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**Integrative and Instrumental Reminiscence Therapies
for the Treatment of Depression in Older Adults**

Lisa M. Watt

**A thesis submitted to the School of Graduate Studies of the
University of Ottawa as partial fulfilment of the requirements
for the degree of Doctor of Philosophy**

c Lisa M. Watt, Ottawa, Canada, 1996

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Dedication

This thesis could not have been completed without the tremendous strength, support, and encouragement provided by Timothy Barker; Charles, Esther, and Aster Watt; Noelle, Andrew and Michael Reeve; Nicola Wright; and Brian Heisel.

Acknowledgements

Dr. Philippe Cappeliez provided tremendous creative encouragement during the development of the research. Throughout the thesis work he reliably asked questions and provided information which helped me to refine and launch the research forward into new directions. Working with Dr. Cappeliez provided not only a dynamic, collaborative research experience but also a safe and supportive environment which fostered speculation and reflection on the meaning and implications of the research. Dr. Cappeliez showed an unflagging commitment to the research as is demonstrated by the extraordinary amount of time and creative effort he invested to develop referral sources, to enlist therapists to participate in the study, and to provide training and on-going supervision to the therapist. In addition to his direct contributions to this research, Dr. Cappeliez has also emphasized reflection on the process of doing research itself. The learning process was not restricted to the completion of this research project alone, but also to developing an understanding of the role of research in the work of a clinical psychologist. For these reasons, and more, I would like to thank Dr. Cappeliez for the opportunity to work with him.

I would also like to thank Dr. Pierre Baron, Dr. Susan Johnson, Dr. Michael McCarrey and Dr. Bertha Mook, the members of my thesis committee, for their encouragement, excellent advice, and flexibility in meeting the changing demands of the research work.

Particular thanks go to Roslyn Postner, the therapist in this study, for her collaborative spirit, professional approach, and therapeutic skill.

Thanks also go to the coordinators of the Seniors Resource Centre, the Sandy Hill Community Centre, the Elizabeth Bruyere Health Care Centre, and the Psychogeriatric Clinic for

their interest in the research and collaboration in providing appropriate referrals.

The Centre for Psychological Services provided the use of interviewing and group rooms, audio-visual equipment, and the support of the office management staff.

This research was supported by teaching assistantships and scholarships from the University of Ottawa (University of Ottawa Merit Graduate Scholarship 1990-91, University of Ottawa Research Achievement Scholarship 1991-92, University of Ottawa Research Excellence Scholarship 1992-93); by a scholarship from the Ontario Graduate Scholarship Fund (1991-92); and by an award from the Medical Research Council Studentship Award #ST-40074-AP004359 (1992-93).

Abstract

Reminiscence has been identified as an important contributor to adaptation in later life by gerontologists (e.g., Birren, 1991), developmental theorists (e.g., Erikson, 1980), and clinical practitioners (e.g., Haight, 1991). Despite its wide acceptance as a therapeutic intervention, little is known about how, and for whom, reminiscence acts to produce therapeutic gains. To understand and to evaluate the therapeutic value of reminiscence for a specific clinical problem, contemporary cognitive theories of depression were integrated with reminiscence theory to develop a model that: a) identifies the key therapeutic content of two types of reminiscence interventions (integrative and instrumental); and, b) elucidates the cognitive and emotional change processes evoked in participants of reminiscence therapy that can treat depression. Based on this model, standardized integrative and instrumental reminiscence interventions were developed and implemented with 26 older adults with moderate to severe depression. Using a clinical intervention single case study replication design, results support the utility of the model developed to explain how reminiscence contributes to the treatment of depression. In the Integrative group, constructive reappraisal of initial interpretations and emotional reactions to past self-defining events led to an improvement in self-esteem, purpose, and personal meaning, and a decline in hopelessness and internal, stable, and global attributions for the causes of negative events. In the Instrumental group, memories were used to remove emotional and cognitive barriers to coping by normalizing stress, identifying important needs at stake in current coping, providing evidence of successful past coping, and identifying appropriate coping strategies. As a result, self-esteem, life control, and problem-focused coping increased, and appraisals of stressors as threatening and unchangeable, and escape-avoidance coping decreased.

Evaluation of the effectiveness of integrative and instrumental reminiscence interventions demonstrated greater clinically significant improvement in symptoms of depression in the Integrative and Instrumental groups compared with the Active Socialization Control group. In the Integrative group, 58% of clients demonstrated clinically significant improvement at post-test, yielding an effect size (ES) of .86. At follow-up, 100% of Integrative subjects improved clinically (ES=.96). In the Instrumental group, 56% of clients demonstrated clinically significant improvement at post-test (ES=.81) and 88% improved at three-month follow-up (ES=.89).

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INTRODUCTION

Depression is one of the main mental health concerns among older adults. Between 20 and 25% of adults over the age of 65 manifest dysphoria. Within this group, 10-15% present moderate to severe depressive symptoms, and 5-8% suffer from clinical depression. Among elderly individuals with major life stressors, such as being seriously ill or caring for an ill family member, rates of major depression rise to between 12-55%. As population aging continues, the absolute number of elderly individuals who suffer the debilitating effects of depression will increase, intensifying the need to identify effective interventions for this population (Cappeliez, 1993).

Currently, antidepressant medication is one of the main avenues of treatment for depression in the elderly population. Although this method has been shown to reduce symptoms of depression in older adults, several side effects (e.g., cardiotoxicity, anticholinergic effects, adverse interactions with other medications) contraindicate the use of pharmacotherapy in many older individuals. Further, depressed clients treated exclusively with drugs do not learn the skills developed in psychotherapeutic interventions which may afford long-term protection against the relapse of depression (Barber & DeRubeis, 1987; Evans, Hollon, DeRubeis, Piaciski, Grove, Garvey & Tuason, 1992).

Studies and reviews of psychotherapeutic interventions support the general effectiveness of this type of treatment for late-life depression (e.g., Fry, 1984; Gallagher, Hanley & Thompson, 1990; Gaylord & Zung, 1987; Katona, 1993; Leszcz, 1990; Meyers & Alexopoulos, 1988a; 1988b; Rockwell, Lam & Zisook, 1988; Scogin, Jamison, & Gochnauer, 1989; Scogin & McElreath, 1994; Steur, Mintz, Hammen, Hill, Jarvik, McCarley *et al*, 1984; Thompson,

Gallagher, & Breckenridge, 1987; Woods, 1992; Woods, 1993). It appears that most psychotherapeutic interventions for depressed elderly adults so far studied (e.g., behavioural, cognitive, and psychodynamic) do not differ in their degree of effectiveness. Whether the various psychotherapeutic interventions differ in the type of therapeutic changes which clients experience is as yet unclear (Gallagher & Thompson, 1983; Robinson, Berman, & Neimeyer, 1990; Woods, 1993).

More recently, recognition of the unique needs and concerns involved in adaptation to the later stages of life has led clinicians to modify traditional interventions such as cognitive and interpersonal approaches to address psychological issues of particular relevance to older adults experiencing depression (e.g., Clarke & Lewinsohn, 1989; Cohen, 1990; Hebl & Enright, 1993; Leszcz, 1990; Miller, Frank, Cornes, Imber *et al*, 1994; Moberg & Lazarus, 1990). Unique interventions that are specifically designed for use with older adults have also been developed. Reminiscence (or life review) therapy is one intervention which has been developed to provide an efficient and attractive alternative to the more traditional approaches to psychotherapy with older adults. The idea that reminiscence plays a major role in successful aging (Birren, 1987; Butler, 1974) has gained currency among researchers and practitioners (Birren, 1987; Coleman, 1986; Cook, 1991; Disch, 1988; Kaminsky, 1984). An increasing number of seniors centres and nursing homes have included some form of life review discussion group as part of their regular programs (e.g., Birren & Deutchman, 1991; Kaminsky, 1984). Reports on the clinical value of reminiscence and its attractiveness to the elderly population continue to appear regularly in the literature (e.g., see Thornton & Brotchie, 1987 and Haight, 1991 for reviews; Arian, Perri, Nezu & Schein, 1993; Goldstein, 1987; Magee, 1988; Rybarczyk & Auerbach, 1990).

Empirical assessments of the utility of reminiscence as a clinical intervention have recently been reviewed (Webster & Cappeliez, 1993). This review identifies a large number of studies which have reported various beneficial effects of reminiscence, including treatment of depression. However, many of these reports are descriptive and anecdotal, and research that does not support the effectiveness of reminiscence has also been reported (Brennan & Steinberg, 1983-84; Schafer, Berghorn, Holmes & Quadagno, 1986; Cook, 1991; Stevens-Ratchford, 1993). Given that reminiscence therapy is used extensively with older adults, and that it has shown some potential utility, it is essential that an understanding of the processes whereby reminiscence affects psychological adaptation is developed. In turn, a model of the therapeutic processes involved in reminiscence will aid in the empirical assessment of the therapeutic value of this intervention.

The main difficulty faced by researchers in their attempts to understand and assess the therapeutic value of reminiscence is that the theoretical framework of reminiscence is underdeveloped. In particular, the critical content of reminiscence that contributes to adaptation is not known. Further, the psychological processes evoked by reminiscence that may help to relieve depression have not been clearly identified.

It is the primary goal of this research to address these limitations in knowledge of reminiscence as an adaptive process by developing the first model that identifies the key therapeutic content of reminiscence and the psychological change processes evoked by reminiscence that contribute to relief from depression. By clearly identifying the critical content and processes of reminiscence that are involved in ameliorating or preventing depression, this model will permit initial empirical evaluation of the efficacy of a theoretically-based

remembrance intervention designed to treat depression in older adults. In addition to outcome research, this model will provide an understanding of the factors responsible for improvement in depressive symptomatology following reminiscence.

This research will make three significant contributions to the field of reminiscence research and to the field of psychotherapeutic interventions for depressed elderly adults. First, it will identify the specific cognitive variables and coping processes involved in reminiscence that have a positive impact on depressive symptoms, thereby defining and operationalizing the theoretical foundations of reminiscence. Second, it will help to clear up the controversy in the literature regarding the adaptive function of reminiscence. And third, it will evaluate the viability of reminiscence therapy as an efficient psychotherapeutic intervention designed specifically to treat depression in older adults.

Theoretical Models of Reminiscence

Reminiscence, once considered to be a sign of decline in the elderly (Clark & Anderson, 1967; Reichard, Livson, & Peterson, 1962), has recently gained recognition as an important strategy for coping with the physical, social and psychological changes that occur in later life (Birren & Hedlund, 1987; Coleman, 1986; Kaminsky, 1984). The main theoretical impetus for this interest stems from the work of Erikson (1959, 1963), Butler (1963) and Birren (1964). A review of this literature provides the basis from which a comprehensive model of reminiscence content and processes may be developed.

According to Erikson's theory of ego-development, the life cycle is characterized by a series of active attempts by the individual to deal with external influences--primarily social

realities such as adopting and integrating into a society or making a productive contribution to the community. General well-being and psychological and intellectual development are contingent upon the individual's ability to deal successfully with the tasks imposed by these social influences. The principle task of older adults is to come to terms with the social and emotional implications of aging. Erikson (1959; 1963) suggests that an assessment of the past is an essential component in successful completion of this task. Through life review reminiscence, individuals can develop ego-integrity--the belief that life has been productive and meaningful and that despite hardships and mistakes, life was lived the best way it could have been given the circumstances. The strengths and insights about one's self gained in this review are thought to play an integral role in aiding adjustment to the many inter- and intrapersonal difficulties of aging, and to promote full participation in present life and future goals. If this review is unsuccessful and ego-integrity is not achieved, the individual will experience depression, withdrawal, and despair.

In a similar vein, Butler (1963; Lewis & Butler, 1974) and Birren (1964; Birren & Hedlund, 1987; Birren & Deutchman, 1991) propose that life review reminiscence is an essential ingredient of successful aging. In order to master the challenges of aging, individuals must resolve conflicts from their past and accept the discrepancy between their ideal values and goals, and the reality of their accomplishments. According to Butler and Birren, a successful review of the past contributes to adaptation and psychological health by initiating personal growth, increasing overall well-being and morale, launching future planning, and instilling positive beliefs about the self (e.g., ego-integrity, self-esteem, mastery, self-understanding, wisdom). Furthermore, failure to achieve a successful life review can result in negative consequences such

as loss of self-esteem, guilt, fear of death, depression, and despair.

In this conceptualization of reminiscence, the past acts to shape present adaptation via conscious, cognitive interpretations of recalled experiences. For example, review of past failures and losses can lead to a sense of mastery and greater self-understanding. Recollection of positive memories can serve as a storehouse of wisdom, meaning, and solace which instills positive beliefs about the self. This approach stands in contrast to other theoretical orientations such as learning or analytic theory in which the mechanisms through which the past shape the present are conditioning or early childhood experiences, respectively. As such, reminiscing involves cognitive analysis and interpretation of the past to serve psychosocial, rather than informational goals.

Although reminiscence is described as an interpretive activity that plays a critical role in adaptation in late-life, the theoretical framework provided by Erikson, Butler, and Birren does not specify the content of reminiscence that promote adaptation and prevent or ameliorate depression. As a result, the framework lacks specificity, making it difficult to predict whether recollections will yield positive or negative results. In addition, the framework identifies ego-integrity, wisdom, mastery, and self-understanding as the psychological change processes produced by reminiscence that have a positive impact on depression. These concepts are not well-defined, vague, and difficult to test. Furthermore, they do not clearly explain how reminiscence can prevent depression in terms of contemporary knowledge of the psychological processes that play a critical role in the onset and maintenance of depression.

Based on the information provided by the theoretical model of reminiscence developed by Erikson, Butler, and Birren, researchers face a number of obstacles to determine the value of

remembrance to adaptation and freedom from depression in old age. Despite these difficulties, the theoretical accounts of the adaptive possibilities of reminiscing have inspired numerous investigations of the link between reminiscence, depression, and adaptation in late life. This research has examined the adaptational significance of reminiscence in older adults from three perspectives: 1) the correlation between reminiscing and measures of depression and adaptive functioning; 2) the role of reminiscence in successfully adapting to life changes; and, 3) the therapeutic impact of reminiscence interventions on depression and psychological factors related to depression (e.g., self-esteem, coping processes). This research is reviewed to help identify the content and psychological processes involved in reminiscence that contribute to the treatment of depression in older adults.

Empirical Research on Reminiscence

A recent review of the reminiscence literature (Haight, 1991) indicates that out of more than 100 published articles on the topic, the majority indicate that reminiscence provides a variety of therapeutic benefits to older adults. This positive evaluation of reminiscence, however, is based to a great extent on unreplicated single case studies or clinical observations of reminiscence therapy. Because these reports do not provide a conclusive test of the adaptive function of reminiscence, the following review will include only those articles which have empirically evaluated the impact of reminiscence on the well-being of older adults. In addition, the review will focus primarily on those studies that examine the impact of reminiscence on depression and psychological variables related to depression.

Correlational Studies

One of the earliest correlational studies of the relationship between reminiscence and well being was conducted by McMahon and Rhudick (1967) who found that frequency of reminiscing during interview sessions was only weakly correlated with freedom from depression and intellectual deterioration. In addition to their correlational analysis, McMahon and Rhudick classified reminiscence into three types: life review, storytelling, and escapism. Anecdotal reports indicated that storytellers "seemed" to demonstrate the lowest level of depression and denial. The authors conclude that storytelling reminiscence is adaptive for elderly individuals.

The low correlational findings may be due to an underestimation of the frequency with which the subjects reminisced. The novel and present-oriented conditions in which reminiscence was measured probably do not accurately reflect the amount of reminiscing that occurs with friends or when alone. A more accurate measure of how often the participant reminisced throughout the day may have provided a clearer picture of the adaptational role of reminiscence.

Two other correlational studies examined reminiscence frequency through self-report questionnaires. Havighurst and Glasser (1972) cited a strong association between the frequency of reminiscence, positive affect while reminiscing, and good personal-social adjustment. The generalizability of these results is limited, however, because selection of subjects from *Who's Who* strongly biased the sample toward well-educated, articulate, individuals with a high socio-economic status. Boylin, Gordon and Nehrke (1976) report that frequency of reminiscence involving negative affect is positively related to feelings of intimacy, generativity, and integrity. This finding suggests that a review of memories that may contribute to feelings of depression appears to be associated with a positive outcome within the context of reminiscence. Although

these two studies report a positive association between reminiscence, positive mood state, and positive interpretation of negative events, they used very small samples, experienced low response rates, and used measures of mental health with poor construct validity and reliability. As such, the evidence for an association between frequent reminiscing, mental health, and social adjustment provided by these studies should be treated with caution.

Recently, two studies have explored the relationship between frequency of engagement in particular forms of reminiscence, and adaptation. Taft and Nehrke (1990) measured the frequency of three types of reminiscence (teaching/entertainment, problem-solving, and life review) in a sample of 65 institutionalized older adults. The use of reminiscence for the purposes of entertainment or problem-solving was not related to positive adaptation. In addition, although the use of all types of reminiscence combined was not significantly correlated with ego integrity in this study, a particular type of reminiscence, life review, was associated with high levels of ego integrity.

David (1990) examined the relationship between reminiscence, life satisfaction, and self-esteem in 43 single and widowed community-dwelling men and women. During taped interviews, respondents were asked to describe three memories they had recently thought about. Results indicated that memories with positive evaluations, low victimization, and meaningful connections to the present are related to high self-esteem. Memories involving negative feelings and limited elaboration were related to high life satisfaction.

The findings of these correlational studies do not provide evidence of a direct relationship between reminiscing and freedom from depression. They do, however, suggest that there is an association between reminiscence and variables that can play a role in depression such as,

positive mood state, positive re-interpretation of negative events, life satisfaction, self-esteem, ego-integrity, and social adjustment. Although it is clear that different types of reminiscence are associated with different adaptive outcomes, the findings do not provide consistent information on critical content or processes of reminiscence that are associated with adaptation. For example, story-telling reminiscence was shown to be associated with both positive and negative outcomes. Although limitations in the design, samples, and measures used in these studies may account for the inconsistent findings, the lack of a standard set of definitions for different types of reminiscence may also have contributed to variation in results across studies.

Studies of Adaptation to Life Changes

When exposed to stressful events, individuals can become vulnerable to the development of depression if they do not feel able to respond to or manage the stressors that they face (Billings & Moos, 1982; Folkman & Lazarus, 1984). Reminiscence has been investigated as a possible mediator between the occurrence of stressors and the onset of poor adaptation and/or depression in older adults.

Lieberman and Falk (1971) conducted one of the first studies designed to assess the role of reminiscence in adapting to life changes. Three groups of elderly individuals in different life circumstances (community-dwellers, waiting for institutionalization, institutionalized) were asked to tell their life story and provide some evaluation of their past. Individuals in the unstable life condition (e.g., waiting list) showed more affective and cognitive involvement in their reminiscences. The authors did not, however, address the question of whether reminiscing provided adaptive benefits for these individuals during the time they were experiencing the stress

of waiting to leave their homes. At a one-year follow-up, reminiscence was unrelated to individuals' adaptive status with regard to institutionalization. Although this research indicates that individuals may be more attentive to or involved in memories during times of stress, the findings provide no support for the hypothesis that reminiscence can provide long-term adaptive benefits.

Lewis (1971) investigated the relationship between reminiscence and consistency of self-concept. No difference was found between a group who reminisced and a group who did not reminisce in terms of consistency of self-concept from past to present. However, following an experimentally-induced threat to identity, there was a significantly greater increase in consistency between past and present self-concept in the group who reminisced than in those who did not. These findings suggest that individuals who reminisce may use this process to defend their sense of identity in the face of stressors. As Folkman and Lazarus' (1986) research shows, a strong sense of one's self and one's capabilities may, in turn, promote a sense of competency in coping activities which can then mediate between stress and the onset of depression.

Coleman (1974) investigated the relationship between three types of reminiscence (simple, life review, informative) and adaptation to life stress by content analyzing conversations with a random sample of elderly individuals living alone in sheltered housing. His findings indicated that when dissatisfaction with past life was evident, poor current adjustment was demonstrated by individuals who reminisced infrequently, but not by those who engaged in life review. This finding suggests that life review reminiscence can aid in the resolution of past crises and failures, resulting in enhanced current adaptation in the face of stressors.

Empirical analysis of the ability of reminiscence to mediate between life stressors and adaptation/depression is inconclusive. In accordance with reminiscence theory, there is some evidence that life review reminiscence can assist in resolving and integrating past difficulties and that this process can contribute to personal adjustment when past problematic experiences exist. In addition, there is some support for the hypothesis that reminiscence can counteract current threats to identity (such as retirement or the loss of a loved one). Resolution of stress arising from past experiences, as well as bolstering one's sense of self when current life stressors are encountered, are psychological processes that have been identified as playing a potentially important role in mediating between stress and the development of depression (Billings & Moos, 1982; Folkman & Lazarus, 1986). As such, these studies provide some indirect support for the idea that reminiscence can contribute to freedom from depression in later life. However, the content and processes of reminiscence that contribute to resolution and integration of past difficulties and to the maintenance of a sense of identity are not clearly identified.

Investigations of Reminiscence Therapy

Prospective investigations of reminiscence therapy provide older adults with a reminiscence intervention and assess the impact of that intervention on clinical symptoms. Several investigations have provided support for the utility of reminiscence as a therapeutic intervention. For example, Rattenbury and Stones (1989) compared the psychological well being of 24 elderly nursing home residents who participated in a 16-session reminiscence, current topics, or control group. The authors rated participants' happiness/depression, activity, mood, and functional levels before and after the group interventions. The intervention had a significant

effect only on the happiness/depression measure, with both intervention groups showing positive changes compared to the control group.

Fry (1983) provided a structured reminiscence and unstructured reminiscence intervention to two groups of 54 significantly depressed elderly individuals. In comparison to a socialization control group (n=54), both the structured and unstructured reminiscence groups demonstrated significant improvement on measures of depression, ego-strength, and self-assessment of isolation, pessimism, self-efficacy. The structured reminiscence group, in which subjects were encouraged to discuss memories associated with negative events that they typically avoid, demonstrated greater improvement on the dependent measures than did the unstructured group in which subjects were permitted to discuss as much or as little of a past negative event as they wished.

Arean, Perri, Nezu, & Schein (1993) randomly assigned 75 older adults diagnosed with major depressive disorder to problem-solving therapy (PST), reminiscence therapy (RT), or a waiting-list control (WLC) condition. Participants in PST and RT were provided with 12 weekly sessions of group treatment. At post-treatment, self-report and observer-based assessments of depressive symptomatology demonstrated that both the PST and the RT conditions produced significant reductions in depressive symptoms whereas the WLC group did not. Subjects in the PST group, however, demonstrated significantly less depression than RT subjects.

Other intervention studies have yielded findings that do not support the effectiveness of reminiscence therapy in the treatment of depression. For example, Fallot (1979-80) compared the effect on mood of verbal reminiscing and talking about the future among a group of 36 women aged 46-85. Relative to talking about the present or future, three sessions of individual

reminiscing resulted in less negative affect and fewer self-blame attributions related to the past. These participants also demonstrated less anxiety and fatigue than their counterparts. However, individuals who reminisced showed higher levels of depression and futility related to the present and future than did the future-oriented group. The author proposes that the latter results were related to the tendency of participants to unfavourably compare the past with the present. She suggests that group leaders steer clients away from such negative contrasts.

Perotta and Meacham (1981-82) investigated the effects of five weekly sessions of reminiscence on self-rated depression and self-esteem in a group of elderly community-dwellers. There were no positive changes on either dependent measure for the reminiscence group ($n=7$), the current events group ($n=7$), or no-treatment control group ($n=7$). The authors speculate that a specific form of reminiscence is needed to have an impact on depression, and that this type was not identified or sufficiently promoted in their study. In addition, the diagnostic level of depression demonstrated by subjects prior to the study is not reported so it is unclear to what population these results may be generalized. As Thornton and Brotchie (1987) suggest, a reminiscence intervention may be effective only at certain levels of depression. Cook (1991) hypothesized that reminiscing would increase life satisfaction, self-esteem, and decrease depression in elderly nursing home residents (aged 65+ yrs). Fifty-four residents were randomly assigned to a reminiscence group or to a current events control group. No significant improvement was found in life satisfaction, depression, or self-esteem in either group.

Stevens-Ratchford (1993) investigated the impact of life review reminiscence activities on self-reported depression (BDI) and self-esteem (Rosenberg Self-Esteem Scale). A pretest-posttest experimental design was used in which 24 physically well older adults (aged

69-91 yrs old) living in a retirement community were randomly assigned to an experimental group (6 life review sessions) or to a no-treatment control. An analysis of covariance (ANCOVA) indicated that life review reminiscence activities did not significantly affect depression and self-esteem.

Weiss (1994) investigated the difference in treatment gains between elderly participants in cognitive group therapy (CGT) and those in a life review therapy program (LRT). Forty-eight residents of a personal care home were randomly assigned to either CGT or LRT for 8 weekly 1.5 hour sessions, or to no-treatment control group. The Beck Depression Inventory and the Life Satisfaction in the Elderly Scale were administered before and after the group therapy series and at a 6-week follow-up. Subjects were divided by age: 55-74 yrs and 75-100 yrs. The CGT and the LRT review groups both attained greater improvement in life satisfaction than did the control group, however the two experimental groups did not differ. There was no difference between the experimental and control groups on depression, and no significant differences were found between the two age groups.

Several other studies have been reported in the literature that do not examine the impact of reminiscence interventions on depression directly. Rather, these studies assess the effect of reminiscence interventions on psychological variables that are linked to the onset and maintenance of depression (e.g., mood state, self-esteem, life satisfaction, obtaining social support, efficacy and anxiety related to coping).

Bender, Cooper and Howe (1983, unpublished manuscript reported in Thornton & Brotchie, 1987) conducted two controlled studies of reminiscence groups in nursing homes. Results indicated a trend for the experimental group to show more positive changes on a range of

social and activity measures than the control group. In a third study, comparing reminiscence and reality orientation interventions, there were no significant differences between groups on pre-post-intervention change in cognitive ability and life satisfaction. Thus, the authors conclude that reminiscence has a stimulating rather than a therapeutic effect.

Schafer, Berghorn, Holmes and Quadagno (1986) investigated the effect of 12 sessions of structured and unstructured reminiscence interventions on a group of 185 nursing home residents. Compared with a no-treatment control, the unstructured reminiscence group initiated more verbal interactions with other group members. There were no differences, however, on measures of life satisfaction, perceived control, and perceived friendliness of other residents between the experimental and control groups.

Sherman (1987) compared the impact on development of social supports and a sense of well being among 104 elderly participants of a 10-week life review reminiscence group, an experientially-oriented group which used focusing techniques to experience memories of the past, and a control group. In contrast to the two studies reported above, subjects demonstrated improvements in life satisfaction, self-concept, and frequency and enjoyment of reminiscence. However, there were no significant differences among the groups in the amount of improvement demonstrated on each variable.

Bachar, Kindler, Scheffler, & Lerer (1991) conducted a comparative study of group reminiscence and a "traditional" reflective non-directive therapeutic approach with 22 severely depressed hospitalized patients. The dependent measure, mood, was a more immediate evaluation of the impact of reminiscence than measures of life satisfaction taken in the two studies reported above. Results indicated that patients and staff reported greater improvement in

mood following the reminiscence sessions than after the traditional psychotherapy sessions.

However, as no pre-test post-test measures of depression were obtained, the long-term effect of the two groups on symptom relief is unknown.

As in the study by Sherman (1991), Lappe (1987) compared a ten-week reminiscence group intervention with a current events discussion group on measures of self-esteem in a group of 83 institutionalized older adults. The diagnostic status of members of this group was not reported. The reminiscing group demonstrated higher self-esteem scores than did the present-oriented group, lending support to Sherman's finding that reminiscence has a positive impact on the sense of self.

Several studies have examined the impact of reminiscence therapy on efficacy and anxiety related to coping. Rybarczyk and Auerbach (1990) provided a sample of 104 elderly male patients facing surgery with a standard life review reminiscence interview or one that focused on past successful problem-solving. Results indicate that reminiscing reduced state anxiety and enhanced coping self-efficacy when measured against both attention-placebo and no-intervention control groups. Georgemiller and Maloney (1984) examined the impact of structured reminiscing on anxiety in 63 community-dwelling elderly individuals. Participants were assigned to either a series of seven life review meetings (n=34) or to a control condition (n=29). In comparison to controls, there was a significant decrease in anxiety and denial related to death at post-treatment for subjects in the life review group.

Harp Scates, Randolph, Gutsch and Knight (1985-86) evaluated the effects of a six-session skills oriented cognitive-behavioural intervention, a reminiscence group, and an activity group on the life satisfaction and anxiety level of 50 community dwelling older adults. No

significant pre- and post-test differences were reported in the three groups for life satisfaction or trait anxiety. There was, however, a significant decrease in state anxiety from pre- to post-test in the reminiscence group. The non-significant results reported on satisfaction and trait anxiety may be due to the fact that the majority of participants experienced little trait anxiety and high levels of life satisfaction before the study. If respondents were already at their ceiling on the dependent measures used, treatment could not have been expected to have any additive effects. The authors explain the anxiety-reducing properties of reminiscence in terms of reciprocal inhibition. That is, anxiety-inducing life situations are counterposed with relaxing reminiscences which serve as the vehicle by which anxiety is reduced.

In summary, the research on reminiscence interventions is characterized by inconsistent and inconclusive findings. In a series of controlled experiments examining the impact on symptoms of depression of a reminiscence intervention in comparison to a no-treatment control group, two studies reported a positive impact of participation in reminiscence therapy on symptom relief. Four other studies, however, reported no significant improvement on symptoms of depression in comparison to a control group.

In studies that compare reminiscence therapy with alternative active treatment conditions (e.g., cognitive-behaviour therapy, problem-solving, socialization group) reminiscence therapy was shown to perform as well as cognitive-behaviour therapy in achieving reducing depression. Problem-solving therapy, however, was reported to have a greater impact than reminiscence therapy on the treatment of depression.

Studies that examine the impact of a reminiscence intervention on psychological processes that are related to depression provide somewhat more support for the effectiveness of

reminiscence therapy. Studies demonstrate that reminiscence therapy can decrease state anxiety and improve mood, self-esteem, and coping self-efficacy. No support was found for an increase in cognitive ability, perceived control, or perceived friendliness following reminiscing. The impact of reminiscence on life satisfaction is unclear--contradictory findings have been reported in the literature.

Conclusion

Currently, the literature does not provide overwhelming support for a direct relationship between reminiscing and amelioration or freedom from depression. Correlational studies provide no solid evidence of an association between frequency of reminiscing and personal adjustment or depression (Boylin, Gordon & Nehrke, 1976; David, 1990; Havighurst & Glasser, 1972; McMahon & Rhudick, 1967; Taft & Nehrke, 1990). Controlled investigations of reminiscence therapy have yielded contradictory results. There is support both for (e.g., Arean, Perri, Nezu & Schein, 1993; Fry, 1983; Rattenbury & Stones, 1989), and against the therapeutic impact of reminiscence as a clinical intervention for the treatment of depression (e.g., Cook, 1991; Fallot, 1979-80; Perotta & Meacham, 1981-82; Stevens-Ratchford, 1993; Weiss, 1994).

There is more consistent support for an association between reminiscing and variables that can play a role in depression such as, positive mood state, positive re-interpretation of negative events, life satisfaction, self-esteem, and ego-integrity (e.g., Boylin, Gordon & Nehrke, 1976; David, 1990; Havighurst & Glasser, 1972; Taft & Nehrke, 1990). As well, research demonstrates that reminiscence interventions decrease state anxiety and improve mood, self-esteem, and coping self-efficacy (e.g., Bachar, *et al*, 1991; Georgemiller & Maloney, 1984; Harp

Scates, *et al.*, 1985-86; Lappe, 1987).

Studies examining the role that reminiscence plays as a mediator of life stressors indicate that reminiscence can help counteract the negative effects of problematic past experiences on current adjustment and it can counteract current threats to identity (such as surgery, retirement or the loss of a loved one) thereby bolstering one's sense of self in the face of stressors (Coleman, 1974; Lewis, 1971; Rybarczyk & Auerbach, 1990). These processes have been identified as playing a potentially important role in mediating between stress and the development of depression (Billings & Moos, 1982; Folkman & Lazarus, 1986).

At present, research on reminiscence has not provided a comprehensive or conclusive answer to the question what role does reminiscence play in adaptation. Some of the discrepancies in research findings may be due to the fact that this body of literature has used diverse subject populations (Molinari & Reichlin, 1984-85), different methodologies (LoGerfo, 1980-81), and different measures of the adaptive scope of reminiscence (Perotta & Meacham, 1981-82).

Systematic replication of research which employs standard designs and outcome measures and includes follow-up data is required before conclusions can be drawn about the psychological processes associated with depression in older adults, and the adaptive value of reminiscence therapy for the treatment of depression. Ultimately, however, evaluation of the efficacy of reminiscence will continue to be inconsistent and inconclusive until research is guided by a comprehensive theoretical framework of reminiscence which specifies the content of reminiscence that is critical to adaptation, the function reminiscence serves for specific populations, and the psychological change processes which should be evaluated in reminiscence

interventions. The next section presents the first stage in the development of a theoretical model of the reminiscence processes involved in the treatment of depression in older adults. This work, conducted by Watt and Wong (1991; Wong & Watt, 1991), operationalizes the reminiscence construct in terms of the content and adaptational function of six different types of reminiscence.

Operationalizing the Reminiscence Construct: The Content and Function of Reminiscence

Preliminary attempts to specify the content of reminiscence in terms of cognitive and affective processes have suggested that reminiscence is not a unitary phenomenon. Rather, reminiscence appears to be a multi-dimensional construct comprised of a number of different kinds of recollections (LoGerfo, 1983; Watt & Wong, 1991). Based on his clinical experience, Butler (1963) identified three broad categories of reminiscence: life review, storytelling, and negative reminiscence. Life review involves an evaluation of the past in terms of the value and meaning of past experiences and is generally accompanied by positive affect. Storytelling reminiscence is a descriptive recollection of past pleasurable experiences and again, is typically accompanied by pleasant affect. Negative reminiscence is described by Butler as a failed life review. Individuals engaging in negative reminiscence recall self-defeating memories in an obsessive fashion and express guilt and dissatisfaction with these reminiscences. Over the years, these three categories of reminiscence have been verified by other clinicians (Coleman, 1974, 1986; McMahon & Rhudick, 1967) and additional categories have been suggested, such as, glorification of the past (Lewis, 1971; McMahon & Rhudick, 1964), and recollection of goal-oriented behaviour (Lieberman & Tobin, 1983).

Although some of the different types of reminiscence have been identified in the

literature for a number of years, studies have not examined the differential impact of these types on adaptation because reliable criteria for the classification of reminiscence have never been provided. Rather, investigations of reminiscence therapy have primarily examined the impact of unclassified reminiscence on measures of adaptation. Recent research by Watt and Wong (1991) has responded to the need to develop a comprehensive taxonomy and specify guidelines for the reliable classification of reminiscence (see Table 1). On the basis of past research and content analysis of reminiscence data collected from four hundred seniors, the authors identified six different types of reminiscence: integrative, instrumental, transmissive, narrative, escapist, and obsessive. This taxonomy incorporates various types of reminiscence reported in the literature as well as identifying new types of reminiscence. It also summarizes the postulated adaptive functions of the six different types of reminiscence and provides a set of markers that permit reliable content analysis.

A Taxonomy of Reminiscence

The defining characteristics of integrative reminiscence include statements that indicate acceptance of one's past (Erikson, 1980), viewing one's past life as fulfilling or worthwhile (Butler, 1963), finding one's life meaningful (Wong, 1989), reconciling the discrepancy between ideal and reality (Birren, 1964), acceptance of negative events in the past, resolution of past conflicts, and recognition of a pattern of continuity between past and present (Lieberman & Tobin, 1983). The proposed function of this type of reminiscence is to achieve a sense of self-worth, coherence, and reconciliation with regard to one's past (Butler, 1963). To the extent that one is able to achieve this task, integrative reminiscence should contribute to successful aging via

Table 1
Taxonomy of Reminiscence

| Reminiscence Type | Definition | Example |
|-------------------|--|---|
| Integrative | Acceptance of self and others, conflict resolution and reconciliation, a sense of meaning and self-worth, and integration between past and present. | When I was a teenager my parents divorced and both remarried. I was very resentful because they didn't seem to care about my feelings or needs. But as I grow older and look back I see that they really weren't compatible. They had suffered together for many years before the divorce to try to keep the family together. |
| Instrumental | Recall of successful past coping experiences. Recollection of past plans and goal-directed activities to be used in solving present problems. | I think the worst experience was the day I found out I had tuberculosis. The doctors wanted to take out the lung. They said it was the only hope, but I refused. I was damned if those germs were going to get me, so I practised a positive mental attitude. Two years later I recuperated. I think what helped my progress most was my state of mind. I use that to this day. |
| Narrative* | Description of autobiographical facts. Recounting stories from the past for entertainment purposes. | Every winter my dad used to flood the side lawn and we would have a carnival. We were all dressed up in different costumes. Dad was always a clown. Dad would take all the little girls for a skate. Then we'd come in and have cocoa and sandwiches. |

*See footnote on page 27 for an explanation of this term.

Table 1 (continued)

Taxonomy of Reminiscence

| Reminiscence Type | Definition | Example |
|-------------------|---|---|
| Transmissive | Recounting past events to instruct the listener or to pass along family history and tradition. | When I was at university I wanted to be a doctor. I thought we would learn medicine right away but we had to take a general degree first. It was part of the European tradition, to give a man a broad exposure to all the important things in life--art, music, the Classics. It enriched my practice, but mostly it enriched me. It gives you a career, and a soul. |
| Escapist | Seeking comfort from people and events that inhabit one's memories, combined with an element of exaggeration of the pleasant aspects of the past and depreciation of the present. | My husband and I really had great times together. My memories of the many cities we visited are as vivid as if I were there right now. The sights, sounds, and smells are so beautiful. I long for those days. Life is so very bland and lacklustre now-- my memories are what keeps me going. |
| Obsessive | Persistent rumination on unpleasant past events without resolution. | My husband died when I was away visiting friends out West. He fell in the bathtub and died because there was no one to help him. It's been years now but I still can't forgive myself. I should have been there. I shouldn't have gone. |

increased self-understanding, personal meaning, self-esteem, and life satisfaction (Birren & Hedlund, 1987; Lewis and Butler, 1974; Coleman, 1974, 1986).

Instrumental reminiscence is focused primarily on recollections of past problem-solving and involves memories of how plans were developed to solve a difficult situation, goal-directed activities, the attainment of one's own goals, or goals one has helped others achieve, and evaluation of the success of these activities. Instrumental memories may be recalled in order to provide the individual with evidence of past successes which inspire confidence in current problem-solving, or they may be used to provide concrete plans and activities that can be used to solve present problems. Instrumental reminiscence implicates the use of problem-focused coping strategies which have been shown to be an important buffer against emotional distress (Billings & Moos, 1981; Lazarus & Folkman, 1984; Folkman, Lazarus, Gruen & DeLongis, 1986). It also reflects a sense of internal control, mastery, and continuity which has been shown to be related to life satisfaction and subjective good health (Rodin, Timko & Harris, 1985; Lieberman & Tobin, 1983; Schulz, 1976; Slivinske & Fitch, 1987). Thus, it is predicted that instrumental reminiscence is also related to successful adaptation to the challenges of aging.

As the name implies, informative reminiscence serves the function of passing on cultural values and personal wisdom. This type of reminiscence is evidenced by references to the culture and practices of a bygone era, traditional values and wisdom, or the lessons learned through one's own life experiences. Butler (1980-81) has identified informative reminiscence in his clients and suggests that individuals have a profound need to leave their mark by ingraining in their audience important values and ideas. Jung (1933) has postulated that the transmission of knowledge and experience provides the meaning and purpose of the second half of life. Work by Coleman

(1974) and McMahon and Rhudick (1967) has provided some anecdotal support for the idea that this type of reminiscence is related to successful aging.

Escapist reminiscence is characterized by a tendency to glorify the past and depreciate the present. Reminiscence of this type involves boasts of past achievements, exaggeration of past pleasant experiences (with or without favourable comparisons with the present), or revelation of the desire to return to the good old days. Butler (1963) suggests that although escapist reminiscence is generally not constructive, it can help to maintain a steady-state of psychological functioning. Lieberman and Tobin (1983) point out that elderly individuals may create a "mythical" past, portraying themselves as heroes, and that such myth-making may help protect one's self-esteem in the face of loss and decline.

Empirical studies have yielded some anecdotal support for an association between escapist reminiscence and adaptation (Lewis, 1971; McMahon & Rhudick, 1964). However, preoccupation with the past may also render the individual less effective in dealing with present demands and reduce present life satisfaction (Butler, 1963). Like any form of fantasy, escapist reminiscence may provide instant relief from a painful present, but becomes maladaptive when it is prolonged and excessive to the point of interrupting one's current functioning. On the basis of these hypotheses about escapist reminiscence, it is clear that the relationship between reminiscence and successful aging is complex and cannot be predicted without recording reminiscence over a protracted period of time.

Obsessive reminiscence originates from guilt over one's past experiences. It is indicative of a failure to integrate past events, resulting in ruminations on these disturbing past events. Obsessive reminiscence is evidenced by statements of guilt, bitterness and despair over one's

past. Butler (1963) observed that obsessive reminiscing can lead to depression, agitation, panic states, and even suicide. Coleman (1986) has also documented the negative effects of obsessive reminiscence. Therefore, it is predicted that this type of reminiscence is associated with unsuccessful aging.

Narrative reminiscence¹ is a descriptive rather than an interpretive recollection of the past. The two main characteristics of this type of reminiscence are: 1) to provide routine biographical information, such as date and place of birth; and, 2) to recount past anecdotes which may be of interest to the listener. It is evidenced by statements of autobiographical sketches, matter-of-fact accounts of past events (without interpretation or evaluation), and statements that do not belong to the integrative, instrumental, transmissive, escapist, or obsessive categories. In other words, simple narrative can also be defined by excluding other types of reminiscence.

The adaptive function of narrative reminiscence remains unclear. On the one hand, a long narrative reminiscence may reflect good retention of details of past events, indicating good cognitive functioning. On the other hand, it may reflect verbosity, which has been described as a sign of decline in intellectual functioning (Gold, Andres, Arbuckle, & Schwartzman, 1988). Therefore, there does not seem to be any theoretical or empirical basis to predict the relationship

¹Narrative psychology is a major force within the theoretical literature that attempts to explore the relationship between human consciousness and cognitive processes, and humans' conceptualizations of their reality (Bruner, 1986). In this field, the term narrative is used to describe a form of cognitive organization by which individuals give meaning to human events. In contrast to the use of narrative by narrative psychologists, the term narrative is used in this context to identify a specific type of recollection of the past that involves storytelling and/or provision of autobiographical facts.

between narrative reminiscence and successful aging.

This taxonomy represents the most comprehensive classification of reminiscence types to date. It provides researchers with the ability to identify different forms of memories according to a standard set of definitions. Because the taxonomy allows for the separation of different types of reminiscence in intervention research, the unique functional role that each type plays in adaptation can be evaluated.

Relationship Among Reminiscence Types and Measures of Adaptive Functioning in Older Adults

On the basis of the hypothesized relationships among adaptive functions and different types of reminiscence described above, Wong and Watt (1991) began an initial investigation to determine whether different types of reminiscence do indeed have differential relationships with adaptation and well-being. They directly compared the reminiscence data of 171 elderly subjects, half of whom were deemed successful agers and half unsuccessful agers. Successful aging was operationally defined as being higher than the average elderly person in terms of mental and physical health and adjustment as assessed via the Perceived Well Being Scale (Reker & Wong, 1984), Older Adults Rating Scale (OARS) symptom checklist (Pfeiffer, 1978), and clinical ratings. Unsuccessful aging was defined as a below average score on these ratings.

The results of the comparison of reminiscence content between the two groups supported many of the predicted differences between successful and unsuccessful elderly participants, even when the total amount of reminiscence did not differ between groups. Specifically, successful

elderly people engaged in integrative and instrumental reminiscence to a greater extent than unsuccessful older adults. In contrast, unsuccessful older adults engaged in more obsessive reminiscence than their successful counterparts. The early empirical research on reminiscence combined with the work of Watt and Wong (1991; Wong & Watt, 1991) suggests that reminiscence has shown utility in the treatment of depression in older adults, and that the content of reminiscence most likely responsible for these improvements are integrative and instrumental recollections. The next section presents original research on psychological processes that link specific integrative and instrumental reminiscence content with changes in psychological processes that are linked with reduction in symptoms of depression.

Development of Integrative and Instrumental Reminiscence Models

Objective

To develop a set of hypotheses that identify the specific integrative and instrumental reminiscence content and specific psychological processes that interact to alter symptoms of depression in older adults.

Method

In the next section, two sets of hypotheses or models identifying the therapeutic value of integrative and instrumental reminiscence in alleviation of depression in older adults are developed by integrating an understanding of reminiscence processes with contemporary cognitive models of depression. In turn, this fine-grained analysis of the relationship between

remembrance and the relief of depressive symptomatology will help to identify the critical components of an effective reminiscence intervention with depressed older adults.

Justification

The outcome of the Watt and Wong (1991) study has two important implications. First, by evaluating the function of each type of reminiscence separately, the authors were able to show that different types of reminiscence are associated with different levels of adaptive functioning. This finding reinforces the contention that the adaptive function of reminiscence cannot be clarified without specifying and measuring the diverse types of reminiscence used by different individuals. Studies that do not examine the unique impact of each type of reminiscence on adaptation are likely to obscure the different consequences of each type of reminiscing, resulting in contradictory or inconclusive findings.

Second, the finding that integrative and instrumental types of reminiscence are associated with successful aging provides the rationale for further examination of the specific cognitive and affective processes invoked by the therapeutic use of these two types of reminiscence. As described by Watt and Wong (1991; Wong & Watt, 1991), integrative and instrumental types of reminiscence involve cognitive content and processes thought to be related to the onset and maintenance of depression (e.g., self-evaluation, causal attribution for events, appraisal of personal coping resources, and selection of coping strategies). These processes however, have not been systematically researched, and a clear understanding of how reminiscence affects psychological processes in older adults is not available. A theoretical understanding of how

specific types of reminiscence are linked with appropriate target symptoms is necessary before a viable reminiscence intervention can be developed and assessed in terms of its efficacy as a form of psychotherapy.

Reminiscence and Cognitive Models of Depression

Currently, there is an almost universal emphasis among researchers on the importance of cognitive processes in the etiology, maintenance, and treatment of depression (e.g., Abramson, Alloy, & Metalsky, 1988; Abramson, Seligman, & Teasdale, 1978; Beck, Rush, Shaw, & Emery, 1979; DeRubeis & Beck, 1988; Holahan & Moos, 1990; Folkman & Lazarus, 1986).

Recognition of the important part that cognitive processes play in affective disorders stems from research on the causal role of stressful life events in depression (e.g., Billings & Moos, 1982; Hammen, 1988). These studies demonstrate that there is great variability in individual responses to stressful events. Although the majority of individuals who experience even severely stressful circumstances do not become depressed, many people suffer from reactions ranging from mild demoralization to severe depressive episodes. This variability in response is assumed to result from differences in the cognitive interpretation that individuals apply to a particular stressful event, not variability in the stressfulness of the situation itself.

Cognitive theories of depression differ in terms of the cognitive processes they deem to be critical in the development and maintenance of depression. Models that focus on negative evaluations of the self, the world, and the future (Beck, 1967; Beck, Rush, Shaw, & Emery, 1979) and approaches that emphasize dysfunctional causal attributions for negative events

(Abramson, Alloy, & Metalsky, 1988) provide tools for understanding the impact of integrative reminiscence on the relief of depressive symptomatology. Research that attempts to detail the cognitive appraisals and coping responses that mediate between stressors and depression in the day-to-day adaptational tasks of living (e.g., Folkman & Lazarus, 1986; Rohde, Lewinsohn, Tilson, & Seeley, 1990) offers a useful framework for elucidating the effect of instrumental reminiscence on the alleviation of depression. Together, the two approaches delineate the key cognitive components that should represent the targets of any intervention for depression.

Integrative Reminiscence and the Mediation of Depressive Symptomatology: A Cognitive

Re-attribution Approach

From a cognitive perspective, patterns of thinking that predispose individuals to depression are formed early in life, and derive from personal experiences, identification with important others, and perceptions of the attitudes of other people toward the self (Beck, 1967; Beck & Greenberg, 1986; Beck, Rush, Shaw, & Emery, 1979). Early interactions that emphasize rigid and perfectionistic achievement, and reinforce the importance of evaluation of personal worth by others, are thought to predispose individuals to develop limited sources of self-worth and an over-reliance on external feedback for feelings of self-esteem. In this environment, individuals learn to judge themselves harshly and interpret frustrations, failures, and losses as evidence of negative characteristics such as, unworthiness or ineptitude (Cappelliez, 1988). These critical judgements of the self crystallize into core dysfunctional beliefs such as, "I am unlovable" or "I am incapable".

Latent belief systems are typically activated by situations analogous to the experience responsible for embedding a negative belief (e.g., a current failure or loss). When the schema is activated, the propensity toward self-criticism and self-evaluation based on external standards dominates individuals' thinking, leading to the systematic interpretation of circumstances in a negative way, even when more plausible explanations are available, or evidence contradicting the negative interpretation exists. As part of this process of negative interpretation, individuals make logical errors in the conceptualization of experience. For example, they over-generalize from a single negative incident or selectively attend to a negative detail and ignore any positive aspects of a situation (Beck, 1967; Beck & Greenberg, 1986; Beck, Rush, Shaw, & Emery, 1979). Each cognitive error and distortion confirms the negative schema, precipitating a downward spiral in which the person's thinking style becomes less differentiated and the ability to explore alternative, more adaptive explanations for life events is reduced. Eventually, individuals vulnerable to depression lose the ability to view their negative thoughts with objectivity, and three main cognitive patterns are activated which cause individuals to see themselves ("I am worthless"), their world ("Life is miserable"), and their future ("Everything is hopeless") in a negative manner. Depressive symptoms such as social withdrawal, sadness, and loss of motivation and interest are considered to be consequences of the activation of the negative cognitive triad (Beck, 1967; Beck & Greenberg, 1986; Beck, Rush, Shaw, & Emery, 1979).

Like Beck's (1967) model of depression, the hopelessness paradigm (Alloy, Hartlage, & Abramson, 1988) employs a diathesis-stress model that proposes that depression results from the interaction between negative life experiences and interpretations of those events. From this

perspective, an expectation of hopelessness--the belief that highly aversive outcomes are probable and no response can be made to alter their occurrence--is viewed as the primary cause of depression. This hopelessness develops as a result of attributing the occurrence of important negative life events to stable and global causes. An individual who consistently applies these attributions of causality will develop hopelessness and depressive symptoms when confronted with negative experiences (Abramson *et al*, 1978; Alloy *et al*, 1988).

The primary goal of the cognitive treatment of depression is to train clients to alter the thoughts that maintain their depressed mood and lie beneath their lack of motivation, low activity level, and other symptoms (Beck & Greenberg, 1986). A variety of cognitive and behavioural techniques are used to achieve this end, including activity scheduling; disconfirmation of distorted views of the self that support the negative cognitive and behavioural set; analysis and modification of maladaptive beliefs and assumptions about the world; and, a balanced, realistic re-attribution of responsibility in situations of client self-blame and self-criticism (Beck, 1967; Beck & Greenberg, 1986; Beck, Rush, Shaw, & Emery, 1979).

Integrative reminiscence is similar to a successful life review as described by Butler (1963). It is a process of self-discovery in which individuals attempt to accept negative events in the past, resolve past conflicts, and reconcile the discrepancy between ideal and reality (Birren, 1964; Lieberman & Tobin, 1983). Furthermore, it is aimed at helping people identify a pattern of continuity between past and present (Lieberman & Tobin, 1983), and finding meaning and worth in life as it was lived (Butler, 1963; Erikson, 1980; Wong, 1989). Like cognitive therapy, integrative reminiscence deals with individuals' beliefs about themselves, their attitudes towards

and their assumptions about the world, and the attributions they make about the causes of negative events in their life. As such, integrative recollections deal directly with the negative thoughts and schematic information-processing styles that support negative mood and behavioural symptoms of depression.

Distorted views of the self and the tacit rules for the interpretation of experience that are contained in individuals' schemas are open to modification through the re-constructive nature of integrative reminiscence processes. Integrative recollections do not involve simple recall of by-gone events, rather, past experiences are endowed with meaning and significance as a result of interpretation of those events in the light of current knowledge, perspective, and concerns (e.g., Yang & Rehm, 1993). Past unresolved experiences of failure or loss and negative conclusions about the self and the future can thus be reinterpreted in an adaptive fashion within the context of evidence that disconfirms negative beliefs and through application of information processing strategies that emphasize positive interpretation of events. The links between integrative reminiscence and cognitive theories of depression are developed in the next sections and summarized in Table 2.

Disconfirmation of Negative Self-beliefs

The life review provides individuals with the opportunity to examine evidence that may disconfirm negative self-evaluations associated with depression. To counteract the tendency of many depressed persons to ignore major pieces of positive information and centre on those that support their dysfunctional views, the therapist can help clients to seek fuller, more detailed

Table 2

Integrative Reminiscence Processes and Therapeutic Goals in the Treatment of Depression

| Reminiscence Processes | Goals |
|--|---|
| Disconfirmation of negative beliefs about the self, the world, and the future that arise from negative interpretations of life experiences. | Through review of both successes and failures experienced across the entire lifetime and in many domains, cognitive errors are short-circuited. |
| Reduction in stable, global, and internal attributions for the causes of negative events. | Alternative explanations for negative events are developed that recognize the impact of historical and contextual influences. |
| Reduction in feelings of hopelessness. | Highlight concrete recollections of past experiences that have been resolved, thereby, combatting the sense that life is always negative. |
| Identification of internal guidelines for the evaluation of self-worth that reflect a subjective interpretation of memories in terms of their meaning in the life story. | Interpretation of experiences in terms of their personal meaning in the life story versus objective evaluation of life as good or bad. |
| Development of additional sources of self-worth separate from achievement-based criteria. | Trace the development of personal values, commitments, and purpose across the lifespan. |

accounts of events and correspondingly fuller interpretations to help them structure alternative ways of perceiving past events (Hollon & Garber, 1990; Schneider & Schiffrin, 1977). As individuals review both good and bad experiences within the context of the entire lifetime, the negative impact of any given hardship, failure to act at an optimal level, or negative comparison with others may be dispersed by recognition of good actions taken and happy events experienced. Both the sheer number of positive and negative experiences that fill the lifespan, and the fact that failures in one domain such as career, may be offset by accomplishments in another arena such as family life, reduce the probability of the client committing cognitive errors such as selective abstraction and magnification/minimization. Individuals may thus disconfirm global, negative evaluations of the self that are associated with depression and begin to develop a realistic, adaptive view of the self that incorporates both positive and negative attributes. Furthermore, recollection of difficult past experiences that have been resolved over time can also provide concrete evidence that challenges depressed individuals' belief in their negative qualities and the hopeless attitude that circumstances will never improve or be resolved in the future.

Development of Alternative Explanations for Self-Blame and Self-Criticism

In addition to disconfirming negative beliefs about the self and the future, integrative reminiscence can interrupt the systematic interpretation of events in a negative fashion that results when depressogenic schema are activated. In particular, integrative reminiscence provides the opportunity for a balanced, realistic re-attribution of responsibility in situations of

self-blame and self-criticism.

Individuals develop beliefs about their own worth based on evaluations of how responsibly and appropriately they have acted. These moral evaluations are concerned with whether one did what one ought to have done in a given circumstance, and stand in contrast to causal evaluation which involve examining why events occurred (Brewin, 1986). Integrative reminiscence engages moral evaluations as individuals question the appropriateness of their actions when they attempt to reconcile guilt and blame associated with past conflicts and wrongdoings, and attempt to come to terms with the discrepancy between the ideal and the real self (Butler, 1974; Birren, 1987).

Social comparison has also been identified in the literature as an important source of self evaluation (Festinger, 1954). Social comparison involves an evaluation of whether one measures up to the abilities observed in others and whether one experiences more negative events than others because of one's own personal failings (e.g., Lewinsohn, Mischel, Chaplain & Barton, 1980). Comparisons of the self against others are made during integrative reminiscence when individuals try to measure the impact of their accomplishments and understand the meaning of negative events in their lives (Butler, 1974). In addition, integrative reminiscence addresses social comparisons during the resolution of conflicts such as jealousy within relationships. To the extent that these experiences remain unresolved, they will contribute to the client's negative view of him- or herself. Furthermore, attribution of the causes of these experiences to stable and global factors will increase the likelihood that the client will form an expectation of hopelessness and hence depression (Alloy *et al*, 1988).

Integrative reminiscence gives clients the opportunity to review the causes and consequences of many negative events they have experienced during their lifetime. From a nonjudgemental, middle-ground position, they can be prompted to identify their spontaneous attributions as well as alternative attributions. The life review format provides some distancing from personal and often emotionally-charged material and locates the life story within its historical context. This distance may permit individuals to think in a relativistic fashion about their actions and accomplishments. Negative social comparisons and moral evaluations may be short-circuited by recognition of mediating factors which may have led to differential experiences for each individual. For example, an elderly woman may ascribe her failure to obtain a teaching position to the difficult economic times experienced during the Depression, rather than to personal failings or to the 'fact' that others always get better breaks than she. The different temporal and contextual guidelines provided by the life review may afford elderly individuals' the opportunity to re-interpret their experiences without making negative personal or social judgements (Blanchard-Fields, 1990; Labouvie-Vief, 1982; Labouvie-Vief, Hakim-Larson, DeVoe, & Schoeberlein, 1989). In other words, individuals engage in the development of a new set of beliefs about the self that are less absolutistic and reflect openness to alternative explanations (Riegel, 1973; 1975).

Identification of Internal Guidelines for the Evaluation of Self-Worth

One factor that has been identified as contributing to vulnerability to depression is the reliance on external sources of information about self-worth (Beck & Greenberg, 1986). To the

extent that individuals fail to develop internal guidelines for determining their success and value, their sense of self will remain fragile and vulnerable to changing circumstances. The life review process invites an interpretation of experience that is dynamic, participatory, and governed by standards that reflect personal interests, motivations, and philosophies. The life review provides a forum for individuals to interpret life according to their own emerging standards. As clients weave the stories of their lives, they reinterpret episodes in terms of the meaning they hold for them, rather than whether they are objectively right or wrong, good or bad (Bruner, 1986; Gergen & Gergen, 1986). For example, failure to act effectively to avoid an accident may be taken as a learning experience that has stood the person in good stead over the years. A divorce may be interpreted as the impetus that lead to a voyage of self-discovery for the individual. In both cases the ability to view the events of the past from the point of view of their role in the life story, provides the individual with alternatives to self-recrimination and unfavourable comparison with others. Through the development of a set of subjective, self-affirming assumptions, the individual is able to reinterpret his or her experience in terms of its personal meaning and significance, rather than its negative reflection on the self (Labouvie-Vief, 1982; Labouvie-Vief, Hakim-Larson, DeVoe, & Schoeberlein, 1989).

Development of Sources of Self-Worth

A restricted number of sources of self-worth is another vulnerability factor for the development of depression. In particular, early interactions focusing on rigid and perfectionistic achievement predispose individuals to regard achievement as the central source

of self worth and esteem. The drive toward identifying meaning in life that is one of the hallmarks of integrative reminiscence may provide individuals who are vulnerable to depression with additional sources of self-worth, thereby, providing them with increased protection against the onset of depression. For example, Butler (1963) emphasized that sources of esteem and worth such as the development of personal values and commitments, the identification of spiritual or philosophical meaning, and the recognition of one's place in an intergenerational continuity are outcomes of a successful life review.

Instrumental Reminiscence and the Mediation of Depressive Symptomatology: A Stress and Coping Approach

The psychosocial model of depression proposed by Billings and Moos (1982; 1985) is a useful framework for conceptualizing the onset and maintenance of depression (e.g., Cappeliez, 1993). This model assumes that depression results from an interplay between the situational demands experienced by individuals, their cognitive appraisal of the coping resources they have to meet these demands, and their coping responses to the stressors.

When a potentially stressful event is encountered, individuals first evaluate the importance of the event in terms of their own, or important others', well-being. They next evaluate what, if anything, can be done to overcome or prevent harm, or to improve the prospects of benefit. These primary and secondary appraisals converge to determine whether individuals regard the person-environment transaction as significant to their well-being, and if so, whether it is primarily threatening (containing the possibility of harm or loss), or

challenging (holding the possibility of mastery or benefit) (Lazarus & Folkman, 1984).

Challenge appraisals (in which individuals see the situation as something they can change or cope with) typically initiate active, problem-focused coping responses, which are associated with freedom or relief from depression in older adults (Cappeliez & Blanchet, 1986; Folkman, Lazarus, Dunkel-Schetter *et al.*, 1986; Foster & Gallagher, 1986; Fry, 1993; Gerbaux, Vezina, Hardy, & Gendron, 1988; Vezina & Bourque, 1984; 1985).

Individuals' appraisals of stressors and the coping responses they make are determined by their personal resources and the resources available in their environment. Personal resources such as self-esteem, self-efficacy, a sense of personal meaning, adaptive beliefs about personal control, and rewarding commitments and values can diminish the probability of developing depression by reducing the perceived frequency or intensity of stressful situations, or by facilitating the use of functional coping strategies (Bandura, 1977; Fry, 1989, 1993; Lazarus & DeLongis, 1983; Pearlin, Lieberman, Menaghan, & Mullen, 1981). In turn, depression can have a negative impact on each of the aforementioned resources.

Instrumental reminiscence involves recollections of past coping activities, including memories of plans developed to solve difficult situations, goal-directed activities, and the achievement of one's own goals or goals one helped others meet (Watt & Wong, 1991; Wong & Watt, 1991). Recollection of instrumental memories can help depressed individuals to: a) recognize and develop coping resources that have been identified as important aspects of adaptive coping with depression (e.g., self-esteem, self-efficacy, and positive control beliefs); b) implement coping strategies that promote challenge-oriented appraisals and an active, problem-

focused approach to current problem-solving; and, c) identify concrete, specific coping strategies that have been effective in the past and that may be productively applied to current stressors (e.g., seeking social support in times of crisis). The links between instrumental reminiscence and psychosocial theories of depression are developed in the next sections and summarized in Table 3.

Coping Resources

Self-esteem and efficacy/control beliefs are personal resources that play an important role in the coping process because they support individuals' belief that they can control or deal effectively with on-going stressors. When individuals believe they are capable of managing negative events in their environment, they are less likely to appraise these events as threatening and more likely to appraise them as challenges that can be coped with effectively (Lazarus & Folkman, 1984). These challenge-oriented appraisals lead individuals to take active, problem-focused approaches to alter situations. For example, in a study of community-dwelling older adults, Fry (1993) found that perceptions of self-efficacy lead to greater problem-solving initiatives and integration of social support, moderating the effects of negative experiences. In contrast, low perceived self-efficacy and self-esteem have been found to be negatively related to psychological adjustment and effective coping (Abler & Fretz, 1988; Holahan & Holahan, 1987; Taylor, 1983; Woodward & Wallston, 1987). When individuals believe they are unable to deal effectively with a difficult experience, they typically view the stressor as a threat and use escape or avoidant coping activities such as, wishing the problem

Table 3

Instrumental Reminiscence Processes and Therapeutic Goals in the Treatment of Depression

| Reminiscence Processes | Goals |
|--|---|
| <p>Normalize stress and coping processes.</p> <p>Increase coping resources (e.g., self-esteem, self-efficacy, life control).</p> <p>Increase challenge-oriented appraisals of stressors.</p> | <p>Recollection of past coping experiences.</p> |
| <p>Decrease primary appraisals of unattainable goals as critical to self-worth.</p> | <p>Review of the appropriateness of current goals and commitments.</p> |
| <p>Increase problem-focused coping resources.</p> | <p>Recall of concrete problem-solving strategies successfully used in the past.</p> |
| <p>Decrease escape-avoidance coping responses.</p> | <p>Recognition of the vast array of coping skills and experiences generated over the life span.</p> |

would disappear. Through their impact on adaptive coping, self-esteem and efficacy/control beliefs serve to mediate between the experience of stress and the onset of depression (Billings & Moos, 1982, 1985; Cappeliez, 1993).

Instrumental reminiscence may exert a positive effect on individuals' self esteem and efficacy/control beliefs via recall of mastery experiences in which individuals acted effectively and competently to control their environment. This goal may be obtained by recalling episodes of successful past coping, with a focus on individuals' crucial contribution to the achievement. For example, individuals may recall times when they responded efficiently to a crisis such as an illness in the family, or when they developed solutions to long-term stressors such as being denied the opportunity to pursue educational ambitions because of financial hardship. The concrete and vivid nature of these memories may have a greater impact on peoples' perceptions of their control/efficacy and self-esteem, as well as their subsequent behaviours, than do abstract discussions about level of control and how to exert it (Nisbett & Ross, 1980).

Appraisal Strategies

In addition to promoting control and self-efficacy beliefs, instrumental reminiscence can foster adaptive coping in that memories may be used to highlight specific strategies that promote challenge appraisals and an active, problem-focused approach to coping. Through this process, individuals can rediscover important coping strategies within their own experience. For example, a major feature of adaptive coping is to renounce or relegate to the periphery of

importance those roles and commitments that are no longer rewarding and to invest in others more in tune with current conditions of living (Pearlin, 1980). Throughout life, failed ambitions and dreams, changes in the environment in which one acts, and changes in energy and resources available to a person, necessitate major shifts in long-standing commitments. If these changes in priority are not accomplished when they are required, individuals may continue to struggle without reward, and thereby experience losses in morale and reductions in adaptation (Lazarus & DeLongis, 1983). By examining past experiences when individuals successfully negotiated role changes, the importance of taking stock of roles and commitments and re-evaluating them in the light of present circumstances to identify the appropriate goal in a current coping episode can be highlighted and reinforced.

Other problem-solving skills that promote challenge appraisals and an active problem-focused orientation to coping may also be illustrated through clients' own recollections. For example, defining aspects of a stressful situation that can and cannot be changed, brainstorming alternative solutions to problems, and deciding on an appropriate solution are all essential features of successful coping individuals can recognize in themselves through reminiscence (Nezu, Nezu & D'Zurilla, 1987). By illustrating the importance of identifying the possibilities for change and adaptation that exist in a stressful situation and the development of appropriate and meaningful goals in coping activities, instrumental memories make stressors manageable. The threatening and over-whelming nature of stressors is thus reduced, enabling clients to address negative experiences with a challenge-orientation and a dynamic approach to problem-solving.

Coping Responses

Instrumental reminiscence can have a positive impact on current coping practices by influencing the type of coping responses that are selected. Recent research indicates that older adults who successfully cope with depression use an active and problem-solving approach (Cappeliez & Blanchet, 1986; Foster & Gallagher, 1986; Fry, 1993; Gerbaux, Vezina, Hardy, & Gendron, 1988; Vezina & Bourque, 1984; 1985). Folkman and Lazarus (1986) describe problem-focused coping as a strategy which involves the individual in a deliberate goal-oriented effort to alter the situation (e.g., "I knew what had to be done, so I doubled my efforts to make things work"), coupled with an analytic approach to solving the problem (e.g., "I made a plan of action and followed it", "I came up with a couple of different solutions to the problem"). Instrumental reminiscence, with its focus on the recall of successful problem-solving strategies used in the past that can be applied to current problematic situations, encourages individuals to use the active, problem-focused coping responses that have been identified as anti-depressive.

In addition to focusing the individual on doing something to alter the situation, recollection of past, effective strategies provides the individual with specific strategies to apply. For example, an individual may recall bartering his or her services during the Depression and subsequently implement this problem-solving activity as a viable solution to current reduction in income following retirement. Furthermore, reviewing past coping activities normalizes the experience of environmental stressors and the need to cope with them as a continuous process which clients have participated in successfully throughout life. The idea that coping activities are an expected part of living gives some meaning to coping efforts and is likely to initiate more

active and less avoidant coping activities (Wong, 1989).

In addition to encouraging problem-focused coping activities and appropriate goal-setting, successful application of past problem-solving skills should also contribute to an enhanced sense of control and self-esteem as individuals gain evidence of their current ability to act effectively. Thus, application of these skills will promote self-esteem and personal control which, in turn, encourages positive, challenge-oriented appraisals and more problem-focused and less escape-avoidance coping responses, thereby creating a positive feedback loop. Fry (1989; 1993) has provided support for this conjecture in a demonstration of reciprocal influences between engagement in problem-solving and self-efficacy. Casey and Grant (1993) have also noted that reminiscence that focuses on valuable accomplishments can help individuals regain a sense of control, purpose, and self-efficacy in the present. Furthermore, the focus of instrumental reminiscence on identifying coping skills within the client's own repertoire may increase motivation for and involvement in therapy--two factors that have been identified as significantly related to clinical improvement in older adults, across therapeutic interventions (Weiss & Lazarus, 1993).

Non-specific Therapeutic Factors in Reminiscence Therapy

In addition to the specific therapeutic benefits offered by each type of reminiscence, the use of memories as a therapeutic modality per se may be particularly beneficial to depressed older clients for several reasons. First, reminiscing is a familiar activity to older adults and, therefore, the use of personal recollections as a forum for therapeutic work may be less

threatening and more appealing to older adults than other forms of therapy. Second, the use of personal memories provides older clients with the sense that their life experience is important to their current adaptation--that relief from depression does not require them to abandon the past and learn new approaches to living that are not consonant with their experience. Rather, clients are provided with a sense of normalcy and competency through the use and analysis of their own experience. Finally, the focus on re-establishing a positive view of the past provides clients with feelings of self-worth and self-esteem as they begin to accept, respect, and enjoy what they have been and done in their lifetime. It is likely that the combination of a non-threatening approach and the promotion of a sense of normalcy, competence, and esteem within the therapeutic relationship will promote increased commitment and motivation to participate in therapy, setting the stage for acceptance and implementation of the specific therapeutic techniques offered by integrative and instrumental reminiscence.

Conclusion: Processes of Change in Integrative and Instrumental Reminiscence and the

Mediation of Depressive Symptomatology

A review of controlled outcome research on psychotherapeutic treatment for depression indicates that of the intervention approaches so far studied, there is little evidence for the relative superiority of any one approach over another. As such, the focus of research has shifted from simple outcome evaluation toward identification of the factors responsible for improvement that exist within a therapeutic modality (Robinson, Berman, & Neimeyer, 1990). Given this movement in the depression literature, the focus in the present research was to integrate an

understanding of reminiscence processes with contemporary research on depression to develop two models that identify the hypothesized therapeutic processes involved in reminiscence interventions for the treatment of depression in older adults. Two types of reminiscence--integrative (focused on constructive reattribution and reappraisal of the past) and instrumental (centred on memories of past problem-solving experiences and coping activities)--appear to have promise in the treatment of depressed older adults and are the focus of these models. In addition to the development of these models, initial exploratory data analysis was conducted to permit empirical examination of the ability of the two models to predict the processes of change that occur as individuals engage in integrative and instrumental reminiscence. Finally, the effectiveness of integrative and instrumental reminiscence in treating depressive symptomatology, in comparison to an active socialization control group, was examined in a preliminary fashion through the use of a multiple case study replication design.

Initial Empirical Investigation of Integrative and Instrumental Models: Explanatory and Therapeutic Value

Objective 1: Evaluation of the Explanatory Power of Integrative and Instrumental Models

To evaluate the ability of the models to describe, explain, and predict the cognitive and coping processes involved in integrative and instrumental reminiscence that lead to a decrease in depressive symptomatology in older adults.

Method

To address this question, a clinical intervention manual outlining how integrative and instrumental reminiscence can be implemented in a therapeutic context was developed (see Appendix A). Data collected on the cognitive and coping processes identified in the model will be examined to empirically validate the utility of the models in explaining how reminiscence affects symptoms of depression in older adults. In particular, this research will evaluate if integrative reminiscence reduces depressive symptomatology through the operations of: 1) increased self-esteem; 2) increased purpose; 3) increased personal meaning; 4) decreased levels of hopelessness; and, 5) decreased attributions of the causes of negative events to stable and global factors. Figure 1 describes the links between integrative reminiscence, processes of change, and depression and the measures used to test these hypotheses. Further, we will examine whether instrumental reminiscence decreases depressive symptomatology through the mechanisms of: 1) increased levels of personal control and esteem; 2) decreased levels of inappropriate goal-seeking that leads to appraisals of threat; 3) increased appraisal of current stressors in less threatening and more challenging ways; and, 4) use of more problem-focused and less escape-avoidance coping in dealing with current problems. Figure 2 describes the links between instrumental reminiscence, processes of change, and depression and the measures used to test these hypotheses.

INTEGRATIVE REMINISCENCE CONTENT

-Positive re-appraisal of the causes of past failures, losses, problematic relationships, recognizing the impact of historical and contextual influences

-Re-appraisal of negative events in view of their meaning in the life story vs. objective evaluation of life as good or bad

-Highlight concrete recollections of difficult past experiences that have been resolved

-Short-circuit cognitive errors through review of both successes and failures across the entire lifetime and in many domains

-Trace the development of personal values, commitments, and purpose across the lifespan

PROCESS OF CHANGE VARIABLES

-Decreased global, internal and stable attributions for the causes of negative events (Attributional Styles Questionnaire)

-Increased self-esteem (Rosenberg Self-Esteem Scale)

-Decreased hopelessness (Hopelessness Questionnaire)

-Increased personal meaning and life control (Life Attitude Profile)

OUTCOME

-Decreased depressive symptomatology (Geriatric Depression Scale, Hamilton Rating Scale for Depression, Social Adjustment Scale)

Figure 1. Measures Used to Evaluate the Hypothesized Relationship between Integrative Reminiscence, Processes of Change, and Depression

INSTRUMENTAL REMINISCENCE CONTENT

-Recall of general episodes of successful problem-solving and coping

-Recall of concrete coping strategies including formulation of the problem, goal setting, problem-solving activity, and verification

PROCESSES OF CHANGE VARIABLES

Coping Resources

-Increased self-esteem (Rosenberg Self-Esteem Scale)

-Increased sense of control over life events (Life Control Index of the Life Attitude Profile)

-Decreased adherence to inappropriate goals (Goal Seeking index of the Life Attitude Profile)

Coping Appraisals

-Decreased primary appraisals of stressful events as relevant to the self or important others (Primary Appraisal Questionnaire)

-Decreased secondary appraisal of stressful events as harmful or threatening (Secondary Appraisal Questionnaire)

Coping Responses

-Increased problem-focused and decreased escape-avoidance strategies (Ways of Coping Questionnaire-Revised)

OUTCOME

-Decreased Depressive Symptomatology (Geriatric Depression Scale, Hamilton Rating Scale for Depression, Social Adjustment Scale)

Figure 2. Measures Used to Evaluate the Hypothesized Relationship between Integrative Reminiscence, Processes of Change and Depression

Integrative Reminiscence Hypotheses

Hypothesis 2a: A comparison of pre-, mid-, and post- treatment difference scores across the Integrative and Active Socialization (AS) Control groups will demonstrate greater improvement in self-esteem as measured by the Rosenberg Self-Esteem Scale in the Integrative than the AS Control group.

Hypothesis 2b: A comparison of pre-, mid-, and post- treatment difference scores across the Integrative and AS Control groups will demonstrate less attribution of negative events to internal, stable and global factors on the Attributional Styles Questionnaire in the Integrative than the AS Control group.

Hypothesis 2c: A comparison of pre-, mid-, and post-treatment difference scores across the Integrative and AS Control groups will demonstrate greater relief from hopelessness as measured by the Hopelessness Scale in the Integrative than the AS Control group.

Hypothesis 2d: A comparison of pre-, mid-, and post- treatment difference scores across the Integrative and AS Control groups will demonstrate greater improvement in personal meaning and purpose as measured by the Life Attitude Profile in the Integrative than the AS Control group.

Integrative Reminiscence Justification

Prior research indicates that each type of reminiscence involves different psychological activities that serve different adaptive functions (Watt & Wong, 1991). The activities involved in integrative reminiscence are predicted to have a positive impact on depressive symptomatology because: 1) through review of successes and positive re-appraisal of past failures, losses and problematic relationships experienced across the entire lifetime and in many domains, cognitive errors are short-circuited leading to disconfirmation of negative beliefs about the self, world, and future and increasing positive self-evaluations (Beck *et al*, 1976); 2) re-attribution of the causes and consequences of past losses, failures and problematic relationships that takes into account an

understanding of the impact of historical and contextual influences on the reasons for negative events should reduce stable, global, and internal attributions for the causes of negative events (Alloy, *et al*, 1988); 3) re-appraisal of negative events in view of their subjective meaning in the entire life story should also reduce global and stable attributions for the causes of negative events (Alloy *et al*, 1988); 4) by highlighting concrete recollections of past experiences that have been resolved, integrative reminiscence combats the sense that life cannot change for the better and should reduce feelings of hopelessness (Alloy *et al*, 1988); 5) analysis of the life history from the perspective of subjective interpretation of the meaning of events in the life story as opposed to an objective evaluation of life as good or bad, enhances identification of internal guidelines for the evaluation of self-worth as reflected in higher scores on measures of meaning and purpose in life (Labouvie-Vief, 1982; Labouvie-Vief, Hakim-Larson, DeVoe, & Schoeberlein, 1989); 6) by tracing the development of personal values, commitments, and purpose across the lifespan additional sources of self-worth are identified over and above the achievement-based criteria that can be associated with depression--reflected in the increased scores on measures of meaning and purpose in life (Labouvie-Vief, 1982; Labouvie-Vief, Hakim-Larson, DeVoe, & Schoeberlein, 1989).

Instrumental Reminiscence Hypotheses

Hypothesis 2e: A comparison of pre-, mid-, and post-treatment difference scores across the Instrumental and Active Socialization (AS) Control groups will demonstrate greater increases in self-esteem on the Rosenberg scale in the Instrumental than the AS Control group.

Hypothesis 2f: A comparison of pre-, mid-, and post-treatment difference scores across the Instrumental and AS Control groups will demonstrate greater Life Control and moderate levels of Goal-Seeking on the Life Attitude Profile in the Instrumental than the AS Control group.

Hypothesis 2g: A comparison of pre-, mid-, and post- treatment difference scores across the Instrumental and AS Control groups will demonstrate less threat- and more challenge-oriented appraisals on the Primary Appraisal Questionnaire in the Instrumental than the AS Control group.

Hypothesis 2h: A comparison of pre-, mid-, and post- treatment difference scores across the Instrumental and AS Control groups will demonstrate more appraisals that the situation is changeable and less need to hold back from acting on the Secondary Appraisal Questionnaire in the Instrumental than the AS Control group.

Hypothesis 2i: A comparison of pre-, mid-, and post- treatment difference scores across the Instrumental and AS Control groups will demonstrate greater use of problem-focused and less use of escape-avoidance strategies for dealing with stress on the Ways of Coping Scale in the Instrumental than the AS Control group.

Instrumental Reminiscence Justification

Instrumental reminiscence is hypothesized to have a positive impact on depressive symptomatology because: 1) recall of successful coping in the past is associated with normalizing the stress and coping process and increasing coping resources such as self-esteem and personal control beliefs. These processes promote more challenge-oriented and less threat-oriented primary appraisals of stressful experiences. In turn, challenge-oriented appraisals are associated with more positive coping outcomes which mediate between stressors and the onset of depression (Folkman & Lazarus *et al*, 1986); 2) review of the appropriateness of current goals and commitments within the context of an examination of shifting goals and priorities across the lifespan should decrease the number of unattainable goals which are given a primary appraisal as

threats to self-worth; and, 3) recall of concrete coping strategies and techniques used in the past promote active, problem-focused coping responses to current stressors. This type of coping response is associated with freedom from depression in older adults (Cappeliez & Blanchet, 1986; Foster & Gallagher, 1986; Gerbaux, Vezina, Hardy, & Gendron, 1988; Vezina & Bourque, 1984; 1985).

Objective 2: Evaluation of the Therapeutic Value of Integrative and Instrumental Interventions

To determine the impact of Integrative and Instrumental reminiscence interventions on depressive symptomatology and adaptive functioning in older adults, in comparison to an active socialization control group.

Method

The second stage of this research will be to evaluate the effectiveness of Integrative and Instrumental reminiscence interventions in reducing symptoms of depression in older adults. This will be performed by analyzing the clinical significance of change on the depression and social adaptation scales in the Integrative, Instrumental, and Active Socialization Control groups. Further, the effectiveness of the two reminiscence groups in comparison to a wait-list group will be examined through a Mann-Whitney U test which compares the number of clinically improved, no change, and clinically deteriorated among the three groups.

Hypotheses

Hypothesis 3a): Difference scores from pre- and post-treatment ratings on the Hamilton Rating Scale for Depression (HRS-D; Hamilton, 1967) and the Geriatric Depression Scale (GDS; Yesavage *et al*, 1983), will demonstrate a greater decrease in depression in the Integrative and Instrumental reminiscence groups than in the Active Socialization Control group.

Hypothesis 3b): Difference scores from pre- and post-treatment ratings on the Social Adjustment Scale (SAS; Weissman & Bothwell, 1976) will demonstrate a greater increase in adaptive functioning in the Integrative and Instrumental reminiscence groups than in the Active Socialization Control group.

Hypothesis 3c): It is expected that the predicted between-group differences on the HRS-D, GDS, and SAS will be maintained at follow-up, taken three-months post-treatment.

Justification

Prior research in the area of reminiscence has provided evidence for: 1) a positive correlation between frequency of integrative and instrumental reminiscence and successful adaptation to the physical and psychological demands of aging (Wong & Watt, 1993); and, 2) a positive relationship between frequency of reminiscence and freedom from depression (McMahon & Rhudick, 1967). Furthermore, analysis of the processes involved in instrumental and integrative reminiscence indicates that these two types of recollection involve specific cognitive content and operations that provide protection against the onset and maintenance of depression (e.g., self-evaluation, causal attribution, appraisal and coping processes). This analysis provides theoretical justification for promoting integrative and instrumental types of reminiscence in the context of depression treatment. The efficacy of a reminiscence intervention in reducing depressive symptomatology, however, needs to be empirically evaluated. One

purpose of this research to determine whether group interventions that promote integrative and instrumental reminiscence will lead to improvements in adaptive functioning and depressive symptomatology exceeding those which may be expected from an active socialization control group.

Research indicates that the benefits of currently used psychotherapies (e.g., cognitive, behavioural, cognitive-behavioural, and psychodynamic) for depression are enduring. In the majority of outcome studies, improvement at post-treatment is quite similar to that observed at a later follow-up (Evans, Hollon, DeRubeis, Piacieski, Grove, Garvey, & Tuason, 1992; Robinson, Berman, & Neimeyer, 1990; Shea, Elkin, Imber, Sotsky, Watkins, Collins, *et al*, 1992). To compare the duration of the positive effects of reminiscence therapy with commonly used psychotherapies, a follow-up assessment of depression was conducted three months after the end of the intervention.

METHOD

Participants

Clients were recruited through the Psychogeriatric Clinic, the Elizabeth Bruyere Centre, the Centre for Psychological Services, religious organizations, community centres, and through local radio, television and newspaper ads (see Appendix B). The largest source of referrals (90%) came from newspaper and television advertisements, and radio interviews. Subjects entered into the study at five different times, referred to as Phase 1 to Phase 5. Phase 1 subjects were recruited and entered into the study in October 1992, Phase 2 subjects in April 1993, Phase 3 subjects in September 1993, Phase 4 subjects in January 1994, and Phase 5 subjects in March 1995.

The criteria for inclusion in the study were as follows:

- 1) sixty years of age and older;
- 2) Anglophone or fluently bilingual community-dwelling individuals;
- 3) must provide written consent to participate in the study;
- 4) must demonstrate clinically significant levels of depressive symptomatology as indicated by a score of at least 14 on the Hamilton Rating Scale clinical interview (HRS-D; Hamilton, 1967) and a score of at least 14 on the Geriatric Depression Scale self-report questionnaire (Yesavage, Brink, Lum, Heersma, Adey & Rose, 1983);
- 5) must not be currently receiving anti-depressant medication, or if taking such medication, must be stabilized on that medication for at least three months.

Participants who demonstrated the following symptoms were excluded from the study:

- 1) elevated risk of suicide on the basis of disclosure of serious intent to commit suicide during the Hamilton interview for depression or at any other time during the intake interview;
- 2) alcohol or drug abuse;
- 3) psychiatric disorder other than primary depression;
- 4) significant cognitive impairment as indicated by a score of 25 or less on the Mini-Mental State Examination (Folstein, Folstein, McHugh, 1975);
- 5) physical ailment which may seriously inhibit participation in group therapy;
- 6) current participation in another psychotherapeutic intervention.

A total of 81 persons answered the various advertisements. Fifty-two of these individuals (64%) passed the telephone screening and were given an appointment for an assessment session. Of those 52 people, 49 (94%) came to the assessment session. Of those, 40 (82%) were accepted into the study. In total, 49% of individuals who answered the ads were eventually accepted into the study.

The number of people available for participation in the study at each of the five phases was not enough to permit simultaneous random assignment to the three groups. Instead, subjects were randomly assigned to one of two groups at each phase. Assignment to groups followed an AB-CA-BC-AB-CA-BC design as depicted in Table 4. The goal was to assign 5-6 participants to each of two groups at each phase. As shown in Table 5, a total of twenty-six subjects

Table 4

Strategy for Random Assignment of Subjects to the Integrative, Instrumental, and Control Across the Five Phases of the Research Study

| <u>Phase</u> | <u>Group</u> | | |
|--------------|--------------|--------------|---------|
| | Integrative | Instrumental | Control |
| One | A | B | -- |
| Two | D | -- | C |
| Three | -- | E | F |
| Four | G | H | -- |
| Five | J | -- | I |

Note: Dashes indicate that subjects were not assigned to that group during that phase of the research.

Table 5

Number of Subjects Who Completed in Each of Five Phases of the Research Study for the Integrative, Instrumental, and Control Groups

| <u>Phase</u> | <u>Group</u> | | |
|--------------|--------------|--------------|---------|
| | Integrative | Instrumental | Control |
| One | 3 | 3 | -- |
| Two | 3 | -- | 2 |
| Three | -- | 3 | 0 |
| Four | 4 | 3 | -- |
| Five | 2 | -- | 3 |
| Total | 12 | 9 | 5 |

Note: Dashes indicate that subjects were not assigned to that group during that phase of the research.

completed the study. Over the five phases, twelve subjects completed the Integrative group, nine subjects completed the Instrumental group, and five subjects completed the Active Socialization Control group.

Attrition rates are shown in Table 6. Of the four participants who left the Integrative group before completion of the study, one subject did not attend the first session, two subjects left after the first session stating that they felt uncomfortable discussing emotions in a group situation, and one subject left after the third session due to a decline in physical health status. In the Instrumental group, one subject did not attend the first session and another subject left after the fourth session when she moved to another city. In the Active Socialization Control group, one individual did not attend the first session. One individual left after the first session due to transportation problems. Three individuals left after the third session indicating that they were not being helped by the intervention. One individual left after three sessions because family members were visiting, and one person left after the fourth session due to physical health problems.

Demographic characteristics and initial levels of depression and social adjustment of subjects who completed the Integrative, Instrumental, and Active Socialization Control groups are shown in Tables 7 and 8 respectively. In general, the Integrative and Instrumental groups have approximately equal numbers of men and women participants. As well, there is as a broad range of ages, educational achievement, marital status, and physical health status in both experimental groups. The control group is somewhat more homogeneous being comprised of more females than male and more individuals with high educational achievement than the two

Table 6

Attrition Rates in the Integrative, Instrumental, and Control Across the Five Phases of the Research Study

| <u>Phase</u> | <u>Group</u> | | |
|--------------|--------------|--------------|---------|
| | Integrative | Instrumental | Control |
| One | 1 | 0 | -- |
| Two | 1 | -- | 2 |
| Three | -- | 1 | 4 |
| Four | 0 | 1 | -- |
| Five | 2 | -- | 1 |
| Total | 4 | 2 | 7 |

Note: Dashes indicate that subjects were not assigned to that group during that phase of the research.

Table 7

Demographic Characteristics of the Integrative, Instrumental, and Control Groups

| <u>Variable</u> | <u>Group</u> | | |
|-----------------------------|------------------------|------------------------|-----------------------|
| | Integrative | Instrumental | Control |
| <u>Gender % (no.)</u> | | | |
| Female | 42 (5) | 55 (5) | 80 (4) |
| Male | 58 (7) | 44 (4) | 20 (1) |
| <u>Age (years)</u> | M = 65.33 SD = 5.05 | M = 67.22 SD = 7.14 | M = 67.8 SD = 4.66 |
| <u>Education % (no.)</u> | | | |
| Some High School or Less | 17 (2) | 0 (0) | 0 (0) |
| Completed High School | 25 (3) | 22 (2) | 0 (0) |
| Some College- University | 8 (1) | 22 (2) | 40 (2) |
| Completed College | 17 (2) | 12 (1) | 20 (1) |
| Completed University | 33 (4) | 44 (4) | 40 (2) |

Table 7 (continued)

Demographic Characteristics of the Integrative, Instrumental, and Control Groups

| <u>Variable</u> | <u>Group</u> | | |
|---|--------------------|---------------------|----------------|
| | <u>Integrative</u> | <u>Instrumental</u> | <u>Control</u> |
| <u>Marital Status %</u> <u>(no.)</u> | | | |
| Married | 33 (4) | 56 (5) | 0 (0) |
| Separated | 8 (1) | 0 (0) | 20 (1) |
| Divorced | 67 (5) | 22 (2) | 20 (1) |
| Widowed | 8 (1) | 22 (2) | 20 (1) |
| Single | 8 (1) | 0 (0) | 40 (2) |
| <u>Subjective Rating of</u> <u>Physical Health %</u> <u>(no.)</u> | | | |
| Very Poor | 0 (0) | 0 (0) | 0 (0) |
| Poor | 8 (1) | 0 (0) | 0 (0) |
| Average | 25 (3) | 33 (3) | 40 (2) |
| Good | 42 (5) | 56 (5) | 20 (1) |
| Very Good | 25 (3) | 11 (1) | 40 (2) |

Table 8

Pre-test Depression and Social Adjustment Scores of the Integrative, Instrumental, and Control Groups

| <u>Variable</u> | <u>Group</u> | | |
|------------------------------------|------------------------|------------------------|------------------------|
| | Integrative | Instrumental | Control |
| Geriatric Depression Scale | M = 20.58 SD = 3.82 | M = 18.87 SD = 4.29 | M = 19.18 SD = 4.76 |
| Hamilton Rating Scale - Depression | M = 21.67 SD = 4.31 | M = 22.22 SD = 4.27 | M = 21.78 SD = 4.01 |
| Social Adjustment Scale | M = 1.72 SD = 0.52 | M = 1.41 SD = 0.41 | M = 2.08 SD = 0.66 |

experimental groups. Pre-test levels of depression on the HRS-D and the GDS indicate that all three groups demonstrate moderate to severe depression prior to engaging in the research project. Social adjustment scores demonstrate greater dysfunction than an average community-dwelling sample, but are not as disturbed as those shown in Weissman's initial normative sample of acutely depressed individuals (Weissman, Prusoff, Thompson, Harding, & Myers, 1978). The three groups do not differ in terms of social adjustment.

Procedure

The initial screening and assessment of volunteers was performed in two parts. First, applicants to the study were contacted by telephone. They were given a summary of the purpose of the study and the conditions of participation, they were assured of confidentiality of information, and they were asked a standard series of questions about themselves and their condition (see Appendix C). Second, if the telephone screen was passed, participants were asked to attend an interview session held either at their home or at the Centre for Psychological Services. The interview was conducted by the author, a student in the Clinical Psychology doctoral program at University of Ottawa. During this interview, participants were asked to sign a consent form informing them that the testing and therapy were free of charge, that their participation was voluntary, and that they were free to withdraw from the study at any time (see Appendix D). They were then given the MMSE exam, the Hamilton Interview for Depression, and the inclusion and exclusion criteria were discussed. Participants were then asked to fill out the Geriatric Depression Scale and a Demographic Information Questionnaire.

Participants who did not meet the inclusion and exclusion criteria were given an appropriate explanation as to why they were refused and they were offered therapy outside the context of the study. Subjects who did meet the inclusion and exclusion criteria were given the time and date of the first meeting of the condition to which they had been randomly assigned.

Prior to the first session of the intervention, each participant in the study completed the following measures in one or two sessions, depending on their tolerance: the consent form; Geriatric Depression Scale; Social Adjustment Scale; Effectance Motivation Scale; Hopelessness Scale; Self-Esteem Scale; Attributional Style Questionnaire; Life Attitude Profile; Appraisal Questionnaire; and Ways of Coping-Revised (see Appendix E). The author was present on the first assessment occasion(s) to help subjects fill out the questionnaires. The initial assessment session took approximately one and a half hours. At the mid-point of the intervention (after session three) and at the end of the sixth week, group participants were again assessed on all these measures. The second and third assessments were performed at home by participants and were returned directly to the group leader or were mailed to the author. Two follow-up therapy sessions were held one and three months after the end of the six-week intervention. The follow-up sessions were consistent in content with the therapeutic goals of the treatment group (i.e., subjects in the six-week Integrative treatment group engaged in Integrative reminiscence at the follow-up sessions). To compare the duration of the positive effects of reminiscence therapy with commonly used psychotherapies, a follow-up assessment of depression was conducted after the second follow-up meeting (i.e., three months after the end of the intervention) using the self-report GDS and the interview-based Hamilton Rating Scale for Depression.

Format of the Interventions

The sessions were conducted in a group format with approximately four participants and one leader. The two reminiscence groups consisted of six weekly sessions of 90 minutes. The six week duration was chosen based on findings from outcome studies evaluating psychotherapeutic treatment for depression which have shown that cognitive therapy often leads to rapid symptom reduction. Indeed, significant alleviation of depression occurs within the first few sessions and weeks of therapy (DeRubeis, Evans *et al*, 1990). In addition, this time frame is a parsimonious schedule for an initial exploratory approach to process and outcome research.

The memories recalled focused on a different theme during each weekly session (see Appendix A). The themes were derived from Birren's (1991) guided autobiography approach and included: family history, life accomplishments, major life turning points, history of loves and hates, stress experiences, and life meaning and purpose. The reminiscence group members were asked to write a short response to the week's theme and then bring it in for discussion with the group at the following session (see Appendix A).

The leader of the Integrative group prompted the recall of experiences that provide a sense of meaning and purpose in life, involve coming to terms with or accepting past negative experiences, engage a positive evaluation of how one measures up to one's ideals, and demonstrate some continuity between participants' sense of self in the past and their self-beliefs now (see Appendix A).

The leader of the Instrumental reminiscence group focused on recollections of past problem-solving including memories of past plans, goal-directed activities, the attainment of

goals, helping others solve their problems, past attempts to overcome difficulties, or drawing upon past experience to solve present problems (see Appendix A).

Participants in the Active Socialization Control group were invited to participate in a series of six weekly meetings dealing with topics of concern to contemporary older adults, such as: sensory changes and their impact on daily functioning; current changes in family patterns and relationships; discussion of the impact of social and political concerns on the aging population; creativity and aging (see Appendix E). Members of this group were also asked to prepare a short written discussion of the week's theme. Participants who were assigned to the Active Socialization Control group were offered the opportunity to participate in one of the experimental groups following the Control group. Data were not collected from individuals in the treatment groups who had previously participated in the Control group.

Therapeutic Modality

Procedures used by the NIMH comparative study of depression treatments (Elkin, Pilkonis, Docherty, & Sotsky, 1988) were adopted to ensure that the active ingredients in the treatments were actually delivered. Specifically, the therapist received training in all three interventions. Training involved reading the treatment manual, review of training tapes, and discussion and role-play sessions conducted during a training period spanning four weeks. The therapist received two hours of supervision per week during the six weeks of the intervention and after the two follow-up sessions. This study did not use formal random checks to ensure that the treatment modality was delivered as described in the manual. However, the clinical supervisor

and/or the author monitored all sessions in the therapy phase through a one-way mirror and provided supervision to the therapist on a weekly basis to ensure correct implementation of the treatments.

Intervention Setting and Therapist

The intervention was provided at the Centre for Psychological Services of the University of Ottawa. The Centre for Psychological Services is a community-based mental health facility which serves a broad spectrum of clientele from the Ottawa-Hull area. The Centre is staffed by registered clinical psychologists who provide clinical supervision to doctoral-level interns in clinical psychology. The Centre is equipped with soundproof rooms and audiovisual equipment. Therapy was provided by a Master's level clinical psychologist with approximately 15 years experience in counselling. She was supervised by a clinical psychologist registered in the province of Ontario who is on staff at the Centre for Psychological Services.

Measures

Screening Measures

Telephone Screening Procedure

The telephone screening procedure was devised for the purposes of this study. It was designed to provide an initial screening of those individuals who responded to the advertisements. It includes questions pertaining to the inclusion and exclusion criteria for this study, and some general information concerning what is required from the selected subjects (see

Appendix C).

Cognitive Functioning

The Mini-Mental State Examination (MMSE; Folstein, Folstein, & McHugh, 1975) measures the degree of cognitive impairment on the basis of a short interview. It evaluates orientation (e.g., can you tell me what season it is?), memory (e.g., recall three objects after a short delay), and attention (e.g., count backwards from 100 by 7's). The MMSE yields a range of scores from 0-30. A score at or below 24 is indicative of the presence of cognitive impairment. The MMSE is reliable during 24 hour test-retest by single ($r=.89$) or multiple examiners ($r=.83$), and during 28 day test-retest by single examiners ($r=.98$). Concurrent validity was established with the Weschler Adult Intelligence Scale. The Pearson correlation for the MMSE and the WAIS Verbal IQ was .78 and .66 with the Performance IQ. Criterion validity was established when the MMSE reliably distinguished 206 patients with dementia, dementia and depression, uncomplicated depression, and normals. This scale was used to screen out potential participants who demonstrated cognitive deterioration.

Hamilton Rating Scale for Depression

The Hamilton Rating Scale for Depression is a measure designed to assess the presence of depressive symptomatology on the basis of a clinical interview. The scale contains 17 variables, which are scored in terms of categories of increasing intensity ranging from 0-2 to 0-4. Examples of variables include depressed mood, psychomotor retardation, and changes in work

and interests. The possible range of scores is 0 to 53. Yesavage *et al.* (1983) have reported a mean score of 5.43 for a normal population, 13.35 for mildly depressed, and 25.42 for severely depressed.

A recent validation of the HRS-D (Ramos-Brieva & Cordero-Villafila, 1988) indicates good inter-rater reliability ($r= 0.99$), split-half reliability ($r= 0.89$), and alpha reliability ($r=0.72$). They also report good concurrent ($r= 0.82$) and content (average frequency = 62%) validity. A factor analysis of the HRS-D revealed five factors which explained 56% of the total variance. The HRS-D was used to select participants meeting the criteria for inclusion in the study.

Sociodemographic Variables Measure

On a measure developed for this study, participants reported their age and sex. On five-point Likert scales they indicated marital status (married, separated, divorced, widow/widower, or never married), educational level (eighth grade, high school, some college/vocational school, college degree, or professional degree), and health status (acute or chronic disorders, overall level of physical health). Higher scores on the education and physical health scales represents more education and better health, respectively.

Process Measures

Ways of Coping-Revised

On the Appraisal Questionnaire, subjects are first asked to describe the most stressful event that had occurred to them in the last week. This event is then rated on a scale from 0 (not

at all stressful) to 100 (extremely stressful). Primary appraisals of what is at stake in the stressful encounter described in the first part of the questionnaire were measured by 11 questions each in a 5-point Likert scale format (Folkman & Lazarus, 1986). The scale is comprised of a 4-item sub-scale involving threats to own self-esteem with total scores ranging from 0-16 and an additional, three-item subscale that measures threats to one's own physical and emotional well-being with total scores ranging from 0-12. Three single items measure concern for a loved-one's well-being and a fourth single item asks the subject to rate "Other" stakes that are threatened. The scores on these single items range from 0-4. Higher scores indicate greater perceived threat. The items for this scale were selected from subjects' responses to open-ended questions and a review of the literature and were organized into the sub-scales according to a principal factor analysis with oblique rotation (Folkman & Lazarus, 1980). The mean coefficient alpha over five administrations was .78 for the self-esteem sub-scale and .76 for the threat to a loved one's well-being sub-scale. This scale was used as an outcome measure to compare pre-, mid- and post-treatment scores within the Instrumental reminiscence group and to compare these difference scores between the Instrumental and Active Socialization (AS) Control groups.

Secondary appraisal of coping resources was measured with four items designed by Folkman & Lazarus (1986) which ask subjects to indicate on a 5-point Likert scale the extent to which the most stressful encounter of the past week was one "that you could change or do something about", "that you had to accept", "in which you needed to know more before you could act", and "in which you had to hold yourself back from doing what you wanted to do". These questions are single item-measures that range from 0 (does not apply) to 4 (applies a great

deal). This scale was used as an outcome to compare pre-, mid- and post-treatment scores within the Instrumental reminiscence group and to compare these difference scores between the Instrumental and AS Control groups.

Coping strategies were assessed with a 29-item shortened version of the original 51-item Ways of Coping Questionnaire-Revised (Folkman & Lazarus, 1986). The questionnaire contains a broad range of coping and behavioural strategies that older adults use to manage internal and/or external demands in a stressful encounter. The scale is made up of eight subscales: Confrontation (4 items); Accepting Responsibility (4 items); Self-Control (4 items); Escape-Avoidance (3 items); Distancing (4 items); Positive Re-appraisal (4 items); Problem-solving (3 items), and Seeking Social Support (3 items). Each item is scored on a 4-point Likert scale ranging from 0 (not used) to 3 (used a great deal). Scores on 3 item sub-scales ranges from 0-9, and on 4 item sub-scales from 0 to 12. Higher scores indicate greater use of a coping response. This scale was used as an outcome to compare pre-, mid- and post-treatment scores within the instrumental reminiscence group and to compare these difference scores between the Instrumental and AS Control groups.

The original Ways of Coping-Revised items were drawn from subjects' responses to open-ended questions and a review of the literature (Folkman & Lazarus, 1980) and were organized into the sub-scales using alpha and principle factoring with oblique rotation. The eight subscales account for 46.2% of the variance and alpha values for the scales range from .61 to .79 over five administrations. The shortened version of the Ways of Coping-Revised was developed by Vezina & Gerbaux (unpublished manuscript).

Hopelessness

The Hopelessness Scale (Beck, Weissman, Lester & Trexler, 1974) is a 20-item, true/false, self-report measure intended to tap the degree of respondents' general level of hope. The range of scores on this measure is from 0-20. High scores on this scale indicate greater hopelessness and these individuals endorse such items as "Things just won't work out the way I want them to". Although Beck does not provide clear cut-off points to indicate clinical levels of hopelessness, scores in the normal population are typically around 2.67 (2.58), those with previous psychiatric history range between 6.28 (5.52)- 8.94 (6.05), and individuals who are likely to demonstrate a relapse in depression score in the range of 14.38 (5.58) (Beck, Steer, Kovacs, & Garrison, 1985).

Internal consistency ratings are high, KR-20 = .83 - .93, in clinical populations. However, only one study of test-retest reliability is available, .61. Comparison with clinical ratings of hopelessness provides concurrent validity in the range of .66-.74. This scale was used as an outcome to compare pre-, mid- and post-treatment scores within the Integrative reminiscence group and to compare these difference scores between the Integrative and AS Control groups.

Causal Attributions

The Attributional Styles Questionnaire (Seligman, Abramson, Semmel & vonBaeyer, 1979) consists of 12 hypothetical situations, 6 describing good outcomes and six describing bad outcomes. For each situation, subjects are asked to name the one major cause of the outcome described. The subjects then rate each cause on a 7-point scale for degree of internality, stability,

and globality. In addition, subjects rate how important each situation would be if it happened to them. Scores are grouped together to form two scales, one for good and one for bad outcomes. Mean scores range from 1-7 on each of the importance, internal, stable, and global sub-scales of the two good and bad outcome scales. Individuals with low depression scores (BDI) typically score around 3.9 (.7) for internality, 3.9 (.9) for stability, and 4.0 (1.1) for globality on situations with bad outcomes. Individuals with mild to moderate elevations on the BDI score in the range of 4.7 (1.0) for internality, 4.6 (.8) for stability, and 4.7 (1.0) for globality, on bad outcomes (Seligman, Abramson, Semmel & vonBaeyer, 1979).

This questionnaire has modest internal consistency ranging from .44 to .69. Test-retest reliability is stable in non-clinical populations and decreases in clinical populations as the patient nears discharge. Criterion validity has been demonstrated by reliable discriminations between depressed and non-depressed adults.

We have made minor adaptations to this instrument by devising hypothetical situations that may be more relevant to older adults (see Appendix E). The bad outcome scale was used to compare pre-, mid- and post-treatment scores within the Integrative reminiscence group and to compare these difference scores between the Integrative and AS Control groups.

Self-Esteem

Self-esteem was assessed with the Rosenberg Self-Esteem Scale (1965). The instrument consists of ten items based on a 4-point Likert scaling format, ranging from "strongly agree" to "strongly disagree". The range of possible scores is from 10 to 40. Scores of 20 and below are

considered to indicate low self-esteem, 21-30 moderate self-esteem, 31-40 indicate high self-esteem.

The original normative sample reported by Rosenberg (1965) included a total of 5,024 high school students from 10 randomly selected schools in New York State. He reported a reliability coefficient of .92, and Silber and Tippett (1965) report a test-re-test reliability score of .85. In terms of convergent validity, Silber and Tippett (1965) report correlations of .67, .83, and .56 with three other measures of self-esteem. This scale was used as an outcome to compare pre- and post-treatment scores within the Integrative reminiscence group and to compare these difference scores between the Integrative and AS Control groups.

Personal Meaning and Control

This variable was assessed with the Life Attitude Profile-Revised (Reker, Peacock, & Wong; 1987). The revised version of this scale measures six factorially derived dimensions: Life Purpose, Life Coherence, Life Control, Death Acceptance, Existential Vacuum, and Goal Seeking. Scores on each of the dimensions range from 8 to 56. Two indexes are derived from these dimensions: Personal Meaning Index (Purpose + Control); and, Life Attitude Balance Index (Purpose + Coherence + Life Control + Death Acceptance - [Existential Vacuum + Goal Seeking]). Scores on the Personal Meaning Index range from 16 to 112 and scores on the Life Attitude Balance range from minus 80 to 208. Higher scores on all scales and indices indicate a greater presence of that life attitude.

Internal consistency estimates of the factor scales range from .83 to .56. Concurrent

validity of the factor scales was strong across a number of different instruments including Dean's Alienation Scale, the Reid-Ware Internal-External Locus of Control Scale, and Shostrom's Personal Orientation Inventory. This scale will be used as an outcome to compare pre-, mid- and post-treatment scores within the Integrative reminiscence group and to compare these difference scores between the Integrative and AS Control groups.

Perceived Efficacy

Following Maddux, Norton, and Stoltenberg (1986), effectance motivation will be assessed by three five-item Likert-type questionnaire items relating to: 1) self-efficacy ("I believe I could learn to use reminiscence to effectively combat depression"); 2) outcome expectancy ("For those who can use it, reminiscing is a very effective way to combat depression"); and, 3) outcome value ("I place a lot of value in the ability to effectively combat depression"). Scores range from 1-5 on each item with higher scores representing greater efficacy, expectancy, and value.

Correlational analysis reveals that outcome expectancy ($r=.39$) and self-efficacy ($r=.40$) are independent and nonredundant in predicting behavioural intentions. Furthermore, self-efficacy expectancy was correlated positively with outcome value ($r=.39$), as was outcome expectancy ($r=.23$) (Maddux, Norton, & Stoltenberg, 1986).

Effectance motivation will assess group differences in participants' belief in the ability of the treatment to assist them at pre-, mid-, and post-treatment in order to evaluate the relationship between cognitive change, effectance motivation, and treatment efficacy.

Outcome MeasuresGeriatric Depression Scale

The Geriatric Depression Scale (Brink, Yesavage, Lum, Heersema, Adey & Rose, 1982; Yesavage *et al.*, 1983) was specifically designed to measure depression in the aged, and was originally intended as a screening instrument. This measure consists of a 30-item self-report questionnaire in a Yes/No format which covers the topics of mood quality, level of energy and motivation, hopelessness, social initiative, and subjective evaluation of various cognitive abilities and functions. The GDS can be completed in less than 15 minutes by a depressed elderly population. The possible range of scores on the GDS is 0 to 30, with higher scores representing greater depression. Yesavage *et al.* (1983) have reported a mean score of 5.75 for a normal population, 15.05 for mildly depressed persons, and 22.85 for severely depressed individuals. Yesavage *et al.* (1983) have reported a mean score of 5.43 for a normal population, 13.35 for mildly depressed, and 25.42 for severely depressed.

According to Yesavage *et al.* (1983), the GDS has a high degree of internal consistency, with a median inter-item correlation of 0.56 (range = 0.32 - 0.83). In a sample of 100 elderly subjects. Test-retest reliability coefficients were reported to be .85 over a span of one week, and .86 after a five-minute delay. Convergent validity has been assessed by calculating correlations between the GDS and well-established measures of depression. The correlation between the GDS and the Zung Self-Rating Depression Scale was found to be 0.84 while a correlation of 0.83 was found between the GDS and the Hamilton Rating Scale for Depression (HRS-D). The correlation between the Zung and the HRS-D was 0.80. All these correlations were statistically

reliable at or beyond the .001 level. The Geriatric Depression Scale will be used as an outcome measure to evaluate difference scores from pre-post-treatment measures within each group and across the three groups.

Social Adjustment Scale

The Social Adjustment Scale (SAS; Weissman & Bothwell, 1976) is a 42-item questionnaire that measures role performance, positive and negative aspects of interpersonal relationships, and inner feelings and satisfactions in six major areas of functioning: social and leisure activities; relationships with friends/extended family; roles as a spouse; and role as a parent. The scores of items are summed within each of the six major areas of functioning and a mean score is obtained. An overall adjustment score is obtained by summing the scores of all items and dividing by the number of items actually scored. We selected a sub-set of 19 questions that focused on roles appropriate in an older population (e.g., we removed the category related to work). On this shortened measure, mean scores on the overall adjustment scale range from 1 to 5 with one representing a higher level of social adjustment.

Criterion validity with a social adjustment interview and informant ratings ranged from .40 to .76 for each of the five scales, and .70 to .74 for the overall adjustment score on a sample of 76 depressed patients.

Hamilton Rating Scale for Depression

Follow-up assessment three months after completion of the intervention was measured by

the Hamilton Rating Scale for Depression. See the section on screening measures for a discussion of the psychometric properties of the HRS-D.

Data Analysis

Process Measures: Evaluation of the Explanatory Power of Integrative and Instrumental Models

Objective 1

Integrative and instrumental reminiscence are hypothesized to engage participants in cognitive and coping activities that ameliorate symptoms of depression (see Tables 2 & 3). Analysis of empirical process data collected from subjects who engage in integrative or instrumental reminiscence permits evaluation of how well the hypothesized model describes, explains, and predicts reminiscence processes that are linked to the onset and maintenance of depression.

Method.

Qualitative analysis of data collected from each participant over the course of the intervention involves:

- a) identification of patterns of intra-subject variation on psychological change processes;
- b) aggregation into groups of data that share common patterns of intra-subject variation on change processes;
- c) identification of cases that support and replicate the hypothesized relationship between reminiscence content, psychological change processes, and depression;

d) identification of demographic and diagnostic characteristics of individuals who demonstrate each of the patterns of intra-subject variation in the psychological change processes.

Rationale for the Qualitative Analysis.

For the integrative and instrumental groups, preliminary analysis is conducted at the single case study level to focus on intra-subject change in selected cognitive and coping activities (i.e., process measures). This information is critical as it identifies differences in basic forms of variability across time--information about how reminiscence works that may be lost if individual data are collapsed and presented as group data (Hilliard, 1993). It will also provide information on the reliability of the models and their generalizability.

Objective 2

To determine whether the patterns of change predicted by the Integrative and Instrumental models are more likely to occur in subjects who engage in a structured reminiscence program than subjects in an Active Socialization Control group.

Method.

Statistical analysis:

- a) classification of the intra-subject variability over the intervention into three categories of: match model, partly match model, and do not match model;
- b) Mann-Whitney U provides a statistical test of the null hypothesis that the Integrative

remembrance and Active Socialization Control groups and the Instrumental remembrance and Active Socialization Control groups were drawn from treated clinical populations with the same distribution of categorical patterns of variability. In other words, the experimental and control groups will contain the same proportion of subjects who match, partly match, and do not match the predicted models. Rejection of the null hypothesis indicates that the Integrative group has greater membership in the category that matched the model than the Control group and that the Instrumental intervention group has greater membership in the category that matched the model than the Control group.

c) The Mann-Whitney U also provides an estimate of the magnitude of the effect of the interventions (see Appendix G). This effect size is the estimated probability that a randomly sampled client from the population that is given Integrative or Instrumental therapy will have a categorical outcome superior to the outcome of a randomly sampled client from the population that is given the Active Socialization Control intervention (Grissom, 1994). An example of effect size data using the Mann-Whitney U test is: the estimated probability that a randomly sampled subject from the population that is given Instrumental therapy will demonstrate a pattern of change that matches the model than that of a randomly sampled subject from the population that is given an Active Socialization Control intervention is .7. The magnitude of the probability is judged according to the criteria of a small, moderate, and strong effect size as described by Cohen (1969).

d) The Mann-Whitney U test also provides data from which generalized odds ratios (GOR) can be generated (see Appendix G). The GOR is an additional estimate of the relationship between

therapy group membership and ordinal categorical outcome which indicates the number of subjects for which Intervention 1 is superior to Intervention 2 (Grissom, 1994). For example, if a GOR of 2.31 is obtained, it would mean that there are 2.31 times more subjects in the Integrative group who yield the predicted pattern of change than in the Active Socialization Control group.

Rationale for Quantitative Analysis.

Statistical comparisons are based on an average change score for all participants and thus do not provide information on the effects of reminiscing on cognitive processes for individual clients in the sample. Without information regarding variability of therapeutic process change, a comprehensive understanding of reminiscence processes is unavailable, and there is no way of determining the proportion of clients who fit the hypothesized model. These proportions are of great importance, however, when trying to estimate the efficacy of a given model in describing the process of change in therapy (Greenberg, 1986a).

According to Grissom (1994), the Mann-Whitney U is the appropriate test to use when outcome data is ordinal categorical because it is sensitive to the order in the dependent variable categories and thus provides a directional test of which group is superior, rather than an indication that groups differ in some way in terms of the distribution of scores in various categories (i.e., as in chi-square analysis). In this analysis, the categories of match model, partly match model, do not match model on measures of change processes is the dependent variable and group membership is the independent variable.

Outcome Measures: Evaluation of the Therapeutic Value of Integrative and Instrumental Interventions

Objective 1

To examine the hypothesis that integrative and instrumental reminiscence interventions are effective in producing clinically significant change in depression and social adjustment in a sample of older, depressed adults.

Method.

The clinical significance of the two experimental treatments will be evaluated using a strategy described by Jacobson, Follette, and Revenstorf (1984). First, the post-test score of subjects in the Integrative and Instrumental groups on the HRS-D, GDS, and SAS will be evaluated to determine whether the score is more likely to fall into a functional or dysfunctional population. Scores from a functional population will be those that fall at or beyond a value two standard deviations away from the mean of the dysfunctional population, in the direction of higher functioning. Second, a reliable change index for each patient's post-treatment score will be calculated according to the methods of Jacobson *et al.* The reliable change index identifies changes from pre- to post-test that are not likely to be due to measurement error. The use of these two indexes provides a two-fold criterion for clinical significance. Thus, only those patients whose scores have shown reliable change from pre-test levels, and whose post-test scores are likely to be in a functional population and are considered to have made a clinically significant change.

Rationale.

A limitation of statistical tests of outcome data that analyze group means is that the significance test itself imposes a criterion for determining a treatment effect that can have little clinical relevance. For example, it can demonstrate change that has minimal functional impact on the client's symptoms (Jacobson & Revenstorf, 1988). In addition, statistical tests of outcome data look at the magnitude of change from pre-test to post-test, however, the actual post-test level is more predictive of long-term functioning than is the magnitude of change (Jacobson, *et al*, 1984). Analysis of outcome data in this research from the perspective of clinical significance will indicate whether Integrative and Instrumental reminiscence interventions produce clinically meaningful reduction in symptoms of depression and improvement in social adjustment in a group of older depressed adults.

Objective 2

To examine the hypothesis that the Instrumental and Integrative reminiscence groups will demonstrate greater treatment effectiveness than an Active Socialization Control group as defined by greater statistical and clinical improvement in symptoms of depression and social adjustment.

Method.

a) Analysis of the effectiveness of the two reminiscence groups in comparison to an Active Socialization Control group will build upon the ordinal categorization of data according to

clinically significant change as described in Objective 1. Using a Mann-Whitney U test, the categories of clinical deterioration, no change, and clinical improvement on measures of depression (HRS-D; GDS) and social adjustment (SAS) are the dependent variables and group membership is the independent variable. The Mann-Whitney U test provides a statistical test of the null hypothesis that the Integrative and Control groups and the Instrumental and Control groups were drawn from treated clinical populations with the same distribution of categorical outcomes. Rejection of the null hypothesis indicates that the Integrative group is superior to the Control group and that the Instrumental intervention is superior to the Control intervention in terms of greater subject membership in the clinically improved category.

b) The Mann-Whitney U also provides an estimate of the magnitude of the effect of the interventions. This effect size is the estimated probability that a randomly sampled client from the population that is given Integrative or Instrumental therapy will have a categorical outcome superior to the outcome of a randomly sampled client from the population that is given Active Socialization Control therapy (Grissom, 1994). The magnitude of the probability is judged according to the criteria of a small, moderate, and strong effect size as described by Cohen (1969).

c) The Mann-Whitney U test also provides data from which generalized odds ratios (GOR) can be generated. The GOR is an additional estimate of the relationship between therapy group membership and ordinal categorical outcome which indicates the number of subjects for which Therapy 1 is superior to Therapy 2 (Grissom, 1994).

Rationale.

- a) The Mann-Whitney U test describes the clinical significance as well as the statistical significance of ordinal data from studies of random assignment of clients to 2 or more therapies. As such, it provides evidence of superiority of one therapy over another in the easily comprehensible, non-technical terms of ordinal categories of improvement.
- b) From a theoretical perspective, the goal of this psychotherapy research is to understand person by therapy interactions rather than solely the efficacy of a treatment. Statistical comparisons are limited in achieving this goal because they are based on an average improvement score for all participants and thus do not provide information on the effects of therapy for individual clients in the sample. Without information regarding variability of outcome, there is no way of determining the proportion and characteristics of clients who benefitted from the treatment. These proportions are of great importance, however, when trying to estimate the likelihood that a given individual will benefit from therapy (Jacobson, *et al*, 1984). The Mann-Whitney U addresses these issues by providing an estimate of the probability that a randomly sampled subject from the population treated in the reminiscence therapies will have a better outcome than those in the Active Socialization Control group. In addition, it provides an estimate of the number of subjects in a given group that are likely to show clinically significant improvement.

RESULTS

The primary goal of this research was to clarify how reminiscence contributes to the relief of depressive symptomatology in late life. This goal was addressed through the development of two comprehensive theory-based models that describe the relationship between specific content and processes individuals engage in when they reminisce, and changes in cognitive and coping activities that are linked to the onset and maintenance of depression (see Tables 2 & 3). These models and the theoretical literature upon which they are based are developed in the Introduction section of this document. Two ancillary goals were pursued in this study. First, a preliminary empirical investigation of the two models was conducted to facilitate validation and refinement of the hypothesized relationships between reminiscing and processes-of-change that can alleviate depressive symptomatology. Second, an initial outcome investigation was undertaken to evaluate whether integrative and instrumental reminiscence interventions were: a) effective in producing clinically significant improvement in depression in older adults; and, b) more effective in treating depression in older adults than an Active Socialization Control group.

The empirical investigation of process data examined the fit between empirical data and the two models of reminiscence processes. This goal was addressed by: a) developing an intervention manual that outlines the implementation of integrative and instrumental reminiscence as psychotherapeutic interventions, and a psycho-educational agenda for the Active Socialization Control group; b) operationalizing and selecting tools to measure the therapeutic processes that are hypothesized to mediate between reminiscence and alleviation of depressive symptomatology; c) recruiting and engaging older depressed adults in specified instrumental and

integrative reminiscence content; and, d) measuring the change in cognitive and coping activities at three points in a six week intervention. An experimental clinical intervention replication case study design was chosen to examine, on a single case study basis, intra-subject variation over time (Hilliard, 1993).

Process Research

Qualitative Analysis of Integrative Reminiscence

In the tradition of an experimental clinical intervention replication case study design (Hilliard, 1993), the relationship between integrative reminiscence change processes and depressive symptomatology was examined at the single case level. Inspection of each subject's change score on the GDS at post-test revealed three basic patterns of intra-subject change over time. Aggregating these data into one group would obscure the significant intra-subject variation that exists within the Integrative group. As such, the data were grouped separately on the basis of their change scores on the measure of depression (GDS) and entitled: 1) Matching group - in which all clients demonstrated clinically significant improvement on the GDS at post-test; 2) Partial Matching group - in which all clients demonstrated an improvement in depression scores on the GDS at post-test, although not at a clinically significant level; and, 3) Do Not Match group - in which clients demonstrated no change or a decline on the GDS at post-test. To facilitate an exploration of the relationship between the cognitive change processes produced in an Integrative reminiscence intervention and different outcomes for depression, the scores of each subject in the Integrative group at pre-, mid-, and post-treatment are grouped into the

categories of Match, Partly Match, and Do Not Match and are displayed on their own graph (see Figures 1H-12H in Appendix H).

The number and percentage of subjects that fit the three basic patterns are displayed in Table 9. The majority of cases, 58%, demonstrated clinically significant change on the GDS (the Match group) and also matched the expected pattern of change on the selected cognitive variables. Over the six week intervention, the basic form of the process data in the group that Matches the predicted model is shown in Figures 3 and 4. Means and standard deviations of the process data for the Matching group at pre-, mid-, and post-test are found in Table 10. In general, subjects in the group that Matches the predicted pattern of change processes demonstrate significant changes in the expected direction on at least six out of seven of the process variables. These changes are notable in that subjects in this group move across different levels of symptoms as opposed to smaller within-category movement (e.g., Hopelessness declines from the Severe category to the Mild-Minimal category).

Overall, these empirical data show some support for the predicted model of Integrative reminiscence change processes. Also, support is garnered for the hypothesis that reminiscence processes produce cognitive changes that are associated with an improvement in depression. In-depth analysis of the subjects that showed the expected pattern of change begins with the prototypical case illustration of Mr. A and is followed by examination of cases that provide replication of the pattern of change as well as cases that demonstrate the generalizability of the results to subjects with demographic and diagnostic characteristics that differ from the prototypical case.

Table 9

Percentage and (Number) of Subjects in the Integrative and Control Groups Who Match, Partly Match, and Do Not Match the Predicted Pattern of Process and Outcome Measures

| <u>Group</u> | <u>Category</u> | | |
|--------------|-----------------|--------------|---------|
| | Do Not Match | Partly Match | Match |
| Integrative | 25% (3) | 17% (2) | 58% (7) |
| Control | 20% (1) | 80% (4) | 0% (0) |

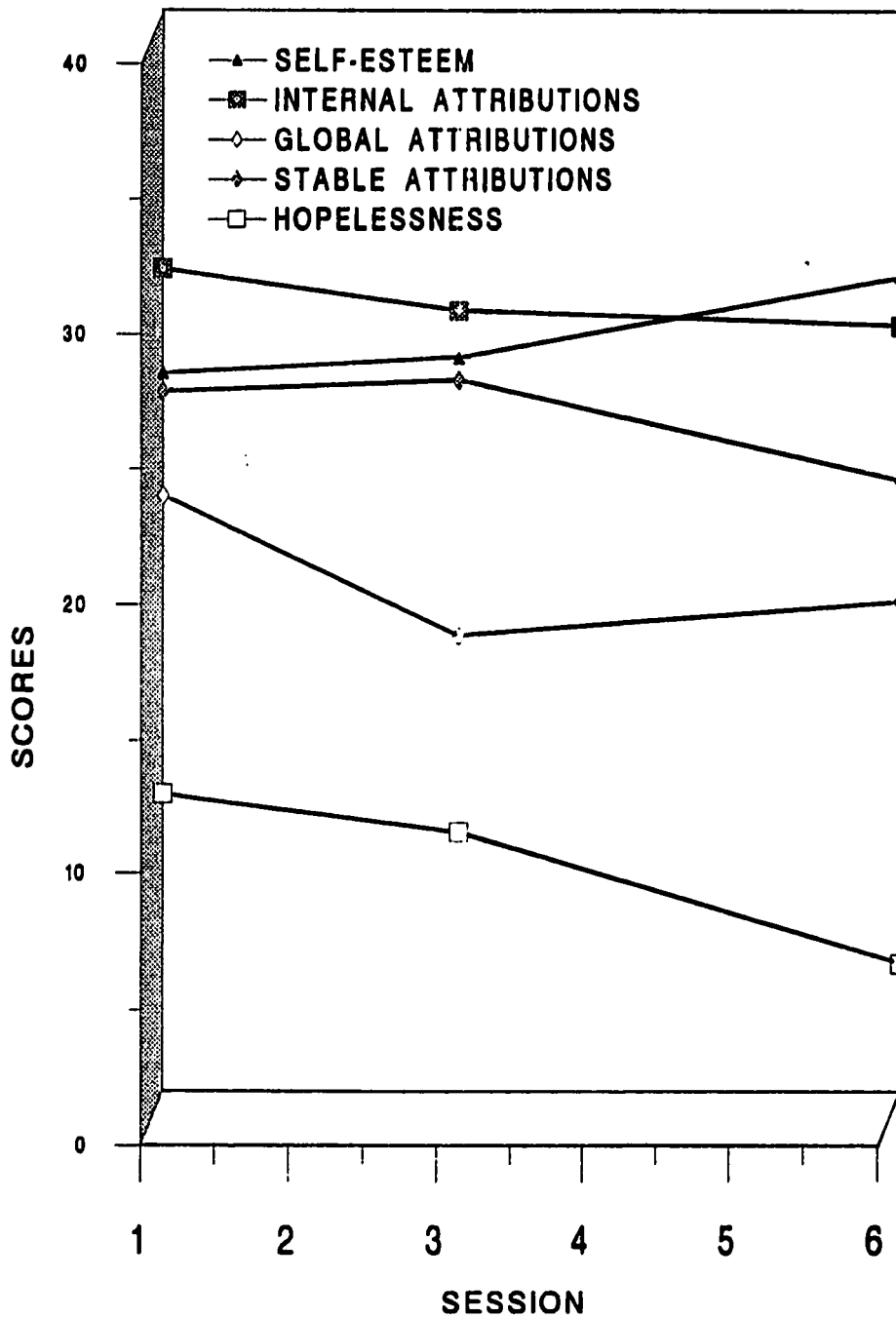


Figure 3. Mean Scores for Integrative Matching Group: Self-Esteem, Hopelessness, and Attributions

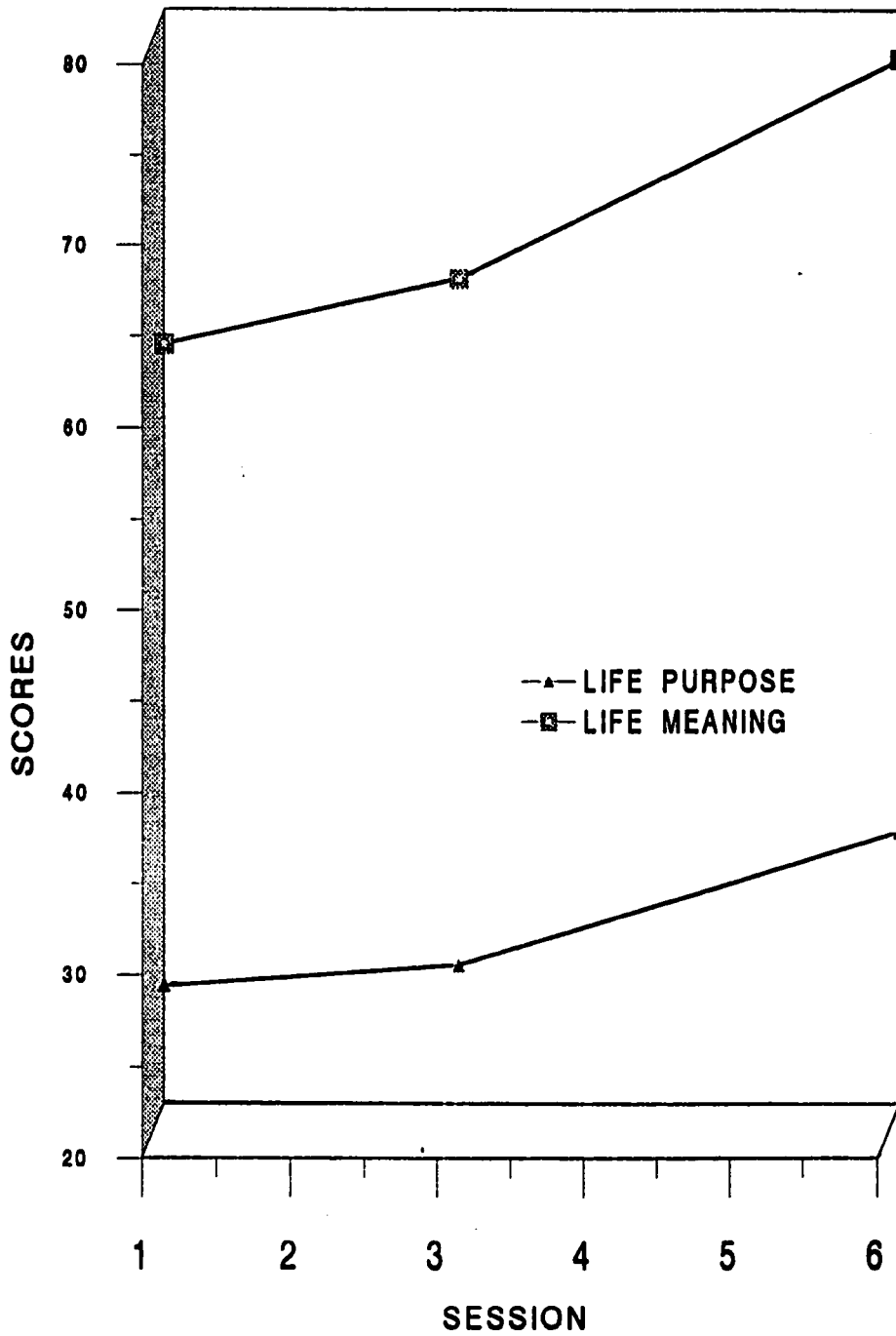


Figure 4. Mean Scores for Integrative Matching Group:
Life Meaning and Life Purpose

Table 10

Pre-test, Mid-Test, and Post-test Means and (Standard Deviations) on the Dependent Variables for Integrative Reminiscence Subjects who Match, Partly Match, and Do Not Match the Predicted Pattern of Change Processes

SELF-ESTEEM

| Group | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 26.57 (2.99) | 27.14 (4.24) | 30.14 (4.10) |
| Partly Match | 26.00 (2.83) | 20.50 (0.71) | 26.00 (5.66) |
| Do Not Match Model | 19.00 (7.81) | 22.67 (4.16) | 27.00 (6.08) |

HOPELESSNESS

| Group | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 11.00 (4.28) | 9.57 (4.47) | 4.71 (2.56) |
| Partly Match | 17.50 (0.71) | 12.00 (2.83) | 14.00 (1.41) |
| Do Not Match Model | 11.33 (7.64) | 9.67 (6.43) | 13.33 (3.51) |

Table 10 (continued)

Pre-test, Mid-Test, and Post-test Means and (Standard Deviations) on the Dependent Variables for Integrative Reminiscence Subjects who Match, Partly Match, and Do Not Match the Predicted Pattern of Change Processes

INTERNAL ATTRIBUTIONS

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 30.43 (7.55) | 28.86 (2.85) | 28.29 (3.73) |
| Partly Match | 28.50 (2.12) | 28.50 (1.73) | 29.50 (4.95) |
| Do Not Match Model | 26.67 (4.04) | 32.00 (5.29) | 32.00 (5.29) |

GLOBAL ATTRIBUTIONS

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 22.00 (6.90) | 16.86 (8.34) | 18.14 (8.82) |
| Partly Match | 26.50 (4.95) | 27.00 (4.24) | 24.50 (7.78) |
| Do Not Match Model | 22.67 (4.04) | 20.00 (3.00) | 22.00 (2.65) |

Table 10 (continued)

Pre-test, Mid-Test, and Post-test Means and (Standard Deviations) on the Dependent Variables for Integrative Reminiscence Subjects who Match, Partly Match, and Do Not Match the Predicted Pattern of Change Processes

STABLE ATTRIBUTIONS

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 25.86 (2.97) | 26.29 (3.25) | 22.57 (3.10) |
| Partly Match | 25.50 (2.12) | 25.50 (2.12) | 27.50 (3.54) |
| Do Not Match Model | 26.30 (4.73) | 31.67 (4.04) | 31.67 (4.04) |

LIFE PURPOSE

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 26.43 (3.64) | 27.57 (7.52) | 34.86 (10.22) |
| Partly Match | 24.00 (2.83) | 24.25 (1.71) | 24.00 (4.24) |
| Do Not Match Model | 22.67 (1.53) | 24.00 (7.21) | 16.67 (6.11) |

Table 10 (continued)

Pre-test, Mid-Test, and Post-test Means and (Standard Deviations) on the Dependent Variables for Integrative Reminiscence Subjects who Match, Partly Match, and Do Not Match the Predicted Pattern of Change Processes

LIFE MEANING

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 61.57 (8.89) | 65.14 (12.05) | 77.29 (12.37) |
| Partly Match | 45.00 (7.07) | 50.50 (0.71) | 50.50 (10.61) |
| Do Not Match Model | 52.00 (4.00) | 51.00 (13.11) | 45.00 (14.73) |

Results that Match the Integrative Model: Case Study of Mr. A and Case Replications

Mr. A, is a 63 year-old married man with a university education who reported being in good physical health. Mr. A had experienced an episode of depression, lasting for about one year, on one previous occasion when he was in his mid-twenties. He did not receive any treatment for depression at that time, although he was given a leave of absence from work.

Approximately three weeks before the study, Mr. A was interviewed and presented with a score of 22 on the HRS-D and 19 on the GDS. He indicated that he had been feeling depressed for 6-8 months. Mr. A's pre-test score on the GDS taken on the day the intervention began was 17, indicating a moderate level of depression. Initially, Mr. A demonstrated a low level of self-esteem, he showed a high level of hopelessness, life purpose and personal meaning were in a moderate range (one standard deviation below the mean), internal and stable attributions for the causes of negative events were within average limits, and he made few global attributions for the causes of negative events.

In general, the pattern displayed in Figure 1H indicates that as Mr. A engaged in the integrative reminiscence process, his scores on the cognitive processes changed in the manner predicted by the model. Self-esteem improved to a level indicating a moderate amount of self-worth. Hopelessness declined to a range consistent with post-test scores for treated depressed clients. Global and stable attributions for the causes of negative events decreased. Measures of life purpose and personal meaning improved significantly. In variance with the model, Mr. A's score on a measure of internal attributions for the causes of negative events dropped slightly mid-way through treatment, but his score climbed so that at post-test there was essentially no change

in comparison to pre-test scores. On outcome measures, Mr. A's score at post-test on the GDS was significantly improved (10) to within the normal range, and he demonstrated improvement in social adjustment scores, particularly in the area of his relationship with his wife. At a three month follow-up, Mr. A's score (7) was within normal limits on the HRS-D.

A series of 6 case replications which, like Mr. A's case, provide support for the model were identified (see Figures 2H-7H). Given that these seven individuals demonstrate a similar pattern of intra-subject variability, their data are aggregated to demonstrate the basic form of the change processes (see Table 10 and Figures 3 and 4). In general, these cases demonstrate increased self-esteem, decreased hopelessness, improved sense of purpose and meaning in life over the course of the intervention. One individual did not demonstrate change on the hopelessness variable, however, the score was within the normal range at pre-test. As with Mr. A, the findings with regard to the attributions of the causes of negative events show some inconsistency, with one individual demonstrating an increase on internal attributions (Figure 2H), as did Mr. A, and two persons demonstrating an increase on global attributions (Figure 2H & 3H). As predicted, all subjects showed a decrease in stable attributions for negative events. On outcome measures, all 7 cases showed a significant decrease in depressive symptomatology on the GDS and the HRS-D, and all but two cases showed significant improvement in social adjustment on the SAS.

In addition to Life Purpose and Life Meaning, the Life Attitude Profile-Revised measures several other indices of life attitudes. Although specific hypotheses concerning these measures were not developed, there were differences among the Match, Partly Match, and Do Not Match

groups that were consistent with the patterns identified in the Life Purpose and Life Meaning scales. As such, it was felt reporting the data on these additional measures may contribute important information about reminiscence processes. The additional measures include: Life Coherence (having a logically integrated analytical and intuitive understanding of self, others, and life in general); Life Control (the degree to which individuals perceive they have personal agency in directing their life); Existential Vacuum (lack of meaning, direction, goals and boredom, apathy, and feelings of indifference); and Goal Seeking (the desire to get away from the routine of life and/or to search for new and different experiences, to welcome new challenges).

As depicted in Table 11 and Figure 5, the Matching group demonstrated an increase in Coherence and Life Control from a low to moderate level over the course of the intervention. Goal Seeking decreased somewhat from a high-moderate to a low-moderate level. Inspection of individual items in this index indicated that subjects experienced a decrease on scores related to a desire to get away from the routine of life, while the search for new experiences and welcoming of new challenges remained constant over the intervention. Existential vacuum scores decreased from a moderate to a low level.

The demographic characteristics, diagnostic status, and pre-intervention levels of the dependent variables in the group that Matches the predicted change processes are shown in Table 12. Within this group, the percentage of individuals who share with Mr. A similar demographic characteristics and scores on depression indices and the dependent variables are found in the column labelled Replication. The percentage of individuals in the Matching group who differ on

Table 11

Pre-test, Mid-Test, and Post-test Means and (Standard Deviations) on the Supplementary Dependent Variables for Integrative Reminiscence Subjects who Match, Partly Match, and Do Not Match the Predicted Pattern of Change Processes

COHERENCE

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 33.67 (8.59) | 37.00 (6.73) | 43.17 (6.05) |
| Partly Match | 21.00 (9.90) | 26.00 (0) | 23.80 (7.50) |
| Do Not Match Model | 29.30 (3.79) | 27.00 (10.58) | 25.00 (9.98) |

LIFE CONTROL

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 34.17 (3.00) | 40.00 (5.20) | 41.90 (4.91) |
| Partly Match | 30.00 (7.07) | 28.50 (9.19) | 27.50 (3.54) |
| Do Not Match Model | 41.00 (1.00) | 42.30 (5.51) | 34.00 (8.49) |

Table 11 (continued)

Pre-test, Mid-Test, and Post-test Means and (Standard Deviations) on the Supplementary Dependent Variables for Integrative Reminiscence Subjects who Match, Partly Match, and Do Not Match the Predicted Pattern of Change Processes

EXISTENTIAL VACUUM

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 38.17 (6.10) | 36.29 (9.27) | 28.00 (8.46) |
| Partly Match | 42.00 (2.83) | 37.00 (1.41) | 38.50 (4.19) |
| Do Not Match Model | 38.00 (9.54) | 39.00 (5.00) | 44.00 (4.24) |

GOAL SEEKING

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 47.83 (4.22) | 47.86 (4.18) | 42.00 (9.97) |
| Partly Match | 50.00 (8.49) | 45.50 (6.36) | 49.00 (7.07) |
| Do Not Match Model | 40.33 (4.04) | 31.67 (7.09) | 33.50 (3.53) |

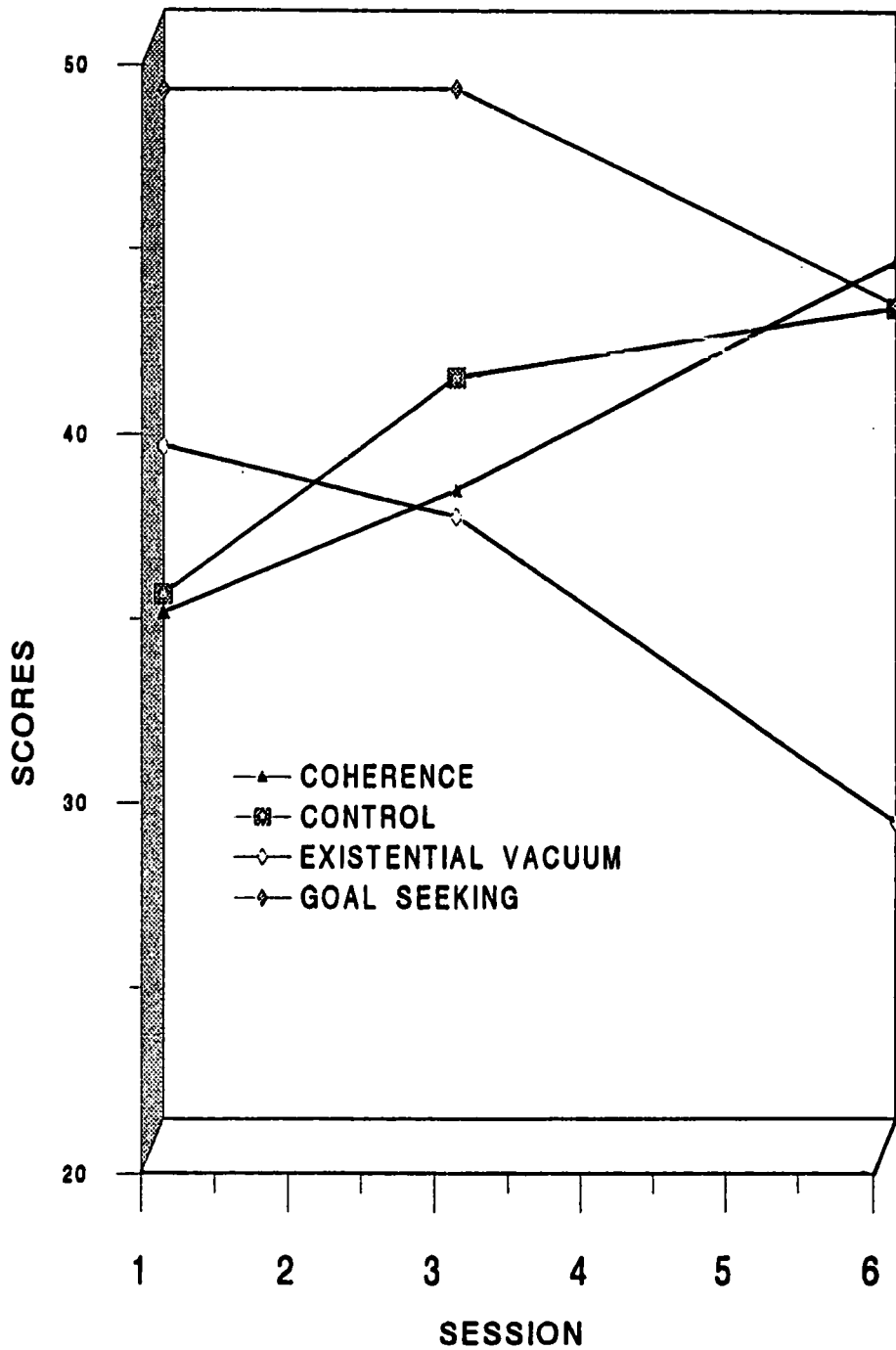


Figure 5. Mean Scores for the Supplementary Life Attitude Measures in the Integrative Matching Group

Table 12

Integrative Case Studies that Match the Predicted Pattern of Change Processes: Replication and Generalization of Demographic Characteristics, and Pre-test Scores on the Dependent Variables and Depression

| Variable | Replication | Generalization |
|------------------------|--------------------|------------------------------|
| Age | 33% Aged 60-65 | 67% Aged 65+ |
| Gender | 50% Male | 50% Female |
| Marital Status | 50% Married | 50 % Not Married |
| Education | 16% University | 83% Less than University |
| Physical Health | 33% Good | 33% Very Good 33% Average |
| Severity of Depression | 67% Moderate (GDS) | 33 % Severe (GDS) |
| Length of Depression | 83% 6 mos-1year | 16% 1year+ |
| Previous Depression | 67% Yes | 33% No |
| Self-esteem | 83% Moderate | 27% High |
| Hopelessness | 17% High | 67% Moderate 17% Low |
| Internal Attributions | 17% Moderate | 67% High 17% Low |
| Global Attributions | 67% Low | 17% High 17% Low |
| Stable Attributions | 50% High | 17% Moderate 33% Low |
| Life Purpose | 33% Moderate | 67% Low |
| Life Meaning | 50% Moderate | 50% Low |

Note: The column labelled Replication displays the percentage of subjects in the Matching group that share characteristics with the prototypical case study of Mr. A. The column labelled Generalization shows the percentage of subjects that differ from Mr. A.

these variables from Mr. A are shown in the column labelled generalization. This pattern is shown by subjects who are: older than Mr. A, female, living alone, and have less education. The predicted pattern is also demonstrated by individuals with more long-standing depression, and in individuals demonstrating both more and less severe scores on pre-intervention measures of the dependent variables. These data indicate that the positive changes on psychological processes related to depression that occur following engagement in integrative reminiscence are not restricted to a unique set of individuals, but are generalizable across a broad range of presenting symptoms and demographic characteristics.

Results that Partly Match the Integrative Model: Case Study of Mrs. B and Case Replications

The following cases include individuals whose pattern of results Partly Match the hypothesized integrative model. In this group, each client demonstrated some improvement on the GDS at post-test, however, the improvement was not clinically significant. Seventeen percent of subjects in the Integrative group fall into this category (see Table 9). Over the course of the intervention, the basic form of the process data that Partly Match the predicted model is shown in Figures 6 and 7. Means and standard deviations of the process data for the Partly Matching group at pre-, mid-, and post-test are found in Table 10. In general, subjects in the group that Partly Matches the predicted pattern of change processes demonstrate less consistent and less profound changes on the dependent variables than do subjects in the Matching group. One subject demonstrated movement in the expected direction on six out of seven process measures and the other subject demonstrated change on two out of seven measures. In both

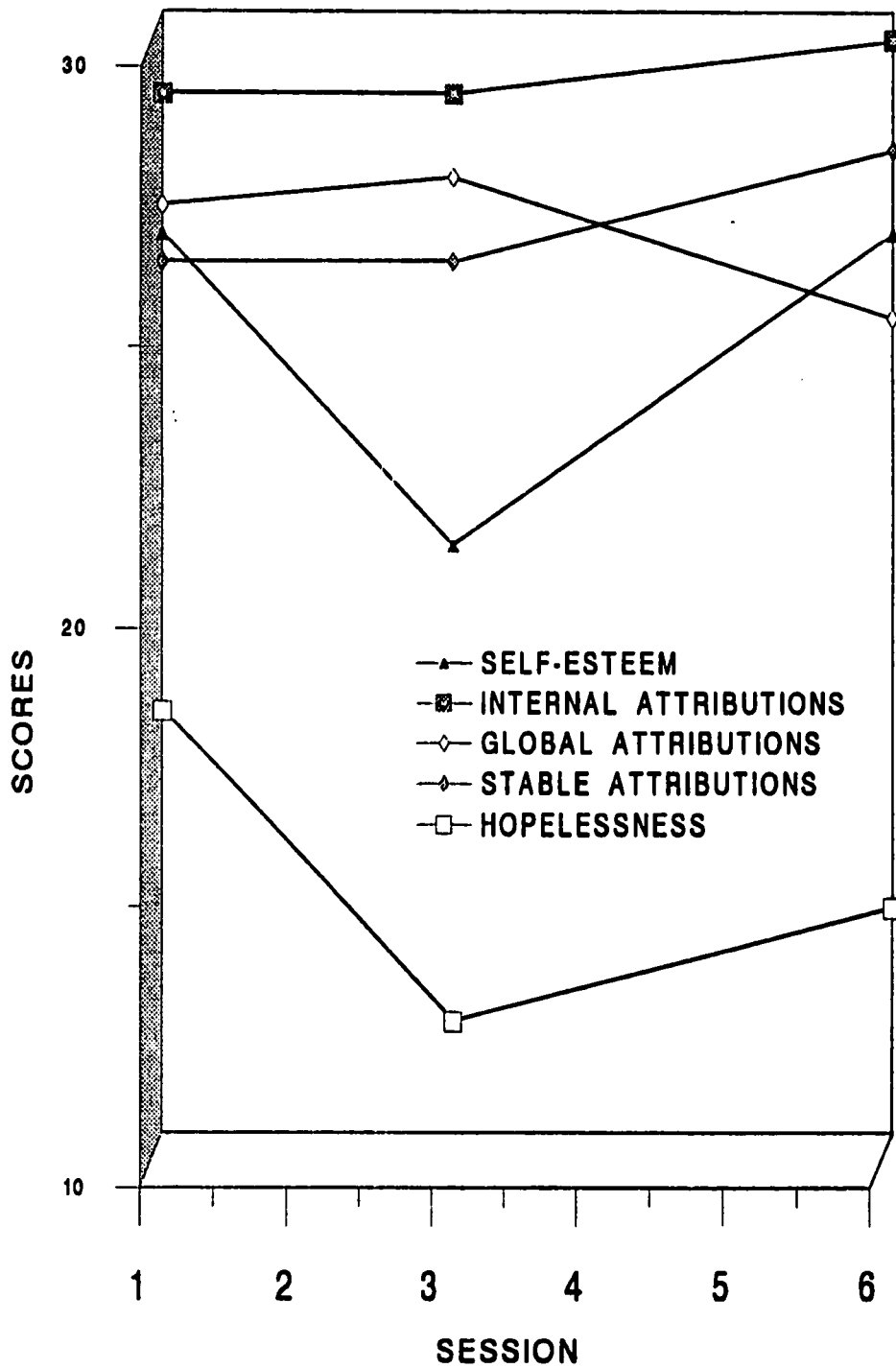


Figure 6. Mean Scores for Integrative Partly Matching Group: Self-Esteem, Hopelessness, and Attributions

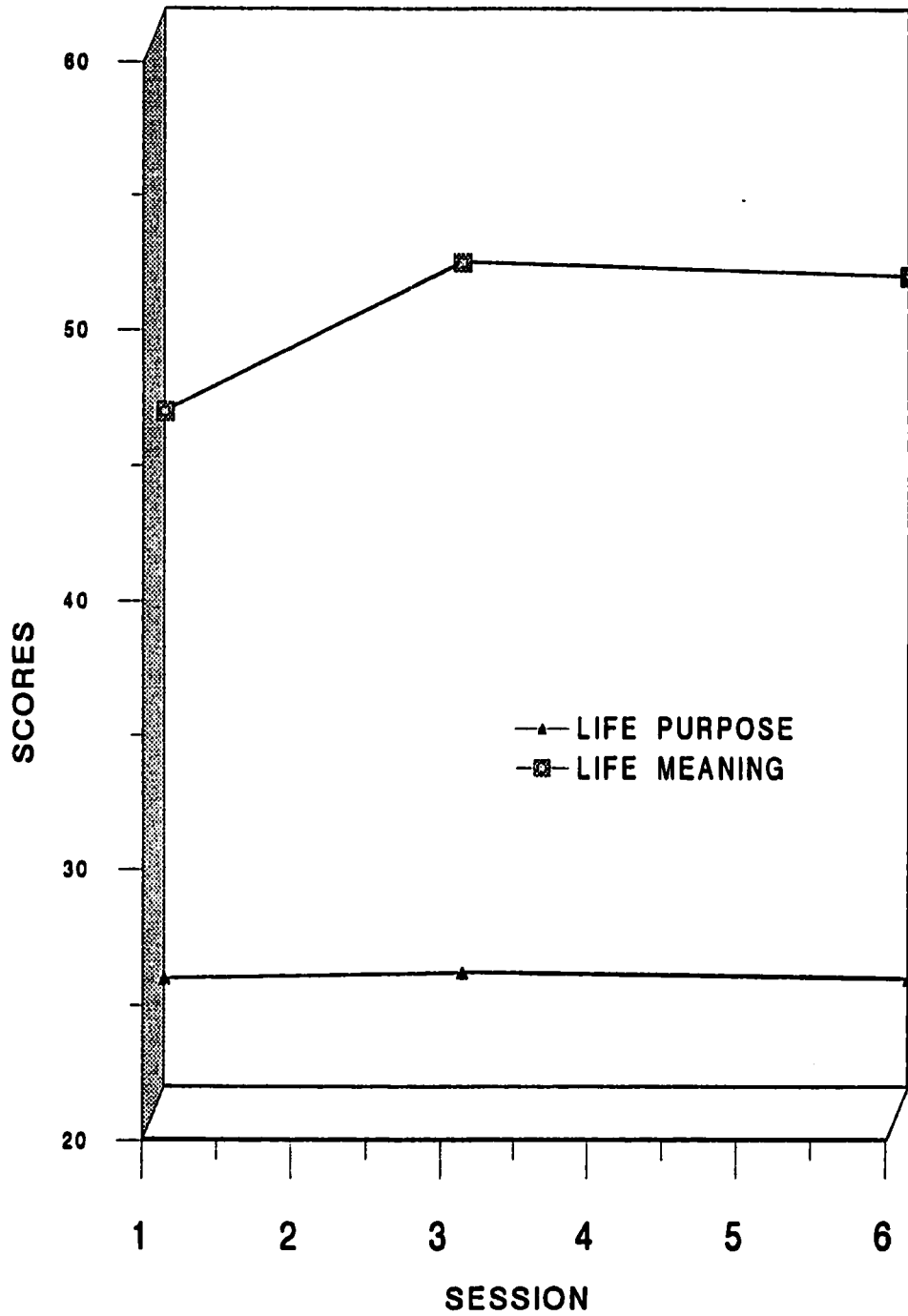


Figure 7. Mean Scores for Integrative Partly Matching Group: Life Meaning and Life Purpose

cases, the change generally represents a small change within a given category. For example, summarizing the data across subjects in this group revealed that Hopelessness, Global Attributions, and Life Meaning all show improvement but remain within the Moderate level. On measures of Self-esteem and Life Purpose, however, there is virtually no change from pre-test to post-test. And on Stable and Internal Attributions, there is a modest increase over time--representing a change in the opposite direction than was predicted by the model.

A prototypical case illustration of the Partly Match group is provided by Mrs. B. This woman is a 73 year-old widow with a university education who reported being in average physical health. Mrs. B had experienced an episode of depression, lasting for about one year, on one previous occasion approximately 5 years ago when her husband entered a chronic care facility. She did not receive any treatment for depression at that time.

Approximately three weeks before the study, Mrs. B was interviewed and presented with a score of 23 on the HRS-D and 21 on the GDS. She indicated that she had been feeling depressed for over a year. Mrs. B's pre-test score on the GDS taken on the day the intervention began remained at 21, indicating a severe level of depression. Initially, Mrs. B demonstrated a moderate level of self-esteem, she showed a high level of hopelessness, life purpose and personal meaning were in the low range (two standard deviations below the mean), internal and stable attributions for the causes of negative events were within average limits, and she demonstrated a high number of global attributions for the causes of negative events.

In general, as Mrs. B engaged in the integrative reminiscence process, her pattern of cognitive processes only partially followed the configuration predicted by the model (Figure 8H).

Self-esteem and hopelessness improved in the expected direction, but the magnitude of the change was small and she did not demonstrate a change in category status (i.e., self-esteem remained within the moderate range, and hopelessness remained within the severe range). There was no significant change in internal and stable attributions for the causes of negative events, however, global attributions for the causes of negative events dropped from a high level to a level below the mean for the average population. Measures of life purpose improved from a low to a moderate range, and personal meaning improved from a high-moderate to moderate range. On outcome measures, Mrs. B's score at post-test on the GDS was one point below her original score and she remained in the severely depressed range. She demonstrated a slight improvement in social adjustment scores. At a three month follow-up assessment, Mrs. B scored within the mildly depressed range on the HRS-D.

One other participant, Mr. C (77 years old, divorced, university educated, very good physical health status) demonstrated a similar pattern of scores--one in which some of the predicted changes were experienced, whereas others were not (Figure 9H). In particular, this subject demonstrated an improvement in life meaning and a decline in hopelessness. In both of these cases, outcome measures following the intervention showed slight improvement (1-4 points on the GDS), although both subjects remained significantly depressed.

These data suggest that, to the extent that integrative reminiscence promotes some of the changes in cognition outlined in the model, there is a small improvement in depressive symptomatology. Supplementary life attitude measures that provide additional information on the patterns of change in integrative reminiscence are displayed in Table 11 and graphed in

Figure 8. There was a small increase in a sense of coherence and a small decrease in existential vacuum in this group that may have contributed to the small reversal in depression. Goal seeking did not change, and there was a small decline in the sense of control over life over the course of the intervention.

As illustrated in Table 13, these two cases differed from the group of subjects who demonstrated a pattern of cognitions that match the model in that the two subjects were older, they were more likely to live alone, they had more education, and were more likely to have been experiencing symptoms of depression for over a year. The initial presentation of depressive symptomatology may also play a role in explaining the differential patterns of change found within the Integrative group. This set of two individuals who demonstrated only a partial fit with the predicted pattern of change processes differed from those individuals that did demonstrate the expected pattern in that they initially demonstrated: more global attributions for the causes of negative events, more hopelessness, and less of a sense of personal meaning.

Results that Do Not Correspond with the Integrative Model: Case Study of Mrs. D and Case Replications

The following cases are individuals whose pattern of results do not match the hypothesized integrative model. In this group, each client demonstrated no change or a decline on the GDS at post-test. Twenty-five percent of subjects in the Integrative group fall into this category (see Table 9). The basic form of the process data that Do Not Match the predicted model is shown in Figures 9 and 10. Means and standard deviations of the process data for the

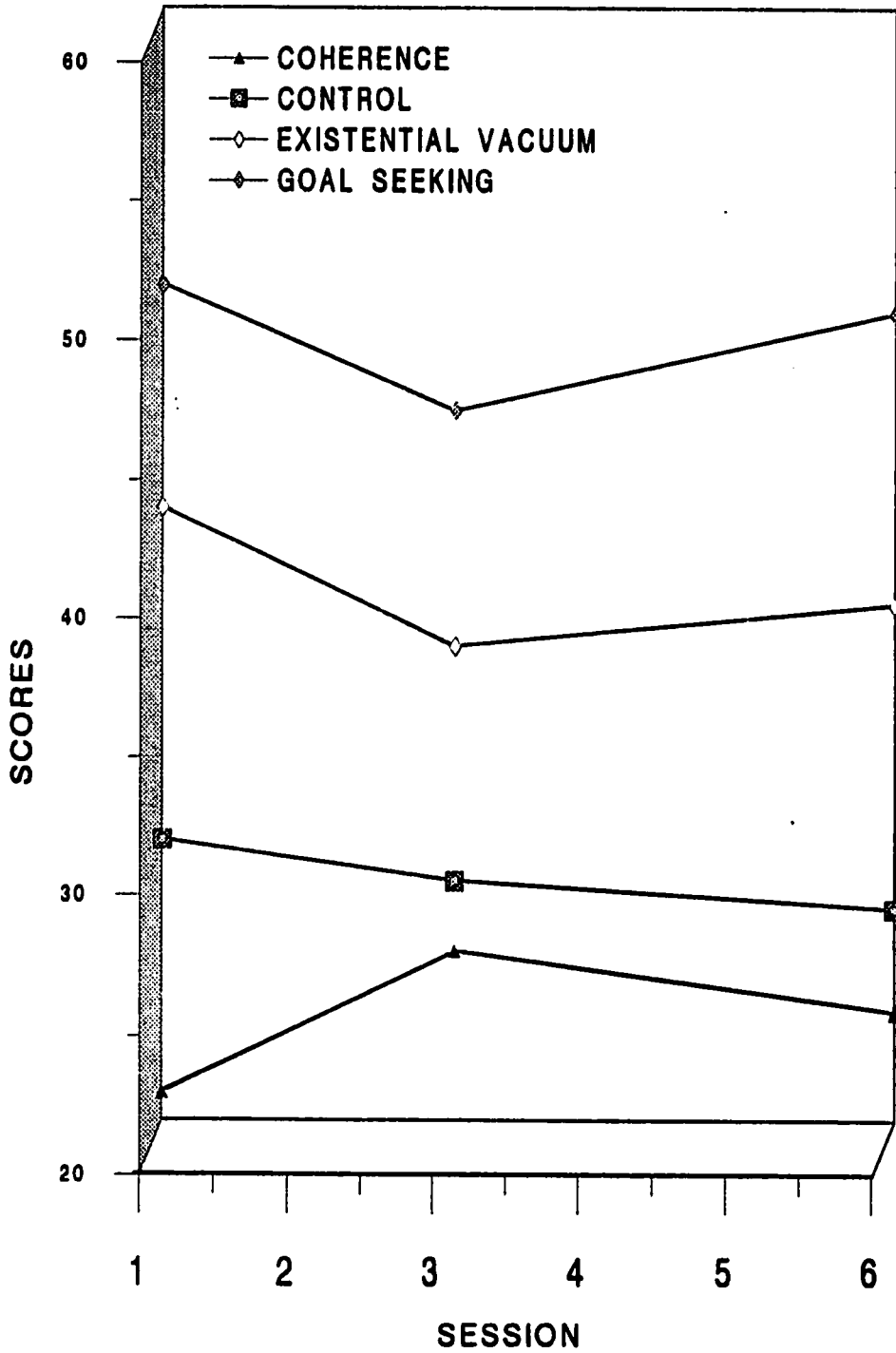


Figure 8. Mean Scores for the Supplementary Life Attitude Measures in the Integrative Partly Matching Group

Table 13

Means, (Standard Deviations), and Percentages of Demographic Characteristics and Pre-intervention Levels on Depression and the Dependent Variables of Integrative Reminiscence Subjects who Match, Partly Match, and Do Not Match the Predicted Pattern of Change Processes

| Variable | Match Model | Partly Match Model | Do Not Match Model |
|-------------------------------|------------------------|------------------------|------------------------|
| Age | 62.86 (2.55) | 75.00 (2.83) | 64.60 (1.15) |
| Gender | 57% Male 43% Female | 50% Male 50% Female | 67% Male 33% Female |
| Marital Status | 43% Married | 0% Married | 33% Married |
| Education* | 3.80 (1.03) | 5.00 (0) | 1.33 (0.58) |
| Physical Health* | 4.00 (0.82) | 4.00 (1.41) | 3.00 (1.73) |
| Severity of Depression (GDS) | 19.14 (3.93) | 22.5 (2.55) | 22.5 (2.12) |
| Length of Depression (months) | 8.29 (1.80) | 14.00 (1.41) | 36.00 (12.00) |
| Previous Depression | 43% Yes | 50% Yes | 100% Yes |
| Self-esteem | 26.57 (2.99) | 26.00 (2.83) | 19.00 (7.81) |
| Hopelessness | 11.00 (4.28) | 17.5 (0.71) | 11.33 (7.64) |
| Internal Attributions | 30.43 (7.55) | 28.5 (2.12) | 26.67 (9.02) |
| Global Attributions | 22.00 (6.90) | 26.5 (4.95) | 22.67 (4.04) |
| Stable Attributions | 25.86 (2.97) | 25.5 (2.12) | 26.33 (4.75) |
| Life Purpose | 26.43 (3.64) | 24.00 (2.83) | 22.67 (1.53) |
| Life Meaning | 61.57 (8.89) | 45.00 (7.07) | 52.00 (4.00) |

Note: * Higher scores indicate higher levels of health and education

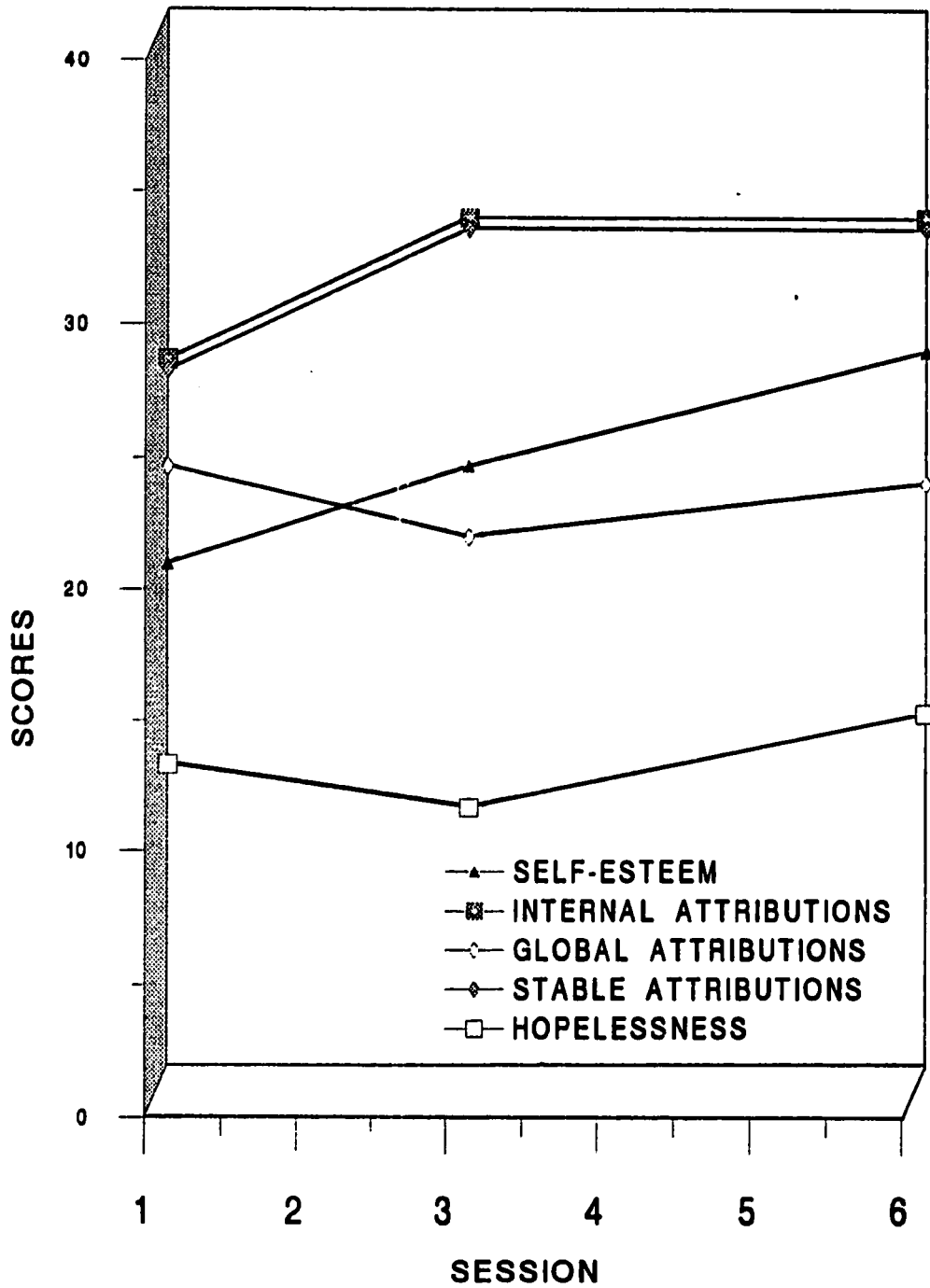


Figure 9. Mean Scores for Integrative Do Not Match Group: Self-Esteem, Hopelessness, and Attributions

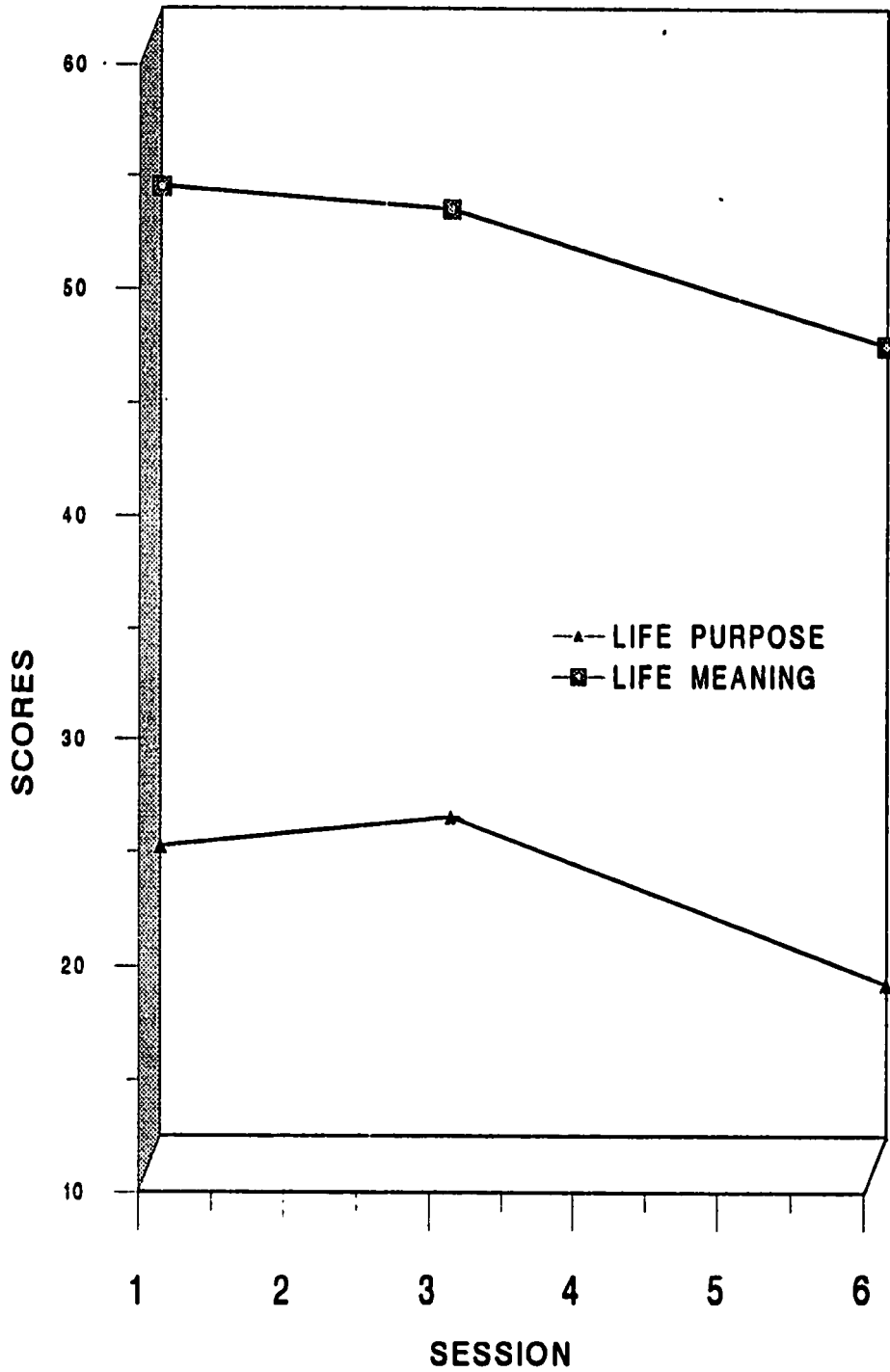


Figure 10. Mean Scores for Integrative Do Not Match Group: Life Meaning and Life Purpose

Partly Matching group at pre-, mid-, and post-test are found in Table 10. For subjects in the group that Do Not Match the predicted pattern of change processes, the majority of measures (at least four out of seven measures) changed in the opposite direction to that predicted by the model. Summarizing the data across subjects in this group, there is an increase in Hopelessness and Internal and Stable Attributions and a decrease in Life Purpose and Life Meaning. There was no change on Global Attributions. However, as predicted by the model, there was an increase in self-esteem.

The pattern demonstrated by subjects in the Integrative group who do not match the predicted change processes is illustrated by the case study of Mrs. D. Mrs. D is a 64 year-old divorced woman with a Grade 8 education who reported being in good physical health. She reports long-standing depression during her adult life and at various times has taken anti-depressant medication with little reported improvement.

Approximately three weeks before the study, Mrs. D was interviewed and presented with a score of 23 on the HRS-D and 20 on the GDS. She indicated that she had been feeling depressed for longer than a year. Mrs. D's pre-test score on the GDS taken on the day the intervention began remained at 20, indicating a severe level of depression. Initially, Mrs. D demonstrated a moderate level of self-esteem, she showed a high level of hopelessness, life purpose and personal meaning were in a low range (two standard deviations below the mean), and internal, stable, and global attributions for the causes of negative events were all high.

In general, (see Figure 10H), as Mrs. D engaged in the integrative reminiscence process, her scores on the cognitive processes either did not change or changed in the opposite manner

predicted by the model (i.e., toward higher levels of dysfunction). Hopelessness and self-esteem did not change, global and stable attributions for the causes of negative events all increased. Measures of life purpose and personal meaning declined. On outcome measures, Mrs. D's score at post-test on the GDS was unchanged (20) and remained within a severe range and there was no improvement in social adjustment. At a three month follow-up, Mrs. D's score (9) was within normal limits on the HRS-D.

Two other subjects demonstrated a pattern of results similar to Mrs. D--characterized by no change or deterioration on both the dependent variables and on measures of outcome at post-intervention (see Figures 11H and 12H). With reference to Table 13, it is evident that these three cases differed from the group of subjects who demonstrated a pattern of cognitions consistent with the model in that the three subjects were slightly older, had less education, were more likely to be living alone, were more likely to have been experiencing symptoms of depression for over a year, and were more likely to have experienced more than one prior episode of self-reported depression. With regard to initial scores on the dependent variables, this set of three individuals who did not fit with the predicted pattern of change processes differed from those individuals that did demonstrate the expected pattern in that they initially demonstrated: less self-esteem, less internal attributions for the causes of negative events, and less of a sense of life purpose and personal meaning.

Consistent with the finding of continuing depression, on the supplementary Life Attitude measures, (see Table 11 and Figure 11), Coherence and Life Control declined while Existential vacuum increased over the course of the intervention. Scores on Goal Seeking

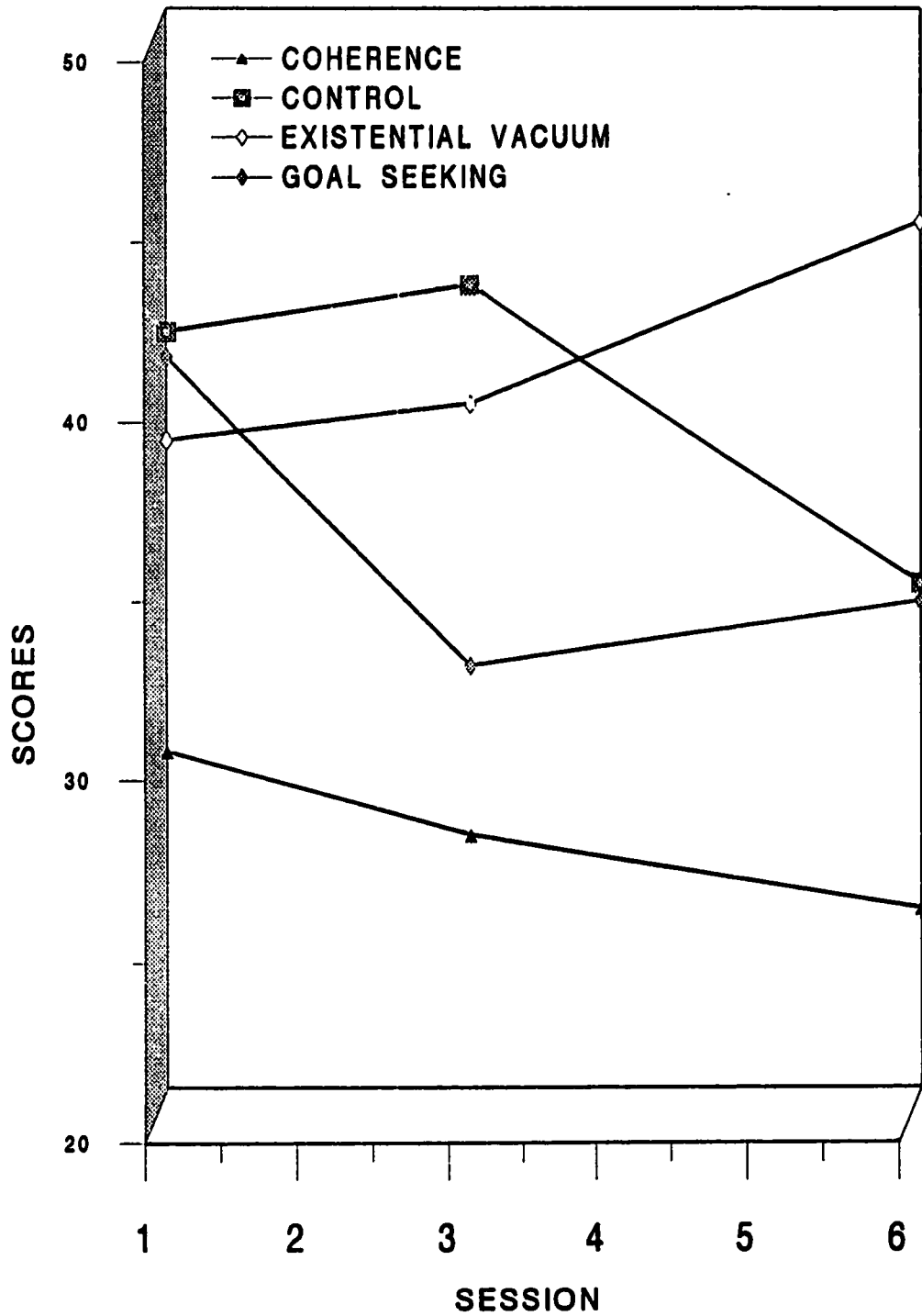


Figure 11. Mean Scores for the Supplementary Life Attitude Measures in the Integrative Do Not Match Group

decreased markedly indicating a loss of interest in pursuing goals and meeting challenges.

Quantitative Analysis of Integrative Reminiscence

The qualitative analysis in the previous section is supplemented by quantitative analysis designed to determine whether the pattern of change predicted by the Integrative model is specific to the Integrative group, or whether it is as likely to occur in the Active Socialization Control group (see Table 9). A Mann-Whitney U test was performed to evaluate the number of subjects in the Integrative group who demonstrated the predicted pattern, as compared to the number who followed the predicted pattern in the Active Socialization Control group. The results indicate that there is a statistically significant difference such that subjects in the Integrative group are more likely to demonstrate the predicted pattern than those in the Active Socialization Control group ($U=42.5$, $p < .05$). The probability that individuals randomly selected from the Integrative group will demonstrate the expected pattern in cognitive change processes is .71. And there are 2.44 times more subjects in the Integrative group who demonstrate the predicted pattern than in the Active Socialization Control group.

Qualitative Analysis of Instrumental Reminiscence

As with the analysis of the data from the Integrative group, the relationship between instrumental reminiscence change processes and depressive symptomatology was examined at the single case level. Inspection of each subject's change score on the GDS at post-test revealed three basic patterns of intra-subject change over time on the dependent variables. To avoid

obscuring the important intra-subject variation that exists within the Instrumental group, the data are aggregated into three separate groups, entitled: 1) Matching group - in which all clients demonstrated clinically significant improvement in depression scores on the GDS at post-test; 2) Partial Matching group - in which all clients demonstrated an improvement in depression scores on the GDS at post-test, although not at a clinically significant level; and, 3) Do Not Match group - in which clients demonstrated no change or a decline on the GDS at post-test.

To facilitate an exploration of the relationship between the cognitive change processes produced in an Instrumental reminiscence intervention and different outcomes for depression, the scores of each subject in the Instrumental group at pre-, mid-, and post-treatment are grouped into the categories of Match, Partly Match, and Do Not Match and are displayed on individual graphs (see Figures 11-18I in Appendix I).

The number and percentage of subjects that fit the three basic patterns are displayed in Table 14. The majority of cases, 56%, demonstrated clinically significant change on the GDS (the Match group) and also matched the expected pattern of change on the selected cognitive variables. Over the six week intervention, the basic form of the process data in the group that Matches the predicted model is shown in Figures 12-15. Means and standard deviations of the process data for the Matching group at pre-, mid-, and post-test are found in Table 15. In general, subjects in the group that Matches the predicted pattern of change processes demonstrate changes in the expected direction on at least ten out of the twelve process variables. Small changes occurred on coping resources (i.e., increased life control and reduced goal seeking). In some cases, primary appraisals of threats to the self were significantly

Table 14

Percentage and (Number) of Subjects in the Instrumental and Control Groups in the Categories of Match, Partly Match, Do Not Match the Predicted Change Processes

| <u>Group</u> | <u>Category</u> | | |
|--------------|-----------------|--------------|---------|
| | Do Not Match | Partly Match | Match |
| Instrumental | 22% (2) | 22% (2) | 56% (5) |
| Control | 60% (3) | 40% (2) | 0% (0) |

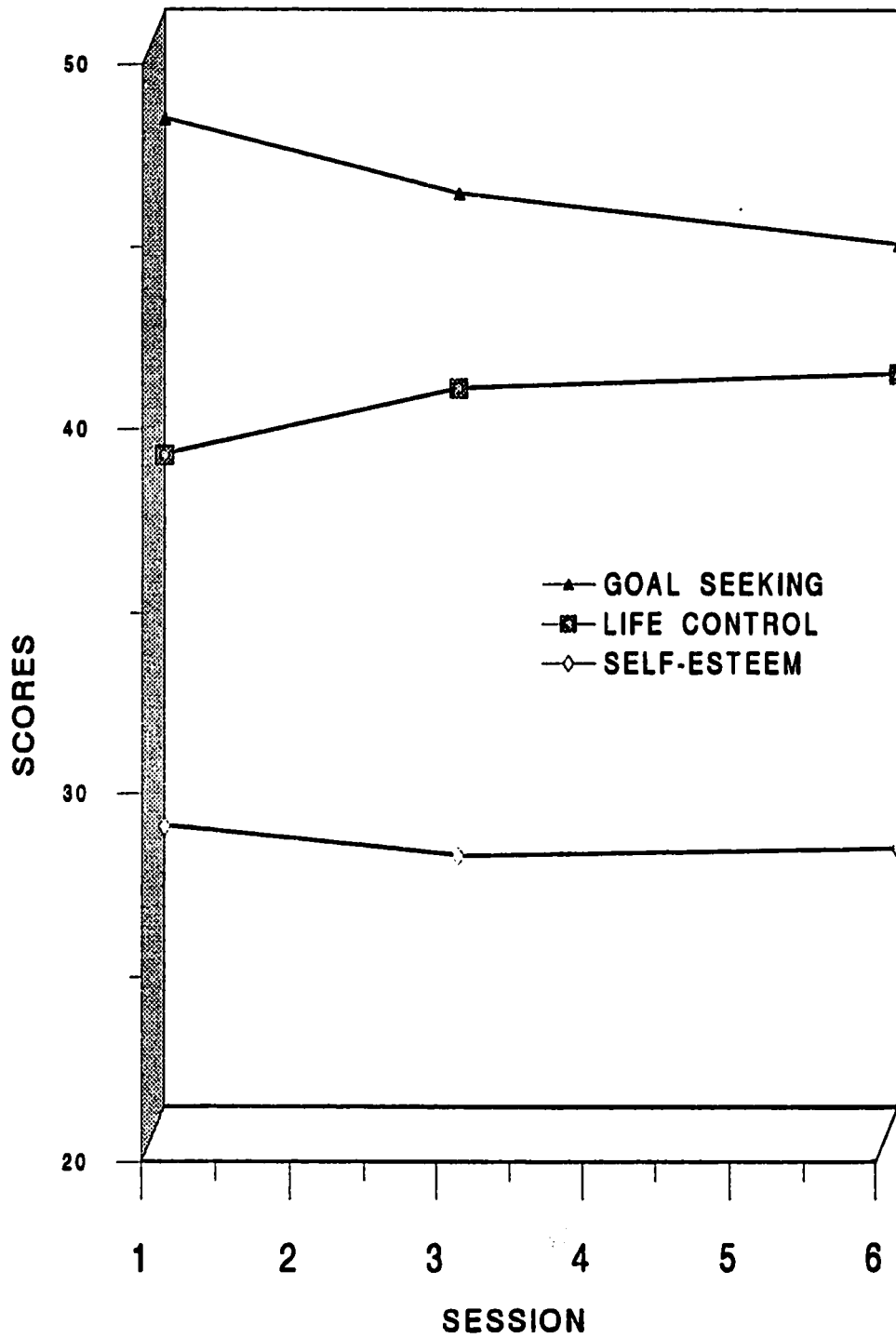


Figure 12. Mean Scores for Instrumental Matching Group: Coping Resources

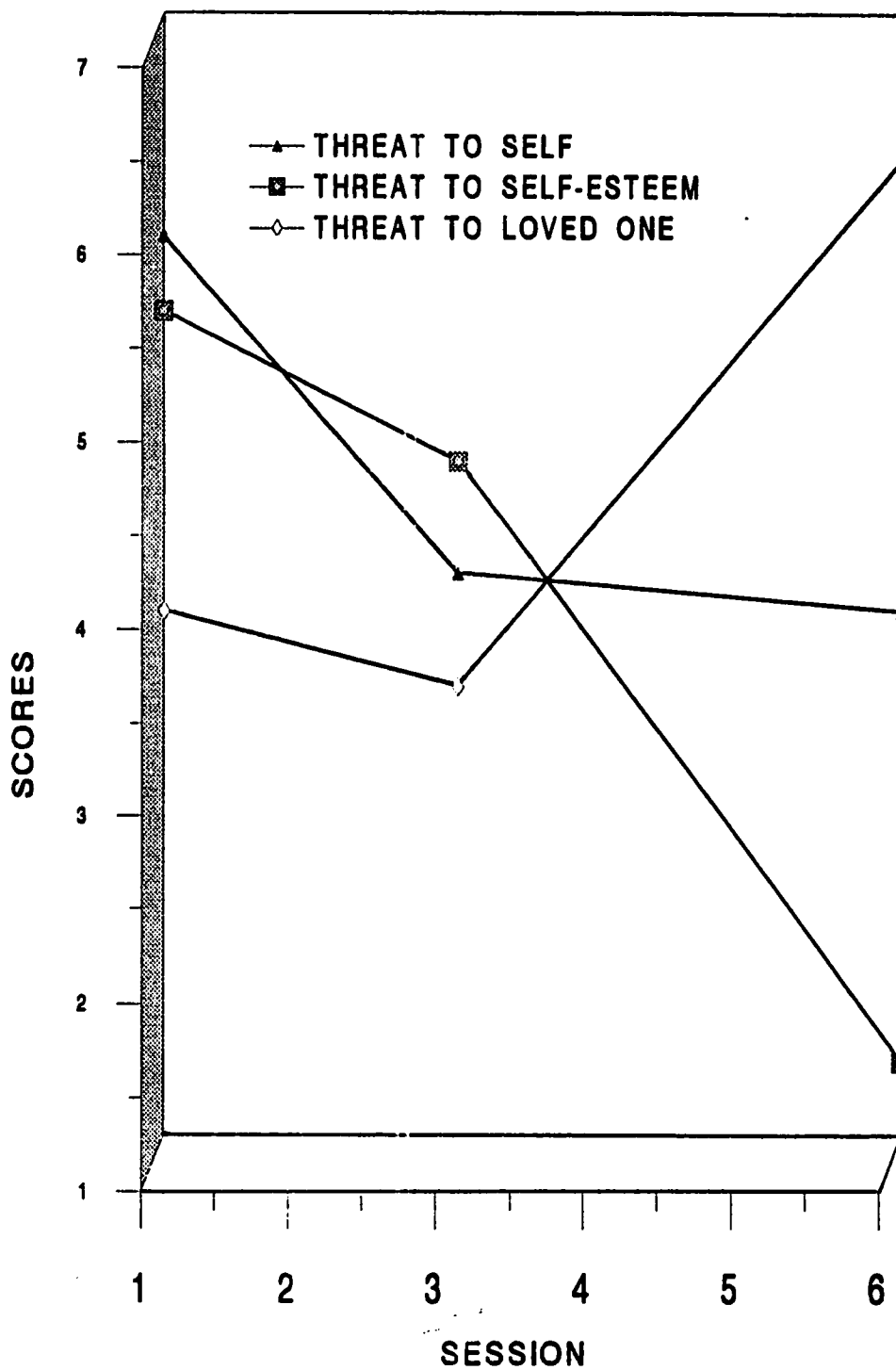


Figure 13. Mean Scores for Instrumental Matching Group: Primary Appraisals

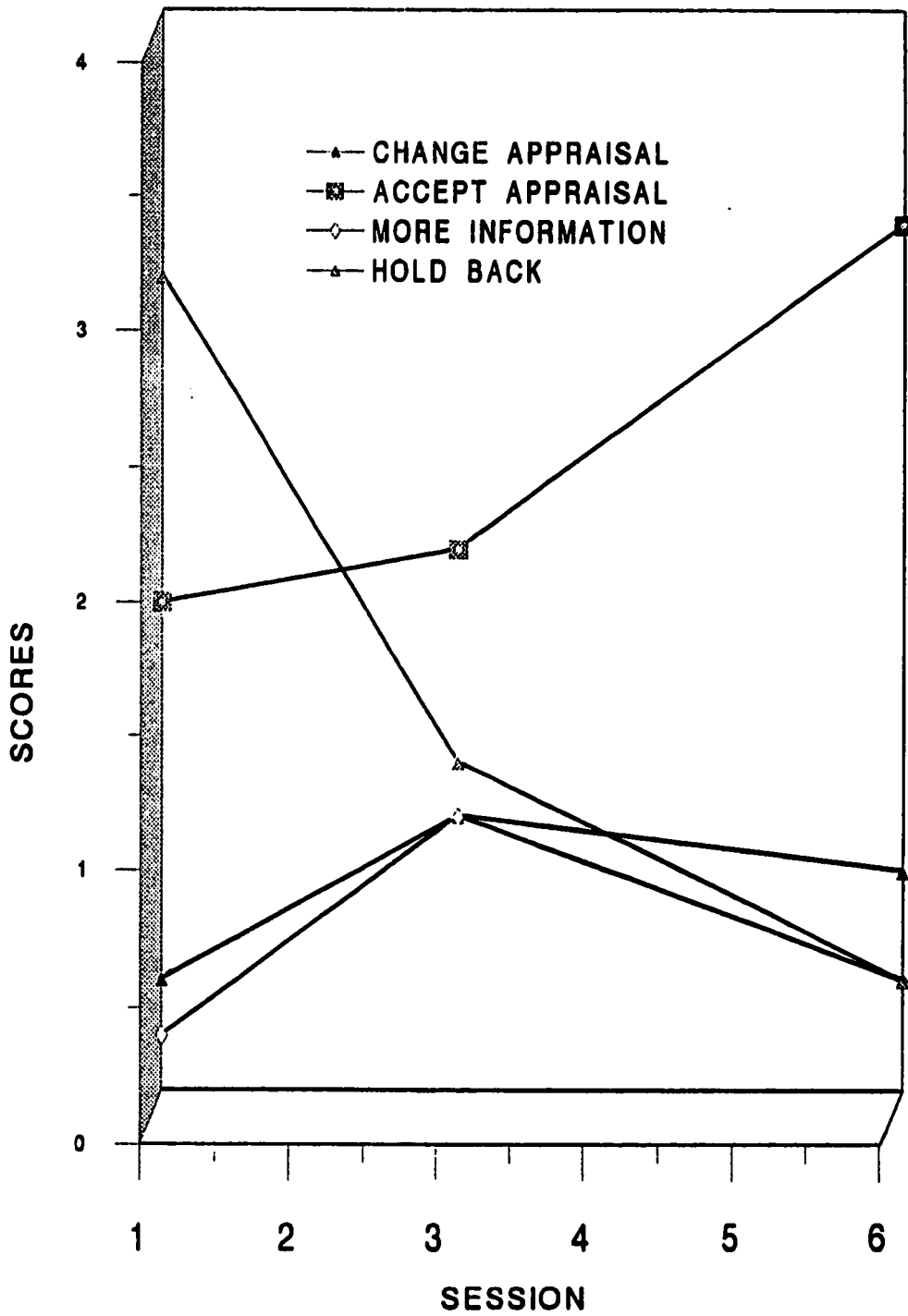


Figure 14. Mean Scores for Instrumental Matching Group: Secondary Appraisals

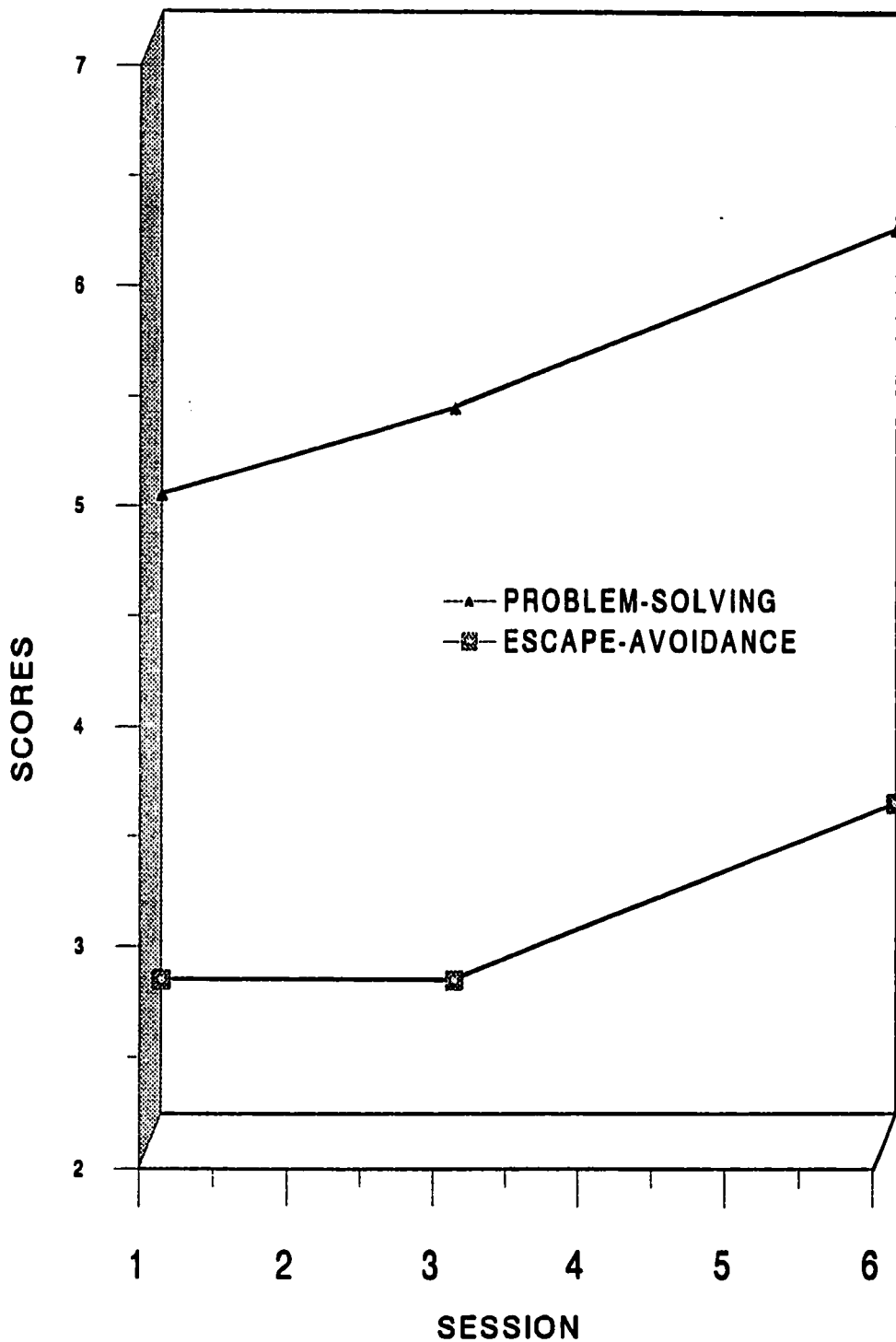


Figure 15. Mean Scores for Instrumental Matching Group: Coping Responses

Table 15

Pre-test, Mid-Test, and Post-test Means and (Standard Deviations) on the Dependent Variables for Instrumental Reminiscence Subjects who Match, Partly Match, and Do Not Match the Predicted Pattern of Change Processes

SELF-ESTEEM

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 27.60 (1.82) | 26.80 (1.30) | 27.00 (1.70) |
| Partly Match | 20.00 (16.97) | 26.50 (2.12) | 27.00 (1.41) |
| Do Not Match Model | 25.50 (0.71) | 25.50 (3.54) | 23.00 (0) |

LIFE CONTROL

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 37.80 (4.55) | 39.60 (1.30) | 40.00 (4.43) |
| Partly Match | 43.50 (3.54) | 43.00 (14.14) | 30.00 (4.24) |
| Do Not Match Model | 28.50 (2.12) | 35.00 (7.07) | 30.00 (4.24) |

Table 15 (continued)

Pre-test, Mid-Test, and Post-test Means and (Standard Deviations) on the Dependent Variables for Instrumental Reminiscence Subjects who Match, Partly Match, and Do Not Match the Predicted Pattern of Change Processes

GOAL SEEKING

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 47.00 (7.84) | 44.60 (4.30) | 43.60 (5.90) |
| Partly Match | 50.50 (7.80) | 41.60 (6.20) | 39.50 (17.60) |
| Do Not Match Model | 41.00 (15.60) | 35.20 (7.20) | 31.50 (4.80) |

PRIMARY APPRAISAL OF THREAT TO ONE'S OWN WELL-BEING

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 5.80 (5.40) | 4.00 (2.00) | 3.80 (3.00) |
| Partly Match | 6.50 (3.53) | 5.50 (4.95) | 5.50 (4.95) |
| Do Not Match Model | 5.00 (0) | 4.50 (2.12) | 8.50 (3.54) |

Table 15 (continued)

Pre-test, Mid-Test, and Post-test Means and (Standard Deviations) on the Dependent Variables for Instrumental Reminiscence Subjects who Match, Partly Match, and Do Not Match the Predicted Pattern of Change Processes

PRIMARY APPRAISAL OF THREAT TO A LOVED ONE'S WELL-BEING

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 3.80 (4.38) | 3.40 (4.67) | 6.20 (3.90) |
| Partly Match | 1.50 (2.12) | 2.50 (0.71) | 1.50 (2.12) |
| Do Not Match Model | 8.00 (0) | 4.00 (1.41) | 1.50 (2.12) |

PRIMARY APPRAISAL OF THREAT TO ONE'S SELF-ESTEEM

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 5.40 (8.26) | 4.60 (4.51) | 1.40 (1.34) |
| Partly Match | 3.00 (1.42) | 4.00 (2.83) | 3.50 (3.54) |
| Do Not Match Model | 7.00 (2.83) | 4.00 (5.66) | 5.00 (4.24) |

Table 15 (continued)

Pre-test, Mid-Test, and Post-test Means and (Standard Deviations) on the Dependent Variables for Instrumental Reminiscence Subjects who Match, Partly Match, and Do Not Match the Predicted Pattern of Change Processes

SECONDARY APPRAISAL OF ABILITY TO CHANGE THE STRESSFUL SITUATION

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 0.40 (0.55) | 1.00 (1.22) | 0.80 (1.30) |
| Partly Match | 0.00 (0) | 0.33 (0.58) | 0.33 (0.58) |
| Do Not Match Model | 1.00 (1.41) | 0.50 (0.50) | 0.50 (0.50) |

SECONDARY APPRAISAL OF HAVING TO ACCEPT A STRESSFUL SITUATION

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 1.80 (0.84) | 2.00 (1.87) | 3.20 (1.79) |
| Partly Match | 0.50 (0.71) | 0.50 (0.71) | 0.50 (0.71) |
| Do Not Match Model | 2.50 (0.71) | 2.00 (1.41) | 2.00 (1.41) |

Table 15 (continued)

Pre-test, Mid-Test, and Post-test Means and (Standard Deviations) on the Dependent Variables for Instrumental Reminiscence Subjects who Match, Partly Match, and Do Not Match the Predicted Pattern of Change Processes

SECONDARY APPRAISAL OF HAVING TO GET MORE INFORMATION ABOUT A STRESSFUL SITUATION

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 0.20 (0.45) | 1.00 (1.22) | 0.40 (0.89) |
| Partly Match | 0.00 (0) | 1.50 (2.12) | 1.50 (2.12) |
| Do Not Match Model | 1.50 (2.12) | 1.50 (2.12) | 1.50 (2.12) |

SECONDARY APPRAISAL OF HAVING TO HOLD BACK IN A STRESSFUL SITUATION

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 3.00 (0.71) | 1.20 (1.79) | 0.40 (0.89) |
| Partly Match | 3.50 (0.71) | 0.00 (0) | 0.00 (0) |
| Do Not Match Model | 4.00 (0.82) | 4.00 (0) | 3.50 (0.71) |

Table 15 (continued)

Pre-test, Mid-Test, and Post-test Means and (Standard Deviations) on the Dependent Variables for Instrumental Reminiscence Subjects who Match, Partly Match, and Do Not Match the Predicted Pattern of Change Processes

PROBLEM-SOLVING COPING RESPONSES

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 4.80 (2.17) | 5.20 (1.79) | 6.00 (3.32) |
| Partly Match | 8.50 (4.95) | 10.00 (2.83) | 8.50 (0.71) |
| Do Not Match Model | 6.50 (6.36) | 6.00 (5.66) | 6.00 (5.66) |

ESCAPE-AVOIDANCE COPING RESPONSES

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 2.60 (0.89) | 2.60 (0.58) | 3.40 (1.52) |
| Partly Match | 6.50 (0.71) | 4.50 (2.12) | 3.00 (4.24) |
| Do Not Match Model | 7.50 (6.36) | 5.50 (0.71) | 5.50 (0.71) |

reduced. In other cases, there appeared to be clarification of the appropriate target of the threat so that threats to the self were re-directed in a more accurate fashion away from the self and toward a loved one. The most notable change in secondary appraisals was a significant decrease in viewing a stressful situation as one in which the subject had to hold back from acting. Problem-solving coping responses increased and to a lesser degree, escape-avoidance coping also increased. At first glance, these results do not appear to clearly match the Instrumental reminiscence model, however, more in-depth analysis of individual cases in this group indicates that the data follow the general direction of change defined in the model. In addition, the fact that these changes are associated with an improvement in depression provides support for the hypothesis that reminiscence processes produce cognitive and coping changes that are associated with an improvement in depression. The in-depth analysis begins with examination of the prototypical case illustration of Mr. E and is followed by examination of cases that provide replication of the pattern of change, as well as cases that demonstrate the generalizability of the results to subjects with demographic and diagnostic characteristics that differ from the prototypical case.

Results that Match the Instrumental Model: Case Study of Mr. E and Case Replications

Mr. E, is a 66 year-old married man with a university education who reported being in good physical health. This episode was Mr. E's first experience with depression, and his current symptoms had lasted between six months to a year. Approximately three weeks before the study, Mr. E was interviewed and presented with a score of 20 on the HRS-D and 17 on the GDS. Mr.

E's pre-test score on the GDS taken on the day the intervention began was 15, indicating a mild level of depression. Initially, Mr. E demonstrated a high level of self-esteem, a moderate level of life control, a moderate level of stress, primary appraisals of threat were moderate, and problem-solving and escape-avoidance were both low.

In general, as Mr. E engaged in the instrumental reminiscence process, his scores on the appraisal and coping processes changed in the manner predicted by the model (see Figures 1I, 2I & 3I). Initially, as he examined stressful experiences in his life, primary appraisal of these stressor as threats to his own well-being and self-esteem increased. Subsequently, secondary challenge-oriented appraisals of the stressor increased so that he felt less pressure to hold back from acting and greater ability to cope with the situation. Problem-solving coping increased, escape-avoidance coping decreased and he attempted to manage the emotions associated with this stressor by using the emotion-focused coping strategies of re-appraisal and self-control. By the end of the six week intervention, Mr. E demonstrated a decline in primary appraisals of threat and self-esteem and life control increased, despite the fact that the intensity of stress was rated at the same level as when the intervention began. On outcome measures, Mr. E's score at post-test on the GDS was significantly improved (11) to within the normal range, and he demonstrated improvement in social adjustment scores. At a three month follow-up, Mr. E's score (6) was within normal limits on the HRS-D.

A series of 4 case replications which, like Mr. E's case, provide support for the model were identified (see Figures 4I-15I). Two of these case replications demonstrated essentially the same pattern as Mr. E (see Figures 4I-9I). Two other cases yielded changes in appraisals, coping

strategies and decreased depressive symptomatology, in a manner that had not been specifically predicted in this research, but that is consistent with Folkman and Lazarus' (1986) formulation of stress and coping (see Figures 10I-15I). In these two cases, individuals interpreted their stressful experience as one in which acceptance, rather than change was needed to cope effectively.

Before the intervention, primary appraisals indicated that subjects felt a threat to their own well being and self-esteem. Secondary appraisals emphasized the need to change something about the situation, and problem-solving coping was high. Over the course of the six week intervention, however, the primary appraisal of threat shifted from the self, to a threat to a loved one's well being. Secondary appraisals shifted from the sense that a change could be made, to a sense that acceptance of the situation as it stands was needed. At this point, problem-solving strategies decreased and coping strategies emphasizing emotional regulation (i.e., letting emotions out, positive re-appraisal, and distancing) increased. Life control rating declined slightly, however, self-esteem remained stable. This pattern of resolution was associated with a significant decrease in depressive symptomatology.

In addition to Problem-focused and Escape-avoidance coping, the Ways of Coping-Revised measures several other types of coping responses. Specific hypotheses concerning these measures were not developed, however, they demonstrated consistent differences among the Match, Partly Match, and Do Not Match groups. It was felt that reporting the data on these additional measures may contribute important information about reminiscence processes. The additional measures include: Distancing (e.g., went on as if nothing happened, refused to think about it too much); Accepting Responsibility (realized I brought the problem on myself, I

apologized or did something to make up); and Positive Re-appraisal (changed or grew as a person in a good way, I found new faith). Over the course of the intervention (see Table 16 and Figure 16), individuals in the Matching group demonstrated a large increase in the use of distancing, accepting responsibility, and positive re-appraisal.

The demographic characteristics and pre-intervention levels of depression and the dependent variables of subjects in the group that matches the pattern of change processes predicted for the Instrumental group are shown in Table 17. These data indicate that the predicted change in psychological processes is replicated in individuals who share similar characteristics with the prototypical subject, Mr. E. Further, these changes in psychological processes are generalizable to subjects who differ from Mr. E on a cross-section of demographic characteristics, and who experience chronic and more long-standing depression, and demonstrate higher levels of self-esteem and greater intensity of stress ratings. All subjects in this group, however, generally do not demonstrate depression that exceeds the mild range.

Results that Partly Match the Instrumental Model: The Case of Mrs. F and Case Replications

The following cases include individuals whose pattern of results Partly Match the hypothesized instrumental model. In this group, each client demonstrated some improvement on the GDS at post-test, however, the improvement was not clinically significant. Twenty-two percent of subjects in the Instrumental group fall into this category (see Table 14). Over the course of the intervention, the basic form of the process data that Partly Match the predicted model is shown in Figures 17-20. Means and standard deviations of the process data for the

Table 16

Pre-test, Mid-Test, and Post-test Means and (Standard Deviations) on the Supplementary Dependent Variables for Instrumental Reminiscence Subjects who Match, Partly Match, and Do Not Match the Predicted Pattern of Change Processes

DISTANCING

| Group | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 2.40 (0.55) | 3.25 (1.40) | 4.33 (1.15) |
| Partly Match | 5.00 (2.83) | 5.00 (2.12) | 12.00 (3.60) |
| Do Not Match Model | 3.50 (2.12) | 5.50 (1.54) | 6.00 (5.66) |

ACCEPTING RESPONSIBILITY

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 2.20 (2.39) | 2.20 (2.39) | 4.00 (2.30) |
| Partly Match | 3.50 (0.71) | 2.50 (2.12) | 2.50 (2.12) |
| Do Not Match Model | 6.00 (1.41) | 2.00 (1.07) | 1.50 (0.71) |

Table 16 (continued)

Pre-test, Mid-Test, and Post-test Means and (Standard Deviations) on the Supplementary Dependent Variables for Instrumental Reminiscence Subjects who Match, Partly Match, and Do Not Match the Predicted Pattern of Change Processes

POSITIVE RE-APPRAISAL

| <u>Group</u> | Pre-test Score | Mid-test Score | Post-test Score |
|--------------------|----------------|----------------|-----------------|
| Match Model | 2.80 (1.79) | 3.20 (2.00) | 4.75 (0.96) |
| Partly Match | 5.00 (1.41) | 4.50 (2.12) | 4.00 (2.25) |
| Do Not Match Model | 3.50 (3.54) | 3.50 (3.54) | 3.75 (2.12) |

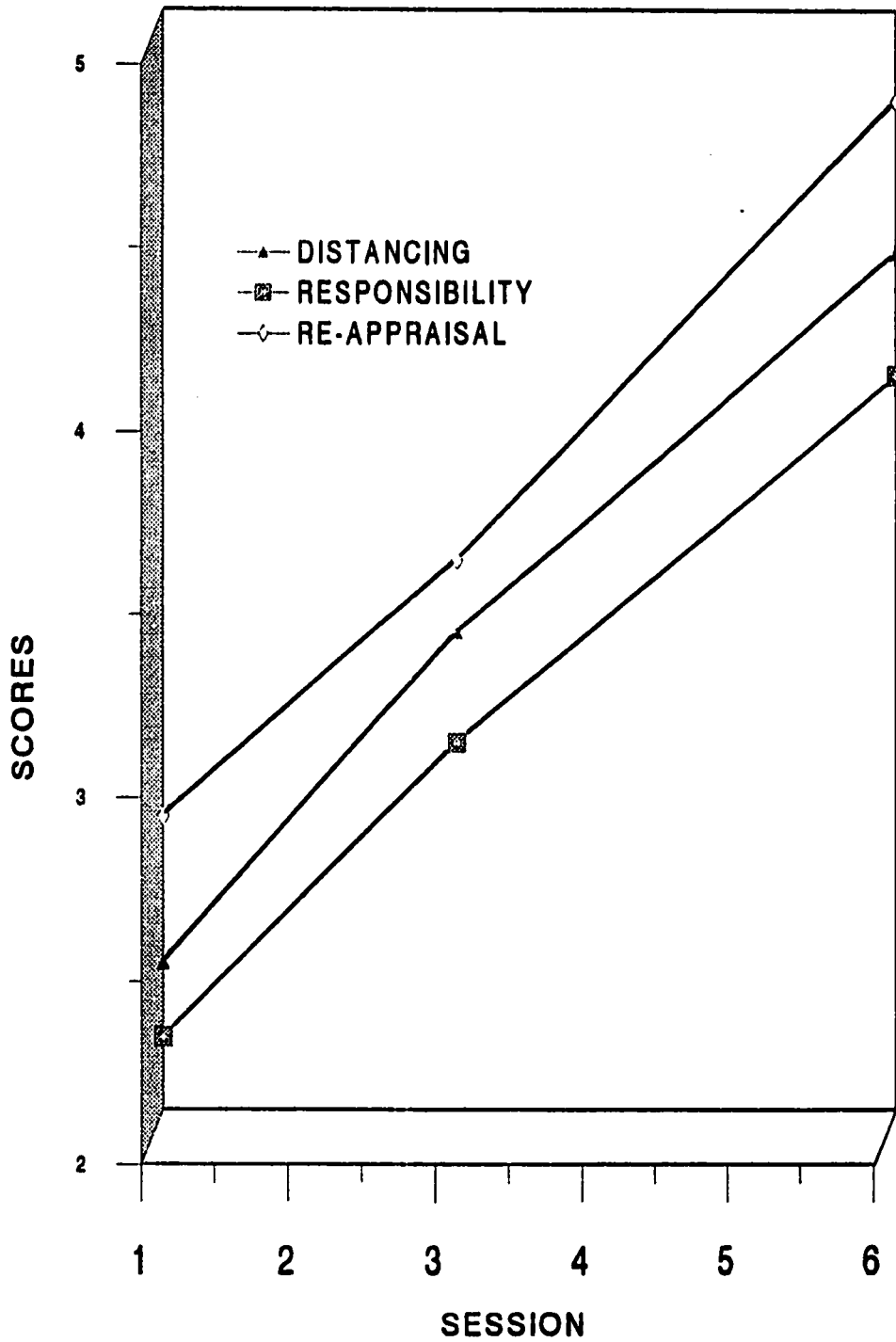


Figure 16. Mean Scores for the Supplementary Coping Responses in the Instrumental Match Group

Table 17

Instrumental Case Studies that Match, the Predicted Pattern of Change Processes: Replication and Generalization of Demographic Characteristics, and Pre-test Scores on the Dependent Variables and Depression

| Variable | Direct Replication | Systematic Replication |
|----------------------------------|--------------------|--------------------------|
| Age | 50% Aged 65+ | 50% Aged 60-65 |
| Gender | 50% Male | 50% Female |
| Marital Status | 50% Married | 50 % Not Married |
| Education | 50% University | 50% Less than University |
| Physical Health | 75% Good | 25% Average |
| Severity of Depression | 75% Moderate (GDS) | 25 % Severe (GDS) |
| Length of Depression | 25% 6 mos-1year | 75% 1year+ |
| Previous Depression | 50% No | 50% Yes |
| Self-esteem | 75% Moderate | 25% High |
| Life Control | 50% Moderate | 50% High |
| Goal Seeking | 75% Moderate | 25% Low |
| Threat to Own Well-Being | 50% Moderate | 25% High 25% Low |
| Threat to Loved One's Well-Being | 50% Low | 50% High |
| Threat to Own Self-Esteem | 75% Low | 25% High |
| Change Appraisal | 100% Low | -- |
| Accept Appraisal | 100% Low | -- |
| Obtain More Information | 100% Low | -- |
| Hold Back | 100% Low | -- |
| Problem-solving Coping | 50% Low | 50% Moderate |
| Escape-Avoidance Coping | 100% Low | -- |

Note: The column labelled Replication displays the percentage of subjects in the Matching group that share characteristics with the prototypical case study of Mr. A. The column labelled Generalization shows the percentage of subjects that differ from Mr. A.

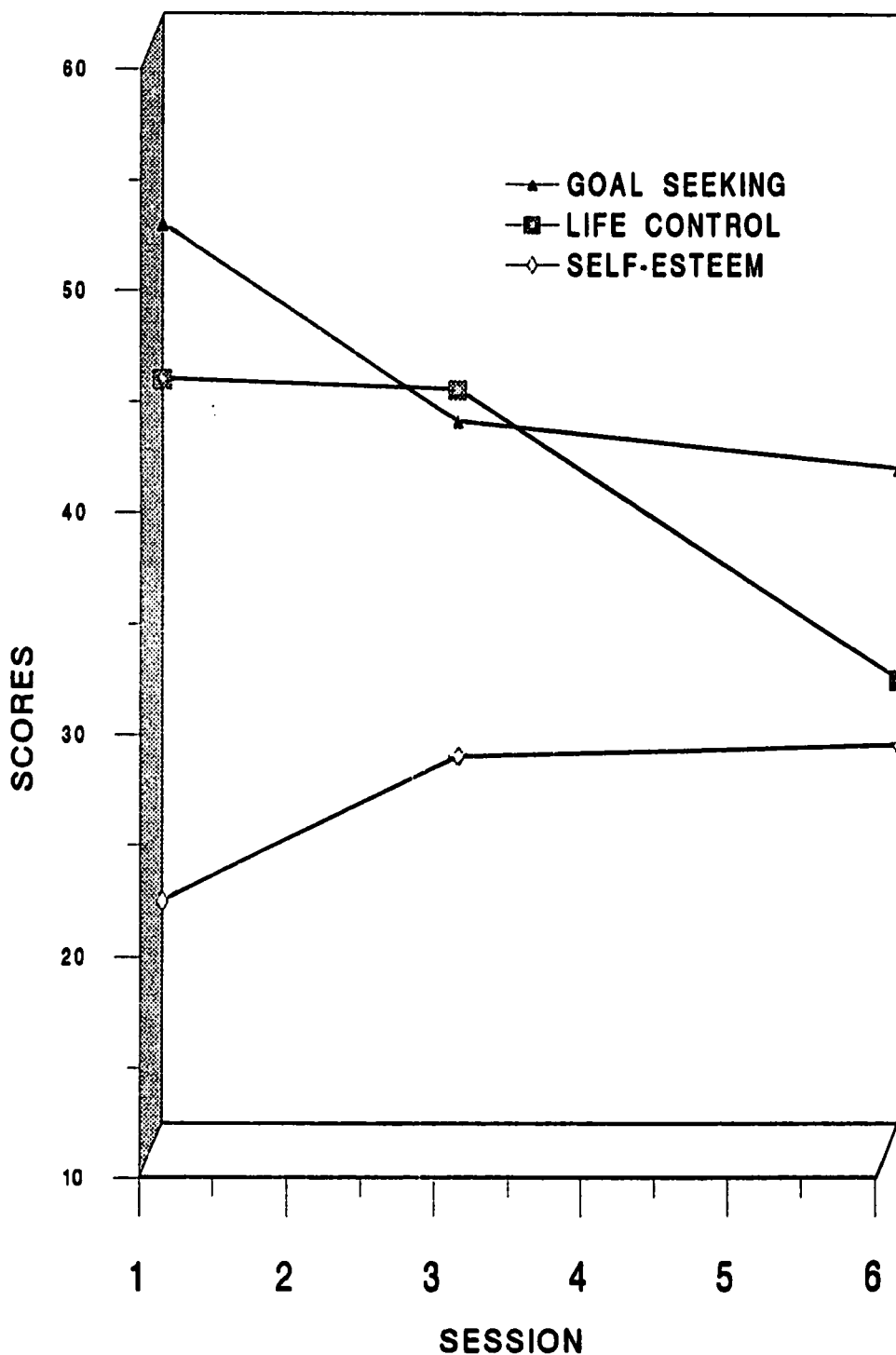


Figure 17. Mean Scores for Instrumental Partly Matching Group: Coping Resources

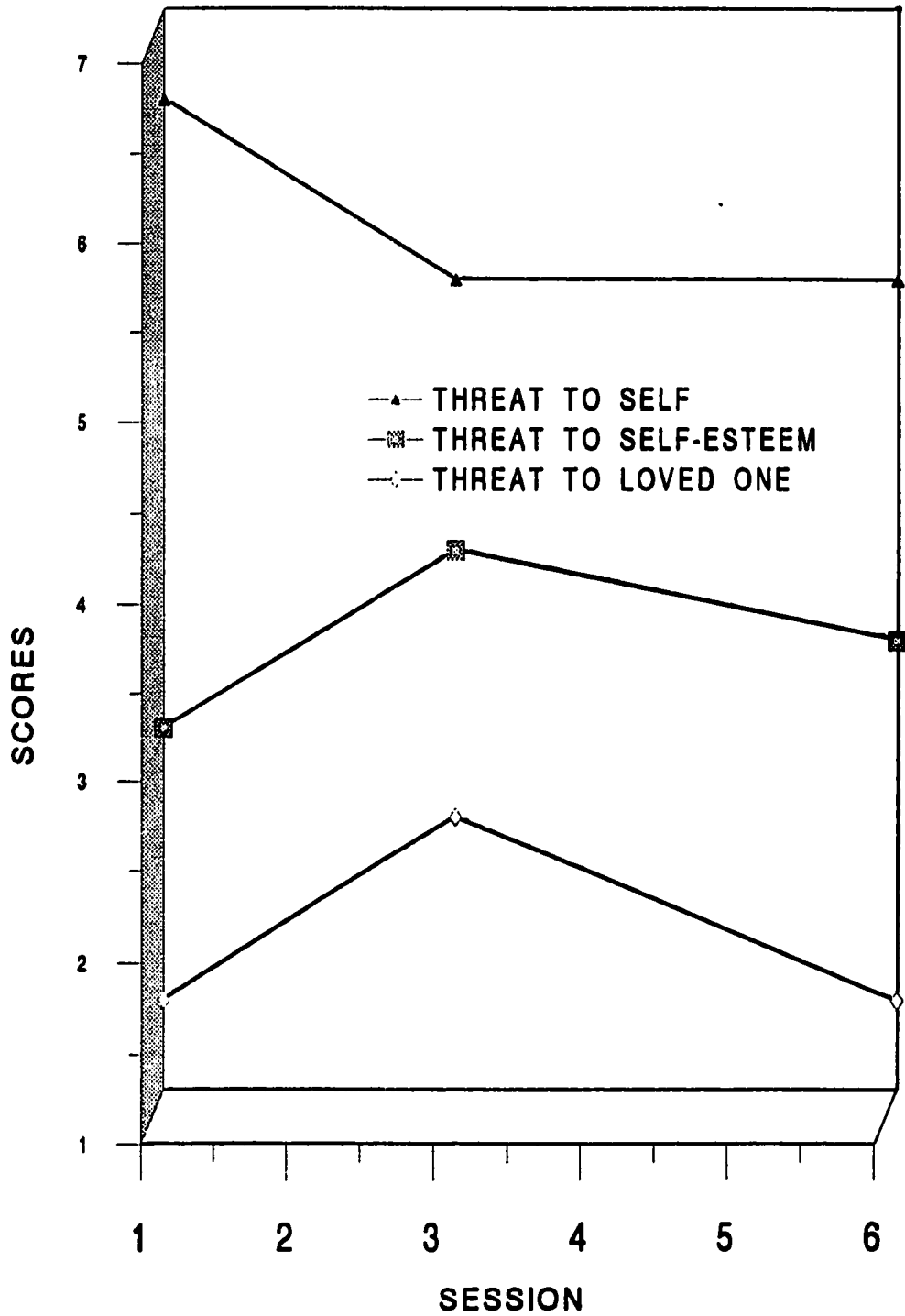


Figure 18. Mean Scores for the Instrumental Partly Matching Group: Primary Appraisals

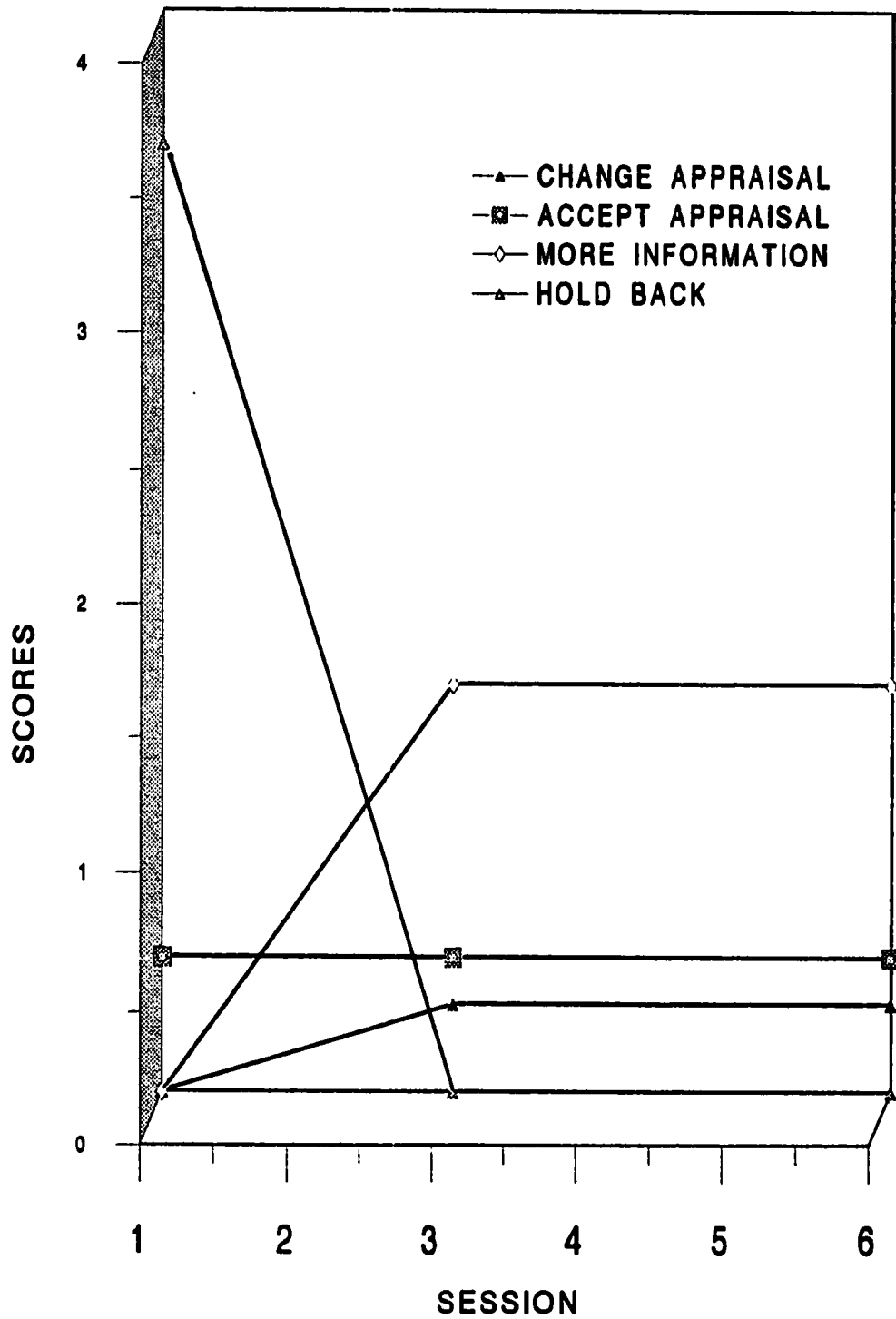


Figure 19. Mean Scores for the Instrumental Partly Matching Group: Secondary Appraisals

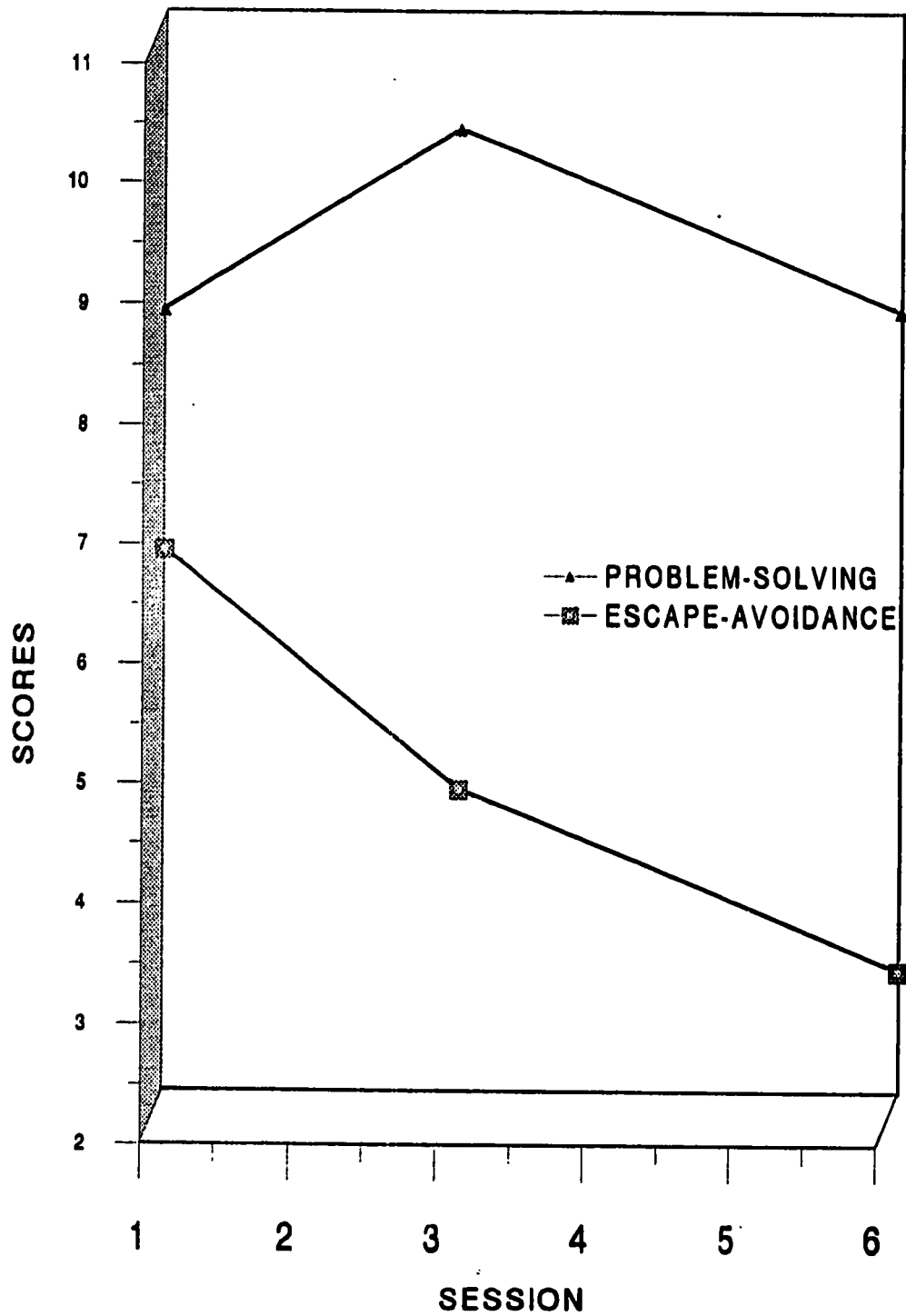


Figure 20. Mean Scores for the Instrumental Partly Matching Group: Coping Responses

Partly Matching group at pre-, mid-, and post-test are found in Table 15.

In general, subjects in the group that Partly Matches the predicted pattern of change processes demonstrate change processes that are consistent with the model on between eight to ten of the twelve measures. For example, summarizing data across the subjects in this group, self-esteem increased, however, the other coping resources measured, life control and goal seeking, did not consistently reflect the predicted pattern of change. Fewer reported primary appraisals of threat to one's own well-being, and a decrease in the felt need to hold back from acting in a stressful situation. Problem-solving coping responses increased at the third session, but returned to their pre-test level at the end of the intervention. It is of note that reported use of problem-solving activities was high at pre-test assessment in this group. Escape-avoidance coping decreased from a moderate to a low level over the course of the intervention.

A prototypical case illustration of the Partly Match group is provided by Mrs. F. Mrs. F is a 60 year-old divorced woman with a college education who reported being in average physical health. She did not report previous episodes of depression. Approximately three weeks before the study, Mrs. F was interviewed and presented with a score of 20 on the HRS-D and 21 on the GDS. She indicated that she had been feeling depressed between six months and a year. Mrs. F's pre-test score on the GDS taken on the day the intervention began was 20, indicating a severe level of depression. Initially, Mrs. F demonstrated a high level of life control and self-esteem, a high level of stress intensity, a high level of threatening primary appraisals, low levels of problem-solving and moderate levels of escape-avoidance coping.

In general, as Mrs. F engaged in the instrumental reminiscence process, her scores on

problem-solving coping increased and escape-avoidance decreased (see Figures 16I-18I). However, primary appraisals of threat increased, and life control, self-esteem, and GDS decreased slightly. There was no improvement in social adjustment. At a three month follow-up, Mrs. F's score (11) was within normal limits on the HRS-D.

One other subject demonstrated a pattern of results similar to Mrs. F--characterized by change in the predicted direction on some variables, but no change or deterioration on other dependent variables combined with little change on the GDS at post-intervention (see Figures 19I-21I). In this case, the individual started in the range of mild depression. Although primary appraisals of threat and secondary appraisals of having to hold back from acting declined, problem-or emotion-focused coping strategies also decreased.

Supplementary measures of coping responses (see Table 16 and Figure 21), indicated that subjects in the Partly Matching group greatly increased their use of distancing, and decreased their use of accepting responsibility and positive re-appraisal as coping responses to stressors.

As demonstrated in Table 18, these two cases did not differ greatly from the group of subjects who demonstrated a pattern of cognitions consistent with the model in terms of demographic characteristics or initial severity of depression. They did differ in that individuals in the partly corresponding group had been depressed for a longer length of time, had higher initial stress ratings, felt greater threat to their own well-being, and had higher initial levels of problem-solving coping and escape-avoidance coping.

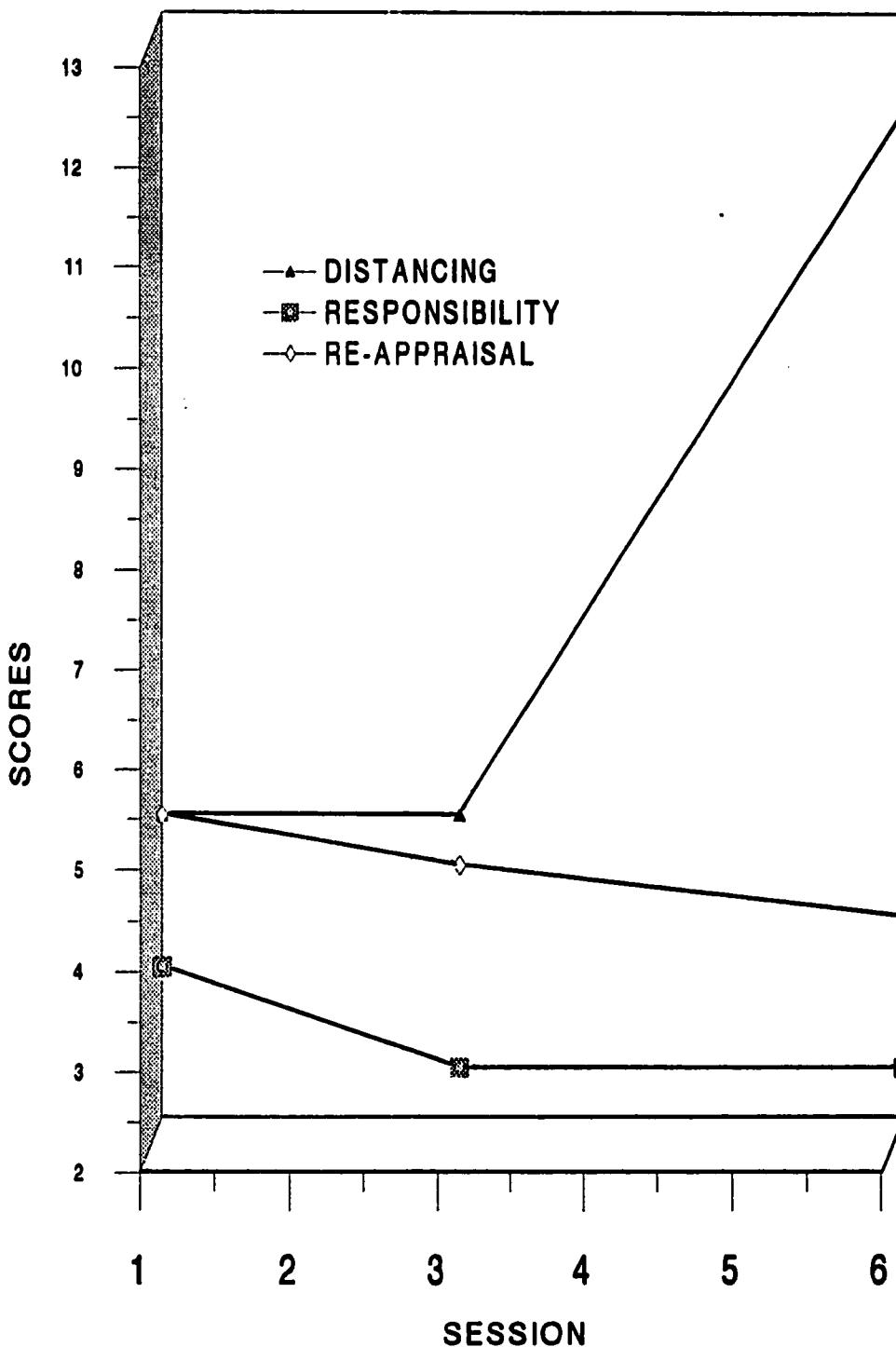


Figure 21. Mean Scores for the Supplementary Coping Responses in the Instrumental Partly Matching Group

Table 18

Means, (Standard Deviations), and Percentages of Demographic Characteristics and Pre-intervention Levels on Depression and the Dependent Variables of Instrumental Reminiscence Subjects who Match, Partly Match, and Do Not Match the Predicted Pattern of Change Processes

| Variable | Match Model | Partly Match Model | Do Not Match Model |
|----------------------------------|------------------------|------------------------|------------------------|
| Age | 68.50 (4.12) | 66.83 (4.67) | 67.88 (7.34) |
| Gender | 60% Male 40% Female | 50% Male 50% Female | 0% Male 100% Female |
| Marital Status | 60% Married | 50% Married | 50% Married |
| Education* | 3.80 (0.48) | 4.50 (0.71) | 2.00 (0) |
| Physical Health* | 3.80 (0.48) | 4.00 (1.41) | 3.50 (0.71) |
| Severity of Depression (GDS) | 17.20 (4.92) | 17.50 (3.54) | 21.0 (7.07) |
| Length of Depression (months) | 15.29 (7.18) | 10.00 (1.41) | 26.00 (7.00) |
| Past Depression | 40% Yes | 0% Yes | 50% Yes |
| Self-esteem | 27.60 (1.82) | 20.00 (16.97) | 25.50 (0.71) |
| Life Control | 37.80 (4.55) | 43.50 (3.54) | 28.50 (2.12) |
| Goal Seeking | 47.00 (7.84) | 50.5 (7.80) | 41.00 (15.60) |
| Threat to Own Well-Being | 3.80 (1.79) | 6.50 (3.54) | 5.00 (0) |
| Threat to Loved One's Well-Being | 3.80 (4.38) | 1.50 (2.12) | 8.00 (0) |
| Threat to Self-Esteem | 5.40 (8.26) | 3.00 (1.41) | 7.00 (2.83) |
| Hold Back | 3.00 (0.71) | 3.50 (0.71) | 4.50 (0.71) |
| Problem-solving Coping | 4.71 (1.80) | 8.00 (5.66) | 7.25 (4.99) |
| Escape-avoidance Coping | 2.60 (0.89) | 6.50 (0.71) | 7.50 (6.36) |

Note: * Higher scores indicate higher levels of health and education

Results that Do Not Match the Instrumental Model: Case Study of Mrs. G and CaseReplications

The following cases involve individuals whose pattern of results do not match the hypothesized instrumental model. In this group, each client demonstrated no change or a decline on the GDS at post-test. Twenty-two percent of subjects in the Instrumental group fall into this category (see Table 14). The basic form of the process data that Do Not Match the predicted model is shown in Figures 22-25. Means and standard deviations of the process data for the Partly Matching group at pre-, mid-, and post-test are found in Table 15. For subjects in the group that Do Not Match the predicted pattern of change on the GDS, there is no consistent pattern of improvement or deterioration on any of the dependent variable categories of coping resources, primary and secondary appraisals, or coping responses. Indeed, at least five to seven of the twelve process measures show a change in the opposite direction than was predicted by the model.

The results demonstrated by subjects in the Instrumental group who do not match the predicted change processes is illustrated by the case study of Mrs. G. Mrs. G, is an 82 year-old widowed woman with a high school education who reported being in average physical health. Mrs. B had experienced several periods of depression throughout her adult life. Approximately three weeks before the study, Mrs. G was interviewed and presented with a score of 17 on the HRS-D and 18 on the GDS. She indicated that she had been feeling depressed for over a year. Mrs. G's pre-test score on the GDS taken on the day the intervention began was 16, indicating a moderate level of depression. Initially, Mrs. G demonstrated a moderate level of self-esteem

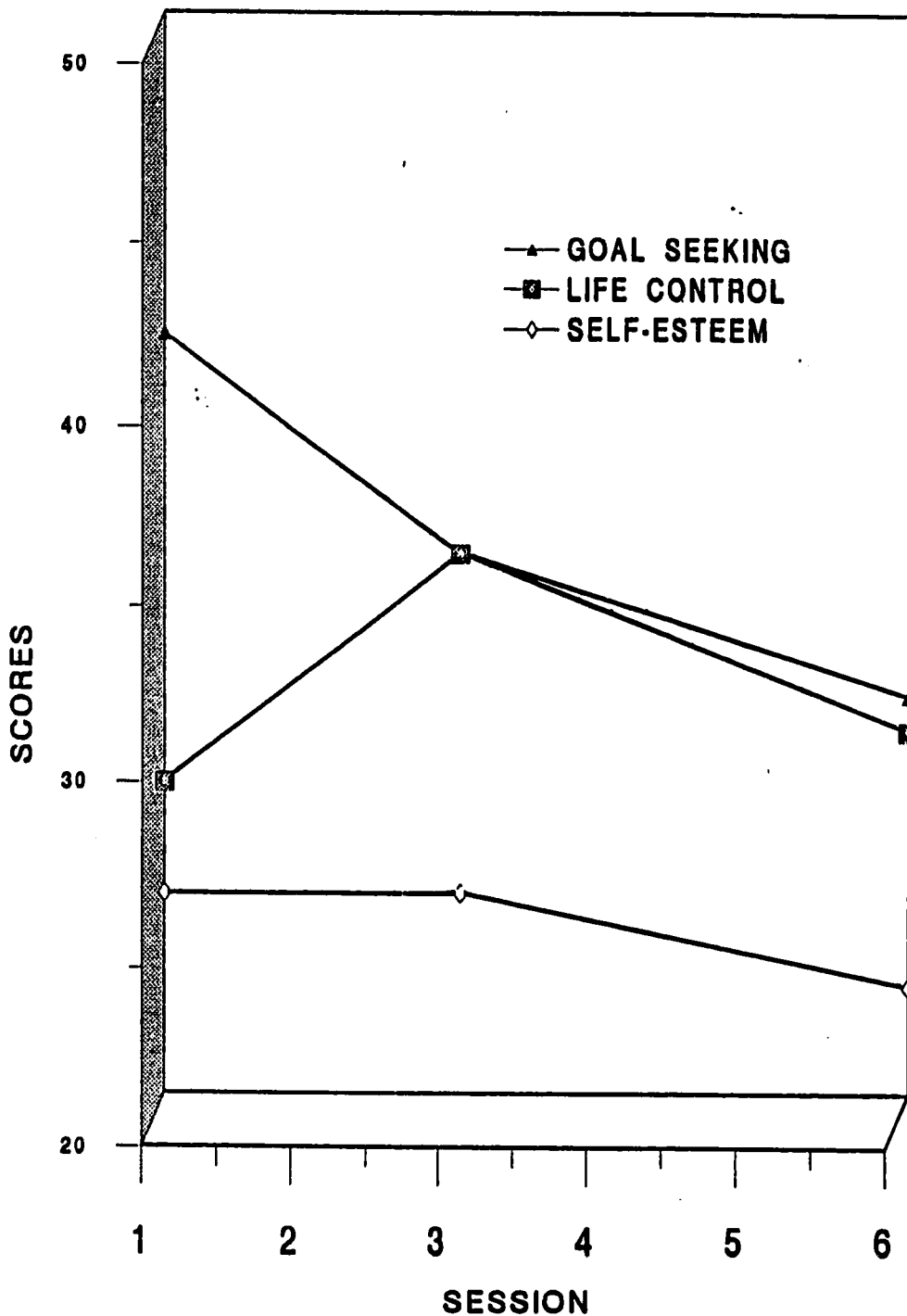


Figure 22. Mean Scores for the Instrumental Do Not Match Group: Coping Resources

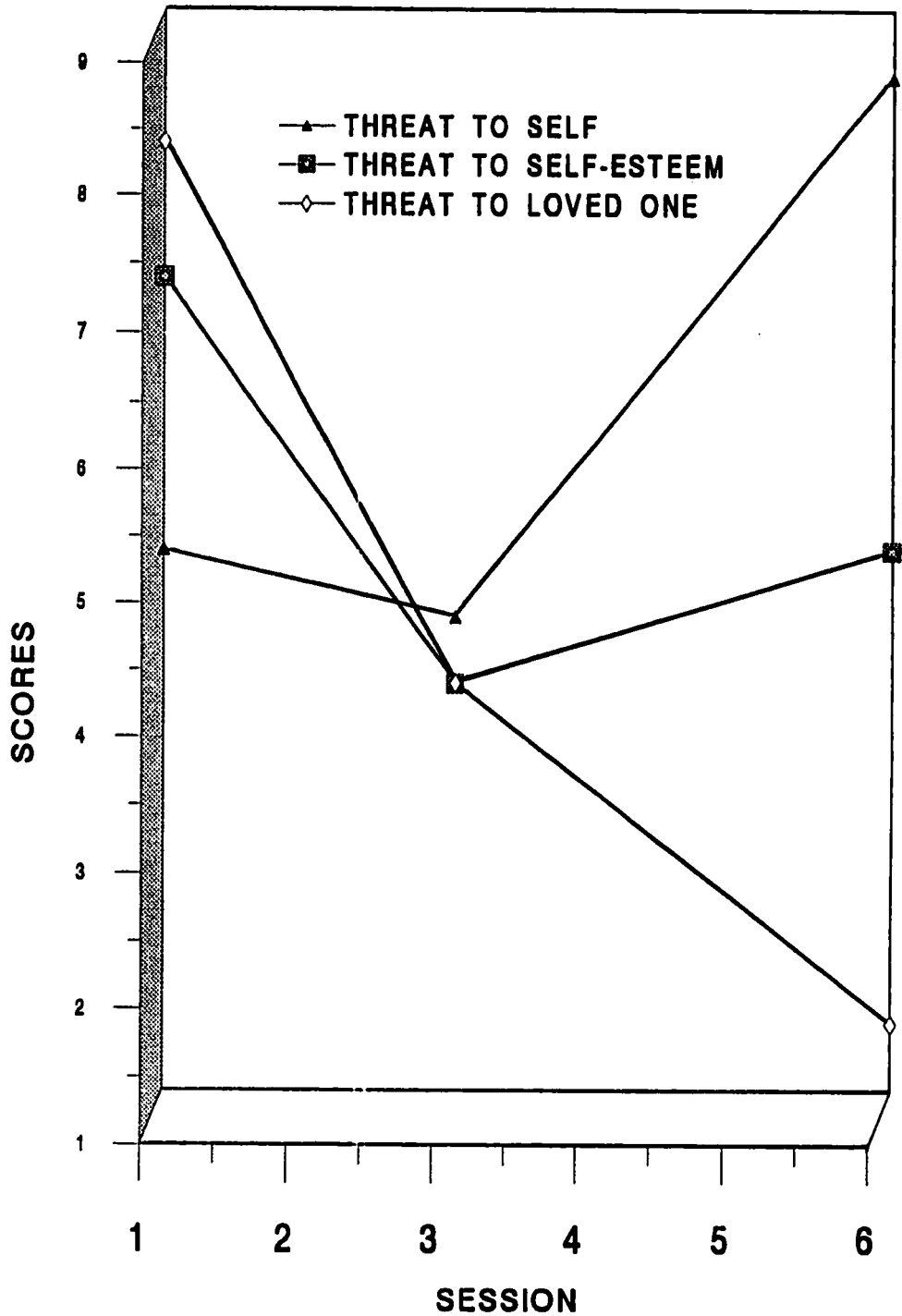


Figure 23. Mean Scores for the Instrumental Do Not Match Group: Primary Appraisals

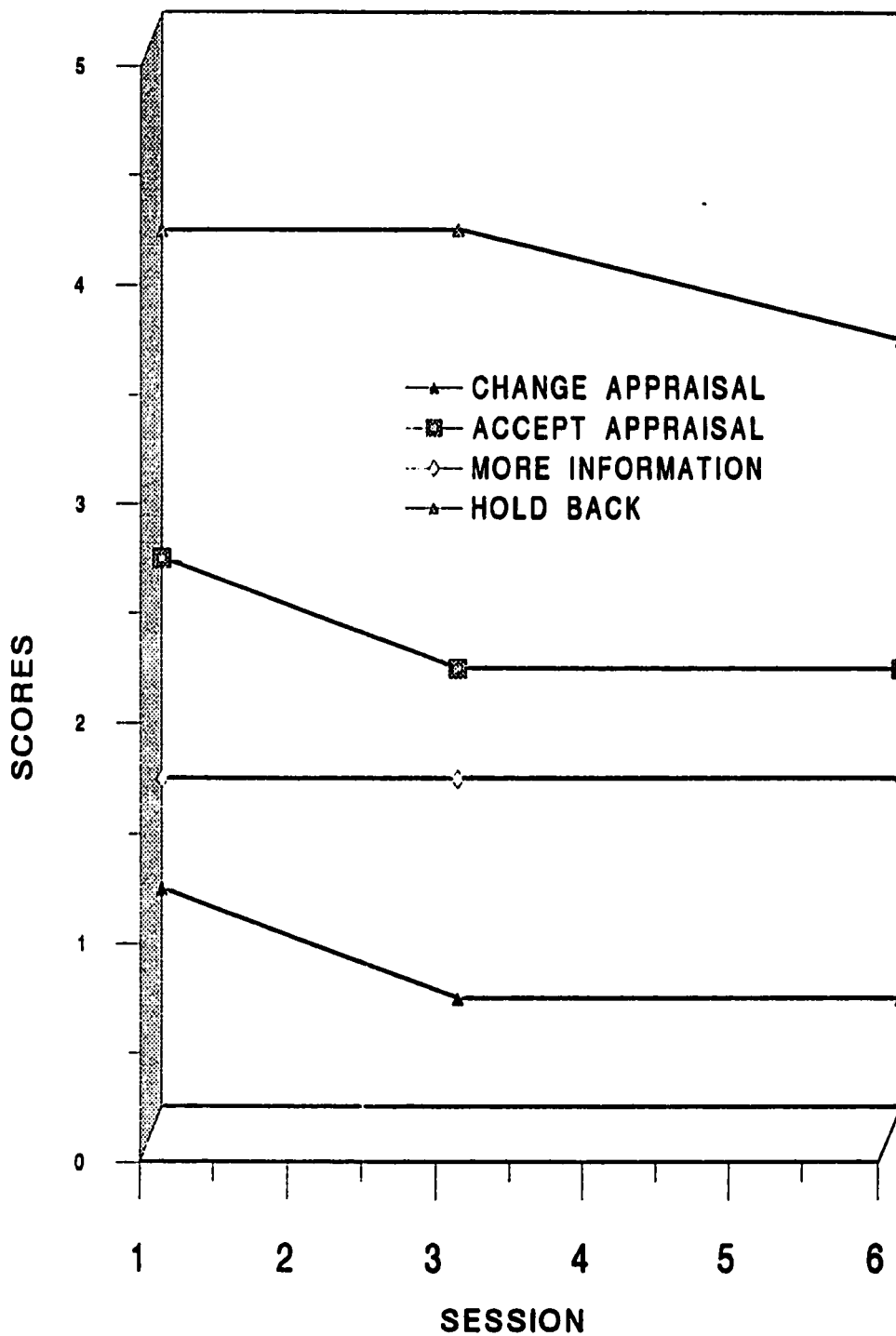


Figure 24. Mean Scores for the Instrumental Do Not Match Group: Secondary Appraisals

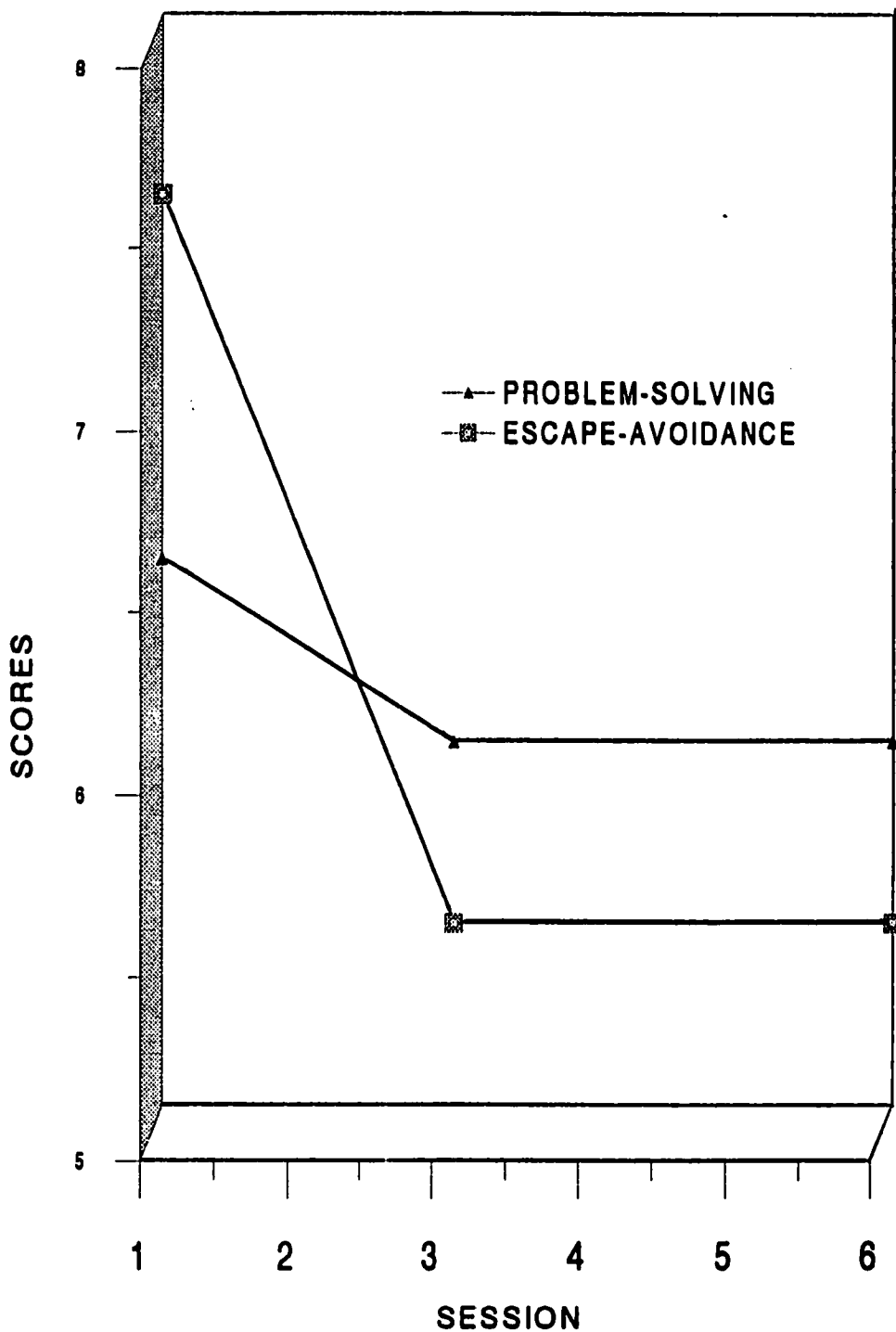


Figure 25. Mean Scores for the Instrumental Do Not Match Group: Coping Responses

and life control. Her stress intensity rating was high, primary appraisals of threat to herself and loved one's were initially high, in terms of secondary appraisals she felt great pressure to hold back from acting, a low level of problem-solving and a high level of escape-avoidance.

In general, as Mrs. G engaged in the instrumental reminiscence process, her coping resources declined, her primary appraisals of threat to her own well being increased, her experience of having to hold back from acting remained high, problem-solving remained unchanged, and escape-avoidance coping decreased, perhaps leading to more depression as she became more aware of her problems (see Figures 22I-24I). In turn, Mrs. G's score on the GDS increased. She demonstrated no improvement in social adjustment scores. At a three month follow-up, Mrs. G scored within the mildly depressed range on the HRS-D.

One other participant, Mrs. H (60 years old, married, high school education, good health status) demonstrated a similar pattern of scores (see Figures 25I-27I). Once coping resources declined, primary appraisals of threat and the need to hold back from acting remained high, problem-solving (perhaps ineffective problem-solving) remained high and stable, but escape-avoidance coping increased. At the end of the intervention, Mrs. H's GDS score had increased one point and she remained in the severely depressed range. On supplementary measures of coping responses (see Table 16 and Figure 26), subjects in the Do Not Match group showed a moderate increase in the use of distancing, a significant decrease in accepting responsibility, and no change in the use of positive re-appraisal as coping mechanisms. As illustrated in Table 18, these two cases differed from the group of subjects who demonstrated a pattern of cognitions consistent with the model in that the two subjects had less education and had

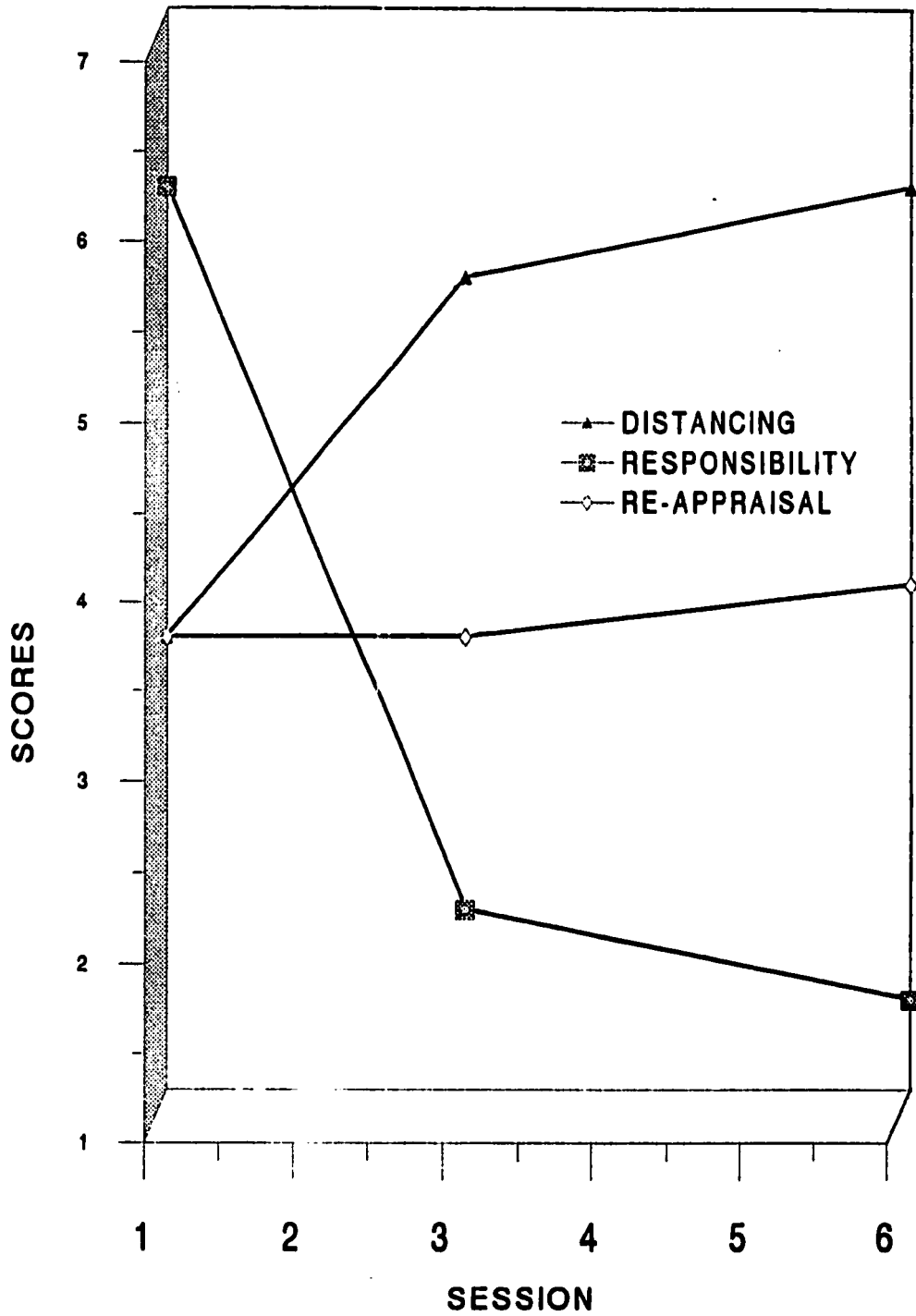


Figure 26. Mean Scores for the Supplementary Coping Responses in the Instrumental Do Not Match Group

experienced chronic depression throughout adult life. These two individuals also demonstrated higher initial levels of stress, higher primary appraisals of threat and secondary appraisals of having to hold back, and more problem-solving and escape-avoidance coping.

Quantitative Analysis of Instrumental Data

The qualitative analysis in the previous section is supplemented by quantitative analysis designed to determine whether the patterns of change predicted by the Instrumental model is specific to the Instrumental group, or whether it is as likely to occur in the Active Socialization Control group. A Mann-Whitney U test was performed which evaluated the number of subjects in the Instrumental group who demonstrated the predicted pattern (i.e., improvement on the GDS and the process measures), as compared to the number who followed the predicted pattern in the Active Socialization Control group. The results indicate that there is a statistically significant difference such that subjects in the Instrumental group are more likely to demonstrate the predicted pattern than those in the Active Socialization Control group ($U= 41$, $p< .007$). The probability that individuals randomly selected from the Instrumental group will demonstrate the expected pattern in cognitive change processes is .91. And there are 11.38 times more subjects in the Instrumental group who demonstrate the predicted pattern than in the Active Socialization Control group.

Outcome Research

The efficacy of Integrative and Instrumental reminiscence interventions was evaluated

by examining the outcome data from the two experimental groups in comparison to the outcome scores achieved in an Active Socialization Control group. Outcome data consist of scores on the GDS and the SAS taken upon completion of the 6-week intervention, and HRS-D scores taken at a three-month follow-up session. These data were classified into three ordinal categories: Decline, No Change, and Improvement. Assignment to one of the three categories was determined by classifying final scores in terms of clinically significant improvement, no change or clinically significant deterioration in performance. Following Jacobson, Revenstorf and Follette (1984), a score was classified as representing clinical improvement when: a) the change in pre-test to post-test scores was reliable (i.e., the amount of change did not reflect measurement error according to Jacobson *et al's* Reliable Change Index); and, b) the post-test scores improved to within a range at least 2 standard deviations away from the mean of the dysfunctional population, in the direction of higher functioning. Clinically significant deterioration was determined when the change in a score from pre-test to post-test was reliable according to the Reliable Change index and in the direction of lower levels of functioning. The null hypothesis that the Experimental and Control therapies are equally effective in achieving clinically significant improvement was evaluated with the Mann-Whitney U test.

In the Integrative group, the null hypothesis was rejected on two of the three outcome measures. The Integrative intervention was superior to the Active Socialization Control intervention in achieving clinically significant improvement on the GDS ($U=51.5$, $p<.01$) and at three month follow-up on the HRS-D ($U=57.5$, $p<.0001$). A significant difference was not found between the number of subjects in the Integrative and Active Socialization Control

groups who experienced clinically significant improvement on the SAS ($U=40$). Table 19 displays the percentage of subjects falling within the 3 categories for the Integrative and Control groups on the GDS, HRS-D, and SAS.

This analysis indicates that the Integrative reminiscence intervention is both statistically and clinically superior to an Active Socialization Control group in terms of treating depression, but Integrative reminiscence did not significantly improve social adjustment. Additional measures that highlight the clinical utility of the Integrative reminiscence intervention (see Table 20) are: a) a high probability that a subject randomly sampled from the Integrative group will have a better outcome than a subject randomly sampled from the Control group (i.e., the effect size); and, b) a larger number of subjects in the Integrative group who experience a superior outcome than do subjects in the Active Socialization Control group (i.e., the Generalized Odds Ratio-GOR).

Analysis of data from the Instrumental intervention indicates that the experimental group was superior to that of the Active Socialization Control intervention in achieving clinically significant improvement on the GDS at post-test ($U=36.5$, $p < .05$) and at three month follow-up on the HRS-D ($U=40$, $p < .01$). Improvement in scores on the SAS for the Instrumental group versus the Active Socialization Control group approached but did not achieve a significant difference the SAS ($U=34.5$). Table 19 displays the percentage of subjects falling within the 3 categories for the Instrumental and Control groups. In addition, both the effect size and the GOR are high on all three outcome measures indicating a high degree of clinical utility for the Instrumental intervention (see Table 20).

Table 19

Percentage and (Number) of Subjects in the Integrative, Instrumental, and Control Groups in the Categories of Clinical Improvement, No Change, and Clinical Deterioration on the GDS at Post-Test Outcome

| <u>Group</u> | <u>Decline</u> | <u>No Change</u> | <u>Improvement</u> |
|----------------|----------------|------------------|--------------------|
| Integrative | 8% (1) | 33% (4) | 58% (7) |
| Instrumental | 11% (1) | 33% (3) | 56% (5) |
| Active Control | 40% (2) | 60% (3) | 0% (0) |

Percentage and (Number) of Subjects in the Integrative, Instrumental, and Control Groups in the Categories of Clinical Improvement, No Change, and Clinical Deterioration on the SAS at Post-Test Outcome

| <u>Group</u> | <u>Decline</u> | <u>No Change</u> | <u>Improvement</u> |
|----------------|----------------|------------------|--------------------|
| Integrative | 0% (0) | 58% (7) | 42% (5) |
| Instrumental | 0% (0) | 33% (3) | 67% (6) |
| Active Control | 20% (1) | 60% (3) | 20% (1) |

Percentage and (Number) of Subjects in the Integrative, Instrumental, and Control Groups in the Categories of Clinical Improvement, No Change, and Clinical Deterioration on the HRS-D at Three-Month Follow-up

Outcome

| <u>Group</u> | <u>Decline</u> | <u>No Change</u> | <u>Improvement</u> |
|----------------|----------------|------------------|--------------------|
| Integrative | 0% (0) | 0% (0) | 100% (12) |
| Instrumental | 0% (0) | 22% (2) | 88% (7) |
| Active Control | 0% (0) | 100% (5) | 0% (0) |

Table 20

Effect Size and Generalized Odds Ratio for Integrative and Instrumental Reminiscence on the GDS at Post-test

| Group | Effect Size | Generalized Odds Ratio |
|--------------|-------------|------------------------|
| Integrative | 0.86 | 6.14 |
| Instrumental | 0.81 | 4.26 |

Effect Size and Generalized Odds Ratio for Integrative and Instrumental Reminiscence on the SAS at Post-test

| Group | Effect Size | Generalized Odds Ratio |
|--------------|-------------|------------------------|
| Integrative | 0.67 | 2.03 |
| Instrumental | 0.76 | 3.35 |

Effect Size and Generalized Odds Ratio for Integrative and Instrumental Reminiscence on the HRS-D at Three-Month Follow-up

| Group | Effect Size | Generalized Odds Ratio |
|--------------|-------------|------------------------|
| Integrative | 0.96 | 24.00 |
| Instrumental | 0.89 | 8.09 |

These findings indicate that both the Integrative and Instrumental reminiscence groups are effective in ameliorating symptoms of depression in older adults. Although the two reminiscence interventions appear to be equally effective at the end of the six-week intervention, at a three-month follow-up the Integrative reminiscence intervention appears to be somewhat more effective than the Instrumental group. This finding suggests that participation in an Integrative reminiscence group may afford greater protection against relapse, however, the small sample size precludes any firm conclusions.

Summary of Results

The hypothesis that integrative and instrumental reminiscence engage participants in cognitive and coping activities that ameliorate depression was supported. In the Integrative group, 58% of participants demonstrated the pattern of psychological change processes predicted by the model developed in this research. An additional 17% were generally consistent with the pattern predicted in the model with the exception that they did not demonstrate the expected changes in internal and stable attributions for the causes of negative events. In the Instrumental group, 56% of participants demonstrated a pattern of responses that is consistent with the model and an additional 22% were generally consistent with the pattern predicted by the model. These findings provide support for the reliability and generalizability of the models developed to explain how integrative and instrumental reminiscence effect therapeutic changes in depressed older adults.

The adjunct hypothesis that the pattern of change in psychological processes that play an important role in depression can be specifically attributed to participation in the Integrative and Instrumental interventions was also supported. The Mann-Whitney U analysis revealed that the predicted pattern of change was statistically more likely to occur in individuals participating in the Integrative and Instrumental groups than in subjects who participated in an Active Socialization Control group.

The assessment of the efficacy of integrative and instrumental reminiscence interventions in the treatment of depression demonstrated that both types of reminiscence are effective in producing clinically significant change in depressive symptomatology in a sample of older, depressed adults. Furthermore, the reminiscence interventions demonstrated greater treatment effectiveness than an Active Socialization Control group.

DISCUSSION

In the theoretical literature, reminiscence has been identified as an activity that can promote adaptation in older adults (e.g., Birren, 1987; Butler, 1963). Empirical research has provided some support for this position with evidence that reminiscing can promote greater life satisfaction, self-esteem, and ability to cope with stressors in older adults (e.g., Coleman, 1974; Rybarczyk & Auerbach, 1990; Sherman, 1987). There is also some data supporting the efficacy of reminiscence in the treatment of clinical syndromes such as depression and anxiety in elderly individuals (e.g., Arean, Perri, Nezu & Schein, 1993; Fry, 1983; Georgemiller & Maloney, 1984; Harp Scates, Randolph, Gutsch & Knight, 1985-86; Rybarczyk & Auerbach, 1990).

These findings, however, are not uncontested and there are a number of studies which do not support the efficacy of reminiscence in treating depression, or improving adaptation in general (e.g., Stevens-Ratchford, 1993; Weiss, 1994). The lack of clarity regarding the adaptive potential of reminiscing has continued to exist primarily because empirical research has been outcome-oriented with little effort made to develop a clear understanding of how reminiscence may act to achieve therapeutic benefits. Without knowledge of the workings of reminiscence, researchers are not able to identify key therapeutic processes or to deliver these therapeutic interventions in a systematic fashion to the appropriate clinical populations.

The primary goal of this research was to address the limitations in knowledge of reminiscence as an adaptive activity by identifying the fundamental therapeutic content of reminiscence and the psychological processes evoked by reminiscence that contribute to relief from depression. This research contributes to the literature on reminiscence and psychotherapy by defining and operationalizing the theoretical foundations of reminiscence interventions.

The second goal of this research was to evaluate the effectiveness of reminiscence as a therapeutic intervention. In contrast to the existing body of literature, the present research identified appropriate target populations and highlighted the key therapeutic elements of reminiscence based on a solid understanding of the dynamics of two particular types of reminiscence--integrative and instrumental. This specific, theory-driven approach has permitted a valid assessment of the effectiveness of reminiscence as a psychotherapeutic intervention designed specifically to treat depression in older adults, and it helps to clear up the contradictory findings regarding the adaptive function of reminiscence. Before exploring the specific content and processes of reminiscence that were found to ameliorate depression in older adults, the findings regarding the effectiveness of reminiscence as a therapeutic intervention are addressed in the next section.

Outcome Research

In evaluating the effectiveness of reminiscence as a therapeutic intervention, a traditional between-groups statistical analysis of the differences between experimental and control groups on measures of depression and social adjustment was not conducted due to a small sample size. As such, this research has some limitations in its comparability to other research. However, it does supply information on the effect sizes of the interventions which can be compared with other studies. In addition, through the use of a clinical intervention replication case study design, this research has the advantage of providing critical data on the proportion of clients helped by the interventions, as well as information on the characteristics of individuals who were or were not served by this intervention.

Despite its recognized heuristic value, the case study is often discounted as a potential

source of scientifically validated inferences because threats to internal validity cannot be ruled out to the same degree as they are in experimentation (e.g., Hersen & Barlow, 1984). However, as Kazdin (1981) and Kratochwill (1992) point out, under several circumstances the case study can lead to knowledge about treatment effects for a given client that approximates the information achieved in experimentation. Kazdin and Kratochwill view case studies and experiments as falling along a continuum that reflects the degree to which scientifically adequate inferences can be drawn. They go on to identify a number of research characteristics that control threats to internal validity and, therefore, maximize valid inferences from case studies. All of the research characteristics designed to control threats to internal validity that were identified by Kazdin and Kratochwill were employed in the present research and are presented in Table 21.

Are Integrative and Instrumental Reminiscence Therapeutic Activities for Older Depressed Adults?

This preliminary investigation of the utility of reminiscence as a treatment for depression in older adults provided support for the hypothesis that certain types of reminiscence, integrative and instrumental, can be therapeutic activities. In comparison to an Active Control group, individuals in both reminiscence groups demonstrated statistically and clinically greater improvement in depression (GDS, HRS-D). Further, at the end of the six-week intervention, both reminiscence groups were equally effective in reducing symptoms of depression.

One of the important aspects of this finding is that specific types of reminiscence were shown to lead to significant improvements in depression. In previous studies in which

Table 21

Research Characteristics Employed to Maximize Valid Inferences from Case-study Research

| Research Characteristics | High-Inference Strategies |
|---|--|
| Type of Data | Objective measures with good reliability and validity. |
| Assessment Occasions | Repeated measurement across phases of the study. |
| Planned vs. ex post facto | Inferences are drawn from an intervention that was part of a direct manipulation of an independent variable. |
| Projections of Performance | The history of the case suggests problems of long duration that are unlikely to change without treatment in the 6 week time period of the study. |
| Effect size | The effect size is large when considering trend and level of change in the data. |
| Effect Impact | The effect impact is immediate within the treatment phase. |
| Numbers of Subjects | The treatment effect is demonstrated across several subjects consistently. |
| Heterogeneity of Subjects | The treatment effect is demonstrated across subjects who differ on a variety of characteristics. |
| Standardization of Treatment | The treatment is procedurally outlined in a manual. |
| Integrity of Treatment | The treatment is monitored during implementation to determine its accuracy and reliability. |
| Impact of Treatment | Impact of treatment is demonstrated on multiple outcome measures with similar strong effects. |
| Generalization and Follow-up Assessment | Formal measures of generalization and follow-up are included. |

participants were free to reminisce as they desired, results were variable--some studies demonstrated an improvement in symptoms whereas others did not. By promoting a specific approach to the review of memories, which targets psychological processes that have been linked with the onset and maintenance of depression (e.g., Abramson's Hopelessness theory of depression; Beck's negative cognitive triad; Billings & Moos and Folkman & Lazarus' psychosocial approach to depression), reminiscing was shown to act as a powerful therapeutic intervention. To the extent that future investigations of reminiscence therapy continue to provide undifferentiated reminiscence interventions, it is likely that the therapeutic impact of the more adaptive forms of reminiscence will be obscured by non-therapeutic or counter-productive contributions made by other forms of reminiscence (e.g., obsessive reminiscence)--perpetuating the contradictory findings regarding the adaptive function of reminiscing.

To more fully understand the scope of reminiscence as a psychotherapeutic intervention, the impact that other types of reminiscence (e.g., transmissive, escapist, narrative) have on selected clinical problems also merits exploration. Further, additional research is needed to determine whether integrative and instrumental reminiscence have a positive impact on other clinical syndromes experienced by older adults, such as anxiety.

Are Integrative and Instrumental Reminiscence Effective and Efficient Therapeutic Interventions for the Treatment of Depression in Older Adults?

Reviews of the effectiveness of psychotherapy for the treatment of depression in adult and geriatric populations report that cognitive, behavioural, brief dynamic, interpersonal, and pharmaceutical therapy all are effective in obtaining positive results, and typically do not differ

in their degree of effectiveness (Gallagher & Thompson, 1982; Hollon, Shelton, & Davis, 1993; Neitzel, Russell, Hemmings, & Gretter, 1987; Robinson, Berman, & Neimeyer, 1990; Scogin & McElreath, 1994; Thompson, Gallagher & Breckenridge, 1987). On average, using the classification of effect sizes developed by Cohen (1969), these interventions produce effect sizes in the moderate range in both adult (0.73) and geriatric populations (0.78) when compared to no-treatment or to a control group (Robinson, Berman, & Neimeyer, 1990; Scogin & McElreath, 1994). In a study conducted by Thompson, Gallagher, & Breckenridge (1987) which examined the comparative effectiveness of psychotherapies for depressed older adults, overall, 53% of geriatric subjects achieved remission and another 18% showed significant improvement in depression following exposure to either behavioural, cognitive, or brief dynamic therapy.

In comparison to traditional treatments for depression, integrative and instrumental reminiscence interventions provide a comparable improvement in depression in older adults. Both integrative and instrumental reminiscence produced statistically significant improvements in depression compared with an active control group. Effect sizes were also within the range achieved by traditional therapies. The Integrative reminiscence intervention produced effect sizes in the moderate to high range--the probability that a given subject who participates in Integrative reminiscence will demonstrate improvement on the GDS and SAS at the end of the six week intervention was 0.86 and 0.67 respectively. In the Instrumental group the effect sizes fell within a similar range at 0.81 on the GDS and 0.76 on the SAS. Reminiscence interventions were also comparable to traditional therapies in terms of the proportion of clients achieving clinically meaningful improvement. In the Integrative group, 58% of clients showed remission of symptoms at the end of the six week intervention and an additional 33% showed some

improvement in symptoms of depression. And in the Instrumental group, the proportion of clients who no longer demonstrated significant symptoms of depression at six weeks was 55%, with an additional 33% showing some improvement in depressive symptomatology.

The fact that the interventions appeared to have less of a positive impact on SAS scores than on measures of depression may be due to the type of social adjustment assessed by the SAS. The SAS measures the quality of relationships with spouse, children, other relatives, and friends--improvements indicate less strife and antagonism and greater trust and communication. Given that the reminiscence interventions did not specifically target interpersonal communication, it is not likely that significant gains would be made in this area, especially over the course of a relatively brief six week intervention. In retrospect, a measure that assesses the degree to which individuals increased the amount of their social interaction and participation in pleasurable activities may have been a better index of the kind of improvement in social adjustment that tends to co-occur with amelioration of depression. It is also of note that initial scores on the SAS were higher than what is typically reported in a depressed population. A ceiling effect may, therefore, have been in operation.

It is significant that positive results comparable with traditional interventions were obtained within a comparatively short time frame involving one 90 minute therapy session each week for a period of six weeks. In their review of psychosocial treatments for depression in older adults, Scogin & McElreath (1994) report that clinical studies on average provide a much greater number of sessions (mean of 12 with a range of 5 to 46 sessions), albeit with effect sizes no greater than those obtained in this study. The rapidity with which the reminiscence interventions had a positive impact on depressive symptomatology may be due to the fact that

reminiscing does not involve learning a new vocabulary or a new set of skills prior to engaging in therapy, rather, clients begin the therapeutic process immediately. It may also be that clients feel comfortable with reminiscing because it is a familiar pastime that focuses on material about which the client is an expert (personal memories). This sense of familiarity may calm fears about engaging in a therapeutic process as well as providing a sense of control over the intensity and rate of disclosure of their reminiscences--which in turn may accelerate the rate of engagement in the therapeutic process.

It is of note that subjects in the reminiscence groups were requested to complete homework between sessions. However, given that homework was also part of many of the cognitive and behavioural interventions reported by Scogin and McElreath (1994) that had similar effect sizes but many more treatment sessions, it is unlikely that the use of homework fully explains the speed with which therapeutic gains were made. It may be, though, that participants performed their homework more often than in the traditional interventions because the homework involved remembering and reflecting on one's life--an activity which is relatively effortless and often occurs unbidden. Homework in the more traditional therapies, however, often requires more effort and may be seen as an activity that has to be scheduled in and "must be done."

Maintenance of Gains and Continued Improvement in Depression at a

Three-month Follow-up Assessment

The rapid treatment effect obtained by some of the subjects in the integrative and instrumental reminiscence groups at the end of the six week intervention was maintained by all

of these subjects at a three-month follow-up assessment. Remarkably, at the follow-up assessment, not only were gains maintained but rates of improvement were significantly higher than at the post-test assessment. In the integrative group the proportion of subjects demonstrating clinically significant improvement rose from 58 to 100%, and in the instrumental group, from 56 to 88% of patients, as measured by the HRS-D. Although these findings need to be replicated on a larger scale than the number of case replications reported here, these rates of improvement far exceed those reported for traditional psychotherapies used to treat depression in older adults.

There is clearly a question of whether the improvement that occurred between the end of the six week therapy sessions and the three month follow-up was due to the reminiscence interventions. Support for this hypothesis stems from the finding that none of the individuals in the Active Socialization Control group demonstrated improvement at the end of the 6 week intervention on the GDS, or at three-months follow-up on the HRS-D. Furthermore, subjects were provided with follow-up booster sessions at 1 and 3 months after the completion of therapy, which may have helped to consolidate gains and promote use of reminiscence. When interviewed at the follow-up session all subjects in the experimental groups indicated that they had continued to use reminiscence during the three-month time period. Indeed, it is unlikely that once exposed to the issues and ideas discussed in the treatment sessions that subjects would not continue to think about and consider their reminiscences.

An additional explanation for the continued improvement following the end of treatment may be due to the format of reminiscing--the review involves attending to longitudinal data across the entire lifespan and, therefore, may only result in change when sufficient data has been

processed over a period of time. It is also possible that the observer rated HRS-D may have provided a more sensitive measure of change in depressive symptomatology than the self-report GDS, with the result that improvement in symptoms was under-reported at the post-test assessment.

It is of note that, although the two reminiscence groups yielded very similar rates of improvement in depression at the end of the six week interventions, at follow-up, the integrative reminiscence group appeared to demonstrate a greater rate of continued progress. It may be that integrative reminiscence interventions promote somewhat greater maintenance of gains and/or protection against relapse than do instrumental interventions, however, this possibility needs further exploration with a larger sample of subjects.

Who Benefits from Integrative and Instrumental Reminiscence?

Individuals who achieved a rapid improvement in depression varied widely in terms of demographic characteristics, diagnostic status, and pre-intervention levels on the dependent variables. As such, the positive impact of integrative and instrumental reminiscence on depression appears to be generalizable within a broad population of older adults. However, as is typical in psychotherapy research (e.g., Thompson, Gallagher, & Breckenridge, 1987), the current study reported significant variability in outcome in both reminiscence groups at the end of the six week intervention. Analysis of individual data revealed several subject characteristics which differentiate those individuals who achieved a significant improvement in depression at the close of a six week reminiscence intervention from those who did not. Compared to those individuals in the Integrative group who did not significantly improve at the end of the six week

intervention, those who improved were more likely to be married, to have experienced symptoms of depression for less than one year, and to have had no previous episodes of clinical depression throughout their adult life. Within the group of 12 individuals who participated in the integrative intervention, there was tremendous range in initial level of dysfunction on the dependent variables. As such, this factor did not seem to play a significant role in affecting the success of the intervention per se.

In the instrumental group, overall, there were few differences between the group that improved at the end of the six week intervention and those who remained at the same level of depression. However, when only those individuals who experienced further decline in functioning at the end of the six week treatment are compared with those individuals who improved significantly, differences between the two groups appear. The individuals in the group who improved had experienced the current episode of depression for a much shorter time, and demonstrated greater coping resources and more positive appraisals of stressors than those individuals who declined over the course of the intervention.

It would appear that initial severity of depression does not play a significant role in predicting those individuals who will benefit from treatment from those who do not improve at the end of the six week treatment. Rather, the length of time the individual has experienced the current depressive episode is an important predictor of outcome in both the integrative and instrumental groups. In the instrumental group initial coping resources also appear to aid in the prediction of outcome, while in the integrative group, the support of a spouse and previous experience with depression play a predictive role.

The importance of length of the current depressive episode and number of previous

depressive episodes has been highlighted elsewhere (Hammen, Miklowitz & Dyck, 1986; Safran, Segal, Hill & Whiffen, 1990; Segal & Vella, 1990). These authors suggest that individuals who have had frequent episodes of depression or who are experiencing a current depressive episode of long duration, develop negative schemas that are more salient and well-developed and, therefore, are more susceptible to activation than the negative schemas of individuals who are suffering from their first depressive episode, or who have been depressed for a short period of time. As such, the brevity of a six week intervention may not have been sufficient time to produce clinically meaningful change in those patients with well-entrenched negative schema (e.g., more threat-oriented approaches to coping; greater feelings of hopelessness).

There appear to be certain factors that predict the rate of a positive outcome in the reminiscence groups. It is of interest, also, to explore possible explanations for the decline in functioning at six weeks of one individual in the Integrative group and one in the Instrumental group as their outcome is not readily explained by these predictive factors. One primary factor which differentiated the two individuals in the integrative and instrumental groups who demonstrated a decline in functioning at post-test was low expectations for the efficacy of the reminiscence treatment. According to self-efficacy theory (Bandura, 1977; 1982), psychological change can be explained and predicted by an evaluation of changes in an individual's expectations regarding the efficacy of a particular treatment. Expectancy evaluations are made up of: 1) outcome expectancy, the belief that a given behaviour will or will not lead to a given outcome (e.g., relief from depression); 2) a self-efficacy expectancy, the belief that the person is or is not capable of performing the requisite behaviour (e.g., successful reminiscence); and, 3) outcome value, the belief that it is important to attain a particular outcome (e.g., relief from

depression). Goldstein (1962) has supported the importance of outcome expectancy to treatment outcome, with the finding that differential expectations about the ability of a treatment to alleviate symptoms can have an effect on attrition, compliance, and outcome of the intervention. Little research has focused on the impact of self-efficacy expectations on treatment outcome, as separate from outcome expectations. Maddux, Norton, and Stoltenberg (1986), however, have shown that self-efficacy and outcome expectancies, and outcome value all are significant predictors of behavioural intentions. In this research, outcome expectations appear to play a predictive role for some subjects in terms of treatment outcome.

It is also of note that the two individuals who declined in functioning at post-test also demonstrated significantly lower levels of education than those who improved. The differential amount of education between groups may also have contributed to a decreased readiness to engage in and comprehend some of the principles discussed in the reminiscence interventions.

A number of factors appear to predict differential rates of improvement at the end of the six week intervention (i.e., length of current episode of depression, previous depressive episodes, outcome expectancy, level of education). The data show, however, that over time all subjects who participated in the Integrative reminiscence intervention and 88% of subjects in the Instrumental group demonstrated clinically significant improvement in depressive symptomatology at the end of the two booster sessions (three months after the close of the six week intervention). As such, in this research, the majority of participants eventually gained substantial benefit from the reminiscence interventions regardless of demographic characteristics, initial severity of depression, pre-intervention levels on the dependent variables, education, initial self-efficacy beliefs, and the frequency and duration of depressive episodes. Indeed, this

finding supports the hypothesis that although individuals with longer current episodes of depression and/or previous experiences of depression may require longer time and practice to overcome depression, reminiscence interventions are effective with people with these symptom histories.

Process Research

The data collected from a group of older adults experiencing depression who participated in the Integrative or Instrumental reminiscence interventions provides insight into the psychological processes involved in these forms of recollecting that have a positive impact on depression. Not all of the subjects in the integrative and instrumental reminiscence groups demonstrated the pattern of change processes predicted by the models developed in this research. However, this finding is consistent with the hypothesis that there is a direct relationship between participating in reminiscence and improvement in symptoms of depression. In other words, those individuals who did not experience positive change on the dependent variables also did not improve in terms of depression. Those individuals who demonstrated some change in the predicted direction on the selected psychological processes also showed some improvement in depression, but not at a clinically significant level. The following discussion of process data, which describes the workings of integrative and instrumental reminiscence, is based on those individuals who both demonstrated a consistent pattern of change on psychological variables and who demonstrated clinically significant improvement in depression.

Integrative Reminiscence

Description and explanation of the relationship between integrative reminiscence and depression was developed from an understanding of theory-based cognitive models of depression as outlined by Beck et al (1976) and Abramson et al (1988). Cognitive models of depression identify individuals' beliefs about themselves, their attitudes towards and their assumptions about the world, and the attributions they make in situations of self-blame and self-criticism, as critical factors that play a role in the onset and maintenance of depression. According to these models, individuals who are vulnerable to depression have negative and self-critical schematic belief systems and their assumptions and attributions are systematically distorted in a negative direction. These negative attributions and thoughts about the self, world, and future are perpetuated by faulty information processing which selectively attends to negative features of life, while ignoring evidence of more positive aspects of living.

Based on this conceptualization of depression, a model was developed to trace the links between integrative reminiscence, changes in thinking processes and beliefs about the self, and relief from depression (see Table 2). Examination of the pattern of changes in process measures in a group of older depressed adults over the course of an integrative reminiscence intervention provides support for this model. Indeed, engagement in specific integrative reminiscence content resulted in the predicted pattern of change on measures of cognition and depression in the Integrative group, but not in the Active Socialization Control group.

Goals, Content, and Therapeutic Techniques in Integrative Reminiscence

Integrative reminiscence therapy recognizes the important role of cognitive processes in

depression. According to cognitive theory, individuals who are vulnerable to depression experience events in their present life which trigger a series of cognitions that are negative and self-defeating. In turn, these thoughts can lead to depression. In integrative reminiscence the drive toward understanding and evaluating one's life is thought to trigger depressogenic cognitions in individuals vulnerable to depression. As Erikson (1981) points out, for older adults, the primary task of late life involves reviewing and evaluating the past. This process may lead to a sense of integrity or acceptance of life as it was lived. The alternative, depression or despair, results when the life review stimulates ideas that one has not fulfilled one's potential, that one's needs have not been met, or that one has experienced enduring sadness throughout life. Although a life review can occur at any time throughout life, the negative cognitions that can arise may be particularly salient as individuals recognize that time for achieving their potential, having their needs met, and enjoying life, is rapidly disappearing.

As with cognitive therapy, the goal in treating depression is to assist individuals to alter the negative thoughts about themselves, the world, and the future that underlie depressive feelings. In pursuit of this goal, integrative reminiscence therapy emphasizes identification of the needs and goals that have been frustrated throughout life that lead to a negative self-definition, and eventually to depression. The focus is on helping individuals understand why they define themselves and their lives as they do, and on altering the self-definition through re-interpretation of the meaning of thwarted needs and goals.

Although it shares some techniques and goals with cognitive therapy, integrative reminiscence differs in its emphasis on memories as the primary content of therapy and the narrative format as the main method of achieving therapeutic progress. Memories from the

distant past (at least five years before therapy begins), form the basic content or therapeutic material of reminiscence therapy. This focus is in line with Butler (1974) and Birren's (Birren & Deutchman, 1991) hypothesis that a life review provides the vehicle through which late life adaptation is gained.

Many existing therapeutic interventions focus primarily on therapeutic content that involves current events or experiences that have occurred in the recent past. When interventions do place significant emphasis on the therapeutic use of older memories, it is often early childhood memories that are identified as having therapeutic importance. These recollections are viewed as windows through which critical motivations, goals, and needs can be identified and addressed in therapy. The memories may permit access to defining experiences that are no longer available to conscious awareness, but motivate the current symptoms and actions that brought the individual to analysis (e.g. Freud, 1899/1973). They may provide access to individuals' current motivations and drives (e.g., Adler, 1927), or they may permit insight into a system of internal thought associations which form individuals' schematic beliefs and influence their interpretations and actions throughout life (e.g, Beck et al, 1979). In all cases, the content of the memories is relevant primarily as an aid to identification and interpretation of individuals' underlying core psychological composition.

As with other therapeutic approaches, in reminiscence therapy, memories are valued because they provide access to the underlying psychological structure. However, it is not just early childhood memories that are deemed important, rather recollections across the entire lifespan are given equal significance. Indeed, it is by examining several critical incidents at different times of life and in different life domains (e.g., family, work, romantic relationships.

stressful times, turning points) that individuals begin to recognize repetitive patterns of emotional issues, ambitions, and needs that span the life course. Information from individual memories are less important than what is learned about the ebb and flow of goals and wants over time.

Clients learn about their needs and wants through investigation of both the content of the memory and the emotional reaction evoked by the events recalled. Examination of what was pleasant or unpleasant about an event, what was important in an experience, and the short- and long-term impact of an event all provide insight into the subjective and unique desires and aspirations at play for the individual. This approach recognizes that both early drives and motivators, as well as current goals and desires play a role in self definition. Indeed, the types of memories recalled will likely reflect important psychological processes formed in childhood, as well as those that are salient and important to the individual at present.

Understanding the psychological processes at play across the life span provides the important therapeutic material of integrative reminiscence. In this approach, the goal of having clients learn to identify the role of psychological processes in determining their self-definition, and thus, their emotions and actions is made a principle target. The client is given the primary role of selecting memories and of identifying the salient goals and needs in each event. As such, the self-definition and the understanding of its sources is conferred by the individual, not by the therapist's interpretation of the latent meaning of the memory. By tracing what was and was not achieved or obtained in these incidents, individuals draw conclusions about what are their important needs and goals, and more importantly, how the achievement and frustration of those psychological motivators contribute to how they define the self, and ultimately their feelings about themselves.

Once memories have been plumbed for the information they reveal about the source, development, and nature of self-definition, the therapeutic task is to re-interpret the definition of self in a way that combats depressogenic cognitions and feelings. Integrative reminiscence achieves this intent by helping clients step back from initial interpretations and emotional reactions to events and to re-interpret them in a self-supportive fashion. The narrative structure of integrative reminiscence is the catalyst to achieving a healthy and integrated view of the self. Adopting a story-telling approach fosters both a different and broader perspective on the life history which stems from: examining self-defining events from the perspective of the entire lifetime; weighing past events in terms of present knowledge and circumstances; recognizing contextual and historical factors that contributed to and determined the outcome of an event; taking the perspective of understanding past events in terms of their subjective meaning in the life story; and taking the perspective that a variety of ways for evaluating an experience are admissible. Ultimately this re-view of life events yields a re-interpretation of the meaning of goals and ambitions in one's life and the impact they have on self-definition and mood.

As demonstrated in this research, like cognitive therapy, integrative reminiscence is effective in altering the depressogenic attributional style and negative thoughts about the self, the world, and the future that occur in depression. However, integrative reminiscence also appears to have an important impact on promoting positive ways of defining the self and understanding the world. In integrative reminiscence, the emphasis is on understanding and re-defining the self, and developing a framework for establishing this re-invented self within a coherent and meaningful world view that recognizes the important needs and goals that underlie activities and mood. The focus on changing negative ideas and thought patterns is secondary.

Psychological Processes Involved in Integrative Reminiscence

Integrative reminiscence involves a review of times when needs and goals were successfully met, and positive re-appraisal of past failures, losses, and problematic relationships experienced across the entire lifetime and in many domains. By providing some insight into the important role that historical and contextual forces play in the causes of negative events, integrative reminiscence also directs the individual away from negative self-definition. Further, integrative reminiscence examines the consequences of failure to achieve goals and meet needs in terms of their ultimate consequences within the life history. This assists individuals to examine the positive impact of difficult experiences, such as directing them toward a new, fruitful direction or promoting psychological growth.

As predicted in the model and demonstrated in this research, through a more balanced re-appraisal of negative life experience, cognitive errors were short-circuited leading to disconfirmation of negative beliefs about the self, world, and future (e.g., I am a failure, I cannot get my needs met) as well as increasing positive self-evaluations as reflected in improvement on measures of self-esteem (Beck et al, 1976). A broader appreciation of the contextual factors involved in one's past history and the long-term consequences of negative events in the life story was shown to reduce stable attributions for the causes of negative events (Alloy, et al, 1988). In addition, review of concrete, past experiences that have been resolved in the integrative reminiscence process combat the sense that life cannot change for the better and reduce feelings of hopelessness (Alloy et al, 1988).

In general, the therapeutic processes outlined in the model that were hypothesized to link integrative reminiscence and relief from depression were supported. The results regarding global

and internal attributions, however, were not as consistent. Some individuals demonstrated reductions in global and internal attributions, others showed an increase on these measures, all however, demonstrated an improvement in depression. It would appear that a broader understanding of the multiple causes of negative events, as well as a subjective re-viewing of the meaning of negative life events leads individuals to question the assumption that the causes of negative events are permanent, however, it does not consistently reduce the areas of life where possible negative events are presumed to occur and it does not reliably shift attributions of cause away from the self. It may be that internal and global attributions alone do not play a critical role in depression to the extent that they are mediated by an understanding that the causes of negative events are shared or multi-determined. Additionally, a sense of coherence (i.e., negative events may happen, but they fit together in a way that is meaningful within the life story) may also mediate the onset of depression in the presence of high internal and global attributions for the causes of negative events.

As alluded to in the paragraph above, changes in depressogenic ideas and thinking styles are not the end point of integrative reminiscence. Rather, these changes are absorbed and embedded in a systematic fashion in individuals' continuously developing sense of self and self in the world. For example, integrative reminiscence starts from the point that one has done good as well as bad things in life. This judgement reflects an understanding of whether one's needs and goals have been met, and a concern with whether one's needs and goals were themselves worthwhile--raising questions of what it means to be good and moral. Tracing the development of needs and goals over time demonstrates that they tend to develop in the direction of greater recognition of one's responsibilities within society and the world. Recognition of the

developmental nature of goals and needs permits a less judgemental view of times when one strived for less informed goals or acted without insight to have needs gratified.

Evaluating the appropriateness of one's ambitions and choices strengthens the idea that one has a moral philosophy and guide and that one has tried to, and sometimes succeeded in, living up to it. In addition, it helps to highlight a supportive, coherent philosophical framework for understanding and defining the self that one can look forward to living within in the future. The presence of a coherent world view ultimately dispels fears and worries that contribute to the sense of living in an existential vacuum. Further, recognition of a unique and subjective framework for interpreting and evaluating life fosters self-definition that is based on subjective standards that make sense within the life story, rather than arbitrary, context-free ideals.

Consistent with the emphasis of integrative reminiscence on a narrative process, as individuals reminisce, their thoughts begin to follow the parameters of story-telling whereby links and connections are made and one begins to understand how one person is affected by others, and how one's own actions affect others. This aspect of integrative reminiscence plays an important role in promoting an understanding of how one's existing views of the self and the world have developed. In this way, individuals begin to identify the sources of negative thoughts about the self (e.g., early childhood interpersonal relationships) and the patterns of interpersonal interaction that maintain these thoughts--promoting a sense of purpose and direction and decreased undirected goal-seeking.

Through a review of the life story, individuals are also able to trace the development of personal, familial, and societal values, commitments, and purpose across the lifespan. This provides individuals with a way of understanding the sources of needs and goals and a coherent

framework from within which to choose those that are and are not satisfactory to the self-- ultimately permitting individuals to develop their own criteria for judging self-worth as they review and integrate their life. Increases in meaning and coherence, and a decrease in the sense of an existential vacuum will follow (Labouvie-Vief, 1982; Labouvie-Vief, Hakim-Larson, DeVoe, & Schoeberlein, 1989).

The data reported in this study (see Table 11) provides support for these hypotheses. The group who successfully engaged in the integrative reminiscence process and who demonstrated relief from depression, showed increases in purpose, meaning, coherence and life control and decreases in existential vacuum and goal seeking. These improvements are characterized by a category change on each measure (i.e., from a low to a medium level, or a medium to high level). Those individuals who did not fully engage in the integrative reminiscence process and basically experienced little change in depressive symptomatology, showed a significantly less pronounced increase in coherence, a decline in life control, and a significantly smaller decline in existential vacuum and goal seeking. Finally, those individuals who did not engage in the integrative reminiscence process and who experienced an increase in depressive symptomatology also demonstrated a decline in coherence and life control, and an increase in existential vacuum. These findings suggest that in addition to the processes outlined in current cognitive theories of depression, through narrative processes, integrative reminiscence systematically promotes the integration of these changes in ideas and thoughts into a coherent, balanced sense of self. The extent to which these changes also occur in cognitive therapy is an issue for further examination. However, to date, cognitive interventions have not identified or emphasized integrative processes.

The therapeutic goal common to all of the narrative processes is for individuals to see their memories change as they review and examine them. Thereby, reducing the pain resulting from old wounds and persistent self condemnation, as well as gaining knowledge of the personal goals, needs, aspirations and ambitions that guide positive self definition in the future.

In summary, although integrative reminiscence can promote cognitive and emotional processes that are linked with freedom from depression in current models of depression, it also appears to have an important impact on promoting positive ways of defining the self and understanding the world. The emphasis on understanding and re-defining the self and one's world stem from the narrative focus of integrative reminiscence which capitalizes on the wisdom gained through aging and the perspective offered by temporal distance from events and the longitudinal unfolding of the life story. The results of integrative reminiscing are seen in its impact on the psychological structures of the life story (e.g., hopelessness, stable attributions, meaning, goal seeking, secondary appraisals) and in the way the life story is thought about (e.g., thinking contextually; thinking in terms of goals, desires, needs; thinking in terms of self-definition). These changes in self-definition and in thinking processes lead to an integrated sense of the evolution of life in the past, present, and into the future. The vocabulary of narrative embeds these changes within the life of the older adult, combining a respect for past experience with a well developed understanding of needs and goals that will guide future plans.

Instrumental Reminiscence

Goals, Content, and Therapeutic Techniques in Instrumental Reminiscence

The psychosocial approach to depression proposed by Billings and Moos (1982; 1985)

was used to develop an understanding of the psychological changes that occur in instrumental reminiscence that lead to an amelioration in depression in older adults. This framework assumes that depression results from an interplay between the situational demands experienced by individuals, their appraisal of the coping resources they have to meet these demands, and their coping responses to the stressors. When individuals feel that they do not have the resources to combat stressors, they tend to use ineffective coping responses, which further reduces self-esteem and confidence in their ability to cope. The loss of control and esteem, combined with the weight of insurmountable obstacles can trigger a depression.

The primary goals of instrumental reminiscence are to combat emotional and cognitive barriers to coping that are experienced by depressed older adults. The content of instrumental reminiscence that provides the material for this intervention are memories of past stress and coping experiences which highlight effective coping, and identify coping strategies and techniques used in the past that promoted successful problem- and emotion-focused coping responses to current stressors.

Several techniques are used to promote adaptive coping. The first task of the therapist is to use the instrumental recollections to enhance clients' belief in their ability to effectively solve current problems. This procedure includes using instrumental reminiscence to illustrate the idea that problems are a normal part of life that clients have been successfully dealing with throughout their lifetime. This should help clients to normalize problems currently existing in their life. The therapist can also use the recalled problem-solving incident to demonstrate to clients that there are a wide range of causes for problems in an individual's life. The point of this exercise is to demonstrate that problems do not arise solely because of personality defects or

failures on the part of the individual. As such, when clients consider current problems, they should feel a reduction in the dysphoria that can result from unrealistic attribution of the causes of negative events to personal failings. Further, the therapist can use past success in coping to enhance clients' belief in their ability to act effectively to deal with problematic situations in their life (Bandura, 1977). This process may involve reviewing a number of successful problem-solving incidents in the past while highlighting the clients ability to act effectively to resolve a problematic situation.

Primary appraisals of stressful experiences involve determining whether an event is relevant and threatening to the self. Therapists assist clients to identify who is threatened in a stressful situation, themselves or a loved one, so that the nature of the threat is known as well as an understanding of the direction to take regarding appropriate coping goals (e.g., able to change the situation, or have to regulate emotions while others attempt to overcome their stressors). It is also important for clients to identify what is at stake in a stressful situation. This requires that clients assess the personal needs and goals that are threatened by the event. This process can be assisted through instrumental reminiscence by examining important goals and needs that were evident in past coping situations. Often, repetitive patterns will emerge from this review that help clients focus on the critical factors at stake in a current situation.

In addition, recognition of the needs and goals at stake permit the opportunity to examine the appropriateness of these goals and to identify alternative ways to have needs met. An examination of goals and priorities across the lifespan helps focus individuals on the essential issues in a coping situation, reducing extraneous worries or attempts to solve non-critical issues. Investigation of coping experiences across the life time also highlights the way in which needs

and goals change and evolve over time--emphasizing the need to take stock of the essential issues in a stressful experience as well as to dispense with goals or needs that are not critical at a given stage of life, thereby, decreasing the number of unattainable goals which are given a primary appraisal as threats to self-worth. Further, observation of the change and development of goals and needs in different coping situations over time can help clients see this as a normal growing process, rather than a threat to the self.

According to Lazarus and Folkman (1984) how an individual appraises a problem has an effect on the strategy the person will use to cope with the difficulty. If individuals construe a problem as a challenge, (i.e, something they are able to do something about), they are more likely to cope actively and effectively with the difficulty than if the problem is seen as a threat. The focus on self-efficacy described above should promote challenge appraisals, however, the therapist may make the relationship between appraisals and effective coping more explicit by exploring with clients the type of appraisals they made when dealing successfully with a past difficulty. This process should clarify for clients the importance of positive appraisals in dealing with current problematic situations.

In addition, the client and therapist may evaluate at this stage the type of coping strategy used. Lazarus & Folkman (1984) indicate that the effectiveness of a particular coping strategy depends upon the situation in which it is enacted. For example, if the individual is realistically unable to alter a situation, the most effective coping strategy may involve trying to come to terms with the problem. On the other hand, if the individual has the resources to change a situation, the most effective coping strategies may involve active attempts to amend the problem. The therapist can explore with the client the different types of coping patterns that were considered

and why they were rejected or accepted. Identifying the appropriate coping strategy works to help individuals feel capable of doing something about a stressful experience and, therefore, appraise it as a challenge rather than a threat.

Because it is recognized that most older adults have a wealth of experience with problem-solving, the emphasis is on removing cognitive and emotional barriers to coping rather than explicit training in problem-solving techniques. However, in situation where clients are at a loss to develop a coping strategy, or may be more appropriately using a different form of coping (e.g., emotion-focused versus problem-focused), the process of problem-solving and selecting a coping strategy can be identified through instrumental memories. This process will provide clients with concrete strategies to use in current problem-solving.

Psychological Change Processes in Instrumental Reminiscence

Examination of the pattern of changes in process measures in a group of older depressed adults over the course of an instrumental reminiscence intervention provides support for the model developed to describe the relationship between instrumental reminiscence and depression. Indeed, engagement in specific instrumental reminiscence content resulted in the predicted pattern of change on measures of cognition and depression in the Instrumental group, but not in the Active Control group. There was, however, intra-subject variation in the change in coping activities that reflected the unique demands of each individual's stress experience. Examination of the situation-specific changes in patterns of coping following instrumental reminiscence may help to refine the model.

In all subjects who benefitted from the instrumental intervention, normalization of the

stress and coping process, recall of successful coping experiences in the past, identification of appropriate, non-threatening goals, and review of effective coping processes was associated with increases in coping resources. In particular, increased self-esteem, and a sense of personal control over the direction and outcome of one's life were both evident in the group that benefitted from the instrumental intervention.

Along with increases in coping resources clients demonstrated: a) a shift from threat-oriented primary appraisals of stressful experiences to more challenge-oriented appraisals; or, b) an appropriate shift in the focus of the threat appraisal (i.e., from the self to a loved one). With an increase in coping resources, individuals appeared to reduce their fear of a threatening situation and re-frame it as a challenge or to attribute the source of the threat to the most appropriate target (i.e., establishing that what is realistically a threat to someone else is not also a direct threat to the self). In addition, there was a small reduction in goal seeking which suggests that benefits arising from instrumental reminiscence accrue when there is a shift in goals, and when these old goals are replaced with new, more appropriate ones. In subjects who did not appear to benefit from instrumental reminiscence, analysis of the appropriateness of goals was not undertaken, or old goals were discarded and new goals were not substituted.

In traditional problem-solving therapies (e.g., D'Zurilla & Nezu, 1982), reduction in emotional distress is assumed to come about after effective coping is put into practice (e.g., brainstorming ideas, selecting an appropriate coping action). As such, the focus is on working through the stages of effective problem-solving. In instrumental reminiscence, however, recollection of past effective coping experiences permits individuals to recall, re-live, and work through the emotional content of stressful experiences that causes primary appraisals of threat,

which in turn, sets the stage for the initiation of coping behaviours.

In terms of secondary appraisals, or what could be done about a stressful situation, the only consistent change that was demonstrated following instrumental reminiscence was a decline in the sense that there was a need to hold back from acting. Folkman & Lazarus (1986) state that in depressed individuals, feelings of hostility and/or worry arise in stressful situations that may cause individuals to feel that they cannot act for fear of releasing aversive emotions that will exacerbate the stressfulness of the experience (i.e., venting, exacting revenge). To the extent that these emotional reactions are reduced, individuals should then experience an increase in agency and a decline in secondary appraisals of having to hold back from acting, which is the case in this data set.

The fact that other secondary appraisals did not show a consistent pattern of change (i.e., had to accept the situation, could change the situation), suggests that the emotional regulation afforded by instrumental reminiscence plays an important role in reducing barriers to challenge-oriented appraisals. Once these barriers are removed, appraisals that are appropriate to the situation can then be made. Different secondary appraisals are appropriate in different situations, so it is not possible to predict a set pattern of secondary appraisals (other than having to hold back) unless one knows the nature of the stressor. In this group, when threats were perceived toward the self, individuals who used instrumental reminiscence were able to reduce barriers to coping and then felt that they were able to do something about the situation. Those individuals who perceived a threat to a loved one, also reduced the felt sense of a barrier to coping, but then made the secondary appraisal of having to accept the situation until the loved one changed the situation to make it less threatening.

Current theories of coping have identified escape-avoidance and problem-solving coping as important variables associated with the presence or absence of depression. What is evident from the present research is that, as with secondary appraisals, the type of coping responses that are associated with decreased depression depends upon the type of stressor encountered. In some cases, where stressors were rated as something that could be changed, the predominant coping mechanisms were active problem-solving, self-control, and decreased escape-avoidance. In cases where the stressor was rated as something that had to be accepted, the primary coping responses were delineating and accepting responsibility for one's role in the situation, positive re-appraisal, distancing, and some escape-avoidance. To the extent that an active solution to the problem cannot be implemented, emotional regulation processes are invoked, even those that may involve avoidance. Both of these situations were associated with improvements in depression.

Clearly, active problem-solving itself is not the sole coping response associated with decreased depression. Rather, it appears that selection of a coping response that is appropriate to the situation is the key factor in decreasing depression. Further, when some avoidance coping responses are being used, the presence of at least some active coping responses (e.g., a realistic understanding of how much responsibility they bore in changing the stressor, attempts to re-frame at least part of the stressor in a positive fashion) appears to help coping and improve depression. It would appear that a clear prediction of exactly what coping activities will reduce depression depends on the situation, however, the presence of coping resources (self-esteem, control, appropriate goals) are critical to successful coping and relief from depression.

It is of note that analysis of the supplementary coping responses measured by the Ways of

Coping-Revised reveals a consistent relationship between improvement in depression and positive re-appraisal and taking responsibility in coping situations. It would appear that in this set of clients, a feature of coping that may be associated with a reduction in depression is the ability to learn from a stressful experience and to accept and admit personal contributions to the existence of stressful situations. In addition to doing something about a negative situation, marking it as a meaningful milestone may help to ameliorate a sense of defeat or purposelessness that can arise when life does not go well.

Subject Characteristics Suited to an Integrative or Instrumental Intervention

Integrative and instrumental reminiscence have both been shown to engage psychological processes which have been linked to amelioration of symptoms of depression. In both cases, the primary content of therapy are memories and the goal is to alter cognitions that contribute to depression. The thoughts and activities that are targeted by each intervention, however, are quite different. Clearly, there is a question of which intervention is best suited for a particular client.

Given that instrumental reminiscence focuses on helping clients cope with current problems, this type of intervention may be most effective for individuals who have a history of successful coping but are having difficulty appreciating how old coping patterns can be applied to the new set of demands that can accompany aging or who are simply overwhelmed with multiple stressors. Instrumental reminiscence may be especially effective in these situations to help individuals link solutions used successfully in the past with current difficulties, as well as to assist individuals in sorting out priorities and re-ordering goals and commitments, thereby, instilling a sense of control and efficacy.

Individuals who have experienced difficulty throughout life in identifying their own needs and goals separate from those around them may also face difficulties in coping that may be ameliorated in an instrumental reminiscence intervention. Focusing on what important needs have to be met in a stressful situation may be a new experience for individuals who have typically filled others needs or sublimated their own. Recognition that one is free to alter and choose one's own goals and commitments may also be a fruitful aid to coping for those individuals have felt and continue to feel themselves under the weight of others' choices and plans for them. In terms of cohort effects, it may be that women who are elderly in the 1990's will have had significant experiences of these kind due to the lack of opportunity for role definition and the expectations placed upon them in the culture in which they lived.

An integrative reminiscence intervention may be useful for individuals who tend to have a rigid self-definition and to set very high standards for themselves, who have also experienced a threat to their sense of self such as role loss or illness. A shake-up in a coherent and reliable vision of the self and the world may be helped by reviewing the constancy of one's convictions and ideals throughout life, leading to the re-instatement of a strong definition of self. It is also possible that individuals who have experienced a change in their view of themselves and the world may benefit from a process which explores change and evolution over the lifespan leading to a more flexible and inclusive perspective on life.

Conclusions and Future Directions

Although reminiscing has been thought of as an activity that has the potential to promote adaptation in later life, clinicians have questioned whether reminiscence can produce clinically

significant change in older adults and have raised concerns about possible negative effects of reminiscing (such as depression). This research demonstrates that reminiscing can make a positive contribution to adaptation in late life when particular types of reminiscence are fostered with an appropriate population. Indeed, integrative and instrumental reminiscence were shown to produce statistically and clinically significant improvement in symptoms of depression in older adults. Not only were reminiscence interventions found to be therapeutic, but in terms of effect sizes and proportion of clients who benefit from these interventions, this preliminary investigation demonstrated that reminiscence therapies are as effective as traditional treatments for late-life depression. Furthermore, these results were achieved with a shorter more intermittent schedule of sessions than is typically provided in traditional treatments.

Clinicians who choose to use reminiscence interventions, however, should ensure that different forms of reminiscence are clearly delineated and only those types of reminiscence that have been shown to promote adaptation for a specific group are fostered. Further exploration of the utility of reminiscing for different clinical populations or targets will also need to separate out different types of reminiscing in order to obtain interpretable findings.

Although integrative and instrumental reminiscing are based on a cognitive conceptualization of depression, some of the methods used to achieve therapeutic change differ from those in cognitive therapy. In particular, reminiscence interventions emphasize memories rather than current activities as the primary content of therapy. In integrative reminiscence, memories are used to gain access to psychological needs and goals which are examined in terms of their contribution to self-definition. Constructive reappraisal of initial interpretations and emotional reactions to past self-defining events leads to alterations in the sense of self and to

improvement in mood. In instrumental reminiscence, memories are used to normalize stress and to provide evidence of successful past coping and appropriate coping strategies. Memories are also used to identify important needs and goals at stake in current coping, which provides a direction and impetus for effective coping.

The process of reviewing experiences that have occurred across the lifespan that is the hallmark of reminiscence also initiates different therapeutic procedures than those used in cognitive therapy. In integrative reminiscence, the longitudinal perspective on memories that is afforded by age fosters both a different and a broader perspective on the life history which promotes re-definition of the self, thereby, altering negative emotional reactions associated with dissatisfaction with the self. This unique perspective stems from: examining self-defining events from the perspective of the entire lifetime; weighing past events in terms of present knowledge and circumstances; recognizing contextual and historical factors that contributed to and determined the outcome of an event; understanding past events in terms of their subjective meaning in the life story; and recognizing that a variety of ways for evaluating an experience are admissible. In instrumental reminiscence, the longitudinal outlook on memories also fosters recognition of the repetitive pattern of needs and goals that play a significant role in overcoming barriers to coping.

Some of the psychological processes that clients undergo in integrative and instrumental reminiscence are the same as those experienced by individuals undergoing traditional cognitive or problem-solving therapy (e.g., decreased hopelessness and stable attributions for the causes of negative events; increased problem-focused coping). However, as with the content and techniques of reminiscence therapy, the psychological changes that clients engage in during a

remembrance intervention also involve processes that at present have not been addressed in traditional cognitive and problem-solving therapies.

For instance, in integrative reminiscence therapy, although individuals challenge blaming and denigrating thoughts about the self, the world, and the future, and replace distorted thinking processes with more realistic ways of interpreting the world, they also experience an increased understanding of why they define the self as they do, what are the standards that they use to evaluate and understand the world, and how they can accommodate a fit between this set of standards and their sense of self. Investigation by older adults of these issues was reflected in the changes reported by subjects in this study on measures of meaning, purpose, coherence, control, existential vacuum and goal seeking. These findings raise questions about the extent to which meaning, purpose, and coherence in life play a role in the development of depression in late-life. It may be that in some cases, depression is less of function of current difficulties in adaptation that bring to the surface well-learned negative thoughts about the self and the world. Rather, depression may develop in response to difficulty in reconciling one's world view with one's sense of self. Indeed, depression in late life may be for some older adults, characterized by a focus on and dissatisfaction with the past rather than current issues of adaptation.

In instrumental reminiscence, results from the study underline the importance of identifying and overcoming emotional barriers to coping and recognizing and giving priority to important needs and goals for elderly clients who are experiencing difficulties with coping. This was demonstrated by increases on measures of coping resources and emotion-focused coping, and in a greater sense of control and selection of appropriate goals in stressful situations. Given the extensive experience with coping that elderly people have, interventions focused on dealing

with current problems may need to focus less on actual problem-solving and selection of coping responses, and more on making choices in these situations based on recognition and understanding of the life long needs and goals at stake in the experience, and in caring for themselves emotionally. It may be that in later life problems lead to demands to discard, choose, or re-order goals and priorities, and that it is the difficulty in making these choices that leads to depression, rather than simply the experience of stressors.

Two main implications stem from these findings with regard to understanding and treating depression in late-life. First, the identification of cognitive and emotional content in late life depression that differ from cognitive and coping models of depression suggests that current models may not provide a comprehensive formulation of depression as experienced by older adults. It will be important for clinicians to be sensitive to the source and content of depression in late-life and to select a treatment that fits with the unique presentation in each older adult.

Second, the fact that the therapeutic procedures used in reminiscing achieved changes in cognitive processes that have been linked to depression suggests that traditional cognitive therapy and problem-solving therapies are not the only method of achieving relief from depression. In fact, it would appear that through life review, older adults gain access to a number of psychological resources that capitalize on their age and life-stage, such as, the longitudinal perspective that promotes understanding of context, the subjective meaning of events, and insight into repetitive patterns of needs and goals. It is incumbent upon clinicians to capitalize on these resources in their treatment work with older adults. Further, investigation of additional ways in which age and life stage interact with the therapeutic process should also be attempted by therapists working with older adults.

Future research on reminiscence as a psychotherapeutic intervention for depression in older adults could take the direction of large-scale studies which address the comparative effectiveness of reminiscence with other interventions. However, a review of controlled outcome research on psychotherapeutic treatments for depression indicates that of the intervention approaches so far studied, there is little evidence for the relative superiority of any one approach over another (Robinson, Berman, & Neimeyer, 1990). Given that at least some of the therapeutic content and techniques of integrative and instrumental reminiscence have been identified in this research, what may be of more interest are studies that attempt to refine these procedures by isolating those factors that contribute most to therapeutic improvement. Aspects of reminiscence therapy such as the emphasis on understanding needs and goals, re-creating a self-definition, and focusing on emotional barriers to coping, may each be examined in their own right with regard to their relationship to changes in depression.

In line with the current focus on identifying what aspects of therapy are effective with what type of client characteristics, additional research may examine the utility of different forms of reminiscing with different clinical populations. Equally important is the need to take into consideration subject characteristics that reflect the realities of an aging client population. It is clear from research in cognitive and neuropsychology that significant changes in cognitive function develop with age. For example, older adults tend to be less flexible in their processing of multiple information in working memory, they also tend to use less encoding strategies when trying to store information than do younger individuals (Malec, Ivnik, & Smith, 1993). These and other predictable changes in cognitive functioning are a source of subject variation that may be addressed by building into reminiscence interventions with older adults strategies that

maximize existing levels of cognitive functioning.

Furthermore, in the aging population, there are numerous individuals experiencing adaptational difficulties who also have some form of acquired brain injury. Work with younger brain-injured patients (e.g., Prigatano & Klonoff, 1988) has led to the development of psychotherapeutic methods to deal with the adaptational difficulties of this population. Reminiscence, with its focus on remote memories, may provide psychotherapeutic material that is less resistant to the ravages of dementia and that may require less processing capacity than dealing with newer topics within the unfamiliar vocabulary of psychotherapy. Also the focus on a life review may provide a useful intervention for older adults who are experiencing the loss of their cognitive abilities. Research that both refines reminiscence interventions to reflect the subject characteristics of older adults, including those with acquired brain injury, and examines the efficacy of reminiscence interventions for this population will fill a vacancy in the armament of therapeutic interventions for the older population.

In summary, this research makes four primary contributions to the psychological literature. First, the insights gained in this research into the therapeutic content and the psychological change processes involved in reminiscence make a significant contribution to the development of a comprehensive theoretical framework for understanding reminiscence in old age. Second, this research has helped to clear up the controversy surrounding the utility of reminiscence as a therapeutic intervention for older adults. When specific types of reminiscence (integrative and instrumental), are used to treat an appropriate target population (older depressed adults), statistically and clinically significant improvements in symptomatology were achieved. Furthermore, reminiscence interventions were shown to be equally as effective as more

traditional forms of psychotherapy with older adults. As such, integrative and instrumental reminiscence are identified as viable alternatives for the treatment of depression in older adults. Third, reminiscing appears to bring a developmental approach to the treatment of depression in older adults by capitalizing on psychological resources that are available and salient in later life (e.g., narrative and life review processes). In other words, unlike traditional interventions for depression, reminiscence addresses content and uses psychological processes that reflect the unique interests and strengths of older individuals. And finally, exploration of therapeutic processes in reminiscence provided insight into the content and sources of depression in older adults that expand the understanding of depression provided by traditional cognitive theory.

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Appendix A: Integrative and Instrumental Reminiscence Intervention Manual

Appendix A: Integrative and Instrumental Reminiscence Interventions Manual

Introduction for Therapists: Rationale, Purpose, and
Appropriateness of a Reminiscence Intervention for Older Adults

Rationale for Reminiscence Therapy

Depression is one of the main mental health concerns among older adults. Between 20 and 25% of adults over the age of 65 manifest dysphoria. Within this group, 10-15% present moderate to severe depressive symptoms. Among elderly individuals with major life stressors, such as being seriously ill or the primary caregiver for an ill family member, rates of major depression rise to between 12-55%. As population aging continues, the absolute number of depressed elderly individuals who suffer the debilitating effects of depression will increase, intensifying the need to identify effective interventions for this population (Cappeliez, 1993).

Currently, antidepressant medication is one of the main avenues of treatment for depression in the elderly population. Although this method has been shown to reduce symptoms of depression in older adults, several side effects (e.g., cardiotoxicity, anticholinergic effects, adverse interactions with other medications) contraindicate the use of pharmacotherapy in many older adults. Further, depressed individuals treated exclusively with drugs do not learn coping skills developed in psychotherapeutic interventions which afford long-term protection against the relapse and re-occurrence of depression (Barber & DeRubeis, 1987; Evans, Hollon, DeRubeis, Piaciski, Grove, Garvey & Tuason, 1992).

Studies and reviews of psychotherapeutic interventions support the general effectiveness of this type of treatment for late-life depression (e.g., Gallagher, Hanley & Thompson, 1990;

Scogin & McElreath, 1994). It appears that most psychotherapeutic interventions for depressed older adults so far studied (e.g., cognitive, behavioural, dynamic, interpersonal) do not differ in their degree of effectiveness. Recently, recognition of the unique needs and concerns involved in adaptation to the later stages of life has led clinicians to modify traditional interventions such as cognitive and interpersonal approaches to address psychological issues of particular relevance to older adults experiencing depression. Unique interventions that are specifically designed for use with older adults have also been developed. Reminiscence (or life review) therapy is one intervention which has been developed to provide an efficient and attractive alternative to the more traditional approaches to psychotherapy with depressed older adults. The idea that reminiscence plays a major role in successful aging has been highlighted in the theoretical literature on aging (Birren, 1987; Butler, 1974), reports on the clinical value of reminiscence and its attractiveness to the elderly population appear regularly in the literature (see Haight, 1991 for a review), and reminiscing is included as a part of regular programming in an increasing number of seniors centres and nursing homes.

Despite its popularity, the clinical utility of reminiscence therapy has not been empirically established. Furthermore, a clear understanding of the key therapeutic components involved in a reminiscence intervention has not been clearly presented in the literature. To fill this gap in the literature, we have developed the first theoretical model that identifies the critical therapeutic components involved in a reminiscence intervention. Those components are presented in this treatment manual. The results of this research study will be used to validate and refine this theoretical model and to evaluate the effectiveness of reminiscence as a therapeutic intervention for the treatment of depression in older adults.

Purpose of Reminiscence Therapy

To date, the efficacy of reminiscence therapy with depressed older adults has not been conclusively demonstrated. There does, however, appear to be theoretical justification for predicting that reminiscence will have a positive effect on depressive symptoms. Reminiscence involves recollection of memories from the past in which the person recalling is either an actor or interested observer. This process can take a number of different forms such as, simple storytelling, or an in-depth evaluation of the past. Two types of reminiscence, integrative and instrumental, have been linked with adaptive functioning in older adults and appear to have potential as therapeutic processes in the treatment of depression (Watt & Wong, 1991; Wong & Watt, 1991).

Integrative reminiscence involves evaluation and synthesis of the past. The focus of this type of reminiscence is on the achievement of a greater understanding of the past, identification of meaning in one's past experiences, and integration of this information with the current self-concept. Integrative reminiscence typically includes statements that indicate acceptance of one's past, viewing one's past life as fulfilling or worthwhile, finding one's life meaningful, reconciling the discrepancy between ideal and reality, acceptance of negative events in the past, resolution of past conflicts, and recognition of a pattern of continuity between past and present. Because integrative reminiscence is associated with an increased sense of self-esteem and personal meaning, it is thought that these self-cognitions will provide protection against the typical depressive symptoms of negative self-evaluation, hopelessness, and belief in the inability to control negative events.

Instrumental reminiscence is focused primarily on recollections of past problem-solving

and involves memories of past plans, goal-directed activities, the attainment of goals, helping others solve their problems, past attempts to overcome difficulties, or drawing upon past experience to solve present problems. This type of reminiscence implicates the use of problem-focused coping strategies which have been shown to be an important buffer against depression. It also reflects a sense of internal control and mastery over stressors which has been shown to mediate between the presence of life stressors, cognitive appraisals of the importance of these stressors, and the onset of depression.

Appropriateness of Reminiscence Therapy to the Life Situation of

Older Adults

Although depression can occur at any age and quite regardless of a person's actual life situation, it must be acknowledged that, for many older adults, later life is attended by circumstantial changes that can contribute to the development of depressive thinking. Limited by economic, social, and health problems, many elderly individuals have time on their hands, few social contacts, and little energy for activities that might stimulate or distract them. These factors, combined with the imminence of death and the desire to review and reorder their lives, provide some older adults with the opportunity to brood over past mistakes, present stressors, and future events. To the extent that individuals have unrealistic expectations of themselves and old age, feel unable to cope with present difficulties, and interpret life changes as negative, these reflections can lead to depressogenic thinking (Yost, Beutler, Corbishley, & Allender, 1986).

Although the lives of many older adults contain factors that could easily contribute to depression, depression need not be their inevitable fate. For several reasons, the focus of

remembrance therapy on cognitive re-appraisal and problem-solving through memories of the past may provide a useful way to deal with problems arising from the reality of old age. First, reminiscence therapy directly attends to issues of concern to older adults, many of which relate to past events, or a comparison of the present to the past (e.g., past mistakes, failures, and losses; the inability to cope with present demands; and the problems of reconciling old values and meanings with present realities). Second, the cognitive focus of reminiscence recognizes that many of the depressogenic factors in client's lives are both unchangeable and continuously present (e.g., the death of a loved spouse or chronic illness). In the face of such unchangeable and inherently distressing life events, the most productive efforts that can be made to ward off depression are in the cognitive domain. Third, changed circumstances in the lives of older adults can lead to difficulties in applying past productive coping strategies, because the applicability of old strategies to new situations is not perceived. The focus on active problem-solving using strategies that are illustrated in the individual's own past experiences may enhance self-efficacy/esteem, current coping, and ultimately, mediate the onset of depression (Folkman & Lazarus, 1986; Fry, 1989; Mitchell, Cronkite, & Moos, 1983).

Appropriateness of the Group Task and Format for Older Adults

Questions often arise concerning the response of older adults to therapy in general, and to group therapy in particular. Family members and even some therapists may believe that older people are too "difficult" to fit into a group or that they demand too much individual attention. On the other hand, it has been suggested that therapy may be too difficult for the older client (see Cohen, 1981 for a review).

Research with groups of older adults, however, has shown that elderly people of all stages of functioning both enjoy and respond to therapeutic group activities (e.g., Corey & Corey, 1982; Steffan & Zeiss, 1992; Weiner & Weinstock, 1979-80). The wide variety of groups that have been conducted with older adults, ranging from sexual enhancement programs to creativity workshops, is a good indication of the ability of many older adults to take a productive role in group activities.

Although there are cognitive changes in learning and memory associated with normal aging, research has shown that these changes can be compensated by simple techniques, and do not preclude the use of therapy with this population. For example, Thompson, Davies, Gallagher, and Krantz (1986) report that cognitive therapy can be successfully adapted for use with older adults by slowing the pace of therapy and providing prompts to enhance recognition memory rather than relying on recall when giving homework assignments or setting up a maintenance program. Zeiss & Lewinsohn (1986) emphasize the need to use age-appropriate content and to present material visually and aurally, and to actively demonstrate techniques. The structure provided by cognitive-behavioural techniques also appear to assist in helping the older individual successfully engage in therapy (Gallagher & Thompson, 1982).

Not only is the group situation effective for older adults, it is often preferable to individual therapy because the group offers unique opportunities that are important but often unavailable to this population: socialization, expression of altruistic needs, and observation of the universality of personal conditions and problems (Yalom, 1985).

Organization of the Reminiscence Intervention

General Overview of the Reminiscence Interventions

The reminiscence interventions consist of six weekly sessions of 90 minutes. Each week, clients discuss reminiscences on a different theme based on topics selected by James Birren (1981) for his work with guided autobiography. The themes are: family history; life accomplishments; major life turning points; history of loves and hates; stress experiences; and, life meaning and purpose. Clients prepare a brief written summary of their memories before each meeting.

Structural Elements of Reminiscence Interventions

Because reminiscence deals with a specific type of cognitive material and uses this material in specific tasks, a structured approach to therapy has been chosen in order to facilitate achievement of the therapeutic objectives. In addition, structured approaches to group therapy (e.g., group cognitive therapy), have been shown to be effective in engaging the participation of older adults by focusing attention and orienting members to the task at hand (Gallagher & Thompson, 1983). The structural elements that are common to all sessions in the three groups include: homework review; development of an agenda for the session; focusing on the reminiscence; contact work with each participant; rounds; discussion of the topic for the following session; and feedback.

Agenda Development

At the beginning of each session, the therapist states the topic of the day and the purpose

of the session (e.g., to use memories in an instrumental fashion to aid present coping, or to use memories in an integrative fashion to promote meaning, value and self-esteem). Clients are then invited to briefly state the experience they have written about in the homework material which they want to discuss in the group. In addition, they may describe any successes or difficulties they had with the homework. As well as assessing compliance with homework tasks, this review provides a structure for the session. Each client's topic is inserted into the fixed elements of the schedule for the session. The schedule is displayed on a flipchart in a prominent place in the room. Input by clients at this point is designed to foster a sense of collaboration in determining the direction the session will take.

Homework Review

Reminiscence therapy teaches clients to use memories in specific ways in order to promote adaptation. Homework plays an integral role in helping clients access these memories, and in assisting them to transfer in-session learning to in vivo practice. In addition, outcome studies of cognitive behaviour therapy indicate that the completion of homework is a crucial component of positive outcome for depressed clients (Beck, Hollon, Young, Bedrosian, & Budenz, 1984). Each week, a worksheet with one of Birren's (1981) themes and accompanying sensitizing questions is given to clients in order to help them identify appropriate memories (see end of this document for homework material). Clients are asked to provide on the worksheet a brief written summary of their memories of the assigned topic. This material is the focus of the in-session work. The questions on the worksheet are designed to stimulate memories, but are not focused on revealing sensitive material which may make the individual dysphoric when they are

completing the exercise outside the session.

The rationale for homework should be explained to participants: reminiscence therapy involves learning new skills, in order to master these skills, clients need to practice them, both inside the group, and outside the group in more real-to-life situations. It is useful for members to spend a bit of time each week practising with memories other than the ones they bring to the group. Furthermore, clients should be encouraged to use the skills they have gained or positive feelings they have discovered to combat depressive feelings during the week. Clients use the worksheets provided in the section on Weekly Sessions for homework practice.

The inertia and the negative cognitions of depression can reduce compliance with homework. In order to increase the probability of participation, clients should be provided with a rationale for homework: they are learning new skills that require practice; it makes sense that the skills be applied in the environment where symptoms occur; there is insufficient time in group sessions to expect that these alone will be effective in reducing depression. In addition, clients should be warned ahead of time that although they may not feel like completing the homework as a result of their depression, it is crucial for them to at least try to engage in the task.

Reviewing homework is crucial if clients are to consider it an essential part of therapy. Therefore, the first task of therapists in the session is to review client's experience with the week's homework. This step is a common element in most homework-based behavioural and cognitive treatments (eg., Beck et al, 1979). The review is designed to provide clarification about concepts, initiate feedback from clients on difficulties they experienced in carrying out the task, and provide positive reinforcement from the therapist and the group for any success in completing the homework. If individuals have had difficulty in completing the homework task,

the therapist will spend some time identifying the difficulty and soliciting feedback from the group on how to solve the problem. Individualized homework exercises may be prescribed for clients who need more detailed instructions and more graduated practice.

Rounds

Rounds involve brief canvassing of each or several group members on a particular issue in order to give each member of the group a chance to comment on what is currently being discussed. Clients are not obliged to say something, but are encouraged to do so. The therapist should model appropriate rounds comments which should be brief so that everyone is able to speak. Rounds are used during the homework review session, after each person has discussed his/her reminiscence, and during feedback at the end of the session.

Focusing on Reminiscence

After the agenda has been set, the participants will attempt to focus their attention on the reminiscences they have prepared for the meeting. The inclusion of a focusing component into the structure of the meeting is designed to assist participants to separate from immediate worries or depressive thoughts that may interfere with memory processes and the use of recollections according to the task instructions. The focusing task will involve a brief, structured format including the following steps:

- 1) Ask clients to relax briefly so as to ease any tautness in their muscles. Have them recline, and close their eyes if they wish.
- 2) Ask clients to clear their minds and focus inwardly on the memories they will

discuss in the meeting.

3) Ask clients to put themselves in the past, and recreate a dominant episode associated with the memories (e.g., if the memories are about family life, the client should try to focus on one image of family life which is particularly powerful for them).

4) Ask clients to focus on the overall thought and/or emotion that best captures how they feel about the memory.

This process should take about 5 minutes and result in enhanced ability to focus on the current task.

Contact Work

A one-to-one encounter between a single therapist and client in the group setting is called contact work. The client is invited to do the work and retains the right to refuse, although in most cases the work is around an agenda item initially agreed upon by the client and therapists. For the duration of the encounter (usually 10 minutes), the other group members are asked to refrain from commenting unless specifically requested to do so by the therapist.

Typically, the contact work consists of the client providing the details of the reminiscence, and then with the help of the therapist, using the reminiscence according to the task demands of the instrumental or integrative group.

Feedback

After each client's contact work other members are asked to contribute constructive

criticism and suggestions about the other members' attempts to achieve the task of the group. In addition, they are asked to share their understanding of the work and its possible application to their own lives. The purpose of this task is to provide clients with positive feedback about their participation and to promote the idea that clients can use each others work as a model for their own performance.

At the end of each session, feedback is also requested by the therapist regarding client's reactions to any aspect of the therapy, from homework assignments to in-session occurrences. If therapists elicit feedback frequently and act upon it quickly, the effect is to increase the client's perception that the therapy is tailored to their needs and that they can have a significant impact on the processes involved in their own progress. The resulting sense of control, collaboration, and mastery may be, in itself, therapeutic (Yost et al, 1986).

Assignment of the Next Topic

In the final stage of each session, the leader summarizes the progress that has been made within the group. In addition, the leader provides a description of the next topic along with sensitizing questions to be used in the preparation of the written summary. At this point, homework exercises designed to help clients generalize their skills will also be provided. Discussion of possible problems involved in fulfilling the task, and encouragement to complete the homework will end the session.

**Agendas for the Six Weekly Sessions of the Integrative and
Instrumental Groups**

Although the weekly sessions of the integrative and instrumental groups share some common features, there are also important differences in the purpose and techniques of each group. The common elements of each weekly session will be outlined below, followed by a description of the goals and instructions which are specific to each group.

**Elements of the Sessions Common to Both Integrative and
Instrumental Groups**

First Session Agenda

The first task of the group is to set the day's agenda. Before proceeding to set the agenda, leaders should provide a rationale for the activity and explain how the group members will participate in setting the agenda in future sessions. (The rationale for the agenda is that it will help the group keep track of what they are doing and what comes next. It also ensures that each member gets a chance to register what they want to discuss in the session). Members will be told that the session today will differ somewhat from the next five sessions in that in this session, more emphasis will be placed on describing and learning the group process. The agenda will be set as follows:

- 1) Introductions (5 minutes);
- 2) Rationale for the use of reminiscence with depression, including definition and examples of different types of reminiscence (10 minutes);
- 3) Discussion of preparation for the group and group procedures (5 minutes);

- 4) Discussion of the processes and procedures involved in either instrumental or integrative reminiscence (10 minutes);
- 5) Practice with the first topic: Branching Points (45 minutes);
- 6) Discussion of Homework (10 minutes);
- 7) Questions and Feedback (5 minutes).

Introductions.

The group begins with a brief round of introductions. The introductions provide members with the opportunity to make an entrance into the group without discussing emotional material. First, the leader will introduce her/himself in order to model both the kind of information that is expected and the brevity that will allow this section to be completed fairly rapidly. The leader will model relatively nonthreatening material such as marital status, hobbies, length of time in the city, children's names. When participants are asked to introduce themselves, the leader may prompt them with "Please tell us what you'd like to be called, what sort of family you have, what your current activities are".

After the introductions, the therapist will offer information and answer questions about his/her qualifications and professional work. Before moving to the next item on the agenda, members should be told that what they have just completed is called a "round". The concept of rounds should be explained, and members should be told when they will use rounds in the group.

Rationale for Reminiscence Therapy.

After the introductions, the leader should discuss the rationale for reminiscence therapy

and his or her expectations for therapeutic improvement in group members. This exchange begins with a brief description of the subjective experience of depression, with an emphasis on the sense of helplessness, loss, and negative view of the past, present, and future. Clients should also be made aware that depression can be associated with many physical symptoms such as lethargy and fatigue which have a significant impact on motivation, and memory loss.

Once a clear definition of depression is provided, the leader discusses the role of reminiscence in combatting the symptoms of depression. First, reminiscence is defined as an activity that is common to people of all ages, and that it is something with which we have all had experience. Specifically, it involves recollections dating back at least one or two years, in which the person reminiscing was either the main person involved in the story, or was an interested observer of others' behaviour. An example should be given to clarify between personal recollections and recollections of historical facts which are not the focus of the intervention (e.g., an historical account of the October Crisis vs. the impact of the October Crisis on one's personal life).

The leader then explains that there are many different types of reminiscence, and that each can serve a different purpose. Depending upon the group, the leader will provide a description of either the integrative or instrumental forms of reminiscence and stress that the particular form of reminiscence described will be the focus of the sessions.

In the integrative group, the leader explains that this type of reminiscence offers individuals the opportunity to review and integrate their diverse and sometimes seemingly disconnected life experience. This process requires the recall of past wrongdoing, failures, and losses, as well as successes, moments of happiness, and growth experiences. By adopting a

flexible, non-judgemental position in which these events are re-evaluated within the context of the whole lifetime, individuals can gain: perspective on the failures and losses in their life; a sense of self-acceptance and self-esteem; and, a sense of meaning and purpose/direction in life. These gains, in turn, offer protection against the feelings of hopelessness and negative view of the past, present and future which typify depression.

In the instrumental group, the leader explains that depression can be seen as the result of difficulty engaging helpful coping responses when faced with stressors in the environment. If individuals feel incapable of dealing with stressors, or if they use unhelpful strategies for dealing with these problems, the stressors may build up and contribute to negative evaluations of the past, present, and future, as well as to a feeling of hopelessness--feelings which typify depression. To the extent that individuals feel capable of dealing with stressors, and initiate adaptive coping measures, they are less likely to experience depressive symptoms.

Instrumental reminiscence can assist members in adaptive coping with stressors in their environment by focusing on the recall of past problem-solving episodes, including memories of making plans, activities designed to achieve those goals, and the attainment of goals either for oneself or when helping others. In addition, this type of reminiscence involves drawing upon past experience to solve present problems. This process is useful to combat depression because it highlights members successful coping strategies in the past, providing them with useful models to use in the present. As well, these past coping attempts can provide members with the self-confidence and feeling of control needed to both protect against the onset of stress and to deal effectively with it when it appears. This approach provides members with concrete skill to be used in the solution of present-day problems, which if left unattended, may contribute to the

onset and maintenance of depression.

Preparation for the Group and Group Procedures.

The therapist begins by conveying the purpose of the group work. The objective of the group meeting is to provide each individual with the opportunity to describe their reminiscence and work through it according to the task demands. In addition, the group offers the opportunity to learn from others' both directly, through the receipt of feedback, and indirectly through modelling. Typically, interaction with other members will spur the recall of forgotten material in one's life, bring to light alternative explanations for experiences, and foster a sense of both uniqueness and commonality that should contribute to self-esteem and alleviate some of the anxiety associated with depressive experiences.

The therapist's role includes ensuring that everyone receives equal opportunity to share their experiences by regulating the pace of the discussion. The therapist may include personal items to facilitate group cohesiveness and empathy, but his or her reminiscences should not be extensive or intrusive. Further, the therapist needs to ensure that appropriate support is given to members as they reveal sensitive and painful material.

In addition to these factors, the therapist assists members in trying to deal with their reminiscences in accordance with task demands. Although reminiscence is a universal practice, specific therapeutic targets need to be achieved in the sessions which should be conveyed to participants.

Expectations of behaviour in the group should be addressed at this stage. These norms include the expectation that members will discuss their own personal reminiscences, not just the

material offered by others. Further, members are expected to make a commitment to change demonstrated by their attempting to use their reminiscences in the manner suggested by the leaders, rather than simply recalling the facts of the past without evaluation or synthesis into current life. Members are also reminded that they are expected to attend every session, even if they do not feel like making the effort, unless attendance is absolutely precluded by an unavoidable circumstance, such as illness. The role of depression in reducing motivation and activity can be emphasized here. Any misunderstandings clients may have about therapy should be cleared up here and discussed.

Issues relating to self-disclosure and confidentiality should also be discussed at this time. The point should be made that although members are expected to discuss personal information, they will not be coerced into disclosing more information than they are ready to provide at a particular time. The leader should explain that it is customary in these groups for members not to identify group members to anyone outside the group, in order to help people feel safe in disclosing personal material.

Clients are told that reminiscence therapy teaches clients to use memories in specific ways in order to promote adaptation. It is useful for them to practice these processes before coming to the group so that group time can be spent dealing with problems they are having with the process and in receipt of other member's feedback, rather than on trying to recall memories. Each week, a worksheet with one of Birren's (1981) themes and accompanying sensitizing questions will be given to clients in order to help them identify appropriate memories. Clients will be asked to fill in and bring this worksheet to the meeting and this material will be the focus of the in-session work. Clients should be encouraged not to focus on the style of writing, but

rather on the content.

Homework Practice.

The rationale for homework should be explained to participants. Reminiscence therapy involves learning new skills. In order to master these skills, you need to practice them, both inside the group, and outside the group in more real-to-life situations. It is useful for members to spend a bit of time each week practising with memories other than the ones they bring to the group. Furthermore, clients should be encouraged to use the skills they have gained or positive feelings they have discovered to combat depressive feelings during the week. Clients will use the worksheets provided in the section on Procedures for Instrumental and Integrative Reminiscence for homework practice.

Questions and Feedback.

The leader will summarize the progress that has been made during the session and indicate the procedure that will be followed over the next sessions. Next he or she will ask for feedback after offering the following rationale: It's important for us to know what thoughts or feelings you might be experiencing and it is important that you tell us even when we don't ask.

Instructions for Sessions Two Through Six

In sessions Two through Six, both the integrative and instrumental groups will follow the same overall agenda as outlined below.

Agenda for Sessions 2-6.

| | |
|--|------------|
| 1) Homework Review and Agenda Development | 10 minutes |
| 2) Relaxation and Focusing on Reminiscence | 5 minutes |
| 3) Contact Work | 50 minutes |
| 4) Feedback to Clients | 15 minutes |
| 5) Assignment of Homework | 5 minutes |
| 6) Feedback to Therapist and Questions | 5 minutes |

Instructions for the Integrative GroupFocus of the Reminiscence

Each week, participants focus on a particular theme or topic, including: Branching Points; Family; Major Life Work or Career; Loves and Hates; Stress Experiences; and Meaning in Life. The purpose of selecting a group topic for each week is to provide continuity in the group discussions and to promote broad coverage of potentially problematic memories. To ensure that the time for therapeutic work in the sessions is maximized, clients are asked to prepare memories ahead of time for discussion in the group. Each week, participants are given homework assignments which are designed to help participants recall and choose important memories which are related to the chosen theme for the next session. These homework assignments help the client to re-familiarize themselves with the memory and the context in which it occurred, however, they do not require clients to review dysphoric memories on their own.

The kind of memories that are the focus of each of the weekly themes should be related to experiences that have had a significant impact on the individual's developmental history such as

loss, failure to meet one's own or others expectations, unreconciled relationships, or instances whose meaning and purpose in the individual's life is unclear.

Therapist Role in the Group Discussion

Integrative reminiscence involves an evaluative review of past experiences designed to help the individual come to terms with negative or unresolved events, to identify meaning in past experiences, and to integrate this information with the current self-concept. This review leads individuals to re-examine, from their current perspective, problematic experiences from the past such as difficult relationships, past conflicts, experiences of loss, or instances in which one failed to live up to one's own or others expectations. As a result of a successful review, individuals are able to re-interpret their attitudes and beliefs about their past in a positive fashion. In turn, these adaptive thoughts about the past yield positive feelings about the self in the present.

The emphasis placed by integrative reminiscence on the important role of cognitions in governing emotions corresponds with the cognitive approach to therapy (e.g., Beck, Rush, Shaw, & Emery, 1979). Both approaches assume that cognitions mediate depressive symptomatology, and that modification of thoughts which are likely to promote depression is one of the primary goals of therapy. The two approaches differ, however, in terms of the type of material that is the subject of therapy. Integrative reminiscence focuses exclusively on memories as the source of therapeutic material, whereas in cognitive therapy, current problems are typically the material of interest.

The two approaches also differ in terms of the therapeutic techniques used. Cognitive therapy attempts to change the way individuals interpret their experiences by using a wide

variety of behavioural and cognitive methods to directly alter the rules according to which clients organize reality. Integrative reminiscence, on the other hand, relies on the narrative structure of a life review to achieve therapeutic change. Integrative reminiscence attempts to alter the negative first impressions and emotional reactions to events that occurred in the past and to actively search for alternative, adaptive interpretations for past events. In turn, these modifications are thought to alter, in a positive fashion, the self concept as it exists as a product of past experiences.

Identifying Depressogenic Beliefs and Attitudes Toward the Past

Clearly, there are both similarities and differences between cognitive therapy and integrative reminiscence, however, reminiscence therapists may benefit from using some of the techniques designed by cognitive therapists to modify depressogenic thoughts. The first step involved in cognitive change is the identification of unrealistic and maladaptive thoughts about past negative events. The four column record method developed for use in cognitive therapy may be helpful in this regard because it requires clients to systematically examine their recollections within a cognitive framework. In this procedure clients follow four steps: they identify a recalled situation that is associated with dysphoric mood; they identify the specific feelings associated with this situation; they identify the thoughts that correspond with the dysphoric feeling; and, fourth they generate alternative interpretations for the event.

Depressogenic beliefs and attitudes related to the dysphoric situation may be elicited by asking the client to: 1) replay the distressing situation aloud; 2) imagine or create thoughts and images that will bring on or intensify the feeling; or 3) identify the conclusions he or she would

draw from the event (e.g., the therapist may ask "And what does that prove?" "How do you interpret that?" "What does it mean when?"). In addition, other group members can be asked to guess at possible expectations, fears, worries, or other cognitive responses to the situation that could have produced the feeling.

Generating Alternative Beliefs About the Past and Examining Their Impact on Self-Definition

After clients have identified maladaptive thoughts about past events which may be contributing to depression, the fourth stage of the four-column record procedure involves generating alternative thoughts which will dispel depressive emotions attached to the event. This process typically involves questioning the veracity of clients' thoughts and beliefs about past negative events. The intervention is undertaken in a questioning stance, allowing and encouraging clients to derive their own conclusions about the nature of the belief and its veracity.

The following questions are helpful in directing the exploration of the accuracy of a belief: 1) Reviewing that event, do you agree with your first impression and emotional reaction you had at that time?; 2) How else can you view or interpret the situation or how would others view it?; 3) Were the consequences of the event as bad as they seemed at the time?; 4) Is there some other explanation of the situation?; 5) How much importance do you want this event to have in your life?; 6) Is your standard too high?; 7) How much are you really to blame for the situation?; and, 8) What is your evidence for this belief? Each of these questions is directed at a different type of negative cognition, as such, the questions will most appropriately be used in specific situations--not all questions should be used at all times.

The process of helping clients distance themselves from negative cognitions by actively

questioning former interpretations of past events can be facilitated by encouraging clients to recognize that they are evaluating their past from a different perspective than when they first experienced the event. Clearly, certain contextual factors such as the social climate or significant others influenced the development of attitudes and beliefs toward a situation. By helping clients to examine the influence of these contextual factors on their interpretation of an event, clients are afforded the opportunity to evaluate whether they continue to interpret an event in the same fashion, given that the context is now changed. Furthermore, an awareness of the influence of contextual factors on one's interpretation of events may assist clients in the formulation of alternative interpretations of past events.

Following is an example of questions or prompts that the therapist may employ to help clients identify and evaluate contextual influences in the interpretation of an unresolved issue relating to the client's career. The prompts and questions can be used singly or in combination, as the situation demands:

1) Identification of the thoughts and feelings regarding career choice, career highlight, or career difficulties:

-How did you get into your major life work?

-What were the feelings and emotions you experienced at the time?

-How intense were these feelings?

-Has your career been continuous or have you experienced ups and downs? Have you had many career changes?

-What are your feelings about these changes?

2) Discussion of internal and external factors which mediate clients' feelings and thoughts about

the experience. These questions are designed to identify reasons for clients' thoughts and feelings, and thus, set the stage for distancing themselves from these reactions, and ultimately re-evaluating them.

-External factors: social and economic context, thoughts and feelings of significant others, environmental restrictions or opportunities, timing of the event in the life span.

-e.g., what have been the biggest influences in directing the path of your career?

-who were the important people involved in your career choice?

-what were the reasons for your career choices?

-how much personal choice did you have in your career?

-Internal factors: the individual's values and moral system, personality variables, intellectual and social resources.

-e.g., what did you hope to accomplish with this career?

-what did your career mean to you at the time?

-did this career fulfil your expectations?

3) Discussion of current internal and external factors which mediate the client's thoughts and feelings about past events. Discussion of how these factors have changed or remained the same over time.

4) Consideration of short-term and long-term consequences of the recalled event or set of events. This step is designed to assist clients in re-evaluating the meaning of certain memories by contrasting the effect of short-term consequences on thoughts and feelings, with the effect that long-term consequences have on thoughts and feelings. It is hoped that this process will convey to clients the idea that many different factors influence how we think and feel about an event, and

we are free to re-interpret the meaning of an event as these factors change or become more or less important.

-e.g., In what way was your life changed because of taking this career?

-What are some of the things you have learned from this career?

Following the identification of alternative cognitions, clients are asked to provide feedback about how their belief systems have changed. The process of giving feedback can be facilitated by having clients rate on a scale of 100 their belief in a particular interpretation of a past event before they begin to generate alternative beliefs. After new interpretations have been considered clients can re-rate the old belief and compare it with the rating they have given the new belief. They are then asked to discuss the impact of this process on their definition of themselves, their world, and their place in the world.

Conclusion

In summary, the therapist's role in the integrative reminiscence group includes the following tasks: 1) therapists will use the homework assignments to prime clients' memories in specific areas for each week; 2) during the group sessions, the therapist will direct clients toward discussing problematic experiences from the past which are related to the weekly theme (e.g., difficult relationships, past conflicts, experiences of loss, or instances in which the client failed to live up to his or her own or others' expectations); 3) next, the therapist will promote cognitive change by helping the client identify unrealistic and maladaptive thoughts about past negative events; 4) the therapist will help the client to generate alternative attitudes and beliefs about past events which are designed to dispel the depressive emotions attached to the event; and finally, 5)

the therapist will help the client to examine the impact of this process on self-definition.

Instructions for the Instrumental Group

Focus of the Reminiscence

Instrumental reminiscence involves recollections of past problem-solving, including memories of making plans to solve a problem or achieve a goal, the activities designed to achieve those goals, and the attainment of goals either for oneself or when helping others. This type of reminiscence also includes recalling past problem-solving experience and applying this knowledge to solve a present problem.

As in the integrative group, participants in the instrumental program focus on a different theme or topic each week, including: Branching Points; Family; Major Life Work or Career; Loves and Hates; Stress Experiences; and Meaning in Life. The participants in the instrumental group will also be asked to do a homework exercise ahead of time to help them prepare memories for discussion in the group. These homework assignments are designed to help the client to re-familiarize themselves with the memory and the context in which it occurred, however, they do not require clients to review dysphoric memories on their own.

Therapist Role in the Group Discussion

The purpose of this group is to examine experiences of past problem-solving in order to instill individuals with pride as a result of their past accomplishments, to promote confidence in their ability to solve current difficulties, and to provide examples of successful coping processes which may be useful in current problem solving. These goals are similar to a problem-solving

approach to depression in which problem-solving coping activities are thought to mediate emotional responses to negative life events and current daily problems (e.g., D'Zurilla & Nezu, 1982). Instrumental reminiscence differs from this approach in that the emphasis is on using memories to promote adaptive coping. In addition, instrumental reminiscence places greater emphasis on overcoming cognitive and emotional barriers to coping and less emphasis on actual problem-solving skills and strategies.

Normalizing Stress and Coping and Building Self-Efficacy

The first task of the therapist is to use the instrumental recollections to enhance clients' belief in their ability to effectively solve current problems. This procedure includes using instrumental reminiscence to illustrate the idea that problems are a normal part of life that clients have been successfully dealing with throughout their lifetime. This should help clients to normalize problems currently existing in their life. The therapist can also use the recalled problem-solving incident to demonstrate to clients that there are a wide range of causes for problems in an individual's life. The point of this exercise is to demonstrate that problems do not arise solely because of personality defects on the part of the individual. As such, when clients consider current problems, they should feel a reduction in the dysphoria that can result from unrealistic attribution of the causes of negative events to personal failings. Further, the therapist can use the past success to enhance clients' belief in their ability to affect or control problematic situations in their life (Bandura, 1977). This process may involve reviewing a number of successful problem-solving incidents in the past while highlighting the clients' ability to act effectively to resolve a problematic situation.

Primary Appraisals of Stressful Experiences

Primary appraisals of stressful experiences involve determining whether an event is relevant and threatening to the self. Clients need to identify who is threatened in a stressful situation, themselves or a loved one, so that the nature of the threat is known as well as an understanding of the direction to take regarding appropriate coping goals (e.g., able to change the situation, or have to regulate emotions while others attempt to overcome their stressors). It is also important for clients to identify what is at stake in a stressful situation. This requires that clients assess the personal needs and goals that are threatened by the event. This process can be assisted by examining important goals and needs that were evident in past coping situations. Often, repetitive patterns will emerge from this review that provide important information for current coping. In addition, recognition of the needs and goals at stake permit the opportunity to examine the appropriateness of these goals as well as alternative ways to have needs met. Review of past situations when goals had to be altered assists this process in the present. Further, observation of the change and development of goals and needs over time can help clients see this as a normal growing process, rather than a threat to the self.

Secondary Appraisals of Stressful Situations

According to Lazarus and Folkman (1984) how an individual appraises a problem has an effect on the strategy the person will use to cope with the difficulty. If individuals construe a problem as a challenge, something they are able to do something about, they are more likely to cope actively and effectively with the difficulty than if the problem is seen as a threat. Although, the focus on self-efficacy described in the section above should promote challenge appraisals, the

therapist may make the relationship between appraisals and effective coping more explicit by exploring with clients the type of appraisals they made when dealing successfully with a past difficulty. This process should clarify for clients the importance of positive appraisals in dealing with current problematic situations.

In addition, the client and therapist may evaluate at this stage the type of coping strategy used. Lazarus & Folkman (1984) indicate that the effectiveness of a particular coping strategy depends upon the situation in which it is enacted. For example, if the individual is realistically unable to alter a situation, the most effective coping strategy may involve trying to come to terms with the problem. On the other hand, if the individual has the resources to change a situation, the most effective coping strategies may involve active attempts to amend the problem. The therapist can explore with the client the different types of coping patterns that were considered and why they were rejected or accepted. Identifying the appropriate coping strategy works to help individuals feel capable of doing something about a stressful experience and, therefore, appraise it as a challenge rather than a threat.

Identifying Effective Strategies for Coping

Because it is recognized that most older adults have a wealth of experience with problem-solving, the emphasis is on removing cognitive and emotional barriers to coping rather than explicit training in problem-solving techniques. However, in situation where clients are at a loss to develop a coping strategy, or may be more appropriately using a different form of coping (e.g., emotion-focused versus problem-focused), the process of problem-solving and selecting a coping strategy can be identified through memories.

The therapist and client will also work together to identify the components of the recalled problem-solving experience which were effective in resolving the difficulty. This process will provide clients with concrete strategies to use in current problem-solving. D'Zurilla and Nezu (1982) have identified four components of successful problem-solving which can be used as guidelines for therapists to help identify strategies appropriate for use by clients. The first component is problem definition and formulation. This process involves assessing the nature of the problem situation and identifying realistic goals for problem-solving. Together, the therapist and client can explore how the client gathered information for this task, how s/he differentiated relevant from irrelevant information and conjecture from fact, how s/he pinpointed the key components of the difficulty that needed to be addressed, and how s/he went about generating realistic problem-solving goals.

The second component is the generation of alternatives. In this phase, the therapist and client can explore the process through which the client generated alternative approaches to coping with the problem. The focus should be on identifying the adaptive aspects of this brainstorming process that were used by clients. Examples of adaptive strategies include generating a large number of alternatives, looking at alternatives with an open mind and not rejecting them out of hand, and specification of concrete strategies to enact general goals (e.g., the writing of resumes is a specific task identified to achieve the goal of obtaining a job).

The third component is decision making which involves the evaluation of available solution possibilities and selection of the most effective alternative(s). The major focus of this process is the evaluation of a given alternative with regard to its consequences. Thus, therapist and clients may explore processes the client used to choose the solution they implemented.

Emphasis should be placed on the client's recognition of both positive and negative, and short- and long-term results of the decision, as well as the effect of the decision on the self as well as others.

The final component of solution implementation and verification involves enacting the chosen solution and comparing the expected with the obtained result. In this phase, therapist and client have the opportunity to verify what aspects of the problem-solving approach were useful and to identify what components were less effective. This process allows the therapist to explore with the client different approaches that may have been more successful at any of the four stages.

Transferring Skills to Current Problems

A third therapeutic task for the instrumental reminiscence therapist is to help clients apply effective strategies from the past to current problematic situations. The therapist will provide the client with a list of the important components in problem solution and review with the client how these strategies can be applied to a present situation (see the following pages for this material). In addition, therapists will assist clients to identify situations in the past in which they solved a similar problem to the current one. The therapist will need to identify the crucial elements of the current problem in order to draw parallels with similar types of problems previously met.

Work At Home Exercises

Coping with difficult or challenging experiences and situations can help protect us from developing feelings of depression. Coping, however, is not always easy. Sometimes we feel overwhelmed and unable to cope with situations because we do not see an effective way to handle the demands placed upon us.

Many of the demands that you experience can be dealt with effectively by using problem-solving strategies that you have developed throughout your life. In fact, your previous experiences of coping with life situations are one of the best sources of ideas and strategies that you can use to deal with current demands.

In the group discussions of successful coping experiences you have had in the past, together we have learned about your well-developed ability to cope and we have identified several important ideas that play a useful role in your coping activities. In order to make use of your knowledge and experience in problem-solving, we would like you to apply some of these ideas and strategies to a problem you are currently experiencing.

Please think of a problem that is currently occurring in your life. As the first step in dealing with this problem, ask yourself the five questions listed below. After thinking about each question, read the short paragraph which outlines some of the important points we have learned from your past problem-solving experiences. Try to keep these points in mind when beginning any problem-solving process.

Orientation to Coping with Challenges

1) Do you feel capable of meeting this challenge or solving this problem?

The group discussion of past problem-solving has shown that you are a competent individual who has dealt effectively with problems and challenges in many areas of life such as family relationships, education, and career. **YOU CAN COPE EFFECTIVELY WITH PROBLEMS.**

2) Do you feel that it is abnormal to have this problem or that you are alone in having this kind of problem?

Everyone in the group has shared past and current problems that they have experienced, in fact, some of these problems have been similar to ones you have experienced. **IF YOU HAVE A PROBLEM YOU'RE NORMAL.**

3) Do you feel that this problem is a major disaster in your life that overshadows the possibility of happiness?

This problem is simply one in a series of challenging experiences that you have dealt with effectively in your life. In the past you have had experiences that you may have considered disastrous or overwhelming at the time. However, as your recollections show, although it may be unpleasant when things don't go the way we want them to, you can cope and you can be happy despite these experiences. IT IS NOT A CATASTROPHE IF SITUATIONS OR EXPERIENCES DO NOT GO RIGHT--YOU HAVE COPEDED BEFORE.

4) Does searching for the perfect solution that will completely fix the problem stop you from trying less-than-perfect solutions which are nonetheless reasonable and more easily attained?

In the group, different people have described how they used different, but equally effective, strategies to solve similar problems. These recollections suggest that there is no perfect solution to a particular problem. Therefore, don't use your energy worrying about finding THE solution, rather, use your energy to enact a solution that is reasonable for you. THERE IS NO PERFECT SOLUTION TO A PROBLEM, THERE IS ONLY THE BEST SOLUTION FOR YOU IN THE CURRENT SITUATION.

5) Are you avoiding dealing with the problem?

One of the important aspects of effective coping that the group identified in past problem-solving was the fact that you diligently attempted to find a solution, even if you did feel anxious or doubtful about the outcome. DON'T AVOID PROBLEMS.

Problem Definition

In the group discussions, together we have established that an important first step in solving problems is the clear definition of the problem and a clear statement of the desired solution to the difficult situation. Thinking about the current problem that you worked on in the last section, apply the following three strategies to help you work toward solving the problem. To help you in this task, think about past problem-solving activities in which you were able to clearly define the problem you faced. Jot down your attempts to clearly define the problem in the spaces provided.

1) ESTABLISH THE IMPORTANT FACTS IN THE SITUATION.

It is necessary to determine the who, what, where, when, how, and why of the problem in order to better understand what is making it problematic. (In other words, you can play scientist, detective, or investigative reporter in order to get a good grasp on the situation).

2) IDENTIFY THE FACTORS AND CIRCUMSTANCES OF THE SITUATION THAT ARE MAKING IT A PROBLEM FOR YOU.

Often, we have difficulty solving problems because we are not sure what are the obstacles we need to tackle in order to solve the problem. For example, we may face the problem of loneliness, but before we can address the problem we have to identify the obstacles that stand in the way of getting rid of loneliness, such as difficulty getting out in the winter, or a reluctance to invite people over unless everything is perfect in the home.

3) IDENTIFY AND DISCRIMINATE BETWEEN REASONABLE AND UNREASONABLE OR UNATTAINABLE GOALS.

Solving problems may also be difficult because we may not have defined a clear, realistic goal regarding how we want the problem resolved. Although to be completely free of loneliness and constantly surrounded by friends may be desirable, it is an unrealistic goal for anyone. However, it is realistic to expect that you can increase your contact with others by scheduling outings or inviting people over even if the house is a little untidy.

Coping with the problems and challenges we all face in our lives is an important part of treating feelings of depression. At certain times in our lives, coping with life circumstances can be difficult because we are experiencing a number of challenges all at once, because or because the type of problems facing us seem different from what we have experienced in the past.

Steps Involved in Effective Problem-Solving

1) Appraisal of the Challenge.

How do you view the problem that faces you? Do you see it as a threat to you or someone you love? Do you see it as a chore? Often, our most effective problem-solving occurs when we see the problem as a challenge--something that will test our skills and provide us with a learning experience. Whether we succeed in meeting the challenge or not, the attempt to reach our goal will be a source of pride in itself.

2) Challenge Definition and Formulation.

The first step in effectively dealing with challenges involves identifying the information needed to address the challenge. What information is relevant to understanding the problem, and what are the key issues that need to be solved. and how s/he went about generating realistic problem-solving goals.

3) Generation of Alternative Solutions.

The second component is the generation of alternatives. In this phase, successful problem-solving involves generating a large number of alternatives, looking at alternatives with an open mind and not rejecting them out of hand, and specification of concrete strategies to enact general goals (e.g., the writing of resumes is a specific task identified to achieve the goal of obtaining a job).

4) Decision Making.

The third component is decision making which involves the evaluation of available solution possibilities and selection of the most effective alternative(s). The major focus of this process is to evaluate a given alternative with regard to its consequences. This involves recognizing both positive and negative, and short- and long-term results of the decision, as well as the effect of the decision on the self as well as others.

In addition, at this stage the type of coping strategy used should be evaluated. The effectiveness of a particular coping strategy depends upon the situation in which it is enacted. For example, if you are realistically unable to alter a situation, the most effective coping strategy may involve trying to come to terms with the problem. On the other hand, if you have the resources to change a situation, the most effective coping strategies may involve active attempts to amend the

problem.

5) Solution Implementation and Verification.

The fourth component involves putting into action the chosen solution and comparing the obtained result with the solution that was expected. In this phase, you will verify what aspects of the problem-solving approach were useful and identify what components were less effective at each of the three stages listed above. This process provides you with concrete information regarding strategies that will be successful in future problem-solving. It also allows you to appreciate the strengths and resources you have brought to the task, and to savour the successes you have achieved.

Homework Assignments for the Integrative Group

Week One: Major Branching Points in Your Life

Take a few minutes to relax, and empty your mind of current worries and thoughts.

A branching point is an experience you have had that involves an important change in your life. Branching points may be big events (e.g., marriage, depressions, retirement) or they may seem small and apparently inconsequential (e.g., reading a certain book, meeting a new friend). What event, experience, or relationship has had a major impact on the way your life has unfolded?

1) What was an important branching point in your life?

2) Did other people play a major role in this branching point, or was it something you experienced on your own?

3) How did this branching point affect your life, or the way you looked at life?

4) Was this branching point something that many people have experienced, or was it something out of the ordinary?

Week Two: Family Life

Take a few minutes to relax, and empty your mind of current worries and thoughts.

Who were the family members who were important in shaping your life in a positive or negative way?

1) In a few brief sentences, how would you describe your early life with your parents and siblings?

2) Who were the important people in your life during adulthood?

3) How much contact did you have with family members over the years?

4) What types of activities did you and your family engage in?

5) Which family member did you feel closest to? Which family member did you know the least, or feel the least close to?

Week Three: Your Career or Major Life Work

Take a few minutes to relax, and empty your mind of current worries and thoughts.

A career or major life work can have many forms. Usually we think of it as work outside the home for pay. However, a career or life work can also involve being a husband, a wife, a parent, or it can involve religious devotion, athletics, artistic endeavours, education, or community service.

1) What was your major life work or career?

2) Who or what was the biggest influence in helping you choose your career?

3) What type of activities were you involved in with this career?

4) Who were some of the people you become involved with because of your career?

5) What was one of the highlights of your career?

Week Four: Your Loves and Hates

Take a few minutes to relax, and empty your mind of current worries and thoughts.

Love is a strong emotional attachment to a particular person, place, or thing. What have been the major loves of your life?

Hate is a strong feeling of dislike or ill will toward some person, place, or thing. What have been the hates or strong aversions in your life?

1) Can you think of a person, place, or thing that you have really loved in your life?

2) How did you first encounter this person, place, or thing?

3) What type of activities did you do with this person, place, or thing?

4) What was something or someone that you really hated?

5) What were the circumstances in which you encountered this person or thing?

Week Five: Stress Experiences

Take a few minutes to relax, and empty your mind of current worries and thoughts.

All of us encounter stressful experiences in our life. These are times in which we must use our wits and our strengths to overcome or come to terms with a problem. Can you think of a stressful time in the past and how you dealt with it then?

1) Have you experienced a stressful time in your marriage, career, or with your children?

2) Who was involved in this situation?

3) What caused this stressful situation?

4) How did you go about resolving this situation? Did you do it alone, or obtain someone else's help?

Week Six: The Meaning of Your Life

Take a few minutes to relax, and empty your mind of current worries and thoughts.

During our life, each of us develops goals which give us a sense of purpose or direction. Some goals, such as educational plans, are fulfilled early in life and give way to new goals. Other goals, such as leading a charitable life, are never completely fulfilled. Think about some of the goals you have had in life.

1) What do you consider to have been your major life goals?

2) How did these goals develop? What experiences, people and thoughts contributed to the development of these goals?

3) Do you have particular ways of living your life which reflect your goals?

4) What is something that makes life meaningful for you?

5) What have you learned in life that you would you like to tell your children or grandchildren?

Homework Assignments for the Instrumental Group

Week One: The Major Branching Points in Your Life

Take a few minutes to relax, and empty your mind of current worries and thoughts.

Branching points are times in our lives when we make a major decision to follow a certain path, or we become involved in an experience which we later see as a turning point in our lives. Can you recall a problem or challenge you experienced at one of these branching points? The challenge may have involved the decision to take a certain pathway, or it may have been a challenge that resulted from choosing a new life course.

1) What was the challenge you experienced at this branching point?

2) Did another person or persons play an important role in this challenge?

3) How did you feel about the challenge at the time? Did you see it as a challenge or a threat? Were you confident in your ability to solve the challenge?

4) What plans and actions did you take to solve the challenge?

Week Two: Family Life

Take a few minutes to relax, and empty your mind of current worries and thoughts.

Can you recall a problem or challenge that you were able to solve that relates in some way to your family? It could be a challenge you had with another family member, it could be a challenge that you and your family had to face together, or it could be a challenge that you helped another family member solve.

1) What was the challenge you experienced?

2) What family members were involved in this challenge?

3) How did you feel about the challenge at the time? Did you see it as a challenge or a threat? Were you confident in your ability to solve the challenge?

4) What plans and actions did you take to solve the challenge?

Week Three: Your Career or Major Life Work

Take a few minutes to relax, and empty your mind of current worries and thoughts.

A career or major life work can take many forms. Usually we think of it as work outside the home for pay. However, a career or life work can also involve being a husband, a wife, a parent, or it can involve religious devotion, athletics, artistic endeavours, education, or community service. Can you recall a problem or challenge that you successfully resolved that relates to your major life work or career?

1) What was your major life work or career?

2) What was the challenge you faced with regard to your career or life work?

3) How did you feel about the challenge at the time? Did you see it as a challenge or a threat? Were you confident in your ability to solve the challenge?

4) What plans and actions did you take to solve the challenge?

Week Four: Your Loves and Hates

Take a few minutes to relax, and empty your mind of current worries and thoughts.

Love is a strong emotional attachment to a particular person, place, or thing. Hate, on the other hand, is a strong feeling of dislike or ill will toward some person, place, or thing. Can you recall a problem or challenge you solved regarding someone or something that you either loved or hated?

1) What was the object of your love or hate?

2) What challenge did you face with this person, place or thing?

3) How did you feel about the challenge at the time? Did you see it as a challenge or a threat? Were you confident in your ability to solve the challenge?

4) What plans and actions did you take to solve the challenge?

Week Five: Stress Experiences

Take a few minutes to relax, and empty your mind of current worries and thoughts.

All of us encounter stressful experiences in our life. These times may involve a short-term crisis such as a family member losing a job, or it may involve a stressful situation that occurred over a long period of time such as caring for an ill member of the family. Can you recall a situation in which you successfully solved a problem or challenge that occurred during a stressful situation or crisis?

1) What was the stressful experience or crisis?

2) Who was involved in this situation?

3) How did you feel about the challenge at the time? Did you see it as a challenge or a threat? Were you confident in your ability to solve the challenge?

4) What plans and actions did you take to solve the challenge?

Week Six: The Meaning of Your Life

Take a few minutes to relax, and empty your mind of current worries and thoughts.

During our life, each of us develops goals which give us a sense of purpose or direction. Some goals, such as educational plans, are fulfilled early in life and give way to new goals. Other goals, such as leading a charitable life, are never completely fulfilled. Can you recall a problem or challenge you resolved that relates to the achievement of a life goal?

1) Describe a major life goal that you experienced a challenge fulfilling.

2) What was the challenge you experienced in trying to achieve this goal?

3) How did you feel about the challenge at the time? Did you see it as a challenge or a threat? Were you confident in your ability to solve the challenge?

4) What plans and actions did you take to solve the challenge?

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Appendix B: Recruitment Notice, Advertisements, and Letters to Community Agencies

Recruitment Notice

Reminiscence Study

Reminiscence is a common and often pleasurable pastime involving the recollection of people, places, and events from our past. These memories play a powerful role in our present lives and can exert a great deal of influence in shaping our future. Recently, psychologists have found that reminiscence can play an important role in helping senior adults cope with some of the stressful and difficult experiences they may encounter. Our research is designed to determine which types of reminiscence provide the greatest help to seniors who are experiencing coping difficulties.

Participants in the research study will meet with a facilitator and four others at the Psychogeriatric Clinic (or Centre for Psychological Services) for six weekly sessions lasting 90 minutes each. The meetings will involve either: 1) a discussion of memories related to your past history, life accomplishments, major life turning points, history of loves and hates, stressful experiences, and meaning and purpose in your life; or, 2) a discussion of current topics of concern to senior adults such as changes in the five senses, alterations in family patterns and relationships, and the role of seniors in current society. Individuals who first participate in the second group may also participate in the reminiscence group should they so desire.

Before the study begins, interested individuals will be asked to complete a few questionnaires to determine whether they will benefit from participation in the study. In addition, at various times during the study, participants will be asked to complete questionnaires related to their current well-being. If you would like to participate or if you have any questions about the study, please contact:

Researcher's Name (telephone number).

Newspaper Advertisement

ATTENTION SENIORS
ARE YOU FEELING DOWN OR BLUE?

Counsellors at the University
of Ottawa Psychology Department
invite you to participate in a
FREE research project designed
to relieve feelings of sadness
through group reminiscence.
Call Lisa Watt at: .

Letter to Community Agencies

Ms. Lisa Watt, M.A.Sc.
Dr. Philippe Cappeliez, C.Psych.
Department of Psychology
University of Ottawa
Ottawa, Ontario
K1N 6N5

December 20, 1994

Dear Colleague:

As part of our research in the Psychology Department of the University of Ottawa, we are conducting a study to examine the efficacy of reminiscence group therapy in alleviating depressive symptomatology in older adults. **We are starting the fifth phase of our intervention study and are interested in obtaining referrals of senior adults from your Centre who may benefit from psychological intervention for depression.**

The intervention, offered at the Centre for Psychological Services of the University of Ottawa, focuses on the use of reminiscence to teach strategies for coping with depression. Individuals who participate in the study will meet with a trained counsellor and four other participants for six weekly sessions lasting 90 minutes each. There will also be two follow-up sessions at one and three months post-treatment. **Participation in this program is free of charge.**

The program is open to interested adults who are: sixty or more years of age, English speaking, manifesting depressive symptomatology, and demonstrating little or no cognitive impairment. We are beginning screening in early January, with a view to starting three groups in February.

I have enclosed a sample of an information sheet that could be given to prospective participants and a poster that could be used to advertise the study. I will telephone you in the next week to discuss whether this program would be of benefit to your clientele and to answer any questions you may have about the project. Sincerely,

Lisa Watt

Appendix C: Telephone Screening Interview

Participant Selection and Instructions

1) Explanation of the Study and Selection Criteria

We are conducting a research study which will examine whether reminiscence therapy can assist senior adults to cope with some of the stressful and difficult experiences they may encounter. If you would like to participate in the study you will need to satisfy certain criteria. These criteria are designed to ensure that the group of people involved in the study all share similar characteristics. In a few minutes, I will ask you a few questions that will indicate whether you meet the initial selection criteria. If you do, we will ask you to come to our office and complete a few psychological questionnaires which will help us decide if you will benefit from participation in this type of therapy.

At that time, you will be informed whether you will be accepted into the study. If so, we will ask you to fill out a form indicating your consent to participate in the study, and we will also give you more detailed information about the research. The study will begin in approximately three weeks, so if you care to participate you will have to wait for treatment until that time. Are you interested in participating in this research study? -If participant answers yes, go to step two.

2) Selection Criteria and Participant Information

I would like to ask you some questions now which will help determine whether you meet the initial criteria for participation in the study. Please let me know if you have any questions about criteria, or if you do not want to answer any of the questions.

a) How old are you?

-must be 60 years of age or older.

b) Do you speak English fluently?

-must be anglophone or fluent in English.

c) Are you currently experiencing any problems with alcohol or drug use?

-must answer no to both questions.

-if the answer is yes, ask participant if he/she is undergoing treatment for the problem. If the participant is in treatment, suggest that he/she continue treatment. Inform participant that concurrent substance abuse makes him/her ineligible for the study at this time.

If participant is not in treatment, ask if he/she would like a referral to the Centre for Psychological Services to obtain counselling (Address: 11 Marie Curie, 6th Floor, Vanier Hall, University of Ottawa; Tel. 564-6875).

d) Are you currently taking any medication for depression?

-if yes, ask participant to describe drug, dosage, and length of time taking the current prescription.

-drug and dosage must have been constant for the last three months.

e) Have you ever made a suicide attempt or considered suicide?

-if yes to current suicidal thoughts or attempts, determine severity of current suicidal intent.

-if participant states that he/she is considering or intends to commit suicide, direct him/her to the Royal Ottawa Hospital immediately (Address: 1145 Carling Ave., Ottawa; Tel. 724-6514).

-if participant expresses distress, anxiety, or depression, provide a referral to the (Address: 11 Marie Curie, 6th Floor, Vanier Hall, University of Ottawa; Tel. 564-6875).

If the participant satisfies the selection criteria, set up an appointment to undertake pre-intervention assessment.

Appendix D: Consent Form

Ms. Lisa Watt, M.A.Sc. 595-0229
Dr. Philippe Cappeliez 564-9460
Department of Psychology
University of Ottawa
Ottawa, Ontario
K1N 6N5

As part of our research at the University of Ottawa, we are conducting a study to examine whether reminiscence therapy can assist senior adults to cope with some of the stressful experiences they encounter.

Individuals who participate in the study will meet with a facilitator and four other participants at the Psychogeriatric Clinic (or Centre for Psychological Services) for six weekly sessions lasting 90 minutes each. The group meetings will involve either: 1) a discussion of memories related to your past history including your accomplishments, the stressful times in your life, and the values and meaning you have developed in your lifetime; or, 2) a discussion of current topics of concern to senior adults such as physical and sensory changes and their impact on your life, alterations in family patterns and relationships, and the role of seniors in current society.

At various times throughout the study, volunteers will be asked to answer questions about how they are feeling emotionally and physically, and how they are coping with current stresses in their life. Participants will also be asked to complete these questionnaires at three and six months after therapy has ended.

Participation is completely voluntary and those individuals who wish to discontinue their participation may leave the study at any time. All participants in the group will be asked to respect the confidentiality of the information disclosed during the meetings. Furthermore, all records of participation will be kept confidential. Only the researchers will have access to this information and it will not be made public in any way that identifies specific persons as participants.

If at any point during the study participants have questions or concerns, they are free to discuss these matters with the group facilitator or contact Dr. Cappeliez at 564-9460.

There are two copies of the consent form. If you decide to participate, please sign them both, return one to the researcher, and keep one for your records.

Participant's Signature

Date

Researcher's Signature

Optional: I wish to receive a summary of the findings of this study upon its completion at the following address:

Appendix E: Measures Used in the Study

Mini-Mental Status Exam

Hamilton Rating Scale-Depression

Demographic Information Questionnaire

Appraisal and Ways of Coping-Revised Questionnaire

Hopelessness Scale

Attributional Styles Questionnaire

Rosenberg Self-Esteem Scale

Life Attitude Profile-Revised

Perceived Efficacy Questionnaire

Geriatric Depression Scale

Social Adjustment Scale

Mini-Mental State

Maximum
Score Score

ORIENTATION

- 5 () What is the (year) (season) (date) (day) (month)?
5 () Where are we: (state) (county) (town) (hospital) (floor)?

REGISTRATION

- 3 () Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until patient learns all 3. Count trials and record.

Trials:

ATTENTION AND CONCENTRATION

- 5 () Serial 7's. 1 point for each correct. Stop after 5 answers. Alternatively spell 'world' backwards.

RECALL

- 3 () Ask for 3 objects repeated above. Give 1 point for each correct.

LANGUAGE

- 9 () Name a pencil and watch (2 points).
Repeat the following: No ifs, ands, or buts (1 point).
Follow a 3-stage command: Take a paper in your right hand, fold it in half, and put it on the floor (3 points).
Read and obey the following: CLOSE YOUR EYES (1 point).
Write a sentence (1 point).
Copy design (1 point).

Total Score

ASSESS level of consciousness along a continuum.

Alert Drowsy Stupor Coma

Hamilton Rating Scale for Depression

INSTRUCTIONS: For each item, circle the number preceding the description which best characterizes the patient.

1. Depressed Mood (sad, hopeless, worthless)

- 0 - Absent.
- 1 - These feelings indicated only on questioning.
- 2 - These feeling states spontaneously reported verbally.
- 3 - Communicates feeling states non-verbally (i.e., facial expression, posture, voice, weeping).
- 4 - Patient reports virtually only these feelings in the spontaneous verbal and non-verbal communication.

2. Feelings of Guilt

- 0 - Absent.
- 1 - Self-reproach, feels he/she has let people down.
- 2 - Ideas of guilt or rumination over past errors or sinful deeds.
- 3 - Present illness is a punishment. Delusions of guilt.
- 4 - Hears accusing or denouncing voices and/or experiences threatening visual hallucinations.

3. Suicide

- 0 - Absent.
- 1 - Feels life is not worth living.
- 2 - Wishes he/she were dead or any thoughts of possible death to self.
- 3 - Suicide ideas or gesture.
- 4 - Attempts at suicide.

4. Insomnia - Early

- 0 - No difficulty falling asleep.
- 1 - Complains of occasional difficulty falling asleep (i.e., more than ½ an hour).
- 2 - Complains of nightly difficulty falling asleep.

5. Insomnia - Middle

- 0 - No difficulty.
- 1 - Complains of being restless and disturbed during the night.
- 2 - Waking during the night and getting out of bed.

6. Insomnia - Late

- 0 - Sleeps until wakened.
- 1 - Waking in early hours of the morning but goes back to sleep.
- 2 - Unable to fall asleep again if gets out of bed.

7. Work and Activities

- 0 - No difficulty.
- 1 - Thoughts and feelings of incapacity, fatigue or weakness related to activities.
- 2 - Loss of interest in activity - either directly reported by client or indirectly in increased listlessness, indecision, and vacillation (a sense of having to push self to activities).
- 3 - Decrease in actual time spent in activities or decrease in productivity.
- 4 - Stopped working because of present illness.

8. Retardation (slowness of thought and speech; impaired ability to concentrate, decreased motor activity)

- 0 - Normal speech and thought.
- 1 - Slight retardation at interview.
- 2 - Obvious retardation at interview.
- 3 - Interview difficult.
- 4 - Complete stupor.

9. Agitation

- 0 - None.
- 1 - Playing with hands, hair, etc.
- 2 - Hand-wringing, nail-biting, hair-pulling, biting of lips.

10. Anxiety - Psychic

- 0 - No difficulty.
- 1 - Subjective tension and irritability.
- 2 - Worrying about minor matters.
- 3 - Apprehensive attitude apparent in fact or speech.
- 4 - Fears expressed without questioning.

11. Anxiety - Somatic physiological concomitant of anxiety, such as:

Gastrointestinal - dry mouth, wind, indigestion, diarrhea, cramps, belching.

Cardiovascular - palpitations, headaches.

Respiratory - hyperventilation, sighing.

Urinary frequency, sweating

Rate severity of any or all as: 0 - Absent 1 - Mild 2 - Moderate 3 - Severe 4 - Incapacitation.

12. Somatic symptoms, Gastrointestinal

- 0 - None.
- 1 - Loss of appetite but eating without encouragement. Heavy feelings in abdomen.
- 2 - Difficulty eating without urging. Requests or require laxative or medication for bowels or medication for GI symptoms.

13. Somatic symptoms, General

- 0 - None.
- 1 - Heaviness in limbs, back or head. Backaches, headache, muscle aches. Loss of energy and fatigability.
- 2 - Any clear-cut symptom.

14. Genital symptoms (loss of libido, menstrual disturbances)

- 0 - Absent.
- 1 - Mild.
- 2 - Severe.

15. Hypochondriasis

- 0 - Not present.
- 1 - Self-absorption (bodily).
- 2 - Preoccupation with health.
- 3 - Frequent complaints, requests for help, etc.
- 4 - Hypochondriacal delusions.

16. Loss of Weight

A. Rating by history

0 - No weight loss

1 - Probable weight loss associated with present illness.

2 - Definite (according to patient) weight loss.

B. Weekly Weighing

0 - Less than 1 lb in a week.

1 - Greater than 1 lb.

2 - More than 2 lb.

17. Insight

0 - Acknowledges being depressed and ill.

1 - Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.

2 - Denies being ill at all.

18. Diurnal Variation

0 - Absent. a.m. ()

1 - Mild. p.m. ()

2 - Severe.

19. Depersonalization and Derealization (such as feelings of unreality, nihilistic ideas)

0 - Absent.

1 - Mild.

2 - Moderate.

3 - Severe.

4 - Incapacitation.

20. Paranoid Symptoms

0 - None.

1 - Mildly suspicious.

2 - Moderately suspicious.

3 - Ideas of reference.

4 - Delusion of reference and persecution.

21. Obsessional and Compulsive Symptoms

0 - Absent.

1 - Mild.

2 - Severe.

PERSONAL INFORMATION

AGE: _____

MARITAL STATUS:

Married _____

Divorced/
Separated _____

Widow/er _____

Single _____

EDUCATION:

Eighth Grade or less _____

High School _____

Some University/College _____

College Degree _____

University Degree _____

HEALTH STATUS:

Please list current medical disorder(s):

On the scale below, please rate your current level of physical health by circling the number that corresponds to your health as you see it.

| | | | | |
|--------------|------|---------|------|--------------|
| 1 | 2 | 3 | 4 | 5 |
| Very Poor | Poor | Average | Good | Very Good |

NAME AND NUMBER OF PHYSICIAN: _____

APPRAISAL QUESTIONNAIRE

The purpose of the following questionnaire is to assess how people cope with stressful situations.

Please take a few minutes and think about the most stressful event which has occurred to you **IN THE PAST WEEK**. This event could be related to your family or friends, your health, your social activities or commitments.

In the space below write a brief description of this stressful event.

On the scale provided below please evaluate the level of stress caused by this event. A rating of 0 indicates that the event was not stressful at all. A rating of 100 would be given to an extremely stressful event. Ratings of 25, 50, and 75 would indicate respectively slightly stressful, moderately stressful, and very stressful events.

| | | | | |
|----------------------|--------------------|----------------------|----------------|---------------------|
| 0 | 25 | 50 | 75 | 100 |
| Not at all Stressful | Slightly Stressful | Moderately Stressful | Very Stressful | Extremely Stressful |

Please indicate **WHY** this situation was stressful for you by identifying the reasons below that apply for you in this situation.

IN THIS SITUATION THERE WAS (IS) THE POSSIBILITY OF:

| | | | | |
|----------------|------------------|------------------|---------------|----------------------|
| Does not Apply | Applies a Little | Applies Somewhat | Applies a Lot | Applies a Great Deal |
|----------------|------------------|------------------|---------------|----------------------|

1) Harm to a loved one's health, safety, or physical well-being.

2) Harm to a loved one's emotional well-being.

3) Harm to your own health, safety, or physical well-being.

4) A loved one having difficulty getting along in the world.

5) Harm to your own emotional well-being.

6) Personally not being able to get along in the world.

7) Losing your self-respect.

8) Appearing incompetent.

9) Losing the affection of someone important to you.

10) Losing the approval or respect of someone important to you.

11) Other: _____

TO WHAT EXTENT WAS THIS SITUATION ONE:

(Please circle the number on each item that best describes the situation).

Not at
All

A Little
Bit

Somewhat

Quite

Very
M u c h
So

1) That you could change or do something about.

2) That you had to accept.

3) In which you needed to know more before you could act.

4) In which you had to hold yourself back from doing what you wanted to do.

If more than one statement in this question applies, please indicate which one best describes the situation by circling the appropriate number here:

1

2

3

4

Please read each item below and indicate, by circling the appropriate category, to what extent you used it in the situation you have just described.

| | | Not used | Used some- what | Used quite a bit | Used a great deal |
|----|--|-------------|-----------------------|------------------------|-------------------------|
| 1 | Tried to get the person responsible to change his or her mind. | 0 | 1 | 2 | 3 |
| 2. | Criticized or lectured myself. | 0 | 1 | 2 | 3 |
| 3. | Tried not to burn my bridges, but leave things open somewhat. | 0 | 1 | 2 | 3 |
| 4. | Hoped a miracle would happen. | 0 | 1 | 2 | 3 |
| 5. | Went on as if nothing had happened. | 0 | 1 | 2 | 3 |
| 6. | I tried to keep my feelings to myself. | 0 | 1 | 2 | 3 |
| 7. | Looked for the silver lining, so to speak; tried to look on the bright side of things. | 0 | 1 | 2 | 3 |
| 8. | I expressed anger to the person(s) who caused the problem. | 0 | 1 | 2 | 3 |

| | | Not used | Used some- what | Used quite a bit | Used a great deal |
|-----|--|-------------|-----------------------|------------------------|-------------------------|
| 9. | Accepted sympathy and understanding from someone. | 0 | 1 | 2 | 3 |
| 10. | I was inspired to do something creative. | 0 | 1 | 2 | 3 |
| 11. | Tried to forget the whole thing. | 0 | 1 | 2 | 3 |
| 12. | Changed or grew as a person in a good way. | 0 | 1 | 2 | 3 |
| 13. | I apologized or did something to make up. | 0 | 1 | 2 | 3 |
| 14. | I made a plan of action and followed it. | 0 | 1 | 2 | 3 |
| 15. | I let my feelings out somehow. | 0 | 1 | 2 | 3 |
| 16. | Realized I brought the problem on myself. | 0 | 1 | 2 | 3 |
| 17. | I came out of the experience better than when I went in. | 0 | 1 | 2 | 3 |
| 18. | Talked to someone who could do something concrete about the problem. | 0 | 1 | 2 | 3 |
| 19. | Rediscovered what is important in life. | 0 | 1 | 2 | 3 |

| | | Not used | Used some- what | Used quite a bit | Used a great deal |
|-----|--|-------------|-----------------------|------------------------|-------------------------|
| 20. | Changed something so things would turn out all right. | 0 | 1 | 2 | 3 |
| 21. | Didn't let it get to me; refused to think too much about it. | 0 | 1 | 2 | 3 |
| 22. | Kept others from knowing how bad things were. | 0 | 1 | 2 | 3 |
| 23. | Talked to someone about how I was feeling. | 0 | 1 | 2 | 3 |
| 24. | Stood my ground and fought for what I wanted. | 0 | 1 | 2 | 3 |
| 25. | I knew what had to be done, so I doubled my efforts to make things work. | 0 | 1 | 2 | 3 |
| 26. | I made a promise to myself that things would be different next time. | 0 | 1 | 2 | 3 |
| 27. | I tried to keep my feelings from interfering with other things too much. | 0 | 1 | 2 | 3 |
| 28. | Wished that the situation would go away or somehow be over with. | 0 | 1 | 2 | 3 |

| | Not used | Used some- what | Used quite a bit | Used a great deal |
|--|-------------|-----------------------|------------------------|-------------------------|
| 29. Had fantasies or wishes about how things might turn out. | 0 | 1 | 2 | 3 |

Hopelessness Scale

Read each sentence and circle T if the statement is true for you or F if it is false.

- 1) I look forward to the future with hope and enthusiasm. T F
- 2) I might as well give up because there's nothing I can do about making things better for myself.
- 3) When things are going badly, I am helped by knowing that they can't stay that way.
- 4) I can't imagine what my life would be like in ten years.
- 5) I have enough time to accomplish the things I most want to.
- 6) In the future I expect to succeed in what concerns me most.
- 7) My future seems dark to me.
- 8) I happen to be particularly lucky and I expect to get more of the good things in life than the average person.
- 9) I just don't get the breaks, and there's no reason to believe I will in the future.
- 10) My past experiences have prepared me well for my future.
- 11) All I can see ahead of me is unpleasantness rather than pleasantness.
- 12) I don't expect to get what I really want.
- 13) When I look ahead to the future I expect I will be happier than I am now.
- 14) Things just won't work out the way I want them to.
- 15) I have great faith in the future.
- 16) I never get what I want so its foolish to want anything.
- 17) It's very unlikely that I will get any real satisfaction in the future.
- 18) The future seems vague and uncertain to me.
- 19) I can look forward to more good times than bad times.
- 20) There's no use in really trying to get something I want because I probably won't get it.

DATE _____

CODE _____

ATTRIBUTIONAL STYLES QUESTIONNAIRE

Please try to vividly imagine yourself in the situations that follow. If such a situation happened to you, what would you feel would have caused it? While events may have many causes, we want you to pick only one -- the major cause if this event happened to you. Please write this cause in the blank provided after each event. Next we want you to answer some questions about the cause and a final question about the situation. To summarize, we want you to:

1. Read each situation and vividly imagine it happening to you.
2. Decide what you feel would be the major cause of the situation if it happened to you.
3. Write one cause in the blank provided.
4. Answer three questions about the cause.
5. Answer one question about the situation.
6. Go on to the next question.

A) The members of your Seniors' Club invite you to become their treasurer.

1. Write down the one major cause _____

2. Is the cause of your appointment due to something about you or to something about other people or circumstances? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|-------------------|
| Totally due to other people and circumstances | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Totally due to me |
|---|---|---|---|---|---|---|---|-------------------|

3. In the future when you receive an appointment, will this cause again be present? (circle one number)

| | | | | | | | | |
|-----------------------------|---|---|---|---|---|---|---|------------------------|
| Will never again be present | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Will always be present |
|-----------------------------|---|---|---|---|---|---|---|------------------------|

4. Is the cause something that just influences this appointment or does it also influence other areas of your life? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|--------------------------------------|
| Influences just this particular situation | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Influences all situations in my life |
|---|---|---|---|---|---|---|---|--------------------------------------|

5. How important would this situation be if it happened to you? (circle one number)

| | | | | | | | | |
|----------------------|---|---|---|---|---|---|---|---------------------|
| Not at all important | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Extremely important |
|----------------------|---|---|---|---|---|---|---|---------------------|

B) The trip you organized for your friends turns out to be a smashing success.

1. Write down the one major cause _____

2. Is the cause of your successful trip due to something about you or to something about other people or circumstances? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|-------------------|
| Totally due to other people and circumstances | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Totally due to me |
|---|---|---|---|---|---|---|---|-------------------|

3. In the future when you organize a trip, will this cause again be present? (circle one number)

NOTE TO USERS

The original manuscript received by UMI contains pages with poor print. Pages were microfilmed as received.

Pages 297-304

This reproduction is the best copy available

Will never again be present 1 2 3 4 5 6 7 Will always be present

4. Is the cause something that just influences this trip or does it also influence other areas of your life? (circle one number)

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

5. How important would this situation be if it happened to you? (circle one number)

Not at all important 1 2 3 4 5 6 7 - Extremely important

C) Your daughter tells you how much your help in babysitting your grandchildren is needed and appreciated.

1. Write down the one major cause _____

2. Is the cause of her recognition due to something about you or to something about other people or circumstances? (circle one number)

Totally due to other people and circumstances 1 2 3 4 5 6 7 Totally due to me

3. In the future when babysitting, will this cause again be present? (circle one number)

Will never again be present 1 2 3 4 5 6 7 Will always be present

4. Is the cause something that just influences your babysitting or does it also influence other areas of your life? (circle one number)

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

5. How important would this situation be if it happened to you? (circle one number)

Not at all important 1 2 3 4 5 6 7 Extremely important

D) Household tasks are becoming too demanding to accomplish yourself, you ask the Social Services for some help.

1. Write down the one major cause _____

2. Is the cause of your inability to perform household tasks due to something about you or to something about other people or circumstances? (circle one number)

Totally due to other people and circumstances 1 2 3 4 5 6 7 Totally due to me

3. In the future when you are doing household tasks, will this cause again be present (circle one number)

| | | | | | | | | |
|-----------------------------|---|---|---|---|---|---|---|------------------------|
| Will never again be present | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Will always be present |
|-----------------------------|---|---|---|---|---|---|---|------------------------|

4. Is the cause something that just influences your ability to perform household tasks or does it also influence other areas of your life? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|--------------------------------------|
| Influences just this particular situation | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Influences all situations in my life |
|---|---|---|---|---|---|---|---|--------------------------------------|

5. How important would this situation be if it happened to you? (circle one number)

| | | | | | | | | |
|----------------------|---|---|---|---|---|---|---|---------------------|
| Not at all important | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Extremely important |
|----------------------|---|---|---|---|---|---|---|---------------------|

E) You try unsuccessfully to fill in your income tax forms by yourself.

1. Write down the one major cause _____

2. Is the cause of your failure to fill in the income tax form due to something about you or to something about other people or circumstances? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|-------------------|
| Totally due to other people and circumstances | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Totally due to me |
|---|---|---|---|---|---|---|---|-------------------|

3. In the future when you try to fill in your income tax forms, will this cause again be present? (circle one number)

| | | | | | | | | |
|-----------------------------|---|---|---|---|---|---|---|------------------------|
| Will never again be present | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Will always be present |
|-----------------------------|---|---|---|---|---|---|---|------------------------|

4. Is the cause something that just influences doing your taxes or does it also influence other areas of your life? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|--------------------------------------|
| Influences just this particular situation | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Influences all situations in my life |
|---|---|---|---|---|---|---|---|--------------------------------------|

5. How important would this situation be if it happened to you? (circle one number)

| | | | | | | | | |
|----------------------|---|---|---|---|---|---|---|---------------------|
| Not at all important | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Extremely important |
|----------------------|---|---|---|---|---|---|---|---------------------|

F) The party you organized for your Seniors' Club does not turn out as planned and the members criticize you.

1. Write down the one major cause _____

2. Is the cause of your unsuccessful party due to something about you or to something about other people or circumstances? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|-------------------|
| Totally due to other people and circumstances | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Totally due to me |
|---|---|---|---|---|---|---|---|-------------------|

3. In the future when you organize a party, will this cause again be present

| | | | | | | | | |
|--------------------------------|---|---|---|---|---|---|---|---------------------------|
| Will never again be present | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Will always be present |
|--------------------------------|---|---|---|---|---|---|---|---------------------------|

4. Is the cause something that just influences organizing a party or does it also influence other areas of your life? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|--|
| Influences just this particular situation | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Influences all situations in my life |
|---|---|---|---|---|---|---|---|--|

5. How important would this situation be if it happened to you? (circle one number)

| | | | | | | | | |
|-------------------------|---|---|---|---|---|---|---|------------------------|
| Not at all important | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Extremely important |
|-------------------------|---|---|---|---|---|---|---|------------------------|

G) You just bought new clothes and a friend compliments you on your appearance and taste.

1. Write down the one major cause _____

2. Is the cause of this compliment due to something about you or to something about other people or circumstances? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|----------------------|
| Totally due to other people and circumstances | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Totally due to me |
|---|---|---|---|---|---|---|---|----------------------|

3. In the future when complimented on your dress, will this cause again be present? (circle one number)

| | | | | | | | | |
|--------------------------------|---|---|---|---|---|---|---|---------------------------|
| Will never again be present | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Will always be present |
|--------------------------------|---|---|---|---|---|---|---|---------------------------|

4. Is the cause something that just influences compliments on dress or does it also influence other areas of your life? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|--|
| Influences just this particular situation | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Influences all situations in my life |
|---|---|---|---|---|---|---|---|--|

5. How important would this situation be if it happened to you? (circle one number)

| | | | | | | | | |
|-------------------------|---|---|---|---|---|---|---|------------------------|
| Not at all important | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Extremely important |
|-------------------------|---|---|---|---|---|---|---|------------------------|

H) Recently your friends have been showing you a lot of affection.

1. Write down the one major cause _____

2. Is the cause of this demonstration of affection due to something about you or to something about other people or circumstances? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|----------------------|
| Totally due to other people and circumstances | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Totally due to me |
|---|---|---|---|---|---|---|---|----------------------|

3. In the future when a friend rejects you, will this cause be present again? (circle one number)

| | | | | | | | | |
|--------------------------------|---|---|---|---|---|---|---|---------------------------|
| Will never again be present | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Will always be present |
|--------------------------------|---|---|---|---|---|---|---|---------------------------|

4. Is the cause something that just influences rejection by this friend or does it also influence other areas of your life? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|--|
| Influences just this particular situation | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Influences all situations in my life |
|---|---|---|---|---|---|---|---|--|

5. How important would this situation be if it happened to you? (circle one number)

| | | | | | | | | |
|-------------------------|---|---|---|---|---|---|---|------------------------|
| Not at all important | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Extremely important |
|-------------------------|---|---|---|---|---|---|---|------------------------|

K) Your offer for volunteer services at the Children's Hospital is turned down.

1. Write down the one major cause _____

2. Is the cause of this rejection due to something about you or to something about other people or circumstances? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|----------------------|
| Totally due to other people and circumstances | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Totally due to me |
|---|---|---|---|---|---|---|---|----------------------|

3. In the future when volunteering, will this cause again be present? (circle one number)

| | | | | | | | | |
|--------------------------------|---|---|---|---|---|---|---|---------------------------|
| Will never again be present | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Will always be present |
|--------------------------------|---|---|---|---|---|---|---|---------------------------|

4. Is the cause something that just influences volunteer work or does it also influence other areas of your life? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|--|
| Influences just this particular situation | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Influences all situations in my life |
|---|---|---|---|---|---|---|---|--|

5. How important would this situation be if it happened to you? (circle one number)

| | | | | | | | | |
|-------------------------|---|---|---|---|---|---|---|------------------------|
| Not at all important | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Extremely important |
|-------------------------|---|---|---|---|---|---|---|------------------------|

L) Your neighbour, with whom you get along very well, moves away without informing you.

1. Write down the one major cause _____

2. Is the cause of this rejection due to something about you or to something about other people or circumstances? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|----------------------|
| Totally due to other people and circumstances | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Totally due to me |
|---|---|---|---|---|---|---|---|----------------------|

3. In the future when friends demonstrate affection, will this cause again be present? (circle one number)

| | | | | | | | | |
|--------------------------------|---|---|---|---|---|---|---|---------------------------|
| Will never again be present | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Will always be present |
|--------------------------------|---|---|---|---|---|---|---|---------------------------|

4. Is the cause something that just influences affection from friends or does it also influence other areas of your life? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|--|
| Influences just this particular situation | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Influences all situations in my life |
|---|---|---|---|---|---|---|---|--|

5. How important would this situation be if it happened to you? (circle one number)

| | | | | | | | | |
|-------------------------|---|---|---|---|---|---|---|------------------------|
| Not at all important | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Extremely important |
|-------------------------|---|---|---|---|---|---|---|------------------------|

I) On your birthday, all your children and grandchildren make the trip to attend the celebration.

1. Write down the one major cause _____

2. Is the cause of this demonstration of affection due to something about you or to something about other people or circumstances? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|----------------------|
| Totally due to other people and circumstances | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Totally due to me |
|---|---|---|---|---|---|---|---|----------------------|

3. In the future when family show affection, will this cause again be present? (circle one number)

| | | | | | | | | |
|--------------------------------|---|---|---|---|---|---|---|---------------------------|
| Will never again be present | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Will always be present |
|--------------------------------|---|---|---|---|---|---|---|---------------------------|

4. Is the cause something that just influences affection from family or does it also influence other areas of your life? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|--|
| Influences just this particular situation | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Influences all situations in my life |
|---|---|---|---|---|---|---|---|--|

5. How important would this situation be if it happened to you? (circle one number)

| | | | | | | | | |
|-------------------------|---|---|---|---|---|---|---|------------------------|
| Not at all important | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Extremely important |
|-------------------------|---|---|---|---|---|---|---|------------------------|

J) You meet a friend who acts hostilely toward you.

1. Write down the one major cause _____

2. Is the cause of your friend's hostility due to something about you or to something about other people or circumstances? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|----------------------|
| Totally due to other people and circumstances | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Totally due to me |
|---|---|---|---|---|---|---|---|----------------------|

3. In the future when a friend moves away, will this

| | | | | | | | | |
|--------------------------------|---|---|---|---|---|---|---|---------------------------|
| Will never again be present | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Will always be present |
|--------------------------------|---|---|---|---|---|---|---|---------------------------|

4. Is the cause something that just influences your friend's move or does it also influence other areas of your life? (circle one number)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|--|
| Influences just this particular situation | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Influences all situations in my life |
|---|---|---|---|---|---|---|---|--|

5. How important would this situation be if it happened to you? (circle one number)

| | | | | | | | | |
|-------------------------|---|---|---|---|---|---|---|------------------------|
| Not at all important | 1 | 2 | 3 | 4 | 5 | 6 | 7 | Extremely important |
|-------------------------|---|---|---|---|---|---|---|------------------------|

DIRECTIONS: Below is a list of 10 statements which people use to describe themselves. Please read each one carefully. After you have done so, please fill in one of the spaces to the right with a check (✓) that describes HOW YOU FEEL RIGHT NOW. Make only one check mark for each item.

| | Strongly Agree | Agree | Disagree | Strongly Disagree |
|--|----------------|-------|----------|-------------------|
| 1. On the whole, I am satisfied with myself. | | | | |
| 2. At times I think I am no good at all. | | | | |
| 3. I feel that I have a number of good qualities. | | | | |
| 4. I am able to do things as well as most other people. | | | | |
| 5. I feel I do not have much to be proud of. | | | | |
| 6. I certainly feel useless at times. | | | | |
| 7. I feel that I am a person of worth, at least on an equal plane with others. | | | | |
| 8. I wish I could have more respect for myself. | | | | |
| 9. All in all, I am inclined to feel that I am a failure. | | | | |
| 10. I take a positive attitude towards myself. | | | | |

(c) Gary T. Reker

This questionnaire contains a number of statements related to opinions and feelings about yourself and life in general. Read each statement carefully, then indicate the extent to which you agree or disagree by circling one of the alternative categories provided. For example, if you STRONGLY AGREE, circle SA following the statement. If you MODERATELY DISAGREE, circle MD. If you are UNDECIDED, circle U. Try to use the undecided category sparingly.

| | SA | A | MA | U | MD | D | SD |
|---|-------------------|-------|---------------------|-----------|------------------------|----------|----------------------|
| | STRONGLY AGREE | AGREE | MODERATELY AGREE | UNDECIDED | MODERATELY DISAGREE | DISAGREE | STRONGLY DISAGREE |
| 1. My past achievements have given my life meaning and purpose. | SA | A | MA | U | MD | D | SD |
| 2. In my life I have very clear goals and aims. | SA | A | MA | U | MD | D | SD |
| 3. I regard the opportunity to direct my life as very important. | SA | A | MA | U | MD | D | SD |
| 4. I seem to change my <u>main</u> objectives in life. | SA | A | MA | U | MD | D | SD |
| 5. I have discovered a satisfying life purpose. | SA | A | MA | U | MD | D | SD |
| 6. I feel that some element which I can't quite define is missing from my life. | SA | A | MA | U | MD | D | SD |
| 7. The meaning of life is evident in the world around us. | SA | A | MA | U | MD | D | SD |
| 8. I think I am generally much less concerned about death than those around me. | SA | A | MA | U | MD | D | SD |
| 9. I feel the lack of and a need to find a real meaning and purpose in my life. | SA | A | MA | U | MD | D | SD |
| 10. New and different things appeal to me. | SA | A | MA | U | MD | D | SD |

| | SA STRONGLY AGREE | A AGREE | MA MODERATELY AGREE | U UNDECIDED | MD MODERATELY DISAGREE | D DISAGREE | SD STRONGLY DISAGREE | | | | |
|---|-------------------------|------------|---------------------------|----------------|------------------------------|---------------|----------------------------|---|----|---|----|
| 11. My accomplishments in life are largely determined by my own efforts. | | | | | SA | A | MA | U | MD | D | SD |
| 12. I have been aware of an all powerful and consuming purpose towards which my life has been directed. | | | | | SA | A | MA | U | MD | D | SD |
| 13. I try new activities or areas of interest and then these soon lose their attractiveness. | | | | | SA | A | MA | U | MD | D | SD |
| 14. I would enjoy breaking loose from the routine of life. | | | | | SA | A | MA | U | MD | D | SD |
| 15. Death makes little difference to me one way or another. | | | | | SA | A | MA | U | MD | D | SD |
| 16. I have a philosophy of life that gives my existence significance. | | | | | SA | A | MA | U | MD | D | SD |
| 17. I determine what happens in my life. | | | | | SA | A | MA | U | MD | D | SD |
| 18. Basically, I am living the kind of life I want to live. | | | | | SA | A | MA | U | MD | D | SD |
| 19. Concerning my freedom to make my choice, I believe I am absolutely free to make all life choices. | | | | | SA | A | MA | U | MD | D | SD |
| 20. I have experienced the feeling that while I am destined to accomplish something important, I cannot put my finger on just what it is. | | | | | SA | A | MA | U | MD | D | SD |
| 21. I am restless. | | | | | SA | A | MA | U | MD | D | SD |
| 22. Even though death awaits me, I am not concerned about it. | | | | | SA | A | MA | U | MD | D | SD |
| 23. It is possible for me to live my life in terms of what I want to do. | | | | | SA | A | MA | U | MD | D | SD |

| | SA STRONGLY AGREE | A AGREE | MA MODERATELY AGREE | U UNDECIDED | MD MODERATELY DISAGREE | D DISAGREE | SD STRONGLY DISAGREE | | | | |
|-----|---|------------|---------------------------|----------------|------------------------------|---------------|----------------------------|---|----|---|----|
| 24. | | | | | SA | A | MA | U | MD | D | SD |
| | I feel the need for adventure and "new worlds to conquer". | | | | | | | | | | |
| 25. | | | | | SA | A | MA | U | MD | D | SD |
| | I would neither fear death nor welcome it. | | | | | | | | | | |
| 26. | | | | | SA | A | MA | U | MD | D | SD |
| | I know where my life is going in the future. | | | | | | | | | | |
| 27. | | | | | SA | A | MA | U | MD | D | SD |
| | In thinking of my life, I see a reason for my being here. | | | | | | | | | | |
| 28. | | | | | SA | A | MA | U | MD | D | SD |
| | Since death is a natural aspect of life, there is no sense worrying about it. | | | | | | | | | | |
| 29. | | | | | SA | A | MA | U | MD | D | SD |
| | I have a framework that allows me to understand or make sense of my life. | | | | | | | | | | |
| 30. | | | | | SA | A | MA | U | MD | D | SD |
| | My life is in my hands and I am in control of it. | | | | | | | | | | |
| 31. | | | | | SA | A | MA | U | MD | D | SD |
| | In achieving life's goals, I have felt completely fulfilled. | | | | | | | | | | |
| 32. | | | | | SA | A | MA | U | MD | D | SD |
| | Some people are very frightened of death, but I am not. | | | | | | | | | | |
| 33. | | | | | SA | A | MA | U | MD | D | SD |
| | I daydream of finding a new place for my life and a new identity. | | | | | | | | | | |
| 34. | | | | | SA | A | MA | U | MD | D | SD |
| | A new challenge in my life would appeal to me now. | | | | | | | | | | |
| 35. | | | | | SA | A | MA | U | MD | D | SD |
| | I have the sense that parts of my life fit together into a unified pattern. | | | | | | | | | | |
| 36. | | | | | SA | A | MA | U | MD | D | SD |
| | I hope for something exciting in the future. | | | | | | | | | | |
| 37. | | | | | SA | A | MA | U | MD | D | SD |
| | I have a mission in life that gives me a sense of direction. | | | | | | | | | | |

| | SA STRONGLY AGREE | A AGREE | MA MODERATELY AGREE | U UNDECIDED | MD MODERATELY DISAGREE | D DISAGREE | SD STRONGLY DISAGREE | | | | |
|-----|--|------------|---------------------------|----------------|------------------------------|---------------|----------------------------|---|----|---|----|
| 38. | | | | | SA | A | MA | U | MD | D | SD |
| | I have a clear understanding of the ultimate meaning of life. | | | | | | | | | | |
| 39. | | | | | SA | A | MA | U | MD | D | SD |
| | When it comes to important life matters, I make my own decisions. | | | | | | | | | | |
| 40. | | | | | SA | A | MA | U | MD | D | SD |
| | I find myself withdrawing from life with an "I don't care" attitude. | | | | | | | | | | |
| 41. | | | | | SA | A | MA | U | MD | D | SD |
| | I am eager to get more out of life than I have so far. | | | | | | | | | | |
| 42. | | | | | SA | A | MA | U | MD | D | SD |
| | Life to me seems boring and uneventful. | | | | | | | | | | |
| 43. | | | | | SA | A | MA | U | MD | D | SD |
| | I am determined to achieve new goals in the future. | | | | | | | | | | |
| 44. | | | | | SA | A | MA | U | MD | D | SD |
| | The thought of death seldom enters my mind. | | | | | | | | | | |
| 45. | | | | | SA | A | MA | U | MD | D | SD |
| | I accept personal responsibility for the choices I have made in my life. | | | | | | | | | | |
| 46. | | | | | SA | A | MA | U | MD | D | SD |
| | My personal existence is orderly and coherent. | | | | | | | | | | |
| 47. | | | | | SA | A | MA | U | MD | D | SD |
| | I accept death as another life experience. | | | | | | | | | | |
| 48. | | | | | SA | A | MA | U | MD | D | SD |
| | My life is running over with exciting good things. | | | | | | | | | | |

Please circle the number on the scales below which best represents your answer to the following three questions.

1) I believe I can learn to use group reminiscence therapy to effectively combat feelings of depression.

| | | | | |
|-------------------|-------|-----------------------|----------|----------------------|
| 1 | 2 | 3 | 4 | 5 |
| Strongly Agree | Agree | Undecided/ Neutral | Disagree | Strongly Disagree |

2) For those who can use it, group reminiscence therapy is a very effective way to combat depression.

| | | | | |
|-------------------|-------|-----------------------|----------|----------------------|
| 1 | 2 | 3 | 4 | 5 |
| Strongly Agree | Agree | Undecided/ Neutral | Disagree | Strongly Disagree |

3) I place a lot of value on my ability to effectively combat depression.

| | | | | |
|-------------------|-------|-----------------------|----------|----------------------|
| 1 | 2 | 3 | 4 | 5 |
| Strongly Agree | Agree | Undecided/ Neutral | Disagree | Strongly Disagree |

Geriatric Depression Scale

- | | | |
|-----|--|--------|
| 1. | Are you basically satisfied with your life? | Yes/No |
| 2. | Have you dropped many of your activities and interests? | Yes/No |
| 3. | Do you feel that your life is empty? | Yes/No |
| 4. | Do You Often get bored? | Yes/No |
| 5. | Are you hopeful about the future? | Yes/No |
| 6. | Are you bothered by thoughts that you can't get out of your head? | Yes/No |
| 7. | Are you in good spirits most of the time? | Yes/No |
| 8. | Are you afraid that something bad is going to happen to you? | Yes/No |
| 9. | Do you feel happy most of the time? | Yes/No |
| 10. | Do you often feel helpless? | Yes/No |
| 11. | Do you often get restless and fidgety? | Yes/No |
| 12. | Do you prefer to stay home rather than going out and doing new things? | Yes/No |
| 13. | Do you frequently worry about the future? | Yes/No |
| 14. | Do you feel that you have more problems with memory than most? | Yes/No |
| 15. | Do you think it is wonderful to be alive now? | Yes/No |
| 16. | Do you often feel downhearted and blue? | Yes/No |
| 17. | Do you feel pretty worthless the way you are now? | Yes/No |
| 18. | Do you worry alot about the past? | Yes/No |
| 19. | Do you find life very exciting? | Yes/No |
| 20. | Is it hard for you to get started on new projects? | Yes/No |
| 21. | Do you feel full of energy? | Yes/No |
| 22. | Do you feel that your situation is hopeless? | Yes/No |
| 23. | Do you think that most people are better off than you are? | Yes/No |
| 24. | Do you frequently get upset by little things? | Yes/No |
| 25. | Do you frequently feel like crying? | Yes/No |
| 26. | Do you have trouble concentrating? | Yes/No |
| 27. | Do you enjoy getting up in the morning? | Yes/No |
| 28. | Do you prefer to avoid social gatherings? | Yes/No |
| 29. | Is it easy for you to make decisions? | Yes/No |
| 30. | Is your mind as clear as it used to be? | Yes/No |

DATE:

CODE _____

SAS SCALE

The following questions relate to the social activities and family interactions you have had over the last two weeks. Please circle the response the best describes your activities and interactions. If a particular question does not apply to you (e.g., questions about you and your spouse if you are not married) just go onto the next question.

1) How many close friends do you have?

- a) 9 or more
- b) 5 to 8
- c) 2 to 4
- d) 1
- e) no close friends

If answered c, go to question six.

2) Have you been able to talk about your feelings openly with your friends?

- a) reasonably open with at least 1 person
- b) mildly reticent
- c) occasionally unable to discuss with at least 1 other person
- d) usually unable to discuss feelings
- e) unable to discuss feelings at any time

3) How many times have you done something socially with friends in the last two weeks?

- a) 4 or more
- b) 3
- c) 2
- d) 1
- e) 0

4) How have you been getting along with friends during the last two weeks?

- a) smooth relationships
- b) some difficulty with sensitive situations
- c) rather uneasy, tense relationships
- d) moderate friction
- e) many clashes or avoidance of others

5) Have any of your friends offended you or hurt your feelings in the last two weeks?

- a) no offense or hurt feelings
- b) affected by friends, but recovered in a few hours
- c) affected by friends, but recovered in a few days
- d) behaviour affected, required a week or more to recover
- e) behaviour affected and not yet recovered

6) Have you felt ill at ease, tense, or shy when you have been with people during the last two weeks?

- a) enjoy company
- b) occasionally uncomfortable but can relax
- c) often distressed but can enjoy company at times
- d) mostly distressed
- e) always very distressed in company

7) How often do you participate in hobbies or special interests?

- a) more than once a week
- b) once a week
- c) some hobbies and interests, but sporadic involvement

- d) hobbies and interests not currently engaged in
 - e) no hobbies or interests
- 8) Have you felt lonely and wished for companionship in the last two weeks?
- a) have not felt isolated
 - b) feel isolated occasionally
 - c) moderately isolated
 - d) feel a great need for people
 - e) feel totally alone or lonely every day
- 9) Have you felt bored in your free time in the last two weeks?
- a) not usually bored
 - b) occasionally bored but able to find activity to pass the time
 - c) frequently bored
 - d) bored most of free time
 - e) bored almost every day

If you do not have contact with a spouse or former spouse, please go to question 13.

- 10) During the past two weeks, have you been able to talk about your feelings and problems openly with your husband/wife?
- a) reasonably open with at least one relative
 - b) mildly reticent
 - c) moderately reticent or unable to openly discuss
 - d) usually unable to discuss feelings
 - e) unable to discuss feelings at any time
- 11) How have you been getting along with your husband/wife?
- a) harmonious family relations
 - b) fairly harmonious family relations
 - c) indifferent or a few disagreements
 - d) moderate friction involving more than one person
 - e) very discordant family relations
- 12) During the past two weeks have you had to depend on your husband/wife to help you?
- a) reasonably independent
 - b) dependent in some ways
 - c) moderately dependent
 - d) markedly dependent
 - e) depend on spouse for most things

If you do not have children, substitute other relatives for children in the remaining questions.

- 13) What kinds of things have you been doing with your children during the last two weeks?
- a) active involvement in children's lives
 - b) interested, know children's lives well
 - c) moderate interest
 - d) little interest
 - e) disinterest, totally uninvolved
- 14) Have you been able to talk with your children during the last two months?
- a) communicate easily
 - b) most times can communicate
 - c) fair communication
 - d) rarely able to talk
 - e) never able to talk
- 15) During the past two weeks how much friction has there been between you and the children?
- a) smooth relationships
 - b) a little friction or tension

- c) moderate friction
 - d) marked friction
 - e) constant state of friction
- 16) What have your feelings been toward the children during the last two weeks?
- a) consistently felt affection
 - b) mostly love your children
 - c) moderate dissatisfaction
 - d) marked lack of affection
 - e) total dissatisfaction
- 17) Have you worried about things happening to your spouse or children during the last two weeks?
- a) reasonable concern
 - b) frequently uneasy
 - c) worried a fair amount
 - d) very often worried
 - e) extremely worried by fears
- 18) In the last two weeks have you been feeling that you have let your spouse or children down at any time?
- a) no guilt
 - b) some slight misgivings
 - c) moderately guilty
 - d) very ashamed of your behaviour
 - e) constant distressing feelings of guilt
- 19) In the last two weeks have you been feeling that your spouse or children have let you down at any time?
- a) reasonably satisfied with family
 - b) appreciative but some grievances
 - c) disappointment but some appreciation
 - d) mostly bitter or disillusioned
 - e) strong feelings of bitterness of disillusionment

Appendix F: Active Socialization Control Intervention Manual

Appendix F: Manual for Active Socialization Control Group

Overview of the Therapist's Role in the Active Socialization Control Group

The active control group is designed to provide control subjects with the same amount of therapist contact and group socialization opportunities that is experienced by the experimental groups, without providing any of the therapeutic interventions and activities that occur in the experimental group. By comparing two groups which differ only in terms of their therapeutic content, it is possible to determine whether the active ingredients in the experimental groups produce therapeutic benefits beyond those that result simply from interacting in a therapist-led group situation. In order to ensure that an accurate test of the therapeutic impact of the experimental groups is achieved, Norcross and Goldfried (1992) outline six types of therapeutic activity which should be avoided in the control group:

1) Interpretations of the client's behaviour or feeling, including both present-based interpretations and interpretations that link the present to the past. Examples of such interpretations are: "Perhaps one reason you may avoid contact with your wife is that such conflict brings up old memories and feelings about the awful fights that your parents used to have", or "Could it be that your anger toward your wife is related to some of the conflicts you've been having with your boss at work?"

2) Active attempts to correct negative and distorted thinking. Direct corrections (e.g., "Things just can't be that bad") and indirect corrections through questions (e.g., "Do you think it's as bad as all that?") should be avoided. Beck's cognitive therapy employs a Socratic questioning method to help clients discover for themselves that their thinking is distorted. This usually involves a sustained focus on a particular theme, and the questions are designed to help clients

see the errors in their thinking. Questions of this nature and with this purpose are to be avoided.

3) A persistent focus on interpersonal conflict, interpretations of that conflict, and pointing to ways to resolve the conflict. Consider the example of a depressed woman who is experiencing a very distressing conflict with her adolescent daughter. The therapist should certainly attend to that topic when the client brings it up, but should not try to steer the conversation back to the topic in future sessions. It should be entirely up to the client to return to the subject. The therapist should avoid presenting interpretations of that conflict and also avoid comments that point the client toward feelings which she may be unaware. If the client suggests some reasonable strategies for resolving the conflict, the therapist can respond with support and encouragement as discussed above, but should avoid presenting to the client any new ways of dealing with the situation. The main responses to the topic should be listening, encouraging emotional expression, reflecting thoughts and feelings, and being generally supportive and encouraging of positive attempts at conflict resolution without being specific.

4) Specific behavioural instructions, suggestions, assignments, or "experiments".

5) Psychodynamic explanations of underlying conflicts.

6) A persistent focus on specific psychological themes. The therapist should focus on following and reflecting the client's experience rather than on directing attention to specific themes.

Although these specific interventions and activities are to be avoided as much as possible, it may be difficult to remain therapeutically neutral at all times. Therapists, however, should keep such interventions to a minimum and should not permit them to become a consistent part of the socialization control group.

The primary role of the therapist is to provide participants with information on aspects of aging and to facilitate discussion about these issues. The information to be provided, and questions and comments designed to stimulate discussion are provided in the following sections. The therapist should attempt to present the educational material in an interactive fashion and ensure that everyone receives equal opportunity to share their opinions and ideas by regulating the pace of the discussion. The therapist may include personal items to facilitate the group discussion, but her input should not receive equal time with the group members. Discussion of the presented material may be objective in nature (i.e., focus on the psychology of aging as it relates to elderly people in general), or it may be subjective (i.e., how psychological aspects of aging affect participants personally). The discussion, however, should not focus on how these issues contribute to participants' depression.

Session 1: Introduction to Group and Discussion of Physical/Sensory Changes in Aging.

Introduction

The first part of the session will be spent getting to know the participants and presenting the format and topics of the group. The leader will start by welcoming the participants, introducing herself, and offering information about her qualifications and professional work. Next, she will ask participants to introduce themselves (e.g., name they like to be called, marital status, family, area of residence, short life or career history, current interests and activities).

The structure of the group will be described: 5 participants and one counsellor; six weekly sessions of one hour each, followed by 6 weekly sessions of 90 minutes each; the first 6 sessions will have an educational focus involving an approximately 25 minute presentation of material on topics related to aging followed by an open discussion of the presented material (discussion may focus on how the issues presented are manifested in participants' own lives or the discussion may be more generalized or theoretical in nature); the last six sessions will focus on ameliorating feelings of depression through therapeutic use of reminiscences.

The rationale for the educational sessions to be provided to participants is: 1) to help participants get to know each other and become comfortable working with each other before engaging in discussion of personal and sensitive material; 2) to provide information on topics that are of interest to seniors and which may help them adjust to some of the changes that occur in later life.

Expectations of behaviour in the group should be addressed at this stage. These norms include the expectation that during the first six sessions, participants will attend to the presented material and participate in the group discussions about the issues at hand. It should be stressed

that the purpose of the discussions is to help participants get to know each other and to become comfortable working together with the others. To this end, the discussions should involve sharing opinions and ideas about the material or offering information about how the issues have affected their own lives--the purpose is not to master the presented material as in a classroom session or to simply engage in an intellectual discussion. At this point, it should be stressed that the actual discussion of depressive feelings and coping difficulties will begin in the 7th week after members have reached a level of comfort and ease with each other.

Members are also reminded that they are expected to attend every session, even if they do not feel like making the effort, unless attendance is absolutely precluded by an unavoidable circumstance, such as illness. The role of depression in reducing motivation and activity can be emphasized here. Any misunderstandings clients may have about the focus of the first 6 sessions should be cleared up here and discussed.

Issues relating to self-disclosure and confidentiality should also be discussed at this time. The point should be made that although members are expected to participate in the discussions, they will not be required to discuss anything they are not comfortable with at any time. The leader will also explain that it is customary in these groups for members not to repeat anything that occurred inside the group to anyone outside the group, in order to help people feel comfortable talking about their ideas and opinions. At the beginning of the reminiscence section, issues of confidentiality and self-disclosure will be addressed again in relation to the discussion of personal information.

Sensory and Physical Changes in Later Life.Why do we Age?: Biological Theories of Aging

The process of aging is complex, involving significant loss and decline in some physiological functions, and minimal changes in others. Scientists have long attempted to find the causes of this process. Four main theories have been developed, and although they help our understanding of aging, none is totally adequate for explaining the causes of aging.

1) The Wear and Tear Theory suggests that, with time, the body simply wears out. In this theory, each species has a biological clock that determines its maximum life span and the rate at which each organ system will deteriorate. This rate of decline can be accelerated by external stressors (e.g., poor nutrition). In summary, cells continually wear out, and eventually, existing cells can't repair their damaged components.

2) The Autoimmune Theory proposes that aging is a function of the body's immune system becoming defective and attacks not just foreign bacteria and viruses, but also begins to attack itself. Evidence in support of this theory is increase in cancer, diabetes, and rheumatoid arthritis with age. However, this theory doesn't explain why this change in the autoimmune system occurs.

3) The Cross-Linkage Theory focuses on changes in collagen with age. Collagen is an important connective tissue found in most organ systems. We can see for ourselves the changes in collagen in our skin--wrinkles, less elasticity in the skin. Idea is that changes in collagen accumulate over time and reduce functioning of the organ systems by diminishing their elasticity and ability to heal after damage.

4) Cellular Aging Theory suggests that aging occurs because cells slow down their ability to

reproduce themselves. Cells need DNA to reproduce themselves, and the theory states that there is only a limited amount of DNA in each cell which is eventually used up and cells are not able to reproduce fresh copies of themselves when they die.

Of these four theories, the cellular aging theory appears to be the most accepted view. Important to keep in mind, however, that knowing the cause of the aging process does not permit scientists at this stage to understand how to change or reverse the process of aging.

Possible Discussion Topic: 1) personal beliefs about causes of aging; 2) beliefs of parents and grandparents on the causes of aging; 3) discussion of the benefits and drawbacks of reversing the aging process.

Sensory/Physical Changes with Age

Changes in different senses occur at different rates and stages of life (i.e., can experience changes in 1 sensory system and not in others, and different people experience changes at different ages). These changes are usually gradual and people adapt their environment and compensate by using other, still intact sensory systems.

Vision. Although most older people need glasses, poor vision is not as widespread as is usually thought. About 10% of seniors have some vision impairment and about 80% have fair to adequate visual sharpness at age 90 and beyond. Some of the changes that do occur include a decrease in the ability to dilate the pupil, resulting in difficulty functioning in low light conditions and adjusting to sudden decreases in the amount of light available. This change has an impact on ability to drive at night or under low-light conditions (rain, fog), and can affect functioning in certain places like theatres and dimly lit restaurants.

Another common, normal age change is that the eye loses its ability to keep images sharp at close range resulting in difficulties shifting from near to far vision (e.g., when looking across a room, walking up or down stairs, or writing notes while looking at the blackboard). This hardening of the lens can also result in poor depth perception, especially in very shiny or glossy floors or walls, and when looking at stairs.

The tear glands, which secrete the fluid necessary for continual cleansing and lubrication, lose function with aging, contributing to dryness and eye irritation. In normal aging, the lens becomes more opaque which in severe cases can result in cataracts and blindness. This condition appears in at least one eye in 4.5% of people 52-64 and 46% of people 75-85. It can be remedied through low-risk surgery.

Hearing. The loss of hearing is more usual in older people than the loss of sight; hearing is an area in which more disabilities are related to aging than to any other factor. This decline is especially apparent in the ability to hear high-pitched notes (e.g., doorbells, women's voices), and usually begins after age 50. Often the changes are so gradual that many older people fail to notice them until the disability is extreme. One of the major sources of such hearing impairment involves the cochlea, a spiral tube of the inner ear that resembles a conch shell. At birth, the cochlea contains about 20,000 hair-like nerve cells that gradually die off and are not replaced. Loss of these cells is called prebycusis, and it impairs the transmission of high-frequency sounds. About 5% of the population have hearing loss at age 50. After age 65, 30% of the population have hearing difficulties. Men show more significant hearing loss than women (probably because of noise in the workplace). Hearing loss can be a severe impediment if it isolates seniors from communication with others. Hearing aids, telephone devices, and increased physical

proximity can increase hearing. If you are having trouble hearing others, ask them to face you directly, sit close, speak slowly and clearly, speak in a lower voice, and repeat key points in different words.

Taste and Smell. The sense of smell also declines with age, and 30% of people over age 80 have difficulty identifying common substances by smell. Taste too is affected since 67% of taste sensations are dependent on the ability to smell. Taste buds also sharply decrease with age. Originally there are 250 taste buds in each capsule on the tongue but by old age the number may drop to 100. Thus, higher levels of stimulation for taste and smell are required for older persons than for younger people--this need may be responsible for the complaints and lack of interest in food that sometimes can result in poor nutrition.

An increase in use of herbs and spices can enhance food quality, but increased salt intake should be avoided. Joining cooking classes can be one way to improve nutrition in people who have lost interest in food tastes.

Touch. Special receivers for the sense of touch are located in the skin. These receivers are sensitive to 5 types of stimulation: cold, heat, touch, pressure, and pain. On the basis of present knowledge, it is believed that there are two significant changes in cold/heat sensitivity with aging. Although it is not certain why, with advancing age most older people experience a general reduction of resistance and ability to recover from temperature change. Sensitivity to pain and pressure as a danger is extremely important. Its loss in older persons seems to be related to a loss of tactile response as both perception and motor abilities decline in reaction to stimuli. Pain is a more frequent concern for the aged. The periodic daily aches of rheumatism, the unrelenting pain of arthritis, and the sharp distress of angina are examples. The elderly learn

to deal with these according to their personality, background, and the extent and nature of the pain. As sensitivity to pain decreases, elderly individuals may fail to attend to minor injuries when they occur, may not be alert to potential sources of harm, and may repeatedly incur injury or damage. It is important to note that regular use of the sensory capacities and muscular functions can prevent premature deterioration of these functions.

Skin, Hair, and Body Composition. As we age, visible changes occur in the skin, hair, and shape of the body. For example, during middle age the skin becomes dry and begins to wrinkle as it becomes thinner and loses elasticity and subcutaneous fat. Similarly hair becomes thinner and loses its original colour. Because of the negative connotations frequently associated with wrinkles and grey hair, some individuals actively fight a "cosmetic battle" to change their physical appearance and thereby appear younger than their chronological age. In addition to changing one's appearance, the loss of hair and subcutaneous fat in the middle and later years leads to greater heat loss and to increased susceptibility to "feeling cold". This in turn may initiate a shift from outdoor to indoor activities.

For many adults, especially women, body weight increases up to about 50 years of age, and then there is a decline thereafter because of a change in body metabolism. This increase in weight is due to an accumulation of fat and a reduction in muscle tissue which appears most frequently in the stomach area for men, and in the limbs and stomach area for women. As a result, body shape may change from a lean and youthful appearance to a more portly or mature appearance. This visible change in shape sometimes results in a social labelling process whereby the individual is perceived by others to be older than his or her actual or chronological age. Exercise can serve to reduce this increase in fat, and despite loss of muscle tissue, muscle tone

can be maintained through physical activities.

Another visible sign of aging is the shortening of stature that begins in late middle age. This is related to changes in the structure and composition of the spine: vertebrae may collapse or intervertebral discs may become compressed. These changes are visibly reflected in an increased bowing of the spine and the loss of a few inches in height.

Possible Discussion Topics: 1) Personal impact of sensory/physical changes on self-esteem, mobility, work, socialization; 2) Strategies developed to compensate for sensory/physical changes, personal health promotion regimes (e.g., Vision: talking books, large print on books, clocks, calendars, extra wattage lighting, nonglossy floor coverings to reduce glare); 3) Opinions on the use of vitamins, special diets, cosmetic surgery to combat sensory and physical changes.

Session 2: Cognitive Functioning in Later Life

One of the most important and most studied aspects of aging is cognitive functioning, that is, intelligence, learning, and memory-- mainly because these functions are so critical to an individual's performance in every aspect of life, including work and leisure activities, relationships with family and friends, and roles in the community. Common, stereotypical beliefs suggest that these functions show a steady decline as the individual grows older. However, cognitive changes generally are not so apparent that they impair older people's social functioning and the expectation that aging is uniformly negative is untrue. In fact, there is a great deal of variability in the cognitive changes that occur in aging. Depending upon differences in genetic and environmental conditions, life-style, and the presence of disease (e.g., Alzheimer's, Parkinsons, rheumatoid arthritis), individuals can experience very different levels of cognitive change in old age. Some may lose a great deal of ability due to disease, others may experience normal age related changes, and still others may take steps to compensate for cognitive changes and thereby achieve continued growth and development in later life.

Memory

Memory, of course, plays a critical role in the execution of daily tasks, and in learning new information--in order to use new information we must be able to retrieve it for later use. The memory process involves three basic stages: encoding information in our mind, storing it there for varying lengths of time, and the process of retrieving that information for later use. Studies of memory retrieval have focused on two types of retrieval. Recall is the process of searching through the vast store of information in our long-term memory in order to find a specific piece of information (e.g., list the capital cities of the world; describe how to change a

ture). Recognition requires less searching. Rather, a stimulus in the environment is matched to information in long-term memory (LTM) (e.g., Which of these three cities is the capital of Ontario?). Most researchers have found age-related declines in recall, but few if any declines in recognition.

Recall tasks have been further divided into free recall and cued recall situations. In the former, no aids or hints are provided for retrieving information from LTM. In the latter, the individual is given some information to aid in the search (e.g., category labels such as vegetables, first letter of the word). Older people tend to do much worse than the young in tests of free recall, but perform close to the level of younger people when cues are used (category cues are more effective than structural cues like the first letter of the word). These findings suggest that the best way to test an older person's memory for information is to use recognition tests, then cued recall, and lastly and most difficult are free recall tests. That cueing improves memory is an important fact that allows older people to improve their memory despite age-related changes.

Several theories have been offered to explain why older people may have problems retrieving information from LTM. One explanation is that not using information results in its loss (e.g., disuse theory). In other words, if you don't use it you'll lose it. However, this explanation fails to account for the many facts that are deeply embedded in a person's memory store and that can be retrieved even after years of disuse.

A more widely accepted explanation is that new information interferes with the material that has been stored over a period of many years. For example, newly learned historical facts about Canada may interfere with the recall of older information about Canadian history. In addition, recall of new information is affected by the individual's attention to the information

during the encoding stage. It has been reported that when older people attempt to learn a number of new facts or information at the same time, they are more likely to be distracted by this process than younger people. This interference or distraction at the encoding stage will yield a reduction in the amount of information that is stored in LTM, and therefore reduces the amount of information that can be recalled. As such, recall of new information can be facilitated by learning under conditions of low distraction and by learning each piece of information sequentially, rather than simultaneously.

When surveyed regarding the obstacles they face in everyday life, older people frequently cite memory as being among the foremost difficulties they face in everyday living. As such, you are not alone if you feel that your memory is not what it once was. Fortunately, there are techniques that older people can learn in order to enhance their memory abilities. One of the most important aspects of memory enhancement is the ability to relax and to avoid feeling anxious or stressed during the learning stage. Many older people become overly concerned about occasional memory lapses, viewing them as a sign of deterioration and possible onset of senile dementia. Thus, a young person may be annoyed when a familiar name is forgotten, but will not interpret the memory lapse as a loss of cognitive function, as an older person is likely to do. Unfortunately, society reinforces this belief. How often are we told that we are getting old when we forget a trivial matter? How often do adult children become concerned that their elderly parents sometimes forget to turn off the stove, when in fact they may frequently do this themselves? In other words, recognizing that occasional slips of memory are not predictive of senility, can lead to greater relaxation at the point of learning new material which will facilitate encoding and recall.

Most memory improvement techniques are based on the concept of mediators: that is, the use of visual and verbal links between information to be encoded and information that is already in LTM. Mediators may be visual (e.g., the method of locations) or verbal (e.g., the use of mnemonics). The method of locations (or loci) is useful for learning a list of new words, names, or concepts. Each word is associated with a specific location in a familiar environment. For example, the individual walks through the rooms in succession, each item on the list is associated with a particular space along the way. Older persons using this technique have been found to recall more words on a list than when they used no mediators.

Another way of organizing material to be learned and to assure its storage in LTM is to use mnemonics or verbal riddles, rhymes, and codes associated with the new information (e.g., i before e except after c; 30 days hath September; Every Good Boy Deserves Fudge; Red lights in the harbour signify Right and Return). Other mediators include using the word or concept in a sentence, associating the digits in a phone number with symbols or putting them in a mathematical formula, placing the information into categories, and using multiple sensory memories (e.g., write the word, repeat it aloud, and feel the letters by tracing them with the finger).

Discussion Topics:

- 1) Personal experiences with memory loss.
- 2) Personal strategies designed to cope with memory loss.
- 3) Practical example of the use of the method of loci and mnemonics.

Learning: Aging Loss in the Fluid Mechanics of the Mind

There is evidence that the speed and efficiency of learning new skills and information in old age is less than it is in younger ages. In other words, when young (Y) and old (O) people are together in a university course and are taught new skills for test-taking, both will improve their test performance, but the Y group, will on average, improve to a greater extent and perform at a higher level than the O group because the Y group have a greater capacity to learn new skills and information. Of course, some older people will do better than the younger ones, but in general, group data will show this finding. Think of a computer analogy: all personal computers can perform basically the same functions (e.g., data analysis, word processing). The type of computer you buy determines the speed with which data can be analysed and a result produced. In young people, the computer is fast and efficient. In older people, the computer is slower and less efficient. However, in both cases, the same work can get done, it just takes the older person longer, meaning they are less efficient. One of the implications of this change is that older people can benefit from learning new skills but they will not perform as well as younger people when these skills are tested in timed situations, in untimed situations, however, the differences between the two groups will be less apparent.

How does this reduced capacity affect everyday functioning?

Reduced reserve capacity affects behaviour on any task that requires levels of functioning that exceed the reserves available (e.g., IQ or memory tests demand the absolute best from young and old, given general slowing old do worse, but in doing the dishes, talking to a friend, the levels of functioning required are easily met. Only when the reserve capacity is really lowered, such as in Alzheimer's disease, or when demands accumulate over a series of tasks, will this loss of

capacity be noticed).

Although there is a reduction in the efficiency with which new information and skills are learned, knowledge and common sense can compensate for the losses in experienced in the area of cognitive mechanics. There are two kinds of abilities in intellectual functioning: fluid intelligence involving the mechanics of cognition such as processing information, abstraction, synthesis, and crystallized intelligence involving learned knowledge and procedures. Although fluid intelligence is reduced with age, older people retain their crystallized knowledge and retain the capacity to improve this knowledge (i.e., learn new information). Therefore, older adults can compensate for the reductions they experience in some aspects of cognition by drawing on reserves of learned information and skills or by improving their learned knowledge of facts and procedures.

For example, in a school situation, older adults can do as well as younger ones on a multiple choice test by studying harder and improving their knowledge of the subject. Although the young may answer more questions because they can read the questions faster, access the stored information in the brain faster, and write down the answers faster, they may not get them all right. Older people can even the score by answering less questions, but getting more of them right because they have more factual knowledge.

Strategies for Successful Aging: Optimization by selection and compensation.

-selection: increasing restriction of one's life world to fewer domains of functioning because of an aging loss in adaptive potential. Concentrate on important areas and those areas where your capacities can be effectively used.

-so as to achieve satisfaction and personal control (e.g., an older person who can't golf anymore because of arthritis, now attends University courses)

-optimization: people engage in behaviours to enrich and augment their general reserves and to maximize their chosen life courses and associated forms of behaviour (e.g. learning the school material more thoroughly by extensive review)

-compensation: when specific behavioural capacities are lost or reduced below a standard required for adequate functioning, specific actions are taken to compensate for situations when a wide range of activity and a high level of performance is required (e.g., the older adult suffering from arthritis would record her answers on tape rather than fill in the computer sheets.)

Discussion Issues.

1) Use of optimization, selection, and compensation in own life.

2) Use of these strategies in physically/cognitively impaired older adults. For example, Nursing Homes for older adults with physical disabilities.

-What would be selection: provision of a less demanding physical and social environment. Act in a dependent fashion toward staff and let them take care of bodily needs.

-optimization by opportunities given for practice in domains targeted for further growth. This dependence and complimentary support enables residents to achieve optimization in another area--socialization

-compensation by the availability of technological and medical systems to support functions with diminished reserve capacities.

Learning: Developmental Reserve Capacity in Old Age.

Although the speed and efficiency of new learning in old age may be reduced, older adults can engage in new learning in addition to maintaining past levels of functioning. New learning can include learning in the area of factual knowledge (e.g., taking a course at University, learn the facts presented), or procedural knowledge (e.g., test-taking skills-can learn how to use new skills). This capacity for learning has implications for late-life changes in personality and adaptive interpersonal functioning (e.g., greater interiority, also less aggression, adopting more of the opposite sexes characteristics). In other words, older adults can learn to adapt new ways of being and interacting as a result of what they have learned about the self and others over the years. From a clinical point of view they are amenable to interventions to change maladaptive forms of behaviour.

Most of the research on implications of this reserve capacity for learning in old age has been looked at in terms of the development of wisdom. Wisdom can be defined as " expertise in the fundamental pragmatics of life permitting exceptional insight and judgement involving complex and uncertain matters of the human condition" (e.g. offering advice to a pregnant 14 year old girl or giving one's opinion on the Constitution vote). It is often described as a combination of experience, introspection, reflection, intuition, and empathy. These qualities are thought to be honed over the years and integrated in the older persons interactions with the world. Thus, younger people may have any one of these skills, but their integration requires more maturity. Wisdom also implies that the individual does not act on impulse and can review all aspects of a given situation objectively. The development of wisdom, however, may require the ability to transcend the limitations of basic needs such as health, income, and housing, and

that the individual must have continued opportunities for growth and creativity.

Possible Discussion Questions:

- 1) What is your definition of wisdom?
- 2) What individuals do you know who you would consider wise?
- 3) What roles do you see older adults playing in social, political realms?

Session Three: Personality Development in Late Life

For many generations, psychologists have considered the issue of nature versus nurture; that is, whether we are born with specific personality traits or whether the environment in which we are raised plus our experiences determine our personality. Studies of twins reared apart and newborn babies suggest that some traits are in fact innate. In spite of differences in the environment in which each twin is raised, they often display behaviour that is more similar to each other than to siblings raised in the same environment. Because twins share the same inherited genetic material, this finding suggests that heredity plays a role in personality. Furthermore, anyone who has seen a nursery full of babies has seen individual differences in dependency, passivity, and other traits that cannot be attributed solely to environmental influences.

Still, personality is shaped by experiences throughout a person's life; in this sense, personality development is mediated by the environment. An individual's behaviour in one situation is often quite different from another, depending on the social norms and expectations of each situation, and on the person's needs and motives.

Personality development in adulthood and old age has received increasing attention over the past twenty years. Earlier theories of personality suggested that development takes place only during childhood and adolescence, and stabilizes by early adulthood. For example, Freud's theory of psychosexual development suggests that most of the important personality developments are shaped by learning experiences in the first few years of life. According to this theory, personality traits remain stable after adolescence.

Beginning with Erik Erikson, however, several theorists have suggested that personality

continues to change and evolve into old age. According to Erikson's theory of psychosocial development, individuals undergo eight stages of development of the ego, or self, with the final stage occurring in mature adulthood. At each stage the individual experiences a major crisis or conflict; the conflicts of each stage of development are the foundations for successive stages. Depending on the outcome of the crisis associated with a particular stage, the individual proceeds to the next stage of development in alternative ways.

The individual in the senior stages of life is confronted with the crisis of generativity vs. stagnation, followed by the crisis of ego integrity vs. despair. Generativity involves establishing a sense of care and concern for the well-being of future generations combined with a forward looking perspective that does not dwell on the past. This crisis may be resolved through shifting the focus of one's attention from one's own family concerns to broader involvement in community social, economic, and political concerns, or it may involve defining a new role or the self in relations to one's children--i.e., shifting from a mother role to an advisor in the offspring's future concerns. Stagnation may involve retaining old roles such as a mother or worker when those roles are no longer viable.

In the last stage of development, the individual accepts the inevitability of mortality, achieves wisdom and perspective, or despairs because he or she has not come to grips with death and lacks ego integrity. A major task associated with this stage is to integrate the experiences of earlier stages and to realize that one's life has had meaning, whether or not it was "successful" in a socially defined sense. Older people who achieve ego integrity feel a sense of connectedness with younger generations, and need to share their experiences and wisdom with them. This may take the form of face-to-face interactions with younger people, counselling, or sponsoring an

individual or group of younger people, or writing memoirs or letters. Life satisfaction, or the feeling that life is worth living, may be achieved through these tasks of adopting a wider historical perspective upon one's life, accepting one's mortality, sharing experiences with the young, and leaving a legacy to future generations.

Erikson's theory provides a framework for studying personality in later life because it suggests that personality is dynamic throughout the life cycle. In addition, it provides a descriptive model of how the biologically inherited aspects of personality interact with the demands of our environment, and reflects the experiences and learning we have had throughout life.

The work of Carl Jung also emphasizes the growth of personality across the life span. Jung's model, like Erikson's focuses on the individual's confrontation with death during the last stage of life. Jung also describes a decrease in sex-typed behaviour with aging. According to Jung, all people have a masculine and a feminine side. As they age, people begin to adopt psychological traits more commonly associated with the opposite sex. For example, older men may show more signs of tenderness, expressiveness, nurturance, and need for affiliation, while older women may become more assertive, individualistic, and achievement-oriented as they age.

The Kansas City study represents one of the first attempts to test theories of personality development across the life span. In this study, 300 residents of Kansas City who were aged 50 to 90, living independently in the community, and relatively healthy in the late 1950's were followed for six years. The results showed that with aging, people were found to become more unlike each other. As they aged, people developed more unique styles of interacting with others. The researchers suggested that people become more differentiated because they grow less

concerned about societal expectations.

Despite the fact that older people are more individualistic, there were some changes in personality shared by a majority of those studied: increased preoccupation with their inner lives, less extroversion, and a movement toward less impulsiveness and more sophisticated ego defences. For example, older persons tended to use less denial and more sublimation (e.g., use of humour). The study also indicated that older people's attitudes toward the world were also likely to change with age. However, these changes are not in one direction or all older people (e.g., increased Conservatism or increased religiosity), rather, the changes reflected personal experiences which may have strengthened or weakened former positions.

In contrast to models of personality development that focus on growth of the ego across the life span, the work of Lawrence Kohlberg emphasizes the development of the conscience, or superego, through the acquisition of moral values.

Discussion Issues:

- 1) Views on personal stability or change in personality over the years.
- 2) Development of opposite sex-typed characteristics in the self.
- 3) Changing attitudes toward the world.
- 4) Participation in moral development questionnaire, discussion of responses.

Session Four: Attitudes Toward Seniors: Historical, Cross-Cultural, and Contemporary Issues

The experience of aging is not the same today as it was in earlier historical periods. The social and economic roles of older persons, their expectations of the social system, as well as what society expects of them, are in many ways profoundly different today from previous generations. The experience of aging differs cross-culturally, as well as historically, with perhaps the greatest differences in older people's status occurring between traditional societies and those of the modern Western world. Understanding how aging in contemporary North American society differs from that experienced elsewhere and at different times, helps us to differentiate aspects of aging that are universal or biologically-based, as opposed to factors that are shaped largely by cultural systems. Also, an examination of how other societies, both historical and contemporary, have dealt with issues affecting the elderly can shed light on strategies for developing better environments for older adults, as well as debunking some of the myths about aging in "the good old days".

Although our knowledge of the elderly in prehistoric and primitive societies is limited, we do know that people of advanced age were rare, with most dying before the age of 35. Nevertheless, there were always a few people who were older than most. These few elders were generally treated with respect in a manner that reflected a sense of sacred obligation. Even though positive attitudes toward the young-old were widespread, non-supportive or death-hastening behaviour was shown toward those who survived beyond an "intact" stage of life. This stage of old-old life was often referred to as the "sleeping period". No longer able to contribute to the common welfare or to look after themselves, the old-old were treated harshly among subsistence cultures--often experiencing abandonment, neglect, encouragement to commit

suicide or murdered (albeit often with a sense of honour and ceremony).

In Greek and Roman classical cultures, 80% of the population perished before reaching the stage of life that we now consider to be middle-age. Nevertheless, our chronological conception of age, with old defined as 60 and over, began during this period as a significant portion of people began to live to this age for the first time in recorded history. Age implied power in the ancient cities, which were ruled by councils of elders who derived authority from their years. Within the family, the eldest male's authority was nearly absolute, and the young were dependent on the old by custom and law. However, only the elite members of society, not the peasants, benefitted from the respect accorded age by the community--primarily because older peasants did not hold wealth.

Little is known about the role of older people during the medieval period, except that life expectancy was even shorter than in the Greek and Roman eras. Most individuals perished from war or disease before reaching old age. For those that did survive, old age was a cruel period of life. This attitude is demonstrated by Shakespeare's attribution of wisdom and perspective to middle-age and his view of old age as "second childishness and mere oblivion, sans teeth, sans eyes, sans taste, sans everything". This attitude may reflect the fact that the community was struggling with food shortages and high death rates among its youth, making it difficult to provide for the old.

In seventeenth- and eighteenth-century America, old age was treated with deference and respect, probably because it was so rare. The Puritans, for example, viewed old age as a sign of God's favour and assumed that youth would inevitably defer to old age. Old men occupied the highest public offices, as well as positions of authority within the family until they died. The

primary basis for the power they enjoyed was the control of agricultural land which formed the basis of the society's economy.

Even though the old were exalted by law and custom in colonial times, they received little affection or love from younger people; in fact, they were kept at an emotional distance. Elders frequently complained that they had lived to become strangers in their communities. Old age was not a time of serenity, but rather, anxiety about adequately fulfilling social obligations and demonstrating piety.

This pattern persisted until about 1770 when attitudes toward the elderly began to change and the relative status of youth was elevated. At this time, words such as codger and fuddy-duddy entered the language as a reflection of the diminished status of older adults. Around 1810, the median age began to rise, for the first time in North America, most parents began to live healthily beyond the period of their children's dependency.

As can be seen from this brief historical overview, the authority that older people exercised largely rested on the material and political resources that they controlled. Examples of these resources include traditional skills and knowledge, security through property rights, food, information control (e.g., Bible, location of hunting grounds), and desired services (e.g., child care). The elderly person's social rank was generally determined by the balance between the cost of maintaining them and the societal contributions they were perceived to make. As age became a less important criterion for determining access to and control of valued resources, the elderly's status and authority tended to decline.

Discussion Topics:

1) View of the status of older person's in our society today, and personal experiences in this regard.

2) Discuss reasons for the declining status of the old in our society (e.g., Modernization theory, cultural values of liberty and equality).

a) Modernization theory: The status of older people, as reflected in their resources and the honour bestowed upon them, varies inversely with the degree of technology, social and economic diversity, and occupational specialization (or modernization) in a given society for three reasons. First, modernization leads to progress in health technology which results in reduced infant mortality and maternal death, and to prolonged adult life, thereby, increasing both the number of younger and older persons in the population. With more older people in the labour market, competition for jobs between generations intensifies and retirement develops as a means of forcing older people out of the labour market. In turn, retirement reduces the status of older persons.

Second, scientific technology creates new jobs primarily for the young, with the elderly more likely to remain in traditional occupations that become obsolete (e.g., computerization of industries and agriculture). Unable to perform the socially valued roles of contributor to the workplace, many retirees feel marginal and alienated. Third, modernization is characterized by efforts to promote literacy and education, which tend to be targeted toward the young. As younger generations acquire more education than their parents, they begin to occupy higher status positions.

Intellectual and moral differences between the generations increase, with the elderly

experiencing reduced leadership roles and influence. Occupation and education for older people does not involve a continuous decline as a function of modernization. In fact, status differences between generations decrease and the relative status of the elderly may rise as technology and education increase the wealth of the country. When this wealth is reinforced by social policies such as CPP, local governments encouraging the hiring of older people, and free tuition for older students, older people can benefit from modernization.

b) Others have suggested that the decline in older person's status occurred before industrialization, and is associated with the rise in cultural valuing of the principles of liberty and equality. Both of these values run counter to a hierarchy of authority based on age.

Session Five: Creativity and Aging

Definitions of Creativity

In a survey of thoughts and opinions regarding creativity, a variety of people from different walks of life (e.g., scientists, artists) define creativity in a number of different ways: 1) creativity is the process of being aware of life around, sensing and responding; 2) process of releasing the mind to new approaches and new methods of problem-solving; 3) creativity involves a combination of parts already available that are put together in a new way to form a new thought or new product; 4) creativity denotes openness to growth in all dimensions--the ability to freely play with a large number of options--to remain open to being surprised and surprising oneself; 5) creativity is an openness to seeing possibilities in all persons and in all things that maximizes opportunities for a happy life. From perspectives such as these, everyone can be creative, although not everyone is. Being aware and experiencing, opening oneself to the possibilities in situations, developing new ideas or products -- these are possible for everyone -- old or young.

Creativity in Old Age

Psychologists and other social scientists have been interested in the question of whether creativity naturally declines across the lifespan, or whether it is maintained across the lifespan. One way of addressing this issue is to determine the peak age of creative production in the life span. In order to conduct this research, psychologists have developed a more precise definition of creativity than the ones provided above. This definition describes creativity as an extraordinary product or accomplishment based on creative processes. This accomplishment or

product must be novel, original, and unique. Further, it must be relevant to social need, that is, the product must be either appropriate to common concerns (e.g., scholarly contributions or inventions) or meet aesthetic needs (e.g., art works and great theatrical performances). In an early study charting creativity across the life span, Lehman tabulated by age group the frequency with which creative productions or accomplishments were listed in expert historical accounts. For example, in examining the creative years of chemists, Lehman referred to a written history of chemistry in which the names of several hundred chemists were listed along with the dates on which they made their contributions. Often, he submitted such listings to university teachers for further evaluation. Lehman's basic results are that the maximum production rate for a quality work occurs during the age decade 30 to 39 years. That is, a higher percentage of all quality work is produced during this age period than any other. After this decade there is a steep decline in the production of creative work. Note that the creativity studied in this research is demonstrated in the career work of artists, humanitarians, and scientists and does not look at the daily creative activities of individuals.

There were a couple of serious criticisms levelled against this study. One main criticism is that Lehman combined the data of creative people who died early in life (e.g. Mozart) with those who lived longer (e.g., Tchaikovsky). The short-lived could only have produced early in life and the long-lived could have produced in both young and old. Combining the two makes for a picture of early life production, when this may not be so. The second criticism was that Lehman focused on high-quality works as measures of creativity. These works were selected by other experts in the field. However, there is difficulty in identifying high-quality "masterworks" in the later life of living scientists because contemporary scientists do not have the perspective on

this late work to determine its impact. As a result, there is a bias toward identifying more contributions in early than in later life.

When the data were re-analysed using only long-lived people and focusing on both quantity and quality of work, findings showed that peak performance years in the humanities, sciences, and arts were maintained throughout the lifespan, with only a very gradual decline in productivity in the later years. For example, in the humanities, 41% of the productions were done after age 60, and in the arts, 20% of accomplishments were produced after age 60 (possibly due to the inclusion of physical arts such as ballet or sculpting).

This second study supports the idea that creativity is a lifelong ability. For example, Michelangelo was the chief architect of St. Peter's from age 72 until his death at 89. Thomas Hobbes continued his writing career until age 91, Voltaire still published at 83, Thomas Jefferson (83) and Benjamin Franklin (84) were influential late in their lives. Interestingly, creative contributions of older individuals include more novel interpretation and synthesis of existing knowledge than do the contributions of younger people. The contributions of younger people seem to be primarily new information or ideas. However, older people do continue to contribute new knowledge and ideas, as well as the more integrative works.

Personal views of creative contributions throughout the lifespan

- comments on the definition of creativity used in this research
- personal definitions of creativity
- any personal observations on possible differences in the types of creative accomplishments made by younger and older people

-do you believe that creativity is constant across the life span, or is it intermittently triggered by various stimuli and life situations? If so, what might some of these triggers/circumstances be?

Characteristics of the Creative Person

Research on creative people indicates that they seem to come mainly from middle-class families and have had the benefit of a good or superior education. Creative people are seen as original, flexible, and independent in thought and action. They have been described as open to new experiences, disciplined, and as paying attention to their own thoughts and feelings. Many are highly intelligent, tending to focus upon the broad implications of problems rather than on small details. Reports are that creative people tolerate ambiguity and prefer complexity. They can live with conceptual disorder and need not impose organization immediately. In terms of personality, they have been identified as withdrawn, introspective, precise, critical, resourceful and adaptable. Creative people are frequently dominant, and may be brooding and solemn. Perhaps more than any other trait, they seem to be resistant to social pressures and social rewards. In other words, they create independently of social forces such as warfare and civic turmoil, trials of family life, or personal honours. People who make important contributions, but not "works of genius" appear to have many of the same characteristics as creative geniuses, but they are influenced to a greater extent by their family and social life.

-Comments on how these characteristics may play an important role in creativity, some of the costs or drawbacks of intense creativity/genius

Creativity in the Daily Lives of Older People

John McLeish, the author of The Challenge of Aging: Ulyssean Paths to Creative Living, defines creativity as: "the process by which a man or woman employs both the conscious and unconscious domains of the mind to combine various existing materials into fresh constructions or configurations. These, in some degree, cause significant changes in the self-system of the person concerned, or significantly alter the environment surrounding him or her, whether such a change is great or small." He believes that creativity is not something of grandeur, similar to the original act of creation. Rather, he sees it as a native ingenuity latent in human people that is intermittently roused by thousand's of life's intersections.

According to McLeish, creativity involves thinking or cognitive functioning. Creativity is most commonly associated with "lateral thinking"--that is, thinking in a new key, imaginative abandoning of old routines and rigid protocols, as opposed to "vertical thinking" which is highly logical or programmed thinking and which can interfere with creative solutions. McLeish also discusses the important contributions to creativity that are made by the conscious and the unconscious mind. The conscious mind contributes facts, information, and insights--taking such information and resources and manipulating them to produce fresh insights, inventions, and creative material. It also chooses from the rich but disordered flood of materials pouring forth from the unconscious. The working in creativity of the unconscious mind has been vividly illustrated by a number of sources. For example, Nietzsche reported that while walking in Genoa all of his famous work Thus Spake Zarathustra came to him as if "it had invaded me". Henri Poincare, a mathematician, spent many frustrated days working on a new theorem only to have it spring forth fully formed the moment he stepped on the train for his holidays. This anecdote

points out that a good deal of toil and conscious striving often precedes the illumination.

While the unconscious plays an important role in creativity, conscious steps can be taken that may increase creativity. McLeish argues that if the memories, images, and sensations that pass into the unconscious provide material for creative thinking, then the richer the bank of material, the more creative a person will be. Based on this reasoning, McLeish advocates the following steps to greater creativity:

1) Heighten the sensitivity of the 5 physical senses (e.g., Take some object or person and describe them vividly, what symbols or meaning do you see in ordinary objects?. Take 5 minutes in your day to listen to all the sounds available. What sounds might you normally have missed? Identify smells that arouse feelings and thoughts that are pleasurable to you).

2) Heighten the sensitivity of the inner or psychic senses (e.g., re-create a favoured landscape in your mind, as did prisoners of war who re-created their hometown scenes and transported themselves away from their prison; travel in your mind's eye to a place or time in the past and explore it in detail; travel into your body, becoming conscious of the processes of relaxation and tension).

3) Cut off, like dead tree limbs, old dry routines in doing, thinking, reading, and speaking, and open up to fresh, invigorating experiences. For example, choose new modes of doing things; get involved in new activities; think and read new points of views; compose new phrases and words to spice up old language patterns (e.g., Thankchrist to celebrate a holiday between Thanksgiving and Christmas); surprise your mind by liberating it to fantasy--what would you take on board the Space Ark or imagine being born in a different race or historical time; try new, untried strategies in problem-solving such as brainstorming with friends or combine old

strategies in new ways to solve a current problem.

Discussion:

- What are creative aspects in your life? What contributes to creativity in your personal life?
- How do you increase creativity in your life?
- Have you noticed a change in creativity across the years in your life.
- Comment on the importance of creativity in your own life. What role does it play? Are other characteristics or abilities more important to you?

Session Six: Summing Up

Session six can involve a recognition and celebration of what participants have accomplished over the last five weeks: their ability to commit to and carry through on that commitment to the group; their ability to share their own thoughts and feelings and to accept others' perspectives; recognition of what they have learned about aging; discussion of the impact of the sessions on their thoughts and actions. Alternatively, the topic for the final session can be chosen by the group members to reflect an interest in common to all members.

The material in this manual was adapted from the following sources:

Botwinick J. (1984). Aging and behavior: A comprehensive integration of research findings.

New York: Springer Publishing Co.

Charness, N. (Ed.) (1985). Aging and human performance. New York: John Wiley & Sons.

Hooyman, N.R. & Kiyak, H.A. (1988). Social gerontology: A multidisciplinary perspective.

Boston, MA: Allyn & Bacon.

McLeish, J.A.B. (1983). The challenge of aging: Ulyssean paths to creative living. Vancouver:

Douglas & McIntyre.

Norcross, J.C. & Goldfried, M.R. (Eds.) (1992). Handbook of psychotherapy integration. New

York: Basic Books.

Appendix G: Equations Used to Calculate the Effect Size and Generalized Odds Ratio Based on Data from the Mann-Whitney U Test

Effect Size

The effect size ($p_{1>2}$) is an unbiased estimate of the probability that a randomly sampled client given therapy 1 will have a categorical outcome superior to the outcome of a client given therapy 2.

$$p_{1>2} = U/mn$$

where, U is the product of the Mann-Whitney U test,
 m =sample size of therapy 1, and
 n =sample size of therapy 2.

Generalized Odds Ratio

The Generalized Odds Ratio ($p_{2<1}$) provides an estimate of the number of times clients in therapy 1 will attain a superior result, than will clients given therapy 2.

$$p_{2<1} = 1 - p_{1>2}$$

where, $p_{1>2} = U/mn$ (see above).

Note:

Equations reported in Grissom, R.J. (1994). Statistical analysis of ordinal categorical status after therapies. Journal of Consulting and Clinical Psychology, 62, 281-284.

Appendix H: Figures Depicting Case Study Data for each Subject in the Integrative Reminiscence Group

List of Figures in Appendix H

Subjects in the Match Group:

- Figure 1H. Individual Case Study Data for Subject 1 in the Integrative Group: Attributions and Hopelessness
- Figure 2H. Individual Case Study Data for Subject 1 in the Integrative Group: Self-Esteem, Purpose and Meaning
- Figure 3H. Individual Case Study Data for Subject 2 in the Integrative Group: Attributions and Hopelessness
- Figure 4H. Individual Case Study Data for Subject 2 in the Integrative Group: Self-Esteem, Purpose and Meaning
- Figure 5H. Individual Case Study Data for Subject 3 in the Integrative Group: Attributions and Hopelessness
- Figure 6H. Individual Case Study Data for Subject 3 in the Integrative Group: Self-Esteem, Purpose and Meaning
- Figure 7H. Individual Case Study Data for Subject 4 in the Integrative Group: Attributions and Hopelessness
- Figure 8H. Individual Case Study Data for Subject 4 in the Integrative Group: Self-Esteem, Purpose and Meaning
- Figure 9H. Individual Case Study Data for Subject 5 in the Integrative Group: Attributions and Hopelessness
- Figure 10H. Individual Case Study Data for Subject 5 in the Integrative Group: Self-Esteem, Purpose and Meaning
- Figure 11H. Individual Case Study Data for Subject 6 in the Integrative Group: Attributions and Hopelessness
- Figure 12H. Individual Case Study Data for Subject 6 in the Integrative Group: Self-Esteem, Purpose and Meaning
- Figure 13H. Individual Case Study Data for Subject 7 in the Integrative Group: Attributions and Hopelessness
- Figure 14H. Individual Case Study Data for Subject 7 in the Integrative Group: Self-Esteem, Purpose and Meaning

Subjects in the Partly Match Group:

- Figure 15H. Individual Case Study Data for Subject 8 in the Integrative Group: Attributions and Hopelessness
- Figure 16H. Individual Case Study Data for Subject 8 in the Integrative Group: Self-Esteem, Purpose and Meaning
- Figure 17H. Individual Case Study Data for Subject 9 in the Integrative Group:

Attributions and Hopelessness

Figure 18H. Individual Case Study Data for Subject 9 in the Integrative Group: Self-Esteem, Purpose and Meaning

Subjects in the Do Not Match Group:

Figure 19H. Individual Case Study Data for Subject 10 in the Integrative Group: Attributions and Hopelessness

Figure 20H. Individual Case Study Data for Subject 10 in the Integrative Group: Self-Esteem, Purpose and Meaning

Figure 21H. Individual Case Study Data for Subject 11 in the Integrative Group: Attributions and Hopelessness

Figure 22H. Individual Case Study Data for Subject 11 in the Integrative Group: Self-Esteem, Purpose and Meaning

Figure 23H. Individual Case Study Data for Subject 12 in the Integrative Group: Attributions and Hopelessness

Figure 24H. Individual Case Study Data for Subject 12 in the Integrative Group: Self-Esteem, Purpose and Meaning

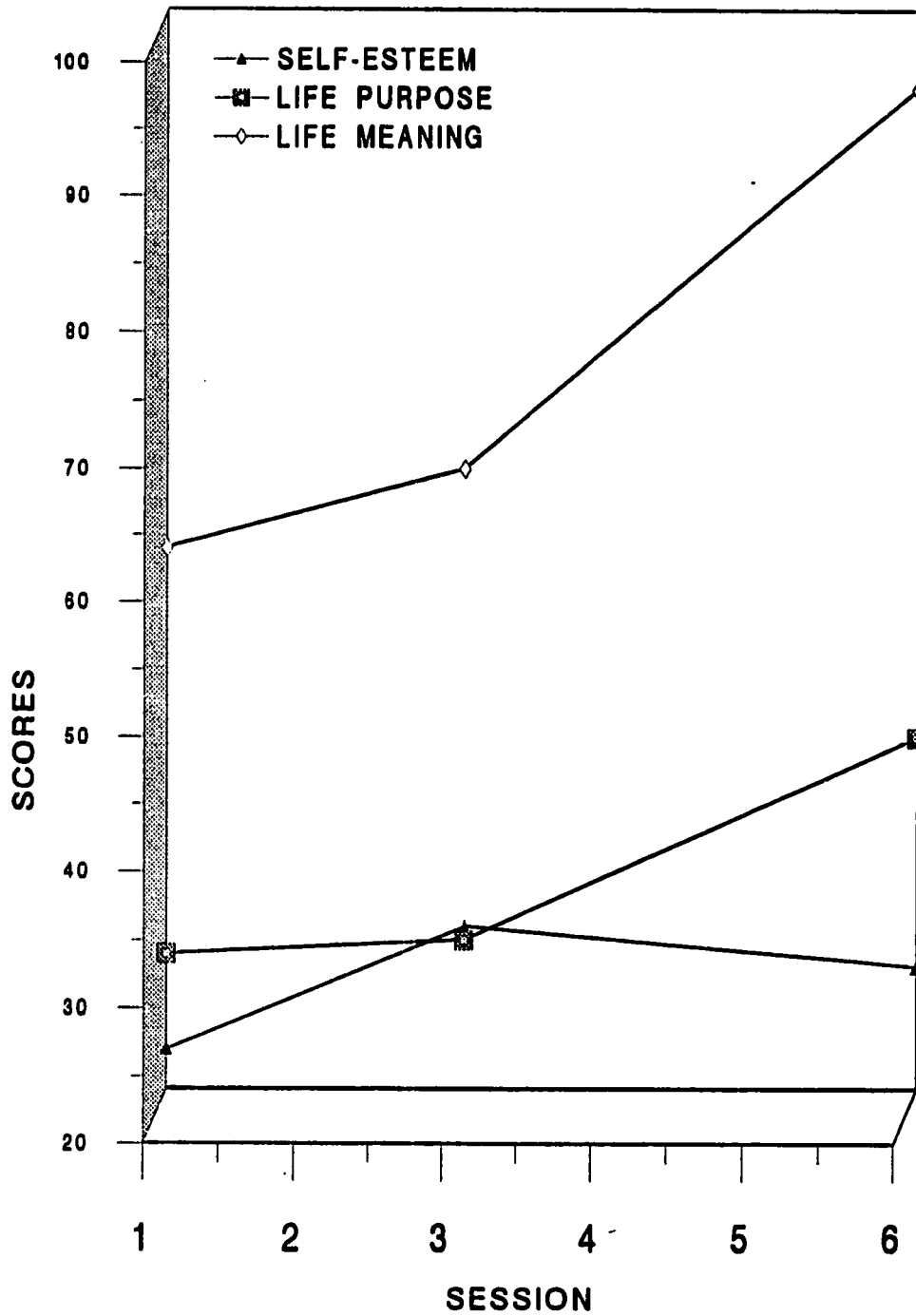


Figure 1H. Integrative Reminiscence Subject One

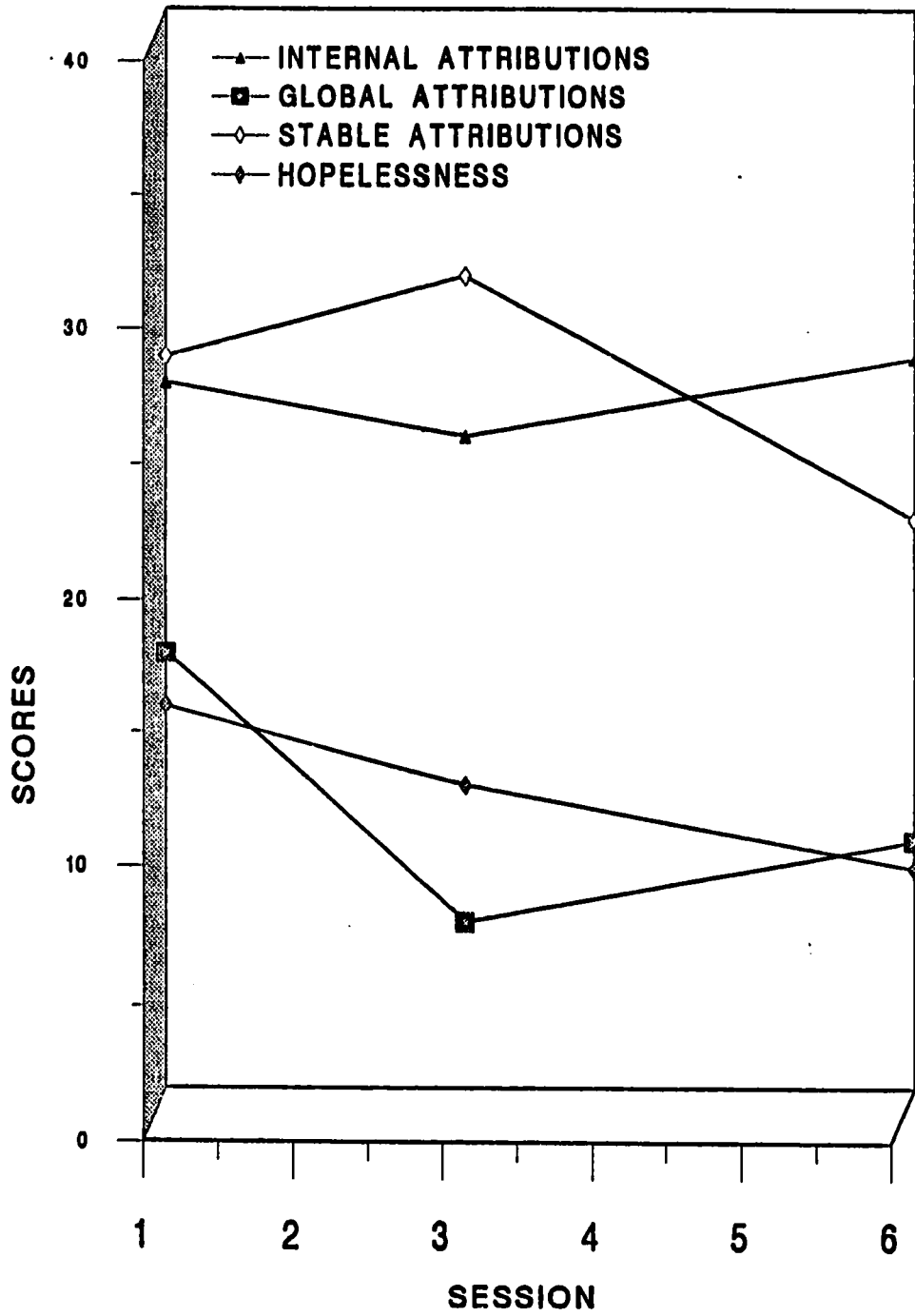


Figure 2H. Integrative Reminiscence Subject One

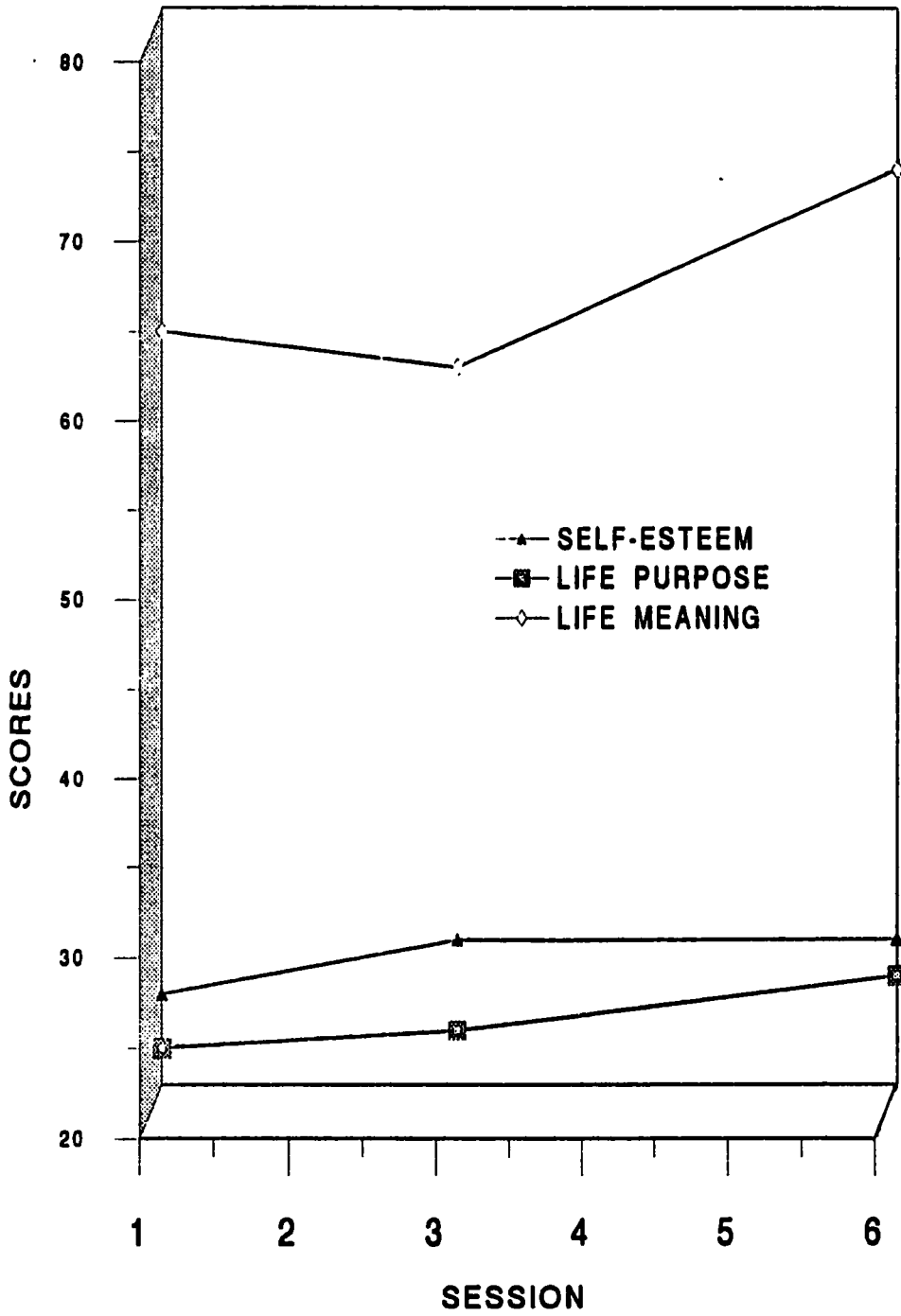


Figure 3H. Integrative Reminiscence Subject Two

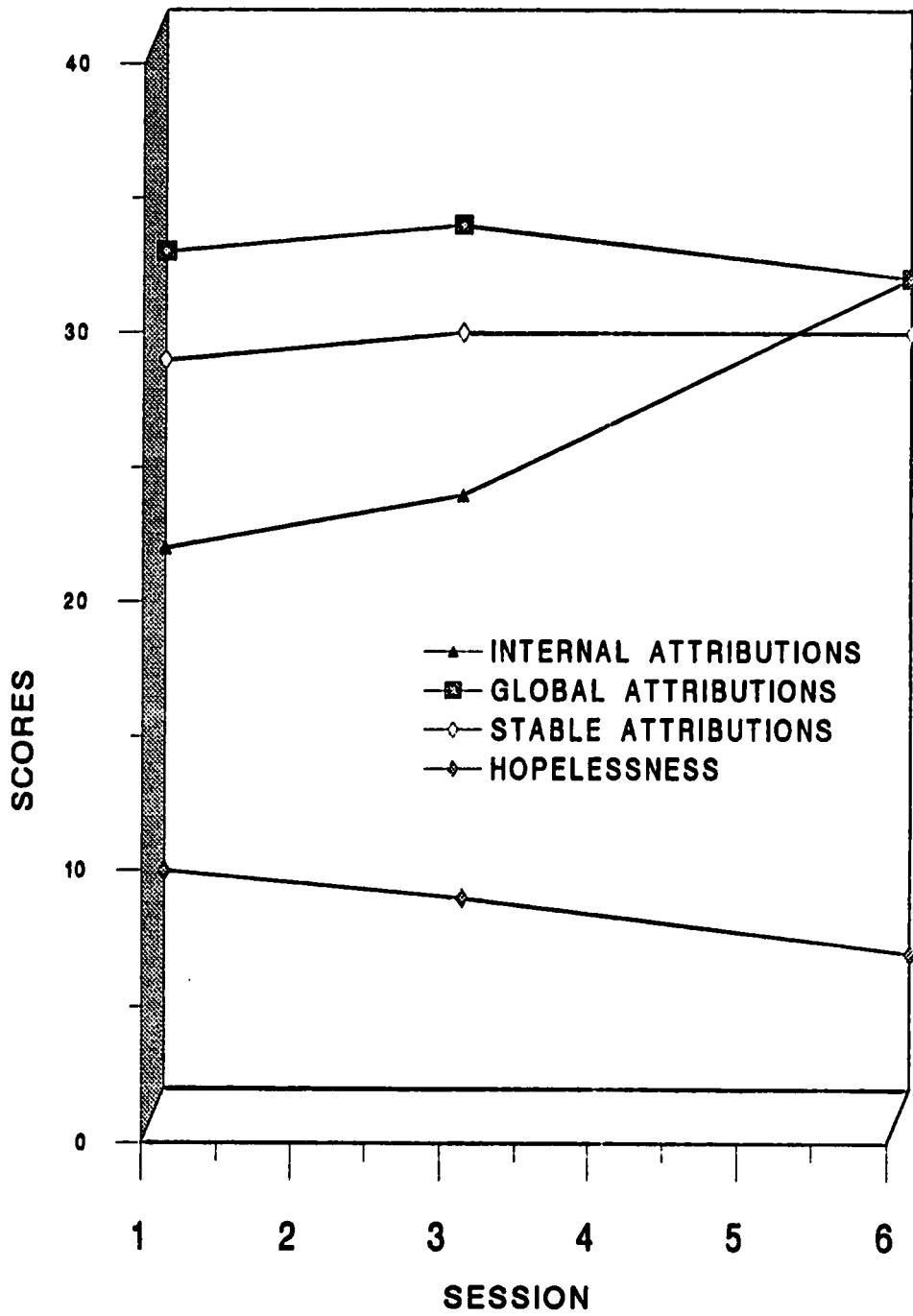


Figure 4H. Integrative Reminiscence Subject Two

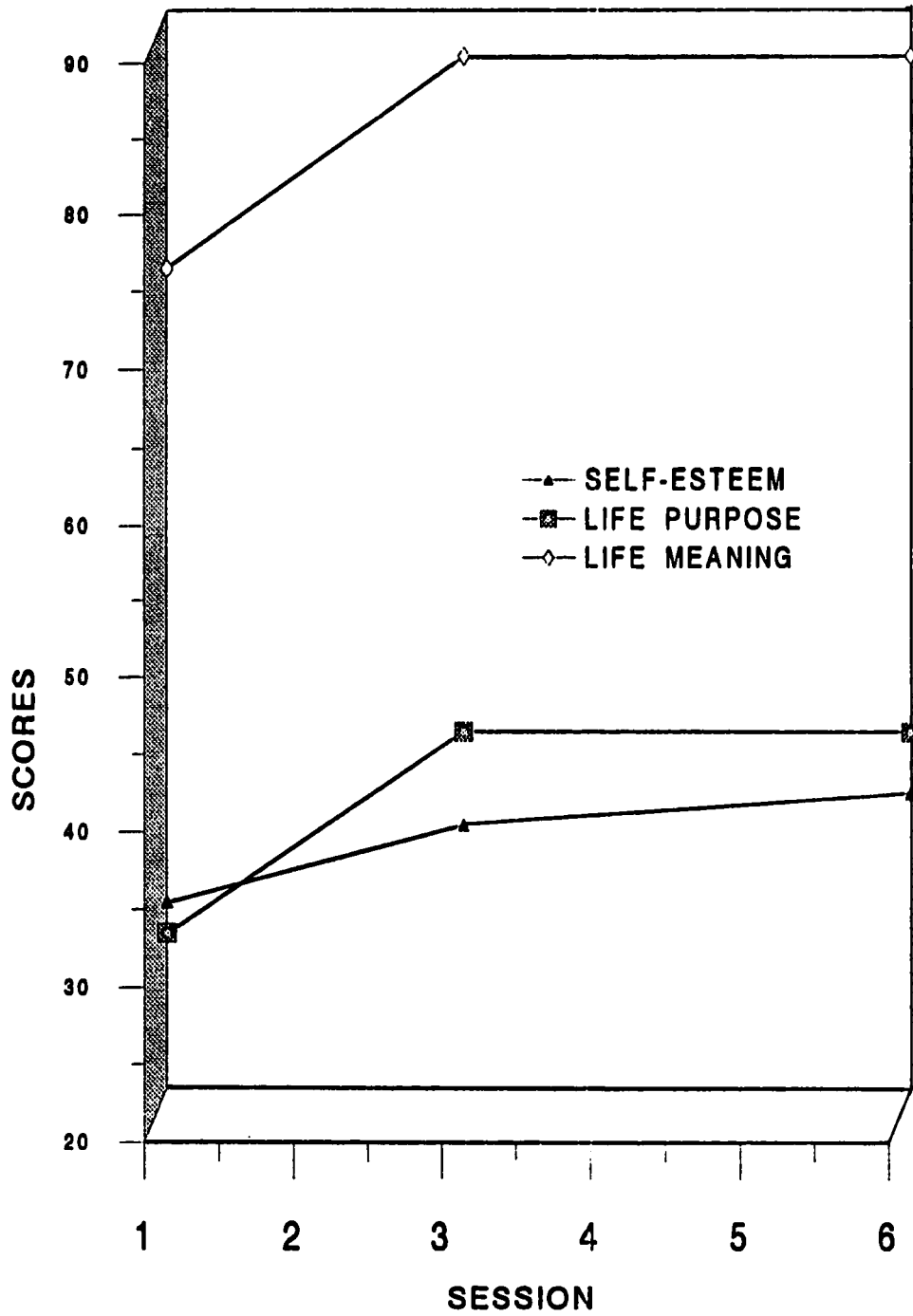


Figure 5H. Integrative Reminiscence Subject Three

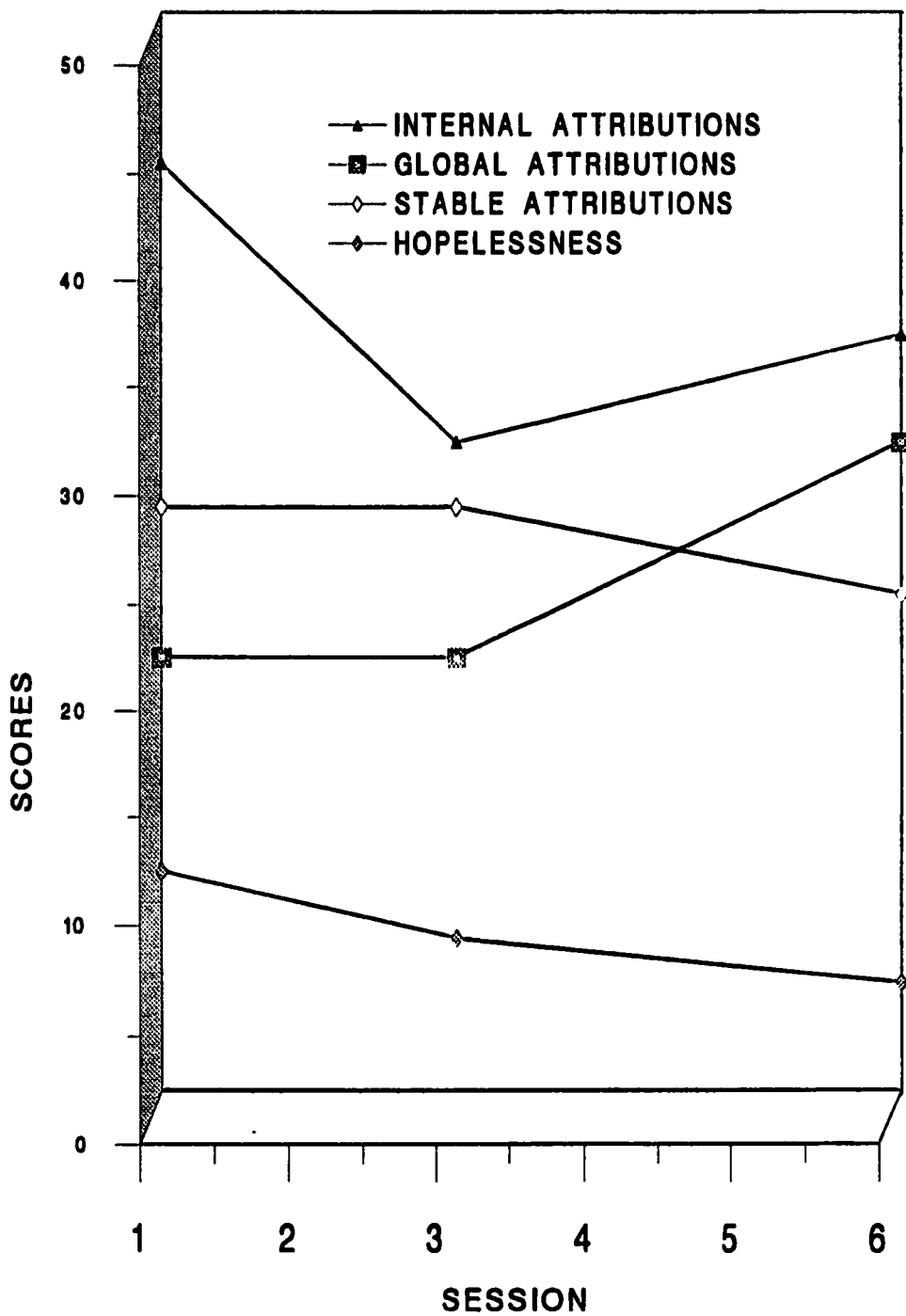


Figure 6H. Integrative Reminiscence Subject Three

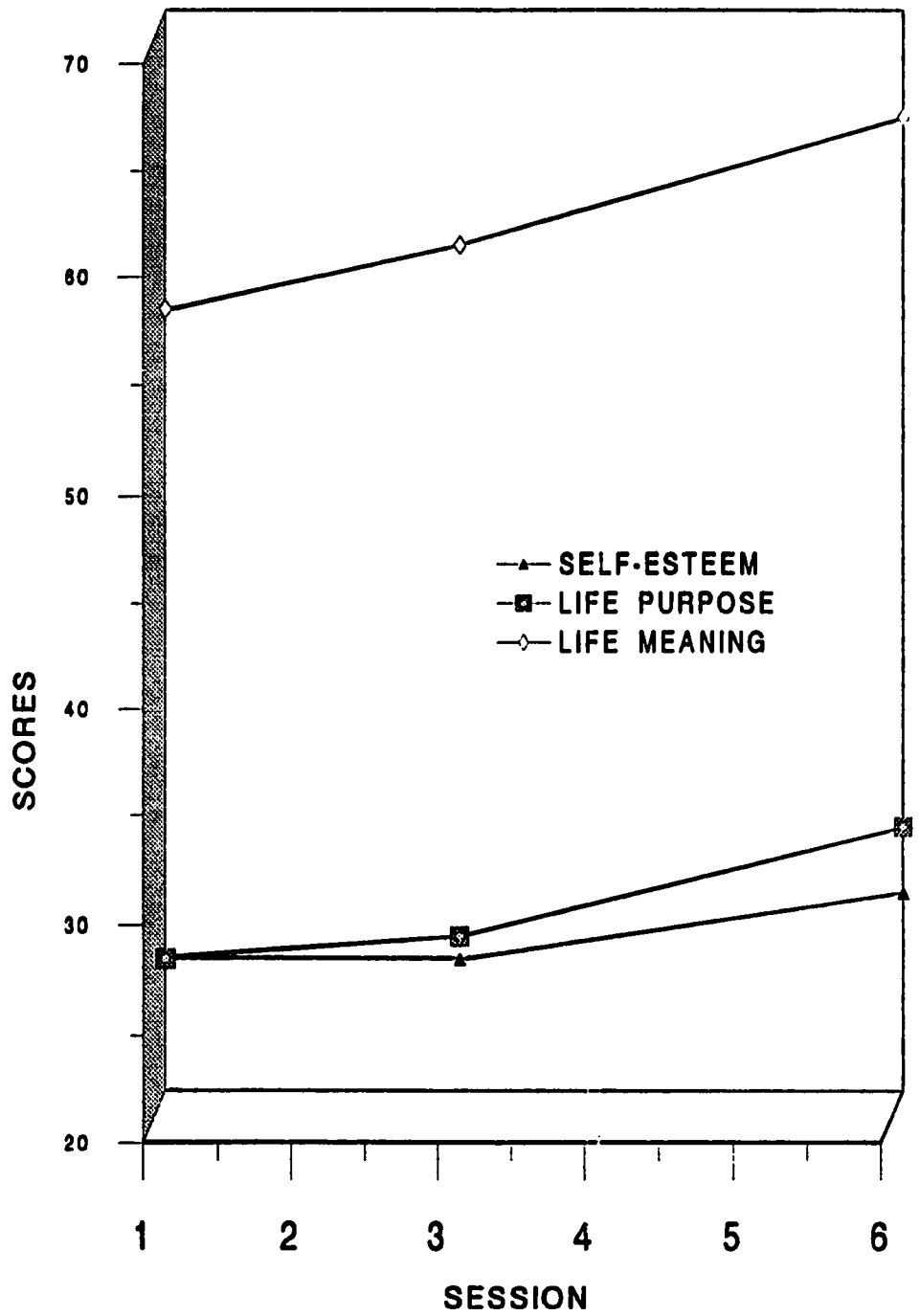


Figure 7H. Integrative Reminiscence Subject Four

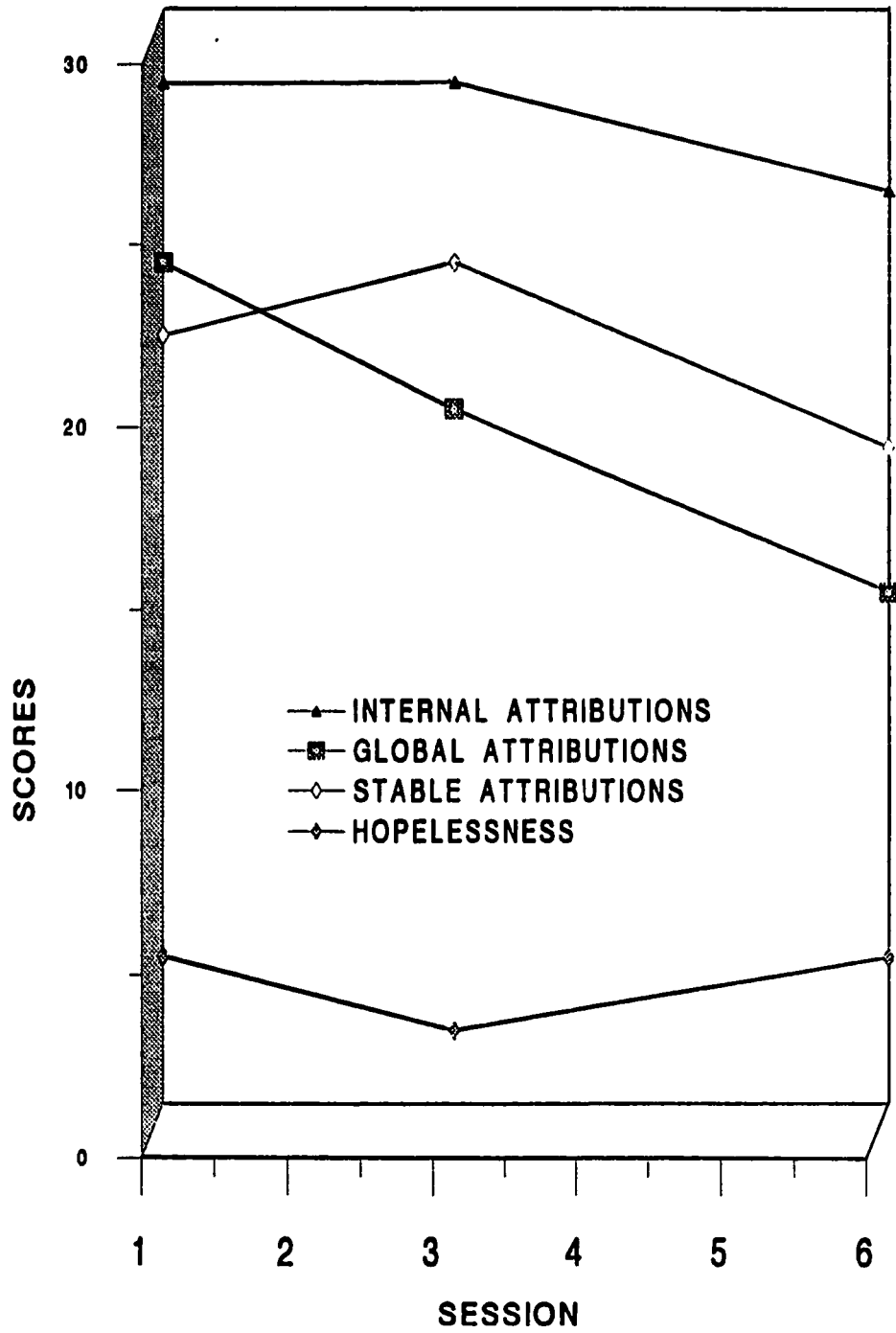


Figure 8H. Integrative Reminiscence Subject Four

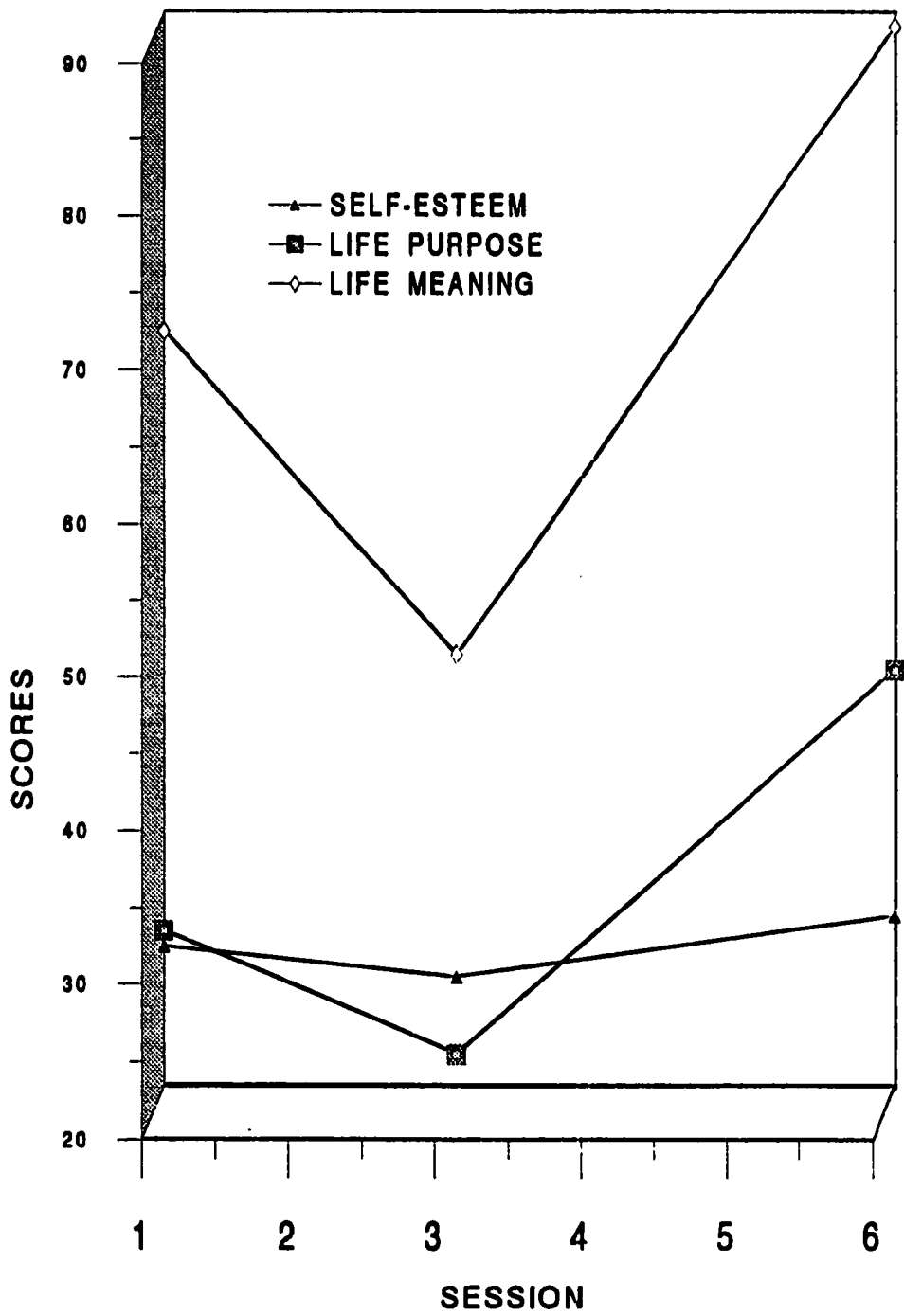


Figure 9H. Integrative Reminiscence Subject Five

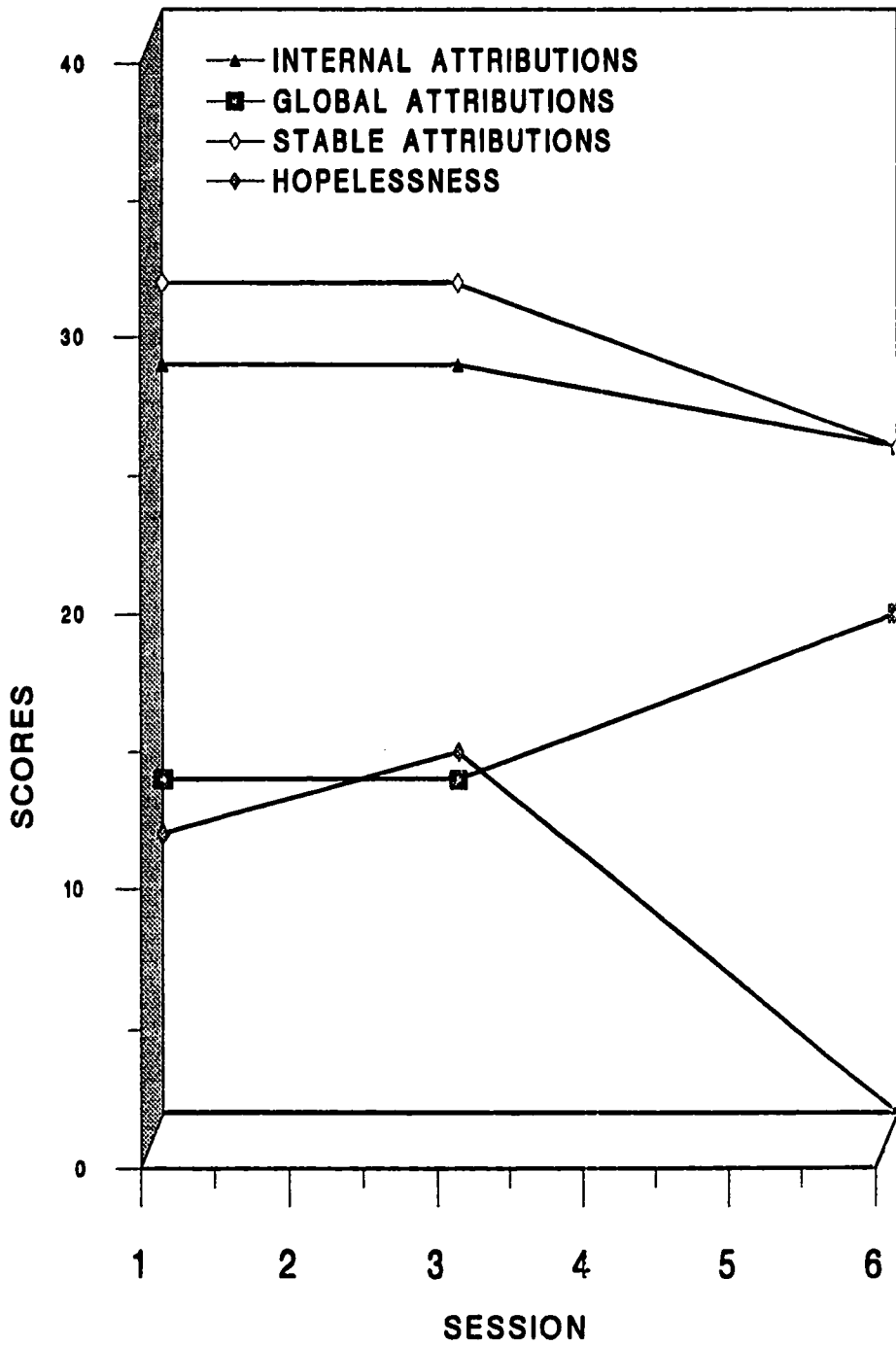


Figure 10H. Integrative Reminiscence Subject Five

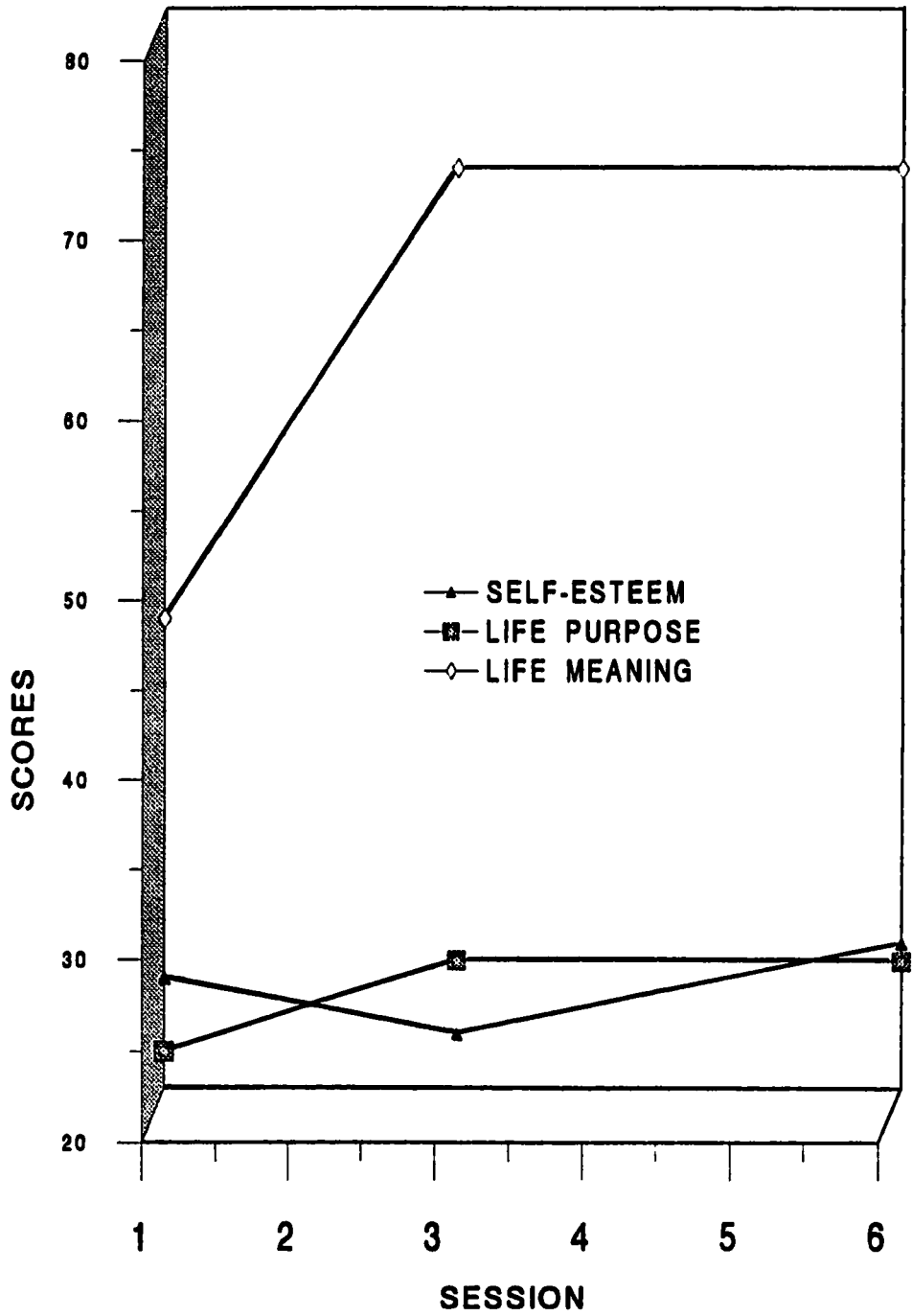


Figure 11H. Integrative Reminiscence Subject Six

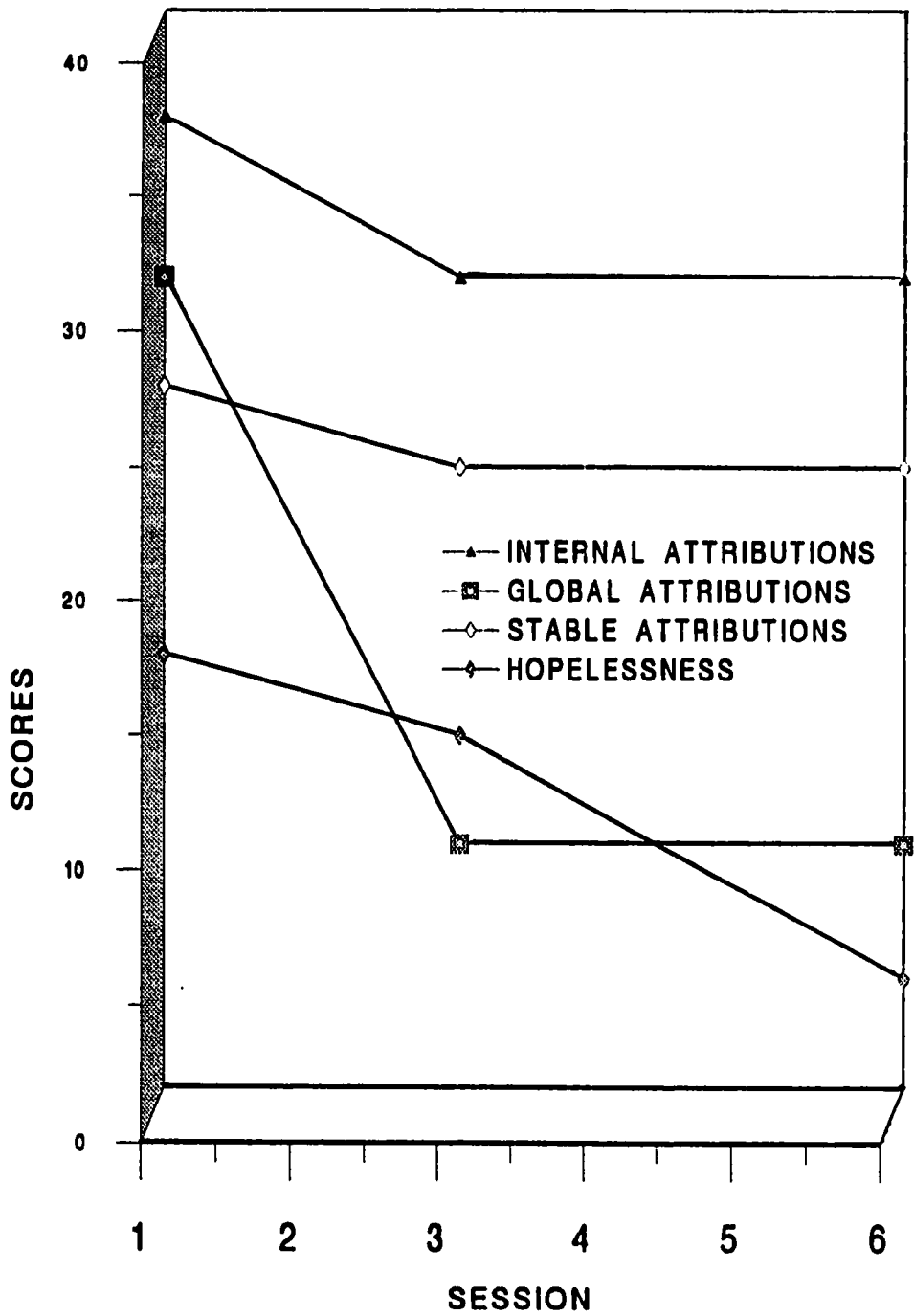


Figure 12H. Integrative Reminiscence Subject Six

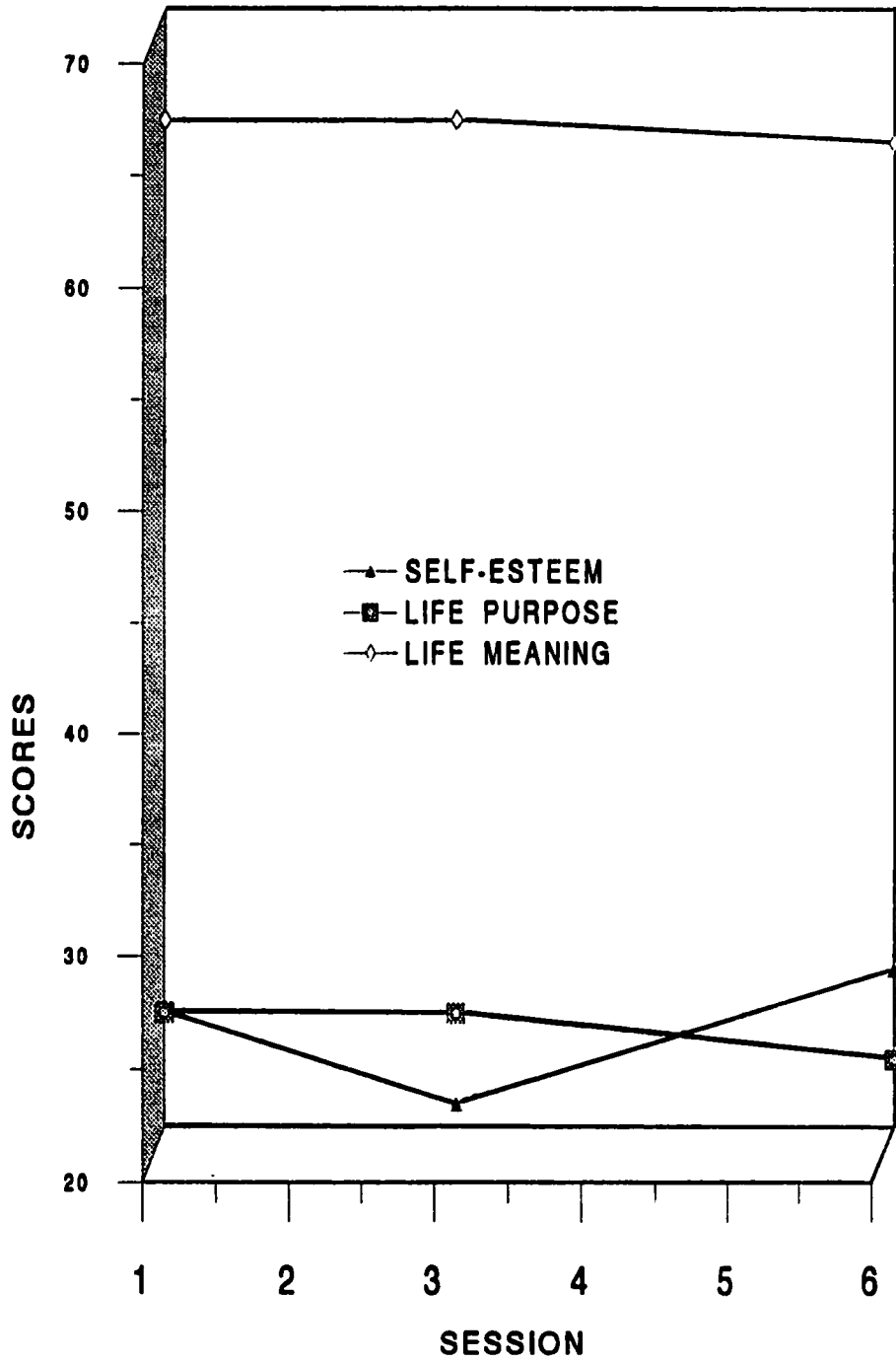


Figure 13H. Integrative Reminiscence Subject Seven

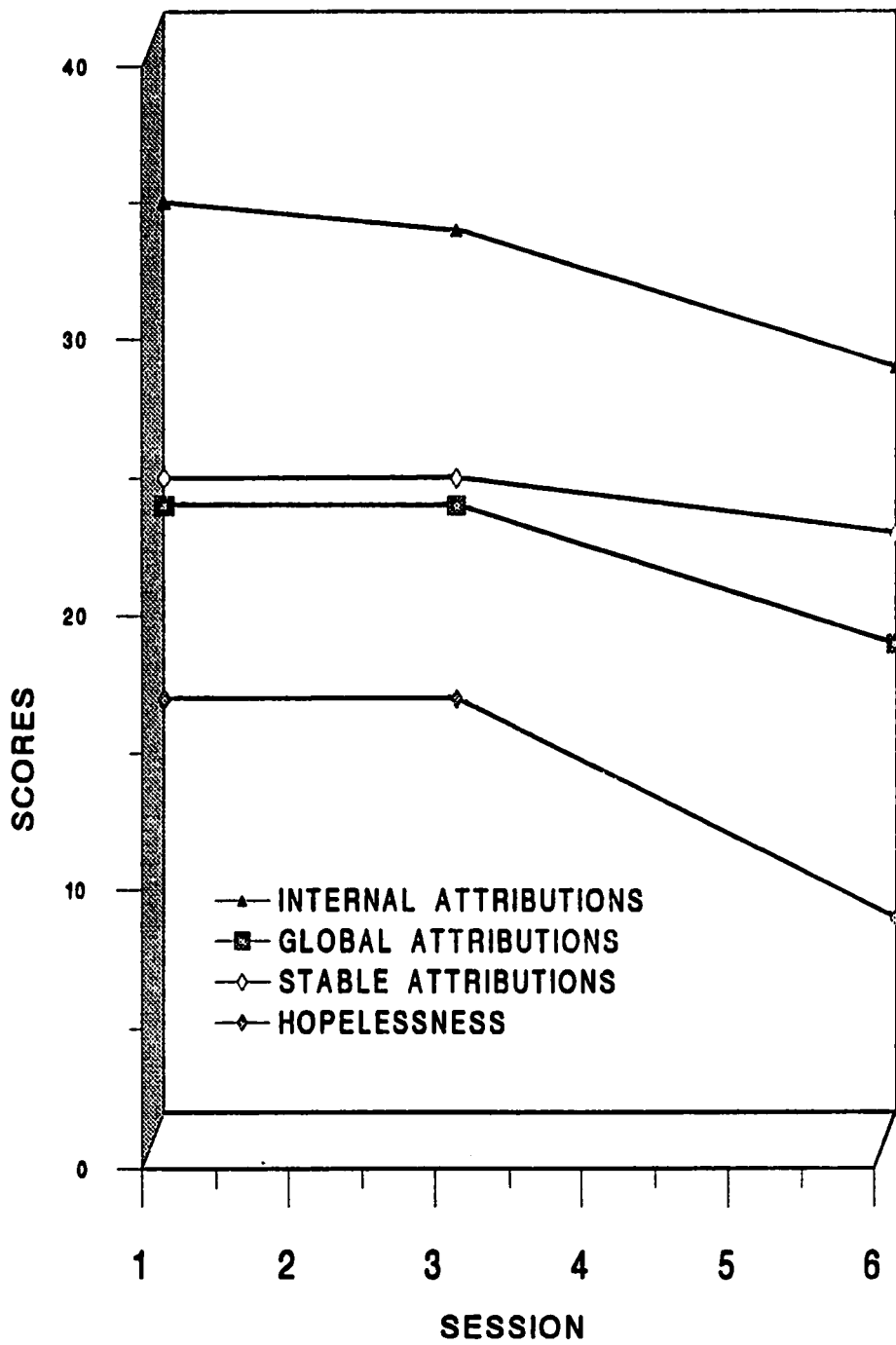


Figure 14H. Integrative Reminiscence Subject Seven

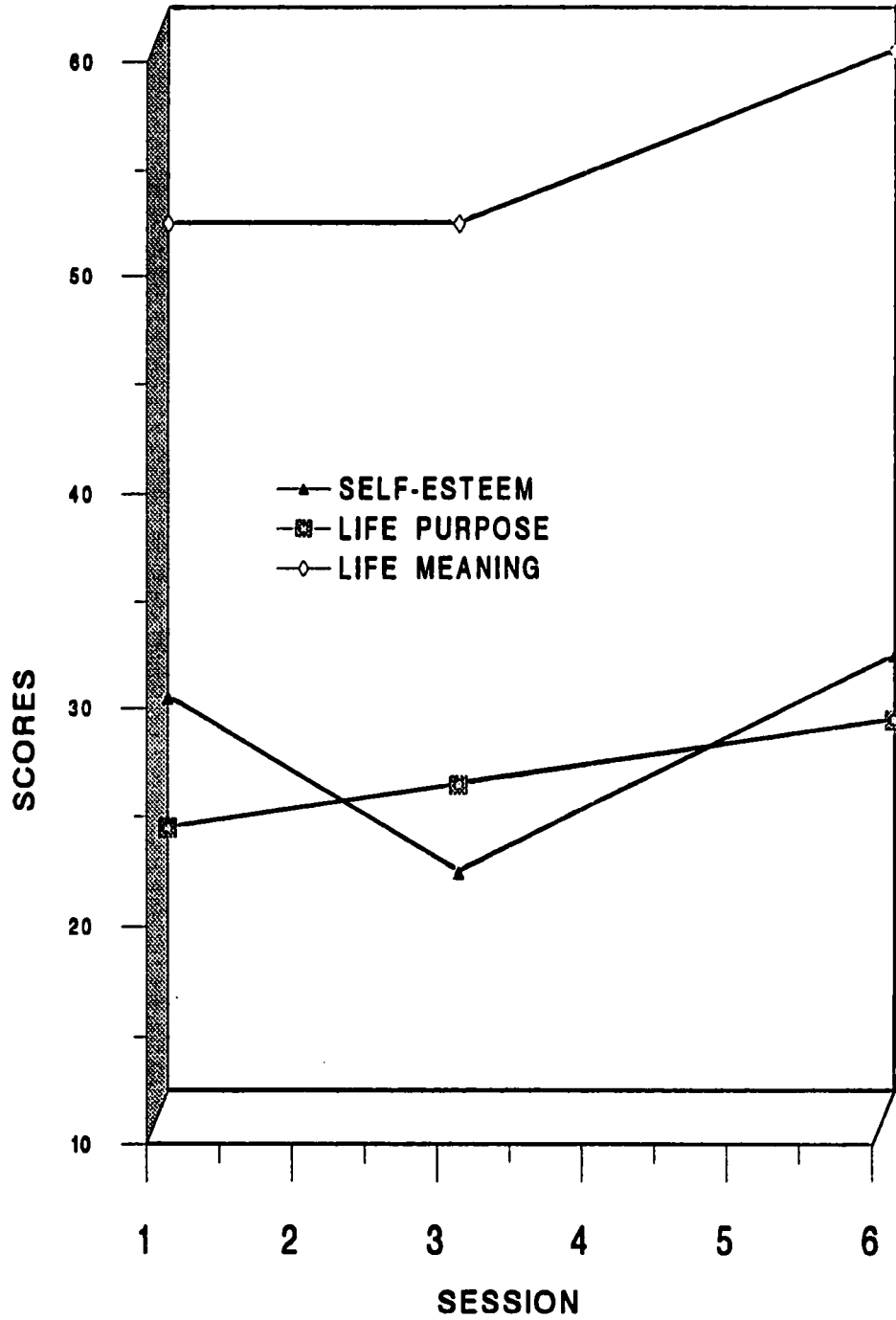


Figure 15H. Integrative Reminiscence Subject Eight

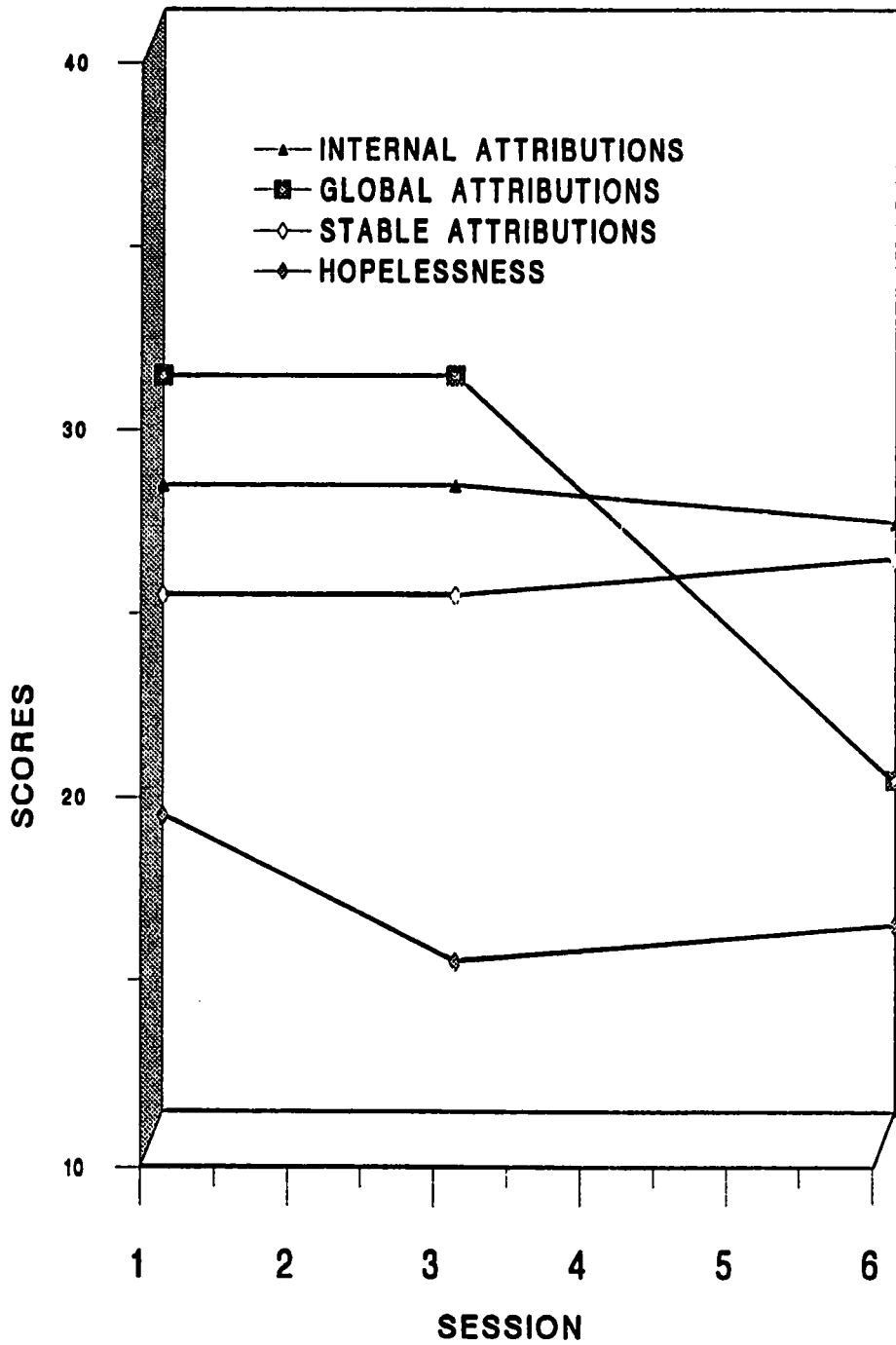


Figure 16H. Integrative Reminiscence Subject Eight

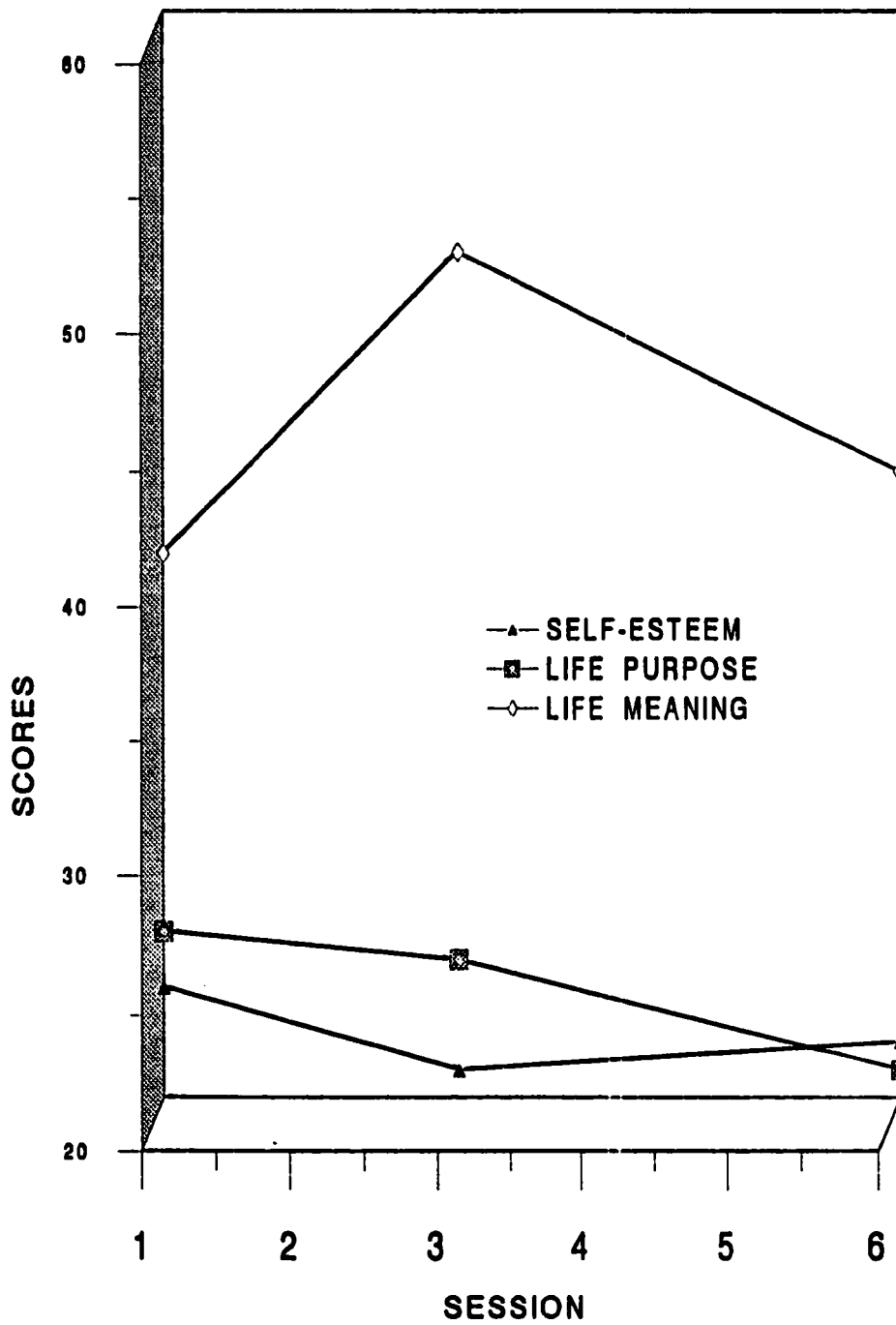


Figure 17H. Integrative Reminiscence Subject Nine

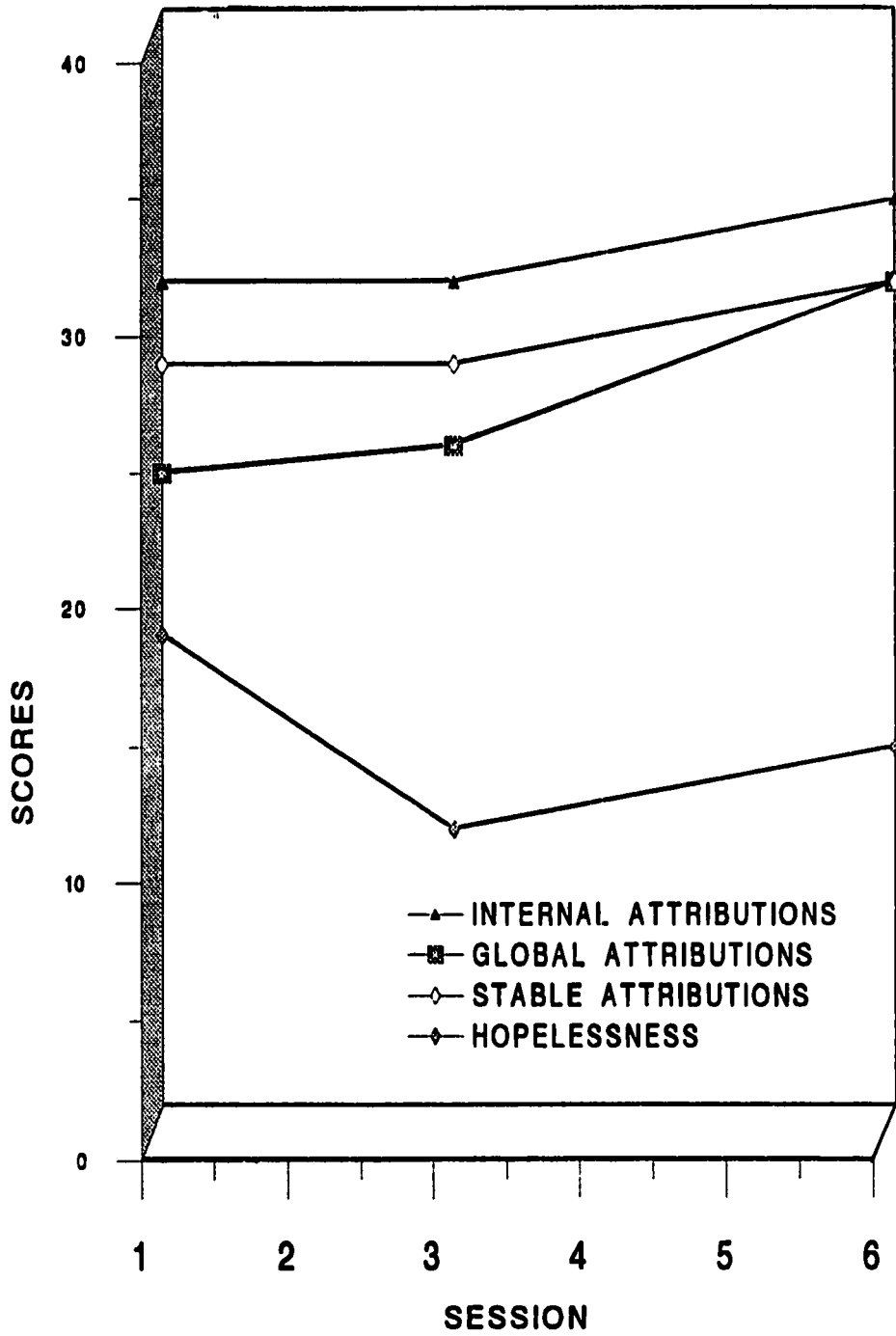


Figure 18H. Integrative Reminiscence Subject Nine

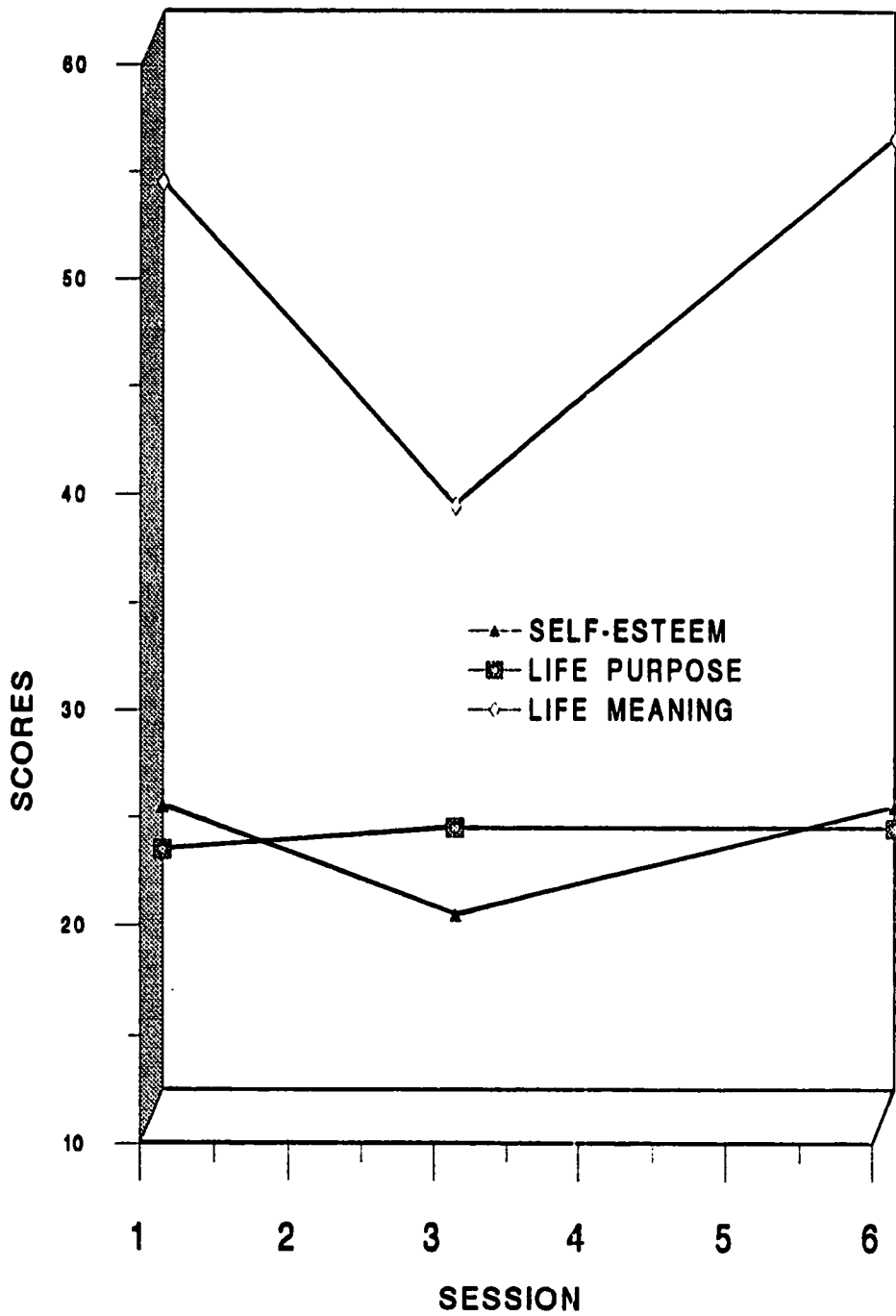


Figure 19H. Integrative Reminiscence Subject Ten

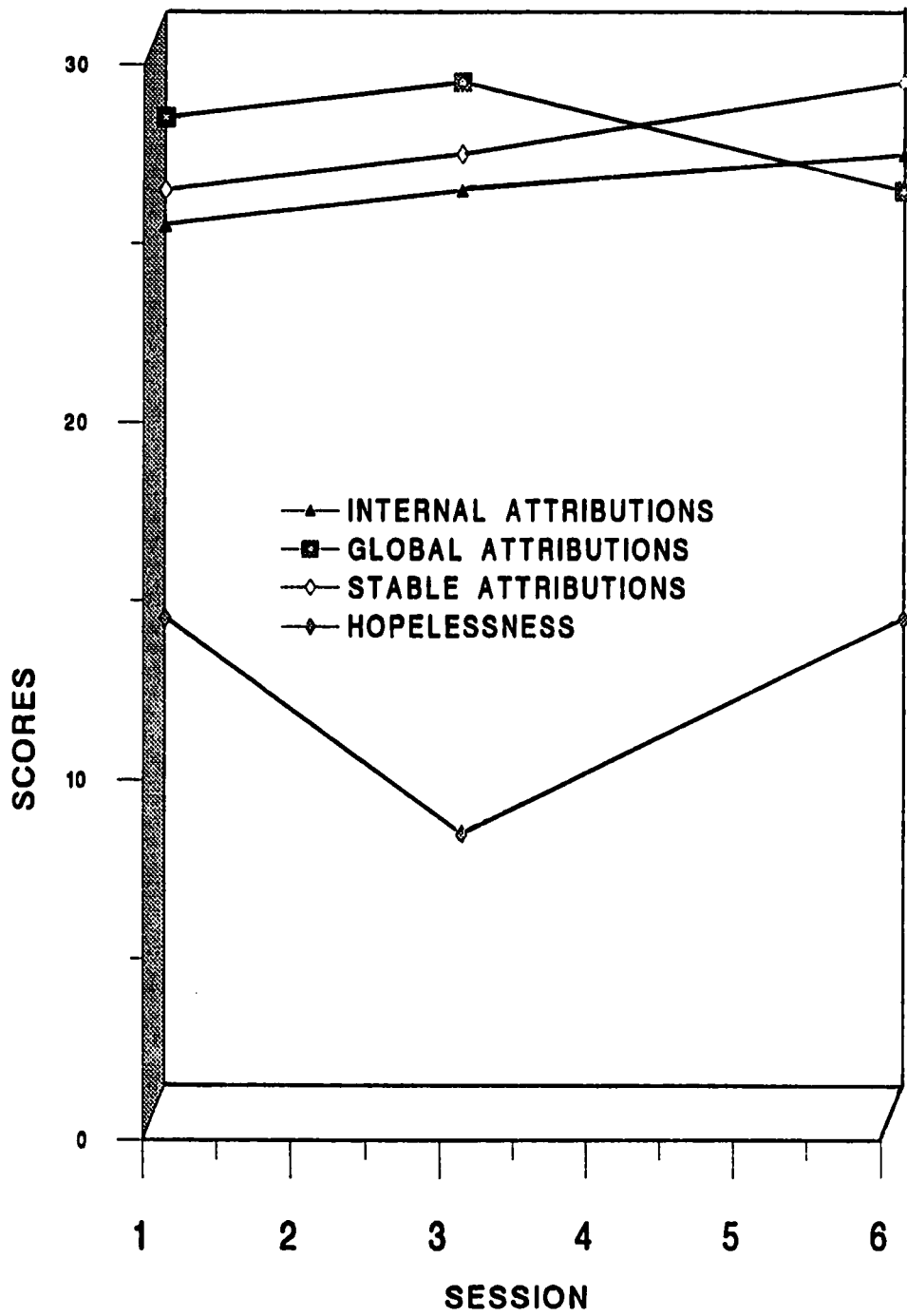


Figure 20H. Integrative Reminiscence Subject Ten

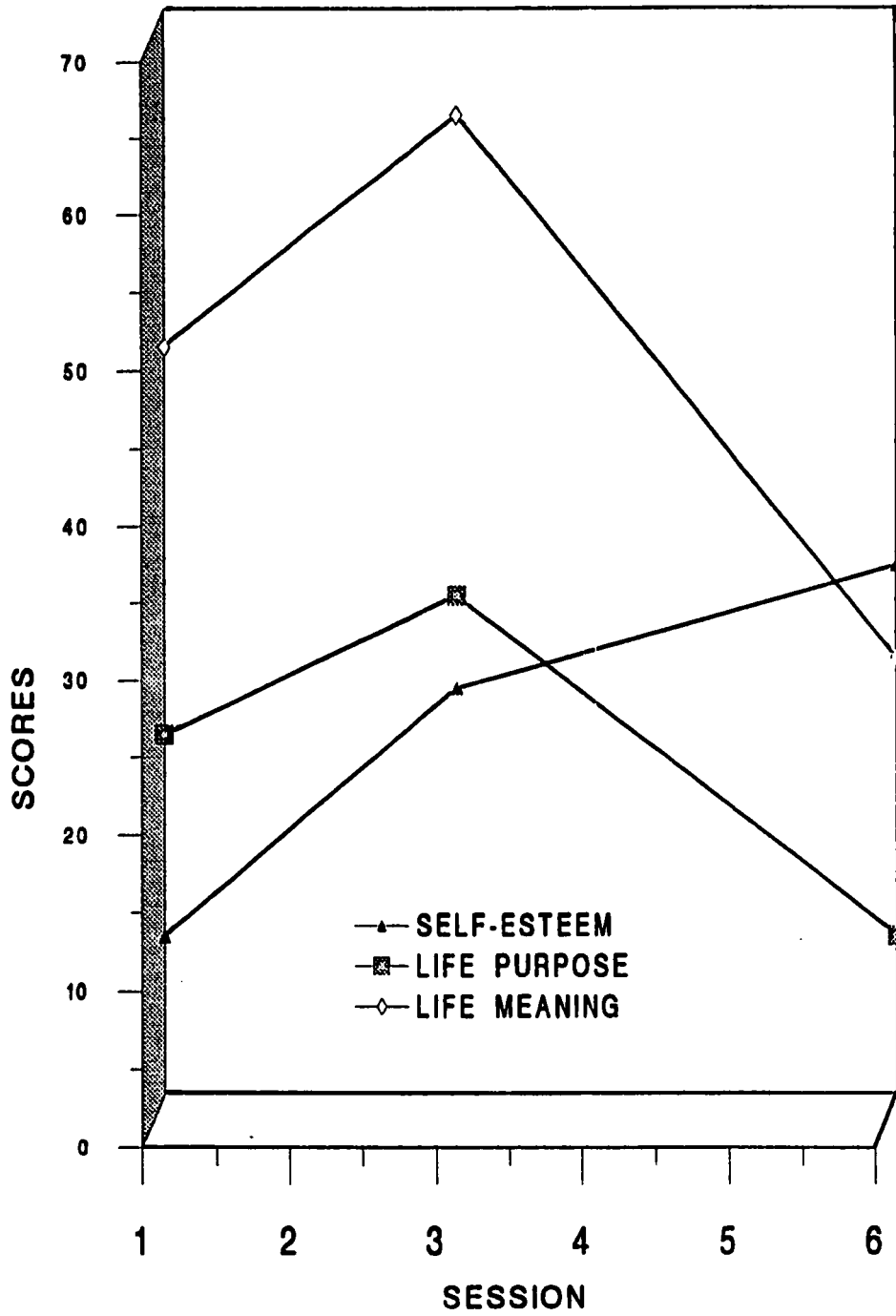


Figure 21H. Integrative Reminiscence Subject Eleven

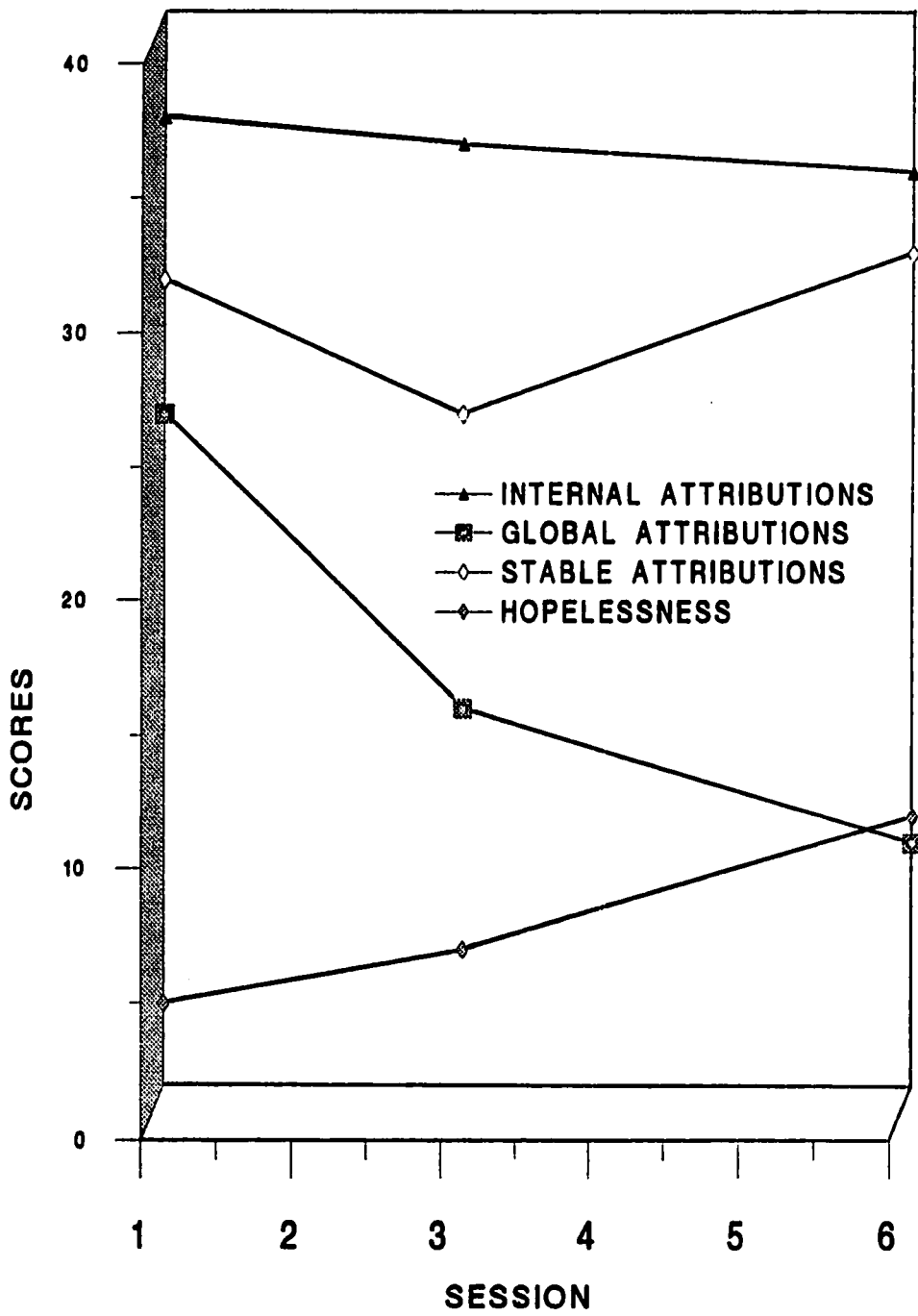


Figure 22H. Integrative Reminiscence Subject Eleven

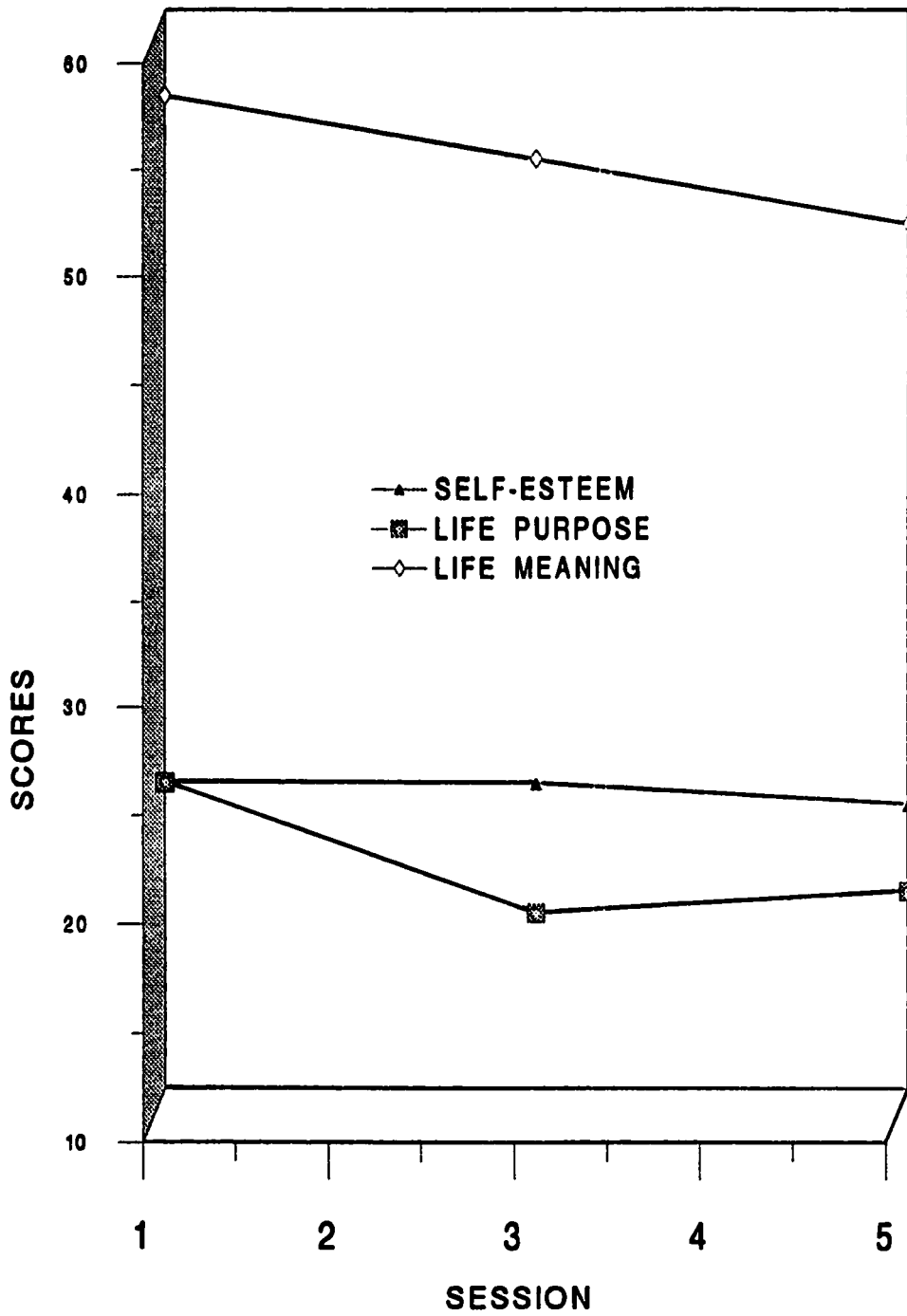


Figure 23H. Integrative Reminiscence Subject Twelve

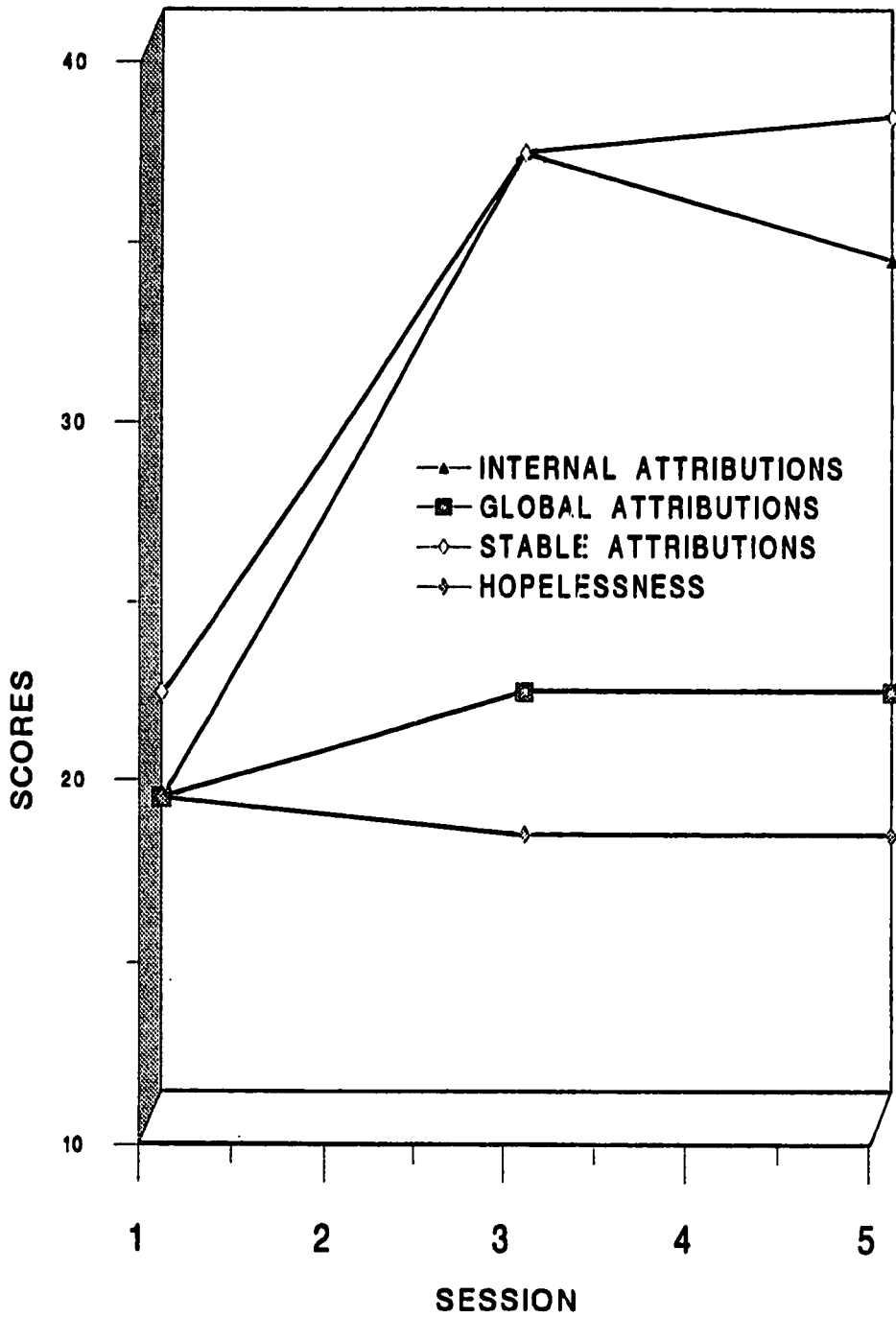


Figure 24H. Integrative Reminiscence Subject Twelve

Appendix I: Figures Depicting Case Study Data for each Subject in the Instrumental Reminiscence Group

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- Figure 3I. Individual Case Study Data for Subject 1 in the Instrumental Group:
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- Figure 4I. Individual Case Study Data for Subject 1 in the Instrumental Group:
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- Figure 5I. Individual Case Study Data for Subject 2 in the Instrumental Group:
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Primary Appraisals

Figure 35I. Individual Case Study Data for Subject 9 in the Instrumental Group:
Secondary Appraisals

Figure 36I. Individual Case Study Data for Subject 9 in the Instrumental Group:
Coping Responses

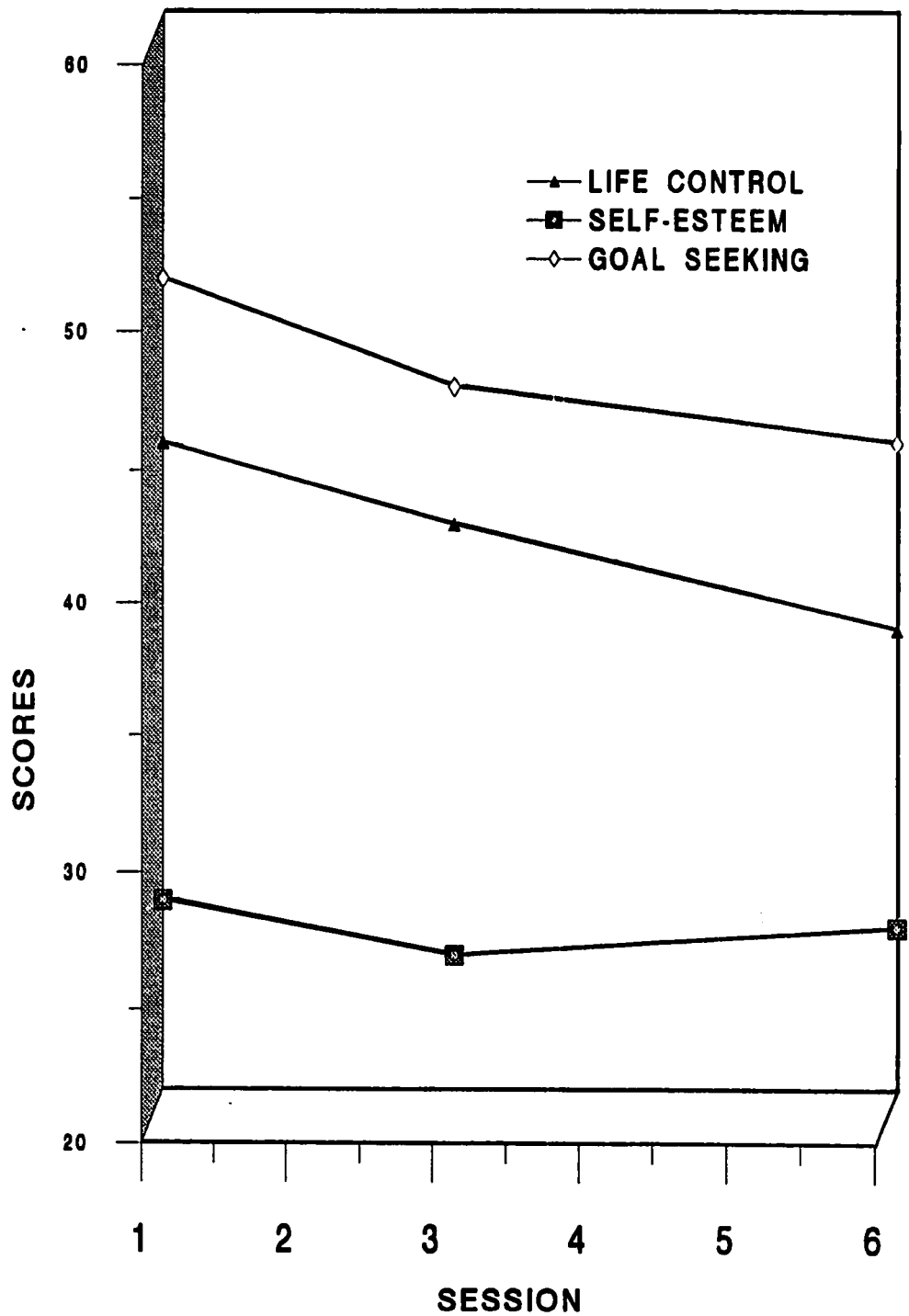


Figure 11. Instrumental Reminiscence Subject One: Coping Resources

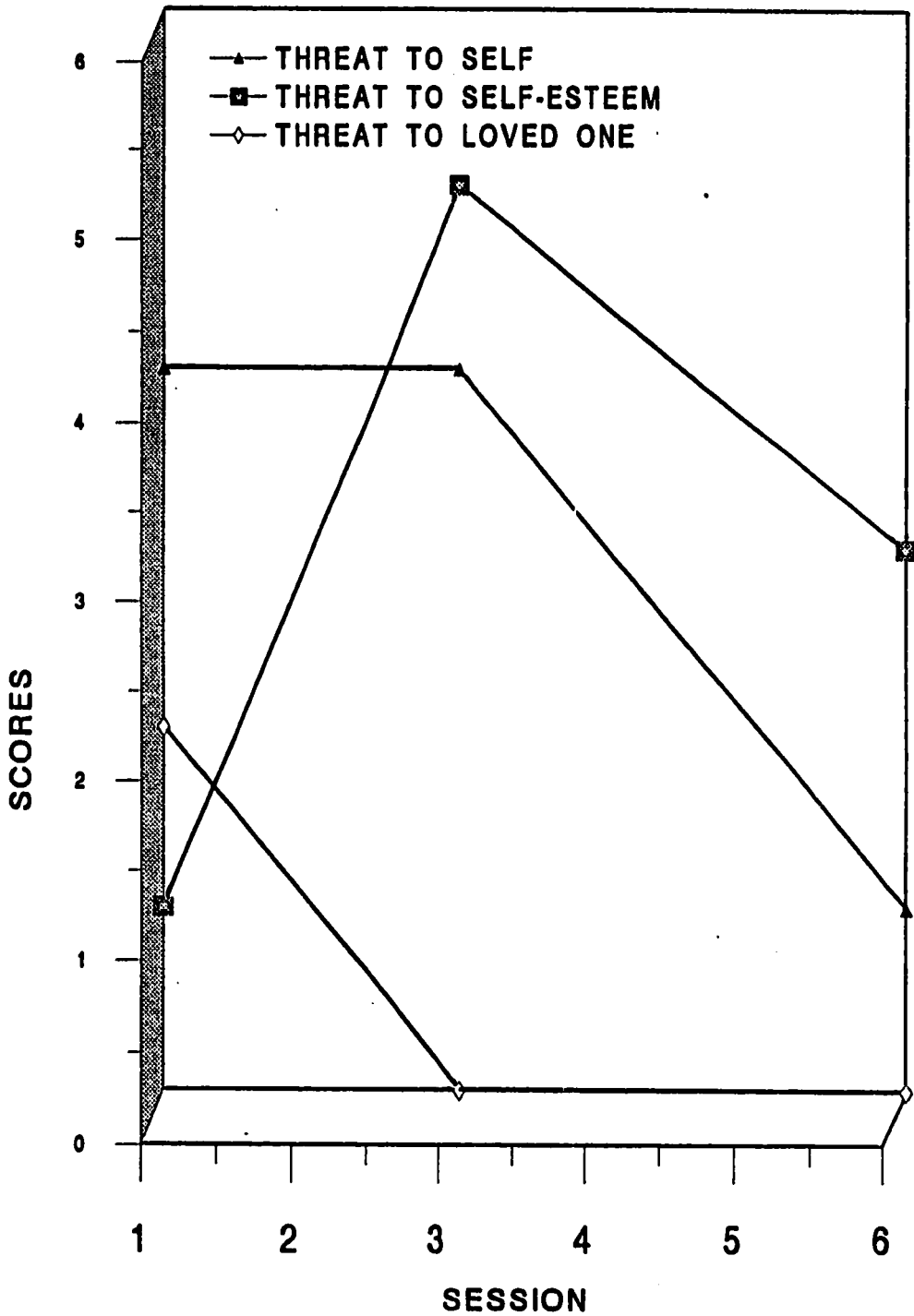


Figure 21. Instrumental Reminiscence Subject One: Primary Appraisals

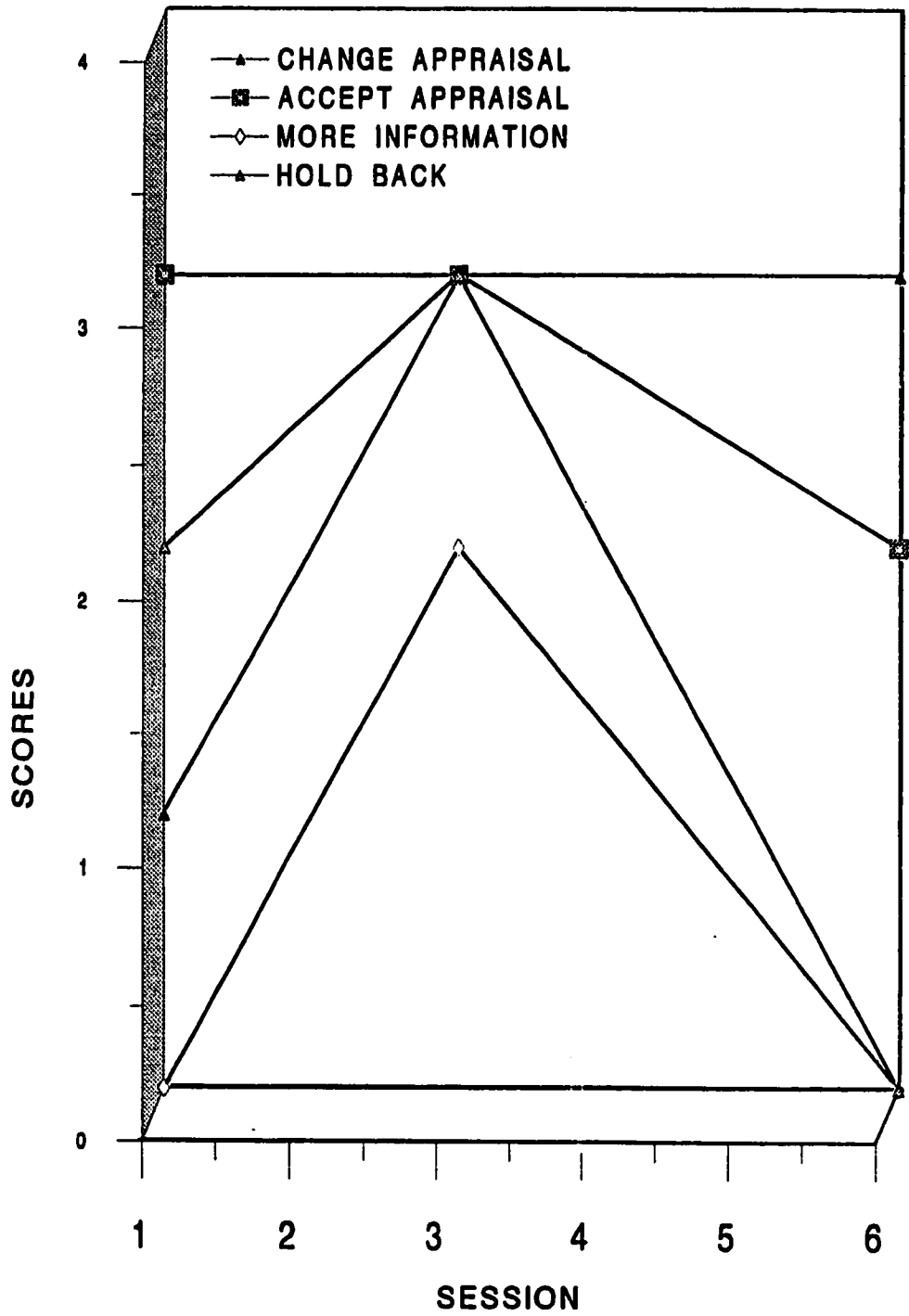


Figure 31. Instrumental Reminiscence Subject One: Secondary Appraisals

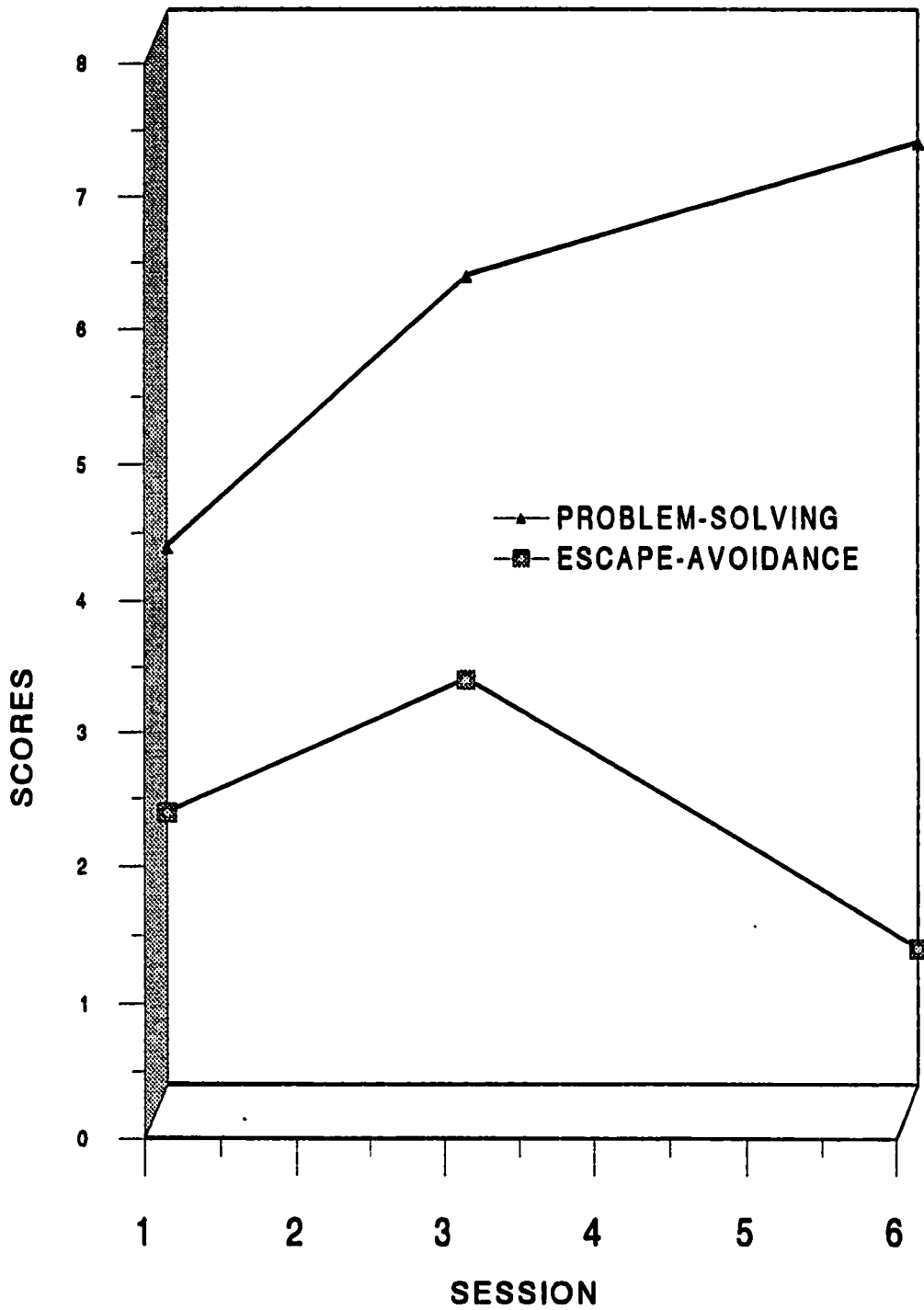


Figure 4l. Instrumental Reminiscence Subject One: Coping Responses

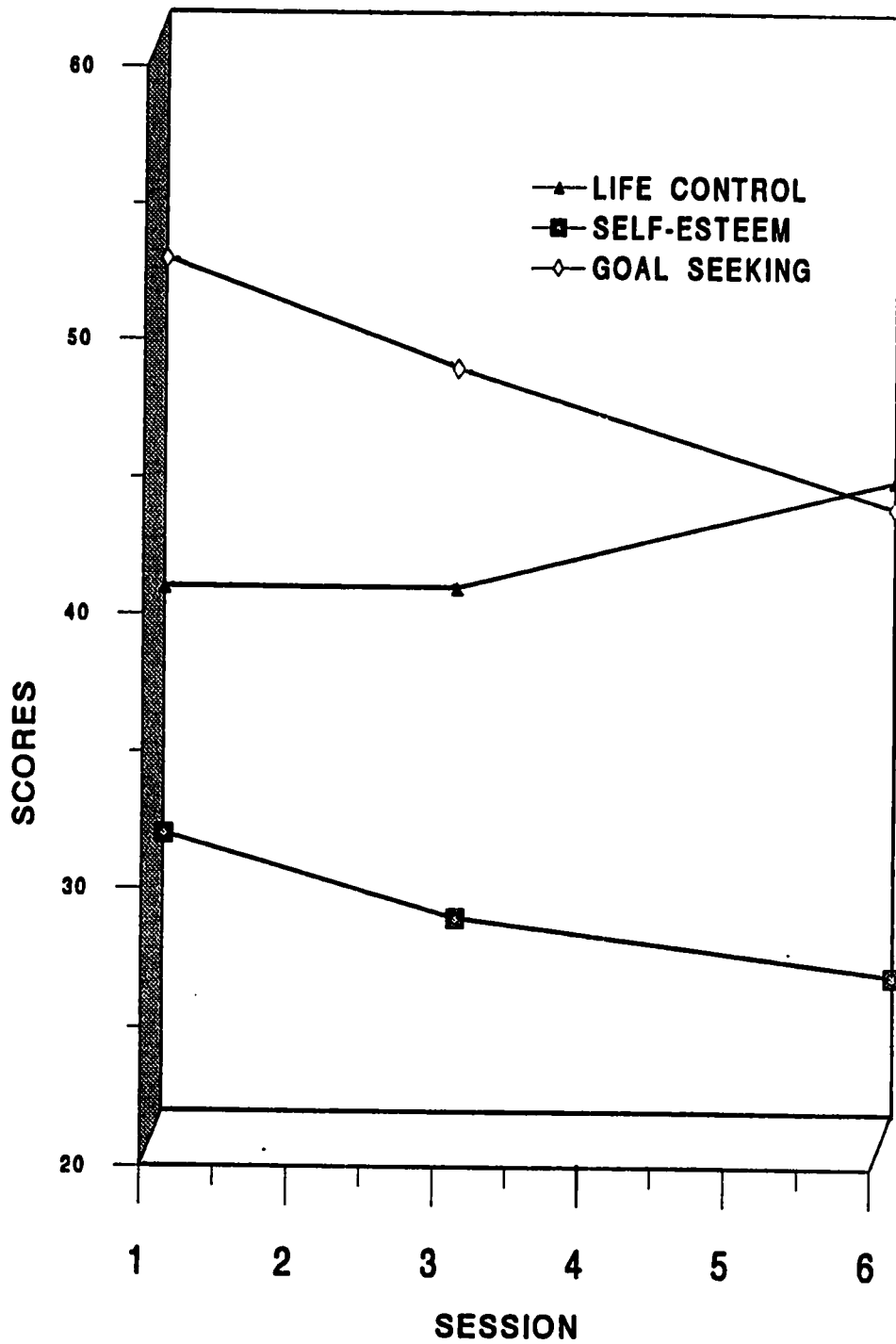


Figure 51. Instrumental Reminiscence Subject Two: Coping Resources

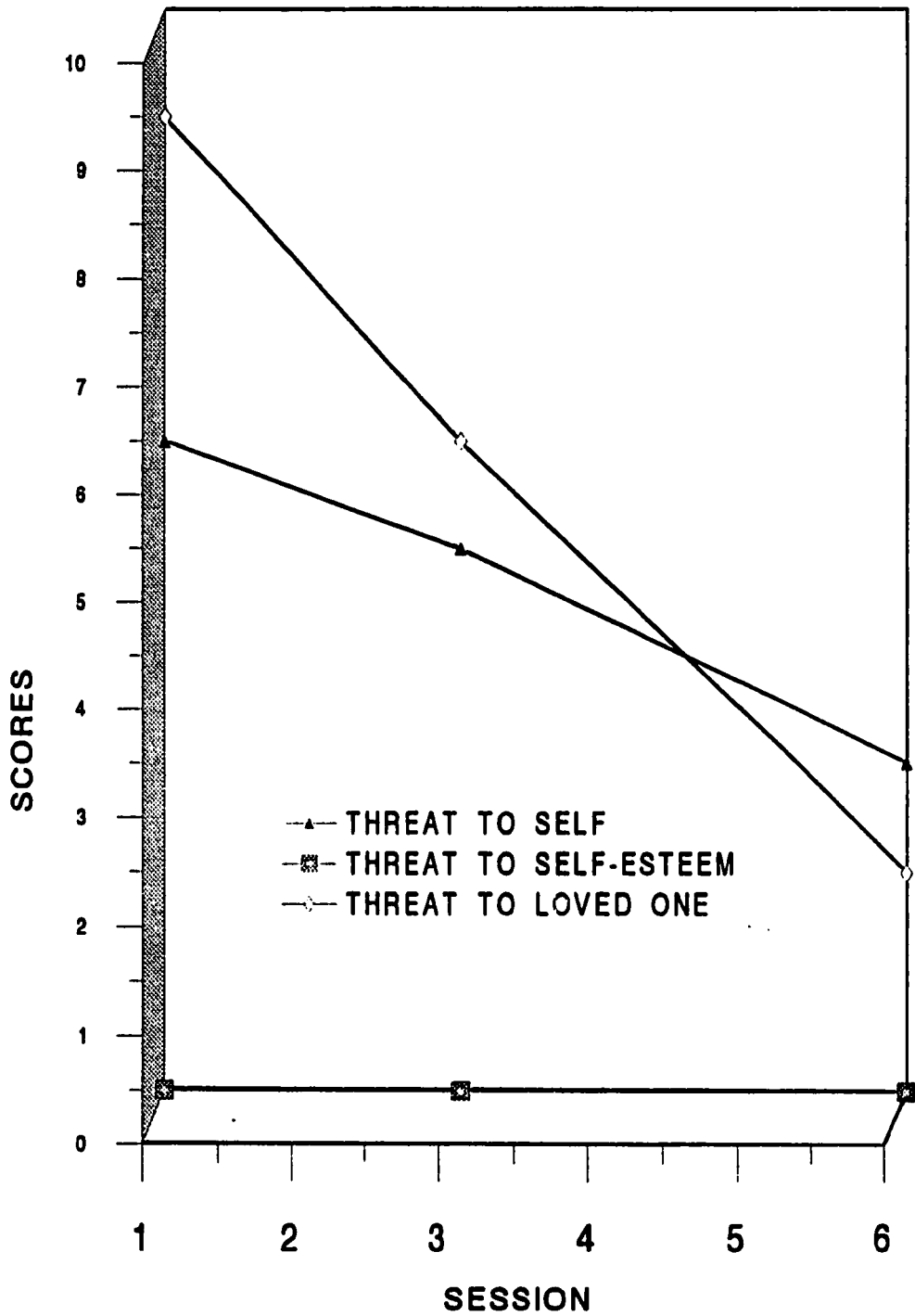


Figure 61. Instrumental Reminiscence Subject Two: Primary Appraisals

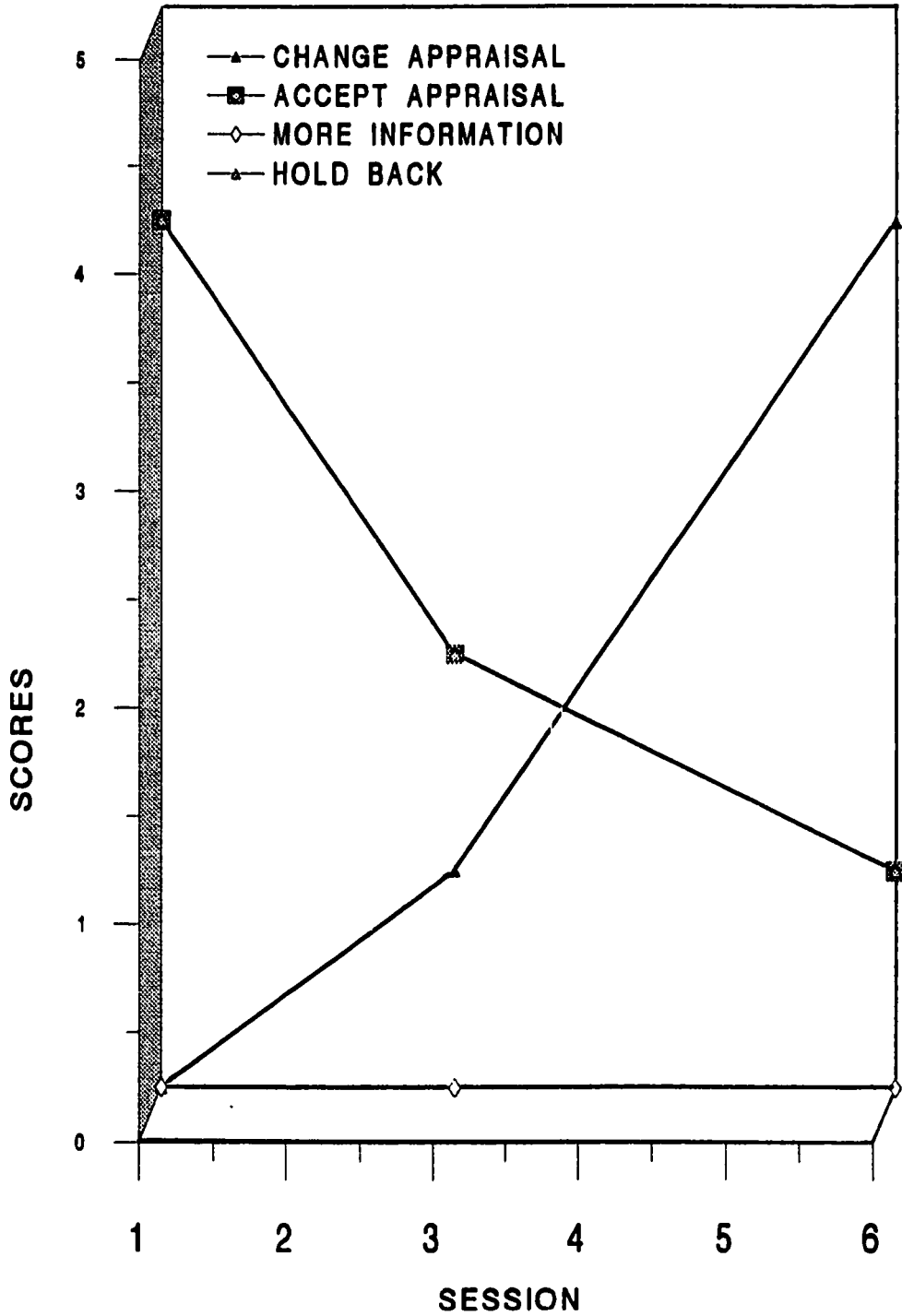


Figure 71. Instrumental Reminiscence Subject Two: Secondary Appraisals

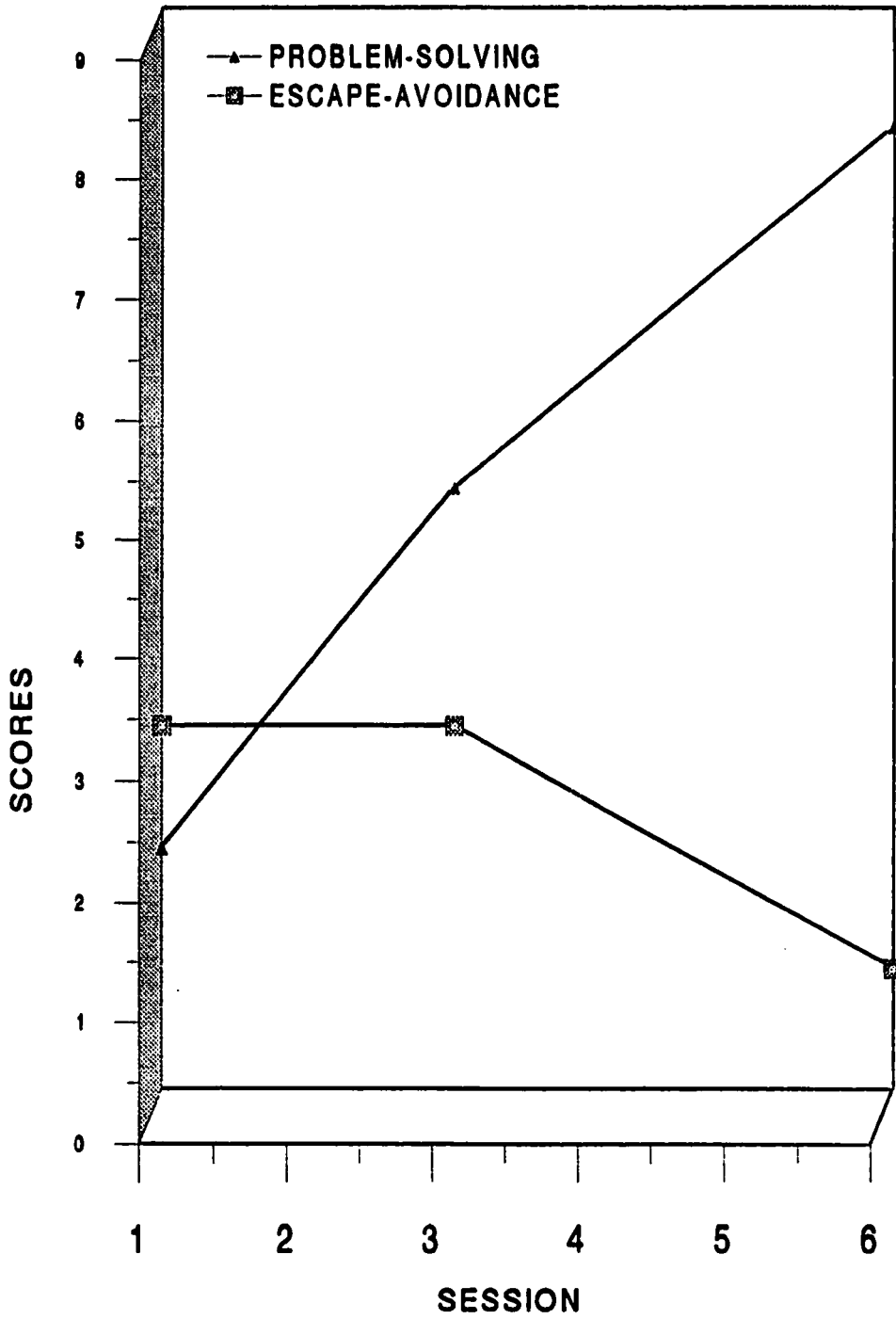


Figure 81. Instrumental Reminiscence Subject Two: Coping Responses

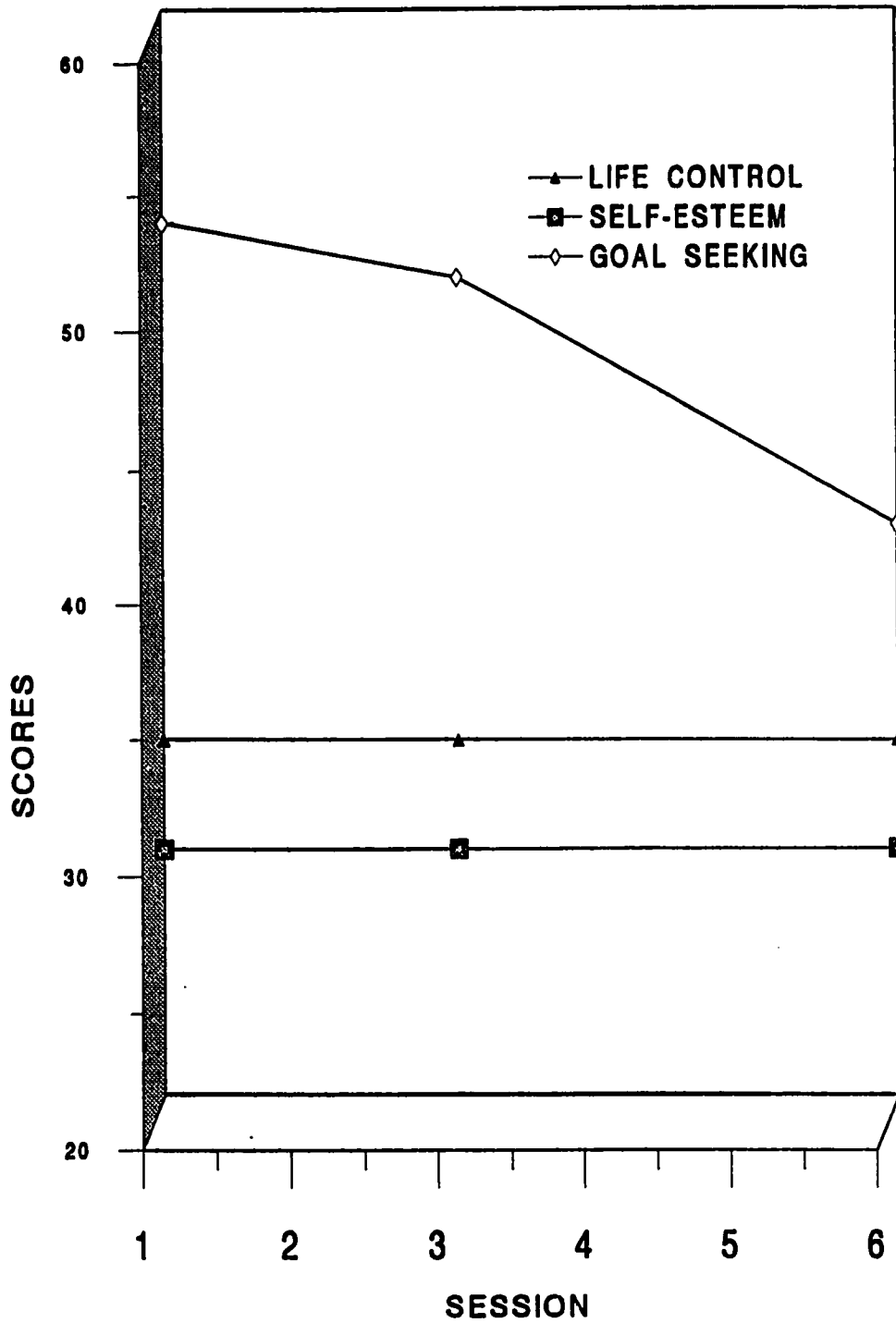


Figure 91. Instrumental Reminiscence Subject Three: Coping Resources

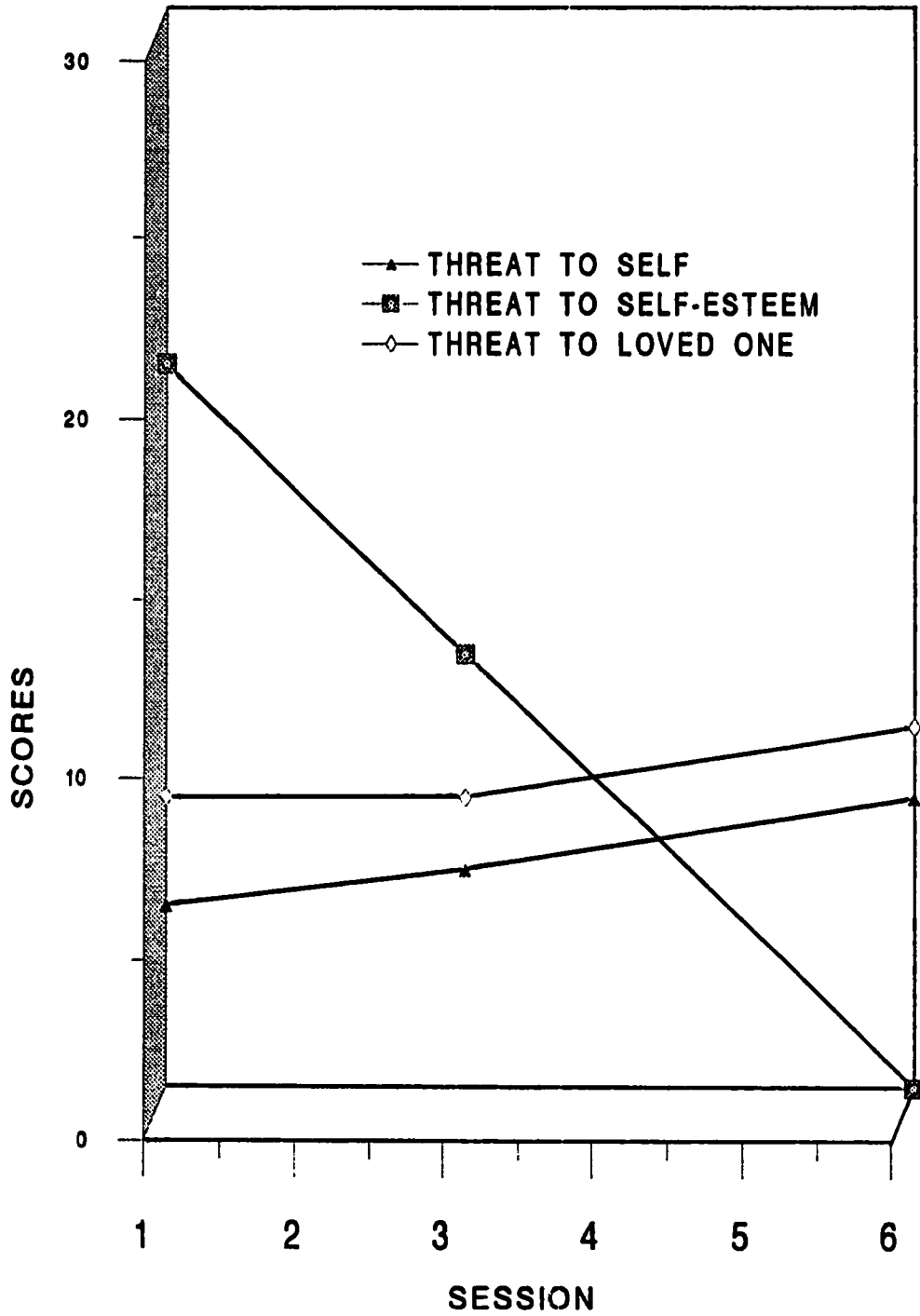


Figure 10l. Instrumental Reminiscence Subject Three: Primary Appraisals

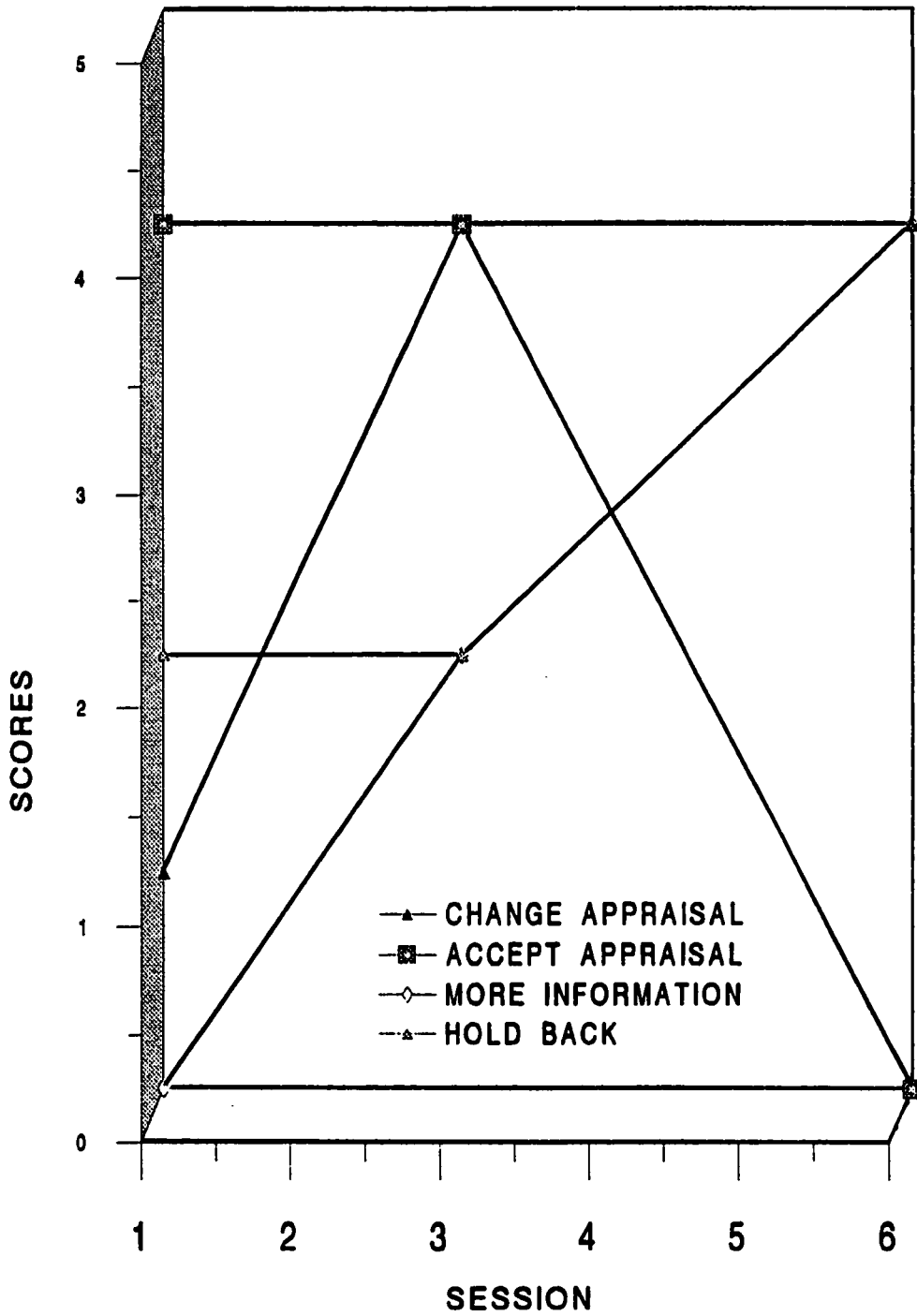


Figure 11l. Instrumental Reminiscence Subject Three: Secondary Appraisals

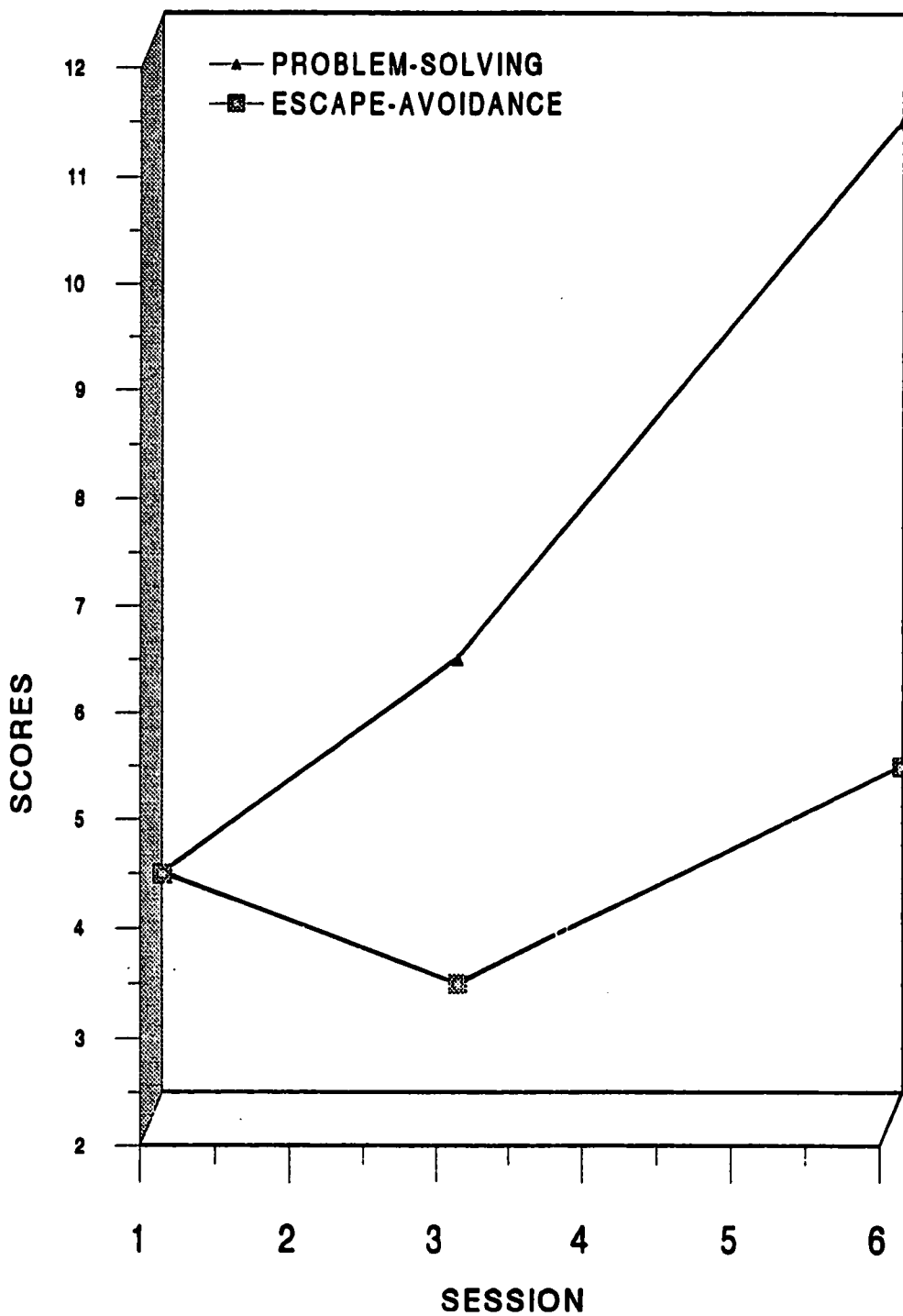


Figure 12I. Instrumental Reminiscence Subject Three: Coping Responses

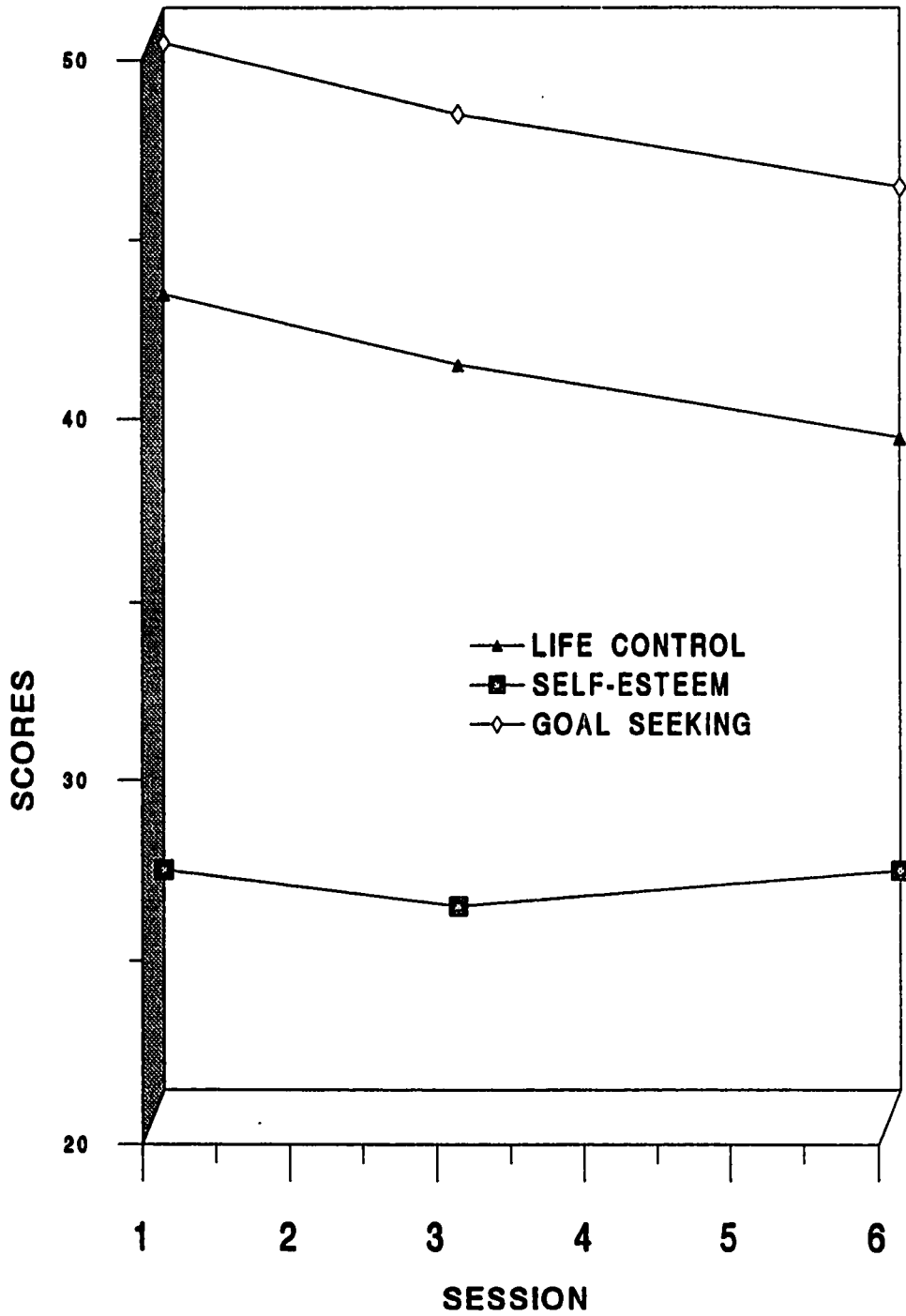


Figure 13I. Instrumental Reminiscence Subject Four: Coping Resources

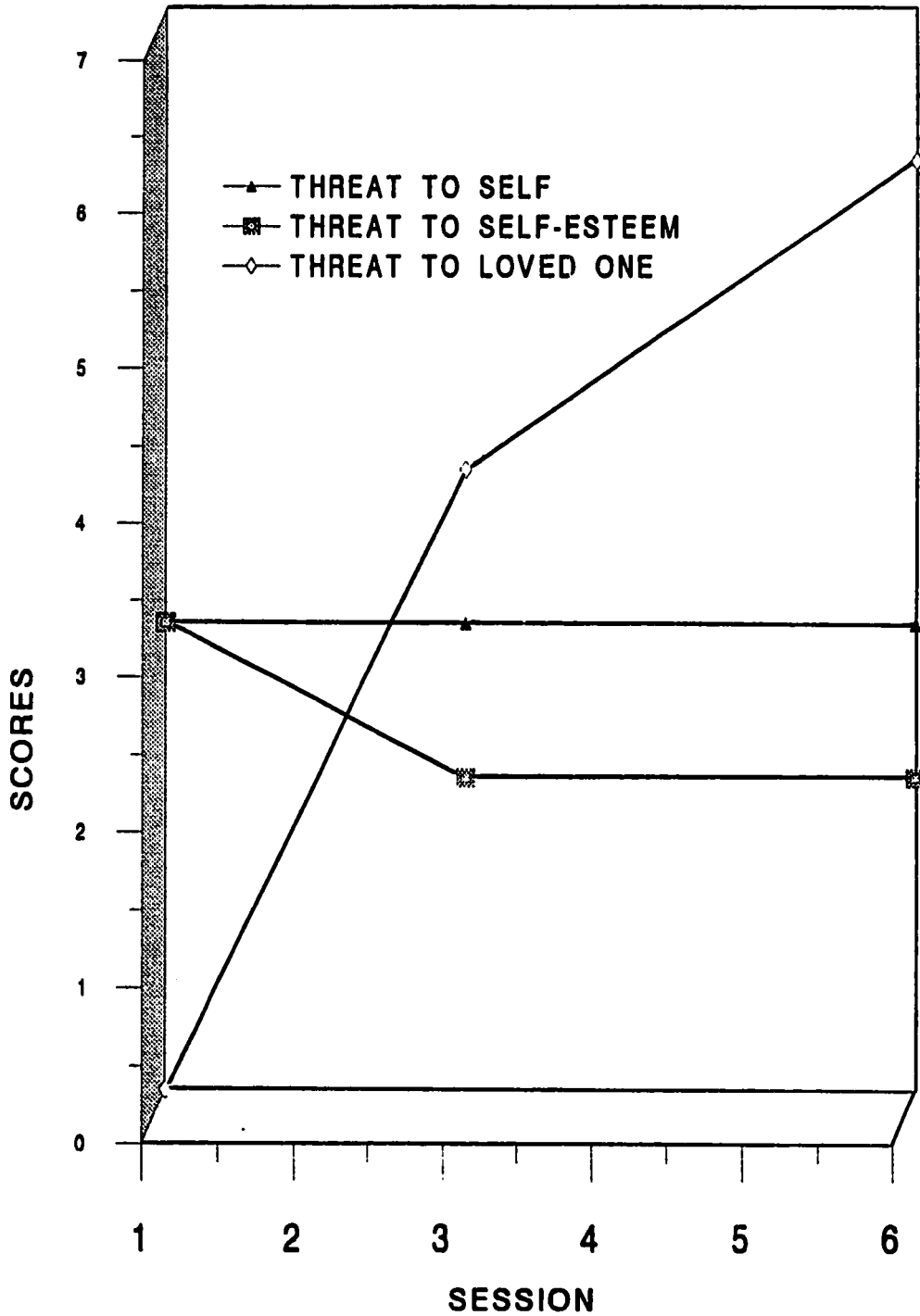


Figure 141. Instrumental Reminiscence Subject Four: Primary Appraisals

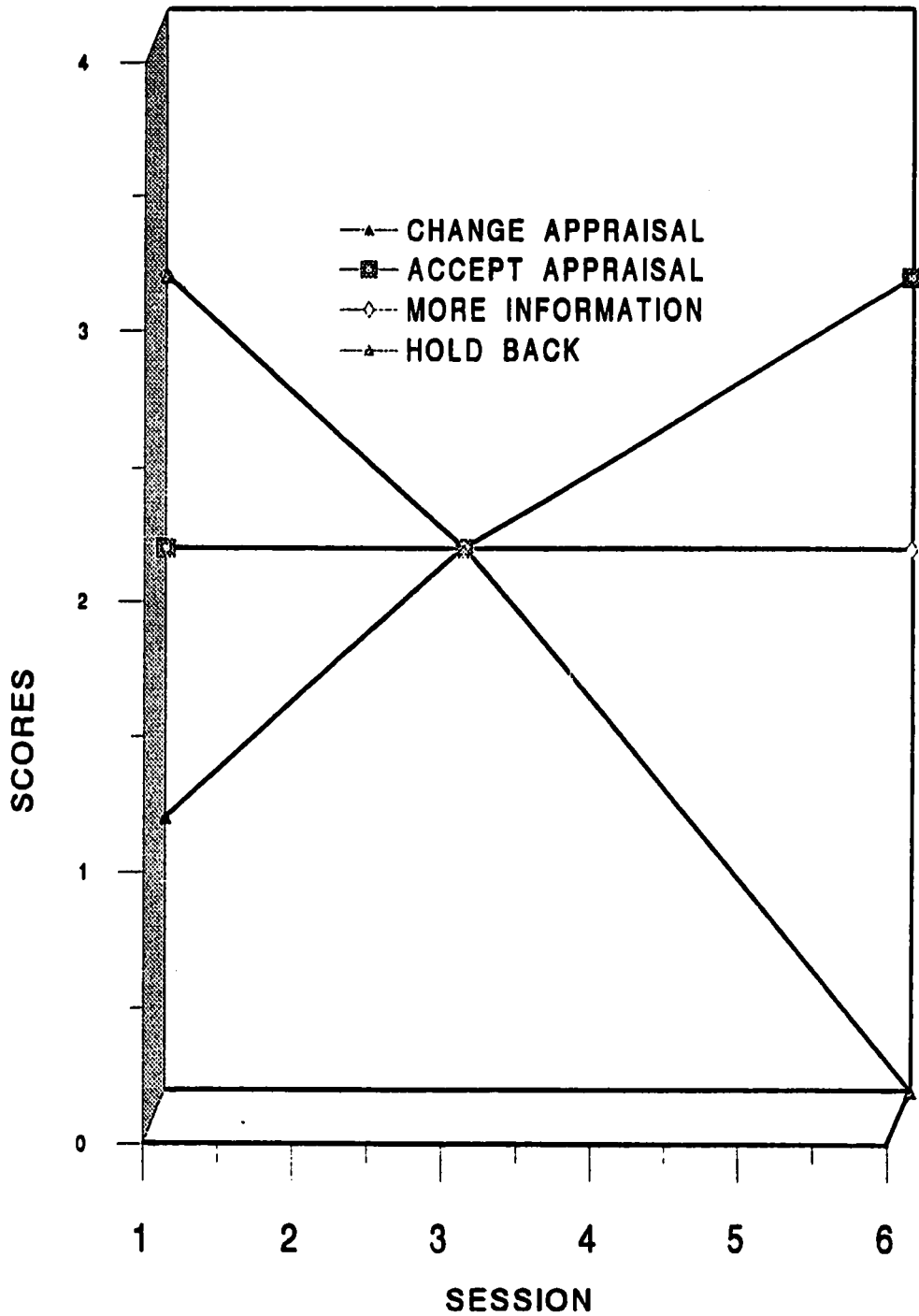


Figure 15I. Instrumental Reminiscence Subject Four: Secondary Appraisals

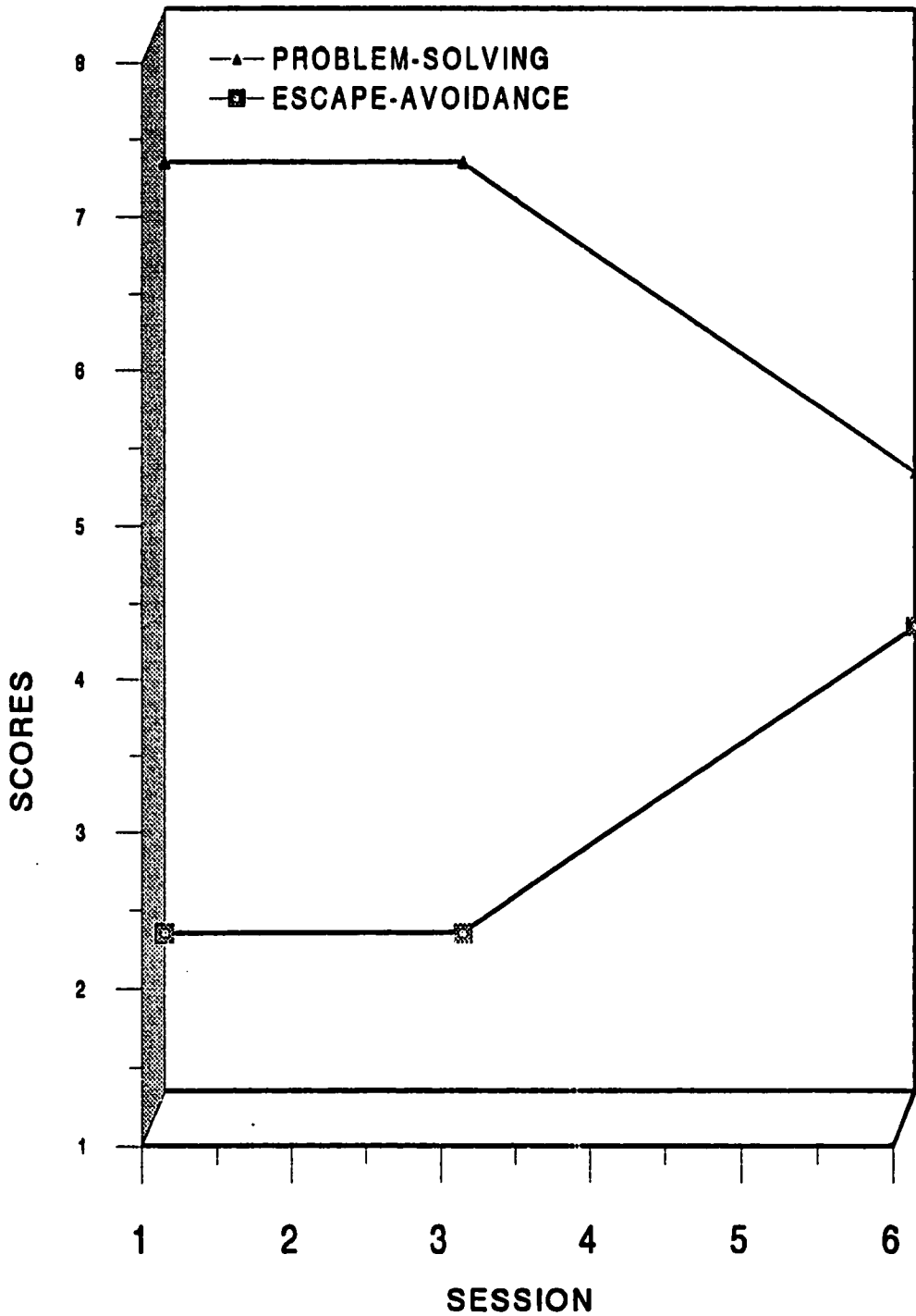


Figure 16l. Instrumental Reminiscence Subject Four: Coping Responses

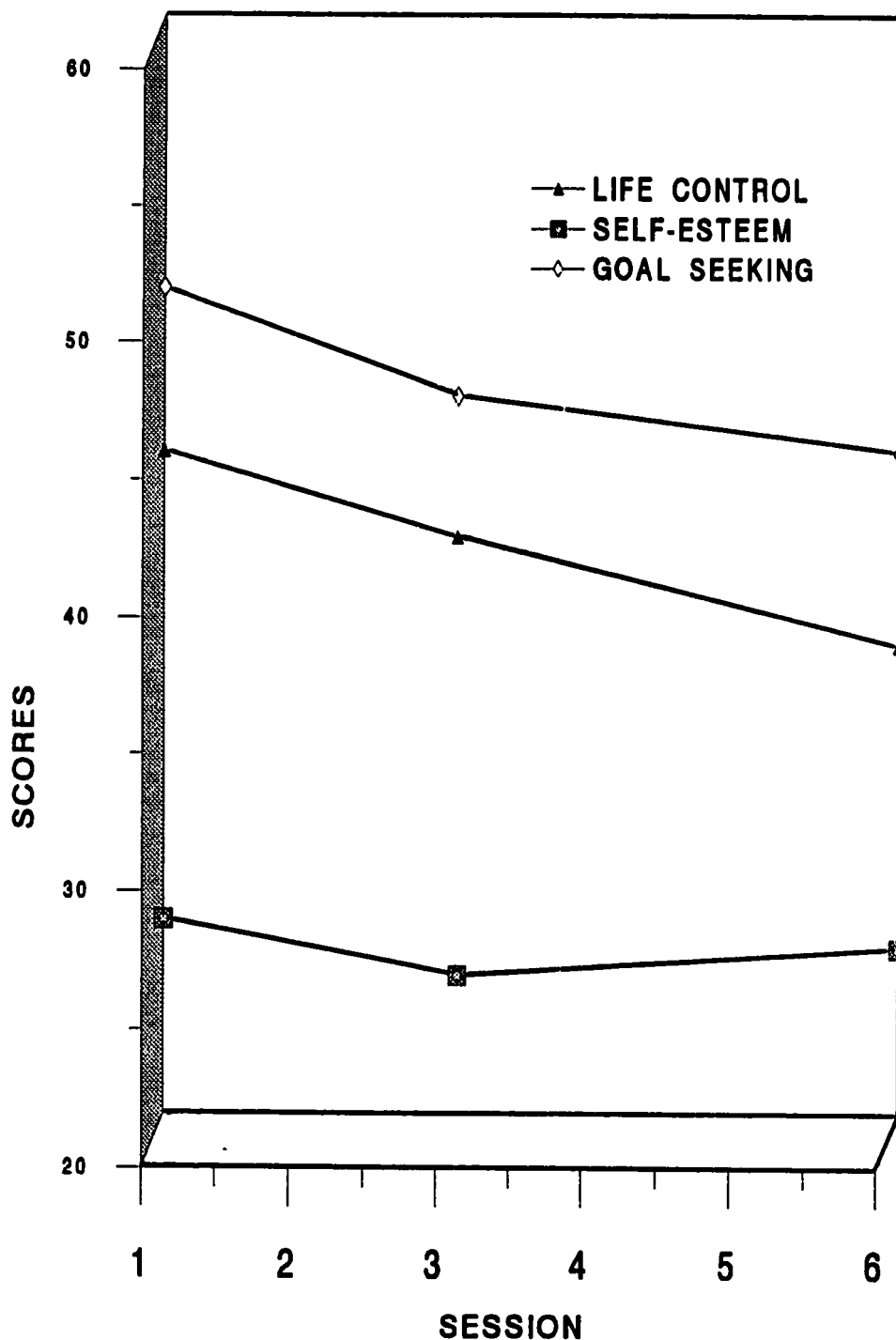


Figure 171. Instrumental Reminiscence Subject Five: Coping Resources

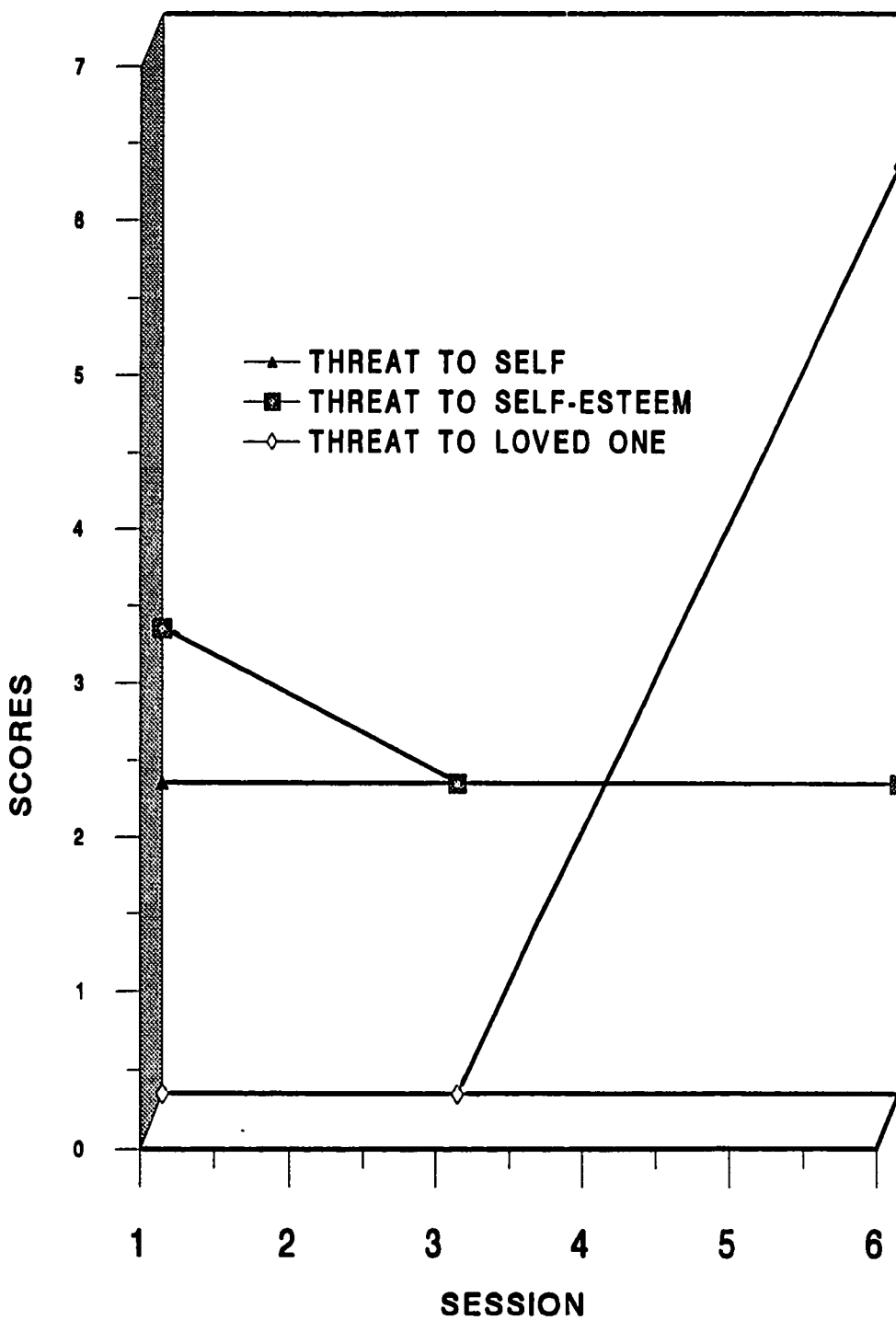


Figure 18I. Instrumental Reminiscence Subject Five: Primary Appraisals

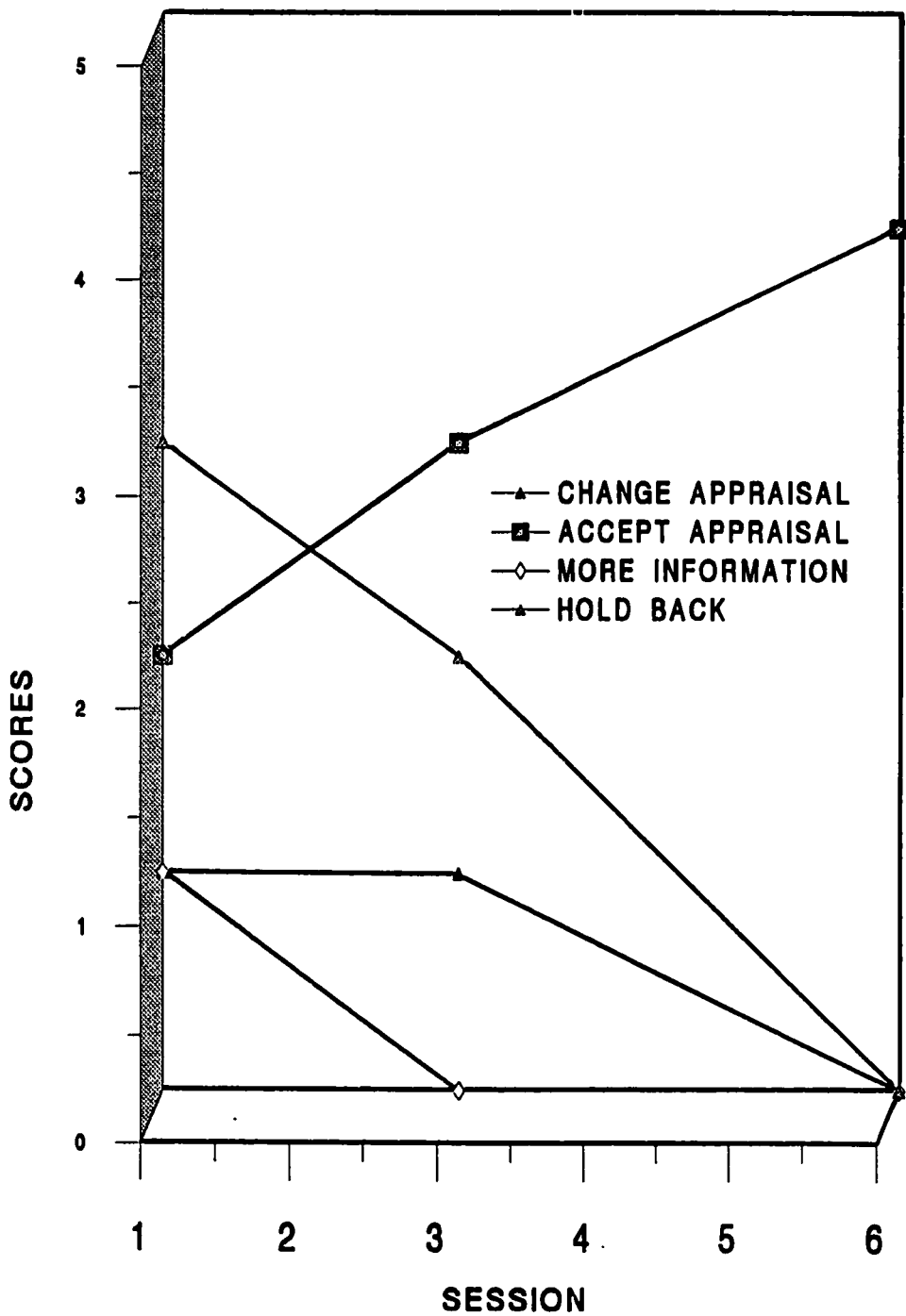


Figure 191. Instrumental Reminiscence Subject Five: Secondary Appraisals

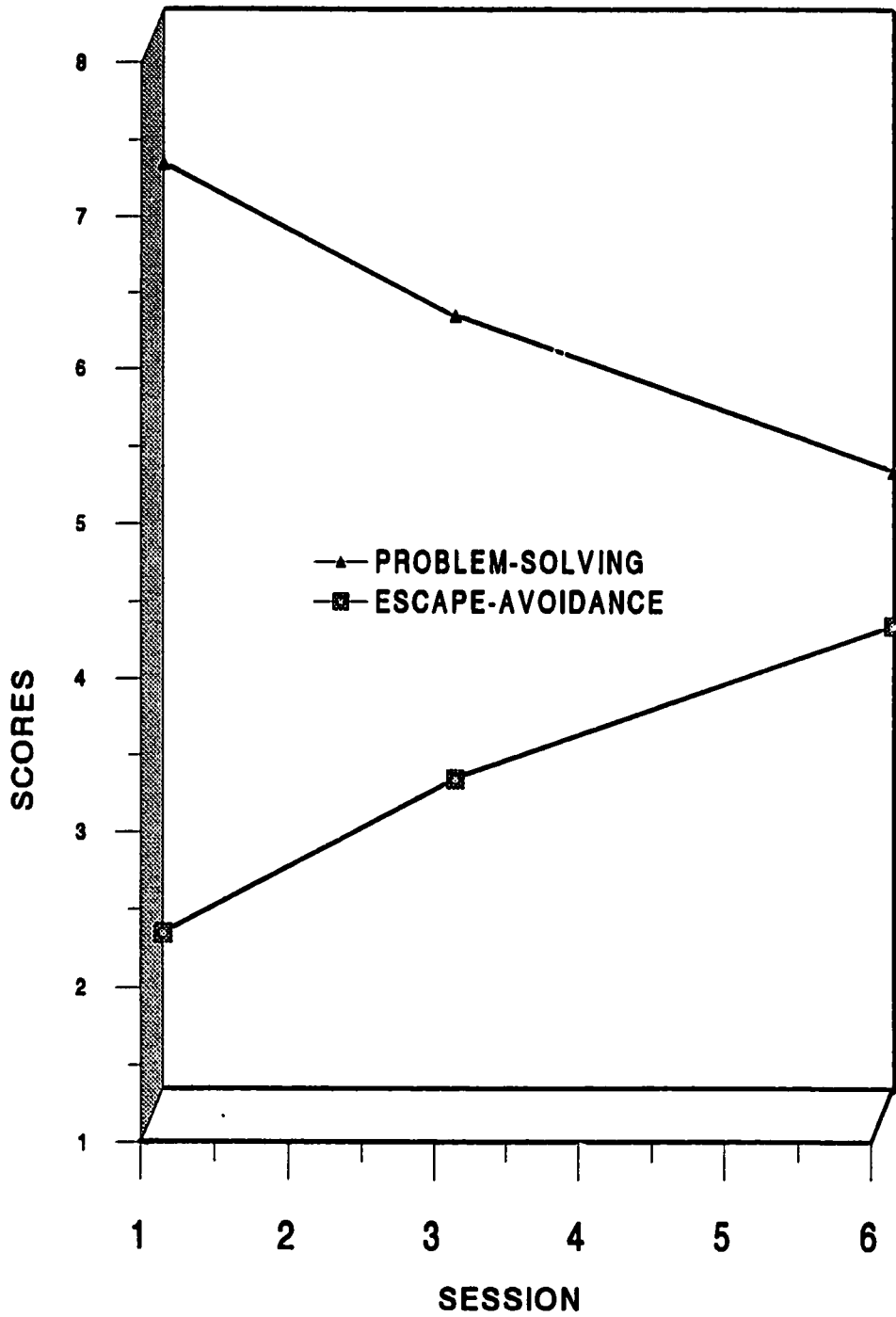


Figure 201. Instrumental Reminiscence Subject Five: Coping Responses

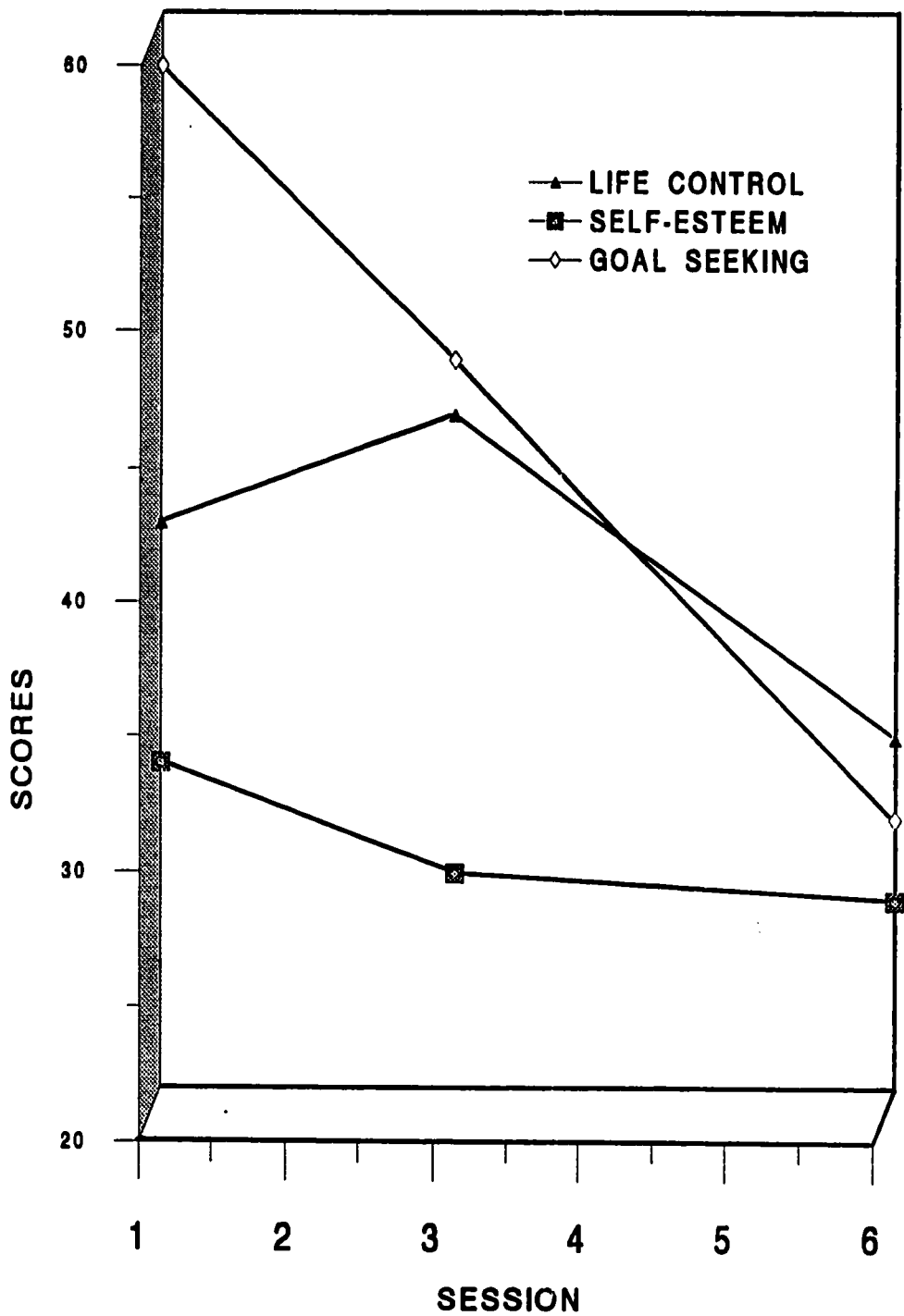


Figure 21l. Instrumental Reminiscence Subject Six: Coping Resources

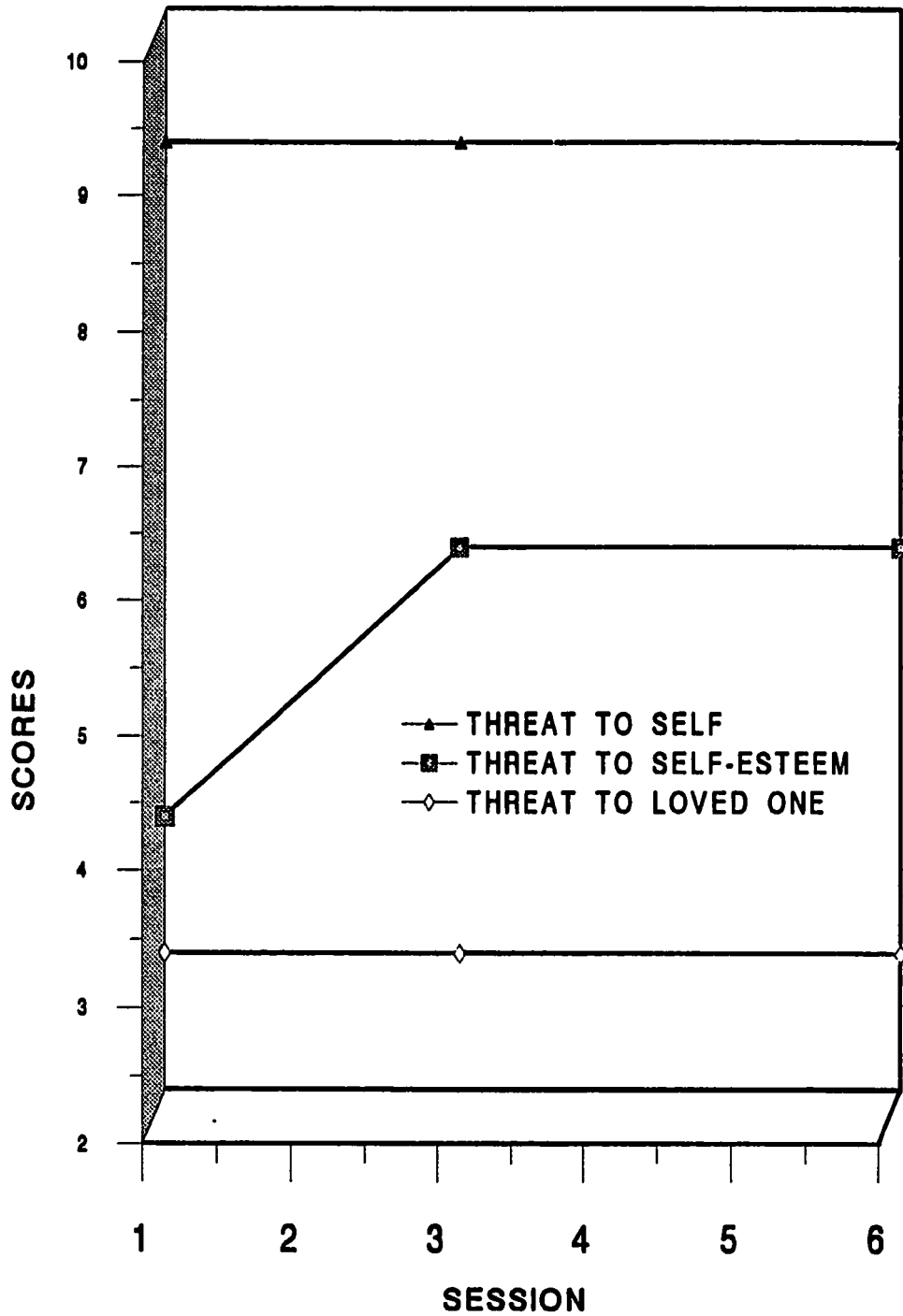


Figure 22i. Instrumental Reminiscence Subject Six: Primary Appraisals

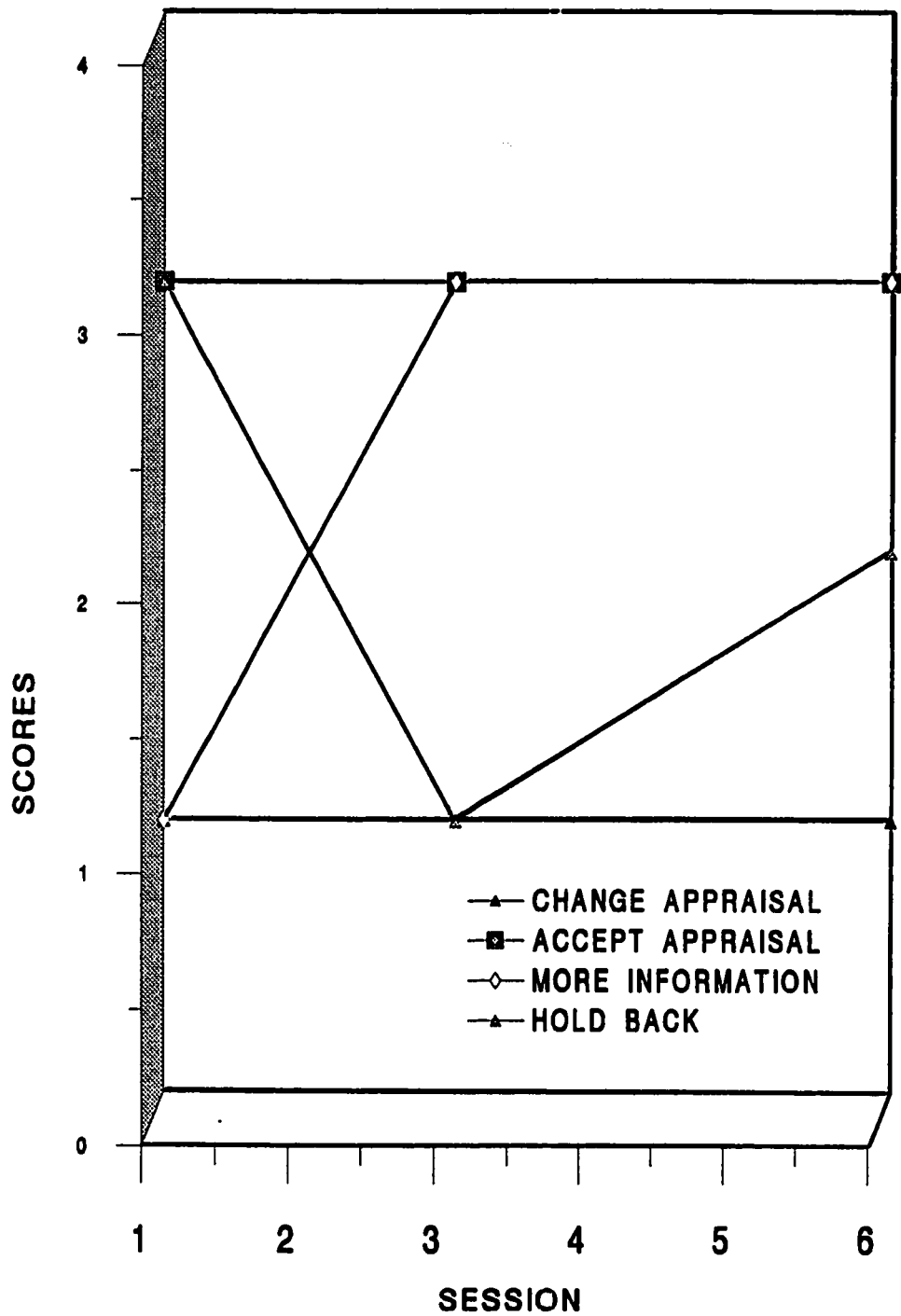


Figure 231. Instrumental Reminiscence Subject Six: Secondary Appraisals

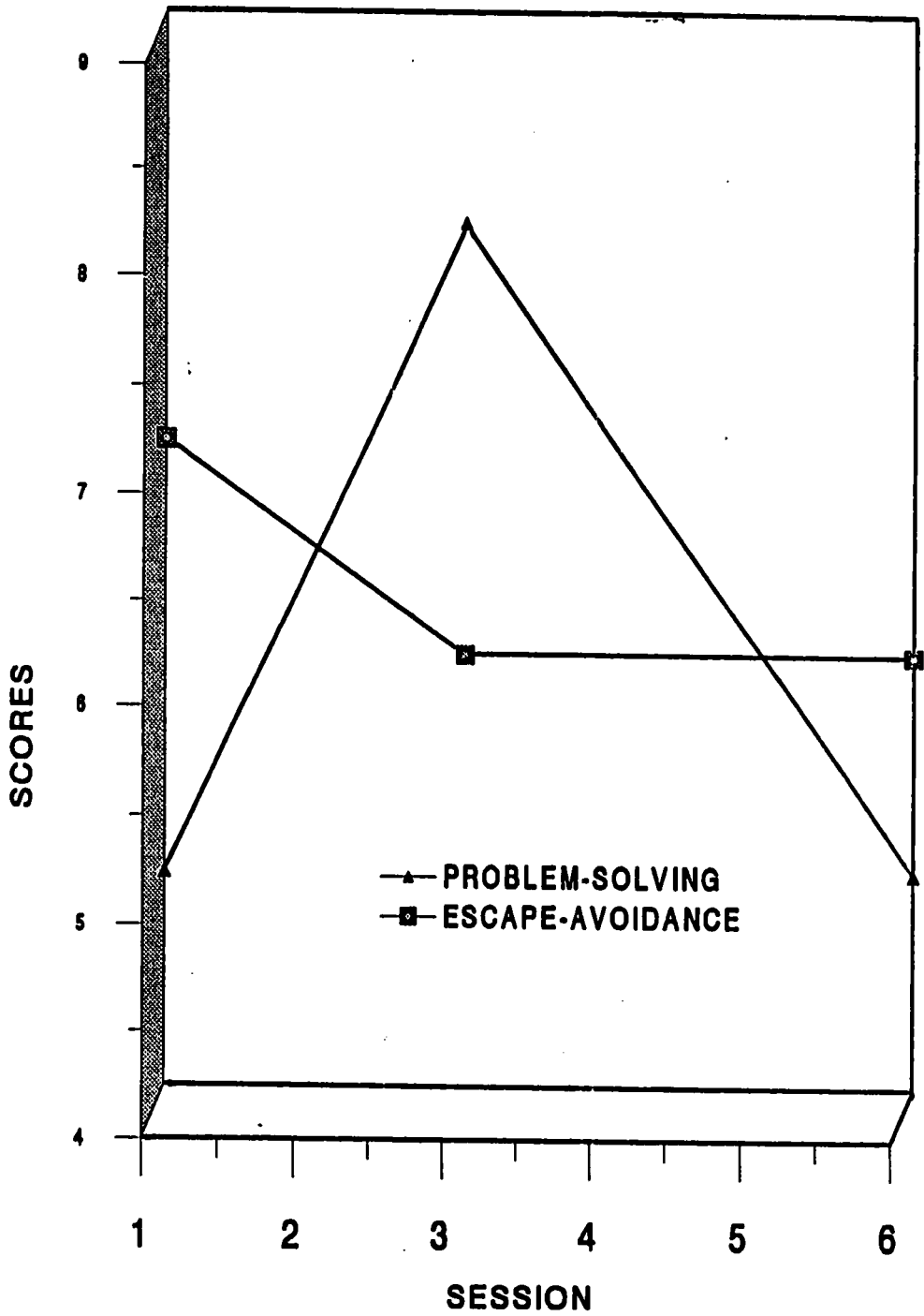


Figure 24I. Instrumental Reminiscence Subject Six: Coping Responses

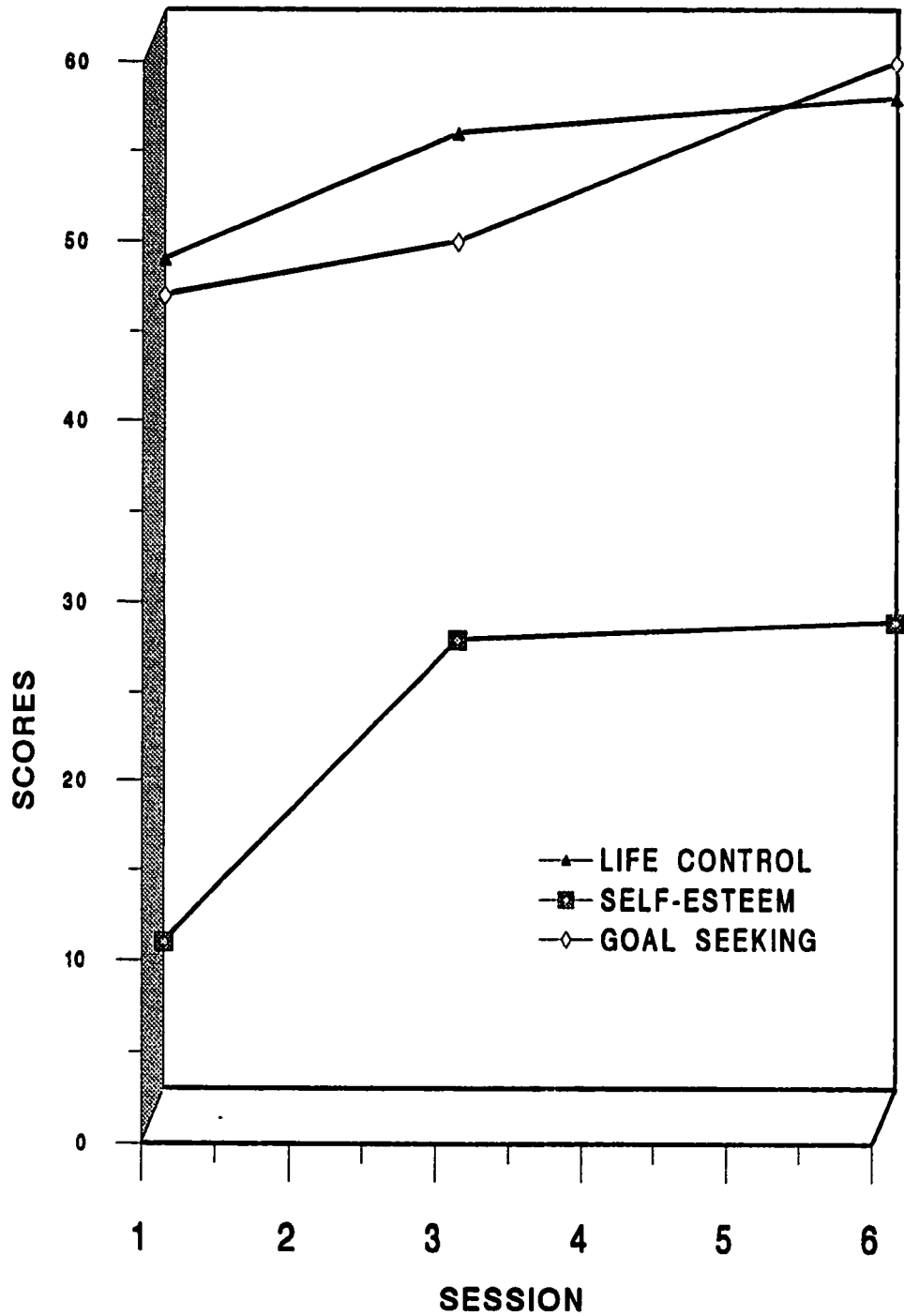


Figure 25I. Instrumental Reminiscence Subject Seven: Coping Resources

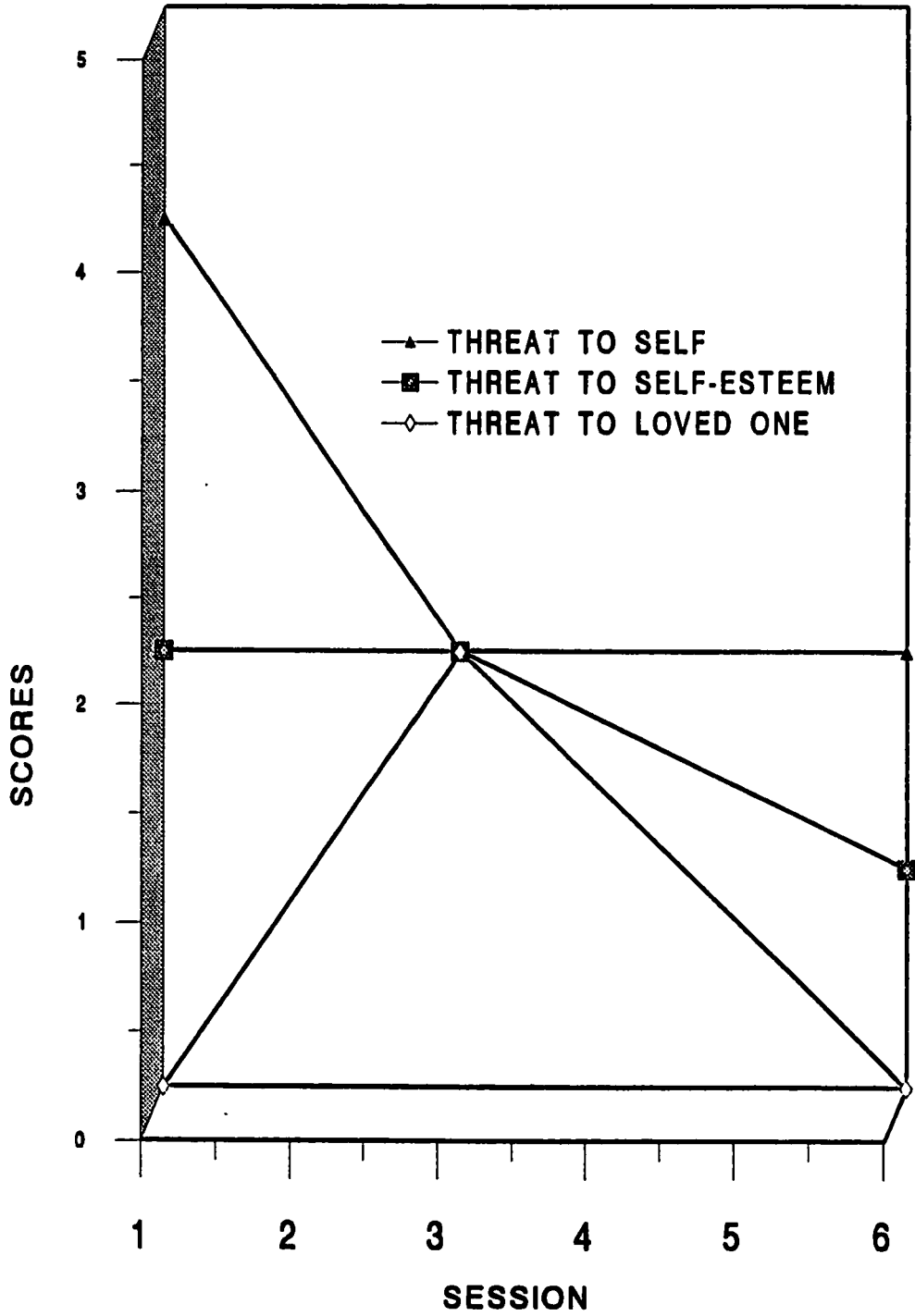


Figure 26l. Instrumental Reminiscence Subject Seven: Primary Appraisals

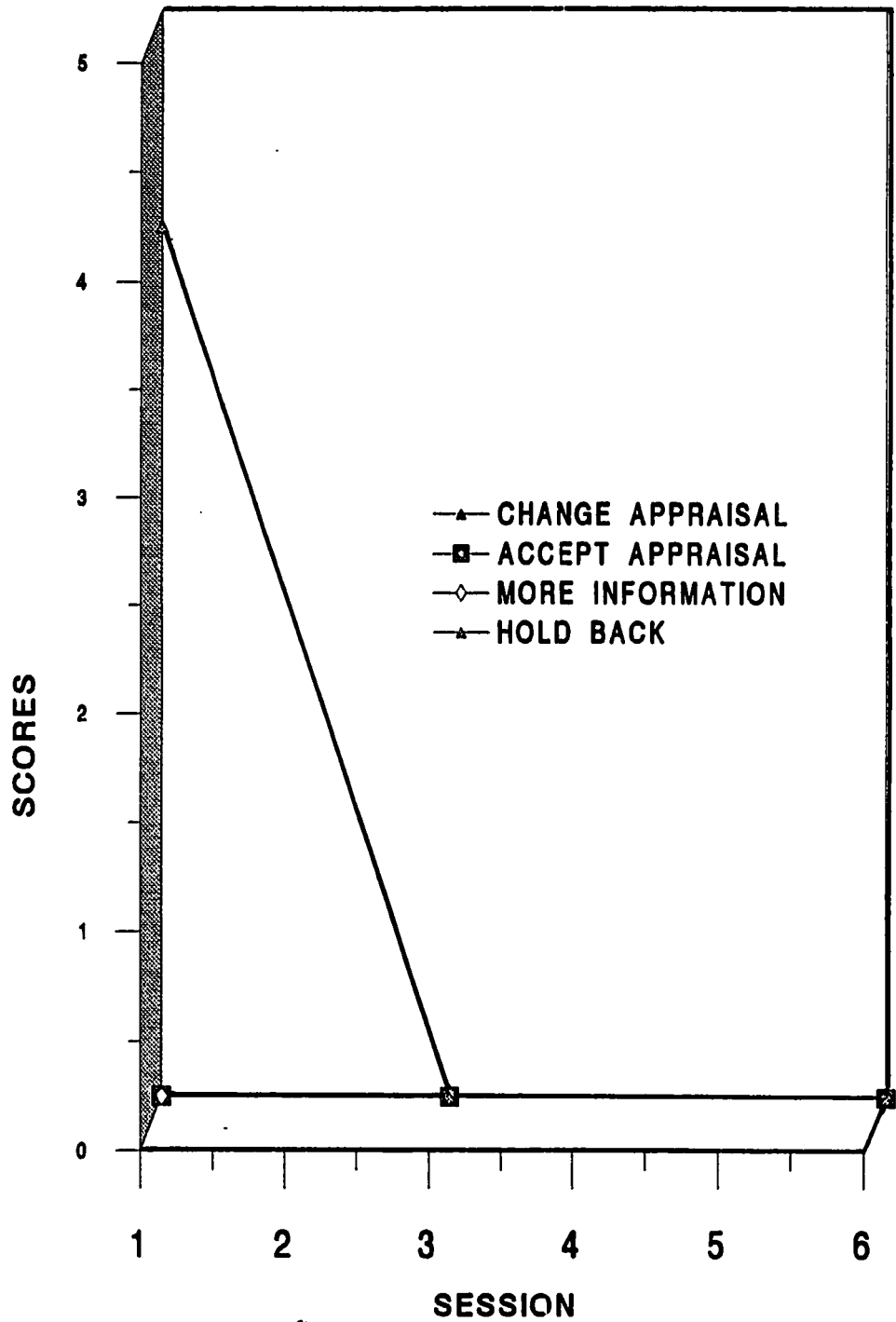


Figure 271. Instrumental Reminiscence Subject Seven: Secondary Appraisals

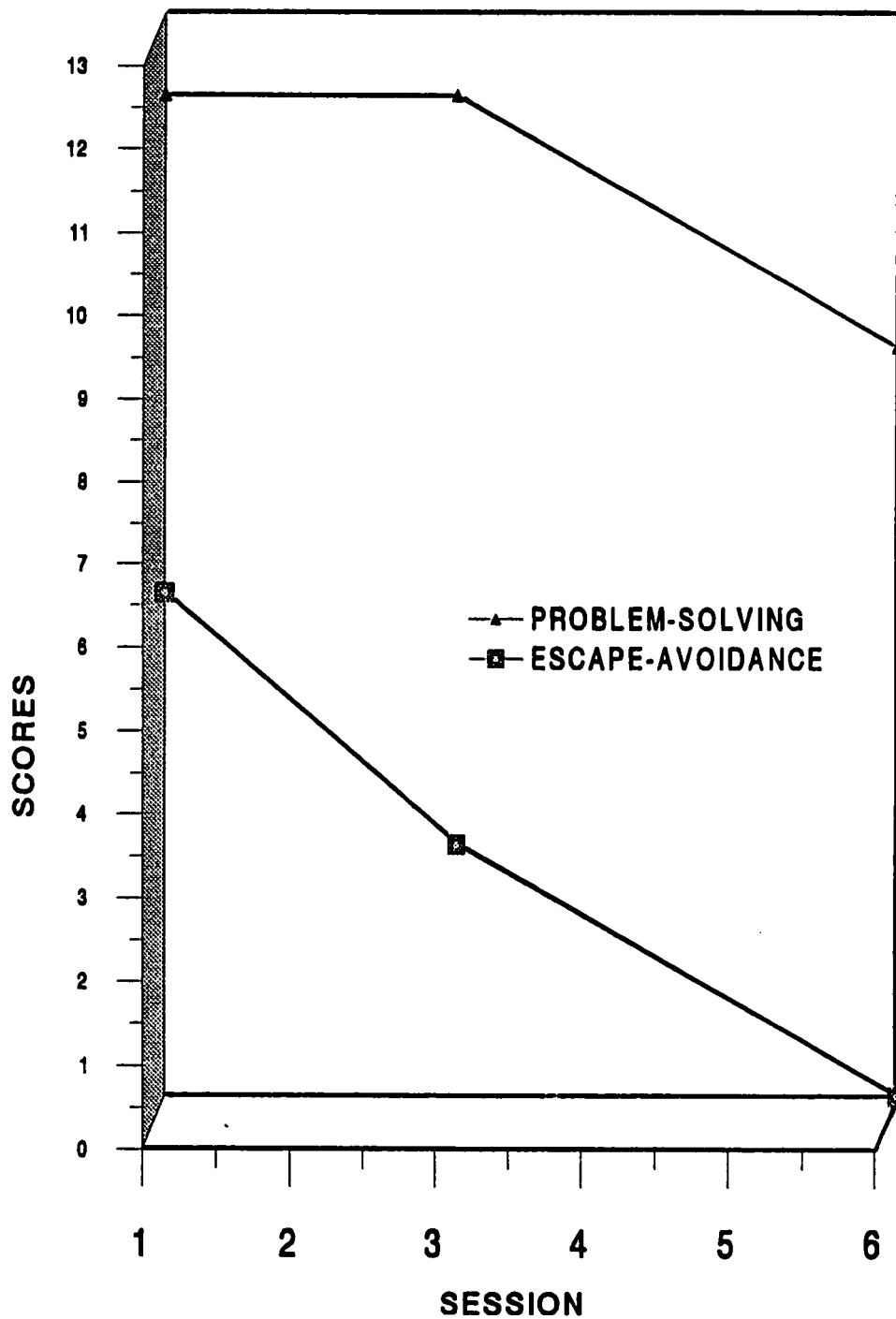


Figure 28I. Instrumental Reminiscence Subject Seven: Coping Responses

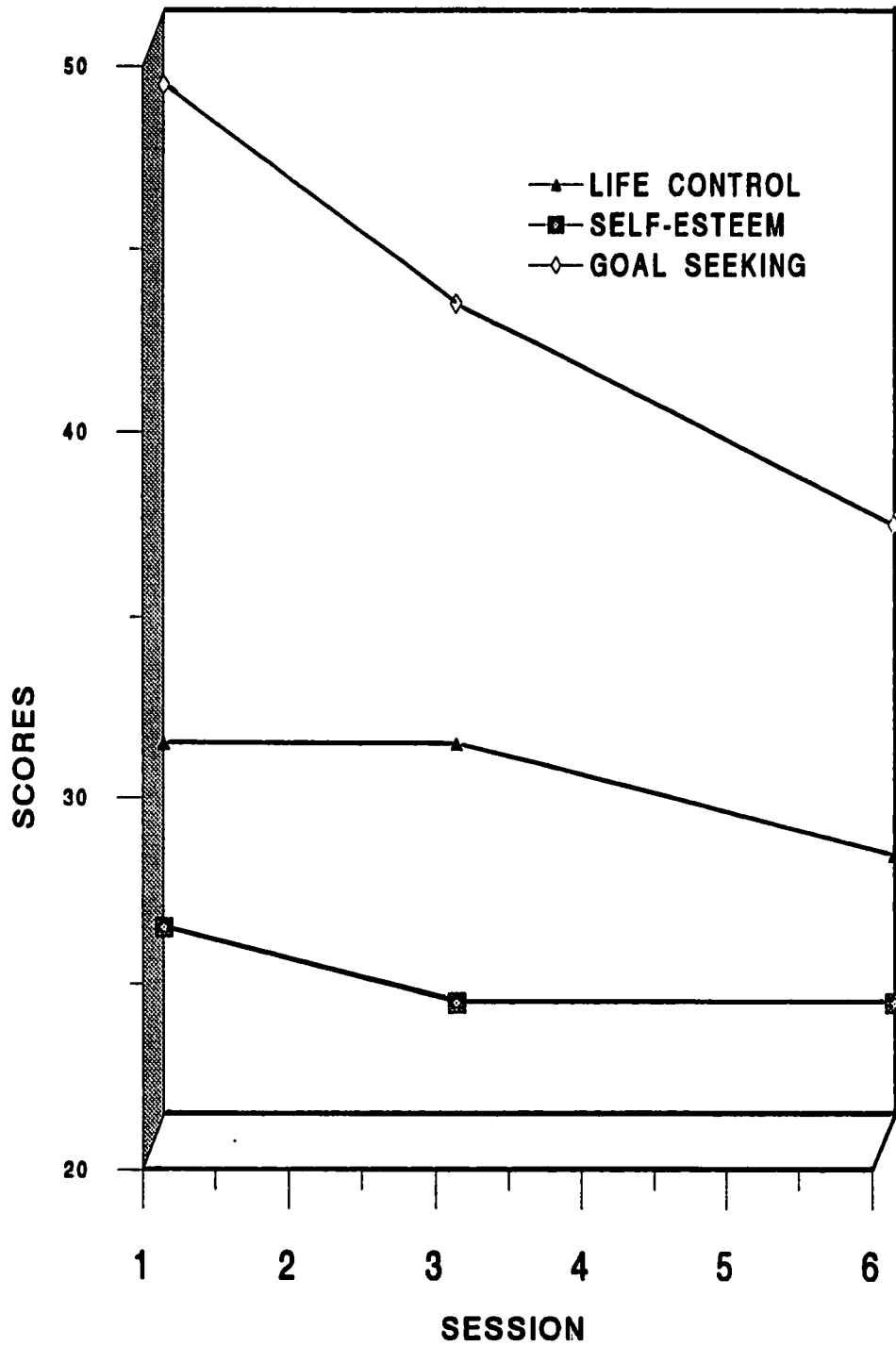


Figure 29I. Instrumental Reminiscence Subject Eight: Coping Resources

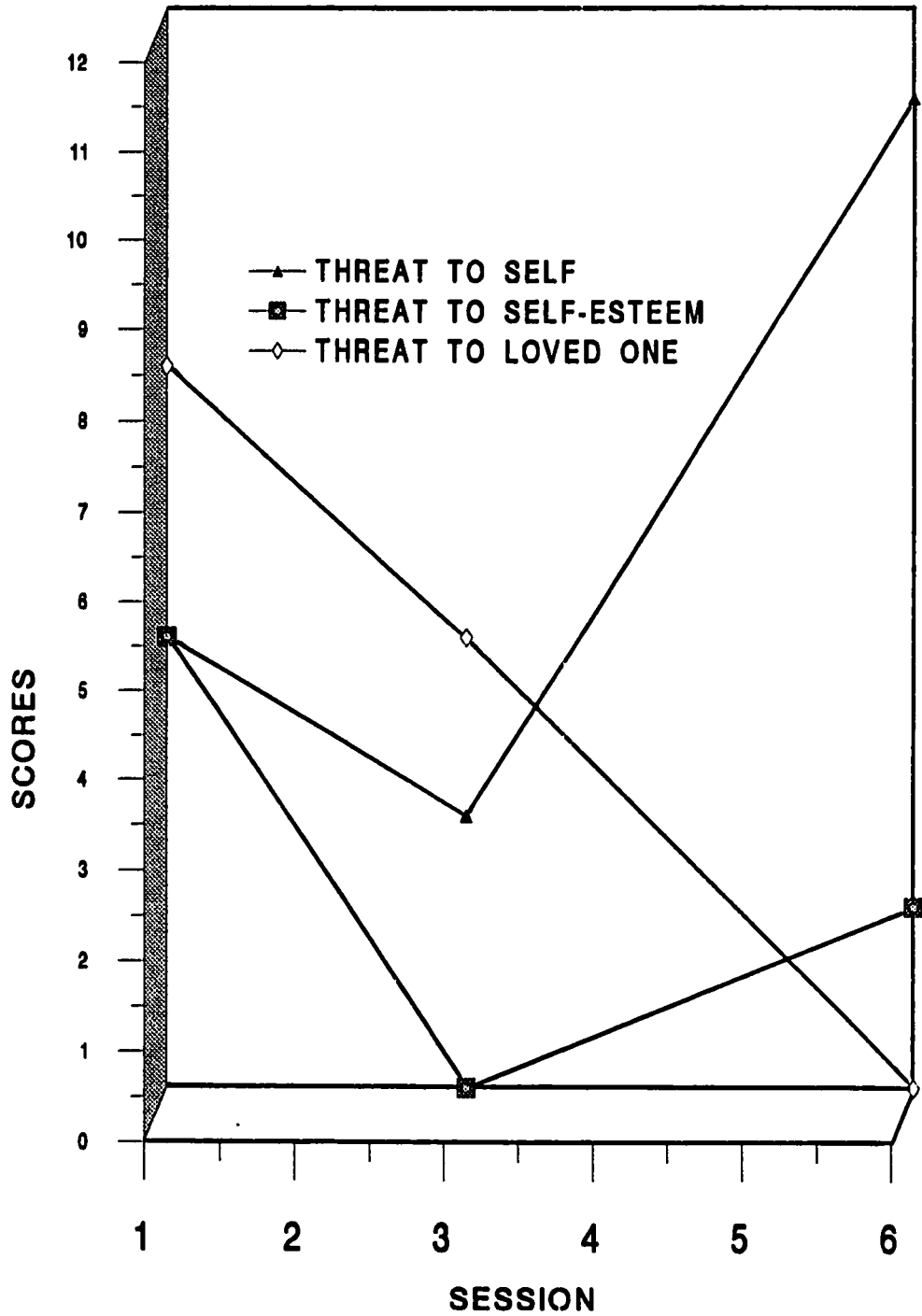


Figure 301. Instrumental Reminiscence Subject Eight: Primary Appraisals

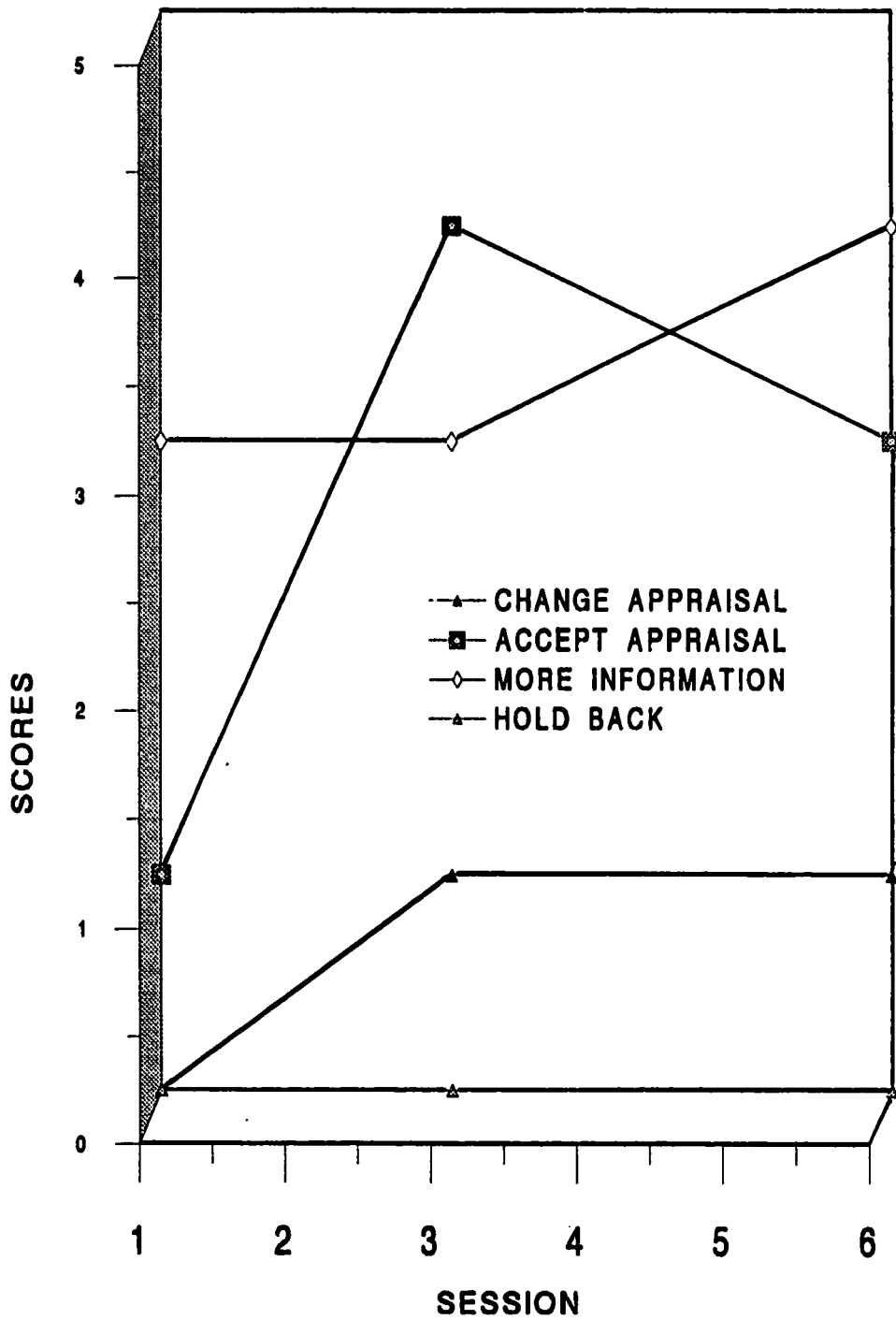


Figure 31l. Instrumental Reminiscence Subject Eight: Secondary Appraisals

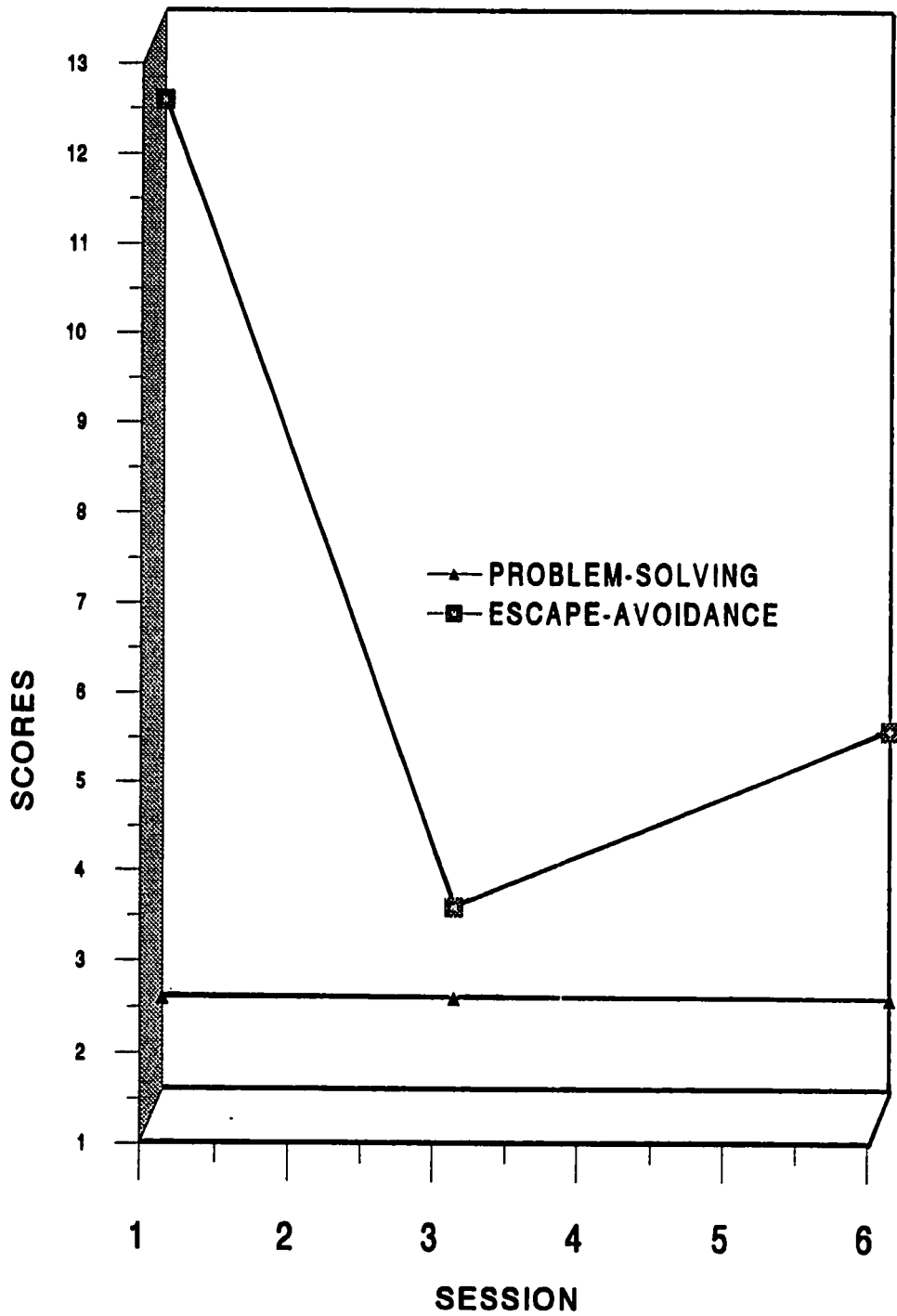


Figure 32I. Instrumental Reminiscence Subject Eight: Coping Responses

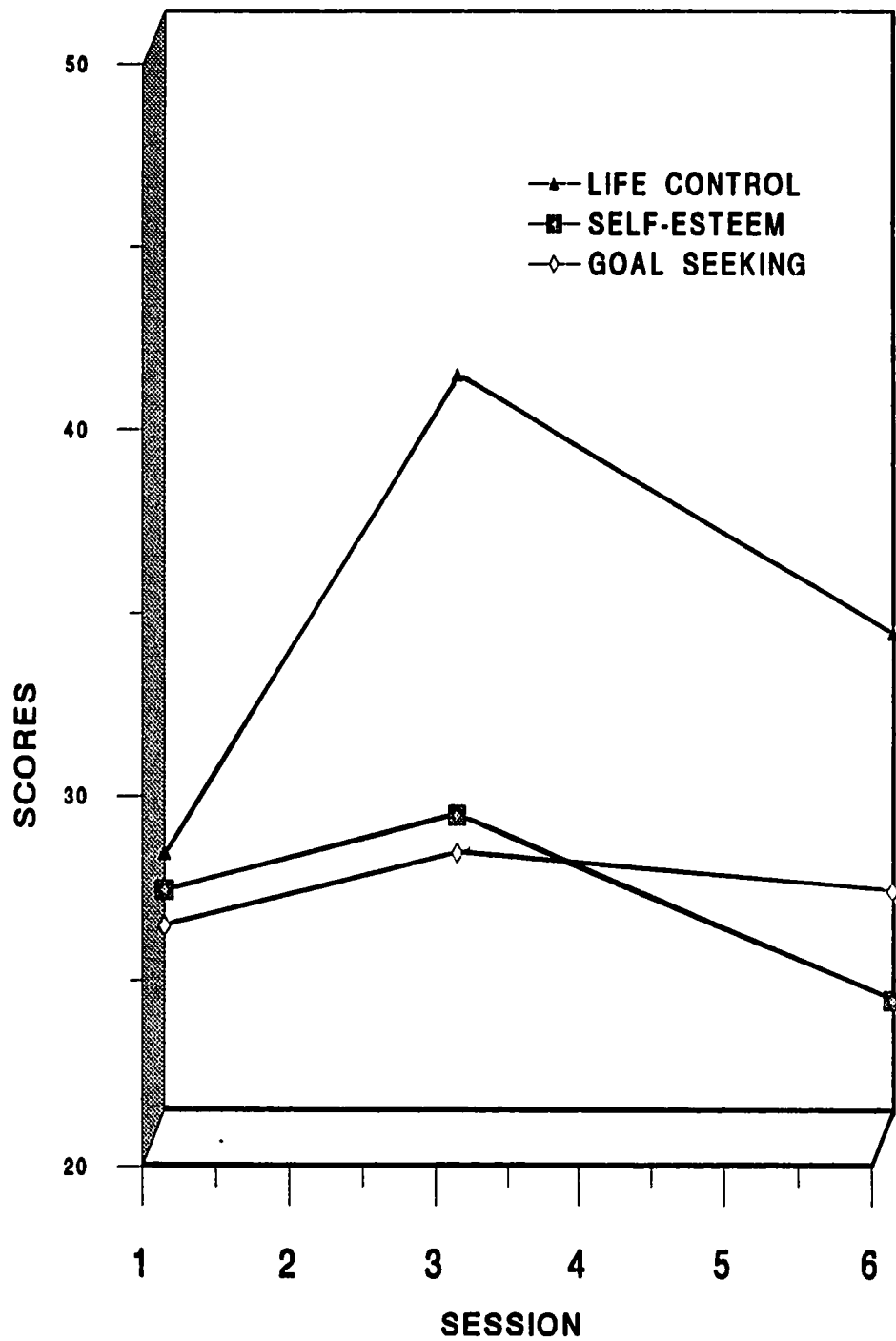


Figure 331. Instrumental Reminiscence Subject Nine: Coping Resources

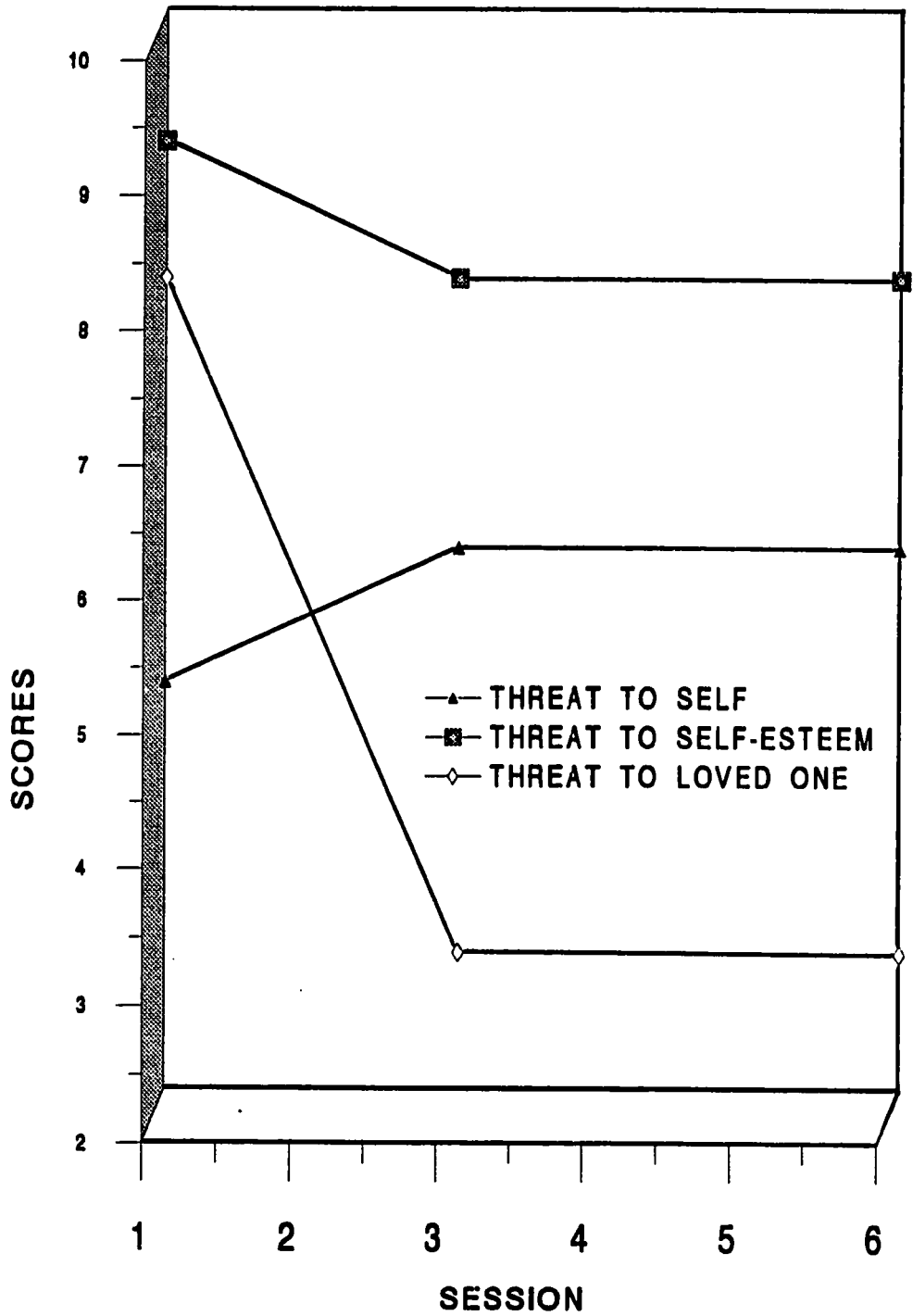


Figure 34l. Instrumental Reminiscence Subject Nine: Primary Appraisals

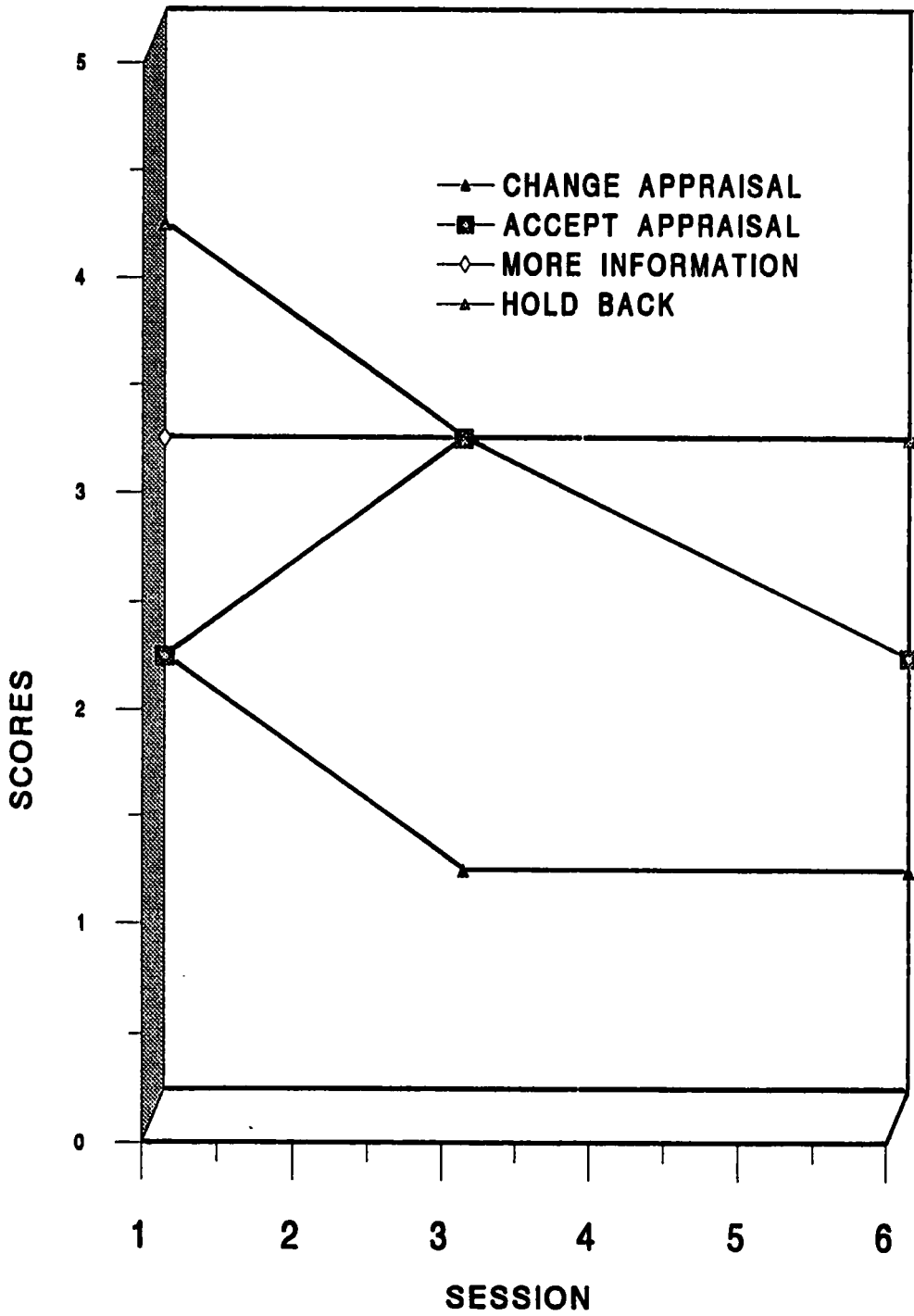


Figure 35l. Instrumental Reminiscence Subject Nine: Secondary Appraisals

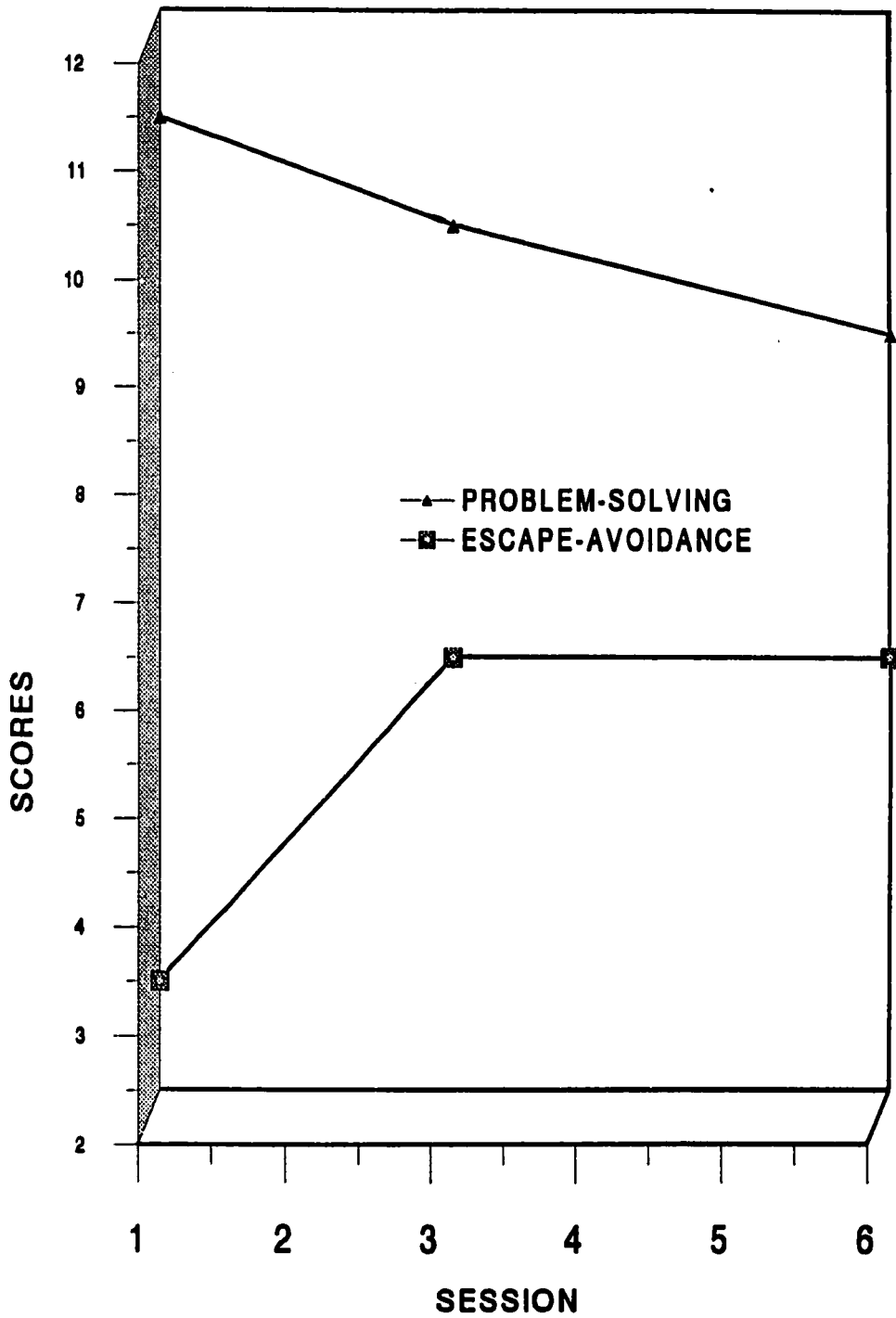
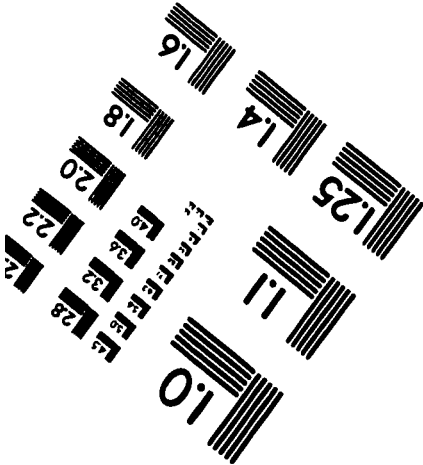
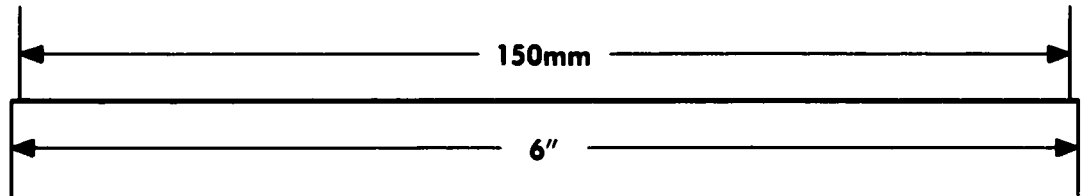
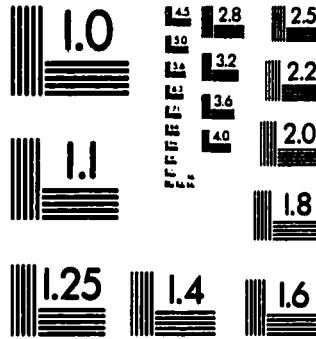
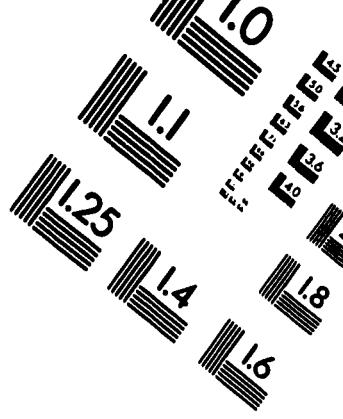
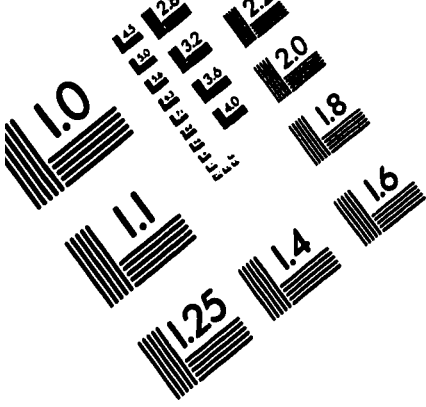


Figure 36l. Instrumental Reminiscence Subject Nine: Coping Responses



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