrative. Clare was fortunate in having a perceptive GP who detected signs of low mood and was brave enough to instigate a discussion around this. The role of GPs in older people's access to counselling will be further discussed in the next section.

Similar findings emerged in Murray et al.'s (2006) study in which GPs reported that older patients rarely mentioned psychological difficulties during consultations. The primary care professionals interviewed reported that many older people regard

depression as a 'sign of weakness' and the perceived stigma of mental illness was widely recognised as a barrier to seeking help.

For the narrators in the present study, emotional isolation and loneliness, either self-imposed or as a result of problematic relationships, were related to a sense that the women did not have people in their lives with whom they felt safe to open up to. This is in line with research presented in the literature review, highlighting the emotional isolation and loneliness experienced by many older people (MacDonald & Morley, 2001; Victor, Scambler, Bond & Bowling, 2004).

The acceptance of counselling was often narrated in the context of this emotional isolation. For some of the women, the decision to enter into counselling was heavily based on not wanting to burden loved ones with their problems. For example, Emily chose to not share her emotional difficulties with her daughter whom she lived with as she did not want to "overwhelm her". Several of the narrators constructed counselling as the only place in their lives in which they did not feel the need to maintain an image of stoicism; as Emily expressed, they could "talk the reality". Facilitated by their counsellors, the women gave themselves permission to emote by acknowledging and connecting with feelings of pain, disappointment, despair, loss, depression and anger. These emotions had been previously masked behind a guise of coping with life's adversities.

Yet, even in the therapeutic process, some of the narrators struggled to detach themselves from their constructed identity of emotionally resilient to reveal different facets of their selves. For Kate in particular, the constructed identity of a strong, self-reliant mother meant that the intimate, exposing interpersonal nature of counselling was a difficult adjustment and a challenge to her way of being with another. As Scrutton (1999) suggests, perhaps it is easier to accept older people's false reassurances both in the GP surgery as well as in the therapy room. Even when older clients are engaging in the therapeutic process, there may be conscious and subconscious barriers that make presenting one's vulnerabilities challenging. Perhaps the implication of this is for therapists to look beneath the surface of an older client's projected image and facilitate curiosity in their client's protective strategies and defenses.

Indeed, in my own clinical practice, many older female clients have initially underplayed their problems voicing phrases such as "it could be worse" or "I

shouldn't complain" signifying a discomfort in admitting to struggling emotionally and allowing oneself to be supported. This is in line with Scrutton's view (1999) that many older people do not normally demand attention and will not come forward readily to request counselling support.

One of the implications for counselling psychology practice is to help older clients use the therapeutic relationship to 'try out' a different way of being with another person, thus allowing hidden parts of themselves, parts that they may be ashamed of, to be seen. Fears and worries about being vulnerable with another person could be explored in the therapeutic relationship. This in turn could encourage clients to use this experience to give themselves permission to emote with loved ones and reduce therapy dependency. As therapists perhaps we need to be particularly curious about other relationships in older clients' lives and how they could be utilised to reduce emotional isolation and shame in experiencing a mental health problem. The current study's emphasis on highlighting the benefits of therapists being mindful of older clients' wider context outside of therapy supports Knight's (2004) contextual, cohort-based, maturity, challenge-specific model which emphasises that the social context will influence older adults' experiences and that therefore their environmental realities should be considered in psychotherapy.

Another related finding from the thesis was that half of the narrators were carers. Research and literature highlight the potential impact of being in a carer role. Caring for a partner or relative alone may contribute to an individual's social isolation and feelings of loneliness. In some cases this could lead to mental health problems such as depression (Barg et al., 2006) or a sense of loss of one's own life as storied in Kate's narrative of caring for her disabled son. Perhaps the implication for counselling psychologists is to be curious about the social context and living arrangements of older clients as suggested by Knight's (2004) model. This could potentially have an impact on a client's ability to do therapy 'homework tasks' between sessions and their ability and permission to dedicate time to themselves in order to maximise the benefits of therapy. Furthermore, as counselling psychologists we should take advantage of our position to be able to signpost or refer older clients to carer support services.

Research suggests that loneliness and social isolation are prevalent amongst older people and may be compounding mental health problems (Cattan et al., 2005; Hawthorne, 2006). Perhaps part of our role as therapists should involve assisting isolated older clients develop social contacts. This could help individuals become

part of wider community networks rather than confining therapeutic interventions to the therapy room.

Furthermore, more outreach is needed to raise awareness of psychological interpretations of problems. For example, mental health professionals might be advised to give talks at community groups for older people. As shown in the findings of the current thesis, older individuals may not seek therapeutic input autonomously for a variety of reasons including lack of awareness of availability, lack of understanding of counselling services or stigma around mental health problems. These findings echo Knight's (1999) claim that contemporary older individuals have little familiarity with the process or benefits of psychotherapy. Indeed, Knight (1999) believes that older people are generally unaware that psychotherapy is an available option.

4.1.3 Taking opportunities: Referrals, client agency and emotional distress

The following section examines how narrators took certain opportunities offered to them which they used to their advantage. Narrators discussed how 'gatekeepers' such as GPs offered them the opportunity to access counselling. The final decision to proceed with counselling was often a shared decision between the patient and gatekeeper. Further, once in the counselling process, the women expressed using counselling as an opportunity to exercise client agency in sessions. This involved having the chance to exercise control over the course of therapy thus strengthening a belief in their control of both the therapeutic process and difficulties that brought them to counselling. Moreover, the women expressed how through counselling, they took the opportunity to search for internal rather than external solutions to their emotional problems. Finally, the narrators described taking the opportunity to listen to themselves in the therapeutic process. Counselling enabled the women to inhabit a reflective space in the presence of another which gave them the opportunity to acknowledge and express emotional distress.

Shared decision-making

Narrators' journeys into counselling were navigated by healthcare professionals, with the exception of one participant, Melanie. These 'gatekeepers' held knowledge about the availability of counselling and had the power to refer. As Riessman (2008) highlights, the social roles of stories- how they are connected to the flow of power in

the wider world – is an important facet in narrative research. In the current thesis, this was important in understanding the women's decisions to enter into counselling. Referrals to counselling were often presented as a shared decision between patients and gatekeepers. Narrators described taking the opportunity of therapy offered to them. These gatekeepers therefore provided opportunities for the women to access counselling which they took advantage of.

Two narrators, Macy and Clare, were referred to counselling by their GPs who were depicted as supportive characters in their stories. However, both women were offered antidepressants as a first resort and Macy was not informed of the availability of counselling until after her course of Prozac had done “absolutely nothing”. These findings tie in with the existing literature which suggests that older adults are generally unaware that psychotherapy is an available option, as well as an adjunct to medication (Knight, 1999). These findings are also consistent with results from the aforementioned survey by Collins, Katona and Orrell (1997) which found that ninety-three per cent of GPs reported that they would consider referring an older person for psychological therapies but only 44% had actually done so. The authors also reported that one in three GPs showed a lack of knowledge of the range of interventions available and the indications for choosing a particular psychological therapy. These results suggest that GP training and further education should emphasise psychological therapies, particularly for GPs without psychiatry experience. Indeed, in primary care settings, it has been proposed that counselling should be available to clients as a first-choice intervention in mild to moderate depression (Baldwin et al., 2003).

Being primarily offered antidepressants appears to conflict with guidelines from the National Institute for Health and Care Excellence (NICE) which advocates a stepwise approach to managing common mental health problems, offering or referring for the least intrusive, most effective intervention first. Therefore, it is recommended that non-drug interventions such as talking treatments should be the mainstay of treatment for many people with depression or generalised anxiety. The guidelines state that medication should be reserved for more severe conditions or when symptoms have failed to respond to non-drug interventions.

Findings from the current study demonstrate that GPs have a pivotal role in how older women conceptualise and therefore respond to their emotional distress. Macy's doctor provided a purely biological aetiology of her depression and anxiety and consequently prescribed antidepressants as a form of treatment. Yet research

suggests that depression and anxiety results from a complex interaction of social, psychological and biological factors (Mirowsky & Ross, 2003; WHO, 2012). Particularly without an in-depth assessment, it may be harmful for GPs to state the cause of a patient's distress as purely genetic as this could reinforce beliefs of being inherently flawed which could compound depressive thoughts. GPs are often people's first point of contact when experiencing emotional distress and tend to be widely trusted and respected by the public (Kmietowicz, 2002). Consequently, these doctors have a huge influence on patients' conceptualisation of their difficulties and subsequent paths of treatment.

The paper *NICE under Scrutiny* by Guy, Thomas, Stephenson, and Loewenthal (2011) highlights the negative consequences for patients of their inability to access the full range of psychotherapies due to NICE's approach to mental health. The paper argues that NICE adheres to an overly medicalised perspective on emotional distress rather than considering a bio-psycho-social aetiology that acknowledges the contextual and historical nature of an individual's problems. The authors highlight that these guidelines are adhered to by NHS doctors who may then also subscribe to a purely biological or genetic explanation of emotional distress. Findings from the current study suggest that GPs' attitudes and beliefs about mental health problems mediate people's access to psychological therapies. Moreover, there is research suggesting older patients are more likely than younger patients to accept and follow their GP's advice, preferring instructions on what to do based on past experiences of not being involved in decision-making (Wetzels et al., 2004).

Western conceptualisations of mental health exist within a medical model. Lists of criteria and categories define whether a cluster of symptoms are considered disordered or not as documented in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013). However, a purely medical model of mental distress is too simplistic and reductionist. It places responsibility at the biological level, rather than considering the person in context and allowing the individual agency.

By drawing on a solely biomedical explanation of mental distress patients could be left feeling that they have an organic deficit. This ignores the now overwhelming evidence that people experience mental distress as a result of a complex mix of social and psychological circumstances (Johnstone, 2013). Perhaps this suggests the need to move away from a purely biomedical model of mental distress to one that incorporates societal and personal factors. One way of doing this is by listening

to the stories of former clients of psychotherapy regarding their emotional distress and what they found helpful in the therapeutic encounter. This is particularly pertinent for older people whose treatment has been largely medical in tone and tends to focus on pharmacological treatment of both physical and mental health problems (Patrick, 2006).

For Macy, the fact that Prozac had no effect reinforced her feelings of inadequacy. She returned to her GP, deflated and frustrated and only then was informed of counselling as an existing option. This raises the question of why her primary care doctor omitted presenting all available options in the first consultation thus allowing her agency and choice. Similar findings also emerged in the aforementioned study by Collins, Katona and Orrell (1997) in which the authors found that the majority of GPs would consider referring an older patient for psychological therapies but many had not put this into action.

Perhaps it would be better practice for decision-making to be shared between healthcare professionals and patients regarding courses of treatment. Although there may be many GPs who subscribe to this ethos, for others a more thorough discussion of available options with patients may need to be integrated into clinical practice. Indeed, as mentioned above, there is research suggesting that one in three GPs showed a lack of knowledge of the range of interventions available and the indications for choosing a particular psychological therapy (Collins, Katona & Orrell, 1997). It is my belief that older adult service users should be given the choice of counselling or antidepressants at a systemic level. Reducing choice for service users takes away agency. This comes at a time when the coalition government has explicitly stated in their 2010 NHS white paper that service users will have 'more choice and control' (Department of Health, 2010, p. 1).

Findings from the current study support the existing literature indicating that attitudes are changing and many older people express a preference for talking treatments rather than medication with their associated side effects (Givens et al., 2006; Rainsford, 2002). These results are consistent with research suggesting that CBT is more acceptable to older adults than anti-depressant medication to treat depression (Landreville, Landry, Baillargeon, Guérette, & Matteau, 2001). Indeed, the present study supports Zank's (1998) findings that for 'younger-elderly' (aged 65–80) cohorts there is an increasing acceptance of psychological treatments.

As explained in the literature review, the good news is that the Improving Access to Psychological Therapies (IAPT) programme for older adults is one of the six core commitments of the IAPT four-year plan set out in 2011. However, the IAPT programme is restricted to 'evidence-based' CBT interventions thus preventing access to the plethora of other forms of therapeutic approaches that may be more suited to some individuals. Indeed, CBT is now so ubiquitous it is often the only talking therapy available in both public and voluntary health settings (Watts, 2015).

GPs have an important role in identifying older adults who may be experiencing emotional distress or be at risk of mental health problems. Many older individuals may not necessarily be forthcoming with disclosures about their emotional distress either due to an unawareness or because they feel shame or worry about wasting resources (MacDonald & Morley, 2001; Scrutton, 1999). There may also be a belief that there is no point in reporting emotional distress 'at their age' as there is nothing that can be done. Unfortunately, many older people misattribute symptoms of major depression to 'just old age' (Burroughs, Morley, & Lovell, 2006) signifying internalised ageist attitudes in line with the loss deficit model of ageing.

Indeed, depression is under-detected in older people, with only one in six older people with depression discussing their symptoms with their GP, and less than half of these receiving adequate treatment (Chew-Graham, Burns, & Baldwin, 2004). Perhaps it would make sense for GPs to be particularly receptive to physical indications of depression in older patients such as lethargy, insomnia and malaise. As highlighted in the introductory chapter, many older people are unable to identify their problems as psychological (Colenda, et al., 2003; Gurin, Veroff, & Feld, 1960). The implication is that a major task of mental health professionals working with older patients is to educate them to correctly identify problems that are psychological in nature (Rokke & Scogin, 1995).

Moreover, there is research suggesting that GPs may lack necessary consultation skills or confidence to correctly diagnose later life depression or may see the symptoms as part of the ageing process. They may be wary of opening a 'Pandora's box' in time-limited consultations and instead collude with the patient in what has been called 'therapeutic nihilism' (Burroughs, Morley, & Lovell, 2006).

Furthermore, Alison's story highlights the importance of appropriate referrals to counselling and how this should be a shared decision-making process. Alison was strongly encouraged to self-refer for counselling by her substance-misuse key

worker, which after hesitating she did. If an individual has comorbid problems such as alcoholism and anxiety, a thorough assessment of whether the person would be able to engage in therapy needs to be conducted. Unfortunately for Alison, following four sessions of counselling she relapsed and was hospitalised. Counselling can be an intense and emotionally demanding process requiring high levels of commitment and engagement. Some people may not be ready for this commitment at a particular time in their lives therefore other services may be more appropriate.

Client agency, listening to oneself and emotional expression

Client agency refers to narrators' sense of control over the course of therapy, their decisions and their sense of accomplishment and empowerment. It refers to clients' development of an active role in shaping the sessions thus taking responsibility for the progress made. For narrators in the present study, counselling was framed as an opportunity to exercise client agency in sessions. Counselling experiences were constructed as providing the opportunity for narrators to develop a sense of agency, strengthening a belief in their own control of both the therapeutic process and their difficulties that brought them to counselling. The women spoke of how their counselling experiences facilitated acceptance of responsibility for their own emotions and a movement away from searching for external solutions. For example, in narrating her struggle with anxiety and depression, Macy reflected upon how her counsellor "helped me realise, that there was no cure. It was my control of it".

Many of the narrators began counselling with a constructed identity as passive recipient expecting to be 'cured' by an expert. They believed that through the therapeutic process, their identities shifted to emerging active agents of change, allowing ownership of responsibility and exercise of control both in the therapeutic context and in their wider lives. For instance, Melanie highlighted that "it was me who sort of created the sessions in a way." This has been shown in a series of studies by Rennie (1994, 2000) highlighting how clients can be active agents within therapy sessions. Central to Rennie's findings are that clients do a lot of work on their own which they do not necessarily report to the therapist.

The current study's findings on client agency supports the aforementioned literature highlighting that independent problem solving and autonomy are important values for many older clients (Zank, 1998). This view is also in line with Knight (2004) who emphasises that it is vital for therapists to acknowledge and work with cohort values. Moreover, findings from the current study support Kunkel and Williams' (1991)

suggestion that those undertaking counselling with older clients should accommodate the individual's need to feel empowered and autonomous. Encouraging personal agency could also help challenge ageist stereotypes about later life being a time of inevitable decline and consequent dependency and depression (Butler, 1969; Knight, 2004).

By taking the opportunity to exercise agency in counselling, the narrators were able to listen to themselves, which facilitated a new relationship to the self that was embedded in curiosity. For example, Melanie shared that "counselling helped when I'm talking, to listen to myself, what I'm saying, whether I'm homing into how I really feel." Counselling was framed as an opportunity to acknowledge vulnerabilities as well as strengths. Narrators expressed taking the opportunity to be in the present and listen to oneself which allowed for spontaneous unfolding in the therapy process. As O' Leary and Barry (2006) highlight, the wealth of experience, wisdom and skills acquired during a lifetime can be applied to improve quality of life.

Two narrators highlighted that the process of listening to oneself needed to be facilitated by their counsellors. It appeared that they were only able to inhabit a reflective space in the presence of another. For instance, Melanie highlighted how sitting down and talking to her counsellor disrupted the cyclical nature of her thoughts and allowed her to ground herself. Likewise, Kate emphasised that counselling involves talking to yourself for your own benefit yet how she was unable to do this "sitting alone". Perhaps this suggests that having to articulate thoughts to a counsellor enabled the process of hearing what one was saying. Narrators appeared to be constructing counselling as a moment of quiet which offered the opportunity to come to terms with themselves and their lives (van Deurzen, 1988).

Related to the subtheme of 'listening to oneself' was the felt permission to express painful emotions. Narrators expressed taking the opportunity offered in counselling to give themselves permission to acknowledge and express painful emotions. The therapeutic space was used to mindfully be in the present thus allowing a reflection on life priorities and emotions. The women took the opportunity offered through counselling to develop a more holistic self-image, incorporating parts of the self that were previously hidden from themselves and others. For example, Clare took the opportunity to express the pain and disappointment felt in her marriage whilst Kate used counselling as an opportunity to connect with suppressed "despair", "anger" and "resentment" borne from sacrificing her life to care for her disabled son.

Some of the narrators felt that due to generational norms and their family upbringing undesirable emotions had been suppressed or hidden. This is illustrated in Kate's narrative in which she revealed that expression of emotional vulnerability was unfamiliar to her, having been brought up in a family environment in which undesirable feelings were suppressed. The current thesis supports Goudie's view (2010), who also suggested that the current older adult population has been discouraged from expressing their emotions. Revealing painful emotions would have been considered shameful and indicative of weakness. For instance, Macy attributed the expectation that she should be able to cope alone to being "indoctrinated" by her generation. Counselling was constructed as the first place in their lives in which permission was felt to acknowledge one's struggle and emote freely, without judgement.

The implication for counselling psychologists is to be mindful of emotional reticence in the therapeutic process when working with older women. This study suggests there should be a facilitation of an environment conducive to the permission of emotional expression. Moreover, an exploration of the meaning this may hold for the individual could be of therapeutic value, particularly in the context of their wider life narrative and self-concept.

Furthermore, of note in the study's findings was the absence of reference to the therapeutic model used in the counselling sessions. When prompted, Kate described the approach as "eclectic" emphasising that this was her own interpretation. The other five narrators could either not recall or stated that this was not discussed. This absence was revealing in itself. I wondered whether the six women were aware of the different therapeutic orientations and whether they had a choice of the model employed by their counsellor.

On the one hand, informed choice could mean that certain approaches are avoided due to former negative experiences. It could also be argued that as therapists we are in a better position to choose the most appropriate approach for our client based on an initial assessment. Furthermore, many therapists change their therapeutic approach as the sessions progress and in light of re-formulations. Indeed, as counselling psychologists we are in the privileged position of being able to work integratively and pluralistically, drawing from a range of therapeutic models.

On the other hand, perhaps the issue of informed choice is worth discussing in therapy services that employ counsellors or psychotherapists who are trained in one

particular model. At the mental health charity attended by the narrators, many of the therapists were trained in one model. The assessor decided which therapist the client should be matched with. This meant that the client had unwittingly committed to a model that they knew nothing about.

One argument is that in therapy services with psychotherapists limited to one particular model, perhaps more agency could be given to the client. This could be done by briefly explaining the various orientations and together with the assessor make a collaborative decision about which therapeutic framework may best address the client's needs. This echoes existing literature on 'therapy education' (Gallagher-Thompson & Thompson, 1996), referring to the responsibility of the therapist to inform the older client about psychotherapy. Nordhus, Nielsen and Kvale (1998) find this term especially relevant with regard to the older client's expectations about psychotherapy. The authors suggest that in terms of maximising the therapeutic effect with the older client, a careful discussion of the individual's expectations and an explanation of the limits of therapy are central elements in establishing the therapeutic relationship.

Contextualising the current study's findings in older women's general help-seeking behaviour

It is important to contextualise the current study's findings in older women's general help-seeking behaviour regarding their health. The aim is to identify what is different and what is the same about the process of seeking counselling for mental health problems compared to seeking professional help for physical health problems in older women. For this purpose, the three overarching themes which emerged from the analysis have been revisited with the view of explaining how the findings fit into the wider literature on older women's help seeking behaviour for health problems.

1. Expectations and attitudes towards help-seeking from healthcare professionals

The current study found that narrators' expectations about engaging with counselling were predominantly negative. Narrators' expectations and subsequent hesitancy about engaging with counselling were largely shaped by cultural and generational factors. Dominant cultural narratives about mental health problems as indicative of weakness and inadequacy permeated narrators' stories. These wider narratives exacerbated feelings of ambivalence and shame about engaging with

counselling. Social stigma around mental health problems and seeking professional help compounded feelings of shame and inadequacy for several narrators.

The literature reveals that women's rates of utilisation of almost all health care services are higher than men's (Corney, 1990) as women are more likely than men to actively seek medical care when they are ill (Tudiver & Talbot, 1999). This reflects women's greater willingness to acknowledge when they are troubled and seek support. Women's greater emotional literacy and readiness to talk to others about their feelings and seek help may act as a protective factor against severe emotional distress (Mental Health Foundation, 2015).

The literature highlights the similarities between the process of seeking help (or not) for physical and mental health problems in older women. Recognising and interpreting symptoms is necessary for help seeking to occur yet, this may not be sufficient to trigger seeking help even if symptoms are interpreted correctly (Smith, Pope & Botha, 2005). Physical symptoms are often minimised or attributed to ageing which appears to be a similar attitude to how older women respond to emotional or psychological problems (Levy & Langer, 1994). Moreover, older women may not want to present to their GPs for seemingly minor physical symptoms to be told nothing is wrong, as this could cause embarrassment (Carson, 2005; Shaw, Brittain, Tansey & Williams, 2008).

Yet, in comparison with seeking help for physical health problems, the literature reveals that mental health services are less frequently used by older women as compared to the family physician or seeing the clergyman (Husaini, Moore & Van Cain, 1994). One of the main reasons for this reticence in seeking help for mental health issues compared to physical health issues is the social stigma still attached to admitting to psychological or emotional problems in older adults (Murray et al., 2006; Scrutton, 1999; Sirey et al., 2001).

The literature suggests that the impact of stigma is two-fold; public stigma is the reaction that the general population has to people with mental illness. Self-stigma is the prejudice which people with mental illness turn against themselves which may prevent them from seeking help (Corrigan & Watson, 2002). Increased awareness of mental health problems is likely to challenge feelings of shame and normalise help-seeking behaviour and therapeutic interventions in the same way that treatment for physical health problems has been largely normalised.

2. Keeping up an appearance of stoicism

Almost all the narrators in the current study spoke about maintaining an image of stoicism and resiliency with family and friends in the face of life's adversities. Consequently, this meant that they had been reluctant to seek help which in some cases exacerbated their problems. The three main factors which maintained this projected image were firstly, the fear of judgement from others regarding their emotional distress. This appeared to mirror wider cultural attitudes towards mental health problems and emotional expression. Secondly, the assumption that other people would not understand or empathise with the narrators' struggles. Non-disclosure was therefore related to the anticipation of negative interpersonal responses to disclosure. Thirdly, shame was a strong factor in experiencing emotional problems which maintained a reticence in seeking help.

Similarly to mental health problems, there is research highlighting the perception that physical illness is associated with a lack of 'moral fibre'. This has been reported frequently, particularly in older women (Blaxter & Patterson, 1982). The literature suggests that consequently there is a natural reluctance for older women to describe themselves as ill (Walters, Iliffe & Orrell, 2001). It has also been argued that older women tend to minimise their health problems in order not to fulfil negative images and be labelled in the negative stereotype of old age (Sidell, 1995).

Another finding from the current study was that half of the narrators were carers. Almost 1.3 million people aged 65 and older are carers in England and Wales (Census, 2011). Whilst the total number of carers has risen by 11% since 2001, the number of older carers has risen by 35% (Caring into later life, Carers UK, 2015). The 2011 Census indicated that 58% of carers are female. Female carers are more likely to suffer from anxiety or depression than women in the general population (Mental Health Foundation, 2015). Caring for a partner or relative alone may contribute to an individual's social isolation and feelings of loneliness, particularly if help is not sought. Perhaps older women feel they need to 'be strong' in order to fulfil their carer role. Indeed, many carers are reluctant to ask for help and local authorities assume that carers are coping well until they tell them otherwise (Douglas & Philpot, 1998).

3. Taking opportunities

Narrators in the current study discussed how 'gatekeepers' such as GPs offered them the opportunity to access counselling. Indeed, the literature suggests that GPs are often people's first point of contact when seeking help for both psychological and physical health problems and tend to be widely trusted and respected by the public (Kmietowicz, 2002). Consequently, these doctors have a huge influence on patients' conceptualisation of their difficulties and play a central role in patients' help-seeking process (Howie et al., 1999).

In the present study, the final decision to proceed with counselling was often a shared decision between the narrator and their gatekeeper. Yet, there is research indicating older patients are more likely than younger patients to accept and follow their GP's advice, preferring instructions on what to do based on past experiences of not being involved in decision-making (Wetzels et al., 2004).

Indeed, many of the narrators began counselling with a constructed identity as passive recipient expecting to be 'cured' by an expert. This was based on their previous experience of treatment for physical health problems. Yet, there is research indicating that from the patient's perspective, the outcome of a GP consultation is not assessed only by cure or symptom relief but by understanding, confirmation, reassurance, change in self-perception and satisfaction (Rudebeck, Andersson & Andén, 2005). Patients assess outcome within a context that embraces the person, the body as an aspect of the person, and the person's understanding of what is going on in his/her own physical body.

In fact, Rudebeck, Andersson and Andén (2005) suggest that cure of an illness or disease is quite often of limited importance compared to other factors related to the doctor-patient relationship such as understanding, trust and reassurance. The study therefore proposes that outcomes of consultations, from the patients' point of view, to a great extent concern how to deal with life changes caused by ill health. Therefore, similarly to the process of psychotherapy in which the client-therapist relationship is of central importance (Bugental, 1978; Corey, 2012; Yardley, 2000), the above study highlights that the quality of the GP-patient relationship is key in patients' assessment of consultations which is likely to influence future help-seeking behaviour (Howie et al., 1999).

Regarding older women's help-seeking behaviour from GPs for physical health problems, there is research suggesting that women aged 65 and above often feel that their problem is not serious enough to seek help from primary care services. They justify this by using internal rationales (they want to be associated with a positive image and attitude) and external rationales (they do not want to waste GPs' time for trivial reasons) (Dollard, Braunack-Mayer, Horton, & Vanlint, 2014). By not taking opportunities offered by primary care services, due to a range of barriers, could mean that many older women's physical and mental health problems are left undetected and untreated.

4.2 Methodological challenges

Throughout the research process I encountered three main methodological challenges, namely my dual roles as researcher and practitioner, ethics of interpretation in analysing the data and establishing validity in narrative research. The following section will explain the dilemmas faced and how with the use of supervision, reflexivity and wider readings attempts were made to navigate through these challenges.

4.2.1. Dual roles as researcher/ practitioner

One of the most challenging ethical and methodological dilemmas was negotiating my dual roles as researcher and practitioner. This was particularly pertinent in the current study as the aim was to elicit stories of counselling thus the narrators storied their difficulties leading them into counselling and the emotional struggles they still faced. During interviews, I was mindful of not slipping into 'therapist mode' and the research interviews evolving into counselling sessions. As narrators were aware of my status as a trainee psychologist, my impression was that I was seen in the same light as some of the women's counsellors. Similarities between some of the narrators' counsellors and myself were remarked upon. For example, Macy commented, "I just felt very comfortable in her presence, and in yours I might say."

Nevertheless, it felt ethical and appropriate to use my skills as a third year trainee psychologist to facilitate the interview process by creating an environment conducive to storytelling. It felt fitting to use the person-centred skills of empathy, unconditional positive regard and transparency. This view is supported by Rosenblatt (1995) who claims that intrinsic to in-depth interviewing is the use of

basic counselling skills such as active listening, being non-judgemental and realising when something has been misunderstood. An effort was made to appreciate how it would feel as a participant in the current study and the challenges involved in disclosing personal experiences to a researcher.

It was hoped that the interview process would be therapeutic with a small 't' for the narrators. The aim was for participants to leave the process in the same or in a slightly more positive state than when they arrived. However, Parker (2005, p. 52) outlines one of the pitfalls of research as researchers' belief that it is 'therapeutic for the interviewees to tell me about this'. He cautions against the assumption that digging out something traumatic for public view can then be covered over. There was an awareness of potential intrusion into painful private material thus narrators were not encouraged to reveal more than they felt comfortable doing regarding their mental health, relationships and counselling experiences.

4.2.2. Ethics of interpretation

The existence of alternative readings of data is a basic assumption of all qualitative research methods (Willig, 2013). In our work as researchers we make choices regarding what to include and what to exclude (Richardson, 1990). We do not simply chronicle what happened. Interpreting and representing the narrators' voices was not an easy task. Respectfulness and humility were therefore important to do justice to the six women who had kindly entrusted me with their personal stories.

Through conducting this research it was found that narrative analysis involves a high level of interpretation of data. The act of interpretation always involves a process of transformation as what presents itself is looked at in a new light, from a different angle, through a different lens shaped by the researcher's aims. As a result, the interpreter has the power to shape what comes to be known about somebody's experience (Willig, 2013). This in itself holds much responsibility. It was hoped that there would be an analysis and synthesis of the data for the purposes of the study whilst at the same time staying true to the narrators' individual stories and privileging the six women's unique voices.

Interpretation in narrative analysis is framed as a central ethical problem in narrative research (Clandinin & Huber, 2010; Squire, Andrews & Tamboukou, 2008). As put by Smythe and Murray (2000, p. 325), 'given [the researcher's] unique perspective on people's stories, it is imperative that they claim some ownership and control' over

the analysis process and findings produced. In the current study an effort was made to accurately represent the women's stories by presenting extensive extracts from the transcripts to highlight and support the analysis. The aim was to convey throughout that interpretations made were my own and did not reflect any form of absolute truth.

4.2.3. Establishing validity

The term valid can be defined as 'well grounded; having such force as to compel acceptance' (Webster, 1966). Narrative research makes claims about how people understand situations, others, and themselves (Polkinghorn, 2007). A challenge identified within narrative research concerns establishing the validity of interview narratives. Many researchers propose a focus on the 'narrative truth' of the material gathered, the individual truth and meaning for that person, rather than measuring it against some objective truth of the outside world (Webster & Mertova, 2007). Indeed, Riessman (2008) suggests that fixed criteria for validity developed for experiential research are not suitable for evaluating narrative studies.

Instead, Riessman (2008) suggests focusing on the trustworthiness of stories collected and the analytic stories developed from them. She highlights that the validity of a study should be assessed from within the paradigms that spawn them. The current study was situated within a contextual constructionist epistemological framework. As a consequence, the aim was not to find a measurable objective truth but rather to elicit personal narratives revealing truths about subjective human experience (Riessman, 2008) whilst taking into account contextual issues and my interpretation of the accounts. In establishing trustworthiness, transparency about the methodological choices made and the analytic procedures employed were explored, whilst adhering to the BPS's ethical guidelines.

Furthermore, Polkinghorn (2007) suggests that interpretations of narratives be well grounded in the narrative data that produces them. In the present study, extensive verbatim quotes from the transcripts were presented in an effort to contextualise and support my interpretations. The present study is not claiming to have found the true meaning of narrators' stories, but rather to present my own subjective interpretations.

4.2.4. Anonymity and ‘giving voice’

As explained in the methodology chapter, the current study ensured the anonymity of the six participants in line with BPS ethical guidelines. However, following wider readings of ethical issues in research, my long-standing assumption of the unequivocal ethical value of anonymity was challenged, particularly in narrative research claiming to ‘give voice’ to narrators as was the case in the current study.

Parker (2005) argues that to conceal the identities of research participants might be the most convenient and easiest option, but not necessarily the most ethical one. He believes that one of the effects of concealing a participant’s identity is that they are thereby denied the very voice in the research that might originally have been claimed as its aim. It may also confirm one of the prevalent images of those who are researched by psychologists as fragile beings needing to be protected by others (McLaughlin, 2003). Parker claims that this portrayal of participants is itself an ethical position. He suggests that it may be more ethical to discuss openly with participants whether or not they might actually prefer to be named and to speak openly for themselves. This was a dilemma; I wonder whether narrators should have had this choice in the current study.

4.3 Evaluation of the study

4.3.1. Limitations

Like all research studies, the current study is not infallible. Due to the small sample size common in qualitative research, the results of this study are not generalisable to the wider population of older female clients. The sample was also limited in the geographical area from which it was drawn, namely the south of England. Yet, the aim was to elicit in-depth descriptions of the six narrators’ counselling experiences and not to predict future older female clients’ experiences. Moreover, the analysis was context specific as it was assumed that the stories were co-constructed by the narrators and myself.

Although an attempt was made to recruit both older male and female former clients, no men expressed an interest in participating in the study. This inevitably presents a bias in the sample. However, perhaps this lack of response is revealing in itself. A

study by MacDonald et al. (2006) found that older men were particularly reluctant to disclose emotional distress to primary care professionals despite being more vulnerable to severe depression and suicide than older women. Moreover, research suggests that many men have a negative image of therapy, seeing it as shameful and indicative of weakness (Twining, 1996). Vacha-Haase (2010) highlights that it may be even more difficult for older men to overcome negative stereotypes about psychotherapy due to traditional gender roles and this is compounded by narrow views of masculinity. Even when men realise they are depressed or have another problem, they are less likely than women to see a mental health professional (Mahalik, Good & Englar-Carlson, 2003). Consequently, it is likely that the pool of potential male respondents in the current study was relatively small.

In addition, the six women in the study were what Neugarten (1974) described as 'young-old', (aged below 80) rather than 'old-old'. The socio-historical contexts of the lives of individuals aged above 80 may have meant that their expectations and experiences of counselling were very different. In support of this view, a study by Zank (1998) found that prejudices and fears about psychotherapy were higher in 'older-elderly' as compared to 'younger-elderly'. Due to time constraints of the DPpsych training course, the study was time-limited. With more time, perhaps I would have had the opportunity to recruit and interview more participants, including individuals aged above 80. This would have meant more varied data which is likely to have enriched the analysis and findings.

Perhaps a further limitation of the study was the use of a single in-depth interview with each participant. If interviews had been conducted on two or even three occasions rather than the one single meeting this could have possibly provided the opportunity to establish an even greater rapport with the participants, putting them at ease and potentially allowing them to feel more able to open up and share more detailed and in-depth data. This may have meant that participants might have felt more comfortable deeply describing difficult or emotionally laden experiences to me as someone with whom they had prior contact and established at least some level of trust (Adler & Adler, 1994). Yet it could be argued that such extended contact may also lead to blurred boundaries between researcher and participant, especially if the researcher is a therapist (Haverkamp, 2005). This echoes the aforementioned challenge of my dual roles as researcher and practitioner.

No research method is without limitations and no method can tell us everything about a phenomenon. Narrative methodology is no exception. It is always problematic to move from lives to texts (Goodley, 2000). In the current study, the process of transcription was problematic in itself regarding capturing the authenticity of narrator's stories of counselling. The transcripts were inevitably subject to manipulation before the official process of Langdridge's critical narrative analysis had begun. By translating from one kind of language into another; from something that was designed to be heard into something that is meant to be read (Parker, 2005) may have meant that some meaning was lost. Changing spoken words into text loses gestural and visual information. Moreover, in presenting extracts from each narrator's interview, I cannot claim that these represented their 'authentic voice'. The process of selection, commentary and analysis of these extracts were inevitably influenced by my position as researcher.

Further, due to its highly interpretative nature, narrative research involves a re-storying of the participants' stories. Indeed, narrative analysis involves the re-representation of a participant's story, a re-representation that runs the risk of an implicit pathologisation of the storyteller (Squire, 2008), especially in relation to stories of personal trouble. This inevitably means that what is represented in the current study's findings is based on my interpretations, analysis and viewpoint. As Riessman (2008, p. 188) highlights, I was 'storying the stories collected'. This raises the question of who's stories are being represented and who can claim ownership of the stories being told in the current study?. As Estroff (1995) states: 'Whose story is it anyway?'.

Indeed, as narrative research is interpretative in nature, the researcher will formulate meanings for participants' narratives which might deviate from participants' understandings of their narratives. This issue of interpretation is thought to be the central ethical problem in narrative research (Clandinin & Huber, 2010; Squire, 2008). Bar-On (1996) claims that interpretative responsibility should be assumed by the researcher in that, once a narrative had been analysed, the text belongs equally to the researcher and to the participant. In the current project, in order to address this issue, I attended to the interview text with the utmost respect and attempted to accurately present participants' told stories by presenting word-for-word excerpts from the transcripts highlighting and supporting the analysis.

With regards to analysis, Langdridge's CNA is a comprehensive form of narrative analysis, enabling the exploration of multiple facets of narrative accounts including tone, function, themes and how the self is presented. However, in adopting this methodological lens, there were aspects of the narratives that were not explored for example, the linguistic properties and structure. Perhaps incorporating social linguist James Gee's (1991) linguistic approach to narratives would have provided an extra layer of structural analysis thus enriching the understanding of older women's experiences of counselling. In Gee's (1991) approach, interpretation of meaning begins with close examination of how a narrative is spoken in units used in planning speech, such as idea units, lines, stanzas and strophes (Riessman, 2008). Due to length constraints of the current study this narrative method will not be discussed in more depth (for further readings see Gee, 1991). Moreover, the analytic process did not include how each narrator's social class, academic background and ethnic background may have shaped experiences of counselling and the expression of these experiences to me, a white British, middle class doctoral student.

There is a view that it is good practice to allow narrators to give feedback on findings from research (Yardley, 2008). Regretfully due to time constraints this was not feasible, therefore all findings reflect my personal interpretations of the interview data. In hindsight, participants could have been invited to read through their transcripts, giving them the opportunity to remove any information they did not want included in the study.

Narrative analysis was a time-intensive analytic procedure. With more time, perhaps I could have engaged in member checking. This is when data, analytic categories, interpretations and conclusions are tested with members of those groups from whom the data were originally obtained. Member checking would have allowed me to collaborate with the participants in co-constructing the meaning of their stories. It could be argued that member checking is a technique for establishing the validity of an account. Indeed, Lincoln and Guba (1985) posit that this is the most crucial technique for establishing credibility.

Member checking would have enabled participants to correct errors and challenge what may have been perceived as wrong interpretations. Yet, Morse (1994), Angen (2000) and Sandelowski (1993) each offer comprehensive critical reviews of the use of member checks for establishing validity in qualitative research. They argue that this process relies on the assumption that there is a fixed truth of reality that can be accounted for by a researcher and confirmed by a

respondent. From an interpretive narrative perspective, understanding is co-created and there is no objective truth or reality to which the findings of a study can be compared.

Furthermore, mindful that stories are always crafted for an audience (Parker, 2005), perhaps the narrators assumed that as I had worked for the mental health charity I only wanted to hear positive experiences of counselling. Perhaps I was positioned by narrators as being affiliated with or even representing the charity or counselling profession and therefore seen as biased. This may have inhibited the narrativisation of negative aspects of experiences or feelings towards the counsellor. Further, regarding the relational aspect of the interviews, perhaps as a researcher in my late twenties, some participants may have felt that I would not be able to fully empathise with their experiences and therefore may have been less forthcoming with personal information.

Finally, participants were self-selecting therefore there is a likelihood that the people who volunteered to take part in this study were also those who had experienced more benefits from counselling and therefore felt comfortable discussing their experiences. Considering this, one can question if this may have had an effect on the sample acquired and then in turn on the data gathered. It may be that people who had a negative experience of counselling would be unwilling to share their stories with a trainee counselling psychologist. Having said that, my experience of the interviews was that a good rapport was established with all six narrators. This allowed the narrativisation of positive and negative aspects of their counselling experiences, including the sharing of their thoughts about their counsellors.

4.3.2. Avenues for future research

The current study identified themes related to older women's experiences of counselling that suggest several avenues for future research. Further exploration of older female clients' sense of agency both in the referral process and in the therapeutic process could help these clients integrate values such as independent problem solving (Zank, 1998) with empowerment and trust in the therapeutic relationship. In addition, a more thorough exploration of emotional expression in older women compared to younger women could further illuminate differentiating factors enabling therapists to appreciate the role and meaning-making of emotions. It may be worth investigating whether there is less emotional expressivity in older

female clients and whether this can be attributed to better emotional regulation in later life or a pattern of suppressing undesirable emotions.

As the current study focused on the experiences of former older female clients, it may be interesting to interview older men on their experiences of counselling or have a mixed gender sample to investigate whether there are gender differences in the stories narrated. It could be useful to clinical practice to investigate older men's decision-making processes in engaging with counselling and how this matched their experience. As there is an increased awareness of mental health problems and psychological treatments, it would be interesting to explore whether these changes are reflected in the attitudes of older men who are considering attending or have attended psychological therapy.

A narrative orientation to making sense of the interview data of older men's expectations and experiences of counselling could shed light on how dominant cultural and generational narratives of masculinity and expression of emotion are presented in personal stories of counselling experiences. For example, it would be interesting to examine how Second World War veterans narrated the story of their decision to enter into counselling and their meaning-making of the encounter. Identifying aspects of therapy older men find most useful would be valuable knowledge for clinical practice.

A narrative orientation to research might be particularly helpful in giving voice to other marginalised or stigmatised groups in our culture such as ethnic and sexual minorities. This could increase insight into their counselling experiences, which could be used to improve clinical practice. A narrative approach to research acknowledges wider societal attitudes by illuminating dominant cultural narratives whilst preserving the integrity of each narrator's personal story.

4.3.3. Final reflections

One of the advantages of adopting a narrative approach to research was its specificity and corresponding depth of focus. This allowed for the documentation of particular constellations of context and relationships that might not have been visible by employing a different approach. However, I underestimated how time-consuming transcribing and analysing would be. The process of narrative analysis was particularly demanding and laborious. Making sense of the extensive data was at times overwhelming and anxiety-provoking. It was helpful to allow myself to stay with these feelings of bewilderment at the early stages of reading through the

interview material and attempting analysis, holding in mind that this was a natural part of the process.

Langdridge's (2007) six-stage model was a tangible, structured form of narrative analysis allowing for the exploration and synthesis of different facets of the narrators' stories. It therefore balanced complex and multi-faceted analysis with a methodical structure, which was ultimately illuminating and rewarding.

As therapists we are constantly listening to clients' stories as gateways into their worlds and meaning-making. By doing so we gain insight into how they position themselves in relation to others, what is focused on and what may be the message or function of the story they are telling us. For this reason, narrative analysis is highly compatible with the ethos of counselling psychology and therefore suited to research from a counselling psychology perspective. Excitingly, the opportunities provided by narrative research are extensive and still being developed (Murray, 2003).

4.4 Conclusion

The aim of the current study was to explore how older women construct their decision to enter into counselling and their experience of counselling. Regarding participants' decision to enter into counselling, a narrative analysis of the data revealed that generational factors and family upbringing coloured older women's perceptions of emotional distress often associating it with personal inadequacy or weakness. This meant that there was hesitancy and ambivalence towards seeking professional help. Also, some of the narrators' preconceptions of counselling had a medical tone, anticipating another medical professional prescribing a treatment that would 'cure' them.

The narrators reported that other healthcare professionals such as GPs played a pivotal role in their decision to engage in counselling. These 'gatekeepers' informed the women of the availability of counselling and referred them for therapy or encouraged self-referral. The attitudes and beliefs of these gatekeepers regarding mental health problems mediated the narrators' access to counselling. Another facet in the women's decisions to enter into counselling was a lack of close, trusting relationships in their lives. Issues of emotional isolation and loneliness often perpetuated the narrators' problems. Moreover, some of the narrators purposefully chose to confide in a counsellor rather than family or friends for fear of burdening

them or because they worried that their perceived identities as “strong” and “resilient” women would be lost.

The narratives generally functioned to challenge social stigma around seeking counselling and other forms of mental health support, emphasising how attitudes had changed dramatically since they were young. Narrators used their own counselling stories as advocates for the benefits of counselling, particularly in acknowledging and expressing emotional distress.

Narrators constructed their experience of counselling as a place in which they could listen to themselves, without outside voices impeding. Engaging in a dialogue with oneself illuminated what was meaningful. This was a novel way of relating to the self for some narrators, especially for those in the role of carer, who had neglected their own emotional needs. Counselling experiences were constructed as giving narrators permission to connect with and express difficult emotions. In the context of wider life stories, this permission had not been previously felt by some of the narrators.

Furthermore, counselling was framed as helping the women develop a sense of agency by strengthening a belief in their control of both the therapeutic process and their difficulties. In the psychotherapeutic process, narrators’ identities shifted from passive recipients of therapy to active agents of positive change. This helped to acknowledge choices in their relationships as well as developing ownership of their emotions and behaviour.

Finally, counselling was presented as a safe place in which most of the narrators felt comfortable to open up. This meant that for some narrators their emotional distress was validated for the first time in their lives. They reported feeling understood and accepted by their counsellor and for some of the women this was narrated against a backdrop of societal ageism. Due to length constraints the theme of ‘opening up in a safe place’ has not been reported in the current study. This theme is presented in Part 2 of the portfolio in a paper intended for publication in the *Journal of Counseling Psychology*.

It is hoped that the current study presents a positive contribution from a counselling psychology perspective towards working psychotherapeutically with older women. Although it is my belief that similarities outweigh differences between younger and older clients, this study sheds light on facets of older women’s experiences that

could help us as therapists to have a greater appreciation of their expectations and meaning-making of counselling.

Counselling psychologists are in a powerful position to challenge the dominant cultural narratives of older age as a time of inevitable decline, illness and emotional distress as portrayed by the loss-deficit model. These cultural discourses perpetuate ageism that impact upon healthcare professionals' attitudes towards engaging with older women. These attitudes may also be internalised by many women, which could further deter help-seeking for problems that are framed as the normal trajectory of later life. This combined with worries about burdening others or wasting resources may mean that many older women will continue to suffer in silence.

With a rapidly increasing life expectancy, by 2030, 20% of the UK population will comprise of the over 65s (Office for National Statistics, 2011). With counselling psychologists' commitment to wellbeing throughout the lifespan (Strawbridge & Woolfe, 2003), an understanding of how older female clients experience counselling is likely to be of increasing importance in the coming years.

4.5. References

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5. Appendices

Appendix 1: Ethics release form

Appendix 2: Recruitment flyer

Appendix 3: Participant information sheet

Appendix 4: Consent form

Appendix 5: Narrative interview schedule

Appendix 6: Resource sheet

5.1 Appendix 1:

Ethics release form

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc M.Phil M.Sc **D.Psych** n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

Older people's decision to enter into counselling and their experience of counselling; A narrative analysis.

2. Name of student researcher (please include contact address and telephone number)

Lydia Rizopoulos

Email: [REDACTED] Telephone: [REDACTED]

3. Name of research supervisor

Dr. Nikki Scheiner

Email: [REDACTED] Telephone: [REDACTED]

4. Is a research proposal appended to this ethics release form? **Yes** **No**

5. Does the research involve the use of human subjects/participants? **Yes** **No**

If yes,

a. Approximately how many are planned to be involved?

8-10 participants

b. How will you recruit them?

I will recruit my participants through [REDACTED] I will put up posters and adverts in their newsletters and magazines.

c. What are your recruitment criteria?

(Please append your recruitment material/advertisement/flyer)

Inclusion criteria: Men and women age 65+ who have had at least one course of counselling in the UK. Fluent in English. This will be assessed over the phone.
Exclusion criteria: Language, communication or severe cognitive impairments (memory, attention) as the collection of data relies upon verbal communication. I will set up a brief telephone conversation with each potential participant to screen for these impairments before deciding upon whom to recruit. People currently in psychological therapy will also be excluded. In my recruitment flyer I will specify my exclusion criteria and if some people have these impairments I will sensitively let them know that they may not be right for my study.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? **Yes** **No**

d1. If yes, will signed parental/carer consent be obtained? **Yes** **No**

d2. If yes, has a CRB check been obtained? **Yes** **No**
(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? (If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).

Each participant will be required to devote approximately one hour of their time to be interviewed. Interviews will be carried out in a private room at City University, however if participants are unable to make this journey I will carry out the interviews in their homes or in a private room in a public library near to their homes.

7. Is there any risk of physical or psychological harm to the subjects/participants? **Yes** **No**

If yes,

a. Please detail the possible harm?

My research involves asking participants to reflect upon and tell the story of how they came to be in counselling and their experience of it. I am mindful that this may bring up some difficult and sensitive topics which may cause some emotional distress. However, my role is not to explore these issues with them but to help them reflect upon the process rather than the content of counselling.

b. How can this be justified?

The interview questions are quite broad so participants can choose what they wish to reveal. In agreeing to participate in the study, I am assuming that they are willing to talk about these experiences.

c. What precautions are you taking to address the risks posed?

I will use person-centred techniques throughout the interview to help my participants feel safe, understood and not judged. However, I will have to be conscious of not allowing the interviews to evolve into counselling sessions. One way I can prevent this is by not digressing from the interview questions and reminding participants that they can seek support after the interview process if need be.
I will debrief participants and ask each person how they feel after the interview and whether they felt emotionally disturbed by the process. I will check to see whether they feel they would need further emotional support after having taken part. A list of local counselling services may be given or a referral will be made if participants are particularly upset.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes No

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

Yes No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes No

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

I will be keeping research notes and audio-recordings of each interview which will be uploaded onto my personal computer for the purpose of transcription. Data on each individual will be anonymised and pseudonyms will be used.

12. What provision will there be for the safe-keeping of these records?

I will use a password secure computer and keep any written confidential data in a locked filing cabinet. I will not share participant information with any third parties.

13. What will happen to the records at the end of the project?

The audio-recordings of the interviews will be deleted from my Dictaphone and computer. Hand-written research notes will be shredded.

14. How will you protect the anonymity of the subjects/participants?

Once the data is uploaded onto my personal computer it will be anonymised. Pseudonyms will be used. The only record of participants' names will be on the informed consent forms which will be kept in a locked filing cabinet.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

During debriefing, I will ask my participants how they felt after the interview and whether they felt emotionally disturbed by the process. I will check to see whether they feel they would need further emotional support after having taken part and will suggest they seek counselling or another form of support if needed. A list of local counselling services will be given and referrals made if necessary.

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

Signature of student researcher - _____ Date _____

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal
Recruitment Material
Information Sheet
Consent Form
De-brief Information

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? **Yes** **No**

If yes,

a. Please detail possible harm?

My only concern regarding potential risk/harm to myself is in conducting some interviews in participants' homes if they are unable to meet in a public place. In agreeing to meet strangers, particularly in their homes, there is always an unknown element which is risky.

b. How can this be justified?

I will try to recruit participants who are able to meet in a public place however if this is not possible and I do have to conduct the interviews at people's home, I will take certain precautions. These will include letting my supervisor or a friend know the address I will be at and if they do not hear from me after a certain time to contact me. If they are not able to get in touch with me for a certain period of time, I will give them permission to contact the police.

Section C: To be completed by the research supervisor

(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature -----

Date-----

Section D: To be completed by the 2nd Departmental staff member

(Please read this ethics release form fully and pay particular attention to any answers on the form where underlined bold items have been circled and any relevant appendices.)

I agree with the decision of the research supervisor as indicated above

Signature -----

Date-----

5.2. Appendix 2:

Recruitment flyer

**Have you had psychological counselling at age 65 or over?
I would be really interested in hearing about your experience
of counselling**

The voices of people aged 65 and over are not often heard. This is an opportunity to tell your story. I am interested in hearing the story of how you decided to enter into counselling and your experience of counselling.

This study is open to men and women who are fluent in English.

Interview duration: Approximately 60 to 90 minutes.

Researcher: Lydia Rizopoulos
3rd Year Doctoral student in counselling psychology at City University,
London

Your name will not be used in the report of the study and all information
provided will be kept confidential.

Disclaimer: This study adheres to the British Psychological Society (BPS) ethics guidelines and has received ethical approval by the Research and Ethics Committee of the School of Arts and Social Sciences, City University London.

5.3. Appendix 3:

Participant information sheet



CITY UNIVERSITY
LONDON

Participant information sheet

Hello, my name is Lydia Rizopoulos. I am a doctoral student in counselling psychology at City University. This information sheet will provide you with some further details about my study that will help you in deciding whether or not you wish to participate.

The voices of people aged 65 and over are not often heard. This is an opportunity to have your story heard. I am interested in hearing the stories of how people aged 65 and over decided to enter into psychological counselling and what their experiences of counselling were. In order to explore this I would like to ask you some questions regarding your experience. You will be free to tell your story in whatever way you like.

You will not be required to disclose the personal issues addressed in your counselling sessions. The aim of this study is to find out about your experience of being in the process of counselling.

With your permission, I will audio record the interview for the purposes of transcription. All information you provide will remain confidential and will not be associated with your name. However, what you tell me will be discussed with my research supervisor at City University.

Your participation in this study will require approximately 90 minutes. Following the interview, there will be some time to discuss how you feel after having taken part. The location and date of the interview can be negotiated but interviews must be carried out in a quiet room for confidentiality and audibility.

You will be free to withdraw from the study at any point during the interview process without having to provide a reason and your information will be discarded. You will also have the option of withdrawing from the study up to one week following the interview date.

Thank you for your consideration in participating.

Yours sincerely,

Lydia Rizopoulos

3rd year doctoral student in counselling psychology at City University, London

Disclaimer: This study adheres to the British Psychological Society (BPS) ethics guidelines and has received ethical approval by the Research and Ethics Committee of the School of Arts and Social Sciences, City University London.

5.4. Appendix 4:

Consent form

Consent form

My name is Lydia Rizopoulos. I am a doctoral student in counselling psychology at City University London. The following will provide you with information about the study that will help you in deciding whether or not you wish to participate.

I am interested in hearing the story of how you decided to enter into counselling at the age of 65 or over and what your experience of counselling was. In order to explore this, I will ask you some questions regarding your experience. Feel free to tell your story in whatever way you like.

With your permission, I will audio record the interview for the purposes of transcription. All information you provide will remain confidential and will not be associated with your name. The content of the interview will be discussed with my research supervisor. Your participation in this study will require approximately 90 minutes. Following the interview, there will be some time to discuss how you feel after having taken part.

You are free to withdraw from the study at any point during the interview process without having to provide a reason and your information will be discarded. You will also have the choice of withdrawing your data from the study up to one week following the interview date.

Please indicate with your name and signature on the space below that you understand your rights and agree to participate in the study and for the interview to be audio recorded.

Print name:.....

Signature of participant:.....

Signature of Researcher.....

Date:.....

5.5. Appendix 5:

Narrative interview schedule

Narrative interview schedule

I'm interested to know what made you respond and want to be involved in the research?

I'm interested in hearing your story of counselling. This includes the decision to enter into counselling and how you found the process. You are not required to reveal the content of the problems addressed, but rather I'm interested in how you found the process of counselling. Please feel free to tell this story in your own way, focusing on whatever was meaningful and important to you. There are no right or wrong answers as that the purpose of the interview is exploratory. As you tell your story I may interject with questions to ensure certain areas are covered but the priority is on hearing the meaning-making of your experience.

Interview guide

I'm curious to know the story of the decision to enter into counselling?

Prompts if needed:

- Were there other people involved in this decision? How accessible was it?
- Why did you choose to have counselling at that particular time in your life?
- What were your expectations\hopes\fears for counselling?
- What were you feeling as you were making this decision? (anxious, sad, curious, confused, angry).

I'm interested in hearing the story of your experience of counselling?

Prompts if needed:

- How did your expectations compare to your experience of counselling?
- How would you describe your relationship with your counsellor?
- Were you aware of any barriers or resistance in the counselling process from either yourself or your counsellor?
- Looking back, do you think counselling was useful? Is it something you would engage in again?

Was your counselling experience different to other forms of support you have received? If so, how?

Constructivist Questions

If you could go back, would you change anything about your counselling experience?

If your story of counselling were to be made into a film or book what genre would it be, for example would it be a drama, comedy, tragedy, adventure, horror? And why?

Who would be the main character and what would they be like?

Would there be a turning point in the film or book?

If a friend or family member said they were considering counselling what would you say to them? Would you give them any advice?

Is there anything else you would like to add?

5.6. Appendix 6:

Resource sheet

Resource sheet

Thank you for your participation in my study. Please find below the contact details of organisations you may find helpful if you experience difficulties following the interview:

SupportLine

Offers confidential emotional support to children, young adults and adults by telephone and email

01708 765 200
info@supportline.co.uk
www.supportline.org.uk

Samaritans

08457 90 90 90 (24h emergency helpline)
www.samaritans.org.uk

Age UK

0800 169 6565
www.ageuk.org.uk

Mind

Mental health charity providing information, advice & publications on all aspects of mental health.

020 8519 2122
www.mind.org.uk

Women's Aid

Domestic abuse charity
0808 2000 247 (24h helpline)
helpline@womensaid.org.uk

Carers UK

Offers advice, information and support for carers
0808 808 7777
www.carersuk.org

Please do not hesitate to contact me if you have any queries regarding the interview.
Email: Lydia.Rizopoulos.1@city.ac.uk, Telephone: 07866 444 250

Part 2 – Publishable Paper

Opening up in a safe place: A narrative
analysis of older women's experiences of
counselling

Prefix

The following paper has been prepared for submission to the *Journal of Counseling Psychology* and is therefore presented in the format suitable for the journal. The criteria for submission to this journal can be found in the Appendix of this section of the portfolio.

Abstract

This paper presents the theme of opening up in a safe place which emerged from a doctoral thesis exploring older women's counselling experiences. As the study was conducted in the United Kingdom, the context for counselling in the United Kingdom compared to the United States will be briefly discussed. The study aimed to address two research questions: 'How do older women construct their decision to enter into counselling?' and 'How do older women construct their experience of counselling?'. Participants were six former female clients of a mental health charity aged between 66 and 74. Data was collected through semi-structured narrative interviews in which counselling experiences were elicited. Interview transcripts were analysed using Langdridge's (2007) critical narrative analysis. Analysis highlighted participants' constructions of counselling experiences and what was deemed important in the process. Accounts highlighted the significance of sharing and being understood. Participants expressed loneliness and emotional isolation, often having nobody with whom they felt safe in disclosing emotional difficulties. Counselling was constructed as a safe place where this need could be met. The counsellor's age was referred to during narrators' appraisals of being understood. There were varied views regarding the relatively young age of each participant's counsellor. Participants generally experienced their counsellors as validating their distress and accepting them as 'human beings'. For some, this was narrated against a backdrop of societal ageism. The expression or suppression of emotion in counselling was also highlighted. In some cases this was understood within the context of generational attitudes towards expressing vulnerability.

Keywords: older women, counselling, emotional expression, validation, narrative research.

Background

A larger doctoral thesis was written entitled *Older women's stories of counselling: A narrative study*. From this thesis, four themes emerged. The current paper presents the fourth theme, *opening up in a safe place*, which was not included in the original study due to length constraints. Further, it was felt that this theme deserved a separate publication as it highlights important aspects of older women's counselling experiences with implications for counselling psychology practice and referrers.

The current study was conducted in the south of England, United Kingdom. It is important to highlight that the context for counselling in the United Kingdom differs from the United States. In the United Kingdom, the title of 'counsellor' is not protected by law meaning that anyone can legally call themselves this title. Furthermore, unlike the United States, the United Kingdom does not regulate the profession by means of licensing. This means that counsellors are not required by law to hold a license in order to practice counselling. Counselling is not a statutorily regulated profession in the United Kingdom, neither is there a nationally recognised qualification at present.

However, The British Association for Counselling and Psychotherapy (BACP) sets minimum standards for competence to practice through its membership criteria and through the Certificate of Proficiency for entry to the BACP Register. Counselling courses accredited by the BACP are widely recognised in the profession. Indeed, the voluntary register maintained by the BACP has been accredited by the Professional Standards Authority. All members are currently bound by the BACP Ethical Framework for Counselling and Psychotherapy.

The current paper has been written with psychological therapists in mind, as it sheds light on particular issues pertinent to clinical practice. The theme of 'opening up in a safe place' highlights six older women's need to share and be understood by their therapists. This paper also discusses the importance of older women's need to feel accepted and validated in therapy. For some of the women, this need was narrated against a backdrop of societal ageism in which they felt invalidated due to their age. At the same time, the current paper highlights some of the narrators' struggle with emotional expression, particularly expression of undesirable or painful emotions. It may therefore be useful for psychological therapists to be aware of these issues when working with older female clients.

This paper has also been written to guide the practice of potential referrers of older women to psychological therapy services. The article encourages potential referrers, such as GPs, to be curious about older women's existing support network and possible emotional isolation which may not be directly expressed by the individual. Further, this paper highlights to potential referrers some of the benefits that can be gained through referring an older woman to counselling, particularly as an opportunity to explore their emotional landscape in a safe place.

Whilst recognising the complexities of defining old age, for the purpose of this study the term 'older adults' refers to people aged sixty-five and above, as Libman (1989) defined old age. This is based upon guidelines from the Department of Health (2001) and current literature (Knight, 2004; Patrick, 2006). The proportion of older people across the world is increasing at a faster rate than any other population group (United Nations Population Fund, 2005). As O'Leary and Barry (2006) strongly advocate, growing numbers of older people imply a need for increased attention from counselling and therapy professionals. The BACP defines counselling and psychotherapy as:

“Umbrella terms that cover a range of talking therapies. They are delivered by trained practitioners who work with people over a short or long term to help them bring about effective change or enhance wellbeing.’ (BACP, 2013).”

The last fifteen years has seen the emergence of a substantial body of literature on the application of psychological therapy and counselling models with older people (Evans & Garner, 2004; Hill & Brettell, 2004; Knight, 1996; O'Leary, 1996; Terry, 1997). As Hill and Brettell (2004) highlight, the increasing focus on evidence-based approaches and treatment outcomes (NICE guidelines; Cochrane Collaborations) more frequently includes older populations within the sampled populations or targets research and reviews specifically at them.

The literature suggests that the main difficulties faced by older people are loss in all its manifestations: loneliness, depression, anxiety, anticipation of death and cognitive decline (Hepple, Pearce & Wilkinson, 2002; O'Leary & Barry, 2006; Orbach, 1996; Wolpert, 2011). There are various theories of ageing, each suggesting how to work psychotherapeutically with older clients. As Knight (2004), explains, the loss-deficit model of older age portrays the normative course of later life as a series of losses and the typical response as depression. As O'Leary and

Barry (2006) cogently argue, the common beliefs and attitudes that accompany this model can be summarised as: ageing, fragility and illness are basically synonymous and inevitable, thus should be accepted as the norm, along with the emotional distress people experience in older age. The authors astutely observe that consequently, these beliefs and attitudes inform the approaches toward working with older adults, viewing therapy as assisting in their adjustment to the natural losses of later life. However, it could be argued that by focusing only on acceptance and coping, this model limits the possibility of optimising functioning and improving life experience.

Knight (2004) advocated a different view on ageing, criticising the loss-deficit model for failing to recognise that loss is not unique to older adults, but rather can occur throughout life. As an alternative, Knight (2004) proposed the contextual, cohort-based, maturity, challenge-specific (CCMSC) model. It could be argued that this model brings greater understanding to the varied factors contributing to older adults' worlds.

According to Knight (2004), cohort differences are explained by membership in a birth-year-defined group that is socialised into certain beliefs, attitudes and personality dimensions that will stay stable as the group ages and that distinguishes that cohort from those born earlier and later. The model advocates that as part of understanding the older client, the therapist needs to explore the client's base of experience as a member of a particular cohort.

The model further asserts that social context will influence older adults' experiences and that therefore their environmental realities should be considered in psychotherapy. Moreover, unlike the loss-deficit model, the CCMSC model recognises the specific nature of challenges thus differentiates the issue from ageing itself and brings more accurate understanding and responsiveness to clients' needs.

The current study was theoretically influenced by Knight's CCMSC model in that it considered the wider social context of participants' narrativisation of counselling experiences. Close attention was paid to narrators' environmental realities including the expression of social and emotional support or lack of and how this related to their counselling encounters. The current study was also mindful of how wider cultural narratives of mental health and attending counselling were woven into

narrators' stories. Further, participants' reference to cohort membership and how this influenced their attitudes and engagement with counselling were also explored. As illuminated by Butler (1969), old-ageism can be seen as reflecting a deep-seated uneasiness on the part of the young and middle-aged: a distaste for growing old, disease, disability and a fear of powerlessness and death. Negative stereotypes of older age have social, psychological, and physiological consequences. Levy and Langer (1994) astutely observe that ageism may compound a client's distress and internalised ageism could influence their self-worth and belief in positive change. This informed the current study, as close attention was paid to the reference of ageism, including internalised ageist attitudes, in participants' narrativisation of counselling experience.

Research has highlighted the complexities in regard to older women attending psychotherapy services. Hayslip, Schneider and Bryant (1989) undertook a study focusing on older women's perceptions of counsellors of the same gender. Ninety-six women served as pseudo-clients in an analogue study in which they were presented with counselling vignettes. They found that the participants would have perceived younger counsellors more positively when discussing intimate topics, whilst preferring older counsellors for discussion of less intimate issues. This perhaps highlights the complexity of the issue of older clients not readily disclosing emotional difficulties. However, this study could be criticised for using artificial scenarios rather than obtaining phenomenological data of real counselling encounters. Nevertheless, the study was helpful in highlighting the counsellor's gender and age in older women's disclosure of intimate topics. Influenced by this study, in the present study, attention was paid to whether stories of counselling included the counsellor's age and the narrator's interpretation of this during their counselling process.

In their study, MacDonald and Morley (2001) found that shame is a strong factor in emotional isolation and non-disclosure of people struggling with emotional and personal experiences. Shame was therefore found to inhibit people from seeking help. In their qualitative study, participants were referred to an NHS psychotherapy department and given a modified form of Oatley and Duncan's (1994) emotion diary which included questions about whether each recorded emotion had been subsequently disclosed to anyone.

One week later the diaries were collected and participants interviewed. The results indicated that a majority of the emotional incidents recorded in the diaries were not disclosed (68%). Analysis of the interview data revealed that non-disclosure and emotional isolation were related to the anticipation of negative interpersonal responses to disclosure in addition to shame. Although the study could be criticised for its small sample size (34), the use of an emotion diary was a useful method of data collection enabling the collection of insightful written data from participants. However, perhaps the study would have been more credible if participants were asked to keep a diary over a longer period of time. This informed the current study as attention was paid to the mention of shame and whether narrators' decisions to enter into counselling made reference to emotional isolation and a perceived lack of people in their lives whom they felt they could disclose emotional difficulties to.

In the existing literature, there is an absence of the voices of older women in narrating their counselling experiences. The literature reveals many assumptions and opinions of healthcare professionals and academics regarding how counselling should be conducted with older women. Yet, it fails to demonstrate the perspectives and stories told by older female clients regarding what is considered meaningful and helpful in facilitating the therapeutic process.

Aim

The aim of the current study was to elicit and analyse older women's counselling narratives by exploring the way these experiences were constructed during the research interview. Attention was paid to how and why particular aspects of experience were storied and what this can reveal about the phenomena of older women's experiences of counselling. The study focused on participants' most recent course of counselling at a mental health charity. The objective was to elicit and analyse rich narrative accounts therefore qualitative methods were suitable, and more specifically a narrative orientation to research was adopted.

Research questions

The present study aimed to address the following two research questions:

- How do older women construct their decision to enter into counselling?
- How do older women construct their experience of counselling?

Methodology

Participants

Six women between the ages of 66 and 74 participated in the study. Four participants were of British origin, one was Cuban and one was Jamaican. They had each attended counselling for up to 20 sessions at a mental health charity. The therapeutic models used in sessions varied depending upon the training of the therapist. They included person-centred, CBT, existential, psychodynamic and integrative therapy.

Researcher

The researcher is a counselling psychologist in training at City University, London in her late twenties. She previously worked as a support worker in a residential care home, as an assistant clinical psychologist on an NHS stroke ward and had completed an MSc in Psychology specialising in counselling and psychotherapy. She has worked in a variety of services conducting psychotherapy with older clients including in a GP surgery, an NHS psychological therapies service and a mental health charity. The challenge was to acknowledge and 'bracket' as much as possible personal assumptions about older women's experiences of counselling to truly hear narrators' individual stories.

Procedure

Recruitment letters were sent out through a mental health charity in the south of England to a random selection of 22 former male and female clients. Recipients had engaged in counselling within the past year and were aged 65 or above at the start of therapy. Of these 22, six women responded.

Participants had a choice of locations for the interview setting including the charity at which they received counselling, in a quiet room at City University, London, at their home or at a local library. All participants preferred to be interviewed at the charity, stating that the location was convenient and familiar. The one exception to this was a participant (Alison) who preferred to be interviewed at her home due to mobility difficulties. Data was collected during a single semi-structured narrative interview with each participant lasting approximately 90 minutes. During the interview participants were encouraged to provide extended accounts of their counselling experiences.

Ethical Considerations

The study gained ethical approval by the Research and Ethics Committee of the School of Arts and Social Sciences at City University London and all British Psychological Society (BPS) ethical guidelines were adhered to. These included assuring participant anonymity through the use of pseudonyms, confidentiality, the right to withdraw from the study and debriefing (Code of Human Research Ethics, BPS, 2010).

The existence of alternative readings of data is a basic assumption of all qualitative research methods (Willig, 2013). As Richardson (1990) explains, in our work as researchers we make choices regarding what to include and what to exclude. In the current study, it was hoped that there would be an analysis and synthesis of the data whilst at the same time staying true to the narrators' individual stories and privileging the six women's unique voices. An effort was made to accurately represent individuals' stories by presenting extensive extracts from the transcripts to support the analysis. The aim was to convey throughout that interpretations made were my own and did not reflect any form of absolute truth.

Data Analysis

Narrative analysis was employed as the method to interpret the interview material. Narrative analysis is an umbrella term for methods of analysing a story from texts (Riessman, 2008). There are a wide variety of definitions of what constitutes a narrative and an equally wide variety of approaches to the analysis of these narratives (Riessman, 1993). The current study was interested in eliciting stories of counselling in order to analyse *what* stories were told as well as *how* they were told. The interview transcripts were analysed using Langdridge's (2007) critical narrative analysis (CNA). This model was chosen as it allowed an overall view of the topic to see what participants talked about rather than focusing on one particular aspect of the narrative.

Langdridge's model incorporates six stages as demonstrated in **Figure 1**. There is a focus on reflexivity, identifying narratives and examining them for tone, function, identity issues and thematic content. There is also a 'critical moment' where the researcher employs imaginative hermeneutics of suspicion. Here the researcher moves beyond a simple focus on the apparent, and using critical engagement with a

social theory, interrogates his or her own way of viewing the topic as well as the narratives. In the current study, Knight's (2004) CCMSC model was drawn upon as an interpretative lens to uncover 'meaning hidden beneath the surface' (Langdridge, 2007, p. 49). The aim of CNA was the synthesis of a variety of analytic tools, enabling a critical analysis of the data to shed light on the phenomenon of older women's experiences of counselling (Langdridge, 2007).

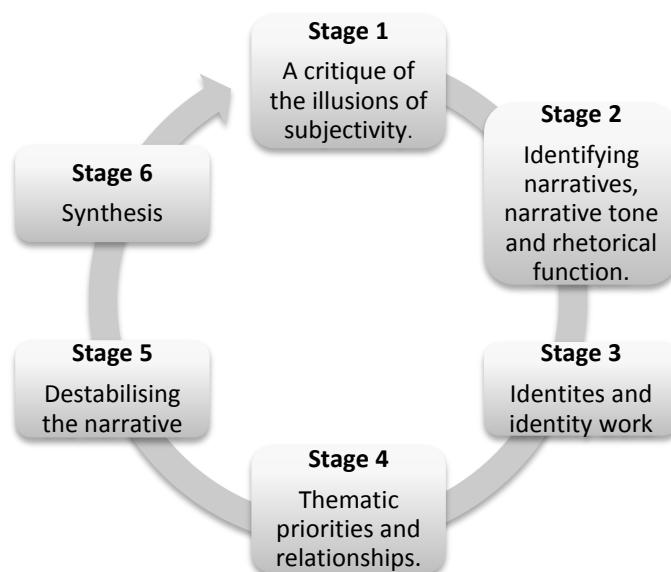


Figure 1: Langdridge's (2007) model of critical narrative analysis

Exemplar

An exemplar segment of a participant's (Emily) transcript has been included in this section as a means to demonstrate how the data was coded and analysed. This part has been included in order to provide transparent evidence to the reader in regards to the process followed. This section is presented in two tables. Table 1 presents on the left hand side the segments of the transcript and on the other is the initial coding that was assigned to these pieces of data.

Table 1: *Example of initial coding phase*

<p><u>Participant</u>: And you know you have to deal with it in a way. The thing with counselling is you can talk the reality. You don't feel like you have to hide, that's the way I feel. I feel like I can say to a person, and he's not judging me, just listening. I shared things that I cannot talk to anybody about, not even friends because sometimes they don't understand. They just tell me what to do and sometimes that makes me feel like I should be able to cope, like it's easy. There's this expectation that we should all be coping easily and if we're not then well there's something wrong with us. Then I feel worse. I'm sure that they talk about me behind my back too because that's what they're like.</p> <p>And sometimes they've got their own problems so they associate their own problems with my problems and that doesn't help because sometimes they put ideas in your head and it's not good ones.</p>	<p>-knowing has to deal with problem</p> <p>-talking the reality</p> <p>-listening/ non-judgement from counsellor</p> <p>-sharing hidden parts</p> <p>-friends sometimes don't understand</p> <p>-friends' approach unhelpful</p> <p>-expectation that we should be coping</p> <p>-feel friends talk about me behind my back</p> <p>-friends unhelpfully associate their problems with mine</p> <p>-friends put 'not good' ideas in my head</p>
<p><u>Researcher</u>: So, counselling was a place where you could talk without outside influences or distractions?</p>	
<p><u>Participant</u>: Yes, and then you can analyse your own self and look for light, you know, to deal with this kind of problem and I had someone who understood I was going through and that was such a relief.</p>	<p>-counselling enables self-analysis</p> <p>-counselling helps deal with problem</p> <p>-felt understood by counsellor</p>

After conducting this stage of the analysis, the early codes were grouped into key categories which formed the basis of the emergence of key themes. These are presented on the right hand side of the transcript in Table 2 below. In this second coding phase, there was also an analysis of narrative tone, social or psychological function of the narrative, identity and how the narrator draws on wider cultural narratives. For clarity and ease of understanding each of these interpretative lenses have been highlighted in a different colour. Analysis of these are presented on the left hand side of the transcript below.

Interpretative lenses:



Tone



Function



Identity



Drawing on wider cultural narratives

Table 2: *Example of second coding phase*

<p>Advocates counselling as a place where you can 'talk the reality'</p> <p>Being listened to & not judged presented as important personal values</p> <p>Frustrated tone when talking about friends' approach</p> <p>Wider cultural narrative of expectations in coping</p>	<p>Participant: And you know you have to deal with it in a way. The thing with counselling is you can talk the reality. You don't feel like you have to hide, that's the way I feel. I feel like I can say to a person, and he's not judging me, just listening. I shared things that I cannot talk to anybody about, not even friends because sometimes they don't understand. They just tell me what to do and sometimes that makes me feel like I should be able to cope, like it's easy. There's this expectation that we should all be coping easily and if we're not</p>	<p>-sharing hidden parts and not being judged</p> <p>-friends don't understand</p> <p>-lack of validation of feelings from friends</p> <p>-wider expectation of coping</p>
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<p>Justifies why doesn't feel safe sharing with friends</p>	<p>then well there's something wrong with us.</p> <p>Then I feel worse. I'm sure that they talk about me behind my back too because that's what they're like. And sometimes they've got their own problems so they associate their own problems with my problems and that doesn't help because sometimes they put ideas in your head and it's not good ones.</p> <p><u>Researcher</u>: So, counselling was a place where you could talk without outside influences or distractions?</p>	<p>-friends' approach unhelpful</p>
<p>Shift to optimistic tone when talking about counselling</p> <p>Relief in being understood by counsellor</p>	<p><u>Participant</u>: Yes, and then you can analyse your own self and look for light, you know, to deal with this kind of problem and I had someone who understood what I was going through and that was such a relief.</p>	<p>-counselling enables self-analysis</p> <p>-felt understood by counsellor</p>

From this example, the reader can see that the initial thirteen codes have been reduced down in order to make most sense of the vast amount of data provided in the transcripts. The key codes are beginning to become established through the analytic process. This facilitated the categorising of data which led to the development of key themes.

Findings

The following diagram, **Figure 2**, outlines the overarching theme and corresponding subthemes which emerged from the narrative analysis described above. These themes will be examined below.

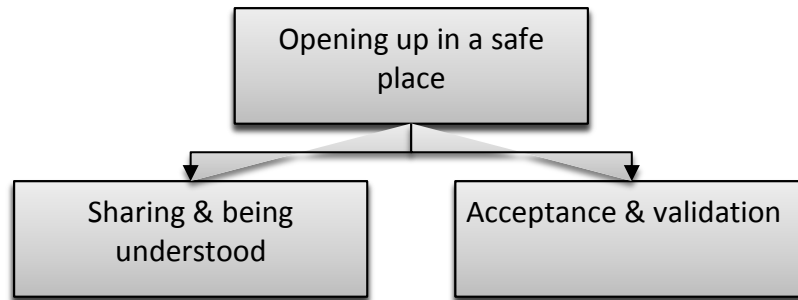


Figure 2: Overarching theme and corresponding subthemes

The overarching theme of *opening up in a safe place* illuminates narrators' construction of counselling as a 'safe' space to explore their emotional landscape and surrounding circumstances. The subtheme of *sharing and being understood* highlights narrators' disclosure of feeling they had nobody to talk to in their lives about emotional difficulties and were not understood. Counselling was constructed as filling this gap, by providing a confidential place where these needs could be met. The subtheme of *acceptance and validation* focuses on narrators' experience of counselling and their counsellor as validating their emotional distress and accepting of them as individual human beings. For some of the women this was narrated against a backdrop of societal ageism. A presentation of the two subthemes follows.

Sharing and Being Understood

Sharing and being understood were often interwoven in the narratives. Four out of the six narrators revealed having nobody in their lives with whom they could talk about personal and emotional problems. Some explicitly disclosed feelings of loneliness and emotional isolation, highlighting a lack of empathy by husbands, friends and family. Sometimes the reluctance to share with others was expressed as a conscious choice, based on a fear of burdening others or believing that others

would not understand. Emily highlighted this lack of support, suggesting that her relatives fear discussing mental health problems:

I don't have anybody to talk to really. Not to talk and they understand, you see, illness of the mind is very complicated and people, even my family sometimes, they don't want to know, because they get scared' []. So all my stress, imagine, and you talk to people and they don't understand.

Knight's (2004) CCMSC model suggests that it is important to appreciate the social context of clients and understand how this impacts on their difficulties and use of the therapeutic space. For Emily, her sense of emotional isolation meant that she highly valued the opportunity to engage in counselling, as it was the only place she felt truly understood. Perhaps as she could not achieve the same level of intimacy and understanding with friends, she had isolated herself and had become dependent on counselling for her emotional needs. Emily explained how sharing with friends is often unhelpful:

And sometimes they've got their own problems so they associate their own problems with my problems and that doesn't help because sometimes they put ideas in your head and it's not good ones.

Emily seemed to be reflecting upon confiding in friends in the past which was responded to by being given advice from their own perspectives. In her narrative, she contrasts this to the therapeutic relationship in which instead of having ideas "put in your head" she felt heard and was encouraged to find her own answers. Clare also compared the counselling relationship to friendships, highlighting the importance of feeling safe and secure as a prerequisite to opening up:

The relationship you have with the counsellor, just being able to find someone you can trust so that you can really talk about anything and everything and it's such a huge help. Knowing its safe and secure. And that's the sort of relationship you can never have with friends.

In the context of Clare's wider narrative, safety and security were particularly pertinent. Living with an abusive husband and her experience of being betrayed by friends rendered sharing with others unsafe. Kate also disclosed an absence of close relationships in which she felt she could share and emote:

The word permission comes to mind. I do not have any forum or relationship where I can emote []. I don't have much conversation other than on the superficialities of the weather and cost of living and so on. [] I'm lonely really, that's what I'm saying.

Counselling was therefore presented against a backdrop of a lonely life. There was a sense of pathos in Kate's tone as she appeared to want to convey to me how physically and emotionally isolated she felt. Both Kate and Clare commented on the benefits of weekly sessions. Kate highlighted the importance of physically leaving the house once a week and being able to share her difficulties with someone who could empathise:

I needed somewhere to get me out of the house and in contact with someone who would be able to share with me how very difficult I was finding this coping that I'd managed for fifty years.

Kate had spent the majority of her life constructing her identity as her disabled son's protector and rescuer. It was only through counselling that she recognised the importance of acknowledging her own needs. Whilst talking about her difficult marriage, Clare also highlighted the benefits of weekly appointments:

Because it was on a weekly basis, I felt if anything happened I could bring that up in counselling. To be able to be really open and honest but at the same time to be reminded that some of the behaviour is not acceptable.

Counselling seemed to provide Clare with the only space in her life where she could be truly open and talk about the reality of her unhappy relationship. She expressed that speaking to a third, impartial person helped reinforce her belief that aspects of her husband's behaviour should not be tolerated. Kate found sharing in the counselling context more challenging. She warned her counsellor that she would find it difficult to not play games in therapy. Although she knew this was a defence against reaching emotional depth, she felt unable to stop herself:

And I did tell him that it would be an effort because one of my defences is to play games and I find it very hard not to do that. And that is a defence and protecting the self because I don't know what the self is, who it is.

She constructed her experience of counselling as being a huge adjustment to her way of being with another person. Accustomed to not letting others see she needed

help, she was faced with someone who wanted to understand who she was. This was a daunting prospect for Kate as she did not know the answer to this question and feared finding out. Counselling was constructed as a type of intimate social interaction that she had previously actively avoided. For the first time, she shared the vulnerable parts of herself and thus began to gain a more holistic understanding of her identity.

Furthermore, the expression or suppression of emotion was central in narrators' accounts of sharing in counselling. Kate spoke about how counselling was the first place she had felt permission to emote fully. This was a significant expression of emotion in the context of Kate's story of counselling and the wider story of her beliefs about showing vulnerability. Kate had been socialised into certain beliefs and attitudes towards expressing emotion that had remained stable over time. The counselling context had encouraged her to reflect upon the protective function of these beliefs and whether they were still functional:

Kate: Oh it doesn't matter; I'll just give them a wipe. One of the things I would not ever have allowed prior to the counselling would be that I would let the tears come; I'm quite good at controlling them you know.

Researcher: So there was something in the counselling that helped give you permission to express those emotions?

Kate: Yes, I think partly of course, one is concerned for the other party and again this sounds very, very calculating and I never broke down and sobbed and I wouldn't but if that happened, well what you're speaking of, actually produces a spontaneous tear or two, then let somebody see it. Give them the opportunity to know it hurts.

Expressing vulnerability was a new way of being for Kate. As she explained, she learned this new way of being with others through counselling. After expressing these thoughts, Kate questioned the validity of her feelings by comparing herself to imagined others:

You see what worries me even now with you here today [pause] I don't think I'm overdramatising it, but there could be thousands of people in my situation who wouldn't feel as bad as I do.

The self-criticism is evident by suggesting that others in her situation would be more emotionally resilient. She therefore questioned the permission she gives herself to express her struggle. Perhaps this echoes her generation's ethos of stoicism and emotional self-sufficiency. Maybe she was concerned about being perceived to be 'moaning' or feared being judged as weak by others. Melanie also described the meaning of sharing her tears with her counsellor:

I was tearful but it didn't matter, because to me that was natural. I felt it was important to allow myself to do that in counselling because it's a sort of release isn't it?

Melanie appeared to be validating her tears in counselling describing them as "natural" and a "release". This suggests that she viewed expression of emotion through becoming tearful as an important part of her therapeutic process by releasing built up emotional energy. Like Kate, she viewed this as giving herself permission to emote in this way. In contrast, Clare described actively holding back her tears in counselling as she believed crying would be a waste of the sessions:

I didn't cry. I think she [counsellor] was a bit worried about that, I was very close to it, I could feel my eyes watering and getting very close. But I did say to her, some of this has been there for so long, and I don't want to waste my counselling time crying.

Clare's belief that by crying she would "waste" counselling time provides an important insight into the meaning and value attached to this expression of emotion. Greater understanding is gained from interpreting this attitude in the wider context of Clare's narrative. At an earlier point in her story she had disclosed that her tears had often been trivialised and dismissed by her husband. Perhaps she had internalised this attitude, thus invalidating her tears, rendering them as a 'waste' of her and other people's time.

Furthermore, the age of the counsellor was often referred to during narrators' appraisal of being understood. There were varied views and degrees of importance placed upon the relatively young age of each narrator's counsellor. All the women guessed their counsellors' age as between late twenties to mid-forties, meaning that they were at least 20 years their junior. For Macy, having a younger counsellor was framed as an advantage and was constructed as contributing greatly to her positive experience of the process:

Well, we've talked about it being a very positive experience and I put that down very much to having a young counsellor who was enthusiastic, like you are for your subject, and was not trying to impose on me. That was unexpected.

Macy's surprise that her counsellor did not "impose" upon her relates to her expectation of her counsellor as telling her to 'pull yourself together' mentioned earlier in her narrative. She would not have wanted a counsellor of her own age:

If there was another old bat of seventy sat where you're sitting, we'd just be swapping things wouldn't we?

The term "old bat" could be viewed as an internalised ageist attitude. Perhaps there was the assumption that a seventy-year-old counsellor would have their own problems, which they would share in the counselling context rather than allowing Macy the space to talk about her issues. Another interpretation may be that she perceived a younger counsellor more positively when discussing intimate topics (Hayslip, Schneider & Bryant, 1989). Macy went on to explain why she would not have wanted a 'middle-aged' counsellor:

I would have been put off if there had been a middle-aged woman who said 'You're going to have to work very hard at this' or something and made me feel yet again, inadequate.

Being told "to work very hard at this" and made to feel inadequate, echoed Macy's father's voice from when she was a child. Perhaps Macy associated people of middle age and older with her father's authoritative and dismissive stance towards her emotional distress and therefore felt safer with a younger counsellor. In contrast, Kate felt that having a counsellor who was "decades younger" reduced her sense of being understood. It was evident that she had constructed a belief that a younger person would not be able to empathise with her situation:

I was with somebody, not just a decade younger but a lot younger and *that* mattered because how can someone of your age have any real understanding of my life experience of fifty years invested in trying to make someone whole who will never be quite whole.

There was a frustrated tone as Kate questioned how a counsellor in their twenties could empathise with her and appreciate the complexity of her situation as a carer

for her disabled son. Alison also felt that her counsellor's young age negatively impacted upon the therapeutic relationship and feeling of being understood:

I don't mean to criticise, I just felt that she possibly was too young, but then she wasn't that young, I mean I would say in her twenties, and she was a mum. I just felt there wasn't... we just didn't connect. I don't know if she fully understood.

Her tone is apologetic and hesitant as she worried about appearing critical. Interestingly, Alison mentioned that her counsellor was a mother, perhaps implying that as she was old enough to care for a child she must have been mature. However, for Melanie, her counsellor's age was not an important factor in her story. She was not interested in whether her counsellor could relate to her but rather that she had the expertise for the job. Melanie therefore trusted her counsellor's professionalism regardless of age:

I see her as her role, not this young person that I'm related to, I saw her role, approaching me with her expertise.

Acceptance and Validation

Most narrators experienced their counsellors as validating their emotional distress and accepting them as human beings. For some of the women this was narrated against a backdrop of societal ageism. Prejudice and stereotyping compounded feelings of being misunderstood or devalued due to their age. Based on Knight's (2004) model, by understanding the wider social context and culture in which older adults live and how this is interpreted, we gain a more holistic appreciation of their experiences. Furthermore, light is shed on the relationship between ageism and emotional distress.

Macy's story of counselling was narrated in the context of societal ageism. She described feeling unsafe and devalued as an older person in society, believing that people of her age were ridiculed by the youth. Indeed, she told a side story of being the victim of vandalism due to her age. Macy's tone was frustrated and sad. Being a target of ageism made her fearful yet she explained that she could understand younger people's anger when comparing generations due to a struggling economy and financial insecurity.

The function of Macy's narrative appeared to be to advocate more communication between younger and older generations to reduce prejudice and anger. She explained that ageist attitudes exacerbated her depression and anxiety. The anger and abuse she had experienced first-hand perpetuated feelings of being unacceptable and inadequate. There were indications that to some extent Macy had internalised ageist attitudes, for example, her previous comment of "old bat of seventy" which is arguably an offensive term for an older woman. Also, she revealed that on receiving the research letter, she assumed that the researcher would not want to see a "batty old thing":

So when your letter came I thought, golly oh, you wouldn't want to see a batty old thing. But it's the object of the exercise, I thought, go and see.

The word 'batty' has connotations of madness (Oxford Dictionary, 2006) which Macy associated with being old in describing herself. Although this was expressed in a light-hearted tone, it could be viewed as revealing an attitude towards what it means to be an older woman. In contrast to societal ageism, Macy emphasised feeling she could be herself in counselling, without being subjected to value judgements. Her counsellor's accepting attitude facilitated an opening up process:

And I think it was that feeling of being relaxed and you know, she had the politeness to listen and smile and I just felt very comfortable in her presence.

Emily also spoke about not being judged by her counsellor:

The thing with counselling is you can talk the reality. You don't feel like you have to hide, that's the way I feel. I feel like I can say to a person, and he's not judging me, just listening.

Talking the "reality" was a refreshing concept for Emily who had hidden her daughter's mental health problems from her friends for years. She believed that even her family were "scared" of her daughter's schizophrenia and bipolar disorder and did 'not want to know'. This highlighted the stigma around mental health problems and the emotional impact this may have on carers. Emily's family's attitude was contrasted with her counsellor's non-judgemental approach. Counselling was constructed as a place in which she felt free and safe to open up not only about her daughter's mental health problems but the associated depression

and anxiety she experienced as a mother and carer. She went on to explain that counselling helped to validate the “not fine” part of her:

They think I’m fine. No, I’m not fine. So counselling helped me to be able to deal with this ‘not fine’ part that I cannot do with anybody else.

Emily elaborated by explaining that she had internalised her counsellor’s validating attitude and now gives herself permission to feel bad at times instead of becoming self-critical:

And sometimes I feel bad but counselling helped me think “no, it’s OK to feel that way”.

Macy also spoke about the importance of validating what she called her “depressive anxiety”:

I didn’t come out thinking it’s cured. I said I know this will come back []. However, there is still that feeling that someone who isn’t family has sat with me and said ‘It’s alright, it’s not very nice, but it’s alright to be like this’.

Counselling was depicted as helping to validate her problems, bringing them out into the open to make sense of them. Macy spoke about accepting the part of her that was depressed and with the help of her counsellor tried to understand it:

And what I got was somebody leading me out of it. And looking at it and not throwing it away, saying it was part of me.

Both Macy and Clare expressed feeling validated as imperfect human beings by their counsellors. As Macy shared her depression she highlighted her therapist’s ability to be with her and gently challenging some of her thoughts:

She pressed the buttons, very gently, very kindly and at the end of it I said ‘I know it’s not going to take the depression away but I have shared it and you haven’t freaked’. And she said ‘you are a human being’ [pause] that was nice.

This contrasted with her initial impression of counselling as a ‘cure’ and the expectation that her counsellor would think she is ‘batty’. Macy framed counselling as a safe place to reveal the depressed part of her to someone who would validate her feelings in the context of her life experience without judging her. One of the

functions of Macy's narrative was to highlight the benefits she had gained from counselling and advocate it for others:

Counselling is something I would recommend to anybody []. Nobody is going to judge you. With this sort of thing we judge ourselves, far more than any counsellor. And they're not freaks, they're not people who think they have a magic power or something, they're ordinary, very nice human beings who care.

The description of counsellors as "freaks" who believe to possess "magic powers" relates to Macy's initial expectations of counselling. These expectations were influenced by wider cultural narratives about therapy. This perhaps highlights cultural misconceptions about the nature of counselling and what the therapeutic process entails.

Discussion and Implications for Practice

Findings from the current study support existing research and literature on the prevalence of loneliness and emotional isolation felt by many older individuals (Orbach, 1996; Victor, Scambler, Bond, & Bowling, 2004; Wolpert, 2011). There was an absence of close relationship in which narrators felt safe in opening up about emotional difficulties. Narrators referred to the stigma around mental health problems as a barrier to feeling safe in opening up with others. Referring back to the original research questions: 'How do older women construct their decision to enter into counselling?' and 'How do older women construct their experience of counselling?', the absence of people in the narrators' lives with whom they felt safe opening up to was a key factor in the narrators' decision to enter into counselling.

Furthermore, half of the narrators were carers. Caring for a relative may contribute to an individual's social isolation and feelings of loneliness. In some cases this could compound mental health problems such as depression (Barg et al., 2006) and anxiety. For some narrators, counselling was constructed as the only place they felt understood and safe to open up about personal difficulties. These findings further theoretical understanding of the function of counselling in older women's emotional isolation and carer roles.

The practical implementations of these findings for psychological therapists might be for them to be curious about older women's wider support network, or lack of, in understanding their presenting problems. Then, if possible, to help them reconnect with or develop supportive relationships with others. This could reduce therapy dependency. Referrers to mental health services and counsellors might also be advised to investigate whether older female clients are carers and how this may be affecting their social engagement and opportunity to be supported themselves emotionally.

The subthemes presented in the current study echo Rogers' (1961) core conditions for therapeutic change. The subtheme of sharing and being understood parallels Rogers' core condition of empathy referring to the therapist's ability to understand the client's experience and feelings. Rogers advocated that the therapist develops an empathic understanding of the client's internal frame of reference and endeavors to communicate this to the client.

Similarly, the subtheme of acceptance and validation echoes Rogers' core condition of unconditional positive regard referring to the therapist's accepting attitude towards the client. Rogers believed that this allows the client to open up and speak about their difficulties without a fear of being criticised or judged. Rogers' core conditions have hugely influenced counselling theory and practice and have helped develop our understanding of the therapeutic relationship and process. However, the core conditions could be criticised for over-prioritising the supportive element of the therapy process. If the emphasis of therapy weighs too heavily on efforts to provide unconditional regard and empathy, then the therapist may lose sight of the need to challenge the client into finding their own way out of a difficult situation.

Although being understood and validated are pertinent for clients of all ages, finds from this study support Butler's (1969) argument that ageist societal attitudes can compound feelings of marginalisation, unacceptance and inadequacy in older people. Ageist attitudes can be internalised thus impacting negatively on a person's self-perception and belief in positive change (Levy & Langer, 1994). Furthermore, finds from this study support Nelson's (2002) view that ageism, as expressed by Macy, can increase feelings of depression and anxiety, convincing older people that they are not as valuable as younger adults.

For some of the narrators, feeling unsafe and devalued as an older person in society was contrasted with being treated like human beings by their counsellors. As

Knight's (2004) model suggests, by understanding the wider social context and culture in which older adults live, we gain a more holistic appreciation of experiences. The practical implication of these findings is for therapists to be aware of how ageism may impact upon emotional distress and feelings of powerlessness in older female clients. The loss deficit model suggests that decline, illness and depression are natural consequences of older age. This pessimistic view of ageing may be adopted by therapists and older female clients thus hindering the therapeutic process if not recognised. Therapists might therefore be advised to use supervision and personal therapy to reflect upon their meaning-making of older age and explore their own possible assumptions, prejudices and fears which may be influencing interactions with older female clients.

The age of the counsellor was often referred to during narrators' appraisal of being understood in counselling. This also emerged in a similar narrative study by Hunter (2011) in which seven of the ten older former clients believed that the age of their counsellor was an important factor in their counselling experience. These findings add to the theoretical understanding of how younger counsellors are perceived by older clients and how this may influence the therapeutic relationship. Counsellors might therefore be advised to explore older women's meaning-making of age differences between the client and therapist with the aim of enhancing the therapeutic alliance. As Clarkson and Pokorny (1994) advise, it is the counsellor's responsibility to be attuned to signs of disconnect which may be attributed to meanings attached to age or cohort differences. The authors emphasise that therapeutic effectiveness has often been strongly associated with the quality of the client-therapist relationship.

Furthermore, the expression or suppression of emotion was central in narrators' accounts of sharing in counselling. This was often linked to childhood upbringings and generational attitudes shaping narrators' meaning-making of emotional expression. Being born around the time of the Second World War, some of the women expressed that difficult emotions were suppressed and mental health problems were dismissed or unrecognised. This could help explain some older female clients' reticence in emotional expression. This study supports Knight's (2004) model by emphasising the importance of appreciating the backgrounds and experiences of older adults in understanding their beliefs, attitudes and behaviours in the therapeutic context.

Therefore it may be useful for counsellors to encourage older female clients to reflect upon their meaning-making around emotional suppression, the protective function it may have served in the past and whether their beliefs remain helpful. As observed by Montepare and Dobish (2013), for some older women like Kate, emotional expression may be associated with shame and weakness. Counsellors could challenge these generational beliefs so clients feel that their emotions are accepted. As was the case for some of the narrators, counselling may be the first place that permission to emote is felt. It is therefore important for counsellors to facilitate a safe space in which older female clients are allowed to express vulnerability and these vulnerabilities be validated and normalised.

Critique of the study

Regarding sampling, although an attempt was made to recruit both male and female participants, no men expressed an interest in being involved in the current study. However, perhaps this lack of response is revealing in itself. As Twining (1996) convincingly argues, many men have a negative image of therapy, seeing it as shameful and indicative of weakness. Consequently, it is likely that the pool of potential male respondents for the current study was relatively small.

As the current study focused on the counselling experiences of older women, future research into the counselling experiences of older men could shed light on how dominant cultural and generational narratives of masculinity and sharing emotional distress are presented in personal stories of counselling. Further, a mixed gender sample could highlight whether there are gender differences in the stories of counselling narrated. As there is an increased awareness of mental health problems and psychological treatments, it would be interesting to explore whether these changes are reflected in the attitudes of older men who are considering attending or have attended counselling. Identifying aspects of therapy older men find most useful would be valuable information for clinical practice and would potentially advance the theoretical knowledge of older men and counselling.

Furthermore, the six women in the current study were what Neugarten (1974) described as 'young-old', aged below eighty rather than 'old-old'. The socio-historical contexts of the lives of individuals aged above eighty may have meant that their experiences of counselling were very different. Future research into the counselling experiences of older women could include women aged eighty and above. This might mean more varied data which is likely to enhance insight into

how counselling is experienced. Further, this might highlight potential differences in counselling experiences between the 'young-old' and 'old-old'. Perhaps further research into this topic could also include member checking enabling participants to correct errors and challenge what may have been perceived as wrong interpretations.

Further, due to the small sample size and the fact that the sample was limited in the geographical area from which it was drawn (the south of England, UK), the results of this study are not generalisable to the wider population of older female clients. Yet, the aim was to elicit in-depth descriptions of the six narrators' counselling experiences and not to predict future clients' experiences. Furthermore, participants were self-selecting thus there is a likelihood that clients who volunteered to take part in this study were also those who had experienced more benefits from counselling. Considering this, one can question if this may have had an effect on the sample acquired and then in turn on the data gathered. It may be that people who had particularly negative experiences of counselling would be unwilling to share their stories with a trainee counselling psychologist.

Conclusion

This study supports literature highlighting the prevalence of loneliness and emotional isolation in older people. Findings indicate that for some older women counselling may be the only place they are able to disclose emotional distress and feel understood. Feeling validated, accepted and safe facilitated the opening-up process. Counsellors were constructed as supportive characters who validated the narrators' distress. Yet, the current study highlights the struggle some older women face with emotional expression, particularly expression of undesirable or painful emotions. This may be due to generational influences and childhood upbringings around the Second World War in which expression of vulnerability was framed as a weakness and shameful. Disclosure of one's vulnerabilities was therefore viewed as unsafe and consequently emotions were suppressed.

Counsellors might therefore be advised to be curious about the socio-historical context in understanding how older women relate to their difficulties and make sense of their emotional landscape. It may also be helpful for counsellors to be curious about the client's wider support network to avoid therapy dependency. This suggestion corresponds with Knight's (2004) proposal to consider the context both within and outside of therapy. Through the therapeutic relationship older women can

be assisted in feeling safe in opening up to other people in their lives to reduce loneliness and emotional isolation. Furthermore, being attuned to how older female clients may be impacted by societal ageism could help understand whether this compounds their presenting problems. Implicit or explicit internalised ageism may be a barrier to the therapeutic process, especially if the client views emotional distress as an unavoidable consequence of ageing as suggested by the loss deficit model. Further, the study adds to the understanding of how younger counsellors are perceived by older female clients and how this may influence the therapeutic relationship. Counsellors might therefore be advised to explore older women's meaning-making of age differences between the client and therapist with the aim of enhancing the therapeutic alliance.

As the older adult population grows, it is likely that more older women will present to GP surgeries and psychotherapy services. Being mindful of issues that are pertinent to women of this age group may be useful to referrers of psychotherapy services and therapists in order to reduce emotional isolation and maximise the therapeutic effect. Helping older female clients to feel safe in opening up and exploring their emotional landscape both within and outside of therapy could facilitate a validation of their difficulties thus challenging a sense of shame which may be maintaining emotional isolation.

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Appendix: *Journal of Counseling Psychology* submission guidelines

The following criteria for submission to the *Journal of Counseling Psychology* has been lifted from the ‘Instructions to Authors’ section of the website. This has been shortened for the purpose of the current portfolio:

The *Journal of Counseling Psychology*[®] publishes theoretical, empirical, and methodological articles on multicultural aspects of counseling, counseling interventions, assessment, consultation, prevention, career development, and vocational psychology and features studies on the supervision and training of counsellors.

Particular attention is given to empirical studies on the evaluation and application of counseling interventions and the applications of counseling with diverse and underrepresented populations.

Abstract

Manuscripts must be accompanied by an abstract of no more than 250 words. The abstract should clearly and concisely describe the hypotheses or research questions, research participants, and procedure. Please provide up to five key words as an aid to indexing.

Length and Style of Manuscripts

Reports of qualitative studies generally should not exceed 45 pages.

Prepare manuscripts according to the *Publication Manual of the American Psychological Association (6th edition)*.

Manuscripts should be concisely written in simple, unambiguous language, using bias-free language. Present material in logical order, starting with a statement of purpose and progressing through an analysis of evidence to conclusions and implications. The conclusions should be clearly related to the evidence presented.