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The effects of instrumental reminiscence on resilience and coping in elderly

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ABSTRACT

Objectives: Aging, as a stage of development is marked by major changes to which the subject must adapt. Instrumental reminiscence is based on recalling times one coped with stressful circumstances, and analyzing what it took to adapt in those situations. The purpose of the present study was to analyze the effectiveness of an instrumental reminiscent program to enhance adaptive capacity (problem-focused coping and emotion-focused) and resilience in older adults.
Method: Thirty participants noninstitutionalized conducted a pre and post assessment on a treatment consisting of the Mini-Mental State Examination (MMSE), Brief Resilient Coping Scale and Stress Coping Questionnaire (CAE). The program was developed over 8 sessions of 60 min.
Results: Repeated measures analysis of variance showed significant differences in time–group interaction for treatment effectiveness of resilience measures, problem-solving coping, positive reappraisal and avoidance coping that it increased, and on emotion-focused coping and overt emotional expression that gets decreased after treatment.
Conclusion: The instrumental reminiscence has proven to be a highly useful tool and is a potentially efficient way to improve adaptive capacity and resilience in the elderly to cope with adverse situations. Through non-pharmacological therapies, the quality of life has been improved, and subjects are provided with tools, strategies and skills that allow to achieve a satisfactory adaptation.

1. Introduction

An ability human beings develop over the lifespan is adaptation to change. To function optimally while dealing with change, people implement coping strategies that can help them adjust to adverse situations. Lazarus and Folkman (1984) described coping as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). Authors have conceptualized coping's different dimensions in various ways, but the problem-focused versus emotion-focused coping paradigm (Lazarus & Folkman, 1984) is perhaps the most classic. The objective of problem-focused coping is to manage or change the problem itself causing the disturbance. Emotion-focused coping methods, meanwhile, regulate the person's emotional response to that problem. Resilience is inextricably linked to coping, an outcome of good adaptation to stressful situations. Masten (2001) described it as "a class of phenomena characterized by good outcomes in spite of threats to adaptation or development" (p. 228). Resilience is a positive, adaptive approach to stress.

Unlike other stages of development, elderly adults experience an age-associated loss of resources, both material and personal, that can hinder their ability to adjust to unfortunate situations. Thus, being able to adapt and cope with adversity is a determining factor in satisfactory aging. Of the non-pharmacological therapies available, reminiscence is the most suitable for elderly adults to better adapt to stressful situations. It has been recognized for its positive effects and therapeutic value in mental health contexts (O'Rourke, Cappeliez, & Claxton, 2011; Webster, Bohlmeijer, & Westerhof, 2010; Wong & Watt, 1991).

Reminiscence therapy tries to evoke significant memories from the past by sharing associated experiences, information, and events. Webster (2003) defined it as "the recall of personally experienced events from one's past" (p. 203), generally the distant past. Reminiscing in reaction to change and loss is natural and can

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lead a person to reflect on their life and contemplate its meaning. When channeled properly, memories can help elderly adults maintain a sense of integrity and control (Parker, 1999).

With advances in reminiscence therapy research, it has become necessary to differentiate between different types of reminiscence. Cappeliez, O'Rourke, and Chaudhury (2005), building on research by Wong and Watt (1991), and Webster (1997), proposed a comprehensive model of reminiscence functions in everyday life. Their model outlined the relationship between different types of reminiscence and dimensions of psychological functioning. Of the ones they examined, only integrative and instrumental reminiscence correlated with optimal aging measures (Wong & Watt, 1991).

Research in elderly adults has studied the efficacy of integrative reminiscence, which reduces depressive symptomatology by improving variables associated with well-being and satisfaction (Meléndez, Charco, Mayordomo, & Sales, 2013; O'Rourke et al., 2011; Watt & Cappeliez, 2000). Researchers have also examined instrumental reminiscence. Through instrumental reminiscence, people solve current problems by remembering how they overcame adverse situations in the past by implementing adaptive coping strategies (Korte, Bohlmeijer, Westerhof, & Pot, 2011). However, few studies to date have specifically analyzed how this can improve coping strategy use in elderly adults and facilitate adaptation.

Instrumental reminiscence is based on recalling times one coped with stressful circumstances, and analyzing what it took to adapt in those situations. Instrumental reminiscence involves two therapeutic processes. First, the person recalls coping strategies they applied in the past, analyzes their effectiveness, and presently applies the most successful, adaptive ones. Second, instrumental reminiscence minimizes escapist memories, so the person formulates a plan of action to resolve the situation optimally. The main outcome of these two therapeutic processes is improved ability to adapt. Thus, this type of reminiscence therapy is useful for confronting stressful situations, improving levels of self-control, and summoning the resources needed to actively problem-solve (Parker, 1999).

Older adults have to adapt to many changes they do not always have control over, or the resources to deal with. Instrumental reminiscence therapy can improve their ability to adapt, which serves as a protective measure in coping with life's adversities and which increases quality of life, promoting successful aging. In light of the above, the present research aimed to assess an intervention's effectiveness, applying instrumental reminiscence therapy to improve adaptive capacity and resilience in elderly adults. Specifically, we expected the treatment group to show greater resilience, higher scores on problem-focused coping dimensions (focus on problem-solving and positive reevaluation), and a drop in maladaptive aspects like negative self-focus and avoidance, which are emotion-focused dimensions.

2. Methods

2.1. Participants

Participants included 30 elderly adults living in a community in San Juan de la Maguana, Dominican Republic. They were recruited through various health and social centers. To evaluate the program's effects, the experimental design included pretest and posttest measures in a treatment group and a control group. Members of the control group were on a waiting list for treatment.

Participants were initially contacted by telephone and an in-person appointment was scheduled to determine whether or not they met the inclusion/exclusion criteria. Inclusion criteria for both groups required that participants be 65 or older, not be under institutional care, and have no cognitive impairment interfering with their daily activities. Meanwhile, participants with a history of serious neurological illness, psychiatric disorder, systemic disease, history of substance abuse, or chronic use of psychoactive drugs or sedatives, sensory deficit and dependent subjects with impaired mobility were excluded.

Participants who met all criteria gave their informed consent to take part in the study. They were evaluated individually before receiving treatment, if applicable. After that first evaluation, groups were randomly assigned (15 participants each group). Following intervention, posttreatment measures were taken in both groups.

Tests of homogeneity between groups revealed no significant differences at pretreatment: age (74.87 vs. 73.67; $t(28) = 4.37$, $p = 0.755$), gender ($\chi^2(1) = 0.53$, $p = 0.358$), marital status (Mann–Whitney $z = 1.08$, $p = 0.279$), level of education (Mann–Whitney $z = 0.72$, $p = 0.512$), and income level (Mann–Whitney $z = 0.60$, $p = 0.548$). Table 1 presents descriptive data for the total sample, and for each group.

2.2. Instruments

In addition to collecting sociodemographic data, various tests and scales were administered to take pretreatment and posttreatment measures. To gauge cognitive level and screen for potential issues, the Mini-Mental State Examination (MMSE; Folstein, Folstein, & McHugh, 1975) was administered. An MMSE score >23 was the inclusion criterion in this study. No participant was excluded for this reason.

Participants also completed the Brief Resilient Coping Scale, created by Sinclair and Wallston (2004) and adapted into Spanish using Confirmatory Factor Analysis (Tomas, Sancho, Meléndez, & Mayordomo, 2012). This measure, designed to assess the tendency to cope with stress in a highly adaptive way, has shown adequate levels of reliability and validity. According to Sinclair and Wallston (2004), a single Resilient Coping factor underlies the BRCS's four items. Responses are given on a Likert scale from *never* (1) to *always* (5).

The Coping Strategies Questionnaire was administered first. This 42-item, self-report measure (Likert scale from *never* [0] to *almost always* [4]) was designed to assess seven basic coping styles reflecting a tendency to react in a certain manner in the presence of a stressor: (1) problem-solving coping ("I tried to fix the problem by following a well thought out steps"), (2) negative self-focused

Table 1
Demographic data.

	Total	Treatment	Control
Age	73.1 (DT = 8.17)	72.5 (DT = 9.31)	73.67 (DT = 7.2)
Gender			
Man	46.7	40.0	53.3
Women	55.3	60.0	46.7
Marital status			
Married	30.0	20.0	40.0
Single	6.7	13.3	0.0
Widow	13.3	6.7	20.0
Free union	50	60.0	40.0
Educational level			
Under primary	30	26.7	33.3
Primary	41.9	40.0	46.7
Secondary	16.7	20.0	13.3
University	10	13.3	6.7
Income level (1US$ = 32–34DR$)			
<2000 DR$	43.3	40.0	46.7
2000–5000 DR$	36.7	33.3	40.0
6000–10,000 DR$	13.3	20.0	6.7
>10,000 DR$	3.3	6.7	6.7