



EFFICACY OF REMINISCENCE THERAPY IN AUGMENTING PSYCHOLOGICAL WELLBEING IN ALLEVIATION OF DEPRESSION SYMPTOMS AMONG ELDERLY IN SELECTED ELDERLY CARE HOMES IN HYDERABAD, TELANGANA

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ABSTRACT

In low- and middle-income nations, the elderly population is growing in number. Elderly people face mental illnesses in addition to systemic diseases. Effect of group reminiscence therapy in reducing some of the mental health aspects showing a promising effect but the evidence is lacking in Indian settings. The purpose of this study was to ascertain whether or not reminiscence therapy reduced feelings of isolation, depression, and anxiety in institutionally housed elderly people. Methods: Loneliness, depressive symptoms, and anxiety were assessed in this quasi-experimental study using the revised UCLA geriatric depression scale and Geriatric Anxiety Scale, respectively. They received group reminiscence therapy, and the same scales were used for the post-intervention assessment. Results: Significant reduction of anxiety score [1.33 (0.03, 2.64)] was noticed in anxiety. The mean score for depressive symptoms decreased by 0.59 (-0.41, 1.6) but was not statistically significant. In the post-intervention assessment, all three outcomes improved from a higher severity grade to a lower severity grade. The intervention improved depressive symptoms by 66.7 percent, anxiety by 33.3%, and loneliness by 30.8%. Conclusions: The study found reminiscence therapy could be encouraging in resource-poor Indian settings. We recommend for further exploration of the long-term effects of this program, its feasibility, cost-effectiveness, and validation of the content for large-scale implementation.

Keywords: Reminiscence therapy, Elderly, Loneliness, Depressive symptoms, Anxiety.

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Dr. Balasubramanian N. has considerable experience in mentoring doctoral scholars and has actively attended and organized workshops, seminars, and conferences at both national and international levels. His research interests span nursing and allied health sciences, with a strong focus on fostering evidence-based practices and guiding emerging researchers.



INTRODUCTION

Although this proportion is much higher in the high-income report "Elderly in India- Profile and Programmes 2016" by the Government of India, a little more than 100 million elderly people aged 60 years or older were present during the 2011 census, contributing 8.6% of the total population. Life expectancy has increased significantly across the globe over the past few decades. Over the past fifty years, the proportion has increased by one and a half times. The likelihood of experiencing age-related health issues increases with age. In addition to systemic diseases, many older people suffer from mental illnesses like loneliness, depression, and anxiety. The rise in the number and proportion of older adults in the country, shifts in family structure, and contemporary shifts in the psychosocial matrix and values are forcing the elderly to live alone or in nursing homes, which causes them to feel isolated, lonely, anxious, and depressed. As people get older, it is inevitable that they will lose connection with their friendship networks and that it will be harder for them to start new friendships and join new Loneliness, anxiety, and depression are closely associated with each other. Although it is difficult to assess the prevalence separately, the high burden of these mental conditions has been reported around the world. The global prevalence rate of depressive disorders among the elderly population was found in a meta-analysis between 4.7 to 16% with a comparatively higher prevalence of 21.9% in India. Prevalence of late-life anxiety disorders are quite high and can be two to eight times higher than major psychiatric illness like dementia or major depressive disorders. The condition is frequently associated with mental health conditions like depression and can serve as a precursor to a variety of psychological morbidities. On the other hand, despite the fact that loneliness is not measured as a single entity, it is reported to have a high burden among the elderly population across the globe. Nevertheless, in countries like India, where both human resources and infrastructural facilities are lacking to address such a huge burden comparatively low-cost alternative management options are needed. Reminiscence therapy has been proposed as a potentially effective strategy to improve quality of life and psychological well-being for elderly nursing home residents. According to the Nursing Interventions Classification (NIC) system, reminiscence therapy is an intervention using recall of past events, feelings, and thoughts to facilitate pleasure, quality of life, or adaptation to the present. Reminiscence therapy, in general, lasts for a period of six to eight weeks. In each week, one or two sessions are conducted by a psychologist or by a health care worker which last for one to two hours. Although the effects of reminiscence therapy have been studied in a wide range of mental health conditions like depressive symptoms, psychological well-being, and cognitive functions in various parts of the globe, such kind of therapy is yet to countries like Japan, Germany, and Italy; the low and middle-income countries are also experiencing such situation and the rate of increase of geriatric people is comparable with the high-income countries, sometimes even higher. (World Bank) India has the second largest population of elderly in the world. According to the be tested in Indian context, especially among the elderly. In this context, the present study aimed to determine the effect of reminiscence therapy in decreasing the level of loneliness, depressive symptoms, and anxiety in the residents of a selected old age home.

METHODS

Design of the study:

Quasi-experimental design.

Settings and location

The present investigation was carried out in an elderly care facility in Hyderabad, Telangana, a state in the southern part of India. We are withholding the center's name for ethical reasons. This registered center is working for last four decades and presently has services like free health check- ups, medical and financial aid towards the destitute aged and different rehabilitative services. From now on, the terms "home" and "old age home" will be used interchangeably.

Study participants

The study was open to participation from all of the residents. However, considering the fact that serious visual, auditory and physical problems can interfere with participation in 'Group Reminiscence Therapy', we considered residents with complete blindness due to any reason at the time of intervention, severe auditory impairment, residents with clinically significant cognitive impairment as exclusion criteria in addition to consent failure in an otherwise physically well resident. The first author performed the physical assessment by conducting a clinical examination and reviewing medical records with the assistance of skilled nursing staff. None of the residents were taking antidepressants or anxiolytics, despite the fact that these medications were not exclusion criteria.



Sample size

We intended to take all the residents of the home. Although 32 residents were there, the final sample size was 27.

Intervention (reminiscence therapy)

Because there was not enough space to accommodate all of the participants at once, we divided the participants into two equal groups of 15 people after finishing the initial assessment. We held two successive group reminiscence therapy sessions for each of the groups in the same area of the home. To avoid bias, we maintained the duration and content of the sessions according to the protocol for both groups. The PI developed the content of the group reminiscence therapy in accordance with the local culture. We held six sessions for the participants, each lasting 60 minutes and containing the information listed below.

Session 1

Introduction of members (Personal details including name, age, date of birth, place of birth, details of family members with photos if available; prior occupation; hobbies).

Session 2

In this session, participants remembered their school days (elementary, high school, college) including friends and teachers, activities, favourite subjects, examinations, celebrating holidays, national day celebration, sports and games, tours, and picnics etc. Participants who never attended school were asked to talk about their upbringing at home. If there were any photos, participants were encouraged to show them.

Session 3

In this meeting, people talked about jobs and other things to do. The first appointment, salary, promotions, transfers, retirement, and pension, among other things, were discussed together.

Session 4

In this session, we concentrated mostly on family life. Photos, if they were available, and information about the family's relationship were shared.

Session 5

In this session, the participants recalled different favorite items like foods, colors etc. Some experiences when they enjoyed such items. Some of them were encouraged to discuss recipes of different foods as well.

Session 6

In the final week of the intervention, the participants talked about their favorite songs, movies, and characters they had seen. They also engaged in activities like singing songs and imitating artists. We encouraged those who were unable to participate or did not encounter such challenges to talk about anything they enjoyed but had not discussed in any of the previous sessions. Throughout these sessions, our only function as facilitators was that of investigators. Additionally, if necessary, we assessed each resident's clinical condition prior to and during each session. The residents' emotional responses, on the other hand, were not our responsibility because they were part of the outcome measurement. We let residents engage in group activities to manage such a situation. The majority of participants encouraged one another to present their unique talents.

Outcome assessment

Another member of the trained nursing staff used the same instruments to assess the outcome variables one week after the last session.

Outcome variables and research tools

Depressive symptoms

After translating the Geriatric Depression Scale (GDS) into Telugu, we used the short version to measure depressive symptoms.²⁰ This scale has been extensively tested and used among the elderly population. If 10 of the 15 questions were answered positively, depression was present; if none of the questions were answered negatively, depression was present. The scores were categorized as normal (0–4), moderate depression (9–11), severe depression (12–15), and mild depression (5–8).

Loneliness

After translating the Revised University of California, Los Angeles loneliness scale (R-UCLA) into Telugu, we used it to measure loneliness. It has 20 items, and each one is rated on a scale from 1 (Never) to 4 (Often). The score has been divided into three categories: moderate loneliness (41–60), severe loneliness (61–80), and mild loneliness (score 20–40).



Anxiety

The Geriatric Anxiety Scale (GAS), developed by Daniel L., was translated by us. Segal, 2013, into Telugu and administered to screen for anxiety symptoms. Each person was asked to indicate how frequently they experienced each of the 30 GAS symptoms over the previous week, including the day of the assessment. A four-point Likert scale gives each item a score, with higher scores indicating greater levels of anxiety, ranging from 0 (not at all) to 3 (all the time). The possible score ranges between zero and 75. The score was divided into three categories: moderate (26-50), severe (51-75), and mild (0-25).

Statistical analysis

SPSS version 20 was used for statistical analysis, and Microsoft Excel, 2010 was used for data entry. Windows (Armonk, New York: IBM Corporation, 2010). The 95% confidence interval (CI) was used to represent the prevalence of various outcomes. We have provided a mean or median along with a standard deviation (SD) for scores across various domains. We used a paired t-test to see if there was a significant difference in the mean scores before and after the intervention. The study was deemed statistically significant with a p value of 0.05. To determine the intervention's effect, we carried out both per protocol analysis and intention to treat (ITT) analysis. All dropouts were assumed to show no improvement for the minimum effect in ITT analysis, while all dropouts showed improvement for the maximum effect from their baseline. The denominator for this analysis included all dropouts who had depressive symptoms, anxiety, and feelings of loneliness in the pre-intervention assessment.

RESULTS

According to protocol, the intervention was completed by 27 home residents. Table 1 displays the demographic and socioeconomic variables. Females made up the majority of the residents. Three of the four male residents stayed with their partners.

Table 1: Socio-demographic variables of the residents (n=27).

Variables	Frequency (%)
Age	
Mean age in years (SD)	71.8 (9.1)
Range (years)	55-84
Gender (%)	
Female (%)	23 (85.2)
Male (%)	4 (14.8)
Marital status (%)	
Married	16 (59.3)
Unmarried	3 (11.1)
Widow	8 (29.6)
Currently staying with spouse or not (%)	
Yes	6 (22.2)
No	21 (77.8)
Last occupation (%)	
Gainfully working	8 (29.6)
Gainfully not working	19 (70.4)

Table 2: Distribution of pre-test and post-test scores among the residents.

Domain	Mean score (SD)	Difference (95% CI)	P value
Loneliness	Pre-test: 39.8 (9.6)	0.18 (-1.37, 1.73)	0.8
	Post-test: 40.0 (9.4)		
Depression	Pre-test: 5.81 (2.63)	0.59 (-0.41, 1.6)	0.24
	Post-test: 5.22 (2.53)		
Anxiety	Pre-test: 21.52 (16.5)	1.33 (0.03, 2.64)	0.04
	Post-test: 20.19 (16.6)		

All the domains except loneliness showed improvement after the intervention. However, the difference was significant for anxiety only (Table 2).

Table 3: Category wise outcome of intervention.

Outcome variable	Pre-test frequency (%)	Post-test frequency (%)	N (%) showing improvement (Per protocol analysis)	Intention to treat analysis minimum (%) - maximum (%)
Depressive symptoms				
No depression	12 (44.5)	17 (63.0)	10 (66.7)	58.8- 70.6
Mild	10 (37.0)	7 (25.9)		
Moderate	5 (18.5)	3 (11.1)		
Anxiety				
Mild	15 (55.6)	19 (70.4)	4 (33.3)	28.6- 42.9
Moderate	11 (40.7)	7 (25.9)		
Severe	1 (3.7)	1 (3.7)		
Loneliness				
Mild	14 (51.9)	18 (51.9)	4 (30.8)	26.7- 40
Moderate	12 (44.4)	8 (44.4)		
Severe	1 (3.7)	1 (3.7)		

When categorized into various groups (Table 3) based on the severity of the outcome variables, all outcomes demonstrated varying degrees of improvement in the post-intervention evaluation. Out of 15 residents with pre-intervention depressive symptoms, 10 (66.7%) demonstrated improvement to a lower category. Nonetheless, two (7.4%) residents exhibited mild depressive symptoms in the post-intervention evaluation who were within the normal range during the pre-intervention evaluation. In contrast to depression, which has a normal category, the domains of anxiety and loneliness lack such a standard. Taking the 'mild' category as the best outcome achievable post-intervention in both areas, we discovered that four (33.3%) residents experiencing moderate and severe anxiety reduced to the mild category; in the loneliness area, the improvement rate was 30.8%, with four out of 13 residents moving from moderate and severe classifications. None of them transitioned from a lower state to a higher state of anxiety and loneliness

DISCUSSION

Our examination of the impact of structured Reminiscence therapy on feelings of loneliness, depression, and anxiety among residents revealed varied responses. We noted that the group's scores indicate the effectiveness of Reminiscence therapy in significantly reducing anxiety levels. While there was a decrease in the mean score for depression, the loneliness score remained relatively stable. Most research on Reminiscence therapy has demonstrated positive outcomes for loneliness; however, the measurement scales employed varied. Furthermore, the content of the therapy differed across cultures and should be carefully considered before reaching any conclusions. For example, the effectiveness of computer and internet interventions for alleviating loneliness was assessed, revealing a significant reduction in loneliness scores. Such interventions for reminiscence therapy in the Indian context may not be culturally appropriate and thus require modifications that are sensitive to cultural nuances. When we categorized loneliness scores by severity levels, nearly one-third of the residents exhibited improvement from a higher loneliness category to a lower one. No other studies reported improvements categorized in this manner. In our research, the anxiety score improved both in terms of mean score and in the transition from a higher anxiety class to a lower one. Literature from other nations has also reported similar findings. However, there is a lack of high-quality evidence or pooled estimates regarding the reduction of anxiety through such therapy. Additionally, as with depression, the use of different scales in various settings complicates comparisons between studies. In contrast to anxiety, depressive symptoms did not demonstrate a significant reduction in mean scores following the therapy application. The absence of significant results may be attributed to the small sample size. Interestingly, when categorized by severity, more than two-thirds of participants exhibiting any form of depression at baseline showed improvement in their condition.

**CONCLUSION**

While we did not primarily focus on measuring the enhancement of well-being, this advantage may serve as an additional benefit for the elderly. Furthermore, this study allowed us to identify various personal skills among the residents. For instance, several participants demonstrated proficiency in playing the keyboard, singing, and writing poetry, among other talents. This creates an opportunity for a lasting impact of such therapy. All residents expressed their support for the RT program and appreciated the therapeutic content. The RT sessions fostered laughter, enthusiasm, a competitive spirit to share similar experiences, and showcase their talents. The group therapy cultivated a strong sense of belonging and unity among participants, which contributed to alleviating feelings of loneliness. Nevertheless, the content of this therapy requires future validation.

Although we were unable to compare our findings with an appropriate control group, the study possesses its own strengths. The role of reminiscence therapy has been scarcely investigated within an Indian context. Given the positive outcomes observed in our study, we strongly advocate for evaluating the results and technical feasibility of this therapy in a resource-limited country like India. We also suggest further investigation into the long-term effects of this program. Extended follow-up studies could assist in determining the critical periods when reinforcement of such therapy is necessary. Additionally, conducting a cost-effectiveness analysis may aid in policy development for the large-scale implementation of this therapy.

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