

ORIGINAL RESEARCH

COMPARISON OF THE EFFECTS OF REMINISCENCE THERAPY ALONE AND IN COMBINATION WITH PSYCHOEDUCATION THERAPY ON DEPRESSION LEVEL OF ELDERLY IN INDONESIA: A QUASI-EXPERIMENTAL STUDY

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Abstract

Background: Depression can occur in elderly, but it is not a part of normal aging. Untreated depression increases rates of completed suicide and mortality. Therefore, an effort to reduce depression level is needed. Reminiscence and psychoeducation therapy are assumed to be effective in reducing the level of depression in elderly.

Objective: To compare the effects of reminiscence therapy alone and in combination with psychoeducation therapy on depression level in elderly.

Methods: This study employed a quasi-experiment with comparison group design. Seventy-two respondents were selected in this study using a simple random sampling, which 36 were assigned in each group. Data were collected in 2018 using Geriatric Depression Scale (GDS). Dependent and Independent t-test were used for data analyses.

Results: The reminiscence therapy alone or in combination with the psychoeducation therapy were effective in reducing depression level in elderly ($p < .05$). The combination of reminiscence and psychoeducation therapy was much more effective than reminiscence therapy alone ($p < .05$).

Conclusion: These findings serve as an input for the Government of Indonesia to provide the combination of the reminiscence and psychoeducation therapy in the elderly program. This study provides a new knowledge for geriatric nurses to provide new interventions specifically to reduce depression level among elderly.

KEYWORDS

depression; Indonesia; geriatric nursing; psychotherapy

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BACKGROUND

Elderly in general will experience changes spiritually, cognitively, biologically, psychologically, and socially (Touhy & Jett, 2010). Psychologically, changes in the elderly in the form of decreased ability of sensation, perception, and psychomotor appearance, which are very important for the functioning of everyday people's lives (Atchley & Barusch, 2004). However, many elderly are unable to adapt to the psychological changes they experience, which are characterized by symptoms such as sensitive, unstable, easy to feel sad, feelings of hopelessness, paranoia, feelings of guilt, feeling burdened, feelings of loss, loneliness, depression, and difficulty sleep which results in a risk of depression (Miller, 2004).

The prevalence of depression in the elderly in the world is around 8-15% in women, which is twice as many as in men with a ratio of 14.1:8.6. In Indonesia, according to the [National Commission for the Protection of Older Persons \(2010\)](#), the prevalence of depression in the elderly is around 30%. But according to [Frazer et al. \(2005\)](#), the

prevalence of elderly depression in the community ranges from 1% to 44%. While Jambi Province ranks highest with 20% of elderly experiencing emotional mental disorders, especially depression ([Department of Health, 2019](#)).

According to [Touhy and Jett \(2010\)](#), depression will hamper the fulfillment of developmental tasks of the elderly and also shorten life expectancy which causes a decrease in quality of life. Elderly with depression will experience feelings of lack of enthusiasm and lack of socializing to others for fear of being embarrassed. This situation is rarely detected because it is very rarely reported. The further impact experienced by the elderly with depression are physical pain, drug abuse, alcohol and nicotine, and suicide if they do not get the right and immediate intervention (Miller, 2004). The results of our preliminary study found that many elderly people experience depressive symptoms mainly due to physical weakness, decreased health conditions, impaired communication and interactions that result in being unable to carry out

activities as usual. Many of them are very dependent on family members which causes them to tend to be at home and not do activities. Therefore, an intervention to deal with depression in the elderly needs to be done.

In this study, there are two therapies that can be given to the elderly with depression, namely reminiscence therapy and psychoeducation therapy. Reminiscence therapy is a therapy for recalling past events and experiences (Bryant et al., 2005; Wheeler, 2008). Herr (1998) said that reminiscence therapy aims to collect past memories from childhood, adolescence and adulthood including relationships with family, which are done through sharing and facilitated by therapists (Perese et al., 2008). The benefit of this reminiscence therapy is to increase self-esteem, identity, and self-integrity (Frisch & Frisch, 2006; Mckee et al., 2005). However, reminiscence therapy is relatively easy to implement, the costs are affordable, and side effects are minimal (Jones, 2003).

While psychoeducation therapy is one form of family therapy through health education to caregivers patient care about caring for family members, efforts and signs of behavior that can support the strength of the family to reduce the intensity of emotions in the family, and increase family knowledge about diseases that occur in elderly (Frisch & Frisch, 2006; Wheeler, 2008). This family psychoeducation therapy has proven to be effective in increasing family cognitive and psychomotor abilities, lightening the burden, and increasing family coping (Liu et al., 2007; Rafiyah, 2011). However, this therapy is very important, because based on the results of our interviews with caregivers it was found that sometimes caregivers often complain of the condition of the elderly who are like young children again, unstable emotions, and physical weakness. Many caregivers also don't know how to provide for and treat elderly people with depression. Therefore, psychoeducation for this family needs to be done.

By looking at the phenomena and the effects of reminiscence and psychoeducation therapy on depression, this study therefore wants to test the effectiveness of these two therapies in depressed elderly people in Jambi, Indonesia.

METHODS

Study Design

This study employed a quasi-experiment with a comparison group design.

Sample

The samples in this study were 72 respondents who were selected using simple random sampling using a lottery. The sample was based on a previous study with 90% power, 95% confidence interval, significance

at .05, with a total of 25 participants (Syarniah et al., 2010). 30% of the attrition rate was added, with 36 participants at least per group. Criteria for inclusion of the sample are the elderly aged 60 years to 75 years, the elderly living with family, the value of the Geriatric Depression Scale (GDS) ≥ 11 , willing to be a respondent, communicative, and cooperative. As this study also included caregivers, so the samples of caregivers were also 36 in the experimental group and 36 in the comparison group.

Instrument

There are two instruments in this study: the first instrument is to measure demographic data consisting of age, gender, educational status, marriage, employment, and health status. The second instrument is to measure depression in the elderly using the Geriatric Depression Scale (GDS), which is valid in the Indonesian version consisting of 30 questions with a sensitivity level of 90.19% and a specificity of 83.67% (Syarniah et al., 2010). The GDS scale is a universal and accurate measure of depression in the elderly than other depression measures (Touhy & Jett, 2010). A dichotomous scale is used with the choice of "yes" or "no" to answer questions according to the conditions they feel. The range of values for each answer is between 0 and 1 with a total of 30. Depression is detected if a score ≥ 11 . The validity test of this scale used Pearson product moment correlation test with a corrected item-total correlation value of .884 ($> r$ table of .444), which indicates that all items questions on the scale were valid.

Intervention

In the experimental group, there were two interventions given, namely psychoeducation therapy and reminiscence therapy. Psychoeducation therapy was done first and then followed by reminiscence therapy in the next day. Psychoeducation therapy consists of 5 sessions with 5 meetings, and each session was carried out for 45-60 minutes. While reminiscence therapy consists of 5 sessions with 9 meetings and each session carried out for 75 minutes. Psychoeducation and reminiscence therapy were done in groups. The intervention was carried out for 6 weeks, from Monday to Saturday, according to the agreed schedule. The intervention was conducted in two places, namely in Integrated Health Care of Melati and Pomegranate. In reminiscence therapy, the elderly was divided into two groups in one session, and in one group there were 9-10 people. In psychoeducation therapy, participants were only family members from the elderly.

In the comparison group, the intervention was reminiscence therapy for 5 sessions with 5 meetings per session conducted for 75 minutes conducted in groups. There was no difference between reminiscence therapy in the experimental group and the control group. The intervention in the control group was conducted at the Integrated Health Care of Palm and Kemuning I. The steps of psychoeducation therapy and reminiscence can be seen in **Table 1** and **2**.

Table 1. Steps in Reminiscence Therapy

1. Preparation Phase

- 1.1 Agreeing on the implementation of therapeutic activities with the client before session 1 is held.
- 1.2 Reminding the client 1 hour before the implementation of therapy.
- 1.3 Preparing a meeting place
- 1.4 Preparing media / tools:
 - 1.4.1 Nametag of therapist and client

Table 1. Steps in Reminiscence Therapy (Cont.)

- 1.4.2 The therapist evaluates the objects that are still owned by the client in relation to the topic of discussion on reminiscence therapy at the first meeting, which is the most preferred experience of play in childhood. This evaluation activity is carried out 1 day before the therapeutic activity is carried out.
- 1.4.3 The therapist asks the client to bring objects that are still owned by the client which are related to the game of childhood that is most preferred. This activity is carried out 1 day before the therapeutic activity and repeated 1 hour before the implementation of the therapeutic activity.
- 1.4.4 The therapist prepares the process evaluation format, the documentation format, the client's independent evaluation format (report cards), and stationery such as the workbook and pen.

2. Implementation Phase

2.1 Orientation

2.1.1 Therapeutic greetings.

2.1.1.1 Greetings from the therapist.

2.1.1.2 Introducing the therapist's name and nickname.

2.1.1.3 Asking the client's name and nickname and using the nametag.

2.1.2 Evaluation/validation

2.1.2.1 Asking the feeling of client

2.1.2.2 Contract

- Agreeing on the length of the meeting and the number of sessions, namely 9 meetings and 5 sessions: (1) childhood experience sessions, (2) experiences of adolescence, (3) experiences of adulthood, (4) experiences with family and at home, and (5) evaluation activities. Each meeting is 75 minutes long.
- Explaining the purpose of the first meeting, namely: clients share pleasant experiences that occur at the age of the child associated with the game most preferred in childhood; and clients are expected to be able to express their feelings after sharing experiences with group members.
- The therapist explains the following rules: length of activity is 75 minutes, clients follow activities from start to finish, clients play an active role in sharing experiences and expressing their feelings after sharing experiences with others.

2.2 Working

2.2.1 The therapist introduces him/herself: name, nickname, place of residence and educational status.

2.2.2 The therapist asks each group member to introduce themselves including their name, preferred nickname, age and place of residence. This introductory activity starts with the client sitting to the right of the therapist and continues clockwise until all group members have introduced themselves.

2.2.3 The therapist leads the client to perform deep breathing techniques 3 times, then the client is asked to close his eyes. The therapist invites the client to remember the experiences of childhood, then the client is asked to recall games that were often done during childhood, what games had been done, what games were most liked during the child's time, with whoever was playing the game, where the game was done, when the game was played and what events were the most fun or most memorable with the most liked game. Then the client is asked to open his eyes again and take a deep breath 3 times.

2.2.4 The therapist gives an opportunity for 1 client to tell the most enjoyable experience related to the most liked game in childhood.

2.2.5 The therapist gives the client the opportunity to show the objects that he/she still has that are meaningful to the client in relation to the game he/she likes best in childhood.

2.2.6 The therapist asks other clients to respond to the experiences that have been conveyed by their peers.

2.2.7 The therapist discusses the client's feelings after sharing pleasant experiences with others - what the client feels after sharing his/her experience with others, and the benefits that the client feels as well as past relationships with the client's current condition.

2.2.8 The therapist encourages the client to accept his/her pleasant past as a valuable part of the client.

2.2.9 Repeating activities 4 until 8 for other clients until all group members have the same opportunity.

2.2.10 The therapist explains the relationship of remembering and sharing pleasant experiences with others with self-acceptance at this time.

2.2.11 The therapist motivates clients to do the same activities with others without being structured.

2.2.12 The therapist compliments the client's commitment and enthusiasm.

3. Termination Phase

3.1 Evaluation

3.1.1 Asking the client's feelings after reminiscence therapy activities.

3.1.2 Evaluating the client's ability to convey pleasant past experiences in childhood.

3.1.3 Giving positive feedback on the ability and good client cooperation.

3.2 Follow-up

3.2.1 Encouraging clients to recall other pleasant experiences that occurred during childhood, and sharing these experiences with others outside of group therapy activities both in groups and with others individually. Activities carried out by the client will be evaluated at each meeting from the second meeting to the 9th meeting.

Table 1. Steps in Reminiscence Therapy (Cont.)

3.3 Upcoming contract

- 3.3.1 Agreeing on a topic at the second meeting, which is to share fun experiences in childhood related to experiences about most loved friends in childhood. Clients are asked to bring memory objects that are still owned by clients related to the topic.
- 3.3.2 Agreeing on the time and place for the 2nd meeting and the 75-minute meeting time.

4. Evaluation and Documentation Phase

4.1 Process evaluation

Evaluation is carried out during the therapy process, especially at the working phase. The aspect evaluated in session 1 is the ability of the client to introduce him/herself, express his/her feelings, convey his/her experiences on the topic and express his/her feelings after the activity.

4.2 Documentation

Documenting the abilities of the client has during therapy on the nursing process record. If the client is considered capable, then it is recorded as the client following reminiscence therapy session 1, able to express feelings, convey their experiences on topic and express feelings after the activity. Clients can continue to attend session 2. If the client is deemed incapable, then it is recorded as the client following reminiscence therapy session 1, unable to express feelings, not unable to convey his/her experience according to the topic and unable to express feelings after the activity. It is recommended that the client should try to remember the past memories according to topic and doing exercises to convey to others outside of therapeutic activities.

In the psychoeducation therapy, each session has different objective, but the steps are similar. The objectives include: 1) Identifying the changes that occur in the elderly and the problems that arise due to changes in the elderly, 2) Caring for elderly with depression, 3) Family stress management, 4) Management of family burden, and 5) Community empowerment in helping family.

Table 2. Example Steps in the Psychoeducation Therapy (Session 1)**1. Preparation Phase**

- 1.1 Reminding the family 2 days before the implementation of therapy.
- 1.2 Preparing tools and meeting places.

2. Implementation Phase

2.1 Orientation

- 2.1.1 Therapeutic greetings from the therapist.
- 2.1.2 Introducing the therapist's name and nickname, using the name tag.
- 2.1.3 Asking your family name and nickname.
- 2.1.4 Validation: Asking how the family feels in joining the current family psychoeducation program.
- 2.1.5 Contract: Explaining the purpose of the first meeting - to work together and help families who have family members with depression.
- 2.1.6 The therapist reminds the steps of each session as follows: 1) Agreeing on the implementation of therapy for 5 sessions, 2) Activity duration is 45-60 minutes, 3) The family follows the activities from start to finish with the same family members.

2.2 Working

- 2.2.1 Asking about what the family feels so far is related to depression experienced by one family member.
 - 2.2.1.1 Personal problems felt by family members themselves.
 - 2.2.1.2 Problems in caring for family members who are depressed.
 - 2.2.1.3 The family writes down the problem in the family workbook.
 - 2.2.1.4 The therapist writes in his/her own workbook.
 - 2.2.1.5 Ask about the changes that occur in the family with a family member suffering from depression.
- 2.2.2 Providing family opportunities to convey changes experienced in the family such as changes in family roles and family functions after a family member is depressed.
- 2.2.3 Asking the wishes and hopes of the family while attending therapy.
- 2.2.4 Providing family opportunities to ask questions related to the results of discussions that have been conducted.

3. Termination Phase

3.1 Evaluation

- 3.1.1 Summing up the results of session 1 discussion.
- 3.1.2 Asking the family's feelings after finishing session 1.
- 3.1.3 Providing positive feedback on cooperation and the ability of the family to convey their feelings.

3.2 Follow-up: Encouraging the family to convey and discuss with other family members about the problems and the changes that occur in families with depression.

3.3 Contract

- 3.3.1 Agreeing on the topic of session 2, which is about how to treat depressed elderly.
- 3.3.2 Agreeing a time and place for the next meeting.

Data Collection

This research was conducted in the Simpang Kawat Village, Jambi Indonesia from February to June 2018. The data collection was carried out by the researchers themselves assisted by 5 research assistants. The research assistants were cadres in each integrated health care. Each assistant received training to intervene and collect data using a questionnaire. Distribution of questionnaires to the experimental and control groups was done before and after the intervention.

Data Analysis

Descriptive statistics were used to measure demographic data. As the data were normally distributed by Kolmogorov Smirnov ($p = .95$), Dependent and Independent t-test were used to measure depression.

Ethical Consideration

This study was approved by the Ethics Commission of the University of Jambi under 1619/UN21.6/LT/2019 on February 13, 2019. Before

the study was conducted, the researcher gave an explanation to respondents about the aims, procedures, and expectations of this study. If they were willing to participate, they had to sign an informed consent.

RESULTS

Characteristics of Respondents

Most respondents in this study were women (62.5%) than men (37.5%). The average age of respondents in the experimental group was 68.44 years, and respondents in the control group were 68.33 years, with confidence intervals between 60 and 75 years. The majority of respondents were married (72.9%), had attended school (66.7%), and did not work (80.6%). Most were not sick (54.2%). There was no difference in the respondents' characteristics between the experimental group and the comparison group ($p > .05$) (Table 3).

Table 3. Characteristics of Respondents ($N=72$)

Characteristics	Experiment Group ($n=36$)		Comparison Group ($n=36$)		Total ($n=72$)		<i>p-value</i>
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	
Gender							
Male	14	38.9	13	36.1	27	37.5	1.000 ^a
Female	22	61.1	23	63.9	45	62.5	
Age (year)	Mean (SD, Min-Max)		Mean (SD, Min-Max)				.800 ^b
	68.44 (5.102, 60-75)		68.33 (5.340, 60-75)				
Marital Status							
Marriage	22	61.1	19	52.7	41	72.9	.634 ^a
Widow/widower	14	38.9	17	47.3	31	43.1	
Educational Status							
Yes	20	55.6	28	77.8	48	66.7	.080 ^a
No	16	44.4	8	22.2	24	33.3	
Working Status							
Yes	7	19.4	7	19.4	14	19.4	1.000 ^a
No	29	20.6	29	20.6	58	80.6	
Health Status							
Sick	13	36.1	20	55.6	33	45.8	.636 ^a
Health	23	63.9	16	44.4	39	54.2	

^aChi-Square ^bIndependent t-test

Table 4. Effect of Psychoeducation and Reminiscence Therapy on Depression Level in Elderly Between Experiment and Control Group ($N=72$)

Group	Depression		Mean difference (SD)	<i>t</i>	<i>p-value</i>
	Pretest	Posttest			
	Mean (SD)	Mean (SD)			
Experimental group ($n=36$)	15.19 (3.37)	6.11 (2.85)	9.08 (2.91)	18.717	<.001 ^a
Comparison group ($n=36$)	15.00 (4.00)	11.58 (5.22)	3.41 (2)	5.543	<.001 ^a
<i>p-value</i>	.175 ^b	.001 ^b			

^aDependent t-test | ^bIndependent t-test

Effect of Psychoeducation and Reminiscence Therapy on Depression Level in Elderly

Based on the Dependent-t-test, there were significant differences in the levels of depression in the experimental group before and after the intervention ($p < .05$). Similar to the comparison group, there was a significant difference in the level of depression before and after the intervention ($p < .05$). It could be interpreted that the combination of

psychoeducation and reminiscence therapy, or even reminiscence alone can reduce depression in the elderly. However, based on the results of the Independent t-test, there was a significant difference in the level of depression after the intervention, which the combination therapy in the experimental group was better at reducing depression level than in the therapy in the comparison group ($p < .01$) (Table 4).

DISCUSSION

The purpose of this study is to compare the effects of reminiscence therapy alone and in combination with psychoeducation therapy on depression level of the elderly. The results of this study indicated that there was a significant effect of reminiscence therapy alone or in combination with psychoeducation therapy on depression level in the elderly. The results obtained by this study were in line with [Chiang et al. \(2010\)](#) which states that reminiscence therapy could reduce depression and negative feelings in the elderly. Likewise, [Frazer et al. \(2005\)](#) found that reminiscence therapy was effective in reducing depression in the elderly.

In reminiscence therapy, the therapist helped the elderly to recall the positive aspects and things that are meaningful to the elderly who have experienced the elderly in their past to integrate these positive things in the daily lives of the elderly in their old age at this time to assess the life they have passed until now, so that the elderly could feel satisfaction with their lives ([Herr, 1998](#)). The core of reminiscence therapy activities focuses on exploring the successes that have been achieved by the elderly, thereby increasing feelings of happiness, pleasure and pride in yourself, and eliminating negative and sad feelings. However, reminiscence therapy is an effective therapy for reducing depression ([Jones, 2003](#); [Stinson, 2009](#); [Touhy & Jett, 2010](#)).

Interestingly, it was also found that the combination of reminiscence therapy and psychoeducation showed a better effect than reminiscence therapy alone. The results of this study were in line with [Schulenberg and Melton \(2010\)](#), which states that reminiscence is very good when combined with other therapeutic methods. Supported also by [Andr n and Elmst hl \(2007\)](#) who said that involving the family caregivers by providing information and education would help families to improve skills, understand the situation, and have coping in caring for a sick family. However, the role of the family is very important in this matter. In this study, caregivers were taught about caring for themselves related to problems that can be experienced in treating elderly people with depression. This is intended to improve coping and knowledge of the caregivers themselves. In addition, caregivers were also taught to identify changes and problems due to changes that occur in the elderly, and how to care the elderly with depression. [Kate et al. \(2013\)](#) states that the provision of family psychoeducation and reminiscence therapy affect the increase in knowledge of caregiver care and the elderly in reducing depression.

Another important point is that the reminiscence and psychoeducation therapy were carried out in groups which each respondent could interact with each other, exchange information and experience and feel that they have the same fate, which could increase positive attitudes and motivate each other. This was in line with [Wheeler \(2008\)](#) stated that the implementation of therapy carried out in groups could reduce depression, which group therapy provides an opportunity to socialize, share experiences so as to reduce feelings of isolation, hopelessness, helplessness and solitude.

This study provides the insights of new knowledge for geriatric nurses to apply reminiscence therapy alone or in combination with psychoeducation therapy to reduce depression levels in the elderly. The results of this study fit in with the context of the phenomenon today

which most likely the elderly feel lonely and depression. It is our homework as nurses to help them live their lives.

CONCLUSION

Reminiscence therapy alone or in combination with psychoeducation therapy is effective in reducing depression levels in the elderly. The combination of reminiscence therapy and psychoeducation therapy is much more effective than reminiscence therapy alone. The results of this study serve as an input for the Government of Indonesia to provide these therapies in the elderly program specifically to reduce depression levels.

DECLARATION OF CONFLICTING INTEREST

I declared that there is no conflict of interest.

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AUTHOR CONTRIBUTION

I made all contributions to this study, including developing proposal, collecting data, analyzing data, and drafting the manuscript.

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