



Remembering the story of me:

To what extent can nurses use group reminiscence interventions to facilitate psychosocial health promotion amongst nursing home residents?

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## **Abstract**

**Background:** With a growing geriatric population, the psychosocial health of the elderly is an increasingly relevant topic in healthcare. Depression and loneliness are widespread among nursing home residents. Knowledge about psychosocial health and relevant nursing care interventions equip nurses to offer their patients holistic care.

**Purpose:** To determine the extent to which nurses can use group reminiscence interventions to facilitate psychosocial health promotion amongst nursing home residents.

**Method:** Literature review.

**Result:** Group reminiscence seems to produce a small to moderate improvement on the psychosocial health of nursing home residents, while the theoretical validity of the intervention remains unestablished. The self-described psychosocial experience of the nursing home resident indicates a need for psychosocial interventions focusing on meaningful group interaction.

**Keywords:** reminiscence therapy, psychosocial needs, geriatric health promotion

## **Sammendrag**

**Bakgrunn:** En voksende geriatrisk befolkning gjør at den psykososiale helsen til eldre pasienter blir et stadig viktigere tema i helsevesenet. Depresjon og ensomhet er utbredt blant sykehjemsbeboere. Kunnskap om psykososial helse og relevante tiltak kan utruste sykepleiere til å yte mer helhetlig omsorg.

**Hensikt:** Å utforske i hvilken grad sykepleiere kan bruke reminisens i grupper for å fremme psykososial helse blant sykehjemsbeboere.

**Metode:** Litteraturstudie.

**Resultat:** Den selvbeskrevne psykososiale opplevelsen til sykehjemsbeboere indikerer et behov for psykososiale tiltak som fokuserer på meningsfylt gruppeinteraksjon. Gruppe-reminisens synes å gi en liten til moderat forbedring på den psykososiale helsen til sykehjemsbeboere, men den teoretiske gyldigheten av tiltaket forblir uavklart.

**Nøkkelord:** reminisens behandling, psykososiale behov, geriatrisk helsefremming

Av og til er jeg nødt om  
å ta livet mitt med på  
en aldri så liten luftetur.

Hans Børli

Etterlatte dikt (1991), Tilståelse.

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## 1.0 Introduction

My interest in nursing was first piqued while working as a nursing home care assistant at the age of twenty. The residents required help to bathe, get dressed, use the bathroom and even eat. It was a phase of life where, long after childhood had passed, people returned to a state of clear and undeniable dependency on others. The elderly men and women I cared for spoke of missing their homes, families, and former lives. In their files or from other personnel I gained further glimpses of their many rich and varied experiences. One resident had presented charitable initiatives before the United Nations. Another had worked as a flight attendant and described the privilege of once serving John F. Kennedy. A third had raised six children. Their lives in the nursing home ward were very different from what they had been. They weren't doing as exciting things anymore and they couldn't care for themselves. They needed help with many basic activities. The activities and self-care they were still able to perform had to be done in a strange and foreign environment, surrounded by people with whom they had not chosen to live. I heard many of the residents expressed loneliness, boredom, and hopelessness. I didn't have a framework for understanding what I observed – nor did I know how to help.

## 1.1 Background

The topic I have chosen for this assignment is geriatric psychosocial health promotion. A recent study found that between twenty-five and thirty-one percent of Norwegian nursing home residents struggle with depression, and that depression is undiagnosed in up to half of these (Iden, Engedal, Hjørleifsson, & Ruths, 2013). The Norwegian Institute of Public Health estimates that up to forty percent of nursing home residents experience depression at some point. A recent Scandinavian study found that 55 percent of nursing home residents experience loneliness (Nyquist, 2006). Research has established that loneliness and depression are interrelated (Cacioppo, 2006) and that loneliness causes reduced mental health in the elderly (Wilson, 2006).

Nursing home residents are a large and increasing patient group (Kirkevold, 2010, p.29) particularly vulnerable to depression (Kirkevold, 2010, p.383). Nurses working with the elderly must therefore be equipped with knowledge to identify at-risk residents and familiarize themselves with interventions which can promote psychosocial health within this patient group.

According to Norwegian law, all healthcare personnel are obligated to practice their profession in accordance with the professional integrity and nurturing care appropriate to the health personnel's qualifications (Helsepersonelloven, 2018).

The general goal of nursing can be described as care for the patient that has the patient's health, quality of life, and mastery in focus, and identifies health promotion as the first of the basic functions of nursing (Kristoffersen, Nortvedt, & Skaug, 2016). Moreover, according to our national value statement, Norwegian nurses are pledged to provide holistic care to their patients and assist them in maintaining hope, courage, and a sense of achievement (Norsk Sykepleier Forbundet, 2016). Nursing actions and interventions, then, must not focus exclusively on treatment of disease. Nurses must address both prevention of further health decline among the sick and prevention of health failure among the well (Kristoffersen, Nortvedt, & Skaug, 2016). Knowledge and implementation of psychosocial health-promoting interventions are therefore aspects of responsible and diligent nursing practice.

## 1.2 Statement of purpose

According to Inger-Johanne Thidemann (Thidemann, 2015, p. 53) in her book *Bacheloroppgaven for sykepleierstudentene*, the purpose of a bachelor's thesis is to grow in knowledge and insight within a chosen research question relevant to one's field of study, as well as in experience with an independent, systematic, and thorough writing process. I am passionate about nursing as it relates to both the elderly and psychosocial health. As I look forward to a career in geriatric nursing, I recognize that wholistic and responsible care for my patients must be grounded in and informed by updated scientific knowledge. I also want to be a resource to my colleagues as they work to do the same. In service of these goals, I am using this assignment to build on the knowledge gained through my school courses, practicums, and work experience by studying and interpreting scholarly research on my topic of choice.

Although healthcare professionals acknowledge both preventative care and psychosocial needs as important, in my experience these aspects can be deprioritized and even completely neglected due to staff restrictions and budget limitations. Because finite resources are a real and constant concern healthcare, I wanted to research a cost-effective intervention that employs and cultivates

resources generally available to a nursing home resident: their own life history, and fellow residents.

### 1.3 Presentation of problem, scope, and delimitations

Problem: To what extent can nurses use group reminiscence interventions to facilitate psychosocial health promotion amongst nursing home residents?

Three sub-questions delineate my research question further:

1. What is the psychosocial experience of nursing home residents?
3. What is the responsibility of the nurse toward this patient group considering their psychosocial condition?
2. What is the theoretical validity and scientific justification for group reminiscence therapy as a nursing intervention for this patient demographic?

Residents with mild to moderate dementia are included for the purposes of this assignment, but those with a diagnosis of severe dementia are excluded. As severe dementia necessitates more specialized care, excluding these patients allows me to delve more deeply into the impact of reminiscence on a larger patient group. Additionally, I have found little research on reminiscence therapy conducted with severe dementia patients.

For the purposes of this assignment, the physical health of nursing home residents is relevant only to the extent of its impact on their psychosocial health (Kirkevold 2010) or their ability to participate in group reminiscence interventions.

According to my practicum and work experience, nursing home residents are a widely varying patient group. Therefore, to discuss my research question in some depth, it is necessary to establish further limits of the patient group. The target group on which this assignment is focused is accordingly characterized by the following:

- at or above the age of 65: allows for a similar amount of life-experience for the purposes of reminiscence
- long-term placement in a somatic ward: allows for the building of long-term peer-to-peer relationships and community

- adequate hearing ability: necessary for participation in group conversations
- adequate cognitive and psychological function level: to allow for regular group interaction and participation

## 1.4 Clarification of key concepts

### 1.4.1 Health promotion

The World Health Organization defines health promotion as that which “enables people to increase control over their own health” (WHO, 2016). More specifically, health promotion works in service of the health, welfare, and quality of life of the patient, and is directed towards both healthy individuals, those whose health is particularly at risk and those in danger of developing health complications (Kristofferson, 2016, p. 18).

### 1.4.2 Psychosocial health

The Oxford English Dictionary defines *psychosocial* as: pertaining to the influence of social factors on an individual’s mind or behaviour, and to the interrelation of behavioural and social factors (Oxford University Press, 2018). The term *psychosocial health* goes back to the World Health Organization’s definition of health as ‘a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity’ (Bartley, 2002), (World Health Organization, 2018). The Norwegian National Advisory Unit on Ageing and Health further delineates the concept of psychosocial health into the following needs: personal identity, experiencing security and satisfaction in life, to achieve and overcome, and to experience fellowship and support (Aldring og Helse, 2017).

### 1.4.3 Reminiscence Therapy

Since this therapy originated in the United States, I have chosen to take my basic definitions of key concepts from the American Psychological Association's *Dictionary of Psychology*.

According to the APA, *reminiscence therapy* is the use of life histories – written, oral, or both – to improve psychological well-being. *Life history* as used here is defined as: in therapy and counseling, a systematic account of the client's development from birth to the present, including the meaningful aspects of the client's emotional, social, and intellectual development (VandenBos, 2007). *Group reminiscence therapy* is used in this assignment to refer to reminiscence therapy in a context where there are two or more participants.

### 1.5 Assignment outline

In chapter one background and rationale for this assignment was presented, as well as the research question with its scope and delimitations. The remainder of this assignment is organized as following:

- Chapter two contains choice of and description of method, literature search, and source criticism.
- Chapter three presents theory and research which shed light on the research question.
- Chapter four follows with a discussion of the research question.
- Chapter five concludes with a reflection on the assignment process and findings.

## 2.0 Method

In this chapter I will present and substantiate my choice of method. Method as a general concept, according to sociologist Wilhelm Aubert as quoted in *Metode og Oppgaveskriving*, is a means of gaining knowledge and solving problems (Dalland, 2017, p. 51). Method can also be described as a certain path towards a goal, or more specifically as a tool in an investigation. For the purposes of this assignment, method is my data-gathering process (ibid). A detailed explanation of the method used is a step in establishing the credibility of one's work – one must therefore substantiate the choice of method and describe its characteristics (Holland & Watson, 2012, p. 77).

### 2.1 Literature Review

This assignment has been researched and written using the literature review method. According to *Writing for Publication in Nursing and Healthcare*, literature reviews attempt to summarize what is known and not known about a topic, although they may not summarize all the relevant literature and do not contribute any new knowledge to the field (Holland & Watson, 2012, p.105). The research question in a literature review is clearly stated, the search thoroughly described, and the selection criteria for the presented literature established and followed (ibid). This method allows for examination and discussion of both qualitative and quantitative scholarly research. The *quantitative* method uses standardized questionnaires and other tests to gather and present data in measurable units – thereby yielding a larger picture from a more neutral viewpoint. The *qualitative* method uses adaptable interview questions, other forms of conversations and field observations to gain a better understanding of subjective experiences (Dalland, 2017, p. 52).

### 2.2 Presentation of literature search

#### 2.2.1. Search strategy

I began by searching in academic databases, including PubMed and Cinhal, which are core databases for health personnel according to Thidemann (2015, p. 85). My search was restricted to English language and academic journals. I did not specify only full-text, as I wanted to consider all relevant articles and then search elsewhere for the complete text if necessary. The school's

databases were a good start, and I supplemented that search with Oria and PsychINFO searches through the University of Oslo library. As I read article abstracts and full-text articles I observed which academic expressions were used by scholars to designate the health concepts and patient group I had in mind.

I also searched on Google, where I was able to two articles in full-text that were only available as abstracts in the school's academic databases. I found two articles through cross-referencing, meaning that I located them by studying the reference page of other research articles found through my word search.

To gather background knowledge on my topic, I referenced books and articles from my school course curriculum. However, textbooks are insufficient literature to inform a bachelors thesis (Dalland, 2017). Therefore, beyond course required reading, I referenced books written by psychiatrists, psychiatric nurses, nursing theorists, and psychologists.

Search words used included: Reminiscence therapy, elderly, nursing home, care home, life story therapy, institution, psychosocial, mental health, institution.

### 2.2.2. Inclusion and exclusion criteria

According to Thidemann, a presentation of my inclusion and exclusion criteria clarifies my data collection process for the reader further (Thidemann, 2015).

Inclusion criteria:

- Abstract indicates significant relevance to the research question
- Written in English or Norwegian
- Published in a peer-reviewed journal to ensure academic credibility (Dalland, 2017)
- Less than 10 years old to ensure relevance for current nursing practice
- Western cultural context to ensure findings are transferable to Norwegian cultural context
- Article includes reflection over study limitations to limit researcher bias
- If **quantitative**, a controlled trial or summarizing controlled trials to limit researcher bias
- If **qualitative**, clear description of data analysis method
- If **secondary source**, thoroughly describes quality measures of summarized studies

Exclusion criteria:

- Scholarly articles presenting theories on my topic rather than studies with results

### 2.3 Source criticism

Source criticism, according to Dalland (2017, p 81.) involves a critical evaluation of the sources used during research; specifically, the reflections of the researcher on his or her own biases that may have affected the choice of research or the search method used to answer the research question.

My findings include six research articles. Two are primary sources, or original research, and three are secondary sources, or review articles that summarize and analyze prior published original research (Dalland, 2017). Review articles, according to Dalland, summarize and compile results from studies within a given area of research (2017, p.163). Under some circumstances secondary sources are considered less credible than primary sources, as some of the original data may have been lost (ibid). The reason that I have chosen to include several secondary sources is that extensive research has been done on my topic, so I needed to look at summaries of many studies rather than only individual studies.

To better understand the impact reminiscence can have on psychosocial health I have used quantitative studies. These studies used tests and other standardized tools to achieve a broad picture of their results, which will be useful in answering my research question. I also wanted to view my research question from the resident's perspective, and to achieve this I have used qualitative studies that either conducted interviews with the residents themselves or synthesized information from many resident interviews.

According to *Godt, rett, rettferdig: etikk for sykepleiere* researchers should have a relationship to the academic community and know their subject well, conduct their research ethically and legally, and (Johannessen, Molven, Roalkvam, 2007, p. 271). I have therefore chosen only articles authored by academics who have published several articles within this field, and who show reflection over their ethical considerations in the research article itself.

Four out of my five articles have been published in the last ten years to ensure recent scientific findings. The only article outside this date range is from 2005, and was included because it was a qualitative study in the context of Norwegian nursing homes, and therefore highly relevant to my research question. On the other hand, my chosen meta-analysis includes 128 studies reaching back to the 1970's and is therefore representative of the body of reminiscence research.

## 2.4 Ethical considerations

Ethical considerations come into play as we reflect over the consequences of how we gather, interpret, and use research (Dalland 2017).

My greatest ethical challenge during this assignment has been to identify and set aside the bias of researchers as well as to restrain the bias I myself developed during my data-gathering process. It has been helpful to direct my focus mainly on the results section of research articles to shield myself from the potential bias of the authors. However, the more I read on my topic the more I began to form my own opinions and bias about the concepts central to my research question. This meant that I had to refrain from deliberately shaping my search results, selecting my research through an emotional lens, or focusing only on the information in my articles that served my agenda.

## 3.0 Theory

This chapter is divided into four different types of theory helpful for understanding the research question. First will be presented qualitative research on the psychosocial experience of the resident followed by four theoretical frameworks. Subsequently, quantitative research exploring the effect of reminiscence therapy on psychosocial health will be reviewed. Lastly, a few key concepts from Sr. Callista Roy's Adaptation Model will be briefly explained – specifically those fundamental to her view of health, the person, nursing, and the nurse's role.

### 3.1 Psychosocial health: what is it, why is it important?

We have seen that the World Health organization defines health as “a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity” (WHO 2018). The term *psychosocial* is comprised of both the mental and social aspects of health and can thus be seen to encompass all aspects of health except the physical. We have also seen that the Norwegian National Advisory Unit on Ageing and Health considers personal identity and the experience of social support two key elements of psychosocial health. Due to the space constraints of this assignment, I will be focusing on psychosocial health as it relates to these two core aspects: personal identity and social support. I will now introduce qualitative research which illuminates the psychosocial experience of nursing home residents. I will subsequently present a brief outline of three psychosocial health theories and one relevant concept, which will provide a framework for understanding the psychosocial experience of my target group.

#### 3.1.1 The psychosocial experience of the nursing home resident according to research

##### *Nursing homes are a challenge to one's identity*

An Austrian qualitative study entitled *Being a Nursing Home Resident* (Riedl, Mantovan, & Them, 2013) asked the research question: What is the experience of new nursing home residents during their initial adjustment period to patient life, and how can they maintain independence and establish a new social identity? These researchers used individual interviews and a qualitative data analysis of 20 respondent's answers to shed light on this question. The interviews were

analyzed for themes and patterns, and participant answers were subsequently sorted into five categories to represent the residents' experience: demands on identity, coping with changes, maintenance of autonomy through mobility, establishment of a new identity by creating a new normality, and wishes and expectations for the future. Significant strains on identity included loss of home, job, and previously derived sense of value (for example, as a caretaker for grandchildren). Residents found comfort in faith, visits to the cemetery, talking to stuffed animals, or chatting with other residents. Additionally, they maintained as much independence as their physical function allowed and used the continued practice of old habits and personalizing their rooms to stabilize their sense of identity.

### *The importance of peer relationships to psychosocial health*

A Norwegian qualitative study entitled *The significance of peer relationships to thriving in nursing homes* (Bergland, Kirkevold, 2006) study used field observation and interviews in two nursing homes to describe the residents' perception of the significance of peer-to-peer relationships to their experience of thriving. Interviews were conducted first with sixteen residents, and then with an additional ten residents following an initial analysis of the interview data. Results indicated that twelve out of the twenty-six participants had formed at least one personal relationship with a peer and considered this to be an important part of a thriving experience. Half of those who had not formed any such relationships did not want one, while the other half did and were active in social events intended to promote relationship-building - but without effect. The study found that not all social activities provided by the care homes facilitated meaningful social engagement. Additionally, results indicated that caregivers can significantly influence whether peer-to-peer social interactions are meaningful and produce relationships.

### *Components of quality of life within the nursing home*

A systematic qualitative review entitled *Living well in care homes* (Bradshaw, Playford, Riaz, 2012) aimed to examine residents' self-experienced quality of life and make recommendations for improvements based on these findings. The results synthesized 31 qualitative studies done in different nursing homes. Structured, semi-structured, unstructured interviews and conversations, and focus groups were the data collection methods. A thematic analysis approach supplemented by features of meta-ethnography was used to review the results of 1,223 participant responses. Studies were compared by coding through Microsoft Excel, and diagrams were used to identify links and develop themes and sub-themes. Four main themes were identified in resident experiences of quality of life: acceptance and adaptation, connectedness and involvement with others, a home-like environment, and caring (nursing) practices. Acceptance and adaptation to their situation facilitated a positive outlook, which then mitigated the losses residents were facing. Friendships with peer residents and good relationships to staff were found to be important for a positive experience of institution life.

#### 3.1.2 Psychosocial health theory: personal and social identity

This section provides four theoretical views relevant for an understanding of psychosocial health and development, particularly pertaining to the formation and interrelation of personal and social identity.

#### *Psychosocial development theory of identity*

Erik Erikson was a psychoanalyst who expanded upon Freud's theories with his eight stages of *psychosocial development* in 1950 (Erikson, in Hassevoort, Perry, Ruggiano, & Shtompel, 2015). One distinctive aspect of Erikson's theory of psychological development is his heavy emphasis on the influence of the social environment on individual growth (ibid). He believed that individual personality evolved as it encountered and resolved psychosocial crises, such as establishing trust in others or a sense of identity in society. An individual unable to resolve the crisis of each stage will have a less healthy sense of self. The central crisis for his eighth stage of "old age" is ego- integrity vs. despair. Ego-integrity, according to Erikson, results when older adults revisit their earlier psychosocial developments and adapt skills learned earlier in life for use in their current situation,

and are able to look back on their lives with contentment and acceptance (Erikson, in Hassevoort, Perry, Ruggiano, & Schtompel, 2015).

In summary, Erikson's psychosocial development theory of identity posits that:

- An individual nearing the end of their lives with a perception of having lived unproductively or wastefully is at risk for despair
- This crisis needs to be resolved through reviewing one's history and choosing to accept one's life choices, rather than give in to bitterness and regret
- The result of this positive resolution is ego-integrity, or acceptance leading to wisdom – which can then be shared with others  
(Erikson, in Gibling, 2011)

### *Narrative Identity*

In 1985, psychologist Dan P. McAdams proposed *narrative identity* as part of his three-level model of personality (McAdams, 2001). Narrative identity was researched and implemented in therapy throughout the 90's and has been used as the theoretical framework in reminiscence studies (used in Mills, 1997). McAdam's model is rooted in Erikson's understanding of psychosocial identity as an evolving and integrative aspect of personality (McAdams, 2001, p. 101-102). McAdam posits that identity is a way in which the self can be arranged; an evolving story of the self which uses narrative as a means of resolving, or integrating, conflicting roles or events (ibid). Identity is a life-defining story that not only relates life events and their context, but also explains them. For example, identity could be the narrative of why and how someone who used to be an agnostic is now a Christian, or the narrative of a university professor and former tri-athlete who is now a nursing home resident with many stories to tell (ibid).

In summary, narrative identity theory argues that:

- Identity can evolve and be actively shaped by the individual
- the meaningful arrangement of life events, such as that which occurs in the telling of a life-story, is the mechanism for identity formation.  
(McAdams, 2001, p. 101-03).

### *Social Identity Theory*

Social identity theory was developed by Henri Tajfel and John Turner first in 1979, and has been implemented in reminiscence research (used in Haslam, et al. 2010). Tajfel argued that social environments were not just the context in which individual identity existed, but that they instead were a central part of individual identity because they give us a sense of belonging in the world. Tajfel and Turner's theory included three stages that we use to understand ourselves and others: social categorization, social identification, and social comparison (McLeod, 2008):

- Social categorization: placing ourselves and others in groups gives us a framework for understanding ourselves and others
- Social identification: we conform our personal identities after the identity of the group to which we belong
- Social comparison: we compare our groups to other groups, and whether our group compares favorably or unfavorably to others can impact our self-esteem

Social identity theory argues that people define their sense of selves through formal or informal group membership. If we leave a group, this will affect our sense of personal identity negatively and require an adjustment period, and changes in social roles will induce instability in an individual's sense of self. In summary, social identity theory argues that group life serves as a social identifier that strengthens and stabilizes personal identity (Haslam S. A., Haslam, Jetten, & Postmes, 2009, p. 1-7).

### *Social networks*

Finnish psychologist Jaakko Seikkula has developed and published within social networking theory. He defines social network as: the human relationships which create an individual's social identity (Arnkild and Seikkula, 2007, p.12). His definition is further elaborated upon by psychiatric nurse Jan Kåre Hummelvoll in his classic work *Helt – ikke Stykkevis og Delt*. Hummelvoll views social networks as the formal and informal context in which an individual lives and moves and which can provide:

- emotional support, information, and help to orient oneself in one's surroundings and overcome challenges
- friendship, common interests and values

- practical and concrete help according to need (Hummelvoll, 2012, p. 603).

This concept is dissociated from social identity theory primarily by its emphasis on natural *environment* rather than formed *groups*. It is included as relevant theory for the research question as it provides a more general understanding of the value of social environments to individual psychosocial health.

### 3.3 The nurses role and function

Some groundwork for the scientific and theoretical importance of psychosocial health to the experience of general wellness has now been laid, but how does psychosocial health relate to the nursing profession? Nursing can be described as generally as to assist a patient with their basic needs (Kristoffersen, 2011, p. 21) - but what does that involve, and how can nurses best structure the care they offer? These are a couple of the questions discussed by nursing theory.

#### 3.3.1 The Roy Adaptation Model of Nursing (RAM)

Sister Callista Roy began developing her nursing model as a graduate student at the University of California, and her model was subsequently published in 1970. Since then she has continued to develop and refine her model, and it is widely implemented in nursing practice. Her model has been developed to address both individual and group needs; this summary focuses on her model as it relates to the individual rather than groups (i.e. the family). RAM provides a concrete, structured, and comprehensive model to be used by nurses. Its value to nursing practice is confirmed by the amount of research, both past and recent, that has applied and expanded upon her model since its publication to the present day (Roy in Masters, 2015).

The most relevant concepts of RAM for the purposes of this assignment are defined below, and are summarized or adapted from a primary source.

*The person:* a holistic adaptive system that is constantly growing and developing in changing environments (Roy & Andrews, 1999 p. 31).

*The environment:* all circumstances and influences affecting the development and behavior of persons and groups (Roy, 2009, p. 12).

*Adaptation*: the process by which individuals use conscious awareness and choice to create human and environmental integration, and which leads to optimal health and well-being, quality of life, and death with dignity. Adaptation level affects the individual's ability to respond positively in a situation (adapted from Roy & Andrews, 1999, p.54 ).

*The goal of nursing*: to promote adaptation for individuals and groups in the four adaptive modes; physiologic-physical mode, self-concept-group mode, role function mode, and interdependence mode (adapted from Roy & Andrews, 1999, p.81)

- Physiologic-physical mode: includes five basic physical needs
- Self-concept–group-identity mode: includes physical (for example body image) and metaphysical self-perception. Both personal identity and group identity (interpersonal relationships, social milieu, and group image) are included in this mode.
- Role function mode: includes the role of the person in society and the roles within a group
- Interdependence mode: relates to significant others and support groups

(adapted from Roy & Andrews, 1999, p. 44-45 )

*The role of the nurse*: to promote the adaptation of the patient in times of illness and health, and to promote health by enhancing the interaction of human systems (individuals) with the environment (adapted from Roy & Andrews, 1999, p.55 )

*The goal of nursing intervention*: is to enhance coping (Roy, 2009, p. 78), and promote adaptation by transforming ineffective behavior to adaptive behavior (adapted from Roy & Andrews, 1999, p.81)

*Health*: a condition and process of being and becoming integrated and whole that reflects the interrelation between the individual and his/her environment (Roy, 2009, p. 12).

Roy's model was chosen for this assignment for her integrated view of the individual, which is consistent with the integrated view of psychosocial health featured in this assignment (World Health Organization, 2018) (Aldring og Helse, 2017). Additionally, her structured approach is useful in addressing abstract patient needs, such as those of psychosocial health. Finally, three out of her four modes focus on the relationship between the individual and their social environment.

One weakness of her model may be that in its entirety (only a few main concepts are presented here) is so comprehensive that for the novice user it may seem overwhelming. However, a nurse might begin by applying her four modes of adaptation to their nursing approach, and slowly adding other aspects as their familiarity with her model grows.

### 3.3 Group Reminiscence Therapy

#### 3.3.1- Brief overview of reminiscence therapy

Geriatric psychiatrist Dr. Robert Butler published in 1963 his paper, *The Life Review: an Interpretation of Reminiscence in the Aged*. In it, Butler expanded on Erik Erikson's eighth stage of psychosocial development, in which life review was prompted by concerns about death (Butler in Webster, Bohlmeijer, Westerhof, 2010, p. 529). Butler documented his clinical observations of an increased recalling of the past by elderly patients, and proposed that this was due to a realization of one's own vulnerability and the approaching end of life (ibid). He acknowledged that many age groups may review their past as the result of a crisis, but believed that this was particularly common among the elderly (Webster, Bohlmeijer, Westerhof, 2010, p. 530). Prompted by Butler's work, many researchers throughout the 1970's and 1980's conducted studies rooted in different theoretical frameworks to explore the impact of various forms of reminiscence, both on individuals and in group settings. Researchers have studied the impact of reminiscence on many psychosocial variables, including adaptation, depression, self-esteem and life satisfaction (ibid).

#### 3.3.2 Scientific evidence for impact of reminiscence

Three recently published studies convey the scientifically measured impact of reminiscence on psychosocial health.

##### *The effects of reminiscence interventions on psychosocial outcomes*

A quantitative meta-analysis (Forstmeier and Pinguart, 2012) used statistical analysis to combine and review findings from 128 controlled studies on the effect of both individual and group reminiscence on the psychosocial health of various age groups. Results indicated that

reminiscence interventions produce moderate (although statistically significant) improvements on depression and ego integrity. Post-test results indicated that reminiscence interventions produce small improvements on purpose in life, death preparation, mental health symptoms, positive well-being, life satisfaction, ego integrity, cognitive performance and social integration (among other variables that showed statistically insignificant improvement). These improvements were all reduced in varying degrees when follow-up tests were conducted three to six months later. The greatest improvement in level of depression was found on depressed rather than healthy participants. The effect size was the same for both group and individual interventions.

#### *Group reminiscence therapy impact on loneliness, anxiety and depression in older adults in long-term care*

A quantitative systematic review (Elias, Neville, Scott, 2015) analyzed eight recent non-randomized experimental studies to summarize the impact of group reminiscence therapy intervention studies on loneliness, anxiety, and depression in elderly and institutionalized study participants. Results indicated that two studies found significant impact of reduced depression. Three studies found insignificant results for depression impact. One study found insignificant effect on depression and anxiety, but a significant effect on well-being. One study found significant improvement on loneliness. The last study found a significant effect on depression for group and individual reminiscence as well as the control group.

#### *The benefits of group interventions in residential care settings*

A quantitative study (Haslam et al., 2010) aimed to compare and evaluate the impact of individual reminiscence, group reminiscence, and a control intervention on the identification, memory, and self-perceived well-being of residents in long-term care. The 73 randomly selected participants were residents spanning nine nursing homes and aged between 58-95. The participants at each home were systematically placed into the three groups, and each group was randomly assigned to either the group reminiscence, individual reminiscence, or control group intervention for six weekly sessions. Results were gathered from pre and post-tests measuring cognitive ability, personal identity strength, sense of group identity and belonging, and well-being (comprised of separate depression and anxiety, quality of life, and life improvement tests). Results indicated that of the two reminiscence interventions, only the group reminiscence (GR)

intervention produced a significant effect on the variables. Memory performance was significantly improved for the GR group as compared to the individual reminiscence (IR) and control group (CG). Well-being (including mental health and quality of life aspects) was significantly increased for the control group intervention - but not for either of the reminiscence intervention groups.

## 4.0 Discussion

This discussion will be structured according to my three-part research question:

1. What is the psychosocial experience of the nursing home resident?
2. What is the responsibility of the nurse toward this patient group considering their psychosocial experience?
3. What is the theoretical validity and scientific justification for group reminiscence therapy as a nursing intervention for this patient demographic?

### 4.1 What is the psychosocial experience of the nursing home resident?

My theory chapter limited the concept of psychosocial to the key aspects of identity and social support, and for the sake of space I will do the same in my discussion.

#### 4.1.1 Identity

Nursing home residents experience a significant strain on their identity due to the sudden change in their environment, shift in societal expectations, and loss of familiar social networks (Riedl, Mantovan, & Them, 2013). The Austrian study (Riedl, Mantovan, & Them, 2013), presented in my findings found that some residents felt that they were “nobodies” because they felt they had no role to play or contribution to make in their new environment.

They missed the part they had played in caring for grandchildren or contributing to their children’s home. In addition, residents mentioned the difficulty of being surrounded by others in various states of physical and cognitive decline, as this reminded them of their own reduced health and social status. Many of these residents often wished for death. As the residents were in a new environment where they are no longer expected to be productive, or need to earn a living wage, they experienced a decrease in sense of self-worth and self-esteem (Riedl, Mantovan, & Them, 2013).

The concept of “role” can be defined as the sum of the norms we attach to a certain position in society, and the transition from a clear, actively contributing role to an unclear role can cause a feeling of uselessness for the individual (Svabø, 2000). Further, to be forced by health issues to move into a nursing home is what is called an age transition - or irreversible change - which can trigger a traumatic crisis for a resident (Hummelvoll, 2012, p. 379). I observed this in praksis also. I remember one resident commenting to me as I was making lunch for the group, “You’re doing a good job”. Then she paused and said, “I haven’t done a good job at anything for a long time.”

However, the systematic review of 31 qualitative studies (Bradshaw, et. al, 2012) indicated that many residents were able to accept their new stage of life, and that this acceptance increased positivity and resilience - which in turn mitigated the pain of their life transition. This acceptance of their new life was predicated on a strong sense of self that was cultivated by the continued practice of life-long habits and interests, the personalization of their rooms, and by maintaining as much autonomy in daily tasks as possible. This study, then, suggests that many residents are capable of adaptation to their new roles if given the necessary space and support by health personnel to exercise their personal autonomy and maintain continuity in personal habits.

#### 4.1.2 Social support

One lucid male resident I got to know during a practicum was well-traveled and had formerly been a bank president. He had no living family, sat often alone in his wheelchair, and had been diagnosed with depression. He regularly expressed enjoyment of staff conversation and company, but we didn’t have time to sit with him regularly. When I couldn’t sit and talk with him, he would ask if there was anything other way I could help him. My suggestions didn’t fit his needs, though - he never wanted to sit in the sun, watch TV, or attend the group exercise hour. Once, when he asked me to do something positive for him, I kissed him on the cheek. He said, “That was unbelievably positive!”. Consistent with this experience, literature on geriatric health claims that the elderly are at risk of developing mental health problems due not only to reduced functionality, but also their combined social losses (Hummelvoll, 2012, p. 378-79). By moving into an institution many residents have lost their closest friends (Kirkevold, 2010, p. 232) and death has often taken others (Kirkevold, 2010, p. 27). Consequently a recent study shows that up to 55 percent of Norwegian nursing home residents experience loneliness

(Nyquist, 2006).

Also consistent with the above described experience from my practicum, the systematic review by Bradshaw, et al. (2012), demonstrated that a sense of connectedness with others was essential for a good quality of life in nursing homes. Positive relationships with staff and other residents contributed to a sense of personal value. A challenge, however, was that discrepancies in cognitive function levels left some residents feeling lonely even though they were surrounded by others - because although the corridors were filled with residents, it was difficult to find peer relationships.

Both of these findings were corroborated by Bergland and Kirkevold's qualitative study (2006), in which 40 % of the residents interviewed had cultivated a peer social network at the home and considered this important for their quality of life. Of those without a peer social network, half wanted and had attempted without success to build meaningful relationships with others, while the second half did not want personal relationships with the other residents, and preferred instead to maintain a close connection to their families. Those wanting contact with peers mentioned two main obstacles: the reduced cognitive and physical (i.e. poor hearing) function levels of their fellow residents impeded significant social contact, and the persistently unsuccessful social activities provided by the health personnel.

While the activities occupied the residents for a short time, they failed to facilitate the meaningful social interaction that might lead to personal relationship development. Activities mentioned included attending singing group, bingo, and reading groups - all of which encouraged physical proximity to other residents, but none of which encouraged personal and meaningful conversation. The relationships they valued most had formed spontaneously - on their own initiative rather than through the assistance of health personnel. The valued relationships were mutually maintained and involved visiting each other's rooms and sharing both their former lives and current experiences. The study by Riedl, Mantovan, & Them (2013), also confirmed that while nursing home residents sometimes enjoyed chatting or taking a walk with other residents, they did not enjoy the activities arranged by the health personnel.

In summary, nursing home residents experience significant psychosocial challenges (Riedl,

Mantovan, & Them, 2013). Their identity is challenged by the move to a home, role transition, reduced health and a feeling of an unproductive existence (ibid). On the social front, residents have lost much of their prior social network (ibid). Although not all residents want a new network, many of those who do experience difficulties in establishing one (Bergland, Kirkevold, 2006). Nursing home life appears to be psychosocially challenging, but research also show that many residents also possess potential resources in this area: 1) a strong sense of self leading to acceptance of one's situation contributes to resilience and positivity, and 2) the desire for, and ability to engage in, new social support networks (Bradshaw, et al., 2012).

Considering these findings, what is the role of the nurse in promoting the psychosocial health of the resident?

## 4.2 What is the responsibility of the nurse toward this patient group considering their psychosocial experience?

### 4.2.1 RAM model

RAM (1970) offers a framework for understanding the patient's needs and for planning appropriate interventions for the psychosocially vulnerable nursing home resident. Relevant adaptive modes include the self-concept-group-identity mode, role function mode, and interdependence mode (Roy and Andrews, 1999, p. 44-45), which have been outlined in the theory chapter.

The resident responses featured in Riedl's study (2013) indicated that the nurse's role in the self- concept-group-identity mode could look like encouraging the patient to maintain as many old habits as possible, assisting them in personalizing their rooms, and motivating the patient to maintain as much autonomy in activities of daily living as their physical function allowed. Encouraging chatting with other residents could also increase acceptance of the resident's new group identity. In Bradshaw's systematic review (2012), acceptance of their circumstances required awareness and a strong sense of self; an appropriate nursing intervention aimed at increasing coping might include encouraging a resident to write in a diary.

Also in Bradshaw (2012), involvement with others and meaningful activities increased quality of

life. A nursing intervention aimed at enhancing coping within the role function mode might therefore be facilitating meaningful group interactions, or encouraging a resident to interact with their social network outside the nursing home. This could increase the resident's experience of maintaining a worthwhile existence despite their role transition, and meaning something for others.

Riedl's study (2013) found that residents enjoyed going for walks with peer residents; a nursing intervention aimed at increasing adaptation in the interdependence mode might include introducing patients with similar interests to one another so that they could spend quality time together. Some residents in Riedl's study did not wish to attend group activities. In this case, a nursing intervention could be to identify networks to which the resident formerly belonged (for example, church, or charitable initiatives). The nurse could then both motivate them to and assist them with maintaining those networks. This could in turn promote adaptation by increasing continuity in the patient's social network.

#### 4.2.2 Meaningful group interaction

Although the appropriate interventions were slightly different in each mode, an instrumental nursing intervention for each of these involved meaningful group interaction. The study conducted by Bergland and Kirkvold (2006) found that some health personnel were able to facilitate positive and meaningful interactions - and in this way contribute to the establishment of peer-to-peer relationships. By initiating group conversation with the right questions and then guiding the conversation to new topics at appropriate intervals, healthcare personnel could help sustain personal interactions between group members that otherwise would not converse. Healthcare personnel familiar with the personal histories of the residents could naturally invite them into the conversation. Residents in Bergland and Kirkvold's study (2006) verbally expressed enjoyment of these types of conversations, and when this was done during mealtimes they ate more and evidenced increased awareness of their neighbors. The success of these social gatherings was predicated on two conditions: the conversation engagement capability of the gathered residents, and the level of ease, familiarity, and skill with which the facilitator exercised their function as conversation leader. If these conditions were not met, the attempt could not only fail, but backfire, and cause stress for the residents.

My personal experience confirms this. My first year of nursing school, I attempted this type of

role during the nursing home practicum I was placed in. I had participated a couple of times in “newspaper groups” as an assistant leader, and witnessed the community that meaningful conversation could develop among the patients - but when asked to lead I became stressed. My lack of ease led to overlooking a few of the residents in the conversation, so that several of them were left out. This seems to emphasize the importance of using not just anyone, but qualified or trained staff in this type of intervention. A staff member able to identify cognitively and social healthy patients, who either knows the patients well or has access to their history files and has been trained to lead health interventions. In other words: a nurse.

Bergland and Kirkevold’s findings seem to have several implications for the role of nurses in the area of psychosocial health promotion. The nurse would seem best positioned to successfully implement the intervention if he or she: 1) knows the residents on a personal level in order to actively include them in the conversation 2) is able to accurately identify cognitive and social function levels in order to gather a cohesive conversation group 3) has the skills, either naturally or through training, necessary not only lead the conversation but also to remain calm and comfortable while in this role.

Group reminiscence therapy is one intervention a nurse might be able to use in such a group.

#### 4.3 What is the theoretical validity and established impact of group reminiscence therapy as a nursing intervention for this patient group?

According to the research I have presented in this paper, nursing home residents are psychosocially vulnerable (Riedl, Mantovan, & Them, 2013). Per Callista Roy’s nursing model, the role of the nurse is to promote human and environmental integration, and the goal of nursing intervention to enhance coping. Meaningful group interaction is established as important to psychosocial adaptation and promotion by three qualitative studies (Riedl, Mantovan, & Them, 2013), (Bradshaw, 2012), (Bergland, Kirkevold, 2006). But why is group reminiscence specifically considered a viable intervention for psychosocial health?

Dr. Robert Butler’s initial presentation of reminiscence therapy was based on Erik Erikson’s theory of psychosocial development. Social identity theory, narrative identity theory, and the

related concept of social networks have all been utilized as theoretical models in reminiscence research (Haslem, et al, 2010), (Mills, 1997), (Bergland, Kirkevold, 2006). Which, if any, of these theoretical bases for group reminiscence therapy fit with the scientific findings regarding the psychosocial benefits of reminiscence? A theory explaining the mechanism behind reminiscence therapy would help validate group reminiscence as a psychosocial nursing intervention for nursing home residents.

Narrative identity theory claims that identity formation occurs in the story-telling itself; as the teller arranges and explains events in a meaningful context, the teller's sense of self will be strengthened (McAdams, 2001). Erikson also posited that reviewing life history can lead to acceptance of events rather than bitterness and regret (. This, in turn, could theoretically improve psychosocial health (Aldring og Helse, 2017). From my work at a nursing home I remember well one bedridden resident with depression who had many pictures on his walls of his family and days in the military. When I had a few minutes to spare, I would go and sit with him after I'd served him his dinner, and ask him to tell me more about the men he knew in Air Force, or the years he and his wife spent living in England and California. He always ate more of his meal those days and displayed increased interest in his environment, and I wondered if there could be a connection. Potentially either narrative identity theory (McAdams, 2001) or Erikson's identity theory (Giblin, 2011) could explain the effect that sharing his life story seemed to have on him.

On the other hand, Haslam, et al. (2010) found that that individual reminiscence therapy had no strengthening impact on identity, and instead actually reduced a sense of group belonging. Theoretically a reduction in group belonging would decrease psychosocial health (Haslam, et al., 2010), (Aldring og Helse, 2017). Haslam's study showed that while only group reminiscence had a positive effect on memory, both the group reminiscence intervention and the control group intervention positively impacted personal identity strength. If it is the telling of one's story that strengthens our sense of self, then individual (or one-on-one) reminiscence therapy would presumably have the same effect as group reminiscence - but in this study, the opposite was proved. These results could indicate that it is not the memory or narration aspect of reminiscence that has a positive impact on psychosocial health, but the group membership achieved through the therapy sessions.

If the psychosocial value of group reminiscence lies primarily with the sense of group belonging it

cultivates, then the theoretical value of reminiscence might be best explained by social identity theory. Haslam, et al.'s study (2010) results may support this interpretation. The study indicated that playing a group bowling game had a significant effect on well-being, whereas group reminiscence had none. This could be interpreted to mean that simple team work has at least as much (and potentially more than) of a group membership-forming quality as group reminiscence. Social identity theorists claim that personal identity is based on formal or informal group belonging, and that group membership strengthens and stabilizes personal identity (Haslam S. A., Haslam, Jetten, & Postmes, 2009, p. 1-7). If this is true, then nurses do not need to use reminiscence or memory review to promote psychosocial health at all, but simply regularly gather residents for a group activity or meal.

I recall from work experience a scenario consistent with the idea of social belonging as health promotion. A group of four residents were the only lucid residents in their corridor, so the nurses began seating them at the same table for meals. Every evening they'd share wine together and sometimes desserts or favorite foods that their family members have brought for them. For the two years I worked at the nursing home, they took their time with meals, laughing and talking about everything from the food and the events of day to the news and how they would spend the upcoming holiday. They became such good friends that the staff dubbed them "the dinner club". In this situation, the simple nursing action of rearranging the seating created an informal social group or network, resulting in a clear and consistent impact on well-being. Here, no reminiscence implementation was necessary – which would support the premises of both social identity theory and social networks as the theoretical value of group reminiscence therapy.

If it is the social belonging cultivated by group reminiscence that comprises its impact on psychosocial health, is this claim best substantiated by social identity theory or by the simpler concept of social networks? In other words, do clear groups need to be formed in order to promote psychosocial health or is simply existing in the same milieu as others enough to promote psychosocial health. Social networks emphasizes the formation of clear and exclusive groups (McLeod, 2008), while social networks are simply the social context in which people live (Hummelvoll, 2012, p. 603). Bergland and Kirkevold's study (2005) on peer relationships in nursing homes seem to shed light on this question. Their study indicated that the meals and activities offered in the home served only to put the residents in the same physical space. A group of residents seated at the same table did not necessarily produce meaningful interaction. Bergland

and Kirkevold's study, field observations indicated that meaningful conversations between residents rarely occurred spontaneously, but rather in response to the initiation of a skilled facilitator. This seems to highlight the importance of deliberate interventions and clear groups that encourage meaningful interactions rather than simple coexistence. Social identity theory would then seem a likelier explanation for the impact of reminiscence than social network theory; and in any case it would seem that the mechanism behind group reminiscence is social belonging and not memory.

On the other hand, the meta-analysis of 128 studies (Forstmeier and Pinguart, 2012), showed that reminiscence interventions produced an improvement on ego-integrity scores – whether this intervention was in the form of group or individual therapy. This seems to suggest that memory review – or life story telling – improves psychosocial health after all. In fact, in concurrence with Erikson's psychosocial development theory (Giblin, 2011) and narrative identity theory (McAdams, 2001), individual reminiscence therapy was more consistently effective for participants with a depression diagnosis than was group reminiscence. But since a minority of the studies included were on individual therapy sessions, it is difficult to draw a firm conclusion. Because the study includes both individual and group reminiscence therapy, it can neither conclusively support or contradict either the memory or the social belonging theories. The positive impact of reminiscence could be due to either the identity-strengthening effect of group belonging or memory review. These results do not assist in clarifying the theoretical explanation for the impact of reminiscence.

This primary value of this meta-analysis (Forstmeier and Pinguart, 2012) to this discussion, then, seems to be its support of reminiscence as an intervention. Can it at least be concluded that reminiscence (whether group or individual) should be practiced with elderly Norwegian nursing home residents? Due to both Erikson and Butler's initial emphasis on the importance of life-review during old age, most reminiscence research is done among the elderly (Forstmeier and Pinguart, 2012). Many, but not all of the studies reviewed in Forstmeier and Pinguart's meta-analysis used elderly participants. Nevertheless, not all the studies were on elderly participants. Neither institutional settings, nor group interventions, were inclusion criteria for their meta-analysis. All three of these factors pose some difficulty in generalizing the meta-analysis results to the use of group reminiscence therapy for Norwegian nursing home residents. On the other hand, Forstmeier and Pinguart's results are corroborated by the systematic review conducted by

Elias, et al. (2015), in which five out of eight studies concluded that group reminiscence therapy did significantly improve either loneliness, well-being, or depression. This corroboration would appear to confirm what is indicated in the meta-analysis, therefore allowing me to generalize these results to my target group of Norwegian nursing home residents.

It is unclear whether the operating mechanism behind group reminiscence intervention is memory review, the formation of group identity and belonging, the facilitation of meaningful fellowship, or a combination. The question still stands, in this assignment as in the research community (Haslam, et. al, 2010): what is the theoretical validity of reminiscence therapy? After reviewing the research, Erikson's psychosocial developmental theory, narrative identity theory, social identity theory, and social network-building are all still viable explanations. Although my discussion on the theoretical basis for reminiscence is inconclusive, the research presented herein psychosocial health sends a clearer signal. The meta-analysis, systematic review, and single clinical study all indicate that group reminiscence interventions positively impact one or more aspects of psychosocial health - so the general thrust of reminiscence research may support the use of group reminiscence for psychosocial health promotion. I don't know why or how group reminiscence therapy works, and the extent of the impact varies - as the studies featured here have shown. Nonetheless, decades of research seem to indicate that it is still a viable psychosocial health nursing intervention for nursing home residents. When group reminiscence therapy is used it would seem that health personnel should have reasonable, but not high, expectations for a psychosocial improvement (Forstmeier and Pinquart, 2011).

## 5.0 Conclusion

In this assignment I have reviewed and discussed: firstly, the psychosocial experience of the nursing home resident. Secondly, the responsibility of the nurse towards the patient in light of this context. Thirdly, the theoretical validity and scientific justification for group reminiscence therapy as a nursing intervention for the patient demographic.

My stated purpose in researching and writing this assignment was to gain knowledge that would allow me to offer holistic and knowledgeable psychosocial care to geriatric patients. I am pleased with what I have learned about the nursing home resident's psychosocial experience, and how I might structure a nursing care approach for this patient group. Although group reminiscence research has yielded varying results, there is much evidence indicating a psychosocial health-promoting effect. This effect may be anywhere from small to moderate, and does not have a clearly established theoretical validity. However, the intervention is free and places relatively little demand on staff time. It also may be one way to cultivate the patient's own resources in his or her nursing care; facilitating the patient's promotion of their own health.

Perhaps it would have been satisfying to develop a clear and final answer to my research question. However, the fact that I have been unable to do this seems to allow for more flexibility within nursing care for psychosocial needs. The exact effect of, and mechanism behind, group reminiscence therapy remains to be determined by science. Until research proves otherwise, introducing two like-minded residents and supporting their friendship, discussing the newspaper with a few residents in the living room, seating lucid residents together at the dinner table, and implementing formal group reminiscence therapy may all have an equally significant impact on the psychosocial health of nursing home residents.

## Literaturliste

- Aldring og Helse. (2017). Hentet fra ldringoghelse.no/e-l ring/palliasjon-og-demens\_/modul-b-rev-nov-08\_ny/psykososiale-behov/#0
- Arnkil, T. E., & Seikkula, J. (2007). *Nettverksdialoger*. Oslo: Universitetsforlaget.
- Bartley, M. L. (2002). Psychosocial Determinants of health in Social epidemiology. ss. 1091-1093.
- Bergland,  ., & Kirkevold, M. (2006). The significance of peer relationships to thriving in nursing homes. 1295-1301. doi:10.1111/j1365-2702.2007.02069.x
- Bergland,  ., & Kirkevold, M. (2006). Thriving in nursing homes in Norway: contributing aspects described by residents. *43*(6), 681-691. doi:10.1016/j.ijnurstu.2005.09.006
- Bradshaw, S. P. (2012). Living well in care homes: a systematic review of qualitative studies. *Age and Ageing*, ss. 429-440.
- Cacioppo, J. e. (2006). Loneliness as a specific risk factor for depressivev symptome: Cross-sectional and Longitudinal Analysis. *Psychology and Aging*, ss. 140-151.
- Dalland, O. (2017). *Metode og oppgaveskriving* (6. utg.). Oslo: Gyldendal akademisk.
- Elias, S., Neville, C., & Scott, T. (2015). The effectiveness of group reminiscence therapy for loneliness, anxiety and depression in older adults in long-term care: a systematic review. *Geriatric Nursing*(36), ss. 372-80.
- Forstmeier, S. P. (2012). Effects of reminiscence interventions on psychosocial outcomes: a meta-analysis. *Aging and Mental Health*(16), ss. 541-58.
- Giblin, J. C. (2011). Successful Aging. *Journal of Pscychosocial Nursing*, *49*(3), 23-26.
- Haslam, C., Haslam, S. A., Jettern, J., Bevins, A., Ravenscroft, S., & Tonks, J. (2010). The social treatment: the benefits of group interventions in residential care settings. *25*(1), 157-167. doi:10.1037/a0018256
- Haslam, S. A., Haslam, C., Jetten, J., & Postmes, T. (2009). Social Identity, Health, and Well-Being: An Emerging Agenda for Applied Psychology. *Applied Psychology: An International Review*, *58*(1), 1-23. doi:10.1111/j.1464-0597.2008.00379.x
- Hassevoort, L., Perry, T. E., Ruggiano, N., & Schtompel, N. (2015). Applying Erikson's wisdom to self-management practices of older adults: findings from two field studies. *Research on Aging*, *37*(3), 253-274.
- Helsepersonelloven. (2018). Lov om Helsepersonell, kap 4.
- Holland, K., & Watson, R. (Red.). (2012). *Writing for Publication in Nursing and Healthcare*. West Sussex: John Wiley & Sons.
- Hummelvoll, J. K. (2012). *Helt - ikke stykkevis og delt* (7. utg.). Oslo: Gyldendal akademisk.
- Iden, K. R., Engedal, K., Hjørleifsson, S., & Ruths, S. (2013). Prevalence of Depression among Recently Admitted Long-Term Care Patients in Norwegian Nursing Homes: Associations with Diagnostic Workup and Use of Antidepressants. (37), 154-162.
- Kirkevold, M. B. (2010). *Geriatrisk Sykepleie*. Oslo: Gyldendal Norsk Forlag.

- Kristoffersen, N. J., Nortvedt, F., & Skaug, E.-A. (2016). Grunnleggende Sykepleie. 1. Lov om Helsepersonell, Kapittel 4. (2018). *Helsepersonellloven*. .
- Masters, K. (2015). Roy Adaptation Model: Sister Callista Roy. I K. Masters, *Nursing Theories: a framework for professional practice* (2. utg., ss. 127-142). Burlington, Mass: Jones & Bartlett.
- McAdams, D. (2001). The psychology of life stories. *Review of General Psychology*(5), ss. 100-122.
- McAdams, D. (2013). Narrative Identity. *Current Directions in Psychological Science*(2), ss. 233-238.
- McLeod, E. (2013). *Erik Erikson*. Hentet April 5, 2018 fra [www.simplypsychology.org/Erik-Erikson.html](http://www.simplypsychology.org/Erik-Erikson.html)
- McLeod, S. (2008). Social Identity Theory. Hentet 4 1, 2018 fra <https://www.simplypsychology.org/social-identity-theory.html>
- Mills, M. A. (1997). Narrative Identity and Dementia: A Study of Emotion and Narrative in Older People with Dementia. *Ageing and Society*(6), ss. 673-698.
- Norsk Sykepleier Forbundet. (2016). *Yrkesetiske Retningslinjer for Sykepleiere*.
- Nyquist, F. e. (2006). Social Capital and Loneliness among the very old living at home and in institutional settings. *Journal of Aging and Health*.
- Oxford University Press. (2018). psychosocial. Oxford English Dictionary. Hentet 3 1, 2018 fra <https://en.oxforddictionaries.com/definition/psychosocial>
- Riedl, M., Mantovan, F., & Them, C. (2013). Being a nursing home resident: a challenge to one's identity. *2013*, 9. doi:10.1155/2013/932381
- Roy, C. A. (1999). *The Roy Adaptation Model* (2. utg.). Ann Arbor: The University of Michigan.
- Roy, S. (1984). *Introduction to Nursing: An Adaptation Model* (2. utg.). Englewood Cliffs, New Jersey: Prentice Hall.
- Roy, S. C. (2009). *The Roy adaptation model*. (3. utg.). Upper Saddle River, NJ: Pearson.
- Svabø, A., & Bergland, Å. (2000). *Sosiologi og sosialantropologi for helsearbeidere* (2. utg.). Oslo: Gyldedal akademisk.
- Thidemann, I.-J. (2015). *Bachelor-oppgaven for sykepleier-studenter*. Oslo: Universitetsforlaget.
- VandenBos, G. R. (Red.). (2007). *APA dictionary of psychology*. Washington, D.C.
- Webster, J. D., Bohlmeijer, E., & Westerhof, G. J. (2010). Mapping the Future of Reminiscence: A Conceptual Guide for Research and Practice. *Research on Aging*(4), ss. 527-564.
- Wilson, R. e. (2006). Loneliness and the risk of Alzheimer's disease. *Archives of General Psychiatry*, ss. 234-240.
- World Health Organization. (2018). *Constitution of WHO*. Hentet April 10, 2018 fra [www.who.int/about/mission/en/](http://www.who.int/about/mission/en/)



Vedlegg: Her legger jeg ved mer grundig dokumentasjon for literatursøket mitt. Også inkludert er en grundigere gjennomgang av mine forskningsartikler, der jeg oppsummerer funnene for hver studie og går inn i dybden på kildekritikk. Dette er gjort i IMRAD format for å gjøre det mest mulig oversiktelig.

Literatursøk i Cinhal, PubMed, PsychINFO:

Search terms used	Number Of Results
remembrance group therapy OR life review AND elderly AND institution	57,215
remembrance group therapy AND nursing home or long-term care or residential care	115
remembrance therapy AND nursing home or care home or institution or long-term care AND mental health	11
remembrance group therapy AND nursing home or care home or institution or long-term care AND psychosocial	2

Article title	Effects of reminiscence interventions on psychosocial outcomes: A meta-analysis
Journal (year)	Aging & Mental Health (2012)
Author(s)	Forstmeier, Simon; Pinguart, Martin
Research design	Meta-analysis
Purpose of study	To analyze results from many controlled trials on the impact of reminiscence interventions on a broad range of variables, as seen in post-test and follow-up results.
Method	Quantitative. A statistical analysis of the results of 128 controlled studies on the effect of reminiscence on psychosocial health were combined and analyzed to provide a single estimate.
Result	Reminiscence interventions produce moderate improvements on depression and ego integrity. Post-test results indicated that reminiscence interventions produce small improvements on purpose in life, death preparation, mental health symptoms, positive well-being, life satisfaction, ego integrity, cognitive performance and social integration (among other variables that showed statistically insignificant improvement). These improvements were reduced in varying degrees at follow-up. Greatest improvement in depression was found on depressed rather than healthy participants. Effect size was the same for both group and individual interventions.
Study limitations	Study quality varied. Three broad categories used for reminiscence. Number of studies which substantiated each variable outcome varied widely. There was no minimum sample size required for the included studies which makes it difficult to generalize results.
Source criticism	There were 23 unpublished studies included in the results. 95 studies were randomized. Only 21% of the studies featured follow-up. The scholars are experienced researchers within reminiscence and have published other studies including an earlier meta-analysis. Information on participant use of anti-depressants (which could impact results) was missing as a study characteristic in the meta-analysis; this was not mentioned by the authors as a limitation.
Relevance to research question	38 of the studies had used individual rather than group reminiscence therapy. Results not specific to elderly or nursing home residents. The unknown cultural settings of the studies may affect transferability of results to Norway. Some participants may have had severe dementia – which is a patient group outside the scope of this paper. 90/128 of the studies analyzed were on group (rather than individual) reminiscence therapy. Participants included both depressed and healthy subjects; results are relevant to both psychosocial health improvement and promotion. Study gives an overview of all controlled reminiscence intervention experiments (which tested a psychosocial health variable and sufficient information for computing effects) published/presented before 2011. It is representative of the documented impact of reminiscence on psychosocial health since the 1970's, and highly relevant to my research question.

Article title	The effectiveness of group reminiscence therapy for loneliness, anxiety and depression in older adults in long-term care: a systematic review
Journal (year)	Geriatric Nursing (2015)
Author(s)	Elias, Sharifah; Neville, Christine; Scott, Theresa
Research design	Systematic review of eight non-randomized experimental studies.
Purpose of study	To analyze the findings of group reminiscence therapy intervention studies regarding the impact on loneliness and anxiety in addition to depression.
Method	Quantitative. Analyzed eight non-randomized quantitative studies. Results presented in narrative rather than numerical form due to various factors.
Result	Two studies found significant impact of reduced depression ( $p = 0.013$ at six-month follow-up; $p = 0.01$ ). Three studies found insignificant results for depression impact. One study found insignificant effect on depression and anxiety, but a significant effect on well-being ( $p = 0.04$ ). One study found significant improvement on loneliness ( $p = 0.0001$ at three-month follow-up). The last study found a significant effect on depression ( $p = 0.04$ ) for group and individual reminiscence as well as the control group.
Study limitations	Only eight studies were considered. Impact on loneliness is substantiated only by one study; impact on anxiety by two. No studies were confirmed as randomized controlled trial. Small sample size makes it difficult to generalize results.
Source criticism	The study is based on the research of others and contributes no new clinical results that can be generalized to other patients. Two authors have doctorates and have published many studies in the fields of nursing and psychology.
Relevance to research question	Three out of eight studies were conducted in non-Western cultures, which may decrease the application potential of these findings to Norwegian residents. All studies were on group reminiscence interventions for elderly residents in long-term care settings and focused on aspects of psychosocial health. All studies done within the last sixteen years. The focus of this paper is psychosocial health promotion rather than treatment, but depression is underdiagnosed in the elderly (S). The reminiscence impact on depression adds to the potential value of the intervention for elderly who have undiagnosed depression. The study sheds helpful light on the impact of reminiscence on the psychosocial health of nursing home residents.

Article title	The Social Treatment: The Benefits of Group Interventions in Residential Care Settings
Journal (year)	Psychology and Aging (2010)
Author(s)	Bevins, A; Haslam, C; Haslam, S.; Jetten, Jolanda; Ravenscroft, S; Tonks, J.
Research design	Classic controlled experiment
Purpose of study	To compare and evaluate the impact of individual reminiscence, group reminiscence, and a control intervention on the identification, memory, and self-perceived well-being of residents in long-term care.
Method	Quantitative. 73 randomly selected residents spanning nine nursing homes and aged between 58-95 participated. The participants at each home were systematically placed into the three groups, and each group was randomly assigned to either the group reminiscence, individual reminiscence, or control group intervention for six weekly sessions. Results were gathered from pre and post-tests measuring cognitive ability, depression and anxiety, quality of life, personal identity strength, and social group homogeneity.
Result	Only the group reminiscence (GR) intervention produced a significant effect. Memory performance was significantly improved for the GR group as compared to the individual reminiscence (IR) and control group (CG). Well-being was comprised of four separately tested aspects; depression, anxiety, quality of life, and life improvement. Well-being significantly increased for the control group intervention as compared to both IR and GR.
Study limitations	Neither participants nor study facilitators (who conducted the participant interviews and subsequent intervention sessions) were blind – meaning that bias could have affected the results. Small sample size makes it difficult to generalize results. The outcomes of those who withdrew from the study due to illness or death are not included. Well-being and identification tests were not tailored to geriatric participants.
Source criticism	The study was led by well-known and experienced scholars who are widely published, including others on reminiscence. No follow-up test to verify duration of impact on participants. Western cultural setting and results are likely transferable to Norway.
Relevance to research question	Participants had a mean MMSE score of 16.15, which means that some of them likely suffered from severe dementia – a patient group outside the scope of this paper. Study measures reminiscence impact on several aspects of psychosocial health in nursing home residents. Study measures the impact of group vs. individual reminiscence, which sheds light on which qualities of group reminiscence are health promoting.

Article title	The significance of peer relationships to thriving in nursing homes
Journal (year)	Journal of Clinical Nursing (2005)
Author(s)	Bergland, Ådel; Kirkevold, Marit
Research design	Descriptive exploratory study
Purpose of study	To describe how nursing home residents' perception of the significance of relationships with peer residents to their experience of thriving
Method	Qualitative. Field observation and interviews in two nursing homes. Observation was carried out by one of the authors who spent time with residents during activities and in common areas to supplement the interviews with additional information about milieu. Interviews were conducted first with sixteen residents, and then with an additional ten residents following an initial analysis of the interview data.
Result	Twelve out of the twenty-six study participants had formed at least one personal relationship with a peer and considered this to be an important part of a thriving experience. Half of those who had not formed any such relationships did not want one, while the other half did and were active in social events intended to promote relationship-building. Caregivers can significantly influence whether peer-to-peer social interactions are meaningful and produce relationships.
Study limitations	Small sample size. It is unclear whether the author who first conducted the field observations also conducted some or all the interviews. If a resident thought that the interviewer would continue socializing in the ward, their responses regarding ward life and fellow residents may have been biased. It is also unclear whether the interviewer was perceived as health care personnel, which also may have influenced the interviewee's self-perceived freedom of response.
Source criticism	The study is thirteen years old. It is rooted in subjective experience which makes it difficult to generalize. Researchers are well-known nationally in the field of geriatric nursing and have published articles and books.
Relevance to research question	It is rooted in subjective experience which is necessary to understanding the resident's perspective. Conducted in Norwegian nursing homes. Sheds light on different aspects of social life and conveys the importance that meaningful peer-to-peer interactions and relationships have to a positive experience of nursing home life. It illuminates the importance of psychosocial health from the resident's viewpoint as well as the role of staff in promoting psychosocial health and is therefore relevant to my research question.

Article title	Living well in care homes: a systematic review of qualitative studies
Journal (year)	Age and Ageing (2012)
Author(s)	Bradshaw, Siobhan; Playford, Diane; Riazi, A.
Research design	Systematic qualitative review
Purpose of study	To produce a systematic review of qualitative studies that have examined residents' views of quality of life and make recommendations for improvements
Method	Qualitative systematic review of qualitative studies on the views of residents in nursing and residential homes. Thirty-one articles met the inclusion criteria. A thematic analysis approach supplemented by features of meta-ethnography was used to review, identify and synthesize themes in study results. Studies were compared by coding through Microsoft Excel, and diagrams were used to identify links and develop themes and sub-themes.
Result	1,223 participant responses were summarized. Structured, semi-structured, and unstructured interviews and conversations as well as focus groups were the data collection methods. Four main themes were identified in resident experiences of quality of life: acceptance and adaptation, connectedness with others, a home-like environment, and caring (nursing) practices.
Study limitations	English-language only studies were included. Limited to qualitative studies studying subjective experiences, which are difficult to generalize. Results included studies several decades old.
Source criticism	Quality of summarized studies varied. Study size information of individual studies is not given. Physical, psychosocial and cognitive health of participants unreported for most of the included studies. Use of psychopharmaceuticals is likewise unreported. Study contributes no new knowledge to the field but combines the work of others. Two authors have published many prior studies.
Relevance to research question	All thirty-one studies were qualitative and focused on the resident's perspective on life in the care home. Most studies conducted in Western cultural contexts (two in Norway) and results are likely to be transferable to Norway. The findings show that both relationships with others – staff and peers – and psychological adjustment are core aspects of residents' experience. The study illuminates factors contributing to psychosocial welfare from the residents' perception. It is relevant to my research question.