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Effectiveness of Structured Reminiscence Group Psychotherapy in Elderly Care

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Abstract

Background and objective: In the current social scenario, the growing elderly population is facing multifarious problems in the absence of proper care and attention by their family members, and others after their retirement. They are being shifted from the family environment to old age homes. It is a new set-up where this homogenous group in terms of the age can particularly avail care outside their family. The purpose of this study was to determine the effectiveness of Structured Reminiscence Group Psychotherapy (SRGP) in social work practice with the elderly.

Method: Sixty elderly persons aged 60–80 years were selected from two old age homes located in rural West Bengal, which were run by non-governmental organizations (NGOs) in the assistance with the Government of India. Half of them were randomly assigned to the experimental group and the other half to the control group.

Result and conclusion: In both the groups, the mental health of the elderly was found to be either very poor (26.6%) or poor (48.3%) during the pre-test. There was a significantly greater increase ($p< 0.001$) in the level of mental health for those who participated in the treatment group (SRGP) compared with those in the control group. Furthermore, there was a significant association on pre-test ($p < 0.001$) and post-test ($p > 0.05$) between level of mental health and educational level of the control group.

Keywords: Old age home; Reminiscence group psychotherapy; Mental health; Elderly; Family care

Introduction

The aging population is increasing globally. India too is witnessing a silent demographic revolution due to the steadily growing older population. Decline in morbidity rate, reduction in birth rate, and increase in life expectancy has led to an increase in elderly population. The size of India's elderly population aged 60 and above is expected to increase from 77 million in 2001 to 179 million in 2031, and further to 301 million in 2051 [1]. The proportion of population of elderly is likely to reach 12 per cent in 2031 and 17 per cent in 2051 [2]. At the global level, the population of those above 60 years is projected by the UN Population Division to increase from just under 800 million today (representing 11% of world population) to over 2 billion in 2050 (representing 22% of world population). World population is projected to increase 3.7 times from 1950 to 2050 [1].

The elderly face various problems such as: (a) physical fitness and health problems, (b) financial problems, (c) psychological problems and (d) problems of interaction in a social or family setting. Psychosocial and environmental problems include feeling of neglect, loss of importance in the family, loneliness and feeling of unwantedness in family as well as society, feeling of inadequacy and obsolescence of skills, education, and expertise. These aspects are somewhat eventually interdependent in nature; each aspect may affect the quality and quantity of the problems in all categories [3].

Undoubtedly, family is the best place for the elderly (after crossing the age of 60) to spend their later part of life) and their living arrangements with children and grandchildren would be most preferable for their happiness. However, when they cease to be functional, they may be viewed as a 'burden' upon the family and the community and ending up in old age home. So, their living arrangement is often shifted to an old age home, an institution for taking care of the elderly. In India, staying outside the family is considered humiliating by the elderly. The changing scenario towards a nuclear family (a family group consisting of a pair of adults and their children), the family contents only parents, son/daughter and grandchild (ren) has narrowed the living space of the elderly in the family because the study shows in urban or rural life the elderly population have their separate living space and there were altogether 356 old age homes in India [4].

One study showed that the most common reason for getting admitted in an old age home in Mumbai, India was family disharmony [5]. This same study showed that the main reason for being unhappy at the old age home was the boring, institutional life, insecurity, loneliness, and lack of psychological satisfaction.

The major developmental crises associated with aging include: dependence, isolation, illness, loss, retirement, and death. Persons who reminisce (recall past experiences) together may gain a sense of continuity between the past and present, gain deep insight into their past and present relationships, transmit their cultural heritage, and build self esteem. They may resolve conflicts and acquire a sense of life achievement, which increases their social interaction. Reminiscing may also preserve a sense of history and it may assist a person to solve their present problems by identifying past strengths. It is a method to cope up with the difficulties in life situation. A study conducted to provide therapeutic treatment through dealing with past losses, to recognize and appreciate inner resources and to find meaning in the significant past life events that shape the recent events [6].

It is believed that reminiscence is useful in periods of crisis, transition and high stress. Because of life's inconsistencies, losses, and shifting realities, reminiscence allows one to remove oneself mentally from the present and it creates significant meaning of the losses.

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Research reveals that reminiscence is effective to improve self-esteem and morale among institutionalized elderly [7]. Michelson (as cited by Burnside [8]) states that the technique of reminiscence as a nursing intervention can be easily learnt and be implemented in a nursing setting. Moreover, old age need not be a stage of alienation from society or oneself; instead, it can be a continuation of the process of life, growth, and experience.

Reminiscence or reviewing one's past life is a psychosocial intervention that can increase the holistic care to an elderly patient [8]. It is an independent therapeutic approach used in multiple settings to gain a sense of continuity between past and present, gain deeper insight into their past and present relationship, transmit their cultural heritage, and it helps to revive self-esteem [9]. It also helps to resolve conflicts and acquire a sense of life. The achievement increases social interaction and promotes a bridge of understanding between and within generations. Life review and reminiscence are often confused. Both use the past and both make use of memory. According to Erikson, human psychological development progresses in stages. Life culminates in the eight stages, that is "ego integrity versus despair", whereby individuals begin to weigh their past life and failures. Thus, old age is a time to resolve and reconcile prior to death. Reconsideration of past experience, missed opportunities, and mistakes help the aged to find meaning in their lives, integrate their life experience, reach integrity, and face death without fear. Successful resolution of conflicts is considered adaptive; the inability to resolve and accept the vicissitudes of one's past is judged as maladaptive [10].

Over a decade of descriptive research supports the notion that reminiscence is a component of the normal development processes as reminiscence increases ego integrity, and is linked with life satisfaction of the aged. The inability to reminisce has been linked to depression and poor adaption to relocation by McMohan and Rhudick [11] in their research. Other researchers have searched for a relationship between self-esteem and reminiscence. Researchers discovered that reminiscence favorably affects the self-esteem of the aged, allowing positive adaption to occur, and Erikson (Bulechek [10]), implied that the individual must reminisce in order to work through earlier life events and problems to achieve a consistent and positive evaluation of the past. Furthermore, researchers suggested that spontaneous reminiscing by older adults may be useful in putting their lives in perspective, proving that their lives have been worthwhile, and preparing themselves for death with minimum fear or anxiety. In another study, it was found that reminiscence reduces the sense of isolation and depression of aging [12]. Beaton [13] found that clients who are in a homogenous group may continue their identities and it validates their self-esteem through a shared past as an affirmation of "the good old days". Bramlet and Gueldner [14] designed an experimental study to investigate the usefulness of reminiscent story telling as a therapeutic modality to enhance the sense of power in elders aged 60–86 years. Subjects were post tested at the end of the reminiscence sessions and again after a five-week interval. Both experimental (n = 34) and control (n = 41) groups demonstrated a small, but significant increase in sense of power between pre- and post-test. Both groups then experienced a significant increase in power between post-test 1 and post-test 2. Researchers recommended that research energies should be directed towards the investigation of this topic.

Nugent [15] designed four case studies for patients to implement reminiscence effectively to mobilize coping resources to meet physical and emotional self-care demands by increasing self-esteem. The patients' medical diagnosis and nursing diagnosis showed pulmonary embolus and a left-sided cerebrovascular accident, metastatic cancer involving the lungs and bone, unstable angina, Kaposi's sarcoma, and pneumocystis pneumonia. In general, anxiety and alternation in comfort were the common nursing diagnoses among the four of them. The findings of the study indicated that reminiscence was an effective way of promoting self-esteem and enhanced coping that compensated for losses or self-care deficits in some situations. The researcher recommended that reminiscence might be used as a therapeutic modality for a wide range of nursing diagnoses to promote successful aging with the goal of attaining integrity and life satisfaction.

Social work as a sharing and caring profession intervenes the care of elderly through various techniques [16]. The Government of India has extended its social security program for the elderly of poor and backward community. The policy includes institutionalized care of the elderly through setting up old age homes in collaboration with non-governmental organizations (NGOs) under the "Integrated Programme for Older Persons". The scheme provides scope to the professional social workers to work with the elderly. The program provides food, shelter, healthcare, and other facilities to the elderly beneficiaries. No study has been found relating to SRGP for old age home residents in India as yet with regard to social worker intervention. The study was therefore designed to determine the effectiveness of the structured reminiscence group psychotherapy for elderly care.

Materials and Methods

Participants

Out of 100 candidates, sixty elderly subjects aged 60–80 were selected from two old age homes in rural West Bengal that were run by NGOs with government assistance. The inclusion criteria were age, intact cognition, memory and resident of the old age home for the last six months, and Bengali language as the mother tongue.

For the purpose of the study, an experimental pre-test– post-test control group design was chosen. Simple random sampling was done to select the subjects. Thirty of them were randomly assigned to the experimental group and the remaining 30 to the control group. The study consisted of two parts: Part I was the Demographic Data questionnaire, which included age, sex, education, marital status, and so forth; and Part II was the Mental Health Questionnaire (Appendix-A), which consisted of 20 items. Both positive and negative items were included in the questionnaires for the pre test and the post test. The majority of the items was adapted and modified from the following established scales : (i) OARS (Older Americans' Resources & Services) Mental Health Screening Questionnaire (Duke University, centre for the study of Aging, Durham, 1978) (Eliopoulos [17]), (ii) Multi Dimensional Observational Scale for Elderly Subjects (MOSES), [18]), (iii) The World Health Organization's Quality of Life 100 Questionnaire(WHOQOL Group, Division of Mental Health, n.d.) and (iv) The Sense of Coherence Questionnaire [19]. Out of 20 items, eight were negative in nature. For the Mental Health Questionnaire the total scoring for 20 items was 80(eighty). Each positive item was scored as: always -4; sometimes- 3; uncertain-2; rarely-1; and never-0. The negative items were scored in reverse order. The scores were divided into four categories, representing four levels of mental health: very good- from 61 to 80976-100%); good- from 41 to 60(51-70%); poor- from 21 to 40 (26-50%) and very poor- from 0 to 20(0-25%). To establish validity and reliability, a pilot study was conducted. For content validity, medical, nursing and research experts reviewed the tool. Several items were adapted from established scales. Sixty subjects completed the Mental Health Questionnaire as a pre-test prior to the

SRGP sessions. Of the 60, 43 completed the questionnaire, and 17 (9 in experimental group and 8 in control group) were interviewed by the researcher using the same instrument. The pre-test was administered on 29th April, 2012 to 60 subjects. On the first day of the SRGP session for both the morning and evening experimental group, the investigator briefly explained the topics for the 20 session. The sessions were held from 6th May, 2012 to 2nd June, 2012, every day except Saturdays and Sundays. There was no contact between investigator and the control group after the pre-test until the administration of the post test. The post test was administered to the 60 subjects from 5th June, 2012 to 9th June, 2012. The data were analyzed using descriptive statistics (percentage, means and standard deviation, etc.) and the simple *t*-test, the paired *t*-test and chi-square were also used.

Result

Demographic description of the old age home residents

The two old age homes had subjects with varied backgrounds and demographic characteristics. They were mainly admitted into the homes through referral services of the government and other agencies. From the study we find that the majority of the experimental group (30.3%) was under the age group of 76–80 years while in the control group, 36.7% were in the age group of 66–70 years. Both the groups were dominated by females; 80% and 73.3% in experimental and control group, respectively. Considering both the groups together, most of them were illiterate or had only primary level of education.

The marital status of the elderly in our study shows that they were widow(er) at large. Their economic status reveals that most of the male residents were daily laborers and the females were housewives. Due to lack of care and support from their families, a majority of them had chosen this institution. Secondly, the rate of elderly abuse was also high. Lastly, majority (43.3% of each group) of them had been in the old age home from 6 months to 2½ years.

Level of mental health in pre-test of old age home residents

Among 60 the subjects, 26.6% had a very poor level of mental health (Table 1; Figure 1). The majority (48.3%) of them had a poor level of mental health and 20% of them had a good level of mental health. However, only 5% of them had a very good level of mental health. The two groups were fairly comparable with respect to the level of mental health.

The difference in the level of mental health was not significant in pre-test (Table 2).

Table 3 shows the level of mental health as measured by the post-test. Here, the majority of the experimental group (63.3%) had a good level of mental health status while the majority of the control group (43.3%) had poor level of mental health (Figure 2).

There was a highly significant difference between the two groups on the level of mental health following SRGP (Table 4; Figure 3).

Table 5 and 6 show that there was no significant association in

Level of Mental Health	Experimental Group (*n* = 30)	Control Group (*n* = 30)	Total (*n* = 60)
Very Good	2 (6.6%)	1 (3.3%)	3 (5%)
Good	6 (20%)	6 (20%)	12 (20%)
Poor	16 (53.4%)	13 (43.3%)	29 (48.4%)
Very poor	6 (20%)	10 (33.3%)	16 (26.6%)
Total	30 (100%)	30 (100%)	60 (100%)

Table 1: Level of Mental Health of Old Age Home Residents in Pretest.

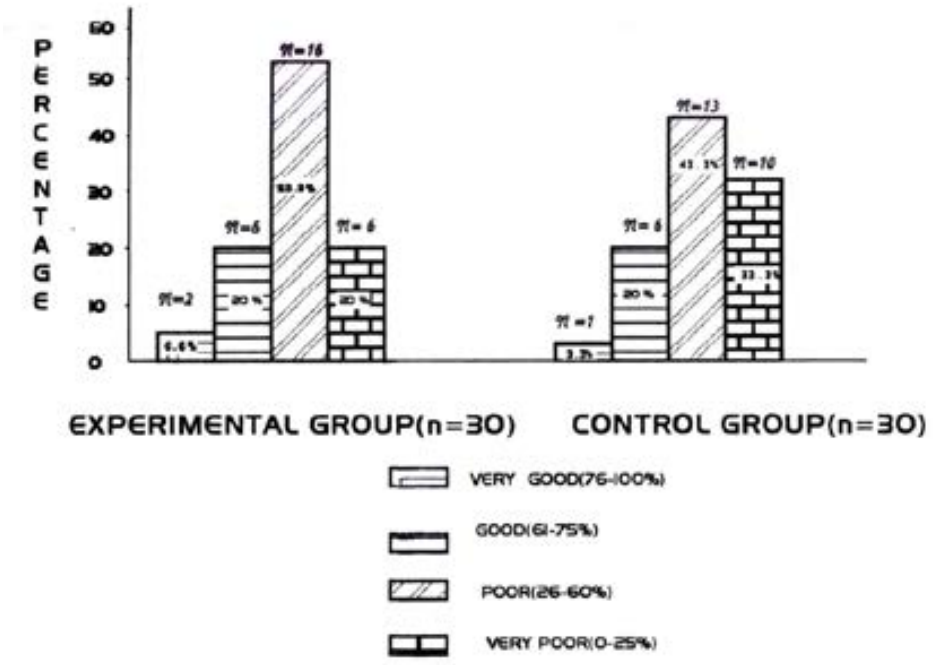

Figure 1: Level of Mental Health of Old Age Home Residents in Pre-test (*n* = 60).

Group	M	SD	t-test
Experimental	33.4	15.5	1.1 (NS)
Control	29.4	14.3	

Table 2: Difference between Experimental and Control Groups on Level of Mental Health of Old Age Home Residents in Pre-test.

Level of Mental Health	Experimental Group (n = 30)	Control Group (n = 30)	Total (n = 60)
Very Good	2 (6.6%)	-	2 (3.3%)
Good	19 (16.4%)	8 (26.7%)	27 (45%)
Poor	9 (30%)	13 (43.3%)	22 (36.7%)
Very poor	-	9 (30%)	9 (15%)
Total	30 (100%)	30 (100%)	60 (100%)

Table 3: The Level of Mental Health of Old Age Home Residents after giving Structured Reminiscence Group Psychotherapy (SRGP) (post-test).

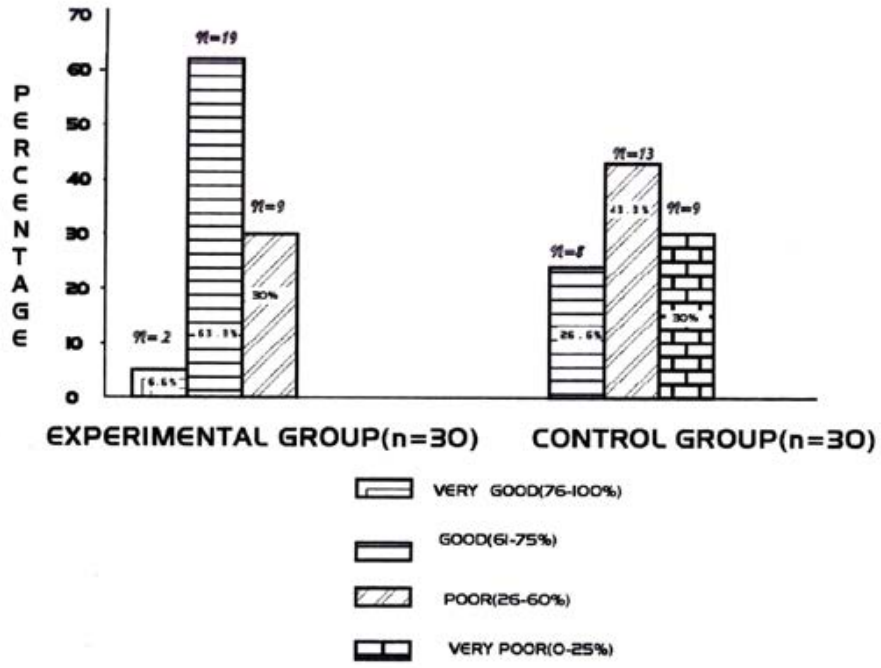

Figure 2: Level of Mental Health in Post-test among Old Age Home Residents (n = 60).

either pre-test or post-test between the levels of mental health and age in both the groups.

Table 7 and 8 show that there was no significant association on the pre- and post-test between the levels of mental health and other demographic variables (sex, educational level, and marital status) of the elderly in the experimental group.

From Table 9, we can see that there was a significant association ($p < 0.01$) on pre-test between the levels of mental health and their educational level in the control group.

There was a significant association on the post-test between the levels of mental health and their educational level in the control group.

However, there was no significant association on pre-test and post-test between the levels of mental health and selected demographic variables (age, sex, and marital status) of both the groups.

Discussion

The experimental study was conducted to determine the effectiveness of the structured reminiscence group psychotherapy on the mental health level of the elderly in institutionalized care. In the pre-test, out of 60 residents, 26.6% had very poor level of mental health and majority of them (48.3%) had a poor level of mental health. It was seen that 20% of the residents of the experimental group had very poor mental health and 53.3% had a poor level of mental health. Similarly, among the control group, 26.6% of them had a very poor level and 48.3% had a poor level of mental health.

In our study, majority of the subjects were female who were abused and had no one to look after them. There was a highly significant difference between the experimental group and control group following the SRGP on the levels of mental health. It was observed that after the daily SRGP, the old age home residents in the experimental group showed keen interest by usually asking the topics for the next session. The experimental group showed some improvement in their behavior, communication, interest, and expression. In relation to the effectiveness of the structured reminiscence group psychotherapy, there was no difference between the morning and the evening experimental groups. But the investigator observed that the afternoon group used to be a little passive to start the session initially (the first two to three sessions). The investigator had to stimulate them more in between; this was not much needed for the

Test	Experimental Group (n = 30)		Control group (n = 30)		t-Test
	M	SD	M	SD	
Pre-test	33.4	15.5	29.4	14.3	
Post-test	46.5	11.8	29.6	12.1	
Paired difference	13.1	10.8	-0.43	6.2	3.45*

Note: A one-tailed test was used to test the unidirectional hypothesis 0
*p < 0.001

Table 4: Level of Mental Health by Experimental and Control Group in Pre- and Post-Test.

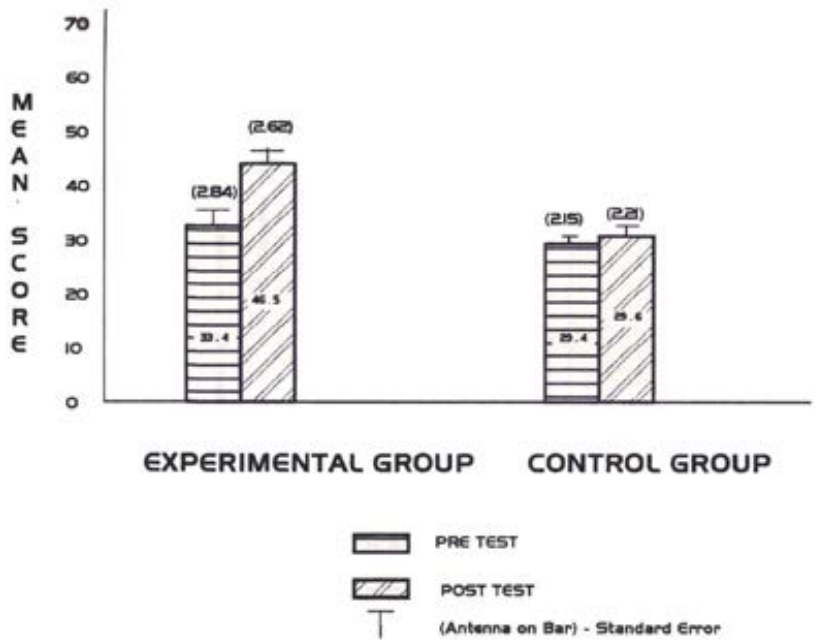

Figure 3: Mean Scores and Standard Error of Experimental and Control Group in Pre- and Post-test.

Age (in years)	Experimental Group			
	Pre-test		Post-test	
	Very good & Good (51–100%)	Poor & Very Poor (0–50%)	Very good & Good 51–100%)	Poor & Very poor (0–50%)
60–70	2 (6.7%)	10 (33.3%)	7 (23.3%)	5 (16.7%)
70–80	4 (13.3%)	10 (33.3%)	10 (33.3%)	4 (13.3%)
80 and above	2 (6.7%)	2 (6.7)	4 (13.3%)	-

Table 5: Association on Pre-test and Post-test between Levels of Mental Health and Age of Old Age Home Residents in Experimental Group.

Age (in years)	Control Group			
	Pre-test		Post-test	
	Very good & Good (51–100%)	Poor & Very Poor (0–50%)	Very good & Good (51–100%)	Poor & Very poor (0–50%)
60–70	5 (16.7%)	12 (40%)	5 (16.7%)	12 (40%)
70–80	2 (6.7%)	7 (23.3%)	3 (10%)	6 (20%)
80 and above	-	4 (13.3)	-	4 (13.3%)

Table 6: Association on Pre-test and Post-test between Levels of Mental Health and Age of Old Age Home Residents in Control Group.

morning group. But after the third session, the investigator did not find any difference between the morning and evening experimental groups.

It was found that there was no significant association on pre-test and post-test between the levels of mental health and selected demographic variables (sex, age, and marital status) of both the experimental and control group. There was no significant association on the pre-test and post-test between levels of mental health in the experimental group. However, there was a significant association on the pre-test (p < 0.01) and post-test (p < 0.05) between the levels of mental health and educational level of the elderly in the control group.

The investigator observed that, on the first contact, 70-80 years of age group residents were not taking such interest to initiate the session or discussion. They used to take much time to reflect on their thoughts before sharing with the groups. This problem was overcome when a good rapport was established between investigator and with this age group of residents.

Demographic variables	Experimental Group			t-test
	N	M	SD	
Sex				
Male	6	41.2	12.8	
Female	24	31.5	16.02	1.37 (NS)
Educational level				
Illiterate & Primary	20	33.3	15.9	
Above primary	10	33.9	14.9	0.09 (NS)
Marital status				
Unmarried	8	37.4	17.23	
Married, widow, widower and separated group	22	32.04	14.7	0.84 (NS)

Table 7: Association on Pre-test between Levels of Mental Health and other Demographic variables (sex, educational level, and marital status) of old age home residents in Experimental Group (n=30).

Demographic variables	Experimental Group			t-test
	N	M	SD	
Sex				
Male	6	51.2	10.01	
Female	24	45.5	11.8	1.09 (NS)
Educational level				
Illiterate & Primary	20	46.7	12.01	
Above Primary	10	46.6	11.9	0.02 (NS)
Marital status				
Unmarried	8	51.8	12.8	
Married, widow, widower and separated group	22	44.7	11.0	1.49 (NS)

Table 8: Association on Post-test between Levels of Mental Health and other Demographic variables (sex, educational level, and marital status) of old age home residents in Experimental Group (n=30).

Demographic variables	Control Group			t-test
	N	M	SD	
Sex				
Male	8	24.0	11.8	
Female	22	31.5	15.07	1.27 (NS)
Educational level				
Illiterate & Primary	22	25.7	12.8	
Above Primary	8	39.8	14.7	2.57**
Marital status				
Unmarried	6	24.0	10.2	
Married, widow, widower and separated group	24	30.8	19.2	0.83 (NS)

**$p < 0.01$

Table 9: Association on Pre-test between Levels of Mental Health and other Demographic variables (sex, educational level, and marital status) of old age home residents in Control Group (n=30).

Regarding observations by the investigator, the SRGP was a therapeutic tool to facilitate ego integrity through shared memories of significant events of a personal or historical nature. The orientation was always towards the older persons' sense of competence and the conviction that they had occupied a positive space in the history of the human race. The investigator observed universality, catharsis, group acceptance, verification and giving validity to the experience of one another during the reminiscence session. This was demonstrated during the session when the subjects shared their significant memories as a group. It was observed that day by day the memories of the group became more orderly and were expressed with more assurance and frankness. For the first one or two sessions, the investigator in his role as a leader acted as a 'catalyst' while simultaneously functioning as an accepting authority figure. Within those 50 minutes, there were a few requests for attention to physical needs (mainly urination). Later, this sort of request became very rare; even so, it used to be a problem to finish a session exactly within 50 minutes. The study found that once the subjects felt secure among the group members, they used to bring up their experiences concerning their immediate families, losses, displeasures and sorrows. Out of which tears used to come spontaneously sometimes, but it never used to be something bursting out (Figure 4).

Conclusion

The shared memories are developmental tools for the aged, which are a means of coping with the last stages of life. Exploration and elaboration of both pleasant and painful memories would be encouraged with historically significant places, persons and events. A social worker as therapist should encourage sharing significant life experiences. Underlying the group process, it is believed that every individual who is approaching the end of life needs to be able to see himself/herself as having contributed to history; it enhances a sense of dignity and integrity in the person.

To conclude, the level of mental health among the majority of the elderly in our sample was poor. SRGP is an effective social work intervention in such a setting to improve their mental health. There is

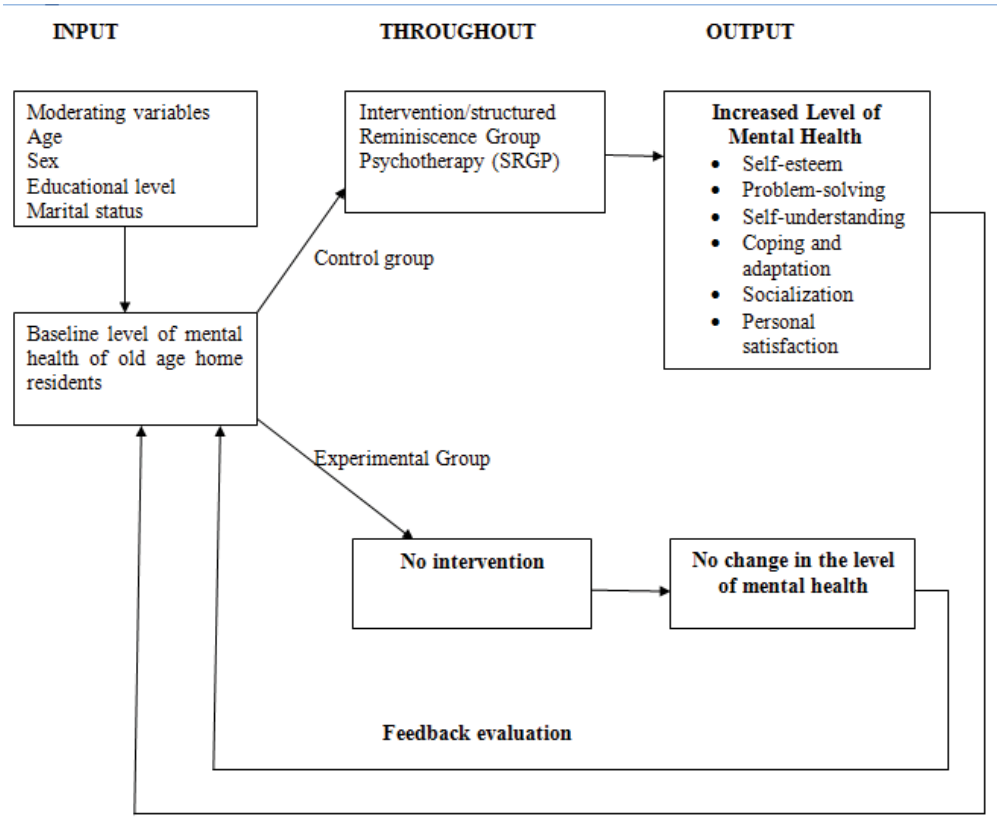

Figure 4: Impact of reminiscence group psychotherapy among old age home residents. It shows the impact of the SRGP in mental health of the elderly.

an association between the level of mental health and their educational level.

The following points need to be considered:

- SRGP can be adapted for other elderly institutionalized clients who minimize the meaning and importance of their existence. SRGP can be introduced there as a stimulating mode of intervention by the social workers.
- It is important that the social workers should be trained on SRGP with proper knowledge of intervention.
- Resources should be available to plan reminiscence activities, like reminiscence kits containing posters, pictures and memorabilia or social workers can develop their own kits to use in reminiscence therapy. Workbooks, song books and games can be developed to facilitate SRGP.

Today's contemporary high-tech world often allows only minimal human contact and a diminishing quality of life for the aged. Novel modalities such as reminiscence offer a human to human exchange, which may hold the key to this modern day challenge.

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