LIFE REVIEW AND THE INSTITUTIONALIZED ELDERLY

By

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ABSTRACT

Using a pre- and post-test design with both experimental and control groups, the research was conducted to see if life review improved the independence, depression, and integrated functioning of the institutionalized elderly. The elderly on the long term care unit of an acute care hospital waiting to be placed in a long term care facility were studied using a pre- and post-test design. Patients who were not depressed and could communicate in English were included in the study. They were randomly assigned to the experimental and control groups when possible. Patients in the experimental groups attended eight life review sessions over a four week period while the control groups carried on with the usual activities on the unit. Three scales, the Geriatric Depression Scale, Activities of Daily Living Evaluation Form, and the Geriatric Rating Scale were administered before the four week period and after. Data was also collected during the sessions on group process using the Group Process Observational Checklist on the experimental groups. Demographic data was collected on all the patients in the study. It was found that the experimental group did become more independent, integrated and less depressed. This study indicated that life review is beneficial for the institutionalized elderly but, it could not show exactly what variables in the life review process contributed to these positive results. Replication studies are needed to validate these findings.

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CHAPTER I THE PROBLEM

Background of the Problem

Various professionals have attempted to improve the quality of life of elderly clients using different methods of assistance. Two methods in particular, life review and reminiscence, have received considerable attention over the last three decades. Numerous review articles on this topic have appeared in the last few years, (Beuchel, 1986; Kastenbaun, 1982; Merriam, 1980; Molinari & Riechlin, 1985; Pincus, 1970; Romaniuk, 1981; Thornton & Brotchi, 1987). Most have claimed that life review helps individuals adapt better to life circumstances. In some of the literature the terms "life review" and "reminiscence" have been used interchangeably.

Studies by Boylin et al (1976), Havighurst and Glasser (1972) and Romaniuk (1981) suggest that life review helps individuals in a state of transition or crisis to adapt. One such group in transition may be the elderly entering long term care. Kiernat (1979) stated "the institutionalized elderly have a special need to review the past in order to successfully cope with the stress levels associated with their internal and external environments" (p. 307).

The elderly in long term care facilities have usually just come from an acute care facility or the community with some sort of physical or psychosocial loss and are waiting

for placement. The individuals are in a new place, have usually suffered a loss of their home, community, social support, privacy, freedom and sometimes even their spouse. These individuals in transition need help to cope with their present situation as evidenced by the high rate of depression (20-50%) (Hawranik & Kandratuk, 1986, p. 26).

Purpose of Study

The purpose of the research was to study the influence of life review sessions with the elderly on integrated functioning, independence and depression. There are two questions that need to be answered.

1) Do life review sessions, when systematically conducted using critical life events, enhance integrated functioning and independence and decrease depression?

2) If life review sessions enhance integrated functioning, independence and decrease depression, then what aspects of the life review process enhance independence and integrated functioning and decrease depression?

Research Design

A quasi-experimental research design was employed (Campbell & Stanley, 1963). The sample was selected from the longterm care unit of a 250 bed community hospital. Patients who could communicate in English and were not depressed were selected and randomly assigned to the control and

experimental groups when possible. Pre- and post-tests to measure integrated functioning, independence, and depression were administered to the sample. Demographic data was collected on all patients. Group process data was collected on the experimental group during the eight life review sessions which they attended.

Definition of Terms

Reminiscence - is the process of recalling one's past, either verbally or mentally (in one's mind) at anytime with or without purpose.

Life review - is the process of verbal recall of the past for a specific purpose. It is a subset of reminiscence.

Independence in Activities of Daily Living - the ability to bathe, dress, toilet, transfer and eat without assistance as measured by the Activities of Daily Living Evaluation Form (Katz et al 1963).

Group Interactions - is the process of communication with another in a structured setting.

Integrated Functioning - the ability to function in a holistic manner as defined by the Geriatric Rating Scale (Plutchik et al, 1970).

Depression - feeling of unwellness and lowered affect measured by the Geriatric Depression Scale (Yeasavage & Brink, 1983).

Major Life Event - a social transition period in an

individual's maturation process, a life stage.

Limitations of Study

The study was restricted to the men and women on the long term care unit of a community based family practice oriented hospital in Vancouver, British Columbia. The study was further restricted to only those patients who could tolerate activity for forty-five minutes and those who could socially interact in English. Patients who had been medically diagnosed with depression were not included in the study. A few patients were not able to participate in all sessions due to some underlying disease process.

Justification of Study

Most elderly in long term care units have gone through many changes and losses associated with institutionalization and aging. Depression, decreased self-esteem, decreased independence and loneliness and isolation are common symptoms amongst them (Matteson & Munsat, 1982; Norris et al 1982). Various authors stated that life review decreases depression, and increases socialization, independence and the quality of life. Other authors have claimed that life review has many benefits. Lappe (1987), Parsons (1986), Perschbacher (1984), and Ryden (1981) looked at the effects of group "reminiscing" on various outcomes. Not a single study on the use of Bale's group process categories with life review groups in an

institutional setting could be found in the literature reviewed. If the process can be systematically studied and benefits identified perhaps it can be incorporated into the care of the elderly to enhance their independence and decrease their depression and contribute to the quality of their life.

CHAPTER II RELATED LITERATURE

Many articles on life review have been published based on Butler's concept of life review and Erikson's theory on life stages (Babb de Ramon, 1983; Boden & Bielby, 1983; Boylin, Gordon, & Nehrke, 1976; Butler, 1963; Butler, 1974; Buechel, 1986; Coleman, 1974; David, 1990; Ellison, 1981; Green, 1983; Havighurst & Glasser, 1972; Kiernat, 1979; Jones & Zeiss, 1984; Lewis, 1971; Lewis & Butler 1974; Lo Gerfo, 1980; McMahon & Rhudick, 1967; Perotta & Meacham, 1981; Poulton & Strassberg, 1986; Romaniuk, 1981; Taft & Nehrke, 1990; Tarman, 1988; Webster & Young, 1988). Reminiscence has been defined in various ways in the literature and different benefits cited. Most of the studies, whether group or individual, have focussed on the adaptive value of life review. In this chapter definitions of life review and reminiscence are presented. Some benefits of life review are cited. The adaptive and maladaptive consequences of life review are discussed followed with an explanation of triggers. Benefits of individual and group techniques are described and the chapter concludes with a description of the institutionalized elderly.

Reminiscence

In the literature, life review and reminiscence are used interchangeably. Hence, a literature review of both concepts

was undertaken. Though the purpose of this paper was to study life review, in the literature review section both life review and reminiscence are summarized because some authors believe the terms to be synonymous. Moreover, since life review is a subset of reminiscence, the term reminiscence can be used in place of life review, but not vice versa.

Reminiscence has been described in different ways by different people in the literature. Webster's dictionary (1980) defined reminiscence as the act of recalling or retelling the past. Hughston and Merriam (1982) defined it as calling to mind experience or fact (p. 140). Beaton (1980) believed reminiscence to be "an aimless wandering of the mind" (p.272). Coleman (1974) divided reminiscence into two categories: "simple reminiscence" the recall of the past, and "informative reminiscence" a way of using the past to emphasize important matters.

Beaton (1980) described four types of reminiscence.

1) Validating - is a retrospective process providing reassurance that because a person once had competence and worth this is still true (p. 273).

2) Integrating - is the balance between achieving present satisfaction and looking ahead (p.275).

3) Guiding - is the provision of direction for the younger generation (p. 276).

4) Connecting - is the interaction between person

and environment (p.278).

McMahon and Rhudick (1967) described three types of reminiscence: 1) that which glorifies the past and berates the present 2) storytelling which neither glorifies the past nor berates the present and 3) evaluative reminiscence (life review in Butler's terms).

Lo Gerfo (1980) believed there are three different types of reminiscence.

1) Informative - the reliving and retelling of past events for leisure and to increase self-esteem.

2) Evaluative - a means to come to terms with old guilt, conflicts and defeats to find meaning in one's life.

3) Obsessive - is when reminiscing becomes dysfunctional because an individual does not resolve his past. The individual ends up in despair and may become agitated, depressed or suicidal (p. 40).

Reminiscence may be guided or unstructured (Butler, 1963; Fry, 1983; Lewis, 1973; Pincus, 1970). Reminiscence may be done silently or articulated to another person. Lewis (1973) believed that to achieve psychological gains, reminiscing may require another person as an audience.

Havighurst and Glasser (1972) summed up the definition: "all of us from time to time look back over our lives, recalling people and events, thoughts and feelings.

Sometimes, such recall comes unbidden, as idle thoughts, and daydreams. Sometimes we purposely think back trying to remember and reconstruct. Such retrospection, both purposive and spontaneous, may be called reminiscence" (p. 245).

Most authors believe reminiscence is some kind of recall of past events (Coleman, Hughston & Marion, McMahon & Rhudick and Webster). Beaton is the only one who believes that reminiscence is "an aimless wandering of the mind." The author disagrees with Beaton. The sequence of recall may not always have meaning for the listener, but it may be very significant for the reminiscer. Beaton makes the above statement, but later defines four types of reminiscing. His definitions are not very clear (p. 9). In fact he really descibes four different reasons why people reminisce: to increase self-worth, to become balanced with the environment, to provide information and to come to grips with reality. McMahon and Rhudick describe what they call three different types of reminiscence (p. 10), but again they are just decribing three reasons for reminiscing: to glorify the past (increase self-worth as stated by Beaton), to simply tell a story (could be the same as information giving described by Beaton) and to evaluate one's life (may be same as to come to grips with reality described by Beaton). This third purpose for reminiscence appears to be similar to Butler's life review. Again in Lo Gerfo's three types of reminiscence (p. 10) there is one similar to life review (to resolve old

conflicts). All these authors believe they are describing three different types of reminiscence, but they are really describing the different purposes for recalling events of the past. Reminiscsence is the recall of past events. When these events are recalled for a specific purpose, then it is called life review.

Reminiscence occurs more frequently in the elderly is it fiction or fact? Boden and Bielby (1983) found that in twelve minute sessions unimpaired community elderly dyads (over the age of 62) talked more about the past than dyads from a freshman sociology class. Lieberman and Falk (1971) found elderly (mean age 79) engaged more in reminiscing than the middle aged (mean age 49). Revere and Tobin (1980) found the elderly (ages 65-103) were more involved in their past than middle aged persons (age 45-55).

In contrast Eson and Greenfield (1962) found no relationship between age and recall in their sample of adolescent age subjects and elders (aged 60 and over). Coleman (1974) also found no link between age and frequency of reminiscing. According to Havighurst and Glasser (1972) reminiscing is a universal process which can occur as soon as the child has the ability to remember things. Although a great number of elderly talk about the past when given the opportunity, there is limited evidence that they reminisce any more than any other age group and the research is controversial and inconclusive.

In summary, reminiscence is the recall of past memories that occurs at any age. This recall may be articulated to another person or not. It may be purposeful or spontaneous. Reminiscing can be done with or without a facilitator. It includes life review.

Life Review

Life review, the term first coined by Butler in 1963, refers to an "active evaluation" of one's past life to achieve ego-integrity that occurs between the sixties and older years of life (Lewis & Butler, 1974). Butler (1963) defined life review as "a naturally occurring, universal mental process characterized by the progressive return to consciousness of past experience and particularly, the resurgence of unresolved conflicts. Simultaneously, and normally, these revived experiences and conflicts can be surveyed and reintegrated" (p. 63). Life review results when the realization occurs that life is finite (Buechel, 1986). Coleman (1974) stated that life review is one type of reminiscence where an individual reworks or reanalyze's past experience to achieve integration and acceptance of ones life. Romaniuk (1981) stated that life review can be done privately. According to Boden and Bielby (1983) life review is a process for helping someone remember the past. Jones and Zeiss (1984) stated that the term life review is usually used to refer to the review, organization and evaluation of

the overall picture of one's life (p. 6).

The author believes life review is a subset of reminiscence. Life review is the recall of past memories for a specific purpose. It is an evaluation of the past in light of the present. Life review can be done alone or with a facilitator. While it is a part of reminiscence, it does not include the whole phenomena.

Benefits or Functions of Life Review

The literature claims there are many psychosocial benefits of life review. Butler (1963) believed the function of life review is to successfully complete Eriksons eighth life stage of ego-integrity versus despair. Lewis (1971) stated that "...retrospective memories seem to provide the raw material for working through losses, for crowding out unpleasant thoughts and for reestablishing a secure self-identity based on past experiences" (p. 121). Along the same line Romaniuk (1981) stated "successful resolution of each crisis results in the acquisition of new ego skills, attitudes and basic virtues while unsuccessful resolution can result in frustration" (p. 312). If successful, the individuals gained wisdom, but if the person was dissatisfied after a review of his life then despair resulted (Romaniuk, 1981). King (1981) reiterated that reminiscence (meaning life review) helps maintain and enhance self-esteem, develop and maintain relationships and decrease loneliness and

isolation (p. 23).

Increased smiling, increased interest in personal hygiene and increased communication are some other benefits associated with life review (Baker, 1985; King, 1982; Lesser, Lazerus, Frankel, & Havasy, 1981; Lo Gerfo, 1980; Matteson & Munsat, 1982; Perschbacher, 1984; Rosenthal, 1982). All these benefits help promote the psychological well being of the person (Froehlich & Nelson, 1986). Boden and Bielby (1981) agreed that the role of life review is to achieve personal integration and understand present day life circumstances (p. 310). Pollack (1981) believed that the elderly review their life to gain insight into their own behaviour. Pincus (1970) stated functions of reminiscence (specifically life review) are to help cope with the process of aging, help allay stresses and anxieties and work through personal losses. In other words the various authors stated life review serves an adaptational function.

Adaptive and Maladaptive Consequences of Life Review

What is adaptation? Adaptation is the ability to cope with present life problems. Successful adaptation in the elderly means maintaining self-esteem while some intellectual and physical abilities are declining. It means being able to cope with grief, illness, change in environment and social status. If the life review process has adaptive consequence it helps the individual cope with life stresses; otherwise it

is maladaptive. Many papers have been published on the adaptational significance of life review. However, very little consideration has been given to its maladaptive consequences. The literature is generally biased in showing that life review is adaptive and beneficial. An attempt has been made to uncover adaptive and maladaptive qualities of life review in this paper.

Some studies showing the adaptive value of life review and reminiscence are cited. McMahon and Rhudick's study (1964) was the earliest study conducted to show the adaptive value of reminiscence. McMahon and Rhudick's sample consisted of 25 volunteers between the ages of 78 and 90 from a war veteran's clinic. They had hour long non-directive interviews with each subject that were taped and the data was analyzed in terms of present, past and future orientation, depression and loss of self-esteem and degree of intellectual deterioration, to determine their relationship to reminiscence. Their findings indicate that reminiscence is not directly related to intellectual deterioration, but it is positively correlated with successful adaptation through maintenance of self-esteem, freedom from depression, reaffirming one's sense of identity and working through losses.

Lewis (1971) looked at the relationship between reminiscence and adaptation. He hypothesized that "reminiscers": 1) would have a greater consistency between

present and past self concept, 2) in the face of a social threat would decrease their discrepancy between past and present self concept, and 3) when given a chance to reminisce after the social threat, the discrepancy would decrease more between the present and past self-concept. Lewis conducted a two session study with twenty-four community elderly men (mean age seventy-three). In the first session he administered two Q-sorts, forty-eight items each on present and past self-concept and then had subjects talk for thirty minutes about what they thought was important in life. In the second session the subjects were asked to talk about a student revolt and the Q-sorts were readministered. Lewis found those that were classified as reminiscers and those who were classified as non-reminiscers both had no change in self-concept through the experiment. A significantly greater number of non-reminiscers regarded the past in negative terms than did reminiscers. Aslo, reminiscers, when there opinion was threatened, showed a significant correlation between their past and present self-concepts compared to non-reminiscers ($t=2.16$, $p<.025$). It appears that elderly who reminisce are better able to maintain their self-esteem in a threatening situation.

Havighurst and Glasser (1972) conducted an exploratory study on middle class educated community elders. They collected self reports from 204 men and 325 women on the frequency, affective quality, content and function of

reminiscence. The questionnaires had open and closed ended questions. They did not give a description of how these questionnaires were scored. Havighurst and Glaser found: 1) there were significant gender differences between frequency and affective quality of reminiscence; 2) high frequency of reminiscence and positive affect were positively correlated with positive evaluation of the experience; 3) content of reminiscence varied between groups; and 4) reminiscence served different functions for different people. They concluded that reminiscence is a phenomena caused by a multiplicity of factors in the personality and the life experience of a person (p. 253).

Boylin, Gordon, and Nehrke (1976) modified the questionnaire developed by Havighurst and Glasser (1972) to use with a sample of 41 elderly war veterans (mean age 64.37 years) to determine if ego adjustment is related to reminiscing. They found a significant correlation between frequency of reminiscing and scores on a measure of ego adjustment based on Erikson's theory. This finding suggests that reminiscing can serve an adaptive function for the older person according to Erikson's criteria of successful adjustment to old age.

Coleman (1974) looked at the relationship of three types of reminiscence (simple, life review and informative) to adaptation. He talked to 48 London community residents between the ages of 69 and 92. Of these 23 were men and 25

were women. The subjects were visited six times each over a one and one-half to two year period and an hour long tape recording was done for each subject. Questionnaires were given in the last sessions. Coleman found 41% fit into simple reminiscence, 19% to life review and 27% to informative reminiscence. He did not find a relationship between present adjustment or recent losses and life review. But data did support that life review is related to adjustment in the presence of dissatisfaction with the past. He also found that men talked more about global events and women more about family.

Kiernat (1979) found that some behaviour changes on a "ward behaviour scale" were noted after 20 life review sessions conducted with 22 nursing home residents. The residents did not attend regularly and there was no control group. The findings suggested that high attendance was correlated with greatest improvement on a "ward behaviour scale" measuring such things as facial expression, extent of conversation, attentiveness to group activity, and presence of nonpurposeful behaviour.

Fallott (1980) studied the impact on mood of verbal recall of the past compared to talking about the present or future in a group. He studied a group of 36 females between the ages of 46 and 85. He stated that self reports on mood were more positive after reminiscing than after talking about the present or future. From these results he concluded that

reminiscing may serve an adaptational function in later life. Revere and Tobin (1980) found that mythicizing, remembering the past in such a way that it makes the person appear "heroic and immortal", serves an adaptational function. The elderly see themselves as they want to and not necessarily as they were. In this way "the past becomes unique, and in the myth becoming a reality, one's life becomes justified" (Revere & Tobin, 1980, p. 15). In their study of 35 elderly (ages 65-103) and 25 middle aged (ages 44-55), they found the elderly mythicized more about the past than the middle aged.

Perotta and Meacham (1981) used a pre- and post- test control group design to see if reminiscing intervention altered depression and self-esteem. Perotta and Meacham call it reminiscing but in fact, they used life review - the group members met individually with the researcher for 30-45 minutes for five sessions over a five week period. At these sessions the experimenter helped interpret and evaluate the person's life. One group had no sessions and the third group had sessions on current events. The dependent variables depression and self-esteem were measured by the Rosenberg Self-esteem Scale and a modified version of Zung's Depression Scale. No difference was found in pre-and post measures and the hypothesis was not supported.

Fry (1983) studied the effects of structured and unstructured reminiscence and depression among the elderly

(162 caucasians between the ages of 65 and 80). The investigator met with each subject individually for about 90 minutes. The two treatment groups talked about past life events and the control group members were visited in their homes and some mutually satisfying activity was done with them such as watching television, discussing programs or current events. Fry found that structured reminiscing (life review) significantly ($p<.05$) decreased depression, and increased feelings of self-confidence and personal adequacy.

Greene (1983) discussed the use of life review in adapting to family roles. She stated life review can help with major adjustments that are required in old age such as adjustment to retirement, change in social status, change in environment, change in relationship with spouse and change in daily living pattern.

Lappe (1987) compared the effects of a current events group and a life review group in terms of self-esteem using the Rosenberg Self-esteem Scale. All her subjects were from four privately owned long term care institutions. She had 83 subjects with a mean age of 82.6. She had a "reminiscing group" [meaning life review] and one "current events group" at each institution. Each group had 8-14 subjects. Some groups met once a week and others met twice a week. She concluded that group sessions utilizing life review increased the self-esteem scores of institutionalized elderly to a

greater degree than current events groups. She stated that whether the group meet once a week or twice a week did not effect the self-esteem scores yet her diagram (p. 14) appears to indicate that the "reminiscing group" that met twice a week scored the highest self-esteem score. Also she called her groups reminiscing groups but they could be more accurately labelled life review because the researcher decided on the themes for discussion and photographs and other memorabilia were used to stimulate discussion.

Taft and Nehrke (1990) studied reminiscence, life review and ego integrity in nursing home residents. Their sample was drawn from four nursing homes, and consisted of fifteen men and fifteen women aged sixty-five and older with a mean age of 84.13 and a standard deviation of 9.42. The respondents were given the twenty-five item reminiscence, life review, and ego integrity scales. A correlation matrix was done between the dimensions of reminiscence and life review, frequency of reminisence and ego integrity. Only the measure of life review correlated positively with ego integrity [$r=.56$, $p<.001$].

David (1990) looked at reminiscence, adaptation, and social context in old age. She interviewed 43 subjects from two retirement communities. The subjects consisted of widowed men, widowed women and single women ages sixty-eight to ninety-five. Using taped interviews where the subjects were asked to describe three memories. In the second part,

the respondents were asked specific questions about their memories and experiences of reminiscing. Then they were given two structured scales on life satisfacton and self-esteem. Scores on the measures of reminiscence and adaptation were compared across single women, widowed women, and widowed men using the Mann-Whitney test. The only significant difference was found on the life satisfaction scale. Single women had significantly ($p<.05$) higher life satisfaction scores than widowed men .

Poulton and Strassberg (1986) in an article describing the therapeutic uses of reminiscence, summarized the adaptive consequences of reminiscence as: " 1) resolution of previously unresolved conflicts and the reintegration of personality; 2) maintenance of social roles, status and public esteem; 3) maintenance of goal-directed behaviour and the perception of its meaningfulness; 4) maintenance of self-esteem and personal significance; 5) rediscovery of lost skill and reengagement on lost activities and, 6) in coping with loss or grief" (p. 384-387). These consequences apply equally well to life review.

From the review of the literature it can be concluded that reminiscence in general and life review in particular has adaptive consequences. Therefore, life review has important implications as an educative intervention with the institutionalized elderly.

Life review and reminiscence are not always adaptive.

Various authors have listed depression, hostility, guilt, grief, despair, worthlessness and hopelessness as possible negative consequences of life review and reminiscing (Ebersole, 1976; Ellison, 1981; Lewis, 1971; Lewis & Butler, 1974; Lo Gerfo, 1980; McClosky, 1985; Perschbocher, 1984; Poulton, 1976;& Schnase, 1982). However, the potential negative effects of either have received very little experimental attention. Only a single study (Tobin, 1972) could be found that reported negative consequences.

Tobin (1972) questioned the institutionalized elderly about reminiscing. Many of them stated that they liked to reminisce but tried not to because they did not want to burden other people. The elderly felt that those around them viewed reminiscing negatively. Therefore, they felt guilt when they reminisced.

Butler (1980) talked about three types of individuals that may not benefit from life review. The first type was those that were future oriented and achievers. The second type was the criminals- those who intentionally injured other people. The third type was those individuals described as arrogant and full of pride. These types of individuals may not be able to resolve their conflicts and despair may result. According to Lo Gerfo (1980) obsessive reminisence may result from a stress such as death. The person may not be able to stop from mourning for he or she may not be able to find a replacement for the loss. This obsessive

reminiscing that can result in despair is caused by guilt, stress or grief.

Poulton and Strassberg (1986) stated that there are three maladaptive consequences of reminiscence: 1) avoidance of present situation, 2) exacerbation of guilt and inadequacy, depression, pain and obsessive ruminations and 3) alienation from other people. These consequences may apply equally to life review. It appears that life review and reminiscence can be maladaptive if it is too excessive or used with inappropriate clients. If individuals recall past events continuously without reintegration and evaluation then despair results. Therefore, when using life review its maladaptive effects should not be ignored.

Triggers

Jones (1984) defined triggers as "any form of stimuli that will prompt memory recall " (p.7). These stimuli usually have special significance to the individual. There are two types of triggers: major life events , and people, objects and events. Major life events are social transitions (Romaniuk & Romaniuk, 1981, p. 488). The depression, war, marriage, and death are some major events that have been used. It is believed that the elderly recall childhood experiences better than events within the last year, but significant events such as marriage, death of a spouse, a first house and the birth of a child are always remembered

best (Baker, 1985; Coleman, 1974).

According to Funch and Marshall (1984) life events are to be used cautiously. In their study using a large national sample, they studied fall-off rates. Fall-off rate is the inability to recall events that have occurred, and is given as a percentage. They found that fall-off is rapid in the first 12 months and then levels off. Also they found some events such as the death of a spouse, marriage, and birth of a child show no fall-off while other events such as death of a friend and illness in the family have immediate and severe fall-off.

The second type of triggers are objects, people, and events. Lewis and Butler (1974) listed very specific object type triggers in their paper such as pilgrimages, reunions, visitations to childhood places, and genealogy. Other triggers have been used in different studies. McCloskey (1985) used music; Buechel (1986) and Kiernat (1979) used activity. Any object such as "a picture of a sewing machine, a notebook from high school, or a favorite quilt can elicit memories (Ellison, 1981; p. 531). Ruth Perschbacher (1984) asked the elderly to recall historical events. McCormack (1979) gave the subjects a word and asked for the first event they recalled and put it on a life line. Donahue (1982) used life events in a particular period as a trigger. Others have used objects, music, art, poetry, family albums, scrapbooks, customs and critical life events (Baker, 1985; Butler, 1974;

Job, 1983; Lo Gerfo, 1980; Pollack, 1981; Taylor, Jones & Zeiss, 1983; Wysocki, 1983). Any person, object or thing that can prompt recall can be used as a trigger.

The only study found on triggers in the literature search was done by Romaniuk and Romaniuk in 1981. They studied reminiscence functions and triggers. Their purpose was "to determine if hypothesized functions and triggers of reminiscence could be supported empirically through the development and testing of a Reminiscence Uses Scale and Reminiscence Triggers Scale, and 2) to determine if there were any predictable relationships between what triggers reminiscence activity and the way in which these memories are used by a sample of elderly individuals" (p. 479). In other words, they recorded whatever initiated recall and the reason for the review of life. They collected data from 91 elderly residents of a retirement community. A factor analysis of the Reminiscence Uses Scale yielded three subscales: self-regard/image enhancement, present problem solving, and existential/self-understanding. The Reminiscence Triggers Scale yielded five subscales: awareness/resignation, death awareness-other, realization of goals/accomplishments, changes/threats to body, and change in career/life's direction. "A multiple regression analysis indicated that self-regard/image enhancement was predicted by realization of goals/accomplishments and reminiscence frequency. Present problem solving was predicted by death awareness/resignation

and existential/self understanding by changes/threats to body and life review" (p. 472). They found that death of a significant person was the greatest trigger, followed with change or threat to body and then change in career or life direction.

There are many different types of triggers, however, the most meaningful triggers are objects or events that hold special meaning for the individual.

Benefits of Group Technique

Life review using group technique has been documented since the 1960's. Klein, Le Shan and Furman (1965) suggest that groups encourage socialization and help the elderly remember and increase self-esteem. Many believe group technique increases socialization and feelings of belongingness (Baker, 1985; Ellison, 1982; Kiernat, 1979; Matteson & Munsat, 1982). Lewis and Butler (1974) believed groups can promote recall of the past. They suggested having a cross-generational group and having the elderly draw from memory to help solve current family problems. Lewis (1971) said that without social bonds created in group contact, the elderly may lose their identity and become "hopeless" and depressed. Ebersole (1973) stated that

> group reminiscing may instill a sense of solidarity and importance not available to an isolated person, particularly in a culture which puts little value

> on the aged individual...opportunity for catharsis in the group setting enhances cohesiveness and is a corrective emotional experience, while candid consensual validation of guilt, inadequacies, failures and successes raise self-esteem (p. 226).

Baker (1985) said that participating in a group gives the elderly a sense of belonging and helps develop a positive attitude.In fact group socialization influences individual behaviour frequently beyond the original goal for which it was first brought together (Hare, 1962, p. 75).

In a pre- and post-test design Parsons (1986) showed that life review using group technique decreased depression in the elderly. Sherman (1987) conducted a study on 104 community seniors to see if a structured life review group focussing on life cycles and a group focussing on memory recall over a three month period increased life satisfaction and self concept. The Life Satisfaction Form Z and the Mange Self-Concept Measure were administered before the first session and after the last or tenth session. Significant positive changes in life satisfaction, and self concept were found in all groups, but a group focussing on memory recall reported more life satisfaction. Froehlich and Nelson (1986) compared verbal and activity groups. Two of the groups engaged in reminiscing while the other two groups did meaningful activity (made drawings and collages) while

reminiscing. Affective meaning did not differ significantly between the verbal and activity groups.

Poulton and Strassberg (1986) stated that group technique is an effective tool to use with elderly clients. It helps with the reorganization of the past in coping with the present. It helps increase socialization and self-esteem (Poulton & Strassberg). According to these authors life review using group technique helps promote the psychological wellbeing of the individual.

Benefits of Individual Technique

Most of the life review literature deals with groups. Although similar benefits can be obtained with individuals only a few applications could be found in the literature. Life review in one of its oldest forms, autobiography, has been around for more than 200 years (Gunn, 1982).

Butler (1987) stated that autobiography increased self esteem. Donahue (1982) interviewed six nurses between the ages of 61 to 80 for the purpose of obtaining historical information. Donahue concluded that many of the same benefits were seen in her sample as those cited in the literature for groups. The nurses stated they enjoyed the experience (p. 275). Lewis and Butler (1974) have worked with individuals one-on-one to facilitate the reminiscing process to help individuals reach Erickson's stage of ego-integrity. They have noted that some individuals "prefer to

work alone with a tape recorder or pencil and paper" (p. 172). Writing, according to Butler (1987), can help establish an individual's self-worth and psychological well-being. These individuals working alone, however, would not gain socialization benefits. When the individual technique is used the person has more time to speak or write, thus may show benefits in a much shorter time. In a group, the time per person decreases as group size increases. Although similar benefits can be achieved through individual technique, the group technique is more often used because it is conducive to helping the individual maintain social identity and it is more cost effective.

Institutionalized Elderly

The elderly on long term care units are those waiting for assessment and placement usually to an intermediate care or an extended care facility. These elderly may have transferred from an acute care hospital or the community following some kind of physical or psychological loss and are waiting for placement. These elderly are in a new environment without their usual social support system and experience loss of their home, independence, community, privacy, self-esteem, and personal belongings (Parsons, 1986). Due to numerous physical and psychological ailments the elderly frequently suffer from pain, have difficulty breathing, have bladder and bowel elimination problems and a

decreased level of activity. They are not able to walk, get in and out of bed, bathe, comb their hair, shave, dress, eat, go to the bathroom or dial the telephone (Ebersole & Hess, 1985).

Since the institutionalized elderly suffer from many losses and changes it is easy to see why "reactive depressions resulting from various losses are among the most common emotional disorders found in old people" (Matteson and Munsat, 1982, P. 178). In fact the incidence of depression is said to be as high as 50% (Hawranik & Kandratuk, 1986, p. 26). Because of all the changes that have occurred due to hospitalization, these individuals may display rage and anger and be very difficult to nurse (Ebersole, 1976, p. 1305). Also while waiting for placement, it is not uncommon for the client to experience the death of another patient on the ward.

These institutionalized elderly with decreased self-esteem and feelings of depression are in an environment that triggers reminiscing because death and change or threat to a body and change in life direction are strong triggers (Matteson & Munsat, 1982; Romaniuk & Romaniuk, 1981).

The elderly clients are in a new environment with many losses and need help to "readjust, resolve, reorganize, and reintegrate" (Schnase, 1982, p. 16). Butler (1963) might suggest that these individuals need to participate in life review to successfully reorganize their past life in order to

accomplish Erikson's eighth life stage of ego integrity versus despair.

Summary

Reminiscence, a major concept, has been defined as the act of recall. A subset of reminiscence, life review, has been defined as the act of purposeful recall. Studies supporting benefits of life review such as a decrease in depression and isolation, and an increase in self-esteem and in activities of daily living have been cited. The literature on the adaptive and maladaptive significance of life review and reminiscence has been reviewed indicating the bias toward adaptive significance. Triggers have been defined as anything that promotes recall. Both group technique and individual technique have been presented as being beneficial, but group technique is said to be more cost effective and also has the added element of socialization. The psychosocial environment of the institutionalized elderly has been described to show that the elderly may benefit from a life review program.

CHAPTER III METHODOLOGY

A quasi-experimental research design was chosen for this study (Campbell & Stanley, 1963). A pre- and post-test design was selected to study the influence of life review on the institutionalized elderly. This chapter discusses the sample and setting used in this study; the instruments used to measure independence, integrated functioning, depression, and group process; the data gathering procedures; the independent-dependent variables used; and ethical consideration.

Sample and Setting

This study took place in the long term care unit of a community based family practice oriented hospital in Vancouver, British Columbia. A convenience volunteer sample of thirty-five elderly patients from one unit in the hospital was used. The elderly (aged 60 and older) on this unit were in a state of transition. These elderly were moved to this particular 20 bed unit from other medical and surgical units in the hospital when they were not able to recover from their admission diagnosis or function with the help of their support system and or homecare help at home. These patients stay on this unit until they can be placed in an appropriate care facility. Placement may take up to one year. Thus the unit is called a transfer unit.

Patients were selected from a unit which was staffed by 3.5 staff on days, 2.5 on evenings and 2 on nights. The staff mix consisted of registered nurses and patient care aides. There was only one registered nurse on each shift. On day shift, the unit also shared one nursing coordinator and clinical nurse educator with a 75 bed unit. On evening and night shifts there was a hospital nursing coordinator available to deal with emergencies. There was no rehabilitation therapy coverage on this unit. Patients could be visited by social services and pastoral care department members if referrals were made for these services by any member of the staff. There were no regularily planned activities for patients on this unit. Sometimes after the patients have been on this unit for a long time, they were allowed to go on bus trips with the patients from the extended care unit.

The area of the city served by the chosen hospital was a primarily middle to upper class area. There was a variety of ethnic groups who resided in this area but almost everyone who was in the study was Caucasian. At the time of the study, the unit had mainly Caucasian patients. There were two Oriental patients on the unit of which one was included in the study. Only one Oriental patient was included because only one patient fit the selection criteria.

In order to achieve some measure of homogeneity the sample was limited to patients who met the following

criteria:

1) They were able to communicate in English. (The patient was considered to have adequate English skills if he or she could comprehend the talk on the purpose of the study and carry on a comrehensible conversation with the researcher in English.)

2) The staff believed the patient could tolerate an activity for forty-five minutes. (The person was believed to have the ability to participate in a forty-five minute activity if he or she was judged as being able to participate without disrupting the group and without bowel or bladder incontinence by the registered nurse on the unit or if the nurses notes on the patient's chart stated that the person had not been incontinent more frequently than every two hours and there was no record of disruptive behaviour.)

3) They were not clinically diagnosed with depression. (The individual was assumed to be not clinically depressed unless a diagnosis of depression was charted in the medical history or progress notes.)

Instruments

Four different measurement instruments were used.

1) The Geriatric Rating Scale (GRS); first developed by Plutchik et al, 1976; was used to measure the patient's ability to function in an integrated manner (see Appendix A). It consists of 31 items related to patient behaviour that are

scored from 0 to 2. The higher the score, the higher the degree of functional dependence. The scores are added to obtain a GRS score. The instrument was administered by the researcher in about 10 minutes. Its interrater reliability is about .87 (Plutchik et al, 1976). "Its validity has been established by Plutchik et al (1976) and Smith et Al (1977) and it can also be inferred from its close approximation of the Stockton Geriatric Rating Scale" (Plutchik et al, 1976). The original sample for the GDS was 220 hospitalized geriatric patients. For this sample the Hoyt estimate of reliability is 0.87 with a standard error (SE) of 3.20 for the pretest and 0.86 with a SE of 3.25 for the posttest. This result is consistent with the literature.

2) The Activities of Daily Living Evaluation Form (ADL) is a six item instrument that was used to measure the functional independence or dependence of patients with regard to bathing, dressing, going to toilet, transferring, continence and feeding (Appendix B). It is rated A to G. "A" being independent in all six functions and "G" being dependent in all six functions. It was first designed by Katz et al (1963) as a measure of function that could be used in objective evaluation on chronically ill and aging population. The ADL was converted to the A-G scale in 1970. No validity or reliability measures could be found for the scale. The scale has "been used to assess need for care, effectiveness of treatment and as a teaching aid in

rehabilitation" (Katz et al, 1970, p. 914). The ADL can be easily administered by nursing staff working with the patients in about two minutes. In this study, the registered nurses on the unit completed the ADL. From this study the Hoyt estimate of reliability was calculated to be 0.75 with a SE of 1.07 for the pre-test and 0.85 with a SE of 1.02 for the post-test.

3) The Geriatric Depression Scale (GDS) is a 30 item instrument that was used to measure depression (Appendix C). It consists of dichotomous (yes/no) questions. Twenty questions indicate depression when answered "yes" and ten questions indicate depression when answered "no". It can be self-administered. In this study the investigator read the questions to the subjects and recorded the responses. Brink et al (1982) developed the self-rating GDS scale. They found it to have a sensitivity of .90 and a specificity of .80. They compared it with the Zung and Hamilton Scales and got a correlation of .82. In this study item analysis was done. The Hoyt estimate of reliability for the scale was calculated as 0.84 with a SE of 2.23 for the pretest and 0.89 with a SE of 2.12 for the posttest. The instrument has been extensively cited in the literature.

4) The Group Process Observational Checklist (GPOC) has been developed by the researcher to determine what behaviors occur in the group (Appendix D). It is a 13 item checklist that includes behavioral and verbal observations (Appendix

E). The 13 items on the checklist (GPOC) are derived from Bale's Group Process Categories (Appendix F). In Bale's Group Process instrument there are three categories that are considered positive: shows solidarity, shows tension release, and agrees; and there are three negative categories: disagrees, shows tension and shows antagonism (Bales, 1985). The GPOC is believed to have validity because it is a checklist of observations that are displayed in a group and also because it is directly derived from Bale's group process categories that have been extensively used for numerous years with groups, mainly children in schools.

To test its reliability, the researcher and another nurse educator went to a long term care unit and attended group meetings. They both observed and recorded two sessions. An interrater reliability of at least .7 was needed. The recordings of the two observers were identical, however, it can not be assumed that the interrater reliability would be 1.0. This was a special case because both observers were professional colleagues and had a very similar educational background. Also before the sessions they discussed how they would classify each behavior. Though one cannot assume a reliability of 1.0, one can safely say the reliability of the GPOC is very high.

Data Collection

After consultation with the registered nurse on the unit, patients who met the criteria for acceptance in the study were contacted on the unit by the researcher. Each potential subject was given an explanation of the purpose and details of the study. All patients were informed that their participation in the study was voluntary and that it would involve a 20 minute interview in the next week and again in four weeks time (Appendix G). It was emphasized that the patients could withdraw at any time without affecting their present and future medical and nursing care. A consent form with the same information was left with the patient to be picked up later by the researcher (Appendix H). This way the patient could discuss the study with his or her family prior to consenting. In two cases, the researcher explained the study to the family at the patient's request. If the patient agreed to participate he or she signed the consent form and kept a copy. Consent was obtained from the respective physicians allowing their patients to partake in the study (Appendix I). The patients who had consented were randomly assigned to the control or experimental group.

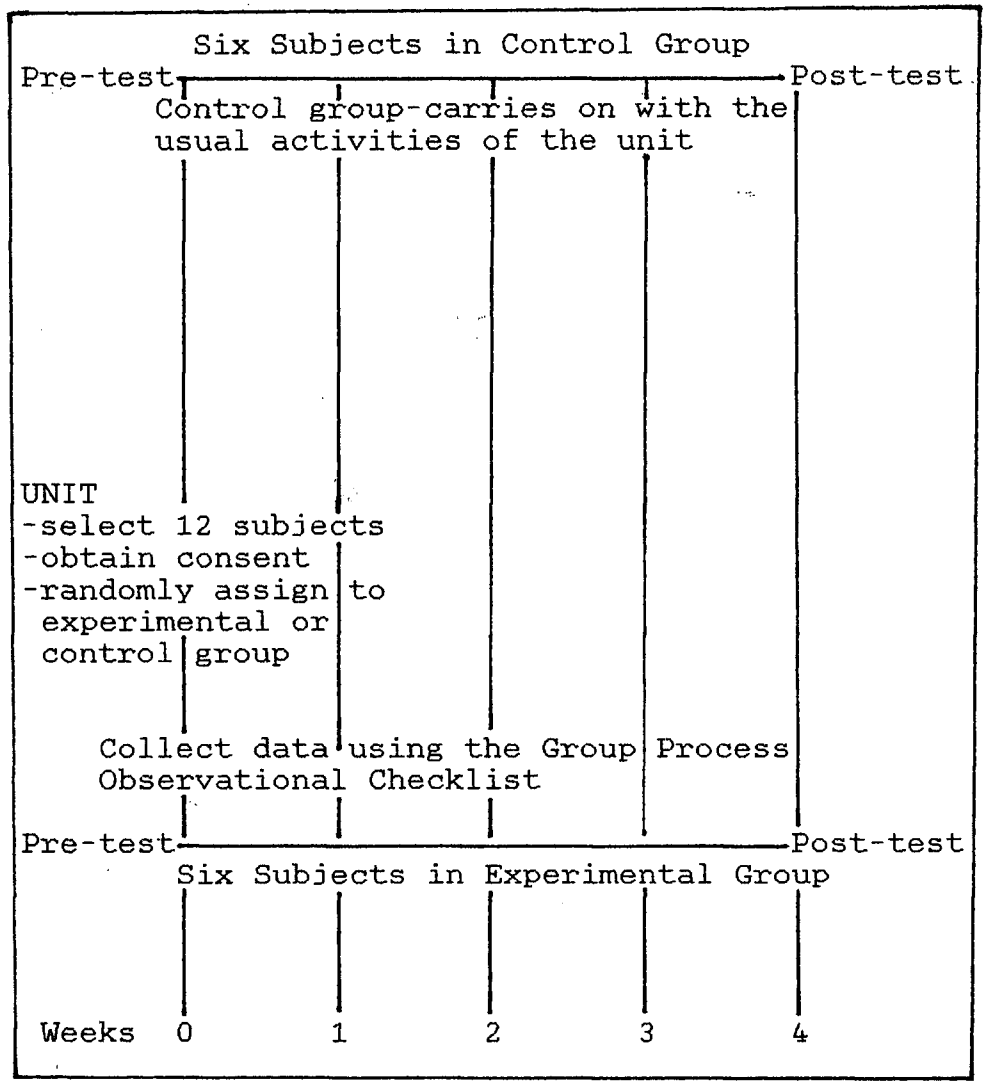
Those assigned to the experimental group were approached by the researcher in the same manner to sign another consent form to participate in the eight life review sessions (Appendix J). These subjects were told about the life review sessions which would be held twice a week for four weeks on

the unit and about the topics that were going to be discussed (Appendix K). Again the consent form was left with the patient. The researcher later returned to pick up the completed consent form. If consent could not be obtained from all patients, others were randomly assigned to the experimental group until consent was obtained from half the group.

There were eight different groups in total, four experimental and four control. Each group was to have six subjects because Bass and Norton (1951) suggest that it is difficult to observe and keep track of interactions beyond the size of seven. Also the time available per individual to interact decreases as size increases. It is also more difficult for the leader to coordinate activity as the group size increases, and as group size increases members feel more threatened or inhibited to speak. Thus interaction time can be dominated by a few individuals in groups larger than seven.

The plan had been to select 12 subjects at a time that met the selection criteria for each of the 4 groups and then assign six of them to the experimental subgroup and six to the control subgroup (Figure 1). In reality this was impossible. Twelve subjects were selected for the first group but they could not be randomly assigned for only 6 of them wanted to be in the experimental group. When it was time to select the second group, only 6 new subjects were

Figure 1. Diagrammatic Representation of Study.



Repeat above procedure 3 more times

available, the unit had had a very low turn over rate that month. The researcher was not sure whether to assign three subjects to the experimental subgroup and three to the control or to assign all of them to the experimental group and use the six subjects from the previous group as the control for the second group. After consultation with the other committee members, it was decided to assign all of these subjects to the experimental group. This was not possible. One subject did not want to be in the experimental group so was assigned to the control. She did not want to be in the experimental group because she did not want to commit to attending eight life review sessions. Later the committee decided that using the same control group again would confound the data. Therefore, that set of data as deleted from the results. For the third group only eight new subjects fitting the selection criteria were available. Of these four were randomly assigned to the experimental subgroup and four to the control. For the fourth group, 11 new subjects were available. Of these five were randomly assigned to the experimental group and six to the control. There were a total of 35 subjects. Eighteen in the experimental groups and 17 in the control groups.

The researcher took the three scales: the GRS, ADL and GDS, to the unit, before the first life review session and after the last. The researcher read the items on the GDS scale to the subject and marked the subject's response. The

researcher had the full time registered nurse on the unit complete the GRS, and ADL. Demographic data was collected from the client's charts and from the client using a structured interview schedule (Appendix G). Data about the patient's response to the life review sessions was also collected. Data was collected daily through observations, journal entries and staff and family interviews. It was hoped that this kind of data would help illuminate some of the quantitative findings and account for the life review process.

Each experimental subgroup attended eight life review sessions co-lead by two registered nurses, one being the researcher. The sessions took place in the unit's dining room. Each session was audiotaped and later analyzed for frequency of verbal response, time length of speaking, number of life events and type of interaction responses. A behavioral checklist was completed for each session. Tea and cookies were served at each life review session to increase socialization. The control group carried on with the usual activities of the unit. After the eighth life review session, the GRS, ADL and GDS were readministered to experimental and control group patients who did not drop out.

Hypotheses

Data were analyzed in order to test the following hypotheses:

1] There will be a decrease on test scores of integrated functioning, independence and depression after eight life review sessions.

2] The variables frequency of speech, time length of speech, positive behaviors, and number of major life events cited will positively correlate with each other.

3] The variables frequency of speech, time length of speech, positive behaviors, and number of major life events cited, will positively correlate with integrated functioning, independence level of functioning, and negatively correlate with depression.

4] The variables integrated functioning and independence level of functioning will be positively correlated with each other and negatively correlated with depression.

Independent-Dependent Variables

The independent variable or the treatment variable was the life review group process. The treatment consisted of eight life review sessions over a four week period. Two sessions were held weekly one on Tuesday and one on Thursday lasting about 45 minutes each. The sessions were co-lead by the researcher and another registered nurse.

Each life review sessions had a set topic but otherwise

were not structured. The topics were as follows:

Session 1 - Introduction, First Move of Patient

Session 2 - School Days

Session 3 - Marriage

Session 4 - First Child

Session 5 - First Hospitalization

Session 6 - Death of Significant Other

Session 7 - Move to Care Facility

Session 8 - Closure/Good-bye

The independent variable, the group process, was analyzed in terms of the Group Process Observational Checklist (GPOC). All group sessions were audio recorded. These tapes were analyzed for time length of speaking, number of times spoken and number of major life events talked about.

The dependent variables were: 1) Integrated functioning was measured by a score on the Geriatric Rating Scale (GRS). 2) Independence in activities of daily living was measured by the Activity of Daily Living Evaluation Form (ADL). 3) Individual's depression level was measured by the score on the Geriatric Depression Scale (GDS).

Ethical Consideration

The research proposal was submitted to the University of British Columbia Behavioral Sciences Screening Committee and approval obtained. Permission to conduct the study was obtained from the Nursing Research Committee of the hospital.

Nursing staff assisted in the selection of potential subjects according to the sample criteria. Physician consents were obtained. Each potential subject was approached individually by the researcher. The subjects were told that participation or non-participation in the study would not affect present and future medical and nursing care. They were also told that they could withdraw from the study at any time if they so desired without jeopardizing their care. To protect confidentiality, the subjects were given pseudo names.

CHAPTER IV RESULTS

The data from the instruments were analyzed to determine any significant differences in the independence level of functioning, integrated functioning, and depression between the control and experimental groups. Frequency counts of group process behaviors were also determined and correlated with the scores on the three instruments: Activities of Daily Living Evaluation Form, Geriatric Rating Scale and the Geriatric Depression Scale.

This chapter is divided into two sections. The first part reports the data regarding the specific demographic characteristics of the sample. The second section describes the data related to the four hypotheses of the study.

Demographics

The study consisted of 35 patients divided between the experimental and control groups. There were 18 patients in the experimental groups and 17 in the control groups (Appendix L & M). Of the 18 in the experimental group 14 were female and 4 were male. In the control group, 13 were female and 4 were male. The average age in the experimental group was 82.61 years with a range of 66 to 95 years. The average age in the control group was 81.53 years with a range of 66 to 103 years. They all had some kind of medical condition varying from arthritis to a stroke. The patients

in the experimental group had an average of 6.94 living family members with a range of 0 to 20 and the control group had an average of 10.06 living family members with a range of 0 to 28. Of the living family members in the experimental group an average of 3.5 per patient lived in the Vancouver area with a range of 0 to 15, of the control group an average of 5.18 lived in Vancouver with a range of 0 to 26. On average the patients belonged to 0.55 organizations with a range of 0 to 2 in the experimental group and 0.88 with a range of 0 to 4 in the control. They all came to the long term care unit from an acute care unit in the hospital. Of the 18 patients in the experimental group 15 of them lived alone prior to hospitalization and three of them lived with their spouse. Of the control group nine patients lived alone and eight lived with their relatives. Out of the eight, four patients lived with their spouse, three with their siblings and one with a child. Their occupations varied from homemaker to professional.

Results

Since the study was exploratory, and the groups were small an alpha value of .10 was used. More significant results were identified where they occured.

The findings of the study are organized in terms of the four hypotheses.

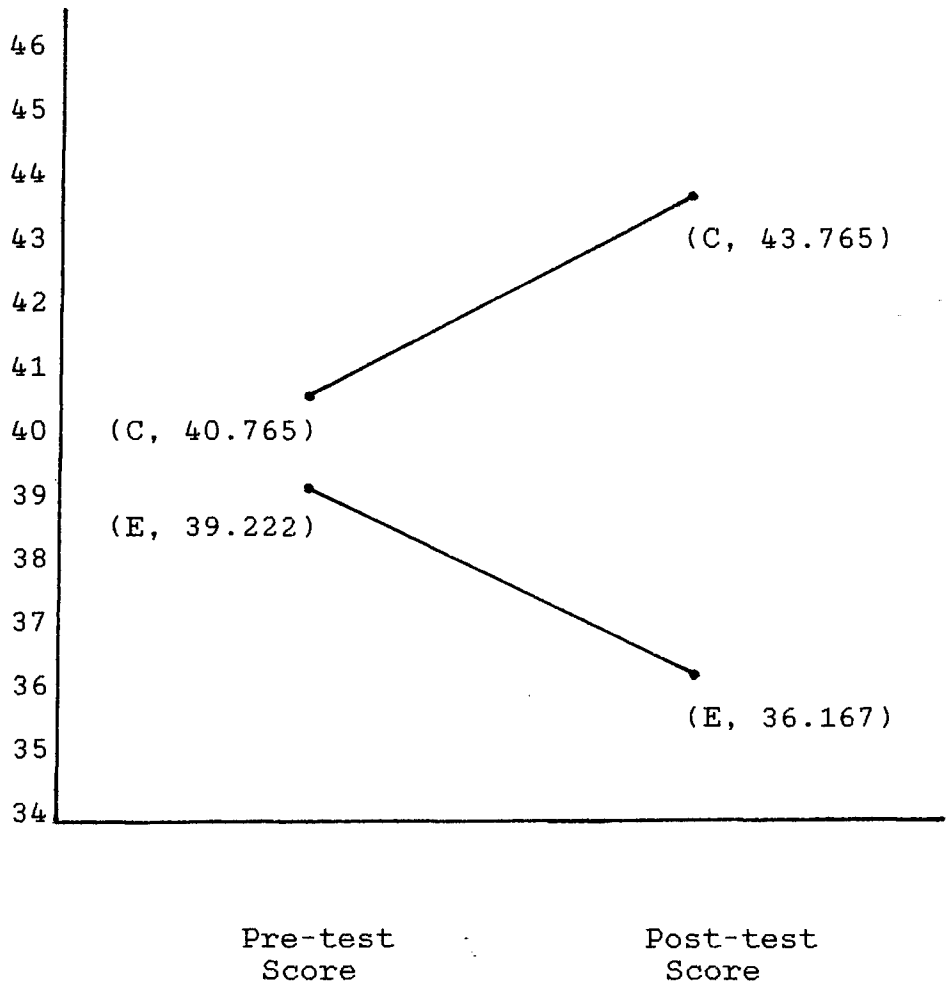
Hypothesis Number One:

> There will be a decrease on test scores of integrated functioning, independence and depression after eight life review sessions.

To test this hypothesis, "t" tests were done of the experimental and control group's pre- and post-test scores on the the Geriatric Depression Scale (GDS), the Activities of Daily Living Evaluation Form (ADL), and the Geriatric Rating Scale (GRS).

The scores on the GDS varied from 31 to 53 with a mean of 39.86 and a standard deviation (SD) of 6.38 (Appendix N, O). The mean pre-test score for the experimental group was 39.222 with a SD of 5.537, and 40.765 for the control group with a SD of 5.729. The mean post-test score for the experimental group was 36.167 with a SD of 4.668 and 43.765 for the control with a SD of 5.629. Using the Multivariate Mixed-Model Manova, the differences in scores of the experimental and control group was .000 ($p<.05$) (Figure 2). The level of depression decreased for the experimental group of patients and increased for the control group. The significance between the pre-test scores of the experimental and control groups was not calculated using a statistical test because the difference in the means of the two groups is less than 1/5 of a standard deviation. Thus, the pretest scores of the experimental and control groups are considered to be similar. Therefore, this part of the hypothesis , there will be a decrease on test scores of depression after

Figure 2. Mean Sample Scores of the Geriatric Depression Scale



Note. A low score is better.

The difference in scores of the control and experimental groups is .000 ((p<.05).

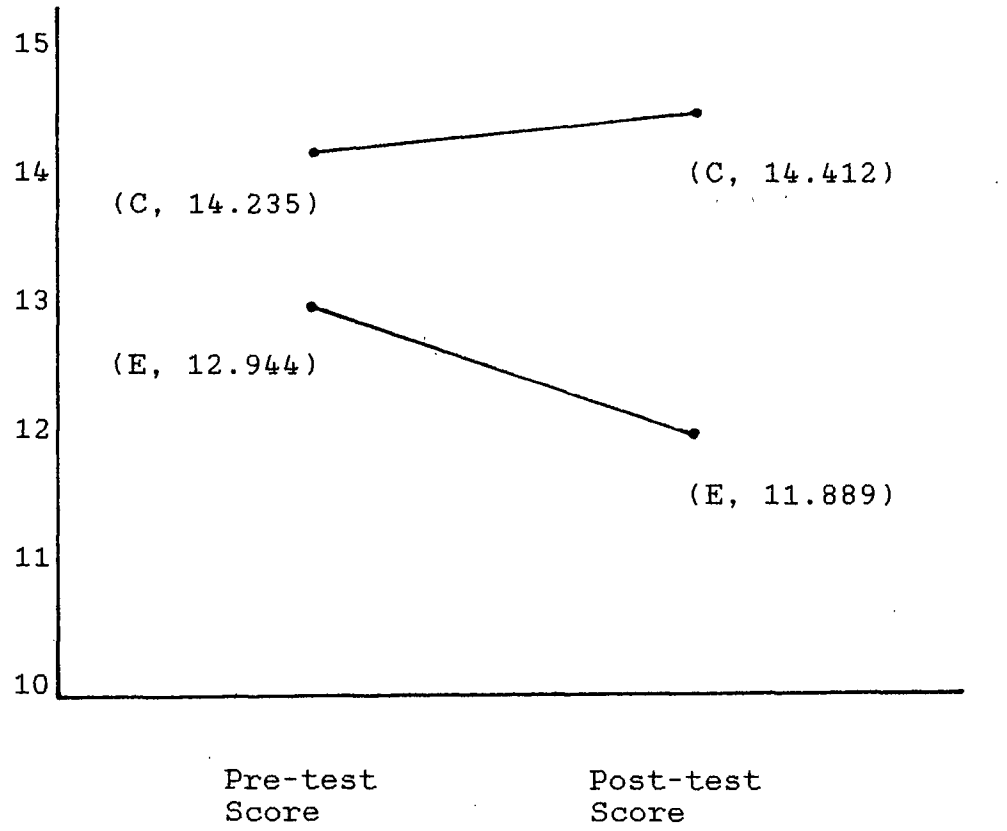
C= Control Group

E= Experimental Group

eight life review sessions, was supported.

The ADL [Activities of Daily Living Evaluation Form measuring the independence level of the patients] was filled out by the staff on the unit. The range of scores for the ADL was 6.00 to 18.00 with a mean of 13.11 and a SD of 2.92 (Appendix N, O). The mean pre-test scores for the experimental group were 12.944 with a standard deviation of 2.775 and for the control group the mean was 14.235 with an SD of 1.602. The mean post-test scores were 11.889 with a SD of 3.359 for the experimental group and 14.412 with a SD of 1.622 for the control group. Using the Multivariate Mixed-Model Manova, the difference in scores of the experimental and control group was 0.113 (Figure 3). The significance between the pre-test scores of the experimental and control group were not calculated using a statistical test because the difference in the means of the two groups is less than 1/3 of a standard deviation. This part of the hypothesis was not supported statistically. The data suggests the change toward independence (12.944 to 11.889) was not as much as expected (p=.113) although the change was in the right direction. Since this was a physical ability that was being assessed, it is not surprising that there was no significant improvement in the four short weeks during which the study was conducted. The GRS [Geriatric Rating Scale, measuring integrated functioning] was filled out by the staff on the unit. The pre-test scores varied from 38 to 69 with a mean

Figure 3. Mean Sample Scores of the Activities of Daily Living Evaluation Form



Note. A low score is better.

The difference in the experimental and control groups is .113.

C= Control Group

E= Experimental Group

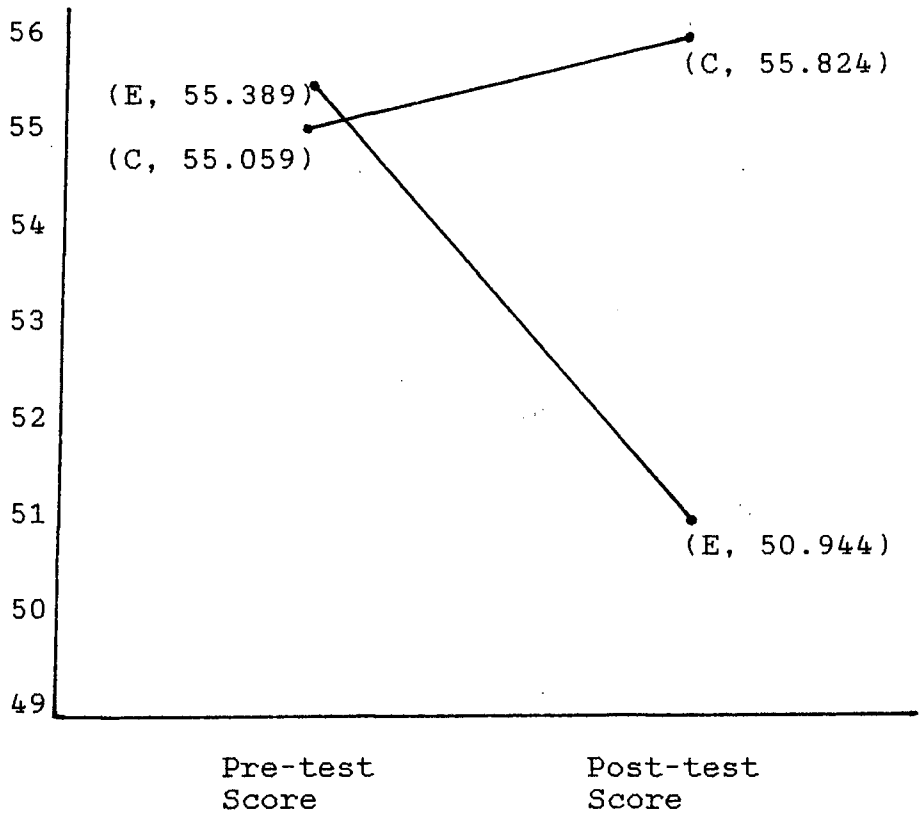
of 53.31 and a SD of 8.89 (Appendix N, O). The mean pre-test score was 55.389 with a SD of 8.846 for the experimental group, and 55.059 with a SD of 9.371 for the control group. The mean post-test score was 50.944 with a SD of 8.033 for the experimental group, and 55.824 with a SD of 9.302 for the control. Using the Multivariate Mixed-Model Manova the differences in scores of the experimental and control groups was 0.014 ($p<.05$) (Figure 4). The significance between the pretest scores of the experimental and control group were not calculated using a statistical test because the difference in the means of the two groups is less than 1/25 of a standard deviation. Thus, the pre-test scores are believed to be similiar. The data supports this part of the hypothesis that there is a decrease on test scores of integrated functioning after eight life review sessions.

Hypothesis Number Two:

> The variables frequency of speech, time length of speech, positive behaviors and number of major life events cited will positively correlate with each other.

Adjusted average scores were obtained for the 12 behaviors on the Group Process Observational Checklist (GPOC) and each behavior was correlated with the rest. The thirteenth behavior, physically attacks, was removed from the Group Process Observational Checklist because not a single patient attacked another patient. The scores needed to be adjusted because every patient did not attend every session (Appendix Q). Pearson correlation coefficients were

Figure 4. Mean Sample Scores of the Geriatric Rating Scale



Note. A low score is better.

The differences of the control and experimental groups is .014 ($p<.05$).

C= Control Group

E= Experimental Group

obtained. Correlations among the following behaviors were significant ($p<.10$). $P<.10$ was used because this was the first time that the GPOC was used in a life review group. Smiles was positively correlated with: nods in agreement (.44), laughs (.84), verbalizes agreement (.49), and offers verbal encouragement (.40) (Table 1). Nods in agreement was positively correlated with: laughs (.66), jokes to release tension (.56), verbalizes agreement (.76), offers verbal encouragement (.71), and negatively correlated with displays withdrawl (.33), and physically disrupts (.34). Laughs was positively correlated with: jokes to release tension (.46), verbalizes agreement (.56) and offers verbal encouragement (.54). Jokes to release tension was positively correlated with offers verbal encouragement (.42). Verbalizes agreement was positively correlated with offers verbal encouragement (.83). Displays withdrawl was positively correlated with: physically disrupts (.58), and verbally diminishes (.79). Verbalizes withdrawl was positively correlated with physically disrupts (.35). Verbalizes hostility was positively correlated with verbally interrupts (.69). Physically disrupts was positively correlated with: verbally interrupts (.47), and verbally diminishes (.53).

For this part of the hypothesis, that the positive behaviors will correlate positively with each other, there is support. However, there was one positive behavior, nods in agreement, that correlated significantly ($p<.10$) with the

Table 1

Pearson Correlation Coefficients Among the Behaviors on the Group Process Observational Checklist

Behavior	Smiles	Nods in Agreement	Laughs	Jokes to Release Tension	Verbalizes Agreement	Offers Verbal Encouragement
Smiles	1.00	.44*	.84**	.00	.49*	.40*
Nods in Agreement	.44*	1.00	.66**	.56**	.76**	.71**
Laughs	.84**	.66**	1.00	.46*	.56**	.54**
Jokes to Release Tension	.00	.56**	.46*	1.00	.21	.42*
Verbalizes Agreement	.49*	.76**	.56**	.21	1.00	.83**
Offers Verbal Encouragement	.40*	.71**	.54**	.42*	.83**	1.00

#p<.10. *p<.05. **p<.01.

Table 1 Continued

Pearson Correlation Coefficients Among the Behaviors on the Group Process Observational Checklist

Behavior	Displays Withdrawl	Verbalizes Withdrawl	Verbalizes Hostility	Physically Disrupts	Verbally Interrupts	Verbally Diminishes
Smiles	-.06	.06	-.01	.01	-.16	.14
Nods in Agreement	-.33#	-.20	-.24	-.35#	-.31	-.22
Laughs	-.28	.16	-.02	-.25	-.21	-.07
Jokes to Release Tension	-.28	.02	-.14	-.16	-.11	-.22
Verbalizes Agreement	-.29	.08	.12	-.25	-.01	-.21
Offers Verbal Encouragement	-.27	-.02	.14	-.16	.07	.22

#p<.10. *p<.05. **p<.01.

Table 1 Continued

Pearson Correlation Coefficients Among the Behaviors on the Group Process Observational Checklist

Behavior	Displays Withdrawl	Verbalizes Withrawl	Verbalizes Hostility	Physically Disrupts	Verbally Interrupts	Verbally Diminishes
Displays Withdrawl	1.00	.14	-.04	.58**	.08	.79**
Verbalizes Withdrawl	.14	1.00	.10	.35#	.17	.10
Verbalizes Hostility	-.04	.10	1.00	-.01	.69**	.04
Physically Disrupts	.58**	.35#	-.01	1.00	.47*	.53**
Verbally Interrupts	.08	.17	.69**	.47*	1.00	.05
Verbally Diminishes	.79**	.10	.04	.53**	.05	1.00

#p<.10. *p<.05. **p<.01.

negative behaviors of displays withdrawl (-.33) and physically disrupts (-.35).

Next the variables frequency of speech [FRS], time length of speech [TLS] and number of major life events [LE] were correlated with each other. FRS, TLS, and LE were all significantly correlated with each other as predicted ($p<.01$) (Table 2). Next the variables frequency of speech, time length of speech and number of major life events were correlated with each other and the 12 behaviors on the GPOC. The following significant correlations were found between the frequency of speech, time length of speech, and number of major life events ($p<.10$). Frequency of speech correlated positively with: nods in agreement (.32), laughs (.44), jokes to release tension (.47), verbalizes agreement (.34), offers verbal encouragement (.65), verbalizes hostility (.39) and verbally interrupts (.33) and negatively correlated with dispalys withdrawl (-.39). Time length of speech positively correlated with nods in agreement (.39), laughs (.33), jokes to release tension (.67) and offers verbal encouragement (.41). Number of major life events correlated positively with: smiles (.36), nods in agreement (.49), laughs (.50), jokes to relaease tension (.54), verbalizes agreement (.34), and offers verbal encouragement (.56); and negatively correlated with displays withdrawl (-.34). This part of the hypothesis that the positive behaviors would correlate positively with frequency of speech [FRS], time length of

Table 2

Pearson Correlation Coefficients Among Frequency of Speech, Time Length of Speaking and Number of Major Life Events

Group Process Variables	Frequecny of Speech	Time Length of Speaking	No. of Major Life Events
Frequency of Speech	1.00	.70**	.76**
Time Length of Speaking	.70**	1.00	.92**
No. of Major Life Events	.76**	.92**	1.00

**p<.01

speech [TLS] and number of major life events [LE] was supported. At least five of the six positive behaviors correlated with each item, FRS, TLS, and LE (Table 3).

Hypothesis Number Three:

> The variables frequency of speech, time length of speech, number of major life events cited, and positive behaviors will positively correlate with integrated functioning, independence level of functioning, and negatively correlate with depression.

To test the part of the hypothesis that states; the positive behaviors will positively correlate with integrated functioning, indpendence level of functioning, and negatively correlate with depression; the Geriatric Depression Scale (GDS), Activities of Daily Living Evaluation Form (ADL), and the Geriatric Rating Scale (GRS) were correlated with the behaviors on the Group Process Observational Checklist. Pearson correlation coefficients were calculated.

The following were the significant correlations ($p<.10$). The GDS correlated positively with negative behaviors: displays withdrawl (.49), physically disrupts (.61), and verbally disrupts (.45). The ADL positively correlated with displays withdrawl (.36). The GRS correlated positively with the negative behavior: displays withdrawl (.32), verbally withdraws (.37), verbalizes hostility (.57) and verbally interrupts (.67). It negatively correlated with nods in agreement (-.40).

The correlational results of the GDS with the GPOC were in the predicted direction, and in support of the hypothesis.

Table 3

Pearson Correlation Coefficients of the Group Process Behaviors with Frequency of Speech, Time Length of Speaking, Number of Major Life Events, Geriatric Depression Scale, Activities of Daily Living Evaluation Form and the Geriatric Rating Scale

Behavior	Frequency of Speech	Time Length of Speaking	No. of Major Life Events	Geriatric Depression Scale	Activities of Daily Living Evaluation Form	Geriatric Rating Scale
Smiles	.24	.13	.36#	-.23	-.10	.04
Nods in Agreement	.32#	.39#	.49*	-.21	-.15	-.40*
Laughs	.44*	.33#	.50*	-.29	-.13	-.14
Jokes to Release Tension	.47*	.67**	.54**	-.08	.00	-.29
Verbalizes Agreement	.34#	.14	.34#	-.28	-.21	-.19
Offers Verbal Encouragement	.65**	.41*	.56**	-.08	-.05	-.25

#p<.10. *p<.05. **p<.01.

Table 3 Continued

Pearson Correlation Coefficients of the Group Process Behaviors with Frequency of Speech, Time Length of Speaking, Number of Major Life Events, Geriatric Depression Scale, Activities of Daily Living Evaluation Form and the Geriatric Rating Scale

Behavior	Frequency of Speech	Time Length of Speaking	No. of Major Life Events	Geriatric Depression Scale	Activities of Daily Living Evaluation Form	Geriatric Rating Scale
Displays Withdrawl	-.39#	-.16	-.34#	.49*	.36#	.32#
Verbalizes Withdrawl	.10	-.16	-.16	-.17	.25	.37#
Verbalizes Hostility	.39#	-.0	-.03	.02	.24	.57**
Physically Disrupts	-.09	-.09	-.17	.61**	.21	.25
Verbally Interrupts	.33#	-.05	.03	.30#	.31#	.67**
Verbally Diminishes	-.17	-.01	-.11	.45*	.18	-.11

#p<.10. *p<.05. **p<.01.

The GDS was correlated positively with three of the six negative behaviors; and the correlations with the positive behaviors were all in the negative direction. The ADL correlated significantly with only one negative behavior. This implies that if an individual was physically independent, he or she displayed withdrawl in the group. This result was difficult to explain. The GRS was negatively correlated with one positive behavior and positively correlated with four negative behaviors. This contradicts the hypothesis. Perhaps those individuals that have high scores on integrated functioning are self centred. They do not want to listen to those who are not as integrated as them and perhaps do not have patience for others with limited ability. There is very limited support for this part of the hypothesis that the positive behaviors will positively correlate with integrated functioning, independence level of functioning, and negatively correlate with depression.

To test the part of the hypothesis that state; the variables frequency of speech, time length of speech, and number of major life events cited will positively correlate with integrated functioning, independence level of functioning, and negatively correlate with depression; the variables frequency of speech [FRS], time length of speech [TLS] and number of major life events [LE] were correlated with the Geriatric Rating Scale [GRS], the Activities of Daily Living Evaluation Form [ADL], and the Geriatric

Depression Scale [GDS]. Pearson correlation coeffecients were calculated. There were no significant correlations ($p<.10$) (Table 4). In fact none of the correlations were in the predicted direction. The GDS correlated negatively with FRS (-.06) and LE (-.04) as predicted, but it correlated positively with TLS (.05). This may be because the individual who was depressed tended to focus on one event and keeps talking about it in hopes of resolving the past conflict concerning that particular event. The ADL correlated positively with FRS (.20) and TLS (.00) (Table 4). predicted but it correlated negatively with LE (-.13). This would mean that those who were more independent talked about fewer major life events. This may be because those who were more independent were also cognitively more aware thus may have recalled more details about the events they chose to share with the group. The GRS correlated positively with FRS as predicted but correlated negatively with TLS and LE. This means that if an individual is generally well [functionally integrated], then he or she may talk less about fewer major life events. These results would fit Butler's work. If the individual is integrated, presumably he or she has resolved his or her past conflicts and may already be in Erickson's final stage of ego-integrity. Therefore, the individual would not have many events to talk about and may not spend much time talking because he is at peace with his situation.

Table 4

Pearson Correlation Coefficients of Frequency of Speech, Time Length of Speaking, and Number of Major Life Events with the Geriatric Depression Scale, Activities of Living Evaluation Form, and the Geriatric Rating Scale

Scale	Frequency of Speech	Time Length of Speaking	Number of Major Life Events
Geriatric Depression Scale	-.06	.05	.04
Activities of Daily Living Evaluation Form	.20	.00	-.13
Geriatric Rating Scale	.02	-.21	-.28

Hypothesis Number Four:

> The variables integrated functioning and independence level of functioning will be positively correlated with each other and negatively correlated with depression.

Correlations of the three scales, GDS, ADL, and GRS, were done with each other. Pearson correlation coefficients were calculated between the GDS and ADL as 0.40, between the GDS and GRS as 0.37 and between the GRS and the ADL is 0.67 (Table 5). The GDS was significantly correlated with ADL using ($p<.05$). The GDS was significantly correlated with ADL and GRS ($p<.10$). The GRS was significantly correlated with ADL ($p<.05$). The GDS was not negatively correlated with ADL and GRS as predicted. This means if an individual's independence level is high then his or her score on integrated functioning is high. Only a part of the hypothesis that stated integrated functioning and independence level of functioning will positively correlate with each other is supported.

Table 5

Pearson Correlation Coeffecients Among the Geriatric Depresssion Scale, Activities of Daily Living Evaluation Form, and the Geriatric Rating Scale

	Geriatric Depression Scale	Activities of Daily Living Evaluation Form	Geriatric Rating Scale
Geriatric Depresssion Scale	1.00	.40*	.37#
Activities of Daily Living Evaluation Form	.40*	1.00	.67**
Geriatric Rating Scale	.37#	.67*	1.00

#p<.10. *p<.05. **p<.01.

CHAPTER 5 DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

It is generally believed that people of all ages reminisce about their past. The elderly are believed to reminisce more. This raises many questions. If the elderly are led to discuss their past life in a group setting, does that contribute to their quality of their life? If the answer to the first question is yes, what is it about the group process that contributes to the general well being of the individual. The purpose of this research was to study the influence of life review sessions with the institutionalized elderly. There were four hypothesis that were tested in this study:

1] There will be a decrease on test scores of integrated functioning, independece and depression after eight life review sessions.
2] The variables frequency of speech, time length of speech, positive behaviors, and number of major life events cited will positively correlate with each other.
3] The variables frequency of speech, time length of speech, positive behaviors, and number of major life events cited, will positively correlate with integrated functioning, independence level of functioning, and negatively correlate with depresssion.
4] The variables integrated functioning and independence level of functioning will be positively correlated with each other and negatively correaltaed with depression.

This chapter is organized into three sections. In the first section the findings are discussed, in part two the conclusions from the study are drawn. This is followed with recommendations.

Discussion

The results clearly indicate that life review sessions are beneficial to the elderly. The findings from this study show that after eight life review sessions, the patients were less depressed, more independent and more integrated. This statement is supported by both statistical and narrative data.

The difference in the level of depression, measured by the Geriatric Depression Scale, between the experimental and control group was found to be statistically significant. This means that the level of depression in the experimental group decreased in comparison to the control group. This is consistent with the narrative findings. Narrative data was collected about the patients by observation and discussion with the patient's nurses and families. Ms. H. and Ms. J. became more attentive to their appearance, and Ms. B., Ms. F., Mr. R. and Mr. P. became more alert and oriented as the group sessions progressed. A few of the patients started to socialize in and outside the group sessions. Ms. D., Ms. F., Ms. G., Ms. H., Ms. J., Ms. K., Ms. L., Mr. Q., and Mr. R., helped pass out tea and cookies in the group sessions. Ms. C. made friends outside the group, Ms H. and Mr. K. initiated conversations with others outside of the group sessions, Ms, M. started to eat in the dining room, Ms. P. encouraged others in the group to speak, Mr. R. and Mr. Q. became friends, Ms. S. started to converse more with patients and

staff and Mr. T. became less drowsy in the sesions (Appendix P). Also the groups stated they enjoyed the life review sessions. The above results are consistent with earlier findings of McMahon and Rhudick (1964), Kiernat (1979), Fry (1983) and Parsons (1986). The results of this study contradict the findings of Perotta and Meacham (1981) who found that there was no change in the level of depression after life review sessions.

This study also showed that patients were more integrated, generally felt and functioned better, after eight life review sessions. Scores on integrated functioning as measured by the Geriatric Rating Scale were statistically significant between the control and experimental groups. Items on the Geriatric Rating Scale include a patient's physical ability, his or her communication skills and his or her socialization on the ward. It basically measures the patient's general well being. This means that individuals in the experimental group were more integrated than those in the the control group. Also in support of this hypothesis qualitative data was collected through observation and conversation with the staff on the unit and the patients' families. In general the patients in the experimental group became more sociable, more oriented, were more concerned about their appearance, had better recall, became more attentive in the group and could physically do more in the group than outside the group session. Also some patients

wanted to discuss death and dying with staff after the group sessions (Appendix P). Ms. B. and Ms. D. both wanted to talk about death and dying. They were both referred to the pastoral care department. Ms. D. died three weeks after the group finished its sessions. The Director of Pastoral Care states she died at this time because both the group and the sister from pastoral care gave her permission to die. Sister R. from paastoral care believes "she finally completed her business." Ms. C. who normally had a poor memory remembered to come to the group meeting on her own. Mr. Q. wandered off the ward less frequently as the group progressed. These findings fully support Butler's theory that life review serves an adaptational purpose because both Ms. C. and Mr. Q. appeared to adjust to their surroundings.

The independence level of functioning was measured by the Activities of Daily Living Evaluation Form. The scores between the experimental and control groups were found not to be statistically significant. Though the statistical results were not significant, there was narrative data in support of increased independence. The narrative data suggests there was improvement in the patient's independence level of functioning. Ms. E. and Mr. T. who normally required help feeding, fed themselves in the group sessions. Ms. H. attempted to move her wheelchair on her own and Ms. S. started to mobilize herself more. Ms. J. started to dress better and pay more atention to her appearance, Ms. K.

started to have her hair done on a regular basis (Appendix P).

The findings of this study suggest that independence was increased. The reason there was no statistically significant change could be due to the fact that this is a physical ability. To improve a physical ability of an individual with chronic illnesses requires more than just four weeks. All three scales, GDS, ADL, and GRS, were positively correlated with one another. This means that no scale was totally independent of the others. In other words, the scales overlap in the items of measurement. The Geriatric Rating Scale was positively correlated with the Activities of Daily Living Evaluation Form (.67, $p<.01$). The Geriatric Rating Scale also has questions on physical as well as psychological ability. This suggests that perhaps the Activities of Daily Living Evaluation Form was not a reliable measure. Yet on the Hoyt estimate of reliability done by the researcher, the scale showed to be very reliable.

The patients did improve in their level of depression, integrated functioning and independence. Therefore, life review is found to be beneficial. This is consistent with the findings of Klein, Le Shan and Furman (1965), Kiernat (1979), McMahon and Rhudick (1964), Parsons (1986) Poulton and Strassberg (1986), Sherman (1987) and Taft and Nehrke (1990). The only study the findings do not support is that of Tobin (1972) in which the elderly stated they tried not to

reminisce because they did not want to burden other people. In Tobin's study the elderly felt those around them viewed their reminiscing behavior negatively, so they felt guilty when they reminisced. It can be inferred from Gurm (1990) that life review sessions with the institutionalized elderly over a long period of time, could improve their well-being.

If life review sessions enhance integrated functioning and independence and decrease depression, what aspects of the life review process enhance it? The three scales: Activities of Daily Living Evaluation Form (ADL), Geriatric Rating Scale (GRS), and the Geriatric Depression Scale (GDS) were correlated with the Group Process Observational Checklist (GPOC) and frequency of speech (FRS), time length of speaking (TLS), and major life events (LE) and each other (Table 3). There were no significant correlations between the positive behaviors of the GPOC and the GDS, ADL, and GRS. Five out of the six behaviors of the GPOC were positively correlated with FRS, TLS and LE. This means that no conclusions can be drawn from the study to indicate what variables in the life review process contribute to the positive changes on the three scales. Many of the behaviors on the Group Process Observational Checklist were positively correlated with each other, but some were not (Table 1). There were significant correlations between FRS, TLS and LE. There are no studies in the literature to contradict or support these results. This could possibly mean that the

group process can not be broken down into components to be analyzed. The whole is greater than the sum of it's parts because the data states that the life review process increased the general well-being of the patients, but exactly what in the process was not pin-pointed.

There were some unexpected results. The data suggested that the negative behavior of patients in the group process was correlated positively with the three measures. One could speculate that these observed negative behaviors were an expression of past unresolved conflicts. Once these individuals expressed these negative behaviors, they felt better. Thus their scores on the GDS, ADL, and GRS improved. The number of major life life events the individual talked about in any session did not appear to contribute to better scores on the measures. Individuals may tend to concentrate on their unresolved conflicts rather than several major life events. If the individuals can resolve the one conflict over the life of the group, they may get better scores on the GDS, ADL, and GRS. It can only be said that this study supports the many case studies that have been done in the past stating that the process of life review helps.

Hypothesis one; there will be a decrease on test scores of integrated functioning, independence, and depression after eight life review sessions; was supported. Hypothesis two; the variables frequency of speech, time length of speech, positive behaviors, and number of major life events cited

will positively correlate with each other; is supported. Hypothesis three; the variables frequency of speech, time length of speech, number of major life events cited, and positive behaviors will positively correlate with integrated functioning, independence level of functioning, and negatively correlate with depression; was partially supported. The Geriatric Rating Scale, and Activities of Daily Living Evaluation Form did not positively correlate with the positive behaviors on the Group Process Observational Checklist. Hypothesis four; the variables integrated functioning and indpendence level of functioning will be positively correlated with each other and negatively correlated with depression; was partially supported. The Geriatric Depression Scale was not negatively correlated with the Activities of Daily Living Evaluation Form, and the Geriatric Rating Scale as predicted.

Conclusions

In conclusion, this study has attempted to add to the body of knowledge regarding the process of life review. It has been shown that the life review process improves the well-being of the institutionalized elderly. Individuals who participated in these sessions were found to be less depressed, more integrated and more independent. The patients in the experimental group stated they enjoyed the life review groups. An attempt was made to find out exactly

what in these sessions caused the improvement in the quality of life in these individuals. However, this experiment could not pinpoint the exact mechanism that produced these improvements in one's day to day life. Further, more detailed studies are needed to pinpoint this exact mechanism.

Weaknesses to be Considered

There are some indications in the literature that life review is beneficial to the institutionalized elderly, but the results were not conclusive. There were no studies of the life review group process using the GPOC and the GDS, GRS, and the ADL found in the literature searched. This was the first time that the group behaviors in an elderly life review group have been studied and correlated with the GDS, GRS and ADL.

The sample size was to be 48 subjects, 24 in the control and 24 in the experimental group, but each group became small with attrition and lack of patient turnover on the unit used in the study. There were 18 patients in the experimental group and 17 in the control group. The individuals in the control group had more living family members, more family members residing in the Vancouver area and more of the patients lived with someone prior to hospitalization (Appendix L, M). The control group had more social support, initially, than the experimental group. This may have played a factor in the observed results. The life review may have

become the social support for the experimental group and this may have contributed to the positive results on the ADL, GDS and GRS. Its possible, but unlikely because the measures on the ADL, GDS, and GRS were similar prior to the life review sesssions.

This was a quasi-experimental research design in which all the patients could not be totally randomized (Campbell & Stanley, 1963). Also, involvement in this study was voluntary. Because volunteers fitting certain criteria were used, the findings are not generalizable nor conclusive. Generalizations from this study are limited to the geriatric population of the unit being studied. Also, a four week period did not appear to to be long enough to see changes in physical abilities as measured by the Activities of Daily Living Evaluation Form.

Recommendations

This study supported the conclusion that the educational process of life review is very beneficial to the institutionalized elderly. Arising from this there are four major recommendations.

First, elderly patients in longterm care settings who are not diagnosed with depression and are able to communicate verbally in English should be given the opportunity to participate in the process of life review. This process should be facilitated by a professional with some psychiatric

training who has gone through the process. This is necessary because individuals may focus on unresolved conflicts of the past and become depressed. The health professional must be able to determine if the patient is becoming clinically depressed and refer him or her to the appropriate professional for counselling. The possible appropriate professionals for this role are: health educators, social workers, doctors, pastoral care workers, and registered nurses with bachelor degrees. There should always be a group operating in the health facility to keep the patient's minds working. Each group should be a minimum of four weeks, but preferably longer. The reason it should be longer is because four weeks is not enough time to obtain the full benefits of increasing the independence level of the patients in the group. The time length of the study should be increased to perhaps a maximum of twelve weeks. The reason the maximum of twelve weeks is presented is because twelve critical life events are more than enough to help individuals resolve their unresolved conflicts. The reason that a longer period is not suggested for the process is because there should be at least four different groups in a year so there is opportunity for twenty-four patients to participate in a year. The turnover rate on these type of units is one year. Each group should have no more than six patients because if the session is an hour long it gives each patient enough time to talk about the topic.

Secondly, replication of the data regarding the benefits of the life review process are necessary to validate these findings. The scales used in this study are valid and reliable and should be used again. If life review processes are done for a period longer than four weeks to potentially assess the proces can enhance an individual's independence level significantly.

Thirdly, since the study could not pinpoint the mechanism in the life review process that contributes to the positive results, perhaps the Group Process Observational Checklist should not be used in its present form. Maybe the behaviors should only be catagorized as positive and negative and not broken down further.

Finally, the number of groups should be increased to as large of a number as posssible in various health facilities so that generalizations can be made about the benefits of the life review process.

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APPENDIX A

GERIATRIC RATING SCALE (GRS)

Items of the Geriatric Rating Scale

		Circles only the number which applies		
1.	When eating, the patient requires:			
	No assistance (feeds self)	0		
	A little assistance (needs encouragement)		1	
	Considerable assistance (spoon feeding, etc.)			2
2.	The patients is incontinent:			
	Never	0		
	Sometimes (once or twice per week)		1	
	Often (three times per week or more)			2
3.	When bathing or dressing, the patient needs:			
	No assistance	0		
	Some assistance		1	
	Maximum assistance			2
4.	The patient will fall from his bed or chair unless protected by side rails:			
	Never	0		
	Sometimes		1	
	Often			2
5.	With regard to walking, the patient:			
	Has no difficulty	0		
	Needs assistance in walking		1	
	Does not walk			2
6.	The patient's vision, with or without glasses, is:			
	Apparently normal	0		
	Somewhat impaired		1	
	Extremely poor			2
7.	The patient's hearing is:			
	Apparently normal	0		
	Somewhat impaired		1	
	Extremely poor			2

		Circle only the number which applies
8.	With regard to sleep, the patient:	
	Sleeps most of the night	0
	Is sometimes awake	1
	Is often awake	2
9.	During the day, the patient sleeps:	
	Sometimes	0
	Often	1
	Most of the day	2
10.	With regard to restless behaviour at night, the patient is:	
	Seldom restless	0
	Sometimes restless	1
	Often restless	2
11.	The patient's behaviour is worse at night than in the daytime:	
	Never	0
	Sometimes	1
	Often	2
12.	When not helped by other people, the patient's appearance is:	
	Almost never sloppy	0
	Sometimes sloppy	1
	Almost always sloppy	2
13.	The patient masturbates or exposes himself publicly:	
	Never	0
	Sometimes	1
	Often	2
14.	The patient is confused (unable to find his way around the ward, loses possessions, etc.):	
	Almost never	0
	Sometimes	1
	Often	2

		Circle only the number which applies
15.	The patient knows the names of:	
	More than one member of the staff	0
	Only one member of the staff	1
	None of the staff	2
16.	The patient communicates in any manner (by speaking, writing, or gesturing) well enough to make himself easily understood:	
	Almost always	0
	Sometimes	1
	Almost never	2
17.	The patient reacts to his own name:	
	Almost always	0
	Sometimes	1
	Almost never	2
18.	The patient plays games, has hobbies, etc.:	
	Often	0
	Sometimes	1
	Almost never	2
19.	The patient reads books or magazines on the ward:	
	Often	0
	Sometimes	1
	Almost never	2
20.	The patient will begin conversation with others:	
	Often	0
	Sometimes	1
	Almost never	2
21.	The patient is willing to do things asked of him:	
	Often	0
	Sometimes	1
	Almost never	2

		Circle only the number which applies
22.	The patient helps with chores on the ward:	
	Often	0
	Sometimes	1
	Almost never	2
23.	Without being asked, the patient physically helps other patients:	
	Often	0
	Sometimes	1
	Almost never	2
24.	With regard to friends on the ward, the patient:	
	Has several friends	0
	Has just one friend	1
	Has no friends	2
25.	The patient talks with other people on the ward:	
	Often	0
	Sometimes	1
	Almost never	2
26.	The patient has a regular work assignment:	
	Away from the ward	0
	On the ward	1
	No regular assignment	2
27.	The patient is destructive of materials around him (breaks furniture, tears magazines, etc.):	
	Never	0
	Sometimes	1
	Often	2
28.	The patient disturbs other patients or staff by shouting or yelling:	
	Never	0
	Sometimes	1
	Often	2

	Circles only the number which applies

29. The patient steals from other patients or staff members:

Never	0
Sometimes	1
Often	2

30. The patient VERBALLY threatens to harm other patients or staff members:

Never	0
Sometimes	1
Often	2

Note: from Research Instruments in Social Gerontology Volume 3 Health, Program Evaluation, and Demography by D.J. Mangen & W.A. Peterson (1984). Minneapolis: University of Minnesota Press.

APPENDIX B
ACTIVITIES OF DAILY LIVING (ADL) EVALUATION FORM

Name_____
Date of Evaluation_____
For each area of functioning listed below, check the description that applies. (The word "assistance" means supervision, direction of personal assistance).

1. BATHING--either sponge bath, tub bath, or shower.
   ( ) Receives no assistance (gets in and out of tub by self if tub is usual means of bathing).
   ( ) Receives assistance in bathing only one part of the body (such as back or leg or getting in and out of the tub).
   ( ) Receives assistance in bathing more than one part of the body (or not bathing).

2. DRESSING--gets clothes from closets and drawers, including underclothes, outer garments and using fasteners (including braces, if worn).
   ( ) Gets clothes and gets completely dressed without assistance.
   ( ) Gets clothes and gets dressed without assistance, except for assistance in tying shoes.
   ( ) Receives assistance in getting clothes or in getting dressed, or stays partly or completely undressed.

3. TOILETING--going to the "toilet room" for bowel and urine elimination; cleaning self after elimination, and arranging clothes.
   ( ) Goes to toilet room, cleans self and arranges clothes without assistance (may use object for support such as cane, walker or wheelchair, and may manage night bedpan or commode, emptying same in morning).
   ( ) Receives assistance in going to toilet room or in cleaning self or in arranging clothes after elimination or in use of bedpan (night) or commode.
   ( ) Doesn't go to room termed "toilet" for the elimination process.

4. TRANSFER
   ( ) Moves in and out of bed as well as in and out of chair without assistance (may be using object for support such as cane or walker).
   ( ) Moves in or out of bed or chair with assistance.
   ( ) Doesn't get out of bed.

5. CONTINENCE
   ( ) Controls urination and bowel movement completely by self.
   ( ) Has occasional "accidents."
   ( ) Supervision helps keep urine or bowel control; catheter is used, or is incontinent.

6. FEEDING
   ( ) Feeds self without assistance.
   ( ) Feeds self except for getting assistance in cutting meat, buttering bread or opening containers.
   ( ) Receives assistance in feeding or is fed partly or completely by using tubes or intravenous fluids.

Note: In Studies of Illness in the aged: The Index of ADL, a Standardized Measure of Biological and Psychcosocial Function in Journal of the American Medical Association, 185, 914-919 by S. Katz et al.

APPENDIX C
GERIATRIC DEPRESSION SCALE (GDS)

1.	Are you basically satisfied with your life?	yes/no
2.	Have you dropped many of your activities and interests?	yes/no
3.	Do you feel that your life is empty?	yes/no
4.	Do you often get bored?	yes/no
5.	Are you hopeful about the future?	yes/no
6.	Are you bothered by thoughts you can't get out of your head?	yes/no
7.	Are you in good spirits most of the time?	yes/no
8.	Are you afraid that something bad is going to happen to you?	yes/no
9.	Do you feel happy most of the time?	yes/no
10.	Do you often feel helpless?	yes/no
11.	Do you often get restless and fidgety?	yes/no
12.	Do you prefer to stay at home, rather than going out and doing new things?	yes/no
13.	Do you frequently worry about the future?	yes/no
14.	Do you feel you have more problems with memory than most?	yes/no
15.	Do you think it is wonderful to be alive now?	yes/no
16.	Do you often feel downhearted and blue?	yes/no
17.	Do you feel pretty worthless the way you are now?	yes/no
18.	Do you worry a lot about the past?	yes/no
19.	Do you find life very exciting?	yes/no
20.	Is it hard for you to get started on new projects?	yes/no

APPENDIX C CONTINUED

21.	Do you feel full of energy?	yes/no
22.	Do you feel that your situation is hopeless?	yes/no
23.	Do you think that most people are better off than you are?	yes/no
24.	Do you frequently get upset over little things?	yes/no
25.	Do you frequently feel like crying?	yes/no
26.	Do you have trouble concentrating?	yes/no
27.	Do you enjoy getting up in the morning?	yes/no
28.	Do you prefer to avoid social gatherings?	yes/no
29.	Is it easy for you to make decisions?	yes/no
30.	Is your mind as clear as it used to be?	yes/no

Note: from Development and Validation of a Geriatric Depression Scale: A preliminary report. By J. A. Yeasavage & T. J. Brink in Journal of Psychiatric Research 17 (1) 37-49.

APPENDIX D
GROUP PROCESS OBSERVATIONAL CHECKLIST

Subjects ----	1	2	3	4	5	6	total
Positive Behaviors ------total							
smiles							
nods in agreement							
laughs							
jokes to release tension							
verbalizes agreement							
offers verbal encouragement							
Negative Behaviors ------total							
displays withdrawl							
verbalizes withdrawl							
physically attacks							
verbalizes hostility							
physically disruptive							
verbally interrupts							
verbally diminishes							

APPENDIX E
DEFINITIONS OF BEHAVIORS

Smile- a facial expression to express amusement or pleasure.

Nods in Agreement- head movement up and down indicating mutual understanding.

Laugh- a show of joy with a smile and chuckle or explosive sound.

Jokes to Release Tension- a comment made to provoke laughter.

Verbalizes Agreement- a spoken statement indicating "yes", a mutual understanding.

Offers Verbal Encouragement- a spoken fostering statement (i.e. yes, tell us more).

Displays Withdrawal- a detached and unresponsive look (i.e. stares at wall).

Verbalizes Withdrawal- a statement indicating detachment (i.e. I don't want to talk about that).

Physically Attacks- a movement of the body or parts to strike an object or person (i.e. bangs hand against wheelchair).

Verbalizes Hostility- an unfriendly statement (i.e. This is rediculous).

Physically Disruptive- interrupts group activities by removing self or inappropriate body language.

Verbally Interrupts- a statement made to interfere with group activity (i.e. calls a person walking by).

Verbally Diminishes- a statement made to belittle group members (i.e. that's not correct).

APPENDIX F
BALES GROUP PROCESS CATEGORIES

1. Shows solidarity, raises other's status, gives help, reward:

2. Shows tension release, jokes, laughs, shows satisfaction:

3. Agrees, shows passive acceptance, understands, concurs, complies:

4. Gives suggestion, direction, implying autonomy for other:

5. Gives opinion, evaluation, analysis, expresses feeling, with:

6. Gives orientation, informaion, repeats, clarifies, confirms:

7. Asks for orientation, information, repetition, confirmation:

8. Asks for opinion, evaluation, analysis, expression fo feeling:

9. Asks for suggestion, direction, possible ways of action:

10. Disagrees, shows passive refection, formality, withholds help:

11. Shows tension, asks for help, withdraws out of field:

12. Shows antagonism, deflates other's status, defends or asserts self:

1-3 are positive

4-9 are neutral

10-12 are negative

Note: from Interaction Process Analysis. A Method for the Study of Small Groups, by R.F. Bales, 1985. Chicago: The University of Chicago Press.

APPENDIX G
DEMOGRAPHIC DATA SHEET

Name_____

Occupation_____Age_____

Medical Condition- Alzeihmers/CardiacDisease/CVA/
Diabetes/Hip Surgery/Hypertension/Other:

Do you have any living family members?			Do they live in Van?	
Husband	Yes/No		Yes/No	
Children	Yes/No	How many_____	Yes/No	How many_____
Grandchildren	Yes/No	_____	Yes/No	_____
Siblings	Yes/No	_____	Yes/No	_____
Neice/Nephew	Yes/No	_____	Yes/No	_____
Aunt/Uncle	Yes/No	_____	Yes/No	_____
Cousin	Yes/No	_____	Yes/No	_____

Do you belong to any organizations?
Church_____ Clubs_____ Community_____ Other_____

You came to this ward from:
An acute care hospital/ a care facility/ home/ other_____

Did you live alone?
Yes/No

Who did you live with?
husband/children__/grandchildren__/sibling__/niece/nephew__

APPENDIX K
QUESTIONS FOR LIFE REVIEW SESSIONS

Session 1 - Introduction. Tell us your name and something about yourself you would like to share with the group? Tell us about the first time you moved? What was it like? How did you feel?

Session 2- School Days. Tell us about your school days? Can you recall any specific incidents?

Session 3 - Marriage. Tell us about your wedding day? What do you remember best? (If not married, can you remember a wedding that you attended? What made it memorable?)

Session 4 - First Child. Recall the birth of your first child (or a child)? What was it like?

Session 5 - First Hospitalization. What was it like being in a hospital for the very first time? Share something about your first day in the hospital?

Session 6 - Death. Recall the death of your husband or a special friend? Describe how you felt? Tell us about your experience with death?

Session 7 - Move to Care Facility. Describe your feelings about going to a care facility? What does the move mean to you?

Session 8 - Closure/Good-bye. Did you enjoy the group? How did you feel about coming to the group? Were you comfortable with the topics discussed? How do you feel about the group ending? Is it difficult to say good-bye?

APPENDIX L
DEMOGRAPHICS OF PATIENTS IN CONTROL GROUP

Patient	1	2	3	4	5	6	7	8	9
Sex	F	M	M	M	F	F	F	M	F
Age	82	79	65	83	84	75	103	89	83
Occupation	HM	CA	TK	JNL	SS	LW	ST	ST	SC
Medical Condition	HC	CVA	CVA	B/P	CA	HC	HC	CVA	CVA
Living Family Members (No.)	18	4	5	3	21	26	1	15	5
Living Family Members in Van. (No.)	2	3	2	3	14	26	1	13	0
Membership in Org. Number	1	1	0	3	1	1	0	0	0
Lived alone Prior to Hospital-ization	Y	N	N	N	N	Y	Y	N	N
Lived with Whom Prior to Hospital-ization	-	Sp	Sib	Sib	Sib	-	-	Sp	Sp

Legend for Demographics of Patients in Study TAble

Medical Condtionsl: HC=Heart Condition, CVA=Stroke, ATH-Arthritis, B/P=Hypertension, ALZ=Alzeihmer's Disease, and CA=Cancer.

Occupations: HM=Homemaker, ST=School teacher, CA=Chartered Accountant, TK=Timekeeper, JNL=Journalist, SS=Seamstress, LW-Laundry worker, SC=store clerk, DOA=Dental Office assistant, BNK=Banker, FR=Farmer, IW- Iron worker, CS=car Salersperson.

Relations: Sp=Spouse, Ch=Child, Sib=Sibling

Y=yes N=no

APPENDIX L CONTINUED
DEMOGRAPHICS OF PATIENTS IN CONTROL GROUP CONTINUED

Patient	10	11	12	13	14	15	16	17
Sex	F	F	F	F	F	F	F	F
Age	75	76	93	75	83	77	74	90
Occupation	HM	AD	CA	HM	HM	SC	CK	ST
Medical Condition	ALZ	ATH	CVA	HC	CVA	HC	B/P	HC
Living Family Members	1	12	5	5	10	12	28	0
Living Family Members in Van. (No.)	1	6	3	3	3	0	6	0
Membership in Organi-zations (No.)	0	4	0	1	1	1	0	0
Lived alone Prior to Hospital-ization	Y	N	Y	N	Y	Y	Y	Y
Lived with Whom Prior to Hospital-ization	-	CH	-	SP	-	-	-	-

Legend for Demographics of Patients in Study TAble

Medical Conditions: HC=Heart Condtion, CVA=Stroke, ATH=Arthritis, B/P=Hypertension, ALZ=Alzeihmer's Disease, and CA=Cancer.

Occupations: HM=Homemaker, ST=School teacher, CA=Chartered accountant, TK=Timekeeper, JNL=JOurnalist, SS=Seamstress, LW=Laundry worker, SC=Store clerk, DOA=Dental office assistant, BNK=Banker, FR=Farmer, IW=Iron worker, CS=Car salesperson.

Relations: Sp=Spouse, Ch=Child, Sib=Sibling

Y=yes N=no

APPENDIX M
DEMOGRAPHICS OF PATIENTS IN EXPERIMENTAL GROUP

Patient	18	19	20	21	22	23	24	25	26	27
Sex	F	F	F	F	F	M	M	M	F	M
Age	76	88	92	90	66	72	78	81	95	69
Occupation	ST	DOA	Bnk	HM	HM	FR	IW	SC	SC	CS
Medical Condition	HC	HC	CVA	CA	HC	HC	HC	HC	HC	CVA
Living Family Members (No.)	20	7	20	3	16	0	7	8	2	5
Living Family Members in Van. No.)	2	7	15	1	2	0	7	0	2	5
Membership in Organi-zations (No.)	0	0	0	4	1	0	0	1	1	0
Lived alone Prior to Hospital-ization	Y	Y	Y	Y	N	Y	Y	N	Y	N
Lived with Whom Prior to Hospital-izaiton	-	-	-	-	-	-	-	Sp	-	Sp

Legend for Demographics of Patients in Study Table

Medical Conditions: HC=Heart Condition, CVA=Stroke. ATH=Arthritis, B/P=Hypertension, ALZ=Alzeihmer's Disease, and CA=Cancer.

Occupations: HM=Homemaker, ST=School teacher, CA=Chartered Accountant, TK=Timekeeper, JNL=-Journalist, SS=Seamstress, LW=Laundry worker, SC=Store clerk, DOA=Dental office assistant, BNK=Banker, FR=Farmer, IW=Iron worker, SC=Car salesperson.

Relations: Sp=Spouse, Ch=Child, Sib=Sibling

APPENDIX M CONTINUED
DEMOGRAPHICS OF PATIENTS IN EXPERIMENTAL GROUP

Patient	28	29	30	31	32	33	34	35
Sex	F	F	F	F	F	F	F	F
Age	90	84	92	84	92	72	84	82
Occupation	T	HM	ST	T	HM	SC	ST	HM
Medical Condition	CA	CA	HC	CA	ATH	HC	HC	CVA
Living Family Members (No.)	1	0	7	0	7	2	6	14
Living Family Members in Van. (No.)	0	0	5	0	7	2	2	6
Membership In Organi-zations (No.)	1	1	1	1	0	0	0	2
Lived alone Prior to Hospital-ization	Y	Y	Y	Y	Y	Y	Y	N
Lived with Whom Prior to Hospital-ization	-	-	-	-	-	-	-	Sp

Legend for Demographics of Patients in Study Table

Medical Conditions: HC=Heart Condition, CVA=Stroke, ATH=Arthritis, B/P=Hypertension, ALZ=Alzeihmer's Disease, and CA=Cancer.

Occupations: HM=Homemaker, ST=School teacher, CA=Chartered Accountant, TK=Timekeeper, JNL=Journalist, SS=Seamstress,LW=Laundry worker, SC=Store clerk, DOA=Dental office assistant, BNK=Banker, FR=Farmer, IW=Iron worker, CS=Car Salesperson.

Relations: Sp=Spouse, Ch=Child, Sib=Sibling

N=no Y=yes

APPENDIX N

SUMMARY OF PRE- AND POST-TEST SCORES OF THE GERIATRIC DEPRESSION SCALE (GDS), ACTIVITIES OF DAILY LIVING EVALUATION FORM (ADL), AND THE GERIATRIC RATING SCALE (GRS) FOR THE CONTROL GROUP

Subject	GDS Pre-Post Scores		ADL Pre-Post Scores		GRS Pre-Post Scores	
1	35	40	15	14	46	46
2	46	49	15	15	66	66
3	50	53	15	14	57	53
4	40	41	15	15	55	56
5	30	38	12	15	49	54
6	38	44	14	16	61	66
7	43	45	16	14	69	68
8	44	52	14	14	46	52
9	46	46	14	14	53	50
10	38	41	15	15	62	61
11	35	38	17	13	53	44
12	44	47	15	18	48	62
13	40	39	15	15	63	61
14	37	39	10	10	37	38
15	33	34	13	13	43	44
16	49	52	14	15	69	69
17	45	46	15	15	59	59

On all scales, a low score is better

Scale	Pre-test Mean and SD		Post-test Mean and SD	
GDS	40.765	5.729	43.765	5.629
ADL	14.235	1.602	14.412	1.622
GRS	55.059	9.371	55.824	9.302

Scale	Range
GDS	33-53
ADL	10-17
GRS	37-69

APPENDIX O

SUMMARY OF PRE- AND POST-TEST SCORES OF THE GERIATRIC DEPRESSION SCALE (GDS), ACTIVITIES OF DAILY LIVING EVALUATION FORM (ADL), AND THE GERIATRIC RATING SCALE (GRS) FOR THE EXPERIMENTAL GROUP

Subject	GDS Pre-Post Scores		ADL Pre-Post Scores		GRS Pre-Post Scores	
18	43	38	9	8	41	39
19	36	36	15	14	65	57
20	41	38	11	13	57	66
21	35	32	7	6	51	43
22	34	31	14	13	47	50
23	32	31	12	12	52	51
24	38	34	13	13	69	52
25	38	34	11	7	57	48
26	35	42	13	13	54	53
27	47	41	16	15	59	51
28	41	37	11	9	41	40
29	44	36	17	6	54	46
30	34	34	11	11	49	39
31	54	50	15	13	62	50
32	44	35	11	13	44	52
33	36	37	17	17	61	53
34	37	32	15	16	67	62
35	37	33	15	15	67	65

A low score is better

Scale	Pre-test Mean and SD		Post-test Mean and SD	
GDS	39.222	5.537	36.167	4.668
ADL	12.944	2.775	11.889	3.359
GRS	55.389	8.846	50.944	8.033

Scale	Range
GDS	31-54
ADL	6-17
GRS	39-69

APPENDIX P
NARRATIVE DATA

Group 1

Ms. B. interrupted the group quite often with sarcastic comments. She did not say much when we discussed death and dying. After the group ended she kept demanding staff time, the staff pointed out to me. She wanted anyone to come and talk to her about death and afterlife. I referred her to the pastoral care team. She was and is still seen by pastoral care. They have been helping her sort out her feelings about dying and afterlife.

Ms. C. seemed to be drowsy and close her eyes in the first few sessions. Later she became very alert. The nurses, the recorder and the group leader all noticed how the group meetings just seemed to perk her up. Also for the last half of the group meetings she did not need to be reminded to come to the group, she remembered on her own. As one nurse commented, "that is pretty good for someone with a poor memory". She also became good friends with Ms. E.. She already knew Ms. E., who was her roommate. She made a point of mentioning to the group how she helped Ms. E. - "she would be lost without me. I call the nurse for her and get help when she needs it". Ms. C. stated how much she enjoyed the group and why did it have to come to an end. As the new groups started she always came to the group leader and asked "why can't I be in the group, I'll sit quietly in a corner". She knew this was a study but she could not understand how the results would differ if she just sat quietly in a corner and observed the group.

Ms. D. helped other members in the group. She quite often helped pass out cookies. She also asked prompting questions to other subjects to assist them to talk. According to the nurses Ms. D. asked them to spend a lot of time with her to talk about death and afterlife. She was also referred to pastoral care. Pastoral care visited her regularily. About 3 weeks later she died. A member of pastoral care and I discussed this case. We conluded that she died at this particular time because she had been given permission to die by both the group and the counselling by pastoral care. Also she may have finally completed her "business" that she needed to before death.

Ms. E. had quite a poor memory. She quite often interrupted the group by moaning. Both the recorder and leader thought this was attention-seeking behavior. While she was talking she felt great. According to the nurses, she required help with feeding. In the group she drank her drink and ate her cookies without assistance.

APPENDIX P CONTINUED

In general, all subjects stated they enjoyed the group very much and would like it to continue. They all stated the topics were relevant and should be discussed again.

Group II

Ms. F. had a very difficult time remembering past events accuarately according to the staff. She was very sociable in the group, she passes out tea and cookie and smiles a great deal.

Ms. G., according to the nurses, talked more to other people since she had been participating in the group. Before the group started the leader was up on the unit, Ms. G. said how she was looking forward to the group. Also the nurses state, her memory seemed to have improved since she had been participating in the group.

Ms. H. was a very talkative person that sometimes wandered from the topic or monopolized the conversation. She was often reminded by the leader of the topic or to give others a chance to talk. According to her daughter, the patient since joining the group attempted to move her wheelchair with her feet, "she had never tried that before" stated her daughter. Also the daughter stated the subject initiated conversation with strangers in the hall and cafetaria.

Ms. J. was a very closed person in the beginning and would not say very much. As time went on she volunteered information. She also had her daughter bake goodies for the group on 2 occasions. She dressed better later and became more attentive to her appearance as the group progressed.

Ms. K. was very sleepy in the first few sessions of the group. Near the end she was staying awake during the whole session. Also she paid more attention to her appearance. She had her hair done on a regular basis and one day as the group leader wheelled her to the group she asked "is my hair alright?"

The group in general was very sociable. They talked between themselves before and after the sessions. They all helped pass out cookies and tea and one time or another. They all stated they enjoyed the group very much and wished that it would be continued on a regular basis. They thought the topics discussed were appropriate and could not think of any different ones.

APPENDIX P CONTINUED

Group III

Ms. L. was at times confused and interrupted others. She was told by the leader on many occasions "Lets listen to ---- talk, she is not finished yet". Twice she was removed from the group because she interrupted others very inappropriately. She helped pass the goodies to others many times. Near the end of the group meetings she started conversation with other patients on the unit. Somedays her memory and appropriateness were better than other days. At times when she did remember the staff state she looked forward to the group meetings.

Ms. M. was someone who kept very much to herself according to the staff. After mid way through the group sessions she ate in the dining room and socialized with other patients. She became friends with Ms. N.

Ms. N. after the initial few sessions, remembered what the topic of the day was. She came to the session on her own and was quite often prepared to speak on the topic. She became friends with Ms. M. and stated how the group was a good idea in terms of giving people a chance to speak about the topics but also to meet others on the ward. At one session when Ms. M. started to cry she offered her a kleenex and stated that it was good to cry "my doctor says cry, if you need to cry, don't hold it in" she told Ms. M.

Ms. P. after the first few group sessions was very good at encouraging others to speak. She herself had a very difficult time remembering her past. Sometimes she just got quite tearful trying to remember. She became friends with Ms. N. Also she initiated conversation with most patients on the ward on her own.

In general the group was very sociable in handing out cookies and tea. They all stated they enjoyed the group very much and thought the topics were appropriate.

Group IV

Mr. Q. was disoriented around the ward before the group sessions started. Near the end he was oriented to the ward. He was very sociable from day one, handing out cookies and pouring tea. He became friends with Mr. R. whom he hadn't talked to before even though they shared a room. The nurses noticed that he didn't go wandering off the ward as the group sessions continued.
The nurses also stated that the patient became more cooperative as the group progressed.

APPENDIX P CONTINUED

Mr R. ws disoriented around the ward before the group started and became more oriented as the group went on. Also the staff state he became a more "cooperative patient". He also helped hand out cookies and tea at every session. He became friends with Mr. Q. In one group session he mentioned that he used to play the piano in a band. On one of the wards in the hospital, there is a piano. He was taken to it by a staff member and he played very well. He stated he hadn't played for 8 years. He very much enjoyed the experience as did those patients that listened to him play.

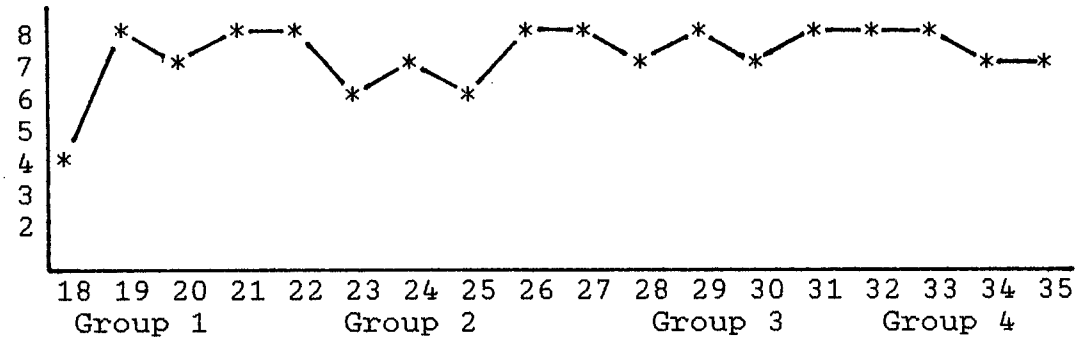
Ms. S. did not talk much to other people before the group sesions. According to the group she started to converse more with other patients and staff. Also she started to mobilize herself more. A visitor of hers stated to the staff that the subject told her about the group and how much she enjoyed. She also discussed with the visitor the topics talked about in the group.

Mr. T. was very dependent on staff for feeding. In the group he fed himself the cookies and drinks the tea on his own. At the beginning he was very drowsy in the group, half closing his eyes. In later sessions he stayed more awake.

Ms. V. was confused on and off. In one session she and Mr. R pretended to be husband and wife. Ms. V. had never been married. Anyways, she became friends with Mr. R. but nothing ever developed. She talked with most people she saw in the hallways after the group sessions started according to the staff. Her visitor told the staff that the subject talked to her about the group. The visitor thought the group was a good idea.

In general the group was very sociable. They stated they enjoyed the sessions and thought it would be a good idea to continue them. They had no suggestions for different topics that could be discussed.

APPENDIX Q
NUMBER OF GROUP SESSSIONS ATTENDED BY SUBJECT



Note: 18 total subjects
Range = 4-8
Mean = 7.2