" A STUDY TO EVALUATE THE EFFECTIVENESS OF REMINISCENCE THERAPY ON DEPRESSION AMONG THE ELDERLY RESIDING IN SELECTED OLD AGE HOME AT MADURAI"

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CERTIFICATE

This is to certify that this dissertation titled**,** " **A STUDY TO EVALUATE THE EFFECTIVENESS OF REMINISCENCE THERAPY ON DEPRESSION AMONG THE ELDERLY RESIDING IN SELECTED OLD AGE HOME AT MADURAI"** is a bonafide work done by **Mrs.P.Selvarani** College of Nursing, Madurai Medical College, Madurai - 20, submitted to the Tamilnadu Dr.M.G.R. Medical University, Chennai in partial fulfillment of the university rules and regulations towards the award of the degree of Master of Science in Nursing, Branch V, Mental Health Nursing Under our guidance and supervision during the academic period from 2009—2011.

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ABSTRACT

A study to assess the effectiveness of reminiscence therapy on depression among the elderly residing in a selected old age home at Madurai was conducted by Mrs. **P.Selvarani** in partial fulfillment of the requirement for the degree of Master of Science in Nursing at college of nursing Madurai medical college, Dr. M.G.R. medical university, Chennai during the year 2011.

The Objectives of the study were

1. To assess the level of depression among the elders residing in a selected old age home before and after reminiscence therapy.
2. To evaluate the effect of reminiscence therapy on depression among the elders residing in a selected old age home at Madurai
3. To associate the effectiveness of reminiscence therapy on depression with selected demographic variables.

The conceptual framework was developed based on the widenbachs human art of nursing theory. Content validity for the tool was obtained from nursing experts. The reliability of the tool is 0.94 for depression. One group pre test and post test design and convenient sampling was used . After the pilot study the data was collected from the elderly residing in selected old age home at Madurai. The data collected from subjects were analyzed using descriptive (mean, standard deviation) and inferential (paired‘t’ test and chi square test) statistical method. The study showed that (36.67 %) of the respondents experienced mild depression and (63.33%) of them had moderate depression in the pre test, and (70%) of them experienced mild depression and (30%) of them experienced moderate depression in the post test. The “t” value shows that there is a significant association between the level depression and reminiscence therapy. The study concluded that majority of the subjects developed significant respond to reminiscence therapy.

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CHAPTER I

INTRODUCTION

"***Youth is like a fresh flower in May***

Age is like a rainbow that follows

The storms of life. Each has its own beauty".

-Davidpolis

Aging is an irreversible process. In the words of Seneca "old age is an incurable disease". Ayurveda terms old age as **"Vardhakya"** which begins from the age of sixty. It is projected that 65 years and older with potentially disabling serious mental illness will double to 15 million in 2030 (Samhsa 2004). Helping older adults maximize their potential can be a challenging and rewarding experience for the nurse. The opportunity to interact one to one with an older adult can lead the nurse to consider this specialty area. (Canselosi 2007).

More recently James sterling Ross commented "you do not heal old age", you protect it, and you promote it. Life expectancy has increased in recent years. In India the life expectancy projected in 2011-2016 has been 67 years for males and 69 years for females. 21% of the Indian population will be above 60 years of age by the year 2050. Industrialization, urbanization, education and exposure to western life style are bringing changes in values of life. The old age population has become vulnerable due to which they become distressed and depressed. Growing old in a society that has been observed with youth may have a critical impact on the mental health of many people. The situation has serious implications for psychiatric nursing.

CONCEPT OF "OLD"

The concept of "old" has changed drastically over the years. Our prehistoric ancestors probably had a life span of 40 years, with the average individual living

around 18 years. As civilization developed, mortality rates remained high as a result of periodic famine and frequent malnutrition. An improvement in the standard of living was not truly evident until about the middle of 17th century. Since that time, assured food supply, changes in food production, better housing conditions and more progressive medical and sanitation facilities have contributed to population growth, declining mortality rates, and substantial increases in longevity.

India has 42 million elderlies (60+) constituting 6% of population. This is expected to cross 60 million by the turn of the century and will more than double by AD 2025. Three-quarters of them are young-old and the rest old-old. (Dr. Venkoba Rao) Eighty percent of the country's population and 83% of the elderlies live in villages. India's scriptures fixed a life span of 100 years recommending incessant activity. Man's life is demarcated into four successive stages (Ashramas): of studentship, the householder, an ascetic and the forest dweller'. The last two favour ‘disengagement' and are prescribed for the old. In practice, they are rarely followed. The ‘joint-family' has fissured resulting in altered intra family roles and care of the elderly precarious. Location within the family does not assure one's integration; while living alone does not necessarily mean one's social isolation. The state of well being varies from 22.1% to 52.1% in the elderlies. The prevalence rate of mental morbidity is 89/1000 elderlies with geriatric depression accounting for 60/1000. Psychiatric disorder is seldom an isolated event and is associated with a high degree of physical comorbidity. F Suicides have been on the rise and the rate is 12/100,000; higher than the National rate: 7/100,000. Health care of the aged is to be a ‘total' one comprising physical, psychological, social, economical, nutritional, educational and rehabilitational aspects. In the management of the final challenge’, psychological concepts should form part of the measures adopted. In Tamilnadu current year (2011) census shows 72138958 , among them 36158874 were males and 35980087 were females and above 60 years of aged are 7580.

The term old cannot be defined by a number everyone, particularly health care workers, should see aging people as individuals , each with specific needs and abilities, rather than as a stereotypical group. Finally the term old must be self determined. Poor people who have worked all their lives can expect to become poor only after becoming old. The number of days in which usual activities are restricted because of illness or injury increases with age. The American geriatrics society (2005)

reported that 82% of individuals 65 and older have at least one chronic condition, and two thirds have more than one chronic condition, emotional and mental illnesses increase over the life cycle.

DEFINITION OF AGING

Biologic aging: Refers to changes in structure and functions of the body that occur over the life span (Zarit, 1980)

Functional aging: Refers to the capacities of individuals for functioning in society, as compared with that of others of the same age (Birren & Renner, 1977)

Psychologic aging: Refers to behavioral changes in self perception and reactions to biologic changes (Gress & Bate 1984)

Sociologic aging: Refers to the roles and social habits of individuals in society (Birren & Renner, 19770)

Spiritual aging: Refers to changes in self and perceptions of self, of relationships of self to others, of the place of self in the work and the self world view (Stall wood stoll, 1975)

DEPRESSION

Depression is a common and troublesome mental disorder among older adults, who are at higher risk because of changes in self concept and the multiple losses they have likely experienced. Many older people have an increase in stressful life events at the very time when they may have limited sources for managing such difficult circumstances. The more those stressful life events occur, the more their sense of helplessness becomes reinforced. If they reach the point of believing energy to cope with life, and depression frequently results. (Zubenks 1997). Approximately 50% of cases of depression may go undiagnosed and untreated (Angst 1992)

Depression is one of the common psychiatric disorder in the community based settings. It can also be said to be the most common psychiatric disorder in elderly all over the world. Various researches in India showed that life history and problems can lead to depression. Various research findings have explained the importance of assessing risk factors like conflicts, disharmony and other losses.

Party and Gail (2004) in his study revealed major depressive disorder to be an independent factor that increased the risk of death by 59% in the nursing home setting. The prevalence of clinically significant depression in nursing homes ranges from 24% to 50%.

The later years constitute a time of especially a high risk for emotional distress. Sadock and shaddock (2003) stated that Several psychosocial risk factors predispose older people to mental disorders. These risk factors include loss of social roles, loss of autonomy, the deaths of friends and relatives, declining health, increased isolation, financial constraints and decreased cognitive functioning. Depressive disorders are the most common affective illnesses occurring after the middle years. The incidence of increased depression among elderly people is influenced by variables such as physical illness, functional disability, cognitive impairment and loss of a spouse.

PREVALENCE OF DEPRESSION

Skapinakis (2009) Studies show that at least 10-25 % of all elderly people show clear symptoms of depression. 1-5 % have so-called serious depressive episodes, and 2-8 % suffer from loneliness and melancholy. Studies on residents in homes for the elderly find that 5-15 % suffer from depression. Up to 30 % of the residents have more or less pronounced symptoms of depression such as tiredness, lack of appetite and dejection. It is also known that much depression among the elderly is not diagnosed by psychiatric services.

Geriatric depression have been found in various parts of the world. Hope (2001) summarized the findings of the National Service Framework (NSF) for older people, which was published by the Department of Health in Great Britain stating "The NSF for older people indicates that 10%-15% of people living in the community, over the age of 65, had depression severe enough to warrant clinical intervention. In referring to the same data, Baldwin (2000) commented that this is probably an underestimate owing to factors of presentation and recognition. Even given problems in defining the unique presentation of depression among the elderly in a homogenous way, similar statistics have been found in various countries throughout the world.

OLD AGE HOMES

In the recent times a new trend is being observed among the middle class aged population of India. More and more senior citizens hailing from the Indian middle class background are seeking accommodation in the old age homes. In India numerous old age homes have sprung up across the length and breadth of the country. There are two types of old age homes in India, namely the free old age homes and the paid old age homes.

The patron of this charity organization is the honorable ex-president of India, Mr. R. Venkataraman. India has over 728 old age homes. Help Age provides help and support to about 194 old age homes of India. It offers medical care and attention to the senior citizens of India. A total of 278 old age homes all over the country are available for sick and 101 homes are exclusively for women. Madurai has nearly 28 old age homes. Among them I have selected “Inba Illam” for my study setting.

1.1 NEED FOR THE STUDY

Only one third of older people with depression discuss it with their General Practioner, (GP) and only half of them are diagnosed and receive treatment..A key barrier for many older people with depression is the reluctance to discuss mental health issues with GPs and other health care professionals. For many older people, and the wider public, depression remains a taboo subject and many people feel uncomfortable talking about sadness, stress and anxiety. When depressed, older people may present with somatic symptoms or the depression may be masked by long-standing physical or mental illness. Older people themselves may think that depression is a normal or inevitable part of ageing and do not recognize that depression is a manageable health condition. GPs themselves sometimes reinforce this attitude by focusing purely on the treatment of physical symptoms. Many of these problems are exacerbated by a lack of invest age concern in psychological therapies for older people, which limits the range of effective treatment options available to the patient.

The researcher felt that age concern measures to break down the barriers of seeking help, will modify the reluctant behavior of elderly with depression. Information in the form of leaflet and fact sheets that contains simple information about depression should be made readily available to elderly. These resources will make it easier for older people with depression to have the confidence and vocabulary to discuss depression and to access the treatment and support they need. Since the elderly staying in old age home are left alone without their family members may aggregate the depressive episodes. A combination of information and reminiscence therapy will enable the elderly to discuss openly and thereby improve their mental status and quality of life.

The 21st century is often called as “age of ageing”. One of the world’s greatest challenges of the present century is the enormous increase in the absolute number and proportion of older persons in the world. According to the united nation’s projections, by the year 2050, the number of older persons is expected to be more than three fourth, from 600 million to almost 2 billion. Out of India’s more than 100 crores population 8% constitutes elderly population. All these data indicates that India’s ageing population is on the rise. In India, life expectancy has gone up from20 years in the beginning to 62 years today.

The Indian aged population is the second largest problem in the world. The proportion of those who would be aged 60 years and above is estimated to be 7.7% for the year 2020, and this proportion is expected to reach 12.6% in 2025.1.The main problem among these is depression. Considering this prevalence of depression the researcher selected this study

REMINISCENCE THERAPY

Reminiscence Therapy is an intervention which involves the elderly in the active recollection of life experiences. It allows them to relive personal events from their past in a way that is vivid and engaging, and encourages them to communicate those experiences to a listener. Interaction with objects and images from the past aids the recollection of memories. The Hurstville City Museum & Gallery Reminiscence Therapy Kits contains items that will be of significance to the lives of elderly people and will encourage reminiscence through touch, sight and smell.

Depression is a condition that is common and disabling amongst the ever increasing population of older adults (Bohlmeijer, Smit & Cuijpers, 2003). Reminiscence therapy is an alternative treatment to medication in reducing depression levels amongst older adults (Stinson, 2009; Stinson & Kirk, 2006). Reminiscence therapy is becoming increasingly popular in the treatment of older adults and is a technique used to assist people in thinking, recalling and talking about their life, within an institution or in the community, in a structured or unstructured group or with individuals (Bornat, 1997; Stinson, 2009; Stinson & Kirk, 2006).

Apart from all these events, while the researcher visited the particular old age home as a part of their curricular requirement, happened to see the most of the inmates were in depressed mood . On discussion the researcher had a chance to see the and feel the pent up emotional feelings of the elderly. At the moment the researcher decided to do any one of the intervention study on depression among elderly in that particular old age home so the researcher selected this topic as an interesting experience and sharing with elderly apart from the curricular requirement.

1.2 STATEMENT OF THE PROBLEM

A study to evaluate the effectiveness of reminiscence therapy on depression among the elderly residing in selected old age home at Madurai.

1.3 OBJECTIVES OF THE STUDY

- To assess the level of depression among the elderly residing in selected old age home before and after reminiscence therapy
- To evaluate the effectiveness of reminiscence therapy on depression among the elderly residing in a selected old age home at Madurai
- To Associate the effectiveness of reminiscence therapy on depression with selected demographic variables.

1.4 HYPOTHESES

H_1 - There will be a significant relationship between reminiscence therapy and level of depression

H_2 - There will be a significant association between the

reminiscence therapy and depression score of selected demographic variables.

1.5 OPERATIONAL DEFINITION

Elderly people: refers to the individual who are above 60 years of age and living in selected old age home at Madurai.

Old age home: refers to a place where elders were taken care with all facilities to meet their basic needs.

Effectiveness: refers to the outcome of reminiscence therapy in reducing the level of depression among the elders residing in selected old age home and as measured by a geriatric depression scale.

Depression: Refers to the mood in which the individual is sad, worried, looses interest in life and looses energy and feels helpless, hopeless and worthless i.e measured by using geriatric depression scale.

Reminiscence therapy: Refers to an intervention which includes the active recollection of life experiences.

1.6 ASSUMPTION

- Depression is found common among elderly.
- Reminiscence therapy assists the elderly to resolve conflicts, deals with past losses, recognize and appreciate inner resources and find meaning in the significant past life events.
- Reminiscence therapy enhances mental well being and promotes quality of life.

1.7 DELIMITATION

- The study was delimited to the elderly people who were residing in selected old age home at Madurai
- Data collection period was delimited to 4 weeks

1.8 PROJECTED OUTCOME

This study will reveal the existing level of depression among the elderly people residing in selected old age home at Madurai. It will also highlight the effectiveness of non pharmacological approaches especially reminiscence therapy in reduction of depression among elderly. The result of the study will be a strong motivator for psychiatric nurses since it requires minimal resources and is cost effective. Findings of this study will help health professionals to plan reminiscence therapy in the areas where depression management is practical and certainly it will add value to geriatric nursing.

CHAPTER II

REVIEW OF LITERATURE

A review of literature on the research topic makes the researcher familiar with the existing studies and previous information that helps to focus on a particular problem and lay a foundation for new knowledge. It also helps to guide the investigator to design the proposed study in a specific manner so as to achieve the desired results. The related literature review for the study is divided into 3 parts.

I. Literature related to Old age
II. Literature related to Depression in old age
III. Literature related to reminiscence therapy in relation to depression

2.1 LITERATURE RELATED TO OLD AGE

Everybody wants to live a long time but
Nobody wants to grow old

Human aging is a complex ill mysterious process. Attempts to push back the clock have existed since biblical times. While we do not yet have a universally accepted definition of aging, we do have increasing scientific information which makes the study of gerontology interesting and exciting. The growing numbers of elderly persons in the population and the more active role they are assuming have increasing have increased society awareness of qualities, rights and needs of its older members. The increased number of the aged has influenced the helping professions to become more closely involved in the fields of gerontology and geriatrics. The nursing profession is experiencing in an outstanding attitudinal shifts in view of caring for the aging.

2.2 LITERATURE RELATED TO DEPRESSION IN OLD AGE

yen hu shah (2006) conducted A cross-sectional study N= 250 elderly were administered the General Health Questionnaire (GHQ), the Hindi Mental State

Examination (HMSE) after taking their socio-demographic profile. Residents screening positive were administered the Structured Clinical Interview for DSM-III-R and a DSM-III-R derived algorithm for Dementia. Based on case identification interview, prevalence of psychiatric disorders was 49.2%. Depression (23.6%), Dementia (11.6%) and Anxiety disorder (10.8%) were the most common disorders.

Niamadhab khar, et al, (2007) identified the point prevalence of depressive disorders in the elderly population in India, conducted a cross sectional study over a period of eight months in the three taluks of Udupi , Kundapura and Karkala. They selected 627 people in the age group of 60 years and above for the study. Simple random sampling without replacement method using the probability proportionate to size (PPS) technique was used. The results shown the rate of depression in elderly population was determined to be 21.7% . the Indian version of WHO – five well being index (1998 version) showed a sensitivity of 97% specificity of 86.4% positive predictive value of 66.3% and an over all accuracy of 0.89%. They finalized the result that the Indian version of WHO (five) well being Index was found to be an effective instrument for identifying depression in elderly Indian community.

A. P. Rajkumar, et al,(2005) conducted a study to establish the nature, prevalence and factors associated with geriatric depression in a rural south Indian community , they recruited 1000 participants aged over 65 years from Kaniyambadi block, Vellore, India. The following structured assessment tools:Geriatric Mental State, Community Screening Instrument for Dementia, Modified CERAD 10 word list learning task, History and Aetiology Schedule Dementia Diagnosis and Subtype, WHO Disability Assessment Scale II, and Neuropsychiatric Inventory. They adopted a case control framework to study the factors associated with geriatric depression. The results have shown that Geriatric depression is prevalent in rural south India. Poverty and physical ill health are risk factors for depression among elderly while good social support is protective.

Ankur Barua, et al, conducted a cross sectional study performed on the elderly subjects of rural area of Udupi taluk Karnataka in South India over 8 months

period. (N=627). 60 years and above were participants. Results were subjected to statistical analysis i.e proportions and their 95% confidence intervals, Chi-square test, multiple logistic regression and its 95% confidence interval. The prevalence of depression in elderly population was determined to be 21 .7%. The prevalence in the age group of 80 years and above and those individuals who had a history of death in the family within the last six months were found to be 34.4% and 52.4%, respectively. Multiple logistic regression analysis revealed that these two correlates were independently associated with depressive disorders in elderly population.

Eisses, et al, (2004) conducted a cross- sectional and longitudinal study on prevalence and incidence of depression in residential homes for the elderly in Drenthe, Netherland. Out of 479, 295 non- depressed subjects were estimated the incidence rate after six months. The results showed the prevailing of major depression was 4.1% and the same rate was found for minor depression. The 6 month incidence of major and minor depression combined was 2.1%. The prevalence rate for depressive disorders obtained was twice as high as reported for the advance elderly in the general population, where as the rate were lower than those usually found in residential homes.

Another cross- sectional done by Jongenelis, et al, (2004) on prevalence and risk indicators of depression in elderly nursing home patients. Prevalence and risk indicators of depression were assessed in 333 nursing home patients living on somatic wards of 14 nursing homes in the north west of Netherland. The result findings showed that the prevalence of depression in the nursing home population is very high. The prevalence rate found was three to four times higher than in the community- dwelling elderly. Age, pain, visual impairment, stroke, functional limitations, negative life events, loneliness, lack of social support and perceived inadequacy of care were found to be risk indicators for depression.

Aman Sood, Parsotham.D. (2006) conducted a study to evaluate the profile of psychiatric disorders in geriatric inpatients with 528 individual elderly. The ICD-10 criteria were used for psychiatric diagnoses. General medical conditions were diagnosed by consultants of the respective departments. The patients were finally assessed by the consultant of the Department of Psychiatry. The obtained data were analysed using the chi-square test. Results showed that 260 (49%) had psychiatric co-morbidity. The most common psychiatric disorder was depression (25.94%), and the

above findings emphasized the importance of consultation-liaison psychiatry, especially in geriatric patients.

Aartjan T.F. , Rudi G.J. (2006) conducted a prospective population-based study of 85-year-olds, (N=476) to asses the impact of depression and perceived loneliness in the oldest old which is largely unknown. The authors studied the relationship between the presence of depressive symptoms and all-cause mortality in old age. Mini mental status examination scale was used as a tool. Results showed Depression was present in 23% and associated with marital state, institutionalization, and perceived loneliness. When depression and perceived loneliness were not assessed during follow-up, they found to have a significant effect on mortality. However, those who suffered from both depression and feelings of loneliness had a 2.1 times higher mortality risk.

Barry LC, et al, (2009) evaluated the association between level of depressive symptoms and severity of subsequent disability over time and determined whether this relationship differed by sex. Participants included 754 community-living persons aged 70 years or older who underwent monthly assessments of disability in four essential activities of daily living for up to 117 months. Disability was categorized each month as none, mild, and severe. Depressive symptoms, assessed every 18 months, were categorized as low (referent group), moderate, and high. Multinomial logit models invoking Generalized Estimating Equation were used to calculate odds ratios and 95% confidence intervals. Results revealed that Depressive symptoms were associated with disability burden in both men and women, with modest differences by sex; men had an increased likelihood of experiencing severe disability at both moderate and high levels of depressive symptoms, whereas only high depressive symptoms were associated with severe disability in women.

A. Rashid, et al, *(* 2011) conducted a cross sectional study to determine the prevalence of depression among the elderly Malays living in rural Malaysia. The study was among the elderly population in 24 villages in north Malaysia. Geriatric Depression Scale was used to screen for depression among the participants. Analysis was done using SPSS version 13 Results revealed that The prevalence of depression was 30.1%. Being unmarried (OR 2.06), unemployed (OR 1.81), earning less than RM 600 (OR 2.16) and living alone (OR 2.32) were significantly associated with the risk of being depressed. Being unemployed (1.82) and earning less than RM 600 (OR

1.79) were significant predictive variables. The author suggested Employment opportunities which can provide reasonable income are important for the elderly.

Ankur & Basilio (2010) the community-based mental health studies have revealed that the point prevalence of depressive disorders in the elderly population of the world varies between 10% and 20% depending on cultural situations. A retrospective study based on meta-analysis of various study reports. N= 4,87,275. The study was held at Community-based mental health surveys on geriatric depressive disorders conducted in the continents of Asia, Europe, Australia, North America, and South America. All the studies that constituted the sample were conducted between 1955 and 2005. Results have shown that the median prevalence rate of depressive disorders in the world for the elderly population was determined to be 10.3% [IQR = (4.7%-16.0%)]. The median prevalence rate of depression among the elderly Indian population was determined to be 21.9% [IQR = (11.6%-31.1%)]. Although there was a significant decrease trend in world prevalence of geriatric depression, it was significantly higher among Indians in recent years than the rest of the world.

2.3 LITERATURES RELATED TO EFFECT OF REMINISCENCE THERAPY IN DEPRESSION MANAGEMENT

By 2030, estimates indicate there will be 60 million persons over 65, clinical interventions for this age group will increase both in the physical and psychosocial realms of care. Because the over 85 age group is the fastest growing group within the elderly population, nursing intervention will be important to improve the quality of their lives. Reminiscing provides a pleasurable interaction as well as providing information for a healthy history. Reminiscence may enhance the lives of older adults, especially the old- old. Nurses intervening reminiscence to reduce depression increase life satisfaction; improve esteem and help older adults deal with crises and losses.

Reminiscence is defined as recall of past events. During intervention, participants are encouraged to talk about these past events, often assisted by aids such as photos, music, objects and videos of past.(Orrell & Woods.2001)

Reminiscence therapy: Refers to the discussion of past activities, events and experiences with another person or group of people, usually, with the aid of tangible

prompts such as photographs, household and other familiar items from the past, music and sound recording.

Jones ED (2008), conducted A study to determine the effects of a 3- week, six-session Reminiscence intervention on the level of depression among elderly women residing in one assisted living long term care facility using a pre test- post test, quasi experimental design. The convenience sample of women 30 women (M=81.7 years). Depression was measured using geriatric depression scale. The findings of this study suggest that Reminiscence therapy, was an effective treatment in reducing symptoms of depression among elderly women.

Cully, Lavoie (2006) explored the effectiveness of reminiscence therapy as an effective means of reducing depression among institutionalized, rural dwelling elderly women. Single group pre test and post test design (N= 31) was used and level of depression was assessed by geriatric depression scale. Results have shown statistically significant reduction in depression score. The author concluded that individual reminiscence therapy contributes to the improvement of older adult's quality of life, reduces their depression, and enhances their morale.

Fillip Smit, Erast Buhlmejjer (2004) aimed to assess the effectiveness of reminiscence on depression among different target groups and treatment modalities. They retrieved twenty controlled outcome studies and conducted a meta analysis. Results showed that reminiscence and life review are effective interventions for depressive symptoms in the elderly.

Chao Shu, Tsung et al (2006) conducted a quasi experimental study to find out the effect of group reminiscence therapy on older nursing home resident's depression (N=24) with 12 control group and 12 experimental group. Geriatric depression scale was used to measure the depression level. Result showed reminiscence therapy could enhance elder's social interaction with one another in nursing home settings.

Wang JJ Cheng Kung (2007) conducted a randomized control trial to assess the effectiveness of group reminiscence in reduction of cognitive impairment depressed mood (N=102). MMSE, GDS were used to assess the depression. Results have shown that the intervention has significant effect on cognitive function and

affective function. The author concluded that the reminiscence therapy is a positive and valuable intervention in reducing depression among elderly residing at long term care settings.

Ellen Klausner J, George S. et al (2006) conducted a randomized control trial study on institutionalized elderly. (N=481). Two RCTs compared treatment groups. Six RCTs compared treatment with a placebo group. Eight RCTs compared treatment with a standard care group. Three RCTs found significant reduction in depression score. Study findings revealed RCT has a significant effect of reminiscence therapy in the age group of 65-74, but not in the age over 74 years of depressed elderly.

Wang Jing Jy (2005) in his quasi experimental study he assessed the comparative effects of reminiscence on elderly people residing in long term care facilities and at home. (N=48). Purposive sampling technique was used. The results showed significant reduction of depression score after reminiscence. The author suggested that reminiscence is appropriate intervention for depressed older people residing in long term care facilities.

Ya- Chan Hsu (2005) conducted a longitudinal study to find out the effectiveness of reminiscence therapy on depressed elderly. (N=40). Face to face interview and study instruments were administered. Results have shown tha longer the duration reminiscence therapy played a significant role in the reduction of depression level among elderly. The author suggested that reminiscence is a effective nursing intervention to reduce depression and to promote quality of life for elderly population.

Herieh, Wang Lin et al (2007) conducted a true experimental study to find out the effect of group reminiscence and increasing self transcendence in older women. (N=24). Result showed a positive effect of group reminiscence. Study revealed that group reminiscence offers a possible intervention for treatment of depression in older women.

Pillemer et al (2008) In their cohort study (N=157) found the gender difference in reminiscence behavior across the life span. The sample consisted of two cohorts. Younger cohort 68-71 years, older cohort 76-79 years. Interview technique was used. Findings showed women had significantly higher scores. Study revealed

that the higher frequency of recounting specific memories by women was due to the fact women placed greater value on reminiscing.

Eller L.s et al (2007) a part of the larger study of symptoms of self management examined the prevalence correlates and characteristics of depressive symptoms and self care activities used to manage those symptoms in old age home elderly. (N=1217) epidemiologic studies depression scale was a self care interventions for depressive to find out the depressive symptoms. Results revealed 19 self care interventions for depressive symptoms. Self care behaviors for depressive symptoms which fill in to six categories. 1. Complementary therapy 2. Reminiscence therapy 3. Distraction techniques 4. Physical activity 5. Meditation 6.avoidant coping. Results showed reminiscence has significant association.

Jing-Jy Wanga Ya et al, (2004) They assessd the effects of reminiscence on four selected mental health indicators, including depressive symptoms, mood status, self-esteem, and self-health perception of elderly people residing in community care facilities and at home. A longitudinal quasi-experimental design was conducted, using two equivalent groups for pre–post test and purposive sampling with random assignment. Each subject was administered pre- and post- tests at a 4 month interval but subjects in the experimental group underwent weekly intervention. (n=94), a statistically significant difference (p=0.041) was found between the pre–post tests on the dependent variable, depressive symptoms. However, no statistical significance was found in subjects' level of mood status, self-esteem, and self-health perception after the intervention in the experimental group, but slightly improvement was found. Reminiscence not only supports depression of the elderly but also empower nurses to become proactive in their daily nursing care.

Afonso R, et al, (2008) study analyzed the effectiveness of an individual, delimited, semi-structured reminiscence program as an intervention strategy to reduce depressive symptomatology in a population of Portuguese old people.A semi-structured reminiscence program was developed in 5 individual sessions. The program's impact on depressive symptomatology was tested in 90 subjects aged over 65 years with depressive symptoms, no antidepressive medication, and no signs of dementia. In a randomized experimental design, participants were assigned to one of 3 groups: a) experimental group (exposed to the program); b) control group, or c)

placebo-control group (with weekly relaxation sessions). Pre and post-test score differences in Center for Epidemiologic Studies Depression Scale (CES-D) (adapted by Gonçalves and Fagulha, 2000-2001, from the original developed by Radloff, 1977), were analyzed in all participants at the same time intervals. As per findings In the experimental group, significant improvements were found in depressive symptomatology. The results suggest that elaboration of positive and negative autobiographical memories, stimulation of instrumental and integrative reminiscences and narration of specific and positive autobiographical memories using the reminiscence program, as designed and analyzed in this study, may be a tool for psychological intervention to reduce depressive symptomatology in old age.

2.4 CONCEPTUAL FRAMEWORK

This study was based upon Widenbachs helping art of clinical nursing theory. The central purpose of this theory refers to the nurse's desires to accomplishment. A nurse develops a prescription based on the central purpose and implements according to the reality of the situation.

The main concepts of this theory were

- ☞ Identifying need for a help.
- ☞ Ministering needed help
- ☞ Validating that need for help was met

Identifying need for help:

It involves viewing the patient as an individual with unique experiences. Determining a patient's need for help is based on the existence of a need whether the patient realizes the need and what prevents the patient from meeting the need. In this study it refers to the assessment of level of depression (by using GDS scale) among the elderly before administering reminiscence therapy.

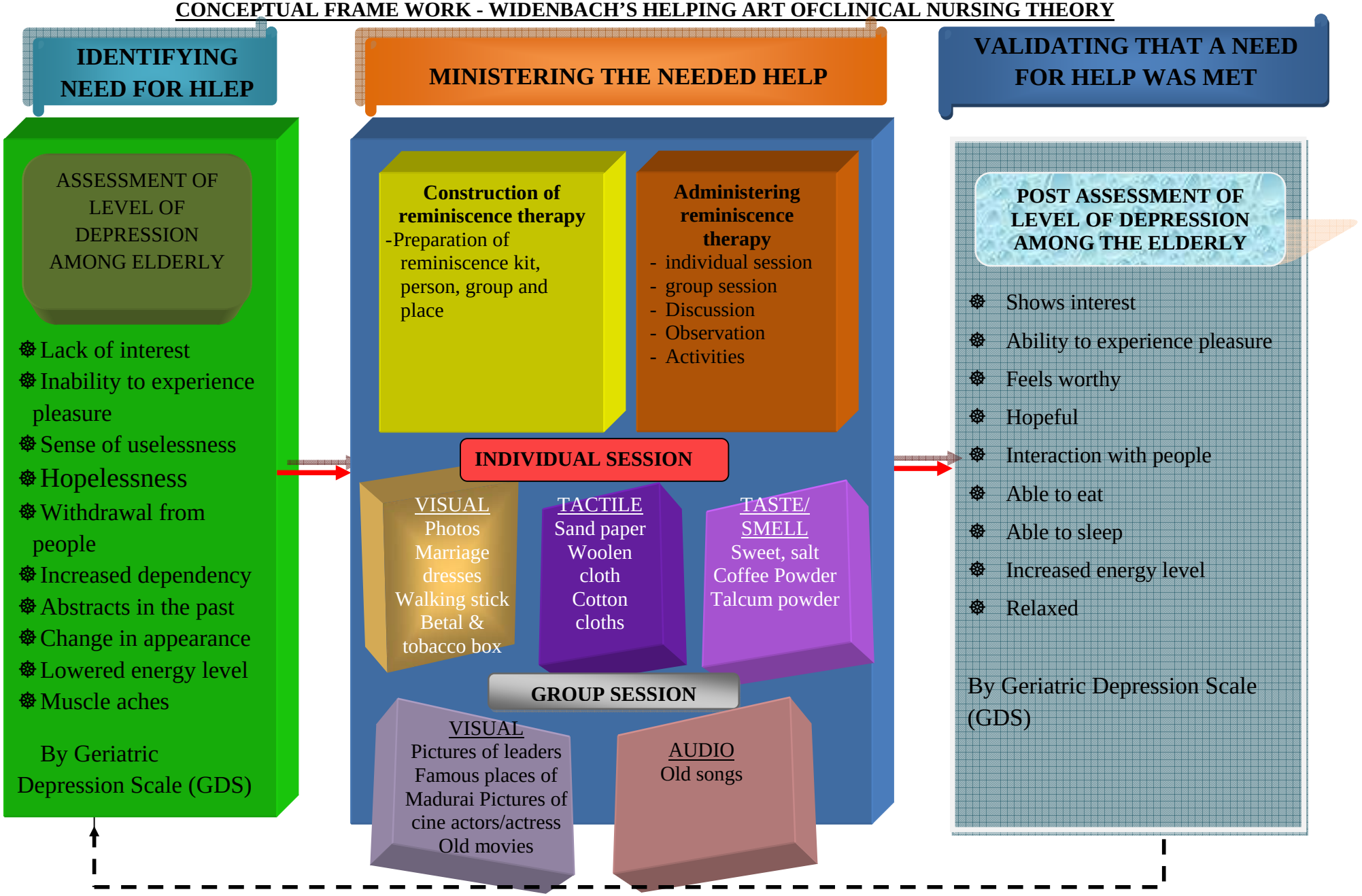
Ministering the needed help:

It means the provision of needed help. This requires a identified need and a patient who wants help. In this study it refers to ministering reminiscence therapy to the elderly with mild or moderate depression. This will be administered both in individual and group sessions.

Validating that a need for help was met:

It means evaluation of the level of depression by geriatric depression scale and also evaluating the improvement in emotional and psychological well being, recalling past memories by means of relaxed mood and feedback. Reassessment of depression level if it is needed.

CONCEPTUAL FRAME WORK - WIDENBACH'S HELPING ART OFCLINICAL NURSING THEORY



CHAPTER III

RESEARCH METHODOLOGY

The methodology of research indicates the general pattern of organizing the procedure for gathering valid and reliable data for investigation. This chapter provides a brief description of the method adopted by the investigator in this study. It includes the research approach, research design, setting of the study, population, sample, and sample size, sampling technique, description of the tool, pilot study, data collection procedure and plan for data analysis.

The present study aims to evaluate the effectiveness of reminiscence therapy in reducing depression among the elders residing in a selected old age home at Madurai.

3.1 RESEARCH APPROACH

Two approaches were used in this study

PHASE I

Survey approach was used to assess the level of depression among the elders residing in a selected old age home at Madurai.

PHASE II

Evaluative approach was used to evaluate the effectiveness of reminiscence therapy in reducing depression among the elders residing in a selected old age home at Madurai.

3.2 RESEARCH DESIGN

The research design used was one group pre-test post-test pre experimental design.

Group	Pre test	Intervention	Post test
Experimental group	O1	X	O2

3.3 VARIABLES

Variables are characteristics that vary among the subjects being studied.

Independent variable- **-** Reminiscence therapy

Dependent variable -Depression among elderly assessed by geriatric depression scale.

3.4 SETTING OF THE STUDY

This study was conducted in a selected old age home at Madurai. It is run with help of Help Age India. It consists of 60 inmates. It is governed by the private concern. The principal of TTS institution was the head of the old age home. The home has shared accommodation for the inmates. It provides medical facilities. It also has provision for recreation and a place for religious activities and meeting. The home is situated 12 kilometers away from the college.

3.5 POPULATION

The target population of the study was the elders residing in a selected old age home at Madurai.

The accessible populations of the study were elders with mild and moderate depression scored by Geriatric Depression Scale

3.6 SAMPLE

Samples were the elderly who had either mild or moderate depression and were residing in a selected old age home at Madurai& those who fulfilled the inclusion criteria.

g. SAMPLE SIZE

The sample size was 30.

3.8 SAMPLING TECHNIQUE

The sampling technique used was convenient sampling.

3.9 CRITERIA FOR SAMPLE SELECTION

Inclusion criteria:

1. Elderly persons residing in a selected old age home at Madurai.
2. Elderly persons who were with mild and moderate depression.
3. Elderly who can speak and understand Tamil / English
4. Elderly who were willing to participate in the study.

EXCLUSION CRITERIA

1. Elderly people who were very sick.
2. Elderly people who were with severe depression.

3.10 RESEARTH TOOL

Part I: It included the demographic characteristics of the elderly people, such as age, gender, religion, education, pre retirement employment status, marital status, economic support, period of stay and mode of entry.

Part II: Geriatric depression scale was used to assess the level of depression among the elderly people.

The geriatric depression scale developed by TL Brink et al is a 30 item self rated scale. The geriatric depression scale has been reported to be a useful screen for depression in elderly population.

3.11 SCORING PROCEDURE

Each item of the geriatric depression scale was answered either “yes” or “No”. There were 20 items which indicated depression when answered No (item 1,5,7,9,15,19,21,27,29,30). A total score provided which consisted of one point from each depressive answer. Non depressive answers were scored zero and did not add to the total score. The total score was interpreted as follows:

Normal	: 0-9
Mild depression	: 10-16
Moderate depression	: 17-23
Severe depression	: 24-30

3.12 RELIABILITY OF THE TOOL

Reliability: The geriatric depression scale had demonstrated very good internal consistency (alpha 0.94) and split half reliability of 0.94. Stability of the scale was also very good, with a test retest correlation of 0.85 over one week. [Yesavage J.A.Brnk TL, etal, "development and validation of a geriatric depression screening scale: a preliminary report," J. psychiatry Res, 1982, 17(1) : 37-49]. The content validity was obtained from four nursing experts and two medical experts.

3.13 PILOT STUDY

In order to test the feasibility, relevance and practicability of the study, pilot study was conducted among five elders in an old age home in a manner in which the final study would be done. It was carried over from 21.10.2010 to 27.10.2010. It revealed that the study was feasible. Data were analyzed to find out the suitability of statistical method.

3.14 DATA COLLECTION PROCEDURE

The data collection procedure was done for four weeks from 01.11.2010 to 30.11.2011 in selected old age home at Madurai. Before conducting the study, the researcher obtained permission from the head of the institution. Geriatric depression scale was used to assess the level of depression of the elders. Written consent was obtained from all subjects. Approximately 30-45 minutes was taken to complete the assessment on each individual. In the first week pre test level of depression was assessed. From 60 inmates, 30 elders who fulfilled the inclusion criteria were selected for the reminiscence therapy. Following the assessment, 2 weeks of reminiscence therapy was administered individually and as well as in groups. Individual sessions were conducted for 30 minutes. Group sessions were conducted for 2 hours, reminiscence therapy was administered using visual props, tactile props, and taste/ smell props. In the 4^{th} week, post test level of depression was assessed on each individual. Schematic representation of the data collection procedure is depicted in this chapter.

BENEFITS OF REMINISCENCE THERAPY- ACCORDING TO SPENCER& JOYCE (2000)

- Increases social interaction through the sharing of experiences
- Emphasize the individual identity and unique experiences of each person
- Allow the older people to take on a teaching role through the sharing of their experiences
- Help people to come to terms with growing older
- Encourage older people to regain interest in past hobbies and past times
- Encourage creativity
- Increase self worth and provide a sense of achievement
- Reduce apathy and confusion, especially in confused or disoriented people
- Alleviate depression
- Increasing life satisfaction
- Improving self care
- Helping older people deal with crisis, losses and life transitions (Jones 2003)
- Meeting psychological and emotional needs (Wareing, 2000)
- Involvement in a meaningful and pleasurable activity and positive interaction

TYPES OF REMINISCENCE THERAPY

- ❖ Simple reminiscence: Here the idea is to reflect on the past in an informative and enjoyable way.
- ❖ Evaluative reminiscence: Is more of a therapy and may for example, be used as a life reviewing or sometimes conflict resolving approach
- ❖ Offensive – defensive reminiscence is occasionally, unpleasant and stressful information is recalled. It can be either the reason or the result of behavioral and emotional issues. Dealing with them can provide resolution- a coming to terms with life events and possible closure.

TIPS ON APPROACHING REMINISCING

A person centered approach used with sensitivity, flexibility, awareness and personal warmth (Wareing, 2000).

- A focus on positive interaction with emphasis on brief, high quality interactions. Focus on the remaining abilities of the person with depression taking in to account each individual's strengths, their past and present interests and difficulties (Spender& Joyee, 2000).

- It does not matter if the enjoyment is for a short time or fleeting as it is still of value of that person (Coaten, 2001).

- Be aware of attempts to communicate as what we see as "difficult behavior" could simply be an attempt to communicate.

- Spending time listening to a person says to them they are special and what they have to say is valuable.

- Reminiscing with humour not only provides opportunities to enjoy it, but also gives permission to express it (Kellick, 2003).

It is important to recognize the many factors that influence one's life. Growing up in a different country, living in regional areas or interest at all offer different experiences. Other influences on a person's life can be growing up as part of a large family, different cultures, customs and language.

USE OF FIVE SENSES IN REMINISCENCE THERAPY

Hearing, sight, smell, taste, touch

Coaten (2001) quoted that few elderly may no longer have the ability to explain or express their thoughts through words. Reminiscing is much more than simply talking about a memory. Reminiscing can involve all the senses. For people with cognitive impairment and difficulties in communicating verbally the opportunities offered by a different, non verbal way of communicating may be of great importance (Coaten, 2001). Providing sensory stimulation through sound, movement, dance, rhythm, beat, smell, changes in light and colour, objects, tactile surfaces, materials, vibration, food and experiencing flavors can provide vivid and strong reminiscence. The importance of hearing and touch:

Hearing is one of the last sense to go as an older person looses abilities, thus hearing is a major sense.

- Deterioration of other senses can result in touch being one of the only non verbal type of communication that can be fully perceived.
- If elderly people are not touched they can lose touch with the environment. This can result in a loss of reality.
- An agitated older person will often relax when someone sits and holds their hand and talks to them.
- Touch conveys attitude and feelings. Touch is something which cannot be faked. So ……..what is communicated if we do not touch?(Boney, 1994).
- When reminiscing brings up difficult, sad or distressing emotions:
- Not all memories are positive so it is important to 'check in' with the person throughout the reminiscing experience. Keep the following in mind:
- If an older person starts remembering a sad or difficult time in their life it is not necessarily a bad thing. Sometimes it is all right for the person to explore their feelings and for these feelings and to be acknowledged.
- Often sad experiences will be recalled as part of reminiscence therapy. These experiences are just as important as happy ones, so don't feel you need to have discussion on to a happier topic unless it is clear that the person or group is becoming distressed.
- Sometimes reminiscence can lead to feelings of depression and may require one to one follow up. Environment should be supportive and confrontations should be avoided. When painful emotions arise and the group has difficulty in dealing with it, the leader should intervene or advice should be sought from staff and family.

ENGAGING A PERSON IN A REMINISCING SESSION

- It is important to gain the attention of the person you will be with during the reminiscing session:
- Be physically at the same level with the older person.

- Make eye contact if possible.
- If eye contact is not possible be sure to have your hand or the reminiscing objects in a place the person will be able to see as this will help to make a connection. If the person has sight impairment let them know you are with them through touch, movement, talking or possibly move them to an area where there will be a difference in light.
- Always use a space where the person can feel comfortable, where there are minimal distractions and where you will not be interrupted.
- Use the following methods for an introduction.
- Introduce yourself and possibly mention something the person has told you on a previous reminiscence or use an object they reacted well to previously.
- Give the person a clear introduction to the reminiscing session and theme.
- Don't rush the person. Allow time for them to communicate in a way they are comfortable with.
- If using objects from a reminiscing kit handle the person an object one at a time. Keep to the pace of the older person. Some people will keep interest in objects for a long time whilst others for only a short time.
- When closing the reminiscence make sure the activity has a formal ending and that the person knows the reminiscing is coming to an end.
- Check that the older person is not left thinking about a sad or distressing memory. If someone is thinking about a sad or distressing memory keep the following in mind.
- 'Walk the person out of that memory onto another.
- Acknowledge how the person is feeling, that their emotions are genuine.
- Stay with the person a little longer if time permits.

TIPS FOR SUCCESSFUL CONVERSATION

- Keep the following in mind for clear communication:
- Don’t ask specific questions that are closed. Ask open ended questions as they often work better.
- Building up a sense of trust is important. Be realistic and recognize that it may take a while to get to know the person.
- Be a good listener. Listening means learning to stop wait and allow the older person time to speak. What may seem like an uncomfortable, silent wait for us can allow the older person time to gather their thoughts and respond.

REMNISCING WITH GROUPS

When holding a group reminiscence keeps the following in mind:

- Group numbers should be small. Let the following be a guide:
- No more than 8 or 10 when working with older people who do not have distress.
- No more than 3 when working with older people who have advanced depression
- An appropriate group size allows objects to be circulate rapidly to stimulate discussion. The right group size allows people a good experience and ensures everyone gets chance to speak or be involved.
- Session times may vary depending on the group.
- Let the following be a guide:
- Up to 45 minutes when working with a group of people who can reminiscence and communicate well.
- 20-30 minutes with a group who may be in moderate level of depression.

- Quiet, intimate and comfortable surroundings are important in order to make people feel at ease.
- Placing seats close together helps promote an intimate atmosphere.
- Starting the session with a cup of tea or coffee and biscuits helps and to the sense of occasion.
- It is important not to use too many objects per session, as this can bombard participants with too much stimulus material.
- Select up to 6 objects that you feel are most appropriate for the group.
- As facilitator it is important to keep track of who has not spoken in the session. As a facilitator provide them with extra support and encouragement to join in, while always respecting the participant's right to privacy.
- Don't be concerned if the discussion leads to subjects beyond the theme of the session. One memory can trigger many others and all are important in he reminiscence process.

SUGGESTIONS FOR GROUP WORK

- Use a room where the participants will feel comfortable and able to talk.
- Seating in semi circle allows for easy passing of objects and for participants to hear others.
- Use the opportunity to hear different versions of an event from different people but be careful not to offend or disregard anyone's personal experience.
- Use the differences within the group, such as age, to obtain greater insights into each object or experience. Introduce the topic and then gradually pass the items around.

3.15 PLAN FOR DATA ANALYSIS

The data obtained were analyzed by using both descriptive and inferential statistics. Tests used in the study were frequency and percentage distribution, standard deviation, mean, chi square test and paired “t” test.

3.16 PROTECTION OF HUMAN SUBJECTS

The proposed study was conducted after the approval of dissertation committee of the college of nursing. Permission was obtained from the ethical committee Government Rajaji Hospital Madurai and principal of the college of nursing. Permission was obtained from the principal of selected old age home. Written consent of each subject was obtained before starting the data collection.

SCHEMATIC REPRESENTATION OF THE DATA COLLECTION PROCEDURE

<table>
<tr><td rowspan="2">PRE TEST</td><td colspan="5">FORE NOON</td><td colspan="2">AFTER NOON</td><td>WEEKS</td></tr>
<tr><td colspan="7">Group a
Group b
Group c
Group d
Group e
ANALYSIS</td><td>Week I</td></tr>
<tr><td rowspan="3">REMINIS THERAPY CENCE</td><td rowspan="3">INDIVIDUAL</td><td>VISUAL
Photos, Marriage Dresses, Marriage</td><td>Group a
Group b
Group c
Group d
Group e</td><td rowspan="3">GROUP</td><td>PROPS
Picture of Leaders, places, photos of Madurai</td><td>Group a
Group b
Group c
Group d
Group e</td><td>Week II</td></tr>
<tr><td>TACTILE
Sand paper, Wool clothes, Cotton clothes</td><td rowspan="2">Group a
Group b
Group c
Group d
Group e</td><td>BRAIN STROMING
Actors/ Actress
Movies, Jobs, Political Figures</td><td rowspan="2">Group a
Group b
Group c
Group d
Group e</td><td rowspan="2">Week III</td></tr>
<tr><td>TASTE /SMELL
Sweet Salt, Coffee powder, Talcum powder</td><td>AUDIO
Old Songs
VIDEO
Old movies</td></tr>
<tr><td>POST TEST</td><td colspan="7">Group a
Group b
Group c
Group d
Group e
ANALYSIS</td><td>Week IV</td></tr>
</table>

CHAPTER IV

DATA ANALYSIS AND INTERPRETTATION

This chapter deals with the analysis of the data collected from 30 depressed elderly in selected old age home at Madurai. Statistical procedure enabled the researcher to deduce, summarize, organize, evaluate, interpret and communicate the numeric information. Statistical analysis is a method of rendering quantitative information meaningful and intelligible. The analyzed data were tabulated and presented according to the objectives.

OBJECTIVES OF THE STUDY WERE

To assess the level of depression among the elderly residing in selected old age home before and after reminiscence therapy

To evaluate the effectiveness of reminiscence therapy on depression among the elderly residing in a selected old age home at Madurai

To associate the effectiveness of reminiscence therapy on depression with selected demographic variables of the elderly.

In this chapter the data collected were edited, tabulated, analyzed and interpreted. They were arranged in the following headings.

SECTION I: Frequency distribution of demographic characteristics of the elderly

SECTION II: Distribution of the elderly according to the level of depression the pre test and post test

SECTION III: Comparison of the level of depression before and after reminiscence therapy

SECTION IV: Association between the effectiveness of reminiscence therapy on depression with demographic variable of the elderly people.

SECTION V: Association between the level of depression and reminiscence therapy

SECTION I

TABLE-1: FREQUENCY DISTRIBUTION OF DEMOGRAPHIC CHARACTERISTICS OF THE ELDERLY		N=30
	Frequency	**Percentage**
Age		
60-69 Yrs.	14	46.67
70-79 Yrs.	16	53.33
80 and Above	0	0.00
Gender		
Male	10	33.33
Female	20	66.67
Religion		
Hindu	8	26.67
Christian	22	73.33
Muslim	0	0.00
Education		
Primary	3	10.00
Middle	9	30.00
High School	4	13.33
Higher Secondary	2	6.67
Degree	2	6.67
Illiterate	10	33.33
Pre Retirement Employment Status		
Retired	2	6.67
Private Job	2	6.67
Business	2	6.67
Cooly	16	53.33
Un employed	8	26.67
Marital Status		
Un Married	7	23.33
Married	6	20.00
Divorced	1	3.33
Widow / Widower	16	53.33
Economic Status		
Pension	1	3.33
Old Age Pension	20	66.67
Family Support	2	6.67
Friends Support	1	3.33
No Support	6	20.00
Period of Stay		
0-5 Yrs	15	50.00
5-10 Yrs	7	23.33
10-15 Yrs	4	13.33
15 Yrs above	4	13.33
Mode of Entry		
Self	13	43.33
Family	5	16.67
Friend	12	40.00

Table 1 showed frequency and percentage distribution of demographic variables of the elderly. Among the depressed elderly more than half of them (53.33%) are on the age group of 70-79 years. 67% of the old aged are of female and 33% of them are male. Majority (73.33%) of the elderly sample belongs to Christian religion. Only 6.6% are graduate 33.33% are illiterate. As for as pre retirement employment concern more than 53.33% of them are cooly and nearly ¼ of them (26.67%) of them unemployed. More than half of them 53.33% are either widow or widower. Majority of 67% depressed elderly are pensioner and 20% of them have no support. Almost equal number of the elders stayed for 10-15 years or 25 years & above. Half of them stayed for five years.

Figure - 1 Distribution of subjects according to age

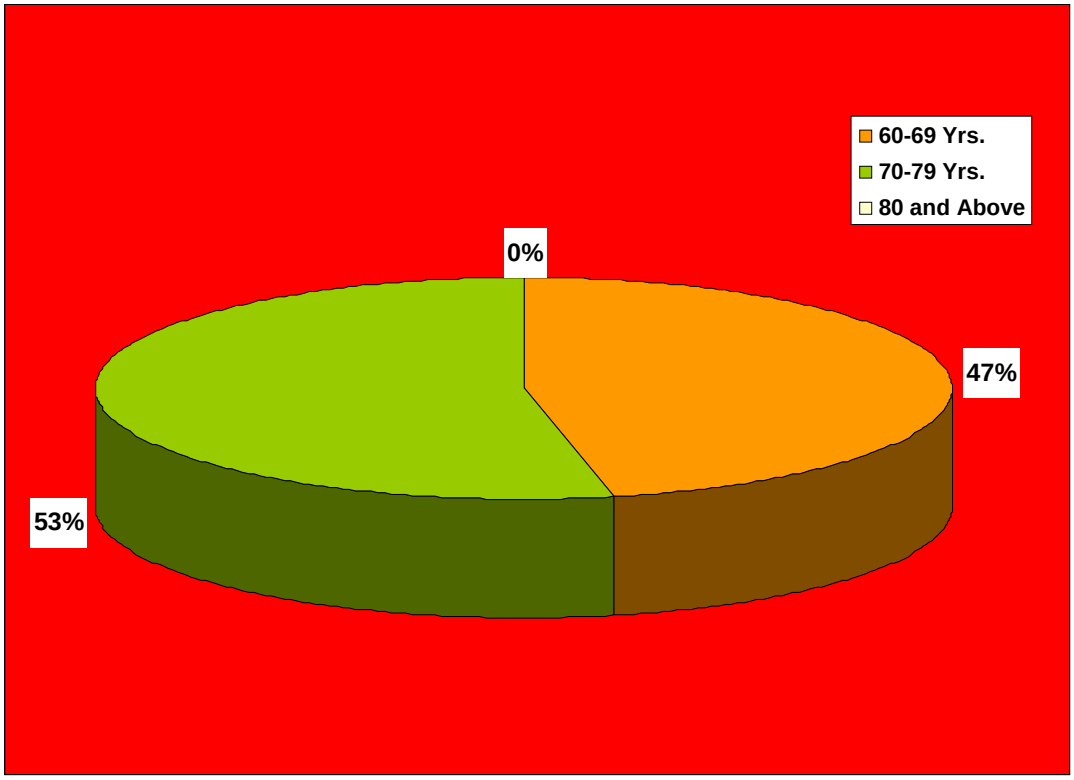


Figure 1 shows among the depressed elderly more than half of them (53.33%) are on the age group of 70-79 years.

Figure - 2 Distribution of subjects according to gender

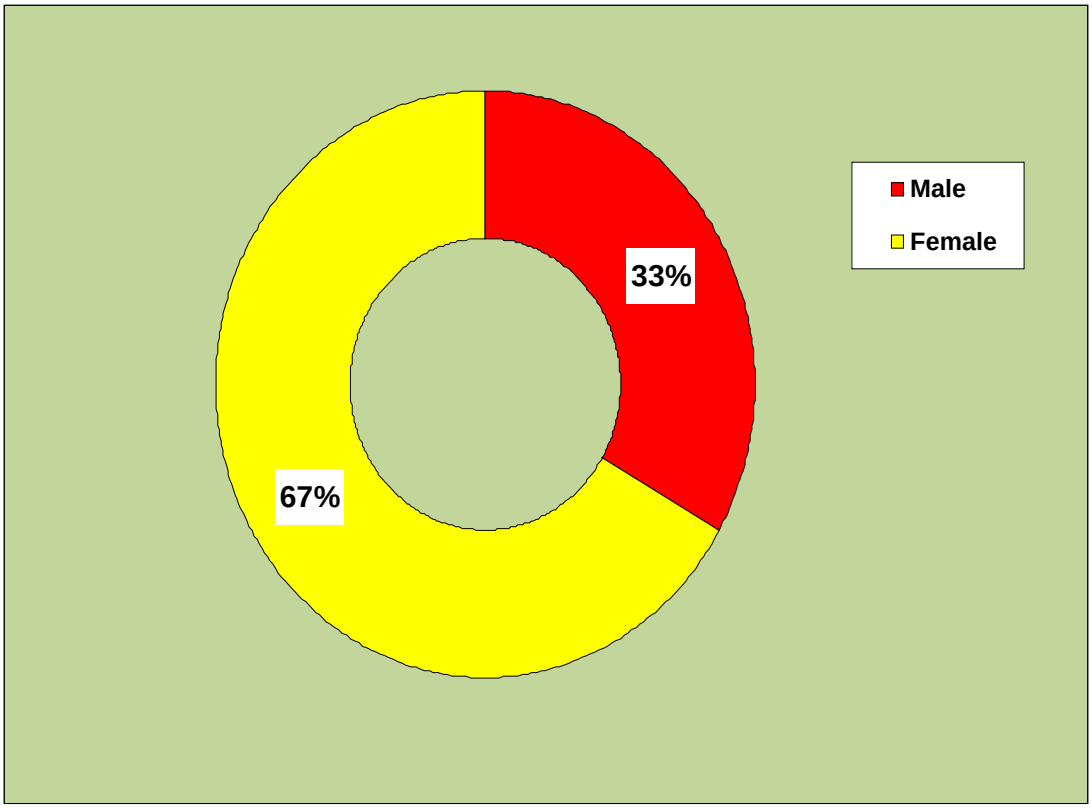


Figure 2 shows 67% of the old aged is of female and 33% of them are male.

Figure - 3 Distribution of subjects according to religion

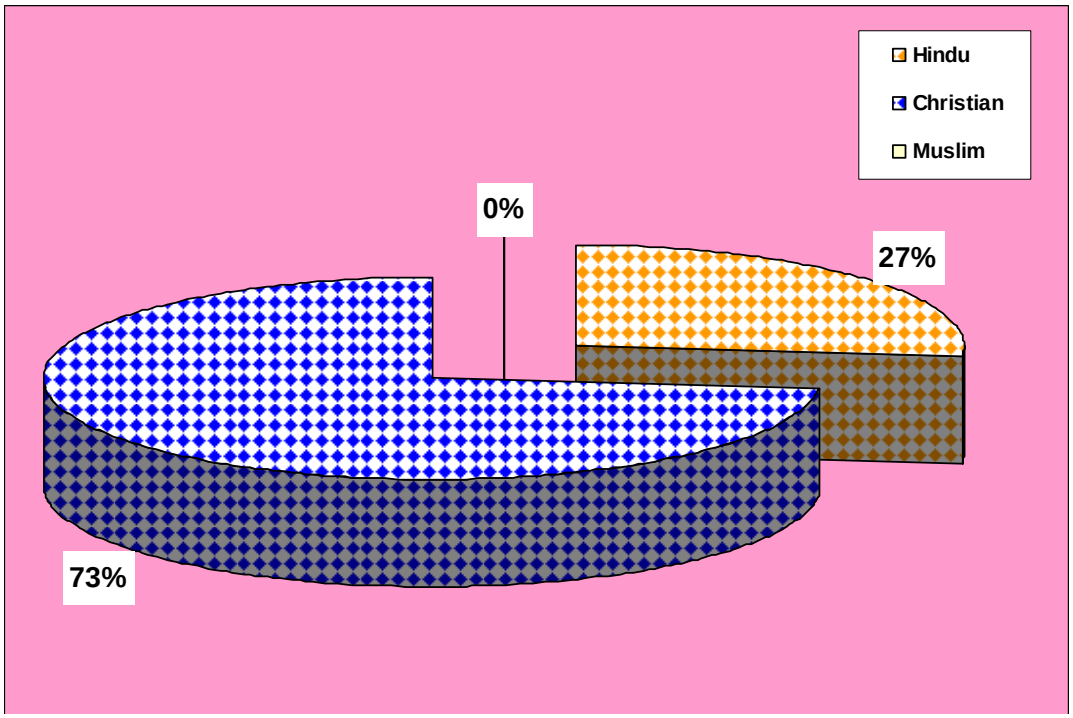


Figure 3 shows Majority (73.33%) of the elderly sample belongs to Christian religion.

Figure - 4 Distribution of subjects according to education

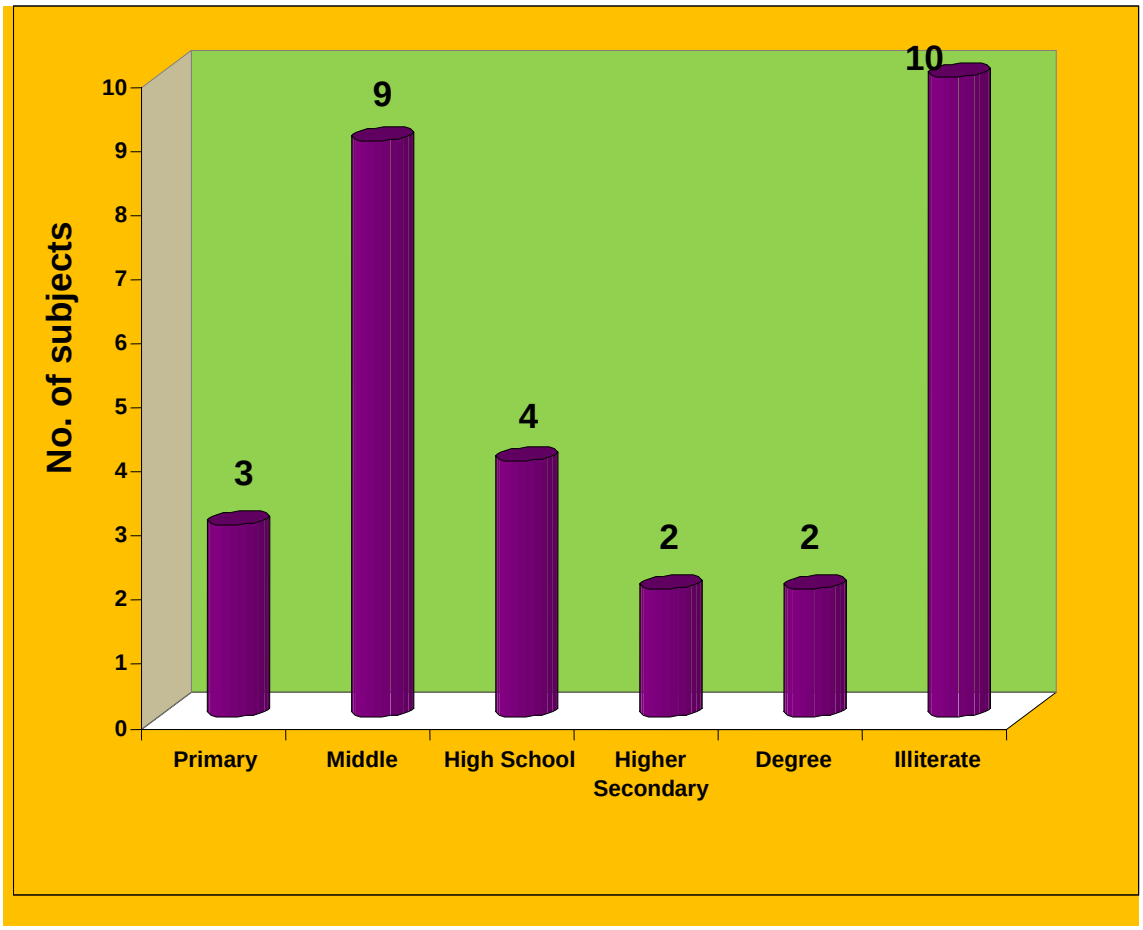


Figure 4 shows only 6.6% are graduate 33.33% are illiterate.

Figure -5 Distribution of subjects according to pre retirement employment status

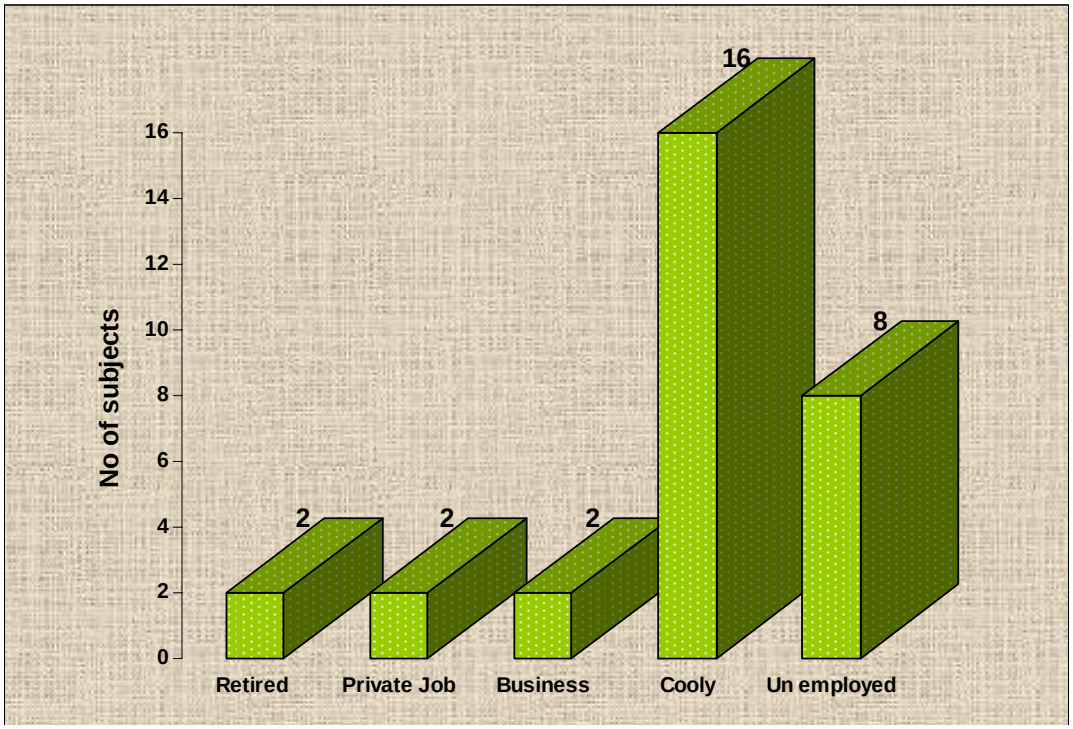


Figure 5 shows as pre retirement employment concern more than 53.33% of them are cooly and nearly ¼ of them (26.67%) of them unemployed.

Figure -6: Distribution of subjects according to marital status

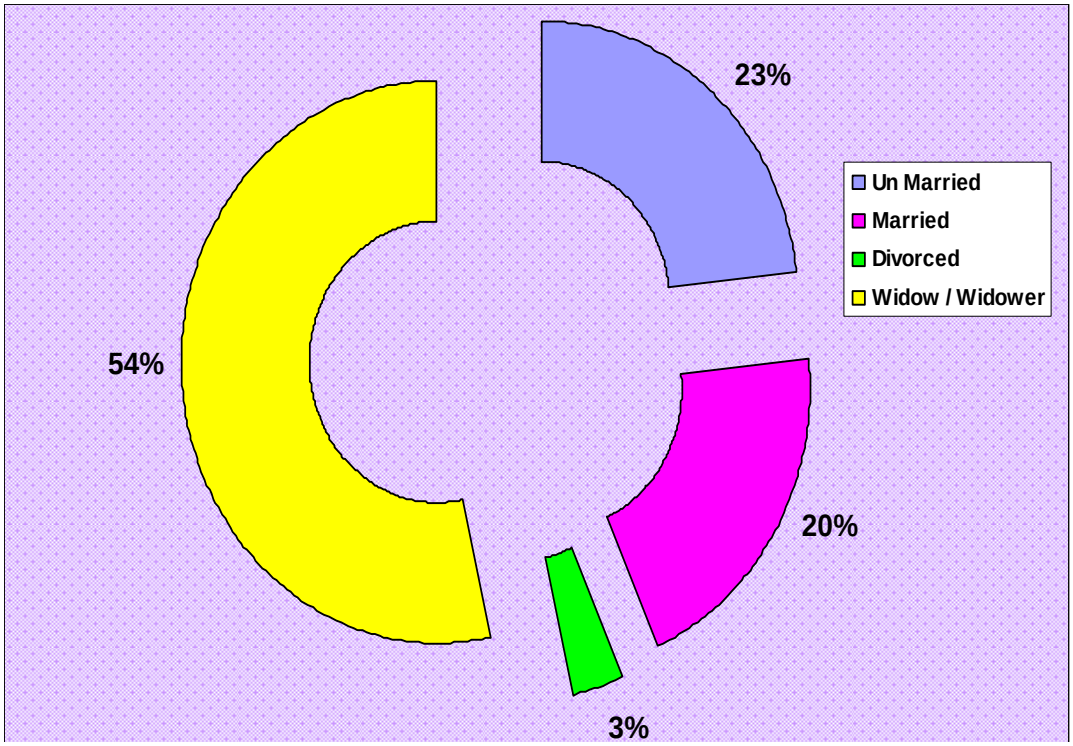


Figure 6 shows more than half of them 53.33% are either widow or widower.

Figure :7 Distribution of subjects according to economic support

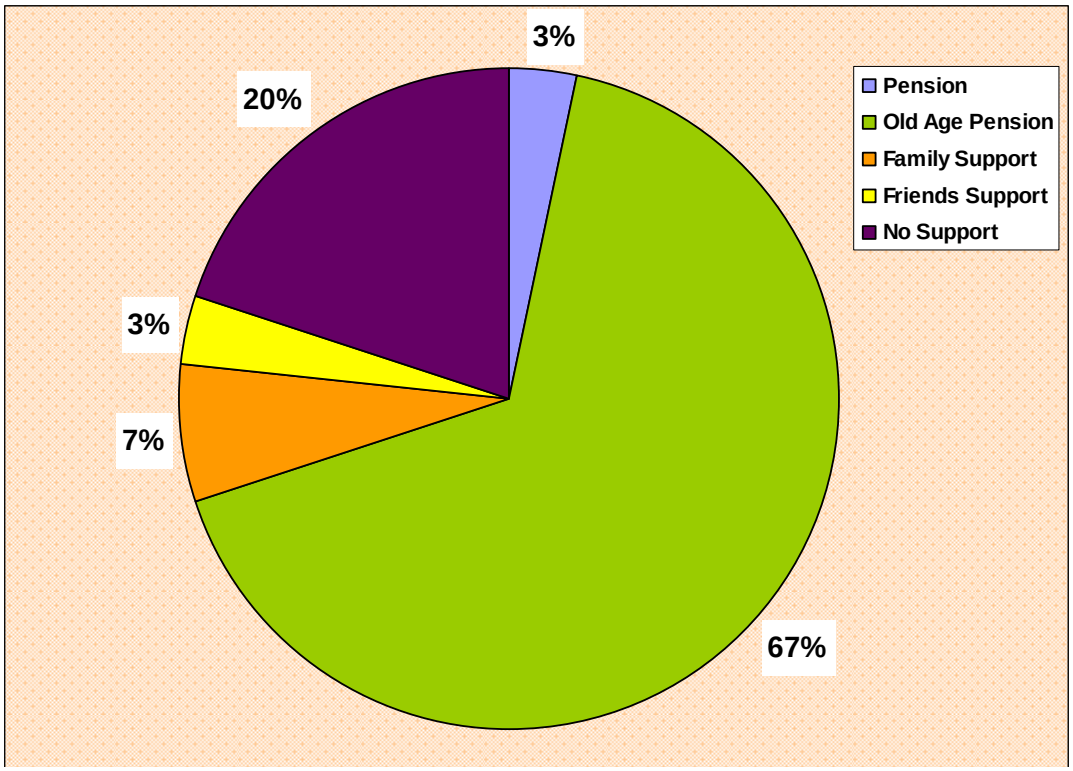


Figure 7 shows Majority of 67% depressed elderly are pensioner and 20% of them have no support.

Figure - 8 Distribution of subjects according to period of stay

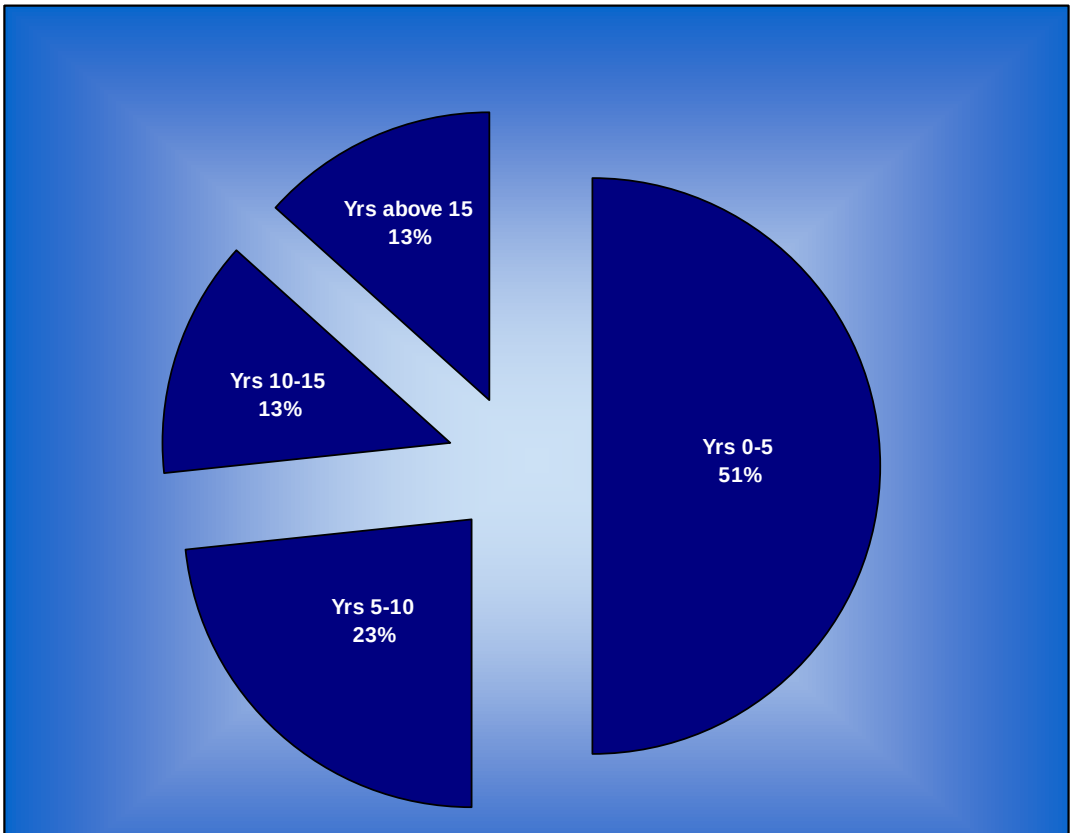


Figure 8 shows Almost equal number of the elders stayed for 10-15 years or 25 years & above. Half of them stayed for five years.

Figure :9 : Distribution of subjects according to mode of entry

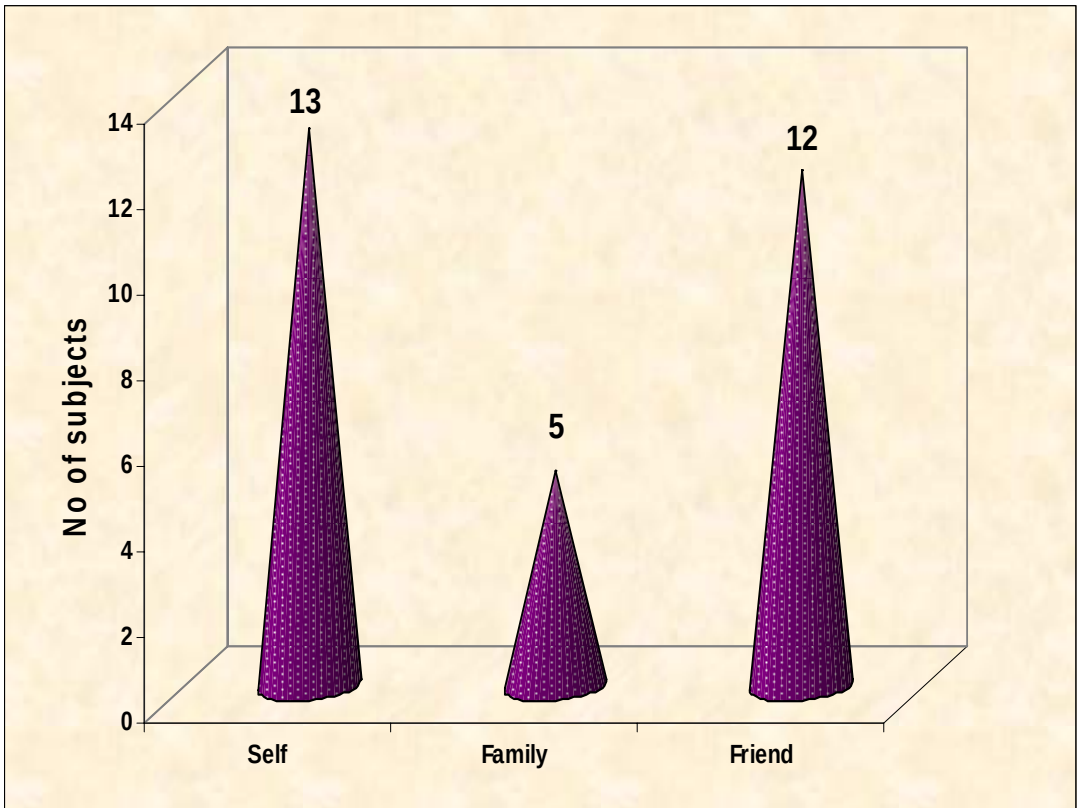


Figure 9 shows Majority of the depressed elder's mode of entry to the home is through self (13) and through friends (12) and very less contributes through the family.

TABLE NO:2

DISTRIBUTION OF THE ELDERLY ACCORDING TO THE LEVEL OF DEPRESSION IN THE PRE TEST AND POST TEST N=30				
Level of Depression with score	**Pre Test**		**Post Test**	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Mild - 10 – 16	11	36.67	21	70.00
Moderate - 17- 23	19	63.33	9	30.00
Severe - 24 - 30	0	0.00	0	0.00

Table No.2 showed that most of the elderly 19 (63.33%) were assessed to have moderate level of depression (17-23) in the pre test which is reduced to 9 (30%) in the post test. Ultimately Mild level of depressed elderly in the pre test 11 (36.67%) was found increased 21 (70%) In the post test. This revealed that reminiscence therapy has great impact in reducing post test depressive scores.

TABLE NO. 3

COMPARISION OF THE LEVEL OF DEPRESSION BEFORE AND AFTER REMINISCENCE THERAPY				
Variable	**Mean**	**Mean Difference**	**Stand Deviation**	**T Value**
Pre Test	18.70	5.47	3.81	6.73
Post Test	13.23		3.82	

P value <0.05 ** significant

Table No.3 showed that the mean post test depressive score is lower than the mean pre test depressive scores. “t” value (6.73) is two degree significant at p=0.05 level. Report revealed that reminiscence therapy has significant effect on reduction of depression score of the elderly in both mild and moderate level in post test.

Figure : 10 DISTRIBUTION OF THE ELDERLY ACCORDING TO THE LEVEL OF DEPRESSION

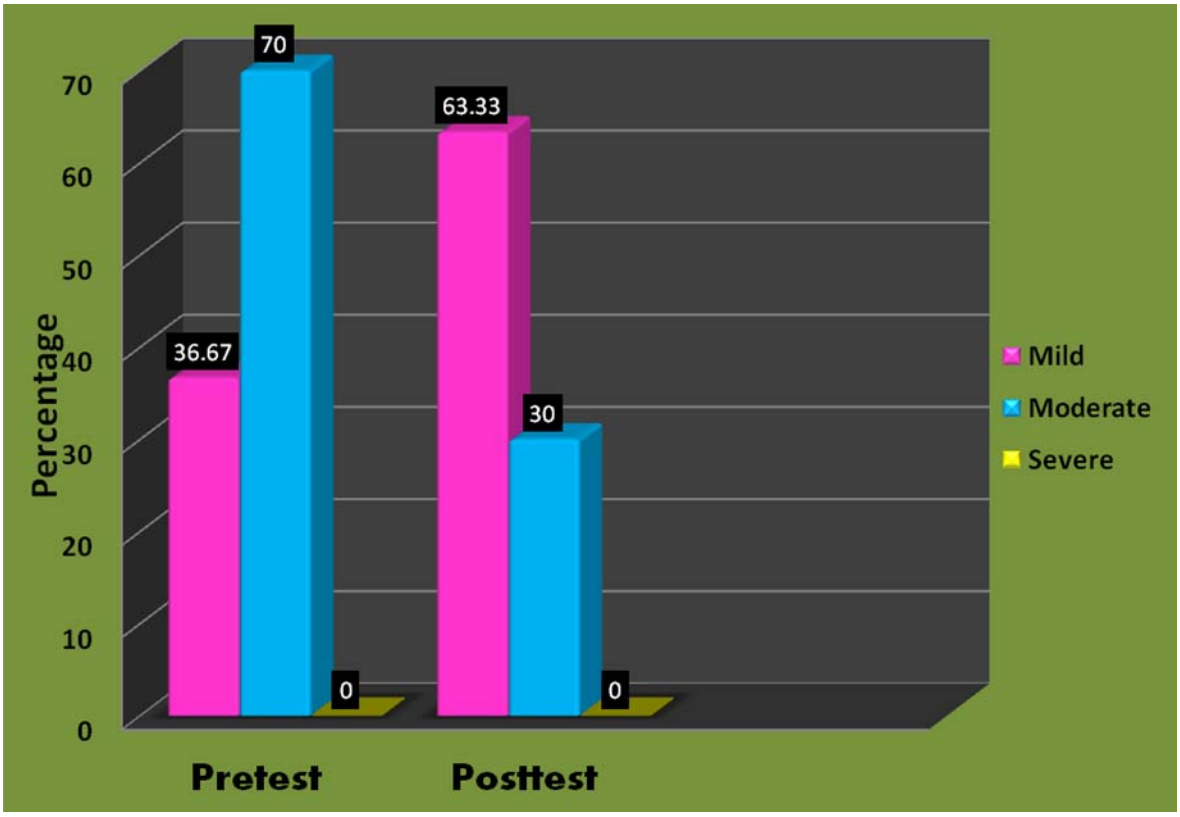


Figure No.10 shows that most of the elderly 16 (63.33%) were assessed to have moderate level of depression (17-23) in the pre test which is reduced to 9 (30%) in the post test. Ultimately Mild level of depressed elderly in the pre test 11 (36.37%) was found increased to 21 (70%) In the post test. This revealed that reminiscence therapy has great impact in reducing depressive scores.

Figure : 11 COMPARISION OF THE LEVEL OF DEPRESSION BEFORE AND AFTER REMINISCENCE THERAPY

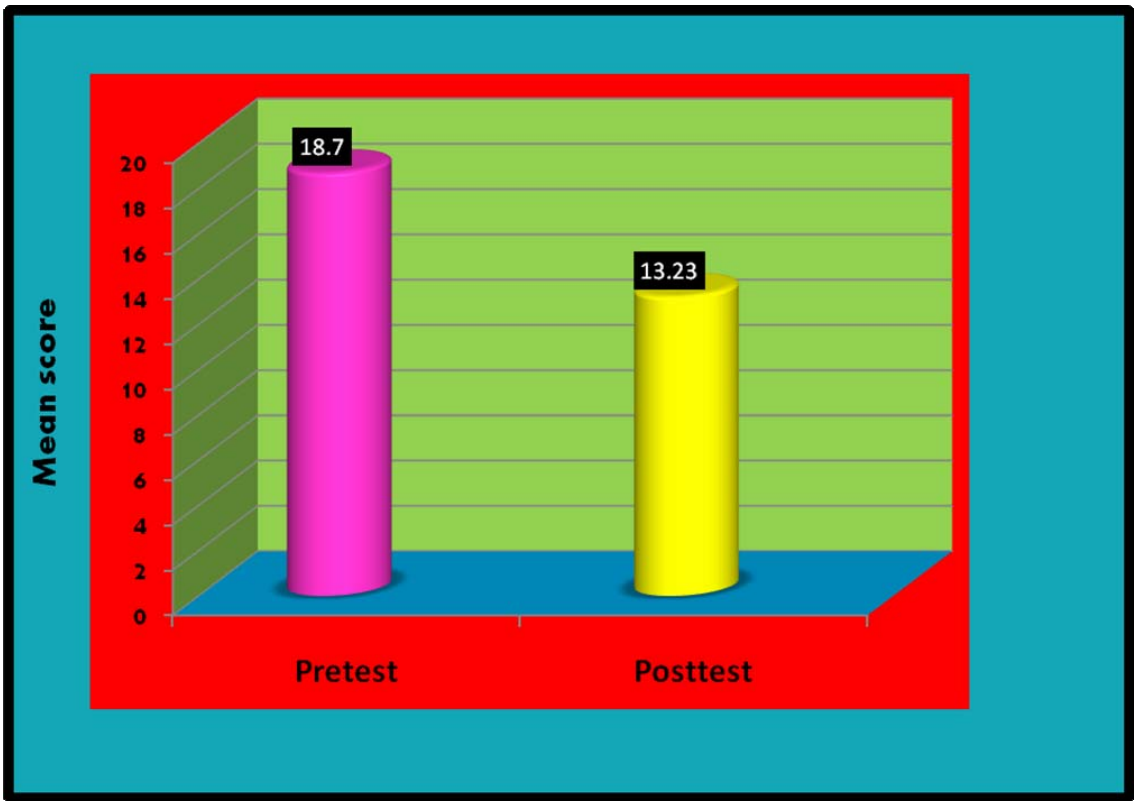


Figure 11 shows significant difference between level of depression before and after reminiscence therapy

TABLE NO-4			
ASSOCIATION BETWEEN EFFECTIVENESS OF REMINISCENCE THERAPY ON DEPRESSION WITH SELECTED DEMOGRAPHIC VARIABLE OF THE ELDERLY PEOPLE n=30			
Particulars	**Mild**	**Moderate**	**Chi Square Value**
AGE			
60-69	11	3	0.9184 P=0.05- significant*
70-79	10	6	
GENDER			
Male	6	4	0.7143 P=0.05- significant*
Female	15	5	
RELIGION			
Hindu	5	3	0.2922 P=0.05- significant*
Christian	16	6	
EDUCATION			
Primary	2	1	2.5397 P=0.05- significant *
Middle	6	3	
High School	2	2	
Higher Secondary	2	0	
Degree	2	0	
Illiterate	7	3	
PRE RETIREMENT EMPLOYMENT STATUS			
Retired	1	1	4.4095 P=0.05- significant*
Private Job	2	0	
Business	2	0	
Cooly	12	4	
Un employed	4	4	
MARTIAL STATUS			
Un Married	5	2	0.479 P=0.05-significant*
Married	4	2	
Divorced	1	0	
Widow / Widower	11	5	
ECONOMIC SUPPORT			
Pension	1	0	17.8571 P=0.05- NS
Old Age Pension	17	3	
Family Support	2	0	
Friends Support	1	0	
No Support	0	6	

PERIOD OF STAY	MILD	MODERATE	CHI SQUARE VALUE
0-5 Yrs	11	4	10.916 P=0.05- NS
5-10 Yrs	4	3	
10-15 Yrs	3	1	
15 Yrs above	3	2	
MODE OF ENTRY			
Self	9	4	12.3052 P=0.05- NS
Family	4	1	
Friend	8	4	

Table- 5 showed demographic variables such as age, gender, religion, education, pre retirement employment status, marital status, have significant association with depression level, and reminiscence therapy. Economic support doesn't have any significant association with level of depression and reminiscence therapy since the calculated value (17.8571) is higher than table value at p= 0.05 interval. Period of stay (10.916) and mode of entry (12.3052) also don't have significant association with level of depression and reminiscence therapy.

TABLE No : 5			
ASSOCIATION BETWEEN THE LEVEL OF DEPRESSION AND REMINISCENCE THERAPY			
Level of Depression with score	**Pre Test**	**Post Test**	**Chi-square**
Mild - 10 - 16	11	21	6.70 (df – 1)** Significant
Moderate - 17- 23	19	9	

**** - Significant at 0.05 level**

The above table elicits that the calculated value (6.70) is greater than the tabulated value at 0.05 levels (3.84). So it is concluded that there is a significant association between the level of depression and reminiscence therapy.

Figure :12 Association between level of depression and reminiscence therapy

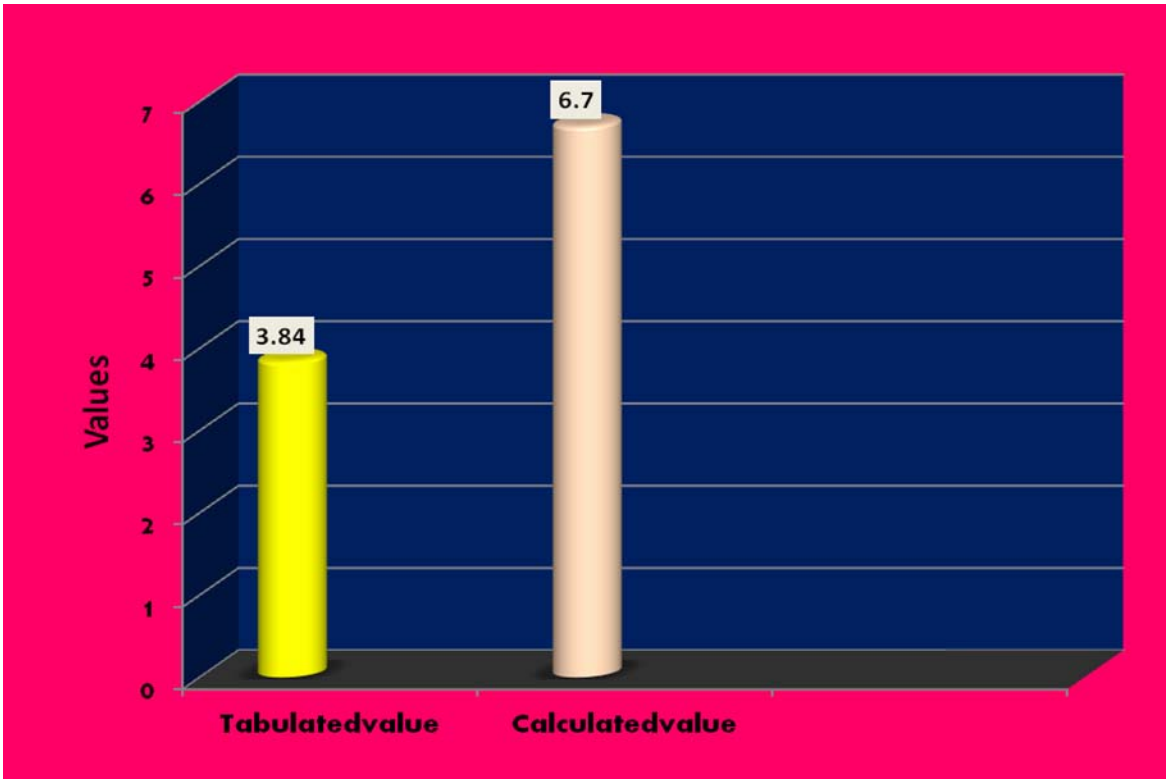


Figure 12 shows significant association between level of depression and reminiscence therapy("t" value 6.70 at p= 0.05 level interval)

CHAPTER V
DISCUSSION

The chapter deals with the detailed discussion on the findings of the study interpreted from the statistical analysis. The aim of this study was to evaluate the effectiveness of reminiscence therapy on depression among the elders residing in a selected old age home at Madurai.

DEMOGRAPHIC VARIABLES OF THE DEPRESSED ELDERLY

Among the depressed elderly more than half of them (53.33%) are on the age group of 70-79 years. 67% of the old aged are of female and 33% of them are male. Majority (73.33%) of the elderly sample belongs to Christian religion. Only 6.6% are graduate 33.33% are illiterate. As for as their pre retirement employment is concerned more than 53.33% of them are cooly and nearly one fourth of them (26.67%) were unemployed. More than half of them (53.33%) are either widow or widower. Majority of (67%) depressed elderly are pensioner and 20% of them have no support. With regard to the period of stay in old age home almost equal (13.33%) numbers of the elders are residing for 10-15 years 15 years & above. Half of them (50%) residence for five years.

The first objective of the study was to assess the level of depression among the elderly residing in selected old age home before and after reminiscence therapy.

The tool used for the study investigated the level of depression of the elders. The total pre test score tabulated and revealed that (63.33%) of the elderly suffered from moderate level of depression. Post reminiscence scores showed reduction in the moderate depression from 63.33% to 30%. The reduction in the level of depression was more significant with certain items used in Geriatric Depression Scale.

These findings are in consistent with the studies conducted by Chao Shu (2006) cully yeon, where reminiscence therapy showed significant reduction in depression scores. It enhanced not only social interaction but also increased self esteem.

The reduction in the level of depression was seen statistically significant with certain questions in GDS. To quote the question on mostly happy life. The standard deviation (SD) value of post test is 4.24 which is greater than pre test SD 2.82.this marked raise in the scores clearly indicated that after reminiscence therapy the elders felt that they are still worth while and could initiate positively with others thus enhancing their self worth.

Similarly for the question clarity of mind is as before. Pre test SD score 9.89 revealed the boardom and inadequacy of the elderly residing in old age home. This drastic increase in post test SD value 12.72 indicated their enhanced social interaction and increased self worth after RT. Similar findings were observed in the study done by chao shu Tsang (2006) where group RT enhanced not only social interaction but also increased the self esteem of the elderly living in old age home.

Majority of the elders (94%) did not feel happy most of the time during their stays before reminiscence therapy. But after reminiscing only 82% felt the same way. This result clearly showed that reminiscence therapy had helped the elders to deal with losses and life transition. Providing sensory stimulation through sound, objects and pictures provided vivid and strong reminiscence. This has helped them to regain interest in past sorrows as well as joyful emotions, thus making them feel happy and satisfied.

The elderly residing at old age home were emotionally injured with their pent –up feelings and locked up talents. These feelings were depicted in were the higher levels of depression before reminiscence therapy. Since reminiscence therapy enhanced the elders to practice self expression and sharing of experience promoted their feeling of belongingness

and togetherness were promoted. These mental statuses have definitely influenced the scaling down in the depressive level.

The second objective of the study was to evaluate the effect of reminiscence therapy on depression of the elders residing in a selected old age home at Madurai.

Reminiscence therapy had greatly influenced the depression levels of the elderly. This was evident by the decreasing scores in the geriatric depression scale (9%). This effectiveness of reminiscence therapy was revealed in the greater sense of hopefulness and lesser sense of emptiness ratings in the post test depression evaluation (table number 3 t value 6.73). The other facts which the researcher believes to have contributed to this effectiveness of reminiscence therapy are elaborated below along with verbatim of the elderly which still reflects the memory of the researcher.

(“When I see these recent photographs of my grand children, I come to realize that I am old now”

“Looking back in to the days when I used to plough the land, how seeds are waiting endlessly for the rains”. “I feel rejuvenated”

“Talking about my past instigates me to retry my dexterity skills in making the craft items which I previously enjoyed doing”.

“This picture of meenakshiamman kovil remains me of those days when I provided ANNATHANAM (Providing food for the needy) in gratitude to the health and wealth rendered by my KULATHEIVAM (God worshipped by one’s family) which had given me enormous peace of mind”.

“During my early adulthood I was working as a bank cashier. I used to be very sincere in my duty and at that time and even now I am un married. Several females had affair with me and they used to appreciate my work as well as my personality.

“Till now he is so smart in his attitude and activities”).

These findings were configured with the following literature:

Cully, Lavoie (2006) who explored the that reminiscence therapy has an significant effect by means of reducing depression among institutionalized, concluded that individual reminiscence therapy contributed not only to the improvement of older adult’s quality of life, but also reduced the depression and enhanced their morale.

Fillip Smit, Erast Buhlmejjer (2004) in their also concluded that reminiscence and life review are effective interventions for depressive symptoms in the elderly showed reminiscence therapy could enhance elder’s social interaction with one another in nursing home settings.

In the study of Wang JJ Cheng Kung (2007) findings revealed RCT has a significant effect of reminiscence therapy as a positive and valuable intervention in reducing depression among elderly residing in long term care settings.

Chao Shu, Tsung et al (2006) conducted a quasi experimental study to find out the effect of group reminiscence therapy on older nursing home resident’s depression. Result showed reminiscence therapy could enhance elder’s social interaction with one another in nursing home settings.

Wang JJ Cheng Kung (2007) conducted a randomized control trial , Results have shown that the intervention has significant effect on cognitive function and affective function.

The author concluded that the reminiscence therapy is a positive and valuable intervention in reducing depression among elderly residing at long term care settings.

Ellen Klausner J, George S. et al (2006) conducted Study and findings revealed RCT has a significant effect of reminiscence therapy in the age group of 65-74, but not in the age over 74 years of depressed elderly.

Wang Jing Jy (2005) in his quasi experimental study the results showed significant reduction of depression score after reminiscence. The author suggested that reminiscence is appropriate intervention for depressed older people residing in long term care facilities.

Herieh, Wang Lin et al (2007) conducted a true experimental study and results revealed that group reminiscence offers a possible intervention for treatment of depression in older women.

The above findings strongly support the present study findings. Reminiscence therapy is proved to be a cost – effective safe non pharmacological treatment for mild and moderate depression among elderly.

The third objective of the study was to associate the effectiveness of reminiscence therapy on depression among the elderly with selected demographic variables.

An analysis on whether the variables in the study exert any influence in the level of depression is stated below.

The age of elderly displayed significant association with their level of depression and reminiscence therapy. Hence it can be referred as that reminiscence therapy not only diminishes the depressive symptoms during post retirement days, but also dispels the depression caused by cognitive and physiological deterioration.

The following study had proven it . Ellen Klausner J, George S. et al (2006) randomized control trial study on institutionalized elderly found significant reduction in depression score after reminiscence therapy and concluded that RCT has a significant effect of reminiscence therapy in the age group of 65- 74, but not in the age over 74 years of depressed elderly.

Inferential statistics further elicited that gender was associated with level of depression of the elderly and women are more benefited by reminiscence than males. This directly reflects that reminiscence therapy emphasizes difference in the individual identity and different experience of each person.

Recent cohort study conducted by Pillemer et al (2008) found the gender difference in reminiscence behavior across the life span and findings showed women had significantly higher scores. This supportive study also revealed that the higher frequency of recounting specific memories by women was due to the fact women placed greater value on reminiscing.

More than half of the elderly who participated in the study were Christian. The religion of the elderly is associated with their level of depression after reminiscence. It implied that reminiscence therapy reinforced the traditional and ritualistic practice of the elderly which could have further helped them to have greater feeling of well being.

Majority of the elderly participated in the present study were said to be cooly, but reminiscence therapy worked wonders among all the elderly. It was concluded that RT had significant effect on depression score according to pre retirement employment status.

In general, majority (33.33%) of the participant were illiterate. This reflects that reminiscence therapy is effective on all educational background because it communicates a universal language, arouses the memory segment of the individual and places the

requirement on sound intellectual capacities and concluded that higher the education higher the benefits of reminiscence on depressed elderly.

Most of the elderly did not live with spouse. It is evident that this group which superimposed the sample size had affected a greater sense of loss of their loved one. In spite of permanent loss, their social interaction and self expression had made reminiscence therapy an effective tool in emptying their loneliness though they were separated from their spouse and concluded that there is association between marital status of the elderly and their post test level of depression.

Most of the old age persons are getting old age pension, results showed that there is no significant association between economic support and depression. It is cent percent sure that they are not in need of money , since they are provided with adequate basic needs (by Help age India). So it was concluded very clearly that economic support has no part to play or not directly associated with depression in elderly.

Period of stay and mode of entry also don't have much of association between the level of depression and reminiscence therapy. One of the risk factor identified is living in a long term care setting. This could be one risk factor why the residents of the present study had experienced depression.

A similar finding was evident in Eisses, A.M., & Kluiter, H. (2004) cross- sectional and longitudinal study on prevalence and incidence of depression in residential homes for the elderly in Drenthe, Netherland, the results showed the prevailing of major depression among elderly staying in residential homes and concluded that depression was increased with age generally and especially among nursing home residents.

SUMMARY

Reminiscence therapy is an effective intervention for depressed elderly. As a complementary process, reminiscence therapy has proven to be an effective intervention for depression among elderly. Reminiscence therapy helps clients work through depression by revisiting past and pleasant times, rediscovering coping skills and finding meaning by reevaluating good and bad aspects of their lives.

CHAPTER VI

SUMMARY& CONCLUSION

This chapter contains the summary of the study and conclusion drawn. It clarifies the limitations of the study and the implications. The recommendations are given for different areas like nursing education, administration and health care delivery system (nursing practice) and nursing research.

6.1 SUMMARY

This study was undertaken to determine the effectiveness of reminiscence therapy on depression among the elders residing in selected old age home at Madurai. The study was conducted at selected old age home for the aged at Madurai. The population of the study was the elders who were residing in the old age home and who met the inclusion criteria. Total enumerative sampling technique was used to select 30 patients who were residing in the old age home. Then convenient sampling was used for selected moderataely and mild depressive elderly. Standardized geriatric depression scale was used for data collection procedure, to assess the level of depression. First the pre test level of depression was assessed and after pre test, reminiscence therapy was administrated individually and in groups.post test level of depression was assessed two weeks after reminiscence therapy. Data were analyzed using descriptive and inferential statistics.

6.2 MAJOR FINDINGS OF THE STUDY

- Among the depressed elderly more than half of them (53.33%) are on the age group of 70-79 years.
- 67% of the old aged are of female and 33% of them are male.
- Majority (73.33%) of the elderly sample belongs to Christian religion.

- Only 6.6% are graduate 33.33% are illiterate.
- As for as pre retirement employment concern more than 53.33% of them are cooly and nearly ¼ of them (26.67%) of them unemployed.
- More than half of them 53.33% are either widow or widower.
- Majority of 67% depressed elderly are pensioner and 20% of them have no support.
- Almost equal number of the elders stayed for 10-15 years or 25 years & above. Half of them stayed for five years.
- Most of the elderly 19 (63.33%) were assessed to have moderate level of depression (17-23) in the pre test which is reduced to 9 (30%) in the post test. Ultimately Mild level of depressed elderly in the pre test 11 (36.67%) was found increased 21 (70%) In the post test. This revealed that reminiscence therapy has great impact in post test depressive scores.
- Demographic variables such as age, gender, religion, education, pre retirement employment status, marital status, have significant association with depression level, and reminiscence therapy. Economic support, period of stay and mode of entry don't have any significant association with level of depression and reminiscence therapy since the calculated value is higher than table value at p= 0.05 interval.
- The mean post test depressive score is lower than the mean pre test depressive scores. "t" value (6.73) is two degree significant at p=0.05 level. Report revealed that reminiscence therapy has significant effect on reduction of depression score of the elderly in both mild and moderate level in post test.

6.3 CONCLUSION

These findings of the study have been discussed in terms of the objectives, theoretical base and hypotheses. The following conclusions were drawn from the study findings:

1. Most of the people residing in the old age home suffered from either

   Mild are moderate depression.

2. Reminiscence therapy was effective in reducing level of depression among the elders in the old age homes.
3. Since there was some association between the level of depression and selective demographic variables except economic support, period of stay and mode of entry, it indicates that reminiscence therapy can be administered to all the groups of elderly in reducing the level of depression.

APPLICATIONS

Reminiscence therapy is an effective therapy for depressed elderly resing at old age homes, Lavoie (2006), Ellen Klausner J, George S. et al (2006). Reminiscence therapy helps clients work through depression by revisiting past and pleasant times, rediscovering coping skills and finding meaning by re-evaluating good and bad aspects of their lives. These psychological treatments are safe effective alternatives to drug therapy for mild to moderate depression. Psychological treatments are of particular importance for people who are unable to or uninterested in taking medications.

6.4 IMPLICATION OF THE STUDY

IMPLICATIONS FOR NURSING PRACTICE

1. The study findings revealed the importance of nurses' role in reducing depression among elderly using a cost- effective, safe, non pharmacological treatment that is reminiscence therapy.
2. Study findings signify the importance of formulation of guidelines and implementation of reminiscence therapy especially in old age homes where literature reveals lack of psycho therapeutic intervention.
3. Nurses specializing in geriatrics need to be empowered in administering reminiscence therapy.
4. In clinical areas there must be provision for administering reminiscence therapy

IMPLICATIONS FOR NURSING EDUCATION

1. Current concepts and trends in geriatric care should be included in nursing curriculum
2. Post – graduate nursing students specializing in psychiatry should be trained in administering reminiscence therapy
3. Nursing personnel working in geriatric ward and old age homes should be given in service education regarding reminiscence therapy.
4. All nursing personnel should be motivated to administer reminiscence at all community dwellings

IMPLICATIONS FOR NURSING RESEARCH

The findings of the present study have added knowledge to the already existing literature and the implications for the nursing research are given in the form of recommendation. This study can be baseline for future studies to build upon and motivate other investigators to conduct further studies

IMPLICATIONS FOR NURSING ADMINISTRATION

1. The nursing administrators especially of nursing homes and geriatric wards can organize continuing nursing education on depression and reminiscence therapy.
2. The administrators can encourage the nurses to use different safe, cost effective, psycho therapeutic intervention in reducing depression among elderly
3. A considerable amount in the budget can be allocated for organizing the continuing education program and in preparing and maintaining reminiscence kits.
4. Staff nurses can be trained specially to administer reminiscence therapy.

6.5 RECOMMENDATIONS

- Nurses can be appointed as regular counselor to conduct reminiscence sessions in community settings and residential homes
- Supportive interventions such as relaxation technique, yoga, meditation can be taught by the nurses to the elderly
- Nurses should make arrangements to involve all the inmates in attending social activities and special functions
- Positive reinforcement, rewards, encouragement in doing minor activities as much as possible to be enforced.

6.6 SUGGESTIONS FOR FUTURE RESEARCH

On the basis of the present study the following suggestions have been made for the further study.

1. A longitudinal study can be undertaken to see the long term effect of reminiscence therapy in reducing the level of depression
2. The same study can be conducted by using the control group to see the effectiveness of reminiscence therapy.
3. It can be conducted with large sample to generalize the findings

4. A comparative study can be conducted among individual reminiscence therapy and group reminiscence therapy
5. A similar kind of study can be conducted to assess the effect of reminiscence therapy on dementia, self esteem, family coping and life satisfaction
6. A qualitative approach can be tried in studying the effects of reminiscence therapy on depression
7. A similar kind of study can be undertaken to evaluate the effect of creative reminiscence therapy on depression among elders.

6.7 LIMITATIONS OF THE STUDY

1. The study was conducted among the elders from a selected old age home at Madurai city only. So generalization must be done with caution
2. This study was done on a small sample size of 30, hence generalization is possible only for the selected participants
3. This study was limited to mild and moderately depressed elderly. Hence generalization is possible only for the selected elderly.

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APPENDICES

APPENDIX-I

Copy of letter seeking permission to conduct the study at Inba Illam, Madurai

From

Principal

College of nursing

Madurai medical college

Madurai

Ref : CON/MMMC/ Madurai 2010 Date :

TO

The principal

TTS Group of Institutions

Arasaradi

Madurai – 16

Respected sir,

Sub: College of Nursing, Madurai Medical College , Madurai- dissertation work of M.SC (N) student permission regarding

I would like to introduce Mrs. P.Selvarani, one of the final year M.SC (Nursing) student has to conduct a research project, which is to be submitted to the Tamilnadu Dr. M.G.R. Medical university, Chennai in partial fulfillment of university requirement.

The topic of research is " a study to evaluate the effectiveness of reminiscence therapy on depression among elderly residing in selected old age home at Madurai".

We request you to kindly permit her to do the research work in your old age home under your valuable guidance and suggestion.

Thanking you

Yours faithfully

For CON, MMC, Madurai-20

APPENDIX II

PROTOCOL FOR ONE TO ONE REMINISCENCE

A. PROTOCOL

1. Determine whether reminiscence is appropriate intervention for the individual. Check available information about the individual. Determine the length of the session.
2. Gather available information prior to interview to assist in formulating strategies to implement reminiscence.
3. Based on above, determine how reminiscence is to be introduced in to the interview.
4. Select a quiet, well light, warm room with comfortable, straight- backed chair with arms for client. When possible, interview older person in own room in institution or in the room they select so that the person may lip read, if necessary.
5. Place yourself about 3-4 feet from the person. If the person has hearing or vision problem, sit 6-12 inches from him.
6. Introduce yourself: state that you are a nurse, request the name the person wishes to be called.
7. Plan interview ahead so interruptions do not occur.
8. Explain reasons for interview. Assess quickly for anxiety, confusion, and ability to focus, vision, hearing and comprehension to judge how much reminiscence to elicit. Use language at a level that is appropriate for the individual.
    a. Anxiety is often manifested by hand- wringing, avoiding eye contact, smoking, tapping fingers, swinging feet, talking rapidly, wanting to leave, eyes glued to TV set etc.
    b. For confusion, use mental status questionnaire. Inability to focus is manifested by rambling and an inability to complete the memory/thought.
    c. Vision: move in until the person can see you.
    d. Hearing: check for hearing aid and if batteries are in place.
    e. Obtain educational level of client
9. Explain briefly the format to be used to emphasize that interview is not a social visit.
    a. Decide on type of format to implement- structured/ guided reminiscence
    b. Change format if not successful in producing memories.
10. State the time allotted for the interaction
11. List nursing diagnoses to assist in gauging amount and depth of reminiscence.
12. Begin by saying “tell me about…….” Instead of direct questions.

PRIMERS MIGHT INCLUDE

1. Help me better understand the illness you mentioned having.
2. How did your childhood health affect you in later years?
3. Tell me about your work, occupation, job, retirement, volunteering.
4. What was really important to you as you look back?
5. Tell me about (examples)
    a. Your major illnesses/ accidents
    b. Growing up in the depression
    c. Being in the service
    d. Being alone during the war years
    e. Being widowed so young
    f. Losses(children, pets, homes, jobs loved ones etc) those are important for health history.
    g. Probe only for information needed to complete reminiscence session or health history.
    h. Refocus on those areas in which data are most needed for tentative nursing care plans.
13. Incorporate knowledge about simple reminiscence.
    a. Allow enough time for client to answer your queries.
    b. Rephrase if client does not understand your question or request
    c. If repetition occurs, redirect by asking client to add something else to the memories which have been presented
    d. Try not to rush the client
14. Closure
    a. A few minutes before the time is up indicate closure to refocus the individual to present time and place
    b. Briefly summarize the interview
    c. Think client for sharing
    d. Give time to consider information they have forgotten. Allow him or her to ask questions of you
15. Special problems and techniques to consider
    a. Problem: excessive perpetuation of past. 1. Ask him if he/she are treating the past as though it were the present. 2. Listen for constant themes of guilt, anger, grief; he may be endeavoring to resolve these.(life review sessions which would help the person

work on such feelings may be indicated in addition to the reminiscence interview. 3. Gently state the risk of the person alienating self from current situation and other because of repetitive accounts. Constant repetition may turn of listeners, especially family members.

b. Problem : excessive replaying. 1. Discourage excessive repetition. E.g, " yes, you told us that", 2.change slant, e.g, " what else do you remember about the incident? 3. Refocus e.g," and what did your siblings do then? 4. Respect the 'time . scene" selected, especially if its is new to you. assess for individual's contact with present reality. 6. Give feedback honestly and gently- not out of sense of irritation of boredom.

c. Problem: lack of validation: 1. Encourage scanning of past to reveal examples of a. competence b. having been loved 2.reminiscened individual of past accomplishments.3. discuss early loves: boyfriends, girlfriends, childhood crushes, and teenage romances. 4. Do not be little or treat lightly any memory shared, even though the significance may be unclear to the interviewer. 5. Remember previous statements made, and restate them to further validate his belief about self. 6. Do not encourage statements about weaknesses or failures, but accept them when offered. 7. Validate strengths often.

APPENDIX III

PROTOCOL FOR GROUP REMINISCENCE

TECHNIQUES

1. Contracts- verbal and written
2. Name tags for members and leader
3. Refreshment
4. Special tasks necessary to complete for agency or research
5. Member selection
6. Other modalities to be combined with reminiscence, 1. Sensory stimulation 2. Music 3. Poetry 4. Art assignment 5. Exercise 6. Scirbotherapy(writing exercise
7. Bibliotherapy (reading aloud)
8. Visual and audio aid

A. Determine whether reminiscence is most appropriate group modality.(for example there are reality orientation, remotivation, and validation, music, video film, current event groups, etc]

B. List group goals to validate with group members.

C. Obtain permission of administration to conduct group and present written goals and objective

D. Asses potential group members and leader before launching the group

E. List desired outcomes

F. List special strategies common to reminiscence groups

   a. Themes and alternate themes. 1. A theme is a topic selected for a meeting. 2. The choosen themes may not be successful; therefore the leader should have other themes ready. 3. Time lines are useful for theme selection

   b. Determine if props will be used according to type of group and the composition of members. 1. Props are artifacts, pictures, objects introduced in the group to trigger memories. 2. Props must be appropriate for the group; they need to be gender specific, cohort specific, culturally and geographically appropriate. 3. There should be a mutual fit between themes and props. 4. If props are used, introduce only one at a time, especially if group members have dementia. 5. Permit group members to hold the prop. Observe nonverbal and

verbal responses. 6. For sensory deprived individuals, select props which might be appropriate for more than one sense: for example, an orange can be looked at, touched, smelled and eaten.

c. Determine how to intervene when negative or painful memories are discussed.
d. Size of the group- 6 to 10 members
e. Length of the group meetings- ½ to ¾ hour, ongoing, may be twice weekly
f. Room for meeting
g. Visit members for 5 to 10 minutes prior to each group session
h. First meeting format
    a. Introduce yourself
    b. Explain purpose of group
    c. As leader, offer unconditional positive regard for each member.
    d. Do not come across as a controlling leader
    e. State the ground rules: 1. Confidentiality members need no share sensitive areas 2. Only one person speaks at a time 3. Expects to share about self, to initiate the interactions 4. Tell that they do not have to share anything they are not comfortable sharing 5. State the date the group will finish
    f. Emphasize attendance

G. Suggested format for meetings
    a. One hour is usual length
    b. Use open ended questions
    c. Summarize previous meetings and name acknowledgement by member's contributions
    d. Note any absences
    e. Select a theme for reminiscence
    f. If group needs help getting started, leader shares a memory
    g. Triggers are important
    h. Refreshments can be served before or after the meeting according to the client's need
    i. Shake hands with each member for attending
    j. Record highlights of the meeting in a log for future reference

DEMOGRAPHIC VARIABLES

Age

1. 60-69 Yrs. ❑
2. 70-79 Yrs. ❑
3. 80 and Above ❑

Gender

1. Male ❑
2. Female ❑

Religion

1. Hindu ❑
2. Christian ❑
3. Muslim ❑

Education

1. Primary ❑
2. Middle ❑
3. High School ❑
4. Higher Secondary ❑
5. Degree ❑
6. Illiterate ❑

Pre Retirement Employment Status

1. Retired ❑
2. Private Job ❑
3. Business ❑
4. Cooly ❑
5. Un employed ❑

Marital Status

1.Un Married ❑
2.Married ❑
3.Divorced ❑
4.Widow / Widower ❑

Economic Status

1. Pension ❑
2. Old Age Pension ❑
3. Family Support ❑
4. Friends Support ❑
5. No Support ❑

Period of Stay

1. 0-5 Yrs ❑
2. 5-10 Yrs ❑
3. 10-15 Yrs ❑

4. 15 Yrs above ❑

Mode of Entry

1. Self ❑
2. Family ❑
3. Friend ❑

APPENDIX IV –A -GERIATRIC DEPRESSION SCALE (GDS) ENGLISH VERSION

APPENDIX IV –B -GERIATRIC DEPRESSION SCALE (GDS)
TAMIL VERSION

S.NO	QUESTIONS	YES	NO
1.	Are you basically satisfied with your life?		
2.	Have you dropped many of your activities and interests?		
3.	Do you feel that your life is empty?		
4.	Do you often get bored?		
5.	Are you hopeful about the future?		
6.	Are you bothered by thoughts you can't get out of your head?		
7.	Are you in good spirits most of the time?		
8.	Are you afraid that something bad is going to happen to you?		
9.	Do you feel happy most of the time?		
10.	Do you often feel helpless?		
11.	Do you often get restless and fidgety?		
12.	Do you prefer to stay at home rather than go out and do things?		
13.	Do you frequently worry about the future?		
14.	Do you feel you have more problems with memory than most?		
15.	Do you think it is wonderful to be alive now?		
16.	Do you feel downhearted and blue?		
17.	Do you pretty worthless the way you are now?		
18.	Do you worry a lot about the past?		
19.	Do you find life very exciting?		
20.	Is it hard for you to get started on new projects?		
21.	Do you feel of energy?		
22.	Do you feel that your situation is hopeless?		
23.	Do you think that most people are better off than you are?		
24.	Do you frequently get upset over little things?		
25.	Do you frequently feel like crying?		
26.	Do you have trouble concentrating?		
27.	Do you enjoy getting up in the morning?		
28.	Do you prefer to avoid social occasions?		
29.	Is it easy for you to make decisions?		
30.	Is your mind as clear as it used to be?		

KjpNahh; kdr;Nrhh;T msTNfhy;

t.vz;	nghUslf;fk;	Mk;	,y;iy
1.	cq;fs; tho;f;if cq;fSf;F jpUg;jpahf cs;sjh?		
2.	cq;fSila gy nray;fisAk;> Mh;tq;fisAk; tpl;Ltpl;Bh;fsh?		
3.	cq;fSila tho;f;if ntWikahdJ vd;W czh;fpwPh;fsh ?		
4.	cq;fSf;F mbf;fb tho;f;if mYj;Jtpl;ljh ?		
5.	cq;fSila vjph;fhyj;ij gw;wpa ek;gpf;if ,Uf;fpwjh?		
6.	cq;fSila epidit tpl;L mfyhj tp\aq;fisg;gw;wp epidj;Jf; nfhz;NlapUg;gPh;fsh?		
7.	jhq;fs; mjpf Neuq;fspy; ey;y epiyapy; ,Ug;gPh;fsh ?		
8.	VNjDk; nfLjy; elf;fg;NghfpwJ vd;W gag;gLtPh;fsh ?		
9.	mjpf Neuq;fspy; kfpo;r;rpahf ,Ug;gPh;fsh ?		
10.	ePq;fs; mbf;fb cjtp fpilf;fhjJ Nghy; czh;fpwPh;fsh ?		
11.	ePq;fs; mbf;fb mikjpapy;yhky; mq;Fkpq;Fk; miyfpwPh;fsh?		
12.	ngUk;ghd;ik Neuk; ntspapy; nrd;W Ntiy nra;tij tpl tPl;bypUf;f tpUk;GfpwPh;fsh ?		
t.vz;	**nghUslf;fk;**	**Mk;**	**,y;iy**

13.	vjph;fhyj;ijg;gw;wp mbf;fb ftiyg;gLfpwPh;fsh ?		
14.	kw;witfis tpl Qhgf rf;jpahy; gytpjkhd gpur;ridfs; cUthfpwJ vd;W czh;fpwP;hfsh ?		
15.	ePq;fs; ,g;nghOJ capUld; ,Ug;gJ Mr;rhpakhd tprak; vd;W vz;ZfpwPh;fsh?		
16.	cq;fSf;F kdr;Nrhh;T ,Ug;gjhf czh;fpwPh;fsh?		
17.	ePq;fs; ,g;nghOJ cgNahfkw;W ,Ug;gijg; Nghy; czh;fpwPh;fsh?		
18.	fle;j fhyj;ijg;gw;wp mjpfkhff; ftiyg;gLfpwPh;fsh?		
19.	ePq;fs; tho;f;ifia fpsh;r;rpA+l;Ltjhf czh;fpwPh;fsh ?		
20.	Gjpa jpl;lq;fis Muk;gpg;gj fbdkhf ,Uf;fpwjh?		
21.	ePq;fs; KOrf;jpAld; nray;gLtjhf czh;fpwPh;fsh?		
22.	cq;fs; epiy ek;gpf;ifaw;W ,Ug;gjhf czh;fpwPh;fsh?		
23.	ePq;fs; ,g;nghOJ ,Ug;gijtpl kw;wth;fs; vy;yhk; ey;y epiyapy; ,Ug;gjhf epidf;fpwPh;fsh?		
24.	ePq;fs; mbf;fb rpd;d rpd;d tpraq;fSf;fhf epiy jLkhWfpwPh;fsh?		

t.vz;	nghUslf;fk;	Mk;	,y;iy
25.	mbf;fb mOf Ntz;Lk; Nghy; Njhd;Wfpwjh?		
26.	kdij xUikg;gLj;JtJ rpukkhf cs;sjh?		
27.	fhiyapy; kfpo;r;rpahf vOe;jpUf;fpwPh;fsh?		
28.	ePq;fs; r%f epfo;r;rpfisj; jtph;f;f tpUk;GfpwPh;fsh?		
29.	cq;fSf;Fj; jPh;khdq;fs; vLg;gJ vspjhf ,Uf;fpwjh?		
30.	cq;fs; kdk; Kd;G Nghy; njspthf ,Ug;gjhf epidf;fpwPh;fsh?		

xg;Gjy; mwpf;if

vdf;F ,e;j Ma;itg;gw;wpa KO tptuk; tpsf;fkhf vLj;Jiuf;fg;gl;lJ. ,e;j Ma;tpy; gq;FngWtjpy; cs;s ed;ifs; kw;Wk; jPikfs; gw;wp ehd; Ghpe;J nfhz;Nld;. ehd; ,e;j Ma;tpy; jhdhfNt Kd;te;J gq;F ngWfpNwd;. NkYk; vdf:F ,e;j Ma;tpy; ,Ue;j ve;j NeuKk; tpyfpf;nfhs;s KO mDkjp toq;fg;gl;Ls;sJ. vd;Dila rpfpr;ir Mtzq;fisg; ghh;tiapl;L mjpy; cs;s tptuq;fis Ma;tpy; gad;gLj;jpf; nfhs;s mDkjp mspf;fpd;Nwd;. vd;Dila ngah; kw;Wk; milahsq;fs; ufrpakhf itj;Jf; nfhs;sg;gLk; vd;Wk; vdf;F cWjpaspf;fg;gl;Ls;sJ.

,g;gbf;F>

APPENDIX V

SCORING KEY TO GERIATRIC DEPRESSION SCALE (GDS)

S.NO	QUESTIONS	YES	NO
1	Are you basically satisfied with your life?		(1)
2	Have you dropped many of your activities and interests?	(1)	
3	Do you feel that your life is empty?	(1)	
4	Do you often get bored?	(1)	
5	Are you hopeful about the future?		(1)
6	Are you bothered by thoughts you can't get out of your head?	(1)	
7	Are you in good spirits most of the time?		(1)
8	Are you afraid that something bad is going to happen to you?	(1)	
9	Do you feel happy most of the time?		(1)
10	Do you often feel helpless?	(1)	
11	Do you often get restless and fidgety?	(1)	
12	Do you prefer to stay at home rather than go out and do things?	(1)	
13	Do you frequently worry about the future?	(1)	
14	Do you feel you have more problems with memory than most?	(1)	
15	Do you think it is wonderful to be alive now?		(1)
16	Do you feel downhearted and blue?	(1)	
17	Do you pretty worthless the way you are now?	(1)	
18	Do you worry a lot about the past?	(1)	
19	Do you find life very exciting?		(1)
20	Is it hard for you to get started on new projects?	(1)	
21	Do you feel of energy?		(1)
22	Do you feel that your situation is hopeless?	(1)	
23	Do you think that most people are better off than you are?	(1)	
24	Do you frequently get upset over little things?	(1)	
25	Do you frequently feel like crying?	(1)	
26	Do you have trouble concentrating?	(1)	
27	Do you enjoy getting up in the morning?		(1)
28	Do you prefer to avoid social occasions?	(1)	
29	Is it easy for you to make decisions?		(1)
30	Is your mind as clear as it used to be?		(1)

SCORING PROCEDURE

Each item of GDS is answered “yes” or “No”. There are 20 items which indicate when answered yes, and 10 items which indicate depression when answered no. A total score is provided which consists of one point from each depressive answer. Non depressive answers are scored as zero and do not add to total score.

Normal	: 0 – 9
Mild depression	: 10 – 16
Moderate depression	: 17 – 23
Severe depression	: 24 - 30

APPENDIX VI

CONTENT VALIDITY CERTIFICATE

TO WHOM SOEVER IT MAY CONCERN

This is to certify that the tool developed for data collection by **P.SELVARANI** on thesis entitled "*A study to assess the effectiveness of reminiscence therapy in terms of reducing depression among elderly residing in a selected old age home at Madurai*" is relevant valid and fulfill the study objectives.

Date 27/10/10

Signature

[V. JESINDA VEDANAYAGI]

Seal

SACRED HEART NURSING COLLEGE
THASILDAR NAGAR
MADURAI-20.
4/285, COLLEGE ROAD

CONENT VALIDITY CERTIFICATE

TO WHOMSOEVER IT MAY CONCERN

This is to certify that the tool developed for data collection by P. SELVARANI on thesis entitled " A study to assess the effectiveness of reminiscence therapy in terms of reducing depression among elderly residing in a selected old age home at Madurai" is relevant valid and fulfill the study objectives.

Date 22.11.10

Signature

Ms. Baby R
Reader in Nursing
College of Nursing
MTPG & RI UB

Seal

CONENT VALIDITY CERTIFICATE

TO WHOMSOEVER IT MAY CONCERN

This is to certify that the tool developed for data collection by P. SELVARANI on thesis entitled " A study to assess the effectiveness of reminiscence therapy in terms of reducing depression among elderly residing in a selected old age home at Madurai" is relevant valid and fulfill the study objectives.

Date 10/11/10

P. Jamunari
Signature 10/11/10
Lecturer,
KMCH College of Nursing.
Coimbatore.

Seal

CONTENT VALIDITY CERTIFICATE

TO WHOM SOEVER IT MAY CONCERN

This is to certify that the tool developed for data collection by **P.SELVARANI** on thesis entitled "*A study to assess the effectiveness of reminiscence therapy in terms of reducing depression among elderly residing in a selected old age home at Madurai*" is relevant valid and fulfill the study objectives.

Date

Signature

20/10/10

Seal

Dr. G.P. [illegible]
HOD & Prof. of Psychiatry
Dept. of Psychiatry
Govt. Rajaji Hospital &
Madurai Medical College
Madurai.

CONTENT VALIDITY CERTIFICATE

TO WHOM SOEVER IT MAY CONCERN

This is to certify that the tool developed for data collection by **P.SELVARANI** on thesis entitled "*A study to assess the effectiveness of reminiscence therapy in terms of reducing depression among elderly residing in a selected old age home at Madurai*" is relevant valid and fulfill the study objectives.

Date 22-10-2010

Signature

Dr. M. KARTHIKEYAN, M.D., (Psy.)
REG. 81348
ASSISTANT PROFESSOR OF PSYCHIATRY
MADURAI MEDICAL COLLEGE &
GOVT. RAJAJI HOSPITAL,
MADURAI.

Seal

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Date 21/10/2010.

N. Suresh Kumar 21/10/2010.

Signature

N. SURESH KUMAR.
M.A., M.Phil.(Clin.Psy)
Asst. Prof, Cum Clinical Psychologist
Dept. of Psychiatry
Govt. Rajaji Hospital, Madurai-2

Seal

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Name R. JANCY RACHEL DAISY

Signature R. Daisy

Seal Reader - Psychiatric Nursing
C.S.I Jeyaraj Annapackiam College of Nursing
Pasumalai, Madurai

Date 12/10/2010

RESIDENTS OF INBAILLAM

INVESTIGATOR CONDUCTING GROUP REMINISCENCE THERAPY

INVESTIGATOR CONDUCTING GROUP REMINISCENCE THERAPY

INVESTIGATOR CONDUCTING INDIVIDUAL REMINISCENCE THERAPY

INVESTIGATOR CONDUCTING INDIVIDUAL REMINISCENCE THERAPY

APPENDIX VII

REMINISCENCE KITS USED IN THE STUDY

AUDIO- OLD CINE SONGS

1. **vj;jid fhyk;jhd; Vkhw;Wthh; ,e;j ehl;bNy?**
2. **Mapuk; iffs; kiwj;J epd;whYk; Mjtd; kiwtjpy;iy**
3. **rl;b Rl;ljlh iftpl;ljlh**
4. **ekJ ntw;wpia ehis rhpj;jpuk; nrhy;Yk;> ,g;gb Njhw;fpd; vg;gb nty;Yk;?**
5. **cyfk; gpwe;jJ vdf;fhf? XLk; ejpfSk; vdf;fhf**
6. **ciof;Fk; iffNs! cUthf;Fk; iffNs!**
7. **,jatPiz Jhq;Fk;NghJ ghl KbAkh?**
8. **fiuNky; gpwf;f itj;jhd;? vq;fis fz;zPhpy; kpjf;f itj;jhd;?**
9. **gilj;jhNd! kdpjid Mz;ltd; gilj;jhNd?**
10. **kyh;e;Jk; kyuhj ghjp kyh; Nghy tsUk; tpoptz;zNk!**

VIDEO – OLD MOVIES

1. **cyfk; Rw;Wk; thypgd;**
2. **glNfhl;b**
3. **Mz;ltd; fl;lis**
4. **ghr kyh;**
5. **ghfg;gphptpid**
6. **gpy;yh**
7. **ghl;rh**
8. **ve;jpud;**
9. **kJiuia kPl;l Re;jughz;bad;**
10. **Mapuj;jpy; xUtd;**

APPENDIX VII

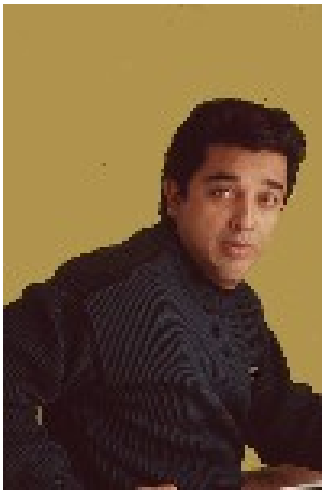
REMINISCENCE KIT

FAMILY PHOTO OF THE ELDERLY INMATE

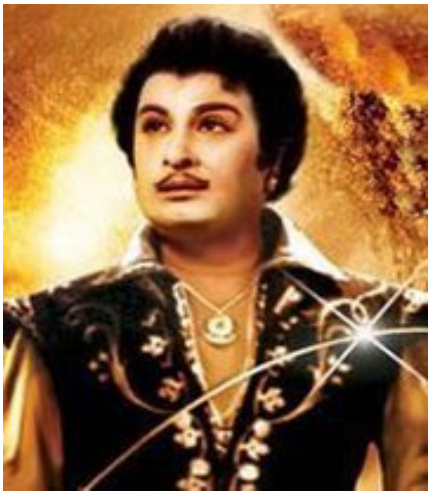
VISUAL SHOW

INDIVIDUAL SESSION- PICTURES OF HEROS & HEROINS

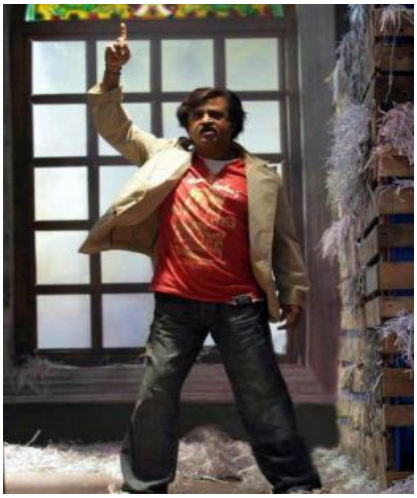
NADIGAR THILAGAM SIVAJI GANESAN



KAMALA HASAN



M.G. RAMACHANDRAN



RAJINI GANTH

VIJAI

SAROJA DEVI

PADMINI

K.R.VIJAYA

GROUP SESSION

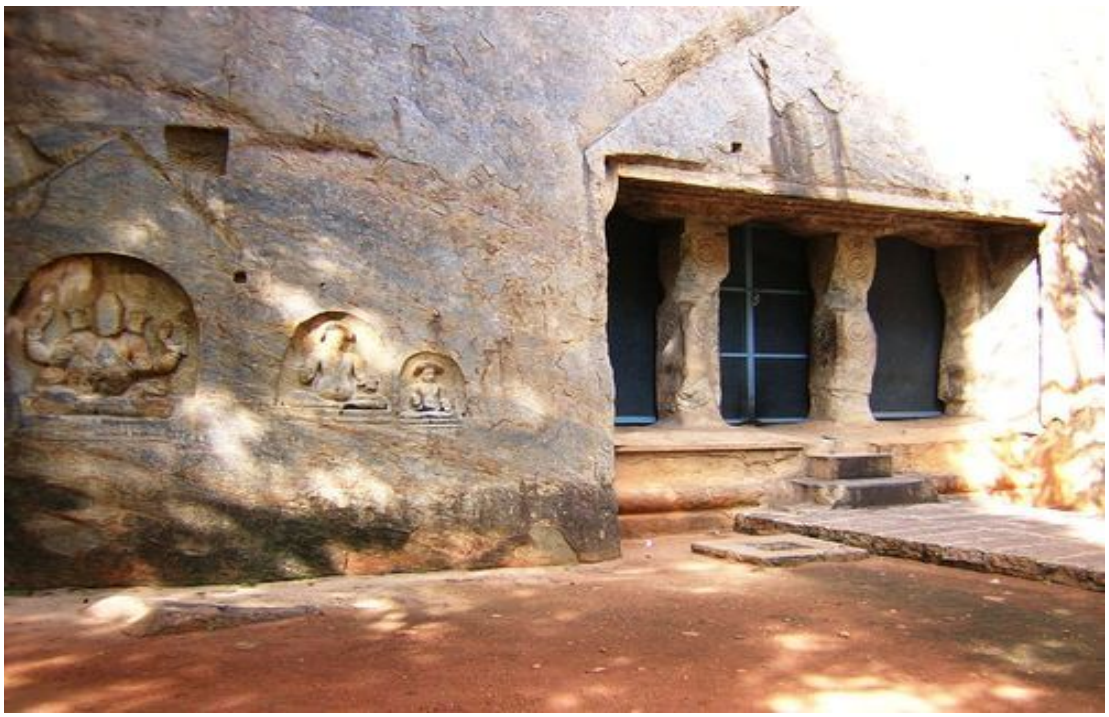
VISUAL SHOW

FAMOUS PLACES IN MADURAI

MEENAKSHI AMMAN TEMPLE

THIRUMALAI NAYAKAR MAHAL

MADURAI VANDIYUR TEPPAKULAM

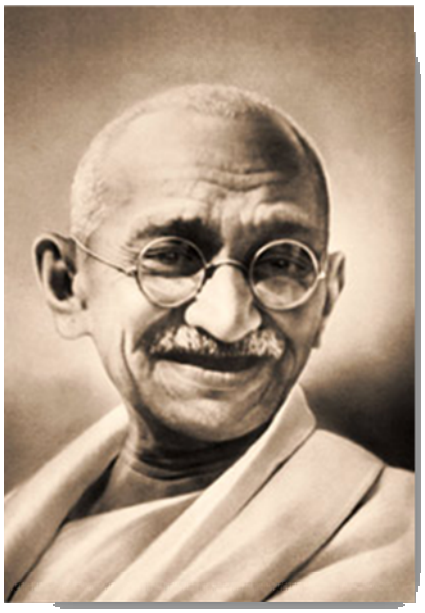


THENPARANGKUNDRAM

THIRUPPARANKUNDRAM

GROUP SESSION
VISUAL –SHOW

NATIONAL LEADERS

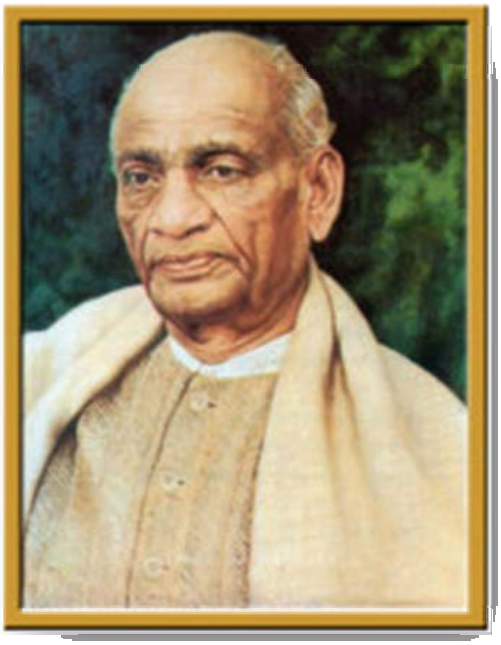


MAHATMA GANDHI

PANDIT JAWAHARLAL NEHRU

SHRIMATHI.INDIRA GANDHI

NETHAJI SUBASH CHANDRA BOSE



SHRI.SARDAR VALLABHAI PATEL