Addressing Social Participation and Quality of Life in Older Adults: Implementation of a Group Reminiscence Therapy Program

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Abstract

The study aimed to develop, implement, and evaluate a group reminiscence therapy program to promote meaningful social participation in a long-term care facility. A doctoral capstone experience student conducted a weekly 45-60 minute group reminiscence therapy program across six sessions. A total of 29 participants attended some or all of the sessions. Pre-test/post-test outcome measures were the Older People's Quality of Life - Brief version and the Three-Item Loneliness Scale. The student noted observations from the sessions and administered a feedback survey at the last session. The program did not significantly impact the participants' quality of life or loneliness level. However, participants provided positive feedback on the feedback survey, reporting satisfaction with the activity. The study implies the future continuation of the program may be successful for an enjoyable and meaningful activity but may need to be offered more frequently with smaller groups and assessed with other outcome measures to evaluate for impact on quality of life or loneliness effectively. Thus, occupational therapists can incorporate concepts of reminiscence therapy into practice to promote meaningful social participation with the therapist and promote improved quality of life.

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The definition of social participation is "activities that involve social interaction with others, including family, friends, peers, and community members, and that support social interdependence" (American Occupational Therapy Association (AOTA), 2020). Social participation is vital for overall quality of life, as it increases health and wellness and provides structure and meaningfulness in daily life (Fox et al., 2017; Nordin et al., 2017; Roberts & Adams, 2018). There has been extensive research on the topic in the older adult population, including a quantitative study, with researchers reporting increased participation in formal social activities was associated with a slower rate of decline of overall quality of life (Roberts & Adams, 2018). In addition to improved quality of life, residents in nursing homes with higher levels of social engagement, compared to those with lower social engagement, tended to live longer, with an 18% lower 5-year mortality risk and a 3-year higher median survival (Pastor-Barriuso et al., 2020).

Several researchers, including Li et al. (2017) and Holtfreter et al. (2017), found lower levels of social participation associated with higher levels of depressive symptoms in older adults. However, Holtfreter et al. (2017) noted that high-quality familial ties lessened the association between depression and inactivity. Other researchers focused on a narrow population of older adults, including Kang (2012) who focused on older adults with dementia. Kang (2012) found that older adults with dementia tended to display a negative correlation of participation in meaningful social activities and performance of ADLs, impaired cognition, depression, and vision. According to the Centers for Disease Control and Prevention (2021), in 2016, 47.8% of residents in nursing homes within the United States had a diagnosis of Alzheimer's disease or

other dementias. The large prevalence of a dementia diagnosis among residents of care facilities emphasizes the need for addressing social participation in this population.

The purpose of this paper is to discuss the Doctoral Capstone Experience (DCE) that an occupational therapy doctoral capstone student completed at a senior living facility. The site serves older adults by providing multiple levels of care, including assisted living, long-term care, rehabilitation, and memory care. The program development completed for the DCE aimed to promote social participation to improve quality of life for the residents.

Literature Review

Introduction

The literature review serves to provide an understanding of the barriers and facilitators that older adults experience relating to social participation; identify a need to improve social participation levels in senior living facilities; and outline methods for promoting social participation in the older adult population living in care facilities. The literature review includes 15 research articles sourced from online databases, including both quantitative and qualitative studies. The literature suggests that older adults often experienced decreased social participation due to a variety of barriers. The literature also indicated there are many facilitators to social engagement and several methods to promote social participation, including reminiscence therapy. Additionally, researchers suggest that lower levels of social participation are associated with decreased health and wellness and decreased performance in activities of daily living (ADLs).

The reviewed literature aids in identifying the gap between social participation desire and actual social participation. The identified gap applies to the DCE project, aiming to improve high-quality and meaningful social participation levels of older adults with and without dementia at the facility.

Barriers to Social Participation

Numerous factors can act as barriers to the social participation of older adults. Researchers of a quantitative study about leisure engagement listed common barriers to be physical environment, social environment, medical conditions, mobility difficulties, and activity limitations (Nilsoon et al., 2015). The most influencing factor to social participation was activity limitations, examples of which were fear of falling, use of mobility devices, and partial dependence to complete bathing or cleaning (Nillsoon et al., 2015). Other researchers focused on the physical environment within residential care facilities, and indicated that the social participation decreases when there are barriers of the physical environment (Nordin et al., 2017). Examples of physical barriers identified include closed doors without automatic opening, heavy doors, and smaller rooms (Nordin et al., 2017).

Goll et al. (2015) found illness and disability to be a barrier to social engagement. Other researchers have found specific conditions, such as visual impairments and glaucoma, to influence formal and informal social participation, with participation levels being lower than older adults without visual impairments (Jin et al., 2019; Rudman et al., 2016). According to Rudman et al. (2016), common reasons for the decrease in social engagement of older adults with visual impairments were increased mobility difficulties and increased fall risk due to the physical environment. Other researchers focused on the impact of incontinence on social participation and depressive symptoms, finding incontinence to be significantly associated with lower levels of social participation (Lai et al., 2017). Kang (2012) and Theurer et al. (2015) both focused on the condition of dementia, reporting that there tend to be lower levels of social participation, possibly due to communication difficulties associated with symptoms of dementia.

Researchers conducted a qualitative study regarding activity disengagement with participants aged 60 and older, finding the most common activities maintained to be considered

instrumental or low-demand (Fox et al., 2017). The activities listed as the most maintained were often performed alone, such as shopping for groceries, watching television, paying bills, and taking out the trash (Fox et al., 2017). The study indicated that social activities are given up or performed less (Fox et al., 2017). Within the same study, the most common barrier to engaging in social activities was having no one to do them with (Fox et al., 2017). The researchers reported that older adults often continue participation in easier or unavoidable tasks and decrease engagement in social activities due to social limitations (Fox et al., 2017). Goll et al. (2015) found that barriers to social engagement include loss of friends, family, and community, which correlates with the findings from Fox et al. (2017), as individuals may have lost their friends or family that they previously engaged with socially.

Other barriers of social participation were related to psychological aspects of the individual, such as fear of social rejection or exploitation and fear of losing aspects of identity, including independence, youth, and preferred social identity (Goll et al., 2015). Similarly, Rudman et al. (2016) found that older adults with age-related vision loss experience an additional fear of social embarrassment or misunderstanding.

Facilitators to Social Participation

Although there are many barriers to the social participation of older adults, researchers have also identified facilitators through qualitative and quantitative research. Researchers found that the most common facilitator to social participation was to do an activity with someone (Fox et al., 2017). Similarly, individuals living with someone else experienced higher levels of leisure engagement (Nilsoon et al., 2015). Another common facilitator to social participation was having more opportunities for general leisure activities (Fox et al., 2017). Other researchers found that individuals with a higher income experienced higher levels of leisure engagement (Nilsoon et al.,

2015). A possible connection between the two studies is that when an older adult has a higher income, they can access more opportunities due to less financial strain.

Researchers also found that the physical environment was a facilitator for social engagement. On the contrary to the limiting aspects of the physical environment described as barriers previously, Nordin et al. (2017) found that an open floor plan and larger rooms increased the opportunity for independent mobility. With a physical environment that is easier to navigate independently, it can ease socializing with others in the room, the building, or the community (Nordin et al., 2017; Rudman et al., 2016).

The Desire for Social Activities

Researchers indicated that there were activities that many older adults desire to do again or more often. Many of these desired activities involve social engagement, such as attending concerts, attending a party or picnic, visiting with friends, and visiting with friends or family who are ill (Fox et al., 2017). Likewise, Nordin et al. (2017) identified that many residents of residential care facilities wished to independently participate in social activities such as gardening or eating with others. Tak et al. (2015) emphasized the desire to participate in meaningful social activities rather than activities intended to stay busy. However, although there is an established desire for social activities, Nordin et al. (2017) reported residents often encountered barriers that decrease the ability to participate in the activities at the independence level they desire.

Promoting Social Participation

Many approaches can impact the social participation levels of older adults living in care facilities. One approach is identifying and addressing the barriers listed above to create facilitating factors. For example, making environmental modifications to increase physical ability to participate. Staff can also create activity modifications to account for medical

conditions that may be limiting participation, such as visual impairments or physical deficits (Jin et al., 2019; Rudman et al., 2016; Tak et al., 2015). Another method to increase social participation is to implement meaningful social activities. Researchers reported that residents of care facilities preferred to take part in activities that they considered meaningful rather than something to keep busy (Tak et al., 2015). Theurer et al. (2015) emphasized a need for social revolution in residential care, describing a need for a switch from providing superficial recreational activities to providing meaningful activities that allow for emotional and social connection. Staffing can obtain the residents' input for activities they would find meaningful and have interest in attending (Theurer et al., 2015).

Reminiscence therapy is the process of using multi-sensory stimuli to recall meaningful or positive personal experiences from the past, completed as a group or individually (Meléndez-Moral et al., 2013). As a group, it provides opportunities for meaningful social interaction and relationship building. Reminiscence therapy as an intervention or activity for older adults in care facilities provides the benefit of social participation. This activity is often meaningful to participants as they can discuss their personal past. Many other benefits include the following: increased self-esteem, increased life satisfaction, increased quality of life, and decreased depressive symptoms (Chang & Chien, 2018; Kim et al., 2016; Meléndez-Moral et al., 2013; Siverova & Buzgova, 2018). Reminiscence therapy is often used with individuals diagnosed with mild or moderate dementia since it decreases demands on cognitive impairments and focuses on preserved cognitive functions, including long-term memory (Kim et al., 2016).

Conclusion

Reviewing recent research highlights a perspective that emphasizes the need for increased social participation in older adults that is also meaningful. There is a disconnect between the desire that older adults experience to participate in meaningful social activities and

the actual time spent doing social activities. Health and wellness should be a priority for older adults, especially when they go through changes in the physical or social environment. Continued social participation is one way to maintain or improve quality of life. It should be a focus for occupational therapists because it is a part of the Occupational Therapy Practice Framework (AOTA, 2020).

Through the findings of numerous research studies, it was evident that a program to increase meaningful social participation levels of older adults in a care facility would be beneficial, especially for individuals diagnosed with dementia. The program involved aspects of reminiscence therapy to promote social participation, mental health, and well-being. Throughout the creation of the program, the student considered barriers and facilitators of social participation to ensure an optimal environment for the residents participating. Overall, improving the social participation levels of older adults in a care facility was likely to consequently enhance the participants' quality of life.

Needs Assessment

The doctoral capstone student completed a needs assessment prior to being at the site through interviews and research and then during the initial two weeks at the site through interviews, research, and observation. The on-site needs assessment consisted of observing various activities offered at the facility in assisted living, long-term care, and memory care, to assess current social participation levels. In addition, the student completed observation of a monthly "Town Hall" meeting for assisted living residents and at a monthly resident council meeting for long-term care residents to listen to the residents' concerns about the facility. Semi-structured interviews were conducted with staff members, including the activity director, therapy supervisor, and therapy speech-language pathologist (SLP) staff (see Appendix A for semi-structured interview questions). Unstructured interviews were completed with activity assistants.

The needs assessment revealed that the site offers various activities and accounts for resident input through the monthly resident meetings. The offered activities, however, are limited due to Covid-19 safety precautions. At the time of completing the DCE project, the restrictions were lessening than they had been prior, which allowed for more participation in socially distanced activities. Another finding is that the activity department also has a protocol to encourage social participation for all residents on the units. In addition, they complete one-on-one socializing with individuals who do not want to attend the offered group activities. A concern noted is that many of the activities do not encourage direct conversation between residents. Often, the activities provide a space for residents to be around other residents, but they do not take part in conversation.

Additionally, findings revealed that education of methods to promote social participation is lacking, especially information about promoting social participation specifically with individuals diagnosed with varying levels of dementia. While the site uses the global deterioration scale (GDS) with the SLP therapy patients, the other staffing departments are not all aware of what this scale means and how to apply it to encouraging meaningful social participation.

The overall findings of the needs assessment, in combination with the literature review, resulted in the program development, implementation, and evaluation of a reminiscence therapy group for the residents in the long-term care units of the site. In addition, the student created educational materials and distributed the materials to inform staffing of evidence-based methods to promote social participation and how to address social participation based on GDS score. Resources about facilitating a reminiscence therapy program, and reminiscence kits containing themed objects and pictures, were also provided to the activity department to promote sustainability of the program.

Theoretical Framework

The occupation-based model (OBM) that will guide the doctoral capstone experience (DCE) is the Model of Human Occupation (MOHO). The primary focus of the MOHO is on the impact that the mind and body can create on occupational performance and volition (Cole & Tufano, 2008). Additionally, there is a focus on how the environment influences volition, behavior, and occupational performance (Cole & Tufano, 2008). Researchers applied the MOHO in a study focused on community participation, which supports the use of the MOHO applied to the population of older adults, particularly for social activities (Papageorgiou et al., 2016). The MOHO applied to the population of older adults living in a care facility is a relevant guiding model because it focuses on how the environment impacts motivation to participate in occupations and the quality of participation. Furthermore, the MOHO brings attention to the performance skills impacting the other aspects of the human. In the population of older adults living in a care facility, these performance skills are often decreased.

Moreover, the frame of reference (FOR) of Lifespan Development will guide the DCE project. The Lifespan Development FOR is relevant to guide the project because of the project's focus on helping clients with transitional tasks, which in this setting can occur when moving into the facility, or from adapting to physical or cognitive changes from a medical condition (Cole & Tufano, 2008). The Lifespan Development FOR impacts the concepts of the MOHO through the consideration of a client's age and how it aligns with their performance skills and habituation.

Lastly, the Activity Theory will also guide the DCE project. The Activity Theory supports that maintaining participation in physical and mental activities is correlated with higher life satisfaction as people age (Havighurst, 1961; Li et al., 2017). As the DCE project focuses on promoting meaningful social participation, and consequently, quality of life, the activity theory is a perfect guiding theory. The Activity Theory correlates with the concepts from Lifespan

Development through encouraging continued participation that is age-appropriate throughout the aging process. The concepts from the MOHO relate to the Activity Theory through focusing on the impact that the environment has on occupational participation, which should be addressed and maximized when viewing from the perspective of the Activity Theory.

Materials and Methods

This section outlines the implementation of a group reminiscence therapy program to promote meaningful social participation and improve quality of life of the older adults involved. Details are included of the participants, outcome measures, and procedures.

Participant Recruiting

Twenty nine older adults participated between two LTC units at the senior living facility. The student recruited participants through voluntary response sampling. Any individuals living on the units were able to attend the program. The program was advertised in the monthly activities calendar that the residents received at the start of each month. In addition, a flyer was posted each week on the units as a reminder of when the program was and the details of that week's theme.

Materials

The materials that follow were used as outcome measures to evaluate the program's impact on the participants. The student based the selection of outcome measure materials on the evidence-based research of what psychosocial aspects were impacted by participating in a group reminiscence therapy program.

Older People's Quality of Life - Brief version (OPQOL-Brief)

The OPQOL-Brief was a self-report, pre-test and post-test outcome measure to assess changes in quality of life (QoL). The student administered the assessment at the first and last session. The OPQOL-Brief consists of 13 scored items and an additional single item on global

QoL, outlined in Appendix B (Bowling et al., 2013). The items were scored on a Likert scale, as follows: Strongly agree, Agree, Neither, Disagree, Strongly disagree. The single item on global QoL is the only exception, scored on a Likert scale, as follows: Very good, Good, Alright, Bad, Very bad. The tool has been shown to have high reliability and high convergent and discriminant validity when used with older adults (Bowling et al., 2013).

Three-Item Loneliness Scale

The Three-Item Loneliness Scale was a self-report, pre-test and post-test outcome measure to assess for changes in level of loneliness. The student administered the assessment at the first and last session. The Three-Item Loneliness Scale consists of 3 items outlined in Appendix C (Hughes et al., 2004). The items were scored on a Likert scale, as follows: Hardly Ever (1), Some of the Time (2), Often (3). The tool has demonstrated good reliability and good concurrent and discriminant validity (Hughes et al., 2004).

Feedback Survey

The student administered a survey at the last session to receive feedback on the program (see Appendix D for survey questions). The survey consists of five total questions, with a mix of open-ended and closed-ended questions. The questions focus on the personal perspective of the participants regarding their satisfaction, what they enjoyed about the program, and what they would like to see changed in the program.

Procedure

Residents in the two LTC units completed a survey for the student to gain more information about the possible participants. The survey provided information for planning the themes and items needed for the individual program sessions (see Appendix E for questions).

Seventeen individuals responded to the survey. The student used responses from the questions to assist in planning for sensory stimuli brought to the sessions.

The student then created an activity protocol template to follow throughout the sessions (see Appendix F for activity protocol template). Each session consisted of the same format, including an introduction, educational concepts, activity with discussion, and a summary. The format slightly differed for the first and last session, incorporating time to complete the outcome measures of the OPQOL-Brief and the Three-Item Loneliness Scale. At the last session, the student administered the feedback survey. Participants received assistance, if needed, to complete the outcome measures. The student provided assistance to those who had difficulty reading or writing due to visual, motor, or cognitive deficits. The activity facilitator also used observation of participation at each session as a means of results.

The activity of each session used the same outline, revolving around the chosen theme, and incorporated the five senses of touch, sight, smell, taste, and sound. The sensory stimuli used at each session were individualized based on the theme of the session. The DCE student acted as the activity facilitator for a total of six 45-60 minute sessions. The themes included childhood; favorite holidays; life at home and work; vacations; dating, weddings, and marriage; and family, parenting, and pets. The student used open-ended questions throughout the sessions to prompt further discussion of memories. At each session, the student encouraged participants to attend the next session.

Results

Participants

A total of 29 residents participated, consisting of four males and 25 females. See table 1 for details on the number of sessions attended by participants.

Table 1

Number of Sessions Attended by Participants

Number of Sessions Attended	Number of Participants
1	9
2	4
3	3
4	1
5	8
6	4

Older People's Quality of Life - Brief version (OPQOL-Brief)

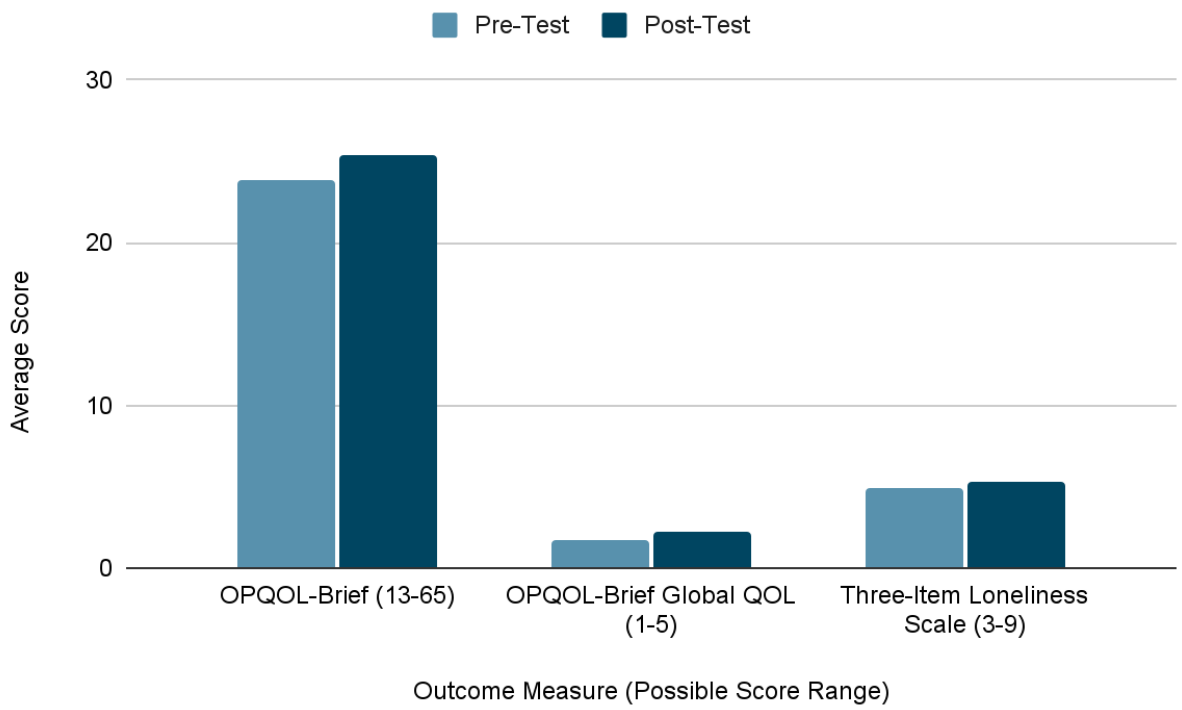
Seventeen participants completed the pre-test, and ten of those participants completed the post-test. Only participants who completed both were included in the results to assess for score changes. The OPQOL-Brief scores showed an initial average of 23.9. After participating in the program, the average scores were 25.4. The OPQOL-Brief global QOL item showed an initial pre-test average of 1.7 and a post-test average of 2.2. Figure 1 displays the changes between the pre-test and post-test scores.

Three-Item Loneliness Scale

Seventeen participants completed the pre-test, and ten of those participants completed the post-test. Only participants who completed both were included in the results to assess for score changes. The Three-Item Loneliness Scale scores showed an initial average of 4.9. After participating in the program, the average scores were 5.3. Figure 1 displays the changes between the pre-test and post-test scores.

Figure 1

Pre-Test and Post-Test Average Results



Feedback Survey

Ten participants completed the feedback survey. Regarding satisfaction with experiences in the program, five participants were extremely satisfied, four were satisfied, and one was neutral. Nine out of ten participants reported interest in participating in future sessions, and one participant said they might attend a future session. Participants suggested the following new themes: life before 60, schooling, and friendships. The participants reported enjoyment of looking at pictures, sharing their stories, listening to others, learning what they had in common with other participants, recalling about family, comparing their life with new generations, and general reminiscing. One participant suggested changes to the program implementation to include more encouragement for participating. The other participants reported feeling the sessions were adequate as they were. One participant commented about general activities at the facility, stating that they should be more applicable to the residents.

Observations

The activity facilitator noted during sessions that smaller groups of eight or less participants demonstrated higher participation success than larger groups of nine or more participants. The participants heard each other better to engage in conversations. Participants also displayed higher participation and engaged in more conversations when they were able to sit closer to each other. An additional observation is that many of the participants enjoyed the activity; however, some did not enjoy it as much and did not attend many of the sessions due to this.

Discussion and Implications

The results indicate that the program did not significantly impact participants' quality of life or loneliness. This differs from Siverova and Buzgova (2018) finding that reminiscence therapy increases quality of life with a weekly group reminiscence therapy program. Future program evaluation may include a quality of life scale that scores in domains like The World Health Organization Quality of Life-BREF (WHOQOL-BREF) or The World Health Organization Quality of Life-Old (WHOQOL-OLD). In addition, future program evaluation could include measuring depressive symptoms, as several previous studies found reminiscence therapy to decrease depressive symptoms (Holtfreter et al., 2017; Li et al., 2017).

Although there were no significant changes on the pre-test/post-test outcome measures, the participants provided positive feedback on their satisfaction with the program, indicating that the continued offering of a reminiscence activity may be enjoyable and meaningful. The satisfaction with offered activities is an important consideration for success, supporting Theurer et al. (2015) who described a need to switch from providing superficial recreational activities to providing meaningful activities that allow for emotional and social connection.

The observation of increased success in smaller groups indicates that future use of reminiscence therapy activities should be completed in smaller groups of eight or less or have more group facilitators to split the participants into smaller groups. This aligns with Kim et al.'s (2016) findings that group reminiscence therapy yields more positive results with no more than five individuals to one facilitator. Additionally, according to Kim et al. (2016), a higher frequency of more than one time per week may yield stronger results. Therefore, future programming may consider offering more often than weekly in order to aim for a larger positive impact on the participants. Another suggestion for future programming from Kim et al. (2016) is to individualize the sensory stimuli with the participant's personal photos or objects.

Implications include that many residents of the site would enjoy a continued program of reminiscence therapy. Suggestions for change throughout the discussion should be implemented to enhance the program's benefits, and the program should continue to be evaluated for impact on the participants. The reminiscence kits and materials provided to the site aim to help in the sustainability of the program.

Occupational therapists may implement the concepts of reminiscence therapy into their treatment with older adults to promote meaningful social participation with the therapist and promote quality of life. Occupational therapists can also promote meaningful social participation through other methods, including advocating for the desired meaningful activities of residents, which aligns with the concepts of Theurer et al. (2015).

Limitations

COVID-19 pandemic precautions limited the study due to initial social distancing and mask requirements. This decreased the ability of the residents to hear each other as well and engage in conversation. Another limiting factor was the inconsistency in participant attendance.

Although there were some participants that attended consistently, some did not attend as much so those individuals may have experienced less of the potential program benefits. Lastly, inability to impact all areas of quality of life led to many aspects of the outcome measure not changing significantly. Due to this, it may be beneficial for future program evaluation to choose a quality of life outcome measure that is broken into domains.

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Appendix A

Semi-Structured Interview Questions

Semi-Structured Interview Questions with Therapy Supervisor (Prior to Being On-Site)

1. What levels of care does the facility provide? What does this look like?
2. What are the current goals that your therapy department is trying to achieve? Are there plans in place to achieve these goals?
3. What are some areas of your therapy department or the general facility that you think could be improved that could become a focus for my DCE project? Do you have any ideas for further development?
4. Do you find that the activities offered at the facility are client-centered?
5. Do the residents engage in much social participation?
    a. In what ways do they do this?
    b. In what ways does the facility encourage social participation?
    c. For those in assisted living, do they often leave the facility? If so, do they have any difficulties with community mobility?

Semi-Structured Interview Questions with Therapy Supervisor (After Starting On-Site)

1. Is occupational therapy (speech or physical therapy) involved in any social activities / groups with residents? If so, what type of involvement? If not, do you think it would be beneficial for the department to have more involvement?
2. Does the facility utilize ACL or similar assessment tools with any residents?
3. What is your perception of the current quality of life of residents?

Semi-Structured Interview Questions with Activity Director

1. What activities are currently available for residents? Is there a schedule I can have a copy of?
2. How do you decide what activities to offer? Is resident satisfaction with offered activities considered and do you account for what activities they may be interested in having started up?
3. What are current visitor restrictions with family/friends?
4. Is there anything set up for residents to socialize with family other than visitation? Video calls, phone calls, etc.? If so, what assistance is provided to patients who have difficulty with using technology?
5. Do you keep track of participation levels in the offered activities? If so, how?
6. Do you keep track of participation levels of individual residents to know if they are being socially isolated and need increased encouragement? If so, how?
7. What are restrictions/rules with Covid around current activities?
8. What are limitations non-Covid related that tend to decreased social engagement?
9. What actions do you take right now to try to improve social engagement?
    a. How do you encourage social engagement?
10. What resources are available that I may be able to use as I either work on current programs or develop a new program?

11. How are activities funded?
12. What is your perception of the quality of life of residents?
13. Do you have any advice for me as I look into developing current activities or creating new activities to promote social engagement?
14. What do you think could be improved with your activities programs?
15. With new residents, is there a method that you use to track how they are doing with adjusting to the facility?
16. How do you determine what activities new residents may be interested in?

Semi-Structured Interview Questions with Therapy Staff (SLP)

1. ACL levels / GDS levels: how are they used to benefit client care after your evaluation of their level? Are other staffing departments (nursing, activities, etc.) aware of what it means to be at a certain ACL or GDS level, and how to facilitate the best quality participation in activities or social engagement?
2. Is there education provided to other non-therapy staffing on cognitive levels and how to adapt activities based on this? If so, what does this entail? Do you think there is room for improvement in this?
3. What is the typical level of cognitive function on the different units at this facility?
4. Do you think the idea of reminiscence / recollection-based therapy as a small group would be beneficial? Do you think long-term care and/or memory care would benefit from this?
5. Do you have any advice on implementing a reminiscence therapy group?

Appendix B

Older People's Quality of Life - Brief version (OPQOL-Brief)

OPQOL-brief:

The OPQOL-BRIEF questionnaire has 13 items, with a preliminary single item on global QoL, shown below. This single item is not scored with the OPQOL; it is coded as Very good (1) to Very bad (5).

OPQOL-Brief scoring:

Each of the 13 items is scored Strongly agree=1, Agree=2, Neither=3, Disagree=4, Strongly disagree=5. The items are summed for a total OPQOL-Brief score, then positive items are reverse coded, so that higher scores represented higher QoL.

We would like to ask you about your quality of life:

Single item - global QoL:

Thinking about both the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole?

Your quality of life as a whole is:	Very good	Good	Alright	Bad	Very bad
	☐	☐	☐	☐	☐

OPQOL-Brief

Please tick one box in each row. Please select the response that best describes you/your views. There are no right or wrong answers.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I enjoy my life overall	☐	☐	☐	☐	☐
I look forward to things	☐	☐	☐	☐	☐
I am healthy enough to get out and about	☐	☐	☐	☐	☐
My family, friends or neighbours would help me if needed	☐	☐	☐	☐	☐
I have social or leisure activities/ hobbies that I enjoy doing	☐	☐	☐	☐	☐

I try to stay involved with things	☐	☐	☐	☐	☐
I am healthy enough to have my independence	☐	☐	☐	☐	☐
I can please myself what I do	☐	☐	☐	☐	☐
I feel safe where I live	☐	☐	☐	☐	☐
I get pleasure from my home	☐	☐	☐	☐	☐
I take life as it comes and make the best of things	☐	☐	☐	☐	☐
I feel lucky compared to most people	☐	☐	☐	☐	☐
I have enough money to pay for household bills	☐	☐	☐	☐	☐

Thank you for your help

Appendix C

Three-Item Loneliness Scale

Question	*Hardly Ever*	*Some of the Time*	*Often*
First, how often do you feel that you lack companionship: Hardly ever, some of the time, or often?	1	2	3
How often do you feel left out: Hardly ever, some of the time, or often?	1	2	3
How often do you feel isolated from others? (Is it hardly ever, some of the time, or often?)	1	2	3

NOTE: For both scales, the score is the sum of all items

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2394670/

Appendix D

Feedback Survey

Mingling and Memories Feedback

Thank you for your participation in the Mingling and Memories (reminiscing) program. Please answer the following questions the best that you can to provide important feedback about your experience. As a reminder, themes were as follows: Childhood, Holidays, Work, Vacations, Dating & Weddings/Marriage, and Family & Parenting.

1. How satisfied were you with the program? Please circle one.

Extremely Satisfied	Satisfied	Neutral	Unsatisfied	Extremely Unsatisfied

2. What did you like about the sessions?

3. What changes do you suggest for future sessions?

4. Would you attend more sessions of this activity if it was offered again? Please circle one.

Yes	Maybe	No

   a. If yes, what types of memories would you like to reminisce on?

5. Provide any other comments here.

Appendix E

Resident Survey Questions

1. What were your favorite childhood games and/or pastimes?
2. What was your favorite toy as a child?
3. What was your favorite snack growing up?
4. What was your favorite thing to do with your parents?
5. What is your favorite vacation spot you have been to?
6. What is your favorite movie or show from when you were younger?
7. Who is your favorite musician/band from when you were younger?
8. What are some hobbies you did when you were younger?
9. What did you do for a living?
10. What is your favorite recipe to cook or bake?
11. What was your favorite thing to do with your children when they were young?

Appendix F

Activity Protocol Template

1. **Group title:** Mingling and Memories (Reminiscence Therapy)
2. **Session title:** _____ **Session theme**: _____
3. **Format**
    a. Warm-up and introductions: 5 minutes
    b. Educational Concepts: 5 minutes
    c. Activity: 25 minutes
    d. Sharing/Discussion: 20 minutes
    e. Summary: 5 minutes
4. **Supplies:** Must be about the theme chosen, preferably supplies are from the time period of the participants' childhood and adulthood. The goal is to include as many senses as you are able to throughout the session to promote reminiscing (touch, sight, hearing, smell, taste).
    a. Touch: Objects to pass around
    b. Visual: Pictures to look at (printed or on digital slide show if large screen available for viewing) or short video to watch
    c. Smell: Scents to smell
    d. Taste: Snacks/Drinks
    e. Sound: Music or sound effects
5. **Description**
    a. Warm-up and introductions
        i. Optional: Play 1-2 songs as participants come in and get settled
        ii. Introduce self, name/title of group, participant introductions
            1. "Hello, my name is ____. Thank you for joining today for Mingling and Memories. Today's session is called ____, which will focus on the theme of ____. We are going to start by everyone introducing themselves, and then I will explain more about the purpose and plan for today's session."
            2. Participants will now take turns to introduce themselves.
    b. Educational Concepts
        i. "Thank you for introducing yourselves, I am excited to get us started on the session and reminisce with you all for the next hour. The purpose of this group is to provide an opportunity for positive social interaction, as well as a chance to learn more about each other and build friendships. It also provides an opportunity for you to feel happy emotions as you share your memories from the past. By taking part in reminiscing on the past and talking about your happy memories, researchers have found this to help with holding onto these memories that are dearest to you. It is also beneficial for increasing your happiness, self-esteem, and life satisfaction. To help you in remembering times from your past, I have chosen a theme for today's session, and have brought a variety of items with me, which are focused around this theme. The items I brought will help you use your different senses of touch, sight, hearing, smell, and taste, in order to remember the past. The reason for doing this is because research shows that by using the different senses, it helps you

to remember things that you may have not thought about in a long time. Your brain stores a lot more memories than you may think, and you may be surprised with what you are reminded of today."

c. Activity
    i. "We are now going to start with our activity of sharing memories. You are all welcome to share any memory that you feel comfortable sharing. I want this to be an open space to learn more about each other and enjoy remembering times from your past. You are welcome to comment on each other's stories if it reminds you of something from your own life, or you just want to say something positive or ask a question. We will start with ____ (choose activities below based on sensory experiences provided this session. Use prompts under the sharing/discussion section as needed.)."
    ii. Objects - Participants will choose an object from the table or walk around with a basket/bag of objects for them to choose from. Participants will share why they chose that object and what it makes them think about. Give each resident a chance to do this. Participants can comment on each other's stories and objects as they take turns sharing.
    iii. Pictures - Participants will look at provided pictures about the session theme, and take turns sharing what the pictures make them think about. Give each resident a chance to do this. Participants can comment on each other's stories and objects as they take turns sharing.
    iv. Scents - Pass around scented objects (ex - unlit candle, spices), and ask participants what the smell reminds them of. Participants can comment on each other's stories as they take turns sharing.
        1. Another option is to have an essential oil diffuser turned on throughout the session with oil choice based on theme. You can also use the smells of snacks brought to the session. Ask participants what the smell reminds them of. Participants can comment on each other's stories as they take turns sharing.
    v. Snacks/Drinks - Have participants choose a snack/drink (if multiple options provided) and share why they chose the one they did, and what it reminds them of. Participants can comment on each other's stories as they take turns sharing their stories.
    vi. Music/Sounds - Play chosen music or sounds and ask participants to share what it reminds them of. Participants can comment on each other's stories as they take turns sharing.
        1. You may ask participants to choose songs from a certain time in their life (based on the theme of the session), and then play these songs through your phone, playing over a speaker, or through a CD if one is available.

d. Sharing/Discussion
    i. Throughout activities above, use the following prompt ideas, as needed, to facilitate sharing and discussion. Ask any other open-ended questions that are relevant to the discussion happening.
        1. What does this picture/object/smell/food/sound remind you of?
        2. What is your favorite memory of ___ (ex - childhood, parenting, holidays, etc.)?

3. Think back to what it was like when you were ___ (ex - growing up, getting married, having children, on vacation). Describe the sights, sounds, and smells of the time you are remembering.

e. Summary
   i. "Thank you for being here and participating in sharing your stories and listening to each other. I hope you all enjoyed yourselves as you reminisced about your past and learned more about each other. We will have another session next week on ___ (day) at ___ (time) that I hope you will come to, with the theme of ___."