1991

Effects of reminiscence therapy on self-esteem and depression levels in the elderly

Patricia Dinan
San Jose State University

Follow this and additional works at: https://scholarworks.sjsu.edu/etd_theses

Recommended Citation

Dinan, Patricia, "Effects of reminiscence therapy on self-esteem and depression levels in the elderly" (1991). *Master's Theses*. 110.
DOI: <https://doi.org/10.31979/etd.tyvy-5pgv>
https://scholarworks.sjsu.edu/etd_theses/110

This Thesis is brought to you for free and open access by the Master's Theses and Graduate Research at SJSU ScholarWorks. It has been accepted for inclusion in Master's Theses by an authorized administrator of SJSU ScholarWorks. For more information, please contact scholarworks@sjsu.edu.

INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

U·M·I

University Microfilms International
A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
313/761-4700 800/521-0600

Order Number 1344256

**Effects of reminiscence therapy on self-esteem and depression
levels in the elderly**

Dinan, Patricia Lynn, M.S.N.

San Jose State University, 1991

U·M·I

300 N. Zeeb Rd.
Ann Arbor, MI 48106

EFFECTS OF REMINISCENCE THERAPY ON SELF-ESTEEM AND
DEPRESSION LEVELS IN THE ELDERLY

A Thesis

Presented to

The Faculty of the Department of Nursing
San Jose State University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science

By

Patricia Dinan

May, 1991

APPROVED FOR THE DEPARTMENT OF NURSING

Virgil Parsons

Virgil Parsons, D.N.Sc., R.N.

Clara W. Boyle

Clara W. Boyle, Ed.D, R.N.

Bobbie Gorenberg

Bobbie Gorenberg, D.N.Sc., R.N.

APPROVED FOR THE UNIVERSITY

Serena H. Stanford

ABSTRACT

EFFECTS OF REMINISCENCE THERAPY ON SELF-ESTEEM AND DEPRESSION LEVELS IN THE ELDERLY

by Patricia Dinan

This study assessed the value of reminiscence as a therapeutic intervention for older persons ($N=39$). A decrease in depression and an increase in self-esteem were the hypothesized outcomes. The Zung Re-modified Self-Rating Depression Scale (1965) and the Rosenberg Self-Esteem Scale (1965) measured depression and self-esteem levels before and after 6 one hour reminiscence sessions. Roy's Adaptational Model (1976) formed the conceptual framework.

Using a quasi-experimental design, participants were conveniently assigned to four groups: 2 experimental groups and 2 control groups. Analysis of change from pretest to posttest revealed no significant difference for either depression or self-esteem in the experimental and control groups. There were no differences between age groups. The data supports the need for improving self-esteem and raising depression levels in the elderly. The question remains as to which segment of the population would benefit the most from reminiscence therapy.

ACKNOWLEDGMENTS

To my family, friends, faculty
and particularly to my
friend, Carol Lacey,
who helped and supported
me in the writing
of this thesis.

TABLE OF CONTENTS

	Page
Abstract	iii
Acknowledgments	iv
LIST OF TABLES	ix
 Chapter	
1. INTRODUCTION	1
Statement of the Problem	4
Purpose of the Study	6
Research Questions	7
Scope and Limitations	8
Definition of Terms	8
2. CONCEPTUAL FRAMEWORK AND LITERATURE	
REVIEW	10
Conceptual Framework	10
Literature Review	14
Reminiscence	21
Validation	23
Integration	23
Guiding	24
Connecting	24
Categories of Reminiscence	25
Informative Reminiscence	26
Valuative Reminiscence	27
Obsessive Reminiscence	28

Reminiscing and Group Therapy	29
Summary	33
3. METHODOLOGY	35
Design of the Study	35
Setting	37
Sample	39
Intervention	40
Data Collection Instruments.	42
Data Analysis	47
Procedure	48
4. ANALYSIS AND INTERPRETATION OF DATA	50
Question 1: Demographic profile of the clients	51
Question 2: Does reminiscence therapy decrease depression as measured by Zung's Re-modified Self-Rating Depression Scale in the elderly?	55
Question 3: Does reminiscence therapy increase self-esteem levels in the elderly as measured by the Rosenberg Self-Esteem Scale?	58

Question 4: Was there a difference in depression levels and self-esteem response between the old groups and the young groups from the reminiscence experience?	60
Observational Data	60
5. CONCLUSIONS AND RECOMMENDATIONS	65
Conclusions	66
Implications,	69
Recommendations	70
Limitations	71
REFERENCES	72
APPENDICES	
A. Demographic Profile.	80
B. Rosenberg Self-Esteem Scale	82
C. Zung Re-modified Self-Rating Depression Scale	84
D. Life Review and Experiencing Form (LREF) . . .	86
E. The Mini-Mental State examination (MMS) . . .	89
F. Institutional Review Board--Human Subjects Approval Letter San Jose State University	92
G. Approval Letter to use Ambulatory Health Clinic as a Research Site	94
H. Participant Consent Form	96

I.	Permission to use the article containing the Zung Re-modified Self-Rating Depression Scale and the Rosenberg Self-Esteem Scale	99
J.	Permission Letter to use the Life Review and Experiencing Form (LREF)	101

LIST OF TABLES

Table		Page
1.	Key for Scoring SDS	57
2.	Analysis of Variance of Zung's Re-modified Self-Rating Depression Scale	61
3.	Analysis of Variance of Rosenberg's Self-Esteem Scale	62

Chapter 1

INTRODUCTION

According to Abraham Maslow (1954), all people need to esteem or value themselves. Whatever self-concept a person holds, he needs to be able to place high positive value on himself. Having a positive self-image helps a person seek and deal with environmental experiences (Roy, 1976).

A person's self-concept is the result of a lifetime of social experiences. At any given time, an individual's self-concept is a composite of his beliefs about himself, representing his total appraisal of his appearance, background, abilities, resources, attitudes, and feelings.

Any experience or situation that causes a person to question his self-worth may cause a decline in self-esteem. Among the elderly in particular, experiences of loss tend to create problems of lowered self-esteem. It is not difficult to identify losses experienced by the elderly that have the potential to reduce their self-esteem. Often, these people must cope with loss of health, appearance, jobs, loved ones, homes, friends, and/or status, as well as loss of memory and, in some cases, cognitive abilities. Certainly, the number and severity of losses vary from individual to individual

based on past achievement, personal integrity, past coping mechanisms, and the availability of support systems.

However, because many of the elderly face an accumulation of losses, older people as a group are at a higher risk than other age groups for problems of lowered self-esteem (Taft, 1985).

Neugarten (1977) notes that by describing old age primarily in terms of problems and losses, rather than freedom and gains, we fail to do it justice. This tendency undoubtedly reflects stereotypical views of aging derived from studies of the ill elderly. Fortunately, a growing body of knowledge about normal processes of aging indicates that while meeting basic needs is a serious problem for many, most of the elderly consider themselves in good mental and physical health.

Goldfarb (1971) observed that economic security, education, social relationships, and social status are psychologically protective for the elderly population, contributing to self-esteem, freedom from fear, social and emotional support, and role adjustment. Furthermore, he observed that negative effects on mental health can occur when elderly individuals become increasingly dependent on their families for a variety of reasons including illness,

loss of financial security, and loss of other significant support systems.

There is growing recognition of the value of group work as a therapeutic nursing intervention in meeting the psychosocial needs of the elderly. By far, the most crucial concept in group therapy is that the aging individual is a treatable client (Taft, 1985). Inclusion of the elderly in group process has demonstrated that they are not too old to learn or benefit from group communication. Groups may be organized to meet any level of need in Maslow's (1954) hierarchy; obviously they often meet multiple needs. By assessing social climate and human needs, a nurse can determine the type of group most suitable in a given situation.

Loss of self-esteem, represented by a feeling of uselessness, lack of worth, lack of love objects, lack of recognition, and depression, can be common in the life of elderly persons. Types of groups which have proven beneficial for enhancing self-esteem include health orientation, reality orientation, remotivation, and reminiscence groups. These groups are used to facilitate acceptance of the individual's life experience, through shared memories of significant events of a personal or historic nature. The group process is based on Erikson's

(1950) theory of the maintenance of ego integrity. The main benefit of group work is its emphasis on the individual's competence and his or her conviction that he or she has occupied a positive space in the history of the human race (Burnside, 1976). The process of sharing feelings occurs through communication and group support. The goals of these groups are to develop self-esteem and reduce depressive episodes. They also promote socialization, reduce isolation, increase stimulation and interest, and enhance self-care and appearance.

Statement of the Problem

Gerontology recognizes that growing old inevitably means the loss of significant life supports. Retirement signals separation from an occupational identity. Death of irreplaceable loved ones leaves the elderly person increasingly alone. Declining physical abilities often mean the cessation of accustomed life habits.

Lewis (1971) believes that some old people may adjust effectively by satisfactorily "disengaging" from society or life in general. However, for others, old age can bring a reduction in self-esteem even to the point of clinical depression unless a means can be found for coping with losses and re-evaluating the impact of aging on the self. When the elderly are constantly confronted with

people who consider them incapable of productive activity, asexual, senile, and untreatable, the effect on their self-esteem may be negative.

Many of these people would benefit from mental health services, but unfortunately they are not receiving these services in proportion to their representation in the population or in proportion to their estimated need for such services. According to Knight (1978), major barriers to utilization of such services by the aged are the prejudices of care providers, the poverty of the aged, and lack of public commitment to the provision of services to this special population.

New trends for therapeutic interventions are beginning to develop in this area. Group therapy sessions are starting to evolve within senior communities. These interventions are usually public health oriented, accessible to seniors, do not require payment for services, and are directed toward changing social attitudes towards the elderly. They also attempt to improve self-esteem and raise depression levels.

One such intervention is reminiscing, that is, the rehearsal and sharing of comforting memories. Reminiscing with other members of a group can result in a sense of belonging, improved self-esteem through confirmation of

uniqueness, and a lowered risk of depression. Reminiscing does not diminish the importance of coping with everyday living but, used maximally, enriches daily life.

Purpose of the Study

This study assessed the value of reminiscing as a therapeutic nursing intervention for older persons. The goal of the study was to investigate claims that reminiscing is an effective short-term therapeutic intervention in decreasing depression and raising self-esteem in the elderly.

Some of the types of reminiscing discussed in the literature are: (a) life-review, (b) simple reminiscing, (c) informative reminiscing, and (d) positive reminiscing. All four types of reminiscing, with the exception of life-review, are focused on providing pleasure and enhancing self-esteem through re-living and re-telling past events.

Butler's (1963) life review process applies Erikson's concept of ego-integrity in old age. The life-review process attempts to come to terms with old guilt, conflicts, and defeats, and to find meaning in one's accomplishments. According to Butler, through life review, an individual may attain the final developmental stage posited by Erikson (1950), which is ego integrity.

The literature about reminiscence that has developed since Butler's initial conception has been characterized by a wide variety of interpretations about the nature and function of reminiscence. The terms reminiscence and life review have been used interchangeably (Butler, 1963).

In this study, reminiscing was conducted through a life review format with the intent of allowing this psychosocial intervention to be free-flowing or structured depending on the group process. The goal of this study was to increase self-esteem, positive identity, acceptance of losses, life satisfaction, and psychological well-being for those clients who participated in the study.

Research Questions

The study attempted to answer four questions:

1. What was the demographic profile of subjects participating in the study?
2. Does reminiscence therapy decrease depression in the elderly as measured by Zung's Re-modified Self-Rating Depression Scale?
3. Does reminiscence therapy increase self-esteem levels in the elderly as measured by the Rosenberg Self-Esteem scale?
4. Is there a difference in depression levels and self-esteem response between the old groups (ages 76 and

older) and the young groups (ages 60 to 75) from the reminiscence experience?

Scope and Limitations

One limitation of this study was that only simple reminiscing through life review was chosen for the group sessions. There is no sound empirical evidence that any single type of reminiscing is especially suited to the needs of the elderly, and this type of life review was deemed to be the most generally recognized. Another limitation is the small sample size and investigation at only one site. Lastly, only one segment of the elderly population was studied for the effects of reminiscence on self-esteem and depression levels. Possibly an institutionalized sample would have yielded different results.

Definition of Terms

The major terms used in the study were defined as follows:

1. Self-esteem is that pervasive aspect of the personal self-component which relates to the worth or value the person holds of himself (Roy, 1976, p. 233).
2. Ego-integrity is satisfaction with one's life and decisions; an acceptance of one's life cycle (Erikson, 1963, p. 72).

3. Self-concept is a composite of the feelings and beliefs that an individual holds about himself (Roy, 1976, p. 169).

4. Life-review is a naturally occurring universal mental process characterized by the progressive return to consciousness of past experiences (Butler, 1963, p. 66).

5. Reminiscence is a mental recollection of a long forgotten experience or fact; the process or fact of thinking or telling about past experiences (Webster, 1965, p. 1920).

6. Socialization is an active participation in the group process (Webster, 1965, p. 2162).

7. Reconceptualization is the act of reforming concepts (Webster, 1965, p. 1897). Reconceptualization is the process of reviewing the personal sense and meaning of the life cycle as it relates to Life-Review (Butler, 1974, p. 72).

8. Nihilism is the viewpoint that traditional values and beliefs are unfounded and that existence is senseless and useless (Butler, 1974, p. 169).

9. Gerontology is a branch of knowledge dealing with aging and the problems of aging (Webster, 1965, p. 952).

Chapter 2

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

Conceptual Framework

The nursing theory employed as the conceptual framework for this study was detailed in 1976 by Sister Callista Roy in Introduction to Nursing: An Adaptation Model. According to Roy (1976), man is a biopsychosocial being in constant interaction with a changing environment. To cope with this changing environment, man has certain innate and acquired mechanisms, which are biological, psychological, and social in origin. Man's positive response to a changing environment is commonly known as the process of adaptation. Roy's Adaptation Model was developed from Erikson's eight stages of the life cycle, each with its transition point or maturational crisis. Erikson explored each stage in relation to the developing self-concept. From Erikson's exploration of the life cycle marked by stages of psychosocial development, Roy identified four areas in which man adapts to his environment: physiological needs, self-concept, role function, and interdependence.

Roy gives equal importance to all four areas; man's need for psychic integrity is as important as the need for physiological integrity. Just as man adapts

physiologically to his environment, he also adapts through self-concept. Each person has a concept of himself which is affected by and also used to cope with situations of health and illness.

Self-concept and self-esteem, the individual's perception of his worth, are both directly and indirectly affected by the negative labeling and stigmatization of the elderly population. If one's self-image and behavior come to reflect negative stereotypes, self-esteem declines. As self-esteem declines, belief in one's ability to exercise control over the environment also decreases.

Crises and stressful situations occur throughout life but tend to be more devastating in the later years when people may have less reserve adaptive capacity (Ebersole & Hess, 1985). Psychologic homeostasis fluctuates within a smaller range of normal. When crises and cumulative stresses stretch the limits of coping capacity beyond the person's range, adaptive behavior temporarily deteriorates, and helplessness, lack of control, powerlessness, and dependency emerge.

Roy's Adaptation Model assumes that man has a need for ego-integrity, and that this need is met by the person knowing who he is and feeling that this self is an

adequate self. Roy's theory of ego-integrity is based on the eighth and last transition point in Erikson's (1963) life cycle which is ego integrity versus despair. This last stage of man's development is very much dependent on all the previous stages. A person who has achieved some sense of trust, autonomy, initiative, industry, intimacy, and generality is ready to meet this crisis by feeling satisfied with his life and decisions. Ego integrity involves acceptance of one's life as something that had to be. Although the person is aware of other and different life styles that give meaning to others, he possesses a feeling of fullness and satisfaction of the dignity and completeness of his life (Roy, 1976).

In old age, however, sometimes a person has not achieved ego-integrity, that is, having a feeling of satisfaction with his life and decisions he has made. He may, instead, feel despair, suffer a loss of his accrued fullness of self, and actually fear death. He does not feel that who and what he is and was are enough or right. He has not met self-expectations.

Through a lifetime of coping with stress, some individuals develop an ability to adapt to developmental and situational crises while others do not. In some situations, an individual of advancing age finds himself

gradually giving up rights and obligations of relationships, thereby feeling powerless.

Roy identifies focal, contextual, and residual factors that need to be considered when assessing self-esteem. Any situation or stimulus causing the person to question self-value may be considered focal. For example, a conflict or disagreement with a significant family member can precipitate a questioning of self-worth, especially for an elderly individual. The person's awareness of self-worth, feedback, and reinforcement provide the contextual stimuli. Any previous experience with loss that limits the ability to cope with challenges, e.g., loss of a job, possibly being replaced by a "younger," more capable person, provides ongoing residual stimuli.

Thus, a person's own projection of his current level of self-esteem develops over a period of time depending on past experiences, both developmental and situational. Since our society has developed labels that create certain sets of negative expectations with regard to aging, it is likely that people will act in a manner consistent with these labels. Expectations based on the "label" of senility, for example, may have a great impact on the way old people view themselves (Butler, 1980).

Roy suggests that one intervention to deal with the problem of low self-esteem is to help the individual express his feelings and explore ways to understand the maturational and situational crises he is experiencing. Through either group process or individual counseling, the nurse can help the person see life as a continuing series of experiences out of which he can continue to define who and what he is in a meaningful and self-valuing way (Roy, 1976).

Roy then suggests that individuals need help understanding how and why past experiences have contributed to their current valueless feelings. In addition, Roy (1976) states that self-esteem, or value placed on the self, is a necessity if people are to adapt satisfactorily to their environment.

Reminiscing or life-review is one way aged people can review their past, attempt to make order and meaning, and reconcile conflicts and disappointments during their lifetime. Reminiscing may be a particularly adaptive process for improving self-esteem in the elderly.

Literature Review

According to Butler (1980), aging is the neglected stepchild of the human life cycle. Many Americans find it difficult to think about old age until they are in it

themselves or have a relative or friend who is suffering the effects of aging.

Attention to the status of the aged has grown more slowly in the United States than in older European nations, partly because youth-centered values have dominated our thinking and our planning. However, with improved medical technology, we have added years to the life span of many persons in our country. Between 1900 and 1985, the percentage of Americans 65 and over tripled (28.5 million). This represents an increase of 25.4 million or nine times the population in 1900 of persons over 65 years. The elderly represent about one in every eight Americans, or 12% of the U.S. population. Of this number, 2.7 million are over the age of 85. In 2050, one in 20 (or close to one quarter of all persons) could be this old (American Association of Retired Persons, 1986). While the increase in the "very-old" population is one of the major achievements of improved disease prevention and health care in this century, it has far-reaching implications for public policy because of the high probability of health problems and need for health and social services for this age group (Manton, 1984).

According to Butler (1980), in reality, the way one experiences old age is contingent upon physical health,

personality, earlier life experiences, the actual circumstances of late-life events and social supports such as adequate finances, shelter, medical care, and religion. Butler (1980) goes on to say that old age is like any other stage in life. It has ups and downs, joys and fears, accomplishments and failures. The tragedy of old age is not the fact that each of us must grow old and die, but that insensitivity and ignorance, at least in the past, have made the process of doing so excruciatingly painful, humiliating, devastating, and isolating.

Fortunately, in the past decade or so there seems to be a shift in a positive direction in terms of attitudes of the general population towards the elderly. For example, it has been found that the real buying power of many elderly households is much larger than the buying power they had in their middle years. The home ownership rate among the elderly has stayed high, and most have paid off their mortgages. In addition, the average financial asset holdings for people 65-75 are higher than for any other age group (Manton, 1984). In addition, Manton (1984) states that people over 65 report loneliness as a problem much less often than those 25 and under, even though they were more likely to live alone. He goes on to say that only 20% report poor health as a problem.

Although attitudes are changing in a more positive direction, our society continues to use labels that create certain sets of negative expectations with regard to aging. Thus, it is likely that aging people will act in a manner consistent with these labels. These negative attitudes can create chronic depression, lowered self-esteem, and diminished feelings of control (Langer, 1980).

Butler notes that the process of aging and eventual death must ultimately be accepted as something we all experience. To live a meaningful old age, the elderly must clarify and find use for what they have attained in a life time of learning and adapting; they must conserve strength and resources when necessary and adjust creatively to those changes and losses that occur as part of aging.

In general, lowered self-esteem is a direct result of the negative attitudes, decreased social interaction, and decreased power and control in this age group. These factors generate complex problems for which there are no simple solutions.

Related literature supports the need for improving self-esteem and raising depression levels in the elderly. According to Lewis (1971), age may necessitate a lowering of self-esteem, perhaps to the point of being clinically

depressed. Parsons (1986) states that depression is a well documented problem in the elderly population, resulting from severe health problems and from multiple losses such as independence.

The literature was inconclusive as to whether reminiscence actually increases self-esteem and decreases depression levels. The value of reminiscing in old age is supported by research (McMahon & Rhudick, 1964) which found that old men who reminisce seem less depressed compared to non-reminiscers. Other than the McMahon and Rhudick study, results of other research reported in the literature recounting the significance of reminiscing in old age report conflicting results.

Perrotta and Meacham (1982) demonstrated no significant changes in self-esteem or depression after 5 weeks of reminiscing with elderly subjects. Lappe (1987) conducted a study on group reminiscence, which was set up to measure self-esteem levels of 2 groups. Emphasis in the reminiscing sessions was on events that occurred in the remote past. The other group was a current events group. Each session was based on occurrences that were being discussed in the news at the time. The findings of the Lappe study contradicted Perrotta and Meacham and show that group sessions employing reminiscence increase self-

esteem scores of the elderly institutionalized to a greater degree than group sessions employing current events. These results imply that the introduction of reminiscence rather than group process alone produces an increase in self-esteem scores.

Parsons (1986) conducted a 6-week reminiscence study with 6 elderly participants. All 6 participants demonstrated decreased depression levels during post session testing. It must be pointed out that all subjects were identified as depressed through the use of the Geriatric Depression Scale prior to the study. The Geriatric Depression Scale (GDS) chosen for this study uses a dichotomous closed-ended questionnaire. The scale was designed specifically for use with persons aged 65 and older. Those participants scoring between 11 and 20 on the scale were described as moderately depressed prior to the study. Several hypotheses were studied from the result of this study. Reminiscence could have served as a stimulus for reevaluation and reorganization of one's life memory. It is also possible that one of the main factors in decreasing levels of depression was increasing social interaction. For some subjects, reminiscence in a group session may serve as an emotional catharsis. In spite of the conflicting research, the literature seems to indicate

that certain old people may deny the full implications of threats to their self-esteem by cognitively linking their present to the past and, therefore, reminiscence may be a psychologically healthy form of communication. At least it would seem to be a good beginning.

Recognition is growing of the value of group work as a therapeutic nursing intervention to meet the psychosocial needs of the elderly. Inclusion of the elderly in group therapy communicates that they are not too old or too confused to participate in group sharing. Self-esteem is promoted by reinforcing positive achievements, both in the present and past experiences. Many types of groups are being utilized presently in an attempt to reinforce a more positive self-concept, increase self-esteem, and decrease depression levels. One such therapeutic intervention is reminiscence which provides the elderly individual the opportunity for the reflection and observation that can only come from having lived an entire life span. A lifetime accumulation of personality and experience is available to be used and enjoyed in such a setting (Lappe, 1987).

Some authors (Lewis & Butler, 1974) have reported that reminiscence can allow the elderly individual a sense of security through recall of comforting memories, a sense

of belonging through sharing these memories and an increased self-esteem through confirmation of usefulness. Unfortunately, the potentials for satisfactions and even triumphs in late life are underexplored.

Reminiscence

The last 10 years or so have brought a concerted effort to decrease stereotypes and repudiate myths about aging. Groups of older people have become more vocal and more visible in their struggle to improve their lives. Butler's work in reminiscence in many studies has found that the most effective efforts to improve older people's situation involve a reconceptualization of aging in a more positive light. One way to achieve this is by adding useful techniques or concepts to the framework for nursing practice, such as reminiscence, the process or practice of thinking or telling about past experiences. Reminiscence is a complex man-environment interaction vital to both the old and the young that can effect a more positive view of aging (Beaton, 1980).

Views of the nature and function of reminiscing vary widely. Reminiscence has been described as a way to escape old age and impending death, as an aimless wandering of the mind, and as a symptom of illness. It has also been viewed as a method to expiate guilt, resolve

intrapsychic conflicts, and reconcile family relationships. Butler (1963) conceived the idea of "life review," which he defined as a "naturally occurring universal mental process characterized by the progressive return to consciousness of past experiences" (p. 66). Butler stated that life review was experienced by people of all ages, and was "promoted by the realization of approaching dissolution and death" (p. 66). Following Butler's lead, many clinicians have tried using reminiscence as a form of life review in therapeutic settings, particularly with the aged.

Most studies of reminiscence have been descriptive, and the comments about the aged who reminisce range from insult to idealization (Beaton, 1980). Some theorists propose that the old live in the past. In contrast, Burnside (1975) notes the importance of listening to the aged and emphasizes the contributions they can make through reminiscence:

Listen to the aged for they will tell you about living and dying. Listen to the aged for they will enlighten you about problem-solving, sexuality, grief, sensory deprivation, and survival. Listen to the aged for they will teach you how to be courageous, loving, and generous. They are the distinguished faculty without formal classrooms... they teach not from books, but from long experience in living. (Burnside, 1975, p. 1801)

Rogers (1970) theorizes that life is unidirectional and that remembrance of things past may be considered a re-patterning of life that moves an individual to increasing complexity and diversity. According to Beaton (1980), four functions of reminiscence--validation, integration, guiding, and connecting--facilitate this repatterning.

Validation

Validation is achieved when the retrospective process provides reassurance that because a person once had competence and worth, this is, by implication, still true (Kastenbaum, 1974). When the validation message is received, heightened self-esteem and self-worth are confirmed. In her work with groups of aged people, Burnside (1969, 1970) found Erikson's phrase, "to be through having been," the most important theoretical concept she used.

Integration

Beaton (1980) says that a multidimensional yet ever shifting sense of time is present at all stages of development. Kastenbaum (1974) believes that people must be willing to consider a past, present, and future at every point in the life cycle. Just as old people are thought to focus only on the past, the young are said to

look solely to the future. However, a balance between achieving present satisfaction and looking ahead is needed. Integrative repatterning provides continuity by allowing movement to many points in space and time for individuals at all developmental levels.

Guiding

The older generation can provide direction for the younger generation through reminiscence. Reminiscent story-telling can provide the young with information about a world gone by and past experiences that they will never see. Referring to a formulation of Erikson, Kellett (1975) noted that "each age group furnishes others in the society with an image and a model of the corresponding stage in life..." and thus "the aged have the responsibility to show the next generation how to face the ultimate concerns of life" (p. 16).

Connecting

Beaton feels that reminiscence itself makes a connection between the person and the environment. Patterns of relating continually change. With each change in human development and human relationships, the past is incorporated and new ideas and thoughts emerge. If reviewing one's life calls forth a resurgence of unresolved conflicts, as Butler suggested (1963), then

reminiscence may be a vehicle for resolution.

Categories of Reminiscence

After two decades of experimental studies, there is still disagreement on the frequency and effects of reminiscence among the elderly. For example, while Cameron (1972), Chiriboga and Gigy (1975), and Giambra (1977) reported only minor differences among age groups in the temporal setting of thoughts and day dreams, Lieberman and Falk (1971) and Sherman and Havighurst (1970) suggested that the frequency of reminiscence increases markedly with age. In the studies of McMahon and Rhudick (1964), Havighurst and Glasser (1972), Boylin, Gordon, and Nehrke (1976), and Lewis (1971), a greater frequency of reminiscence was associated with good adjustment, ego integrity, or stability of self-concept. However, Lieberman and Falk (1971) found no correlation between preoccupation with the past and subsequent adjustment.

Part of the disagreement on the effect of reminiscence in the elderly results from the fact that studies have been done on very different people in widely different ways. The elderly subjects studied have varied from the employed to the retired, to the recently institutionalized as well as those facing imminent death.

Methodologies for study have also varied tremendously, from single questions to elaborate questionnaires.

In spite of this, many experts in the field continue to argue that as a therapeutic intervention, reminiscence can bring about positive responses in the elderly in the form of increased self-esteem and decreased depressive episodes. Advocates of reminiscence intervention suggest that efficiency in working with recollection can be increased by a better understanding of three forms of reminiscence: informative, valuative, and obsessive.

Informative Reminiscence

This type of process functions mainly to provide pleasure and to enhance self-esteem through reliving and re-telling past events. This essentially non-structured form of reminiscence is probably the most common among older people. In their study of the life cycle, Lieberman and Falk (1971) found that the most common and frequent reason for reminiscing was personal satisfaction. People who wished to participate in free and unstructured recollection appeared eager to share an established sense of themselves and their past.

Stimulating informative reminiscence has been found to increase mental alertness, improve functioning, and bring a better sense of identity, as Ebersole and Hess

demonstrated in their nursing home work (1985). Ebersole also found that focusing on recollection brought people together therapeutically in addition to providing socialization and fellowship. It has also been shown to enhance education and artistic creation.

Valuative Reminiscence

This second type of reminiscence primarily reflects Butler's concept of life review. Through life review, an individual may attain the final developmental stage posited by Erikson: ego integrity, or the acceptance of one's life history as right and inevitable (Butler, 1963). Life review is "psychologizing" about life-long personality and motivational trends (LoGerfo, 1980, p. 42).

Life review is seen by Butler (1963) as a universal mental process brought about by the realization of approaching dissolution and death. It marks the lives of all older persons in some manner as death begins to be viewed as an imminent personal reality. Life review as explained by Butler (1963) is characterized by the progressive return to consciousness of past experiences. This recollection process appears to have a positive psychotherapeutic function, in which the older person reflects on his life in order to resolve, reorganize, and

reintegrate what is troubling or preoccupying him. The success of life review depends on the outcome of the struggle to resolve old issues of resentment, guilt, bitterness, mistrust, dependence and nihilism (Lewis & Butler, 1974).

Obsessive Reminiscence

Unfortunately, informative and valuative reminiscence may become obsessive and dysfunctional. Instead of working through the past in a constructive review process, an older person may concentrate on a problematic experience that cannot be resolved, and the person may well become seriously agitated, depressed, or even suicidal (LoGerfo, 1980). Obsessive reminiscing may be precipitated by stress. Pincus (1970) noted that excessive reminiscence may result from an ungratifying present life situation. Mourning is another occasion in which prolonged, obsessive reminiscence can be maladaptive. According to Beaton (1980), when this type of maladaptive behavior occurs, full discharge of emotion may be prevented by insufficient opportunities to express feelings to an empathetic listener.

Clearly, techniques that stimulate the full expression of emotion, like life review therapy, psychodrama, and Progoff's techniques, which are a guided

in depth re-experiencing of an entire relationship can be helpful in allowing an individual to release negative feelings (LoGerfo, 1980). The goal in this type of reminiscence therapy is not to cut off the obsessive behavior completely, but to focus it in the direction of a healing process until it is no longer needed.

One reason for not using reminiscence as a psychotherapeutic tool is the fear that the older individual is too psychologically fragile. As in all good therapy, the therapist begins where the older person is and proceeds respectfully and sensitively. If anxiety, guilt, despair, and depression ensue, obviously this type of intervention is not therapeutic for the individual and psychiatric evaluation is indicated, which is usually out of the realm of nursing boundaries. Except in this type of situation, however, psychologists, social workers, and nurses with psychiatric backgrounds are all professionals who can facilitate extremely productive and enriching reminiscing groups.

Reminiscing and Group Therapy

Burnside (1976) found Erikson's developmental framework useful in understanding the process of group growth. Leaders must be aware that assembling people together does not necessarily make a group. Initially,

trust must be established among the group members and the leader. When the group members begin to trust, they will rebel in an effort to establish autonomy. As the group moves forward, the members develop initiative by making specific constructive suggestions; finally, they start to evaluate and share their accomplishments (Burnside, 1976).

Burnside (1976) notes that a major issue in group work with the aged is the validity of segregation. Are there differences in aged individuals which warrant setting them apart? Is there a "group consciousness" among the aged? Are groups viable when individual members feel devalued? These are some of the issues brought out in group studies with the aged.

Geriatric group work has been reviewed by Burnside (1970) and Goldfarb (1971), who have examined most of the published work in the field since 1950. Their comprehensive, thoughtful surveys clearly show the proliferation of groups in the late 1960's as compared to the preceding period. In geriatric group work then, as now, few published studies measured the effectiveness of group intervention in any precise manner. Burnside (1970) claims that much past and current group therapy is highly effective but not well controlled. Controlled studies of group reminiscence are difficult for many reasons: (a) the

elderly will not participate unless there is meaning for them, (b) the intense participation and activity required of the therapist leave little energy for analysis of scientific details, and (c) tape recorders are often ineffective and videotape is too inhibiting for the elderly (Burnside, 1976).

A number of practitioners have implemented group approaches to reminiscence in institutional settings and have reported positive outcomes (Ingersoll & Goodman, 1983; McMordie & Blom, 1979). Their reports, however, tend to be anecdotal. An exception was the work of Ingersoll and Silverman (1978), who compared a life review-reminiscence form of group psychotherapy with a "here and now" behavioral type of group therapy. Their study included not only a comparison of two types of reminiscence groups, but also a comparison with control groups, to determine whether these two types of reminiscence groups could enhance the development of social supports and a sense of well-being among the elderly. All groups increased in satisfaction and self-concept, but the experimental groups displayed more elusive, less avoidant types of reminiscing than the control groups. Also, the experimental groups incorporated the greatest measure of feelings and thoughts

in reconstruction of the past (Ingersoll & Silverman, 1978).

Clinical experiences and other writings on practice with the elderly (Sherman, 1981, 1984) suggest that this experimental approach to reminiscence made a difference in the lives of the participants. Greater vividness and reflective engagement were evident in their reminiscences, although the positive changes in their life satisfaction measures were not large enough to be statistically significant.

Reminiscing in groups is a way of achieving verbal communication. Increased reminiscence may involve an effort to enhance one's self-esteem and to gain support for the validity of one's beliefs about the world--two factors seriously threatened by the onset of old age (Ingersoll & Silverman, 1978). As people age, they often have fewer opportunities to communicate with peers. When a person feels accepted by significant others, as in a group, this increases self-esteem. Baker (1985) says that communicators generally have at least three purposes: those of self, subject, and others. The use of groups as a means of communication for the elderly establishes conditions that may improve self-esteem and self-worth among this group. Through group reminiscence, the elderly

may find a way to improve self-concept and in turn provide similar experiences for others. It appears that group reminiscence leads to greater frequency and enjoyment of reminiscing and to an interest in continuing further peer group activity.

Summary

In summary, it has been recognized in gerontology that growing old in our society may mean increased isolation, loss of support systems, decline in physical abilities, and cessation of other accustomed life habits. Unfortunately, attention to the status of the aged has grown more slowly in the United States than in older European nations. Although these negative trends and attitudes towards our older population are slowly changing, and have changed for the better in the last decade, there are many reasons that account for some of these changes, including improved medical technology and increased incomes.

Fortunately, a growing body of knowledge about normal processes of aging indicates while meeting basic needs is a serious problem for many, many others consider themselves in good mental and physical health. Some older people adjust very effectively to old age. However, for others, old age can bring a reduction in self-esteem even

to the point of clinical depression, unless a means can be found in coping with losses and reevaluating the impact of aging on the self.

There is a growing recognition of the value of group work with the elderly as a therapeutic nursing intervention. Reminiscence is one of many types of groups proven beneficial in enhancing self-esteem in the elderly. The group process is based on Erikson's theory of the maintenance of ego-integrity. Roy's Adaptation Model was developed from Erikson's eight stages of the life cycle. From Erikson's theory, Roy developed a conceptual framework identifying four areas in which man adapts to his environment, one of which is self-concept. Butler's process of life review applies Erikson's concept of ego integrity in an attempt to attain the final developmental stage which is ego-integrity.

Reminiscing or life-review is one way aged people can review their pasts in a positive and therapeutic way. It can be a particularly adaptive process for improving self-esteem. Following Butler's lead, many clinicians are using reminiscence as a form of life review in therapeutic settings with the aged.

Chapter 3

METHODOLOGY

Design of the Study

The purpose of this research was to determine whether reminiscing reduced depression and improved self-esteem in the elderly. Two experimental groups received reminiscing therapy, and their depression and self-esteem levels were compared to those in two control groups who received no reminiscence therapy. A pretest was administered to the four groups prior to the therapeutic intervention. A posttest was given after the experimental groups had participated in the intervention for 6 weeks.

A pretest-posttest design using two control groups and two experimental groups was appropriate for this study. The four study groups were:

1. a treatment group (young-old, ages 60-75) who received the reminiscing intervention.
2. a no-treatment control group (same ages).
3. a treatment group (old-old ages, 76 years and older) who received the reminiscing intervention.
4. a no-treatment control group (same ages).

Control groups were necessary in order to ascertain whether changes in self-esteem or depression in the reminiscing groups were due to the reminiscing

intervention and not to non-treatment factors such as experimenter contact and attention. Two experimental and treatment groups were included to control for the effects of age.

Members of all four groups were given self-esteem and depression scales and were asked to complete the Demographic Profile (see Appendix A). The Rosenberg Self-Esteem Scale (see Appendix B) and Zung's Re-modified Self-Rating Depression Scale (see Appendix C) were used. Both experimental groups received the same intervention within the same time frame but with different group facilitators. Both facilitators were nurses currently working on advanced degrees in gerontology. One nurse facilitated the young experimental group (ages 60-75). The other nurse facilitated the old experimental group (ages 76 years and older).

To control for variance, it was decided to follow a structured format. Both nurse facilitators used Haight's (1988) Life Review and Experiencing Form (see Appendix D) as a guide to conduct the sessions. The sessions began with introductions, completion of forms, and a discussion of how the reminiscence sessions would be conducted. The subsequent sessions included discussion of childhood memories, adolescence, family and home, adulthood, and a

summary in the last session. Prior to the beginning of the sessions, both nurse facilitators discussed leadership style. It was decided to use a highly structured active and directive leadership style, but with emphasis on the importance of being sensitive to nonverbal communication. Also, emphasis was placed on the importance of being a good listener and ensuring that everyone, including those who did not speak, felt included in each meeting.

Setting

The setting for this study was a community based, ambulatory geriatric clinic operated by a county health department since October, 1976. Funded by the State and County, the program offers comprehensive preventive health services to seniors. In determining priorities for the clinic's programs, special attention is given to services not covered by third-party payers and to problems encountered by seniors in obtaining health care.

The geriatric health clinic's services include complete physical exams; vision, hearing, and dental screening; basic laboratory and EKG testing; preventive health services; treatment of minor illnesses, including medications when necessary; and case management services. The services are provided by geriatric nurse practitioners

working in collaboration with and under the direction of a board-certified medical internist.

Consumers and providers have worked together to plan program elements and to determine priorities. In addition to health services, two major elements of the program are: (a) assisting seniors with application procedures for other services, and (b) coordinating available resources to maintain or improve the quality of life.

The target population for the program is approximately 50,500 seniors, the estimated population of persons 60 years of age and older residing in the County. Although the program is available to anyone 60 years of age or older, outreach efforts are directed toward minority, frail elderly, low-income clients, and those with no other resources. A cross-section of socioeconomic levels is represented at two clinic locations, a Senior Citizens Center and the County Health Department.

The two settings supplied the sample for this study. To conduct the study, a sample of 40 subjects was chosen, 10 for each experimental group and 10 for each control group. The sample size of 40 was chosen for group process and ease of facilitation for group interaction, not for statistical purposes.

Sample

The criteria for inclusion in the study were:

1. age 60 years and older,
2. a score on the Folstein Mini-Mental Exam (see Appendix E) of 23 or above signifying no cognitive impairment, and
3. consent to participate.

The age span criterion of 60 years and older was easily met as the age for eligibility for clinic services is 60 years. Sex of the participants was not a criterion factor for inclusion in the study. The Folstein Mini-Mental Examination was administered to all perspective participants of the study. Only 3 individuals failed to score above 23 in the test. They were not included in the study.

Each group was a heterogenous mix of 10 participants. Burnside (1976) found in her studies that this particular type of group provided the most interesting group mix for encouraging physical and verbal expression of feelings. A group of 8-10 patients was considered to be manageable for the group facilitators. This was based on studies by Osborne (1989) and Parsons (1986) who used similar reminiscence groups of the same size.

One experimental group was comprised of clients ages 60-75; the other group, clients ages were 76 years and older. The 2 control groups were similarly divided by age. Participants were assigned to groups. This was done by having the study participants sign two lists. One list was for those individuals who were 60-75 years old, and the other list for those 75 and older. From those two lists, participants were selected for their ability to attend the sessions for either the control or treatment group in their age range. Those that were unable to attend the 6 reminiscence sessions for either transportation reasons or other reasons were automatically placed in the control groups for convenience of the researcher.

Intervention

Intervention for the two groups of elderly clients was reminiscence therapy. Each group was facilitated by a nurse practitioner with similar experience and background. Both nurses were completing their advanced degrees in community health nursing with a gerontological focus. Both had worked in the field of gerontology for at least 10 years.

Goals for participants receiving the intervention were:

1. elevation of self-esteem;
2. decrease in depression levels;
3. increased socialization and ability to share meaningful memories with others;
4. heightened awareness among members of the individuality and uniqueness of each member, as well as the personal effectiveness and significant contributions of each participant; and
5. stimulation of thinking, enhancement of and support for the natural healing process of life review, so that the client can find meaning, worth, and acceptance of what life has been.

Simple reminiscing through life review was chosen as the intervention due to lack of sound empirical evidence that any single type of reminiscing is most suited to the needs of the elderly, and because simple reminiscing through life review is the easiest type to facilitate (Perrotta & Meacham, 1981). The groups were set up as structured groups in terms of specific recollections to generate memories of a specific event, occasion, or period of life. It was thought that this format would be most useful for members who may need some help with

communication and verbal exchange. In addition, structured groups facilitate communication and expression of thoughts and ideas more quickly.

The structured format based on Butler's process of life review, covering all life's stages, was used as a guideline to conduct the reminiscing sessions. This format used for the research was developed by Haight (1988). During the first session, participants were given time to socialize, pretests were administered, and format for the upcoming sessions was discussed. During the sessions that followed, each stage of life was reviewed beginning with childhood, adolescence, family and home, and adulthood with a summary during the last session.

Control groups represented the same population of clients as the experimental groups. Neither control group was given a therapeutic intervention at the time of the study. Persons chosen for control groups were informed that they were to participate in the study indirectly but would not participate in the actual reminiscence groups.

Data Collection Instruments

The Folstein Mini-Mental Exam was given to all four groups prior to the study to evaluate cognitive abilities. All subjects scoring 23 or more on the Mini-Mental Exam and consenting to participate were given (a) the Zung

Re-modified Self-Rating Depression Scale, and (b) the Rosenberg Self-Esteem Scale. In addition, a demographic questionnaire was administered to all participants prior to the intervention.

The Mini-Mental State (MMS) includes 11 questions, requires only 5-10 minutes to administer, and is therefore practical to use serially and routinely. It is "mini" because it concentrates only on the cognitive aspects of mental functions, and excludes questions concerning mood, abnormal mental experiences, and the form of thinking (Folstein, Folstein & McHugh, 1975). The MMS is a valid test of cognitive function. It separates patients with cognitive disturbance from those without such disturbance. Its scores follow the changes in cognitive state when and if patients recover and correlate with a standard test of cognition, the Weschsler Adult Intelligence Scale (WAIS). The MMS is reliable on 24 hour or 28 day retest by single or multiple examiners. When the Mini-Mental status was given twice, 24 hours apart by the same tester, on both occasions the correlation by a Pearson Coefficient was .887. Thus, the scores seem stable even when multiple examiners are used. The practice effect is small.

The Self-Rating Depression Scale is a modified version of Zung's scale. According to Zung (1965), the

modified scale assesses three most commonly found characteristics of depression: pervasive affect, characterized by depression in mood, guilt, and loss of self-esteem; physiological concomitants, which include loss of appetite and sleep disturbance; and psychological concomitants, which include personal devaluation, hopelessness, and confusion. For this study, the physiological items in the Zung's Re-modified Self-Rating Depression Scale were deleted as those items are thought to be easily confused with physical disabilities, and may or may not be depressive characteristics.

Examples of the items deleted were: "I eat as much as I use to," and "I have trouble with constipation." These examples cited might be confused with physiological concomitants of depression. Because these items were deleted, the tool for this study was re-modified for the study and thus renamed the Re-modified Self-Rating Depression Scale. Reliability and validity of this tool has not specifically been documented; however, reliability and validity of the Zung's Self-Rating Depression Scale were tested by Parsons in her study on reminiscence in 1986. The instrument chosen for this study was the Geriatric Depression Scale, which is a scale designed specifically for use with those aged 65 and older. This

scale was measured for convergent validity using Zung's Self-Rating Depression Scale and the Hamilton Rating Scale for depression with correlations of .84 and .83, respectively. The scales were tested for internal consistency and reliability by median correlation with total scores mean inter-item correlation, alpha coefficient, and split-half reliability. All measures showed a high degree of internal consistency and reliability (Parsons, 1986).

The Rosenberg Self-Esteem Scale consists of 10 items listed along a four-point continuum from "strongly agree" to "strongly disagree." The 10 items are statements relating to self-worth. Examples of statements on this scale are: (a) "I feel that I'm a person of worth, at least on an equal basis with others," and (b) "I feel that I have a number of good qualities." The scale was designed specifically with brevity and ease of administration in mind. It was developed to be a Guttman Scale, meaning a larger pool of items was reduced by selecting items which differed substantially in the numbers of people answering each way. A Guttman Scale reproducibility coefficient of .92 was obtained for reliability and homogeneity. Silber and Tippet (1965) found a test-retest correlation over 2 weeks of .85

(N=28). Silber and Tippettt also found that the scale correlated from .56 to .83 for validity with several similar measures and clinical assessment.

The demographic questionnaire was developed by the researcher after reviewing demographic tools used in similar studies on reminiscing, and after reviewing an unpublished thesis written by Rilling (1983) which examined health care services for the elderly in a northern California County. Osborne (1989), in her study on reminiscence, reported that variables in demographic tools included sex, ethnic background, marital status, living status, retirement status, self-rated health status, and ability to function independently. The reliability and validity of Osborne's tool was not specifically documented; however, similar demographic information was obtained from participants in other research studies on reminiscence.

In this study, respondents were asked their sex, age, ethnic background, marital status, retirement status, educational background, living status, self-rated health status, and income. In addition, information was asked as to whether there was a need for assistance with household activities. The last item on the demographic profile asked the respondents to identify as many needs as they

felt they had. The choices were socialization, medical care, transportation, financial help, and other. Thus, the tool attempted to elicit information about the participants' needs in general, as well as health care needs which might affect depression levels and self-esteem, in addition to purely demographic information. Since this is a newly developed tool, reliability and validity have not been established. However, nurse clinicians who work with and treat the elderly population were asked to review the questions and offer input in an attempt to establish content validity of the tool. The tool takes approximately 10 minutes to complete.

Data Analysis

A 3-way Analysis of Variance (ANOVA) was carried out for both the self-esteem scores and the depression scores to determine whether there was a statistical difference between the group, age, and test. The data from the questionnaire summarized in Chapter 4 includes (a) demographics, (b) health status, (c) economic status, (d) support systems, and (e) educational background. Frequencies, means, and percentage data were used to provide the descriptive analysis which is presented in Chapter 4.

Procedure

Prior to beginning the study, permission to conduct the study was granted by the Institutional Review Board - Human Subjects for San Jose State University (see Appendix F). In addition, approval was given by the Assistant Division Director for Community and Clinical Health Services to conduct the study at the clinic sites (see Appendix G). Participants in the study signed a consent form. The consent form briefly explained the study and noted that there were no identifiable risks or benefits to participating in the study, but some benefit may be derived in terms of increased self-worth and self-esteem and the opportunity to share in the group process of reminiscing (see Appendix H). Confidentiality was maintained by using a coded numbering system on each questionnaire and pretest and posttest data.

The study began with 40 prospective participants. Forty participants were selected for group process and ease in facilitating group sharing and interaction. Participants were placed in appropriate groups according to age. The decision was made to place those individuals in the experimental groups according to their ability to attend all 6 reminiscence sessions. The remaining individuals were placed in control groups for their

appropriate age. The control group participants were told that they would be considered first for participation in reminiscence sessions planned in the future.

Once all groups had been identified, a date and time were selected for the first reminiscence session. The sessions of 1 hour duration were scheduled for 6 consecutive weeks at the same time and at the same site. Each nurse practitioner was assigned to facilitate one group and administer the questionnaires on the first session and the last session. Both practitioners used Haight's Life Review and Experiencing form as a guide, commencing with childhood thoughts on the first session and summarizing on the last session day.

Chapter 4

ANALYSIS AND INTERPRETATION OF DATA

A convenience sample was used to obtain 40 subjects for the 2 control groups and the 2 experimental groups from an ambulatory geriatric clinic in the western United States. One subject was dropped due to hearing problems, leaving a sample of 39. The participants were pretested with three tools prior to the 2 experimental groups receiving reminiscence therapy for a 6-week period of time. Frequencies, means, and percentages were used to compile the demographic data of the participants. Prior to conducting the analysis of data, a Hartley's F-Max test for homogeneity of variance was performed. A 3-way Analysis of Variance, Repeated Measures Design (ANOVA) was used to analyze for differences in group (control versus experimental), age--young (60-75) versus old (76 years and older), and test (pretest versus posttest) for the SDS Index Scores recorded on the Zung Re-modified Self-Rating Depression Scale and separately for the number of positive responses recorded on the Rosenberg Self-Esteem Scale.

Duncan's new multiple range test was the comparison technique used to find occurrence of differences and interactions in group, age, and test. Duncan's test was

also used to determine if a significant F-value resulted from the analysis of variance.

The questions in the study were:

1. What was the demographic profile of subjects participating in the study?
2. Does reminiscence therapy decrease depression in the elderly as measured by Zung's Re-modified Self-Rating Depression Scale?
3. Does reminiscence therapy increase self-esteem levels in the elderly as measured by the Rosenberg Self-Esteem Scale?
4. Is there a difference in depression levels and self-esteem response between the old groups (ages 76 and older) and the young groups (ages 60 to 75) from the reminiscence experience?

Question 1: Demographic profile of the clients

The demographic tool was administered to group participants during the first reminiscence session. The control groups were given the demographic tool to complete during the same time frame. All participants completed the tool except for one person in the old treatment group who decided she could not participate because of a severe hearing problem.

Questions asked were age, sex, ethnic background, marital status, retirement status, educational level, household composition, evaluation of health status, and monthly income. In addition, 2 questions were asked related to the need for assistance with household activities and identification of greatest needs (socialization, medical care, transportation, financial help, and other).

The total number of clients participating in the study was 39. They ranged in age from 62 to 92 years. The mean age for the control group was 68 years in the young control group and 90 years in the old control group. The mean ages for the treatment groups was 69 years for the young treatment group and 91 years for the old treatment group.

Of the 39 participants, 20% were male and 80% female in the young control group. Forty percent were male and 60% were female in the old control group. The treatment groups were 10% male and 90% female in the young treatment group, and 22% male and 78% female in the old treatment group. The distribution of clients by age and sex was fairly equal between control and experimental groups.

There were 37 Caucasians, 1 Black, and 1 Hispanic participating in the study. Because of the majority of

Caucasian participants, it is doubtful whether ethnic background influenced the study.

In the category of marital status, there was a total of 9 married, 11 divorced, 18 widowed, and 1 single. In the young control group, 30% were married, 50% divorced, and 20% were widowed. In the old control group, 20% were divorced, 30% married, and 50% widowed. In the young treatment group, 20% were divorced, 30% married, and 50% widowed. In the old treatment group, 12% were single, 22% divorced, and 66% widowed. It was found there were more widowed in the older groups than the younger, more married in the younger groups than the older, and finally more divorced in the younger groups than the older groups. It was expected that the younger groups (ages 60-75) would have more married, and the older groups (ages 76 years and older) would have more widowed due to age.

Thirty-five out of 39 participants were retired. The majority of the study participants had either some high school or a college education; 1 had an advanced degree. Only 4 stopped at a grammar school education level.

In the 4 groups, 23 persons lived alone, and 10 lived with a spouse. The remaining 6 lived with either a brother or sister, a child, or significant other. Of the 23 who lived alone, the majority (15) were in the 2 older

groups. There were only 3 in the older groups that lived with a spouse. The remaining 7 living with a spouse were in the younger groups. When comparing the older and younger groups, the distribution of participants in this category showed more older people living alone.

Of the 39 participants, only 1 rated his health as poor. The remaining 38 rated his or her health as either fair or good. The distribution was equal throughout the four groups.

Monthly income level was the next category discussed in the profile. The categories were divided into below \$500 monthly, between \$500-\$1,000 monthly, \$1,000-\$1,500 monthly, and over \$2,000. There were 9 responses in the under \$500 category, 19 responses in the \$500-\$1,000 category, 8 responses in the \$1,000-\$1,500 category, and 3 responses in the over \$2,000 category.

The last two categories focused on household assistance and greatest needs. The majority of participants stated that they did not need assistance with household activities. The responses were equally distributed throughout all groups with the total number being 26 out of 39 who did not need assistance. There were 11 responses indicating occasional assistance and 4 responses with much assistance needed.

The last category was greatest needs. The categories were not mutually exclusive. The choices for needs were socialization, medical care, transportation, financial, and other. There was a total of 16 responses for socialization, 19 for medical care, 13 for transportation, and 3 for financial. There were no significant trends seen between groups. However, the need for medical care was identified as the greatest need throughout all groups.

In summary, the majority of the total number of participants were Caucasian female between the ages of 62 and 92. Most were widowed, and almost all were retired. The majority had either a high school or college education. Most participants lived alone with an average monthly income of approximately \$500-\$1,000. They rated their health status as good, and most did not identify a need for assistance with household activities. Medical care was identified by all groups as the greatest need.

Question 2: Does reminiscence therapy decrease depression as measured by Zung's Re-modified Self-Rating Depression Scale in the elderly?

All participants were administered the Zung Re-modified Self-Rating Depression Scale prior to the beginning of the reminiscence sessions and again at the conclusion of the last session. A conversion table has

been developed by Zung to convert the raw scores to the Self-Depression Scale Index (SDS) key for scoring. A higher SDS index score represents an increase in depression levels, and a lower SDS index score represents a lower depression level. The highest raw score possible was 40 in this study. The raw scores were divided by 40 to obtain the SDS index. Table 1 represents the key for scoring the SDS.

The mean SDS Index was computed for the pretest and posttest scores for the four groups. The mean index for the young control group for the pretest was 0.42, while the mean index for the posttest was 0.45. The mean index for the old control group for the pretest was 0.44, while the posttest was 0.42. The mean index scores for the young treatment group for the pretests and posttests were no different, with a score of 0.48 for both. The mean index scores for the old treatment group was 0.38 for the pretest and 0.35 for the posttest.

The range of SDS index scores was from 0.30 to 0.55 on the pretest and 0.25 to 0.60 on the posttest scores in the young control group. The old control group pretest index score ranged from 0.25 to 0.80 on the pretest to 0.25 to 0.70 on the posttest. The SDS index scores for

Table 1

Key for scoring SDS

0

Re-modified Items	A Little of the Time	Some of the Time	Good Part of the Time	Most of the Time
1. I feel down-hearted and blue.	1	2	3	4
2. Morning is when I feel the best	4	3	2	1
3. I have crying spells or feel like it.	1	2	3	4
4. I feel hopeful about the future.	4	3	2	1
5. I am more irritable than usual.	1	2	3	4
6. I find it easy to make decisions.	4	3	2	1
7. I feel that I am useful and needed.	4	3	2	1
8. My life is pretty full.	4	3	2	1
9. I feel that others would be better off if I were dead.	1	2	3	4
10. I still enjoy the things I used to.	4	3	2	1

NOTE: 1 = lowest depression level

4 = highest depression level

the young treatment group ranged from 0.30 to 0.75 on the treatment group SDS scores ranged from 0.25 to 0.65 on the pretest and 0.33 to 0.45 on the posttest. Using the 3-way Analysis of Variance (ANOVA), there was no significant difference from pretest to posttest in any one of the four groups ($F(1,36)=0.29, p>.05$).

In summary, the statistical analysis using a 3-way Analysis of Variance was performed, showing no significant differences between age groups from the pretest to posttest in the SDS index scores on Zung's Re-modified Self-Rating Depression Scale at the $p>.05$ level.

Question 3: Does reminiscence therapy increase self-esteem levels in the elderly as measured by the Rosenberg Self-Esteem Scale?

All participants were administered the Rosenberg Self-Esteem Scale prior to the beginning of the first session and at the conclusion of the last session. The scale consists of 10 items answered on a 4-point scale from strongly agree to strongly disagree, although they are scored only as agreement or disagreement. Each question in the scale was assigned 2 numbers from 1 to 4. One represents strongly agree, 2 represents agree, 3 represents disagree, and 4 represents strongly disagree.

Since the scale is set up to score either agreement or disagreement, each question was given either a negative or a positive score depending on how the questions were answered. The number of positive answers were summarized and a mean score was computed for the pretest and posttest results for the four groups; the higher the score, the higher the self-esteem and the lower the score, the lower the self-esteem,

If reminiscence made any difference in self-esteem, one would expect that there would be a significant increase in positive responses from the pretest to the posttest. There was a slight increase in the positive response in the old control which has no significance ($F(1,36)=.04, p>.05$). There were no increases in the positive responses for the other three groups.

A 3-way Analysis of Variance with repeated measures on the factor test was performed. It was found that there was no significant difference between the 2 groups ($F(1,36)=1.02, p>.05$). There was no significant difference between the 2 ages ($F(1,36)=.041, p>.05$). There was no significant difference between pretest and posttest responses ($F(1,36)=1.01, p>.05$).

Question 4: Was there a difference in depression levels and self-esteem response between the old groups and the young groups from the reminiscence experience?

To determine if age made any difference in self-esteem and depression scores between the young-old and the old-old groups, a 3-way Analysis of Variance was performed on the data from the Zung Re-modified Self-Rating Depression Scale and Rosenberg Self-Esteem Scale. The Zung scores showed a slight trend in the treatment groups old and young, and in the old control towards a positive response for less depression. The young control group had a slight trend towards increase in depression levels. On the Rosenberg Scale, there was a very slight trend for the older groups to have more positive responses than the younger groups although not statistically significant ($F(1,36)=.041, p>.05$). Tables 2 and 3 summarize the results of the Analysis of Variance of Zung's Re-modified Self-Rating Depression Scale and Rosenberg's Self-Esteem Scale, respectively.

Observational Data

The researcher used a structured supportive approach to promote free-flowing reminiscence. This was done with the life review format (see Appendix J). The researcher felt that the members of the group might be uncomfortable

Table 2

Analysis of Variance of Zung's Re-modified Self-Rating Depression Scale (N=39).

<u>Summary Results</u>				
Source	df	SS	MS	F
Between Groups	39	1.1523	2.9547	
A: Group	1	.00275	.00275	9.69
B: Age	1	.06724	.06724	2.37
AxB	1	.05882	.05882	2.07
Subjects w/in Groups	36	1.0235	2.8431	
Within Subjects	40	.23093	.00577	
C: Test	1	.00038	.00038	6.27
AxC	1	.00344	.00344	.56
BxC	1	.00569	.00569	.93
AxBxC	1	.00175	.00175	.29
CxSubjects w/in Groups	36	.21965	.00610	.29
Total	77	1.3832		

Note: 10th observation for the old treatment group was composed of the mean of the first 9 subjects in order to create a balanced design to conduct the analysis.

Table 3

Analysis of Variance of Rosenberg's Self-Esteem Scale
(N=39).

Source	df	<u>Summary Results</u>		
		SS	MS	F
Between Groups	39	187.95	4.819	
A: Group	1	5.00	5.00	1.02
B: Age	1	.2	.2	4.07
AxB	1	6.05	6.05	1.23
Subjects w/in Groups	36	176.7	4.908	
Within Subjects	40	48	1.2	
C: Test	1	1.25	1.25	1.01
AxC	1	.2	.2	.16
BxC	1	1.8	1.8	1.45
AxBxC	1	.05	.05	4.03
Subjects w/in Groups	36	44.7	1.242	
Total	79	235.95		

Note: 10th observation for the old treatment group was composed of the mean of the first 9 subjects in order to create a balanced design to conduct the analysis.

if there was not enough structure provided so that members knew what to expect and what was expected of them.

Group members enjoyed the first question in the life review--What is the very first thing you can remember in your life? This first memory digressed in varied directions, and led to other memorable events which all groups members enjoyed sharing. Once the groups were developed, they progressed to unstructured groups as members grew in their ability to relate to each other.

By the third session, all members spontaneously shared memories, talking to each other and not necessarily to the group facilitator as in the initial meeting. As each session progressed, a feeling of group identity and group cohesiveness developed. Both facilitators participated in the reminiscing process.

Each week a new topic in the life review format was presented. Sometimes discussion digressed from the topic, but the atmosphere of the group allowed for free-flowing verbal exchange on a variety of topics from the days of The Great Depression to current events, including opinions on teenage pregnancy and the drug scene today. This researcher found that with each session, there was a feeling of sharing and of comparing life's events. The participants recognized aspects of others' pasts that

resembled their own experiences. Also, opinions regarding many current topics shared within the group were supported vehemently. These current event topics also stimulated discussion about the past and about "the way things use to be!"

On the whole, the groups were very verbal, and the experience was positive. Some topics were more popular than others, and some days were better than others. During the study, the researcher learned from the group process. When planning for a group, a great deal of consideration should be given to the group purpose, structure and rules, leadership style, and group process.

In summary, one can see that the data analyzed from the reminiscence therapy experience did not yield any statistical evidence that reminiscence makes a difference in self-esteem and depression levels in the elderly. Chapter 5 will discuss the conclusions from this study, and implications for further study.

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

This study was based on a conceptual framework suggested by Roy (1976) based on Erikson's eight stages of the life cycle, which supports the belief that self-concept is a composite of beliefs and feelings that one holds about oneself at a given time. It is formed from perceptions of others' reactions and directs a person's behavior. Self-esteem is integral to each component of self-concept as outlined in the conceptual framework. This study surveyed the value of reminiscence as a therapeutic intervention for older persons by assessing self-esteem and depression levels prior to and after the reminiscing intervention.

Based on the literature, this study was designed to measure self-esteem and depression levels before and after reminiscence sessions. It was also designed to measure the difference in responses between two separate age groups of 60 to 75 and 76 years and older. Perotta and Meacham (1981) have suggested that persons in their sixties may benefit more from reminiscing than persons in their seventies or eighties. A control group which did not participate in the reminiscence was set up for each of

the two age groups. The study attempted to answer four questions:

1. What was the demographic profile of subjects participating in the study?
2. Does reminiscence therapy decrease depression as measured by Zung's Re-modified Self-Rating Depression Scale?
3. Does reminiscence therapy increase self-esteem levels in the elderly as measured by the Rosenberg Self-Esteem scale?
4. Is there a difference in depression levels and self-esteem response between the old groups (ages 76 and older) and the young groups (ages 60 to 75) from the reminiscence experience?

Conclusions

The 39 participants in this study completed both a pretest and posttest. They comprised a convenience sample drawn from a population of ambulatory patients receiving health care from a county clinic. Participants were divided into two experimental groups that were receiving reminiscence therapy and two control groups that were not receiving the reminiscence therapy. Comparison of the demographic profile characteristics of the four groups proved homologous. A Repeated-Measure Analysis of

Variance Test determined that no significant differences existed on the Rosenberg Self-Esteem Scale and the Zung Re-modified Self-Rating Depression Scale from pretest to posttest for the total sample.

The findings of this study did not demonstrate that reminiscence in group sessions significantly decreased depression levels or raised self-esteem in the elderly. However, that is not to say that there is not a place for reminiscence being used as a therapeutic intervention in the elderly to improve self-esteem and raise depression levels. As a result of the data analysis, it became apparent that the evolution of one's self-concept is ongoing over a lifetime, and that depression states have also taken years to develop. According to Roy (1976), each person continually during a lifetime attempts to achieve an adequate self-concept in order to preserve psychic integrity. Therefore, attempting to influence one's self-esteem and level of depression may not occur over such a relatively short period of time as 6 weeks. This is supported by similar studies that also demonstrate no significant change in self-esteem and depression before and after treatment (Perrotta & Meacham, 1981; Lappe, 1987).

One could also question whether the elderly persons in this study are those who could best benefit from reminiscence therapy. From the results of the demographic profile, the majority of these participants lived alone, independently, and required little assistance with household activities. They rated their health as fair to good. Other possible explanations for the results of this study include (a) lack of a clear understanding by participants as to how to complete questionnaires accurately, (b) small subject pool, (c) changes in health status during the 6 weeks, and (d) possible co-leaders' influence on the participant responses.

One major finding in this study, which is supported by the literature (Lappe, 1987), is that reminiscing came naturally to these elderly participants. Often the only stimulus needed to start an interesting session was a single statement such as "Tell me about your first date." This was found with both experimental age groups. There was no difference demonstrated in the responsiveness and eagerness to participate in reminiscence between age groups. This reinforces research that found self-esteem was promoted by positive affiliations with others (Medley, 1976).

Although there were no significant results from this study, reminiscence seems to fit into the pattern outlined by the disengagement theory as it enables an old person to reemphasize the past and identify himself with former roles. Reminiscence seems to answer a need felt by disengaging old persons to identify with their pasts. Reminiscence also enables them to re-engage by seeking out potential listeners. Therefore, there seems to be definite implications for reminiscence as a treatment for older people, but so far results from research in this field have not shown one specific elderly population who would benefit most from this type of intervention therapy.

Implications

While this study did not find that self-esteem and depression levels were changed significantly with reminiscence therapy, the findings do have important implications. Group reminiscence therapy may be a potentially important form of treatment for depression in the elderly. Group reminiscence therapy is more economical and time efficient than individual therapy. Group reminiscence might result in cost savings through decreased use of anti-depressants. It can be implemented in many different settings, and serve as an opportunity for otherwise isolated individuals to participate in group

socialization and group interaction.

This research supports Butler's (1963) findings that rather than being a symptom of aimless wandering of the mind, reminiscence may be a valuable tool that enables individuals to reaffirm a sense of identity. Nurses who take an interest in their clients, are good listeners, and are able to use a structured supportive approach, have the potential to conduct effective reminiscence groups in a variety of geriatric settings.

Recommendations

The results of this study are applicable only to the populations represented by the sample. Elderly people from different environments might respond very differently to the treatment methods of reminiscence therapy. It would be valuable to study persons from different settings and backgrounds. The literature as well as the results of this study suggests that persons from non-institutionalized settings, in which healthy persons live, may show less change than those living in a situation that gives little or no external stimulation to its residents. Therefore, instituting an intervention into a group of people in an institutionalized setting, who are already presumed to be depressed, might yield very different results than the results found in this study.

Limitations

Limitations of this study include the small sample size of the groups, the short time frame of the study, lack of control for extraneous variables, and the unforeseen problems in completing the questionnaires accurately. In addition, the sample population represents similar background characteristics in that participants are living independently in the community. The sample does not represent institutionalized persons who very well may have had more profound depressive characteristics prior to the study. Further research needs to be undertaken with larger samples, more diverse elderly populations, and perhaps different levels of cognitive functioning. Finally, reminiscence itself needs to be further investigated to gain better understanding of its content, function, and process as an adaptive mechanism and, lastly, for its place in the elderly health care setting.

REFERENCES

References

- American Association of Retired Persons [AARP]. (1986).
A Profile of Older Americans (PF 3049[1086]D996).
Washington DC: Author.
- Baker, N. J. (1985). Reminiscing in group therapy for
self-worth. Journal of Gerontological Nursing, 11(7),
21-24.
- Beaton, S. (1980). Reminiscence in old age. Nursing
Forum, 19(3), 271-283.
- Boylan, B., Gordon, S., & Nehrke, M. (1976). Reminiscing
and ego integrity in institutionalized elderly males.
The Gerontologist, 16(2), 118-124.
- Burnside, I. (1969). Group work among the aged. Nursing
Outlook, 17, 68-72.
- Burnside, I. (Fall, 1970). Group work with the aged.
Gerontologist, 1, 241-246.
- Burnside, I. (1975). "Listen to the Aged." American
Journal of Nursing, 75(10), 1800-1802.
- Burnside, I. (1976). Nursing and the aged. New York:
McGraw-Hill Book Company.
- Butler, R. (1963). The life review: An interpretation of
reminiscence in the aged. Psychiatry, 26, 65-76.

- Butler, R. (1974). Successful aging and the role of the life review. Journal of the American Geriatrics Society, 22, 529-535.
- Butler, R. (1980). The life review: An unrecognized bonanza. International Journal of Aging and Human Development, 12(1), 35-37.
- Butler, R. (1980). Ageism: A foreward. National Institute on Aging. Journal of Social Issues, 13(2), 8-11.
- Cameron, P. (1972). The generation gap: Time orientation. The Gerontologist, 12(2), 117-119.
- Chiriboga, D. A., & Gigy, L. (1975). Perspectives on life course. In M. F. Lowenthal, M. Thurber, and D. A. Chiriboga (Eds.). Four stages of life. San Francisco: Jossey-bass.
- Ebersole, P., & Hess, P. (1985). Toward healthy aging. Human needs and nursing response (2nd ed.). St. Louis, Mo: Mosby.
- Erikson, E. (1950). Childhood and society. New York: W. W. Norton.
- Erikson, E. (1963). Childhood and society (2nd rev. ed.). New York: W. W. Norton.
- Folstein, Folstein & McHugh. (1987). The Mini-Mental State examination (MMS). Geriatrics, 42(3), 55.

- Giambra, L. (1977). Daydreaming about the past. The Gerontologist, 17(1), 35-38.
- Goldfarb, A. (1971). Group therapy with the old and aged. In H. Kaplan and B. Sadock (Eds.). Comprehensive group psychotherapy, (pp. 140-147). Baltimore: The Williams & Wilkins Co.
- Haight, B. K. (1988). Excerpts from life review: Part 1; A method for pastoral counseling. Journal of Religion and Aging. American Association of Retired Persons (AARP), Washington, DC, 5, 33-39.
- Havighurst, R., & Glasser, R. (1972). An exploratory study of reminiscence. Journal of Gerontology, 27(2), 245-253.
- Ingersoll, B., & Silverman, A. (1978). Comparative group psychotherapy for the aged. The Gerontologist, 18(2), 201-206.
- Ingersoll, B., & Goodman, L. (1983). A reminiscence group for institutionalized elderly. In M. Rosenbaum (Ed.). Handbook of short-term therapy groups, (pp. 187-201). New York: McGraw-Hill.
- Kastenbaum, R. (1974). . . .Gone tomorrow. Geriatrics, 29, 127-134.
- Kellett, A. (1975). Update on aging: Its problems, its promises. Image, 7(3), 10.

- Knight, B. (1978). Psychotherapy and behavior change with the non-institutionalized aged. International Journal of Aging and Human Development, 9(3), 221-236.
- Lappe, J. (1987). Reminiscing: The life review therapy. Journal of Gerontological Nursing, 13(4), 12-16.
- Langer, R. J. (1980). Aging labels: The decline of control and the fall of self-esteem. Journal of Social Issues, 36(2), 12-29.
- Lewis, C. (1971). Reminiscing and self-concept in old age. Journal of Gerontology, 26(2), 240-243.
- Lewis, C. (1973). The adaptive function of reminiscing in old age. Journal of Geriatric Psychiatry, 6, 117-121.
- Lewis, M., & Butler, R. (1974). Life review therapy: Putting memories to work in individual and group psychotherapy. Geriatrics, 29, 165-173.
- Lieberman, M., & Falk, J. (1971). The remembered past as a source of data for research on the life cycle. Human Development, 14, 132-141.
- LoGerfo, M. (1980-81). Three ways of reminiscence in theory and practice. International Journal of Aging and Human Development, 12(1), 39-48.
- Manton, K. G. (1984). The Graying of America: Demographic challenges for socioeconomic planning. New Jersey: Prentice Hall, Inc.

- Maslow, A. H. (1954). Motivation and personality. New York: Harper & Row.
- McMahon, A. & Rhudick, P. (1964). Reminiscing: Adaptational significance in the aged. Archives of General Psychiatry, 10, 292-298.
- McMordie, W., & Blom, S. (1979). Life review therapy: Psychotherapy for the elderly. Perspectives in Psychiatric Care, 17, 152-166.
- Medley, M. (1976). Satisfaction with life among persons sixty-five years and older: A causal model. Journal of Gerontology, 31(7), 448-455.
- Neugarten, B. (1977). Personality and aging. In J. Birren and K. W. Schaie (Eds.) Handbook of the Psychology of Aging, (pp. 161-163). New York: Van Nostrand Rheinhold.
- Osborne, C. L. (1989). Reminiscence when the past eases the present. Journal of Gerontological Nursing, 15(10), 6-12.
- Parsons, C. (1986). Group reminiscence therapy and levels of depression in the elderly. Nurse Practitioner, 11(3), 68-76.
- Perrotta, P., & Meacham, J. (1981). Can a reminiscing intervention alter depression and self-esteem? International Journal of Aging and Human Development, 14(1), 23-30.

- Pincus, A. (1970). Reminiscence in aging and its implications for social work practice. Social Work, 15, 47-53.
- Rilling, L. F. (1983). Feasibility of adult day care/day health care services for residents of the Monterey Peninsula. Unpublished masters' thesis. San Jose State University, San Jose, California.
- Rogers, M. (1970). An introduction to the theoretical basis of nursing. Philadelphia: F. A. Davis.
- Rosenberg, M. (1965). Society and the adolescent self-image. Princeton, NJ: Princeton University Press.
- Roy, S. C. (1976). Introduction to nursing: An adaptational model. New Jersey: Prentice Hall Inc.
- Sherman, S., & Havighurst, R. J. (1970). An exploratory study of reminiscence. Abstract in The Gerontologist, 10, 42.
- Sherman, E. (1981). Counseling the aging: An integrative approach. New York: Free Press.
- Sherman, E. (1984). Working with older persons. Boston: Kluwer-Nijhoff.
- Silber, E., & Tippet, J. (1965). Self-esteem: Clinical assessment and measurement validation. Psychological Reports, 16, 1017-1071.
- Taft, L. B. (1985). Self-esteem in later life: A nursing perspective. Advances in Nursing Service, 8(1), 77-84.

Webster's Third New International Dictionary. (1965).

Springfield, MA: Merriam-Webster.

Zung, W. K. (1965). A self-rating depression scale.

Archives of General Psychiatry, 12, 63-70.

APPENDIX A
Demographic Profile

Demographic Profile

1. Your Sex M _____ F _____
2. Your Age? _____
3. Your Ethnic Background? Caucasian _____
Black _____
Other _____
4. Your Marital Status? Single _____
Divorced _____
Married _____
Widowed _____
5. Are you retired? Yes _____ No _____
6. Your Educational Level? Less than 6th grade _____
Grammar School Diploma _____
High School Diploma _____
Some College Education _____
Advanced Degree _____
7. Who are you living with? Alone _____
Spouse _____
Children _____
Sibling _____
Other _____
8. How do you rate your health status? good _____
fair _____
poor _____
9. Your income per month? Less than \$500 _____
\$501 - \$1,100 _____
\$1,001 - \$1,500 _____
More than \$2,000 _____
10. Do you need assistance with household activities? Never _____
Occasional help _____
Moderate help _____
Much help _____
11. What do you think your greatest needs are?
(mark as many as you wish) Socialization _____
Medical care _____
Transportation _____
Financial Help _____
Other _____

APPENDIX B
Rosenberg Self-Esteem Scale

PLEASE NOTE

Copyrighted materials in this document have not been filmed at the request of the author. They are available for consultation, however, in the author's university library.

83

85

87-88

90-91

University Microfilms International

APPENDIX C

Zung Re-modified Self-Rating Depression Scale

APPENDIX D

Life Review and Experiencing Form (LREF)

APPENDIX E

The Mini-Mental State examination (MMS)

APPENDIX F
Institutional Review Board -
Human Subjects Approval Letter
San Jose State University

A campus of The California State University

Office of the Academic Vice President • Associate Academic Vice President • Graduate Studies and Research
One Washington Square • San Jose, California 95192-0025 • 408/924-2480

To: Patricia L. Dinan, Nursing

From: Charles R. Bolz
Office of Graduate Studies and Research

Date: June 7, 1990

The Human Subjects Institutional Review Board has approved your request to use human subjects in the study entitled:

"Does Reminiscence Therapy Increase Self-Esteem
and Decrease Depression Levels in the Elderly?"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Dr. Serena Stanford immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have any questions, please contact Dr. Stanford or me at (408) 924-2480.

cc: Marcia Canton, Ph.D.

APPENDIX G

Approval Letter to Use
Ambulatory Health Clinic
as a Research Site

DISTRICT HEALTH DEPARTMENT

April 13, 1990

Human Subjects Institutional Review Board
San Jose State University
San Jose, California 95912

Dear Members of the Review Board:

Ms. Patricia Dinan has shared her proposed research protocol with me and has requested permission to conduct the research through our Ambulatory Geriatric Health Clinic.

Approval has been given to conduct the research. We are hopeful that the research outcome will assist us by providing documentation of the effectiveness of reminiscing therapy in decreasing depression and raising self-esteem in the elderly client.

Sincerely,

A handwritten signature in cursive script that reads "Donna L. Legg".

Donna L. Legg, R.N.
Assistant Division Director
Community and Clinical Health Services

APPENDIX H
Participant Consent Form

"Informed Participation Statement"

I am a candidate for the Master of Science degree in Nursing at San Jose State University. Currently I am doing research for my thesis which concerns reminiscence in the elderly.

As a patient of the Geriatric Clinic, you are invited to participate in this study. Participation will involve attending six one-hour sessions and completing three questionnaires if you are in the treatment group. If you are not in the treatment group, then you will be only asked to complete the questionnaires.

There may be some identifiable risks and/or benefits to your participation in this study. The benefits that may be derived from participating in this study are increased self-worth and self-esteem as well as the opportunity to share in the group process of reminiscing. Some of the possible risks that could occur might be anxiety, agitation and/or depression, although it is not expected that this will be a problem.

Your consent for participation is voluntary. You may refuse to participate or you may withdraw from this study or any part of this study at any time without prejudicing any relationship with San Jose State University and/or with the Geriatric Clinic. Your responses to all questions will be kept confidential: a numerical system will be used to keep track of answers. No names will be used on any questionnaire. Participants may receive a synopsis of the study after it is completed upon request.

The results from this study may be published, but any information from this study that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.

Any questions about your participation in this study will be answered by myself, Patricia L. Dinan (702-329-9350). Complaints about the procedures may be presented to Dr. Bobbye Gorenberg, Graduate Coordinator, Department of Nursing, San Jose State University, San Jose, California (409-924-3134). For questions or complaints about research subject's rights, or in the event of research related injury, contact Serena Stanford, Ph.D. (Associate Academic Vice President for Graduate Studies & Research) at 408-924-2480.

If you will participate, please sign and date this form.

MY SIGNATURE INDICATES THAT I HAVE READ THE INFORMATION PROVIDED ABOVE AND THAT I HAVE DECIDED TO PARTICIPATE. I have received a copy of this consent form for my file.

DATE

SUBJECT'S SIGNATURE

INVESTIGATOR'S SIGNATURE

APPENDIX I

Permission to use the article containing
the Zung Re-modified Self-Rating Depression Scale
and the Rosenberg Self-Esteem Scale

July 31, 1990

Patricia Dinan, RN/APN

RE: International Journal of Aging and Human Development-V14(1)
"Can A Reminiscing Intervention Alter Depression and Self-Esteem?"
Peter Perrotta, and J. A. Meacham

Dear Ms. Dinan:

Permission is granted for the use of the above mentioned article(s), on the understanding that full credit will be given to the original publication of the material listed by Author and Article, or Chapter Title; to the Journal or Book by Title, Volume and Issue Numbers (where applicable); and that our copyright line, as it appears on the copyright page of the Book or the first page of the Article, will be reprinted in full in your acknowledgement.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Barbara Lauro'.

Barbara Lauro
Permissions Department

APPENDIX J

Permission Letter to use the
Life Review and Experiencing Form (LREF)

COLLEGE OF NURSING
Gerontological Nursing
Graduate Program
(803) 792-3108 or 3816

MEDICAL UNIVERSITY OF SOUTH CAROLINA
171 Ashley Avenue
Charleston, South Carolina 29425-2403

October 11, 1990

Patricia L. Dinan

Dear Patricia:

I am writing in response to your letter dated October 3, 1990. You have my permission to use the Life Review and Experiencing Form (LREF) in your research.

Sincerely,

Barbara K. Haight, RNC, Dr.PH.
Professor of Nursing

BKH/kjb