Spiritual reminiscence therapy for older people with loneliness, anxiety and depression living in a residential aged care facility, Malaysia: The effectiveness and older people’s experiences

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Abstract

Background: Spiritual reminiscence therapy (SRT), a type of spiritual integration in reminiscence therapy (RT), has shown its potential in providing a positive impact for older people living in residential aged care facilities (RACFs). Using a social identity approach, it is expected that SRT can help older people to deal with loneliness, anxiety, and depression by promoting a sense of social connectedness with other people. SRT might be particularly useful for a Malaysian population given the importance of religion and spirituality for Malaysian culture. The practice of SRT is increasing; however, limited studies have investigated the effectiveness of SRT for older people with loneliness, anxiety and depression and these studies have found mixed results.

Aim: To determine if a SRT program is effective in reducing loneliness, anxiety and depression for older people living in a residential aged care facility in Malaysia and to investigate its acceptability to this population.

Methods: Using the Psychotherapy Adaptation and Modification Framework, the SRT program was modified according to recommendations made by older Malaysian people (N=10) — modifications particularly related to cultural, religious and language differences. The adapted program was piloted with a convenience sample of older Malaysian people (N=10). It was well accepted by the pilot participants, providing a strong basis to conduct a randomised controlled study with older people living in a RACF in Malaysia.

A randomised controlled trial design with qualitative components conducted concurrently and sequentially was used. This study was conducted in a RACF in Malaysia, involving permanent residents (N=34) who understood and spoke the Malay language and had been resident for more than four weeks. At recruitment, participants were screened with the Mini-Cog, the Loneliness screening tool, a short form of the Geriatric Anxiety Inventory and the 4-item Geriatric Depression Scale.

Participants were randomly allocated to one of two intervention groups or a control group. Participants in the intervention groups received the SRT program in weekly 60–90 minute sessions for six weeks. The control group participated in activities such as painting, drawing and playing games over the same six weeks. Data were collected at pre-test, post-test, and three-month follow-up. The primary outcome measures were the UCLA Loneliness Scale, the Geriatric Anxiety Scale (GAS) and the Malay version of the 14-item Geriatric Depression Scale (M-GDS-14). The measurement instruments were translated and the translation subsequently verified by translating
backwards and forwards between English and Malay. To evaluate the effectiveness of the intervention, the mean scores were compared at baseline, a week after intervention and at three-month follow-up.

To investigate participants’ experiences of the program and its acceptability with this population, observations were recorded during the six weeks of intervention sessions. Seven participants in the intervention groups also participated in a focus group discussion (FGD) after completion of the intervention to share their experiences of the SRT program.

**Results:** Of 180 residents, 34 participated, with 18 participants in the intervention groups and 16 in the control group. Participants in both groups were in the young old age group (Intervention: $M = 67$, $SD = 4.67$ and Control: $M = 69$, $SD = 6.60$). Chronic medical illness burden was low ($M = 2.12$, $SD = 2.10$). The dropout rate was 8.8%. The main effect between groups was not significant, suggesting no difference between the intervention groups and the control group for the UCLA Loneliness Scale, GAS and M-GDS-14 scale. Within-group analysis revealed that both the intervention groups and the control group showed a significant mean difference for the UCLA Loneliness Scale and the M-GDS-14 scale. Post hoc comparisons showed that UCLA Loneliness Scale mean scores for the intervention groups in the pre-test were significantly improved from the scores at three-month follow-up. UCLA Loneliness Scale mean scores for the control group showed a significant improvement from pre-test to post-test, but not between post-test and three-month follow-up. M-GDS-14 mean scores for both groups were significantly improved from pre-test to three-month follow-up. Analysis of focus group and observational data relating to participants’ experiences and acceptability of the SRT program revealed four themes: enthusiastic participation and enjoyment of the program, connection-making across boundaries between participants, use of the sessions as space for expressing and reflecting, and successful use of triggers.

**Conclusion:** Although the findings showed no significant between-groups differences, there were significant within-groups differences for loneliness and depression. This finding suggests SRT is a worthwhile program and a future development of SRT among older people living in RACFs is supported. The significant within-group results for the control group on measures of loneliness and depression suggest the value of group based interventions in RACFs. While the findings did not confirm the effectiveness of SRT as a whole, they suggested that SRT was not only an acceptable and enjoyable experience for the participants, but developed a shared identity and connectedness across perceived differences, as social identity theory predicts.
Declaration by author

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Honorary A/Prof Christine Neville (Principal Advisor), Dr. Theresa Scott (Associate Advisor) and Dr. Andrea Petriwskyj (Associate Advisor) provided extensive guidance and input into the development of this thesis and throughout the PhD candidature. All of the supervisors critically reviewed and provided comprehensive feedback on the content of this thesis multiple times.

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None
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Thank you for being a part of my PhD journey. Terima Kasih.

“Things ends. But memories last forever.”
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aged, anxiety, depression, elder, loneliness, older, reminiscence therapy, residential aged care, spiritual reminiscence therapy

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This thesis is dedicated to my late older sister, Sharifah Norezah Syed Elias (1980–2002)
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List of Abbreviations

CIRS-G Cumulative Illness Scale for Geriatrics
FGD: Focus Group Discussion
GAD Generalised Anxiety Disorder
GAS: Geriatric Anxiety Scale
GDS Geriatric Depression Scale
LTC Long-term Care
M-GDS-14: Malay version of the 14-item Geriatric Depression Scale
RACF: Residential Aged Care Facility
RCT Randomised Controlled Trial
RT: Reminiscence Therapy
SRT: Spiritual Reminiscence Therapy
UCLA Loneliness Scale: University of California, Los Angeles Loneliness Scale
<table>
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<th>Glossary</th>
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<tr>
<td>Caucasian:</td>
<td>A white-skinned person that originated from Europe</td>
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<tr>
<td>South-East Asia:</td>
<td>Sub region of Asia in which the countries are geographically located south of China, west of New Guinea and north of Australia</td>
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<td>Long-term care:</td>
<td>A variety of services that focus on meeting the health and personal care needs of people who cannot look after themselves for long periods</td>
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<tr>
<td>Mental health problems:</td>
<td>A variety of mental health conditions such as anxiety and depression. In the context of the present study, loneliness is considered as a mental health problem.</td>
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<td>Residential aged care facilities:</td>
<td>The Malaysian Social Welfare Department (1983) described residential aged care facilities (RACF) or Home of Sweet Memories (in the Malay language: Rumah Seri Kenangan) as the facilities that provide care, treatment and shelter to older people who are underprivileged to improve their quality of life. In the present study, a RACF is a facility that provides accommodation, treatment and assistance with day-to-day living for independent older people who are underprivileged.</td>
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<tr>
<td>Western:</td>
<td>Related to the countries of North America and Western Europe</td>
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Chapter 1  General Introduction

1.1  Introduction
This chapter presents background to this thesis related to the mental health problems of loneliness, anxiety and depression. For older people living in residential aged care facilities (RACFs), these mental health problems become more prevalent due to several factors such as relocation to a new environment, a decrease in social interactions and poorer physical health (Amzat & Jayawardena, 2016; Brownie & Horstmanshof, 2011). Pharmacological intervention is often the first option to treat these problems. However, several issues related to low prescription and multiple adverse effects highlight the need for non-pharmacological interventions such as spiritual reminiscence therapy (SRT). This chapter also describes the significance of the study, lists the aim, research questions and research objectives, and provides definitions for significant terms.

1.2  Study background
Loneliness, anxiety and depression are a major concern because of the significant number of older people they affect, particularly in residential care facilities. It is estimated that among older people living in RACFs in Malaysia, approximately 95.5% of older people experience loneliness (Nikmat, Hashim, Omar, & Razali, 2015), 38% have anxiety (Khairudin, Nasir, Zainah, Fatimah, & Fatimah, 2011) and 85.5% have depression (Nikmat et al., 2015). If these mental health problems are left untreated, they may reduce the quality of life among older people (Dykstra, 2009; Eva, Elisa, Piera, Lyrakos, & Luca, 2015; Smith et al., 2008). Further, they can be a risk factor for health-related problems such as dementia and cardiovascular diseases as well as an increased suicide rate (Holwerda et al., 2016).

1.2.1  The role of social connectedness in loneliness, anxiety and depression
Several factors may contribute to these mental health problems in older people. Poorer physical health, for example, is associated with loneliness (Ong, Uchino, & Wethington, 2016; Pitkala, 2016), anxiety (de Beurs et al., 1999) and depression (Abdul Manaf, Mustafa, Abdul Rahman, Yusof, & Abd Aziz, 2016; Hoover et al., 2010). Deterioration of physical health such as reduced physical mobility and decreased hearing and speech ability can make it a challenge for some older people to develop new relationships and maintain contact with family and close friends (Amzat & Jayawarden, 2016).

Furthermore, several changes that occur in older people’s lives could contribute to loneliness, anxiety and depression such as changes in their roles and relationships (Brownie & Horstmanshof, 2011) and dealing with grief and loss (Alpass & Neville, 2003) such as loss of meaningful relationships.
(Baldacchino & Bonello, 2013; Cruwys, Haslam, Dingle, Haslam, & Jetten, 2014; Pinquart & Sorensen, 2001) and death of family members and friends (Barg et al., 2006). All these changes can cause challenges in developing and maintaining close personal relationships. Loss of meaningful relationships with close friends and family can result in reduced social interaction (Brownie & Horstmanshof, 2011). Developing new relationships can be stressful for those not equipped with the skills to socialise with new people (Hodgson, Freedman, Granger, & Erno, 2004). Many older people prefer to maintain their previous social networks and old friendships (Wiles, Leibing, Guberman, Reeve, & Allen, 2012) and social interaction with new people may be difficult for them because they tend to appreciate old relationships (Amzat & Jayawardena, 2016).

Loneliness, anxiety and depression may be more prevalent for older people living in residential aged care facilities (RACFs) as a result of a range of factors including moving to an unfamiliar environment (Amzat & Jayawardena, 2016), loss of previous connections and networks (Nikmat et al., 2015; Wiles et al., 2012), and deterioration of physical health (Amzat & Jayawardena, 2016). Hodgson et al. (2004) identified that most stress arises within four weeks after moving into a RACF, and primarily occurs due to the relocation experience. If the stressful feelings are still unresolved after four weeks, more serious problems such as depression may develop (Hodgson et al., 2004).

Loneliness, anxiety and depression are normally characterised by social withdrawal and decreased social connectedness (Amzat & Jayawardena, 2016; Baldacchino & Bonello, 2013; Cacioppo, Grippo, London, Goossens, & Cacioppo, 2015; Cruwys et al., 2014; Singh & Misra, 2009). Social withdrawal can be recognised when older people isolate themselves from any activities that they previously enjoyed (Cruwys et al., 2014). This can compound the impact of reduced meaningful social networks on older people’s mental health.

Lack of social connectedness, therefore, has a key role in loneliness, anxiety and depression. Social connectedness relates to the attachment feelings that people develop towards individuals or people in groups (Haslam, Cruwys, Haslam, & Jetten, 2015). Social connectedness occurs through interaction with other people and this produces a sense of shared social identity (Haslam et al., 2015). Social identity develops when people find reason and motivation to engage in a group and feel themselves to be part of a group (Haslam et al., 2015). Group membership provides emotional value that is central in the sense of self-value (Ysseldyk, Matheson, & Anisman, 2010). Group membership can also aid redevelopment of a person’s self-concept when people view the group as a part of themselves (Liu, 2012). Social identity is meaningful whenever it has significance or importance to the individual (Cruwys et al., 2014). In general, social identities emphasise the sense of ‘us’ (such as one’s family
and one’s community) that offer a shared network that bind people together (Cruwys et al., 2014).

### 1.2.2 Interventions for loneliness, anxiety and depression in older people

Pharmacological intervention is often a first-line approach to treat clinically diagnosed anxiety (Flint, 2005) and depression (Wilson, Mottram, Sivananthan, & Nightingale, 2001) in older people. However, there are a number of concerns about the use of pharmacological interventions. The prescription of pharmacological treatment for depression and anxiety is low among older people living in RACFs. This is due to multiple diagnoses of physical illnesses and disorders such as depression and anxiety being seen as a normal consequence of chronic illnesses in particular (Brown, Lapane, & Luisi, 2002). Misdiagnosis is also a problem; for example, some symptoms of depression such as reduced weight can be misdiagnosed as other medical illnesses such as pneumonia and angina (Voyer & Martin, 2003) or considered as part of the normal ageing process or in extreme circumstances, dementia (Benek-Higgins, McReynolds, Hogan, & Šavickas, 2008; Duyan, Şahin-Kara, Camur Duyan, Özdemir, & Megahead, 2016; Wolitzky-Taylor, Castriotta, Lenze, Stanley, & Craske, 2010). Older people themselves may also under-rate symptoms of loneliness, anxiety and depression, leading to a missed diagnosis (Barg et al., 2006). Although pharmacological intervention has been found to be effective for older people with anxiety and depression, this treatment may not be the best option because it causes various adverse effects (Coupland et al., 2011) such as risk of falls (Frazer, Christensen, & Griffiths, 2005) and risk of orthostatic hypotension associated with fractures (Lindsey, 2009). Further, loneliness is not a condition that requires pharmacological interventions.

Given the serious issues related to medication, non-pharmacological interventions may be more appropriate for older people with loneliness, anxiety and depression. Cognitive behavioural therapy (CBT) has been shown to successfully treat anxiety (Wolitzky-Taylor et al., 2010) and depression (Fuentes & Aranda, 2012). However, it requires in-depth training for a psychotherapist and is out of reach for many RACFs, which often have resourcing issues. Another useful intervention is reminiscence therapy (RT). RT uses the recall of past events, feelings and thoughts to facilitate pleasure, quality of life or adaptation to current circumstances (Bulechek, Butcher, & Dochterman, 2008). RT has been found to have many advantages such as cost-effectiveness (Hsu & Wang, 2009), improved life satisfaction (Chao, Chen, Liu, & Clark, 2008), increased social interaction (Chao et al., 2006) and improved sense of attachment (Sabir, Henderson, Kang, & Pillemer, 2016). Haight and Webster (1995) found that, in comparison to other age groups, reminiscence was more important for older people due to their awareness of their mortality. Another benefit of RT is that new skills are not necessarily essential for its implementation, and it is therefore suitable for some particular groups of
older people such as those with dementia (Chen, Li, & Li, 2012; Hsieh & Wang, 2003) and reduced physical function (Chen et al., 2012).

Social identity theorists have suggested that RT, when conducted as a group, enhances social identity through sharing memories with other people. Social identity theory posited social groups such as religious, community and workplace groups play an important role in developing the sense of self-identity through social interactions and relationships (Haslam et al., 2010). These social interactions give meaning about ‘who we are’, for example an older person or a man/woman. In relation to RT, Haslam et al. (2013) claimed that social identity is formed when members of the group RT within the same age group shared their life experiences. The process of sharing memories with others in group RT facilitates meaningful social connectedness (Sabir et al., 2016) and this will promote the sense of social identity (Haslam et al., 2010; Haslam et al., 2013). As has been discussed earlier in the chapter, social connectedness also plays a key role in treating loneliness, anxiety and depression.

RT, particularly conducted in a group, may therefore be an effective approach for older people with loneliness, anxiety and depression. However, inconsistent findings due to a lack of standardised approaches to RT (Westerhof, Bohlmeijer, & Webster, 2010), lack of theoretical understandings of the mechanism of action for RT (Webster, Bohlmeijer, & Westerhof, 2010; Westerhof et al., 2010), and different methodological techniques used in previous studies (Westerhof et al., 2010) limit the evidence base. Therefore, further development of the evidence in regard to the effectiveness of RT for older people with loneliness, anxiety and depression is needed.

1.2.3 The use of reminiscence therapy for a Malaysian population

This thesis explores the use of RT in the context of Malaysia. Despite being an accepted and even promoted therapy in Malaysia, there is limited evidence for its effectiveness in this country. RT is recognised as one of the psychotherapies used to treat mental health problems in the Malaysian Clinical Practice Guidelines (CPG) 2007 (Ministry of Health Malaysia, 2007). In these guidelines, psychotherapy has been highly recommended as grade A evidence (based on meta-analysis, systematic review or randomised clinical trials) for older people with depression (Ministry of Health Malaysia, 2007) and older people with dementia with symptoms of anxiety (Ministry of Health Malaysia, 2009). No information was available for loneliness in this population. As the CPG were developed based on previous systematic reviews and controlled trials which involved older people in Western populations, there is a need to adapt and investigate the usefulness of RT for the Malaysian population.
A central focus for any adaptation of RT is cultural appropriateness. In Malaysia, culture is strongly linked with religious and spiritual practices (Haque, 2008). The integration of religion and/or spirituality in RT is therefore an appropriate approach to promote its usefulness and acceptability for older Malaysians. This integration is known as spiritual reminiscence therapy (SRT). Spiritual reminiscence therapy (SRT) is a review of life events or stories that involve people trying to find meaning in their life and their future hopes (Mackinlay & Trevitt, 2010). Although SRT has not been tested in an older Malaysian population, it uses an approach similar to RT, with a specific focus in the content on spirituality. For example, SRT involves themes such as meaning in life, joy, sadness, grief and regrets (Byrne & MacKinlay, 2012) and can cover topics about an individual’s relationship with God and spiritual needs.

From a social identity perspective, SRT could promote a sense of meaningful identity among the Malaysian population such as spiritual and religious identity. To date, no studies implement spirituality as a culturally relevant approach to investigate the mechanism of social identity in RT. A previous study used religious identity as an extension of social identity theory in RT (Haslam et al., 2013). They found that people in a religious song RT group developed a sense of religious identity through finding similarities with people in that group. The religious group identification was found to be related to reduced anxiety levels.

Within this thesis, an adaptation of RT into a SRT approach suitable for older Malaysians living in a RACF is presented. It is then evaluated for its effectiveness to treat loneliness, anxiety and depression, and the acceptability and experiences of the program for these older people are explored.

1.3 Significance of the Study

In the first instance, this study is significant because the implementation of SRT may be able to reduce health care costs. The high prevalence rates of loneliness, anxiety and depression have significant cost implications for treatment. The escalation of health care costs could be reduced by improving preventive care such as SRT or RT as alternatives to medication or hospitalisation, especially among older people. It is reported that in Malaysia approximately 30% to 60% of health care funds are used by older people (Ministry of Health Malaysia, 2010). RT has been identified as a cost-effective option for the treatment of depression (Budi, Sang-arun, & Patcharee, 2012; Hsu & Wang, 2009), although the details of cost-effectiveness require further exploration.

Secondly, the present study offers policy implications for the Eleventh Malaysia Plan (2016–2020) with the theme “Anchoring Growth On People” (Economic Planning Unit, 2015). This plan is the
final milestone in the “Vision 2020” journey to achieve a developed nation. As the older Malaysian population increases, how to support and maintain the well-being of older people becomes an increasing concern for the government. Starting from the Ninth Malaysia Plan (2006–2010) until the current Malaysia Plan, concern was expressed about mental health problems among older people, with the focus on support programs for stress, anxiety and depression. It was also highlighted that more research was required to particularly support active ageing and improve the quality of life for older people. This study implemented SRT for older people with mental health problems as a support program for the Eleventh Malaysia Plan.

Finally, the present study is significant because of the importance of developing interventions without the side effects and prescription issues of pharmacological interventions. Several side effects of pharmacological interventions were highlighted earlier in this chapter. The adverse effects of medications may decrease the quality of life among older people (Lindsey, 2009); however, no prescription is required to conduct RT, and it is a very low-risk intervention.

1.4 Aim
There is a clear need for investigation of treatments for loneliness, anxiety and depression in older people, particularly those living in RACFs. With high prevalence rates of these mental health problems and side effects of pharmacological interventions, there is a need for further development of non-pharmacological interventions. This study investigated the potential of SRT as a useful intervention in the context of a Malaysian population. In order to suggest this intervention be used in practice, it is important to determine the effectiveness of SRT and its acceptability for this population. Therefore, the aim of the present study was to determine if a SRT program is effective and acceptable in reducing loneliness, anxiety and depression for older people living in a RACF in Malaysia.

1.5 Research questions
The research addresses two research questions:

1) Is the SRT program effective in reducing loneliness, anxiety and depression among older people?

2) What are the experiences and acceptability of the SRT program for the participants?

1.6 Research objectives
The research addressed two research objectives:
1) To test the effectiveness of SRT in reducing loneliness, anxiety and depression immediately after, and three months following intervention, in comparison with a non-therapeutic activity control.

2) To explore the experiences of the SRT program for the participants in order to provide insights into its acceptability and usefulness for this population.

### 1.7 Definitions

A number of significant key terms used in this thesis are described here.

**Older people**

Most developed countries around the world use 65 years of age and older based on a chronological definition of age (World Health Organization, 2013). In Malaysia, the cut-off age for an older person is 60 years of age and over, based on the United Nations definition (United Nations Population Fund, 2012). Thus, the present study defined older people as aged 60 years and over.

**Loneliness**

Loneliness is defined as the lack of significant relationships with people or inability to have sufficient connections (Brownie & Horstmanshof, 2011).

**Anxiety**

Anxiety is defined as “worries about several real-life problems, occurring for at least six months” (American Psychiatric Association, 2013). For a diagnosis, the person must have difficulty controlling the worry and presenting with at least three associated symptoms such as tension, irritability, trouble concentrating and insomnia (American Psychiatric Association, 2013).

**Depression**

Depression is defined as low mood or loss of interest in activities for more than two weeks. It can be diagnosed based on several symptoms such as depressed mood, decline in interest and pleasure, weight loss or weight gain, sleeplessness, insomnia or hypersomnia, slowdown of psychomotor responses or excitement, exhaustion, fatigue and loss of energy, sense of guilt, lowered self-esteem, loss of attention capacity and suicidal thoughts (American Psychiatric Association, 2013).

### 1.8 The flow of the thesis

This thesis contains nine chapters:
• As the study was conducted in Malaysia, Chapter 2 provides an overview of the ageing population and the aged care system in Malaysia.

• Chapter 3 looks at the prevalence rates of loneliness, anxiety and depression and the current treatments for these conditions.

• The current debates and issues regarding RT are discussed in Chapter 4, including a review of literature on the evidence regarding the use of RT in reducing loneliness, anxiety and depression, benefits of RT, and the usefulness of RT from the social identity perspective.

• In Chapter 5, the process of adapting RT to meet the multiethnic population in Malaysia, including the inclusion of spirituality as central to Malaysian culture, is discussed. This chapter reviews the evidence regarding the use of SRT as an intervention for loneliness, anxiety and depression.

• The knowledge gaps identified in Chapters 4 and 5 inform the research design and methodology that is detailed in Chapter 6.

• Chapter 7 provides the results and discussion regarding the effectiveness of the SRT program in reducing loneliness, anxiety and depression.

• Chapter 8 provides the results and discussion relating to the participants’ experiences and acceptability of the SRT program.

• Finally, Chapter 9 provides a general discussion that integrates the qualitative and quantitative findings and explores them in the context of social identity theory, and presents the limitations of this study and recommendations for future studies.

1.9 Summary
This chapter has served to highlight the significant problem of loneliness, anxiety and depression among older people, particularly those living in RACFs. It has also provided brief context for the chapters that follow, in which the approaches to these mental health problems are addressed in more detail.
Chapter 2  Malaysia, the ageing population and the aged care system

2.1 Introduction
This chapter provides a brief historical overview of Malaysia’s socioeconomic development and how this has resulted in a multiethnic and multireligious country. As with most other countries, Malaysia has an ageing population with a greater number of older people living longer. Old age is often associated with more health concerns that require care provided by other people. In Malaysia, the traditional system of caring for older people has been based on filial piety but this system is under pressure from changes such as urbanisation and higher costs of living. The aged care system that is developing in response to these changes in modern society is described in this chapter, thereby setting the background for this study.

2.2 A brief overview of Malaysia
Malaysia is located in South-East Asia (Figure 2.1) and has two regions: Peninsular Malaysia (West Malaysia) and Malaysian Borneo (East Malaysia). It has a total area of 329,750 square kilometres. Peninsular Malaysia consists of 11 states and is categorised into four regions: (1) Northern region – Perlis, Kedah, Pulau Pinang and Perak, (2) Southern region – Johor, Melaka and Negeri Sembilan, (3) Central region: Selangor, (4) East coast region: Kelantan, Pahang and Terengganu. In Peninsular Malaysia, there are two federal territories: Kuala Lumpur and Putrajaya. East Malaysia consists of the state of Sabah and Sarawak and the one federal territory of Labuan.

The historical development of Malaysia as a country is shown in Figure 2.2. The original inhabitants of Malaysia were Malays and Indigenous people such as Orang Asli in West Malaysia and other ethnic groups in East Malaysia (Andaya & Andaya, 2001). The Malays, under the law of Malaysia, are not in the group of Indigenous people and should be recognised as Malays (Subramaniam, 2015).The Malays and Indigenous people were combined into one group known as Bumiputera (sons/daughters of soils). These ethnic groups were traditionally associated with the animism belief system (Chandia & Choong, 2015). In the 15th century, Islam was first introduced by Arab and Persian traders (Chandia & Choong, 2015). Islam greatly influenced Malays, until all Malays, and a significant number of Indigenous people are now Muslim (Muhamat et al., 2012).

As early as the 1500s, Malaysia was an attractive target for colonialism due to its geographical location in the South China Sea, making it a strategic meeting place for the East and the West (Muhamat et al., 2012). Other attractive features were rich natural resources such as aromatic woods and gold (Andaya & Andaya, 2001). Malaysia was colonised for over four centuries by the
Portuguese, the Dutch and the British (Andaya & Andaya, 2001). It was an immigration policy introduced by the British to increase the workforce that made the most significant changes to the ethnic and religious mix of the Malaysian population. The promotion of immigration saw a large number of people from southern China and southern India permanently relocate to Malaysia (Muhamat et al., 2012), bringing with them the religions of Hinduism and Buddhism. These religions were in addition to Christianity that was introduced by the Portuguese and the British (Muhamat et al., 2012). The colonial era established Malaysia as the multiethnic and multireligious country that exists today.

*Figure 2.1 Map of Malaysia*

(Atlas of Malaysia, 2013)
Figure 2.2 The development of Malaysia as a country

To understand Malaysia’s multiethnic and multireligious make-up in more detail, it is worthwhile to look at the distribution of the different cultural subgroups. The Malaysian population comprises of the Bumiputera – Malays and Indigenous people (68.6%), Chinese (23.4%), Indians (7%), and other ethnic groups (1%) (Department of Statistics Malaysia, 2016). In Malaysia, Islam is a national religion, and approximately 61.3% of the total population are Muslims (Department of Statistics, 2010). The other religions are Buddhism (19.8%), Christianity (9.2%), Hinduism (6.3%) and other religions (3.4%) (Department of Statistics Malaysia, 2010). Table 2.1 shows the distribution of the Malaysian population based on ethnicity and religion.
Table 2.1 Religions and ethnicity in Malaysia

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Islam</th>
<th>Christianity</th>
<th>Buddhism</th>
<th>Hinduism</th>
<th>Confucianism, Taoism and Tribal/folk/other traditional Chinese religion</th>
<th>Other religion</th>
<th>No religion</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malay</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.7</td>
<td>11</td>
<td>83.5</td>
<td>0.2</td>
<td>3.4</td>
<td>0.1</td>
<td>0.9</td>
<td>0.2</td>
</tr>
<tr>
<td>Indian</td>
<td>4.2</td>
<td>6</td>
<td>1.7</td>
<td>86.2</td>
<td>0*</td>
<td>1.9</td>
<td>0*</td>
<td>0*</td>
</tr>
<tr>
<td>Indigenous people</td>
<td>40.4</td>
<td>46.5</td>
<td>1</td>
<td>0.1</td>
<td>4</td>
<td>1.5</td>
<td>4</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Note: 0*: The percentages are too small

(Department of Statistics Malaysia, 2010)
After Malaysia gained independence in 1957, the Malaysian economy depended on the agricultural sector such as the production of natural rubber and tin (Yusof & Bhattasali, 2008). In 1970, the economy changed to be more multi-sectorial due to the introduction of the New Economic Policy (1970–1990). Since then continual policies have been introduced: the National Development Policy (1990–2000) and the National Vision Policy (2001–2010) to boost the economic growth of Malaysia from an upper middle-income country to a high-income country (Yusof & Bhattasali, 2008). This 40-year program has had a substantial positive impact on the economic outlook for Malaysia with a Gross Domestic Product per capita of RM 1,157.1 billion in 2015 (Department of Statistics Malaysia, 2016). Malaysia is now the third richest country in South-East Asia after Singapore and Brunei.

Along with the economic growth of Malaysia, there has been an increased trend of urbanisation, in particular, among the younger population. Young people have left extended family arrangements and moved to the cities for better employment opportunities, improved housing facilities and better access to education and health care (Ishak, 2015). Consequently, a greater concentration of older people reside in rural areas (Ong, Phillips, & Hamid, 2009). Figure 2.3 shows the percentage of urban population rose from 62% in 2000 to 71% in 2010 (Department of Statistics Malaysia, 2010).

![Figure 2.3 The percentage of urban population in Malaysia](Department of Statistics Malaysia, 2010)

The urbanisation rate is expected to increase to 75% in 2020 and 80% in 2030 (Economic Planning Unit, 2015). The excessive rate of urbanisation has increased the cost of living particularly in the cities (Siwar, Ahmed, Bashawir, & Mia, 2016). This has resulted in the younger generation often working more than one job, with a growing number of women working to support their families.
(Ambigga et al., 2011; Woon, Sulaiman, & Arif, 2013) and an increase in the number of nuclear families (Department of Statistics Malaysia, 2010; Noor, Gandhi, Ishak, & Wok, 2014). Nuclear family can be defined as a family unit that involves a mother and a father and their children (Nam, 2004). Figure 2.4 shows the increased number of nuclear families from 62.8% in 2000 to 65.4% in 2010.

Rapid urbanisation has changed family structures and extended family living arrangements. This in turn, has decreased the practice of family care for older people (Ambigga et al., 2011). Malaysia, like other Asian countries, has traditionally practiced filial piety which means the family members are responsible for the care of older relatives (LooSee & Yoong, 2013). The three major ethnicities of Malay, Chinese and Indian recognise filial piety. Also, women who commonly took the responsibility of looking after older family relatives are now working outside the home to provide additional income, limiting their ability to provide care (Woon et al., 2013). The pressures of modern living are realising an erosion of filial piety, with many younger family members considering residential care outside the family home as an option.

Figure 2.4 Percentage of households by household type, Malaysia, 2000 and 2010

(Department of Statistics Malaysia, 2010)
However, there are many factors which make this option a difficult decision. It not only impacts on the psychological and social wellbeing of older people, but their families as well. Although *filial piety* is not an actual law, the government does not support the decision to send older relatives to RACFs. It is stated in the admission criteria of public RACFs that older people who still have children or relatives must live with their family members, but the only monetary support given to family carers is a tax exemption of up to RM5000. In addition to very little government support, family members may also struggle psychologically to send older relatives to a RACF. Culturally, especially for Malays, it is not socially and spiritually acceptable to send older relatives to a RACF (Tey et al., 2016). In Islamic principle, it is the obligation of the children to look after their older relatives and failing to do so is regarded as a major sin (Stivens, 2006). Older people who were born before the social and economic changes of the 1960s and 1970s would also have expectations of living with, and being cared for by, family members as they would have done for their older relatives (Amzat & Jayawardena, 2016; Omar, 2003; Teh, Tey, & Ng, 2014). Furthermore, older people generally prefer to live with their family members (Teh et al., 2014). The move to a RACF may lead to feelings of abandonment (Momtaz, Ibrahim, Hamid, & Yahaya, 2010) and decreased social support (Saleh, 2013) — all contributing factors for loneliness, anxiety and depression. The impact of these historical and ongoing social changes on the whole of Malaysian society will be all the more amplified given the ageing of the world’s population and that of Malaysia.

2.3 The ageing population worldwide and in Malaysia

According to the most recent report from the United Nations, the world’s population is ageing rapidly (United Nations, 2015). The percentage of people aged 60 years and over rose from 9.2% in 1990 to 11.7% in 2013 (United Nations, 2013) and it is expected to increase from 12.3% in 2015 to 16.5% in 2030 (United Nations, 2015). In the United Nations report, the countries and regions of the world are categorised as Africa, Asia, Europe, Latin America and the Caribbean, Northern America and Oceania (United Nations, 2015). These categories can be classified into three groups: more developed regions, less developed regions and least developed countries. The less developed regions comprise all regions of Africa, Asia (excluding Japan), Latin America and the Caribbean, and Oceania (excluding Australia and New Zealand). The more developed regions include all other regions with these three countries: Japan, Australia, and New Zealand. The least developed countries consist of 48 countries (such as Bangladesh and Myanmar) other than the countries in the more developed regions and the less developed regions.

The growth rates of the older population in the more developed regions, less developed regions and least developed regions illustrate a different pattern. In the more developed regions, the growth rate
of the older population increased to 29% between 2000 and 2015. The growth rate is projected to slow to 26% between 2015 and 2030. By contrast, the growth rate of the older population in developing regions is growing faster than more developed regions. The growth rate of the older population increased by 60% between 2000 and 2015. The population aged 60 years or over is expected to increase between 2015 and 2030 by 71%, reaching 1 billion in 2030. The projections between 2030 and 2050 are anticipating that approximately 80% of older people, which is 1.7 billion, will live in the less developed regions.

Meanwhile, the proportion of the older population in the least developed countries is also increasing. The number of older people rose by 54% between 2000 and 2015 and is projected to increase by 70% between 2015 and 2030. Although the pattern increased for the least developed countries, older people from these countries only represented 5.8% of the total older people population in the world in 2015. The proportion of older people in these countries is projected to be 6.3% in 2030 and 8.9% in 2050 (Figure 2.5).

Figure 2.5 The pace of the ageing population in developed and developing regions of the world

(United Nations, 2015)
The same trend exists for Malaysia, a country which is geographically placed in the less developed region of South-East Asia. In recent years, Malaysia’s older population has been increasing. According to census data, the entire population increased from 18.4 million people in 1990 to 28.3 million in 2010 (Department of Statistics Malaysia, 2010) and 31.7 million in 2016 (Department of Statistics Malaysia, 2016). The population is expected to be approximately 33.3 million in 2020 (Department of Statistics Malaysia, 2010) which is an increment of 80% over the three decades (Mafauzy, 2000). However, the population of older people is expected to increase from 1.05 million to 3.26 million within the same duration — an increment of 210% (Mafauzy, 2000). Figure 2.6 shows the change indicators of the increment of the ageing population in 2010 as compared to 2000 (Department of Statistics Malaysia, 2010).

![Figure 2.6 Population numbers by gender and age group, Malaysia, 2000 and 2010](image)

Figure 2.6 Population numbers by gender and age group, Malaysia, 2000 and 2010

(Department of Statistics Malaysia, 2010)

The percentage of older people across Malaysia can be divided based on the states and federal territories as can be seen in Table 2.2. In 2010, the highest proportion of older people population was in Perak.
Table 2.2 Proportions of the total population of people aged 60 years and over

<table>
<thead>
<tr>
<th>States of Malaysia</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peninsular Malaysia</strong></td>
<td></td>
</tr>
<tr>
<td><em>Northern region</em></td>
<td></td>
</tr>
<tr>
<td>Perak</td>
<td>9.4</td>
</tr>
<tr>
<td>Perlis</td>
<td>9.2</td>
</tr>
<tr>
<td>Pulau Pinang</td>
<td>8.0</td>
</tr>
<tr>
<td>Kedah</td>
<td>8.0</td>
</tr>
<tr>
<td><em>Southern region</em></td>
<td></td>
</tr>
<tr>
<td>Melaka</td>
<td>8.2</td>
</tr>
<tr>
<td>Negeri Sembilan</td>
<td>7.4</td>
</tr>
<tr>
<td>Johor</td>
<td>6.4</td>
</tr>
<tr>
<td><em>Central region</em></td>
<td></td>
</tr>
<tr>
<td>Selangor</td>
<td>4.5</td>
</tr>
<tr>
<td><em>East coast region</em></td>
<td></td>
</tr>
<tr>
<td>Kelantan</td>
<td>7.3</td>
</tr>
<tr>
<td>Terengganu</td>
<td>6.1</td>
</tr>
<tr>
<td>Pahang</td>
<td>5.6</td>
</tr>
<tr>
<td><em>Federal territories</em></td>
<td></td>
</tr>
<tr>
<td>Kuala Lumpur</td>
<td>5.4</td>
</tr>
<tr>
<td>Putrajaya*</td>
<td></td>
</tr>
<tr>
<td><em>East of Malaysia</em></td>
<td></td>
</tr>
<tr>
<td>Sarawak</td>
<td>6.5</td>
</tr>
<tr>
<td>Sabah</td>
<td>3.9</td>
</tr>
<tr>
<td><em>Federal territory</em></td>
<td></td>
</tr>
<tr>
<td>Labuan</td>
<td>3.2</td>
</tr>
</tbody>
</table>

Note: * no available information

(Department of Statistics Malaysia, 2010)

2.4 The aged care system in Malaysia

With the increase of the older population, the Malaysian government has shown commitment to addressing the ageing issues by developing the National Policy for the Elderly (NPE) in 1995. The policy intended to ensure that older people are healthy, receive adequate care/treatment and are socially active. In this policy, the government provides aged care services for older people, for example, the Ministry of Health delivers numerous health care services to older people through 1061 public health clinics and 143 public hospitals (Ministry of Health Malaysia, 2016). The services deal with health-related problems (e.g. health screening and treatments) as well as health promotion (e.g. counselling and health education). While the Ministry of Health focuses on health care services for older people, the Department of Social Welfare Malaysia offers residential and social services for
long-term care such as RACFs, nursing homes, respite care, home help, day care centres and elderly activity centres. Non-government organisations (NGOs) and private organisations also provide several services such as private RACFs, respite care and home care nursing which is an option for older people with strong financial support.

Table 2.3 shows how RACFs are organised in Malaysia. Generally, older people who are poor and abandoned will be placed in public RACFs rather than private RACFs. Meanwhile, those who can afford to pay for services usually select the private RACFs.
Table 2.3 The bodies/organisations involved in residential aged care facility (RACF) administration

<table>
<thead>
<tr>
<th>The bodies/organisations</th>
<th>Types of RACF</th>
<th>Admission criteria to RACF</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Government bodies (Department of Social Welfare, Malaysia)</td>
<td>Public</td>
<td>a. Malaysian citizen, 60 years of age and older, poor, independent, have no relatives or caregivers, no permanent home and have no communicable diseases</td>
<td>a. Free services like shelter, healthcare, counselling, occupational rehabilitation, physiotherapy, religious facilities/program and leisure activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. No entrance fees</td>
<td>b. Residents receive an allowance of RM 350 ($AUD 117) per month.</td>
</tr>
<tr>
<td>2. Non-government organisations</td>
<td>Private</td>
<td>a. No specific admission criteria but may receive applicants as young as 40 years for medical needs</td>
<td>The services are similar to the public RACFs, but some services* may not be available in private RACFs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Have entrance fees</td>
<td></td>
</tr>
<tr>
<td>3. Charitable organisations</td>
<td>Private</td>
<td>a. No specific admission criteria but basically for older people (aged 60 years and over)</td>
<td>The services are similar to the public RACFs, but some services* may not be available in private RACFs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. May require some entrance fees</td>
<td></td>
</tr>
<tr>
<td>4. Religious organisation</td>
<td>Religious homes such as Muslim religious home</td>
<td>a. Voluntary and independent older people</td>
<td>Learning about religion and preparing themselves for life after death.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Have to pay for entry fees between RM 20,000 to RM 50,000</td>
<td></td>
</tr>
</tbody>
</table>

Note: RACF: Residential aged care facility; RM: Ringgit Malaysia – Malaysian currency; some services*: rehabilitation, physiotherapy, religious facilities/program

(Department of Social Welfare Malaysia, 2016; Syed Akil, Abdullah, & Sipon, 2014)
Nine of the public RACFs in Malaysia are entirely publicly funded by the Department of Social Welfare Malaysia, Ministry of Women, Family and Community Development (Department of Statistics Malaysia, 2012), with a total number of 1,997 public RACF residents in 2014 (Department of Social Welfare Malaysia, 2014). The residents of public RACFs are from different ethnicities, cultures, and religions, except for the religious homes that only admit people from a specific religion. However, to live in a public RACF, one must be a Malaysian citizen. Most of the residents in public RACFs come from a low socioeconomic background; they are often homeless, have no income and are forced to move to RACFs under The Destitute Persons Act (DPA) 1977. However, some older people voluntarily move to a public RACF because they live alone, have no relatives and are concerned about their health and wellbeing. There are also some residents of public RACFs that have been abandoned by relatives and the Department of Social Welfare takes action to relocate these people to public RACFs.

Despite the increasing number of older people, it has been reported that the government has no plan to open new RACFs (Irene, 2016). This is due to a government decision to deter the younger population, who are reluctant to look after their older relatives, from placing them in public RACFs. Although there are strict admission criteria to the public RACFs, the government will consider other relevant applications such as older people with family relationship problems, or who have family members with health and financial problems that are not able to or cannot afford to provide care. There has, however, been misuse of this service by some families which has led to a significant number of older people with relatives now living in the public RACFs despite the main purpose of these facilities being for those people without relatives.

The public RACFs in Malaysia provide several services to older people (Table 2.3) in accordance with the National Policy for Older Persons under the supervision of the Ministry of Women, Family and Community Development (Syed Akil et al., 2014). Staff usually consists of a manager, an assistant community development officer, community development assistants, an occupational therapist, an Islamic affairs assistant, administrative assistants, a hostel warden, community nurses, health attendants, drivers and security guards.

In comparison to private RACFs, publically funded RACFs may not be fully equipped with facilities such as self-catered, individual rooms. This is often due to limited budgets and limited space in the RACFs. An example of a government funded RACF is RACF Cheras which has a capacity of 336 residents. This RACF has one small apartment building (for married couples) and small houses based on five clusters, with each cluster comprising of three houses. Each house consists of two big rooms
which have 10 to 12 beds, lockers, a kitchen, a living hall and four to five bathrooms. Except for the bathrooms, there are no private areas in each house. Men and women live separately in different houses. There are scheduled activities from Monday to Sunday, with different activities each day; however, the rotation of the activities is the same for each week. The activities include exercise (every morning), playing games or karaoke and playing traditional musical instruments. The residents decide whether they want to participate or not in the scheduled activities. In private RACFs, there are also scheduled activities that similar to activities in public RACFs such as exercise and playing games. Meanwhile, religious homes offer activities that are focused on spiritual activities such as congregational praying and learning about religion.

2.5 Summary
This chapter describes the historical background of Malaysia and its rapid economic growth. The impacts of economic development are increased urbanisation and a higher cost of living. These changes have affected the care of older people who have traditionally been cared for by family members. While the Malaysian government provides the aged care services, some services such as public RACFs were specifically planned for older people who have no relatives and are underprivileged. Relatives who are still present to look after older people may have demanding jobs; therefore, compromising their caring ability for older people. Despite their busy life, the decision to send older relatives to RACFs may not be easy due to a lack of government support and cultural practices.

The next chapter, Chapter 3, continues the discussion about residential aged care in Malaysia with a specific focus on the prevalence rates of loneliness, anxiety and depression in older people living in RACFs.
Chapter 3  
Loneliness, anxiety and depression in older people

3.1 Introduction
This chapter explores research on the relationship between loneliness, anxiety and depression in older people and the impact these mental health problems have on their lives. It examines the rates of loneliness, anxiety and depression among older people living in residential aged care facilities (RACFs). The chapter concludes by examining the treatments available to address these mental health problems.

3.2 Loneliness, anxiety and depression in older people
Loneliness, anxiety, and depression are serious mental health problems among older people. Although separate conditions, they are interconnected, often co-morbid and share similar symptoms. Loneliness is a subjective and negative feeling when there is a difference between an individual’s expectation and his/her own social network (Holwerda et al., 2016; Pitkala, 2016). Older people may experience loneliness even if they are surrounded by other people (Ong et al., 2016). While there are no specific criteria for recognising loneliness in older people because each may perceive loneliness differently, it is often indicated by symptoms such as disturbed sleep, reduced satisfaction from social networking, diminished interest in social activities, and weight gain (Ong et al., 2016; Pitkala, 2016).

Anxiety can occur suddenly or increasingly over hours to even years. The longer duration of anxiety is more related to anxiety disorder. Anxiety disorder can take multiple forms and can be classified into Generalised Anxiety Disorder (GAD), Panic Disorder, Specific Phobia, Separation Anxiety Disorder and other types. GAD is the most common type of anxiety disorder in older people. The diagnostic criteria for anxiety are difficulty controlling worry and the presence of at least three associated symptoms such as muscle tension, restlessness, irritability, trouble concentrating, fatigue and insomnia (American Psychiatric Association, 2013). Depression is a common mental disorder that can present with loneliness and anxiety (Singh & Misra, 2009). Depression in later life can range from mild depression to major depression (Luppa et al., 2012). A major depressive disorder is indicated by a broad range of symptoms; these include prolonged depression, decreased interest and pleasure in activities, significant weight loss or weight gain, insomnia, psychomotor agitation or retardation, loss of energy, feelings of worthlessness, the reduced ability to think or concentrate and suicidal ideation (American Psychiatric Association, 2013).

There is, therefore, considerable overlap and similarity in the symptoms of loneliness, anxiety and depression such as in the symptoms of sleep disturbance and weight gain/weight loss. This overlap
can make it difficult to differentiate between these conditions (Almeida et al., 2012; Therrien & Hunsley, 2012). Adding further complexity, unlike anxiety and depression, loneliness is not an illness that requires a diagnosis and has no clear criteria.

3.2.1 The significant relationship between loneliness, anxiety and depression

A considerable amount of literature has been published on the relationship between loneliness, anxiety and depression. Indeed, each of these conditions has been found to be significantly related to the others among older populations. The evidence suggests a significant relationship between loneliness and depression in older people (Adams, Sanders, & Auth, 2004; Alpass & Neville, 2003; Donovan et al., 2016; Han & Richardson, 2010; Syed Elias, Khatijah, Chui, & Chin, 2012; Wan Mohd Azam et al., 2013). For example, Alpass and Neville (2003) examined the association between loneliness and depression among 217 older men aged 65 years and over from community clubs and groups such as service clubs and church congregations in New Zealand. They found a significant relationship between loneliness and depression with older men who were lonelier, reporting higher scores on the Brink et al. (1982) Geriatric Depression Scale – 30 items. A significant positive moderate relationship (r = 0.4, n = 161, p < 0.01) was found between emotional loneliness and depression in a study involving 161 community-based older people in a rural area in Malaysia (Wan Mohd Azam et al., 2013). This study also found that social loneliness demonstrated a weak positive correlation with depression (r = 0.2, n = 161, p < 0.05 ). Another study, which involved 369 older people who attended three outpatient clinics in Malaysia, found that loneliness was a significant predictor of depression (AOR 2.28 95% CI 1.31, 3.49) (Syed Elias et al., 2012). In a study involving 234 residents of two retirement villages in the United States of America, there was a significant moderate correlation (r = 0.5, n = 234 , p<0.005) between loneliness and depression; however, loneliness was also identified as a risk factor (Adams et al., 2004). And yet another study, which involved 40 Caucasian and African American older people living in the community, found that loneliness was significantly correlated with depression (r = 0.57, p < 0.01) (Han & Richardson, 2010). Loneliness was also a predictor of depression in the US Health and Retirement study, spanning 12 years of research starting from 1998, involving 8382 men and women aged 65 years and over (Donovan et al., 2016).

Similarly, studies have also reported a significant relationship between loneliness and anxiety. Loneliness was found to have a significant relationship (p<0.001) with anxiety among people aged 65 years and over in a study of 102 older people in primary health clinics (Barg et al., 2006). Another study involving older people living in the community, which sampled 97 people aged 100 years and over living in two communities in Portugal, also found a significant relationship between loneliness
and anxiety (OR = 3.45, 95% CI = 1.218-9.775) (Ribeiro, Teixeira, Araujo, Afonso, & Pachana, 2015). Loneliness was also found to be a predictor of anxiety (p<0.001) among 200 community-dwelling older people in Iran (Khademi, Rashedi, Sajadi, & Gheshlaghi, 2015).

Studies also indicated a significant relationship between anxiety and depression. A review of 182 studies concluded that anxiety is highly related to depression (Wolitzky-Taylor et al., 2010). In Haugan, Innstrand, and Moksnes (2013) study, a significant association between anxiety and depression (p< 0.05) was found in 202 nursing home residents in Norway who were cognitively intact. More recently, a study involving 250 older people in the United States of America found that anxiety positively predicted depression (B =0.331, CI =0.004–0.682, d=0.271), especially within 48 months of bereavement (Jacobson, Lord, & Newman, 2017). Altogether, these studies provide good evidence of an association between loneliness and depression, loneliness and anxiety, and anxiety and depression among older people. However, no studies were identified which examined the three mental health problems together, let alone for older people in residential aged care in Malaysia.

Despite this, it is important to keep in mind that although loneliness, anxiety and depression share similar symptoms and are significantly related, they remain distinct mental health problems. Cacioppo and Patrick (2009) argued that loneliness is related to negative feelings or poor satisfaction with a significant relationship such as family relationship, while depression concerns feelings of worthlessness and helplessness which do not necessarily originate from relationships. Similarly, the worrying that characterises anxiety does not necessarily stem from social connections. Therefore, understanding the factors that contribute to each of these mental health problems is essential.

3.2.2 Factors that contribute to loneliness, anxiety and depression in older people
A vast and growing body of literature has investigated risk factors for loneliness, anxiety and depression in older people. This literature suggests that there is some overlap between the conditions in the risk factors. For example, a review involving one meta-analysis and two cross-sectional studies found that risk factors for loneliness were related to sociodemographic, social-related problems and health-related factors including being widowed, female, single, lacking contact with close friends, the deterioration of physical health and low socioeconomic background (Ong et al., 2016). In a recent integrative review, Wright-St Clair, Neville, Forsyth, White, and Napier (2017) found loneliness was associated with health, quality of life and minority ethnic groups, especially for older immigrants. Wright-St Clair et al. (2017) reviewed nine studies that were conducted in New Zealand. In the Malaysian population, a Syed Elias et al. (2012) study found that loneliness was associated with race (p<0.000), education level (p<0.000) and living arrangement (p<0.003). For anxiety, a review of 182...
studies found that the risk factors for anxiety in older people are female gender, single status, health problems, disability, low educational background and past traumatic histories (Wolitzky-Taylor et al., 2010). For depression, a meta-analysis reviewing 20 studies from 1966 to 2001 found that the risk factors for depression in older people were sleep problems, grieving, being female and disabled (Martin & Nandini, 2003). In the above noted study of Syed Elias et al. (2012) found that educational level (p<0.000) and income (p<0.04) were associated with depression. Some risk factors, therefore, overlap such as being female, single, and having health-related problems.

More specifically focusing on older people living in RACFs, several risk factors may contribute to loneliness, anxiety and depression. A phenomenological study involving three RACF residents aged 55 years and over in Malaysia found extrinsic and intrinsic factors contributed to loneliness, including mundane daily routines, weak relationships with family members and untrustworthy relationships with other residents and staff, as well as emotional conflict (Zakaria, Alavi, & Subhi, 2013). A recent study by Amzat and Jayawardena (2016) reported two factors contributed to loneliness in ten older residents in RACFs which were health-related problems and weak family connections. A review that examined older people living in RACFs identified several factors that could contribute to loneliness (Grenade & Boldy, 2008). These included poor health and diminished cognitive capacity, less contact with family members, less meaningful social connections with other residents and unfamiliar environments. Little evidence was reported regarding the risk factors for anxiety for those living in long-term care. Drageset, Eide, and Ranhoff (2013) conducted a cross-sectional study of 227 older people with more than six months as a resident in long-term care and found several risk factors for anxiety. These included social-related problems such as social withdrawal and loss of significant others, and being institutionalised, as well as physical disability. A Baldacchino and Bonello (2013) study, involving face-to-face interviews of 42 older residents in four nursing homes also found almost similar risk factors for anxiety and depression. This study reported factors of a physical nature such as decreased mobility, social isolation when residents feel a loss of connection with their homes, friends and families, and also a lack of ability in making decisions. For depression, risk factors for those living in RACFs have been found to include health-related problems such as cancer and increased cognitive problems (Boorsma et al., 2012). In a study involving 274 residents in seven RACFs in Canada found almost similar risk factors for depression (McCusker et al., 2014). These were health-related problems such as delirium, pain, diabetes and cognitive impairments.

Overall, many but not all risk factors for loneliness, anxiety and depression in older people living in long-term care were similar. Health and social-related problems have been identified as common risk factors for loneliness, anxiety and depression in older people residing in RACFs. Social-related
problems such as decrease social connections and interactions were strongly related to loneliness; more so than anxiety and depression. Nevertheless, the similarities of risk factors for loneliness, anxiety and depression suggested that these problems may be usefully targeted together.

### 3.2.3 The impact of loneliness, anxiety and depression in older people

Loneliness, anxiety and depression can have a significant impact on the lives of older people. For example, a longitudinal study involving 2101 adults aged 50 years and over in the United States of America found that loneliness can be a risk factor for mortality (OR = 1.14, 95% CI 1.06 – 1.23) (Luo, Hawkley, Waite, & Cacioppo, 2012). A more recent longitudinal study over 19 years found loneliness to be a predictor of mortality in older men (OR = 1.50, 95% CI 1.31 - 1.72) and older women (OR = 1.49, 95% CI 1.29 – 1.71) (Holwerda et al., 2016). Holwerda et al. (2016) also reported depression to be a significant predictor of mortality in older men (OR = 1.43, 95% CI 1.17 - 1.74) and older women (OR = 1.44, 95% CI 1.21 - 1.70).

A literature review found that depression was the common mental disorder present in most suicides carried out by older people (Kiosses, Szanto, & Alexopoulos, 2014). Conwell, Van Orden, and Caine (2011) reported in a review that depression had been identified in up to 97% of suicide deaths in older people. Meanwhile, loneliness and anxiety were found associated with suicidal ideation in older people with depression (Kiosses et al., 2014).

In addition to their relationships with mortality, these conditions can also affect the health and quality of life of older people. Luanaigh and Lawlor (2008) reported in their literature review that loneliness can be a risk factor for health deficiencies such as a high risk of developing dementia and cardiovascular diseases. Loneliness was found to predict an increase in blood pressure at two, three and four years later (B = 0.15, SE 0.09, p < 0.05) (Hawkley, Thisted, Masi, & Cacioppo, 2010). This longitudinal study with a sample of 229 older people measured blood pressure in each of five consecutive years. In a study that involved 3530 older people living in the community, it was found that loneliness was significantly correlated with increased hospital visits (B = 0.075, SE = 0.034, p < 0.001) (Gerst-Emerson & Jayawardhana, 2015).

Older people with anxiety and depression are more prone to report a low quality of life, various types of diseases and have a shorter lifespan (Freudenstein, Jagger, Arthur, & Donner-Banzhoff, 2001). A cross-sectional study involving 350 older people from 17 RACFs in the Netherlands reported a significant impact of anxiety and/or depression to less wellbeing (B = 4.70, 95% CI 3.73 – 5.67) (Smalbrugge et al., 2006). These included higher usage of medications and increased consultations.
with medical professionals. Depression can also impact one’s cognitive status. Mild depression (B = -0.08, 95% CI 0.14 – -0.02, p = 0.01) and severe depression (B = -0.2, 95% CI -0.28 – -0.06, p = 0.003) were found to be significantly related to cognitive decline (Donovan et al., 2016).

Therefore, loneliness, anxiety and depression are serious mental health problems with considerable implications, including suicide, for the wellbeing of individuals. Identification of older people with these problems can aid in early intervention and treatment which could potentially decrease the negative impact of these problems in older people. Innovative interventions, particularly those with minimal risk of harm such as reminiscence therapy (RT) should be of great benefit to the broader aged care system as well.

3.3 A review of prevalence rates of loneliness, anxiety and depression

A review of the prevalence rates of loneliness, anxiety and depression was conducted to understand how often older people living in long-term care develop these problems. This study is the first attempt to present the prevalence rates of loneliness, anxiety and depression among older people living in long-term care settings such as RACFs, nursing homes and assisted living facilities in one study. Previous reviews of the prevalence rates of anxiety involved older people with confirmed anxiety disorders and involved populations other than long-term care settings (Ong et al., 2016; Wolitzky-Taylor et al., 2010). Further, no previous review has reported the prevalence rates of loneliness in Malaysia. Previous reviews of prevalence rates of depression in older people living in long-term care settings were based in developed countries in Europe and North America. Other researchers have suggested a future review and collection of data from developing countries (Seitz, Purandare, & Conn, 2010).

A systematic search was conducted to identify the relevant articles. The search was conducted using electronic databases including Medline, CINAHL, PsycINFO and Cochrane library such as Cochrane Database of Systematic Review, Other Reviews and Trials with the keywords: prevalence AND loneliness OR anxiety OR depression AND older people OR older adults OR elder AND residential care OR assisted living OR nursing home. Grey literature (Google Scholar) was included in the review. Reference lists of retrieved articles were read to identify studies eligible for inclusion. The search was limited to studies published in English and Malay from 2000 to 2017 to retrieve only the most current studies. Studies were included if they estimated the prevalence of loneliness, anxiety and depression in long-term care as an outcome measure. This review excluded studies that involved participants younger than 60 years and participants living in the community, or hospitalised samples.
The studies that used mixed population such as mixed age groups and mixed settings were excluded, unless a clear separation between these populations was reported.

The search strategy yielded 984 studies through Medline (46), CINAHL (256), PsycINFO (106), Cochrane library (433) and grey literature (143). Of the 984 studies, 18 met the inclusion criteria. The reasons for excluding 964 studies were due to: not measuring prevalence, samples younger than 60 years, and full-text articles published in Spanish, Dutch, French and Norwegian. Of 18 studies, three measured both anxiety and depression and one measured both loneliness and depression. Two studies measured prevalence rates of loneliness, four measured prevalence rates of anxiety, and 16 measured the prevalence rates of depression (Table 3.1).
Table 3.1 Prevalence rates of loneliness, anxiety and depression among older people living in long-term care settings

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Total Participants/Gender(N)</th>
<th>Minimum Age (Years)</th>
<th>Number Long-term Care</th>
<th>Prevalence Rate (%)</th>
<th>Measurements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Loneliness</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Jayasinghe, Rocha, Sheeran, Wyka, and Bruce (2013)</td>
<td>USA</td>
<td>249 F: 152 M: 97</td>
<td>65</td>
<td>30 NHs</td>
<td>3.2</td>
</tr>
<tr>
<td>3.</td>
<td>Khairudin et al. (2011)</td>
<td>Malaysia</td>
<td>100 F: 49 M: 51</td>
<td>65</td>
<td>Not reported</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Brown et al. (2002)</td>
<td>USA</td>
<td>42901 F: 32275 M: 10626</td>
<td>65</td>
<td>1,492 NHs</td>
<td>10.9</td>
</tr>
<tr>
<td>4.</td>
<td>Goud and Nikhade (2015)</td>
<td>India</td>
<td>80 F: 51 M: 29</td>
<td>60</td>
<td>2 RACFs</td>
<td>53.8</td>
</tr>
<tr>
<td></td>
<td>Study</td>
<td>Country</td>
<td>Sample Size</td>
<td>Gender</td>
<td>Age</td>
<td>Setting</td>
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<tr>
<td>5.</td>
<td>Khairudin et al. (2011)</td>
<td>Malaysia</td>
<td>100</td>
<td>F: 49 M: 51</td>
<td>65</td>
<td>Not reported</td>
</tr>
<tr>
<td>8.</td>
<td>Levin et al. (2007)</td>
<td>(USA)</td>
<td>76735</td>
<td>F: 57627 M: 19108</td>
<td>65</td>
<td>921 NHs</td>
</tr>
</tbody>
</table>

Note: AGECAT: the Automated Geriatric Examination for Computer-assisted Taxonomy system; ALF: Assisted living facilities; BAI: Beck Anxiety Inventory; CAS: Clinical Anxiety Scale; C-GDS-SF: the Chinese version of the Geriatric Depression Scale—Short Form; CESD-S: the Center for Epidemiological Studies Depression Scale; CSSD: Cornell Scale for Depression in Dementia; F: Female; FS: Friendship Scale; GDS-15: the 15 items Geriatric Depression Scale; GDS-30: the 30 items Geriatric Depression Scale; HADS: The Hospital Anxiety and Depression Scale; M: Male; MDS: Minimum Data Set; NH: Nursing homes; RACF: Residential aged care facilities, RAID: The Rating Anxiety in Dementia; SPS: Social Provision Scale; USA: the United States of America
From the retrieved studies, two reported the prevalence rates of loneliness among older people in two different countries: 56% in Norway (Drageset et al., 2011) and 95.5% in Malaysia (Nikmat et al., 2015). The search strategy found four studies investigating prevalence rates of anxiety that met the inclusion criteria (Drageset et al., 2013; Jayasinghe et al., 2013; Khairudin et al., 2011; Neville & Teri, 2011). The prevalence rates ranged from 3.6% to 38%. Sixteen studies investigating the prevalence of depression met the inclusion criteria (Al-Jawad et al., 2007; Brown et al., 2002; Drageset et al., 2013; Goud & Nikhade; Hoover et al., 2010; Khairudin et al., 2011; Khaw et al., 2009; Ku et al., 2006; Levin et al., 2007; Lin et al., 2007; Lun Chow et al., 2004; McDougall et al., 2007; Neville & Teri, 2011; Nikmat et al., 2015; Normala et al., 2014; Shahar et al., 2011; Tsai, 2006). The results revealed a huge variation in the prevalence rates of depression among older people living in long-term care settings, from 11% to 85.5%. Overall, the results suggest high prevalence rates of loneliness, anxiety and depression among older people living in long-term care. Malaysia reported the highest rates of loneliness at 95.5% (Nikmat et al., 2015), anxiety at 38% (Khairudin et al., 2011) and depression at 85.5% (Nikmat et al., 2015). However, it is important to note that Nikmat et al. (2015) study involved older people with cognitive impairment, which is associated with increased risk of loneliness and depression.

Overall, research reports differed in the methodology and research designs implemented, which may account for the wide variability in findings. For example, the two studies addressing loneliness used a distinctive research population and different old age classifications. The anxiety studies involved different populations drawn from the United States of America (USA) (Jayasinghe et al., 2013; Neville & Teri, 2011), Norway (Drageset et al., 2013) and Malaysia (Khairudin et al., 2011). Likewise, the depression studies were conducted in several countries including the USA, Taiwan, Malaysia, Hong Kong, India, Norway, England and Wales. Six studies were conducted in Malaysia, with sample sizes differing substantially from 71 to 76735 participants.

The number of settings involved may also influence the variation of prevalence rates of depression. The studies reporting the prevalence rates of depression ranged from one setting to 1492 settings. As a result, the wide variety of settings may contribute to the wide range of prevalence rates of depression. Although all the studies of loneliness and anxiety were conducted from more than one site, the range of settings was not too different. Loneliness studies involved four to 30 long-term care settings. Meanwhile, anxiety studies involved 18 to 30 long-term care settings, except for one study that did not report the specific number of nursing homes involved (Khairudin et al., 2011).
The measures used for each of the key constructs differed between studies. For example, the loneliness studies used the Social Provision Scale (Cutrona & Russel, 1987) and the Friendship Scale (Hawthorne, 2006). Similarly, several tools were used to screen for anxiety such as the Clinical Anxiety Scale (Snaith, Baugh, Clayden, Husain, & Sipple, 1982), Beck Anxiety Inventory (Beck, Epstein, Brown, & Steer, 1988) and the Hospital Anxiety and Depression scale (Zigmond & Snaith, 1983). Further, different depression scales were used such as the 15 item Geriatric Depression Scale (GDS-15) (Sheikh & Yesavage, 1986), Minimum data set (MDS) assessment (Minimum Data Set Plus Training Manual, 1991), the 30 item Geriatric Depression Scale (GDS-30) (Yesavage et al., 1982), Center for Epidemiological Studies Depression Scale (Radloff, 1977), Automated Geriatric Examination for Computer Assisted Taxonomy (AGECAT) (Copeland, Dewey, & Griffiths-Jones, 1986) and Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983). The studies also used different criteria for depression, for example, Nikmat et al. (2015) reported high prevalence rates of depression (85.5%) based on depressive symptoms using the 15 item Geriatric Depression Scale and Brown et al. (2002) reported lower prevalence rates of depression (11%) based on participants who were clinically diagnosed with depression. Therefore, careful interpretation is needed.

Despite the heterogeneity of the findings, it can be argued that the prevalence rates of loneliness, anxiety and depression in older people living in long-term care settings is high. The high prevalence rates of loneliness, anxiety and depression among older people living in long-term care settings indicate that these mental health problems need to be taken seriously as their severity may contribute to a decrease in the quality of life and the increased morbidity and mortality of the individual. This is a pressing concern and shows strong cause for intervention research.

### 3.4 Treatments for loneliness, anxiety and depression in older people

For many years, pharmacological interventions and non-pharmacological interventions have been the primary effective treatments for anxiety and depression. The pharmacological interventions for depression involve antidepressants. Selective serotonin reuptake inhibitors and monoamine oxidase inhibitors were all found effective in comparison to placebos when treating depression among institutionalised older people (Wilson et al., 2001). Anxiolytic medications such as benzodiazepines are the most common pharmacological treatment for anxiety in older people (Lindsey, 2009). Antidepressants were the primary option to treat Generalised Anxiety Disorder (GAD) in older people (Flint, 2005). As for loneliness, however, it is a condition that does not require medication to control the symptoms.
While medication may be the first preference for health care providers instead of non-pharmacological interventions, there is growing interest with using other modalities due to the adverse effects of medications such as the risk of falls (Frazer et al., 2005; Wolitzky-Taylor et al., 2010) and risk of orthostatic hypotension associated with fractures (Lindsey, 2009). Furthermore, older people showed inadequate responses to antidepressants, including the possibility of medication interactions (Jonsson et al., 2016). Therefore, there is a need for evidence-based non-pharmacological intervention for anxiety and depression. Non-pharmacological interventions are also suitable for loneliness, which does not require medication.

In a review about the management of loneliness among older people living in RACFs, several non-pharmacological interventions were found useful. These included reminiscence therapy (RT), pet ownership, gardening, leisure and volunteer activities (Brownie & Horstmanshof, 2011). Two recent systematic reviews found that non-pharmacological interventions such as cognitive behavioural therapies, RT and problem-solving therapy were effective in improving depression among older people (Apóstolo, Bobrowicz-Campos, Rodrigues, Castro, & Cardoso, 2016; Jonsson et al., 2016). In a systematic review and meta-analysis of 27 randomised controlled trial studies found that both pharmacological interventions and non-pharmacological interventions were effective in treating anxiety, particularly GAD (Gonçalves & Byrne, 2012).

The treatment for major depressive disorder among older people is well-established in Malaysia. Based on the Malaysian Clinical Practice Guidelines (CPG) for depression, the first-line antidepressants for major depressive disorder are selective serotonin reuptake inhibitors (Ministry of Health Malaysia, 2007). Additionally, for depression, psychological interventions such as problem-solving therapy, interpersonal therapy, brief psychodynamic therapy and reminiscence therapy should be provided to older people with depression as well as medication. Electroconvulsive therapy (ECT) should be provided for older people with life-threatening depression. No guidelines have been given for the treatment of anxiety; however, psychotherapy has been suggested for older people with dementia and anxiety symptoms based on Malaysia’s CPG for dementia (Ministry of Health Malaysia, 2009). Malaysia’s CPG showed that it supported the practice of RT for older people with anxiety and depression; however, there is no specific treatment or intervention promoted to treat loneliness among older people, in spite of previous studies showing that loneliness was interrelated with anxiety and depression. As loneliness does not require medication for the control of symptoms, using RT for those with loneliness could be suggested.
Despite the effectiveness of medications and psychosocial interventions, older people living in RACFs are prone to under-treatment. Several factors contribute to under-treatment such as the belief that these conditions are a part of the ageing process (Benek-Higgins et al., 2008). Loneliness, anxiety and depression may be interpreted as normal ailments among older people, thereby preventing or delaying timely and proper treatment. The lack of a standard screening process for older people living in RACFs may also contribute to the under-treatment of these conditions (Watson, Zimmerman, Cohen, & Dominik, 2009). Further, misdiagnosis and confusion with the symptoms of other conditions can hide these problems. Anxiety in older people is frequently masked by dementia which has made its detection and diagnosis difficult (Bryant et al., 2013). Another common misconception is that anxiety always exists with depression, yet many older people have anxiety without depression (Bryant, Jackson, & Ames, 2008). This misconception may also arise from the co-existence of physical problems; for instance, older people with depression may be underdiagnosed due to the presence of physical symptoms such as fatigue, sleep deprivation and general pain experiences (Benek-Higgins et al., 2008). Additionally, older people generally deny the physical symptoms are due to depression and relate the symptoms to physical problems (Benek-Higgins et al., 2008). As a result of these factors, loneliness, anxiety and depression can be under-recognised, misdiagnosed and under-treated among older people living in RACFs.

Overall, both non-pharmacological and pharmacological interventions have been applicable to treat problems of anxiety and depression. With the concern of side effects from medications, non-pharmacological interventions should be the first choice; however, older people are at risk of under-treatment. This significant gap in the use of non-pharmacological interventions is concerning, particularly given the serious impact of these mental health problems on older people and the high prevalence rates of these problems among those living in long-term care such as in RACFs.

3.5 Summary
This chapter explored the evidence of the interrelated symptoms of loneliness, anxiety and depression in older people and the relationships between these mental health problems. Research indicates several risk factors for loneliness, anxiety and depression such as health and social-related problems. Social related problems such as reduced social connection and social withdrawal can be key factors in developing treatments for loneliness, anxiety and depression. The high prevalence rates of these conditions in older people living in RACFs, especially in Malaysia, suggest the urgent need for treatment among this group of older people. Current approaches to treatment include both pharmacological and non-pharmacological interventions; however, older people living in a RACF are at risk of under-treatment. Overall, these findings suggest the need for non-pharmacological
interventions such as RT to treat loneliness, anxiety and depression. Therefore, searching for evidence of the effectiveness of RT, especially in Malaysia, is important before this intervention can be suggested to older people with loneliness, anxiety and depression.

Chapter 4 discusses RT for older people with loneliness, anxiety and depression.
Chapter 4  Reminiscence therapy

4.1  Introduction
Reminiscence therapy (RT) provides benefits to older people in dealing with their past life; however, the evidence is as yet not conclusive in supporting RT. Social identity theory offers the most useful approach to understand RT because it addresses a key factor in loneliness, anxiety and depression among older people which is social connection and interaction. Although Group RT has been widely practiced in the Malaysian population, its effectiveness among older people in the Malaysian population has never been tested. This gap in knowledge about the effectiveness of Group RT within the Malaysian population will be discussed in this chapter.

4.2  Overview of reminiscence therapy
RT can be defined as a discussion of memories with other individuals or in a group with the aid of triggers such as photos and music (Cho, 2016; Woods, Spector, Jones, Orrell, & Davies, 2005). RT was first introduced by Butler (1963) within the concept of life review. Butler (1963) described life review as a recall of past experiences or events where individuals reflected their bitter and happy memories. Life review included evaluation of memories in a sequential approach such as memories starting from young age to old age and was usually conducted in an individual approach (Woods et al., 2005). Life review as a therapy focused on the systematic evaluation of negative past events and struggles (Westerhof & Bohlmeijer, 2014). RT, on the other hand, does not focus on a sequential approach and on every detail of one’s memories (Afonso, Selva, & Postigo, 2015; Haight & Webster, 1995). RT is focused on the social and emotional benefit that the individual receives and not so much on the stories (Gillies & James, 2013). This feature of RT is different with other therapy such as oral history where the focus is on oral contributions for the purpose of recording history (Gillies & James, 2013) or dignity therapy where the focus is on recorded stories to improve dignity of terminally ill patients (Hall, Goddard, Opio, Speck, & Higginson, 2012).

The features of RT can also be identified based on five components of recall which are unique to RT (Figure 4.1).

(1) Evaluation: People evaluate their memories during RT and after RT. They may need assistance from the facilitator to access their memories, or it can occur within themselves or with help from other people;
(2) Spontaneity: Memories can be recalled with a specific aim or purpose such as using photos related to the themes of the sessions;
(3) Structure: RT is structured in small components, with specific topics for each session. People can share the stories that they believe are related to the topics;

(4) Frequencies: Triggers increase the frequency of memory recall in RT;

(5) Comprehensiveness: The process of memory recall in RT lacks comprehensiveness, because the focus is on the benefits of recalling memories and not the details of these memories.

**Figure 4.1** Five elements of recall in the process of reminiscence for reminiscence therapy

(Haight & Webster, 1995)

RT is a useful approach for older people with loneliness, anxiety and depression because it provides benefits such as a supportive therapeutic environment (Liu, Lin, Chen, & Huang, 2007; Wang, Hsu, & Cheng, 2005). The environment encourages older people to share their life stories with other people where they may feel supported through the process of RT, for example sharing similar experiences and giving and receiving attention (Hsu & Wang, 2009). Older people feel appreciated when someone is willing to spend time with them and listening to their stories. The process of sharing life stories also allows older people to express sad, happy or regretful feelings about their past life in a therapeutic environment, which can provide them some relief (Wong & Watt, 1991).
RT offers a platform for older people to find meaning in their own lives (Chueh & Chang, 2014; Hallford, Mellor, & Cummins, 2012). The process of sharing memories is not only focused on the stories, but also related to the feelings behind the memories, whether positive or negative (Mackinlay & Trevitt, 2010). In relation to negative feelings, the process of sharing memories assists older people to learn from their negative experiences and how these can shape their present life (de Guzman et al., 2009; Mackinlay & Trevitt, 2010; Westerhof & Bohlmeijer, 2014). The process of RT helps older people to search for meaning in their life from their memories.

RT offers a coping strategy, especially for those who have experienced painful life events. It assists older people in coping with bitter memories and to learn how to deal with the memories (Cappeliez & Robitaille, 2010; Hallford et al., 2012) and feelings of self-competence (Djukanović, Carlsson, & Peterson, 2016). That is, this strategy helps older people to modify their perception towards bitter memories and learn to cope with them. Several studies have reported that this approach was found to be beneficial for older people with depression (Gaglioli et al., 2013; Hallford & Mellor, 2013; Melendez Moral, Fortuna Terrero, Sales Galan, & Mayordomo Rodriguez, 2015; Meléndez-Moral, Charco-Ruiz, Mayordomo-Rodríguez, & Sales-Galán, 2013) and anxiety (Gibson, 2011).

Although the majority of studies reported the benefits that RT could offer to older people (Gibson, 2011; Liu et al., 2007), there is a possibility that RT could also bring harm to older people. A literature review of RT for older people with depression in long-term care facilities suggested that not all older people received benefits from RT, especially older people with depression (Housden, 2009). Older people with depression were susceptible to problems reconciling with their memories. That is, RT may trigger traumatic memories and could bring harm and serious complications to their psychological health (Housden, 2009). If such situations occur, Housden (2009) suggested assessment and monitoring of psychological health before and after RT to prevent an event where older people may be traumatised or experience depressive episodes from recalling memories. Despite the potential for such a harmful effect of RT, to date there are no published studies that have reported adverse effects of RT for older people.

RT is widely practised in long-term care settings such as RACFs because of the belief that RT is a worthwhile therapy for older people (Kris, Henkel, Krauss, & Birney, 2017). RT was firstly practised for the purpose of social communication and diversional therapy (Westerhof et al., 2010). The practice of RT has since been changed from simply a social interaction and leisure activity to more a therapeutic role for psychological problems (Woods et al., 2005). The change of practice was due to RT showing a positive impact on older people’s wellbeing and psychological health (Woods et al.,
Liu et al. (2007) reported that Taiwanese older people provided positive feedback about RT, including that they felt happy and less lonely by participating RT. Furthermore, Haslam et al. (2010) conducted RT for older people with anxiety and depression and found that participants reported feeling more connected to other participants after being involved in RT. In a recent study involving 18 participants, older people positively evaluated RT because it provided an understanding of themselves, improved social connections, and enhanced self-esteem (Djukanović et al., 2016). The practice of RT also received active support from health care providers working in long-term care settings. RT is listed in the Nursing Intervention Classification (NIC) (Bulechek et al., 2008) which has suggested RT is a part of a nurse’s role. This recommends that nurses could perform this intervention independently as skilled reminiscence therapists (Budi et al., 2012; Bulechek et al., 2008; Nugent, 1995). RT was highly valued by the RACF staff as a useful psychosocial treatment (Woods et al., 2005). In a recent study by Kris et al. (2017) involving 43 nursing caregivers (registered nurses, licensed practical nurses and certified nursing assistants) practising RT, it was found that 76.8% of nursing caregivers reported RT was a very pleasurable experience. Thus the acceptability of RT among older people and RACF staff has been demonstrated.

Overall, RT offers several benefits to older people such as a supportive environment, guidance to understand the meaning of their life and coping skills that may support the practice of RT in a RACF. RACF nursing staff and other health care workers can conduct RT as a core part of their work is to have meaningful and/or therapeutic interactions. Skills and training can be obtained by personal study of evidence based research and protocols, attending RT courses and conferences (Gudex, Horsted, Jensen, Kjer, & Sørensen, 2010; Klever, 2013). Given support for the implementation of RT in RACFs shown in previous research, it is important to further investigate the potential of RT for mental health problems in older people.

4.3 The effectiveness of reminiscence therapy
To the best of our knowledge, there has been no systematic review published on the effectiveness of RT for loneliness and anxiety, but several have been published on the effectiveness of RT for depression. The most recent systematic review involving non-pharmacological interventions, including RT for older people with depression, argued that RT is a valuable therapy for older people with depression, although the evidence of RT for older people with depression is unconvincing (Apóstolo et al., 2016; Franck, Molyneux, & Parkinson, 2016; Jonsson et al., 2016). The Apóstolo et al. (2016) study reviewed several non-pharmacological interventions for older people with depression such as cognitive behavioural therapy, competitive memory training, RT, problem adaptation therapy and problem-solving therapy. However, results regarding the effectiveness of RT for depression were
not convincing, as only one published RT study was included in the review. Similarly, Franck et al. (2016) claimed the effectiveness of RT based on one study only. Jonsson et al. (2016) reviewed 14 randomised control trials (RCTs) on psychological treatment of depression such as RT, cognitive behavioural therapy (CBT) and problem-solving therapy. Of 14 studies, only three studies used RT. The results showed RT to be effective; however, this was based on limited evidence or few published studies to date (Jonsson et al., 2016). Given the limited evidence in available systematic reviews, a review of RT for older people with loneliness, anxiety and depression was conducted.

A systematic search was conducted to identify research related to the effectiveness of RT. The search strategy involved peer-reviewed literature: Medline, CINAHL, PsycINFO and Cochrane library such as Cochrane Database of Systematic Review, Other Reviews and Trials, using the keywords: reminiscence AND loneliness OR anxiety OR depression OR depressive symptoms. Grey literature (Google Scholar) was included in the review. Reference lists of retrieved articles were read to identify studies eligible for inclusion. The search was limited to papers published in English and Malay from 2002 to 2017 to retrieve only the most current studies. It included RT studies measuring outcomes for loneliness, anxiety or depression that have been conducted in any setting and involved individual or group RT. This review excluded systematic reviews, studies that involved participants younger than 60 years and older people with clinically diagnosed dementia. The search strategy yielded 1140 studies through Medline (391), CINAHL (505), PsycINFO (129), Cochrane library (50) and grey literature (65). Of 1140 studies, 30 met the inclusion criteria. Three studies measured more than one outcome. The reasons for excluding 1110 studies were due to loneliness, anxiety and depression not being the main focus of the study, and/or involving participants younger than 60 years. The total number of studies that were included in the review was four studies on loneliness, five studies on anxiety and 24 studies on depression (Table 4.1).
Table 4.1 Summary of studies about reminiscence therapy for older people with loneliness, anxiety and depression

<table>
<thead>
<tr>
<th>Authors/Year/Country</th>
<th>Design</th>
<th>Setting</th>
<th>Sample size (n)</th>
<th>Interventions (n)</th>
<th>Theory</th>
<th>Duration (weeks)</th>
<th>Outcome measures</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Studies of Loneliness</strong></td>
<td></td>
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<tr>
<td>Liu et al./2007/Taiwan</td>
<td>Quasi-experimental</td>
<td>Community</td>
<td>26</td>
<td>GRT</td>
<td>-</td>
<td>10 weeks</td>
<td>UCLA-LS</td>
<td>Effective in reducing loneliness ($p&lt;0.05$)</td>
</tr>
<tr>
<td>Chiang et al./2010/ Taiwan</td>
<td>Experimental</td>
<td>Nursing homes</td>
<td>92</td>
<td>GRT</td>
<td>-</td>
<td>2 months</td>
<td>UCLA-LS</td>
<td>Significantly improved feelings of loneliness until 3 months follow-up ($p&lt;0.0001$)</td>
</tr>
<tr>
<td>Gaggioli et al./2013 Milan, Italy</td>
<td>Quasi-experimental</td>
<td>Social senior center</td>
<td>32</td>
<td>Intergenerational GRT</td>
<td>-</td>
<td>3 weeks</td>
<td>ILS</td>
<td>Significantly decreased feelings of loneliness ($t=2.195, p&lt;0.05$)</td>
</tr>
<tr>
<td>Nooripour, Ghasemzadeh, Rahnama, Ardekan, and Farnia/2015/Iran</td>
<td>Experimental</td>
<td>Community</td>
<td>70</td>
<td>GRT</td>
<td>-</td>
<td>6 weeks</td>
<td>UCLA-LS</td>
<td>Significantly reduced feelings of loneliness ($p&lt;0.03$)</td>
</tr>
<tr>
<td><strong>Studies of Anxiety</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Emery/2002/USA</td>
<td>Quasi-experimental</td>
<td>Assisted living facility</td>
<td>35</td>
<td>SRT &amp; GRT</td>
<td>Erikson’s theory</td>
<td>8 weeks</td>
<td>STAI</td>
<td>SRT &amp; GRT were not significantly effective for anxiety F (1.76, 1) =0.07, $p=0.20$</td>
</tr>
<tr>
<td>Haslam et al./2010/ Australia &amp; UK</td>
<td>Quasi-experimental</td>
<td>Nursing homes</td>
<td>73</td>
<td>GRT&amp; IRT</td>
<td>Social identity theory</td>
<td>6 weeks</td>
<td>HADS</td>
<td>Significant effect of group reminiscence, individual reminiscence and group control activity on wellbeing (anxiety) measures F (2, 71) =3.36, $p=0.04$</td>
</tr>
<tr>
<td>Haslam et al./2013/Australia &amp; Canada</td>
<td>Experimental</td>
<td>Community</td>
<td>40</td>
<td>Secular song RT, religious song RT and standard story RT</td>
<td>Social identity theory/ Religious identity</td>
<td>6 weeks</td>
<td>Geriatric Anxiety Inventory</td>
<td>Non significant effective for anxiety outcome *p-value not reported</td>
</tr>
</tbody>
</table>
### Studies of Depression

<table>
<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>Sample Size</th>
<th>Interventions</th>
<th>Duration</th>
<th>Outcome Measure</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emery/2002/USA</td>
<td>Quasi-experimental Assisted living facility</td>
<td>35</td>
<td>SRT &amp; GRT</td>
<td>8 weeks</td>
<td>GDS-15</td>
<td>SRT &amp; GRT were not significantly effective for depression F (0.06, 1) =0.00, p=0.81</td>
</tr>
<tr>
<td>Chiang et al./2010/Taiwan</td>
<td>Experimental Nursing home</td>
<td>92</td>
<td>GRT</td>
<td>2 months</td>
<td>CES-D</td>
<td>A significant reduction of CES-D after 3-months follow-up (p&lt;0.0001)</td>
</tr>
<tr>
<td>Haslam et al./2010/ Australia &amp; UK</td>
<td>Quasi-experimental Care homes &amp; Specialised care units</td>
<td>73</td>
<td>GRT &amp; IRT</td>
<td>6 weeks</td>
<td>HADS</td>
<td>Significant effect of GRT &amp; IRT on wellbeing (depression) measures F (2, 71) =3.36, p = .04</td>
</tr>
<tr>
<td>Shellman, Mokel and Hewitt/2009/USA</td>
<td>Quasi-experimental Community</td>
<td>56</td>
<td>Integrative RT</td>
<td>13 weeks</td>
<td>CES-D</td>
<td>Significant decreased of CES-D on depression after intervention, F(2, 52) = 8.6, p = .001</td>
</tr>
<tr>
<td>Afonso, Bueno, Loureiro, and Pereira (2011)/Portugal</td>
<td>Experimental A health centre</td>
<td>90</td>
<td>GRT</td>
<td>5 weeks</td>
<td>GDS</td>
<td>A significant effect of GDS mean scores *p-values not reported</td>
</tr>
<tr>
<td>Chueh and Chang/2014/Taiwan</td>
<td>Quasi-experimental Nursing home</td>
<td>21</td>
<td>Group RT</td>
<td>4 weeks</td>
<td>The Taiwan GDS</td>
<td>The mean score of the Taiwan GDS decreased significantly at post-test (p&lt;0.001), after 3 months (p=0.005) and after 6 months (p=0.001)</td>
</tr>
<tr>
<td>Hanaoka, Muraki, Yamane/2011/ Japan</td>
<td>Quasi-experimental Community</td>
<td>22</td>
<td>GRT</td>
<td>8 weeks</td>
<td>GDS-15</td>
<td>The average score of GDS-15 significantly reduced after intervention (p=0.008)</td>
</tr>
<tr>
<td>Karimi et al./2010/Iran</td>
<td>Experimental Nursing home</td>
<td>29</td>
<td>Integrative RT &amp; instrumental RT</td>
<td>6 weeks</td>
<td>GDS</td>
<td>Significant decreased of GDS after intervention (p&lt;0.01)</td>
</tr>
<tr>
<td>Study Authors and Year</td>
<td>Type of Study</td>
<td>Setting</td>
<td>Participants</td>
<td>Intervention Duration</td>
<td>Intervention</td>
<td>Control</td>
</tr>
<tr>
<td>------------------------</td>
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<tr>
<td>Sharif, Mansouri, Jahanbin and Zare/2010/Iran</td>
<td>Quasi-experimental</td>
<td>A day centre</td>
<td>49</td>
<td>GRT</td>
<td>Erikson’s theory</td>
<td>3 weeks</td>
</tr>
<tr>
<td>Stinson &amp; Kirk/2006/USA</td>
<td>Experimental</td>
<td>Assisted living facilities</td>
<td>24</td>
<td>GRT</td>
<td>Erikson’s theory</td>
<td>6 weeks</td>
</tr>
<tr>
<td>Hsu and Wang/2009/Taiwan</td>
<td>Quasi-experimental</td>
<td>Four long-term care facilities</td>
<td>45</td>
<td>GRT</td>
<td>-</td>
<td>6-8 weeks</td>
</tr>
<tr>
<td>Wilson/2006/USA</td>
<td>Quasi-experimental</td>
<td>2 nursing homes</td>
<td>45</td>
<td>GRT</td>
<td>-</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Chao et al./2006/Taiwan</td>
<td>Quasi-experimental</td>
<td>A nursing home</td>
<td>24</td>
<td>GRT</td>
<td>-</td>
<td>9 weeks</td>
</tr>
<tr>
<td>Liu, Lin, Chen and Huang/2007/Taiwan</td>
<td>Quasi-experimental</td>
<td>Community</td>
<td>26</td>
<td>GRT</td>
<td>-</td>
<td>10 weeks</td>
</tr>
<tr>
<td>Willemse, Depla, and Bohlmeijer (2009)/The Netherlands</td>
<td>Quasi-experimental</td>
<td>3 psychiatric hospitals &amp; 1 sheltered housing program</td>
<td>36</td>
<td>CRT</td>
<td>-</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Meléndez Moral, Fortuna Terrero, Sales Galán, &amp; Mayordomo Rodríguez, /2014/Republic Dominican</td>
<td>Quasi-experimental</td>
<td>Community</td>
<td>34</td>
<td>Integrative RT</td>
<td>-</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Meléndez-Moral et al./2013/Spain</td>
<td>Quasi-experimental</td>
<td>2 retirement houses</td>
<td>34</td>
<td>GRT</td>
<td>-</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Zhou et al. (2012)/China</td>
<td>Experimental</td>
<td>Community</td>
<td>125</td>
<td>GRT</td>
<td>-</td>
<td>6 weeks</td>
</tr>
<tr>
<td>Study Authors</td>
<td>Study Design</td>
<td>Setting</td>
<td>N</td>
<td>Intervention</td>
<td>Duration</td>
<td>Assessment</td>
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</tr>
<tr>
<td>Wang/2005/Taiwan</td>
<td>Quasi-experimental</td>
<td>Long-term care facilities</td>
<td>48</td>
<td>GRT</td>
<td>Erikson’s theory</td>
<td>4 months</td>
</tr>
<tr>
<td>Ghanbarpanah, Khoshknab, &amp; Mohammadi Shahbalaghi/2014/Iran</td>
<td>Experimental</td>
<td>Long-term care facilities</td>
<td>72</td>
<td>GRT</td>
<td>-</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Cho/2016/Korea</td>
<td>Quasi-experimental</td>
<td>Community</td>
<td>55</td>
<td>GRT</td>
<td>-</td>
<td>Six weeks</td>
</tr>
<tr>
<td>Choy &amp; Lou/2016/Hong Kong</td>
<td>Experimental</td>
<td>Elderly community centres</td>
<td>114</td>
<td>Instrumental RT</td>
<td>-</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Djukanović, Carlsson, &amp; Peterson/2016/Sweden</td>
<td>Quasi-experimental</td>
<td>Community</td>
<td>18</td>
<td>GRT</td>
<td>Erikson’s theory</td>
<td>10 sessions</td>
</tr>
<tr>
<td>Duyan, Şahin-Kara, Camur Duyan, Özdemir, &amp; Megahead/2016/Turkey</td>
<td>Quasi-experimental</td>
<td>Nursing homes</td>
<td>30</td>
<td>GRT</td>
<td>-</td>
<td>10 weeks</td>
</tr>
</tbody>
</table>

Note: CES-D: Center for Epidemiological Studies Depression Scale; CRT: Creative Reminiscence Therapy; GDS: Geriatric Depression Scale; GDS-S: Geriatric Depression Scale – Short Form; GRT: Group Reminiscence Therapy; HADS: Hospital Anxiety and Depression Scale; ILS: The Italian Loneliness Scale; IRT: Individual reminiscence therapy; UCLA-LS: UCLA Loneliness Scale; SRT: Spiritual reminiscence therapy
The retrieved studies (see Table 4.1), showed that RT was effective for loneliness outcomes (Chiang et al., 2010; Gaggioli et al., 2013; Liu et al., 2007; Nooripour, Ghasemzadeh, Rahnama, Ardekani, & Farnia, 2015). These studies conducted RT in groups and it can be speculated that the effectiveness might be in some way related to the group situation. For anxiety outcomes, three out of five studies found significant differences (Haslam et al., 2010; Pishvaei, Ataie Moghanloo, & Ataie Moghanloo, 2015; Rawtaer et al., 2015). For depression outcomes, the studies showed mixed findings of RT. Overall, RT was effective for loneliness but had mixed findings for anxiety and depression. These results were due to different methodological approaches such as different research designs, types of RT, contents of RT and number of RT sessions. Another possibility that can help to explain the mixed findings was from theoretical approaches that affect the process of RT. Each of these differences will be discussed in detail in the following section.

4.3.1 Methodological issues

Varying research designs, such as randomised controlled trials (RCTs), quasi-experimental trials, and trials that used small samples leading to a lack of power, may have contributed to the mixed findings. It can be seen that previous studies employing small sample sizes ranging from 24 to 40 participants reported no significant results (Chao et al., 2006; Duyan et al., 2016; Emery, 2002; Haslam et al., 2013; Liu et al., 2007; Stinson & Kirk, 2006). Adequately powered RCTs may be a more suitable design to determine the effectiveness of RT. For example Zhou et al. (2012) used a RCT design with a sample of 125 older people and found significant results. A significant reduction in depression was found, suggesting that using more rigorous research designs and larger samples was needed to determine the effectiveness of RT.

Different types of RT lead to uncertainty about which types of RT are effective for a given study population. For example, Haslam et al. (2013) found that secular song RT, religious song RT and standard story RT were not effective for anxiety. Further analysis suggested that only religious song RT was associated with less anxiety. There was also the case of previous studies having used similar types of RT resulting in mixed findings. Two previous studies used group RT that produced mixed findings for older Taiwanese people living in long-term care (Chao et al., 2006; Chiang et al., 2010). These previous studies involved older people with depression, in which only Chiang et al. (2010) found that group RT was effective. This conflicting finding suggested that it was useful to explore the types of RT that are believed to be effective for the study population. It was supported in a study by Hanaoka, Muraki, Yamane, Shimizu, and Okamura (2011) about the importance of knowing the preferable types of RT from the study populations. Their study used odor RT, which uses smells as triggers for reminiscence, because the majority of participants preferred this type of RT to help them
recall memories. This finding highlights the importance of selecting the correct ‘fit’ or type of RT for a particular study population before the study is conducted.

The majority of previous studies tended to use RT specifically developed for this study, so there was no standardised RT in the reviewed studies. For instance, Liu et al. (2007) developed RT with the topics such as “unforgettable events”, “important life experiences” and “past and present”. In Haslam et al. (2010) topics differed across six-weeks of RT and included memories of childhood, school time, home life, marriages, personal life, and vacations. Liu et al. (2007) emphasised the significant events without specific topics; meanwhile Haslam et al. (2010) focused on memories that more related to individual/personal memories with the specific themes. Haslam et al. (2010) found significant results as opposed to Liu et al. (2007) whose results were found to be not significant. The selection process on what topics should be included in RT was not extensively discussed in previous studies. Thus, it might be useful to select suitable content of RT for the study population.

The length of an RT program required for effective outcomes is unclear from the previous literature. The effective length of a program aimed at loneliness, anxiety and depression has been shown to be as few as three weeks (Gaggioli et al., 2013; Sharif, Mansouri, Jahanbin, & Zare, 2010) and one study found significant results after implementation of RT for one year (Rawtaer et al., 2015). These three studies were conducted in community samples. In relation to older people living in RACFs, the effective length of time for RT programs was found to be between four weeks (Chueh & Chang, 2014) and four months (Wang, 2005). It has been suggested to use a longer program, or to include it as a regular scheduled activity in order to improve the wellbeing of older people (Cho, 2016). However, if a longer program is needed, the issue of dropout should be considered to ensure it would not influence the study results. Wang (2005) reported the dropout rate as 21.4% after four months of RT suggesting the length should consider participation rates. Based on the evidence, it can be suggested that a suitable length of program for RT sessions for older people living in RACFs is between four weeks and four months.

Overall, the results of the effectiveness of RT showed inconclusive results for anxiety and depression. Although RT was found effective for older people with loneliness, the evidence was based on four studies only. In view of the inconclusive findings, more RCTs are needed in support of this evidence. Generally, the variety of methodological approaches to examine RT were one of the main factors that led to the mixed evidence about the effectiveness of RT. Examining the range of theoretical approaches used may provide further understanding of the inconclusive findings.
4.3.2 Theoretical approaches

Another reason for the inconsistent findings of the effectiveness of RT might be due to different theoretical approaches in understanding RT, which affect how it’s practised. To date, there is no specific formal theory of RT (Webster & McCall, 1999). Three major theoretical approaches have been applied to support the use of RT for older people experiencing loneliness, anxiety and depression. These theories include Erikson’s theory of developmental stages (Erikson, 1963), social identity theory (Tajfel & Turner, 1979), and cognitive adaptation theory (O'Rourke, 2002) (Table 4.2). There is a different concept and ideological understanding in each theory. In Erikson’s theory, the emphasis is on the ability of an individual to achieve ego-integrity — the last stage in development. The ability to achieve “ego-integrity” means that an individual has accepted their life experiences, has gained wisdom, and is ready for the future, including facing death (Erikson, 1963). Cognitive adaptation theory also focuses on memories; however, this theory emphasises re-evaluation of bitter memories and developing positive thinking about one’s past and present life. Social identity theory focuses on helping people recognise their self-identity in social groups. The main key in this theory is group identification. Social identity theory speculates that each individual might position themselves within several groups that represent multiple social identities for them (Liu, Lawrence, Ward, & Abraham, 2002). Social identity can be useful especially when dealing with several challenges in life such as depression (Begeny & Huo, 2016; Cruwys et al., 2014), anxiety and psychological stress (Begeny & Huo, 2016). Social identity develops from social relationships and is useful in reducing these mental health problems just as previous studies suggested that social connectedness brings a sense of ‘us’ and could be useful in treating these mental health problems.
### Table 4.2 Theories in relation to reminiscence therapy

<table>
<thead>
<tr>
<th>Theories</th>
<th>Concept</th>
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<tbody>
<tr>
<td>Erikson’s theory of psychosocial development (1963)</td>
<td>Eight developmental stages:</td>
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<tr>
<td></td>
<td>• Stage 1 Oral-sensory (Trust versus distrust): children develop sense of trust whereby lack of care could contribute distrust</td>
</tr>
<tr>
<td></td>
<td>• Stage 2 Muscular-anal (Autonomy versus doubt): children develop sense of independence to achieve sense of autonomy</td>
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<td></td>
<td>• Stage 3 Locomotor-Genital (Initiative versus Guilt): children start to manipulate the environment to learn new things</td>
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<td></td>
<td>• Stage 4 Latency (Industry versus Inferiority): children learn to adapt to new environments, failing to adapt will lead to inferior feelings</td>
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<td></td>
<td>• Stage 5 Puberty and Adolescence (Identity versus Role Confusion): teenagers develop their personal identity, those who are unable to find their identity lead to role confusion</td>
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<td></td>
<td>• Stage 6 Young Adulthood (Intimacy versus Isolation): young adults develop personal relationships with others, those who failed to achieve this stage may develop social isolation</td>
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<td></td>
<td>• Stage 7 Adulthood (Generativity versus Stagnation): adults create new interests such as building family and career, those who failed in this stage generate stagnation</td>
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<tr>
<td></td>
<td>• Stage 8 Old age (Ego-integrity versus Despair): older people reflect their past lives, those who are not satisfied with their lives may develop despair</td>
</tr>
<tr>
<td>Cognitive adaptation theory (Taylor, 1983)</td>
<td>Three most important themes:</td>
</tr>
<tr>
<td></td>
<td>• Searching the purpose of life</td>
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<tr>
<td></td>
<td>• The process of control and management of life events</td>
</tr>
<tr>
<td></td>
<td>• The evaluation process of all the actions taken to handle life events</td>
</tr>
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Note: RT: Reminiscence therapy
Erikson’s theoretical approach suggests that RT is a useful intervention for older people to achieve the ego-integrity stage; that is, by helping the individual to recognise unsatisfactory life events, and discuss these with others. Previous studies support Erikson’s theory that older people can achieve the ego-integrity stage by recalling and evaluating past events (Djukanović et al., 2016; Sharif et al., 2010; Wang, 2005). A study that reported a reduction of depression after a six-week intervention supports group RT as a useful intervention in reducing depression (Stinson & Kirk, 2006). On the other hand, Emery (2002) used Erikson’s theory to guide RT and spiritual reminiscence therapy (SRT) with 35 assisted living residents; however, no significant differences in anxiety and depression were found. SRT is a subtype of RT which uses spiritual elements and concepts of RT. The study also measured other outcomes such as spiritual support and meaning in life and found significant findings for both RT and SRT. This suggests that the ego-integrity stage can still be achieved by using SRT and RT. This study claims that implementation of Erikson’s theory in the process of RT was useful in assisting older people with mental health problems to prevent despair and develop the ego-integrity stage by discussing and evaluating past events with others.

The use of cognitive adaptation theory as a framework for RT showed that RT was suitable in helping older people to alter their bitter memories towards more positive memories. One study used cognitive adaptation theory as a framework for RT (Shellman, Mokel, & Hewitt, 2009). The result showed that integrative RT had a positive effect on depression. Shellman et al. (2009) used integrative RT, a type of RT that addresses both past memories and current memories to assist the acceptance of others and themselves (Wong & Watt, 1991). This study included 56 older African Americans to determine the effectiveness of integrative RT on depression. However, the suitability of cognitive adaptation theory to explain RT is limited, due to inadequate available evidence to support the use of this theory in RT.

Social identity theory is a suitable theory to explain the social dimension of RT because it focuses on shared social identity that results from group RT. A study by Haslam et al. (2010) examined the effectiveness of group RT and individual RT on 73 older people living in RACFs. The results determined that a group-based intervention (group RT and control group activity) showed a significant effect on reducing anxiety and depression. This finding suggested development of a shared social identity between participants. Haslam et al. (2013) subsequently examined the effectiveness of story-based RT, religious song-based RT and secular song-based RT in a sample of 40 older people living in the community. In their study, religious song-based RT was related to an improvement of life satisfaction and reduced anxiety (Haslam et al., 2013). Their results support that a sense of shared religious identity (a type of social identity) in RT contributed to significant findings. Thus, it can be
supported that social identity theory is a suitable theory to link the findings from RT to a social dimension of RT.

Although previous studies integrated theory in their studies, there was a lack of a consistent established theoretical link with RT. Emery's (2002) study failed to acknowledge the contribution of the mechanism of RT to the development of Erikson’s theory. Similarly, previous studies showed a lack of a consistent established link with significant findings (Djukanović et al., 2016; Sharif et al., 2010; Shellman et al., 2009; Wang, 2005). Further, Stinson and Kirk (2006) used Erikson’s theory to design the study but did not link the non-significant findings with the theory. However, studies that linked their findings with a chosen theory (Haslam et al., 2010; Haslam et al., 2013) suggested that social identification based on social identity theory in the group activities resulted in positive improvements in reducing anxiety and depression (Haslam et al., 2010; Haslam et al., 2013).

Of these theoretical approaches, social identity theory offers the most useful approach to understand RT than Erikson’s theory and cognitive adaptation theory. From within social identity theory, RT may be seen as a group therapy that promotes self-identity. For instance, social identity theory recommended RT not only preserves social identity, but also improves the wellbeing of older people (Haslam et al., 2010). In comparison to social identity theory, Erikson’s theory is the most common theory used in RT studies. Erikson’s theory argues RT is useful to assist older people deal with their past life events and to prevent them from developing despair and frustration (Djukanović et al., 2016; Sharif et al., 2010; Stinson & Kirk, 2006; Wang et al., 2005). However, Emery's (2002) study used Erikson’s theory and failed to find significant effects for anxiety and depression, but it did find significant effects for spiritual support. On the other hand, the evidence of cognitive adaptation theory is limited to support the usefulness of this theory in RT. Further, the focus of cognitive adaptation theory on adapting undesirable feelings or memories (Shellman et al., 2009) may not be suitable because this theory is less focused on pleasant memories. Thus, social identity theory is most suitable for the present study, given that the focus is on shared social identity and the study is situated in a RACF.

### 4.3.2.1 Social identity theory

Social identity theory is concerned with people’s definition of their identity that develops through group memberships or in social environments (Liu, 2012; Russell, 2007). Development of social identity is a continuing process of interaction between people and the group (Liu, 2012) with the feelings of attachment and value to the group (Tajfel & Turner, 1979). Social identity theory posits that social relationships not only give connections between people but also cultivate a sense of ‘us’
or ‘who we are’ (Cruwys et al., 2014). The key principle of social identity theory is the transition of individual identity to social identity. Individual identity is when people have their own interest and behaviors that are different from other people (Cruwys et al., 2014). Social identity is centred on shared interests and behaviors with other people in a group (Cruwys et al., 2014; Hogg, 2016).

Social identity theory focuses on the power of group memberships to develop social identity. Social identity theory claims that feelings of being as a part of a group encourages people to feel as a part of a group (Cruwys et al., 2014). Once people believe that the group is meaningful they appreciate their group membership (Cruwys et al., 2014). Feeling part of the group, developed through group interaction, helps keep people motivated to participate in group activities (Haslam, 2012). The group membership promotes a sense of ‘us’ and helps to build shared social identity among people in group activities.

Social identity theory emphasises group identification. One way to instill the benefits of group identification could be done through group RT. Haslam et al. (2010) suggested that group RT promoted meaningful social engagement that created a sense of shared group identification among the group participants. Haslam et al. (2013) claimed that the mechanism of religious group RT promoted group identification and this identification helped in improving health outcomes of group participants. Therefore, social identity theory is suitable to explain the mechanism of group activities such as group RT.

Furthermore, social identity theory addresses a key factor in loneliness, anxiety and depression among older people — social connectedness (Haslam et al., 2010; Haslam et al., 2013). On entering a RACF, social interaction is decreased due to the loss of meaningful relationships with close friends and family (Brownie & Horstmanshof, 2011). Social interaction may be difficult among older people because they tend to appreciate old relationships (Amzat & Jayawardena, 2016). Reduced meaningful social interaction and social withdrawal may increase the possibility of developing loneliness (Amzat & Jayawardena, 2016; Cacioppo et al., 2015; Singh & Misra, 2009), anxiety (Baldacchino & Bonello, 2013) and depression (Baldacchino & Bonello, 2013; Singh & Misra, 2009). Therefore, to reduce loneliness, anxiety and depression, an intervention should integrate activity that increases social interaction. Based on social identity theory, RT, when conducted as a group, could be an effective treatment by creating meaningful social connectedness between people (Haslam et al., 2010; Haslam et al., 2013).

Published studies have provided support for this understanding as a basis for RT. To date, two studies
have used social identity theory as a basis for their studies (Haslam et al., 2010; Haslam et al., 2013). Previous studies that used social identity theory showed that group identification promotes self-identity within participants. For example, Haslam et al. (2013) found that mechanism of group religious song RT developed religious identity among participants. Haslam et al. (2010) suggested that mechanism of group RT promoted self-identity in group participants. However, it was uncertain whether the findings from previous studies could be generalised to a non-western population, such as that in Malaysia, as previous studies were conducted in Australia and the United Kingdom (UK) (Haslam et al., 2010) and Australia and Canada (Haslam et al., 2013). Wakefield et al. (2016) argued that nationality influences group identification. Group identification of the participants in western populations and Malaysian populations might differ in terms of the cultural values that influence a sense of self-identity. Cultural values are commonly visible in a multi-ethnic country in the form of social interaction and social values in order to preserve cultural identity in that population (Alegria, Atkins, Farmer, Slaton, & Stelk, 2010).

Overall, social identity theory is the most appropriate theory in explaining RT for the present study. Social identity theory supports the usefulness of a sense of shared social identity in RT for older people with loneliness, anxiety and depression. A sense of shared social identity can be promoted through the implementation of RT as a group intervention. Exploring the effectiveness of group RT is needed before this intervention can be implemented among older people with loneliness, anxiety and depression.

4.4 Group reminiscence therapy for older people with loneliness, anxiety and depression

The focus of group RT is to create meaningful social interactions through sharing memories with other people. There is evidence that this approach helps to encourage meaningful social interaction (Haslam et al., 2010) and a sense of belonging (Song, Shen, Xu, & Sun, 2014). Through the activities of sharing memories in the group, older people may feel connected to other people (Sabir et al., 2016) and a sense of social identity may develop (Haslam et al., 2010; Haslam et al., 2013). A meta-analysis of group RT which reviewed ten randomised controlled trials of group RT for older people with depression also shows that group RT improved group identification for participants (Song et al., 2014).

To date, there are no systematic reviews specifically designed to evaluate the effectiveness of group RT for older people with loneliness, anxiety and depression living in a long-term care setting. This long-term care setting included residential aged care facilities (RACF), nursing homes and assisted living facilities. Thus, there is a clear need to conduct a systematic review of the available evidence
for group RT, and such a review forms part of this thesis. The differences between these long-term care settings are the level of nursing care and assistance required by residents. The residents of assisted living facilities are more independent and require less assistance in activities of daily living than residents of RACFs which in turn are more independent than those living in nursing homes. Nursing homes provide a great deal of nursing care and assistance especially for those with cognitive impairment or suffering from complications of medical problems. The cost of nursing homes is higher than RACFs and assisted living facilities due to high level of health care and support provided by nursing homes.

4.4.1 Publication
The following is a publication of a systematic review of group RT for older people with loneliness, anxiety and depression. This publication was published in a Geriatric Nursing Journal and is focused on the review of group RT for older people with loneliness, anxiety and depression residing in long-term care.

The manuscript is presented as it was published, but the numbering of the pages, figures and tables has been adjusted to fit the overall style of the thesis. The references for this article are found in the references at the end of the thesis. In this manuscript, the words ‘older adults’ were used instead of older people.

Publication

ABSTRACT
Objective: The aim of this paper was to systematically review the literature in order to explore the effectiveness of group reminiscence therapy for older adults with loneliness, anxiety and depression in long-term care.

Methods: The Joanna Briggs Institute’s (JBI) method for a comprehensive systematic review was used to guide the study. This review paper considered all types of research designs, except systematic review studies. The intervention of interest was group reminiscence therapy and outcomes of interest were loneliness, anxiety, and depression. The inclusion criteria were studies of participants aged 60 years and over, residing in a long-term care facility. The search strategy involved peer reviewed
literature (Medline, Embase, Cinahl, PsychInfo, Cochrane, Scopus and Science direct and grey literature).

Results: Only eight studies met the inclusion criteria. These studies were critically appraised and data were extracted and collated. Results indicated that group reminiscence therapy is an effective treatment for depression and may reduce feelings of loneliness, anxiety and depression.

Conclusions: Group reminiscence therapy is an effective treatment for depression in older adults, however to date, there is limited research support for its effectiveness to treat loneliness and anxiety. Further research and an improvement in methodological quality, such as using qualitative and mixed methods approaches, is recommended to help establish an evidence base and provide better understanding of the effectiveness of group reminiscence therapy.

INTRODUCTION
In many countries, long-term care (LTC) for older adults who have poor physical and/or mental health and functional disabilities is a common part of the aged care system. For example, a broad range of recent estimates of older adults in long-term care are: Australia 5.3% (Australian Institute of Health and Welfare, 2012); Malaysia, 0.08% (Department of Statistics Malaysia, 2012); United States of America, 3.9% (National Center for Health Statistics, 2009); United Kingdom, 4.1% (Laing Buisson, 2012); Germany, 3.2% (Molinuevo, 2008). Although these percentages indicate only a small proportion of the population, the levels of disability and the type of care required is significant and this will become a larger issue over the coming decades as the world population of older adults increases disproportionally to other age groups (World Health Organization, 2012).

The move into LTC can be very stressful for an older adult and debilitating feelings of loneliness, anxiety and depression is a significant feature (Manion & Rantz, 1995). These feelings can last up to four years after admission to LTC (Nay, 1995). Other problems identified by older adults when relocating to LTC include difficulty in establishing meaningful interpersonal relationships with other residents and staff (Hutchinson, Hersch, Davidson, Chu, & Mastel-Smith, 2011; Lee, 2001; Roos & Malan, 2012), loss of identity and purpose in life (Saunders & Heliker, 2008) sadness and boredom (Fraher & Coffey, 2011) and lack of social support (Keister, 2006).

The prevalence rate of loneliness in LTC older adults has been reported as high as 56% (Drageset et al., 2011); prevalence rate for anxiety as 14% (Drageset et al., 2011) and prevalence rate for depression as 71.8% (Shahar et al., 2011). Loneliness can be defined as the loss of valued interpersonal relationships or inability to establish satisfying relationships (Brownie & Horstmanshof, 2011). Loneliness is a risk factor for physical and psychological health deficiencies such as dementia
(Luanaigh & Lawlor, 2008), depression (Alpass & Neville, 2003; Barg et al., 2006), anxiety (Barg et al., 2006) and cardiovascular diseases (Luanaigh & Lawlor, 2008). Anxiety can be defined as “an anxiety and worry about several real-life problems, occurring for at least six months” (American Psychiatric Association, 2013). Anxiety is often an unrecognized comorbidity of depression (Lenze, 2003). Depression is defined as depressed mood or loss of interest in activities of daily living for more than two weeks that can be diagnosed based on several symptoms such as depressed mood, decline in interest and pleasure and weight loss or weight gain (American Psychiatric Association, 2013). Both depression and anxiety are undertreated in older adults (Almeida et al., 2012; Benek-Higgins et al., 2008; Steffens, 2009; Therrien & Hunsley, 2012). The symptoms of anxiety and depression are difficult to diagnose due to coexistence with physical problems and the misbelief that these conditions are a part of the normal ageing process (Benek-Higgins et al., 2008). Undertreated depression and anxiety can lead to low quality of life, other more serious diseases and a shorter life span (Freudenstein et al., 2001). Suicide is also a risk for older adults with depression (Han & Richardson, 2010).

Several approaches such as pharmacological and non-pharmacological strategies can be used to treat or prevent loneliness, anxiety and depression. Loneliness is not a condition amenable to drug treatment but can be treated through psychosocial measures such as group therapy. Pharmacological treatment such as psychotropic drugs is usually the first option to treat depression and anxiety. Common psychotropic drugs in use are antidepressants, anxiolytics, hypnotics and antipsychotics. The excessive or moderate use of psychotropic drugs can lead to insomnia, depression, falls, hyponatremia, fracture and epilepsy (Coupland et al., 2011; Voyer & Martin, 2003). Due to the adverse effects of psychotropic drugs, it is prudent to use non-pharmacological treatments such as health education, counselling and psychotherapies as the first option.

Reminiscence therapy is one type of psychotherapy that could alleviate feelings of loneliness, anxiety and depression among older adults. Reminiscence by definition is a method or technique to recall past memories (Westerhof et al., 2010). Therapy itself can be defined as the branch of medicine that deals with different methods of treatment and healing in the cure of disease (Martin, 2010). Reminiscence therapy can be defined as: uses the recall of past events, feelings and thoughts to facilitate pleasure; better quality of life and better adjustment to present circumstances (Bulechek et al., 2008). Reminiscence therapy can be structured or unstructured, and conducted in a group or individual setting (Stinson & Kirk, 2006). Reminiscence is known as reminiscence therapy when it involves communication between two or more individuals and the achievement of certain goals based on individuals needs. Reminiscence therapy is different from simple reminiscence whereby certain
elements should be considered, such as: where the therapy takes place, the aims of the therapy, the theory that may underpin the therapy, the types of participants involved, and the qualifications of facilitators (Webster et al., 2010). It is stated that there were important elements that differentiate reminiscence from other therapies (Gibson, 2011). In reminiscence therapy, the participants are free to discuss their life stories and they can focus on both pleasant and sad memories (Gibson, 2011). At the same time, participants can learn something from their past problems to shape their present life (de Guzman et al., 2009). The value of reminiscence therapy above and beyond other therapies is that it may help older people gain their personal value (Klever, 2013) and self-identity (Gudex et al., 2010) by recalling past memories. Given today’s challenges in LTC, this therapy is valuable because it can be conducted during normal activities of daily life in LTC, such as during mealtime and walking around the facility LTC (Klever, 2013). Furthermore, staff in LTC reported that reminiscence therapy enhanced their interaction with residents, increased work satisfaction, and developed their understanding of the residents (Gudex et al., 2010).

Three types of reminiscence therapy are identified in the literature, simple reminiscence, life review and life review therapy (Webster et al., 2010; Westerhof et al., 2010). Simple reminiscence is defined as unstructured spontaneous reminiscence with the goals to increase social wellbeing of older people (Webster et al., 2010; Westerhof et al., 2010). In comparison to simple reminiscence, life review more structured and focused on both positive and negative life events. Life review therapy, is an advanced type of reminiscence therapy, which is a more formal and in-depth intervention (Burnside & Haight, 1994). Life review therapy is conducted when dealing with a particular problem (Stinson & Kirk, 2006) and can be psychotherapeutic for people who are severely depressed or anxious (Webster et al., 2010; Westerhof et al., 2010).

Eight functions of reminiscence therapy were identified (Webster, 1993). Briefly, these were 1) Identity – appreciating oneself; 2) Problem Solving – recognising one’s own strengths in dealing with problems; 3) Death Preparation – facilitating acceptance of death; 4) Teach/Inform – sharing life stories with intent to teach; 5) Conversation – developing ways of communication with other people; 6) Bitterness Revival – revisiting memories of difficult life events; 7) Boredom Reduction – reminiscing to relieve feelings of boredom; and 8) Intimacy Maintenance – remembering significant people. It was found that the eight functions of reminiscence therapy (Webster, 1993) could be grouped according to three higher order dimensions linked to well-being: positive self-functions, negative self-functions, and pro-social functions (Cappeliez & Robitaille, 2010). Positive self-functions referred to preserving or developing self-awareness and included reminiscence for Identity, Problem Solving, and Death Preparation. Negative self-functions related to regrets about the past and
rumination and included Bitterness Revival, Boredom Reduction and Intimacy Maintenance. Pro-social functions of reminiscence fostered relatedness with others such as Conversation and Teach/Inform. These functions of reminiscence therapy have relevance to older adults with depression, loneliness and anxiety. For example, Bitterness Revival, Boredom Reduction and Intimacy Maintenance functions may enhance well-being for older adults with depression. Problem Solving, Death Preparation, and Teach/Inform may be appropriate for older adults with anxiety. Identity, Problem Solving, Teach/Inform, Conversation, Boredom Reduction, and Intimacy Maintenance functions may be applicable to older adults who are lonely.

There are different types of reminiscence therapy such as transmissive reminiscence, integrative reminiscence, instrumental reminiscence and spiritual reminiscence. Transmissive reminiscence is defined as sharing past life events from one generation to the next generation (Wilson, 2006). Integrative reminiscence therapy focuses on reviewing past events irrespective of whether these were negative or positive experiences. The aim of integrative reminiscence is to develop positive self-esteem and links between past and current memories, as well as energizing negative memories (Hallford et al., 2012). Instrumental reminiscence therapy examines how past events have been resolved to enhance self-esteem (Wong & Watt, 1991). Finally, spiritual reminiscence therapy is defined as life review that involves people trying to find the meaning of their life and their future hopes (Mackinlay & Trevitt, 2010).

Some therapists prefer to use individual reminiscence therapy (Shellman et al., 2009; Wang, 2004) but there is evidence to support the effectiveness of group reminiscence therapy. Group reminiscence therapy usually comprises six to ten participants in each therapy session to enhance group dynamics, whereas individual reminiscence therapy is conducted on a one to one basis (Chong, 2000). When comparing group reminiscence therapy to individual reminiscence therapy use in LTC, at least three authors preferred group reminiscence therapy since it encouraged social contact between the residents, enhanced communication skills, and established new relationships (Burnside & Haight, 1994; Roos & Malan, 2012; Zhou et al., 2012). Furthermore, a systematic review of reminiscence therapy for the treatment of depression established that the social role function of group reminiscence therapy was the defining factor that made it more effective than individual reminiscence therapy (Housden, 2009). From a financial appraisal, group reminiscence therapy was more cost-effective than individual reminiscence therapy (Burnside & Haight, 1994).

The present systematic review expands previous work (Housden, 2009) by including loneliness and anxiety as well as depression. It was found that loneliness could be a risk factor for anxiety (Barg et
al., 2006) as well as depression (Alpass & Neville, 2003). Anxiety is a common comorbid condition with depression; nevertheless many individuals may have anxiety without depression (Bryant et al., 2008). To differentiate between anxiety and depression is a challenging task due to the similarity in the presentation of symptoms of depression and anxiety (Almeida et al., 2012; Therrien & Hunsley, 2012). Therefore, it is worthwhile to look at these three outcomes together as they are interrelated conditions often experienced by residents of LTC (Ellis, 2010; Manion & Rantz, 1995). The use of group reminiscence therapy in LTC is also of interest. The research question guiding this review is: ‘what is the effect of group reminiscence therapy on reducing feelings of loneliness, anxiety and depression, in older people diagnosed with symptoms of loneliness, anxiety and depression residing in long-term care settings?’

METHODS
The Joanna Briggs Institute’s (JBI) method for a comprehensive systematic review was used to guide the study (Joanna Briggs Institute, 2013).

Inclusion criteria
This review included experimental, non-experimental, observational and qualitative studies. Systematic reviews were excluded. The population of interest was people aged 60 years and over. LTC encompassed nursing homes, assisted living facilities and residential aged care facilities. The intervention was group reminiscence therapy. Studies that used individual reminiscence therapy were excluded. The outcomes of interest were loneliness, anxiety and depression.

Search strategy
Both peer reviewed literature and grey literature were included in the search. The databases included in the search were Medline, Embase, Cinahl, PsychInfo, Cochrane, Scopus and Science direct. Grey literature, such as Google scholar and Proquest databases were searched for dissertations and theses. Hand searches of reference lists of studies were conducted to ensure all relevant studies were retrieved. Studies published in English and Malay languages between 2002 and 2014 and full text articles were considered for inclusion in this review. Keywords with Boolean operators that were searched in each database included: (reminiscence) OR (reminiscence therapy) OR (psychotherapy) AND (loneliness) AND (anxiety) AND (depression) OR (depressive symptoms) AND (older people) OR (older adults) OR (elderly).

The literature search strategy identified 3521 potentially relevant studies (Figure 4.2). Figure 4.2 provides an overview of the PRISMA strategy used to identify articles that met the inclusion criteria.
(Liberati et al., 2009). Initially, 3146 duplicates studies were excluded; resulting in 375 articles screened for inclusion in this review. A further 354 studies were removed based on the title and abstract. The remaining 21 articles were assessed for inclusion in this review. Fourteen articles were excluded for the following reasons: individual reminiscence therapy; for older adults with dementia; community and hospital/clinics setting; participants aged below 60 years, and published in languages other than English and Malay language. The reference lists of the seven articles that met the inclusion criteria for this review were searched for additional relevant articles. This literature search method identified one further article that met the inclusion criteria. In total, eight studies met the inclusion criteria for this review. These eight studies were assessed for methodological quality, and further data extraction and synthesis.
Figure 4.2 Modified PRISMA flow diagram of article screening and selection.
Assessment of methodological quality

The eight studies were quantitative studies. All studies were critically appraised using standardized critical appraisal instruments from the Joanna Briggs Institute Meta-Analysis of Statistics Assessment and Review Instrument (JBI-MAtSARI) (Joanna Briggs Institute, 2013). Three independent reviewers performed the methodological validity assessments. The reviewers then met and discussed any disparity of the assessments to reach a final conclusion. Results from the assessments of methodological quality supported the inclusion of all eight studies in the review (see Table 4.3). Since none of the eight studies met all 10 of the JBI MAtSARI criteria – especially concerning the treatment groups and experimental design – a decision criteria cutoff of five, out of a possible 10 points was agreed among the reviewers.
### Table 4.3 Assessment of methodological quality of group reminiscence studies using JBI MA-tSARI

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was the assignment to treatment groups truly random?</td>
<td>U</td>
<td>N</td>
<td>Y</td>
<td>NA</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>2. Were participants blinded to treatment allocation?</td>
<td>U</td>
<td>NA</td>
<td>Y</td>
<td>NA</td>
<td>U</td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>3. Was allocation to treatment groups concealed from the allocator?</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>U</td>
<td>U</td>
<td>U</td>
<td>U</td>
<td>U</td>
</tr>
<tr>
<td>4. Were the outcomes of people who withdrew described and included in the analysis?</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>NA</td>
<td>U</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>5. Were those assessing outcomes blind to the treatment allocation?</td>
<td>U</td>
<td>U</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>U</td>
<td>U</td>
<td>N</td>
</tr>
<tr>
<td>6. Were the control and treatment groups comparable at entry?</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>7. Were groups treated identically other than for the named interventions?</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>8. Were outcomes measured in the same way for all groups?</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>9. Were outcomes measured in a reliable way?</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>10. Was appropriate statistical analysis used?</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

Note: Y = Yes, N = No, U = Unclear, NA = Not applicable
Data collection and extraction
The data were collected and extracted from the studies using the standardized data extraction tool from JBI-MAStARI (Joanna Briggs Institute, 2013). The first author performed data extraction while the second author checked the data that were extracted. The data extracted included specific details about the methodology, settings, participants, interventions, duration, outcome measures and findings.

Data synthesis
Due to heterogeneity of the results such as different methodological approaches, different findings and a limited number of studies for loneliness and anxiety outcomes, it was not possible to conduct meta-analysis of these three outcomes. Therefore, the results were presented in narrative form, including tables to clarify these.

RESULTS
A summary of study characteristics is presented in Table 4.4. Only one study examining an outcome of loneliness was found (Chiang et al., 2010). Two studies examining anxiety (Emery, 2002; Haslam et al., 2010) and eight studies examining depression (Chao et al., 2006; Chiang et al., 2010; Chueh & Chang, 2014; Emery, 2002; Haslam et al., 2010; Karimi et al., 2010; Stinson & Kirk, 2006; Wilson, 2006) were identified. Three studies measured more than one outcome (Chiang et al., 2010; Emery, 2002; Haslam et al., 2010). Of the eight studies, three studies were from the United States of America (USA) (Emery, 2002; Stinson & Kirk, 2006; Wilson, 2006), three studies were from Taiwan (Chao et al., 2006; Chiang et al., 2010; Chueh & Chang, 2014), one study from the United Kingdom (UK) (Haslam et al., 2010), and one study from Iran (Karimi et al., 2010). None of the eight studies employed a randomized controlled trial (RCT) design. These involved small sample size, ie. fewer than 100 participants. Two studies involved males only (Chao et al., 2006; Chiang et al., 2010), one study involved females only (Stinson & Kirk, 2006) and five studies involved both males and females (Chueh & Chang, 2014; Emery, 2002; Haslam et al., 2010; Karimi et al., 2010; Wilson, 2006). All of the studies used a control group, the interventions were between four and twelve weeks’ duration.

In relation to the outcome of loneliness, the single study was conducted in Taiwan with 92 participants (45 participants in the reminiscence group and 47 participants in the control group). The therapy was conducted over an eight-weeks period. The scale measuring loneliness was the Revised University of California Los Angeles loneliness scale (RULS-V3) (Russell, 1996). The finding was a significant positive short-term effect (3 months follow-up) of reminiscence therapy to combat loneliness.
In regard to the outcome of anxiety, two studies were found. These studies were conducted in the USA and the UK. Both of these studies were quasi-experimental. Sample size differed; 35 participants (Emery, 2002) and 73 participants (Haslam et al., 2010). These studies implemented different elements in reminiscence therapy. One study explored reminiscence therapy and spiritual reminiscence therapy (Emery, 2002) whereas another study investigated group reminiscence therapy and individual reminiscence therapy (Haslam et al., 2010). Although both measured anxiety, they used different scales (Emery, 2002; Haslam et al., 2010). Emery (2002) used the State-Trait Anxiety Inventory (STAI) (Spielberger, Gorssuch, Lushene, Vagg, & Jacobs, 1983) and Haslam et al. (2010) used the Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983). A significant result was found by one study – group reminiscence, individual reminiscence and group control activity were effective in alleviating anxiety (Haslam et al., 2010). However, post hoc analysis discovered the group control activity produced significant improvements in well-being measures as compared to the other two groups. By contrast, another study found that spiritual reminiscence therapy was not significantly effective in reducing anxiety (Emery, 2002).

In relation to the outcome of depression, all eight studies were quasi-experimental. One study was conducted in a specialised care unit for older adults (Haslam et al., 2010), two studies were conducted in assisted living facilities (Emery, 2002; Stinson & Kirk, 2006) and five studies were conducted in nursing homes (Chao et al., 2006; Chiang et al., 2010; Chueh & Chang, 2014; Karimi et al., 2010; Wilson, 2006). The number of participants involved in the reminiscence therapy groups ranged from 21 to 73. Three studies compared the different types of reminiscence therapy for older adults with depression. One study compared reminiscence therapy and spiritual reminiscence therapy (Emery, 2002). The other two studies compared between (1) integrative reminiscence and instrumental reminiscence (Karimi et al., 2010) (2) reminiscence and transmissive reminiscence (Wilson, 2006). Four studies compared group reminiscence to a control group (Chao et al., 2006; Chiang et al., 2010; Chueh & Chang, 2014; Stinson & Kirk, 2006) One study explored the effectiveness of group reminiscence compared to individual reminiscence and a control group (Haslam et al., 2010). Five of the eight studies found that reminiscence therapy was markedly effective in reducing depression (Chiang et al., 2010; Chueh & Chang, 2014; Haslam et al., 2010; Karimi et al., 2010; Wilson, 2006). However, three studies revealed non-significant findings regarding the effects of reminiscence therapy on depression (Chao et al., 2006; Emery, 2002; Stinson & Kirk, 2006).
Table 4.4 Summary of studies about group reminiscence therapy for older adults with loneliness, anxiety and depression residing in long term care

<table>
<thead>
<tr>
<th>Author/ Year/Country</th>
<th>Design</th>
<th>Setting/ No. of sites</th>
<th>Sample size (n)</th>
<th>Interventions (n)</th>
<th>Duration (weeks)/ session</th>
<th>Outcome measures</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Studies of loneliness and depression</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Chiang et al/ 2010/ Taiwan</td>
<td>Quasi-Experimental study</td>
<td>Nursing home/1</td>
<td>92 males</td>
<td>Reminiscence: 45</td>
<td>8/ weekly</td>
<td>RULS-V3</td>
<td>A significant positive short-term effect (3 months follow-up) of reminiscence to loneliness, as compared to those in the comparison group was found. ($p&lt;0.0001$)</td>
</tr>
<tr>
<td>Emery/ 2002/ USA</td>
<td>Quasi-Experimental study</td>
<td>Assisted living facility/2</td>
<td>35 males &amp; females</td>
<td>Conventional reminiscence: 10 Spiritual reminiscence: 14 Wait-list (no intervention): 11</td>
<td>8/ weekly</td>
<td>STAI GDS (15 items)</td>
<td>Spiritual reminiscence therapy did not significantly decrease anxiety $F (1.76, 1) =0.07, p=0.20$ and depression $F (0.06, 1) =0.00. p=0.81$</td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Setting</td>
<td>Participants</td>
<td>Treatment</td>
<td>Frequency</td>
<td>Measures</td>
<td>Results</td>
</tr>
<tr>
<td>-------------------------------</td>
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<tr>
<td>Haslam et al./2010/UK</td>
<td>Quasi-experimental study</td>
<td>Standard or specialized care unit/7</td>
<td>14 males 59 females</td>
<td>Group reminiscence: 41 Individual reminiscence: 34 Group control activity (skittles): 40</td>
<td>6/weekly</td>
<td>HADS</td>
<td>Significant effect of group reminiscence, individual reminiscence and group control activity on wellbeing measures $F(2, 71) = 3.36, p = .04$.</td>
</tr>
<tr>
<td>Wilson/2006/USA</td>
<td>Quasi-experimental study</td>
<td>Nursing homes /2</td>
<td>45 males &amp; females</td>
<td>Reminiscence: 15 Trans missive: 15 Reminiscence Control: 15</td>
<td>12/weekly</td>
<td>GDS (30 items)</td>
<td>Both treatment groups evidenced lower scores on the GDS after the intervention period $F(2, 41) = 70.46, p = .00$. The difference between the efficacy of the reminiscence group and that of the transmissive reminiscence group was not statistically significant, but both were effective in decreasing depression scores.</td>
</tr>
<tr>
<td>Karimi/2010/Iran</td>
<td>Quasi-experimental study</td>
<td>Nursing home/1</td>
<td>12 males 17 females</td>
<td>Integrative reminiscence group: 10</td>
<td>6/weekly</td>
<td>GDS (15 items)</td>
<td>Integrative and instrumental reminiscence differed significantly ($F(27.095), p &lt; 0.01$). Integrative reminiscence showed statistically</td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Setting</td>
<td>Participants</td>
<td>Group</td>
<td>Activity</td>
<td>Frequency</td>
<td>Outcome Measures</td>
</tr>
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</tr>
<tr>
<td>Stinson &amp; Kirk/2006/USA</td>
<td>Quasi-Experimental study</td>
<td>Assisted living facility/1</td>
<td>24 females</td>
<td>Reminiscence group: 12</td>
<td>Activity (control) group: 12</td>
<td>6/twice weekly</td>
<td>GDS (30 items)</td>
</tr>
<tr>
<td>Chao et al./2006/Taiwan</td>
<td>Quasi-Experimental study</td>
<td>Nursing home/1</td>
<td>18 males</td>
<td>Reminiscence group: 12</td>
<td>Control group: 12</td>
<td>9/weekly</td>
<td>GDS-S</td>
</tr>
<tr>
<td>Chueh &amp; Chang/2014/Taiwan</td>
<td>Quasi-Experimental study</td>
<td>Nursing home/1</td>
<td>21 males</td>
<td>Reminiscence: 11</td>
<td>Control group (routine care): 10</td>
<td>4/twice weekly</td>
<td>TGDS</td>
</tr>
</tbody>
</table>
Note: RULS-V3=Revised University of California Los Angeles loneliness scale (Russell, 1996); STAI= State-Trait Anxiety Inventory (Spielberger et al., 1983); HADS=Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983); GDS 15 items= Geriatric Depression Scale (Sheikh & Yesavage, 1986); CES-D=Center for epidemiological studies depression scale (Roberts, Roberts, Lewinsohn, & Seeley, 1991); GDS 30 items= Geriatric Depression Scale (Yesavage et al., 1982); GDS-S=Chinese version of the GDS-S (Geriatric Depressive Scale-Short Edition) (Liu et al., 1997); TGDS= The Taiwan Geriatric Depression Scale (Liao, Yeh, Yang, & et al, 2004)
With regard to the content or topics of discussion included in the group reminiscence therapy studies, five (Chiang et al., 2010; Chueh & Chang, 2014; Emery, 2002; Haslam et al., 2010; Karimi et al., 2010) provided full information, one study provided some information of the therapy contents (Chao et al., 2006) and another two studies reported no information about the topics discussed (Stinson & Kirk, 2006; Wilson, 2006) (see Table 4.5). One study (Chueh & Chang, 2014) replicated topics from a previous study (Chiang et al., 2010) with modification. Facilitators were experienced in conducting reminiscence therapy or had received training on group reminiscence therapy. However, one study did not provide information about the facilitator of the group reminiscence therapy (Stinson & Kirk, 2006). Four studies involved one facilitator (Chao et al., 2006; Chueh & Chang, 2014; Karimi et al., 2010; Wilson, 2006), two studies involved two facilitators (Chiang et al., 2010; Emery, 2002) and one study involved three facilitators (Haslam et al., 2010).
Table 4.5 Group reminiscence protocol for each study

<table>
<thead>
<tr>
<th>Author</th>
<th>Topics included in group reminiscence therapy</th>
<th>Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiang et al. (2010)</td>
<td>Topics included in 8 weeks of therapy: (1) Self-introduction and sharing of past life events; (2) Increasing consciousness of feelings and assisting participants to discuss their feelings; (3) Recognizing any positive relationships from past memories and the ways to integrate good aspects of past relationships to current relationships; (4) Remembering family and personal life memories; (5) Shifting of life; (6) Recognizing personal achievements and finding personal aims; (7) Emphasizing personal aims and strengths; and (8) Reviewing all sessions and conclusion.</td>
<td>Two facilitators who were master students with experience working with older people and group reminiscence therapy.</td>
</tr>
<tr>
<td>Emery (2002)</td>
<td>Topics included in 8 weeks of therapy: (1) “Firsts” such as stories of first baby and first time driving; (2) School days; (3) Life work; (4) Customs; (5) Battles won and lost, such as memories during World War II, and battles with their addiction; (6) Critical moments in life; (7) Past and present and (8) Inspirational words</td>
<td>Two facilitators involved who were clinicians and had received training on group reminiscence therapy.</td>
</tr>
<tr>
<td>Haslam et al. (2010)</td>
<td>Topics included in 6 weeks therapy: (1) Childhood memories; (2) School time memories; (3) Home life; (4) Marriages; (5) Personal life; and (6) Vacations.</td>
<td>Three facilitators had completed training in reminiscence and had experience conducting group activities.</td>
</tr>
<tr>
<td>Wilson (2006)</td>
<td>Information not available</td>
<td>One facilitator conducted group reminiscence therapy to reduce experimental</td>
</tr>
<tr>
<td>Study</td>
<td>Topics Included</td>
<td>Notes</td>
</tr>
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<td>------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Karimi et al. (2010)</td>
<td>Topics included in 6 weeks of therapy: (1) Personal history; (2) Life achievements; (3) Critical moments in life; (4) History of good and bad things; (5) History of distress or grief and (6) The purpose of life and faith. Participants were also given the topic prior to the next session to prepare the memories that they wanted to share with group members.</td>
<td>A facilitator holding a master degree conducted the group reminiscence therapy and was supervised by a registered clinical psychologist.</td>
</tr>
<tr>
<td>Stinson &amp; Kirk (2006)</td>
<td>Information not available</td>
<td>Information not available</td>
</tr>
<tr>
<td>Chao et al. (2006)</td>
<td>Topics included in 9 weeks of therapy: (examples only provided) childhood history; history of home/family; and significant memories in their life.</td>
<td>A facilitator with college-level qualifications in psychiatric nursing led the group reminiscence therapy with the assistance of a head nurse.</td>
</tr>
<tr>
<td>Chueh &amp; Chang (2014)</td>
<td>Topics included in 4 weeks (two sessions per week) that was modified from Chiang et al. (2010); (1) Self-introduction and life moments in relation to wars; (2) The importance of sharing their feelings; (3) Recognizing past meaningful relationships and how to integrate the positive components of past relationships to present relationships; (4) Remembering past personal events; (5) Remembering problems related to life transitions; (6) Recognizing personal achievements and personal aims; (7) Recognizing own strengths and (8) Conclusion of eight sessions.</td>
<td>One described only as very experienced facilitator in group reminiscence therapy led the sessions.</td>
</tr>
</tbody>
</table>
DISCUSSION

Quality of the studies

The assessment of methodological quality revealed that three of the eight studies met the minimum score of five out of the ten criteria. No study included the important step of concealment of allocation to treatment groups by the allocator – ie. criteria 3. However, the included studies were quasi-experimental studies. The studies fulfilled similar criteria in the methodological quality assessment checklist. For example, all eight studies had comparable groups, identical treatment except for the treatment group, parallel outcome measurements across all groups, reliable outcome measurements and correct use of statistical tests.

Another important issue was the implementation of a control condition. Five out of eight studies implemented waiting list control groups (Chao et al., 2006; Chiang et al., 2010; Chueh & Chang, 2014; Emery, 2002; Wilson, 2006). Another three studies applied attention control activities such as skittles and social interaction (Haslam et al., 2010; Karimi et al., 2010; Stinson & Kirk, 2006). It is important to evaluate the control group since some studies implementing a waiting list control group produced significant results. As identified in one study, group reminiscence therapy was effective in reducing depression for a six-month period compared to routine care (Chueh & Chang, 2014). However, this result must interpreted with consideration given to the lack of equivalence of social interaction in the comparison condition. That is, it is not possible to rule out whether social interaction with other group members may have been the mechanism for change in the group reminiscence condition compared to the usual care condition. Therefore, it is suggested that in future research the control group should ideally be an attention-controlled condition to address this limitation.

The variability in outcomes could be attributed to a number of methodological components such as dropout rates, follow-up time after the implementation of the interventions, and content of the therapy. Most of the studies reported the dropout rate and follow-up time after implementation of the intervention. One study reported high attrition (31%), which did not appear to influence the results as the findings showed reminiscence therapy was significantly effective for older adults with loneliness and depression (Chiang et al., 2010). The reasons for high attrition, reported by the majority of the studies, included hospitalisation, death, and attending health appointments. In terms of reminiscence therapy content, six out of eight studies detailed the specific content of the therapy/sessions (Chao et al., 2006; Chiang et al., 2010; Chueh & Chang, 2014; Emery, 2002; Haslam et al., 2010; Karimi et al., 2010). Although reminiscence therapy content differed between the studies, each covered three important phases; self-introduction, topics of discussion, and conclusion.
Clinical effects of group reminiscence therapy

This paper reviewed eight studies that examined the effectiveness of group reminiscence therapy on loneliness, anxiety, and depression in older adults in LTC. Only one study investigated group reminiscence therapy and loneliness (Chiang et al., 2010). Despite the significant findings, it is difficult to make a conclusion regarding the clinical effects of group reminiscence for loneliness from this one study. Additionally, the control group was a waiting list control condition that did not include an equivalent activity. This study also involved only males therefore limiting the ability to generalise the findings to females. Therefore there is limited evidence to conclude that reminiscence therapy is effective in decreasing or eliminating feelings of loneliness for older people in LTC.

The evidence for the effectiveness of reminiscence therapy to treat anxiety was also limited due, in part, to the variability of methods used in the included studies. Various types of interventions (conventional versus spiritual reminiscence and group reminiscence versus individual reminiscence), various settings (assisted living facilities and specialized care unit), duration of the interventions (eight weeks and six weeks) and different outcome measures (STAI and HADS) make it difficult to sum up the effectiveness of the therapy. More rigorous research in this field is crucially needed.

The findings related to depression varied across the included studies. Although numerous scales were used to measure depression, the Geriatric Depression Scale (GDS) (Sheikh & Yesavage, 1986) was the most frequently chosen. Differing versions of GDS were used, three of six studies reported significant results (Chueh & Chang, 2014; Karimi et al., 2010; Wilson, 2006). Another three studies reported non-significant results (Chao et al., 2006; Emery, 2002; Stinson & Kirk, 2006). Non-significant results may have resulted from the small sample sizes, which were less than 35 participants. Two other studies that used different scales, HADS and the Center for Epidemiological Studies Depression scale (CES-D) also reported significant results (Chiang et al., 2010; Haslam et al., 2010). Both of these studies were quasi-experimental and involved larger sample sizes – 92 participants (Chiang et al., 2010) and 73 participants (Haslam et al., 2010). Due to heterogeneity of the results, it was not possible to conduct a meta-analysis of the studies examining the outcome of depression. Yet, the available evidence indicated that group reminiscence therapy could support older adults who are depressed. Furthermore, it was found that social interaction between people in the group reminiscence therapy increased and this finding has relevance to older adults living in LTC (Haslam et al., 2010).
Theoretical Framework
Out of eight studies, only two studies used a theoretical framework. One study used social identity theory to guide their study (Haslam et al., 2010). From this framework, it was predicted that group reminiscence therapy would provide better outcomes as compared to individual reminiscence. Their study categorised the outcomes into cognitive improvement and enhanced well-being (Haslam et al., 2010). The results revealed that group reminiscence therapy, individual reminiscence therapy and group control activities produced significant effects on well-being measures of depression, anxiety, life improvement and quality of life pre- to post-intervention. However, further between-groups analysis showed that only the group control activity produced significant improvements in well-being compared to group reminiscence and individual reminiscence. The usefulness of social identity theory was clear in this study since the group control activity that encouraged more social activities reduced feelings of anxiety and depression for participants.

Another study used a framework called the Lin framework (Stinson & Kirk, 2006). This framework includes five stages; antecedent, individual assessment, establishing the therapeutic purposes, choosing a suitable reminiscence therapy modality, and outcome measurements. However, their study did not critically discuss the integration of the Lin framework into their study (Stinson & Kirk, 2006).

Types of reminiscence therapy
From this systematic review, several types of reminiscence therapy have been identified. These are transmissive reminiscence therapy (Wilson, 2006), integrative reminiscence therapy (Karimi et al., 2010), instrumental reminiscence therapy (Karimi et al., 2010) and spiritual reminiscence therapy (Emery, 2002). In this review only integrative reminiscence therapy was found to be significantly effective in reducing depression among older adults in LTC (Karimi et al., 2010). Although the use of transmissive and instrumental reminiscence led to a reduction on depression scores, these were not at a statistically significant level. Therefore, despite the modest findings it is clear that there is a great deal of scope for further study on transmissive reminiscence, instrumental reminiscence and spiritual reminiscence therapy.

Generally, several limitations of group reminiscence therapy were identified in this review, such as small sample size, attrition rates that may have influenced the findings, insufficient evidence for the long-term effects of the therapy, lack of social interaction in control conditions, and varying content of group reminiscence therapy. Special training for staff in LTC in group reminiscence therapy is important prior to conducting it, and may require monetary support from the institution, although conducting the therapy itself is cost-beneficial (Budi et al., 2012; Hsu & Wang, 2009)
RECOMMENDATIONS
Only a few studies identified the benefits of group reminiscence therapy for loneliness, anxiety and depression in older adults in LTC. Moreover, all studies in this review were quantitative studies. Thus, diverse research designs were needed for a clearer understanding of group reminiscence therapy as a whole. That is, qualitative studies and mixed-method studies might provide different views of the effectiveness of group reminiscence therapy. Qualitative work might be beneficial to provide a better understanding from the older adults’ perspective regarding group reminiscence therapy, such as their experiences after group reminiscence therapy. Further studies from different cultural groups could enhance this body of knowledge. It has been suggested that different methodologies, including a combination of experimental studies and qualitative research could provide a better understanding of the effects of reminiscence therapy (Blake, 2013; Westerhof & Bohlmeijer, 2014). Furthermore since different types of reminiscence therapy had been examined in the studies included in this review – spiritual, transmissive, integrative and instrumental reminiscence therapies – which resulted in inconsistent outcomes, further exploration of the effects of different types of reminiscence therapy are recommended.

Although several studies have been conducted on the effectiveness of group reminiscence therapy for older adults who are lonely, depressed and anxious, no firm conclusions can be made from the results. This is due to the differing implementation strategies for the intervention, therapy durations and scales used to evaluate the effectiveness of the therapy. Thus, a standardised protocol for reminiscence therapy, such as topics to be covered and uniform duration, is needed for implementation across the populations.

CONCLUSION
The majority of group reminiscence therapy studies reviewed were quasi- experimental and included small participant samples, therefore there are no conclusive findings to be made. Notwithstanding the lack of empirical evidence, as there are no reported adverse events to reminiscence therapy, and it can be practically implemented in long term care settings, it should certainly be considered a worthwhile treatment.

Summary
This publication showed that group RT could be a valuable therapy for older people with loneliness, anxiety and depression. In this publication, it was highlighted to include a spiritual element, as spirituality is crucial for older people, especially for those with loneliness, anxiety and depression. The integration of new elements, such as a spiritual element may improve the effectiveness of RT.
This systematic review also highlighted the lack of qualitative studies on older people’s experiences from RT.

There are some reasons RT may be better conducted as a group than the individual. RT as a group intervention helps older people build new friendships (Gibson, 2011) and get connected with other people (Mackinlay & Trevitt, 2010). Through sharing their life experiences with other people, older people may realise that they might take the same journey with other people (Liu et al., 2007). Group RT may be useful for those with extroverted personalities that enjoyed sharing and telling stories with other people (Cappeliez & O'Rourke, 2002) and neurotic personalities to learn from their bitter memories (Cappeliez & O'Rourke, 2002). Limited evidence is available regarding the suitability of RT for those with introverted personalities. However, some studies have reported that people with introverted personalities were reportedly actively engaged in group RT sessions (Gudex et al., 2010). The combination of different personality types in one group RT may help in balancing group personality types. When comparing group RT to individual RT, at least three authors preferred group RT since it encouraged social contact between the residents, enhanced communication skills, and it established new relationships (Haslam et al., 2010; Haslam et al., 2013; Song et al., 2014).

Considering the value of a socially-oriented approach, social identity theory is the most appropriate theory. Based on social identity theory, RT’s basis as a group intervention may assist older people to cultivate self-identification from sharing memories with others, and help identification of the meaning of their past and current roles such as a father/mother, a religious person and also as an older person (Haslam et al., 2010). On the other hand, Erikson’s theory assists in understanding the acceptance of the bitter memories (Erikson, 1963). Erikson’s theory, however, may not be suitable in explaining the social benefit of RT as a group-based intervention due to the focus on understanding meaning behind memories. Another theory, the cognitive adaptation theory, views RT as an intervention that encourages a positive way of thinking (Taylor, 1983). This theory does not provide an explanation of the social aspect of RT; rather it focuses on re-evaluating memories. The use of social identity theory therefore seems suitable to examining the social dimension of group RT.

There is a gap in knowledge about the effectiveness of group RT in the Malaysian population because to the best of our knowledge, it has never been tested in Malaysia. It was found that most studies on RT involved predominantly Western populations. There is a significant gap regarding ethnic/cultural differences in using RT for older people with loneliness, anxiety and depression. RT is influenced by cultural values that may impact the outcomes (Webster et al., 2010). For example, Chong (2000) suggested that in Hong Kong, Chinese culture may prevent older people from sharing their memories.
with other people to maintain a good self-image, which may reduce their ability in getting positive outcomes in RT. Despite there being no empirical evidence for the effectiveness of RT among the Malaysian population, it has been widely practised in long-term care settings, including RACFs (Ministry of Health Malaysia, 2007, 2009). Malaysian Clinical Practice Guidelines for psychotherapy treatments such as RT, were developed based on the evidence from RCTs and systematic reviews that were conducted outside of Malaysia. Thus, it is important to determine the effectiveness of RT among the Malaysian population.

4.5 Summary
RT offers numerous benefits to older people with loneliness, anxiety and depression such as a supportive environment, searching for meaning from memories and coping skills. The evidence of the effectiveness of RT and Group RT showed mixed findings and a review from methodological approaches found several designs were used. The theoretical component of the previous studies showed a lack of clarification on how the theory guided RT and how it linked with the study findings. Group RT was found to be beneficial to older people as it improves social connections between older people living in RACFs. Improving social connections can reduce feelings of loneliness, anxiety and depression. The meaningful social relations that were promoted from group RT improved the sense of self-identity among the participants. Social identity theory is the most suitable theory to relate the benefit of social interaction from group RT. Previous studies on group RT were mostly conducted in western populations. The implementation of RT in a Malaysian population requires adaptation because this population is highly influenced by cultural and spiritual values.

The next chapter will discuss the theoretical background of spiritual reminiscence therapy (SRT) and the adaptation involved in a SRT program.
Chapter 5  Spiritual Reminiscence Therapy

5.1  Introduction
This chapter describes the need for an adaptation of reminiscence therapy (RT) for the Malaysian population. Several important elements are identified as being significant to this population which include religious, spiritual and cultural considerations. Malaysia is a multi-ethnic, multi-religious country where an adapted SRT program to meet the specific needs will enhance acceptance of the program. This chapter also discusses the adaptation of an established spiritual reminiscence therapy (SRT) program for this population.

5.2  The need for an adaptation of reminiscence therapy
Current reminiscence therapy (RT) programs need to be adapted for the Malaysian population because this population is highly influenced by cultural practices, many of which are based in religious traditions. Webster et al. (2010) pointed to the importance of cultural integration in RT, as cultural beliefs may influence the acceptability of the program content. Furthermore, the adaptation process is essential because RT involves the recall of memories that strongly relate to cultural values (Conway & Pleydell-Pearce, 2000; Harris, 1997). Cultural values may offer identity for people in a group by incorporating a cultural element that is suitable for that population (Chang, Jetten, Cruwys, & Haslam, 2017). Cultural identity is an extension of social identity (Chang et al., 2017) that usually exists in all individuals in any community. Activities that bring together individuals with a similar cultural identity help to develop the cultural identity within an individual (Alegria et al., 2010).

Malaysia is considered a collectivist society like many other Asian countries, in which the values of the group are more significant than the values of individuals (Sumari & Jalal, 2008). This means that cultural traditions within an ethnic group are more highly valued than the culture of each individual. Alegria et al. (2010) claimed that cultures are a collective understanding that develop through social influence. As identified in Chapter 2, the dominant ethnic groups in Malaysia are the Malays and the Indigenous people, Chinese and Indians. Each of these ethnicities has its own customs, values and traditions, but their cultural values have combined to a relatively large degree as an outcome of socialisation. For example, as described in Chapter 2, each of these cultures practises filial piety. This suggests that despite the multi-ethnic population, interventions that combine ethnicities and incorporate common cultural elements might be useful.

For the Malaysian population, cultural practices are intertwined with religious practices (Haque, 2008). Islam is the main religion of Malaysia, and Malay culture is highly influenced by Islamic
practice (Haque, 2008). In Islam, religious practices include prayers, reciting the Qur’an and practising good deeds (Ibrahim, 2014). Chinese cultural practice is related to Buddhism, in which religious practice is focused on behaviours that promote love and care through a relationship with people and their surroundings (Ibrahim, 2014). Indian cultural practice is related to Hinduism, in which the expression of religiosity is through prayers, meditation, Mantra (spiritual singing) and yoga that are performed as individuals or in groups (Ibrahim, 2014). The centrality of religious values to cultural practices suggests that incorporating an understanding of religious identity is an important part of adaptation to a Malaysian population.

Religious identity can be developed from group activities such as religious community groups or group interventions that encourage group discussion about religion (Jetten, Haslam, & Haslam, 2012). Religious identity is related to how religious memberships guide people to learn and develop their identity (Jackson & Hogg, 2010). From a social psychological perspective, religious identity is an extension of social identity that people gain from religious group interventions (Ysseldyk et al., 2010). A religious identity derived from the relationships with religious groups has been argued to assist people to learn about themselves and develop their shared religious identity with others (Jetten et al., 2012). This suggests that religious identity can be developed from religious integration in group interventions such as RT.

Religious identity as a mechanism of RT may enhance meaningful identity in a Malaysian population. In the Haslam et al. (2013) study, religious identity guided the selection of religious song RT. Haslam et al. (2013) investigated the effectiveness of three different treatments: secular song RT, religious song RT and standard story RT with 40 participants who identified as Christians. The mechanism of religious song RT was to cultivate a sense of religious identification among older people in that group. It was found that religious song RT developed religious identity among older people with anxiety (Haslam et al., 2013). Their findings supported the ideas of MacKinlay and Trevitt (2012) in that the ability to find religious identity may enhance meaningful identity in older people. Haslam et al. (2013), however, highlighted the significance of religious identification as a mechanism rather than just an outcome. This means that the sense of religious identity among the group resulted in outcomes such as decreased anxiety levels. Given the deep significance of religion to Malaysian culture, the integration of religion in RT could be particularly suitable for an older Malaysian population.

The integration of cultural and religious practices in RT may also increase the acceptability of this intervention for this population. In the study conducted by Merriam and Mohamad (2000) in Malaysia, older people reported that they were more interested in joining activities that involved
religious and spiritual values compared to activities that focused on personal or material values. Their study included 19 older people aged 60 years and older with various religions: Islam, Christianity, Hinduism and Buddhism. These older people were in favour of religious and spiritual interventions that assisted them to find purpose of their life (Merriam & Mohamad, 2000). Further, a qualitative study that involved 20 older people living in residential aged care facilities (RACFs) in Malaysia found that activities with a religious component improved feelings of wellbeing (Syed Akil & Abdullah, 2015). When religious values have been integrated with psychotherapy, the combination has been found to be of greater value than conventional psychotherapy for Malaysian older people (n = 30) suffering grief and bereavement (Azhar & Varma, 1995). In a more recent study, Razali, Aminah, and Khan (2002) investigated the effect of religious–cultural values in psychotherapy compared to a control group (received standard treatment for anxiety) among 165 Malaysian people with anxiety. The enhanced psychotherapy showed significant improvement in anxiety compared with those in the control group. These studies demonstrate the significance of religious integration into therapeutic approaches for older people in Malaysia.

5.2.1 The use of a spiritual approach to adaptation

While religious identity is central to cultural identity in Malaysia, it is a multi-religious population. In a group setting, particularly in RACFs, participants are likely to be from multiple religions. Therefore, it may be useful to adopt an approach to spirituality rather than religion per se.

Religiosity and spirituality are separate but interrelated constructs, despite occasionally being interpreted as identical (Koenig, King, & Carson, 2012). Spirituality is the interaction between oneself and the environment, religion, family and nature (MacKinlay & Trevitt, 2006, 2012). However, it is seen as complex, with no broadly accepted definition. Spirituality is a broad concept in relation to how individuals define themselves, related to the meaning and relationship with the transcendental (Koenig et al., 2012). Religion is distinguished from spirituality as an organised system of ideology, religious traditions and worships (Koenig et al., 2012). Religion guides connectedness to the maker or God, and religious practices can be performed either alone or in groups. Kiesling, Sorell, Montgomery, and Colwell (2006, p. 1270) defined spiritual identity as: “symbolic religious and spiritual content of a culture is appropriated by individuals in the context of their life”. Religion is therefore one component of spirituality, and is a part of spiritual identity.

Spirituality has been shown to have benefits for older people. One of the advantages of spirituality is it can be a protective agent and provide support (Abolfathi Momtaz, Hamid, Ibrahim, Yahaya, & Abdullah, 2012; Han & Richardson, 2010), offering healing action towards mental health (Haque,
In particular, for loneliness, anxiety and depression, spirituality acts as a buffer through a more positive outlook and coping strategies (Amzat & Jayawardena, 2016; Koenig, McCullough, & Larson, 2001). Amzat and Jayawardena (2016) conducted interviews with ten Malaysian older people (Malays, Chinese and Indians) from two different RACFs. One of the coping strategies identified to successfully manage loneliness was spiritual coping. This approach was beneficial to help people face reality by developing positive thinking. Spirituality has also been reported to serve as a coping mechanism among older people with anxiety (Stanley et al., 2011), and reduce the strength of the relationship between chronic diseases and depression among 1415 older Malay Muslims (Abolfathi Momtaz et al., 2012).

Spirituality may also help older people to understand the meaning and purpose of life (Kim, Hayward, & Reed, 2014). However, it must be noted that the sample of Kim et al. (2014) study was drawn from churches and temples, in which participants were considered to have particularly high spiritual levels (Kim et al., 2014). Byrne and MacKinlay (2012) claimed that a healthy spiritual life guided older people to search for meaning in their life. Their study involved 11 older people with dementia who lived in RACFs. Similarly, MacKinlay (2014) (in her review paper), argued spirituality guided the identification of meaning in life especially regarding the relationship with the creator. Older people have reported spiritual values in their memories during RT sessions, sharing their memories related to spiritual activities and feeling encouraged to pray often (Collins, 2006). Collins (2006) focused on stories that were recorded during 12 sessions of group RT. Several themes were found, including spiritual beliefs and roles; it was found that participants appreciated the importance of spirituality in memories and also in their lives. This supports the usefulness of spiritual integration in RT.

Furthermore, the possibility of developing loneliness, anxiety and depression has been found to be related to the level of spiritual practices. For example, those with low levels of spirituality may be at risk of higher levels of depression (Wink, Dillon, & Larsen, 2005). Wink et al. (2005) stated that those with low levels of spirituality could function well until they have a hardship situation that can lead to a significant problem like depression. In this situation, older people with low levels of spirituality may experience less buffering against depression in comparison with those who are more spiritual. Furthermore, spiritual activities also can protect older people from having depression (Gaggioli et al., 2013) especially those living in RACFs (Choi, Wyllie, & Ransom, 2008). Spirituality was also found to protect against loneliness in a review study of Victor, Scambler, Bond, and Bowling (2000). McConnell, Pargament, Ellison, and Flannelly (2006) studied 1629 participants with an average age of 49 years and reported that those with low levels of spiritual practices might have increased tendencies to develop anxiety and depression. A recent study showed that higher spiritual
levels reduced anxiety among 143 older people after controlling for personality, gender and education levels (MacKinlay & Burns, 2017). Their study used mixed methods design, and results from quantitative data and qualitative data showed that higher spirituality levels were related to lower levels of anxiety.

Spiritual activities have been found to be useful in dealing with loneliness, anxiety and depression in older people. Active participation in spiritual activities has been reported to reduce feelings of loneliness in 1791 participants, comprising Malays, Chinese, Indians and other Indigenous groups aged 60 years and over (Teh et al., 2014). Further, encouraging older people to practise spiritual activities has been demonstrated to weaken the relationship between loneliness and depression (Han & Richardson, 2010). Kim et al. (2014) similarly studied 157 older people and their caregivers in Korea. It was found that people with high levels of spirituality could identify the purpose of their life, and this in turn reduced depression. Khairudin et al. (2011), in a study in Malaysia, found that among older people with anxiety, non-Malays who were less spiritual reported higher levels of anxiety than Malays (who were considered as highly spiritual). These authors suggested that those with high spiritual levels used spiritual beliefs as a coping strategy for anxiety. The benefits of including a spiritual element in RT is obvious and could be of even greater significance for older people dealing with loneliness, anxiety and depression.

The sense of connectedness that is central to spirituality may be instrumental in reducing loneliness, anxiety and depression. MacKinlay and Trevitt’s (2012) broad definition of spirituality is fluid, depending on the important dimensions in the life of each individual. Spirituality can be expressed in many ways; however, the key concept is “connectedness”. Generally, those who identified themselves as religious people relied more on religion for their spiritual activity. Through spiritual activities such as prayer and meditation, people sense connectedness to God and other people (Byrne & MacKinlay, 2012). Those without faith may find relationships with friends and connection with the environment and nature are as significant as spiritual activities (MacKinlay & Trevitt, 2012). This sense of connectedness is an important component of older people’s mental health. This was supported by Lundman et al. (2010) who claimed connectedness is one of the inner resources in improving health among older people aged 85 years and over. Similarly, Haslam et al. (2013) argued that a sense of connectedness is a main component of improving health outcomes. For example, low feelings of connectedness were related to loneliness among 40 older people who were housebound (Han & Richardson, 2010). The significance of connectedness to other people has been identified as a vital component in nurse–patient interaction; this was related to a reduction in feelings of anxiety and
depression among 202 cognitively intact older people living in a RACF (Haugan et al., 2013). Therefore, the adaptation of spirituality in RT promotes the sense of connectedness among older people that will reduce loneliness, anxiety and depression.

The inclusion of spirituality rather than religiosity into RT may be valuable in both the acceptability of RT in this population, and in helping to understand the mechanism of RT. The integration of spirituality in RT is known as spiritual reminiscence therapy (SRT).

5.3 The effectiveness of spiritual reminiscence therapy

The difference between RT and SRT is that, for the latter, the process of sharing memories is guided by a spiritual element, with the purpose to find the meaning of life from the memories that are shared. SRT involves evaluation of life experiences by sharing memories with others that guide individuals to understand the purpose of their life and future hopes (Emery, 2002; Mackinlay & Trevitt, 2010). It also involves the integration of their life stories with their spiritual life journey as an individual and with their family, community and God (MacKinlay, 2006). In Chapter 4, the researcher demonstrated that the use of RT as an intervention for older people with loneliness, anxiety and depression showed mixed results. The effectiveness of SRT more specifically for this population also needs greater interrogation before this intervention can be recommended.

An integrative review of the literature was conducted to explore this question. The search involved published and unpublished studies using the keywords: spiritual reminiscence OR spiritual life review OR religious life review OR spiritual therapies. The search strategy resulted in 847 studies from the electronic databases of Medline (573), CINAHL (216) and PsycINFO (58). Reference lists of retrieved articles were read to identify additional studies eligible for inclusion; however, no relevant studies were found. The search was limited to studies published in English from 2000 to 2017 to capture the most current time period for the context of this study. Studies were included if they employed or developed SRT. The review excluded studies that did not mention spiritual or religious elements in SRT. Of the 847 studies, five met the inclusion criteria. The reasons for excluding 842 studies were: duplicates studies, book review; not available as a full-text article; or did not use a spiritual element in the reminiscence/ life review therapy (Figure 5.1).
Of the five SRT studies selected (Table 5.1), four were published and one was unpublished. Although Haslam et al. (2013) did not identify their study as SRT, they implemented a religious element in RT (religious song RT). Out of these five studies, three were quantitative studies, and two were qualitative studies. The quantitative studies measured different outcomes: anxiety, depression, hope, life satisfaction, spiritual wellbeing, meaning, social support, personal growth, self-acceptance and spiritual support. The qualitative studies involved older people with dementia. The majority of studies were conducted in Western countries: one in the United States of America (Emery, 2002) and three in Australia (Haslam et al., 2013; MacKinlay, 2009; Mackinlay & Trevitt, 2010). One study involved Taiwanese older people with traditional folk religion in Taiwan (Wu & Koo, 2015). The majority of participants were Caucasian and Christian. The program durations were from six to eight weeks. Program details including themes addressed were reported in four studies (Emery, 2002; MacKinlay, 2009; Mackinlay & Trevitt, 2010; Wu & Koo, 2015). Haslam et al. (2013) did not provide program information. Three studies used a program developed and tested by MacKinlay and Trevitt in 2006 (MacKinlay, 2009; Mackinlay & Trevitt, 2010; Wu & Koo, 2015).
The evidence regarding the effectiveness of SRT was limited. Only one previous SRT study has been conducted among older people with anxiety and depression, but the result was not significant (Emery, 2002). Additionally, it was conducted almost 15 years ago. Participants were not screened for anxiety and depression before the recruitment, and the study was quasi-experimental, with no randomisation. Haslam et al.’s (2013) study investigating the effectiveness of religious song-based RT compared with secular-song based RT and story-based RT found no significant effect for anxiety, although those in the religious identity group had reduced anxiety levels. This demonstrated that religious integration in RT may have some usefulness for older people with anxiety.

In relation to other outcomes, a recent study by Wu and Koo (2015) implemented a SRT program among 103 older people with mild to moderate dementia in a Taiwanese Hospital, producing significant findings for hope, life satisfaction and spiritual wellbeing. The SRT programs used in these three studies emphasised the sense of “connectedness” that is important for older people to improve their wellbeing (MacKinlay, 2009; Mackinlay & Trevitt, 2010; Wu & Koo, 2015). The qualitative results of previous SRT studies supported the notion that SRT guided older people to find meaning in their life (MacKinlay, 2009; Mackinlay & Trevitt, 2010). MacKinlay (2009) explored the shared life stories of three older Latvian people living in Australia during SRT sessions. The results found that connectedness and spiritual practices were among the themes revealed from the older people’s experiences of SRT. Mackinlay and Trevitt (2010) qualitative study involving 113 participants with dementia identified two themes which were ‘the meaning in life’ and ‘vulnerability and transcendence’, suggesting that SRT provides meaningful connection among participants in SRT. Despite limited evidence from the quantitative findings, the qualitative findings suggested that SRT can be a worthwhile intervention for older people.

To date, no studies have measured the effectiveness of SRT for loneliness; therefore, research is required to determine the effectiveness of this intervention. As discussed in Chapter 3, loneliness, anxiety and depression can be interrelated mental health problems. Interventions that address these three mental health problems together could be of great benefit. Therefore, there is a need in future research to further understand SRT as an intervention for interrelated mental health problems such as loneliness, anxiety and depression.
Table 5.1 Characteristics of spiritual reminiscence therapy studies for older people

<table>
<thead>
<tr>
<th>Authors</th>
<th>Population/Religion</th>
<th>Study design</th>
<th>Types of SRT</th>
<th>Duration</th>
<th>Theories</th>
<th>Program details</th>
<th>Measurement</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emery (2002)</td>
<td>United States of America/Caucasians/Christians</td>
<td>Quantitative (Quasi-experimental)</td>
<td>Story based</td>
<td>8 weeks</td>
<td>Erikson’s theory</td>
<td>Self-developed Week 1: First Week 2: School Days Week 3: Life Work Week 4: Traditions Week 5: Battles Won &amp; Lost Week 6: Turning points Week 7: Then &amp; Now Week 8: Words of Wisdom</td>
<td>ERC, GDS, PG, PLI, PWB, R-COPE, SNI, STAI</td>
<td>No significant improvement on measures of depression ($p = 0.62$), anxiety ($p = 0.28$) and self-acceptance ($p = 0.52$) SRT group reported more personal growth ($p = 0.01$), spiritual support ($p = 0.04$), and purpose in life ($p &lt; 0.05$)</td>
</tr>
<tr>
<td>Haslam et al. (2013)</td>
<td>Australia/Caucasians/Christians</td>
<td>Quantitative (Randomised controlled trial)</td>
<td>Song and story based</td>
<td>6 weeks [12 sessions, two per week]</td>
<td>Religion identity and Social identity theory</td>
<td>No information included</td>
<td>GAI, ICC, IRG, RI, SAGE, SLS</td>
<td>No significant effect on cognition, anxiety and depression.* no $p$-values were reported Fit with religious song reminiscence was associated with GAI ($r = -0.66, p = 0.014$) &amp; LSS ($r = 0.68, p = 0.011$)</td>
</tr>
<tr>
<td>Wu and Koo (2015)</td>
<td>Taiwan/ Taiwanese/Traditional folk religion</td>
<td>Quantitative (Randomised controlled trial)</td>
<td>Story based</td>
<td>6 weeks</td>
<td>Erikson’s theory and Continuity theory</td>
<td>SRT program established by MacKinlay and Trevitt (2006)</td>
<td>HHI, LSS, MMSE, SIWB</td>
<td>Improved hope ($p = 0.005$), life satisfaction ($p &lt; 0.001$) and spiritual well-being ($p = 0.001$)</td>
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<tr>
<td>MacKinlay (2009)</td>
<td>Australia/Latvian/No information on religion</td>
<td>Qualitative &amp; Story based</td>
<td>6 weeks</td>
<td>-</td>
<td>SRT established by MacKinlay and Trevitt (2006)</td>
<td>Week 1: Life meaning Week 2: Relationships, isolation and connecting Week 3: Hope, fears, and worries Week 4: Growing older and transcendence Week 5: Spiritual and religious beliefs Week 6: Spiritual and religious practices</td>
<td>-</td>
<td>Eight themes were connectedness, spiritual and religious practices, vulnerability and transcendence, physical health issues, wisdom and memory, war experiences, hope/fear and communication style of facilitator</td>
</tr>
</tbody>
</table>
Week 4: Growing older and transcendence
Week 5: Spiritual and religious beliefs and
Week 6: Spiritual and religious practices

Mackinlay and Trevitt (2010)

Australia / Caucasian/Christians Qualitative Story based 6 weeks Erikson’s theory

SRT established by MacKinlay and Trevitt (2006)
Week 1: Life meaning
Week 2: Relationships, isolation and connecting
Week 3: Hope, fears and worries
Week 4: Growing older and transcendence
Week 5: Spiritual and religious beliefs and
Week 6: Spiritual and religious practices

Two themes revealed ‘meaning in life’ and ‘vulnerability and transcendence’

Note: ERC: Elder Role Checklist; GAI: Geriatric Anxiety Inventory; GDS: Geriatric Depression Scale-30 items; HHI: Herth Hope Index; ICC: Identification with care community; IRG: Identification with reminiscence group; LSS: Life Satisfaction Scale; MMSE: Mini Mental State Examination; PG: Personal Growth; PLI: Purpose in Life Index; PWB: Psychological Wellbeing Inventory; R-COPE: Religious Coping Activity Scales; RI: Religious identity; SAGE: Self-Administered Gerocognitive Examination; SNI: Social Network Inventory; SIWB: Spirituality Index of Wellbeing; SLS: Satisfaction with Life Scale; SRT: Spiritual reminiscence therapy; STAI: State-trait anxiety inventory
5.4 Theoretical approaches in spiritual reminiscence therapy

As is the case for broader approaches to RT, the inconsistent use of theoretical underpinnings in SRT such as Erikson’s theory, continuity theory and social identity theory may limit our understanding. Similar to RT, there are no specific theories for SRT and the approaches vary between studies.

Erikson's (1963) developmental theory concentrated on the development of the ego-integrity state. According to this approach, older people consequently feel satisfied with their life experiences and prepared for unexpected things that might yet occur. However, Emery (2002) used Erikson’s theory to guide SRT and found no significant effect for anxiety and depression. Although there was some description of this theory in Emery’s study, there was no link made between Erikson’s theory and the findings, limiting the ability to develop an understanding of the mechanism of ego-integrity development in this intervention.

In comparison to Emery's (2002) study, Wu and Koo (2015) described several theories in relation to RT but not SRT. These theories included Erikson’s theory and continuity theory. Continuity theory, developed by Butler (1963), posited that the reminiscence process guides people to adjust themselves to the changes that happen in their life. This theory suggests that the ability to adapt to changes in their life influences the present characteristics of individuals. Wu and Koo (2015) found significant findings for life satisfaction, hope and spiritual wellbeing. However, there was limited description about the mechanism of RT from these two theoretical perspectives. Furthermore, the use of continuity theory in the study conducted by Wu and Koo (2015) did not focus on mental health problems.

Further, Erikson’s theory and continuity theory do not address social connectedness, which was highlighted earlier in this chapter as central to addressing loneliness, anxiety and depression. This limits their usefulness to inform and explain the mechanism of SRT in this present study. Social identity theory, on the other hand, focuses on the importance of social connectedness. Using this theory, SRT may be understood as bringing a sense of social connectedness among the older people involved in the therapy group, as an outcome of meaningful interaction within the group.

While no studies have yet specifically explored the mechanism of SRT through this theoretical lens using the concept of spirituality more broadly, Haslam et al. (2013) used religious identity as an extension of social identity. Haslam et al. (2013) argued that group identification through religious song RT was enhanced by religious identity and group identification was negatively correlated with anxiety. It was demonstrated earlier in this chapter that a broader approach to spirituality is more
appropriate for the Malaysian population; however, Haslam et al.’s finding supports the usefulness of a social identity approach.

Based on these theoretical understandings, SRT can be expected to be a suitable approach among Malaysian older people with loneliness, anxiety and depression and the implementation of SRT may add to theoretical understandings. However, it is important to select the appropriate SRT program to be adapted to the Malaysian population.

5.5 The need to adapt spiritual reminiscence therapy to a Malaysian population

There is a need to adapt SRT programs to a Malaysian population because this population represents several religious and cultural traditions. Existing SRT programs were developed in the United States of America and Australia; therefore, adaptation of the SRT program used in this study was needed to ensure its relevance to the population under study and so that participation is encouraged and the program is accepted (Hwang, 2006). Adaptation is preferred as development of a new program would be costly and time-consuming (Hwang, 2006). The importance of cultural adaptation in SRT was also highlighted by MacKinlay (2009), who suggested cultural values needed to be integrated in SRT for Latvian people because their life experiences were highly integrated with culture.

Specific, culturally adapted RT programs have been found to be effective (Choy & Lou, 2016; Nooripour et al., 2015; Shellman et al., 2009; Zhou et al., 2012). In a RT study which involved 114 older people living in a community in Hong Kong, Choy and Lou (2016) found cultural adaptation of RT significantly improved depression. The cultural adaptation process involved two expert validations and a pilot work with five participants with depression. Their study found four elements of cultural adaptations which were: developing bonds with participants to improve understanding about RT; follow-up for absent participants to increase participation; home tasks related to Chinese culture for each week; and having an additional researcher as an observer. Similarly, culturally adapted RT for Iranians (Nooripour et al., 2015), African Americans (Shellman et al., 2009) and Chinese (Zhou et al., 2012) was found to be effective for loneliness and depression. This supports the need for cultural adaptation of SRT in the present study.

5.6 The adaptation process of the spiritual reminiscence therapy program

The adaptation process involves identifying the unique characteristics of the new population and integrating those criteria in the program without affecting the program effectiveness (Chen, Reid, Parker, & Pillemer, 2013). After selecting a suitable program, the process of adaptation was based on
the Psychotherapy Adaptation and Modification Framework (PAMF) (Hwang, 2006). The adapted program was then piloted with the pilot participants living in the community.

5.6.1 Selection of a suitable SRT program
Selection of a SRT program was based on the contents that were specific to loneliness, anxiety and depression. A number of existing programs had limitations that precluded their use. For example, Emery's (2002) program was general, without specific approaches to particular mental health problems and there was no clear description of how spirituality was integrated into the program. Haslam et al. (2013) focused on one element of spirituality — religious songs — an approach that is not suitable for religions such as Islam and Buddhism, where singing is not included as a way of spiritual practice. In the MacKinlay and Trevitt (2006) program, however, the topic of Week 1 is ‘Life Meaning’ which is pertinent for depression; the topic of Week 2 is about ‘Relationships— isolation, connecting’ which relate to loneliness; and Week 3 covers hope, fears and worries, which could help with anxiety. This program showed positive results for older people with dementia (MacKinlay, 2009; Mackinlay & Trevitt, 2010; Wu & Koo, 2015). Mackinlay & Trevitt (2006) also used story-based SRT, which is more suitable for a multi-faith population such as that in Malaysia. This program has been tested in a multi-faith Latvian population (MacKinlay, 2009) and has been used with older Taiwanese people (Wu & Koo, 2015). Thus, the MacKinlay and Trevitt (2006) SRT program was selected for the present study.

5.6.2 The adaptation of the SRT program based on the PAMF
For the second step of adapting SRT to suit a Malaysian population, the Psychotherapy Adaptation and Modification Framework (PAMF) was used (Hwang (2006). PAMF consists of six therapeutic domains (Figure 5.2).

(1) Dynamic issues and cultural complexities (2) Orientation (3) Cultural beliefs
(4) The client–facilitator relationship (5) Understanding cultural differences (6) Highlighting cultural issues about the relevant population

Figure 5.2 The six therapeutic domains of the Psychotherapy Adaptation and Modification Framework (PAMF)
i. Dynamic issues and cultural complexities domain

The dynamic issues and cultural complexities domain involves appreciating older people’s cultural identities within cultural complexities. Given the multi-ethnic population in Malaysia (e.g. Malays, Chinese, and Indians) that may be involved in this research, adjustments would have to be made to make it feasible and acceptable. For example, Malays and Chinese depend on traditional healing to treat mental health problems (Haque, 2008). As SRT is not a traditional healing practice, it may be less acceptable to these groups. To enhance participation, the program must recognise differences in cultural and spiritual beliefs, and this includes those of the group facilitator. In this domain also, the group facilitator should have some prerequisite knowledge about the different cultures and religions of the participants so that nuances can be identified and responded to appropriately. Such an approach takes account of Hwang’s (2006) assertion that multiple identities contribute to cultural complexities.

Hays (2001) introduced the ADDRESSING framework to assist in the management of cultural complexities and multiple identities. The ADDRESSING framework includes Age, Developmental, acquired Disabilities, Religion and spiritual orientation, Ethnicity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin and Gender. In relation to the Malaysian population, older people may hold multiple identities that need to be considered. For instance, an older Malay woman who is Muslim and has depression might hold several identities such as age, disability, religious and spiritual orientation, ethnicity, and gender. Therefore, the program should be adapted to relate to the composite identity of this woman, making it more acceptable and effective.

ii. Orientation domain

For the orientation domain, older people learn about the program and develop aims for what they want to achieve from participation. It is essential to perform a program orientation to increase comfort and familiarity. For the purpose of program orientation, Shulman (2012) used a framework that guided an SRT program in four phases. The preliminary phase involved equipment preparation and the setting, such as a comfortable room. In this phase also, the facilitator explained the purpose of the program, the process and ethical issues. This phase is critical to encourage familiarity and facilitate feelings of safety. The beginning phase involved an introduction to each topic and reminder of the ethical issues. The middle phase included the implementation of the topics of the SRT program. The end phase involved conclusion information about topics for the next session.

iii. Cultural beliefs domain

For the cultural beliefs domain, the program is integrated with cultural values. Harris (1997) supported that discussion topics of RT should highlight religions and cultures of the population
involved in the study. In this study, the program was integrated with cultural elements from Malaysia. Several multisensory triggers with cultural and spiritual significance were employed. These multisensory triggers were related to vision, taste, sound, smell and touch. The objective of adding the triggers in the program is to assist older people to remember past events. Triggers promote personal interaction and help participants to concentrate on the topic (Pollanen & Hirsimaki, 2014). The use of human senses increases, helping them to recall certain memories or events (Pollanen & Hirsimaki, 2014). Importantly, triggers may also make the program more interesting and pleasurable.

The development of triggers was based on program content in relation to older Malaysian adults’ cultures and spiritual beliefs. All triggers were integrated into the middle phase of the SRT program.

- For Week 1 (Life meaning), visual triggers such as family photos and printed pictures that related to cultural events (‘Eid celebration, Chinese New Year and Diwali), health, friends, pets, pain and disability were used. Participants were encouraged to bring their family photos, photos relating to cultural events, or any photos that were meaningful to them.

- For Week 2 (Relationships–isolation, connecting), visual triggers such as the older people’s pictures with old and new friends were used.

- For Week 3, the program content was related to hopes, fears, and worries. Pictures were used relating to participants’ fears such as falling, death and disability. The discussion also incorporated their religious beliefs about death and how this belief helps them to reduce fears and worries.

- Week 4 involved topics on growing older and transcendence. Visual and taste triggers were used to help in memory recall. For visual triggers, the participants were encouraged to bring photos of their younger selves. The discussion also involved their memories of cultural attitudes towards them when they were young and in comparison, when they were getting older. Taste triggers included familiar candies and mango/orange fruits. This was used as part of an activity to identify mixed feelings about growing older.

- For Week 5 (Spiritual and religious beliefs), sound triggers, visual triggers, and smell triggers were used. Sound triggers involved Quran recitation, church choir, temple sounds, traditional music and old favourite songs. Visual triggers included photos of a church, mosque, and a temple, as well as prayer videos. Smell triggers included the smell of flowers like hibiscus, roses, pandanus leaves and cinnamon that were familiar. Hibiscus was used in this program as it is the Malaysian national flower, and pandanus leaves were used as most Malaysian signature dishes use these leaves, regardless of ethnicity.

- For Week 6 (Spiritual and religious practices), tactile triggers involved the Quran and Bible
or any religious books related to the participants’ beliefs. The facilitator guided the participants in recalling memories according to their religious beliefs while being aware of any potential religious constraints between the participants.

iv. The client–facilitator relationship domain

In this adaptation process, the researcher is known as the facilitator because, although the two roles were filled by one person in this study, the facilitator does not necessarily need to be a researcher. In this step, the bond between the participants and the facilitator is strengthened by encouraging each party to understand their roles and through the facilitator’s understanding of cultural issues. To nurture this relationship, the facilitator must first start developing rapport with the participants. It is important to be aware that Malaysian culture emphasises respect for older people. Older people in Malaysia value themselves as being experienced and respected in the community and aware of their roles as mentors or leaders in society (Muhammad & Merriam, 2000). If the facilitator is a younger person they should show respect to the older participants in this way. Unlike western countries that may acknowledge older people with their name, calling older Malaysians by their name is a sign of rudeness. Appropriate terms to use also vary among different ethnicities. For example, for Malays, older men are called ‘pakcik’ and older women are called ‘makcik’. For Chinese, ‘ahsok’ is used for older men. Further, the relationship can be improved by setting realistic goals so that participants know what to expect from the program. For instance, it is important that older people know that the program is not for treating ‘mental illness’, rather for relieving the symptoms related to mental health problems.

v. Understanding cultural differences domain

Addressing this domain requires that the researcher has awareness of the differences in communication styles and the influence of ethnicities in self-expression. In this domain, the researcher recognises cultural differences in older people in Malaysia such as their reaction towards mental health problems. Different cultures and different religions may perceive their mental health problems in a different way (Rokach, Orzeck, & Neto, 2004). For instance, older people who are Muslim or Hindu may have a different reaction towards mental health problems. Muslims may see their mental health problems as being God’s punishment or a test from God (Ciftci, Jones, & Corrigan, 2013) and supernatural activities such as black magic and spirit possession of the body (Haque, 2008). Meanwhile, Hindus may believe it is because of an unknown previous sin (Behere, Das, Yadav, & Behere, 2013). This may present as a challenge when the researcher’s cultural belief is different from the participants’ cultural beliefs (Alegria et al., 2010). For instance, a particular culture may refuse some treatment that the researcher believes is worthy (Alegria et al., 2010). Therefore, the researcher
should understand the cultural differences as they may influence an older person’s perceptions of the program.

vi. Highlighting cultural issues about the relevant population domain
The facilitator must identify any cultural issues that could interfere with the program, and understand how social positions and life experiences influence the effectiveness of the program. An example pertinent to Malaysia is the possibility of rejection of a new program that originated from western countries. As Malaysia was colonised by European countries for over four centuries, there are negative perceptions towards anything coming from western countries (Sumari & Jalal, 2008). This attitude commonly originates from an older generation that lived during the war era, who believe that western countries tried to damage their cultural values (Sumari & Jalal, 2008). The role of the facilitator is to be tolerant of such beliefs and buffer the impact of these beliefs by explaining the purpose of the program and how it has been adapted to be more specific for them.

5.6.3 Expert validation and pilot of the SRT program
For the third step, the translated and adapted SRT program was tested using a pilot study. The SRT program was first translated from the English language to the Malay language. The translated SRT program was then validated by two experts in the gerontological nursing field in Malaysia. The first expert was working in an academic role as a Lecturer at the International Islamic University Malaysia. The second was working in a clinical role as a geriatric nurse in the Geriatric ward, General Hospital Kuala Lumpur and currently completing a Master of Nursing Science. Discussion was held between these experts to determine whether the content of the program and triggers were suitable for older people in Malaysia, and whether any additional topics were needed. After the program had been reviewed and consensus was reached, pilot work commenced.

Ten older people living in a small village community in Kuantan, Pahang, Malaysia were approached using convenience sampling. The pilot participants were approached to participate at the community hall after a government event. They were given information about the process of the pilot work including information about the SRT program, the benefits and the risks of SRT program participation and their right to withdraw from the program (Appendix A). These ten participants provided written informed consent to participate in this pilot work. Out of ten participants, six were male, and four were female. The mean age of participants was 64.6 years ($SD$: 4.9). All of the participants were from the Malay ethnic group and identified as Muslim. Nine participants were married, and one was divorced. The mean number of children of participants was 6 ($SD$: 1.4). Four participants had never worked, three used to work as government servants, two
were previously self-employed, and one previously worked as a private servant. Out of ten participants, six had secondary school education, three received primary school education, and one had no formal education. Three participants had prescribed medications. The six-week SRT program was conducted at a community hall for six days consecutively for the purposes of the pilot. The six days of the SRT program used a similar program to the six-week SRT program (see Chapter 5). For example, the first day of the pilot work discussed life meaning, similar to the first week of the full six week SRT program. The sessions were conducted in the morning, as requested by the pilot participants. All the content of the SRT program and all the triggers were used in the pilot study to ensure that it was feasible and understandable to be used in Malaysian population. The pilot participants were asked in the group about the contents of the SRT program and suggestions for the program after completed each session of the SRT program. The responses were recorded as notes. An example question posed to the pilot participants was “Did you understand the topic (such as life meaning) that was discussed today?” In response, the participants suggested more introduction and explanation about the topics by the facilitator at the beginning of the session to give them some ideas. There was some difficulty in obtaining feedback as some pilot participants required more detailed explanation about the questions to facilitate comment. Further explanation and rephrasing of the questions was needed to encourage more responses and feedback.

Overall, the SRT program was seen as appropriate by this group of pilot participants. The allocated time of between one and two hours was reported as suitable. The triggers used in the program were supported by the participants; however, it was noted that more triggers were required to help them understand the discussed topics. Participants also suggested that the printed pictures be larger. There were no further specific suggestions. Participants reported that they understood all the topics and were able to recall and share memories related to discussion topics. There was no stress or emotional disturbance during the program sessions. These findings demonstrated that the program was acceptable to an older population in Malaysia in its adapted form, with minor changes as described above.

**5.7 The need for an intervention study**

Recommendations from the systematic review of group RT in chapter 4 and review of SRT in this chapter prompted this intervention study using a different type of RT, with a more robust control group design and a standardised program. Additionally, most of the previous studies chose or selected participants without screening for the presence of loneliness, anxiety and depression. From previous studies, there is a relative paucity of research empirically assessing the benefits of meaningful social identity such as religious and spiritual identity in the context of multiple religions. Clearly more
research is needed to disentangle the complexities in the benefits of religious and spiritual identity as an extension of social identity theory. Although there have been attempts to integrate theories in SRT in previous studies, the inclusion of these theories has not been rigorously investigated. To the best of our knowledge, this study is the first study to use social identity theory as a mechanism of SRT. Further, this study is the first to implement SRT in a non-western, multi-ethnic and multi-religious population and involves an adapted program. Therefore, it is important to explore older people's experiences from a SRT program. This study will explore whether the effect of SRT on anxiety, loneliness and depression is significant, and how such a program is experienced by participants, using a social identity theory.

5.8 Summary
This chapter discussed the need for adaptation of a SRT program for the Malaysian population because of its multi-ethnic and multi-religious make-up. Due to heterogeneity of the Malaysian population, it was preferable to adopt spirituality than religiosity. A suitable SRT program was selected that underwent an adaptation process for a Malaysian population.

The next chapter will discuss the methodology adopted to implement the SRT program, and investigate its effectiveness, and participants’ experiences of the program.
Chapter 6  Methodology

6.1 Introduction
This chapter describes the research approach that was used in this study. The study adopted a randomised controlled trial design with qualitative components conducted concurrently, and sequentially, with the quantitative intervention study. This research design was used to investigate both the effectiveness and the acceptability of the spiritual reminiscence therapy (SRT) program for Malaysian older people with loneliness, anxiety and depression living in a residential aged care facility (RACF). One RACF in Malaysia was selected as the study setting. This chapter describes the process of recruitment, intervention, quantitative and qualitative data collection, and analysis. The chapter also outlines the ethical considerations of the study.

6.2 Study design
The research question in this thesis focused on the use of the SRT program to reduce loneliness, anxiety and depression among older people. That is, the thesis addressed the questions:

1) Is the SRT program effective in reducing loneliness, anxiety and depression among Malaysian older people living in a RACF?

2) What are the experiences and acceptability of the SRT program for the participants?

6.2.1 Pragmatism
Pragmatism was adopted as the paradigmatic approach for this research. A number of paradigms are well-known in guiding research, particularly positivist, interpretivist and critical approaches (Creswell, 2009). All research paradigms engage with four worldview elements of ontology, epistemology, axiology and methodology (Neuman, 2014). These four worldview elements relate to what exists, how it exists, how we know things, and how we can investigate reality. The major paradigms tend to be associated with particular methodological approaches — positivism with quantitative approaches and interpretivism with qualitative approaches. Both have been used in research about reminiscence therapy (RT). For example, Ancient (2016) study used a positivist approach, employing a cross-sectional survey about perception of memories in reminiscence for older people. Meanwhile, O'Rourke (2006) used an interpretivist approach in her case study on group RT.

Pragmatism critiques the requirement to choose between qualitative and quantitative approaches (Johnson & Onwuegbuzie, 2004; Tashakkori & Teddlie, 2010). A main element of pragmatism is methodological pluralism, which contrasts with positivist and interpretivist approaches that emphasise monomethod research (Johnson & Onwuegbuzie, 2004). Pragmatism is commonly
associated with mixed-method research design (Tashakkori & Teddlie, 2010), but it is also suitable for other research designs.

A pragmatic approach was most useful for the present study because the research problem guides the selection of methods rather than methods being chosen based on research philosophy (Morgan, 2007). This flexible approach allows the researcher to employ multiple methods to answer the research question (Creswell, 2009; Johnson & Onwuegbuzie, 2004; Morgan, 2007). Pragmatism offers an abductive process which allows the researcher to move between different methods related to the theory or phenomena of interest (Morgan, 2007). The focus of the present study was to determine whether a SRT program was acceptable and effective for older people with loneliness, anxiety, and depression. A quantitative approach offers evidence for the effectiveness of the SRT program. Qualitative data from the participants involved in the SRT program allowed investigation of the acceptability of the program. While the majority of the previous studies on SRT or RT have used a quantitative approach, gathering quantitative data alone may only provide information about the effectiveness of the program. The combination of methods can provide insight into participants’ experiences of the program and its acceptability for this population. As discussed in Chapter 5, this element is essential to our understanding of the acceptability of the program and to give insight into its feasibility and usefulness with this new population of Malaysian older people living in RACFs.

A pragmatic approach has been used together with social identity theory (see section 4.3.2.1). Pragmatism is about the methodology which for this study is a randomised controlled trial design with qualitative components. A randomised controlled trial design with qualitative components was used to not only gain deeper knowledge about the effectiveness but knowledge about the experience and acceptability of the SRT intervention for this population. On the other hand, social identity theory helps to understand the mechanisms by which the intervention works, understanding people’s experiences, what this means for the development of SRT program and how the intervention impacts on loneliness, anxiety and depression experienced by the older people.

### 6.2.2 A randomised controlled trial design with qualitative components

The present study employed a randomised controlled trial design with three-month follow-up incorporating concurrent and sequential qualitative data collection. This design was suitable for several reasons. First, as demonstrated in Chapter 4, most of the previous studies on RT used a quasi-experimental study design and majority of the existing findings were inconclusive. Qualitative data about participants’ experiences and the acceptability of RT were also limited in previous studies. A more rigorous study design with a control group, such as a randomised controlled trial, is needed
(Thompson & Panacek, 2006). Further, a combination of quantitative and qualitative data can provide a better explanation of the effectiveness, the acceptability and participants’ experiences of SRT, particularly given its adaptation in this study to a different population (Blake, 2013; Westerhof & Bohlmeijer, 2014). The study was conducted between October 2015 and March 2016 (Appendix B). The study started with a screening phase, which was then followed by baseline assessment and implementation of the intervention (Figure 6.1). Observation was performed during the SRT program. Quantitative assessment was repeated at completion of the program (post-test) and at three months after completion. The focus group discussion (FGD) exploring participants’ experiences of the program was conducted after the post-test.

Figure 6.1 Adapted Consolidated Standards of Reporting Trials (CONSORT) Diagram – Recruitment, randomisation and assessment procedures

(Moher, Schulz, & Altman, 2001)
6.3 Study setting
The study was carried out in a residential aged care facility (RACF) located in Klang Valley, Malaysia. Klang Valley is the region in Selangor, Malaysia including the capital city of Malaysia, Kuala Lumpur. This RACF was located in Cheras, one of the districts of Klang Valley (Figure 6.2).

Resource constraints such as time, personnel and location, limited the ability to include more RACFs. Therefore, generalisability is limited. However, the residents in this RACF were originally from several RACFs in Malaysia, having relocated there after its opening in 2012.

![Map of Malaysia showing the location of the RACF in Cheras, Selangor](Google maps, 2015)

6.4 Population
6.4.1 Sample
The target population was permanent residents of the RACF (in the Malay language: *Rumah Seri Kenangan Cheras*). The total number of permanent residents in RACF Cheras was 180 (N.Izzati, personal communication, June 9, 2014). The study sample was drawn from among these residents.
6.4.1.1 Inclusion and exclusion criteria

The inclusion criteria were:

1. RACF resident aged 60 years or older;
2. understood and spoke Malay language;
3. cognitively intact according to the cognitive screening tool (The Mini-Cog), legally competent and able to sign the consent form;
4. having signs of loneliness, anxiety or depression according to the loneliness screening tool, anxiety screening tool (A short form of the Geriatric Anxiety Inventory) and depression screening tool (Depression Scale 4 items)
5. not taking any antidepressant and antianxiety medications, or if taking they must have stabilised conditions for at least three months prior to the study to ensure the are able to participate; and
6. had lived in the RACF for more than four weeks. This was to ensure that feelings of loneliness, anxiety and depression were not due simply to recent location to the RACF, as the most psychological stress for this type of population has been found to occur during the first four weeks after relocation among institutional settings, reducing after this time (Hodgson et al., 2004).

The exclusion criteria were:

1. diagnosis of sensory deficit such as untreated cataract, glaucoma, diabetic retinopathy, speech problems and severe hearing problems;
2. severe or chronic mental illness such as schizophrenia and bipolar disorders; and
3. severe depression.

These residents were excluded from the study because these issues require greater and more targeted attention.

6.4.2 Sample size

The sample size was calculated using the sample size formula for two means (Suresh & Chandrashekara, 2012). This calculation was selected because it involved an intervention group and control group. The total sample size for the study with \( r = 1 \) (equal sample size), \( \alpha = 5\% \) and power at 80\% was calculated as 28 participants (Figure 6.3). Pooled standard deviation (\( \sigma \)) and difference of means of two groups (\( d \)) were selected from Chao et al. (2006) as this previous study implemented group RT for older people with depression living in nursing homes with similar characteristics to the present study. In regard to the attrition rate, several studies that implemented
RT in older Asian populations reported 27% (Karimi et al., 2010) and 25% (Chao et al., 2006) attrition. A conservative attrition rate of 30% was therefore adopted, resulting in a minimum target sample of 40 participants (Figure 6.3).

\[
N = \frac{(r+1)(Z_{\alpha/2} + Z_{1-B})^2\sigma^2}{rd^2}
\]

(Suresh & Chandrashekar, 2012)

N= n1 (sample size for group 1) + n2 (sample size for group 2)
\(r\) (ratio of sample size required for two groups) = 1
\(Z_{\alpha/2}\) = normal deviate at a level of significance = 1.96
\(Z_{1-B}\) (normal deviate at 1-B% power with B% of type II error = 0.84
\(\sigma\) (pooled standard deviation) = 2.3 (Chao et al., 2006)
\(d\) (difference of means of two groups) = 1.72 (Chao et al., 2006)

\[
N = \frac{(1+1)(1.96+ 0.84)^2 (2.3)^2}{1 \times (1.72)^2}
\]

\[
N = 2 \left(\frac{7.84}{5.29}\right) \left(\frac{5.29}{2.96}\right)
\]

\[N = 28 \text{ participants (+30% attrition rate)} = 40 \text{ participants}\]

**Figure 6.3 Sample size calculation**

In regard to the potential attrition rate, it is advisable to implement unequal participants between the intervention group and control group for prevention of loss of power (Dumville, Hahn, Miles, & Torgerson, 2006). This approach has been adopted in previous studies (Emery, 2002; Haslam et al., 2010). Haslam et al. (2010) employed unequal participants in their RCT with group RT (29 participants), individual RT (24 participants) and a group control activity (20 participants). Emery (2002) implemented unequal participants between their intervention group (14 participants) and control group (11 participants). The present study adopted a similar approach. It was planned to have 19 participants in the intervention groups and 17 participants in the control group. However, only 34 participants were successfully recruited. Of these, 18 participants were allocated to the intervention groups and 16 to the control group.

6.4.3 **Recruitment of participants**

The screening process was conducted in two steps in which firstly by a RACF manager and then by the researcher – see
Figure 6.4. All residents of the RACF were potential participants (N=180). The manager of the RACF identified suitable potential participants based on their health records to meet the inclusion and exclusion criteria. The potential participants were asked for their verbal agreement and the manager of the RACF provided a list of names of potential participants who agreed to be approached by the researcher. The researcher then provided these individuals with an invitation to participate, including the information sheet and consent form (Appendix C). All those who signed the consent form were screened to ensure they met the inclusion criteria.

Of 180 residents, the staff in the RACF provided a namelist of 46 potential participants based on their health conditions; for example, screening out those with dementia or sensory deficit like hearing and speech problems that would severely impact their ability to participate in a group discussion. All 46 potential participants were involved in screening which resulted in 100% response rate. Of these, 34 participants were eligible and consented to participate in the SRT program. For the participants’ allocation, the researcher employed randomisation. Thus, 18 participants were allocated to the intervention groups, and 16 participants were allocated to the control group. All participants completed a pre-test (baseline assessment) in the week before the start of the intervention. The post-test assessment took place in the week after the six-week intervention. The researcher also performed a three-month follow-up data collection for the intervention and control groups.
Figure 6.4 Recruitment of participants based on Adapted Consolidated Standards of Reporting Trials (CONSORT) Diagram

(Moher et al., 2001)
6.4.4 Screening

In the screening phase, the researcher asked the manager of the RACF to identify potential participants. Of 180 residents residing in the RACF, the manager excluded 134 residents who had cognitive problems and physical problems based on health documents, or who declined to participate in the study. Health records also were checked to ensure that participants were not taking any antidepressant and antianxiety medications, or if taking they must have stabilised conditions for at least three months prior to the study to ensure they were not in uncontrolled conditions that would severely impact their ability to participate in the study.

The researcher performed a screening test on the remaining participants (N = 46). Each individual completed the Mini-Cog to determine their cognitive levels. Those who were identified as negative for cognitive impairment with normal CDT were selected as study participants. Those who were cognitively intact according to the Mini-Cog completed the screening tools for loneliness, anxiety and depression. Then, they were verbally informed about their screening results. Those who were cognitively intact and showed signs of loneliness or anxiety or depression were selected as participants and continued to pre-test and allocation.

From the Mini-Cog test (Borson, Scanlan, Brush, Vitaliano, & Dokmak, 2000), three residents were excluded because of cognitive impairment. The screening process involved the Loneliness Screening Tool (Bondevik & Skogstad, 1996), a short form of the Geriatric Anxiety Inventory (GAI-SF) (Byrne & Pachana, 2011) and the Geriatric Depression Scale 4 items (GDS4) (D'ath, Katona, Mullan, Evans, & Katona, 1994). Nine participants were excluded who did not have loneliness, anxiety or depression. Therefore, 34 residents were eligible to participate. The frequencies of loneliness, anxiety, and depression among these participants are provided in Figure 6.5.
Figure 6.5 Total number of participants (N = 34) and frequencies of loneliness, anxiety and depression

6.4.4.1 Dropout rate
The dropout rate for the present study was 8.8%. A participant was considered to have dropped out if they did not attend at least one session for intervention group and control group. Of 34 participants, three participants did not attend at least one session. Of the remaining 31 participants, ten participants attended all six sessions. Therefore, 21 participants did not attend all sessions. The total number of the participants involved in the SRT program for intervention group varied from 8 to 15 participants (Table 6.1). The non-attendance was unsystematic. There were several reasons for not attending such as health problems, other commitments and failure to turn up. Appendix D provides the reasons for non-attendance for each of the participants.
Table 6.1 The total number of participants involved in the spiritual reminiscence therapy program

<table>
<thead>
<tr>
<th>The week of the SRT program</th>
<th>SRT program</th>
<th>Total participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group A (n)</td>
<td>Group B (n)</td>
</tr>
<tr>
<td>Week 1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Week 2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Week 3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>Week 4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Week 5</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Week 6</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Note: n: total number of participants; SRT: Spiritual reminiscence therapy

6.4.4.2 Measurement instruments

In the screening process, the potential participants were assessed for their cognitive levels, loneliness, anxiety and depression to determine their eligibility to participate in the study. Table 6.2 shows the measurement instruments for screening. These screening tools are detailed further in Appendix E.

The cognitive levels of the participants were assessed using The Mini-Cog (Borson et al., 2000). The Mini-Cog requires three minutes for administration, compared with the Mini Mental State Examination (MMSE) (Folstein, Folstein, & McHugh, 1975), which requires six minutes for administration (Borson et al., 2000). The Mini-Cog was selected because this tool has high sensitivity (99%) and is not influenced by the educational level and language of the participants (Borson et al., 2000). Loneliness was assessed using the Loneliness Screening Tool. This tool has been used in previous studies involving older people living in RACF (Bondevik & Skogstad, 1996; Drageset et al., 2011) and found appropriate to measure loneliness among an older population. For anxiety screening, the short form of the Geriatric Anxiety Inventory (GAI-SF) (Byrne & Pachana, 2011) was used. The GAI-SF was chosen due to its suitability for older people and has been reported as having high sensitivity (75%) and specificity (87%). For depression screening, the Geriatric Depression Scale 4 items (GDS4) (D’ath et al., 1994) was used. GDS4 shows high sensitivity of 89% and specificity of 65% (D’ath et al., 1994).
Table 6.2 Scoring for the screening instruments

<table>
<thead>
<tr>
<th>Concept</th>
<th>Measurement</th>
<th>Total no. questions</th>
<th>Time to complete (mins)</th>
<th>Informant</th>
<th>Scoring</th>
</tr>
</thead>
</table>
| Cognitive level        | The Mini-Cog                                  | 3 items of memory recall and clock driving test (CDT) | 3                       | Self-report/One-to-one Interview | 0 = Positive for cognitive impairment  
1–2 = Positive for cognitive impairment if abnormal CDT  
1–2 = Negative for cognitive impairment if normal CDT  
3 = Negative screen for dementia (no need to score CDT) |
| Loneliness screening   | Loneliness Screening tool                     | 1                   | 1                       | Self-report/One-to-one Interview | 1 and 2 = Lonely  
3 and 4 = Not lonely |
| Anxiety screening      | A short form of the Geriatric Anxiety Inventory | 5                   | 5                       | Self-report/One-to-one Interview | 1–2 = No anxiety  
3–5 = Anxiety |
| Depression screening   | Geriatric Depression Scale 4 items            | 4                   | 4                       | Self-report/One-to-one Interview | 2–4 = Depressed  
1 = Uncertain  
0 = Not depressed |

**Maximum time burden for the measurement instruments:** 13 minutes

6.5 **Quantitative measurement**

A quantitative approach was used to address the research question: “Is the SRT program effective in reducing loneliness, anxiety and depression among older people?” A randomised controlled trial research design was used. The measurement instruments, the procedure involved in data collection, and the steps in data analysis will be detailed in this section.

6.5.1 **Measurement instruments**

Table 6.3 shows the measurement instruments used for pre- and post-test and follow-up (Appendix E). These measurement instruments were different from the measurement instruments used for screening, to reduce the risk of repeat testing bias (Indrayan, 2014). This type of bias occurs when participants remembered the answer that they previously gave and give the answer that they think is most accurate.
Table 6.3 Measurement instruments for pre- and post-test and follow-up

<table>
<thead>
<tr>
<th>Concept</th>
<th>Measurement</th>
<th>Total number of questions</th>
<th>Time to complete (minutes)</th>
<th>Informant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sociodemographic</td>
<td>Questionnaire</td>
<td>11</td>
<td>5</td>
<td>Self-report/ One-to-one Interview</td>
</tr>
<tr>
<td>Chronic medical illness burden</td>
<td>CIRS-G</td>
<td>14</td>
<td>15</td>
<td>Researcher</td>
</tr>
<tr>
<td>Loneliness level</td>
<td>UCLA-LS</td>
<td>20</td>
<td>20</td>
<td>Self-report/ One-to-one Interview</td>
</tr>
<tr>
<td>Anxiety level</td>
<td>GAS</td>
<td>30</td>
<td>30</td>
<td>Self-report/ One-to-one Interview</td>
</tr>
<tr>
<td>Depression level</td>
<td>M-GDS-14</td>
<td>14</td>
<td>10</td>
<td>Self-report/ One-to-one Interview</td>
</tr>
</tbody>
</table>

Maximum time burden for the questionnaire: 80 minutes

Note: CIRS-G: The Cumulative Illness Rating Scale for Geriatrics; GAS: Geriatric Anxiety Scale; M-GDS-14: Malay version of Geriatric Depression; UCLA-LS: The UCLA Loneliness Scale

Sociodemographic characteristics

Sociodemographic characteristics recorded for participants included gender, date of admission (length of stay in RACF), age, country of origin, religion, current marital status, number of children, employment history, educational status and prescribed medications.

Chronic medical illness burden (Cumulative Illness Rating Scale for Geriatrics)

Chronic medical illness burden was measured using the Cumulative Illness Rating Scale for Geriatrics (CIRS-G) (Miller et al., 1992). This tool has demonstrated good interrater reliability of 0.78 and 0.88 (Miller et al., 1992). This tool involves scores from 0 to 4 on each of a series of medical problems involving heart, vascular, hematopoietic, respiratory, eye, ears, nose, throat and larynx, upper gastrointestinal tract, lower gastrointestinal tract, liver, renal, genitourinary, musculoskeletal/integument, neurological, endocrine/metabolic and breast, and psychiatric illness. The ranges of the total score of CIRS-G are from 0 to 56 with the increasing score indicating an increase in chronic medical burden. A total score of CIRS-G above 25 indicates severe pathology in several body systems.

Loneliness (UCLA Loneliness Scale)

The UCLA Loneliness Scale (Russell, 1996) was chosen because it measures loneliness as a unidimensional concept, which is also the definition adopted in this study (i.e. a broad concept rather than classification into social and emotional loneliness). The UCLA Loneliness Scale has also demonstrated high internal consistency (Cronbach’s alpha of 0.89 to 0.94) (Russell, 1996). A high test-retest coefficient of 0.73 over 12 months also was found (Russell, 1996). A study focused on Malaysian older people with loneliness found Cronbach’s alpha of the UCLA Loneliness Scale was
Convergent validity in previous studies has demonstrated high significant correlations with other loneliness scales such as the NYU loneliness scale and Differential Loneliness scale. The Scale consists of 20 items, 11 negatively worded and nine positively worded. Each item is scored on a scale of 1 to 4. The total score of the scale is 20 to 80 points with no identified cut-off score; however, increasing scores show increased levels of loneliness.

**Anxiety (Geriatric Anxiety Scale)**

The present study selected the most recent anxiety scale: the Geriatric Anxiety Scale (GAS) because it acknowledges anxiety as a distinctive mental health problem (Segal, June, Payne, Coolidge, & Yochim, 2010). In comparison to scales such as the Geriatric Anxiety Inventory that focus on worry symptoms, the GAS is more comprehensive and focuses on four areas: cognitive, somatic, affective and worry. The GAS is composed of 30 self-report items: 25 items are divided into three common areas of anxiety symptoms among older people (cognitive, somatic and affective) and five items represent worry areas. The highest score on the GAS is 90, and the lowest score is zero. Increasing scores indicate increasing levels of anxiety.

Although the GAS scale has not been tested in RACFs, it has shown good internal reliability in community ($\alpha : 0.98$) and clinical settings ($\alpha : 0.98$) (Segal et al., 2010). The GAS has been tested in a non-western population and reported high Cronbach’s alpha. The GAS was translated into Persian for an older Iranian population with a reported Cronbach’s alpha value of 0.92 (Bolghan-Abadi, Segal, Coolidge, & Gottschling, 2013). Convergent validity with different anxiety scales reported significant correlations with the Beck Anxiety Inventory ($r=0.82$), State-Trait Anxiety Inventory scale ($r=0.79$) and Adult Manifest Anxiety Scale-Elderly Version ($r=.77$) (Segal et al., 2010).

**Depression (M-GDS-14)**

This study used the Malay version of the 14-item Geriatric Depression Scale (M-GDS-14) (Ewe & Che Ismail, 2000). The M-GDS-14 consists of 14 items with dichotomous responses (yes or no). The scoring of M-GDS-14 is 0 to 5 as normal and 6 and above indicating depression. The M-GDS-14 removed item 9 in the GDS 15 (Yesavage et al., 1982) scale since it has no discriminatory value in differentiating depression and no depression in a Malaysian population (Ewe & Che Ismail, 2000). The scale has shown Cronbach’s alpha of 0.84, test-retest reliability of 0.84 and good concurrent validity with MADRS (Montgomery-Asberg Depression Rating Scale) (Spearman's rho 0.68) (Ewe & Che Ismail, 2000). A recent study also found acceptable reliability of 0.73 among Malaysian older people who were attending outpatient clinics (Syed Elias et al., 2012). At the cut-off point of 5/6, M-GDS-14 detected all clinically significant depression with 95.5% sensitivity, and 84.2% specificity.
Measurement instrument translation

The study instruments were translated from the English language to the Malay language. To the best of the researcher’s knowledge, there was no standard guideline or protocol for instrument translation and the techniques used for instrument translation differ between studies. The present study used the instrument back-translation strategy used by Maneesriwongul and Dixon (2004). First, the researcher performed forward translation of the original version of the instruments from English to Malay and then back to English. A professional translator — a native English speaker who is fluent in Malay and living in Malaysia — checked the translation. Email discussion between the two translators was held to discuss any differences and to ensure semantic equivalence (Beaton, Bombardier, Guillemin, & Ferraz, 2000). Appendix F is the letter of proofreading for the translated instruments. All the measurement instruments in the present study were translated except the UCLA Loneliness Scale and Malay version of the Geriatric Depression Scale (M-GDS-14) because the Malay versions were already available.

6.5.2 Quantitative measurement procedure

All measurement instruments were administered a week before the implementation of the SRT program (pre-test), a week after the implementation of the SRT program had finished (post-test), and three months after completion of the program (follow-up). Most of the participants were reluctant to complete the measurement instruments by themselves and asked the researcher to read the measurement instruments for them. Therefore, the researcher implemented one-to-one interviews for collection of this data. For chronic medical illness burden, medical records were accessed and recorded information used to complete the Cumulative Illness Rating Scale for Geriatrics (CIRS-G) (Miller et al., 1992). If any discrepancies in the participant’s health status were detected, for example, severe depression on the M-GDS-14, these were to be immediately reported to the RACF manager.

6.5.3 Intervention and control procedure

Participants were divided into two conditions: intervention and control. Simple random sampling (simple lottery method) was used to reduce selection bias (Thompson, 2012). The researcher randomly selected the numbers with the numbers parallel to subjects to create the sample (Thompson, 2012). The last number of the sample (34) was assigned to the intervention group. The present study implemented single blinding because it was not feasible to perform double blinding since the researcher was the facilitator for the SRT program.
Those who were received into intervention were divided into two intervention groups. The participants in the two intervention groups (Group A and Group B) received the SRT program (Appendix G). There were nine participants for each intervention group and they were randomised into two intervention groups. These groups received separate SRT sessions, following the same program. The SRT program was conducted once a week in a 60 to 90-minute session. The researcher was the facilitator and led the SRT session. The SRT program took six weeks as did MacKinlay and Trevitt's (2006) program. This length of program was considered appropriate given the potential for illness or frailty in this population. Timelines and preferred days for sessions were decided in collaboration with the RACF manager to maximise participant availability around other activities.

The program contained different topics for each week:

- Week 1: Life-meaning;
- Week 2: Relationships–isolation, connecting;
- Week 3: Hopes, fears and worries;
- Week 4: Growing older and transcendence;
- Week 5: Spiritual and religious beliefs; and
- Week 6: Spiritual and religious practices.

In the first session, the facilitator started the SRT program by self-introduction of the facilitator and the participants. The purpose of the program and the process of the SRT program were explained to the participants. Each participant was given up to five minutes to share their stories thereby allowing all a relatively equal share of time. Ethical issues were highlighted including each participant being reminded to avoid discussion outside the session. Each session typically comprised of three sequential phases; (1) Beginning phase, (2) Middle phase and (3) End phase. In the beginning phase, the facilitator introduced the topic for the session and reminded everyone about ethical issues. The middle phase involved discussion of topics. Participants took turns in making their contributions about the topic, followed by fluid discussion with other participants and the facilitator. Each week, participants shared and discussed memories or experiences related to the topics with the aid of triggers and guidance by the facilitator. At the end phase, the facilitator concluded the discussion and informed participants about the next week’s topic. Each participant was given a token bag containing packets of food and drinks.

Horner, Rew, and Torres (2006) suggested several strategies to ensure intervention fidelity such as comprehensive guidelines of intervention content, offering training to facilitators about the intervention and observing the intervention throughout the sessions. However, no training about the intervention was required for this study as the researcher was the only facilitator. The researcher also
developed the detailed manual for the SRT program which included the aims and purpose of the SRT program, the aims for each week of the six-week SRT program (Appendix G) and the guideline/content of the program for six-week SRT program. The manual of SRT program also described the triggers for all the sessions. Every session of the SRT program was monitored and recorded in notes by the facilitator to ensure that all topics were covered.

The control group was involved in attention control activities. The attention control activities were activities for the control group that involved active social interaction with the facilitator (which was the researcher), but the core component of spiritual reminiscence activity was not included. For example, activities included painting, drawing and playing games. These activities were conducted over the whole six weeks, with similar session length to the intervention of 60 to 90 minutes. The facilitator started the sessions by greeting participants and asking them what they wanted to do. There were no standardised activities for the control group. All participants were encouraged to participate in any activities they were interested in. The facilitator was actively involved in these activities. The participants were asked to remain in their groups until everyone had finished their activities; however, they were able to leave the session if they wished. Instead of using RT without a specific spiritual focus for the control group, attention control activities were selected due to the religious and spiritual element that may emerge in RT (Mackinlay & Trevitt, 2010). At the end of the session, each participant was received token bags containing packets of food and drinks.

6.5.4 Data analysis

The quantitative data analysis involved descriptive and inferential analysis using statistical software (IBM SPSS Statistics version 23.0). The descriptive analysis for pre- and post-measurement instruments produced means, standard deviations, frequency and percentages. The date of admission was transformed to the length of stay in the RACF as it provided more meaningful data for the present study. The tests involved in the descriptive data analysis were Independent T-test, Mann-Whitney U test, Chi-square test and Fisher’s exact test (Table 6.4). The significance level used for all quantitative data analysis was 0.05.

Three scales (UCLA Loneliness Scale, Geriatric Anxiety Scale, and M-GDS-14) were Likert scales. Parametric tests were used for these instruments after testing for assumptions such as randomisation, independence of data and normality (Pell, 2005). In the inferential analysis, mixed design analysis of variance (SPANOVA) was used for between- and within-groups analysis. The same test was applied in a previous study that tested the effectiveness of RT for 24 older people with depression (Stinson & Kirk, 2006). In SPANOVA, it is safer to interpret multivariate statistics because this test does not
have an assumption of sphericity. Post-hoc analysis was conducted using Bonferroni correction to determine the time effects. Both intention-to-treat (ITT) analysis and per-protocol (PP) analysis was performed and these results were compared and discussed by the researcher and advisors. The two intervention groups were combined for the purpose of data analysis. This followed the procedure used in previous studies (Chiang et al., 2010; Nooripour et al., 2015).

Table 6.4 Quantitative data analysis procedures

<table>
<thead>
<tr>
<th>Measurement instruments</th>
<th>Time measurement</th>
<th>Statistical data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sociodemographic</td>
<td>Baseline</td>
<td>Descriptive analysis</td>
</tr>
<tr>
<td>background</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIRS-G</td>
<td>Baseline</td>
<td>Descriptive analysis</td>
</tr>
<tr>
<td>UCLA Loneliness Scale</td>
<td>Pre-test, post-test, and three-month follow-up</td>
<td>Descriptive analysis &amp; SPANOVA</td>
</tr>
<tr>
<td>GAS</td>
<td>Pre-test, post-test, and three-month follow-up</td>
<td>Descriptive analysis &amp; SPANOVA</td>
</tr>
<tr>
<td>M-GDS-14</td>
<td>Pre-test, post-test, and three-month follow-up</td>
<td>Descriptive analysis &amp; SPANOVA</td>
</tr>
</tbody>
</table>

Note: M-GDS-14: Malay version of the Geriatric Depression Scale; GAS: Geriatric Anxiety Scale; SPANOVA: Mixed design analysis of variance

Figure 6.6 shows the number of participants involved in PP analysis and ITT analysis. ITT analysis involved all participants based on random assignment (34 participants). This analysis disregards incomplete treatment, drop-outs from the intervention, changes in study protocol and any other factors that might change after random assignment (Gupta, 2011). The purpose of the ITT analysis was to provide an unbiased result for the intervention effect by maintaining the predictive balance produced from random assignment (Gupta, 2011).

PP analysis acted as a sensitivity analysis for ITT analysis, and the results can be assumed as reliable if both analyses yield almost parallel results (Kabisch, Ruckes, Seibert-Graf, & Blettner, 2011). In PP analysis, the participants (N = 20) who attended at least three weeks of the six-week SRT program and attention control activities were included. This criterion was based on previous findings that RT should be at least three weeks in length to be effective for older people with depression (Stinson, Young, Kirk, & Walker, 2010).
6.6 Qualitative components

The qualitative component consisted of two sources of data: a focus group discussion (FGD) and observation (field notes). The observation was conducted concurrently with the intervention, and the FGD conducted sequentially, after the post-test. These data sources were combined in analysis to address the research question relating to the participants’ experiences of the SRT program and its acceptability for this population.

6.6.1 Observation (Field notes)

Observation was undertaken throughout the SRT program. Observation was included in the research design as it can capture information beyond what participants may share when directly asked (Flick, 2014). Silverman (2006) also favoured observation as the main method for collecting data about the interactions between people. This technique is important because it assists the researcher to understand group interaction and to record the process of activities (Mulhall, 2003). In the present study, the acceptability of the SRT program and how participants experienced the program were identified as key to understanding the process and usefulness of the adapted approach for this new population. This was investigated in part using observation of the process of group interaction and individual participation in the SRT sessions.

Unstructured observation was used. This is an approach that uses no structured guidelines or lists with which to conduct the observation (Mulhall, 2003). An unstructured observation was selected because of the flexibility of the approach to capture any occurrence in the field notes. It was needed because there was no prior knowledge about expected behaviour, interaction and activities that might occur during the SRT program with this sample. The objective of the unstructured observation was to observe the activities, behaviour, interactions, and emotional feelings expressed throughout the SRT program.

The observations were recorded in field notes. This process used guidelines from Spradley (1980), observing the activities, interaction, and emotional feelings that emerged during the program. It
included verbal and non-verbal behaviours, participant engagement, participant discussion, and the researcher’s reflections on the experiences of conducting the SRT program. In deciding what to record in field notes, the researcher continually reflected on repeated themes in participants’ behaviours, interaction and emotional feelings, and used the research questions and social identity theory to guide them. Social identity theory suggests that involvement and attachment in group activities assists people to identify their shared social identity (Tajfel, 1981). This theory guided the researcher to observe and record any activities that demonstrated involvement and attachment of participants to SRT program.

6.6.1.1 Observation sample
The sample for the observation was all participants in the intervention groups (n = 18). These participants consented to being observed during the implementation of the program as part of the informed consent process.

6.6.1.2 Observation procedure
The observation was conducted throughout the implementation of the six-week SRT program. Each week of the program consisted of one session with each of the intervention groups (Group A and Group B). One observer — the researcher who facilitated the sessions — documented the observations. Initially, permission was obtained for one staff member (a community nurse) to attend the sessions to conduct the observation and to learn how to conduct SRT. However, scheduling and staffing limitations made this difficult and after discussion with the RACF manager, it was agreed that the researcher would conduct the sessions, and the observations, alone.

Observations were documented using a pen and small notebook via simple notes immediately following the observation of the two intervention groups each week. These notes included the date, time and setting of the observation and keywords regarding what was observed. These keywords related to: emotions that had been observed and expressed by the participants; the stories related by participants; the social interaction between participants; and any relevant events that occurred during the sessions. At the end of the program, the researcher took time to reflect on the notes and added any important information to further clarify them, following the recommendation of Musante and DeWalt (2010). The expanded notes were then typed for analysis.

6.6.2 Focus group discussion
Focus Group Discussion (FGD) was selected as an additional method for eliciting participants’ experiences of the program because it emphasises group interaction (Wilkinson, 2016). FGD offers
interactive discussion, in contrast to survey and individual interview, for example relating to other participants’ experiences and responses to the SRT program and comparing and discussing experiences. The group interaction allows discussion and reflection among participants of their experiences and enables participants to build on each other’s responses, allowing for exploration of the collective experiences of the group (Liamputtong, 2013).

Facilitation skills are important for an effective FGD. The facilitator should have skills in stimulating active discussion, encouraging participation by quiet members of the group, and minimising control or domination by particularly vocal participants (Byrne & MacKinlay, 2012; MacKinlay, 2006). The present study followed the guide for FGD by Hennink (2014) in terms of preparing and conducting FGDs. These involved strategies for participants’ recruitment, developing topics for discussion and ethical considerations.

### 6.6.2.1 Focus group sample

The sampling strategy for the FGD was self-selection among the participants in the intervention groups. All participants in the intervention groups were invited to participate in the FGD, with information about the group discussion included in the participant information sheet that was given to all participants. Those who agreed to participate provided written consent. One week and immediately before the FGD started, the participants who had consented were asked again whether they were willing to participate.

Guidelines for conducting FGDs recommend the use of homogeneous groups (Greenwood, Ellmers, & Holley, 2014; Hennink, 2014). This is seen as important to ensure participants feel comfortable to share their views, in order to produce active discussion (Greenwood et al., 2014). However, Greenwood et al. (2014) further suggest that it is not necessarily the case that better data comes from homogeneous groups than from heterogeneous groups. For example, in the present study, while the participants in the FGD were from different sociodemographic backgrounds, their different perspectives on exposure to the same SRT program could provide rich information. Further, the participants had an existing relationship with the facilitator and each other, having met for the SRT sessions over six weeks. This helped to reduce the effects of differences between individuals during the FGD. One disadvantage of having participants belonging to one small group (one RACF) is that participants may be anxious about sharing their experiences because of fear the group members might share the stories with other people in their social network. This was specifically addressed with the participants by asking them not to share anything that had been discussed in the FGD with other people.
Eight to ten participants in one group is considered a suitable size to encourage discussion among group members, as well as for group dynamics (Chong, 2000; Hennink, 2014). In all, 18 participants provided consent, and two groups were planned. However, only seven participants attended the FGD. Reasons for non-participation, and participant characteristics, are given in Chapter 8.

6.6.2.2 Focus group procedure
Choosing the right place, times and location for a FGD has been highlighted as central to ensuring uninterrupted, private, open discussion and maximising participation (Krueger & Casey, 2015). The meeting room, times and location were chosen with the assistance of the manager of the RACF. The researcher considered important information relating to outing days, the involvement of the participants with other activities, hospital appointments, eating and rest times, as well as the availability of a room that was suitable and where the discussion would not be disturbed. A maximum of two hours was allocated due to participants’ potential to experience fatigue and loss of interest in the discussion (Liampuntong, 2013).

Although the participants confirmed their participation in the FGD, a reminder was given to the participants by the facilitator and RACF staff invited and assisted them to the room. Some participants attended the room by themselves. At the beginning of the session, participants were welcomed and allowed to seat themselves according to their preference.

The participants were informed about the presence and purpose of the audio recorder, from which the audio file of the recording was uploaded for storage on a password-protected computer, accessible only to the researcher. They were also informed that they could withdraw at any time. This was important to mitigate the risk that some participants may feel obliged to participate since they had known the researcher from the beginning of the study.

The development of the discussion guide is important for focus groups, including the use of open-ended questions. The development of the FGD topic guide was based on previous studies. The topics included emotional experiences/feelings (Housden, 2009), the process of SRT (Gibson, 2011) and the benefits of SRT (Mackinlay & Trevitt, 2010). The present study also included suggestions to improve the program in future studies. The facilitator started the FGD session with the broad question: “Can you share your experiences of the SRT program?” Key questions related to experiences in the program including the experiences, benefits, process, likes and dislikes from the program and any suggestions for future improvement (Appendix H). The flow of the FGD was adapted according to the participants’ responses. At the end of the FGD, participants were invited to ask any questions.
before the researcher terminated the group. Participants were given token bags containing packets of food and drinks, and small gifts.

6.6.3 Qualitative data analysis

The qualitative data from the FGD and field notes were analysed manually using thematic analysis. The thematic analysis was undertaken based on the research question, which addressed the acceptability and experiences of the SRT program. The qualitative data were analysed thematically using six steps based on Braun and Clarke (2006) (Figure 6.7).

Figure 6.7 The six stages of thematic analysis

(Braun & Clarke, 2006)

The researcher transcribed the recorded FGD and field notes and read the transcripts. Since the present study was conducted in the Malay language, the researcher then translated the transcripts from Malay to English. The same translator who had assisted with translation of quantitative instruments performed back translation to confirm the translation of the transcripts. The researcher and the translator discussed any differences in translation to produce the validated English version of the transcription.

Codes were manually developed from the validated English translation using highlighters. Codes were developed inductively from the data through an iterative process. Initial codes (43 codes) were identified from the transcripts and then categorised under potential subthemes (12 subthemes), then, combined into themes (4 themes) with the example of coding illustrated in Error! Reference source not found.. Theme development involved sorting different codes into possible subthemes and themes and combined all relevant codes within the themes. At the same time, the researcher considered
whether the different codes could be combined into an overarching theme and the relationship between codes, sub themes and themes. The themes and subthemes were then compared with other themes and the entire dataset to ensure that the themes/subthemes were true reflection of dataset.

<table>
<thead>
<tr>
<th>Enthusiastic participation</th>
<th>Enthusiasm and enjoyment</th>
<th>Enthusiasm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Happiness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enjoyment</td>
</tr>
<tr>
<td>Time in sessions as a welcome distraction</td>
<td></td>
<td>Meet new friends</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Better than nothing to do</td>
</tr>
<tr>
<td>Pleasure in reminiscence</td>
<td>Ownership/belonging</td>
<td>Satisfaction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pleasurable feelings</td>
</tr>
</tbody>
</table>

| Connections across boundaries                   | Forming connections through interaction | Conversation of life stories                    |
|                                                 | Connecting through difference       | Discussing of different religions               |
|                                                 | Respectful sharing                 | Respectful conversation                         |

| Expressing and reflecting                       | Sharing emotions                  | Compare stories                                 |
|                                                 | Use of spirituality in reflection  | Tough times                                     |

| Successful use of triggers                      | Eliciting feelings                | Memories recall                                 |
|                                                 | Facilitating connection           | Humour response                                  |
|                                                 | Facilitating memories             | Different purpose                                |
|                                                 | Facilitating calm and respect     | Religious triggers                              |

Figure 6.8 Example of coding

The development of themes was an iterative process involving several stages of interpretation,
reflection, and reinterpretation of the data. The themes were interpreted through comparison with the other qualitative and quantitative data, social identity theory, and the findings of past studies (Holloway & Wheeler, 2010). For example, the theme of Connections across boundaries was linked to a core component of social identity — social connectedness — and previous studies about social engagement that suggested RT increased social interaction (Chao et al., 2006) and feelings of connection to other people (Sabir et al., 2016). The subthemes of forming connections into interaction, connecting through difference and respectful sharing showed that there was social connection between participants. Social connectedness is a vital component for development of shared social identity among group participants as suggested by social identity theory. Codes relating to enjoyment and ownership/belonging suggested the theme of Enthusiastic participation. These codes, taken together, viewed in relation to social identity theory, showed that feeling a part of the group through group membership keep people motivated to participate in the group. More specifically, in social identity theory, group membership develops a sense of ‘us’ and helps to build shared social identity among people in the group. Previous studies on group membership have suggested that group RT promoted group membership through sharing memories (Haslam et al., 2010; Haslam et al., 2013).

The researcher discussed the themes with the research advisors to ensure that the result was systematic and rigorous. The researcher first developed the themes and showed them to the research advisors. The research advisors then reviewed the themes and provided feedback and suggestions. Any disagreements in regard to the themes were justified between the researcher and the research advisors until a final conclusion was made.

6.6.4 Trustworthiness
The trustworthiness of qualitative approaches refers to the criteria of credibility, confirmability, transferability and dependability (Holloway & Wheeler, 2010). Credibility focuses on the believability of the data from the participants’ points of view (Holloway & Wheeler, 2010). Despite the small amount of data obtained in the FGD, the use of multiple methods including FGD and observations helped to support the credibility of the study findings. To promote participants’ honesty throughout the process of data collection, the participants were reminded about their anonymity and confidentiality of data in the FGD. Furthermore, reminders of the voluntary nature of participation and the right to withdraw were given to help ensure participants felt free to share openly. Comparison of the findings with existing literature was also undertaken to explore the consistency of the findings with other research evidence. The prolonged time in the data collection site (six weeks) improved participants’ trust in the researcher, helping to minimise the effect of the researcher’s presence on
data quality. The use of peer debriefing also enhanced the credibility of the study findings. Feedback and comments from peers on the study findings guided review of the findings and interpretation. Another strategy to improve credibility was to conduct persistent observation. The researcher prolonged interaction with participants (that occurred in the six weeks of the SRT program) to help understand participants’ characteristics throughout the study.

Confirmability emphasises the confirmation or subjectivity of the findings (Shenton, 2004). Confirmability is important to ensure that the findings are based on participants’ experiences rather than the researcher’s preferences. Confirmability can be achieved through an audit trail and reflexive journal. An audit trail allows other people to understand the steps involved in the procedure to achieve the findings. Rich and detailed description was used in the study including documentation of decisions regarding the paradigmatic approach and data collection methods, and use of social identity as a theoretical framework. The raw data (transcriptions of FGD and field notes), analysis notes and data presentation in finding reports were kept for auditing and ethical purposes. In a reflective journal, the researcher recorded all events that occurred in the field and personal reflections throughout the study. For triangulation, the researcher used different sources of data such as focus group discussion and observation to improve the quality of data.

Transferability refers to the extent to which the findings may be applicable to another population (Anney, 2014; Shenton, 2004). The researcher can assist future researchers to assess the transferability of the findings by providing ‘thick description’ (Anney, 2014; Elo et al., 2014). In this study, the researcher provided a thick description of the context of the qualitative data through detailed explanation about research processes such as strategies in data collection, sampling methods and characteristics of the participants, the RACF context, and the intervention. This strategy allows future researchers to make a clear assessment as to whether the findings of the present study are applicable to their population. Performing purposeful sampling also helped to improve the transferability of study findings (Anney, 2014). The researcher selected participants from the intervention groups as these participants were involved in the SRT program and therefore knowledgeable about the topic under study.

Dependability can be defined as the ability of the study findings to be maintained when being conducted in different situations and over time (Elo et al., 2014; Shenton, 2004). Dependability can be enhanced using an audit trail, peer checking (Anney, 2014; Krefting, 1991) and detailed description of methodology (Krefting, 1991). All documents involved in data collection and data analysis including raw data, FGD transcription and field notes were retained for further assessment.
and findings, and interpretations were discussed with research advisors and colleagues who were experienced in conducting qualitative research. A full description of conceptualisation, data collection, analysis and interpretation was documented to provide a transparent description of the processes and context of the study.

Reflexivity is an important strategy for enhancing trustworthiness in qualitative research. Holloway and Wheeler (2010) argued reflexivity is a process through data collection, analysis, data interpretation and writing up, where the researcher critically reflects on their preconceptions and monitors their relationships with the participants and their reactions to participants’ accounts and actions. Barrett and Stauffer (2009) suggested that researchers collecting data based on life stories need to be aware of their backgrounds and perspectives that may influence the interpretation of the results. From the beginning of the study, the researcher was aware of her position as a young person conducting observations on older people’s interactions, behaviour and emotion throughout a program that she had developed and delivered — and she as a Muslim, observing participants who were discussing Buddhism, Hinduism and Christianity. Engaging in a reflexive process throughout the study helped to address the biases that she could bring to the study. Reflecting back on the field notes and FGD data, while writing and interpreting the results, helped to ensure all details and information had been recorded and assisted in reducing bias. Discussing the findings with the research advisors raised thoughts that the researcher may not have previously considered and helped to challenge her interpretations and conclusions.

6.7 Ethical considerations
The present study received ethical clearance from the ethical committees of The University of Queensland, Economic Planning Unit (EPU) in Malaysia and Department of Social Welfare, Ministry of Women, Family and Community Development, Malaysia (Appendix I, Appendix J and Appendix K). The ethical clearance from the Department of Social Welfare, Ministry of Women, Family and Community Development in Malaysia included the RACF in which data collection occurred.

The study highlighted several ethical issues. First, informed consent was vital. The participants were provided with information about the research topics, the research objectives, the duration of the study, and the instruments being used to collect the data. All participants provided written consent for their participation in the study and no individuals without capacity to provide written informed consent were included. Second, to maintain confidentiality, participants were reminded in every session to avoid discussing the topics and the disclosures of participants outside of the session and the FGD. No personal information was exposed in the reported results. Third, anonymity was also maintained
throughout the study using a code sheet that assigned pseudonyms to participants. This code sheet was kept in a secure location with access only by the researcher. All documents and audio recordings that were collected at the RACF were kept in a locked bag and transferred to a secured locker at the researcher’s office.

For those who were positive in the screening for cognitive impairment, the researcher informed the manager of the RACF, with their permission. The present study involved older people with loneliness, anxiety and depression, who were potentially vulnerable people with increased risk of distress. The participants were informed that they could discontinue involvement in the SRT program if they became too distressed. The researcher was prepared to refer participants to the community nurses for immediate referral to counsellors if necessary. The participants were also informed about potential negative effects of participation. They were informed that they might withdraw from the study at any time and may choose not to respond to any question or topic. This information was included in the Participant Information Sheet (Appendix A).

6.8 Summary
The present study employed a randomised controlled trial design with qualitative components conducted concurrently, and sequentially, to provide in-depth investigation of the effectiveness, the acceptability and the participants’ experiences of the SRT program. Participants were screened for cognitive function, loneliness, anxiety and depression, resulting in 34 participants identified as eligible to participate in the study. The participants were divided into two groups: intervention groups (SRT program) and control group (attention control activities). The measurement instruments were given before intervention, after intervention, and at three-month follow-up. Observations were conducted throughout the six weeks of the SRT program, with a FGD conducted with seven participants after the program was completed. Quantitative data were analysed using IBM SPSS Statistics version 23.0 software and qualitative data were analysed manually using thematic analysis. Several ethical considerations were addressed, including confidentiality, anonymity, risk of emotional or psychological impacts and data management.

The next chapter will discuss the study results relating to the effectiveness of the intervention.
Chapter 7    Quantitative component (Results and Discussion)

7.1 Introduction
This chapter describes the results and discussions of the randomised controlled trial study. It consists of recruitment of participants, screening results, sociodemographic characteristics of the participants and the presence of chronic medical illnesses. This chapter describes the non-significant results of the SRT program on loneliness, anxiety and depression. It also includes discussion of the results in relation to previous studies and the theoretical framework of social identity theory.

7.2 Results
7.2.1 Descriptive results
7.2.1.1 Sociodemographic characteristics of participants
Table 7.1 presents the characteristics of the residents who participated in the study. The participants in both intervention and control groups were similar in terms of gender. Islam was the main religion in both groups. Other religions in the intervention groups consisted of Buddhism (1 participant), Christianity (2 participants) and Hinduism (2 participants). Other religions in the control group consisted of Buddhism (2 participants) and Hinduism (4 participants). A small number of participants reported being still married. Several tests were used to determine any significant differences between the groups: (1) Independent t-tests: length of stay and age variables; (2) Chi-square tests: gender, religion and number of children variables; (3) Fisher’s exact tests: marital status, educational status and prescribed medications variables. As shown in Table 7.1, the groups may be considered equivalent.
Table 7.1 Characteristics of participants

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Intervention groups (n=18) (%)</th>
<th>Control group (n=16) (%)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td>0.72</td>
</tr>
<tr>
<td>Male</td>
<td>9 (50)</td>
<td>7 (44)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>9 (50)</td>
<td>9 (56)</td>
<td></td>
</tr>
<tr>
<td>Length of stay</td>
<td></td>
<td></td>
<td>0.82</td>
</tr>
<tr>
<td></td>
<td>M: 48 (SD: 30.07)</td>
<td>M: 46 (SD: 33.10)</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td>0.26</td>
</tr>
<tr>
<td></td>
<td>M: 67 (SD: 4.67)</td>
<td>M: 69 (SD: 6.60)</td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>M: 66 (SD: 5.52)</td>
<td>M: 71 (SD: 9.23)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>M: 68 (SD: 3.70)</td>
<td>M: 67 (SD: 3.28)</td>
<td></td>
</tr>
<tr>
<td>Origin</td>
<td></td>
<td></td>
<td>0.55</td>
</tr>
<tr>
<td>Malaysia</td>
<td>18 (100)</td>
<td>16 (100)</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Islam</td>
<td>13 (72)</td>
<td>10 (63)</td>
<td></td>
</tr>
<tr>
<td>Other religions</td>
<td>5 (28)</td>
<td>6 (47)</td>
<td></td>
</tr>
<tr>
<td>Current marital status</td>
<td></td>
<td></td>
<td>0.99</td>
</tr>
<tr>
<td>Married</td>
<td>2 (11.2)</td>
<td>2 (12)</td>
<td></td>
</tr>
<tr>
<td>Divorced, Widowed, Separated/Single</td>
<td>16 (88.8)</td>
<td>14 (88)</td>
<td></td>
</tr>
<tr>
<td>Number of children</td>
<td></td>
<td></td>
<td>0.09</td>
</tr>
<tr>
<td>No children</td>
<td>13 (72)</td>
<td>7 (44)</td>
<td></td>
</tr>
<tr>
<td>One and more than one child</td>
<td>5 (28)</td>
<td>9 (56)</td>
<td></td>
</tr>
<tr>
<td>Employment history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government servant</td>
<td>3 (17)</td>
<td>5 (32)</td>
<td></td>
</tr>
<tr>
<td>Private servant</td>
<td>5 (28)</td>
<td>4 (25)</td>
<td></td>
</tr>
<tr>
<td>Self-employed</td>
<td>7 (38)</td>
<td>3 (18)</td>
<td></td>
</tr>
<tr>
<td>Not working</td>
<td>3 (17)</td>
<td>4 (25)</td>
<td></td>
</tr>
<tr>
<td>Educational status</td>
<td></td>
<td></td>
<td>0.50</td>
</tr>
<tr>
<td>Tertiary level &amp; Secondary school</td>
<td>8 (44)</td>
<td>9 (56)</td>
<td></td>
</tr>
<tr>
<td>Primary school &amp; Nil</td>
<td>10 (56)</td>
<td>7 (44)</td>
<td></td>
</tr>
<tr>
<td>Prescribed medications</td>
<td></td>
<td></td>
<td>0.43</td>
</tr>
<tr>
<td>Yes</td>
<td>15 (83)</td>
<td>11 (68)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>3 (17)</td>
<td>5 (32)</td>
<td></td>
</tr>
</tbody>
</table>

Note: M: Mean; SD: Standard deviation
7.2.1.2 Health status

The health status of the participants was measured with the Cumulative Illness Rating Scale for Geriatrics (CIRS-G) (Miller et al., 1992). Fourteen items are scored from 0: No problem, 1: Mild current problem or past significant problem, 2: Moderate disability or morbidity; requires "first-line" therapy, 3: Severe or constant significant disability; uncontrollable chronic problem, to 4: Extremely severe (life threatening); severe impairment in function. Data were retrieved from medical records with the assistance of community nurses who were employed by the Social Welfare Department that managed all public RACFs. Total scale scores range from 0 to 56, with increasing scores indicating more chronic medical illness burden. In relation to the current sample, the total scores for CIRS-G reported mean 2.12 ± 2.10 with all participants (N=34) considered as having a low chronic medical illness burden.

As shown in Table 7.2, the mean scores of CIRS-G for both groups indicated low chronic medical illness burden. The normal distribution of the CIRS-G scores was found for both the intervention and control groups. The Independent T-test was conducted to determine the mean difference of the baseline measurement between the intervention and control groups. The result was no significant difference for the CIRS-G between the intervention and control groups, $F (1, 32) = 0.68, p = 0.06$ (Table 7.2).

Table 7.2 The mean and standard deviation data for the Cumulative Illness Rating Scale for Geriatrics (CIRS-G)

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Intervention groups (n=18)</th>
<th>Control group (n=16)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIRS-G</td>
<td>2.78 (1.73)</td>
<td>1.38 (2.28)</td>
<td>0.055</td>
</tr>
</tbody>
</table>

Note: CIRS-G: Cumulative Illness Rating Scale for Geriatrics

A number of participants (n=15) were categorised as having moderate disability with vascular health that required medication (Table 7.3). Eight participants were categorised as having a moderate disability with endocrine/metabolic health, for example, Diabetes Mellitus Type 2. Six participants reported having moderate disability with musculoskeletal/integument health, for example, osteoarthritis. No participant reported having chronic medical illness burden with hematopoietic, upper gastrointestinal tract, liver, renal, genitourinary or neurological health.
Table 7.3 The mean scores of each medical problem for the Cumulative Illness Rating Scale for Geriatrics

<table>
<thead>
<tr>
<th>Medical problems</th>
<th>Frequency (n=34)</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart</td>
<td>0.03 (0.17)</td>
<td></td>
</tr>
<tr>
<td>Vascular</td>
<td>0.88 (1.01)</td>
<td></td>
</tr>
<tr>
<td>Hematopoietic</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td>0.15 (0.50)</td>
<td></td>
</tr>
<tr>
<td>Eyes, ears, nose, throat and larynx</td>
<td>0.09 (0.40)</td>
<td></td>
</tr>
<tr>
<td>Upper gastrointestinal tract</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Lower gastrointestinal tract</td>
<td>0.03 (0.17)</td>
<td></td>
</tr>
<tr>
<td>Liver</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Renal</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Genitourinary</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal/integument</td>
<td>0.41 (0.78)</td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Endocrine/metabolic and breast</td>
<td>0.47 (0.86)</td>
<td></td>
</tr>
<tr>
<td>Psychiatric illness</td>
<td>0.06 (0.34)</td>
<td></td>
</tr>
</tbody>
</table>

7.2.1.3 Baseline measurement of the UCLA Loneliness Scale, the Geriatric Anxiety Scale and the Malay version of Geriatric Depression Scale (M-GDS-14)

Table 7.4 shows the baseline measurement of the UCLA Loneliness Scale, the Geriatric Anxiety Scale (GAS) and the Malay version of Geriatric Depression Scale (M-GDS-14). The results of Independent t-tests showed that there were no significant differences between the control and intervention group for baseline measures of the UCLA Loneliness Scale, $F(1, 32) = 2.88, p = 0.87$, the Geriatric Anxiety Scale (GAS), $F(1, 32) = 0.69, p = 0.34$ and the Malay version of Geriatric Depression Scale, $F(1, 32) = 0.13, p = 0.21$. 
Table 7.4 Mean and standard deviation data for baseline measurement of the UCLA Loneliness Scale

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Intervention group (n=18)</th>
<th>Control group (n=16)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCLA Loneliness Scale</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>46.22 (13.48)</td>
<td>45.56 (9.50)</td>
<td>0.87</td>
</tr>
<tr>
<td>Geriatric Anxiety Scale</td>
<td>25.72 (13.72)</td>
<td>21.31 (12.37)</td>
<td>0.34</td>
</tr>
<tr>
<td>M-GDS-14</td>
<td>6.50 (2.53)</td>
<td>5.4 (2.58)</td>
<td>0.21</td>
</tr>
</tbody>
</table>

7.2.2 Intervention results

In this section, quantitative data analysis was performed based on intention to treat (ITT) analysis and per protocol (PP) analysis. As most of data were collected using a face-to-face interview, missing data were minimised and were not systematic. Three participants (two participants from intervention group and one participant from control group) had withdrawn after the pre-test data collection and consequently did not have complete data at the three measurement times. The missing values were imputed in the IBM SPSS Statistics software version 23.0 by entering the mean data sets of pre-test scores. The single imputation method was performed in order to maintain the distribution of data (Armijo-Olivo, Warren, & Magee, 2009). Although this method did not introduce new information/data, it improved the sample size (by including all participants with missing data) and reduced the standard of error (Kang, 2013).

Reliability tests were conducted for the UCLA Loneliness Scale, the GAS and the M-GDS-14. The results showed acceptable Cronbach’s alpha for UCLA Loneliness Scale at pre-test (0.79), post-test (0.79) and three-month follow-up (0.71) (Loewenthal, 2001). The results for the GAS were considered good at pre-test (0.89), post-test (0.89) and three-month follow-up (0.89) (Loewenthal, 2001). The results for M-GDS-14 were considered approaching acceptable at pre-test (0.59), post-test (0.56) and three-month follow-up (0.46) (Loewenthal, 2001).

To answer the research objective: to determine the effectiveness of SRT in reducing loneliness, anxiety and depression immediately after, and three months following the intervention, a mixed between-within subjects analysis of variance (SPANOVA) was used. Both ITT analysis and PP analysis produced identical results in terms of significant and not significant findings. Thus, the results presented were based on ITT analysis. The assumptions for SPANOVA were met.

Results from mixed between-within subjects analysis of variance for the UCLA Loneliness Scale
• Between-groups (Intervention group, Control group)
The main effect between groups was not significant, $F(1, 32) = 0.03, p = 0.87$, partial eta squared < 0.01 suggesting no difference between the intervention group and the control group.

• Within-groups (Pre-test, Post-test and Three-month follow-up) and Post-hoc comparisons (Bonferroni correction)
A significant main effect of time was found, suggesting that scores on the UCLA differ for different time points, Wilks Lambda = 0.75, $F(2, 31) = 5.20$, $p = 0.01$, partial eta squared = 0.25, with both groups showing a reduction in UCLA Loneliness scores. Based on Cohen (1988) interpretation, 0.25 is considered a small effect.

Post-hoc comparisons showed that the mean UCLA score at pre-test (intervention group) was significantly higher than the mean score at post-test (intervention group) and three-month follow-up (intervention group) (Table 7.5). However, the mean score at post-test (intervention group) did not differ significantly from the mean score at three-month follow-up (intervention group), as shown in Figure 7.1.

Post-hoc comparison showed that the mean UCLA score at pre-test (control group) was significantly higher from the mean score at post-test (control group). The mean score at pre-test (control group) did not differ significantly from the mean score at three-month follow-up (control group). The mean score at post-test (control group) did not differ significantly from the mean score at three-month follow-up (control group) as shown in Figure 7.1.

• Interaction between group condition and time period
There was no significant interaction found between group condition and time period, Wilks Lambda = 1.00, $F(2, 31) = 0.01$, $p = 0.99$, partial eta squared <0.01.
Table 7.5 The mean scores of the UCLA Loneliness Scale for the intervention group and control group

<table>
<thead>
<tr>
<th>Group condition</th>
<th>Intervention Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean</td>
</tr>
<tr>
<td>Time period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-test</td>
<td>18</td>
<td>46.22</td>
</tr>
<tr>
<td>Post-test</td>
<td>18</td>
<td>41.89</td>
</tr>
<tr>
<td>Three-month follow-up</td>
<td>18</td>
<td>40.56</td>
</tr>
</tbody>
</table>

Figure 7.1 Plot mean scores of the UCLA loneliness mean scores over three time measurements, where higher scores indicate higher loneliness level

Results from mixed between-within subjects analysis of variance for the Geriatric Anxiety Scale

- Between-groups (Intervention group, control group)
  
The main effect between groups was not significant, $F (1, 32) = 1.38, p = 0.25$, partial eta squared = 0.04 suggesting no difference between the intervention group and the control group.

- Within-groups (pre-test, post-test and three-month follow-up)
The main effect of time was not significant, Wilks Lambda = 0.95, $F (2, 31) = 0.79$, $p = 0.46$, partial eta squared = 0.05, suggesting that scores on the GAS did not differ for the three time measurements as shown in Table 7.6 and Figure 7.2.

- Interaction between group condition and time period

There was no significant interaction found between group and time, Wilks Lambda = 0.98, $F (2, 31) = 0.31$, $p = 0.74$, partial eta squared = 0.02.

Table 7.6 The mean scores of the Geriatric Anxiety Scale for the intervention group and control group

<table>
<thead>
<tr>
<th>Group condition</th>
<th>Intervention Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time period</td>
<td>n</td>
<td>Mean</td>
</tr>
<tr>
<td>Pre-test</td>
<td>18</td>
<td>25.72</td>
</tr>
<tr>
<td>Post-test</td>
<td>18</td>
<td>23.89</td>
</tr>
<tr>
<td>Three-month follow-up</td>
<td>18</td>
<td>24.28</td>
</tr>
</tbody>
</table>

Figure 7.2 Plot mean scores of the Geriatric Anxiety Scale mean scores over three times measurements, where higher scores indicate higher anxiety level

Results from mixed between-within subjects analysis of variance for the Malay version of Geriatric Depression Scale (M-GDS-14).

- Between-groups (Intervention group, control group)
The main effect between groups was not significant, $F (1, 32) = 0.69, p = 0.41$, partial eta squared $= 0.02$ suggesting no difference between the intervention group and the control group.

- Within-groups (Pre-test, Post-test and Three-month follow-up) and Post-hoc comparisons (Bonferroni correction)
  A significant main effect of time was found, suggesting that scores on the M-GDS-14 differ for different time points, Wilks Lambda $= 0.80$, $F (2, 31) = 3.77$, $p = 0.03$, partial eta squared $= 0.20$, with both groups showing a reduction in the M-GDS-14 scores. Based on Cohen (1988) interpretation, 0.20 is considered a small effect.

Post-hoc comparisons showed the mean M-GDS-14 score at pre-test (intervention group) was significantly higher from the mean score at three-month follow-up (intervention group). The mean score at post-test (intervention group) did not differ significantly from the mean score at pre-test (intervention group) and three-month follow-up (intervention group), as shown in Table 7.7 and Figure 7.3.

Post-hoc comparisons showed the mean score M-GDS-14 score at pre-test (control group) was significantly higher from the mean score at three-month follow-up (control group). The mean score at post-test (control group) did not differ significantly from the mean score at pre-test (control group) and three-month follow-up (control group).

- Interaction between group condition and time period
  There was no significant interaction between the intervention types and time, Wilks Lambda $= 0.94$, $F (2, 31) = 1.04$, $p = 0.37$, partial eta squared $= 0.06$.

Table 7.7 The mean scores of the Malay version of Geriatric Depression Scale (M-GDS-14) for the intervention group and control group

<table>
<thead>
<tr>
<th>Group condition</th>
<th>Intervention Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time period</td>
<td>n  Mean Standard deviation</td>
<td>n  Mean Standard deviation</td>
</tr>
<tr>
<td>Pre-test</td>
<td>18  6.50 2.53</td>
<td>16  5.38 2.58</td>
</tr>
<tr>
<td>Post-test</td>
<td>18  5.67 2.38</td>
<td>16  5.25 2.62</td>
</tr>
</tbody>
</table>
Three-month follow-up 18 5.00 1.97 16 4.75 2.18

Figure 7.3 Plot mean scores of the Malay version of Geriatric Depression Scale (M-GDS-14) mean scores over three times measurements, where higher scores indicate higher depression level

7.3 Discussion
This study examined whether a SRT program reduced loneliness, anxiety and depression. Participants in the intervention group received a six-week SRT program. The outcome measures of the study were for loneliness, anxiety and depression. These outcomes measures were assessed one week before the intervention, immediately after, and three months following the intervention.

7.3.1 Recruitment of study participants
Due to constraints of time, the recruitment process of potential residents was terminated, although the target number of participants was not achieved. The decision was made due to several important considerations. The key consideration was the restriction of time in which the study was to be completed — that is, six months were allocated for all data collection. This study involved only one public RACF due to the dispersed geographical locations of all RACFs in Malaysia. The location of public RACFs in Malaysia is more than 250 km to one another and it was not feasible to conduct the intervention with more than one RACF, because the researcher administered all aspects of the study,
that is, all data collection, SRT and active control group sessions. The involvement of private RACFs was not considered due to the admission criteria being different from public RACFs, such as medically ill residents and higher socioeconomic backgrounds. Such differences may have made the characteristics of study participants too broad and unduly influenced the study findings as previous studies have reported that socioeconomic background and health status was associated with loneliness, anxiety and depression (Boorsma et al., 2012; Drageset et al., 2013; Grenade & Boldy, 2008; Syed Elias et al., 2012). Furthermore, in an intervention study as is the present study, it is important to have a homogenous group with similar baseline characteristics.

7.3.2 Characteristics of study participants
In the present study, it was found that more than half of the participants (58%) had no children because the RACF is specific to those without living children or relatives. In terms of religion, the findings showed that there were several different religions represented in the sample, Islam being the most common. This is congruent with the total population in Malaysia, where Islam is the main religion (Department of Statistics Malaysia, 2010). It was also found that for most participants the highest education level attained was primary school education, or there was no formal education, which is probable given that educational opportunities during their time (before Malaysia Independence Day in 1957) were very limited. The majority of the participants received prescribed medications, suggesting that most of them had clinically diagnosed diseases. This was likely given that at least 68% of older people in Malaysia suffer with a chronic diseases such as hypertension and diabetes mellitus (Samsudin, 2016). This result, however, needs to be interpreted with caution since these were self-reported data and not from health records that were different with cumulative illness rating scale for geriatric (CIRS-G).

From CIRS-G, the participants were reported to have a low chronic medical illness burden. The result was expected given that the admission criteria to a RACF was older people who were independent with manageable chronic diseases (Department of Social Welfare Malaysia, 2016; Syed Akil et al., 2014). In relation to loneliness, anxiety and depression levels, the finding was that the majority of participants in both groups had low levels of loneliness, low levels of anxiety and low levels of depression at baseline. Regarding anxiety and depression data, these results were based on screening instruments and not on a clinical diagnosis.

7.3.3 Effects of a SRT program: loneliness measures (UCLA Loneliness Scale)
The purpose of the SRT program was to decrease or eliminate loneliness. Although the results showed trends toward improvement in loneliness in both groups, the differences were not statistically
significant. This might be because the mean scores of the UCLA Loneliness Scale, for this sample, were low at baseline and it may have been challenging to reduce mean scores of the UCLA Loneliness Scale that are already at low levels. The absence of a significant effect is perhaps not surprising given the course of loneliness. The unstimulating environment of RACFs such as unexciting daily routines and low social interaction with other people, as well as emotional conflict related to decisions moving to a RACF, are among the factors contributing to loneliness (Zakaria et al., 2013). Furthermore, 89% of the participants in this study were widowed, separated or single. This factor was found to be associated with loneliness in a previous study (Ong et al., 2016) suggesting that loneliness might be difficult to reduce with the majority of participants who were widowed, separated or single. Although the SRT program was not effective enough to reduce loneliness, the improvement of loneliness levels may be a step forward for further development of SRT programs.

In relation to previous studies, there have been no other studies of SRT for loneliness as an outcome. Hence, it is necessary to look more widely for comparable studies to interpret this finding. The non-significant result of the present study was not consistent with previous RT studies for older people with loneliness (Chiang et al., 2010; Gaggioli et al., 2013; Liu et al., 2007; Nooripour et al., 2015). The conflicting findings might be attributable to methodological differences in prior research studies such as types of control groups. The use of an active control group in the present study may influenced the lack of significant differences between the two groups (Kinser & Robins, 2013) due to active ingredients in the control group, such as discussion and attention. It was reported that previous studies used less active control groups such as usual care (Chiang et al., 2010) and wait-list (Liu et al., 2007) compared to the present study that used an active control group. Gaggioli et al. (2013) did not have a control group in their study. The use of an active control group in the present study was to rule out whether social interaction with other group members may have been the mechanism for change in the group reminiscence condition compared to the usual care condition. Thus, although the results were not congruent, the different study protocol and target population and the use of an active control group may have contributed to the non-congruent finding.

There were significant within-group differences for both the intervention and control groups for the loneliness outcome. This suggests that both the SRT program and the attention control activities might have some benefit for older people. It was found that both activities promoted certain values such as social engagement, attachment and joint attention. These values were found to be commonly lacking among older people with loneliness (Ong et al., 2016). Furthermore, the control group activities may have included activities that indirectly contained a reminiscence process. For instance, control group activities involved playing Malaysian traditional games such as congkak (traditional Malay games...
involving at least two players), which may have evoked past memories related to it. It was supported that the remembrance process cannot be controlled, and it may happen spontaneously for individuals in any place (Webster et al., 2010). A sustained positive effect was found for the intervention group participants. That is, the positive result within the intervention group was maintained at three-month follow-up. However, the positive result within the control group was maintained only until post-test. This may indicate that there are possibilities of longer term benefits of SRT than attention control activities, although the difference between the groups was not significant.

Overall, the failure to find a significant reduction of loneliness following the SRT program is particularly important, as it suggests that the effect was not caused by reminiscing alone but rather the process of sharing memories in a group. Nevertheless, the long-lasting effect of SRT on loneliness suggests that this program might be beneficial for older people, although the effect was not high enough to produce significant difference. Future studies may compare the SRT with RT to determine the true effect of SRT for older people with loneliness.

7.3.4 Effects of a SRT program: anxiety measures (the Geriatric Anxiety Scale)

The results showed that there was no significant difference between the intervention groups and the control group for the anxiety outcome. Although the mean Geriatric Anxiety Scale (GAS) scores reduced for both groups, the reduction was not statistically significant. The within-groups differences were not significant. The findings of the present study were not congruent with significant findings of previous studies (Haslam et al., 2010; Pishvaei et al., 2015; Rawtaer et al., 2015). However, these previous studies used different types of RT, such as group RT, integrative RT and music RT. The differing types of RT employed in the previous studies may limit the ability to compare the findings with the present study. In regard to the different characteristics of participants, the majority of participants in the present study showed comorbid mental health problems (n= 23 participants, 68%). The majority of previous studies did not involve participants with comorbid mental problems. For example, the Pishvaei et al. (2015) study measured anxiety as an outcome and Haslam and colleagues (2010) and Rawtaer and colleagues (2015) measured both anxiety and depression outcomes. The presence of more than one mental health condition in the present study may require more treatment time for the SRT program to have benefit and therefore result in significant findings, due to the complex mental health problems. Future research should investigate this proposition.

In relation to previous studies focused on SRT, the present finding was congruent with previous studies that found non-significant differences for anxiety outcomes (Emery, 2002; Haslam et al., 2013). All of these previous studies and the present study were conducted in RACFs, suggesting that
the living environment of a RACF may influence the effectiveness of the results. That is, the risk factors for anxiety among those living in a RACF, such as social withdrawal (Drageset et al., 2013), requires consistent interaction between residents. As the SRT program was only conducted as one weekly session for each group for six weeks, the participants could discontinue their social participation with other people after the session ended.

The present result showed that the GAS scores marginally increased from the six-week SRT program to a follow-up of three months. Previous studies that used SRT (Emery, 2002) and religious song RT (Haslam et al., 2013) to examine anxiety as an outcome did not include follow-up data. A possible reason for the escalation of anxiety levels might be due to situations or scenarios that may provoke anxious responses, such as illnesses. Although the mean scores of the CIRS-G scale showed that participants had a low chronic medical illness burden, further analysis of each medical problem in this scale showed some concerns. That is, a number of participants were categorised as moderate disability that requires first-line therapy in regard to vascular health (n=15), endocrine/metabolic health (n=8) and musculoskeletal/integument health (n=6). Thus, it can be speculated that some participants were impacted by specific health conditions that could have contributed to increased anxiety outcomes.

Overall, despite the non-significant results, the present study provides insight that the SRT program is a worthwhile program as shown in the reduction in anxiety. Future studies might consider investigating the effectiveness of the SRT program with a larger sample size and increased power, and the inclusion of RT as a comparison group.

7.3.5 Effects of a SRT program: depression measures (the M-GDS-14)

The results showed that there was no significant difference between the intervention and control groups for depression outcomes. The cut-off score for depression according to the M-GDS-14 is 6 and above. The mean scores of the M-GDS-14 scale showed depression in the intervention group \( (M = 6.50) \) and no depression in the control group \( (M = 5.38) \). The low levels of depression may result in a loss of ability to find a significant reduction of the scores post-intervention. In spite of the non-significant results between groups, the within-groups’ results showed significant reduction in M-GDS-14 scores from pre-test to three-month follow-up for both groups. This means that both the SRT program and attention control activities may have some ability to attenuate depression. Social identity theory posited people develop a shared sense of social identity through group interventions that are meaningful for them (Cruwys et al., 2014). The findings suggested that participants may have created a sense of shared social identity through sharing memories in the SRT program and also activities in
the control group. Interestingly, the mean scores of the M-GDS-14 scale from the intervention group alone showed that the scores reduced from having depression (in pre-test) to not having depression (after a three-month follow-up). The finding suggests some benefits of the SRT program for depression, given the reduction of mean scores of the M-GDS-14.

The failure to find significant findings was probably not that surprising in the context of insufficient evidence from previous studies. Small sample size might be one of the reasons for the non-significant finding. The small sample size was the contributing factor for the non-significant finding in previous studies (Chao et al., 2006; Stinson & Kirk, 2006). The reduction of M-GDS-14 mean scores suggested that differences may exist between the intervention and the control groups, but the sampling error due to a small sample size may have covered the differences between both groups. The non-significant findings on depression were congruent with previous studies using SRT (Emery, 2002).

The SRT program in the present study that focused on social connectedness through sharing memories may have less influence on the other factors that contribute to depression. Previous studies found that the were other factors contributing to depression among older people were related to their sociodemographic background such as being female, having educational problems and low income (Martin & Nandini, 2003; Syed Elias et al., 2012) and health-related problems such as sleep problems, being disabled and increased cognitive impairment (Boorsma et al., 2012; Martin & Nandini, 2003; McCusker et al., 2014). These factors might exist in the present study and the SRT program did not focus on these factors.

Overall, even though non-significant results were found between the intervention group and control group, there was no harm or adverse effects reported throughout the intervention. Thus, SRT might be beneficial for older people with depression and should be further explored in future studies.

7.4 Summary
There were 34 participants in the present study. The dropout rate was low at 8.8%. There was no significant difference in measurements at baseline. The results found that there was no significant difference between the intervention group and the control group for loneliness, anxiety and depression. There was a significant within-group difference for the loneliness and depression outcomes for both the intervention group and the control group. For depression outcomes, the mean scores in the intervention group significantly decreased from having depression to not having depression.
The non-statistically significant results for loneliness outcome were not congruent with previous studies. This might be due to the use of an active control group in the present study and to low levels of loneliness at baseline in the participants. The within-group results showed that the intervention groups’ loneliness scores were significantly lower at three-month follow-up. The non-significant finding for anxiety was not congruent with previous studies that used RT, but congruent with studies that used SRT. The non-significant finding for depression was also not consistent with the previous RT studies. Although the non-significant findings were reported for three outcomes, the improvement of loneliness, anxiety and depression in the SRT program suggested that the SRT program might be beneficial to older people living in RACFs.

In relation to social identity theory, religious identity as a mechanism of SRT, may have some value as demonstrated by the positive results for loneliness and depression outcomes within the intervention group conditions. Given the non-significant results comparing quantitative outcomes for both intervention group and control group, the findings from the qualitative component may provide some insight into the usefulness of SRT for older people with loneliness, anxiety and depression.

These are described in Chapter 8 — the qualitative component that focuses on participants’ experiences and the researcher’s observation throughout SRT program.
Chapter 8 Qualitative component (Results and Discussion)

8.1 Introduction
Chapter 8 describes the qualitative findings from the focus group discussion (FGD) and field notes. This chapter considers the experience of the SRT program from the perspective of program participants. It also discusses the researcher’s observations of the program. Analysis of the data identified four key themes: enthusiastic participation and enjoyment of the program, connection-making across boundaries between participants, use of the sessions as space for expressing and reflecting, and successful use of triggers. These findings are discussed in relation to findings from the previous studies.

8.2 Results
The findings from the FGD and observation (field notes) were used to address one research question: What are the experiences and acceptability of the SRT program for the participants?

8.2.1 Observation (Field notes)
Between four and six observations were recorded in the field notes per SRT session. The field notes were initially recorded during and immediately after the intervention groups session. This technique, however, was not feasible as an ongoing strategy, as two sessions were run in quick succession. For subsequent sessions, field notes were written following the two groups. Each session of the SRT program was between 60 minutes and 90 minutes in length; for the six weeks of the SRT program, over seven hours of the program were observed.

8.2.2 Focus group discussion
At the start of the SRT program, 18 participants from the intervention groups consented to participate in the FGD. Two FGDs of nine participants each were planned; however, of the 18 participants who had consented, only seven attended. Reasons for non-attendance included being too tired and involvement in other activities; however, some did not provide a reason. The remaining participants were followed up for the new FGD session or offered an in-depth interview. All seven participants participated in the group discussion; none chose an individual interview.

Participant characteristics are provided in Table 8.1. Of the seven participants, five were women and two were men. Participants came from three different ethnic and religious backgrounds.

Table 8.1 Background of the study participants involved in focus group discussion (FGD)
<table>
<thead>
<tr>
<th>Gender</th>
<th>Age range</th>
<th>Ethnicity</th>
<th>Religion</th>
<th>Level of education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>2 male</td>
<td>64–73</td>
<td>5 Malay</td>
<td>5 Muslim</td>
</tr>
<tr>
<td></td>
<td>5 female</td>
<td></td>
<td>1 Chinese</td>
<td>1 Buddhist</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 Indian</td>
<td>1 Hindu</td>
</tr>
</tbody>
</table>

### 8.2.3 Identified themes

Table 8.2 shows the themes identified in the thematic analysis. Four overarching themes were identified: 1) Enthusiastic participation; 2) Connections across boundaries; 3) Expressing and reflecting; and 4) Successful use of triggers. Within these themes, 12 subthemes were identified.

Table 8.2 Identified themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Enthusiastic participation</strong></td>
<td>Enthusiasm and enjoyment</td>
</tr>
<tr>
<td></td>
<td>Time in sessions as a welcome distraction</td>
</tr>
<tr>
<td></td>
<td>Pleasure in reminiscence</td>
</tr>
<tr>
<td><strong>2. Connections across boundaries</strong></td>
<td>Forming connections through interaction</td>
</tr>
<tr>
<td></td>
<td>Connecting through difference</td>
</tr>
<tr>
<td></td>
<td>Respectful sharing</td>
</tr>
<tr>
<td><strong>3. Expressing and reflecting</strong></td>
<td>Sharing emotions</td>
</tr>
<tr>
<td></td>
<td>Use of spirituality in reflection</td>
</tr>
<tr>
<td><strong>4. Successful use of triggers</strong></td>
<td>Eliciting feelings</td>
</tr>
<tr>
<td></td>
<td>Facilitating connection</td>
</tr>
<tr>
<td></td>
<td>Facilitating memories</td>
</tr>
<tr>
<td></td>
<td>Facilitating calm and respect</td>
</tr>
</tbody>
</table>

### 1. Enthusiastic participation

The theme of enthusiastic participation described participants’ responses to involvement in the SRT program. Within this theme, three subthemes related to participants’ growing enthusiasm and the expressed and observed enjoyment of the sessions, their use of sessions as a distraction and stimulation, and the pleasure experienced through engaging in reminiscence.
**Enthusiasm and enjoyment**

All the contents of the program were understood by the participants. One participant confirmed in the FGD that they had found the whole program relevant:

> Muthu: All good ... all the discussions were related to us.

*(Recorded FGD)*

Further than this, however, the observational data indicated that participants found enjoyment in the program and were showing increasing enthusiasm. By the third week of the program, participants were arriving early for sessions:

Some of the participants came early and already waited for me. I thought I was late, but I was not. I asked them why they came early and they said they just couldn’t wait for the program to start. I felt happy as they showed support for the program although I was not expecting it.

*(Field notes – Week 3 SRT program)*

At the end of the final session, the participants appeared to demonstrate a feeling of belonging and even ownership of the program, assisting the facilitator to pack up from the session rather than leaving as in previous weeks:

Some participants stayed longer even though the program had finished and helped me to clean the room.

*(Field notes – Week 6 SRT program)*

These findings demonstrate not only the relevance, but the increasing enjoyment and sense of belonging and commitment to the program over the six weeks.

**Time in sessions as a welcome distraction**

The majority of participants considered the one to two-hour length of the SRT sessions to be appropriate and reported that they did not face any difficulty in being involved due to the time frame. One commented that there was a little activity for them in the RACF, suggesting that the sessions were a welcome distraction from an otherwise unstimulating environment:

> Muthu: We don’t have any problem; we can come here to spend our time for a while.

> Sally: No, it’s not too long. It’s better than just sitting, without doing anything.

> Ramlah: Some people are always sleepy because there’s nothing to do.

*(Recorded FGD)*

This finding may also shed some light on the minimal differences found between the intervention and control groups in the intervention. The general limitations in meaningful activities for residents may
have meant that any interactive group activity would be a significant change in routine and consequently in the lives of the participants.

Pleasure in reminiscence

Both the FGD and observation of the SRT sessions suggested that participants enjoyed the experience of the program and that the process of sharing memories was a pleasurable one:

Sabri: I feel happy. I’m so touched.
Facilitator: What else?
Sabri: Satisfied. I love sharing my stories with others.
Sally: I feel happy. I felt satisfied that I got a chance to attend the therapy. Sharing about myself to other people.

(Recorded FGD)

These feelings of enjoyment were observed throughout the implementation of the program. This could be seen in participants’ nonverbal responses to the process of sharing experiences and memories and finding commonality in their experiences. This promoted sharing by members of the group:

The participants smiled and laughed when sharing their memories of when they were young. They laughed when some of them just realised that they were from the same region of Malaysia. They enjoyed sharing the same foods from festival celebrations that are not available in the RACF. Two participants were surprised when they realised that they had similar occupations when they were young soldiers.

(Field notes – Week 1 SRT program)

2. Connections across boundaries

This theme emerged as connections between participants were expressed and observed in the SRT program. Three subthemes within this theme related to the participants using the program to form connections through interaction with other people, developing connections through differences such as ethnicities and religions, and expressions of respect between participants and towards the facilitator.

Forming connections through interaction

The opportunity to improve their social interaction by having conversations and getting to know other people was identified in the FGD as something participants particularly liked about the program. The FGD suggested that the program helped participants to know each other more deeply and to share with each other on a personal level:
Muthu:  We can know a bit about the human heart. We can learn about people. We can share opinions from other participants.
Norani:  Yes, I agreed with him … that share opinions with other participants.
Sally:    We can have a chance to chat with each other. The conversations were about old stories and conversations about new stories.

(Recorded FGD)

The participants formed connections with each other through their stories. The participants related to each other through shared interest in each other’s memories:

The participants responded to each other’s stories by asking questions and nodding their heads. Sharing of stories helped people relate to each other rather than simply recounting stories individually.

(Field notes – Week 2 SRT program)

Participants formed connections that extended beyond the session. For example, this was indicated by people asking each other why an absent participant was not able to attend, and by participants sharing reasons for non-attendance on behalf of others.

Emotional connections were also formed among the participants and between the participants and the facilitator. After close to two months of interaction in the sessions, the participants expressed sadness at reaching the end of the program:

The end session of this week was quite emotional as I told them it was the end of the program. These feelings were not only towards me as a facilitator but towards other participants who were also living in the RACF. I observed female participants hugging each other as though they would not see each other again.

(Field notes – Week 6 SRT program)

The SRT program helped the participants form new friendships with other participants. This had implications for their emotional wellbeing:

Facilitator: What were the experiences that you received from the program?
Sabri: Change of feelings. More or less change of feelings … I feel happy now. I’ve got a new friend now [pointing to Sally].

(Recorded FGD)

Connecting through difference
The SRT program allowed the participants to talk to people they may not otherwise have approached. For example, some participants identified negative perceptions they had held about others:

Some participants shared their negative perceptions towards other participants. One of the participants mentioned that he thought that one of the female participants had
mental problems as she seldom talks to other people. This female participant at the same time shared that she believed that this participant had a fierce face. Because of that, she chose not to talk to or look at him.

*(Field notes – Week 1 SRT program)*

These negative perceptions changed after the participants completed the program. For example, one participant highlighted this in the FGD:

Siti: Attitude towards other people. They are different when you know them in the group.

*(Recorded FGD)*

The SRT program offered a platform for forming connections between participants from different ethnicities and religious groups.

Muslim participants mentioned that they remembered some of their earliest memories of attending the mosques with their father, especially during the fasting month. They also enjoyed having food after congregational prayers. A non-Muslim participant commented that she remembered going to her Muslim friend’s house during the Eid celebration and eating *rendang* (a traditional food that is usually served during a festival celebration).

*(Field notes – Week 5 SRT program)*

The program allowed the participants to create a shared environment of learning and understanding, discussing their different religions. The participants asked each other questions and showed interest in each other’s faith traditions. One participant shared his previous religious practice and how he became a pastor in a temple when he was younger.

He said later he devoted himself to being a pastor in the temple and never got married.

The other participants, who were Muslim, asked him what it was like to be a pastor; he said that he felt closer to God.

*(Field notes – Week 5 SRT program)*

As well as asking questions, the participants found commonality and shared experiences across faiths. I observed [participant] brought her prayer beads and was using them while waiting for others to come at the beginning of the session. She shared with the other participants how she uses the prayer beads. One participant, who was Buddhist, told her that Buddhists also had prayer beads but in a different colour, larger and usually used by the pastor.

*(Field notes – Week 6 SRT program)*

All participants reported that the SRT program provided an enjoyable opportunity to mix with others from different ethnic backgrounds. The SRT program involved three main ethnicities in Malaysia:
Malay, Chinese and Indian. Ramlah and Muthu expressed a preference for the combination of all ethnicities in a single heterogeneous group to benefit from listening to and interacting with people of other backgrounds.

   Ramlah: It was fun when we combined.
   Facilitator: Why it was fun?
   Ramlah: Combination was better, all races. We can have a chat, listen to other people’s stories.

(Recorded FGD)

Regardless of different ethnicities and faith traditions, some participants touched hands and patted the back of other participants when they became sad and cried during sessions. These findings indicated that the participants formed emotional connections and a mutually supportive environment regardless of, and sometimes through the vehicle of, their ethnic and religious differences.

In the FGD all participants agreed to the mix of women and men in one group. Norani particularly commented that she had fun when in the group with men. Despite this preference, the social interaction in the first week of the SRT program was more among those of the same gender. When first arriving, female participants sat on the chairs to the left of the facilitator, and male participants sat on the chairs to the right of the facilitator. This may be due to this RACF having gender specific houses, with limited previous opportunity for interaction. Later, the facilitator mixed the arrangement of the participants by putting their names on the chairs. In subsequent sessions, the interaction between men and women increased.

The participants agreed that it was best to have a mix of age groups, reporting that age differences did not impact the group. The participants communicated actively with each other despite age differences.

   Muthu: It’s the same … nothing different in age.
   Sabri: I don’t care about age. They (older participants) talked more than me [laugh].

(Recorded FGD)

It is notable, however, that there was not a large age range among participants, with all the group members between the ages of 60 to 78 years old.

All participants also agreed to combine all types of personality in one group, suggesting that this may help to elicit discussion among quiet participants.
Norani: I prefer combined. People who do not talk much will not share anything. They will be quiet. People who talk a lot will help people who do not talk much.

*(Recorded FGD)*

This was also supported by observation of the sessions, in which participants who were reluctant to share initially were encouraged by others’ sharing:

Some participants did not talk very much, but they started contributing after listening to other participants’ stories.

*(Field notes – Week 1 SRT program)*

These findings suggest that mixed groups in terms of faith, gender, age, and personality may not only be useful, but may be preferred by participants. In particular, the mix of ethnic and religious backgrounds was a source of interest and of opportunity for connection, just as similarities were.

*Respectful sharing*

The connections between participants were assisted by, or perhaps themselves influenced, the environment of respectful communication that was observed throughout the program. Maintaining respectful communication is important in the SRT program as it provides an opportunity to all participants to talk and for the facilitator to guide the session. Respect was observed between participants, as well as between participants and the facilitator:

There was a situation in which one participant was too eager to share his stories. This participant had dominant characteristics and continued talking without giving other people a chance to share their stories. I had to stop this participant nicely to give other participants a chance to talk. He said he had so many stories to tell that it made him forget to give other people a chance to talk. This participant respected me as a facilitator by stopping talking and allowing other participants to speak.

*(Field notes – Week 4 SRT program)*

This demonstrated not only respect for the facilitator but also respect for other participants, as this participant realised he had become dominant and changed his approach to the discussion. This was also demonstrated in the environment of religious and cultural respect, in which participants were open to and engaged positively with the traditions, stories, and disclosures of others in the group.

### 3. Expressing and reflecting

The SRT program offered participants an opportunity to express and reflect on their memories to other people in the group. This included sharing emotional responses to their past and current
circumstances. The spiritual element of the sessions was particularly relevant, and useful, to some participants in finding meaning and making sense of their memories and responses.

Sharing emotions
Participants used the SRT sessions as a forum for airing their anxieties and sharing them with their peers and with the facilitator. Participants had mixed feelings about living in the RACF and health was a major concern. This anxiety became more prominent for one participant when she believed that she received no support from the RACF.

One of the participants stated that he worries about his hypertension and is afraid of having a stroke and becoming a burden to other people. Another participant said she always feels pain in her knees, and although she complained to the staff of the RACF, they did not do anything. She even asked me whether I could provide some medications to her.

(Field notes – Week 3 SRT program)

Some expressed this through emotional responses such as crying. This finding suggests that the SRT program offers a forum for the participants to express their concerns and emotions in a supportive environment.

Sharing of their memories allowed participants to hear and compare the stories of others with their own. For one participant, this brought her to the conclusion that her own negative experiences were not as bad as she had previously felt:

Aini: Hearing people’s stories, my stories. Sometimes [my sad stories] are not that bad.

(Recorded FGD)

This suggests the SRT program allowed some participants to reflect on and re-evaluate their responses to their memories.

Use of spirituality in reflection
The FGD participants particularly recalled the spiritual dimension of the SRT program and highlighted the value of the program in learning about their own, and other, beliefs.

Muthu: Everyone has their god, shares their stories about the power of their god. Some people pray, some don’t. We love to hear the stories. We learnt a lot about other religions. We can also know better our own religions.
Sabri: Information about religion … we can learn about each religion. Different religions have … a different way of thinking about life.

(Recorded FGD)

The spiritual dimension of the SRT program helped the participants to recognise how spirituality had helped them, especially during tough times. The participants mentioned they put trust in God when life became challenging.

A participant said that it is the only resource that he can turn to when he does not have anyone in his life to share his struggles. Another participant said that living in the RACF gave them no choice but to turn to and depend on God. He further added that he had at least one friend that he can trust, but sometimes conflict happened that made him feel lonely.

(Field notes – Week 5 SRT program)

This finding suggests that a spiritual focus is both appropriate and important for this population.

4. Successful use of triggers

The use of triggers was found to be helpful throughout the program. Triggers used for the SRT program involved several senses such as taste, smell, touch, hearing and sight. The purpose of the triggers was to stimulate recall of memories or to facilitate expression of feelings. The participants were asked about the contents of the program that they remembered. They highlighted the triggers used in the program.

Sabri: I remember Norani brought her photos and you brought photos …

(Recorded FGD)

This suggests that the triggers remained salient to participants and were significant in the experience of the program.

Eliciting feelings

These triggers were successful in eliciting memories and helping participants to share their experiences and feelings during the sessions. For example, one session used candy that was popular during the participants’ younger years; and oranges, with participants asked to choose one or the other to represent their feelings about being older. The selection of candy linked to their satisfaction and happiness being older. The use of oranges connected to their negative feelings about growing older. One participant picked oranges and related her empty feelings about living in the RACF.
Facilitating connection

Some use of triggers elicited humour among participants:

I started the session by showing the printed photos of family, friends, and older people. Participants had begun by being silent, but it changed to an active session. They actively discussed the printed photos prepared by me, and some shared stories based on their photos. The use of their past photos also created humour, especially for those who looked different when they were younger.

This humorous response to the triggers also served to facilitate connections between the participants:

They kept making jokes to each other about the changes to their physical appearance due to ageing. They laughed hard because some of the participants had so many grey hairs and lost teeth, while the others still looked young at their age.

This suggests that the triggers were a useful vehicle for eliciting interaction, sharing of memories, and creating connections through humour.

Facilitating memories

Some triggers, while not eliciting the discussion intended, were nevertheless useful in creating discussion regarding memories. For example, theoretically, plants are linked to spirituality where people feel spiritually connected to the environment. In this study, the participants were asked whether plants, gardens, or pets can be one way of expressing spirituality. In Week 5 of the SRT program, the facilitator brought hibiscus flowers and pandanus leaves as triggers. Instead of describing plants in relation to spirituality, the participants discussed their experiences of gardening when they were young. Some of the participants mentioned that they enjoyed gardening, and sometimes helped one of the staff in gardening at the RACF. Therefore, while using plants was helpful to elicit a sense of connection for participants with their past interests and with others in the RACF, it may not be relevant to discuss spirituality with this sample.

Facilitating calm and respect

Religious triggers more specifically were central to one of the sessions with a focus on religion and an expression of spirituality. The use of religious triggers created a calm environment and helped to facilitate respectful interaction.

I brought the Quran and borrowed a Bible from the RACF in Week 5. Some of the Muslim participants brought their Quran and prayer beads. For Buddhism and Hinduism,
I showed them a picture of temples. I also played the Quran recitation and temple sounds. The environment felt quite different from the previous week. There was not so much laughing, but it was not tense. It looked more like a respectful discussion.

(Field notes – Week 5 of the SRT program)
This, along with the findings regarding the interest about others’ faith traditions, suggests that religious triggers were effective and acceptable to participants, even in a multi-faith group.

8.3 Discussion
This study sought to explore the experiences of the participants in the program. As mentioned in Chapters 4 and 5, little is known about participants’ experiences of SRT. Two previous SRT studies implemented qualitative approaches, but focused on older people with dementia (MacKinlay, 2009; Mackinlay & Trevitt, 2010). Four previous studies have reported older people’s feedback on RT without a specific spiritual component (Chong, 2000; Haslam et al., 2010; Liu et al., 2007). However, the use of a spiritual approach was important in the adaptation of the program to a Malaysian population.

The positive experiences of the SRT program were evident in the expressed and observed responses, such as laughter, increasing sharing and interaction, and increasing involvement and ownership of the group. The participants were supportive of the SRT program and enjoyed sharing memories. These findings were congruent with those of previous studies (Liu et al., 2007; Mackinlay & Trevitt, 2010) which reported participants gained enjoyment from SRT/RT. These findings indicate the acceptability of the program contents and structure to these participants. Previous studies have indicated that older people with loneliness, anxiety and depression can find it difficult to enjoy activities and tend to socially withdraw (Cruwys et al., 2014; Jacobson et al., 2017). Conversely, these findings suggest that for this sample, the SRT program gave enjoyment and facilitated social interaction and emotional connection.

The SRT sessions facilitated social connections across religious, ethnic and personal boundaries. The mixed groups in the SRT program in terms of faith, gender, and personality were not only useful, but may be preferred by participants. The acceptability of multi-faith groups was consistent with a previous study, which found that an SRT program was acceptable for older people with dementia living in multi-faith populations (MacKinlay, 2009). In relation to gender, the finding was not consistent with Chong (2000) study, which reported that older women felt uncomfortable sharing their life stories in the presence of men. The inconsistent results might be due to cultural differences and the involvement of multiple ethnic groups. Further, it is notable that despite the participants agreeing to mixed groups, their interactions at the start of the SRT program were with those of similar
gender. The interactions between members of the opposite gender were improved towards the end of the program. The finding in the present study that participants preferred a mix of personalities supports previous studies, which have reported that participants with introverted personalities started sharing memories after listening to other people’s stories (Collins, 2006; Liu et al., 2007). These findings suggest that the SRT program was a way of sharing and forming connections with others that was acceptable and practicable for this mixed group of older people living in a RACF.

The findings indicated that the SRT program provides benefit to the participants as it helps to change their negative perceptions of other people, and share commonalities across multiple faiths. They were also able to understand other participants’ spiritual practices and beliefs. The negative perceptions of other people that were initially expressed were congruent with the findings of the study by Zakaria et al. (2013), which reported that negative perceptions of other people contributed to untrusting relationships with other residents. The SRT program appeared to play a role in counteracting these negative perceptions.

The participants’ experience of connecting through finding commonalities was an interesting finding that has not previously been reported. These similarities arose from food, former occupations and the places they came from. The sense of commonality among group participants could improve the sense of belonging (Song et al., 2014) and encourage the sense of shared social identity (Ysseldyk et al., 2010). This finding provides some support for the SRT program as a way of helping participants to develop shared identity and connectedness across perceived difference.

The SRT program generated feelings of attachment between the participants and with the facilitator. This sense of attachment is significant since many of the participants had lost significant relationships and attachments through their relocation to the RACF. This supports the findings of previous studies (Sabir et al., 2016; Song et al., 2014). This sense of attachment can be important in reducing loneliness (Choi et al., 2008; Drageset et al., 2011), anxiety (Drageset et al., 2013) and depression (Cruwys et al., 2014). The finding suggests that the SRT program provides a platform for developing attachments through discussing and connecting with other people’s stories.

The SRT program was a new intervention emphasising spiritual elements. These activities were different from the other scheduled activities in the RACF, which were repeated every week (Department of Social Welfare Malaysia, 2016; Syed Akil et al., 2014) and might have created feelings of boredom in the residents. Furthermore, the RACF offered activities that focused on physical activities such as dancing, singing and exercises rather than on emotional or spiritual
elements. However, spiritual values can be beneficial to older people especially for those with loneliness, anxiety and depression, because spirituality itself can be a protective agent and provide support to older people (Abolfathi Momtaz et al., 2012; Han & Richardson, 2010). Previous studies reported that participants appreciated any activities that contained spiritual values (Merriam & Mohamad, 2000) or religious integration (Collins, 2006). Similarly, positive experiences of the spiritual elements of SRT and the expressed importance of spirituality for meaning-making by participants in the present study further support the usefulness of the SRT program as a new intervention among older people.

The SRT program was of benefit to the participants in their expression and reflections on their feelings and memories. This opportunity for self-expression and reflection is seldom offered in the RACF environment, but is helpful for older people to deal with loneliness, anxiety and depression (Chiang et al., 2010; Pishvaei et al., 2015; Wilson, 2006). The findings of the present study resonate with the existing literature, which reports that older people used RT as one way of expressing their feelings about past events to other people — an opportunity that was not available through other activities (Housden, 2009). Wang et al. (2005) suggested that RT was of benefit to older people with depression because it provided this platform for expressing feelings about their past events. In the present study, the participants expressed emotions related to their concerns about health, concerns about other participants, and their mixed feelings about living in the RACF. The SRT program provided opportunities for them to express and in some cases re-evaluate their negative emotions.

The spiritual dimension of the SRT program helped the participants to recall memories and elicited discussion about how spirituality had guided them during their tough times. Previous studies showed the protective effect and supportive role of spirituality for older people (Abolfathi Momtaz et al., 2012; Han & Richardson, 2010; Mackinlay & Trevitt, 2010) and have highlighted the role of SRT in spiritual care through helping to find meaning in life through memories (Mackinlay & Trevitt, 2010). The spiritual element in SRT has been reported as instrumental in reducing the strength of the relationship between loneliness and depression (Abolfathi Momtaz et al., 2012; Han & Richardson, 2010). Therefore, the spiritual component of the SRT program is essential to its role in countering negative mental health outcomes.

Multi-sensory triggers were useful to help participants recall memories as they elicited feelings, facilitated connections, made people calm, happy and feel respected and respectful. These findings support those of previous studies, which have suggested that triggers in RT can improve social engagement with other people (Pollanen & Hirsimaki, 2014) and assist in memory recall (Chao et al.,
Several different triggers were found useful in previous studies. For example, Hanaoka et al. (2011) found that smell triggers were effective in the process of memory recall among participants involved in group RT. Chao et al. (2008) used several triggers in RT and suggested that old photos were the most useful. In relation to the present study, multi-sensory triggers were used, and were likewise useful in facilitating the recall of memories. This provides insight into the significance of triggers in the implementation of the SRT program to improve memory recall and encourage social interaction.

Overall, the SRT program provided enjoyment and positive emotional experiences, which is significant for the acceptability of the program for older people with loneliness, anxiety and depression. Generally, the SRT program offered connections across different religions, ethnicities and personalities, suggesting that the program was useful for a multi-religious and multiethnic population and that it can be used with heterogeneous groups. For some, the SRT program also provided a platform for expressing their negative emotions and helped them to deal with negative thoughts. The integration of the spiritual element in the SRT program was useful for recalling memories and facilitating connections and shared understanding and meaning between the participants. These connections often became deeper emotional bonds. How these findings may be understood through the lens of social identity is explored in the following chapter.

8.4 Summary

Four themes were identified in the focus group and observational data relating to increased enjoyment, enthusiasm, and sense of belonging to the program; the formation of connections, bonds, and shared understandings across differences; the expression of and reflection on emotions; and the successful use of multisensory triggers to elicit memories, interaction and discussion, and emotional expression. These findings suggest that the process of reminiscence on which the program was based was enjoyable for the participants and created opportunities to form connections with other members of the group. The SRT program allowed the participants to share their feelings and relate to and connect with others, including making friendships and connecting on an emotional level. They connected through sharing emotions, humour, providing mutual support, learning about each other’s religious traditions and finding experiences through which to relate.

Acceptability was indicated through a number of findings suggesting positive responses to the program. The use of relevant triggers in the SRT program that related to the Malaysian cultures, ethnicities and religions seemed helpful to engage the participants and were acceptable across the
different religions and ethnicities. The results from both the FGD and field notes support the acceptability of the SRT program across different religions and ethnicities.

The next Chapter (9) will bring together the qualitative and quantitative findings and consider them in light of social identity.
Chapter 9  General discussion

9.1 Introduction
Reminiscence therapy (RT) is a common intervention for older people living in RACFs. However, only a small amount of research has been directed at spiritual integration in RT, known as SRT. In this thesis, social identity theory has been used to inform an SRT approach to addressing loneliness, anxiety and depression among older Malaysian people living in a RACF. This chapter starts with a summary of the trends relating to the ageing population in Malaysia and the exploration of RT and SRT in previous studies, then briefly summarises the approach used in this study. This chapter then brings together the findings from the different components of this study to draw broader conclusions. It also highlights the limitations of the study, and several recommendations are suggested for future studies related to SRT. It then concludes with general implications and future directions for research in this field.

9.2 Summary of thesis
Malaysia’s population trends show an increasing ageing population. The growth of urbanisation among the younger population and a changing of family systems in Malaysia have caused a significant impact on caregiving for older people, including relocation to RACFs. The review of the literature in Chapter 3 showed evidence of high prevalence rates of loneliness, anxiety and depression among those living in RACFs. The prevalence rates of loneliness, anxiety and depression in RACFs were reported as 95.5% (Nikmat et al., 2015), 38% (Khairudin et al., 2011) and 85.5% (Nikmat et al., 2015) respectively. This can be due to reduced social interactions with significant others (Brownie & Horstmanshof, 2011), moving to an unfamiliar environment (Amzat & Jayawardena, 2016), and unexciting routines in RACFs (Zakaria et al., 2013) among other causes. Without intervention, these mental health problems may increase suicide rates (Kiosses et al., 2014) and have significant implications for older people’s quality of life. Therefore, it is important to identify and adopt suitable interventions to reduce the impact of these mental health problems.

RT can be a useful intervention to addressing these mental health problems (Honigh-de Vlaming, Haveman-Nies, Ziylen, & Renes, 2013; Housden, 2009; Rawtaer et al., 2015). Until now, RT has been widely practised for older people in RACFs including in Malaysia. RT is a worthwhile therapy because it provides a supportive environment (Liu et al., 2007; Wang et al., 2005) and assists older people to cope with life (Cappeliez & Robitaille, 2010; Hallford et al., 2012). Despite this practice and acceptance of the benefits of RT, the effectiveness of this approach remains uncertain, particularly for older people with loneliness, anxiety and depression.
There is some evidence to support the use of group reminiscence therapy (RT) as an intervention for older people with loneliness, anxiety and depression. The detailed review of literature in Chapter 4 demonstrates its value in terms of improved social connectedness for older people, although the evidence on its effectiveness is limited. This social connectedness plays a key role in loneliness, anxiety and depression in older people (Haslam et al., 2010; Sabir et al., 2016) through promotion of meaningful social relations in group RT. Viewed through the lens of social identity theory, the mechanism is to enhance meaningful identity in people attached to the group. This suggests that RT may be best implemented as a group activity because group RT emphasises the creation of meaningful social interaction by sharing memories with other people. However, evidence for the effectiveness of group RT, specifically for those living in RACFs, has been limited.

After an extensive search of the literature, there were no systematic reviews found that were specifically designed to evaluate the effectiveness of group RT for older people with loneliness, anxiety and depression living in RACFs. The systematic review in Chapter 4 sought to address this important knowledge gap. The systematic review found limited evidence across eight studies determining the effectiveness of group RT for older people with loneliness, anxiety and depression; however, it was considered a worthwhile intervention for older people because no harm was reported and group RT encouraged social contact between older people, enhanced communication skills and established new relationships. Recommendations from the systematic review included methodological improvement and further exploration of different types of RT such as SRT.

As the older Malaysian population is highly influenced by cultural practices, many of which are religion-based, SRT was identified as a potentially relevant approach for this population. This was supported by previous approaches to social identity, including the use of religious identity as a mechanism in RT (Haslam et al., 2013). SRT has been tested among older people with dementia living in RACFs and the results supported the implementation of SRT for older people (MacKinlay, 2009; Mackinlay & Trevitt, 2010; Wu & Koo, 2015). However, there was limited evidence on the effectiveness of SRT for older people with loneliness, anxiety and depression. The only study that tested the effectiveness of a SRT program for anxiety and depression found non-significant results (Emery, 2002). Further, this study had methodological limitations such as a lack of randomisation, and the content of the program was not specifically designed to address mental health problems. It was identified that improved methodological approaches to researching SRT were crucial to investigate its effectiveness for loneliness, anxiety and depression. To the best of our knowledge, the present study is the first intervention study (RCT research design) that has evaluated the effectiveness
of a SRT program for older people who were screened for the presence of loneliness, anxiety or depression.

This study was designed to compare the effectiveness of the intervention (SRT program) with a control (attention control activities) in reducing loneliness, anxiety and depression in an older Malaysian population living in a RACF. The control involved activities such as colouring, drawing, painting and playing games. The effectiveness of the SRT program was evaluated based on changes in loneliness (UCLA Loneliness Scale), anxiety (the GAS) and depression (the M-GDS-14). In this study, significant differences were not observed when comparing between-groups for the UCLA Loneliness Scale, the GAS and the M-GDS-14. However, significant differences were found within-groups for the intervention and control groups for the UCLA Loneliness Scale and the M-GDS-14. The significant differences within-groups for the UCLA Loneliness Scale was maintained until three-month follow-up. This finding suggests that there may be some potential for the SRT program to be useful in addressing loneliness and depression. Future studies with a larger sample may identify further differences reaching statistical significance for the outcomes addressed in this study.

To address the research objective of examining participants’ experiences of a SRT program, qualitative components were conducted sequentially and concurrently with the RCT research design. A number of observations were recorded in field notes for the six weeks of the SRT program. These observations included verbal and non-verbal behaviours, participant engagement, participant discussion, and the researcher’s reflections throughout the program. One focus group discussion (FGD) was conducted one week after the SRT program. The qualitative data revealed four themes: enthusiastic participation; connections across boundaries; expressing and reflecting; and successful use of triggers. The findings also supported the acceptability of the SRT program across different religions and ethnicities, as existed in the current sample. The findings were congruent with those of previous studies (Liu et al., 2007; Mackinlay & Trevitt, 2010) that reported participants enjoyed the SRT and RT programs, because these brought participants happiness.

9.3 Social identity and SRT
The present study drew on social identity theory to inform its approach. Using this theory, it was expected that the SRT program should result in decreased loneliness, anxiety and depression levels, through the mechanism of social connectedness. Previous studies have shown that social connectedness has an important role in loneliness, anxiety and depression among older people (Amzat & Jayawardena, 2016; Baldacchino & Bonello, 2013; Cacioppo et al., 2015; Cruwys et al., 2014; Singh & Misra, 2009). It was found that social connection is one of the inner resources in improving
health among older people (Haslam et al., 2013; Lundman et al., 2010). Social connectedness was also an important component in reducing anxiety and depression which was found through interaction between nurses and older people (Haugan et al., 2013). Older people also found that increased social contact such as making new friendships can reduce loneliness (Amzat & Jayawardena, 2016).

The present study used spirituality as a culturally relevant approach to investigate the mechanism of social identity in group RT with a Malaysian population. Using this approach, the process of sharing memories through the SRT program was expected to promote social connectedness and shared group identity through religious and spiritual reflection and storytelling. This connectedness and shared social identity, in turn, was expected to have a positive impact on symptoms of loneliness, anxiety and depression. Social identity theory suggested that integration of spirituality in RT may be helpful to develop meaningful identity such as spiritual and religious identity.

The findings showed that both the SRT program and attention control activities equally improved loneliness and depression. This suggests that it may be involvement in group-based activities more generally that improves symptoms of these mental health concerns. This reflects social identity theory, in that both types of activities were interactive group activities in which a sense of shared identity may be developed. Further, this finding supports the view of social identity theory that group membership provides emotional support to people in that group (Ysseldyk et al., 2010), especially for people who have an emotional attachment to that group (Liu, 2012). This is also supported by the qualitative findings in the present study, which indicated that in the SRT program participants provided emotional support to each other. It may be that this was the case for both groups.

Further, the sustained effect of SRT at follow-up for loneliness compared with the control is important particularly considering loneliness is not a condition that can be treated through medication. This suggests the potential for SRT to help create social connections that last beyond the length of the intervention. This was also reflected in the qualitative findings, which indicated that participants made emotional connections and friendships. The finding that SRT, as a culturally adapted therapy, is comparable to other group activities in addressing loneliness and depression warrants further investigation of its potential.

At their most basic level, the qualitative findings supported the acceptability of the SRT program across different religions and ethnicities. This is important in supporting the use of a spiritual approach in a multi-ethnic and multi-religious population. The qualitative findings showed that the program was enjoyable for participants, and that they developed a sense of belonging to, or ownership
of, the program. The use of triggers was also useful to stimulate and connect memories between participants. This suggests that as an adaptation, the SRT program was both, culturally appropriate, and appropriate to this group of older people living in a RACF.

Further, from the perspective of social identity theory, the qualitative findings suggested that the participants in the SRT program connected with each other and formed shared identity across religious, ethnic and cultural boundaries. This occurred through the use of spiritual and religious reflection as well as through the use of the sessions as space for emotional expression and personal reflection. The shared social identity and sense of belonging was developed through finding commonalities such as from food, former occupations and place of origin. This finding supports the notion that a sense of shared identity might be developed by forming connections across different religions and ethnicities and finding experiences through which to relate. In this study, this appeared to occur by connecting through, not only despite, the differences.

Previous studies found a sense of shared identity among the group participants, developed through meaningful social interaction within the group (Haslam et al., 2010; Haslam et al., 2013). However, previous studies (Haslam et al., 2010; Haslam et al., 2013) used a homogeneous group of Caucasians and Christians, while the present study involved a heterogeneous group, incorporating multiple ethnicities and religions. This finding suggested social identity can be developed with involvement of different ethnicities and religions. This finding supported the concept of spirituality as connectedness, in which connectedness may occur in several ways and not necessarily just through religion. For example, some people sense connectedness to God and other people (Byrne & MacKinlay, 2012), whereas others sense connectedness through relationships with friends, and connection with the environment and nature (MacKinlay & Trevitt, 2012). For instance, one participant in the present study felt connected to other participants when they shared their experiences in using similar prayer beads. The finding of the present study supports spirituality as a culturally appropriate approach to investigating social identity in a multiethnic and multireligious population and offers some insights into the development of shared identity across these differences.

Taken together, the quantitative and qualitative findings suggest that the SRT program might be a useful program for older people with loneliness and depression because of its ability to provide shared social identity through the use of spiritual and religious reflection and recounting of life experiences to create connections. This finding supports the social identity approach that focuses on the value of social connectedness in older people with mental health concerns such as loneliness and depression. Social identity theory (Tajfel & Turner, 1979) posited people identify their self-identity from
participation and connection in groups (Tajfel, 1981). The key in this theory is group identification. Social identity theory speculated that each individual might position themselves within several groups and it was social connectedness within groups that aids development of self-identity (Liu et al., 2002). Social identity that developed from social connections has been identified as useful in reducing depression (Begeny & Huo, 2016; Cruwys et al., 2014), anxiety and psychological stress (Begeny & Huo, 2016) because social connectedness brings a sense of ‘us’.

Further, the connectedness that is central to spirituality may be instrumental in reducing loneliness and depression. MacKinlay and Trevitt’s (2012) broad definition of spirituality is fluid depending on the important dimensions in the lives of each individual; spirituality can be expressed in many ways; however, the key concept is ‘connectedness’. The findings resonate with those of previous studies (Haslam et al., 2010; Haslam et al., 2013) that social identity and religious identity were instrumental in the effectiveness of RT and SRT. In the present study, participants connected with each other through religious and spiritual reflection, and also through sharing of memories. While the effect of the SRT program was not significantly different from that of the control activities, the qualitative findings suggested the spiritual focus may have assisted the acceptability of the SRT program and also that this focus was a successful approach to developing social and emotional connections across and through religious difference.

Overall, the present study provides some insight into a social identity approach to this type of intervention in that social connectedness in the SRT program successfully facilitated creation of connection and shared identity in a multi-ethnic and multi-religious population like Malaysia. On a practice level, while the SRT program was not significantly different from the control in its mental health outcomes, the finding that it is at least as effective as other group activities warrants further investigation of its potential. Further, the findings suggest that a spiritual approach to group activities, including group RT, is useful as a cultural adaptation. On a theoretical level, the use of a spiritual approach provides some valuable insights into the development of emotional connections and shared identity across, and through, religious and ethnic differences.

9.4 Limitations and strengths
This thesis has some limitations that have to be taken into account when interpreting the results. First, in the case of the systematic review of group RT for loneliness, anxiety and depression, the low numbers of studies that measured these mental health problems did not allow for firm conclusions regarding the effectiveness of group RT.
The study findings cannot be generalised to other populations such as healthy older people as the study involved only older people with loneliness, anxiety and depression living in a RACF. Therefore, generalisability among older people is uncertain. This study only involved one RACF, thus the findings cannot be generalised to all older people living in RACFs. Further testing of the SRT program with a larger sample of older people with loneliness, anxiety and depression in a range of RACFs is required before this program can be more generally recommended for clinical practice and at different types of RACFs.

The most significant limitation of the present study is the limited sample size. In all, 34 participants participated in the study. The sample size was relatively small due to the involvement of a vulnerable population, older people living in a RACF. The presence of a large number of other serious mental health problems, e.g. schizophrenia, made it challenging to recruit a larger sample. Due to unforeseen personal situations, such as hospitalisation of participants, it was decided that the numbers of older people who completed all the SRT program sessions was acceptable. However, this small sample meant that a more homogeneous sample was recruited. A larger sample size may provide a more heterogeneous group. The attrition rate might have also reduced the power of the study, and the trustworthiness of study results. Nevertheless, the present study employed per-protocol (PP) analyses and intention-to-threat (ITT) analysis to compare the results of both analyses. It was found that both analyses produced identical results in terms of the significant and non-significant findings.

The present study has made some improvements on the research designs used in previous studies in this field. The majority of previous studies used quasi-experimental designs rather than pre-test and post-test research design or RCTs. The present study employed a RCT research design with a small qualitative component. This qualitative approach assisted the researcher to explore the acceptability of the SRT program and to evaluate the SRT program from the participants’ experiences. Although double-blinding/triple-blinding is preferable in experimental studies, this was not feasible in the present study. The researcher conducted the intervention, thus single blinding was used, in which the participants had no information regarding the group to which they were allocated. The use of single blinding reduced the likelihood of a Hawthorne effect in which those in the intervention group tend to provide positive results.

There was a possibility of contamination in the present study; however, participants in the intervention were asked to keep all the information shared in the group confidential. Further, although there is the possibility that participants may have shared the contents of the SRT program with those in the control group, the SRT program included specific strategies for delivering the program,
including the use of various triggers (smell, vision, taste triggers); therefore, delivery of this information by the participants would have been missing essential elements of the program.

Another limitation stemmed from the involvement of the RACF manager in recruiting participants. There was the possibility that this manager selected participants in an unsystematic or biased way. To address this as much as possible, the researcher provided a list of the exclusion criteria and the manager checked the potential residents’ health conditions based on health records.

Further, there was an uncontrolled difference between the intervention groups and control group. The intervention participants were divided into two groups with nine participants each. Only one control group was involved in the study with all 16 participants in one group. The use of two intervention groups was necessary to maintain group dynamics in the SRT program. However, this was a difference between the intervention and control conditions that may have reduced the social contact between participants and facilitator in the attention control activities compared with the intervention groups.

The process of gathering qualitative data from the FGD revealed some challenges. The FGD lasted for 22 minutes and 10 seconds. The participants contributed and responded to each topic raised in the FGD; however, they appeared to have difficulty providing detailed responses, and their responses were consequently limited. When attempting to explain their experiences, they tended to repeat others’ responses, using the same words repeatedly. Paraphrasing of words and topics to attempt to further explain the questions seemed to be a useful approach. Repeated attempts were made to elicit further details from the respondents, but their answers remained short. They did not, however, appear shy or uncomfortable while discussing their experiences.

In regard to response bias in the FGD, there was a potential for acquiescent responding. For example, the researcher asked the participants about their dislikes relating to the SRT program. All participants responded that they had no dislike of the program. This might be because the researcher was the one who also facilitated the intervention. The participants might have responded differently to an independent interviewer; however, resource limitations made this impossible. Further, in relation to the limited data gathered from the FGD, it might be that the participants were afraid to speak publicly about their opinions about the SRT program. In comparison to the FGD, the participants actively discussed their stories in the SRT sessions. Furthermore, the participants came from a low socioeconomic background with low educational levels with likely limited social exposure, thereby making it more difficult to articulate their thoughts. As these population characteristics are common
for older people living in RACFs in Malaysia (Department of Social Welfare Malaysia, 2016), it is important information for future work to look at the skill of participants to answer and fully participate in a FGD.

The use of a semi-structured observation tool for reflecting on each session after the SRT program, grounded in the elements of social identity is recommended for future studies to avoid overlooking relevant behavior and social interaction in the SRT program. In the present study, in deciding what to record in field notes, the researcher continually reflected on repeated themes in participants’ behaviours, interaction and emotional feelings, and used the research questions and social identity theory to guide them.

The use of social identity theory has strengths and limitations. As has been predicted by social identity theory, the SRT program promoted shared social identity. In spite of participants from diverse backgrounds such as multi-ethnicities and various religions, it showed that they connected to each other and it helped in development of shared social identity. The life experiences and background of the participants in which majority had no close family members and low educational level might be relevant for further development of SRT program. However, the limitation of social identity theory is that it does not lend itself easily to explain whether the behavior observed in SRT program is a natural behavior or it was due to experimental set-up. Further, this theory cannot make a prediction of people’s behavior and whether or not they will act similarly towards the SRT program in the future. The effect of social constraints such as no family members or relatives may have an impact on people’s behavior in SRT program, however, it cannot be explained from this theory. It has been highlighted in the earlier chapter that the participants had no family members or relatives to care of them. Besides, the significant finding of attention control activities in reducing loneliness and depression were not adequately explained by this theory and therefore warrants further investigation.

9.5 General Implications and Future Directions

This study produced an adapted SRT program for use with older people living in RACFs in Malaysia. This program involved cultural and religious integration that related to a multiethnic and multireligious population. This thesis offers some support for SRT as a possible treatment option for loneliness and depression, but a larger randomised controlled trial (RCT) should be conducted to investigate its value further. Further, the inclusion of in-depth interviews in a RCT may be suitable for a future mixed methods study. The initial evidence in terms of acceptability and experiences of SRT among those with loneliness, anxiety and depression living in a RACF is positive. The SRT program did not have any adverse consequences for the participants. The findings suggested the value
of social connectedness in the SRT program to cultivate development of social identity through spirituality. The finding contributes to understanding social identity theory and that shared spiritual identity is possible in multiethnic and multireligious populations through connecting across different religions and finding similarities from shared memories and stories. The SRT program could be easily replicated using this established program.

This study has served to highlight many questions in need of further investigation. More research is needed to determine the efficacy of this program in reducing loneliness, anxiety and depression among older people. A large scale RCT with double-blinding and the involvement of several RACFs could provide more definitive evidence. The present study also recommends exploration of the long-term effect of this program, such as a follow-up with participants after one year to provide a clear understanding of the long-term effect of the program in addition to such issues as the cost and manpower required. The group format of the SRT program can be more cost-effective than individual approaches; however, the cost-effectiveness still requires testing in future research.

As the present study did not examine the effectiveness of the SRT program together with medication consumption, the extent to which the SRT program may complement the use of medications, especially for those with clinically diagnosed anxiety and depression, remains undetermined. Future studies may compare the effectiveness of SRT with SRT plus medications, and medications alone, in treating anxiety and depression. A further study could also assess the effectiveness of SRT and RT to determine the true effect of spirituality in RT. Additionally, studies may consider assessing spiritual/religious levels to add more information about a person’s level of spirituality prior to involvement in SRT. Future studies may also consider comparing between group SRT and individual SRT approaches to further explore the mechanism of social identity.

Further, a study investigating the recorded stories of the older people during the program, with a focus on life stories might provide insight into how older people perceive their life events, particularly from a spiritual perspective. Such input would also provide a more comprehensive understanding of the mechanism of SRT. Finally, it would also be interesting to explore RACF staff experiences in conducting SRT as it may provide a clearer understanding of the challenges and barriers to its implementation in this environment.

9.6 Conclusion
While the study found no significant differences between the SRT program intervention and the control group, and no significant within-group results for anxiety, the within-group results showed
SRT significantly reduced loneliness and depression. This offers insights into the usefulness of SRT among older people with loneliness, anxiety and depression. In particular, the significant within-group results for the control group on measures of loneliness and depression suggest the value of group based interventions in RACFs. The SRT program was acceptable and an enjoyable experience according to the participants.

The present study drew on social identity theory, which suggests that SRT works to address loneliness, anxiety and depression by promoting social connectedness. Although the quantitative results showed no statistically significant difference between the intervention and control groups, there were significant differences for within-groups for loneliness and depression. The qualitative findings suggested that a shared identity was developed in the SRT program. It promoted connections across religious, personal and ethnic boundaries, including through humour, emotional expression and mutual support, and shared personal experiences. The participants in the SRT program connected to other participants with different religions and ethnicities by finding similarities and differences in memories. This suggests the value of the program in facilitating social connectedness and supports the use of a spiritual approach such as SRT as a mechanism to create and enhance connectedness and social identity. Taken together, this finding supports further exploration of the SRT program for older people with loneliness, anxiety and depression living in RACFs in Malaysia.
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Participant Information Sheet

“Pilot study of Spiritual Reminiscence Therapy for older people”

Researcher: Sharifah Munirah Syed Elias
PhD student, The University of Queensland, Australia

You are invited to take part in this research project. This research project involves new therapy called spiritual reminiscence therapy. Spiritual reminiscence is a life review process that involves people trying to find the meaning of their life. The aim of the study is to determine the effectiveness of spiritual reminiscence therapy for older people.

Participation in this research is voluntary. If you don’t wish to take part, you don’t have to. If you decide you want to take part in the research project, you will be asked to sign the consent section. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine treatment, your relationship with those treating you or your relationship with staff of residential aged care facilities.

The benefits of spiritual reminiscence therapy are it may reduce feelings of loneliness, anxiety and depression as well as help to cope with past life events. There are no foreseeable risks due to your involvement in the study. However, you may feel that some of the questions we ask are stressful or upsetting. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately.

There are no additional costs associated with participating in this research project, nor will you be paid. All therapy required as part of the research project will be provided to you free of charge.

This research project (spiritual reminiscence therapy) will be conducted in a group for six days consecutively in a 90-min session by a researcher who will be the facilitator of the therapy. Confidentiality will be informed and discussed with all the participants in the spiritual reminiscence group regarding the stories shared during therapy. All the participants will be reminded in every session to avoid discussion of the stories outside of the therapy session. Anonymity will be maintained throughout the project. Your personal information will not be exposed in the results published and will be maintained confidentiality. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission.

The ethical aspects of this research project have been approved by a Behavioral & Social Sciences Ethical Review Committee (BSSERC) of The University of Queensland and Department of Social Welfare Malaysia, Ministry of Women, Family and Community Development. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the researcher on [+60199888461] and The University of Queensland Ethic’s Officer (+61733653924)
Consent Form

Title
Spiritual reminiscence therapy for older people

Principal Investigator
Sharifah Munirah Syed Elias

Supervisor(s)
Assoc. Prof. Dr Christine Neville
Dr Theresa Scott

Location
A community hall in Balok village, Malaysia

Declaration by Participant

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I understand that I will not benefit financially from the involvement in this research project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the study without affecting my future health care.

I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print) _________________________________________

Signature __________________________ Date __________________________

Name of Witness* to Participant’s
Signature (please print) _________________________________________

Signature __________________________ Date __________________________

* Witness is not to be the investigator, a member of the study team or their delegate. In the event that an interpreter is used, the interpreter may not act as a witness to the consent process. Witness must be 18 years or older.

Declaration by Principal Investigator

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Principal Investigator (please print) Sharifah Munirah Syed Elias

Signature __________________________ Date __________________________

Note: All parties signing the consent section must date their own signature
**Appendix B  
Timeline for data collection**

Note: RACF: Residential aged care facility

<table>
<thead>
<tr>
<th>Activities</th>
<th>Week</th>
<th>Date/Day</th>
<th>Time</th>
<th>Month</th>
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<tr>
<td>Pilot work (5–11.10.2014)</td>
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<tr>
<td>1. Visited RACF, checked the setting, any matters arising to be discussed</td>
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<td>15.10.2014/Wed</td>
<td>8.00 am–4.00 pm</td>
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<td>2. Screening session</td>
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<td>16.10.2014/Thu</td>
<td>8.00 am–4.00 pm</td>
<td>October</td>
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<td>3. Intervention group</td>
<td>Pretest</td>
<td>20.10.2014/Mon</td>
<td>8.00 am–4.00 pm</td>
<td>October</td>
</tr>
<tr>
<td>4. Control group</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5. Intervention group A</td>
<td>Week 1</td>
<td>27.10.2014/Mon</td>
<td>8.45 am–9.45 am</td>
<td>October</td>
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<tr>
<td>6. Intervention group B</td>
<td></td>
<td>27.10.2014/Mon</td>
<td>10.30 am–11.30 am</td>
<td>October</td>
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<tr>
<td>7. Field notes for groups A and B</td>
<td></td>
<td>27.10.2014/Mon</td>
<td>1.00 pm–1.45 pm</td>
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<tr>
<td>8. Control group</td>
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<td>27.10.2014/Mon</td>
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<td>9. Intervention group A</td>
<td>Week 2</td>
<td>3.11.2014/Mon</td>
<td>8.45 am–9.45 am</td>
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<td>10. Intervention group B</td>
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<td>3.11.2014/Mon</td>
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<td>11. Field notes for groups A and B</td>
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<td>3.11.2014/Mon</td>
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<tr>
<td>12. Control group</td>
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<td>3.11.2014/Mon</td>
<td>2.30 pm–3.30 pm</td>
<td>November</td>
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<td>13. Intervention group A</td>
<td>Week 3</td>
<td>10.11.2014/Mon</td>
<td>8.45 am–9.45 am</td>
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<td>14. Intervention group B</td>
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<td>10.11.2014/Mon</td>
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<td>15. Field notes for groups A and B</td>
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<td>November</td>
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<td>16. Control group</td>
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<td>17. Intervention group A</td>
<td>Week 4</td>
<td>17.11.2014/Mon</td>
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<td>18. Intervention group B</td>
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<td>17.11.2014/Mon</td>
<td>10.30 am–11.30 am</td>
<td>November</td>
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<td>19. Field notes for groups A and B</td>
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<td>20. Control group</td>
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<td>17.11.2014/Mon</td>
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<td>21. Intervention group A</td>
<td>Week 5</td>
<td>24.11.2014/Mon</td>
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<td>22. Intervention group B</td>
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<td>24.11.2014/Mon</td>
<td>10.30 am–11.30 am</td>
<td>December</td>
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<td>23. Field notes for groups A and B</td>
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<td>24.11.2014/Mon</td>
<td>1.00 pm–1.45 pm</td>
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<td>24. Control group</td>
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<td>Intervention group A</td>
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<td>Field notes for groups A and B</td>
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<td>30.</td>
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<td>31.</td>
<td>Focus Group Discussion</td>
<td>12.12.2014/Fri 8.30 am–10.30 am, December</td>
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<td>32.</td>
<td>Closing session</td>
<td>12.12.2014/Fri 3.00 pm–5.00 pm, December</td>
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<td>33.</td>
<td>Intervention group A and group B</td>
<td>21.3.2015/ Sat 8.00 am–5.00 pm, March</td>
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<td>34.</td>
<td>Control group</td>
<td>22.3.2015/ Sun 8.00 am–5.00 pm, March</td>
<td></td>
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</table>
Participant Information Sheet

“Spiritual Reminiscence Therapy for older people with loneliness, anxiety and depression”

Researcher: Sharifah Munirah Syed Elias
PhD student, The University of Queensland, Australia

You are invited to take part in this research project. This research project involves new therapy called spiritual reminiscence therapy. Spiritual reminiscence is a life review process that involves people trying to find the meaning of their life. The aim of the study is to determine the effectiveness of spiritual reminiscence therapy for older people with loneliness, anxiety and depression.

Participation in this research is voluntary. If you don’t wish to take part, you don’t have to. If you decide you want to take part in the research project, you will be asked to sign the consent section. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine treatment, your relationship with those treating you or your relationship with staff of residential aged care facilities.

The benefits of spiritual reminiscence therapy are it may reduce feelings of loneliness, anxiety and depression as well as help to cope with past life events. There are no foreseeable risks due to your involvement in the study. However, you may feel that some of the questions we ask are stressful or upsetting. If you do not wish to answer a question, you may skip it and go to the next question, or you may stop immediately.

There are no additional costs associated with participating in this research project, nor will you be paid. All therapy required as part of the research project will be provided to you free of charge.

The participants will be divided into two groups: intervention group and control group using a random assignment. A simple random sampling will help in random assignment. The participants in the intervention group will receive spiritual reminiscence therapy and participants in the control group will receive attention control activities.

This research project (spiritual reminiscence therapy) will be conducted in a group once a week, for a six-week program in a 90-min session by a researcher who will be the facilitator of the therapy. Participants in the intervention group will be observed throughout the intervention. Before, after and three month-follow-up completing six weeks’ therapy, you will be asked to complete a questionnaire about loneliness, anxiety and depression. Focus group discussion will be conducted after the intervention with the six to ten participants in the group. The focus group discussion will be conducted once only and it will be recorded. There will be no minimum amount of time; however, the maximum time for focus group discussion is two hours or it will be finished upon saturation of the data.

A summary of the findings of the research will be available at no financial cost. It will take approximately six months for the participant to receive the summary of the results.

Confidentiality will be informed and discussed with all the participants in the spiritual reminiscence group regarding the stories shared during therapy. All the participants will be reminded in every session to avoid discussion of the stories outside of the therapy session. Anonymity will be maintained throughout the project. Your personal information will not be exposed in the results published and will be maintained confidentiality. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission.

The ethical aspects of this research project have been approved by a Behavioral & Social Sciences Ethical Review Committee (BSSERC) of The University of Queensland and Department of Social Welfare Malaysia, Ministry of Women, Family and Community Development. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the researcher on [+60199888461] and The University of Queensland Ethic’s Officer (+61733653924)
Consent Form

Title
Spiritual reminiscence therapy for older people with loneliness, anxiety and depression

Short Title
Spiritual reminiscence therapy

Principal Investigator
Sharifah Munirah Syed Elias

Supervisor(s)
Assoc. Prof. Dr Christine Neville
Dr Theresa Scott

Location
A Residential aged care facility in Malaysia

Declaration by Participant

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I understand that I will not benefit financially from the involvement in this research project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the study without affecting my future health care.

I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print) ___________________________________________

Signature ___________________________ Date ___________________________

Name of Witness* to Participant’s
Signature (please print) ___________________________________________

Signature ___________________________ Date ___________________________

* Witness is not to be the investigator, a member of the study team or their delegate. In the event that an interpreter is used, the interpreter may not act as a witness to the consent process. Witness must be 18 years or older.

Declaration by Principal Investigator

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Principal Investigator (please print) Sharifah Munirah Syed Elias

Signature ___________________________ Date ___________________________

Note: All parties signing the consent section must date their own signature
Helaian Maklumat peserta
“Terapi Imbasan Kenangan Spiritual untuk warga tua yang mengalami kesunyian, kebimbangan dan kemurungan”

Penyelidik: Sharifah Munirah Syed Elias
Pelajar PhD, The University of Queensland, Australia

Anda dijemput untuk mengambil bahagian dalam penyelidikan ini. Projek ini melibatkan terapi terkini dipanggil terapi imbasan kenangan. Terapi imbasan kenangan merupakan proses mengimbas kembali kehidupan yang mana manusia cuba untuk mencari makna dalam kehidupan. Tujuan penyelidikan ini adalah untuk menentukan keberkesanan terapi imbasan kenangan spiritual untuk warga tua yang kesunyian, kebimbangan dan kemurungan.


Projek penyelidikan ini (terapi imbasan kenangan spiritual) akan dilaksanakan dalam satu kumpulan sekali seminggu dalam 90 minit setiap sesi oleh penyelidik yang akan menjadi fasilitator untuk terapi. Anda akan diminta untuk menyiapkan cerita-cerita tentang kesunyian, kebimbangan dan kemurungan sebelum, selepas enam minggu terapi dan tiga bulan susulan. Perbincangan kumpulan berfokus akan dijalankan selepas intervensi dengan enam sehingga 10 peserta. Perbincangan kumpulan berfokus akan direkodkan dan dijalankan sekali sahaja. Tiada had masa ditetapkan tetapi masa maksimum adalah 2 jam.


Borang Kebenaran - Kebenaran daripada orang dewasa

Tajuk
Terapi imbasan kenangan spiritual untuk warga tua yang mengalami kesunyian, kebimbangan dan kemurungan

Tajuk ringkas
Terapi imbasan kenangan spiritual

Penyelidik utama
Sharifah Munirah Syed Elias

Penyelia
1. Assoc. Prof. Dr Christine Neville
   2. Dr Theresa Scott

Lokasi
Rumah Seri Kenangan Cheras, Malaysia

Pengakuan oleh Peserta
Saya telah membaca Helaian Maklumat Peserta atau seseorang telah membaca kepada saya dalam bahasa yang saya faham.

Saya faham tujuan, prosedur dan risiko penyelidikan yang dihuraikan dalam projek ini.

Saya faham bahawa saya tidak akan mendapat faedah kewangan daripada penglibatan dalam projek penyelidikan ini.

Saya telah mendapat peluang untuk bertanya soalan dan saya berpuas hati dengan jawapan yang saya terima.

Saya bebas bersetuju untuk mengambil bahagian dalam projek penyelidikan ini seperti yang diterangkan dan memahami bahawa saya bebas untuk menarik diri pada bila-bila masa semasa penyelidikan tanpa menjegaskan penjagaan kesihatan saya pada masa depan.

Saya faham bahawa saya akan diberikan satu salinan dokumen yang telah ditandatangani untuk disimpan.

<table>
<thead>
<tr>
<th>Nama peserta (sila tulis)</th>
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<th>Tarikh</th>
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<table>
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<th>Nama saksi* kepada tandatangan peserta (sila tulis)</th>
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<th>Tarikh</th>
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</table>

* Saksi bukan penyelidik, seorang ahli pasukan penyelidikan atau ahli pasukan penyelidikan atau delegasi mereka. Sekiranya jurubahasa digunakan, jurubahasa itu tidak boleh bertindak sebagai seorang saksi untuk proses kebenaran. Saksi mestilah berumur 18 tahun atau lebih tua.

Pengakuan oleh Penyelidik Utama
Saya telah diberikan penjelasan secara lisan tentang projek penyelidikan, prosedur dan risikonya dan saya percaya bahawa peserta telah memahami penjelasan itu.

<table>
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Nota: Semua pihak menandatangani seksyen kebenaran mesti meletakkan tarikh tandatangan mereka
### Appendix D  Attendance log: Participation and Reasons for Non-Attendance

<table>
<thead>
<tr>
<th>Participant</th>
<th>SRT Sessions &amp; Attention control activities</th>
<th>Reasons for Non-Attendance</th>
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<td>x</td>
</tr>
<tr>
<td>17</td>
<td>√</td>
<td>x</td>
</tr>
<tr>
<td>18</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>19</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>20</td>
<td>√</td>
<td>√</td>
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<tr>
<td>21</td>
<td>√</td>
<td>√</td>
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<tr>
<td>22</td>
<td>√</td>
<td>x</td>
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<tr>
<td>23</td>
<td>√</td>
<td>√</td>
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<tr>
<td>24</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>25</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>26</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>27</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>28</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>29</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>30</td>
<td>x</td>
<td>√</td>
</tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>√</td>
<td>x</td>
</tr>
<tr>
<td>32</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>33</td>
<td>√</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>

Note: SRT: Spiritual Reminiscence Therapy, √: Attended, x: Non-Attendance
Appendix E Measurement instruments

MEASUREMENT INSTRUMENTS FOR SCREENING

COGNITIVE SCREENING INSTRUMENT
Mini-Cog Test (To be completed by researcher)

Instructions
Inside the circle draw the hours of a clock as if a child would draw them.
Place the hands of the clock to represent the time “forty five minutes past ten o’clock”

1. Instruct the patient to listen carefully and repeat the following
   APPLE     WATCH     PENNY
2. Administer the Clock Drawing Test.
3. Ask the patient to repeat the three words given previously.
   __________ __________ __________

Scoring
Number of correct items recalled ________ [if 3 then negative screen. STOP]
If answer is 1–2:
Is CDT abnormal? No / Yes
If No, then negative screen.
If Yes, then screen positive for cognitive impairment.
LONELINESS SCREENING INSTRUMENT

Do you sometimes feel lonely?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Often</td>
</tr>
<tr>
<td>2</td>
<td>Sometimes</td>
</tr>
<tr>
<td>3</td>
<td>Rarely</td>
</tr>
<tr>
<td>4</td>
<td>Never</td>
</tr>
</tbody>
</table>

(Score 1 and 2 = lonely; 3 and 4 = not lonely)

ANXIETY SCREENING INSTRUMENT

1. I worry a lot of the time. Agree / Disagree
2. Little things bother me a lot. Agree / Disagree
3. I think of myself as a worrier. Agree / Disagree
4. I often feel nervous. Agree / Disagree
5. My own thoughts often make me nervous. Agree / Disagree

(Score 1 to 2 = not anxiety, 3 to 5 = anxiety)

DEPRESSION SCREENING INSTRUMENT

1. Are you basically satisfied with your life? Yes / NO
2. Do you feel that your life is empty? YES / No
3. Are you afraid that something bad is going to happen to you? YES / No
4. Do you feel happy most of the time? Yes / NO

(Score 1 for answers in block capitals: 2–4 = Depressed, 1 = Uncertain, 0 = Not depressed)
**Section A: Demographic data**

1. Gender: [ ] Male     [ ] Female  
2. Date of admission:  
3. Date of Birth:  
4. Age:  
5. Country of Origin:  
6. Religion:  
7. Present marital status:  
8. Number of children:  
9. Employment history:  
10. Educational status:  
11. Prescribed Medications:     [ ] Yes     [ ] No
### Section B: Health Status (Cumulative Illness Rating Scale for Geriatrics)

Rater: _______________________________________________________________

<table>
<thead>
<tr>
<th>Rating Strategy</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  No problem</td>
<td></td>
</tr>
<tr>
<td>1  Mild current problem or past significant problem</td>
<td></td>
</tr>
<tr>
<td>2  Moderate disability or morbidity; requires &quot;first-line&quot; therapy</td>
<td></td>
</tr>
<tr>
<td>3  Severe or constant significant disability; uncontrollable chronic problem</td>
<td></td>
</tr>
<tr>
<td>4  Extremely severe (life threatening), severe impairment in function</td>
<td></td>
</tr>
</tbody>
</table>

Write a brief description of the medical problem(s) that justified the endorsed score on the line following each item.

<table>
<thead>
<tr>
<th>Medical System</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart</td>
<td></td>
</tr>
<tr>
<td>Vascular</td>
<td></td>
</tr>
<tr>
<td>Hematopoietic</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
</tr>
<tr>
<td>Eyes, ears, nose, throat, and larynx</td>
<td></td>
</tr>
<tr>
<td>Upper gastrointestinal tract</td>
<td></td>
</tr>
<tr>
<td>Lower gastrointestinal tract</td>
<td></td>
</tr>
<tr>
<td>Liver</td>
<td></td>
</tr>
<tr>
<td>Renal</td>
<td></td>
</tr>
<tr>
<td>Genitourinary</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal/integument</td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
</tr>
<tr>
<td>Endocrine/metabolic and breast</td>
<td></td>
</tr>
<tr>
<td>Psychiatric illness</td>
<td></td>
</tr>
</tbody>
</table>
Section C UCLA Loneliness Scale

Please answer all the questions by placing a clear \( \sqrt{\text{ }} \) sign in the space provided.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>How often do you feel that you are ‘in tune’ with the people around you?</td>
<td>1</td>
<td>Never</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>How often do you feel that you lack companionship?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>How often do you feel that there is no one you can turn to?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>How often do you feel alone?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>How often do you feel part of a group of friends?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>How often do you feel that you have a lot in common with the people around you?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>How often do you feel that you are no longer close to anyone?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>How often do you feel that your interests and ideas are not shared by those around you?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>How often do you feel outgoing and friendly?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>How often do you feel close to people?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>How often do you feel left out?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>How often do you feel that your relationships with others are not meaningful?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>How often do you feel that no one really knows you well?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>How often do you feel isolated from others?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>How often do you feel that you can find companionship when you want it?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>How often do you feel that there are people who really understand you?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>How often do you feel shy?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>How often do you feel that people are around you but not with you?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>How often do you feel that there are people you can talk to?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>How often do you feel that there are people you can turn to?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total score
Section D Geriatric Anxiety Scale
Below is a list of common symptoms of anxiety or stress. Please read each item in the list carefully. Indicate how often you have experienced each symptom during the PAST WEEK, INCLUDING TODAY by checking under the corresponding answer.

<table>
<thead>
<tr>
<th></th>
<th>Not at all (0)</th>
<th>Sometimes (1)</th>
<th>Most of the time(2)</th>
<th>All of the time (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>My heart raced or beat strongly.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>My breath was short.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>I had an upset stomach.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>I felt like things were not real or like I was outside of myself.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>I felt like I was losing control.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>I was afraid of being judged by others.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>I was afraid of being humiliated or embarrassed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>I had difficulty falling asleep.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>I had difficulty staying asleep.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>I was irritable.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>I had outbursts of anger.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>I had difficulty concentrating.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>I was easily startled or upset.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>I was less interested in doing something I typically enjoy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>I felt detached or isolated from others.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>I felt like I was in a daze.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>I had a hard time sitting still.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>I worried too much.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>I could not control my worry.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>I felt restless, keyed up, or on edge.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>My muscles were tense.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>I had back pain, neck pain, or muscle cramps.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>I felt like I had no control over my life.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>I felt like something terrible was going to happen to me.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>I was concerned about my finances.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>I was concerned about my health.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>I was concerned about my children.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>I was afraid of dying.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>I was afraid of becoming a burden to my family or children.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Section E Malay version of Geriatric Depression Scale (M-GDS-14)**
Choose the best answer for how you felt over the past week. Circle the most suitable answer.

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Answer Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Are you basically satisfied with your life?</td>
<td>yes / NO</td>
</tr>
<tr>
<td>2</td>
<td>Have you dropped many of your activities &amp; interest?</td>
<td>YES / no</td>
</tr>
<tr>
<td>3</td>
<td>Do you feel that your life is empty?</td>
<td>YES / no</td>
</tr>
<tr>
<td>4</td>
<td>Do you often get bored?</td>
<td>YES / no</td>
</tr>
<tr>
<td>5</td>
<td>Are you in good spirits most of the time?</td>
<td>yes / NO</td>
</tr>
<tr>
<td>6</td>
<td>Are you afraid that something bad is going to happen to you?</td>
<td>YES / no</td>
</tr>
<tr>
<td>7</td>
<td>Do you feel happy most of the time?</td>
<td>yes / NO</td>
</tr>
<tr>
<td>8</td>
<td>Do you often feel helpless?</td>
<td>YES / no</td>
</tr>
<tr>
<td>9</td>
<td>Do you feel that you have more problems with memory than most?</td>
<td>YES / no</td>
</tr>
<tr>
<td>10</td>
<td>Do you think it is wonderful to be alive now?</td>
<td>yes / NO</td>
</tr>
<tr>
<td>11</td>
<td>Do you feel pretty worthless the way you are now?</td>
<td>YES / no</td>
</tr>
<tr>
<td>12</td>
<td>Do you feel full of energy?</td>
<td>yes / NO</td>
</tr>
<tr>
<td>13</td>
<td>Do you feel that your situation is hopeless?</td>
<td>YES / no</td>
</tr>
<tr>
<td>14</td>
<td>Do you think that most people are better off than you are?</td>
<td>YES / no</td>
</tr>
</tbody>
</table>

**TOTAL SCORE**
Ujian Mini-Cog *(Diisi oleh penyelidik)*

**Arahan**
Di dalam bulatan, lukis waktu jam sepertimana kanak-kanak melukisnya. Letakkan tangan jam untuk mewakili masa 10.45.

1. Arah pesakit untuk mendengar dengan teliti dan mengikuti yang berikut:
   Epal       Jam       Sen
2. Lakukan ujian lukisan jam.
3. Minta pesakit mengulang kembali tiga perkataan yang diberikan sebelum ini.
   _______ _________ __________

**Skor**
Bilangan perkara yang diulang semula dengan betul _______ [sekitanya 3 maka saringan negatif. BERHENTI]
Jika jawapan adalah 1–2:
   Adakah ujian lukisan jam abnormal?  Tidak       Ya

Jika Tidak, maka saringan negatif.
Jika Ya, maka saringan positif untuk kemerosotan kognitif.
SARINGAN KESUNYIAN

Adakah anda kadang-kadang berasa sunyi?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Selalu</td>
</tr>
<tr>
<td>2</td>
<td>Kadang-kadang</td>
</tr>
<tr>
<td>3</td>
<td>Jarang-jarang</td>
</tr>
<tr>
<td>4</td>
<td>Tidak pernah</td>
</tr>
</tbody>
</table>

(Skor 1 dan 2 = sunyi; 3 and 4 = tidak sunyi)

SARINGAN KEBIMBANGAN

1. Saya berasa bimbang di kebanyakan masa  Setuju / Tidak setuju
2. Perkara-perkara kecil banyak merungsingkan saya  Setuju / Tidak setuju
3. Saya rasa saya seorang yang mudah berasa bimbang  Setuju / Tidak setuju
4. Saya selalu berasa bimbang  Setuju / Tidak setuju
5. Fikiran saya sendiri selalu membuatkan saya bimbang  Setuju / Tidak setuju

(Skor 1 dan 2 = tidak bimbang, 3 hingga 5 = bimbang)

SARINGAN KEMURUNGAN

1. Adakah anda pada asasnya berpuas hati dengan kehidupan anda?  Ya / TIDAK
2. Adakah anda berasa hidup anda kekosongan?  YA / Tidak
3. Adakah anda bimbang sesuatu yang buruk akan terjadi pada anda?  YA / Tidak
4. Adakah anda berasa gembira dalam kebanyakan masa?  Ya / TIDAK

(Skor 1 untuk jawapan huruf besar: 2–4 = Kemurungan, 1 = Tidak pasti, 0 = todak kemurungan)
BORANG SOAL SELIDIK (Bahagian intervensi)

Bahagian A: Data Sosiodemografi

1. Jantina: □ Lelaki □ Perempuan
2. Tempoh tinggal di RSK: _____________________________
3. Tarikh lahir: _________________________________
4. Umur: _________________________________
5. Negara asal: ________________________________
6. Agama: ________________________________
7. Status perkahwinan: ________________________________
8. Bilangan anak: ________________________________
9. Sejarah pekerjaan: ________________________________
10. Status pendidikan: ________________________________
11. Pengambilan ubat-ubatan: □ Ya □ Tidak
Bahagian B: Status Kesihatan (*Cumulative Illness Rating Scale for Geriatrics*)

Penilai: _______________________________________________________________

<table>
<thead>
<tr>
<th>Strategi penilaian</th>
<th>Skor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Tiada masalah</td>
<td></td>
</tr>
<tr>
<td>1 Masalah semasa yang ringan atau masalah lalu yang penting</td>
<td></td>
</tr>
<tr>
<td>2 Disabiliti atau penyakit sederhana; memerlukan terapi tahap pertama</td>
<td></td>
</tr>
<tr>
<td>3 Disabiliti teruk atau kekal signifikan, masalah kronik yang tidak dapat dikawal</td>
<td></td>
</tr>
<tr>
<td>4 Terlalu bahaya (mengancam nyawa), kemerosotan fungsi yang teruk</td>
<td></td>
</tr>
</tbody>
</table>

Tulis deskripsi ringkas masalah-masalah perubatan sebagai penjelasan untuk setiap skor yang diberikan untuk setiap perkara.

<table>
<thead>
<tr>
<th>Area</th>
<th></th>
<th>Skor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jantung</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaskular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hematopoietik</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respirasi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mata, telinga, hidung, tekak, and larinks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trek gastrousus atas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trek gastrousus bawah</td>
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Bahagian C: Skala Kesunyian

Sila jawab semua soalan dengan menandakan tanda yang jelas pada ruangan yang telah disediakan

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<td>Kerapakah anda rasa bahawa terdapat orang yang anda boleh meminta pertolongan?</td>
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</table>

Jumlah Skor
Bahagian D: Skala Kebimbangan Geriatrik

Berikut adalah senarai simptom umum untuk kebimbangan atau tekanan. Sila baca setiap perkara dalam senarai dengan berhati-hati. Nyatakan bagaimana anda mengalami setiap simptom pada minggu lepas termasuk hari ini dengan menandakan jawapan yang berkaitan.

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<td>Saya berasa dipisahkan atau diasingkan dari orang lain.</td>
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<td>Saya mempunyai waktu yang sukar untuk duduk diam.</td>
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<td>Saya bimbang terlalu banyak.</td>
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<td>Saya tidak boleh kawal kebimbangan saya.</td>
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<td>keharga atau anak.</td>
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Bahagian E: Skala Kemurungan
Sila jawab semua soalan mengenai perasaan anda sepanjang minggu lepas dengan membulatkan jawapan anda

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<td>Adakah anda pada asasnya berpuas hati dengan kehidupan anda?</td>
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<td>2</td>
<td>Adakah anda telah meninggalkan banyak kegiatan dan minat anda?</td>
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<td>3</td>
<td>Adakah anda berasa hidup anda kekosongan?</td>
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<td>Adakah anda sering bosan?</td>
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<td>Adakah anda bersemangat dalam kebanyakan masa?</td>
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<td>Adakah anda bimbang sesuatu yang buruk akan terjadi pada anda?</td>
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<td>Adakah anda berasa gembira dalam kebanyakan masa?</td>
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<td>8</td>
<td>Adakah anda sering berasa tidak terdaya?</td>
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<td>Adakah anda berasa bahawa anda mempunyai lebih banyak masalah daya ingatan daripada orang lain?</td>
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<td>Adakah anda fikir alangkah baiknya untuk hidup sekarang?</td>
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<td>Adakah anda berasa keadaan anda sekarang kurang berguna?</td>
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<td>Adakah anda berasa penuh bertenaga?</td>
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<td>Adakah anda berasa keadaan anda tidak ada harapan?</td>
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JUMLAH SKOR
Appendix F   Proofreading instrument

DATE: November 4, 2014

Subject: Letter of Proofreading Completion.

To Whom It May Concern:

GrammarProofing.com hereby certifies that Mr. Philip John Morgan performed proofreading services, at the request of Sharifah Munirah, for the following document:

Title: Proofreading 1.docx
Completion date: October 28, 2014

This letter certifies that Mr. Philip Morgan is a Native Englishman, born in London, England in 1962. Mr. Morgan graduated from Queen Elizabeth’s Grammar School, London, followed by Barnet College of Further Education in 1979, on completion of his Pre-Diploma Science course, which included the City & Guilds qualification for English Language.

It has been the pleasure of GrammarProofing.com to assist Sharifah Munirah Syed Elias, and may I take this opportunity of wishing every success in the future.

Yours sincerely,

Philip Morgan

Mr. Philip Morgan
## Appendix G Spiritual reminiscence therapy program

<table>
<thead>
<tr>
<th>SRT Program (MacKinlay &amp; Trevitt, 2006)</th>
<th>Adapted SRT program</th>
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<tbody>
<tr>
<td><strong>Preliminary phase</strong></td>
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<tr>
<td>• Equipment</td>
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<tr>
<td>o Quiet and comfortable room</td>
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<td>o Chairs (maximum 12)</td>
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<td>o Audio recorder</td>
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<td>o Pen &amp; notes</td>
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<td>o Mineral water</td>
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<tr>
<td><strong>Week 1: Life-meaning</strong></td>
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<tr>
<td><strong>A. Beginning phase</strong></td>
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<tr>
<td>o Self-introduction (facilitator and participants)</td>
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<tr>
<td>• The purpose: to reduce the feelings of loneliness, anxiety and depression, to explore their experiences after therapy.</td>
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<td>• Once per week for six weeks and each session will take approximately 90 minutes.</td>
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<tr>
<td><strong>Ethical issues</strong></td>
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<td>o Confidentiality: each participant is reminded to avoid discussion outside the therapy session.</td>
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<tr>
<td>o What gives greatest meaning to your life now? And follow-up with questions like:</td>
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<tr>
<td>o What is most important in your life?</td>
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<tr>
<td>o What keeps you going?</td>
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<tr>
<td>o Is life worth living?</td>
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<tr>
<td>o If life is worth living, why is it worth living? If not, why not?</td>
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<tr>
<td><strong>B. Middle phase</strong></td>
<td>List of topics [adapted from (MacKinlay &amp; Trevitt, 2006)]</td>
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<tr>
<td>o What gives greatest meaning to your life now? And follow-up with questions like:</td>
<td></td>
</tr>
<tr>
<td>o What is most important in your life?</td>
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<tr>
<td>o What keeps you going?</td>
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<tr>
<td>o Is life worth living?</td>
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<tr>
<td>o If life is worth living, why is it worth living? If not, why not?</td>
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<tr>
<td>o Looking back over your life:</td>
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<tr>
<td>• What do you remember with joy?</td>
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<tr>
<td>What do you remember with sadness?</td>
<td>What do you remember with sadness?</td>
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<td>Visual Triggers: family photos, printed pictures such as health, friends, pets, pain, disability</td>
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<td>C. End phase</td>
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<td>o Conclusion about the topics</td>
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<td>o Inform about topics for the next session</td>
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<td>Thank you for their participation.</td>
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**Week 2: Relationships-isolation, connecting**

<table>
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<tr>
<th>A. Beginning phase</th>
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<tr>
<td>o Introduction to the topic</td>
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<tr>
<td>o Ethical issues</td>
</tr>
<tr>
<td>a. Confidentiality: each participant is reminded to avoid discussion outside the therapy session.</td>
</tr>
<tr>
<td>b. Anonymity</td>
</tr>
<tr>
<td>o What are/have been the best things about relationships in your life?</td>
</tr>
<tr>
<td>Use this as a starting point for exploring relationships with the group:</td>
</tr>
<tr>
<td>o Think of a number of questions, such as: Who visits you? Who do you miss? Who have you been especially close to?</td>
</tr>
<tr>
<td>o Do you have many friends here? How many friends do you have?</td>
</tr>
<tr>
<td>o Do you ever feel lonely? When? Follow up on things that might be associated with time of day, place etc.</td>
</tr>
<tr>
<td>o Do you like to be alone?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Visual triggers: Friends photos</th>
</tr>
</thead>
</table>

**Week 3: Hopes, fears and worries**

<table>
<thead>
<tr>
<th>A. Beginning phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Introduction to the topic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. End phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Conclusion about the topics</td>
</tr>
<tr>
<td>o Inform about topics for the next session</td>
</tr>
<tr>
<td>Thank you for their participation.</td>
</tr>
<tr>
<td>Ethical issues</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>a. Confidentiality: each participant is reminded to avoid discussion outside the therapy session.</td>
</tr>
<tr>
<td>b. Anonymity</td>
</tr>
</tbody>
</table>

**What things do you worry about?**  
**Do you have any fears? What about?**  
**Do you feel you can talk to anyone about things that trouble you?**  
**What gives you hope now?**

**B. Middle phase**  
List of topics [adapted from (MacKinlay & Trevitt, 2006)]  
- **What things do you worry about?**  
- **Do you have any fears? What about?**  
- **Do you feel you can talk to anyone about things that trouble you?**  
- **What gives you hope now?**

**Visual triggers: Fall, death, disability**

**C. End phase**  
- Conclusion about the topics  
- Inform about topics for the next session  
Thank you for their participation.

**Week 4: Growing older and transcendence**

<table>
<thead>
<tr>
<th>A. Beginning phase</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>o Introduction to the topic</td>
<td></td>
</tr>
<tr>
<td>o Ethical issues</td>
<td></td>
</tr>
<tr>
<td>a. Confidentiality: each participant is reminded to avoid discussion outside the therapy session.</td>
<td></td>
</tr>
<tr>
<td>b. Anonymity</td>
<td></td>
</tr>
</tbody>
</table>

- **What’s it like growing older? For example:**  
- **Do you have any health problems? Do you have memory problems? If so, how does that affect what you want to do?**  
- **What are the hardest things in your life now?**  
- **Do you like living here? What’s it like living here? Was it hard to settle in? And other questions of a similar kind.**  
- **As you reach the end of your life, what do you hope for now? What do you look forward to?**

<table>
<thead>
<tr>
<th>B. Middle phase</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>List of topics [adapted from (MacKinlay &amp; Trevitt, 2006)]</td>
<td></td>
</tr>
</tbody>
</table>
| - **What’s it like growing older? For example:**  
- Do you have any health problems? Do you have memory problems? If so, how does that affect what you want to do? |  |
| - **What are the hardest things in your life now?** |  |
| - **Do you like living here? What’s it like living here? Was it hard to settle in? And other questions of a similar kind.** |  |
| - **As you reach the end of your life what do you hope for now? What do you look forward to?** |  |

**Visual triggers: Young adult photo to older adult photo (Each participant is encouraged to bring their own photos.)**
<table>
<thead>
<tr>
<th>Taste triggers: candy and mango, orange</th>
<th>Week 5: Spiritual and religious beliefs</th>
</tr>
</thead>
<tbody>
<tr>
<td>C. End phase</td>
<td>A. Beginning phase</td>
</tr>
<tr>
<td>Conclusion about the topics</td>
<td>o Introduction to the topic</td>
</tr>
<tr>
<td>Inform about topics for the next session</td>
<td>o Ethical issues</td>
</tr>
<tr>
<td>Thank you for their participation.</td>
<td>a. Confidentiality: each participant is reminded to avoid discussion outside the therapy session.</td>
</tr>
<tr>
<td></td>
<td>b. Anonymity</td>
</tr>
</tbody>
</table>

**Week 5: Spiritual and religious beliefs**

- **Beginning phase**
  - Introduction to the topic
  - Ethical issues
    - Confidentiality: each participant is reminded to avoid discussion outside the therapy session.
    - Anonymity

- **Middle phase**
  - List of topics [adapted from (MacKinlay & Trevitt, 2006)]
    - Do you have an image of God or some sense of a deity or otherness? Or, use other words that are meaningful to the group, such as: What do you think God is like?
    - If you hold an image of God, can you tell me about this image?
    - Do you feel near to God?
    - What are you earliest memories of church, mosque, temple or other worship? Where do you go to get spiritual support?
    - Who is the most important person to give you spiritual support?
    - Do you find art or music expresses spirituality for you?
    - Do you find plants, gardens or pets are ways of expressing spirituality for you?

- **End phase**
  - Conclusion about the topics
  - Inform about topics for the next session
  - Thank you for their participations

**Sound triggers:** Quran recitation, church choir, temple sounds, traditional music, popular songs during their times

**Visual triggers:** Photos of church, mosque and temple, prayer videos

**Smell triggers:** plants/gardens such as hibiscus, roses, pandanous leaves, cinnamon

---

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<table>
<thead>
<tr>
<th>Week 6: Spiritual and religious practices</th>
<th>Week 6: Spiritual and religious practices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Beginning phase</strong></td>
<td><strong>B. Middle phase</strong></td>
</tr>
<tr>
<td>- Introduction to the topic</td>
<td>- Do you take part in any religious/spiritual activities now? For example, attend church services, bible or other religious readings, prayer, meditation?</td>
</tr>
<tr>
<td>- Ethical issues</td>
<td>- How important are these to you?</td>
</tr>
<tr>
<td>- Confidentiality: each participant is reminded to avoid discussion outside the therapy session.</td>
<td>- How can we help you to find meaning now?</td>
</tr>
<tr>
<td>- Anonymity</td>
<td><strong>C. End phase</strong></td>
</tr>
<tr>
<td><strong>Do you take part in any religious/spiritual activities now? For example, attend church services, bible or other religious readings, prayer, meditation?</strong></td>
<td>- Conclusion about the topics</td>
</tr>
<tr>
<td><strong>How important are these to you?</strong></td>
<td>- Thank you for their participation.</td>
</tr>
<tr>
<td><strong>How can we help you to find meaning now?</strong></td>
<td>Summary of all the topics</td>
</tr>
</tbody>
</table>

*Tactile triggers: Quran, Bible*
Spiritual Reminiscence Therapy Program (Malay version)

Protokol Terapi Imbasan Spiritual

Fasa persediaan:
- Peralatan
  - Bilik yang selesa dan senyap
  - Kerusi (maksimum 12)
  - Perakam suara
  - Pen dan nota
  - Air mineral

Minggu 1: Makna kehidupan
A. Fasa permulaan
- Pengenalan diri (fasilitator dan peserta)
- Protokol terapi imbasan kenangan
  - Tujuan: Mengurangkan kesunyian, kebimbangan dan kemurungan
  - Proses
    - Sekali seminggu untuk enam minggu dan setiap sesi akan mengambil masa lebih kurang 90 minit
Setiap peserta dikehendaki berkongsi cerita mereka sekurang-kurangnya lima minit setiap seorang
Peserta diingatkan supaya menghormati orang lain
  o Isu etika
    ▪ Kerahsian: setiap peserta diingatkan untuk mengelakkan perbincangan di luar sesi terapi
    ▪ Tanpa nama

B. Fasa pertengahan
   Cadangan topik (MacKinlay & Trevitt, 2006)
• Apakah yang memberi makna terbesar dalam kehidupan anda sekarang? Dikuti dengan soalan susulan seperti:
• Apakah yang terpenting dalam hidup anda?
• Apakah yang membuat anda teruskan?
• Adakah hidup ini bernilai?
  o Jika hidup ini bernilai-mengapa ia bernilai? Jika tidak, mengapa tidak?
• Imbas kembali kehidupan anda:
  o Apa yang anda ingat dengan kegembiraan?
  o Apa yang anda ingat dengan kesedihan?

Pencetus visual: Gambar keluarga, Gambar kesehatan, sahabat, binatang ternak, orang tua dalam kesakitan, disabiliti

C. Fasa penutup
  o Rumusan mengenai topik
  o Maklumkan topik untuk minggu hadapan
  o Ucapkan terima kasih untuk penyertaan mereka

Minggu 2: Hubungan-pengasingan, Mengikatkan
A. Fasa permulaan
• Pengenalan diri (fasilitator dan peserta)
• Isu etika
  o Kerahsiaan: setiap peserta diingatkan untuk mengelakkan perbincangan di luar sesi terapi
  o Tanpa nama

B. Fasa pertengahan
   Cadangan topik (MacKinlay & Trevitt, 2006)
• Apakah perkara-perkara terbaik tentang hubungan dalam hidup anda?
• Gunakan ini sebagai titik permulaan untuk menerokai hubungan dalam kumpulan
  o Fikirkan beberapa soalan seperti: Siapa yang melawat anda? Siapa yang anda rindu? Siapa yang anda pernah rapat?
  o Adakah anda mempunyai ramai kawan di sini? Berapa ramai kawan yang anda ada?
  o Adakah anda pernah berasa sunyi? Bila? Membuat susulan kepada perkara-perkara yang mungkin dikaitkan dengan masa, tempat dan sebagainya.
  o Adakah anda suka bersendirian?

Pencetus visual: Gambar kawan-kawan

C. Fasa penutup
• Rumusan mengenai topik
• Maklumkan topik untuk minggu hadapan
• Ucapkan terima kasih untuk penyertaan mereka
Minggu 3: Harapan, Ketakutan dan Kebimbangan

A. Fasa permulaan
- Pengenalan diri (fasilitator dan peserta)
- Isu etika
  a. Kerahsiaan: setiap peserta diingatkan untuk mengelakkan perbincangan di luar sesi terapi
  b. Tanpa nama

B. Fasa pertengahan
Cadangan topik (MacKinlay & Trevitt, 2006)
- Apakah perkara-perkara yang anda risaukan?
- Adakah anda mempunyai apa-apa ketakutan? Apakah itu?
- Adakah anda rasa anda boleh bercakap kepada sesiapa tentang perkara-perkara yang menyusahkan anda?
- Apakah yang memberi anda harapan sekarang?

Pencetus visual: Orang tua jatuh, kematian, disability

C. Fasa penutup
- Rumusan mengenai topik
- Maklumkan topik untuk minggu hadapan
- Ucapkan terima kasih untuk penyertaan mereka

Minggu 4: Menjadi tua dan keulungan

A. Fasa permulaan
- Pengenalan diri (fasilitator dan peserta)
- Isu etika
  o Kerahsiaan: setiap peserta diingatkan untuk mengelakkan perbincangan di luar sesi terapi
  o Tanpa nama

B. Fasa pertengahan
Cadangan topik (MacKinlay & Trevitt, 2006)
- Apakah yang anda rasa menjadi semakin tua? Contohnya adakah anda mempunyai apa-apa masalah kesihatan? Adakah anda mempunyai masalah ingatan? Jika ya, bagaimanakah itu menjelaskan apa yang anda mahu lakukan?
- Apakah perkara-perkara yang paling sukar dalam kehidupan anda sekarang?
- Adakah anda suka tinggal di sini? Apa yang anda rasa tinggal disini?
- Adakah ia sukar untuk menyesuaikan diri? dan soalan-soalan lain yang seumpamanya.
- Sebagaimana anda sampai ke akhir hayat apa yang anda harap sekarang?
- Apa yang anda nantikan/harapkan?

Pencetus visual: Gambar orang muda dan gambar orang tua (setiap peserta digalakkan membawa gambar sendiri)

Pencetus rasa: Gula-gula, coklat dan oren

C. Fasa penutup
- Rumusan mengenai topik
- Maklumkan topik untuk minggu hadapan
- Ucapkan terima kasih untuk penyertaan mereka

Minggu 5: Spiritual dan kepercayaan agama

A. Fasa permulaan
Pengenalan diri (fasilitator dan peserta)
- Isu etika
  - Kerahsian: setiap peserta diingatkan untuk mengelakkan perbincangan di luar sesi terapi
  - Tanpa nama

B. Fasa pertengahan
Cadangan topik (MacKinlay & Trevitt, 2006)
- Adakah anda mempunyai gambaran Tuhan atau kefahaman dewa atau lain-lain?
- Atau menggunakan kata-kata lain yang bermakna kepada kumpulan seperti: Apa yang fikir tentang Tuhan?
- Jika anda mempunyai gambaran Tuhan, boleh anda beritahu saya tentang gambaran ini?
  - Adakah anda rasa dekat kepada Tuhan?
- Apakah kenangan terawal anda tentang tempat ibadah anda (masjid/gereja/tokong/tempat ibadah lain) Di manakah anda pergi untuk mendapatkan sokongan spiritual? Siapakah orang yang paling penting untuk memberikan sokongan spiritual?
- Adakah anda dapat seni atau muzik meluahkan spiritual untuk anda? Adakah anda dapat tumbuh-tumbuhan, taman-taman atau haiwan peliharaan adalah cara untuk menyatakan kerohanian kepada anda?

Pencetus bunyi: Bacaan Al-Quran, Koir gereja, bunyi loceng tokong, muzik tradisional, lagu-lagu lama popular.
Pencetus visual: Gambar masjid, gereja dan tokong, video orang sembahyang
Pencetus bau: pokok-pokok dan tanaman seperti bunga ros, daun pandan, kulit kayu manis

C. Fasa penutup
- Rumusan mengenai topik
- Maklumkan topik untuk minggu hadapan
- Ucapkan terima kasih untuk penyertaan mereka

Minggu 6: Spiritual dan amalan-amalan keagamaan
A. Fasa permulaan
- Pengenalan diri (fasilitator dan peserta)
- Isu etika”
- Kerahsian: setiap peserta diingatkan untuk mengelakkan perbincangan di luar sesi terapi
- Tanpa nama

D. Fasa pertengahan
Cadangan topik (MacKinlay & Trevitt, 2006)
- Adakah anda mengambil bahagian dalam mana-mana aktiviti-aktiviti keagamaan/spiritual sekarang? Contoh: mengikuti kelas-kelas agama di masjid, menghadiri acara gereja
- Sejauh mana pentingnya ini kepada anda?
- Bagaimana kita boleh membantu anda untuk mencari makna ini?

Pencetus sentuhan: Quran, Bible (setiap peserta digalakkan mebawa sendiri)

C. Fasa penutup
- Rumusan mengenai topik
- Maklumkan topik untuk minggu hadapan
- Ucapkan terima kasih untuk penyertaan mereka
- Rumusan semua topik-topik yang telah dibincangkan
## Focus Group Discussion Topic Guide

<table>
<thead>
<tr>
<th>Activities</th>
<th>People involved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction</strong></td>
<td></td>
</tr>
<tr>
<td>1. Welcome and thanks to all the participants</td>
<td>Facilitator</td>
</tr>
<tr>
<td>2. Introduce myself and all the participants</td>
<td></td>
</tr>
<tr>
<td>3. Purpose and the process of FGD</td>
<td></td>
</tr>
<tr>
<td>4. Rules in FGD</td>
<td></td>
</tr>
<tr>
<td>• Everyone should participate</td>
<td></td>
</tr>
<tr>
<td>• Information must be kept confidential</td>
<td></td>
</tr>
<tr>
<td>• Share views with the group and no side conversations are allowed</td>
<td></td>
</tr>
<tr>
<td>5. Start with a general question: Can you share your experience on the Spiritual Reminiscence Therapy (SRT) program? (<em>probe: people, topics, activities</em>)</td>
<td></td>
</tr>
<tr>
<td><strong>Body</strong></td>
<td>Facilitator and participants</td>
</tr>
<tr>
<td>1. Emotional experiences/feelings</td>
<td></td>
</tr>
<tr>
<td>(<em>probe: ask why</em>)</td>
<td></td>
</tr>
<tr>
<td>2. Process of the SRT program</td>
<td></td>
</tr>
<tr>
<td>a. Likes or dislikes about the SRT program</td>
<td></td>
</tr>
<tr>
<td>(<em>probe: the reasons</em>)</td>
<td></td>
</tr>
<tr>
<td>b. Benefits of the SRT program</td>
<td></td>
</tr>
<tr>
<td>3. Suggestions to improve the SRT program in the future</td>
<td></td>
</tr>
<tr>
<td><strong>Conclusion</strong></td>
<td>Facilitator</td>
</tr>
<tr>
<td>1. Thank all the participants &amp; session closure</td>
<td></td>
</tr>
</tbody>
</table>
Diskusi Kumpulan Fokus (Kajian Qualitatif)

Pengenalan
1. Selamat datang dan terima kasih kepada semua peserta
2. Memperkenalkan diri sendiri dan semua peserta turut diminta untuk memperkenalkan diri sendiri
3. Tujuan dan prosess diskusi kumpulan fokus
4. Peraturan dalam FGD
   a. Kesemua perta diminta untuk menyertai perbincangan
   b. Maklumat hendaklah dirahsikan
   c. Kongsi pengalaman dengan ahli kumpulan dan perbincangan di luar kumpulan adalah tidak dibenarkan
5. Mulakan dengan soalan umum: Bolehkah anda ceritakan pengalaman anda mengenai terapi imbasan kenangan spiritual? (*probe: orang, topik, aktiviti*)

Isi
Topik berkenaan diskusi kumpulan fokus
1. Pengalaman dan perasaan (*probe: tanya kenapa*)
2. Proses terapi imbasan kenangan spiritual
   a. Perkara yang digemari atau tidak digemari tentang terapi imbasan kenangan spiritual
   b. Kelebihan terapi imbasan kenangan spiritual
3. Cadangan untuk memperbaiki terapi imbasan kenangan spiritual

Penutup
1. Mengucapkan terima kasih kepada semua peserta
Appendix I  The University of Queensland Ethics Approval

THE UNIVERSITY OF QUEENSLAND
Institutional Human Research Ethics Approval

<table>
<thead>
<tr>
<th>Project Title:</th>
<th>Spiritual Reminiscence Therapy For Older People With Loneliness, Anxiety And Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Investigator:</td>
<td>Ms Sharifah Munirah Eycl Eldaz</td>
</tr>
<tr>
<td>Supervisor:</td>
<td>A/Prof Christine Neville, Dr Theresa Scott</td>
</tr>
<tr>
<td>Co-Investigator(s):</td>
<td>None</td>
</tr>
<tr>
<td>School(s):</td>
<td>Nursing and Midwifery</td>
</tr>
<tr>
<td>Approval Number:</td>
<td>2014000340</td>
</tr>
<tr>
<td>Granting Agency/Degree</td>
<td>Malaysian Government</td>
</tr>
<tr>
<td>Duration:</td>
<td>31st March 2017</td>
</tr>
</tbody>
</table>

Comments/Conditions:

Note: If this approval is for amendments to an already approved protocol for which a UQ Clinical Trials Protection/Insurance Form was originally submitted, then the researcher must directly notify the UQ Insurance Office of any changes to the Form and Participant Information Sheets & Consent Forms as a result of the amendments, before action.

Name of responsible Committee:  
Behavioural & Social Sciences Ethical Review Committee
This project complies with the provisions contained in the National Statement on Ethical Conduct in Human Research and complies with the regulations governing experimentation on humans.

Name of Ethics Committee representative:  
Associate Professor John McLean
Chairperson
Behavioural & Social Sciences Ethical Review Committee

Signature [Signature]  Date 16/4/2014

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APPLICATION TO CONDUCT RESEARCH IN MALAYSIA

With reference to your application, I am pleased to inform you that your application to conduct research in Malaysia has been approved by the Research Promotion and Co-Ordination Committee, Economic Planning Unit, Prime Minister’s Department. The details of the approval are as follows:

Researcher's name : SHARIFAH MUNIRAH SYED ELIAS
Passport No./IC No. : 821101-06-5638
Nationality : MALAYSIA
Title of Research : “SPIRITUAL REMINISCENCE THERAPY FOR OLDER PEOPLE WITH LONELINESS, ANXIETY AND DEPRESSION”.
Period of Research Approved : 4 YEARS

2. Please collect your Research Pass in person from the Economic Planning Unit, Prime Minister’s Department, Parcel B, Level 4, Block B5, Federal Government Administrative Centre, 62002 Putrajaya, Malaysia and bring along two (2) colour passport size photographs.

“Versi Melayu Ke Amaran Kerja Keratan”
3. I would like to draw your attention to the undertaking signed by you that you will submit without cost to the Economic Planning Unit the following documents:

   a) A brief summary of your research findings on completion of your research and before you leave Malaysia; and

   b) Three (3) copies of your final dissertation/publication.

4. Lastly, please submit a copy of your preliminary and final report directly to the State Government where you carried out your research. Thank you.

Yours sincerely,

(MUNIRAH BT. ABD MANAN)
For Director General,
Economic Planning Unit.
E-mail: munirah@epu.gov.my
Tel: 88882609
Fax: 88883798

ATTENTION

This letter is only to inform you the status of your application and cannot be used as a research pass.
Appendix K  Malaysia Social Welfare Department Ethical Clearance

JABATAN KEBAJIKAN MASYARAKAT  
(Department of Social Welfare) 
Araas 6, 9-18, No 55 Persiaran Perdana, 
Presint 4,  
62100 PUTRAJAYA.  

Rujukan Tuan: 
Rujukan Kami: JKM 100/12/5/2 : 2014 / 003 
Tarikh: 19-06-2014 

SHARIFAH MUNIRAH SYED ELIAS  
B21101066038  
SCHOOL OF NURSING & MIDWIFERY  
THE UNIVERSITY OF QUEENSLAND,  
EDITH CAVELL BUILDING, HERSTON  
4029  
JOHOR 

Tuan/Puan,  

PERMOHONAN MENJALANKAN KAJIAN/PENYELIDIKAN DI JABATAN KEBAJIKAN MASYARAKAT 

Tajuk Kajian/Penyelidikan : Terapi Imbasan Kenangan Spiritual untuk warga tua yang mengalami kesunyan, kebimbangan dan kemurungan 

Tempat Kajian/Penyelidikan : RUMAH SERI KENANGAN CHERAS 

Dengan hormatnya saya merujuk kepada perkara di atas. 


Sekian, terima kasih. 

"BERKHIJMAT UNTUK NEGARA"  
"BERKAT BERJASA" 

Saya yang menurut perintah, 

NORAZIAH BINTI CHEMOK ALI  
b.p. Ketua Pengarah Kebajikan Masyarakat  
Malaysia  

s.k.: