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The Process and Outcome of Life Review Psychotherapy With Depressed Homebound Older Adults

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Abstract

The purpose of this study was to examine the process and outcomes of life review therapy provided by an advanced practice geropsychiatric nurse to older adults discharged from psychiatric hospitals to home health care. Eighty older adults over 65 years of age with a primary diagnosis of depression were treated at home for life review psychotherapy sessions ($M = 13.24$, $SD = 8.65$). Content analysis methods, both latent and manifest, were used to analyze the data and identify themes. Themes were classified as empowerment (connection, coping, efficacy, hope, and trust) or disempowerment (denial, despair, helpless, isolation, loneliness, and loss). Findings showed that, as a result of the life review therapy, there was a significant decrease ($p < .0001$) in total disempowerment themes ($M_1 = 13.07$; $M_2 = 9.14$).

The most common functional psychiatric condition of late life is depression (Blazer & Busse, 1996; Jenike, 1996). Depressive diagnoses range from common adjustment disorders in response to events such as retirement, a move, or loss of a loved one to severe and life-threatening major depression episodes or syndromes (Blixen, Wilkinson, & Schuring, 1994). Depressive symptoms occur in 15% to 20% of community residents over 65 years of age, in 12% to 36% of medically ill outpatients over 65 years of age, and in more than one third of medically ill inpatients over 65 (Blixen & Wilkinson, 1994; Heidrich, 1994; Steiner & Marcopulos, 1991). For older adults with chronic depression, the risks of increased use of medical resources, institutionalization, or even death are high (Barsky, Wyshak, & Klerman, 1986; Fogel, Gottleib, & Furino, 1990; Sadavoy, Smith, Conn, & Richards, 1990). One out of every four suicides is committed by a person 65 years of age or older, and depression underlies two thirds of these suicides (Blixen, McDougall, Suen, 1996; Conwell & Brent, 1995; Moscicki, 1995; Schmid, Manjee, & Shah, 1994).

Because of its association with excess morbidity and mortality, depression in older adults merits aggressive intervention. Studies have shown that older persons respond like younger persons to psychosocial treatments for depression (National Institutes of Health, 1991). Indeed, a recent meta-analysis of 17 studies in which older adults received psychosocial treatments, such as cognitive, behavioral, reminiscence, psychodynamic, and supportive therapies for depression, indicated that on self-rated and clinician-rated measures of depression the treatment was reliably more effective than no treatment (Scogin & McElreath, 1994; Thompson, Gallagher, & Breckenridge, 1987). However, the cost of such treatments is high and often is not fully reimbursed by Medicare or other insurance.

Life review is a less expensive therapy that can be provided by advanced practice psychiatric nurses. Butler (1963) defined life review as a naturally occurring, universal mental process

characterized by the progressive return to consciousness of past experiences, and, particularly, the resurgence of unresolved conflicts, which can then be surveyed and reintegrated. Butler's approach built on Erikson's (1968) psychosocial stages of development. Both Butler and Erikson believed that later life was a time to resolve the conflict between ego integrity and despair and believed that this could be accomplished through life review. However, no studies have examined the effects of life review therapy for the homebound elderly, although this group has a high need for psychosocial treatment (Knight, 1986; Lasoski & Thelen, 1987; Lindesay & Thompson, 1993; Spector & Kemper, 1994).

Psychiatric home health care for the elderly with mental illness is viewed as a skilled nursing intervention rather than a specific type of therapy and is considered to be reimbursable by the Health Care Financing Administration under Medicare Part B (Pelletier, 1988). Advanced practice psychiatric nurses are currently providing life review therapy to patients in their homes, but there has been no research on the process or clinical outcomes of the therapy provided in this setting. The purpose of this study, therefore, was to examine the process and outcomes of life review therapy provided by a geropsychiatric home care nurse to older adults discharged from psychiatric hospitals to homebound status.

Related Literature

A number of studies have examined the effectiveness of reminiscence or life review in community and nursing home samples, but the results have been inconsistent. Using structured and unstructured reminiscence therapy in a one-to-one format in a community sample, Fry (1983) found that those who participated in the structured therapy had significantly decreased depression as measured by the Beck Depression Inventory and increased feelings of self-confidence and personal adequacy. Fry found that either the structured or unstructured therapy produced greater improvement in participants than those individuals in the control group who received no therapy. Interestingly, women in both the two treatment and control conditions showed less change in depression and ego-strength than men. Brennan and Steinberg (1983) used structured one-to-one reminiscence therapy with 40 women between 64 and 88 years of age attending senior centers. The results indicated that recalling the past is a correlate, rather than a substitute, for social activity and that reminiscing may have more of an impact on mood than morale.

Among 20 homebound older adults receiving six 1-hour life review sessions, Haight (1988) found significant increases in life satisfaction, psychological well-being, and activities of daily living scores, although there was no change in level of depression as measured by the Zung Self-Rating Depression Scale. Haight and Dias (1992) examined the process and outcomes of four types of reminiscence therapy in 8 weekly sessions. The elders participating in the therapy lived in high-rise apartments ($n = 117$) and were residents of nursing homes ($n = 71$). The results indicated that a structured evaluative life review process reduced depression and increased self-esteem, psychological well-being, and life satisfaction.

Parsons (1986) found a decrease in depression measured by the Geriatric Depression Scale in nine older adults living in a federally funded housing facility who participated in six group reminiscence therapy sessions. After processing the information in life review therapy with four elderly female survivors of childhood sexual abuse, McInnis-Dittrich (1996) found that the emotional damage inflicted by abuse was still experienced 60 years after the event. However, in therapy, the clients experienced symptom relief immediately and maintained high levels of social functioning.

In 30 nursing homes, Berghorn and Schafer (1986) recruited a sample of 185 residents who participated in reminiscence groups over a 3-month period. Although depression was not

measured in this study, the value choices related to mental adaptability that were made by participants improved as a result of the intervention. Among 60 nursing home residents who participated in six group reminiscence therapy sessions, Youssef (1990) found a decrease in depression in the group (n = 21) between 65 and 74 years of age, but no differences in a group (n = 18) 75 years of age and older.

Head, Portnoy, and Woods (1990) conducted two reminiscence groups with older adults in two day care centers—one hospital and one community based. The outcome measures were patterns of interactions between staff and patients during different group activities. Among the hospital day care center participants, the reminiscence group (n = 4) showed significant changes in their communication with staff members and with the group leader as the treatment progressed. However, in the day care center that was believed to have a richer environment (more physically attractive, staff more knowledgeable about reminiscence therapies, and more varied activities), the treatment did not produce change. Blankenship, Molinari, and Kunik (1996) found that the effect of structured life review therapy with male veterans (n = 25) produced no changes in psychiatric symptoms.

Burnside (1993) reported that for women the use of the specific themes of favorite holiday, first pet, and first job in three reminiscence therapy groups seemed to promote better discussions. Wong and Watt (1991) found that successfully aging elders, those with higher than average ratings in physical and mental health, used significantly more integrative and instrumental reminiscence and less obsessive reminiscence.

The findings of these studies are not only inconsistent, but it is also unclear whether the outcomes were specific to the particular therapy used—either life review or reminiscence—to the setting, or to the characteristics of the individual participants. Further, although a few studies used standardized psychometric measures of depression, many did not. Thus, the usefulness of life review therapy for the elderly remains unclear.

Methodology

Sample

The study reported here was a retrospective analysis of the therapy notes and records from psychiatric home visits with 101 patients 65 years of age and older who were discharged to homebound status from three freestanding psychiatric hospitals in the southern part of the United States. Subjects with the primary diagnoses of dementia, psychosis, and other personality disorders were eliminated from the analysis because these conditions have questionable treatment outcomes (Scogin & McElreath, 1994). The remaining sample (n = 80) met the following criteria: (a) eligible for Medicare reimbursement; (b) diagnosed with depression based on the Diagnostic and Statistical Manual of Mental Disorders (DSM) and initial evaluation by a psychiatrist; (c) willing to participate in in-home psychotherapy after discharge for 30 to 60 minutes duration, a minimum of one and a maximum of three sessions per week for 60 days; and (d) able to speak English and to hear spoken words with or without correction. The sample of patients consisted of 54 (68%) women and 26 (32%) men with a mean age of 74.15 years. Subjects (98%) were primarily White and the remainder were Black. Twenty one (26%) individuals were married; 48 (60%) were widowed; 10 (13%) were divorced; and 1 (1%) had never married. Forty-three (54%) of the individuals lived alone; 16 (20%) with a spouse; 7 (9%) with children; and 14 (17%) with a 24-hour per day caregiver. The overall sample had been hospitalized (M = 18.99; SD = 18.11), and all individuals had a DSM diagnosis of depression, which includes such diagnoses as bipolar depression. Subjects had medical diagnoses (M = 3.04, SD = 1.47) with cardiovascular (n =34), musculoskeletal (n = 18), and neurological (n = 12) diagnoses being the major categories of chronic conditions,

All participants had been discharged with prescription medications for their medical ($M = 4.75$, $SD = 2.77$) and psychiatric problems ($M = 1.5$, $SD = .97$). Subjects were taking significantly ($t = 10.68$; $df = 79$; $p < .0001$) more nonpsychotropic medications than psychotropic medications. However, women were taking significantly (F [1, 78] = 4.04, $p < .05$) more psychotropic medications ($M = 1.65$) than men ($M = 1.19$). The most commonly prescribed psychotropic medications were antidepressants. There were significant (F [1, 78] = 4.41, $p < .05$) gender differences in the number of psychotherapy sessions, with women receiving more sessions than men (14.67 vs. 10.42). There were no gender differences in age, hospital days, medical or psychiatric diagnoses, nonpsychiatric medications, and content themes.

Procedures

The elders received follow-up at home by an advanced practice geropsychiatric nurse for short-term therapy that was reimbursed under Medicare Part B for homecare. The therapist's notes consisted of several paragraphs in which the therapist recorded subjective and objective assessment and planning aspects of the treatment, as well as process and immediate outcomes. The subjective component included one or more significant statements from the individual, written verbatim and highlighted with quotation marks. The objective component included signs and symptoms of physical and mental health and vital signs, including blood pressure, pulse, and respiration. Outcomes included progress or regress toward goals of the treatment. Approximately 1,200 notes from psychotherapy sessions provided the data for analysis. While hospitalized, these older adults had participated in individual, family, and group therapies, and they were ready to continue this work after discharge. They were referred by the psychiatrist to a home health agency, and the postdischarge plan of care was given to the agency. The advanced practice nurse provided an initial home visit that included a documented assessment. Before the in-home psychotherapy commenced, a plan of care was developed by the advanced practice geropsychiatric nurse and the psychiatrist who acted as a consultant. This plan identified goals that could be reached in a 60-day period. A few examples of goals included being free of suicidal or homicidal ideations or plans, being able to verbalize feelings of grief and loss about a deceased husband, and/or being able to identify all prescribed medications and their purpose.

In order to enable these depressed older adults to deepen their insights and attain their goals, the geropsychiatric nurse used the process of life review as the main focus of psychotherapy. Explicit questions about negative life events, strong emotions, unresolved conflicts, and guilt feelings were used to elicit recall and integration of the past. Being at home in familiar surroundings helped these individuals to discuss topics that are usually left unspoken by older adults. The nurse not only followed this life review process with the patient but also attended to other aspects of health assessment, medication management, and teaching of self-care skills. Often it was necessary to have counseling sessions with the caregiver, and sometimes family therapy was conducted when these interventions were expected to influence client outcomes.

Data Analysis

Content analysis methods were used to analyze the data. Krippendorf (1980) characterizes content analysis as a method of inquiry into the symbolic meaning of messages and implies that both latent and manifest content should be included in the interpretation of data. Latent themes were defined as those that inform vicariously or indirectly, describe events from a distant location, discuss objects from the past, or reflect on ideas in other people's minds. Manifest themes were defined as themes that were clearly apparent to the sight or understanding, such as a set of symptoms, signs, or scores required for diagnosis (Holsti, 1968). Manifest content analysis requires that coding be intersubjectively verifiable and reliable (Cole, 1988; Krippendorff, 1980). The quantification of qualitative data in manifest content analysis is accomplished through the inclusion or exclusion of content based on a priori

rules; in this study, the rules were the stated definition of themes. However, this requirement has led some scholars to be concerned with the omission of latent content. Latent content analysis is accomplished through aposteriori inductive processes in order to deduce reasoning from facts or move from particulars to general principles. This latent content may be considered to be the qualitative portion of the data and the manifest content may be considered to be the quantitative portion.

A theme, or thematic unit, was defined as a discrete thought unit communicating an item of information. Themes were often identified by quotation marks in the records. Theme data units were further analyzed into content or theme categories. The coding scheme consisted of a recording unit, categories, context unit, and the enumeration unit (Cole, 1988). The context unit may have been the paragraph from the notes or the summary of the entire session to understand the context of the recording unit. The enumeration unit was the frequency of themes appearing during the session. Every occurrence of the concept was counted during a session. The subjective statements were the recording unit. The recording unit in turn served as a mechanism for identifying categories within a context unit. There were no a priori rules to include or exclude any particular themes. Themes were classified into two categories, disempowerment and empowerment, and were further identified as either latent or manifest. Any theme that had a negative connotation was classified as a disempowerment theme and included anxiety, denial, despair, helplessness, isolation, loneliness, and loss. Any theme that had a positive reference was considered to be an empowerment theme and included connection, coping, efficacy, hope, and trust. Examples of themes in each category follow.

Disempowerment

Anxiety

Anxiety was defined as a state of being uneasy, apprehensive, or worried about what may happen about a possible future event. In psychiatric conditions, this state is intensified and is characterized by varying degrees of emotional disturbance and psychic tension. Examples of latent anxiety from clients were “Yesterday was a major crisis—I was so upset I smoked a cigarette” (Client 30), and “I am not sleeping at night—I am worried about everything that has to be done—the rats, the screen doors, the toilet” (Client 62). A manifest example of anxiety from Client 43 was “I was fearful that the oxygen is going off.” An example from Client 22 was “I am concerned and uncomfortable about my sister-in-law coming to visit me—she is too critical.”

Denial

Denial was defined as a statement in opposition to another or a contradiction; the act of disowning or repudiation. Examples of a latent denial theme were, “I don’t consider myself an alcoholic—I just have a problem with wine” (Client 1), and “I just don’t worry about my daughters—I am going to look at my stories [soap operas]” (Client 3). Expressions of a manifest denial theme were “This place [psychiatric hospital from previous hospitalization as a young adult] does not fit my image, it does not do good things for my family” (Client 34), and “I still don’t understand why I am incarcerated— I haven’t been a bad girl—have I?” (Client 67).

Despair

Despair was defined as being overcome by a sense of futility or defeat or having an utter lack of hope. Latent expressions of despair were “I am generally feeling good except for an occasional ‘what’s it all for?’” (Client 2), “I am going crazy today I guess” (Client 66), and “Retirement didn’t turn out like I expected—I saved my money and thought I could travel, but it didn’t work out” (Client 12). Manifest expressions of despair were “I just want to give up—

I woke up feeling like I just did not want to be any place" (Client 89), and "I have so many things going against me—my life has begun to unravel" (Client 33).

Helplessness

Helplessness was defined as a feeling of being incompetent, ineffective, and powerless and/or a feeling of weakness. A latent expression of helplessness was "Dr. P. [neighbor] was out of town in California and my son is working today—I had no ride to the MD's office" (Client 50). Examples of a manifest helpless expression were "I am not feeling good and I am about to run out of my medicine" (Client 14) and "I had a spell with chest pain the other day and had to put the patch on my chest but it came right off"' (Client 78).

Isolation

Isolation was defined as being separated from a group or whole and set apart. Isolation may also be defined as free of external influence; insulated. Examples of a latent theme implying a lack of connectedness were "I don't go out much because I have so much to tend to here" (Client 75), and "I don't like being around groups of people, especially senior citizens—I feel so much younger than them" (Client 38). An example of a manifest expression of isolation was "I am scared of people and I don't want anyone outside my family to see me in my condition" (Client 21).

Loneliness

Loneliness conveys a heightened sense of solitude and gloom. It was defined as unhappiness at being alone; longing for family, friends, or company. An expression of manifest loneliness was "I sit around and wait for my [deceased] husband—and wish he were with me" (Client 55). Expressions of latent loneliness were "I have never accepted living alone and I am terribly lonely" (Client 63), and "I have not been able to visit with my neighbors in the apartment because of my condition— shaking legs and corn on the foot" (Client 54).

Loss

Loss was defined as the harm or suffering caused by losing, being lost, or being deprived of something. An example of a latent loss theme was "I feel disgusted and feel like crying when I think about losing my eyesight" (Client 9). Examples of a manifest loss theme were "I try not to think about his [husband's] death" (Client 35), and "I can't read the paper anymore because of my eyesight" (Client 77).

Empowerment

Connection

Connection was defined as the relation between humans that depend on, involve, or follow each other. Expressions of latent connection themes were "My neighbor is coming over today to clean the house…my daughter will come by tomorrow to wash my hair" (Client 52), and "It's always nice to see a new face" (Client 68). Expressions of manifest connection themes were "I thought it [desire for alcohol] was over but I don't want our friendship to end—I just feel bad about you having scruples!—It upset me to know you [nurse] were upset" (Client 41), and "I am excited and looking forward to my son coming to visit" (Client 10).

Coping

Coping was defined as the ability to contend or strive especially on even terms or success; to contend with difficulties and act to overcome them. Examples of latent coping themes were "I want to be happy the rest of my short life" (Client 61), "They were trying to tie me down and I did not like that however, I was kicking and fighting" (Client 72), and "After living with my

alcoholic husband who I believe almost destroyed me—but I am a survivor" (Client 76). Examples of manifest coping themes were "I have been in a pretty good mood this week; spending time reading" (Client 89), and from the same client as the therapy progressed, "I think they [therapy sessions] were good for me, but not at first, but now I look forward to your coming…I find it hard to talk with people about personal things—except with my friends. I am open to advice from somebody who is well qualified … I don't think Dr. does well—he talks down to me."

Efficacy

Efficacy was defined as effectiveness; or as the power or capacity to produce a desired effect. An example of a latent efficacy theme was "I lived in a halfway house once for three months after my husband died and I had a nervous breakdown—I hated being there—the place stunk so I left!" (Client 27). Examples of a manifest efficacy theme were "I walked outside, up and down the driveway on Friday and Saturday—I used the cane and had no balance problems!" (Client 16), and "I am worn out from not wearing the TENS [pain management] unit for three days…I put it back on today!" (Client 60).

Hope

Hope was defined as a feeling that what is wanted will happen; a desire accompanied by expectation. An example of a latent expression of hope was "I want to get on with life and forget the past" (Client 40). Examples of manifest expressions of hope were "My heart is giving me a lot of trouble—I have not given up" (Client 1), and "I am somewhat hopeful about the future and enjoyed spending holidays with the family" (Client 4).

Trust

Trust was defined as a firm belief or confidence in, for example, honesty, integrity, reliability, and justice of another person or thing—faith; reliance. An expression of latent trust was "I am angry at my granddaughter for running up a large telephone bill—I guess I don't trust her" (Client 73). An expression of manifest trust was "The medication mix up was distressing but I trust my caregiver was not at fault…it was the pharmacy that made the mistake" (Client 23).

To detemiine whether changes in the themes occurred during the therapy, the number of sessions for each subject was divided in half. The first half of the sessions were called T1 and the second half, T2. The total number of themes was also counted. The coding sheet was divided into two sections, disempowerment themes and empowerment themes. Each section and each theme was divided in half so that there were T1 and T2 variables for each theme. In addition to the major themes described above, there were two final variables that were summed scores —total empowerment and total disempowerment. These categories were also divided in half so that there were empowerment (T1 and T2) and disempowerment (T1 and T2) totals.

Confirmability

Several methods were used to increase the confirmability of the findings. The credibility of the first investigator was established by hundreds of hours spent in the field, as evidenced by the number of recorded sessions. Persistent observation was thorough enough to produce in-depth information and to differentiate relevant from irrelevant observations. Some methods of establishing credibility such as triangulation, negative case analysis, and informant checking could not be used because this was a secondary data analysis. However, transcribed data were analyzed by the investigator and co-investigator, and 20% (n = 21) of the cases were also analyzed by two expert judges. One judge was a doctorally prepared geropsychiatric nurse, and the other was a doctorally prepared counseling psychologist familiar with the data analysis

method used. Reproducibility, that is, intercoder reliability or intersubjective agreement, was established by having the two expert judges apply the coding instructions independently. Differences were found only 4% of the time between the experts. When a disagreement occurred, an agreement was made after careful analysis and discussion. Confirmability was also established by maintaining complete records, including a trail of raw data, data reduction and analysis, and coding and counting decisions. Stability was determined by coding and recoding the same data at different times and checking for intracoder reliability.

Results

Means and standard deviations were computed for all thematic variables, which were nominal data (Tables 1 and 2). The findings are presented in two sections, disempowerment and empowerment themes. Within-subject change was determined by computing the Wilcoxon signed-rank test on T1 and T2 theme data. To determine change over time, the themes were divided into empowerment—T1 and T2 and disempowerment—T1 and T2. This involved counting the number of sessions for each subject and dividing them in half. Each subject then had four cells with scores that could be computed in the first and second halves of the therapy, permitting the Wilcoxon signed-rank test to be run. Although there were no differences in the total overall empowerment and disempowerment themes after completing the therapy, there were differences in the disempowerment themes over the course of the therapy sessions. In the early phases of treatment, disempowerment themes ($M = 13.073$, $SD = 7.73$) were dominant. As treatment progressed, the number of total disempowerment themes ($M = 9.14$, $SD = 6.04$), such as anxiety, denial, despair, and isolation, significantly decreased; $p < .0001$. There were no T1 or T2 differences in empowerment themes.

Discussion

This study is unique in that it provides insight into the process and outcome of life review psychotherapy with homebound depressed older adults. All participants had been hospitalized in geropsychiatric treatment programs and had been evaluated by a psychiatrist in a face-to-face clinical interview using the DSM. All had follow-up home-based psychotherapy conducted by one geropsychiatric nurse who used the same consistent life review approach with each individual. One reason that in-home life review therapy was beneficial may be the result of the previous hospitalization in a specific treatment program in which the subjects participated in individual, family, and group therapies and were ready to continue this work after discharge. Lasoski and Thelen (1987) found that although older adults selected outpatient services less often than younger adults, their attitudes toward mental health services were positively influenced by previous exposure to psychiatric services.

Over the course of therapy, from T1 to T2, the participants showed significant decreases in the disempowerment themes of anxiety, denial, despair, and isolation. Although the decrease in isolation may have been a result or a response to the regularity of the therapist's home visits, it was nevertheless important in assisting the individual through the transitional period after discharge. In a managed care environment, this has particular significance for preventing relapse and rehospitalization.

Changes in the other themes clearly reflected a different outlook despite the subjects' physical conditions. Other investigators have reported similar results. Fishman (1992) found that better health was related to fewer negative emotions about past events. Heidrich (1994) found that the elderly in poor physical health had higher depression but that they identified positive relations with others as an important dimension of their lives. It was recommended that interventions targeted for older women address the managing of health problems and depressive symptomatology together rather than individually. In this study, the participants'

mental health problems were addressed as well as other aspects of their physical health, including health assessment, medication management, and teaching of self-care skills.

This study thus provides further evidence that psychosocial treatments developed specifically for older adults have a positive impact on their overall well-being and facilitate their ability to remain independent and live at home. The elders in this study were able to make the transition during life review therapy from a high number of disempowerment themes *(M* = 13-07) to a significantly ($p < .0001$) decreased number of disempowerment themes ($M = 9.14$). The significant decrease in disempowerment (negative) themes fits with theories of depression, which suggest that individuals with depression often have low self-esteem; with negative thoughts; and, in older adults in particular, with numerous somatic complaints, particularly memory problems and other physical manifestations (Beck, 1974; Grotjahn, 1951, 1955; Kaplan, 1991).

In short-term, problem-focused psychotherapy, the goals must be specific and attainable. In this study, the participants received 13 therapy sessions. Howard, Kopta, Krause, and Orlinsky (1986) use the term dose-effect to describe length of treatment and patient benefit. Based on 30 years of research, they found that by eight sessions approximately 50% of patients are measurably improved and approximately 75% are improved by 26 sessions. Crits-Christopher (1992) found in a meta-analysis that there must be at least 12 sessions for efficacious results. Knight (1988) studied elders receiving psychotherapy in their homes and found that those individuals with diagnoses of psychoses and anxiety showed the greatest changes, with depression and adjustment disorders showing more modest changes. Elderly people over 80 years of age gained the most from more therapy sessions (> 16 sessions) and improved as much as those elderly between 60 and 79 years of age in fewer sessions (between 8 and 16 sessions). Given the serious nature of the depression in this sample, a decrease in negative themes was the best possible outcome for the cost of treatment. A decrease in negative thoughts may also have value in terms of positive health outcomes. However, this was not possible to ascertain in the current study. The results of this study suggest that life review therapy may be an effective therapy for many homebound elderly with depression.

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TABLE 1

Means and Standard Deviations of Disempowerment Themes Variables at Time Points Durine Therapy

	Time 1		Time 2		
	M	**(*SD*)**	***M***	**(*SD*)**	***P***
Anxiety	2.95	(2.52)	2.02	(1.96)	.0006
Denial	2.63	(3.01)	1.81	(2.06)	.004
Despair	3.47	(3.21)	2.30	(2.61)	.0005
Helplessness	1.00	(1.15)	.78	(1.00)	NS
Isolation	.94	(1.48)	.59	(.93)	.03
Loneliness	.62	(.80)	.49	(.88)	NS
Loss	1.47	(.20)	1.15	(1.48)	NS
Total	13.07	(7.73)	9.14	(6.04)	.0001

N = 80.

TABLE 2

Means and Standard Deviations of Empowerment Themes Variables at Time Points During Therapy

	Time 1		Time 2		
	M	**(*SD*)**	***M***	**(*SD*)**	***P***
Connection	2.78	(2.89)	2.33	(2.21)	NS
Coping	3.01	(2.68)	3.37	(2.71)	NS
Efficacy	3.32	(3.72)	3.80	(3.30)	NS
Hope	.37	(.56)	.38	(.62)	NS
Trust	.17	(.38)	.17	(.38)	NS
Total	9.65	(7.63)	10.06	(6.75)	NS

N = 80.