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EFFECTS OF REMINISCENT THERAPY OF A DEPRESSED ELDERLY MALE POPULATION

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EFFECTS OF REMINISCENT THERAPY ON A DEPRESSED ELDERLY MALE POPULATION

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ABSTRACT

This quasi-experimental study was designed to describe the effects of reminiscent therapy on a depressed elderly male population. The study consisted of a pre/post test design with an experimental and control group. The experimental group was comprised of five residents who participated in eight weekly group reminiscing sessions. The control group was comprised of five residents who were tested but did not participate in group reminiscing sessions.

Data were collected by using the Beck Depression Inventory Scale for pre and post therapy sessions. An analysis of the findings indicated no statistically significant difference between the two groups nor within the groups on pre and post scores. Further research with a larger sample size is indicated to establish the usefulness of reminiscent therapy as a treatment modality for depressed elderly males.

CHAPTER I

INTRODUCTION

Depression in the elderly is a major mental health problem and accounts for the majority of mental disorders occurring late in life. Depression and suicide in the elderly are important public health problems and will become more important as the elderly population expands (Wasylenki 1980).

The risk of depression increases with age. Women are more at risk than men, except after the age of sixty-five, when the risk is equal. Thirty percent of people over age sixty-five suffer from moderate to severe psychiatric disorders, about half of which are affective disorders. Fifty percent of depressed geriatric patients experience their first depressive episode after age sixty (Wasylenki 1980). Blumenthal (1980) reports that although people over sixty-five constitute only a little more than ten percent of our population, people in this age group account for twenty-five percent of all suicides.

Guidelines for the treatment of depressed elderly patients are lacking. The most common approach to the depressed elderly patient is to ignore the problem or to treat the person with anti-depressant drugs, frequently of inadequate dosage. Barraclough (1972) studied thirty cases of suicide victims over age sixty-five. Two thirds of the people had been depressed for less than a year. Just under half had died one week after seeing their general practitioner, and ninety percent had died within

three months after doing so. Anti-depressants had been prescribed for only five, and in three instances, the dose was inadequate. Psychopharmacological therapy is sometimes combined with electroconvulsive therapy in the treatment of depressed elderly patients, however, electric convulsive treatment may be given to those patients who do not respond to medication.

In addition to psychopharmacology and/or electroconvulsive therapy, other treatment modalities have been suggested, particularly preventative measures. Stenback (1980) discusses crisis intervention, not as a depression therapy, but rather as a preventative measure against depression. Its aim should be restoration of the previous activity level, thus intervention which avoids a depressive state.

Stenback (1980) also suggests other forms of brief therapy which should be given to elderly people. These therapies should contribute to developing new objects after experienced loss and relieving bitterness, low self-esteem, and feelings of hopelessness. Some approaches include joining small community groups or life review therapy.

Cognitive psychotherapy (Beck 1967) focusing on the patient's depression generating cognitions is one approach to restoring the internal balance of aged persons. Mintz, Steuer and Jarvik (1981) point out that memory impairment in older people affects recent memory more than remote memory. Therefore, psychotherapy focused on the here and now events, like the cognitive-behavioral psychotherapy of depression developed by Beck, may not be as effective as a therapy that focuses on more remote events and relationships. Reminiscent therapy or a review of life events has been proposed as a beneficial therapy for elderly depressed persons.

Reminiscent therapy as an approach to life review was described by Butler (1963). Reminiscing is a common activity for most aged people. Telling about life as it once was can be therapeutic for the elderly patient and useful to the nurse in planning care. A nurse can use reminiscenses to learn about a client's past life, his struggles, his concerns, his habitual coping mechanisms, his losses, his strengths, his fears and his triumphs. Talking about the past is one way of looking at past coping mechanisms, which can often be applied to current problem solving. More important, when an older person perceives his memories as valued, an empathic communication process begins, thus a relationship of therapeutic value is established (Ebersole 1976).

Statement of the Problem

This study focuses on the following hypothesis: Depressed elderly male residents who participate in reminiscent therapy will evidence lower levels of depression than depressed elderly males who do not participate in reminiscent therapy.

Theoretical Framework

Related concepts from several sources will be explored in the development of a theoretical framework. These concepts include examining Erikson's eighth stage of the life cycle, Neugarten's study of personality in middle and late life and social theories discussed by behavioral scientists. These related concepts and theories will be discussed in terms of Butler's and Ebersole's work with life review and reminiscent groups.

The theoretical framework for this study was developed around Erikson's (1950) theory which stressed the importance of reminiscing for

the psychological health of the individual. According to Erikson, as a person grows closer to death, a crisis is precipitated in which he/she examines life experiences and accomplishments in terms of whether his/her major life goals have been attained. He identifies this last stage of life as ego integrity or despair (disdain), depending upon whether one has found satisfaction or dissatisfaction with one's life. Persons who feel satisfied with their life and/or their life work will experience ego integrity. In describing the eight stages of life, Erikson refers to the eighth stage as the late adulthood ego transcendence versus ego preoccupation.

Erikson refers to the last stage as the night of the ego. He states that if one has lived his life generously and unselfishly then the prospect of death looks and feels less important. Instead an individual builds a broader, larger future than an ego could encompass. This is accomplished through children, cultural contributions, and friendships. Death is inevitable and the ability to adapt to the prospect of death, according to Erikson, may be the most crucial achievement of the older years.

The eight stages in the life cycle as delineated by Erikson are represented by a choice or crisis for the expanding ego. As one moves from the identity versus confusion problem of adolescence into young adulthood, the focus shifts to intimacy versus isolation, that is, the ability to merge oneself with the self of another. Adulthood, the next stage, is concerned with generativity versus self-absorption (investment in the product of one's own creation and identification with the future), and in late adulthood the crisis of ego integrity (the view that one's

life has been the product of one's own making, that it could not be different, and that it had been a meaningful life), versus disgust and despair (Busse and Blayer 1980).

Research correlating health and social support systems has led to the development of two social theories, the disengagement theory and the activity theory. The disengagement theory maintains that high satisfaction in old age is usually present in individuals who accept the inevitability of reduction in social and personal interactions. Disengaging from social and personal interactions, accepting this as a natural process and maintaining a sense of satisfaction with one's life implies ego integrity as defined by Erikson.

The activity theory holds that the maintenance of activity is important to most individuals as a basis for obtaining and maintaining satisfaction, self-esteem and health (Busse and Blayer 1980). Maintaining activity implies some level of self-esteem, thus ego integrity. Both of these theories satisfy Erikson's concept of ego integrity versus disgust and despair. That is, as long as satisfaction with one's life is maintained, and self-esteem preserved, the ego remains in a state of integrity. Whether disengaging or maintaining activity, the process is a positive one and not a product of a feeling of despair.

Neugarten (1964) published a study of personality in middle and late life. Eight empirical approaches were utilized, each focusing upon a personality theory. Neugarten's study of Erikson's theory of ego development concluded that Erikson's model of personality in assessing adult personality was relatively successful, and it was concluded "the hypothesized interdependence of ego dimensions and their proposed hierarchical order

has some validity." This study found that personalities maintained their characteristics in middle and late life, and personality changes or disintegration were not related to age per se, but to losses, particularly those involving health and social support systems (Busse and Blayer 1980).

Erikson's theory lends itself to work on reminiscence or life review. It follows that an individual who feels his life has been productive and worthwhile will experience ego integrity.

Butler (1963) states that the life review mechanism, as a possible response to the biological and psychological fact of death, may play a significant role in the psychology and psychopathology of the aged. Butler conceives of the life review as a rationally occurring, universal mental process characterized by the progressive return of past experience to present awareness and the resurgence of unresolved conflicts. These reviewed experiences and conflicts can be examined and reintegrated. Presumably this process is prompted by the realization of approaching dissolution and death and the inability to maintain one's sense of personal invulnerability.

Butler's (1963) work on life review in the aged suggests that reexamining unresolved conflicts results from the need to establish ego integrity. Life review is an attempt at integration, or an attempt to put one's house in order before death. Life review looks at past events, feelings, memories and ideas as well as past coping mechanisms. Negative perspectives can be changed into positive ones with evidence from the past applied to present problems. This helps raise the patient's self-esteem and allows him to focus on healthy coping behaviors.

Ebersole (1974) conducted reminiscent groups with the elderly in order to raise self-esteem. She found that the elderly gained ego strength by restructuring their ego identity which integrated their past, making order and giving meaning to what their life had been.

The desired result of reminiscent therapy in this study would be an increase in the subject's level of self-esteem, which affects ego integrity as defined by Erikson.

Causal Model from the Theoretical Framework

positive life review ____+____ self esteem ____+____ ego integrity

Summary

Depression is a major health problem among the elderly. Guidelines for the treatment of depressed elderly patients are lacking. Various treatment modalities have been explored in the literature, however, reminiscent therapy was chosen for this study because it utilizes the personality and the life-style together with a review of remote events. It is anticipated that depressed elderly males will evidence lower levels of depression after engaging in reminiscent therapy.

CHAPTER II

REVIEW OF LITERATURE

Review of the literature addresses the incidence of depression in the elderly, research considerations and implications for treatment. The effects of reminiscence on depressed elderly patients and the use of reminiscence as a positive adjustment mechanism for elderly people is explored. The literature also demonstrates that the use of reminiscent group therapy results in elevated self-esteem and increased socialization. This supports the use of reminiscence as an appropriate treatment modality for depressed elderly patients.

Depression in the Elderly

Blumenthal (1980) discussed the need to be alert to symptoms of depression among the aged who present with physical illnesses. She points out that depression may be drug induced and that some depressions are caused by certain physical illnesses. The author stressed the need for appropriate dosage as well as awareness of side effects and contra-indications of drugs. She suggested that many depressions can be treated on initial evaluation by allowing the patient to ventilate feelings and by being alert to physical illnesses and their effects on mood.

Mintz, Steuer and Jarvik (1981) considered research considerations for psychotherapy with depressed elderly patients. They explored the issues of patient homogeneity, external validity, internal validity, choosing and implementing specific treatment modalities, therapist experience and attitudes, therapist age, reliability and validity of measures, and problems obtaining follow-up information when studying treatment of depressed elderly patients. The authors addressed themselves to the argument that the geriatric patient has little time left to live, so that the cost-benefit ratio for psychotherapy is unfavorable. They submit that this argument is unwarranted and that patients over age sixty who engage in group therapy improve significantly.

Wasylenki (1980) advocated aggressive treatment of depressed elderly. He stated that since elderly patients convictions of helplessness and ineffectuality develop in response to losses and the absence of substitute gratifications, a powerful, protective figure should be used to help restore feelings of security. As patients become convinced of their good standing with their therapist, their self-esteem increases. The author suggested that a supportive relationship that contains aspects of earlier important relationships may enhance self-esteem, thus resolving depression.

Blazer and Williams (1980) surveyed 997 elderly people living in the community and found the rate of significant dysphoric symptomatology was 14.7 percent. Forty-five of these individuals suffered from dysphoric symptoms of a major depressive disorder. The frequency of widowhood, impairment in social resources, and impairment in economic resources was greater for individuals with symptoms of a major depressive disorder.

The entire sample used psychiatric services at a very low rate.

Coetzee (1981) studied the psychosocial stress factors and the prevention of depressive illness in the elderly. It was found that psychosocial factors play a relatively unimportant role in the genesis of depressive illness. A constitutional predisposition probably plays a larger or at least equally important role. A program of early identification and treatment combined with a program of primary prevention with regard to psychosocial stress factors for those elderly at high risk for depressive illness would yield the best results.

Reminiscence

McMahon and Rudicke (1961) studied twenty-five non-institutionalized Spanish-American War veterans between the ages of seventy-eight and ninety. Each subject was interviewed for an hour in a nondirective fashion. The interview was taped and a transcription analyzed. A sentence was designated as a unit of measurement and the responses were classified as to whether the content referred to the past, present, or future. Responses referring to the remote past were classified as reminiscences. During the interview, the subjects were also rated as to the presence of depression based on clinical criteria of the effect of hopelessness and helplessness. Those rated as clinically depressed exhibited all those criteria. One year later, the investigators found that three of the four subjects rated as depressed had died; four of the five subjects rated as suspected depressed had died; and only one of the sixteen subjects rated as not depressed had died. Statistical results suggested a tendency of the depressed group to reminisce less than the nondepressed group. Depressed subjects had the greater difficulty in

reminiscing. They appeared to have given up all hope and self-esteem. Their physical status at the time of interview did not appear to be poor. The findings of this study imply that reminiscing is positively related to freedom from depression and to personal survival.

Butler (1963) viewed life review as a naturally occurring, universal mental process characterized by the progressive return to consciousness of past experiences, as well as a resurgence of unresolved conflicts. The process is prompted by the realization of approaching death and to increased vulnerability to stresses in the environment. Butler supported his premises with case studies and concluded that the content and significance of reminiscence should not be lost, because there are rewards for anyone who listens to the elderly relate their lives.

Havighurst and Glasser (1972) found that sixty-seven percent of their respondents reminisced "often" or "occasionally" when they were alone. Of the same group, seventy-nine percent said they reminisced when they were with spouse, friends, or relatives. The investigators studied silent reminiscence by using semi-structured interviews and relying upon self-reports of the amount and affective quality and content of reminiscence (silent and/or oral). Their subjects ranged in age from seventy to seventy-five. The results were that the majority of subjects engaged in silent and oral reminiscence and that the phenomenon is related to actual life experiences of people. They also concluded that there is a syndrome of good personal-social adjustment, positive affect of reminiscence and high frequency of reminiscence.

Lewis (1971) studied twenty-three men over age sixty-five who were classified as reminiscent or nonreminiscent, based on a

nondirective taped interview. The investigation found that following stress there was a significant increase in past-present orientation and increased self-concept for reminiscents compared to nonreminiscents. These findings suggest that reminiscing and identifying with one's past may be a defense mechanism for certain old people.

Boylin, Gordon and Nehrke (1976) administered a questionnaire on reminiscing to elderly institutionalized veterans together with scales to assess ego adjustment. Findings showed that men who reminisced most frequently achieved high scores on the measure of ego integrity.

Tedesseo (1977) discussed the role of reminiscence in psychoanalysis. The author suggested that reminiscence offers guidance and direction by reminding one of the precepts of conscience and the expectations of the ego ideal. In short, reminiscence plays a major role in the formation, evaluation and maintenance of one's identity. The importance of reminiscing to issues of loss and incomplete mourning are addressed. The author suggested that reminiscence provides consolation by serving as a buffer against loss and depression. It confirms that something actually took place; what remains has enough substance to comfort and reassure.

Fallot (1980) studied the impact on mood of verbal reminiscing as compared with talking about the present or future. He studied thirty-six females between the ages of forty-six and eighty-five. He found a more positive effect of reminiscing, thus supporting the hypothesis that reminiscence may serve an adaptive function in later life. The major effect of reminiscing appeared to be a reduction of negative mood rather than any striking increase in positive emotions.

Hala (1975) used reminiscent group therapy in a long-term care facility for the aged. The purpose was to promote self-esteem and socialization of residents. Hala conducted a study and found an increased willingness to participate in group meetings, an increased confidence in expressing feelings, and an increase in socialization and participation in other kinds of activities following reminiscent group therapy. The participants developed new attitudes and new interests.

Ebersole (1976:124) used group reminiscing on an intermediate care unit of a veterans hospital. The age range was forty-seven to ninety-seven. The number of sessions held was not reported. Goals for the group were elevation of self-esteem, increased socialization, and ability to share memories with others and a heightened awareness among members of the individuality and uniqueness of each member. Early in the group sessions, the leader had to act as a catalyst until the members developed trust in the leader. When trust was established, the members began to interact freely.

Summary

The review of literature reveals the use of reminiscent therapy as a positive influence on self-esteem, therefore increasing ego integrity. Reminiscents tended to be less depressed and experience more ego integrity than non-reminiscents; thus there was an adaptive value for individuals. Reminiscents tended to be persons with good personal-social adjustment, and findings suggested that identifying with one's past may be a defense mechanism for certain old people. The effect of reminiscing appeared to be a redirection of negative mood rather than an increase in positive emotions.

CHAPTER III

METHODOLOGY

This quasi-experimental study was designed to describe the effect of group reminiscing on depressed residents of a self-care domicile. The following topics are presented in this chapter: design of the study, sample population including control and experimental groups, data collection instrument, method of data collection and method of data analysis.

Design of the Study

This study consisted of eight weekly group reminiscing sessions with five residents of a self-care domicile comprising the experimental group. Five residents who did not participate in reminiscing sessions comprised the control group. Each group was pre and post tested using the Beck Depression Inventory Scale. A privately owned and operated home for men in southwestern United States was the setting for the study.

Procedure

A meeting was held with the administrator and his assistant to explain the purpose and design of the study. Permission to do the study in this fifty-two bed self-care facility was obtained from the administrator after assuring all resident's rights would be protected and that residents will remain completely anonymous.

The room selected for use was a small television room which was rarely used. This allowed for maximum privacy and a circular chair

arrangement. The circular chair arrangement encouraged communication by reducing hearing, sight and mobility problems.

Sample Population

All residents were given an opportunity to participate. The researcher introduced herself to each resident, explaining the group reminiscing project and inviting them to participate. This process continued until all residents had been approached and a convenience sample was obtained. The only criteria for participation was:

1. a resident of the domicile
2. able to see, speak and hear
3. able to speak and read English.

Those resident who were willing to participate in testing and group activity were assigned to the experimental group. Those residents who were willing to participate in testing only were assigned to the control group. All residents of the domicile were male and the age range of the residents was from sixty to eighty-seven. Therefore, both the experimental and the control group consisted of residents of a domicile, male, over sixty years of age, able to see, speak and hear, and who were able to speak and read English. When verbal consent was obtained, the residents were asked to read and sign a consent form approved by the Human Subjects Committee of the University of Arizona (see Appendix A).

The method of obtaining the sample was based upon a self-selection process. This process did not guarantee that the most appropriate or the most depressed residents were participants. However, subsequent testing with the Beck Depression Inventory showed no significant difference between the experimental and the control group prior to the commencement of

reminiscent therapy.

In order to insure that cross contamination between the experimental and the control subjects would be unlikely to occur and thus not confound the findings of this study, observations were made on five occasions. Communication among the residents was sparse. Prior to the development of the study, the investigator unobtrusively observed residents' interactions. On three occasions the residents were observed for one hour between 10:00 a.m. and 11:00 a.m. in the large day room. On each occasion there were no interactions among residents and on one occasion there was one interaction between a resident and a staff member. Twice the men were observed during meal time. There was one interaction between two residents when one resident accidently sat in the wrong chair and was told by the other to move. On each of the two occasions when observations were made during the noon meal there was one interaction with staff asking for more food and one interaction asking for the salt to be passed. The paucity of communication was easily observable and staff confirmed that such lack of communication was an accepted norm for the residents. Therefore, the possibility of cross contamination between experimental and control groups was unlikely, except for the experimental effect, that is, the control group benefiting from the lessening of negative mood which may be demonstrated by the experimental group. The impact of this will be explored in the discussion of the data analysis. At the first session and at the beginning of each subsequent session the group participants were asked to maintain the confidentiality of the group for the duration of the study.

Procedure

After the observations were made the residents who were participating in the experimental group were informed of the day, time, length, location, and purpose of the group. Prior to the commencement of the reminiscent group sessions, each subject in the experimental group completed the Beck Depression Inventory. Control group members also completed the Beck Depression Inventory at the same time. The responses were totaled to obtain a score for each resident's level of depression. The control group did not participate in group activity. The experimental group was conducted for eight weeks. Five residents comprised the experimental group and five residents comprised the control group.

Following each session, the investigator wrote anecdotal notes of the session, recording significant interactions, interactions for potential follow-up sessions, attendance, and major themes.

At the end of eight weeks of group reminiscing, the Beck Depression Inventory was readministered to each participant of the experimental and the control groups.

At the first session, group members were asked to introduce themselves and to tell something about themselves that they were comfortable about revealing. The therapist led the introductions by introducing herself, reinforcing the purpose of the group, the day and time it would meet and the location. Termination was mentioned and reminders of termination were mentioned at each session, reinforcing the remaining weeks.

Reminiscing was introduced at each session by the therapist in a semi-planned manner. That is, a plan was developed for each session, however, spontaneity was encouraged and the plan discarded if appropriate. The following topics were included in the plans for discussion:

1) family; 2) childhood experiences; 3) sports participated in as adolescents; 4) animals; 5) military experiences; 6) occupations; 7) modes of travel, especially horses and automobiles; and 8) courting rituals. Articles were brought to the sessions to enhance and stimulate topics. Each resident was encouraged to participate and to acknowledge each other by responding to the contributions of each member.

Summary of Each Session

First Session

The first session began with the investigator introducing herself and explaining the purpose of the group. Each participant was asked to introduce herself and to tell something about himself that he was comfortable in sharing. The theme became a family one, with each participant sharing the vital statistics concerning his life, including stories about parents and siblings. Each resident participated in the first session and there were some expressions of surprise, such as, "I didn't know you were a farm boy."

Leader Impressions - the first group meeting began awkwardly with the participants hesitating to speak. However, half-way through the session the group appeared to become more assured and continued with all men participating.

Second Session

The second session began with Mr. A. explaining to the group the reason why he remained single. His story was a humorous one with Mr. A. explaining that he was so popular with the ladies that he could not chose just one. His humor also extended to stories about courting ladies,

always taking the slowest horse on dates. The other participants responded to his humor with laughter. The discussion centered around comparing the courting rituals of yesterday with courting rituals of today. All but one participant stated they were more comfortable with the simpler life style of their generation. However, Mr. C., the eighty-seven year old resident, thought he would like to have women ask him for a date.

Leader Impressions - The group appeared to have established some level of cohesiveness due mostly to Mr. A.'s humor. Participation was more spontaneous and the group seemed reluctant to break up.

Third Session

This investigator brought her pet cat to the session. The residents responded with surprise and delight. Each participant took turns petting the cat, however, Mr. C. continued petting the cat throughout the entire session. This led to a discussion about animals with Mr. E. leading the conversation describing his German shepherd dog. Mr. D. also had a German shepherd and the two men compared notes. Mr. C. insisted that even though he had owned dogs he liked cats better. Mr. A. offered that his favorite animal was the horse and told the story of his slow horse again. This time Mr. A. produced a picture of himself as a young man and each participant agreed he was a handsome young man and probably was very popular with the ladies. Mr. A. was obviously pleased with himself.

Leader Impressions - The third session was the most active group thus far. The stimulation of the live pet brought out animated conversation with each resident participating. Mr. C.'s continuous petting of the cat was particularly heartwarming because his gestures were shy and hesitant at first, and as the session progressed he appeared to be totally

absorbed in the animal. Mr. A. was reinforced when he received positive response to his picture, thus recapturing positive ego integrity.

Fourth Session

The session began by again discussing animals and pets. However, the conversation led to what it was like to be a child in their lifetime. The reminiscing on childhood focused on the need to work while very young. Pets were intertwined with this theme because pets seem to offer one of the few pastimes that were pleasurable. Mr. B. and Mr. D. also offered reminiscences about near fatal childhood accidents.

Leader Impressions - The fourth group was a more serious one than those preceding groups with emphasis on hard times and hard work. However, the residents appeared to gain strength by talking about what they had endured. The conversation appeared to give the impression that the men were saying, "We are a special breed of men; we have survived much, and we are strong."

Fifth Session

The fifth session was a spin-off of the fourth session. The leader encouraged the men to talk about fun times. The men talked about baseball and softball. The only other pastime discussed in adolescence was horseback riding. However, childhood baseball predominated with the conversation leading to great ball players they admired. Lou Gehrig and Babe Ruth appeared to be the favorites with Joe DiMaggio a close third place.

Leader Impressions - All the residents in the group were participating spontaneously by this time. The group was cohesive and members obviously enjoying identification with each other.

Sixth Session

The leader introduced the topic of military experience. Only two residents in the group had been in the military and the conversation quickly changed to occupations. Mr. C. reminisced about his life as a cowboy, a subject that the other participants seemed to enjoy. Mr. A. and Mr. E. talked about their lives as farmers and Mr. B. talked about being a house painter. Mr. D. described his life on the high seas with a flair which held the attention of all participants.

Leader Impressions - the group waited in the meeting room each week for the arrival of the group leader. It appeared that they would lead the reminiscing groups, chosing the topics as desired. At this point, the group leader was a captive audience whose main function was to maintain order.

Seventh Session

The seventh session was initiated by Mr. E. who brought a picture of the model T Ford. Each of the men described their first automobile and Mr. A. again talked about his slow horse. Each of the men had flown in an airplane at least one time, however, they preferred to talk about old cars including the cost of maintaining an automobile. Mr. B. described the ration system of World War II and Mr. A. again insisted that horses were more reliable.

Leader Impressions - The group was reminded that there was one session left. They expressed concern about losing the group. They were encouraged to continue their reminiscing after the sessions ended. At this point, the group had developed a camaraderie and it was reasonable to assume that some form of interaction would continue.

Eighth Session

The eighth and last session contained reminiscences within reminiscences. The participants chose to discuss the preceding seven sessions, repeating many of the stories told and expressing their enjoyment of the sessions.

Leader Impressions - The termination process was difficult because by this time the group leader had become a significant other to each of the men. They were encouraged by the group leader to continue interacting with each other and with other residents.

Data Collection Instrument

The instrument used in this study was the Beck Depression Inventory (see Appendix B). The Beck Depression Inventory was printed in large type to accommodate any visual problems the sample population may suffer.

Beck Depression Inventory

The Beck Depression Inventory (BDI) was designed to provide a standardized means of assessing depression. Beck (1974:162) states,

> ...the author recognizes the value of clinical judgements of depression while simultaneously acknowledging the disadvantages of the clinical approach. An instrument such as the BDI provides a standardized consistent measure that does not rely on the theoretical orientation of the interviewer.

In order to facilitate the use of the BDI in family practice, a shortened form of the BDI was developed (Beck and Beck 1972).

For development of the shortened BDI, stringent criteria were set by Beck. These criteria called for a ten to fifteen item test that would correlate better than 0.90 with the long form and would have maximum correlation with the clinical evaluation of the severity of depression.

After only seven items, the criterion with the total BDI score was reached. The criterion correlation with the clinician's rating was reached after thirteen items. The final result was a thirteen item questionnaire correlating 0.96 with the total BDI score and 0.61 with the clinician's rating for depth of depression. "In this same sample," state Beck and Beck (1972:84), "the total score of the unabridged version of the BDI had correlated 0.59 with the clinician's rating, indicating a better correlation for the shorter version."

There have been multiple assessments of the BDI documented in the literature. Beck et. al (1961:61) states,

> The inventory was able to discriminate effectively among groups of patients with varying degrees of depression. It also was able to reflect changes in the intensity of depression after an interval of time. In view of these attributes of reliability and validity, this instrument is presented as a useful tool for research study of depression, and as a step in the direction of placing psychiatric diagnosis on a quantitative basis.

The average content being measured in the BDI is unidimensional in that it measures one overall concept - depression. Thirteen features of depression are measured on a scale of 0-3. Those features include: sadness; pessimism; sense of failure; dissatisfaction; guilt; self-dislike; self-blame; social withdrawal; indecisiveness; self-image change; work difficulty; fatigability; and anorexia.

Reliability and Validity

The Kruskal-Wallis Non-Parametric Analysis of Variance by Ranks was used to evaluate internal consistency. Item scores and total scores for each patient (N=200) were compared. All items were significantly correlated with the total score (Beck 1974:162-3).

The Spearman-Brown reliability coefficient of 0.93 was obtained when split-half reliability was computed (N=97) (Beck 1974:162-3).

Concurrent validity was assessed by comparing clinical judgement of each patient's depth of depression with testing of the BDI. The BDI was administered twice at four week intervals to thirty-eight patients. BDI scores were found to be parallel to the clinical ratings (Beck 1974: 162-3).

Further validity testing was obtained by correlating BDI scores with other measures of depression. The correlations were 0.65 with clinician's ratings, 0.75 with Hamilton's Rating Scale for depression and 0.75 with the MMPI-D scale. Various correlations reported include 0.55 with the depression-anxiety scale, 0.66 with the depression scale of Multiple Affect Adjective Checklist, and 0.76 with the Zung Self-Rating Depression Scale (Beck 1974:162-3).

Construct validity was tested by correlating BDI scores with measures of depression - related concepts. A relationship of significance with "negative self-concepts," "identification with the loser," "pessimism," and "hostility-inward," scale have been reported in the literature (Beck 1974:162-3).

Beck and Beck (1972:82) state, "Finally, unlike some other tests designed to measure depression..., the BDI discriminated well between anxiety and depression."

Scaling Type/Levels of Measurement

The BDI is a self-report scale. Each item consists of a series of four graded self-evaluative statements. The aspects of depression are measured in an ordinal fashion. The instrument is a quantitative

assessment of the intensity of depression. Responses are weighed 0, 1, 2, and 3, with 0 = neutral and 3 = severe depression.

Method of Data Analysis

Each resident's scores on the Beck Depression Inventory were analyzed for pre and post treatment comparison using the Sign Rank test and the experimental and control groups post-treatment differences were compared using the Mann-Whitney U test.

The levels of depression as defined by Beck will be compared individually for all subjects, pre and post reminiscing group therapy. Levels of depression across experimental group and control group will also be compared using Beck's scale.

Summary

Five residents were self-selected for the experimental group and for the control group. The Beck Depression Inventory Scale was used as a pre and post test for each group. The experimental group met weekly for eight weeks for the purposes of reminiscing. Reminiscing was introduced each week in a semi-planned manner with spontaneity encouraged.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

Characteristics of the Sample

General Characteristics

All of the subjects in the study were residents of a self-care domicile, male, over age sixty, who could see, hear, and who could read and understand English. The experimental group had a mean age of seventy-six and the control group a mean age of seventy. None had more than twelve years of schooling, with the least number of years being five. All were either single or divorced. None of the participants had important people in their lives who visited them. One resident visited an ailing sister in a nursing home approximately three times a year. Another resident received an occasional telephone call from a daughter, but reported to have had one visit during his three-year stay. Length of stay ranged from six months to three years with a mean length of stay of two years one month. The residents were all capable of self-care, however, some had walking or breathing difficulties. Information on the economic status of the residents was not available.

All of the residents who participated in the study verbally admitted to some level of depression and some offered explanations. The most prevailing theme centered around losses such as loss of health and loss of independent action.

Individual Characteristics - Experimental Group

Mr. A., a seventy-eight year old single man was raised on a farm in the midwest. He remained a farmer his entire life until retirement. He was an active participant of the group who appeared to enjoy the attention of the group as evidenced by a smile each time he was addressed.

Mr. B., a sixty-eight year old divorced man lived in the midwest most of his life. His occupation was as a house painter, however, Mr. B. spent a total of twenty years in institutions for the mentally ill with recurring episodes of schizophrenia. At the time of participation in the group, his schizophrenic process was in remission. His participation was passive the majority of the time; that is, he listened more than he talked.

Mr. C., an eighty-seven year old divorced man of Mexican-American descent was the oldest resident in the group. He spent his life in the southwest as a cowboy. He participated actively and appeared to derive a great deal of enjoyment in group sessions. He was always waiting patiently for the group to begin and smiled and joked frequently.

Mr. D., a sixty-five year old single male spent most of his life in the northeast. He was a retired merchant seaman. Mr. D. was new to the domicile, expressed frustration with his living situation and a desire to return to the northeast. His contributions to the group were spontaneous when the subject was of interest to him.

Mr. E., a seventy-two year old divorced man was born in the midwest on a farm, but spent most of his life in the southwest at various occupations. Prior to coming to the domicile, he was living alone, a marginal existence. His self-description was that of a hermit. He participated in the group and appeared to enjoy the interaction of the other participants.

Individual Characteristics - Control Group

Mr. F, a sixty-three year old single man spent thirty years of his life in a mental institution for chronic schizophrenia. He came from a privileged background and seemed preoccupied by a large sum of money left him by his family. He stated that he was never mentally ill but rather a delinquent and his father institutionalized him for the purpose of control. He chose not to participate in the group because of his history and saw non-participation as an act of freedom.

Mr. G., a sixty-five year old divorced man described himself as a world traveler. His occupation was that of a commercial artist. He admitted to having the "blues" from time to time, but did not want to participate in the group. He explained that he had a car and went to town daily, therefore, he did not want to commit himself to a time frame.

Mr. H., a seventy-five year old divorced man agreed to take the Beck Depression Inventory Scale but would offer no information about himself. He spent most of his time reading and appeared to be reluctant to mingle with others.

Mr. I., a seventy year old divorced man spent his days sitting in a chair dozing. He appeared to be withdrawn and non-communicative, however, he agreed to take the BDI because his former wife was a nurse and he wanted to help the investigator.

Mr. J., a seventy-eight year old single man of Mexican-American descent suffered paralysis on his right side. His personality was congenial, however, his paralysis embarassed him and he chose to stay in his room except for meals.

Table 1: Characteristics of the Sample

	Age	Education	Marital Status	Physical Impairments	Family Visits	Length of Stay	Community Interaction
Experimental Group							
Mr. A.	78	6 years	single	difficulty walking; uses cane	none	2 years	none
Mr. B.	68	10 years	divorced	emphysema	none	1 year	biweekly visits to town
Mr. C.	87	5 years	divorced	walks with cane	occasional	3 years	none
Mr. D.	65	8 years	single	none	none	6 months	occasional visits to town
Mr. E.	72	6 years	divorced	none	none	2 years	none
Control Group							
Mr. F.	63	12 years	single	none	none	3 years	occasional visits to ailing sister
Mr. G.	65	12 years	divorced	none	none	3 months	frequent trips to town
Mr. H.	75	6 years	divorced	none	none	3 years	none
Mr. I.	70	12 years	divorced	breathing problems; walks with cane	none	2 years	none
Mr. J.	78	5 years	single	paralysis, right side	none	2 years	none

Analysis of Data

The following table, taken from Beck and Beck (1973:84) shows how the scores are interpreted:

Table 2:

Range of Scores	Degree of Depression
0 - 4	None or minimal
5 - 7	Mild
8 - 15	Moderate
16+	Severe

The participants showed a varied pattern in their pre and post treatment scores. The following table represents the raw scores of each participant:

Table 3: Table of Raw Scores

Experimental Group	Pre-treatment	Post-treatment
Mr. A	3 None or Minimal	0
Mr. B	11 Moderate	9 Moderate
Mr. C	29 Severe	12 Moderate
Mr. D	0	0
Mr. E	3 None or Minimal	14 Moderate
Control Group		
Mr. F	13 Moderate	13 Moderate
Mr. G	2 None or Minimal	2 None or Minimal
Mr. H	3 None or Minimal	3 None or Minimal
Mr. I	2 None of Minimal	7 Mild
Mr. J	0	0

Three of the participants showed an improved raw score following treatment; one of the participants remained the same at 0; and the fifth participant showed a marked increase in his level of depression. Possible explanations for an increase in depression could be that the participant did not respond to reminiscent therapy or he was made more aware of his depressed feelings due to the therapy sessions. Another explanation is that he did not take the BDI accurately during the pre-treatment phase. This latter explanation seems most viable because the therapy process itself built a camaraderie and trust which might have triggered a more honest response during the post treatment phase.

This mechanism is also a possible explanation for the participant who scored 0 on the pre and post testing. The participant frequently expressed negative feelings about his status in life and his wish to return to the northeast. It is conceivable that he chose to bias his responses on testing in order to maintain his "I'm O.K.; everyone else has problems" demeanor.

In the control group, three participants remained the same with a range of None or Minimal to Moderate. One participant showed an increased level of depression on post testing. And as in the experimental group, one resident scored 0 on the pre and post testing. This resident was withdrawn and remained in his room except for meal time and trips to the bathroom. His congenial personality is in contraindication to his behavior, since he obviously enjoyed people and smiled broadly when addressed. It is possible that he did not answer the questions on the BDI accurately.

The raw scores are significant in that sixty percent of the participants in the experimental group showed some post treatment improvement

while sixty percent of the control group showed no change in a positive direction. These scores indicated that the intervening variable, reminiscent therapy, did effect the state of depressed mood in three of the subjects in the experimental group to some degree.

The Mann-Whitney U test was used to test whether the two independent groups were taken from the same population. The pre-treatment difference ranged in scores of 0 to 29, with a mean of 6.6 and a standard deviation of 9. The following table represents the pre-treatment difference using the Mann-Whitney U test:

Table 4:

Pre-treatment Difference

The Mann-Whitney U Test

Score	Rank	Group
0	1.5	E
0	1.5	C
2	3.5	C
2	3.5	C
3	6	E
3	6	E
3	6	C
11	8	E
13	9	C
29	10	E

$1 + 1 + 1 + 4 = u = 7$

$p = .155$

The pre-treatment difference yielded a U score of 7 with a $p = 1.55$. Therefore, there were no significant differences in the two groups prior to reminiscent therapy.

The Mann-Whitney U test was applied to test for post treatment differences.

Table 5:

Post Treatment Difference

The Mann-Whitney U Test

Score	Rank	Group
0	2	E
0	2	E
0	2	C
2	4	C
3	5	C
7	6	C
9	7	E
12	8	E
13	9	C
14	10	E

$2 + 2 + 2 + 4 = U = 10$

$p = .345$

The post treatment differences yielded a U score of 10 with a $p = .345$. Therefore, there was no significant differences in the two groups after reminiscent therapy.

The Sign Test was used to test for individual differences within the group of matched pairs. The following tables represent the experimental

and the control groups using the Sign Test.

Table 6:

Experimental Group

Pretest	Post Test	d	Rank of d
3	0	3	2
11	9	2	1
29	12	7	3
0	0	0	
3	14	-11	-4

T = 3

p = .5

Table 7:

Control Group

Pretest	Post Test	d	Rank of d
13	13	0	
2	2	0	
3	3	0	
2	7	-5	-1
0	0	0	

T = 1

p = .97

The experimental group resulted in a p = .5, therefore no significant difference was noted. The control group with a p = .97 also resulted in no significant difference.

Even though the statistical evidence did not substantiate the effectiveness of reminiscent therapy on a depressed population, the clinical evidence suggests that reminiscence may be an effective therapeutic modality.

An analysis of the anecdotal notes and the statistical evidence indicates the following findings.

The anecdotal notes revealed a progressively cohesive group had developed. The sessions ended reluctantly with several of the men commenting on their feelings. Some comments included statements such as, "Do we have to stop?" "You make us feel better.", "I'll look forward to next week." This self-reporting by the residents was unsolicited and demonstrates positive spontaneous feelings for the group activity. In addition, the assistant administrator made comments regarding the group activity. They included, "Your groups are the best thing that ever happened in this place.", "The men really look forward to your group sessions.", "The men seem to get so much out of your groups; I wish you would teach me how to run the group so I can continue them after you leave."

This last comment led to several meetings with the assistant administrator with discussions on reminiscent therapy and with the sharing of literature.

The self-reporting by the participants together with the comparison of raw scores using the Beck table supports that the treatment had a positive effect. More study is needed with a larger sample to statistically support the effects of reminiscent therapy on depressed patients.

Summary

The participants in this study responded to the group sessions in an increasingly spontaneous manner. They all attended each session and appeared to anticipate the weekly meetings with enthusiasm. The clinical observations of the participants would indicate some positive benefits of reminiscent therapy. This is evidenced by the participants self-reporting on the benefits of the group sessions. However, statistical analysis revealed no significant differences between the pre and post therapy testing with the Beck Depression Inventory Scale. More study is needed to explore this further with a larger sample.

CHAPTER V

DISCUSSION, CONCLUSIONS, SUMMARY AND RECOMMENDATIONS

The study consisted of an esperimental group of five elderly males and a control group of five elderly males. Each group was given the Beck Depression Inventory Scale one week prior to therapy and one week following therapy.

Data was evaluated by comparing each group pre and post therapy using the Mann-Whitney U test. There were no significant differences between the two groups. The Sign Test was used to compare the individuals with the matched pairs. There were no significant differences between subjects in pre and post comparisons for the experimental and control groups. However, clinical evidence as revealed in the anecdotal notes was supportive of affective change and indicated that further research with a larger sample population may substantiate the hypothesis.

Discussion

The self-selection process used for this study implies a bias in terms of whether the most depressed residents actually volunteered for therapy sessions. The self-selection method may have yielded those residents who were moderately or minimally depressed or those residents who were not depressed. It is conceivable that those men who were most deeply depressed would avoid any attempts at activity and/or therapy.

Past data on the use of the Beck Depression Scale with depressed elderly patients is limited. Since the patient's cooperation and

comprehension of the items in the test are required for the appropriate application, this could cause limitation on the usefulness of the BDI with an elderly population. The element of cooperation is of primary importance because it is conceivable that elderly males would be reluctant to reveal their true feelings. The men in this age group are survivors of many social changes and pressures and tend to perceive themselves as strong individualists. An admission of sadness, a sense of failure or indecisiveness as indicated in the BDI could be different for someone in this age group. This is a possible explanation for those participants in the experimental group who tested out with increased depression following reminiscent therapy. That is, following eight weeks of group sessions it is possible that the level of trust that had been developed allowed a more accurate evaluation of his depression.

Cultural differences also play a role in the manner in which people respond to tests, especially a test which deals with feelings. The BDI has not been tested for reliability and validity among different cultural groups. The participant in the control group who scored 0 on the pre and post test was of Mexican-American descent. He was also a man who was socially withdrawn and stayed in his room most of the time. The validity of his scores were questionable. Speculation on this phenomena is that he was embarrassed to give sincere responses to the BDI. The concept of machismo may have inhibited his responses to the BDI, or he may not have trusted the investigator. It is also possible that the items on the BDI were not an accurate measure of depression for one from a Mexican-American culture. It is possible that depression may manifest itself with subtle differences in symptoms in other cultures.

The selection of reminiscent therapy as a group treatment modality for depressed elderly persons was a result of clinical experience in the use of individual therapy using reminiscence. The positive results of reminiscent therapy on individual depressed elderly clients made it a potential tool for group work with the same type of patients. However, considering the apathetic demeanor of the participants and the lack of stimuli in their environment, it is possible that any type of group activity might have carried a positive response. The act of coming together weekly, talking in a group, interacting with an interested therapist, having something to look forward to and having an opportunity to talk about oneself may have been enough to create an impact on the population. Another variable, the personality of the therapist, must also be considered. The participants were men with no close family bonds and the element of transference to the therapist is another variable worth consideration. Weekly visits by a warm, caring, female could provoke identification with mother, sister, daughter, wife or any number of significant females in their lives. One participant in the control group wished to be tested because his former wife was a nurse and he wished to be helpful to the nurse-investigator.

Reminiscent therapy has been used successfully by nurses as a treatment modality for elderly patients. This is well documented in the literature. Reminiscent therapy is a modality that lends itself to use by nursing personnel. It has been used to increase social interaction and social awareness by increasing ego integrity. Ego integrity is achieved by recapturing old self-esteem. Therefore, it is a potential tool in the treatment of depression. Many variables effect the treatment outcome in all forms of therapy, not just reminiscent therapy.

Conclusion

Clinical data suggested that depressed elderly males enjoy reminiscence and respond to the modality in a positive fashion. Affect, enthusiasm, and self-reporting evidenced this positive response.

Statistical data did not support the clinical observations. The lack of a statistically significant finding may be due to the small sample size or it may be due to the instrument used to measure depression.

The BDI has not been tested extensively with elderly populations and has not been tested for cross-cultural usage. There is evidence to support the conclusion that not all participants took the BDI test in a forthright manner.

Many variables effect the outcome of therapy and further research comparing reminiscent therapy to other modalities is indicated. Reminiscent therapy for depressed elderly patients also needs further study to establish it as a viable option in the treatment of depression for elderly patients.

Summary

The intent of this study was to document the effectiveness of a treatment modality for a depressed elderly male population, thus adding to the repertoire of nursing intervention techniques. Reminiscent therapy was the treatment modality selected for this study because the literature suggests that reviewing life events in terms of the individual's personality and life-style is a means of gaining ego integrity. It was hypothesized that depressed elderly male residents who participated in reminiscent therapy would evidence lower levels of depression then depressed elderly males who did not participate in reminiscent therapy.

Recommendations

In accordance with the conclusions, the researcher recommends that:

1. Further research is needed utilizing reminiscent therapy as a treatment modality for depressed elderly patients.
2. Research needs to be conducted with a larger sample population.
3. Reminiscent therapy is a modality in which nurses can participate in both groups as well as individual treatment as evidenced by the clinical data.
4. The reliability and validity of tools to measure depression must be determined for an elderly population.

APPENDIX A

SUBJECTS CONSENT FORM

Project Title: Effects of Reminiscent Therapy on an Elderly Male Population

I am being asked to participate as a member of a group led by a professional nurse and a caseworker from La Frontera Clinic, utilizing the technique of Reminiscent Therapy. The purpose of the project is to assess the effects of Reminiscent Therapy in the treatment of depression.

I have been asked to participate in the study because I am a resident of Marshall Home.

I will not receive remuneration for participating in the study. The benefits that I may derive from participation in the study include free professional assistance in a group situation, free evaluation of my perceived degree of depression, and referral to other health professionals if indicated in an assessment conducted by a nurse/investigator of the College of Nursing, University of Arizona.

The group sessions that I will participate in will occur every Monday at 10:00 a.m. for eight consecutive weeks. During that time I will be expected to interact with the co-therapists and group members and to complete a biography. I am also aware that I will be asked to complete a paper and pencil assignment tool before and after the eight weeks of group. I will be photographed, along with my fellow residents, in

candid shots at the Marshall Home. I understand that I will also be observed by the investigators during a meal before the group begins and at the end of the eight weeks.

I have been informed that there are no known physiological or psychological risks associated with these procedures. If in the opinion of the investigator I need more intensive treatment I will receive a referral to La Frontera Clinic. I understand that I am free to ask questions or to withdraw from this study at any time without evoking ill will. All data will be kept confidential and the results will be reported anonymously.

I am aware that data from this study will be used for a thesis and may appear in professional publications.

I understand that a copy of this consent form will be filed in an area (designated by the Human Subjects Committee) accessible to the primary investigator. A copy of this consent form is available to me upon request.

Subject's signature _____ Date_____

Witness's signature_____ Date_____

APPENDIX B

NAME_____ DATE _____

INSTRUCTIONS

ON THIS QUESTIONNAIRE ARE GROUPS OF STATEMENTS. PLEASE READ THE ENTIRE GROUP OF STATEMENTS OF EACH CATEGORY. THEN PICK OUT THE ONE STATEMENT IN THAT GROUP WHICH BEST DESCRIBES THE WAY YOU FEEL TODAY, THAT IS, RIGHT NOW! CIRCLE THE NUMBER BESIDE THE STATEMENT YOU HAVE CHOSEN. IF SEVERAL STATEMENTS IN THE GROUP SEEM TO APPLY EQUALLY WELL, CIRCLE EACH ONE. BE SURE TO READ ALL THE STATEMENTS IN EACH GROUP BEFORE MAKING YOUR CHOICE.

A. (SADNESS)

3 I AM SO SAD OR UNHAPPY THAT I CAN'T STAND IT.

2 I AM BLUE OR SAD ALL THE TIME AND I CAN'T SNAP OUT OF IT.

1 I FEEL SAD OR BLUE.

0 I DO NOT FEEL SAD.

B. (PESSIMISM)

3 I FEEL THAT THE FUTURE IS HOPELESS AND THAT THINGS CAN NOT IMPROVE.

2 I FEEL I HAVE NOTHING TO LOOK FORWARD TO.

1 I FEEL DISCOURAGED ABOUT THE FUTURE.

0 I AM NOT PARTICULARLY PESSIMISTIC OR DISCOURAGED ABOUT THE FUTURE.

C. (SENSE OF FAILURE)

3 I FEEL I AM A COMPLETE FAILURE AS A PERSON (PARENT, HUSBAND, WIFE).

2 AS I LOOK BACK ON MY LIFE, ALL I CAN SEE IS A LOT OF FAILURES.

1 I FEEL I HAVE FAILED MORE THAN THE AVERAGE PERSON.

0 I DO NOT FEEL LIKE A FAILURE.

D. (DISSATISFACTION)

3 I AM DISSATISFIED WITH EVERYTHING.

2 I DON'T GET SATISFACTION OUT OF ANYTHING ANYMORE.

1 I DON'T ENJOY THINGS THE WAY I USED TO.

0 I AM NOT PARTICULARLY DISSATISFIED.

E. (GUILT)

3 I FEEL AS THOUGH I AM VERY BAD OR WORTHLESS.

2 I FEEL QUITE GUILTY.

1 I FEEL BAD OR UNWORTHY A GOOD PART OF THE TIME.

0 I DON'T FEEL PARTICULARLY GUILTY.

F. (SELF-DISLIKE)

3 I HATE MYSELF.

2 I AM DISGUSTED WITH MYSELF.

1 I AM DISAPPOINTED IN MYSELF.

0 I DON'T FEEL DISAPPOINTED IN MYSELF.

G. (SELF-HARM)

3 I WOULD KILL MYSELF IF I HAD THE CHANCE.

2 I HAVE DEFINITE PLANS ABOUT COMMITTING SUICIDE

1 I FEEL I WOULD BE BETTER OFF DEAD

0 I DON'T HAVE ANY THOUGHTS OF HARMING MYSELF

H. (SOCIAL WITHDRAWAL)

3 I HAVE LOST ALL OF MY INTEREST IN OTHER PEOPLE AND DON'T CARE ABOUT THEM AT ALL.

2 I HAVE LOST MOST OF MY FEELING FOR OTHER PEOPLE AND HAVE LITTLE FEELING FOR THEM.

1 I AM LESS INTERESTED IN OTHER PEOPLE THAN I USED TO BE.

0 I HAVE NOT LOST INTEREST IN OTHER PEOPLE.

I. (INDECISIVENESS)

3 I CAN'T MAKE ANY DECISIONS AT ALL ANYMORE.

2 I HAVE GREAT DIFFICULTY IN MAKING DECISIONS.

1 I TRY TO PUT OFF MAKING DECISIONS.

0 I MAKE DECISIONS ABOUT AS WELL AS EVER.

J. (SELF-IMAGE CHANGE)

3 I FEEL THAT I AM UGLY OR REPULSIVE LOOKING.

2 I FEEL THAT THERE ARE PERMANENT CHANGES IN MY APPEARANCE AND THEY MAKE ME LOOK UNATTRACTIVE.

1 I AM WORRIED THAT I AM LOOKING OLD AND UNATTRACTIVE.

0 I DON'T FEEL THAT I LOOK ANY WORSE THAN I USED TO.

K. (WORK DIFFICULTY)

3 I CAN'T DO ANY WORK AT ALL.

2 I HAVE TO PUSH MYSELF VERY HARD TO DO ANYTHING.

1 IT TAKES EXTRA EFFORT TO GET STARTED AT DOING SOMETHING.

0 I CAN WORK ABOUT AS WELL AS BEFORE.

L. (FATIGABILITY)

3 I GET TOO TIRED TO DO ANYTHING.

2 I GET TIRED FROM DOING ANYTHING.

1 I GET TIRED MORE EASILY THAN I USED TO.

0 I DON'T GET ANY MORE TIRED THAN USUAL.

M. (ANOREXIA)

3 I HAVE NO APPETITE AT ALL ANYMORE.

2 MY APPETITE IS MUCH WORSE NOW.

1 MY APPETITE IS NOT AS GOOD AS IT USED TO BE.

0 MY APPETITE IS NO WORSE THAN USUAL.

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