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A Structured Life Review Intervention to Improve Life Satisfaction in Home Health Service Patients: A Feasibility Study

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Abstract

Two million older adults in the U.S. suffer with depression. Adults who live with the difficulties of depression concurrently experience dissatisfaction with life. Life review is a systematic recollection of past events. Dr. Robert Butler postulated that, as the elderly and those with terminal illness approach the end of their lives, there is a resurgence of life experiences in the conscience (1963). A successful life review conducted by an active listener assists the individual to process unresolved conflicts and attain ego-integrity in the final stage of life. Home health services have become an increasingly accepted option for managing chronic illnesses in older adults because it allows care to be provided in the most comfortable environment for patients. In employing the use of a four-session Structured Life Review (SLR) intervention, the research team aimed to test the feasibility of this intervention on patients receiving at-home care. A one-group pre/post-test design was used to conduct this study. A convenience sample of fourteen adults were recruited from the Middlesex Health Care at Home program with four adults completing the intervention. The participants reported satisfaction with the intervention and learned about their resilience through this experience. Recruitment was difficult and strategies should be improved for future research studies. The findings of this study show that this structured life review intervention is feasible and enjoyable for the homecare population. Recruitment and retention strategies for future studies will be presented.

Keywords: structured life review, SLR, older adults, homecare, care at home, life review, Barbara Haight, Robert Butler, lifestory work

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In the current climate amidst a three-year pandemic, depression has become one of the most prevalent problems for Americans. Out of approximately 34 million Americans aged 65 or older, more than two million suffer behind the barriers of depression. In addition, approximately 21 million adults aged 18 years or older had at least one major depressive episode in the year 2020. (U.S. Department of Health and Human Services, 2022). Approximately 15-20% of older adults living in communities have been diagnosed with minor depression in the United States (CDC, 2015). Ten to fifteen percent of older adults also manifest depressive symptoms below the threshold of major depressive disorder (Husain et al., 2021).

Depression is a common mood disorder, which can cause thought processes to be affected, as well as how individuals feel and handle daily activities of life (NIMH Depression). To be diagnosed with depression by a healthcare provider, an individual must have symptoms such as (anxiety, hopelessness, isolation, sadness, etc.) for at least two weeks. The way individuals experience depression may differ from person to person, however, most attribute depression to interfering with much of their life activities. Woman experience depression more often than men and depression may become present when individuals begin to experience other comorbidities, such as old age, cancer, arthritic complications, and heart disease (Husain et al., 2021).

Older adults who are experiencing symptoms of depression will simultaneously experience dissatisfaction with life. There are many factors that cause dissatisfaction with life, such as a) present sickness, b) older age limitations, c) limited mobility, d) dependence, e) social isolation, and f) unresolved conflicts from the past (Gibson & Haight, 2019). In a study exploring the effects of depression on life satisfaction, it was found that there is an association between individuals having major depressive disorder and life dissatisfaction (Rissanen et al., 2011). In participants positive for major depressive disorder, it was found that depression correlates to a lower life satisfaction score (2019). In Gigantesco's research study from 2019 that explored the association between life satisfaction and depression, it was found that females generally had higher life satisfaction than males.). In addition, approximately 9.2% of non-Hispanic African Americans experience depression compared to 7.9% of non-Hispanic Caucasians experiencing symptoms of depression (CDC, 2018).

Erik Erikson, a 1900s psychologist and pioneer of life stage development work, documented the final stage of life as one in which an individual either reaches ego-integrity or a state of despair. Ego-integrity describes the degree of peace an individual may feel towards how they have lived their life. Despair encompasses an individual's loss of hope. When adults have unresolved conflicts, they risk reaching a state of despair as they approach old age (Erikson, 1950). Butler (1963) poses that being in a state of despair is what accounts for late-life depression. Attaining a state of ego-integrity is ideal for older adults and is a point that many strive to reach. In his article from 1963, Butler proposed that as individuals with terminal illness approach the end of life, they begin to review life events and, more specifically, negative events and unresolved conflicts. Individuals who have come to terms with these conflicts from the past attain ego-integrity. Life review at this period was new and had little to no research to support

how beneficial it could be for older adults in attaining satisfaction with life. Butler continued to advocate for the benefits of this intervention, which led other researchers to explore its benefits.

In 2007, a professor of nursing at the University of South Carolina, Barbara Haight, published her own handbook of structured life review (SLR). Barbara Haight spent much of her professional career learning and exploring more of the benefits linked to structured life review. Haight has been a vital part to how life review has gained more popularity in the past decade in other nursing schools, hospitals, and skilled nursing facilities. Barbara Haight has found that structured life review helps individuals attain greater life satisfaction and reduces depression citation of study). Haight created the handbook to help facilitators guide participants in reflecting on their lives. and contains questions leading from early childhood to the present. Her handbook also includes various techniques regarding communication with participants during each life review session, goals, and instructions for how to continue each session throughout the eight weeks. Life review and structured life review, while similar, hold distinctive characteristics. Structured life review has four specific characteristics: a) structure, b) duration, c) individuality, and d) evaluation. Structure comes from the facilitator who guides each participant through Erikson's stages of life throughout the intervention. Duration encompasses the length of the intervention itself. Most SLR interventions are six to eight one-hour sessions. Individuality is maintained through private one-on-one life review sessions. Lastly, evaluation helps individuals reflect on their past problems to assess present problems.

In my review of past research studies exploring the effects of life review on patients who rely on home health services, there are many gaps regarding knowledge on the efficacy of the life review. In a systematic review conducted by Huang et al., (2009) that analyzed studies utilizing life review, only three out of six studies concluded that life review increases quality of

life. The authors reported there were many variables such as design, intervention duration, and measurements that differed between each study. For example, four studies utilized a randomized controlled trial design, and two studies utilized a one-group pre-test post-test design. Each study also varied in intervention duration: four studies utilized a three-week intervention, one study utilized a 24-week intervention, and the last study varied from person-to-person (Huang et al., 2020). The lack of a standard intervention between each study analyzed within this systematic review may be a reason life review was only found to have significant effects in three of the six studies investigated. In a study conducted by Kleijn et al., (2018), significance was proven in the positive effects of life review on palliative care patients. In this study, the investigator explored the use of life review in cancer patients living in palliative care units. Although this randomized control trial study did show that life review has positive benefits for patients, no significance was found on the degree of despair, distress, or quality of life found in these patients. During my review of literature, it was noted that the terms palliative care and home care were used interchangeably, which may also have contributed to the ambiguity of the results during analysis. Based on this literature review, there seems to be a large gap in knowledge surrounding the effects of life review on home care patients. Therefore, this study's purpose was to test the feasibility of a structured life review intervention on homecare patients. Results will inform the next step in my program of life review research to conduct a larger, experimental study. The structured life review intervention protocol was implemented, and the following were evaluated:

a. participant engagement by exploring recruitment, retention, and satisfaction data and evaluating participants' experiences through semi-structured interviews;

b. suitability and acceptability of data collection measures and procedures and

c. preliminary evaluation of homecare patients' responses to the Structured Life Review

using a one-group, pre/posttest design, comparing the changes in the primary outcomes of quality of life, ego integrity and depressive symptoms from baseline testing and post-intervention.

Methods

A one-group pre/post-test design was employed to compare changes in the primary outcomes from baseline to post-intervention testing. Contextual data regarding participant engagement, acceptability of the questions, and participants' evaluations of the intervention were collected via semi-structured interviews with participants.

A convenience sample of 4 older adults, aged 65 or older in the home healthcare program at Middlesex Health in Middletown, Connecticut, comprised the sample. Each participant was given a choice between meeting with the principal investigator in their home or via telephone due to circumstances surrounding pandemic and the vulnerability of the sample population.

Middlesex Health Care at Home provides medical care in-home. The services provided include nursing, rehabilitation, home health aides, social work, palliative care, and hospice care. The clientele that they serve are individuals living with multiple chronic illnesses that prevent them from completing daily activities as they normally would. Many of these individuals are aged 65 or older, but their population is not limited to older adults.

A social worker in the home healthcare program and a nursing professor with a joint appointment helped create referrals and recruit their patients. Any individuals with cognitive impairment were excluded from the study due to the intensity of the intervention. The original

estimated sample was 25 older adults with an estimated attrition rate of 25%. Recruitment of participants occurred from May 2022 to April 2023.

Data Collection Procedure:

After initial referrals, each participant was contacted to gauge their interest in participating in this intervention. Once a participant stated their interest, the participant scheduled an appointment to review the consent form and ask questions within their home setting. A consent form reviewed by the UConn and Middlesex Health Institutional Review Board was given to each participant, which gave a description of the life review intervention, as well as risks and benefits to participating in this research and what the research intended to do for each participant.

After consent was obtained from each participant, the principal investigator created tentative schedules with each participant that described where and when each of the four structured life review sessions would occur. The researcher met with each participant four times in two consecutive weeks.

Measurements:

a) *Satisfaction with Life Scale:* assesses an individual's satisfaction with life by providing five questions, and using a seven-point scale that ranges from one (strongly disagree) to seven (strongly agree) (Diener et al., 1985). Reliability is 0.74.
b) *Geriatric Depression Scale-Short Form:* measures depression in older adults using 15 questions. Each question is answered with either a "yes" or "no," and total scores range from zero (normal) to 15 (severe depression) (Sheikh & Yesavage, 1986). Reliability was 0.83.

c) *Ego-Integrity Scale:* a 16-item scale based on the concept of Erikson's ego-integrity that measures life satisfaction, guilt/regrets, and anxiety Reliability is 0.74 for ego-integrity and 0.75 for despair. (Tahreen and Shahed, 2014; Ryff and Heincke, 1983).

d) *Modified Reminiscence Functions Scale*: identifies what function individuals might reminisce. The seven functions that reminiscence might be used for include; a) problem-solving, b) death preparation, c) bitterness revival, d) intimacy maintenance, e) teaching, f) boredom reduction, and g) conversation. Internal consistency of the subscales ranges from .73 to .91 (Washington, 2009; Shellman & Zhang, 2014).

e) *Demographic Form:* self-report items regarding age, gender, race, ethnic group, highest level of education completed, and marital status. This data was used to describe the sample.

Structured Life Review Intervention The structured life review (SLR) intervention was developed for homecare patients using the four key characteristics that help differentiate it from other life reviews that exist: (a) structure, (b) duration, (c) individuality, and (d) evaluation (Haight & Haight, 2007). The structure for this study was maintained by focusing on Erickson's stages of psychosocial development. This study had four consecutive sessions with three sessions focusing on Erickson's stages: 1) early childhood and adolescence, 2) questions about early and middle adulthood, and 3) questions about late adulthood and the present. The duration of the study was a four-week intervention including four life story sessions lasting one hour for two consecutive weeks. Each individual participated in one-on-one SLR sessions. At the end of the four-session intervention, participants were asked to evaluate the intervention and what they had learned.

The Satisfaction with Life Scale, the short-form version of the Geriatric Depression Scale, the Modified Reminiscence Functions Scale and the Ego-Integrity Scale were given during the first and fourth sessions, which allowed the research team to evaluate if/how an individual changed from before to after the SLR intervention. The PI recorded the data from each participant via Qualtrics and an audio recorder. After the data collection phase was complete, one month was taken to analyze the data collected.

Data Analysis

Both qualitative and quantitative data were analyzed to determine how feasible the SLR intervention was for homecare patients, as well as to determine the acceptability and efficacy of the testing. Content analysis was employed for the qualitative analysis of transcripts, which helped the research team find themes within the results obtained.

Results

Feasibility

Recruitment and retention

Fourteen participants were recruited to this study. Of the fourteen, eight individuals referred to me did not answer their phone or voicemails left. Six agreed to participate in the study. One participant completed pre-test data collection and five life review sessions, and another participant completed pre-test data collection and one life review session. The reasons for not finishing the intervention included being “too busy with other activities” and being “too sick to continue the intervention.” Three participants chose to participate in an in-home SLR intervention, and three participants chose to participate via telephone. Four participants completed all parts of the intervention. Table 1 below shows demographic characteristics.

Table 1

Demographics	***N*** (%)
Age (years) (Mean, SD)	79.5 (8.9)
Sex (female)	4 (100%)
Race (White)	4 (100%)
Ethnicity (Non-Hispanic)	4 (100%)
Educational Level	
Graduate Degree	
College Degree	4 (100%)
High School	
Junior High	
Prefer Not To Say	

Acceptability of measurements

Participants were asked to report any unclear questions or directions about the Geriatric Depression Scale, Northwestern Ego-Integrity Scale, Satisfaction with Life Scale, and the Modified Reminiscence Functions Scale. Some participants reported discomfort when asked about bitter or painful memories in the Modified Reminiscence Functions Scale. Participant discomfort was not noticed during the session other than occasional comments about scale questions being sensitive, such as questions asked about bitter or painful memories. I also found that, depending on each participant's family life, certain stages of life were more sensitive to talk about than other stages of life. None of the participants refused to answer any questions asked. Otherwise, the data collection measures were widely accepted. Data were collected Qualtrics to store the data. Participants responded to each question asked and the data collector would record them, which appeared to be an effective way to collect data with this population. Participants preferred afternoon life review sessions, which prevented participant fatigue and kept everyone engaged in the session. One participant asked to limit each session to 30 minutes or less to prevent fatigue. As a result, we extended the intervention to five sessions to accommodate this change. However, this participant did not complete the post-test data collection or the evaluation questions. Another

individual requested to limit the SLR intervention to three sessions with the first session including pre-test data collection and early childhood, the second session combining middle and late adulthood, and the third session including post-test data collection and evaluations. Limiting the session to three sessions benefited the participant and worked effectively. This participant reported great satisfaction with this change, however.

Participant experiences

Besides objective data from the pre/post-test collection measurements, subjective data through participant evaluations of the intervention. Since evaluations were only asked from participants who completed the entire intervention, the feedback emphasized participants satisfaction with the intervention and their lives. When asked to describe how they felt sharing memories from each life stage in a one-on-one session, participants enjoyed doing so very much. Most participants felt as though they were learning about themselves through this process. For example: "well, just overall the fact that I've come through a difficult life and remain happy and satisfied. I've had wonderful, good things and bad things and when you even it out that's just how life is. I would recommend this to other people." Another participant felt she learned to utilize technology more effectively through this process over the phone. When asked what they liked about each life review session, participants reported that they felt comfortable sharing their memories with a trusted facilitator. Participants also stated that these life review sessions made them think deeper about their lives, which they enjoyed. One participant stated: "I like that you make me think. There is not much incentive to think about things." One participant recommended that the research team allows family members and friends to join in on the sessions in future studies, which would strengthen bonding of families. When asked what the most important thing they learned about themselves through each session was, each participant stated that reflecting

made them realize how strong they were despite their struggles. One participant also reported that she realized that learning from others has allowed her to cope with her past struggles.

Preliminary evaluation of outcome measures

Post-test scores measuring depression decreased after the intervention while life satisfaction increased. However, the small sample size limits the evaluation, and these results are not generalizable to the rest of the homecare population. According to participant responses on the Modified Reminiscence Scale, participants use reminiscence to remember positive memories, reflect on their life accomplishments, and reduce boredom. Table 2 reflects scale scores.

Table 2

Scale	*Score*	*Pre-Test (N=4)*		*Post-Test (N=4)*	
		M	SD	M	SD
Geriatric Depression Scale	0 to 15 *>5 suggests depression*	3.5	3	1.25	1.09
Northwestern Ego-Integrity	9 to 54 *Higher scores indicate higher ego-integrity*	37.5	3.70	37.75	5.07
Satisfaction with Life Scale	5 to 35 *30-35 → highly satisfied* *20-24 → average score* *10-14 → dissatisfied*	20	6.93	24.50	5.68
Modified Reminiscence Functions Scale	19 to 145 Higher scores indicate higher frequency of reminiscence for specific function	77.75	13.23	74	16.20

Discussion

After completing this intervention, results have shown that the SLR intervention is feasible for homecare patients. The intervention itself, as well as the data collection measures were widely accepted by this population. One particular challenge that the researchers ran into was recruitment

within this population. In December, about halfway through the data collection process, I was able to change my recruitment method to include both telephone and at-home interviews. Participants were given this choice because I noticed that many participants were still anxious about the ongoing pandemic and fluctuating Covid-19 cases in Connecticut. Before implementing this change, only two participants were recruited to the intervention. This recruitment strategy change was an improvement because I was able to recruit four more participants (with lots of difficulty).

During my research, a major challenge was recruitment. One of the greatest barriers that prevented me from recruiting the original amount I intended to recruit for this study was the lack of commitment from some of the individuals due to family interference and sickness. Some individuals were not committed enough to finish the intervention, and others had unexpected hospital stays that prevented them from participating in the SLR program. Burden is known to be higher in this population, especially since homecare patients are more vulnerable to getting sick and developing fatigue during any intervention (Mody et al., 2008). It has also been found that older adults with major emotional problems like depression can increase apathy towards these types of interventions. Since measurement of depression in this population was a variable in this study, I anticipate this may have contributed to participants dropping out of the study. Many of these participants joined the homecare program after a long hospital stay. Having to deal with multiple illnesses, new illness, easy fatiguability, and chronic pain could impact their comfort and their ability to participate in this intervention (Mody et al., 2008). Another barrier I found in this research was reachability. Many older adults do not answer their phones due to their vulnerability in receiving spam phone calls. In Tegeler's randomized controlled trial exploring recruitment strategies for home-living older adults with depression, it was reported that 80.5% of participants were recruited through gatekeepers, and 19.5% of participants were self-referred

through newspapers and other forms of media (2022). In another study investigating recruitment of older adults, the research team reported the percentage of individuals recruited from different facilities: a) community hospital program (30%), b) senior center (22%), c) retiree residential communities (14%), d) health fair (13%), e) newspapers (8.5%), f) newsletters (5%), g) referrals (3.3%), h) churches (1%), I) study team referral (0.4%) (McHenry et al., 2015). These statistics show that study team referral (of which we utilized for this study) is an ineffective way to recruit older adults with illnesses. However, the homecare population was not studied, which may indicate that there is more difficulty recruiting in the homecare population. While I believe SLR is beneficial for this population, it may not be entirely feasible unless nurses are involved directly in recruitment. I also found that the duration of the intervention may have been considered lengthy for this population.

In the future, I recommend that there should be a participant incentive for participating in research. This may skew credibility of results, but it would provide motivation for individuals to complete the intervention. To retain participants, finding a gatekeeper in a community could help recruit participants more effectively. Although the team did communicate with a social worker that knew this population quite well, there may be better ways to recruit. For example, finding one nurse in a homecare program that has built rapport with their patients would be ideal. Researchers performing the intervention should consider following the nurse to the homes of participants, which would increase comfortability of participants and increase engagement with the intervention. Educating the gatekeepers on the ability of the participants to complete the intervention is important. Not all participants are appropriate for this type of intervention, so identifying the right individuals is important. Another way to increase participation would be to provide a monetary incentive. Another possible factor in the participant retention observed in this

study was possible misunderstanding of what the intervention was about. In the future, I recommend that researchers provide participants with an information sheet on the study, its risks and benefits, and more literature on past research regarding life review. It is important to keep the participants as informed as possible and, perhaps, the consent form was not enough information for them. From past studies as a research assistant, I observed that older adults appreciate gift cards to local grocery stores. This will give participants motivation to complete the intervention. Limiting sessions to an hour to an hour and a half would also be preferable. I also found that creating a set schedule for all four sessions helped keep participants on schedule for finishing the intervention in two weeks. Having a set schedule will help participants stay on track and keeps them informed, rather than creating a schedule after each session. In my future research, I would aim to improve recruitment strategies for older adults. This was quite a barrier for the research team, and this proves that there is a gap in how we choose to recruit older adults. I would also like to expand research on SLR to younger populations, as well as palliative care and hospice because of how beneficial it is in increasing life satisfaction. i

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Appendix A

Evaluation Questions

A) *Describe how you felt when sharing your memories from each life stage in a one-on-one interview.*
B) *What did you like about the life review sessions?*
C) *What do you think could be changed to improve the life review sessions?*
D) *What was the most important thing that you learned about yourself from reminiscing about your experiences, especially how you have coped with past experiences?*