Critical Review:

Does reminiscence therapy including life story work improve the quality of life of people with dementia?

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This critical review examines whether reminiscence therapy and life-story work improve the quality of life of individuals with dementia. A revie

all groups. Further analysis revealed additional improvements in quality of life for the RT group at 12 weeks and 6 months post treatment.

Strengths of this study include a large sample size and selection criteria requiring participants to meet DSM-IV criteria for Alzheimer's dementia. Additionally, confounding variables such structured sessions (without life story work) and social contact alone were controlled for.

A limitation of this study is the use of an outcome measure that lacks reliability in this population (Kane et al., 2003). Furthermore, cognitive decline was not controlled for and could have counteracted any potential improvements caused by the intervention (Kane et al., 2003).

Despite these limitations, the overall validity of the study provides moderately suggestive evidence for the use of RT to improve the quality of life of individuals with dementia.

Haslam et al. (2010) compared the effect of group RT with independent RT and group control (social contact without RT) on the quality of life of 73 adult care residents with Alzheimer's dementia. Group and individual RT sessions (6 in total) consisted of facilitated conversations about pre-determined topics using tangible objects from each time period. Quality of life was measured using a well-being score consisting of the Quality of Life in Alzheimer's disease (QoL-AD), the Quality of Life Change Scale and the Life Improvement Scale. Appropriate statistical analysis showed greater improvement in well-being scores for the control group relative to either intervention group. The authors determined that RT therapy improved memory, whereas group social interaction improved quality of life. They conclude that RT may have improved memory, making residents more aware of their situation leading to no change in quality of life, although no evidence is provided to support this idea.

Strengths of this study include controlling for the potential confounding variable of social interaction. Furthermore, the methodology included implementation of a protocol congruent with RT.

A limitation of this study includes inconsistency in participants regarding presence of dementia. Additionally, residents with significant language impairments were excluded from participating. As language impairment is one of the defining characteristics of dementia the generalizability of the results to dementia is limited (McKhann et al., 2011). Furthermore, administration of intervention and assessment were completed by the same researchers allowing for biased results.

Overall mildly suggestive evidence was provided that indicates RT may not have an effect on quality

caregivers who were provided training on implementation of RYCT at home, as well as communication strategies. Quality of life was measured using the QoL-AD. Multiple t-tests revealed no significant change in quality of life post intervention.

Strengths of this study include selection criteria requiring a diagnosis of dementia and the blinding of the assessor to group allocation. Expected change over time was controlled for using a group of participants who received usual care.

Limitations of this study include a small sample size making significant results more difficult to obtain and increasing the possibility of Type II error. Additionally, the use of multiple t-test warrants some caution as it increases the possibility of Type I error.

Furthermore, family members provided the majority of the intervention but their skill level was not assessed. Inconsistency in quality and amount of RT received at home may have limited the possibility of finding an effect in a limited sample.

Due to these limitations, this study provides equivocal evidence for the use of RYCT for people

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