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REMINISCENCE, LIFE SATISFACTION, DEPRESSION, AND PERCEIVED HEALTH IN ELDERLY WOMEN: A DESCRIPTIVE STUDY

A Thesis

Presented to the

Faculty of

California State

University, San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Art

in

Psychology

----

by

Katherine DeWinter McGregor

July 1988

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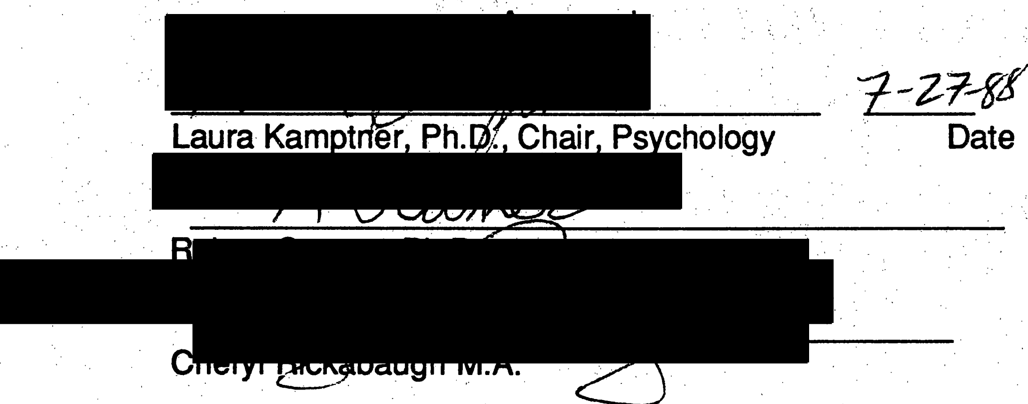

Laura Kamptner, Ph.D., Chair, Psychology — 7-27-88 — Date

Cheryl Rickabaugh M.A.

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ABSTRACT

The purpose of this study was to explore the impact of reminiscence on life satisfaction, depression, and perceived health. Subjects were 12 elderly Caucasian women who attended a structured reminiscence, unstructured reminiscence, or a non-reminiscence discussion group for weekly 75-minute sessions for four weeks. Due to the small sample size, nonparametric descriptive statistics were utilized. The results suggested that unstructured reminiscence tended to improve life satisfaction, depression, and perceived health. The only notable difference for structured reminiscence, on the other hand, was an increase in depression after the treatment. Although this report is descriptive, unstructured reminiscence, where subjects are permitted to reminisce in a non-structured setting, seemed to be more personally beneficial.

INTRODUCTION

A commonly held notion in our society is that reminiscence, the process of reviewing or dwelling on one's past, is a sign of intellectual deterioration in the elderly. An elder who engages in reminiscence is often derogatorily dismissed as being senile or experiencing his/her second childhood--shunned as being boring and engaging in meaningless babble. Research suggests, however, that reminiscence is actually beneficial and serves an adaptive function in the aging process.

Reminiscence, the act or process of recalling past experiences, is a complex phenomenon and it can take many forms. It can be private or public, directed or without direction, broad or narrowly focused, or entertaining or serious. All of us recall the past at times, sometimes in the simple form of daydreams, other times in purposeful retrospection (Havighurst & Glasser, 1972). Perhaps the earliest mention of reminiscence was more than a millenium ago by Aristotle (cited in Ross, 1927), who alluded to reminiscence and the elderly when he wrote about the aged living in a state of memory rather than a state of hope. Aristotle thought that elderly people lived in a hopeless state because they faced imminent death. Because of this, he thought, reminiscence could give them pleasure and help them cope with their futile state in life. This idea has prevailed for centuries, and it has more recently sparked the interest of psychologists. Reminiscence is a natural, adaptive developmental process in old age. However, unanswered questions remain as to which types of reminiscence are most beneficial, and which settings and conditions are most likely to facilitate this process.

Definition and Theories of Reminiscence

Current theories of reminiscence are based on the life-stage and disengagement theories of several developmentally-oriented psychologists and gerontologists. Jung (1934) proposed that the second half of life presents one with psychic tension regarding the meaning of life and personal accomplishments, which calls for one to review his/her past life and goals and thus reduce psychic imbalance and restore inner order. Linden and Courtney (1953) also proposed a stage theory using the process of life review, and suggested that towards the end of the senescence stage of the life cycle one is faced with the conflict of making sense of life. In order for this conflict to be mastered, he suggested that one must rely on the process of reviewing his/her past life. Erikson (1959), in his eight-stage developmental theory, theorized that in late adulthood one is faced with resolving the crisis of ego-integrity versus despair. According to Erikson, the awareness of death creates a need in the elder to review and evaluate his/her life experiences. To exercise this activity will enhance the quality of his/her present life, whereas if one does not do this, it could lead to despair.

Other stage theorists have also contributed to the theoretical framework of reminiscence. Buhler (1959) examined hundreds of life histories, and through careful investigation concluded that the human condition consists of a basic structure that must utilize the process of life review as a tool to aid in development. This is achieved by the realization and assessment of goals. More recently, Levinson (1978), utilizing a psychoanalytic perspective, proposed a developmental theory that identified and described transitional periods in adult life. He contended that, prompted by an awareness of one's mortality, the midlife transition presents a need to reappraise the past in order to determine the meaning for the present and the future.

Although the developmental stage theorists developed the ground work for reminiscence and life review, it was Butler (1963) who offered the most

detailed and direct account of this process. Butler does not consider life review and reminiscence to be synonymous-- rather, he defines life review as a:

> ....naturally occurring universal mental process characterized by the progressive return to consciousness of past experience...prompted by the realization of approaching dissolution and death, and the inability to maintain one's sense of personal invulnerability. (p. 66)

Therefore, the life review includes reminiscence and consists of both pleasant and unpleasant aspects of one's past life experiences. Reminiscence is the mechanism that assists in the life review process.

Several investigators have attempted to clarify the concept of reminiscence by defining various "categories" of this process. McMahon and Rhudick (1964), for example, conducted a private one-hour interview with 25 non-institutionalized war veterans between the ages of 78 and 90. They identified three categories of reminiscences: 1) storytelling, which enhances self-esteem through pleasurable recall and does not glorify or berate the present or the past, 2) informational, which is more objective and provides information for life review, and 3) defensive, which is anxiety associated in that the reminiscer tends to depreciate the present and glorify the past. Through a different investigation which measured spontaneous conversation of elders living in supervised housing, Coleman (1974) observed three types of reminiscences: 1) simple, which involves recalling of past life experiences, 2) informative, which is used to teach others or convey information, and 3) life review, which was related to measures of past and present adjustment. Finally, LoGerfo (1980) more recently defined three types of reminiscences which included: 1) informative, which involves pleasure of retelling the past, 2) evaluative, which is similar to Butler's life review, and 3) obsessive, which manifests guilt and defense

against an ungratifying present life. In sum, the content and intention may vary in reminiscences, perhaps in accordance with individuals' varying needs, motivations, and personalities.

Reminiscence and Adaptation

Frequency of Reminiscence Three studies have addressed the "frequency" dimension of reminiscence in an effort to determine the amount of time that would be most beneficial for one to engage in reminiscence. Havighurst and Glasser (1972), for example, designed a questionnaire in an attempt to describe content, frequency, and function of reminiscence in the elderly. They found a positive relationship between the frequency of reminiscence and social adjustment for those that engaged in oral or silent reminiscence. Further, they concluded that no single variable was highly correlated with the frequency or affective quality of reminiscence. Romaniuk (1978) studied subjects over the age of 62, and compared low frequency and high frequency reminiscers. He found a positive effect for high reminiscers and social adjustment. Finally, Merriam and Cross (1982) found that all adults reminisced regarding events in their past life, and older adults reminisced more frequently and gained more satisfaction from the experience compared to younger adults.

Reminiscence and stress. Two studies explored the relation between reminiscence and the ability to adapt to stress. Lewis (1971) proposed that reminiscers would adapt more readily to stress when faced with a socially-threatening situation. Using a measure of past and present self-concept, he studied 24 men over the age of 65. He found a high positive correlation between self-concept for those individuals who tended to reminisce. In a different study, Lieberman and Falk (1971) tested the adaptive function of stress and considered age-related content of reminiscence. They studied three different samples of aged individuals: those in institutions, those living in the community, and those waiting to enter homes for the aged. The investigators sought to compare age differences, degree of importance, types of reminiscence, the kinds of memories reminisced about, and the

organization of memories. The findings indicated that older people were more interested and involved in reminiscence than younger people, and viewed reminiscence as a personally satisfying experience. Further, they found that aged subjects waiting to be admitted to senior homes reminisced more than the other elderly subjects. Younger people, on the other hand, thought that young people reminisced simply as a function of problem solving. The investigators concluded that reminiscence aids in the process of adapting to stress.

Reminiscence and grief. Other researchers have linked reminiscence to the grieving process as a method for coping with loss (e.g, Parkes, 1970). Lindemann (1965) studied survivors of the Coconut Grove Fire and found that they spent a substantial amount of time mulling over the events, relationships, and losses of the experience. Castelnuovo-Tedexco (1980) observed that reminiscence was functionally analogous to the mourning process, in that during times of grief people reminisce in a reflective self-absorbed manner as a means of relinquishing their losses. Pincus (1970) also found reminiscence to be effective for resolving grief and other intrapersonal adjustments. His findings indicated that obsessive reminiscence was most often experienced when one's present life was not gratifying. Finally, in their survey of three large groups of well-educated middle-class elderly, Havighurst and Glasser (1972) suggested that reminiscence was used to cope with serious loss.

Reminiscence Therapy

Treating psychiatric patients. Reminiscence therapy has been effective in treating patients in a psychiatric setting. Liton and Olstein (1969) and Hellebrandt (1978) encouraged reminiscence for their senile dementia patients and found that the treatment promoted a higher degree of self-respect and self-awareness. Unfortunately, although these studies objectively documented positive effects, both lacked internal validity because they did not utilize control group comparisons.

Goldfarb (1969) studied nursing home patients with varying degrees of brain damage. She concluded that, since the most common symptom of brain damage is recent memory deficit, reminiscence utilizes the impaired patients' strongest cognitive asset, which is his or her past memory. Positive results were reported, in that patients were more verbal and enthusiastic about group activities. Lazarus (1976), in a different study, conducted an experiment with the elderly from a private psychiatric hospital. He encouraged them to talk about the "good old days" and found that the experience alleviated depression and promoted pride in past accomplishments. Lesser, Lazarus, Frankl, and Havasy (1981) noted several improvements in a group experience of reminiscence when patients were asked to switch the conversation to issues of the past. More specifically, patients demonstrated greater alertness, increased animation, increased inter-member communication, and mute members spoke more spontaneously. Further, they found that recalling negative or sad past experiences proved to have a positive effect on self esteem. These studies collectively support the notion that there are benefits derived from reminiscence, at least in clinical populations. Finally, Boylin, Gordon, and Nehrke (1976) questioned 41 elderly institutionalized veterans and devised a scale to assess ego-integrity. They defined ego integrity in concordance with Erikson's crisis of ego integrity versus despair and found a positive relationship between the amount of reminiscence and ego integrity. That is, the more one reminisced, the higher one scored on ego adjustment.

Treating the "healthy" elderly: individual versus group settings. Reminiscence therapy has been tested in group as well as in individual settings (i.e., where the leader works with one person at a time). Several investigators who have utilized the private interview technique have reported positive effects of reminiscence therapy. For example, McMahon and Rhudick (1964) interviewed 25 war veterans ranging in age from 79 to 90, and found that the respondents who engaged in reminiscence were

less depressed and better adjusted than those who did not. They also noted that reminiscence enhanced their self-concept, improved self-esteem, and helped the subjects deal with the anxieties of aging. Fallot (1979), in a different study, compared the effects of reminiscence and non-reminiscence by spending three individual one-hour sessions with 36 subjects ranging in age from 36 to 85. Half of the time was spent in reminiscence while the other half of the time was spent in non-reminiscence discussion. Self-ratings of mood were obtained before and after the final two sessions. The participants' moods were also rated by the hypothesis-blind experimenters. The findings indicated that the reminiscence experience resulted in a decrease in reported anxiety, a decrease in depression, and a lowered fatigue rating.

Several studies have applied reminiscence therapy in group settings and found similar positive results. Ingersoll and Silverman (1978) studied 17 subjects in two psychotherapy groups and assessed anxiety, self-esteem and somatic complaints. In one condition, the "Here and Now Group", the focus was on coping strategy and progressive relaxation. It also included modeling, reinforcing and role-playing. In a second condition, the "There and Then Group," the major focus was on reminiscence and the life review process. The subjects were encouraged to keep journals about their memories. A pretest and post-test was administered and progress notes, reported by the investigator, were evaluated for each session. The findings indicated a significant improvement on somatic behavior for the "There and Then Group." No other differences were significant, but most members of both groups improved by their experience in therapy whether it included reminiscence or not.

Scates (1986) also experimented with the group application of reminiscence therapy. She randomly assigned 50 subjects to one of three groups in an attempt to measure trait anxiety, state anxiety, and life satisfaction. The three groups included a reminiscence group, an activity group, and a cognitive-behavioral therapy group. Each group met for one-

hour sessions, twice a week, for three consecutive weeks. They found an improvement in state anxiety for the reminiscence group.

In sum, studies on reminiscence in both group and individual settings have proven to be effective in terms of enhancing one's self-concept, increasing one's self esteem, reducing anxiety, decreasing depression, and improving somatic behavior.

Structured verses unstructured setting. Based on the theoretical framework of Butler's life review process, experimenters have concentrated their efforts on the exploration of structured, or guided reminiscence. Through a private interview technique, Haight (1984) provided structured reminiscence therapy to six non-institutionalized subjects, age 60 and older. The treatment group was compared to a control group. The experimenter visited the subjects individually in their homes six times within a 30-day period. The subjects in the treatment group were initially given a copy of a life review and experience form that was designed by the experimenter to aid in the subject's review. This form was used as a structured guide to investigate the subject's life review process. A pretest and post-test measure of life satisfaction was administered to both groups and the results indicated a significant increase in life satisfaction for the treatment group. There was, however, a problem with the design in this experiment. The subjects in the control group were visited for 20 to 40 minute sessions, whereas the treatment group subjects were visited for 60-minute sessions. Although the authors proposed that this design controlled for the variable of "significant other", there was a potential threat to validity since the subjects in the control and the treatment did not receive the same amount of time, (e.g., Rosenthal & Rosnow, 1984).

Fry (1983) also used a structured format for reminiscence in an individual therapy format. She studied 162 depressed elders between the ages of 65 and 96, and divided them randomly into three groups: structured reminiscence, non-structured reminiscence, and a control group. It was

hypothesized that reminiscence would improve depression and ego strength Further, it was expected that structured reminiscence would be more effective than unstructured treatment. Each subject met individually with the researcher for a 90-minute weekly session for a period of five consecutive weeks. Individuals receiving the structured reminiscence therapy were instructed to dwell on eight life event topics on a ten-minute interval schedule. These events highlighted such issues as treasured objects, events, hopes, dreams, and unresolved feelings. The results indicated that depression scores for those receiving structured therapy improved significantly from the scores of those receiving unstructured therapy. Ego-strength scores indicated a significant improvement in the structured and unstructured therapy groups. Further, those receiving structured therapy improved significantly more than those receiving unstructured therapy.

Perrotta and Mecham (1981) used a private interview technique and did not find positive results with reminiscence therapy. They randomly assigned 21 subjects to one of three different groups: a structured reminiscence group, a current life events group, and a no-treatment control group. The experimenter met with the subjects individually for 45-minute weekly sessions for a period of 5 weeks. Depression and self-esteem were measured and there were no significant differences between the groups. The small number of subjects in each of the groups could have affected the outcome of this study, however.

Two studies explored structured reminiscence in a group therapy format. According to Botwinick (1973), older adults function more adequately in a structured setting. That is, they feel more comfortable and appear more confident than they would in an unstructured setting. Support for this idea is offered by McMordie and Blom (1979), who provided structured reminiscence groups to high functioning nursing home residents. They provided structure for each session by planning memory-evoking techniques

such as reviewing old newspapers and tapes of early radio shows. They found that the subjects in the structured setting responded more favorably. Georgemiller and Maloney (1984) offered life review workshops to assess the utility of structured reminiscence to 63 non-institutionalized seniors. The workshops were conducted at senior centers and consisted of seven weekly meetings for 90-minute sessions. The structured treatment, with assignment to groups, required the subjects to focus discussion on certain topics, and a control group was used for comparison. Reminiscence was considered related to health measures, religiosity and denial of death. The results indicated a significant decrease in denial of death for the treatment group. They also found that as the frequency of reminiscence increased, so did religiosity and improvement on health measures.

Collectively, these studies of the effects of structured versus unstructured reminiscence, most of which have been conducted utilizing an individual therapy format, suggest that structured reminiscence shows better results compared to unstructured reminiscence. (i.e., subjects appear more confident, comfortable, and respond more favorably).

Summary and Purpose of Study.

In general, the literature suggests many positive effects of reminiscence therapy that aid in coping and adapting to old age. Positive outcomes have been reported for reminiscence therapy both in the structured and unstructured setting, with more recent work tending to favor the structured format. Further, the therapy has been conducted in both the individual and group settings and although positive results have been found in each, results to date have primarily favored the individual setting. There appear to be, however, advantages to both settings. In the individual setting, the subject is provided with the experimenter's undivided attention which may account for potentially faster growth. In the group setting, however, there appear to be the advantages of decreasing one's sense of isolation, encouraging socialization, promoting group support, and enabling more people to be helped at one time (e.g., Butler, 1963,1976; Ebersole, 1976;

Lewis & Butler, 1974; McMordie & Bloom, 1979).

The purpose of this investigation was to examine the impact of reminiscence on life satisfaction, depression, and perceived health using a controlled experimental design. This study examined the relative impact of three kinds of discussion groups by comparing structured reminiscence, unstructured reminiscence, and non-reminiscence discussion groups. It was hypothesized that life satisfaction would increase, depression would decrease, and perceived health would improve with reminiscence. It was further hypothesized that structured reminiscence would have a more positive effect than unstructured reminiscence on the measures of life satisfaction, depression, and perceived health.

This study was unique in that it compared structured reminiscence and unstructured reminiscence in a group setting utilizing control group comparisons. To further enhance the design the two types of reminiscence groups were compared to a non-reminiscence discussion group (which served as a control group), and a no-treatment control group

METHOD

Subjects

There were originally 27 female subjects from various senior centers in a suburban community of Southern California that responded to the solicitation of joining an experimental discussion group. Subjects were solicited from facilities matched on socio-economic status. Fifteen subjects were excluded from the analysis for the following reasons. Four subjects from four different centers were excluded because they were sole members of a group. An additional five subjects were excluded because a male joined the group in the third session. (i.e., these five women did not receive the same treatment as the women in the other groups because there was a man present in half of their sessions). Three other subjects were excluded because they failed to respond to the post-test questionnaire. Finally, three subjects were excluded because they only attended half of the required sessions.

Of the remaining 12 female subjects, there were 3 subjects in each of the 4 conditions (Condition 1= Structured Reminiscence, Condition 2= Unstructured Reminiscence, Condition 3= Non-Reminiscence, Condition 4= No-Treatment). The subjects had a mean age of 69 years, a mean number of 2.4 social engagements per week, and a mean of 1.5 confidants (Table 1).

All subjects included in the study passed minimum screening requirements which evaluated their ability to hear in a group setting, their commitment to attend every session, their commitment to keep the sessions confidential, their willingness to sign a written consent form, and their freedom from mood-altering drugs.

Table 1
Demographic Data

	Condition *			
	1 (n=3)	2 (n=3)	3 (n=3)	4 (n=3)
Mean age (in years)	62.3	77.0	68.0	68.3
Marital Status:				
married	2	1	3	2
divorced	1	1		
widowed		1		1
Occupation:				
clerical/sales	1	3	1	
technicians	1			3
managers	1		1	
professional			1	
Mean number reported confidants	2.3	2.7	4.7	3.0
Frequency of social engagements per week	2.7	2.7	2.7	1.7

*Condition 1=Structured Reminiscence, Condition 2=Unstructured Reminiscence, Condition 3=Non-Reminiscence, Condition 4=No-Treatment.

Instruments

Life satisfaction. The Life Satisfaction Scale Index A (Neugarten, Havighurst, & Tobin, 1961) was administered as a pretest and post-test assessment of perceived life satisfaction. Participants rated items on a 3-point Likert-type scale (agree, disagree, or not sure). The measure consisted of 20 statements about life events that reportedly represent a valid perspective of the subject's state of life satisfaction. This measure was selected because of its wide use in the field of gerontology. Two examples of the statements include; "As I grow older, things seem better than I thought they would be", and "I expect some interesting and pleasant things to happen to me in the future" (see Appendix A).

Depression. The Beck Depression Inventory (short form) (Beck & Beck, 1972) was administered as a pretest and post-test assessment of depression (Appendix B). Participants rated items on a 4-point Likert-type scale (0=not depressed, 3 =severely depressed). A total of13 items assess such factors as sadness (e.g.,"I am so sad or unhappy that I can't stand it"), dissatisfaction (e.g.,"I am dissatisfied with everything"), and social withdrawal (e.g.,"I have lost all of my interest in other people and don't care about them at all"). These items yield a total score that indicate the subject's state of overall depression. This version reportedly has a .90 correlation with the original version. The original Beck Depression Inventory was based on a sample of 598 psychiatric patients, with a split-half reliability of .93. As reported by Beck and Beck (1972), this inventory correlated significantly with clinicians' depression ratings and other depression inventories.

Health. The self-report health measure by Shanas, Townsend, Wedderburn, Friis, Milhoj, and Stehouwer (1968) was administered as a pretest and post-test measure of subject's evaluation of their own health (Appendix C). Subjects rated a 5-point Likert scale (1= excellent, 5=very poor) the following statement: " For someone your age, do you consider your health to be..." This single-item measure has been successfully

validated by physicians' assessments of respondents' health. Further, as noted by Wolinsky and Zusman (1980), psychological health is a person's subjective perception and evaluation of their physical health. Finally, according to Liang (1986), the construct validity of self-reported health is consistently supported by convergent results.

Background and screening items. A screening and background form designed by the experimenter contained questions of a demographic nature regarding each subjects' age, gender, occupation, number of confidants, frequency of social engagements, frequency of church attendance, and marital status. Screening questions were asked to determine each subject's ability to function in a group experiment such as their ability to hear in a group setting, their commitment to attend every session, their ability to maintain strict confidentiality, and their drug and medication usage (Appendix D).

Validity check. A simple three-item questionnaire designed by the experimenter was filled out by each subject at the close of each group session (Appendix F). This measure assessed whether any major changes had occurred in the subjects' lives that would contaminate the experiment (e.g., changes in medications or any unusually tragic or exciting event in their life).

Procedure

The original plan was to solicit subjects from two different types of senior centers (i.e., nutrition site centers and non-nutrition site centers). Within these two types of centers, the subjects would be matched by center type (i.e., economic status). This was set up in this manner to assure randomization of the two treatments, (i.e., structured reminiscence and unstructured reminiscence). That is, in one nutrition site center and one non-nutrition site center, the subjects would ideally assign themselves to one of the two possible treatment groups but they would not know which type of reminiscence they would receive. The control groups (i.e.,the non-reminiscence and the no treatment group) were to be solicited at a nutrition

site and a non-nutrition site that were matched for socio-economic status. This way, the reminiscence groups would not be able to get together with the non-reminiscence groups and discuss their treatment. A similar idea to assure randomization and to avoid equalization of the treatment was applied by Laing (1986).

Solicitation from the nutrition site centers was poor as only four subjects signed up in four different groups. These subjects received the complete treatment designed in this experiment, but the data were not analyzed. Although the response to participate was better in non-nutrition site centers, there were not enough subjects who signed up. More non-nutrition site centers were then solicited in an attempt to attract more subjects. Although these non-nutrition site centers were matched by socio-economic status, randomization was sacrificed as the treatments became confounded by facility (Rosenthal,1984). That is, each center received only one condition, and the condition one received was dependent upon which center they were involved with.

Each subject was administered a pretest and post-test questionnaire which included the Life Satisfaction Scale (Neugarten et al.,1961), the Depression Scale (Beck & Beck, 1972), and the Self Reported Health Measure (Shanas et al., 1969). In addition, screening and demographic items were collected at the first session, and a validity check questionnaire was handed out at the end of each session. All subjects were treated in accordance with the ethical principles established by the American Psychological Association.

The groups that received the therapy met in small groups for weekly 75-minute sessions for a period of four weeks. To control for certain subjects' domination of the discussion time, the experimenter began each meeting by instructing the members to take turns and talk for a 3-minute period. The remaining part of the session functioned in a more spontaneous manner. The experimenter functioned as the group leader and assertively

blocked any subject from dominating the conversation. Most of the time this could be handled in a subtle manner by re-directing the conversation to another subject. (e.g. "Thank you for sharing Dorothy, How do you feel about this, Addie?"). On a few occasions a more direct approach was needed to assure that each subjects received an equal opportunity to talk. (e.g., "Rosemary, that is very interesting, but we must move on now so everyone will have a chance to share").

Condition 1:

The "structured reminiscence" group was topic-directed by the experimenter to facilitate the evaluative life review. The subjects were given the topic and time frame that they would be expected to talk about at the next session. They were also encouraged to brings photos or treasured possessions to facilitate their recall. The ideas for the format structure of these sessions was based on the work Fry (1983, 1986), Georgemiller and Maloney (1984), and McMordie and Blom (1979). The format for the structured reminiscence sessions was as follows:

Session 1: Orientation, earliest memories, and childhood(birth- age 20).

Subjects were asked to recall such topics as their very first memory, first day of school, first romance, and completion of school and entrance into work or marriage.

Session 2: Young adult years (ages 20-40).

Subjects were asked to consider ways they were similar to their parents, birth of children, and issues of working years.

Session 3: Middle adult years (ages 40-65).

Subjects were asked to consider this time frame in light of raising children and career development.

Session 4: Later adult years (age 65 to present).

Subjects were asked to consider their childrens' advancement into adulthood, summarize their life review, and consider future goals.

Condition 2:

The unstructured reminiscence group focused their discussion on any issue, problem, or relationship that occurred in the past. They were given minimal direction by the experimenter. The subjects were encouraged to think of issues that they would like to discuss the following session. When subjects were not talkative, the experimenter suggested topics similar to those utilized in structured reminiscence with the exception that they were offered in a random order.

The subjects from both the unstructured reminiscing and the structured reminiscing groups were given a homework assignment for the following week. Both groups were encouraged to keep journals, review photo albums and scrapbooks, or communicate with relatives to enhance the reminiscence experience. They were also encouraged to bring mementos to the group for sharing.

Condition 3:

The non-reminiscence discussion group focused on current or future issues of interest. The content was decided upon by the group members and included many different issues such as current problems, current relationships, and current and future goals. The experimenter was careful to block any discussion that referred to past life experiences--no reminiscence was permitted. A simple statement was effective in re-directing the discussion to the proper time frame. (e.g., "Okay ladies, we need to keep the discussion focused on current life issues"). At the end of the session, the subjects were encouraged to think about issues they would like to discuss in the following session.

The subjects in the non-reminiscence control discussion group were also encouraged to keep journals about current issues and discuss current issues that may enhance their discussion experience. They were also encouraged to bring any memento (that had current relevance) to share with the group. All subjects participated in at least one of these tasks.

Condition 4:

The "no therapy" comparison group only received the pretest and the post-test measures. These tests were administered concurrently with the subjects from the other conditions. These subjects (three of the 12 who participated in this study) were volunteers recruited by the experimenter to complete the pretest and post-test questionnaires.

RESULTS

Because of the very small sample size this research mandated the use of descriptive statistics. For descriptive purposes, the results were considered by individual condition and then by collapsing the conditions into various combinations to shed more light on the data.

<u>Life Satisfaction</u>

Figures 1 and 2 illustrate the pretest and post-test mean scores for life satisfaction (1=poor life satisfaction, 18=high life satisfaction). Figure 1 presents the data for each individual condition. Figure 2 presents the data for all discussion groups (Conditions 1,2, and 3), for both reminiscence groups (Conditions 1 anf 2), and for both control groups (Conditions 3 and 4). For the individual conditions, the only notable difference in life satisfaction scores was for Condition 2 (unstructured reminiscing). Life satisfaction increased for this group with a pretest mean score of 14.0 and the post-test mean score of 16.33. It is important to note that the Life Satisfaction score for Condition 1 (structured reminiscence) was low before the treatment with a pretest score of 10.0. There was no notable difference when the conditions were combined.

Figure 1 Pretest and Post-test mean scores for Life Satisfaction. (Condition 1=Structured Reminiscence, Conditon 2=Unstructured Reminiscence, Condition 3=Non-Reminiscence, Condition 4= No-Treatment).

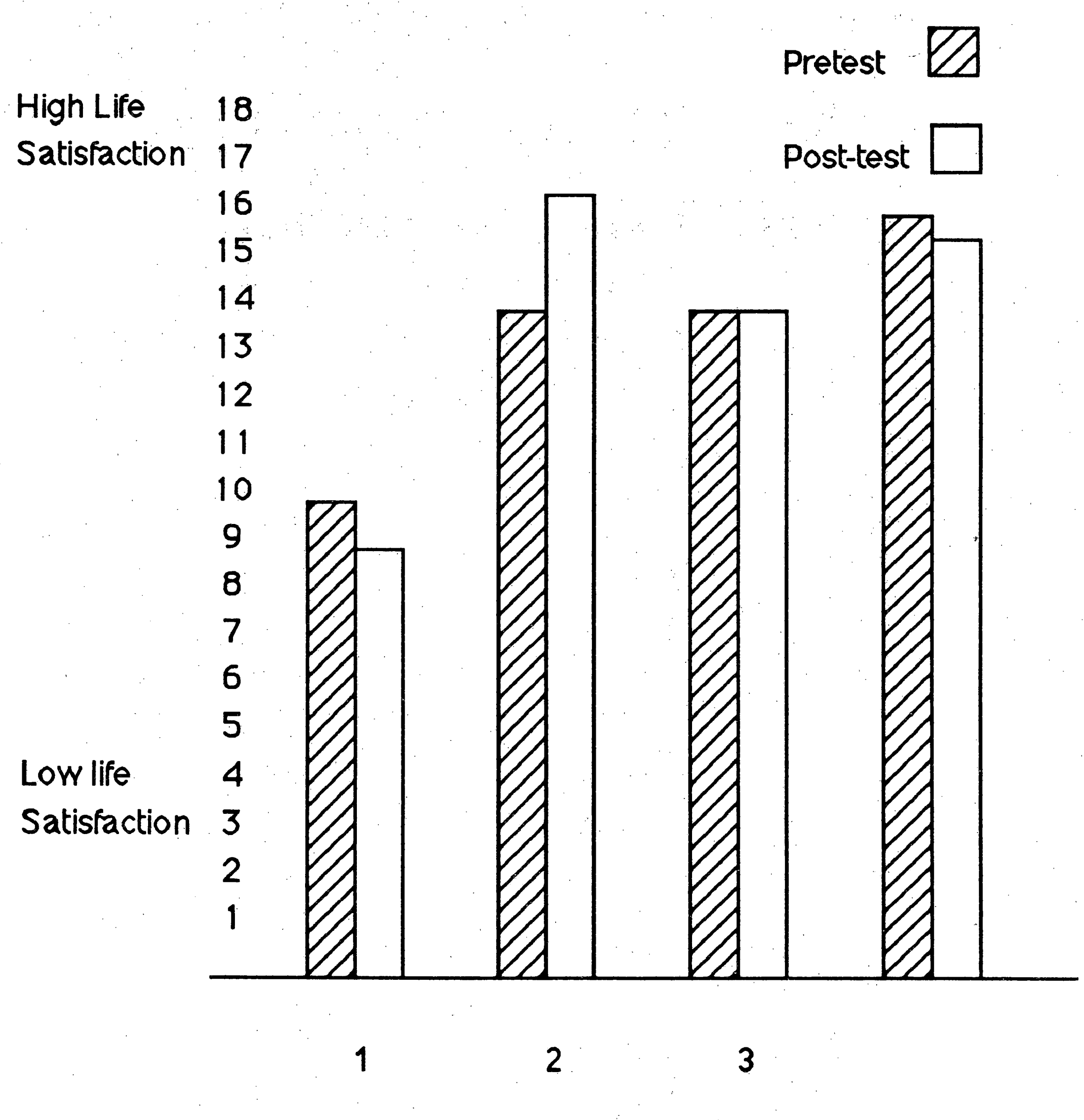
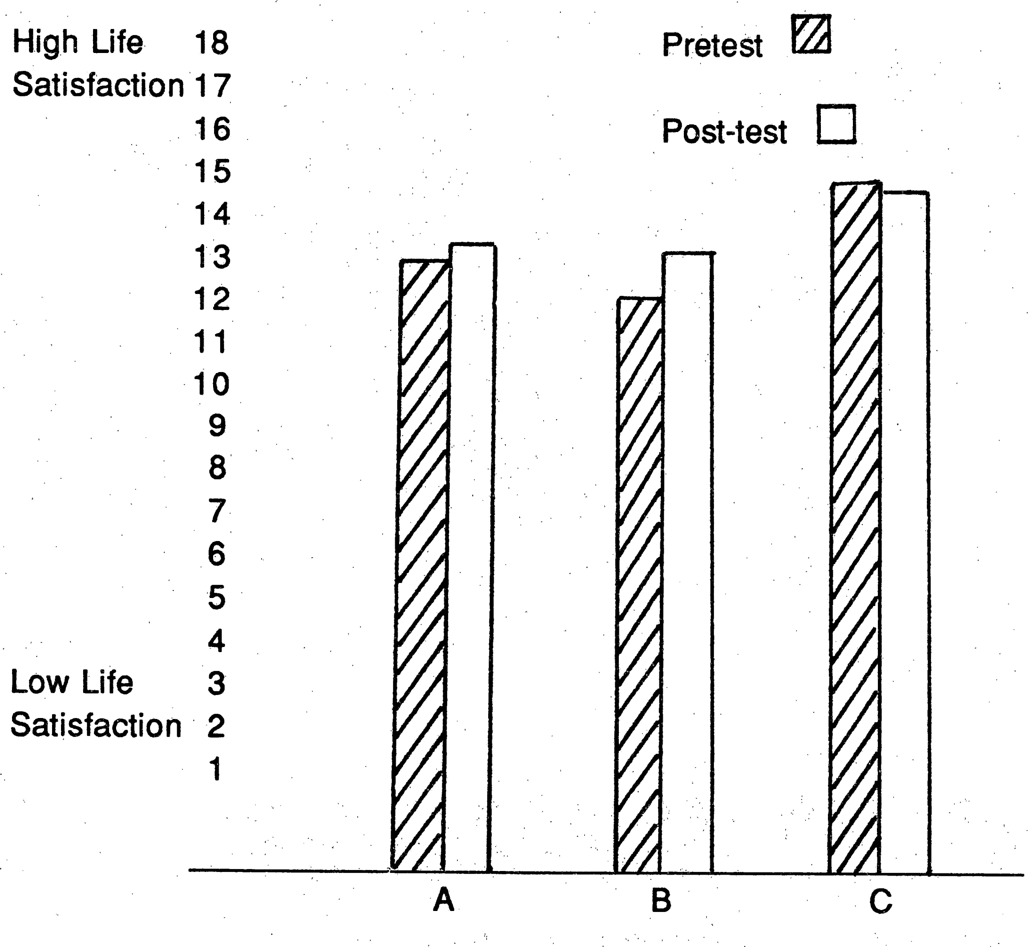


Figure 2 Pretest and Post-test mean scores for Life Satisfaction.
(A=Combined Discussion Groups : Structured Reminiscence, Unstructured Reminiscence, Non-Reminiscence. B=Combined Reminiscence Groups: Structured Reminiscence, Unstructured Reminiscence. C=Combined Control Groups: Non-Reminiscence, No-Treatment.)



Depression

Figures 3 and 4 illustrate the pretest and post-test mean scores for depression (0=not depressed, 8=very depressed). There were differences in the pretest and post-test depression scores for Condition 1 (structured reminiscence), Condition 2 (unstructured reminiscence) and Condition 4 (no-treatment). For Condition 1 (structured reminiscence) showed an increase from a pretest mean score of 4.0 and a post-test mean of 5.33. For Condition 2 (unstructured reminiscence), the mean for depression dropped from 2.33 to 1.67 Condition 4 (no-treatment) also showed a decrease in depression score from 2.33 to 1.33. In other words, depression seemed to be worse after the treatment of structured reminiscence but better after the treatment of unstructured reminiscence and after no-treatment. It is important to note, however, that the depression scores for condition 1 were higher before the treatment with a pretest score of 4.0. There were no notable differences in the combined conditions.

Figure 3 Pretest and Post-test mean scores for Depression. (Condition 1=Structured Reminiscence, Condition 2=Unstructured Reminiscence, Condition3= Non-Reminiscence, Condition 4=No-Treatment).

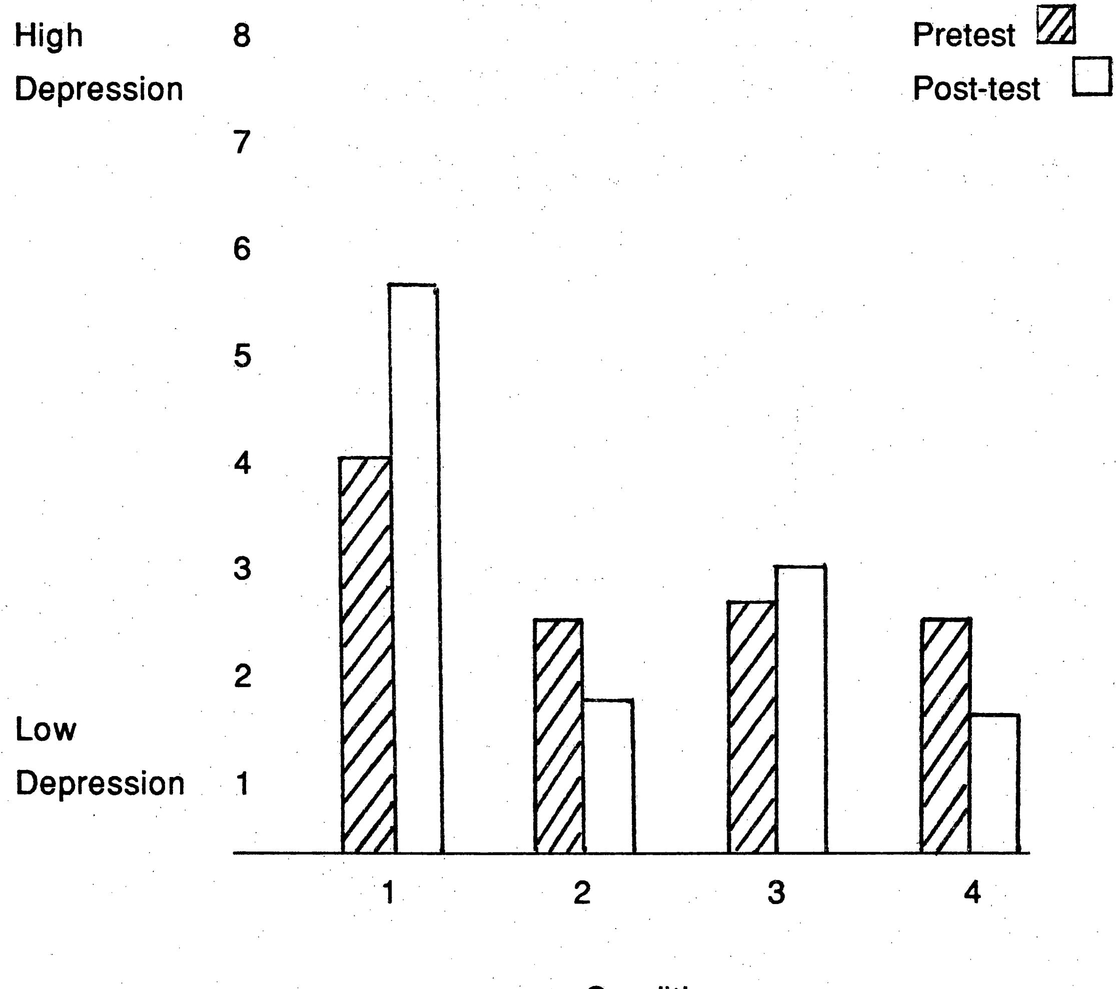
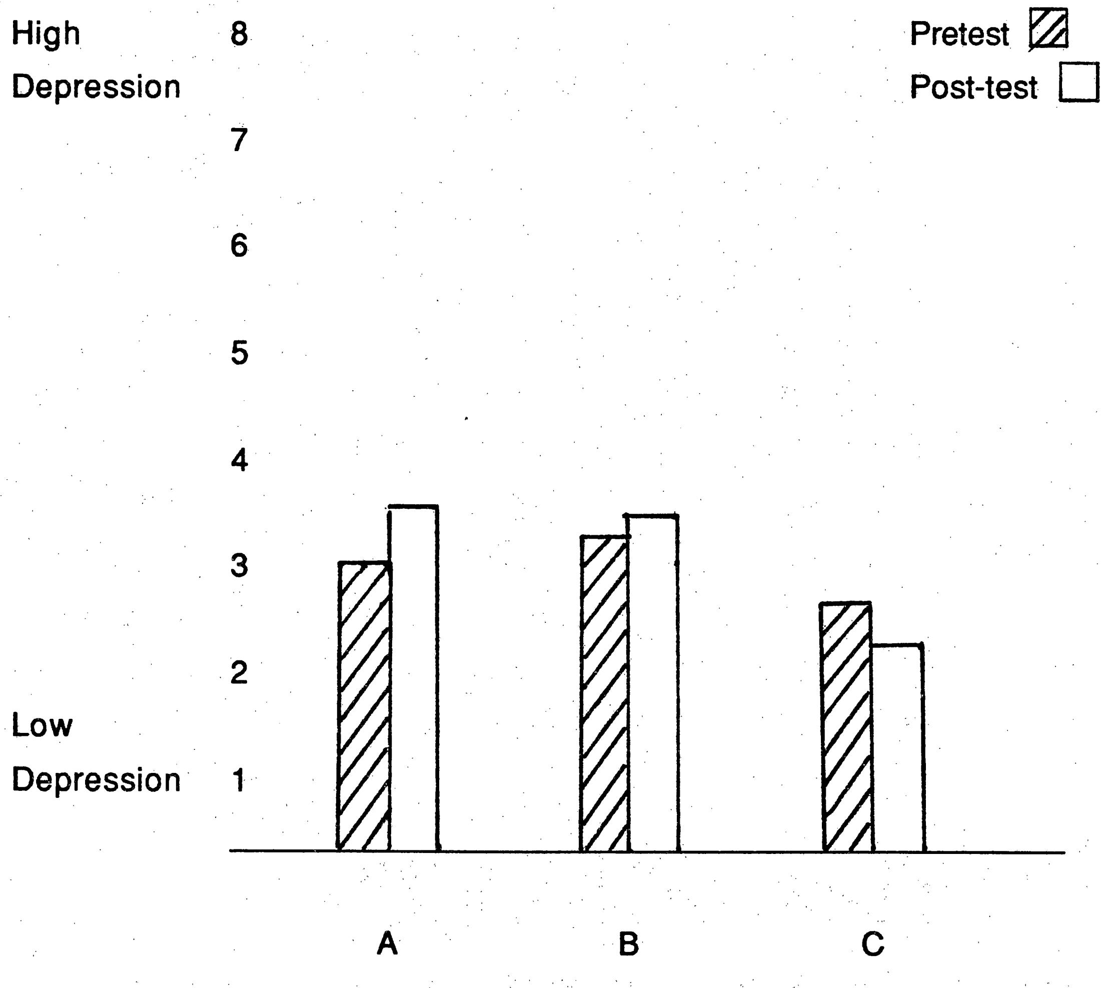


Figure 4 Pretest and Post-test mean scores for Depression. (A=Combined Discussion Groups: Structured Reminiscence, Unstructured Reminiscence, Non-Reminiscence. B=Combined Reminiscence Groups: Structured Reminiscence, Unstructured Reminiscence. C=Combined Control Groups: Non-Reminiscence, No-Treatment).



Perceived Health

Figures 5 and 6 illustrates the pretest and post-test scores for perceived health (1=excellent, 5=very poor). The only notable difference for perceived health was for Condition 2 (unstructured reminiscence) with a pretest mean score of 2.67 and a post-test mean score of 2.0. In other words, perceived health seemed to improve after the treatment of unstructured reminiscence. There was no notable difference when the conditions were combined.

Figure 5 Pretest and Post-test mean scores for Perceived Health. (Condition 1= Structured Reminiscence, Condition 2=Unstructured Reminiscence, Condition 3=Non-Reminiscence, Condition 4=No-Treatment).

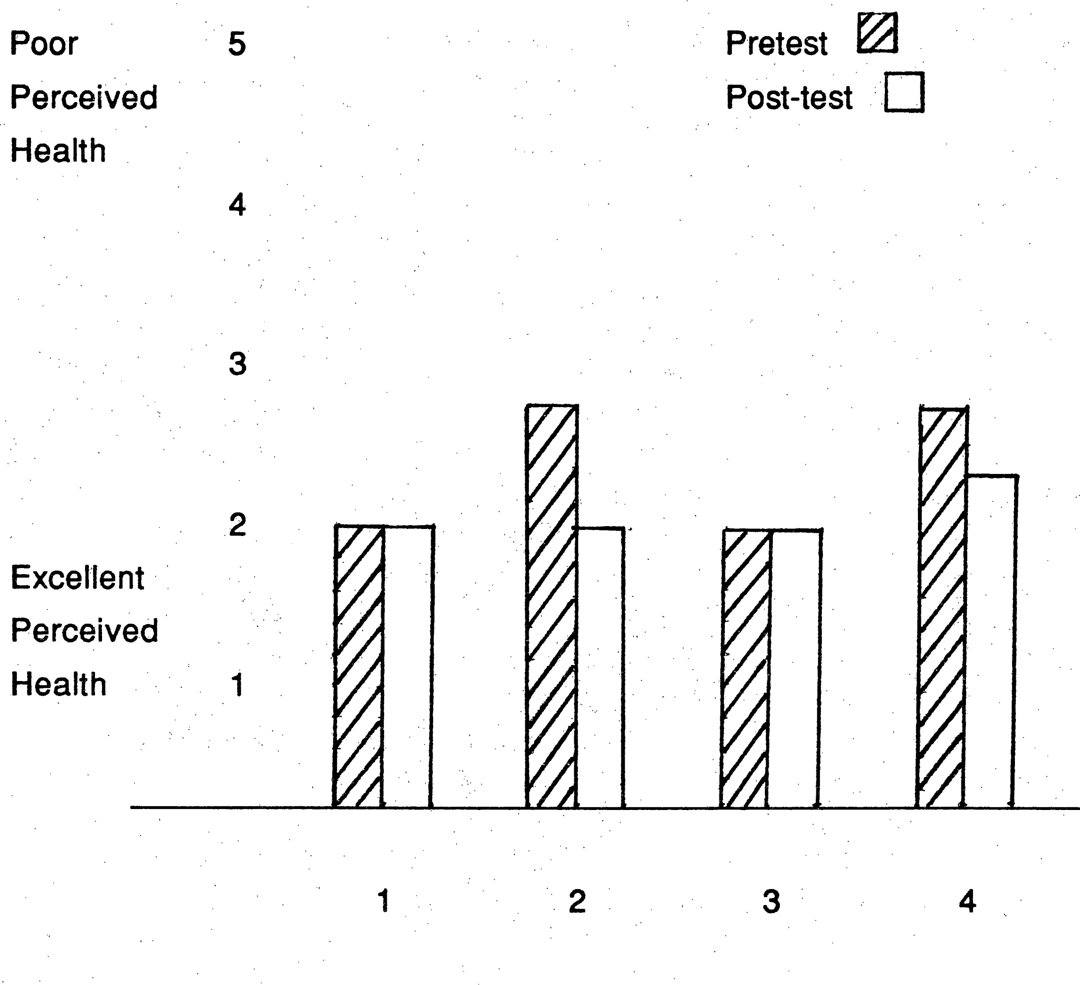
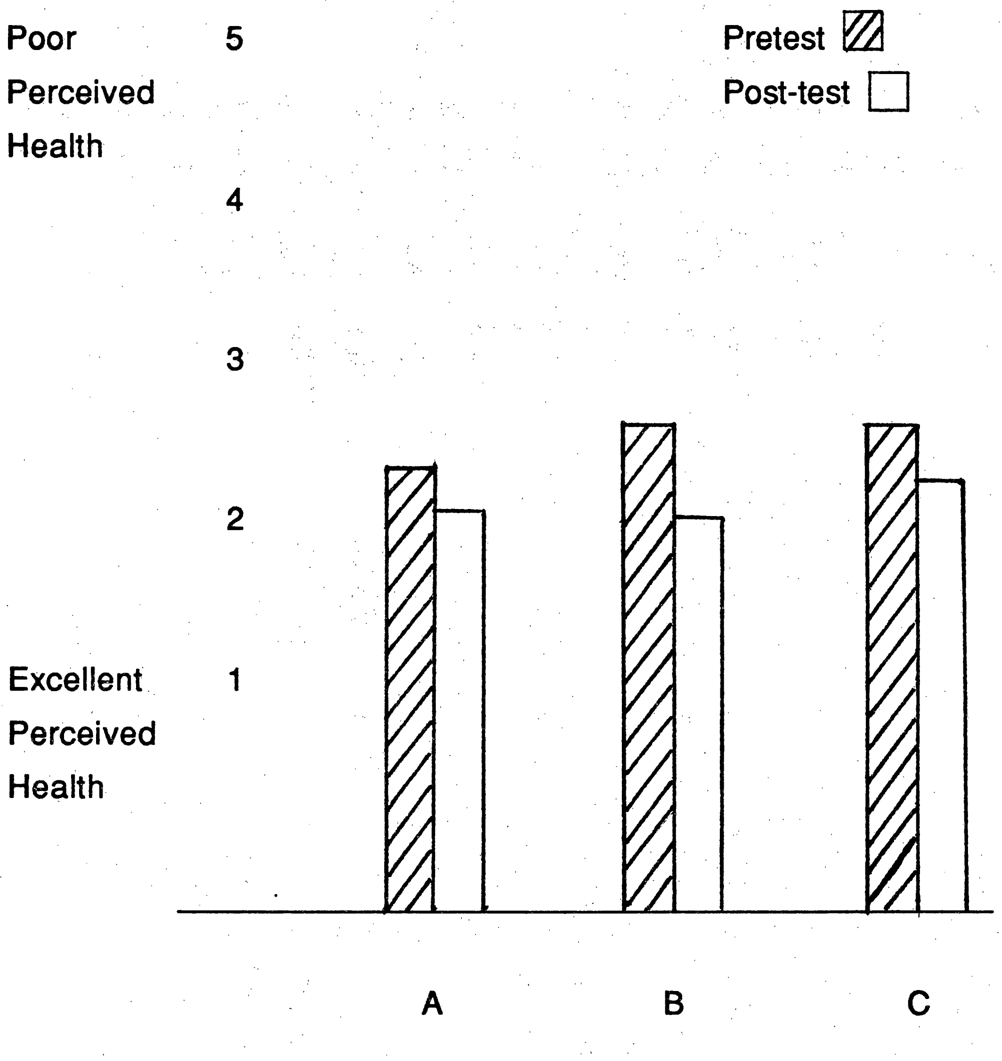


Figure 6 Pretest and Post-test mean scores for Perceived Health. (A=Combined Discussion Groups: Structured Reminiscence, Unstructured Reminiscence, Non-Reminiscence. B=Combined Reminiscence Groups: Structured Reminiscence, Unstructured Reminiscence. C=Combined Control Groups: Non-Reminiscence, No-Treatment).



DISCUSSION

The hypothesis that reminiscence results in an increase in life satisfaction and perceived health, and a decrease in depression was unable to be tested due to the small sample size. The original plan was to analyze the data by 3, 2-WITHIN X 4-BETWEEN MATCHED DESIGN ANOVAS, but because of the small sample size the results can only be considered in a tentative descriptive manner.

The hypothesis that structured reminiscence would be the most beneficial treatment in this study cannot be supported. The results, although very tentative, indicated that life satisfaction decreased, depression increased, and perceived health remained the same. There are several possible explanations for the direction of this data. First, it could indicate that forcing individuals to think about a certain isuue or time period in their lives may not always yield positive results. It may, for example, stir up less-than-happy memories, whereas if they were permitted to choose what to remember, they may be more apt to remember happier memories. Second, the group members did not seem to want to reminisce. On numerous occasions their discussion would would shift to current life issues and they would need to be re-directed to past life issues. Third, the subjects in this group were eight years younger than the mean age of other groups members. It is possible that they were not in the same developmental stage as the subjects in the other groups (e.g., Erikson, 1959). Finally, it is also important to note the difference in the pretest scores for the structured reminiscence group. The subjects in this group scored higher in depression

and a lower in life satisfaction at the outset of this study compared to subjects in the other groups.

The hypothesis that unstructured reminiscence would also increase life satisfaction, improve perceived health, and decrease depression can only be tentatively supported from this small sample. Although life satisfaction, depression, and perceived health changed in the desired direction, no suggestion can be assumed from this small sample size this study.

The hypothesis that structured reminiscence would be more beneficial than unstructured reminiscence regarding life satisfaction, depression and perceived health, is not suggested by this small sample. In fact, the results indicated otherwise-- that unstructured reminiscence was actually more beneficial than structured reminiscence in all of these areas. The research by Haight (1984), Fry (1983), and Georgemiller and Maloney (1984) all suggested that structured reminiscence would be more beneficial than unstructured reminiscence. However, because of the small sample size and large age and pretest score differences between the subjects in these two groups, these findings do not attempt to contradict their findings.

The hypothesis that non-reminiscence discussion groups would be less beneficial than reminiscence was also not supported by this data. Life satisfaction and perceived health remained the same for this group, while depression increased. This increase in depression may be explained by the validity check. One subject in the third session reported being severely depressed and was being treated by a physician for a chemical imbalance. The stability of life satisfaction and perceived health present several possibilities. It is possible that the non-reminiscence discussion treatment simply did not provide these beneficial results. It is also possible that the time period of 4 weekly 1.25 hour sessions is not enough time to achieve the desired results. Further, the members of this group reported having more confidants, greater church attendance, and more social engagements than the mean. This suggests these subjects may have been more socially

inclined to begin with, and may therefore benefit less from this type of experience.

It is important to emphasize the many differences among the subjects in these four groups which may have effected the outcome of the data. First, the subjects in the structured reminiscence group had a lower life satisfaction and a higher depression score than the subjects in the other groups. Second, the subjects in the unstructured reminiscence group were much older than the subjects in the other groups. Third, there was a vast difference in marital status among the members of all four groups. There were two married subjects and one divorced subject in the structured reminiscence group. There was one married subject, one divorced subject, and one widowed subject in the unstructured reminiscence group. There were three married subjects in the non-reminiscence group. Finally, there were two married subjects and one widowed subject in the no-treatment cotrol group. It is apparent that none of these groups were matched in marital status and with this small sample size this difference is very distinct.

The overriding problem in this study was the difficulty in obtaining a sufficient sample size for a group study with this type of design in a natural setting. First, there was a problem in initially choosing sites to recruit subjects. I ruled out soliciting subjects from religious organizations because they would represent a biased sample of the population. I originally thought senior retirement homes would be a likely setting to solicit subjects, but recruiting subjects at these locations was difficult, perhaps because a wide variety of activities already exist at these locations. I later decided that day senior centers would be an ideal place to solicit subjects because older adults go there to seek out activity.

A second problem of subject solicitation focused on the different types of day senior centers. It became apparent to me that older adults who frequent a center for a free lunch were different than those who attend a center for enrichment activities where free lunches are not available. I

found that the nutrition site center's patrons were not interested in belonging to discussion groups and I obtained very low participation. I only had four subjects in nutrition site centers join the experiment and each of these subjects joined a different group. Thus, while I felt morally obligated to give them the entire treatment, I was not able to include them in the analysis. In this setting, if funding was available to pay the subjects for their participation, participation would probably be improved. Participation was more successful in the non-nutrition site senior centers where community members were more likely to join an enrichment activity. In this setting I doubt that paying for participation would be an effective motivator for this type of individual. Typically, I found this older adult to value their free time and attendance was a problem.

Once the subjects were solicited from non-nutrition day senior centers, a third problem focused on attrition. Some subjects were excluded from the analysis because they did not attend enough of the sessions to be considered. Some subjects were excluded from the analysis because of failure to complete the post-test questionnaire. This could have been prevented by simply stating that there must be a minimum number of joiners to warrant the activity. Further, to avoid contamination, five subjects were excluded from analysis in this study because a male joined the experiment in the third session. This was difficult to prevent. Even though the solicitation specifically requested "women", the director of this particular center felt it would be improper to refuse an elderly male entry into the group.

To further the understanding of reminiscence, future research might continue to compare the reminiscence group experience with other therapeutic group techniques. There is also a need for longitudinal studies to determine if reminiscing is effective over long a long period. For example, if reminiscence manifests a positive effect for a person at age 50, will it also be adaptive when that person is 70? It is possible that various kinds of reminiscence are adaptive for some people and not others at given times

and situations. Future controlled group-setting experiments on the various types of reminiscence and personality measures might add pertinent information on this issue. In the literature, little attention has been paid to the time period in which reminiscence has been applied and evaluated. Studies could expand on this issue by comparing spaced versus mass application of reminiscence therapy. For example, subjects may be exposed to reminiscence treatment on daily, weekly, and bi-monthly basis, and then compared. Future work is needed to compare reminiscence with other therapeutic group techniques and also compare the effect of reminiscence in individual and group settings.

This study was originally designed with intent of confirming the theories of Erikson (1959) and Butler (1961) which suggest that reminiscence is indeed an adaptive process in aging. After completing this study I am doubtful however, about the uses of reminiscence therapy. It was my experience that women who were active and involved tended to focus their conversation to current life issues. Women who were unhappy with their current life, on the other hand, tended to favor talking about their past. It is interesting to note that the non-reminiscing group in Sunnymead is still functioning and growing. Several of the women in this groups were caring for their sick husbands and apparently talking about current life issues and problems is beneficial in this situation. Perhaps self-assessments would be a useful tool in evaluating reminiscence. Because of the small sample in this study nothing conclusive can be derived to support the assumption that reminiscence is an adaptive process for the elderly. The design of this study, however, could add pertinent information to the subject matter if a larger sample is utilized.

APPENDIX A - LIFE SATISFACTION

Here are some statements about life in general that people feel differently about. Would you read each statement on the list, and if you agree with it, put a check mark in the space under "AGREE". If you do not agree with a statement, put a check mark in the space under "DISAGREE". If you are not sure one way or the other, put a check mark in the space under "NOT SURE". PLEASE BE SURE TO ANSWER EVERY QUESTION ON THE LIST.

Agree	Disagree	Not sure	
______	______	______	As I grow older, things seem better than I thought they would be.
______	______	______	I have gotten more of the breaks in life than most of the people I know.
______	______	______	This is the dreariest time of my life.
______	______	______	I am just as happy as when I was younger.
______	______	______	These are the best years of my life.
______	______	______	Most of the things I do are boring or monotonous.
______	______	______	I expect some interesting and pleasant things to happen to me in the furure.

Agree	Disagree	Not sure	
______	______	______	The things I do are as interesting to me as they ever were.
______	______	______	I feel old and somewhat tired.
______	______	______	I feel my age, but it does not bother me.
______	______	______	As I look back on my life, I am fairly well satisfied.
______	____	______	I would not change my past life even if I could.
______	______	______	Compared to other people my age, I've made a lot of foolish decisions in my life.
______	______	______	Compared to other people by age, I make a good appearance.
______	______	______	I have made plans for things I'll be doing a month or a year from now.
______	______	______	When I think back over my life, I didn't get most of the important things I wanted.
______	______	______	Compared to other people, I get down in the dumpts to often.
______	______	______	tI've gotten pretty much what I expected out of life.
______	______	______	In spite of what people say, the lot of the average man is getting worse, not better.

Appendix B - Depression

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

A. (Sadness)

____ I am so sad or unhappy that I can't stand it.
____ I am blue or sad all the time and I can't snap out of it.
____ I feel sad or blue.
____ I do not feel sad.

B. (Pessimism)

____ I feel that the future is hopeless and that things cannot improve.
____ I feel I have nothing to look forward to.
____ I feel discouraged about the future.
____ I am not particularly pessimistic or discouraged about the future.

C. (Sense of failure)

____ I feel I am a complete failure as a person (parent, husband, wife.)
____ As I look back on my life, all I can see is a lot of failures.
____ I feel I have failed more than the average person.
____ I do not feel like a failure.

D. (Dissatisfaction)

___ I am dissatisfied with everything.
___ I don't get satisfaction out of anything anymore.
___ I don't enjoy things the way I used to.
___ I am not particularly dissatisfied.

E. (Guilt)

___ I feel as though I am very bad or worthless.
___ I feel quite guilty.
___ I feel bad or unworthy a good part of the time.
___ I don't feel particularly guilty.

F. (Self-dislike)

___ I hate myself.
___ I am disgusted with myself.
___ I am disappointed in myself.
___ I don't feel disappointed in myself.

G. (Self-harm)

___ I would kill myself if I had the chance.
___ I have definite plans about committing suicide.
___ I feel I would be better off dead.
___ I don't have any thoughts of harming myself.

H (Social withdrawal)

___ I have lost all of my interest in other people and don't care about them at all.
___ I have lost most of my interest in other people and have little feeling for them.
___ I am less interested in other people than I used to be.
___ I have not lost interest in other people.

I. (Indecisiveness)

___ I can't make any decisions at all anymore.
___ I have great difficulty in making decisions.
___ I try to put off making decisions.
___ I make decisions about as well as ever.

J (Self-image change.)

___ I feel that I am ugly or repulsive-looking.
___ I feel that there are permanent changes in my appearance and they make me look unattractive.
___ I am worried that I am looking old or unattractive.
___ I don't feel that I look any worse than I used to.

K. (Work difficulty)

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

L. (Fatigability)

___ I get too tired to do anything.
___ I get tired from doing anything.
___ I get tired more easily than I used to.
___ I don't get any more tired than usual.

M. (Anorexia)

___ I have no appetite at all anymore.
___ My appetite is much worse now.
___ My appetite is not as good as it used to be.
___ My appetite is no worse than usual.

APPENDIX C - SELF PERCEIVED HEALTH MEASURE

For someone your age, do you consider your health to be:

1	2	3	4	5
excellent	very good	average	poor	very poor

Please circle your selected answer.

APPENDIX D - SCREENING AND BACKGROUND INFORMATION FOR TREATMENT GROUPS

Please respond to the following statements and answer the questions to the best of your ability. Please do not leave any blank spaces.

Your identification number will be:

______ ______	______ ______	______	______
your father's first & last initial	your mother's first & last initial	month of your birth	day of your birth.

When were you born?__________________ Your age today is________

What was your main occupation during your working years? (If you were a housewife, what was your husbands occupation?)____________________.

Do you have a "confidant", someone with whom you can share your innermost feelings and thought, someone who will always listen to you when you need to talk? ___________

How many confidants would you say you currently have?________

Who are your confidants? (Put the number of confidants you have next to each person):
friend______, spouse______, sister or brother______,
other relative______, other______.

Are you taking any prescription or over the counter medication?________
If so, What?____

Are you able to hear well in a group setting?_______

Are you commited to attend every session?________

Are you commited to maintain strict confidentiality regarding the group sessions ?_______

Please cirlcle the one that applies to you:

How often do you attend church, synagogue, or temple?

several times a week

once a week

twice a month

once a month

few times a year

never

If you do not attend a religious group, do you consider yourself a spiritual person. __________. Explanation optional ____________________________
____

How many social engagements do you participate in each week?

0 1 2 3 4 5 6 7 8 9 10

What is your current marital status?

never married married divorced widowed

APPENDIX E - SCREENING AND BACKGROUND INFORMATION FOR NO TREATMENT CONTROL GROUP

Please respond to the following statements and answer the questions to the best of your ability. Please do not leave any blank spaces.

Your identification number will be:

_____ _____	_____ _____	_____	_____
your father's first & last initial	your mother's first & last initial	month of your birth	day of your birth.

When were you born?__________________ Your age today is________

What was your main occupation during your working years? (If you were a housewife, what was your husbands occupation?)_____________________.

Do you have a "confidant", someone with whom you can share your innermost feelings and thought, someone who will always listen to you when you need to talk? ___________

How many confidants would you say you currently have?________

Who are your confidants? (Put the number of confidants you have next to each person): friend______, spouse______, sister or brother______, other relative______, other______.

Are you taking any prescription or over the counter medication?________
If so, What?____

Please cirlcle the one that applies to you:

How often do you attend church, synagogue, or temple?

several times a week

once a week

twice a month

once a month

few times a year

never

If you do not attend a religious group, do you consider yourself a spiritual person. __________. Explanation optional ________________________

____

How many social engagements do you participate in each week?

0 1 2 3 4 5 6 7 8 9 10

What is your current marital status?

never married married divorced widowed

APPENDIX F - VALIDITY CHECK

Please write your identification number:

___ ___,	___ ___,	___	___.
your father's first and last initial	your mother's first and last initial	month of your birthday	date of your birthday

Please answer all of the following question:

1. Are you taking any new medications since the last session?_________
   If yes, what kind?____

2. Has any extraordinary exciting event taken place in your life since the last sessions?___________
   If yes, what happened? ______________________________________

3. Have you had an unusually sad or tragic event occur in your life since the last session? ___________
   If so, what happened? ______________________________________

APPENDIX G- LETTER TO SOLICIT SUBJECTS FOR TREATMENT GROUPS

Dear Senior:

I am a graduate student at San Bernardino State University conducting a study on what types of discussion groups people prefer. I would like to form reminiscence discussion groups at your center which will focus discussion on your past experiences. These groups will meet for one hour and 15 minutes for a period of four weeks. You will have the option of joining the 9:00 or the 10:15 group on Monday mornings. The meetings will begin January 4th and end January 25th.

If you join a group, your participation involves filling out a short written questionnaire at the first and the last sessions. During the weekly group meetings you will be asked to share experiences about your past, and listen to others share their life experiences. If you join a group, it is important that you attend every session, and be committed to keep the discussion group experience confidential.

Please consider joining one of the groups so you can help me determine what kind of groups are most affective. Also there have been many claims that reminiscence is an enjoyable and beneficial experience. So please come and share your life, I am anxious to learn more about you!

Thank you for your interest, your participation will be greatly appreciated. Please see sign-up sheet.

Thank you,

Kathy Mc Gregor
M.A. Graduate Student

Faculty Advisors:
N.L. Kamptner Ph.D.
R.E. Cramer Ph. D.
C. Rickabaugh M.A.

APPENDIX H - SAMPLE SIGN-UP SHEET
FOR REMINISCENCE GROUPS

PLEASE SIGN UP FOR THE REMINISCENCE GROUP THAT BEST FITS YOUR SCHEDULE. GROUPS BEGIN JANUARY 5th AND END JANUARY 26TH.

Name and Telephone numbers

TUESDAYS 9:00 until 10:15

____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

TUESDAYS 10:30until 11:45

____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

APPENDIX I - LETTER TO SOLICIT SUBJECTS FOR THE NON-REMINISCENCE CONTROL GROUPS

Dear Senior:

I am a graduate student at San Bernardino State University conducting a study on discussion groups for my thesis project. I would like to facilitate discussion groups at your center and I need you help!

The social support discussion groups for current life issues will meet for one hour and 15 minutes weekly for a period of four weeks. You will have the option of joining the Friday morning 9:00 o'clock group or the Friday morning 10:30 group. The groups will begin January 8th and end Jauanry 29th.

If you join a group, your participation involves filling out a 1/2 hour written questionnaire at the first and the last sessions. During the weekly group meetings you will be expected to share issues of interest to you about your current life.

It you join a group, please be committed to attending every session. Thank you for your interest and your participation will be greatly appreciated. Please see attached sign-up sheet.

Thank you,

Kathy McGregor
Graduate Student

Faculty Advisors:
N.L. Kamptner Ph.D
R.E. Cramer Ph.D.
C. Rickabaugh M.A.

APPENDIX J - SIGN-UP SHEET FOR NON-REMINISCENCE CONTROL GROUP SUBJECTS

PLEASE SIGN UP FOR THE DISCUSSION GROUP THAT BEST FITS YOUR SCHEDULE.

Name and Telephone Number

THURSDAY 8:30 until 9:45

______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

THURSDAY 10:00 until 11:15

______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

APPENDIX K - SAMPLE SOLICITATION HANDOUT FOR NON-REMINISCENCE CONTROL GROUPS

LET'S ENRICH OUR LIVES---

Research tells us that social support groups can be a very beneficial experience. Such activities can enrich our lives, enhance personal growth, and be a very pleasant experience.

Support groups for current life issues will begin soon for women 65 and over. The sessions will focus on discussion, but they will be tailored to meet your special interests. Such activities as relaxation techniques, assertiveness training, and guided imagery will be some of the available options.

For your convenience, there will be two groups available. One will meet on Fridays from 9:00 until 10:15, and the other group will meet on Fridays from 10:30 until 11:45. Please sign up early because space is limited.

I am sure we will have an enriching experience. If you have any questions or would like more details please call: Kathy McGregor 784-5190.

APPENDIX L - SAMPLE SOLICITATION HANDOUTS FOR REMINISCENCE DISCUSSION GROUPS

LET'S ENRICH OUR LIVES---

Research tells us that reminiscence can be a very beneficial experience. Such activities can enrich our lives, enhance personal growth, and be a very pleasant experience.

Reminiscence groups will begin soon for women 65 and over. The sessions will focus on discussion of the group member's past life experiences and feelings.

For your convenience, there will be two groups available. One will meet on Wednesdays from 9:00 until 10:15, and the other group will meet on Wednesdays from 2:00 until 3:15. Both groups will meet on January 6th, 13th, 20th, and 27th. Please sign up early because space is limited.

I am sure we will have an enriching experience. If you have any questions or would like more details please call: Kathy McGregor 784-5190.

APPENDIX M - CONSENT FORM COVER LETTER FOR THE REMINISCENCE AND NON-REMINISCENCE DISCUSSION GROUPS

Dear Participant:

The purpose of this study is to investigate various types of discussion groups. We hope to gain more understanding about individuals and their life satisfaction by the topics they discuss.

This study will involve approximately 6 hours of your time. Five hours will be spent in group discussion, and you will be requested to answer questions about your life and feelings, which will take approximately 1 hour.

Your participation will be strictly confidential. No identifying information other than age will be recorded.

Your cooperation in this study is greatly appreciated. Thanks to your contribution the findings will yield valuable information on this subject.

Sincerely,

Kathy McGregor
Graduate Student

Faculty Advisors:

N. L. Kamptner Ph.D.
R. E. Cramer Ph.D.
C. A. Rickabaugh M.A.

APPENDIX N- CONSENT FORM FOR REMINISCENCE AND NON-REMINISCENCE DISCUSSION GROUPS AND CONTROL TREATMENT GROUP

This study is designed to investigate various kinds of study groups and how they relate to life satisfaction, depression and perceived health.

We will need 6 hours of your time. Five hours will be spent in group discussion, and 1 hour will be spent answering questions about your life and feelings.

1. I understand that my participation will involve a total of 6 hours of my time. Five of the hours will be spent in group discussion and 1 hour will be spent responding to a written questionnaire.

2. I understand that I am free to discontinue my participation in the study at any time and without penalty.

3. I understand that the results of the study will be treated in strict confidence and within this restriction, group results of the studywill be made available to me at my request.

4. I understand that my participation in the study does not guarantee any beneficial results to me.

Signed ______________________

Dated ______________________

APPENDIX O - CONSENT FORM COVER LETTER FOR NO-TREATMENT CONTROL SUBJECTS

Dear Participant:

The purpose of this study is to investigate various types of discussion groups. We hope to gain more understanding about individuals and their life satisfaction by the topics they discuss.

This study will involve approximately 1 hour of your time, 30 minutes now, and 30 minutes four weeks from now. You will be requested to answer questions about your life and your feelings.

Your participation will be strictly confidential. No identifying information other than age will be recorded.

Your cooperation in this study is greatly appreciated. Thanks to your contribution the findings will yield valuable information on this subject.

Sincerely,

Kathy McGregor
Graduate Student

Faculty Advisors:

N. L. Kamptner Ph.D
R. E. Cramer Ph.D
C. A. Rickabaugh M.A.

APPENDIX P - CONSENT FORM FOR NO-TREATMENT CONTROL GROUP

This study is designed to investigate various kinds of discussion groups and see how they relate to life satisfaction, depression and perceived health.

We will need 1 hour of your time, 30 minutes now and 30 minutes in 4 weeks. You will be requested to answer some questions about your life and your feelings.

1. I understand that my participation will involve 1 hour of my time to respond to a written questionnaire.

2. I understand that I am free to discontinue my participation in the study at any time and without penalty.

3. I understand that the results of the study will be treated in strict confidence and within this restrictions, group results of the study will be made available to me a my request.

4. I understand that my participation in the study does not guarantee any beneficial results to me.

Signed ______________________________

Dated ______________________________

APPENDIX Q - DEBRIEFING FORM

Dear Participant:

Thank you for participating in this project. This study was designed to investigate different types of discussion groups. Often people engage in conversation about past experiences, and presumably this is an enjoyable pasttime. Past research has supported numerous claims as to the beneficial aspects of engaging in reminiscence. This project has intended to expand the available knowledge in this area by comparing structured verses free reminiscence groups and reminiscence groups verses non reminiscence groups.

We also wanted to gain more understanding about older adults and see if life satisfaction, depression and perceived health is affected by their involvement in reminiscence groups. We suspected that structured reminiscence would be more beneficial than non-structured reminiscence and that non-structured reminiscence would be more beneficial than current issue social support discussion groups.

I will be giving a talk on the findings of this study at your facility in February. You will be notified of the exact time and location. Thank you again for participating in the study.

Kathy McGregor

Graduate Student

Faculty Advisors:

N. L. Kamptner Ph.D.
R. E. Cramer Ph.D.
C. A. Rickabaugh M.A.

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