CADENZA Community Project

Cherish Our Life: Enhancing Psychological Well-being of Elders

Project Report

香港大學
THE UNIVERSITY OF HONG KONG

Cadenza 流金頌

捐助機構
Funded by:

香港賽馬會慈善信託基金
The Hong Kong Jockey Club Charities Trus

香 港 大 學
THE UNIVERSITY OF HONG KONG

Cadenza 流金頌
賽馬會流金計劃新里程
A Jockey Club Initiative for Seniors

CADENZA Community Project

Cherish Our Life: Enhancing Psychological Well-being of Elders

Project Report

捐助機構
Funded by:
香港賽馬會慈善信託基金
The Hong Kong Jockey Club Charities Trust

CADENZA Community Project

Cherish Our Life: Enhancing Psychological Well-being of Elders

Project Report

Table of Content

Acknowledgements

The CADENZA Community Project Cherish Our Life: Enhancing Psychological Well-being of Elders is fully funded by The Hong Kong Jockey Club Charities Trust. The project team wishes to express its deepest gratitude to the Trust for its generous support for the development of services for the elderly under the project. We would also like to thank all the elders who participated in the project. Their involvement is the key to the project's success and is wholeheartedly appreciated by all project team members.

Preface

CADENZA: A Jockey Club Initiative for Seniors, Sik Sik Yuen and Department of Social Work and Social Administration of HKU, launched the two-year programme "CADENZA Community Project: Cherish Our Life: Enhancing Psychological Well-being of Elders" in 2011, in order to help the elderly living in the Wong Tai Sin District to reduce depressive symptoms and prevent elderly suicide.

The evidence-based evaluation was conducted by Dr Vivian Lou, the CADENZA Fellow and Assistant Professor of Department of Social Work and Social Administration of HKU. It was found that depressive symptoms of the elderly were reduced effectively through the preventive treatment programme and supporting services by the social workers.

This project report summarizes the findings and preventive treatment programme of the project. I hope this publication will serve as a useful practical guide for any agencies committed to elderly services in the community. I would also like to thank the great efforts of Sik Sik Yuen and Dr Lou's research team to make this project successful.

Mr Douglas So

Executive Director, Charities
The Hong Kong Jockey Club

I am pleased to present this project report on the CADENZA Community Project Cherish Our Life: Enhancing Psychological Wellbeing of Elders. With the support of The Hong Kong Jockey Club Charities Trust, a collaboration was established between the University of Hong Kong and Sik Sik Yuen in order to develop the Instrumental Reminiscence Intervention (IRI-HK) for local use and examine its effectiveness in alleviating depressive symptoms among Chinese older adults living alone or with their spouse only in Hong Kong.

The two years of the project have been a rich and fruitful experience for the team. I would like to take this opportunity to thank all the team members from Sik Sik Yuen and the University of Hong Kong for their hard work. Without their efforts, this project could not have been completed. Together, we are proud to announce that the IRI-HK has been successfully adapted for use in the Hong Kong cultural context and is effective in alleviating depressive symptoms.

Moreover, the project was about more than just achieving these goals; there were many moments to treasure during the development of IRI-HK. Our journey as team members to overcome obstacles such as a lack of suitable older adult participants and difficulties in retaining them was ultimately an enjoyable and productive one. The practice wisdom we gained cooperatively after overcoming these hardships is as valuable as the development of the intervention itself.

We are indebted to The Hong Kong Jockey Club Charities Trust for their full support of this project. At the same time, the project team would like to express its gratitude to all the participants for their involvement contribution. We sincerely wish them all a fruitful and healthy future.

This report demonstrates our achievements in the development of IRI-HK. We look forward to disseminating the IRI-HK at the community level. It will be our pleasure to further promote the IRI-HK to enable more social service providers to recognize how it can be used in order to serve the best interests of elderly people.

Dr. Vivian Lou W. Q.

Assistant Professor of Department of Social Work & Social Administration
Associate Director of Sau Po Centre on Ageing
The University of Hong Kong

According to the "Hong Kong 2011 Population Census Thematic Report: Older Persons", in 2011, the number of Hong Kong senior citizens living alone reached 119,376, i.e. 12.7% of senior citizens. Most of them have to deal with day-to-day problems on their own, including poor health conditions, a lack of social support and financial constraint, etc. If they are unable to solve these problems, they may feel lonely and helpless, and some may even develop symptoms of depression.

Depression is projected to be the second largest health problem by The World Health Organization (WHO). The Hospital Authority Fast Track Clinic Programme believes that depression could easily generate suicidal thoughts among elderly people. Statistics from The Hong Kong Jockey Club Centre for Suicide Research and Prevention, The University of Hong Kong, also show that the suicide rates among senior citizens are the highest of all age groups. Therefore, the issue of depression among senior citizens living alone demands immediate attention.

In 2011, SIK SIK YUEN received funding from The Hong Kong Jockey Club Charities Trust to launch a two-year project called "CADENZA Community Project: Cherish Our Life: Enhancing Psychological Well-being of Elders". Based on a brand new Instrumental Reminiscence Intervention model, this project helped depressed elderly who live alone or in couples to deal with their problems by recalling past problem-solving experiences. This not only can help elderly people overcome the cognitive barrier of

resolving problems, but can also rebuild their personal confidence to cope with difficulties. Through support services and treatment programme, the project can reduce depressive symptoms of elderly people and help prevent more serious mental health risks.

According to the WHO's definition, health is a state of complete physical, mental and social well-being. Over the past two years, this project had conducted mental health assessments for nearly 1,500 elderly people, of whom 150 with depressive symptoms took part in our treatment programme to improve their self-efficacy and problem-solving skills. In order to measure the effectiveness, we have invited Dr. Vivian Lou W. Q., Assistant Professor of Department of Social Work & Social Administration, The University of Hong Kong, to conduct an evidence-based evaluation of the project. We are glad to share the project results and achievements with all of you including friends in the social welfare field and the general public through this project report.

The project would not be successful without the donation from The Hong Kong Jockey Club Charities Trust, together with the effective support from CADENZA: A Jockey Club Initiative for Seniors, and the effort from Dr. Lou's research team. I wish to thank all of them as they have provided a great help to allow elderly people living alone or in couples to walk away from a haze of depression and into a bright tomorrow.

Mr. WONG Kam-choi

Chairman of SIK SIK YUEN

List of Tables

List of Figures

List of Appendices


高價收購
電話：9509-2448 伍生
虎骨酒
貴州茅臺
軒尼詩XO
馬爹利
舊版紙幣、連體鈔、兌換券、紀念幣
連體鈔
CD碟
二手名表
上門收購
抽濕機
單膠碟
Sony
遊戲機
劈
先衣機
Hifi
音響
相機
冷氣雪拒
電視機
手提電話
請電、

I. Introduction

This is a report on the CADENZA Community Project: Cherish Our Life: Enhancing Psychological Wellbeing of Elders, a research study funded by the Hong Kong Jockey Club Charities Trust. The study was conducted collaboratively with the University of Hong Kong and Sik Sik Yuen. It aimed to examine the effectiveness of the Instrumental Reminiscence Intervention (IRI) in alleviating depressive symptoms among elders living alone or with their spouse only in the community in Hong Kong. The report outlines the background, methodology, results, and conclusions of the study.

One of the outputs of the study is a Chinese-language manual for use with the Hong Kong adaptation of the IRI (IRI-HK). This is presented in a separate booklet and is aimed at registered social workers and other qualified professionals who specialize in elderly care to reduce depressive symptoms among clients. It is a practical guide based on the research team's experience and practice wisdom gained from the local implementation of the IRI. It is strongly recommended that users also read this research report thoroughly to obtain knowledge about the background to, and theoretical basis of, the IRI and can follow the intervention protocol (in terms of inclusion and exclusion criteria, session plans, homework, and individualized follow up) so as to optimize the effectiveness of the intervention.

II. Background

i. Aging and later-life depression in Hong Kong

The rapidly aging population

Over the past two decades, the population of elderly people in Hong Kong has increased rapidly as a result of higher life expectancy and a decreasing birth rate. In 1991, 482,040 Hong Kong residents were aged 65 or above, or 8.7% of the population (Census and Statistics Department, 2007). The proportion of elders had increased to 11.2% (747,052) in 2001 (Census and Statistics Department, 2007) and further to 13.2% (935,100) in 2011 (Census and Statistics Department, 2012). In 2006, the estimated annual growth rate of the Hong Kong aged population over a five-year period was 2.5% compared with 0.4% for the whole population (Census and Statistics Department, 2008). Moreover, with such rapid growth expected to continue, it has been predicted that the proportion of elders will rise to 28% by 2039 (Census and Statistics Department, 2010). The aging population makes and will undoubtedly continue to make huge demands on Hong Kong's limited resources. At the same time, owing to changes in living arrangements and capacity, elders are encountering various difficulties that prompt the community to give them attention and support.

PROPORTION OF ELDERS IN HONG KONG 1991-2039

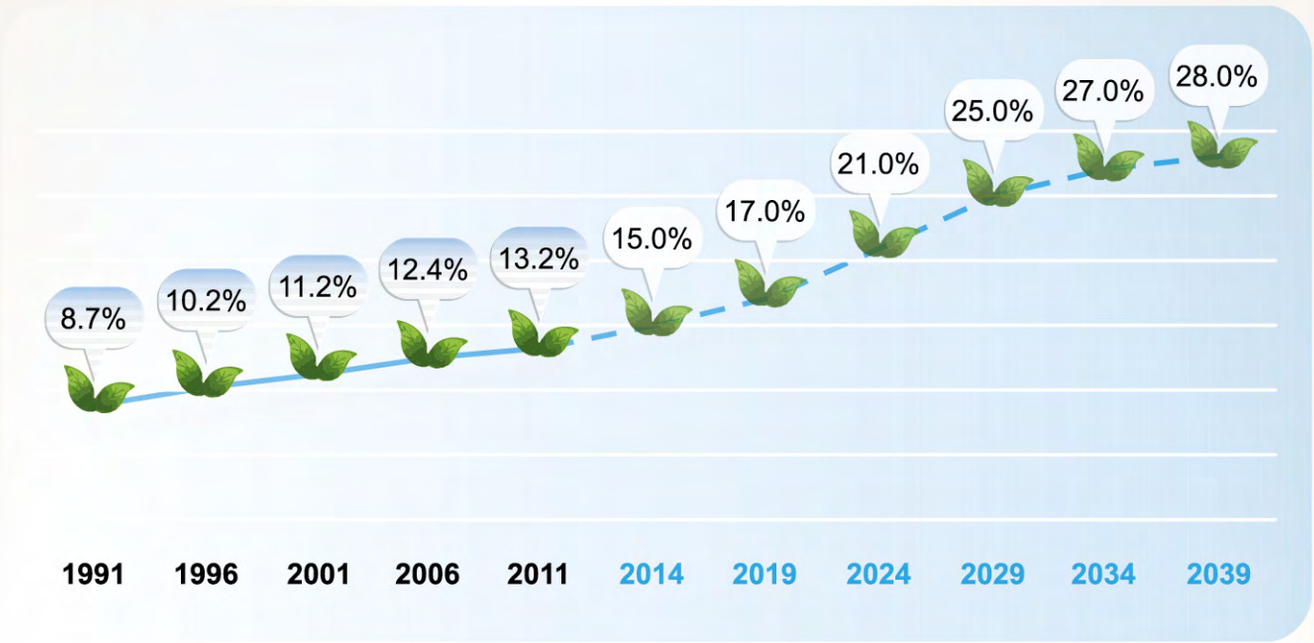


Figure 1
Proportion of elders in Hong Kong 1991-2039

Remarks: Projected figures are shown in dotted lines.

Sources:

Census and Statistics Department, H.K. (2007). ***Demographic trends in Hong Kong 1981-2006***. Hong Kong: Census and Statistics Department, HKSAR. Retrieved from http://www.statistics.gov.hk/publication/stat_report/population/B1120017022007XXXXB0200.pdf

Census and Statistics Department, H.K. (2012). ***Hong Kong in Figures, 2012 Edition***. Hong Kong: Census and Statistics Department, HKSAR. Retrieved from http://www.statistics.gov.hk/publication/general_stat_digest/B1010006201 2AN12E0100.pdf

Census and Statistics Department, H.K. (2010). ***HK population projection***. Hong Kong: Census and Statistics Department, HKSAR. Retrieved from http://www.statistics.gov.hk/publication/stat_report/population/B1120015042010XXXXB0100.pdf

Elders living alone or with their spouse only in Hong Kong

A change in living arrangements is among the most significant shifts experienced as Hong Kong elders have aged. For various reasons, mainly the tendency of adult children to move out of the household, a remarkable proportion of elders now live alone or with their spouse only. According to a thematic report by the Census and Statistics Department (2008), in 2006 about 11.6% of elders lived alone and 21.2% with spouse only, compared to 5.4% and 10.6% of the population as a whole. Not surprisingly, loneliness has been found to be a significant correlate of depressive symptoms among community-dwelling elders (Chou & Chi, 2005). These elders are among the

	Proportion of population					
	1996		2001		2006	
	Elders	Whole population	Elders	Whole population	Elders	Whole population
Community dwellers	94.5%	98.7%	90.9%	97.5%	90.0%	96.7%
Living alone	11.5%	4.3%	11.3%	4.3%	11.6%	5.4%
Living with spouse only	16.2%	9.0%	18.4%	9.3%	21.2%	10.6%
Living with spouse and child(ren)	32.1%	34.4%	34.4%	34.4%	30.4%	32.9%
Living with child(ren) only	28.2%	5.8%	24.7%	5.9%	23.1%	6.5%
Others	6.5%	45.2%	4.4%	43.6%	3.7%	41.3%
Non-community dwellers	5.5%	1.3%	9.1%	2.5%	10.0%	3.3%

Table 1
Living arrangements of elders and the population as a whole in Hong Kong 1996, 2001, and 2006

Sources:

Census and Statistics Department, H.K. (2008). ***2006 Population Census. Thematic Report: Older Persons***. Hong Kong: Census and Statistics Department, HKSAR. Retrieved from http://www.statistics.gov.hk/publication/stat_report/population/B1120053 2006XXXXB0100.pdf

most vulnerable to depression and deserve particular attention in regard to preventive services.

One study comparing Chinese elders living alone and with others in the community (Chou & Chi, 2000) shows that the former are younger and more likely to be single, divorced or widowed. Also, older people living alone self-rate their health as poorer than do those living with others. They tend to have a smaller network of relatives, to have less frequent contact with relatives, and to receive less emotional and instrumental support. Furthermore, older people living alone report a higher level of financial strain, a lower level of life satisfaction, and more depressive symptoms. All these characteristics suggest that this group of elders is at risk for developing depression.

Traditional Chinese cultural values also contribute to the vulnerability of elders living alone in Hong Kong. Dependence on children in later life is a traditional Chinese cultural concept. Living alone is commonly viewed as deviating from this cultural norm and may lead to low self-image. A comparison of elders living alone in Hong Kong and Sweden (So, 2008) indicates that the

former group were more vulnerable to feelings of loneliness and felt less capable of meeting family members because of financial difficulties. Low self-image, loneliness, and lack of family support are all risk factors for developing depressive symptoms.

Depressive symptoms and their impact on the elderly

Depression is a major mental health concern for older people internationally. The World Health Organization (WHO, 2012) has identified depression as one of the major chronic conditions affecting older people worldwide. The active aging framework suggested by WHO advocates that nations should pay attention to depression, which in Hong Kong is often underdiagnosed.

A negative coping style of adaptation is often associated with depression among elders. As they age, people may experience more stress than before as a result of stressful life events and a deterioration in their physical and cognitive ability. A negative coping mechanism in response, including passivity, escapism, and avoidant behaviors (Rohde, Lewinsohn, Tilson, & Seeley, 1990) will induce depressed mood and eventually lead to depression. A recent local study estimates the prevalence of depression among Hong Kong elders aged 60 or above living in the community to range from 10-15% using the Geriatric Depression Scale (GDS-15) cutoff score ≥ 8 (Chi et al., 2005). Local and foreign studies alike have identified several major risk factors for depressive symptoms in elders including poor self-rated health, functional impairment, visual limitation, pain, chronic illness, lack of social support, loneliness, perceived inadequacy of care, stressful life events, and financial strains (Chi et al., 2005; H.-C. Chiu, Chen, Huang, & Mau, 2005; Chou & Chi, 2000; Chou, Chi, & Chow, 2004; Jongenelis et al., 2004). In particular, local research emphasizes that lower levels of self-reported loneliness, higher availability of social support, and satisfaction with such support are all correlated with a lower risk of depression, whereas the occurrence of negative life events is associated with more depressive

Figure 2
Illustration of the impact of loneliness and depressive symptoms on the elderly

symptoms (Chi et al., 2005; Chou & Chi, 2005).

The impact of depressive symptoms among the elders cannot be neglected. It has been shown that such symptoms are among the major risk factors contributing to suicidal ideation (Yip et al., 2003). In a recent local cohort study involving 56,000 Chinese elders in Hong Kong, the presence of depressive symptoms significantly predicted suicide (Sun, Xu, Chan, Lam, & Schooling, 2012). The suicide rate of Hong Kong residents aged 65 or above in 2010 was 28.9 per 100,000, compared with 13.6 per 100,000 for all ages (HKJC Centre for Suicide Research and Prevention, 2012). It is suggested that urgent action is required to reduce the suicide risk among elderly people.

Wong Tai Sin and Sham Shui Po: Aging districts with high elder suicide rates

In the current study, Wong Tai Sin and Sham Shui Po, two districts in Hong Kong, were selected for investigation and intervention. In 2011, the proportion of elders in Wong Tai Sin (17.6%) and Sham Shui Po (17.0%) were the highest among all districts in Hong Kong, followed by Kwun Tong (16.3%) and Kowloon City (16.0%), compared with 13.3% of the whole population (Census and Statistics Department, 2013). Moreover, the estimated proportion of elders living alone or with their spouse only in Wong Tai Sin (29.6%) and in Sham Shui Po (34.5%) in 2006 was higher than that among all districts in Hong Kong (30.4%).

	Wong Tai Sin	Sham Shui Po	All districts in Hong Kong
Proportion of elderly (2011)	17.6%	17.0%	13.3%
Proportion of elderly living alone or with spouse only (2006)[1]	29.6%	34.5%	30.4%
Elderly suicide rate (2006)	31.8 per 100,000	33.2 per 100,000	27.4 per 100,000

Table 2
Characteristics of older adults in Wong Tai Sin and Sham Shui Po compared to all districts in Hong Kong

1 Estimated figures from the findings of the Hong Kong Council of Social Service reports.

Sources:

Census and Statistics Department, H. K. (2013). ***2011 Population Census. Thematic Report: Older Persons***. Hong Kong: Census and Statistics Department, HKSAR Retrieved from http://www.statistics.gov.hk/pub/B112006420 13XXXXB0100.pdf

The Hong Kong Council of Social Service (2012). ***Demographics of the low-income population in Wong Tai Sin***. Hong Kong: The Hong Kong Council of Social Service. Retrieved from http://www.hkcss.org.hk/pra/report_card/wongtaisin.pdf

The Hong Kong Council of Social Service (2012). ***Demographics of the low-income population in Sham Shui Po***. Hong Kong: The Hong Kong Council of Social Service. Retrieved from

http://www.hkcss.org.hk/pra/report_card/shumshuipo.pdf

HKJC Centre for Suicide Research and Prevention, H. (2008). ***Report on Hong Kong Suicide Deaths in 2006***. Hong Kong: HKJC Centre for Suicide Research and Prevention, The University of Hong Kong.

According to the Centre for Suicide Research and Prevention, elderly people living in Wong Tai Sin or Sham Shui Po are at a higher risk of suicide than those in other districts. The elderly suicide rates of these areas in 2006 were relatively high (31.8 per 100,000 in Wong Tai Sin; 33.2 per 100,000 in Sham Shui Po), compared to 27.4 per 100,000 among all districts (HKJC Centre for Suicide Research and Prevention, 2008). Wong Tai Sin and Sham Shui Po were thus selected as the sites for this project in order to explore elderly mental health enhancement interventions and suicide prevention.

The current study investigates the use of the IRI as a means to enhance the psychological wellbeing of elders. Depressive symptoms among elders in Hong Kong should not be neglected. Social service providers and policymakers

are urged to act to improve their mental health and quality of life. IRI, an intervention which aims to alleviate depressive symptoms and prevent suicide in the community, could be a tool to reduce the burden such problems place on the health care system. The next section outlines the rationale for this intervention.

ii. Rationale of the intervention approach

Manifestation of mental illness in Chinese culture

Later-life depression among Chinese populations is commonly unrecognized and undertreated in gerontological care settings. Suffering from the symptoms of depression makes elders feel less satisfied with their current lives, less outgoing, and less engaged in hobbies which they previously enjoyed. These characteristics make them invisible to health professionals. Furthermore, elderly people living alone or with their spouse only have less family support and less of a connection to the available social resources. Identification and service provision for depressed elders in these circumstances is an especially difficult task.

Instead of presenting with the mental suffering associated with depression, Chinese older adults tend to somatize their emotional symptoms. Somatization is a pattern of behaviors in which an individual presents with a set of somatic symptoms (that is, they report bodily rather than mental or emotional symptoms). One study in Macau shows that over 50% of older Chinese people present somatically at their first medical consultation for depression (Piterman & DaCanhota, 2001). Instead of indicating the presence of a mental pathology, Chinese elders often make physical complaints as a coping response to psychological distress (Kleinman, Anderson, Finkler, Frankenberg, & Young, 1986). This emphasis on bodily sensations interferes with their direct communication of mental experiences as well as help-seeking behaviors.

Public mental health services in Hong Kong are currently inadequate and not accessible enough to cater for the needs of the elderly population. Elders usually visit general outpatient clinic services in hospitals or private family doctors for medical consultations. Specialist clinics such as Psychiatric and Geriatric Services require referrals from general practitioners (GPs) but the tremendous demand on the general clinic service means most GPs do not have enough time to carry out a proper mental state examination. A proportion of elders with depressive symptoms or other mental illnesses thus remain unrecognized in the community. The limitations in the current mental health system present the huge challenge of identifying elders with mental illness within professional services.

Help-seeking behavior of Chinese older adults with mental ill-health

Chinese older adults with mental illness are usually reluctant to seek help because of stigma. Heavily influenced by traditional Chinese culture, they feel embarrassed to express feelings of loneliness and sadness and perceive such expression as a sign of weakness. Depression and other mental illnesses are often viewed as a form of madness or insanity. Some may even attribute depression to unknown or spiritual forces. Informal support from families, friends, or religious leaders (Leung, Cheung, & Tsui, 2012) will likely be the preferred choices of elders experiencing mental health problems. The stigma of mental illness associated with Chinese cultural values contributes to a low motivation to seek formal help among the elderly.

The misunderstanding of mental illness and psychotherapy among Chinese elders also affects their help-seeking behaviors. The most common stereotype of mental health within the Chinese community is that it is a Western problem of the mind and that a typical Chinese individual should not be affected by it. They regard depression as a private everyday experience, distinct from illness, disorder, or disability, that prohibits seeking help from formal mental health services (Draguns, 1996). Psychiatric specialties or psychological consultations

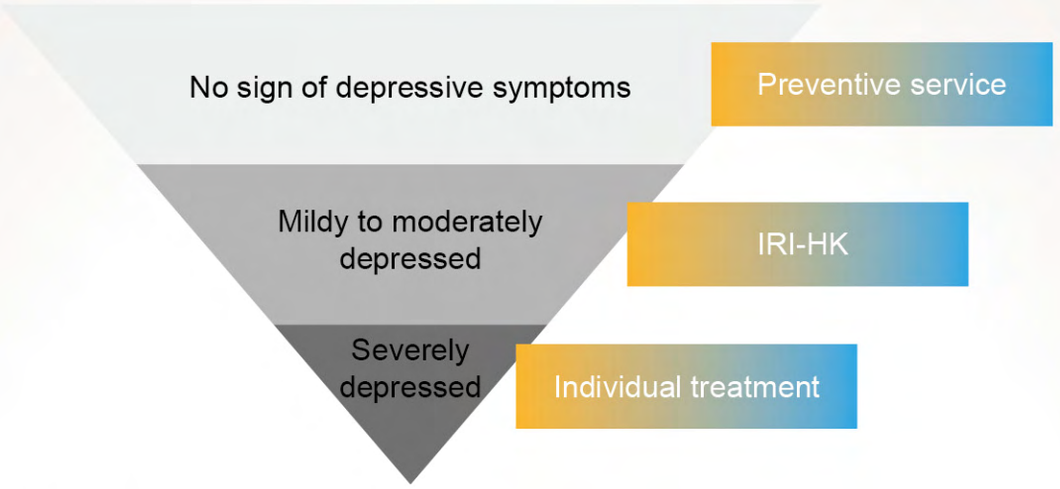


Figure 3
A three-tier intervention model for treating depressive symptoms among elders living alone or with spouse only

Sources:
Lou, W. Q. V., Tsang, S. W. P., & Choy, C. P. J. (2012). Treating Depressive Symptoms among Living Alone Older Adults in Wong Tai Sin: A District Elderly Community Centre Initiative. Paper presented at the 19th Annual Congress of Gerontology, Hong Kong.

are considered Western and modern concepts to Chinese elders. Their lack of knowledge and experience about mental illness and psychotherapy poses another obstacle to formal help-seeking when they suffer from mental illness.

Furthermore, Chinese daily life is highly family oriented. It is widely believed that support from a closely connected family or ethnic community can enable someone to deal effectively with stressors without external intervention (Leung et al., 2012). Even when Chinese elders decide to seek help about mental illness, their decision to do so will probably also depend on their family members' opinions. Since Chinese people tend not to seek help from formal services for mental illness, this tendency further limits their help-seeking initiative. In addition, as family has a high priority in daily life, family activities may hinder elders' participation in psychotherapy or other forms of intervention.

A three-tier intervention model

The situation of elders living alone in the community and who are at a high risk of developing depressive symptoms denotes an indicated prevention approach. Indicated prevention targets "high-risk people who are identified as having minimal but detectable signs or symptoms foreshadowing mental disorder or biological markers indicating predisposition for mental disorder

but do not meet diagnostic criteria for disorder at that time" (p. 25) (Mrazek & Haggerty, 1994). Among the interventions for depression, either at the individual or group level, the cognitive approach is one of the most widely applied and studied (Dozois & Dobson, 2004; Ingram, 1990). A three-tier model of intervention involving IRI, which employs the key elements of cognitive approach, is discussed and explored in this study.

The authors propose a three-tier model for treating depressive symptoms among older adults living alone or with spouse only in the community (Lou, Tsang, & Choy, 2012) (Figure 3). In this model, older adults are categorized into three groups according to their level of depressive symptomatology. In the first tier, preventive services such as mental health talks are offered to elders showing no signs of depression. In the second tier, the IRI-HK as proposed in this study is implemented for elders with mild to moderate levels of depressive symptoms to mobilize their coping resources to handle stress in daily life. Their self-esteem and -efficacy can be increased as they gain a better sense of control over stressors and daily problems so that depressive symptoms can be alleviated (Watt & Cappeliez, 2000). In the third tier, individual treatment is provided promptly by a multidisciplinary team consisting of a clinical psychologist, a social worker, and a nurse to effectively treat severe depressive symptoms. The proposed three-tier model of intervention enables District Elderly Community Centres (DECCs) to address the needs of older adults living alone with the appropriate allocation of resources so as to prevent and treat depressive symptoms.

This study evaluates the effectiveness of IRI in alleviating depressive symptoms in the second tier of the proposed model. A meta-analysis (Bohlmeijer, Smit, & Cuijpers, 2003) shows that reminiscence and life review intervention significantly reduce depressive symptoms among elders, with an overall effect size of 0.84 (95% CI = 0.31 to 1.37). Other recent reviews (Hsieh & Wang, 2003; Lin, Dai, & Hwang, 2003) and meta-analyses (Bohlmeijer, Roemer, Cuijpers, & Smit, 2007) also indicate that reminiscence can be an

effective intervention for alleviating depression and improving psychological wellbeing in the older population.

As discussed above, many elders with depressive symptoms do not seek appropriate assistance and remain untreated in the community. Given the underrecognition and cultural stigma of depression among Chinese elderly people, the authors recommend this nonstigmatizing approach, which involves the identification of depressed elders in the community living alone or with spouse only followed by the targeted provision of IRI to promote healthy ageing in Hong Kong.

iii. Theoretical framework

The IRI developed by Professor Philippe Cappeliez was adopted and modified for local use. A guide outlining the development of the original IRI manual was obtained from Professor Cappeliez solely for use in the development of the IRI-HK in this study. Close contact with Professor Cappeliez was maintained throughout in order to obtain his opinion on the research team's theoretical and practical understanding of the intervention manual. As a result, the IRI-HK was developed with suitable cultural adaptations. Differences between Western and Chinese elders might lead to difficulties in the use of IRI in Hong Kong. The development of the IRI-HK aimed to promote the use of IRI more widely as an effective tool for alleviating depressive symptoms that can be used by elderly social service providers.

Definition of reminiscence and its uses

Reminiscence is the conscious or unconscious act or process of recollecting memories of one's self in the past (Bluck & Levine, 1998). Watt and Wong (1991) propose a widely-adopted taxonomy of reminiscence which identifies six different types as follows. Integrative reminiscence is a type of life review in which individuals achieve an integrated view of their past life by resolving conflicts, accepting the difference between past and present, finding the

meaning of life, and preparing for their own death. Instrumental reminiscence refers to recollection of the problem-solving and coping behaviors one has used in the past. Transmissive reminiscence involves passing knowledge of a cultural heritage or personal legacy to the next generation. Narrative reminiscence includes a descriptive recalling of autobiographical information or facts and past anecdotes. Escapist reminiscence refers to the recollection of memories which glorify the past and deprecate the present. Obsessive reminiscence is the reiteration of negative memories which trigger feelings of guilt, bitterness, and despair.

The therapeutic uses of reminiscence in reducing depressive symptoms for elders have been widely studied and evaluated (Karimi et al., 2010; Pot et al., 2010; Serrano, Latorre, Gatz, & Montanes, 2004; Stinson, Young, Kirk, & Walker, 2010; Wang, 2007; Watt & Cappeliez, 2000; Wu, 2011). Among the six reminiscence types, integrative and instrumental are thought to be associated with mental health improvement (Wong, 1995). The former focuses more on cognitive appraisal and restructuring, while the latter aims at developing adaptive coping by drawing on successful previous experiences (Watt & Cappeliez, 2000).

Instrumental reminiscence was adapted and applied in this project for two reasons. Firstly, the level of education of the current cohort of older people in Hong Kong is comparatively lower than that of Western elders and accordingly an instrumental approach might be more suitable. Secondly, the instrumental approach is essentially pragmatic insofar as it emphasizes problem solving and adaptive coping with reality. Accordingly, it is expected to help older people living alone to focus on the problems in daily life that are currently causing their depressive symptoms.

Retrieval of past coping strategies

Instrumental reminiscence mainly focuses on the recollection of problem-solving experiences. It involves recalling memories of past goal-directed activities and plans, the attainment of goals, previous attempts to overcome difficult situations for oneself or others, and referring to past experience to solve present problems (Watt & Wong, 1991). It is closely associated with the use of problem-focused coping strategies, which have been shown to be an important factor in combating depression. It also reflects a sense of internal control and mastery over life stressors, which has been shown to mediate the relationship between the presence of such stressors, cognitive appraisals of their importance, and the onset of depression (Cappeliez & O'Rourke, 2006).

In the IRI intervention, the therapist helps an elder to identify and recollect successful problem-solving experience in the past in which they acted effectively to control their environment and stressors. Individuals who found themselves to be capable of managing such negative life events are more likely to view these events as challenges and to cope effectively with the problems they cause (Watt & Cappeliez, 2000). Experience of adaptive coping provides people with a positive sense of self-esteem and efficacy, which are important safeguards against the onset of depression.

Moreover, by recalling successful problem-solving strategies, elders are encouraged to use an active and problem-focused coping response to present issues. It has recently been shown that older adults who cope successfully with depression tend to use an active and problem-solving approach (Watt & Cappeliez, 2000). A problem-focused coping response involves a deliberate goal-oriented effort to alter the situation, coupled with an analytic approach to solve the underlying problem (Folkman & Lazarus, 1986). During the IRI, after mobilizing and consolidating the coping resources recalled from the past, the therapist will go on to encourage the client to use a problem-focused coping approach, which has been identified as anti-depressive, to address their current life circumstances.

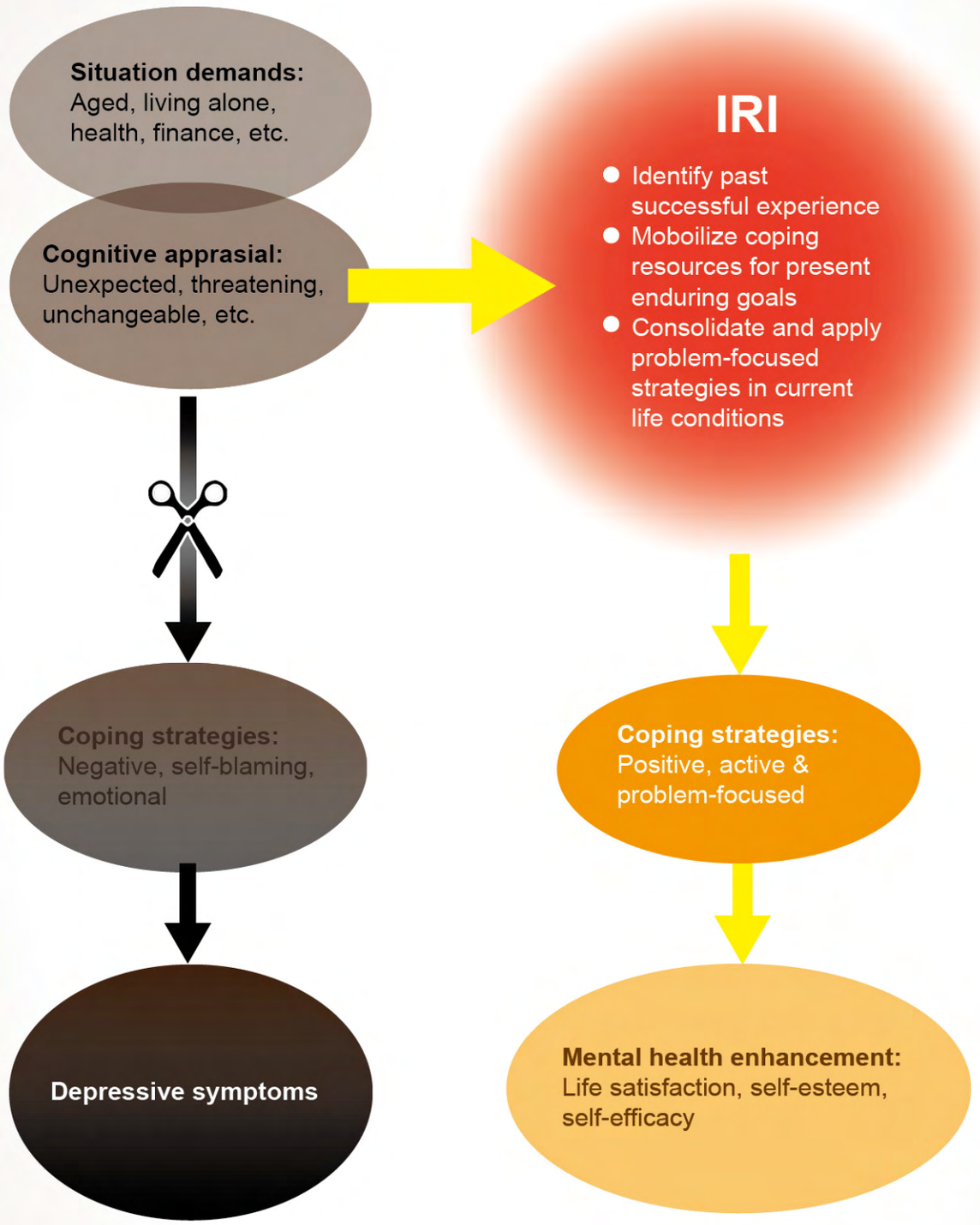


Figure 4
A conceptual framework of the effect of the IRI on elders with depression

Application of cognitive restructuring

Cognitive restructuring is involved during the process of IRI when the therapist attempts to change the elderly client's thoughts to help him or her cope with the current problems.

At the beginning of cognitive restructuring, the therapist should identify the elders' thoughts during problem situations (Cormier & Cormier, 1998). It is important to identify enduring goals and renounce those commitments which are no longer rewarding or attainable. For example, changes in physical health, financial status, or social support may inevitably lead to changes in elders' capacity to accomplish their goals. If they cannot accept the change of role and continue retain previous goals which are no longer attainable, they will struggle without reward, experience a reduction in morale, and fail in adaptive coping (Watt & Cappeliez, 2000). Therefore, it is essential to identify elders' thoughts and support them to reevaluate their goals in the light of present circumstances.

Once relevant and irrelevant sources of stress have been identified, adaptive thoughts can be introduced to assist the elders to shift from self-defeating to coping approaches (Cormier & Cormier, 1998). During the intervention, elders will become motivated to undertake a challenge-oriented secondary appraisal of their ability to meet life stressors (Watt & Cappeliez, 2000). From their own recollection, problem-solving skills which promote challenge appraisals might be identified. Through reminiscence, the elders can achieve successful coping by deciding on an appropriate solution, which they have adopted in the past, for use with the present problem. Instrumental memories will help the elders identify the possibilities for change and adaptation that exist in a stressful situation. Coping with daily problems and stressors would become more feasible through the development of meaningful goals and the practice of coping activities (Watt & Cappeliez, 2000). Elders will thus become more capable of treating negative experiences as a challenge and taking an active approach to problem solving.

Conceptual model illustrating the impact of the IRI for elders with depressive symptoms

The IRI involves three core elements as follows:

1. Identifying and recollecting successful experiences in which one acted effectively and competently to control the environment.
2. Mobilizing coping resources collected from past experiences to seek alternative solutions for achieving long-term goals within current living conditions (particularly living alone).
3. Consolidating problem-solving strategies by focusing on the recall of successful approaches used in the past that can be applied to current circumstances.

Based on a stress and coping framework, depression results from the interplay among the situational demands experienced by individuals, their cognitive appraisal of their coping resources, and their coping responses (Billings & Moos, 1982). Instrumental reminiscence breaks this loop by changing the person's appraisal of the current situation, enhancing a sense of mastery and competence, and eventually cultivating a positive self-image and problem-solving approach in response to environmental demands (Cappeliez & O'Rourke, 2006).

Past application of the IRI in Hong Kong and other countries

The IRI has been used and evaluated in Hong Kong. The HKSKH Lady MacLehose Centre (Liang, Feng, & HKSKH Lady MacLehose Centre, 2005) conducted IRI in order to alleviate depressive symptoms in elders. Like this study, it followed the practice guide developed by Professor Cappeliez, who originally developed IRI. Though this was not an empirical study, it provided us with important information and practice notes for the application of IRI in Hong Kong in future.

Furthermore, Watt and Cappeliez (2002) in their study of alleviating depression in elders showed that use of the IRI resulted in a significant decrease in GDS-15 scores. Another, similar study by Karimi et al. (2010) also revealed that participating elders' GDS-15 scores fell from 9.22 to 7.02, reflecting a change from moderate to mild depression. They found that the IRI had a clinically though not statistically significant effect on reducing depressive symptoms.

The effectiveness of IRI in reducing elders' depressive symptoms is therefore supported by some empirical findings. Exploration of its practice and an evaluation of its effectiveness are essential steps in order to confirm the IRI-HK as an alternative approach for use in elderly services in Hong Kong. In the current study, a team drawn from two different organizations developed the IRI-HK to be applicable in the local context and evaluated its effectiveness.

III. Project Design and Research Methods

i. Objectives

The project set out to evaluate the effectiveness of the IRI in reducing depressive symptoms among older people living alone in Hong Kong. In particular, it aimed to:

- Develop a culturally adapted IRI-HK for use with Chinese older adults in Hong Kong;
- Evaluate the effectiveness of the IRI-HK in reducing depressive symptoms among Chinese older adults living alone or with spouse only in Hong Kong.

ii. Participants

All participants were drawn from the Wong Tai Sin and Sham Shui Po districts in Hong Kong. A total of 1,473 community-dwelling elders, all of whom were members of District Community and Neighborhood Centres for Senior Citizens (Sponsored by Sik Sik Yuen) were recruited via these centres and screened by trained researchers. Twenty-nine failed to complete the questionnaire due to cognitive impairments or use of a different dialect, resulting in 1,444 participants completing the screening questionnaire. Of these, 150 were invited to take part in the intervention as they met the following criteria for inclusion:

1. 60 or older;
2. Living alone or with spouse only, in the community;
3. Mild to moderate level of depressive symptoms as shown by a score of 8-13 on the GDS-15 Chinese version (Lee, Chiu, & Kwong, 1994); and
4. Not currently taking antidepressant medication, or if doing so, being stable on that medication for at least three months.

Participants who demonstrated any of the following characteristics were excluded from the study:

- Elevated risk of suicide;
- Substance abuse;
- Any psychiatric disorder other than primary depression;
- Cognitive impairment, as indicated by a score lower than 24 (for those with middle school or higher education) 21 (elementary education) or 18 (no schooling), respectively, on the Mini-mental State Examination (MMSE) Chinese version (Chiu, Lee, Chung, & Kwong, 1994) ;
- Physical impairment that would have seriously hindered the individual from joining the group program; or
- Currently participating in any other psychological and/or long-term care intervention.

iii. Procedures

Recruitment and randomization

At the beginning of the screening procedure and intervention session, informed consent was obtained in writing from each participant (see Appendix II).

All participants were recruited by phone to take part in a screening interview conducted by a trained researcher. After the screen, participants meeting the

	1st round	2nd round	3rd round	4th round	Total
Screened elders	251	321	399	473	1444
IRI participants	27	34	36	53	150
Experimental group	13	19	15	26	73
Control group	14	15	21	27	77

Table 3
Number of participants included

selection criteria were invited to participate in the intervention. Those who consented to join were randomly assigned to either an experimental or control group.

Since each group could only accommodate about seven or eight elders, participants were brought into the study in four different rounds. The same screening criteria and randomization procedures were adopted in each round.

A total of 150 participants were enrolled in the study with 73 in the experimental and 77 in the control groups. Depending on the number of participants in each round, more than one intervention group was arranged to accommodate everyone who wanted to join. The number of participants included in each round is listed in Table 3.

A waiting-list control pre-post research design was adopted. Since the project targeted a high-risk population with detectable signs or symptoms of depression, a waiting-list design was ethically preferable to using a no-treatment group. The waiting-list control design has been widely adopted in evaluative studies of depression (Posternak & Miller, 2001). In this study, the experimental and waiting-list control groups were each provided with the IRI intervention immediately and 12 weeks (that is, twice the six-week intervention time), respectively, after the baseline assessment.

In order to overcome potential threats to the validity of the study, such as

selection bias, two strategies were adopted. Firstly, members of the elderly centre were randomly assigned to one of the four rounds for invitation. Secondly, randomization was adopted to assign the selected participants to either the experimental or the waiting-list control group in each round.

The IRI consisted of six structured weekly sessions and two follow-up meetings held two and six weeks after the final session. The waiting-list control group was offered no treatment during the waiting period. There was no restriction preventing the participants from joining in with the activities organized by the elderly centre.

Figure 5 illustrates the flow of participants throughout the stages of the study. A full intervention and assessment schedule for the project can be found in Appendix I.

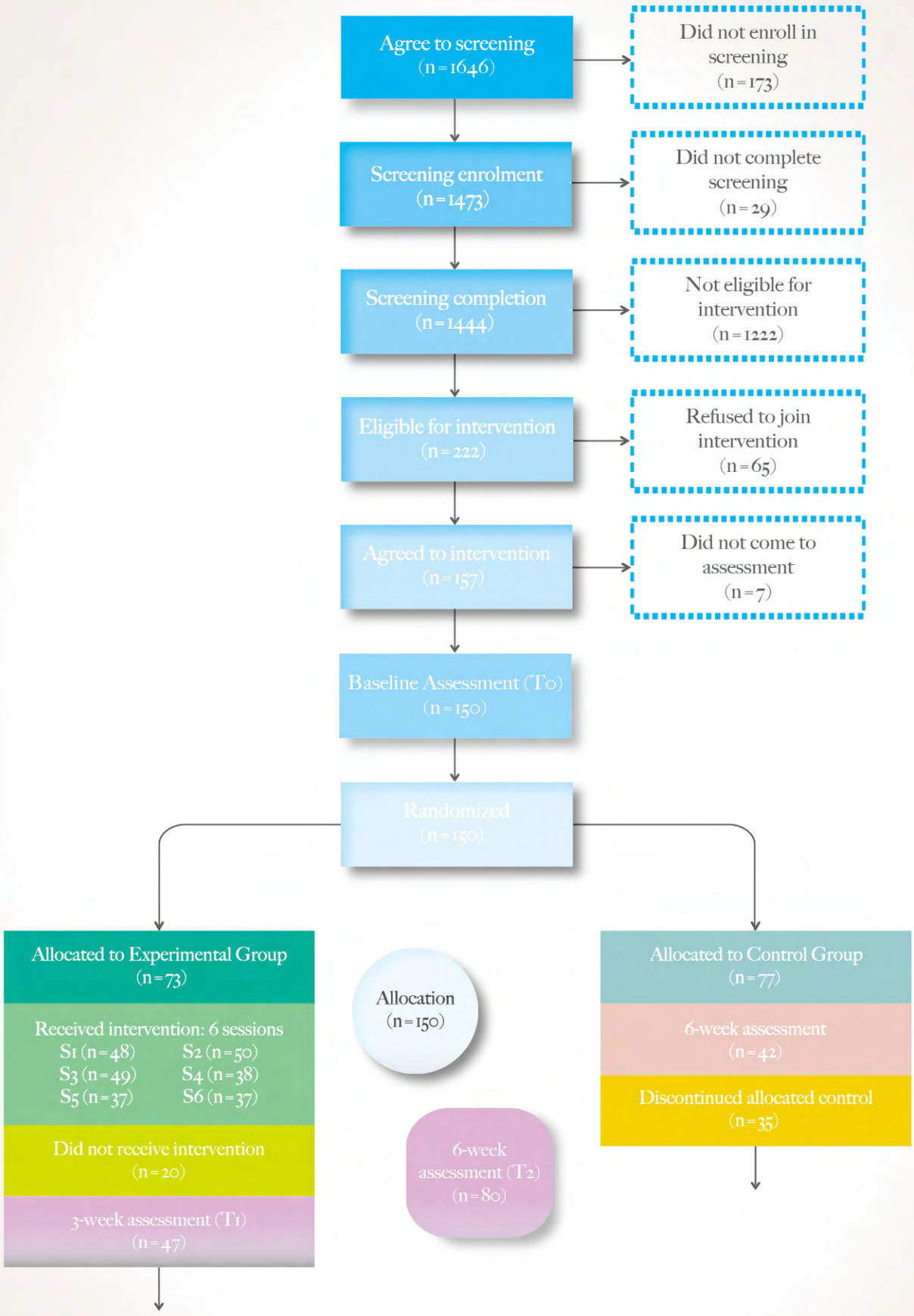
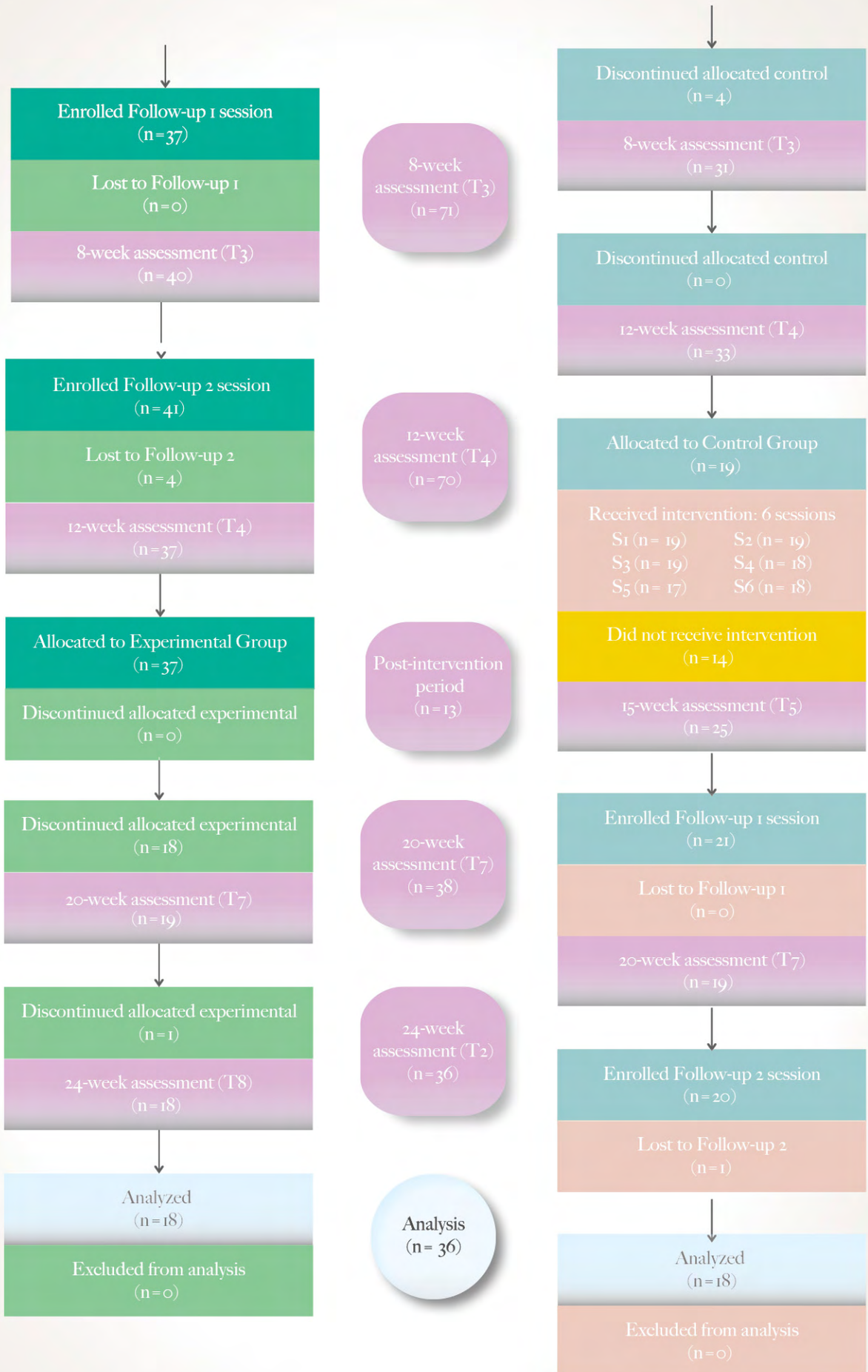


Figure 5
Changes in the number of participants throughout the study


Enrolled Follow-up 1 session (n=37)
Lost to Follow-up 1 (n=0)
8-week assessment (T3) (n=40)
8-week assessment (T3) (n=71)
Discontinued allocated control (n=4)
8-week assessment (T3) (n=31)
Enrolled Follow-up 2 session (n=41)
Lost to Follow-up 2 (n=4)
12-week assessment (T4) (n=37)
12-week assessment (T4) (n=70)
Discontinued allocated control (n=0)
12-week assessment (T4) (n=33)
Allocated to Experimental Group (n=37)
Discontinued allocated experimental (n=0)
Post-intervention period (n=13)
Allocated to Control Group (n=19)
Received intervention: 6 sessions
S1 (n= 19) S2 (n= 19)
S3 (n= 19) S4 (n= 18)
S5 (n= 17) S6 (n= 18)
Did not receive intervention (n=14)
15-week assessment (T5) (n=25)
Discontinued allocated experimental (n=18)
20-week assessment (T7) (n=19)
20-week assessment (T7) (n=38)
Enrolled Follow-up 1 session (n=21)
Lost to Follow-up 1 (n=0)
20-week assessment (T7) (n=19)
Discontinued allocated experimental (n=1)
24-week assessment (T8) (n=18)
24-week assessment (T2) (n=36)
Enrolled Follow-up 2 session (n=20)
Lost to Follow-up 2 (n=1)
Analyzed (n=18)
Excluded from analysis (n=0)
Analysis (n= 36)
Analyzed (n=18)
Excluded from analysis (n=0)

Referral mechanism

After the screening assessment, if any elders were identified as presenting with either severe depression (GDS-15 score ≥ 14) or suicidal ideation, they were referred to a registered social worker or clinical psychologist for immediate follow up in order to prevent any serious consequences arising.

Assessment procedure

All of the assessments in the current study were conducted in an individual face-to-face setting. The questions were verbally administered in Cantonese by trained researchers.

The screening questionnaires took 15-20 minutes per person to complete and included measures of cognitive functioning, depressive symptoms, demographics, history of mental illness and medication, the use of elderly care or counseling services, and the presence of suicidal thoughts (Appendix III). Elders who matched the screening criteria were invited to take part in the intervention and assessment.

Participants were assessed at baseline (T0), 3 weeks (T1), 6 weeks (T2), 8 weeks (T3), 12 weeks (T4), 15 weeks (T5), 18 weeks (T6), 20 weeks (T7), and 24 weeks (T8) (refer to Appendix I).

At T0, T2, T4, T6, and T8, participants completed a full set of standardized measures of depressive symptoms, life satisfaction, self-rated health, self-rated financial adequacy, and social network (Appendix IV)

At T1, T3, T5, and T7, participants were assessed using a briefer set of measures of depressive symptoms, life satisfaction, self-rated health, and self-rated financial adequacy (Appendix V).

Table 4 lists the item distribution in the questionnaires.

Pre-intervention individual interview

Individual interviews were conducted before the implementation of the IRI. During the interview, participants were asked about their hobbies, past working experiences, favorable and unfavorable people or

Domain	Screening	Full set (T0, T2, T4, T6, T8)	Brief set (T1, T3, T5, T7)
Demographics and background information			
Gender	✓		
Age	✓		
Highest education attainment	✓		
Marital status	✓		
Number of children	✓		
Religious belief	✓		
Major sources of finance	✓		
Mental illness and medication history	✓		
Use of elderly care or counseling services	✓		
Suicidal thoughts	✓		
Outcome measures and other variables			
Cognitive functioning	✓		
Depressive symptoms	✓	✓	✓
Life satisfaction		✓	✓
Self-rated health		✓	✓
Self-rated financial adequacy		✓	✓
Social support network		✓	

Table 4
Item distribution in questionnaires

events, medical conditions, family, lovers, friends, values, significant events, and current difficulties and challenges. This was intended to enable the therapists to better understand the participants and hence prepare for the intervention more effectively.

iv. Measures

Cognitive functioning. The MMSE Chinese version (Chiu et al., 1994) was adopted to measure the cognitive functioning of the elders. It is a widely adopted measure in Hong Kong. Ten items with a maximum total score of 30 cover participants' orientation, memory, attention, object naming, ability to follow verbal and written commands, ability to compose a complete sentence, and ability to copy a complex polygon. A higher score indicates a higher level of cognitive functioning.

Cognitive functioning was one of the selection criteria for the intervention participants. Different cut-off points of the MMSE score were applied to elders with different levels of education in order to discriminate between cognitively impaired and normal participants. Cut-off points of 17/18, 20/21, and 23/24 were adopted for elders with no schooling, elementary education, and secondary level or above, respectively.

Primary outcome

Depressive symptoms. The Chinese version of the Geriatric Depression Scale-Short Form (GDS-15) (Lee et al., 1994) was used to measure the elders' depressive symptoms. It is a 15-item scale with a maximum score of 15. For each item, participants are asked to indicate whether or not they have experienced a particular depressive symptom in the week preceding the interview. Their responses (0: No, 1: Yes) are then summed to obtain a scale score ranging from 0 to 15. A higher score reflects a higher level of depression.

Depressive symptoms was another important selection criterion for the intervention participants. Participants with a GDS-15 score ranging from 8-13

were considered mildly to moderately depressed and were invited to take part in the intervention group. A GDS-15 score of 14-15 indicates the presence of severe depression and accordingly such participants were referred to suitable clinical or counseling services.

Secondary outcome

Life satisfaction. This was measured using the Life Satisfaction Scale-Chinese (LSS-C) (Lou, Chi, & Mjelde-Mossey, 2008). This consists of eight items, each representing one of eight specific life domains, plus one item measuring overall life satisfaction. The items cover family relationships, intergenerational communication, friendships, partner, food/meal, finance, housing, and health. Responses are collected using a scale ranging from 0= very dissatisfied to 4= very satisfied. A scale score is obtained by dividing the total item score by eight (or the number of valid response). A higher score is associated with a higher level of life satisfaction.

Control variables

Self-rated health. This was assessed by a single item. Participants were asked to rate their overall health at the present time using a 5-point scale (0=very poor, 1= poor, 2= fair, 3= good, and 4= very good). Self-rated health is frequently used to assess the health condition of older adults including the Chinese population (Bjorner et al., 1996; Chi & Boey, 1993).

Self-rated financial adequacy. Self-rated financial adequacy was measured by a single item. Participants were asked to indicate whether they had enough money to cover their daily expenses using a 5-point scale (0= very inadequate, 1= inadequate, 2= just enough, 3= adequate, and 4= adequate). This item is widely adopted to measure the financial status of the elderly and has been shown to demonstrate satisfactory reliability and validity among Chinese elder populations (Chou & Chi, 1999).

Social support network. The Lubben Social Network Scale (LSNS) was

used to measure the social support and network available to the elders overthe past three months (Lubben, 1988). It consists of a 12-item scale with half of the items measuring family support and the other half support from a friends' network, both using a 6-point scale for responses. The questions cover the number of family members and friends the person has, and the frequency of contact. The scale and subscale scores (that is, family or friends) range from 0-60 and 0-30, respectively. A higher score indicates more social support.

Demographics. Demographic and other background information was also collected in the screening. This included the participants' gender (1= male, 2= female), age, highest educational attainment (1= no schooling, 2= primary education, 3= junior or senior secondary education, 4=tertiary education or above), marital status (1= never married, 2= separated, 3= divorced, 4= widowed, 5= married and living with spouse, 6=other), number of children, religious belief (1= no religion, 2= Chinese traditional beliefs, 3= Christian, 4= Catholic, 5= Islam, 6= Buddhism, 7= Taoism, 8= other), major sources of finance (pension, Comprehensive Social Security Assistance (CSSA), Old Age Allowance (OAA), wages, family support, Disability Allowance (DA), savings, and so on), their history of mental illness and medication, their use of elder care or counseling services, and the presence of suicidal thoughts in the month prior to assessment.

v. Monitoring of group process

Several measures were used to monitor the group process and delivery of the intervention.

An observer was assigned to each group to assist the therapist and observe the participants (Lillehoj, Griffin, & Spoth, 2004). Instead of leading the group discussion actively, the observer was responsible for rating the participants' performance on a specialized observation form. The following areas were covered in the observation; willingness to join in, attention, interaction, participation, enjoyment, and homework completion (Appendix V)

Moreover, a regular reflective debriefing was also held after every intervention session in which the therapist and observer shared their opinions and evaluated the improvement in each participant.

In addition to these two measures, an individual profile was kept to record changes for each participant during the intervention period. A research assistant was responsible for updating the record regularly and sharing it with the therapist after each assessment.

vi. Retention strategies

Older adults with depressive symptoms are very likely to isolate themselves and withdraw from social activities. In order to increase their engagement with the intervention, it was necessary to build a good rapport with them and also to include some motivational incentives (Coday et al., 2005; Curry & Jackson, 2003; Levkoff & Sanchez, 2003; Marx, Cohen-Mansfield, & Guralnik, 2003).

Rapport building

Three core elements for good rapport building were identified by the therapists during their practice of the IRI.

Firstly, empathy is essential for understanding the participants' experiences and building good communication. During the group discussion, participants would share many experiences that the therapist might not have experiences, such as war, imprisonment, the loss of a home, the death of a spouse, severe illness, and so on. The therapist should try to listen actively, understand the participants' feelings in these situations, follow their thoughts, and respond in a clear and concise manner. Empathy paves the way for communication and allows the participants to feel the therapists' care.

Secondly, sincerity is another key to helping participants effectively. As the participants always spoke about their current problems in the group, the therapists needed to take this seriously and interact sincerely. Otherwise, if

words are spoken carelessly, relationships will be damaged. Furthermore, appreciation and heartfelt admiration can create a trustworthy environment and enhance cohesiveness among participants. These are important factors in motivating the elders' continued participation. Sincerity facilitates participants' learning about problem solving and gives rise to better relationships within the group.

Last but not least, mutual respect between therapist and participant is necessary for effective learning in the IRI. The therapist should note that instead of taking a leading or guiding role, the IRI emphasizes a parallel relationship with the participant. Being a peer who respects and walks with the elders is more important than being a leader. Moreover, participants should be given equal opportunities to share experiences and express opinions. It is the therapist's main job to maintain this balance so that participants can learn from each other's stories and comments. In our practice, a card illustrating a coping strategy was given to the participant who had shared it, as a sign of recognition and appreciation of their contribution. If some participants are reluctant to express their feelings, the therapist should not force them to speak up but respect their choice and encourage their participation in a subtle way. Mutual respect among group members is crucial in the IRI in order to build sustainable relationships and encourage active participation.

Use of token reinforcement system and gifts

A token reinforcement system and gifts were also used as motivational incentives (Coday et al., 2005) for the participants. The choices of gifts were made after serious consideration of the needs of community-dwelling elders.

Gifts were given to the participants every time they attended an assessment session. They included daily necessities (such as tableware), food (such as oatmeal, instant Chinese soup packs, biscuits), healthcare products (such as a cold and hot pack), and health checks (such as a blood sugar or cholesterol test). Among these, food was the most popular gift (except for soup, as elders

living alone or with spouse seldom prepare soup at home). Making use of these gifts was an effective strategy for attracting and retaining participants, especially for the more deprived elders. This is because it directly helped to ease their daily difficulties. Nevertheless, a few elders would refuse the gift as they thought acceptance would be an act of greed.

Furthermore, a token reinforcement system was also designed to encourage continuous attendance. Participants who attended four sessions of the intervention were rewarded with a four-hour homecare cleaning service. Those who attended six sessions received a supermarket cash coupon valued at HK$100. Many participants were motivated to continuing participating as a result of these gifts.

Homecare cleaning service

The homecare cleaning service referred to above helped the elders directly with daily tasks. It was provided to all IRI participants who had attended four sessions as well as nonparticipants who needed the service. It covered the cleaning of windows, kitchen, bathrooms, and other areas in the home. Most participants gave positive feedback about the cleaning service as it had helped them to deal with many areas they had been unable to clean for themselves.

vii. Project operations

Means of recruitment

Participants were recruited via means such as banners, posters, leaflets, announcements, direct mailing, and telephone calls.

Banners advertising the project were placed at the entrance of Ho Chui District Community Centre and Ho Hing Neighborhood Centre for Senior Citizens (Sponsored by Sik Sik Yuen). Posters and leaflets were also distributed to all the social service units sponsored by Sik Sik Yuen, other elderly service units in Wong Tai Sin, and all DECCs in Hong Kong to promote the project

further. Project staff contact details were printed on all these materials so that elders could enquire as necessary. Announcements about the project were also made to the elders in the monthly meeting, home visits, talks, and other activities held in the Centres. In addition, Ho Kin District Community Centre for Senior Citizens (Sponsored by Sik Sik Yuen) posted out an invitation letter with project details to elders in the Sham Shui Po district.

Telephone calls were the major means of recruitment. All calls were conducted by trained project staff from Sik Sik Yuen. Four techniques for successful invitation were identified. Firstly, the worker stated at the outset the purpose of the call and the organization to which he or she belonged, in order to ease the worries of the elders. Secondly, simple and precise wording was preferred to aid understanding. Thirdly, elders were more likely to show up if it was emphasized there would be a gift for completing the questionnaire. Lastly, repeating the appointment details could help to consolidate the elders' memory. The worker might ask the elders to repeat back the date, time, and venue of the interview if necessary.

Post-intervention reunions

Reunions were held after the intervention to strengthen the skills and strategies that had been learned and help to establish a better social network for the participants. Participants who had completed all eight sessions were invited. A total of eight reunion sessions were held, from November 2012 to July 2013.

Each reunion was held with different themes, such as "say no to loneliness," "we are not afraid of stress," and "let's relax." Activities, including mental health talks, discussion, mini games, and experience sharing, were also conducted during the reunions. The aim of the reunion was to consolidate the coping strategies learned in the IRI sessions and apply them to daily life, while at the same time giving the elders a platform to exchange up-to-date welfare information. Most of them participated actively in the reunions by sharing their

knowledge and problem-solving skills. More importantly perhaps, the reunions were also social gatherings which facilitated interaction and developed the elders' social network.

Data management and coordination procedures

All the data collected were administered very carefully. Throughout the study, all the assessments were conducted in the elderly centres sponsored by Sik Sik Yuen. A trained researcher from the University of Hong Kong was responsible for bringing the data from a locked store in the Sik Sik Yuen offices back to the University for processing and analysis. This took place no later than one week after the date of collection. No data were stored anywhere other than the University of Hong Kong or Sik Sik Yuen.

Confidentiality of participants

The identities of all participants remained strictly confidential during the study. On all the printed materials prepared for the assessment, codes instead of names were used to indicate identity. Furthermore, as all participants were members of the Sik Sik Yuen elderly community centres, only Sik Sik Yuen staff knew who they were. All information which might disclose participants' identities, such as names, addresses, and phone numbers, were removed from all electronic documents sent to the University of Hong Kong.

viii. The IRI-HK intervention

IRI-HK intervention content summary

IRI-HK was developed as a cultural adaptation of the IRI which was originally proposed by Professor Philippe Cappeliez of the University of Ottawa. It was modified from the original version to suit the characteristics of elders in Hong Kong. The intervention advocates the rediscovery of successful strategies developed and adopted by individuals in tackling previous life obstacles, so that they can try to use identical approaches in confronting present

difficulties. Its core therapeutic element relies on the use of "problem-focused" coping strategies, which Watt and Cappeliez (2000) suggest can serve as a significant buffer against depression since they allows individuals to experience a sense of internal control and mastery over stressors. Thus the IRI-HK emphasizes the retrieval of previous attainment and goal-directed activities, particularly problem-solving scenarios that have appeared to be effective earlier in life.

The objectives of the IRI-HK are to reduce depressive symptoms among participants by applying it within a therapeutic group setting and to facilitate participants' cognitive restructuring of the self and self-efficacy, so as to empower them with adequate ability to confront current life issues.

Each therapeutic group is led by a registered social worker with an observer. The former assumes a facilitation role while the latter assists in observing group dynamics as well as the development of participants' involvement in the group. Six 90-minute sessions are conducted on a weekly basis. Each session is contextualized with a specific theme for discussion in the context of reminiscence. Examples of themes are listed in Table 5. Brief session plans for the IRI-HK are shown in Table 6.

Session	Theme
1	Branching points
2	Family
3	Major life's work or career
4	Loves and hates
5	Stress experiencees
6	Meaning in life

Table 5
Themes of discussion in the IRI-HK

Session 1		
Item	**Event**	**Objective(s)**
1	Introduction	• To introduce the purpose and content of the group; • To allow mutual acquaintanceship to develop among workers and group members.
2	Introducing the concept of the IRI	• To allow group members to acknowledge the rationale of the IRI.
3	Contracting and preparation	• To facilitate involvement and a sense of belonging among group members.
4	Introducing the process and procedures of the IRI	• To allow group members to understand how the IRI can benefit them within the group
5	Theme discussion: Branching points	• To facilitate the recall of previous achievements in tackling life obstacles; • To allow group members' self-recognition of their problem-solving abilities, and to encourage them to extend such efficacy to the present living situation.
6	Discussion of homework	• To consolidate the cognitive integration of group members on the theme discussed; • To assist group members to try applying and practicing strategies discovered in the session to the present living situation.

Table 6
Session plans for the IRI-HK

Session 2-6		
Item	**Event**	**Objective(s)**
1	Introduction and review of homework	• To assist members to reintegrate themselves to the group; • To facilitate mutual exchange of experiences with the homework task; • To explore any difficulties that members might have encountered when attempting the homework task, and to discuss possible solutions as a group.
2	Relaxation and refocusing exercise	• To prepare group members to engage in the subsequent reminiscing section.
3	Theme discussion (contact work): Family	• To facilitate the recall of previous achievements in tackling family obstacles; • To allow group members' self-recognition of their problem-solving abilities, and to encourage them to extend such efficacy to the present living situation.
4	Feedback from group members	• To encourage mutual interaction among group members; • To allow members to absorb various views on the experiences shared, in particular on the strategies used by group members when confronting previous family dilemmas.
5	Discussion of homework	• To consolidate the cognitive integration of group members on the theme discussed; • To assist group members to try applying and practicing previous strategies and attainments discovered in the session to their present living situation; • To introduce the theme of reminiscence of the next session
6	Questions and feedback	• To consolidate the cognitive integration of group members on the theme discussed; • To assist group members to try applying and practicing strategies discovered in the session to the present living situation.

Table 6
Session plans for the IRI-HK

Practice wisdom of the IRI-HK

A pre-intervention individual interview is crucial to the success of the IRI. Themes and discussion in each intervention session are based on the personal experiences of the participants. The preintervention interview allows the therapist to tailor the themes in order to meet individual needs. Furthermore, learning from the interview also helps the therapist to develop a sense of empathy toward the personal experience of each participant. Therapists should be aware of the group members' strengths and weaknesses so as to make appropriate and concise interventions which will help them to retrieve the coping strategies from their past experience. The preintervention individual interview is therefore a tool to boost the effect of the IRI.

The IRI emphasizes the individual uniqueness of each participant. During the intervention, the therapist should assist the elders to explore their uniqueness and raise their self-esteem. Through instrumental reminiscence, elders can identify suitable coping strategies from their own past experience. This process will allow them to realize their capacity for self-determination in order to cope with current problems. Along this journey of learning and exploration, the therapist should maintain a degree of openness and avoid making inferences from the participants' opinions during discussion. Respecting the individualization of participants is the key to success in the IRI.

The IRI intervention group is a flexible environment for participants to search for and recollect their past coping strategies. The themes of each session are always flexible so as to enable the participants to be guided to recognize their own strengths according to their individual backgrounds. Within this environment, the therapists should actively listen and respond to what the elders share. Concise responses that help the participants search for past coping strategies are preferable. Therapists should also have mastery of the coping strategies learned from the intervention groups. If the participants get stuck in their discussion and sharing, the therapists are responsible for gently hinting at possible strategies. In general, an atmosphere that mobilizes elders to recollect their own past coping strategies should be maintained.

IRI-HK homework

Homework is necessary in a cognitive therapy like the IRI to consolidate learning. This can be difficult when working with a group like Hong Kong elders where the literacy rate is low. In this study, during the design and development of the IRI-HK homework, we identified four core elements for success. Firstly, individualized homework is recommended. In our practice, each participant was given a pile of cards with drawings representing the coping strategies originating from their own ideas. Greater enjoyment and satisfaction was observed as they practiced the strategies with the aid of these individualized cards. Secondly, reinforcement should be offered from time to time throughout the intervention. Depressed elders lack the motivation to change as well as to complete homework tasks. It is the therapist's duty to motivate participants by appreciating the minor changes they have made and reemphasizing the importance of homework. Thirdly, the homework tasks have to be achievable and understandable by the participants. We avoided difficult wording and used simple drawings to consolidate learning. It was noted that the participants had more frequent recall of what they learned from the intervention as they found the homework less stressful. Lastly, homework should be designed to raise the difficulty level incrementally. For instance, we asked the elders firstly to recall their past coping strategies, remember the coping strategies they had recalled, apply these strategies to their current situation, and share these experiences in the group, all in sequence. This allowed the elders to make substantial and significant improvements during the period of intervention.

Motivation to take part

One of the main duties of the therapist is to motivate the participants to make improvements by joining in with the intervention. A marked feature of later-life depression is social withdrawal. Elders often lack insight into their symptoms and are reluctant to change. In the preintervention individual interview and the first session of the IRI, the therapist should make an effort to

motivate the elders by guiding them to recognize the possibility of improving their lives in terms of their mental health.

In addition, social service providers might consider providing motivational incentives for participants. In the current project, most participants gave positive feedback about the food and daily necessities they were given as gifts. Since continuous participation is essential for the intervention to have effect, these motivational incentives are highly recommended as a strategic measure to maintain attendance levels.

For the best implementation of the IRI-HK, practitioners should refer to the IRI-HK intervention manual in Chinese presented in a separate booklet. Practice wisdom in the delivery of intervention, homework implementation, and cultural adaption for Chinese elders are described in detail in this manual.

IV. Results

i. Profile of screening participants

Demographics

The elders who completed the screening test were all living in the community, either alone or with their spouse only. The characteristics of the elders in each round of the intervention are listed in Table 7. In general, more than half were female (66.6%) and about half were aged 70-79 (48.0%). Most had either no education (39.3%) or a primary school education only (45.4%). Over half were widowed, divorced, or separated (52.4%); 21.0% had no children and 13.1% one child only. In terms of religion, nearly half (45.9%) reported having no religious belief or practice. The major source of finance for these elders was CSSA (51.9%) while 33.0% were financially supported by family members.

	Round 1 (n=251)		Round 2 (n=321)		Round 3 (n=399)		Round 4 (n=473)		Total (N=1444)	
	Freq	(%)	Freq	(%)	Freq	(%)	Freq	(%)	Freq	(%)
Gender										
Male	94	37.5	117	36.4	125	31.3	146	30.9	**482**	**33.4**
Female	157	62.5	204	63.6	274	68.7	327	69.1	**962**	**66.6**
Age										
60-69	21	8.4	18	5.6	75	18.8	80	16.9	**194**	**13.4**
70-79	124	49.4	170	53.0	171	42.9	228	48.2	**693**	**48.0**
80-89	101	40.2	116	36.1	136	34.1	154	32.6	**507**	**35.1**
90 or above	5	2	17	5.3	15	3.8	11	2.3	**48**	**3.3**
Education										
No schooling	116	46.2	152	47.4	152	38.1	148	31.3	**568**	**39.3**
Primary	105	41.8	129	40.2	181	45.4	241	51.0	**656**	**45.4**
Secondary	24	9.6	34	10.6	52	13.0	73	15.4	**183**	**12.7**
Tertiary or higher	6	2.4	4	1.2	11	2.8	11	2.3	**32**	**2.2**
Marital status										
Never married	32	12.7	40	12.5	35	8.8	44	9.3	**151**	**10.5**
Married and living with spouse	70	27.9	134	41.7	159	39.8	172	36.4	**535**	**37.0**
Widowed and other	148	59	147	45.8	205	51.4	257	54.3	**757**	**52.4**
Number of children										
No children	66	26.3	70	21.8	63	15.8	104	22.0	**303**	**21.0**
1	40	15.9	43	13.4	51	12.8	55	11.6	**189**	**13.1**
2-3	69	27.5	102	31.8	139	34.8	173	36.6	**483**	**33.4**
4-5	53	21.1	79	24.6	109	27.3	119	25.2	**360**	**24.9**
6 or above	23	9.2	27	8.4	35	8.8	28	5.9	**113**	**7.8**
Religious belief										
No religion	108	43	156	48.6	147	36.8	252	53.3	**663**	**45.9**
Chinese traditional belief	65	25.9	75	23.4	122	30.6	108	22.8	**370**	**25.6**
Buddhism	37	14.7	49	15.3	72	18.0	66	14.0	**224**	**15.5**
Others (Catholic, Christian, etc.)	41	16.3	41	12.8	54	13.5	53	11.2	**189**	**13.1**
Major financial sources										
Pension	4	1.6	8	2.5	13	3.3	15	3.2	**40**	**2.8**
CSSA	155	61.8	162	50.5	181	45.4	251	53.1	**749**	**51.9**
OAA	11	4.4	23	7.2	15	3.8	189	40.0	**238**	**16.5**
Work	2	0.8	0	--	5	1.3	8	1.7	**15**	**1.0**
Family	59	23.5	105	32.7	158	39.6	155	32.8	**477**	**33.0**
DA	0	--	2	0.6	2	0.5	7	1.5	**11**	**0.8**
Saving	19	7.6	21	6.5	22	5.5	61	12.9	**123**	**8.5**
Insurance	0	--	0	--	0	--	1	0.2	**1**	**0.1**
Others	1	0.4	0	--	0	--	1	0.2	**2**	**0.1**

Table 7
Demographic characteristics of the elders who participated in screening

Cognitive functioning

The cognitive functioning of the elders was also assessed during the screening. Those who were cognitively impaired were excluded from the intervention. The majority (87.9%) were cognitively well (Table 8).

	Round 1 (n= 251)		Round 2 (n= 321)		Round 3 (n= 399)		Round 4 (n= 473)		Total (N= 1444)	
	Freq	(%)	Freq	(%)	Freq	(%)	Freq	(%)	**Freq**	**(%)**
Cognitively well	231	92.0	270	84.1	356	89.2	412	87.1	**1269**	**87.9**
Cognitively impaired	20	8.0	51	15.9	43	10.8	61	12.9	**175**	**12.1**
No schooling	12	4.8	26	8.1	17	4.3	26	5.5	**81**	**5.6**
Primary education	2	0.8	23	7.2	21	5.3	26	5.5	**72**	**5.0**
Secondary education or above	6	2.4	2	0.6	5	1.3	9	1.9	**22**	**1.5**

* Elders were identified as cognitively impaired under either one of the following conditions:1) no schooling with MMSE score <18, 2) primary education with MMSE score <21, or 3) secondary education with MMSE score < 24.

Table 8
Level of cognitive functioning of the elders who participated in screening

Depressive symptoms

Only elders with a mild to moderate level of depression were invited to participate in the intervention (19.0%). The majority were not depressed or were only slightly depressed (78.0%). Only 3% of elders were found to be severely depressed and were referred to a clinical psychologist for immediate support (Table 9).

	Round 1 (n= 251)		Round 2 (n= 321)		Round 3 (n= 399)		Round 4 (n= 473)		Total (N= 1444)	
	Freq	(%)	Freq	(%)	Freq	(%)	Freq	(%)	**Freq**	**(%)**
Levels of depression (GDS-15 score)										
No depression to slightly (0-7)	208	82.9	248	77.3	321	80.5	349	73.8	**1126**	**78.0**
Mild to moderate (8-13)	42	16.8	61	19.0	73	18.3	98	20.7	**274**	**19.0**
Severe (14-15)	1	0.4	12	3.7	5	1.3	26	5.5	**44**	**3.0**

Table 9
Level of depression of the elders who participated in screening

ii. Profile of the IRI-HK intervention participants

Table 10 lists the characteristics of the intervention participants collected from the baseline assessment in all rounds and groups. An independent t-test was conducted to check the difference between the experimental and control groups prior to the intervention. Overall, the only significant difference was in age ($t = -2.39$, $p < .05$).

	Round 1 (n= 27)					Round 2 (n=34)				
	E (n= 13)		C (n= 14)			E (n= 19)		C (n= 15)		
Domain (range)	M	SD	M	SD	t	M	SD	M	SD	t
Demographic										
Gender[1]	1.69	0.48	1.57	0.51	0.63	1.47	0.51	1.73	0.46	-1.54
Age	76.15	8.40	79.36	5.75	-1.16	76.32	6.09	75.93	6.27	0.18
Education level[2]	1.46	0.52	1.79	0.89	-1.14	1.74	0.81	1.60	0.74	0.51
Primary outcome										
Depression symptoms (0-15)	9.62	2.14	9.14	2.25	0.56	9.05	3.50	8.53	2.56	0.48
Secondary outcome										
Life satisfaction (overall) (1-5)	2.46	0.88	2.29	0.61	0.61	2.21	0.63	2.53	0.64	-1.47
Control variables										
Self-rated health (0-4)	2.00	0.58	2.07	0.73	-0.28	1.74	0.73	1.93	0.70	-0.79
Self-rated financial adequacy (0-4)	2.00	0.82	2.36	0.50	-1.38	2.26	0.65	2.27	0.59	-0.02
Social support network (0-60)	12.15	12.05	10.93	6.02	0.34	9.63	8.39	17.53	15.01	-1.95

1 Gender: 1 = male, 2 = female
2 Education level: 1 = no schooling, 2 = primary, 3 = secondary, 4 = tertiary of above
*p< .05, **p< .01

Table 10
Profile of intervention participants at baseline

	Round 3 (n= 36)					Round 4 (n=53)				
	E (n= 15)		C (n= 21)			E (n= 26)		C (n= 27)		
Domain (range)	M	SD	M	SD	t	M	SD	M	SD	t
Demographic										
Gender[1]	1.93	0.26	1.57	0.51	2.53*	1.62	0.50	1.74	0.45	-0.97
Age	76.60	8.94	80.19	6.66	-1.38	74.58	8.57	78.52	7.86	-1.75
Education level[2]	1.53	0.64	1.67	0.80	-0.54	1.85	0.61	1.81	0.83	0.16
Primary outcome										
Depression symptoms (0-15)	9.60	2.82	9.90	2.28	-0.36	9.72	1.79	8.38	2.23	2.35*
Secondary outcome										
Life satisfaction (overall) (1-5)	2.27	0.88	2.24	0.63	0.11	2.32	0.69	2.15	0.61	0.91
Control variables										
Self-rated health (0-4)	2.00	1.25	1.95	0.74	0.14	2.84	0.80	2.77	0.82	0.31
Self-rated financial adequacy (0-4)	2.20	0.78	1.95	0.74	0.97	2.92	0.64	2.65	0.80	1.31
Social support network (0-60)	15.00	15.68	13.81	11.87	0.26	20.16	11.73	14.62	11.40	1.71

	Total (N= 150)				
	E (n= 73)		C (n= 77		
Domain (range)	**M**	**SD**	**M**	**SD**	**t**
Demographic					
Gender[1]	**1.66**	**0.48**	**1.66**	**0.48**	**-0.06**
Age	**75.73**	**7.93**	**78.62**	**6.92**	**-2.39***
Education level[2]	**1.68**	**0.66**	**1.73**	**0.81**	**-0.35**
Primary outcome					
Depression symptoms (0-15)	**9.50**	**2.57**	**8.97**	**2.36**	**1.30**
Secondary outcome					
Life satisfaction (overall) (1-5)	**2.31**	**0.74**	**2.28**	**0.62**	**0.26**
Control variables					
Self-rated health (0-4)	**2.22**	**0.97**	**2.25**	**0.84**	**-0.19**
Self-rated financial adequacy (0-4)	**2.43**	**0.78**	**2.33**	**0.74**	**0.81**
Social support network (0-60)	**14.86**	**12.49**	**14.29**	**11.56**	**0.29**

1 Gender: 1= male, 2= female
2 Education level: 1= no schooling, 2= primary, 3= secondary, 4= tertiary of above
*p< .05, **p< .01

Table 10
Profile of intervention participants at baseline

iii. Effectiveness of the IRI-HK on primary outcome

The GDS-15 score was used as the major indicator of the effectiveness of the IRI-HK in reducing depressive symptoms among the elders. Figure 6 illustrates the trend of the change in participants' depressive symptoms whereas Table 11 lists the participants' levels of depression over time.

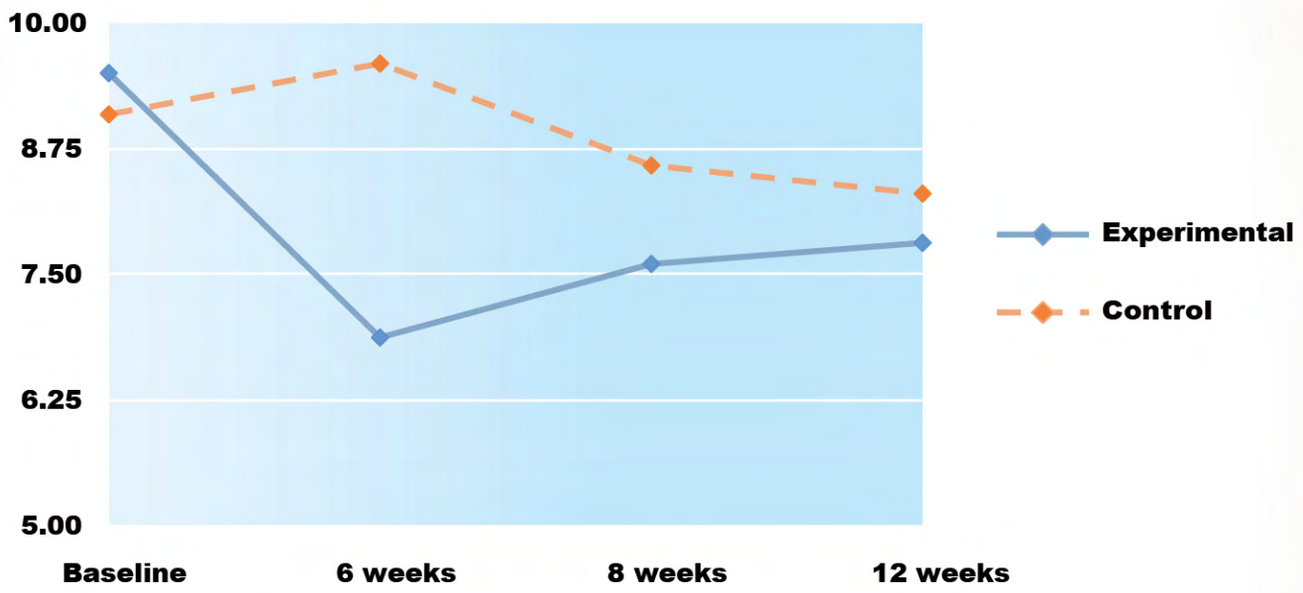


Figure 6
Changes in level of depression across time

	Round 1				Round 2				Round 3			
	E (n= 13)		C (n= 14)		E (n= 19)		C (n= 15)		E (n= 15)		C (n= 21)	
Assessment	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
Baseline	9.62	2.14	9.14	2.25	9.05	3.50	8.53	2.56	9.60	2.82	9.90	2.28
6 weeks	7.00	4.17	9.27	2.83	7.69	2.63	9.20	3.71	6.00	1.00	10.82	1.72
8 weeks	8.75	4.59	9.17	2.48	8.55	3.33	7.00	3.07	8.25	1.71	9.88	2.10
12 weeks	8.00	4.51	8.86	3.85	8.30	3.23	6.13	3.56	7.33	1.53	9.89	1.97

	Round 4				Total			
	E (n= 26)		C (n= 27)		E (n= 73)		C (n= 77)	
Assessment	M	SD	M	SD	M	SD	M	SD
Baseline	9.72	1.79	8.38	2.23	**9.50**	**2.57**	**8.97**	**2.36**
6 weeks	6.21	2.36	9.00	2.54	**6.87**	**2.83**	**9.60**	**2.77**
8 weeks	6.29	3.84	8.44	2.51	**7.60**	**3.77**	**8.58**	**2.67**
12 weeks	7.53	3.06	8.67	2.55	**7.81**	**3.23**	**8.42**	**3.18**

Table 11
Participants' levels of depression over time

Comparisons between the experimental and control groups were conducted at several time points. The immediate effect of the intervention was analyzed by comparing the GDS-15 score between groups at six weeks with the score at baseline controlled. A significant between-group difference was found with $F(1, 79) = 35.21$, $p < .001$. This indicates that the IRI-HK had had a significant effect in reducing depressive symptoms immediately after completion. Furthermore, a significant between-group difference in GDS-15 score was also found at eight weeks; $F(1, 70) = 4.30$, $p < .05$ (Table 12).

Assessment	F	sig.
6 weeks	35.21 (1,76)	***
8 weeks	4.30 (1,67)	*
12 weeks	2.34 (1,67)	0.13

Remarks: Univariate tests were conducted by comparing the GDS-15 scores between experimental and control group at different times with the GDS-15 score at baseline being controlled.

*p< .05, **p< .01, *** p < .001

Table 12
Effect of the IRI-HK on alleviating depression at different time points

iv. Effectiveness of the IRI-HK on secondary outcome

Life satisfaction was the secondary outcome adopted to observe the effectiveness of the IRI-HK. Figure 7 and Table 13 demonstrate the changes in participants' overall life satisfaction throughout the intervention.

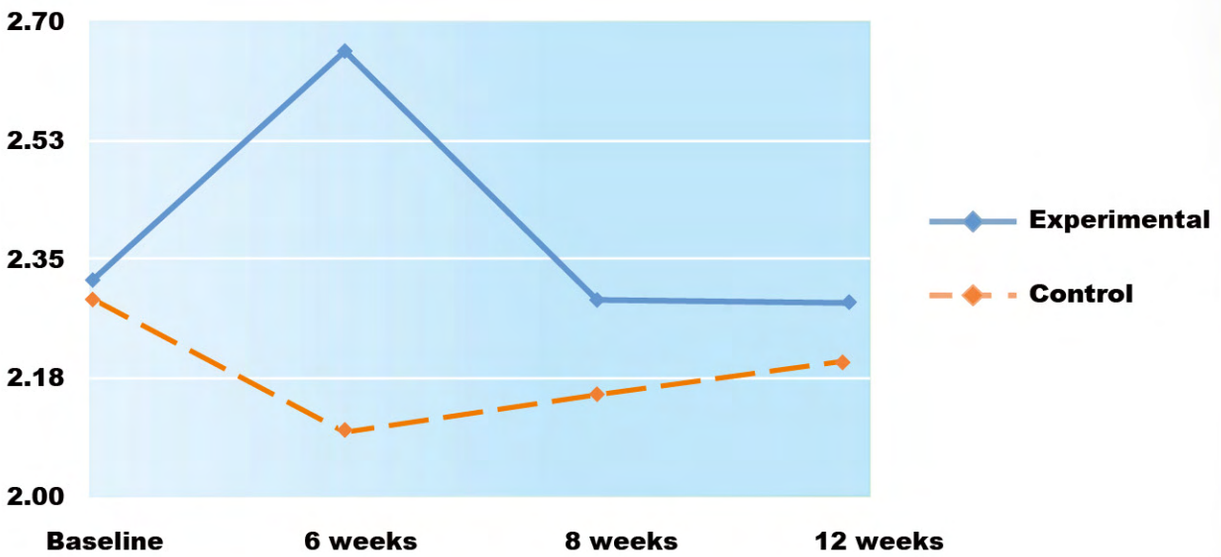


Figure 7
Changes in level of life satisfaction across time

	Round 1				Round 2				Round 3			
	E (n= 13)		C (n= 14)		E (n= 19)		C (n= 15)		E (n= 15)		C (n= 21)	
Assessment	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
Baseline	2.46	0.88	2.29	0.61	2.21	0.63	2.53	0.64	2.27	0.88	2.24	0.63
6 weeks	2.63	1.06	2.09	0.54	2.46	1.05	2.10	0.57	3.33	0.58	2.09	0.54
8 weeks	1.75	1.04	2.33	0.52	1.91	0.54	2.25	0.46	2.75	0.96	2.13	0.64
12 weeks	2.29	0.76	2.14	0.69	2.20	0.42	2.63	0.92	1.67	1.16	1.78	0.83

	Round 4				Total			
	E (n= 26)		C (n= 27)		E (n= 73)		C (n= 77)	
Assessment	M	SD	M	SD	M	SD	M	SD
Baseline	2.32	0.69	2.15	0.61	**2.31**	**0.74**	**2.28**	**0.62**
6 weeks	2.71	0.73	2.00	0.67	**2.66**	**0.91**	**2.07**	**0.56**
8 weeks	2.65	0.79	1.89	0.60	**2.28**	**0.88**	**2.13**	**0.56**
12 weeks	2.41	0.71	2.22	0.44	**2.27**	**0.69**	**2.18**	**0.77**

Table 13
Participants' levels of life satisfaction across time

Comparisons between the experimental and control groups were conducted at several time points. The immediate effect of the intervention was analyzed by comparing life satisfaction between groups at six weeks with the score at baseline controlled. A significant between-group difference was found; $F(1, 79) = 14.32$, $p < .001$. This means that the IRI-HK had had a significant effect on enhancing life satisfaction immediately after intervention. However, no significant difference in life satisfaction between groups was observed at 8 or 12 weeks (Table 14).

Assessment	F	sig.
6 weeks	14.324 (1,76)	***
8 weeks	0.258 (1,67)	0.61
12 weeks	0.001 (1,67)	0.97

Remarks: Univariate tests were conducted by comparing the GDS-15 scores between the experimental and control group at different times with the life satisfaction score at baseline being controlled.

*p< .05, **p< .01, *** p < .001

Table 14
Effect of the IRI-HK on life satisfaction at different time points

V. Discussion and implications

i. Development of the IRI-HK

The current project contributed to the development of the IRI-HK by implementing a successful cultural adaptation from the original IRI. The IRI-HK intervention manual will facilitate the broad use of the IRI technique in Hong Kong elder care. The findings of this study confirm the effectiveness of the IRI-HK on alleviating depressive symptoms among elders living alone or with spouse only. It presents a new intervention option for social service providers who are interested in treating depression in the elderly.

Other than introducing the IRI-HK to local social services, the project team also strengthened their own knowledge about designing suitable homework for an intervention involving elders. Previous practice in elderly social service indicates that it can be difficult to design homework for elderly participants whose literacy and motivation are low. Our experience of the development of the IRI-HK has helped us to identify four core elements in effective homework design, namely individualization, reinforcement, achievability, and increasing difficulty incrementally. Such practice wisdom provides local users with more insights to use in implementing the intervention.

Furthermore, valuable experience was also gained by using motivational strategies to retain the depressed elders in the intervention. Because depression often results in social withdrawal, depressed elders have tended to become dropouts early from such interventions. Incentives such as providing daily necessities and building rapport through means such as telephone support were the major motivational strategies used in this project. Positive feedback and a good retention rate demonstrates their importance and efficacy.

ii. Effectiveness of the IRI-HK

The primary goal of the project was to alleviate depressive symptoms among the elders living alone or with spouse only using the IRI-HK. The findings of this study support the effectiveness of the intervention. As illustrated in Figures 6 and 7, the intervention effect was the strongest at six weeks. This represents an immediate alleviation of depressive symptoms followed by enhanced life satisfaction on completion of the intervention. A statistically significant difference between the experimental and control groups was found, confirming that the IRI-HK demonstrated an immediate and strong therapeutic effect on elders with mild to moderate depressive symptoms.

As well as examining the short-term effect, we also looked at the long-term impact of the IRI-HK. Although the trend in post-intervention levels of depression was towards an increase, a mild long-term intervention effect was also observed. The GDS-15 scores measured at the 8- and 12-week intervals were both below 8. With a cut-off GDS-15 score of 8 in the current study, it is suggested that the intervention had a therapeutic effect for elders with mild to moderate depressive symptoms at both 8 and 12 weeks. Moreover, a statistically significant difference between the experimental and control groups was found at 8 weeks, which is a sign that the IRI-HK had a long-term effect in reducing depressive symptoms.

Continuous implementation of the IRI-HK is recommended to yield a better and sustainable effect. The IRI-HK generates incremental changes in

elders' thoughts and coping behaviors along the intervention journey. In our study, given the purpose of the research and the limited time and resources available, the project team delivered a six-week intervention adopted from the original manual. Social service providers may wish to modify the number of intervention sessions to make best use of their resources and, more importantly, serve the best interests of the elderly participants. The empirical findings reported here support a six-week intervention effect. Further investigation is needed to explore the optimum number of sessions as well as the long-term effects of the IRI-HK.

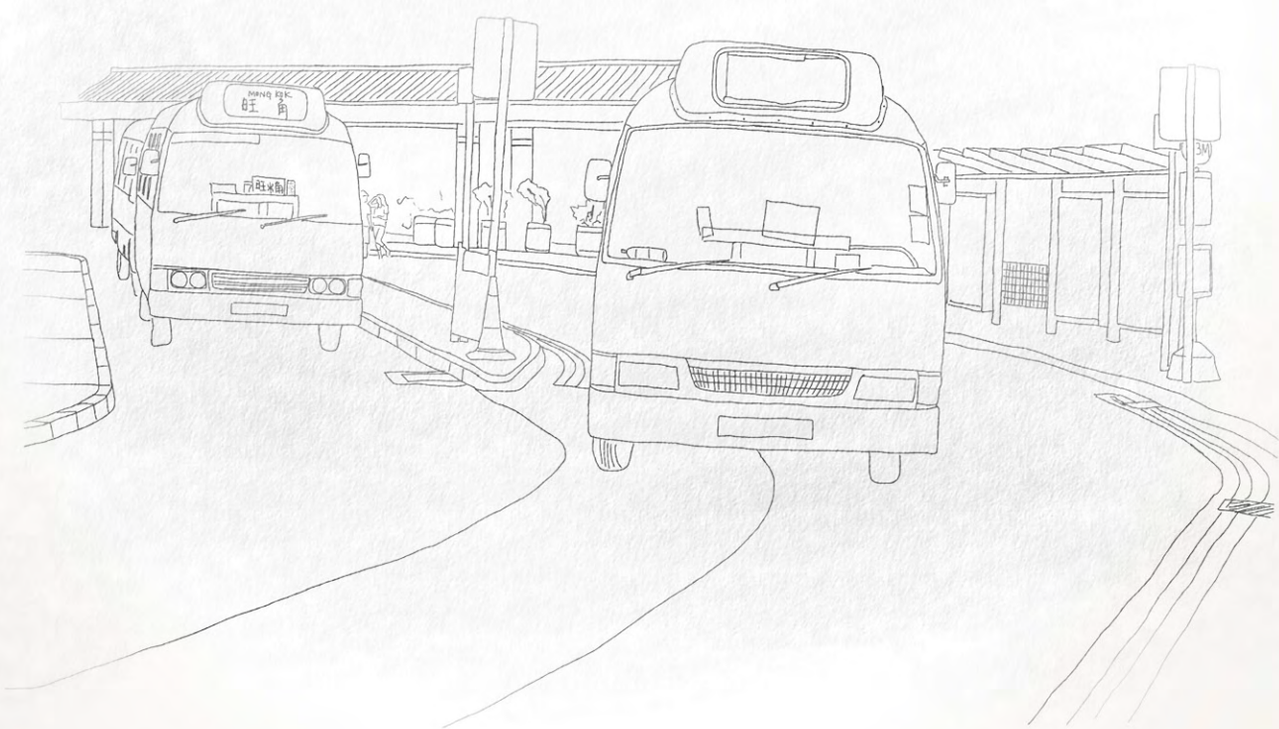
iii. Dissemination of the IRI-HK

The findings from the current study are published in this project report and the IRI-HK intervention manual. This report enables readers to understand the current situation of later-life depression in Hong Kong; the relationships between depression, reminiscence, and coping; our project design and research methodology; and the major statistical findings. The Chinese-language IRI-HK intervention manual contains the essence and details of the intervention in order to help practitioners implement the IRI-HK for themselves. By publishing our findings and experiences from the current project, the project team aims to facilitate the implementation of IRI in local social services in order to help and support elders living alone or with spouse only.

Further training is necessary to ensure the successful implementation of the IRI-HK. The project team recommends the use of the culturally adapted intervention manual to organize workshops for practitioner training on the intervention in future. Further study and practice are needed to support the development of standardized training on the IRI-HK.

iv. Conclusion

The IRI-HK has been adapted and developed for local use. It represents an alternative option for social service providers to treat depressive symptoms in elders living alone or with spouse only in the community. The project has generated concrete practice wisdom about homework design and motivational strategies in cognitive interventions involving older adults. More importantly, it has confirmed the effectiveness of IRI-HK on alleviating depressive symptoms among elders living alone or with spouse. Further study and practice is encouraged to strengthen our understanding of the long-term effect of the IRI-HK and the relationships between different types of reminiscence and the psychological wellbeing of elderly people. Dissemination of this project report and the IRI-HK intervention manual is intended to enhance practitioners' understanding of the IRI-HK and help them to apply the intervention in a local setting. The project team looks forward to standardized training in the IRI-HK being developed and launched in future.



VI. References

Billings, A. G., & Moos, R. H. (1982). Psychosocial theory and research on depression: An integrative framework and review. ***Clinical Psychology Review, 2***(2), 213-237. doi:10.1016/0272-7358(82)90013-7

Bjorner, J. B., Søndergaard Kristensen T., Orth-Gomér, K., Tibblin, G., Sullivan, M., 7 Westerholm P. (1996). ***Self-rated health: A useful concept in research, prevention and clinical medicine.*** Stockholm: The Swedish Council for Planning and Coordination of Research.

Bluck, S., & Levine, L. J. (1998). Reminiscence as autobiographical memory: A catalyst for reminiscence theory development. [null]. ***Ageing & Society, 18***(02), 185-208.

Bohlmeijer, E., Roemer, M., Cuijpers, P., & Smit, F. (2007). The effects of reminiscence on psychological well-being in order adults: A meta-analysis. ***Aging & Mental Health, 11***(3), 291-300. doi:10.1080/13607860600963547

Bohlmeijer, E., Smit, F., & Cuijpers, P. (2003). Effects of reminiscence and life review on late-life depression: A meta-analysis. ***International Journal of Geriatric Psychiatry, 18***(12), 1088-1094. doi:10.1002/gps.1018

Cappeliez, P., & O'Rourke, N. (2006). Empirical validation of a model of reminiscence and health in later life. ***The Journals of Gerontology: Series B: Psychological Sciences and Social Sciences, 61B***(4), P237-P244.

Census and Statistics Department, H. K. (2007). ***Demographic trends in Hong Kong 1981-2006***. Hong Kong: Hong Kong Special Administration Region Government Printer. Retrieved from http://www.statistics.gov.hk/publication/stat_report/population/B1120017022007XXXXB0200.pdf

Census and Statistics Department, H. K. (2008). 2006 population census. ***Thematic report: Older persons.*** Hong Kong: Hong Kong Special Administration Region Government Printer. Retrieved from http://www.statistics.gov.hk/publication/stat_report/population/B1120053200 6XXXXB0100.pdf

Census and Statistics Department, H. K. (2010). ***Hong Kong population projections 2010–2039.*** Hong Kong: Hong Kong Special Administration Region Government Printer. Retrieved from http://www.statistics.gov.hk/publication/stat_report/population/B1120015042010XXXXB0100.pdf

Census and Statistics Department, H. K. (2012). ***Hong Kong in figures 2012.*** Hong Kong: Hong Kong Special Administration Region Government Printer. Retrieved from http://www.statistics.gov.hk/publication/general_stat_digest/B1010006201 2AN12E0100.pdf

Census and Statistics Department, H. K. (2013). ***2011 population census. Thematic report: Older persons.*** Hong Kong: Hong Kong Special Administration Region Government Printer. Retrieved from http://www.statistics.gov.hk/pub/B1120064201 3XXXXB0100.pdf

Chi, I., & Boey, K. W. (1993). Hong Kong validation of measuring instruments of mental health status of the elderly. ***Clinical Gerontologist: The Journal of Aging and Mental Health, 13***(4), 35-51. doi:10.1300/J018v13n04_04

Chi, I., Yip, P. S. F., Chiu, H. F. K., Chou, K. L., Chan, K. S., Kwan, C. W., . . . Caine, E. (2005). Prevalence of depression and its correlates in Hong Kong's Chinese older adults. ***The American Journal of Geriatric Psychiatry, 13***(5), 409-416. doi:10.1176/appi.ajgp.13.5.409

Chiu, F. K. H., Lee, H. C., Chung, W. S., & Kwong, P. K. (1994). Reliability and validity of the Cantonese version of mini-mental state examination—a preliminary study. ***Journal of Hong Kong College of Psychiatrists, 4***(SP2), 25-28.

Chiu, H.-C., Chen, C.-M., Huang, C.-J., & Mau, L.-W. (2005). Depressive symptoms, chronic medical conditions and functional status: A comparison of urban and rural elders in Taiwan. ***International Journal of Geriatric Psychiatry, 20***(7), 635-644. doi:10.1002/gps.1292

Chou, K.-L., & Chi, I. (1999). Determinants of life satisfaction in Hong Kong Chinese elderly: A longitudinal study. ***Aging & Mental Health, 3***(4), 328-335. doi:10.1080/13607869956109

Chou, K.-L., & Chi, I. (2000). Comparison between elderly Chinese living alone and those living with others. ***Journal of Gerontological Social Work, 33***(4), 51-66. doi:10.1300/J083v33n04_05

Chou, K.-L., & Chi, I. (2005). Prevalence and correlates of depression in Chinese oldest-old. ***International Journal of Geriatric Psychiatry, 20***(1), 41-50. doi:10.1002/gps.1246

Chou, K.-L., Chi, I., & Chow, N. W. S. (2004). Sources of income and depression in elderly Hong Kong Chinese: Mediating and moderating effects of social support and financial strain. ***Aging & Mental Health, 8***(3), 212-221. doi:10.1080/13607860410001669741

Coday, M., Boutin-Foster, C., Sher, T. G., Jennifer Tennant, M., Greaney, M. L., Saunders, S. D., & Somes, G. W. (2005). Strategies for retaining study participants in behavioral intervention trials: Retention experiences of the NIH Behavior Change Consortium. ***Annals of Behavioral Medicine, 29***(2), 55-65.

Cormier, S., & Cormier, B. (1998). ***Interviewing strategies for helpers: Fundmental skills and cognitive behavioral interventions (4th ed.).*** Belmont, CA: Thomson Brooks/Cole Publishing Co (1998). (1998) xvi, 681 pp.

Curry, L., & Jackson, J. (2003). The science of including older ethnic and racial group participants in health-related research. ***The Gerontologist, 43***(1), 15-17.

Dozois, D. J. A., & Dobson, K. S. (Eds.). (2004). ***The prevention of anxiety and depression: Theory, research, and practice.*** Washington, DC: American Psychological Association (2004). (2004) xii, 330 pp.

Draguns, J. G. (1996). Abnormal behvior in Chinese societies: Clinical, epidemiological, and comparative studies. In M. H. Bond (Ed.), ***The handbook of Chinese psychology*** (pp. 412-428). New York, NY: Oxford University Press.

Folkman, S., & Lazarus, R. S. (1986). Stress processes and depressive symptomatology. ***Journal of Abnormal Psychology, 95***(2), 107-113. doi:10.1037/0021-843X.95.2.107

HKJC Centre for Suicide Research and Prevention (2008). ***Report on Hong Kong suicide deaths in 2006.*** Hong Kong: HKJC Centre for Suicide Research and Prevention, The University of Hong Kong.

HKJC Centre for Suicide Research and Prevention (2012). ***Suicide rates and deaths by age group.*** Retrieved 24/5/2012, from HKJC Centre for Suicide Research and Prevention, The University of Hong Kong http://csrp.hku.hk/WEB/big5/statistics.asp

Hsieh, H.-F., & Wang, J.-J. (2003). Effect of reminiscence therapy on depression in older adults: A systematic review. ***International Journal of Nursing Studies, 40***(4), 335-345. doi:10.1016/s0020-7489(02)00101-3

Ingram, R. E. (Ed.). (1990). ***Contemporary psychological approaches to depression: Theory, research, and treatment.*** New York, NY: Plenum Press (1990). (1990) ix, 198 pp.

Jongenelis, K., Pot, A. M., Eisses, A. M. H., Beekman, A. T. F., Kluiter, H., & Ribbe, M. W. (2004). Prevalence and risk indicators of depression in elderly nursing home patients: The AGED study. ***Journal of Affective Disorders, 83***(2-3), 135-142. doi:10.1016/j.jad.2004.06.001

Karimi, H., Dolatshahee, B., Momeni, K., Khodabakhshi, A., Rezaei, M., & Kamrani, A. A. (2010). Effectiveness of integrative and instrumental reminiscence therapies on depression symptoms reduction in institutionalized older adults: An empirical study. ***Aging & Mental Health, 14***(7), 881-887. doi:10.1080/13607861003801037

Kleinman, A., Anderson, J., Finkler, K., Frankenberg, R., & Young, A. (1986). Social origins of distress and disease: Depression, neurasthenia, and pain in modern China. ***Current Anthropology, 24***(5), 499-509.

Lee, H.-c. B., Chiu, H. F. K., & Kwong, P. P. K. (1994). Cross-validation of the Geriatric Depression Scale short form in the Hong Kong elderly. ***Bulletin of the Hong Kong Psychological Society. 32,*** 72-77.

Leung, P., Cheung, M., & Tsui, V. (2012). Help-seeking behaviors among Chinese Americans with depressive symptoms. ***Social Work, 57***(1), 61-71.

Levkoff, S., & Sanchez, H. (2003). Lessons learned about minority recruitment and retention from the Centers on Minority Aging and Health Promotion. ***The Gerontologist, 43***(1), 18-26.

Liang, X., Feng, J., & H.K.S.K.H. Lady MacLehose Centre. (2005). ***Mental health promotion project for the elderly: Group intervention manual.*** Hong Kong: H.K.S.K.H. Lady MacLehose Centre.

Lillehoj, C. J. G., Griffin, K. W., & Spoth, R. (2004). Program provider and observer ratings of school-based preventive intervention implementation: Agreement and relation to youth outcomes. ***Health Education & Behavior, 31***(2), 242-257.

Lin, Y.-C., Dai, Y.-T., & Hwang, S.-L. (2003). The effect of reminiscence on the elderly population: A systematic review. ***Public Health Nursing, 20***(4), 297-306. doi:10.1046/j.1525-1446.2003.20407.x

Lou, W. Q. V., Chi, I., & Mjelde-Mossey, L. A. (2008). Development and validation of a Life Satisfaction Scale for Chinese Elders. ***The International Journal of Aging & Human Development, 67***(2), 149-170. doi:10.2190/AG.67.2.c

Lou, W. Q. V., Tsang, S. W. P., & Choy, C. P. J. (2012). ***Treating depressive symptoms among living alone older adults in Wong Tai Sin: A district elderly community centre initiative.*** Paper presented at the 19th Annual Congress of Gerontology, Hong Kong.

Lubben, J. E. (1988). Assessing social networks among elderly populations. ***Family & Community Health: The Journal of Health Promotion & Maintenance, 11***(3), 42-52.

Marx, M. S., Cohen-Mansfield, J., & Guralnik, J. M. (2003). Recruiting community-dwelling elderly at risk for physical disability into exercise research. ***Journal of Aging and Physical Activity, 11***(2), 229-241.

Mrazek, P. J., & Haggerty, R. J. (1994). Reducing risks for mental disorders: ***Frontiers for preventive intervention research.*** Washington, DC: National Academy Press (1994). (1994) xxvii, 605 pp.

Piterman, L., & DaCanhota, C. M. N. (2001). Depressive disorders in elderly Chinese patients in Macau: A comparison of general practitioners' consultations with a depression screening scale. [Article]. ***Australian & New Zealand Journal of Psychiatry, 35***(3), 336-344. doi:10.1046/j.1440-1614.2001.00893.x

Posternak, M. A., & Miller, I. (2001). Untreated short-term course of major depression: A meta-analysis of outcomes from studies using wait-list control groups. ***Journal of Affective Disorders, 66***(2-3), 139-146. doi:10.1016/s0165-0327(00)00304-9

Pot, A. M., Bohlmeijer, E. T., Onrust, S., Melenhorst, A.-S., Veerbeek, M., & De Vries, W. (2010). The impact of life review on depression in older adults:

A randomized controlled trial. ***International Psychogeriatrics, 22***(4), 572-581. doi:10.1017/s104161020999175x

Rohde, P., Lewinsohn, P. M., Tilson, M., & Seeley, J. R. (1990). Dimensionality of coping and its relation to depression. ***Journal of Personality and Social Psychology, 58***(3), 499.

Serrano, J. P., Latorre, J. M., Gatz, M., & Montanes, J. (2004). Life review therapy using autobiographical retrieval practice for older adults with depressive symptomatology. ***Psychology and Aging, 19***(2), 272-277. doi:10.1037/0882-7974.19.2.272

So, F. H. (2008). Living alone – a comparison between Hong Kong and Sweden. ***The Hong Kong Anthropologist, 2***, 94-126.

Stinson, C. K., Young, E. A., Kirk, E., & Walker, R. (2010). Use of a structured reminiscence protocol to decrease depression in older women. ***Journal of Psychiatric and Mental Health Nursing, 17***(8), 665-673. doi:10.1111/j.1365-2850.2010.01556.x

Sun, W. J., Xu, L., Chan, W. M., Lam, T. H., & Schooling, C. M. (2012). Depressive symptoms and suicide in 56,000 older Chinese: A Hong Kong cohort study. ***Social Psychiatry and Psychiatric Epidemiology, 47***(4), 505-514. doi:10.1007/s00127-011-0362-z

Wang, J.-J. (2007). Group reminiscence therapy for cognitive and affective function of demented elderly in Taiwan. ***International Journal of Geriatric Psychiatry, 22***(12), 1235-1240. doi:10.1002/gps.1821

Watt, L. M., & Cappeliez, P. (2000). Integrative and instrumental reminiscence therapies for depression in older adults: Intervention strategies and treatment effectiveness. ***Aging & Mental Health, 4***(2), 166-177. doi:10.1080/13607860050008691

Watt, L. M., & Wong, P. T. (1991). A taxonomy of reminiscence and therapeutic implications. ***Journal of Gerontological Social Work, 16***(1-2), 37-57. doi:10.1300/J083v16n01_04

Wong, P. T. P. (1995). The processes of adaptive reminiscence. In Haight, Barbara K. & Webster, Jeffrey Dean (Eds). ***The art and science of reminiscing: Theory, research, methods, and applications*** (pp. 23-35). Philadelphia, PA, US: Taylor & Francis.

World Health Organization (2012). Primary health care. Retrieved 24/5/2012, from http://www.who.int/ageing/projects/age_friendly_standards/en/

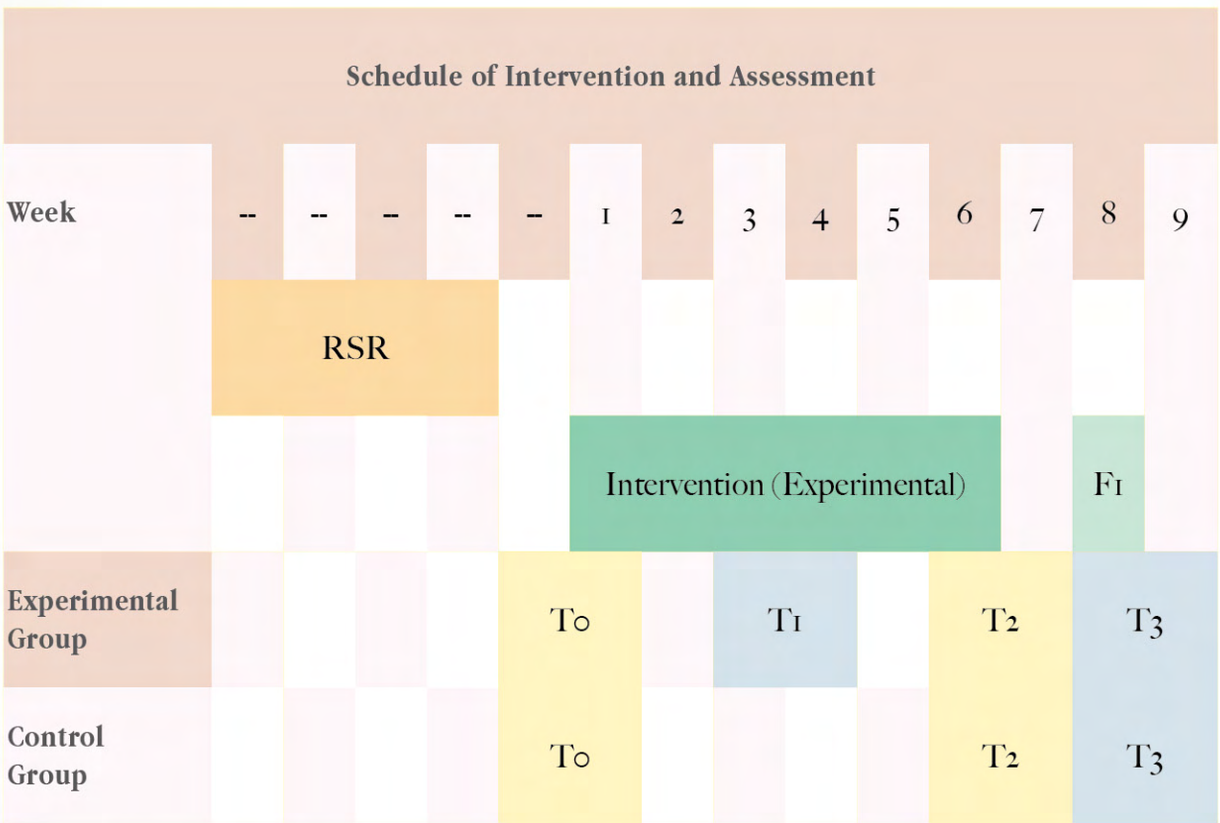
Wu, L.-F. (2011). Group integrative reminiscence therapy on self-esteem, life satisfaction and depressive symptoms in institutionalised older veterans. ***Journal of Clinical Nursing, 20***(15-16), 2195-2203. doi:10.1111/j.1365-2702.2011.03699.x

Yip, P. S. F., Chi, I., Chiu, H., Wai, K. C., Conwell, Y., & Caine, E. (2003). A prevalence study of suicide ideation among older adults in Hong Kong SAR. ***International Journal of Geriatric Psychiatry, 18***(11), 1056-1062. doi:10.1002/gps.1014

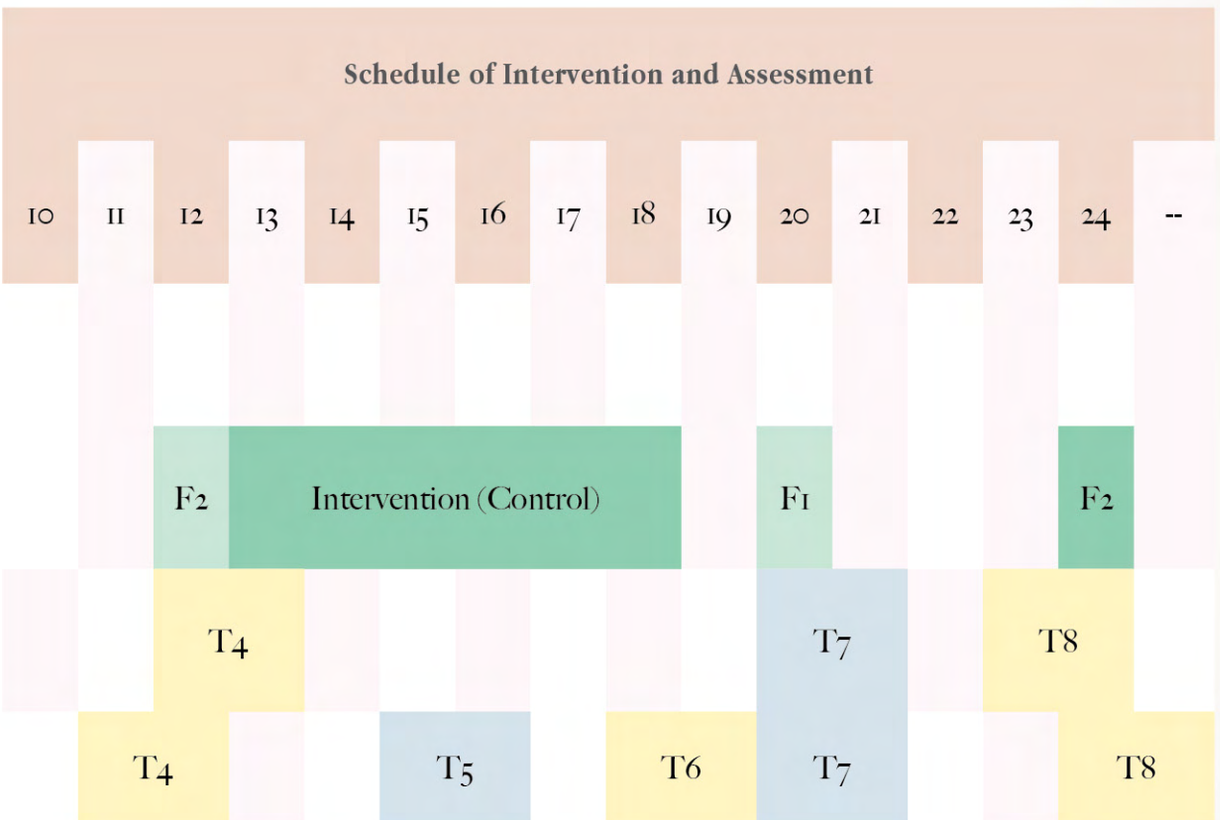
VII. Appendices

Appendix I

Intervention and assessment schedule in one round



RSR = recruitment, screening, and randomization.
E = Experimental group; C = Control group.
F1 and F2 are the 1st follow-up and 2nd follow-up sessions respectively.
Assessment: T0, T2, T4, T6, T8 were full sets of measures; T1, T3, T5 and T7 were brief sets of measures.


Schedule of Intervention and Assessment
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
--
F2
Intervention (Control)
F1
F2
T4
T7
T8
T4
T5
T6
T7
T8

Appendix II

Consent form for screening interviews and baseline assessment

流金頌社區計劃

「愛生命．長者有明天」
- 緬懷小組運用於獨居長者的成效研究
服務對象初步調查（篩選）
同意書 I

是項計劃名為「『愛生命．長者有明天』- 緬懷小組運用於獨居長者的成效研究」，是一項由香港賽馬會資助的流金頌社區計劃，並由香港大學社會工作及社會行政學系樓瑋群博士及嗇色園社區服務部主理。本計劃的主要目的是透過緬懷小組去提昇社區獨居長者的精神健康及檢討其成效，長遠的目的是希望為本港社區長者精神健康支援服務的發展提供實證的資料。

為了讓我們更瞭解計劃中的服務對象的狀況，閣下現在被邀請參與上述計劃中的服務對象初步調查。若閣下同意參與是項調查，您將會與調查員進行一個問卷訪問（需時約二十至三十分鐘）。調查員將會問一些問題去瞭解您的認知能力、精神健康狀況及基本個人資料。調查所收集的資料，只會作服務提供或者研究用途；您所提供的個人資料，只有負責是次計劃的香港大學及嗇色園的研究小組成員可以接觸；而能識別出您的身份的資料（例如參加者名單），我們會使用獨立的檔案去記錄並由研究小組保管，該檔案將會在是次計劃完結後 5 年銷毀。另外，調查結果將會以集體數據形式作報告，在任何報告中都不會出現能識別您的身份的個人資料。是次研究並不會為 閣下提供個人利益，參與純屬自願性質，您可隨時終止參與是項行動，有關決定將不會引致任何不良後果。

您的參與將有助我們瞭解社區獨居長者的精神健康狀況，以及為本計劃提供寶貴的參考資料。因此，我們誠意希望您能接受邀請，與我們一起為長者的福祉作出貢獻。如您對是項研究有任何問題，請現在提出。如日後你對是項研究有任何查詢，請與首席研究員樓瑋群博士聯絡 (852-2219-4835)。如你想知道更多有關研究參與者的權益，請聯絡香港大學非臨床研究操守委員會 (852-2241-5267)。

如你明白以上內容，並願意參與是項調查，請在下方簽署。

參加者簽署：_____

日期：_____

流金頌社區計劃

「愛生命・長者有明天」
- 緬懷小組運用於獨居長者的成效研究
同意書 II

是項計劃名為「『愛生命・長者有明天』- 緬懷小組運用於獨居長者的成效研究」，是一項由香港賽馬會資助的流金頌社區計劃，並由香港大學社會工作及社會行政學系樓瑋群博士及嗇色園社區服務部主理。本計劃的主要目的是透過緬懷小組去提昇社區獨居長者的精神健康及檢討其成效，長遠的目的是希望為本港社區長者精神健康支援服務的發展提供實證的資料。

閣下現在被邀請參與是次研究計劃，如您同意參與，您將會加入一個由專業社會工作者帶領的緬懷小組，小組主要目的是透過回顧人生去協助獨居長者重建正面思考、提昇抗逆力及對抗負面的情緒。根據隨機分配的結果，您將會被安排在下星期 或 在 12 個星期後開始小組。小組共有六節，將在 6 個星期內完成，每節需時約一小時三十分鐘，而在小組完成後的第二及第六個星期，將會各有一次跟進聚會。是次介入小組的過程將會進行錄音，有關的錄音資料只有是項計劃的香港大學及嗇色園研究小組成員可以接觸。研究小組可享有自由運用錄音內容於合適的場所的全部決定權，包括剪接及畫聲同步的語音處理，並用於關聯的宣傳項目、計劃的檢討及日後嗇色園及香港大學教學及培訓等場合。研究小組可行使閣下於錄音期間提供之姓名或假名，聲音及自身背景資料。閣下的錄音資料會經過聲音特別處理，研究小組亦會用假名去代替閣下的姓名，以防止第三者識別出您的身份。在完成研究後，有關的錄音資料將於研究完成後 5 年銷毀，而沒有涉及個人資料的錄音內容敘述將會永久保存。

另外，小組前後、中段及於跟進聚會時，將會有一位調查員與您進行簡短的訪問（約需時三十分鐘），內容問及您的精神健康及生活狀況，目的是為瞭解參加小組對您的影響。若您被編排在12個星期後開始小組，在這段等待期間的第1、6、8及12個星期，您均會被邀請進行簡短的訪問。在這些問卷中將不會有任何可識別您個人身份的資料，而能識別出您的身份的資料（例如參加者名單），我們會使用獨立的檔案去記錄由研究小組保管，該檔案將會在是次計劃後 5 年銷毀。所有調查中收集的資料只會作研究用途，個人資料將絕對保密，調查結果將會以集體數據形式作報告。是次研究並不為 閣下提供個人利益，參與純屬自願性質，您可隨時終止參與是項行動，有關決定將不會引致任何不良後果。

您的參與將有助我們瞭解社區獨居長者的精神健康狀況及為本計劃提供寶貴的參考資料。因此，我們誠意希望您能接受邀請，與我們一起為長者的福祉作出貢獻。如您對是項研究有任何問題，請現在提出。如日後你對是項研究有任何查詢，請與首席研究員樓瑋群博士聯絡 (852-2219-4835)。如你想知道更多有關研究參與者的權益，請聯絡香港大學非臨床研究操守委員會 (852-2241-5267)。

如你明白以上內容，並願意參與是項研究計劃，請在下方簽署。

參加者簽署：_____

日期：_____

Appendix III

Screening questionnaire

流金頌社區計劃
「愛生命 • 長者有明天」
－緬懷小組運用於獨居長者的成效研究

初步篩選調查

受訪者編號：_____
訪問員姓名：_____
日期：_____

☐ 簽署同意書

☐ 完成第一部分

☐ 完成第二部分

☐ 完成第三部分

☐ 完成第四部分

☐ 符合參與小組條件

☐ 未受過教育
(MMSE ≥ 18)

☐ 私塾或小學程度
(MMSE ≥ 21)

☐ 中學程度或以上
(MMSE ≥ 24)

(MMSE: ____ ; GDS:____)

流金頌社區計劃
「愛生命 • 長者有明天」
－緬懷小組運用於獨居長者的成效研究

服務對象初步調查（篩選）

訪問員自我介紹：

您好！我是流金頌社區計劃「愛生命・長者有明天」的訪問員。流金頌社區計劃旨在幫助在社區居住的獨居長者能更好的適應生活，並提高生活質素。是次計劃由香港大學社會工作及社會行政學系樓瑋群博士負責評估，由嗇色園負責招募參加者及計劃的實施。現在誠邀您參與以下的問卷調查，目的是探索獨居長者的需要，並根據不同需要提供針對性的服務（例如邀請參與長者中心活動、安排義工上門探訪、邀請參與緬懷小組等等）。您的參與將會為我們進一步瞭解社區獨居長者的需要提供寶貴的資料。我們所得的資料將用於服務配對及研究用途，能識別您身份的個人資料將會絕對保密。我現在會向您解釋「參與同意書」的內容，當您明白整個參與過程並同意參與後，我們才會正式與您進行問卷訪問。（訪問員向長者宣讀「參與同意書」內容，並邀請同意參與的長者簽署同意書）

邀請結果：

☐ 長者同意參與調查並簽署同意書 → 開始訪問

☐ 長者拒絕參與調查 → 謝謝長者並結束訪問

訪問結果（成功邀請參與後才需要填寫）：

☐ 成功完成訪問

未能完成訪問，原因：

☐ 長者訪問中途退出

☐ 長者認知障礙令他／她不能理解問題

☐ 其他，註明：_____

_____

第一部分　基本個人資料

1. 受訪者性別：（觀察）　　1 ☐ 男　　2 ☐ 女

2. 您的出生年份（根據身份證）：_____ 年

3. 您目前的婚姻狀況：

1 ☐ 從未結婚　　2 ☐ 分居　　3 ☐ 離婚　　4 ☐ 鰥寡

5 ☐ 已結婚並有配偶　　6 ☐ 其他（請註明：_____）

4. a) 您共育有幾多個兒子和女兒（包括契子 / 女）？[如果沒有，請填「0」]

兒子 _____ 個；女兒 _____ 個

b) 您現時有幾多個活着的兒子和女兒（包括契子 / 女）？

兒子 _____ 個；女兒 _____ 個

5. 您的宗教信仰是：

1 ☐ 沒有宗教信仰　　2 ☐ 傳統中國民間信仰（拜祖先、土地等）
3 ☐ 基督教

4 ☐ 天主教　　5 ☐ 伊斯蘭教　　6 ☐ 佛教　　7 ☐ 道教

8 ☐ 其他（請註明：(_____)

6. 最近 3 個月內，您的經濟來源是甚麼？[可選多項經濟來源]

	有	沒有
退休金	1 ☐	0 ☐
綜合援助金	1 ☐	0 ☐
高齡津貼	1 ☐	0 ☐
工作收入	1 ☐	0 ☐
家人供養	1 ☐	0 ☐
傷殘津貼	1 ☐	0 ☐
儲蓄利息	1 ☐	0 ☐
保險金	1 ☐	0 ☐
其他（請註明：_____）	1 ☐	0 ☐

在這些收入來源中，最主要的是（用子題編號表示答案，例如「13.1」表示「退

休金」）：

第二部分　認知能力 (MMSE)

7. 以下問題將會測試您的認知能力，請您仔細聆聽我的問題，盡量回答就可以。

分數

(　)/5　依家係乜野日子（年份）（季節）（月份）（幾號）（星期幾）?

(　)/5　我地依家係邊度？

（九龍／新界／香港）（九龍／新界／香港既邊度）（邊條街）（邊一座）（邊層樓）；

或（九龍／新界／香港）（九龍／新界／香港既邊度）（邊個屋村）（中心名字）（邊層樓）；

或（九龍／新界／香港）（九龍／新界／香港既邊度）（邊條街／屋村）（院舍名字）（邊層樓）

(　)/3　依家我會講三樣野既名，講完之後，請你重複一次。
請記住佢地，因為幾分鐘後，我會叫你再講番俾我聽。
[蘋果]、[報紙]、[火車]。依家請你講番哩三樣野俾我聽。
（以第一次講的計分，一個一分；然後重複物件，直至全部三樣都記住。）

(　)/5　請你用一百減七，然後再減七，一路減落去，直至我叫你停為止。（減五次後便停）[93　86　79　72　65]（每答對一個計一分）

或　依家我讀幾個數目俾你聽，請你倒轉頭講番出黎。[4 2 7 3 1]
（每答對一個計一分）

(　)/3　我頭先叫你記住既三樣野係乜野呀？

(　)/9　哩樣係乜野？（鉛筆）（手錶）。(2)

請你跟我講句說話 [姨丈買魚腸] (1)

依家檯上面有一張紙。用你既右手拿起張紙，用兩隻手一齊將紙摺成一半，然後放番張紙係檯上面。(3)

請讀出哩張紙上面既字，然後照住去做。拍手 (1)

請你講任何一句完整既句子俾我聽。如：[我係一個人]、[今天天氣好好](1)

哩處有幅圖，請你照住黎畫啦。(1)（見另圖）

總分　____/30

8. 您的最高教育程度是：

1 ☐ 未受過教育　2 ☐ 私塾 或小學程度　3 ☐ 中學程度 (初中及高中)
4 ☐ 大專程度或以上

判斷認知能力是否乎合參與研究計劃的準則	
長者教育程度	判斷為在認知能力方面乎合本研究計劃的參加條件的分數
未受過教育	第一題的總分 ≥ 18/30
私塾或小學程度	第一題的總分 ≥ 21/30
中學程度或以上	第一題的總分 ≥ 24/30

第三部分　精神健康狀況 (GDS) 及 服務使用

9. 在過去一星期內，你是否曾有以下的感受？

	是	不是
您基本上對自己的生活感到滿意嗎？	0 ☐	1 ☐
您是否已放棄了很多以往的活動和嗜好？	1 ☐	0 ☐
您是否覺得生活空虛？	1 ☐	0 ☐
您是否常常感到煩悶？	1 ☐	0 ☐
您是否很多時感到心情愉快？	0 ☐	1 ☐
您是否害怕將會有不好的事情發生在您身上？	1 ☐	0 ☐
您是否大部分時間感到快樂？	0 ☐	1 ☐
您是否常常感到無助？	1 ☐	0 ☐
您是否寧願留在家而不愛出外做些有新意的事？ (如和家人到新開張酒樓吃飯)	1 ☐	0 ☐
您是否覺得您比大多數人有多些記憶的問題？	1 ☐	0 ☐
您認為現在活着是一件好事嗎？	0 ☐	1 ☐
您是否覺得自己現在一無是處呢？	1 ☐	0 ☐
您是否感到精力充足？	0 ☐	1 ☐
您是否覺得自己的處境無望？	1 ☐	0 ☐
您是否覺得大部分人的境況比自己好？	1 ☐	0 ☐
	總分：____ /15	

判斷抑鬱徵狀是否乎合參與研究計劃條件的準則
第 9 題的總分介乎 8 和 13 (包括 8 和 13 分)

10. 您在過去半年內有否遇到以下情況？

被診斷患有精神病 (除了抑鬱症外)	1 ☐ 有	0 ☐ 沒有
濫用藥物或酗酒	1 ☐ 有	0 ☐ 沒有
在醫生指示下服用抗抑鬱藥物	1 ☐ 有。已持續地服用該藥物 _____ 月 (如超過半年，請如實際月數填寫)	0 ☐ 沒有

11. 您現在有接受以下任何服務嗎？

	有	沒有
綜合家居照顧服務 (體弱個案)/ 改善家居及社區照顧服務	1 ☐	0 ☐
長者日間護理中心服務 / 其他長者日間護理單位的服務	1 ☐	0 ☐
個別輔導服務	1 ☐	0 ☐
小組輔導服務	1 ☐	0 ☐
抑鬱治療小組	1 ☐	0 ☐
其他情緒介入服務 (註明：_____)	1 ☐	0 ☐

12. 您現時的身體健康狀況是否足以讓您到本區的社區中心參與活動？

1 ☐ 是　0 ☐ 否

13. 您有興趣成為本機構（嗇色園）的義工嗎？　1 ☐ 有　0 ☐ 沒有

14. 在過去一個月內，您曾否想過要自殺？

1 ☐ 有，有否自殺的計劃？　0 ☐ 沒有

1 ☐ 有

0 ☐ 沒有

謝謝您的參與！

Appendix IV

Questionnaire with full set of assessment

流金頌社區計劃
「愛生命 • 長者有明天」
－緬懷小組運用於獨居長者的成效研究

詳細問卷
(T　　)

受訪者編號：_____
組別：_____
訪問員姓名：_____
日期：_____

☐ 完成第一部分

☐ 完成第二部分

☐ 完成第三部分

流金頌社區計劃
「愛生命 • 長者有明天」
－緬懷小組運用於獨居長者的成效研究

詳細問卷

訪問員自我介紹：

您好！我是流金頌社區計劃「愛生命．長者有明天」的訪問員。感謝您參與是次計劃的緬懷小組，現在我會與您進行一個問卷訪問，需時約四十五分鐘。您的參與將會為我們提供寶貴的資料，有助我們評估緬懷小組的成效。我們所得資料將用於研究用途，能識別您的個人資料將會絕對保密。（如長者沒有其他問題，訪問員便可開始。）

第一部分　　生活狀況

1. 您覺得您現在的健康狀況如何？

0 ☐ 非常差　　1 ☐ 差　　2 ☐ 一般　　3 ☐ 好　　4 ☐ 非常好

2. 最近 3 個月內，您覺得您有足夠的錢來維持日常開支嗎？

0 ☐ 非常不足夠　　1 ☐ 不足夠　　2 ☐ 啱啱夠　　3 ☐ 足夠
4 ☐ 足夠有餘

第二部分　　精神健康狀況

3. 在過去一星期內，您是否曾有以下的感受？
(注意：若問題勾起了長者的傷心回憶，影響了他 / 她的情緒，訪問員應讓長者抒發一下，切勿急於發問。同時，為了控制時間，訪問員應儘量讓長者有 不多於 2 次抒發的機會。)

	是	不是
您基本上對自己的生活感到滿意嗎？	0 ☐	1 ☐
您是否已放棄了很多以往的活動和嗜好？	1 ☐	0 ☐
您是否覺得生活空虛？	1 ☐	0 ☐
您是否常常感到煩悶？	1 ☐	0 ☐
您是否很多時感到心情愉快？	0 ☐	1 ☐
您是否害怕將會有不好的事情發生在您身上？	1 ☐	0 ☐
您是否大部分時間感到快樂？	0 ☐	1 ☐
您是否常常感到無助？	1 ☐	0 ☐
您是否寧願留在家而不愛出外做些有新意的事？ (如和家人到新開張酒樓吃飯)	1 ☐	0 ☐
您是否覺得您比大多數人有多些記憶的問題？	1 ☐	0 ☐
您認為現在活着是一件好事嗎？	0 ☐	1 ☐
您是否覺得自己現在一無是處呢？	1 ☐	0 ☐
您是否感到精力充足？	0 ☐	1 ☐
您是否覺得自己的處境無望？	1 ☐	0 ☐
您是否覺得大部分人的境況比自己好？	1 ☐	0 ☐

總分：____ /15

4. 在過去一星期內，請問您滿意您生活的各個部分嗎？（以圖畫輔助：揀選一項以表示滿意程度）

	非常不滿意	不滿意	一般	滿意	非常滿意
與家人聯絡的方式和次數（家庭關係）	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
與子女 / 孫子女的溝通	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
與朋友聯絡的方式和次數（友誼）	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
配偶或生活伴侶	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
每天的飲食	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
收入和財產（經濟狀況）	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
一般的健康狀況	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
住房的類型，狀況和環境（居住條件）	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
總體生活情況	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

第三部分　　支援網絡狀況

5. 以下問題將會問及您與家人和親戚的關係（家人和親屬包括配偶、子女、（外）孫子女及其配偶、兄弟姊妹等等）：

在最近 3 個月內，您有多少個每個月至少來往一次的不是住在一起的家人和親戚？
0 ☐ 無　　1 ☐ 一個　　2 ☐ 兩個　　3 ☐ 三四個
4 ☐ 五到八個　　5 ☐ 九個或以上

在最近 3 個月內，您感到關係很好而且可以找他們幫忙的家人和親戚有多少個？
0 ☐ 無　　1 ☐ 一個　　2 ☐ 兩個　　3 ☐ 三四個
4 ☐ 五到八個　　5 ☐ 九個或以上

在最近 3 個月內，可以讓您很放心地討論私人事宜（如個人錢財或糾紛處理）的家人和親戚有多少個？
0 ☐ 無　　1 ☐ 一個　　2 ☐ 兩個　　3 ☐ 三四個
4 ☐ 五到八個　　5 ☐ 九個或以上

在最近 3 個月內，您與交往最多的不是住在一起的家人和親戚多長時間來往一次？
0 ☐ 少於一個月一次　　1 ☐ 一個月一次　　2 ☐ 一個月二至三次
3 ☐ 一週一次　　4 ☐ 一週幾次　　5 ☐ 每天

在最近 3 個月內，當您的一位家人或親戚有重要決定要做時，他有幾經常會找您商量？
0 ☐ 從不　　1 ☐ 很少　　2 ☐ 有時　　3 ☐ 多數
4 ☐ 經常　　5 ☐ 任何時候

在最近 3 個月內，當您需要做出重大決定時，您有多大可能性能夠找到至少一位家人或親戚去討論？
0 □ 從不　1 □ 很少　2 □ 有時　3 □ 多數
4 □ 經常　5 □ 任何時候

6. 以下問題將會問及您與朋友的關係：

在最近 3 個月內，您有多少個每個月至少來往一次的不是住在一起的朋友？
0 □ 無　1 □ 一個　2 □ 兩個　3 □ 三四個
4 □ 五到八個　5 □ 九個或以上

在最近 3 個月內，您感到關係很好而且可以找他們幫忙的朋友有多少個？

0 □ 無　1 □ 一個　2 □ 兩個　3 □ 三四個
4 □ 五到八個　5 □ 九個或以上

在最近 3 個月內，可以讓您很放心地討論私人事宜（如個人錢財或糾紛處理）的朋友有多少個？
0 □ 無　1 □ 一個　2 □ 兩個　3 □ 三四個
4 □ 五到八個　5 □ 九個或以上

在最近 3 個月內，您與交往最多的不是住在一起的朋友多長時間來往一次？

0 □ 少於一個月一次　1 □ 一個月一次　2 □ 一個月二至三次
3 □ 一週一次　4 □ 一週幾次　5 □ 每天

在最近 3 個月內，當您的一位朋友有重要決定要做時，他有幾經常會找您商量？
0 □ 從不　1 □ 很少　2 □ 有時　3 □ 多數
4 □ 經常　5 □ 任何時候

在最近 3 個月內，當您需要做出重大決定時，您有多大可能性能夠找到至少一位朋友去討論？
0 □ 從不　1 □ 很少　2 □ 有時　3 □ 多數
4 □ 經常　5 □ 任何時候

謝謝您的參與！

Appendix V

Questionnaire with brief set of assessment

流金頌社區計劃
「愛生命 • 長者有明天」
－緬懷小組運用於獨居長者的成效研究

簡易問卷
(T　　)

受訪者編號：_____
組別：_____
訪問員姓名：_____
日期：_____

☐ 完成第一部分

☐ 完成第二部分

流金頌社區計劃
「愛生命 • 長者有明天」
－緬懷小組運用於獨居長者的成效研究

簡易問卷

訪問員自我介紹：

　　您好！我是流金頌社區計劃「愛生命・長者有明天」的訪問員。感謝您參與是次計劃的緬懷小組，現在我會與您進行一個簡短的問卷訪問，只需時約十五分鐘。您的參與將會為我們提供寶貴的資料，有助我們評估緬懷小組的成效。我們所得資料將用於研究用途，能識別您的個人資料將會絕對保密。(如長者沒有其他問題，訪問員便可開始。)

第一部分　　生活狀況

1. 您覺得您現在的健康狀況如何？

　　0 ☐ 非常差　　1 ☐ 差　　2 ☐ 一般　　3 ☐ 好　　4 ☐ 非常好

2. 最近 3 個月內，您覺得您有足夠的錢來維持日常開支嗎？

　　0 ☐ 非常不足夠　　1 ☐ 不足夠　　2 ☐ 啱啱夠　　3 ☐ 足夠　　4 ☐ 足夠有餘

第二部分　精神健康狀況

3. 在過去一星期內，您是否曾有以下的感受？
（注意：若問題勾起了長者的傷心回憶，影響了他 / 她的情緒，訪問員應讓長者抒發一下，切勿急於發問。同時，為了控制時間，訪問員應儘量讓長者有 不多於 2 次抒發的機會。）

	是	不是
您基本上對自己的生活感到滿意嗎？	0 ☐	1 ☐
您是否已放棄了很多以往的活動和嗜好？	1 ☐	0 ☐
您是否覺得生活空虛？	1 ☐	0 ☐
您是否常常感到煩悶？	1 ☐	0 ☐
您是否很多時感到心情愉快？	0 ☐	1 ☐
您是否害怕將會有不好的事情發生在您身上？	1 ☐	0 ☐
您是否大部分時間感到快樂？	0 ☐	1 ☐
您是否常常感到無助？	1 ☐	0 ☐
您是否寧願留在家而不愛出外做些有新意的事？（如和家人到新開張酒樓吃飯）	1 ☐	0 ☐
您是否覺得您比大多數人有多些記憶的問題？	1 ☐	0 ☐
您認為現在活着是一件好事嗎？	0 ☐	1 ☐
您是否覺得自己現在一無是處呢？	1 ☐	0 ☐
您是否感到精力充足？	0 ☐	1 ☐
您是否覺得自己的處境無望？	1 ☐	0 ☐
您是否覺得大部分人的境況比自己好？	1 ☐	0 ☐

總分：____ /15

4. 在過去一星期內，請問您滿意您生活的各個部分嗎？（以圖畫輔助：揀選一項以表示滿意程度）

	非常不滿意	不滿意	一般	滿意	非常滿意
與家人聯絡的方式和次數（家庭關係）	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
與子女 / 孫子女的溝通	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
與朋友聯絡的方式和次數（友誼）	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
配偶或生活伴侶	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
每天的飲食	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
收入和財產（經濟狀況）	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
一般的健康狀況	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
住房的類型，狀況和環境（居住條件）	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
總體生活情況	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

謝謝您的參與！

Appendix VI

Observation form

流金頌社區計劃
「愛生命 • 長者有明天」

緬懷小組組員觀察表

組員姓名：＿＿＿＿＿＿＿＿＿＿　觀察者：＿＿＿＿＿＿＿＿＿＿

組員編號：
（例：T001, T002）＿＿＿＿＿＿＿＿＿＿

組別：
（例：E1a, C2b）＿＿＿＿＿＿＿＿＿＿

節數（日期）	1 (　)	2 (　)	3 (　)	4 (　)	5 (　)	6 (　)	7 (　)	8 (　)
願意出席程度								
0= 缺席 / 拒絕出席參與小組								
1= 需要游說								
2= 需要提醒								
3= 出席小組而不需任何提醒								
4= 活躍地出席小組，對出席小組很感興趣								
注意力								
0= 在小組中完全未能集中								
1= 在小組中只有少許時間能集中（約 20 分鐘）								
2= 在小組中約一半時間能集中（約 45 分鐘）								
3= 在小組中大部份時間都能集中（約 70 分鐘）								
4= 在整個小組過程中都能保持集中								
與人交往								
0= 不會參與對話								
1= 只在被帶領者提問時才回答								
2= 會回應其他參與者								
3= 會主動與其他參與者談話								
4= 會主動與其他參與者交流，並在活動中關心他人/ 給予幫忙								

節數（日期）	1 (　)	2 (　)	3 (　)	4 (　)	5 (　)	6 (　)	7 (　)	8 (　)
參與程度								
0= 完全不作任何回應								
1= 不合作 / 少許參與								
2= 在引導或刺激下能積極參與								
3= 在不需要引導或刺激下也能積極參與								
4= 主動積極參與，並帶動/ 支持其他參與者一起參與								
享受小組程度								
0= 沒有跡象顯示享受小組								
1= 很少表現出開心								
2= 間中表現出開心								
3= 能享受大部分小組時間								
4= 完全享受小組時間								
功課完成程度								
1= 沒有嘗試完成功課								
2= 嘗試過但只完成了很少部分								
3= 完成了功課的一半左右								
4= 完成了大部分功課，但沒有完全達到要求								
5= 完成了整份功課，達到了組長的要求								
6= 比組長的要求完成了更多								

CADENZA Community project

Cherish Our Life: Enhancing Psychological Well-being of Elders

Project Report

Authors

Dr. Lou Vivian W. Q.
Department of Social Work and Social Administration
The University of Hong Kong

Sik Sik Yuen – Social Services' Project Members

Project members

Department of Social Work and Social Administration
The University of Hong Kong

Dr. Lou Vivian W. Q., Assistant Professor
Mr. Choy Chak Pui Jacky, Research Assistant
Mr. Tang Wai Hong Garfield, Research Assistant (December 2011 – May 2012)
Ms. Au Wing Nam Judith, Research Assistant (June 2012 – August 2013)

Sik Sik Yuen - Social Services
Mr. Yeung Chiap To, Social Services Secretary
Ms. Wong Tze Mei Athena, Assistant Social Services Secretary
Ms. Lee Chow Ling, Centre-in-charge
Ms. Tsang Sze Wai Psyche, Social Worker
Mr. Wong Kam Hong, Project Officer
Ms. Siu Wing Yin Eaco, Assistant Project Officer

Published by

The Hong Kong Jockey Club
Tel 2966 8111
Fax 2504 2903
Website http://www.hkjc.org.hk

ISBN 978-988-15262-8-1

Published in September 2013