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Guided Life Review: A Social Work Intervention in Geriatric Depression

by

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A Practicum Report
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

Master of Social Work

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba

ISBN 0-612-13366-4

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GUIDED LIFE REVIEW:

A SOCIAL WORK INTERVENTION IN GERIATRIC DEPRESSION

BY

ROBERT S. MCVETY

A Thesis/Practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

MASTER OF SOCIAL WORK

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ABSTRACT

Geriatric depression was the target problem addressed by this social work practicum. A small number of depressed senior persons, all out-patients of Deer lodge Centre, Winnipeg, were guided through a private, individualised review of their lives. The life review conversations explored each participant's memories, life experiences, milestones and values. The discussions with each person focused on the eight developmental tasks identified by the life-stage theorist, Erik Erikson.

The practicum afforded the student an opportunity to use guided life review as a therapeutic intervention. At the same time, the student was able to observe the unfolding of the life review process first described by Robert Butler in 1963.

The practicum demonstrates that life review therapy is a workable, labour-intensive intervention which can be used by social workers. The results of the practicum further suggest that guided life review may be particularly useful in cases of long-lasting depression where senior individuals demonstrate that they are troubled by unresolved issues from the past.

ACKNOWLEDGEMENTS

Academic tradition does not allow students to produce a thesis or practicum report without the help of other people. The final document submitted to the university represents contributions of time, expertise and encouragement from a number of individuals. I should like to acknowledge the support which I have received in preparing this report.

My first words of thanks must go to the Participants in my study. By admitting me to their homes and lives, these people made my work possible. The Administration of Deer Lodge Centre was generous in allowing me to conduct my practicum under the auspices of that institution. The Treatment Outreach Team at Deer Lodge suggested the names of people who might take part in my study. Members of the Team showed collegial interest in my work. I appreciate their support.

I owe a particular debt of gratitude to the three people who served as members of my Practicum Committee. Geri McGrath, the Director of Psychogeriatric Services at Deer Lodge Centre, has given many hours to chairing the Practicum Committee and to supervising my work. Geri's attention to detail, her good humour and her communication and supervisory skills helped to make my practicum experience rewarding and pleasant.

Dr. Lorna Guse enriched me both as my teacher and as External Examiner for the practicum. I have benefited from Lorna's careful reading of the manuscript and her knowledge of aging issues from a Nursing perspective.

The third member of the committee, Dr. Atsuko Matsuoka, contributed to my understanding of social work through her skill and dedication as my teacher. When I first began to think about a practicum topic, Atsuko offered numerous helpful suggestions. After she moved to York University, Atsuko graciously made arrangements to continue as a long-distance member of my committee.

The three individuals to whom I have just referred were my first choices for a practicum committee. To my delight, all of them agreed to take part. From the beginning, Geri, Lorna and Atsuko have been patient with the delays which have resulted from my uncertain health. I can not forget the genuine encouragement that each, in her own way, has offered me.

I also wish to thank Mayer Pallow, my case worker at the Society for Manitobans with Disabilities. Throughout my studies, Mayer has provided practical help and shown interest in my progress. I appreciate, too, the assistance received from Disability Services and the Parking Office at the University of Manitoba.

Finally, I should like to thank my mother, my brother, my sister as well as my friends, Andrea and Terry, for helping me to believe that a mid-life career change was possible. Left to myself, I might have given up this project long ago.

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INTRODUCTION

This practicum report describes an intervention undertaken by a student as part of his Master of Social Work studies at the University of Manitoba. The student identified depression in seniors as the target problem of his study. With the guidance of his Practicum Committee, the student designed the intervention described in this report.

Ageist stereotypes suggest that being old means being sad and depressed. Research in aging matters continues to challenge this assumption. Nevertheless, depression is a reality and a presenting problem for certain older individuals. Those who work with the elderly continue to seek understanding of the phenomenon of geriatric depression. Since medication is not effective in some cases of depression, care-providers keep searching for other effective ways to respond to the distress of their depressed clients.

The services of social workers are rarely required by healthy community-dwelling elders, among whom the incidence of depression is low. Rather, it is in institutional settings that geriatric social workers tend to encounter depression as a presenting problem. Higher levels of depression are found among out-patients who have had a history of emotional difficulties and in long-term residents of hospitals and personal care homes.

In reviewing the literature of geriatric depression, the student discovered the concept of *life review* introduced by Butler (1963). The student noted suggestions in the literature which proposed that life review therapy may be an effective intervention for some depressed senior persons.

The student developed a hypothesis which might be stated as follows: if carefully selected depressed individuals are led through an individualised review of their lives, these persons may experience some change in their levels of depression. Accordingly, the student designed, implemented and evaluated an intervention to test his hypothesis.

The findings of the practicum suggest that guided life review, a drug-free intervention, can serve as an adjunct to other interventions which a depressed senior may receive. Social workers can perhaps

include life review work in their care plans more easily than those helping professionals whose time is taken up with attending to the medical and physical needs of the elderly.

This report summarises the literature which the student reviewed. The design, implementation, and results of the intervention are presented. The report concludes with the student's comments about his learning in the practicum. As well, the practical details of life review therapy are examined and suggestions for further research are made.

In essence, the student's findings indicate that guided life review is a relatively safe intervention. Seniors invited to review their lives seem to understand what they are being asked to do. If life review therapy is sensitively done, it may allow care providers access to the core values and formative experiences of individual elders. With this information, social workers and other helping professionals may be better able to deliver appropriate services to their senior clients.

CHAPTER ONE

LEARNING OBJECTIVES

In completing his Master of Social Work practicum, the student's overall aim was to prepare himself for employment as a geriatric social worker. He imagined himself finding work in a large institution, perhaps a hospital or long-term care facility. His particular interest was to develop skills as a counsellor. With these goals in mind the student designed a practicum to help prepare him for employment. He chose geriatric depression as a target problem and guided life review as his intervention.

This chapter presents the specific learning objectives which the student identified.

1.1 To acquire a working knowledge of the literature of life review and reminiscence

After preliminary reading about life review, the student understood that his first task was to define "life review" and "reminiscence". These two terms are frequently interchanged (and sometimes confused) in the literature. Having developed his own working definitions, the student could then search the literature for material relevant to his intervention.

1.2 To gain an overview of the current literature of geriatric depression

The student wanted to increase his understanding of the world in which seniors live, and of the issues which they face. Moreover, the student was seeking to understand the factors most likely to contribute to the onset of depression in older people. A key question was: What symptoms does a depressed elder present?

1.3 To acquire a working knowledge of the theoretical background and practical applications of the inventory of life strengths developed by Kivnick (1991)

Questions from this inventory were used to structure the life review process with each individual who received the student's intervention. Kivnick (1991) developed the inventory or discussion guide to assist professionals in designing informed, sensitive care-plans attuned to the specific needs and desires of individual elders. The student wanted to assess how useful Kivnick's questions might be in guiding an older person through a review of his or her life.

1.4. To gain both theoretical knowledge of, and practical experience in using qualitative research

In reflecting on the anticipated content of the individuals' review of their lives, the student expected to encounter subjective, highly personal material. The memories of each individual life could not be assessed by any available, standard measure. Thus the challenge faced by the student was to learn how qualitative research methods might inform his study. At the same time, the student hoped to understand how he could combine qualitative methods with quantitative methods.

In a preliminary examination of the literature of qualitative research, the student encountered the work of feminist researchers. The student determined that basing his practicum on feminist research principles would be of both personal and professional value.

1.5 To gain practical experience in using life review therapy as a social work intervention in geriatric depression

In choosing the form of his intervention the student went through a number of intellectual steps. His course work in the area of aging had suggested that geriatric depression was a problem which he, as a social-worker-to-be, could expect to encounter frequently. As he examined the literature, the student had an intuitive sense of the potential usefulness of life review methods. As well, the student was intrigued by

the concept of life stages as described by Erikson (1980/1950). The student's interest in Erikson's work led to discovery of a discussion guide by Kivnick (1991). Since this guide is based on Erikson's concept of the life cycle, the student began to ask how, in practical terms, the questions in the discussion guide might provide an outline for life review conversations with depressed seniors.

1.6 To evaluate the effectiveness of guided life review therapy as a social work intervention in response to geriatric depression, and thereby to contribute to the development of social work knowledge

As described above, the student developed an intellectual interest in life review therapy. In reviewing the literature, the student found that social work has not yet made widespread use of life review methods. An important objective of this practicum was, therefore, to see how theoretical knowledge developed chiefly in other disciplines might be transposed into practical and effective social work practice.

1.7 To acquire experience in working as a geriatric social worker

The student wanted to learn about working with geriatric social workers and mental health professionals in a large institutional setting. An objective of this practicum was to begin to answer questions such as these: a) What are the responsibilities and roles of a professional social worker? b) What is the particular contribution made by social work in the provision of service to clients in a large geriatric care institution?

CHAPTER TWO

THE LITERATURE OF DEPRESSION

In order to understand the phenomenon of depression, the student began a review of the relevant literature. Since his intervention was directed toward depressed older people, the student focused his literature review on the symptoms and epidemiology of geriatric depression. Because social work tries to take a systems approach to human problems, the student looked for information about environmental factors which might contribute to the onset of depression. In his search, the student examined what the literature had to say about the origin of depression, and about the use of classification systems.

This chapter presents the results of the student's review of the literature of depression.

2.1.0 Symptoms of depression

The phenomenon of depression has been observed since at least the time of Hippocrates (c. 460-357 BCE). Hippocrates mentions an affective illness called "melancholia" from the Greek roots *melan* [black] and *chole* [bile] (Stenback, 1980). Simply put, depressed people were believed to be suffering from an excess of black bile.

In more recent times, the language of depression has taken on both clinical and popular meanings. In everyday conversation people may say they are "depressed." This self-description may refer to any number of transient emotions including sadness, unhappiness, loneliness or discouragement.

More precise content for the term "depression" is required. A review of the literature indicates that many writers have tried to say what depression is. Beck (1967), for instance, presents a general discussion of the phenomenon of depression. From a study of 966 psychiatric people, Beck has described the symptoms of depression under four headings: a) emotional; b) cognitive; c) motivational; d) and vegetative.

Although Beck's description of depression is certainly not the most recent source available, his work provides a useful overview of depressive symptoms. The accessibility of Beck's discussion made

his work extremely useful for the purposes of this practicum. The main points of Beck's discussion are therefore presented below.

2.2.0 Emotional manifestations of depression

Beck (1967) included several symptoms under the heading of emotional manifestations. Depressed people may speak of having a lump in the throat, a heaviness in the chest, or an empty feeling in the stomach. People may experience fluctuating times of sadness which become progressively more fixed as the depression grows more severe. As depression worsens, people may complain that they are less and less able to "snap out of it." Positive outside stimuli such as jokes or compliments make little or no impact on their unhappy mood. The table below presents a summary of Beck's description of emotional symptoms in depression.

Table 2.1

Summary of emotional manifestations of depression from Beck (1967)

EMOTIONAL MANIFESTATION	MODERATE	SEVERE
1) Negative feelings about oneself	People may believe they have failed themselves or disappointed others. People may express strong disgust at their perceived inadequacies.	People may describe themselves as "terrible" or "despicable" or "not fit to live."
2) Loss of gratification (anhedonia)	People lose pleasure in ordinary activities such as eating or sex or interacting with loved ones.	People receive no pleasure from anything at all.
3) Loss of emotional attachment	People cease to feel attachment for people and activities they once valued highly.	People may speak of hating loved ones.
4) Crying spells	People may cry easily and uncharacteristically.	Some people may find themselves unable to cry, even when they believe crying might help them.
5) Loss of mirth response	People may be increasingly unmoved by humour. They may respond to attempts at levity with hurt or disgust.	

2.3.0 Cognitive manifestations of depression

Beck's (1967) description of how depression can affect cognitive processes is summarised in the following table. [Please note, also, that a later work by Beck et al. (1979) on the cognitive model of depression is described in section 2.11.0 of this chapter.]

Table 2.2

Summary of cognitive manifestations of depression from Beck (1967)

COGNITIVE MANIFESTATION	COMMENT
1) Low self-evaluation	People may dismiss their personal strengths and positive qualities to dwell on inadequacies and sins. They may become convinced that they are burden to others. They may believe they are impoverished or complete moral failures.
2) Negative expectations	People may believe the future is completely hopeless. They may hold no hope of improvement. Note: Melges and Bowlby (1969) suggested that depression develops in certain people as a result of their inability to let go of plans they had for their life. Such people blame themselves even if circumstances beyond their control thwarted their dreams.
3) Self-blame and self-criticism	Depressed people may exhibit what Beck (1967) called "egocentric notions of causality" (p. 24). That is, people assign blame to themselves without reference to objective facts. Everything is their fault.
4) Indecisiveness	Decision-making is difficult for depressed people. They expect to make wrong decisions. Lack of motivation causes them to postpone making decisions. In severe cases, even the simplest everyday decision (such as what clothes to wear) becomes difficult.
5) Distortion of body image.	Depressed people may become deeply preoccupied with what they consider the negative aspects of their physical appearance. They may imagine they have gained or lost weight. They may persuade themselves that they are physically disfigured.

2.4.0 Motivational manifestations of depression

Beck (1967) described how depression may affect a person's ability to interact with the environment and to undertake activity. The motivational manifestations identified by Beck are summarised in the following table.

Table 2.3

Summary of motivational manifestations of depression from Beck (1967)

MOTIVATIONAL MANIFESTATIONS	COMMENT
1) Paralysis of will	Depressed people may lose any inner drive to act. Spontaneity disappears. Routine activities become difficult. People may become immobile and cease to speak.
2) Avoidance, escapist and withdrawal wishes	Depressed people begin to avoid taxing or uninteresting activities. They may become preoccupied with thoughts of escape. They may wish to withdraw from human contact. Suicide is possible. (Please see section 2.5.0 below.)
3) Increased dependency	As some people become depressed they surrender their normal independence. They express an anxious desire for help, support and guidance from others.

2.5.0 Suicide among the elderly

As already indicated, depressed people may wish to withdraw from life and human contact. The ultimate expression of this desire is suicide. Citing Stenback (1980), Belsky (1984) noted that when depression is broadly defined, nearly 100% of suicides among elders have been preceded by depressive symptoms.

Beck (1967) found a high correlation between the intensity of people's desire to kill themselves and the severity of depressive illness. Mildly depressed people may say that they would be better off dead; or that they do not care whether they live or die. Yet those who are mildly depressed are not likely to do anything to hasten death. With deeper depression, however, the wish for death may become more compelling. Some individuals may then be prone to impulsive or premeditated suicide. Those persons "at risk" for suicide may engage in dangerous behaviours such as reckless driving.

2.5.1 Prevalence of suicide among older people

Although it ranks as the ninth or tenth cause of death among older people in most western countries, suicide nevertheless appears to be a serious problem (in both relative and absolute terms) for older people (de Leo & Diekstra, 1990).

Based on examination of data collected by the World Health Organization from 1960-1985, de Leo and Diekstra (1990) found a general trend toward increased suicide rates with increasing age, especially among older males. The following two tables summarise Canadian statistics drawn from a presentation of international geriatric suicide statistics by these researchers.

Table 2.4

Comparison of suicide rates among Canadian males and females, aged 70-74

from de Leo and Diekstra (1990)

YEAR	GENDER	AGE RANGE	SUICIDE RATE
1960	males	70-74	26.5/100,000 population
1985	males	70-74	31.7/100,000 population
1960	females	70-74	7.6/100,000 population
1985	females	70-74	7.6/100,000 population

Table 2.5

Comparison of suicide rates among Canadian males and females, aged 80-84

from de Leo and Diekstra (1990)

YEAR	GENDER	AGE RANGE	SUICIDE RATE
1960	males	80-84	11.0/100,000 population
1985	males	80-84	34.8/100,000 population
1960	females	80-84	6.9/100,000 population
1985	females	80-84	5.1/100,000 population

2.5.2 Characteristics of suicide among elders

From their survey of the literature of elderly suicide, de Leo and Diekstra (1990) described some of the main characteristics of suicide among older persons. First, these suicide attempts are generally serious. Most so-called "attempted" suicides should probably be seen as "failed" suicides, thwarted by circumstances unforeseen by those who were attempting to kill themselves. Second, elders may tend to select "harder" methods of suicide such as drowning, hanging, and serious self-inflicted wounds. Other means of suicide include stepping in front of moving vehicles, taking poison and inhaling car exhaust

fumes. Another method of suicide, harder to document, but still important among elders is "suicidal erosion." This term describes intentional self-neglect in not eating food, or not taking necessary medications (de Leo & Diekstra, 1990).

As well, de Leo and Diekstra (1990) note that the literature suggests that older people are less likely to tell others of their suicidal intentions. In attempting suicide elders appear to be less motivated than younger people by any desire to get others to notice their emotional distress, or to offer assistance. Frequently, also, elderly suicides tend to occur in situations where there is less chance of interruptions by outsiders.

2.5.3 Gender differences in older suicides

The literature indicates that there gender differences in geriatric suicide. In a study of 154 suicides in Albertans (aged 60 or over) from 1968-1973, Jarvis and Boldt (1980) found that physical illness led to suicide in elderly men more often than in elderly women. Older women who committed suicide were more likely to have had a mental disorder. The researchers also noted 64% of the older men shot themselves, whereas 46% of the older women hung themselves.

From a review of the literature Belsky (1984) noted that successful elderly male suicides tend to use violent methods such as jumping and shooting while completed female elderly suicides tend to involve passive methods such as taking pills.

The high suicide rate among older men is frequently mentioned in the literature. In the United States, the National Center for Health Statistics (1987) reported that white males over seventy-five have the highest suicide rate of any population group. Among elders 65-70 men are five times more likely than women to commit suicide. By age 85, men are ten times more likely than women to kill themselves.

Commenting on the high rate of suicide among elderly white men, Belsky (1984) noted some speculations from the literature. Perhaps older white males are more likely to kill themselves because the reversals of old age are harder for this group to accept. As white males they have been accustomed to being at the top of the social ladder in a way white females and black men have not. Another speculation is that older men are more vulnerable to social isolation, especially after the death of a spouse or partner, since these men are less likely than women the same age to have close relationships apart from marriage

or its equivalent. A third speculation is that since men tend to use more violent methods of suicide than women, older men's deaths are recorded as suicides while the deaths of some older women (from drug overdoses, for example) are recorded as accidents.

2.6.0 Vegetative manifestations of depression

The fourth and last general heading under which Beck (1967) discussed the manifestations of depression is vegetative manifestations. These manifestations are summarised in the following table.

Table 2.6

Summary of vegetative manifestations of depression from Beck (1967)

VEGETATIVE MANIFESTATION	COMMENT
1) Loss of appetite	Depressed people may lose all interest in eating. Their weight may decrease noticeably. Some people may have to be forced to eat.
2) Sleep disturbances	People may report disordered sleep patterns. Problems can include difficulty falling asleep or staying asleep; waking too early; waking without feeling rested; and not being able to stop thinking when one tries to sleep.
3) Loss of libido or sexual interest	Depressed people may become unresponsive to sexual stimuli. Severely depressed people may develop an aversion to sex.
4) Fatigue	Beck (1967) used the term "fatigibility". People may complain of being tired all the time. They may not have energy for common tasks.

2.7.0 Physical and behavioural characteristics of depressed individuals

Based on his clinical experience, Beck (1967) suggested that most depressed people have a characteristic physical appearance, sometimes with characteristic behaviours. The following table summarises his comments.

Table 2.7

Summary of physical and behavioural characteristics of depressed individuals

from Beck (1967)

PHYSICAL CHARACTERISTIC	COMMENT
1) Gloomy, sad expression	Note: People with a "smiling depression" may try to maintain a cheerful façade. They may offer a mirthless smile in response to humour.
2) Stooped posture	
3) Slow, deliberate movements	
4) Slow speech	Some depressed speak little or not at all. Others start sentences which they do not finish.
5) Psychomotor retardation	Beck's term is "stupor." People may be virtually motionless whether standing , sitting or lying down. In extreme cases, people may drool because they virtually stop swallowing. Others may develop eye problems because they blink so rarely. Serious constipation is also possible.
6) Agitation	People may be extremely restless. They may wring their hands, and clench and unclench their fingers. Some pick at their clothing or skin. Some may wail, scream or groan.

2.8.0 Epidemiology of depression

Koenig and Blazer (1992) examined the prevalence of depression and depressive symptoms among three groups of elders: a) those who live in the community; b) those who are medically ill, both out-patients and in-patients; and c) those who are institutionalised. These researchers challenged the common assumption that depression occurs more often among older people than in any other age group.

2.8.1 Depression among elders who live in the community

Commenting on their examination of various epidemiologic studies of depression among community-dwelling elders, Koenig and Blazer (1992) argued that the impact of aging on mood may have been overestimated--even when allowing for the impact of adversity faced by many older people and for the effects of brain diseases. These researchers argued that the incidence of major depressive disorder is less commonly found in the current generation of both community-dwelling and hospitalised senior adults than in equivalent samples of younger persons.

Koenig and Blazer advanced various explanations to account for the lower-than-expected rates of depression among today's elderly. First, methodological or sampling errors might be a possible explanation. Koenig and Blazer proposed cohort effect as a second explanation. A cohort effect might suggest that for some as yet unknown reason, people born prior to 1920 are psychologically healthier. A third explanation might be that the findings represent a period effect . That is, most people over 65 have experienced the difficulties of life during the Great Depression and World War II. Since the end of that war, the economic quality of life for most of this cohort has improved. Most members of the younger baby-boomer cohort, by contrast, has never known "what it is to do without." In the current economic hard times, these younger people are facing competition for jobs and resources. As a result of their struggle to maintain the standard of living to which they have always been accustomed, some of the baby-boom generation may be growing depressed.

However, the argument by Koenig and Blazer (1992) for lower-than-expected rates of depression does not mention the issue of ageism in society. Possibly older people are embarrassed to admit to being depressed, since they believe that disclosing emotional distress may be a sign of "going crazy." Elders may have been persuaded that depression is an inevitable, yet unacceptable or shameful part of growing older. Not daring to "complain" (even when they feel depressed), distressed older people may never receive a diagnosis of depression.

Professional caregivers may also under-report the incidence of geriatric depression through a failure to take seriously the somatic symptoms depression in older people. Ageist assumptions may lead these professionals to regard any physical complaints of the elderly as an unavoidable aspect of old age.

Koenig and Blazer reviewed 17 studies of the prevalence of depression in elders who reside in the community. The studies, completed between 1980 and 1991, included samples from the United States, South Africa, England, Finland and Singapore. The review suggested that, at any time, about 15% of older people in the community may be experiencing some form of depression. Callahan et al. (1994) screened 3767 people, 60 years or older, who visited primary care medical practices in Indiana between January 1991 and May 1993. This study found that 612 people (16.2%) exceeded the threshold for depression with scores of 16 or more on the Centers for Epidemiologic Studies depression scale.

From their survey of current literature, Koenig and Blazer (1992) made observations about the incidence of major depression and dysthymia. The Diagnostic and Statistical Manual of Mental Disorders (4th edition) or DSM-IV (American Psychiatric Association, 1994) describes major depression as an mood disorder lasting at least two weeks in which there is either a) a depressed mood or b) a loss of interest and pleasure in nearly all activities. Four of the following symptoms must be present: a) changes in weight, appetite, sleeping patterns or psychomotor activity; b) decreased energy; c) feelings of guilt or worthlessness; d) difficulties in concentration or thinking (or memory among the elderly); recurrent thoughts of death or suicide. The symptoms must be newly present and clearly worse when compared with the person's pre-episode mood. The symptoms must be present most of the day, almost every day for at least two weeks.

The DSM-IV (American Psychiatric Association, 1994) describes dysthymia as a chronically depressed mood that endures most of the day, nearly every day, for at least two years, during which time there are no symptom-free periods of more than two months' duration. At least two of the following symptoms must be present: a) over-eating or poor appetite; b) inability to sleep, or sleeping too much; c) fatigue; d) low self-esteem; e) difficulty in making decisions or concentrating; f) hopelessness.

Koenig and Blazer (1992) found that both major depression and dysthymia appear twice as often in older women as in older men. However, this divergence narrows with advancing age in both sexes. Koenig and Blazer also noted that depression appears to be more common among elders with less education and lower incomes. Whether people live alone or with others; and whether people reside in rural or urban areas do not appear to affect rates of depression. However those who are separated or divorced are more likely than those who are married to be depressed.

2.8.2 Depression among elderly medical patients

In an examination of nine American studies (1982-1990) of medically-ill, older out-patients, Koenig and Blazer (1992) reported that rates of depression vary widely from 7%-36%, On average, this rate of depression is estimated to be 5% higher than the levels of depression found in elders who reside in the community.

Koenig and Blazer also reviewed 16 studies (done in the United States, England and Ireland from 1974-1991) of elderly, medically-ill hospital patients. Taken together, these studies suggest that about 40% of older hospital patients experience some form of depression. About 10% of this population may have clinically significant depression.

NOTE: Clinically significant depression "is one in which (1) the survival of the person is jeopardized (in terms of personal suffering, social disability, or suicidal risk), and (2) the depression becomes self-perpetuating or autonomous and no longer under control of the individual" (Koenig and Blazer, 1992, p. 236).

To be considered "clinically significant" the depressed mood must significantly impair an individual's social or occupational functioning. In extreme cases of clinically significant depression the individual may be unable clothe or feed himself or herself. As well, the person may not be able to maintain personal hygiene.

Koenig and Blazer noted that high rates of depression may be especially associated with neurologic disorders, endocrinologic and metabolic disorders, myocardial infarction, malignancy, and chronic obstructive pulmonary disease. However, these researchers argued that the experience of functional disability which result from these various conditions needs to be considered. Perhaps the *negative impact of changes* brought by illnesses are more important than the actual conditions themselves in triggering depression.

2.8.3 Depression among institutionalised elders

Koenig and Blazer (1992) examined depression rates indicated by 11 studies (1976-1991) of long-term nursing home residents. Here major depression was found in 12-16% of people, and other depressive disorders in 30 - 35% of the residents. The researchers specified that the term other depressive disorders included "dysthymia, adjustment disorder, organic mood syndrome and depressive disorder not otherwise specified" (Koenig and Blazer, 1992, p. 236).

2.9.0 Changing life functions and the onset of depression

Even a superficial examination of the literature of geriatric depression indicates that a variety of factors--biological, psychological and environmental--may predispose some older people to depression. Various writers structure their discussion of the antecedents of depressions according to any number of conceptual frameworks.

Zung (1980), for example, asserts that the way can be prepared for geriatric depression through changes in the basic functions of life. These functions are a) behaviour; b) growth; c) metabolism; d) reproduction; e) movement; f) responsiveness; and g) adaptation. Human life grows out of the constant interplay of these seven functions as they move through development, maturity of function and finally, decline. Thus, the human organism is in flux from the point of conception until the moment of death.

The following table summarises the presentation by Zung with some supplementary material from other sources.

Table 2.8

The impact of changing life functions on the development of geriatric depression

NOTE: All material is taken from Zung (1980) unless otherwise stated.

BASIC LIFE FUNCTION	CHANGES OVER TIME	COMMENTS
1) Behaviour	Children experience an inner propulsion to master a wide variety of skills. With age, people do not have the same drive to acquire new skills. If people learn new behaviours in maturity, they usually do so partly by choice.	The unwillingness or inability to keep learning new skills may predispose some people to depression.
2) Growth and metabolism	Human metabolism changes across the life cycle.	The metabolising action of the enzyme monoamine oxidase (MAO) appears to accelerate at about age 45. Increased levels of MAO may lower amounts of the biogenic amines which regulate various bodily processes. Decreased amounts of the amine, norepinephrine (NE), may lead to mood disorders. Monoamine oxidase inhibitors (MAOIs) have been developed by pharmacologists. MAOIs function as anti-depressants by helping to maintain NE levels necessary for the regulation of mood.
3) Physiological capacity	Rowe (1977,1985) argued that as humans age, their capacity to re-establish biological homeostasis is compromised. Neural conduction, immune responses, metabolic rate, cardiac output, plasma flow, filtration and lung capacity all decline. Thus the aging body is less able to recover from traumas induced by surgery, illness, burns and intensive courses of medication (Rowe, 1985; Feller et al., 1976).	The decreased capacity of the body to respond to various changes and assaults may predispose some individuals to depression.

Table 2.8 (continued)

The impact of changing life functions on the development of geriatric depression

NOTE: All material is taken from Zung (1980) unless otherwise stated.

BASIC LIFE FUNCTION	CHANGES OVER TIME	COMMENTS
4) Sexuality and Reproduction	Some people may no longer have a sexual partner available because of illness, death or divorce. Colostomies (both sexes),untreated vaginitis (females) and prostate problems (males) can be impediments to intercourse (Butler and Lewis, 1977) People may not have important sexual information available. They may be inhibited from sexual activity by fear of "overdoing it." They may assume that a prostatectomy or orchidectomy means the end of their sexual activity (Butler and Lewis, 1977).	Sviland (1978) suggested that not feeling that one is sexually desired can contribute to depression in people of any age. Weg (1987) discussed the impact of sexual stereotypes on the aging woman. Older women have usually been socialised to feel that they are not desirable when they cease to be young and fertile. Weg argued that an emphasis on orgasm has led to the undervaluing of other kinds of intimacy.
5) Movement	Deterioration of muscles and joints can mean less flexibility and mobility for some people.	People may have to curtail pleasurable activities such as exercise, shopping and socialising. Such changes may be related to the onset of depression in some individuals. Butler and Lewis discussed the phenomenon of "body-monitoring" (1977) in which people, fearing injury, give more thought than before to routine activities such as walking.
		Williamson and Schulz (1992) studied the association between chronic pain and depression in older community-dwelling adults. This study suggested that the perception of being disabled contributes as much to depression as does the actual pain and discomfort.

Table 2.8 (continued)

The impact of changing life functions on the development of geriatric depression

NOTE: All material is taken from Zung (1980) unless otherwise stated.

BASIC LIFE FUNCTION	CHANGES OVER TIME	COMMENTS
6) Responsiveness	Age-related impairment of hearing and vision may make people less able to cope with their environment.	That hearing tends to decline with age appears well-documented (Corso, 1981).Researchers have noted a marked association between hearing loss and depression (National council on Aging, 1975). Although hearing loss can produce greater social isolation than blindness, changes in vision nevertheless cause real adjustment problems (Butler and Lewis, 1977). Vision problems limit people's ability to drive, to orient themselves and to move about independently. Any kind of sensory deficit makes people feel more vulnerable to crime and violence. The perceived loss of safety and independence may be related to depression in some people.
7) Adaptation to loss	Zung (1980) argued that successful psychosocial aging involves an on-going acceptance of loss and separation as a part of life.	Those who can not accept the inevitability of loss may behave in anti-social ways such as irritation, mistrust, intolerance and rigid behaviour.
8) Heredity	Heredity is sometimes assumed to be a predisposing factor in depression (Blazer, 1980).	Blazer (1980) commented that genetic factors are unlikely to account for the onset of late-life depression, unless the person has had depressive episodes earlier in life.

2.10.0 Social factors and the onset of depression

The literature of geriatric depression suggests that, in addition to the impact of changes in the basic life functions, other circumstances may contribute to the onset of depressive illness. Some of these predisposing factors are summarised in Table 2.9, below.

Table 2.9

Social factors which may contribute to the onset of geriatric depression

SOCIAL FACTOR	COMMENT
1) Loneliness	Peplau and Perlman (1982) described "loneliness" as a subjective feeling experienced by people who perceive a deficiency in their social relationships. In a study of 208 elderly residents in 10 senior housing apartments, Mullins and Dugan (1990) found a clear and consistent association between loneliness and depression.
2)Chronic stress	Blazer (1990) discussed the possible relationship between chronic stress, elevated cortisol levels and severe depression. An example of "chronic stress" might be the feelings of anxiety in regard to personal safety which a senior experiences each time he or she walks the city streets. Cortisol is a chemical released by the adrenal gland whenever a person prepares to confront perceived danger. In severely depressed individuals cortisol levels are higher than normal. Blazer (1990) stated the increased cortisol levels in depressed people have led some researchers "to suspect that depression derives in part as a response to chronic stress" (1990, p. 71).
3) Attack, restraint and threat	Levin (1963) argued that depression in elders can be precipitated not just by loss, but also by experiences of attack, restraint and threat. "Attack" can be any external force which causes pain, discomfort or injury. "Restraint" is any external force which restricts people's freedom to gratify their basic needs, including sexual ones. "Threat" refers to any perception which suggests the possibility of loss, attack or restraint in the future. People can worry about things which might happen in the future: the loss of loved ones, illness, shortage of money.

Table 2.9 (continued)

Social factors which may contribute to the onset of geriatric depression

SOCIAL FACTOR	COMMENT
4) Ageism	The term "ageism" was introduced by Butler 1963 to describe stereotyping and discrimination experienced by people because they are old. Butler saw ageist attitudes reflected in stereotypes of the elderly; jokes about them; discrimination in regard to housing policies, employment, and services. Schaie (1983, 1990a, 1990 b) challenged widespread assumptions about inevitable cognitive deterioration in elders. Nevertheless, older people expect to be treated as less competent than others. Nuttbrock and Kosberg (1980) suggested older people tend to believe there is no point in reporting new medical problems. Elders do not expect to be taken seriously.
5) Retirement	Many commentators mentioned the role of retirement in the etiology of depression in certain people (Butler and Lewis, 1997; Stenback, 1980; Zung, 1980; Chaisson-Stewart, 1985). Ekerdt (1987), after reviewing epidemiological studies, argued that retirement has less negative impact than expected on physical and mental health, and on marital relationships. Ekerdt suggested that some predictions about the negative impact of retirement reflect an ageist assumption that retirement life can not be good.
6) Changes in society	Some elders may be stressed by changing values and lifestyles in the society around them. Elders are stressed by increasing social isolation (Lopata, 1988; Hansson and Carpenter, 1994). The increasingly mobile, urbanised society leaves many elders without the community support of well-known neighbours and nearby relatives which earlier generations of older people experienced.
7) Elder abuse	Podneiks (1992) defined elder abuse as any sort of injury -- physical, mental, sexual -- inflicted on an older adult. Elder abuse includes financial exploitation. Abuse can come in the form of neglect and of "paternalistic" interference by professionals and family members who think they know "what's best" for the older adult. A Canadian study found that 4% of elder Canadians had recently experienced some form of abuse. Of these, 19% had experienced more than one kind of mistreatment (Podneiks, Pillemer, Nicholson, Shillington, and Frizzel, 1990).

Table 2.9 (continued)

Social factors which may contribute to the onset of geriatric depression

SOCIAL FACTOR	COMMENT
8) Failure of plans and ventures	Zung (1980) suggests elders may be stressed by finding their retirement years are not what they expected them to be. For example, people may have expected to have more retirement income than they have. Older people may have hoped to be emotionally close to their children. In fact, seniors may experience depression when they receive less emotional support from their children than they had anticipated. Mullins and Dugan (1990) found that loneliness in elders who are parents is not related so much to physical proximity of their children as to the experienced quality of relationship with the children.
9) Disappointment with organisation or religious group.	People who have invested a great deal in an volunteer organisation or religious group may be disappointed if the group fails to "repay" years of volunteer service with continued interest in, and support of the older person. Such a reaction can be explained by "equity theory" (Rook, 1987) which suggests that in all relationships, people expect a reciprocal exchange of resources. If this exchange is not balanced, people may experience strong psychological reactions.
10) Loss of status	Zung (1980) argued that some elders are predisposed to depression by a loss of status. With age, some people may have to surrender a job, a role or a volunteer position on which they depended heavily for a sense of self-worth.
11) Loss of pets	Zung suggested (1980) that some people are predisposed to depression by the death or loss of a valued pet which had become a significant companion.
12) Exit events	Myers et al. (1968) studied the entrance and exit of significant people from a person's social field. "Exit events" or the loss of significant relationships tend to aggravate medical and psychiatric symptoms more than do "entrance events" or the entry of new people in one's life. Alexopoulos and Chester (1992) found that psychiatric people and people with depression tend to have experienced more exit events than people in the general population.

2.11.0 The cognitive model of depression

An examination of the literature suggests that the cognitive model of depression and cognitive therapy developed by Beck et al. (1979) have influenced current thinking on the subject of depression.

2.11.1 The cognitive model of depression

The model proposed by Beck et al. (1979) starts with the assumption that certain experiences of depression may be the consequence of a series of thought processes termed "the cognitive triad."

The first element of the cognitive triad is people's negative view of themselves. Depressed persons believe that their unhappiness is due to their being somehow psychologically, morally, or physically defective. These presumed deficiencies render such people (in their own eyes) worthless, undesirable and powerless to change.

The second element of the cognitive triad is "schemas" or stable cognitive patterns formed over time. These patterns represent the characteristic ways by which individuals make sense of their experience through attending to some stimuli and ignoring others. Each situation evokes particular schemas which, in turn, determine how people will respond. The schemas of depressed persons tend to be distorted. As a result, depressed people will view a situation in a negative way -- regardless of what the objective reality may actually be. Once a negative schema has been activated, it will influence how people process all sorts of stimuli -- even those which are only distantly, or not at all, related to the current situation. Thus the negative perception of reality generalises and extends.

The more depressed people become, the less voluntary control they can exert over the negative processing which they are doing. As a result, people will steadfastly maintain their negative viewpoint. With repetition, these destructively negative patterns become so autonomous that severely depressed people no longer even register changes in their environment. For such people, reality has become unremittingly hopeless and bleak.

The third element of the cognitive triad is a negative view of the future. Simply put, depressed people expect the worst, now and always. They have come to believe that nothing they undertake can possibly succeed.

The negative patterns of the cognitive triad result in faulty information processing. Cognitive theory outlines six errors often made by depressed people.

- a) People may draw arbitrary conclusions, regardless of any supporting or contradicting evidence.
- b) They may selectively abstract certain details of a situation while ignoring others. That is, people's view of "reality" tends to be shaped by their expectations.

- c) Depressed people may over-generalise so that one negative, isolated incident becomes the basis for predicting all sorts of outcomes.
- d) They may magnify or minimise the significance of events in a grossly distorted manner.
- e) They may personalise an external event in an unrealistic way.
- f) Those who are depressed may tend to think in "either/or" terms. Such people have little tolerance of ambiguity.

On the basis of their cognitive model, Beck et al. (1979) explained how people's early experiences can make them prone to depression. An early negative event such as the death of a parent, for example, can affect children profoundly. Patterns of negative cognition develop as children attempt to deal with their loss. The particular schemas embedded at the time of the parent's death can be activated by other experiences of loss in later life.

The cognitive model of depression proposes that symptoms of depression are related to the manner in which people construct reality. Individuals may, for example, have become convinced that they have been rejected. Accordingly, they will respond emotionally (with sadness, anger and loneliness) as though they have, indeed, been rejected.

Moreover, the negative cognition of depressed people can make them feel hopeless. Any will to undertake things or solve problems can be paralysed. In extreme cases, the situation is construed as being so hopeless and unbearable that suicide appears the only alternative.

Convinced that they are inept and without resources, depressed people can become highly dependent on others for reassurance, guidance and help. Depending on others reinforces the belief of depressed persons that they are truly powerless to help themselves. Such people may sink into apathy.

The concept of "reciprocal interaction" is an element of the cognitive model of depression. This term refers to the impact people's actions have on one another. Convinced of their unworthiness, depressed people may distance themselves emotionally from significant people in their lives. These others may respond negatively to this distancing. The depressed people then spiral deeper into thoughts

of self-criticism and self-rejection. In other cases, strong social support from others -- encouragement, affirmation, loyalty -- may sometimes help to temper the full effects of depression.

The cognitive model acknowledges that there are types of depression -- such as those caused by neurological damage or other physiological disorders -- on which support from the environment has no positive impact. Moreover, Beck et al. (1979) stated that their model does not address itself to the ultimate causes of depression such as "hereditary predisposition, faulty learning, brain damage, biochemical abnormalities, etc. or any combination of these" (p. 19).

2.11.2 Cognitive therapy

The cognitive model encompasses not only a theory of depression but also therapeutic goals and techniques. In general terms, cognitive therapy aims to identify the personal paradigm or worldview of depressed people. Because their view of themselves and their life is distorted, depressed people process information incorrectly, and as a result, experience depressive symptoms. To address these symptoms, the dysfunctional perceptions of depressed people need to be reversed. If therapy succeeds, and the distorted perceptions can be realigned with reality, depressed people may begin to show improvement.

Beck et al. (1979) suggest cognitive therapy for people with unipolar, non-psychotic depressions where, for whatever reason, antidepressant medication is contraindicated. (Note: "Unipolar, non-psychotic depressions" might be defined as those mood disorders in which there are no episodes of expansive or elevated moods, no rapidly alternating moods, no delusions and no hallucinations.)

However, standard therapy (including hospitalisation and somatic interventions) are recommended for any sort of severe depression (including bipolar varieties) and for any depression involving serious regression or high suicide risk. (Note: "Bipolar" depression involves recurrent episodes of elevated or expansive or rapidly alternating moods. "Severe regression" might be defined as a movement to an earlier, more primitive level of psychological functioning which may put the individual's health, safety or life at risk.)

2.12.0 Attachment theory and depression

An examination of the counselling literature suggests "attachment theory" can contribute to an understanding of depression. Because attachment theory takes seriously the lifelong impact of the early interactions of infants and young children with their primary caregivers, this theory offers insight into some of the themes which could emerge in the process of life review.

Bowlby (1988) suggested that attachment is a biological function which is activated in infants in order to assure that their primary caregiver stays near them to provide protection. Bowlby describes "attachment behaviour" as an innate behaviour rooted in the biological urge for protection and shared with other species. A young child is prompted to seek security in staying close to an adult -- that is, to an "attachment figure" -- who is perceived as strong enough to help the child cope with the world. Early attachment experiences appear to influence individuals and their relationships throughout their lives.

Researchers have identified various patterns of attachment which can develop in infants and children. In "secure attachment" children are confident that the parent or primary caregiver can be relied upon to be available and responsive. Securely attached children are confident in exploring the world around them. Such children have experienced a parenting style which is consistently responsive to their need for protection and comfort.

When children develop an "anxious resistant attachment" pattern, they are uncertain whether the parent will be available and responsive when help or comfort is needed. These children tend to be clinging. They are anxious about moving out into the world around them.

Children who have an "anxious avoidant attachment" pattern not only do not trust the availability of their caregiver, but they expect to be rebuffed. Such children try to be emotionally self-sufficient. In later life they may be diagnosed as narcissistic. [Note: The DSM-IV (Amercian Psychiatric Association, 1994) defines narcissism as " a pervasive pattern of grandiosity, need for admiration, and lack of empathy that begins in early adulthood and is present in a variety of contexts" (p. 658).]

Children who have experienced abuse or neglect may exhibit a "disoriented" or "disorganised" pattern of attachment in which they react to stress with a variety of disturbed behaviours. The caregivers

of such children may be suffering from bipolar disorders. They may themselves have experienced physical or sexual abuse. Such parents may never have resolved their feelings in regard to the early loss of a parental figure.

Bowlby (1988) stated that the early attachment patterns developed by children tend to persist into adulthood. Gradually children formulate "working models" of relationships based on their own early life experience of relating to their parental figure. As these working models become more and more internalised, children tend to expect all their other relationships to have basically the same characteristics of security or anxiety or rejection.

As a result of their early experiences, children tend to form a view of themselves and human relationships based on the interactions they had with their parental figure. If the parental figure is generally consistent in taking seriously the *whole* range of children's emotional communication, the children are more likely to enter adulthood with a resilient, healthy attitude. However, if the parental figure is selective in affirming some emotions and ignoring others, children may lose touch with their own feelings and personalities. Bowlby argued that the resulting distortions may predispose some individuals to depression, anxiety and other mental-health problems.

Diamond and Blatt (1994) cited various recent studies which suggest a connection between insecure attachment styles and the development of depression. These writers saw a relationship between anxious attachment patterns and the depressive symptoms of dependency and fears of abandonment. The same writers also proposed a connection between avoidant attachment styles and such depressive symptoms as harsh self-criticism, feelings of guilt and unworthiness, as well as social isolation.

Parker (1994) investigated possible connections between parental bonding and depressive disorders. This researcher found that adults with nonmelancholic (or neurotic or dysthymic) depression are more likely than non-depressed individuals to rate the parenting they received as low in terms of "care" (i.e., affection, responsiveness, availability) but high on "protection" (i.e., parental vigilance and control). Parker states that "the view that uncaring and/or overprotective parenting is a risk factor for nonmelancholic depression has been consistently confirmed in empirical studies, and the risk to adult depression has been shown to be considerable" (p. 307). Parker found that children who experience

rejecting parenting styles may become adults who are especially vulnerable to the critical comments of others. In fact, these adults tend expect and experience rejection even in circumstances which, objectively, are neither critical nor threatening.

Parker commented that parental overprotection tends to have an adverse effect on a child's later development of interpersonal skills, at least of those skills needed outside of the family. Overprotected children tend to receive more vigilance than genuine care from their anxious parents. These children are thus deprived of the experience of relaxed, nurturing interactions. Damaged by the combination of intrusive vigilance and low care given by their parents, such individuals enter into adulthood without a strong sense of independence and without competence in relationships. Such people may find themselves predisposed to depression later in life.

2.13.0 Classification systems

Over the years researchers have attempted to organise and classify the diverse symptoms of depression. Although the history of the development of classification systems is interesting, an extensive discussion of that history is really beyond the scope of this literature review. However, three general observations might be made.

First, researchers have long debated the question of etiology. Does the experience of depression result chiefly from physiological, chemical or neurological changes or imbalances within the human organism? Or is depressive illness generally a response to the impact of stress experienced through interaction with the environment?

Second, researchers continue to question whether there is a unitary phenomenon that can be called depression. Or is the term "depression" really a means of speaking of a variety of related, yet distinct phenomena?

Third, an examination of the literature indicates that a variety of classification systems are used by mental-health professionals in various parts of the world. Currently, in North America the

classification system of choice is the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (1994) or DSM-IV.

Note:

Excerpts of sections in the DSM-IV relevant to this practicum are reproduced in Appendix A of this report.

2.14.0 Summary

Affective illness has been noticed and described since the time of Hippocrates. The early Greeks attributed the dark, despairing moods of depression to an excess of black bile. Over time depression has come to be viewed as a systemic condition that can be manifested in terms of emotional, motivational, cognitive, vegetative, and physical symptoms.

Epidemiological studies have challenged a common assumption that depression is widespread and inevitable among older people. In fact, some researchers have been intrigued by the emotional resilience generally found among those seniors who were young during the Great Depression and the Second World War. Some researchers are beginning to argue that although affective illness is a reality for some elders, the majority of seniors deal with less depression than those who are considerably younger. However, this argument may not take seriously enough the impact of ageist assumptions. The reluctance of some elders to admit to being depressed might explain the lower-than-expected incidence of depressive illness. At the same time, the failure of mental-health professionals to recognise somatic indicators of geriatric depression might contribute to an under-reporting of depression among older people.

The literature of geriatric depression suggests that a variety of factors may prepare the way for depressive illness in later life. Each person's experience of depression is unique. However, some of the internal predisposing factors discussed in the literature include the inability or unwillingness to learn new age-appropriate behaviours; as well as changes in metabolism, physiological capacity, reproductive

functions and movement. Some researchers regard decreased ability to adapt to loss and other stresses as an important predisposing factor in the development of depression.

As people grow older, they experience various internal changes. They may also be obliged to confront ageism and other societal attitudes which attack their sense of self-worth. Moreover, some older people may feel restrained and threatened by external forces which undermine their sense of competence and independence. Some seniors may be disturbed by a rapidly changing society. They may face elder abuse. They may need to cope with the loss of loved people, roles and status. In addition, the literature discusses the role of negative thought-patterns in the development of depressive illness.

Researchers in the field of attachment theory suggest that there may be a connection between certain adult dysthymic depressive disorders and early experiences of parental treatment. Adults generally bring the pattern of attachment learned in childhood to their interpersonal relationships. Since some of these patterns foster dependent, isolating, inauthentic or socially inappropriate styles of relationship, certain individuals may be predisposed to unsatisfactory interactions with others, and thus to depression.

Researchers still debate the question of how depression ought to be classified. Some theorists see all depressive illness as a unitary phenomenon ranged along a continuum of severity. Others view the various manifestations of depression as evidence of distinct disease entities. Discussion continues about which treatment modalities are most effective.

CHAPTER THREE

THE LITERATURE OF LIFE REVIEW

The student reviewed the literature to understand the practice issues involved in life review. The first goal was to clarify the meaning of the terms "life review" and "reminiscence." The student wanted to understand what prompts the life review process. He also sought to learn about the ways, both positive and negative, that life review manifests itself. Finally, the student looked for reports from others who had used life review as a therapeutic intervention.

This chapter presents the results of a review of the literature of life review.

3.1.0 The life review literature

The original idea for this practicum began with an interest in using what Lewis and Butler (1974) called "life review therapy" as a therapeutic intervention with depressed seniors. Since Butler (1963) first used the term "life review" as an interpretation of the phenomenon of reminiscence, considerable confusion has appeared in the literature. Some commentators have used the terms "life review" and "reminiscence" almost interchangeably. In other cases, the two terms have been assigned clearly distinct meanings. Because of the lack of precision in terminology, some researchers have not always been clear as to exactly which phenomenon they have been studying. Recent contributors to the literature have noted the language confusion and the resulting lack of clarity in research findings (Molinari and Reichlin, 1984-85; Haight, 1988; Tarman, 1988; Taft and Nehrke, 1990; Kovach, 1991; Coleman, 1992; Newbern, 1992; Merriam, 1993).

3.2.0 The concept of life review

An article by Butler (1963) prompted the gerontological community to re-examine its understanding of reminiscence in older people. Until Butler's article appeared, reminiscence activity was generally viewed as something negative. Older people who reminisced were simply "living in the past." Conventional wisdom regarded such looking back at memories as evidence of senility, or in some cases,

of pathology. Butler found that apart from an occasional positive remark in the autobiographies of a few famous people, most commentators tended to describe reminiscence in negative ways. Elders recalled their memories, it was thought, without any real purpose other than amusing themselves, or filling time or avoiding reality.

3.3.0 The meaning of the terms "reminiscence" and "life review"

As noted above, the literature reflects confusion as to the precise meaning of the terms "reminiscence" and "life review." The distinctions made Butler himself and by more recent writers deserve mention.

3.3.1 Butler's definition

Butler (1963) defined reminiscence as "the act or process of recalling the past" (p. 66). Butler further stated that "the life review is not synonymous with, but includes reminiscence; it is not alone either the unbidden return of memories, or the purposive seeking of them, although both may occur" (p. 67). Indeed, life review was defined, much more specifically, as:

> a naturally occurring, universal mental process characterized by the progressive return to consciousness of past experiences, and, particularly, the resurgence of unresolved conflicts; simultaneously and normally, these revived experiences and conflicts can be surveyed 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. It is further shaped by contemporaneous experiences and its nature and outcome are affected by the life-long unfolding of character. (p. 66)

3.3.2 Later clarification of the distinctions between reminiscence and life review

After a review of the literature of reminiscence in general, and the life review in particular, Molinari and Reichlin (1984-85) provided a useful description of life review. They argued that life review reminiscence is more than simple story telling. Rather life review is a psychological process involving inner conflict by which an individual can again struggle with past experiences of loss, failure or disappointment. These authors described life review as a form of reminiscence which involves an active evaluation of the past.

In an examination of the conceptualisation and uses of structured life review, Haight (1988) asserted that "life review has been misinterpreted too often as reminiscing. Reminiscence is totally different from the integrative task of life review" (p. 43).

Osborn (1989) and Kovach (1991) further clarified the distinction in their comparisons of life review therapy and reminiscence therapy. Both researchers agreed that life review therapy can be understood as psychoanalytically-based. The goal of life review therapy (which may well use reminiscence as one of its tools) is to help clients examine the meaning of their lives and their unresolved issues. Reminiscence therapy, on the other hand, is more psychosocially-based. Though reminiscence can focus on any number of topics, positive or negative, it is not directed toward self-analysis or self-evaluation.

After a review of some 41 American journals, 1960-1990, Haight (1991) concluded that reminiscence is a complicated and varied behaviour, each part of which needs to named and described. The many different kinds of reminiscence behaviour -- including life review reminiscence -- should be clearly identified so that each specific activity can be studied and measured. Such an examination demands precisely spelled-out categories of variables, processes and outcomes.

3.4.0 Factors which may prompt life review

Butler (1963) discussed the role of various factors in initiating the process of life review. Butler acknowledged that younger persons may be prompted to review their lives, especially those people who

expect death because they are terminally ill; or because they are condemned to die. However, older people, Butler argued, are more likely to engage in life review since retirement gives them more time to reflect; and since employment is no longer available to provide a defence against anxiety. Further, Butler suggested, the real or subjective experience of isolation and loneliness may contribute to the sometimes severe consequences of reviewing one's life. However, Butler made clear that "the explicit hypothesis intended, here . . . is that the biological fact of approaching death, independent of -- although possibly reinforced by -- personal and environmental circumstances prompts the life review " (p. 67).

3.5.0 Manifestations of life review

Butler (1963) described manifestations of the life review. The process of reviewing one's life generally takes places silently and slowly, with only vague awareness on the part of reviewer. Lewis and Butler (1974) noted, however, that some individuals may be completely conscious that they are reviewing their lives. Such persons may state clearly that they want to put their lives in order.

Butler (1963) suggested that the life review process can manifest itself in a variety of forms that range from mild nostalgia and regret to severe anxiety, despair, guilt and depression. Butler said that for some individuals, extremely negative outcomes are possible. Some people may become so obsessively preoccupied with their past that they may become terrified and attempt suicide.

In some cases the process of life review may show itself in the seemingly random thoughts people have about themselves and their past. Sometimes these thoughts become more or less continuous. Certain people may dream about their past, or even have nightmares. Others may find that gazing in the mirror prompts musings about how old they have become; and about what they have done, or failed to do with their lives.

3.6.0 Positive outcomes of life review

Butler (1963) suggested that in its positive form, the process of life review may prompt certain individuals to reconsider, reorganise, and expand their understanding of what their life has meant to

them. With such constructive thoughts may come an new acceptance of death and a lessening of fear. Butler believed that life review activity assists the majority of older people in reorganising their personalities. The result of this psychological process is the development of such qualities as wisdom and serenity. Though he acknowledged that an absence of loss and hardship in life may enhance positive reorganisation in some personalities, Butler asserted that most successful reorganisation is more related attributable to such intangible qualities as self-awareness, personal strengths and flexible attitudes.

3.7.0 Negative outcomes of life review

Butler (1963) noted that not every life review has positive consequences. In some people, reviewing their lives may prompt severe depression, panic, guilt, obsessive rumination and increasing rigidity. Certain individuals find the insights produced by their life review so unacceptable that they have difficulty describing their experience to others. Butler suggested that such negative feelings may be linked to increased suicide rates in older people.

Butler proposed three conditions which may contribute to negative and severe outcomes in the life review process.

a) Life review may be painful for people who have always looked to the future to compensate for what the unsatisfactory present has lacked. Now that they have grown old, such people see that the limited time remaining to them is not likely to provide the hoped-for realisation of their dreams and plans.

b) The life review experience may evoke anguished guilt feelings in people who have deliberately chosen to harm others. At the end of their lives, they see no way to make amends for what they have done.

c) Individuals whose personalities have been characteristically vain and arrogant may regard the approach of their death as a narcissistic threat.

Butler (1963) further suggested that the life review process can have both healing and disruptive effects on the important relationships in older people's lives. People may find themselves more appreciative of significant people in their lives, and more capable of giving these people honesty and

intimacy. However, life review may also bring into consciousness long-denied feelings of resentment and hatred toward certain persons.

3.8.0 Studies in regard to the existence of life review

Since Butler (1963) first described life review, researchers have sought to test various assumptions which are implicit in Butler's work including a) the universality of the life review; and b) its association with approaching death.

3.8.1 The universality of life review

Three decades of investigation appears to suggest that while life review activity *does* occur, this phenomenon may not be universal as Butler suggested. Some key studies are summarised below in Table 3.1.

Table 3.1

Key studies of life review

STUDY	FINDINGS
1) Havighurst and Glasser (1972)	Reminiscence seems to be universal in all ages after middle adulthood.
2) Romaniuk and Romaniuk (1981)	Study of elders in retirement communities revealed that 81% had reviewed their lives or were doing so.
3)Lieberman and Tobin (1983)	Study of life review activity in two groups of elders. Among 79 "young old" (less than 80 years): -- 46% were avoiding life review; -- 23% were involved in active life review; -- 32% had resolved their life review. Among 44 "old old" (80 years and over): -- 39% were avoiding life review; --5% were actively reviewing their lives; --57% had resolved their life review.

Table 3.1 (continued)
Key studies of life review

STUDY	FINDINGS
4) Merriam (1993) NOTE: Merriam directly disputed claim by Butler (1963) that life review is universal. "Those who have not reviewed their lives have not felt the need to do so; they are satisfied with themselves and their past lives (p. 172).	Study of cognitively intact community dwelling elders. People aged 100 (n=105) 43.8% reported NOT having reviewed their lives. 41% reported having reviewed their lives; 15.2% were currently reviewing their lives. People aged 80 (n=94) 44.7% reported NOT having reviewed their lives; 41.5% reported having reviewed their lives; 13.8% were currently reviewing their lives People aged 60 (n=90) 51.1% reported NOT having reviewed their lives; 25.6% reported having reviewed their lives; 23.4% were currently reviewing their lives.

3.8.2 Life review and distance from death

Research appears to be inconclusive with regard to the contention made by Butler (1963) that the approach of death prompts the life review. As so often happens in this literature, there is not always a clear distinction drawn between reminiscence and life review.

A study of older people by Lieberman and Tobin (1983) did not find support for the contention made by Butler (1963) that the life review is prompted by the approach of death. In fact, Lieberman and Tobin found "that those closest to death showed significantly less reminiscence activity and significantly less introspection when compared with matched controls" (p. 290).

However, Merriam (1993) cited a review of the literature by Marshall (1980) which looked at

studies of the association between awareness of the nearness of death and the process of life review. Merriam (1993) stated that Marshall concluded "that Butler's claim can be generally supported. However there is little to support the notion that the process of life review is age-dependent" (p. 167).

Webster (1994) who studied reminiscence in 94 people, aged 18 to 81, found that young people *also* reminisce relatively frequently. This researcher called for a re-examination of the assertion that impending death triggers reminiscence activity.

3.9.0 Life review as a therapeutic intervention

Lewis and Butler (1974) stated that "in individual psychotherapy, the life review obviously is not a process initiated by the therapist. Rather, the therapist taps into an already ongoing self-analysis and participates in it with the older person" (p. 168). Lewis and Butler added that "the purpose of psychotherapeutic intervention into the life review is to enhance it, to make it more conscious, deliberate, and efficient" (p. 168).

3.9.1 Ways that memories may be evoked

Butler, Lewis and Sunderland (1991) described life review therapy as "a more structured and purposive concept than simple reminiscence or recalling the past" (p. 414). Lewis and Butler (1974) discussed several structured and purposive ways that the memories of elders may be called forth. These writers' comments are summarised in Table 3.2, below.

Table 3.2

Ways to evoke memories in older people from Lewis and Butler (1974)

SUGGESTED ACTIVITY TO EVOKE MEMORIES	REMARKS
1) Prepare an autobiography.	Elders might put their memories on paper or on tape.
2) Make a pilgrimage to a place that has been significant in one's life.	If a journey is impossible, correspondence and conversations might help to recall memories.
3) Attend reunions.	At such events, people see how time has affected them and their contemporaries.
4) Learn about family history.	Elders are reminded that others have lived and died. People may begin to see their place in the universal cycle of life and death.
5) Examine memorabilia.	Old letters, photos and scrapbooks may bring back memories.
6) Write or tell the story of one's life work.	Reviewing work history may remind people without families that their lives had meaning.
7) Establish or re-establish connections with one's ethnic heritage.	Reflecting on one's ethnic traditions may be a path to recalling the past.

3.9.2 Therapeutic possibilities of life review

Lewis and Butler (1974) suggested that the use of life review activities may afford various therapeutic possibilities. These possibilities are summarised in Table 3.3.

Table 3.3

Therapeutic possibilities in life review activities

1) Making sense of one's experience.	Re-examining their life may help people see past events in a different light.
2) Solving old problems.	Issues from the past might be resolved. Amends could be made.
3) Dealing with regret.	People may come to terms with dreams and aspirations that were never realised.
4) Examining foibles and harmful acts.	Life review may clarify distinction between real guilt and neurotic guilt.
5) Facing fears of death.	Life review may help people to confront their mortality, and free them to enjoy the present.
6) Seeing that one did the best one could in one's particular circumstances.	People can be helped to see how personal or societal circumstances interfered with the accomplishment of certain goals.
7) Deciding on one's legacy.	Life review may prompt people to think about what they want to leave to others.
8) Choosing to do things one has always wanted to do.	People are sometimes inspired to do things which they never before had time to undertake.
9) Considering how one wishes to live the rest of one's life.	Life review may prompt decisions about what really matters in one's life.
10) Coming to terms with one's need for help from others.	Life review may help individuals see that the time has come to accept assistance from others.

3.9.3 Possible dangers of the life review process

Lewis and Butler (1974) addressed criticisms that therapists may raise about the dangers of the life review process. Some helping professionals have argue that certain individuals may be too fragile to cope with powerful emotions of guilt, despair and depression. Lewis and Butler suggested that negative consequences are more likely to occur when individuals condemn themselves in isolation, without

reference to the opinions and perspectives of others. Most people can come to terms with their guilt if they can do so in an atmosphere of acceptance and support.

3.10.0 Studies of the adaptational and therapeutic dimensions of life review

In preparation for this practicum a substantial portion of the literature of reminiscence and life review was examined. However, only studies which pertain to life review and life review therapy are summarised in Table 3.4.

Table 3.4

Studies of the adaptational and therapeutic dimensions of life review

STUDIES OF LIFE REVIEW AND LIFE REVIEW THERAPY	FOCUS OF THE INVESTIGATION	FINDINGS
1) McMahon and Rhudick (1964)	To investigate the adaptational significance of reminiscence.	Researchers identified a group of obsessive-compulsive subjects who used reminiscence to justify their lives.

Table 3.4 (continued)

Studies of the adaptational and therapeutic dimensions of life review

STUDIES OF LIFE REVIEW AND LIFE REVIEW THERAPY	FOCUS OF THE INVESTIGATION	FINDINGS
2) Coleman (1974)	To test hypothesis that people with an acceptable self-image should not need to review their lives as much as those who are dissatisfied with themselves and their past.	People dissatisfied with their lives, but who did not engage in life review, showed signs of maladjustment.
3) Coleman (1986)	To follow subjects of the 1974 study until their deaths.	Researcher identified four groups of reminiscers, including a group who appeared to be experiencing the negative consequences of life review as predicted by Butler (1963). The thoughts of these individuals seemed to turn compulsively toward the past.
4) Fallot (1979-80)	To examine the impact of verbal reminiscing on the mood of older adults.	Researcher found that reminiscing has an adaptive function in later life by reducing such feelings as depression and shame. Talking about the present or future leads to increased depression and diminished elation.
5)Romaniuk and Romaniuk (1981)	To examine reminiscence functions and triggers.	Researchers identified various uses of reminiscence, including a form that employs life review for problem solving and self-understanding.
6) Taft and Nehrke (1990)	To see if any of the reminiscence functions proposed by Romaniuk and Romaniuk (1981) had an impact on "ego integrity" as described by Erikson (1950/1985).	Researchers found a significant correlation between life review reminiscence and the development of ego integrity.

Table 3.4 (continued)

Studies of the adaptational and therapeutic dimensions of life review

STUDIES OF LIFE REVIEW AND LIFE REVIEW THERAPY	FOCUS OF THE INVESTIGATION	FINDINGS
7) Sherman and Peak (1991)	To study the reminiscence functions proposed by Romaniuk and Romaniuk (1981).	Researchers found that life review reminiscence did not have a significant negative effect on mood. Researchers identified a group of subjects who used life review reminiscence for pleasure, entertainment and self-understanding. These individuals had positive affect scores. Their outlook on life resembled Erikson's description of integrity.
8) Haight (1988) "Perhaps this modest indication of the safety of the life review as a therapeutic intervention will encourage others to use this modality with more confidence" (p.43).	To study the impact of structured life review on homebound elderly.	Researcher compared life satisfaction, psychological well-being and depression in group who had received six friendly visits and group who had received six life review visits. The life review group: a)did not experience any increase in depression; b) had a sense of accomplishment; c)were more ready than those receiving friendly visits to terminate the process.

Table 3.4 (continued)

Studies of the adaptational and therapeutic dimensions of life review

STUDIES OF LIFE REVIEW AND LIFE REVIEW THERAPY	FOCUS OF THE INVESTIGATION	FINDINGS
9) Reese Beaton (1991) "In gathering this data, the investigator had the consistent and distinct impression that she had gained a different level of engagement with the person interviewed than had previously been her experience in nursing practice" (p. 61).	To study the relationship between levels of ego development and reminiscence in older female residents of long-term care facilities.	Researcher used criteria developed by Fallot (1976):to rate reminiscence as "negating", "despairing" or "affirming". Positive correlation found between higher levels of ego development and an "affirming" style of reminiscence. Researcher reported that all subjects immediately grasped what was meant by "life story."
10) Watt and Wong (1991)	To study reminiscence uses in 460 institutionalised and community-based elders.	Researchers found six uses of reminiscence, one of which is "integrative reminiscence." This form is similar to Butler's (1963) life review. Researchers encouraged the use of integrative reminiscence to help elders look at the accomplishments and meaning of their lives, as well as their negative emotions and disappointments.

3.11.0 Other uses of life review techniques

In addition to studies about the existence of life review and its therapeutic possibilities, the literature indicates that life review methods have been used by a variety of helping professionals. The common theme in these reports is that encouraging an older person to tell his or her life story has helped professionals obtain important information about the their clients. Table 3.5, below, summarises some of those reports.

Table 3.5

Other uses of life review techniques

OTHER USES OF LIFE REVIEW TECHNIQUES	COMMENTS
Butler (1980-81) Harris and Harris (1980-81) Ebersole and Hess (1985) Lappe (1987) Reese Beaton (1991) Newbern (1991)	All these researchers affirmed the value of taking life histories as a means of medical assessment of the elderly. Careful listening to life stories provides important information and fosters rapport between elders and younger health care providers.
Hughston and Cooledge (1989) Hargrave and Anderson (1992)	These family therapists suggested that life review methods can be effective assessment tools in systemic family interventions.
Gelassi (1991)	This researcher reported positive outcomes from a life review workshop for gay and lesbian elders.

3.12.0 Summary

In the slightly more than three decades since Butler (1963) first discussed the life review, the literature has undergone a subtle shift in emphasis. At first, researchers were concerned to see if, indeed, there were such a phenomenon as the life review. Now few question the suggestion that at least some people review their lives. However, the exact nature of life review remains a debated issue.

Much attention has been paid to Butler's idea that the life review process is triggered by the approach of death. The more recent literature seems to suggest that there are other triggers besides death. Besides speculating about what prompts the life review, researchers have explored the question of whether the life review experience is universal. The current literature clearly indicates that not all people review their lives. Nevertheless, the existence of the life review process has received recognition as an important, if not universal, feature of the psychology of the aged.

The literature documents a developing awareness of the need for researchers to be clear about the language they use. At first, there appeared to be considerable confusion in the distinctions between reminiscence and life review. Now there is more agreement that reminiscence involves recalling the past for a variety of purposes including entertainment, teaching, cultural transmission and problem solving.

Life review, however, tends to be seen as an internal, integrative psychological process in which individuals recall their memories in order to confront unresolved issues and to understand and accept their life experience. For some, the life review process -- though not necessarily always easy or pleasant -- ultimately contributes to the integration of the personality.

For others, looking at their lives may only serve to deepen already-existing despair and alienation. In spite of the possibility of negative outcomes, recent researchers are beginning to express tentative confidence in the general safety of using life review methods sensitively with particular individuals.

The methodology of life review research appears to be changing over time. Early research, of necessity, tried not to be directive or suggestive. The goal was to establish the empirical reality of a phenomenon. Emphasis was placed on the kinds and numbers of words used by life-reviewers. Now,

however, the literature is becoming more concerned with the practical implications and qualitative dimensions of life review. Recent investigators report that inviting elders to tell "the story of their lives" may set in motion a process of self-revelation and integration. Life reviewers seem to understand, instinctively, that to speak of their life story is to do something worthwhile. Recent research encourages listeners to become actively and attentively involved in what elders are saying.

CHAPTER FOUR

DISCUSSION GUIDE FOR LIFE REVIEW CONVERSATIONS: THE LIFE STRENGTHS INVENTORY BY KIVNICK (1991)

4.1.0 Origin, theory and content of the life strengths inventory

An inventory of life strengths was developed by Kivnick (1991) to assess psychosocial strengths in long-tern care clients. Questions from this inventory were used to guide the life review conversations in the intervention described in this report. This chapter discusses the origin, theory and content of the inventory.

4.1.1 The origins of the inventory

Kivnick (1991) developed a discussion guide to help care providers assess the social strengths of long-term care clients. Kivnick argued that in the past, care-plans for the frail elderly have tended to focus on functional deficits, without often acknowledging the clients' strengths and capacities. Older people have learned to define themselves in terms of the "medical model." That is, elders have tended to focus on "what's wrong" with them: what they can not do, and what they do not have.

In arranging for the care of older people, helping professionals have not always been sensitive to the unique personalities, life experiences and long-held values of the individuals they are trying to help. Kivnick's inventory seeks to provide a means for caregivers to uncover the core values rather than the superficial preferences of their clients. Kivnick (1991) stated:

> Rather than assessing solely for functional deficits and non-deficits we must learn to assess, as well, for the life strengths that give everyday functioning its larger meaning. Rather than developing care plans for the frail elderly, we must learn to think in terms of life plans that encourage elders to maintain ageless identities, enact central values, and maximize personal life strengths. (pp. 4-5)

Accordingly, Kivnick (1991) developed an inventory of questions intended to help discern the values that really matter to them. Because the inventory invites people to recall memories about a wide variety of experiences, relationships and values, the questions were used in this practicum to provide a framework for the life review conducted with each subject.

4.1.2 Psychological theory as the basis of the inventory

Kivnick's questions are based on a reworking of the life cycle theories proposed by Erikson (1950/1985; 1980; 1985) and further described by Erikson, Erikson and Kivnick (1986). In essence, Erikson's model suggested that human beings move through eight developmental stages from infancy to old age. At each stage of development people are faced with balancing two conflicting tendencies. First, the positive or "syntonic" tendency favours an acceptance of themselves, their lives, and their experience together with an expansion of personality. Second, the counter or "dystonic" tendency pulls people toward a rejection of themselves, a narrowing of their experience and a constriction of the personality.

How people respond to each developmental stage influences their experience in the next stages and impacts upon the stages already negotiated.

Erikson conceived of human life as a work in progress. Throughout their life cycle individuals continue to revisit and rework the issues focal to each developmental stage. "Successful" people are those who manage to strike a workable, age-appropriate balance between the various conflicting tendencies within themselves.

Kivnick (1991) suggested new names for each of the eight stages in the Erikson developmental model. Instead of using the language of stages, Kivnick preferred to discuss "psychosocial themes." Kivnick suggested that these themes emerge as individuals struggle to balance weaknesses with strengths. Throughout life people must find creative ways of coming to terms with the particular challenges that life presents. Again and again individuals revisit all of the developmental themes as each new stage of life unfolds. The task is always to find an age-appropriate balance between personal capacities and deficits.

4.1.3 The content of the inventory

Tablw 4.`1 shows the relationship between the "psychosocial themes" outlined by Kivnick (1991, pp. 9-53) and the developmental stages of Erik Erikson. The table also summarises the essence of the issues which Kivnick's discussion guide was developed to assess.

Table 4.1

Psychological strengths and deficits assessed by Kivnick's (1991) inventory

KIVNICK'S PSYCHO-SOCIAL THEME	ERIK ERIKSON'S EQUIVALENT DEVELOP-MENTAL STAGE	PSYCHO-LOGICAL ISSUE	STRENGTHS OR DEFICITS ASSESSED BY THE INVENTORY
1) Hope and faith	1) Basic trust versus basic mistrust	Is the world a predictable, benevolent place?	Beliefs and moral values which might enhance a person's sense of security.
2)Willfulness independence and control	2) Autonomy versus shame and doubt	How can I maintain control of my body and my life?	Personal independence and control. Ability to distinguish between the kinds of personal control which must be maintained and those which can be surrendered.
3) Purposefulness, pleasure and imagination	3) Initiative versus guilt	How can I find ways to express myself that are neither anti-social nor self-inhibiting?	Curiosity, imagination and ingenuity to imagine possibilities for oneself and initiative to realise those possibilities.
4)Competence and hard work	4) Industry versus inferiority	Am I competent to do things and solve problems?	Awareness of present skills and areas of expertise.
5)Values and sense of self	5) Identity versus confusion	What kind of a person am I? What are my values?	Ability to maintain identity and sense of self in the face of change and loss.
6)Love and friendship	6) Intimacy versus isolation	How can I be "close" to people in relationships characterised by respect for the other and recognition of personal boundaries?	Ability to recognise one's own capacity for sustaining and developing mutually supportive relationships.

Table 4.1 (continued)
Psychological strengths and deficits assessed by Kivnick's (1991) inventory

KIVNICK'S PSYCHO-SOCIAL THEME	ERIK ERIKSON'S EQUIVALENT DEVELOPMENTAL STAGE	PSYCHO-LOGICAL ISSUE	STRENGTHS OR DEFICITS ASSESSED BY THE INVENTORY
7) Care and productivity	7) Generativity versus self-absorption	How can I find appropriate ways to contribute to the well-being of those who come after me?	Ability to identify those people and causes about which one has cared and about which one continues to care. Ability to balance inward-looking concern for self with outward-looking care for the world.
8) Wisdom and perspective	8) Integrity versus despair	Do I accept my particular life-cycle as uniquely my own? Do I accept my life as it has been, good and bad?	Capacity to identify current sources of meaning and despair in one's life. Capacity to identify and to accept the aspects of one's life which one wishes had been different.

Table 4.1, above, summarises the theoretical constructs which lie behind the "Interview Guide" developed by Kivnick (1991, pp 62-64) to assess the "life strengths" of long-term care patients. Excerpts from the interview guide have been reproduced in Appendix B of this report.

The student selected questions from Kivnick's interview guide to initiate life review conversations with the participants who received the intervention described in this report. The student assumed that some of Kivnick's questions (especially those with a focus on the past) might help participants to recall their own unique experience of meeting the developmental challenges of a lifetime.

CHAPTER FIVE

THE LITERATURE OF QUALITATIVE RESEARCH

The concept of qualitative research was new to the student. His first task was to understand how qualitative research methods differ from those of quantitative research. In his reading the student encountered discussions of the advantages and disadvantages of qualitative research methods. He was also introduced to ethical considerations which might apply in qualitative research. Finally the student looked at various forms of qualitative research, in particular the use of in-depth interviews.

This chapter presents the results of the student's review of the literature of qualitative research..

5.1.0 Differences between quantitative and qualitative research

Quantitative research, seeks to present a picture of a particular phenomenon in the language of numbers and standardised measures. Ideally, these numbers and measures yield important information by lending themselves to various statistical procedures.

Qualitative research, by contrast, aims describe those dimensions of reality which can not be easily expressed in numerical and statistical terms. Qualitative research is concerned with depicting the specificity and concreteness of a particular phenomenon, as well as perhaps its essence and meaning.

5.2.0 Complementary aspects of quantitative and qualitative research

An examination of the literature of qualitative research indicates that in the past, the relationship between quantitative and qualitative research has been misunderstood. The result has been that qualitative research methods have sometimes been dismissed or under-valued. Some researchers have failed to see qualitative research as complementary to quantitative research.

5.2.1 Common misconceptions about qualitative research

Although quantitative and qualitative research methods may explore different aspects of reality, they should not, necessarily, be seen as mutually exclusive or antithetical. Rowles and Reinharz (1988) discussed the "myths" which may confuse people's understanding of the two kinds of research.

> One myth is that qualitative and quantitative research are mutually exclusive; another is that qualitative methods are always subjective, whereas quantitative methods are always "uncontaminated" by context and are objective; and a third is that qualitative researchers are unconcerned about issues of generalizability, validity, and reliability, where quantitative researchers are satisfied with superficial insights. (pp. 13-14)

5.2.2 An alternative view of the relationship between quantitative and qualitative research

Rowles and Reinharz (1988) presented two alternative ways of regarding quantitative and qualitative research. First, rather than being viewed as polar opposites, the two forms of research can be seen as separate but equal ways of answering different research questions. Second, qualitative research examines meaning, while quantitative research looks at correlations and distributions. Third, qualitative research can generate hypotheses which may then be tested by quantitative research. Four, quantitative results can be usefully enhanced by qualitative studies to provide interpretation and elaboration. Fifth, the separate-but-equal relationship between the two forms of research can be seen in the construction of test instruments. The open-ended questions of qualitative research can provide data for the development of instruments which eventually can be tested on a large scale and standardised.

Rowles and Reinharz (1988) proposed another way of understanding how quantitative and qualitative research can be used in tandem. The "integrated or triangulated" viewpoint "involves combining different methods in the same project to reveal different dimensions of the same

phenomenon; to shore up the shortcomings of each method; or to double-check findings by examining them from several vantage points" (p. 15).

5.3.0 Characteristics of qualitative research

From their review of the literature, Rowles and Reinharz (1988) identified some particular characteristics of qualitative research: a) personal interaction; b) context; c) concepts of knowledge; d) intentionally-chosen samples; d) ongoing data collection; and e) open-ended questions.

5.3.1 The importance of personal interaction

Qualitative research involves personal interaction between interviewers and participants and the participants' environment. By interacting and observing carefully, researchers may be able to comprehend issues that lie behind an otherwise straightforward reality. For instance, family members anxious about the welfare of an elderly relative may be suggesting that she move from her long-time residence. Through in-depth interviews qualitative researchers may be able to understand that the family is trying to persuade the elderly person to give up much more than a house. In actual fact, she is being pushed to leave a place invested with the memories of a lifetime--marriage, child-rearing, entertaining, hard work, accomplishment, disappointment, sadness and joy. The elderly person's entire sense of the meaning of her life and identity may somehow be tied to a house that is no longer convenient or safe for her.

5.3.2 The role of context

Qualitative research recognises the importance of context. Thus, though they may be primarily interested in one particular behaviour, researchers try to consider the attitudes, beliefs, experience and environment of their participants. Rowles and Reinharz (1988) suggested that such a contextual approach requires the researchers to reflect on how they are experiencing the process. The researchers' own reactions and learning become part of the data of the project. The researchers allow for the possibility that

the encounter with participants may somehow bring change not just in the participants, but also in the researchers as well.

5.3.3 Two concepts of knowledge

Related to the idea that qualitative research may change both participants and researchers are the concepts of "connected knowing" and "separate knowing." Drawing on the original work of Clinchy and Zimmerman (1985), Silverman (1988) draws distinctions between the two kinds of knowledge.

Connected knowing recognises the researcher's own experience as a legitimate source of information. Indeed, the researcher's experience can be used as a guide and resource for his or her investigation of a particular topic. In contrast, the paradigm of separate knowing tends to trust only knowledge which comes from outside the researcher.

The research method selected by scientists often tends to reflect the experiences and socialisation that these persons have had. Thus, some researchers favour the "separate knowing" of quantitative research methods while other investigators prefer the "connected knowing" of qualitative methods.

5.3.4 The intentional choice of samples

Whereas quantitative research may involve random statistical sampling, qualitative research is more likely to seek a small, intentionally chosen sample. The goal of qualitative research is not to determine the distribution or frequency of a phenomenon, so much as to describe and understand what the phenomenon *is*.

5.3.5 The ongoing collection of data

Quantitative research may have distinct phases of data collection and data analysis. The qualitative researcher, however, uses data collected *throughout* the process to guide the further collection strategies.

In this practicum an attempt was made at each session to determine how each participant had experienced his or her depression since the last interview. Formal testing of depression levels was conducted at the beginning and end of the intervention. But often throughout the weekly interview sessions, the theme of depression was revisited. These informal discussions tended to add to the student's qualitative picture of each participant's unique experience of depression.

5.3.6 The use of open-ended questions

In quantitative research, participants tend to be asked standardised questions to which standardised responses are given. The more open-ended questions of qualitative research may call forth everyday language and spontaneous reactions of the participants. In fact, the language and reactions of the participants constitute important data for qualitative research. Reports of qualitative research, accordingly, can be expected to involve detailed descriptions of what people say and of how they act.

Rowles and Reinharz (1988) contrasted the descriptive methods of qualitative researchers with those of novelists or journalists. The researchers argue that the descriptions of qualitative researchers differ from those of other writers because qualitative research reports are informed by concepts and theory in ways that may not characterise other approaches.

5.4.0 Qualitative research with elders: advantages and disadvantages

Rowles and Reinharz (1988) discussed both the advantages and disadvantages of qualitative research methods in working with seniors.

5.4.1 Advantages

One comment by Rowles and Reinharz (1988) about the advantages of using qualitative research with older people might have been written with this practicum in mind.

> Advantages stem from the congruence between the aspirations of the qualitative researcher to develop rapport and the apparent psychological needs of many older

> people to review their lives, to educate the young, and to find companionship, particularly when significant others are no longer available. The interest older people have in recounting important experiences and lessons has been defined by Erik Erikson as a distinct psychosocial stage and elaborated by Robert Butler in his concept of the "life review" (Butler, 1963). Even without the presence of researchers, elderly people might write their memoirs either for family use or for publication . . . . Involvement with a qualitative researcher may reinforce this inclination. Indeed, elderly research participants may find special pleasure in examining photographs, treasured personal possessions, and other objects that remind them of the past and in sharing these with researchers interested in their lives. (p. 20)

In this practicum there appeared to be a congruence between the student's goal of studying life review and the participants' willingness to speak about their past. The development of rapport between the student and the participants was crucial for the life review conversations to take place. At the same time, some of the participants were lonely individuals who appeared to welcome a chance to talk with an interested listener. As the life review conversations progressed, some of the participants reported that they found themselves recalling events to which they had given little thought prior to the life review process.

5.4.2 Disadvantages

Rowles and Reinharz (1988) also discussed disadvantages of using qualitative research methods with the elderly. Some people may be uncomfortable with the sort of consent forms necessary for this kind of research. And indeed, in this practicum one of the participants *was* uneasy about "signing anything" until she could have a family member check the consent form.

Other people may be intimidated by the idea of "scientific research". They may insist that they have little to contribute. Still others may be disconcerted by the self-exposure required to answer the

open-ended questions posed by the qualitative researcher. Interestingly, all of the participants in this study were willing to be self-revealing. The participants seemed to feel that their honesty could "help" the student with his project.

Comprehension difficulties as a result of physical, cognitive or educational deficits may present a problem in qualitative research with seniors. In this study, one participant (whose ill health prevented completion of all the interviews) did experience difficulty in following certain questions that were asked.

As well, Rowels and Reinharz (1988) suggested that some interviewers, especially those considerably younger than the participants, may be reluctant to ask direct personal questions of an older person. Given the nature of topics discussed, researchers run the risk of being confronted with strong emotions, both in the participants and in themselves. Rubinstein (1988) used the terms "transference" and "counter-transference" to describe the powerful emotions which may be generated during an in-depth interview.

In a recent discussion of transference Hamilton (1994) traced the origin of the term to Freud who suggested that people tend to experience their psychoanalyst as they might have experienced some significant person earlier in their lives. That is, individuals "transfer" certain emotions and perceptions from the original person to their therapist. How the individuals then "feel" about the therapist can be a clue to unresolved issues from the past.

Hamilton (1994) explained that countertransference was once defined as all the psychoanalyst's own unresolved issues which were evoked in reaction to the patient's transference issues. However, current thinking understands the concept differently. "All the therapist's emotional reactions to the patient . . . are now considered under the rubric of countertransference. This broader definition allows the therapist to use emotional reactions as a tool for more deeply understanding the patient" (Hamilton, 1994, p. 328).

Matsuoka (1993) provided an example of the sort of countertransference issues which might well have arisen in this practicum. Discussions with the elderly may trigger unresolved feelings in the interviewer about old age and death. Matsuoka recommended that in preparation for research with elders, interviewers examine their own negative images of older people.

5.5.0 Ethical considerations in the use of qualitative research

Disclosure of highly personal information and feelings can make elderly persons vulnerable to exploitation. Rowles and Reinharz (1988) stressed the importance of honesty so that elderly participants understand exactly what the purpose of the research is. At the same time, participants deserve to know what can (and what can not) be expected from researchers. Moreover, researchers ought to be prepared to manage sensitively the ending of relationships with participants, especially when the participants' intimate disclosures may have created a human bond between the participants and researchers.

Because researchers may hear extremely private, personal details of participants' lives, researchers ought to be scrupulous in respecting confidentiality issues. Furthermore, the importance of protecting confidentiality raises ethical issues for researchers in terms of publication. Not only must they safeguard confidentiality in their published work, but qualitative researchers must also avoid a distorted presentation of their findings. The research relationship should not be romanticised; nor should stereotypes about the elderly be reinforced, even unwittingly. Participants should be portrayed as the unique individuals that they are.

5.6.0 "Action research" in this practicum

The literature has a fair amount to say about in-depth interviews. Most writers assume that the interview method is to be used for the purposes of gathering information. Little appears to have been written about using in-depth interviews--as this practicum did-- not only to gather information but also to intervene therapeutically.

Jones (1985) made reference to action research. Jones stated that in action research "processes of data collection become linked to those of feedback and dialogue whereby persons can work on specific problems within the research topic for themselves" (p. 53).

Jones provided the example of a researcher who made a contract with a group of unemployed workers. The workers were offered advice and counselling in exchange for talking about their experience of being unemployed.

In this practicum a sort of "exchange" took place between the student and the participants. The student collected data about the participants' experience of depression and about their life stories. The life review conversations with the student afforded the participants a chance for "feedback and dialogue" (Jones, 1985, p. 53) in regard to their experiences and memories.

5.7.0 In-depth interviews in this practicum

Walker (1985) discussed four methods of qualitative research: a) "depth interviews" or "in-depth interviews" as they are usually called in North America; b) group interviews; c) participant observation; and d) projective techniques. Walker rated each method according to three degrees of appropriateness: "high", "moderate" and "less so."

Walker suggested that in-depth interviews (of the sort done in this practicum) are highly appropriate where the research topic is complex and sensitive; and where the participants may be inhibited or inarticulate. Walker further stated such interviews are highly appropriate when research participants are of either high or low status. Also, Walker argued interviews are appropriate when the data gathering depends on verbal communication.

At the same time, Jones (1985) suggested that in-depth interviews provide a useful means to explore the meaning which participants may attach to their experience: This interview method allows the researcher to probe beneath overt behaviours and "expected" responses to encourage participants to speak of their reality *in their own way*. In-depth discussions can reveal more of the richness of an individual personality than might be captured by a few lines written on paper.

5.8.0 Using in-depth interviews

Even a superficial examination of the literature indicates that the use of in-depth interviews is a much more sophisticated concept than the idea of a simple discussion between two people. In his review of the literature the student discovered that there are numerous issues to be considered in the use of this research method.

5.8.1 Structure and freedom

Jones (1985) discussed the question of how much structure should be imposed on interviews. Qualitative researchers who seek to comprehend the social world of their participants "do not rigidly structure the direction of enquiry and learning within simplifying, acontextual, a priori definitions" (p. 46). Thus, researchers who doggedly work through a long list of questions may fail to understand the lived experience and world-view of their participants. On the other hand, researchers who try to be non-directive in their approach may leave participants to wonder what the interviewers are really expecting. Indeed, participants may never speak about topics that matter to them.

Jones (1985) argued for an interview style which balances structure and freedom. She suggested the interviewers begin with questions chosen for a clear purpose. Interviewers should then be prepared, as they listen to the participants, to modify or even abandon the particular line of questioning in order better to understand what participants are saying.

5.8.2 Interviewer bias

Jones (1985) suggested that researchers need to enable participants to communicate their unique reality and experience of the world. Researchers, therefore, should be aware of how their own actions and theories may "get in the way" of interactions with their participants. Researchers also should consider how their values may be influencing their perceptions.

5.8.3 Social interaction and self-disclosure

Jones (1985) identified social interaction as a third issue to be considered in in-depth interviewing. In all human encounters, people rely on verbal and non-verbal cues received from others in a particular situation. Therefore, qualitative researchers should strive to create a safe, non-threatening, non-judgmental environment in which participants feel sufficient trust and comfort to reveal their true thoughts and feelings.

5.8.4 Relevance

Jones (1985) wrote that the stated objectives of researchers (such as completing projects or finishing degrees) may be irrelevant to the participants of a study. As a result, participants may not be prepared to disclose highly personal material in a situation that means little to them. Researchers ought, therefore, to be as aware as possible of the limitations of the methods used to collect data.

Jones commented that conducting more than one interview may suggest commitment on the part of researchers. As a result, participants may begin to develop more trust. Further, trust can perhaps be fostered by talking directly about the purposes of the study, and by offering to provide participants with information about the findings.

The concept of "action research", mentioned above, may be yet another way of enhancing the relevance of qualitative research. Here researchers and participants "contract" to do certain things. The participants agree to supply their perceptions of a particular situation while researchers undertake to provide resources to help participants in dealing with the situation.

5.8.5 Impact of time

Rubinstein (1988) discussed the role which time plays in depth interviewing. Rubinstein discovered that a series of interviews allowed the participants to revise some of the statements made early in the interview series. Rubinstein described a "short-term series" of interviews with older men who lived alone. Gradually, over the course of several interviews, some of these men admitted to being more lonely than they had acknowledged at the beginning of the interview series. Rubinstein also conducted what he called a "long-term series" of interviews. The researcher found that such a series of interviews appeared to reveal more about the identity of individuals than might have been discovered in a shorter process of interviewing.

5.9.0 Summary

Two important research methods have developed in the social sciences. Quantitative research attempts to describe reality in numbers and measurements which lend themselves to further statistical interpretation. This form of research has contributed to the development of knowledge by insisting on the importance of empirical data. The rigour of this approach challenges conclusions reached by relying upon hasty, unfounded assumptions, generalisations and predictions.

Feminist thought suggests that quantitative methods of "knowing" have sometimes been valued at the expense of other, equally valid means to knowledge. The dominant patriarchal culture of western society has failed, historically, to acknowledge the existence of alternative ways of perceiving, describing and understanding reality. Qualitative research seeks to supply what may not be captured in quantitative methods. That is, qualitative research rests on the assumption that knowledge can derive from an intentional effort to describe and understand the specificity, essence and concreteness of a phenomenon.

Qualitative research need be no less rigorous than quantitative research. However, instead of the standardised measures used by quantitative research, qualitative research chooses other methods for the collection of data. Qualitative researchers understand that they are *intentionally* entering into a process in which they themselves (with their subjective reactions) become instruments for gathering data. Because their decision to use qualitative research is a chosen one--necessarily informed and disciplined by a theoretical framework--qualitative researchers seek to present data which can not be dismissed as mere "impressions."

Since qualitative research is an interactive process in which human beings are engaged with each other, qualitative researchers require sensitivity to the dynamics of human communication. Respect for the person interviewed is paramount. Confidentiality and honesty must be assured. Qualitative researchers are being permitted into the life and private experience of another. Therefore, researchers seek the most effective ways of communicating with particular individuals. The goal is to uncover what is unique, rather than general, about each person's experience. Accordingly, researchers can not allow

themselves to be too invested in a particular script of questions, or in a specific outcome. As the interaction between researchers and participant unfolds, the researchers need to make contingent decisions about how best to proceed in collecting the data which they seek.

Finally, the literature suggests that the two research methods can be used together or "triangulated" in ways that allow complementary aspects of the same reality to be effectively described. The assumption that such a triangulation is possible (and indeed, desirable) underlay the design of the study undertaken in this practicum.

CHAPTER SIX

DESCRIPTION OF THE INTERVENTION

Having reviewed the literature of depression, life review and qualitative research, the student's next task was to translate theory into practice. This chapter describes how participants of the intervention were selected; how the study was conducted; and how the results were recorded.

6.1.0 Criteria and procedures for selection of participants

6.1.1 Recruitment

People selected as participants for this intervention were all out-patient clients of Psychogeriatric Services at Deer Lodge Centre. Before the practicum began, the student made a presentation to the Treatment Team of Psychogeriatric Services at Deer Lodge Centre. In this presentation, the student described the aims, selection criteria and methodology of his proposed intervention. Based on the information presented by the student, the Treatment Team then suggested the names of individuals who might be suitable participants for the intervention.

6.1.2 Sample size

It was understood that the four potential participants with whom the student wanted to work might not be immediately available. However, within a short time of his presentation to the Treatment Team, he was given the names of three possible participants. Each of these persons proved suitable to participate in the study. Each individual completed the interview process.

The student attempted to intervene with a fourth participant and then, with a fifth participant. For health reasons, neither participant was able to complete the process.

In consultation with his Practicum Committee, the student chose not to seek a sixth candidate. This report presents what the student learned in working with the three participants who completed the

process. Some reference will also be made to the benefit the student received from discussions with the fourth and fifth participants.

6.1.3 Diagnosis criterion

The design of the study required that each participant should already have been diagnosed as depressed by Deer Lodge Psychogeriatric Services. Each participant had been referred to Deer Lodge Centre; and each had received at least one home visit from members of the Treatment Team.

6.1.4 Standardised testing criteria

All of the participants had received psychological testing upon applying for service from Deer Lodge Centre. The plan was to select only participants with scores of 24 or higher on the Mini-Mental Status examination or MMSE (Folstein, Folstein and McHugh, 1975); and only individuals determined to be mildly or moderately depressed by the Geriatric Depression Scale or GDS (Yesavage et al., 1975).

6.1.5 Psychological criterion

Besides selecting participants who were cognitively intact and not severely depressed, the student looked for individuals who, at the same time, might be somewhat psychologically-minded. By the term "psychologically minded" the student was referring to a person's interest in understanding his or her feelings and experience. The rationale for this selection criterion was as follows. The student assumed that the life review process would require cognitive abilities, as well as willingness to look at, and talk about one's own inner world. All of the five participants proved willing and--in varying degrees--capable of examining and discussing aspects of their individual emotional and psychological experience. Moreover, all of the participants were willing to speak about their memories.

6.1.6 Gender criterion

The student hoped that his sample might include both male and female participants. In the end, the complete intervention was directed toward three female participants.

The student wondered if gender might influence an individual's willingness to participate in life review work. In this small sample, the student found men and women equally interested in taking part and equally capable of understanding the basic intent of the intervention.

Another motivation in seeking both male and female subjects was to learn more about possible differences in depression between older males and older females. The literature of geriatric depression suggests that such differences do exist. The student also wanted to discover what qualitative differences might exist between the life review of older men and older women.

The unavailability of suitable male participants did not permit the student to explore gender differences in any depth.

6.2.0 Setting

Initially, the student planned to give the participants a choice of meeting with him in their homes or at Deer Lodge Centre, if that location were preferred by the participant. The student's goal was to seek a comfortable interview setting which offered the participants privacy.

All of the participants chose to be interviewed in their homes. The student discovered the value of conducting the interviews in the participant's home. In their own homes, the participants were surrounded by memories and valued possessions. During the interviews all of the participants left their chairs to find photos and other items to show the student.

6.3.0 Personnel

Each participant was first approached by a member of the Treatment Team. Once the individuals agreed to consider participation in the study, the student--in four of the five cases--first telephoned the individual (or family member) to arrange an initial home visit. The student conducted the first meeting, all

testing and all interviews by himself. Although some of the participants received home visits from members of the Deer Lodge Treatment Team during the course of the study, the student was never present at any of these visits.

It should be noted that although the student did the interviews and testing by himself, he consulted frequently with the supervisor of the practicum, Geri McGrath, the director of Psychogeriatric Services at Deer Lodge Centre. Geri McGrath monitored the student's work through frequent conversations with him and through listening to audio-tapes of the life review conversations.

During the course of the intervention, some of the participants were visited by members of the Treatment Team at Deer Lodge Centre. From time to time, the Team members reported their impressions of the participants' condition to the student. In addition to this informal feedback about the impact of his intervention, the student also consulted with one participant's home-care co-ordinator who stated that this participant had reported benefiting from the life review conversations.

6.4.0 Design

The student wanted the design to meet two requirements. The design, first, needed scientific rigour. Second, the design required a kind of flexibility that might do justice to the rich personal memories and reflections that were the very substance of the whole study.

The design chosen for the study was described as "integrated or triangulated" by Rowles and Reinharz (1988). To be specific, the design incorporated *both* quantitative and qualitative methods of research.

6.4.1 Quantitative research methods

In terms of quantitative research, this intervention might be viewed as what Kazdin (1982, pp. 92-94) called "Case Study Type III, with multiple cases, continuous assessment and stability information".

a) The term case study is appropriate to describe the method of data collection and analysis in this intervention. The student's expectation was to learn from the careful examination of a small number of individual cases.

b) The study involved multiple cases in the sense that the student started to work with five individuals. Only three participants received the complete intervention.

c) The student attempted to meet the criterion of continuous assessment by using a self-anchored scale at the beginning of each session. The participants were asked to rate their level of depression since the last interview. (The self-anchored scale, part of the Student Log, may be seen in Appendix D.)

d) The continuous assessment was supplemented by objective data provided through two standardised measures administered before and after the intervention. The two measures were a) The Mini-Mental State examination or MMSE (Folstein, Folstein and McHugh, 1975) and b) The Geriatric Depression Scale or GDS (Yesavage et al., 1983). [Note: the two standardised measures are discussed in more detail in section 6.6.1, below.]

e) Kazdin's (1982) requirement that this sort of case study include stability information was assured by the fact the Treatment Team at Deer Lodge Centre referred for intervention only those participants whose depression has been diagnosed to be an ongoing condition.

Kazdin (1982) argued that with objective data, multiple cases, continuous assessment, and stability of problem, the following threats to internal validity can be ruled out: history, maturation, testing, instrumentation and statistical regression. Kazdin (1982) further stated that the form of case study chosen for this practicum:

> provides a strong basis for drawing valid inferences about the impact of treatment. The manner in which the multiple case report is designed does not constitute an experiment, as usually conceived, because each case represents an uncontrolled demonstration. However, characteristics of the type of case study can rule out

specific threats to internal validity in a manner approaching that of true experiments. (p. 94)

6.4.2 Qualitative research methods

The design of the intervention incorporated several characteristics of qualitative research identified by Rowles and Reinharz (1988).

a) Personal interaction played a key role in this study. Fortunately, sufficient mutual trust developed between the student and each of the participants for honest discussion to take place.

b) Without doubt, the consideration of context proved to be important in this study. The highly personal nature of the life review process *demands* attention to context. The student frequently found himself asking for clarification of some reference made by the participants. In the process of listening to the explanations, the student learned about social history, especially during the Great Depression and World War II.

c) Throughout the practicum, the student was often reminded of the value of what Silverman (1988) calls "connected knowing." The student became increasingly persuaded that any concept of knowledge which might inform life review work has to take very seriously *the participant's own experience* as an important source of data.

In talking with Participants # 1 and 2 the student had experiences of using what he believes was "connected knowing." Both participants spoke at length of their loneliness. Because health problems have removed the student from the work force for more than a decade, he has for some years been deprived of the normal social supports and stimulation a person his age might expect. Without the experience of his own loneliness, the student does not believe he would have been able to grasp as easily what the participants were trying to describe. His own understanding of the participants' situations helped the student in framing questions about their experience of being retired and single and alone. Without his own reference points, the student would have had to rely more on what "separate knowing"

(that is, knowledge outside himself) might have to say about the connections between loneliness and depression.

d) Since the participants for this study were chosen to be cognitively intact, somewhat psychologically-minded, and motivated to participate, they clearly constituted an intentionally-chosen sample. As already indicated, the term "psychologically minded" refers to a capacity to take an interest in one's own feelings and psychological processes.

e) In doing life review with each of the participants, the student found himself engaged in .an ongoing collection of data . Every conversation revealed new information about each participant's biography and experience of depression. The three participants who completed the process were all comfortable in discussing their depression; so the topic could be explored easily and often. The student log in Appendix D shows the sorts of data the student was collecting at each session. The student log is discussed in more detail in section 6.6.4, below.

f) The life review discussions required the use of open-ended questions . Such questions allowed the participants to follow their memories. No recollection or story could be ruled to be "off topic."

The interview guide developed by Kivnick (1991), excerpts of which are reproduced in Appendix B, provided a thematic framework for the discussions. The student's goal was to help each participant examine her own experience of the eight developmental stages described by Erikson (Erikson, Erikson and Kivnick, 1986). Although inevitably, the discussions touched on a large number of biographical details, the student's real interest was uncovering problem areas in the participant's developmental process. The student assumed that a review of unfinished developmental tasks might help to decrease the level of depression in each participant.

6.4.3 "Action research" as a component of the design

Jones (1985) described the concept of "action research". In this form of research, not only is data collected merely for the sake of increasing knowledge of a topic; but the collection of data also becomes an opportunity for the informant to receive feedback and information.

In this intervention the student experienced a kind of "exchange" taking place. All of the participants were willing to talk about their memories. Their participation allowed the student to observe the experience of depression and the life review process. It was hoped that, at the same time, the participants might benefit from telling their stories to an interested, sympathetic listener.

A discussion of "action research" raises an issue with which the student struggled in designing the practicum. The student wished to articulate precisely how his relationship to the participants might be defined. His stated goal was to use life review as an intervention in depression. The sensitive and intimate nature of the material discussed with participants might well have confused both student and participant.

Though he might be hearing about each participant's personal problems, the student was not the participant's primary therapist. Since the student was not primary therapist or social worker to the participants, he entered the study with certain assumptions. That is, the student's task was not to intervene in any current problems the participant might be experiencing. If such a problem had come to the attention of the student, he had committed himself to do two things.

First, he would have asked the participant if he or she wished the student to speak to the primary therapist or social worker. If the participant had wished the student to speak to someone else, he would have done so.

Second, the student would have respected the participant's wishes about referring or not referring *except* where he perceived a risk of suicide. If he had detected suicidal thoughts or plans in the participant, the student would have consulted immediately with the primary therapist.

The student observed that participants seemed clear about his purpose in meeting with them: *he was there to talk about their lives.* From time to time, current problems were discussed--but more with the attitude one might have in talking to a friend rather than to a therapist. There did not seem to be any expectation on the part of the participants that the student was there to solve their problems. The participants appeared to want to continue working their way through the process. There was a certain curiosity and anticipation as to what questions might be coming. This interest in what might be asked next added momentum to the interview process.

6.5.0 Procedures

6.5.1 Initial session with the participants

After first telephoning to arrange an appointment, the student made an initial visit to each of the participants. The student introduced himself and his study. The student requested the help of the participants, if they should choose to participate. No pressure was put on the participants to take part. The consent form (a sample of which can be found in Appendix C) was read and explained to the participants. Special care was taken to explain why the sessions were to be audio-taped. None of the participants declined to participate; but one participant did want to get a family member to review the consent form before she agreed to take part.

6.5.2 Second session: history-taking

With each of the participants, the student used the second session to take a detailed history of the participant's experience of depression. Information gathered during this process is included in the individual case studies which follow in Chapter Seven of this report.

6.5.3 Life review sessions and final visit

Since the discussion guide developed by Kivnick (1991) covers eight major themes, the student anticipated that about eight sessions would be needed with each participant. With the three participants able to complete the process, this estimate proved to be correct. Each session ranged in length from about one hour to sometimes more than two hours, in the case of one highly verbal participant.

The final visit was reserved for re-testing the participants on the standard measures; and for thanking the participants for their participation. The student promised to make a follow-up visit to each of the three participants at some point in the future. At that time, the audio tapes of sessions were to be given to the participants.

6.5.4 Follow-up testing

In late February and early March, 1996 the student paid a follow-up visit to each of the three participants who completed the process. At that time, the student gave each participant the audio-tapes of the life review discussions. As well, the student administered the GDS (Yesavage et al., 1983) to see if there had been change in the participants level of depression.

The student also read each participant a typed transcript of excerpts from the life review discussions. Each participant was asked if there were any comments that she wanted deleted. The student then requested the participants to sign a consent form which allows the student to quote from the transcript in this report and in any subsequent presentations he may make. The participants were assured that their identities would be kept confidential. A sample of this consent form may be seen in Appendix E.

6.5.5 Issues of closure and referral

One of the concerns in this study was the issue of closure. The student established an emotional connection with the three participants who completed the process. Therefore, the student wanted, from the start, to make clear that the number of sessions would be limited. None of the participants appeared to have difficulty accepting that the process was not about friendship or friendly visiting. Two participants indicated that they wanted the satisfaction of finishing something. A third participant had a parting Christmas gift for the student.

The student felt sadness at ending regular contact with the two participants who had gone most deeply into the process. Both of the individuals had talked of intimate matters as honestly as they could. The student felt both touched and honoured by the trust they placed in him. The student understands the observation by Coleman (1986) that the researcher became sufficiently connected to some of his life review clients that he followed them until their deaths.

6.5.6 Duration

The study was conducted between September 8, 1995 and December 23, 1995, with the follow-up visits being done in February and March, 1996. None of the participants started or finished at exactly the same time. However, interviews with the three participants who completed the process and the fourth (who started but did not finish) were ongoing during the same period.

When the fourth participant clearly demonstrated that illness was preventing his further participation, a fifth participant was proposed. The student visited this individual December 23, 1995. This person was not able to participate any further due to hospitalisation on December 25.

During a telephone consultation in January 1996 with members of the Practicum Committee, the student received permission to end his practicum. It was agreed that this report should include the work done with first three participants as well as the substance of the work with the fourth and fifth participants.

6.6.0 Recording

The design of this study involved four methods of recording: a) standardised measures; b) continuous assessment; c) audio-tapes and d) a student log.

6.6.1 Standardised measures

In setting up this study, the student was assured that each participant referred to him would have already undergone testing by the Treatment Team at Deer Lodge Centre. The measures used by the Team would be a) the Mini-Mental State examination or MMSE (Folstein, Folstein and McHugh, 1975 and b) the Geriatric Depression Scale or GDS (Yesavage et al., 1983) At the beginning and end of the study, those participants who completed the process were tested with the same measures.

a) The first measure used was The Mini-Mental State examination or MMSE (Folstein, Folstein and McHugh, 1975). The MMSE is well-known and widely administered. U'Ren (1987) described the

MMSE as "probably the most widely used cognitive screening instrument in the United States" (p. 54).

Folstein, Folstein and McHugh (1975) reported that the MMSE demonstrated validity in detecting cognitive improvement or changes in people who received appropriate treatment for depression. These individuals had cognitive impairment associated with depression. As their depression levels decreased, these people experienced improved cognitive functioning, whereas individuals with uncorrectable brain disease showed little change in cognitive functioning after treatment. When compared with other measures of verbal and performance intelligence, the MMSE. had concurrent validity scores of Pearson $r = 0.776$ ($p < 0.0001$) and Pearson $r = 0.660$ ($p < 0.001$) respectively (Folstein, Folstein and McHugh , 1975).

In terms of reliability, Folstein, Folstein and McHugh (1975) reported that the MMSE is reliable on 24 hour or 28 day re-tests with single or multiple examiners. These researchers found Pearson $r = 0.887$ ($p < 0.0001$) for 24 hour re-tests and Pearson $r = 0.988$ ($p < 0.0001$) for 28 day re-tests.

The Mini-Mental State examination or MMSE (Folstein, Folstein and McHugh, 1975) consisting of eleven questions and requiring five to ten minutes to complete, measures the client's memory, attention and orientation to reality. The MMSE assesses the client's ability to name objects, to follow instructions, to write a sentence and to copy a geometric figure.

In developing the MMSE, the researchers first tested 69 psychiatric patients who presented clear examples of clinical conditions. The scores of these patients were compared with those of 63 normal seniors, resident in the community. Out of a possible maximum score of 30, the following mean scores were obtained:

i) patients with dementia: 9.7;

ii) depressed patients with cognitive impairment: 19.0;

iii) patients with an uncomplicated affective disorder, depressed: 25.1;

iv) normal non-patients: 27.6.

Next, to standardise the measure, the researchers tested 137 consecutive admissions to the same psychiatric hospital. In this trial, the researchers found that only those individuals with delirium,

dementia, schizophrenia or affective disorder obtained scores of 20 or lower. Normal elders and those diagnosed to have neuroses or personality disorders tended to score higher. The researchers argued, therefore, that their instrument provides a useful quantitative measure of the severity of cognitive impairment.

Folstein, Folstein and McHugh (1975) also noted that they found the MMSE "particularly useful in documenting the cognitive disability found in some patients with affective disorder (Post's pseudodementia) and the improvement of this symptom with appropriate therapy for the mood disorder" (p. 195). Consequently one of the assumptions of this study was that improvement on MMSE scores might suggest that the intervention had had some positive impact on the level of depression.

b) The second standardised measure used in this practicum was the Geriatric Depression Scale or GDS (Yesavage et al., 1983). Like the MMSE, the GDS is widely recognised in the geriatric literature. Katona (1994) reported that the GDS has been recommended in Britain by the Royal College of Physicians, the British Geriatric Society and the Royal College of General Practitioners. Fischer and Corcoran (1994) reported that in regard to reliability, the GDS has excellent internal consistency (alpha of .94) and excellent stability (one-week test-re-test correlation of .85). The same authors reported that the GDS has excellent concurrent validity with correlations of about .83 when compared with other depression scales.

The GDS was developed to address three problems encountered in the assessment of depression in elderly patients.

First, because depression in older persons is frequently accompanied by cognitive impairment and memory loss, depression may be wrongly diagnosed as dementia.

Second, previous tests for depression tended to stress somatic symptoms. Thus, earlier tests did not always allow for the possibility that some physical complaints in seniors may be related to causes other than depression.

Third, existing measures of depression were not always sensitive to the unique situation of elderly persons. Questions about sexuality, for instance, might create more resistance in older persons than in younger patients. At the same time, elderly persons might respond to questions about their hopes for the future in a different manner than younger people who naturally expect to have many years ahead of them.

In developing the GDS, the researchers chose 100 questions designed to distinguish depressed older persons from non-depressed individuals. The questions were administered to 47 people who either had no history of depression, or who had been hospitalised for depression. The 30 items which correlated mostly highly and significantly with non-somatic symptoms of depression were then included in the GDS. Next, during the validation phase, the 30-item test was administered to one group of 40 normal elderly persons and to a second group of 60 depressed patients. Yesavage et al. (1983) stated that the results of trials and analyses "provide evidence that the GDS is a reliable and valid measure of geriatric depression. A high degree of internal consistency was found for the scale, and total scores on the GDS were reliable over a one-week interval" (p. 45).

The researchers further suggested that the GDS can distinguish between normal, mildly depressed and severely depressed elderly individuals. Scores of 0-10 are considered to be within the normal range. Scores of 11 or greater may indicate the presence of depression. The test is also effective in distinguishing between non-depressed, and depressed physically-ill elders. Finally, the test has been shown to be valid in measuring depression in both demented and normal elders.

6.6.2 Continuous assessment instrument:

At the beginning of each session, the participants were asked to rate their perception of their current level of depression. The student used a continuous assessment tool in which the participants were asked, "How do you feel you are doing with your depression since we last talked?" The participants were then given a choice of five possible responses, each of which had been assigned a numerical value on a

scale of 1 ("much better") to 5 ("much worse"). An example of the continuous assessment tool is contained in Appendix D.

The instrument was developed by the student for two purposes: a) to permit easy administration to the participant at the beginning of each session; and b) to allow the participant a sense of participation in his or her treatment. A similar scale was to be completed in each session by the student to record his general impression of the participants current level of depression.

In noting his impressions of each participant's current level of depression, the student referred to the list of symptoms which each participant had identified as particularly troubling. The individualised list of symptoms was compiled during the second meeting with each participant when each individual's experience of depression was discussed in detail.

One example will illustrate how the student used the participants' own lists in looking for changes in the level of depression. In her in-depth discussion of her experience of depression, Participant #2 stated that when she was very depressed, she could not concentrate enough to read. Since this individual had always valued reading, she found her inability to concentrate extremely distressing. Therefore, in assessing this participant's current level of depression at each session, the student always asked Participant #2 if she had been able to do any reading since the last session.

In actual fact, the student experienced some difficulty in using the continuous assessment instrument. Two of the participants insisted that they were no longer depressed. Their answer was always tied to a comparison with the period during which they first became clients of Deer Lodge Centre. Invariably, both participants reminisced about how bad they felt ***back then.*** But, they insisted, they were "so much better now." The participant who tested as most depressed did not respond to the idea of rating her depression level since the last interview. In her opinion, her depression was an inevitable, ongoing, unalterable condition.

Nevertheless, the student continued to ask the question at the beginning of each session. The student noted both the answer he received and his own subjective impressions. In retrospect, the student now believes that this scale might have been used more effectively.

If the actual printed form of the instrument had been put before the participants at the beginning of each session, the student believes that he might have received a more precise response. The three participants were willing to complete the written parts of the MMSE when asked to do so. The student now speculates that a similar readiness might have been demonstrated if the participants had actually been asked to take pencil in hand. Presentation of the question in verbal form clearly was not completely effective in collecting quantitative data. Rather than sticking to the categories suggested by the instrument, the participants tended to give a longer, often more rambling response.

In looking back at the sessions he had with each participant, the student sees that he and the participants developed a certain ritual for conducting each interview. If a paper-and-pencil completion of the continuous assessment scale had been made into a ritual, there might have been a more (quantitatively) precise collection of data.

6.6.3 Audio-tapes

All the guided life review sessions were audio-taped to capture the interaction between participant and student. At the end of the practicum, the tapes were then given to the participants for their own use. Transcripts of the conversations with the three participants who completed the process are contained in Appendices F, G and H.

It should be noted that inviting the participants to review the transcripts of life review conversations helped to strengthen the credibility of data collected during the practicum. The participants were encouraged to delete any remarks which they did not feel appropriate. None of the participants elected to delete anything. Thus, it may be assumed that the transcripts are a reasonably accurate record of the participants' experience of guided life review.

6.6.4 Student log

The student developed a log form (an example of which may be found in Appendix D) to record his impressions of each life review session. The student completed the log while listening to the audio-tapes of each session.

The log was intended to record information such as: a) the results of the self-anchored scale administered at each session; b) any possible physical indicators of depression which had been suggested by a review of the geriatric depression literature[e.g., body language or tears]; c) any significant biographical details [e.g., important milestones in the participant's life]; and d) any topic which might require further exploration at another time.

Overall, the student found the chief value of the log to be its usefulness in recording the continuous assessment scores. The log also proved helpful, from time to time, for other reasons. Although none of the participants showed great change in physical appearance or body language, the log did remind the student to pay attention to tears, energy levels and voice quality.

The student did not make extensive use of the section of the form reserved for biographical notes. With only three (very different) participants and frequent reference to each individual's "big stories," the student soon had a working outline of each person's life. The biographical notations did however help the student to be precise about dates and other details.

The student found the log useful when he was reviewing the audio-tapes. From time to time, the student noted topics which required more explanation or further exploration. Probably the greatest value of the log was in reminding the student to be as alert and as active a listener as possible.

CHAPTER SEVEN

EVALUATION OF THE INTERVENTION

Please note that all tables mentioned

in Chapter Seven

are located at the end of the chapter.

As already indicated, the intervention attempted in this practicum was targeted at geriatric depression. The hypothesis was that leading carefully-selected seniors through an individualised review of their lives might reduce their levels of depression.

The practicum will be evaluated by examination of two major topics. The first part of evaluation will discuss the impact of the intervention itself by reference to case studies and quantitative data. The second part of the evaluation will focus on the practicum as an educational experience. The contribution made by the practicum to social work research and practice will be discussed. As well, some suggestions for further research will be offered.

7.1.0 The use of qualitative data in this report

As already indicated, the primary aim of this intervention was to examine the effect of guided life review on geriatric depression. Accordingly, this chapter examines the impact of the intervention on the participants of the study.

However, a description of quantitative data alone does not reflect the totality of the student's learning in this practicum. Besides his primary goal, the student had the secondary aims of learning to conduct life review therapy and qualitative research.

Not surprisingly, the numerous life review sessions and the qualitative research methods produced considerable amounts of anecdotal data. Discussions with both Participant #1 and Participant

#2 uncovered long-standing personal issues which may indeed have contributed to these participants' experience of depression. The student, therefore, has selected the information he believes might be related to the genesis and continuance of depression in these participants.

Participant #3, by contrast, does not appear to have had a long history of depression. The developmental process of this individual does not seem to have had much bearing on her current depression. Therefore, although discussions with this individual also generated a great amount of data, much of that material will not be included in what follows.

7.2.0 Case study of Participant #1

Please note: Excerpts from interviews with Participant #1 are presented in Appendix F

7.2.1 General description of Participant #1

This 82-year-old woman has never married. She struggles to continue to live alone in an apartment. She receives regular visits from a home care worker and a nurse. The participant has several years of post-secondary education. After working at a variety of jobs, she found her niche as a special education teacher.

7.2.2 Participant #1's history of depression

By her telling, Participant #1 has had a long and complicated history of depression. Born into a large and poor farm family, she had lost both her parents by age six. As a result she and her siblings were separated. From age six to age nine, the participant underwent a number of dislocations.

Finally, at age nine, she went to live with an older married sister about whom she had ambivalent feelings as long as this sister lived. This sister functioned as both sibling and surrogate mother. The participant declared that she never felt completely free to assert herself. In addition, the sister's husband abused the participant both sexually and emotionally. She was obliged to keep quiet by this

man's threats and intimidation. The participant sees herself as having struggled until she was 26 to escape from her brother-in-law.

The participant reported having had several experiences of depression. The first experience, in her elementary school years, is connected in the participant's mind with bullying she received for a variety of reasons.

The first episode of depression for which she received treatment occurred when the participant was a young woman. After moving several times to find work and failing to secure a living wage, she was hospitalised with what her doctors called "nervous exhaustion." About this time, she suffered the loss of the one man whom she had wanted to marry. The participant rates this man's death as highly significant in her life.

Eventually the participant managed to qualify as a professional church worker. She returned to Manitoba to live with the sister who had raised her. By that time widowed, this sister continued to exercise powerful emotional control over participant's life and decisions.. At this sister's urging, the participant gave up her work with the church. The participant then studied to be a teacher. In this job she finally achieved steady employment and some emotional independence. Throughout her objectively successful career as a teacher, the participant struggled with perfectionist tendencies and a profound sense of inferiority.

Her sister's death in 1963 brought the participant another episode of depression. The participant remembers regretting that she had not understood that her sister was dying. At the time of the sister's death, the participant experienced a complicated mix of grief, regret, guilt and resentment.

The participant reported long periods of loneliness during her years as a teacher. She involved herself in community organisations, church activities and numerous hobbies. She depended a great deal upon a good friendship with a female colleague.

The participant's more recent episodes of depression (since 1989) appear to coincide with a variety of health problems. She has had numerous hospitalisations. High anxiety has several times prompted her to check herself into hospital. When she presents at the hospital emergency department in a

visibly anxious and tearful condition, she states that she is suffering from "nervous exhaustion" (the term used at her first diagnosis in the 1930's). She attributes her anxiety to her frustration with the limitations imposed by several physical problems as well as to her inability to persuade medical and home-care authorities of the severity of her physical complaints. She is extremely concerned about being sick when she is alone and unable to summon help Recently, as well, she has felt herself deserted by her friends at her church to whom she had looked for emotional support. She sees herself as battling alone to receive the services necessary for her to continue to live in her apartment. She believes that she was being forced to enter a nursing home.

During these recent depressive episodes, the participant remembers herself as frequently tearful. She recalls feeling seriously unwell, physically. She reports frustration at her inability to perform routine activities of daily living. She describes a lack of motivation to leave her apartment. She also had problems with both eating and sleeping.

At the beginning of the student's intervention, the participant stated that she believed her depression was over. She emphasised how much better she felt both physically and emotionally. Throughout the intervention the participant continued to say that her depression was over.

The follow-up visit with Participant #1 was conducted in a hospital where she was recovering from pneumonia. The slightly higher depression score recorded during this visit appears to reflect the participant's discouragement with her physical problems rather than any change in her basic psychological state.

7.2.3 Results of standardised testing with Participant #1

Table 7.1 and Table 7.2 (located at the end of this chapter) present the results of standardised testing with Participant # 1.

7.2.4 Results of continuous evaluation with Participant #1

The results of the continuous evaluation process with Participant # 1 are presented in Table 7.3 at the end of this chapter. At the beginning of each interview during the life review process, the participant ["P"] was asked to rate her experience of depression (since the last interview) on a five-point, self-anchored scale which offered response choices from "much worse" (5 points) to "much better" (1 point). At the same time, the student rated his perception of change (since the last interview) in the participant's level of depression.

Examination of Table 7.3 indicates that the participant most often selected "about the same" to describe her depression level. As already stated, she consistently declared that she was not depressed at the time of the intervention. The student's ratings tended to agree with the participant's assessment.

7.2.6 Participant #1's life review process

Repeated comments by Participant #1 suggest that the life review process was essentially positive for her. She made similar remarks to her home-care co-ordinator, her home-care workers and to social workers who visited her after the intervention ended. She repeated the same comments during the student's follow-up visit.

The thematic questions suggested by Kivnick (1991) appeared to be an effective means to elicit a comprehensive discussion of the participant's life and experience. An extremely verbal person, Participant #1 responded, often in considerable detail, to any question she was asked. There was no topic which she declined to discuss.

The low GDS scores both before and after the intervention raise important questions. Was Participant #1 depressed? Various care providers who have had contact with Participant #1 consistently describe her as anxious. However, unanswered questions remain. Are the symptoms of anxiety presented by Participant #1 evidence of a depression not detected by the GDS; or are those symptoms related to the participant's serious, on-going cardiac-pulmonary problems? Or is some undiagnosed personality disorder at the heart of the participant's continuing anxiety?

In terms of the psychosocial themes presented by Kivnick (1991), Participant #1 may have life-long deficits in a number of areas which could, perhaps, be related to her depression.

Willfulness, independence and control: The participant's sense of being in control of her life may have been violated in a variety of ways. Though she was aware (at age nine) of discussions about the possibility of her being adopted, the participant was never invited to state her wishes. She wanted very much to be adopted; and her foster family wanted to adopt her. However, the adoption never took place. The participant does not appear ever completely to have understood why the adoption did not occur.

When she came to live with her sister and her husband, the participant was encouraged to feel indebted for her care. The unclear role of her older sister (as both sibling and surrogate mother) denied the participant any chance for normal adolescent independence or self-assertion. In addition, the abusive, manipulative treatment received from her brother-in-law kept the participant in an emotional "bind." Though the participant wanted to be on her own, the brother-in-law insisted she was "needed" to help her ailing sister. As well, the brother-in-law constantly reminded her of how much she owed him for taking her in. He often suggested that the participant was not intelligent enough to survive on her own.

Furthermore, the brother-in-law used manipulation to prevent the participant's developing relationships with boys her age. She states that she was never "allowed" to have a boyfriend.

The issue of independence appears never to have been resolved in the participant's life. As long as the older sister lived, she continued to exert powerful influence over her younger sibling. Even at the end of her own life, the participant is still struggling to make independent decisions about what kind of care she needs.

As he listened to the participant's detailed accounts of her struggle for independence, the student was reminded of the Parker's (1994) investigations of parental bonding and depressive disorders. Participant # 1 seems to have received (surrogate) parenting low in "care" (that is, in affection and responsiveness) but high in "protection" (that is, in vigilance and control.) Furthermore, the surrogate parental "control" function was used to cover abuse by the participant's brother-in-law. Parker (1994) commented that "the combination of low care and over protection is not uncommon, and its particularly

malignant effects on the later development of depression in adulthood can be seen to emerge from these two differing mechanisms" (p. 308).

Competence and hard work: There is evidence to suggest that this participant's sense of her own competence was seriously undermined during her elementary school years. First, with the break up of her family, she was obliged to move and change schools several times. The result was that more than once, she was either moved ahead or back a grade. Therefore, she repeatedly found herself at class levels which were not age-appropriate. She stated that some of her teachers assumed that she was "slow." Somewhat over weight and rather large for her age, she was the target of mockery by certain of her male classmates. Added to these problems was the prejudice she experienced because she was rumoured to be her sister's illegitimate child.

Her poor self-image was further reinforced by the insidious abuse perpetrated by her brother-in-law. One of his strategies to keep her at home was to tell her that she did not "have enough sense to come in out of the rain." He also threatened to "punish" the participant's sister if the participant did not obey him.

Looking back, the participant describes herself a "slow learner" who today would be placed in the classes for special needs children which she herself later taught. This self-description did not ring true to the student who found Participant # 1 to present as an educated, articulate woman with broad general knowledge. Her excellent memory permits her to recall long passages of poetry and songs she learned as a child. Her apartment reflects her interest and considerable skill in a number of complex crafts. She showed the student cherished letters from former students who had wanted to express their appreciation for her skill and kindness as a teacher.

Participant #1 appears to have struggled throughout her life to prove her competence. She clearly was deeply discouraged in her young adulthood (the depression-ridden 1930's) by her inability to find work. She seems to have interpreted her failure to find work as evidence of her incompetence. It might be speculated that her current battle to continue to live in her apartment is yet one more attempt to demonstrate her competence.

It is worth noting that Participant #1 appears to have been relatively free of depression since her sister's death in the mid-1960's. For the last three decades the participant has been able to exercise a good deal of independence. She has developed some sense of herself as a competent teacher and wage-earner. Now as her health is deteriorating, her symptoms of depression and anxiety have reappeared. Could it be that the participant experiences ill-health as an assault on her sense of independence and confidence? Could the reappearance of depression in recent years be related to the reawakening of old, unresolved developmental issues?

Finally, in the conversations with Participant #1 (more than with the other participants) the student believes he happened to be doing his intervention at a time when an active life review was already in process. Lewis and Butler (1974) stated that "in individual psychotherapy, the life review obviously is not a process initiated by the therapist. Rather, the therapist taps into an already ongoing self-analysis and participates in it with the older person" (p. 168).

7.3.0 Case study of Participant #2

Please note: Excerpts from interviews with Participant #2 are presented in Appendix G

7.3.1 General description of Participant #2

This 73-year-old widow lives alone in an apartment. She has no children. Though she does her own housework, she does receive visits from a nurse. Apart from a weekly friendly chat with a volunteer visitor and occasional telephone conversations with a sister, she has almost no social interaction.

7.3.2 Participant #2's history of depression

This participant started her description of her experience of depression by saying that she used to be a happy person, someone who was "always on the go."

Her first experience of depression came on quickly when she was forty. She found herself crying all the time. She could not motivate herself to do anything. Her general practitioner referred her to an internist who subsequently referred her to a psychiatrist. This bout of depression (which lasted more than a year) was characterised by powerful fears, especially the fear of dying. Although other symptoms decreased in time, the fears continued for two or three years. She received no medication.

After being "quite fine" for about 16 years, Participant #2 again experienced depression at age 61, when her husband died. Although less fearful this time, she describes herself as a "zombie." She states that she ate all the time. She had difficulty sleeping. Four months after her husband's death, she deliberately tried to drink herself to death. Within a month of heavy drinking, she was forced to stop by the discomfort resulting from a hiatus hernia.

Even in the midst of her depression, Participant #2 continued to do a great deal of walking, something she had always done with her husband. Eventually she took a variety of volunteer jobs to keep herself busy. When she could concentrate, she filled a lot of time by reading.

She states that her depression has been virtually constant since her husband's death in 1985. She believes that her symptoms intensified during and after the lingering death of her sister in 1992. Participant #2 saw herself as the only support of this sister whom she visited every day of her final illness.

Around the time of her sister's death, Participant #2 felt intensely angry at other family members for their unwillingness to visit the sister (who often exhibited bizarre schizophrenic behaviour.) Participant # 2 describes "angry streaks" during which she would swear and feel "angry about everything." She contemplated jumping off a bridge or taking an overdose. What "held her up" she says, was the teaching of her religion that suicide is a sin. After her sister's death--with no family support--Participant #2 made her sister's funeral arrangements, settled her estate and closed her apartment.

Since 1992, Participant #2 has had a number of depression-related hospitalisations. She expresses grief at the death, in 1994, of a trusted psychiatrist who had been working with her for seven years. A sad but fond memory to which she often returned during the life review conversations had to do

with the psychiatrist. After his death, the psychiatrist's staff told Participant # 2 that the doctor had often told them, "Be sure you look after [the participant]."

The participant reports having tried a number of anti-depressants with no long-term improvement.

During an initial history-taking session with the student, Participant #2 spoke of being troubled with regrets about not having done more for her sister. The participant complained of her inability to concentrate enough to read. She described great restlessness. She reported recurrent fears that she would die alone; that her body would not be found for days.

7.3.3 Results of standardised testing with Participant #2

Table 7.4 and Table 7.5 (at the end of this chapter) present the results of standardised testing with Participant # 2.

It should be noted that at the time of the follow-up testing , Participant #2 was experiencing considerable stress. First, she had been virtually house-bound for several weeks as the result of a knee fracture. Consequently, the participant had been unable to go for her daily walks which have always been a means of coping with anxiety and loneliness.

Second, at the time of her knee fracture, the participant had been hospitalised briefly. While in hospital, the participant was traumatised by a physician's suggestion that she should prepare a living will. The physician did not take time to explain the suggestion. The participant was left to conclude that her death must be imminent. One of the participant's greatest fears is that she will die alone.

Third, the participant was being harassed by a mentally-ill relative who keeps asking for handouts of money. Asserting herself has always been difficult for this participant.

7.3.4. Results of continuous evaluation with Participant #2

Results of the continuous evaluation process with Participant # 2 are presented in Table 7.6. At the beginning of each interview during the life review process, the participant ["P"] was asked to rate her experience of depression (since the last interview) on a five-point, self-anchored scale which offered response choices from "much worse (5 points) to "much better" (1 point). At the same time, the student rated his perception of change (since the last interview) in the participant's level of depression.

As examination of Table 7.6 indicates Participant # 2's self-rating of depression varied little. She consistently expressed resignation and hopelessness in regard to improvement in her depression. The student's rating tended to agree with the Participant's assessment. Starting with review session # 8 the student observed that the participant appeared more relaxed and cheerful. The participant seemed to gain energy during the course of the later discussions, as though her sense of loneliness had been temporarily reduced.

7.3.6 Participant #2's life review process

Before discussing this participant's developmental issues and their possible relation to depression, certain remarks should be made. For one thing, there may be a hereditary predisposition to depression in Participant #2. This participant remembers her father as being depressed, even suicidal at times. In addition, one of the participant's sisters, now deceased, was a diagnosed schizophrenic. This sister's surviving son is mentally ill.

It should also be noted that Participant # 2 has been under psychiatric care for many years. Anti-depressant medication has never improved her condition for any sustained period.

As with the other participants in this study, the inventory by Kivnick (1991) called forth a good response from Participant # 2. Though soft-spoken and reticent, Participant #2 willingly answered all the questions put to her. As she became more comfortable with the student, she gave more detailed replies which often indicated her intelligence, humour and insight.

The particular way in which two psychosocial themes emerged in the life of Participant #2 may have further complicated what appears to be her hereditary and physiological predisposition to depression.

Willfulness, independence and control: As a child, Participant #2 appears to have received little encouragement to exercise her independence. Born into a large family, she was simply one among many children. Her hard-working but impoverished parents stressed austere religious values and the imperative of obedience.

Participant #2 had none of the toys or fashionable clothes of the neighbour children, the sons and daughters of prosperous land-owning farmers. At school she remembers watching her classmates throw away half-eaten apples. An apple was almost an unknown luxury to the participant whose diet consisted largely of potatoes, bread and lard. The other children made fun of her damaged eye, her very plain clothes and never-cut hair. They mocked her misshapen legs and her physical awkwardness, both the result of her having had rickets.

At age thirteen, she left school to work on neighbouring farms. Whatever money she earned she gave to her mother. From about age sixteen until she married in her early twenties, she worked at unskilled, domestic and factory jobs. In none of these situations was she allowed to think for herself or assert herself.

She married a kind man whose values were, nevertheless, clearly patriarchal. He expected to make decisions and choices for himself and his wife. Thus Participant # 2's life and decisions were directed first by parents and then by her employers. Finally, in her early twenties she surrendered the control of her life to a loving, yet domineering husband. To illustrate, the husband did not approve of short hair on women. Thus, even though she dislikes long hair on herself, the participant gave up the convenient short hairstyle she had adopted during the few years when she lived neither with her parents nor with her husband.

Another patriarchal belief of this participant's husband was his conviction that his wife should not work outside the home. However, at some points, Participant #2 was obliged to do day work to supplement the meagre disability allowance her husband, a disabled war veteran, received.

Her husband was a restless man who insisted on moving 39 times in 40 years of marriage. Participant #2 hated the rootlessness of their life, as well as the constant packing and unpacking. Partly as a result of this nomadic lifestyle, the participant and her husband failed to develop any lasting friendships. They almost never socialised. For most of their marriage, they lived thousands of miles from Participant #2's relatives in Manitoba. This participant was not able to attend the funerals of either parent. She was never part of any rites of passage observed by her extended family in Manitoba.

To this day, the participant reports difficulty in asserting herself. She states that she has bought dresses she hates because is reluctant to say no to a salesclerk. She is currently troubled by a family member who keeps asking her to give him money.

Values and sense of self: It is interesting to speculate that the thwarted development of independence in Participant #2 may have interfered with the development of her values and sense of self. The environment in which she was raised did not encourage any independent thinking. She was required to accept without criticism the value system of her parents. She was taught, for instance, that a man ought to be the head of the house. This belief prepared her for life with her husband who had the same conviction. In addition, her parental home inculcated a strong belief in sin and hell. Even today, this participant wonders if she is "good enough" to get into heaven. Although she has the intelligence and curiosity to think about philosophical questions, she has never believed her thoughts matter.

Participant #2 seems to have defined her identity completely in terms of her husband. He made all their decisions. In many ways, his praise and approval became her reasons for living. When her husband died after nearly forty years of marriage, this participant was a woman with no other identity than wife. She had no children to offer emotional support. Her husband's insistence on so many moves had left her without a social network. She had never worked at a job which allowed any self-expression or self-discovery.

To sum up, there appears to be reasonable grounds to believe that Participant #2's depression may be biologically-based. However, her life review suggests that for a variety of reasons, she may never have achieved the independence necessary to develop her own value system and sense of herself. In a person of such sensitivity, the pain of never asserting herself and never realising her potential may have contributed to the development of her depression.

The lack of independence which has troubled Participant # 2 might be also be explained in terms of what Seligman (1975) called "learned helplessness." Seligman suggested that as a person experiences a series of negative events, the individual may lose faith in his or her ability to affect the environment. The person becomes "helpless" and succumbs to depressive symptoms. Participant # 2 has experienced much adversity: the loss of sight in one eye; rickets; poverty; isolation; the absence of educational opportunity; "rootlessness" due to frequent moves; poor social supports; illness and death in several important people in her life including her husband, sister and psychiatrist.

Though Participant # 2 exercises as much control as she can in looking after her apartment, taking care for her appearance, following her doctors' instructions, and paying all bills promptly, she sees herself as virtually helpless in the face of the biggest issues in her life--loneliness and depression.

7.4.0 Case study of Participant #3

Please note: Excerpts from interviews with Participant # 3 are presented in Appendix H

7.4.1 General description of Participant #3

This individual is 83 years of age. She lives with an unmarried son in the home in which she herself was born. She was widowed in 1952 while she was pregnant with her third child. After her husband's death, she took business training. Eventually she found work as an office manager, a position she held for 25 years. She has had a very active life has a single mother and employee. She has a long

history of involvement in church, community and volunteer activities. After many extremely active retirement years, she was obliged to cope with the onset of near-blindness as the result of a car accident in 1994.

7.4.2 Participant #3's history of depression

Although Participant # 3 reported significant loss and adversity in her life, she firmly indicated that she had never been depressed before a car accident in 1994.

Shortly after the accident, the participant noticed a rapid deterioration in her vision. Always active and independent, she found herself suddenly unable to perform everyday activities that she had previously taken for granted--reading, writing, knitting and typing. She complained that she could no longer read her mail, do household chores, watch television or take walks in her neighbourhood.

In describing the symptoms of her depression, the participant said she was "cranky." She complained of a weight loss of fourteen pounds after having maintained the same weight for twenty years. She spoke of uncharacteristic brooding and sleep difficulties. She summed up her reaction to the sudden loss of her treasured self-sufficiency by stating, "I had the world before. Now I have four walls."

7.4.3 Results of standardised testing with Participant #3

Table 7.7 and Table 7.8 (at the end of this chapter) present the results of standardised testing with Participant # 3.

7.4.4 Results of continuous evaluation with Participant #3

Table 7.9 presents the results of the continuous evaluation process with Participant # 3. At the beginning of each interview during the life review process, the participant ["P"] was asked to rate her experience of depression (since the last interview) on a five-point, self-anchored scale which offered

response choices from "much worse (5 points) to "much better" (1 point). At the same time, the student rated his perception of change (since the last interview) in the participant's level of depression.

Examination of Table 7.9 reveals that the participant's self-rating of her depression showed little variation. She continued to insist that her depression had disappeared. The student's ratings tended to agree. Toward the end of the intervention, the participant talked much more about her blindness than her depression

7.5.6 Participant #3's life review process

Participant #3 provides an interesting contrast to the previous two participants. First, her depression appears to be a recent development (since her car accident) and not a problem of many years' duration.

Second, in contrast to the other two participants, Participant # 3 is a much more outgoing and less introspective individual. Though Participant #3 was a willing and curious participant in the life review process, she seemed more interested in telling her story than in reflecting upon that story. Unlike the other two participants, she did not appear to require any insight into her life. She evidenced few doubts about herself and little regret about her past.

Third, whereas the other two participants were raised in homes with patriarchal figures, this participant was the product of a matriarchy. As did her mother before her, Participant #3 raised her children alone. Unlike the other two participants, she does not have memories of being intimidated or victimised by males.

As already stated, Participant #3's depressive episode appears to be related to problems she has had in adjusting to the limitations imposed by her loss of sight. After careful consideration of audio-taped interviews with this participant, the student could not identify any particular developmental deficit which might have a bearing on this participant's experience of depression.

In terms of the eight psychosocial themes presented by Kivnick (1991), this participant seems to exhibit what Kivnick calls "wisdom and perspective." In her mid-eighties, she looks back on a full life.

She has largely done things "her way." She has a philosophy of life that includes prayer, neighbourliness, hard work and action (as opposed to introspection.) She has few regrets and no acknowledged fear of death.

7.5.0 Brief description of Participant #4 and Participant #5

7.5.1 Participant #4

At the beginning of the intervention this 83-year-old man was resident in a personal care home. He was hospitalised soon after the life review sessions began. He and his first wife had one child. Several years after his wife's death, he remarried. His second wife died a short time after their marriage. University educated, he worked a variety of jobs related to his profession. Alcoholism has had a serious impact on his life.

Because the interview process with this participant had to be terminated for health reasons, the student was not able to establish the complete history of this individual's depression. Clearly, though, his frail health and numerous life losses appear to be factors in the onset of his mood disorder.

7.5.2 Participant #5

This 80-year-old individual and his wife live in an apartment. They have four adult children. University-educated, this man worked as a clergyperson all his life. With his family he lived and worked in a number of places across Canada. An intellectually and socially vigorous retirement was recently interrupted by unsuccessful surgery. Since that time, his life has changed in many ways. He is now disoriented and unwell. His depression appears to be related to numerous adjustment issues.

7.6.0 Comparison of the quantitative data for Participants #1. #2 and #3

7.6.1 The Mini-Mental State examination (Folstein, Folstein, and McHugh, 1975)

The rationale for looking at MMSE scores was the suggestion by Folstein, Folstein and McHugh (1975) that when depression (which is not related to brain disease) receives appropriate treatment, some signs of depression-related dementia may decrease. As a result, the MMSE scores may improve.

Examination of Table 7.10 (at the end of this chapter) indicates that the pre-intervention and post-intervention scores of the three participants show little change. At the beginning of the intervention, all of the participants were high functioning in terms of the MMSE. An improvement in their depression scores would not likely have been expected to effect the already high scores of the three participants.

7.6.2 The Geriatric Depression Scale (Yesavage et al., 1983)

The GDS was chosen for this study because the instrument is widely recognised for its reliability and validity in measuring geriatric depression levels. Table 7.11 summarises the GDS scores of the three participants.

Examination of Table 7.11 indicates that the depression levels of the three individuals did not increase dramatically during the intervention. The results suggest, at the very least, that the intervention did no harm as predicted by Haight (1988). In fact, the level of depression in Participant #2 markedly decreased.

All three participants show increases in the follow-up testing. Participant #1's level of depression remained virtually unchanged throughout the intervention. The follow-up testing indicated an increase of about 6.7% in her level of depression.

Participant #2's level of depression which had decreased by 53% during the intervention rebounded by about 37% at the follow-up test.

Participant #3's depression level, unchanged through the intervention, climbed by about 6.7% at the follow-up test. It should be noted that in the time between the post-test and the follow-up test, all three individuals had been participant to some severe health stresses and other personal problems.

7.6.3 Comparison of each participant's responses to the GDS

The student compared the responses given by each participant to the same questions in the GDS (Yesavage et al, 1975) across the three testing times. For example, how did Participant #1 answer question #1 on each occasion when the question was put to her? This analysis enabled the student to see where movement, positive or negative, had taken place in the participants' responses.

To illustrate, in the second and third tests, Participant #2 sustained responses indicating less depression. In the pre-intervention test, in response to the GDS question # 10, "Do you often feel helpless?" Participant #2 answered "yes." However, on two subsequent tests, she said "no" to GDS question #10. She explained that making decisions was easier for her now; and thus, she did not feel so helpless. Another change was noticeable in her response to question # 18: "Do you worry a lot about the past?" In the initial testing, Participant #2 said "yes". She had explained that she was very troubled with regrets. In the second and third testing situations, her answer was "no." She stated that she did not "seem to worry about those things in the past any more."

7.6.4 The continuous evaluation instrument (self-anchored scale)

Results from use of the continuous evaluation instrument have been discussed and presented above. Continuous evaluation across the intervention showed little dramatic change. For the most part, participants claimed their feelings of depression were "about the same." The student's ratings tended to agree.

The strengths of the continuous evaluation instrument were as follows.

a) The necessity of administering the test at each session helped the student to focus on the principle aim of the intervention which was to see what impact, if any, the life review process was having on the participant's levels of depression.

b) The regular use of the instrument also provided an "early warning system" for the student. Had a participant ever reported that she felt "much worse" since the last session, the student would have needed to assess what might have been disturbing the life review process. Fortunately, although each of the participants relived some extremely painful or sad memories, none of them appeared to experience any lasting distress.

7.7.0 Summary comments about the three participants

7.7.1 Participant #1

a) *The impact of the intervention on Participant #1*: This participant scored only 3/30 on both the pre-intervention and post-intervention GDS tests. Her follow-up test produced a GDS score of 5/30. The three GDS tests consistently suggest that she is not depressed. Nevertheless, she has so often exhibited tears and symptoms of anxiety that many of her health-care providers have often labelled her as "depressed."

Although the intervention appears to have had negligible impact on the participant's low depression scores, the life review discussions may have had unanticipated positive results. The participant has stated that she has benefited from the process. She commented that the life review discussions somehow strengthened her for the recent health crisis she has experienced.

When the student visited the participant in hospital for the follow-up testing, she described the terrifying experience she had undergone recently when she had collapsed in her apartment (from complications related to pneumonia and a critical electrolyte imbalance.) She woke up a day later in hospital. This kind of collapse has been precisely the sort of event she had long dreaded. Anxiety about

breathing problems and physical weakness has several times prompted her to go the emergency room of her local hospital. Hospital authorities have tended to regard her as a psychiatric admission.

Describing the recent events to the student, she said, "Now the worst [collapsing alone at home] has happened and I survived!" She described how she "tried to hold her mind together" for several hours before she lost consciousness completely. She claimed that she forced herself to repeat over and over in her mind hymns and poems that she had memorised. She went on to speak of various ways she has tried to take control of her life since she has been in hospital. Participant # 1 repeatedly told the student that the life review discussions had helped her to see she needed to start "sticking up" for herself.

In assessing the impact of the intervention for Participant #1, the student can not ignore the fact that this participant is extremely lonely and isolated. She lacks people with whom she can speak in depth about her life. Perhaps the experience of having a regular visitor was the most helpful aspect of the intervention. The life review conversations may have allowed her to speak of personal matters with more honesty than she would have considered appropriate in other contexts.

For example, her reminiscing about the loss of the man she had loved led into a general discussion of how men and women tend to view relationships. The participant remarked that she had always wished to discuss male-female differences; but that she had never before been given the opportunity to do so. Participant #1 said that she had longed to talk to her brothers about what boys expected in terms of dating and friendship. However, she was too shy to approach her brothers who were much older than she. She thus entered adolescence and adulthood without any accurate information about sexuality and relationships. Deprived throughout her life of a trusted confidante, she had never felt free to examine the religious and essentially Victorian value system inculcated by her upbringing. Needless to say, she had been left alone, more or less, to come to terms with the sexual abuse perpetrated by her brother-in-law.

b) *Participant #1's contribution to the* study: Although her depression appears to have been effectively controlled by medication throughout the intervention, this participant's vivid recounting of her memories

helped the student to see what long-term toll of depression can be. Articulate and extremely psychologically-minded, the participant entered into the process with trust and great honesty. The student was able to observe the unfolding of the life review process. Some memories the participant recounted only once. Others she continued to present until, in the later sessions, she was able to articulate what meaning she assigned to these particular recollections. In the final session, without prompting from the student, the participant tearfully said what she believed her "life problem" to be. That is to say, she indicated that the sexual and emotional abuse perpetrated by her brother-in-law had interfered with her relationships with the opposite sex, undermined her self-worth, and contributed to a lifetime of loneliness.

7.7.2 Participant # 2

a) *The impact of the intervention on Participant # 2*: With a pre-intervention score of 28/30 on the GDS, this participant did not meet the student's original selection criterion that participants be "moderately depressed." However, since the participant appeared willing to take part, the student chose to include her in the study.

Across the intervention, the participant's GDS score dropped to 12/30 and then climbed to 23/30 in the follow-up testing. Despite considerable isolation and worry (due to a fractured knee) between the end of the intervention and the follow-up visit, the participant appeared to be maintaining a modest decrease in her level of depression. She continued to report improved concentration and absence of old guilt feelings. Taken together, the objective testing, the participant's self-report and the student's observation suggest that the intervention may have had a modest positive impact on Participant # 2's level of depression. An alternative explanation may be that the most recent anti-depressant prescribed to the participant midway through the intervention may have been controlling her depressive symptoms.

b) *Participant #2's contribution to the study*: More than the other participants in the study, Participant #2 gave the student an intimate picture of the day-to-day behaviour and outlook of a chronically depressed person. The participant's willingness to be honest and self-revealing allowed the student to probe the experience of depression in depth.

The modest improvement in this participant's depression scores suggest that the life review process, when sensitively done, may not be harmful to a seriously depressed person. Though life review might not eradicate such a deep and enduring depression, such a review might still be a useful intervention for individuals similar to Participant #2.

Indeed, the life review intervention obliges a depressed participant to interact regularly at a deep level with another human being. Depressed people often withdraw from any but the most superficial human interaction. Thus isolated, such people have virtually no opportunity to speak of their lives. Encouraging the depressed participant to talk in depth about his or her life validates that person's experience, as difficult as that experience may have been.

At the same time, a life review intervention may help the enduringly depressed person come closer to what Kivnick (1991) called "wisdom and perspective." By listening carefully to a individual's life story, a therapist helps the participant to take his or her own life seriously. The depressed person may begin to look his or her life in a different way. Instead of focusing only on themes of loss and failure, the individual may begin to see that his or her experience is also a story of patience and survival in the face of suffering.

7.7.3 Participant #3

a) *The impact of the intervention on Participant #3*: Participant #3's pre-intervention and post-intervention GDS scores remained unchanged at 11/30 points. The follow-up testing produced a score of 13/30 points. Clearly, the intervention had little impact on this participant's level of depression. Just at the beginning of the intervention, the participant was placed on an anti-depressant. About seven weeks later,

during the fifth meeting with the student, the participant stated emphatically, "The depression is gone! I don't want to sit and brood anymore." From that point, she consistently maintained that she was not depressed by her definition. She was emphatic in distinguishing between her feelings of frustration at her blindness and her earlier experience of depression.

b) *Participant #3's contribution to the study*: Participant #3 made an important contribution to the student's learning. First, the participant's depression appears to be of recent origin, related directly to adjustment problems in regard to failing eyesight. With no report of previous depression and no hospitalisations, she provided a contrast to Participant #1 and Participant #2.

Participant #3's life review process was qualitatively different from those of the other participants. Her stories contained none of the memories of self-doubt, regret and depression that characterised the life review work of the others. Though she had definitely faced adversity, this participant appeared to be expressing the final developmental psychosocial which Kivnick (1991) called "wisdom and perspective." Participant #3 could say, in effect. "My life hasn't been easy in many ways. But it has been my life; and it is OK."

Unlike the other participants, Participant #3 did not articulate any connection between changed perspectives and the life review process. More than once, she attributed her decreased depression levels to the medication she was taking. The student's perception is that, except for enjoyment she received from telling her stories, the participant received no particular benefit from the intervention. Various interpretations are possible.

i) This participant may belong to that group of elders described by Merriam (1993) who have had no need to review their lives. Certainly, the life review discussions did not suggest any unresolved issues from the past.

ii) The participant may not have been sufficiently psychologically-minded to enter into the process. The life review process revealed that this participant had almost never questioned her worth or

her motives. Seemingly she had never worried about what others thought of her. Describing her personality and her values was somewhat difficult for her.

iii) A life review intervention may not be appropriate for an adjustment-related depression of recent origin. Possibly this participant's situation called for a more solution-focused approach in which the individual could be supported in finding appropriate ways to adjust to her changed circumstances.

iv) The participant may already have done her life review. She has not been socially isolated in the way the other two participants have been. Participant # 3 has family members, in particular a daughter, with whom she speaks regularly. Earlier in her life, she appears to have talked a great deal with her mother who lived with the participant. Today, she chats with a female neighbour of about the same age. The participant revealed that she and her neighbour have often talked about "the old days."

7.8.0 Overall impact of the intervention

Although directed toward a very small sample of participants, this study appears to support certain findings in the literature of life review. The results agree with the finding by Haight (1988) as to the safety of life review as a therapeutic intervention. At the time of the follow-up visit, none of the participants in this study appeared--at that point--to have had any lasting negative consequences from participation in life review. Haight also predicted the sense of accomplishment that participants have at the end of the process. This feeling appeared to be especially present in Participant #1.

As well, this study supports the claim by Reese Beaton (1991) that participants in life review seem to grasp immediately what they are being asked to do. Certainly the student found that all participants in the study understood at once the concept of "life story."

The GDS scores (Yesavage et al, 1983) of Participant #1 and Participant #3 did not change during the intervention and rose only slightly in the follow-up testing. Both participants told the student before the intervention began that they were no longer depressed. Nevertheless, Participant #1 stated that she had benefited from the opportunity to talk about "unfinished business" in her life. Participant #3, by

contrast, seems to have derived little benefit except the pleasure of telling her story and describing her of accomplishments.

The GDS scores of Participant #2 showed more movement across the intervention and follow-up testing. With an initial score of 28/30 which dropped to 12/30 and then climbed to 23/30, Participant #2 is of some interest. Unlike the other two participants, Participant #2 unhesitatingly identified herself as being depressed. No direct association between the trend to lower depression levels and the intervention can be made because the participant was started on another anti-depressant medication during the intervention. What may be significant is her report that she no longer worried about the past.

7.9.0 Contribution of the practicum to social work knowledge

a) Because the life review process looks at the whole of a person's life, including his or her social milieu, relationships, work and values, this intervention is consistent with the systemic approach to problems favoured by social work.

b) This intervention may make a modest contribution to social work knowledge by combining two other (nursing) interventions which had, until now, been used to respond to different needs in the elderly population. In one intervention, Haight (1988) studied the impact of structured life review on life satisfaction and depression in housebound elderly participants. In another sort of intervention, Kivnick (1991) proposed an inventory of life strengths to be used by in helping develop care-plans for elders. The student recognised that a number of items in this inventory which might be used as life review questions.

Therefore, student tried to combine elements of the two healthcare interventions in a new social work intervention. The student's assumption was that the kind of intervention described by Haight might be enriched by questions proposed by Kivnick.

As already indicated elsewhere in this report Kivnick's inventory is grounded in the eight-stage developmental theory of Erik Erikson (Kivnick, 1991; Erikson, Erikson and Kivnick, 1986). Since the student was aiming to do life review work rather than reminiscence work, he wanted questions which might review a participant's psychological experience through the years. Many of Kivnick's questions

appear to be useful in accomplishing such a review. Indeed, as the student used the items from the inventory, he had the sense that the questions he was asking were "real" questions that called forth "real" answers from the participants.

In short, the student believes that his practicum may have added something to social work knowledge in the following ways.

i) This intervention lends support to earlier research which indicated the relative safety of life review work (Haight, 1988; Sherman and Peake, 1991; Reese Beaton, 1991; Watt and Wong, 1991).

ii) This intervention clearly distinguished between the concepts of reminiscence and life review. Moreover, the intervention translated the theoretical concept of life review therapy into a practical demonstration. The intervention attempted to show, concretely, how life review work is not simply recalling memories or talking about the past.

iii) This report presents the materials a social worker might need to do life review therapy. Chapter Four presents the theoretical background of life review. The inventory by Kivnick (1991) has been tested and recommended. As well, this chapter reports what the student has learned about the practical details of doing life review therapy.

7.10.0 Suggestions for further research

Following are some suggestions for further research into the possible uses of guided life review as a social work intervention in geriatric depression.

7.10.1 Assisting chronically depressed people who are not helped by medication

The variation in the scores of Participant #2 might suggest some possibilities for further research. A future study could select individuals who, like Participant #2, have had a long history of depression and who have not been much helped by medication. Such participants could be led through a structured life review process and followed for some time to see what might happen to their depression levels.

7.10.2 Developing an initial screening tool

Another useful line of research might be to attempt to develop an initial screening inventory which could identify those depressed elders whom a life review intervention might be expected to help. The student's hunch is that participants likely to benefit would be individuals who might answer "yes" with little initial hesitation to a screening tool with questions such as the following:

- When you look back across your life, would say you have been troubled by doubts about yourself or your abilities?
- Are you often bothered by regrets?
- Are there issues in your life which have not yet been resolved to your satisfaction?
- Do you worry a great deal about the past?
- For the most part, are you satisfied with the way your life has gone? If not, what are some of things you wish had been different?
- Are there things in your past that still make you feel guilty or ashamed? Could you try to say something more about what it is that is still bothering you?
- Do you find yourself going over and over some past incident in your past?
- Are there some stories from your past that you would like to tell someone if you could just find the right person to tell?
- Have there been times in the past when you feel your words or actions were seriously misinterpreted by others? Could you tell me your side of the story now?

7.10.3 Exploring gender differences in life review

Since the student was unable to complete the life review process with any older men, the student suggests that future studies might include both senior males and senior females. The inclusion of both groups would allow exploration of gender differences.

7.10.4 Enhancing delivery of services in long-term care situations

Based on this small sample, the results seem to suggest that life review work may be effective in establishing communication with older individuals. The student wonders if life review might be effectively used in long-term care situations where helping professionals expect to have continuing contact with particular individuals.

If a social worker were to do life review work with new admissions to a personal care home, the social worker might discover the issues that are most important for a particular individual. This information could then be shared with other care providers in the institutional setting.

An example from this study might be found in the case of Participant #1. This person has had a life-long struggle for independence. With data collected from life review work, the care providers might be more sensitive to this individual's strong need to feel that she has some control of her life and destiny. Such sensitivity to individual differences and values is consistent with the intention Kivnick (1991) had in developing her inventory of life strengths.

7.10.5 Renewing therapy with depressed individuals

The student wonders if doing life review work with depressed older individuals might somehow help to "open a door" to further discussions with that individual. Depressed people sometimes withdraw from contact with others. In a depressive state, certain individuals may be lethargic or irritable. They may feel that telling their story again is simply "too much work."

If a social worker had already established trust with the depressed person through life review work, the worker might be able to make an informed guess about where to start a new dialogue with the individual who is in distress.

7.11.0 The student's learning about life review therapy

As indicated in his discussion of learning objectives in Chapter One of this report, the student wanted to study life review therapy in both a theoretical and practical sense. Table 7.12 summarises what he learned in using guided life review.

7.12.0 Educational benefits for the student

Table 7.13 summarises the student's rating of the educational benefits derived from the practicum. In essence, the student found the practicum a positive and enriching experience which benefited him both professionally and personally.

7.13.0 The practicum in brief

The intervention described in this practicum report was directed at seniors who had been diagnosed as clinically depressed. In preparation for the practicum the student reviewed the literature of geriatric depression, life review and qualitative research.

An intervention was designed to lead carefully selected participants through a review of their lives. The hypothesis was that a guided, individualised life review might decrease depression levels in the participants. The case study method was selected to present and evaluate data generated by the intervention.

Five depressed out-patients were proposed as potential participants by the Psychogeriatric Treatment Team of Deer Lodge Centre, Winnipeg. Three individuals, all female, received the intervention. During approximately three months--in an average of twelve meetings--the student led each individual through a review of her life.

Before the intervention began, two of the participants stated that they were no longer depressed. Their claims were supported by GDS scores within the normal range. The third participant was clearly depressed as indicated both by her self-report and by a high GDS score.

At the end of the intervention, the two participants with low GDS scores maintained those scores. In follow-up testing about two months after the intervention, both participants showed a slight increase in their GDS scores. The GDS score of the third participant declined dramatically at the end of the intervention. In the follow-up testing this participant's score had risen again; but the score had not returned to pre-intervention levels.

The two participants with previous experiences of depression indicated to the student that the life review intervention had been helpful to them. One participant believed that she was more ready to "stick up" for herself. The other participant reported that she was less troubled by the past.

The intervention seemed to be less significant for the third participant. This individual had not ever been depressed until she recently began to lose her eyesight. Her life review work did not suggest that she had any unresolved developmental issues. She did not to regard the intervention as having produced any change in her outlook or self-concept.

The student believes that the practicum provided him with an excellent learning experience. He has benefited from the review of literature. He acquired a working knowledge of the symptoms of depression and the theory and practice of life review. He enjoyed doing qualitative research. He was satisfied that he interacted with the participants in a manner that is consistent with his understanding of feminist principles.

Moreover, the student was completely satisfied with the guidance and support he received from the Practicum Committee. He is equally appreciative of the generous and helpful supervision provided by Geri McGrath.

This practicum may have contributed to social work knowledge in its attempt to articulate distinctions between the concepts of "reminiscence" and 'life review." The intervention tested an inventory of life strengths by Kivnick (1991) as a guide for the life review discussions with the

participants. This series of question gives a clear developmental focus to life review therapy. The questions also bring to the process the rich theoretical background and research of the life-stage theorist, Erik Erikson.

Areas which require further research have been identified by this practicum. Future studies of guided life review might look at gender differences. Effort might be made to develop a screening tool to predict those individuals likely to benefit from a life review intervention. Investigators might explore whether information gained from life review discussions can be used to assist a variety of care providers in enhancing delivery of services to individuals in long-term care facilities.

The practicum demonstrates that life review therapy is a workable, but labour-intensive, intervention which can be used by social workers. Life review therapy might be helpful in cases of long-lasting depression where medication has not relieved the symptoms; and where senior individuals demonstrate that they are troubled by unresolved issues from the past.

7.14.0 Tables in Chapter Seven

7.14.1 Participant #1

Table 7.1

Participant #1's scores on the MMSE (Folstein, Folstein and McHugh, 1975)

Pre-intervention test by student	September 15, 1995	29/30
Post-intervention test by student	December 1, 1995	27.5/30

Note: The MMSE is discussed in detail in section 6.6.1 (a) of this report.

Table 7.2

Participant # 1's scores on the GDS (Yesavage et al., 1983)

Test on admission as out-patient	not available	not available
Pre-intervention test by student	September 15, 1995	3/30
Post-intervention test by student	December 1,1995	3/30
Follow-up test by student	March 12, 1996	5/30

Note: The GDS is discussed in detail in section 6.6.1 (b) of this report.

Table 7.3

Participant #1's self-rated depression score

Session	Date	P.'s self-rating	Student rating	Remarks
-1- Initial visit	08/09/95			P. states she is not depressed anymore due to medication.
-2- History, testing	15/09/95	3	3	P. again states she is not depressed.
-3- Life review	22/09/95	3	3	P. appears to have same enthusiasm and energy as in previous sessions.
-4-	29/09/95	3	3	P. shows some tearfulness in speaking of an old regret.
-5-	06/10/95	3	3	P. once again insists that she is not depressed.
-6-	13/10/95	4	4	P. reports breathing difficulties, other health problems in previous week. Less energetic.
-7-	20/10/95	3	2	P. insists she is not depressed anymore. P. appears to have regained the energy she had prior to session 13/10/95.
-8-	27/10/95	3	3	
-9-	03/11/95	3	3	
-10-	10/11/95	3	3	
-11-	17/11/95	3	3	P. exhibits some tearfulness in speaking of various regrets about the past. The theme of regret has to do with what P. perceives to be her failure to be sufficiently caring and sensitive.
-12- Testing	01/12/95	2	3	P. reports feeling somewhat better physically. P. also comments on insight she feels she has received from life review process. P. expresses considerable grief for some of her losses. P. speaks of what she considers the "real" problem of her life.
-13- Follow-up Testing (conducted in hospital)	12/03/96	2	3	P. describes physical problems that brought her to hospital. She again expresses appreciation of life review process. P. tells student of recent instances where she has chosen to be more assertive. P. feels positive about being able to "stick up for herself."

Note: At the beginning of each life review session the participant [P] was asked to rate her depression since the last conversation on a scale from "much worse" (5 points) to "much better" (1 point). The student used the same scale to rate his perception of the participant's current level of depression.

7.14.2 Participant # 2

Table 7.4

Participant # 2's scores on the MMSE (Folstein, Folstein and McHugh, 1975)

Pre-intervention test by student	October 5, 1995	28/30
Post-intervention test by student	December 14, 1995	28/30

Note: The MMSE is discussed in detail in section 6.6.1 (a) of this report.

Table 7.5

Participant # 2's scores on the GDS (Yesavage et al., 1983)

Test on admission as out-patient	February 21, 1995	29/30
Pre-intervention test by student	October 5, 1995	28/30
Post-intervention test by student	December 14, 1995	12/30
Follow-up test by student	February 29, 1996	23/30

Note: The GDS is discussed in detail in section 6.6.1 (b) of this report.

Table 7.6

Participant # 2's self-rated depression score

Session	Date	P's self-rating	Student rating	Remarks
-1- Initial visit	28/09/95	--	--	P. presents as very shy, soft-spoken, somewhat timid.
-2- History, testing	05/10/95	3	3	
-3- Life review session 1	13/10/95	3	4	Energy level appears lower.
-4-	19/10/95	3	2	Energy increased during session.
-5-	27/10/95	4	3	P. has been trying to read again after being unable to do so.
-6-	03/11/95	4	4	P. states: "Seems like I'm getting worse."
-7-	09/11/95	4	3	P. has changed anti-depressant; P. says that she is very depressed on awakening.
-8-	16/11/95	3	2	P. has increased dosage of anti-anxiety drug. Has been sleeping better. Longest session to date. Most talkative to date. Most laughter to date.
-9-	24/11/95	4	3	P. declares she is "up and down." P. is trying another anti-depressant. P. is not sleeping well.
-10-	30/11/95	3	2	P. continues to appear more relaxed and animated. More laughter. P. continues to be able to read.
-11- Testing	14/12/95	3	3	P. continues to appear more relaxed and less shy.
-12- Follow-up Testing	29/02/96	4	4	P. appears very depressed at start of session. Several statements of hopelessness.

Note: At the beginning of each life review session the participant [P] was asked to rate her depression since the last conversation on a scale from "much worse" (5 points) to "much better" (1 point). The student used the same scale to rate his perception of the participant's current level of depression.

7.14.3 Participant #3

Table 7.7

Participant # 3's scores on the MMSE (Folstein, Folstein and McHugh, 1975)

Pre-intervention test by student	October 11, 1995	25/30
Post-intervention test by student	December 19, 1995	28/30

Note: The MMSE is discussed in detail in section 6.6.1 (a) of this report.

Table 7.8

Participant # 3's scores on the GDS (Yesavage et al., 1983)

Test on admission as outpatient	September 14, 1995	18/30
Pre-intervention test by student	October 11, 1995	11/30
Post-intervention test by student	December 19, 1995	11/30
Follow-up test by student	March 7, 1996	13/30

Note: The GDS is discussed in detail in section 6.6.1 (b) of this report.

Table 7.9

Participant # 3's self-rated depression score

Session	Date	P.' self-rating	Student rating	Remarks
-1- Initial visit	04/10/95	--	--	P. appears energetic, curious, ready to engage in the process. P. takes care to learn and use student's name. P. expresses reluctance to sign consent form until it has been checked by a relative. P. underlines bad side effects she experienced with the first anti-depressant she tried.
-3- Life review	18/10/95	2	3	P. states, "I feel so much better this week.".
-4-	25/10/95	2	2	P. states, "I'm not so apprehensive. I think things are coming around."
-5-	01/11/95	1	2	P. declares emphatically, "[The depression] is gone! I don't want sit and brood anymore."
-6-	08/1195	3	3	P. states, "I think [the depression] is fading away. I'm not sitting and brooding."
-7-	15/11/95	3	3	While P. is somewhat worried about the outcome of eye surgery to be performed the next week, she does not exhibit any increase in depression.
-8-	06/12/95	3	3	
-9- Life Review, Testing	19/12/95	3	3	P. does not appear more depressed, despite uncertain outcome of eye surgery and some developing family worries.
-10- Follow-up visit	07/03/96	2	2	While not despairing, P. appears more discouraged about her vision problems and the resulting limitations.

Note: At the beginning of each life review session the participant [P] was asked to rate her depression since the last conversation on a scale from "much worse" (5 points) to "much better" (1 point). The student used the same scale to rate his perception of the participant's current level of depression.

7.14.4 Summaries of quantitative data for the three participants

Table 7.10

Comparison of the participants' scores on MMSE (Folstein, Folstein and McHugh, 1975)

Testing time	Participant #1	Participant #2	Participant #3
Pre-intervention	29/30	28/30	25/30
Post intervention	27.5/30	28/30	28/30

Note: The MMSE is discussed in detail in section 6.6.1 (a) of this report.

Table 7.11

Comparison of the participants' scores on GDS (Yesavage et al., 1983)

Testing time	Participant #1	Participant #2	Participant #3
On admission	not available	29/30	18/30
Pre-intervention	3/30	28/30	11/30
Post-intervention	3/30	12/30 (-53%)	11/30
Follow-up	5/30 (+6.7%)	23/30 (+37%)	13/30 (+6.7%)

Note: The GDS is discussed in detail in section 6.6.1 (b) of this report.

Table 7.12

The student's learning about life review therapy

COMPONENTS OF THE LIFE REVIEW PROCESS	REMARKS
a) Investment of professional time	i) Guided life review is labour-intensive. In this demonstration the student made an average of 11.7 visits /participant at an average length of 95 minutes /visit.
b) Professional preparation	i) Working knowledge of the eight psychosocial themes discussed by Kivnick (1991) is essential. ii) It is important that the interviewer understand the developmental process well enough that he/she does not need to have a slavish dependence on the questions in the life strengths inventory. The qualitative research issue of "structure and freedom" identified by Jones (1985) is relevant here. The interviewer needs to make contingent decisions as the interviews unfold in order that the issues truly important to the individual can be explored. At the same time, the interviewer can bring focus to the discussions so that neither the interviewer nor the respondent gets side-tracked into discussion of less important side issues. iii) It is very useful for interviewer to have some knowledge of the social history which may have affected the older person's view of the world--e.g. world War II. iv) An effort to learn about the culture of the respondent is recommended, especially if that culture is different from the interviewer's own. Life review work is heavily dependent on context. Rowles and Reinharz (1988) stressed that attention to context can yield important qualitative data.
c) Professional skills	i) Approaching a participant with respect is crucial. People show great trust when they agree to talk about their lives with a professional helper. ii) The interview process requires patience. Life stories are told in a circular fashion with frequent repetition of details. iii) Non-judgmental listening is important. Elders do not always hold "politically correct" attitudes by today's standards. The life review guide's challenge is to understand what particular opinions indicate about the participant's view of the world. The guide needs to avoid stereotyping the older person. As people review their lives, they may reveal surprising or inconsistent aspects of themselves.

Table 7.12 (continued)

Summary of the student's learning about life review therapy

COMPONENTS OF THE LIFE REVIEW PROCESS	REMARKS
d) Personal characteristics of the interviewer	i) The life review guide can prepare for the conversation with an older person by examining his or her own feelings about themes that may emerge in the life review process-- love, romance, loneliness, suffering, sickness, disability, retirement, death. ii) The interviewer should expect that he or she may be personally affected by some the stories and feelings of the senior individual. Matsuoka (1993) pointed out that younger interviewers may stop short of talking about issues such as death because they, themselves, have not yet dealt with their own feelings. The older person, by contrast, may be very ready to enter into such a discussion. iii) Empathy is essential. The life review guide must ask him or herself, "How would I feel if these questions were being asked of me?" iv) Some understanding of transference and counter-transference is important. The younger life review guide should be aware when he or she may be assuming a certain "role" with the older person--e.g., as the older person's grandchild.
e) Setting	i) The student's experience suggests that the senior individual's home is the preferred setting for life review work. Photos and other momentos are close at hand.
f) Audio-taping	i) None of the participants in this study objected to the tape recorder. The student benefited from later listening to the audio-tapes, especially when the discussion involved complex biographical details. Peoples tend to feel they are being taken seriously if the interviewer remembers important dates and names, etc. .
g) Number of sessions	i) The number of sessions depends on the individual person. The student found that the two initial meetings with the participants (initial visit and testing/ history-taking) helped develop rapport and trust. The eight topics in the guide by Kivnick (1991) seem to require at least one session each. ii) It is helpful to announce the next topic at the end of each session. The interviewer might say, "The next time we meet, I'd like to hear about your work through the years."

Table 7.12 (continued)

Summary of the student's learning about life review therapy

COMPONENTS OF THE LIFE REVIEW PROCESS	REMARKS
h) Length of sessions	i) The student found that in addition to friendly conversation at the beginning and end of each session, he usually required 45-60 minutes to allow a good discussion of a topic. Sessions may grow longer as trust develops.
i) "Surprise" learning re: follow-up visit	i) In his original design of the intervention, the student proposed to visit each participant to give her the audio-tapes of the life review session. ii) As the student reviewed the audio-tapes in preparation for evaluating the intervention, he decided to re-administer the GDS during the follow-up visit in order to generate stability data. The data thus produced adds to knowledge of the longer-term effects of the intervention. iii) After listening to the audio-tapes, the student chose to produce transcripts of the participants' remarks. (Please see Appendices F, G, and H of this report.) These transcripts were read to each participant during the follow-up visit. Each participant's permission to reproduce the transcripts in this report was secured without hesitation. None of the participant wished to delete any of the transcribed remarks. iv) Reading the transcribed remarks to the participant appeared to be useful both for the participants and the student. Each participant listened to the reading without interrupting. Each participant appeared lost in thought after the reading. The student again asked if the participant wished to delete any remark. All of the participants responded in a similar way, "No, I'm surprised to hear what I said. But I know I said those things and it is certainly OK to include them in your report." v) The fact that each of the participants verified the transcripts to be faithful to their original remarks adds credibility to the data collected in this study.

Table 7.13

Educational benefits derived from the practicum

LEARNING OBJECTIVES (as described in Chapter One of this report)	STUDENT RATING	REMARKS (The rating system in this table uses a scale of 0 to 10 where 0 = not at all satisfied and 10 = extremely satisfied.)
1. *"To acquire a working knowledge of the literature of life review and reminiscence"*	9.0	i) The student believes that the wide range of current life review material available in the University of Manitoba libraries made possible a comprehensive review of the literature. ii) An important "breakthrough" in the student's learning occurred when he was able to distinguish between "reminiscence" and "life review." iii) The student understands reminiscence to mean the recall of memories for a variety of purposes such as pleasure, entertainment, problem-solving and the transmission of heritage. iv) Life review, in the student's understanding, is an integrative psychological process aimed at helping an individual to come to terms with the past.
2. *"To gain an overview of the current literature of geriatric depression"*	7.5	i) The student believes that in spite of the extent and complexity of the literature he was able to gain an adequate overview of the subject. ii) For his purposes in this practicum, the student found Beck (1967) and Zung (1980) the most helpful in developing a conceptual framework of depression and in understanding the experience of the three participants of the study.
3. *"To acquire a working knowledge of the theoretical background and practical applications of the inventory of life strength developed by Kivnick (1991)"*	9.2	The student found Kivnick (1991) and Erikson, Erikson and Kivnick (1986) especially useful in understanding and using the inventory.

Table 7.13 (continued)

Educational benefits derived from the practicum

LEARNING OBJECTIVES (as described in Chapter One of this report)	STUDENT RATING	REMARKS (The rating system in this table uses a scale of 0 to 10 where 0 = not at all satisfied and 10 = extremely satisfied.)
4. *"To gain both theoretical knowledge of, and practical experience using qualitative research methods"*	8.3	i) The student found Jones (1985), Rowles and Reinharz (1988) and Silverman (1988) useful in developing a conceptual framework. ii) The literature of qualitative research helped to make explicit the student's long-held, but not clearly articulated intuition that people's personal stories are a legitimate source of knowledge. iii) Encountering the concept of "connected knowing" was important, intellectually, for the student. The student's description of his experience of "connected knowing" is found in section 6.4.2.e, above. iv) As a result of his exposure to the literature of qualitative research, the student decided that he wished to conduct his practicum, as much as possible, from a feminist perspective. That is, the student intended to talk with the participants in a way that was non-hierarchical, non-coercive and collaborative. The student is satisfied that he achieved this goal.

Table 7.13 (continued)

Educational benefits derived from the practicum

LEARNING OBJECTIVES (as described in Chapter One of this report)	STUDENT RATING	REMARKS (The rating system in this table uses a scale of 0 to 10 where 0 = not at all satisfied and 10 = extremely satisfied.)
5. *"To gain practical experience in using life review therapy as a social work intervention with senior clients who have been identified as clinically depressed"*	8.7	i) The student is satisfied that even with the small sample of participants, he had an significant opportunity to use life review therapy as a social work intervention. ii) The student's experience (and data) would have been enhanced if he had been able to complete the life review process with one or more male participants. iii) The student's very limited contact with male participants suggests that older men, like older women, understand what telling their "life story" means. The male participants appeared as willing to participate as the female participants. iv) Throughout the process the student had the clear impression that he was doing "real" research and work rather than merely completing a project for a degree.

Table 7.13 (continued)

Educational benefits derived from the practicum

LEARNING OBJECTIVES (as described in Chapter One of this report)	STUDENT RATING	REMARKS (Rating system in this table: 0 = not at all satisfied and 10 = extremely satisfied.)
6. *"To evaluate the effectiveness of guided life review therapy as a social work intervention in response to geriatric depression, and thereby to contribute to the development of social work knowledge"*	8.7	i) The satisfaction rating in this section does not refer to the effectiveness of the intervention, but rather to the student's level of satisfaction with the opportunity afforded by the practicum to design, implement and evaluate an intervention. ii) The student is satisfied that the practicum had a clear focus. That is, the student's task was to evaluate the impact of guided life review on the depression levels of the participants. iii) The student is satisfied that the intervention was consistent with social work practice. That is, the intervention allowed to study a human problem from a systemic perspective. The design permitted the student to look at the total person in the context of a whole lifetime-- and not simply at one isolated aspect of an individual such as her depression or her age or her gender. iv) The practicum may have contributed to social work knowledge through adapting two nursing interventions for use in a social work context. The practicum has assembled and tested "tools" which a social worker might use in doing life review interventions.
g) "To acquire experience in working as a geriatric social worker"	8.2 Mean Score (all categories) 8.5	i) Over all, the supervision, referrals and resources provided by Deer Lodge Centre furnished an excellent learning experience for the student. He believes himself to have gained important exposure to the issues that seniors face. He is extremely satisfied with the opportunity provided by the practicum to enhance his clinical skills. ii) The only limitation of the practicum was that the design of the study necessitated the student's doing most of his work in the homes of the participants. As a result, the student did not have as much chance as he might have wished to observe the day-to-day activity of geriatric social workers employed in a large institution.

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APPENDIX A

THE CLASSIFICATION SYSTEM USED BY THE DSM-IV

The classification system used by the DSM-IV

The DSM-IV (American Psychiatric Association, 1994) presents depressive disorders under the general heading of "Mood Disorders". For the purposes of this practicum, the decision was made to reproduce directly the following summaries of the relevant mood disorders: a) major depressive episode; b) dysthymic disorder; c) cyclothymic disorder; d) melancholic features.

Because the DSM-IV defines the criteria for various disorders by including certain symptoms and excluding others, the summaries of d) mixed episode and e) hypomanic episode will also be reproduced below.

1) The DSM-IV (p.327) presents the **criteria for major depressive episode** as follows:

> *Criteria for Major Depressive Episode*
> A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest and pleasure.
>
> Note: do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.
>
> (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad or empty) or observation made by others (e.g. appears tearful). Note: In children and adolescents, can be irritable mood.
> (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others.
> (3) significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
> (4) insomnia or hypersomnia nearly every day
> (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
> (6) fatigue or loss of energy nearly every day
> (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
> (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
> (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
>
> B. The symptoms do not meet criteria for a Mixed Episode [see below].
>
> C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
>
> D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
>
> E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation. (p. 327)

2) The DSM-IV (p. 349) presents the criteria for **dysthymic disorder** as follows:

Diagnostic criteria for . . . Dysthymic Disorder

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years. Note: in children and adolescents, mood can be irritable and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:
(1) poor appetite or over eating
(2) insomnia or hypersomnia
(3) low energy or fatigue
(4) low self-esteem
(5) poor concentration or difficulty making decisions
(6) feelings of hopelessness

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in criteria A or B for more than 2 months at a time.

D No Major Depressive episode (see above) has been present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, In Partial Remission.

Note: There may have been a previous Major Depressive Episode provided there was a full remission (no significant signs or symptoms for 2 months) before development of the Dysthymic Disorder. In addition, after the initial 2 years (1 year inn children or adolescents) of Dysthymic Disorder, there may be a superimposed episodes of Major Depressive Disorder, in which case both diagnoses may be given when the criteria are met for a Major Depressive Episode.

E. There has never been a Manic Episode [see below], a Mixed Episode [see below], or a Hypomanic Episode [see below], and criteria have never been met for Cyclothymic Disorder [see below].

F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.

G. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. (p. 349)

3) The DSM-IV (pp. 365-366) presents the criteria for **cyclothymic disorder** as follows:

Diagnostic criteria for . . . Cyclothymic Disorder

A. For at least 2 years, the presence of numerous periods with hypomanic symptoms [see below] and numerous periods of depressive symptoms that do not meet criteria for a Major Depressive Episode. **Note:** In children and adolescents, the duration must be at least 1 year.

B. During the above 2-year period (1 year in children and adolescents), the person has not been without the symptoms in Criterion A for more than 2 months at a time.

C. No Major Depressive Episode [see above], Manic Episode [see below], or Mixed Episode [see below] has been present during the first 2 years of the disturbance. (p. 365)

4) The DSM-IV (p.384) presents the criteria for **melancholic features specifier** as follows:

Criteria for Melancholic Features Specifier
Specify if: **With Melancholic Features** (can be applied to the current or most recent Major Depressive episode in Major Depressive Disorder . . . .)

A. Either of the following, occurring during the most severe period of the current episode:
(1) loss of pleasure in all, or almost all, activities
(2) lack of reactivity to usually pleasurable stimuli (does not feel much better, even temporarily, when something good happens)

B. Three (or more) of the following:
(1) distinct quality of depressed mood (i.e., the depressed mood is experienced as distinctly different from the kind of feeling experienced after the death of a loved one)
(2) depression regularly worse in the morning
(3) early morning awakening (at least 2 hours before usual time of awakening)
(4) marked psychomotor retardation or agitation
(5) significant anorexia or weight loss
(6) excessive or inappropriate guilt. (p. 384)

5) The DSM-IV (p. 335) presents the criteria for **mixed episode** as follows:

Criteria for mixed Episode:
A. The criteria are met both for a Manic Episode [see below] and for a Major Depressive episode [see above] (except for duration) nearly every day during at least a 1-week period.

B. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism). (p. 335)

6) The DSM-IV presents the criteria for **hypomanic episode** (p. 338) as follows:

Criteria for Hypomanic Episode

A. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood.

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
(1) inflated self-esteem or grandiosity
(2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
(3) more talkative than usual or pressure to keep talking
(4) flight of ideas or subjective experience that thoughts are racing

(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.

F. The symptoms are not due to direct physiological effects of a substance (e.g. a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism). (p.338)

APPENDIX B

INVENTORY OF LIFE STRENGTHS DEVELOPED BY KIVNICK (1991)

This appendix presents excerpts from the "Interview Guide" (pp.62-66) in Kivnick (1991). Some of the following questions were used to lead the participants in the intervention through a review of their lives. Obviously, the student did not select all of the items because of their focus on the present. He did try, however, to ask questions that might help the subject look at how various developmental issues presented themselves across a lifetime.

INTRODUCTION (p. 62)

What is it about your life

that makes you feel most alive?

that is most worth living for?

that makes you feel most like yourself?

HOPE AND FAITH (p. 62)

What is it in your life that gives you hope?

How do moral beliefs and values fit into your life?

How have they fit in earlier times?

What is your religious affiliation?

What about religion is most important to you?

How do you like to express your religious beliefs?

Is religion something you practise in private? Is some group religious activity important to you?

What is it in your life that gives you a sense of security?

What do you tell yourself or think about when you're afraid

and you need to believe that things will be all right?

WILLFULNESS, INDEPENDENCE AND CONTROL (pp. 62-63)

We all like to be in control of our lives. and when you think about it, we spend most of our lives trying to strike a tolerable balance between being independent and in charge and having things the way we want them, on one hand, and accepting help, following rules, and going along with other people's wishes, on the other hand.

What parts of your life is it most important that you stay in charge of?

What kinds of control are easier to give up, as long as you remain in charge of what's really important?

What kinds of independence would you find especially painful to give up?

What do you think might make it easier to accept help, when you wish you didn't need help in the first place?

What is it that has always given you confidence in yourself/

What kinds of decisions are absolutely most important that you make for yourself?

What kinds of decisions are you willing to have someone else make for you? Who?

PURPOSEFULNESS, PLEASURE AND IMAGINATION (pp. 63-64)

What kinds of things do you enjoy doing?

What kinds of activities give you pleasure?

What kinds of activities have always given you pleasure?

What do you do for fun these days?

What would you do for fun if you could do anything in the world?

What have you done, in your life, that makes you proudest?

What is there that you've always been curious about?

What do you want to do, most of all, with the rest of your life?

COMPETENCE AND HARD WORK (p. 64)

What have you worked at?

What would you like to be working at now, if you were able?

What kinds of things have you always been good at?

What kinds of things are good at now? What skills do you have? Or areas of expertise?

What is there that you've always wanted to learn, but never quite gotten around to?

What do you wish you could do better?

Would you find it easier to accept assistance, if you could trade some skill or activity in return?

VALUES AND SENSE OF SELF (p. 64)

What is it about your life that makes you feel most like yourself/

What do you believe in?

Do you have a philosophy of life that has guided the way you live? That guides your life today?

What kind of person would you say you are? That you have always been?

What is the image that you carry around inside, about who you are in the world?

When people describe you, what do they say? What would you like them to say?

LOVE AND FRIENDSHIP (pp. 64-65)

Who is important to you in your life today? Where are they?

Whom do you count on these days? Who counts on you?

Whom do you have contact with these days?

Who, among these, are people you contact by choice?

Tell me about someone you've loved at some point in your life.

Can you tell me about your marriage? About your best friend?

What do the people who know you like best about you? What do they respect most in you?

Who, in which relationships, has brought out the best in you?

How do you feel about being alone these days?

CARE AND PRODUCTIVITY (p. 65)

Who or what do you especially care about?

How do you show your caring?

Who is there that you lean on, these days? Who leans on you?

Who is there, that it's important for you to be good for? Or be nice to? Or set a good example for?

What is there about yourself and your life that you want to make sure people remember?

Who and what have you cared about over the years? Tell me about them.

What's the most important thing for you to do with your life these days?

Who is the person who makes you think, "This is the one who will carry on for me when I'm gone"?

WISDOM AND PERSPECTIVE (p. 65)

What is there about your life that you wish had been different?

What is there that you're struggling to make sense of, about the world?

What has been most meaningful about your life so far?

How do you deal with disappointment? How do you experience joy?

What strategies have you used in coping with fear?

Let's talk a bit about death. Do you believe in life after death?

What are your thoughts about your own death?

- how you'd like to die?
- when might be the right time?
- where you'd like to die?
- who should be there with you?
- anything you'd want to be sure and get done first?
- anything you'd want to be sure to say to anyone first?
- who should take what kinds of measures to prolong your life?

Have these thoughts changed over the years?

Are you afraid of dying?

Do you know what you're afraid of?

Do you have any ideas about what might help you be less afraid?

PUTTING IT ALL TOGETHER AGAIN (p. 66)

What is it about your life today that:

- makes you feel most alive?
- is most worth living for?
- makes you feel most like yourself?

I'd like you to think back over your whole life. Over everything you've seen and everything that's happened to you. And I'd like you to tell me a story about something in your life. Anything. But a story from your life that is somehow meaningful for you.

APPENDIX C

Participant Consent Form

Participant Consent Form

I - - - - - name - - - - agree to particpate in a study of the impact of guided life review on depression.

I understand that this study is being conducted by Robert McVety, a graduate student in the Faculty of Social Work at the University of Manitoba. I understand that Robert McVety is being supervised by Geri McGrath M.S.W., Director of Psychogeriatric Services at Deer Lodge Centre.

I understand that my participation in this study is completely voluntary; and that a decision not to participate shall in no way result in the withdrawal or denial of service by Psychogeriatric Services at Deer Lodge Centre. I understand that I am free to withdraw from the study at any time; and that I am free to refuse to answer any question.

I agree that each interview will be tape-recorded. I understand that the taping is for two puposes: a) to document my discussions with Robert McVety in order that he may further his learning; and b) to provide an opportunity for Geri McGrath to supervise Robert McVety's work. I understand that at the conclusion of the interviews with Robert McVety, I will be given the tapes, if I desire. Otherwise, the tapes will be destoyed.

I understand that my identity will be kept completely confidential; and that my name will not be disseminated to others throughout the sessions or in the final practicum report. However, I further understand that if during our sessions Robert McVety and I agree that my problems require further attention, Robert McVety will discuss my problems with my worker or with the Psychogeriatric Team.

I understand that if I believe, for whatever reason, I am being mistreated in the course of this study, I have the right at any time to appeal to Geri McGrath and to the Administration of Deer Lodge Centre.

The study has been explained to me; and all my questions have been answered to my satisfaction.

Client's signature----------Date----------

Robert McVety's signature----------Date----------

APPENDIX D
STUDENT LOG

PARTICIPANT'S NAME	DATE INTERVIEW #

PART I. PARTICIPANT'S RESPONSE

SELF-ANCHORED SCALE	POSSIBLE RESPONSES	NUMERICAL VALUE
"HOW DO YOU FEEL YOU ARE DOING WITH YOUR DEPRESSION SINCE THE LAST TIME WE TALKED?"	1. "MUCH WORSE" 2. "WORSE" 3. "ABOUT THE SAME" 4. "BETTER" 5. "MUCH BETTER"	5 POINTS 4 POINTS 3 POINTS 2 POINTS 1 POINT

PART II STUDENT'S OBSERVATION

(NOTE: In rating participant's level of depression, keep in mind the particular symptoms of depression identified by the participant at the beginning of the intervention.)

STUDENT RATING	POSSIBLE RATINGS	NUMERICAL VALUE
"HOW DO YOU RATE THE PARTICIPANT'S LEVEL OF DEPRESSION COMPARED WITH THE LAST INTERVIEW?"	1. "MUCH WORSE" 2. "WORSE" 3. "ABOUT THE SAME" 4. "BETTER" 5. "MUCH BETTER"	5 POINTS 4 POINTS 3 POINTS 2 POINTS 1 POINTS

PART III POSSIBLE INDICATORS OF DEPRESSION

1)ENERGY LEVEL	
2) GENERAL APPEARANCE	
3) VOICE QUALITY [MONOTONE, EXPRESSIVE, ETC.]	
4) EYE CONTACT	
5) TEARS	
6) BODY LANGUAGE, POSTURE	
7) OTHER INDICATORS	

PART IV OTHER NOTES

CONCERNS TO DISCUSS WITH PRIMARY THERAPIST OR SOCIAL WORKER	
IMPORTANT BIOGRAPHICAL DETAILS TO NOTE (DATES, EVENTS, ANNIVERSARIES, ETC.)	
TOPICS TO EXPLORE FURTHER	
SUMMARY GENERAL COMMENTS	

APPENDIX E

PERMISSION TO QUOTE EXCERPTS FROM AUDIO-TAPED CONVERSATIONS

PERMISSION TO QUOTE EXCERPTS FROM AUDIO-TAPED CONVERSATIONS

I- - - - - name- - - - - have read (or have had read to me) the typed transcripts of conversations I had in the autumn of 1995 with Robert McVety, a graduate student in the Faculty of Social Work at the University of Manitoba. I have been given a copy of the transcripts for my own records.

I hereby give Robert McVety permission to quote from the transcripts, in part or in full, in the Practicum Report which he is preparing. I also authorise Robert McVety to quote, in part or in full, from these transcripts in any other written or oral presentations that he may make, subsequent to his Practicum Report.

I understand that at no time shall my name or my identity be revealed in any written or oral presentations made by Robert McVety. I give him permission to use only those quotations which I myself have reviewed and approved.

Subject's signature . . . . . .

Robert McVety's signature . . . . . Date . . . . . .

APPENDIX F

EXCERPTS FROM AUDIO-TAPED CONVERSATIONS WITH PARTICIPANT #1 SEPTEMBER - DECEMBER, 1995 (quoted with the Participant's written consent)

September 22, 1995

What helps to make your life worth living?

I don't want the things I've learned to be lost when I'm lost. My hobby is trying to pass on what I've learned.

When I see someone die, I feel sad that all that talent couldn't be passed on.

What helps make you feel secure?

The way things keep turning out for me. I'm knitting for the blind. I'm being useful.

September 29, 1995

When you were younger, did you ever feel you had to struggle for your independence?

Yes! I often thought, "Just wait until I can run my own life."

What has given you confidence in yourself?

I'm inclined to think that it is my faith that carried me through. I couldn't see any life without faith.

In what way was teaching important to you?

I didn't want children to be shoved around the way I was.

As you look back, do you feel that your life has had a purpose?

This has been the ruling thing in my life: that I was put here for a purpose.

What have you done in your life that has made you proud?

I have had a very full life. When I look at what I have now, I wouldn't have believed I'd have retired with the income I have now. I've gone from rooms in boarding houses to a house to an apartment. I've had travel.

October 27, 1995

What has work meant to you?

I felt I had a destiny that meant something. I've always felt that. I wanted to follow it [my destiny]. I think I ended up where I was meant to me because I really feel I was meant to be working with children.

Each thing I learned [to do] gave me that much more confidence. Being able to work has helped my sense of self-confidence.

November 3, 1995

What are the things that you want to see continue even after you are gone?

That is one of the reasons that I really fight to keep my crafts going. I want to pass on the idea that that [doing crafts] is good for us; that we need it. People keep saying that knitting takes so much time; and you can buy it cheaper; but I can't buy things as good as I can make. Therefore, I still feel it's worth my time to make them.

Are there other causes that you have cared about, over the years?

I would still like women to get their rightful place in the world. I'm not a feminist or anything like that. But I'd still like women to get their place.

What would you like women to achieve?

Well, for one thing, I would like the ones who have families to get the idea that they are more important to their families than the money they can bring in. -- in most cases. The children I dealt with . . . I know it was from sheer neglect at home.

I'd like to see women get proper credit. When a woman gets a high office, she doesn't get the respect that a man does. After all, if she has the ability to do the job, then she should have the same respect. I really feel that.

I just generally have a feel for improving humanity. There's nothing much I can do about it.

November 10, 1995

What about your life makes you feel good?

I feel that I haven't wasted too much of the talent that was given to me. Certainly I know I have some skills that other people envy. That has built me up, knowing there are things I can do.

I still maintain that what has brought me through is my faith.

Is there anything about your life that you wish could have been different?

I've always wished I could have made more friends. I seem to have turned so many people against me. They thought I was stuck up. But actually I was shy.

You've obviously had to deal with a great deal of depression in your life. Was there ever a time that you considered suicide?

No, I believe we have a certain time on earth and we can't shorten it.

November 17, 1995

Can you speak about some of the things you've learned in your life?

We have to be extremely careful. [At this point Participant #1 described a time, at age eight, when she was very nearly caught in a fanning mill on the farm where she lived as a child.]

You make your own luck. If you want something bad enough and fight hard enough, you may eventually get it.

This is the biggest lesson I've learned. When I gave up trying to map out my own programme and began to follow wherever a door opened . . . if it looked a little better than the door I had at present, then I took it. That was when life went better for me. I was possibly about thirty when I decided on that.

I think [life started to go better for me] when I tried to make that bargain with God. [It was as though I said,] "You let me have that -- and I'll do anything you say." From then on, I was forced into it. I didn't have a choice. I found that God can discipline you very severely.

What advice would you give to younger people?

Know where you want to go. Try to know as much as you can about what it needs and try to prepare yourself. We have to be well prepared.

At first, I didn't realise the way things were going [in my life.] But I was being pushed in that direction [into teaching children with special needs.]. There was a certain thing that I was meant to do.

A person said to me, "Some teachers are born and some are made. I was made but you were born." That [comment] was an important point in my life because that was one of the things that turned me toward seriously thinking about teaching.

Your mother died when you very young. Then your father died not many years later. How did you try to understand what their deaths meant?

As I stood and watched that coffin [the coffin of my father] go down, I wanted to cry. But I didn't because they had always told me that big girls don't cry. And I was now six. I couldn't understand. Everybody was crying; yet they told me: "Big girls don't cry."

You have said that you believe you have always suffered from a sense of inferiority. How have those feelings affected you?

I've always felt that I was meant for a life of service in one way or another. It seems almost as though I wanted to justify my existence by being helpful. I guess I've sort of been apologetic about living. Almost as if it's some special favour that I'm allowed to live.

Are you starting to believe the supportive things people are saying to you these days?

I think so. Possibly you making me go back and bring all these things together . . .see, they'd all been little incidents separated . . . now they're all brought together in my mind . . . there's continuity and that's where I think it [the life review process] has helped me . . . that it's really put my life into focus . . and I'd always sort of had the feeling, well, it [life] wasn't for me.

Do you still feel that way?

No, I don't. I think I'm beginning to claim more of my rights than I did before. I didn't feel like an equal. I always felt that I had to be grateful for everything that was given to me. That was one resentment I had against [the relative who took me in when my parents died.] He was <u>always</u> reminding me that the rest of my family [brothers and sisters] didn't do anything for me -- that I had to depend on him. Yet, the rest of the family had their own problems and they had very little money.

I really felt most of my life that nobody cared.

Is that feeling changing?

Yes, I'm finding many more people who would try to make me believe that [they do care.] But it's rather hard to put into words.

December 1, 1995

Did the idea of death worry you when you were younger?

I didn't have too many questions. I grew up on the farm. I had seen animals die.

You've said that there is something you'd like to tell me about your life, something that might help me understand your life better.

I have a very warped opinion of men; and I've had it for a long, long time. And it's been very difficult for me. A few men seem to understand me . . . to get through to me . . . and that's fine. A few of them I can be comfortable with.

I told you I hated [the relative who took me into his home when my parents died.] Well, I had more than the fact that he was always tearing me down. [Because of this relative] I never had a boyfriend. When I finally did get away from home, I was really champing at the bit [to be on my own.] I hated [this relative] from the time I was thirteen. Up to thirteen, I had thought he was absolutely wonderful. [What happened from age thirteen until I left home] has made everything difficult.

Any man I knew had to come up to a very high standard before I could trust him. I never could quite believe that men had any interest in me as a person. It always seemed to me that it [men's interest in me] was false. I told you about Mr. -------. He was on a very high plane [with many good qualities.] He was different and I didn't feel I was good enough for him. So I think maybe that [feeling of inferiority] was a lot of my trouble.

[The memory of not feeling good enough for Mr. --------] has hounded me all the way. But . . . lately since I've been talking to you, I've been looking at things in a different way.

APPENDIX G

EXCERPTS FROM AUDIO-TAPED CONVERSATIONS WITH PARTICIPANT #2 OCTOBER - DECEMBER, 1995 (quoted with The Participant's written permission)

October 13, 1995

Before you were depressed. what gave you hope?

At home we were taught the ten commandments; and we were taught to say our prayers. Otherwise, in my young days I didn't think much about religion at all.

I've always been a bad person for pushing things in the back of my mind, for running away from things. That's how I dealt with things which is not the good way at all. I've always done that. I've tried to run away from it [whatever problem.]

As you look back across your life, what made you secure?

My husband did. He looked after everything.. We were taught that the man is the head of the house. That's what I miss now that he's gone: I have to make decisions.

October 19, 1995

Was there ever a time that you felt you were in control of your life?

Oh yes, for a long time in my younger years [before I became depressed.]

Since you've been depressed has that sense of being in control changed?

It's been bad lately. I can't make decisions; and when I do, I make the wrong ones. Now I'm scared of making any kind of decision.

Would you say that you take charge of your life by wanting to pay your bills promptly, doing your own housework and so on?

That's just why, you see, why I've sort of refused a lot of offers and different things. I figured people wanted to control my life.

I'm too proud a person . . . I couldn't share . . . (I guess I could if I had to) . . . I couldn't share a suite with someone else. Being on my own is very important to me. Seems lately as if people are starting to make me feel I'm losing control.

I'm always terrified if I get sick. Who is going to pay the rent? I have nobody [here in the city] to depend on.

If it came to it that I had to move out of here and I couldn't manage . . . the thought of having to move out of here . . . the decisions I'd have to make about what to get rid of . . . I don't even want to think about it.

October 27, 1995

Could you tell me about your happiest memory in your life?

Well, it was that one year when we lived in -------. I would say that was my best time.

What was really good about that time?

Just ordinary things, you know, simple things, really simple things. Strange that I had that one really good year and then boom! [I became depressed.] Happy memories really don't help you much

sometimes. You look back on them . . . I don't know how to express it . . . it just seems you were an entirely different person.

Do you have any happy memories from when you were a little girl?

Well, the strangest thing was that we didn't know any different . . .in those days children were given chores to do and that . . . we had no toys or anything; but I remember in summer time, oh I used to just love playing, you know! I'd make a farm. I'd have all kinds of different things to represent different things . . . a spool would be a horse . . . and I'd build the little fences. I was really happy . . . [even though] we had to weed the garden, you know, and feed the cows. I felt happy because I didn't know any different.

You've said you could use your imagination when you were little. What sorts of things did you imagine?

Oh! I'd make up stories in my mind, you know, about families and stuff like that. I had a great imagination. Too much really.

In what way was it too much?

I think I got too much away from reality through imagination.

Was your imagination sort of a way to escape from all the troubles you had as a child?

I used to imagine that, oh, that there'd be a time come when there'd be enough money; and then I could have my eye fixed up because, see, there was a cataract grow over it very fast. The children used to ask me if I was born cross-eyed. That really bothered me. Also with my rickets, with my bones being twisted . . . . I used to imagine a time when somebody could do something for that; and then I'd not feel so self-conscious. People were always reminding me of these things. I always felt self-conscious. I think that [feeling of being self-conscious] had a lot to do with me being a loner. I just had to accept it [the physical problems.] There was nothing else to be done.

When you were a little girl, and then a teenager and so on, did you have any dreams of what you'd like to do?

Oh yes! Travelling! Go to other countries, oh, that was always in my mind. When I started working [for neighbours, at age thirteen] I gave all my money to my mother. She needed money for a new kettle. When I came to the city to work, I had a list written out, years before, of things I was going to buy myself. and I got them bought through the years!

What sorts of things were on the list?

Clothes mostly. Some jewellery, things like that. A dictionary was something I wanted, you know, because I read a lot. It took years but I finally got all the things on my list!

What other dreams did you have?

I wanted to travel all over. Especially what I wanted was to go on these liners, you know these big ships. That was something that I really thought was <u>wonderful!</u> You know I had that dream all, most of my life till finally it just faded away. Now I have the money; but I've lost interest.

As you look back, what accomplishment makes you proud?

I'm not sure . . . . One thing, after my husband died, a small thing was learning to type. I got a typewriter and a book. I knew nothing about typing; but I got a book out of the library and I learned to type, just two fingers; but I can type. And I don't make as many mistakes as I see in some of the letters I get. I thought it was pretty good at my age that I did that. Also, some years before I took a book from the library and learned to play solitaire. I never had played cards before. I learned seven different games.

You've said it's hard for you to do the things you used to like to do -- baking, for instance. What makes it difficult to do those things now?

Well, you see, the whole thing was when I did these things, it was appreciated. If I was baking bread, my husband would come in and I'd take the loaves out. He'd say, "Oh what bonnie loaves!" Everything was baked nice and brown, you know. It was for him. Now there's nobody to appreciate what I do. That's why I lost interest.

You've been telling me that in the last few years memories of your parents have come back to you, things you thought you'd forgotten. Could you tell me one of those good memories?

How sometimes my mother and I would just sit . . . in the old days people didn't show as much affection as they do today. Not so openly. But what she would do sometimes when we were just sitting -- she'd come and just stroke our hair, you know. She'd do that. And my dad, of course, he took me on his lap.

One thing I could certainly say: we were never abused by our parents in any form.

They were good parents?

We were taught the ten commandments, to obey our parents and things like that. I don't have any bad memories -- even though I did get a lickin' when I was fourteen. I haven't forgotten that. I disobeyed my father. It never happened again.

I never had any resentment against either of my parents. My mother lived quite a lot longer than my father. After I got married, I could talk to her. We could talk like a mother and daughter could, you know, without any restraint about things. More like friends.

And I had a very good husband, too. He was very loving, a kind person. He was a reserved person; but the last few years, when he wasn't well, he used to come every morning and put his hands around my shoulders and say, " I'm so glad you're around."

Actually at the time I don't think I realised how precious his gestures were, you know. A lot of women can't remember any kindness from their husbands. I have some very good memories of my husband, also some very sad ones. There's always good and bad things in life for everybody, I guess.

November 9, 1995

Are there any people who have been a big influence on you?

Well, my husband was for one thing. He was a much stronger character than I was. Living with him, always being with him, I started to feel different about things than I had before. When he was around I never worried much about anything. He always saw to things. In the last year or so it's been hard to make decisions. It's an ordeal . . . even to get myself to the phone to phone someone. It's ridiculous.

My family doctor said, "You've got to push yourself." But how far can you push yourself? Sure has been a long drag!

A relative said to me, "Oh, you're always talking about your troubles, but you'll most likely live to a hundred." She really put me down. [laughter] I wouldn't want to live to be a hundred, with this depression!

Are there beliefs that have been important to you in your life?

Well, one thing I do believe. You have a certain time from the time you're born. Your time is set, regardless what happens. When your time comes, that'll be it.

Are there any values that your parents taught you that are still important to you.

They drummed the ten commandments into us. But then when you are in your teens, and young and carefree, you slip pretty far down from there.

Are there any other values that matter to you?

One thing I always try to stick to -- and it's getting harder and harder -- I don't want a messy place.

I would never say things to people that would hurt them . . . at least not intentionally.

I really am very thankful that I stuck it through, looking after my sister [as she was dying.]. I could have said, "Well, I can't stand it." But I stuck it through, right to the very end. My sister said she wouldn't mind dying if there was somebody there with her. That's why I sat there all those hours. I said to my sister-in-law, "I kept my promise, but she didn't know." My sister-in-law said, "She probably knew."

I feel I did the best I could in looking after her -- the shape I was in, being depressed.

November 16, 1995

You said you were your father's pet. How did he let you know that?

I used to be an awful cry-baby. You see, I was a very sickly baby. I had pneumonia a number of times. Then I got rickets and I couldn't walk until I was about three. When I finally could walk, I got the wire poked in my eye from the screen door. I remember that . . . sitting in the high chair, the blood running down my face. It broke the pupil -- that's why I can't see out of that eye.

I used to be fussy. I didn't want to eat. There never was that much choice of things to eat. My father used to take me on his lap a lot. My mother was loving too, but she was busy. She didn't have that much time. In those days you had to work hard, baking bread and what not.

What's it been like to be alone since your husband died?

Awful! One time my neighbour [a married woman] says to me, "Boy, you're lucky that you can live alone." And I said to her, "Don't say that to me. I've spent ten miserable years."

It [being alone] might be right for some of them, but not for me. It's a very lonely life. Do you know that for I don't know how long, -- just sort of automatically -- I'd set the table for my husband? Till I'd realise that he wasn't there.

A couple of months after my husband died, I gave away some of his good clothes, his suits. but his other clothes . . . it was a strange thing . . . even after he died, I washed the clothes he had been wearing. Just washed them like I always did. Then I packed them all up and just put them in the closet. I couldn't give them to Goodwill -- because I knew they wouldn't want them. But I couldn't make myself put the clothes down the garbage shute. But when I moved here, of course, I couldn't move all that stuff. So what I did was I took some of my old dresses and some different things that I had worn, and packed them up with his stuff. Then I threw them down the garbage . . . part of me going with him. It's crazy sounding, but it was the only way I could make myself do it.

I've kept a few of husband's things, small things. There's just some little thing, you know , that you want to keep of them so it not like they're just wiped off the face of the earth, like as if they never lived.

Did you find that you went through various stages after your husband died?

At first, I was restless, terribly restless. I walked and walked all these places where we used to walk together . . . as if I was searching for him. I felt this terrible need to get out and walk all those places.

To me it's been a very lonely life, because we lived so much for each other. No ties with anybody else. I still feel very alone, but now I've accepted it more.

In the weeks before my husband died, he was very quiet. He said to me one time, "I'm not really much company to you now. I don't talk anymore." And I said, "That doesn't matter. You are there, you're still there."

There was still somebody there. It was quite a different thing once he was gone. And that's what made it so hard. I'd come in and see where he used to be lying down. I couldn't think about it. I'd have to go out again.

It was a pretty difficult time to go through. It's a strange thing how when you live with someone for nearly forty years or so, how that person never really seems to get older. He never seemed to age. To me he was always the same age, the same person he was. To me, it never seemed like he was old, you know.

These people that marry within a year -- that I can never understand.

November 24, 1995

What was good for you about the volunteer work that you did?

It was all being among people, and all the activity. I had to keep my mind on my job. You can't make mistakes.

Can you think of other things you've done that have been taking care of people?

My friend, I looked after her. I used to go at least three times a week when she broke her foot. I used to do her shopping for her. I used to do her cleaning, and get her books to read, and things like that.

It was a long stretch because she was older. And when you break a bone, it takes a long time. She still writes to me and says how good I was to her.

Do you enjoy looking after people?

Yes, it takes my mind off myself, you know.

November 30, 1995

As you look back over your life, do you wish that anything had been different?

Not wanting things or anything like that. I was always content with what things were. But sometimes I wish I'd been a bit more . . . I have regrets about some things . . . . My husband's endless moods -- that was the hardest. We moved so much, you never felt it was home wherever you lived . . . except for the one place we lived for a few years. That place was home. I didn't want to leave it, but we moved anyway.

How did you cope with that -- with moving even though you didn't really want to do so?

I'd been very much of a person if anything bothered me, I'd just push it out of my mind. When I had my first depression, the man who used to bring the groceries said I did that too much. It all piled up, all these things I didn't want to think about. It would have been better if I'd faced the things instead of pushing them out of my mind. I was also a great reader. You can lose yourself in a book.

If it had just been depression, just sadness . . . but it was the fears that went with it. Just horrible fears. I just lived with fears, day in and day out.

To tell you the truth, my depression started off with palpitations. This one night I was just frightened out my skin. I thought I was dying. Ever since that, I just thought of death. I was always afraid of dying. I don't know why.

Now I'm not afraid of death, just of dying alone. I've lived my Bible times [three score years and ten.] I'm living on borrowed time now.

What worries me is -- will I go to heaven? It's all such a mystery. The Bible is hard to understand in places.

Do you have a sense that you've been looked after in your life?

I think that . . . I have a feeling that God gave me the strength to keep going.

Could you say a bit about your memories of your husband's death?

When somebody dies in the hospital, it's all in a mad rush, you know. My husband died at night time. Early in the morning I had to go and choose a coffin. There wasn't enough time, and with it being between Christmas and New Years, it had to be rushed. It was all too much of a rush for me. It made it too unreal. I just couldn't believe he was really gone.

When he used to talk about how he didn't have much longer to live, I just wouldn't believe that. To me, I would just shut it out of mind. I just wouldn't think about it -- that he was going to die.

Can you still put things out of your mind in the way you did when your husband died?

Oh, no, no! The things all come back now from years ago . . . things I never thought of for years. They all come back.

Do you deliberately try to bring this material back?.

No, it just comes -- a lot comes in dreams. There's a lot of stuff in my dreams I never thought of before. The dreams are in a jumble. There's nothing bad about it. Just memories of things that have happened. My doctor said, "Let the dreams come -- let them come. It's good."

It sounds as though you have some very good memories?

Yes, yes, I have some very good memories! For a while, I was bothered very much by some of the bad memories. You know there are always some bad memories. And it really bothered me, you know, until I finally admitted to myself that that was the way I was, that's what I did. Now they don't bother me anymore.

Would you say that was sort of like accepting yourself, forgiving yourself?

I guess it would be forgiving myself. It's much easier to forgive other people than yourself.

Do you have a sense of letting go of the past?

For quite a while I was really bothered with the mistakes I made, and the things I did and shouldn't have done and things I should have done. Different things would go around and around in my mind. But I finally accepted that that was the way God made me, I guess. I couldn't do any better.

Can you remember the point at which your feelings changed?

It was very gradual. My doctor told me that it was my religious upbringing that made me so hard on myself. The way I look at it now -- it's that I have to forgive myself and accept myself the way God made me. Because we didn't make ourselves.

December 14, 1995

What's it been like for you to talk about your memories?

I think somehow that has really helped me to sort of forgive myself. Thinking of the past . . . I think this has helped me.

I suppose you didn't want to think about the things that were hard to forgive . . . .

No, I didn't! It was in my mind day and night. So it got to be awful. I just couldn't get it out of my mind. But it sure has eased up now. They say that sometimes if you talk about stuff . . . . With my family I never let on that I'm depressed. And I couldn't talk to any of them. As far as my doctor is concerned, you're in and you're out.

I did an awful lot of dreaming, too. Maybe that has helped to solve the guilt feelings.

APPENDIX H

EXCERPTS FROM AUDIO-TAPED CONVERSATIONS WITH PARTICIPANT #3 OCTOBER - DECEMBER, 1995 (quoted with The Participant's written permission)

October 18, 1995

As you look back over your life, what are the things that made you feel most alive?

I was always very happy with my family, especially the grandchildren. They made a big difference to me. And then I have a little [summer] place in ------. I would stay there for the whole summer. I'd pick berries and bring berries galore back with me for all my neighbours. I just loved picking berries! I got a great lot of pleasure out of that. I'd go for long walks with my friend. That was one of my happiest times.

I have a big brass bed at the lake. To me it's wonderful!

Do you sometimes still visit the lake in your head, in your memories?

Definitely! Definitely! I think of the first time my husband and I went there. We were just married and bought the place. I spent my honey-moon there.

Tell me about some of the good memories you have of your grandchildren.

We would have a family gathering when it was their birthdays. That was always great. The kids would all come over and play around. If they were just starting school they had to tell me all about it.

Are there other things that have been especially satisfying for you?

The most satisfying time I ever had in my life was the days I spent at the lake. I can't get them out of mind.

What part has your faith played in your life?

I like to go to church of a Sunday. That was one of my outlets, going to church. I'd sit and contemplate. I got a great lot of comfort out of that. I was the chief elder for so many years. I've had so many positions in that church! I've spent so much of my life in the church.

I was involved with the women's missionary society. They're still one of my pet projects. But just like everything else, one member died and then another member died. So we don't have a women's missionary society *per se* anymore. I think I'm the last one. The rest of them are all dead.

How does it feel when you think that they are all gone?

It doesn't bother me. Because I know that's the way life is. I'm not dreading dying. It can't come soon enough, now that I'm in this spot. Before I used to have lots of plans. Now I can't plan anything because I can't see.

[Being unable to see] has made a big difference!

Your feelings about dying have changed since your eyesight is gone?

Definitely!

What has given you hope through your life?

I put my trust in the Lord. I've been praying to him to help me through this tough time I've having. I'm feeling so much better this week. I think he's finally answering me.

What have been the moral beliefs that you've always held? Are there values you've always believed in?

My mother had that old one -- "Do unto others." I try to follow that rule. Sometimes not too successfully.

What has made you feel secure through the years?

When you're young you don't think too much of security. But I remember when my husband died, I thought, "Well, now I've got two children and I'm expecting another one. I've got to think about their futures. Work is the only thing that is going to take me out of my doldrums." So I proceeded to get a job.

Was there anything you told yourself in the rough times, to keep you going?

My mother always said that hard work never hurt anybody. And I worked hard!

What are some of the things you've learned through your life that make for a good life?

Working hard. Caring for other people. And always take time for prayer. You don't have to wait until it's night time. I can pray any time of the day. I can be walking along the street and see something. And I'll say a silent prayer. I'm a great believer in prayer. You don't always get what you want right away.

Prayer has been important to you in your life .What does it do for you?

My soul seems to be rejuvenated. And I'm very peaceful when I go to church.

Can you think of a time in your life when you felt really safe and secure?

I used to wonder after my third child was born [just after my husband died], what's in store for her? And yet everything turned out so nice. She was such a good baby. My other two children were so good. Also, I got a lot of help from my family.

October 25, 1995

What has it meant to you to be independent in your life?

I don't know where I got the independence from, but it just came out of nowhere. I believe in the power of prayer. I was very worried after my hubby died, and I was pregnant and I had two young children. My mother had been left in the same position as I was, only she had four children to look after. She said that she just decided not to sit at home and worry about it. She went out and got herself two jobs at once. A local girl looked after us kids. Everything went fine for my mother.

So perhaps your mother was kind of a role model for you?

Definitely! I owe an awful lot to my mother.

Do you remember as a child wanting to be independent, asserting yourself?

Oh! I always wanted to be the leader. I wasn't hesitant. I enjoyed being a leader. I used to stand up for my rights. I gained a reputation as a fighter. Girls used to say I was their cousin (even though I was no relation) to scare away kids who were bothering them.

Can you think of a time when you started to feel that you really were on your own?

It was a great shock to me when my stepfather died [when I was twelve.] I used to say to my mother, "Gee, I wish the days would come back when we were rich." We weren't rich! But in my mind, I thought having a father was a wonderful thing. He was so kind to us kids. That was one of the biggest blows in my life. I still think about him, right to this day.

Did the issue of independence become important to you when your husband died?

Yes, I thought, "I'm not going to sit around here and brood. I've got to get out and do something with my life." I had three children to look after. When my husband died, we had been married short of ten years.

Since you've been depressed, it's been hard for you to get started at things. Was it ever like that before?

Never! Boy, [even after I retired] I used to get up at six in the morning! The neighbours would wonder why I got up so early. I'd do a few things around the house and I had some place to go every day. I was great one to volunteer.

Looking back, what were the toughest decisions you had to make.

Financial! My mother had a rule that as soon as you got a bill, you had to go and pay it. The water bill or the light bill or anything else. I grew up with that. So I endeavoured to pay my bills as soon as I got them. Sometimes, maybe, I didn't have twenty-five cents left to do me for another week.

Sometimes did you worry about those bills quite a lot?

Sure I did, because I had those kids to feed and clothe, you see. One time, my children all got new shoes for school. Then we went to the lake. My son insisted on wearing his shoes. They got thoroughly saturated.

Without even asking me what to do about these wet shoes, he took them off and put them in the oven of the cookstove. After the next meal, I thought, "What's that smell?" I opened the oven door, and there were his new shoes. They were all shrivelled up. His old runners were full of holes. I was ashamed of him the first day back at school. But there was nothing I could do. I just didn't have the money to buy him another pair. I cried. That was awful.

Now that you are older, what is it important for you to be in control of?

Right now I'm not in control of anything! Not since the accident. I've had to leave everything to my children [to do.] It makes me sad because I never used to ask anybody for anything!

What are the things you used to control, but now you can't?

Well, reading my mail for one thing. Another thing, when I tried to vote, I could see I'd really lost my independence. I had to get somebody else to help me with the ballot. I can't read the paper. I can't even watch TV.

What has always given you confidence through your life?

I don't know why, but I've always been confident, even when I was a kid. I never doubted myself until this accident. My mother drilled it into me --"You're just as good as the Queen of England." You see, the Irish and the English never got on. My mother told me some of the things that happened in Ireland in her day. She'd say, "You're just as good as anybody. Always remember that." My mother always said, "We're all equal."

November 1, 1995

What was your first job?

It was in a bag factory. Things were so tough then. You couldn't a job! It was terrible! This was before the [second world] war. I went all over looking for jobs. Somebody who worked there let me know that they were going to take on new people.

Tell me about going back to work after your husband died.

When my husband passed away [in 1952], I went down to the provincial welfare and asked them to come and tell me what I could do. They sent somebody. They were going to give me ninety dollars a month to live on. You can imagine it wouldn't go very far with three children and myself. "Just a minute," I said, "where is this money coming from?" I was told, "From the government." So I said , "No."

My mother was here. I called her in. I told her what he had said.. She practically threw the man out. She said, "We've never had charity from anyone. We'll make our way without your help!" The man left in disgust.

I said to my mother, "What do I do now?" She said, "Well, after all, you're a pretty smart girl. Why don't you try to brush up on your education?" I didn't know how I would fit in because everything was changing in the business world. So I went to a business college. My family all pitched in and helped me.

When you think about working, would you say it's been good for you?

Definitely! When I retired, I was home maybe a month . . . and my son said, "You sure look miserable, Mother." I said, "I can't sit here day after day. I've got to do something." My son told me that they were desperate for volunteers at [a school for special needs children.] I was fascinated by these children. We would take them on picnics and things like that. I even went away one weekend, camping with them. That was nice! So that's what I did when I retired. I was there for eight years.
November 8, 1995

Who were some of the people who had an influence on you and on your values?

My mother! She had all these sayings, you know. She believed in the work ethic. She practised it herself. My mother was uneducated. She had never gone to school one day. But she sure appreciated education. When I started school -- I was the youngest -- I would come home and tell her what I'd learned that day, but she never really grasped it. But, she was very anxious for me to get an education.

I was influenced by my school principal. (He gave me my first strap!) He impressed on me to be a good citizen, which I tried to be. He gave me the strap, five times on each hand. He said to me, "You'll think twice before you break another window." He took an interest in me for some reason. Later, my mother used to knit his gloves and socks. He used to talk to me and tell I had to get a good education. He said, "Your mother works too hard. You've got to get a good education."

My Sunday School teacher pounded it into me; and I've had an interest in religion ever since. I idolised her and I used to call on her every Thursday night. I guess she was sick of me, but she never said a word. Eventually she got married and went to the States. Years later, I found her. I took some pictures with me. I knocked on her door. I told her who I was. And she couldn't even remember me! And that just about broke my heart. I said, "I was supposed to be bad, surely you remember something."

Then she remembered me!

[Years before] we were going on a picnic [with a church group.] She put me and another girl in charge of the sandwiches.] By the time we got out to [the site of the picnic] we had consumed quite a few of those sandwiches. Mrs --------- said, "I remember you *now*-- when we got out there, you had eaten half the sandwiches! If they said you were bad, you were!"

She was a big influence to me. She worked in the soda fountain of one of the big department stores down town. Every time I went there she would give me a drink, lemonade or something. Wonderful memories of her!

Sometimes people don't feel they are the age they are. How old do you feel you are?

I have a feeling often that I'm not going to be eighty-four. Prior to this accident, I used to feel around, say, twenty-five.

What has contributed to your philosophy of life?

When we were very small, we were going to bed. My mother would be at the bottom of the stairs. She'd give us a little bit of salt in our hands. We'd go upstairs and clean our teeth thoroughly.

Then we'd kneel down on the cold floor and say our prayers. She sat on the edge of the bed. We prayed for the sick every night. I still do, though I get into bed now for my prayers!

I still believe in the power of prayer.

Sounds as though being a good neighbour has been part of your philosophy.

We're quite close to the railway shops. In the bad times, the young men were riding the rods. They'd come right to our house. My mother was always feeding these fellows. They were always hungry. They were going all over the country looking for work. She always made sure she gave them something to eat and lots of times, she persuaded them to go upstairs and have a bath.

How would you describe the kind of person you are?

I haven't thought about that . . . I thought I was able to conquer an obstacle when it came round. But I found out that . . . with my eye problem . . . that I didn't know whether I was coming or going.

Before my accident, I was happy-go-lucky.

I have a lot of compassion for people. I can feel the hurt.

I never make fun of anybody.

I've always been very curious about what's going on today.

How do you think other people might describe you?

Somebody asked me, "How come you're always laughing?" They used to say I used to laugh a lot.

Is there anything you hope people might say about you?

I hope that they'd say I have risen above the fact that I'm blind.

November 15, 1995

You mention driving your car. How long did you have your car?

Until two years ago. I drove for two years without a licence. So one day my boss asked me to go down town. I said that I'd never gone down town because I didn't have a licence.

"Well," he says, "you take the rest of the day off and get a licence. Some day you might need it." He asked me how I could run in my car without a licence. I said, "Well, I'm a respectable widow and nobody would ever think of challenging *me*!" That was when I was about forty-two.

All the kids on the street . . . there weren't [many] women driving in those days . . . . and the kids would stand and yell at me "Woman driver! Woman driver!" It was quite a novelty. I was the only woman on the street who had a car.

I had a tendency to take my kids out at night time because they belonged to groups at the church. My kids would hide in the back of the car. They didn't want the other kids to see because it was disgrace to have a woman driving a car.

Tell me about your holiday on the farm.

We had a housekeeper. They lived out on the farm. One summer her mother wanted her to help on the farm. My mother said the housekeeper could go home for the summer if she took the girls [my sisters and me.] She took my sisters and my brother and we all went out there -- at no cost to my mother. My brother used to help them with the chores, and I would feed the chickens and things like that.

Her mother was quite a stern lady. She told us we must eat whatever was on our plate. First day we got there, we had a chicken. But I looked at my sister and my sister looked at me. I said, "What are we going to do with the bones?" My sister said, "Put them up your pant leg." In those days there was always

elastic in girls' pants. So we stuck the bones up our pant leg. When we got finished dinner, we went outside and got rid of the bones. I always remember that.

When you think about your husband and your marriage, do you feel that he had an impact on you?

I don't think so. I'm a very strong-willed person.

What are some of your fondest memories of your husband?

Our little cottage at the lake, when we were there by ourselves.

What was your husband like?

My husband was a very quiet man, altogether different from me. I was the noisy one at the time, him quiet .We may have had tiffs, but never any arguments.

How did he die? Was he sick?

I noticed that he had a lump, the size of a big nickel, on his right shoulder. He said he'd had it when he was a boy. Then his braces started annoying the lump. He went to the doctor. (Our own doctor was away.) This doctor cut out the lump and put a bandage on it. In no time at all, it was healed. But my husband said it was so itchy. So he went back to the doctor. Our own doctor was [still] away on a medical trip.

By the time our doctor came back from his trip, my husband had been in and out of the hospital. I had to get a hospital bed for him. Then our [regular] doctor came to visit. He said, "I hear you have a sick man here."

I told our doctor that the other doctor wasn't telling my husband anything. We didn't know what was wrong. Our doctor told me to go outside with him. Standing outside at the fence, he told me. He says, "Your husband is not long for this world. He's got a cancer of the lymph nodes."

I said, "How come that other doctor didn't tell us?" [The other doctor thought] there was no use telling us, it was too far gone. Our doctor says, "You've got to prepare yourself."

I said, "What am I going to do? I'm pregnant again." Our doctor said, "You'll have to plan for the birth, but your husband will be gone by then."

My husband never did see our third child. I was born under the same circumstances [born after my father's death.] and so was my mother. She says, "Now it's happened three times in our family." She was superstitious. She said it would never happen again. I was worried when my daughter was expecting, that [the same thing] would happen to her. But it didn't.

My husband died in August. The baby was born in November.

Were you in shock when the doctor told how very ill your husband really was?

I sure was! I didn't want to tell my husband.

Finally he went back to the hospital. It was awful! I went there everyday. And I'd have to lie to him, let on there was nothing the matter. He said, "Look how thin I'm getting!" I said, "Now, you're not getting exercise and you're not getting the food that you got at home. When you get up and get going again, you'll be better." But I didn't tell him.

[When he died] it was terrible! I had to come home. I remember walking in the house and having to tell my mother.

Did you tell your children right away?

No, it was at night time. I told them the next day. My neighbours said I made mistake [because] I didn't let the children go to the funeral. I got another neighbour to look after them. She took them to the park. I didn't want them to have any bad memories.

Could you say more about what you mean by "bad memories"?

When my step-father died, they brought his body back and he was lying in the front room over night. And you know, that really bothered me. Never got over it. The smell of roses always reminds me

of it. They took the living room window out to get that coffin in. Somebody had to sit beside the body all night.

That would make a big impression on you as a little girl.

Oh yes! Never having a dead body in the house before.

Did people explain what was happening?

Nobody made a remark. I never let my children see my husband [after he died.]. I'd had a shock once myself with my step-father.

Could you tell me a bit about what it was like after your husband died?

Quite a few people asked me why I didn't name the baby after my husband. I didn't want to. I don't know why. I didn't want to.

You must have had a lot of mixed feelings.

Oh, I sure did! But I had a lot of support from the same neighbours that I have now. From the church. One of the ladies from the Ladies' Aid came to see my husband everyday. And the minister lived right up the street and he came. So I had lots of comfort with people coming. Everybody wanted to mind the baby.

After your husband died, who were the people who were really important?

My children! And my mother of course.

Did you ever consider re-marrying?

Not really . . . my husband had a friend and he used to come. He was a bachelor. My mother put fear into the kids , you know. "He's coming around to see your mother," [she told them.]

My son says to me, "We don't want another father. Promise me that you won't get married." I said, "I have no intention of getting married!" I gave my mother the dickens for mentioning it to the children.

When I started at [my longest-held] job my mother asked me what kind of people were there. I said, "There's forty-five men and me. But they're all dogs, Mother! So don't try and tie me up with anybody!"

Do you have any particular memories of the time when you children were growing up and leaving home?

Sunday was a big day with us. We were all home on Sundays. We always had brunch on Sunday when I got home from church. We'd have bacon and eggs and fried tomatoes. Scones and things like that. Eventually the two younger children got married. We still have brunch, my son and I, but it's cut down now.

Could you tell me about the relationship you have with your children now that they are adults.

One of my sons came over. I told him I felt he had deserted me. He said, "I haven't deserted you. but my prime purpose in life now is my wife and children, so I have no time for you." He told me that straight to my face. O God! I was really hurt! When I thought about it, I gave up my life for those kids. And this is the way he's paying me back. I thought, you know, that he could be kinder to me.

December 6, 1995

You've taken care of a lot of people and organisations over the years. Do any memories stand out for you?

I was always very interested in children's work. One of the first things I did, when my boys were old enough, was to put them in Cubs and Scouts. I did a lot of work with the children.

You've cared a lot about the church.

Definitely! I was a Sunday School teacher. I became interested in the women's missionary society. I was always missionary-minded. I did a lot of work for them. I was secretary for years for them. I was the youngest one there. I was forty years old, but I was the youngest one.

When my husband was sick, these missionary women would come every day to visit. Now they never got into see my husband -- he was too sick. But they would come and see me. I thought, "That's a great group!" So when my husband passed away, I says, "I am going to join the women's missionary society!" Everybody told me that was for old ladies. I said, "I don't care." They were so good to me. I couldn't get over it.

As you look back, what has given you the most satisfaction in helping other people?

Oh, that would be the young ones. I like young people.

What would you like people to remember about your life?

We had a woman who used to live next door. She told my mother, "Your daughter is the biggest tomboy going." I eventually became a baseball player. That 's what I concentrated on. I know I was quite tomboyish. I used to scale the fence. I couldn't do it now.

Is there anything else you would like people to remember?

Not really.

Is there anybody who makes you think, "This person will carry on for me when I'm gone"?

No. no. They're getting too old. They're in my age category. Nobody comes to mind. My daughter has a lot of my traits. Where she goes to church, right away they nabbed on to her to be a Sunday School teacher. "I'm carrying on your work, Mom!" she says. I was so happy!

Is there anything about your life that you wish could have been different?

Well, my first blow was my husband's passing away. I even mention that to the boys once in awhile. "If only your dad had been alive to see what you can do, or you can't do!" He never did see our daughter.

I'll tell you, I'm not an envious person. I don't care if you're dressed in silks and sables. But at church, I see people I know, in there with their husbands . . . I look around and I'll say, "I wonder what my husband would be like if he was sitting beside me." I'm kind of envious.

Over the years, were you angry about losing your husband?

I accepted it! I knew it wasn't fair. I told you about my mom being left fatherless. I was left fatherless. My daughter was left fatherless. My mother says, "That's gone around three times. That's it. You'll be OK from now on." So I believed it. I had a lot of faith.

December 19, 1995

Are there lessons you have learned in your life that you believe might be important for other people to learn?

You've got to keep busy, even in the face of obstacles. [After the accident] I went back to knitting with the help of the CNIB. I knitted for years. I didn't lose the art of knitting; but it's a lot slower than it used to be.

I'm very apprehensive about every row I knit. I can't see that good; but you can feel. I've got the power now of feeling, which I never used to have. I hope that it can take me back to typing because I feel so alone now. I can't even write. It has to be with a big marker or I don't even know what I've written. I'm hoping I can pick up my typing.

I have a relative whose baby was born retarded. Such an upset for the whole family. Due to the fact I had had a lot of experience with retarded children, I thought I was going to sit down and write her a letter and give her some hope. I made such a mess of the letter that I just felt I couldn't send something like to somebody who is suffering.

What was the message you wanted to give her?

I wanted to give her the message of hope. You know, I think no matter how dark a thing appears, there is always hope.

You've seen changes in retarded children, haven't you, in working with them?

Oh, definitely! This girl is so full of love for this baby. It's a pity when you see them together. She knows his every move. She's devoting her whole life to him, and yet she has her own business.

The day I sat down to write her a letter I was so full of words of wisdom . I couldn't express it. My fingers wouldn't do it. That was such a blow to me!

I suppose that one of the big things you've learned is that when there's trouble, you have to keep going?

Definitely! There's no use sitting down, thinking about it and crying. I learned that from my mother. She was the big instigator in my life, the big influence. I only hope she realises that now.

Are there other lessons that you've learned?

My mother always believed in the work ethic. She got up one Saturday morning in the summer before five o'clock. She had our church painted in time for the service at eleven the next day. My mother was just a little woman. She wasn't even five feet. But, oh boy, could she ever work!

Are there any values you'd like your grandchildren to have?

My primary object is that they all get a good education. That's the most important thing. I was able to instil that in my younger son. He got the drift. But the older boy, no, he passed Grade Twelve and he couldn't get out of school fast enough. Even my daughter who was the smartest of the three, she didn't realise the value of an education. Now she says she wishes she'd taken my advice. She wanted to get to work so she'd have her own money to spend.

What were some of the big turning points in your life?

When my husband died, and I had to figure out how to take care of my children.

Do you think there's anything in your life that has defeated you?

I think that I have had some defeats. I can remember saying to myself, "Well, it's just another hurdle." You've got to shake yourself, more or less, and get on.

After your accident, did you feel like giving up?

Yeah. There was a young social worker who used to come here. He helped me a lot.[Here Participant #3 listed various other mental health professionals and social workers who had helped her. She could not recall the exact sequence of events that led to her getting help.]

Do you ever find yourself thinking about dying?

No! it doesn't worry me one iota. If I died tomorrow, that would be OK with me. Then I'd be reunited with my husband and my mother. I really believe in an after life!

Do you have the feeling of having unfinished business?

I think everything's in order. I've given my niece anything that was related to her mother [my younger sister] that was left in this house. I had an older sister. But we never ever hit it off. I was never close to her. She got along with everybody but me. I couldn't do any thing to please her.

Do you feel bad about not getting along with her?

Not really. I did my best. I used to baby-sit for her a lot when she had her first child. But we just didn't get along. My other sister and my brother, we got along. My brother was away most of the time. Then he got married and he and his wife parted. There'd never been anything like in our family. My mother said," I won't be able to walk down the street! People will know they are parted."

I said, "They're not going to know unless you tell them!" Because he lived in [another city.] They were both wonderful people, my brother and his wife. Him and I got along like two peas in a pod. In 1959 he bought me a brand new car. He certainly was good to me, and he was good to my children.

When you look over your life, would you say it's been worth it?

Oh, yes. I always think the bad thing for me was my husband dying. I look at my daughter's oldest boy. [He has the same name as his grandfather.] And I've got big hopes for him.

In these last weeks, we've covered a lot of your memories. Do you think there's anything we've missed?

Maybe I'm morbid, but why am I the only one in the family who ever visits my mother's grave? My father died before I was born. I didn't even know him. It wasn't until two years ago that I had enough surplus money that I could put a stone on his grave. My mother could never afford to do that.

My boys will never visit their father's grave or their grandma's grave. And their grandma was very important in their lives. My daughter used to be very good taking me to the cemetery. But it didn't mean anything to her.