The Effects of a Reminiscence Group on Self-Esteem and Depression in a Group of Elderly Persons

by

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A Thesis

Presented to
The Oregon Health Sciences University
School of Nursing
in partial fulfillment
of the requirements for the degree
Master of Nursing

June 1986

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This study was partially supported by Traineeships from the United States Public Health Service Grant Numbers 1 TOL MH17172-01 and 2 A11 NU00250-09, and by a Research Grant from the Beta Psi Chapter of Sigma Theta Tau.

ACKNOWLEDGEMENTS

I would like to acknowledge the following persons whose support, encouragement, and assistance helped make this thesis a success.

To the faculty of the Mental Health Nursing Department, I wish to thank all of you for your teaching and sharing. Specifically, I wish to thank the following persons:

Beverly Hoeffer, for your encouragement, patience, advice, and sharing of ideas and knowledge throughout this project, and for your faith in my ability to complete this study and disseminate the results.

Sarah Porter-Tibbetts, for your support and assistance with my first group experience with the elderly, and for your willingness to critique the writing of this thesis.

Mary Cowan, for your support during the two years in which I balanced course work, teaching, and thesis writing.

Mary Kay King, for your much needed encouragement and support during my first year in graduate school.

To Sandra Fresh and the staff and clients of the Adult Day Health Care Program, I wish to thank all of you for your interest and willingness to assist me with this study.

To my family--Ken, Becky, and Jeff--I wish to thank you for your faith in me and for your endurance and patience throughout the past three years of study.

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Chapter I

Problem Statement

Throughout the lifespan, adults face a variety of life events or changes which occur primarily within the context of family, work, health, finances, and friendship (George, 1982). For older adults, these changes frequently involve losses that may increase their susceptibility to mental health problems. More specifically, Kane, Ouslander, and Abrass (1984) have identified biological, physical, psychological, and social factors which predispose the elderly to depression. These factors can be conceptualized as losses, such as loss of central nervous system functioning, loss of health, loss of memory, and loss of family, friends, job, and income. If an elderly person is unable to cope with these losses, the result may be decreased self-esteem, hopelessness, despair, and depression (Salzman & Shader, 1978).

Because the elderly population in the United States is rapidly increasing in size and proportion, their susceptibility to mental health problems is a relevant concern for mental health nursing and other health care providers. Currently, the elderly account for 11.4% of the U.S. population (U.S. Bureau of Census, 1982); however, it is estimated that they will account for 20% of the projected population by 2025 (Fuller, 1983). One recent

estimate is that 15% to 25% of the elderly experience significant mental health problems, a rate higher than that of the general population (President's Commission, 1978). Gurland and Cross (1982) estimated that 15% to 20% of the elderly may be underserved and need mental health services, primarily for treatment of dementia and depression.

The most common mental health problem among the elderly reported in the literature is depression (Barnes, Veith, & Raskind, 1981; Solomon, 1981; Zung, 1967). Solomon predicted that 30% to 50% of the elderly population will experience depressive symptoms severe enough to interfere with daily functioning. Kane et al. (1984) agreed with Barnes et al. that about 5% of the elderly experience a clinical depression, and noted that 10% of those in the community experience a dysphoric mood. However, the results of a study conducted by Blazer and Williams (1980) indicated that the prevalence of depressive symptomatology for elderly persons in the community was 14.7%. Solomon stated that depression is the main cause of psychiatric hospitalization for the elderly. Further, members of this age group account for 25% of the nation's suicides, with the suicide rate of elderly men being four times as great as that of the general population (Barnes et al., 1981).

As previously mentioned, mental health problems such

as depression may result from the elderly person's experience, perception, and manner of coping with losses, rather than from the losses per se (Salzman & Shader, 1978). One coping mechanism discussed in the literature that may be especially effective for the elderly is reminiscence (Hamner, 1984; Lewis, 1964; McMahon & Rhudick, 1964). The literature suggests that individual and group reminiscence is adaptive for elderly persons because it enhances self-esteem and relieves depression. Gerontologists and others who serve the elderly have described and postulated about individual and group reminiscence (Butler, 1963; Ingersoll & Silverman, 1978; Lewis, 1971; McMahon & Rhudick, 1964). Descriptive accounts by nurses (Beaton, 1980; Ebersole, 1976a & 1976b; Ellison, 1981; King, 1982; MacRae, 1982; Ryden, 1981) support the usefulness of reminiscence with elderly clients as a nursing intervention. Conducting reminiscence groups for elderly clients in institutional and community settings may be a valuable mental health nursing intervention. However, intervention studies are needed to test the effectiveness of this approach. Thus, the problem to be addressed in this study is whether a reminiscence group is an effective intervention for noninstitutionalized elderly experiencing low self-esteem and depression.

Review of the Literature

The review of the literature will consist of nursing and nonnursing articles which address reminiscence and/or life review. Butler's (1963) conceptual article fostered speculation and research about reminiscence. For this reason, a brief discussion of Butler's article will precede the remainder of the review. This will be followed by a review of experiential nursing articles directed at reminiscence or life review as a nursing intervention. Finally, a critical review of research studies which address the function of individual and group reminiscing, followed by a summary of the literature and implications for research, will be presented.

Butler's (1963) article was written in response to his own discontent with an entropic view of the aging process. Within this view, reminiscence, the act of recalling or remembering the past, was viewed negatively, that is, as a nonpurposive escape or regression to the past, signifying the advance of senility. Based on his extensive experience with older people, Butler proposed that reminiscence provides the material with which to conduct a life review. He believed that the life review is a naturally occurring process which is initiated by the realization of approaching death and increased feeling of personal vulnerability. It involves a progressive return to past

experiences for survey and integration, and is shaped by one's personality and contemporary experience. Butler postulated that the life review is adaptive through reintegration of the ego and maintenance of psychological functioning. However, he warned that life review could result in severe depression, panic, guilt, obsession, and suicide for some psychiatrically disturbed patients. It should be noted that Butler's ideas were based primarily on experience with psychiatric patients, and on silent, unshared life review.

Butler's (1963) proposal on the life review process was highly significant. He encouraged other gerontologists to examine the process of life review and reminiscence, and to view these as significant and vital to the aging process. Multiple articles by nurses and others serving elderly clients have followed Butler's key article. Some articles were reports of studies describing or examining various aspects of reminiscence, while others were experiential or conceptual, and primarily written by nurses who believed or found reminiscence or life review to be useful in working with elderly persons. Over the years, reminiscence has gained more favorable attention. This writer has observed that many of the more contemporary writers tend to use the terms "reminiscence" and "life review" interchangeably, perhaps reflecting a synthesis of

the two terms. However, life review was originally intended to denote the analysis of one's life as viewed through reminiscence (Butler, 1963).

Nursing Literature

Most of the nursing articles included conceptual discussions, literature reviews, experiential material, and recommendations for nursing. They clearly indicate an interest in reminiscence and a belief in its value as a nursing intervention for elderly clients.

Ebersole (1976a & 1976b) wrote the earliest nursing articles on reminiscence. She described reminiscence as a nursing intervention which makes use of a natural process to benefit the depressed, confused, helpless, or fearful elderly client. Ebersole discussed the value of reminiscence, emphasizing the improvement of self-esteem for these frail older people and the value of reminiscence for nursing as both an intervention and assessment tool. She also described some of the difficulties she encountered in conducting groups with elderly clients and offered experientially-based advice for problem-solving. Although Ebersole's work was with institutionalized elderly, she suggested that elderly persons in day-care or senior centers might also benefit from participation in reminiscing groups.

Ryden (1981) also recommended the use of reminiscence

with elderly persons as a nursing intervention. She discussed reminiscence in terms of its goals and specific nursing actions. She cited the nursing goals of reminiscence as (a) helping the client to cope with loss, and (b) to increase self-esteem. Specific nursing actions included initiating and reinforcing reminiscence, helping the client to deal with feelings associated with reminiscing, and assisting family members to deal with reminiscing behavior. Ryden strongly urged nurses to utilize the healing process of reminiscence by using their knowledge of interpersonal skills and understanding the concept of reminiscence.

Further recommendations for the formation of reminiscing groups for the elderly came from Ellison (1981). Her recommendation was based on her review of the literature and her graduate student experience as the leader of a reminiscence group in a nursing home. She reported observing the function of the curative factor of instillation of hope. She also observed increased interaction and socialization, and recommended that nurses institute these groups in a variety of settings to aid in meeting the emotional and adaptational needs of the elderly.

King's (1982) article was essentially a review of the literature incorporated with a report of her own experience

as the therapist for a reminiscence group in an adult day care center. She used Ebersole's (1976a & 1976b) model of reminiscence groups and employed a life cycle sequence to structure the content. King observed that members of her group experienced improved self-esteem and an increased awareness of their own feelings. She suggested that participants in reminiscing group therapy have the opportunity to resolve past conflicts, and bolster their self-esteem and self-concept. She also suggested, like Ryden (1981), that families may also benefit from reminiscence.

Beaton (1980) explored reminiscence in a conceptual rather than an experiential manner. She conceptualized reminiscence within Martha Rogers's framework of unitary man. According to this framework, life is viewed as unidirectional. Thus, reminiscence becomes a repatterning, instead of regression to the past. Beaton derived four functions of reminiscence, those of validation, integration, guiding, and connecting, and offered suggestions for their nursing utility. She also identified the need for nursing research to further substantiate the value of reminiscence as a nursing intervention. Specifically, Beaton recommended studies to (a) examine the effectiveness of reminiscence in increasing self-esteem and decreasing depression, (b) determine when reminiscence is

helpful, and (c) assess its effects on interpersonal interactions. Beaton also suggested that more studies be done with noninstitutionalized elderly.

The consensus of these nurses (Beaton, 1980; Ebersole, 1976a & 1976b; Ellison, 1981; King, 1982; Ryden, 1981) is that reminiscence has value as a nursing intervention. Their beliefs were based on experience and literature review. These authors recommended reminiscence for individuals, groups, and families, and delineated nursing goals and actions. However, as Beaton (1980) noted, there remains a lack of nursing research on reminiscence as an intervention.

Research Studies

The review of the literature research includes a critical analysis of nine studies that explore the adaptive function of reminiscence. The majority of the studies are non-experimental; two are quasi-experimental studies. A review of the four nonnursing articles supporting a relationship between individual reminiscence and adaptation in old age will be followed by a review of the five nursing and nonnursing articles supporting a relationship between group reminiscence and adaptation.

Individual reminiscence.

McMahon and Rhudick (1964) conducted one of the first major studies of the relationship between individual reminiscing and adaptation.

In this descriptive, correlational study, the volunteer subjects were 25 elderly volunteers, who were noninstitutionalized male veterans. The subjects were interviewed for reminiscence content and for presence of depression as evidenced clinically by decreased affect, loss of self-esteem, and feelings of helplessness and hopelessness. Intellectual competency was also measured, using the Wechsler Bellevue Intelligence Test. Survival rate one year after the interview was also determined. McMahon and Rhudick found that reminiscence was not related to level of intellectual competency. However, they found that nondepressed men tended to reminisce more than depressed men and that a significant correlation existed between depression and subsequent death within one year. McMahon and Rhudick concluded that reminiscence is positively related to absence of depression and to personal survival, and that their findings support the idea that reminiscence fosters successful adaptation to old age. These findings contribute to the body of knowledge about reminiscence by suggesting its adaptive function and its lack of dependence on intellectual competency. However, limitations of this study restrict the definitive generalizations and conclusions offered by McMahon and Rhudick. The limitations include use of volunteer subjects of one gender and of very old age (78 to 90 years of age),

and inadequacy of the design to determine cause-effect relationships.

McMahon and Rhudick (1964) also contributed to the body of knowledge on reminiscence by identifying three types of reminiscence as a result of their content analysis. The first type of reminiscence involved fantasies of invulnerability and glorification of the past. They described this type as a means of maintaining self-esteem and coping with anxiety associated with the aging process. The second type of reminiscence was that which provided the material for a life review in preparation for death. This form of reminiscence was observed in several subjects whose reminiscences reflected guilt, unmet goals, and a need to justify their lives. The third type of reminiscence observed was labeled storytelling. Those subjects demonstrating this kind of reminiscence told stories about their past in a pleasurable, entertaining, and informative manner. McMahon and Rhudick observed that these men were the most well adjusted of the subjects and demonstrated no depression. They concluded that storytelling preserves self-esteem and allows a person to contribute meaningfully to society.

Havighurst and Glasser (1972) also conducted a correlational, descriptive study of the experience of reminiscence. They interviewed three groups of selected

elderly women and men in community settings (N > 500). These subjects were mostly healthy and successful middle class people, some of whom were listed in Who's Who, and most of whom were college graduates, professionals, or businessmen and women. A moderate positive correlation (r = .34) for males and a low positive correlation (r = .18) for females between high frequency of reminiscing and pleasant affect of reminiscing were found. A low positive correlation (r = .16) between pleasant affect of reminiscence and favorable self-concept was found. Further, a moderate positive correlation (r = .47) between frequency of reminiscing and amount of mental imagery was found. The content of reminiscence in this sample reflected the experiences of the individuals, which were largely successful and pleasant. This study provided some needed descriptive data about reminiscence. However, the generalizability of these results to persons with less successful lives is questionable. Furthermore, the design does not allow for a causal interpretation; whether good adjustment results in frequent, pleasant reminiscence, or vice versa, is unclear.

A third descriptive, correlational study by Boylin, Gordon, and Nehrke (1976) identified further the potential relationship between individual reminiscing and adaptation. They used the interview tool developed by Havighurst and

Glasser (1972) to measure frequency, affect, and time of reminiscing in 41 elderly, institutionalized male veterans. They also measured ego integrity, or ego adjustment, using subscales based on the resolution of the developmental crises described by Erikson (1950). Face validity of the subscales with Erikson's concepts was established, but no other measures of reliability nor validity were presented. Boylin et al. found a significant moderate positive correlation ($r = .41$) between frequency of reminiscence and ego integrity as measured by the subscale. They also found a significant moderate positive correlation ($r = .45$) between ego integrity and negative feelings associated with reminiscence. This would seem to contradict the feelings of McMahon and Rhudick (1964) and of Havighurst and Glasser (1972), but may reflect a different emotional or reminiscing process for institutionalized as opposed to noninstitutionalized elderly. It may also be a product of measuring affect and adjustment in different ways in each of these studies. In spite of the contradiction and the limitations of the study, the findings are in general congruent with the previously described studies, that is, that reminiscence may facilitate adaptation in old age.

The fourth study of individual reminiscence and adaptation, conducted by Lewis (1971), was the first reminiscence study to utilize a control group. In this

quasi-experimental study, 23 elderly males from the community were studied to determine whether a relationship between reminiscing and self-concept existed. The subjects were separated into two groups, those who were identified as reminiscers and those who were not. Q-sort was used to identify the self-concept of each subject before and after their expressed opinion was challenged in the experimental situation. The group identified as reminiscers showed a significant increase in the correlation between their past and present self-concept as compared to non-reminiscers, when their expressed opinion was challenged. Lewis suggested that identifying with one's past through reminiscence and the resulting increase in self-concept consistency may represent an adaptive coping mechanism for some elderly. A primary contribution of this study is its quasi-experimental design and its support of the adaptive function of reminiscence. However, the sample size was very small and limits generalizability of findings.

Thus, there were four major studies which examined individual reminiscing and adaptation. Although a number of variables, such as depression, survival, ego integrity, self-concept, pleasant affect, and morale were measured, a positive relationship between reminiscing and adaptation was found in each study. A review of these studies indicates a need for experimental studies to examine the

causal relationships between reminiscence and mental health outcomes.

Group reminiscence. The next group of studies examined the relationship between group reminiscing and adaptation. Four of the studies were primarily pre-experimental and one was quasi-experimental in design.

Norris and Eileh (1982) conducted 10 sessions of a reminiscence group with six male inpatients of a psychogeriatric ward. They hypothesized that participation in a reminiscence group would improve the quality of life and sense of personal identity for these elderly men. Their findings were based on tape recordings of the sessions and causal observation of the men. They observed that the men became more animated and spontaneous and exhibited an increased readiness to participate. They also observed increased verbalization among mute and confused men. All the men appeared to enjoy the experience. This study has serious limitations, including lack of reliable and valid observation tools, lack of a well-defined dependent variable, and lack of a control group. However, this nursing study did provide an example of a case in which a reminiscence group seemed to be beneficial to its participants.

Rosenthal (1982) also supported the beneficial aspects of reminiscence groups. She speculated that a reminiscing

group would improve life satisfaction or a personal sense of well-being for its participants. She conducted nine weekly reminiscence group sessions with seven residents of a nursing home. She used a Wheel of Life with quadrants for each of four stages of life to structure the group. All sessions were taped and the frequency of reminiscence for each group member recorded. Rosenthal observed that the highest frequency of reminiscence occurred after the Wheel of Life was completed. She also observed positive changes in the participants' nonverbal behavior and an increase in their interaction, both within and outside of the group. This nursing study was subject to the same kinds of limitations found in the Norris and Eileh (1982) study.

Another study by Lesser, Lazarus, Frankel, and Havasy (1981) relied on observation of behavior change to determine whether participation in a reminiscence group would be therapeutic for psychotic geriatric patients. The subjects were six inpatients of a state psychiatric hospital. Three were diagnosed with major depression, two with organic brain syndrome, and one with chronic schizophrenia. The subjects were involved in a traditional therapy group weekly for 11 weeks. Then the group format was changed to reminiscence and frequency increased to twice weekly for 11 weeks. In essence, the subjects served

as their own controls. Lesser et al. noted the following changes that they believed to be a result of reminiscing. The subjects demonstrated increased spontaneous verbalization, increased interpersonal interaction, decreased patient-therapist interaction, increased group receptiveness, and a decreased need to rely on structured content. Lesser et al. concluded that reminiscence group therapy increases group cohesiveness and fosters the group's therapeutic value. They further speculated that the process of group reminiscence promotes reintegration and evolution of more mature defense mechanisms for the psychotic patient.

Lesser et al. (1981) were aware of the limitations of their study and suggested changes in design for future studies. In a more systematic and controlled study, they planned to randomly assign patients to a reminiscence group and a traditional therapy group. They planned to videotape all sessions, rate interactions, quantitatively measure socialization outside the group, rate defenses of subjects, and assess depression with the Hamilton and Beck Depression scales. They hoped to demonstrate support for the value of reminiscence groups. If this happened, they recommended further studies to assess the impact of reminiscing groups on persons with specific diagnoses, such as depression, paranoia, or dementia.

Matteson (1984) conducted a nursing study that addressed the effect of participation in a reminiscence group on depression in the elderly. Her study was similar to others in that it lacked a control group. However, she did use a widely accepted measurement tool, the Zung Depression Scale, to measure the dependent variable. She conducted a pretest and a posttest using this scale. Participants whose Zung Depression Scale scores were greater than 55 were selected for two groups from two intermediate care facilities. There were six in the first group and eight in the second group. Although the results of the posttests were not immediately available, Matteson reported that the participants demonstrated improved affect and expressed verbally that they felt better and enjoyed the group. Several factors limit the validity of this study. These include the selection of subjects, and the mortality or dropout of subjects. The effect of reading the Zung Depression Scale to the participants and interpreting meanings of words or phrases may have affected internal validity. Further, it is difficult to analyze the study without the pretest and posttest data, which were not presented in this source. Including a nonreminiscing control group would provide a basis for comparison and improve internal validity.

The final research study compared the effects of

reminiscing group therapy and behavioral group therapy on self-esteem and on anxiety and somatic behavior for elderly participants. Ingersoll and Silverman (1978) randomly assigned nine elderly nonpsychotic volunteer subjects from the community to a "Here and Now" group and eight to a "There and Then" group. Each group was predominantly female, with only two men present in each. A minority of black persons was represented, two in the behavioral group and one in the reminiscing group. However, the groups shrank to six and four respectively, with gender and race of the remaining unknown. The pretest and posttest were comprised of self-esteem questions from Rosenberg (1965) and anxiety and somatic behavior questions from Derogatis, Lipman, and Covi (1973). The two groups met weekly for two hours, for a total of eight sessions. Ingersoll and Silverman found that although the participants of both groups demonstrated an increase in their self-esteem, the increase was not statistically significant. They noted that, overall, the reminiscing group seemed to be most helpful. They concluded that perhaps the opportunity to interact with peers in a supportive environment helped strengthen the elderly person's ability to adapt. The final sample size was small due to mortality. This and various extraneous variables may have had an unknown effect on the results. The researchers recommended further

studies with larger samples and a control group.

The research literature supports the idea that reminiscing individually or in a group may be adaptive in terms of increasing self-esteem, maintaining self-concept, decreasing depression and anxiety, improving affect and group behavior. Tables 1 and 2 compare the studies in terms of dependent variables and other factors. Questions arise as to whether gender, race, institutionalization, past life experiences, and veteran status affect the results. Further research is needed which (a) strengthens the design through use of random assignment to a control group, if possible, or use of a comparison group to control for extraneous variables and (b) utilizes valid and reliable measures of the dependent variables.

Conclusions

This review of the literature depicts the state of knowledge and research in the area of reminiscence. Results from primarily descriptive studies suggest that reminiscence has an adaptive function for elderly individuals and groups. However, the characteristics of persons who benefit, and the kind of reminiscence that is beneficial, is unclear. Most individual reminiscence studies involved noninstitutionalized subjects, while most of the group studies involved institutionalized subjects. Adaptation has been measured in a variety of ways, such as

Table 1

Studies of Individual Reminiscence

Study	Sample Characteristics	Size	Variables	Findings
Boylin et al., 1976	Institutionalized male veterans, mean age--64.37	N = 41	Ego integrity and generativity	Significant correlations between frequency of reminiscence and ego integrity, and between ego integrity and negative feeling of reminiscence.
Havighurst & Glasser, 1972	Successful community residents, age ≥ 62	N = 555	Frequency, affect, quality, function, imagery of reminiscence	Moderate correlations between high frequency reminiscence and pleasant feelings, and between pleasant feeling of reminiscence and favorable self-concept; moderate correlation between frequency of reminiscence and amount of mental imagery; reminiscence content reflected individual experiences.
Lewis, 1971	Male community residents age > 65	N = 24	Self-concept	Significant increase in correlation between past and present self-concept for reminiscers when opinion challenged.
McMahon & Rhudick, 1964	Noninstitution-alized male veterans, age 78-90	N = 25	Depression, intellect	No relationship between reminiscence and intellect; tendency for nondepressed to reminisce more than depressed.

Table 2

Studies of Group Reminiscence

	Sample				
Ingersoll & Silverman, 1978	Nonpsychotic community volunteers, mostly female, age ≥ 60	N = 10	1 reminisc. group, 1 behav.group, 8 weekly sessions	Self-esteem, anxiety, somatic behavior	Increased self-esteem for participants of both groups; reduced somatic behaviors for reminiscing group participants.
Lesser et al., 1981	Psychiatric inpatients, gender unspecified, average age = 69.7	N = 6	11 trad. weekly sessions, then 11 weeks of biweekly remin. groups	Group behaviors	Increased spontaneous verbalization, interpersonal interaction, group receptiveness, and group cohesiveness.
Matteson, 1984	Intermediate care care facility residents; age and gender unspecified	N = 14	2 remin. groups, 8 weekly sessions	Depression	Improved affect.
Norris & Eileh, 1982	Elderly male psychogeriatric inpatients	N = 6	1 group, biweekly sessions, 5 weeks	Behavior changes	Increased animation, spontaneity, participation, readiness, and verbalization.
Rosenthal, 1982	Nursing home residents, gender unspecified, age ≥ 64	N = 7	1 group, 9 weekly sessions	Behavior changes, reminiscence frequency	Increased interaction; positive behavioral changes; highest frequency of reminisence at completion of Wheel of Life.

increased self-esteem, maintenance of self-concept, decreased depression, improved affect, improved morale, good adjustment, and increased socialization. Standardized tests or other reliable measurement tools have been used infrequently. In general, the designs of the studies are pre-experimental and limit the conclusions that can be drawn about the effectiveness of reminiscence as an intervention.

Conceptual Framework

The proposed study is based on a conceptual framework that illustrates the relationship between stressors, coping, and depression in the elderly. These concepts and the links between them and reminiscence are described and illustrated in the following discussion.

Stress and Coping in the Elderly

Coping is an activity or response which protects against or controls the effects of stress for the individual (Hamner, 1984; Lesser et al., 1981; Pearlin & Schooler, 1978; Stagner, 1981). Pearlin and Schooler noted that the term coping is synonymous with mastery, adaptation, and defense. However, Stagner differentiated coping from defense by virtue of the voluntary and stress-protective nature of coping, compared to the unconscious strain-reducing characteristics of defense. Pearlin and Schooler identified coping as a response to life stress

that prevents, controls, or avoids emotional stress. This is similar to Hamner's definition of coping as a process that defends the self against fear and anxiety. For this paper, coping describes any process that reduces, prevents, or avoids the effects of stressors. A stressor is a life event that is perceived to have negative implications for personal well-being (George, 1982).

The coping abilities of the elderly differ very little from those of younger persons. Pearlin and Schooler (1978) found that young and old are equally endowed with coping mechanisms. McCrae (1982) concluded that the coping mechanisms of the elderly are similar to those of younger persons, except that the elderly are less included to use hostility and fantasy.

Although coping abilities may be similar across the adult life span, McCrae (1982) found some differences in types of stressors. In his cross-sectional study of age differences in coping, he observed that losses occurred at all ages with equal frequency. However, the context in which losses occur is different. Challenges, involving work and family, decreased with age, while threats, especially those involving health, increased with age. Thus, the stressors with which the elderly must cope may be more threatening than those experienced at a younger age.

Depression in the Elderly

The American Psychiatric Association (APA) (1980) provides the current diagnostic operational criteria for depression. It identifies a dysphoric mood as the major feature of depression. Feelings of sadness, hopelessness, discouragement, no longer caring, being down in the dumps, describe a dysphoric mood. This mood is often associated with other depressive symptoms, which may include disturbed appetite, disturbed sleep, change in weight, difficulty concentrating, decreased energy, loss of interest in usual activities, psychomotor retardation or agitation, feelings of worthlessness or guilt, or thoughts or plans of suicide. The duration, intensity, and number of symptoms determine a classification of major depressive disorder, dysthymic disorder, or adjustment disorder with depressed mood. The presence of depressive symptoms, rather than a classification or diagnosis, will be identified in this study.

Depressive symptoms in the elderly may differ from those of younger persons in terms of etiology. Loss of self-esteem is a major factor in geriatric depression (Kane et al., 1984; Salzman & Shader, 1978; Zung, 1967). Salzman and Shader described the decrease of self-esteem as the result of a loss of anything to which there is a major "narcissistic attachment." This could involve loss of

health, body parts or functions, mobility, cognitive abilities, or independence. They further stated that the withdrawal of social support enhances these feelings of loss and reduced self-esteem. Loss, or fear of loss, of both function and social support may result in loss of self-esteem and, subsequently, in depression.

Kane et al. (1984) compared and contrasted depressive symptoms for older and younger adults. They noted that for older adults, somatic complaints may predominate over a dysphoric mood. They also observed that apathy, withdrawal, and lack of concentration are common among the elderly. These symptoms, in addition to memory loss, disorientation, and distractibility, are sometimes mistaken for dementia in the elderly (APA, 1980). Kane et al. found that guilty feelings were less common for the depressed elderly, and loss of self-esteem was prominent.

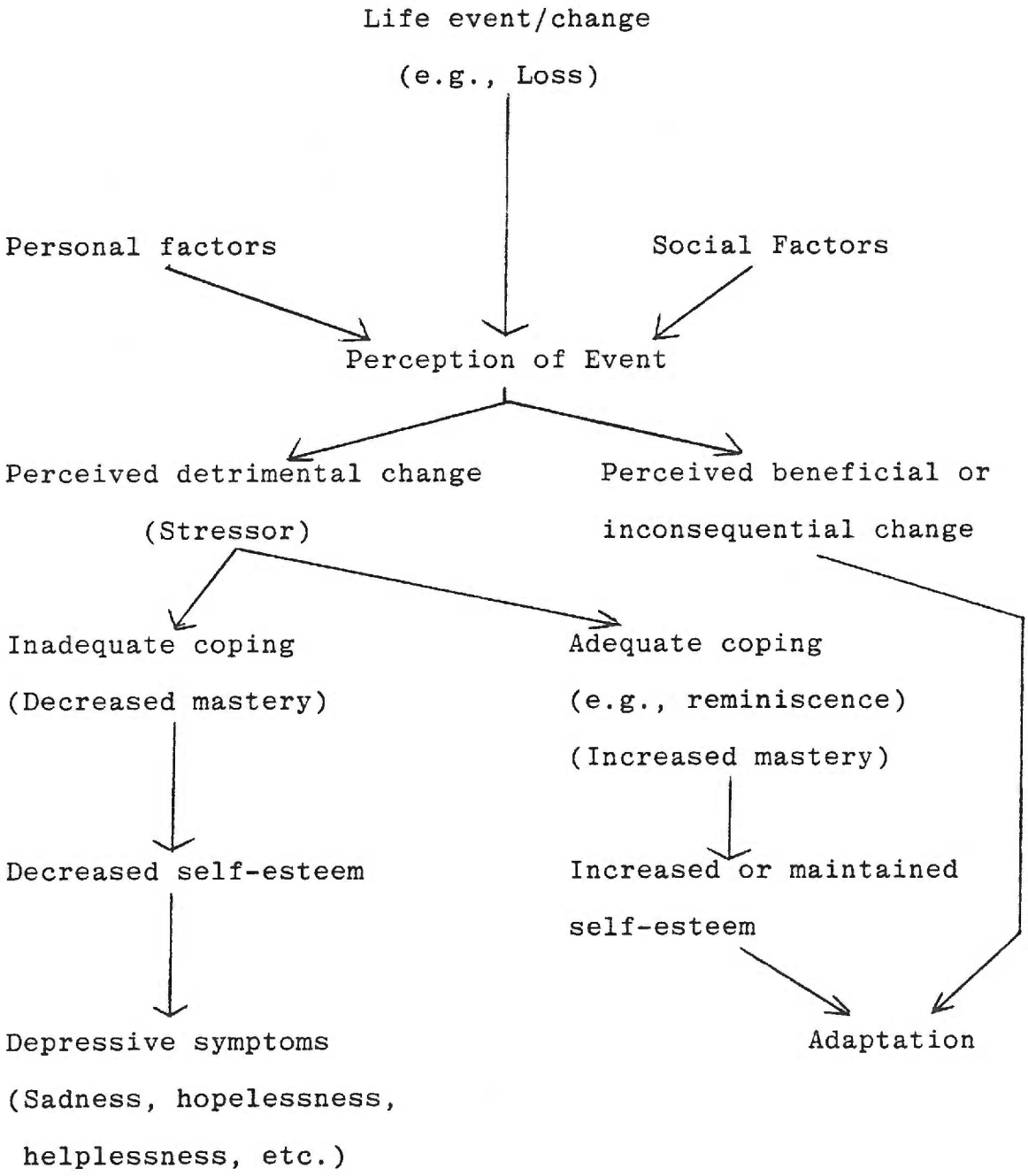
Reminiscence, Coping, and Depression

The relationship between coping and depression has been described by Salzman and Shader (1978) and Solomon (1981). Solomon proposed a sequence of events that may lead to depression if one's coping mechanisms are inadequate. The sequence begins with multiple stressors. According to George (1982), these stressors include a life event or change, which is perceived as detrimental, inconsequential, or beneficial. Individual factors, such

as personality traits, and social factors, such as financial resources and social support networks, influence the perceived meaning of the life event or change. The change perceived as detrimental becomes a stressor. Solomon stated that some elderly may experience a decreased ability to master these stressors because of biologic, psychologic, or social problems. Decreased mastery may result in loss of self-esteem and a sense of hopelessness (Salzman & Shader, 1978), and an increase in dependency and helplessness (Solomon, 1981). Hopelessness may lead to despair (Salzman & Shader, 1978) and helplessness may lead to fear or anger. Salzman and Shader noted that coping skills decrease the awareness of emotional pain and increase sources of gratification. According to Solomon, adequate coping skills result in problem-solving, whereas inadequate coping skills result in symptoms of mental health disturbance. Thus, the presence of adequate coping mechanisms may prevent or decrease depression. Figure 1 illustrates the relationship between life events, stressors, coping, and depression.

Hamner (1984) identified reminiscence as one of five coping mechanisms used frequently by the elderly. Reminiscence is a process of recalling and re-experiencing the personally significant past (Beaton, 1980; McMahon & Rhudick, 1964; McMordie & Blom, 1979; Pincus, 1970), as

Figure 1. Life Events, Stressors, Coping, and Depression.



influenced by personality, time, and current experiences (King, 1982). Reminiscence serves to validate continued growth, integrate various parts of one's life, guide other generations, and connect the individual with the environment (Beaton, 1980). It serves as a means of evaluating, understanding, and accepting the meaning of one's life (McMordie & Blom, 1979), and fosters resolution, reorganization, and reintegration (Butler, 1963; Ebersole, 1976a; Lewis & Butler, 1974).

Thus, reminiscence acts to increase an older person's sense of mastery of life by synthesizing past and present experiences. When reminiscence occurs in a group setting, a therapeutic environment that promotes interaction and fosters personal awareness among persons with similar experiences is created. As Ingersoll and Silverman (1978) summarize, group reminiscence helps the individual cope with personal losses through maintaining the individual's sense of identity, increasing self-esteem, and subsequently decreasing depression.

Purpose of Research

The purpose of this study was to examine the effectiveness of a reminiscence group versus a nonreminiscing group in increasing self-esteem and decreasing depressive symptoms in a group of noninstitutionalized elderly persons.

Statement of Research Questions

The questions addressed in this study were:

1. Does participation in a reminiscence group increase self-esteem of noninstitutionalized elderly more than participation in a nonreminiscence group?

H_1: There will be a positive relationship between participation in a reminiscence group and self-esteem.

H_2: There will be a significant increase in self-esteem of participants in a reminiscence group compared to participants in a nonreminiscence group.

2. Does participation in a reminiscence group decrease depressive symptoms of noninstitutionalized elderly more than participation in a nonreminiscence group?

H_3: There will be a negative relationship between participation in a reminiscence group and depressive symptoms.

H_4: There will be a significant decrease in depressive symptoms for participants in a reminiscence group compared to participants in a nonreminiscence group.

Definition of Terms

Elderly persons: Those persons whose age is equal to or greater than 60 years of age.

Reminiscence group: A group composed of six group participants and two group leaders that meets at a

regularly scheduled time for the primary purpose of reminiscing.

Nonreminiscing control group: A group composed of six participants that meets regularly for a primary purpose that does not include reminiscing.

Participation: Attendance and attempted active involvement in at least two-thirds of the assigned group sessions.

Noninstitutionalized: Persons whose place of residence is in their own home, or that of a friend or relative, or in a foster care home.

Reminiscence: Verbalization of recalled memories of one's past.

Depressive symptoms: Feelings of sadness, hopelessness, discouragement, worthlessness, or guilt; appetite and/or sleep disturbance; impaired concentration, loss of interest in usual activities, apathy, withdrawal; suicidal thoughts or plans, as measured by a self-report scale.

Self-esteem: Positive self-regard and self-acceptance, as measured by one's perception of self, or self-concept, on a self-report scale.

Chapter II

Methods

Design

This pilot study was designed to test the effectiveness of group reminiscence as an intervention strategy. A pretest-posttest control group design was employed. Subjects who volunteered to participate were randomly assigned to either the treatment group (reminiscence group approach) or to the control group (nonreminiscence group approach). The independent variable is reminiscence. The dependent variables are depressive symptoms and self-esteem.

Sample and Setting

Subjects were selected from an adult day health care program serving veterans of a Pacific Northwest metropolitan area. The primary purpose of this program is to provide an alternative to nursing home care for frail elderly veterans who reside in supportive home environments. The program provides these veterans, who are significantly functionally or cognitively impaired, with a variety of health care services to maintain or improve physical health, functional capacity, and quality of life. Criteria for admission to the program include high risk of nursing home placement, significant impairment of activities of daily living, need for close health status

monitoring, and presence of an adequate support system at home. Separate programs are provided for those who are found by the program's psychologist to be cognitively impaired. The criteria for inclusion in this study included (a) participation in this day program and (b) willingness to participate in the study and to answer specified questions. Criteria for exclusion included (a) cognitive impairment, (b) inability to function in a group setting, and (c) presence of a thought disorder (e.g., schizophrenia).

The first 12 persons who volunteered to participate in the study comprised the sample. A probability approach of random assignment of subjects to either the experimental or the control group occurred by drawing subjects' names out of a bowl and alternating assignments to each group. The original sample consisted of 11 males and 1 female. Nine of the 12 subjects attended at least 7 of the 11 group sessions; 3 men were hospitalized and unable to complete the study. The mean age of this sample was 79 years, with a range of 61 to 94 years of age. All subjects were experiencing multiple medical problems, as well as disabilities related to communication and mobility. The demographic data are further described in Tables 3 and 4 in Chapter III.

Instruments

The Beck Depression Inventory. The abridged form of the Beck Depression Inventory (BDI) was used to measure the dependent variable of depressive symptoms. The BDI is a clinically derived, self-report measure comprised of 21 items that inventory 21 categories of depressive symptoms. Each category is accompanied by four self-evaluative statements with rating values of 0 to 3. The subject responds by circling the statement that best describes how he or she feels at that time. The test score, the sum of item ratings, indicates the severity of depression.

The BDI has been extensively tested for reliability and validity. The reliability of the BDI was reported by Beck, Ward, Mendelson, Mock, and Erbaugh (1961). Determination of split-half reliability using a sample of psychiatric patients (N = 97) yielded a reliability coefficient of r = .86, which was raised to r = .93 with a Spearman-Brown correction for attenuation. Gallagher, Nies, and Thompson (1982) demonstrated the adequacy of the BDI as a clinical instrument for the elderly. They assessed the reliability of the instrument for measuring depressive symptoms of elderly persons in a study of normal (N = 82) and depressed (N = 77) elderly. Test-retest reliability was r = .86 for the normal sample, r = .79 for the depressed sample, and r = .90 for the total sample.

Split-half reliability was r = .74 for the normal sample, r = .58 for the depressed sample, and r = .84 for the total sample. Internal consistency, as measured by Cronbach's coefficient alpha, was a = .76 for the normal sample, a = .73 for the depressed sample, and a = .91 for the total sample.

Concurrent and construct validity of the BDI have been assessed. Concurrent validity was supported in three studies. Beck et al. (1961) found a strong correlation (r = .65) between the BDI and clinicians' ratings and BDI scores, which ranged from r = .61 to r = .73 (Beck & Beamesderfer, 1974). In comparison with other standardized measures of depression, Schwab, Bialow, and Holzer (1967) obtained a correlation coefficient of r = .75 between the BDI and Hamilton's Rating Scale for depression. Zung (1969) found a correlation of r = .76 between the Self-Rating Depression Scale and the BDI in England.

Beck and Beamesderfer (1974) also tested the construct validity of the BDI by examining relationships based on theoretical predictions. They set up seven hypotheses regarding depression which were to be tested using the BDI as a criterion measure. Beck and Beamesderfer indicated that each hypothesis was tested in a separate study. Since the relationships between depression and other variables, as measured by the BDI, received support, Beck and

Beamesderfer concluded that strong support for the construct validity of the BDI was evident.

The validity of the BDI for measuring depression specifically in elderly populations has not been assessed. The validity of the BDI and other self-report scales for measuring depression in elderly populations has been questioned because of the number of somatic items included in these scales. Zemore and Eames (1979) found that there may be a greater prevalence of somatic complaints among the elderly, compared to younger groups. Further, Gallagher, Thompson, and Levy (1980) observed that elderly persons may interpret the somatic test items differently than younger persons. These two factors may result in higher total depression scores that may not accurately reflect the elderly subject's level of depression. Thus, until the validity of these scales is assessed with elderly samples, it is recommended that the results of the BDI and other self-rating scales be interpreted with caution and sound clinical judgment (Gallagher, Thompson, & Levy, 1980).

The abridged form of the BDI was used for this study because its shortened length facilitates administration to elderly persons. The abridged BDI consists of 13 items taken from the original 21 BDI items. Beck and Beamesderfer (1974) found a cumulative correlation of $r = .96$ between the abridged form and the total score of

the original BDI. They also found a correlation of r = .61 between the abridged BDI and clinicians' ratings of depression. The abridged form is scored in the same manner as the original form. Score values for the abridged form are as follows: 0 to 4 = no or minimal depression; 5 to 7 = mild depression; 8 to 15 = moderate depression; 16 or greater = severe depression (Beck & Beck, 1972). The abridged BDI can be found in Appendix A.

The Self-Concept Scale. The Self-Concept Scale, developed by Longino, McClelland, and Peterson (1980a & 1980b), was used to measure the dependent variable of self-esteem. This six-item scale is intended to measure the subject's perception or conception of self, which indicates the degree of positive self-regard and self-acceptance, or one's self-esteem. For each item, the subject chooses a self-rating of very descriptive (3), somewhat descriptive (2), or hardly at all descriptive (1). The items define the subject's conception of self as friendly, active, alert, handy, adaptable, and wise. Although the scale has been administered orally, for this study it was adapted to paper and pencil format to alleviate interference from subjects' hearing impairment. Appendix B illustrates the adapted format.

Internal consistency and reliability for the Self-Concept Scale have been demonstrated. The reliability

of the scale has been examined using elderly subjects (ages $\geq$ 65) of a national Harris survey (N = 2797). A factor analysis of responses to the six scale items resulted in factor loadings ranging from .471 for the last item to .774 for the first item (Longino et al., 1980b). When administered to elderly subjects with arthritis (N = 81), item-total test correlations for the six items ranged from r = .74 to r = .87, and internal consistency for the total test using Cronbach's alpha was .89 (Burckhardt, 1982). Although reports of validity are lacking, this self-concept scale is reliable and brief, and is the measure of choice for use with the elderly because it has been tested with older adults. The construct of self-esteem for younger adults and children found in other instruments, and the length and complexity of the tests, restricts their utility for measuring self-esteem of elderly persons.

Methods of Procedure

Approval for conducting this study in the proposed setting was granted by the program's coordinator (see Appendix E) and by three Veterans Administration committees: (a) the Nursing Research Committee, (b) the Subcommittee on Human Studies, and (c) the Research and Development Committee. Following this approval, clients in the program who met criteria were asked to participate in a

study on the well-being of older people. Those who agreed to participate were asked to make a commitment to attend as many of the group sessions as possible. They were assigned randomly to one of two groups by drawing names out of a bowl, assigning the first person to the experimental group, and then proceeding with alternate group assignment of the remaining names. The two groups met under similar conditions, but for different purposes. Each group met for 45 minutes, two times per week for 5 weeks, and once during the sixth week because of a federal holiday.

The experimental group met for the purpose of reminiscing, while the control group met for a specific purpose exclusive of reminiscence. The reminiscence group sessions were structured to follow a life cycle sequence for reminiscing, from early childhood to senior citizenship. The first and last sessions also included introductory and termination issues respectively. Some flexibility in the life cycle was allowed so that subjects could reminisce on topics of special interest as they arose. The control group met concurrently with the reminiscence group, but in a separate room. Both groups were part of the day's schedule of activities attended by all participants. Control group subjects were involved one session per week in cooking and one session per week in special projects, such as building flower boxes. To check

the extent of reminiscence occurring in the control group, the group leader was interviewed for this information following completion of the 11 sessions. The group leader kept process notes for each group session and was unaware of the specific purpose of this study. The group leader reported that the special projects sessions were task-oriented, with no encouragement of nor spontaneous initiation of reminiscence. Reminiscence was encouraged in the cooking sessions, but the percent of time control group participants spent reminiscing while cooking was estimated to be less than or equal to 10%.

The pretest was administered to all participants within two weeks prior to beginning the groups. The pretest consisted of the abridged BDI and the Self-Concept Scale. Demographic data were also collected at the time of the pretest (see Appendix C for this form). The investigator also gathered data on medical diagnoses, affective problems, medications, and disabilities from each subject's medical record. These data were recorded on a form shown in Appendix D. The posttest, also comprised of the abridged BDI and the Self-Concept Scale, was administered within two weeks following the last group session.

Protection of Human Subjects

The following procedures were used to protect

subjects' rights. Before participating in the study, the subjects were asked by the investigator to read and sign consent forms. The informed consent was written for ease of comprehension by elderly persons (see Appendix E). Subjects were informed that the purpose of this investigation was to study the effects of group interventions on the well-being of older persons. To mention that the study would focus on two specific aspects of well-being (i.e., self-esteem and depression) could have distorted subjects' responses to the instruments. The subjects were also informed that their participation or nonparticipation at any point in the study would not affect their care in the adult day health care program nor in any program of the VA system. If any subject became upset during the course of the group sessions, mental health treatment staff were available to help them. Confidentiality was maintained by use of a code number for each subject and by keeping data in a locked file. Results of the study are focused on group data and are written in such a way that individual subjects are not identifiable.

Data Analysis

The data were analyzed using the Statistical Package for the Social Sciences (SPSS) (Nie, Hull, Jenkins, Steinbrenner, & Bent, 1975) and the SPSS Update (Hull & Nie, 1981). Descriptive statistics were used to describe

the characteristics of the participants in the two groups. Then, correlational and inferential statistics were used to test each of the four hypotheses, since the measures of dependent variables yield continuous data. Since this was an exploratory study, $p \leq .10$ level of significance was used.

To test H_1 and H_3, Spearman's rank order correlation coefficients were calculated. Participants were scored as reminiscence (1) or nonreminiscence (0). This score on the independent variable was correlated with scores on the self-concept scale (6-18) and the depression scale (0-39), the two dependent variables. A nonparametric statistic was chosen because of the small sample size (Siegel, 1956).

To test H_2 and H_4, Mann-Whitney U tests were used to analyze the difference between the two groups on pretest and posttest scores for depression and self-esteem. Then, Wilcoxon matched-pairs ranked-signs tests were computed on the gain or difference scores (posttest minus pretest) for each group to determine whether significant differences existed. These nonparametric statistics were chosen because of the small sample size (Siegel, 1956).

Chapter III

Results

The results of the data analysis are presented in this chapter. First, a description of the group's characteristics are presented, followed by a report of the data analysis for each of the research questions. The data analysis was conducted twice, the second time eliminating one of the reminiscence group participants. This participant was excluded because of the possible effects on the small sample of his markedly different group behavior. Unlike the other participants, he frequently came late and left the group for periods of time. The results of the analysis using $\underline{N}$ = 9 (reminiscence group $\underline{n}$ = 5, control group $\underline{n}$ = 4) and $\underline{N}$ = 8 (reminiscence group $\underline{n}$ = 4, control group $\underline{n}$ = 4) are reported for each research question. Finally, additional serendipitous results are presented.

Group Characteristics

A comparison of groups on the demographic characteristics of age, sex, and race revealed a total sample composed primarily of white, married men ranging in age from 61 to 94 years. The composition of the reminiscence group was notable because it included the youngest and the oldest participant, as well as the only female in the study. The only nonwhite participant was in the control group. The data analysis demonstrated no

significant difference between the two groups for age ($U = 7.5$, $p = .56$).

A comparison of the two groups on the remaining demographic characteristics (marital status, income, years of school, and living situation) revealed variance within each of the groups, but no significant differences. The total sample was about evenly divided between married and unmarried subjects, but more than 50% of the reminiscence group members were unmarried. Nevertheless, the results of Fisher's exact probability test = .36, indicating no significant differences between the groups for marital status. The annual income of the participants ranged from $5,000 to $10,500, with no significant difference between the groups (Fisher's exact probability test = .50). Years of school completed ranged from 3 to 16 years. The control group was remarkable in that all of its members had completed high school; however, no significant difference ($\chi^2 = 3.6$, $p = .17$) was found between the groups on this variable. The majority of the participants were living in their own home, with a minority living in foster care or with a relative. Fisher's exact probability test = .60, demonstrating no significant difference between the groups on living situation. Table 3 contains a summary of the demographic characteristics for this sample.

A comparison of the health-related characteristics of

Table 3

Demographic Characteristics

Characteristics	Group		
	Reminiscence[a]	Control[b]	Total Sample[c]
Age			
Range	61-94	72-88	61-94
Mean	77	81.5	79
SD	13.74	5.92	10.76
Sex			
Females	20%	0%	11%
Males	80%	100%	89%
Race			
White	100%	75%	89%
Black	0%	25%	11%
Marital Status			
Never Married	20%	0%	11%
Married	40%	75%	56%
Widowed	40%	25%	33%
Income			
$5,000-$7,499	60%	33%	50%
$7,500-$10,500	40%	67%	50%
School			
Range	3-16	10-15	3-16
Mean	8.6	12.5	10.33
SD	4.72	2.38	4.18
Living Situation			
At home	60%	75%	67%
Other	40%	25%	33%

[a] $n = 5$. [b] $n = 4$. [c] $N = 9$.

the participants in the two groups revealed a frail sample with numerous health problems. Every participant had multiple medical diagnoses and took multiple medications. A description of these diagnoses and medications is found in Appendix G. Nearly half of the participants had been identified by program staff as having an affective problem (e.g., depression). No significant difference was found between the groups for this variable (Fisher's exact probability test = .64). Nearly one-fourth of the participants were taking antidepressant medication (e.g., Desipramine and Doxepin), and one member of the reminiscence group was taking an antianxiety medication (Valium). However, there were no significant differences between the two groups on use of these medications (Fisher's exact probability test = .47). Every participant was disabled for communication and mobility. Expressive aphasia, hearing loss, and vision impairment were commonly observed communication disabilities. Ambulation was the most notable mobility problem; every participant used either a cane, a walker, or a wheelchair. Table 4 presents a summary of health-related characteristics for this sample.

Each group was also compared on the number of sessions attended by each participant. For the reminiscence group, the range was 7 to 11 sessions, $\underline{M}$ = 9.2. For the control

Table 4

Health-Related Characteristics

Characteristics	Group		
	Reminiscence[a]	Control[b]	Total Sample[c]
Medical diagnoses			
Multiple	100%	100%	100%
Affective problem	40%	50%	44%
Disabilities			
Communication & mobility	100%	100%	100%
Medications			
Antidepressants	20%	25%	22%
Antianxiety	20%	0%	11%

[a] $n = 5$. [b] $n = 4$. [c] $N = 9$.

group, the range was 7 to 10 sessions, M = 8.5. For the total sample, the mean was 8.9. Fisher's exact probability test = .64, indicating no significant difference between the groups on number of sessions attended.

Findings for Research Question I

Does participation in a reminiscence group increase self-esteem of noninstitutionalized elderly more than participation in a nonreminiscence group?

Hypothesis 1 states that there will be a positive relationship between participation in a reminiscence group and self-esteem. For the sample of 9, a modest but statistically nonsignificant positive correlation (r = .13, p = .18) was attained between participation in the reminiscence group and posttest scores on the Self-Concept Scale (SCS). For the sample of 8, there was essentially no correlation between participation in the reminiscence group and the SCS scores (r = .05, p = .22). Thus, although the direction of relationship between the variables was in the predicted direction, the hypothesis was not supported.

Hypothesis 2 states that there will be a significant increase in self-esteem of participants in a reminiscence group compared to participants of a nonreminiscence group. For the sample of 9, Mann-Whitney U tests revealed no significant differences between the groups on pretest scores (U = 8.5, p = .37), nor on posttest scores (U = 8.5,

p = .37). Similar results were obtained for the sample of 8; there were no significant differences between groups on pretest scores (U = 6.0, p = .35), nor on posttest scores (U = 7.5, p = .45). Further, the Wilcoxon matched-pairs signed-ranks tests demonstrated no significant differences for the sample of 9 between pretest and posttest scores for the total sample (Z = -1.15, p = .12), nor for the reminiscence group (Z = -.73, p = .23). However, a significant difference was found between pretest and posttest scores for the control group (Z = -1.34, p = .09). For the sample of 8, the differences between pretest and posttest scores remained nonsignificant for the total sample (Z = -.67, p = .25), and for the reminiscence group (Z = .00, p = .50); the differences between pretest and posttest scores for the control group remained significant (Z = -1.34, p = .09). Thus, Hypothesis 2 was not supported.

Because of the difficulty attaining statistical significance with a very small sample, the raw data are presented for examination. Table 5 presents the changes in self-concept scores from pretest to posttest for each group and for the total sample. Since omitting the unusual participant resulted in no change in outcome, these results are for the original sample (N = 9). The greater variability in scores for the reminiscence group may

Table 5

Self-Concept Scale Scores

	Group		
	Reminiscence[a]	Control[b]	Total Sample[c]
Pretest			
Range	12-17	11-16	11-17
Mean	13.40	13.00	13.22
SD	2.19	2.16	2.05
Posttest			
Range	8-18	11-18	8-18
Mean	14.40	14.00	14.22
SD	3.78	2.94	3.23
Mean Difference	-1.00	-1.00	-1.00
SD	3.32	1.16	2.45

[a] $n = 5$. [b] $n = 4$. [c] $N = 9$.

account for the lack of statistical significance found between pretest and posttest scores for this group. Figure 2 presents a visual picture of the change in pretest to posttest Self-Concept Scale scores for the participants of each group.

Findings for Research Question 2

Does participation in a reminiscence group decrease depressive symptoms of noninstitutionalized elderly more than participation in a nonreminiscence group?

Hypothesis 3 states that there will be a negative relationship between participation in a reminiscence group and depressive symptoms. For the sample of 9, a modest but statistically nonsignificant negative correlation ($r = -.17$, $p = .16$) was attained between participation in the reminiscence group and posttest scores on the Beck Depression Inventory (BDI). Although this is not a strong correlation, the magnitude increased from that attained with the pretest ($r = .09$, $p = .21$). For the sample of 8, the correlation was slightly stronger, yet still did not reach statistical significance ($r = -.22$, $p = .15$). Again, an increase in magnitude from the pretest correlation ($r = .11$, $p = .20$) was noted. Although the correlations attained were not statistically significant, they were in the predicted direction and of modest magnitude, thus providing partial support for Hypothesis 3.

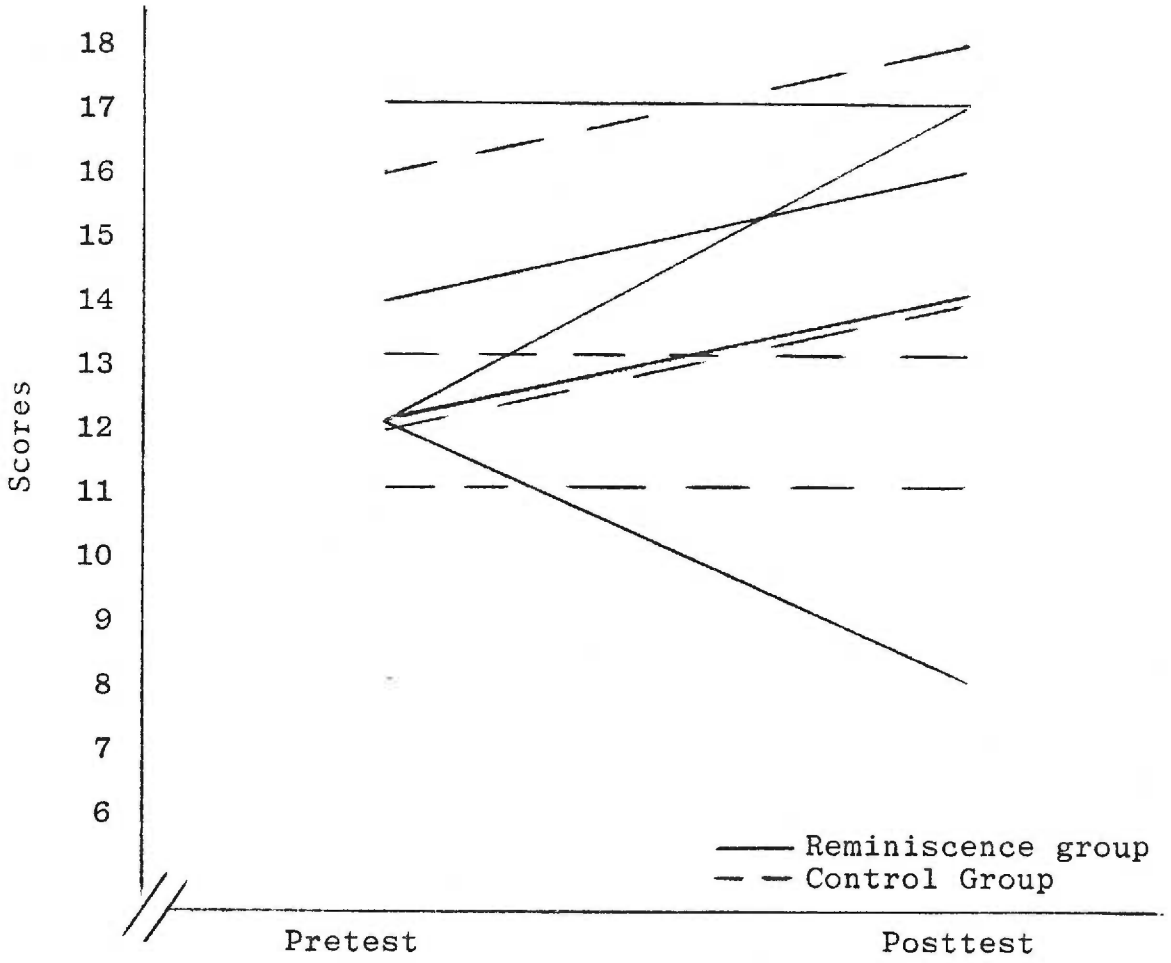


Figure 2. Comparison of each subject on pretest and posttest Self-Concept Scale scores.

Hypothesis 4 states that there will be a significant decrease in depressive symptoms for participants in a reminiscence group compared to participants in a nonreminiscence group. Results of the Mann-Whitney U tests for the sample of 9 showed no significant differences between the two groups on the pretest BDI scores ($U = 9.0$, $p = .37$), nor on the posttest BDI scores ($U = 8.0$, $p = .37$). Results of these tests for the sample of 8 were similar on the pretest scores ($U = 7.0$, $p = .45$) and on posttest scores ($U = 6.0$, $p = .35$). Results of the Wilcoxon matched-pairs ranked-signs tests for the sample of 9 revealed a significant difference between pretest and posttest scores for the total sample ($Z = -1.69$, $p = .05$), and between pretest and posttest scores for the control group ($Z = -1.60$, $p = .06$). However, for the reminiscence group, the difference was not significant at the .10 level ($Z = -1.10$, $p = .14$). For the sample of 8, the results of the Wilcoxon tests became increasingly significant. There was a significant difference between pretest and posttest scores for the total sample ($Z = -2.20$, $p = .01$), for the control group ($Z = -1.60$, $p = .05$), and for the reminiscence group ($Z = -1.60$, $p = .05$). These results indicated that there was a significant decrease in depressive symptoms for participants in a reminiscence group ($N = 8$), but that there was also a significant

decrease in depressive symptoms for participants in the control group. Thus, even though participation in the reminiscence group had the predicted effect on depression, Hypothesis 4 was not supported because no significant differences were found when the two groups were compared on posttest BDI scores.

Because of the difficulty in attaining statistical significance with a very small sample, the raw data for BDI score changes are also presented. Table 6 presents the changes in BDI scores from pretest to posttest for each group and for the total sample. The table shows a greater change in the mean BDI scores for the reminiscence group than for the control group for both samples (N = 8 and N = 9). Figure 3 provides a visual picture of the range and changes for BDI pretest and posttest scores for the participants of each group (N = 9).

Serendipitous Findings

The purpose of this section is to report additional findings that are indirectly related to the two research questions. First, the relationships between background characteristics and the dependent variables are reported. Then, relationships between the dependent variables are described. Finally, the participants' satisfaction with and recommendations for the group experience are summarized.

Table 6

Beck Depression Inventory Scores

	Group				
	Reminiscence$_1$[a]	Reminiscence$_2$[b]	Control[c]	Sample$_1$[d]	Sample$_2$[e]
Pretest					
Range	2-23	2-23	4-18	2-23	2-23
Mean	10.60	12.75	10.50	10.56	11.63
SD	10.50	10.78	5.59	8.20	8.07
Posttest					
Range	2-14	2-14	2-14	2-14	2-14
Mean	5.80	5.75	7.25	6.44	6.50
SD	4.81	5.56	5.12	4.69	5.01
Mean differences	4.80	7.00	3.25	4.11	5.13
SD	9.37	9.20	3.40	6.99	6.69

[a] $n = 5$. [b] $n = 4$. [c] $n = 4$. [d] $N = 9$. [e] $N = 8$.

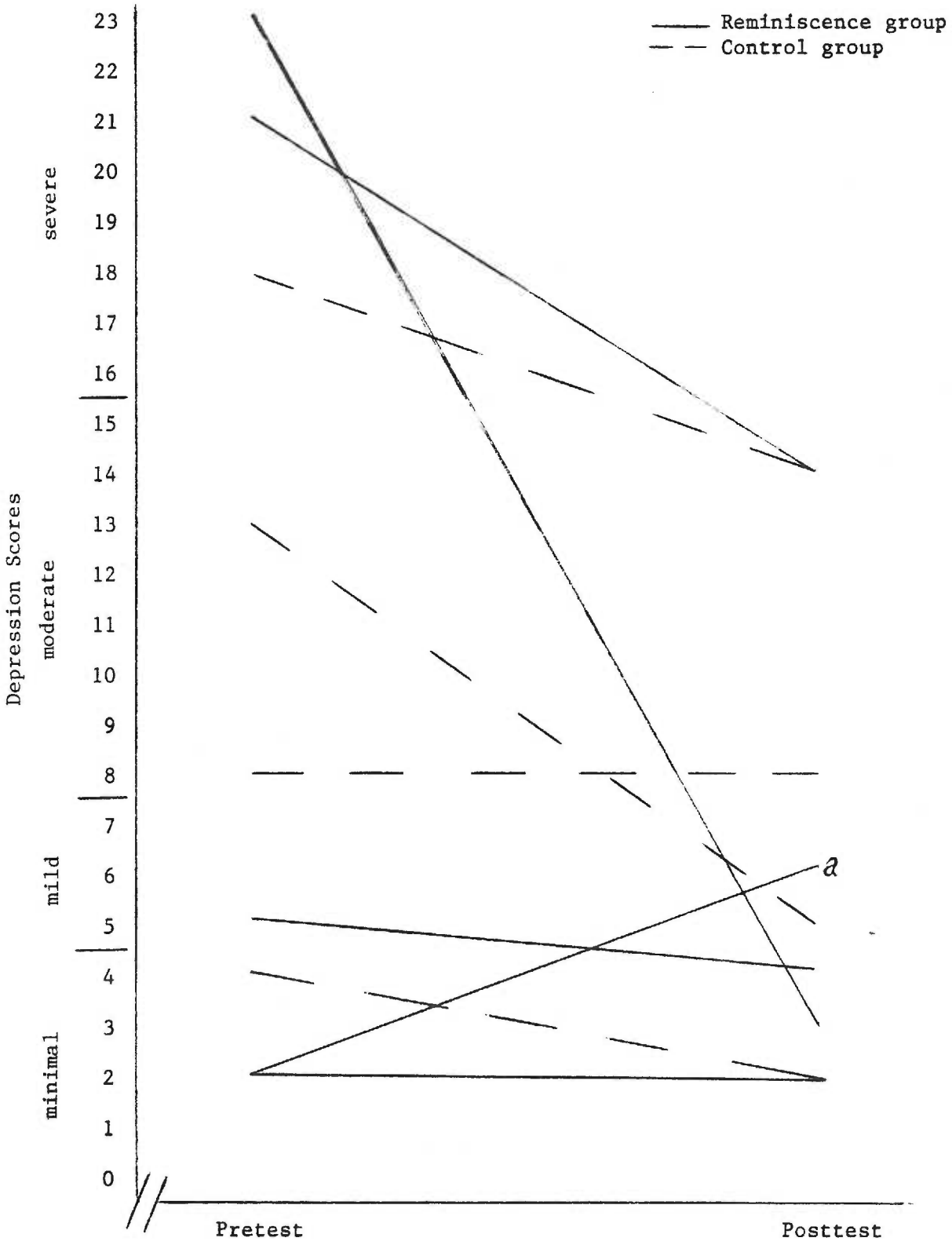


Figure 3. Comparison of each subject on pretest and posttest Beck Depression Inventory scores.

([a]Scores of subject omitted in analysis when N = 8).

Background Characteristics and the Dependent Variables

There were no significant correlations between either the SCS scores or BDI scores and demographic characteristics, except for annual income. There was a strong positive, although statistically nonsignificant correlation ($r = .60$, $p = .12$), between income and the SCS pretest scores, which remained a strong but statistically significant relationship for the posttest scores ($r = .73$, $p = .02$). There was a strong negative and statistically significant correlation between income and the BDI pretest scores ($r = -.62$, $p = .10$); however, the correlation between the posttest scores and income was less strong and statistically nonsignificant ($r = -.52$, $p = .18$).

In regards to health-related characteristics, there was a strong positive and statistically significant correlation ($r = .78$, $p = .04$) between affective problems and the BDI pretest scores. This correlation became slightly weaker but remained significant ($r = .61$, $p = .08$) for affective problems and BDI posttest scores. In contrast, the correlation between affective problems and the SCS pretest scores was not statistically significant ($r = -.45$, $p = .20$), nor was the correlation between affective problems and the SCS posttest scores ($r = -.56$, $p = .12$), although a modest negative relationship was found between variables in both cases.

There were no statistically significant relationships between the number of group sessions attended and the posttest scores for the BDI and SCS. However, although not statistically significant, there was a modest negative correlation between sessions attended and BDI posttest scores ($r = -.21$, $p = .58$), and between number of sessions and SCS posttest scores ($r = -.21$, $p = .58$).

Relationships between the Dependent Variables

A modest negative but not statistically significant correlation between BDI and SCS scores was found prior to group intervention ($r = -.20$, $p = .30$). However, a strong negative correlation which was statistically significant was found following group intervention ($r = -.73$, $p = .01$). This would be expected, since most of the depression scores decreased after intervention, while the self-esteem scores remained relatively stable for the sample.

Participant Satisfaction

Each of the participants was interviewed regarding satisfaction with his or her group experience. This was a brief informal interview conducted by the investigator following completion of the posttest. Each participant was asked whether he or she was satisfied with the experience, whether there was anything he or she liked or disliked about the group experience, and whether he or she had any recommendations for improvement of the experience.

All of the reminiscence group participants reported satisfaction with the group. Two of them reported particular enjoyment of sharing memories of life experiences. One aphasic veteran reported that despite the difficulty of expressing himself, the experience of silent personal reminiscing and of listening to oral reminiscence of group members was meaningful. The majority of the control group participants expressed satisfaction with their group experience. One of the control group participants expressed dissatisfaction with his own inability to "do anything" within the group. The control group participants were unable to state what they liked or disliked specifically. None of the participants of either group offered recommendations for improvement of the group experience.

Chapter IV

Discussion and Conclusions

The purpose of this pilot study was to examine the effectiveness of a reminiscence group versus a nonreminiscence group in increasing self-esteem and decreasing depressive symptoms in a group of noninstitutionalized elderly persons. This chapter discusses the findings and influences affecting the outcome of this study. First, a discussion of the findings for each research question is presented, followed by a discussion of the serendipitous findings. Then, limitations of the study are described. A summary and conclusion section precede the implications for nursing and the recommendations for further study.

Discussion of Research Question 1

This question and the related hypotheses were concerned with the increase of self-esteem for reminiscence group participants as compared to nonreminiscence group participants. The results of the data analysis provided no statistically significant support for the hypothesis that self-esteem would be positively related to participation in a reminiscence group, nor to the hypothesis that there would be a significant increase in self-esteem of participants in a reminiscence group compared to

participants of a nonreminiscence group. However, the raw data showed that the mean Self-Concept Scale (SCS) score for each group did begin to have an impact on the self-esteem of the participants. A review of score changes for each participant showed that self-esteem either increased or remained stable for all participants, with the exception of one member of the reminiscence group. This participant's SCS score indicated a decrease in self-esteem, a finding that is unexplained. Although the participant frequently verbalized a feeling of being unable to talk, he expressed enjoyment of the group. Since the sample was so small, this participant's unpredicted score change may have prevented the attainment of statistically significant changes in SCS scores for the reminiscence group.

The literature on self-esteem offers several explanations for the small increase in SCS scores. These explanations include the influence of significant others and the stability of self-esteem. Since self-esteem becomes more stable and more resistant to change with time and experience (Stanwyck, 1983), a longer period of intervention may be required to produce significant changes in this trait. Related to this is the important influence of interpersonal relationships on self-esteem (Stanwyck, 1983). The three participants whose scores remained stable

were new admissions to the adult day health care program when the study began, and perhaps had not developed significant relationships with peers and staff. Further, the primary group leader of the activity group was well-known to participants, whereas the relationship with the primary group leader of the reminiscence group was limited to the testing and group sessions only. This lack of a familiar relationship between primary group leader and reminiscence group participants may partially account for the lack of a statistically significant change in scores for the reminiscence group.

The findings related to Research Question 1 may have also been affected by the measurement tool. No studies examining the validity of the SCS for measuring self-esteem of elderly subjects were available. However, this tool remains the most useful for this population in comparison to other self-esteem measures, which are more lengthy and complex, and constructed for younger populations.

Discussion of Research Question 2

Research Question 2 and the related hypotheses were concerned with the decrease of depressive symptoms for reminiscence group participants as compared to nonreminiscence group participants. The results of the data analysis provided partial statistically significant support for the hypothesis that depressive symptoms would

be negatively related to participation in a reminiscence group, but provided no statistically significant support for the hypothesis that there would be a significant decrease in depressive symptoms of reminiscence group participants as compared to nonreminiscence group participants. However, the raw data and the statistically significant decrease in depressive symptoms for participants of both groups (N = 8) suggested that both groups were effective in decreasing depressive symptoms when the unusual participant was excluded from the data analysis. This participant's Beck Depression Inventory (BDI) score, which increased from a minimal to a mild degree of depression, together with his behavior and other personal factors, suggest that group effects may not counterbalance intervening external factors.

Although a statistically significant decrease in depressive symptoms occurred for participants of both groups, there were no statistically significant differences between the groups on depressive symptoms. These results can be explained by the difficulty of differentiating the effects of an individual group intervention from the effects of the total program and of peer and staff relationships. Further, since reminiscence occurs spontaneously (Butler, 1963), and was encouraged somewhat during cooking groups, it is possible that participants of

both groups experienced a degree of reminiscence sufficient to impact on depressive symptoms. However, the impact of both groups on depressive symptoms for participants has clinical significance, particularly for participants experiencing moderate or severe degrees of depression initially. Thus, a combination of oral reminiscence and structured activities that foster reminiscence may be even more effective as a nursing intervention for this sample. Activities suggested by the nursing literature to foster reminiscence included tape recording histories, making a memorabilia box, compiling scrapbooks and collages, and visiting places of past significance (Ryden, 1981). Other suggestions included listening to old popular records and tapes of early radio shows, looking at picture books, and examining old farm equipment (McMordie & Blom, 1979). Based on the findings from this study, the effects of combining these kinds of activities with oral reminiscence for a reminiscence-focused activity group deserves exploration.

The measurement tool may have had an effect on the internal validity of the findings for this research question. Although the reliability of the BDI as a measure of depression in the elderly was supported (Gallagher, Nies, & Thompson, 1982), its validity as a measure of depression in elderly persons has not been assessed. Thus,

it is possible that the obtained depression scores did not accurately reflect the level of depression for the subjects of the study. Studies need to be conducted to assess the validity of the BDI as a measure of depression in elderly persons.

Discussion of Serendipitous Findings

The serendipitous finds are of interest even though the study did not address them directly. The discussion will be limited to the relationships between the dependent variables and income, number of sessions attended, and affective problems, the relationship between the dependent variables themselves, and the satisfaction of the participants.

There was a strong relationship between the dependent variables and one background characteristic, income. A strong positive relationship was attained for the relationship between income and the SCS score, although the relationship reached statistical significance only for the posttest. A strong negative relationship was found between income and the BDI score, but it reached statistical significance only for the pretest score. These findings suggest that for this sample, there may be a positive relationship between income and self-esteem, and a negative relationship between income and depressive symptoms. Although the relationships between income and self-esteem

and between income and depressive symptoms varied some from pretest to posttest, they remained moderate to strong in magnitude. This suggests that the availability of certain kinds of personal resources, such as financial resources, may impact on self-esteem and depression. In addition to undertaking psychosocial interventions aimed at reducing depressive symptoms and increasing self-esteem, nursing staff working with fail elderly need to assess or be aware of the adequacy of these resources and to assist their clients in obtaining and receiving all benefits (e.g., SSI) to which they are entitled.

The findings indicated a moderate negative but statistically nonsignificant relationship between both dependent variables and the number of group sessions attended. A negative relationship between number of sessions attended and depressive symptoms was unexpected and is unexplained. This finding raises the question of the influence of time on self-esteem. Perhaps other factors are more important than time or duration of intervention in changing self-esteem.

The findings indicated a strong positive and statistically significant relationship between having an affective problem and depressive symptoms, both before and after group intervention. In contrast, the relationship between affective problems and self-esteem was

statistically nonsignificant, but of a modest magnitude and negative direction. These findings were expected and suggest that affect is more strongly related to depressive symptoms than to self-esteem, which is a more stable and enduring trait.

A modest negative but statistically nonsignificant preintervention relationship between self-esteem and depressive symptoms became strong and statistically significant postintervention. The negative relationship attained is in agreement with the conceptual framework, that a decrease in self-esteem is associated with an increased severity of depressive symptoms. The stronger statistically significant relationship postintervention can be explained by the overall decrease in depressive symptoms and the slight increase in self-esteem for the participants.

All of the participants reported satisfaction with his or her group experience. It is of clinical significance that these frail elderly persons derived satisfaction from group interventions despite the frequent difficulties they encountered because of their disabilities. Since the reminiscence group focused on oral reminiscing, the fact that the participants with expressive aphasia reported enjoyment of the group experience and satisfaction with the reminiscence process, despite their

limitations, has clinical relevance. This suggests that even those elderly persons with expressive communication limitations can benefit from this experience. Since satisfaction was reported with both oral group reminiscence and structured group tasks (control group activities), the effectiveness of a reminiscence-focused activity group deserves exploration.

Limitations of the Study

Characteristics of the sample may have influenced the internal validity of this study. Since the groups were selected by random assignment and were not significantly different, group differences can be excluded as a possible influence on the results of this study. However, because the sample was selected from a congregate setting where participants participate together in a milieu setting, it is difficult to separate the effects of one group intervention (reminiscence or activity group) from the effects of the setting. It is possible that the increases in self-esteem and decreases in depressive symptoms observed for each group resulted from participation in the program rather than participation in one group.

Several aspects of the research design may have influenced the internal validity of this study. Maturation, or the passage of time, competes as a partial explanation of the results. Because of the time element in

conducting the testing, the interval of time from pretest to intervention and from intervention to posttest was not equal for each participant. Thus, processes occurring for individual participants as a function of these unequal time intervals, such as length of time from holidays to pretest, pretest to beginning of group, or group termination to posttest, could partially explain individual differences in degree of change in self-esteem or depressive symptoms.

The effects of oral administration of the self-report scales also could have affected the internal validity of the study. The need for social desirability during oral response to such scales could enhance subject scores. However, since all subjects of both groups were treated equally, it is more likely that the need for social desirability enhanced mean scores for both groups, thus negating this effect.

The external validity of this pilot study was limited by the small sample size. Thus, generalization of these results to a larger population of noninstitutionalized elderly persons should be made with caution. Certainly further research is warranted with larger samples in a variety of settings in order to improve external validity of the findings.

Summary and Conclusions

This study has examined the effectiveness of a

reminiscence group versus a nonreminiscence group in increasing self-esteem and decreasing depressive symptoms for noninstitutionalized elderly persons. Two research questions were addressed, using a pretest-posttest control group design with random assignment of frail noninstitutionalized elderly subjects to the experimental (reminiscence) or control (nonreminiscence) group. Descriptive and nonparametric correlational and inferential statistics were used to describe and analyze the data. Sample effects and maturation represented possible threats to the internal validity of this study. Regarding external validity, the small sample size was an expected limitation of the study. Thus, cautious generalization of the results and further studies with larger samples and various settings are warranted.

The findings of this study did not provide full support for the hypotheses for each research question, but did suggest that the effects of both groups were clinically significant. The findings concerning the effects of participation in a reminiscence group versus a nonreminiscence group on self-esteem suggested that both groups began to impact on self-esteem. Since self-esteem is a relatively stable trait and influenced by significant relationships, a longer period of intervention and further development of relationships may produce more significant

changes. The findings concerning the effects of participation in a reminiscence group versus a nonreminiscence group on depressive symptoms suggested that participation in both groups effectively reduced the participants' depressive symptoms. The serendipitous findings concerning the negative relationship between self-esteem and depressive symptoms, and the strong relationship between affective problems and depressive symptoms lend support to the conclusions for each research question. The participants' reported satisfaction with the group experience gave additional support to the conclusion that both groups positively influence adaptation among noninstitutionalized elderly and that participation in a reminiscence-focused activity group may also be an effective nursing intervention for this population.

Implications for Nursing Practice

The results of this pilot study suggest that the use of a reminiscence group as a nursing intervention should be pursued. Although a few clients may not respond as expected because of personal or situational factors, nurses may expect that, in general, adaptation for noninstitutionalized elderly clients who participate in a reminiscence group is facilitated by decreasing the severity of depressive symptoms. In addition, self-esteem of participants may also be positively affected, but

further investigation is needed. The implementation of reminiscence-focused activity groups should also be considered, since it would combine the positive attributes of both groups.

Recommendations for Further Study

Further studies should include replication of this study as well as production of new studies. The recommendations for further study are as follows:

1. Replication of this study with the following changes:

   a. using a larger sample
   b. equalizing the time interval between testing and intervention for all subjects
   c. ensuring that the primary group leaders for each group have similar relationships with group participants
   d. increasing the number of group sessions and total duration of the study
   e. conducting the study outside of a milieu program

2. Comparison of the effects of a reminiscence group, activity group, and a no-treatment group.

3. Exploration of the effects of a reminiscence-focused activity group.

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Appendix A

The Beck Depression Inventory (Abridged Form)

B.D.I. - 1973 REVISION (ABRIDGED FORM)

Instructions: This is a questionnaire. On the questionnaire are groups of statements. Please read the entire group of statements in each category. Then pick out the one statement in that group which best describes the way you feel today, that is, right now! Circle the number beside the statement you have chosen. If several statements in the group seem to apply equally well, circle each one.

Be sure to read all the statements in each group before making your choice.

A.
0 I do not feel sad
1 I feel sad
2 I am sad all the time and I can't snap out of it
3 I am so sad or unhappy that I can't stand it

B.
0 I am not particularly discouraged about the future
1 I feel discouraged about the future
2 I feel I have nothing to look forward to
3 I feel that the future is hopeless and that things cannot improve

C.
0 I do not feel like a failure
1 I feel I have failed more than the average person
2 As I look back on my life all I can see is a lot of failures
3 I feel I am a complete failure as a person

D.
0 I get as much satisfaction out of things as I used to
1 I don't enjoy things the way I used to
2 I don't get real satisfaction out of anything anymore
3 I am dissatisfied or bored with everything

E.
0 I don't feel particularly guilty
1 I feel guilty a good part of the time
2 I feel guilty most of the time
3 I feel guilty all of the time

F.
0 I don't feel disappointed in myself
1 I am disappointed in myself
2 I am disgusted with myself
3 I hate myself

G.
0 I don't have any thoughts of killing myself
1 I have thoughts of killing myself but I would not carry them out
2 I would like to kill myself if I had the chance
3 I would kill myself if I had the chance

PLEASE TURN THE PAGE

H.
0 I have not lost interest in other people
1 I am less interested in other people than I used to be
2 I have lost most of my interest in other people
3 I have lost all of my interest in other people

I.
0 I make decisions about as well as I ever could
1 I put off making decisions more than I used to
2 I have greater difficulty in making decisions than before
3 I can't make decisions at all any more

J.
0 I don't feel I look any worse than I used to
1 I am worried that I am looking old or unattractive
2 I feel that there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly

K.
0 I can work about as well as before
1 It takes extra effort to get started at doing something
2 I have to push myself very hard to do anything
3 I can't do any work at all

L.
0 I don't get any more tired than usual
1 I get tired more easily than I used to
2 I get tired from doing almost anything
3 I am too tired to do anything

M.
0 My appetite is no worse than usual
1 My appetite is not as good as usual
2 My appetite is much worse now
3 I have no appetite at all anymore

Code No._____

Appendix B

The Self-Concept Scale

Self-Concept Scale

Please read each item (A through F) and then check the response for each that fits best for you at this time.

A. Bright and alert

_____ very descriptive of me

_____ somewhat descriptive of me

_____ hardly at all descriptive of me

B. Good at getting things done

_____ very descriptive of me

_____ somewhat descriptive of me

_____ hardly at all descriptive of me

C. Open-minded and adaptable

_____ very descriptive of me

_____ somewhat descriptive of me

_____ hardly at all descriptive of me

D. Physically active

_____ very descriptive of me

_____ somewhat descriptive of me

_____ hardly at all descriptive of me

E. Wise from experience

_____ very descriptive of me

_____ somewhat descriptive of me

_____ hardly at all descriptive of me

PLEASE TURN THE PAGE

F. Friendly and warm

_____ very descriptive of me

_____ somewhat descriptive of me

_____ hardly at all descriptive of me

Code No._____

Appendix C

Demographic Data Questionnaire

Demographic Data

Code No. _____

Birthdate: _____

Marital Status:
____ Never married
____ Currently married
____ Divorced/separated
____ Widowed

Where subject lives:
____ Own residence
____ Home of relatives
____ Home of friends
____ Other, list _____

Number of years of school completed: _____

Gross annual income:
____ Less than $2500
____ $2500 to $4999
____ $5000 to $7499
____ $7500 to $9999
____ $10,000 or more

Race:
____ White/Caucasian
____ Black/Afro-American
____ Hispanic
____ Asian/American or Oriental

Appendix D

Medical Record Data Form

Medical Record Data

Code No. _____

Medical diagnosis:

Affective problems:

Disabilities:

Medications:

Appendix E

Informed Consents

CLINICAL RECORD

Report on _____
or
Continuation of S. F. _____
(Strike out one line) (Specify type of examination or data)

(Sign and date)

Informed Consent

STUDY:* THE EFFECTS OF GROUPS ON THE WELL-BEING OF OLDER PERSONS, by Pam Stover, RN, BSN, under the supervision of Beverly Hoeffer, RN, D.N.Sc.

I understand that this study will examine the effects of groups on the well-being of older people. If I agree to be in this study, I will agree to attend as many as possible of 12 group sessions to which I am assigned, during a period of six weeks. Each group session will last about 45 minutes. I also agree to answer the questionnaires which will be given to me at the beginning and end of the study. These will take about 15 minutes to fill out.

I understand that I may benefit from the group experience. I also understand that the information collected by Pam Stover will be kept confidential, and

(Continue on reverse side)

CLINICAL RECORD

Report on _____
or
Continuation of S. F. _____
(Strike out one line) (Specify type of examination or data)

(Sign and date)

that my name will not appear on any of the questionnaires. If I have any questions or concerns about by being in this study, Pam Stover or Sandra Fresh, RN, MS, will be available to talk with me. I understand that my participation is voluntary and that I may decide to withdraw or not participate in this study at any time. This will not affect my involvement in the VA Adult Day Health Care program, nor will it result in any penalty or loss of my VA benefits.

I have read and understand the above and agree to be in this study.

_____ _____
Date Subject's signature

_____
Witness

*The Effects of a Reminiscence Group on Self-Esteem and Depression in a Group of Elderly Persons

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.

WARD NO.

REPORT ON _____ or CONTINUATION OF _____

STANDARD FORM 507
General Services Administration and
Interagency Committee on Medical Records
FPMR 101-11.80 6-8
October 1975 507-106

PART I-AGREEMENT TO PARTICIPATE IN RESEARCH BY OR UNDER THE DIRECTION OF THE VETERANS ADMINISTRATION

DATE

1. I, _____, voluntarily consent to participate as a subject
(Type or print subject's name)

in the investigation entitled THE EFFECTS OF GROUPS ON THE WELL-BEING OF OLDER PERSONS
(Title of study)

2. I have signed one or more information sheets with this title to show that I have read the description including the purpose and nature of the investigation, the procedures to be used, the risks, inconveniences, side effects and benefits to be expected, as well as other courses of action open to me and my right to withdraw from the investigation at any time. Each of these items has been explained to me by the investigator in the presence of a witness. The investigator has answered my questions concerning the investigation and I believe I understand what is intended.

3. I understand that no guarantees or assurances have been given me since the results and risks of an investigation are not always known beforehand. I have been told that this investigation has been carefully planned, that the plan has been reviewed by knowledgeable people, and that every reasonable precaution will be taken to protect my well-being.

4. In the event I sustain physical injury as a result of participation in this investigation, if I am eligible for medical care as a veteran, all necessary and appropriate care will be provided. If I am not eligible for medical care as a veteran, humanitarian emergency care will nevertheless be provided.

5. I realize I have not released this institution from liability for negligence. Compensation may or may not be payable, in the event of physical injury arising from such research, under applicable federal laws.

6. I understand that all information obtained about me during the course of this study will be made available only to doctors who are taking care of me and to qualified investigators and their assistants where their access to this information is appropriate and authorized. They will be bound by the same requirements to maintain my privacy and anonymity as apply to all medical personnel within the Veterans Administration.

7. I further understand that, where required by law, the appropriate federal officer or agency will have free access to information obtained in this study should it become necessary. Generally, I may expect the same respect for my privacy and anonymity from these agencies as is afforded by the Veterans Administration and its employees. The provisions of the Privacy Act apply to all agencies.

8. In the event that research in which I participate involves certain new drugs, information concerning my response to the drug(s) will be supplied to the sponsoring pharmaceutical house(s) that made the drug(s) available. This information will be given to them in such a way that I cannot be identified.

I_____
NAME OF VOLUNTEER

HAVE READ THIS CONSENT FORM. ALL MY QUESTIONS HAVE BEEN ANSWERED, AND I FREELY AND VOLUNTARILY CHOOSE TO PARTICIPATE. I UNDERSTAND THAT MY RIGHTS AND PRIVACY WILL BE MAINTAINED. I AGREE TO PARTICIPATE AS A VOLUNTEER IN THIS PROGRAM.

9. Nevertheless, I wish to limit my participation in the investigation as follows:

/A FACILITY	SUBJECT'S SIGNATURE
VITNESS'S NAME AND ADDRESS *(Print or type)*	WITNESS'S SIGNATURE
INVESTIGATOR'S NAME *(Print or type)*	INVESTIGATOR'S SIGNATURE

☐ Signed information sheets attached. ☐ Signed information sheets available at:

SUBJECT'S IDENTIFICATION *(I.D. plate or give name • last, first, middle)*	SUBJECT'S I.D. NO.	WARD

AGREEMENT TO PARTICIPATE IN RESEARCH BY OR UNDER THE DIRECTION OF THE VETERANS ADMINISTRATION

VA FORM SEP 1979 10-1086

SUPERSEDES VA FORM 10-1086 JUN 1975, WHICH WILL NOT BE USED.

Appendix F

Letter of Support from Clinical Agency

Medical Center

Vancouver Division
3710 Southwest U.S.
Veterans Hospital Road
P.O. Box 1035
Portland OR 97207

Veterans Administration

October 1, 1985

In Reply Refer To: 648/111V-ADHC

Beverly Hoeffer, D.N.S.
Chairperson, Thesis Committee
Department of Mental Health Nursing
Oregon Health Sciences University
3181 SW Sam Jackson Park Road
Portland, OR 97201

Dear Dr. Hoeffer:

I was pleased to be approached by Ms. Pam Stover as a potential site for her to conduct her research project regarding reminiscence in the elderly.

I am keenly interested in potential treatment options for the elderly population and support her efforts. I believe the frail elderly population of the new VA Adult Day Health Care Program will be well served by this clinically significant investigation. I am also looking forward to the staff learning from Ms. Stover's expertise.

Sincerely,

[redacted]

SANDRA FRESH, R.N., M.S.
Coordinator, Adult Day Health Care

Appendix G

Medical Diagnoses and Prescribed Medications of the Study Sample

Table G-1

Frequent Medical Diagnoses by System Categories

Cardiovascular	Gastrointestinal
cardiovascular accident	chronic dyspepsia
cerebrovascular disease	constipation
congestive heart failure	ulcer
coronary heart disease	
hypertension	Endocrine
	diabetes
Musculoskeletal	hypothyroidism
amputation	
arthritis	Neurological
	Parkinson's Disease
Urinary tract	various types of palsy
chronic renal failure	
prostatitis	Ophthalmological
urinary tract infection	cataracts
	glaucoma
Integumentary	
dermatitis	Psychiatric
	depression

Table G-2

Frequently Prescribed Medications by Major Categories

Cardiovascular Drugs	Gastrointestinal Drugs
antianginals	antacids
antiarrhythmics	anti-nausea agents
cardiotonics	laxatives
vasodilators	ulcer medications
Nervous System Drugs	Hormones
analgesics	antidiabetic agents
antianxiety agents	thyroid
anticonvulsants	
antidepressants	Nutrition
skeletal muscle relaxants	vitamins
	minerals
Fluid and Electrolyte Balance	
diuretics	Ophthalmic Drugs
replacements	artificial tears
	antiglaucomatous agents

AN ABSTRACT OF THE THESIS OF

PAMELA R. STOVER

FOR THE MASTER OF NURSING

Date of Receiving this Degree: June 13, 1986

Title: The Effects of a Reminiscence Group on Self-Esteem and Depression in a Group of Elderly Persons

Approved: [redacted]

Beverly Hoeffer, R.N., D.N.Sc., Thesis Advisor

The purpose of this pilot study was to examine the effectiveness of a reminiscence group versus a nonreminiscence group in increasing self-esteem and decreasing depressive symptoms in a group of noninstitutionalized elderly persons. Two research questions were addressed:

1. Does participation in a reminiscence group increase self-esteem of noninstitutionalized elderly more than participation in a nonreminiscence group?

2. Does participation in a reminiscence group decrease depressive symptoms of noninstitutionalized elderly more than participation in a nonreminiscence group?

This was an experimental study, employing random assignment of consenting subjects to either the

experimental (reminiscence) or the control (nonreminiscence) group, each of which met for 11 sessions over a six week period. The sample was selected from a VA Adult Day Health Care Program. It was comprised of nine frail elderly persons, five in the reminiscence group and four in the control group. The independent variable was reminiscence. The dependent variables, self-esteem and depression, were measured by the Self-Concept Scale and the abridged Beck Depression Inventory, administered as a pretest and a posttest. Demographic and health-related information were also collected. Descriptive statistics were used to describe the participants' characteristics. Spearman's rank order correlation coefficients, Mann-Whitney U tests, and Wilcoxon matched-pairs ranked-signs tests were used to test the research questions.

Results of the data analysis for the first research question revealed that participation in a reminiscence group did not increase self-esteem of noninstitutionalized elderly more than participation in a nonreminiscence group. For this sample, there was no correlation between reminiscence group participation and self-esteem and no statistically significant differences between the groups on Self-Concept Scale scores.

The results of the data analysis for the second

research question revealed that participation in both a reminiscence and an activity group was associated with a significant decrease in depressive symptoms ($p = .05$), but that there were no statistically significant differences between the groups on depression scores.

The results of this study suggest that both reminiscence and activity groups may be effective nursing interventions for decreasing depressive symptoms among frail noninstitutionalized elderly persons. Self-esteem may also be positively affected, but further investigation is needed. Recommendations for further study include use of larger samples and a variety of settings, inclusion of a no-treatment group, and exploration of the effects of a reminiscence-focused activity group.