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Life Review Therapy Using Autobiographical Retrieval Practice for Older Adults With Depressive Symptomatology

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The aim of this study was to examine the efficacy of life review based on autobiographical retrieval practice for treating depressed older adults. Forty-three adults aged 65–93 with clinically significant depressive symptomatology and no dementia were randomly assigned to treatment or to no treatment. The results indicated significant differences between experimental and control groups after 4 weeks of autobiographical retrieval practice. At posttest, those in the treatment condition showed fewer depressive symptoms, less hopelessness, improved life satisfaction, and retrieval of more specific events. The findings suggest that practice in autobiographical memory for specific events may be among the components of life review that account for its effectiveness and could be a useful tool in psychotherapy with older adults.

Drawing from theory and research about the effects of depression on autobiographical memory, we developed a life review therapy and tested whether this therapy led to changes in depressive symptomatology in older adults. Life review is often promoted as a therapy for depression in older adults. Originally, life review took its rationale from Erikson's (1959) theory of life stages, in which life review facilitated resolution of Erikson's eighth stage, that is, achieving ego integrity. Diverse activities have been proposed that aim to augment life review processes. One of the first proponents of life review was Butler (1963, 1974), who suggested use of different stimuli, for example, old photographs, to foster memories, audiotaping one's autobiography, attending reunions, and constructing a genealogy. Haight and Dias (1992) concluded that the most therapeutic aspects of life review included participation in individual one-on-one reminiscence, reflection on one's personal evaluation of events, and coverage of the entire lifespan. A book by Haight and Webster (1995) provides systematic guidance on conducting life review groups and includes recommended topics for discussion. Birren and Birren (1996) conducted classes in guided autobiography where members wrote and shared their autobiographies. They developed various sensitizing questions to structure participants' writing.

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Life review has most often been used with older adults who are not selected for clinical depression but are potentially at high risk for depression, such as those who are homebound or residents of nursing homes (e.g., Haight, Michel, & Hendrix, 1998). Our focus was older adults with clinically significant depressive symptomatology. A few controlled studies of life review have been conducted with older adults who are depressed. Fry (1983) found that both individually administered structured life review and unstructured reminiscence interventions reduced depressive symptoms significantly when compared with an attention placebo group, and that life review was superior to unstructured reminiscence. In nondemented nursing home residents with mild to moderate depression, Dhooper, Green, Huff, and Austin-Murphy (1993) observed significantly reduced depression in those who received a combined structured life review and problem-solving intervention compared with a no-treatment control group. In a community sample of older adults who were diagnosed with major depression, Arean et al. (1993) compared group-administered life review with problem-solving group therapy and a waiting list control condition. Life review was significantly better than the waiting list control in reducing depression but less effective than problem-solving therapy. Even across these studies, notably, there was considerable variability in what was regarded as life review.

Our life review intervention was based on research about autobiographical memory. Studies on autobiographical memory show that if depressed people are presented with a cue word, they retrieve less specific and more general memories than a control group of nondepressed persons (e.g., Kuyken & Dalgleish, 1995; Moore, Watts, & Williams, 1988; Puffet, Jehin-Marchot, Timsit-Berthier, & Timsit, 1991; Williams & Dristchel, 1988; Williams & Scott, 1988). This problem of overgeneral recall has been replicated in depressed and suicidal patients and is one of the most reliable features of memory in depression (Kuyken & Brewin,

1995; Williams, 1992; Williams & Broadbent, 1986). When people try to retrieve autobiographical memories, they first access general descriptions, using these as intermediate steps to point to specific event descriptions (Reiser, Black, & Abelson, 1985; see Rubin, 1996, for a review). Autobiographical memory can be characterized as a hierarchy. General information is higher in the hierarchy, and more detailed, specific information is lower in the hierarchy. People normally can navigate through the hierarchy and select the level of specificity that makes most sense in any given situation.

Williams and Dristchel (1992) pointed out that although people normally can control the specificity of their recollections, some seem to find it too effortful. Studies of autobiographical memories show that both depressed individuals (Williams & Scott, 1988) and older adults (Winthorpe & Rabbitt, 1988) have difficulties being specific in autobiographical memory. If an individual does not produce a specific memory, then an overgeneral memory is recalled.

Although overgeneral memory was originally described as a stable characteristic (Brittlebank, Scott, Williams, & Ferrier, 1993), it may, in fact, be open to change. Compared with a group of controls, Williams, Teasdale, Segal, and Soulsby (2000) found that depressed patients who received 8 weeks of mindfulness-based cognitive therapy showed a reduction in overgeneral memories. Watkins, Teasdale, and Williams (2000) found that Nolen-Hoeksema and Morrow's (1993) distraction induction led to diminution of overgeneral memory in depressed and dysphoric participants. However, overgeneral memory was maintained if participants were given rumination induction, in which they were essentially encouraged to continue engaging in dysfunctional types of thinking that have been associated with depressive disorder.

On the basis of this literature, the approach that we took to life review was to provide practice for participants in producing specific autobiographical memories. If participants produced specific memories, we theorized, then the types of rumination that maintain depression should be reduced. The aim of our study was to examine the effects of autobiographical retrieval practice for specific events in older adults with depressive symptomatology. We predicted that older adults who received practice would improve their mood state, as reflected in decreased depressive symptoms, decreased hopelessness, and increased life satisfaction.

Method

Participants

One hundred twenty older adult volunteers who were clients of Social Services in Almansa (Albacete), Spain, were recruited. Participants in the study were receiving 1 hr of social services per day, 5 days per week, from the private corporation Service Assistant Almansa's Home, which also helped with recruitment.

After verbal consent was given, five assistants screened all volunteers. Criteria for inclusion in the study were as follows: Individuals had to have clinically significant symptoms of depression (as determined by a score of 16 or higher on the Center for Epidemiological Studies—Depression [CES–D; Radloff, 1977] scale); had to show no evidence of dementia (as determined by a score of 28 or higher on the Mini-Mental State Examination [Mini Exámen Cognoscitivo, MEC; Lobo, Ezquerra, Gómez Burgada, Sala, & Seva-Díaz, 1979]); and could not be receiving pharmacological treatment for depression. Seventy-six individuals scored 16 or higher on the CES–D. Within this group, 12 scored below 28 on the MEC and were excluded, and 14 decided not to participate (response rate = 78%). The remaining sample of 50 participants was assigned to matched pairs according to baseline CES–D, gender, and age. Within each pair, one participant was randomly assigned to the experimental group and the other to the control group. The control group received social services as usual. The experimental group received the life review intervention while continuing with social services.

During the intervention, 7 participants dropped out of the study (retention rate = 86%). Of these, 3 moved to another city, 1 was hospitalized due to illness, 1 died, and 2 were not motivated to continue. Of the latter 2, one was in the experimental, and the other, the control group. Dropouts were not significantly different from those who continued on their baseline CES–D, Beck Hopelessness Scale (BHS), Life Satisfaction Index, or number of specific events recalled. If anything, they were somewhat less depressed and more hopeful, although not significantly so.

The final sample, shown in Table 1, included 43 older adults ranging in age from 65 to 93 years (M = 77.19 years; SD = 7.68); 33 were women and 10 were men. The educational levels were able to read and write (7.0%), completed elementary school (67.4%), completed secondary school (23.3%), and attended university (2.3%). There were no differences between experimental and control groups in age, gender, or education. Experimental and control groups did not differ significantly at pretest on CES–D, BHS, Life Satisfaction Index, or number of specific memories, either including or excluding the dropouts.

A short form of the Composite International Diagnostic Interview (Kessler, Andrews, Mroczek, Ustun, & Wittchen, 1998) was used to evaluate whether participants met criteria for major depressive disorder. The pretest interview asked about symptoms during the past 2 years; at posttest, participants were asked about the past 2 weeks. At pretest, experimental and control groups did not differ significantly in proportion with major depression (50% of the experimental group vs. 30% of the control group).

Mood Measures

Depression. Depression was measured by the CES–D (Radloff, 1977; translated into Spanish by Latorre Postigo & Montañés Rodríguez, 1997). The CES–D is a 20-item self-report scale developed to screen for depressive symptomology in the general population, with each item scored on a 4-point scale from 0 (*little or no experience of the symptom over the past week*) to 3 (*nearly constant experience of the symptom*). Total scores range from 0 to 60, with higher scores indicating more depressive symptoms. In the present sample, Cronbach's alpha was .63.

Table 1
Background Data for Participants in the Study

Variable	Experimental group (n = 20)	Control group (n = 23)	Statistical test
Age, M (SD)	75.8 (8.1)	78.4 (7.3)	$t(41) = 1.11$
Education (frequency)			$\chi^2(3, N = 43) = 5.08$
Able to read and write	0.0%	15.0%	
Completed elementary school	73.9%	60.0%	
Completed secondary school	26.1%	20.0%	
Attended university	0.0%	5.0%	
Gender			$\chi^2(1, N = 43) = 0.95$
Male	17.4%	30.0%	
Female	82.6%	70.0%	

Note. None of the differences are statistically significant.

Life satisfaction. Life satisfaction was measured with the Life Satisfaction Index A (LSIA; Adams, 1969). The original Life Satisfaction Index (Neugarten, Havighurst, & Tobin, 1961) consisted of 20 "agree" or "disagree" attitude items. Adams (1969) reduced the scale to 18 questions, using Wood's scoring method (Wood, Wylie, & Sheafor, 1969). This method assigns 2 points for positive answers, 0 for negative answers, and 1 for "don't know" answers, providing a range of 0 to 36, with the highest scores indicating the greatest satisfaction. The scale was translated into Spanish by Stock, Okun, and Gómez (1994). In the present sample, Cronbach's alpha was .66.

Hopelessness. The hopelessness instrument (BHS; Beck, Weissman, Lester, & Trexler, 1974) reflects an individual's negative expectancies of the probability of attaining important goals. Twenty items representing the types of pessimistic statements made by psychiatric patients are answered true or false, and the scale is scored for pessimism, with a score of 20 reflecting the highest degree of pessimism. The authors of this article translated the BHS into Spanish. In the present sample, Cronbach's alpha was .74.

Autobiographical Memory Test

This test measures respondents' ability to retrieve a specific memory under timed conditions in response to a cue word. The procedure is taken from Williams and Broadbent (1986). We generated cue words for the Spanish version of the test by presenting a list of 30 words to a focus group, who identified which were more familiar positive, negative, and neutral words. These words were presented orally to the respondent. In this experiment, we used five positive (*funny*, *lucky*, *passionate*, *happy*, *hopeful*), five negative (*unsuccessful*, *unhappy*, *sad*, *abandoned*, *gloomy*), and five neutral words (*work*, *city*, *home*, *shoes*, *family*). Words were presented in a fixed, alternating order as above. To ensure that participants understood the instructions, we provided examples of general memory (e.g., summers in the city) and specific memory (e.g., the day I got married).

In this procedure, participants were asked for a memory of which the cue word reminded them, one that should have occurred at a particular time and place and lasted no longer than a day. (The interviewer's question for the positive and negative words was "Try to remember a day or situation in the past when you felt [*cue word*]. Can you describe it?" For neutral words the question was "Try to remember a special day about . . ."). Participants were given 30 s to produce a memory. If no memory was recalled in 30 s, this was noted as an omission; the participant was not prompted. Each memory was rated on whether it was general or specific. If the recalled event lasted no longer than a day, it was coded as specific. If the memory happened on a number of occasions, it was coded as general. Because the total number of stimulus words was 15, the maximum score for either category was 15 and the sum of general plus specific memories could not exceed 15. Additionally, each memory was rated for whether it was positive, negative, or neutral. Two psychologists served as raters and independently scored the responses of all participants; raters were blind to the hypotheses of the study, to experimental or control group, and to pretest or posttest. Interrater reliability for general versus specific was .89 at pretest and .91 at posttest. At pretest, interrater reliability for positive was .78; for negative, .80; and for neutral, .79. At posttest, the respective results were .77, .79, and .79.

Procedure

The intervention was individually administered on a weekly basis by Juan Pedro Serrano. Participants were told that the study was investigating effects of memory recall on mood and that the interviews were designed to evoke memories. In the 1st week, participants gave consent, received an explanation of the study, provided basic demographic data, and completed the pretest mood measures. These measures were administered by two assistants blind to the purpose of the study. In the 2nd week, participants completed the autobiographical memory pretest.

During the 3rd to 6th weeks, the life review therapy was carried out with the experimental group, and the control group was visited only for social assistance. The life review consisted of autobiographical retrieval practice that entailed focusing on a particular life period each week—childhood, adolescence, adulthood, and summary. For each period, 14 questions were prepared (based on Haight & Webster, 1995) that were designed to prompt specific memories. Examples of questions include, "What is the most pleasant situation that you remember from your childhood?"; "What did your mother or father do one day when you were a child that astonished you?"; "During adolescence, what moment do you remember as special because it was the first kiss you received or because you shared something special with someone with whom you were in love?"; "Tell me about a day when you were an adolescent and you did something out of the ordinary"; "Tell me a time that you remember experiencing the most pride at work"; "Did someone close to you or someone you knew recuperate from a grave illness?"; "If everything in your life were to happen exactly the same, what moment would you like to re-live?"; and "What do you consider to be the most important thing that you have done in your life?"[1] Participants' reported memories were recorded, and each was coded as to whether it was general or specific and whether it was positive, negative, neutral.

Autobiographical memory posttesting took place the 7th week, and the 8th and final week concluded with the CES–D, BHS, and LSIA scales. The self-report measures were again administered by two assistants blind to the design of the study.

Intervention sessions were tape-recorded and were scored by a psychologist blind to the purpose of the study to ensure that the intervention was presented according to the protocol. Each response to the prompting questions was coded for whether the answer was positive, negative, or neutral and whether it was specific or general. This coding determined that each prompting question was administered to each participant and that the participants performed the intervention. In addition, absence of unspecified components such as encouragement or advice was confirmed.

Results

Our chief hypothesis was that individuals in the life review therapy condition would show decreased depression and hopelessness and increased life satisfaction. In addition, because the focus of the intervention was increasing specificity of memories, it was predicted that number of specific memories would increase from pretest to posttest for those individuals who received life review. Means and standard deviations for experimental and control groups at pretest and at posttest are included in Table 2. Experimental and control groups were not significantly different at pretest on any of the four dependent variables, confirming that random assignment was successful. Four analysis of variance procedures (ANOVAs) were carried out, with treatment group (experimental vs. control) as a between-subjects factor and time (pretest vs. posttest) as a within-subject factor. The dependent variables were CES–D, BHS, LSIA, and specific recall scores. A significant Group $\times$ Time effect indicates that the experimental group changed significantly more than the control group. For all four ANOVAs, the main effects for time and the Group $\times$ Time interaction were statistically significant, as seen in Table 2. For BHS, the main effect for group was also significant. Older adults who received practice in autobiographical memory retrieved more specific memories at posttest compared with the control group, indicating that the intervention was successful in encouraging older adults to generate more specific memories. In support of our

[1] A copy of the treatment protocol is available from Juan Pedro Serrano.

Table 2
Means (and Standard Deviations) for the Main Dependent Variables in the Study

Variable	Experimental group (n = 20)		Control group (n = 23)		F(1, 41)		
	Pretest	Posttest	Pretest	Posttest	Group	Time	Time × Group
CES–D	30.70 (6.76)	20.45 (7.25)	27.61 (6.29)	27.61 (7.48)	1.07	38.99****	38.99****
Beck Hopelessness Scale	12.10 (3.04)	8.25 (3.54)	11.96 (4.08)	12.96 (4.38)	4.35*	11.62**	33.66****
Life Satisfaction Index	13.55 (4.73)	19.50 (6.48)	14.83 (6.29)	14.04 (7.77)	1.24	16.95***	28.78****
Specific recall							
Positive specific memories	1.60 (1.79)	3.25 (2.07)	1.95 (1.49)	2.17 (1.80)	0.64	8.87**	5.22*
Negative specific memories	1.45 (1.61)	2.50 (1.61)	1.17 (1.19)	1.78 (1.31)	1.99	10.36**	0.73
Neutral specific memories	0.10 (0.31)	0.60 (0.88)	0.30 (0.56)	0.22 (0.52)	0.44	2.79	5.63*
Total specific memories	3.15 (3.10)	6.35 (3.36)	3.42 (2.55)	4.17 (2.72)	1.63	15.34***	5.99*

Note. CES–D = Center for Epidemiologic Studies Depression Scale.
* $p < .05$. ** $p < .01$. *** $p < .001$. **** $p < .0001$.

hypothesis, the experimental group, which received the practice in autobiographical memories, improved in their levels of depressive symptoms, hopelessness scores, and life satisfaction, when compared with the control group.

Analyses were repeated with just individuals who met Composite International Diagnostic Interview criteria for major depressive disorder at pretest. Those with a history of major depression had significantly higher CES–D scores at pretest than those without a history of major depression, but amount of change on the CES–D was not significantly different for those with versus those without a history of major depression. However, within the experimental group, the proportion meeting criteria for major depression dropped from 50.0% at pretest to 25.0% at posttest, whereas for the control group, the proportion meeting these criteria was similar at pretest and at posttest: 30.4% and 34.8%, respectively.

Additional analyses tested whether change on specific memories was related to change on the outcome measures. A change score was calculated by taking the difference between number of specific memories generated at posttest and number generated at pretest. Three regressions were carried out, using all 43 participants, with posttest scores on CES–D, BHS, and LSIA as the outcomes and two predictors: pretest scores on the corresponding measure and change on specific memories. For all three outcomes, posttest scores were significantly predicted by pretest scores. In addition, controlling for pretest scores, change on specific memories was a significant predictor for posttest hopelessness ($\beta = -.29$, $p = .01$) and life satisfaction ($\beta = .24$, $p = .03$), and there was a trend in the same direction for posttest CES–D ($\beta = -.25$, $p = .06$). These results suggest that participants who increased the most in production of specific memories were also those who improved most on depressive symptoms, hopelessness, and life satisfaction.

A test for mediation (Baron & Kenny, 1986) was also performed on (a) the relationship between group (experimental vs. control) and outcome; (b) the relationship between change in specific memories and outcome; and (c) whether the relationship between group and outcome was reduced when the measure of specific memories was included in the equation. For hopelessness, there was partial mediation, with the effect of group still significant although slightly reduced, from $\beta = .53$ to $\beta = .48$. For life satisfaction, the effect of group was reduced from $\beta = .45$ to $\beta = .42$; for CES–D, it was reduced from $\beta = .60$ to $\beta = .58$.

A more detailed, descriptive examination of positive specific, negative specific, and neutral specific responses is shown in Table 2. Repeated measures ANOVAs revealed significant Group × Time interactions for specific positive and specific neutral responses and significant main effects for time on all three measures. The experimental group increased more than the control group in production of both positive specific memories and neutral specific memories.

Finally, number of specific memories produced during the intervention was correlated with increase in specific memories between pretest and posttest. This relationship was most pronounced for number of specific memories in response to neutral cue words, where $r = .38$, $p < .10$, for the 20 participants in the intervention.

Discussion

The aim of this study was to examine the benefits of practice in autobiographical memories in the context of life review therapy in older people with depressive symptoms. We investigated whether older adults who received autobiographical retrieval practice improved their mood state and whether improvements would be associated with changes in recall of specific memories. The life review process involves emotional processing of events from the individual's past. Autobiographical retrieval practice focused on bringing up specific events that these older adults might not have spontaneously reviewed. The results showed that older adults who received autobiographical memory practice improved their mood state, with decreased depressive symptoms and feelings of hopelessness, and improved their life satisfaction, compared with a control group, who did not show changes in their mood state. The results also provide further evidence that overgeneral memories in depression are modifiable over short time periods; participants in a life review therapy protocol in which they were trained on autobiographical memory generated significantly more specific memories at posttest than at pretest compared with those who did not receive life review therapy.

We cannot claim that the improvements in mood were unambiguously due to the focused attention on specific recall during the life review sessions. However, the results do suggest that increasing the specificity of recall in autobiographical memory may be an important mechanism in explaining how life review therapy might achieve its effects. This conclusion is supported by both the fact

that the intervention led to increases in specific memories and the fact that those who increased more in specific memories also improved more in mood. What cannot be resolved is whether decreased depression led to less overgeneral memory, or whether successful practice in specific memory did, in fact, lead to reductions in depressive symptoms.

We should note some limitations of the present findings. First, there was no placebo control group in which participants received the same amount of attention from the therapist but not the autobiographical retrieval practice. Total amount of contact was not equated across conditions, as the control group received only typical social services, in the form of visits from the social services assistant. Therefore, we cannot definitively attribute the changes in depression to the autobiographical memory practice. Second, the prompting questions during the intervention primarily targeted positive memories, although some questions were clearly neutral and others referred to adversity, and the questions did stimulate negative and neutral as well as positive responses. Therefore, it is not possible to clearly separate elicitation of positive specific memories from elicitation of specific memories as the mechanism for improvement. Notably, the experimental group increased their production of positive, negative, and neutral specific memories, with the increase in positive and neutral memories greater for the experimental than for the control condition. Third, there was no follow-up to learn how long the changes maintained. Nevertheless, the main intention of this study was to learn whether overgeneral memory could be modified and whether this form of life review was effective in improving mood among participants who had symptoms of depression. Fourth, the sample size was rather small. All the same, significant changes in mood were found in spite of the size of the sample. Fifth, not all respondents had major depressive disorder. Nonetheless, all did have significant depressive symptoms.

These findings may help clarify what mechanisms underlie effective life review therapy. Past research has led to equivocal evidence regarding the impact of life review on depression (see Karel & Hinrichsen, 2000). One reason for the inconsistency may be the diversity of activities used by different life review therapies. In the present study, we based the life review intervention on current research about memory and depression. In conclusion, this study provides further evidence that overgeneral memory in depression can be modified by brief cognitive intervention and that life review based on these principles can be useful in treating symptoms of depression in older adults.

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