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The Effects of Integrative Reminiscence on Depressive Symptoms in Older African Americans

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The purpose of this pilot study was to evaluate the effect of integrative reminiscence on depressive symptoms in older African Americans. Fifty-six community-dwelling participants from a northeast urban setting were randomized into a reminiscence intervention group ($n = 19$), attention control group (health education; $n = 19$), or true control group ($n = 18$). Data were collected pre- and posttest using the Center for Epidemiological Studies Depression Scale. Significant differences were found between groups, $F(2, 52) = 8.6, p = .001, \eta^2 = .10$. Using Holm's method of post hoc analysis, the mean score for the reminiscence group was 6.8 ($SD = 4.7$), significantly different from the control group 14.6 ($SD = 10.1$) and the health education group 11.7 ($SD = 7.1$). Findings demonstrate that integrative reminiscence has a positive effect on decreasing depressive symptoms in older African Americans.

Keywords: *reminiscence intervention; depressive symptoms; older African Americans*

Late-life depression is a public health problem in the United States with significant economic and health consequences. According to the National Institute of Mental Health (2003), an estimated 2 million of the 35 million older adults in America have a depressive illness and another

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5 million have subsyndromal or minor depression. Studies examining the impact of depression on health care costs found that depressed elderly patients have significantly higher health care costs than nondepressed elders regardless of chronic morbidity (Katon, Lin, Russo, & Unutzer, 2003).

The consequences of untreated depression in older adults include increased mortality, suicidal ideation, and decreased functional abilities and life satisfaction (Cook, Pearson, Thompson, Black, & Rabins, 2002; Frojdh, Hakansson, Karlsson, & Molarius, 2003). Although late-onset depression is a common illness among older adults, few receive adequate treatment. It has been shown that in older adults who died as a result of suicide, 40% visited a primary care physician within a week before their suicide (Conwell, 2001). According to the Surgeon General's 2001 Mental Health Report "Culture, Race and Ethnicity" (U.S. Department of Health and Human Services, 2001), the disparities affecting mental health care of minorities are the result of having less access to mental health services, receiving poorer quality of care, and an underrepresentation of minorities in mental health research. Specifically, African Americans are more likely to be underdiagnosed and undertreated for depression than other ethnic groups (Das, Olfson, McCurtis, & Weissman, 2006). With the increase in the older African American population and inequities surrounding depression research and treatment in this population, there is a critical need for the development and testing of culturally acceptable and cost-effective therapeutic interventions to decrease depressive symptoms. The purpose of this article is to describe a study that tested the effects of reminiscence on depressive symptoms and life satisfaction in older African Americans.

Depression Interventions and Minority Older Adults

Studies of brief therapies for depression have not included adequate samples of ethnic minority patients to evaluate their effectiveness (U.S. Department of Health and Human Services, 2001) on this minority group. Recent studies have shown that older African Americans are less likely to be identified as depressed (Gallo, Bogner, Morales, & Ford, 2005) and find counseling and antidepressant medication less acceptable than Whites (Cooper et al., 2003). In a comprehensive, systematic review of the literature to identify mechanisms of interventions to eliminate disparities in depressive disorders outcomes between non-Hispanic Whites and ethnic minorities, it was noted that socioculturally tailored prevention interventions may be more efficacious than standard depression treatment programs

(Van Voorhees, Walters, Prochaska, & Quinn, 2007). Cultural tailoring refers to matching intervention goals with the needs and sensitivities of the specific population. In this study, the reminiscence intervention matches the strong oral traditions of the African American culture while remaining sensitive to the stigma associated with depression among older African Americans (Shellman, Mokel, & Wright, 2007).

Reminiscence

Life review and reminiscence are often used interchangeably and may be misinterpreted. Life review is thought to be a universally, naturally occurring process that is systematic and more evaluative in nature (Butler, 1963, 1974). Life review is precipitated by the awareness of one's mortality or a major crisis such as a death of a loved one. Reminiscence is part of and can facilitate the life review. Researchers have described reminiscence as a rubric with several different functions and represents different reminiscence phenomena (Haight & Webster, 1995; Webster & Haight, 2002). For example, Watt and Wong (1991) identified a taxonomy of reminiscence that included six different types. Their taxonomy includes (a) integrative reminiscence, when there is acceptance of self and others and integration of the past and present; (b) instrumental reminiscence, defined as drawing from past experiences to solve present day problems; (c) transmissive reminiscence, similar to storytelling and oral history when there is a sharing of personal wisdom from one generation to another; (d) escapist reminiscence, referred to as defensive reminiscence, which occurs when one seeks comfort from people and events; (e) obsessive reminiscence, characterized by persistent rumination of unpleasant events often accompanied by feelings of guilt, shame, and resentment; and (f) narrative reminiscence, having more of a descriptive nature, consisting of the recounting of past events without interpretation or evaluation.

For the purpose of this study, reminiscence was defined as interpersonal and integrative (Watt & Wong, 1991) as older adults were encouraged to reflect on their past accomplishments, failures, and other experiences whereas the reminiscence facilitator probed and validated these experiences through active listening. Through integrative reminiscence, older adults may come to terms with unresolved conflicts, deal with losses, appreciate their accomplishments, and find meaning in significant past events that shape the present. Reminiscence may occur silently, but it is enhanced in the presence of a supportive listener who facilitates the process through questions and validations (Butler, 1963, 1974).

Conceptual Framework

The use of integrative reminiscence to decrease depressive symptoms is based on the theory of cognitive adaptation (O'Rourke, 2002). According to this theory, the way that people interpret their interpersonal relations and life experiences is significantly associated with wellness in later life. The key construct of the theory is "cognitive reconstruction." Individuals are helped to think differently about a phenomenon. Through integrative reminiscence there is reconstruction of negative thoughts, attitudes, and beliefs. The strategies that promote integrative reminiscence as an intervention to decrease depressive symptoms are (a) identifying and shifting depressogenic thinking, (b) generating alternative thinking about the past (reframing thinking), (c) identifying coping strategies, and (d) emphasizing competence (Cappeliez, 2007). These strategies, according to Cappeliez, result in cognitive reconstruction for the older adult and allow for new and positive ways of thinking about their lives.

There has been a strong link between integrative reminiscence and physical and mental well-being (Cappeliez & O'Rourke, 2006). Facilitating the integrative reminiscence process with an older adult through supportive listening and validating the older adult's life experiences, acknowledging past coping skills, and emphasizing accomplishments will assist the older adult to reframe his or her thinking. This process decreases feelings of regret, despair, and other negative thoughts that emerge as depressive symptoms in day-to-day life activities. In a review of the literature of the effects of reminiscence on depressive symptoms, Hsieh and Wang (2003) found inconclusive results because of small sample sizes, lack of a clear definition of reminiscence, and variations in treatment protocols. A meta-analysis of the effects of reminiscence on depressive symptoms conducted by Bohlmeijer, Smit, & Cuijpers (2007) found very few high-quality studies that met the criteria for inclusion in the meta-analysis. However, the few studies analyzed indicate reminiscence to be a potentially effective treatment to decrease depressive symptoms, especially in community-dwelling older adults. The authors recommend that the findings need to be confirmed by randomized control trials using rigorous designs and methods. More recently, a meta-analysis that examined the effects of behavioral interventions on depressed older adults found effect sizes were stronger for reminiscence than active control groups, psychoeducation, physical exercise, psychodynamic therapy, and supportive interventions (Pinquart, Duberstein, & Lyness, 2007).

Purpose

The primary purpose of this pilot study was to test the effects of a theory-based integrative reminiscence intervention on depressive symptoms in community-dwelling older adults. The research question addressed in this study was the following: Will there be differences in depressive symptoms after controlling for pretest scores between participants receiving the reminiscence intervention and those who did not receive the reminiscence intervention? It was hypothesized that there would be a statistically significant decrease in depressive symptoms in the reminiscence group as compared with the health education and control groups. The secondary purpose of this study was to test the feasibility of the reminiscence intervention study in an older African American adult population (Shellman et al., 2007; Shellman & Mokel, in press). The focus of this article is to describe the results of a pilot study that tested the effects of a reminiscence intervention on depression and life satisfaction in older African Americans.

Method

Design

A three-group pre-post-test experimental study design was employed. Participants were randomly assigned to an attention control group receiving health education, the treatment group receiving the reminiscence intervention, or the control group with no active intervention. The two control groups were offered the reminiscence intervention after the study was completed. Because this was the first control trial study of its kind, an unblinded trial approach was used. The outcome, depressive symptoms, was measured using the Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977) at three points in time: baseline, conclusion of the 8-week intervention, and 30 days later to assess for sustained effects of the intervention.

Sample

The convenience sample ($N = 56$) of American-born African American older adults included 43 females (77%) and 13 males (23%). The mean age of the group was 72.6 years ($SD = 8.6$). Fifty-four percent of the sample lived alone and 42% reported that they had graduated from high school.

Table 1
Sample of Reminiscence Questions^a

-
1. Let us begin with you describing your earliest memory. Describe what life was like for you when you were young.
 2. Describe your family, parents, and siblings as you saw them as a child.
 3. Was religion important to your family as you were growing up? If so, talk about how it was important. Has your faith been important to you over the years? In what way?
 4. Describe what it felt like the first time you rode in a car, a train, a plane.
 5. Did you have any special aspirations or dreams for your life when you were younger? Did they become true?
 6. Over the years you have seen many changes in the way people live. How do you feel about the changes? What do you like about the changes? What do you dislike about the changes?
 7. What change in your life brought about the most pleasure?
 8. Do you have any regrets about your life? Describe.
 9. What advice would you give to young people to help them enjoy life more?
 10. Describe your favorite memory.
-

a. This sample of questions does not include probing questions or validation responses.

Income ranged from 1,000 to 5,860 per month. The mean for number of years attending church was 53.3 ($SD = 21.9$). Recruitment took place in two senior centers and two churches in a northeast urban area.

According to Polit and Beck (2006), for a three-group test of one variable with one testing point, a sample size of 19 is needed to attain an effect size of .15 ($power = .80$). This is a repeated-measures design of two variables that decreases the sample size needed. Therefore, a conservative sample size of 18 per group was recruited for this pilot study.

Intervention group. Cognitive adaptation theory (O'Rourke, 2002) guided the interpersonal and integrative reminiscence intervention. Participants in the reminiscence group received 8 weeks of 45-minute once a week individual integrative reminiscence sessions held in a private room at the senior center or church. Reminder phone calls were made the day before the scheduled sessions. Sessions were held on the same day each week to facilitate adherence to the treatment. The research assistant facilitated integrative reminiscence using a questionnaire developed by the principal investigator (PI; see Table 1) based on the structured life review by Haight (1992) and the PI's own clinical experiences. The questions facilitated memories ranging from childhood, growing up in the South, holiday traditions, work, and family life. The participants shared experiences; the facilitator probed and validated these experiences through active listening

techniques with the goals of (1) identifying and shifting depressogenic thinking, (2) generating alternative thinking about the past (reframing thinking), (3) identifying coping strategies, and (4) emphasizing competence (Cappeliez, 2007). For example, if the older adult repeatedly reviewed negative experiences, the facilitator would assist the older adult to identify how he or she coped with each situation and emphasize positive thinking by highlighting the coping skills of the individual. In this example, the reminiscence facilitator assisted the older adult to shift his or her negative thinking by pointing out the strengths of the individual. The coping skills are identified and emphasized as positive attributes of the older adult to reframe his or her thinking in a more positive way.

Health education group. Participants in the health education group received 8 weeks of 45-minute once a week health education sessions. Topics included medication management, prevention of falls, nutrition, exercise, stress management, managing high blood pressure, diabetes education, and a topic of the participant's choice. Research assistants were trained to focus on health education and not encourage reminiscence during the sessions. Participants received handouts and brochures related to the topics. As in the reminiscence group, sessions were held at the senior center and churches, and reminder calls were made the day before the scheduled sessions to promote adherence. Health education sessions were taught by one research assistant or the PI, and sessions were held on different days to avoid contamination between groups. The health education group was implemented as attention control so that any differences in depressive symptoms posttreatment could reasonably be attributed to integrative reminiscence and not just the nurse–client interaction.

Control group. The participants in the control group received no active intervention for 8 weeks. Phone calls were made biweekly to keep in touch with the participants to remind them about the final data collection period. Reports kept by the data collector indicate that 3 participants dropped out of the study in the control group. The low attrition rate could be related to the consistent weekly visits to the sites by the research team in combination with reminder phone calls. All participants completing the study in the control group and health education group were offered the reminiscence intervention after Test 2. Six participants accepted and 18 declined citing not enough time as the reason for not participating in the additional reminiscence sessions. The 4 remaining participants either moved or were unavailable because they could not be located.

Instruments. For this study, each participant was asked to complete a demographic form and the CES-D. The demographic form included gender, age, living arrangements, marital status, income, and years of attending church and asked if the participants were taking antidepressants or had a diagnosis of depression. The CES-D was administered to assess the severity of depressive symptoms as reported by the participants. Response categories, ranging from 0 to 3, were “rarely or never,” “some of the time,” “occasionally,” or “mostly or always.” The CES-D is a 20-item, reliable and valid instrument (coefficient $\alpha > .85$) and test–retest correlation ($r > .5$) that has been used with diverse populations and has been found to be sensitive for detecting depressive symptoms among older African Americans (Baker, Velli, Freidman, & Wiley, 1995; Roberts, 1980). The alpha coefficients for the CES-D were .83 for Time 1 and .80 for Time 2. Both scores are above the recommended .70 (Devellis, 1991).

Procedure

Once approval for the study was obtained from the university’s internal review board, recruitment for African American research assistants began. African American research assistants were selected to collect the data and conduct the intervention because shared group membership has been described as a way of facilitating discussion and disclosure of sensitive topics (Jackson, 1991) and inclusion of researchers who belong to the ethnic group under study has the potential to reduce the threats to a valid research process (Porter & Villarruel, 1993). Research assistants were trained by the PI to administer forms, conduct culturally sensitive interviews, and maintain reflective journals. All research assistants participated in the protection of human subjects training required by the university. Training manuals that included assigned readings, self-study materials, and role-playing scenarios were developed for each specific role (data collector, reminiscence facilitator, or health educator). The four African American research assistants were assigned to one of the roles to avoid contamination during the research study.

The purpose and procedures of the study were explained to the participants prior to obtaining consent. The consent form was read to each participant and signed before data collection began. Once data had been collected for Time 1 (pretest), the participants were randomized to the reminiscence (experimental), attention control (health education), or control group. All participants received a \$25 gift card to the store of their choice for their time and effort to participate in the study.

Analysis

Descriptive statistics, frequencies, percentages, and univariate analyses were calculated to describe the characteristics of the study population. Data were plotted for normal distribution and outliers. After a preliminary review of data, scores obtained after Test 2 (30 days after Test 1) were dropped because of significant time variations in the required 30-day interval. A one-way between-group analysis of covariance was conducted to compare the effectiveness of the reminiscence intervention designed to decrease depressive symptoms as measured by the CES-D. Participants' scores on the pretest administration of the CES-D were used as the covariate in this analysis.

Tests for random assignment to a group were conducted comparing the three groups on differences for age and years of education. Preliminary analyses were conducted to ensure that there were no violations of the assumptions of normality, linearity, homogeneity of variances, homogeneity of regression slopes, and reliable measurement of the covariates. When reviewing the third test point data (data obtained after Test 2), it was noted that the variability in the 30-day data collection point was significantly different between groups. Subsequently, scores obtained after Test 2 scores were dropped from the analysis.

Results

Dependent Variable

Means and standard deviations for baseline, pretreatment, and post-treatment by randomization assignments for the CES-D are presented in Table 2. Preliminary analyses were conducted to ensure that there were no violations of the assumptions of normality, linearity, homogeneity of variances, homogeneity of regression slopes, and reliable measurement of the covariate.

Intervention Effects

The research question "Will there be differences in depressive symptoms after controlling for pretest scores between participants receiving the reminiscence intervention and those who did not receive the reminiscence intervention?" was answered using analysis of covariance. After adjustment for preintervention CES-D scores, there were significant differences

Table 2
CES-D Outcome Measure Means in the Reminiscence
Group, Health Education Group, and Control Group

	Baseline ^a CES-D		Posttest 1 CES-D	
	<i>x</i>	<i>SD</i>	<i>x</i>	<i>SD</i>
Control group (<i>n</i> = 18)	11.3	12.5	14.6	10.8
Reminiscence (<i>n</i> = 19)	9.9	5.3	6.8	4.7
Health education (<i>n</i> = 19)	11.5	8.2	11.7	7.1

Note: CES-D = Center for Epidemiological Studies Depression Scale.

a. Before adjustment of preintervention scores.

between groups on postintervention CES-D scores, $F(2, 52) = 8.6, p = .001$, partial $\eta^2 = .25$, and $\eta^2 = .10$. Post hoc comparisons using Holm's correction test indicated that the CES-D (depressive symptoms) mean score for the reminiscence group, $M = 6.8$ ($SD = 4.7$), was significantly different from the control group, $M = 14.6$ ($SD = 10.1$), and the health education group, $M = 11.7$ ($SD = 7.1$).

Discussion

This is the first reminiscence intervention study that targeted a community-dwelling older African American population using a three-group randomized control trial. In this study, older community-dwelling African Americans were randomly assigned to an integrative reminiscence group, attention control group receiving health education, or a true control group. After controlling for pretest differences, older African Americans receiving the integrative reminiscence intervention and those in the health education group reported fewer depressive symptoms than the true control group. However, group comparisons indicate that the reminiscence group was significantly different from both the health education and control groups. The effect size of .10 is small according to Cohen's (1988) criteria. This finding is similar to the meta-analysis findings of Pinquart et al. (2007) when examining studies with an active placebo. Overall, they found large effect sizes for cognitive behavioral therapy and reminiscence interventions for improvement of self-rated depression. However, in studies with an active placebo and of higher methodological quality, there were weaker improvements of depressive symptoms. In this study, the smaller effect size

may be attributed to the nonspecific treatment effects such as attention by the research assistant leading the health education on a weekly basis. For example, the research assistant noted that reminiscence occurred naturally during the health education sessions. Although reminiscence was not facilitated by the research assistant and the participant was directed back to the health education session, this could account for the smaller effect size found in this study.

In this sample ($N = 56$), the baseline CES-D scores of $M = 11.0$ ($SD = 9.0$) indicate self-reported depressive symptoms below the threshold of the traditional cut point of 16. However, in a study that was conducted by Hybels, Blazer, and Pieper (2001), it was found that depressive symptomatology below the threshold of the CES-D cut point of 16 was associated with impairments in functioning older adults. There is increasing evidence that many older adults do not meet the standard diagnostic criteria for depression, yet suffer from depressive symptoms that impair functioning and are associated with emotional suffering and greater cumulative functional morbidity (Blazer, 2003; Lyness et al., 2007). When depression symptomatology is viewed as a continuum, an episode of minor depression is often a precursor of major depression. Findings from this study indicate that integrative reminiscence is effective in decreasing minor depressive symptomatology not meeting diagnostic criteria. This has implications for prevention of minor and major depression in older African Americans and warrants further research. Reminiscence programs developed by nurses in senior centers and churches could be implemented with little cost and effort while decreasing depressive symptomatology and preventing major depression.

There are limitations to consider when reviewing the results of this study. First, findings may only be generalizable to older African Americans living in the community. The reminiscence intervention was highly tailored to cultural traditions of older African Americans born in the United States and, therefore, the results may not be generalizable to other African American subgroups. Second, difficulty with obtaining the 30-day follow-up posttest scores to measure sustained effect limits the ability of this study to determine the degree of the possible long-term effects of the intervention. Third, there were numerous challenges to implementing a mental health study with this population including recruitment and retention of participants, the stigma associated with depression, and the length of the intervention that may have affected the findings. These challenges with recommendations for future mental health research with older African Americans are described elsewhere (Shellman & Mokol, in press). Fourth, this preliminary study was an unblinded trial. The limitation to this kind of

trial is the possibility of bias. However, because this study was also a preliminary investigation to assess feasibility, it was important for the investigator to know which intervention the participants were assigned to monitor attrition and evaluate the intervention. Additionally, research assistants were trained specifically for data collection and were not involved in the delivery of the intervention to decrease the chance of biased data collection. Finally, the researchers initially intended to provide one-on-one health education sessions as the attention control group. As recruitment issues mounted, it became logistically impossible with regard to time to conduct the attention control group in this manner. Therefore, the decision was made to hold health education group sessions because the participants would be receiving a nurse–client interaction for the same amount of time as the reminiscence intervention group.

Although the challenges of conducting this study are described elsewhere (Shellman & Mokel, *in press*), their potential impact on the outcome of the dependent variable warrants discussion. The most critical challenges found while conducting this study were the level of mistrust between gatekeepers and universities and the stigma associated with depression in this population. These issues affected the length of time needed for recruitment for the study as well as the measurement of depressive symptoms. Recruitment for the study took more than 18 months because of hesitancy of participants to enroll in a depression study. The stigma associated with depression in this sample could have affected the initial reporting of depressive symptoms. For example, as seen in Table 1, CES-D means or depressive symptomatology in the control group increased with each testing point. One explanation for this finding is the development of trust between the research team and participants over time. The research assistants observed that participants appeared more comfortable reporting depressive symptoms with each time point. Additionally, the research assistant conducting the reminiscence sessions reported increased trust through the use of reminiscence. The issues of mistrust and resistance to participation in mental health studies have led this research team to conclude that creating a sustainable peer reminiscence intervention program would require a new approach centered on increased community participation. Peer-to-peer interventions have been shown to be effective approaches with African Americans in diabetes management (Samuel-Hodge et al., 2006), weight loss (Kennedy et al., 1998), and increased prostate cancer screening (Weinrich et al., 1998). Using a community-based approach could mitigate the factors that have resulted in reluctance among African Americans to participate in mental health research studies, such as mistrust of researchers

and stigma. Finally, there is a call for shifting the research focus from treatment to prevention of depression in older adults based on the Institute of Medicine Report on prevention of mental disorders (Pinquart et al., 2007; Whyte & Rovner, 2006). Findings from this reminiscence intervention study support this change in focus to decrease depressive symptoms in older African Americans. However, although these reminiscence findings are promising, further research is warranted. A peer-to-peer reminiscence intervention matches the strong oral traditions of the African American culture while remaining sensitive to the stigma associated with depression among older African Americans that this research team experienced. Based on the findings from this study, the next step of this reminiscence research program is to conduct a larger randomized, double-blinded control trial to test the effects of a community-developed peer reminiscence program to decrease depressive symptoms in older African Americans.

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