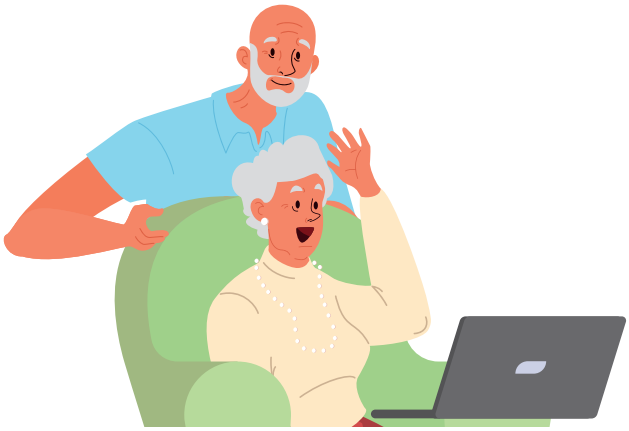

REMINISCENCE THERAPY

Life story work – Life review therapy
Joint reminiscence groups

KEY POINTS

- To decrease depressive symptoms, avoid social withdrawal and improve communication, social interaction, quality of life, mood.
- This intervention involves cognitive, social and emotional processes.
- Observed effects are an improvement in quality of life, cognition, communication and a decrease in behavioural and psychological symptoms.
- In group, individually or with family caregiver.
- For people with mild to moderate dementia.

PRESENTATION

A. Definition

Reminiscence work with people with dementia typically involves the discussion of past activities, events and experiences, usually with the aid of tangible prompts or "memory triggers" (photographs, household and other familiar items from the past, music and archive sound recordings). In recent years, digital storage and presentation of photographs, music and video clips have become widely used. In a group context, the aim is usually to evoke personal and shared memories and encourage communication. Life story work is often carried out on an individual basis and results in the production of a "life story book", enabling the person to tell their life story from their own perspective. The "book" may be in digital or a conventional paper format. Where the individual reminiscence work involves evaluation of memories and their associated emotions, for example in a psychotherapeutic context, this is described as "life review therapy".

B. Fundamentals

The first study on reminiscence work with people with dementia was reported by Kiernat in 1979[1]. Around that time, increasing interest in oral history meant that the reminiscences of elderly people were valued more greatly, with reminiscence seen as a natural and often adaptive process. Reminiscence triggers (objects, photographs and audio-clips) became widely available for use in day care centres, care homes and hospitals, leading many staff to establish some form of reminiscence work. These approaches have continued to grow in popularity in care settings in many countries.

THEORETICAL BACKGROUND

A. Processes involved

- Cognitive processes: remote memory, memory for past events, often appears relatively intact in dementia. Events may be recalled from childhood, whilst those from an hour ago are forgotten. Accordingly, reminiscence appears to capitalise on cognitive strengths. Research suggests that, in fact, remote memory across the whole lifespan is impaired but people with dementia, like all elderly people, recall more memories from earlier life. Some of the memories represent well-rehearsed items or anecdotes. It is possible to envisage a disconnection between past and present, attributable to

very low levels of autobiographical memory (memory for personal events) from the person's middle years. Such a disconnection could contribute to difficulty in retaining a clear sense of personal identity. Reminiscence may therefore be a therapy that taps into the person's strongest store of memories, enhancing conversation and communication relating to experiences and events in earlier life, and, by encouraging autobiographical memory, could reinforce a sense of identity.

- Affective processes: reminiscence also involves emotional processing: memories often have positive or negative associations. "Life review" is a structured, evaluative process, usually conducted individually, covering the whole life-story chronologically, seeking to integrate negative and positive memories, consistent with Erikson's late-life developmental stage[2]. Reminiscence, including life review, is consistently reported to benefit elderly people with depressed mood[3-4] including those with depressed mood living in long-term care environments[5]. As depressed mood is more common in people with dementia, reminiscence may help to improve mood here also.
- Social processes: in a group context, reminiscence facilitates social interaction, helping group members find areas of common interest and experience as they get to know each other as individuals with diverse life-stories, leading to a sense of belonging and togetherness. In groups or one-to-one, staff providing care also learn about the individual, his/her experiences, interests, values, relationships, and preferences and so are better able to offer person-centred care, potentially enhancing quality of life.

B. Neurophysiological correlates

There are no studies to date on the neurophysiological correlates of reminiscence therapy.

SCIENTIFIC EVALUATION

Many studies have evaluated reminiscence therapy, but results are often inconsistent, influenced by different approaches (e.g., individual versus group; simple reminiscence versus life review) and settings (community versus institutional care). Reviews, including up to 23 randomised controlled trials with 1,763 participants, indicate improvements in:

- Quality of life [6], notably in care homes [7].
- Depressive symptoms particularly in institutional settings[8] or associated with individual reminiscence[6-7].
- Cognition [8], most evident in care homes and individual reminiscence [7].
- Communication, especially associated with group reminiscence [7].
- Behavioural and Psychological Symptoms (BPSD) [6].

Detailed evidence about cost-effectiveness is available from only two large-scale studies, including a total of 779 participants. Both evaluated joint reminiscence groups, where people with dementia and their family caregivers participate together in an active programme covering themes across the life-span[9]. They concluded that joint reminiscence groups are "unlikely to be cost-effective"[10] and that they are "not cost-effective when considering outcomes for carers or most outcomes for people with dementia"[11; p.103]. However, when the costs included replacing time and input of the family caregiver, joint reminiscence groups were cost-effective in relation to a measure of quality of life of people with dementia (the QoL-AD)[11; p.103].

IMPLEMENTATION AND PRACTICAL ADVICE

A. Training and/or knowledge required to provide the intervention

All involved in reminiscence work should have a good understanding of the principles of person-centred care and practice. No professional qualification is needed to work on a life story book with a person with dementia nor to lead a small reminiscence group. All those undertaking life review therapy must make use of regular supervision or guidance from an experienced practitioner, providing the opportunity to discuss and reflect on the work undertaken. Those undertaking life review therapy with persons with dementia who have significant depressive symptoms must have training and experience in counselling and therapeutic skills. Joint reminiscence groups have been led by a range of professionals – nurses, occupational therapists, clinical psychologists – and by those from a creative arts practice background.

B. Practical and clinical advice

LIFE REVIEW THERAPY	SIMPLE REMINISCENCE
Participants profile People with mild to mild/moderate dementia, preferably with supportive family member / friend to assist with identifying helpful photographs and memorabilia.	People with mild or moderate dementia and, in joint reminiscence groups, family caregivers. Identifying profile of participants' interests before starting the intervention can be helpful.
Indications Low mood, social withdrawal, depressive symptoms, reduced quality of life.	To increase social interaction and communication, quality of life.
Contra-indications Alcohol-related dementia, high levels of agitation, uncorrected sensory problems.	Alcohol-related dementia, high levels of agitation, uncorrected sensory or communication problems. Survivors of abuse or people with post-traumatic stress disorder.
Contributors Typically a one-to-one therapy, with one person with dementia and one facilitator / therapist. Family member may join for part of session.	Facilitator(s), assistants, volunteers, family members. In a group, minimum of two facilitators / assistants required.
Setting of intervention Office or quiet room in care home or community care centre or person's own home. Comfortable chairs, well-lit and ventilated, free from interruptions and background noise. Drinks available. Table for setting out memory triggers. Wifi for accessing internet resources.	Good-sized group room in care home or community care centre, well-lit and ventilated, with good acoustics, low background noise. Drinks and other refreshments readily available. Seats set around a table where memory triggers can be set out. Whiteboard and screen easily viewed by all. Wifi for accessing internet resources.
Dosage Individual sessions. ■ Period: from 8 to 12 weeks. ■ Frequency: at least weekly. ■ Duration: typically, 60 minutes session.	In individual sessions or usually in groups of 6-12 participants. ■ Period: from 8 to 12 weeks. ■ Frequency: at least weekly. ■ Duration: typically, 60 minutes session.
Session sequencing **1** Recap from previous session, check life story book so far; **2** Move onto next chronological phase of life-story with open, evaluative questions, using personal memory triggers to assist; **3** Plan next session – seek assistance of family in identifying appropriate triggers. *A break in the middle of the session is recommended.*	**1** Welcome and introductions; **2** Introduce theme for the session and relevant memory triggers, including photographs, memorabilia, and music; **3** Facilitate discussion, ensuring all participants have opportunities to share memories; **4** Plan next session, offering participants opportunity to contribute their own memory triggers to share with others; **5** A refreshment break is recommended, preferably to link in with the theme of the session.
Observance / Attendance Lack of engagement can be addressed in the sessions and discussed in supervision. Can mean that greater efforts need to be made to identify appropriate memory triggers, or that the person has unhappy or traumatic memories that are difficult to discuss.	Although many older people enjoy reminiscing, it is not universally enjoyed. Some people value privacy and find a group context difficult. People have different backgrounds, interests, and experiences, and so some participants may be less interested in some topics and themes. Unexpected unhappy or traumatic memories occasionally emerge, and facilitators need to be prepared to allow the person space, time, and support if this occurs.
Assessment Anxiety and/or depression with the Geriatric Depression Scale (e.g. GDS-15) and/or the Hospital Anxiety & Depression Scale (HAD); Quality of life with the QoL-AD questionnaire.	Quality of life with the QoL-AD questionnaire. Communication with the Holden Communication Scale. Interest, enjoyment, and immediate well-being with smiley face scales.

FOR MORE INFORMATION

Social Care Institute for Excellence (UK):

1 'Reminiscence for people with dementia' (includes reading list, useful links, and resources etc.) https://www.scie.org.uk/dementia/living-with-dementia/keeping-active/reminiscence.asp

2 'Creating a life story using technology' (includes useful tips and links) https://www.scie.org.uk/dementia/support/technology/creating-life-story

Cochrane Collaboration:

1 'Do memories matter? Is reminiscence over-rated as a therapy for people with dementia?' Evidently Cochrane, June 2018 http://www.evidentlycochrane.net/do-memories-matter-is-reminiscence-over-rated-as-a-therapy-for-people-with-dementia/

2 Podcast 'Reminiscence therapy for dementia' https://www.cochrane.org/podcasts/10.1002/14651858.CD001120.pub3

Dementia UK:

'Life story work' (template and resources) https://www.dementiauk.org/for-professionals/free-resources/life-story-work/

European Reminiscence Network:

http://www.europeanreminiscencenetwork.org/

Recommended Reading:

- Gibson, F. (ed.) *International perspectives on reminiscence, life review and life story work*. London: Jessica Kingsley.
- Kaiser, P. & Eley, R. (eds) *Life story work with people with dementia: ordinary lives, extraordinary people*. London: Jessica Kingsley.

ABOUT THE AUTHOR

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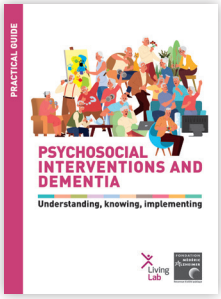

This sheet corresponds to a chapter of the guide ***Psychosocial interventions and dementia: understanding, knowing, implementing*** directed by the Fondation Médéric Alzheimer.

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