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EnACTing change: an exploration of Older Adults experiences of change with Acceptance and Commitment Therapy

Ella Casey Kicks, MA (Hons), MA

A thesis submitted in partial fulfilment of the requirements for the degree of **Doctorate of Clinical Psychology**

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Abbreviations

ACT	Acceptance and Commitment Therapy
CI	Change Interview
CF	Common Factors
CP	Change Processes
HSCED	Hermeneutic Single-Case Efficacy Design
OAs	Older Adults
RTA	Reflective Thematic Analysis
SQA	Secondary Qualitative Analysis
TA	Thematic Analysis

Thesis Abstract

Background

Older adults (OAs) are an increasing demographic, with a range of physical health and mental health challenges that are unprioritized. Psychotherapy has utility with OAs, despite assumptions about their difficulties engaging due to the comorbidities of their physical and mental health and social stressors. The promising evidence base and the transdiagnostic and practical nature of Acceptance and Commitment Therapy (ACT) makes it appear uniquely suited for this client group (Petkus & Wetherell., 2013; Robert et al., 2016). However, there is a lack of exploration of the processes of change for ACT, for OAs, and generally – despite that understanding processes of change is thought allow for the optimisation of psychotherapy (Kazdin, 2007).

Methods

This thesis project completed secondary qualitative analysis using Change Interview data from three Hermeneutic Single Case Efficacy Design series studies that used ACT interventions with OAs with dementia, or depression and anxiety, or who were hearing voices. An inductive-deductive reflexive thematic analysis was used, and the inductive analysis allowed for exploration of OAs experiences of change. The deductive analysis allowed for exploration of the theoretically proposed ACT-specific and common factors processes that might have underpinned experiences of change. Analysis was completed on the semantic and latent levels of meaning, and saliency analysis and consultation with an expert by experience were used to enhance analysis.

Results

Three themes were generated from the data and highlighted that participants experiences of change were moderated by whether it was the right time for them to engage considering their circumstances and access to internal and external resources, that therapy led to behavioural changes and realisations, and that they experienced they experienced positive therapeutic relationships and their therapists as skilled, but that therapy was exposing. ACT-specific processes of psychological flexibility were evidenced throughout, but so were the processes of psychological inflexibility. This might explain some of the variance in change captured in the original studies.

Discussion

This thesis has provided a unique contribution to the literature by highlighting how OAs experienced change, the contexts that impact their experiences of change, and the therapy-specific and common factors processes that mapped onto their experiences of change. The findings have provided evidence towards the transdiagnostic nature of ACT. The findings are theoretically aligned the findings with the understanding of change-processes, the behavioural origins of ACT. However, the results give greater detail about the contexts and types of factors that impact OAs experiences of change, and provide experiential evidence to supplement the current evidence base for ACT. Future research would do well to address the limitations of this study in terms of the limited diversity of OAs, and to consider using current ideas like social capital or stabilisation to help OAs to engage at the right time and with the right resources to benefit from therapy.

This study has also provided evidence towards the utility of secondary qualitative analysis for the field of contextual behavioural science, and how Change Interview data can be used to provide new insights with populations where research can be burdensome.

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Thesis	
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Journal Paper

EnACTing change: an exploration of Older Adults experiences of change with Acceptance and Commitment Therapy

Ella Casey Kicks*[1], Dr Danielle De Boos[1], and Dr Nima Moghaddam[2]

[1]Trent Doctorate in Clinical Psychology, University of Nottingham, Nottingham, UK

[2]Trent Doctorate in Clinical Psychology, University of Lincoln, Lincoln, UK

*Correspondence to: Ella Kicks. Email: @nottingham.ac.uk. Address: YANG Fujia Building, B Floor, Jubilee Campus, University of Nottingham, Wollaton Road, Nottingham, NG8 1BB, UK.

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Data Availability Statement

Data is available from the corresponding author upon reasonable request.

Ethics

Ethical approval was not required for this study.

Declaration Of Interest Statement

Authors declare no competing interests.

Abstract

Background: Acceptance and Commitment Therapy has shown to be efficacious for a variety of conditions for older adults. However, there is limited understanding of the processes underpinning therapeutic change for older adults, and a scarcity of research exploring their lived experiences of Acceptance and Commitment Therapy. This limits our understanding of how older adults might engage with and benefit from this therapy.

Methods: This study used inductive and deductive reflexive thematic analysis to analyse Change Interview data from three studies where older adults completed an acceptance and commitment therapy intervention. Experiences of change were explored, and inferences drawn about change mechanisms.

Results: The inductive analysis highlighted that older adults experienced their circumstances and access to internal resources (like capacity for reflection) and external resources (like social support) as important moderators of change. The deductive analysis highlighted therapy-specific theoretical change processes like committed action and defusion and common factors like new insight and catharsis that underpinned participants experiences.

Conclusions: This study reinforced Acceptance and Commitment Therapy's transdiagnostic potential in facilitating change for older adults with diverse presentations. It has highlighted changes processes that could be optimised and the need to support older adults' personal circumstances and resources to increase their ability to experience change as a result of therapy.

Keywords: Older adults, change processes, Acceptance and Commitment Therapy

Introduction

The mental health needs of Older Adults (OAs) continue to be overlooked (Age UK, 2019; Royal College of Psychiatrists, 2018). National Institute for Health and Care Excellence Guidelines (2016) recognise the detrimental impact of health and social challenges of older age on OAs wellbeing, yet psychological interventions are underutilised. The physical health and cognitive difficulties associated with older age has been shown to complicate treatment of mental health concerns like depression (Scher et al., 2023).[1] These complications and the rising numbers of this demographic (World Health Organisation, 2023) makes it crucial to identify and optimise appropriate psychotherapies.

Acceptance and Commitment Therapy (ACT: Hayes et al., 1999) is a contextually focused therapy with cognitive and behavioural origins (Wilson et al., 2011)[2]. The transdiagnostic and value-driven nature of ACT should resonate with OAs given their comorbidities (Pettkus & Wetherell, 2013) and their life stage being characterised by greater reflection (Roberts & Sedley., 2016). ACT has now been evidenced for OAs for conditions like treatment-resistant anxiety (Gould et al., 2021) and depression (Sun et al., 2024). OAs with chronic pain have even responded better to ACT than traditional cognitive behavioural therapy (Wetherell et al., 2016)[3]. However, meta-analyses have identified a need to focus on processes of therapeutic change (Gloster et al., 2020) since the evidence base for ACT with OAs is somewhat inconclusive (Sun et al., 2024) and it has proved challenging to determine or evaluate specific mechanisms of change (Coto-Lesmes et al., 2020). Understanding change

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[1] See extended paper section 1.3 for further information on OAs

[2] See extended paper sections 1.4 and 1.5 for further information on ACT and the philosophical and theoretical underpinnings

[3] See extended paper section 1.4.1 for specific information about ACT and OAs

processes (CPs) should help optimise therapeutic change (Kazdin, 2007)[4]. There is a literature gap in understanding the mechanisms of change for ACT (Cheng et al., 2019; Gloster et al., 2020), and an absence of literature about CPs for OAs generally.

The processes or factors that impact patient outcomes in therapy have been separated into categories like specific therapy techniques, extra-therapeutic factors and non-specific or ‘common’ factors (CFs; Lambert & Barley, 2001). CFs should not be neglected (Weinberger & Eig, 1999), and research should integrate common and therapy-specific factors when evaluating CPs (Browne et al., 2021). CFs include well-evidenced factors like the therapeutic relationship and alliance, empathy, and expectations of helpfulness that are considered necessary to support meaningful change (Wampold, 2015)[5].

The central mechanism of change in ACT is purported to be psychological flexibility, the ability to be in contact with the present moment, one’s values and act accordingly despite discomfort or distress (Ciarrochi et al., 2010). Psychological inflexibility is considered the primary cause of pathology (Hayes et al., 1999). The processes underpinning psychological inflexibility (please see Figure 1) are associated with psychopathology in OAs. For example, experiential avoidance moderates OAs relationships between health, and anxiety and depression (Andrew et al., 2007), internalised stigma and help-seeking behaviour (Murphy & Mackenzie, 2023) and anhedonia (Ferguson et al., 2017).[6]

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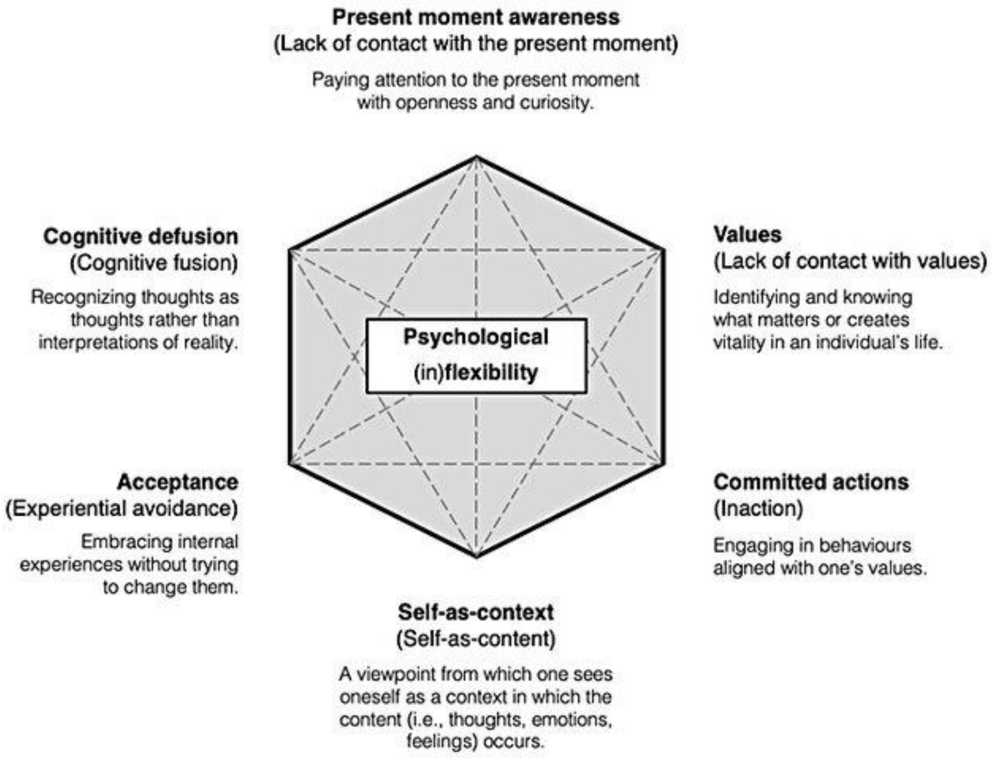
[4] See extended paper section 1.7 for further information about mechanisms/processes of change

[5] See extended paper section 1.9 for discussion about Common Factors

[6] See extended paper section 1.8 for discussion about processes of change for ACT

Figure 1

Processes of Psychological Flexibility (Ptáček & Jelínek, 2024, adapted from Hayes et al., 1999)



Analysing language, context and cognition is necessary to understand human behaviour according to the philosophy underpinning ACT (Hayes, 2004)[7]. Unfortunately, qualitative research has been neglected in this field despite its' value in understanding the context and processes of change (Jando & Dionne, 2024)[8]. Current qualitative research has focussed on experiences of interventions more generally rather than of change (Ruan et al., 2023). Some authors have used qualitative data to explore experiences of change following ACT interventions (e.g. Edwards et al., 2023) and used Change Interview (CI; Eliott, 2006)[9] data to explore experiences of change for other therapies (Dourdouma et al., 2019)[10]. Qualitative research provides a valuable means of exploring the subjective and nuanced experiences of marginalised populations like OAs (Phoenix, 2018) making this an apt approach for understanding processes underpinning therapeutic change. Using qualitative methodology

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[7] See extended paper section 1.5 for discussion of the philosophies underpinning ACT

[8] See extended paper section 1.6 for discussion about qualitative research and the context of ACT

[9] See extended methods section 2.1.1 for information about Change Interviews

[10] See extended paper section 1.6.1 for specific information about qualitative research in ACT

will provide triangulation of methods, giving deeper understanding and more credibility to the current evidence-base (Bans-Akutey & Tiimub, 2021)[11] for ACT. This study analysed qualitative CI data to explore OAs experiences of ACT interventions.

Aims

This study aimed to use qualitative analysis to explore the experiences of change of OAs who had undergone ACT interventions.

The second aim was to explore how experiences of change map onto underlying CPs (as informed by the literature on ACT and on CPs in psychotherapy more generally).

Methods

This study used secondary qualitative data analysis (SQA) to synthesise and explore accounts and experiences of CPs. Ethical approval was sought but not required. Approval for the original studies included reanalysis[12]. The SQA's purpose was to evaluate new research questions from the primary studies (Heaton, 2004, 2008)[13]. Three studies were selected by the research team due to comparability of the ACT interventions, methodology and participants – whilst purposively integrating a range of presenting concerns and comorbidities, given ACT's transdiagnostic potential[14]. Consideration was given to the richness of the data (Fusch & Ness, 2015), and concepts of saturation, sufficiency and information power (Braun & Clarke, 2012a; LaDonna et al., 2021; Malterud et al., 2016)[15].

Interventions

All three studies used adjudicated hermeneutic-single case efficacy designs (HSCEDs; see Elliott, 2002)[16]. HSCEDs integrate multiple forms of evidence (including CIs) to assess individual therapeutic change, making HSCEDs suited to in-depth exploration of psychotherapy processes. The original HSCEDs assessed the role of ACT processes and extra-therapeutic processes to judge the extent that any meaningful change could be attributed specifically to ACT. Participants completed an ACT intervention with a therapist-researcher (who was a trainee clinical psychologist) and completed a CI with another researcher independent to the projects[17]. Participants in Study One had a caregiver present to support engagement. Commonalities included that the studies had the same supervision team, used the same fidelity checking processes (ACT Fidelity Measure, O'Neill et al., 2019)

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[11] See extended methods section 2.3 for discussion about the value of qualitative research

[12] See appendix B through to J for ethical approval documents for this study and the primary studies

[13] See extended methods 2.3 section for further rationale for a secondary qualitative approach

[14] See extended methods section 2.4 for consideration about the sample size

[15] See extended methods section 2.4 for discussion of these principles in relation to this study

[16] See extended methods 2.2 for information about HSCED methodology

[17] See extended methods section 2.6 for information about researchers

and that all three therapist-researchers had additional training in ACT prior to their interventions[18]. All three primary studies were rated highly for ACT fidelity.

Participants

Please see Table 1.

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[18] See extended methods section 2.7 for further information about the original studies

Table 1

Study and Participant Characteristics

Study	***Recruitment***	***N***	***Pseudonyms***	***Presenting Issues***	***Intervention***	***Age range***	***Delivery***	***Outcome of Therapy***
1	NHS Memory Assessment Service (n=2)	3	Minnie	Dementia	12, weekly ACT sessions	71-90	Online	Meaningful improvement attributable to ACT
			Agatha					Overall unchanged
	Join Dementia Research (n=1)		Phyllis					Some improvement, overall unchanged
2	OAs Community Mental Health Teams (CMHT)	3	Carol	Anxiety or Depression	12, weekly ACT sessions	66-77	Telephone	Overall unchanged
			Jean					Overall unchanged
			Mike					Meaningful improvement attributable to ACT

3	OAs CMHT	2	Ann	Hearing Voices	12, weekly ACT sessions	65-75	Face to Face	Meaningful improvement attributable to ACT
			Maggie					Meaningful improvement attributable to ACT

Analysis

An inductive-deductive reflexive thematic analysis (RTA: Braun & Clarke, 2019) was completed using NVivo 14 software (Lumivero, 2023). Thematic analyses are suited for clear research aims (McLeod, 2015) and RTA specifically for exploring context and experience (Braun & Clarke, 2022) across whole data sets – allowing inferences to be applied more widely (Braun & Clarke, 2021) than with other qualitative methods (Starks & Trinidad, 2007). During the inductive analysis, data-driven codes were generated that evolved with deeper understanding of the data (Braun & Clarke, 2021) – an organic approach that felt important given the lack of qualitative analysis in this area[19]. RTA also enabled deductive analysis, and a deductive framework was compiled informed by theories of change mechanisms (see Appendix)[20]. In the spirit of RTA, the phases of TA (Braun & Clarke, 2006) stated below were applied flexibly based on engagement with the data[21]:

Table 2

Stages of RTA (Braun & Clarke, 2006)

STAGE	
1	Familiarisation of the data through reading of the transcripts
2	The generation of initial codes based on points of interest in the data, evidence collated for codes.
3	The creation of themes from initial codes
4	Reviewing of themes based on evidence from the previous steps
5	Defining themes with names or clear definitions based on the data within the themes
6	Production of report, using the themes and examples of themed data to communicate to the readers

The original studies resulted in eight (each approximately an hour-long) CI's. Transcripts were read several times and initial codes discussed before data sets were analysed recursively and iteratively (with an audit trail kept of the analysis process). In the spirit of reflexive rather than procedural TA, the analysis being inductive *and* deductive, allowed for interpretation on semantic *and* latent levels of meaning (Braun & Clarke, 2019; 2021; 2022). This captured explicitly described experiences, and interpreted implications for potential underlying theorised mechanisms of change. Saliency analysis was used to assess codes

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[19] See extended methods section 2.8.1 for further information about RTA

[20] See extended methods section 2.8.2 for information about the deductive framework

[21] See extended discussion section 4.5 for reflection on how RTA was applied

based on recurrence and importance (Buetow, 2010)[22]. A reflective diary was kept to support transparency and reflexivity during the analysis 'journey' (Braun & Clarke, 2019). This was shared with research supervisors at regular intervals, and codes and themes were discussed and created with the research supervisors at these points. Inductive and deductive findings did not need additional integration and final themes represented patterns of shared meaning united by core underpinning salient concepts (Braun et al., 2014) rather than shared topics or domains (Braun & Clarke, 2019). A member of an Expert by Experience Panel provided a consultation session on the final themes, to offer an additional perspective and help identify and address any biases and assumptions that were shaping the analysis and write-up. Throughout analysis, consideration was given to guidelines about trustworthiness (Lincoln & Guba, 1985; Nowell et al., 2017) and good practice (Braun & Clarke, 2020) for TA[23].

Reflection highlighted what factors might have influenced the analysis (Braun & Clarke, 2022). The primary researcher recognised their knowledge of ACT (including of the theoretically proposed CPs), experience utilising an ACT-informed approach with patients (including OAs) and expectations about the utility with this population. All researchers were familiar with the literature about CPs[24]. From a functional contextualist stance, the researchers were interested in the context of which change was experienced[25].

Results

Three over-arching themes were constructed in relation to participants' experiences of change and engagement in therapy: (1) *Right Time and Place*, (2) *Skilled Encounters*, and (3) *Therapy as the Catalyst* for change. Figure 2 illustrates the relationships between themes and subordinate themes.

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[22] See extended results section 3.1 for information about the saliency analysis and how this shaped results

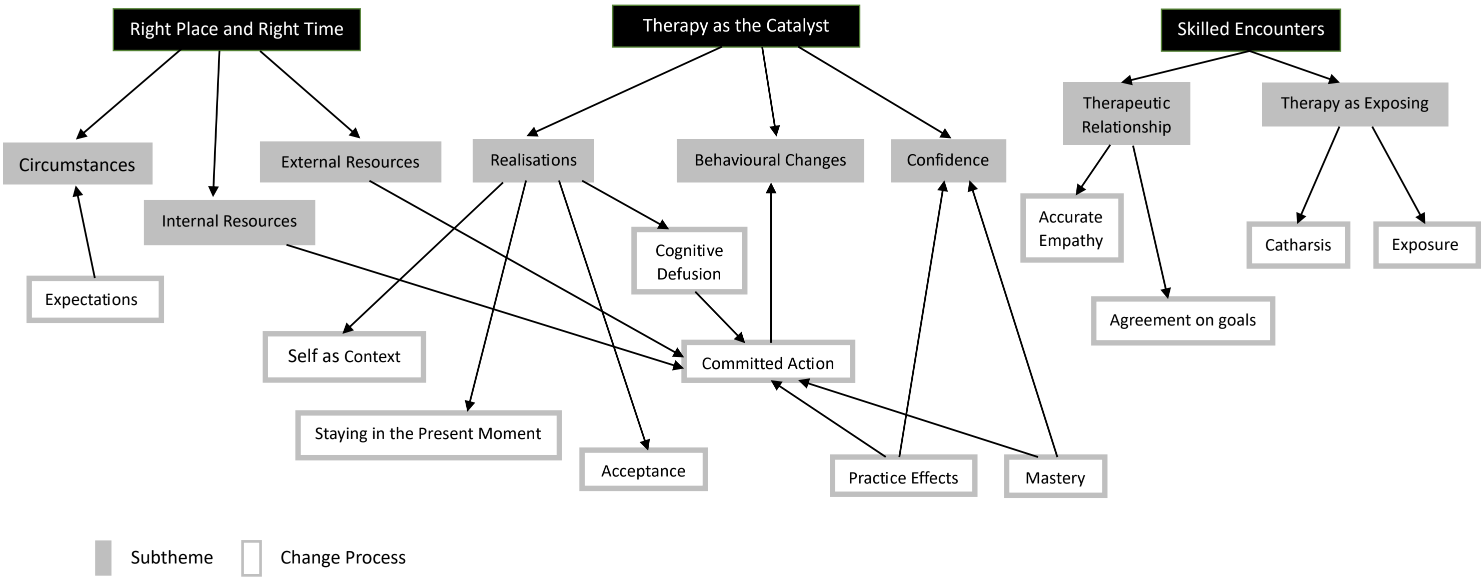
[23] See extended discussion section 4.5 for information on these concepts and reflection on how they shaped this study

[24] See extended methods section 2.6 for further consideration about the research team and the impact on analysis

[25] See extended methods section 2.4 for information about the epistemological stance of this study

Figure 2

Thematic Map



Right Time, Right Place

All participants experienced change as impacted by whether it was the right time for them for therapy. Some participants spoke about being in the right headspace for therapy, as captured by Minnie who was unsurprised by the changes she experienced because “you weren’t me, you weren’t in my head...I was in a position where I was beginning to pull myself together... I was in a position that I wasn't fighting my corner at that point”. Others experienced change as moderated by whether it was the right time regarding subordinate themes like their social circumstances, internal and external resources and expectations. This finding has provided insights into the contexts that influenced experiences of change.

Circumstances

Six participants spoke specifically about how their social circumstances facilitated change, with ‘Ann’ sharing how improvements to housing circumstances meant she was finally “very, very safe here…I wasn’t where I lived before.”, and changes she experienced would not have been the case without this safety. One participant highlighted how the lack of distress within her personal life had allowed her to engage, whereas others identified distressing personal situations as barriers to change. Circumstances were experienced as impacting specific CPs like committed action, where the time of year was highlighted by some participants to allow for value-directed behavior but the restrictions of the lockdowns for others hindered their ability to engage in this process to experience change. These results suggest that whether or not participants engaged in therapy during the right time and place for them was experienced as a moderator to change generally, and in terms of underlying processes.

Interestingly, participants seemed to experience a balance between having their social circumstances sufficiently settled enough to be able to engage in therapy, but also to be currently experiencing an appropriate amount of vulnerability for therapy to be useful and relevant in its timing. 'Jean' experienced her family difficulties as challenging but appropriate to be addressed through therapy, sharing "when I first went into therapy, [family] was a big issue in my life... and I was quite, churned up, at the time, when the time came for [therapy]" but that she had been able to open up and address this with the therapist. Where it *was* the right time and right place for some individuals to experience change, this was strikingly not the case for other participants who identified their social circumstances as barriers to experiencing change. 'Carol' spoke at length about challenges in her family system and how "things come up every, single, day, of my life, that causes me upset." and how therefore "it's not always a remedy to be mindful". 'Agatha' spoke of struggling to manage the time commitment for therapy and the limitations caused by the extent of her dementia and her health (the latter a sentiment shared by Jean). These examples highlight the tension participants experienced between having circumstances settled enough to facilitate engagement, with challenges and vulnerabilities enough for therapy to be relevant to them, yet not so much as to be experienced as barriers.

Internal resources

All participants identified internal resources that were experienced as supporting change. Carol recognised the value of her own reflective nature, and Phyllis and Ann showed commitment and determination - saying respectively that "I mean, if you're going to do something, you do it" and "Outside of therapy it was just putting my mind to it.". Where all participants spoke about personal characteristics, Minnie also found her experiences of grief helped her to connect with therapy, as they had primed her "to realise that you've got to change your thought patterns a little bit".

Conversely, participants experienced internal barriers to change. Jean reported that "the hardest is, opening up that I've got a problem. Because, as I say I, I don't open up very easily. Very hard to get to... holding everything in and not letting it out." and 'Maggie' reported how "I'm very independent. I like to try and do things my own way…you're trying to give me new ways". Mike and Minnie talked about how their motivation can waver, captured through Mike saying "at the end it's very difficult to keep the momentum going". Some participants showed evidence of struggling within the interview itself to reflect on themselves and their experiences, with Jean exclaiming (when questioned about how her personal strengths might have helped in therapy) “Me? No! I can’t see how I could help”. These instances of lack of insight were interpreted as evidencing internal barriers.

Participants internal expectations were also experienced as impacting change. Some participants, like Carol spoke clearly about how bringing expectations that were unaligned with ACT was unhelpful and hindered the possibility of change. Most participants talked about how their ambivalence or lack of expectations hindered change, despite all identifying experiencing positive changes. The exception was Agatha who held positive expectations, citing ‘I was just curious and I suppose I must have been thinking if there’s anything that might help, I should give it a try’, but then felt disappointed and experienced the least amount of change.

External resources

Change was moderated by the resources around participants, in terms availability of social networks and family, and their local communities. Jean gave examples of family support having helped her practically to engage in the therapy and overcome technological barriers, and Maggie highlighted her relationship with her partner as motivating her engagement in therapy because she valued how his joy in her recovery. The value of external social resources was not limited to family members, as Phyllis valued her neighbour’s support and Maggie appreciated how her Occupational Therapist supported her to practice ACT techniques outside of therapy sessions.

Family as an external resource also acted as a barrier to change. Some participants identified that their networks of support were limited, and Carol explicitly named her family as unhelpful and causing ‘the devastation that I am continuously having’. Some participants discussed the barrier of the covid 19 lockdowns, with Phyllis, Minnie and Jean having shared in detail about the impact of the lockdown on the external world around them and what community resources they could access.

Therapy as the Catalyst

Participants experienced therapy as the ‘catalyst’ for prompting new realisations and behavioural changes that mapped onto underpinning CPs.

Realisations

Therapy was described (by Phyllis’s carer) as ‘the catalyst’ for participants realisations about themselves, their lives, and their difficulties. Therapy led to what Carol described as “an epiphany”. Some of these realisations involved normalising, changes of perspective. Mike found therapy made it “not so unacceptable to have strange thoughts and feelings” and experienced realisations where “I hadn’t even thought of it before. It's like a massive carbuncle that you've not seen before, you suddenly think, "oh my god, yeah. Why did I not see that?"…it has been a revelation". Other realisations involved recognising, confronting and accepting their difficulties.

> "therapy, it sort of nudged me into a position that I realised I could take control of what was happening to me and to understand the reasoning and what was happening to me. It's not what I would have liked to expect, but this is where I was" (Minnie)

Participants realisations about their own resources facilitated engagement in committed action. For example, Minnie found "therapy reminded me of methods that I could use to get to a stable place where I was alright. All the time there is that, 'I don't want to be a burden to the children'". Minnie also "realised that I'd got to move on, that it's no good sat there brooding about what you've lost" and realised the value of "diverting the bad thoughts into querying thoughts about what I'm doing". These quotes demonstrate realisations about the benefit of Staying in the Present Moment and moving on from the bereavements in her past, and her headway into viewing herself as the observer to her own thoughts. Other participants realized the value of viewing themselves as the Context: "I can rationalize it now...it's kind of looking at it objectively. It's just hit me Jonathan said, "with curiosity," objectively it should be ok, so I'll do it. Which is very useful." (Mike).

Unfortunately, at other times participants viewed themselves in ways more consistent with psychological *in*flexibility processes like Cognitive Fusion or of Self-as-Content and, with Mike sharing "I feel a little fruitcase" and Maggie reporting "I still think I'm barmy." Participants experienced varying degrees of Acceptance, with Ann reporting how "I wanted to get rid of the voices. And it's just accepting that they won't go away. That they're there, and just cope with them.". In contrast, Carol shared how an exercise prompted realisations about the extent of her own experiential avoidance:

> "I was asked to get more in touch with my own feelings. And I know it sounds like a stupid thing, but he asked me to picture it in my mind, and I did, and I had to really sort of go back and analyse that, because my heart was in a box with a chain round it…because I wanted to protect it…I don't always give me permission to get in touch with me feelings"

Despite some salient headway in Acceptance, participants still demonstrated experiential avoidance. Mike shared that "I came to the conclusion that it's me, it's something about me that is just so resistance to...or frightened of, to be honest, of, accepting the past." And Maggie reported "I try and hold myself… umm… Back from getting angry...but it doesn't always work". Where CPs were present and often intertwined, so were the reverse processes. Agatha exhibited a mix of the psychological *in*flexibility processes of experiential avoidance and cognitive fusion/self-as-content: “I try to make myself calm down and be a bit less manic, but it doesn't work that well. I mean, I think it's just how I am, perhaps how I've always been”.

For behavior change

Participants did not explicitly talk about values but instead described how therapy catalysed behavioral changes in their lives, in line with things that were important to them – which the deductive analysis highlighted mapped onto the process of committed action. These changes included accessing places and social groups that were important to them, engaging more in hobbies, and purposefully increasing positive contacts with family, friends, and even spouses. Phyllis shared feeling “more aware of sort of going out and, talking to people or just observing what they do and trying to help if help is needed” underpinned by the implied value of helping others. Committed action appeared to be reinforced by the common factor process of practice effects, with Mike highlighting how despite his hesitancies towards value-driven behavior then “on quite a few occasions, I've actually done something…and it's worked out really well. Which is quite rewarding.”

Deductive analysis found that behavioral changes were underpinned by engagement in processes like defusion, that enabled their engagement in processes like committed action, and demonstrates how the underlying processes that participants experiences mapped onto were often intertwined.

> “We talked about how to defuse the thoughts and need to create distance from them. And I think that helped my mum a lot more 'cause I think she'd been focusing for quite a few weeks about her mobility and what people would think so I actually think by discussing that, she then started to go more regularly to the Parish Hall, to the cafe there” (Phyllis’ carer).

However, where Committed Action was evidenced to some degree for all participants then most still showed some elements of behavioural inaction or ‘stuckness’.

> “Some of it may be my Christian view. I don’t go to church any more, but it’s put others before you put yourself. You know, and I, I don’t do, I don’t accept that philosophy any more, but that doesn’t mean I can stop doing it.” (Carol)

This was sometimes in the context of particular circumstances, with participants like Jean talking about the Covid-19 Lockdowns as having “got in the way of my life completely. I feel stuck in here with my life away.”, demonstrating her behavioural stuckness in this context. Whilst therapy, through processes like committed action and practice effects appeared to catalyse some important behavioural changes, then this is likely to have been moderated by themes earlier discussed such as access to external resources or difficulties like health.

Catalyst for confidence

"I'm a little bit more self-assured...I feel more able to cope with things...I feel happier in myself...you know, happier than I did" (Ann)

All participants (except Agatha) spoke about the increase in their internal confidence as a result of the therapy, whether naming this the CI or implying it through showing confidence in their ability to cope, with Jean highlighting "I can cope with it better that I have done in the past" and Mike saying "I can sort of deal with [things going wrong]". Carol shared how despite reporting one of her initial problems as 'not feeling important' then she now found "I don't really care now, because I'm an individual person and…I'm important to me.".

The catalyzing of internal confidence mapped onto underlying CFs, with some participants showing an increased sense of mastery. Minnie reported tackling the tasks of therapy "reminded me of who I was and what I've done already and it gave me the confidence to move forward" and Ann reported "There was stuff that I could get my teeth into and go back on and that". At other times, the ability to use ACT exercises to more confidently cope with distress was interpreted as the result of practice effects and exposure:

> "To be honest it's not always easy to do mindfulness when…anyone's around. You know you get interruptions, somebody at the door, the phone rings...but, again, I can sort of deal with that. I think we used to say, if a session went really, really well and nothing happened to spoil it, it probably wasn't the best of sessions. But things did happen, the dustbin man came, I had to open the gate. Kind of over the weeks I got used to the idea, well, that's really what it's all about. I'd like everything to go smoothly, but it wouldn't help me because they don't" (Mike)

Skilled Encounters

Participants experienced their encounters with the therapists as skilful, but often as exposing. These experiences mapped onto CPs, particularly in relation to the therapeutic relationship.

Therapeutic relationship

All participants highlighted the therapist's role in their experiences of change. The therapists skills were particularly salient, with Agatha labelling this 'patience' and Maggie and Carol reporting how well their therapists put across what they were portraying. Ann and Jean valued their therapists' listening skills, and Jean spoke at length of the ability of her therapist to say the right things to 'bring her round' and 'coax' her into the behavioural changes she experienced as per the previous theme. The deductive analysis highlighted how these experiences mapped onto different aspects of the therapeutic relationship, most saliently whether participants did or did not agree on the tasks of therapy.

> "It's been a very thorough therapy. It's addressed a whole variety of issues in different ways. And it's given me resources that I have been using. Which I wouldn't otherwise have either known about or used. Or like mindfulness, I wouldn't have realised were, really were quite so useful. I think it's the imagery, you know, in particular. I can see the images in my mind of the minibus. The blue sky beyond the clouds. And I like those, they're kind of happy things. They're uplifting things." (Mike)

In contrast to Mike, Agatha stated "Oh, it was the mindfulness. I'm afraid I just, I just couldn't, it wasn't me if you like", a sentiment earlier shared by Carol. Interestingly, only mindfulness tasks were talked about with such specific disagreement. There appeared to be a moderating influence over whether participants found the tasks of therapy to be relatable or familiar, as nicely highlighted by Minnie:

> "you get on and you move forward and [your interests] become an anchor. And it's technique I've had to use two or three times in my life. I always say I was a creature of the 60s and the breathing and all those exercises were all very reminiscent of a 60s lifestyle."

Participants encountered accurate empathy expressed by their therapists and experienced it as important for change. Jean, who we saw earlier identifying her lack of openness as a barrier to therapy stated:

> "I was holding a lot in. He seemed to know the right words to…relax me... It was, it was, I felt relaxed enough to speak about it, more than I did with any other therapy that I've done in the past."

Exposure

Participants experienced the process of therapy itself as exposing, particularly when reflecting on themselves felt unfamiliar or reflections were emotive. Participants became used to the demands of therapy through the process of exposure. Phyllis declared "It felt alright, it's just that I'm not used to people asking sort of personal questions, so… but I got used to it as time went on, you know?". Exposure mapped to the process of catharsis, with Maggie saying "It's been nice having her here to discuss things. It gets it off your chest doesn't it.". Mike shared how "clearly, a trouble shared and all that". The context of the budding therapeutic relationship allowed participants to engage (and benefit from catharsis) despite the exposing nature of therapy.

> "I found I got more and more relaxed with him, and able to say what I'm feeling instead of keeping it inside of me. That's a bad habit of mine. Of not letting people know how I am feeling...I opened up to him." (Jean)

Discussion

This study answered the call for qualitative research in ACT (Jando & Dionne, 2024) and demonstrates SQA can provide valuable insights and additions to the evidence base - here by shedding light on experiences of change for ACT with OAs and the underlying CPs that these experiences mapped onto. This study has provided qualitative and experiential support for the proposed mechanisms of change for ACT, and further understanding of which non-specific factors were experienced as facilitating change in this context – both of which have been underexplored in ACT research with OAs. The integrative analysis demonstrated how ACT-specific processes and CFs interacted to facilitate or hinder change. The transdiagnostic potential of ACT is supported by the consistency of findings across participants despite heterogeneity in the presenting issues, therapy delivery, and personal circumstances. Core ACT processes like defusion and committed action were relevant across clinical presentations, reinforcing ACT's suitability for OAs with diverse health concerns. Psychological inflexibility processes were also present, supporting the theoretical basis of ACT and (alongside the moderating impacts discussed in theme one) providing an explanation for the lack of overall change experienced by some participants in the primary studies.

Findings were theoretically aligned to the current understanding of CPs. For example, the catalysing of behavioural changes fits the sentiment (Wampold, 2015) that change is facilitated through encouraging health-promoting behaviours. Although new insights, as captured in the theme of Therapy as the Catalyst, is considered a common factor (McAleavey & Castonguay, 2014), this study elaborated on what new realisations were experienced in this context, by this demographic, and what other processes mapped to this. The behavioural origins of ACT means catalysing behavioural change is unsurprising, but match the evidencing of ACT-congruent behavioural changes by other authors (Ruan et al., 2023). The cognitive changes captured in the realisations subtheme are similarly unsurprising with ACT being a third-wave cognitive behavioural therapy (Hayes, 2004). The generation of themes may have been influenced by researcher's awareness of these origins and socialisation to such models. Being theoretically aligned does not weaken the utility of this study, as our findings adds greater experiential and personalised detail. This is important given that most ACT research to date for OAs (Sun et al., 2024) and generally (Gloster et al., 2020; Hayes et al., 2006) rely instead on brief quantitative self-report measures.

Committed action occurred in the absence of strong values identification and was related to CFs processes like mastery, yet valued action and value clarity are often conflated within ACT research (McLoughlin & Roche, 2023). Although committed action is considered the latter stage of ACT (Harris, 2006), it could be considered whether focussing on practice-based approaches rather than explicit values work might help OAs to begin to benefit from this process and from the related processes. This idea is supported by the finding that behavioural activation approaches to supporting OAs significantly reduce depression (Orgeta et al., 2017). Our findings suggest integrating ACT-specific and CFs to adapt ACT might support therapeutic change. Although such potential adaptions warrant further investigation, the presence of processes of psychological inflexibility (like experiential avoidance and behavioural stuckness) demonstrate processes that also need addressing to help optimise ACT for this demographic.[26]

When considering our findings in the context of the extant literature, a qualitative analysis of ACT by Edwards et al (2023) found participants experienced changes in their perspectives. Despite the demographic differences between our studies, this matches our finding about realisations and tentatively suggests ACT taps into underlying CFs like new insights, adding to the literature on insight as a process (McAleavey & Castonguay, 2014) by highlighting what therapy-specific processes can be related to this. Edwards et al (2023) also found disagreement with the tasks of mindfulness, suggesting that clinically that this task might be more divisive, and consideration should be given to whether individuals agree with mindfulness as a task and how this might impact therapeutic alliance.

A meta-synthesis by Ruan et al (2023) found participants discussed increased self-confidence, but conclusions could not be drawn about underpinning CPs – whereas the increase in internal confidence found in this study mapped to processes like mastery and practice effects. Ruan et al (2023) also found participants noticed and reported barriers to therapy, but their analysis was limited to finding this a result of life commitments or preferences about the delivery of ACT. This demonstrates that the increased analytic depth of this study has helped identify processes/factors underpinning more widespread findings. Self-confidence is not cited as an aim or common outcome measure for ACT - where studies usually use psychological flexibility and quality of life or more presentation specific measures[27] but this might be considered in future.

The CI appeared to have an appropriate balance of being structured enough to elicit helpful responses, but unstructured enough for useful depth and breadth of insights. This is evidenced by the results not mapping too closely to the original interview questions, showing how something new was elicited through the interview process[28]. The value of SQA was first highlighted by Glaser (1963) but not given due attention until Thorne (1994) and beyond

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[26] See extended discussion section 4.2.1 for further discussion of findings in relation to the extant literature about common factors and change processes

[27] See extended discussion section 4.2.3 for further discussion of findings in relation to the extant literature on ACT for OAs

[28] See extended discussion section 4.1 for further discussion of findings in relation to the design of the study

(Heaton, 2008) but this study has exemplified the utility of SQA with CI data as a worthwhile way to access participants qualitative insights. Not all participants experienced meaningful or clinically significant change in the HSCEDs that this SQA was based on but this analysis has clarified processes of psychological inflexibility that were still present as well as the factors that were experienced as moderators or barriers. SQA might be considered in future research where lack of scope or resources to analyse data to this depth in original studies meant data has not been analysed to the full advantage, either for new purposes or to clarify findings. SQA did mean the sample was smaller than some recommendations for qualitative research (Ando et al., 2014) and that the demographics captured were restricted. Most participants were female, younger OAs and all were of a similar background.[29] Hopefully the range and depth of findings, as well as their saliency, supports the utility of the sample even though future research might considering capturing greater diversity.

The necessity of it being the Right Time and Place for therapy means that future research might consider factors like motivation or readiness for change (Willis et al., 2023), and ideas like stabilisation that are known to increase engagement (Staudenmeyer et al., 2022) but are not being considered in the context of ACT. Consideration could also be given (both in research and clinically) to how expectations are managed for this demographic, as these findings did not match assumptions about expectancy effects. The impact of external resources as a moderating factor for the participants relates to the role of social capital – defined as the different degrees of networks and social support than individuals have available (Bhandari & Yasunobu, 2009). Social capital, particularly on the level of informal social contacts, are key to support wellbeing and prevent mental ill health (Forsman et al, 2013; Nyqvist et al., 2013). This study goes further to highlight a role of social capital in how OAs engage in psychotherapy when their wellbeing has deteriorated, with our participants experiencing their social networks and community access as important for facilitating engagement in the tasks of therapy and supporting processes like committed action. To optimise the success of psychotherapy with OAs it might be that some OAs need support to increase or support their social capital prior to intervention. Future research could look at trialling the impact of intervention on social capital or considering stabilisation and readiness for therapy in the context of ACT interventions.

Conclusion

Participants experienced change as moderated by a variety of external and internal factors that impacted whether it was the right time for them to engage with therapy. Participants

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[29] See extended discussion section 4.3 for further consideration of the demographics captured and not captured in this study

experienced ACT as the catalyst for behavioural and cognitive changes despite the presence of psychological inflexibility processes. ACT-specific and CFs were identifiable through participants experiences, often without being explicitly discussed. Participants found their experiences in the therapy itself important, including the relationship with and the skill of the therapist, and the exposing (but cathartic) nature of the therapy itself.

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Appendix

Deductive Framework

Framework	***Codes***	
ACT-specific processes	Self-as-context	Self as content
	Cognitive defusion	Cognitive fusion
	Committed action	‘Stuckness’
	Values (recognition of and shaping behaviour)	Lack of values
	Present moment (non-judgemental contact with)	Stuck in the past or present
	Acceptance (willingness to have and accept private experiences)	Experiential avoidance
Common Factors	Therapeutic alliance	Agreement on goals
		Agreement on tasks
		Relationship/bond
	Confronting the problem	
	Therapist (accurate) empathy	
	Shared rationale/narrative for the clients problems	
	Expectation of helpfulness/improvement	
	New understanding or insights	
	Mastery	
	New learning experiences/effects of practice	
	Unconditional positive regard	
	Catharsis	
	Genuineness/Congruence	

Extended Paper

1.0 Extended Introduction and Background

1.1 Chapter Introduction

This extended section will discuss further information about the context and status of older adult mental health, appropriate interventions, and the rationale for an ACT approach. It will also give further information about ACT - including about the development, the underpinning theories and philosophies, and provide rationale for qualitative approaches in this field. Finally, it will discuss processes of change, generally and for ACT.

1.2 Journal Choice

The decision was made to prepare the journal paper for submission to the Journal for Contextual Behavioural Science (JCBS) based on the lack of qualitative research for this field, as recognised in the recent paper by Jando and Dione (2024) published in the JCBS. The JCBS is also the predominant journal for research into ACT, which was felt appropriate given that this thesis, despite the context of older adults and change processes, is primarily still a research thesis about ACT.

1.3 Older adults

OAs are traditionally viewed as anyone in the demographic category over the age of 65 (British Psychological Society, 2024). The difficulty in mental health treatment for OAs is regarded as particularly concerning when considering that the population and proportion of OAs is increasing, and that they are an increasingly large demographic compared to other age groups (World Health Organisation, 2024). As a demographic, they have been understudied despite continuing to make up an increasing segment of the population (Petkus & Wetherall, 2013). Despite the growth of this demographic, mental health treatment for OAs has continued to be slow to develop compared to the medical approaches to OAs care (Reynolds et al., 2022). Conclusions and assumptions about mental health treatment for OAs are additionally complicated by the fact that OAs comprise of different generations who are likely to have different psychological needs and expectations of mental health care (Laidlaw, & Pachana, 2009). OAs generally experience greater amounts of non-medical factors that impact their health, ranging from social isolation, role transitions, and increased incidence of bereavements, to the wider healthcare disparity in mental health care (Reynolds et al., 2022). These are also called ‘social determinants of mental health’, described as being the social, environmental and behavioural risk factors for mental health difficulties (Compton & Shim, 2015). The social determinants of mental health are considered to apply to OAs in greater numbers than to other age groups as a result of their current life stage, and the cumulative effect of their previous life experiences (Reynolds et al., 2022). Even early formulation approaches used with OAs might need to vary greatly depending on whether (or to what degree) the individual identifies historical versus current experiences as relating to long-standing and/or current difficulties (Charlesworth, 2022). It is thought that older adulthood and the greater presence of such non-medical risk factors means psychotherapy may be less effective for OAs than younger counterparts (Cuijpers et al., 2014).

Currently, treatment for OAs mental health tends to be pharmacological despite that psychological treatment is regarded as having better long-term outcomes, and the two tend not to have been investigated comparative to each other (Reynolds et al., 2022, Cuijpers et al., 2014). The psychological treatments used with OAs range from cognitive behavioural therapy (CBT) to psychodynamic and counselling, with CBT and problem-solving therapy having been found to be the most effective (Cuijpers et al., 2014). It is worth noting that this study was prior to the inclusion of ACT research. Research needs to continue to investigate the available psychotherapy offerings for OAs to identify and optimise which therapies are appropriate to which OAs in what contexts (Mitchell & Pachana, 2020).

The perception that psychotherapy is less successful with OAs is not supported by studies and meta-analyses, which find no significant differences between older and younger adults (Cuijpers et al., 2009), comparable outcomes (Karlin et al., 2013) and sometimes that OAs have better engagement (Charlesworth, 2022) and outcomes in psychotherapy than other age groups (Cuijpers et al., 2020; Saunders et al., 2021). Indeed, Wetherall et al (2016) found age moderated outcomes in psychotherapy but that it depended on the type of psychotherapy delivered – with OAs responding better to ACT and younger adults to CBT. It might not be that psychotherapy is inherently less successful with OAs, as much as that psychotherapy might need to look different for OAs. Unfortunately, factors like the comorbidity of physical and mental health conditions are barriers to seeking and accessing mental health care for OAs (Lavingia et al., 2020). The comorbidities that OAs present with can be challenging for traditional psychotherapy approaches like CBT where protocols are often focussed on singular diagnoses (Charlesworth, 2022). This adds further weight to the argument that research needs to prioritize exploring what interventions are most appropriate for OAs and how best to optimise them. The evidence base for psychotherapy with OAs has been hindered by the low number and quality of research, and a failure to compare with pharmacological treatments (Cuijpers et al., 2014). This provides rationale for continued research in this area, as does the continued changes in the psychological challenges facing OAs as different generations enter the OAs bracket over time (Laidlaw & Pachana, 2009).

Upon reviewing the variety of treatments for OAs with mental illnesses then Reynolds (2022) concluded that interventions should promote engagement in more positive lifestyles, be personalised and target social factors like social isolation. ACT has the primary goal of helping individuals to lead a meaningful life, and importance is placed on the highly individualised nature of the delivery (Harris, 2006). Petkus & Wetherall (2013) discuss how ACT is particularly suited to OAs because the transdiagnostic nature removes the need for disorder-specific approaches to treatment and care planning that are problematic when working with OAs (Charlesworth, 2022).

1.4 Acceptance and Commitment Therapy (ACT)

Acceptance and Commitment Therapy, or ACT, is described as a third-wave cognitive behavioural therapy that aims to support people to change the context of cognitive experiences and behave in line with their values (Hayes, 2004) to live a meaningful life (Harris, 2006). ACT has significant evidence bases for conditions like depression, obsessive-compulsive disorders, chronic pain, psychosis and chronic health conditions (Levin et al., 2024). ACT is described to work through firstly identifying the processes of cognitive fusion and avoidance before learning to defuse and practice mindfulness and acceptance over avoidance, to allow for behaviour that is value-aligned (Hayes, 2004). The transdiagnostic claim of ACT comes from the fact that ACT does not position disorders or states of distress themselves as the problem - but views the tendency to take the content of such experiences as the truth and to fight against the distress that this elicits, as the heart of the problem

(Hayes, 2004). ACT relies heavily on the use of metaphors, like that of quicksand, to highlight how attempting to fight against or control distress perpetuates psychological suffering (Harris, 2006). The philosophical paradigms that ACT sits within allows ACT to view these tendencies as inherently human rather than seek to pathologize them (Hayes et al., 2012). The hope is that ACT provides flexible strategies and skills that can then be used for a number of challenging life events (Karlin et al., 2013), and to address these maladaptive tendencies.

The ACT model can be divided into what authors describe as 'Commitment and Behaviour Change Processes' and 'Mindfulness and Acceptance Processes' (Hayes et al., 2012) that collectively make up the concept of psychological flexibility.

Mindfulness and Acceptance Processes

Self as Context

Sometimes also called the Observing Self (Harris, 2006) then the idea of viewing oneself as the context is that one can learn cognitions or distressing experiences can occur but that they do not define the essence of who individuals are. There is a tendency to take the content of distressing psychological experiences as a reflection of ourselves, which is captured by the psychological inflexibility process of self-as-content, whereas self-as-context aims to highlight that this need not be the case and that we can observe rather than define ourselves through our experiences (historical or psychological). This process is achieved through metaphors, mindfulness and experiential exercises (Hayes et al., 2006) some of which overlap with the concept of cognitive defusion (Blackledge & Barnes-Holmes, 2009).

Cognitive Defusion

This is the ability to view cognitions as nothing more than cognitions, rather than accepting them as objective truths or facts (Harris, 2006). The opposite of this, cognitive fusion, is held to drive psychological inflexibility. With the perspective that distressing thoughts and feelings are inherently human, then cognitive defusion exercises encourage individuals to change how they interact with these psychological events (Hayes et al., 2006). These exercises range from mindfulness exercises to promote noticing and labelling thoughts and feelings with increased emotional distance, to repeating or verbally altering distressing thoughts until they lose their salience (Blackledge & Barnes-Holmes, 2009).

Acceptance

Acceptance in ACT is the process of accepting unwanted or distressing internal events like cognitions and feelings (Hayes et al., 2006). This is in direct contrast to the psychological inflexibility process of avoidance of distressing experiences. The hope is that by stopping fighting or struggling with distress through exercises like mindfulness then these events can come and go (Harris, 2006), leaving us free to focus our efforts instead on our values (Blackledge & Barnes-Holmes, 2009) rather than on experiential avoidance.

Commitment and Behaviour Change Processes

Present Moment Awareness

Often equated to mindfulness (Ciarrochi et al., 2010) then the aim of fostering present moment awareness is to shift individuals from focussing on the past or future to remain present in the current moment and engaged in what they are doing (Harris, 2006). Remaining focussed in the past or the future is the process of psychological inflexibility that corresponds to this, whereas remaining focussed on the present should allow for behaviour that is more value-consistent (Hayes et al., 2006).

Values

ACT actively encourages participants to identify, explore and clarify their own personal values (Harris, 2006). Values are conceptualised as ways of behaving that are in line with what we hold most important and likely to foster the life experiences we desire (Blackledge & Barnes-Holmes, 2009). Not having contact with or clarification of values is thought to perpetuate psychological inflexibility. ACT purports that there are multiple ways to behave in line with values and seeks to help participants to clarify their values and problem-solve because behaviour that is not motivated by values is less likely to lead to goal attainment or support wellbeing (Hayes et al., 2012). This is done through a variety of different exercises (ranging from explicit value-exploration exercises to metaphors and experiential exercises) whilst using other techniques like defusion to undermine tendencies to behave in line with avoidance, fusion or social compliance (Hayes et al., 2006).

Committed Action

Sometimes also referred to as valued-living (Blackledge & Barnes-Holmes, 2009) then after successfully exploring and considering values then ACT encourages individuals to find ways to live consistently with their values. The corresponding process of psychological inflexibility is behavioural inaction or stuckness. ACT therapists may set homework or complete particular problem-solving exercises to encourage individuals to make behaviour change in valued-directions (Hayes et al., 2006).

1.4.1 ACT with Older Adults

Despite concerns in quality and methodological rigor raised by early meta-analyses (Öst, 2008; 2014) and the evidence base being largely focused on working-age adults then the variety of conditions that ACT has been evidenced for gives hope to the utility of ACT with this population. More traditional CBT approaches can be challenging to deliver to OAs because of the losses (of persons and in functioning) that they have experienced, the resulting hopelessness, and the demotivating effect of their upcoming mortality (Laidlaw & McAlpine, 2008). Some of the difficulties OAs face that impact their mental health are unchangeable (Mitchell & Pachana, 2020) such as cumulative social determinants of mental health (Reynolds et al. 2022) or objective difficulties like increased disability with older age (Office for National Statistics, 2023). By contrast to other approaches then ACT focusses on how one can live a meaningful and valuable life despite the difficulties that are present and without focussing on symptom reduction (Harris, 2006). Roberts and Sedley (2016) highlighted the need to consider the practical concerns of delivering ACT with OAs (given their cognitive functioning or physical health difficulties and fluctuations) as well as appropriateness of all the exercises - and that these factors might feel daunting to the less experienced clinician. This point highlights the need for research to explore and address any concerns with delivery or adaptions that would be needed for OAs to benefit from ACT. Despite evidence of the efficacy in other populations then the comparative lack of research for ACT with OAs is at odds with the arguments about the appropriateness of ACT for OAs. As will be discussed in section 1.7.1 then differences have been found for OAs in the change processes that underpin how individuals respond to psychotherapy, making it important to explore this in this population.

1.5 Relational Frame Theory and Contextual Behavioural Science

To thoroughly appreciate the gap in the literature base that this study attempts to address (and the choice to do so through qualitative analysis) then this next section will consider the relationship of ACT to the theories and philosophies that underpin it. ACT is underpinned by relational frame theory (RFT; Hayes et al., 2001) and is situated in the field of Contextual Behavioural Science (CBS). CBS is historically rooted in behavioural analysis but with a greater emphasis on the role of context, language and cognition (Levin et al., 2015). CBS itself is underpinned by the philosophy of functional contextualism which sees ones' perception of the real world as a psychological act influenced by context and individual history and shaped further through language. The purpose of functional contextualism is to predict behaviour through understanding context (Vilardaga et al., 2007), a goal shared by the field of CBS (Levin et al., 2015).

RFT positions behaviour, both external and internal, as being learnt through reinforcement in relation to context. RFT suggests that the verbal relations between stimuli can generalise with such success to encourage processes like experiential avoidance (Hayes, 2004). RFT attempts to account for the complexity of human language, cognition, and behaviour that earlier behavioural analysis could not, in the context of human psychopathology (Barnes-Holmes et al., 2004). RFT has drawn controversy due to its differing account of language to predominant theories and for the implications of this on applied behavioural analysis (Gross & Fox, 2009) because where RFT is the underlying philosophy for behavioural approaches then it becomes necessary to consider language and cognition to hope to understand human behaviour (Hayes, 2004). It stands to reason then, that when attempting to understand human behaviour in response to ACT interventions, methodology needs to be utilised that can capture the complexity of language, cognition and context - particularly since the question of interest from an ACT and CBS lens is about how to best to most precisely predict and influence behaviour (Ong et al., 2023). For all their methodological rigor and strengths, quantitative methodologies cannot always explore the contextual or cognitive factors of the human experience (Jando & Dione, 2024). Similarly, given the interwoven nature of processes like experiential avoidance and cognitive fusion then quantitative methodology can lack the scope and depth to explore these processes.

1.6 Qualitative Research, CBS and ACT

The underpinning philosophy of functional contextualism does not propose that quantitative methods are the only ways to evidence scientific findings, which CBS researchers acknowledge – yet there is a lack of qualitative research in the field (Jando & Dionne, 2024). Although the current evidence base for ACT has given appropriate attention to theoretically relevant concepts like psychological flexibility, then it would be strengthened through paying more attention to the ACT-specific processes (Ong et al., 2023) like those that comprise psychological flexibility. A recent systematic literature review by Ruan et al (2023) highlighted that the literature base for qualitative studies thus far is of good quality and supports ACT-congruent behavioural change, but that mechanisms of change and barriers to change need further exploration, and with different populations and presentations.

Fulfilling the aims of CBS means utilising methods that allow for examining theoretical processes of change to see whether interventions are having the desired effects of influencing behaviour (Levin et al., 2015). Being underpinned by RFT and CBS means that ACT research should seek to capture the verbal and contextual nuances that shape human behaviour. Indeed, it has been argued how reviews of the evidence base for ACT have focussed on aspects like methodological rigor, to the neglect of considering the need for nuance and context when viewing research from a CBS and RFT approach (Levin & Hayes, 2009). Although researchers have sought to address the need to capture context and processes then this has primarily been through quantitative methodology (Jando & Dione, 2024), despite the success that qualitative studies like those reviewed by Ruan et al (2023) have had in advancing our understanding of ACT and furthering the CBS agenda (Jando & Dione, 2024). Qualitative research provides depth about experiences that tends to be context specific (Willig, 2012). A fault in the efforts to operationalise non-observable phenomena is that these efforts towards empiricism rely on self-evaluation of experiences through methods like self-report, whereas qualitative research methodologies allow attention instead on the meaning of experiences (Slife et al., 2005). When considering these arguments, and the theoretical location of ACT it becomes more salient of the need for, and value of, using qualitative research to help further our understanding of the processes and barriers to change for ACT and OAs – which as Ruan et al (2023) highlighted needs further exploration.

Hayes et al (2021) argued that the research base for CBS would benefit from moving towards methodology like single-case designs that are more intensive and longitudinal, in order to capture processes. This is not to position qualitative research against quantitative, but only to argue how using different methodologies can complement the evidence basis for therapy (Hughes, 2018). As per the name, Contextual Behavioural Science and therefore ACT relies on viewing meaningful change *in context* (Biglan & Hayes 2016; Jando & Dionne, 2024). To predict and influence behaviour, as is the purpose of CBS, then the context of behaviour must be considered and the meaning understood (Jando & Dionne, 2024). Wampold (2015) describes therapy as a meeting of strangers, where the client determines (among other things) whether the therapist will endeavour to understand the problem and the context the problem and client are situated within. Without having necessary appreciation of the context embedded in practice and informed or encouraged by research, it would be expected that this would jeopardise the therapeutic alliance. As this is consistently found to be a vital process of therapeutic change (Martin et al., 2000) then a lack of appreciation for context could impair the potential for therapeutic change from therapy.

Elliott (2002) discussed how research initially looked at either the extent that outcomes change or what processes occurred within psychotherapy sessions, but that change process research seeks to bridge the gap by investigating what the ingredients are that bring about changes over the course of psychotherapy. Quantitative change research has sought to test hypotheses about the factors that cause or facilitate change, yet findings have been contradictory or too general to be clinically useful (Elliott, 2002). Stiles and Shapiro (1994) highlighted that process research relies on the idea that increasing the levels of a successful process in psychotherapy will increase positive therapeutic outcomes, but this does not necessarily correlate with outcomes as anticipated. This was taken to show the flaws in this assumption, and thus in much of the literature base for change processes. Hayes et al (1996) argued that this does not make such research redundant thought, because when combined with other methods of enquiry then many process variables are well-evidenced and theoretically grounded. Hayes et al (1996) view this argument as holding for common factors. Regardless, the view of Elliott (2002) is that such quantitative designs do not capture the complexity and nuance involved in change processes in the way that other designs can – furthering the rationale for qualitative approaches.

1.6.1 Qualitative Research in ACT

Thematic analysis (TA) has been used successfully by Contreras et al (2022) to investigate the acceptability of ACT, and by Børtveit et al (2024) to highlight how adults with depression experienced an online ACT intervention. Authors drew interpretations and themes from the data, within the context of the participants experiences and the intervention itself, to consider how to develop the intervention. Thompson et al (2018) used TA to explore participants perspectives on the behavioural changes they experienced from an ACT intervention for chronic pain. As captured by a nested qualitive study within a pilot study of ACT in a psychiatric inpatient setting (Tyrberg et al., 2017a, 2017b) then qualitative investigation can provide insights about the positives and the challenges of intervention delivery that moderate the quantitative results. Without the qualitative data to understand these in more detail, assumptions might be made towards the efficacy of ACT based purely on quantitative measures. Having a greater understanding of positives and challenges experienced in interventions also allows for refinement in future research. Although this is a position that is taken within acceptability and feasibility research (Yardley et al., 2015), it is less considered within the general literature base. Bacon et al (2014) used interviews to gather qualitative data to explore participants experiences of ACT for psychosis, finding experiential support for some of the purported processes of change in ACT. Although qualitative studies for ACT are relatively few, then they highlight the role of qualitative methodology in exploring and defining context (Jando & Dionne, 2024) and (as described above) have given useful insights towards the evidence base for ACT. The majority of qualitative studies have investigated ACT in a chronic pain context or investigated the perspectives of clinicians, rather than experiences of change, or for specifically OA populations.

1.7 Mechanisms and processes of change

Understanding the processes by which psychotherapy causes change for participants is important to close the gap between psychotherapy clinicians and psychotherapy researchers - a gap that has arisen as a result of the lack of attention in this area (Mulder et al., 2017). Kazdin (2007) helpfully clarified terms in relation to change. Mechanisms are viewed as the processes responsible for therapeutic change, with moderators being processes or factors that influence the direction or strength of the outcome, and mediators being variables that statistically account for relationships between variables (Stockton et al., 2019; Kazdin, 2007). By contrast, the mechanism is the process or events that cause the change (Kazdin, 2007). Kazdin (2007) argued that several requirements are needed to establish a mechanism of change: strong association, specificity, consistency, experimental manipulation, timeline, gradient and plausibility. Although these will not be further discussed, it is worth highlighting that many of these appear to lend themselves to quantitative measurement – such as to assess the strength or gradient of an association between outcomes and a potential mechanism or mediator. Indeed, although Kazdin (2007) discussed statistical techniques to study mechanisms of change, then the potential role of qualitative methods is neglected. Elliott (2010) raised that often research designs intending to investigate change processes might establish the existence of a causal relationship between variables but not the actual nature of the relationship. Despite significant progress in the field of psychotherapy then the lack of evidence-based explanations for the mechanisms of change in well-studied interventions is a discredit (Kazdin, 2007). A greater understanding of mechanisms of change can enable researchers and clinicians to refine and tailor interventions to presentations, groups or individuals. Although Kazdin (2007) recognised the complexity of this task, it appears an obvious pathway to optimising treatments – especially for populations like OAs who are underserved and may need adaptations to usual therapy (Petkus & Wetherall, 2013).

Research finds that the macro and micro-level processes of change are interrelated and that there is a wide range of ways that this could be (and is) studied (Krause, 2024). Krause (2024) discusses how change process research focusses on everything from facilitators of or obstacles of change, to the evolution of change, change events and the impact of ruptures. Although there are multiple ways to conduct research that is specifically focussed on change processes (Elliott, 2010) then it is considered better to firstly focus on understanding, before moving onto targeted process research (Doss, 2004). In line with this, the philosophical and theoretical underpinnings of ACT, and the lack of investigation of change processes in the context of OAs who have completed ACT interventions then it is important to firstly look at the experiential data to help understand the experiences of and context of change. Investigating *experiences* of change (rather than just the statistical relationships between variables involved in change) is important because change processes like the therapeutic relationship are processes that are internally experienced (Norcross, 2002) rather than easily externally operationalizable or quantifiable (Slife et al., 2005).

1.7.1 In an Older Adult Context

Alongside the rationale that exploring change processes can help to optimise interventions then it is worth considering what might be different about OAs as a demographic, in relation to change processes, that warrants specific investigation. There are differences in moderators of change for children and adolescents that support the argument to investigate change processes specifically for this age group (Kazdin & Nock, 2003). It stands to reason then that the particularities of older adulthood as earlier described make it worthwhile to investigate change processes for OAs as a demographic. For example, Bergin and Walsh (2005) discuss the role of hope as a particular facet of facilitating change for OAs compared to other age groups. Rizopoulos (2015) found a particular role of generational experiences and attitudes in shaping the expectations OAs had of counselling and psychotherapy. The generational element of this suggests that the effects of expectations might be different for different generations and age-related demographics. Rizopoulos (2015) also found that during the process of psychotherapy OAs valued being able to ‘tap into’ their inner resources that were shaped through decades of maturation and the different roles held over their lifetimes. It would be a reasonable assumption that this might be a less important aspect of change process for different age groups, who are likely to have less wealth of time and depth of roles to draw on.

A qualitative analysis by Thompson et al (2018) with working-age adults (with the mean age of 48) following an ACT intervention for Chronic Pain found that participants experienced change as fostered by their willingness to accept private events, having more awareness of values, interacting with others, and specific behavioural ways to cope with pain. These findings differ to those of Ng (2020) who completed interviews with OAs (with an age range between 68 and 93) who found that the process of acceptance was related to their prior experiences and OAs expectations of pain as appropriate to their life stage. The OAs interviewed by Ng (2020) appeared to have a greater focus on adapting to their pain for the purpose of their values, rather than simply the greater awareness of values reported by Thompson et al (2018). Although neither of these studies explicitly investigated change processes then together, they highlight that there appears to be differences in the processes reported by participants in different age categories - at least for chronic pain. The suggestion from these studies that change processes might be experienced differently by OAs helps to justify why research should investigate experiences of change for OAs.

1.8 Processes of change for ACT

The core processes for ACT have been evidenced consistently. Villatte et al (2016) found that different ACT modules that targeted different theoretical processes produced larger effect sizes on the targeted effects, taken to support the theoretical underpinnings of ACT. However, the heavy reliance on self-report measures (that are often not specific to ACT-processes) and the low power of many of the studies so far weakens the evidence base (Hayes et al., 2006). Despite this, the evidence base generally is consistent and encouraging in that ACT processes appear to be psychologically active in line with theory (Hayes et al., 2006). A review by Stockton et al (2019) updated the findings of Hayes et al (2006). They found that whilst the results from mediation studies are consistent with the psychological flexibility model then flaws in the evidence base remain – such as through the inconsistent use of validated or objective measures and failure to reliably account for factors like the psychotherapist. The latter finding suggests a need for the inclusion of common factor processes like the therapeutic relationship when exploring processes of change in ACT. The differences in findings about whether specific ACT processes did or did not appear to act as mechanisms of change shows a general weakness in the evidence basis for ACT. Indeed, studies like Vasiliou et al (2022) that claim to investigate and provided evidence towards the theoretical mechanisms of change in ACT could be more accurately described as evidencing statistical mediators of change. This is not just a linguistic difference, since mediators may statistically account for relationships between variables but not necessarily be the process or mechanism of change in themselves (Kazdin, 2007).

Arch et al (2012) found that cognitive defusion significantly mediated their outcomes for both ACT and for CBT. This is perhaps unsurprising given ACT is described as being a ‘third-wave’ therapy that hails from traditional cognitive behavioural therapy, but it does highlight the need to evaluate ACT-specific change processes in more detail to establish what indeed might be ACT-specific and theoretically-consistent as opposed to processes tapped into through other psychotherapy approaches. This might depend somewhat on the condition or presentation that is being treated. For example, Trompetter et al (2015) found that psychological flexibility was the only identified direct causal mechanism of change in their ACT intervention for chronic pain but their analyses determined that catastrophising might have a mediational effect on psychological flexibility and is therefore potentially an indirect mechanism. This not only raises the question of how mechanisms of change might differ for different groups and populations, but also highlights the possibility of interrelated direct and indirect mechanisms. ACT needs to be investigated with underserved populations (Levin et al., 2024), and in a way that captures the possibility of interrelated processes and accounts for common factor processes like the therapeutic relationship.

Fishbein et al (2023) also investigated using ACT to address chronic pain but found that age had a moderating effect, and that their older clients found more improvements *during* ACT but that during a six-month follow-up period they tended to plateau or relapse. This contrasted with the results for younger adults, who maintained and improved on their therapeutic gains. The authors drew from this the need to investigate age as a moderating factor for treatment trajectories, and for further research to better explore the mechanisms that impact how OAs respond to treatment. The different response during and post-treatment and for OAs is an unfortunate finding, given that an earlier randomised control trial into the moderating impact of age by Wetherell et al (2016) found that OAs responded better to ACT (and younger to CBT) for chronic pain. The findings from these two studies tentatively give further evidence to the thought that it is not that ACT is the wrong intervention for OAs (as it seems to be appropriate, acceptable, feasible and efficacious for many of their presenting difficulties and conditions) but that further investigation into the change processes is needed to help this intervention match the particular needs of this client group. Given the neglect of OAs in the literature base, despite ACT being found efficacious for many of the conditions associated with old age, then the particular processes of change for this client group warrants further analysis.

Arch et al. (2023) positions the inconsistency of evidence that ACT processes are specific and mediate relevant outcomes as one of the challenges to viewing ACT as as theory and process driven as it claims to be. Meta-analysis like that of Ren et al (2019) find different strengths of significance for different psychological flexibility processes in the literature. With the processes underpinning psychological flexibility being assumed to account for change then more research is required to evidence these processes as integral to change - as research is either unspecific (looking generally at psychological flexibility), ‘sparse’ (Arch et al., 2023) or neglects particular processes like ‘self-as-context’ (Stockton et al., 2019).

1.9 Common Factors

Diverse psychotherapies provide different therapeutic experiences and engagement in different behaviours yet can have similar outcomes and invoke similar common processes (Asay & Lambert, 1999). Originally discussed by Rosenzweig (1936) and popularised by Frank and Frank (1991) then common factors (sometimes termed nonspecific factors; McAleavey & Castonguay, 2014a) are those factors that are common to therapeutic situations (regardless of the specific therapy) that are thought to affect the process and outcomes of therapy. Some of these are thought to occur organically, and others to be fostered more explicitly in psychotherapy (Weinberger & Rasco, 2007). Although ‘common factors’ and ‘common therapeutic factors’ are often used as interchangeable terms, then Lampropoulos (2000) highlights that popular common factors often lack the operationalisation or empirical evidence base to conceive of them as therapeutic. Considering that misconception, then the definition used in this thesis is of common factors being commonly present processes in therapies (McAleavey & Castonguay, 2014a) that are evidenced as impacting change. Common factors can be divided into different types or categories, from those that are therapist variables to those that are a result of the *interaction* with the therapist or the *reaction* of the client to the therapist (Lampropoulos, 2000).

Common factors are certainly no longer unrecognised as claimed by Rosenzweig (1939). There has been debate in the literature about the role and importance of various common factors, and even of whether common factors or therapy-specific factors most heavily determine psychotherapy outcomes (Browne et al., 2021). Research has often found that the outcomes of psychotherapy are best attributed to the common factors rather than any approach-specific therapy ‘ingredients’ (Ahn & Wampold, 2001), but such research tends to be correlational and the meta-analyses on the topic are impacted by the low statistical power and bias in these primary studies (Cuijpers et al., 2019). A large proportion of the commonalities shared by diverse therapeutic approaches are thought to be change processes (Grencavage & Norcross, 1990), and it is the more accepted and balanced view that common factor processes are necessary ingredients *alongside* specific therapy ingredients, in order to be sufficient in producing meaningful change (Imel & Wampold, 2008). As discussed by McAleavey & Castonguay (2014a) then the literature base is still concerned with understanding whether the effects of different psychotherapies are due to their unique elements, or due to what they all share. These authors take the position that a better understanding of commonalities will facilitate a better understanding of the impact of psychotherapy, given their belief that common factors and unique/therapy-specific factors work symbiotically.

Several authors have compiled lists and frameworks to account for the role of common factors with various definitions and organisation (Imel & Wampold, 2008). As different authors pay differing attention to categories of common factors then there is a lack of consensus in the literature (Lampropoulos, 2000). A more recent contextual model of common factors has been proposed, arguing that psychotherapy works through the therapeutic relationship, building expectations of treatment and disorder, and through health-promoting behaviour (Wampold, 2015). The contextual model proposes that specific therapy factors work through fitting those expectations and by the therapy-specific health-promoting actions that are likely tailored to the presentation of concern (Wampold, 2015). A healthy therapeutic alliance is seen as integral to both of these pathways within the model. In terms of research into understanding change processes – it might not be looking for specific factors existence that is important, but looking for whether and how specific factors might have been actioned upon that is useful to our understanding of common factors in the context of specific psychotherapies.

Frank and Frank (1991) earlier but similarly viewed the commonalities of successful intervention as hinging on the relationship between therapist and patient. However, even the expectations of helpfulness that clients enter therapy with in the first place are thought to be an underemphasised factor impacting change that is blamed for much of the variance in outcomes (Weinberger & Rasco, 2007). Expectancy effects are found to account for up to 27% of the therapeutic change process (Thomas, 2006). Expectancy effects could potentially be captured in Change Interviews because the format captures whether participants expected their reported changes to occur or not (Elliott, 2006). This allows inferences to be made about expectations as a common factor process.

Frank and Frank (1991) view the therapeutic relationship as the vehicle to foster experiences that lead to mastery and clarifying the problem or symptom narrative. The therapeutic relationship is positioned as necessary to increase the morale in the patient to then enact changes in themselves or their environments. The therapeutic relationship was first posited to be about the strength of trust and alliance – with therapeutic alliance being characterised by the extent of agreement on goals, tasks and the developing relationship (Bordin, 1979). It has even been suggested that with humans as inherently social creatures, then the therapeutic relationship provides a social mechanism of healing through the virtue of *being* a relationship (Wampold, 2015). Alongside factors specifically posited to be a result of the relationship, then there are other common factors that therapists themselves are thought to bring to therapy. Rogers (1957) described these as necessary and sufficient for therapeutic change. He described that alongside the client being in a therapeutic relationship with the therapist, then the therapist must bring a genuineness (as opposed to a façade) to this relationship, respond to the client with positive regard unconditionally, and be empathetic and accurate in their understanding of the clients' experience. Research on these conditions since has demonstrated their role across different presentations and therapeutic approaches (McAleavey & Castonguay, 2014a).

Where some the factors above are linked to the therapist and the therapeutic relationship then others are positioned more within the client, and their reactions (Lampropoulos, 2000). Rosenzweig (1936) identified that psychotherapy implicitly fosters processes like catharsis and the ability to integrate new understanding about their difficulties. New understanding has been reconceptualised as the process of new insights (McAleavey & Castonguay, 2014b).

The behavioural processes commonly enacted for clients in psychotherapy include that of confronting the problem, which behavioural therapies will tend to term exposure (Weinberger & Rasco, 2007). Therapy provides the setting to encourage participants to have new learning experiences where practice will support change (Frank and Frank, 1991). Sometimes this is in the form of mastery over one's problems, which has been positioned as a ubiquitous goal of psychotherapy (Liberman,1978) and can be defined as the process of change from feeling generally out of control in one’s life to feeling back in control or able to exert appropriate amounts of control (Marken & Carey, 2015). Mastery as a process can range from mastery in the context of self-control in interpersonal situations (Grenyer & Luborsky, 1996). Processes of change are likely interlinked. For example, Stolowicz-Melman et al (2023) found that although the degree of accurate empathy towards negative emotions impacts how positively patients experience psychotherapy sessions then this was moderated by how exploratory the session was about negative emotions, suggesting a link between processes like new understanding and accurate empathy. Therapeutic alliance has not only been reliably established to mediate outcomes in psychotherapy (Baier et al., 2020) but mediates other factors such as expectancy effects (Constantino et al., 2021). The interplay for these factors can be challenging for analysis, as for example, research found that when addressing negative expectancy effects then manipulating the warmth and competence of the therapist could serve to violate and overcome negative expectations to the benefit of treatment (Seewald & Rief, 2023). Although common factors are often criticised for being untestable (Laska & Wampold, 2014) and correlational (Cuijpers et al., 2019), then qualitative research provides a way to explore the experiences of these common factor processes that does not attempt or claim to be empirical. Indeed, how events are experienced is one of the key questions that qualitative research methods are posed to answer (Willig, 2012). This is important when considering that these processes are experienced as interrelated as discussed.

2.0 Extended methods

2.1 Chapter Introduction

At the risk of falling into the trap of feeling the need to over-explain qualitative methods (Newton et al., 2012) then this section shall discuss in further detail the methodology used in this study and the justification for it, as well as for decisions related to the design and sample size of the study. It will also discuss the methodology of the original primary studies.

2.2 HSCED methodology

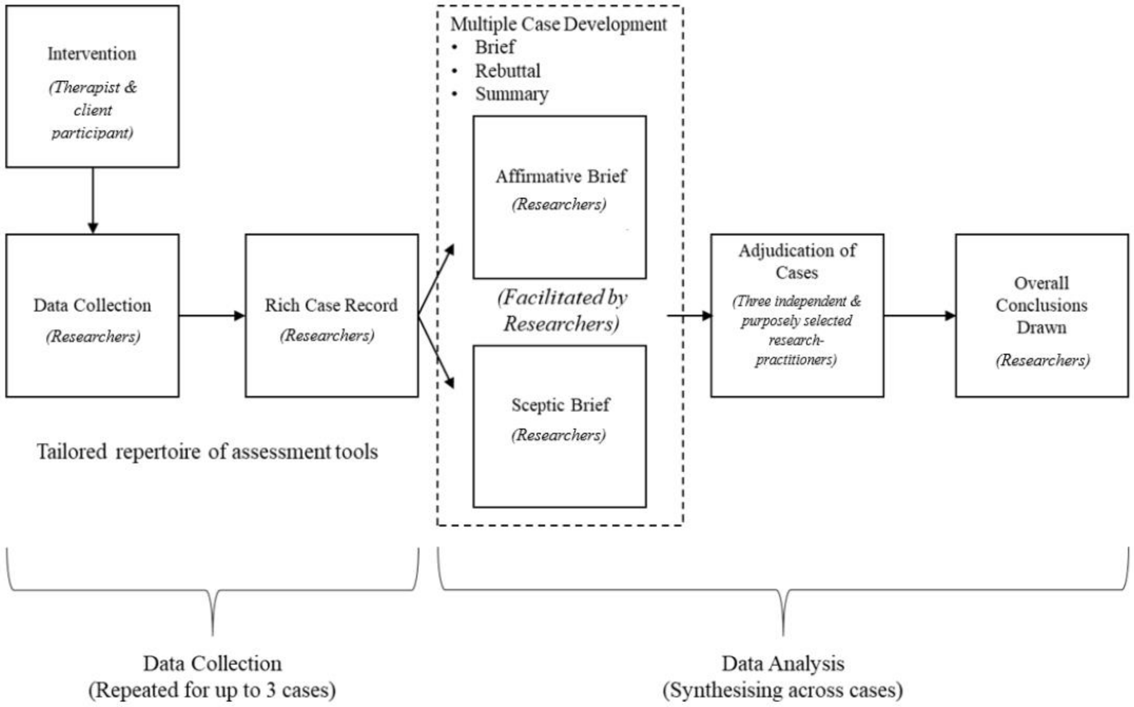
The three primary studies used a series of Hermeneutic Single Case Efficacy Designs (HSCEDs; Elliott, 2002). The development of the HSCED aimed to address the challenges of other research approaches to investigating change (Elliott, 2002). Change research historically addressed either the extent that therapeutic outcomes changed, or processes occurring within psychotherapy sessions - whereas change process research sought to bridge this gap by investigating the ingredients that bring about changes over the course of psychotherapy (Elliott, 2002). Quantitative change research tested hypotheses about the factors that cause or facilitate change, yet findings were contradictory or too general to be clinically useful (Elliott, 2002). Process research relied on the idea that increasing the levels of a successful process in psychotherapy increases outcomes, but this does not necessarily correlate with outcomes as anticipated (Stiles & Shapiro,1994). This flawed assumption impacts much of the literature base for change processes, even though many specific and common factor variables are well-evidenced and theoretically grounded when combined with other methods of enquiry (Hayes et al., 1996). Regardless, such quantitative designs did not capture the complexity and nuance involved in change processes (Elliott, 2002). Randomised control trials and meta-analytic research based on these designs had limited ability to investigate context and variations between groups, which is particularly problematic when considering the need for understanding of context as discussed in section 1.6.

The HSCED is a mixed methods design that developed to address these concerns by evaluating treatment causality in singular cases through considering whether meaningful change has occurred, and whether it is attributable to interventions or to non-therapeutic explanations (Elliott, 2002). HSCEDs aim to bridge the gap between research and practice (Wall et al., 2017). Completing a

HSCED with a small series of cases has a procedure (see Figure 3) that involves active consideration of non-therapeutic explanations and where possible independent critique (Elliott, 2015), to enhance the ability to draw causal inferences (Elliott, 2002) across a small range of participants.

Figure 3

HSCED series protocol diagram (Wall et al., 2017)



Single case methodology captures greater complexity and context by nature of the design (McLeod, 2010) particularly with the Change Interview. The design of the Change Interview (Elliott, 2006) captures patients views about change and the reasoning behind changes they may have experienced in therapy – with the deliberate consideration of extra-therapeutic factors or negative therapeutic experiences to help locate the context of change (Elliott, 2011). This is in line with the underpinning philosophy of ACT, as functional contextualism sees capturing environmental variables as vital to understanding and analysing behaviour (Levin et al., 2015).

The primary studies utlised HSCED methodology successfully to explore whether their OAs experienced meaningful change, that was attributable to ACT. Fidelity was measured in the primary studies using the ACT Fidelity Measure (ACT-FM, O'Neill et al., 2019). The ACT-FM is a 25 point item measure to assess whether the approach of a therapist is consistent or inconsistent with ACT (see Appendix A sample of studies of sessions were purposively selected to represent each client and different stages of therapy. Session recordings were assessed with the ACT-FM by a member of the research team (not the primary author) who was an expert in ACT.

2.3 Rationale for Secondary Qualitative Research

The decision to complete this study as a secondary qualitative analysis (SQA) was made not only pragmatically (on the basis of the data available to the research team that answered the research question), but because it allowed a way to explore experiences of change for OAs who had undergone relatively comparable-ACT interventions, with similar inclusion and exclusion criteria, and accounting for important essential considerations like access to the same supervision team (Hinds et al., 1997), and within a similar timeframe. The differences in presentation were chosen to allow for an analysis that could not claim to be presentation specific, in line with the transdiagnostic claims of ACT - and to hold true to the reality of the comorbidities and complexity in presenting needs when working with this client group. Additional Change Interview data was available from ACT studies with similar commonalities but with different age ranges. The decision was made by the research team to keep the analysis restricted to exploring experiences of change specifically in an older adult population to address this specific literature gap. It has been recognised that SQA can allow for access to data from populations who are ‘elusive’ or experience barriers to engaging in the research process (Long-Sutehall et al., 2011), a concern which is certainly relevant to OAs, despite the benefits that engaging in research brings them (Fudge et al., 2007).

Although there are many debates regarding the ethics, rigor and value of SQA, then it is considered a useful and cost-effective way to maximise data and gain insights for new questions without additional burden on participants or the administrative and implementation costs of additional data collection processes (Ruggiano & Perry, 2019). Having further research completed by new researchers to the original ones has long been thought to add strength and objectivity to the evidence-bases (Glaser, 1963). Although the three original studies showed compelling evidence for the utility of ACT interventions for OAs with dementia, voice-hearing and psychological distress then this secondary analysis provides another layer to the evidence base by exploring how (or in some cases, why not) meaningful change was experienced to have occurred. This is in line with the functional contextualist underpinnings of ACT as discussed in sections 1.5 and 1.6.

As discussed by Walters (2009) then a problem with SQA is that it is removed from the original social, cultural and political context that the data was initially collected in. Given that the data still span a four-year (2020-2024) period that included the Covid-19 pandemic, then due diligence was given to keeping an audit trial and reflective diary to introduce some rigor into the process (Thorne, 1994). The likelihood with SQA that the researcher was not there at the time of data collection is considered a limitation of SQA from an ethnographic perspective but less so for qualitative approaches using interview data (Irwin & Winterton, 2011) like this study. The distance between the researcher and the primary analyses means that a limitation of SQA is that there is less ability to check interpretations with other sources of evidence (Irwin & Winterton, 2011). This limitation is somewhat addressed by the consultation with an expert by experience as described in section 2.8.2. It is also worth highlighting that this data analysis was completed in the autumn of 2024, which is not, in the scheme of research, too far removed from the timeframes of the original three studies. This is only a few months removed from the last data collected, with study three collecting data earlier in 2024. Another common criticism of SQA is whether the data is appropriate to 'fit' to different research questions, despite acknowledgement that generally the semi-structured nature of qualitative data collection goes someway to negate this (Heaton, 2008). With the data being used to answer the question about experiences of change being from Change Interviews, this felt appropriate. This decision can be retrospectively supported when considering the wealth of relevant data for the eight transcripts and the interesting findings that were generated. The sheer volume of coded items both in the inductive and the deductive analysis (see Appendix N) supports a fit between the secondary data and the research questions of this study.

2.4 Sample Size

Part of the decision process relevant to completing SQA is that of the amount of data available. For qualitative research generally then Braun and Clarke (2021a) discuss the idea of data saturation, also called information redundancy (Lincoln & Guba, 1985), whereby the size of a pool of data is sufficient that no new themes or codes are expected to be drawn from the data. Although this idea initially arose from

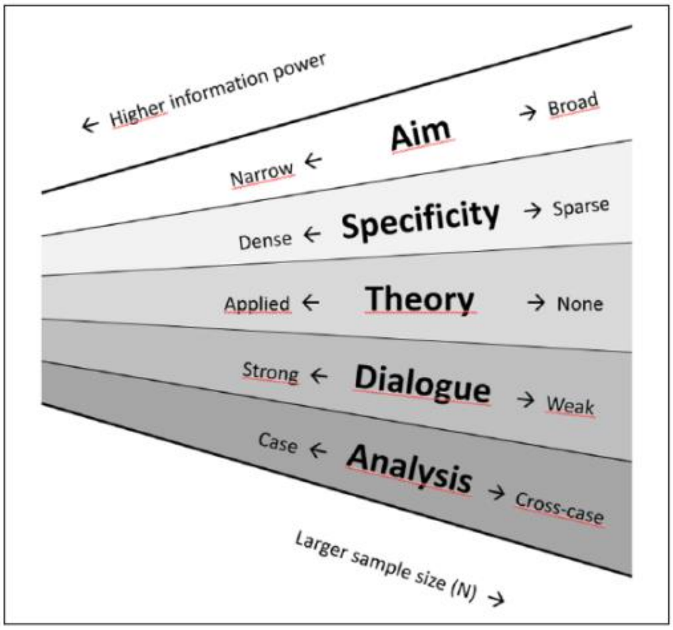
Grounded Theory, data saturation has been assumed to be a useful way for qualitative analysis more generally to evidence reliability. It has been suggested that qualitative research key themes are identifiable within 12 interviews (Guest et al., 2006), and previous qualitative change-process studies have found sufficient data from smaller sample sizes (e.g. Dourdouma et al., 2020). Although often quoted along with other studies as suggesting that between six and 12 interview sets is enough for thematic saturation then Braun and Clarke highlight that this is simply a pragmatic practice (2021b) rather than one, particularly for RTA, that is theoretically coherent. The eight data sets used in this study is a sample size that some of these authors would consider on the smaller side for qualitative research, but this was a purposeful choice to keep the data specific to the question. The *richness* and *thickness* of the data were considered to help justify the sample size, based on the definitions of thickness being the sheer quantity of data in the transcripts and richness representing the level that the data is layered, detailed and nuanced (Fusch & Ness, 2015). Some of this was supported by the supervision team already having some familiarity with the data, to consider the richness and thickness when deciding which studies to include for the project. Sufficiently rich interpretations and themes were created from the included data sets, retrospectively providing support for this decision.

There are alternative positions to the arguments about data saturation, despite that data saturation is argued to be the key point to reference when evaluating qualitative research (Newton et al., 2012). The role of qualitative research in medical fields is to produce results that are robust enough to be transferable to practice settings and promote thought or questions (LaDonna et al., 2021) rather than aiming for generalisability (Lincoln & Guba, 1985). One way to do this is to consider the 'sufficiency', meaning the richness of the data generated and the rigor of the analysis (LaDonna et al., 2021).

Information power (Malterud et al., 2016) is a defined concept with more specific criteria to be used as an alternative to data saturation (Malterud et al., 2021) to help gage data sufficiency (LaDonna et al., 2021). Information power is considered to be a result of the study aims, the specificity of the sample, application of theory, dialogue quality and the analysis strategy (see Figure 4; Malterud et al., 2016).

Figure 4

Information Power Items and Dimensions (Malterud et al., 2016)



In line with the considerations shared by Malterud et al (2016) then the aim of this study appears appropriately narrow (in the focus on an initial exploration of qualitative data, from Change Interviews, from ACT interventions, from OAs populations) for the sample size to have addressed the aims. Had the aims been broadened out then this likely would have limited this and required a more comprehensive sample. This study had well established theoretical backing, both for the ACT processes and for the common factor processes that were used in the deductive analysis, despite these processes not yet having been considered in the specific context of OAs experiences of change from ACT interventions. The quality of the dialogue was generally very strong as can be clearly evidenced by the long and varied quotes included in the results. However, in the interests of transparency then this quality was slightly weaker for the two hearing voices transcripts (Study Three). It was unclear whether this is a result of the specific interviewer, their interviewing style or their rapport with the participants, the participants themselves, or simply an artifact of having a small sample size and participants who just happened to have a less conversationally broad response in the interviews. Although this did not compromise their transcripts (which were still rich, if less thick) or the overall analysis then it is still a point to consider when considering the overall dialogue quality and information power of this study. The analysis strategy also impacts the information power (Malterud et al., 2016), and as a cross-case analysis then more participants are required, yet this study still fits within the rough six + cases to be likely to provide sufficient information for analysis (Malterud et al., 2016; Braun & Clarke, 2021b). Sample specificity is considered on a range of dense to sparse depending on how much the participants contribute data that is specific to the study and varied enough to be worth exploration (Malterud et al., 2016). The range of participants included and their experiences of change (including a range of whether ACT was found to exhibit meaningful change in the original HSCEDs) shows that this study had some range. This discussion has not been with the intention of calculating information power or as a checklist for it, but to show systematic consideration about the sample size and how it relates to different aspects of the research process (from the initial aims, to the dialogue analysed).

2.5 Epistemological position

As discussed by Carter and Little (2007) then the epistemological position of qualitative research is actively adopted by reflexive researchers, to acknowledge an awareness of knowledge and how it is constructed. This then influences the implementation and the representation of the qualitative method, and the value judgements made towards the findings. Consistent with the underpinnings of ACT itself as discussed in section 1.5 then this study took a functional contextualist epistemological stance whereby the assumption is that there is a real world but that the perception of this world is shaped by context, history and language and is therefore a psychological act. Functional contextualism therefore bears some similarity to more classic social constructionist views in the positioning of reality as a psychologically or verbally perceived phenomena but remains distinct in having the purpose of predicting behaviour through understanding of context (Vilardaga et al., 2007). The meaning of ‘truth’ to the functional contextualist is based on whether the understanding gained ‘works’ (Biglan & Hayes, 1996; Hayes et al., 2013). This means that in terms of data analysis, it is necessary to draw inferences about the contextual factors and the interpretations of the participants and consider how these work to explain their behaviour in their contexts.

There has been increasing pressure on qualitative research (and researchers) to demonstrate a rigor and standardisation of results in line with the influence of evidence-based medicine cultures (Carter & Little, 2007). This is despite the different ontological and epistemological positions that underpin these cultures (Malterud, 2022). Qualitative methods can help develop the evidence base, despite the differences in standards of rigor. The lack of understanding about qualitative methodologies and epistemological positions has impacted the reception of qualitative research to clinical practice settings (Malterud, 2022). Although discussion will be given to ideas like the trustworthiness of this research then it is worth highlighting that the epistemological position of this study as functional contextualist allows the main focus to remain on exploring experiences (the psychological acts) and the influence of the context (the intervention) rather than incorrectly seeking to provide anything rigorous and standardised to add to the research base. An objective 'truth' was not sought within the data, but inferences were made inductively and deductively to then make interpretations about participants' experiences and the underlying change processes and moderators.

2.6 Researcher information

The primary researcher of this study is in their third year of a doctoral programme in clinical psychology, in the United Kingdom. The primary researcher-therapists of the initial three studies were also students of this same programme, and their projects took place across their second and third years of study. All three had similar experience of ACT in terms of direct teaching on the programme, and additional short-courses in ACT undertaken as a result of their thesis topics. These three researcher-therapists were not in the same cohort, and their studies were not directly related despite the commonalities. The primary researcher of this study has had no direct contact with the previous researcher-therapists, and access to data was managed by the supervisors and administrative staff of the doctoral programme. This means that the secondary analysis has not been influenced by any interactions with the initial researcher-therapists and their views or opinions.

The supervisory team of the current study and the three primary studies consists of two clinical psychologists from the doctoral programme, one who is an expert in ACT and the other who is an expert in qualitative research.

2.7 Data collection

As a SQA, data was not directly collected for this study. In the three original HSCEDs then the Change Interview data was collected by peer trainee psychologists to that of the primary researcher. This may explain some of the slight variance in the richness and thickness of the data. Although the primary researcher did not have an explicit relationship with participants per se, then attention was still given in supervision sessions to discuss the researchers' feelings towards participants based on transcripts to ensure that this relationship was being considered. This was a deliberate choice to go some way to address the lack of reflexive practice often found in qualitative research (Newton et al., 2012).

2.7.1 Recruitment

Sampling was purposive and for the majority of participants, through convenience. Please see Table 3 for recruitment criteria.

Table 3

Inclusion and Exclusion Criteria

Study	Inclusion Criteria	Exclusion Criteria
1	A diagnosis of dementia (any type) Clinically significant level of psychological distress (scores of ≥8 on the GAD-7 and/or ≥10 on the PHQ-9	Were already receiving psychotherapy Had insufficient English or language abilities to engage in therapy Were unable to consent to and/or engage in therapy
2	≥ 65 years of age ≥ 8 on the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) anxiety or depression sub-scale Referred for psychological support within the OACMHT Having capacity to give informed consent Willingness to engage in one-to-one psychotherapy over telephone or videocall	<23 on the MoCA (Feeney et al., 2016) or <18 on the MoCA-Blind13 (Pendlebury et al., 2013) to screen for cognitive deficit that would be difficult to accommodate for Currently undertaking another psychological therapy Inability to understand English to a level required to participate fully in the intervention Experiencing active psychosis or delirium
3	≥ 65 years of age Currently experiences voice-hearing that is at minimum moderately distressing as defined and measured using the Depression, Anxiety and Stress Scales-21 (DASS-21).	Diagnosis of cognitive impairment or dementia (as confirmed by referring clinician) Current engagement with another psychological therapy Unable to independently communicate in English without an interpreter

	Capacity to provide informed consent (in accordance with the Mental Capacity Act) Willingness to engage in psychological intervention	

2.7.2 Ethical Considerations

Ethical approval was not required for this study because it was a secondary analysis (see Appendix C) but was received for the initial data sets from Health and Care Research Wales (see Appendices D-F). The initial information sheets all included that data taken from the study may be re-used (see Appendices G-I). Since all three studies were supervised by the same supervisory team and the primary researchers were all trainee clinical psychologists on the same doctorate course (albeit different years) then the stages of ensuring scientific and ethical rigour were the same. All three studies received ongoing research supervision, and their projects were developed through research proposal panels, research proposal presentations, and a research protocol assignment.

Informed Consent

The participants in the primary three studies were provided with information and information sheets (see Appendices G-I and opportunities to ask questions prior to providing written consent. Participants were reminded that participation was voluntary and that they were free to withdraw at any point (although data collected up to that point could not be deleted).

Confidentiality and Data Protection

Authors used NHS encrypted laptops to store information in line with their local NHS Information Governance polices. Pseudonyms were used, as in this study, to reduce participant identification. Information was omitted that might have alluded to participants identities – for example locations or other specifics. These efforts were made by the original authors, and the transcripts received for the data analysis in this study had already been anonymised.

Participant Burden and Risk

The ACT interventions were all considered to be consistent with routine care. Consideration was given to the extra measures that participants completed and how these may have contributed to participant burden. Authors attempted to minimise this by using short-form outcome measures, using measures where possible that reflected usual clinical practice, offering breaks and support in completion of measures, being made aware of their right to withdraw, and (via the information sheets) the reason behind the measures being necessary in the first place. The participants in Study 1 were able to bring a nominated caregiver for support in the interventions and the interviews.

As all of the researcher-therapists and interviewers were trainee clinical psychologists then there was the expectation that their training in managing distress meant that they were able to respond appropriately to verbal and non-verbal cues suggesting burden or distress during all stages of the projects. Participants were advised via information sheets and by their researcher-therapists how they could access additional support should they feel like they needed it.

2.8 Data analysis

2.8.1 Reflective Thematic Analysis

It was decided that the dual aims of exploring experiences and exploring how these mapped onto underlying change processes suited RTA better than other qualitative methods. Other qualitative methods would have focussed more exclusively on particular aspects such as either the phenomenology of the experience, or on the processes in context of the experiences (Starks & Trinidad, 2007) rather than allowing for an interpretation capturing both. RTA goes beyond other thematic analyses approaches to focus on the necessity of immersive and reflective engagement with the data/analysis process (Braun & Clarke, 2019), appreciating subjectivity and making efforts to show reflexivity in action (Trainor & Bundon, 2021). The fact that there is a literature base available meant that the analysis could not be entirely inductive, nor would that have allowed for the exploration of change processes that might have been experienced. Similarly, an entirely deductive approach would be inappropriate given that participants bring their own sets of experiences. The recursive and iterative nature of RTA (Trainor & Bundon, 2021; Braun & Clarke, 2019) meant that in the inductive analysis where initial inductive codes might have been more on the manifest and semantic levels, then the later codes represented latent meaning due to deeper engagement with the data. For example, the move from an early inductive code of ‘gaining practical skills’ to the additional later code of ‘gaining internal confidence’ represented a move from accepting just the semantic meaning of participants talking about valuing gaining different practical ways and feeling more able to cope with their various difficulties, to also capturing the latent meaning which was interpreted to be that participants valued the increased confidence to cope with difficulties rather than the specifics of the exercises. The development in the numbers of inductive codes and subcodes across the time period of the inductive analysis represent this on a more quantifiable level.

The stages of RTA (Braun and Clarke, 2006) were completed flexibly as per the spirit of RTA compared to more procedural forms of thematic analysis. Braun and Clarke (2020; 2023) have responded to arguments about their approach promoting procedure over reflexivity and theoretical sensitivity by reiterating that it provides accessible guidance and that quality practice in RTA should rely on the following recommendations.

Table 4

Recommendations for RTA (Braun & Clarke, 2023)

	Recommendation
1	Recognize the plurality of TA; determine where your chosen TA approach is located on the scientifically descriptive (small q)—artfully interpretive (Big Q) spectrum.
2	Determine your underlying research values and philosophical assumptions; locate your use of TA theoretically.
3	Consider your analytic practice; ensure all methodological procedures and concepts cohere with your research values and TA approach
4	Justify divergences from established practice and “mashups;” ensure these are theoretically coherent
5	If using reflexive TA, link personal reflexivity to your analytic practice; don’t mention bias
6	Discuss how exactly you engaged with your chosen approach to produce your analysis
7	Recognize the differences between topic summary and meaning-based interpretative conceptualisations of themes; ensure your type of theme is coherent with your TA approach (and justify any divergences).
8	Ensure your language around theme development is coherent with your TA approach.

9	Provide a clear overview of your themes/thematic structure in the form of a list, table or thematic map
10	Ensure the quality standards and practices used cohere with your TA approach and underlying theoretical assumptions

The awareness of the primary researchers' prior knowledge and assumptions provides another argument for the need for the analysis to have been inductive *and* deductive. Braun and Clarke (2020) argue that the inescapable nature of paradigmatic, epistemological, and ontological assumptions is such that there simply cannot be a theoretical vacuum for a purely inductive approach.

2.8.2 Deductive Analysis Framework

The deductive analysis met the second aim of the study, that of exploring how participants experiences mapped onto underlying change processes – as it allowed for explicit consideration of change processes within the data through coding in line with the deductive framework. Considering common factors without considering therapy-specific factors is unlikely to be clinically useful (Mulder et al., 2017) so the deductive framework itself was compiled following review of the literature both for ACT and for change processes. The processes underpinning psychological flexibility and their counterparts (e.g. acceptance and the counterpart process of experiential avoidance) were included as the therapy specific ingredients for change. Following on from the key literature (as discussed in section 1.9), the codes for inclusion on the deductive framework were the therapeutic relationship (with subcodes as the agreement on goals, tasks, the development of the relationship), mastery, having a shared problem narrative or rationale, confronting the problem, expectations, accurate empathy, unconditional positive regard, genuineness/congruence, catharsis, new understanding and insight, practice effects (through new learning experiences), and mastery. It is important to raise at this point that the deductive framework created and used in this study does not represent an attempt to provide a thoroughly inclusive list or conceptual framework for common therapeutic factors, which often leads to misconceptions as discussed by Lampropoulos (2000). The deductive framework (see Table 5) instead represents a selection of common factors based on the primary researchers' review of the literature.

Table 5

Deductive coding framework table

ACT-specific processes	
Self-as-context / Self-as-content	
Cognitive defusion / Cognitive fusion	
Committed action / 'Stuckness'	
Values (recognition of, and shaping behaviour) / Lack of values clarification	
Present moment (non-judgemental contact with) / Stuck in the past or future	
Acceptance (willingness to have and accept private experiences) / Experiential avoidance	
Common factors	
Therapeutic alliance • Agreement on goals • Agreement on tasks • Relationship/bond	Bordin (1979)
Confronting the problem	Weinberger & Rasco (2007)
Therapist (accurate) empathy	Rogers (1957)
Shared rationale or narrative for the clients problems	Frank and Frank (1991)
Expectation of helpfulness/improvement	Frank and Frank (1991)
New understanding or insights	McAleavey & Castonguay (2014b)
Mastery	Frank and Frank (1991)
New learning experiences/practice	Frank and Frank (1991)
Unconditional positive regard	Rogers (1957)
Catharsis	Rosenzweig (1936)
Genuineness/Congruence	Rogers (1957)

There can be a risk of confirmation bias with deductive approaches to analysis (Fife & Gossner, 2024). The inductive analysis also meant that data had already been analysed for alternative meanings that were not related to the constructs being considered in the deductive analysis. Efforts were made in the deductive analysis to capture data that disconfirmed constructs, for example, the active inclusion of codes that were the opposite of ACT change processes. This was not done as explicitly as with methods like critical theorising (Knapp, 2009), but instead through a more general process of reflexive practice facilitated through the use of the reflexive diary and methods like peer debriefing to enhance the *trustworthiness* (Nowell et al., 2017) of the process. Although the deductive framework had predetermined codes based on the literature then this is not to be confused with post-positivist coding reliability approaches. As such, the deductive analysis did not follow recommendations for multiple coders or coding reliability measures. In the spirit of RTA, themes were actively created by the primary researcher and the research supervision team based on engagement with the inductive and deductive data and views about the stories interpreted from the data (Braun & Clarke, 2019; Braun & Clarke, 2021a)

Deductive analysis involves (Fife & Gossner, 2024) a level of interpretation, and the deductive approach ensured that analysis was beyond the manifest (Braun & Clarke, 2022) or semantic (Braun & Carke, 2021a) levels of meaning as attention was focussed on the latent meanings that mapped towards deductive codes. For example, where a participant described positive experiences of accessing the community then the deductive framework prompted consideration of whether there were latent meanings around valued/committed action, mastery or practice effects. Deductive analysis can be used where theory is not the primary aim (Fife & Gossner, 2024) as here. The use of deductive approaches in qualitative analysis can allow for researchers to examine individual processes and phenomena with theory to provide further evidence to refine or refute the evidence base (Fife & Gossner, 2024). Following reflection with the supervision team, there was a deliberate effort to code being mindful of semantic differences that might have arisen in the data as a result of the therapist, for example the usage of terms like 'hooked' (to describe the processes of cognitive fusion and sometimes experiential avoidance) where the definition is understood to differ depending on practitioner preferences (Harris, 2019). Harris (2019) acknowledges the difficulty in terminology in ACT, with another example being the usage of the word mindfulness and the variety in ACT processes this might actually be referring too. Consideration of therapist effects like this allowed for engagement in the data that did not interpret artificial differences between participants, and encouraged deeper consideration of the latent meanings of how participants described their experiences of change. With the understanding and reflection on assumptions and positionings being a critical part of RTA (Braun & Clarke, 2019) then insights gained through the reflexive diary were regularly discussed with the research supervision team.

The deductive framework also meant that following reflection on the researchers' prior knowledge of ACT and change processes in psychotherapy, core concepts like cognitive defusion or accurate empathy that I might have been tempted to identify within the data were already captured on the deductive framework therefore reducing the tendency to generate codes around these during the inductive analysis. Having these ideas already captured on the deductive framework allowed potential theoretically informed codes to be 'put aside' for the deductive coding and engagement to be more organic and inductive to the data during the inductive stage of analysis.

Consistent with the RTA approach then both the final inductive and deductive codes and clusters highlighted during the saliency analysis and discussed with the supervision group were integral to developing the themes, rather than the deductive framework being incorrectly used to seek evidence for pre-conceptualised themes (Braun & Clarke, 2020). This is why deductive codes like the core ACT processes and common factors like catharsis are found enmeshed within broader themes rather than standing alone in their own deductively evidenced categories.

2.8.2 Expert by Experience Consultation

Consultation was sought with an expert by experience member of the Service User and Carer Advisor Panel (SUCAP) from the primary researcher's university. Service user involvement tends to be restricted to the beginning phases of research when considering agendas and project development (Domecq et al., 2014) despite that it is possible (if challenging) to have service users participate during analysis and interpretation stages (Byrne et al., 2009). When service users are involved in the analysis (rather than simply the design of) health research then it has been found to enhance the validity of themes but also raise new details that researchers miss (Locock et al., 2019). Service user involvement can also challenge the assumptions and perspectives that are carried by the researcher into analysis (Locock et al., 2019). Although there are compelling arguments involving service users in data analysis procedures (Sweeney et al., 2013) then having reflective conversations as part of the analysis process is considered the best way to retain lived experience whilst reducing participatory burden and making the best use of their time (Locock et al., 2019). The SUCAP member had already received and participated in teaching about research methods and been engaged with the process of doctoral research at the university - factors that are considered important to fostering appropriate collaboration between researchers and experts by experience (Ameel et al., 2024).

3.0 Extended Results

3.1 Chapter Introduction

This chapter will discuss the results of this study in more detail, including how results were shaped by the saliency analysis and consultation with the Expert by Experience. It will also discuss the results of this SQA in the context of the results of the primary study.

3.2 Saliency Analysis

The saliency analysis determined which codes were salient based on both the reoccurrence and the importance of them, and ranked these as shown in Table 6.

Table 6

Saliency Analysis Table (based on Buetow, 2010)

RANK	BASED ON
1	Important AND recurrent
2	Important NOT recurrent
3	Recurrent NOT important
4	Neither Recurrent OR important

'Importance' in saliency analysis is defined by Buetow (2010) as the addition of new knowledge or usefulness for real world issues, whereas reoccurrence is based on the frequency within the data set. Importance was operationalised as giving additional knowledge or usefulness in answering the aims of this study. For instance, the code of practical skills was recurrent (see Appendix O) but it did not highlight more than that those participants recognised they gained practical skills through therapy, which did not add anything useful about their experiences of change. By contrast, codes like the unrelatability of tasks were less recurrent, but for those participants who did find tasks unrelatable then it was clear how this prevented them from experiencing change – therefore adding something new to our understanding about change processes by highlighting this is a barrier to allowing change. The epistemological position of the research will have shaped the decisions about importance. Recurrency was measured more objectively, and the software used (NVivo) captured the frequency of codes and across how many data files they apply.

Saliency analysis also ensured that codes that were not as recurrent but felt important were still captured (Buetow, 2010), such as the codes of mastery and catharsis. These were only present in 6 and 5 transcripts respectively, and with few mentions, but it was clear how they underpinned the other processes discussed. Similarly, the code that captured how therapy led to gaining new perspectives that were more normalising than previous perspectives, was less recurrent than other codes and was only present for three participants. However, those participants spoke about it in a way that highlighted how for them it was a vital aspect of the new understanding that they had gained through therapy. It also meant that codes that were recurrent but not particularly important were given appropriate amount of attention, but not given too much prominence in the final write up. For example, all participants talked about their expectations shaping therapy in one way or another. As something that was also primed for by the Change Interview, and well explored within the literature on change processes then stating that expectations had a role would not be new information for inclusion. Reflection highlighted that what was important to include about expectations was that the impact of expectations did not match researchers' assumptions based on the literature. This allowed this code to be ranked lower than other codes and shaped this code being clustered under the internal factors subheading, rather than giving it greater prominence within theme development. The identification of the codes that were most important and recurrent helped to shape the naming and description of themes. There was of course a lot of subjectivity still involved here, in terms of determining what was important, and what counted as recurrent enough. Some of the codes were reconceptualised during the analysis process, such as the inductive code 'distancing' (which was both prominent and recurrent) being captured better by the deductive code of defusion. This demonstrates some of the overlap between the deductive and inductive analysis. Some aspects, like the role of catharsis were recognised during the inductive analysis but later captured anyway on the deductive framework. Codes that might have overlapped with the deductive framework were kept during the coding process to help the inductive analysis remain organic, despite revision during these later stages when clustering and theme generation was completed using the results of both analyses.

Saliency analysis also highlights the role of deep reflection about what an analysis does *not* show in relation to the research question (Buetow, 2010; White et al., 2003). This was useful for generating findings such as about how the self-reflection that was not shown by some participants into their personal resources might be interpreted as demonstrating a lack of insight or capacity to reflect, helping to shape the generation of the internal factors sub-theme.

3.3 Expert by Experience Consultation

The SUCAP consultation with an expert by experience worked as an informal way to help test the assumptions and interpretations that had led to the findings (Locock et al., 2019). This helped address this limitation of SQA (Irwin & Winterton, 2011). The consultation highlighted several areas of the results that the expert by experience member felt were consistent with their own experiences. This ranged from agreement with the tentative balance or tension between having an appropriate amount of vulnerability for therapy to work with whilst not experiencing too great an amount of distress to engage in therapy, to agreement about the role of external resources and personal circumstances as moderators for change.

The finding about the role of family as both an external resource and external barrier for participants was reflected by the SUCAP member to feel like a finding more distinctive to this life stage, given the smaller social networks typical in older adulthood. Although social networks are impacted by factors like personality characteristics then it is found that social networks shrink in older adulthood as a result of cumulative life events leading up to older age (Wrzus et al., 2013). The highlighting of this reality also allowed the primary researcher to draw the inference between the role of external resources, and the ideas captured in the theme about Therapy being the Catalyst, and the greater role that the therapist might have where individuals do not have social networks to draw motivation from. The SUCAP consultation also added a new inference that for individuals who have had had negative reflections on their life and how they have spent their last decades (in terms of career, hobbies, or family time) they might place greater importance on their family networks – which was why this was recognised by the participants. It also prompted the thought that the limited social networks of OAs might make processes like catharsis particularly important for this age group than has been recognised in previous qualitative change process research because of their reduced opportunity to share their thoughts with a receptive audience. The consultation highlighted that OAs perhaps more than other demographics might have circumstances or resources less open to change – which is of course one of the very rationales for an ACT approach. This reinforced the perspective of the primary researcher that psychotherapists might need an increased amount of creativity to address the level of ‘stuckness’ that was shown. The perspective was shared by the expert by experience that older adulthood involves a certain level of acceptance of one’s own limitations, which might offer an informal explanation for the level of ‘stuckness’ that was found in the deductive analysis. This matches the perspectives of participants like Agatha and Jean who shared the barrier that their health presented and how this impacted their behavioural inaction. This interpretation served as a reminder for the need for psychotherapists to support participants to initiate change that is reasonable for their circumstances and limitations.

The subordinate theme about how therapy was exposing was also evaluated in a wider light following consultation. The expert by experience challenged the assumption that therapy is an inherently exposing process with the supplementary interpretation that for OAs, with a wealth of life experiences behind them, then the reflections prompted in therapy might feel particularly confronting. The notable example of this sentiment was by Mike, who can be seen earlier as talking about his difficulty “accepting his past”. The ability for any one therapy or therapist to address a life of difficulty was presented as a concern by the expert by experience, and perhaps explains why participants found so much value in finding that their therapists were skilful and accurately empathetic.

The thoughts and reflections generated through this consultation were then the subject of critical reflexivity to ensure that I had used this consultation to bridge between my knowledge of theory and the experts’ experiential knowledge (Harris et al., 2023). I reflected on the process of the consultation itself, on the values and beliefs that had underpinned my interpretations and where these original interpretations had been challenged or confirmed through this consultation. I later reflected on what had underpinned my interpretations of the experts’ thoughts and reflections. Where my original interpretations had been challenged or elaborated on within the consultation, then I reflected on both *what* my interpretation had been and *how* I had arrived at it, to then reconstruct (or co-construct) my interpretation with the inclusion of the experts reflections (Etherington, 2017).

3.4 Additional findings

There were some findings that could not be given more attention or inclusion in the final write up but are interesting to consider in this extended results section. This pertains particularly to the ACT processes, as those common factor processes and the inductive codes that did not make the final analysis are also not important or recurrent enough for discussion in this section. What was more interesting than the undeniable presence of ACT-specific processes in the data, was the strength of presence for the opposite of the ACT processes. Although experiential avoidance and cognitive defusion were talked about most explicitly in the main results section, then all of the psychological inflexbility processes were identifiable in the data. For instance, with Agatha here having identified her increasing tendency to remain stuck in the future than in the present, “One particular problem has worsened… worrying about getting things wrong”. Mike also talked at length about being stuck in the past:

> I think one things is, not just ruminating and being controlled by past events in life. I think I said to Jonathan it's like pushing a big rubber ball up a hill, so that all the nonsense and stupidity of the past is contained. I couldn’t bear to think that what I’ve done in the past would be revealed to family. It’s just…I suppose, you would say and everybody, “we all make mistakes.” But I just feel I’ve got an A plus in, well, everything going I suppose…being bullied and doing stupid things and saying stupid things. And when I was sort of quite ill, it affected the family. I can’t seem to…I can’t find a way of untangling that (sounds emotional). And that’s a bit of a burden. As you can probably here.

Although it was not salient enough to be included in the final reports then some participants did make explicit reference to their values, with Mike exclaiming how:

> “I’ll tell you one thing which it is obviously big on, is values, instead of goals. And I do use that a lot. And I think, “I’ll will do this, according to my values.” Over the period, I’ve realised my values are not actually what I thought they were (chuckle). And that’s been quite revealing. I’ve been living

> the way I thought I should live, and not really the way I want to. And I suppose that’s a key point of it.”

Where the rest of the participants simply neglected to explicitly discuss their values, then Minnie also can be seen describing using values to drive herself forward, in the context of the losses that she has experienced:

> “Well, I suppose since then I've lost my mother, sister and husband, so you learn to actually cope with this and yeah, you accept that it's happened, you can't change it, so you’ve got to learn to live with the losses you’ve got. But that shouldn't overcome the other interests in life and ways of moving forward.”

One of the interesting inductive codes that missed inclusion was that of the increased contact with pleasurable situations that committed action brought, such as with Jean sharing how her therapist “was trying to coax me to visit my friend. Hadn’t seen her for a year. She lives round the corner virtually. Anyway, on Friday, I went to see her. And it was *lovely”.* Maggie also shared how nice it was feeling that she can cheer her husband up as a result of some of the exercises she rehearsed outside of session. These additional results highlight that although there were processes and themes that were salient across the whole data set then some individuals had additional experiences.

3.5 Comparison to the primary results

This next section will consider our results in contrast to the results from the primary analyses completed in the original three papers. Our findings discuss how all participants, despite the level of their clinically meaningful change as determined in the original studies, experienced some level of personally meaningful or identifiable change. Participants did not tend to identify key points during the course of therapy where they experienced significant change, although some participants were more explicit about exercises where they noticed experiencing change. The evidence from this study suggests that there was a great degree of identifiable psychological inflexibility that accounts for some of the lack of change. This study also has explored and identified some of the factors that participants experienced as barriers or moderators. The theme of it being the Right Time and Place particularly explains, and in detail, why clinically meaningful change was not found for participants like Carol and Agatha. This section will also report the results of the fidelity checking in the primary studies.

Study One

Study One measured meaningful change using a mixture of quantitative self-report measures and qualitative data gathered from Change Interviews, session recordings and therapist notes. The self-report measures included the Generalised Anxiety Disorder Questionnaire (GAD-7; Spitzer et al., 2006) and Patient Health Questionnaire (PHQ-9; Spitzer et al., 1999) to measure psychological distress, a measure of psychological flexibility (the Comprehensive assessment of Acceptance & Commitment Therapy Measure; Morris, 2019), the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMBS; Tennant et al., 2007) and measures to capture changes in the client's problems (the Personal Questionnaire; Elliott et al., 1999;) and therapeutic alliance (the Session Rating Scale; Duncan et al., 2003). The ACT fidelity assessment found a mean consistency score of 31/36 and an inconsistency score of 0.3/36.

Adjudication concluded that Minnie had meaningful and measurable improvement in her key problem areas, in the quantitative self-report measures, and evidence of engagement in Committed Action. The changes Minnie experienced and discussed, and the variety of change processes that these mapped onto in the results of this study are consistent with the presence of quantitatively recognisable change. However, adjudication could not conclude that Agatha and Phyllis had experienced meaningful change that was attributable to the intervention - despite evidence of statistically reliable change areas like psychological flexibility and psychologist distress, and evidence of engagement in ACT processes. For Agatha, who can be seen in the results of this study as displaying a lot of psychological inflexibility and determining it was not the Right Time or Place for her (due to time commitments and her health) then perhaps it is less surprising that judges did not deem her to have experienced meaningful change overall. The greater question remains for Phyllis. The original paper shows some debate during adjudication about Phyllis, mainly because of being unable to attribute change to the ACT intervention specifically. Our findings further elaborate that although Phyliss did engage in Committed Action underpinned by processes like Cognitive Defusion and supported by her internal resources then she experienced her opportunities for changes as greatly limited by the Covid 19 lockdowns.

Study Two

Study Two assessed meaningful change using a mixture of quantitative and qualitative measures. Alongside qualitative information gathered from the Change Interviews and the Helpful Aspects of Therapy questionnaire (Llewelyn et al., 1988) then quantitative measures provided data on anxiety and depression symptoms (the Hospital Anxiety and Depression Scale; Zigmond & Snaith, 1983), quality of life (the Older People's Quality of Life Questionnaire, Brief Version; Bowling et al., 2013), psychological flexibility (the Comprehensive assessment of Acceptance & Commitment Therapy Measure; Morris, 2019), changes in the client's problems (the Personal Questionnaire; Elliott et al., 1999), general progress (the Outcome Rating Scale; Miller, et al., 2003) and therapeutic alliance (the Session Rating Scale; Duncan et al., 2003). The ACT fidelity assessment measure found a mean ACT consistency score of 30/36 and mean ACT inconsistency of 1/36 for Study Two, suggesting sampled sessions were ACT consistent.

Adjudication concluded that neither Jean nor Carol showed clinically meaningful change in their presentations, whereas Mike showed moderate improvements that were consistent with his experiences of change as explored in this study. Although Carol and Jean showed improvements in their problem areas and psychological flexibility then these were cancelled out by other (mainly extra-therapeutic) factors. This study has highlighted in more detail the processes that have both helped and hindered these participants, for example, how the difficulties in their personal circumstances impacted the timing of therapy being appropriate for Jean and Carol, and the value for Mike of mindfulness and acceptance processes.

Study Three

Measures in Study Three captured the severity of participant's voice-hearing (the Psychotic Symptom Rating Scales; Haddock et al., 1999) as well as their beliefs (Beliefs About Voices Questionnaire-Revised; 29-item version; Strauss et al., 2018), and acceptance (Voices Acceptance and Action Scale-9; Brockman et al., 2015) of their voice-hearing experiences. Measures also assessed symptoms of anxiety, depression and stress (Depression, Anxiety and Stress Scales-21; Lovibond &

Lovibond, 1995), quality of life (the Older People's Quality of Life Questionnaire, Brief Version; Bowling et al., 2013), psychological flexibility (the Comprehensive assessment of Acceptance & Commitment Therapy Measure; Morris, 2019), and changes in the client's problems (the Personal Questionnaire; Elliott et al., 1999),

Both Ann and Maggie were judged to have shown meaningful change following adjudication. Judges concluded that ACT accounted for the majority of change, but recognised the role of the therapeutic relationship, the participants motivation, and familial support as mediating factors. This matches with findings such as about how both Ann and Maggie recognised that it was the right time for them to be able to engage in therapy, and that they had the internal resources like determination to do so, and that they benefitted from processes like acceptance, mastery, catharsis and the qualities that their therapists had – even where processes of psychological inflexibility were still present.

The ACT fidelity assessment found a mean ACT consistency score of 34.5/36 and mean ACT inconsistency of 1.5/36 for Study Three, suggesting sampled sessions were ACT consistent.

4.0 Extended discussion and reflection

4.1 Chapter Introduction

This chapter will discuss and reflect on this study, the findings in relation to the extant literature and the implications of the findings. It will also offer critiques, and reflections about the design of the study and how this might have impacted or influenced the findings.

4.2 Findings in relation to the design

One of the considerations about our findings is whether participants responses have been primed in some way through the design of the study. With utilising qualitative data that had come from CIs which themselves aim to explore change (Elliott, 2006), than some of the findings were not particularly surprising – such as those about the role of external factors, given that this is prompted by one of the questions. The rationale for the inclusion of such questions can be traced back to Elliott and Williams (2003) who recognised the role of the events and feelings clients had experienced prior to therapeutic input. It is also a likely assumption that the qualitative researchers own knowledge of extra-therapeutic factors and change processes coloured the analysis. However, this finding is still useful and has highlighted ways that ACT for OAs could be optimised through addressing the impact of the particular extra-therapeutic factors that this study identified moderated experiences of change.

Another consideration about how findings might have been primed by the design of the study is whether participants shared experiences of change in recognisable terms that they had been primed to do so through the delivery of the intervention itself. Interventions like ACT that have therapy-specific theoretical change processes embedded within the delivery (such as with explicit exercises that talk about values or defusion) could be viewed as being at risk of having socialised participants into language that represents the delivery of the approach rather than true experiences of processes. For example, participants could verbally report the value of ‘cognitive fusion’ in the CIs, having learnt this term, but not necessarily be experiencing cognitive fusion as a process. In terms of the literal delivery, then the fact that there were no salient findings relating to the impact of the three different delivery modalities fits with previous literature that ACT is just as effective and acceptable delivered face to face or online (Herbert et al., 2017).

Some of the findings did not match expectations, which supports that this study has yielded useful and organic findings despite the restrictions/priming of the design. For example, cognitive defusion was only really present as an underpinning process in certain contexts (like when facilitating committed action) and was not explicitly labelled by participants. Other processes that were explicitly labelled were often talked about in different terminology, such as mindfulness – which was only explicitly labelled as ‘mindfulness’ by the two participants who disagreed with its utility. Other participants tended to refer more generally to exercises they enjoyed by name, or elements of the mindfulness exercises that they enjoyed, such as breathing techniques or their awareness of the power of mindfully noticing things in their immediate environments. Similarly, for committed action then participants did not talk about this using this language, or even often through the language of values (which given the delivery of ACT might have been anticipated) but instead spoke about examples where they had shown behavioural change that was underpinned by something that was important to them – such as Phyliss interacting with her community more in the aim of being helpful. These examples suggest that what participants were experiencing (and what was being interpreted) were the processes rather than simply reiterating the terminology. Had the findings about change processes been an artifact of participants being socialised into the model then it would be a reasonable assumption that participants would speak in more ACT-specific language.

The fact that the deductive framework allowed for mapping of findings onto change processes has helped to shape the findings in ways that other qualitative research methods could not. For example, although Smith (2017) explored experiences of ACT for depression and anxiety in a group context then the interpretative phenomenological approach, whilst yielding its own unique insights, meant that there was not the scope in the method to explore whether findings like that of her participants moving from feeling alone to feeling a sense of solidarity with others mapped onto any processes like mastery or of new understanding and insights. The lack of findings for processes like unconditional positive regard might be a result of the design in that these processes are experienced more by the therapist (Rogers, 1957) despite the assumption that this might have been experienced or identifiable in the experiences of the OAs.

Elliott (2011) sees change process research as having the potential to support clinical practice but being underutilised, because of being restricted to certain research designs (Elliott, 2002). However, this study has shown how rather than needing to go through the challenges of designing, recruiting, implementing and analysing the typical methodology then SQA can be used pragmatically and with success. Although the qualitative design cannot determine if participants experiences of change were mechanisms or moderators in the stricter sense (Kazdin, 2007) then it has highlighted how, for example, it being the Right Place or Time for therapy was *experienced* as a moderator. Triangulation of quantitative research methodology would be needed to establish this as a formal moderator.

As well as the critiques of how the original designs might have impacted on the results, are critiques coming from this study being a secondary analysis. The data was collected by researchers affiliated with the primary studies, giving this study a lack of control over this process. Although there are benefits to this as mentioned in sections 2.3 and 2.6 then there are potential difficulties from this. For example, the difference in data in study three (as the transcripts were shorted, and of slightly lower quality) could have been a result of that particular interviewer, or of those particular participants, or reasons relating to their presentation - or simply coincidental. Having different interviewers means that it is unclear what such differences should be attributed too, if anything. The interviewers may have used different styles, explored to different degrees (what with the interviews being semi-structured) or simply had different rapport with their respective

The design of this study in terms of the methodology also has some limitations to consider. Although RTA did allow for the desired balance between exploring experience, and exploring ACT-specific and non-specific change processes then this data analysis strategy did lose the specificity for the processes that might have been gained with other methodologies. For example, Framework analysis is similar but might have provided greater transparency and refinement of themes towards a conceptual framework (Smith & Firth, 2011) than the more subjective and interpretative RTA is able to do (Attride-Stirling, 2001).

4.3 Findings within the context of the extant literature

4.3.1 Common Factors and Change processes in ACT

As discussed by Felice et al (2019) then although the literature base finds common factors account for the majority of variance in psychotherapy outcomes then common and specific factors are not necessarily as independent and distinct as has been suggested. This has been evidenced in studies like that of Trompetter et al (2015). Our findings provided experiential support for how common factor and therapy-specific processes were experienced as working in an interrelated way - with specific processes like committed action being experienced as reinforced by common factors like mastery and practice effects, or the finding that new understanding and insights, as supported by exposure and therapeutic alliance, helped to facilitate participants to be open to the specific understanding about the value and usefulness of processes like cognitive defusion. The strength of committed action can also be explained through how, despite the interrelated nature of the core ACT processes then committed action can be viewed as the ‘final’ stage of this (Hayes et al., 2006).

The finding that experiential avoidance was present for all the participants despite them experiencing increased ability to accept, shows how imbedded this can be as a strategy. Meta-analytic results support experiential avoidance as a process for conditions like depression, anxiety, obsessive-compulsive disorders and post-traumatic stress disorder (Akbari et al., 2022). Our findings have provided qualitative experiential evidence supporting the transdiagnostic presence of experiential avoidance for OAs. This also fits with literature emphasising the idea that experiential avoidance functions as a generalised maladaptive tendency (Kashdan et al., 2006; Spinhoven et al., 2016).

Therapy as a Catalyst speaks to the idea that some of the change in therapy is a result of the reaction of the client or patient to the therapist (Lampropoulos, 2000). Although the title of this theme was generated from a notable quote by Phyliss's carer then Rosenzweig (1936) referred to the impact of a good therapist as being experienced as 'catalytic'. Early research into experiences of change highlighted the processes of gaining insight and new perspectives, awareness of the problem and being able to confront it (Hanna & Ritchie, 1995). However, even studies like that of Hanna and Ritchie (1995) that aimed to identify the contextual factors impacting change report being unable to do so. The findings within the subordinate theme that new understanding was experienced in the context of other processes is consistent with the findings of McAleavey & Castonguay (2014b) that new insights in therapy are related to other processes such as the directiveness of the therapeutic approach and the presence of other common factors. Where our findings fit with these long-recognised common factors, then this study has been able to further elaborate on the context that common factors were experienced within – for example, catharsis being experienced in the context of a tolerable amount of exposure and positive therapeutic relationships, in turn characterised by accurate empathy and agreement on tasks (if not goals).

Interestingly then not all the deductive codes were salient, or even particularly evidenced. One of the most surprising of these was that although some participants recognised the value in confronting the problem then this was more in line with general realisations about themselves, and the value of a shared problem narrative or rationale was not recognised semantically or latently despite being a well evidenced common factor that is thought to promote the maintenance of expectations of helpfulness and promote agreement on goals (DeFife & Hilsenroth, 2011). This finding is an example of a finding that was slightly surprising given the primary researcher's prior expectations and knowledge of the literature base for common factors. On reflection, a possible explanation for this finding (or lack of) might be that ACT's short term and practical focus meant that the lack of focus on the problem narrative was overcome by the solutions-focussed work. This is supported by the prominence of committed action as a process experienced by participants, suggesting that participants leant into practical and goal-driven action rather than noting the absence of a shared problem narrative. Although this is just a potential explanation, it could be taken to suggest that ACT might have utility for those individuals (such as through cognitive deficits, personality, or difficulties with reflection) who would find the construction of a shared problem narrative a harder task than more practical steps to address their mental health. This train of thought is supported by the evidence for ACT as helpful for adults with conditions with associated cognitive impairments, such as those with multiple sclerosis (Proctor et al., 2018; Thompson et al., 2022), chronic fatigue (Roche et al., 2017), traumatic brain injury (Sander et al., 2021) and of course Study One of this analysis - older adults with dementia (Robinson et al., 2022).

4.3.2 ACT for Older Adults

Petkus and Wetherall (2013) argued that ACT might be more appropriate for OAs than other approaches partly because of their lower levels of mental health awareness and the goal of ACT being about valued-living in the present moment rather than focusing on specific mental health concerns like anxiety or depression. A systematic review by Ruan et al (2023) found that patients perceptions of ACT are that it is about personal growth, and finding new ways of living, relating to internal negative experiences and integrating with the world. These perceptions were sometimes a barrier to therapy, with one participant memorably saying they thought it was some sort of "hippie psychology". Perhaps, like Petkus and Wetherall (2013) seem to suggest then ACT is less confronting, more acceptable or carries less stigma than more traditional psychotherapies. This idea matches the reports by Mike that part of what he valued in ACT was that it was not a 'mental health' therapy as much as an accessible wellbeing therapy. Although this idea was not salient enough for the final report, it does suggest that the perceptions of ACT (that might be different to the perceptions of other psychotherapy approaches) might have a role for OAs.

It is thought that different factors might be at play at different times in therapy, with the example of expectations and collaboration on goals as being important during the earlier stages (DeFife & Hilsenroth, 2011). Interestingly, the context of the stage in therapy was not recognised during analysis for common factors. There are some natural conclusions that came out of the data, such as that catharsis was experienced later on in therapy once the therapeutic relationship had time to build and participants became exposed to the process of therapy, or that committed action was experienced following the earlier processes of new realisations that often included specific processes like defusion.

A meta-analysis by Ren et al (2019) found that the processes of acceptance, contacting the present moment and values was statistically significant despite not being key findings in this study. This highlights that as suggested in section 1.7.1 then there are differences in this demographic and context. Despite the rationale for ACT focussing on how OAs are in a life stage characterised by reflection on values, this was not brought up by the analysis. It is important to keep open-minded for what this might show however, as it might not discredit the importance of values for OAs/the life stage of older adulthood or the utility of ACT in tapping into values. It could be, for instance, that values were not experienced as an important process of change because OAs were already in touch with their values, but what ACT provided them was a way to move towards using their values to shape their behaviour.

Following from discussion of the conflicting findings in chronic pain research for ACT in section 1.8 and how this raises the need to explore what impacts OAs ability to experience change (e.g Fishbein et al., 2023), then this study has given a detailed and personalised understanding of the types of factors (both general, and in terms of ACT-specific and common factor processes) that account for the lack of change in some of the participants.

4.4 Demographic considerations

4.4.1 Older Adults

It is interesting that some of the initial codes on the deductive framework that were derived from the literature base were not prevalent or prominent within the data. This highlights the need to complete qualitative psychotherapy research on specific populations and in specific contexts to help triangulate which change processes they might be experiencing rather than assuming the presence of evidenced mechanisms from wider fields of research. It cannot be concluded from our analysis whether the common factor processes that were not evidenced and the ACT processes that were less evidenced than others are a result of the context or of the OA participant pool. For example, although agreement on goals is an evidenced aspect of the therapeutic relationship and included on the deductive framework then this was not something present on the semantic or latent levels. Reasonable explanations for this include that ACT is not as specific in goal setting in the way that other therapies like CBT are, because ACT positions the participant as responsible for their own goals, and the therapist as encouraging value-directed behaviour rather than positioning goal-setting as a routine collaborative exercises (Collard et al., 2019). However, the lack of agreement on goals as an aspect of therapeutic alliance in this study could also be a feature of this demographic as research finds that OAs show a tendency to prioritise harmony in their relationships with psychotherapists and to defer to them as the experts or figures of authority (Boschann et al., 2024). Regardless of the reason, this suggests an avenue for further consideration in that where this study has highlighted what participants experiences in relation to change, and some of the processes underpinning it – then it has not been able to determine why.

One of the most challenging questions for clinicians and researchers is that of what interventions are suitable and for whom (Roth & Fonagy, 2005). Given that part of the rationale for this study was the need to investigate experiences of change and change processes in OAs, then it is interesting that factors well evidenced for other age groups were not present in this study. For example, a meta-analysis by López-Pinar et al (2024) found support for psychological flexibility for ACT with adolescents but some research only supports specific processes like acceptance and defusion (Swain et al., 2015) or values work (Petersen et al., 2024). In contrast, this study highlighted most saliently the role of committed action. Ruiz (2010) concluded their review by stating that the data suggest ACT works through the reduction of experiential avoidance and cognitive fusion whereas again, for OAs in this study found they continued to experience significant experiential avoidance, and that committed action was experienced as vital to change. This supports the argument of the importance of (and continuing too) explore change processes in specific demographics and contexts, as they might have experiences that do not match other demographics.

OAs continue to report a lingering stigma towards accessing psychotherapy (Hannaford et al., 2019) and in their beliefs about mental illnesses (Segal et al., 2005) that are thought to contribute towards their underutilisation of mental health services. There is evidence contradicting the assumption that OAs have negative help-seeking attitudes generally (Mackenzie et al., 2006; Mackenzie et al., 2008), with younger cohorts of OAs showing more positive views (Currin et al., 1998). It appears that factors like resources are likely to be a bigger barrier than their attitudes towards help-seeking and treatment (Mackenzie et al., 2008). Consideration should be given to how barriers or views might fluctuate as different demographics enter this life stage, and the impact of that on psychotherapy and on the validity of the literature base (including the findings and implications of this study).

4.4.2 Older Older Adults

It is a common research trend that those older demographics of OAs are neglected in research, in part because of the difficulty studying them (except in institutional environments), the higher likelihood of comorbidities, and the difficulty disentangling medical problems with psychiatric or psychological ones (Blazer, 2000). There are differences in wellbeing between OAs and the ‘oldest old’ that were thought to be due to the increase in chronic illness and decrease in functioning most prevalent for the oldest old (Smith et al., 2002). Attempts to categorise older adulthood into distinct categories have found that it is better to view older adulthood as a continuum whereby the decrease in wellbeing is a result of the increased challenges in circumstances over that time period (Cohen-Mansfield et al., 2013). This suggests perhaps that this study would have benefitted from the inclusion of individuals across the continuum of OAs, or that further research could investigate the experiences of change with these older individuals.

4.4.3 Gender

Although arguments have already been put forward about the consideration that was given to data saturation, sufficiency, and the information power of the sample, then a different point to note is that bar one participant then all the sample were female. Whilst this in no way serves to negate the results or potential transferability of the findings, as ‘Mikes’ experiences of change were not notably different in any way from his female peers, then it does raise the question about the role (or not) or gender. There have been some differences in gender reported when investigating experiences of psychotherapy, with women attending more to the therapeutic relationship than men (Bieliauskienė, 2014). Interestingly, the gender of the therapist is also found to impact experiences of psychotherapy, with contradictory evidence in terms of actual outcomes, but clear differences in the qualities patients attribute to their therapists and in the therapeutic styles of male and female therapists (Schweitzer et al., 2024). The therapist-researcher for Study Two was male, but as with 'Mike' there were no discernible differences noted in the transcripts generally or specific to the gender of the therapist. This line of thinking does beg the question of whether further research that made a conscious effort to be more aware of differences in gender or had more consciously recruited a more equal gender split would capture differences in experiences of psychotherapy. There is mixed evidence about the gender differences in mental health for OAs (Keily et al., 2019) but men report being less open to acknowledging mental health concerns and less open to professional support (Mackenzie et al., 2006). The reluctance of men to attend psychotherapy is reported to be higher than that of their female counterparts (Liddon et al., 2018) and older men have long been recognised to be generally underrepresented in psychotherapy research (Kosberg & Mangum, 2002). Whatever the potential interplay between the barriers of age and of gender that is impacting men's attendance in psychotherapy and in research then further research could benefit from considering exploring men's experiences of change or at least being more mindful about this in recruitment stages.

The points discussed above are particularly interesting when considering that, as perhaps reflected in the wealth of quotes that are included from him, Mike was actually very open during therapy and during his Change Interview. He showed a strong capacity for reflection and was thoughtful and thorough in his answers. Without gender being considered during recruitment then no assumptions can be drawn about whether this verboseness was a trait exclusive to him as a person, or whether it represented something else - such as about the type of man that might be interested in therapeutic intervention research. What is clear is that as the only male participant, his verboseness voice did not at all become obscured by the other participants.

4.5 Extended Critique

Despite addressing a general gap in the literature for exploring experiences of change for OAs following ACT interventions, then this study has unfortunately followed the research pattern of continuing to neglect those most frail subpopulations of OAs (Petkus & Wetherall, 2013). Although this was partly because of the decision to utilise readily available data it represents a general trend of failing to capture the experiences of the older cohorts. Similarly, the lack of gender or ethnic diversity (with the majority of participants being female, and all participants being white British as far as this author is aware) means that the findings of this study are limited in how far they can be generalised to subpopulations within the OAs demographic. This could also be considered a limitation of the choice to complete this as an SQA.

Despite the justification for the SQA method used in this study then it has meant that this study is not exempt from critiques of the original methodology. There is a certain degree of uncertainty here, as any flaws of the previous studies that have not been reported to this author might have influenced this study. Similarly, the decisions taken by the original researchers and the impact of those were not something that could be addressed through secondary analysis.

Particularly for Study 1 then there is the argument about whether the cognitive difficulties associated with the participants presenting conditions will have affected their recall in the Change Interviews. The Change Interviews did not utilise any methods to enhance recall, nor has the Change Interview protocol been created or tested (to this authors knowledge) in the context of OAs. The reliance on this data leads to these critiques, even though the Change Interview data fit the purpose of the study neatly and yielded interesting and salient results. Experiences of therapeutic change have long been understood as being subjective to the individual (Gendlin, 1961) and the reliance on this subjective qualitative data means that the assumptions, biases or any desires of the participants to reflect their interventions/therapists in a positive light (regardless of their genuine experiences of change) will have altered the data. This is an important critique when considering that there was not substantial quantitative change for all participants (as discussed in section 3.4) despite the changes discussed in the qualitative data.

4.6 Clinical Implications

This study has provided detailed and experiential evidence for practitioners to consider OAs circumstances in relation to beginning psychotherapeutic work. The findings in this study about the need for it to be the right time and place for therapy, and the clarifications about what this means to OAs (such as being in the right headspace for change, or having appropriately settled circumstances and external and internal resources to draw on) can shape how clinicians decide on ACT as an intervention or how they support individuals to engage in/prior to ACT.

This study has also highlighted the interplay between different change processes and suggested those which for OAs in an ACT context were experienced as more important. This can help guide practitioners when planning their interventions, specific sessions, or prioritising content. For example, where practitioners might be aware of the theory around the role of therapeutic alliance, this study found that participants experienced this in terms of agreement on the tasks of therapy but not on the goals of therapy – which could be interpreted clinically as suggesting that focussing on obtaining agreement between clinicians and patients about the tasks is the priority within this model and demographic. Similarly, the wealth of evidence towards committed action means this might be an easier ‘win’ of a process to facilitate some change, but that overcoming experiential avoidance and fostering acceptance might be a harder target but one that needs to be addressed. The ‘stuckness’ that a lot of participants experienced seemed to be a case of whether it was the Right Time and Place for therapy. This means that some of the factors discussed in this theme could be considered by clinicians to allow for clinicians and patients to address these factors more creatively and directly where possible, to allow for greater change.

It was a positive that the therapeutic relationship was so salient in the findings, given that one of the reasons suggested for challenges in delivering therapy to OAs is the difference in age between therapists and patients (Charlesworth, 2022). Although the data for the ages of the therapists in the original studies is not available, then the average age range for trainee clinical psychologists is between 25 and 29 (British Psychological Society, 2024). Both experienced and trainee psychologists show a general disinterest and reluctance for working in OAs services (Bryant & Koder, 2015; Lee et al., 2003), perhaps because of the many different adaptions required for completing psychotherapy, as a result of their different cognitive, social and health contexts (Knight, 2004). Research like this might go some way towards reassuring those trainee and qualified psychologists (who find the age difference increases their reluctance for supporting this demographic) that they can build positive therapeutic relationships that support change.

4.7 Future Research

Although recommendations and considerations for future research have been shared throughout, then future research could specifically build on the arguments discussed in this extended paper to explore experiences of change with other under-researched demographics. It would be interesting to see the differences in experiences of change and the processes that these map onto – as well as to highlight clinical implications about the delivery of ACT. Similarly, then research could explore the experiences of change for OAs with increased frailty, such as those in the older demographic, in care facilities or with greater comorbidity. It would be interesting to consider whether the experiences of change following ACT interventions were different, given the assumption of their greater unchangeable circumstances that might increase their need for acceptance (Mitchell & Pachana, 2020) but also that our findings highlighted how difficulties like health and social circumstances could be experienced as barriers to change. Future research could also consider the benefits of using SQA to complete such research and gain useful insights from existing data, adding valuable contributions to the literature base whilst removing the demands placed on participants and the logistical difficulties of primary research – especially if considering researching the experiences of frailer or harder-to-access populations.

Further research could consider exploring the perceptions of ACT compared to more traditional psychotherapies, and whether, as suggested by Petkus and Wetherall (2013) and evidenced by Mike, this impacts OAs experiences of therapy. Similarly, it would be interesting to determine why the OAs experiences in our study did not always match those expected by the literature base and whether this is a product of the context of ACT or the context of this demographic.

4.8 Critical reflection

As an individual with a passion for understanding the nuance of psychotherapy and working with disadvantaged groups then at times it required extra thinking to ensure that what felt to me, like an obvious justification for this research was appropriately communicated to the audience. Similarly, whilst the need to understand the processes of change to help optimise interventions like ACT (that seem appropriate for this demographic) appears obvious to one such as myself with a research interest and passion in the field, then it required some thought about how to thoroughly explain the rationale for this to others. Researching this through SQA felt pragmatic and a way to yield useful findings without the ethical issues that primary research can bring. However, I had the awareness that not all researchers would hold the same position. Despite all of the justifications for qualitative research and for SQA then I felt a pressure to produce a report that demonstrated the value of this in a field where qualitative research continues to be neglected (Jando & Dione, 2024). This was heightened by the fact that the justification for this lies in this extended paper rather than in the journal paper, primarily due to the limitations of word count – leaving me to rely on the results 'speaking for themselves' in demonstrating the value of this methodology. As a researcher, there were also some personal challenges in completing an SQA – such as the lack of control over the original studies or my lack of insight into decisions that the original researcher made. For example, the differences in method of delivery of the intervention, as having this standardised would have been my preference. As reflected upon in Section 4.1 then including three distinct (if, usefully comparable) primary studies in my SQA left me aware that the lack of standardisation over interviewers/the interview process has limited my ability to draw conclusions. My own curiosity about interviewers' decisions when to explore and elaborate on certain points has been fostered during the process of analysis, and I have recognised my own slight frustration that I did not have control or insight into this process, the reasoning or perhaps the biases behind these decisions - despite relying on this data for my study. It is the consistency of my findings from the RTA across all participants (regardless of presentation or interviewer) that has served to assuage this frustration, rather than necessarily my own acceptance of the aspects of this project that were outside of my control due to the very nature of SQA.

Having had a career change from social work to clinical psychology then the tendency to think about where psychotherapy sits within the wider social contexts' that individuals are situated within was a challenge to mitigate against throughout. Indeed, although I am confident in my findings and how they fit with existing literature, then it might be argued that my previous professional background influenced my recognition of the role of participants social circumstances - that then may have contributed towards generating the theme of it being the Right Place and Time for therapy. I have been proactive in being open about such thoughts and influences in research supervision, and in the consultation with the expert by experience in the hopes to mitigate such impacts on the findings but I recognise that my engagement with the data will have naturally been shaped by the lens that I hold. Although I was secure in my justifications for the inductive and deductive analysis then as discussed by Willig (2012) qualitative analysis should be primarily inductive as does not seek to tests hypothesis. Unfortunately, the extent that I recognised I would be shaped by the literature base already meant that a completely inductive approach would not be realistic, nor would it have been useful when considering the secondary aim of this study and the rationale for that aim.

The different paradigms that qualitative research can be embedded in make it a challenge to articulate general quality criteria. Braun and Clarke (2020) gave recommendations as shown earlier in Table 4 that have been considered throughout the development and writing of this project. Similarly, efforts were made to support the trustworthiness of the findings by methods such as careful and thorough selection of quotes to exhibit the interpretations discussed and detailed reporting of the analysis method to allow readers enough information to form their own opinions (Nowell et al., 2017). Due consideration was given throughout the analysis process to adhere to Nowell et al (2017) trustworthiness procedure as informed by Lincoln and Guba (1985).

Table 7

Trustworthiness procedure for RTA (Nowell et al., 2017, informed by Lincoln and Guba, 1985).

Phase	**Means of establishing trustworthiness**
Phase 1: Familiarizing yourself with your data	Prolong engagement with data Triangulate different data collection modes Document theoretical and reflective thoughts Document thoughts about potential codes/themes Store raw data in well-organized archives Keep records of all data field notes, transcripts, and reflexive journals
Phase 2: Generating initial codes	Peer debriefing Researcher triangulation Reflexive journaling Use of a coding framework Audit trail of code generation Documentation of all team meeting and peer debriefings
Phase 3: Searching for themes	Researcher triangulation Diagramming to make sense of theme connections Keep detailed notes about development and hierarchies of concepts and themes
Phase 4: Reviewing themes	Researcher triangulation Themes and subthemes vetted by team members Test for referential adequacy by returning to raw data
Phase 5: Defining and naming themes	Researcher triangulation Peer debriefing Team consensus on themes Documentation of team meetings regarding themes Documentation of theme naming
Phase 6: Producing the report	Member checking Peer debriefing Describing process of coding and analysis in sufficient details

	Thick descriptions of context Description of the audit trail Report on reasons for theoretical, methodological, and analytical choices throughout the entire study

Whilst some of these were completed as rote (for example supervision notes serving to document all team/researcher meetings) then an active effort was made for others. Supervisions were held on a regular basis throughout all phases of analysis to allow amply opportunity for elements like member checking, vetting of themes and subordinate themes and debriefing. This sometimes yielded specific results, such as the increase in code development during one part of the inductive analysis that would go on to shape the generation of subordinate themes within the Right Place, Right Time theme. At times it certainly felt like there were a lot of different criteria to try to hold in mind whilst remaining present and immersed in the data analysis process. Although this extended paper has gone some way to mitigate it, then it is an easy reflection to make that the constraints of word count for the journal paper have hindered how thoroughly I have been able to follow recommendations for phase six.

In the spirit of TA and considering the recommendations above (Table 7) and earlier (Table 4) then the reflexive diary shows my development from a more concerned and naïve standpoint to becoming gradually more immersed and thoughtful about the data. This excerpt from early in phase 1 shows some attempt to consider the role of my own knowledge and experience in shaping my ability to engage with the data.

Figure 5

Early Reflective Diary Excerpt

> Having now completed my own HSCED study, with some similarities to these three studies then I'm finding it a little tricky to orient my attention away from reading about what changes they've experienced and what was helpful and how important things were, to instead reading more deeply into their experiences. I assume, that this will come more naturally once I've read the whole data set and begin recognising (well, 'creating') codes and themes and similarities (or differences?) within data sets. It feels hard at this point to read beyond the semantics of the changes they've experienced to the latent meaning about the processes but again perhaps I need to be mindful to leave some of this for the deductive framework. I suppose it is natural to be reading into the semantic data first? Perhaps by becoming more integrated or emersed in the data then some of the influence of my previous HSCED research will feel less at the front of my mind, but this might be something worth returning too at a later phase. This makes me think about the journey of being a researcher, and how easily I am shaped by the research that I have just completed despite (clearly) needing to move focus into being a qualitative researcher for this purpose.

By contrast, this excerpt from later in the analysis process (see Figure 6) shows the iterative and recursive nature of RTA in action through my internal debate about the naming and meanings of current codes, with the decision to recode for one particular element that I was generating a more latent meaning for.

Figure 6

Later Reflective Diary Excerpt

> Wondering about the wording I have used when generating the resources codes and where I've noted 'lack of'. Looking at this data is this better characterised or interpreted as 'barriers to resources' or as a barrier in general? Is a 'lack of a resource' also not then a barrier to the moderating effect that resource would have if it were present? In particular the data for the presence of family support as a social resource comes to mind because of how sharply those who did not experience the positive moderating effect of family support talk about this as being hindering to their experiences of change. I think I need to look back through, but it's coming to mind that (at least for this example) it might be that although the presence of a resource has generally been experienced as positive for change then the absence of this is a barrier for change. A potential barrier at least. Danielle's advice to split the resources code into subcodes that more accurately capture the presence as well as the difficulty in accessing resources has likely shaped my language use here but I suppose this is part of the process of negotiating my own interpretations alongside that of Danielle and Nima. I actually feel that noting the absence of a resource as potentially a barrier is a deeper level of interpretation than simply noting the lack of it would be. This reflection has fuelled my certainty of the need to go back through and code for this.

It also shows a development in my thinking and writing in a manner consistent with RTA as there is greater evidence of thoughtfulness and of knowledge of the data set, and my language is more consistent with the approach then in the first extract, where I actively have to check myself to remind that I am 'generating' not ‘recognising’ themes. This fits with my greater understanding of TA throughout the later stages of analysis, and ability to report (even in my personal reflexive diary) my active role in the TA rather than using language that incorrectly presents TA as a passive process where findings are waiting to be discovered rather than generated (Braun & Clarke, 2020). Beyond the actual findings this study has provided towards the literature base, then the most rewarding aspect of this was seeing my own development as researcher and the increased confidence and curiosity that I developed as I moved through the stages of the RTA.

The process of completing an inductive-deductive analysis has been valuable in yielding greater insights by having distinct findings in each element of the analysis. The decision to complete the inductive analysis first felt like the correct decision to fulfill the intended aims of the study, as it allowed for a more organic interaction with the data that allowed for the creation of codes and themes with less influencing or conceptual overlap with those informed by the literature. One of the difficulties came when integrating the inductive and deductive codes during the initial stages of theme development. Some codes needed altering that were conceptually too similar between the inductive and deductive, which also usefully highlighted where perhaps I had been subconsciously influenced in code generation by my pre-existing knowledge of change processes. The Expert by Experience consultation was an addition to the analysis that felt particularly valuable. Although this singular consultation was completed in the latter stages of analysis, it served to give me confidence in my theme generation and also raised a couple of areas where a different interpretation could be added as discussed earlier. Completing the final report (here, the journal paper) also highlighted how easy it was to lean into the tendency to overuse quotes (White et al., 2003).

It felt like a conceptual challenge at times to ensure that the wording of this thesis was clear in defining the aims as exploring experiences of change and what that can tell us about underlying change processes, rather than incorrectly claiming to be an investigation of mechanisms of change. My final reflection is that despite my efforts to complete strong research in an important area and to justify the need for this and the value that my findings have brought to the field, then the impact of this is beyond my control.

4.9 Contribution to the literature

As aimed, this study has made a unique contribution to the literature by highlighting the experiences of change for OAs that have undergone ACT interventions. It has helped identify experiences for this demographic, and the change processes (both therapy-specific and non-specific) that underpin these – as well as demonstrating the interplay between some of these processes. It has also determined what might be different for OAs compared to other demographics when looking at these findings compared to those in the extant literature. Finally, it has provided experiential and qualitative evidence for the theoretically proposed processes of change specific to ACT. This helps to provide triangulation to the evidence base for ACT.

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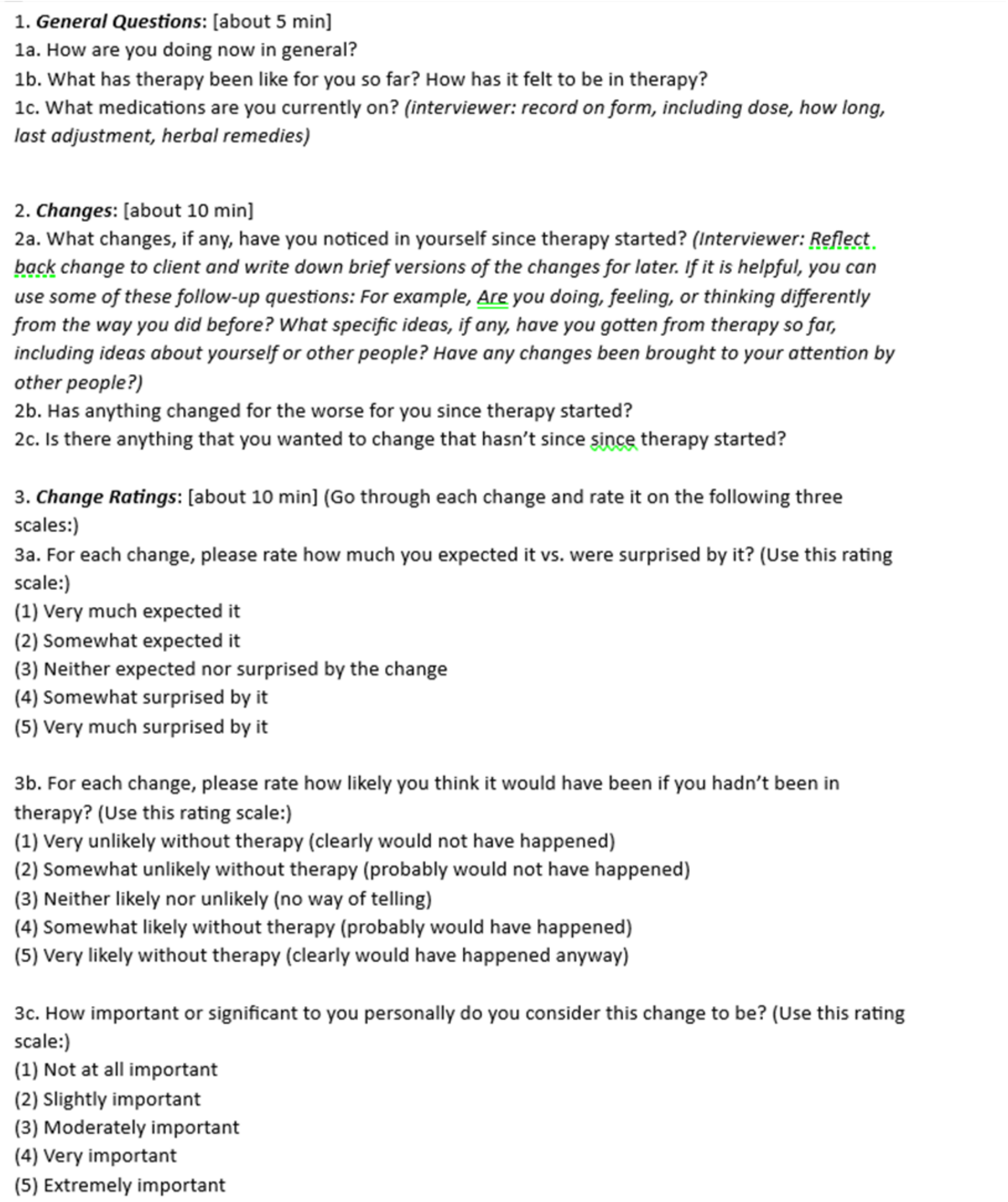
Appendices

Appendix A: Change Interview Schedule (Elliott, 2006)



1. ***General Questions***: [about 5 min]
1a. How are you doing now in general?
1b. What has therapy been like for you so far? How has it felt to be in therapy?
1c. What medications are you currently on? *(interviewer: record on form, including dose, how long, last adjustment, herbal remedies)*

2. ***Changes***: [about 10 min]
2a. What changes, if any, have you noticed in yourself since therapy started? *(Interviewer: Reflect back change to client and write down brief versions of the changes for later. If it is helpful, you can use some of these follow-up questions: For example, Are you doing, feeling, or thinking differently from the way you did before? What specific ideas, if any, have you gotten from therapy so far, including ideas about yourself or other people? Have any changes been brought to your attention by other people?)*
2b. Has anything changed for the worse for you since therapy started?
2c. Is there anything that you wanted to change that hasn't since since therapy started?

3. ***Change Ratings***: [about 10 min] (Go through each change and rate it on the following three scales:)
3a. For each change, please rate how much you expected it vs. were surprised by it? (Use this rating scale:)
(1) Very much expected it
(2) Somewhat expected it
(3) Neither expected nor surprised by the change
(4) Somewhat surprised by it
(5) Very much surprised by it

3b. For each change, please rate how likely you think it would have been if you hadn't been in therapy? (Use this rating scale:)
(1) Very unlikely without therapy (clearly would not have happened)
(2) Somewhat unlikely without therapy (probably would not have happened)
(3) Neither likely nor unlikely (no way of telling)
(4) Somewhat likely without therapy (probably would have happened)
(5) Very likely without therapy (clearly would have happened anyway)

3c. How important or significant to you personally do you consider this change to be? (Use this rating scale:)
(1) Not at all important
(2) Slightly important
(3) Moderately important
(4) Very important
(5) Extremely important

4. ***Helpful Aspects***: [about 10 min] Can you sum up what has been helpful about your therapy so far? Please give examples. (For example, general aspects, specific events)

5. ***Attributions***: [about 5 min] In general, what do you think has caused the various changes you described? In other words, what do you think might have brought them about? (Including things both outside of therapy and in therapy)

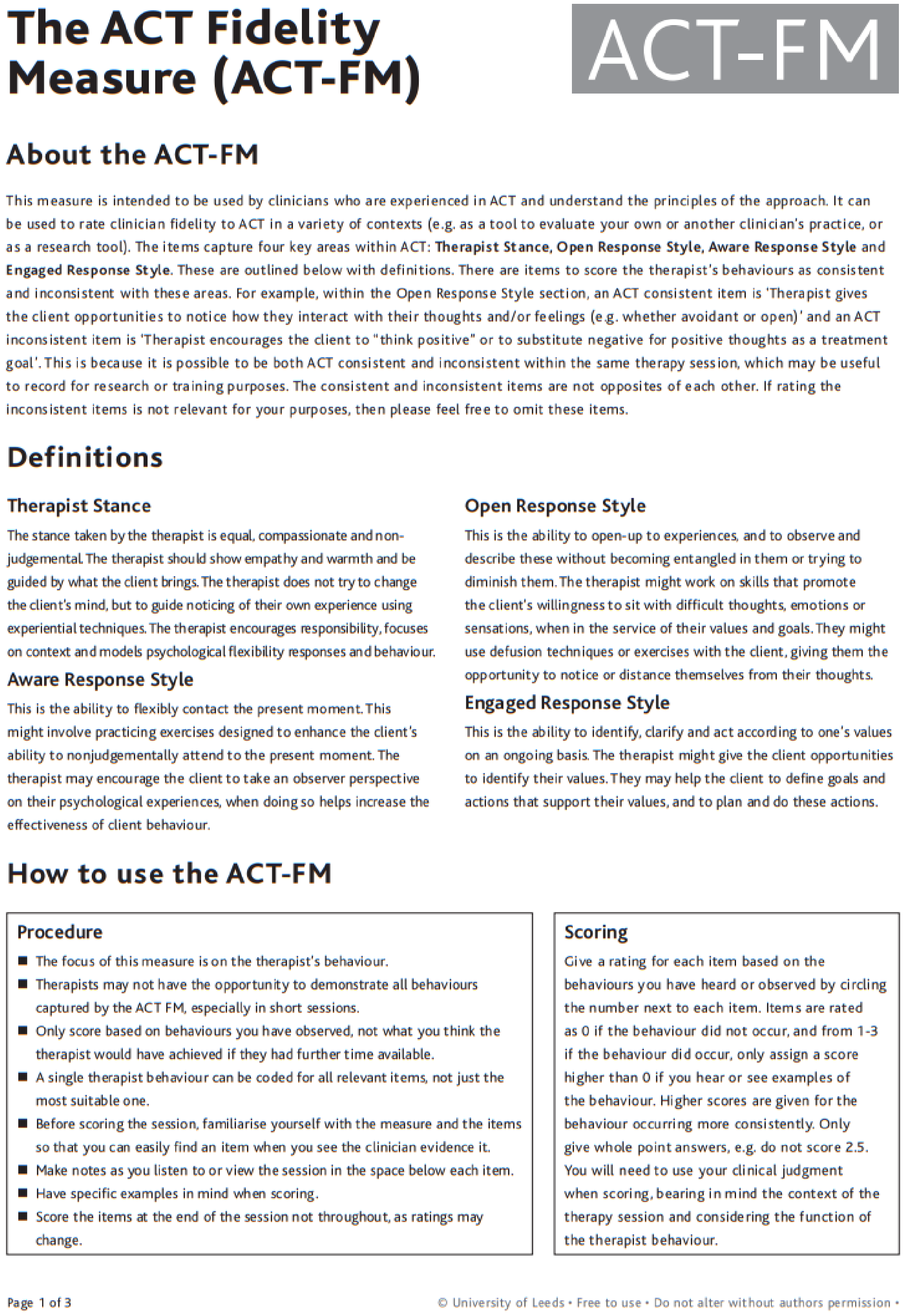
6. ***Resources***: [about 5 min]
6a. What personal strengths do you think have helped you make use of therapy to deal with your problems? (what you're good at, personal qualities)
6b. What things in your current life situation have helped you make use of therapy to deal with your problems? (family, job, relationships, living arrangements)

7. ***Problematic Aspects***: [about 5 min]
7a. What kinds of things about the therapy have been hindering, unhelpful, negative or disappointing for you? (For example, general aspects. specific events)
7b. Were there things in the therapy which were difficult or painful but still OK or perhaps helpful? What were they?
7c. Has anything been missing from your treatment? (What would make/have made your therapy more effective or helpful?)

8. ***Limitations***: [about 5 min]
8a. What personal weaknesses do you think have made it harder for you to use therapy to deal with your problems? (things about you as a person)
8b. What things in your life situation have made it harder for you to use therapy to deal with your problems? (family, job, relationships, living arrangements)

9. ***Suggestions***. [about 5 min] Do you have any suggestions for us, regarding the research or the therapy? Do you have anything else that you want to tell me?

Appendix B: ACT-FM (O'Niell et al., 2019)



The ACT Fidelity Measure (ACT-FM)

ACT-FM

About the ACT-FM

This measure is intended to be used by clinicians who are experienced in ACT and understand the principles of the approach. It can be used to rate clinician fidelity to ACT in a variety of contexts (e.g. as a tool to evaluate your own or another clinician's practice, or as a research tool). The items capture four key areas within ACT: **Therapist Stance, Open Response Style, Aware Response Style** and **Engaged Response Style**. These are outlined below with definitions. There are items to score the therapist's behaviours as consistent and inconsistent with these areas. For example, within the Open Response Style section, an ACT consistent item is 'Therapist gives the client opportunities to notice how they interact with their thoughts and/or feelings (e.g. whether avoidant or open)' and an ACT inconsistent item is 'Therapist encourages the client to "think positive" or to substitute negative for positive thoughts as a treatment goal'. This is because it is possible to be both ACT consistent and inconsistent within the same therapy session, which may be useful to record for research or training purposes. The consistent and inconsistent items are not opposites of each other. If rating the inconsistent items is not relevant for your purposes, then please feel free to omit these items.

Definitions

Therapist Stance

The stance taken by the therapist is equal, compassionate and non-judgemental. The therapist should show empathy and warmth and be guided by what the client brings. The therapist does not try to change the client's mind, but to guide noticing of their own experience using experiential techniques. The therapist encourages responsibility, focuses on context and models psychological flexibility responses and behaviour.

Aware Response Style

This is the ability to flexibly contact the present moment. This might involve practicing exercises designed to enhance the client's ability to nonjudgementally attend to the present moment. The therapist may encourage the client to take an observer perspective on their psychological experiences, when doing so helps increase the effectiveness of client behaviour.

Open Response Style

This is the ability to open-up to experiences, and to observe and describe these without becoming entangled in them or trying to diminish them. The therapist might work on skills that promote the client's willingness to sit with difficult thoughts, emotions or sensations, when in the service of their values and goals. They might use defusion techniques or exercises with the client, giving them the opportunity to notice or distance themselves from their thoughts.

Engaged Response Style

This is the ability to identify, clarify and act according to one's values on an ongoing basis. The therapist might give the client opportunities to identify their values. They may help the client to define goals and actions that support their values, and to plan and do these actions.

How to use the ACT-FM

Procedure

- The focus of this measure is on the therapist's behaviour.
- Therapists may not have the opportunity to demonstrate all behaviours captured by the ACT FM, especially in short sessions.
- Only score based on behaviours you have observed, not what you think the therapist would have achieved if they had further time available.
- A single therapist behaviour can be coded for all relevant items, not just the most suitable one.
- Before scoring the session, familiarise yourself with the measure and the items so that you can easily find an item when you see the clinician evidence it.
- Make notes as you listen to or view the session in the space below each item.
- Have specific examples in mind when scoring.
- Score the items at the end of the session not throughout, as ratings may change.

Scoring

Give a rating for each item based on the behaviours you have heard or observed by circling the number next to each item. Items are rated as 0 if the behaviour did not occur, and from 1-3 if the behaviour did occur, only assign a score higher than 0 if you hear or see examples of the behaviour. Higher scores are given for the behaviour occurring more consistently. Only give whole point answers, e.g. do not score 2.5. You will need to use your clinical judgment when scoring, bearing in mind the context of the therapy session and considering the function of the therapist behaviour.

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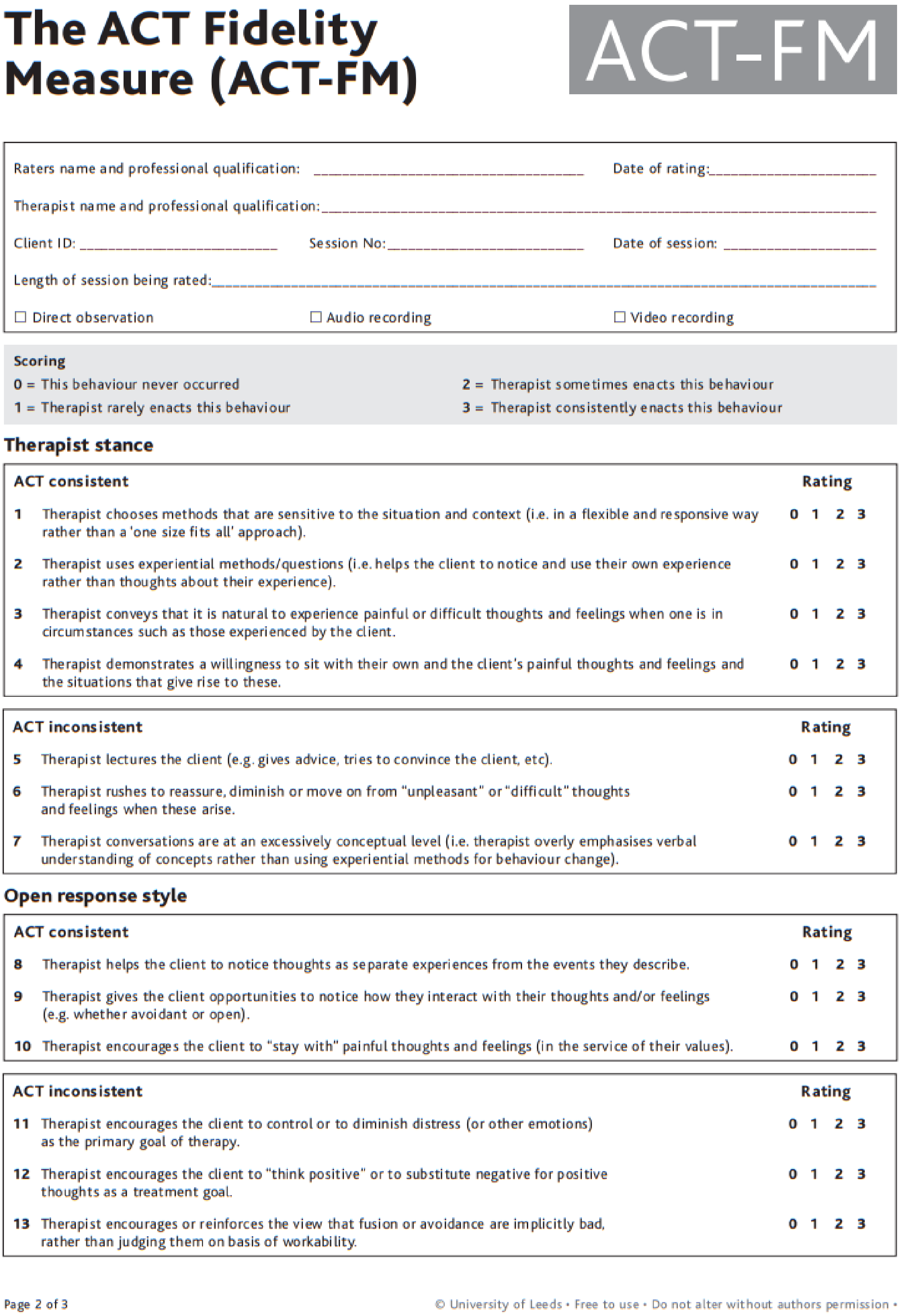


The ACT Fidelity Measure (ACT-FM)

ACT-FM

Raters name and professional qualification: ______________________ Date of rating:______________

Therapist name and professional qualification:____

Client ID: ________________ Session No:________________ Date of session: _____________

Length of session being rated:____

☐ Direct observation ☐ Audio recording ☐ Video recording

Scoring

0 = This behaviour never occurred

1 = Therapist rarely enacts this behaviour

2 = Therapist sometimes enacts this behaviour

3 = Therapist consistently enacts this behaviour

Therapist stance

	ACT consistent	**Rating**
1	Therapist chooses methods that are sensitive to the situation and context (i.e. in a flexible and responsive way rather than a 'one size fits all' approach).	**0 1 2 3**
2	Therapist uses experiential methods/questions (i.e. helps the client to notice and use their own experience rather than thoughts about their experience).	**0 1 2 3**
3	Therapist conveys that it is natural to experience painful or difficult thoughts and feelings when one is in circumstances such as those experienced by the client.	**0 1 2 3**
4	Therapist demonstrates a willingness to sit with their own and the client's painful thoughts and feelings and the situations that give rise to these.	**0 1 2 3**

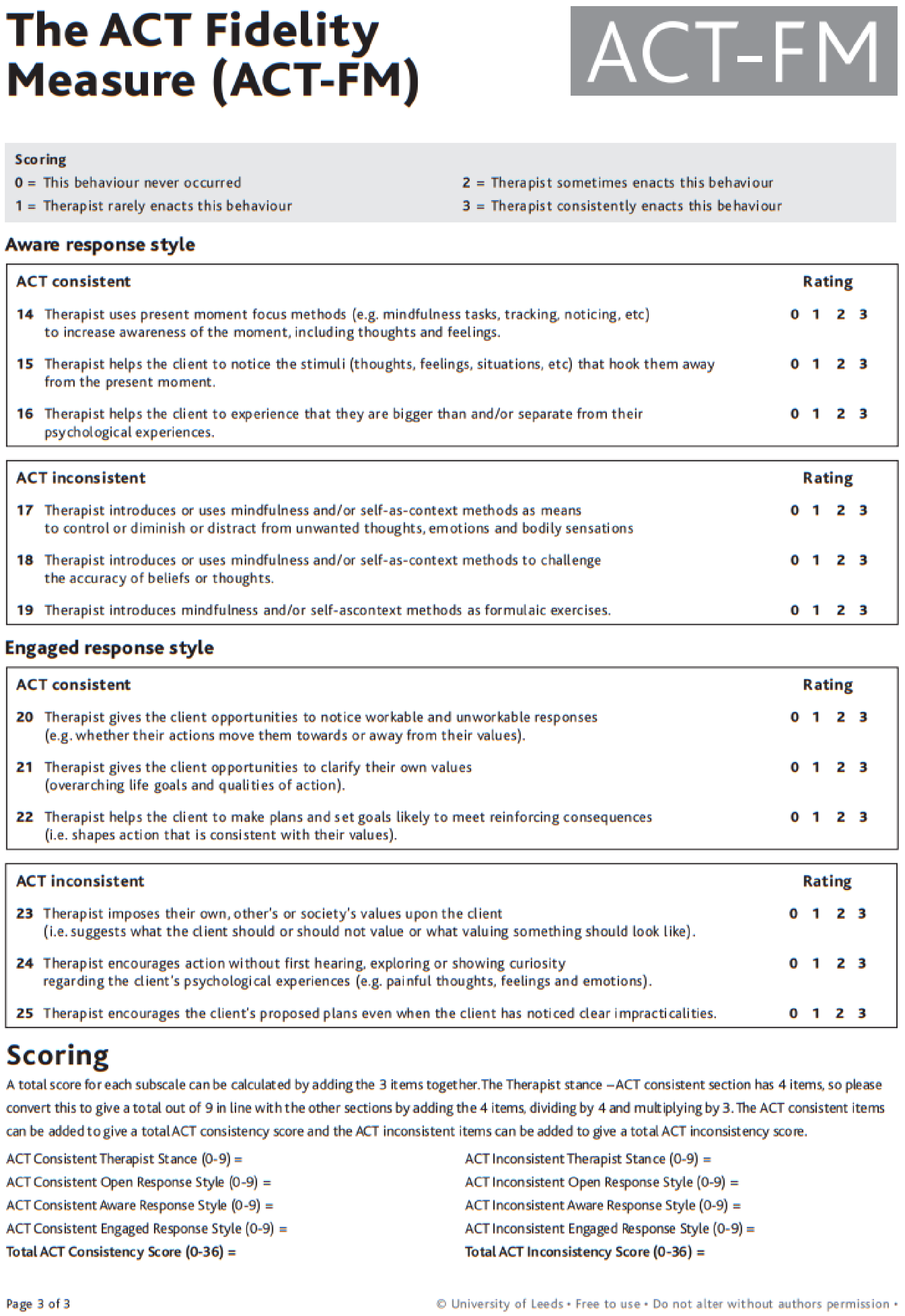
	ACT inconsistent	**Rating**
5	Therapist lectures the client (e.g. gives advice, tries to convince the client, etc).	**0 1 2 3**
6	Therapist rushes to reassure, diminish or move on from "unpleasant" or "difficult" thoughts and feelings when these arise.	**0 1 2 3**
7	Therapist conversations are at an excessively conceptual level (i.e. therapist overly emphasises verbal understanding of concepts rather than using experiential methods for behaviour change).	**0 1 2 3**

Open response style

	ACT consistent	**Rating**
8	Therapist helps the client to notice thoughts as separate experiences from the events they describe.	**0 1 2 3**
9	Therapist gives the client opportunities to notice how they interact with their thoughts and/or feelings (e.g. whether avoidant or open).	**0 1 2 3**
10	Therapist encourages the client to "stay with" painful thoughts and feelings (in the service of their values).	**0 1 2 3**

	ACT inconsistent	**Rating**
11	Therapist encourages the client to control or to diminish distress (or other emotions) as the primary goal of therapy.	**0 1 2 3**
12	Therapist encourages the client to "think positive" or to substitute negative for positive thoughts as a treatment goal.	**0 1 2 3**
13	Therapist encourages or reinforces the view that fusion or avoidance are implicitly bad, rather than judging them on basis of workability.	**0 1 2 3**

Page 2 of 3



The ACT Fidelity Measure (ACT-FM)

ACT-FM

Scoring

0 = This behaviour never occurred
1 = Therapist rarely enacts this behaviour
2 = Therapist sometimes enacts this behaviour
3 = Therapist consistently enacts this behaviour

Aware response style

ACT consistent	Rating
14 Therapist uses present moment focus methods (e.g. mindfulness tasks, tracking, noticing, etc) to increase awareness of the moment, including thoughts and feelings.	0 1 2 3
15 Therapist helps the client to notice the stimuli (thoughts, feelings, situations, etc) that hook them away from the present moment.	0 1 2 3
16 Therapist helps the client to experience that they are bigger than and/or separate from their psychological experiences.	0 1 2 3

ACT inconsistent	Rating
17 Therapist introduces or uses mindfulness and/or self-as-context methods as means to control or diminish or distract from unwanted thoughts, emotions and bodily sensations	0 1 2 3
18 Therapist introduces or uses mindfulness and/or self-as-context methods to challenge the accuracy of beliefs or thoughts.	0 1 2 3
19 Therapist introduces mindfulness and/or self-ascontext methods as formulaic exercises.	0 1 2 3

Engaged response style

ACT consistent	Rating
20 Therapist gives the client opportunities to notice workable and unworkable responses (e.g. whether their actions move them towards or away from their values).	0 1 2 3
21 Therapist gives the client opportunities to clarify their own values (overarching life goals and qualities of action).	0 1 2 3
22 Therapist helps the client to make plans and set goals likely to meet reinforcing consequences (i.e. shapes action that is consistent with their values).	0 1 2 3

ACT inconsistent	Rating
23 Therapist imposes their own, other's or society's values upon the client (i.e. suggests what the client should or should not value or what valuing something should look like).	0 1 2 3
24 Therapist encourages action without first hearing, exploring or showing curiosity regarding the client's psychological experiences (e.g. painful thoughts, feelings and emotions).	0 1 2 3
25 Therapist encourages the client's proposed plans even when the client has noticed clear impracticalities.	0 1 2 3

Scoring

A total score for each subscale can be calculated by adding the 3 items together.The Therapist stance –ACT consistent section has 4 items, so please convert this to give a total out of 9 in line with the other sections by adding the 4 items, dividing by 4 and multiplying by 3. The ACT consistent items can be added to give a total ACT consistency score and the ACT inconsistent items can be added to give a total ACT inconsistency score.

ACT Consistent Therapist Stance (0-9) =
ACT Consistent Open Response Style (0-9) =
ACT Consistent Aware Response Style (0-9) =
ACT Consistent Engaged Response Style (0-9) =
Total ACT Consistency Score (0-36) =

ACT Inconsistent Therapist Stance (0-9) =
ACT Inconsistent Open Response Style (0-9) =
ACT Inconsistent Aware Response Style (0-9) =
ACT Inconsistent Engaged Response Style (0-9) =
Total ACT Inconsistency Score (0-36) =

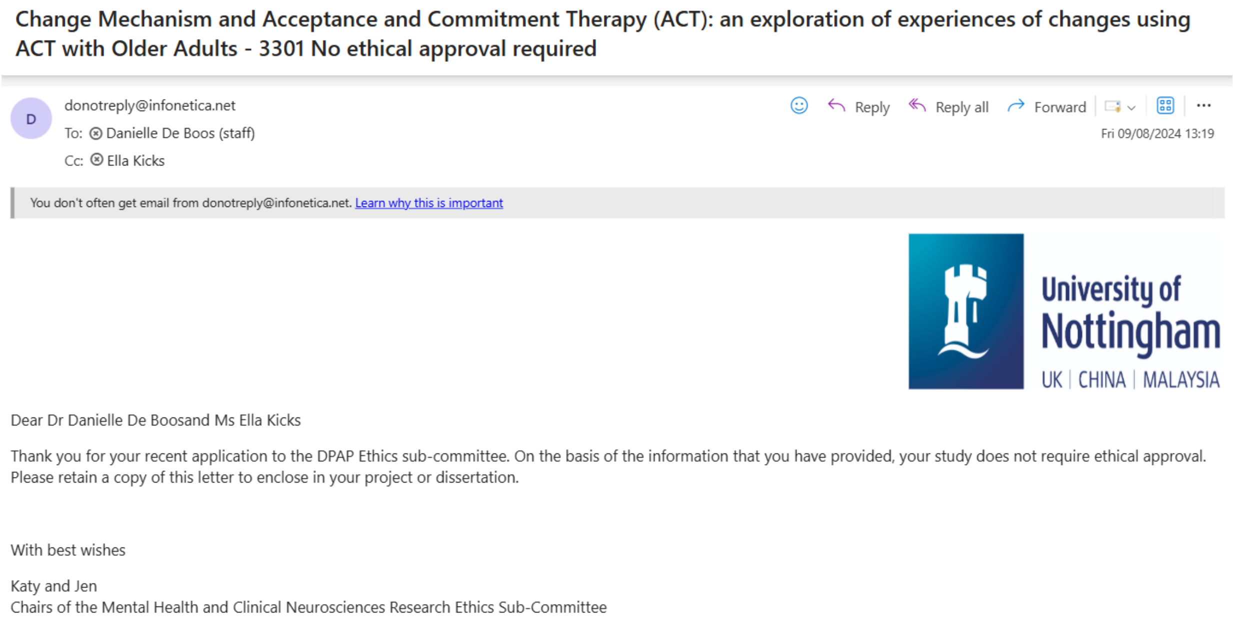
Appendix C: Ethical Approval for the SQA

Change Mechanism and Acceptance and Commitment Therapy (ACT): an exploration of experiences of changes using ACT with Older Adults

3301

Project Tree

Action Required on Form	Status	Review Reference	Date Modified
No	No approval required	MHCN - 2024 - 3301 - 1	09/08/2024 13:11



Change Mechanism and Acceptance and Commitment Therapy (ACT): an exploration of experiences of changes using ACT with Older Adults - 3301 No ethical approval required

donotreply@infonetica.net
To: Danielle De Boos (staff)
Cc: Ella Kicks

Fri 09/08/2024 13:19

You don't often get email from donotreply@infonetica.net. Learn why this is important

University of Nottingham
UK | CHINA | MALAYSIA

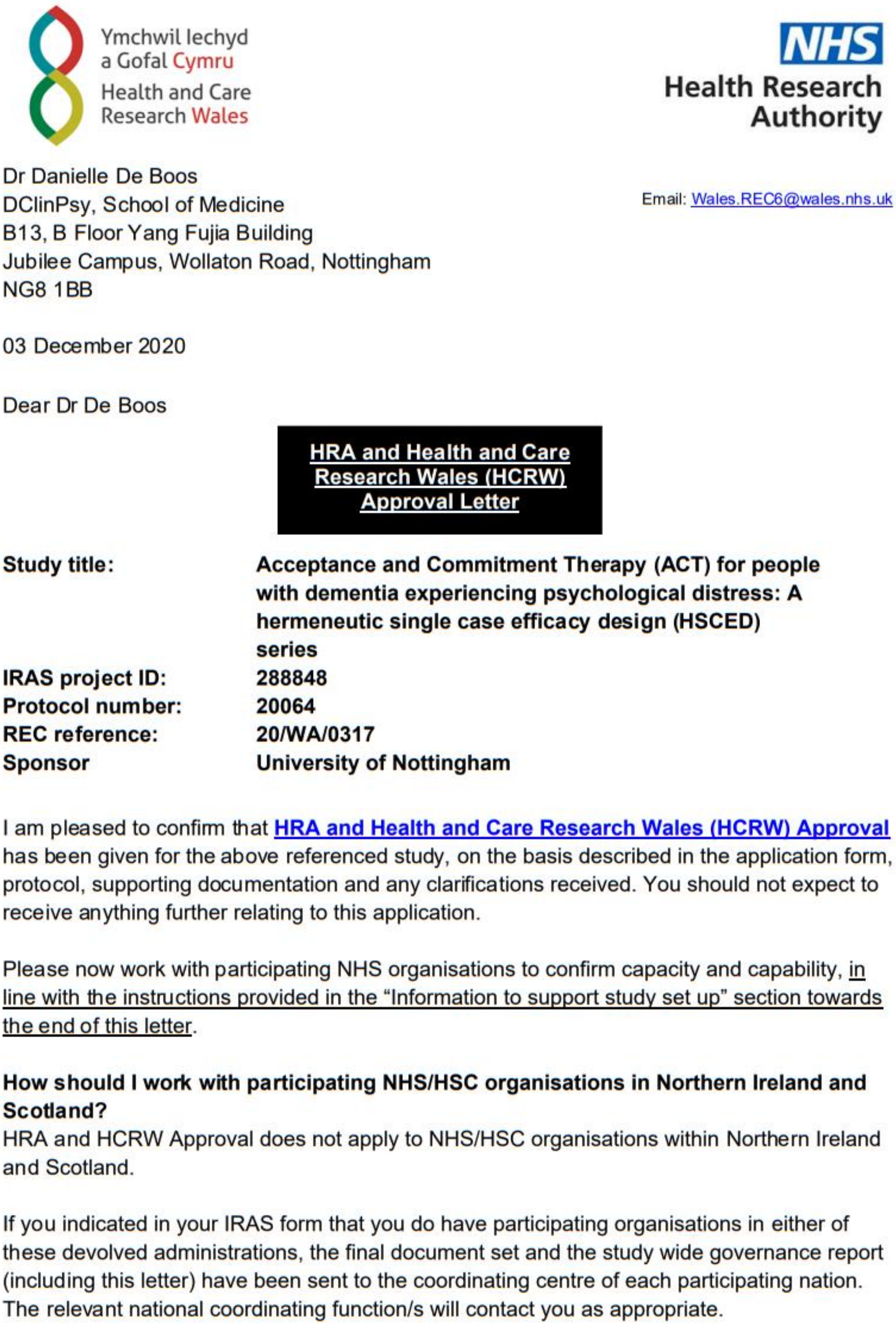
Dear Dr Danielle De Boosand Ms Ella Kicks

Thank you for your recent application to the DPAP Ethics sub-committee. On the basis of the information that you have provided, your study does not require ethical approval. Please retain a copy of this letter to enclose in your project or dissertation.

With best wishes

Katy and Jen
Chairs of the Mental Health and Clinical Neurosciences Research Ethics Sub-Committee

Appendix D: Ethical Approval for Study One



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email: Wales.REC6@wales.nhs.uk

Dr Danielle De Boos
DClinPsy, School of Medicine
B13, B Floor Yang Fujia Building
Jubilee Campus, Wollaton Road, Nottingham
NG8 1BB

03 December 2020

Dear Dr De Boos

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Acceptance and Commitment Therapy (ACT) for people with dementia experiencing psychological distress: A hermeneutic single case efficacy design (HSCED) series**
IRAS project ID:	**288848**
Protocol number:	**20064**
REC reference:	**20/WA/0317**
Sponsor	**University of Nottingham**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

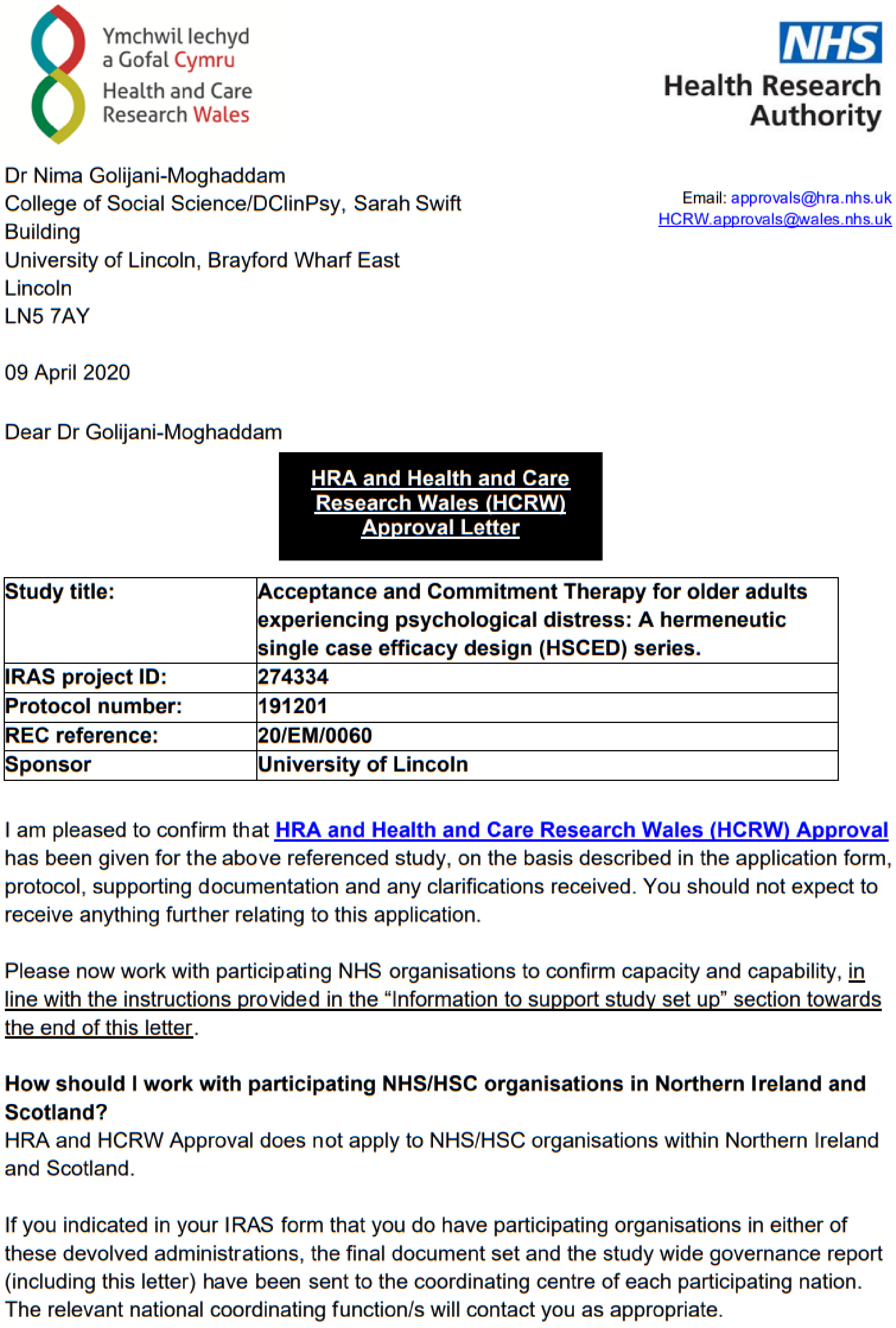
Your IRAS project ID is **288848**. Please quote this on all correspondence.

Yours sincerely,
Ann Parry

Email: Wales.REC6@wales.nhs.uk

Copy to: *Ms Angela Shone*

Appendix E: Ethical Approval for Study Two



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

Dr Nima Golijani-Moghaddam
College of Social Science/DClinPsy, Sarah Swift
Building
University of Lincoln, Brayford Wharf East
Lincoln
LN5 7AY

09 April 2020

Dear Dr Golijani-Moghaddam

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Acceptance and Commitment Therapy for older adults experiencing psychological distress: A hermeneutic single case efficacy design (HSCED) series.**
IRAS project ID:	**274334**
Protocol number:	**191201**
REC reference:	**20/EM/0060**
Sponsor	**University of Lincoln**

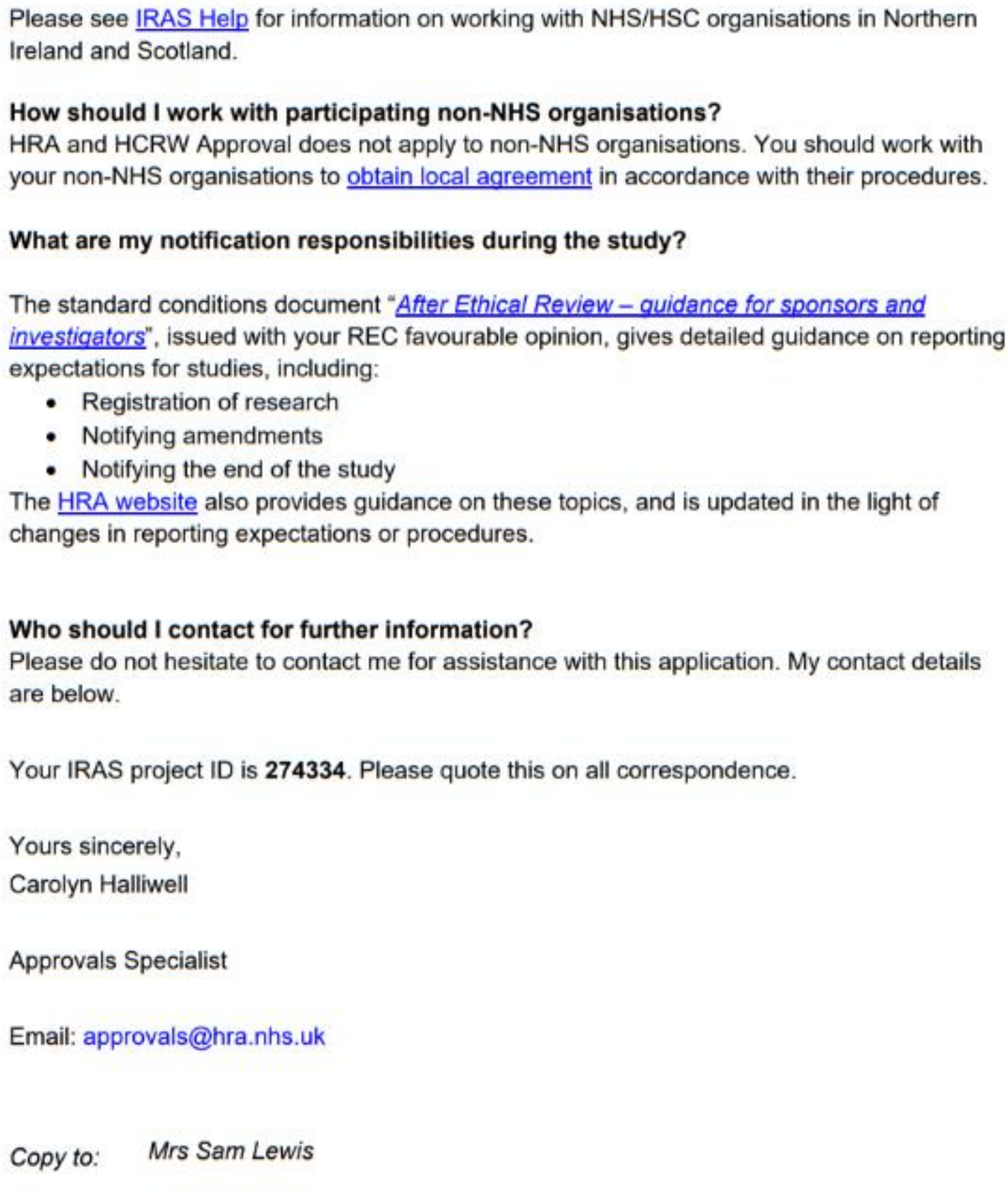
I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the “Information to support study set up” section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.



Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **274334**. Please quote this on all correspondence.

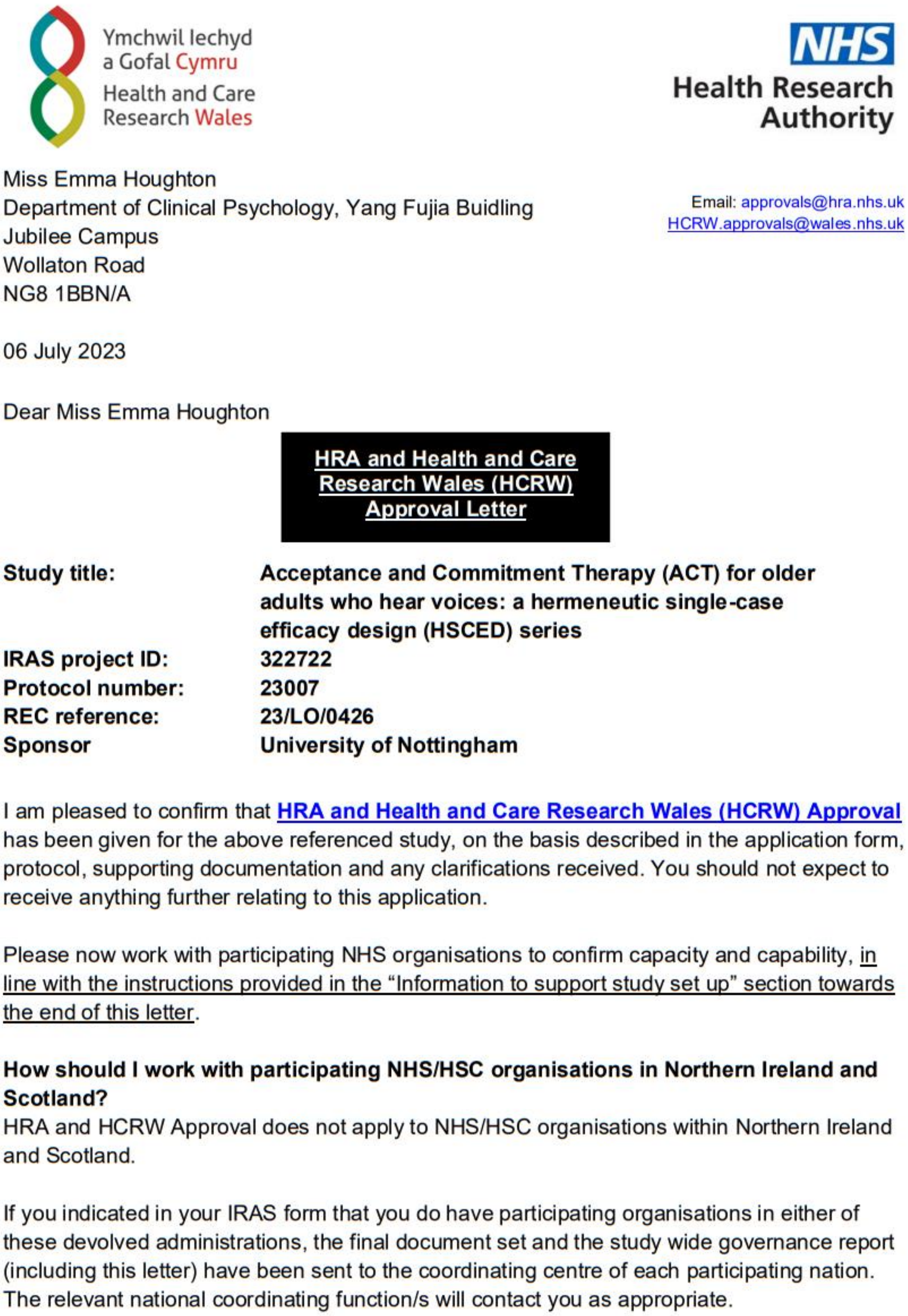
Yours sincerely,
Carolyn Halliwell

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Mrs Sam Lewis*

Appendix F: Ethical Approval for Study Three



Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Emma Houghton
Department of Clinical Psychology, Yang Fujia Buidling
Jubilee Campus
Wollaton Road
NG8 1BBN/A

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

06 July 2023

Dear Miss Emma Houghton

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title: **Acceptance and Commitment Therapy (ACT) for older adults who hear voices: a hermeneutic single-case efficacy design (HSCED) series**
IRAS project ID: **322722**
Protocol number: **23007**
REC reference: **23/LO/0426**
Sponsor **University of Nottingham**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **322722**. Please quote this on all correspondence.

Yours sincerely,
Barbara Cuddon

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Ms Angela Shone*

Appendix G: Participant Information Sheets for Study One

Participant Information Sheet
(Final Version 2.0: 23/11/20)

IRAS Project ID: 288848

Title of Study: Acceptance and Commitment Therapy (ACT) for people with dementia experiencing psychological distress

Name of Chief Investigator: Danielle De Boos
Local Researcher(s): Amie Robinson & Nima Moghaddam

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

We would like a better understanding of if and how Acceptance and Commitment Therapy (ACT) may reduce anxiety and depression in people with dementia. ACT is a talking therapy with one therapist which can help to increase psychological flexibility. Psychological flexibility means that a person is able to lead a meaningful life, despite feelings of anxiety and depression. We know that this therapy is effective for reducing anxiety and depression but there is lots we need to know about how it might work for people with dementia.

Why have I been invited?

You are being invited to take part because you have a diagnosis of dementia and have said you would like therapy. We are inviting three participants like you to take part.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

Part 1

Once you have consented to take part, you will be contacted by Amie Robinson (Trainee Clinical Psychologist and lead researcher) to arrange to meet with her for 12 weeks of therapy. It might be that you and Amie decide to meet face-to-face at a convenient location, or due to the Coronavirus, it may be that you decide to do therapy remotely, either by phone or by videocall. If it is helpful, we could ring you on the morning of each therapy session to remind you of when and where we are due to meet.

Each session may last up to 90 minutes, although we can decide how long is best for you. With your consent, we can also involve your caregiver in the study (e.g. family member, friend, carer), so they can support you in therapy sessions if you wish.

Therapy sessions will be recorded and stored electronically using an encrypted laptop so that they can be checked by the research team to make sure that the therapy is being delivered by Amie correctly. The recordings may also be helpful for Amie to listen back to when she transcribes recordings and writes up the study. We will seek your consent in the event we include what you say (direct quotations) in the study write-up. Recordings will be kept **strictly confidential** on an NHS shared drive for up to one year. Once recordings have been transcribed and possibly included in the study write-up, they will be confidentially destroyed (deleted from the laptop). Any information about you (e.g. via therapy recordings, transcripts) which leaves the NHS site will have your name, address and any identifiers removed, and a pseudonym will be used so that you cannot be recognised from it.

During the 12 weekly sessions, you will be asked to complete several short questionnaires. At session 1, session 6 and session 12, Amie will go through two questionnaires with you about your mood, one questionnaire which measures psychological flexibility, one questionnaire about your wellbeing, one about your goals for therapy and one about your relationship with the therapist (Amie). Every week, Amie will go through with you the questionnaires which will measure any changes in your psychological flexibility and your relationship with her over time. During sessions, we may also use pictures and written information to remind you to complete any tasks between sessions.

Part 2

Approximately one week after the final therapy session, an independent researcher will meet with you and your caregiver at a time that suits both of you to discuss your opinions of the therapy and any changes in your anxiety or low mood. This discussion will be recorded and kept **strictly confidential** at the University of Nottingham.

Lastly, two brief questionnaires will be sent to you (1 and 3 months after the therapy has ended) with a stamped addressed envelope for you to return them to Amie.

Expenses and payments

Participants will not be paid to participate in the study. Travel expenses such as parking and petrol costs will be offered if participants attend for face-to-face therapy appointments and provide evidence of costs (e.g. receipts). Mileage will be reimbursed at 24p per mile.

What are the possible disadvantages and risks of taking part?

There are no likely risks of taking part in this study. However, there are possible disadvantages. For example, therapy is often time-consuming and requires some emotional investment and commitment to regularly attend. You will also be required to fill out some questionnaires on a regular basis so that we can see if and how your mood and anxiety changes over time. If this proves to be too demanding or burdensome for you, a fallback option might be observer ratings (which can be completed either in session or another time outside of session, with your consent).

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help explain how it may help in the future. Acceptance and Commitment Therapy (ACT) is a talking therapy that can reduce anxiety and depression, but we cannot guarantee this will happen. If you still require therapy after the study, you can opt for 'usual care' from your GP or Memory Assessment Service.

What happens when the research study stops?

When the study ends, we will use the data collected about you in the study write-up. This study is part of a Doctoral Thesis at the University of Nottingham and may be read by other students, but you will not be identified from the study. It is hoped that findings from the study will be published and presented in the future. In 2022, an information sheet with a summary of the study's main findings will be made available and posted to you at your request, therefore we require your consent to hold your contact details until then.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting the Patient Advice and Liaison Service (PALS) by telephone on **0115 993 4542**, email **PALSandComplaints@nottshc.nhs.uk** or postal address **PALS and Complaints, Highbury Hospital, Highbury Road, Nottingham NG6 9DR.**

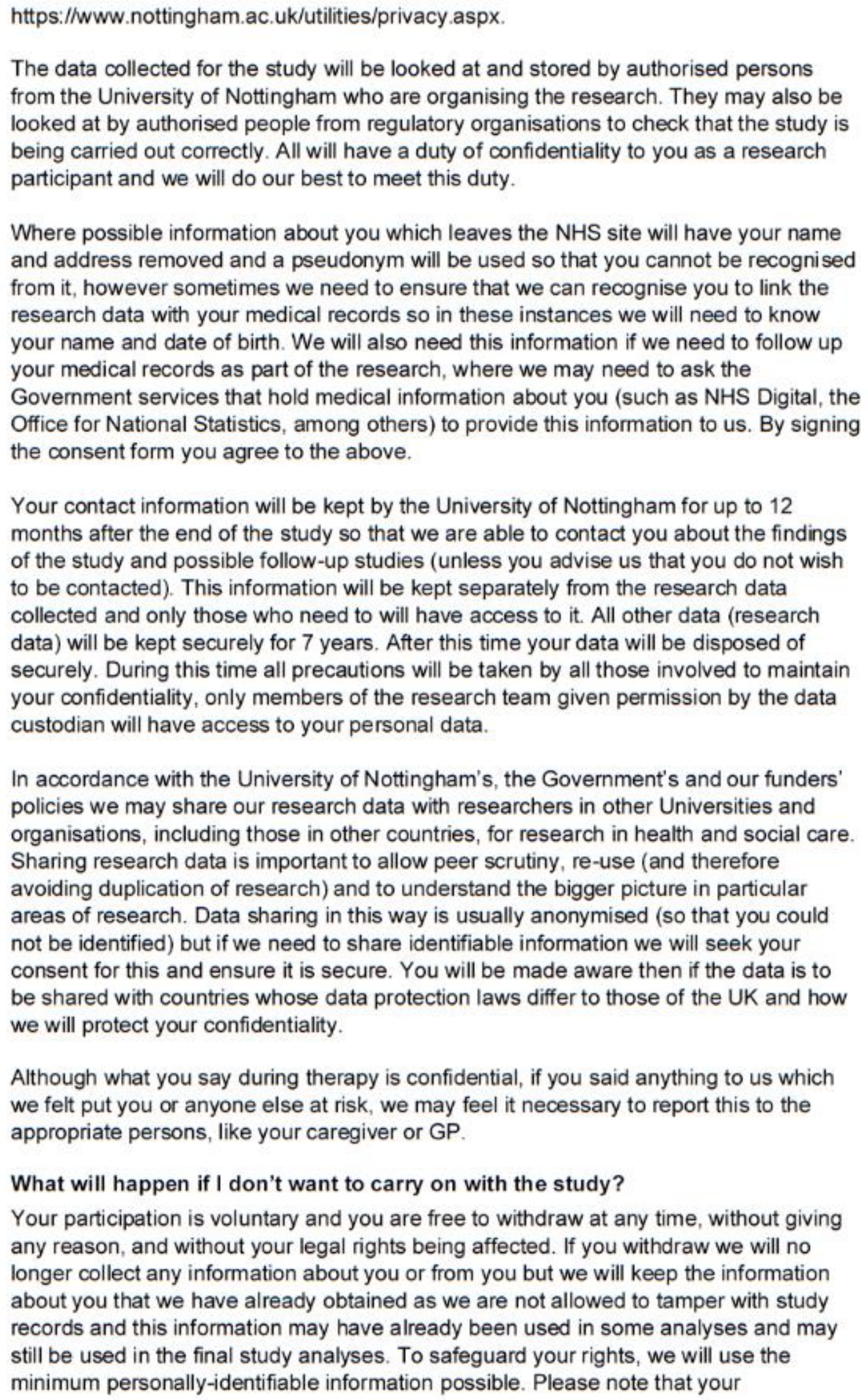
In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Nottingham but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, we will use information collected from you during the course of the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:



https://www.nottingham.ac.uk/utilities/privacy.aspx.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

Where possible information about you which leaves the NHS site will have your name and address removed and a pseudonym will be used so that you cannot be recognised from it, however sometimes we need to ensure that we can recognise you to link the research data with your medical records so in these instances we will need to know your name and date of birth. We will also need this information if we need to follow up your medical records as part of the research, where we may need to ask the Government services that hold medical information about you (such as NHS Digital, the Office for National Statistics, among others) to provide this information to us. By signing the consent form you agree to the above.

Your contact information will be kept by the University of Nottingham for up to 12 months after the end of the study so that we are able to contact you about the findings of the study and possible follow-up studies (unless you advise us that you do not wish to be contacted). This information will be kept separately from the research data collected and only those who need to will have access to it. All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information we will seek your consent for this and ensure it is secure. You will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Although what you say during therapy is confidential, if you said anything to us which we felt put you or anyone else at risk, we may feel it necessary to report this to the appropriate persons, like your caregiver or GP.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw we will no longer collect any information about you or from you but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally-identifiable information possible. Please note that your

participation in therapy may also be stopped by the researcher (Amie) if you do not attend regularly or if there are concerns about your safety, but this would be discussed with you beforehand.

What will happen to the results of the research study?

This study is part of a Doctoral Thesis at the University of Nottingham and may be read by other students, but you will not be identified from the study. It is hoped that findings from the study will be published and presented in the future. In 2022, an information sheet with a summary of the study's main findings will be made available and posted to you at your request.

Who is organising and funding the research?

This research is being organised and funded by the University of Nottingham. The study is being undertaken as part of an educational project as a requirement of the Trent Doctorate in Clinical Psychology (DClinPsy).

Who has reviewed the study?

All research in healthcare is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by University of Nottingham Research Governance Team.

Further information and contact details

Amie Robinson (Trainee Clinical Psychologist)
Email: amie.robinson@nottingham.ac.uk
Department of Psychiatry and Applied Psychology, Yang Fujia Building, Jubilee Campus,
University of Nottingham, Wollaton Road, NG8 1BB

Dr Danielle De Boos (Associate Professor & Deputy Programme Director)
Email: danielle.deboos@nottingham.ac.uk
Phone: 0115 846 6696
Department of Psychiatry and Applied Psychology, B13 Yang Fujia Building, Jubilee Campus,
University of Nottingham, Wollaton Road, Nottingham, NG8 1BB

Dr Nima Golijani Moghaddam (Research Clinical Psychologist/Senior Lecturer)
Email: nmoghaddam@lincoln.ac.uk
Phone: 01522 837733
Trent Doctorate in Clinical Psychology, Sarah Swift Building, University of Lincoln, Lincoln, LN6 7TS

Caregiver Information Sheet
(Final Version 2.0: 23/11/20)

IRAS Project ID: 288848

Title of Study: Acceptance and Commitment Therapy (ACT) for people with dementia experiencing psychological distress

Name of Chief Investigator: Danielle De Boos
Local Researcher(s): Amie Robinson & Nima Moghaddam

We would like to invite you to take part in our research study, alongside the person you care for. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

We would like to gain a better understanding of if and how Acceptance and Commitment Therapy (ACT) may reduce anxiety and depression in people with dementia. ACT is a talking therapy with one therapist which can help to increase psychological flexibility. Psychological flexibility can enable people to lead meaningful lives, despite feelings of anxiety and depression that may be associated with their condition. We are aware that ACT is effective for reducing anxiety and depression generally, but there is lots we need to know about how it might work for people with dementia.

Why have I been invited?

You are being invited to take part because you support somebody with a diagnosis of dementia and they have told us that they would like you to be involved throughout their therapy. We are inviting three participants like you (caregivers) to take part.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights. However, the person you care for can continue to take part in the study without your involvement, if they wish and if it is feasible or appropriate to do so.

What will happen to me if I take part?

Part 1

Part 1 of the study involves the person you support participating in therapy with Amie. Therapy sessions may last up to 90 minutes and will be conducted weekly for 12 weeks but will be reviewed at 6 weeks. It might be that therapy is conducted face-to-face at a location convenient to you and the person you support, or due to the Coronavirus, it may be that it is conducted remotely, either by phone or videocall. You and the person you support will discuss with Amie which you think is best for you.

Therapy sessions will be recorded and stored electronically using an encrypted laptop so that they can be checked by the research team to make sure that the therapy is being delivered by Amie correctly. The recordings may also be helpful for Amie to listen back to when she transcribes recordings and writes up the study. We will seek your consent in the event we include what you say (direct quotations) in the study write-up. Recordings will be kept **strictly confidential** on an NHS shared drive for up to one year. Once recordings have been transcribed and possibly included in the study write-up, they will be confidentially destroyed (deleted from the laptop). Any information about you (e.g. via therapy recordings, transcripts) which leaves the NHS site will have your name, address and any identifiers removed, and a pseudonym will be used so that you cannot be recognised from it.

Your involvement in Part 1 will be in a supporting capacity for the person with dementia. It would be extremely helpful if you could offer reminders and prompts about therapy attendance to the person you support and encourage with any between-session tasks. If therapy is conducted in person, support with transportation to and from therapy would be greatly appreciated. Alternatively, if therapy is conducted remotely, any support you could provide with technology (e.g. telephone, accepting videocall invitations) would be valuable.

At the beginning of each therapy session, Amie will offer introductions, provide reminders about the purpose of the study, confidentiality and its limits and gain verbal consent to proceed. Reported changes will also be captured at the beginning of each session, for example, ‘checking-in’ with the person you support by inviting them to share any reflections on therapy or changes they have noticed between sessions. However, it would also be incredibly helpful for you to share your thoughts on the effectiveness or value of therapy and any changes you may or may not have noticed in the person you support. Therefore, there is the potential to capture any changes that the person you support may not report (if you have agreed with them beforehand that it would be OK to share with Amie). It may be that you keep brief written notes that you can share with Amie.

Part 2

Approximately one week after the final therapy session, an independent researcher will meet with you and the person you support at a time that suits both of you to discuss your opinions of the therapy and any changes in low mood or anxiety in the person you support. This discussion will be recorded and kept **strictly confidential** at the University of Nottingham.

Lastly, two brief questionnaires will be sent to the person you support (1 and 3 months after the therapy has ended) with a stamped addressed envelope for them to return to Amie. Any support you could offer the person with dementia with completing these questionnaires would be greatly appreciated.

Expenses and payments

Participants will not be paid to participate in the study. Travel expenses such as parking and petrol costs will be offered if participants attend for face-to-face therapy appointments and provide evidence of costs (e.g. receipts). Mileage will be reimbursed at 24p per mile.

What are the possible disadvantages and risks of taking part?

There are no likely risks of taking part in this study. However, there are possible disadvantages. For example, participation in research can often be time-consuming and therapy will require commitment to regularly attend. Therefore, there may be pressures on your time in transporting the person you support to therapy appointments, being present throughout them, the time taken to support with any between-session tasks and supporting the person with dementia to complete regular questionnaires in session so that we can see if and how their mood and anxiety changes over time. If this proves to be too demanding or burdensome for the person you support, a fallback option might be observer ratings (which can be completed either in session or another time outside of session, with their consent).

What are the possible benefits of taking part?

We cannot promise the study will help the person you support but the information we get from this study may help explain how it may help in the future. Acceptance and Commitment Therapy (ACT) is a talking therapy that can reduce anxiety and depression, but we cannot guarantee this will happen. If the person you support still requires therapy after the study, they can opt for 'usual care' from your GP or Memory Assessment Service.

What happens when the research study stops?

When the study ends, the data collected about you and the person you support will be used in the study write-up. This study is part of a Doctoral Thesis at the University of Nottingham and may be read by other students, but you will not be identified from the study. It is hoped that findings from the study will be published and presented in the future. In 2022, an information sheet with a summary of the study's main findings will be made available and posted to you at your request, therefore we require your consent to hold your contact details until then.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting the Patient Advice and Liaison Service (PALS) by telephone on **0115 993 4542**, email **PALSandComplaints@nottshc.nhs.uk** or postal address **PALS and Complaints, Highbury Hospital, Highbury Road, Nottingham NG6 9DR.**

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Nottingham but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, we will use information collected from you [and your medical records] during the course of the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

Where possible information about you which leaves the NHS site will have your name and address removed and a pseudonym will be used so that you cannot be recognised from it, however sometimes we need to ensure that we can recognise you to link the research data with your medical records so in these instances we will need to know your name and date of birth. We will also need this information if we need to follow up your medical records as part of the research, where we may need to ask the Government services that hold medical information about you (such as NHS Digital, the Office for National Statistics, among others) to provide this information to us. By signing the consent form you agree to the above.

Your contact information will be kept by the University of Nottingham for up to 12 months after the end of the study so that we are able to contact you about the findings of the study and possible follow-up studies (unless you advise us that you do not wish to be contacted). This information will be kept separately from the research data collected and only those who need to will have access to it. All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information we will seek your consent for this and ensure it is secure. You will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Although what you say during therapy is confidential, if you said anything to us which we felt put you or anyone else at risk, we may feel it necessary to report this to the appropriate persons, like your GP.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw we will no longer collect any information about you or from you but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally-identifiable information possible. Please note that your participation in therapy may also be stopped by the researcher (Amie) if you or the person you support do not attend regularly or if there are concerns about your safety, but this would be discussed with you beforehand.

What will happen to the results of the research study?

This study is part of a Doctoral Thesis at the University of Nottingham and may be read by other students, but you will not be identified from the study. It is hoped that findings from the study will be published and presented in the future. In 2022, an information sheet with a summary of the study's main findings will be made available and posted to you at your request.

Who is organising and funding the research?

This research is being organised and funded by the University of Nottingham. The study is being undertaken as part of an educational project as a requirement of the Trent Doctorate in Clinical Psychology (DClinPsy).

Who has reviewed the study?

All research in healthcare is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by University of Nottingham Research Governance Team.

Further information and contact details

Amie Robinson (Trainee Clinical Psychologist)
Email: amie.robinson@nottingham.ac.uk
Department of Psychiatry and Applied Psychology, Yang Fujia Building, Jubilee Campus, University of Nottingham, Wollaton Road, NG8 1BB

Dr Danielle De Boos (Associate Professor & Deputy Programme Director)
Email: danielle.deboos@nottingham.ac.uk
Phone: 0115 846 6696
Department of Psychiatry and Applied Psychology, B13 Yang Fujia Building, Jubilee Campus, University of Nottingham, Wollaton Road, Nottingham, NG8 1BB

Dr Nima Golijani Moghaddam (Research Clinical Psychologist/Senior Lecturer)
Email: nmoghaddam@lincoln.ac.uk

Phone: 01522 837733
Trent Doctorate in Clinical Psychology, Sarah Swift Building, University of Lincoln, Lincoln, LN6 7TS

Appendix H: Participant Information Sheets for Study Two

(Final Version 1.3 07.04.20)

Title of Study: Acceptance and Commitment Therapy for older adults experiencing psychological difficulties: A hermeneutic single case efficacy design (HSCED) series
Name of Researcher(s): Jonathan O'Keeffe
Contact Details of the Researcher(s) are given at the end.

We'd like to invite you to take part in our research study. Joining the study is entirely up to you, before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through this information sheet with you, to help you decide whether you would like to take part and answer any questions you may have. We'd suggest this should take about 10 minutes. Please feel free to talk to others about the study if you wish. There is a timeline for the study at the end of this sheet.

What is the purpose of the study?

This study is being completed as part of a Doctoral program in Clinical Psychology and it is sponsored by the University of Lincoln. The study aims to investigate how effective Acceptance and Commitment Therapy (ACT) is for older adult clients who are referred to older adult mental health services. ACT is a type of psychotherapy used in clinical practice to help people experiencing a range of psychological and physical difficulties. It uses a variety of processes to achieve this; such as reducing avoidance of difficult feelings, and increasing behaviours that are in line with a person's values.

The researchers believe ACT may be especially suited to older adult clients due to the high rate in co-existing psychological and physical difficulties as people age. Additionally, older adults are often excluded from research studies due to such coexisting difficulties. This means psychotherapies are not fully investigated within the older adult population. To address this gap in the research, the study will use ACT in normal clinical practice. The Doctoral student and researcher (Jonathan O'Keeffe) is also the therapist for the study, and will use ACT with up to four older adult clients. The intervention will involve up to 12 individual sessions (see Participant Timeline for more details). Due to social distancing measures, these sessions will either be offered by telephone or by videocall. We will ask you which you prefer and if you have the facilities for videocall therapy (the internet and a smartphone or laptop/iPad/PC). You will be sent full instructions for how to setup videocall therapy and we can talk you through this if there are any difficulties.

Why have I been invited?

You have been invited to take part because you have been referred for psychological support.

Do I have to take part?

It is your choice whether you would like to take part in the study. If you do decide to take part, you will be given this information sheet to keep and be asked to provide verbal consent to taking part in the study. You do not have to decide right away will be given time to think about taking part in the study. If you decide to take part, you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

We will also ask you whether you consent to us contacting your GP. This would be to inform them that you have taken part in the study and what psychotherapy you are undertaking. We would also provide them with a summary of your involvement in the study once you have finished sessions.

If you do choose to withdraw, data collected up until that point will still be analysed. This is because it will still give us information about how effective the treatment was for you. All data collected will be kept anonymous and stored safely throughout the study (see below for more details).

The findings from this study will be published in a research study which will use anonymised details of the participants. We will also need to use your quotes as part of the analysis of the data from this study. We will be asking you whether you consent to us using direct quotes as part of the analysis and write-up of the study. We will be very considerate in how we use your quotes, making sure not to use anything that is too personal, or anything that could identify who you are.

What will happen to me if I take part?

If you decide to take part in the study, you will receive similar care and support to anyone else referred for psychology support to the service. The differences to this would be that ACT will be the only therapeutic model used in treatment. Most often, clinical psychologists use several models; however, we do not believe this will result in negative consequences for you. Another difference with the study is that you will be asked to complete more questionnaires than we would use in standard clinical practice.

The intervention itself will involve committing to 12 sessions plus an interview the week after sessions finish. Sessions will be audio recorded by Jonathan O’Keeffe to help identify the processes of change throughout therapy. Audio files will be stored on a secure NHS Trust encrypted device and will be transcribed (typed up) by Jonathan O’Keeffe. The audio files will be kept until the end of the study; however, anonymised transcriptions will be stored for up to five years in a secure, encrypted format at the University of Lincoln, who is the Sponsor for this research study.

All sessions will take place by telephone or videocall, and ideally be on a Monday. Sessions will be weekly where possible, but will take your schedule into account. Should you agree to take part Assistant Psychologist at the OACMHT will be in touch with you to arrange dates of when you can start and attend sessions. She will also help you to go through the first set of questionnaires, which will be posted out to you. A full timeline of what you will be asked to do is included at the end of this sheet and is named Participant Timeline.

As part of the study, we will monitor any change in your difficulties as well as gather your views on what is contributing to any change. To do this we will ask you to complete a pack of questionnaires at various time points in the study, as well as

some short questionnaires before and after each session. We have tried to minimise how many questionnaires you will need to fill in and chosen shortened versions where possible. We will support you to complete these by phone/videocall.
One week after you have finished the ACT sessions, we will ask you to complete an interview. This will last around one and a half hours and will be conducted by a secondary researcher whom you will not have met before. This interview will ask for your opinion on the ACT sessions, and what you felt has contributed to any change during the sessions. We ask you to be completely honest here, and your views will not have any impact on your future care. The interview will also be audio recorded so that your comments can be noted accurately.

Expenses and payments

You will be compensated for participating in those parts of the study which are over and above what would usually be expected in normal clinical practice. This will be in the form of a £40 gift certificate for your time completing the questionnaires and attending the interview one week after completing the ACT intervention. Additionally, any travel expenses incurred for attending the interview will be reimbursed (dependent on social distancing rules).

What are the possible disadvantages and risks of taking part?

A disadvantage of taking part in the study could be that you find ACT does not help improve the difficulty you have been referred for. Furthermore, you may find that the intervention does not ‘fit’ with you. ACT is a very flexible treatment, and we will make every effort possible to adapt the intervention to suit your way of working.

What are the possible benefits of taking part?

The benefits of taking part are that you would be receiving an evidence-based psychotherapy to help alleviate any psychological distress that you are experiencing. As stated above, ACT has been shown to work with a number of psychological and physical difficulties by decreasing experiential avoidance and increasing behaviours which are meaningful to the person. This can mean that people still experience anxiety or depression but are better able to manage this within their lives.

How will we use the information about you?

We will need to use information from you for this research project. Additionally, the lead researcher, Jonathan O’Keeffe, will have access to your electronic patient record so that summaries of each session can be recorded on this. It is standard clinical practice to record notes from therapy sessions on your electronic patient record.

The information held for the purpose of this study will include:

- your initials
- NHS number
- name
- contact details
- relevant medical history

People will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

Although what you say during the therapy sessions and interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons. This would usually be the Clinical Psychologist at the service.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be
- reliable. This means that we may not be able to let you see or change the
- data we hold about you.
- We will offer you the choice of receiving a summary of the findings once the study is completed, should you choose.

Where can you find out more about how your information is used?
The University of Lincoln is the lead organisation for this study. You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- Research Participant Privacy notice https://ethics.lincoln.ac.uk/research-privacy-notice/ will explain how we will be using information from you in order to undertake this study and will be the data controller for this study.
- by asking one of the research team
- by sending an email on compliance@lincoln.ac.uk or by post at Information Compliance, Secretariat, University of Lincoln, Brayford Pool, Lincoln, LN6 7TS.

What will happen to the results of the research study?
Results from this study will be written up as a Doctoral Thesis, which will include a summary paper to be submitted to an academic journal. It is anticipated the journal will be published in July 2021. All participants will remain anonymous in any written report, and key information changed so that they will not be identified. You will be offered a summary of the results from the study, should you wish to receive this.

Who is organising and funding the research?
This research is being organised and sponsored by the University of Lincoln. As Sponsor for the study, and a member of U. M. Association Limited, the University of Lincoln has insurance and indemnity in place to cover the current study, should anything go wrong.

Who has reviewed the study?
All research in the NHS, is reviewed by an independent group of people, called a

Research Ethics Committee - to protect your rights, dignity and wellbeing. This study has been reviewed and given favourable opinion by East Midlands -Derby Research Ethics Committee.

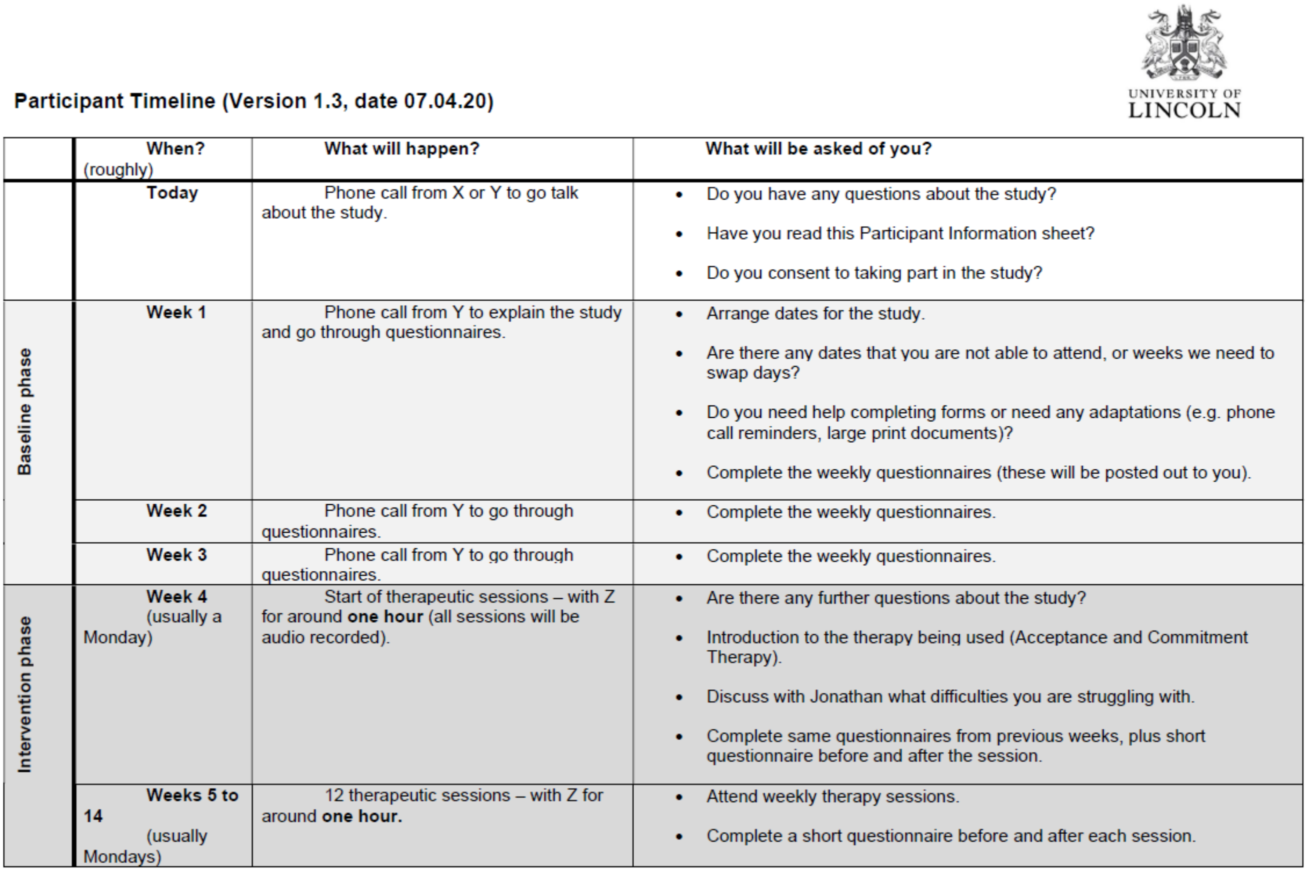
What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting ethics@lincoln.ac.uk.

As the study is taking place in an NHS service, you can also complain to the Patient Advice and Liaison Service (PALS) at Nottinghamshire Healthcare NHS Foundation Trust (details also below).

Further information and contact details

(Excluded for thesis submission)



Participant Timeline (Version 1.3, date 07.04.20)

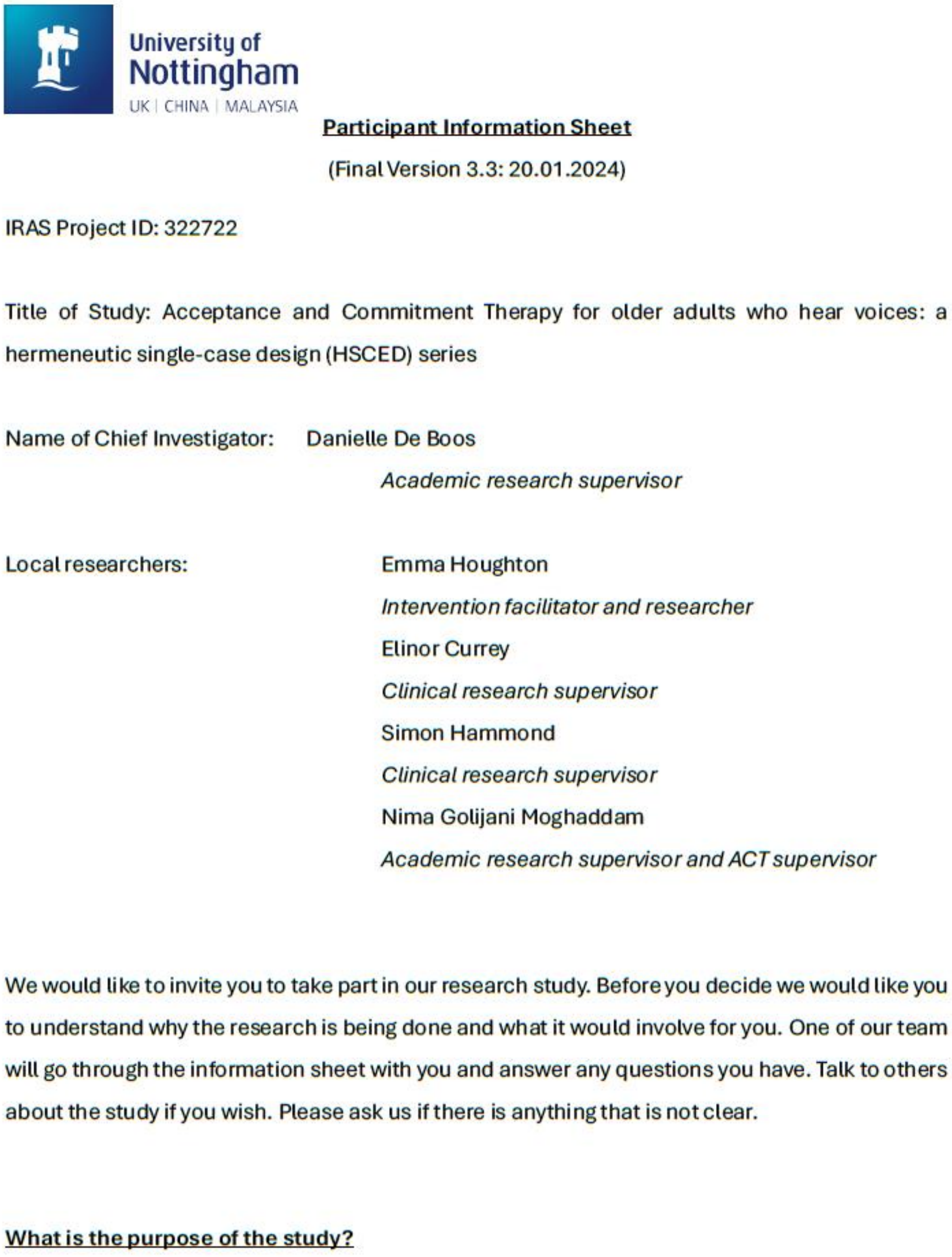
UNIVERSITY OF LINCOLN

	When? (roughly)	What will happen?	What will be asked of you?
	Today	Phone call from X or Y to go talk about the study.	• Do you have any questions about the study? • Have you read this Participant Information sheet? • Do you consent to taking part in the study?
Baseline phase	**Week 1**	Phone call from Y to explain the study and go through questionnaires.	• Arrange dates for the study. • Are there any dates that you are not able to attend, or weeks we need to swap days? • Do you need help completing forms or need any adaptations (e.g. phone call reminders, large print documents)? • Complete the weekly questionnaires (these will be posted out to you).
	Week 2	Phone call from Y to go through questionnaires.	• Complete the weekly questionnaires.
	Week 3	Phone call from Y to go through questionnaires.	• Complete the weekly questionnaires.
Intervention phase	**Week 4** (usually a Monday)	Start of therapeutic sessions – with Z for around **one hour** (all sessions will be audio recorded).	• Are there any further questions about the study? • Introduction to the therapy being used (Acceptance and Commitment Therapy). • Discuss with Jonathan what difficulties you are struggling with. • Complete same questionnaires from previous weeks, plus short questionnaire before and after the session.
	Weeks 5 to 14 (usually Mondays)	12 therapeutic sessions – with Z for around **one hour.**	• Attend weekly therapy sessions. • Complete a short questionnaire before and after each session.

	Week 15	End of sessions– with Z for around **one hour.**	- Review the therapy and discuss what helped. - Talk about next steps after therapy.
nterview	**Week 16**	Interview – with a researcher for around **one hour.**	- Discuss whether you think there were any changes as a result of therapy and why.
ollow-up	**Week 20**	Follow-up questionnaires **five weeks** completing interview.	- Phone call from Y to complete final questionnaires.

Note: X = Clinical Psychologist from the OACMHT; Y = Assistant Psychologist from the OACMHT; Z = first author, therapist-reseracher for the project; Mike's first session was on Week 3.

Appendix I: Participant Information Sheet Study for Three



Participant Information Sheet

(Final Version 3.3: 20.01.2024)

IRAS Project ID: 322722

Title of Study: Acceptance and Commitment Therapy for older adults who hear voices: a hermeneutic single-case design (HSCED) series

Name of Chief Investigator:	Danielle De Boos *Academic research supervisor*
Local researchers:	Emma Houghton *Intervention facilitator and researcher* Elinor Currey *Clinical research supervisor* Simon Hammond *Clinical research supervisor* Nima Golijani Moghaddam *Academic research supervisor and ACT supervisor*

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Please ask us if there is anything that is not clear.

What is the purpose of the study?

Hearing voices can be associated with increased psychological distress. Acceptance and Commitment Therapy (ACT) has been shown to improve distress levels for people who hear voices, however, this has not yet been investigated amongst the older adult population. The purpose of this study is to increase understanding of whether ACT can reduce the distress of older adults who hear voices, and the mechanisms behind this process.

Why have I been invited?

You are being invited to take part because you have been identified by a member of your mental health team as being potentially eligible to take part in this study. We are inviting a total of three people like you to take part in this study.

To be eligible to take part in the study, you must be 60+ years of age, experience voice-hearing that causes you to feel distressed, be willing to take part in a psychological therapy, be able to communicate independently in English, be able to provide informed consent to take part in the study, not currently be involved in another psychological therapy, and not have a diagnosis of dementia.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights or affect the quality future medical care. If you decide not to take part, you will continue to receive routine care from your current mental health team and will not have any further involvement with this study.

What will happen to me if I take part?

If you are interested in taking part in the study, you will be asked by a staff member from your mental health team to provide consent to be contacted by Emma Houghton (the primary researcher and person who will be delivering the ACT intervention). You will then have a conversation with Emma to further discuss participation in the study and to confirm whether you are eligible to participate in the study. This will involve completing a questionnaire about your mood. Providing you are eligible and wish to take part, you will then be asked to sign a consent form.

A copy of your consent form will be uploaded to your medical records and your clinical team will be informed of your participation in this research. You will also receive a copy of your consent form to keep, with the final copy being held by the research team for this study.

You will then be asked to complete several questionnaires (also referred to as 'outcome measures') about your current experiences of voice-hearing, goals for therapy, mood, quality of life, and psychological flexibility. These questionnaires will be administered at four points over the course of your involvement with the study (at the start, in the middle, at the end, and at follow-up).

We will arrange a time and location for weekly Acceptance and Commitment Therapy (ACT) sessions to take place. ACT is a psychological therapy that aims to reduce distress by improving psychological flexibility. This is the ability to connect with the present moment and to live life in line with your values, despite the potential presence of difficult internal experiences (i.e., unpleasant voices, thoughts, or feelings). Achieving this can help someone to alter the relationship they have with their voices and learn how to cope with them so that they are less distressing. Examples of topics that may be focused on during ACT sessions includes identifying core values, increasing awareness of experiences, learning to view experiences in a non-judgemental way, and identifying ways to live life in accordance to core values.

You will be invited to complete 12 sessions across a 14-week period. Sessions will be delivered on an individual basis, with each session estimated to last up to 1.5 hours (however this can be flexible to suit your needs). In each session, you will be asked to complete a short questionnaire to review their therapy-related goals. If you are noted to be frequently missing sessions, your continuation in the study may be reviewed.

All therapy sessions will be audio recorded and reviewed by an approved member of the research team to evaluate whether the therapist is delivering the therapy as it is designed to be delivered. Recordings will be kept strictly confidential by a principal investigator at the University of Nottingham.

Notes of each session will be documented on your mental health medical records. These notes will detail whether you attended therapy and brief summary of the content of the session. These notes will be accessible to your mental health team, and will be kept strictly confidential, following the regular policies and procedures of your local NHS trust.

After therapy has finished, an independent researcher will meet with you to discuss your views of the therapy and any changes (or lack thereof) to your distress levels. This will be done at a time and place that suits you. This discussion will be audio recorded and kept strictly confidential by a principal investigator at the University of Nottingham.

To determine whether or not the therapy was effective, a 'case record' will be put together that contains information about your experience of therapy, the questionnaires you completed, and any changes to your voice-hearing experiences. This document will be reviewed by an 'expert panel' of judges, which will be made up of 3 people employed by Nottinghamshire Healthcare Foundation Trust, Derbyshire Healthcare Foundation Trust, The University of Nottingham, and/or the University of Lincoln. When the expert panel of judges is established, we will inform you in writing who they are. The judges will review the case record to conclude whether or not the ACT intervention was effective in improving psychological distress that is related to voice-hearing experiences. Identifiable information will be removed from the documents to protect your anonymity.

From start to finish, your overall involvement of the study is expected to last 24-weeks, with the therapy phase lasting approximately 14 weeks. An example of a timeline of what your involvement with the study may look like can be seen in the table below. It should be noted that these dates are an estimate and are subject to change.

Month	**Participant Activity**
First month	Complete initial paperwork (e.g., consent forms) and eligibility confirmation. Arrange a suitable time / location for ACT sessions Complete pre-therapy outcome measures
Second month	Weekly individual ACT therapy sessions with Emma
Third month	Weekly individual ACT therapy sessions with Emma Complete mid-therapy outcome measures
Fourth month	Weekly individual ACT therapy sessions with Emma Complete end of therapy outcome measures
Fifth month	Complete post-therapy outcome measures

	Post-therapy discussion with independent researcher about your experiences of the therapy

Expenses and payments

You will receive a £30 gift card as a ‘thank you’ for completing follow-up outcome measures and post-therapy discussion, as these activities are extra to normal clinical practice. No compensation for travel costs will be offered, as sessions will take place at the site of your usual care or a location convenient for you if reasonable adjustments are required.

What are the possible disadvantages and risks of taking part?

During therapy sessions, it is common to explore difficult and distressing experiences to gain understanding of how to manage them. This can result in experiences of psychological discomfort and/or distress. This will be monitored during sessions and you will receive appropriate support for this. This is not uncommon during therapy, as the aim of therapy is to equip you with the skills to manage this kind of distress.

What are the possible benefits of taking part?

Whilst we cannot promise the study will help you, research has shown Acceptance and Commitment Therapy (ACT) to be an effective therapy at reducing distress levels for people who hear voices. Taking part in this therapy could help you to manage distress and improve your quality of life, leading to improvements in overall wellbeing. Furthermore, the information we get from this study will be used to further the understanding of whether ACT can help older adults who are distressed by hearing voices, which may be used to inform future guidance and clinical practice.

What happens when the research study stops?

Through the duration of your therapy, you will remain under the care of your allocated mental health team. Depending on your needs, you will continue to receive care from this team after the study ends, or if appropriate, you may be discharged if this is no longer a service that you require.

If you require ongoing psychological support following your participation in this study, your clinical team will support you to access this.

If you wish, you are welcome to be sent information about the results of the study once the study is complete. In order to inform you of this, we will need to gain your consent to hold your contact details so that we can update you accordingly.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers' contact details are given at the end of this information sheet.

If you remain unhappy and wish to complain formally, you can do this by contacting the Patient Advice and Liaison Service (PALS) at Nottinghamshire Healthcare NHS Trust Patient Experience Team on 0115 9934542, or by emailing PALS@nottshc.nhs.uk or complaints@nottshc.nhs.uk.

If you want to complain about how researchers have handled your information, you should contact the research team. If you are not happy after that, you can contact the Data Protection Officer at dpo@nottingham.ac.uk. If you are not happy with their response or believe they are processing your data in a way that is not right or lawful, you can complain to the Information Commissioner's Office (ICO) (www.ico.org.uk or 0303 123 1113).

Whilst it is not expected that your participation in the study will cause you any harm, we ask that if you are experiencing any problems in relation to your involvement with the study that you inform a member of the research team. Should any harm be caused that is a result of your involvement with the study, the University of Nottingham sponsor (i.e. the organisation that takes on the legal responsibility for the research) may need to be informed, as this is part of routine procedures.

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence, you may have grounds for a legal action for compensation against the University of Nottingham but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

If you are struggling with your mental health and need additional support, please contact the appropriate healthcare service (e.g., your local mental health team, GP, local crisis team, or emergency services).

Involvement of your Mental Health Team

The Mental Health Team that are involved in your care will be informed of your participation in this study. They will be provided a copy of your consent form which may then be stored on your medical records, in addition to a copy of the Participant Information Sheet and the Plain English Summary.

Your attendance to therapy sessions and a summary of the content of your therapy sessions will be documented on your mental health records that your current clinical team use. This means the summarised session notes will be accessible to your mental health team. As per the standard policies and procedures of your local NHS trust, this documentation will remain strictly confidential.

Should any concerns in relation to your mental and/or physical health arise whilst you are participating in the study, you should contact your GP / mental health team in the first instance. Through the duration of the study, your clinical team will maintain overall responsibility for your care.

Whilst it is not expected, should any issues arise over the course of therapy that may indicate risk of harm to self or others, a member of your mental health team will be alerted so that you can be provided with the right support.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

The information you provide through your involvement in the study will be kept **strictly confidential.** As mentioned above, a summarised account of therapy sessions will be documented in your mental health records so that your clinical team can remain up to date on the intervention you are being offered, and if any concerns are raised. This data will be handled in accordance to the policies and procedures of your local NHS trust.

All additional research data will be stored in a secure and locked office and/or on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security), and the Chief Investigator of this study is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally – identifiable information possible.

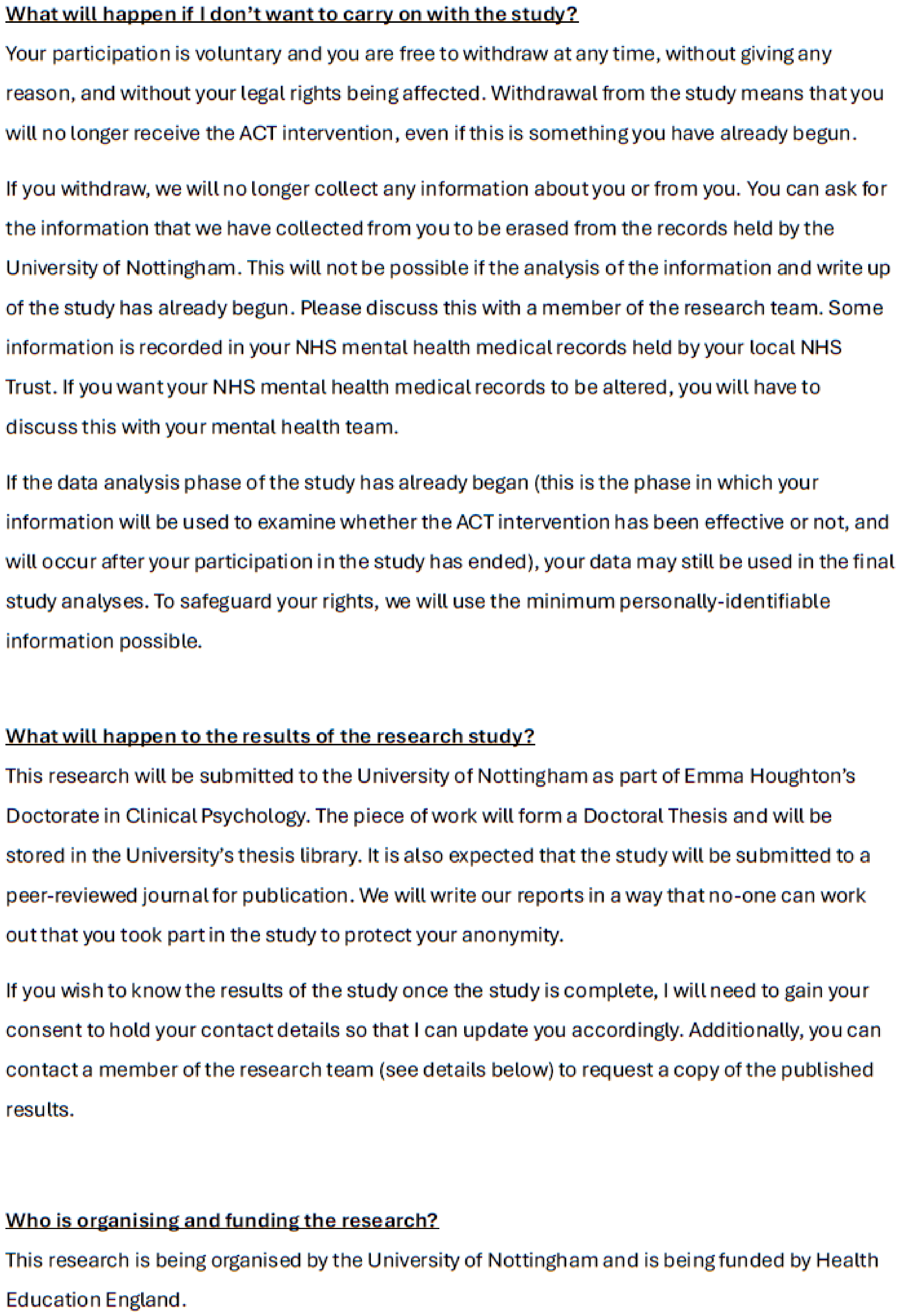
You can find out more about how we use your information and to read our privacy notice at: https://www.nottingham.ac.uk/utilities/privacy.aspx

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

Your contact information will be kept by the University of Nottingham for 6 months after the end of the study so that we are able to contact you about the findings of the study and possible follow-up studies (unless you advise us that you do not wish to be contacted). This information will be kept separately from the research data collected and only those who need to will have access to it. All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information we will seek your consent for this and ensure it is secure. You will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Although what you say to us is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.



What will happen if I don’t want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. Withdrawal from the study means that you will no longer receive the ACT intervention, even if this is something you have already begun.

If you withdraw, we will no longer collect any information about you or from you. You can ask for the information that we have collected from you to be erased from the records held by the University of Nottingham. This will not be possible if the analysis of the information and write up of the study has already begun. Please discuss this with a member of the research team. Some information is recorded in your NHS mental health medical records held by your local NHS Trust. If you want your NHS mental health medical records to be altered, you will have to discuss this with your mental health team.

If the data analysis phase of the study has already began (this is the phase in which your information will be used to examine whether the ACT intervention has been effective or not, and will occur after your participation in the study has ended), your data may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally-identifiable information possible.

What will happen to the results of the research study?

This research will be submitted to the University of Nottingham as part of Emma Houghton’s Doctorate in Clinical Psychology. The piece of work will form a Doctoral Thesis and will be stored in the University’s thesis library. It is also expected that the study will be submitted to a peer-reviewed journal for publication. We will write our reports in a way that no-one can work out that you took part in the study to protect your anonymity.

If you wish to know the results of the study once the study is complete, I will need to gain your consent to hold your contact details so that I can update you accordingly. Additionally, you can contact a member of the research team (see details below) to request a copy of the published results.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by Health Education England.

Who has reviewed the study?

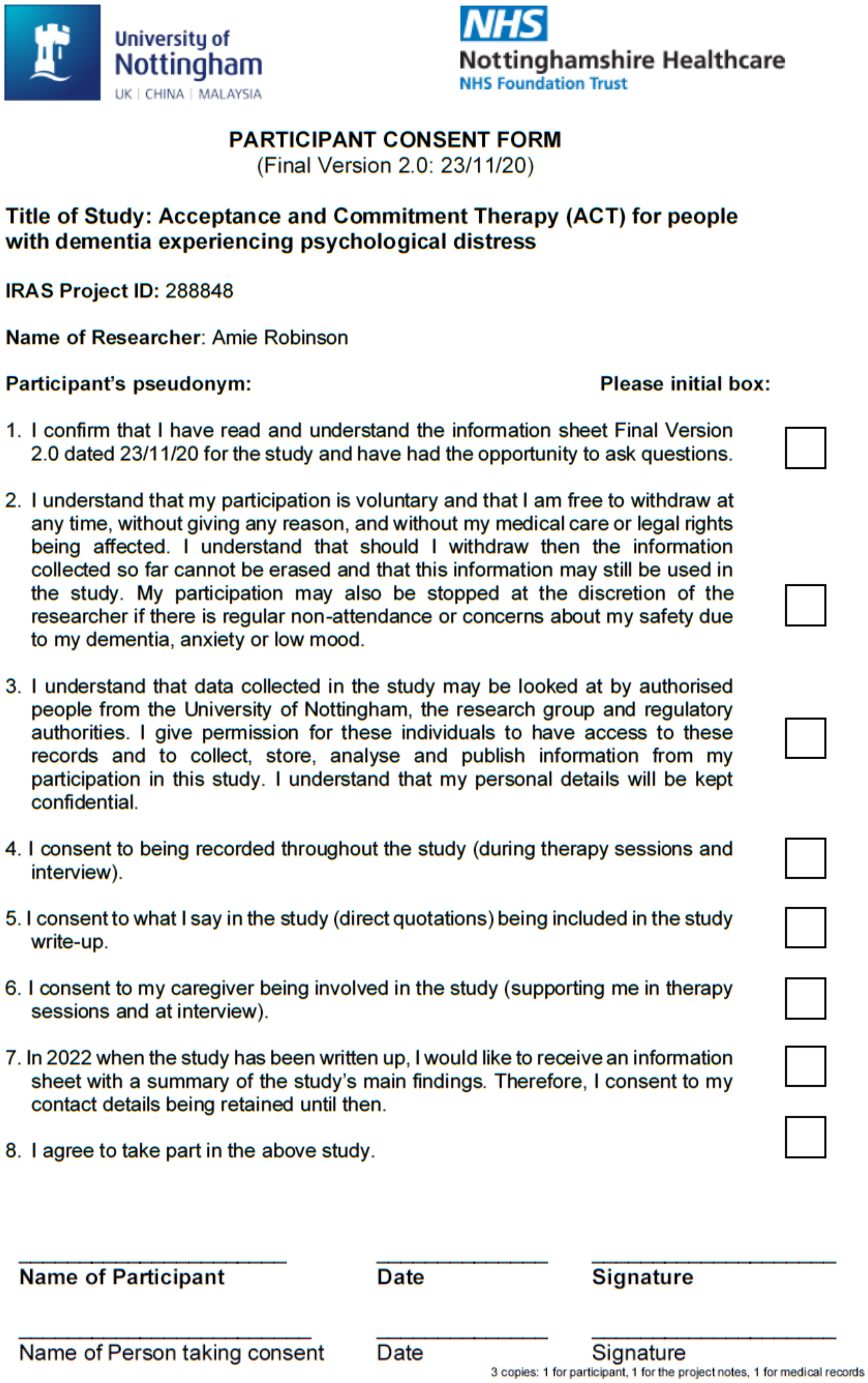
All research in healthcare is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and been given favourable opinion by Research Ethics Committees at Camberwell St Giles (London).

Further information and contact details

Emma Houghton (Trainee Clinical Psychologist)
Primary researcher and ACT Intervention Facilitator
Email: lpxeh4@nottingham.ac.uk
Phone: +44 (0)7741 609 244 (NHS Mobile)
Address: Trent Doctorate in Clinical Psychology
School of Medicine, University of Nottingham
B9 Yang Fujia Building, Jubilee Campus,
Wollaton Road, Nottingham, NG8 1BB

Dr Danielle De Boos (Programme Co-Director, Associate Professor)
Chief Investigator and primary academic supervisor to Emma Houghton
Email: danielle.deboos@nottingham.ac.uk
Phone: 0115 846 6696
Address: Trent Doctorate in Clinical Psychology
B9 Yang Fujia Building, Jubilee Campus, University of Nottingham,
Wollaton Road, Nottingham, NG8 1BB

Appendix J: Participant Consent Forms for Study One



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NHS
Nottinghamshire Healthcare
NHS Foundation Trust

PARTICIPANT CONSENT FORM
(Final Version 2.0: 23/11/20)

Title of Study: Acceptance and Commitment Therapy (ACT) for people with dementia experiencing psychological distress

IRAS Project ID: 288848

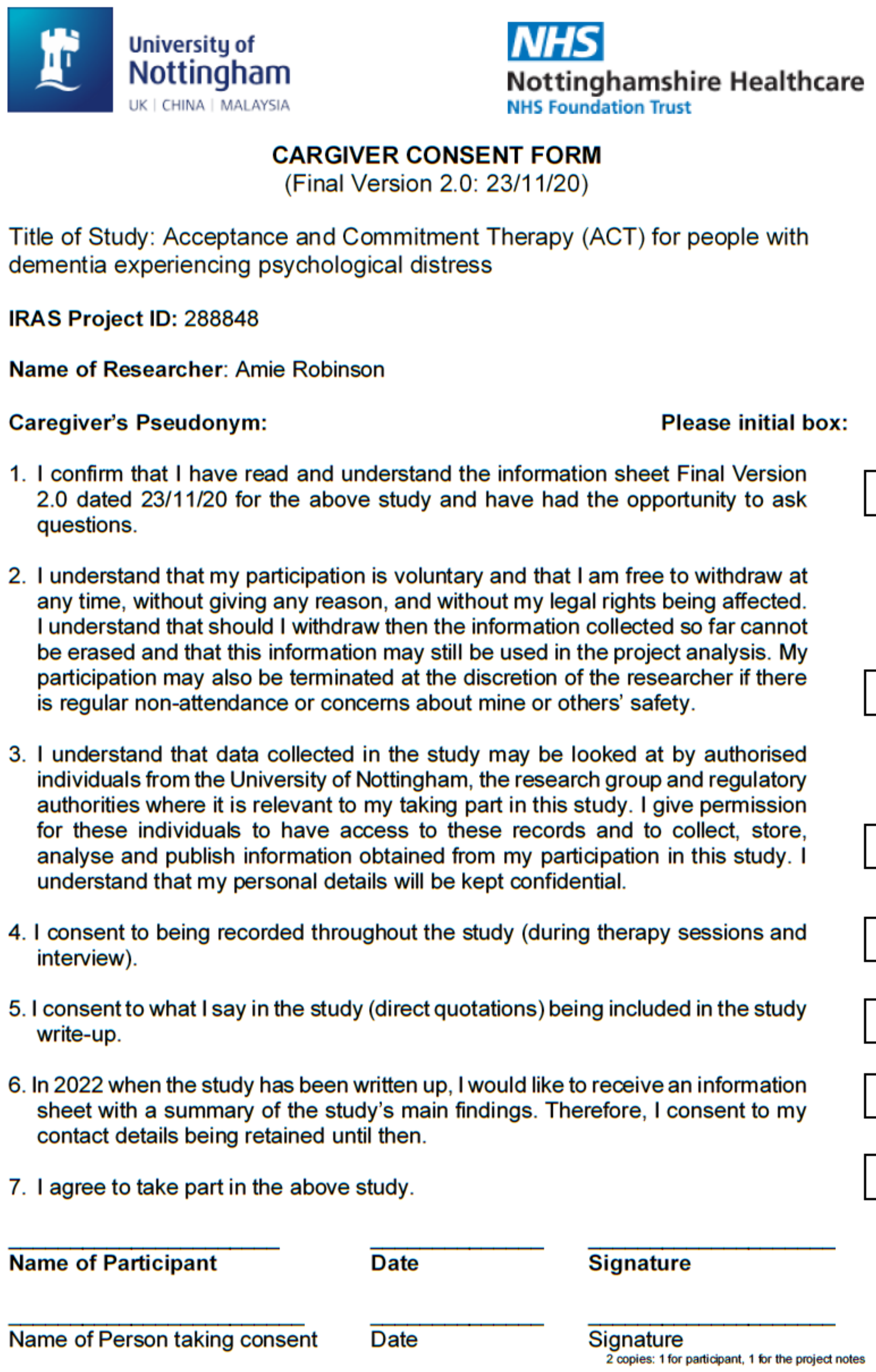
Name of Researcher: Amie Robinson

Participant's pseudonym: **Please initial box:**

1. I confirm that I have read and understand the information sheet Final Version 2.0 dated 23/11/20 for the study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the study. My participation may also be stopped at the discretion of the researcher if there is regular non-attendance or concerns about my safety due to my dementia, anxiety or low mood. ☐
3. I understand that data collected in the study may be looked at by authorised people from the University of Nottingham, the research group and regulatory authorities. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I consent to being recorded throughout the study (during therapy sessions and interview). ☐
5. I consent to what I say in the study (direct quotations) being included in the study write-up. ☐
6. I consent to my caregiver being involved in the study (supporting me in therapy sessions and at interview). ☐
7. In 2022 when the study has been written up, I would like to receive an information sheet with a summary of the study's main findings. Therefore, I consent to my contact details being retained until then. ☐
8. I agree to take part in the above study. ☐

______________________	______________	____________________
Name of Participant	**Date**	**Signature**
______________________	______________	____________________
Name of Person taking consent	Date	Signature

3 copies: 1 for participant, 1 for the project notes, 1 for medical records



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NHS
Nottinghamshire Healthcare
NHS Foundation Trust

CARGIVER CONSENT FORM

(Final Version 2.0: 23/11/20)

Title of Study: Acceptance and Commitment Therapy (ACT) for people with dementia experiencing psychological distress

IRAS Project ID: 288848

Name of Researcher: Amie Robinson

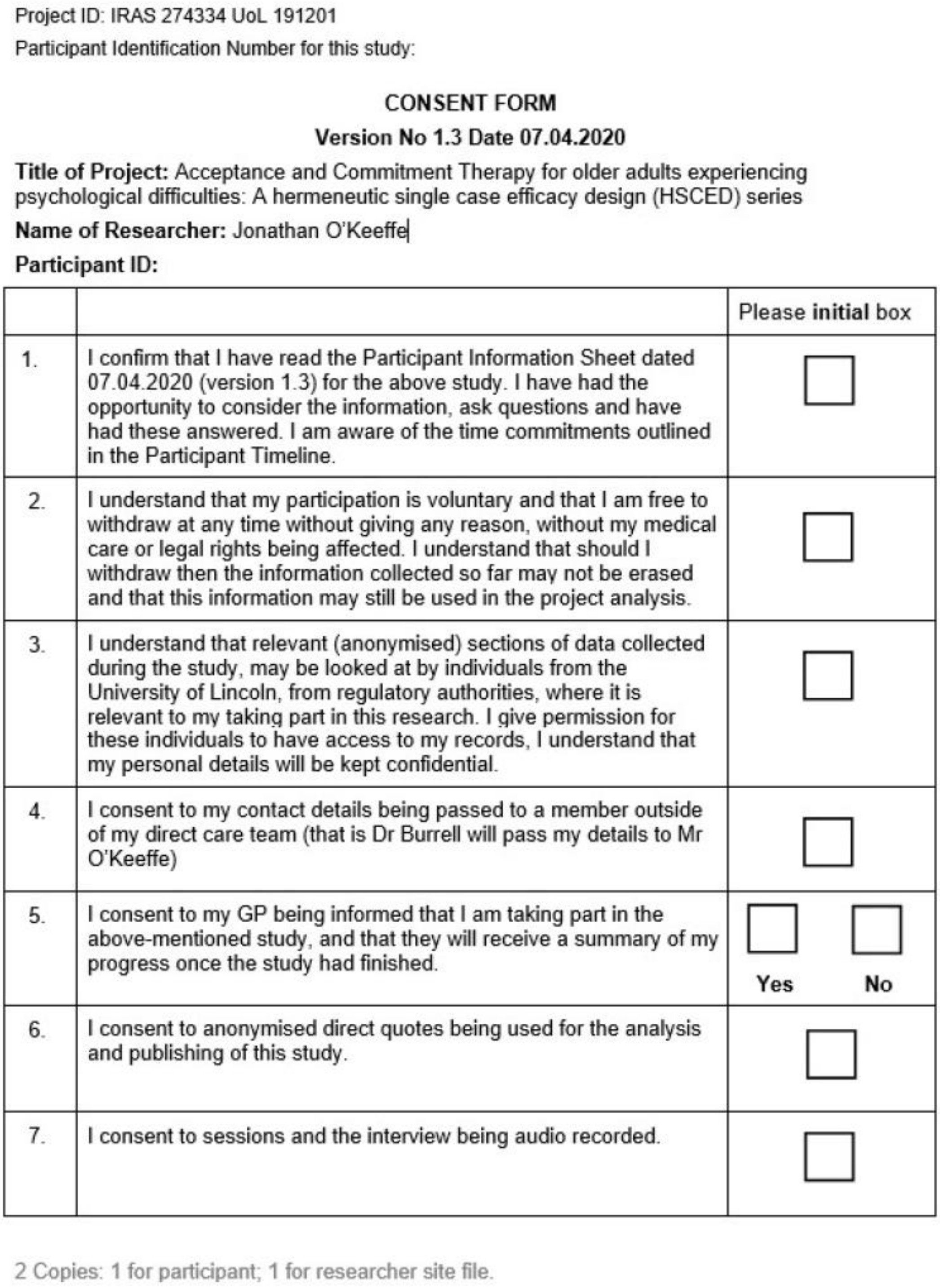
Caregiver's Pseudonym: **Please initial box:**

1. I confirm that I have read and understand the information sheet Final Version 2.0 dated 23/11/20 for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. My participation may also be terminated at the discretion of the researcher if there is regular non-attendance or concerns about mine or others' safety. ☐
3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I consent to being recorded throughout the study (during therapy sessions and interview). ☐
5. I consent to what I say in the study (direct quotations) being included in the study write-up. ☐
6. In 2022 when the study has been written up, I would like to receive an information sheet with a summary of the study's main findings. Therefore, I consent to my contact details being retained until then. ☐
7. I agree to take part in the above study. ☐

Name of Participant	**Date**	**Signature**
Name of Person taking consent	Date	Signature

2 copies: 1 for participant, 1 for the project notes

Appendix K: Participant Consent Form for Study Two



Project ID: IRAS 274334 UoL 191201

Participant Identification Number for this study:

CONSENT FORM

Version No 1.3 Date 07.04.2020

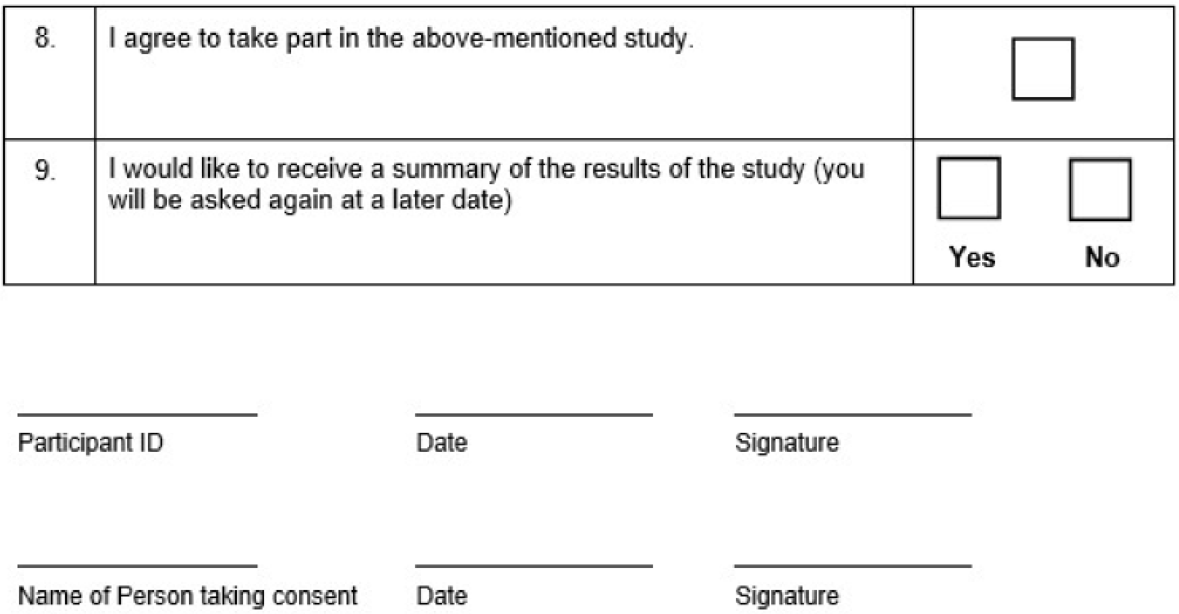
Title of Project: Acceptance and Commitment Therapy for older adults experiencing psychological difficulties: A hermeneutic single case efficacy design (HSCED) series

Name of Researcher: Jonathan O'Keeffe

Participant ID:

		Please **initial** box
1.	I confirm that I have read the Participant Information Sheet dated 07.04.2020 (version 1.3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered. I am aware of the time commitments outlined in the Participant Timeline.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far may not be erased and that this information may still be used in the project analysis.	☐
3.	I understand that relevant (anonymised) sections of data collected during the study, may be looked at by individuals from the University of Lincoln, from regulatory authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records, I understand that my personal details will be kept confidential.	☐
4.	I consent to my contact details being passed to a member outside of my direct care team (that is Dr Burrell will pass my details to Mr O'Keeffe)	☐
5.	I consent to my GP being informed that I am taking part in the above-mentioned study, and that they will receive a summary of my progress once the study had finished.	☐ **Yes** ☐ **No**
6.	I consent to anonymised direct quotes being used for the analysis and publishing of this study.	☐
7.	I consent to sessions and the interview being audio recorded.	☐

2 Copies: 1 for participant; 1 for researcher site file.

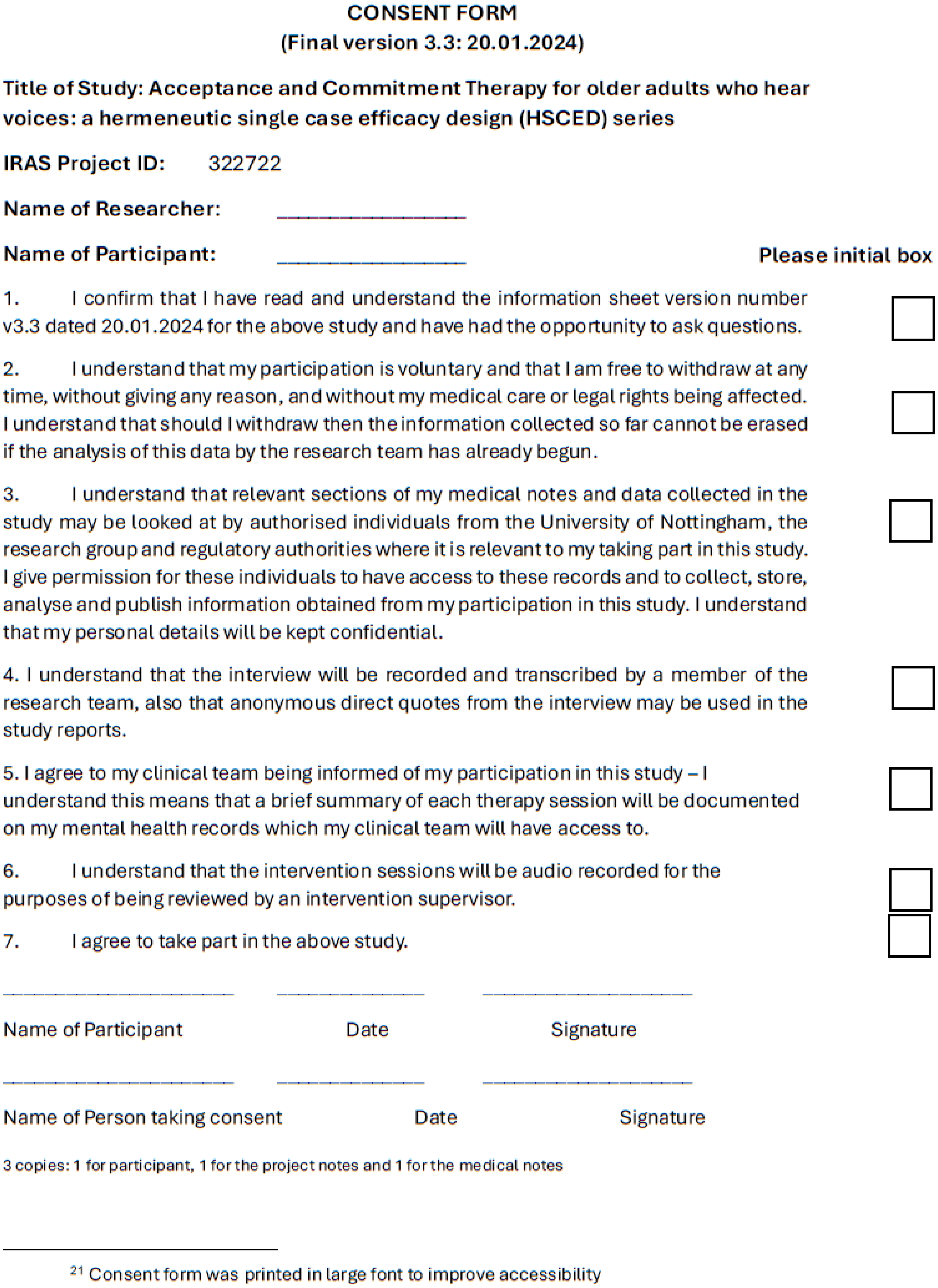


8.	I agree to take part in the above-mentioned study.	☐
9.	I would like to receive a summary of the results of the study (you will be asked again at a later date)	☐ Yes ☐ No

Participant ID ____________ Date ____________ Signature ____________

Name of Person taking consent ____________ Date ____________ Signature ____________

Appendix L: Participant Consent Form for Study Three



CONSENT FORM
(Final version 3.3: 20.01.2024)

Title of Study: Acceptance and Commitment Therapy for older adults who hear voices: a hermeneutic single case efficacy design (HSCED) series

IRAS Project ID: 322722

Name of Researcher: ________________

Name of Participant: ________________ **Please initial box**

1. I confirm that I have read and understand the information sheet version number v3.3 dated 20.01.2024 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased if the analysis of this data by the research team has already begun. ☐

3. I understand that relevant sections of my medical notes and data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the interview will be recorded and transcribed by a member of the research team, also that anonymous direct quotes from the interview may be used in the study reports. ☐

5. I agree to my clinical team being informed of my participation in this study – I understand this means that a brief summary of each therapy session will be documented on my mental health records which my clinical team will have access to. ☐

6. I understand that the intervention sessions will be audio recorded for the purposes of being reviewed by an intervention supervisor. ☐

7. I agree to take part in the above study. ☐

____________________ ____________ __________________

Name of Participant Date Signature

____________________ ____________ __________________

Name of Person taking consent Date Signature

3 copies: 1 for participant, 1 for the project notes and 1 for the medical notes

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[21] Consent form was printed in large font to improve accessibility

Appendix M: Example of inductive coding

Lack of social support/external resources

Prompting realisations

Perspective and normalisation

Not the right time for therapy

Distancing

Lack of internal resources

Practical Skills

Confidence

This sounds like the timing of the lockdown is impacting changes Mike has noticed?

It's "just" my wife sounds like a lack of support from elsewhere

Realisations have been achieved about his moods and his own signs of heading towards a 'meltdown'

INTERVIEWER: So have you noticed perhaps any changes in how you are feeling? Or has anyone else noticed anything different?

MIKE: Well, I'm meeting so few people, you know, with the lockdown. It's just my wife. I don't know…I think there's more of an understanding when I'm heading towards a bit of meltdown that, it is something that is happening to me, and it real. Even though to onlookers it might seem…I don't know, stupid, childish. And that's helped, that's helped over a long period you know. And again, with ACT I can, I think I can explain better why I get in particular moods or whatever, and it's a very easy therapy to, not only to use, but to explain to other people.

He is validating and normalising for himself here

This reads as though he is trying to distance himself from whatever others might think

INTERVIEWER: Yeah

MIKE: Which I, normally I keep…you know…I suppose one thing, doing it as home as I have, normally I keep my therapy quite distant from family because…well it's all a bit bonkers isn't it really?

Even though family sound present he is identifying this is not a support and that he feels he has to keep his distance?

INTERVIEWER: Mmhmm

MIKE: …you know, to normal people. I think there are some very concrete examples. You can say, "I can do this, I can do that," etc. I've not had any comments, I don't look for comments (slight laugh)

Is this describing a sense of confidence gained from the practical things he has learnt?

He is recognising some concrete examples of things in therapy to use and talk about even if he hasn't told us what they are

INTERVIEWER: That's ok. I guess just building on what you've just said. Do you think you would have explained things before, or do you think that since starting therapy you've been able to explain things to other people more, like your wife?

He seems to have gone back to talking ACT in a normalising/validating way that does not stigmatise him

Mike discusses this exercise more than once

MIKE: I think that's a big factor, yeah. It's almost making it, rather than a mental health therapy, it's like a well-being therapy. I've got the papers here and I can look at the Choice Point, and I can show it to somebody else, and they might say, "yeah I can really understand that, that's not *mental health* problems, that's just life problems." It's just when I set off on the wrong route, I cannot stop (chuckle). You know literally, I get to a point where I just don't know what to do with myself. Honestly, it just makes me feel really ill. You know, I feel a little fruitcase (chuckle). But, the quick answer to your question is, yes I do feel more able to discuss it with people. It's not like psychodynamic therapy, you know, psychotherapy, which is…

This speaks to some sort of internal difficulty

It sounds like something (internally?) is preventing him thoroughly regulating at this time, is he not at this

INTERVIEWER: Yeah. That's not one you can easily explain to other people is it?

MIKE: No, not at all. Not in anyway. No. I mean, totally the opposite. Keep it absolutely, you know, confidential from other people, because it sounds bonkers. I think the name, ACT, is a very good name actually. Because that doesn't say anything that general public would…they might go, "that sounds interesting." But if you say you're going in for psychodynamic therapy, "right," you know. You get space for yourself on the bus (chuckle).

INTERVIEWER: Yep, yeah, I can see that (slight chuckle). So, just to recap, so the reason I've been writing as you've been talking is to summarise the main changes that you have identified into snappy statements. So, I've written down four. And, let me know if I need to change wording of any of these, or the wording of them all together.

MIKE: Yeh

INTERVIEWER: So, the first one that I wrote down was that you're starting to think about things differently.

MIKE: Yes definitely.

He agrees he has been gaining new insight and ways of thinking even if he is not demonstrating this here

INTERVIEWER: Um, that you're avoiding things less.

MIKE: Yes definitely, yes. I mean things like phoning people up that I've not phoned for ages. I can rationalise it now. Whereas before, you know, it was a bad time, they're always here, I haven't rung for ages. It's kind of looking at it objectively. It's just hit me Jonathan said, "with curiosity," objectively it should be ok, so I'll do it (chuckle). Which is very useful.

This sounds like he has the worries about ringing but successfully distances from them

Appendix N: Example of deductive coding

New insights/understanding

Experiential avoidance

Self as content

Self as context

Acceptance

Committed Action

Cognitive Defusion

Cognitive Fusion

Agreement on tasks

Seeing this as something onlookers might have the thought of, but not letting this impact him

New/increased insight and understanding about himself

INTERVIEWER: So have you noticed perhaps any changes in how you are feeling? Or has anyone else noticed anything different?

MIKE: Well, I'm meeting so few people, you know, with the lockdown. It's just my wife. I don't know…I think there's more of an understanding when I'm heading towards a bit of meltdown that, it is something that is happening to me, and it real. Even though to onlookers it might seem…I don't know, stupid, childish. And that's helped, that's helped over a long period you know. And again, with ACT I can, I think I can explain better why I get in particular moods or whatever, and it's a very easy therapy to, not only to use, but to explain to other people.

Agreeing with the therapy as something useful and explainable

INTERVIEWER: Yeah

MIKE: Which I, normally I keep…you know…I suppose one thing, doing it as home as I have, normally I keep my therapy quite distant from family because…well it's all a bit bonkers isn't it really?

INTERVIEWER: Mmhmm

This thought is making him wanting to avoid uncomfortable interactions with family? This avoidance is preventing him sharing?

MIKE: …you know, to normal people. I think there are some very concrete examples. You can say, "I can do this, I can do that," etc. I've not had any comments, I don't look for comments (slight laugh)

Not looking for others opinions in case they are uncomfortable or represent judgement as suspected above?

INTERVIEWER: That's ok. I guess just building on what you've just said. Do you think you would have explained things before, or do you think that since starting therapy you've been able to explain things to other people more, like your wife?

Agreement/usage of the choice point task

Sometimes unable to defuse from thoughts/unhelpful routes of thinking

MIKE: I think that's a big factor, yeah. It's almost making it, rather than a mental health therapy, it's like a well-being therapy. I've got the papers here and I can look at the Choice Point, and I can show it to somebody else, and they might say, "yeah I can really understand that, that's not *mental health* problems, that's just life problems." It's just when I set off on the wrong route, I cannot stop (chuckle). You know literally, I get to a point where I just don't know what to do with myself. Honestly, it just makes me feel really ill. You know, I feel a little fruitcase (chuckle). But, the quick answer to your question is, yes I do feel more able to discuss it with people. It's not like psychodynamic therapy, you know, psychotherapy, which is…

Judging himself here by the content of his thoughts

It sounds like the stigma of other therapies encourages him to avoid talking about them even if this isn't applicable to ACT

INTERVIEWER: Yeah. That's not one you can easily explain to other people is it?

MIKE: No, not at all. Not in anyway. No. I mean, totally the opposite. Keep it absolutely, you know, confidential from other people, because it sounds bonkers. I think the name, ACT, is a very good name actually. Because that doesn't say anything that general public would…they might go, "that sounds interesting." But if you say you're going in for psychodynamic therapy, "right," you know. You get space for yourself on the bus (chuckle).

INTERVIEWER: Yep, yeah, I can see that (slight chuckle). So, just to recap, so the reason I've been writing as you've been talking is to summarise the main changes that you have identified into snappy statements. So, I've written down four. And, let me know if I need to change wording of any of these, or the wording of them all together.

MIKE: Yeh

INTERVIEWER: So, the first one that I wrote down was that you're starting to think about things differently.

Not an example per se but does show he recognises experiencing new insights

MIKE: Yes definitely.

INTERVIEWER: Um, that you're avoiding things less.

Not much of an example but he agrees with accepting rather than avoiding

MIKE: Yes definitely, yes. I mean things like phoning people up that I've not phoned for ages. I can rationalise it now. Whereas before, you know, it was a bad time, they're always here, I haven't rung for ages. It's kind of looking at it objectively. It's just hit me Jonathan said, "with curiosity," objectively it should be ok, so I'll do it (chuckle). Which is very useful.

Commitment to the action that he wants to do of phoning people he cares about

These sound like the previously fused thoughts preventing him taking the action he wanted to take (phoning) that have now shifted/he is able to shift

Being the observer of his thoughts and being the context of them, looking at them 'objectively'

Appendix O: Saliency Analysis Results

INDUCTIVE CODES	RECURRENCE		RANK
	Files	Codes	
THERAPIST SKILL	8	18	1
THERAPIST ATTUNEMENT	4	10	3
FONDNESS TOWARDS THE THERAPIST	4	7	3
CONTACT WITH THINGS THAT TAP INTO VALUES	1	4	4
PRESENCE OF INTERNAL RESOURCES	8	22	1
RELATABILITY/FAMILIARITY OF EXERCISES	7	23	1
EXERCISES AS UNRELATABLE/UNFAMILIAR	4	8	2
LACK OF INTERNAL RESOURCES	7	27	1
RIGHT HEADSPACE	4	12	2
SOCIAL CIRCUMSTANCES FACILITATING CHANGE	6	15	1
NOT THE RIGHT TIME FOR THERAPY	6	38	1
CONFIDENCE	8	25	1
DISTANCING	6	18	1
EMOTIONAL CATHARSIS	5	10	2
THERAPY AS EXPOSING	6	9	2
THERAPY LEADING TO EXPOSURE IN THE REAL WORLD	2	2	4

INCREASED CONTACT WITH PLEASANT EXPERIENCES	5	7	4
DRAWING ATTENTION TO PROBLEMS	3	7	4
SOOTHING	4	6	4
LETTING THINGS GO	2	5	4
THERAPY PROVIDING PURPOSE	3	4	4
INCREASED GRATITUDE	2	4	4
PRESENCE OF EXTERNAL RESOURCES	7	17	1
• FAMILY	6	8	2
• LOCALLY	3	2	2
LACK OF EXTERNAL RESOURCES			
LACK OF INTERNAL RESOURCES	6	18	1
NORMALISING PERSPECTIVES	3	14	2
THERAPY PROVIDING ACCOUNTABILITY	2	5	4
PRACTICAL SKILLS	6	36	3
EXPERIENCES OF MINDFULNESS	5	8	3
DEDUCTIVE CODES			
ACT SPECIFIC PROCESSES			
EXPERIENTIAL AVOIDANCE	8	27	1
ACCEPTANCE	7	26	1
COMMITTED ACTION	8	15	1
INACTION/STUCKNESS	5	15	2
PRESENT MOMENT AWARENESS	5	15	2

STUCK IN THE PAST/FUTURE	4	11	2
COGNITIVE DEFUSION	5	12	2
COGNITIVE FUSION	4	11	2
VALUES	5	24	3
LACK OF VALUES CLARIFICATION	0	0	4
SELF AS CONTEXT	6	14	1
SELF AS CONTENT	4	14	2
COMMON FACTORS PROCESSES			
TASKS OF THERAPY	8	29	1
GOALS OF THERAPY	3	12	4
BOND	2	6	4
GENUINENESS/CONGRUENCE	1	1	4
ACCURATE EMPATHY	7	19	1
CATHARSIS	5	13	2
CONFRONTING THE PROBLEM	5	11	
UNCONDITIONAL POSITIVE REGARD	1	2	4
EXPOSURE	7	11	1
MASTERY	6	20	1
RATIONALE/PROBLEM NARRATIVE	1	1	
PRACTICE EFFECTS	6	13	1
NEW INSIGHTS	7	50+	**1**
ACCURATE EMPATHY	7	19	1
CATHARSIS	5	13	2
EXPECTATIONS	8	22	3
MASTERY	6	20	1

PRACTICE EFFECTS	6	13	1
NEW INSIGHTS	7	50+	1

Poster

UNIVERSITY OF LINCOLN

EnACTing change: an exploration of Older Adults experiences of change with Acceptance and Commitment Therapy (ACT)

Ella Hartshorn, Danielle De Boos & Nima Moghaddam
Trent Doctorate in Clinical Psychology

University of Nottingham
UK | CHINA | MALAYSIA

Background

The mental health of Older Adults (OAs) is an unprioritized concern. ACT is efficacious for lots of conditions that affect OAs and seems particularly suited to this demographic (Petkus & Wetherall, 2013) but there is a literature gap for understanding the mechanisms of change. Qualitative research has been neglected in this area, despite the insights it can give towards change processes (Jando & Dionne, 2024)

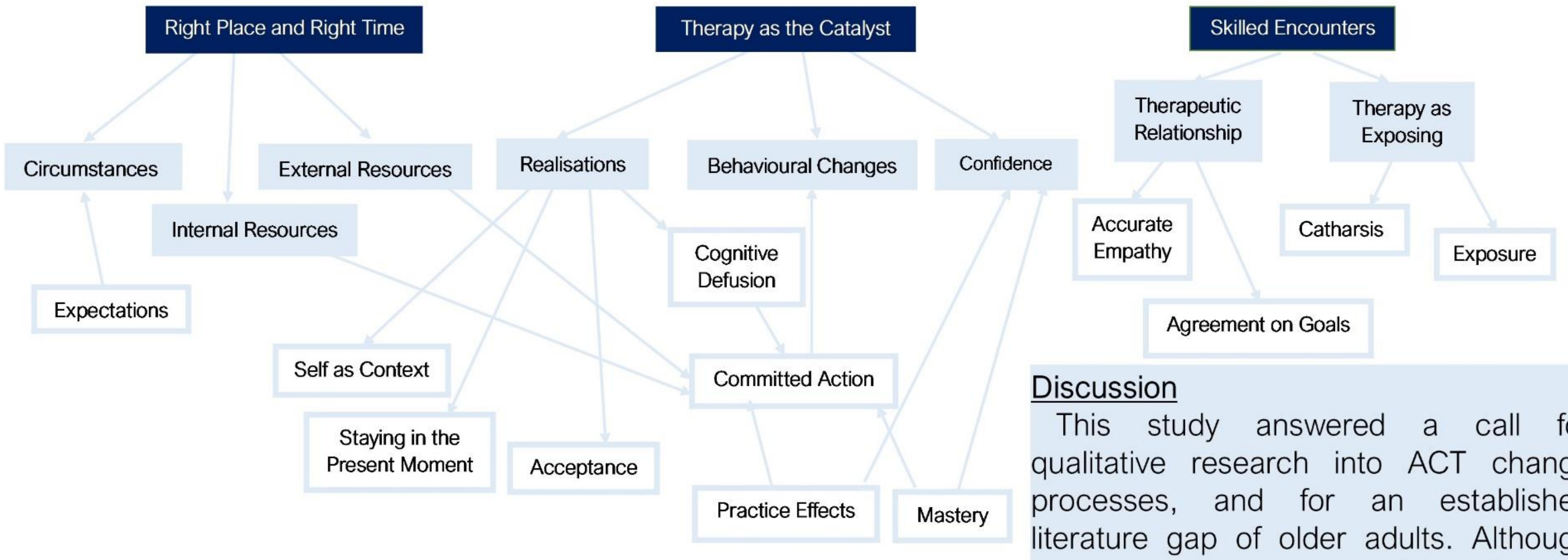
Objectives

- To explore OAs experiences of change following an ACT intervention
- To explore how experiences of change map onto underlying change processes

Methodology

This study used an inductive-deductive Reflexive Thematic Analysis (Braun & Clarke, 2019) to analyse Change Interview (Elliott, 2006) data from three studies that used ACT with OA's.

Study	N	Presentation	Intervention	Ages	Delivery
1	3	Dementia	12 weekly ACT	71-90	Online
2	3	Anxiety or Depression	12 weekly ACT	66-77	Telephone
3	2	Hearing Voices	12 weekly ACT	Mid 60s-mid 70s	Face to Face



Right Place and Right Time
Circumstances
External Resources
Internal Resources
Expectations

Therapy as the Catalyst
Realisations
Behavioural Changes
Confidence
Cognitive Defusion
Self as Context
Staying in the Present Moment
Acceptance
Committed Action
Practice Effects
Mastery

Skilled Encounters
Therapeutic Relationship
Therapy as Exposing
Accurate Empathy
Catharsis
Exposure
Agreement on Goals

Results

Right place right time: OA's experienced change as moderated by whether it was the right time and place for them to engage - in terms of their life circumstances, headspace, access to internal and external resources, and their expectations of therapy.

Therapy as the Catalyst: for new realisations (often underpinned by ACT-specific processes like Self as Context and Cognitive Defusion), behavioural changes (underpinned by Committed Action and reinforced with practice effects), and an increase in confidence (underpinned by mastery, exposure and practice effects).

Skilled Encounters: OAs experienced their therapists as skilled, but the therapy as exposing but cathartic. They experienced aspects of the therapeutic relationship as underpinning how skilled these encounters felt.

Discussion

This study answered a call for qualitative research into ACT change processes, and for an established literature gap of older adults. Although some results were unsurprising, they did not map too closely to the Change Interview and some were new insights.

These results provide qualitative and experiential support for the theoretically proposed mechanisms of change for ACT and it's transdiagnostic nature. Results suggests some areas to try to optimise ACT for OAs such as in stabilisation work or maximising social capital to ensure it is a better place and time to engage in therapy. This might be an area for future research and intervention.

Findings align with other qualitative studies but add greater experiential depth, and in the context of OAs.

References: Petkus, A. J., & Wetherell, J. L. (2013). Acceptance and commitment therapy with older adults: Rationale and considerations. *Cognitive and Behavioral Practice, 20*(1), 47–56. https://doi.org/10.1016/j.cbpra.2011.07.004
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Elliott, R. (2006). *New version of client change interview schedule* (IPEPPT Version, 12/06). http://pe-eft.blogspot.com/2006/12/new-version-of-client-change-interview.html
Jando, C., & Dionne, F. (2024). A call for qualitative research in Contextual Behavioral Science. *Journal of Contextual Behavioral Science.* https://doi.org/10.1016/j.jcbs.2024.100751