



City Research Online

City St George's, University of London

Citation: Parry-Vaughan, N. (2025). How do White British older adults make sense of their experiences of video-based psychological therapy and its place in later life?. (Unpublished Doctoral thesis, City St George's, University of London)

This is the accepted version of the paper.

This version of the publication may differ from the final published version. To cite this item please consult the publisher's version.

Permanent repository link: <https://openaccess.city.ac.uk/id/eprint/38483/>

Copyright and Reuse: Copyright and Moral Rights remain with the author(s) and/or copyright holders. Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge, unless otherwise indicated, provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way. For full details of reuse please refer to [City Research Online policy](#).

‘Revealing the Unseen’

Natalia Parry-Vaughan

**A Portfolio Submitted for the Award of Doctorate of Counselling
Psychology (DPsych)**

September, 2025

Department of Psychology and Neuroscience

City St George's, University of London

Table of Contents

List of Tables and Figures	7
Preface	8
 PART A: Doctoral Research Project	
“How do White British older adults make sense of their experiences of video-based psychological therapy and its place in later life?”	11
Abstract	12
1 Introduction and Literature Review	13
1.1 Introduction.....	13
1.2 Terminology.....	13
1.2.1 Who are Older Adults?	13
1.2.2 What is Psychological Therapy?	14
1.2.3 What is Video Therapy?	14
1.3 Search Strategy.....	14
1.4 Older Adults and Mental Health Needs.....	15
1.5 Ageism.....	18
1.6 Older Adults and Digital Technology.....	19
1.7 Video Therapy: Therapeutic Alliance, Benefits and Challenges.....	20
1.7.1 Therapeutic Alliance.....	20
1.7.2 Benefits and Challenges.....	21
1.8 Therapist Perspectives.....	22
1.9 Older Adults and Video Therapy.....	23
1.9.1 Quantitative Research.....	23
1.9.2 Qualitative Research.....	25
1.10 Conclusion.....	28
1.10.1 Limitations in the Literature.....	28

1.10.2	Rationale and Aims for Study.....	30
1.10.3	Research Question.....	30
2	Methodology.....	31
2.1	Personal Reflexivity.....	31
2.2	Ontological and Epistemological Position.....	33
2.3	Rationale for a Qualitative Design.....	34
2.4	Rationale for IPA.....	35
2.5	Theoretical Underpinnings of IPA.....	37
2.6	Validity and Quality.....	39
2.7	Design.....	41
2.7.1	Semi-Structured Interview.....	41
2.7.2	Development of the Interview Schedule	42
2.7.3	Pilot Interviews.....	42
2.8	Data Collection.....	43
2.8.1	Sampling.....	43
2.8.2	Inclusion and Exclusion Criteria.....	44
2.9	Recruitment.....	44
2.9.1	Participant Summary.....	46
2.10	Procedure.....	48
2.10.1	Initial Screening.....	48
2.10.2	Interview Process.....	49
2.10.3	Recording and Transcription.....	50
2.11	Methodological and Procedural Reflexivity.....	50
2.12	Analytic Process.....	51
2.13	Ethical Considerations.....	54
3	Analysis.....	55
3.1	Introduction.....	55
3.2	Group Experiential Themes.....	57

3.3	GET 1: Fearing Loss.....	57
3.3.1	Sub-Theme 1: <i>“They’re all dead”</i> : Confronted by Mortality.....	57
3.3.2	Sub-Theme 2: <i>“Maybe she’ll think I’m not there, and she’ll give up”</i> : Uncertain Connections.....	60
3.3.3	Sub-Theme 3: <i>“I suppose miraculously, I pressed the right button.”</i> : Connection as Cure.....	65
3.4	Group Experiential Theme 2: Un(Safe)	67
3.4.1	Sub-Theme 1: <i>“You don’t have to worry about getting somewhere and going into somebody’s space”</i> : On Home Turf.....	67
3.4.2	Sub-Theme 2: <i>“I always was able to look out at the garden during sessions”</i> : Anchorage or Avoidance?	71
3.4.3	Sub-Theme 3: <i>“Could anybody just pop into the session?”</i> : Holding Back....	74
3.5	Group Experiential Theme 3: Seen Through a Screen.....	77
3.5.1	Sub-Theme 1: <i>“We’re not worth.. we’re not worth it to anybody anymore.”</i> : Fading From View.....	77
3.5.2	Sub-Theme 2: <i>“An old mate”</i> : Near and Far	81
3.5.3	Sub-Theme 3: <i>“If your bottom lip starts to tremble, she can see that”</i> : Seeing and Being Seen	86
4	Discussion.....	89
4.1	Introduction.....	89
4.2	Theory and Literature.....	89
4.2.1	GET 1: Fearing Loss.....	89
4.2.2	GET 2: Un(Safe)	91
4.2.3	GET 3: Seen Through a Screen.....	94
4.3	Key Theories and Concepts.....	96
4.3.1	Relational and Micro Processes in Video Therapy	96
4.3.2	Existential Ageing.....	99
4.3.3	I-Thou Relationship.....	101
4.4	Review and Conclusion.....	103

4.4.1	Impact of Findings to Counselling Psychology.....	103
4.4.2	Recommendations For Practice.....	105
4.4.2	Final Reflections.....	107
4.4.3	Future Directions for Research.....	108
4.4.4	Conclusion.....	110
	References.....	111
	Appendices.....	134
	Appendix A.....	134
	Appendix B.....	137
	Appendix C.....	138
	Appendix D.....	139
	Appendix E.....	140
	Appendix F.....	141
	Appendix G.....	146
	Appendix H.....	148
	Appendix I.....	150
	Appendix J.....	155

PART B: Publishable Paper

	“Seen Through a Screen: A Qualitative Study of the Lived Experience of Older Adults and Video Psychological Therapy”.....	158
5.1	Foreword.....	159
5.2	Abstract.....	159
5.3	Background.....	159
5.4	Method.....	161
5.5	Results.....	164

5.6	Discussion.....	169
5.7	Conclusion and Future Research	170
	References.....	172

PART C: Clinical Case Study

	“Through the Looking Glass”	177
6.1	Introduction	178
6.2	Client Study.....	181
6.2.1	Referral and Allocation Process.....	181
6.2.2	Triage Assessment.....	181
6.2.3	Supervision.....	181
6.2.4	Initial Meetings.....	182
6.2.5	Formulation and Treatment Plan.....	183
6.2.6	Interventions.....	185
6.2.7	Outcome and Ending.....	187
6.3	Process Report.....	188
6.3.1	Overview.....	188
6.3.2	Transcript and Commentary.....	188
6.3.3	Session Ending and Evaluation.....	196
6.4	Reflective Discussion.....	197
6.5	References.....	199
6.6	Appendix.....	203

List of Tables and Figures

PART A: Doctoral Research

Table 1: Participant Summary.....46

Figure 1: Diagrammatic representation of GET's and Sub-Themes.....56

PART C: Clinical Case Study

Figure 1: Psychopathological dynamic forces (Davanloo, 2000).....185

Figure 2: Triangle of Person (Malan, 1979) 185

Figure 3: Triangle of Conflict (Malan, 1979) 186

Preface

This doctoral portfolio comprises three components reflecting my training as part of the doctorate in Counselling Psychology at City, University of London: a research project, a publishable journal article, and a clinical case study. The first component presents a qualitative research project exploring how older adults experience psychological therapy via video. The second component offers a journal article focused on one theme of the research project. The third component is a clinical case study, illustrating my development as a practitioner and the shift in my practice from a focus on the concrete to reflecting on the nuances.

Across these components, a thread emerges: revealing the unseen. Whether in the research interviews, clinical practice, or my own personal development, I encountered a human desire to be seen and understood. Participants in the research spoke about their experiences of invisibility, describing moments when their presence and their voices were overlooked or disregarded. They also highlighted the healing potential in feeling seen and connected to another. The theme of invisibility was mirrored in the clinical psychodynamic case study, where the client presented a layered experience of hiding parts of herself, both within and outside the therapeutic context. The work of therapy became a shared journey toward authenticity, exploring the defences that shielded her from being fully known and supporting the gradual emergence of hidden feelings. In engaging with these processes, I too was invited to examine my own visibility, and how my own journey toward self-understanding intersects with the work I do with others.

PART A: Doctoral Research Project

This section presents a qualitative study exploring older adults' experiences of psychological therapy delivered via video. The literature review highlighted invisibility in both the research into this area and the general lived experience of older people. Eight participants with lived experience of video therapy were interviewed, allowing for the exploration of the idiosyncrasies of their experiences. Interviews were analysed using Interpretative Phenomenological Analysis, first through a detailed exploration of each case, then through identification of group themes. The project concludes with a discussion of themes in relation to existing literature, a critical reflection on the project, and clinical implications.

The focus of this research is on the older adult population, a group for whom I hold a deep respect and affection. Engaging with this population has not only reinforced my commitment to understanding their lives but has also provided me with valuable insights into their unique experiences. Through the research process, I have had the privilege of hearing their rich and diverse experiences. This engagement has heightened my appreciation for the individuality of

each older adult, highlighting the ways in which personal history, social context, and lived experience shape how it is to be in their world.

PART B: Publishable Paper

The second component of this portfolio is the journal article that summarises the findings of the research project and presents one of the key themes. This theme was chosen as it felt it best captures the older adult experience, and has strong relevance and applicability to clinical practice. The journal article is intended for publication in the *Counselling Psychology Review*, a journal chosen for its emphasis on counselling and psychotherapy through a non-pathologising, empowering lens, and its focus on linking research to clinical practice. Publishing in this journal will allow the findings to reach both an international academic and practitioner audience, increasing the visibility of older adults within mainstream psychological research and services. The article contributes to the field by highlighting experiences of an often invisible population and by providing a foundation for future research and clinical application.

PART C: Clinical Case Study

The clinical case study provides an example of therapeutic work that represents making the unseen seen. Conducted in the third year of the doctorate, this work captures a midpoint in a course of therapy with a client presenting with anxiety and sleep difficulties and experiencing ongoing family stressors. The case study demonstrates my evolving clinical practice, shifting from a Cognitive Behavioural Therapy (CBT) approach toward psychodynamic exploration of hidden processes and nuanced interpersonal dynamics. This therapeutic piece, titled '*Through the Looking Glass*', reflects the relational essence of therapy, capturing my shift from therapist as expert to therapist as co-explorer within the therapeutic space, and creating room for more of myself to emerge within sessions.

Personal Reflection

Throughout the three years of doctoral training, I have experienced a continuous process of losing and finding myself, both academically and personally. Beginning the course while my daughter was eighteen months old presented challenges in balancing professional and familial responsibilities, and highlighted the importance of creating space for personal reflection and development. This journey has moved my identity away from scientist practitioner to reflective practitioner, integrating scientific rigour with relational sensitivity. In my therapeutic work, this

evolution has fostered more equal relationships with clients, privileging curiosity, collaboration, and attunement. Throughout this portfolio I hope to shed light on thoughts, feelings, and experiences that may be unseen.

PART A: Doctoral Research Project

”How do White British older adults make sense of their experiences of video-based psychological therapy and its place in later life?”

Abstract

The proportion of the population classified as older adults is increasing rapidly, coinciding with the growing digitisation of healthcare services. This raises important questions about the accessibility and suitability of digital interventions for this population within mental health. Despite the expansion of digital therapy, little is known about how older adults experience psychological therapy via video. This study employs Interpretative Phenomenological Analysis (IPA) to explore older adults lived experiences of video therapy. Eight participants were recruited and interviewed in semi-structured telephone interviews. Analysis of the data generated three overarching themes. The first theme, '*Fearing Loss*', describes participants' experiences of personal loss and their anxieties about connecting with the therapist. The second theme, '*Un(Safe)*', highlights the variable experience of psychological safety and trust, alongside how participants anchored themselves within session. The third theme, '*Seen Through a Screen*', explores experiences of invisibility as an older adult and the ways in which closeness and reassurance through the video medium fostered a sense of being seen. These findings highlight the importance of visibility and relational connection in video therapy, which are explored in relation to the I-Thou framework. The discussion also considers contextual factors, including Existential Ageing, to illuminate the uniqueness of older adults' experiences. The strengths and limitations of the study are reviewed, alongside clinical implications and directions for future research.

1 Introduction and Literature Review

1.1 Introduction

This chapter critically examines the existing literature concerning older adults and video therapy. It begins by defining key terms and concepts to ensure conceptual clarity, particularly given the varied terminology used across studies.

The literature review commences by outlining the search strategy, before offering a review of the broader literature relevant to the topic, including studies on older adults' mental health needs, their engagement with digital technologies, and the delivery of psychological therapy via video within the general population. The review concludes with an exploration of older adults and video therapy, with both quantitative and qualitative studies considered.

The chapter concludes by identifying key limitations and gaps in the current literature, before outlining a rationale for the study and its relevance to Counselling Psychology.

1.2 Terminology

1.2.1 Who Are Older Adults?

The term older adults broadly refers to individuals entering a later stage of life. There is variation within the literature regarding the specific age at which an individual is considered older. The World Health Organization (WHO, 2024) defines an older person as someone aged 60 years or above, to account for global variations in life expectancy worldwide.

Within this project, the term older adult will refer to people aged 65 and over. The researcher deemed this important to ensure exploration of experiences within this particular life stage. There have also been criticisms of research into older adults for lowering the inclusion age (Smith et al., 2021), which the researcher believes can reduce the quality and impact of the research, particularly when disseminating findings into clinical practice. This classification also aligns with definitions used by services such as Age UK (2019a) and the National Health Service (NHS, 2025). Traditionally, the age of 65 has carried social significance, often marking the point of retirement and eligibility for various social and health services.

There is also heterogeneity within the older adult population. Forman et al. (1992) offered a useful typology that distinguishes between the *young-old* (60–69 years), the *middle-old* (70–79 years), and the *old-old* (80 years and above). However, chronological age alone does not

necessarily correspond with biological, psychological, or social markers of ageing. Age UK (2020) distinguishes between frailty and old age, outlining how frailty is generally characterised by reduced muscle strength and fatigue and impacts around 10% of those aged over 65 and between 25% and 50% for those aged over 85. This highlights how vulnerability and support needs are not uniformly distributed across age groups.

1.2.2 What Is Psychological Therapy?

For the purposes of this thesis, the terms *psychological therapy*, *psychotherapy* and *therapy* are used interchangeably to describe a “psychological service provided by a trained professional that primarily uses forms of communication and interaction to assess, diagnose, and treat dysfunctional emotional reactions, ways of thinking, and behavior patterns.” (APA, 2023, para. 1). Such psychological interventions are delivered by a range of practitioners with diverse training backgrounds, including doctoral-level qualifications, postgraduate diplomas or certificates. Common therapeutic modalities include Guided Self Help, Cognitive Behavioural Therapy (CBT), and Counselling (NHS, 2022) and practitioners may be referred to using various titles including psychologist, counsellor or CBT therapist, depending on their training.

1.2.3 What Is Video Therapy?

The term *video therapy* is used to refer specifically to the delivery of psychological therapy via video-based platforms, such as Zoom or Skype. While this term is employed for consistency within the current study, it is important to acknowledge the range of alternative terminology used across the literature. One such term is *telehealth*, which is frequently used to describe healthcare services delivered through digital means. However, telehealth is generally applied as an umbrella term for both physical and mental health care, rather than referring specifically to psychological interventions. The term *remote therapy* also appears regularly in the literature and denotes a broader category of therapy conducted at a distance, and includes sessions delivered via telephone, video, or digital platforms offering structured interventions such as internet-based CBT (Smith et al., 2021).

1.3 Search Strategy

An initial search was conducted in April 2023 and employed the primary terms *older adults*, *remote* and *therapy*. However, this search predominantly yielded studies on internet-based interventions (e.g. Guided Self Help or text-based interventions) which were excluded from the current review due to the researcher deeming these too far removed from video therapies to be applicable, something which is echoed by Grondin et al. (2019) who described in-person

and video therapies as having high medium richness, and text and audio-based as having low medium richness.

A second literature review was conducted in July 2025 to extend and refine the initial findings. This review utilised two primary search term categories, each accompanied by relevant synonyms to enhance the breadth and sensitivity of the search. The first category focused on the population of interest, using the term *older adults* along with related terms such as *older person*, *geriatric*, *ageing*, and *elderly*. The second category targeted the modality of interest, using the term *video therapy* alongside synonyms including *video counselling*, *telehealth*, *telepsychology*, *video conferencing*, *remote counselling*, and *remote therapy*. It is important to clarify that this review was limited to literature concerning older adults, with studies focusing on video therapy with other demographic groups excluded from the scope of this analysis.

As the initial search returned over 400 articles, an elimination process excluded those focusing solely on physical health conditions, in-person therapies, telephone therapy, virtual reality and internet-based interventions such as computerised CBT, as these were deemed to deviate from the research question and not be reflective of video therapy itself. The search was limited to those in the English language and excluded dissertations. The publication date of the search was initially limited to five years to account for the onset of the COVID-19 pandemic and the increased use of digital psychotherapies. However, due to the limited research, the researcher expanded this to include the past 10 years (since 2015). The search returned eight articles in total, of which four were quantitative, two qualitative and two which were mixed methods.

Due to the limited number of studies returned in the search, the literature review presented below was expanded to include wider research on older adults and mental health needs, older adults and digital technology and video therapy in the general population. The wider literature was identified through PsycInfo, the City University Library database, and grey literature from organisations such as Age UK, NHS, and the Office for National Statistics. Additional practitioner-focused resources such as the Positive Practice Guide (Age UK, 2024) and The Clinician's Guide to CBT with Older People were also reviewed (Laidlaw et al., 2016).

1.4 Older Adults and Mental Health Needs

There is a growing pressure on community and healthcare providers to cope with an ageing population. Age UK (2019b) projects the number of older adults to double between 2017 and 2040. According to the United Nations (UN, 2023), older adults will account for over 28% of the global population in developed countries by 2050. The UN have declared 2021-2030 as

the decade of healthy ageing, pushing for collective action on delivering person-centred integrative care and improving access to quality long-term care (WHO, 2024).

The prevalence of mental health difficulties in older adults is documented in the literature. According to estimates by The Royal College of Psychiatrists approximately 22% of men and 28% of women aged over 65 experience symptoms of depression (RCPsych, 2018). Furthermore, adults aged 85 and above are reported to have the highest suicide risk of any age group (Centre for Disease Control and Prevention, 2025). However, findings from the Office for National Statistics (2023) indicate that older adults are less likely than younger adults to experience depression and severe anxiety.

The researcher questions the accuracy of these statistics, and the extent to which they reflect reality, or whether mental health difficulties in the older population are being under-reported. Older adults experience significant changes and life stressors that can put them at risk for mental health difficulties, such as loneliness. While loneliness can affect people across the lifespan, specific “pressure points” (Age UK, 2019, p. 3), particularly around loss, can increase the likelihood of loneliness for older people. The death of loved ones, poor health, and financial worries are cited as the most common triggers for mental health difficulties in older people (Age UK, 2017). Research suggests that the COVID-19 pandemic exacerbated experiences of loneliness, with older adults being significantly impacted by the pandemic and resulting isolation (Cocuzzo et al., 2022). This shift in social norms during the pandemic led to loneliness and depression, as well as higher rates of suicidality (Carr et al., 2021). On the other hand, during the pandemic older adults demonstrated greater resilience and more effective coping strategies in the face of negative events (Lopez et al., 2020). Additionally, Lebrasseur et al. (2021) reported that although older adults experienced negative psychological effects during the pandemic, the impact was less severe compared with younger age groups, which again raises questions about whether this reflects reality or under-reporting.

The literature reports variations in the way in which symptoms of mental health difficulties present in older adults compared to younger adults. Older adults are more likely to experience physical health conditions, which can worsen or trigger mental health conditions (Age UK, 2023), with 80% of those aged over 65 being diagnosed with more than one long-term health condition (The King’s Fund, 2013). The overlap between physical and psychological symptoms presents a diagnostic challenge. Older adults are more likely to express emotional difficulties through somatic complaints rather than overt psychological symptoms, with a systematic search reporting how older people with depression reported more agitation, hypochondriasis, and somatic symptoms compared to younger depressed adults (Hegeman

et al., 2015). Common physical symptoms reported by older adults include fatigue, sleep disturbances, decreased energy, and appetite changes, which overlap with low mood and anxiety, with symptoms more likely to manifest as medical and somatic symptoms than psychological distress (Wetherall et al., 2021). This can confound symptoms and clinical presentation, with indications that later life mental health difficulties often go undiagnosed (DiNapoli et al., 2017). In response, Age UK (2019b) advocates for a more integrated approach to health and social care in late-life, to ensure that mental health is not marginalised.

Evidence suggests that older adults are significantly less likely to seek psychological support compared to younger populations. Recent data from the Office for National Statistics (2023) highlight that while 13.6% of younger adults access therapy, only 4.5% of those aged 65 and over do so. This disparity is also reflected in NHS Talking Therapies services, where referrals decrease as age increases, with Age UK (2024) reporting how individuals aged over 75 account for just 2% of national Talking Therapy referrals. This under-utilisation of services is echoed in findings from the wider literature. A Europe-wide survey by Horackova et al. (2019) found that approximately 75% of older respondents exhibiting symptoms of depression had not sought professional help for their low mood.

Multiple factors contribute to the low rates of help-seeking for mental health support among older adults. Age UK (2017) found that over one-third of people aged 55 and over were unsure about where to access appropriate support. Barriers also stem from both older adults' own beliefs and the attitudes of healthcare professionals. Karlin and Duffy (2004) reported that providers often lack awareness or experience with interventions for late-life anxiety and may be reluctant to discuss these issues with older patients. More recently, a qualitative review of healthcare professionals' attitudes toward ageing reported evidence of therapeutic nihilism (Jeyasingam et al., 2023). Mental health difficulties are sometimes framed as an inevitable part of ageing, while concerns about stigma or fears of being a burden further discourage older adults from seeking help (Age UK, 2019).

Despite the low referral rates into psychological therapy services, research shows that psychotherapy is effective for older adults, with a good evidence base for late-life depression and anxiety. Evidence supports the use of CBT, problem-solving therapy, and interpersonal therapy as effective interventions for this population (Scogin et al., 2005). Further support comes from studies on Talking Therapies, which indicate that older adults not only engage well with treatment but also tend to have higher completion and recovery rates compared to younger individuals (NHS Digital, 2020; Saunders et al., 2021).

1.5 Ageism

Social stigma rooted in age-based stereotypes can also be acknowledged as ageism, which is pervasive and has been described as the last socially acceptable prejudice (Weir, 2023). Ageism develops in a similar way to racism or sexism (Bartels & Naslund, 2013) and occurs as a result of negative stereotypes that can be found in television shows and movies, as well as through social media (Fullen, 2018). Negative stereotypes, such as having lower motivation and greater resistance to change (Posthuma & Campion, 2009), can create a barrier to accessing services for older adults. Unfortunately, there is also potential evidence of ageism in clinical services, with Saunders et al. (2021) finding that in London Talking Therapies services, older people are more likely to be treated with low-intensity therapy and less likely to be stepped up to higher intensity treatment.

Alongside ageism occurring within the wider population and within healthcare services, there is also evidence of internalised ageism, where older adults themselves hold ageist beliefs. A recent qualitative review by Yin et al. (2024) reported how statements that aligned with ageism were dominant in all stakeholders, including older adults themselves. This internalised stigma can prevent older adults from acknowledging mental health difficulties or seeking professional support (Choi et al., 2014). However, ideas around stigma have been challenged by Knight and Winterbotham (2020), who in their study of older adults' perceptions of remote mental health services, found that reluctance to seek help was not primarily driven by stigma as previously thought. Rather, participants expressed a strong preference for self-management of symptoms, reflecting a belief in self-sufficiency as a positive and valued trait.

Within the counselling psychology profession, we are not exempt from unconscious biases, which are influenced by both systemic factors and individual factors. There is a lack of interest in the field of ageing according to statistics from the USA, with only 3% of psychologists specialising in working with older adults, compared to 30% with children and adolescents (APA, 2015). This is perpetuated systemically by training institutions, with a lack of gerontological content in programmes and in textbooks (Gross & Esbaugh, 2011). The invisibility and the pervasiveness of ageism impact the core values of counselling psychology, including client advocacy and social justice. Fullen (2018) recommends three approaches for tackling ageism in the psychological profession including, better education for counselling psychologists, stronger advocacy for older adults, and psychologists contributing to research in this area.

1.6 Older Adults and Digital Technology

Compared to their younger counterparts, older adults frequently report lower levels of digital confidence and competence (Lee et al., 2019) and are reluctant to use technology due to limited experience and health literacy (Ball et al., 2019). They cite barriers such as insufficient digital skills, mistrust of online platforms, and limited access to necessary devices or broadband infrastructure (Age UK, 2025). Community groups have attempted to bridge this gap, with the Digital Champions programme (Age UK, 2025) to raise awareness of the benefits of digitalisation, providing skills sessions and help with technology and connectivity.

Within the older adult population, there is considerable variation in digital engagement, with disparities often shaped by factors such as income, education, age, location, and disability (van Dijk, 2020). For example, research suggests that those with higher levels of education are more likely to use digital technologies (Pywell et al., 2020; Orr et al., 2020). Those from underserved or socioeconomically disadvantaged backgrounds remain under-represented in both digital research and the co-design of digital interventions. This limits the inclusivity and relevance of these technologies across the older adult population (Ellis et al., 2022).

The present research is timely, given that recent advancements in technology have made the delivery of healthcare at a distance more appealing and widespread (Stiles-Shields et al., 2014). The COVID-19 pandemic accelerated this shift, and the integration of telehealth across health services. In parts of the US, the availability of telehealth services in mental health facilities increased by more than 50% compared to pre-pandemic levels (McBain et al., 2023). A study conducted during the pandemic in a Talking Therapies service reported how the transition to remote therapy was generally beneficial across age groups, except for individuals aged 80 and over, who did not experience the same level of benefit (Nguyen et al., 2022). Nguyen and colleagues suggested that people in this age group may be less familiar or at ease with technology, although they did reflect that this was speculation and a stereotypical viewpoint, and this outcome warrants further investigation. Although services returned to face-to-face delivery after restrictions eased, many people in the general population are still opting to have therapy remotely (NHS England, 2023).

Accessible home technology provides opportunities to support the preventative health and psychosocial needs of healthy older adults (Pearson et al., 2023). Research on digital psychological interventions for this population mainly covers remote modalities like telephone-based and computerised CBT (Goodarzi et al., 2022). Whilst older adults may be reluctant to use unfamiliar technologies at first, studies find that once engaged, their satisfaction with

technology-mediated psychological support is high and comparable to that of face-to-face treatment (Zimmerman et al., 2021).

1.7 Video Therapy: Therapeutic Alliance, Benefits and Challenges

1.7.1 Therapeutic Alliance

The therapeutic alliance refers to the collaborative and trusting relationship between therapist and client, grounded in shared goals, agreed-upon tasks, and a personal bond (Bordin, 1979). A meta-analysis of remote therapies by Flückiger et al. (2018) highlights a strong link between alliance and treatment outcomes, consistent with findings in the in-person therapy literature. The importance of considering the therapeutic alliance in remote settings is emphasised by Sabin and Harland (2017), who argue that the alliance must stay flexible enough to adapt to technological settings while offering stability for containment, attunement, and safety. In a study into an online group intervention with older adults, Westerhof et al. (2019) found that participants valued what they termed *profound contact*, suggesting the importance of meaningful interactions and the therapeutic relationship.

Fundamental to the formation of a therapeutic alliance is the ability to communicate, and research has observed changes to communication in remote therapy. For example, Grondin et al. (2021) suggest that therapists working online make less empathic statements, which they suggest could impact the bond or therapeutic alliance. Video therapies are also criticised for losing vital information such as non-verbal cues. Transmission delays may distort interpersonal interaction and paralinguistic features such as tone of voice or response speed (Schoenenberg et al., 2014). To address this, Simpson et al. (2021) recommend some compensatory adjustments such as improved eye contact, camera positioning, and screen proximity, to enhance feelings of safety, intimacy, and connection.

In contrast to literature reporting communication deficits posed by working remotely, Schoenenberg and Martin (2024) reported how despite the lower number of nonverbal interaction cues, they found there was no difference between video and in-person therapy with any of the assessed therapeutic process variables including empathy, bond and working alliance. These results are supported by secondary literature. In a narrative review of 24 studies comparing video and face-to-face therapy in Australia, USA, Canada and the UK, Simpson and Reid (2014) found that 22 studies reported equivalent levels of therapeutic bond and perceived presence across modalities.

To conclude, although the research on video therapy and the therapeutic alliance suggests that certain aspects of communication may be weakened, existing evidence reports that these differences do not substantially affect the therapeutic alliance in the overall population. However, the literature on older adults and technology provides limited insight into the idiosyncrasies of individual experience, leaving the personal experiences of older people using video therapy largely unexplored.

1.7.2 *Benefits and Challenges*

Much of the existing literature on video therapy emphasises outcomes, often weighing its advantages and disadvantages. While the researcher acknowledges that this approach can feel reductionist to the complexity of the human experience, it can be helpful to understand the current standpoint of literature in this area. Therefore, this section will explore the benefits and challenges of video therapy as presented in the research, and the literature focusing on lived experiences will be explicitly addressed towards the end of this chapter. Unless otherwise stated, the research in this section refers to the general population, meaning people of all ages.

There is evidence that video therapies have comparable outcomes to those of in-person sessions. A recent review conducted by Thomas et al. (2021) identified 69 articles exploring the use of videoconferencing to deliver individual psychotherapies to adults with mental health difficulties. They highlighted an established evidence base, particularly with mild-to-moderate cases, reporting it to be an effective modality for therapy delivery. They also reported how every Randomised Control Trial (RCT) comparing video to in-person therapy reported no group differences on measures of satisfaction; and all but one study reported no group differences with drop-out rates.

Additionally, Thomas et al. (2021) reported how participants expressed concerns about privacy from others within their home. They also found that participants often reported initial discomfort and a short period of adjustment when using a digital platform. However, for many this anxiety typically subsided as users became more familiar with the technology. A weakness of this review, however, is that it predominantly focuses on interventions using CBT, highlighting how there is little research into videoconferencing with other therapeutic modalities.

When considering people with limited mobility, accessing therapy through a video from a home location provides some benefits for those with comorbidities and long-term conditions, helping to eliminate structural barriers to high-quality and specialised care (Gros et al., 2013). This is particularly relevant for older adults, who are more likely to reside in rural or remote areas where access to in-person services is limited (Chakrabarti, 2015). Remote delivery of therapy can help to overcome barriers related to transportation, mobility limitations, and geographic isolation, thereby reducing the burden associated with attending appointments (Wuthrich & Frei, 2015). In addition to financial savings associated with reduced travel, older adults also benefit from time saved on commuting and waiting for in-person sessions (Hantke et al., 2020). However, there is also a cost implication of internet access and appropriate hardware, potentially making this modality even less accessible for those of lower socioeconomic statuses (Gould et al., 2020).

Video therapy can also be a way of keeping emotional distance (e.g. Aafjes-van Doorn et al., 2021). This is supported by research in neuroscience, which reports that the distance at which we perceive a person shapes the neural empathic response and in turn our sense of connection (e.g. Schiano Lomoriello et al., 2018). Whilst this impact on connection may limit one's sense of closeness, clients may appreciate this feeling of emotional distance. A study by Lee et al. (2018) on individuals with trichotillomania reported how 40% of participants indicated they would not have sought in-person therapy due to feelings of shame. Similarly, Simpson et al. (2005) found that participants often experienced remote therapy as less intimidating, reporting a heightened sense of control, reduced self-consciousness, and an overall easier experience with communicating, compared to face-to-face sessions.

1.8 Therapist Perspectives

Research suggests that therapists, rather than clients, have been slow adopters of technology (Simpson & Reid, 2014). Additionally, healthcare providers are shown to be less satisfied than patients with video technologies (Chakrabarti, 2015; Hubley et al., 2016). For example, Watts et al. (2020) reported that video therapy clients rated a stronger therapeutic alliance via video than in-person clients, while therapists rated the conditions as the same.

Therapists have identified several challenges associated with delivering video therapy. These include concerns related to informed consent, confidentiality, and the management of crises within remote settings (Rochlen et al., 2004). This is echoed more recently by Reilly et al. (2022) who explored psychologists' perspectives of teletherapy and reported how they

experienced a lack of control over therapeutic boundaries with clients. Scepticism regarding the quality of the therapeutic relationship remains prevalent, with therapists reporting a widely held perception that video therapy is inferior to in-person approaches (Hubley et al., 2016). These concerns may be influenced by difficulties in interpreting non-verbal cues and the initial discomfort some practitioners experience when adapting to videoconferencing platforms (Thomas et al., 2021). Therapists also described having to work harder to connect with clients due to the loss of information through non-verbal cues (Reilly et al., 2022).

In contrast, therapists have also identified several benefits of video therapy. Lindsay et al. (2017) found that observing clients in their home environments provided valuable contextual information, enhancing therapists' understanding of the clients' lived experience. More recently, Aafjes-van Doorn et al. (2024) conducted semi-structured interviews with 31 therapists, 23 of whom reported that teletherapy worked surprisingly well, despite initially holding negative expectations. Therapists highlighted its flexibility and the increased accessibility it offered, particularly for populations such as older adults.

Provider attitudes play a critical role in the adoption and implementation of therapeutic modalities, as clinicians often act as gatekeepers to access and delivery (Wootton et al., 2006). There is also some evidence to suggest that providers with negative expectations of video therapy are more likely to provide fewer and shorter episodes of care (Christensen et al., 2021). Simpson et al. (2021) emphasised the importance of addressing therapist concerns to ensure the sustainability of video-based therapeutic practices. They argue that it is essential for practitioners to adapt to technological advancements in clinical work, regardless of personal preference. They warn that failure to do so may result in an increase of non-professional sources of online psychological support.

1.9 Older Adults and Video Therapy

1.9.1 Quantitative Research

The literature review extracted four quantitative journal articles regarding one-to-one video therapy with older adults from the last ten years which will be discussed further below (Choi et al., 2016; Fronza et al., 2025; Rollandi et al., 2025; Scogin et al., 2018). Due to the limited research returned within the search, to expand the scope of the review I have also included some literature on group therapy (Martinson et al., 2024; Shapira et al., 2021), and systematic reviews (Cremers et al., 2022; Goodarzi et al., 2022; Harerimana et al., 2019), although it

should be noted that these review all remote therapies, not solely video therapy. When presenting the research, the researcher has been transparent regarding the age of the participants in the studies and the interventions used, due to the variations of these within the literature. As highlighted above, much of the quantitative literature reviewed focuses on outcomes and efficacy of video therapy. The upcoming section on qualitative research offers more insight into experiences.

There is literature comparing the outcomes on depression of video therapy and in-person sessions, such as Rollandi et al. (2025) who evaluated a brief behavioural activation intervention delivered over ten sessions to older adults (aged 60+) victims of elder abuse. They reported significant symptom reductions across in-person, video, and phone formats, with video leading to faster improvement. However, generalisability is limited by the specific sample, and it is unclear whether these outcomes would translate to a broader older adult population. Another study highlighted similar findings; Choi et al. (2016) studied 158 adults (aged 50+) with depression and suicidal ideation, randomising participants to in-home or video sessions of problem-solving therapy. While both formats reduced depression, only video therapy significantly reduced suicidal ideation. The researchers reported that although they expressed a preference for in-person sessions, almost all participants embraced video sessions and had more positive evaluations than in-person problem solving therapy. The authors attributed this to a possible increase in perceived self-efficacy through engagement with technology.

Other studies offer a different perspective of therapeutic outcomes for depression via video. Scogin et al. (2018) present more mixed findings regarding the efficacy of video therapy for older adults (aged 50+) with rural populations. In their study participants were assigned to either a control group or an integrated care group which targeted both depression and insomnia through a ten-week CBT course, delivered via video. Whilst they found significant improvements for insomnia, depression was similar to the control group. This suggests that the intervention may have been effective for sleep-related concerns but less effective for mood related outcomes.

Several factors may account for the disparity in findings above. One explanation may be that Scogin et al. (2018) employed the Hospital and Depression Scale (HAD-B) to assess for depressive symptoms, whereas Rollandi et al. (2025) used the PHQ.9 and Choi et al. (2016) used the Hamilton Rating Scale for Depression (HAM-D). This variation in outcome measures limits direct comparison, as the tools differ in sensitivity, focus and clinical cut offs.

Other studies have explored the outcomes of video therapy on anxiety. Fronza et al. (2025) conducted an RCT where ten older adults (average age 66) with anxiety and a cognitive impairment accessed a video CBT intervention. This intervention primarily focused on relaxation techniques which took place over six sessions. Post-intervention, participants average anxiety scores had decreased to just below the cut-off. However, both studies are limited by small sample sizes, increasing the likelihood of type 2 errors, and participant sizes not large enough to detect significant effects. This is echoed in a group CBT intervention for chronic pain in military veterans had significant improvements in disability rating, physical health, quality of life, generalised anxiety and pain outcomes (Martinson et al., 2024).

One study explored the impact of a group intervention on loneliness, offering a study focused on relevant social issues that older adults face, as opposed to disorder-based research. In their study of a group-based CBT intervention on older adults (aged 65+) living in the community, Shapira et al. (2021) reported how although there were significant improvements in loneliness compared with the social group, improvements in loneliness and social support were not maintained post-therapy. This finding highlights a potential shortcoming in the existing literature, where focusing primarily on mood related outcomes can ignore other potential challenges faced by older adults. It also suggests that social issues such as loneliness, may not be fully addressed through therapy alone.

In summary, the quantitative research offers some understanding as to the outcomes of video therapy for older adults, and promising initial findings that this can be as effective as in-person therapy. There are however numerous criticisms of this research, including the small sample sizes, the age of what constitutes an older adult and the research focusing on structured interventions such as CBT, which will be discussed further in the limitations of the literature. The researcher notes an obvious shortage of research in this area, with few researchers exploring this topic, and offers a criticism that the quantitative research gives us a reductionist view of older adults' experiences.

1.9.2 Qualitative Research

Similarly to the quantitative research, older people were invisible in the qualitative literature. The literature review identified only two qualitative studies regarding older adults' experiences of having psychological therapy via video (Christensen et al., 2021; Pearson et al., 2023), with only one of these studies that explored participants experiences in depth (Christensen et al., 2021). The researcher also identified two mixed methods studies (Campbell et al., 2025;

Fallon et al., 2024) and one review (Yin et al., 2024), with the review again focusing on all digital mental health interventions, as opposed to solely video therapies.

The qualitative research reviewed focused primarily on intervention as opposed to therapeutic relationship or client experience. For example, in Campbell et al.'s (2025) case study of a 78-year-old female participant who completed video Acceptance and Commitment Therapy for chronic pain, they primarily report on the interventions delivered, with a session-by-session outline of the topics covered. They reported minimal information on the client's experience of the intervention stated only how she described therapy positively, and felt supported to avoid medication and maintain proactive behaviours.

The focus on intervention continues in other studies, with Fallon et al. (2024) using thematic analysis to analyse results from a survey of five participants who had completed a video therapy intervention of dignity therapy, which is a brief psychotherapy prompting people to reminisce on the past (Chochinov, 2012). The study aimed to assess the programs acceptability, practicality and the benefits of the therapy, and resulted in five themes: inscribing one's legacy, a deeper connection to others, triggering new self-insight, an integrated and strengthened view of self and accepting the past with self-compassion. However, the detail reported in the themes reviewed the efficacy and acceptability of the intervention itself, as opposed to the client experience.

When the literature did reference older adults experience, participants described the importance of the qualities of the therapist, and how they were experienced through the screen. In Pearson et al.'s (2023) study into video music therapy sessions by nine older adults (aged 70+), participants used positive language to describe the therapist, including caring, wonderful and friendly. This was echoed by Fallon et al. (2024) where participants described how the intervention helped them deepen their relationships with others and how they were able to develop and "intimate" connection with the therapist.

There were also technical difficulties reported in some studies. Pearson et al. (2023) described how technical difficulties were commonplace, with participants experiencing difficulties in 50 out of 86 sessions. In this study, some participants described technology as being a barrier to a positive experience, such as interrupting the music therapy experience; however, that they generally demonstrated a high tolerance for minor technical disruptions, which were not perceived to compromise the overall quality of the intervention. Similarly, Fallon et al. (2024) reported how there were some technological setbacks, including issues with compatibility with their hardware and the programme used. However, they reported that participants stated that the benefits of the online format (e.g. financial savings, comfort) outweighed the costs

associated with travelling. Some participants described initially feeling apprehensive but pleased with their ability to access and engage online (Campbell et al., 2025); with acceptability increasing over time as they gained experience, familiarity and competence with technology (Christensen et al., 2021).

In the qualitative literature reviewed, one paper explored both client (aged 65+) and providers experiences of videoconferencing in depth (Christensen et al., 2021). However, it should be noted that this was for a mixture of health services, including different professionals such as nurses and psychologists, therefore experience specifically related to psychology or mental health are unknown. In their study, researchers conducted semi-structured interviews and focus groups and used thematic analysis to report three key themes: patients and providers experiences of technical challenges, the use of video conferencing as clinical supportive technology, and the therapeutic relationship, and each will be discussed in turn.

The first theme explored experiences of technical challenges and highlighted how participants experienced transmission interruptions and disruption, which led to feelings of frustration, in addition to perceived incompetence with technology. These disruptions were reported to play less of an important role for patients, as opposed to providers, with the patients describing the technical challenges as “little things”. The researchers also reported providers holding a belief that patients would be resistant to developing the technical skills, however they found that technical challenges were no different in those who were inexperienced or experienced with technology. They also reported how for clients, initial scepticism evolved into a positive experience, as they gained more familiarity, experience and competence with technology. Interestingly, they noted that whilst patient participants would choose video therapy again, the providers views remained more rigid that video therapy is less suitable for older adults.

The second theme explored how video therapy is used as a clinical supportive technology tool. They reported how participants viewed the easy access to communicating as advantageous and how not leaving their home reduced the inconvenience of travel. Participants valued how if they were low in mood or had little motivation to get dressed then video therapy felt more convenient. They also described how the flexibility of the modality allowed for shorter and more frequent consultations, helping them to feel better supported.

Finally, the third theme centred around the therapeutic relationship. The findings in this theme indicated that older adults felt empowered to express themselves better at home. They described having less of a sense of ‘being ill’ when having video therapy, compared to in-person and they valued being able to read facial expressions as it provided confirmation that the person was listening. They did however, express how they would like an initial face-to-

face appointment, viewing this as facilitating building an initial relationship. Participants reported experiencing the therapy sessions conducted via video as more concentrated and guided compared to telephone conversations, which was described as beneficial for addressing issues directly. Those diagnosed with mild depression indicated that the therapeutic relationship via video was comparable to in-person; however, those with more complex difficulties stated that video therapy was insufficient, citing the absence of physical presence as a limitation.

Finally, a review by Yin et al. (2024) examined qualitative experiences across all forms of remote therapy, although they defined older adults as aged 50 and above, which limits the transferability of the findings. One theme revealed that both older adults and healthcare providers expressed negative perceptions of ageing, with some older adults viewing depression as a normal part of ageing (Choi et al., 2014), making help-seeking a significant step. The review also reported that older adults learning new technologies often enjoyed the experience and felt a sense of achievement. Their experiences were however strongly influenced by the attitudes of those around them, particularly trusted healthcare professionals and peers. Overall, older adults generally reported that remote therapies were beneficial for their mental health and wellbeing.

In summary, the qualitative research presented offers an initial insight into how video therapy is experienced by older adults. Common themes highlighted include the importance of the therapeutic relationship, and how the qualities of the therapist are experienced through a screen. It also offers an insight into technical challenges encountered and the way in which these are experienced. The Christensen et al. (2021) paper also offers an interesting comparison, suggesting how providers themselves hold the more rigid and inflexible beliefs around older adults and technology, with older adults themselves demonstrating more flexibility and openness.

1.10 Conclusions

1.10.1 Limitations in the Literature

There is clearly a paucity of literature into older adult's experience, with the absence of research that explores this populations experiences of video therapy in depth. The quantitative research focuses on outcomes as opposed to experience approaching research through a positivist lens, which feels reductionist to the human experience. Within the qualitative

research the focus is more on the transferability of a technique to video therapy, as opposed to the experience of the medium itself, with the exception of one paper (Christensen et al., 2021). The limitations of the findings presented here are echoed in previous summaries, with Cremers et al. (2022) reporting how research that does include qualitative data is typically limited to one or two questions and was sought informally and Smith et al. (2021) describing how there is little research exploring older adults' experiences in depth.

The emphasis on interventions and outcomes is echoed in a review conducted by Thomas et al. (2021) who reported that studies into video therapies typically use behavioural techniques and more reflective therapies are relatively less tested. This is surprising given that the therapeutic relationship and client factors have repeatedly been demonstrated as strong predictors of effective psychotherapy, above technique or intervention (Wampold & Imel, 2015). It perhaps represents the current medicalised model within psychological therapies treatment, particularly used within the NHS, where the emphasis is on evidence-based interventions. This is concerning and not in line with client preference, with a study reported how over half the older adults interviewed expressed a preference for counselling over other therapeutic modalities (Gould et al., 2020).

Further criticisms come from the participant samples include the under-representation of several groups; namely males, those who are over 85, are of low socioeconomic status and from communities of diverse ethnicities and languages (Goodarzi et al., 2022). Over 85's are also less likely to complete interventions, with Cremers et al. (2022) suggesting we are unable to assess the efficacy of remote therapies in this age group. Explanations of this could come from the lack of help-seeking within this age group, or the lack of appropriate and accessible interventions.

Recruitment difficulties seem to plague research into older adults. This is reported explicitly in some studies, as Fronza et al. (2025) described not meeting their sample size; and Goodarzi et al. (2022) reporting how the small sample sizes in quantitative research causes homogeneity issues and rendered them unable to complete a meta-analysis. To address small sample sizes, researchers have adopted strategies that may inadvertently compromise the quality and relevance of findings. In primary studies, this includes extending study durations or broadening inclusion criteria, such as lowering the minimum participant age to 40 (Westerhof et al., 2019) or 50 (Choi et al., 2016; Scogin et al., 2018). This feels questionable to the relevance and comparability of the data, with the researcher questioning whether someone aged over 50 and above could be classified as an older adult. This affects the quality of the research presented as by broadening the inclusion criteria we can reduce the population specificity, making research less generalisable or even misleading for the target group.

1.10.2 Rationale and Aims for the Study

The literature review intended to provide an overview of older adult's experiences of video therapy; however, due to the scarcity of literature, resulted in highlighting the invisibility of older adults both in society and in research. It revealed how we know very little about how older people experience video therapy, particularly when it comes to the depth and textures of lived experiences. In particular, we know very little about what is important to older adults in video therapy, what matters to them, what it is like to have therapy at home, and how they experience seeing a therapist and being vulnerable through a screen.

Qualitative research offers a valuable means of accessing the perspectives and subjective experiences of these people, particularly as it draws upon the unique expertise that older adults have through years of lived experience (Fortuna et al., 2019). Unlike quantitative approaches, which may reduce experiences to measurable outcomes, qualitative enquiry has the capacity to capture the nuanced ways in which older adults interpret and respond to newer modes of service delivery.

To the author's knowledge there are no studies published that have examined older adults' lived experiences of video psychological therapy, nor any that have adopted a phenomenological lens. This absence means that critical dimensions, such as the emotional responses elicited by digital therapeutic encounters and the processes of meaning-making that occur remain underexplored. The lack of qualitative enquiry, and particularly the absence of phenomenological investigation, limits the depth of our understanding and risks overlooking important experiential factors that may shape both the acceptability and effectiveness of video-based interventions for this population.

When considering the clinical implications of this, video psychological services are designed by working age professionals, the majority of whom will be without lived experience of being an older adult. This is concerning, particularly given some of the ageist beliefs highlighted in the review, and goes against recommendations for services to be co-produced with older people. As Kaiser et al. (2025) passionately argue, there must be a cultural shift to reform practices and challenge the pervasive ageism in services (Kaiser et al., 2025), ensuring a world for all ages.

1.10.3 Research Question:

How do White British older adults make sense of their experiences of video-based psychological therapy and its place in later life?

2 Methodology

The **Introduction** sets the stage by offering a critical review of the existing literature around older adults and video therapy and presented a rationale for the present study. The **Methodology** chapter provides a detailed description of the research design, situating the study within my own ontological and epistemological position and offering reflections on reflexivity. A rationale for the use of qualitative methods, and in particular Interpretative Phenomenological Analysis (IPA) will be offered. The chapter also maps out the procedure for data collection, including sampling, the inclusion and exclusion criteria and the interview and analytical strategy. The chapter will conclude with consideration of ethical and safety concerns ensuring the project not only seeks knowledge, but also honours the duty of care to the participants.

2.1 Personal and Epistemological Reflexivity

The importance of reflexivity is highlighted by Clancy (2013) as it enables the researcher to pay close attention to their own responses to others' material. Without this, the researcher can project their own thoughts and feelings, impacting not only the interview process, but also the interpretation of qualitative data (Willig, 2019). Practising *epoché*, that is the suspension of judgement, enables us to notice and reflect at moments of judgement, and to implement bracketing, allowing the researcher to put aside the world we take for granted, to consider our perception of the world (Husserl, 1983).

My motivations for conducting research into older adults comes from my own experience of being raised by my Nana (Shirley) for much of my younger years. She was warm and caring and did stereotypical Nana activities like baking and gardening. She died from a brain tumour at home when I was eleven years old and is the only close family loss I have experienced. In my adult years, I enjoy hearing stories told by older people, and with this in mind I joined a befriending scheme where I visited a lady named Edna every week for several years. This pairing with Edna highlighted to me our differences in our experiences and attitudes, but how we were able to build a strong connection despite those. It also highlights to me the loneliness that occurs in older age, and how the limitations of Ednas' body made it impossible to connect to others like she previously would, reducing her power and visibility in society.

Already having an affinity with older adults, the topic for my research project was solidified when commencing the Counselling Psychology doctorate programme, as I noticed the under-

representation of older people, both within the age range on the course, as well as limited discussions around ageing and ageism, in comparison to other social issues.

Reflecting on my own assumptions, I tend to view older people through rose tinted glasses, and lean more towards hermeneutics of trust, as opposed to hermeneutics of suspicion (Ricouer, 1970). There can be a risk with trusting participants implicitly, that I take things at face value and there can be a loss of critical distance. I noticed this when starting the analytic process, wanting to stay true to the participants word, and at times silencing my own interpretations. Through discussion in supervision and encouragement from my supervisor I allowed my interpretations to take shape.

There were also times where I found myself more connected to some participants experience and disconnected to others, which runs the risk of silencing perspectives. This happened with one participant, Simon, with whom I found the most challenging to interview. It felt difficult to get close to Simon's lived experience and I felt intimidated as he talked about his professional role, as opposed to his lived experience. This led me to make assumptions around how his professional role had impacted his views, moving more towards a narrative, than interpretative stance. Keeping a reflective diary enabled me to bracket these assumptions when completing the analysis, and helped me to re-connect to his experience, and reframe the distancing as part of his lived experience.

The analytic process required me to engage reflexively on my assumptions about ageing, therapy and visibility. Having experience delivering video therapies within a Talking Therapies service, and working as the long-term conditions' specialist, my role involved increasing accessibility to older adults. Feeling passionate about this, I bracketed assumptions around video therapy as being "good", something which became more challenging when much of the literature in the review represented video therapy in this light. Through bracketing these assumptions, I could view the nuances and idiosyncrasies in the participants experience, and move away from a reductionist view of good and bad.

As a researcher-clinician, I recognised that my position shaped both the research encounter and my interpretation of participants' experiences. As a counselling psychologist in training, I brought an existing investment in the therapeutic relationship and an understanding of therapy as a relational and meaning-making process. This may have heightened my attention to experiences of connection, safety, visibility and the therapeutic relationship within participants' accounts, while potentially leading me to give greater significance to these processes than might have been emphasised by a researcher from a different disciplinary perspective.

My position as a younger adult also placed me differently in relation to participants' experiences of later life, mortality, loss and changing identity. I was therefore mindful of the risk of interpreting participants' experiences through assumptions about ageing that were not necessarily shared by them. At the same time, approaching these experiences with curiosity rather than assuming shared understanding encouraged participants to articulate their own meanings. My clinical identity also influenced how I understood participants' accounts, particularly where they described vulnerability or relational difficulties. I sought to maintain a distinction between the therapeutic and research relationship, recognising that my role was to facilitate participants' meaning-making rather than provide psychological intervention.

To demonstrate my reflexivity in real time, I will offer reflective notes throughout the thesis represented by text boxes, in line with Olmos-Vega et al. (2023) who recommend reflexivity be presented throughout the whole manuscript. This aims to provide an immediate reflexive response to the difficulties or dilemmas encountered throughout the research process and offers extracts from my reflexive diary.

2.2 Ontological and Epistemological Position

Prior to undertaking research, the researcher must reflect on their philosophical assumptions underpinning the methodological design which is said to be a core skill for researchers and therapists alike (Willig, 2013). The ontological and epistemological stance of the researcher informs the methodology chosen (Smith et al., 2022), shaping the questions asked, how we engage participants and how data is interpreted.

Ontological positions are concerned with what exists and the things one assumes to exist (Willig, 2019), and span from objectivist to subjectivist, with objectivists believing there is one true reality to be known, and subjectivists taking the stance that there is no reality and it is a projection of the human imagination (Diesing, 1966). It can be helpful to consider the development of my own ontological beliefs in line with my own therapeutic practice. Entering the course as a CBT therapist, my initial ontological beliefs leant towards *positive realism*, observing directly cognitions and behaviour. Throughout my practice on the doctorate, my experience of different therapeutic modalities such as psychodynamic and systemic therapy have expanded my perspective to take a view that is less black and white, and more multi-faceted. My perspective has shifted towards taking a *critical realist* lens, now believing that there can be many accounts of a single phenomenon, making a person's experience subjective and that a mind-independent reality exists but is not truly known (Maxwell, 2012). Critical realism was pioneered by Bhaskar (1975, 2008), as he described how reality exists

independent of human perception, however, our understanding of reality is always mediated and subjected to interpretation.

Whilst ontology seeks the classification of entities, epistemology concerns itself with the nature of knowledge in general (Willig, 2019), as well as the possibility and scope of knowledge (Crotty, 1998). Consideration was originally given to a *social constructivist* ontology, due to resonating with knowledge being created through social and cultural contexts. However, despite still acknowledging the important of context, I am more interested in the way in which our personal and social context shapes our experiences and meaning making, as opposed to believing that reality is constructed through these interactions. After consideration, I more closely align with a *Phenomenological* epistemology, believing that knowledge comes from lived experience. As outlined by Husserl (2000), the essence of a phenomenon represents its true nature, and in order to capture the essence, one must engage with a persons lived experience (Lopez & Williams, 2004).

In the present study, I adopt a *critical realist stance*, recognising that while video therapy exists as an external reality, our understanding of it is inevitably filtered through individual experiences. Each participant interprets their experience of video therapy through their own context, assumptions, and prior experiences, meaning the phenomenon cannot be fully known in an objective sense. As I am not an older adult, my perspective differs from that of the participants, and I acknowledge that my interpretations are influenced by my own assumptions and experiences. To address this, I adopt a *phenomenological* approach, striving to engage closely with participants' lived experiences and to understand the phenomenon from their perspective.

2.3 Rationale for a Qualitative Design

When conducting the literature review it became apparent that there is a paucity of research within this area generally, with most of the research conducted quantitatively and with small sample sizes (Goodarzi et al., 2022). Previous qualitative research into video therapy with older adults has been limited to one or two questions, and was sought informally (Cremers et al., 2022), with no research exploring peoples' experiences in depth (Smith et al., 2021). To allow detailed exploration of older adults' experiences, a qualitative approach is a natural fit, and one that counselling psychologists are aptly placed to undertake (Morrow, 2007), with the humanistic ethic at the core of counselling psychology closely aligning with the research design (Woolfe, 2016).

A quantitative or mixed methods approach was briefly considered, as rating tools such as surveys and questionnaires could be used to explore experiences of video therapy. However, I was keen to move away from approaches that may ignore individual experiences and could be considered reductive of human experience (Richards & Morse, 2012). I also wanted to prioritise older adults' voices, given that they are often under-represented or overlooked in research. A qualitative design felt like it could also be flexible to the individual needs of the participants, and adaptations could be made if there were any cognitive differences or sensory impairments, making participation more acceptable and inclusive.

2.4 Rationale for Interpretative Phenomenological Analysis (IPA)

Selecting an appropriate qualitative methodology required careful consideration of both the research question and the type of knowledge the study sought to generate. The present study aimed to explore how older adults made sense of their experiences of video-based psychological therapy, prioritising the meanings participants attributed to those experiences rather than seeking to explain behaviour or develop theory. Consequently, several qualitative methodologies were considered before selecting IPA as the most epistemologically and methodologically congruent approach.

One methodology initially considered was Reflexive Thematic Analysis (RTA; Braun & Clarke, 2006), due to its flexibility and widespread use within health psychology research. RTA seeks to identify and interpret patterns of shared meaning across a dataset, allowing researchers to generate rich thematic accounts of participants' experiences. Its theoretical flexibility means it can be applied across a range of epistemological positions and research questions, making it particularly useful for exploring under-researched topics such as older adults' experiences of video therapy.

Despite these strengths, the analytic priorities of RTA differed from those of the present research. Whilst RTA can preserve complexity within individual accounts, its primary analytical focus remains the development of patterns of meaning across participants rather than an in-depth exploration of each person's experiential world. In contrast, IPA adopts an explicitly idiographic approach, requiring detailed engagement with each participant's account before examining convergence and divergence across cases (Smith et al., 2022). Given that the present study sought to understand how each older adult experienced and made sense of video therapy within the context of their unique life circumstances, preserving the integrity of individual accounts was considered particularly important. This was especially relevant given the diversity of experiences relating to ageing, health, bereavement, identity and social

connection that emerged throughout the interviews. Consequently, IPA's case-by-case analytical process was judged to offer greater phenomenological depth than would have been achieved through a thematic analysis.

Another methodological approach considered was Narrative Analysis because of its emphasis on the stories people construct to make sense of their lives (Frost et al., 2010). Narrative approaches recognise that experiences are understood within broader personal, cultural and historical contexts, making them particularly valuable when exploring life transitions and change over time (Josselson & Hammack, 2021). This methodology would allow for participants to situate their experiences of video therapy within wider accounts of ageing, relationships, retirement, illness and bereavement - generating valuable insights into how the explored phenomena becomes integrated within their broader life stories.

However, the primary analytical interest of Narrative Analysis differs from that of IPA. Rather than focusing primarily on the lived experience of a particular phenomenon, narrative researchers are typically concerned with how experiences are organised into stories, including their structure, performance, language and social function (Riessman, 2008). Whilst these dimensions would have been interesting, they were not central to the aims of the present study and research question. The intention was not to examine how participants constructed narratives of ageing or psychological therapy, but rather to understand the meanings they attributed to the experience of engaging in therapy through video technology. Although participants inevitably draw upon their wider life experiences when reflecting on therapy, these broader narratives are understood as providing context for the phenomenon rather than constituting the phenomenon itself. IPA therefore offered a closer methodological fit by allowing exploration of both participants' lived experiences and the meanings they attached to those experiences whilst remaining focused on the phenomenon of video therapy.

IPA was selected as the most appropriate methodology because it offered the greatest alignment between the research question and analytic aims. Rooted in phenomenology, hermeneutics and idiography, IPA seeks to understand how individuals make sense of significant lived experiences whilst acknowledging the interpretative role of the researcher throughout the analytic process (Eatough & Smith, 2017; Smith et al., 2022). Its emphasis on the double hermeneutic, whereby participants attempt to make sense of their experiences while the researcher seeks to make sense of the participants' sense-making, was particularly congruent with the present study.

Furthermore, IPA's commitment to detailed idiographic analysis enabled each participant's account to be explored within the context of their unique circumstances before identifying

shared experiential themes across the group. Rather than reducing these experiences to common patterns alone, IPA enables a rich reflection of each individuals' experiences. In doing so, the methodology remained consistent with the aims of Counselling Psychology, which values subjective meaning and the exploration of lived experience within its broader interpersonal and social context.

2.5 Theoretical Underpinnings of IPA

IPA is a research approach used in psychological and social sciences research which explores how people make sense of their lived experiences. IPA originated in the 1990's by Jonathan Smith (1996) and has strong roots in phenomenology, hermeneutics and idiography, which will each be explored in the following section.

The earlier phase of phenomenology was largely associated with Husserl's concept of a lifeworld, which is the practical world of everyday experience (Husserl, 1970). He suggested how the phenomena under question should be studied free of prior beliefs and assumptions (Larkin et al., 2011) and criticised the objectivist scientific positions, outlining how the lifeworld is a world of varying truths (Cudjoe, 2023). Husserl was interested in not only the consciousness itself, but the phenomena that consciousness discloses about the world. Gallagher (2022) described our consciousness as being "our window onto the world" (pg. 20), suggesting how before we study the phenomena outside of the window, we must firstly be concerned about the condition of the window, and how this impacts what we see outside.

Key to phenomenology is the concept of practicing epoché or bracketing, which means to suspend our metaphysical and scientific judgements not only about objects, but also in the surrounding world, and the world itself (Gallagher, 2022). For Husserl, bracketing is a defining characteristic of phenomenology and connects to uncovering the essential structures of an experience. Through bracketing, we expose and engage with our own preconceptions (Finlay, 2002), as we pay attention to the appearance of the phenomena, seeing how it appears to us and how it is experienced (Zahavi, 2003). We disengage from the *natural attitude* (Husserl, 1983), which is described by Cudjoe (2023) as the mode of our existence that is unquestioned and stays natural until we engage with it; and this enables us to adopt a phenomenological approach.

The later phase of phenomenology, known as hermeneutic phenomenology, was shaped by Heidegger and Merleau-Ponty. In *Being and Time* (1927), Heidegger redefined phenomenology as ontology, focusing on the meaning of Being. Rejecting Husserl's transcendental approach, he argued that knowledge is gained through interpretation and

described humans as *Dasein*, meaning “being-in-the-world” (Spinelli, 1989). From an IPA perspective, thoughts are thus seen as integral to *Dasein*, not separate processes (Eatough & Smith, 2017). This was echoed by Merleau-Ponty (1968) who reconceived nature as “flesh,” inseparable from perception, and emphasised embodied intersubjectivity, where understanding arises through gestures, expression, and shared perceptual space. This influenced later cognitive science, with Larkin et al. (2011) describing embodied active situated cognition, in which cognition emerges through the dynamic interplay of body, action, and world.

Differing from Husserl’s more descriptive approach where the researcher bears witness to the participants account (Barbour, 2007), IPA recognises the role of the researcher who is making sense of participants experiences (Smith, 2004) and has been described as a variant of phenomenology (Finlay & Ballinger, 2007). A double hermeneutic exists where alongside the participant making sense of their world, the researcher is interpreting the participants sense-making (Smith et al., 2009), with the researcher moving back and forth, considering their relationship to the data, as part of the hermeneutic circle.

Throughout the analytic process, the researcher remains committed to the particular, undertaking a rigorous and detailed exploration of each participant’s account before considering patterns across cases. This idiographic approach seeks to understand how a particular group of people make sense of a particular phenomenon within a particular context (Smith et al., 2022). Rather than aiming to produce findings that are statistically generalisable, IPA prioritises an in-depth understanding of lived experience. Consistent with its phenomenological and interpretative foundations, IPA acknowledges that another person’s experience can never be known directly but is accessed through their account and the researcher’s interpretative engagement with it (Smith et al., 2009). Consequently, the value of IPA lies in its potential for theoretical or analytical transferability, whereby readers can consider the relevance of the findings to other contexts (Smith et al., 2009, 2022).

Several methodological and philosophical considerations have been raised in relation to IPA. One concerns the extent to which language can fully capture lived experience. As phenomenological accounts are necessarily mediated through grammar, syntax and historically situated meanings, participants may be unable to fully articulate their experiences (Gallagher, 2022). IPA does not assume that participants’ verbal accounts provide a complete or transparent representation of experience; rather, the interview provides an opportunity for participants to explore and articulate meanings that may not initially be fully formed or readily accessible. The researcher can support this process through attentive listening and appropriate follow-up, allowing participants to elaborate and clarify their experiences in their own terms.

Furthermore, IPA acknowledges that participants' accounts are interpreted through the researcher's own position, meaning that findings are understood as co-constructed rather than as objective representations of participants' experiences. This interpretative process has raised questions regarding the transparency and credibility of qualitative analysis (Pringle et al., 2011; Williams et al., 2020). However, within IPA, researcher involvement is not viewed as a methodological weakness to be eliminated, but as an integral part of the interpretative process. Rigour is therefore supported through transparency in the analytic process, reflexive consideration of the researcher's position, and sustained engagement with participants' accounts (Mays & Pope, 1995). Rather than seeking to remove researcher influence, the aim is to make the interpretative process visible and to critically consider how meanings were developed through the interaction between participants' accounts and the researcher's interpretation.

2.6 Validity and Quality

Assessing the quality and validity of qualitative research ensures that study design and methodology are fit for purpose and of a high standard. Validity in qualitative research ensures its trustworthiness, which is vital when dealing with research exploring meanings, stories and interpretations. Whilst there are different methods for ensuring validity and quality, the researcher opted to use the framework outlined in Yardley (2000). The use of this framework was deemed most suitable as it is non-prescriptive and adaptable, and allows for a critical reflection as opposed to purely assessing compliance. Yardley (2000) suggested four broad essential characteristics of good research - sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance; and each will be explored in turn.

Sensitivity to context refers to an awareness of the literature and empirical work which frames the research. Yardley argues the importance of understanding the extensive grounding in the philosophical approach of our particular methodology and the research already applied to the topic, as a broad awareness of different perspectives can help create a more "profound and far-reaching analysis" (Yardley, 2000, pg. 220). In order to demonstrate sensitivity to context, a full and extensive literature review was completed, both at the onset and throughout the project. An awareness of the sociocultural setting came through immersing myself in the world of older adults, attending Age UK events, care homes and community centres. This allowed me to reflect my own differences in context in comparison to the participant pool. Within the interview, I demonstrated sensitivity by creating a friendly and open dialogue, using my clinical skills to build a rapport.

For a thoroughness in data collection, one must ensure commitment and rigour. Yardley outlines how commitment refers to developing competence with the methodology used and a deep immersion with the topic and data. In this project, both the interviews and the analytic process were conducted over several months, allowing sufficient time for each participant's interview and for subsequent reflection. As part of this process, mood boards were created for each participant (see Appendix A) to expand my understanding beyond the cognitive level and to encourage more abstract thinking, with the aim of capturing the essence of each participant.

The third characteristic of good research comes from the researcher demonstrating transparency and coherence through describing each detail of the data collection process. Within this paper I have been transparent regarding my process and reflexivity and include excerpts from my reflexive diary which I hope makes sense of my research process, and offers an insight into my own experiences and assumptions.

The final essential characteristic according to Yardley (2000) is impact and importance. This refers to research to be undertaken should be useful and applicable to the field in some way. The value of the research was highlighted through the gaps identified in the literature review. The impact of findings for counselling psychology and future directions for research will be discussed towards the end of the paper.

Whilst Yardley's paper is widely used within qualitative research, it has been criticised as being a broad brush for all methodologies, that doesn't take into account how concepts differ (Williams et al., 2020). The researcher will also ensure the quality and validity of their research by utilising specific guidance from IPA. Smith et al. (2022) outline seven ways that the quality of IPA can be enhanced, which will now be discussed in reference to the present study.

1. The researcher considered the analytic span of the paper, with an emphasis on depth rather than breadth, by recruiting a small sample size of eight participants, allowing for in-depth analysis of each study.
2. The study made space to explore each theme in detail, allowing multiple weeks per interview and reflective time between analysing transcripts.
3. The researcher ensured high-quality data through good interview skills and techniques, adapting skills gained through the Counselling Psychology course.
4. The present paper hopes to demonstrate a sound demonstration of rigour and reference to relevant literature.
5. The analysis section provides a detailed account of the complexity of the analysis and illuminates how different participants manifest the same themes, in distinctive ways, by highlighting different textures of experience and making reference to opposing experiences.

6. The analysis also illustrates analytic depth by moving away from the purely descriptive interpretations, offering both linguistic and conceptual interpretations on participants experience.
7. The researcher hopes to demonstrate a binding narrative throughout the whole paper.

Further guidance on high-quality IPA research comes from Nizza et al. (2021) who propose four key quality indicators. Firstly, they emphasise the importance of conveying a compelling story, with the narrative building between each quote. They also outline how a good IPA paper will pay attention to the different levels of experiential or existential meaning (Smith, 2019). Another quality indicator comes from the researcher's detailed analysis of the quotes revealing a fuller meaning than offered by the quote. Finally, Nizza and colleagues suggest how quality IPA research strikes a balance between outlining participants' commonalities along with the participants' unique idiosyncratic experiences.

2.7 Design

2.7.1 Semi-Structured Interview

IPA research aims to elicit rich and meaningful data through participants descriptions of a phenomenon, which can be elicited through various methods including interviews and focus groups. According to Smith et al. (2022), the most commonly used method in IPA is semi-structured interview. This type of interview enables the interviewer to create a list of questions aimed to guide and inform the interview approach, meaning it is versatile and allows attention to lived experiences, whilst also addressing specific areas of interest (Galletta & Cross, 2013).

Whilst a semi-structured interview is said to produce rich data (Smith & Osborn, 2008), there are several limitations to consider. Given its limited structure, it requires the participant to maintain focus on the topic which may be difficult for some participants. It also requires a good rapport to be built in a short space of time, with the hope of facilitating a space where the participant can build trust enough to speak openly to their lived experience. There will also be bias within the interview, where the researchers' tone or phrasing of questions can unintentionally lead participants responses. Due to the above factors, there will be variability across interviews, making comparisons more difficult.

As a researcher I am relatively new to IPA research and interviewing. Having completed an IPA research study once before, this was over ten years ago, and the study employed a structured interview design. Therefore, my confidence in interviewing within IPA research is rusty, and I feel anxious in these early interviews.

With the above in mind, when the interviews went off topic, I interrupted and re-directed conversation towards the research questions, which became easier as my confidence grew in later interviews. This was more successful in some interviews than others, with some interviewees wanting to talk more about the context and their life experiences around the therapy experience, reflecting an ease at focusing on their external rather than internal world. Whilst a good rapport was built with all participants, they did vary in their ability to be vulnerable and open within the interviews.

2.7.2 Development of the Interview Schedule

The research questions were prepared in advance, in line with guidance from Smith and Osborn (2008) who also suggest questions are to be used as a guide rather than prescriptively. The interview questions in the opening segment were designed to be broad and open to create a space for participants to narrate their own experience, with much of the topics for exploration in the interview elicited from the material presented in this segment, with the researcher listening attentively and noting topics to revisit during the interview (Galletta & Cross, 2013).

Several services were contacted to assist in the design of the research questions; however, I did not receive a response from those contacted. I acknowledge I could have been more persistent with my request; however this did reflect the general lack of enthusiasm I received when attempting to engage services within this project, which will be reflected on further in the Recruitment section.

Specific questions around feelings were asked as Willig (2013) warned of the reductionist element to focusing on thinking, rather than feelings and hunches. Later questions were designed to explore more specifics, to explore anticipated nuances in the story, before concluding the interview by asking if they had anything additional they would like to share. See Appendix B to view the interview schedule.

2.7.3 Pilot Interviews

The researcher conducted two pilot interviews in preparation for the study, with the intention of reflecting on the phrasing of their questions, the order and usefulness. This also built the researchers' confidence in interviewing as a researcher, following which there was a period of

reflection in supervision and personal therapy on how to maintain the stance of a researcher as opposed to a therapist.

Ideally, the pilot interviews would have been conducted with older adults with experience of video therapy, however due to the difficulties in the early stages of recruitment alternatives were sought. In line with recommendation from Galletta & Cross (2013) to include individuals who reflect some of the inclusion criteria, one interview was conducted with an older adult, and another with a fellow counselling psychology trainee who had experienced video therapy. Both participants followed the procedure in line with ethical guidance; and received a debrief following the interview.

The pilot participant who was an older adult themselves was interviewed on their experiences of retirement, with the interview questions deemed not relevant excluded or rephrased. This interview felt more like a question-and-answer rather than a dive into their lived experience, and it felt this was perhaps due to the inorganic nature of the interview, and my own anxiety at this being the first interview. However, the pilot participant provided some useful feedback, such as them questioning the wording of a question “what does it mean to be an older adult who has had video therapy” which led to this question being rephrased.

2.8 Data Collection

2.8.1 Sampling

There are variations in the literature as to the recommended sample size, with quantity not being a substitute for quality. Within IPA methodology and for those completing a doctoral theses Smith et al. (2022) recommend a sample size of approximately ten participants, and in the present study eight participants were recruited. As IPA is concerned with giving a full appreciation to each participant’s experience, emphasis is on breadth rather than depth.

Purposive sampling was employed to recruit participants from a specific demographic group (older adults) who shared a common lived experience of engaging in video therapy. Smith et al. (2009) recommend that researchers aim for a relatively homogenous sample. In considering this, the researcher reflected on ways of increasing homogeneity, such as restricting participation to individuals who had engaged in a single type of therapy (e.g., CBT) or focusing exclusively on the therapeutic relationship. However, it was determined that the sample would remain sufficiently homogenous by including participants who had experienced any form of one-to-one therapy. The researcher also anticipated potential recruitment

challenges, as noted in previous studies, and therefore prioritised maintaining the age range of 65 years and above to align with the established definition of older adult.

Consideration was also given to whether participants should be required to have completed a course of therapy or to have attended a minimum number of sessions. While such criteria would increase the homogeneity of the sample, it was recognised that limiting participation to those who had completed therapy would exclude individuals who may have encountered difficulties engaging with video sessions. Including these perspectives was deemed important, particularly within IPA research, as it enables exploration of the phenomenon across a range of lived experiences.

2.8.2 Inclusion and Exclusion Criteria

Participants were required to meet specific inclusion criteria. Firstly, they had to be aged 65 years or older at the time they engaged in therapy. Second, they must have attended at least one session of counselling or psychotherapy, delivered in a one-to-one format via a video platform such as Zoom. No restrictions were placed on the specific type of therapy accessed, provided that at least one session had been completed. Finally, participants must have completed therapy at least three months prior to recruitment. This timeframe was chosen to allow for a period of reflection and consolidation, as well as to provide sufficient space for the processing of any distressing emotions that may have arisen during therapy.

Exclusion criteria were also established. Participants were required to provide informed consent, which was obtained both verbally and in written form to ensure clarity and to provide an opportunity for questions. In addition, participants were screened using outcome measures during the pre-screening call, and only those scoring below the threshold for clinically significant symptoms of low mood or anxiety were eligible to take part. Finally, potential participants were asked about risk during the pre-screening process; however, no concerns regarding risk were reported by any of those who proceeded to participate in the study.

2.9 Recruitment

The initial recruitment strategy aimed to recruit participants through one or two organisations providing psychological services to older adults. Several older adult specialist services, including general wellbeing and bereavement services, were approached but declined to participate. One service initially expressed interest but subsequently did not respond to further

contact attempts. This provides insight into the challenges researchers face and how difficult this population group can be to access.

This stage of recruitment is particularly challenging. I had a lengthy phone call with an older adult who is the gatekeeper of a specialist service. Within this phone call I was advised that CBT and video therapy is “dangerous” and was provided with a case example of an older adult who had been upset due to CBT therapy. This gave me an insight into some of the attitudes adopted by older adults themselves and also gatekeepers of services, and how can be discouraging people from not only conducting research, but also accessing therapies.

Following limited success with the initial recruitment strategy, I moved away from therapy organisations, towards other organisations associated with older adults, including care homes and Age UK. I attended around five Age UK events, some of which hosted over 70 people (where I recruited no participants) and some hosted just 5 people (where I recruited one).

I'm struck by the level of support Age UK offers, and also the openness of older adults themselves to have conversations around mental health and therapy at these events.

A research poster was created to advertise the project with places with high footfall of older adults including local community centres and charity shops (see Appendix C). Following feedback from the pilot interview that older people may be more familiar with the word ‘counselling’, than the more ambiguous ‘therapy’, the former was used in the poster. This approach recruited one participant.

Participants were also recruited through word-of-mouth, that is, through colleagues who were also therapists who had worked with older adults. Two participants were recruited via this route.

The most successful recruitment strategy involved placing an advertisement on a local forum for therapists. The advertisement aimed to inform therapists about the study and to encourage them to identify and inform clients who might be interested in participating of my details, however resulted in several older adults who were therapists themselves taking part. Four participants were recruited via this approach.

Overall, ten individuals expressed interest in participating in the study, two of whom were excluded for being under the age of 65 at the time of their therapy. Reflecting on the recruitment process, I recognise that, due to the challenges of recruiting, I may not have been

as rigorous in ensuring that all participants could stay on topic to describe their experiences, keen to recruit participants into the study. This may have resulted in some participants discussing their experiences in less depth. Nevertheless, in hindsight, even these less detailed or “invisible” experiences also offered rich and meaningful reflections.

Initially, no monetary remuneration was offered to participants, as the intention was to avoid introducing response bias or any perception of coercion. However, due to initial recruitment challenges, a £10 voucher for a supermarket of the participant's choice was subsequently offered as a token of appreciation. It is acknowledged that offering remuneration may have influenced responses during the interviews; nonetheless, the literature presents both arguments for and against participant compensation (Warnock et al., 2022). To mitigate potential bias, participants were explicitly informed that the study sought to explore all types of experiences of video therapy and that they would still receive remuneration if they chose to withdraw. In retrospect, I consider the decision to provide remuneration appropriate, both to recognise participants' time and to convey appreciation and value.

2.9.1 *Participant Summary*

The present study includes the experiences of eight individuals aged 65 and over who had previously received video therapy. The table below is intended to contextualise participants' experiences and provide transparency regarding variations in homogeneity. Participants were also asked to identify the type of therapy they had received; however, most were unable to recall the modality, and therefore this information has been excluded. This observation suggests that the specific therapeutic modality may be less salient or memorable to participants than the therapist themselves, a point reflected upon in the analysis and discussion.

Table 1: Participant Summary

Name	Gender	Age	No. of Sessions	Modality	Was video preferred?	Relationship Status	Job Status	Long-Term Conditions
Amber	F	65	1	Video only.	Yes	Widowed	Retired	Cancer.
Bonnie	F	71	12+	Video only, previous f2f.	Yes	Married	Counsellor	Healthy.
Martin	M	66	6	Video only.	No	Married	Retired	Cancer.
Jackie	F	66	12+	Mixture.	No	Married	Counsellor	Healthy.
Delilah	F	67	12+	Video only, previous f2f.	Yes	Single	Counsellor	Healthy.
Simon	M	68	12+	Video only, previous f2f.	No	Single (recent separation)	Counsellor	Healthy.
Lorraine	F	67	12+	Mixture.	Yes	Single	Retired	High blood pressure.
Jess	F	69	12+	Video only, previous f2f.	Yes	Single	Retired	Hearing difficulties.

The participant group represented a relatively homogenous sample, comprising White British, predominantly middle-class older adults residing across the UK. Given that experiences of ageing, identity, family roles, and attitudes towards psychological therapy are culturally situated, the findings should be understood as reflecting the perspectives of White British older adults rather than older adults more broadly. The absence of participants from other ethnic backgrounds means that culturally specific experiences of video therapy were not captured.

Although participants varied in health and relationship status, these factors may also have shaped their experiences. For example, participants living with health conditions, such as cancer or hearing difficulties, may have experienced video therapy differently due to the accessibility and practical advantages of remote delivery. Whilst those who were widowed, single or navigating the end of a relationship may have brought differing experiences of social connection and support into therapy.

During the interviews, some contextual variation became apparent that had not been anticipated during sampling. For example, half of the participants (Bonnie, Jackie, Delilah and Simon) disclosed that they were themselves psychological therapists. Although consideration was given to analysing therapists and non-therapists separately, this was not pursued due to the similarity of experiences identified during analysis. Nevertheless, participants with professional therapeutic backgrounds may have drawn upon psychological language and conceptual frameworks when reflecting on their experiences, and it was sometimes necessary to encourage them to speak from their perspective as clients. Whilst efforts were made to bracket assumptions throughout the research process, it is unlikely that participants' identities (and experiences) as both therapists and clients could be entirely disentangled.

Consequently, the findings cannot be assumed to represent the experiences of all older adults, and particularly those from more diverse cultural or socioeconomic backgrounds, nor those with different levels of physical health, social support, or access to digital technologies.

2.10 Procedure

2.10.1 Initial Screening

Following an expression of interest, an initial screening call took place via telephone to assess for suitability in the study, build a rapport and answer any concerns or questions the participants may have. Suitability for the study was assessed through adherence to the inclusion and exclusion criteria, the completion of outcome measures and through discussion of the screening questions (see Appendix D), all conducted in the telephone call.

The outcome measures used were the PHQ.9 (Kroenke & Spitzer, 2002) and GAD.7 (Spitzer et al., 2006), as they are commonly used within therapeutic services to assess for symptoms indicative of low mood and anxiety. The researcher is also familiar and confident with interpreting these measures. A distress protocols was in place should any distress occur during the screening call or interview (see Appendix E).

Once the participants were deemed appropriate following the screening questions, they were given an opportunity to ask any questions or raise any concerns. The information sheet and consent form were explained verbally and then posted to the participants with a self-addressed envelope included, for written consent to be provided (see Appendices F and G). The researcher explained how the interview will take place via the telephone and booked in directly a convenient time for the participants, pending receipt of the consent form.

2.10.2 Interview Process

Interviews were conducted by telephone at mutually agreed times. While face-to-face and video interviews were initially considered, face-to-face interviews were excluded due to this limiting the participant pool to those who could travel into London. Video were also set aside as I wanted to ensure accessibility for individuals who might be uncomfortable with or unable to use video technology. Telephone interviews offered an inclusive approach, which is supported by Enoch et al. (2023), who showed that rich data can be generated by phone. However, during the interview, some participants described phone calls as talking into a “*black block you’ve got in your hand*” (Amber, 29) and another as a “*disembodied black box*” (Jackie, 355). While using purely telephone interviews did reduce potential variability in data quality, with the perspectives offered above, in hindsight I would have offered participants a choice of format.

On commencement of the interview, participants were reminded of the information sheet and the consent form, with space made for any questions. Participants were advised that the interviews could last for 45-90 minutes, as recommended by Smith et al. (2022), with interviews taking approximately 60 minutes. The interview was semi-structured and sought to answer the research question ‘sideways’ through the facilitation of exploration of relevant topics (Smith et al., 2022). The interview followed an informal conversational style to allow for building of rapport and providing a sense of safety and containment, through being warm and friendly, and through asking some soft opening questions.

I notice I have been asking the questions more rigidly due to feeling nervous and unfamiliar. I worry I may have been more directive and less flexible. I think Simon also felt confused about whether the study aimed to compare in-person and remote therapies due to the phrasing of some of my questions.

As the interviews progressed, my confidence grew, enabling me to move away from a rigid adherence to the interview structure and instead engage more fully with participants’ experiences. The later interviews consequently captured greater depth and individuality, as participants appeared more comfortable sharing their perspectives when the conversation felt less tightly guided.

After each interview, participants received a full verbal and written debrief (see Appendix H), including information about their local Talking Therapies service should they wish to seek

further support. Most participants concluded the interview by reflecting positively on their therapy experience and noting that the interview had provided a valuable opportunity for personal reflection. Following each interview, I recorded observations in my reflective journal.

2.10.3 Recording and Transcription

The interviews were recorded using the recording element on Zoom, with the session immediately being deleted from the researcher's personal computer and uploaded to Citys University OneDrive, as per City university guidance for recording and confidentiality.

The interviews were transcribed verbatim using Otter software at the beginning stage of analysis to allow the researcher to re-immers themselves in the interview. The transcription included semantics such as significant pauses, laughs and other features. Any references to names of places or people and any other identifying information were omitted from the transcript and demarked using X's. Please see example of transcript in Appendix I.

The identity of participants has been protected through the use of pseudonyms. participants disclosed their long-term physical health conditions and their professions throughout the interview, which felt important to include in the analysis chapter where appropriate, as it forms part of their context and lived experience.

2.11 Methodological and Procedural Reflexivity

A key strength of this research is it's the consideration and sensitivity to creating sound research. Although IPA offers limited generalisability to all adults experiencing video therapy (Smith et al., 2022), it does offer a credible account as to how these eight people experienced the phenomena and shines a light on how the context of being an older adult may shape their experience. The researcher ensured quality and validity through adhering to guidance from Yardley (2000) and Nizza (2021) and the hope is it will offer a unique and valuable contribution to the field.

The interviews were conducted via telephone which elicited both strengths and limitations, something which is summarised by Enoch et al. (2023). Having interviews virtually opened for a nationwide recruitment process with the aim of accessing more diversity, as opposed to concentrating recruitment in London only. The rationale for video interviews was to ensure participants with challenging experiences of video were able to take part. However, this was an assumption on my part as technology challenges were rarely reported by participants within the interviews. With hindsight, a video interview may have encouraged better recall through

mirroring the therapy experience. Participants reflected during the telephone interviews how they felt uncomfortable as they couldn't gauge my reaction. This highlights how feeling seen in therapy, also may be important to participants within research.

Despite the study being open to any older adults aged 65 and above, all of the participants were White British, and six out of eight were female. As a female White British researcher myself, this may have impacted the limited diversity of the sample reflected in the research. Limited diversity is a common problem in research, and there could be a vicious cycle wherein people from minoritised backgrounds are less likely to access services and thus less likely to be included in research. As all of the participants were also White British, therefore findings should be applied to other cultures with caution, as invisibility in ageing could be unique to the British culture.

The age of participants was something that took careful consideration, and several people who expressed an interest were unable to take part in the study due to having therapy before the age of 65. Maintaining this age range adheres to NHS and Age UK definitions of an older adult (Age UK, 2019a; NHS, 2025). and enabled recruitment of participants in their late 60's and 70's. However, recruitment with people aged over 80 was limited. Given that the research was predominantly advertised through community centres and Age UK events, it is likely that participants had greater mobility, and the harder to reach older adults that are homebound were not accessed.

Finally, there were some unanticipated issues with homogeneity. Participants differed in the number of sessions they had completed, and the time elapsed since finishing therapy, which ranged from three months to up to five years. Retrospective reflections on experiences from several years ago could have introduced variability in recall. Additional differences included socioeconomic status, employment, education levels, and prior experience with video-based therapies. Half the participants were therapists themselves, which could also have reduced the study's homogeneity. During interviews, participants with counselling training reflected on their experiences as therapists, as well as being a client. To address these issues and maintain focus on client perspectives, I excluded from the analysis any extracts where participants spoke directly from their professional role, as these often contradicted their experiences as clients.

2.12 Analytic Process

IPA is based on a common process, moving from descriptive to interpretive, with the focus being on sense-making. The process of analysis was dynamic, and although Smith et al.

(2022) outline seven stages, it was applied flexibly, with continuous movement between the part and the whole.

The researcher waited until all the interviews had been completed, to transcribe the interviews in a word processing document, with wide margins and line numbers. The researcher focused on transcribing and analysing each interview in turn to allow time to immerse themselves within the data, with each interview taking approximately 2 weeks to progress through Steps 1 to 5.

Step 1: Reading and Re-Reading the Transcripts

This process commenced with listening through the interview to allow chance to re-engage with the participants world. This was completed in a quiet space free from any disturbances. Each interview was listened and read twice before the researcher moved onto the next stage. Parallel to this process, the researcher made notes on any reflections or initial observations in a reflective diary, as recommended in Smith et al. (2022).

Step 2: Exploratory Noting

In this stage, exploratory notes were made in the transcript margins to engage with the experiences emerging from each interview. Particular attention was paid to aspects of participants' experiences that were most meaningful, including relationships, places, and processes. I ensured reflection and interpretation across descriptive, linguistic, emotional, and conceptual lenses. Both linguistic and emotional interpretations came more naturally to me, while conceptual analysis required longer periods of reflection, and were supported by the creation of mood boards for each participant (see Appendix A).

Step 3: Experiential Statements

This stage focused on producing concise and pithy summaries of important aspects within the exploratory notes (see Appendix I for example). Throughout this stage, the hermeneutic circle was held in mind, considering how parts related to the whole and vice versa. For some interviews experiential statements were repeated, as similar themes repeated themselves throughout the interview. This stage required multiple revisits, as some initial statements felt superficial and less interpretative. Interpreting the meaning behind participants' accounts, rather than taking them at face value, was at times challenging. This difficulty was partly attributed to the researcher's CBT background, where clients' thoughts and feelings are often accepted as presented. However, as the researcher's development as a Counselling Psychologist progressed, so did the capacity for deeper conceptual interpretation.

Step 4: Connections Across Experiential Statements

At this stage, the researcher moved away from the computer and worked on paper, cutting out each experiential statement and arranging them into emerging themes. This was a fluid process and involved frequent movement and reorganization. Some themes were excluded at this stage if they were unrelated to the phenomenon of video therapy, in line with guidance from Willig (2008). For example, it was necessary to distinguish when therapist participants were discussing their experiences as therapists rather than as clients. Participants also shared experiences outside of therapy that, while interesting, were not directly relevant to video therapy and were therefore set aside. Two quotes that were particularly challenging to exclude are included in the discussion.

Step 5: Naming and Organising Themes

During this stage, some themes were separated while others were combined as the researcher developed the Personal Experiential Themes (PETs). The process involved moving between individual excerpts and the whole transcript to ensure that theme names accurately reflected participants' experiences. Once the themes were refined, they were transferred back onto the computer and organised into a table for each participant (see Appendix J for example).

Step 6: Analysing Further Individual Cases

The researcher proceeded with the analysis of each interview in the same way as above, with steps 1 to 5 repeated for each participant in turn. The researcher ensured space between each interview to allow for pause and reflective time and to ensure bracketing of assumptions carried from the previous analysis.

Step 7: Developing Group Experiential Themes (GETs)

As outlined in Smith et al. (2022), this stage involved identifying similarities and differences between each participants PET's, and they warn of novice researchers being too cautious in their interpretations. This process took significant time moving between the parts and the whole, returning to each transcript and the meaning of the experiential statements. The write up occurred during this stage.

Having really enjoyed naming and organising the PETs, it feels more difficult doing the GETs. This is the most challenging stage of the analysis and something which I feel stuck on. I am grappling with having to tear apart some initial clusters in favour of keeping some together. I realise the interpretative stance doesn't come naturally to me and I find myself repeatedly drawn to the safety of being logical and descriptive. My supervisor has said for me to trust my hunches and interpretations, rather than minimise these and stay at a surface level of the participants experience. I am frustrated at myself and my tendency to prioritise others view above my own.

2.13 Ethical Considerations

The present study complied with the HCPC ethical guidelines (Health and Care Professions Council, 2016) for students and the BPS (The British Psychological Society, 2018) ethical guidelines. Ethical approval was obtained from the School of Health and Medical Sciences Ethics Committee at City, University of London with reference code ETH2324-0370. The following ethical considerations were taken by the researcher prior to and during the research process.

Pre-screening calls were conducted to minimise risk by excluding participants experiencing current symptoms of low mood, anxiety, or suicidal ideation, with crisis service signposting provided. Participants also received an information sheet (see Appendix E) detailing the study, data privacy, their right to withdraw, and the limits of confidentiality. Those wishing to participate provided informed consent (see Appendix F) and were informed that the £10 remuneration would be given regardless of completion.

Consideration was paid to both mine and participants emotional wellbeing throughout the study. A distress protocol was in place (see Appendix D) in case the interview caused distress, however this was not required during any interviews. The researcher's wellbeing was supported through regular supervision and bi-weekly personal therapy during data collection and analysis.

After each interview, a verbal and written debrief addressed any concerns, provided crisis contacts, and offered further support, with researcher and supervisor contact details available for withdrawal or follow-up. Through transcription and write up, participant identities were anonymised using pseudonyms.

3 Analysis

3.1 Introduction to Analysis

The analysis chapter presents the themes derived from the interviews, answering the research question of how older adults experience video therapy. Due to the large quantity of material collected, this chapter aims to capture the themes that were most representative of the participant experience as a result of the eight interviews conducted. In line with IPA's ideographic approach, the textures of each participants experiences will be discussed, within the themes prevalent in the overall sample. To accurately understand participants experiences and meanings as an older adult, descriptions of context will be referred to throughout the analysis (Larkin et al., 2006).

The analysis uses direct quotes from each participant alongside my own tentative interpretations to provide a deeper understanding of their experience. Despite initially referring to literature within the analysis, I later decided to remove this to stay close to the participants lived experience (Larkin et al., 2006). Quotations are indented and marked in italics. In order to ensure quality and validity careful consideration has been paid to ensure the quotes are represented within context, and that they represent the entirety of the participants experience. I have included pauses (.....) and notes on speech such as laughter and grammatical errors to stay close to the participants words and to capture the essence of each participant.

Through the analytic process, participants offered similar accounts of their experiences, and three GET's emerged: '*Fearing Loss*', '*(Un)safe*', and '*Seen through a Screen*'. Each GET contains between three sub-themes. It should be noted that there is inevitable overlap between the different themes, as each account is interlinked with another.

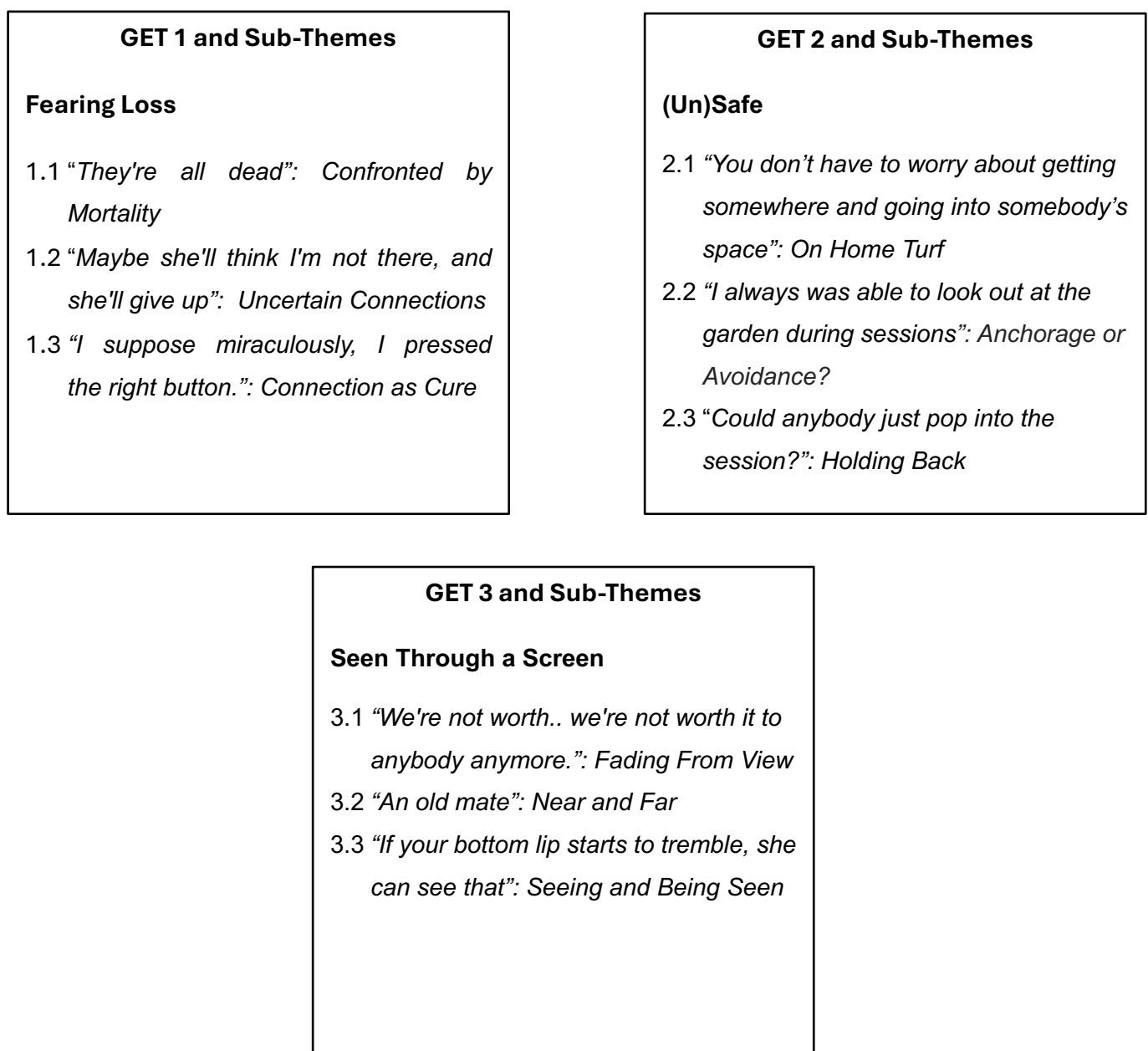
The first GET, '*Fearing Loss*', describes how participants feared losing connection with the therapist. Participants described their recent experiences with loss which appeared to shape their anxieties and dread around whether the therapist would be there for them, both in physical form but also emotionally. The realisation that the therapist was present for them, and they were able to connect, took different forms for participants.

The second GET, '*(Un)safe*', explores participants experiences of safety and trust through having video therapy. Participants described how having therapy within their own space felt, and the ways in which they exerted their increased levels of control and responsibility, and whether this was anchorage or avoidance. This theme also describes how they experienced a sense of guardedness, or holding back within the therapeutic encounter, fearing someone could intrude on their space.

The third GET, '*Seen through a Screen*' outlines the way in which participants felt seen through the video therapy. The context of coming into therapy and feeling invisible is outlined, before exploring the way in which participants experienced a sense of closeness and distance, and sought reassurance through faces.

Each theme will be firstly represented in visual form, before being explored in further detail in the analysis.

Figure 1: Diagrammatic representation of GET's and Sub-Themes



3.2 Group Experiential Themes and Sub-Themes

3.3 GET 1: Fearing Loss

All but one participant described their experiences with loss that led them to seek psychological support, and this context feels essential to understanding the meaning of their experiences within the therapy room. These losses varied, from the death of family members to the end of significant relationships or a shift in identity due to ageing. This theme will reflect on both their therapeutic experiences and the personal contexts that shaped them; reflecting on the parallel processes that weave these experiences together.

In the first sub-theme I explore the losses participants had experienced and described as they entered into the therapy sessions, and the way in which this built up a tension of an existential threat as their connections crumbled around them. The second sub-theme reflects how participants expressed fears and uncertainties that they wouldn't connect with the therapist, both emotionally and technologically. The final sub-theme conveys how participants' anxieties around loss were soothed through the realisation that the therapist was there for them.

3.3.1 Sub-Theme 1: *"They're all dead": Confronted by Mortality*

Nearly all participants described losses as the catalyst for seeking therapeutic support, which provided the content for the issues they were discussing and working on in therapy. This sub-theme explores the losses experiences by older adults, and how these give rise to feelings of loneliness and disconnection. I will also describe how several participants experience physical health problems as more significant than psychological problems, and the way in which this harkens to an existential dread.

Although nearly all participants experienced some losses, one participant described the repetition of losses throughout her life:

"Of course, the loneliness, especially for us, older ones, we don't have people living at home with us, our husbands, or whatever they're.. they're all dead. Our parents are dead. Our kids have all moved away... that's if we've got some. And we are really left behind" (Amber, 786)

Amber communicates her experiences in short, abrupt phrases, marked by a bluntness that seems to reflect the harsh finality of death. Her statements that their husbands are dead, her parents are dead, and her children have moved away, starkly lists the complete absence of immediate family, conveying a profound sense of isolation. The repetition and rhythm of her words almost mimic a roll call of loss, each name underscoring the growing void in her life.

There is a tone of anger or resentment in Amber's delivery when she says "*our kids have moved away*", suggesting feeling abandoned and forgotten. These cumulative losses are difficult to fully comprehend. I find myself recoiling slightly as I read this quote, not out of judgement, but due the difficulty grasping the enormity of this loss. This makes me think that Amber may be pulling back from the world, seeking protection as her close connections diminish. Alongside this, there appears to be a felt loss of identity, both in her role within the family and in her belonging to the family community.

Other participants were also grappling with their experiences of loss:

"I felt really, really isolated because everybody else was having a bubble with their own grandchildren oh it was, it was a dreadful" (Jess, 124).

Jess experiences a contrast between herself and others who were having a "*bubble*" with their families during the COVID-19 pandemic, a period marked by widespread cultural exposure to loss, grief and mortality. The term "*bubble*" feels like it offers both physical and emotional protection, connection and a sense of safety. In comparison, Jess felt outside of protective space, exposed and unsupported. Jess noted how "*everybody else*" was surrounded by people, revealing a comparison to others, feeling like she was the only one isolating alone. I imagine this comparison heightened Jess's feelings of isolation and may have contributed to feeling "*dreadful*", which feels like it emphasises how extreme or overwhelming the experience felt for her.

In several of the participants accounts I sensed an undercurrent of existential dread. As they approach the later stages of life, each loss feels to have a cumulative effect, intensifying the emotional weight they carry and heightening the awareness of their own mortality. Participants refer to this existential dread in different ways. As one participant describes:

"And.. and to see all those sick people, and then the ladies from oncology, you have your follow ups and that. And I went to see her, and I just bust into tears, and I just said, I'm so low. I'm so really, really low because I'm so isolated. And these people up here make me cry because they are extremely sick. And I wasn't extremely sick. I was being fixed. I was I was better than.. than some of them. Some of them had scars all over their... one lady, scars all over her head, no hair, walking stick. And I'm like, Good Lord, that I've got more time than her. And, yeah, and it used to make me cry, and I got so depressed. It was also the Winter." (Amber, 270)

Through her visits to the hospital Amber is directly confronted with the impermanence of her life as she is surrounded by illness and death. She draws parallels between her mood and the wintertime, as though she is surrounding both internally and externally by bleakness and hopelessness. When she describes a woman with "*scars all over her head, no hair, walking*

stick", it is as though this woman represents death to her, something which feels frightening and vulnerable. Death is something Amber is unable to identify with, something she rejects and pushes away. When she exclaims "*Good Lord*", it reads as a desperate plea, a cry not just of fear, but of hope, to resist decline and death and move back towards life.

For other participants, existential dread was the catalyst for seeking support, as three participants only sought psychological help when their physical health became compromised. Martin, for example, was recommended by a health professional to seek support when "*I went best part of like, eight or nine weeks without getting any sleep*" (Martin, 15). Another participant was also spurred to seek support through the onset of a physical health concern:

"And that kind of added to my anxiety, and it was partly that, that, and because my blood pressure was going up, that made me think, right, okay, you know, I'm losing confidence. I'm not handling this. I'm finding it really unsettling (speech quickened). I need some support." (Lorraine, 211)

Anxiety, in and of itself, didn't feel to be a sufficient reason for Lorraine to seek support which speaks to a level of self-neglect around her mental health. It was only when it impacted on her blood pressure, and therefore her life, that she was prompted to pursue psychological therapy. As her speech quickens while recounting this experience and she describes finding it "*really unsettling*", she seems to be grappling with the fear of death, something which she finds uncomfortable and difficult to shift. There is an underlying sense of urgency, as though the threat to her physical wellbeing activated an immediate need to access support.

A feeling of existential dread was expressed by another participant more explicitly, as she actively sought video therapy to discuss the ending of her life:

"What sort of I think, with something as potentially hard work..er.. as that as death sessions about your death and your dying, erm... I think there were moments where I was trying to lighten the mood a little bit, keep it at the level of safety, and just sort of, oh god. This is heavy. This is heavy. This is tricky.... Erm, but there was one time when I did cry, and the only thing that really made me cry was thinking about leaving my children and my grandchildren and my husband, and that was the only thing that really got me in the in the sort of emotional." (Bonnie, 120)

When Bonnie exclaims "*oh god*" it feels like a wave of grief crashes over her, revealing the intensity to which she is fearful towards the ending of her life and permanent separation from loved ones. It feels like there is a parallel process between what happens in our interview and what might happen in a therapy session as she says "*This is tricky*". Words like "*heavy*" and "*tricky*" convey a weightiness and awkwardness to navigating this existential threat, as though it is too much to bear, as there is no escape to this inevitability. As she says "*Erm*" she pulls

herself out of this feeling, out of the stuckness of reliving it, and into the distant safety of a memory when she says *“but there was one time...”*. Bonnie is able to shift her focus and redirect her attention away from painful topics, which she also speaks to when she says how she can *“lighten the mood”*. I wonder if humour in particular helps Bonnie to bring other aspects of her identity and personality, rather than being defined solely by death and distress. Humour also feels like it can offer some connection with the therapist, and creates moments of warmth and reciprocity, both of which are reminders of life, as opposed to death.

3.3.2 Sub-Theme 2: *“Maybe she’ll think I’m not there, and she’ll give up”*: Uncertain Connections

This theme includes the experiences of all participants, with the majority (six out of eight) describing the importance of being able to connect with the therapist, and the fears of losing the therapist. Although loss and connection are not direct opposites, it felt for participants being able to connect with the therapist, was confirmation they hadn’t lost them. While participants rarely articulated fears of losing the therapist explicitly, I interpreted their concerns about technology as revealing a deeper, embodied anxiety about potential disconnection. For many, this fear surfaced as a concern about establishing and maintaining connection through the technology in the early stages of therapy, though for some it persisted over time. In contrast, two participants did not report experiences of fear or uncertainty, which will also be discussed.

For several participants, technology represented something intimidating, something to be afraid of:

“Do that? Press that? Oh yeah. But actually, can you do it on this, and does it work on the phone as my iPad? Or is it a laptop? And then suddenly you’ve got all this equipment thing in which bits do I use for what. Are they all the same and then if your signal drops out, Oh God, what do I do now? Do I wait for somebody to get in contact with me? Or am I supposed to contact them?” (Jackie, 734).

As Jackie confronts technology, she ruminates into hypothetical concerns as to what might go wrong when she tries to connect. Her series of multiple questions, reveal stress and anxiety unfolding. I interpret her worries around technology to also reflect her worries around losing or being unable to make contact with the person on the other end; with her fear of losing a stable connection as a reflection of a deeper fear of disconnection from her therapist. When she asks *“Do I wait for somebody.... Or am I supposed to contact them?”* I sense a strong desire to get it right, as though she fears making a mistake or causing tension with the therapist

by overstepping a boundary. This sentiment was echoed by other participants who also expressed concerns around connecting:

“Er...I was a bit worried. I thought “I ain’t got Wi Fi”, and it’s like, Oh, you got follow this link. I talked to me daughter XXX. you’ve got follow this link. Do you see I’ve only got a phone? How do I do this? So I was quite worried.” (Amber, 187)

Similarly to Jackie, Amber repeatedly asks questions, as the pressure builds for her to ensure she can connect. I notice how Amber transitions from feeling a *“bit worried”* to *“quite worried”*, as she recalls how she felt at her first session, as though she tentatively suggests feeling *“worried”*. I wonder if she was initially minimising how worried she felt about the sessions, testing out if I would dismiss this feeling or disagree with her, fearing my reaction or possible rejection. This highlights how important bi-directional communication and feedback is for her, as I’m aware the interviews were taking place over the telephone, it may be harder to gauge my reaction.

Several participants blamed themselves for difficulties around connecting, which highlighted a tendency to internalise, rather than externalise loss. As one participant states *“I think it’s whenever I’m asked to do anything online, my go to is I won’t be able to do it”* (Lorraine, 578). By saying *“I won’t be able to do it”*, Lorraine is attributing difficulties connecting to a personal failure. Several other participants expressed something similar, with Jackie referring to how being an older adult meant they were more likely to struggle:

“But I, you know, I was thinking, Oh God, I don’t want to be the old fuddy duddy that’s taken up everybody’s time, because I’ve not got some grips with this yet. And of course, turns out, of course, I was probably on par with everybody else. We’re all we were all finding ways to do things. Erm... and even now, even now, some of my more mature colleagues will ask me for advice. And well, I can’t, I must have picked it up better than I thought then!” (Jackie, 775).

The term *“fuddy duddy”*, is a slang term used to describe someone who is old-fashioned and tends to be used in a derogatory way. It seems Jackie judges herself in a negative way for being older, and fears others will do the same. As she describes worrying about *“taken up everybody’s time”*, I imagine her to be reluctant to seek support and engage with others for fear of this judgement. I wonder how this manifested within the video therapy, and whether she initially felt self-conscious taking up space in therapy also. It seems it would have been easy for Jackie to blame herself for any technical difficulties, further enhancing feelings of low confidence. I notice a contrast in how whilst she uses this language to describe herself, she is more sensitive when describing others, referring to them as *“more mature colleagues”*, indicating a discrepancy between how she views herself, and how she views others,

suggesting others are more worthy than her. Jackie seems delighted and surprised that some of her colleagues have asked her for advice, suggesting how over time, her experience of herself as an older adult using video technologies changed.

For several participants they were more accepting of the possibility of losing connection, and attributed this loss to the medium, as opposed to a personal failing:

“So having worked on Zoom for... since 2020 for a couple of years before I was a client with XXXX, I kind of knew the challenges. I knew, erm, you know, I've had some really difficult connections with... particularly students that are living in the attic and things like that, you know, where the broadband has been awful. So I think I was quite accepting of at some point something might be an issue, because we're working with technology here.” (Delilah, 334)

Delilah describes how the way in which she experiences technological challenges has changed over time. As she says “*we're working with technology here*” she speaks in a matter of fact way that conveys an acceptance that challenges with technology and within relationships, are an inherent part of connecting with people. She shows some resilience and trust, that even if there is an interruption to their connection and she loses the person in the moment, she won't lose them completely. It seems she has a confidence that connection endures beyond the immediate moment, and that even if technology isn't reliable, humans are.

Another participant, also spoke to a level of acceptance gained over time:

“I feel pretty intensely relaxed about it really because I think when I was younger and less experienced, I kind of had this idea that there would be someone out there who got me (laughs) and it was all going to be amazing and fantastic. And over the years, I've kind of realized that that's not going to happen. And also it's not important either, and it's not (sighs) it's really about it's really about me pushing... becoming more comfortable with being uncomfortable. I think, I think that is where the learning edges, or whatever you want to call it, and so... yeah, I feel pretty relaxed about the experience of being a client nowadays. I'm able to take use of it whatever it is.” (Bonnie, 586)

Bonnie describes how her experiences with therapy over the years had led to accepting the potential of loss. When she describes how she used to think it would be “*amazing and fantastic*” I hear her hope and optimism about their being a “perfect” match in a therapist. In not finding that connection, Bonnie feels like she has focused on herself and is less dependent on the need for others to fill the void for her. Although she says it isn't important her sigh tells

me something different. I wonder if perhaps there is a sense of loss, not of connection, but of the hope of a connection. And whether she has truly accepted this or has given up.

In contrast to the views presented by Delilah and Bonnie, where time soothed fears, one participant described how her fears remained persistent throughout:

“So it was so difficult always, every single time to set up the video thing, that every time I went on, I was anxious, because it built up all my anxiety in about the half an hour before the session to make sure, you know, am I doing this right. And, you know, it was just like terrifying.” (Jess, 200)

As Jess states how difficult it was “every single” time, I sense feelings of frustration that difficulties persisted and weren’t resolved. It sounds like this was draining for Jess, and like an ordeal she had to endure each week. Jess uses the word “*terrifying*”, which conveys a strong emotional reaction of fear or horror. More so than other participants, I really feel the deep fear and sense of danger Jess felt at each session, as though it was almost unbearable. She continues:

“I was always ready to come on at least five minutes before she was ready, and sometimes she was a minute or two late because she was getting a cup of tea between clients. That was fine. No, I’m not blaming it. I’m just saying this is my anxiety. So I would try and click into this link and then I’m thinking, oh my god, it’s four minutes until she should come on and, oh, going to lose the link and start over again. And then I’ll start over again, and maybe she’ll think I’m not there, and she’ll give up. Might not get the link properly. And oh god, it was. I did go through a lot of anxiety, making, the making, the... the making it so that we talk together.” (Jess, 224)

As Jess speaks, her anxiety and anticipation seem to resurface, evident in the way she jumps rapidly from one thought to another. Her repeated exclamations of “*oh*” and “*oh my god*” convey a sense of being on tenterhooks, bracing for something to go wrong. The way she counts down the minutes until the session begins adds to the tension, suggesting that this watchfulness may be sustaining her anxiety. Jess speaks to a fear of the potential abandonment of the session or even the therapist herself. There is a sense of how precious these sessions are to her, as if she is holding them tightly.

The importance and significance of connecting with the therapist is highlighted in the measures participants took to ensure that they would be able to connect. Along with Jess, several other participants described the measures they would take, as Delilah describes the moments moving into the session:

"I always check that Zoom was working before I was due to link up. So it was trying to make sure that, erm, you know, physically, everything was was, you know, I was in a good place, and I'd done as much as I could to ensure that we were going to connect. Erm, yeah, to kind of preparing, not kind of rushing into it." (Delilah, 204)

As Delilah talks, I reflect on her having a sense of personal responsibility to take measures to ensure they would connect and prevent a loss from happening. Preparation seems important to Delilah, and by taking it slow she can check she has done everything correctly. She uses the idiomatic expression of being *"in a good place"* which could mean both the physical space and also feeling emotionally stable. The preparation feels like it provides some safety or stability for Delilah, and is a way of soothing her anxieties. It also seems for Delilah like it is important to be on the good side of the therapist. I wonder if she fears being blamed, or again losing the relationship or the trust within her relationship with the therapist.

Other participants also found their fears of loss soothed in other ways:

"I..was very lucky in my therapist, in that she was we both understood each other's starting point, if you like, and and as a result, she was very open with me about her experiences. As I was with her." (Jackie, 64)

"One of the reasons we all go to therapy is that we feel there's something lacking (laughing) within and when, and so when something new comes along and and you have all those doubts and uncertainties about how it's going to pan out. It's.. it's really reassuring to know that it works for the person that you're sitting opposite as well." (Jackie, 88)

Jackie speaks to how knowing the therapist had similar fears herself created an openness and transparency that helped to normalise and soothe her fears. In Jackie's extracts, she refers to relationships with others, and how important this connection is to her; suggesting she experiences herself in relation to the other, as opposed to in isolation or alone, which makes me think how acceptance from others is important. This is also mirrored in our interaction as when she describes *"something lacking"*, followed by laughter. It felt as though she was hesitant or uncomfortable sharing something intimate with me - a stranger. I was also struck by her choice of words when describing the therapist as instead of saying *"the therapist"*, Jackie says *"the person"*, which could be interpreted as a sign that Jackie sees the therapist as an equal.

In contrast to the above accounts, for another participant there was a noticeable absence of fear or anxiety in those early sessions:

".....(long pause).....No, not really.... I suppose, because I'm quite intellectual. You know, I got as far as thinking intellectually. Oh, yeah, I think narrative therapy would

be good for me, but I think that was quite an intellectualisation in the sense that I think any therapist would have been good for me. And the, you know, the framework, yeah, helped. So I think I was probably intellectualizing quite a lot in the first couple sessions.” (Simon, 269).

Simon, who is also a therapist, described how he tended to “*intellectualise*,” a defence mechanism in psychotherapy used to avoid experiencing difficult emotions. His intellectualising in the early sessions suggests that there may be some underlying fear that prevented him from feeling fully relaxed and comfortable, however these feelings were pushed far away, indicating a need to keep feelings at a distance. This contrasted with nearly all other participants, who openly expressed worries or concerns.

3.3.3 Sub-Theme 3: “*I suppose miraculously, I pressed the right button.*”: Connection as Cure

Given that all participants completed at least one video therapy session, they were all able to connect to the therapist, and this connection felt to be the antidote to fears around loss. For some, this cure appeared to be surprising and magical, almost out of nowhere. For others this was a gradual process, which built over time. The parallels between connecting technologically and emotionally continue, as many participants were able to build strong connections with both.

Several participants described a magical quality to the way in which the technology worked:

“Oh yeah, well I suppose miraculously, I pressed the right button. But I could then see her on the screen, and she could see me.” (Martin, 196)

Martin’s language carries an ethereal quality, as he describes “*miraculously*” pressing the “*right*” button. This suggests the experience felt outside of his conscious control, bordering on the extraordinary. Miraculous has the same etymology as miracle, both coming from the Latin *miraculum*. These words imply divine intervention, making me think this was a lifeline, particularly when understanding the context of Martin undergoing cancer treatment at the time he sought therapy. There seems to be both relief that the connection succeeded and an underlying awareness of how fragile the process felt. Had the outcome been different, frustration with technology may have dominated, yet here the moment is imbued with wonder, as though the success could not fully be attributed to him, but to some other worldly force.

Another participant also describes similar magical qualities:

“Well, anyway, I didn't have to do none of that, you know, because my daughter said to me, “ No, you gotta put an app on your phone. You gotta go through the app.” You

didn't have to do that at all. It was a piece of cake. Okay, the email, the email came in, and I think I tapped on it, and she did whatever she did on her end, and whatever and and whatever and hey presto. There she was on my phone!" (Amber, 209)

Amber also uses playful, magical language, when she exclaims "*hey presto*", with *Presto* being borrowed from Italian, meaning quick, suggesting an effortless connection. This sense of ease contrasts with Amber's earlier worries and her unnecessary attempts to prepare for the session. Additionally, Amber uses the metaphor a "*piece of cake*" several times in the transcript, which conveys the comfort and informality she felt when she connected to the session. The imagery of "*piece of cake*" evokes something indulgent and enjoyable treat, leading me to wonder if Amber viewed the therapy session, as a special, pleasant experience she could genuinely savour.

Other participants also spoke to connecting instantaneously, as one participant in different parts of the interview spoke to the instant technological connection, and also the instant emotional connection:

"I just had to click on it. I thought it'd be more complicated than that. It wasn't." (Lorraine, 572)

"And then, you know, our first session, I knew exactly it, you know, it was the right, right choice." (Lorraine, 809)

These quotes provide insight into how Lorraine experiences connection with others. She seems to anticipate that forming connections will be "*complicated*", which may reflect her past relationships. However, in video therapy, she describes an instant connection, referring to her therapist as being the "*right*" choice. I sense that Lorraine feels a sense of pride in having selected the "*right*" therapist, as though this in itself boosting her confidence at being able to establish a meaningful connection.

For several other participants, connection appeared to be more of a gradual process, with difficulties and challenges along the way. As one participant describes:

"it's taken quite an adjustment....erm... to feel comfortable with a new form of communicating." (Jackie, 760).

As Jackie states it was "*quite an adjustment*" I hear it took her time to feel comfortable, as she struggled to adapt to the new processes and struggling to believe that the connection may be permanent. Another participant described similar ideas to Jackie, in that comfort in connecting took place as a process over time:

"It was pretty unfamiliar. But it's like everything in life, once you've experienced it a few times,.. like zoom now is like a doddle to me. Because I could, you know, get in zoom

and do things much better now than I could back, you know, three or four years ago, when it was unfamiliar. “ (Martin, 196)

Martin uses the word “*unfamiliar*” several times which is an antonym for the word familiar; a word of Latin origin and means ‘belonging to the family’. This choice of word evokes a sense of feeling outside or not feeling fully belonging during the video therapy sessions. In contrast, his use of the colloquial term “*doddle*”, meaning something easily accomplished, reflects the comfort and confidence he now has with the technology through its repeated use. When Martin says “*it’s like everything in life*”, he speaks about his adjustment to the technology in a casual, nonchalant way, perhaps because his earlier difficulties with Zoom now feel like a distant memory. At the time of having video therapy, he was undergoing cancer treatment, so his struggles with technology may have seemed minor compared to his health challenges. Drawing on his life experiences as a source of strength, he likens this adjustment to other situations where things have gradually become easier over time.

3.4 GET 2: (Un)Safe

This theme includes all participants and reflects on their experience of safety, and the way in which having therapy via video and within their home environment leads to feelings of safety and unsafety; as one participant said, “*instead of one space shared by two, it is two spaces shared by two*” (Jackie, 459). The first sub-theme explores how having therapy at home brings about a sense of comfort and relief as one avoids the stresses of travelling or experience someone else’s space. The second sub-theme explores how participants used their greater sense of control and responsibility having therapy from their own home to ground themselves within session. The final sub-theme describes how participants felt guarded, or like they were holding back, with some building a feeling of trust and others feeling vulnerable about being disturbed by the environments around them.

3.4.1 Sub-Theme 1: “You don’t have to worry about getting somewhere and going into somebody’s space”: On Home Turf

This sub-theme explores how over half of the participants experienced relief at having therapy in their own space, as they described the stresses of travelling to in-person appointments. For several participants, having therapy at home meant they avoided knowing more about the therapist, which gave a sense of safety through the neutrality of the therapeutic environment.

Therapy taking place through video meant participants were able to experience therapy from the comfort of their own home, in an environment chosen by themselves. Several participants described how this comfort avoided worries and anxieties around travelling to and from an appointment. As one participant states:

“Because us old un’s we like loads of wee weezies. So when we got to do long journeys and things like that, especially in the cold like so it is more convenient” (Amber, 605).

Amber’s use of “us old uns” reflects a warm, positive identification with being an older adult, while “wee weezies” conveys a childlike vulnerability when needing the toilet on public transport. This warmth contrasts with the discomfort of “long journeys” and “cold” winters, highlighting both the sense of community in ageing and the burdens of travel. The arduousness of travel feels to be the antithesis of a therapy session which may be focused on improving wellbeing, as though the travel to and from the therapy session eradicates benefits that may have come from the therapy.

Another participant also described some of the worries they have travelling to appointments and how this contrasts with the ease and convenience of having therapy at home:

“Well, I’ve had both, so I think it’s very convenient to have video. I really like that. You know, you don’t have to worry about getting somewhere going into somebody’s space, stay in your own space. It’s wonderful. That’s really important. And don’t have to sort of tidy up the place for somebody to come in and I don’t have to travel to go somewhere else. And then there’s the other formalities of knocking at a door, parking the car, and just find it was so very convenient to have it at home.” (Jess, 325)”

This extract from Jess highlights the worries she feels when travelling to in-person appointments. She lists multiple different points within the journey when she would feel stressed – “getting somewhere...travel...knocking at the door...parking...” - I imagine Jess to be anticipating problems at each of these points, which feels laborious and effortful. I interpret Jess to feel overwhelmed by each of these different steps when attending in-person appointments. When Jess contrasts “somebody’s space, stay in your own space” I get the sense she feels like she is intruding. Having therapy at home for Jess is “wonderful”, which feels warm and uplifting, and as though she feels grateful that she has the option and opportunity to have therapy on her own terms.

For one participant, the convenience of having therapy at home also came from the monetary saving:

“God at the moment, is two pound each way, but four pounds still a lot. It is for a single person, and they just got to pay all their own bills and everything.” (Amber, 1138).

Amber explicitly describes herself as a “*single person*” which speaks to her feelings of being alone, without family support. I sense some envy towards people who may have some more family support, and how travelling to appointments can highlight to her that she is “*single*” and lives alone. This feels like a shift in identities for Amber, having spent the majority of her life within a family support system, and now navigating travel and life stressors alone. I note that Amber was the only participant to speak to the monetary cost of travel, however, it feels significant as it highlights how people from varying socioeconomic statuses or with lower incomes may experience travel to and from therapy sessions.

For several participants, having therapy at home meant it occupied less space and time:

“And sometimes that was a relief, like, oh, well, that’s okay. It’ll, you know, it’s just that hour, and I can fit it in then, because it’s only an hour and I, you know, to go anywhere or be anywhere or do anything” (Simon, 316).

As Simon describes relief from not having to “*go anywhere or be anywhere*”, it makes me think of how stress can build up for when having to go through the effort of travelling to an appointment. As though not having this pressure provides a feeling of relief and ease. I imagine Simon to almost dread the effort involved in the therapy sessions and speaks to the mixed feelings I imagine him to have around therapy. When Simon states “*it’s just that hour*” it does feel as though the therapy session carries less importance. I wonder if this speaks to his feelings of video therapy itself and how that feels less important than say in-person sessions. In particular, the use of the word “*just*”, makes me think that in taking less time, effort and planning, it reduces the significance and power or significance of the session.

The downsides of less effort involved was also echoed by another participant:

“Again, when we make things really, really easy, do we also wake.. waste our time in in the shallows?” (Bonnie, 838)

The imagery of wading in the shallows elicits feelings of caution and wanting to stay safe. It implies tentatively dipping in, as opposed to full immersion in therapy. There also feels to be a gentleness to the shallow water, where movement is slower and more deliberate, where we can see our surroundings and it feels less threatening.

Further downsides to having therapy at home were described by another participant, who used our telephone interview to reflect on what the experience is like having sessions at home:

“And I’m surrounded by all sorts of detritus which you can’t see, thank goodness, which could be a big distraction. And I’m aware that as a client, that I am easily distracted by stuff.” (Jackie, 463)

Jackie describes how when feeling comfortable in one's surroundings can be too comfortable, as she describes the "*detritus*" surrounding her. It seems like her attention is divided between the therapy session and her environment. This could also reflect how it can be easy for Jackie to feel intrusions from the outside world, perhaps speaking to difficulties in feeling settled internally if there is some chaos externally.

For several participants, there was something about the neutrality of the therapeutic space created a sense of safety:

"And also it kept an impersonal atmosphere between us, because I wouldn't have to enter her space, so I wouldn't have to have any curiosity about her space and what was in her room and what she was wearing, and how many rooms in the house and all that sort of thing. And was all that was very impersonal that really, really helped me just to the subject matter of what, what I was there for, and these other things didn't interfere with, you know, to do with her life. I didn't have to deal with her life in any way whatsoever and I just dealt with her as a person who was just very caring and empathetic and was going to help me solve my problems, and I didn't need to know anything else about her. And so that was very good. I really, I really, have no objection to that at all. I much prefer it." (Jess, 336).

There is something about the therapist being anonymous which feels safer for Jess. As though seeing or knowing anything about them, might make them into a real person, which may result in her adjusting her behaviour or how she communicates. As she states "*I didn't have to deal with her life in any way whatsoever*" she sounds passionate and clear about how little she wants to know about the therapist. I sense the determination in her voice, as though this is the one space where she doesn't need to be faced with the issues of the other person, as though he is fed up dealing with other people's issues. Although this anonymity provides a sense of safety and comfort, I also wonder if she minimises the opportunity for these aspects to be spoken about in therapy.

Another participant also felt protected by the neutrality of a video therapy space:

"So we're both coming with nothing, if you're coming with nothing, erm, so you can't judge, you can't make reference to anything ...apart from, maybe that's a lovely scent in that candle, what is it? That might be the only one? But other than that, I would it removes the option for some investigation which may or may not be relevant." (Jackie, 241).

Jackie echoes Jess's sentiment of appreciating a neutral ground as she values when both the therapist and the client are "*coming with nothing*". I wonder though whether both people can truly be coming with nothing, or whether this is an illusion provided by video therapy, and

perhaps through the use of blurred backgrounds, that can be maintained, as opposed to challenged when attending sessions face-to-face.

In contrast to Jackie and Jess's experience of valuing a neutral background, others recounted how they were endeared through an unexpected disturbance in the background during a session. Several participants described how animals made an appearance on screen as Bonnie, recalled how she *"didn't really mind that much"* (Bonnie, 433) when a dog entered into the room. Other participants expressed a similar forgiving attitude yet acknowledged these interruptions could still be distracting. Jackie reflected on her experience saying *"all I could see was the dog behind and I have to say it was a bit of a distraction (laughs)..."* (Jackie, 439). Another participant states:

"So we had a little joke, because I could see in the background, and I could see what she was doing and where she was sat, and she could see where I was sat and what I was doing, and, you know, things in the background. So we can sort of like break the conversation a little bit, like the serious bits, we just sort of break that by, like, her cat went past, and I said, it's a nice kitty you've got there (laughs)." (Amber, 49)

For Amber, the presence of an animal provided some light relief. The way in which she fondly says *"nice kitty"* suggests a genuine affection for animals, as she recalls the experience with warmth and happiness. This gives the participants a glimpse of the therapist as a human and not just a therapist, something Amber recounts with warmth as they had a *"little joke"*. Amber describes this interruption to the session not as something disruptive, but as a *"break"*, a term used to indicate a welcome rest. This choice of word hints at how she may have been feeling bored or distressed in the session and speaks to the intensity one can feel of maintaining focus in a therapy session.

3.4.2 Sub-Theme 2: *"I always was able to look out at the garden during sessions": Anchorage or Avoidance?*

This sub-theme speaks to the way in which over half the participants were able to create a sense of grounding and anchorage through having more responsibility and control over their environment; although the question is raised whether this was anchorage or avoidance. For others they found it more difficult to create a sense of containment.

As one participant describes:

"I liked it because I like, I feel comfortable where I'm sitting, like, in fact, I'm not sitting in the chair that I would use to work in. I'm sitting on a settee." (Bonnie, 353)

Bonnie uses the word “*comfortable*” to describe how she feels having therapy from her own home. It seems important for Bonnie to make a clear distinction between her workspace and her therapy space, which I sense supports her to switch between different cognitive and physiological states. She seems to associate her work seat with her professional persona, and I wonder if this evokes a more directive part of herself. Sitting in a different place and on a “*settee*” feels like it slows down the pace, and evokes something more comfortable, cosy and safe. The “*settee*” feels like it is a secure and holding base, something not easily moveable. This external stable base helps give some containment and anchorage to the internal vulnerabilities Bonnie may be experiencing within the therapy.

Several other participants echoed enjoying a sense of comfort in the session, as Amber describes sitting in her “*nice, cozy little pyjamas (laughs)*” (Amber, 677) evoke a sense of comfort and relaxation. Another participant felt grounded through being able to connect to nature:

“I always sat in the same place. And I sat in the room at the back of the house that overlooked the garden so and so I always was able to look out at the garden during sessions....erm, so that just, I suppose, sort of just made it feel more... peaceful.” (Lorraine, 622)

Lorraine describes the continuity of sitting in the “*same place*” for each session, suggesting that the familiarity of the environment created a sense of predictability and safety for her. She mentions overlooking her garden, and the surrounding nature, and I imagine that during difficult moments, she gazed out the window which provided calming refuge. This imagery of the greenery evokes a sense of grounding and stability, looking out into nature that is constant and predictable. I wonder if it could feel challenging to experience co-regulation of emotions through a video screen, and whether the natural environment of the garden served as an alternative source of grounding. This could also however, be a way of avoiding the conversation, and avoiding feelings, by gazing into the garden rather than focusing on the screen itself.

In contrast to the purposeful containment others experienced, another participant reflected on the way in which she found it difficult to exercise the same control:

“So, and I was a bit apprehensive, because part of the therapy for me was the journey to the therapist, where you get yourself organized in your head while you're driving along, but you wonder what's been bubbling up? Oh yes, it's that, you know, we'll talk about that. Isn't it lovely weather today or whatever? And it's very different when you're doing video, because you're straight in, if you like, it's sort of, oh gosh, right.

You've got to sit down and have a session, and you don't give yourself the same sort of time to get in the zone, should we say?" (Jackie, 424)

As Jackie enters a video therapy session, she exclaims, "*Oh gosh, right*", capturing the suddenness of being thrust into the therapeutic space without giving herself any transitional time. Jackie seems to be swept up in other responsibilities, making therapy less of a priority, leaving little time to prepare or "*get in the zone*". When attending in-person appointments, she reflects on what's been "*bubbling up*" which suggests an emotional check in to notice which emotions have surfaced. Without this process, Jackie enters into the session unsure of what she wants to explore, which I sense leaves her feeling less in control and more vulnerable. Whilst it seemed easier for Jackie to overlook her emotional needs before a video session, she made a deliberate effort to light a candle, something which she replicated from her in-person therapy experience. This makes me think it is easier for Jackie to implement grounding when she has been guided by the therapist, and how it can be difficult for her to make space of her own volition. Jackie speaks further on the appreciation she has for grounding qualities of a candle:

"It's, it was, gosh, it was like the warmth. It was something to focus on it and the scent. I never did find out what the scent was. So it doesn't matter, you find one your end, but it's, it's this, I mean, I like..lavender's the common calmer of nerves, etc. So if you have that sort of scent going on, it can, obviously, that can have some impact on your mood, because it's actually something really sensory... which I think enhances the work you're doing. If it's on video, because it's, it's bringing in a wholeness to the encounter, instead of just being on a flat screen." (Jackie, 283)

Replicating the candle from her in-person therapy sessions seemed to trigger her memory and recreate the atmosphere and sense of containment. I wonder if the candle serves as a transitional object, helping her to feel a sense of safety and continuity with her therapy experience. The emotion and enthusiasm with which she speaks about the candle, gives a sense as to the disruption she felt when having to move from in-person to video therapy during the COVID-19 pandemic, as though it was some source of stability she could hold on to. The candle also seems to transform her experience from a two-dimensional experience to a three-dimensional experience, activating senses that may otherwise be lost in this experience, such as a change in sight, smell and a change in touch, something which is the "*calmer of nerves*", suggesting Jackie's nervousness around the video therapy sessions.

3.4.3 Sub-Theme 3: “Could anybody just pop into the session?”: Holding Back

This sub-theme reflects how six participants described their experience of trust and safety within their therapy sessions. Some participants built a trusting relationship with their therapist which made them feel safe and secure. However, for others, there was a wariness, with participants reporting a hyper-vigilance towards background interruptions during their sessions, creating a sense of holding back.

One participant speaks to their feelings of safety in the encounter:

“I think very quickly, or quite quickly, I realized that actually it did feel safe...This was somebody that I could trust. Whether I was online or face to face.” (Delilah, 188).

Having had face-to-face sessions with her therapist several years before, in the interview Delilah had expressed concerns as to how switching to video would differ. When she says *“this is somebody I could trust”*, it speaks to how for Delilah, her feelings of safety were based on the relationship with the therapist herself. It is as though Delilah was able to experience the personal qualities of the therapist through the screen in the same way she did in-person, and this relationship seemed to protect against other potential threats to safety. Another participant speaks to building trust online with a new therapist:

“I suppose, you know this, like trust that is built up to be completely open, you know, and that's quite... to actually feel comfortable enough and trusting enough in someone.... to be able to be completely open and not hold back.... Because I felt then, if I hold back, I'm not, I'm not necessarily going to get all the help that I need... erm, because I'm keeping some things that are quite important hidden.... Yeah, so that, you know, for somebody to be able to, to build up trust quite quickly...was great (laughs).” (Lorraine, 482)

In this extract, Lorraine reflects on how trust enables openness. As she says, *“because I'm keeping some things that are quite important hidden...”* prompts me to consider whether Lorraine is used to concealing aspects of herself from others. Throughout the interview, I visualised Lorraine as a butterfly emerging from a cocoon. Her accounts of holding back and hiding evoked a sense of confinement, isolation, and darkness, offering insight into how guarded she felt. As trust developed, it seemed that Lorraine allowed the therapist access to these previously hidden parts of herself, ultimately emerging from the cocoon and expressing her authentic self.

In contrast to the *“completely”* open and trusting relationship Lorraine experienced, several participants expressed less trusting experiences:

“Probably there is a bit of a barrier, I suppose, when you're looking at somebody via the video link, and you don't know who they are, or you know what they're obviously what their motives are, probably the wrong word, but you know. You're sort of trying to listen to what they're saying and trying to... they're trying to help you.” (Martin, 141)

When reading this extract, I am struck by the Martins selection of words. He describes there being a “*barrier*”, something that seems to prevent him from fully opening up. Although he later retracts this term, he describes the therapists’ intentions in terms of “*motive*”, which carries a tone of suspicion. This word “*motive*” conjures the image of Martin as a detective, being curious or even wary of the therapist’s underlying agenda. This raises the possibility that Martin struggled to trust that the therapist was genuinely who they claimed to be.

A sense of suspicion was also expressed by another participant:

“Was it secure, you know, with, with, with, you know, I think that was one of my concerns. Could anybody just pop into the session?” (Delilah, 401).

Delilah expresses her concerns around the security of the video therapy room itself, or what I thought of as the third therapy room. She questions whether anybody can “*pop*” onto the session; the use of the word “*pop*” indicates something brief and quick, as though it felt likely someone could jump onto the session out of nowhere. I imagine Delilah to feel wary, and like she is holding back in session; as though she can’t fully relax or disclose personal content for fear of someone intruding.

Whilst Delilah expressed an awareness for interruptions via the programme itself, others sat in fear of background disturbances:

“You're still in your own environment, then you're responsible in your own environment for things that go on around it. So....you...you probably, I sense that you can never truly be as open and....erm...or get to those parts of your brain that want to be unlocked, because you're always slightly aware of something that might happen around you.....that would be my old fashioned and aged approach.” (Jackie, 713)

I imagine Jackie to be on guard in her surroundings, preventing her from fully immersing herself in the therapy session. She describes being unable to unlock some parts of her brain, as though there are barriers or protective shields, she is unable to get past. However, Jackie expresses some uncertainty as she voices this opinion, as there are multiple pauses, and she uses adverbs such as “*probably* and *slightly*” which introduce a sense of doubt. She describes her view as “*old fashioned and aged*”, which minimises her experience and attributes this to her age, and I wonder if myself as the interviewer being younger, she is apprehensive about me disagreeing with her, and is thus holding back.

In addition to being aware of their own background, participants also noticed their therapists' background, with one participant appreciating how their therapist always sat in the same place:

'And you know, I got used to, I would know, because she was always in the same place and I was always in the same place. So I guess that in itself, makes it safe, doesn't it? It makes it in some way, contained and predictable. So you know that, er, you're not going to open up onto zoom and it be somewhere very different.' (Delilah, 261)

For Delilah, the predictability and reliability provided of the background offered a sense of stability and continuity. When she says "*she was always in the same place and I was always in the same place*", it feels like there was an unspoken bond between the two of them, where each were holding a safe and consistent space for each other. It highlights how communication can be implied and inferred, without ever being discussed.

Whilst Delilah spoke to the appreciation of a safe background, others had a conflicting experience:

"She was in her hallway, I think she had a big, a big Glasgow Hall in a flat, one of those tenement flats. And so I was in a hallway, and I felt like that's a bit weird somehow, and to feel contained enough like somebody's going to walk in the front door in a minute...." (Bonnie, 406)

Reading this gives rise to a feeling of being exposed in the "*big big hall*", as Bonnie vividly describes being in a large hallway - an expansive, empty space that feels too vast to ever feel contained. This stands in stark contrast to the sense of containing Delilah described. The space Bonnie depicts feels intrusive, as though someone is listening in. When she says "*I was in a hallway*", I sense Bonnie to feel dismissed or uncared for, being placed in the least safe room in the house. As Bonnie uses the word "*weird*", I imagine her to feel unsettled and wary. This seems to reflect a deeper distrust, perhaps not only of her surroundings but of the therapist as well.

Along similar lines, Bonnie reflects on another video therapy experience where the lack of safety came from not the room itself, but the objects within the room:

"That was something that I did with a therapist, a man, a few years ago, and behind his head on a mantle piece on the other side of the room, there was a thing that looked.. it was hard to see exactly what it was, but it looked like a doll, and it looked like a black doll, a doll, a black doll, like black and white minstrels' doll. And after a couple of sessions, I had to say to him, what's that thing behind you on the mantle piece, because it's really bothering me. He didn't explain exactly what it was, but, but he did take it away." (Bonnie, 466)

There is something about how Bonnie felt safe, but also unsafe within this extract. The sense of unsafety coming from a background she found offensive, something which she tolerated for several sessions before mentioning. Yet, her eventual ability to voice this concern also speaks to a growing sense of safety within the therapeutic relationship, perhaps one that needed time to develop. I wonder if the video format itself made it easier for her to address this issue and gave her a greater sense of power. When she says *“I had to say to him”*, it alludes to an internal conflict; on the one hand, her feminist values compel her to address the issue, while on the other, it seems as though she needed to summon the courage or readiness to do so.

3.5 GET 3: Seen Through a Screen

This theme includes the experiences of seven participants and explores the way in which they felt seen through a screen, speaking to the way in which they were able, or unable to build a deep and meaningful connection through the screen. The importance of feeling seen, particularly for older adults seems to be linked to their confidence and identity, as one participant states *“Nobody gives a fuck about what I think, nobody looks at me. Nobody winks at me, nobody has any interest, romantic interest whatsoever, from anybody ever.”* (Bonnie, 33).

The first sub-theme examines participants’ experiences of invisibility both inside and outside the therapy room. The second sub-theme considers the varying sense of closeness and distance participants described when engaging in therapy through a screen. The third sub-theme highlights how reassurance was derived not only from observing the therapist’s face, but also from the reciprocal experience of being visibly acknowledged by the therapist.

3.5.1 Sub-Theme 1: *“We’re not worth.. we’re not worth it to anybody anymore.”: Fading From View*

This sub-theme explores how six participants experienced feeling invisible in the world outside the therapy room, but also at times inside the therapy sessions themselves. It feels valuable to understand the context of coming into therapy as an older adult, particularly due to a parallel process of invisibility occurring both inside and outside the therapy room. However, there was some divergence, with other participants describing how the visibility they had in session provided a stark contrast to that they experienced outside.

For several participants, invisibility was experienced within in the wider context of society:

“As a feminist, I spent much of my life trying to avoid the male gaze and but now I'm in my 70s, just about.. I'm kind of thinking, oh!... okay, invisible, you know, not of any interest to anybody in any sense whatsoever, either physically or intellectually or, you know, there is a little bit of a sort of, “Oh, my God. How am I going to keep working and how I, how am I going to, how am I going to deal with my ego and my self-confidence as I as I go into my 70s.” It's interesting. It's quite interesting.” (Bonnie, 41)

Bonnie reflects on how she used to “avoid the male gaze”, describing how this attention felt unwanted or intrusive. It feels like Bonnie has shifted from resisting this gaze, to now confronting the erasure that comes with ageing. I hear a conflict between two parts of her identity, the part of her who is a feminist and feels how the “male gaze” positions women as objects in society, and the part of her identity that feels powerful and wants to be seen. It feels like Bonnie is stuck, with too much attention feeling objectifying but too little attention leads to a feeling of invisibility and a loss of social value.

Whilst Bonnie experienced conflicting identities, another participant experiences invisibility as a rejection from society:

“There's no point in anything anymore, because that's how they made you feel. You know, the world, the society, how the world is coming on. It's like, one of the old donkeys in Spain innit, and they just push them off the side of a cliff, because they're useless. We're not worth we're not worth it to anybody anymore. We don't work anymore. We don't pay taxes anymore. But once you're 60, if there's anything wrong with you, you don't go to that surgical ward anymore for that particular thing that's wrong with you. Do you know you go to a geriatric ward? Yeah, whether you got a sore front, sore bum, sore foot, you don't go to that particular ward for the sore bum. You go to one ward where all the geriatrics go for all the ailments. That's where you go. How about that for ageism!” (Amber, 1044)

As Amber repeats “we're not worth it”, she highlights the way in which society views her as useless and worthless. When she says “How about that for ageism!” I hear her moral outrage and anger at this injustice. I notice how Amber contrasts *we* and *they*, speaking to a sense of comradeship and safety with her peers, as though they are in battle with the external world and society that devalues and causes harm. When she says “once you're 60”, she is speaking to a temporal threshold, and how there is a clear life boundary that changes how someone is treated. I also reflect with Amber through the passionate tone and use of colloquial language, there is an authenticity and immediacy to her communication, how she is talking from the heart with little reserve or caution. I wonder whether she is like this in every interaction or if she experiences me as an older adult ally, as opposed to the system. Although there is clear

frustration in this extract, her comparison of herself to a “*donkey*” and her reference to having a “*sore bum*” introduce a humorous tone, which reflect Amber’s personality and hints at a source of inner strength, that despite the societal shifts, she remains the same person.

Whilst both Amber and Bonnie describe their experiences feeling invisible within the wider community, several other participants described this experience within their closer social groups. As one participant states:

“And you know, to be listened to... was I... mean, even just talking about it now, it’s quite emotional (crying), because I felt so shut down, you know, with my interactions with people who were my friends...erm... you know, and I just felt quite lonely.....So that was huge...”. (Lorraine, 459)

Lorraine describes how she felt “*so shut down*” which speaks to an emotional emptiness and closing off from others. I imagine her suffering in silence with her friends, feeling she had no voice or power. Lorraine juxtaposes this emptiness, with the attentiveness and care she received from the therapist, that was “*huge*”, as she transitions from being shut down, to opening up. When she cries, I sense the love and gratitude for her therapist, highlighting how something as simple as being listened to, can be as rare as gold dust.

In contrast to Lorraine’s experience of feeling visible and seen within therapy, several other participants described moments when they felt invisible to their therapist:

“Obviously she was, you know, constructive in what he was saying about making time for myself and trying to relax and all this type of thing. And doing these various techniques for...um... you know.. helping with my sleeping pattern... like.. doing more exercise.. ah that was one of the big things actually, do a lot more. Like going out and walking.” (Martin, 148)

I pick up on this sense of invisibility in Martin’s account, yet it’s not so much about what is said, but rather about what remains unsaid, what is invisible in his words. As Martin describes his therapy, he seems to frame it in terms of outcomes and practical benefits as he describes the tasks he was recommended to do. However, the language he uses to describe these changes feels restrained. Words like “*constructive*” suggest functionality but lack the emotional depth or intensity, with the perfunctory tone in this extract suggests an absence of emotional connection. It is almost as though whilst the therapist provided the tools and techniques, Martin didn’t experience this therapy as a relational experience and didn’t feel truly seen or visible to the therapist.

Another participant was more explicit about feeling unseen in sessions:

“There were four or five of these round icons, and they blocked her face even more. See her face hardly with... with this interference on the bottom of the screen, and her face being so down on the screen. And I asked her, I said, you know, could you please make it so I can lip read? And she did it, and it lasted for about five minutes, and then it went down again to how it was, and I'm not quite sure what her technical setup was. It wasn't satisfactory from that point, yeah, but it didn't stop me, stop us communicating. I just felt a little bit frustrated sometimes.” (Jess, 254)

Jess not only struggled to see the therapist physically, but when she raised this issue and it remained unresolved, she was left feeling unseen. I sense that asking for this adjustment required courage from Jess, as though expressing her needs carried an emotional risk of rejection or dismissal. The therapist is also positioned here as the person who has the power to accept or reject her needs. When this remained unresolved, I hear her anger, which she appears to minimise when she says she felt *“a little bit frustrated”*. I imagine Jess continued to struggle throughout the sessions and whilst this may not have disrupted the overall communication, I suspect it triggered moments of anger throughout the course of therapy, which I imagine to be also invisible and unspoken. In addition to the visual invisibility between herself and the therapist, Jess also experienced an emotional one:

“I was disappointed that she didn't go into it because this was my mother. I thought it was a failing on her part, and I couldn't understand why she always shied away from that subject whether she had a problem with her own mother. She didn't want to talk about my relationship with my mother, and it's equally destructive. I didn't understand her logic, but maybe it was doing her training that she was only interested in the awful effect of parental fathering. I don't know, I didn't go into it with her, but I just knew that I had to make up that deficit myself.” (Jess, 411)

Jess reflects on why her relationship with her mother was overlooked in therapy, attempting to make sense of the therapist's omission. She describes this as a *“failing”* and feels let down, suggesting that she believed it was the therapist's responsibility to address the topic. Jess appears sensitive to others' emotions, noting that the therapist did not explicitly shut the topic down but *“shied away”* from it. When she states, *“I didn't go into it with her, but I just knew that I had to make up that deficit myself,”* it suggests a willingness to work harder independently rather than risk a potential conflict. Simultaneously, she experiences the therapist as *“just such a lovely, gentle, friendly person”* (Jess, 72), which raises the possibility that the therapist's warmth may have made Jess less likely to raise the issue for fear of upsetting her or compromising the therapeutic bond.

One participant described a shadow side to feeling seen within a therapeutic context, describing what happens when we are unable to find that level of visibility outside the therapy room:

“And it didn’t matter whether it was zoom or face to face, you know, there was, there was something about, about that, you know, the depth that we went to together, that when I was talking to my supervisor, that I was talking about, it’s just her responses, and I thought, just don’t think you get it. And then I feel frustrated, and then I feel really isolated, and then I feel very alone with it, you know? So, yeah, so it’s a double-edged sword anyway, because I wouldn’t not want to have this awareness, the knowledge and understanding, but I think having it, it’s sometimes, yeah, quite lonely.” (Delilah, 615)

Delilah describes how allowing herself to be truly visible within the therapy room created a feeling of isolation and loss outside of it, as she longs for that visibility in her interactions with others. It seems that the attentiveness and understanding she felt from her therapist is something not easily replicated or experienced.

3.5.2 Sub-Theme 2: “An Old Mate”: Near and Far

This sub-theme explores how all but one participant described how through a video they felt a sense of closeness, or for some, a distance through a screen. For some participants they could feel and experience the whole of the therapist, whereas for others there seemed to be parts missing.

Amber describes the friendliness and openness conveyed by seeing the therapist in her video sessions which brought about a sense of closeness:

“It was a bit like seeing an old mate. It was so funny, because it’s like, I never done it before. And anyway, she pops up, and she said, Hello!, XXXX. And it’s like, oh, I find it quite exciting, yeah, and she was really nice. So it was like, it’s like an old mate.” (Amber, 139)

As Amber talks, I can hear the nervousness at speaking to someone new. It seems the emotions of nervous and excited sit closely for Amber as she experiences both in close succession as she shifts from strangeness (*“I’ve never done it before”*) to comfort (*“quite exciting”*). She describes the therapist as feeling like an *“old mate”*, harkening to a familiarity, as though she has met her somewhere before, despite meeting her for the first time. This feels like a paradox where something entirely new also feels like a reunion, something that feels like it happens when her face *“pops up”* and they are able to see each other. This suggests

that Amber experiences seeing and feeling seen relationally, and this can occur quite quickly through feeling the therapist's human warmth and friendliness. Amber further highlights the closeness she felt with the therapist, particularly through seeing her through a screen:

"You can almost touch them, if you know what I mean." (Amber, 625).

This feels open to two interpretations. On the one hand, there is a sense of closeness, Amber describes feeling the therapist's presence so vividly that despite being in separate spaces, it was as if they could touch. On the other hand, the word "*almost*" hints at something lacking, a nearness that remains just out of reach. As though the connection is incomplete and not quite as fulfilling as being physically present together. Another participant also described a sense of closeness, but perhaps also with some distance:

"I think, because just that, the size of her face was just that it was, it was almost as though she was in the room with me..... where, I think.... you know, maybe, maybe doing, I mean, I don't know, because we didn't do it on the phone. We always did it on the laptop....Erm, So maybe it, maybe it would have been the same (unsure in tone), but it was it just, I suppose it was like the next step from face to face to laptop. And we could have gone, could have gone to phone... but it just felt as though, yes, that, that she was a real presence in, in the room, rather than, you know, just a little picture on, you know, a little screen." (Lorraine, 367)

Similarly to Amber, Lorraine also uses the word "*almost*" to reflect on how close the interaction felt in comparison to being in the same room as someone. There is repetition of the word "*maybe*" as Lorraine mulls over whether the size of her face had an impact. There was something about the amount of space the therapist took up in the room, and the size of the screen that gave her a "*real presence*", which seems as though she could feel and sense her in the room with her, as though she wasn't alone. She contrasts this with a phone that would have made the therapist "*just a little picture on, you know, a little screen*" which feels to be mechanical and of minimal impact. This contrast speaks to a richness and lifelikeness of the interaction Lorraine experienced, as though the therapists humanness was able to pour out into the room.

In contrast to the closeness experienced by Amber and Lorraine, another participant had mixed feelings as to the felt presence of the therapist. Simon described experiencing some warmth from her - "*And she was a fairly sort of motherly sort of person*" (Simon. 457); implying someone who is caring, supportive and safe. He also experienced missing the physicality of the full body:

"The you know, her presence was very....what's the word....er.... unmoving. So it was very verbal, you know, depending on what I said. So as I say, you know, I said the last

time we talked, there were pauses, significant pauses, and, er... that that was some deepening, but it it felt.. on reflection, kind of static. She always seemed to be in one place.... I suppose I remark that because I tend not to be static, I tend to sort of gesture quite a lot.” (Simon, 236)

Simon’s description of the lack of physicality in the session appears to have a double meaning. As he says the word “*unmoving*” he describes not only the physical movement of the therapist, but also the way in which he felt emotionally unmoved, or numbed, by the therapist’s presence. I wonder if he experienced the therapist as cold in some way. Simon also uses the word “*static*” which can be used to indicate interference, suggesting he felt the video medium interfered with his ability to get close to the therapist.

In contrast, another participant described how they were surprised that the lack of physicality had less impact than they thought:

“Yeah, and there was a there was a thought that maybe because it was being video, you..you didn’t have to give as much commitment to it, if that makes sense, if that’s the right word to use, that you don’t have to be wholeheartedly committed to it in the same way, because you can’t be... you can hide behind a screen, which is probably my understanding, maybe. Whereas when you face to face, you get the whole person, and every nuance of body language is important. You don’t have that same experience when it’s video. But actually it can be (laughs).” (Jackie, 150)

When Jackie describes the “*commitment*” involved in having video therapy as being less than in-person, I imagine she refers to the level of emotional exposure she would experience through a video screen. Jackie describes how she thought she would be able to “*hide behind a screen*” which feels like a metaphor for concealment, suggests some avoidance or concealment of herself, as though she felt like she needed this barrier as protection. Jackie imagined the screen to be both be a shield and a barrier, but it seems like it was neither of those things; in fact it feels like she found the sessions more disarming than expected.

The feelings of closeness for several participants, provided a welcome counterbalance to some of the heaviness of the content of the therapy as one participant describes:

“I found her really inspiring, because she was so friendly and open. And at that point, I didn’t have anybody in my life apart from my family, that I felt was friendly and open. Everybody was all completely neurotic around me, and so she was, she was very welcome every week. And so she’s she had a completely different way of looking at things than other therapies that I’ve had, dealt with ongoing situations. She wanted to go right back to my childhood, which she did in a very heavy manner, which I found really quite as being raked over. But then, on the other hand, I felt it was being helpful,

and she did in a very supportive way, but it was new stuff. That was quite disturbing.”
(Jess, 28)

Jess describes the therapist as a “*welcome*” change compared with the “*completely neurotic*” people around her, suggesting that sessions offered relief from difficult interpersonal interactions. Her phrase “*each week*” conveys a sense of reliability and consistency, while describing the therapist as “*friendly and open*” indicates a feeling of safety within the relationship. This stable grounding appears to have provided a secure base from which she could engage with “*heavy*” material. The metaphor of “*raking over*” suggests that therapy was probing and unsettling rather than gentle, evoking the physical and emotional sensation of hidden or raw material being brought to the surface, exposing Jess to difficult feelings.

A similar sentiment was described by another participant, who also found the closeness to the therapist provided a safe base from which to explore more emotive content:

“As I say, I feel quite emotional talking about it, I think as we.. because we, we, in a way, we worked it out together because she, she'd had very little experience of working with twins or a twin. Erm, and I was really just trying to understand myself and what, what the, what the twin identity and what, how that fits with my own individual identity, my self identity, and how did those.. how did that fit together, you know? So it's really we really worked. We worked so hard together to make some sense of it, to make some sense of therefore, what that was like as a child.” (Delilah, 527)

The repeated use of “*we*” highlights a closeness, by suggesting there was a comradery and team effort. This shows they were working through things together, evoking a feeling of closeness, as though they were alongside each other. I wonder if the “*we*” also speaks to the merging of the different parts of herself as a result of the therapeutic process; that is, her twin identity and self-identity are now integrated.

In contrast to those highlighted above, one participant found that when the content of material in session was emotional, they felt a distance rather than a closeness:

“I was saying it felt strange at times when it would have got more intensely emotional... that's when it felt strange you're like, you know, kind of crying in a room on your own.. behind a screen You know, it wasn't, it wasn't unpleasant, and it wasn't sort of, but, you know, I just kind of know from doing how, you know, I've taught a lot of counselors, I've done a lot of training, I've done a lot of group work, that somehow there's sort of, some of the intensity of working through...er... emotions seemed to be a bit kind of missing.....” (Simon, 53).

Simon highlights the strangeness of crying in a room “*on your own*”, which speaks to him feeling isolated in these moments, as though emotions move him away rather than towards the therapist. It is as though video therapy is capable of evoking difficult and painful emotions, in him, but he is unable to experience the therapist as supportive and receptive in the same way back. For Simon, it seems like working through emotions is not just an internal, but is more of an interpersonal experience, that relies on sharing a space with someone else and an embodied interaction. This is highlighted when he says later how “*maybe needs to hold the hand or something*” (Simon, 80), suggesting how Simon relies more on bodily communication, than verbal.

Simon made suggestions for what he felt would have brought about a greater sense of closeness:

“I think.... talking about it more frequently, talking about, hey, we're meeting online. How is that feeling? How are you feeling? This is strange or a bit too distant sometimes. She never asked me questions like that. That would have been helpful.” (Simon, 330).

For Simon, the elephant in the room remained unaddressed, as the strangeness of having therapy via video remained unspoken between them. When Simon says “*she never asked me questions like that*” I imagine him to feel unseen by the therapist, as he struggled with feeling a sense of distance that appeared unnoticed. I interpret this silence as something that affected the therapeutic relationship, creating an undercurrent where important experiences and feelings were present but left unsaid. It strikes me Simon did not raise these concerns himself, taking more of a passive role in therapy, perhaps speaking to a power imbalance, or a felt sense of worthlessness where his perspectives don't matter. This unspoken layer may have deepened Simon's sense of disconnection, reinforcing a sense of invisibility.

Whilst Simon experienced the distance as a barrier to feeling seen, another participant experienced the distance as protective:

“...more emotionally protected and self-protecting, but also a little bit more in control. And I could always, you know, end the call, if I wanted to, you can't easily do that in the room. Not so easily.” (Bonnie, 163).

For Bonnie, having some distance between her and the therapist provided a sense of safety knowing she could easily “*end the call*”. This easily accessible escape route gave Bonnie the freedom to withdraw if she felt unsafe or vulnerable. Sitting in a separate room to someone we may feel less aware of their physical presence, and they may feel less imposing. I wonder if for Bonnie, this made her feel more powerful and as having more agency. Ending the session

from a distance feels safer as Bonnie doesn't have to hear or manage the other persons reaction.

3.5.3 Sub-Theme 3: “if your bottom lip starts to tremble, she can see that”: Seeing and Being Seen

This sub-theme describes how over half the participants experienced seeing the therapists face, and the therapist seeing their face, as being reassuring. There seemed to be a comfort and security for many in seeing and attending to non-verbal communication, alongside verbal communication.

Even prior to commencing therapy, one participant had a sense of the therapist based on her photograph:

“...because she was exactly how I thought she would be from her photograph (sounds happy). Yeah, there was sort of gentleness and warmth about her” (Lorraine, 400).

Lorraine describes the fantasy she had of her therapist prior to meeting her, as though she felt a sense of closeness from seeing her picture. Lorraine uses the words “*gentleness and warmth*” to describe the therapist, which are both words that evoke the sense of touch, that feel soft, safe and warm. These qualities were permeated and be felt by Lorraine through a picture and also through the screen.

Other participants described the way in which the therapist seeing their face, allowed them to feel more at ease:

“Yeah, more, like, at home, and when you're talking about things, especially if you've got, like, you know, depression, things and that sort of thing, and you're sort of worried, you need to be at ease. You need to relax. When you get a bit all confused and a bit cuff-ffuld and a bit stressy, you've you forget what you're trying to say. Well, I do. I think a lot of us older ones do we forget what we're trying to say.” (Amber, 59)

Amber emphasises the importance of feeling at ease when having therapy sessions. She describes some of the difficulties she experiences in communication, outlining how she feels “*cuff-ffuld and a bit stressy*”, and there may be a parallel process in the interview where she hesitates as uses filler words such as “*like*”. Amber experiences both psychological and somatic states as being intertwined, almost as a vicious cycle with stress and worry obstructing communication, which then creates a barrier to resolving the stress and worry. As Amber says “*you've you forget what you're trying to say. Well, I do. I think a lot of us older ones do*” I hear a self-consciousness as she moves from externalising the forgetfulness, to taking ownership of it, to making it part of her group identity as an older adult. This makes me wonder if the

forgetfulness is something she is ashamed of and being in a situation where she can see the therapists face helps her to feel calmer, reduces this shame. Amber continues:

“So she could see me smile and or if, or if your bottom lip starts to tremble, she can see that, and she can detect it, so she can change her tone of voice, or she can give me a bit more reassurance, or say, you know, would you like a break a minute get a glass of water? You know, it's always, it's all right. You know, she can do the sympathy it was, so I don't worry everybody that when somebody can't see your face crumbling, or, you know, a bit different.” (Amber, 102)

This extract suggests how Amber finds it difficult to verbally express her needs or how she feels, and at times relies on people to read her expressions to best support her. She uses the term *“face crumbling”*, an idiom, to describe signs that she is going to cry, which makes me think of her emotions being written across her face but not always verbalised. She experiences greater attunement to her needs from the therapist when they can read her body language and facial expressions. I am curious about the language used by Amber when she says *“do the sympathy”*, which makes me question whether she always experiences sympathy as genuine, or perhaps there is an awkwardness with her feeling comfortable accepting sympathy or care from others.

Whilst Amber and Jackie describe the reassurance they feel by knowing that the therapist can see them, another participant speaks to how seeing the facial expressions of the therapist can cause them to feel comfort or discomfort, depending on the therapist:

“I don't get on very well with the blank faced psychotherapist” (Bonnie, 392).

Bonnie expresses a dissatisfaction with more traditional therapeutic modalities. The use of the word *“blank”* elicits an image of a person talking to a brick wall, as though she might as well be talking to herself. Whilst she doesn't explicitly describe how she feels in the presence of blank expressions, I imagine her to experience some discomfort as there is a sterility or detachment, rather than a warmth or humanness she might hope to find in a therapist's face.

Another participant also highlighted how seeing the face through a video can create a sense of discomfort:

“It's all faces and not, you know, because, like, I often maybe look into the distance when I'm talking about something. Do you see what I mean? And having that sort of eye to eye contact, and sort of, you know, front of face to front of face contact, I think is, is probably a bit, yeah, it strikes me as slightly unnatural.” (Simon, 379)

When he says *“it's all faces”* I sense there be something intimidating about having the permanent gaze of the therapist. There is something about how Simon describes the *“eye to*

eye” contact, that feels animalistic, maintaining strong eye contact, almost as though there will be a fight. I interpret this to mean that Simon feels intimidated or intruded upon by having the full attention of the therapist and perhaps feels pressure to maintain eye contact (or emotional contact) when he would rather look away.

4 Discussion

4.1 Introduction to Discussion

The **Analysis** chapter presented the themes resulting from an Interpretative Phenomenological Analysis of eight interviews exploring older adults' experiences of video psychotherapy. In order to remain closely aligned with participants lived experiences, relevant literature was deliberately not referred to within this chapter.

The **Discussion** chapter will explore the literature in line with the findings presented. The chapter will be structured in three parts:

The first part will provide a brief overview of the themes, before examining each theme in reference to the existing literature. This will include both literature introduced within the introduction and new aspects of research not anticipated. Given the limited research in this area the discussion will incorporate findings from studies on broader populations including video therapy with all ages and wider literature on older adults.

The second part will explore two overarching concepts that appeared to underpin the themes and were fundamental to older adults' experience and the way in which older adults experience those around them: 'Existential Ageing' and 'The I-Thou Relationship'.

Finally, the chapter concludes with a critical review. This will discuss the clinical implications for counselling psychology and wider psychological therapy services, evaluate the strengths and limitations of the study and offer recommendations for future research.

4.2 Theory and Literature

4.2.1 GET 1: *Fearing Loss*

The first GET, '*Fearing Loss*', described how the participants context and experiences with loss provided a catalyst for help seeking through the sub-theme '*Confronted by Mortality*'. With this background context, participants came into therapy experiencing '*Uncertain Connections*', fearing being unable to connect with the therapist, both physically and emotionally. Some participants blamed themselves for challenges with connecting, whereas others took measures to manage their worries. In the final sub-theme, '*Connection as Cure*', participants experienced making a connection with the therapist as magical, surprising and pleasant. For

many, connection worked as a quick antidote to the fear of loss, whereas for others this process was more of a gradual adjustment.

It is striking that all but one participant described experiencing losses; including loss of employment, ending of relationships, loss of physical capabilities, loss of social status and deaths of family members. Although losses can occur at any age, older age has been described as a succession of losses, which can be gradual or sudden, and is said to lead to separation of the self in relation to others (Butler & Lewis, 1982).

The experience of loss felt close to the surface for participants, as they experience physical illness and death as being “*heavy*” (Bonnie, 125) and “*unsettling*” (Lorraine, 215). The literature supports the idea that loss in later life prompts older adults to reflect on their own death and can reshape their identity and sense of time left (Carr & Utz, 2020). This speaks to participants undergoing a life stage conflict of ego integrity vs despair, as outlined by Erikson (1950) in his Life Stages theory. Erikson suggests how within the final life stage, one can accept their own mortality: choosing to live authentically, to reconcile regrets and to embrace freedom (ego integrity) or have difficulty approaching death, experiencing feelings of hopelessness or depression (despair). There is further exploration of the experience of life and death in ‘Existential Ageing’ in the second part of the discussion.

The participants seemed to be reminded of the finitude of life through experiencing and noticing physical health problems, with several participants only seeking support when encouraged to do so by a physical health professional. Somatic presentations are reported to be more common in older adults (Wetherall et al., 2021) and physical health professionals are essential to bridging the gap between older adults and remote psychological therapies (Yin et al., 2024). It makes me wonder if older adults are more ‘tuned in’ to somatic symptoms, experiencing these as risky and life-threatening. In comparison to psychological symptoms which are often minimised or viewed as a normal part of ageing (Choi et al., 2014).

With this hyper-vigilance in mind, participants came into the therapeutic environment anticipating a loss, both technologically and emotionally. Participants worried about connecting with the therapist, with the risk of not connecting for some participants experienced as “*terrifying*” (Jess, 206). Several participants blamed themselves for challenges with connecting, feeling like it would be a personal failure if they were unable to. Whilst there is research that suggests shame and embarrassment is common in all ages in the early stages of therapy (Kleiven et al., 2020), the use of language by participants such as “*fuddy duddy*” (Jackie, 797), speaks to internalised ageism. This internalised ageism is a serious problem, as it prevents older adults from acknowledging mental health difficulties or seeking professional support (Choi et al., 2014). However, aside from being an individual problem, it

is a structural and cultural problem which turns socially shared negative age stereotypes into negative self-perceptions of ageing (Ishikawa, 2023). Ageism has also been shown to impact cognitive health, as Lamont et al.'s (2015) literature review and meta-analysis found how stereotype threat negatively altered both memory and cognitive performance, causing a self-fulfilling prophecy; suggesting that stereotypes can be more damaging than facts.

For many participants, connection felt to be curative, as once participants had made the connection with the therapist, for the majority, this soothed fears around loss, as it confirms that connection is possible. I wonder if through connecting, there is a temporal anchoring that situates the person back to the here and now in a way that reduces the anticipatory dread. In her research on people who have been bereaved, Hughes (2022) outlines how mourners experience a temporal dyssynchronisation, that is, a speeding up or slowing down of time, and people can race towards the inevitability of their own death. The instantaneous connection reported by some participants, and the following relief could be a part of an anchoring in the present moment, an experience that counteracts the temporal disorientation (Morin & Grondin, 2024).

Considering connecting through a more descriptive lens, for several participants connection occurred instantaneously and "*miraculously*" (Martin, 196), whereas for others it took more of an adjustment. This is supported in the literature that reports how initial scepticism in older adults evolved into a positive experience, as they gained more familiarity, experience and competence with interacting using technology (Christensen et al., 2021). This is further supported in the literature of technology use in older adults with Vaportzis et al. (2017) reporting how those new to tablet use expressed greater willingness to continue using them after brief exposure, suggesting how even a limited interaction can positively influence the likelihood of engaging in technologies again in the future.

4.2.2 GET 2: (Un)Safe

The second GET outlined participants experiences of feeling '*(Un)Safe*'. The first sub-theme outlined how participants had therapy '*On Home Turf*' with participants describing the ease and comfort of having therapy at home and in an environment where they felt comfortable, creating a feeling of safety. However, this ease for some, felt like it made therapy less valuable. Another sub-theme explored how participants navigated '*Anchorage or Avoidance?*' within their own home, favouring grounding and consistent spaces. The final sub-theme reflected on a feeling of '*Holding Back*', and how participants experienced a sense of unease or suspicion.

For many participants, home seemed to be a place of safety and belonging. This is echoed in the literature into older adults, as Hatcher et al. (2019) describes the home as a place where

they can preserve independence. The language participants used to describe having therapy at home, such as “*relief*” (Simon, 317) and “*convenient*” (Jess, 326) have calming connotations, as they didn’t have to experience the effort of travelling to appointments. Similarly, Lee et al. (2024) who conducted a qualitative study into an exercise intervention in women aged over 80, reported how participants found home to be a safe place due to the familiarity of being in their own territory, and felt a sense of ease and reduced stress levels from eliminating any travel barriers.

There is further evidence supporting the benefits of reduced travel time. Evidence comes from the literature into the general population, with Moeller et al. (2022) reporting how participants described benefits of reduced travel time, preparation time and finding it more relaxing having sessions at home. This time saver can be of particular benefit to older adults, as research suggests their health-related activities can take up to 23 hours a week (Jowsey et al., 2013). Travelling to appointments can be stressful, with Age UK (2017) reporting how 24% of older people felt that public transport would be unable to get them to a hospital appointment on time. This is supported in a systematic mixed studies review by Ilali et al. (2023) who found that the most cited facilitator was location and travel time, due to the increased accessibility, and convenient time saving.

On the other hand, there seemed to be a shadow side to the ease of video therapy, with participants experiencing it as holding less value and potentially having less of a deep emotional impact. As one participant exclaims “*oh gosh, right*” (Jackie, 432) as she is thrust from day-to-day life into the therapy session and another stated “*it’s only an hour*” (Simon, 319), indicates how video therapy is deprioritised, and may hold less value than in-person therapy. The literature in support of this comes from therapists’ experiences of video therapy. Lagetto et al. (2024) reported how whilst some therapists experienced the level of depth of video therapy to be the same, others suggested the process tended to focus more on symptom management. They also suggested clients tended to move through topics faster, which prevented them from being explored in detail.

Having video therapy from one’s own home gave participants a greater sense of control and responsibility. Participants autonomously found ways to anchor and ground themselves into the therapy sessions through sitting on a “*settee*” (Bonnie, 356), or choosing to “*look out at the garden*” (Lorraine, 624). Whilst on the one hand, this anchorage could be considered a method of regulating their emotions when feeling distressed, as they focus on the external world rather than internal (Najavits, 2002), it could also be considered avoidance. That is, rather than face emotionally difficult content, the client has easier access to means for which to distract or disengage from the therapy session, something which could be more difficult

when in-person and when having less control over the environment. This has been noticed by therapists, with Lagetto et al. (2024) outlining how therapists noticed clients are frequently distracted during online sessions.

Many participants mentioned the backgrounds of their therapist, however, there seemed to be divergence on how this was experienced. Some participants experienced a neutral background as safe and containing, and it felt to facilitate a sense of safety and opening up. This is echoed in the literature, with Taiwo et al (2023) highlighting how privacy concerns can impact the therapeutic relationship, clients' disclosures and attendance. For others, background distractions were experienced as humanising, such as those participants who experienced pets on the screen. These background distractions seemed to represent the therapist as a person and brought an authentic person to person encounter (Buber, 1923/1958), which will be discussed in further detail in the second part, in terms of the I-Thou Relationship. It also seemed like this encounter allowed for humour in the interaction, which can strengthen the therapeutic bond, with Longe (2018) reporting a relationship between the presence of humour and a good therapeutic relationship.

Further experiences of holding back came when one participant questioned the "*motives*" (Martin, 145) of the therapist, speaking to a suspicion as to their credibility. This makes me reflect on the presentation and informality of video therapy. When attending in-person sessions, there is a formal process, with perhaps the therapy taking place in a clinic, perhaps there is a receptionist or someone wearing a uniform. Video therapy removes these formalities and without obvious clinical surroundings, it feels like the formality is reduced, also reducing trust.

In contrast, other participants felt they were "*able to be completely open*" (Lorraine, 486) and "*safe*" (Jackie, 581). These participants experienced video therapy as being a safe and containing space, that facilitated an openness and transparency. This is echoed by a study into remote therapy, where therapists observed that some clients felt less threatened and experienced the therapist as less judgemental, resulting in more openness and greater disinhibition (Jesser et al., 2022), disclosing topics that hadn't been raised in-person. Further support comes from Isaacs-Russell (2015) who highlights how the erasure of the ability to "kiss or kick" while working on a screen alters the conditions of a therapeutic encounter.

4.2.3 GET 3: *Seen Through a Screen*

The third and final GET explored how participants were '*Fading From View*' within friendship groups and the wider community. Some participants also experienced being invisible to their therapist, with the screen acting as a barrier to being seen. The second sub-theme explored the sense of '*Near and Far*' participants experienced, with some being able to feel and experience the therapist through the screen, and others feeling a greater separation, which felt like a barrier for some, and for others protective. Finally, '*Seeing and Being Seen*' reflects on how the face is experienced through the screen, with many experiencing it as calming, and one as intimidating.

Within the wider world and within therapy participants experienced themselves as invisible as an older adult. They spoke to a shift in identities where they have transitioned from working, good health and feeling attractive to ostracised from society, as one participant states "*nobody gives a fuck about what I think*" (Bonnie, 34). This experience resonates with broader literature identifying invisibility in later life as a pervasive social concern. For example, research exploring older adults' experiences of their rights to their cities and neighbourhoods in the UK has documented how many report feeling socially invisible (Menezes et al., 2023). This invisibility often appeared intertwined with a sense of worthlessness as participants stated, "*we're not worth it to anybody anymore*" (Amber, 1049). Comparable findings are evident in emergency department research, where 37% of older adult participants reported feeling like a burden to others, 27% felt they did not belong, and 15% felt they would be better off gone, with 52% reporting at least one of these experiences (Kandasamy et al., 2018).

It is notable that the participants included within the sub-theme of '*Fading From View*' were all female, thus there is a chance this speaks only to the female older adult experience. Whilst we are unable to generalise these findings or make sweeping statements, it is interesting to consider gender differences in the literature. There is literature that suggests older women are more acutely aware of ageism in comparison with older men, who perceive it as a more removed social problem (Hurd Clarke & Korotchenko, 2016). Additionally, an insightful article by Westwood (2023) reported findings from a UK survey on experiences of ageism and sexism by women aged 50 to 89. They argue how older women experience discrimination at the nexus of ageism and sexism and their experiences of nonrecognition and misrecognition are sources of social injustice. There is some evidence in the literature however that men also experience social separation and estrangement. Martin et al. (2019) suggest how men feel obliged to "step aside", due to a perceived threat of them being in a position of power. This makes me wonder whether men in the present study felt they had to put aside their experiences of invisibility when talking to a female interviewer.

The screen appeared to function either as a facilitator or a barrier to closeness between participant and therapist. One participant, for instance, expressed surprise at discovering that video therapy did not allow her to “hide” as she had initially expected (Jackie, 155). Evidence of video as a facilitator of closeness is echoed in Chen et al. (2021), who reported that veterans in video therapy described experiencing greater accountability, with therapists able to observe and respond to subtle cues. Participants also noted feeling a stronger sense of connection with their provider, perceiving them as more present and attentive than during telephone sessions. This sense of presence may enhance relationship quality, aligning with Cacioppo and Patrick’s (2008) argument that, both phylogenetically and ontogenetically, humans depend on the valued presence of others whom they can trust and collaborate with in order to thrive.

However, experiences with closeness varied: one participant experienced a distance and found sessions “unmoving” (Simon, 234). This suggests the screen was a barrier to the therapists attunement or attentiveness to his needs. This is in line with research that suggests therapists convey less empathy working online (Grondin et al., 2019), and how vital communication is lost through video therapies (Schoenenberg et al., 2014). This also aligns with neuroscience findings that online interactions show reduced neural synchrony compared to in-person settings (Trub, 2024; Zhao et al., 2023).

Some participants valued the distance created by video therapy, appreciating the sense of protection it offered. One participant noted, “*I could end the call, if I wanted to*” (Bonnie, 165), framing this as a potential escape from challenging material. Similar findings have been reported in the wider literature, with Moeller et al. (2022) highlighting how video therapy can offer an easy exit, allowing clients to disconnect rather than face difficult relational moments. This raises questions about how often clients actually end sessions prematurely, or whether the reassurance of having that option simply creates a greater sense of comfort. It also points to the variability in individual needs for distance, as research suggests that clients and therapists alike can perceive each other as either too distant or too close, with implications for therapeutic engagement (Egozi et al., 2023).

The screen could also be viewed as rebalancing of power, as clients are able to navigate the power dynamics by controlling the technology (Kolehmainen, 2024). Mitchell (2020) also describes a shift in the power balance in video therapy as both client and therapist share their personal environment; suggesting how the automatic psychological defences that are generated from being in a room are lowered in the remote encounter. Consequences to this equality to the power dynamic can be two-fold. On the one hand, this can support clients to feel less self-conscious (Simpson et al., 2005), which can be particularly important when

dealing with shame-related issues (Simpson et al., 2021). There can be downsides to this balance, however, as it can result in an unwanted closeness (Jesser et al., 2022).

The experience of being able to see the persons face, and them to be able to see your face formed a key part of visibility within therapy. Participants seemed to experience facial expressions as reassuring, creating an environment where they could express themselves freely. There also seemed to be comfort knowing that the therapist could read their facial expressions, which took pressure off verbal communication. Faces have been shown to be reassuring within other studies. Moeller et al. (2022) reported how a participant described how when having a psychological crisis, seeing the therapists face calmed her down as she could better read the therapists' attitude. Seeing the therapists face has also been shown to instil a sense of trustworthiness (Pywell et al., 2020) and is associated with the 'truth' (Synnott, 1997). One participant however, found eye contact to be intimidating, feeling pressured to maintain it, supporting Paradisi et al.'s (2021) argument that eye contact is central to non-verbal communication. The literature on the importance of non-verbal cues has, however, been challenged by Bedi and Duff (2014) who report how non-verbal gestures and body language overall is rated as significantly less important than the therapists validation of the patients experience.

4.3 Key Theories and Concepts

4.3.1 *Relational and Micro Processes in Video Therapy*

The findings of the present study suggest that the processes underpinning the therapeutic relationship were both altered and preserved within video therapy. Therapeutic connection was not determined by the online medium itself, but by how interpersonal processes such as attunement, empathy, trust, and non-verbal communication were experienced through the screen. Rather than portraying video therapy as inherently less relational, participants described a more nuanced experience in which closeness and distance could coexist. These experiences appeared to be shaped by the physical, sensory, visual, and technological conditions through which the therapeutic relationship was enacted.

As video therapy takes place across two separate locations, the physical environment differs for the client and therapist, contrasting with in-person therapy, where both occupy a shared space specifically structured for therapeutic work. The majority of participants received

therapy in their own homes, with one participant attending from a family member's home, while most therapists also worked from their own homes. Researchers have conceptualised the absence of a shared therapeutic space as a loss of spatial location (Frittgen & Haltaufderheide, 2021). However, the present findings suggest that this may be better understood as a transformation of the therapeutic environment rather than an inherent loss, particularly as many participants valued the convenience and comfort of receiving therapy in familiar surroundings. Participants were aware of both their own surroundings and, to some extent, those of their therapists, meaning that features of these environments could become part of the therapeutic encounter. This is consistent with Smith and Gillon (2021), who suggest that working across separate environments can provide therapists with insight into aspects of clients' lives that may remain unseen within a traditional therapy room, including relational and contextual information conveyed through background noise, interruptions, and other features of the home environment.

The separation between physical spaces was experienced as both containing yet exposing. Participants valued the relatively neutral or impersonal nature of the online setting, which could provide a comfortable distance and a greater sense of autonomy within therapy. At the same time, the home environment was more permeable to external intrusion than a dedicated therapy room, with participants describing interruptions such as therapists' pets appearing on screen or features of therapists' environments becoming visible. These interruptions were experienced in different ways: in some cases, the presence of pets provided light relief and increased warmth and safety; in others, aspects of therapists' backgrounds contributed to feelings of unease or unsafety. This reflects concerns outlined in the literature regarding privacy and safety in online therapy, with Smith and Gillon (2021) highlighting therapists' reduced control over privacy and disruptions when working across separate environments.

The sensory dimensions of the therapeutic encounter further shaped experiences of relational connection. Physical proximity and touch have been suggested to contribute to emotional connectedness (Robson & Robson, 1998), and several participants described a sense that something was missing from the interaction, which may reflect the reduced embodied experience of video therapy where physical presence cannot be reproduced through the screen. Smith and Gillon (2021) found that therapists adapt their communication and expressions of empathy to compensate for the loss of physical presence; however, the present findings suggest that, for some participants, such adaptations may not fully compensate for what is experienced as missing.

Nevertheless, the majority of participants did not experience physical distance as a significant barrier to connection. Suler (2004) suggests that the absence of physical co-presence may paradoxically enhance psychological connection by reducing external distractions and allowing greater focus on therapeutic dialogue. This was reflected in the present study, where most participants described becoming absorbed in the therapy session and their relationship with the therapist. Physical distance could also have a protective function, as Frittgen and Haltaufderheide (2021) suggest that the absence of touch may be advantageous during moments of tension, as it reduces the possibility of physical contact being experienced as threatening or intrusive. The differing experiences suggest that physical proximity may be less important than the subjective experience of psychological presence, with clients able to experience a strong sense of connection despite the absence of physical co-presence.

The visual nature of video therapy similarly appeared to both support and constrain relational connection. Participants valued being visually recognised by their therapists, particularly through the perception of subtle facial expressions and emotional cues, illustrating the importance participants placed on being both visually and emotionally recognised by their therapist. Smith and Gillon (2021) found that therapists consciously adapt their online practice to communicate empathy through the medium, and the present findings suggest that these adaptations may be experienced by clients as forms of validation and recognition. However, while the video interface facilitates access to facial expressions, it also restricts the visual field primarily to the face and upper body, limiting access to broader bodily cues (Frittgen & Haltaufderheide, 2021). This may constrain the therapist's ability to perceive embodied expressions of emotion and, as research into therapists' experiences suggests, may contribute to emotional disconnection (Broome & Roberts, 2025). This limitation may be particularly significant given evidence that bodily cues contribute to the interpretation of strong emotions (Aviezer et al., 2012).

Finally, one notable absence from the interviews was the impact of technical difficulties. Although participants commonly anticipated potential difficulties prior to engaging in therapy, only one participant described the therapist's adjustment of the camera as insufficient and as a barrier to connection; with this participant still reporting an overall meaningful and beneficial experience with their therapist. This contrasts with previous research identifying technical difficulties as an important feature of online therapeutic work (e.g., Christensen et al., 2021), with researchers highlighting that they can cause significant disruption to the therapeutic process (Frittgen & Haltaufderheide, 2021). The limited impact of technical difficulties in the present study suggests that their significance may depend on the extent to which they interfere with the therapeutic encounter. Where technology functioned 'well enough', it appeared to

become largely invisible, enabling participants to focus on the therapeutic relationship rather than the medium through which therapy was delivered.

Overall, the findings suggest that video therapy does not remove the relational processes of therapy but rather reconfigures the conditions through which they are experienced. Physical separation, sensory and visual limitations, environmental permeability, and technology each created both potential losses and opportunities for connection. Importantly, these processes were experienced differently across participants, indicating that relational depth in video therapy is not an inherent property of the medium itself, but emerges through the interaction between technology, the therapeutic relationship, and individual experience.

4.3.2 Existential Ageing

“And these people up here make me cry because they are extremely sick.....Some of them had scars all over their one lady, scars all over her head, no hair, walking stick. And I'm like, Good Lord, that I've got more time than her. And, yeah, and it used to make me cry, and I got so depressed.” (Amber, 274).

In exploring older adults' experiences of video therapy, it became apparent, particularly within the first and third theme, that participants were grappling with ageing. Ageing itself carries an existential weight, as it raises issues of mortality, finitude, diminishing roles and shifting identities. By situating participants experiences within an existential framework, we can move beyond a purely social or medical understanding of ageing, to allow for a more nuanced understanding of what shapes an older adult's experience. This feels aptly placed within an IPA paper, with Smith (2019) suggesting how a strong IPA paper pays attention to different layers of experiential or existential meaning, to allow for a richer understanding of participants meaning making, whilst revisiting some of the philosophical roots that underpin both IPA and existentialism.

Existentialism is centred around reflections on life's meaning, personal identity and the inevitability of mortality (Yalom, 1980). Heidegger outlines the significance of time and death and suggests that our awareness of death is what enables an authentic existence. He postulates how only when we face death resolutely are we jolted into an authentic relationship with our own existence through rejecting social norms and expectations.

The term existential ageing was used by Kellehear and Garrido (2023) who conducted a review into the intersection between ageing and dying and used this term to describe an experience of a sense of being near to death, gained from a self-consciousness of the passing years and greater vulnerability and powerlessness. In the present study, participants grappled

with their own mortality, both those who were experiencing ill-health, and those who described themselves as healthy. For example, one stated *“it’s a pity I’m at the end of my life now”* (Jess, 636) and another *“The only thing that really made me cry (in therapy) was thinking about leaving my children and my grandchildren and my husband”* (Bonnie, 127). These references suggest some of their experiences may be also shaped by an unconscious awareness, with Yalom (1980) suggesting how existential anxiety often manifests indirectly and unconsciously.

An awareness of one’s finitude can prompt both distress and opportunities for growth. As outlined in the introduction and also reported within the first theme, many older adults tend to seek psychological support when faced with physical health problems, or faced with their own mortality. Given that the average life expectancy in the UK is 78.8 for males and 82.8 for females (Office for National Statistics, 2024), it is unsurprising that those aged over 65 would be acutely aware of this existential threat, being in the later stages of their life. This is supported in the literature, with Bergman and Bodner (2020) reporting how depression was more likely in those with a heightened sense of their age.

While one participant engaged with their mortality by attending video therapy with a death doula, most participants appeared fearful of life’s end, treating death as something to avoid thinking or speaking about. As reflected in the quote above, they struggled to align themselves with life rather than death. Their difficulty in accepting mortality could be limiting their ability to live authentically, reconcile regrets, and embrace the freedom of shaping their own narrative (Erikson, 1950). From an existential perspective, this avoidance resonates with Sartre’s notion of *bad faith*, in which individuals evade a genuine confrontation with finitude through denial or self-deception.

In contrast to Erikson’s perspective on limited growth, Tornstam (2005) proposes a theory of geotranscendence which describes later life as a stage of potential growth and transformation. Many participants described how they were able to feel seen throughout the therapy, how they were able to transform from feeling invisible to visible, and to feel more valuable in their interactions with others. This is supported by Tornstam’s theory, within which in later life people have a heightened sense of connection, a redefinition of identity and altered relationships with others. Some of these dimensions are reflected in the current study, with participants experiencing connection as being the antidote to loss, and the importance of being seen and of meaningful connections. The importance of a strengths focused approach is highlighted by Weiss (2014) who adds that later-life identities often emerge through generational belonging, which can help offset personal losses by shifting focus from decline to shared experiences.

Additionally, many participants spoke to the way in which therapy had impacted their relationships outside of the therapy room. Although not included as a theme in the final draft,

it feels important to mentioned how the meaningful relationships within the therapy room, were mirrored outside of the therapy room. One participant in particular, described how from only having one therapy session, they were signposted to community events which had been significant in their recovery. This links to the idea of generativity in older age (Villar, 2012) as pursuing meaningful interests, goals, and activities fosters both social development (e.g., contributing to others, community involvement) and personal development (e.g., growth, skills, self-fulfilment). This is a reminder that whilst meaningful connection is valuable within the therapy room, we cannot ignore how much of this healing comes from outside the therapy room, through a sense of community.

Alongside the nearing of death, older people also experience shifts or losses in identity and must find new sources of meaning to maintain psychological wellbeing. In the study, participants experienced invisibility as painful and visibility as healing and supportive. The importance of meaningful connections is echoed in the literature with Green et al. (2017) identifying five domains essential for fulfilment: meaningful relationships, supportive networks, good physical and mental health, financial and housing security, and access to local activities and resources. Each of these domains becomes increasingly vulnerable with age, and losses across them can trigger existential crises, which are challenges that, as Green and colleagues argue, cannot be resolved through medication alone. This is an area with limited research however, with Kellehear and Garrido (2023) highlighting how few studies examine how ageing itself reshapes identity in healthy older adults, with most research centred instead on end-of-life contexts such as cancer or palliative care.

4.3.3 The I-Thou Relationship

The significance of meaningful relationships was highlighted by all participants, and is explored within each theme and will be referred to in turn. Aristotle suggested relationships are moral institutions, and that intimate interactions develop identity and character and relationships can literally change each other (Goodsell & Whiting, 2016). More recently, Martin Buber (1923/1958) coined the term *I-Thou* to describe a mode of presence where individuals encounter each other as whole beings, and described how our truest experience for the world comes through relation, not separation. This stance contrasts with the *I-It* relationship, which is an everyday mode of interaction, wherein people are treated as objects to be used or categorised.

Within '*Fearing Loss*' participants described the emotional impact of the loss or absence of close relationships and the way in which this led to them seek therapy. Their experiences within therapy were then shaped by fearing a loss of connection, anticipating they will be unable to connect with another. Within this theme participants experienced themselves in an *I-It* mode, viewing themselves as incompetent. When participants realised they are able to connect, they experience a sense of relief, as though their fears have been soothed.

In the theme of '*(Un)Safe*' experiences of safety and connection speak directly to the core of the *I-Thou* encounter. Most participants reported how they were able to find a place of psychological safety when having therapy through a screen, either organically or through purposeful adjustments. For some, the absence of a trusting or containing relationship for others elicited a sense of unsafety, threatening the *I-Thou* relationship.

In feeling '*Seen Through a Screen*' participants spoke to how it feels being an invisible older person, and how the *I-It* experience manifested in how society treats them. They experienced feeling seen by the therapist, as they felt listened to, understood, guided, close to and supported, harkening to an *I-Thou* relationship, where facial expressions provided a window to creating this relationship. Some participants, however, felt unseen through the screen and struggled to build an *I-Thou* relationship, experiencing the screen as a barrier to this connection.

The majority of participants appeared to experience an *I-Thou* relationship at points throughout the therapy, demonstrating the video modality as being able to do so. It seems for many, they were able to experience a *psychotherapeutic presence*, which is a process in which the therapist maintains deep respect and reverence for the client's integrity, decentring from their own feelings, needs, and expectations in order to remain fully attuned to the client's process (Erskine, 2011).

The modality of therapy appeared to be less important for participants, and it was unclear as to what therapy all but one participant had. From their descriptions and experiences highlighted in the themes, the therapeutic relationship formed a key part of their experience, although it is unclear as to whether this was intentional or unintentional by the therapist. Person centred therapy was developed by Carl Rogers' (1957) and essentially translates Buber's concept of *I-Thou* into a therapeutic framework. Both Buber and Rogers emphasise that meaningful change begins within the individual and emerges through the relationship with the other (Merrill, 2008). Rogers (1957) further outlined that, under the right conditions, all people have the capacity for growth. Within a therapeutic *I-Thou* relationship, the therapist facilitates this growth by embodying unconditional positive regard, empathy, and congruence.

Support for the importance of the *I-Thou* relationship is highlighted in medical research, where even when the treatment is placebo, being heard and valued by medical professionals is curative (Kaptchuk et al., 2008). This is mirrored even more crucially in psychological therapy, as clients often cite a trusting relationship, as more helpful than the technical skills therapists utilise (Fife et al., 2014); and therapists who take the relationship seriously enhance psychotherapy (Slife & Wiggins, 2009). When considering counselling psychology as a field in particular, Amari (2020) describes four key ingredients for effective counselling psychology practice, based on the *I-Thou* relationship; surprise in the encounter, confirmation as acceptance of a clients becoming, trust as openness to the unknown and direction as commitment to ethics.

Within the present study participants described feeling seen within the therapeutic relationship as being fundamental to their experience. There was however some evidence of gender differences in the experiences of male (n=2) and female (n=6) participants in their descriptions of their connection to the therapist and their relationship. Male participants tended to be more descriptive and matter of fact, using words such as “*she responded effectively*” (Simon, 50). Women, on the other hand, used more emotive language, such as “*gentleness and warmth about her*” (Lorraine, 403). This could be idiosyncratic to the participants experiences in this study, and there could be a range of explanations for this noted difference. However, Arora and Bhatia (2022) argue that there are gender differences in the factors influencing therapeutic outcomes. They found how while both men and women placed equal value on the therapeutic relationship, men were more sensitive to elements that hindered the process and more frequently reported a sense of “something missing” in sessions.

4.4 Review and Conclusion

4.4.1 Impact of Findings to Counselling Psychology

This study offers valuable insight into how older adults experience video therapy and is particularly important given the limited attention this population has received within research, making it a field that remains both under-resourced and under-explored. The lack of focus on older adults has even been described as a crisis, as research reports how in the USA, only 1.2% of doctoral psychologists surveyed specialised in geropsychology, (Moye et al., 2019) while less than 1% of published articles addressed issues concerning older adults (Keum, 2018). This is reflected in the literature review which highlighted just how little research exists

in this area, emphasising the importance of contributing to this field within Counselling Psychology.

The theme of existential ageing highlights the unique experience and context of older adults, something which can be difficult for working age professionals such as myself to fully grasp. We can however, encourage open discussions around what it is like to be an older adult, including topics around shifting identities and the finitude of life. As outlined in the findings, older adults can be likely to view themselves and their experiences as invisible, and therefore it is our responsibility to bring visibility, and to be interested in some of these unique experiences.

This invisibility may manifest by older adults not expressing their opinions and being more likely to withdraw or be guarded when feeling unsafe within therapy. We must be closely attuned to their experience to be able to notice when this happens, and pay attention to the implicit, as well as the explicit. Establishing an open dialogue between therapist and client is therefore essential, as the conditions that foster safety are likely to vary from person to person. It is important as counselling psychologists we pay close attention to the power imbalance held within the therapeutic interaction and take initiative to open communication channels about their experience of therapy, during therapy.

This research highlights how a meaningful *I-Thou* relationship can be forged over the screen, with participants experiencing a closeness and felt presence of the therapist, despite not being in the room with them. This suggests that video therapy can be an effective and viable therapeutic option for older people wanting to access support from their own homes. There were, however, idiosyncrasies in the experience, and it is also possible that some people may experience the screen as a barrier, or there be a noticeable emotional distance through the screen. This emphasises the importance of client preference and responding to the needs of the individual. One participant (Simon) did make recommendations for overcoming some of the strangeness of working online, suggesting an open dialogue between therapist and client about how it feels to be working in this way, which could at least take some steps towards bringing client and therapist closer.

Although not explicitly described in the analysis due to the limited applicability to the research question, participants described the importance of meaningful relationships occurring outside of the therapy room as a result of therapy. It became apparent through conducting the research that there is a wealth of community services available, including Age UK, which offers a wide range of social groups for older people. This, for one participant (Amber), proved to be more transformative than the therapy itself. Therefore, it is important for the profession to be

aware of collaborative working, having a good knowledge of local resources and being able to signpost clients appropriately.

Additionally, this study echoed findings from the literature review, reporting how older adults may be less likely to seek psychological support, and more likely to be concerned with and present with somatic symptoms. This emphasises the need for joint working between physical and mental health providers. It also emphasises the importance of challenging ageist assumptions within healthcare providers, particularly as Yin et al. (2024) report how older adults are strongly influenced by the attitudes of those around them, including trusted healthcare professionals.

4.4.2 Recommendations for Practice

The findings of this study suggest that video therapy can provide meaningful and relationally valuable experiences for older adults, but that its suitability cannot be assumed on the basis of age or technological accessibility alone. Video therapy appears to reconfigure, rather than remove, the conditions through which therapeutic connection, safety and presence are experienced. Recommendations should therefore recognise the individual and relational nature of these experiences.

Firstly, therapists should create opportunities for clients to discuss how they experience therapy through the screen. Participants varied considerably in their experiences of connection, distance, visibility and trust, suggesting that the medium itself can become part of the therapeutic process. Therapists could therefore invite ongoing dialogue about whether the client feels connected and able to communicate openly, particularly when difficulties in engagement emerge. This may also help identify internalised ageism, including shame or self-blame about technological difficulties, without assuming that older adults are inherently less technologically capable.

Secondly, therapists should attend to the physical and relational environment in which video therapy takes place. Participants experienced their home environments as both containing and potentially distracting, while therapists' backgrounds and interruptions could either humanise the encounter or undermine safety. Therapists should therefore consider how their own visible environment may affect clients and collaboratively explore whether clients' environments support privacy and engagement. Preparation and transition time before and after sessions may also help compensate for the loss of the physical journey into and out of face-to-face therapy.

Thirdly, therapist training and supervision should incorporate the relational and phenomenological dimensions of video therapy alongside technical competence. Participants demonstrated that facial visibility, eye contact, physical distance and environmental separation could each facilitate or inhibit connection. Training should therefore support therapists to recognise altered forms of presence and non-verbal communication and to remain attentive to moments when the screen may be experienced as either protective or distancing. Therapists should reflect on their own attitudes and anxieties around video therapy. For example, noticing when they may brush past an interruption rather than using it as an opportunity to explore; or when their own attitudes could be impacting disconnection (Rathenau et al., 2022).

Finally, practitioners should remain open to the existential and social dimensions of later life. Participants' experiences of loss and invisibility suggest that these concerns may form an important context for psychological distress, while meaningful relationships and community participation may also support wellbeing. Therapists should therefore be willing to explore these issues when relevant to the client, while avoiding assumptions that later life is defined solely by decline or loss.

Services should provide genuine choice between video, telephone and face-to-face therapy wherever clinically and practically feasible, rather than treating video as an inherently inferior or universally accessible option for older adults. Digital inclusion should similarly be understood as extending beyond access to devices and internet connectivity to include psychological and relational accessibility. Services should also support practitioners through appropriate training and supervision in age-sensitive and relationally informed video therapy. Greater collaboration between physical and psychological healthcare may further support help-seeking, particularly where psychological distress is initially expressed through physical health concerns. Finally, services should develop links with community resources, recognising that meaningful connection and recovery in later life may extend beyond the therapy room. Overall, policy should support video therapy as an important option for older adults while ensuring that choice and relational quality remain central to its delivery.

4.4.3 Final Reflections

My position as an ‘outsider’ researcher sometimes made participants’ experiences difficult to fully grasp. Having experienced relatively few losses and still holding visibility within society, it was challenging to truly imagine what it feels like to be an older person living within this context. Within one of the interpretations, I noticed myself recoiling as the participant described their experiences with loss and death. This gave me a sense as to how as professionals we can turn away from older adults, as perhaps it is a reminder of the finitude of life. The literature suggests it is common for therapists to struggle to connect to older adults’ experiences, and noted how we employ defensive strategies to cope with our own fears of death (Lederman and Shefler, 2023).

The research process itself was enlightening, with gatekeepers to services posing as barriers to conducting research. Further insight came from the participants who were therapists themselves, who reflected on how they had prior assumptions about video therapy being inferior to in-person therapies. However, they all reported how their lived experience of video therapy differed to what they had been taught within their training courses. This tension is highlighted by Bonnie, who stated “*Personally, as a therapist, I prefer to have people in the room..But as a client, I think I prefer zoom....*” (Bonnie, 144). This highlights the important roles of training institutions and emphasises the cost of the paucity of research into lived experiences, meaning training courses are not informed by service user experience.

Further reflection comes from noticing how some participants preferred to focus on their external world and context, as opposed to their internal world, suggesting they were even invisible to themselves. For some participants several years had passed since their therapy, and the detail or richness of their experiences seemed to be lost; whether it had faded from their memory, or whether there were barriers to them expressing themselves in the interview. This could reflect experiences noted within the themes around invisibility and difficulties remembering or expressing internal experiences. I note that this could have affected the depth to which participants were able to speak to their experience, and with hindsight, I could have made more time in the pre-screening calls to ensure participants were able to talk about their internal experience in detail.

Another methodology critique comes from reflecting on the role of language within the present study, something highlighted by Willig (2022), who suggests language does not simply describe reality but actively constructs it, meaning that participants’ choice of words offers insight into how they frame their experiences rather than the experiences themselves. This was evident in the present study when Martin described connecting “*miraculously*” (Martin,

196). He later used the word again to describe an unrelated experience to video therapy. This suggests this word may be a habitual feature of his vocabulary and perhaps carried less weight than my initial interpretation implied.

One of the most challenging aspects of the research was to open my mind to thinking creatively and to look below the surface of experience. Having a background as a CBT therapist, I have historically been drawn to the concrete. This felt like a battle within the research process, as when I would be stuck, I naturally sought security in the logical and evidence based. This became a process of being pulled into the concrete, and pulling myself away, which became easier as the course, and the research project progressed. I reflect that this could have impacted the study, particularly within earlier interviews, when my follow-up questions could have been more positivist leaning, which is in direct contrast with guidance by Willig (2022) to always ask open ended and non-directive questions. The later interviews reflected my journey not only as a researcher, but as a therapist, where I became more comfortable with less structure and greater fluidity.

4.4.4 Future Directions for Research

Future research could build on the present findings by further exploring how older adults make sense of video-based psychological therapy across different social and cultural contexts. The present sample comprised eight White British participants, with greater representation of women than men and no participants aged over 80. Further qualitative research should therefore seek to include older adults who remain under-represented within the literature, including those from diverse ethnic, cultural and socioeconomic backgrounds and different age groups, particularly those aged over 80. This is important not only to establish whether the experiences identified in the present study are shared across groups, but also to avoid treating the experiences of a relatively homogeneous sample as representative of older adults more broadly.

Gender also warrants further investigation. Although the present study was not designed to examine gender differences, there was a higher proportion of female participants, who appeared to speak in greater depth about experiences of invisibility. This is echoed in previous research which identified differences in working alliance between men and women in online therapy (Aafjes-van Doorn et al., 2021). Future research could therefore explore whether gender shapes experiences of visibility and relational connection within video-based therapy.

The findings also highlight the need for greater attention to the sensory and embodied dimensions of video-based therapy. Participants described experiences that may reflect changes or absences in sensory information, including the lack of physical co-presence and differences in what can be sensed and experienced across separate environments. Frittgen and Haltaufderheide (2021) similarly highlight the limited attention given to senses such as smell within digitally mediated therapeutic encounters. Future qualitative research could therefore investigate more explicitly how sensory information contributes to clients' experiences and memories of therapy, including whether clients develop ways of intentionally incorporating sensory or environmental cues into the therapeutic encounter. This could provide a more nuanced understanding of how the therapeutic environment is constructed when therapy takes place outside a dedicated clinical space.

Comparative research could further clarify which aspects of the present findings are specific to video therapy and which may reflect broader processes within psychological therapy in later life. Comparisons between video, telephone and face-to-face therapy could examine differences in experiences of connection, safety, visibility and therapeutic presence. There may also be value in exploring differences between therapeutic modalities, such as cognitive behavioural, person-centred and psychodynamic approaches, particularly given that different modalities may place different demands on sensory and relational communication.

A further avenue for research would be to explore the experiences of video therapy through a narrative approach. Participants frequently situated their experiences of therapy within the broader context of their lives, including experiences of loss and transitions in later life. A narrative methodology may therefore offer a complementary way of understanding how older adults construct meaning around video therapy in relation to their wider life stories, rather than examining the therapeutic encounter in isolation. It may also provide greater insight into how participants position video therapy within their ongoing processes of adaptation and meaning-making in later life.

Finally, longitudinal qualitative research could also examine how these experiences develop over time. The present findings suggest that the significance of technology and the physical environment may change as familiarity with video therapy increases and the therapeutic relationship becomes established. Following participants across the course of therapy could therefore provide insight into whether initial concerns about video therapy diminish, persist, or acquire different meanings over time.

4.4.5 Conclusion

In conclusion, this study set out to explore how older adults experience video therapy. Through an Interpretative Phenomenological Analysis, three overarching themes were identified: 'Fearing Loss', 'Un(Safe)', and 'Seen Through a Screen'. Within 'Fearing Loss', participants expressed fears around connecting with their therapist, with ultimately all participants establishing a connection. Participants also reflected on their sense of feeling '(Un)Safe' in video therapy, noting how being at home could foster both comfort and convenience, but also a sense of guardedness. Finally, participants described experiences of being 'Seen Through a Screen' and feelings of both closeness and distance.

This study suggests that video therapy can be an acceptable and beneficial mode of delivering psychological support for many older adults, with the screen being both a facilitator and barrier to closeness and communication. This variation highlights the importance of recognising the individuality of older adults' needs, rather than assuming homogeneity within this age group. The findings are especially significant given the social invisibility that many older adults experience, and it suggests that video therapy may serve as one means of countering this invisibility by providing spaces in which they feel seen and heard.

Ultimately, I hope this research encourages other psychologists to contribute to this field with openness and curiosity, challenging both professional and societal ageism while seeking innovative ways to support older adults' psychological wellbeing. As I continue to fly the flag of visibility for older adults, I end on a quote from the interviews:

"I'm still riding along on the excitement of everything. It's, it's quite strange. It's been... it's been building up and building up and building up. And it's like (phew) I need a rest now! Oh, now, what have I got to do tomorrow? Put the clock on whereas, you know, going, going back eight months ago, it was like I can't be arsed to get out of bed, what for..... Now me calendars, full. I keep the calendar behind the door, like a lot of old people and write it all on... the calendars our little Bible, and then we look at it every night. So we know what we're doing in the mornings. I just like, volunteer for everything (laughs happily)." (Amber, 410).

References

- Aafjes-van Doorn, K., Békés, V., & Prout, T. A. (2021). Grappling with our therapeutic relationship and professional self-doubt during COVID-19: Will we use video therapy again? *Counselling Psychology Quarterly*, 34(3–4), 473–484.
<https://doi.org/10.1080/09515070.2020.1773404>
- Aafjes-van Doorn, K., Békés, V., Stukenberg, K. W., & Roberts, K. E. (2024). Therapists' views and recommendations on the ins and outs of practicing teletherapy. *Counselling Psychology Quarterly*, 37(3), 398–418.
<https://doi.org/10.1080/09515070.2023.2227133>
- Abrahamsson, N., Ahlund, L., Ahrin, E., & Alfonsson, S. (2018). Video-based CBT-E improves eating patterns in obese patients with eating disorder: A single case multiple baseline study. *Journal of Behavior Therapy and Experimental Psychiatry*, 61, 104–112. <https://doi.org/10.1016/j.jbtep.2018.06.010>
- Age UK (2017, October 5). *Half of adults aged 55 and over have experienced mental health problems, says Age UK*. <https://www.ageuk.org.uk/latest-news/articles/2017/october/half-aged-55-have-had-mental-health-problems/>
- Age UK (2019a). *Later life in the United Kingdom*.
https://www.ageuk.org.uk/siteassets/documents/reports-and-publications/late_life_uk_factsheet.pdf
- Age UK (2019b). *Mental Health (England)*.
https://www.ageuk.org.uk/siteassets/documents/policy-positions/health-and-wellbeing/ppp_mental_health_england.pdf
- Age UK (2020, July 21). *Understanding Frailty*. <https://www.ageuk.org.uk/our-impact/policy-research/frailty-in-older-people/understanding-frailty/>
- Age UK (2023). *The State of Health and Care of Older People in England 2023*.
https://www.ageuk.org.uk/siteassets/documents/reports-and-publications/reports-and-briefings/health--wellbeing/age_uk_briefing_state_of_health_and_care_of_older_people_july2023.pdf
- Age UK (2024). *NHS Talking Therapies Positive Practice Guide: Older People (2024)*.
<https://www.ageuk.org.uk/siteassets/documents/professionals/mental-health-hub/nhs-talking-therapies-older-people-positive-practice-guide-2024.pdf>

- Age UK (2025, January). *Helping Older People Get Online*. <https://www.ageuk.org.uk/our-impact/programmes/digital-skills/>
- Amari, N. (2020). Counseling psychology practice as the pursuit of the I-Thou relationship. *The Humanistic Psychologist*, 48(4), 410-426. <https://doi.org/10.1037/hum0000155>
- American Psychological Association (2023, October 15). *APA Dictionary of Psychology*. <https://dictionary.apa.org/psychotherapy>
- Andrews, J. A., Brown, L. J., Hawley, M. S., Astell, A. J. (2019). Older adults' perspectives on using digital technology to maintain good mental health: interactive group study. *Journal of Medical Internet Research*, 21(2), e11694. <https://doi.org/10.2196/11694>
- American Psychological Association (2015). *Survey of psychology health service providers*. <https://www.apa.org/workforce/publications/15-health-service-providers/report.pdf>
- Arora, S., & Bhatia, S. (2022). Gender differences in factors that facilitate successful therapeutic progress and outcome: A pilot study. *Counselling and Psychotherapy Research*, 22 (4), 1030-1040. <https://doi.org/10.1002/capr.12564>
- Aviezer, H., Trope, Y., & Todorov, A. (2012). Body cues, not facial expressions, discriminate between intense positive and negative emotions. *Science*, 338(6111), 1225–1229. <https://doi.org/10.1126/science.1224313>
- Ball, C., Francis, J., Huang, K., Kadylak, T., Cotten, S. R., & Rikard, R. V. (2019). The Physical–Digital divide: Exploring the social gap between digital natives and physical natives. *Journal of Applied Gerontology*, 38(8), 1167-1184. <https://doi.org/10.1177/0733464817732518>
- Barbour, R. (2007). *Introducing Qualitative Research: A Student Guide to the Craft of Doing Qualitative Research*. Sage Publications. London.
- Bartels, S. J., & Naslund, J. A. (2013). The underside of the silver tsunami—Older adults and mental health care. *The New England Journal of Medicine*, 368, 493–496. doi:10.1056/NEJMp1211456
- Bedi, R. P., & Duff, C. T. (2014). Client as expert: A Delphi poll of clients' subjective experience of therapeutic alliance formation variables. *Counselling Psychology Quarterly*, 27(1), 1–18. <https://doi.org/10.1080/09515070.2013.857295>
- Bergman, Y. S., & Bodner, E. (2020). Age is not just a number: Age awareness, subjective nearness-to-death, self-esteem, and depressive symptoms among older adults. *Aging & Mental Health*, 24(6), 906-913. <https://doi.org/10.1080/13607863.2019.1566815>

- Bhaskar, R. (2008). *A realist theory of science*. Routledge. (Original work published 1975)
- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, 16(3), 252–260. <https://doi.org/10.1037/h0085885>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Broome, K. L., & Roberts, S. (2025). How do counsellors make sense of the online disinhibition effect when counselling clients via video-conferencing? An interpretative phenomenological analysis study. *Counselling and Psychotherapy Research*, 25(4), e70054. <https://doi.org/10.1002/capr.70054>
- Buber, M. (1958). *I and Thou* (2nd ed.; R. G. Smith, Trans.). Edinburgh, UK: T & T. Clark Ltd. (Original work published 1923)
- Butler, R. N., Lewis, M. L. (1982). *Aging and mental health: positive, psychosocial and biomedical approaches*. (3rd ed.) St Louis: Mosby.
- Cacioppo, J. T., & Patrick, W. (2008). *Loneliness: Human nature and the need for social connection*. W. W. Norton & Company.
- Campbell, R., Podugu, Sai Durga Vara Prasada Rao, & Morris, M. (2025). Online acceptance and commitment therapy for chronic pain in an older adult: A telehealth approach amid COVID-19. *Clinical Gerontologist*, 48(4), 844-854. <https://doi.org/10.1080/07317115.2025.2487008>
- Carr, D., & Utz, R. L. (2020). Families in later life: A decade in review. *Journal of Marriage and Family*, 82(1), 346–363. <https://doi.org/10.1111/jomf.12609>
- Carr, M. J., Wright, A. K., Leelarathna, L., Thabit, H., Milne, N., Kanumilli, N., Ashcroft, D. M., & Rutter, M. K. (2021). Impact of COVID-19 on diagnoses, monitoring, and mortality in people with type 2 diabetes in the UK. *The lancet. Diabetes & endocrinology*, 9(7), 413–415. [https://doi.org/10.1016/S2213-8587\(21\)00116-9](https://doi.org/10.1016/S2213-8587(21)00116-9)
- Centre of Disease and Prevention (2025, March 25). *Suicide Data and Statistics*. <https://www.cdc.gov/suicide/facts/data.html>
- Chakrabarti, S. (2015). Usefulness of telepsychiatry: A critical evaluation of videoconferencing-based approaches. *World Journal of Psychiatry*, 5, 286-304. <https://doi.org/10.5498/wjp.v5.i3.286>

- Chen, P. V., Helm, A., Caloudas, S. G., Ecker, A., Day, G., Hogan, J., & Lindsay, J. (2022). Evidence of Phone vs Video-Conferencing for Mental Health Treatments: A Review of the Literature. *Current psychiatry reports*, 24(10), 529–539. <https://doi.org/10.1007/s11920-022-01359-8>
- Chen, P. V., Helm, A., Fletcher, T., Wassef, M., Hogan, J., Amspoker, A., Cloitre, M., & Lindsay, J. (2021). Seeing the value of video: A qualitative study on patient preference for using video in a veterans affairs telemental health program evaluation. *Telemedicine Reports*, 2(1), 156-162. <https://doi.org/10.1089/tmr.2021.0005>
- Chinn, J. J., Martin, I. K., & Redmond, N. (2021). Health Equity Among Black Women in the United States. *Journal of Women's Health* 30(2): 212–219. <https://doi.org/10.1089/jwh.2020.8868>.
- Chochinov, H. M. (2012). *Dignity therapy: Final words for final days*. Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780195176216.001.0001>
- Choi, N. G., Hegel, M. T., Marti, N., Marinucci, M. L., Sirrianni, L., & Bruce, M. L. (2014). Telehealthproblem-solving therapy for depressed low-income homebound older adults. *The American Journal of Geriatric*, 22, 263–271. <https://doi.org/10.1097/JGP.0b013e318266b356>
- Choi, N. G., Marti, C. N., & Conwell, Y. (2016). Effect of problem-solving therapy on depressed low-income homebound older adults' Death/Suicidal ideation and hopelessness. *Suicide & Life-Threateneing Behavior*, 46(6), 323-336. <https://doi.org/10.1111/sltb.12195>
- Christensen, L. F., Wilson, R., Hansen, J. P., Nielsen, C. T., & Gildberg, F. A. (2021). A qualitative study of patients' and providers' experiences with the use of videoconferences by older adults with depression. *International Journal of Mental Health Nursing*, 30(2), 427-439. <https://doi.org/10.1111/inm.12803>
- Clancy, M. (2013). Is reflexivity the key to minimising problems of interpretation in phenomenological research? *Nurse Researcher*, 20(6), 12–16. <https://doi.org/10.7748/nr2013.07.20.6.12.e1209>
- Cocuzzo, B., Wrench, A., & O'Malley, C. (2022). Effects of COVID-19 on Older Adults: Physical, Mental, Emotional, Social, and Financial Problems Seen and Unseen. *Cureus*, 14(9), e29493. <https://doi.org/10.7759/cureus.29493>
- Conrad, P. (1987). The experience of illness: Recent and new directions. *Research in the Sociology of Health Care*, 6, 1-31.

- Cremers, G., Taylor, E., Hodge, L., & Quigley, A. (2022). Effectiveness and acceptability of low-intensity psychological interventions on the well-being of older adults: A systematic review. *Clinical Gerontologist*, 45(2), 214-234. <https://doi.org/10.1080/07317115.2019.1662867>
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process* (1st ed.). Routledge.
- Cudjoe, E. (2023). Making Sense of Husserlian Phenomenological Philosophy in Empirical Research. *International Journal of Qualitative Methods*, 22. <https://doi.org/10.1177/16094069231171099>
- Diesing, P. (1966). Objectivism vs. Subjectivism in the Social Sciences. *Philosophy of Science*, 33(2), 124-133. Doi:10.1086/288081
- DiNapoli, E. A., Pierpaoli, C. M., Shah, A., Yang, X., & Scogin, F. (2017). Effects of home-delivered cognitive behavioral therapy (CBT) for depression on anxiety symptoms among rural, ethnically diverse older adults. *Clinical Gerontologist*, 40(3), 181-190. <https://doi.org/10.1080/07317115.2017.1288670>
- Eatough, V. & Smith, J. (2017). Interpretative Phenomenological Analysis. In Stainton Rogers, W. & Willig, C. (Eds.), *The sage handbook of qualitative research in psychology* (2nd eds), pp. 193-211. SAGE Publications Ltd. <https://doi.org/10.4135/9781526405555>
- Egozi, S., Talia, A., Wiseman, H., Tishby, O. (2023). The experience of closeness and distance in the therapeutic relationship of patients with different attachment classifications: An exploration of prototypical cases. *Frontiers in Psychiatry*, 14, 1029783. <https://doi.org/10.3389/fpsy.2023.1029783>
- Ellis, D. M., Draheim, A. A., & Anderson, P. L. (2022). Culturally adapted digital mental health interventions for ethnic/racial minorities: A systematic review and meta-analysis. *Journal of Consulting and Clinical Psychology*, 90(10), 717–733. <https://doi.org/10.1037/ccp0000759>
- Enoch, J., Subramanian, A., & Willig, C. (2023). “If I don’t like it, I’ll just pop the phone down!”: Reflecting on participant and researcher experiences of telephone interviews conducted during the COVID-19 pandemic. *SSM - Qualitative Research in Health*, 4, 100351. <https://doi.org/10.1016/j.ssmqr.2023.100351>
- Erikson, E. H. (1950). *Childhood and society*. New York, NY: Norton.

- Erskine, R. G. (2011). Attachment, relational-needs, and psychotherapeutic presence. *International Journal of Integrative Psychotherapy*, 2, 10–18.
- Fallon, J., Bhar, S., & Quinn, S. (2024). Telehealth dignity therapy for community-dwelling older adults: Feasibility and potential efficacy. *The Journal of Positive Psychology*, 19(6), 1109-1118. <https://doi.org/10.1080/17439760.2023.2298957>
- Fife, S. T., Whiting, J. B., Bradford, K., & Davis, S. (2014). The therapeutic pyramid: A common factors synthesis of techniques, alliance, and way of being. *Journal of Marital and Family Therapy*, 40(1), 20–33. <https://doi.org/10.1111/jmft.12041>
- Fishbane, M.
- Finlay L, Ballinger C (2006) *Glossary*. In: Finlay L, Ballinger C (Eds) *Qualitative Research for Allied Health Professionals: Challenging Choices*. Whurr Publishers, Chichester.
- Finlay, L. (2002). "Outing" the researcher: The provenance, process and practice of reflexivity. *Qualitative Health Research*, 12(4), 531-545. <https://doi.org/10.1177/104973202129120052>
- Finlay, L. (2008). A dance between the reduction and reflexivity: Explicating the "phenomenological psychological attitude". *Journal of Phenomenological Psychology*, 39(1), 1–32. <https://doi.org/10.1163/156916208X311601>
- Fluckiger, C., Del Re, A. C., Wampold, B. E., & Hovarth, A. O., (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy (Chicago, Ill.)*, 55(4), 316-340. <https://doi.org/10.1037/pst0000172>
- Forman, D. E., Berman, A. D., McCabe, C. H., Baim, D. S., & Wei, J. Y. (1992). PTCA in the elderly: the "young-old" versus the "old-old". *Journal of the American Geriatrics Society*, 40(1), 19–22. <https://doi.org/10.1111/j.1532-5415.1992.tb01823.x>
- Fortuna, K. L., Torous, J., Depp, C. A., Jimenez, D. E., Arean, P. A., Walker, R., Ajilore, O., Goldstein, C. M., Cosco, T. D., Brooks, J. M., Vahia, I. V., & Bartels, S., J. (2019). A future research agenda for digital geriatric mental healthcare. *The American Journal of Geriatric Psychiatry*, 27 (11), 1277 – 1285. <https://doi.org/10.1016/j.jagp.2019.05.013>
- Frittgen, E., & Haltaufderheide, J. (2022). 'Can you hear me?': Communication, relationship and ethics in video-based telepsychiatric consultations. *Journal of Medical Ethics*, 48(1), 22–30. <https://doi.org/10.1136/medethics-2021-107434>
- Fronza Pacas, G., Mitchel, L. K., Pachana, N. A., Byrne, G. J., Liddle, J., Yang, J., Brooks, D., Au, T., Pourzinal, D., Worthy, P., Comans, T., Beattie, E., Bennett, S., Russell, T.,

- & Dissanayaka, N. N. (2025). Telehealth cognitive behavior therapy to reduce anxiety in people living with cognitive impairment: A randomized feasibility pilot study. *Clinical Gerontologist*, 48(4), 684-698. <https://doi.org/10.1080/07317115.2024.2336187>
- Frost, N., Nolas, S. M., Brooks-Gordon, B., Esin, C., Holt, A., Mehdiadeh, L., & Shinebourne, P. (2010). Pluralism in qualitative research: The impact of different researchers and qualitative approaches on the analysis of qualitative data. *Qualitative research: QR*, 10(4), 441-460. <https://doi.org/10.1177/1468794110366802>
- Fullen, M. C. (2018). Ageism and the Counselling Profession: Causes, Consequences, and Methods for Counteraction. *The Professional Counsellor*, 8, 104-114. <https://doi.org/10.15241/mcf.8.2.104>
- Gallagher, S. (2022). *Phenomenology* (2nd ed.). Springer International Publishing. <https://doi.org/10.1007/978-3-031-11586-8>
- Galletta, A., & Cross, W. E. (2013). *Mastering the semi-structured interview and beyond: From research design to analysis and publication*. New York University Press. <https://doi.org/10.18574/9780814732953>
- Goodarzi, Z., Holroyd-Leduc, J., Seitz, D., Ismail, Z., Kirkham, J., Wu, P., Fox, L., Hykaway, W., Grossman, L., Ewa, V., Veroniki, A. A., Tricco, A. C., Straus, S., & Watt, J. (2022). Efficacy of virtual interventions for reducing symptoms of depression in community-dwelling older adults: A systematic review. *International Psychogeriatrics*, 35(3), 131-141. <https://doi.org/10.1017/S1041610222000412>
- Goodsell, T. L., & Whiting, J. B. (2016). An Aristotelian theory of family. *Journal of Family Theory & Review*, 8(4), 484–502. <https://doi.org/10.1111/jftr.12169>
- Gould, C. E., Loup, J., Kuhn, E., Beaudreau, S. A., Ma, F., Goldstein, M. K., Wetherell, J. L., Zapata, A. M. L., Choe, P., & O'Hara, R. (2020). Technology use and preferences for mental health self-management interventions among older veterans. *International Journal of Geriatric Psychiatry*, 35(3), 321-330. <https://doi.org/10.1002/gps.5252>
- Green, M., Iparraguirre, J., Davidson, S., Rossall, P., Zaidi, A. (2017). *Index of Wellbeing in Later Life*. Age UK. <https://asauk.org.uk/wp-content/uploads/2018/02/AgeUK-Wellbeing-Index-Summary-web.pdf>
- Grondin, F., Lomanowska, A. M., & Jackson, P. L. (2019). Empathy in computer-mediated interactions: A conceptual framework for research and clinical practice. *Clinical Psychology (New York, N. Y.)*, 26(4), 17-n/a. <https://doi.org/10.1111/cpsp.12298>

- Gros, D. F., Morland, L. A., Greene, C. J., Acierno, R., Strachan, M., Egede, L.E., Tuerk, P. W., Myrick, H., & Frueh, B. (2013). Delivery of evidence-based psychotherapy via video telehealth. *Journal of Psychopathology and Behavioral Assessment*, 35(4), 506-521. <https://doi.org/10.1007/s10862-013-9363-4>
- Gross, P. E., & Eshbaugh, E. M. (2011). Tuning them in versus turning them on: How do we interest students in working with older adults? *Gerontology & Geriatrics Education*, 32, 122–134. doi:10.1080/02701960.2011.572037
- Halliday, M .A. K. (1973). *Explorations in the Functions of Language*. London: Edward Arnold.
- Hannes, K., Lockwood, C., & Pearson, A. (2010). A comparative analysis of three online appraisal instruments' ability to assess validity in qualitative research. *Qualitative health research*, 20(12), 1736–1743. <https://doi.org/10.1177/1049732310378656>
- Hantke, N., Lajoy, M., Gould, C. E., Magwene, E. M., Sordahl, J., Hirst, R., & O'Hara, R. (2020). Patient Satisfaction With Geriatric Psychiatry Services via Video Teleconference. *The American journal of geriatric psychiatry : official journal of the American Association for Geriatric Psychiatry*, 28(4), 491–494. <https://doi.org/10.1016/j.jagp.2019.08.020>
- Harerimana, B., Forchuk, C., O'Regan, T. (2019) The use of technology for mental healthcare delivery among older adults with depressive symptoms: a systematic literature review. *International Journal of Mental Health Nursing*, 28(3):657–670. <https://doi.org/10.1111/inm.12571>
- Hatcher, D., Chang, E., Schmied, V., & Garrido, S. (2019). Exploring the Perspectives of Older People on the Concept of Home. *Journal of aging research*, 2019, 2679680. <https://doi.org/10.1155/2019/2679680>
- Health and Care Professions Council. (2016). *Guidance on conduct and ethics for students*. HCPC. <https://www.hcpc-uk.org/globalassets/resources/guidance/guidance-on-conduct-and-ethics-for-students.pdf>
- Hegeman, J. M., de Waal, M. W. M., Comijs, H. C., Kok, R. M., & van der Mast, R. C. (2015). Depression in later life: A more somatic presentation? *Journal of Affective Disorders*, 170, 196-202. <https://doi.org/10.1016/j.jad.2014.08.032>
- Heidegger M. (1962). *Being and time*. New York: Harper. (Original work published 1927).

- Horackova, K., Kopecek, M., Machů, V., Kagstrom, A., Aarsland, D., Motlova, L. B., & Cermakova, P. (2019). Prevalence of late-life depression and gap in mental health service use across European regions. *European Psychiatry*, 57, 19-25.
- Hubley, S., Lynch, S. B., Schneck, C., Thomas, M. & Shore, J. (2016). Review of key telepsychiatry outcomes. *World Journal of Psychiatry*, 6, 269.
- Hughes, E. (2022). The depths of temporal desynchronization in grief. *Psychopathology*, 55(5), 362-372. <https://doi.org/10.1159/000525261>
- Hurd Clarke, L. & Korotchenko, A. (2016). 'I Know It Exists ... but I Haven't Experienced It Personally': Older Canadian Men's Perceptions of Ageism as a Distant Social Problem. *Ageing & Society*, 36(8), 1757-1773.
- Husserl E. (1970). *The crisis of European sciences and transcendental phenomenology: An introduction to phenomenological philosophy*. Northwestern University Press.
- Husserl E. (1983). *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy. First book* (F. Kersten, Trans.). Nijhoff (German original 1913).
- Husserl E. (2000). *Logical investigations I–II* (transl. JN Findley). Routledge.
- Ilali, M., Le Berre, M., Vedel, I., & Khanassov, V. (2023). Telemedicine in the primary care of older adults: A systematic mixed studies review. *BMC Family Practice*, 24(1), 152-21. <https://doi.org/10.1186/s12875-023-02085-7>
- Isaacs Russell G. (2015) *Screen Relations: The Limits of Computer-Mediated Psychoanalysis and Psychotherapy*. Boca Raton, FL: Routledge.
- Ishikawa, M. (2023). Internalization of negative societal views on old age into self-perceptions of aging: Exploring factors associated with self-directed ageism. *Frontiers in Sociology*, 8, 1291325-1291325. <https://doi.org/10.3389/fsoc.2023.1291325>
- Jesser, A., Muckenhuber, J., & Lunglmayr, B. (2022). Psychodynamic Therapist's Subjective Experiences With Remote Psychotherapy During the COVID-19-Pandemic-A Qualitative Study With Therapists Practicing Guided Affective Imagery, Hypnosis and Autogenous Relaxation. *Frontiers in psychology*, 12, 777102. <https://doi.org/10.3389/fpsyg.2021.777102>
- Jeyasingam, N., McLean, L., Mitchell, L., & Wand, A. P. F. (2023). Attitudes to ageing amongst health care professionals: a qualitative systematic review. *European geriatric medicine*, 14(5), 889–908. <https://doi.org/10.1007/s41999-023-00841-7>

- Jones, S.L. (2014). *An efficacy trial of therapist-assisted internet-delivered cognitive-behaviour therapy for older adults with generalized anxiety*. PhD thesis, University of Regina.
- Josselson, R., & Hammack, P. L. (2021). Conceptual foundations for the method. In R. Josselson & P. L. Hammack, *Essentials of narrative analysis* (pp. 3–15). American Psychological Association. <https://doi.org/10.1037/0000246-001>
- Jowsey, T., McRae, I., Gillespie, J., Banfield, M., & Yen, L. (2013). Time to care? Health of informal older carers and time spend on health related activities: An Australian survey. *BMC Public Health*, 13 (1), 373-373. <https://doi.org/10.1186/1471-2458-13-374>
- Kaiser, P., Dykes, K., & Lord, N. (2025). Age equality in mental health: Déjà vu all over again. *Psychology and psychotherapy*, 10.1111/papt.12594. Advance online publication. <https://doi.org/10.1111/papt.12594>
- Kandasamy, D., Platts-Mills, T. F., Shah, M. N., Van Orden, K. A., & Betz, M. E. (2018). Social Disconnection Among Older Adults Receiving Care in the Emergency Department. *The western journal of emergency medicine*, 19(6), 919–925. <https://doi.org/10.5811/westjem.2018.9.38784>
- Kaptchuk, T. J., Kelley, J. M., Conboy, L. A., Davis, R. B., Kerr, C. E., Jacobson, E. E., Kirsch, I., Schyner, R. N., Nam, B. H., Nguyen, L. T., Park, M., Rivers, A. L., McManus, C., Kokkotou, E., Drossman, D. A., Goldman, P., & Lembo, A. J. (2008). Components of placebo effect: Randomized controlled trial in patients with irritable bowel syndrome. *BMJ*, 336(7651), 999–1003
- Karlin, B. E., & Duffy, M. (2004). Geriatric Mental Health Policy: Impact on Service Delivery and Directions for Effecting Change. *Professional Psychology: Research and Practice*, 35(5), 509–519. <https://doi.org/10.1037/0735-7028.35.5.509>
- Kellehear, A., & Garrido, M. (2023). Existential ageing and dying: A scoping review. *Archives of gerontology and geriatrics*, 104, 104798. <https://doi.org/10.1016/j.archger.2022.104798>
- Keum, B. T. (2018). Older adult research in the journal of counseling psychology, the counseling psychologist, and counseling psychology quarterly: A 15-year review and implications for research. *Counseling Psychology Quarterly*, 31(4), 446-459. <https://doi.org/10.1080/09515070.2017.1324762>

- Killen, A., & Macaskill, A. (2015). Using a gratitude intervention to enhance well-being in older adults. *Journal of Happiness Studies*, 16(4), 947–964.
<https://doi.org/10.1007/s10902-014-9542-3>
- Kim, M., Oh, J., & Kim, B. (2021). Experience of digital music services and digital self-efficacy among older adults: Enjoyment and anxiety as mediators. *Technology in Society*, 67, 101773. <https://doi.org/10.1016/j.techsoc.2021.101773>
- Kleiven, G. S., Hjeltne, A., Råbu, M., & Moltu, C. (2020). Opening Up: Clients' Inner Struggles in the Initial Phase of Therapy. *Frontiers in psychology*, 11, 591146.
<https://doi.org/10.3389/fpsyg.2020.591146>
- Knight, B. G., & Winterbotham, S. (2020). Rural and urban older adults' perceptions of mental health services accessibility. *Aging & Mental Health*, 24(6), 978–984.
<https://doi.org/10.1080/13607863.2019.1576159>
- Kolehmainen M. (2025). Vibrant Screens: Remote therapy and counselling through the lens of digital materiality. *Health (London, England : 1997)*, 29(2), 181–199.
<https://doi.org/10.1177/13634593241234491>
- Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of general internal medicine*, 16(9), 606–613.
<https://doi.org/10.1046/j.1525-1497.2001.016009606.x>
- Lagetto, G., Teti, A., Fortunato, L., Urone, C., Gullo, S., Ciccarese, G., Lardo, P. P., & Gelo, O. C. G. (2024). The therapeutic relationship in videoconferencing psychotherapy: A qualitative study of therapists' experiences. *Clinical Neuropsychiatry*, 21(5), 418–435.
<https://doi.org/10.36131/cnfioritieditore20240506>
- Laidlaw, K., Kishita, N., & Chellingsworth, M. (2016). *A Clinicians Guide to: CBT with Older People*. <https://assets.uea.ac.uk/f/185167/x/2345637901/norwich-medical-school-cbt-with-older-people.pdf>
- Lamont R. A., Swift H. J., Abrams D. (2015). A review and meta-analysis of age-based stereotype threat: Negative stereotypes, not facts, do the damage. *Psychology and Aging*, 30(1), 180–193. 10.1037/a0038586
- Larkin, M., Eatough, V., & Osborn, M. (2011). Interpretative phenomenological analysis and embodied, active, situated cognition. *Theory & Psychology*, 21(3), 318–337.
<https://doi.org/10.1177/0959354310377544>

- Larsson, E., Nilsson, I., & Larsson Lund, M. (2013). Participation in social internet-based activities: Five seniors' intervention processes. *Scandinavian Journal of Occupational Therapy*, 20(6), 471–480. <https://doi.org/10.3109/11038128.2013.83.9001>
- Lebrasseur, A., Fortin-Bédard, N., Lettre, J., Raymond, E., Bussi res, E. L., Lapierre, N., Faieta, J., Vincent, C., Duchesne, L., Ouellet, M. C., Gagnon, E., Tourigny, A., Lamontagne, M.  ., & Routhier, F. (2021). Impact of the COVID-19 Pandemic on Older Adults: Rapid Review. *JMIR aging*, 4(2), e26474. <https://doi.org/10.2196/26474>
- Lederman, S., & Shefler, G. (2023). You can't treat older people without "getting old" yourself: A grounded theory analysis of countertransference in psychotherapy with older adults. *Professional Psychology: Research and Practice*, 54(5), 352–360. <https://doi.org/10.1037/pro0000523>
- Lee CC, Czaja SJ, Moxley JH, Sharit J, Boot WR, Charness N, et al. Attitudes toward computers across adulthood from 1994 to 2013. *Gerontologist*. (2019) 59:22–33. doi: 10.1093/geront/gny081
- Lee, E.B., Haeger, J.A., Levin, M.E., Ong, C.W., & Twohig, M.P. (2018). Telepsychotherapy for trichotillomania: A randomized controlled trial of ACT enhanced behavior therapy. *Journal of Obsessive-Compulsive and Related Disorders*, 18, 106–115. <https://doi.org/10.1016/j.jocrd.2018.04.003>
- Lee, J. L. C., Chan, K. O. W., Kwan, R. Y. C., & Wong, A. Y. L. (2024). Vitality at home: A phenomenological study of tele-exercise in women aged 80 and older. *European Review of Aging and Physical Activity*, 21(1), 25-11. <https://doi.org/10.1186/s11556-024-00360-9>
- Levy B. (2009). Stereotype Embodiment: A Psychosocial Approach to Aging. *Current directions in psychological science*, 18(6), 332–336. <https://doi.org/10.1111/j.1467-8721.2009.01662.x>
- Lindsay J. A., Hudson S., Martin L., Hogan J. B., Nessim M., Graves L., Gabriele J., White D. (2017). Implementing video to home to increase access to evidence-based psychotherapy for rural veterans. *Journal of Technology in Behavioral Science*, 2, 140–148. <http://dx.doi.org/10.1007/s41347-017-0032-4>
- Longe, O. (2018). *Can I laugh Now? Understanding humour within psychotherapy from the client's perspective*. Submitted for MA in Psychotherapy from Department of Psychotherapy, Dublin Business School. <https://esource.dbs.ie/server/api/core/bitstreams/02511285-aa85-4b1c-811e-1f11fcee75e4/content>

- Lopez K. A., Willis D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research*, 14(5), 726–735. <https://doi.org/10.1177/1049732304263638>
- López, J., Perez-Rojo, G., Noriega, C., Carretero, I., Velasco, C., Martinez-Huertas, J. A., López-Frutos, P., & Galarraga, L. (2020). Psychological well-being among older adults during the COVID-19 outbreak: a comparative study of the young-old and the old-old adults. *International psychogeriatrics*, 32(11), 1365–1370. <https://doi.org/10.1017/S1041610220000964>
- Mace, R. A., Mattos, M. K., & Vranceanu, A. M. (2022). Older adults can use technology: why healthcare professionals must overcome ageism in digital health. *Translational behavioral medicine*, 12(12), 1102–1105. <https://doi.org/10.1093/tbm/ibac070>
- Malim T, Birch A, Wadeley A (1992) *Perspectives in Psychology*. First edition. Macmillan Press, Hampshire
- Martin, A. E., North, M. S., & Phillips, K. W. (2019). Intersectional Escape: Older Women Elude Agentic Prescriptions More Than Older Men. *Personality & social psychology bulletin*, 45(3), 342–359. <https://doi.org/10.1177/0146167218784895>
- Martinson, A., Johanson, K., & Wong, S. (2024). Examining the Efficacy of a Brief Cognitive-Behavioral Therapy for Chronic Pain (Brief CBT-CP) Group Delivered via VA Video Connect (VVC) Among Older Adult Veterans. *Clinical gerontologist*, 47(1), 122–135. <https://doi.org/10.1080/07317115.2023.2186303>
- Maxwell, J.A. (2012) *Qualitative Research Design: An Interactive Approach*. Sage Publications, Inc., Thousand Oaks, CA.
- Mays, N., & Pope, C. (1995). Rigour and qualitative research. *BMJ (Clinical research ed.)*, 311(6997), 109–112. <https://doi.org/10.1136/bmj.311.6997.109>
- McBain, R. K., Schuler, M. S., Qureshi, N., Matthews, S., Kofner, A., Breslau, J., & Cantor, J. H. (2023). Expansion of telehealth availability for mental health care after state-level policy changes from 2019 to 2022. *JAMA Network Open*, 6 (6), e2318045. <https://doi.org/10.1001/jamanetworkopen.2023.18045>
- Menezes, D., Woolrych, R., Sixsmith, J., Makita, M., Smith, H., Fisher, J.,... Murray, M. (2021). 'You really do become invisible': Examining older adults' right to the city in the United Kingdom. *Ageing & Society*, 1-20. doi:10.1017/S0144686X21001793
- Merill, C. (2008). *Carl Rogers and Martin Buber in Dialogue: The Meeting of Divergent Paths*. Charles Merrill Sonoma State University.

- Merleau-Ponty, M. (1968). *The visible and the invisible* (A. Lingis, Trans.). Northwestern University Press.
- Morrow, S. L. (2007). Qualitative Research in Counseling Psychology: Conceptual Foundations. *The Counseling Psychologist*, 35(2), 209-235. <https://doi.org/10.1177/0011000006286990>
- Mitchell, E. (2020). "Much more than second best": therapists' experiences of videoconferencing psychotherapy. *European Journal of Qualitative Research. Psychotherapy*, 10, 121-135. <https://doi.org/10.24377/EJQRP.article2991>
- Moeller, A. M., Hansen, J. P., & Andersen, P. T. (2022). Patients' experiences of home-based psychotherapy via videoconference: A qualitative study. *Archives of psychiatric nursing*, 39, 91–96. <https://doi.org/10.1016/j.apnu.2022.03.004>
- Morin, A., & Grondin, S. (2024). Mindfulness and time perception: A systematic integrative review. *Neuroscience and Biobehavioral Reviews*, 162, 105567. <https://doi.org/10.1016/j.neubiorev.2024.105567>
- Moye, J., Karel, M. J., Stamm, K. E., Qualls, S. H., Segal, D. L., Tazeau, Y. N., & DiGilio, D. A. (2019). Workforce Analysis of Psychological Practice With Older Adults: Growing Crisis Requires Urgent Action. *Training and education in professional psychology*, 13(1), 46–55. <https://doi.org/10.1037/tep0000206>
- Najavits, L. M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*. Guilford Press.
- Nguyen, J., McNulty, N., Grant, N., Martland, N., Dowling, D., King, S., Neely, L., Ball, J., & Dom, G. (2022). The effectiveness of remote therapy in two London IAPT services. *Cognitive Behaviour Therapist*, 15, <https://doi.org/10.1017/S1754470X22000198>
- NHS (2025). *Improving Care for Older People*. <https://www.england.nhs.uk/ourwork/clinical-policy/older-people/improving-care-for-older-people/#:~:text=Generally%2C%20someone%20over%20the%20age,to%20require%20care%20and%20support.>
- NHS Digital (2022, January 14). *NHS Talking Therapies for Anxiety and Depression*. <https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/nhs-talking-therapies/>
- NHS England (2023). *Improving care for older people*. NHS England. <https://www.england.nhs.uk/ourwork/clinical-policy/older-people/improving-care-for-older->

[people/#:~:text=How%20old%20is%20an%20older,be%20considered%20an%20older%20person.](#)

Nizza, I. E., Farr, J., & Smith, J. A. (2021). Achieving excellence in interpretative phenomenological analysis (IPA): Four markers of high quality. *Qualitative Research in Psychology*, 18(3), 369–386. <https://doi.org/10.1080/14780887.2020.1854404>

Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy*, 55(4), 303–315. <https://doi.org/10.1037/pst0000193>

Office for National Statistics (2023). *Profile of the older population living in England and Wales in 2021 and changes since 2011*.
<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/profileoftheolderpopulationlivinginenglandandwalesin2021andchangessince2011/2023-04-03#:~:text=Source%3A%20Census%202021%20from%20the%20Office%20for%20National%20Statistics,-Embed%20code&text=The%20largest%20differences%20were%20for,85%20and%20over%20in%202021.>

Office for National Statistics (2024). *National life expectancy in the UK*.
<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/nationallifetablesunitedkingdom/2020to2022>

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2022). A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical teacher*, 1–11. Advance online publication. <https://doi.org/10.1080/0142159X.2022.2057287>

Orr, L. C., Graham, A. K., Mohr, D. C., & Greene, C. J. (2020). Engagement and Clinical Improvement Among Older Adult Primary Care Patients Using a Mobile Intervention for Depression and Anxiety: Case Studies. *JMIR mental health*, 7(7), e16341. <https://doi.org/10.2196/16341>

Paradisi, P., Raglianti, M., & Sebastiani, L. (2021). Online Communication and Body Language. *Frontiers in behavioral neuroscience*, 15, 709365. <https://doi.org/10.3389/fnbeh.2021.709365>

Pearson, C., Sham, R., Gardner, S., Klapman, S., & Altschuler, A. (2023). Perceived Quality of Online Music Therapy Sessions by Older Adults Aging at Home. *Canadian Journal on Aging / La Revue canadienne du vieillissement* 42(4), 607–620. <https://doi.org/10.1017/S0714980823000260>

- Posthuma, R. A., & Campion, M. A. (2009). Age stereotypes in the workplace: Common stereotypes, moderators, and future research directions. *Journal of Management*, 35(1), 158–188. <https://doi.org/10.1177/0149206308318617>
- Pringle, J., Drummond, J., McLafferty, E., & Hendry, C. (2011). Interpretative phenomenological analysis: A discussion and critique. *Nurse Researcher*, 18(3), 20–24. <https://doi.org/10.7748/nr2011.04.18.3.20.c8459>
- Pywell, J., Vijaykumar, S., Dodd, A., & Coventry, L. (2020). Barriers to older adults' uptake of mobile-based mental health interventions. *Digital health*, 6, 2055207620905422. <https://doi.org/10.1177/2055207620905422>
- Rathenau, S., Sousa, D., Vaz, A., & Geller, S. (2022). The effect of attitudes toward online therapy and the difficulties perceived in online therapeutic presence. *Journal of Psychotherapy Integration*, 32(1), 19–33. <https://doi.org/10.1037/int0000266>
- Reilly K., Maher M., Smith E., Coyne E., Murphy S., Wilson C. (2022). A qualitative exploration of psychologists' experiences of teletherapy within the Irish Public Mental Health System. *Clinical Psychologist*, 22(3), 644–657. <https://doi.org/10.1002/capr.12542>
- Riessman, C. K. (2008). *Narrative methods for the human sciences*. Sage Publications.
- Richards, L. & Morse, J.M. (2012). *Readme First for a User's Guide to Qualitative Methods*. SAGE
- Ricoeur, P. (1970). *Freud & philosophy: An essay on interpretation*. New Haven: Yale University Press.
- Robson, D., & Robson, M. (1998). Intimacy and computer communication. *British Journal of Guidance and Counselling*, 26(1), 33–41. <https://doi.org/10.1080/03069889808253836>
- Rochlen, A. B., Zack, J. S., & Speyer, C. (2004). Online therapy: review of relevant definitions, debates, and current empirical support. *Journal of clinical psychology*, 60(3), 269–283. <https://doi.org/10.1002/jclp.10263>
- Rogers, C. R. (1957). The Necessary and Sufficient Conditions of Therapeutic Personality Change. *Journal of Consulting Psychology*, 21, 95-103. <http://dx.doi.org/10.1037/h0045357>
- Rollandi, I., Banerjee, S., Qiu, Y., Fiallo, O., Abramson, T., Berman, J., Solomonov, N., & Sirey, J. A. (2025). Improved outcomes for depressed elder abuse victims with video-delivered psychotherapy during COVID-19. *Psychotherapy research : journal of the*

- Society for Psychotherapy Research*, 35(2), 306–318.
<https://doi.org/10.1080/10503307.2023.2292743>
- Royal College of Psychiatrists (RCPsych). (2018). *Suffering in silence: age inequality in older people's mental health care*. www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-reportcr221.pdf?sfvrsn=bef8f65d_2
- Sabin, J. E., & Harland, J. C. (2017). Professional Ethics for Digital Age Psychiatry: Boundaries, Privacy, and Communication. *Current psychiatry reports*, 19(9), 55.
<https://doi.org/10.1007/s11920-017-0815-5>
- Sarbin, T.R. (1986). *Narrative Psychology: The Storied Nature of Human Conduct*. New York: Praeger.
- Saunders, J., & Allen, C. (2021). Transitioning transdiagnostic CBT from face-to-face to telephone delivery during the coronavirus pandemic: A case study. *Clinical Case Studies*, 20(6), 498–514. <https://doi.org/10.1177/15346501211018278>
- Saunders, R., Buckman, J. E., Stott, J., Leibowitz, J., Aguirre, E., John, A., : : & Pilling, S. (2021). Older adults respond better to psychological therapy than working-age adults: evidence from a large sample of mental health service attendees. *Journal of Affective Disorders*, 294, 85–93. <https://doi.org/10.1016/j.jad.2021.06.084>
- Schiano Lomoriello, A., Meconi, F., Rinaldi, I., & Sessa, P. (2018). Out of Sight Out of Mind: Perceived Physical Distance Between the Observer and Someone in Pain Shapes Observer's Neural Empathic Reactions. *Frontiers in psychology*, 9, 1824.
<https://doi.org/10.3389/fpsyg.2018.01824>
- Schoenenberg, K., & Martin, A. (2024). Empathy, working alliance, treatment expectancy and credibility in video and face-to-face psychotherapeutic first contact. *Psychotherapy research : journal of the Society for Psychotherapy Research*, 34(5), 626–637. <https://doi.org/10.1080/10503307.2023.2233685>
- Schoenenberg, K., Raake, A., & Koeppe, J. (2014). Why are you so slow? — Misattribution of transmission delay to attributes of the conversation partner at the far-end. *International Journal of Human-Computer Studies*, 72(5), 477–487. <https://doi.org/10.1016/j.ijhcs.2014.02.004>
- Scogin, F., Lichstein, K., DiNapoli, E. A., Woosley, J., Thomas, S. J., LaRocca, M. A., Byers, H. D., Mieskowski, L., Parker, C. P., Yang, X., Parton, J., McFadden, A., & Geyer, J. D. (2018). Effects of Integrated Telehealth-Delivered Cognitive-Behavioral Therapy

- for Depression and Insomnia in Rural Older Adults. *Journal of psychotherapy integration*, 28(3), 292–309. <https://doi.org/10.1037/int0000121>
- Scogin, F., Welsh, D., Hanson, A., Stump, J., & Coates, A. (2005). Evidence-Based Psychotherapies for Depression in Older Adults. *Clinical Psychology: Science and Practice*, 12(3), 222–237. <https://doi.org/10.1093/clipsy.bpi033>
- Shapira, S., Cohn-Schwartz, E., Yeshua-Katz, D., Aharonson-Daniel, L., Clarfield, A. M., & Sarid, O. (2021). Teaching and practicing cognitive-behavioral and mindfulness skills in a web-based platform among older adults through the COVID-19 pandemic: A pilot randomized controlled trial. *International Journal of Environmental Research and Public Health*, 18(20), 10563. <https://doi.org/10.3390/ijerph182010563>
- Simpson, S. G., & Reid, C. L. (2014). Therapeutic alliance in videoconferencing psychotherapy: a review. *The Australian journal of rural health*, 22(6), 280–299. <https://doi.org/10.1111/ajr.12149>
- Simpson, S., Bell, L., Knox, J., & Mitchell, D. (2005). Therapy Via Videoconferencing: A Route to Client Empowerment? *Clinical Psychology & Psychotherapy*, 12(2), 156–165. <https://doi.org/10.1002/cpp.436>
- Simpson, S., Richardson, L., Pietrabissa, G., Castelnovo, G., & Reid, C. (2021). Videotherapy and therapeutic alliance in the age of COVID-19. *Clinical psychology & psychotherapy*, 28(2), 409–421. <https://doi.org/10.1002/cpp.2521>
- Slife, B. D., & Wiggins, B. J. (2009). Taking relationship seriously in psychotherapy: Radical relationality. *Journal of Contemporary Psychotherapy: On the Cutting Edge of Modern Developments in Psychotherapy*, 39(1), 17–24. <https://doi.org/10.1007/s10879-008-9100-6>
- Slightam, C., Gregory, A. J., Hu, J., Jacobs, J., Gurmessa, T., Kimerling, R., Blonigen, D., & Zulman, D. M. (2020). Patient Perceptions of Video Visits Using Veterans Affairs Telehealth Tablets: Survey Study. *Journal of medical Internet research*, 22(4), e15682. <https://doi.org/10.2196/15682>
- Smith, J., & Gillon, E. (2021). Therapists' experiences of providing online counselling: A qualitative study. *Counselling and Psychotherapy Research*, 21(3), 545–554. <https://doi.org/10.1002/capr.12408>
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology & Health*, 11(2), 261–271. <https://doi.org/10.1080/08870449608400256>

- Smith, J. A. (2019). Participants and researchers searching for meaning: Conceptual developments for interpretative phenomenological analysis. *Qualitative Research in Psychology*, 16(2), 166–181. <https://doi.org/10.1080/14780887.2018.1540648>
- Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 53–80). Sage. <https://doi.org/10.1002/9780470776278.ch10>
- Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis: theory, method and research*. London: Sage.
- Smith, J. A., Flowers, P., & Larkin, M. (2022). *Interpretative phenomenological analysis: Theory, method and research* (2nd ed.) SAGE.
- Smith, K., Moller, N., Cooper, M., Gabriel, L., Jeanette, R. & Sheehy, R. (2021). Video counselling and psychotherapy: A critical commentary on the evidence base. *Counselling & Psychotherapy Research*, 22, 92-97. <https://doi.org/10.1002/capr.12436>
- Spinelli, E. (1989). *The interpreted world: An introduction to phenomenological psychology*. Sage Publications, Inc.
- Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). *Generalized Anxiety Disorder 7 (GAD-7)* [Database record]. APA PsycTests. <https://doi.org/10.1037/t02591-000>
- Stiles-Shields, C., Kwasny, M. J., Cai, X., & Mohr, D. C. (2014). Therapeutic alliance in face-to-face and telephone-administered cognitive behavioral therapy. *Journal of consulting and clinical psychology*, 82(2), 349–354. <https://doi.org/10.1037/a0035554>
- Sturges, J. E., & Hanrahan, K. J. (2004). Comparing telephone and face-to-face qualitative interviewing: A research note. *Qualitative Research*, 4(1), 107–118. <https://doi.org/10.1177/1468794104041110>
- Suler, J. (2004). The online disinhibition effect. *CyberPsychology & Behavior*, 7(3), 321–326. <https://doi.org/10.1089/1094931041291295>
- Synnott A. (1997) *The Body Social: Symbolism, Self and Society*. London: Routledge.
- Taiwo, A., Chinyio, E., Hewson, H., & Agberotimi, S. (2023). Client and therapists' subjective understanding of an ideal therapy room: A divergent reflection of experience. *The European Journal of Counselling Psychology*. <https://doi.org/10.46853/001c.91127>
- The British Psychological Society. (2018). *Code of ethics and conduct*. BPS. <https://beta.bps.org.uk/news-and-policy/bps-code-ethics-and-conduct>

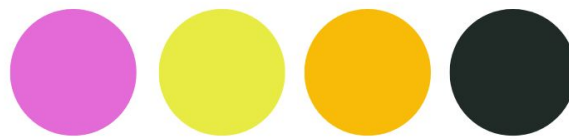
- The King's Fund (2013), *Delivering better services for people with long-term conditions: building the house of care*. London: The King's Fund.
https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-withlong-term-conditions.pdf
- Thomas, N., McDonald, C., de Boer, K., Brand, R. M., Nedeljkovic, M., & Seabrook, L. (2021). Review of the current empirical literature on using videoconferencing to deliver individual psychotherapies to adults with mental health problems. *Psychology and psychotherapy*, 94(3), 854–883. <https://doi.org/10.1111/papt.12332>
- Tornstam L. (2005). *Gerotranscendence: A developmental theory of positive aging*. Springer.
- Trub L. R. (2024). The elephant in the zoom: will psychoanalysis survive the screen?. *American journal of psychoanalysis*, 84(2), 203–228.
<https://doi.org/10.1057/s11231-024-09457-7>
- United Nations (2023). *World Population Ageing 2023*.
https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/undesapd2024_wpa2023-report.pdf
- Van Dijk, Silvia Dian Maria, Bouman, R., Folmer, E. H., den Held, R. C., Warringa, J. E., Marijnissen, R. M., & Voshaar, R. C. O. (2020). (vi)-rushed into online group schema therapy based day-treatment for older adults by the COVID-19 outbreak in the netherlands. *The American Journal of Geriatric Psychiatry*, 28(9), 983–988. <https://doi.org/10.1016/j.jagp.2020.05.028>
- Vaportzis, E., Clausen, M. G., & Gow, A. J. (2017). Older Adults Perceptions of Technology and Barriers to Interacting with Tablet Computers: A Focus Group Study. *Frontiers in psychology*, 8, 1687. <https://doi.org/10.3389/fpsyg.2017.01687>
- Villar, F. (2012). Successful ageing and development: The contribution of generativity in older age. *Ageing & Society*, 32(7), 1087–1105. <https://doi.org/10.1017/S0144686X11000973>
- Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.). Routledge/Taylor & Francis Group.
- Warnock, R., Taylor, F. M., & Horton, A. (2022). Should we pay research participants? Feminist political economy for ethical practices in precarious times. *Area*, 54(2), 195–202. <https://doi.org/10.1111/area.12790>
- Watts, S., Marchand, A., Bouchard, S., Gosselin, P., Langlois, F., Belleville, G., & Dugas, M.J. (2020). Telepsychotherapy for generalized anxiety disorder: Impact on the

- working alliance. *Journal of Psychotherapy Integration*, 30, 208–225.
<https://doi.org/10.1037/int0000223>
- Weir, K. (2023). *A New Concept of Aging: Ageism Is One of the Last Socially Acceptable Prejudice. Psychologists Are Working to Change that.*
<https://www.apa.org/monitor/2023/03/cover-new-concept-of-aging>
- Weiss D. (2014). What will remain when we are gone? Finitude and generation identity in the second half of life. *Psychology and aging*, 29(3), 554–562.
<https://doi.org/10.1037/a0036728>
- Westerhof, G. J., Lamers, S. M. A., Postel, M. G., & Bohlmeijer, E. T. (2019). Online therapy for depressive symptoms: An evaluation of counselor-led and peer-supported life review therapy. *The Gerontologist*, 59(1), 135-146. <https://doi.org/10.1093/geront/gnx140>
- Westwood, S. (2023). “It’s the not being seen that is most tiresome”: Older women, invisibility and social (in)justice. *Journal of Women & Aging*, 35(6), 557–572. <https://doi.org/10.1080/08952841.2023.2197658>
- Wetherell, J. L., Steiner, A. W., & Sisco, S. (2021). Implementing Evidence-Based Psychotherapy in the Home. In Terry, D. L., Mlinac, M. E., Steadman-Wood, P. L. (Eds.), *Providing home care for older adults: A professional guide for Mental Health Practitioners* (pp. 132–148). Routledge, Taylor & Francis Group.
- Williams, V., Boylan, A., & Nunan, D. (2020). Critical appraisal of qualitative research: Necessity, partialities and the issue of bias. *BMJ Evidence-Based Medicine*, 25(1), 9-11. <https://doi.org/10.1136/bmjebm-2018-111132>
- Willig, C. (2008). *Introducing Qualitative Research in Psychology Adventures in Theory and Method*. Open University Press
- Willig, C. (2013). *Introducing qualitative research in psychology*. McGraw-Hill Education. Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). Open University Press.
- Willig, C. (2019). Ontological and epistemological reflexivity: A core skill for therapists. *Counselling and Psychotherapy Research*, 19 (3), 186-194.
<https://doi.org/10.1002/capr.12204>
- Willis, P., Vicker, A., & Jessiman, T. (2022). Loneliness, social dislocation and invisibility experienced by older men who are single or living alone: Accounting for differences

- across sexual identity and social context. *Ageing and Society*, 42(2), 409-431.
<https://doi.org/10.1017/S0144686X20000914>
- Woolfe, R. (2016). Mapping the world of helping: The place of counselling psychology. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket & V. Galbraith (Eds.) *The handbook of counselling psychology*. (4th ed., pp. 5-19). SAGE.
<https://doi.org/10.4135/9781529714968>
- Wootton, R., Craig, J. D. & Patterson, V. (2006). Introduction to telemedicine, 2nd edn. Royal Society of Medicine Press.
- World Health Organisation (2024, October 1). *Ageing and Health*. <https://www.who.int/news-room/fact-sheets/detail/ageing-and-health>
- Wright, B., Williams, C. J., & Garland, A. (2002). Using the Five Areas cognitive-behavioural therapy model with psychiatric patients. *Advances in Psychiatric Treatment*, 8(4), 307–315. <https://doi.org/10.1192/apt.8.4.307>
- Wuthrich, V. M., & Frei, J. (2015). Barriers to treatment for older adults seeking psychological therapy. *International Psychogeriatrics*, 27(7), 1227-1236.
<https://doi.org/10.1017/S1041610215000241>
- Yalom, I. D. (1980). *Existential Psychotherapy*. New York: Basic Books.
- Yang K. (2018). Causal conditions for loneliness: a set-theoretic analysis on an adult sample in the UK. *Quality & quantity*, 52(2), 685–701. <https://doi.org/10.1007/s11135-017-0482-y>
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15, 215-228. doi:10.1080/08870440008400302
- Yin, R., & Martinengo, L., & Smith, H., & Subramaniam, M., & Griva, K/m & Tudor L. C. (2024). The views and experiences of older adults regarding digital mental health interventions: a systematic review of qualitative studies. *The Lancet Healthy Longevity*. 5(11), 100638. <https://doi.org/10.1016/j.lanhl.2024.08.007>.
- Zahavi D. (2003). *Husserl's phenomenology*. Stanford University Press.
- Zhao, N., Zhang, X., Noah, J. A., Tiede, M., & Hirsch, J. (2023). Separable processes for live "in-person" and live "zoom-like" faces. *Imaging neuroscience (Cambridge, Mass.)*, 1, imag-1-00027. https://doi.org/10.1162/imag_a_00027

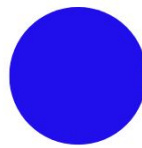
Zimmerman, M., Benjamin, I., Tirpak, J. W., & D'Avanzato, C. (2021). Patient satisfaction with partial hospital telehealth treatment during the COVID-19 pandemic: Comparison to in-person treatment. *Psychiatry research*, 301, 113966. <https://doi.org/10.1016/j.psychres.2021.113966>

Appendix A: Examples of Mood Boards



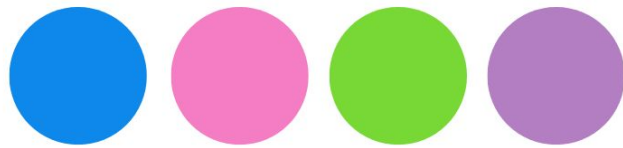
Amber



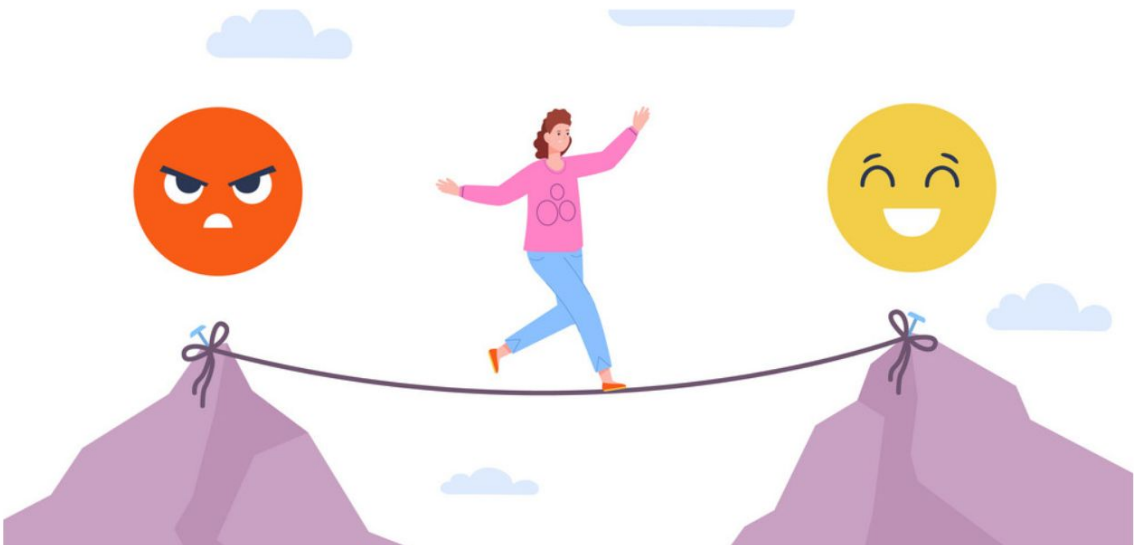


Simon





Bonnie



Appendix B: Interview Schedule

1. What made you want to take part in this study?
2. Can you tell me about your experience of accessing therapy?
 - What were your expectations of therapy?
 - What was it like when you first started therapy?
 - How do you feel about your experience of therapy?
3. What did you make of accessing therapy using a digital device (computer, tablet etc.)?
 - How did you access the video therapies?
 - Did you have any questions or queries about accessing therapy via video?
 - Did you have any additional support?
4. What does it mean to you that you are over 65 and accessing therapy online?
5. Did accessing therapy via video meet your expectations? Why/why not?
6. How do you think accessing therapy via video compares to face-to-face therapy?
7. What impact (if any) did therapy have on your life?
8. How does this compare to other therapies you've accessed before? (if applicable)
9. How did your experience of therapy meet or differ to your expectations? (explore how things could be improved).

Appendix C: Recruitment Poster

Department of Health and Psychological Sciences City, University of London

PARTICIPANTS NEEDED FOR RESEARCH INTO VIDEO COUNSELLING.

I am looking for volunteers to take part in a study of those aged over 65 who have experience of psychological therapy or counselling via video.

We will firstly arrange a welcome call, where you will be given the opportunity to find out more about the study and I will ask some screening questions. If we both agree for you to take part in the study, then you will be asked to attend a one-off one-to-one interview via telephone which will last for between 45 and 90 minutes.

Participation is voluntary and you can withdraw at any time. The interview will be confidential, and information will be kept in line with data protection and GDPR.

To say thank you for your time, you will be offered a £10 for supermarket of your choice.

For more information about this study, or to volunteer for this study,
please contact me on:

Natalia Parry-Vaughan (lead researcher)

at

Email:

[This research is supervised by Dr Anna Flo-Arcas](#)

This study has been reviewed by, and received ethics clearance through the Health and Psychological Sciences Department at City, University of London. Ethics application ETH2324-0370.

If you would like to complain about any aspect of the study, please contact Annah Whyton, Secretary to the Senate Research Ethics Committee at senaterec@city.ac.uk

City, University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Compliance Team at dataprotection@city.ac.uk

Appendix D: Pre-Screening Questions

To be used for the welcome screening phone call prior to confirming participation in research. These questions are to be used in conjunction with the PHQ.9 and GAD.7 to screen for symptoms of low mood and anxiety.

“I am going to ask you some questions that help to check that the research is something that would be relevant for you to take part in.”

1. What made you interested in participating in the research?
2. How old are you?
3. How old were you when you had therapy?
4. What type of therapy sessions did you have? E.g. counselling, CBT.
5. How many sessions did you access via video?
6. How much do you remember of the therapy sessions?
7. Do you have any thoughts to harm yourself or others?
8. Do you feel ready to talk about your experience of psychological therapy?
9. Are you currently accessing any support for your mental health?

“I am now going to ask you some questions that help me to understand the demographics of the people taking part in the study, and help to inform recommendations for future research”

1. What area do you live in?
2. How would you describe your ethnicity?
3. What is your employment status?
4. What is your gender?
5. What programme did you use to access your online sessions?

Appendix E: Distress Protocol (adapted from Draucker et al., 2009)



Appendix F: Participant Information Sheet v.3 08.08.24

ETH2324-0370

Title of study

What are the lived experiences of people aged 65+ who have undergone video psychological therapies?

Name of principal investigator/researcher: Natalia Parry-Vaughan

Invitation paragraph

We invite you to take part in our research, exploring your experience of undertaking psychological therapies via video. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. You will be given a copy of this information sheet to keep.

What is the purpose of the study?

The purpose of the study is to explore individual experiences of undertaking therapies from your own home using a video system. This will take place in the form of one standalone interview that will last between 45 and 90 minutes, where you will be encouraged to talk openly and honestly about your experience. The interview will take place on the telephone at a time convenient for you.

Why have I been invited to take part?

You have been invited to take part as you are aged over 65 and have experienced psychological therapy via video that completed over 3 months ago.

Do I have to take part?

Participation in the project is voluntary, and you can choose not to participate in part or all of the project. You can withdraw up until the date of analysis (01 April 2025) without being penalised or disadvantaged in any way. It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part, you are still free to withdraw without giving a reason, and this will not impact any remuneration received.

What will happen if I take part?

1. Screening Call

The interviewer will contact you to arrange a screening call. This will last for approximately 15 minutes and you will be asked some questions to determine your suitability for the research project. You will complete questionnaires to assess for current symptoms of low mood and anxiety. You will also be asked questions about your safety. The researcher will also explain the research procedure and consent form and provide you with an opportunity to ask any questions you may have. Following this call, the researcher will advise you whether you meet the criteria to take part in the research project. If your participation is deemed unsuitable at this time, then the researcher will signpost you to support services.

2. Arrange a day and time.

Following the pre-screening call and once you have provided your consent to take part, the interviewer will arrange a day and time suitable for both parties to conduct the interview. This will take place on the telephone.

3. Interview

The interview will take place and will last for between 45 and 90 minutes. This will be a semi-structured interview where the interviewer will have an idea of questions to ask but will be guided by you and your experience. This type of interview method is interested in the meaning and sense you make of your experiences.

4. Debrief

Following the interview you will debrief with the researcher, where you will be able to express any concerns. The researcher will also answer any questions you may have, and signpost you for further support if required.

What do I have to do if I take part?

In order to take part, you will need to be able to commit to a one-off interview.

What are the possible disadvantages and risks of taking part?

As you will be talking through your experience of psychological therapy, this may involve the discussion of sensitive or emotive topics.

What are the possible benefits of taking part?

The benefits of taking part are that you will be able to feedback both positive and negative experiences with the aim of hopefully improving the experience for those accessing video therapies in the future.

Expenses and Payments

There will be a £10 voucher offered for a supermarket of your choice as a remuneration for the time you have taken to participate in the interview. You maintain the right to withdraw from the study up until the point of analysis (01 April 2025), and this will not impact any payments received.

How is the project being funded?

There are no funding sources for this project.

Conflicts of Interest

The head researcher is a psychological therapist who uses video therapies within their private practice.

What should I do if I want to take part?

If you want to take part, please email the head researcher Natalia Parry-Vaughan on [REDACTED]

Data privacy statement

City, University of London is the sponsor and the data controller of this study based in the United Kingdom. This means that we are responsible for looking after your information and using it properly. The legal basis under which your data will be processed is City's public task.

Your right to access, change or move your information are limited, as we need to manage your information in a specific way in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personal-identifiable information possible (for further information please see <https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/public-task/>).

City will use your name and contact details to contact you about the research study as necessary. If you wish to receive the results of the study, your contact details will also be kept for this purpose. The only people at City who will have access to your identifiable information will be members of the research team, and, if appropriate, individuals with responsibility for monitoring and auditing at City, including of research projects. There may be occasions when regulatory authorities may access research

data in accordance with their statutory powers. City will keep identifiable information about you from this study for 10 years after the study has finished.

You can find out more about how City handles personal data by visiting <https://www.city.ac.uk/about/governance/policies/data-protection-policy>. You can also read City's general privacy notice by visiting <https://www.city.ac.uk/about/governance/policies/general-privacy-notice>. If you are concerned about how we have processed your personal data, you can contact the Information Commissioner's Office (ICO) directly <https://ico.org.uk/>.

Will my taking part in the study be kept confidential?

The interview will be recorded on either Zoom, Microsoft Teams or an encrypted audio device and the audio recording will be transcribed verbatim with the researcher using pseudonyms and coding to ensure no personal identifiable information is transcribed. Both the audio recording and the transcript will be stored on City University's One Drive, as recommended in City University guidelines.

The researcher may use software such as Otter for transcribing, or NVivo to aid analysis, both of which are compliant with The Data Protection Act (2018) and General Data Protection Regulations (GDPR) and links for further information can be found below.

Quotes may be included in the write up and will be anonymized. Confidentiality may be breached if you disclose something that suggests you are a risk to yourself or others, such as safeguarding or public protection concerns, as well as concerns about your safety and wellbeing.

[Otter.ai - AI Meeting Note Taker & Real-time AI Transcription](#)

[NVivo Free Trial - Lumivero](#)

What will happen to the results?

The results will be presented in the interviewers' doctoral thesis and may or may not be published in a journal following this. All anonymity will be maintained, and you are welcome to receive a copy of the publication should this occur. Please let the researcher know – you will need to give explicit consent for this as your data will need to be kept for this purpose.

Who has reviewed the study?

This study has been approved by City, University of London Health and Psychological Sciences Research Ethics Committee.

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is "Older adults experiences of accessing video psychological therapies".

You can also write to the Secretary at:

Annah Whyton

Research & Enterprise Office

City, University of London

Northampton Square

London, EC1V 0HB

Email: senaterec@city.ac.uk

Insurance

City University London holds insurance policies which apply to this study, subject to the terms and conditions of the policy. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Further information and contact details:

Natalia Parry-Vaughan (head researcher)

Email: [REDACTED]

Dr Anna Flo-Arcas (supervisor)

E-mail: [REDACTED]

Thank you for taking the time to read this information sheet.

Appendix G: Consent Form

Name of principal investigator/researcher: Natalia Parry-Vaughan

REC reference number: ETH2324-0370

Title of study: What are the lived experiences of people aged 65+ undertaking online video psychological therapies?

Please
tick or
initial box

1	I confirm that I have read and understood the participant information dated 08/08/24 for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw up until the point of analysis (01 April 2025) without giving a reason and without being penalised or disadvantaged.	
3.	I understand that I will be remunerated for my time with a £10 voucher for a supermarket of my choice, and that this does not affect my right to withdraw.	
4.	I agree to the interview being audio recorded.	
5.	I agree to de-identified quotes being used in the write up.	
6.	I agree to the researcher using software to aid transcription and analysis such as Otter and NVivo (both of which are GDPR compliant).	
7.	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) explained in the participant information and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
8.	I would like to be informed of the results of this study once it has been completed and understand that my contact details will be retained for this purpose.	

9.	I agree to take part in the above study.	
----	--	--

_____	_____	_____
Name of Participant	Signature	Date

_____	_____	_____
Name of Researcher	Signature	Date

When completed, 1 copy for participant; 1 copy for researcher file.

Appendix H: Participant Debrief Form

What are the lived experiences of people aged 65+ who have undergone video psychological therapies?

Thank you for taking the time to take part in this research project. Below is further information regarding the research and signposting services you may wish to consider for further support.

Further information on the study.

The purpose of the study is to investigate the lived experiences of those who have undergone counselling or psychological therapy via video. The semi-structured interview you undertook provides the data for collection and analysis. The aim is to get as close to a person's experience as possible to understand the meaning of the experience in depth. The interview explored this topic by facilitating a conversation around the experience of therapy through a video, with questions exploring thoughts and feelings, however EACH conversation was different and was guided by the ideas raised by the participant. The interviews will be transcribed and analysed, with themes noted and group themes across participants identified.

Background to the study.

There is limited research into this area, with most of the qualitative research being limited to one or two questions, as opposed to an in-depth interview. There is some literature indicating that people aged over 65 find video therapy helpful and effective, but there are also difficulties raised around accessibility, however this hasn't been explored with the over 65's themselves in detail. By taking part in this study, you have helped to contribute to the knowledge base for supporting older people. This research also shines a light on a population that has been described by one older person as invisible.

Signposting Services

It is possible that the interview could have caused some emotional upset, or it may have sparked an interest in you accessing further support. Below are some support services you are welcome to contact, with a brief outline as to the kind of support they offer.

- Your GP can help connect you to support services in your area, and also can provide a consultation for physical or mental health support.
- Most local A&E's have a mental health team, who can be there for people who require immediate support such as having thoughts to end their life.
- Your local Talking Therapies service offers counselling to those experiencing emotional distress and difficulties such as low mood and anxiety. Your local Talking Therapies can be contacted on **insert phone number**.
- The Samaritans is a free 24 hour helpline who provides emotional support for any difficulty – call 116 123.
- Shout provide a text service 24 hours a day in a similar way to the Samaritans, text 85238.
- Silverline is a helpline run by Age UK and is a free confidential telephone service for older people, and provides friendship, conversation and support. Please call 0800 4 70 80 90.

Thank you once again for your participation in this research project. It really is appreciated. If you opted on the consent form to receive the findings, you will be contacted following the completion of the project in September 2025, and will be provided with an overview of the results and discussion.

If you wish to find out more about this research or to withdraw from the research, please contact:

Researcher: Natalia Parry-Vaughan on [REDACTED] or [REDACTED].

Supervisor: Dr Anna Flo Arcas on [REDACTED] —

Ethics Application Code: ETH2324-0370

Appendix I: Excerpt from Lorraine's Transcript

Almost instantaneous connection - 348 GIVING HER WHOLE SELF TO THERAPY - 351 A trusting relationship meant she absorbed guidance. 358 GENTLY GUIDED  FELT HEARD THROUGH RELEVANT READING SUGGESTIONS - 356 A SENSE OF INTIMACY AND CLOSENESS - 368 "<u>almost</u> as though she was in the room with me" 368 Visibility of face created a bigger presence. 367 BIGGER FACE, BIGGER PRESENCE - 378	347. <u>P</u> - Yes. And <u>also</u> I remember saying right at the 348. beginning, I was surprised at how quickly I was noticing 349. a difference. And the counselor said, it's because you 350. were ready. You know, yeah, you know, I, I was 351. absolutely ready, you know, by the time I made the 352. decision that this is what I needed...erm, I was ready for 353. whatever. And because of the sort of person she 354. is...erm, I was very receptive to how, I mean, she didn't 355. tell me what to do, (laughs), but the guidance and 356. support and the reading that she gave me, and the 357. handouts that she gave me made me think you really 358. understand what I'm saying...erm, and <u>and</u> because of 359. that, I think I was receptive to everything that she 360. provided. 361. I - Something you said a second ago struck me. You <u>said</u> 362. that having the video felt like she had more of a 363. presence. And I just wonder if you can tell me a bit 364. more about <u>about</u> that, you know, the video has more 365. of a presence than telephone would and I'd be 366. interested to hear a bit more. 367. P - I think, because just that, the size of her face was 368. just that it was, it was almost as though she was in the 369. room with me <u>....</u> where, I think.... you know, maybe, 370. maybe doing, I mean, I don't know, because we didn't 371. do it on the phone. We always did it on the 372. laptop <u>....Erm, So</u> maybe it, maybe it would have been 373. the same (unsure in tone), but it was it just, I suppose it 374. was like the next step from face to face to laptop. And 375. we could have gone, could have gone to phone... but it 376. just felt as though, yes, that, that she was a real 377. presence in, in the room, rather than, you know, just a 378. little picture on, you know, a little screen.	Change happened quickly. Took time to be sure in decision. Giving therapy 100% - highlights importance. Good match between her and therapist meant she could receive guidance. Felt cared for. Receptive to everything she said. "<u>almost</u> as though she was in the room with me" Using a laptop made her face bigger, which gave her more of a presence.
--	---	--

Instant connection with counsellor. (385) Treasured and valued input from counsellor. (386) Listening by counsellor facilitated listening from <u>client</u> - reciprocity (388) Counsellor got it exactly right. (391) Built a trusting relationship together. (396) Counselling exceeded <u>expectations</u>-. (396) Delighted at how fantasies about counsellor became reality. (402) Feeling qualities of counsellor, a closeness - 403 Displays of care built a secure and trusting base. (404) 	379. I – Yeah...and how did that feel? That presence? 380. P - It felt the same as if I was face to face. <u>So</u> I guess that 381. that's partly, you know, the sort of physical presence, 382. but also, I suppose, because... you know, in the face to 383. face associations, I don't know...erm, just the fact that I 384. felt so comfortable with her...erm... that she was able to 385. right from the beginning...erm, sort of make me 386. feel...erm, that what I was saying was <u>...erm...valuable</u>. 387. And I think you know the fact that you <u>know</u> from one 388. week to another, she would remember something that 389. I'd said and come back to it. And during the sessions, 390. she might say things like...erm... “what I'm hearing is” 391. and, and it was always exactly what I had intended. My 392. words to mean. <u>So</u> I guess, I mean, I can't see you 393. (laughs)... and, you know, this feels fine, and talking to 394. you on the phone, and I can't even see what you look 395. like.... Erm, but, but I suppose maybe it's more, it felt 396. more like building a relationship. 397. I - Yeah, yeah, yeah. And that felt like something that 398. you did with her quite quickly. It sounds like, you know, 399. you said you felt comfortable quite early. 400. P - Yes, and that really surprised me, because, because 401. she was exactly how I thought she would be from her 402. photograph (sounds happy). Yeah, there was sort of 403. gentleness and warmth about her <u>...Erm</u>, And yeah, so I 404. felt very sort of comfortable and secure right from the 405. beginning. 406. I - And I wondered kind of going into that. And going 407. into those sessions before you started them. Did you 408. have any expectations about therapy or what it might 409. be like? 410. P – Erm, I suppose I had had some counseling a long	Connection was instantaneous. Felt the same as face to face. “Valuable” – her opinion was treasured, precious. Feeling her opinion was valued, meant she could value the <u>therapists</u> opinion. <u>Two way</u> street. Accuracy of reflections was important. Built a relationship together. Surprised by benefits. Photograph matched therapist. Fantasies became reality. Caring characteristics created a sense of security.
--	--	---

Uncertainty around <u>connecting</u> - 419 Surprised and delighted at outcome <u>of therapy</u>. 434 FEAR OF REACHING OUT IN CONFLICT WITH DESPERATION FOR HELP - 420 Readiness and willingness to change – 422 Sad and alone, life devoid of colour - 424 IMMEDIATE KNOWING IT WAS THE RIGHT THERAPIST, instant connection - 430 Therapy exceeded <u>expectations</u> - 430	411. time ago when my husband left and things were very 412. difficult...erm... with my children, and their sort of 413. reaction to it all...erm, because they were teenagers. So 414. there were, you know, the difficulties with... dealing 415. with teenagers, you know, 16 and 18, and the shock, 416. you know, because it of the way it was, it 417. happened...erm... and I wasn't sure how, because I only 418. had a few sessions, I didn't really feel as though.... We 419. made much progress. I didn't feel any difference.... So 420. (sighs)... so I wasn't sure... how successful it was going 421. to be...to begin with. <u>So</u> I wasn't sure what the outcome 422. would be...erm... But I knew that I needed to feel better 423. about ~~about~~ life in general, and myself...erm, because I 424. didn't feel that there was any joy or happiness...erm, 425. and I could see that was just (uh) going to be the same, 426. you know, it's always going to be like this sort of 427. miserable and no excitement and no fun...erm, and I 428. couldn't see how all of that could change.... Erm, But 429. really, from the first session, I came out feeling.... Oh! I 430. think this is going to work... you know, I think, I think I'm 431. going to get something out of this. So I wasn't, I didn't 432. anticipate how much I was going to get out of it and 433. how different I would feel...erm... afterwards. Erm... So 434. that was kind of a surprise. 435. I – So, you kind of went in maybe with some I'm not 436. <u>sure</u> what I'm going to get out of it, but quite quickly, it 437. sounds like you know, you met the right person, and 438. you for thought, no kind of that your expectations were 439. flipped. 440. P - Yeah, <u>yes, definitely</u>. And I think it was because early 441. on, I felt I was being listened to and not ~~not~~, you know, 442. just understood.... Erm, <u>And</u> that was really <u>quite</u>	Previous experience of therapy unhelpful. Unsure. Came into this therapy with uncertainty around usefulness of therapy. But <u>sure</u> that she needed therapy. No joy or happiness in life. Desperate for change. Didn't expect it to be as ~~helpful~~ as it was. Oh! Surprise, delight. Relief? Therapy exceeded expectations. Surprised at the impact. Importance of being listened to. Being listened to is incredible.
---	---	--

Displays of care also occurred outside of session. 451 Sees therapist through rose tinted <u>glasses</u> - "Always exactly <u>right</u>" - importance for perfection - 454. Listening / being seen is like gold dust. OPENING UP, NOT SHUTTING <u>DOWN</u>, a port in a storm- 462  A BETRAYAL OF TRUST CREATED BELIEF OF SELF AS FAULTY - 466 NEW NARRATIVES AROUND SELF AND OTHERS, more open minded – 468 Negative perceptions of <u>self challenged</u> through therapy - 474	443. incredible. 444. I - What do you think... I'm interested what, what it was 445. that, that made you feel listened <u>to?</u> If that makes 446. sense, you know, was there anything in particular that 447. you that... that yeah, that she did, or that that helped 448. you to feel listened to? 449. P – Erm, quite a few things, really, because, you know, 450. sometimes not in the session, but, you know, another 451. day I would get an email with... "I think you'll find this 452. video <u>really interesting</u> to look at" or... sending me 453. some reading material, you know, and, and it was 454. always exactly right (laughs). It was <u>really relevant</u>. But 455. in the sessions...erm, she would say things before about 456. "<u>what</u> I'm hearing is", and then she would sort of 457. paraphrase what I had said... and it was exactly, exactly 458. right. And, and so that made me feel like, okay, you're 459. really understanding where I'm coming from. And you 460. know, to be listened to... was I... mean, even just talking 461. about it now, it's quite emotional (crying), because I felt 462. so shut down, you know, with my interactions with 463. people who were my friends...erm... you know, and I 464. just felt quite lonely.....<u>So</u> that was huge....<u>Erm</u>, and 465. then, of course, it was just getting me to, you know, 466. when I was talking about, you know, blaming myself for 467. things, being stupid. For not seeing, you know, what 468. was really going on? You know, little sort of suggestions 469. about, well, you know, you only formed that opinion 470. because of the information you'd been given. You didn't 471. have all, you know, you didn't have. And <u>so</u> I started to 472. think, wasn't it, that's right, I didn't know everything. 473. Yeah, you know. So, so that, you know, and then, you 474. know, looking at it from a different perspective. Erm,	Work continued outside of sessions. Contact out of sessions was valuable. Made P feel thought of and cared for. "Always exactly right" – therapist always got everything right. Sees therapist through rose tinted <u>glasses?</u> Repetition of exactly. The power of listening. Gold dust – "huge" So painful being shut down. Felt isolated and lonely. Labelled herself as stupid. Guidance to challenge perspectives meaningful. Took on perspectives from therapist.
--	---	---

Regret and liberation from self-blame - .476	475.	you know, something that had happened over 20 years	6 months of therapy undid the blame she had been living with for 20 years.
Safety and trust in a stranger unexpected - 485	476.	ago (laughs), you know that I'd lived with for over 20	Freed from the shackles of blame.
Changed from <u>self cruelty</u> to <u>self compassion</u> (480)	477.	years, and you know, feeling how stupid I am. You	Changing from believing she was stupid to having compassion for herself.
A trusting relationship facilitates openness. 486	478.	know, that was incredible...erm, to <u>actually think</u> oh,	From cruelty to compassion.
Choice of settings (online or face to face) encouraged contact.499	479.	gosh, you know, that wasn't all me, that wasn't me	A therapeutic relationship that develops trust means you can be open.
A CALM AND TRANQUIL OCEAN - 505	480.	being stupid, it was because I didn't have all the	Importance of being transparent and honest.
A therapeutic space that is tranquil reduces anxiety.	481.	information. <u>So</u> it was those sorts of things, you	Trust can be built quickly.
501 505	482.	know, very early on, that sort of, I suppose, you know	Therapist <u>flexibility</u> gave confidence in selecting therapist.
	483.	this, like trust that is built up to be completely open,	Environment of setting important – “tranquil”.
	484.	you know, and that's quite... to <u>actually feel</u>	
	485.	comfortable enough and trusting enough in someone....	
	486.	to be able to be completely open and not hold back....	
	487.	Because I felt then, if I hold back, I'm not, I'm not	
	488.	necessarily going to get all the help that I need... erm,	
	489.	because I'm keeping some things that are quite	
	490.	important hidden.... Yeah, so that, you know, for	
	491.	somebody to be able to, to build up trust quite	
	492.	quickly...was great (laughs).	
	493.	I - <u>You</u> said as well that you were glad that you met face	
	494.	to face first.	
	495.	P – I think, I think so it was because I haven't got	
	496.	anything to compare it with, I don't know what, what it	
	497.	would have been like if we'd met on Zoom. Maybe I	
	498.	wouldn't have selected a counsellor who didn't do face	
	499.	to face. I don't, I don't know. So that's a hypothetical,	
	500.	<u>really</u>. But I suppose, you know that the environment	
	501.	that we met in was quite comfortable and warm.... And	
	502.	peaceful...<u>erm</u>, and I suppose because... some of what	
	503.	added to my anxiety, was not having peace in my own	
	504.	home. <u>So</u> to be able to... go somewhere that was very	
	505.	tranquil to start with. Yeah.	
	506.	I - When, when it was kind of going, you know, you had	

Appendix J: Delilah's PETs

	Themes		Subthemes	Line
1	Separation and Connection and Separation	1.1	Sense of isolation	Family ignore significance of impact for client – 586 Uniqueness of experience separates self from others – 598 Sudden abandonment – 546 Speaks to the sparceness of deep connections in society - 636 Attunement from therapists contrasts and highlights misalignment with others (family) – 583 Experiencing self as separate object is painful - 625 Others fall below the standard set by therapist – 611 Lonelier since therapy - speaks to separation of self from other? – 621
		1.2	Worries around (Emotional and Technological) Connection	Anxieties around feeling safe enough to take risk to be vulnerable – 141 Feared breakdown in relationship – 145 Connect as symbolism for technology and relationship – 400 Connecting as meaning psychological or mechanical - 344 Uncertainty around introduction of the other increases online – 377 Technical problems a minimal concern – 325 Relieve practical anxieties through preparation - 655 Knowledge of technical challenges protected against impact – 336 Speaks to both emotional and mechanical connection – 223

				Increased certainty by checking technology - 219 Trust built over time – 175 Responsibility for safety shifts to client – 154 Technology is unpredictable. – 108 Hoping to connect emotionally and mechanically - 118 Stability in same location at home – 231 Sought a sense of comfort at home – 216
		1.3	The Body	A bodily depth??? 79 Something felt but intangible – 79 Acceptance of bodily limitations – 99 Sensory deprivation - 43 Intangible presence – 45 Missing aura of person - 64 Limit to emotional deepening of connection- 54
2	Teamwork	2.1	Making sense of things together.	Humanising that therapist didn't have all the answers - 536 Supported to work together as a team – 509 Responsibility for safety shifts to client – 154
		2.2	Significance of therapeutic relationship	Relationship with therapist trumps mode of therapy – 680 Touched at the support and care received – 527 Special to have a shared experience – 329 Supported and nurtured – 166 Therapist as stable consistent figure – 180 Therapist empathy transcends barriers - 189 Total comfort and safety with therapist – 36

				Safety in sessions with a familiar therapist - 8 Returning back to secure base - 15
		2.3	Absorbing and Profound	Absorbition into the psychological work overrode sensory deprivations – other senses took over? – 286 Surprised by the significance of the work – 172 Mentally, psychologically and emotionally profound – 60 Negligable difference between f2f and online -279 Makes me think of someone blind & hearing gets better. Motivated to do self directed reading – 209 Preparing a focus for session gives a sense of control/power- 206
3	Sense of self	3.1	Deeper and richer	Living a life in colour – 575 Deeper, richer, sense of self - 581 Greater sense of self – 511 Meaningful change – 515 Seperation of emeshment of self with other - 557 Bravery in vulnerability - 159
		3.2	Re-writing narratives	Changed meaning around self and world – 518 Self-compassion – 519 Re-writing the narrative of her life - 539 Life changing therapy – 504 Fears around failing unfounded - 94

PART B: Publishable Paper

“Seen Through a Screen:

**A Qualitative Study of the Lived Experience of Older Adults and
Video Psychological Therapy”**

5.1 Foreword

The article presented below is intended to be submitted for publishing in *Counselling Psychology Review*. This has been written in line with the requirements and holds a limit of 5000 words.

5.2 Abstract

The proportion of the population classified as older adults is increasing rapidly, coinciding with the growing digitisation of healthcare services. This raises important questions about the accessibility and suitability of digital interventions for this population. Despite the expansion of digital therapy, little is known about how older adults' experience psychological therapy via video. This study employs an Interpretative Phenomenological Analysis (IPA) design to explore older adults lived experiences of video therapy. Eight participants were recruited and interviewed in sixty-minute semi-structured telephone interviews. Analysis of the data generated three overarching themes, of which one will be discussed in the present article, '*Seen Through a Screen*', which explores experiences of invisibility as an older adult and the ways in which closeness and reassurance in video therapy fostered a sense of feeling seen. These findings highlight the importance of visibility and relational connection in video therapy, which are explored in relation to the I-Thou framework. The strengths and limitations of the study are reviewed, alongside clinical implications and directions for future research.

5.3 Background

There is growing pressure on community and healthcare providers to cope with an ageing population. In the UK, the number of older adults is expected to double between 2017 and 2040 (Age UK, 2019). Yet, despite their growing presence, older adults frequently report feeling invisible in social and healthcare contexts (Menezes et al., 2021). Research statistics indicate that while 13.6% of younger adults access therapy, only 4.5% of those aged over 65 do so (Office for National Statistics, 2023). This is surprising when older adults experience unique and significant stressors, with older age described as succession of losses (Butler & Lewis, 1982).

There are conflicting explanations for this disparity in the literature. Some researchers argue that older adults demonstrate resilience during times of adversity (Lebrasseur et al., 2021), and that reluctance to seek help is due to a strong preference for self-management of symptoms, reflecting a belief in self-sufficiency as a positive trait (Knight & Winterbotham,

2020). However, the tendency for older adults to express emotional difficulties through somatic complaints can confound symptoms and clinical presentation, with indications that later life mental health difficulties often go undiagnosed (DiNapoli et al., 2017). This raises the question, is this stoicism or invisibility?

Ageism is described as the last socially acceptable prejudice (Weir, 2023) and is a pervasive socio-cultural problem that we as healthcare providers are accountable for. There is evidence of therapeutic nihilism, as providers reflect assumptions that older clients are less likely to benefit from therapy (Jeyasingam et al., 2023). There is a lack of interest in the field of ageing according to statistics from the USA, with only 3% of psychologists specialising in working with older adults, compared to 30% with children and adolescents (APA, 2015). This is also perpetuated systemically through institutions, with training course criticised for the lack of gerontological content in training programmes and textbooks (Gross & Esbaugh, 2011). Not only is ageism prevalent within healthcare providers, there is evidence of internalised ageism within older adults themselves. Ageism is a social issue, and can deter older adults from acknowledging their difficulties or seeking support (Choi et al., 2014).

Despite these barriers, when older adults do access therapy, the literature reports generally positive outcomes. Psychotherapy has been shown to be effective in addressing late-life depression and anxiety, with interventions such as cognitive behavioural therapy (CBT), problem-solving therapy, and interpersonal therapy all supported by evidence (Scogin et al., 2005). Furthermore, older adults engaging with NHS Talking Therapies demonstrate higher treatment completion and recovery rates compared to younger cohorts (NHS Digital, 2020; Saunders et al., 2021).

The rise of digital therapies presents both opportunities and challenges in this context. Since the onset of the COVID-19 pandemic, video therapy has become increasingly commonplace. The literature into older adults suggests video therapy to be a viable therapeutic modality, with quantitative literature highlighting predominantly positive outcomes on depression, anxiety and sleep (Choi et al., 2016; Fronza et al., 2025; Rollandi et al., 2025; Scogin et al., 2018). There is also evidence from several studies that ratings of therapeutic bond are similar in video therapy to that of in-person (e.g. Simpson & Reid, 2014; Schoenenberg and Martin, 2024; Thomas et al., 2021).

Video therapy has however been criticised for its impact on communication. There can be reduced access to non-verbal cues, such as posture and gestures, which are important for conveying empathy and attunement (Schoenenberg & Martin, 2024). It can be common for transmission delays to affect interpersonal interaction, and paralinguistic features such as tone

and response time can impede the flow of interaction (Schoenenberg et al., 2014). Neuroscientific research further suggests that perceived interpersonal distance can alter neural empathic responses and thereby influence the sense of connection (Schiano Lomoriello et al., 2018).

For some clients, however, this sense of distance may be beneficial. Having therapy at home offers advantages around increasing accessibility and eliminating the need for travel (Christensen et al., 2021). For instance, individuals in the general population experiencing shame-related conditions such as trichotillomania have stated they would otherwise not have accessed therapy and others reported that remote therapy feels less intimidating and allows greater openness than in-person formats (Lee et al., 2018). Clients have also reported feeling a heightened sense of control, reduced self-consciousness, and an overall easier experience communicating compared to face-to-face sessions (Simpson et al., 2005).

To the authors knowledge, only a limited number of studies have examined older adults' experiences of video therapy. To date, two mixed-methods (Campbell et al., 2025; Fallon et al., 2024) and two qualitative studies (Christensen et al., 2021; Pearson et al., 2023) exist, with only Christensen et al. (2021) exploring experiences in depth. However, within their study, they looked at both provider and client experiences. Nonetheless, three themes emerged: technical challenges, the supportive role of video as a clinical tool, and impact on the therapeutic relationship. They reported how clients valued therapy at home and felt more empowered to express themselves. They also reported disparity between providers and clients, with providers often viewed technical difficulties as disruptive, while older clients described them as minor.

As the broader literature continues to focus on interventions and outcomes rather than client experiences, there is a pressing need to examine older adults' experiences to ensure that services are not only accessible but also visible, inclusive, and responsive to their needs (Kaiser et al., 2025). This study aims to contribute to this limited field, exploring and asking the question "How older adults experience video therapy?". The present research aims to give some visibility to this population through exploring their experience of visibility within video therapy.

5.4 Method

Research Design and Sampling

The present study employed purposive sampling to recruit older adults with lived experience of video therapy, consistent with recommendations by Smith et al. (2009) to seek a relatively homogenous sample. Participants were required to be aged 65 or above, as part of the researcher's commitment to homogeneity and to fairly represent this demographic. The participants were required to have attended at least one one-to-one counselling or psychotherapy session delivered via a video platform such as Zoom, without restrictions on therapy type or duration.

Recruitment

Initial strategies to recruit participants via therapy organisations yielded limited success, leading the researcher to engage with organisations associated with older adults, such as care homes and Age UK. Participants were recruited from Age UK events, posters in communities' centres, word of mouth, and through a local forum for therapists. In total, ten people offered an expression of interest, two of whom were excluded due to low age, resulting in a final sample of eight participants aged 65 and above. All the participants were White British and resided in the UK. Initially, no monetary remuneration was offered, but due to recruitment challenges, participants were later provided with a £10 supermarket voucher, consistent with ethical arguments for remuneration outlined by Warnock et al. (2022).

Data Collection

Following an expression of interest, participants were contacted to arrange a pre-screening telephone call, where their suitability was assessed. The interview was then arranged at a mutually convenient time, also by telephone. The research interview was completed one-on-one and lasted for approximately 60 minutes, in line with recommendations by Smith et al. (2022). The semi-structured format allowed participants to explore relevant topics flexibly, guided by a list of questions adapted in response to participants' contributions, consistent with Smith and Osborn's (2008) approach to idiographic exploration. Interviews were conversational in style to facilitate rapport, safety, and rich data collection. Interviews were audio-recorded using Zoom, securely stored on City University OneDrive, and transcribed verbatim using Otter software. Following the interview, participants had a full verbal and written debrief.

Ethical Considerations

Ethical approval was obtained from the School of Health and Medical Sciences Ethics Committee at City, University of London. Pre-screening calls assessed suitability against inclusion and exclusion criteria and ensured informed consent.

Participants were required to have completed therapy more than three months prior to the study to allow for reflection and emotional processing. Measures of the PHQ.9 and GAD-7 were taken during the pre-screening process, with those currently experiencing low mood or anxiety symptoms excluded from the study. Additionally, people presenting with any risk concerns, including suicidal ideation, self-harm, or risk to others were also excluded. Distress protocols were in place for managing potential emotional distress during interviews, although no participants expressed any risk concerns throughout the process.

Participant identities were protected via pseudonyms, with all references to names, locations, and family members removed from transcripts and marked with X. Full anonymisation was maintained throughout transcription, analysis, and reporting.

Data Analysis

Interpretative Phenomenological Analysis (IPA) was employed to explore participants lived experiences. IPA focuses on sense-making, moving from descriptive to interpretive analysis within a hermeneutic circle, where the researcher engages dynamically with both the parts and the whole of the data (Smith et al., 2022). The analysis process, while guided by seven stages, was applied flexibly rather than prescriptively.

All interviews were transcribed before analysis, with wide margins and line numbers to facilitate exploratory noting and reflexivity. Each transcript was analysed individually, allowing immersion in the data. Initial stages involved reading and re-reading transcripts while listening to recordings to reconnect with participants' experiences, accompanied by making reflective notes (Smith et al., 2022).

Exploratory noting then captured descriptive, linguistic, emotional, and conceptual observations in the right-hand margin, identifying what mattered to participants (Smith & Osborn, 2008).

Next, concise experiential statements summarising key aspects of the exploratory notes were generated in the left-hand margin. These statements reflected the hermeneutic process, linking parts of the transcript to the whole narrative. Connections across statements were then

examined manually: statements were separated, arranged, and clustered into emergent themes, with irrelevant material discarded (Willig, 2008).

Themes were subsequently named and organised into Personal Experiential Themes (PETs), ensuring they accurately represented participants' experiences, before being tabulated digitally. This process was repeated for each participant, with reflective pauses between analyses to bracket assumptions carried from prior cases. Finally, group-level analysis identified similarities and differences across participants' PETs, producing Group Experiential Themes (GETs) while continuing to move between individual statements and the broader dataset (Smith et al., 2022).

5.5 Results

The analytic process discovered three GETs and nine sub-themes. Firstly '*Fearing Loss*', which comprised of: Confronted by Mortality; Uncertain Connections; Connection as Cure. The second GET '*Un(Safe)*', was composed of: On Home Turf: Anchorage or Avoidance?; Holding Back. The final GET was titled '*Seen Through a Screen*' and comprised of: Fading from View; Near and Far; Seeing and Being Seen.

This article will focus on the third GET, which explores participants experiencing of visibility in video therapy. The first sub-theme examines participants' experiences of invisibility both inside and outside the therapy room. The second sub-theme considers the varying sense of closeness and distance participants experienced when engaging in therapy through a screen. The third sub-theme highlights how reassurance was derived not only from observing the therapist's face, but also from the reciprocal experience of being visibly acknowledged by the therapist.

Sub-Theme 3.1: "*We're not worth.. we're not worth it to anybody anymore.*": Fading From View

This sub-theme explores how six participants experienced feeling invisible in the world outside the therapy room, but also at times inside the therapy sessions themselves. It feels valuable to understand the context of coming into therapy as an older adult, particularly due to a parallel process of invisibility occurring both inside and outside the therapy room. However, there was some divergence, with other participants describing how the visibility they had in session provided a stark contrast to that they experienced outside.

For several participants, invisibility was experienced within in the wider context of society:

“As a feminist, I spent much of my life trying to avoid the male gaze and but now I'm in my 70s, just about.. I'm kind of thinking, oh!... okay, invisible, you know, not of any interest to anybody in any sense whatsoever, either physically or intellectually or, you know.” (Bonnie, 41)

Bonnie reflects on shifting from avoiding the male gaze to confronting the erasure of ageing. Words like “invisible” suggest she feels faded from view. She seems caught between her feminist identity and a desire to be seen, navigating a double bind where too much attention is objectifying, but too little feels like social invisibility.

Another participant echoes a similar sentiment:

“There's no point in anything anymore, because that's how they made you feel. You know, the world, the society, how the world is coming on. It's like, one of the old donkeys in Spain innit, and they just push them off the side of a cliff, because they're useless. We're not worth we're not worth it to anybody anymore. We don't work anymore. We don't pay taxes anymore.” (Amber, 1044)

As Amber repeats “we're not worth it”, she highlights the way in which society views her as useless and worthless and I sense her moral outrage and anger at this injustice. I notice how Amber contrasts “we” and “they”, speaking to a sense of comradeship and positive identification with her peers, in juxtaposition with the external world and society that devalues and causes harm.

Whilst both Amber and Bonnie describe their experiences feeling invisible within the wider community, several other participants described this experience within their closer social groups. As one participant states:

“And you know, to be listened to... was I... mean, even just talking about it now, it's quite emotional (crying), because I felt so shut down, you know, with my interactions with people who were my friends...erm... you know, and I just felt quite lonely.....So that was huge...”. (Lorraine, 459)

Lorraine describes how she felt “so shut down” which speaks to an emotional emptiness and closing off from others. Lorraine juxtaposes this emptiness, with the attentiveness and care she received from the therapist, that was “huge”, expressing the enormity of this change.

Other participants described moments when they felt invisible to their therapist:

“Obviously she was, you know, constructive in what he was saying about making time for myself and trying to relax and all this type of thing. And doing these various

techniques for...um... you know.. helping with my sleeping pattern... like.. doing more exercise.. ah that was one of the big things actually, do a lot more.” (Martin, 148)

The invisibility in Martin’s account is not so much about what is said, but rather about what remains unsaid, what is invisible in his words. As Martin describes his therapy, he frames it in terms of outcomes and practical benefits as he describes the tasks he was recommended to do. However, the language he uses to describe these changes feels restrained. Words like “*constructive*” suggest functionality but lack the emotional depth or intensity.

Another participant was more explicit about feeling unseen in sessions:

“There were four or five of these round icons, and they blocked her face even more. See her face hardly with... with this interference on the bottom of the screen, and her face being so down on the screen. And I asked her, I said, you know, could you please make it so I can lip read? And she did it, and it lasted for about five minutes, and then it went down again to how it was.” (Jess, 254)

Jess struggled not only to see the therapist physically, but also to feel seen when her request went unresolved. Asking for this adjustment seemed courageous, as if expressing her needs felt risky, carrying the fear of rejection. The therapist, holding the power to accept or dismiss her request, reinforced this dynamic.

Sub-Theme 3.2: “*An old mate*”: Near and Far

This sub-theme explores how all but one participant described how through a video they felt a sense of closeness, or for some, a distance through a screen. For some participants they could feel and experience the whole of the therapist, whereas for others there seemed to be parts missing.

The language used by some participants indicated an experience of closeness:

“As I say, I feel quite emotional talking about it, I think as we.. because we, we, in a way, we worked it out together” (Delilah, 527)

The repeated use of “*we*” highlights a closeness, by suggesting there was a comradeship and team effort. I also wonder as Delilah becomes emotional, if she feels not only gratitude, but also mourns the loss of this significant and close relationship.

Another participant describes the way in which the video format brought about a sense of closeness:

"It was a bit like seeing an old mate. It was so funny, because it's like, I never done it before. And anyway, she pops up, and she said, Hello!, XXXX. And it's like, oh, I find it quite exciting, yeah, and she was really nice. So it was like, it's like an old mate." (Amber, 139)

As Amber talks, I can hear the nervousness at speaking to someone new, and she experiences emotions in close succession as she shifts from strangeness (*"I've never done it before"*) to comfort (*"quite exciting"*). There feels to be a paradox where something entirely new also feels like a reunion, something that feels like it happens when her face *"pops up"* and they are able to see each other.

Another participant also described a sense of closeness, but perhaps also with some distance:

"I think, because just that, the size of her face was just that it was, it was almost as though she was in the room with me....." (Lorraine, 367).

She continues:

"it just felt as though, yes, that, that she was a real presence in, in the room, rather than, you know, just a little picture on, you know, a little screen." (Lorraine, 376)

There is a richness and lifelikeness of the interaction, as Lorraine experiences the therapist as having a *"real presence"*. When Lorraine uses the word *"almost"*, on the one hand the word *"almost"* could indicate a togetherness, as though she was sitting in the room with someone; however, I also wonder if the therapist was just slightly out of reach.

Another participant experienced a noticeable emotional distance:

"The you know, her presence was very....what's the word....er.... unmoving. So it was very verbal, you know, depending on what I said. So as I say, you know, I said the last time we talked, there were pauses, significant pauses, and, er... that that was some deepening, but it it felt.. on reflection, kind of static. She always seemed to be in one place.... I suppose I remark that because I tend not to be static, I tend to sort of gesture quite a lot." (Simon, 236)

Simon's description of the lack of physicality in the session appears to have a double meaning. As he says the word *"unmoving"* he describes not only the physical movement of the therapist, but also the way in which he felt emotionally unmoved, or numbed, by the therapist's presence. I wonder if he experienced the therapist as cold in some way. Simon also uses the word *"static"* which indicates an interference, suggesting he felt the video medium interfered with his ability to get close to the therapist.

Whilst Simon experienced the distance as a barrier to feeling seen, another participant experienced the distance as protective:

“...more emotionally protected and self-protecting, but also a little bit more in control. And I could always, you know, end the call, if I wanted to, you can’t easily do that in the room. Not so easily.” (Bonnie, 163).

For Bonnie, having some distance between her and the therapist provided a sense of safety knowing she could easily “*end the call*”. This easily accessible escape route gave Bonnie the freedom to withdraw if she felt unsafe or vulnerable. Sitting in a separate room to someone we may feel less aware of their physical presence, and they may feel less imposing. Ending the session from a distance feels safer as Bonnie doesn’t have to hear or manage the other persons reaction.

Sub-Theme 3.3: “If your bottom lip starts to tremble, she can see that”: Seeing and Being Seen

This sub-theme describes how over half the participants experienced seeing the therapists face, and the therapist seeing their face, as reassuring, or for one participant, threatening.

Even prior to commencing therapy, one participant had a sense of the therapist based on her photograph:

“...because she was exactly how I thought she would be from her photograph (sounds happy). Yeah, there was sort of gentleness and warmth about her.” (Lorraine, 400).

Lorraine describes the fantasy she had of her therapist prior to meeting her, as though she could feel her, from seeing her picture. Lorraine uses the words “*gentleness and warmth*” which are both words that evoke the sense of touch, that feel soft, safe and warm. These qualities were permeated through a picture and also through the screen.

Other participants described the way in which the therapist seeing their face, allowed them to feel more at ease:

“Yeah, more, like, at home, and when you’re talking about things, especially if you’ve got, like, you know, depression, things and that sort of thing, and you’re sort of worried, you need to be at ease. You need to relax. When you get a bit all confused and a bit cuff-ffuld and a bit stressy, you’ve you forget what you’re trying to say. Well, I do. I think a lot of us older ones do we forget what we’re trying to say.” (Amber, 59)

Amber emphasises the importance of feeling at ease when having therapy sessions. She describes some of the difficulties she experiences in communication, outlining how she feels

“cuff-ffuld and a bit stressy”, and there may be a parallel process in the interview where she hesitates as uses filler words such as “like”. Amber experiences both psychological and somatic states as being intertwined, almost as a vicious cycle with stress and worry obstructing communication, which then creates a barrier to resolving the stress and worry. As Amber says “you’ve you forget what you’re trying to say. Well, I do. I think a lot of us older ones do” I hear a self-consciousness as she moves from externalising the forgetfulness, to taking ownership of it, to making it part of her group identity as an older adult.

Whilst for the participants above, seeing and being seen created a calmness, another participant highlighted how seeing the face through a video can create a sense of discomfort:

“It’s all faces and not, you know, because, like, I often maybe look into the distance when I’m talking about something. Do you see what I mean? And having that sort of eye to eye contact, and sort of, you know, front of face to front of face contact, I think is, is probably a bit, yeah, it strikes me as slightly unnatural.” (Simon, 379)

When he says “it’s all faces” I sense there be something intimidating about having the permanent gaze of the therapist. There is something about how Simon describes the “eye to eye” contact, that feels animalistic, almost as though he feels intimidated or intruded upon by having the full attention of the therapist, when he would rather look away.

5.6 Discussion

Participants in this study experienced social invisibility, reflecting a broader societal marginalisation of older adults. Feelings of being devalued or disregarded were often linked to their identity as an older adult and their unique context as one participant stated, “we’re *not worth it to anybody anymore*” (Amber, 1049). This aligns with research documenting older adults’ experiences of social estrangement, burden, and non-recognition (Kandasamy et al., 2018; Menezes et al., 2023).

The video modality acted both as a facilitator and a barrier to participants’ sense of presence and connection with the therapist. Many participants reported feeling fully seen despite the physical distance, challenging assumptions that online therapy diminishes relational quality (Schiano Lomoriello et al., 2018). Facial expressions were particularly important, providing reassurance, with the literature suggesting how seeing a therapists face instils a sense of trustworthiness (Pywell et al., 2020).

The participants varied in their experiences of distance, with some finding this to be isolating, whereas others experienced the distance to be protective, in line with research indicating video

therapy as giving clients a heightened sense of control (Simpson et al., 2005). These findings highlight the idiosyncrasies in experience and the importance of tailoring online therapy to individual comfort levels and relational preferences. Recommendations for overcoming this came from one participant, Simon, who suggested an open dialogue about how it feels to be working in this way, which could take some steps towards bringing client and therapist closer.

The study highlighted the centrality of authentic, relational encounters and how a meaningful I-Thou relationship can be forged over the screen (Buber, 1923/1958), with participants experiencing a closeness and felt presence of the therapist, despite not being in the room with them. Meaningful I-Thou encounters support psychotherapeutic growth, echoing Rogers' (1957) person-centred principles of unconditional positive regard, empathy, and congruence. The findings suggests that video therapy can be an effective and viable therapeutic option for older people wanting to access support from their own homes.

There were some gender differences in the study, with female participants more likely to report invisibility and experiences of ageism, which is supported in the literature highlighting the intersection of ageism and sexism, and women's heightened awareness of social non-recognition (Westwood, 2023). Additionally, female participants emphasised warmth and emotional connection, while male participants described interactions more matter-of-factly, reflecting broader evidence of gendered differences in therapy motivations and relational experiences (Arora & Bhatia, 2022). However, these findings should be approached with caution due to the limited sample size meaning the experiences could be idiosyncratic to the participants.

5.7 Conclusion and Future Research

This study explored how older adults experience video therapy, revealing three central themes: '*Fearing Loss*', '*Un(Safe)*', and '*Seen Through a Screen*'. The screen created both safety and distance, sometimes a comfort, sometimes a barrier. Most strikingly, experiences of being seen or unseen echoed the wider invisibility older adults face in society. Video therapy offered moments of recognition, yet also risked reinforcing feelings of erasure. These findings call us to action: counselling psychology must not only adapt therapy to meet older adults' needs but also challenge the social invisibility that shapes their lives.

Future research should prioritise older adults as a participant group, as they remain under-represented in both qualitative and quantitative studies, and including their lived experiences is essential to avoid incomplete understanding and the reinforcement of age-related assumptions or stereotypes (Mace et al., 2022). Subsequent studies could target more diverse

populations, including non-White participants, adults over 80, homebound individuals, and males, to explore experiences of those even less visible. Future research could also examine first-time users of video therapy and compare experiences across different therapeutic modalities. The engagement of services in support of this could help increase access to participants currently under-represented.

References

- Age UK (2019b). *Mental Health (England)*.
https://www.ageuk.org.uk/siteassets/documents/policy-positions/health-and-wellbeing/ppp_mental_health_england.pdf
- American Psychological Association (2015). *Survey of psychology health service providers*.
<https://www.apa.org/workforce/publications/15-health-service-providers/report.pdf>
- Arora, S., & Bhatia, S. (2022). Gender differences in factors that facilitate successful therapeutic progress and outcome: A pilot study. *Counselling and Psychotherapy Research*, 22 (4), 1030-1040. <https://doi.org/10.1002/capr.12564>
- Buber, M. (1958). *I and Thou* (2nd ed.; R. G. Smith, Trans.). Edinburgh, UK: T & T. Clark Ltd. (Original work published 1923)
- Butler, R. N., Lewis, M. L. (1982). *Aging and mental health: positive, psychosocial and biomedical approaches*. (3rd ed.) St Louis: Mosby.
- Campbell, R., Podugu, Sai Durga Vara Prasada Rao, & Morris, M. (2025). Online acceptance and commitment therapy for chronic pain in an older adult: A telehealth approach amid COVID-19. *Clinical Gerontologist*, 48(4), 844-854.
<https://doi.org/10.1080/07317115.2025.2487008>
- Choi, N. G., Hegel, M. T., Marti, N., Marinucci, M. L., Sirrianni, L., & Bruce, M. L. (2014). Telehealthproblem-solving therapy for depressed low-income homebound older adults. *The American Journal of Geriatric*, 22, 263–271.
<https://doi.org/10.1097/JGP.0b013e318266b356>
- Choi, N. G., Marti, C. N., & Conwell, Y. (2016). Effect of problem-solving therapy on depressed low-income homebound older adults' Death/Suicidal ideation and hopelessness. *Suicide & Life-Threateneing Behavior*, 46(6), 323-336.
<https://doi.org/10.1111/sltb.12195>
- Christensen, L. F., Wilson, R., Hansen, J. P., Nielsen, C. T., & Gildberg, F. A. (2021). A qualitative study of patients' and providers' experiences with the use of videoconferences by older adults with depression. *International Journal of Mental Health Nursing*, 30(2), 427-439. <https://doi.org/10.1111/inm.12803>
- DiNapoli, E. A., Pierpaoli, C. M., Shah, A., Yang, X., & Scogin, F. (2017). Effects of home-delivered cognitive behavioral therapy (CBT) for depression on anxiety symptoms among rural, ethnically diverse older adults. *Clinical Gerontologist*, 40(3), 181-190.
<https://doi.org/10.1080/07317115.2017.1288670>

- Fallon, J., Bhar, S., & Quinn, S. (2024). Telehealth dignity therapy for community-dwelling older adults: Feasibility and potential efficacy. *The Journal of Positive Psychology*, 19(6), 1109-1118. <https://doi.org/10.1080/17439760.2023.2298957>
- Fronza Pacas, G., Mitchel, L. K., Pachana, N. A., Byrne, G. J., Liddle, J., Yang, J., Brooks, D., Au, T., Pourzinal, D., Worthy, P., Comans, T., Beattie, E., Bennett, S., Russell, T., & Dissanayaka, N. N. (2025). Telehealth cognitive behavior therapy to reduce anxiety in people living with cognitive impairment: A randomized feasibility pilot study. *Clinical Gerontologist*, 48(4), 684-698. <https://doi.org/10.1080/07317115.2024.2336187>
- Gross, P. E., & Eshbaugh, E. M. (2011). Tuning them in versus turning them on: How do we interest students in working with older adults? *Gerontology & Geriatrics Education*, 32, 122–134. doi:10.1080/02701960.2011.572037
- Jeyasingam, N., McLean, L., Mitchell, L., & Wand, A. P. F. (2023). Attitudes to ageing amongst health care professionals: a qualitative systematic review. *European geriatric medicine*, 14(5), 889–908. <https://doi.org/10.1007/s41999-023-00841-7>
- Kaiser, P., Dykes, K., & Lord, N. (2025). Age equality in mental health: Déjà vu all over again. *Psychology and psychotherapy*, 10.1111/papt.12594. Advance online publication. <https://doi.org/10.1111/papt.12594>
- Kandasamy, D., Platts-Mills, T. F., Shah, M. N., Van Orden, K. A., & Betz, M. E. (2018). Social Disconnection Among Older Adults Receiving Care in the Emergency Department. *The western journal of emergency medicine*, 19(6), 919–925. <https://doi.org/10.5811/westjem.2018.9.38784>
- Knight, B. G., & Winterbotham, S. (2020). Rural and urban older adults' perceptions of mental health services accessibility. *Aging & Mental Health*, 24(6), 978-984. <https://doi.org/10.1080/13607863.2019.1576159>
- Lebrasseur, A., Fortin-Bédard, N., Lettre, J., Raymond, E., Bussi res, E. L., Lapierre, N., Faieta, J., Vincent, C., Duchesne, L., Ouellet, M. C., Gagnon, E., Tourigny, A., Lamontagne, M.  ., & Routhier, F. (2021). Impact of the COVID-19 Pandemic on Older Adults: Rapid Review. *JMIR aging*, 4(2), e26474. <https://doi.org/10.2196/26474>
- Lee, J. L. C., Chan, K. O. W., Kwan, R. Y. C., & Wong, A. Y. L. (2024). Vitality at home: A phenomenological study of tele-exercise in women aged 80 and older. *European Review of Aging and Physical Activity*, 21(1), 25-11. <https://doi.org/10.1186/s11556-024-00360-9>

- Levy B. (2009). Stereotype Embodiment: A Psychosocial Approach to Aging. *Current directions in psychological science*, 18(6), 332–336. <https://doi.org/10.1111/j.1467-8721.2009.01662.x>
- Mace, R. A., Mattos, M. K., & Vranceanu, A. M. (2022). Older adults can use technology: why healthcare professionals must overcome ageism in digital health. *Translational behavioral medicine*, 12(12), 1102–1105. <https://doi.org/10.1093/tbm/ibac070>
- Menezes, D., Woolrych, R., Sixsmith, J., Makita, M., Smith, H., Fisher, J.,... Murray, M. (2021). 'You really do become invisible': Examining older adults' right to the city in the United Kingdom. *Ageing & Society*, 1-20. doi:10.1017/S0144686X21001793
- NHS Digital (2022, January 14). *NHS Talking Therapies for Anxiety and Depression*. <https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/nhs-talking-therapies/>
- Office for National Statistics (2023). *Profile of the older population living in England and Wales in 2021 and changes since 2011*. <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/profileoftheolderpopulationlivinginenglandandwalesin2021andchangessince2011/2023-04-03#:~:text=Source%3A%20Census%202021%20from%20the%20Office%20for%20National%20Statistics,-Embed%20code&text=The%20largest%20differences%20were%20for,85%20and%20over%20in%202021>
- Pearson, J. L., Cohn, D. A., Cowan, P. A., & Cowan, C. P. (1994). Earned- and continuous-security in adult attachment: Relation to depressive symptomatology and parenting style. *Development and Psychopathology*, 6(2), 359-373. <https://doi.org/10.1017/S0954579400004636>
- Pywell, J., Vijaykumar, S., Dodd, A., & Coventry, L. (2020). Barriers to older adults' uptake of mobile-based mental health interventions. *Digital health*, 6, 2055207620905422. <https://doi.org/10.1177/2055207620905422>
- Rogers, C. R. (1957). The Necessary and Sufficient Conditions of Therapeutic Personality Change. *Journal of Consulting Psychology*, 21, 95-103. <http://dx.doi.org/10.1037/h0045357>
- Rollandi, I., Banerjee, S., Qiu, Y., Fiallo, O., Abramson, T., Berman, J., Solomonov, N., & Sirey, J. A. (2025). Improved outcomes for depressed elder abuse victims with video-delivered psychotherapy during COVID-19. *Psychotherapy research : journal of the*

- Society for Psychotherapy Research*, 35(2), 306–318.
<https://doi.org/10.1080/10503307.2023.2292743>
- Saunders, J., & Allen, C. (2021). Transitioning transdiagnostic CBT from face-to-face to telephone delivery during the coronavirus pandemic: A case study. *Clinical Case Studies*, 20(6), 498–514. <https://doi.org/10.1177/15346501211018278>
- Schiano Lomoriello, A., Meconi, F., Rinaldi, I., & Sessa, P. (2018). Out of Sight Out of Mind: Perceived Physical Distance Between the Observer and Someone in Pain Shapes Observer's Neural Empathic Reactions. *Frontiers in psychology*, 9, 1824.
<https://doi.org/10.3389/fpsyg.2018.01824>
- Schoenenberg, K., & Martin, A. (2024). Empathy, working alliance, treatment expectancy and credibility in video and face-to-face psychotherapeutic first contact. *Psychotherapy research : journal of the Society for Psychotherapy Research*, 34(5), 626–637. <https://doi.org/10.1080/10503307.2023.2233685>
- Schoenenberg, K., Raake, A., & Koeppe, J. (2014). Why are you so slow? — Misattribution of transmission delay to attributes of the conversation partner at the far-end. *International Journal of Human-Computer Studies*, 72(5), 477–487. <https://doi.org/10.1016/j.ijhcs.2014.02.004>
- Scogin, F., Lichstein, K., DiNapoli, E. A., Woosley, J., Thomas, S. J., LaRocca, M. A., Byers, H. D., Mieskowski, L., Parker, C. P., Yang, X., Parton, J., McFadden, A., & Geyer, J. D. (2018). Effects of Integrated Telehealth-Delivered Cognitive-Behavioral Therapy for Depression and Insomnia in Rural Older Adults. *Journal of psychotherapy integration*, 28(3), 292–309. <https://doi.org/10.1037/int0000121>
- Scogin, F., Welsh, D., Hanson, A., Stump, J., & Coates, A. (2005). Evidence-Based Psychotherapies for Depression in Older Adults. *Clinical Psychology: Science and Practice*, 12(3), 222–237. <https://doi.org/10.1093/clipsy.bpi033>
- Simpson, S., Bell, L., Knox, J., & Mitchell, D. (2005). Therapy Via Videoconferencing: A Route to Client Empowerment? *Clinical Psychology & Psychotherapy*, 12(2), 156–165. <https://doi.org/10.1002/cpp.436>
- Simpson, S. G., & Reid, C. L. (2014). Therapeutic alliance in videoconferencing psychotherapy: a review. *The Australian journal of rural health*, 22(6), 280–299.
<https://doi.org/10.1111/ajr.12149>
- Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 53–80). Sage. <https://doi.org/10.1002/9780470776278.ch10>

- Smith, J. A., Flowers, P., & Larkin, M. (2022). *Interpretative phenomenological analysis: Theory, method and research* (2nd ed.) SAGE.
- Thomas, N., McDonald, C., de Boer, K., Brand, R. M., Nedeljkovic, M., & Seabrook, L. (2021). Review of the current empirical literature on using videoconferencing to deliver individual psychotherapies to adults with mental health problems. *Psychology and psychotherapy*, 94(3), 854–883. <https://doi.org/10.1111/papt.12332>
- Warnock, R., Taylor, F. M., & Horton, A. (2022). Should we pay research participants? Feminist political economy for ethical practices in precarious times. *Area*, 54(2), 195–202. <https://doi.org/10.1111/area.12790>
- Weir, K. (2023). *A New Concept of Aging: Ageism Is One of the Last Socially Acceptable Prejudice. Psychologists Are Working to Change that.* <https://www.apa.org/monitor/2023/03/cover-new-concept-of-aging>
- Westwood, S. (2023). “It’s the not being seen that is most tiresome”: Older women, invisibility and social (in)justice. *Journal of Women & Aging*, 35(6), 557–572. <https://doi.org/10.1080/08952841.2023.2197658>
- Willig, C. (2008). *Introducing Qualitative Research in Psychology Adventures in Theory and Method*. Open University Press

PART C: Clinical Case Study

“Through the Looking Glass”