DIGITAL INTERVENTIONS FOR OLDER ADULTS WITH ANXIETY AND OLDER ADULT NARRATIVES OF SEEKING MENTAL HEALTH SUPPORT FOR ANXIETY FOR THE FIRST TIME

Submitted by Victoria Suzanne Williams, to the University of Exeter

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I certify that all material in this thesis which is not my own work has been identified and that no material has previously been submitted and approved for the award of a degree by this or any other University.

Signature: V. Williams

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SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

LITERATURE REVIEW

The effects and acceptability of digital psychological interventions for anxiety for older adults: a systematic review

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Abstract

Background: Older adults face several barriers to receiving mental health support, but with computer literacy increasing, it may be that online interventions could help older adults access support. This systematic review aimed to understand the effects of online psychological interventions in the management of anxiety in older adults and acceptability of these interventions.

Method: A systematic review and narrative synthesis was carried out based on PRISMA-P guidelines. Articles were identified from five databases: PsycInfo, Embase, MEDLINE, Web of Science Core Collection and PubMed Central. Quality of studies was assessed using the Effective Public Health Practice Project's Quality Assessment Tool for Quantitative Studies.

Results: Eleven studies were included, made up eight studies of iCBT, one of app-based iCBT, one of mindfulness app and one of blended online/face-to-face ACT. This review found promise for the acceptability and effect of online interventions for older adults with anxiety. However, the current evidence base remains small, lacks methodological quality and specificity of acceptability measures.

Conclusions: It is challenging to draw strong conclusions about the effects of online interventions for older adults on anxiety or the acceptability of these interventions using the current evidence base. Future research using larger controlled studies and comprehensive measures of acceptability with diverse samples would be beneficial.

Introduction

This paper explores the current evidence for online interventions aimed at treating anxiety symptoms in older adults. With older adults facing several barriers to receiving mental health support, and computer literacy increasing (Pew Research Center, 2021), it may be that online interventions help to increase numbers of older adults accessing mental health support. This UK-based review therefore looks at the current evidence for the effects of online interventions on anxiety symptoms, the acceptability of these interventions in an older adult population and the quality of the current literature.

Experiencing anxiety in older age is common, affecting around 1 in 20 older adults (Bryant et al., 2008; Royal College of Psychiatrists, 2018). Recent figures found that levels of anxiety in older adults increased from 9.4% to 10.9% during the first year of the COVID-19 pandemic in England, where women were more affected than men (Zaninotto et al., 2022). Common signs of anxiety include: excessive worry, difficulty concentrating, irritability and sleep disturbances (Yagudayeva et al., 2019). However, in older adults, symptoms of anxiety may present or be reported differently by older adults compared to younger adults. For example, older adults may endorse fewer symptoms compared to younger adults, and be more likely to report somatic symptoms like feeling dizzy or faint, or gastrointestinal upset (Miloyan et al., 2014). Nevertheless, the impact of anxiety in later life can be profound. Anxiety has been associated with increased disability, diminished wellbeing, cognitive impairment and low mood (de Beurs et al., 1999; Lenze et al., 2005; Rozzini et al., 2009). If not treated, anxiety can last for years (Lenze et al., 2005).

Fortunately, evidence suggests that psychological interventions to treat anxiety are as effective in older adults as working age populations (Kishita & Laidlaw, 2017). Overall,

effect sizes for outcomes of cognitive behavioural therapy (CBT) were not statistically significantly different between older people and working age adults (Kishita & Laidlaw, 2017). CBT has a good evidence base for supporting older adults (Hendriks et al., 2008; Laidlaw, 2015). A small but growing body of research suggests third wave interventions like mindfulness and acceptance and commitment therapy (ACT) may also be effective (Dissanayaka et al., 2016; Foulk et al., 2014; Petkus & Wetherell, 2013; Wetherell et al., 2011). It is therefore important that these types of interventions are easily accessible to older adults who are experiencing anxiety.

Guidelines from the National Institute for Health and Care Excellence suggest that support for conditions like generalised anxiety disorder should take a stepped approach to offer the least intrusive but most effective intervention first (National Institute for Health and Care Excellence, 2020). Low-intensity interventions, such as guided or unguided self-help should therefore be considered in the first instance for mild to moderate anxiety. In recent years, to increase the availability of mental health support, attention has turned to online interventions. These interventions are delivered via the internet and therapeutic tasks may be delegated to clients via their computer, smartphone or tablet device. Meta-analyses in working age adults have found online interventions to be effective and acceptable in treating anxiety (Eilert et al., 2021; Etzelmueller et al., 2020).

Given increasing computer literacy rates in older populations, online interventions may help lessen barriers older adults face when seeking mental health support such as the perceived stigma of seeing a therapist, valuing self-reliance, and mobility problems (Witlox et al., 2018). However, from a scoping review of systematic reviews in older adult populations, an in-depth review of online interventions for older adults with anxiety does

not appear to have been completed. Recent systematic reviews have looked at the effects of online interventions broadly on mental health disorder symptoms or specifically on depression in older adults, with mixed conclusions (Cremers et al., 2019; Dworschak et al., 2022; Xiang et al., 2020). These reviews have included few studies of anxiety interventions (Cremers et al., 2019; Dworschak et al., 2022) or have looked solely at one type of online administration (Grossman et al., 2020) or research design (Riadi et al., 2020). Yet, studies suggest that anxiety can be experienced alone without depression and that patients value anxiety being considered and recognised separately (Archer et al., 2021; Curran et al., 2020).

Many of these systematic review studies also did not look at the acceptability of online anxiety interventions for older adults. Acceptability has been described as a multi-faceted construct including elements like affective attitude, burden, perceived effectiveness, ethicality, intervention coherence, opportunity costs, and self-efficacy (Sekhon et al., 2017). Acceptability and participant satisfaction are important aspects of determining intervention effectiveness. Acceptability of online interventions is especially important to consider for older adults as previous studies have found a mistrust in online interventions, concerns about the technological skills needed to use an online intervention, or a feeling that online interventions may be inferior to face-to-face interventions all served as potential barriers to support (Gaudreau et al., 2015; Pywell et al., 2020).

Given the importance of treating anxiety, the potential benefits of online interventions and the paucity of reviews investigating online interventions for older adult with anxiety, this review therefore aimed to further understanding in this area and offer recommendations to future clinical practice and research.

Aim

To understand the effects of online psychological interventions in the management of anxiety in older adults and acceptability of these interventions.

Objectives

1. To identify and describe studies testing the effects on anxiety symptoms and acceptability of online psychological interventions for anxiety in older adults.
2. To describe the quality of published studies testing online psychological interventions for anxiety in older adults.
3. To make recommendations for clinical practice and research, based on the findings of objectives 1-2.

Methods

Design

This systematic review and narrative synthesis of research findings was designed and reported using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA-P) guidance (Moher et al., 2015).

Eligibility criteria

Participants

While National Health Service older adult services are constructed as being for adults aged 65 years or older, research for older adults often includes adults aged 60 years or older. Therefore, studies including adults with an average participant age of 60 years or

older were included. Participants were not required to have a diagnosis of an anxiety disorder.

Interventions

Studies investigating digital psychosocial interventions to treat symptoms of anxiety were included e.g. internet-delivered CBT (iCBT). Digital interventions were defined as using technology in their delivery remotely, such as the internet, computers, mobile devices including smartphones and tablets, and mobile applications ('apps'). Studies where there was contact with a health professional during the intervention were included, where the digital intervention formed more than half the sessions. Interventions could be underpinned by any psychological model and be of any duration.

Comparisons

Due to the limited research on digital interventions for older adults, eligible studies were not excluded based on whether they had a comparison group or not. For studies with a comparison group, to capture effectiveness of any condition, treatment-as-usual, no treatment, and other interventions were included.

Outcomes

The primary outcome for this review was anxiety symptoms. Studies had to include a measure of anxiety symptoms, such as clinical interview or self-report measure. Studies were not excluded based on timing of the outcome assessment.

Studies were also required to measure acceptability of their intervention. As acceptability is seen as a multi-faceted construct, measurement of acceptability could therefore include any of the following: affective attitude, burden, perceived effectiveness,

ethicality, intervention coherence, opportunity costs, and self-efficacy (Sekhon et al., 2017). Measurement of acceptability could be at any timepoint, to reflect prospective, concurrent or retrospective acceptability (Sekhon et al., 2017).

Study design

This review was open to both quantitative and qualitative research.

For describing the effects of interventions on anxiety symptoms, studies needed to include a comparison group as studies with a single group have an increased risk of bias and it is more challenging to determine effects of interventions (Kendall, 2003).

Studies used to describe acceptability of online interventions were not required to have a comparison group.

Report characteristics

Only published reports were included in this review to capture articles which had undergone the peer-review process and were more likely to follow reporting guidelines, thereby aiding assessment of study quality (Adams et al., 2017). Studies were required to be written in English and could have been published in any year. Letters, opinion pieces, chapters and reviews were excluded.

Information sources

Based on optimal database combinations and previous systematic reviews of mental health interventions for older adults (Bramer et al., 2017; Niclasen et al., 2019), the following electronic databases were searched from inception to 3rd March 2022:

- APA PsycInfo (via Ovid)
- Embase (via Ovid)

- MEDLINE (via Ovid)
- Web of Science Core Collection
- PubMed Central

The reference lists of included papers were hand-searched and forward citation tracking was conducted using Google Scholar.

Search strategy

The electronic searches included article titles, abstracts and key words using the following structure: [Older adults] AND [Anxiety] AND [Digital intervention]. A full example search strategy is available in the appendices.

Table 1.

Search Terms

Older adults	Anxiety	Digital intervention
Older adult	Anxiety	Online intervention
Elderly	Anxious	Online therapy
Elder	Worry	Online treatment
Geriatric		Web-based
Senior		Internet-delivered
Later life		Internet-based
		Virtually-delivered
		App-delivered
		iCBT
		Blended

Data management

Records were managed during this systematic review using Mendeley Desktop version 1.19.8.

Study selection

To aid sensitivity, initial screening of paper titles and abstracts included papers potentially meeting the following criteria:

- Study explored a digital intervention for anxiety
- Participants in the study potentially included adults aged 60 years or older

Using the below exclusion criteria, full text papers were then reviewed.

- Participants' average age is less than 60 years old
- The intervention is not delivered in a digital format for more than half the intervention
- Study does not include any measure of anxiety symptoms or intervention acceptability
- The paper is a review, opinion piece, chapter or letter

Two raters, both trainee clinical psychologists, reviewed the final set of full-text papers. Each rater made an independent decision about whether they should be included in the review. Inter-rater reliability was calculated as 100%.

Data collection process

An electronic form was created to record and collate relevant data from the included papers. Data items included were based on the Cochrane data collection form for randomised controlled trials (RCTs) and non-RCTs (Higgins et al., 2022).

Study risk of bias assessment

Study risk of bias was assessed using the Effective Public Health Practice Project's Quality Assessment Tool for Quantitative Studies (EPHPP; Thomas et al., 2004). This tool rates study quality as either strong, moderate or weak and assesses: selection bias, study design, confounders, blinding, data collection methods, withdrawals and dropouts, intervention integrity and analyses (see appendix A). The EPHPP was used as it can assess randomised controlled trials, non-randomised controlled trials, and pre-post studies, all of which are commonly used in research of psychological interventions. In comparison to other risk of bias tools, the EPHPP has good inter-rater reliability, content validity and construct validity (Armijo-Olivo et al., 2012; Thomas et al., 2004). A second rater reviewed three of the included papers for risk of bias and ratings were discussed between the two raters, finding agreement.

Synthesis methods

Due to the heterogeneity of studies exploring digital interventions for older adults, a meta-analysis of results did not appear to be feasible at present (Valentine et al., 2010). This systematic review therefore forms a narrative synthesis of the literature in this area, focusing on: study and intervention characteristics, effects on anxiety of the interventions, intervention acceptability, and methodological quality of the included studies. Information about the study design and interventions were tabulated to aid comparisons.

Elements of online interventions were compared, focusing on: therapeutic model, mode of administration and clinician contact time. The evidence for CBT being effective with older adults has been well established however other models have a growing evidence base (Dissanayaka et al., 2016; Foulk et al., 2014; Hendriks et al., 2008; Laidlaw, 2015; Petkus &

Wetherell, 2013). This review therefore examined whether there were any similarities or differences between therapeutic models in online interventions. The evidence base for online interventions delivered via smartphones is growing and apps may have advantages such as being able to link with calendars or measuring information in real-time (Firth et al., 2017). This review therefore examined modes of administration such as computers and smart devices. Clinician contact time was important to consider as previous evidence has mixed results as to the effectiveness of differing contact levels (Andersson & Titov, 2014). Moreover, the level of clinician contact time may impact the cost of treatment.

Findings

Study selection and characteristics

Of 487 unique records identified, 10 papers were eligible for review and 1 paper was added from forward citation tracking. These papers represented 11 unique studies, one of which used secondary data combined with novel data. The papers represented 1,755 individual participants, 219 of whom were part of a control group and did not take part in an online intervention for anxiety.

Figure 1.

PRISMA Flowchart

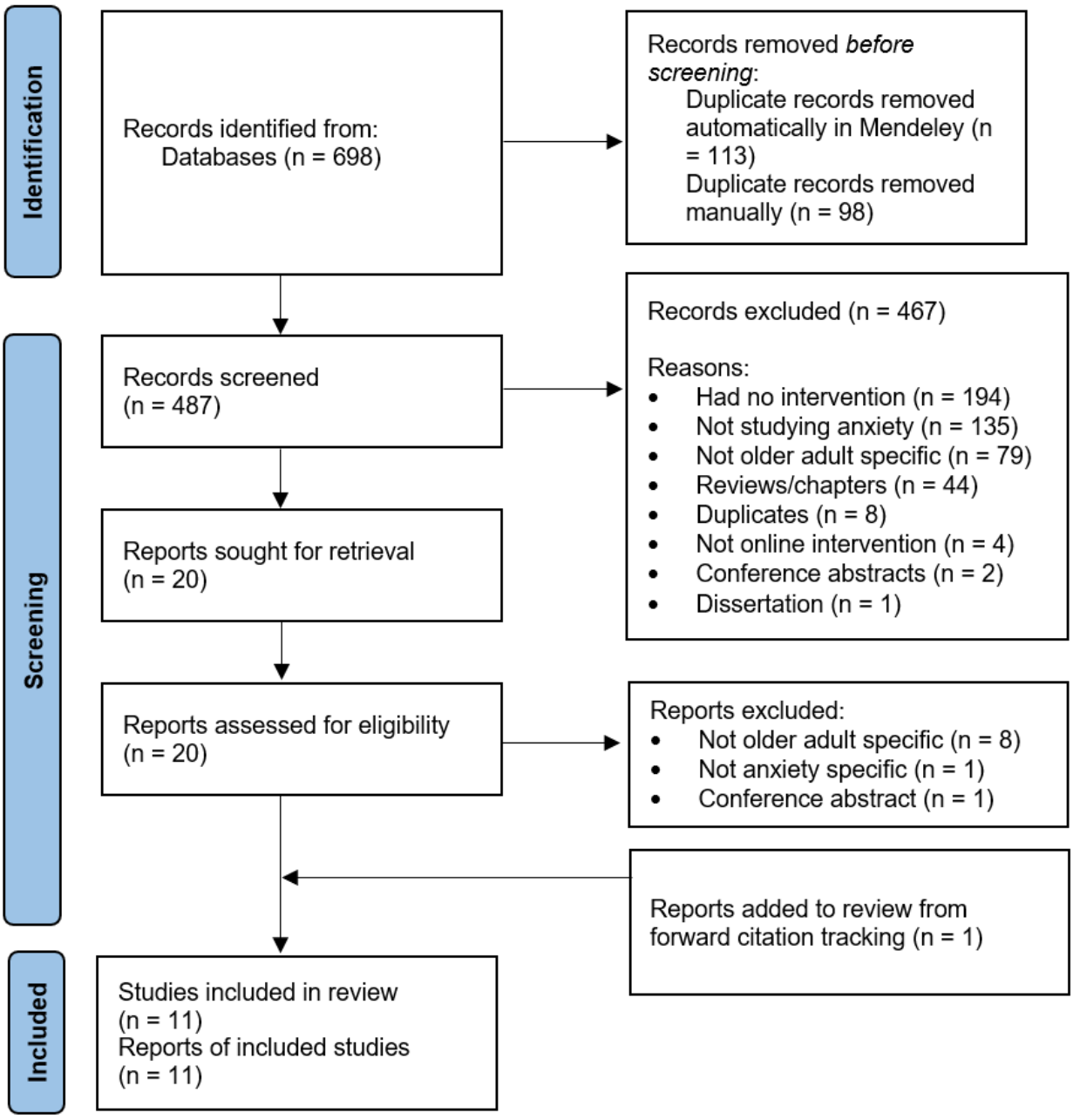

Table 2.

Studies included in narrative synthesis.

No.	Authors & (Publication Year)	Paper title
1	Dear et al. (2015 A)	Examining self-guided internet-delivered cognitive behaviour therapy for older adults with symptoms of anxiety and depression: Two feasibility open trials
2	Dear et al. (2015 B)	Clinical and cost-effectiveness of therapist-guided internet-delivered cognitive behaviour therapy for older adults with symptoms of anxiety: a randomized controlled trial
3	Hobbs et al. (2017)	Integrating iCBT for generalized anxiety disorder into routine clinical care: Treatment effects across the adult lifespan
4	Jones et al. (2016)	A randomized controlled trial of guided internet-delivered cognitive behaviour therapy for older adults with generalized anxiety
5	Kozlov et al. (2022)	The feasibility, acceptability, and preliminary efficacy of an mHealth mindfulness therapy for caregivers of adults with cognitive impairment
6	Silfvernagel et al. (2018)	Individually tailored internet-based cognitive behaviour therapy for older adults with anxiety and depression: a randomised controlled trial
7	Staples et al. (2016)	Internet-delivered treatment for older adults with anxiety and depression: implementation of the Wellbeing Plus Course in routine clinical care and comparison with research trial outcomes
8	Titov et al. (2016)	Treating anxiety and depression in older adults: randomised controlled trial comparing guided v. self-guided internet-delivered cognitive-behavioural therapy
9	Witlox et al. (2021)	Blended Acceptance and Commitment Therapy Versus Face-to-face Cognitive Behavioural Therapy for Older Adults With Anxiety Symptoms in Primary Care: Pragmatic Single-blind Cluster Randomized Trial
10	Ying et al. (2021)	Internet-based cognitive behavioural therapy for psychological distress in older adults without cognitive impairment living in nursing homes during the COVID-19 pandemic: A feasibility study
11	Zou et al. (2012)	Brief internet-delivered cognitive behavioural therapy for anxiety in older adults: a feasibility trial

Description of studies

Study findings are discussed here using number references from Table 2.

Six of the studies included in this review were conducted in Australia, one in the Netherlands, one in Canada, one in China, one in Sweden and one in the USA. Included papers were published between 2012 and 2021 (see Table 3).

Population

The mean age of participants ranged from 62 to 73 years. Between 61% to 95% of participants in the included studies were female. Only Study 1's sample was made up of more male participants (52%).

Only Studies 5 and 9 reported any information about the race or ethnicity of participants, although seven studies required participants to be residents of the research group's country (Studies 1, 2, 4, 7, 8, 10 and 11). Study 9 reported 98% of their sample's country of birth being the Netherlands (2021) and required participants to have a mastery of the Dutch language. Study 5 described the majority of their sample as non-Hispanic white (65%), Hispanic (15%), or African American (13.3%).

Inclusion criteria between studies was similar in many ways. Eight studies required participants to be aged 60 years or older (Studies 1, 2, 4, 6, 7, 8, 10 and 11). Study 9 recruited participants aged between 55 and 75 years. Study 3 recruited adults aged 18 years or older but subdivided participants into age groups including '60 years and over'. Study 5 recruited participants aged 21 years or older, who were caregivers of people with dementia, but found an average age of 62 years in their sample (representative of this population of caregivers who tend to be older (Wimo et al., 2013).

Eight studies required participants to have at least mild symptoms of anxiety (Studies 4, 6, 9, 10 and 11) or for their primary complaint to be of anxiety (Studies 2, 7 and 8), assessed through scores on the Generalised Anxiety Disorder Assessment (GAD-7; Spitzer et al., 2006), clinical interview, or self-report. Only studies 9 and 10 specified excluding participants if they had a severe anxiety score on the GAD-7. All studies, except study 5 (which did not report exact figures), reported an average pre-treatment anxiety symptom score within the mild to moderate range. Studies 7 and 8 specified including participants who scored in the severe range for anxiety, including 25% and 18% of their participants respectively.

Several studies excluded participants with severe symptoms of depression or expressed suicidal ideation (Studies 2, 3, 4, 7, 8, 9, 10 and 11; 47 participants reported as excluded across studies), had a diagnosis of a psychotic disorder or bipolar disorder (Studies 2, 3, 4, 7, 9, 10 and 11; 8 participants reported as excluded across studies), or were dependent on drugs or alcohol (Studies 2, 3, 4, 6, 9, 10 and 11; 2 participants reported as excluded across studies). Study 4 did not specify participant numbers excluded and Study 6 reported 13 participants were excluded but did not give reasons why.

Only two studies reported rationales for exclusion criteria. Study 3 recommended exclusion criteria to prescribing professionals as reasons participants were unlikely to benefit from iCBT. Study 7 reported that in the clinical group, participants were excluded if their clinical presentation indicated they required an in-person assessment.

Intervention

Nine of the study interventions included in this review were based on cognitive behavioural therapy (Studies 1, 2, 3, 4, 6, 7, 8 , 10 and 11), Study 9 was based on acceptance and commitment therapy and Study 5 on mindfulness therapy.

Of the eight interventions tested, five reported adapting their intervention to an older adult audience, for example, by including age-appropriate case examples. See Table 3 for details.

Nine interventions were website-based (Studies 1, 2, 3, 4, 6, 7, 8, 9, and 11). Study 5 and Study 10 used mobile apps. There were varying levels of clinician contact between interventions, from full automation (Study 3), to a blended approach to intervention where participants completed nine sessions online and four face-to-face sessions with a mental health counsellor (Study 9). Study 8 investigated differences in outcomes between differing clinician contact levels.

Seven of the studies included an intervention specifically for anxiety (Studies 1, 2, 3, 4, 5, 9 and 11) and four studies included an intervention designed to treat both anxiety and depression (Studies 6, 7, 8, and 10).

Included study interventions were conducted between 5 to 14 sessions and lasted for between 5 to 12 weeks.

Table 3.

Description of interventions in included studies

First Author and Year	Intervention content	Mode of administration	Therapeutic model	Number of sessions	Duration of intervention	Symptom targeted by intervention	Clinician contact time and clinician profession
Dear et al. (2015 A)	*Managing Stress and Anxiety* Course Primary skills taught: symptom identification, symptom formulation, thought monitoring, thought challenging, controlled breathing, activity scheduling, graded exposure, relapse prevention. Additional resources about: sleep hygiene, assertiveness skills, problem solving and communication skills. Didactic lessons including homework. Adapted to older adults: included age-appropriate vignettes and examples of skills.	Website	CBT	5	8 weeks	Anxiety	5-10 minutes weekly contact with therapist; on telephone or via email-type system. Regular automatic reminder emails and notifications. Clinical psychologist.
Dear et al. (2015 B)	*Managing Stress and Anxiety* Course (as above)	Website	CBT	5	8 weeks	Anxiety	5-10 minutes weekly contact with therapist; on telephone or via email-type system. Regular automatic reminder emails and notifications. Clinical psychologist.
Zou et al. (2012)	*Managing Stress and Anxiety* Course (as above)	Website	CBT	5	8 weeks	Anxiety	Weekly telephone call or secure email with therapist. Clinical psychologist.
Hobbs et al. (2017)	*This Way Up iCBT* Included: psychoeducation, arousal reduction skills, cognitive restructuring (including metacognitive restructuring), problem solving, graded exposure, relapse prevention and assertiveness skills.	Website	CBT	6	12 weeks	Anxiety	Fully automated although prescribing clinicians were encouraged to contact patients after first two lessons to provide support and promote adherence. Prescribing clinicians included: general practitioners, psychiatrists, clinical psychologists, and allied health professionals.

	Didactic lessons including homework. Not adapted for older adults: included fictional character aged in mid thirties-forties.						
Jones et al. (2016)	*GAD Online for Older Adults* Included: psychoeducation, enjoyable activity scheduling, relaxation training, thought monitoring, thought challenging, controlling worry strategies, worry exposure and worry behaviour prevention, problem solving, sleep hygiene. Didactic lessons including homework. Adapted to older adults: reduced number of modules to encourage timely completion, tailored examples and content to older adult audience (e.g. included health worries), and added detailed instructions of how to use website.	Website	CBT	7	10 weeks	Anxiety	Therapist emailed participants once weekly to respond to homework and questions. Phoned by therapist is inactive on website for seven or more days. Clinical psychologist.
Silfvernagel et al. (2018)	Individually-tailored iCBT Modules for everyone: an introduction and relapse prevention Optional modules for therapists to prescribe: cognitive restructuring, panic disorder, agoraphobia, generalised anxiety, social anxiety, behavioural activation, applied relaxation, stress, mindfulness, problem solving, sleep habits. Didactic lessons including homework. Adapted to older adults: content tailored e.g. age of people in examples adjusted and removed activities that referred to having small children.	Website	CBT	6-8	8 weeks	Anxiety and depression	Therapist guidance throughout treatment via secure platform. Feedback on homework given within 24 hours. Client or therapist could initiate contact. Not known.

Staples et al. (2016)	*Wellbeing Plus* Course Primary skills taught: symptom identification, symptom formulation, thought monitoring, thought challenging, controlled breathing, activity scheduling, graded exposure, relapse prevention. Didactic lessons including homework. Adapted to older adults: included case-enhanced stories based on older adults, based on principles and skills tested in older adults to reduce mental health disorder symptoms previously.	Website	CBT	5	8 weeks	Anxiety and depression	Clinic group: clinicians attempted weekly contact via telephone or email to provide guidance on completing course. Psychologist, provisional psychologist in training, indigenous mental health worker, or counsellor. Research group: sample from Titov et al. (2016) analysed as one group as results showed level of clinician contact did not affect outcomes. Clinical psychologist.
Titov et al. (2016)	*Wellbeing Plus* Course (as above)	Website	CBT	5	8 weeks	Anxiety and depression	Three levels of contact: i) 10-20 minute telephone interview with clinician and 10-15 minute weekly contact with clinician during treatment via telephone or email ii) 10-20 minute telephone interview with clinician iii) no contact with a clinician unless symptoms became more severe. Clinical psychologist.
Ying et al. (2021)	*Health Psychological Station* program Included: psychoeducation, understanding cognition and link to emotions, behavioural activation, thought challenging, problem solving strategies. Didactic lessons including homework. Adapted to older adults and culture: lessons and case stories developed with consultation of Chinese patients (most 55 years old or older) with history of depression and anxiety.	WeChat mini-program	CBT	5	5 weeks	Anxiety and depression	Online communication with clinicians who answered questions about the treatment, provided technical assistance, and encouraged use of the program. Clinical psychologist.

Kozlov et al. (2021)	*Mindfulness Coach* Includes: psychoeducation, guided meditations, and seated practices. Not adapted for older adults: orientation to app developed to be specific to caregivers of older adults with dementia.	iOS and Android app	Mindfulness	14 sequential levels and "practice now" area	8 weeks	Anxiety	Orientation session to app (in person pre-COVID and via telephone post-COVID) and 1-week booster phone call to troubleshoot app use problems. Master's level research assistant.
Witlox et al. (2021)	*Living to the Full* course Online lessons focused on: negative consequences of their attempts to control or reduce unwanted thoughts and feelings, tools to be more accepting of internal experiences, identifying core values and steps towards living by these values. Face-to-face sessions focused on: introduction to the online modules, repeating key exercises from online lessons, increasing motivation, evaluating progress and discussing potential problems. Not reported to adapt intervention to older adults.	Website	ACT	9 online, 4 in-person	9 – 12 weeks	Anxiety	4 face-to-face sessions with mental health counsellor at a general practice. Counsellors could not provide web-based feedback but could monitor client web-based progress. Mental health counsellor based in general practice.

Comparators

Six of the 11 studies included a comparison. Five studies were randomised trials: Studies 2 and 4 included waitlist control groups, Study 6 included a control group who received weekly support emails, Study 8 investigated three differing levels of clinician contact, and Study 9 used a face-to-face CBT intervention as comparison. Study 7 included secondary data from Study 8 combined with novel data, to compare the same intervention between research and clinic conditions.

Studies 1, 5, 10 and 11 were repeated measures single-condition analyses. Study 3 compared a group of older adults with other adult age groups across the lifespan.

Outcomes

Nine studies used the Generalised Anxiety Disorder Assessment (GAD-7; Spitzer et al., 2006) to measure anxiety symptoms (Studies 1, 2, 3, 4, 7, 8, 9, 10 and 11). Study 6 used both the GAD-7 and Beck Anxiety Inventory (Beck et al., 1988). Study 5 used the Hospital Anxiety and Depression Scale – Anxiety Subscale (Zigmond & Snaith, 1983). Five studies used the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998) to assess baseline anxiety (Studies 1, 2, 4, 8, and 9). The outcome measure, GAD-7, has been found to be valid and reliable (Löwe et al., 2008; Plummer et al., 2016; Wild et al., 2014). However mixed evidence has been found for the psychometric quality of the BAI and HADS-A (Atchison et al., 2022; Djukanovic et al., 2017; Gould et al., 2013; Therrien & Hunsley, 2012).

Eight studies measured anxiety before and after intervention (Studies 2, 3, 4, 6, 7, 9, 10, and 11). Six studies included follow-up to explore longer-term change after intervention

(Studies 2, 4, 7, 9, 10 and 11). Studies 5 and 9 measured anxiety throughout the intervention.

Acceptability of interventions was measured or indicated in multiple ways throughout the included studies. Six studies asked participants two questions: 1) whether they would feel confident recommending the course and 2) whether they felt the course was worth their time (Studies 1, 2, 7, 8, 10 and 11).

Three studies used different measures to explore intervention acceptability: the Credibility/Expectancy Questionnaire and Anxiety Change Expectancy Scale (Study 4; Devilly & Borkovec, 2000; Dozois & Westra, 2005; Mertens et al., 2017); the Client Satisfaction Questionnaire 8 (Study 9; Attkisson & Greenfield, 2004; De Wilde & Hendriks, 2005); and a scale including items about accessibility of the app and experiences using it (Study 5; Davis, 1989).

Most measures of acceptability were completed after intervention, except for measures looking at expectancy. Two studies, 3 and 6, did not formally measure acceptability but included information about treatment completion, which will be described below as a tentative indication of intervention acceptability.

Risk of bias in individual studies

Using the EPHPP assessment, studies were rated as having a mixed methodological quality from moderate to weak (see Table 4). Three studies were rated as having moderate quality and the other eight were rated as having weak quality. While this high amount of weak quality studies may have reflected the early phase of research into online interventions for older adults, it is also possible it reflects the stringency of the EPHPP which rated studies as weak if they scored weak on two or more domains.

One of the most common methodological issues was selection bias where many studies recruited participants by advertisements, leading to a self-selecting sample. While responding to study advertisements may reflect real-world settings where people could actively seek out mental health support for anxiety, the participants in these studies may have been those who felt more comfortable accessing support, therefore inflating levels of effectiveness or satisfaction.

Another common methodological issue was related to blinding. In many studies it was unclear if participants knew the research question when taking part and studies used self-assessed outcomes. Studies 4 and 9, rated as having moderate risk of blinding bias, explicitly reported the eligibility assessors being blinded to participant allocation.

All studies received a strong rating for data collection methods due to using outcome measures with some evidence of validity and reliability.

Table 4.

Methodological quality of included studies using the EPHPP Quality Assessment Tool

Authors/year	Selection Bias	Study Design	Confounders	Blinding	Data Collection Method	Withdrawals and Dropouts	Global Quality Rating
Hobbs et al. (2017)	2	2	1	3	1	2	Moderate
Jones et al. (2016)	3	1	1	2	1	1	Moderate
Witlox et al. (2021)	2	1	1	2	1	3	Moderate
Dear et al. (2015 A)	3	3	3	3	1	3	Weak
Dear et al. (2015 B)	3	1	1	3	1	1	Weak
Kozlov et al. (2021)	2	3	3	3	1	1	Weak
Silfvernagel et al. (2018)	3	1	1	3	1	2	Weak
Staples et al. (2016)	3	2	3	3	1	3	Weak

Titov et al. (2016)	3	1	1	3	1	1	Weak
Ying et al. (2021)	3	3	3	3	1	2	Weak
Zou et al. (2012)	3	3	3	3	1	1	Weak

Quality Ratings: 1=Strong, 2=Moderate, 3=Weak

Table 5.

Description of included studies and anxiety outcomes

First Author, Year & Country	Study design	No. of participants / *% attrition*	Participant demographics	Comparison group	Anxiety outcome measures	Anxiety outcomes	Effect size
Dear et al. (2015 B) Australia	Randomised controlled trial	72 participants (35 in treatment group, 37 in waitlist control) *13% attrition (n=9)*	Mean age approx. 65 years 39% male	Waitlist control	GAD-7	Treatment group had significantly lower anxiety symptoms than the control group at post-treatment. Anxiety symptoms were significantly lower at post-treatment and all follow ups compared to pre-treatment in the treatment group.	1.43 1.73
Silfvernagel et al. (2018) Sweden	Randomised controlled trial	66 participants (33 in treatment group, 33 in control group) *23% attrition (n=15)*	Mean age 66 years 24% male	Control group received weekly email support from a clinician	Beck Anxiety Inventory (BAI) and GAD-7	Moderate between-group effect on the BAI, favouring the treatment group. Moderate between-group effect on the GAD-7, favouring the treatment group. Average improvement on the BAI in the treatment group was 45.1% compared with 14.7% in the control group.	0.50 0.67
Jones et al. (2016) Canada	Randomised controlled trial and repeated-measures waitlist control group	46 participants (24 in treatment group, 22 in waitlist control) *11% attrition (n=5)*	Mean age approx. 65 years 13% male	Waitlist control	GAD-7	Each group experienced significant reductions in anxiety symptoms over the time of the study, however, the iCBT group experienced symptom reductions at a faster rate. The iCBT group experienced a significant reduction in anxiety symptoms between post-treatment to 1-month follow-up. WLC control participants who received iCBT afterwards, had a significant reduction in anxiety symptoms from post-waitlist to post-treatment, and a non-significant reduction in anxiety symptoms from post-treatment to 1-month follow up.	0.85 0.91 2.05
Witlox et al. (2021) Netherlands	Randomised controlled trial	314 participants (150 in treatment group, 164 in control group) *55% attrition (n=174)*	Mean age 63 years 39% male	Control group given 4 face-to-face CBT intervention sessions and homework	GAD-7	Both groups had significant decreases in anxiety symptoms from assessment to post-treatment (3 months after assessment), significant increases in symptoms from post-treatment to 6-month follow-up and did not change significantly from post-treatment to 12-month follow up.	0.02 0.15 0.08
Titov et al. (2016) Australia	Randomised trial	459 participants (158 in clinician-guided with interview group, 147 in self-guided with interview group, 154 in self-guided without interview group) *12% attrition (n=55)*	Mean age 66 years 36% male	Groups with different levels of support: clinician-guided with interview (iCG), self-guided with interview (iSG), self-guided without interview (SG).	GAD-7	All groups reduced their anxiety symptoms from assessment to post-treatment and from post-treatment to 3-month follow-up.	Clinician-guided with interview: 1.33, 1.57. Self-guided with interview: 1.36, 1.47. Self-guided

							without interview: 1.29, 1.50.
Staples et al. (2016) Australia	Repeated measures group compared with data from a previous study[b]	949 participants (433 in research group[b], 516 in clinic group) *30% attrition (n=288)*	Mean age 66 years 39% male	Same intervention administered in clinic group versus research group	GAD-7	Both groups showed a significant decrease in anxiety symptoms from assessment to post-treatment and assessment to 3-month follow up.	1.4 1.6
Hobbs et al. (2017) Australia	Repeated measures (participants grouped by age in analysis)	942 participants (111 in 60+ years group) *53.18% attrition (n=501)*	Mean age not reported 31% male	Other age groups completing same intervention: 18-29 years, 30-39 years, 40-49 years, 50-59 years.	GAD-7	Each age group experienced significant reductions in anxiety symptoms with treatment, including the +60 years group.	1.01
Dear et al. (2015 A) Australia	Repeated measures single group	27 participants[a] *33% attrition (n=11)*	Mean age 65 years 52% male	None	GAD-7	Significant improvement in anxiety symptoms from pre-treatment to post-treatment, but not from post-treatment to 3-month follow up.	0.99
Kozlov et al. (2021) USA	Repeated measures single group	61 participants *5% attrition (n=3)*	Mean age 62 years 5% male 65% non-hispanic white, 15% Hispanic, 13.3% african american, 5% asian/pacific islander, 1.67% multiracial	None	HADS-A	Anxiety symptoms significantly decreased over the study timeframe. More time spent using the app was associated with decreases in anxiety symptoms.	-
Ying et al. (2021) China	Repeated measures single group	137 participants *31% attrition (n=42)*	Mean age 73 years 32% male	None	GAD-7	Anxiety symptoms decreased significantly from pre- to post-treatment and pre-treatment to follow-up.	1.71 1.27
Zou et al. (2012) Australia	Repeated measures single group	22 participants *5% attrition (n=1)*	Mean age 66 years 32% male	None	GAD-7	Anxiety symptoms decreased significantly from pre-to post-treatment. There were no significant changes in anxiety symptoms between post-treatment and 3-month follow-up.	1.65

[a] – study investigated waitlist control groups for anxiety and depression. Only anxiety waitlist control group described here.

[b] – research group data taken from Titov et al. (2016)

Effects of online interventions on anxiety

Of studies included in this section, four were rated poor in methodological quality (Studies 2, 6, 7 and 8) and two studies were rated moderate (Studies 4 and 9).

All studies investigating iCBT were website-based and found a significant reduction in anxiety symptoms from pre-treatment to post-treatment (Studies 2, 4, 6, 7 and 8). Of these studies which included a waitlist control group or usual care, the online intervention had either significantly lower anxiety symptoms at post-treatment compared to the control (Study 2), or anxiety symptoms reduced at a faster rate (Studies 4 and 6), with medium to large effect sizes.

These controlled studies of iCBT also found clinically significant changes in treatment groups. Study 2 found greater proportions of reliable improvement and recovery on the GAD-7 in their treatment group compared to waitlist control. Similarly, Study 4 found more iCBT participants had a GAD-7 score below 10 at post-treatment compared to the control group. However, the proportion that improved at least 30% did not reach statistical significance between groups in Study 6. Compared to Studies 2 and 4, Study 6 used a comparison group of weekly email support rather than waitlist control, which potentially represented supportive non-directive therapy. Moreover, Study 6 tested individualised iCBT for both anxiety and depression, and with clinician guidance being offered as and when needed, meaning each participant experienced a different set of sessions and anxiety outcome measures may not have been tailored to individual mental health goals. In comparison, Studies 2 and 4 were manualised, solely for anxiety, and included weekly support.

Studies 7 and 8, which compared the same intervention, web-based iCBT, across different referral settings and with differing clinician contact time, found no significant differences in the reduction of anxiety symptoms between conditions. Their findings suggest their intervention was translatable to public health settings and clinician contact during treatment may not be necessary to achieve a reduction in anxiety. Nevertheless, caution should still be given when interpreting these results. Both studies were rated as methodologically weak, both due to selection bias and results being reliant on self-report. Study 7 also reported their clinic setting was very specialised and well supported to deliver online treatment, meaning that it might not generalise to other clinic resources. They included participants with severe symptoms of anxiety, which is not usual for low intensity or internet-delivered interventions, but may have been more possible for a well-equipped clinic. Further research to compare these settings and clinician contact time would be beneficial.

Study 9 investigated an ACT intervention with a CBT intervention in a study rated as having moderate methodological quality. This study found both groups experienced significant decreases in anxiety symptoms from pre-treatment to post-treatment and the between-group effect sizes for these changes were very small. Moreover, symptom reduction was maintained in both groups at 12-months follow-up. Their results suggest that blended ACT was just as effective as face-to-face CBT. Again, the generalisability of these results should be read with caution as there was a very low level of uptake to the study, high dropout, and the participants represented a small subset of individuals (e.g. most had middle to high education levels and those over age 75 years were excluded). It is possible that the resulting sample consisted of people who were highly motivated to take part in an

intervention. This sample was potentially more able to participate due to their age and education, rather than generalising to the wider population of older adults.

Overall, these findings suggest that web-based iCBT may effectively reduce symptoms of anxiety in comparison to a control group. However, the evidence for iCBT aiding clinically significant changes to anxiety compared to control is still mixed. Likewise, while initial evidence supports iCBT being translatable to public health settings and that intensive clinician contact may not be necessary for change, these findings must be interpreted with caution and further research would help to understand these factors better. Blended online/face-to-face ACT also appears to be as effective as face-to-face CBT but this finding may not be generalisable to the wider older adult population.

Table 6.

Description of acceptability outcomes in included studies

First Author, Year & Country	Acceptability outcome measures	Formal Acceptability Outcomes	Uptake	Adherence	Reasons for Withdrawal
Jones et al. (2016)	Credibility/expectancy questionnaire including 6 items assessing treatment expectancy (i.e. how much they thought they would improve by the end of the treatment) and credibility (i.e. how believable or convincing the treatment is). Anxiety Change Expectancy Scale. Higher scores indicate greater positive expectancy for changing anxiety (range = 20 – 100)	Credibility rated at 77.26% on average. Expectancy at 62.52% on average. Participants who rated credibility of the program higher at pre-treatment tended to decreased anxiety symptoms more quickly over the weeks. Average score on ACES was 79.96.	100% of eligible participants started intervention.	On average, participants completed 6.32 of 7 modules.	8% of participants withdrew from treatment after module 1.
Witlox et al. (2021)	Client Satisfaction Questionnaire-8	Treatment satisfaction was significantly higher in the ACT group than the CBT group, and the effect size of the difference was large (B=3.19, P<.001,d=0.78).	9% of participants did not receive ACT intervention due to no-show.	ACT group indicated adherence to all the prescribed elements for 80% of sessions.	45% of participants discontinued the intervention.
Kozlov et al. (2021)	Scale including items about accessibility of the app, participant experiences using the app, satisfaction items and willingness to recommend the app to other caregivers.	Participants reported the app was easy to use and helped them to feel calmer, learn new skills and reduce their stress. 96.5% agreed that most caregivers would benefit from using the app. 84.5% reported they were satisfied with the app.	13% of people who expressed initial interest in the study withdrew due to changing their mind about participation.	19% of participants completed all 14 levels and 20.1% only reached level 1.	2% of participants withdrew due to technical issues and time constraints.
Dear et al. (2015 B)	Treatment satisfaction question; Question about whether it was worth their time; Question about whether they would recommend it to a friend.	(n=28) 88% felt 'very satisfied' or 'mostly satisfied' with the course, 96% indicated it was worth their time, 96% indicated they would recommend it to a friend.	94% of eligible participants started intervention.	85% of participants completed the intervention.	6% of participants formally withdrew from the intervention due to 'insufficient time'.
Titov et al. (2016)	Participants asked: 1) would you feel confident in recommending this course? And 2) was it worth your time doing the course?	95% of iCG, 94% of iSG, and 91% of SG group responded they would recommend the course to others. 94% of iCG, 92% of iSG, and 95% of SG groups responded that the course was worth their time.	5% of eligible participants did not complete pre-treatment	79% completed lesson 5.	1% formally withdrew from the course.

		No significant differences between groups satisfaction rates.	questionnaires or start lesson 1.		
Staples et al. (2016)	Participants asked: 1) would you feel confident in recommending this course? And 2) was it worth your time doing the course?	Of those who completed the evaluation questions, 97.3% of the clinic group and 93.5% of the research group would recommend the course to a friend. 98.7% of the clinic group and 94.3% of the research group reported the course was worth their time. No significant differences between groups in treatment satisfaction.	6% of people eligible for the research trial did not complete pre-treatment questionnaires or start lesson 1.	84% of research group and 75% of clinic group completed all 5 lessons.	0.5% of participants in the research group and 13% of participants in the clinic group formally withdrew from the course.
Dear et al. (2015 A)	Treatment satisfaction question; Question about whether it was worth their time; Question about whether they would recommend it to a friend.	(n=22) 90% felt 'very satisfied' or 'mostly satisfied' with the course, 100% indicated it was worth their time, 95% indicated they would recommend it to a friend.	72% of eligible participants started intervention.	70% of participants completed the intervention.	7.4% of participants formally withdrew from the intervention due to 'insufficient time.'
Ying et al. (2021)	Participants asked: 1) would you feel confident in recommending this course? And 2) was it worth your time doing the course?	80% felt confident to recommend the mini-program to others. 87.62% reported it was worth their time.	7% of participants did not complete pre-treatment questionnaires, start lesson 1 or respond.	87.4% of participants completed all 5 lessons.	13% drop out.
Zou et al. (2012)	Question about whether it was worth their time; Question about whether they would recommend it to a friend.	100% reported they would recommend the program to a friend. 100% reported it was worth their time.		100% of participants completed the 5 lessons.	100% of participants completed the 5 lessons.
Silfvernagel et al. (2018)	No formal measure of acceptability.	-	12% of eligible participants did not complete the first module.	33% completed all prescribed modules within the treatment period. 55% completed 75% of the prescribed modules. 67% completed 50% of the prescribed modules.	33% dropped out at post-treatment assessment.
Hobbs et al. (2017)	No formal measure of acceptability.	-	-	59% of 60+ years group completed all 6 sessions. Patients aged 50 years and older and those who did not have a probable diagnosis of generalised anxiety disorder were more likely to complete treatment. Multivariate analyses showed that older age continued to be associated with adhering to treatment after controlling for pre-treatment probable GAD diagnoses.	-

Acceptability of online interventions

There appeared to be fairly high levels of participant satisfaction with online interventions across studies which measured acceptability in different ways. For example, between 80%-100% of participants reported they would feel confident to recommend their intervention to a friend, which included iCBT and mindfulness, and both apps and web-based interventions (Studies 1, 2, 5, 7, 8, 10, 11). However, due to the small number of studies and multiple ways of acceptability measurement, it is challenging to make direct comparisons between factors such as therapeutic model, mode of administration or clinician contact level.

When looking at levels of participant dropout, intervention uptake and adherence across studies as potential measures of acceptability, Studies 1, 3, 5, 6 and 9 appeared to have the least acceptability. However, it is difficult to determine how these participation levels were intervention or study dependent. Comparing studies with the highest levels of participant dropout (Studies 6 and 9) with those of least participant dropout (Study 8 and 11), it is possible that intervention studies with greater burden were more prone to drop out. Study 6 and 9 included a higher number of intervention sessions and higher number of outcome measures for participants to complete than Studies 8 and 11. Similarly, Study 5 which saw low levels of uptake and adherence for their mobile application intervention, included a sample made up of caregivers of adults with cognitive impairment, meaning participants may have already been busy. In comparison, Study 10, which also tested a mobile application, had higher levels of uptake but was tested in a sample of older adults living in nursing homes, meaning they may have been better supported to participate.

Study 1 and 3 reported lower levels of adherence and uptake compared to other studies. However, Study 1's sample consisted of waitlist control participants from Study 2, meaning that by the time they were delivered the intervention, they may have waited some time and perhaps did not feel a need or want for the intervention. Study 2 in comparison had high levels of uptake suggesting participants were more prepared to take part.

Study 3 tested a fully automated intervention, which was not specifically designed for older adults, potentially impacting the number of older participants willing to continue the intervention. Yet, Study 8 reported no significant differences of satisfaction or adherence between groups in their study of iCBT with differing clinician contact levels. Study 9, which also did not report adapting their blended ACT intervention to older adults, reported significantly higher levels of satisfaction than face-to-face CBT. However, Study 9s treatment satisfaction data were mainly derived from participants who had attended all the interventions face-to-face sessions. Thus, by using indirect measures of acceptability or measures which do not specify which elements of an intervention were acceptable, it is challenging to draw conclusions on the current literature of online interventions for older adults.

Overall, while all interventions appeared to show some acceptability, it is difficult to make systematic comparisons across therapeutic model or mode of administration due to confounding factors in current studies and a lack of consistent acceptability measurement. These findings therefore indicate a need for further research into the acceptability of online interventions for older adults with anxiety, focusing on qualitative feedback about the elements of interventions found to be most or least acceptable.

Discussion

This review synthesised the quantitative evidence to better understand the effects and acceptability of online psychological interventions for anxiety in older adults. Eleven papers were included. The methodological quality of the included studies was rated as mostly weak, with three studies being rated as having moderate quality. The findings of these studies are discussed with respect to effects on anxiety symptoms, acceptability of the interventions, methodological quality, and recommendations for future research.

Effectiveness

Overall, it appeared that website-based iCBT has promise in possibly reducing anxiety symptoms for older adults, but may have mixed evidence for contributing to clinically significant symptom change (Dear et al., 2015; Jones et al., 2016; Silfvernagel et al., 2018). This finding was similar to previous systematic reviews that supported the effectiveness of iCBT to reduce anxiety symptoms in working age-adults (Eilert et al., 2021; Etzelmueller et al., 2020). Yet, it contrasts with another recent meta-analysis exploring the impact of online interventions on general mental health disorder symptoms in older adults, which found no significant effect on anxiety (Dworschak et al., 2022). However, their meta-analysis also found a moderately high level of heterogeneity in the three studies they included, determining that a meta-analysis was perhaps not appropriate. This current review is therefore consistent with these findings in that a greater number of high-quality controlled studies is required to conclude the impact of online anxiety interventions for older adults.

Drawing conclusions about the mode of administration, therapeutic model type, and clinician contact time was also not possible with the current number and quality of

controlled studies. The only studies with a comparison group in this review tested website-based interventions and the two studies testing mobile applications were rated as methodologically weak (Kozlov et al., 2021; Ying et al., 2021).

One study investigating blended face-to-face/online ACT in comparison to face-to-face CBT found no significant difference between intervention outcomes (Witlox et al., 2021), suggesting that blended ACT may be as effective as CBT. However, their ACT intervention still involved four face-to-face sessions and their sample was less generalisable due to being highly educated and participants aged 75 year or older being excluded from the study. Given previous research in support of the use of ACT with older adults, further research to explore its use online with older adults would be pertinent (Delhom et al., 2022). ACT may be particularly relevant for older adults due to its focus on acceptance and values that allows space for unavoidable health problems and loss.

All controlled studies included in this review had some clinician guidance, meaning it is difficult to conclude the difference in effects between unguided and guided interventions. One study that randomised participants to different clinician guidance levels for the same iCBT intervention found no differences in effects between conditions (Titov et al., 2016). While some older adults express a preference for clinician guidance and view interventions without guidance as inferior, condensing the level of clinician input may contribute to greater cost-effectiveness. If current evidence suggests clinician input level does not impact intervention effectiveness, older adults could therefore be given a choice about their level of input, and clinician input level could be an area to explore further in research.

Acceptability

The acceptability of online interventions included in this review was reported to be generally moderate to high. However, many of these interventions' acceptability levels may have been impacted by factors not related to the intervention or its online delivery, including sample characteristics and high study burden. Previous research has also cited these factors as reasons for dropout (Eborall et al., 2011; Sanders et al., 2012). Some studies showed conflicting results, such as a high level of treatment satisfaction found for blended ACT, contrasting with high levels of participant dropout from the same intervention (Witlox et al., 2021). Moreover, almost all studies had a high risk of selection bias as participants responded to study advertisements to take part, meaning participants were potentially more motivated to take part in an online intervention, inflating acceptability findings.

It is also important to note that the studies varied greatly in how they measured acceptability and two studies provided no measure of acceptability at all. Several studies measurements of acceptability, like participant satisfaction, did not go into detail about which aspect of the intervention was acceptable to them. It is possible this reflects the broad definition of acceptability and the different factors that can contribute to acceptance of an intervention (Sekhon et al., 2017). Alternatively, it indicates a lack of consensus on how to measure acceptability of online interventions. However, it is crucial to examine acceptability of interventions for older adult populations as they may face several barriers to mental health support related to stigma and concerns about abilities to undertake treatment.

Sekhon and colleagues recommend the use of qualitative and quantitative tools to assess the multifaceted definition of acceptability from the Theoretical Framework of

Acceptability, throughout an interventions development (2017). They recently developed a questionnaire informed by theory, previous research and stakeholder input (Sekhon et al., 2022). This type of measure may therefore be useful in future research of online interventions for older adults. Moreover, it may be valuable to ensure that feedback on interventions is possible anonymously. None of the studies in this review reported strategies to blind researchers to participant acceptability feedback which may have led to participants feeling under pressure to appease researchers.

Strengths and Limitations

Strengths of this work include a systematic and comprehensive search across multiple databases and the use of two reviewers to independently assess eligibility and quality of studies.

The small number of studies and heterogeneity of research methods and online interventions meant it was not possible to conduct a meta-analysis (as concluded by previous systematic reviews too). Meta-analyses can help to draw conclusions about the effectiveness of interventions and therefore to provide recommendations to practice. This review was therefore unable to provide a conclusion about the effects of online interventions for anxiety in older adults. Nevertheless, single group studies can be helpful to determine the feasibility of interventions and trial designs, helping to decrease the likelihood of high attrition rates in later effectiveness studies (Blatch-Jones et al., 2018). It is therefore hoped that future research may be of a high quality for later systematic reviews.Only one study explicitly reported the race or ethnicity of participants, and one out of the 11 studies was conducted outside of the global west. In addition, the average age of participants across studies was between 62 and 73 years, not representing the oldest cohort

of adults. Given that accessibility to mental health interventions is related to intersectional cumulative disadvantage (for example race, age or wealth), it is important that studies investigating new interventions include a diverse sample of participants (Office for National Statistics, 2022).

Future Directions for Clinical Practice and Research

Due to findings of this review being generally inconclusive as to the effects and acceptability of online interventions for older adults, recommendations for clinical practice would be inappropriate.

However, this review can make recommendations for directions to future research. Using evidence from the current evidence base and trial designs, it would be pertinent to test online interventions with older adults in a larger scale study using a control or comparison group, for example online interventions compared to face-to-face interventions. Studies may build on the evidence for iCBT and online ACT in older adults. New research should also include more comprehensive measures of acceptability, including qualitative data, to understand the elements of interventions that contribute to acceptability among older adults. Efforts to recruit a diverse sample of older adults in terms of age, ethnicity and wealth would be valuable.

Conclusion

This systematic review aimed to understand the effects of online psychological interventions in the management of anxiety in older adults and acceptability of these interventions. Eleven studies were included. While there may be promise for online interventions like iCBT and ACT, the current evidence base remains small and lacking the methodological quality to make strong conclusions on the effects of online interventions

with older adults. Likewise, studies included in this review indicated moderate to high levels of acceptability however there was a high risk of bias impacting the generalisability of these results. Future research using larger, controlled studies, including comprehensive measures of acceptability and a diverse sample would be beneficial.

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Appendices

A. Example search strategy

B. EPHPP Quality Assessment Tool for Quantitative Studies

C. Quality Rating Scores

D. Journal Submission Guidelines

A. Example search strategy

Ovid MEDLINE(R) ALL <1946 to March 03, 2022>

APA PsycInfo <1806 to February Week 4 2022>

Embase <1974 to 2022 March 03>

1 elderly.ab,ti,kw.
2 elder.ab,ti,kw.
3 geriatric.ab,ti,kw.
4 senior.ab,ti,kw.
5 anxiety.ab,ti,kw.
6 anxious.ab,ti,kw.
7 worry*.ab,ti,kw.
8 5 or 6 or 7
9 "online intervention".ab,ti,kw.
10 "online therapy".ab,ti,kw.
11 "online treatment".ab,ti,kw.
12 web-based.ab,ti,kw.
13 internet-delivered.ab,ti,kw.
14 internet-based.ab,ti,kw.
15 virtually-delivered.ab,ti,kw.
16 app-delivered.ab,ti,kw.
17 iCBT.ab,ti,kw.
18 blended.ab,ti,kw.
19 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18
20 "older adult$".ab,ti,kw.
21 "late$ life".ab,ti,kw.
22 1 or 2 or 3 or 4 or 20 or 21
23 8 and 19 and 22

B. EPHPP Quality Assessment Tool for Quantitative Studies

QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES

EPHPP
Effective Public Health Practice Project

COMPONENT RATINGS

A) SELECTION BIAS

(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?

1 Very likely
2 Somewhat likely
3 Not likely
4 Can't tell

(Q2) What percentage of selected individuals agreed to participate?

1 80 - 100% agreement
2 60 – 79% agreement
3 less than 60% agreement
4 Not applicable
5 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

B) STUDY DESIGN

Indicate the study design

1 Randomized controlled trial
2 Controlled clinical trial
3 Cohort analytic (two group pre + post)
4 Case-control
5 Cohort (one group pre + post (before and after))
6 Interrupted time series
7 Other specify _____
8 Can't tell

Was the study described as randomized? If NO, go to Component C.

No Yes

If Yes, was the method of randomization described? (See dictionary)

No Yes

If Yes, was the method appropriate? (See dictionary)

No Yes

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

C) CONFOUNDERS

(Q1) Were there important differences between groups prior to the intervention?

1 Yes
2 No
3 Can't tell

The following are examples of confounders:

1 Race
2 Sex
3 Marital status/family
4 Age
5 SES (income or class)
6 Education
7 Health status
8 Pre-intervention score on outcome measure

(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?

1 80 – 100% (most)
2 60 – 79% (some)
3 Less than 60% (few or none)
4 Can't Tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

D) BLINDING

(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?

1 Yes
2 No
3 Can't tell

(Q2) Were the study participants aware of the research question?

1 Yes
2 No
3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

E) DATA COLLECTION METHODS

(Q1) Were data collection tools shown to be valid?

1 Yes
2 No
3 Can't tell

(Q2) Were data collection tools shown to be reliable?

1 Yes
2 No
3 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

F) WITHDRAWALS AND DROP-OUTS

(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?

1 Yes
2 No
3 Can't tell
4 Not Applicable (i.e. one time surveys or interviews)

(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).

1 80 -100%
2 60 - 79%
3 less than 60%
4 Can't tell
5 Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION	STRONG	MODERATE	WEAK	
See dictionary	1	2	3	Not Applicable

G) INTERVENTION INTEGRITY

(Q1) What percentage of participants received the allocated intervention or exposure of interest?

1 80 -100%
2 60 - 79%
3 less than 60%
4 Can't tell

(Q2) Was the consistency of the intervention measured?

1 Yes
2 No
3 Can't tell

(Q3) Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?

4 Yes
5 No
6 Can't tell

H) ANALYSES

(Q1) Indicate the unit of allocation (circle one)

community organization/institution practice/office individual

(Q2) Indicate the unit of analysis (circle one)

community organization/institution practice/office individual

(Q3) Are the statistical methods appropriate for the study design?

1 Yes
2 No
3 Can't tell

(Q4) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?

1 Yes
2 No
3 Can't tell

GLOBAL RATING

COMPONENT RATINGS

Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

A	**SELECTION BIAS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
B	**STUDY DESIGN**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
C	**CONFOUNDERS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
D	**BLINDING**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
E	**DATA COLLECTION METHOD**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
F	**WITHDRAWALS AND DROPOUTS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	Not Applicable

GLOBAL RATING FOR THIS PAPER (circle one):

1	STRONG	(no WEAK ratings)
2	MODERATE	(one WEAK rating)
3	WEAK	(two or more WEAK ratings)

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

No Yes

If yes, indicate the reason for the discrepancy

1	Oversight
2	Differences in interpretation of criteria
3	Differences in interpretation of study

Final decision of both reviewers (circle one):

1	**STRONG**
2	**MODERATE**
3	**WEAK**

C. Quality Rating Scores

Author	Paper Title	Selection bias			Study Design					Confounders			Blinding			Data collection methods			Withdrawals and dropouts			GLOBAL RATING FOR PAPER
		Q1	Q2	SELECTION BIAS RATING	Q1	Q2	Q3	Q4	STUDY DESIGN RATING	Q1	Q2	CONFOUNDERS RATING	Q1	Q2	BLINDING RATING	Q1	Q2	DATA COLLECTION METHODS	Q1	Q2	WITHDRAWALS AND DROPOUTS RATING	
Dear, B. F.	Examining self-guided internet-delivered cognitive behavior therapy for older adults with symptoms of anxiety and depression: Two feasibility open trials	3	2	**Weak**	5	No	n/a	n/a	**Weak**	n/a	n/a	**Weak**	Yes	Can't tell	**Weak**	Yes	Yes	**Strong**	Yes	3	**Weak**	**WEAK**
Dear, B. F.	Clinical and cost-effectiveness of therapist-guided internet-delivered cognitive behavior therapy for older adults with symptoms of anxiety: a randomized controlled trial.	3	1	**Weak**	1	Yes	Yes	Yes	**Strong**	No	n/a	**Strong**	Yes	Can't tell	**Weak**	Yes	Yes	**Strong**	Yes	1	**Strong**	**WEAK**
Hobbs, M. J.	Integrating iCBT for generalized anxiety disorder into routine clinical care: Treatment effects across the adult lifespan	2	1	**Moderate**	5	No	n/a	n/a	**Moderate**	Yes	1	**Strong**	Yes	Can't tell	**Weak**	Yes	Yes	**Strong**	No	n/a	**Moderate**	**MODERATE**
Jones, S. L.	A randomized controlled trial of guided internet-delivered cognitive behaviour therapy for older adults with generalized anxiety.	3	1	**Weak**	1	Yes	Yes	Yes	**Strong**	No	n/a	**Strong**	No	Can't tell	**Moderate**	Yes	Yes	**Strong**	Yes	1	**Strong**	**MODERATE**
Kozlov, E.	The feasibility, acceptability, and preliminary efficacy of an mHealth mindfulness therapy for caregivers of adults with cognitive impairment	2	1	**Moderate**	5	No	n/a	n/a	**Weak**	n/a	n/a	**Weak**	Yes	Can't tell	**Weak**	Yes	Yes	**Strong**	Yes	1	**Strong**	**WEAK**
Silfvernagel, K.	Individually tailored internet-based cognitive behaviour therapy for older adults with anxiety and depression: a randomised controlled trial	3	1	**Weak**	1	Yes	Yes	Yes	**Strong**	No	n/a	**Strong**	Yes	Can't tell	**Weak**	Yes	Yes	**Strong**	No	2	**Moderate**	**WEAK**
Staples, L. G.	Internet-delivered treatment for older adults with anxiety and depression: implementation of the Wellbeing Plus Course in routine clinical care and comparison with research trial outcomes.	3	1	**Weak**	3	No	n/a	n/a	**Moderate**	Yes	3	**Weak**	No	Can't tell	**Weak**	Yes	Yes	**Strong**	No	3	**Weak**	**WEAK**
Titov, N.	Treating anxiety and depression in older adults: randomised controlled trial comparing guided v. self-guided internet-delivered cognitive-behavioural therapy.	3	1	**Weak**	1	Yes	Yes	Yes	**Strong**	No	n/a	**Strong**	Yes	Can't tell	**Weak**	Yes	Yes	**Strong**	Yes	1	**Strong**	**WEAK**
Witlox, M.	Blended Acceptance and Commitment Therapy Versus Face-to-face Cognitive Behavioral Therapy for Older Adults With Anxiety Symptoms in Primary Care: Pragmatic Single-blind Cluster Randomized Trial.	2	1	**Moderate**	1	Yes	Yes	Yes	**Strong**	No	n/a	**Strong**	No	Can't tell	**Moderate**	Yes	Yes	**Strong**	Yes	1	**Weak**	**MODERATE**
Ying, Y.	Internet-based cognitive behavioral therapy for psychological distress in older adults without cognitive impairment living in nursing homes during the COVID-19 pandemic: A feasibility study	3	1	**Weak**	5	No	n/a	n/a	**Weak**	n/a	n/a	**Weak**	Yes	Can't tell	**Weak**	Yes	Yes	**Strong**	No	2	**Moderate**	**WEAK**
Zou, J. B.	Brief internet-delivered cognitive behavioral therapy for anxiety in older adults: a feasibility trial.	3	1	**Weak**	5	No	n/a	n/a	**Weak**	n/a	n/a	**Weak**	Yes	Can't tell	**Weak**	Yes	Yes	**Strong**	Yes	1	**Strong**	**WEAK**

D. Journal Submission Guidelines for *Systematic Reviews*

Preparing main manuscript text

Quick points:

- Use double line spacing
- Include line and page numbering
- Use SI units: Please ensure that all special characters used are embedded in the text, otherwise they will be lost during conversion to PDF
- Do not use page breaks in your manuscript

File formats

The following word processor file formats are acceptable for the main manuscript document:

- Microsoft word (DOC, DOCX)
- Rich text format (RTF)
- TeX/LaTeX (use BioMed Central's TeX template)

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SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

EMPIRICAL PAPER

Older Adults Narratives of Seeking Mental Health Support for Anxiety for the First Time

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Abstract

Objectives: Older adults with anxiety may experience many factors that hinder their ability to seek mental health support. Yet, little qualitative research has explored their journeys to support seeking. This study aimed to explore older adults' narratives of their journey towards seeking mental health support for anxiety for the first time.

Methods: Narrative methodology was used. Nine older adults were interviewed and narrative analysis was used to analyse the data focusing on: how narratives were organised, turning points to seeking support, and how the journey was experienced through positioning.

Analysis: Overall, older adults told narratives that described their difficult negotiation with anxiety: which they described themselves as more or less susceptible to; contributed to a changed sense of self or experience of overwhelming emotion (leading them to get support), and as something they attempted to resolve by approaching services. Older adults also described differing experiences of empowerment or powerlessness in their support-seeking journey, such as feeling burdensome.

Conclusion: Difficult negotiations with anxiety may have represented the experience of anxiety itself and coming to terms with a stigmatised mental health identity. Health professionals may need to listen for signs of anxiety among a downplaying of symptoms by older adults. Campaigns aimed to destigmatise anxiety but encourage older adults to seek support may be researched further. The analysis also highlights the potential use of acceptance and narrative therapeutic approaches and the importance of empowering older adults by involving them in service development.

Introduction

This paper explores older adults' narratives of their journeys towards seeking mental health support for anxiety for the first time. Older adults face several factors that hinder them from seeking mental health support, including beliefs and values, influenced by dominant societal narratives. However, how older adults seek mental health support is still poorly understood. This study therefore uses narrative methodology to study older adults' experiences of support seeking and considers implications for services and practice to improve access for older adults.

Background

The overall prevalence rates of anxiety in older adults are debatable but during the COVID-19 pandemic, levels of anxiety appeared to have increased in older populations (Bryant et al., 2008; Zaninotto et al., 2022). Anxiety is characterised by feelings of tension, worried thoughts, and physical changes like increased blood pressure (American Psychological Association, 2022). The majority of older adults develop anxiety before age 41 years (Wolitzky-Taylor et al., 2010) but several triggers for anxiety exist in later life too, including: bereavements and ageing-related health fears (Barton et al., 2014). If not treated, anxiety may last for years, or even decades (Lenze et al., 2005). According to models like the Acceptance-Based Model of Generalised Anxiety, anxiety may be maintained through avoiding internal and external experiences that trigger anxiety (Roemer & Orsillo, 2005).

Evidence suggests psychological anxiety interventions, like cognitive behavioural therapy (CBT), are as or more effective in older adults than working age populations (Kishita & Laidlaw, 2017; Saunders et al., 2021). Likewise, a small but growing body of research suggests acceptance-based interventions like mindfulness and acceptance and commitment

therapy (ACT) may also be effective for older adults (Foulk et al., 2014; Petkus & Wetherell, 2013; Wetherell et al., 2011). Some pharmacological treatments, such as selective serotonin reuptake inhibitors, are also recommended as benefitting people with late life anxiety (Lenze et al., 2005, 2009). However, older adults have indicated a preference for psychotherapy over pharmacology for the treatment of anxiety and prescription of medication for anxiety has reduced in over 65s (Archer et al., 2022; Deacon & Abramowitz, 2005; Mohlman, 2012).

Yet, despite effective treatments, evidence suggests older adult anxiety is more likely to be undertreated in primary care settings than mental health problems like depression (Vink et al., 2008). Referrals for older adults in Improving Access to Psychological Therapies programmes are still much lower than the expected level of need (NHS Digital, 2020). Older adults may therefore be facing challenges to access support.

Several barriers to seeking support for anxiety by older adults have been studied. For example, anxiety in older adults may more often be misidentified as symptoms may be different to younger adults, including more physical symptoms like shortness of breath (Diefenbach & Goethe, 2006; Yagudayeva et al., 2019). Older adults and health professionals may be less likely to identify anxiety and by potentially treating symptoms as though linked to physical health, may reinforce ideas for older adults about vulnerability and maladaptive health-seeking behaviours (Anderson et al., 2017; Knight & Winterbotham, 2020; Laidlaw, 2015).

Older adults' beliefs and values, influenced by dominant societal narratives, may also contribute to difficulties accessing mental health support. For instance, valuing self-sufficiency has been described in previous research (Knight & Winterbotham, 2020;

Lawrence et al., 2006; Switzer et al., 2006). For older adults, these beliefs may have been reinforced not only by wartime and post-war narratives about the importance of self-sufficiency, but in recent messages around the COVID-19 pandemic about pressures on health service resources (Brown & Baker, 2012; Hughes, 2017; The King's Fund, 2021). Similarly, societal narratives describe growing older as a negative experience, characterised by increasing dependence on others, poor health, and being stuck in one's ways (Carstensen et al., 2011; Gowling et al., 2016). Mental health problems may therefore be seen by older adults and health professionals as an inevitable part of ageing, for which interventions will not be effective, leading to less help-seeking or fewer referrals to appropriate support (Levy, 2009; Levy & Myers, 2004; Temple et al., 2020). Older adults having lived a longer life alongside stigmatising mental health narratives, and having a longer experience of mental health problems, might also perceive their anxiety as not worth addressing (Sadavoy, 2009).

For individuals who do seek mental health services, the "right time" to seek support has been described as feeling able to adopt an illness identity (Sercu et al., 2015). Illness identities may be seen as a threat where individuals might anticipate discrimination from others based on negative dominant mental health narratives. A study of older adults experiencing loneliness found some may avoid social opportunities due to fearing negative identity characteristics like dependency (Goll et al., 2015). Similarly, a study of older people seeking mental health support reported individuals would attempt to preserve their identity as a person and not just a patient (Reynolds et al., 2020). By telling stories about their lives as successful, older adults attempted to keep valued identities despite stigmatising mental health labels. Hence, the role of identity may be of great importance in the support seeking journey for some.

While several studies have identified barriers and facilitators to seeking support for mental health problems in later life, this type of research may be reductive. Research focusing on barriers and facilitators has been critiqued as oversimplifying potentially complex processes that contribute to decision making and outcomes (Bach-Mortensen & Verboom, 2020). Viewing barriers as something that can be removed may over-reduce the process of how to make change happen. The experiences of *how* older adults seek mental health support is still poorly understood by these studies.

Qualitative research in this area is currently sparse. To the best of my knowledge, no studies have explored how older adults' construct their narratives of mental health help-seeking for anxiety in the United Kingdom in particular. With evidence that there can be several challenges to seeking mental health support, such as identity maintenance, and the UK having a unique health and social care structure, exploration of this gap in the research is necessary.

Narrative research methods are particularly applicable to this qualitative gap with older adults to understand how they seek support and how they experience support seeking. When explaining events, people naturally tell stories (Kenyon et al., 2010; Nuske & Hing, 2013). Narrative inquiry can be a valuable method to reveal what it is like to be a patient in a particular situation (Gregory, 2010). Rather than simply identifying the steps that individuals took to access support, a narrative method would explore the subjective experience, perceived decision making, and turning points identified throughout the process of support seeking. Moreover, narrative analysis allows exploration of how older adults 'position' themselves in their narratives, indicating how they make sense of themselves in terms of status, power, and practices they are allowed to perform according to dominant

societal narratives (Depperman, 2013). Positioning can therefore give insight to how older adults experience the process of support seeking.

Aims

The aim of this research was to explore older adults' narratives of their journey towards seeking mental health support for anxiety for the first time in the UK. Three aspects of participant interviews were attended to: Firstly, how narratives were organised. Secondly, the influential experiences that older adults describe as pivotal in their help-seeking journeys. Finally, positioning within the narratives of older adults was explored.

Methods

Research Approach

Narrative methodology was used to analyse the accounts of older adults seeking mental health support for anxiety for the first time. From this perspective, older people were viewed as making sense of their lives and themselves, and explaining experiences to others, through stories (Kenyon et al., 2010; Riessman, 2008). Through examining narratives, I could understand which experiences were highlighted as most important to older adults in their support-seeking journeys, and how they viewed themselves.

Throughout the study, I took a social constructivist position (Burr, 2015). This approach enabled me to understand how meanings and narratives were made between participants and myself. I also made the assumption that these meaning-making processes and narratives were reflective of their internal sense-making, developed from experience of interacting with others. The influence of socialisation through wider societal narratives about ageing and mental health was therefore considered when analysing participants'

stories as this may have influenced their experience of support seeking and the telling of this experience (Somers, 1994). Consequently, I was aware that dominant discourses influencing power relationships between health professionals and patients may have influenced the narrative construction during interviews between participants and myself.

Participants and recruitment

The recruitment strategy was designed with consultation from an older adult clinical psychologist and from an older adult with lived experience of seeking mental health support. These individuals shared participant recruitment ideas and the lived experience consultant gave feedback on recruitment materials (see appendix A and C).

To be eligible for the study, participants were required to be aged 65 years or older and to have sought mental health support for anxiety for the first time in the last three years (having had at least one conversation with a primary care or mental health professional e.g. GP). The age limit was based on criteria for current UK older adult mental health services that construct older age as 65 years or more (e.g. Somerset NHS Foundation Trust, 2021). By speaking to participants who had sought support in the last three years, it was hoped these experiences would be more easily remembered and reflect current service design. Participants were required to have a good understanding of written and spoken English and be able to give informed consent. Participants who had sought formal support for mental health previously, were excluded from the study.

Exclusion criteria were applied when potential participants filled in a background questionnaire, totalling six people who were excluded from taking part and three who changed their mind about taking part (one due to other life pressures, one due to not thinking their experience was anxiety, and one who did not report a reason). When

interviewing one participant it became apparent they had previously received psychiatric medication. This participant's narrative was still included in the study as their recent experience had been to seek talking therapy.

As recommended in my systematic review, I made efforts to recruit a diverse sample of participants by contacting a range of charities and community groups and by specifically contacting groups created by and for minoritised populations.

Nine participants were recruited through charitable and non-profit organisations designed for older adults or people with physical health problems. Background characteristics have been summarised to maintain anonymity of participants.

Table 1.

Participant Background Information

		N
Age	Mean 73 years (range 68-79)	9
Gender	Female	4
	Male	4
	Non-binary	1
Ethnicity	White British	7
	White European	2
Relationship status	Married	3
	Single	2
	In a relationship >6 months	2
	Widowed	2
Had children		8
Education level	Degree	4
	Postgraduate degree	3
	Left school with no qualifications	2
Employment	Retired	7
	Part-time	1
	No due to ill health	1

Household income	Below £10K	2
	£10K - £20K	2
	£20K - £30K	4
	£30K - £40K	1

Materials and Data Collection

Demographic questions were informed by a review of factors which may influence mental health support seeking. Interviews were based around one open question, "tell me about your experience of anxiety and how that led you to seek mental health support for the first time", designed in collaboration with the lived experience consultant (Wengraf, 2001; see Appendix C). He provided feedback on the question structure which added coherence and depth. Prompt questions were used in the latter half of interviews to clarify chronology and further details. The ordering and phrasing of participants' stories was maintained in follow-up questions to retain their meaning-frame (Holloway & Jefferson, 2013). A pilot interview was conducted to practice the unstructured interview style and led to creating some potential prompts I could use as the interviewer.

Participants completed the consent form and demographics questions before the interview. Interviews were conducted via telephone or video call, allowing for a geographically diverse group of participants to take part. Interviews were audio-recorded and recordings were transcribed orthographically and pseudonymised. Interviews lasted between 24 – 83 minutes. The two interviews that lasted less than 30 minutes consisted of narratives which focused on the recent experience of anxiety and seeking mental health support in less depth. These shorter interviews also included fewer accompanying narratives of experiences related to their support seeking as in longer interviews e.g. earlier life experiences of anxiety.

Data analysis method

A range of methods exist under the umbrella of narrative analysis (Riessman, 2008). For this study, I began by examining the structure of narratives to capture the overall meaning and the ways older adults made sense of their experiences of support-seeking. Key events or turning points were then examined, to understand what made the difference for older people accessing mental health support. To understand what it was like for older people, I drew on the construct of subject positions, to examine how people positioned themselves and others (Depperman, 2013). These analysis approaches are detailed below.

Structural analysis involved deductive analysis of narratives using Labov's model of narrative structure (Labov, 1972). Narratives were taken to refer to the entire response in an interview, as reconceptualised by Riessman (1993), rather than Labov's (1972) restricted definition of event narratives as a minimum of two clauses which are temporally ordered. Riessman's definition allowed for stories which provided context for the participant's overall narrative and was important for interviewing older adults whose stories spanned months, if not years (Andrews et al., 2013). Labov's model suggests narratives are made up of six elements, which may not occur in order or in every narrative, including: an abstract, orientation, complicating action, evaluation, resolution, and a coda. Narratives were read line by line to identify the function of each clause within a participant's story as one of the six elements. These elements were tabled to aid comparison across participants' stories and consider whether similar narrative structures and core narratives recurred between stories. Labov's model was chosen as it allowed for systematic, detailed analysis of how different story components might have been structured and facilitated comparison between different components of narratives (Andrews et al., 2013; Riessman, 2008).

To examine the influential experiences older adults described as pivotal to seeking help, I planned to explore turning points in individuals' stories, with particular attention to events around seeking mental health support for the first time (Gibbs, 2007; Riessman, 2008). Turning points were identified as parts of someone's story that led them to have a different sense of themselves that could affect how they felt or what they did (Mishler, 2006). These differed to complicating actions in Labovian structural analysis which represent any event, not specific to pivotal moments (Riessman, 2008). Some participants did not describe turning points in their initial narrative telling, and key events related to support-seeking were further explored through follow-up questions. Turning points and key events were coded then compared between participants' stories.

Finally, positioning in participants' stories was examined. From positioning theory, positioning refers to the "discursive process whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced story lines" (Davies & Harre, 1990, p.48). Bamberg (1997) adapted this theory and recommended exploring three positioning levels: the characters in the story, between the narrator and interviewer, and how the narrator positions themselves within greater discourses. Positioning quotes were tabled, coded and grouped by theme in participants' stories. Positioning themes between participants' narratives were then explored to determine any cross-narrative positioning themes (see appendix D).

To develop analysis credibility, I discussed the analysis with a supervisor experienced in qualitative research, with peers conducting narrative analysis and with the lived experience consultant. These discussions helped develop additional reflections which facilitated a deeper, but still partial, analysis of the interview data.

Study quality

The use of qualitative research quality criteria and ability of criteria to be generic across epistemologies has been debated (Clarke, 2022). Throughout this study, I drew on criteria ideas lightly to enhance research rigor as tools for reflecting on my practice (Clarke, 2022). The eight criteria set forward by Sarah Tracy (2010), were primarily used as these offer more theoretical flexibility: worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethical, and meaningful coherence.

Reflexivity

In most settings, I did not view myself as 'older' and therefore positioned myself as an outsider to these participants' experiences. I tried to view the concept of older adulthood from multiple perspectives both intellectually and personally. I thought about dominant societal narratives about older adulthood, previous research describing the potential physical and social changes that people can experience as they age, and my own personal experiences of older adults in my life. I thought that adults aged 65 years and older could include several 'cohorts' of older adults socialised in different eras, but who would have been subject to trans-generational narratives too. Through this process, I realised that being 'older' could mean many things to different people across the age spectrum. I therefore attempted to be sensitive to using language to accommodate differing definitions, especially as being 'older' could be viewed as a negative trait by some, and was anxious to build good rapport with participants in this study.

I approached this research with a background in clinical and health psychology and the research question was inspired by previous observations of older adults referred to mental health support for the first time. My perspectives were therefore influenced by

psychological theory and prior expectations that seeking mental health support could be challenging for older adults. Moreover, I assumed that mental health support was something worth seeking. Due to my experiences, I focused more on challenges older adults experienced to seek support and how their support had helped them.

To aid my reflexive capacity, I wrote a reflective journal and completed bracketing interviews with a peer at the beginning of data collection (Tufford & Newman, 2012; see appendix D). I noticed that I may have been influenced by dominant story telling patterns where people face a problem and eventually overcome it. I therefore tried to adopt a position of curiosity during interviews, and adopt more silence in the interviews, which helped allow participants to tell their stories in full detail (Hill et al., 2003).Ethics

Ethical approval was granted by the University of Exeter Psychology Ethics Committee. Criteria by the British Psychological Society for conducting ethical research was followed (2021). Personal information of participants was processed in accordance with the General Data Protection Regulation (GDPR).

Previous literature about conducting research with older adults highlighted two main areas: consent and the representation of older adults (Arrant, 2020; Szala-Meneok, 2009). While cognitive impairment only affects a minority of individuals in older age, the potential for cognitive impairment increases with age (van der Flier, 2005). The possibility of participants' cognitive abilities impacting the informed consent process was therefore considered and I used clinical judgement to assess participants' ability to provide consent. De-valuing of older adults and ageist attitudes can mean older adults are misrepresented in research (Bellingtier & Sharifian, 2016). Nomenclature was therefore attended to throughout the study.

Analysis

This study examined how older adults with anxiety constructed their narratives of getting mental health support for the first time. Overall, older adults described a difficult negotiation with anxiety during their mental health experiences and when navigating support. The older adults in this study described narratives of attempted restitution to their mental health problems, with services viewed as places to achieve resolution. However, satisfaction with services differed between these older adults but for many, resolution of their anxiety was not achieved within their narratives, leading to a thwarted hope. Two main key events that were described as leading to support seeking were: older adults noticing a change in themselves; or, experiencing intolerable strong emotion. Older adults positioning shifted and moved throughout their stories with respect to their susceptibility to anxiety and their powerlessness or empowerment during their journeys.

Structure of Attempted Restitution – Thwarted Hope vs Therapy Success

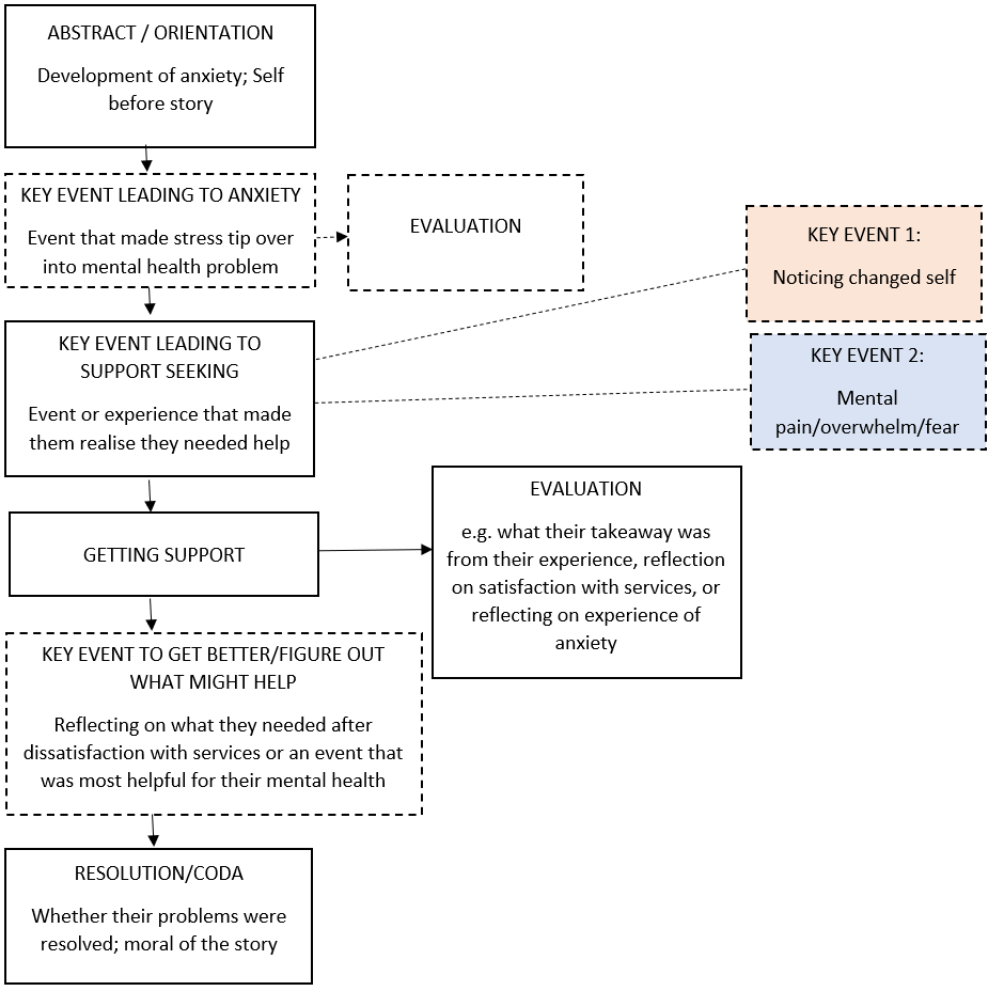
> "so much of the counselling was about wanting a resolution to things and being very upset when there wasn't one“ – Michael

While all older adults' narratives took on a slightly different structure, their narratives appeared to be structured around a journey to attempted restitution, where services were described as a place to resolve their anxiety. Figure 1 presents the universal structure overlying these older adults' narratives. The general trend of older adults' narratives was to describe how they became anxious, how they received support, their evaluations of the support they received and whether they felt they had achieved a resolution to their anxiety from mental health support. In the initial telling of their journey to support seeking, many participants did not specify the key event that led them to seek or

get support. To achieve the second aim of this study, follow up questions were used during the interview to understand this key event better and this was included chronologically in Figure 1 for clarity.

Figure 1.

Universal Structure of Participant Narratives



Almost all older adults' narratives began with telling me about the various events which contributed to anxiety beginning, such as early experiences, death of loved ones, cancer treatment ending, and changes to daily life. James, David and Janet reported being anxious for a long time whereas others thought anxiety was a new experience. Differing

from others, Michael began by describing how he positioned himself in relation to the term 'anxiety', before talking about his causes of anxiety.

> "when I, became aware that I was having, um…mental problems, I described them as mental disturbance" - Michael

> "I lost my wife early, and that has caused a lot of, stress and anxiety first of all. And that was just before the COVID act-, epidemic broke out. And so on top of that the COVID stroke, losing a loved one, I was very anxious" – Alex

While most participants spoke about more than one experience contributing to their anxiety, James and Elizabeth spoke about a specific key event that led their stress to cross a threshold and become noticeable anxiety.

> "as I said the…only problem I had was really was the death of my wife. Which caused, me to get really, to go and get, really ill" – James

Many participants went on to speak about where and how they sought mental health support. Seeking support from a health professional was described as the assumed best course of action. Places for support included: general practitioners (GPs), health charities (such as cancer or bereavement), primary and secondary mental health services, and a chronic pain service psychologist.

> "so I had to, er seek medical help from the, doctor and…I did some talking therapy" – Alex

James and Michael spoke about the specific key event that led them to seeking support in their initial telling of their narrative, whereas others elucidated on this event after being asked for further detail in the interview.

All older adults' narratives, except for Elizabeth, who had not yet received support, discussed their satisfaction with the support they received. James, Linda, David, and Christine spoke primarily about their disappointment with services, including unhelpful advice received or not enough input being offered. In contrast, some spoke about support they found helpful, such as non-judgemental approaches or clear knowledge of resources. Alex and John were primarily positive and Michael and Janet gave mixed responses about their satisfaction.

> "I can go to, Prostate Cancer UK PCUK and speak to specialist nurses um but I think there would be some degree of, psychological help available from them as well. They certainly know, how to talk to people who've just had the shock of the diagnosis" – Michael

> "she seemed a bit bemused by anxieties as though she didn't believe in it or didn't believe it was an illness, but the depression ah she had her arsenal of antidepressants to *laughs* prescribe" – Christine

The older adults ended their narratives by talking about whether they felt their mental health problems had been resolved or what they had learned from their experience of support seeking. James, Elizabeth, Michael, Linda and David felt their mental health problems were still an issue; for Elizabeth, due to being on a therapy waiting list still and the other four due to insufficient support or understanding of their concerns. The hope that services could resolve their anxiety was thwarted. James and David spoke with a sense of closure to their narratives, concluding they were the same as before they sought support and self-reliance being important. Elizabeth, Michael and Linda described an unfinished narrative, speaking about their plans for finding additional support.

> "I just managed. I just coped with it. And that's how I feel. And that's how I've been, that's how I feel now. Exactly the same you know" - James

Alex, Christine, Janet and John spoke about a restitution to their mental health problems, Janet and John reflecting that they could have not got better without support from others and Alex and Christine speaking of their personal role in their recovery and maintenance of their mental health. For Janet, despite finding resolution in her initial experience of seeking mental health support, spoke about receiving a cancer diagnosis which led to seeking support for a second time.

> "after the tablets and the medication from the doctor, and er the talking therapy I managed to get over it, and, now I manage to just make sure I get up every morning and put my mind in the right place" – Alex

Key Events

Overall, the key events described by older adults as leading to seeking mental health support involved either: a noticing of their changed self (James, John and Michael), or a passing of an emotional threshold to overwhelm, pain or fear (Elizabeth, Alex, Linda, David, Christine and Janet).

Noticing a change in themselves could be precipitated by other people telling the participant they thought they were different or needed help. In other instances, mental health symptoms were talked about as reaching a great enough level that allowed participants to notice a change in themselves.

> "I got to a point where people were saying to me, you're not coping are you? And people were telling me, that I wasn't coping." – James

Experiencing a passing of a threshold to intolerable overwhelm, pain or fear was another type of key event described. This manifested in different ways for participants, such as: feeling trapped and suicidal, fearing they may not be able to continue as they were, or mental pain preventing them from living as they wanted to.

> "it was you know the mental pain of it. You know it was, it was just made everything so very hard" – Christine

Positioning

Older adults negotiated two main subject positions throughout their narratives: their susceptibility to anxiety, and their sense of power in service settings. These positions showed up in the way events were described and in dialogue with myself as the interviewer. Participants' narratives used a range of positions, which sometimes overlapped or were in conflict with each other.

Susceptibility to anxiety

When talking about anxiety and mental health problems, participants appeared to construct themselves as someone more resistant to anxiety or someone more sensitive to anxiety.

Resistant to anxiety. The majority of participants in this study spoke about their anxiety as being a change to themselves. As described earlier, for some this could be a motivating factor for seeking help. For example, Linda described herself as usually a relaxed person and through experiencing mental health problems, this relaxed identity was lost. Anxiety was not something she would normally associate herself with.

> "I think, I do seem to, um, be more emotional. I used to be a very very calm person but I don't feel that I am, that person now." - Linda

James described being told by others that he was not acting as he used to, being positioned as someone who now needed mental health help. This was a position that he did not initially agree with. He described himself as naturally nervous but always coping with difficult life experiences independently.

> "I got to a point where people were saying to me, you're not coping are you? And people were telling me, that I wasn't coping. You're not, you know…" - James

Some participants also used their narrative to position themselves as lucky, healthy and well, especially in comparison to others, such as people less financially well off or more anxious.

> "so many people I know of similar ages to myself, because of COVID have still got cabin fever. They won't go out the threshold of their door. They're terrified. Me I'm a, I'm a bit brazen. I'll get out there and do it *laughs*" – Alex

> "I think lockdown rules and that kind of thing um…I don't, object to. I think, but I don't think they were as bad as…they weren't too bad for us. I think they're tough on, a family in a flat, the first lockdown. But, we're retired. We've got a garden You know. We don't have financial worries" – Michael

Sensitive to anxiety. Some participants told their narrative in a way that brought anxiety closer to their identity. James, David, Janet and John spoke about anxiety and nerves being part of who they were from early in life or for a long time.

> "I just wonder if I was naturally anxious when I was born anyway because I, um…I remember seeing a photo of me maybe when I was about 6 months old or, no, three or four months old and I looked anxious in that"– David

John and Alex spoke about the problems described in their narrative as their responsibility. They spoke about how their anxiety was caused by themselves and could only be changed if they took the initiative to do something about it.

> "we had difficulty communicating. So yeah, it things, didn't improve on that front, until I made the effort" – John

Others owned their mental health experiences as a natural reaction to their circumstances. For example, cancer treatment ending, living through the COVID-19 pandemic and nationwide lockdowns, and narratives about older adults naturally being more anxious were described as understandable reasons for anxiety.

> "I think in general one does feel more anxious as one gets older. Because, talking to friends um, it's partly because you're retired and you, you've got less of a routine. And sometimes, I think it's just having more time." – Elizabeth

Powerless and Empowered

Older adults also took up positions as powerless or empowered within their narratives of experiencing mental health problems and navigating services for mental health. Older adults could speak primarily as being more empowered or powerless, oscillate in their power positioning, or spoke in tension about powerlessness and empowerment together. These positions sometimes overlapped with positions about susceptibility to anxiety, such as the amount of responsibility participants described having over their

anxiety. Moreover, these positions did not appear to be linked to whether participants had found resolution to their anxiety or not.

Powerless. Many participants told their narratives in ways that suggested a feeling of powerlessness in their journey to seeking mental health support. Some participants' narratives framed health professionals as holding power and being gatekeepers to accessing mental health support. For example, having to ask permission for support, wait to be seen, or being 'put on' medications were common events told.

> "it wasn't a really a conversation, she would say I will prescribe you this and I would try it and I would feed back after several months, no change" – Christine

> "they allowed me to go on the course" – Janet

In other instances, participants suggested feeling under judgement from others in their narrative, such as feelings of shame for having anxiety or their behaviours related to their anxiety. This positioning took place in dialogue with me as the interviewer too, where participants suggested other people were worse off than them and or that their experience as not 'bad' enough.

> "I shouldn't have been, drinking" – Alex

> "I could sense that there was something a little bit unhinged in how I reacted. Because, actually that was all right that consultation. I didn't, what else would I have said? And it wasn't that important. And she probably thought look don't waste my time I've got other patients to see." – Michael

> "I think you get into that self-blaming game, of thinking well I should be able to fill my time productively. I shouldn't be unhappy. I shouldn't, so you get into that kind

of negativity of thought sometimes when you, coz sometimes you find, times weighing quite heavily on you." – Elizabeth

When discussing the initial causes for their anxiety and mental health problems, many participants spoke about reasons external to them or out their control. These participants positioned themselves as under the power of events they could not change.

"obviously…things started when I was young because as I said to you before, um I was born in the war. I spent the first two years of my life, not that I remember it, in and out of bomb shelters" – James

"Um, because it's [cancer diagnosis] a kind of threat hanging over you really" – Elizabeth

John and Elizabeth spoke about being a burden or wanting to avoid being a burden in mental health settings. They described the NHS as busy and were concerned about overwhelming services or that their problems were not important enough to seek support.

"So, um…so partly thinking well I don't really want to bother the NHS because I don't, you know I haven't got a history of depression and anxiety as such" – Elizabeth

Janet spoke throughout her story with a sense of being stuck and powerless. Difficult life events, chronic health problems and financial problems were described as problems she could not escape independently, and subsequent mental health problems led her to thinking about suicide.

"I had to rely on friends for you know to help me with some money and stuff like that which was really terrible. I hated it" – Janet

Empowered. There were also examples of older adults' narratives that positioned them as being more empowered in different ways.

Almost all participants made negative remarks about the quality of service they received or expected to receive from mental health services. In the telling of their narrative, they were able to give voice to their experiences and suggestions of how services could meet their expectations and desires.

> "some GPs, are very on the ball with recommending, other things, other sources of help or therapy other than medicine. You know, medication. And so I thought that they, they might, you know have something, local that I could er access easily. But it, doesn't seem that that's the case." – Linda

> "I guess the GP thought well you were in the hands of the…so called experts." – David

> "that was all she came up with. Now and, you know you're lonely." – James

In other examples, participants positioned themselves as agents of their mental health. This agency was spoken about positively as helping to relieve their anxiety. Alternatively, having agency of their actions and mental health could be framed negatively as though the cause of their problems was from within themselves, crossing over with positions about susceptibility to anxiety.

> "I've got to make the point, effort of going out. I've got to make the point of socialising with people" – Alex

> "I actually got hold of some books, on CBT, to see if that would help" – John

Lastly, many participants spoke about ways their needs were well accommodated by health professionals and others. While sometimes still acknowledging the power that health professionals had in access to mental health support, participants felt they were listened to, their needs were privileged, or they were able to work collaboratively with health professionals towards a solution.

> "talking therapy helped. Um, the people I talked to were very good. Were very kind. And not too harsh. Not too er…they weren't critical. They're prepared to listen but they're prepared to motivate you if need be.." – Alex

> "So the GP I knew anyway so she was quite supportive. She arranged the referral" – David

Discussion

During this study I aimed to explore older adults' narratives of their journey towards seeking mental health support for anxiety for the first time, focusing on: how narratives were organised, turning points to seeking support, and how the journey was experienced through positioning. Overall, older adults told narratives that described their difficult negotiation with anxiety: which they positioned themselves as being more or less susceptible to at different points, which contributed to a changed sense of self or experience of intense overwhelming emotion for some (leading them to get support), and as something they attempted to resolve by approaching services. Older adults described differing experiences of feeling empowered or powerless when facing anxiety and their journey through support services, which could exacerbate or ease their experience of seeking mental health support. These findings are discussed below in relation to existing

theory and research and their links to how access to mental health services for older adults with anxiety may be enhanced.

The older adults in this study described overwhelming emotions and noticing a change in themselves as reasons for seeking mental health support. This finding supports previous research in other age cohorts that found experiences like psychological distress were associated with support-seeking for mental health (Dhingra et al., 2010; Thompson et al., 2004). Moreover, when exploring the use of Andersen's (1995) Behavioural Model of Health Service Use in mental health settings, mental health needs like distress or self-assessed mental health, were supported as the main reasons for seeking support (Graham et al., 2017). It may be that older adults therefore do not differ from other age cohorts regarding reasons for seeking support. Yet, some of the older adults in this study described living with anxiety for some time before seeking support and so it is important to consider potential reasons for this.

Throughout these older adults' narratives, they appeared to be negotiating their relationship with anxiety continuously, potentially impacting their support seeking journey, and which may have more than one interpretation. Firstly, similar to older adults in Reynold et al.'s (2020) study, it is possible that through telling their narratives, these participants were making sense of their identity and its association with a stigmatised identity of having mental health problems or requiring mental health support for the first time in their lives. Older adults, through living longer lives, were able to draw on many stories, such as their generation having challenges, which contributed to making sense of their anxiety. Nowadays, austerity measures in the UK, the recent COVID-19 pandemic, and increasing pressures on public services like the NHS have reinforced discourses of the importance of

people being self-reliant. At the same time, anxiety in older age may be talked about as a normal part of ageing and older adults discussed as a disproportionate strain on resources (Brown & Baker, 2012; Hughes, 2017; The King's Fund, 2021). These discourses may have contributed to some older adults in this study feeling burdensome. Talking in ways that inferred they were less associated with anxiety and of needing help, such as viewing anxiety as a change to their usual self or being better off than others, may have acted as a way for participants to protect their identities (Doblyte & Jiménez-Mejías, 2017).

An alternative interpretation is that older adults' descriptions of their relationship with anxiety was representative of their experience of having anxiety. For example, the Acceptance-Based Model of Generalised Anxiety (Roemer & Orsillo, 2005), describes problematic relationships with internal experiences. According to this model, anxiety may be associated with negative thoughts about emotional responses, such as anxiety being undesirable or feared (i.e. fear of fear; Behar et al., 2009). These internal experiences, perceived as threatening, are then avoided. It is possible that the narratives older adults gave of their experiences in this study are indicative of a similar process, whereby they viewed anxiety as something undesirable and at times something they wanted to distance themselves from.

Both of these possible interpretations may have contributed to older adults' ability to and experience of seeking mental health support. Some older adults in this study described having experienced anxiety for some time, and it was only when anxiety became unavoidable or they felt their identity had changed that they sought support. Positioning themselves to avoid an identity of anxiety or maintain an established identity, has been discussed as a potential hinderance to seeking mental health support (Doblyte & Jiménez-

Mejías, 2017). In addition, at times positioning themselves as not affected by anxiety or something related to ageing might have contributed to not viewing anxiety as a problem to be tackled. Previous research has suggested that problem recognition could be a significant barrier to initial help-seeking and that people with generalised anxiety may not make sense of what their problem was until after they sought support (Thompson et al., 2008). A difficult negotiation with anxiety might therefore lead to a more complex journey through services if health professionals are not clear on what services users would like to be addressed.

Experiences of anxiety and seeking help described in this study were concurrently underlaid by feelings of powerless or empowerment. For older adults in healthcare settings, descriptions of feeling powerless or insignificant have been cited before (Bridges et al., 2020; Kristensson et al., 2010). Feeling powerless may have been compounded by participants' narratives of restitution, where health services were framed as places supposed to resolve problems, even when this resolution was not achieved. Narratives of restitution are suggested as being the most common and popular types of story relating to health experiences (Frank, 1995). These stories that frame modern medicine and health professionals as heroes, clients as compliant and grateful, and conclude with a conquering of problems may be preferred and celebrated by listeners too (Donnelly, 2021; Pascal & Sagan, 2018). Nevertheless, this study highlighted narratives of empowerment too, where older adults knew what kind of service they wanted, felt some agency of their mental health, and felt accommodated in the right conditions. Given that past experiences of mental health service use can impact the probability of seeking help the same way in the future, it is important that older adults are given the means to feel empowered in their journey through support seeking.

Limitations

The analysis of this study needs to be interpreted in the context of the sample who were interviewed. During recruitment, advertisements were sent to organisations and centres which support marginalised communities. Some of these organisations did not reply to communication about the study and one organisation requested the language of adverts and the interviews be translated to their community's preferred language. Due to my limited linguistic abilities and financial constraints, it was not possible to conduct the study in multiple languages. Therefore, demographically, this sample was mostly made up of older adults who may have privileges that aided them to seek support, such as being white, high education levels, the ability to retire and the majority with a comfortable household income. It is possible that compared to individuals without these privileges, these older adults experienced a less difficult or complex pathway to support. Future studies might benefit from experts by experience who can consult on how best to meet the needs of local marginalised communities to take part in research and provision to understand the narratives of older adults whose first language may not be English.

In addition, sexuality and sexual preferences of participants were not recorded. While sexuality did not come up in any of the stories of these participants, it would be important to include in future studies as it may impact the ability to seek mental health support (Reynish et al., 2022); particularly for older adults who have lived through times of even less understanding and greater stigma around sexuality.

It is interesting to note that the majority of participants did not talk about the key events that led to support seeking in their initial telling of their narrative. I reflected on why this may be in research supervision. By including these key events in the universal structural

diagram, I was constructing participants' narratives to answer the aims of this study. However, this meant that I was not reflecting the ways in which older adults told their narratives. It is possible that many of the participants had not reflected on this aspect of the narrative before the study, found it challenging to think about this stressful part of their experience (i.e. when they perhaps experienced their highest levels of distress) or perhaps thought that other elements of their narrative were more important to explore.

This study benefitted from consultation with a person with lived experience and reflective discussions about the research process and analysis with several others, including supervisors, peers and during a research conference. Consultation aided the research by developing recruitment ideas, enhancing the interview question and contributing to the credibility of the analysis through crystallisation (Tracy, 2010). At times I could find myself drawn to looking for strengths and opportunities in people's stories, potentially due to my training in clinical psychology. This may have steered participants' story-telling, especially if they initially thought that nothing was helpful in their support-seeking journey. Bracketing interview and reflective discussions were therefore used to mitigate this perspective during the analysis in particular. While I viewed that it was impossible to put aside my own assumptions and narratives, I aimed to analyse data from different perspectives and platform older adults' voices.

Clinical Implications and Future Research

Given the sometimes difficult negotiations with anxiety that older adults experienced, to aid older adults in their help-seeking, these findings indicate that health professionals may need to be prepared for high levels of distress at the time of support seeking and a potential lack of clarity about a patient's relationship to anxiety. Health

professionals may be required to identify language which indicates a downplaying of anxiety, such as talk about anxiety symptoms in amongst narratives of not being deserving of support, anxiety as something inevitable with age, or not being a naturally 'anxious' person. The findings of this study may therefore support the routine use of anxiety screening tools, specifically designed for older adults such as the Geriatric Anxiety Scale (Segal et al., 2010), to help problem identification. Campaigns that aid health professionals to think about potential anxiety may also be of help due to time and resource pressures. Further, as shown in this study where older adults sometimes described health professionals, especially GPs, as lacking knowledge about anxiety interventions, health professionals may benefit from further training about older adult anxiety. However, further research to understand current primary care professionals' understanding about older adult anxiety, assessment and interventions would be appropriate.

Future research may investigate how factors like maintenance of destigmatised identities or avoidance of anxiety impact older adults' help seeking behaviour. These findings could add further nuance to existing campaigns by Age UK which urge older adults to 'ditch a stiff upper lip' when it comes to help seeking (Age UK, 2020). For example, campaigns could aim to destigmatise identities related to having anxiety, such as increased anxiety being a sign of getting older and becoming more burdensome or due to unwise personal actions. Campaigns could help older adults to view anxiety as something to seek help for, which is treatable, and which is their responsibility to seek help for but not their fault for having. These campaigns may be evaluated alongside help seeking rates.

The difficult negotiations with anxiety and shame discussed in this study suggest that models of support which include normalisation and acceptance of anxiety and maintenance

of a positive identity alongside getting support would be helpful. For example, therapeutic models such as acceptance and commitment therapy (Hayes et al., 1999) or narrative therapy (White & Epston, 1990), which respectively attend to the acceptance and allowing of emotions and the deconstructing of beliefs and identities and understanding of there being multiple 'truths'. Further research to investigate use of these models in older adult populations, or the investigation of these types of skills in well-established anxiety interventions such as CBT would be beneficial.

Finally, this study highlights the importance of older adults being given a voice in their intervention decision making and discussions about service improvement. All older adults in this study described some experience of feeling less empowered during their narrative. Patient involvement has been found to be beneficial both for patients and staff learning (Dijk et al., 2020) and several guides exist to support services to use patient participatory approaches (e.g. Cantley et al., 2005). Services incorporating patient involvement into their development process and offering patients structured support to make decisions around their treatment choices should therefore be encouraged.

Conclusion

Through conducting this study, I aimed to explore older adults' narratives of their journey towards seeking mental health support for anxiety for the first time, to understand how access to services may be improved. Using narrative methodology, I focused on: how older adults' narratives were organised, their turning points to seeking support, and how their journeys were experienced through positioning. Overall, older adults told narratives that described their difficult negotiations with anxiety and mixed experiences of powerlessness and empowerment when facing anxiety and navigating services for their

mental health. These findings suggest that reasons for seeking mental health support may not differ greatly to other age cohorts, however older adults by living longer were able to draw on many stories when making meaning of their anxiety experience. Difficult negotiations with anxiety may have represented the experience of anxiety itself and coming to terms with a stigmatised mental health identity. These older adults' experiences highlight the importance of empowering older adults during their service use and health professionals listening out for signs of anxiety in narratives that may lack clarity. Future research may focus on health professionals' knowledge and training needs around anxiety interventions for older adults, the use of acceptance and narrative type therapeutic skills, and evaluate campaigns that destigmatise anxiety and encourage older adults to seek support.

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Appendices

A. Participant Recruitment and Data Collection Pack

1. Study advert
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3. Consent form
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A. Participant Recruitment and Data Collection Pack: Study Advert

HAVE YOU STRUGGLED WITH ANXIETY?

Are you aged 65 or older?

Did you access mental health support for the first time in the last 3 years?

How did you find the experience?

You are invited to take part in some research. Your story could help us understand how to improve access to mental health services.

£10 shopping voucher for taking part

To take part in a 1-hour interview, or for more information, please contact:

Vicky Williams (Trainee Clinical Psychologist)

vw277@exeter.ac.uk

07919 112813

Supervised by:
Dr Cordet Smart (c.a.smart2@exeter.ac.uk)
Dr Rachel Handley (r.v.handley@exeter.ac.uk)

UNIVERSITY OF EXETER

A. Participant Recruitment and Data Collection Pack: Information Sheet

Seeking anxiety mental health support for the first time in later life: A narrative study

Participant Information Sheet

Thank you very much for your interest in this research study. Please take your time to consider the information carefully and to discuss it with family or friends if you wish, or to ask the researcher questions.

Who is conducting this research project and what is it about?

My name is Vicky Williams and I am a trainee clinical psychologist from the University of Exeter. I am completing this research project as part of my Doctorate in Clinical Psychology, supervised by Dr Cordet Smart and Dr Rachel Handley.

I am conducting a study to understand older adults' experiences of anxiety, how that led them to seek mental health support for the first time, and what that support-seeking journey was like. Experiencing anxiety in older age is common. If not treated, anxiety can last for years, if not decades. However, despite therapies for anxiety being effective for older adults, referrals for older adults to mental health support are still much lower than expected. This low referral level suggests that older people are facing challenges to access support. There is very little research that explores older adults' experiences of seeking support for the first time. I hope this project leads to recommendations about how support services can make it easier for older adults to get support for anxiety.

Who can take part?

I am looking for adults aged 65 years or older who have sought mental health support for anxiety for the first time in the last three years. Participants should have had at least one conversation with a primary care professional (e.g. GP, Psychological Wellbeing Practitioner) **and/or** a trained mental health professional (e.g. counsellor).

What would taking part involve?

You are invited to take part in a one-to-one interview over the telephone, via video call or in person (depending on whether we can travel). During the interview, I will ask you to tell me about your journey to seeking mental health support for anxiety for the first time. An interview time and date will be arranged with you which is convenient for you, including evenings or weekends. The entire interview will take about one hour, depending on how much detail you choose to provide. The interview will be audio-recorded and transcribed for the purpose of analysis. Before the interview, I will ask you to complete a consent form. You will also be asked to complete a short demographics questionnaire to help me gain a sense of who is taking part in the research. I will discuss what is going to happen in the interview and you will be given an opportunity to ask any questions that you might have before we start. You will be given another opportunity to ask questions at the end of the interview.

Do I have to take part?

It is entirely up to you whether you take part or not. Your decision will not affect your relationship or participation in the National Health Service, University of Exeter, or any other services or research centres you are involved with.

What are the possible benefits of taking part?

You will receive a £10 shopping voucher as a thank you for taking part. Your answers will also help understanding about how support services might be made more accessible. Participants will be given the opportunity to receive a summary of the findings at the end of the study.

What are the possible disadvantages and risks of taking part?

I do not anticipate any particular risks to you participating in this research; however, there is always the potential for research participation to raise uncomfortable or distressing issues. For this reason, I have provided information about some of the different resources which are available to you in the signposting information.

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

You are free to withdraw from taking part in the interview at any time before it takes place, without giving a reason. If you decide you want to withdraw from the research, please contact me via email vw277@exeter.ac.uk or over the phone 07919 112 813. Please note that there are certain points beyond which it will be impossible to withdraw from the research, for instance, when I have submitted my thesis. Therefore, I ask that you contact me within four weeks of participation if you wish to

withdraw your data. Participation in this service evaluation is entirely voluntary and all reports will be anonymised or use pseudonyms (i.e., fake names).

How will my information be kept confidential?

Your interview data will be psuedonymised (i.e., any information that can identify you or others will be removed from the transcript). Only I, my supervisors, and potentially external examiners (only on request), will have access to the data collected in this study. All research data will be stored securely in University of Exeter OneDrive and personal data (e.g., your name) will be stored separately to the research data.

I may have to break confidentiality if I believe there is an imminent and significant risk of harm to a participant or someone else. In this event, if possible, I will tell you I have to do this and who I will be speaking to; for example, my supervisor or a trained clinician (e.g., your GP). Before the interview begins, I will ask about your location in order to tailor signposting to support services if this is needed.

Extracts from the interview data, including quotes from participants, will be used in the research study report. After the report is written and/or published, and my degree award is complete, the interview data and any other personally identifiable data will be deleted. The personal information collected in this research study will be processed in accordance with the terms and conditions of the General Data Protection Regulation (GDPR). Your personal information will only be used or processed as described in this participant information sheet.

The University of Exeter processes personal data for the purposes of carrying out research in the public interest. The University will endeavour to be transparent about its processing of your personal data and this information sheet should provide a clear explanation of this. If you do have any queries about the University's processing of your personal data that cannot be resolved by the research team, further information may be obtained from the University's Data Protection Officer by emailing dataprotection@exeter.ac.uk or at www.exeter.ac.uk/dataprotection.

What will happen to the results of this study?

The data from the interviews will be analysed using narrative analysis to understand the journeys that older adults take to seek support for anxiety for the first time. The findings will then be written up as a thesis as part of my coursework for the award of Doctorate in Clinical Psychology at the University of Exeter. The report may also be published in an academic journal, presented at an academic conference, or disseminated appropriately to improve support service understanding of service user experiences.

Who has reviewed this study?

This project has been reviewed and approved by the Psychology Research Ethics Committee at the University of Exeter.

For further information:

Researcher: Vicky Williams
Email: vw277@exeter.ac.uk
Phone: 07919 112 813

Project supervisors:
Dr Cordet Smart: c.a.smart2@exeter.ac.uk
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Chair of University of Exeter Psychology Research Ethics Committee:
Dr Nick Moberly: n.j.moberly@exeter.ac.uk

A. Participant Recruitment and Data Collection Pack: Consent Form

Seeking anxiety mental health support for the first time in later life: A narrative study

CONSENT FORM

Thank you for agreeing to take part in this study.

Before the interview, please read the following statements and confirm that you understand and agree with each one by adding your initials to the boxes provided.

1. I have read and understood the nature of the study as outlined in the participant information sheet. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary. ☐
3. I understand that I am free to withdraw from the study, without reason, at any time before the interview and up to four weeks after completing the interview. ☐
4. I understand that I am not obliged to answer all questions in the interview. ☐
5. I understand that I will not be personally identified in any reports or write-up from this study but my quotes may be used. ☐
6. I agree to the interview being audio-recorded for the purposes of transcription. ☐
7. I understand that my data will be stored securely and only accessible by the researchers and research supervisors of this study (or external examiners on request). I understand that pseudonymised quotes from my interview may be used in the research report. ☐
8. I understand that confidentiality may be breached if there is an imminent and significant risk to myself or someone else, and that I will be informed of this where possible. ☐

9. I agree to participate in this study. ☐

Name of Participant	Date	Signature
_____	_____	_____
Name of researcher taking consent	Date	Signature
_____	_____	_____

When completed: 1 copy for participant; 1 copy for researcher/project file

A. Participant Recruitment and Data Collection Pack: Participant Background Questionnaire

Seeking anxiety mental health support for the first time in later life: A narrative study

Participant Information Questions

Thank you for agreeing to take part in this study. To help me understand who is taking part in the study, please could answer the following questions before the interview. This information will be summarised along with information about other participants in a table in the report.

1.	How old are you?	_____

2.	How would you describe your gender?	Male ☐ Female ☐ Non-binary ☐ Transgender ☐ Prefer not to say ☐ Prefer to self-describe as: _____

3.	When did you access mental health support for the first time?	_____

4.	Are you currently accessing mental health support?	Yes ☐ No ☐

5.	How would you describe your ethnicity?	Asian or Asian British Bangladeshi ☐ Chinese ☐ Indian ☐ Pakistani ☐ Another Asian background ☐	Black, African, Black British or Caribbean African ☐ Caribbean ☐ Another Black background ☐
		Mixed or multiple ethnic groups Asian and White ☐ Black African and White ☐ Black Caribbean and White ☐ Another Mixed background ☐	White British, English, Northern Irish, Scottish, or Welsh ☐ Irish ☐ Irish Traveller or Gypsy ☐ Another White background ☐
		Another ethnic group Arab ☐ Another ethnic background ☐	Prefer not to say ☐

6.	What is your current relationship status?	Single ☐ In a relationship less than 6 months ☐ In a relationship more than 6 months ☐ Living with partner ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Prefer not to say ☐

7.	Do you have any children?	Yes ☐

		No	☐
		Prefer not to say	☐

8.	What is the highest level of education you have completed to date?	Left school with no qualifications	☐
		O levels/GCSEs/NVQs level 1-2 or equivalent	☐
		A levels/HNDs/NVQs level 3/Highers or equivalent	☐
		Degree/NVQs level 4-5	☐
		Postgraduate qualification	☐
		Other professional qualifications	☐
		_____	
		Prefer not to say	☐

9.	Are you currently employed?	Yes – full time	☐
		Yes – part time	☐
		No – looking for employment	☐
		No – retired	☐
		No – due to ill health	☐
		No – studying	☐
		Other	☐
		_____	
		Prefer not to say	☐

10.	Which of the following best describes your total annual household income? (before tax and deductions, but including any benefits/allowances)	Below £10,000	☐
		£10,001 to £20,000	☐
		£20,001 to £30,000	☐
		£30,001 to £40,000	☐
		£40,001 to £50,000	☐

		Above £50,001	☐
		Prefer not to say	☐

A. Participant Recruitment and Data Collection Pack: Interview Checklist

Interview checklist

Before interview

- Audio recorder?
- Consent form signed?
- Demographics form filled in?

At start of interview

- Check she read participant information sheet - Any questions about the study before we start?
- Okay for me to begin recording?

Are you somewhere comfortable? We can of course take breaks if you like.

The purpose of this interview is to help me understand what your experiences of anxiety were and how that let you to seek mental health support for the first time. You can tell me as much or as little as you would like. You might notice that I will try to say as little as possible to begin with as it is your time to tell me how things were, and particularly as we are on the phone I will wait a few moments before I say anything to try and not interrupt you. I might ask you a few follow up questions nearer the end. So…

"Tell me about your experience of anxiety and how that led you to seek mental health support for the first time"

Could you say some more about that?
What did you mean when you were talking about…?
What did you do then?
How did you react / they react when you said X?
Anything else you would like to add?

End of interview

- Signposting booklet
- Shopping voucher
  - John Lewis / Waitrose
  - Marks & Spencers
  - Amazon
- Any other questions?
- Four weeks to withdraw from the study

A. Participant Recruitment and Data Collection Pack: Signposting Booklet

Seeking anxiety mental health support for the first time in later life: a narrative study

SIGNPOSTING BOOKLET

UNIVERSITY OF EXETER

Contents

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Immediate / Urgent Support

National Health Service (NHS)	NHS 999 will provide emergency services when someone is seriously mentally or physically ill or injured and their life is at risk.	For medical emergencies, call 999. Lines are available 24 hours a day, 365 days a year. Calls are free from mobile phones and landlines.
Samaritans	Confidential telephone, email, and face-to-face support for any problems someone may be experiencing. You do not have to have suicidal thoughts to use this service.	Website: www.samaritans.org Phone: 116 123 Lines are open 24 hours a day, 365 days a year. Email: jo@samaritans.org
Campaign Against Living Miserably (CALM)	For men who are feeling down or in crisis. A confidential service offering support, information and signposting for any issue.	Website: www.thecalmzone.net Phone: 0800 58 58 58 Lines are open 5pm to midnight every day

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Mental Health Support

NHS Psychological Therapies Service (IAPT)	If you live in England, you can access IAPT services. They offer talking therapies such as cognitive behavioural therapy, counselling and guided self-help.	Speak to your GP or self-refer. To find a service near you: www.nhs.uk/service-search/find-a-psychological-therapies-service/
Anxiety UK	Charity to promote relief of people living with anxiety. Provide information about anxiety and where to get support.	Website: www.anxietyuk.org.uk/ Phone: 03444 775 774 Email: support@anxietyuk.org.uk
Mind	Offer advice and support about mental health.	Website: www.mind.org.uk Phone: 0300 123 3393 Text: 86463 Email: info@mind.org.uk

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Rethink	Offer advice and support about mental health.	Website: www.rethink.org Phone: 0121 522 7007
Big White Wall	Digital mental health services providing anonymous support.	Website: www.bigwhitewall.co.uk Phone: 0203 691 1955

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Support for Older Adults

Age UK	Charity aiming to help everyone make the most of later life. Offer advice, support and companionship to older people.	Website: www.ageuk.org.uk/ Phone: 0800 055 6112 Advice line is open 8am – 7pm every day of the year.
Silver Line	Free, confidential helpline providing information, support and friendship to older people.	Website: www.thesilverline.org.uk/ Phone: 0800 4 70 80 90 Open 24 hours a day, every day of the year.
Independent Age	Offer advice about care and support, money and benefits, and health and mobility. Also offer regular friendly contact.	Website: www.independentage.org/ Phone: 0800 319 6789
Friends of the Elderly	Offer one-off grants and regular allowances to older people on a low-income.	Website: www.fote.org.uk/ Phone: 020 7730 8263

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Re-engage	Provide social connections for older people through regular phone calls or social gatherings.	Website: www.reengage.org.uk/ Phone: 0800 716 543 Email: info@reengage.org.uk

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Families and Relationships

Cruse	Offer advice and support about loss, grief and bereavement for people who have experienced the death of someone close.	Website: www.cruse.org.uk/ Phone: 0808 808 1677
Relate	Offer advice and support about relationships, including counselling for individuals, couples and families.	Website: www.relate.org.uk/ Phone: 0300 003 0396

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Housing and Benefits Support

Citizens Advice	Offer information and advice on a range of issues including: benefits, work, debt, consumer advice, housing, health, law, and immigration. Offer specific advice around pensions.	Website: www.citizensadvice.org.uk/ Phone: 0800 144 8848 (England) 0800 702 2020 (Wales) Open 9am – 5pm Mon-Fri
Debt Advice Line	Free, confidential and independent advice about dealing with debt in the UK.	Website: www.nationaldebtline.org/ Phone: 0808 808 4000
Crisis	Offer support, advice, and courses for people who are homeless.	Website: www.crisis.org.uk/
Shelter	Offer support, advice, and information about housing and benefits.	Website: https://england.shelter.org.uk/ (England) https://scotland.shelter.org.uk/ (Scotland) Phone: Urgent helpline – 0808 800 4444

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Alcohol, Drugs and Gambling Support

Alcoholics Anonymous	Support people for people experiencing alcohol addiction or problems.	Website: www.alcoholics-anonymous.org.uk/ Phone: 0800 9177 650 Email: help@aamail.org
Adfam	Offer information and support to the family and friends of people experiencing addiction to alcohol, drugs or gambling.	Website: https://adfam.org.uk/ Phone: 020 3817 9410 Email: admin@adfam.org.uk
Drink Aware	Offer information and advice about alcohol and alcohol misuse	Website: www.drinkaware.co.uk/ Phone: 020 7766 9900 Email: contact@drinkaware.co.uk

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Be Gamble Aware	Provide information to people to make informed decisions about their gambling.	Website: www.begambleaware.org/ Phone: 0808 8020 133 Email: info@gambleaware.org
GamCare	Offer information, advice and support for anyone harmed by gambling.	Website: www.gamcare.org.uk/ Phone: 0808 8020 133
Frank	Offer information, advice and support about drugs and alcohol.	Website: www.talktofrank.com/ Phone: 0300 123 6600 Email: frank@talktofrank.com
Narcotics Anonymous	Support people for people experiencing drug addiction or problems.	Website: https://ukna.org/ Phone: 0300 999 1212

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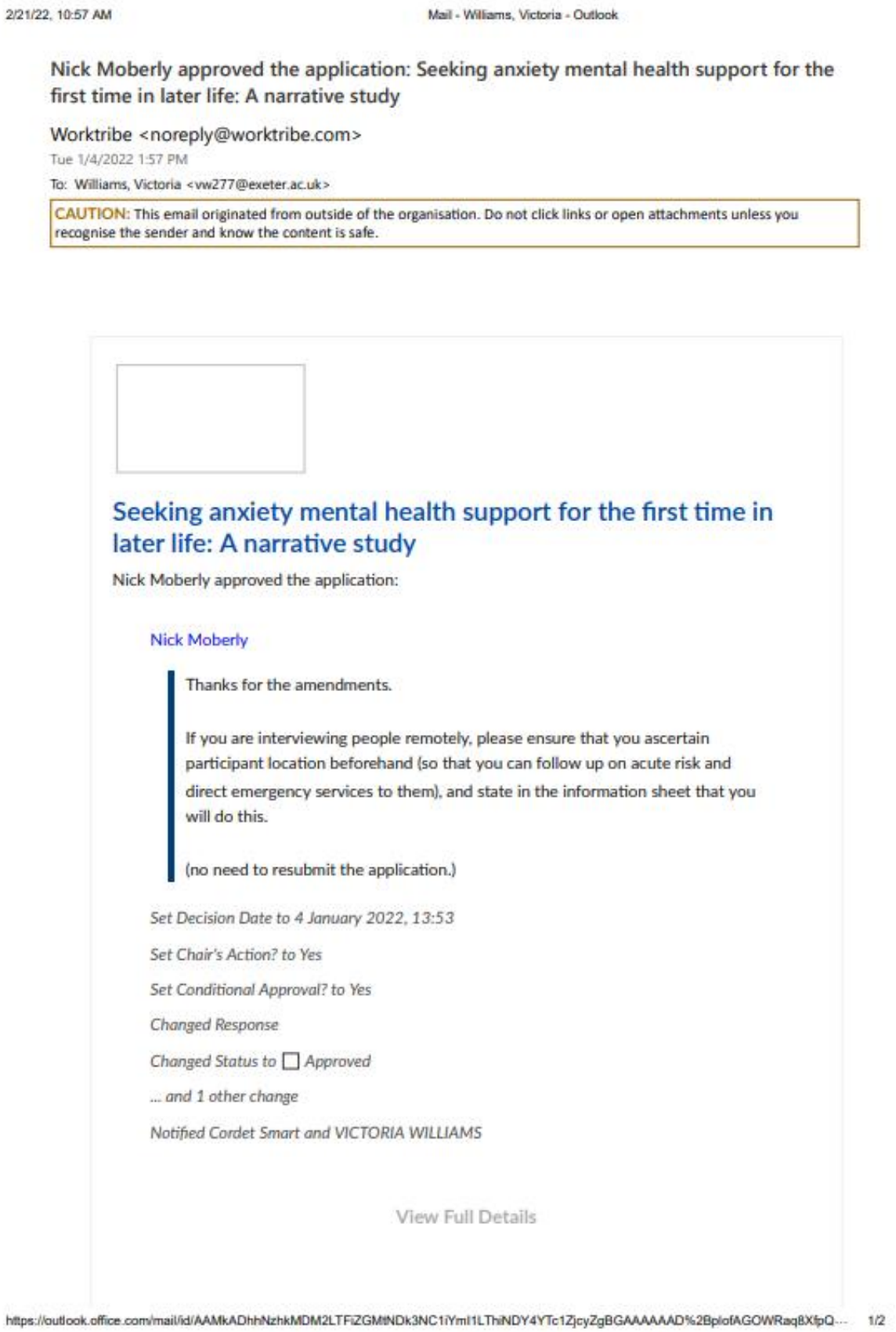
B. Ethics Documentation: University of Exeter Psychology Research Ethics Committee Approval



2/21/22, 10:57 AM Mail - Williams, Victoria - Outlook

Nick Moberly approved the application: Seeking anxiety mental health support for the first time in later life: A narrative study

Worktribe <noreply@worktribe.com>
Tue 1/4/2022 1:57 PM
To: Williams, Victoria <vw277@exeter.ac.uk>

CAUTION: This email originated from outside of the organisation. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Seeking anxiety mental health support for the first time in later life: A narrative study

Nick Moberly approved the application:

Nick Moberly

> Thanks for the amendments.
>
> If you are interviewing people remotely, please ensure that you ascertain participant location beforehand (so that you can follow up on acute risk and direct emergency services to them), and state in the information sheet that you will do this.
>
> (no need to resubmit the application.)

Set Decision Date to 4 January 2022, 13:53

Set Chair's Action? to Yes

Set Conditional Approval? to Yes

Changed Response

Changed Status to ☐ Approved

... and 1 other change

Notified Cordet Smart and VICTORIA WILLIAMS

View Full Details

https://outlook.office.com/mail/id/AAMkADhhNzhkMDM2LTFiZGMtNDk3NC1iYmI1LThiNDY4YTc1ZjcyZgBGAAAAAAD%2BplofAGOWRaq8XfpQ... 1/2

Risk:	High
Applicant:	VICTORIA WILLIAMS
Org Unit:	Psychology (Exeter)
Supervisor:	Cordet Smart
Status:	☐ Approved

C. Public Involvement Documentation: Advisor Information

Public Involvement Advisor Information

Thank you for considering being an advisor for this research project. Below is some information that may help you decide if you would like to get involved.

What is a public involvement advisor?

An advisor is someone from the public who has experience relevant to a research topic. This advisor works with a researcher or research team to conduct the research in line with the needs of those they are researching, through consultation and collaboration. By providing their views to this research, the project can be tailored to the older adult community, to: enhance older adults' experience of the research; enhance quality of the research findings; and provide the findings of the research project in the most user-friendly way.

Who am I?

I am a trainee clinical psychologist studying at the University of Exeter. As part of my training towards my Doctorate in Clinical Psychology, I complete research that aims to contribute to our understanding of mental health and clinical psychology. I also work in the National Health Service to learn clinical skills.

What is my research about?

My research project aims to explore the experiences of older adults who have sought mental health support for anxiety for the first time. Experiencing anxiety in older age is common. If not treated, anxiety can last for years, if not decades. However, despite interventions for anxiety being effective in older adults, referrals for older adults to mental health support are still much lower than expected. Compared to other common mental health problems like depression, anxiety is more likely to be undertreated. This low referral level suggests that these individuals are facing challenges to access support. Although research has found many barriers and facilitators to older adults seeking mental health support, there is very little research that explores older adults' experiences of seeking support for the first time. I hope that this project will lead to recommendations about how support services can make it easier for older adults to get support for anxiety.

What would your role be?

As an advisor, you would be involved in this research through consultation. I plan on meeting with advisors twice: once before the project begins, and once after data is collected, to gather feedback. The kind of things I might ask for feedback on include:

- Language and wording of research materials
- Where and how to reach potential participants
- The kinds of questions to include in research interviews
- The results of the research and how the results could inform support provision

What would be expected of you?

- Personal experience – be an adult aged 65 years or older who has sought mental health support for anxiety as an older adult
- Attendance at two meetings – meetings would typically last for 1-2 hours and dates would be decided with you via email. These meetings might be via videoconferencing or in person, depending on preference and ability to travel.
- Ability to work with other advisors – there may be more than one advisor for this project and meetings may be together.
- Confidentiality – to ensure that everyone who attends meetings feels comfortable sharing their experiences, there would be an agreement to keep discussions discreet and confidential.
- Open, honest communication – my research will be best informed by open and honest feedback from you. Positive as well as negative feedback will help me conduct this research to a high quality.

I don't know anything about research, can I still be involved?

I do not expect you to have a full understanding of the research process and will provide information where needed.

Will all my feedback be used?

All feedback will be listened to and noted however some ideas may not be incorporated into this research project due to reasons such as feasibility. I will endeavour to keep advisors up to date with how I use their feedback throughout the research.

What are the benefits of being an advisor?

By being an advisor, you will contribute to the quality of this research and to knowledge about how to improve access to mental health support for older adults. You could also learn more about research.

Advisors for this project will be reimbursed for their time at meetings at the rate of £25 per hour.

Further information

For more information or if you are interested in getting involved, please contact me:

Vicky Williams

Email: vw277@exeter.ac.uk

Supervised by:

Dr Cordet Smart (c.a.smart2@exeter.ac.uk)

Dr Rachel Handley (r.v.handley@exeter.ac.uk)

C. Public Involvement Documentation: Example of Meeting Log

Advisory Group Log: Feedback and Actions

Date: 29th October 2021 10am-12pm

Format of PI event:

- Face-to-face meeting with older adult who has sought mental health support previously
- Location: Room 107, Washington Singer Building, University of Exeter Streatham Campus

Aims of PI event	**What was learned?**	**Outcome** (what was done in response to feedback?)
1) Feedback from AG on research design 1. Interview single question 2. Online, phone, or in person 3. Researcher being a younger adult	1. Should ask more about 'experience' of anxiety and how they coped with it, rather than 'process' of how people accessed support as this might lead to them listing off the steps they took e.g. went to GP, referred to TalkWorks, assessment, referred to CMHT etc. People will gain more from the study by and have a good experience of the study by being able to talk more about their experiences and their story. Find out more about who they are as people, rather than being so clinical. Being more open-hearted with the main question. Ideas for how to rephrase:	1. Rephrased central question to capture more of background to how people experienced anxiety and what led them to seek mental health support. 2. If given choice and participant happy with any method, perhaps consider encouraging interview methods where I can see participants, such as face-to-face or video call. To let participants who want to be interviewed over the phone know

	"Tell me how you responded when you became aware you were struggling with anxiety, and what steps you took to get help" "How did you manage your anxiety? What helped or didn't help?" "How did you feel?" "When did you begin to feel better, or not?" "I want to hear your story of how you experienced anxiety and the kind of steps that you took to seeking support and what that was like" 2. You could miss out on quite a lot on the phone as you miss face expressions and a sense of who they are. Might want to encourage people to do interview in person or on video. Agreed that pre-amble on phone might be helpful to let people know researcher might leave a long pause after they have spoken to make sure they have finished what they are saying and that researcher doesn't cut across them. 3. Didn't feel that age would be a problem at all. It matters more about how friendly, open, how well they listen and communicate, and how receptive the researcher is to what people are	that I will leave longer pauses after their responses. 3. To try and present myself as open and friendly before and during interviews and help participants feel listened to. To organise interviews with plenty of notice where possible and make sure participants have all the information they need in advance.

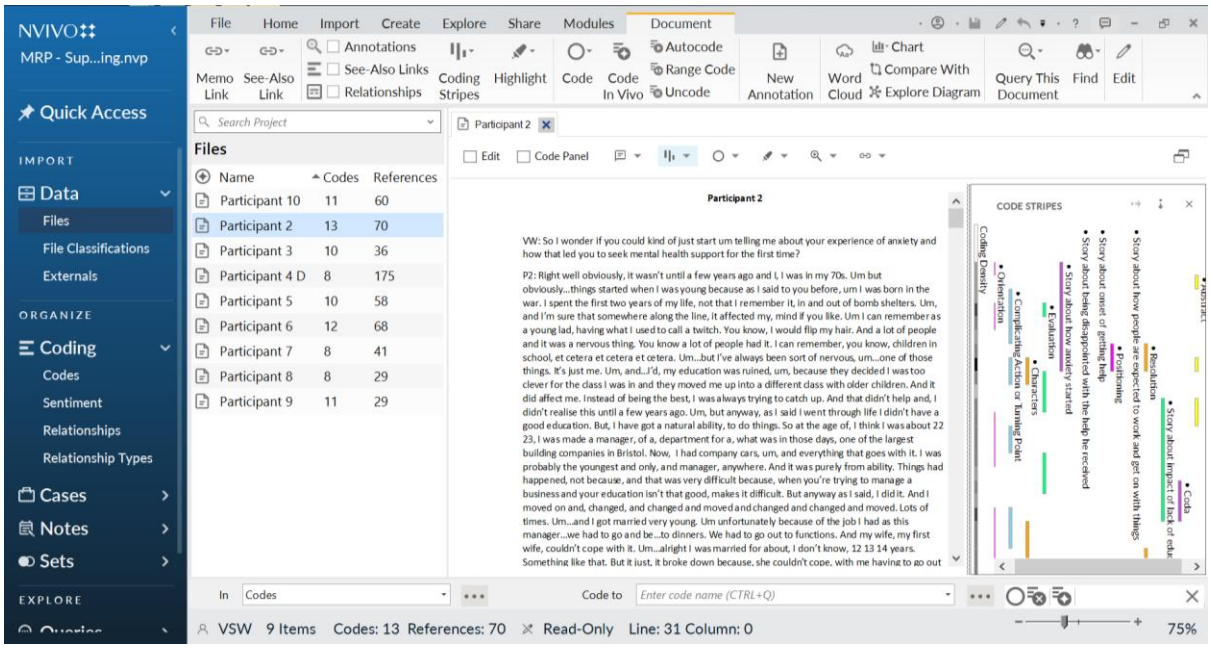
	saying. Being welcoming and encouraging people to talk by giving them space will be important. We've all experienced anxiety at some point and can be empathetic to others – and this is more important than age. Felt that communication has been very proficient for organising the meeting so this could be carried through to interview.	
2) Feedback from AG on recruitment documents Acceptable? Accessible? a. Study advert b. Participant information sheet c. Consent form d. Demographics questionnaire e. Signposting booklet	a. Should have something about anxiety in the headline. It could be research about anything. "Have you had struggles with anxiety? If so, you are invited to take part in research" should be the main question at the top of the poster. Main point of the study is about people who have experienced anxiety and their experienced. Plenty of information provided on the poster – it is enough. Change title to: Have you struggled with anxiety? If so, you are invited to take part in some research. Remove: "Have you had worries or anxiety?" from list of questions. Third question could then be "Was it easy, and how have you found the experience?"	Make edits to study advert to put more focus on anxiety in title.

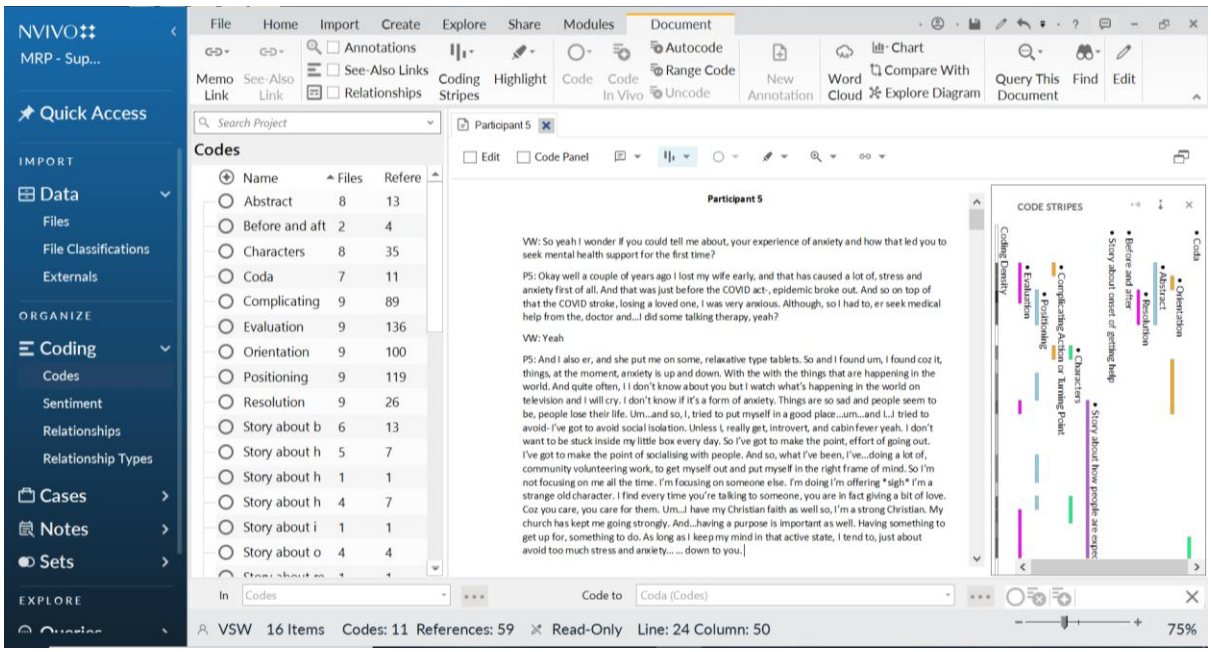
	Change wording from “Your experiences could help us understand…” to “Your story could help us understand…”	
	b. Very clear. If they received that would think the researcher was being very careful and thought about it very carefully, covering all the angles and explained all aspects of taking part. It’s not reems of text and is broken up with subheadings and is fairly easy to read. Covered all angles very well. Could reword part in participant information sheet about “to understand what it is like for older adults to seek mental health support for anxiety for the first time” to “their experiences of anxiety and how that led them to seek support for anxiety for the first time”. PI agreed that this rewording would be better. Shopping voucher for taking part will probably help people to take part. People always like a freebie. Keep choice of shopping voucher as broad as possible so they can choose where to spend it. E.g. WHSmiths, major supermarket (e.g. M&S, Tesco), Amazon, major high street brands (e.g. John Lewis). Some people might struggle ethically with Amazon.	Reword participant information sheet to focus more on experience of anxiety before seeking support. Choose a range of shopping vouchers that participants could opt for.

	Could give people half a dozen choices of what shopping voucher they might like.	
	c. Have everything there and is clear. Important that they won't be personally identified in reports – this will be reassuring on the consent form. Gives people the opt out to withdraw from the study. Feels fine for four weeks to be limit of withdrawing from the study. Correct typo about 'focus group' and change to 'interview'.	Correct typo.
	d. Not sure how relevant income is and wonder if people would feel comfortable to answer this. But there is the option to put 'prefer not to say'. Clear.	Ensure participants know they can choose 'prefer not to say' when filling in initial demographics/background questionnaire before interview.
	e. Some organisations that they hadn't heard of before e.g. Anxiety UK and Campaign Against Living Miserably. Maybe add something like Devon Recovery Learning Community.	Perhaps add resources local to South West such as Devon Recovery Learning Community.
3) Feedback from advisor on recruitment ideas • Any additional ideas?	Suggestion of Devon Recovery Learning Community (run online course about depression, self-compassion, mindfulness etc. Could look if this kind of service is run elsewhere in the UK. Suggestion of charity, Mind.	- Look at Devon Recovery Learning Community as potential recruitment idea (i.e. check they are not an NHS service).

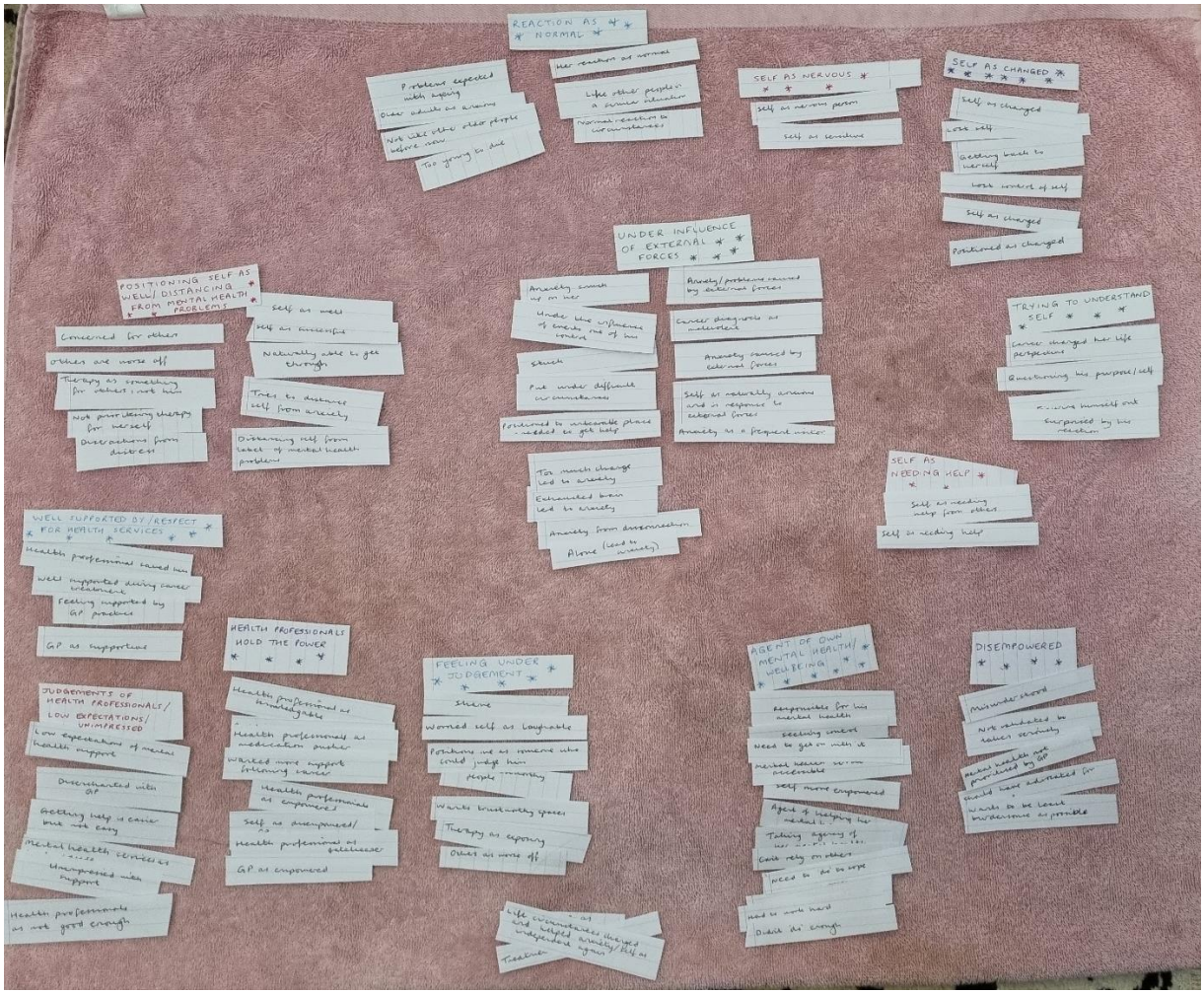
	Suggestion of recruiting through older adult mental health services (i.e. NHS) Suggestion of in GP surgeries. Suggestion of community centres e.g. that run mindfulness, tai chi, yoga groups etc. Suggestion of University of the Third Age. Agreed with Facebook – could not think of any other websites that people might use frequently.	- Find mindfulness groups, tai chi groups and yoga groups and where they are held. For example, if held in a community centre this may be somewhere a poster could be put up.
4) Anything else?		

D. Data Analysis: Example of Structural Analysis Coding Using NVivo





D. Data Analysis: Positioning Analysis Process - Comparison Between Narratives



D. Data Analysis: Example of reflective diary

07.10.22:

During transcription, I noticed a theme coming up around the idea of death and dying being a trigger for anxiety.
Also some people still talked about not wanting to be a burden on services.
Having a long good relationship with a GP was helpful for seeking help from them.
One person spoke about wanting to keep their information about mental health out of their health records (stigma?).
People talk to me from the position of being young and a student or a health professional. In some cases this was trying to teach me about their experience and support my learning, for others it was trying to complain and tell me what I should be doing to be a better health professional. I was aware throughout the study of my position as a young, white, female trainee clinical psychologist and anticipated that this may influence the way stories were told to me, either through being positioned as young and learning or as one of 'them' i.e. a health professional. Participants may have had differing experiences of health professionals, for example powerful, paternalistic and knowledgeable, or as someone who represented a challenge to them getting the help they wanted in the past. However, this also may have created a dynamic between some participants and myself in which I was positioned as someone naïve and learning.

02.11.2022

While reading Arthur Frank's book, The Wounded Storyteller, he says "Both institutions and individual listeners steer ill people toward certain narratives, and other narratives are simply not heard...Reflection on one's own narrative preferences and discomforts is a moral problem, since in both listening to others and telling our own stories, we become who we are". This made me wonder how I may have steered the interviews and whether I influenced the types of stories that participants told. I thought I may have asked more questions about "what helped", which while my research aim to find this out, I may have changed the way participants told their stories. They may have thought that there was nothing that really helped, or viewed that getting support was a serendiptous event.

E. Dissemination Statement

The analysis and conclusions of this study will be disseminated to interested parties through feedback, journal publication and presentation.

Dissemination to participants and organisations. Participants and recruiting organisations who expressed an interest will be sent a summary of the study analysis and conclusions.

Journal Publication. It is planned that this study will be submitted for publication to the journal, Aging and Mental Health (Impact Factor 3.520 in 2021). This journal has a good content-fit to the study and has previously published qualitative research, increasing the chances of publication. Their word count for qualitative pieces of work is 8000 words. The journals' readership would be appropriate to the dissemination of this study, by targeting those interested in psychology and therapy for older adults, and health-seeking behaviour.

Presentation. On 24th January 2023, the preliminary analysis of this study was presented at a research conference for doctoral students at the University of Exeter.

For recruiting organisations that would like to hear more about the study, a presentation of the analysis and conclusions will be arranged.

F. Journal Submission Guidelines

Preparing Your Paper

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

Please include a word count for your paper.

A typical paper for this journal should be no more than 7,000 words for quantitative papers and 8,000 words for qualitative papers inclusive of

- figures
- tables
- references
- tables

Appendix excluded.

All revised papers could have extra 500 words allowance.

Style Guidelines

Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

Any spelling style is acceptable so long as it is consistent within the manuscript.

Please use single quotation marks, except where ‘a quotation is “within” a quotation’.

Please note that long quotations should be indented without quotation marks.

All revised papers should have a clean version.

If there is more than one corresponding author, please unsubmit the paper and visit here.

If there is more than one first author, unsubmit the paper.

All papers should include a statement on ethical approval (with blinded affiliate information). All clinical trials must have been registered in a public repository and trial registration numbers should be included in the abstract, with full details in the methods section.

If the manuscript does not follow the required reference style, please unsubmit the paper and visit AMH reference format guideline.

Formatting and Templates

Papers may be submitted in Word format. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

Word templates are available for this journal. Please save the template to your hard drive, ready for use.

If you are not able to use the template via the links (or if you have any other template queries) please contact us here.

References

Please use this reference guide when preparing your paper. An EndNote output style is also available to assist you.