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Interpersonal psychotherapy for depressed retirees: Developing and testing a clinical treatment manual

Sue G. Miller
Edith Cowan University

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Interpersonal Psychotherapy for Depressed Retirees: Developing and Testing a Clinical

Treatment Manual

Sue G. Miller

BA(Hons)Psych

Faculty of Computing, Health and Science, Edith Cowan University

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Abstract

Most workers adjust well to retirement, but some experience depression due to poor adjustment. No evidence-based treatments were identified that targeted the developmental needs of this complex transition. In phase 1, a treatment manual (IPT-RM) was developed. The manual comprised an adaptation of Interpersonal Psychotherapy. In phase 2, a pilot study was conducted to determine the treatment's feasibility. A series of non-experimental AB single-case studies was conducted with nine retirees. All research participants' depressive symptoms receded into the non-depressed range by the end of the study. The IPT-RM treatment manual was developed to a Stage 1 level, which incorporated peer-reviewed literature and clinical knowledge. Practical implications of the research for future activities include (a) prevention: conduct psychosocial retirement preparation workshops and other delivery formats, such as internet, DVD, and print media and (b) intervention: train psychologists in issues related to retirement adjustment. Future research could trial IPT-RM at a Stage 2 level of evidence-based treatment manual development. Furthermore, a retirement adjustment scale could be developed to predict which retirees are at greatest risk of experiencing depression due to a poor adjustment to retirement.

Declaration

I certify that this thesis does not, to the best of my knowledge and belief:

- incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education,
- contain any material previously published or written by another person except where due reference is made in the text of this thesis, or
- contain any defamatory material.

Sue G. Miller
Ph.D Candidate

Date

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Dedications

To Cindi Grossman, my dearly missed sister who did not pass her teenage years. I hope to make you proud.

To Levi Miller, born 28 November 2011. Thank you for the gift of coming into our lives and allowing us to love and cherish you. We are so very blessed with your presence.

To Max Miller, died 22 July 2011. My little Angel who did not get the chance to take his first breath. Thank you for the possibilities. You shall always be a part of me.

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Chapter 1
Literature Review
Introduction

Significance

The factors explaining why some workers adjust well to retirement and others do not are well documented by researchers. One thing that is needed is an evidence-based psychological treatment for retirees who are experiencing depression due to a poor adjustment to retirement. No evidence-based manual was identified to treat retirement related depression. A treatment designed to meet the developmental needs of retirees may be more efficient and effective than existing treatment models. In their guidelines for psychologists working with older adults, the American Psychological Association (APA, 2004) stated that older adults may benefit from interventions specifically addressing late life issues. Furthermore, the Australian Psychological Society (APS, 2008) highlighted retirement as a key developmental issue that psychologists need to be cognisant of. The objective of this thesis was to evaluate the feasibility of an adapted version of Interpersonal Psychotherapy for clients experiencing retirement maladjustment (IPT-RM).

Background

Retirement is a key life transition experienced by most people and typically creates some degree of disruption (Atchley, 1975). Most workers enter retirement with relative ease, yet some experience depression due to a poor adjustment to retirement (Fry, 1992; Nuttman-Shwartz, 2004; Quine, Wells, de Vaus, & Kendig, 2007). Although exact rates of depression remain unknown, research indicates that about 30% of workers experience difficulties and a smaller percentage experience depression in the adjustment to retirement. In a United States study, around 30% of participants ($N = 1516$; all male) experienced an array of retirement related problems, including feeling bored or too busy, or having concerns with money, adjustment, relationships, and health (Bosse, Aldwin, Levenson, & Workman-Daniels, 1991). Atchley (1975) concluded that around 30% of workers have difficulties in adjusting to retirement (citing research pre-1970). Studies for different countries, genders, and decades often yield a similar figure of about 30% of retirees experiencing difficulties in the adjustment to retirement. Additionally, a study on couples conducted in the Netherlands found that 13% of participants experienced “severe” difficulties in the adjustment to retirement (van Solinge & Henkens, 2005).

These difficulties can be caused or exacerbated by a lack of psychological preparation (Johnson, 1982; Kim & Moen, 2001a), lack of financial resources (Lusardi & Mitchell, 2006), involuntary retirement that is forced or premature (e.g., redundancy, retrenchment, or health

problems) (Kim & Moen, 2001a; Mein, Martikainen, Hemingway, Stansfeld, & Marmot, 2003; Quine et al., 2007; Tinsley & Bigler, 2002), and separation from, or death of, a partner (Atchley, 1975; Wang, 2007). Johnson (1982) argued that a lack of preparation for retirement may adversely affect psychological, emotional, and physical wellbeing. The most frequent difficulties experienced by retirees are depression and anxiety (Fretz, Kluge, Ossana, Jones, & Merikangas, 1989; Nuttman-Shwartz, 2004), disillusionment or dissatisfaction with retirement (Nuttman-Shwartz, 2004), and, arguably, death (Bosse et al., 1991).

There is little evidence that retirement causes death. The association of death and retirement may have been made because of the temporal closeness of a worker retiring due to illness and then death from that illness following shortly thereafter. Depression can be a fatal illness and, at the extreme, suicide could be a result of maladjustment to retirement. In Australia, there is a relatively high incidence of suicide among adults aged over 65 years (Australian Bureau of Statistics, 2011), but no figures were found linking suicide with retirement adjustment problems.

Rationale

Ageing is the most profound change within Australia's population structure. Australia's population is expected to increase from 21 million in 2005 to 35.5 million in 2056 (based on Series B projections, which reflect current fertility, migration, and life expectancy trends; Australian Bureau of Statistics, 2009a). Fertility rates have decreased since their peak of 3.5 babies per woman in 1961 to 1.93 babies per woman in 2007 (Australian Bureau of Statistics, 2008). Mean life expectancy has increased to 78.5 years for men and 83.3 years for women in 2005 (Department of Health and Ageing, 2007). The sharply increasing number of Australians aged over 65 means that issues of health, aged care, and income support now need to be addressed (Australian Bureau of Statistics, 2009a). Compared with 13% of people aged over 65 in 2007, it is anticipated that there will be at least 23% in 2056 (Australian Bureau of Statistics, 2009a).

Data from the Employment Arrangements, Retirement, and Superannuation survey indicated that there were 3.1 million Australians retired in 2007 and this is expected to increase by over one million people in the next ten years (Australian Bureau of Statistics, 2009b). Baby boomers (born 1946 and 1960) started to turn 65 in 2011 and comprise a very large cohort entering retirement at around the same time. While there is no longer a compulsory retirement age, the Australian Government attempts to retain older employees in the workforce by setting the qualification age for the aged pension at 65 (Australian Institute of Health and Welfare, 2008). Recent Government policy envisages a future increase in the

qualification age to 67 for the pension, but not necessarily for accessing superannuation funds (Commonwealth of Australia, 2009).

In 2007, on average, Australian men retired at 58 and women at 47 years of age (Australian Bureau of Statistics, 2009b). The age for women is surprisingly low and the reasons cited for early retirement included health, to care for others, or to spend more time with family or partner. The Sunday Times (Pow, 2011) predicted a contrasting trend in the age of retirement for Generation Alpha (i.e., people born between 2010 and 2024). Compared to current retirees, Generation Alpha is predicted to be more educated, start work later, and work into their seventies or eighties. Such a late retirement age may change the face of the retirement experience as the loss of meaning, structure, finances, activities, and socialisation derived from work may be different from the severance experienced in today's retirement for workers in their fifties and sixties.

With lower retirement ages, increased longevity, and improved health, retirement is no longer a transition to old age (Patrickson & Ranzijn, 2004). With large numbers of Australians now retiring and a significant proportion experiencing depression as a result of retirement (Fry, 1992; Quine et al., 2007), it is now a priority to help ensure the psychological wellbeing of retirees. With one million workers expected to retire in the next decade alone, there will be around 300,000 people potentially experiencing psychological difficulties during the transition and adjustment to retirement (based on research evidence of approximately 30% of retirees experiencing psychological problems).

Helping older adults live well in retirement has personal and societal benefits. Personally, retirees may age successfully (Pruchno, Wilson-Genderson, & Cartwright, 2010), feel good about the lives they have lived (Kunz, 2007), have a sense of pride in ageing (Kelly & Barratt, 2007), and reach the end of their lives with dignity (Erikson, 1997). Socially, retirees may remain active community members who contribute to society through the caring of grandchildren and elderly parents, or doing volunteer work, and thus reducing the burden on the health care system. The community at large, and specifically the APS (Gridley et al., 2000) and *beyondblue*, recognise the importance of research with older adults experiencing depression due to adjustment problems in retirement.

beyondblue was initiated by the Victorian Government in 2000 with the founding mandate "to make suffering depression as freely talked about as having the flu" (Villages Queensland Magazine, 2007, p. 24). This organisation associates retirement and involuntary retirement with depression and one of the three foci of the *beyondblue* Victorian Centre of Excellence in Depression is on "the management of depression in mid to later life. Major life changes during this period, including menopause, bereavement and grief, divorce, retrenchment and

retirement are all of relevance to depression and related disorders, and warrant further investigation as well as intervention” (beyondblue, 2009, p. 1).

Definitions

Retirement. For the Australian Government’s statistical purposes, retirement means that a person worked for longer than two weeks, has no intention to seek further employment, and is no longer in the workforce (Australian Bureau of Statistics, 2009b). Psychological research has referred to retirement as a transition and a process (Kim & Moen, 2001a; Reis & Gold, 1993; Tinsley & Bigler, 2002). Butters (2002, p. 6) referred to internal and external adjustments when she depicted the pre- and post-retirement changes as “an active person with an identity and in great demand, to an individual with complete freedom, no deadlines, and possibly no purpose.” The retirement transition encompasses the pre-retirement phase, retirement itself, and post-retirement adjustment (Ekerdt, Bosse, & Levkoff, 1985). Atchley (2004) suggested that an operational definition of retirement must include two parts: receipt of a pension and the withdrawal or reduction in employment. For the current study, retirement is defined as when an individual has exited fulltime employment, but may engage in bridge employment; and is self-defined as a retiree.

Depression. The term depression refers to a Major Depressive Disorder as defined by the DSM-IV-TR Criteria for Major Depression Episode (American Psychiatric Association, 2000, p. 356):

- A. Five (or more) of the following symptoms have been present during the same two week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
 - 1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
 - 2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
 - 3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
 - 4) Insomnia or hypersomnia nearly every day.
 - 5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
 - 6) Fatigue or loss of energy nearly every day.

- 7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
 - 8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
 - 9) Recurrent thoughts of death (not just fear of dying), recurrent suicide ideation without a specific plan, or a suicide attempt or a specific plan for suicide.
- B. The symptoms do not meet criteria for a Mixed Episode.
 - C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
 - D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
 - E. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than two months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Purpose

The purpose of this literature review is to introduce the problem area, describe and analyse the body of literature in the field, and introduce the current research. An introduction to the topic has now been provided and the rest of this review discusses the literature. Topics to be covered include: ageing, work, theoretical models of retirement, patterns of retirement adjustment, pathways to retirement, depression and older adults, and psychological treatments, and concludes with a summary and the current research.

Ageing

Many theories on ageing exist (Cavanaugh, 1999; Fry, 1992), but no single theory fully explains why and how people grow old. Cavanaugh's theoretical article presents theories on ageing under three categories: biological, behavioural, and social science. One of the key social science theories that has received a great deal of empirical research is Erikson's (1997) psychosocial theory of human development (McAdams, 2001). Of particular relevance to retirees are the seventh and eighth stages of this theory.

Generativity versus stagnation is the seventh stage. Erikson's theory suggests that retirees entering therapy due to a poor adjustment to retirement are likely to do so because they are stagnating. Stagnation may result in significant symptoms of depression among some individuals, where retirees are self-focusing rather than extending themselves into the world. A retiree who has resolved the psychosocial crisis of this stage is productive, contributes to the

community, sets goals, looks forward into the future, and is generally useful. A retiree who is generative is likely to have better mental health than someone who is stagnating.

Integrity versus despair is the eighth stage. The developmental task for older adults in this stage is retrospection. This may entail looking back on one's life, often termed a life review (Haight, 1995), as a means of reflection and reconciliation about how one's life has been lived. It is thought to be done when someone is aware of their impending death. Recent retirees are typically looking forward and still in a denial phase about their eventual death (Kelly & Barratt, 2007), except perhaps if the worker has retired because of ill health. Someone who reaches the end of their life without integrity is said to not have resolved this stage and may experience despair. Psychological intervention may be helpful to someone who is despairing to facilitate a process of life review and emotional reconciliation.

Remaining active plays an important role in resolving both the seventh and eighth stages. Activity theory, generally referring to remaining involved and engaged in older age, was proposed in response to the then-current disengagement theory (Fry, 1992). Disengagement theory, essentially the opposite of activity theory, proposes that as people age they naturally withdraw from society and, furthermore, society mirrors this by subtly excluding older adults. While retirement may bring about a shrinking of the worker's world, with all the incumbent associated losses, retirees have the opportunity to consciously expand their life spheres so they do not become constricted. Indeed, this keeping open and expanding is a key factor of Rowe and Kahn's (1997) successful ageing model.

Successful Ageing

Several models of successful ageing have been proposed (Pruchno et al., 2010; Rowe & Kahn, 1997). These models attempt to explain the relationship between factors that contribute to someone living well in old age despite the naturally occurring limitations incumbent with the ageing process. Rowe and Kahn's model was the first to make a significant impact and a great deal of research has flowed from their work.

The Rowe and Kahn (1997, p. 433) model of successful ageing posits three factors that interact and lead to successful ageing: "avoidance of disease and disability, the maintenance of high cognitive and physical function, and sustained engagement in social and productive activities." Of particular relevance to the retirement literature, and where psychological intervention may have the biggest impact, is engagement with life. The key attributes of this factor include being engaged in social relationships and productive activities. When a retiree is stagnating and a psychological intervention is deemed to be helpful, a treatment such as Interpersonal Psychotherapy may be a good fit. A basic tenet of Interpersonal Psychotherapy is the development and maintenance of social networks as a means to alleviate depressive

symptoms. In regard to facilitating successful ageing, remaining engaged may be encouraged through group activities and volunteer work.

A contrasting view to Rowe and Kahn's (1997) model has recently been proposed by Pruchno et al. (2010) who described a two factor model of successful ageing comprising objective and subjective factors. Objective successful ageing is where the older adult has functional ability, lives with little or no pain, and few chronic diseases. Subjective successful ageing is the older adult's self-rated view on how well he or she is ageing. In contrast to Rowe and Kahn, Pruchno et al. argued that cognitive functioning, social functioning, and psychological wellbeing need to be in place for successful ageing to manifest, rather than these being descriptors of successful ageing.

The Pruchno et al. (2010) and Rowe and Kahn (1997) models of successful ageing have overlapping concepts. The utility of the former model is yet to be demonstrated and its challenge to the Rowe and Kahn model yet to be upheld. While the Rowe and Kahn model has been critiqued as needing to recognise the importance of spirituality and include it as a factor (Crowther, Parker, Achenbaum, Larimore, & Koenig, 2002), it has gained empirical support. The indicators of successful ageing highlighted by Rowe and Kahn enable therapists to work with these factors so clients may adapt to the developmental changes experienced and live well in older age.

Work

People work to satisfy human needs; these may change over time and work can fulfil them to varying degrees (Neff, 1985). Neff lists these key needs as: money, self-esteem, activity, receiving respect from others, and creativity. The need for meaning and social interaction could be added to this list because some retirees acutely experience their loss in relation to retirement. Dawis (2005) suggested a positive correlation between the fulfilment of needs through work and the level of work satisfaction experienced.

Financial Needs

Work fulfils financial needs as money is needed to survive. Neugarten (1968) suggested that the motivators to work change between the ages of 55 and 64. Until the age of 55, Neugarten stated that workers tend to 'live to work'. At age 55, workers are preparing more actively for retirement and begin to 'work to live'. That is, the worker has developed an acute awareness of his or her imminent retirement and the goal changes to having enough money to live well when a replenishable source of income is no longer available. Sterns and Huyck (2001) suggested that another change occurs after the age of 60. Workers become less motivated to work for extrinsic rewards (such as, money) and become more motivated by intrinsic rewards (such as, feeling valued, appreciated, and respected). With regard to retirement, retirees may

be motivated to do volunteer work for the receipt of intrinsic rewards (such as, learning new skills, pride in doing a good job, mentoring others, continuing use of professional expertise, being needed, or social interaction).

Self-Esteem Needs

Self-esteem refers to how a person feels about themselves. Workers calculate their self-worth, albeit unconsciously, by comparing their occupation level, status, and amount earned. Self-esteem is affected by three qualities of the worker's job: autonomy, power, and opportunities for socialisation (Neff, 1985). While retirement provides autonomy and freedom from work schedules and demands, the authority, responsibility, power, and the naturally occurring social interactions are lost from the workplace. These sources of self-esteem are typically taken for granted until, come retirement, the worker no longer has access to them. Retirees may retain self-esteem needs by immersing themselves in unpaid roles (e.g., by becoming the recruitment coordinator for a political party, which involves a lot of work).

If a retiree is stagnating, perhaps due to not being able to reconcile the losses of work with the gains of retirement, a therapeutic intervention may help to repair their self-esteem. Several options are available including volunteer work. Volunteering may create a natural opportunity to socialise, the retiree may specify their level of commitment, and may reinstitute a degree of authority, responsibility, and sense of being needed.

Activity Needs

Participating in work fulfils a need for being active and productive while creating structured time and routine. It is not until a person cannot work (e.g., through disability) that he or she experiences the stress of having this need thwarted. Chronic boredom is stressful and it is the main reason cited for unemployed and underemployed people wanting to work (Neff, 1985). One reason that retirees undergo a major adjustment when they stop work is that their time becomes largely unstructured. However, when workers have interests and activities outside of work they tend to continue with these in retirement. If they do not, however, retirees will need to create activities to avoid stagnating, but this may be challenging to initiate.

In retirement, health and money are determinants of activity involvement (Sterns & Gray, 1999). People who are fit and healthy are more likely to be actively engaged compared to those with poor health (Nelson & Bolles, 2007). Available financial resources, and willingness to spend money, influence a retiree's consumption of leisure activities.

Need for Respect from Others

Society instils respect upon people who are gainfully employed (Neff, 1985). While society permits people with disabilities to not work (Atchley, 2004), it frowns upon so called dole-bludgers, who are people who have the capacity to work but choose not to. Sterns and Huyck

(2001) stated that workers can also receive respect from their employing organisation. The need for respect is met when workers are valued and valuable to the organisation. The respect received tends to be commensurate with the education and training required to do the job, salary, social importance of the work done, and degree of autonomy in the role (Neff, 1985).

Need for Creativity

The need for creativity may be fulfilled when someone is working in a job he or she finds satisfying (Neff, 1985). When work taps into the person's unique capabilities, it provides an avenue to be creative. For a psychologist, this may be working with a client and writing a case study for a scientific journal, which provides insights into a particular psychological condition. In retirement, creativity may be thwarted if the retiree is stagnating. A therapist could assist the client to find opportunities to be creative such as exploring activities they lacked the time for while working, recommencing an activity, trying an activity they always wanted to do, or doing something they now have the confidence to try in older age (Nelson & Bolles, 2007).

Need for Meaning

Work provides meaning to people's lives (Jonsson, Josephsson, & Kielhofner, 2001), whether it be personal meaning, making a contribution to society, or a reason to get out of bed in the morning (Sterns & Huyck, 2001). Work relieves the senselessness and uselessness of not having something to do with one's time (Neff, 1985). Meaning can be derived by older workers when they mentor younger workers, which is an aspect of Erikson's theory of psychosocial development (McAdams, 2001; Sterns & Huyck, 2001).

A retiree who is stagnating may not have a reason to get out of bed in the morning, and this could be an indicator of depression. In one of Yalom's (2000) case studies, he asks three questions of a client who is struggling with retirement issues: (a) What do you miss about your work? (b) What does it mean to not work again? (c) Where do you go in life from here? There is an opportunity for therapists to help retirees who are stagnating by exploring how they can derive meaning from life.

Social Needs

Work is an important source of social contact, sense of place, and meaning (Brief & Weiss, 2002). A workplace is a community of relationships that provides a naturally occurring opportunity to meet people and interact professionally and socially. Social contact at work may relieve loneliness, especially for people living alone. Hence, a worker who realises that retirement will bring about a severing of collegial relationships may delay retirement.

Theoretical Perspectives on Retirement

Various theoretical perspectives explain the different patterns of retirement adjustment that have emerged in research findings. Some have greater explanatory power than others.

The first four to be discussed, disengagement theory, activity theory, role theory, and continuity theory, derive from the social gerontological field. The other two theories, life-course perspective and resource theory, are more recent developments applied to retirement adjustment.

Disengagement Theory

According to disengagement theory, successful retirement adjustment means gracefully withdrawing from the workforce and not replacing it with other roles or activities, but accepting the loss as a natural and inevitable part of the developmental process of ageing (Fry, 1992). Although it was the first formal theory to explain processes of ageing, disengagement theory is now largely out of favour. It has not been referenced by recent authors explaining the retirement experience (e.g., Kim & Moen, 2002; Pinguart & Schindler, 2007; Wang, 2007). Disengagement theory has received criticism and there is little evidence supporting it. Resistance to disengagement by older adults can be seen in the cosmetic and plastic surgery industry. Older adults may go to great expense to delay the ageing process, suggesting they want to remain engaged and part of the youthful crowd who remain visible and favoured by society. Jane Fonda (born 21 December 1937) and Joan Collins (born 23 May 1933) are examples of famous women, who are in their seventies, have undergone cosmetic procedures, and look decades younger than their chronological age. Contrary to the assumptions of disengagement theory, evidence suggests that many retirees remain active and continue their pre-retirement activities.

Activity Theory

Activity theory assumes that participating in society fosters psychological wellbeing. Moreover, wellbeing is maintained or enhanced in retirees who remain active once they leave the workforce. Activity theory was tested by Chambre (1984) but evidence failed to support the theory. The study, however, had limitations which rendered the interpretation of results questionable: it was a secondary analysis of 1974 cross-sectional data and informal voluntary work (such as, time spent caring for ill parents or grandchildren) was excluded. In contrast, a recent study with reliable methods found that retirees remain engaged with productive activities after leaving work (Dosman, Fast, Chapman, & Keating, 2006) and that continuous activity is correlated with life satisfaction (Goldberg, 2002).

Activity theory argues that in retirement an easy adjustment is facilitated by being engaged in activities, which is contrary to disengagement theory. People can have a difficult time adjusting to retirement when they do not have interests outside of work. Weekend or holiday activities that were purely for fun may become unsatisfying when it comes to filling in years or decades of retirement. There are three types of activities – pleasurable, engaging, and

meaningful – and Nelson and Bolles (2007) recommended that retirees incorporate a balance of all three.

Pleasurable activities are those that are fun. Some are consumed, that is, the retiree needs to purchase them. Fun activities include: socialising with family and friends, hobbies, eating out, entertainment, travel, and spectator events. In contrast to activities that are consumed, engaging and meaningful activities are created by the retiree.

Engaging activities are absorbing. These types of activities are challenging enough to avoid boredom, but not too challenging so as to evoke anxiety. Counselling could help retirees find interesting challenges that are a good match for their favourite skills and strengths. Some retirees were too busy during their working lives to pursue areas that they were really interested in and retirement is an opportunity to get involved in them. An example to differentiate the concepts of pleasurable and engaging activities is going to an art gallery (for pleasure) and painting (for engagement).

Meaningful activities are rewarding, have a purpose, and require a personal investment. They usually involve being in service to others or to something larger than oneself. Examples that Nelson and Bolles (2007) suggested include: helping family, animals, neighbours, and the sick; practicing religion; and volunteering to assist a worthy cause. Extending the previous example, a meaningful activity could be selling the paintings to raise money for charity. Involvement in activities, as argued by activity theory, helps retirees keep their world open rather than it prematurely shrinking, as may happen when restricted mobility and health problems occur.

When the work role is lost, so too is the structure of one's time and, for some, a reason to get out of bed in the morning. Activities in retirement can reinstitute that structure. As people age, the type of activities and the amount of activity engaged in may change. For example, activities may become more sedentary and done indoors. Research suggested that by getting involved and doing things, mental health may be maintained (Reis & Gold, 1993).

A retiree can reduce the impact of the loss of work by getting involved in activities before retirement. This way, the retiree is already embedded in replacement communities, such as volunteer work or a sporting club. If retirees are stagnating, counselling could help them assess what is missing and provide the impetus to initiate involvement. Interpersonal Psychotherapy may be a good therapeutic fit for those with limited social involvements because increasing social contact is one strategy employed. Behavioural activation is another therapeutic modality compatible with activity theory due to its assumption that being active relieves the symptoms of depression (Lejuez, Hopko, & Hopko, 2001).

Role Theory

Retirement is considered to be a withdrawal from the work role, where retirees not only leave their job, but an organisation, career, and identity (Adams, Prescher, Beehr, & Lepisto, 2002). Employment is often central to an individual's identity and psychological distress may result from its loss (Pinquart & Schindler, 2007). Role theory argues that a retiree needs to replace the lost worker role to maintain life satisfaction. The degree of loss is mediated by four factors: how suddenly the role was lost, whether other losses have occurred simultaneously, the salience of the role to the individual, and the degree of age identification (Fry, 1992).

The concept of age identification refers to someone who identifies themselves in the old-aged role and has taken on a negative self-concept (Fry, 1992). In Western culture, youth is highly valued and power and prestige are typically seen as dwindling in ageing adults. Phillips (1957) found that retirees were more likely to be maladjusted when they identified themselves in the old-aged role. The measures of maladjustment in the Phillips study, however, were questionable. They were "(a)bsentmindedness, daydreaming about the past, and thoughts of death" (p. 213). Absentmindedness could be related to cognitive deficits or disorders (Iliffe et al., 1990) and no screening was conducted to eliminate this possibility, daydreaming about the past is known to be developmentally appropriate for older adults in regard to life review (Knight, 1996b), and thoughts of death need to be distinguished between passive and active thoughts of suicide since thinking of death and dying may also be developmentally appropriate for older adults (Haber, 2006).

From the role-enhancement perspective, retirees who were heavily invested in and derived most of their self-worth from their work role (Mein et al., 2003; Wang, 2007) may experience psychological distress or even depression (Kim & Moen, 2002). These retirees experienced the loss more acutely as they tended not to have alternative valued roles. From the role-strain perspective, psychological wellbeing may improve in retirees who are leaving a demanding and stressful job (Mein et al., 2003). In this case, the worker experiences relief when retiring.

Researchers have also assessed retirees' work role-attachment as a mediator of retirement adjustment. There are three aspects of attachment: organisational commitment, job involvement, and career identification, where each is related to the worker's emotional attachment to the organisation, job, or profession, respectively (Adams et al., 2002). Adams et al. (2002) found that the only work role-attachment that influenced workers' decisions to stay in their job was their attachment to the organisation. Based on these research findings, it is arguable that workers who have a strong identification with their organisation and are forced to retire may experience a more difficult adjustment.

Continuity Theory

Continuity theory views retirement as a continuous life process. Continuity theory argues that workers in the process of retiring seek to maintain the same routines, activities, patterns of behaviour, and strategies as a means to preserve and maintain psychological balance (Fretz et al., 1989; Mein et al., 2003). Fry (1992) stated that continuity operates at both internal and external levels. Internally, the person may have a stable personality in terms of goals, roles, morals, life satisfaction, and identity. Externally, the person may have stability in terms of social relationships, level of activity and engagement, and skills used. Internal and external patterns of behaviour that were seen before retirement, the theory argues, are expected to be seen in retirement and contribute to an easier adjustment. In the study of early retirees by Robbins, Lee, and Wan (1994), goal continuity referred to a pattern of acting with purpose and setting goals. It was found that when early retirees held stable and meaningful goals that were consistent over the retirement transition, the goals helped to maintain life satisfaction. Counselling may assist retirees by reviewing and assessing their identity and goals to facilitate retirement adjustment.

Life-Course Perspective

A 'newcomer' to the field of retirement adjustment, the life-course perspective has been applied by Moen (1996) to explain gender differences seen in research findings. Research samples in earlier studies often excluded women (Beck, 1982; Bosse et al., 1991; Campione, 1988; Ekerdt et al., 1985; Gall, Evans, & Howard, 1997; MacLean, 1983; Vaillant, DiRago, & Mukamal, 2006); they were known only to be retiring from household duties (Phillips, 1957). While arguably this is the most complex of the theories, it is broad in its conceptualisation of the pathways affecting retirement.

Five concepts need to be explained to understand this theory: life-course, ecology, process, linked lives, and context. Life-course is meant to demonstrate the nature of behavioural change as it occurs throughout the lifespan. The ecology aspect is derived from Bronfenbrenner's ecological systems theory, which views development as being influenced by different levels ranging from the microsystem (such as, the family) to the macrosystem (such as, the broad social context in which the individual lives). Process refers to retirement adjustment being dynamic, as opposed to a single event occurring in time. The unique term 'linked lives' refers to retirement occurring within a social context in which interpersonal relationships influence adjustment. Lastly, context is where factors such as gender and previous levels of psychological wellbeing play a role in the retiree's adjustment. Taken together, the theory suggests that psychological wellbeing in the adjustment to retirement is

affected by resources, interpersonal relationships, and other contextual factors such as marital status, gender, and society.

Moen's life-course studies assessed a range of variables that were comprehensive, though not exhaustive: (i) social integration, gender, historical context, conditions of work, work trajectories, post-retirement behaviours, economic wellbeing, timing, choice, and control of the retirement decision (Moen, 1996); (ii) health, years employed, years in fulltime and parttime work, the importance of work role, pre-retirement planning, and reasons for retirement (Quick & Moen, 1998); and (iii) psychological wellbeing, morale, depressive symptoms, and marital satisfaction and conflict (Kim & Moen, 2002). The breadth of this work has led to retirement researchers utilising the life-course perspective in their theoretical explanations (Dew & Yorgason, 2010; Donaldson, Earl, & Muratore, 2010; McDonald & Donahue, 2000; Phua & McNally, 2008; van Solinge & Henkens, 2007).

Resource Theory

Resource theory was conceptualised by Hobfoll (1989) in a theoretical article, which espoused the perceived inadequacy of other theories in the psychology of stress field. Hobfoll argued that the current conceptualisations of stress were vague and not amenable to direct empirical testing. Resources comprise objects, conditions, personal characteristics, or energies that are important to the individual (Hobfoll, 1989). The theory assumes that people seek to hold onto, defend, and create resources, and psychological stress occurs when they are lost or perceived to be lost.

Resource theory argues that when confronted with a stressful situation, individuals seek to retain their resources and minimise losses. When individuals are in a state of equilibrium and not stressed, they seek to build their current resources. Furthermore, the theory predicts that when individuals become vulnerable, they are stressed and unable to gather the resources needed to cope.

In retirement, resources may be replaced as a way to cope with the transition. For example, the worker role may be replaced by a volunteer role, which becomes a salient source of identity. The structure and activity that work provided may be replaced with pleasurable, engaging, and meaningful activities. Reduced income may be replaced by a change in consumption. Resources also form part of the life-course perspective, but less emphasis is placed on them. Wang (2007) argued that when he utilised other theories (role theory, continuity theory, and the life-course perspective) to explain the pattern of adjustment found in his data, their explanatory power was inadequate. Consequently, Wang applied resource theory to his findings and argued that this single theory was better at explaining his data. (Details of this study are found in the next section on patterns of retirement adjustment.)

However, a consideration of the circumstances surrounding retirement, which is crucial to retirement adjustment, is missing from resource theory. Pathways refers to the factors leading up to and surrounding the retirement process, such as choice, timing, preparation, and individual and social norms. The life-course perspective takes these into consideration and, while it is a more complex theory, is more comprehensive. It seems that resource theory is a useful way to conceptualise retirement adjustment, arguably more formidable than disengagement, activity, role, and continuity theories. No single theory fully explains the retirement transition and adjustment processes and patterns, but activity theory, role theory, continuity theory, and the life-course perspective are the most common in the field. Resource theory has potential but, at present, lacks empirical support.

Patterns of Retirement Adjustment

Pre-Retirement Experiences

Leading up to retirement, workers may have different thoughts and feelings about what it will be like. Nuttman-Schwartz (2004) found that four perceptions dominated with 56 Israeli men who were interviewed six months prior to retirement. The majority of men felt anxious about retiring and thought of it as a period of uncertainty and crisis. Other men were not as stressed about the thought of retiring as they saw it as an opportunity for change and as just another phase in life. The benefit of qualitative research is that individual nuances can be detected and, although Nuttman-Schwartz's research was limited by including only male participants, it provides insight into workers' experience during the period leading up to retirement. Nuttman-Schwartz commented on post-retirement adjustment (12 month post-retirement interviews were conducted); however, the article could have been strengthened by linking workers' pre-retirement experiences with their post-retirement experience. For example, it is unclear how the workers with high anxiety prior to retirement adjusted across the transition. Other studies have found that favourable pre-retirement attitudes predict better adjustment (Fouquereau, Fernandez, Paul, Fonseca, & Uotinen, 2005; MacLean, 1983).

Retirement Adjustment Patterns

Not all retirees adjust to retirement in the same way. In 2007, two articles were published that provide strikingly similar retirement adjustment patterns despite one measuring psychological wellbeing in the United States (Wang, 2007) and the other measuring life satisfaction in Germany (Pinquart & Schindler, 2007). Both studies utilised longitudinal data gathered by interview and sophisticated, latent growth mixture modelling analysis (Jung & Wickrama, 2008).

The three patterns of psychological wellbeing that Wang (2007) identified were the maintaining, U-shaped, and recovering profiles. The maintainers comprised 74% of Sample 2

($n = 1066$) and were characterised by minimal change in wellbeing over the transition period. The maintaining retirees tended to do some kind of work that was different from their main career, they planned for their retirement, they were married, and their partner was not working. The U-shaped profiles (22% of Sample 2) were characterised by a decline in wellbeing at retirement and then an increase in wellbeing within four years post-retirement. These retirees tended to have declining health, poor quality marriages, and their actual age of retirement was earlier than desired. The least common pattern of retirement adjustment was the recovering profile (4% of Sample 2), which was demarcated by low wellbeing before retirement and then significantly increased wellbeing post-retirement. As workers, recoverers tended to hold highly stressful and physically demanding jobs with low job satisfaction. Sample 1 ($n = 994$) comprised 69% maintainers, 27% U-shaped, and 4% recoverers. Sample 1 and Sample 2 were from different waves of data in the United States' National Institute on Aging's Health and Retirement Survey (1992-2000). The author stated that there were no significant differences between the two samples.

Like Wang (2007), Pinguart and Schindler (2007) identified three patterns of retirement adjustment, as measured by life satisfaction. The researchers labelled the patterns as Class 1, Class 2, and Class 3 ($N = 1456$). Class 3 comprised 76% of retirees who, being consistently satisfied with life over the retirement transition, closely resembled Wang's maintaining retirees (74%). Class 3 retirees tended to have more resources than the other classes, came from a higher socioeconomic status, were married, and enjoyed good physical health. Class 2 (15%) retirees had a large temporary increase in life satisfaction around retirement, which then generally stabilised. These retirees tended to be unemployed prior to retirement, unmarried, in low physical health, and have a lower socioeconomic status. Class 1 (9%) retirees experienced a large drop in life satisfaction around retirement, and then made gradual improvement over the next 18 months. These retirees tended to have fewer resources: that is, they were more likely to be single, had more health problems, and were older at retirement than retirees in other groups.

The differences in results between these two studies may be due to methodological design. The Pinguart and Schindler (2007) study used a single-item to measure life satisfaction, unemployed people receiving benefits were included (pre-retirement phase), retirees working in retirement were excluded, and annual measures were taken. Conversely, Wang (2007) used an eight-item measure of psychological wellbeing, included only employed workers (pre-retirement phase), included retirees working in retirement, and measures were taken every two years. Using multiple items to measure wellbeing and taking annual measurements may provide different data for analysis. Pinguart and Schindler included people in the analysis who

were unemployed before retirement. Strictly speaking, people do not qualify as being retired if they have not been in the workforce (Atchley, 2004), although this depends on timing. For example, a worker who is made redundant may, after a period of unemployment, redefine themselves as retired. Pinquart and Schindler also excluded any retirees who were retired but worked in retirement. Doing paid work in retirement is quite common. The exclusion of retirees who work and inclusion of people who were unemployed prior to retirement may allow access to different subgroups within the retirement population. It would have been interesting to conduct data analysis excluding the pre-retirement unemployed participants and including the post-retirement employed participants in the Pinquart and Schindler study as these are the most typical variables of retirement adjustment research (Wang, Zhan, Liu, & Shultz, 2008).

These two studies reconcile differences seen in the literature on retirement adjustment. Studies have claimed that retirement does not affect psychological wellbeing (Beck, 1982), retirement negatively affects psychological wellbeing (Bosse et al., 1991), and retirement positively affects psychological wellbeing (Gall et al., 1997). The Wang and Pinquart and Schindler studies revealed that while all three adjustment patterns exist (stable, declining, and enhanced wellbeing), it is the pathways to retirement that influence retirees' adjustment.

These two studies help to identify workers who are likely to adjust well and those who may be at risk for maladjustment to retirement. Retirement interventions could target those workers most at risk. In Wang's (2007) study, the characteristics identifying the U-shaped group were declining health, an unhappy marriage, and retiring earlier than expected. Added to this list are workers with few resources, as identified by Class 1, with a low socioeconomic status, and being unmarried. The deterioration in psychological wellbeing and life satisfaction noted respectively, are indicators that retirees are having difficulty adjusting to retirement. While the data used were prospective and did not provide clinical measures of depression to indicate psychopathology, the results of these two studies highlight that people adjust differentially and may be at risk of complications. A psychological treatment could then be designed to intervene prior and/or post-retirement.

Phases of Retirement

Atchley (1976) described a five stage model where, following retirement, the typical person moves through periods of excitement (the so-called honeymoon period), dissatisfaction (disenchantment), adaptation (reorientation), contentment (stability), and decline (termination). Partial support exists for this model in the literature, but no studies were found to support it entirely due to a lack of longitudinal scope (e.g., Ekerdt et al., 1985; Gall et al., 1997; Reitzes & Mutran, 2004). These three studies lend partial support to Atchley's model;

because data collection did not extend to measuring the stability or termination stages. Ekerdt et al.'s cross-sectional study, comprising men only, found patterns corresponding to the honeymoon and disenchantment periods. Gall et al. found evidence for the honeymoon period where retirees' psychological wellbeing improved one year into retirement. Reitzes and Mutran measured attitudes toward retirement four times (pre-retirement, 6-, 12-, and 24-months post-retirement) and interpreted the evidence as periods of honeymoon, disenchantment, and reorientation, as purported by Atchley.

Atchley has reconceptualised his understanding of retirement adjustment over the decades. In his earliest theoretical venture, Atchley (1975) utilised three existing theories, namely activity theory, disengagement theory, and continuity theory, to explain the process of retirement adjustment. In a publication the following year, Atchley (1976) proposed the more unified aforementioned five stage model that commenced with the cessation of work. Atchley's (2003) latest model of retirement adjustment was reconceptualised to include six phases. As with other multi-stage processes, Atchley has framed his theory such that some stages may be skipped.

Phase 1: Pre-retirement period. There is a *remote* phase where workers are aware that retirement is a normal part of their working life, but it is in the distant future. However, it is noteworthy that some workers decide to never leave the workforce. There is also a *near* phase of retirement where workers are acutely aware of their impending retirement. Financial planning and saving toward retirement often increases during this phase. Anxiety about how retirement will affect their lives, relationships, and finances are normal.

Phase 2: Retirement. Retirees may then take one of three adjustment pathways upon ceasing work. The retiree may enter a *honeymoon* period where they have positive feelings about stopping work, they may travel, and they tend to be active. Retirement may be thought of as a permanent vacation. Or, the retiree may enter into an *immediate retirement routine*. The retiree comfortably settles into a full and active retirement lifestyle. The third pathway is *rest and relaxation* where the retiree has a temporary period of low activity. Retirees who had heavily scheduled or hectic working lives are likely to take this pathway. These three post-retirement pathways may have a relationship to the stable (routine), declining (rest and relaxation), and improved wellbeing and satisfaction (honeymoon) seen in the Wang (2007) and Pinquart and Schindler (2007) studies on patterns of retirement adjustment.

Phase 3: Disenchantment. A small number of retirees enter the disenchantment phase and they may experience depression. Retirees experience strong feelings of discontentment with being retired, feel dissatisfied with their lives, and may idealise their former working role.

Perhaps retirees who seek the help of a therapist tend to be in this phase of retirement adjustment.

Phase 4: Reorientation. Retirees begin to take stock of their lives and circumstances. They have the awareness that they need to make changes to create a more satisfying and rewarding life in retirement. An awareness of the years left to live may motivate retirees to make the most of their time.

Phase 5: Retirement routine. Retirees eventually fall into a stable and satisfying retirement lifestyle. Life tends to be predictable.

Phase 6: Termination of retirement. If retirees return to work or become disabled, their retiree role ends. The role of worker or the role of disabled person becomes the focus of his or her life and, in doing so, the role of retiree is relinquished.

Atchley's (1976) five stage model has striking similarity to the U-curve theory of cross-cultural adjustment first purported by Lysgaard in 1955 (as cited in Black & Mendenhall, 1991). In cross-cultural adjustment research, the typical study compares foreign students' adaptation to living in a new country. Black and Mendenhall's review of the literature stated that empirical evidence provides partial support for the theory. A more recent study (Markovizky & Samid, 2008) that incorporated both cross-sectional ($n = 382$) and longitudinal data ($n = 133$), continued the cross-cultural adjustment research and found supporting evidence for the U-curve model.

The U-curve model, as described by Black and Mendenhall (1991), has four stages which are named honeymoon, disillusionment, adjustment, and mastery. The names of these stages not only have comparable labels to those in Atchley's model, but have similar definitions. Finding similar theoretical models across disciplines adds weight to both theories, as leaving the workforce and moving to a new country both involve a period of adjustment.

Research on the U-curve model of cross-cultural adjustment may help explain why different patterns of adjustment were found by Wang (2007) and Pinguart and Schindler (2007). Black and Mendenhall (1991) stated that depending on the planning and preparation that one has done before the transition (i.e., none, some, or a lot), the shape of the adjustment curve may change. Reitzes and Mutran (2006) discussed this in terms of role acquisition processes where the honeymoon period may be shortened or prevented due to anticipatory adjustment processes. Additionally, individual differences are also likely to change the shape of the curve, as seen in the retirement adjustment literature (e.g., Reis & Gold, 1993; Robinson, Demetre, & Corney, 2010). Hence in Wang's (2007) and Pinguart and Schindler's (2007) research, the slopes may be flat, inclining, and/or declining.

Pathways to Retirement

Retirement adjustment is affected by many factors. In theorising about life transitions, Schlossberg (1981) identified three characteristics affecting a person's adjustment: (a) the circumstances of the transition itself, (b) the circumstances surrounding the pre- and post-environment of the transition, and (c) what the individual brings to the transition. De Vaus and Wells (2004) specified three categories of factors affecting retirement adjustment: situational, structural, and personal. Utilising these categories, the factors that influence a worker's adjustment to retirement will be discussed in the context of their psychological impact on the individual. The situational factors to be discussed include: degree of control over retirement timing, suddenness of retirement, reasons for retirement, timing, planning, and experiencing multiple life events simultaneously. The structural factors to be discussed include: financial resources, family structure, education, location, gender, social integration, age, health, work factors, and bridge employment. The personal factors to be discussed include: retirement expectations, identity, marriage, job satisfaction and work ethic, interests and leisure activities outside work, and personality. Refer to Table 1 for a summary of this list of pathways.

Situational Factors

Degree of control over retirement timing. Workers may feel they have complete control, no control, or some degree of control over when they retire. Feeling in control of when retirement occurs has psychological benefits, including an easier adjustment to retirement. Data consistently show that when workers have personal control over the timing of when they left the workforce, they fare much better than those who have low control.

Studies have tested different variables that are impacted by control over the timing of retirement. Retirees with low choice or who are involuntarily retired are reported to experience a more difficult adjustment, lower satisfaction with retirement, and lower psychological wellbeing (de Vaus & Wells, 2004; Tordera, Peiro, & Potocnik, 2010; van Solinge & Henkens, 2005, 2008); deteriorating health (Quine et al., 2007; van Solinge, 2007); increased negative and decreased positive affect (de Vaus, Wells, Kendig, & Quine, 2007); and a negatively affected marriage (de Vaus et al., 2007; Quine et al., 2007). Such retirees are more likely to return to fulltime work, but if they are unable to find work they are less likely to report benefits (de Vaus et al., 2007; Quine et al., 2007); and experienced lower levels of social and physical activity (Quine et al., 2007). The impact of low choice over the timing of retirement is typically strong and pervasive.

Retirees with high choice are reported to be better adjusted (Donaldson et al., 2010; Quine et al., 2007). Other indicators include better life satisfaction, increased happiness, less likelihood of having an increased negative affect, better scores on marital cohesion, self-image,

health, and lower financial problems (Calvo, Haverstick, & Sass, 2009; Quine et al., 2007). Overall, there are many psychological benefits when workers have choice as to when they leave the workforce.

Suddenness of retirement. An abrupt retirement entails an immediate and complete withdrawal from the workforce. A sudden retirement that is unexpected means the worker may have lacked the opportunity to prepare for the transition. An Australian study (de Vaus et al., 2007) found that workers who retire suddenly with little choice about the situation, adjust less well and tend to have poorer health. An abrupt retirement could mean less preparation time for the family, which may be why marital cohesion has been seen to deteriorate when the worker has retired abruptly (van Solinge & Henkens, 2005).

A gradual retirement occurs when there is a reduction in work hours before full and complete withdrawal from the workforce. It may also involve bridge employment where the worker enters a different line of work, sometimes in a job with less responsibility, status, and pay. Schlossberg (1981) suggested that a gradual retirement may be easier to adjust to given the availability of time to prepare for the transition. It also appears that choice, regardless of whether the transition is abrupt or gradual, influences adjustment to retirement.

Reasons for retirement. An Australian report utilising Household, Income, and Labour Dynamics in Australia (HILDA) data found that health is the most common reason given by men and women for retiring (Warren, 2006). A Netherlands study (van Solinge & Henkens, 2007) found that workers retire under restrictive circumstances if they cite health, redundancy, or lack of spousal support as reasons for retirement. Other restrictive reasons for retirement include employment problems (e.g., inability to find a job), disability, family care obligations, pressure from someone (e.g., doctor, employer, partner, or children), and age. When workers perceive that they retired under restrictive circumstances, they tend to describe the transition as involuntary or forced (van Solinge & Henkens, 2007).

The reasons for retirement may affect a worker's adjustment to retirement. Studies conducted in the United Kingdom (Robinson et al., 2010) and the United States (Quick & Moen, 1998) resulted in similar findings. Workers retiring due to unrestrictive circumstances tend to report being better adjusted. Examples of unrestrictive reasons for retirement cited in both studies include: wanting to do something else and having enough money not to need to work. Workers retiring due to restrictive circumstances tend to report lower adjustment. Examples of restricted reasons for retirement include retiring because of one's own or a family member's illness, and disliking one's job.

Timing. Retirement may be considered as on-time or off-time. In Australia the conventional retirement age has been 65, which coincides with the government pension eligibility age.

However people may now choose their retirement age. Although no-one becomes eligible for a government pension until age 65, retirement timing is determined individually. Workers tend to have in mind an age at which they would *prefer* to retire and an age at which they *expect* to retire. A discrepancy between these ages might affect adjustment to retirement.

Job characteristics may influence the intended age of retirement. Workers who say they had demanding and stimulating jobs, including university academic staff (Humpel, O'Loughlin, Wells, & Kendig, 2009), intend to retire later than those who do not report such features of employment (Zaniboni, Sarchielli, & Fraccaroli, 2010). In a large study of European employees, workers intended to retire early when they were unhappy with their jobs or when they had lower wellbeing scores (Siegrist, Wahrendorf, von dem Knesebeck, Jurges, & Borsch-Supan, 2007). Group norms, that is, where colleagues favour early retirement, may also influence intentions to retire early (Tordera et al., 2010).

There is a trend across studies (Ekerdt, Kosloski, & Deviney, 2000; Humpel et al., 2009; Taylor & Shore, 1995; Zappalà, Depolo, Fraccaroli, Guglielmi, & Sarchielli, 2008) for a workers current age to influence the intended age of retirement. Younger workers intend to retire earlier than older workers, with the researchers speculating that the closer one gets to the age of retirement, the more realistic workers' perceptions become. Perhaps, also, closer to retirement the workers' financial position becomes clearer and they adjust their planned age of retirement to meet their financial situation.

A study in Italy (Zappalà et al., 2008) found that a group of workers ($N = 275$; M age 51), on average, expected to retire at age 60. Most of these workers (68%), however, preferred to retire before this age. The workers who preferred to work past the expected age of 60 had a certain set of characteristics: they tended to be older, work was more important to them, and the organisation they worked for had positive age policies that supported older workers' continued employment. Likewise, in the Netherlands, workers tend to work longer if employers have positive age policies and positive managerial attitudes (van Solinge & Henkens, 2007).

An Australian literature review of baby boomers concluded that workers expect to remain in the workforce 4 to 5 years beyond the age they prefer to retire (Humpel et al., 2009). This matches Markert's (2008) speculation that baby boomers, who start to turn 65 in 2011, are likely to retire later than the previous generation due to a lack of finances and social integration. Markert found that baby boomers have saved less, so they may need to continue working, parttime at least, to have adequate money to live. Socially, Markert said that baby boomers may keep working for collegial contact rather than experience the potential loneliness of retirement. Similarly, Zaniboni, Sarchielli, and Fraccaroli (2010) found that

retirees intend to work parttime in retirement if they anticipate losing work relationships and feeling lonely.

Early retirement may be considered as occurring prior to age 60 (Quick & Moen, 1998; Tordera et al., 2010; Zappalà et al., 2008). Using this criterion to measure the effects of off-time retirement, Quick and Moen (1998) found that early retirees (i.e., retiring before age 60) report greater satisfaction with their retirement than late retirees (i.e., retiring after age 65). Late retirees were found to consistently report lower satisfaction. In Spain, a study on early retirement found that when there is a correspondence between intentions to retire early and actually retiring early, retirees adjust better (Tordera et al., 2010). Furthermore, when workers intend to retire early and do so, they tend to perceive greater personal choice around the decision (van Solinge & Henkens, 2007), which is known to positively influence adjustment.

Planning. There are different types of planning decisions to be made in the pre-retirement stage. Decisions to be made in the planning process include: if and when to retire, whether to retire gradually or abruptly, and whether or not to work in retirement (Tordera et al., 2010). Moen et al. (2005) suggested that retirement planning can be thought of in three ways: incidence (i.e., whether any planning has been done), timing (i.e., the intended age to retire and the age at which planning began), and degree (i.e., the amount of financial and lifestyle planning conducted).

While most workers intend to retire and plan for retirement, some do not. Ekerdt, Hackney, Kosloski, and DeViney (2001) found that 8.5% of workers were unsure if and when they would retire. In this large sample ($N = 4,921$), the closer the participants got to 61 the more likely they were to report having current retirement plans. The older workers grow, the more planning they are likely to have done on their post-retirement lifestyles (Moen et al., 2005), the more financial planning is prioritised (Phua & McNally, 2008), and the more they think and talk about retirement (Ekerdt et al., 2000).

Interestingly, Government policy may influence whether individuals are active or passive in their retirement planning. American workers tend to start retirement planning sooner than Dutch workers, and they tend to plan and save more (Hershey, Henkens, & Van Dalen, 2007). The researchers attributed this active versus passive planning style to Government policy. In the United States, workers are given greater personal responsibility for funding their retirement. In the Netherlands, the Government is reported to assume the primary responsibility and guarantee retirement income to Dutch people. Americans who are active savers for their retirement tend to come from a higher socioeconomical status and have more knowledge of investing than less active savers (Phua & McNally, 2008). Workers who are more

active planners for their retirement tend to be married, have families, be healthy, and come from a higher occupational status (Campione, 1988).

While a great deal of research has been conducted in the area of retirement planning, little has focused on retirement planning and its effect on adjustment and psychological wellbeing. One study concluded that planning was unrelated to retirement adjustment; however, the sample studied had significantly more resources (education, occupational status, and socioeconomic status were high) than national norms, which was likely to influence this result (Donaldson et al., 2010). Possessing greater resources may buffer negative adjustment effects regardless of the amount of planning conducted. An Australian longitudinal study found that participants who attend a retirement preparation course report greater wellbeing in retirement (de Vaus & Wells, 2004). Retirees who are less financially prepared tend to regret not starting retirement planning sooner and wish they had saved more (Phua & McNally, 2008; Walajtys, 2007).

Experiencing multiple life events simultaneously. It has long been acknowledged that experiencing major life events concurrently creates stress and negatively impacts psychological wellbeing (Holmes & Rahe, 1967). Psychological stress may be at its highest when an individual experiences a series of losses (Harvey & Miller, 1998). Some of the major life events that commonly coincide with retirement include: death of a spouse, illness of self or family member, unexpected challenges related to finances and caregiving, and geographical relocation.

Coping resources are stretched when a retiree relocates around the time of retirement (Davies, 2003). Davies' doctoral research found that health, wellbeing, and satisfaction are lower for retirees who relocate than for those who do not relocate. Most Australians prefer to remain living in their own homes as they age (Department of Health and Ageing, 2007), yet single women remain the most vulnerable as they report more often having to move to cheaper accommodation because of their financial situation (Warren, 2006).

Other normative life events at the time of retirement may stretch coping resources. Decreases in happiness and enjoyment in life are evident when a spouse died or illness occurs at the time of retirement (Calvo et al., 2009; Price & Nesteruk, 2010). When challenges occur that are unexpected, such as financial losses or taking on extensive caregiving responsibilities, retirees report feeling disappointed and disenchanting with their retirement lifestyles (Price & Nesteruk, 2010).

Structural Factors

Financial resources. The Australian retirement system has three components: the means-tested Government pension (the Age Pension), a compulsory superannuation scheme, and

private savings (Australian Government Treasury, 2004). The emphasis is now on the individual to provide for themselves in retirement and, to do so, may involve a fourth component: delayed retirement or no retirement. Indeed, the Australian Government encourages workers to delay retirement by offering incentives at both the employee and employer level (Department of Health and Ageing, 2007). Workers using the Pension Bonus Scheme receive tax benefits by deferring their access to the Age Pension. Employers accessing the Mature Aged Worker Incentive Scheme receive financial benefits when they employ an apprentice over the age of 45.

‘Knowledge is power’ and workers tend to save more toward their retirement when they are equipped with financial knowledge. Younger workers ($N = 118$, M age 33.9) who attended a three hour seminar tended to save more compared to those who did not attend (Hershey, Mowen, & Jacobs-Lawson, 2003). Importantly, this research sample comprised more women than men (n women = 83, n men = 35) and, given that women typically have fewer opportunities to save over their working lives due to intermittent work histories, empowering women with financial knowledge may help to bridge financial vulnerabilities. Moreover, workers report feeling more financially prepared for retirement when they have more financial knowledge (Hershey & Mowen, 2000).

Pre-retirement income level may affect retirement adjustment. One study found that retirees with lower pre-retirement incomes have fewer financial resources, lower perceived financial adequacy, less financial knowledge, and do less financial planning than retirees with higher incomes (Hershey, Henkens, et al., 2007). Another study found that retirees with a very low pre-retirement income report greater unhappiness and are more likely to be from blue collar occupations (Loewenstein, Prelec, & Weber, 1999). An Australian study found that retirees with lower pre-retirement incomes have a more difficult adjustment to retirement (de Vaus & Wells, 2004). Canadian retirees who leave work due to health problems tend to retire early and be financially disadvantaged since they have significantly lower retirement incomes than retirees who do not retire due to health problems (McDonald & Donahue, 2000). Another Australian study found that retirees with high pre-retirement incomes are better adjusted than those with low pre-retirement incomes (Donaldson et al., 2010).

Perceived income adequacy may affect marital satisfaction. One study of 231 retired couples reported that participants have more satisfying marriages when they perceive their income as meeting their needs than when they do not (Smith & Moen, 2004). Conversely, a study found that couples with financial worries report more conflict (Dew & Yorgason, 2010). This cross-sectional study compared three groups of couples: “one group that retired before the study, one that retired during the study, and one group of retirement-aged couples that

did not retire during the study” (Dew & Yorgason, 2010, p. 164). A significant relationship was found between financial worries and marital conflict in all groups except the first. While the authors speculated that this result may be due to retired couples having had time to adjust, there were two methodological flaws that could account for the unexpected finding. Firstly, couples who were already retired but had divorced were excluded from the analysis (since the study was looking at couples and not singles, couples that divorced or separated during the study were excluded) as were couples where one or both had returned to work (since the study used the criteria of complete withdrawal from the workforce as an operational definition of retirement, employed retirees were excluded). The problem with these two exclusions is that divorce and returning to work may be a result of, or a contribution to, financial worries. Hence, retired couples with high conflict due to financial worries may have inadvertently been excluded from the analysis, which may have resulted in a non-significant finding for this group.

Family structure. Life satisfaction in retirement can be influenced by family structure. Some of the common situations that a retiree may experience are in caring for grandchildren, children, partner, or parents. While one article stated that about 80% of care to bedridden older adults is provided by family members (Sterns & Huyck, 2001), there is a distinct lack of research in this area. It would be useful for future research to examine the psychological impact on retirees who are caring for ill relatives because the findings may highlight appropriate support strategies.

An area that has recently received research interest is that of grandparents’ acquisition of a parenting role in the care of a grandchild (Butler & Zakari, 2005; Glass & Huneycutt, 2002; Orb & Davey, 2005). Hinrichsen (2008b) reported that this issue has been seen in clinical presentations where retirees have sought therapy. Social problems, such as substance abuse, teen pregnancy, mental health issues, parental death, abandonment, incarceration, and divorce, may increase the chance of grandparents taking an active parenting role with their grandchildren (Butler & Zakari, 2005; Glass & Huneycutt, 2002). In exploring family structure and responsibilities among Canadian retirees ($N = 2146$), the researchers asked, “How many children of any age are you financially responsible for?” (Marshall, Clarke, & Ballantyne, 2001, p. 392). From the available information, it was indeterminable whether the children were their own or grandchildren. When retirees reported that they were financially responsible for any number of children, they reported greater stress than those who did not have any dependents. A qualitative study in the United States found that the specific problems grandparents experienced were: impact on physical health, anxiety and stress, financial strain, decreased social opportunities, and negative impacts on relationships with family members (Butler & Zakari, 2005). Another qualitative study in Australia found that, like the United States

participants, grandparents feel powerless and ignored when dealing with different institutions, such as schools and Departments of Social Security (Orb & Davey, 2005).

One retiree in a small qualitative study ($N = 15$) spoke about having to return to work to provide financially for his grandchildren better (Walajtys, 2007). The participant said he had enough money for himself and his wife, but that he needed to work as the grandchildren were a significant financial commitment. Despite the necessities to return to work, this participant's narrative revealed gratitude for his grandchildren, who he said were rewarding. In contrast, other retirees have expressed resentment at having to care for grandchildren as it interferes with their ability to enjoy retirement (Orb & Davey, 2005). For example, if taking on the role of raising their grandchildren unexpectedly, retirees may find that they have to change their retirement plans or put them on hold (Glass & Huneycutt, 2002; Orb & Davey, 2005).

Education. The worker's level of education may affect retirement planning, age at retirement, and adjustment to retirement. Limited research has been conducted this area, but the general findings so far suggest that workers with higher education may be more advantaged as they have greater resources at their disposal (Lusardi & Mitchell, 2006; Price, 2003). Women with higher education (Merkes, 2003) and workers who returned to school after age 25 tended to delay retirement (Moen et al., 2005), which may provide greater earning power and opportunity to save for retirement. Vaillant, DiRago, and Mukamal (2006) found that men from professional occupations retired later than men from blue collar occupations, with the manual work of blue collar occupations necessitating earlier retirement. Women with a graduate education reported higher median incomes than those without (Price & Joo, 2005).

Lusardi and Mitchell (2006) reported that Americans with lower levels of financial knowledge tended to not have a university education. There seems to be a clear link between financial knowledge and active planning for retirement (Department of Health and Ageing, 2007; Hershey & Mowen, 2000; Hershey et al., 2003; Phua & McNally, 2008). Retirees who demonstrated financial knowledge were more likely to plan for retirement and be successful in their planning (Lusardi & Mitchell, 2006).

Location. Where retirees live may affect their retirement planning and satisfaction. Urban dwelling retirees and regional, rural, or remote dwelling retirees have access to different employment and housing markets (Humpel et al., 2009). Humpel et al. suggested that there may be less opportunity for a gradual pathway to retirement for rural dwelling retirees. They also tended to have limited access to health and human services (Guralnick, Kemele, Stamm, & Greving, 2003). Rural dwelling retirees were reported to have lower annual incomes compared with urban dwelling retirees (Dorfman, 1998). In a study of 451 retirees living in an American

rural community, 60% did no retirement planning at all and a mere 3% attended any kind of formal retirement preparation class, seminar, or counselling (Dorfman, 1989). Rural dwelling retirees who reported doing planning of any kind were more satisfied with their retirement.

An area of advantage was found for rural dwelling retirees, however, when considering social integration. Rural retirees tended to have better informal social networks and be more involved with formal organisations, all of which contributed positively to retirement satisfaction (Dorfman, 1998).

Gender. Gender differences exist in the experience of retirement. Financial resources remain the largest gender difference, with women at a significant disadvantage (Atchley, 2004). As many as nine out of ten women worry that they have inadequate financial resources for retirement (Merkes, 2003). Women reported engaging in less retirement planning (Hershey, Henkens, et al., 2007; Moen et al., 2005) and were generally more uncertain about their retirement plans (Ekerdt et al., 2001).

The financial disadvantages that women experience are due to discontinuous work histories and lower pay. Where men have careers spanning an average of 38 years fulltime, women only work about 20 years fulltime equivalent (Merkes, 2003). The gaps that women experience in employment also result in gaps in the accumulation of retirement savings. Women often experience further inequity by receiving lower wages for the same work that men do despite holding the same qualifications (Merkes, 2003). The consequence of these gendered experiences may be a more difficult adjustment to retirement, as seen in American women ($N = 458$) and Dutch women ($N = 559$) who reported gaps in their employment histories or worked more parttime hours (Quick & Moen, 1998; van Solinge & Henkens, 2005, 2008).

Social integration. Social interaction is a basic human need. A lack of supportive social relationships has been linked with isolation and mental health problems (Diener & Seligman, 2004). Work is an important source of social support as it provides a natural opportunity for interaction with others. Compared with fulltime workers, retirees reported fewer social contacts, and bigger decreases in collegial confidants and friends (Price & Joo, 2005). Compared with married retirees, single retirees were also more likely to report bigger decreases in social contact. Carter and Cook (1995) speculated that retirees whose sole or primary social contacts had been colleagues may have a harder time adjusting to retirement since it can be difficult to maintain those relationships after leaving the workforce.

A Swedish longitudinal qualitative study found that retirees missed a certain kind of interaction that they could only get through work (Jonsson et al., 2001). Specifically, several participants missed working in groups and solving difficult problems together. Indeed, another qualitative study found that many of the participants who returned to work in retirement did

so partly due to financial reasons, but also due to a need for social interaction (Walajtys, 2007). Finally, an Australian longitudinal study reported that women tended to see retirement as an opportunity to increase social contacts (de Vaus & Wells, 2004), which may partially explain why a lower proportion of women return to work in retirement compared to men (Reitzes & Mutran, 2004).

Age. Age seems to have little to do with adjustment to retirement (de Vaus & Wells, 2004; Reis & Gold, 1993). Rather, it is likely that the circumstances surrounding the retirement transition have a greater influence on adjustment to retirement, such as choice, social integration, and finances. One study found differences among a group of baby boomers who were born between 1946 and 1956 (Moen, Huang, Plassmann, & Dentinger, 2006). The younger workers of the group tended to plan for retirement independently of their partners, whereas the older workers of the group were influenced by their partners' retirement planning. This suggests that workers from different cohorts may experience retirement differently. One factor affecting adjustment related to age is experience. Schlossberg (1981) speculated that retirees who have successfully navigated previous transitions are more likely to cope well with the retirement transition.

Health. The effects of health on the timing of, and adjustment to, retirement are prominent. Two Australian studies found that healthier retirees tended to be better adjusted in retirement (de Vaus & Wells, 2004; Donaldson et al., 2010). In the United States, retirees who reported better health had higher levels of satisfaction with their retirement (Smith & Moen, 2004). When comparing the happiness levels of working men (M age = 61.9 years) with the happiness levels of retired men (M age = 67.9 years), there was a decline in happiness for retired men whose health had likewise declined (Loewenstein et al., 1999). A Canadian study (McDonald & Donahue, 2000) researching poor health and retirement income found that workers retiring due to poor health had retired at earlier ages, had significantly lower retirement incomes, and tended to experience lifelong disadvantages (e.g., intermittent work histories, lower education levels, and lower occupational status). Minority (i.e., Black and Hispanic) women in the United States more often reported leaving the workforce due to poor health than White women (Brown & Warner, 2008). Some groups appear to experience multiple disadvantages in regard to education, health, employment histories, and finances.

Work factors. Work factors, such as the work environment and occupational status, may affect workers' experience of retirement. A work environment can be stressful or dissatisfying, have long hours, little flexibility, little scheduling control, and may expose workers to dangerous situations (Moen et al., 2006; Wong & Hardy, 2009). The job itself may be stressful or physically demanding (van Solinge, 2007). While leaving a physically demanding job in the

Netherlands leads to increased satisfaction in retirement (van Solinge & Henkens, 2008), another study by the same author found that leaving a physically demanding job does not result in improved health (van Solinge, 2007). In regard to health, perhaps there is no improvement in health at retirement, despite leaving a physically demanding job, because the damage has already been done during people's working lives.

Positive work factors may influence the retirement experience. Workers with strong attachment to the labour force or their occupation may delay the age of retirement (Wong & Hardy, 2009). Workers who are satisfied with their job may delay the decision to retire (Shaw, Patterson, Semple, & Grant, 1998). Retirees who described their former occupations as very engaging, reported better adjustment to retirement (Jonsson et al., 2001). Perhaps the commitment, enthusiasm, and perseverance demonstrated at work are also exercised in the adjustment to retirement.

Retirees who formerly held high status jobs are more likely to experience improvements in retirement. An Australian study found that retirees who formerly held high status jobs had wellbeing that improved more in retirement compared with retirees who formerly held lower status jobs (de Vaus & Wells, 2004). An American study found the same result, except that their dependent measure was life satisfaction rather than wellbeing (Quick & Moen, 1998). The researchers speculated that retirees who formerly held high status jobs had access to more resources to assist them in the transition to retirement, and perhaps the greater autonomy experienced as a manager had better prepared them for the autonomous role of retiree.

Bridge employment. Bridge employment is when a retiree engages in some kind of fulltime or parttime work for pay. This kind of employment provides a bridge between the cessation of a career job and permanent withdrawal from the workforce, sometimes making the transition less abrupt. As was mentioned earlier, not all retirees return to work for financial reasons; some return to work for social opportunities (Jonsson et al., 2001; Walajtys, 2007). Wang, Zhan, Liu, and Shultz (2008) found that retirees who engage in bridge employment are younger and better educated, have pre-retirement jobs that are less stressful, and have thought less about retirement than those who do not. There are also differences between retirees who undertake career bridge employment in the same field and those who do so in another field. Retirees taking career bridge employment (i.e., work in the same field as their pre-retirement job) have higher levels of pre-retirement job satisfaction. Retirees taking bridge employment in another field were in better financial positions (Wang et al., 2008); taking a less stressful job but with lower pay was more likely if the retiree had adequate money.

Retired men may return to work more often than women (Reitzes & Mutran, 2004). Moreover, Reitzes and Mutran found that more retirees have returned to work 24 months after retirement than 12 and 6 months after retirement. Six months after retiring, 33% of the male sample had returned to some kind of work for pay. At 12 months, 51% had returned to work and at 24 months, 55% had returned to work. For women, a similar significantly increasing trend was seen: 6 months, 28%; 12 months, 39%; and 24 months, 43%. Possibly, once retirees exit the honeymoon phase of retirement (typically said to be 12 months in duration), they want structure, money, socialisation, and meaning, so more retirees have returned to work by 12 months post-retirement than in the preceding months. The authors speculated that although women have less income than men, the women's return to work rates are lower due to less boredom. Women may have more friends, opportunities for socialisation, and involvement in activities, which provide meaning and satisfaction, so they have less need to return to work.

Personal Factors

Retirement expectations. Retirement anxiety occurs when a worker has negative expectations about the consequences of retirement. Australian workers who were highly anxious about retiring tended to have fewer social interactions in retirement (de Vaus & Wells, 2004). Dutch workers who held negative expectations about their retirement were more likely to have deteriorated health on both objective and subjective measures (van Solinge, 2007). When Dutch couples held negative expectations in regard to social opportunities and their statuses in retirement, they tended to have a more difficult adjustment (van Solinge & Henkens, 2005).

When a retiree's actual experience of retirement is mismatched with how they imagine it to be, they may have a harder time adjusting. A qualitative study (Walajtys, 2007) found that when a mismatch occurs, the retiree experiences leisure activities as ungratifying, they lack meaningful activities, and feel bored. Another study, which sampled men only (Marshall et al., 2001), found higher stress levels and lower levels of life satisfaction when retirees experience incongruent employment expectations (i.e., the retiree expects to work in retirement but does not find work or they do not expect to work but do so).

Retirement optimism occurs when a worker has positive expectations about the effects of retiring. Typically, workers who held positive expectations were more likely to be better adjusted (van Solinge & Henkens, 2008) and more satisfied (Taylor, Goldberg, Shore, & Lipka, 2008) in retirement. European workers who anticipated satisfaction in retirement tended to be satisfied with it (Fouquereau et al., 2005).

Identity. Individuals can actively create their identity, as opposed to passively accepting it (Reitzes & Mutran, 2006). Identity may provide the individual with a sense of unity and purpose (Moen, 1996). Atchley (2004) suggested that retirement involves a shift in identity as an employed person becomes a retired person. How a retiree perceives themselves may be influenced by the changes experienced in their retirement routines, roles, and relationships (Reitzes & Mutran, 2006). Indeed, retirees engaged in bridge employment thought more favourably of themselves when they held a productive identity and compared themselves to retirees who might sit around and watch television (Walajtys, 2007).

Identity may be an important factor in a retiree's adjustment to retirement. Retirees who attempt to hold onto their occupational identity may have a much harder time adjusting. Richardson (2009) described athletes, who typically retired in their twenties or thirties, as experiencing a traumatic adjustment when they held onto their identity as an athlete. One third of orthopaedic surgeons ($N = 708$; n women = 2) said the hardest thing about retiring was the loss of their occupation identity, which included power, status, and prestige (Ritter, Guerriero-Austrom, Zhou, & Hendrie, 1999).

Atchley (2004) suggested that retirees do not relinquish their occupational identity upon retirement, but that a new identity of retiree is added. While the occupational identity may not be relinquished, a process of reordering appears to facilitate adjustment to retirement. Alternate important identities, such as parent, spouse, and friend were seen to assist retirees' adjustment (Reitzes & Mutran, 2006). A qualitative study found that retired professional women who were highly educated ($N = 14$) needed to perceive themselves as more than just their occupation to facilitate the adjustment process (Price, 2003). Perhaps retirees who adjust better have been able to reorder the importance of their occupational identity and the lower the order (e.g., second, third, fourth, etc.) the easier their adjustment becomes. For example, a retired accountant may increase the priority of her roles of grandmother, wife, quilter, and volunteer, and reduce her former occupational role to fifth position.

Marriage. Being married can have a positive influence on retirement adjustment, but it can also create some anxieties. A large study ($N = 1063$) found that half of the respondents intended to retire at the same time as their spouse (there was no data on what eventuated; Moen et al., 2005). Synchronised retirement was operationalised by Ho and Raymo (2009) as retiring within 12 months of one's partner. They found that of 876 couples, only 24% retired together.

Husbands more often seem to influence their wives decision of when to retire than vice versa. Two out of ten husbands reported that their wives influenced their retirement timing (Moen et al., 2005), whereas four out of ten wives said the same. Wives reported feeling more

satisfied with their retirement when their husband did not influence their decision (Smith & Moen, 2004). Most workers and their spouses adjust well to retirement, but if workers experienced problems their spouses adjustment was also found to be negatively affected (van Solinge & Henkens, 2005).

There is a consistent theme that retired husbands with working wives experience difficulties. Two studies using depressive symptoms as a measure of psychological wellbeing found that retired husbands with wives who worked continuously across data points had more depressive symptoms than husbands whose wives were out of the labour force (Kim & Moen, 2002; Szinovacz & Davey, 2004). Retired men whose wives remained in the workforce reported lower life satisfaction and they were more likely to pressure them to retire (Warren, 2006). Similarly, couples reported greater marital conflict when the husband was retired and the wife continued to work (Davey & Szinovacz, 2004). Researchers have speculated that retired men may have difficulty if their spouse continues to work as he may feel lonely and bored without her company (i.e., less social integration), and feel a power difference due to the woman financially supporting the household, especially if he takes on more of the “feminine” household tasks. Indeed, Kulik (2001) found that, in retirement, men tended to do more domestic chores than employed men.

Marriage and marital cohesion are resources. Married women may be happier and healthier in retirement than other marital categories (Price & Joo, 2005). When retirees reported that they enjoyed spending time with their spouse and doing activities together, they were less likely to experience declines in wellbeing (de Vaus & Wells, 2004). This is reflected in a study that measured marital satisfaction in 1989 and retirement satisfaction in 1994, amongst other variables (Hilbourne, 1999). There was a significant relationship such that couples with higher marital satisfaction were also satisfied with their retirement. In contrast, divorced women said they were the least satisfied with their retirement, least financially satisfied, and had lower wellbeing (Price & Joo, 2005). Moreover, married women were typically better off financially in retirement, but poverty rates may rise if widowed (Hodes & Suzman, 2007).

Working couples may have concerns about the impact of retirement. A common concern for couples was how retirement would affect their relationship (Hilbourne, 1999). Specific concerns included: emotional quality, togetherness versus personal space, bereavement and loneliness, and running of the household. A similar result was found in another study where couples were anxious about the impact that retirement would have on marital conflict (van Solinge & Henkens, 2005).

Job satisfaction and work ethic. Retirement timing and adjustment may be influenced by the worker's job satisfaction and work ethic (de Vaus & Wells, 2004). There is little research on these two areas, however, so the conclusions that can be drawn are limited. Clear definitions are also yet to be established. Atchley (2004) defined work ethic as a value that employees express in initiative, industriousness, self-discipline, and commitment to seeing tasks completed. It has also been defined in terms of the degree of attachment to work and the workers' perception of the importance of their work (Szinovacz & Davey, 2004).

In assessing couples' adjustment to retirement, one study measured retirees attachment to work (van Solinge & Henkens, 2005). Attachment to work was operationalised as the workers evaluation of job challenge. In this study, there was no evidence that a strong attachment to work hindered retirement adjustment. A review article suggested that the effects on retirement adjustment may be less to do with attachment to work and more to do with work as a source of identity (Carter & Cook, 1995). A strong attachment to work may mean the worker derives an important source of identity from work, which may make retirement adjustment more difficult when retiring and losing that identity (Carter & Cook, 1995). Atchley (1975) echoed these sentiments when he stated that retirement may be more difficult for workers whose job is ranked as more important than other life aspects, such as family, friends, hobbies, and leisure activities. Indeed, retired men with a strong work ethic who could not see what they did in retirement as useful, reported lower levels of life satisfaction (Hooker & Ventis, 1984).

The Australian Government aims to increase the national average age of retirement by encouraging workers to delay retirement and plans to do this by leveraging workers' job satisfaction (Department of Health and Ageing, 2007). If people work longer, they may accumulate private savings and superannuation rather than accessing Government benefits, which is a dwindling resource with limited availability for future generations. Australia's Mature Age Employment and Workplace Strategy is designed to improve workplace attitudes so that older workers contributions are better recognised and valued. The assumption guiding this strategy is that if workers are satisfied with their jobs and workplaces are amenable to older workers – for age discrimination is an active deterrent force (Gringart & Helmes, 2001) – older adults will keep working. Indeed, one study found that workers who had negative attitudes toward work more frequently considered retirement (Ekerdt et al., 2000).

Interests and leisure activities outside work. Interests and leisure activities are pursued during free time for enjoyment. Typical categories include: achievement (e.g., gardening and drawing), collecting (e.g., coins and rocks), competing (e.g., bowling and golfing), and observing (e.g., home theatre and travelling) activities. Interests and leisure activities pursued

outside work hours may influence a retiree's adjustment to retirement. Participation in activities is said to provide a sense of belonging, which may compensate for the loss of workplace belonging in retirement. Workers adjusted better to retirement when they reported being able to enjoy their leisure time and were not bored outside work (de Vaus & Wells, 2004). Involvement in a wide range of activities positively influenced adjustment (Graham, 1992; van Solinge & Henkens, 2008). The most important activities for 368 retirees who had been retired for about two years were: telephone contact, reading, physical activity, and social activity (in order of importance, scoring >4 out of 5; Pushkar et al., 2010). A review article (Carter & Cook, 1995) concluded that retirees who do not participate in leisure activities may find the transition to retirement more difficult than those who do.

The amount and number of activities conducted in retirement may change over time. An American study (Forman-Hoffman et al., 2008) found that men, but not women, increased their level of exercise after retirement. A Canadian study (Pushkar et al., 2010) found that over a two year period, retirees reduced the number of activities they participated in and that those activities retained were ones that the retirees could more easily perform. An United Kingdom study (Berger, Der, Mutrie, & Hannah, 2005) measured the physical activity of retirees over a five year period. Levels decreased over time and were attributed to the loss of activity formerly derived through work. A New Zealand study (Graham, 1992) found that retirees tended to increase the number of activities they participated in once retired. These various studies found both increases and decreases in the number and amount of activity in retirement. Perhaps cultural and methodological differences played a role in these findings. Methodologically, the type of activities analysed and the sample characteristics (such as, time since retirement, health status, and age) probably influenced the differences in results.

The limits of poor health and illness and their effects on the performance of activities in retirement remain largely unexplored. While Graham (1992) found that activity increased in retirement and involvement in activities enhanced retirement adjustment, the study did not, however, shed light on retirees with poor health since the majority of participants were in very good or excellent health. Little is known about retirees with poor health and its impact on activities, for example, retirees who smoked or retired in poor health tended to be less active (Berger et al., 2005) and retirees who were ill tended to drop activities (Pushkar et al., 2010). This is a valuable area for research as these retirees may be particularly vulnerable to adjustment problems in retirement and could be helped through research.

Volunteering is a common activity pursued by Australians in retirement with over 55 year olds contributing to an estimated \$74 billion in formal and informal volunteer work (Department of Health and Ageing, 2007). When asking workers ($N = 258$, M age = 56) about

their ideal retirement lifestyle, 63% said it would be a life of leisure and 58% said it would include volunteering (multiple choices possible; Smith, 2004). In a study comprising only women, the reported benefits of volunteering included: mental stimulation, flexibility, purpose, and social contact (Merkes, 2003). A large longitudinal study found that volunteering in retirement did not compensate for lost work hours (Hao, 2008). Hao found that even though paid work decreased, volunteering did not increase, which may be a byproduct of the study's design since only formal volunteering was included. Excluding informal volunteering, such as family caregiving, may have influenced the study's results since informal volunteering is very common in retirement (Department of Health and Ageing, 2007).

Personality. Individual differences in personality have long been assumed to influence adjustment to retirement (MacLean, 1983; Reis & Gold, 1993). Personality may be defined as an individual's pattern of response to their environment. Research suggests that personality influences the pre- and post-retirement experience.

In the pre-retirement phase, planning, financial preparedness, and reasons for retirement were influenced by personality factors. Workers who planned for retirement tended to have greater goal clarity, meaning that they were clear and specific in what they wanted to accomplish and had more likelihood of success (Hershey, Jacobs-Lawson, McArdle, & Hamagami, 2007). Workers who felt financially prepared for retirement had stronger future orientations, which were mediated by conscientiousness and emotional stability (Hershey & Mowen, 2000). Future orientation was defined as visualising, planning, and being thoughtful about one's future. Retirees who scored higher on neuroticism (i.e., having a tendency to experience negative emotional states) tended to report negative circumstances as reasons for retirement (Robinson et al., 2010). Conversely, retirees scoring higher on conscientiousness (i.e., having a tendency for thoughtfulness, impulse control, and goal-directed behaviour) reported more positive circumstances as reasons for retirement. While retirees who scored higher on neuroticism were likely to report lower life satisfaction, those higher on conscientiousness were likely to report higher life satisfaction (Robinson et al., 2010). Similarly, an Australian study found that retirees' mastery predicted adjustment to retirement (Donaldson et al., 2010).

Self-efficacy and locus of control are two other personality factors studied in the retirement adjustment literature. Retirees with higher self-efficacy were predicted to have a better adjustment to retirement as they were expected to have a belief in their ability to adapt and the confidence to deal with challenges that may arise in the transition (Carter & Cook, 1995). Indeed, research findings have supported this assertion (MacLean, 1983; van Solinge & Henkens, 2005). Retirees with an internal locus of control were predicted to have a better

adjustment to retirement as they were expected to be proactive in their planning for retirement and be self-directed in carrying out activities in retirement (Gall et al., 1997). Indeed, Gall et al. found that retirees higher in internal locus of control had greater satisfaction with their retirement activities, perhaps because they avoided boredom by having some of their time structured.

Summary

Situational, structural, and personal variables influence how workers adjust to retirement. The retirement transition itself does not cause psychological problems, but a combination of pathways creates a unique dynamic where a retiree may have an adjustment on a continuum from easy to difficult. No literature was found that compiled all of these variables into the one document. A summary of each of the pathways to retirement is provided in Table 1 along with commentary about opportunities to enhance workers' adjustment to retirement.

Depression and Older Adults

Depression is not a normal part of ageing (Van Etten, 2006). As will be discussed shortly, psychologists must be familiar with adult development and ageing processes to competently assess, diagnose, and treat older adults. The term 'older adults' refer to people aged over 65 years of age. The differences across this broad age group led gerontologists to distinguish between subgroups of older adults: young-old, 65-74 years; old-old, 75-84 years; and oldest-old, 85 years and older (Hinrichsen, 2008a).

Older adults typically have more health related issues than younger adults (Arean, Uncapher, & Satre, 1998). If an older adult is depressed, their mood can interfere with recovery from physical health conditions. Older adults with depression tend to recover more slowly from hip fractures, strokes, chronic arthritis, and surgery, and have more hospital stays and problems with activities of daily living (Reynolds et al., 1999; Richardson & Barusch, 2006).

Depression in older adults may be diagnosed as early- or late-onset. Early-onset means the person has experienced depression prior to 64 years of age. Late-onset means the person has experienced depression only after 65 years of age. Reportedly, late-onset depression is accompanied by more extreme weight loss, hypochondriacal preoccupations, sleep initiation problems, agitation, and a preoccupation with guilt (Arean et al., 1998). Although the commonalities in the presentation of depression are greater than the disparities for older and younger adults, older adults may emphasise or exhibit symptoms differently (Richardson & Barusch, 2006) and relapse sooner (Reynolds et al., 1999).

Researchers believe that depression in older adults is caused by a combination of several etiological factors (Arean et al., 1998; Richardson & Barusch, 2006): psychosocial, biological, and physical. Psychosocial factors in older adults' depression include: poor social support

systems, passive and unassertive coping styles (Arean et al., 1998), and loss experiences (Richardson & Barusch, 2006). Biological factors include: severe lesions, problems with neurotransmitters (Arean et al., 1998), and deficiencies in essential vitamins (Richardson & Barusch, 2006). Physical factors include: higher incident rates for acute and chronic medical conditions for older adults (Arean et al., 1998).

Diagnosis of Depression in Older Adults

The diagnosis of depression becomes problematic because the psychologist must distinguish between medical illness and normative ageing processes (Arean et al., 1998; Richardson & Barusch, 2006). Medical problems may mimic depressive somatic symptoms, such as insomnia, early morning awakenings, and loss of appetite (Arean et al., 1998). Normal changes associated with ageing may mask depression, such as altered sleep patterns, fatigue due to age related conditions, and diminished interest in sex (Richardson & Barusch, 2006). Depression may affect concentration and memory, and thereby resemble dementia. A defining feature of the difference between cognitive decline as seen in dementia and cognitive decline as a function of depression, is that cognitive decline due to dementia has a slower rate of onset (Richardson & Barusch, 2006). Richardson and Barusch suggested determining whether the symptoms impair the normal baseline of functioning and connecting the changes in mood with symptoms presented. The client may need to be referred for a medical examination to assist diagnosis.

Assessment of Depression in Older Adults

Given these complications, the tools used in assessment become especially important for facilitating an accurate diagnosis of depression. Psychologists need to use measures that have been normed with older adults and, when this is not possible, to be aware of the implications of using a measure normed with younger adults. Scogin (1997) suggested a three step strategy for the assessment of depression in older adults: (i) screen for depression using a self-report measure, (ii) if depression is indicated, conduct a clinical interview, and (iii) utilise collaborative sources as appropriate, such as consulting with a family member or medical doctor (after receiving due consent from the client). In regard to self-report measures, the Geriatric Depression Scale (15 and 30 item versions) is highly recommended since it was developed for, and extensively evaluated with older adults, is psychometrically sound, and has been well received by clients (Scogin, 1997). The Beck Depression Inventory-II, the Centre for Epidemiological Studies-Depression Scale, and the Hamilton Rating Scale for Depression are also sound measures but were not exclusively designed for older adults (Arean et al., 1998; McGuire, 2009; Richardson & Barusch, 2006; Scogin, 1997).

Psychological Treatments for Depression in Older Adults

This section discusses common treatment options. Firstly, evidence-based treatments are discussed before looking at specific therapies including: cognitive-behavioural therapy (CBT), psychodynamic psychotherapy, life review therapy, and interpersonal psychotherapy (IPT). Considerations of conducting psychotherapy with older adults conclude this section.

Biological interventions are acknowledged as useful treatments for depression in older adults, but do not form a focus of the present study. Biological interventions include pharmacotherapy and electroconvulsive therapy. The basis of pharmacotherapy is the use of anti-depressant medication to alter brain functioning and to reduce depressive symptoms (Arean et al., 1998). Medication is typically faster acting than psychotherapy (Weissman, 2007), but may have complications, such as side effects and drug interactions (Richardson & Barusch, 2006). Psychologists need to remain vigilant toward the possibility of polypharmacy complications in clients (American Psychiatric Association, 2004).

Evidence-Based Treatments

In 2006, the Australian Government added psychological services to its list of publicly rebateable health care provisions under Medicare. Consumers can now receive heavily rebated, or occasionally free, psychological services with a referral from their GP or psychiatrist. Psychologists were in a good position to adopt the accountability requirements of the Medicare system given psychology's emphasis on the scientist-practitioner model. This model trains psychologists in the consumption of research and practice as a scientist to deliver evidence-based services for optimal benefit to consumers (Shapiro, 2002).

In the clinical psychology field, it is recognised that no single treatment for depression is suitable for all older adults (American Psychiatric Association, 2004; McGuire, 2009). There are, however, recommended services based on research evidence. In the United Kingdom, IPT and CBT are strongly recommended by the Department of Health in the treatment of depression (Shapiro, 2002). In the United States, the American Psychological Association (2004) recommended IPT, CBT, and life review therapy as the preferred treatments for depression in older adults. In Australia, IPT and CBT are among the list of evidence-based treatments endorsed by Medicare that registered psychologists may utilise. Randomised controlled trials have demonstrated that IPT and CBT are equally effective (McBride, Atkinson, Quilty, & Bagby, 2006).

The use of evidence-based treatments is now embedded in the field of psychology. Psychologists registering as Medicare providers agree to use only the listed evidence-based strategies, are trained in the scientist-practitioner model, and agree to operate within this framework. Evidence-based treatments are those that have received empirical support.

Treatment manuals have been developed to research the treatment's efficacy and effectiveness. Evidence-based treatments typically evolve through different levels of testing before being endorsed as evidence-based. Feasibility (pilot) studies are typically small scale research endeavours where the purpose is to determine whether the treatment works or not before investing significant resources into larger randomised controlled trials (van Teijlingen & Hundley, 2001). Efficacy studies test a treatment under controlled clinical conditions using comparison groups (Mansfield & Addis, 2001b). Efficacy studies are often criticised for being removed from actual service delivery conditions and, therefore, their utility has been questioned (Seligman, 1995). Effectiveness studies represent the final stage of development for an evidence-based treatment and are conducted under more real-life circumstances (Mansfield & Addis, 2001b). Carroll and Rounsaville (2008) provided an excellent discussion on how a researcher progresses through these three stages toward the development of an evidence-based treatment manual.

The advantages and disadvantages of evidence-based treatments have been well documented. Some of the key advantages of using an evidence-based treatment over an unstructured approach cited in the literature include: leveraging actuarial data in clinical decision making and thereby avoiding some of the pitfalls inherent in clinical judgement (Mansfield & Addis, 2001b), knowing that clients are receiving treatment that has been proven to work (Wilson, 1998) and thereby minimising the risk of harm (Marques, 1998), facilitating the training and supervision of therapists (Lambert, 1998), and understanding that the structured and time-limited nature of these treatments can enhance therapeutic outcomes with both the client and therapist remaining focused on treatment tasks and goals (Mansfield & Addis, 2001a).

Proponents of evidence-based treatments have successfully argued against most of these complaints with the general conclusion that evidence-based treatments will stay. There are two concerns that remain undefended in the advocacy of evidence-based treatments. The first is that some providers fear a loss of autonomy in their choice of treatment delivery (Lambert, 1998). As seen in Australia, registered psychologists operating in the Medicare system are restricted to utilising endorsed evidence-based strategies. The second is that it is unrealistic for a psychologist to learn every evidence-based treatment for each diagnosis (Mansfield & Addis, 2001a). To become proficient in any evidence-based treatment requires face-to-face training, reading of treatment manuals, and practical experience with close supervision, which would be impractical to achieve for all evidence-based treatments.

Cognitive-Behavioural Therapy and Depression in Older Adults

CBT assumes that depression is caused by an interaction of maladaptive behaviours, and thoughts and beliefs. The CBT model states that when an individual has an underlying negative core belief about themselves or the world, it will manifest as negative thinking. These negative thoughts, in turn, create negative feelings. Working with clients in this modality involves seeking to make changes at the cognitive and behavioural levels and, in doing so, changes at the emotional level occur. Homework comprises an important part of this therapy as clients need to record their thoughts, behaviours, and feelings and, with the therapist's help, challenge their unskilled thinking patterns.

Richardson and Barusch (2006) identified three cognitive distortions that older adults may make: 'I'm too old to change, so why try; you are too young to help me; and life would be fine if only one specific problem changed. These faulty thoughts may hinder therapeutic outcomes and can be addressed within the CBT framework. Richardson and Barusch (2006) also suggested changes that could be made to accommodate older adults. If the client exhibits memory problems, information may need to be presented slowly, repeated, or written down. For older clients who are less familiar with psychotherapy and how it works, it may be helpful to instil hope by explaining the efficacy of the treatment and that most clients' depression alleviates over time. This latter point could be equally applied to all treatment modalities.

Life Review Therapy and Depression in Older Adults

Life Review Therapy, also known as Reminiscence Psychotherapy, is the only modality designed specifically for older adults with depression (Scogin, Welsh, Hanson, Stump, & Coates, 2005). It has been used as a technique within other therapies and as a whole therapeutic system (American Psychiatric Association, 2004). Life Review Therapy assumes that depression will be relieved once the client's life history has been systematically revisited and reprocessed (Richardson & Barusch, 2006). It may be helpful to use props to facilitate discussion, such as photographs, memorabilia, history books, genograms, and timelines (Haight, 1995). The goal of Life Review Therapy is to progressively reevaluate and integrate past experiences into a meaningful whole. The client may process unresolved conflicts and gain perspective on their life (Haber, 2006). Knight (1996b) warned therapists against assuming that all older adults enjoy reminiscing and to check the appropriateness with the client before proceeding.

Psychodynamic Psychotherapy and Depression in Older Adults

Psychodynamic Psychotherapy assumes that depression is the result of unconscious intrapsychic conflicts (Scogin et al., 2005). Psychodynamic Psychotherapy is a 'watered down' version of psychoanalysis. Instead of receiving treatment several times a week over a number

of years, Psychodynamic Psychotherapy is more affordable and accessible in its brief format comprising weekly sessions over several months. Psychodynamic Psychotherapy leverages the here and now interactions between the therapist and client to create change (i.e., transference and countertransference). The assumption is that the difficulties that the client creates in their relationships are brought into the therapy room and are repeated with the therapist. It has been suggested that Psychodynamic Psychotherapy may be most useful to clients with dysthymia (a form of chronic mild depression), anxiety, and longstanding interpersonal difficulties (Cutler, Goldyne, Markowitz, Devlin, & Glick, 2004). Arean et al. (1998) suggested that for Psychodynamic Psychotherapy to be effective, older adults need to have an interest in working with unconscious material, have an ability to connect with the therapist, and be motivated to change.

Interpersonal Psychotherapy and Depression in Older Adults

IPT assumes that depression is a result of an interpersonal crisis and targets social relationships to relieve depressive symptoms (Weissman, 2007). To suit a course of IPT, the client must present with a problem that fits into one of the four problem areas: role transitions, grief, interpersonal role disputes, or interpersonal deficits (Weissman, Markowitz, & Klerman, 2000). Usually no more than two problem areas are addressed in a course of IPT given the limited time availability (typically 12 to 16 sessions).

IPT is particularly well suited to older adults given that the problems they experience often fit into this model (Hinrichsen, 2007a). The most commonly occurring interpersonal problem area is role transitions (Miller et al., 1998) and retirement is an example of a common role transition experienced by older adults. When retirement is presented as a clinical issue, Miller and Silberman (1996) described several issues that need working through: loss of identity, structuring time, and finding meaning in life. The goals of dealing with a role transition are to restore self-esteem and a sense of mastery to cope with the major change that has occurred. When dealing with grief, the goals are to help the client gain a balanced perspective of the significant person who died and to re-establish the client amongst the living. Interpersonal role disputes occur when there is conflict between the client and a significant person in their life. The goals are to help them resolve the conflict and teach them to relate more effectively. The final problem area, interpersonal deficits, was rarely seen as a presenting issue at the geriatric mental health outpatient clinic where Hinrichsen (2008a) works. A client working on this problem area tends to have a pattern of difficult interpersonal functioning and a paucity of supportive relationships.

Two unique aspects of IPT are the interpersonal inventory and the sick role. An interpersonal inventory is a useful technique to gain an understanding of the interpersonal

context in which the client operates. This knowledge of the client comprises a fundamental aspect of enabling the therapist to usefully intervene at an interpersonal level. The sick role is given to a client once depression is diagnosed. It is designed to emphasise that depression is an illness rather than a fault of the client and thereby attempt to reduce his or her guilt (Hinrichsen, 2007a). Acquiring the sick role gives the client permission to opt out of social activities that may be hindering his or her recovery.

IPT is structured into three phases, thus providing a useful conceptualisation for the therapist to follow. Over a course of 12 weeks, the first two sessions comprise the initial phase where assessment, diagnosis, and case formation are conducted. The next eight sessions comprise the intermediate phase where the core strategies for the agreed upon interpersonal problem area are employed. The final two sessions comprise the termination phase where therapy is wound down. Monthly maintenance therapy is recommended to prevent relapse (Reynolds et al., 1999).

Sholomskas, Chevron, Prusoff, and Berry (1983) recommended that when using IPT with older adults, two considerations may be useful. The therapist may readily accept gifts offered by the client, as long as they are not devices of manipulation, as the gift is said to carry an underlying meaning that the client is still useful and capable of meaningful contribution. Furthermore, it may be more relevant to help the older client tolerate and live with a difficult relationship rather than leave it. The personal and financial consequences of a late life separation may be too great to leave the relationship. Another viewpoint is offered by Hinrichsen (2008a) who stated that he found little adaptation of IPT necessary when working with older adults. Despite this assertion, Hinrichsen (Hinrichsen & Clougherty, 2006) has a treatment manual on IPT for older adults, which is very useful for troubleshooting problems that therapists may encounter in their work.

Working Therapeutically with Older Adults

The crucial considerations for Australian psychologists working with older adults are outlined in the APS guidelines (2008). Indeed, American psychologists share similar guidelines with Australian psychologists (American Psychiatric Association, 2004). Being abreast of these guidelines is assumed to equip psychologists to work ethically and effectively with older adults. Psychologists must be knowledgeable about suicide risk assessment, especially in conjunction with depression given the high rates of suicide among this age group (American Psychiatric Association, 2004). Additionally, psychologists need to be alert for signs of abuse (i.e., physical, psychological, verbal, and material) perpetrated against vulnerable older adults (McGuire, 2009). Psychologists need to be aware that older adults have unique social experiences, such as more numerous health problems, issues around grandparenting, and age discrimination

than younger adults (McGuire, 2009). Retirement is another social experience typically reserved for the older adult. The APS guideline number 7.5 denotes the importance of retirement by highlighting to psychologists the potential need for intervention. On a positive note, Knight (1996a) advised therapists to leverage older adults' extensive lived experience to facilitate the therapeutic process by tapping into the clients' expertise.

Summary

With Australia's population rapidly ageing there is a congruent surge of workers retiring. While most workers adjust well to retirement, significant numbers have a difficult adjustment and may experience depression. No individual psychological evidence-based interventions were identified for retirees experiencing depression due to a poor adjustment to retirement.

Upon retirement, workers who can remain active and engaged are more likely to resolve Erikson's seventh stage of generativity. Moreover, remaining disability free, mentally intact, and physically functioning will help older adults age successfully. Those who cannot may stagnate and potentially develop depression.

Work is important. It fulfils a large range of human needs including the: acquisition of money, development of self-esteem, involvement in activities, building of respect, opportunity to expand creativity, finding of meaning, and increasing of socialisation. The fact that work fulfils these needs is often taken for granted by workers. The loss is soon realised, however, after leaving the workforce. Retirees may have an easier adjustment to retirement when they have substitute sources to fulfil those needs.

There are five key theoretical perspectives on retirement. (i) Activity theory argues that retirees who participate in pleasurable, engaging, and meaningful activities have an easier adjustment to retirement. (ii) Role theory suggests that retirees who have substitute roles to replace the lost work role, such as volunteer, family member, or caregiver, adjust more easily to retirement. (iii) Continuity theory states that retirees who carry on with their pre-retirement lifestyles after the leaving the workforce have an easier adjustment to retirement. (iv) The life-course perspective explains the retirement experience as a dynamic process occurring across the lifespan with an emphasis on the influence of gender, interpersonal relationships, and marriage. (v) Resource theory suggests that retirees who are well resourced and can utilise their resources have an easier adjustment to retirement.

Theorists acknowledge that retirement is not a stagnant event, but involves a process of adjustment. This process begins with a remote phase when younger workers begin to think about retirement. Imminent retirement may raise feelings of anxiety if workers think of retirement as a time of uncertainty. Workers tend not to feel stressed when they look forward to retirement as an opportunity for change. Following retirement, wellbeing may stabilise,

improve, or decline, which is influenced by the worker's pre-retirement situation. The adjustment process tends to occur in stages with workers taking different paths depending on their circumstances. Some retirees may be active, inactive, or enter straight into a retirement routine, while some experience disenchantment before taking stock and settling into a routine. Retirement is said to end if the retiree returns to work or becomes physically or mentally disabled.

The circumstances leading up to retirement have a major impact on adjustment. The pathways to retirement may be considered in terms of situational, structural, and personal factors. The situational factors affecting retirement adjustment are degree of control over retirement timing, suddenness of retirement, reasons for retirement, timing, planning, and experiencing multiple life events simultaneously. The structural factors affecting retirement adjustment are financial resources, family structure, education, location, gender, social integration, age, health, work factors, and bridge employment. The personal factors affecting retirement adjustment are retirement expectations, identity, marriage, job satisfaction and work ethic, interests and leisure activities outside work, and personality.

Depression is not a normative part of ageing and is a major public health concern. The diagnosis of depression requires knowledge and understanding of the ageing processes and adult development. Diagnosis of depression in older adults may be complicated as it needs to be differentiated from symptoms in medical illnesses, cognitive disorders, and normative ageing. Whenever possible, assessment tools utilised should be chosen from those normed with older adults. As part of the assessment process, referral for a medical examination may be necessary.

Australian psychologists operate within the scientist-practitioner framework. Psychologists' entire practice of assessment, diagnosis, treatment, and research is influenced by this framework. Evidence-based treatments, those that have received empirical support, are endorsed by industry bodies as treatments that psychologists should utilise with clients. IPT, CBT, and life review therapy are typically endorsed for the treatment of depression in older adults.

Treatment manuals progress through several stages of development before being classified as evidence-based treatments. The three stages are conducted as feasibility, efficacy, and effectiveness studies. Advantages and disadvantages of using treatment manuals have been well noted in the literature and it has generally been concluded that structured treatments benefit clients.

No evidence-based manual was identified for the treatment of retirement related depression. IPT may be a very useful treatment with older adults given that its focal problem

areas often match problems experienced by older adults. IPT is predicated on the assumption that interpersonally relevant factors contribute to the onset of depression. Some of the alternative treatments for use with older adults are CBT, life review therapy, and psychodynamic psychotherapy, which target maladaptive thoughts, systematic reprocessing of life history, and unconscious intrapsychic dynamics, respectively. Psychologists operating within any of these treatment modalities need to be familiar with the APS guidelines for working with older adults to ensure optimal client outcomes.

Previous Intervention Research

Despite the enormity of the retirement transition and the potential for associated depression, there is a great paucity of published studies conducting retirement interventions. Goold (2007) conducted a between-subjects group design with retirees aged between 65 and 85 years of age ($N = 84$, M age = 72.3 years). The study aimed to increase happiness levels with cognitive-behavioural group therapy. For each subject, psychoeducation sessions were held weekly for six weeks, with each running for two hours. The focus was on information dissemination, skills training, and practical exercises. Skills training covered topics such as goal setting, problem solving, conflict resolution, anger management, relationships, healthy lifestyles, challenging activities, effective communication, self-nurturing, and relaxation techniques. While Goold found supportive evidence for the efficacy of this study, one main problem with group designs is that they fail to capture individual differences. This problem can be overcome with a single-case design (Barlow & Hersen, 1984; Wonder, 2005).

Another group program was suggested by Tinsley and Bigler (2002). The objectives outlined (Table 2) for this model were designed to be delivered as a 10-week pre-retirement preparation program. No research evidence was provided or found to support this model.

Table 2

*Objectives for Developmental, Structured Group Intervention for Retirement Transitions
Counselling (from Tinsley & Bigler, 2002, p. 380)*

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1. Increase your awareness of myths and stereotypes regarding ageism, sexism, and other isms in American culture.
 2. Identify attitudinal blocks and other potential barriers to effective retirement planning.
 3. Learn about a model for dealing effectively with change.
 4. Clarify your understanding of retirement planning tasks.
 5. Learn more about your interests, skills, and personal strengths and the relation of these to potential future roles.
 6. Develop optimism about your ability to handle your changing life roles and responsibilities.
 7. Learn how to create optimally challenging opportunities in your life.
 8. Evaluate your preferences for geographic location and living arrangement.
 9. Assess your social networks and develop new networking techniques.
 10. Explore issues of loss and learn effective strategies for dealing with loss.
 11. Develop your financial management plans.
 12. Develop plans to improve and maintain your physical health and spiritual well-being.
 13. Explore safety issues related to the changes associated with growing older.
 14. Develop your plans and ability to [specify].
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The Current Research

The research question is: Does Interpersonal Psychotherapy improve depressive symptomatology for retirees experiencing poor retirement adjustment? The current thesis argues that an evidence-based treatment for depression in older adults due to poor adjustment to retirement is needed. Evidence-based treatments fit the field of psychology, which endorses the use of empirically validated treatments. However, no such treatment was found. As has been seen by the foregoing review of the literature, the retirement experience is a complex major life transition. Most workers adjust well to retirement, but a significant minority do not, with some even experiencing depression as a result of poor adjustment. A specially designed and developmentally appropriate treatment may more efficiently and effectively meet the needs of older adults with depression following retirement than existing treatment models. A pilot study that would test the feasibility of such a treatment is fitting under these circumstances.

Accordingly, the current thesis outlines the conduct of a pilot study. Chapter 2 outlines the method implemented. Chapter 3 details the treatment manual that was developed and utilised in the current study. Results of this feasibility testing are found in Chapter 4. Chapter 5 comprises two clinical case studies that exemplify the treatment conducted. A discussion concludes in Chapter 6.

Chapter 2

Method

The preceding chapter reviewed the literature and introduced the research area. This chapter describes the steps taken to answer the research question: Does Interpersonal Psychotherapy improve depressive symptomatology for retirees experiencing a poor retirement adjustment? The treatment manual (IPT-RM) developed comprises Chapter 3.

Manualised treatments are almost a necessity in this age of service delivery and accountability. Treatment manuals detail which clinical techniques may be used and those that are contraindicated. They are necessary for research protocols to minimise threats to validity, but, in clinical practice, therapists are more likely to work from an eclectic model and not strictly adhere to any single model (Godley, White, Diamond, Passetti, & Titus, 2001). Once a treatment manual has received empirical evidence, therapists can replicate the treatment with some confidence that it has previously improved others' psychopathology.

Given the utility of treatment manuals, the current study developed and tested a brief intervention. No evidence-based psychological treatment was found for recent retirees who experience depression due to a poor adjustment to retirement. As with other adaptations of IPT (e.g., Grote, Bledsoe, Swartz, & Frank, 2004; Jill et al., 2005), the developed treatment manual was not a new therapy, but one that was tailored to the retirement transition. The current study had two phases. In Phase 1, a treatment manual was developed. In Phase 2, a pilot study was conducted to determine the feasibility of the treatment developed. The following sections detail these two phases.

Phase 1: Treatment Manual Development

Procedure

Framework for treatment manual development. The first step was to find an evidence-based framework to base the development of the treatment manual. The Carroll and Rounsaville (2008) book chapter, titled *Efficacy and Effectiveness in Developing Treatment Manuals*, was utilised as the reference for the construction of the treatment manual. It was written by experienced treatment researchers with a focus on evidence-based outcomes. While several suggestions for improvement are included in this chapter, overall, the framework is comprehensive, theoretically sound, clearly articulated, and recommended to researchers developing treatment manuals.

There are three types of treatment manuals: session-based, principal-based, and procedure-based (Godley et al., 2001). The current treatment manual falls into the principal-based category as it does not prescribe what takes place each session, but offers a set of

principles to follow. This style of manual is aligned with the existing three main IPT manuals (Hinrichsen & Clougherty, 2006; Stuart & Robertson, 2003; Weissman et al., 2000).

An alternative framework for treatment manual development is the expert-systems approach. In this approach, a treatment manual is developed without adhering to any particular guidelines, a number of “experts” in the field provide their feedback, and, at the discretion of the developers, the feedback is then incorporated into the manual prior to its use. Morley, Shapiro, and Biggs (2004) used this approach for the development of a chronic pain treatment manual and six experts were consulted. While the Morley et al. manual lacked the rigour of being supported by an evidence-based framework, the expert-systems approach highlighted an imperfection in Carroll and Rounsaville’s (2008) approach. That is, after developing a treatment manual, Carroll and Rounsaville fail to recommend an independent evaluation by experts prior to its implementation. This gap could be filled in the Carroll and Rounsaville approach by specifying how the treatment manual is to be approved prior to pilot testing, which becomes important when novel and innovative therapies are developed.

Three stages of treatment manual development. Treatment manuals ideally pass through three separate stages of development prior to their dissemination for general use (Carroll & Rounsaville, 2008). A common complaint about treatment manuals is that they appear on the market without sufficient research evidence. Carroll and Rounsaville propose to overcome this deficit by describing three stages that evolve from one to another with increasing research evidence and clinical utility.

In Stage 1, the treatment manual is constructed and tested. The manual comprises a rationale, description of the clinical problem, theoretical model, treatment goals, prescribed and proscribed interventions, session content, and delivery format (Carroll & Rounsaville, 2008). A Stage 1 manual is pilot tested to determine its feasibility. After determining that the Stage 1 treatment manual warrants further research, Stage 2 development may commence.

In Stage 2, efficacy trials, which are typically more involved and expensive, are conducted. The goal is to use the clinical knowledge gleaned from research trials to refine and elaborate the manual content. This is often done with randomised controlled trials (RCT) and, although significantly more resources are invested, more rigorous research evidence is yielded. Carroll and Rounsaville (2008) specified the additional features found in a Stage 2 manual: therapist selection, training, and supervision; troubleshooting clinical issues; and consideration of other therapeutic approaches. If the results from a Stage 2 trial indicated that the treatment is efficacious, the manual enters a Stage 3 effectiveness trial.

By the time a treatment manual reaches Stage 3 of development, a considerable amount of process and outcome data have been generated (Carroll & Rounsaville, 2008). The key role of

Stage 3 is the real life applicability of the treatment manual. What happens in a research setting is usually different to what a therapist does in his or her office (Clarke, 1995). Compared to a research sample, therapists are likely to encounter more varied clients and incorporate other aspects of treatments to meet individual client's needs (e.g., art therapy techniques, motivational interviewing strategies, and cognitive behavioural therapy tools in the course of treatment). In Stage 3 treatment manual development, the researcher's question is not, does the treatment work, but, for whom does this treatment work best? The variables tested at this stage are diverse and include a variety of therapists, research participants (e.g., gender, age, socioeconomical status, sexuality, and race), and treatment delivery settings (e.g., hospital, community, private, and university training).

The current study reports on the development of a Stage 1 treatment manual. Table 3 is taken verbatim from Carroll and Rounsaville's (2008) article and details what content needs to be included in the manual. Having established the framework for the development of the treatment manual, the literature was consulted for content.

Preparation and construction of the treatment manual. The literature was searched for peer-reviewed articles on relevant topics. The topics included: treatment manual development, ageing, work, retirement, life transitions, depression in older adults, clinical interventions, and working with older adults. The literature search was extensive and thorough.

The starting point was a search for literature on treatment manual development. An understanding of how to approach the actual development was necessary before dealing with its content. The framework needed to be based on a solid foundation to enhance the treatment manual's rigour. Carroll and Rounsaville's (2008) book chapter was the sole source to describe the construction of an evidence-based psychosocial treatment manual. Additionally, the three key IPT manuals were read (Hinrichsen & Clougherty, 2006; Stuart & Robertson, 2003; Weissman et al., 2000) and other treatment manuals were reviewed (Jill et al., 2005; Kingsep & Nathan, 2003; Leichsenring, Beutel, & Leibing, 2007; Lejuez et al., 2001; Nathan, Rees, Lim, Smith, & O'Donnell, 2004).

The development of the treatment manual spanned six months. The organisation of the manual was simplified because the structure was predetermined by the Carroll and Rounsaville (2008) chapter. The process entailed critically evaluating the literature for applicability to the IPT-RM treatment manual. The next step was for the manual to be approved prior to its use.

Treatment manual approval prior to pilot testing. It is important that newly developed treatment manuals are sanctioned by relevant experts prior to being implemented. Ethical considerations should be high on any researcher's agenda, especially when human participants

are involved and psychological risks are present (Allan, 2001). Having the manual sanctioned is an important ethical step.

The treatment manual was approved for pilot testing by the principal investigator's three supervisors. Two supervisors are Ph.D clinical psychologists and the third also holds a Ph.D. The advantage of having clinical psychologists on the supervision team is that they have clinical expertise from which to evaluate the manual. Indeed, one supervisor had specialised training in IPT and served as the clinical supervisor for the duration of the intervention.

Written feedback was received from each supervisor, which subsequently informed the refinement of the manual. Each supervisor received an updated version of the manual, which was approved prior to pilot testing. With the treatment manual signed off, the pilot study commenced. The testing of the manual began in October 2010 and ended in July 2011.

Testing the treatment manual. The purpose of conducting a pilot test is threefold. The researcher wants to (a) determine if the treatment manual is feasible, (b) improve the manual by utilising clinical evidence and research findings, and (c) evaluate the worthiness of progressing to a RCT (van Teijlingen & Hundley, 2001).

The IPT-RM treatment manual was designed to be used in conjunction with a standard IPT intervention. In the present study, it was used with the Weissman et al. (2000) IPT manual throughout the intervention. This manual was preferred over the other two (Hinrichsen & Clougherty, 2006; Stuart & Robertson, 2003) for its simplicity. With the first two research participants, relevant sections of the IPT-RM treatment manual were reviewed prior to each session. This served as a reminder of the tasks, goals, and strategies that needed to be completed. With the third participant, there was greater familiarity with the material and the manual was referred to less frequently.

Concluding Stage 1 treatment manual development. The pilot study indicated that the treatment was feasible. The manual then went through its final review to become a completed Stage 1 manual. Since the treatment manual was initially informed only by the literature, clinical knowledge and research data were incorporated. This included adding vignettes (i.e., therapist-client dialogue), scripts (i.e., typically psychoeducation that a therapist needs to convey to the client), and two clinical case study examples. Content was also amended to reflect clinical knowledge, with some sections being expanded, removed, or rewritten. To assist with the revision process, the Carroll and Rounsaville (2008) chapter was consulted.

After completing this major review of the treatment manual, it was appraised by the supervisors. Supervisors' feedback was incorporated into the manual. The final Stage 1 treatment manual is located in Chapter 3.

Critical evaluation of the Carroll and Rounsaville's (2008) resource. Evaluation of this chapter was necessary since it was extensively consulted and no journal articles were found to comment on its application. Overall, the Carroll and Rounsaville guidelines for treatment manual construction were useful, but several recommendations for strengthening the framework were discerned. These improvements affect the treatment manual introduction, quality control, and additional resources for the therapist.

There were no guidelines on how the developer intended the Stage 1 treatment manual to be used. Little has been said in the literature about how treatment manuals are actually used in research or clinical settings. Godley et al.'s (2001) research found that therapists wanted to know the philosophy behind treatment manuals, which may clarify misunderstandings held by the reader and also make explicit the developer's perspective. The introduction of any treatment manual would ideally include a description of how to use the manual and a philosophy behind treatment manuals. Since there are different types of manuals (i.e., sessional-based, principal-based, and procedural-based), they are likely to be used differently.

Explicit commentaries on the three aspects of quality control in Stage 1 treatment manual development were absent in the Carroll and Rounsaville (2008) chapter. It does not include guidelines as to what standards should apply for the manual to be approved prior to testing. After outlining what content needs to go into the manual, there is no mention of how to quality assure what the researcher has developed. Secondly, while supervision is discussed in Stage 2 manual development, it is neglected in Stage 1. Supervision is necessary when using treatment manuals at all stages (Najavits, Weiss, Shaw, & Dierberger, 2000). The article could do better to include and emphasise the necessity for supervision during a pilot intervention. Thirdly, there was no mention of strategies to self-monitor treatment delivery. The present study utilised a Document of Progress (Miller, Swartz, & Wolfson, 2007) as a tool to reflect on clinical practice. So, suggestions to facilitate quality control would be recommended to improve the framework.

The chapter could be further improved by recommending that a Stage 1 treatment manual include a section on additional resources. These could include a bibliography of books, book chapters, websites, journal articles, and available training. A section which specifies to the therapist when a referral may be warranted could also be helpful. For example, couples counselling or family therapy may be a better option for a client rather than individual IPT work with a role dispute focus.

The Carroll and Rounsaville (2008) chapter seems to be the first of its kind. Treatment manuals that have been developed without the use of this approach, for example, attention management in chronic pain (Morley et al., 2004), aggressive driving treatment manual

(Galovski, Malta, & Blanchard, 2006), and trauma-exposed youth treatment manual (Carrion & Hull, 2010) have neglected to underpin their research within an evidence-based framework. It should be noted that the Morley et al. (2004) and Galovski et al. (2006) studies were conducted prior to the publication of the Carroll and Rounsaville chapter. The Carroll and Rounsaville guidelines provide a rigorous basis for developing treatment interventions.

Phase 2: Treatment Intervention

The pilot stage of the current study explored the feasibility of a manual based treatment (IPT-RM) for recent retirees experiencing depression due to a poor adjustment to retirement. It was hypothesised that this treatment would result in a decline of depressive symptoms and an improvement in interpersonal functioning. Treatment was delivered by the principal investigator who is a Ph.D Candidate (clinical psychology). Details of participants, recruitment, screening, and participant demographics are now outlined.

Participants

Ten participants were recruited and all were diagnosed with major depression. Pilot studies are designed on a small scale to test the feasibility of an intervention before investing resources in a larger controlled trial (Jill et al., 2005). Ten participants was deemed to be sufficient for a pilot study, with similar numbers being used in other studies (van Teijlingen & Hundley, 2001).

Demographics. Table 4 details the pertinent demographics for the 10 research participants. To protect the confidentiality of participants, a numbered code from 1 to 10 was assigned.

Recruitment. Starting in October 2010 and ending in April 2011, various opportunities were taken to recruit participants. It was desirable for participants to start treatment at different times, so the client load was manageable. Advertising was likewise staggered to reach potential participants over the recruitment period. Free advertising consisted of a university website, seniors' organisations, newspaper articles, website notices, presentation promotion, and radio interviews.

The first notice to go online was an Edith Cowan University (ECU) media release. The Joondalup Times Community Newspaper ran an interview on the study with the article also being published online. The Council on the Ageing (WA) emailed a flyer to their distribution list. The principal investigator ran several *pro bono* hour long presentations as part of a series of two-day pre-retirement preparation programs organised by the Work Plan Foundation. The presentation was entitled *Wellbeing in retirement: Planning for future social and emotional wellbeing*. At the conclusion of the presentation, the research study was promoted. There were two radio interviews: Graham Maybury on 6PR Nightline program (January 2011) and Jenny Seaton on Curtin FM 100.1 (April 2011).

Paid advertising consisted of a monthly advertisement, running from January to April 2011, in *Have a Go News* which is a Western Australian newspaper for over 45s. The advertisement read, "Research at ECU, Volunteers Wanted, Have you retired in the past four years and feel depressed? Free counselling in Joondalup for retirees experiencing difficulties adjusting to retirement." The paid advertising was by far the most successful recruitment strategy. Eight participants were recruited from *Have a Go News* advertising, one from the Council on the Ageing (WA) group email, and one from the ECU online media release.

Screening. Potential participants contacted the principal investigator by email or telephone and an information letter (Appendix A) was sent in response. The initial telephone contact typically involved: an explanation of the research and what was involved, enquirer's questions were answered, an overview of their retirement situation was gleaned, and depression was screened utilising the Depression, Anxiety, Stress Scale. These initial calls averaged 25 minutes.

The telephone screening was designed to distinguish retirees who were likely to be eligible to participate in the study. Retirees who met these screening requirements were invited to an initial clinical interview. They were sent an information letter and were provided with details of the meeting location and parking. All retirees invited to an interview arrived as agreed.

Of the 33 enquirers, 10 were eligible to participate in the study. The reasons that 23 enquirers did not get involved in the study were: five were not depressed but wanted to help out with the research (i.e., volunteer), eight did not want to participate after learning details of the study, and 10 were ineligible to participate. The reasons for ineligibility included: being retired for more than four years, experiencing depression unrelated to retirement (e.g., erectile dysfunction due to prostate cancer), or having chronic problems with alcohol. After advising the retiree why they were ineligible to participate in the study, appropriate referrals were provided. All enquirers were referred to their GP for a Mental Health Care Plan where discounted psychological sessions could be accessed. An additional referral was made to Lifeline where 24/7 confidential and free counselling is accessible.

Inclusion criteria. Several requirements needed to be met for a research participant to be included in the study. These were assessed at the initial clinical interview. Validated instruments measuring depression, anxiety, stress, quality of life, and cognitive impairment were utilised in the assessment. To be included in the study, participants needed to (a) have retired within the past four years (since Wang's (2007) research indicated that retirees naturally begin to improve by the fourth year post-retirement, the inclusion period for the current study was retirement within the preceding four years), (b) fulfil DSM-IV-TR criteria for major depressive disorder (MDD), (c) be cognitively unimpaired, (d) have mild to moderate

depression, and (e) have depression preceded or exacerbated by retirement adjustment issues as determined by clinical judgement.

Exclusion criteria. To be excluded from the study, participants needed to (a) be actively suicidal, (b) report chronic problems with alcohol, (c) have an acute medical or psychological condition, (d) be retired for more than four years, and (e) experience MDD diagnosis unrelated to retirement.

Materials

Clinical interview. All treatment sessions were held at the ECU Psychological Services Centre (The Clinic), which is a teaching clinic for postgraduate psychology students. The Clinic is located in the Joondalup Central Business District, which is off campus and conveys a professional image. There were five interview rooms at The Clinic and each room was fitted with a camera for DVD recording and basic furnishings (e.g., sofas, coffee table, wall hangings, cushions, small clock, and small floor rug). Participants were advised to retain their parking receipts as they would be reimbursed these costs at the conclusion of treatment. Five research participants did so and received reimbursement.

At the commencement of the initial interview, participants were advised that the session was being recorded, verbal agreement was received, and a consent form was signed. Since a therapeutic alliance is essential to a helping relationship (Rounsaville, O'Malley, Foley, & Weissman, 1988), a priority was to develop rapport and a working relationship. The primary strategies for developing this alliance were to show engagement through: being attentive in the present moment, remaining emotionally attuned to the participant (empathic), expressing compassion through accurate reflective listening, and asking for feedback. Specific details were typically garnered in the initial interview: establishing a relationship between depression and retirement adjustment, reviewing depressive symptoms (utilising the DSM-IV-TR criteria), gathering a history of depression and anxiety, and completing the interpersonal inventory.

The interview was concluded with the completion of screening and outcome measures. The Mini-Mental State Examination (MMSE) was administered and then the self-report measures (see outcome measures) were completed. In total, the completion of these measures took approximately 15 minutes. Research participants were advised that they would complete the self-report measures a total of five times during the study (i.e., at the initial assessment, Session 1, Session 6, final session, and four weeks after the conclusion of treatment). Before ending the session, participants were asked if they wanted to participate in the study. All agreed. No pressure was placed upon participants to continue and they were clearly advised that they could withdraw at any time. An appointment was made for the following week.

MMSE. The MMSE is a brief, 30-item instrument that is used to screen for cognitive impairment. The principal investigator administered the test, which took 10-15 minutes to complete. Scores below 25 indicate possible cognitive impairment (Iliffe et al., 1990) and, therefore, people with scores of ≤ 25 were excluded.

Outcome measures. The Geriatric Depression Scale-15 (GDS-15), Depression Anxiety Stress Scale-21 (DASS21), World Health Organization Quality of Life (WHOQOL-BREF), and Retirement Satisfaction Inventory (RSI) were the instruments used as outcome measures. The DASS21 was included in addition to the GDS-15 since a reviewer of the research proposal suggested that it would provide clinically useful information. Additionally, given that the GDS-15 was designed with older adults in mind, utilising only the DASS21 may have confounded results. Should only one measure detect the presence of depression, it was decided that the participant would be classified as having depression. Participants' symptoms were assessed at pre-treatment (Time 1), Session 1 (Time 2), mid-treatment Session 6 (Time 3), end-treatment final Session (Time 4), and follow-up (Time 5).

GDS-15. This measure is a 15-item self-report instrument that assesses severity of depression (Bowling, 2005). The Geriatric Depression Scale is the recommended instrument for screening depression by The Royal College of Physicians of London and The British Geriatrics Society (Royal College of Physicians of London, 1992). The GDS-15 is suitable for older adults as somatic symptoms, which could be due to normative ageing, are excluded and it has been normed with older adults (McGuire, 2009). With regard to severity level, scores on the GDS-15 indicate that 0-4 is normal, 5-9 is mild, and >10 is severe. The inclusion criterion was a score of ≤ 9 .

DASS21. This measure has high clinical utility, has high research applicability, and is a valid and reliable instrument (Henry & Crawford, 2005). The DASS21 is a 21-item, self-rating instrument for assessing depression, anxiety, and stress. Each item is rated on a scale of 0 to 3, depending on how much the item applied for the past week. It took approximately 5-10 minutes for research participants to complete. The instrument has been normed in Australia with men, women, and older adults (Lovibond & Lovibond, 1995). It is a useful instrument as it discriminates between depression, anxiety, and stress. With regard to severity level, scores on the DASS21 for depression indicate that 0-9 is normal, 10-13 is mild, 14-20 is moderate, and >21 is severe. Levels for anxiety are 0-7 is normal, 8-9 is mild, 10-14 is moderate, and >15 is severe. Levels for stress are 0-14 is normal, 15-18 is mild, 19-25 is moderate, and >26 is severe. Inclusion criterion was a score of ≤ 20 on depression.

WHOQOL-BREF. Including a measure of research participants' quality of life broadens the evaluation of the treatment beyond that of symptom reduction (Spokas, Rodebaugh, &

Heimberg, 2008). The WHOQOL-BREF is a 26-item, self-report instrument, which assesses several domains of quality of life over the past two weeks (Bowling, 2005). It measures the domains of physical health, psychological health, social relationships, and environment and is suitable for Australian research (World Health Organization, 1997). This instrument is appropriate for use in clinical trials to establish changes in quality of life over the course of treatment (World Health Organization, 1997, 1998). It took research participants approximately 5-10 minutes to complete. Four domain scores and an overall score for quality of life are produced. Items 3, 4, and 26 are reverse scored. Domain scores are calculated by taking the mean of all items included in each domain and multiplying by a factor of four. Scores are then transformed to a 0-100 scale with higher scores denoting a higher quality of life (World Health Organization, 1998). With regard to validity and reliability, the scale has demonstrated sound psychometric properties (Bowling, 2005; World Health Organization, 1998). There is no inclusion criteria associated with the WHOQOL-BREF since it is an outcome measure.

RSI. This 51-item instrument measured satisfaction with retirement and life (Floyd et al., 1992). It asked research participants about their decision to retire and sources of enjoyment in retirement. Research participants completed this instrument at pre-treatment (Time 1) and follow-up (Time 5). Question 51 asked, "Overall, how satisfied are you with your retirement right now?" and was used as an outcome measure. Research participants responded on a 6-point Likert type scale ranging from 1 (very dissatisfied) to 6 (very satisfied).

Participant satisfaction survey. This survey (Appendix B) asked research participants to rate their experience with the treatment received. This survey is utilised at The Clinic. It is sent to all clients to give them an opportunity to provide feedback.

Table 5

Summary of Each Participant's Screening Results at the Initial Clinical Interview

Code	1	2	3	4	5	6	7	8	9	10
GDS-15	4	9	4	8	11	7	8	5	3	8
DASS21										
Depression	12	20	14	12	42	32	16	12	6	16
Stress	0	24	2	6	22	2	10	2	4	2
Anxiety	22	24	6	18	36	18	16	14	8	4
Negative affect	34	68	22	36	100	50	42	28	18	22
WHOQOL-BREF										
Physical	86	50	68	57	89	68	82	68	71	64
Psychological	50	33	50	63	42	58	71	54	50	58
Social	33	42	100	58	42	75	58	42	17	50
Environment	88	63	88	84	84	91	88	66	84	100
Average	64	47	76	66	64	73	75	57	56	68
MMSE	30	28	28	29	27	26	26	28	29	30

With regard to the screening results (Table 5), four comments are warranted. On the WHOQOL-BREF, it was notable that all participants, except two (Codes 3 and 4), scored lower on the psychological and social domains than the physical and environmental domains. No studies were found that correlated the GDS-15 or DASS21 with the WHOQOL-BREF. The IPT model is designed for the treatment of depression in the context of an etiology of interpersonal problems. Therefore, the WHOQOL-BREF appears to have face validity as a screening tool since the low domain scores on psychological health and social relationships are a good fit to identify research participants who experience depression due to interpersonal problems.

Notably, participant 5 fell outside of the inclusion criteria with regard to depression levels on the GDS-15 and DASS21. After supervision consultation, the participant was accepted because:

- there were no suicidal behaviours,
- an anti-depressant medication had been commenced (20 mg Lovan) four weeks prior to starting treatment and research indicates that treatment of severe depression with a combination of pharmacological and psychological treatment tends to be effective (Miller et al., 1998; Reynolds III et al., 1999),
- the participant's GP agreed that the intervention may be helpful,
- the participant wanted to be involved in the study,
- the participant agreed to go under a Mental Health Care Plan if the treatment did not relieve depressive symptoms, and
- the WHOQOL-BREF indicated probable suitability with IPT given the comparably lower scores on the psychological and social domains and higher scores on the physical and environmental domains. The lower psychological domain score confirms the elevated depression scores on the GDS-15 and DASS21. The lower social domain score suggests a fitting target for intervention with this treatment.

After six sessions, the research participant returned to his GP for a review. He was advised that improvements had been made and there would be no medication changes. It is noteworthy to briefly mention that participant 5 was free of depressive symptomatology at the conclusion of the study.

Participant 9 did not fall into the depressed range on her depression measures; that is, she was not depressed when she commenced the study. During the telephone screening the participant had an elevated level of depression on the DASS21. Several factors led to the decision to include her in the study. The participant reported feeling depressed over the past

two months, but it was particularly bad over the previous weekend due to having sun spots removed from her face. She was also not socialising. Clinical observations suggested that the participant's depressive symptoms receded at the commencement of treatment because she was engaged in therapy and had simultaneously started three fortnightly volunteer jobs. These combined factors appeared to contribute to her being in the unimpaired range for depression, but the participant was concerned about relapse. Her social domain score on the WHOQOL-BREF was very low and the psychological domain was likewise low, which suggested a good fit for IPT-RM.

Participant 6 was the only person to withdraw from the study and she expressed her disappointment at having to do so. After three meetings, the participant advised that she would be interstate for two weeks helping to care for a newborn granddaughter. The participant was contacted several times, but her absence was extended to several months. The time remaining in the study was insufficient to accommodate further delays. After consultation with the clinical supervisor, the participant was advised that, regrettably, the study could no longer accommodate further delays in treatment due to the approaching end date. The participant was offered free counselling at The Clinic with a Masters level clinical psychology intern upon her return to Perth.

Design

Non-experimental AB single-case design. A series of non-experimental single-case studies was conducted to monitor the effects of the IPT-RM treatment intervention. This was an open trial, meaning there was no control group as the researcher simply wanted to determine whether the treatment intervention was feasible or not (van Teijlingen & Hundley, 2001). Researchers have suggested that single-case studies are acceptable for the development of a treatment intervention (Lundervold & Belwood, 2000; Ownsworth, Fleming, Desbois, Strong, & Kuipers, 2006; Photos, Michel, & Nock, 2008; Wragg & Whitehead, 2004).

Single-case designs are especially suited to the development and preliminary testing of treatment interventions (Wilson, 2000). Participants act as their own baseline and individual change is documented and analysed by taking systematic measures before, during, and after the treatment intervention (Photos et al., 2008). Single-case designs are more flexible and responsive than group designs, because the intervention can be refined before replicating the study. The single-case design is a simple and cost effective way to test the feasibility of a new treatment prior to investing significant resources in a randomised controlled trial.

In this non-experimental study, a series of independent baselines (A) were followed by the treatment intervention phase (B). The baseline phase (A) is where the behaviour of interest is observed. In the current study, depression, anxiety, stress, and quality of life were measured.

The intervention phase (B) comprised the period where conditions changed and the treatment was introduced. Changes in depression, anxiety, stress, and quality of life were repeatedly measured during the study (i.e., Times 1 to 5) to monitor effects of the treatment. If an associated change is observed, the logical inference to make is that the phase B intervention affected the change. However, the main limitation with a non-experimental design is that causality claims cannot be made because a matching comparison group is not included and there is no experimental manipulation of the timing of the phase B intervention. This lack of experimental control meant that external factors may possibly have caused the observed changes.

To compensate for this limitation, weight can be added to the credibility of the results through replication (Photos et al., 2008). The present study was replicated with nine research participants. One guideline suggested that single-case replication with at least three cases by two or more independent research teams is sufficient to establish a treatment's efficacy (Spokas et al., 2008) and could be conducted in future trials. Other factors used to increase credibility for these designs include clearly specifying the target behaviour, measurements and assessments are conducted objectively, and results need to indicate a marked change in trend from the baseline to the invention phase. The latter is determined through visual inspection of the data, which is explained shortly under Data Analysis.

Scientist-practitioner model. The scientist-practitioner model, which comprises a feedback loop from practice to science, has been promoted for psychologists. Specifically, psychologists are taught to be researchers who apply theoretical knowledge, decision making, and interventions that are scientifically tested (Shapiro, 2002). The field of clinical psychology recognises the importance for clinicians to have the skills of a researcher to practice effectively. Therefore, the scientist-practitioner model dominates the training, education, and supervision of clinical psychologists today. This model was incorporated in the current study.

Evidence-based practice. Psychologists are trained to utilise evidence-based practices within their treatment decision making. Treatments which are ethical and have empirical evidence take precedence over unsupported or untested interventions (Nezu & Nezu, 2008). The current study utilised an evidence-based practice to meet the developmental needs of older adults who are experiencing difficulties adjusting to retirement; that is, Interpersonal Psychotherapy. The treatment that was provided emphasised empirically-based conceptualisations of retirement issues and depression, which may lead to both symptom reduction and improved interpersonal functioning for individuals with challenges related to retirement adjustment.

Procedure

Treatment sessions. After being accepted and agreeing to participate in the study, research participants commenced weekly sessions of IPT-RM. All sessions were conducted at The Clinic between the times of 9 am and 4 pm, Monday to Thursday. There was no necessity to offer after hours sessions since all participants were available during working hours. The number of sessions that participants received ranged from 6 to 20. The shorter cases comprised 6, 7, 8, and 9 Sessions, with participants indicating that they did not require the full 12 sessions offered since they were no longer depressed and were functioning independently. These four cases had their final sessions spread out to ensure there was stability in mood prior to termination. Table 7 details the treatment session dates for each participant.

Treatment termination was carefully managed following IPT guidelines. With short term therapies, an awareness of termination remains prominent throughout treatment as there is limited time to complete therapeutic tasks. Participants were reminded periodically of sessions completed or sessions remaining. The date for termination was agreed upon by the principal investigator and participant in consultation with the clinical supervisor.

In the last two sessions, termination issues were more extensively explored. Issues raised included evaluating progress, asking participants about predictable problems that may cause future relapse, where they would go for help if needed, asking about what they gained from treatment, and finding out how they felt about treatment ending. Measures were completed, parking fees were reimbursed, reminders were given that follow-up measures needed to be completed, and participants were thanked for their involvement in the study. The final contact with participants was by post. Participants were sent follow up measures with a covering letter and a reply paid envelope. The measures comprised the GDS-15, DASS21, WHOQOL-BREF, RSI, and the participant satisfaction survey.

Treatment integrity. Ensuring that the correct treatment (therapist adherence) was administered competently (therapist competence) is a crucial aspect of intervention studies. A treatment integrity protocol was instituted to ensure the research was fully accountable to enhance the rigour of the results. The protocol included the use of a Document of Progress (Appendix B), recorded treatment sessions, independent therapy ratings, and supervision.

The Document of Progress (DoP) was adapted from a report created by researchers for the monitoring of IPT therapy (Miller et al., 2007). The DoP included a cover page detailing sessions attended and four sections facilitating therapeutic monitoring on a session-by-session basis. Section 1 covered case formulation, interpersonal inventory, genogram, depression and anxiety timeline, and an education and work timeline. Section 2 contained a graphical representation of therapy progress. Section 3 was the longest part and provided space for

session notes, reminders of measures to be administered and accompanying results, and tasks to be completed. Finally, Section 4 provided space to consolidate and reflect on the entire case.

All treatment sessions were recorded by DVD or audio with the participant's consent. Recording of sessions is a viable way for researchers and therapists alike to gain feedback on their therapeutic skills. Each recording was reviewed prior to the next session, which facilitated the therapeutic process. Two sets of notes were taken. The first set was detailed case notes typically comprising three A4 sized handwritten pages. These were used for the preparation of the clinical case studies in Chapter 5. The second set of notes was written in the DoP and comprised a concise summary of the session in one A4 handwritten page. This process facilitated reflection on the progress of therapy, clinical skills used, and the future direction of therapy.

A common research strategy for checking therapist adherence and competence is the assessment of treatment sessions. Rounsaville et al. (1988) emphasised the importance of conducting these assessments based on video or audio recorded sessions rather than self-reported sessions. For three research participants, two sessions were randomly selected, one from the first half of therapy and one from the second half, and rated by a blind assessor who was unaware of what treatment was employed (Spokas et al., 2008). The assessor signed a confidentiality agreement to protect participants' confidential (Appendix C). The assessor was a Provisional Psychologist who was trained to rate each therapy session on a therapy rating scale (Appendix D), which was developed by Wagner, Frank, and Steiner (1992). It was designed to distinguish between IPT maintenance and medication clinic sessions. The rating scale included treatment elements that were allowed, prohibited, and common to other treatment modalities including: 11 interpersonal items, six somatic items, and 10 items reflecting CBT or psychoanalytic approaches. Following the Rounsaville et al. (1988) example, unsatisfactory ratings meant the therapist failed to consistently implement strategies and techniques in line with the treatment manual or incorporated contraindicated strategies and techniques. In the present study, satisfactory ratings were found as results indicated that scores were highest on interpersonal factors. The limitations of this process are discussed in Chapter 6.

Supervision. Regular clinical supervision was received from a clinical psychologist (Ph.D) who worked in private practice and at the ECU Psychological Services Centre supervising postgraduate psychology interns. The clinical supervisor had received IPT training with Paul Rushton, a respected Australian trainer, in Queensland. Supervision provided an opportunity to seek feedback, review individual cases, discuss progress, discuss future therapeutic

directions, and raise issues of concern. The DoP and recorded sessions were used within supervision.

Data Analysis

For single-case designs, data are predominantly analysed by visual inspection (Barlow & Hersen, 1984; Photos et al., 2008; Spokas et al., 2008). Improvement is indicated by a large change in level between the baseline (A) and intervention phases (B). The less overlap observed between these phases, the stronger the claim for an effect of the intervention. Variability in the data makes it harder to determine an effect (Lundervold & Belwood, 2000). Results are graphically represented for each measure with accompanying text. The text elaborates on the magnitude of change (mean and level of performance) and the rate of change (trend and latency of change) across phases to describe treatment outcomes (Photos et al., 2008). A reliable effect is determined by the replication of an intervention where baseline data reliably varies under the treatment condition (Barlow & Hersen, 1984). An advantage of visual inspection is that the reader can compare their interpretations of the data with those of the researchers (Spokas et al., 2008).

Statistical analysis becomes redundant when there is a potent effect, yet it can be useful if there is a weak but reliable effect that visual inspection overlooks (Barlow & Hersen, 1984; Photos et al., 2008). After checking for serial dependence through the test of autocorrelation (non-significant results are desirable), *t*-tests can determine whether there are significant changes in means between baseline and treatment phases (Kazdin, 1984). Statistical analysis utilising *t*-tests are acceptable for single-case designs (Photos et al., 2008). Given that the present research design is non-experimental and there were insufficient data points, however, statistical analysis was not possible.

Treatment responders. The criteria for treatment responders were determined *a priori*. Treatment success was defined as a reduction in depressive symptoms and psychological distress, as well as an increase in interpersonal functioning (Mansfield & Addis, 2001b). At the end of treatment, data should not overlap with the baseline phase as judged by visual inspection. In other words, when looking at the graphical results of the outcome measures between the pre-treatment and treatment phases, they will be different. Following Roemer and Orsillo's (2007) recommendation, research participants were considered to meet the criteria for high end state functioning if they fell into the normative range on the GDS-15 and DASS21 post-treatment. A clinically significant treatment response is important in terms of a meaningful change in daily living and this was defined as a 20% change in pre-treatment scores, as specified by Waters et al. (2008). Research participants who do not respond to the treatment may need to see their medical practitioner to get medication, or try a different type

of therapy, or a different therapist (Spokas et al., 2008). If this was necessary, a written referral would have been provided in consultation with the participant and the clinical supervisor. At the conclusion of the study, no participant required a referral.

Ethics

The current study received approval from the ECU Human Research Ethics Committee. Risk management is an important part of ensuring that participants are safe, especially when psychological treatment is involved. Supervision has already been outlined, so confidentiality, training, and reflexivity are now discussed as part of the risk management strategy for the current study.

Confidentiality. Participant confidentiality was carefully managed. The two identifiable documents were the demographics questionnaire (Appendix E) and the participant consent form (Appendix F). The demographics questionnaire included personal details such as name, address, and telephone numbers. The consent form included the participant's full name and signature agreeing to the conditions of the research and set out their rights to withdraw at any time without penalty. The demographics questionnaire was deidentified with a number from 1 to 10. All subsequent forms, including the DoP, were identified by this unique number. All DVD recordings of sessions and identifiable documents were stored at The Clinic in a locked room. On completion of the study, all research data was stored at the ECU School of Psychology's locked facilities where it will remain for the compulsory seven year storage period.

Training. The principal investigator had not been trained in IPT, so this was necessary before commencing treatment. Face-to-face training was received in Sydney by Dr. Scott Stuart in December 2009. Dr. Stuart is a psychiatrist, cofounder of the International Society of Interpersonal Psychotherapy, director of the University of Iowa's Interpersonal Psychotherapy Institute, and coauthor of the textbook, *Interpersonal Psychotherapy: A Clinician's Guide* (Stuart & Robertson, 2003). The training covered the theoretical background, intervention techniques, and opportunities for role plays. To supplement this training, three specialised IPT training manuals (Hinrichsen & Clougherty, 2006; Stuart & Robertson, 2003; Weissman et al., 2000) and a training DVD (Hinrichsen, 2007b) were studied. Complemented by regular supervision, this training combined to create a solid foundation for the use of IPT in this research setting. The aforementioned learning of IPT is aligned with Hinrichsen's (2008b) model for training psychologists: acquiring knowledge of ageing utilising industry guidelines for psychological practice with older adults, becoming familiar with IPT through reading treatment manuals, attending face-to-face training in IPT, and obtaining supervision in IPT.

Reflexivity

The researcher inevitably influences their study and this is especially the case with qualitative endeavours. Given the subject at hand, I will break away from conventional writing used throughout the rest of this dissertation and shift into first person. Reflexivity provides an opportunity to peer into the personal history of the researcher, to understand what has shaped the research, to understand epistemological views, and to gauge his or her level of thoughtfulness about research processes and practices.

Personal reflexivity. I was 36 years of age in June 2011. Since I was significantly younger than the participants in the current study, I was often asked how I became involved in the field of retirement. Three factors motivated this decision.

The most significant factor was that I went through a transition of my own, which paralleled the retirement experience, and thus prompted my interest in the retirement transition. When I was 28 I left an office job that I had held for 10 years to become a fulltime student. To a lesser degree, the transition from fulltime employment to fulltime student was similar to that of retirement. I experienced a decline in status (employee to student), a significant decrease in financial resources (a good wage to government benefits), a change in social network (daily contact with many colleagues to minimal contact as some units were taken externally), and an adjustment in identity (someone who was skilled at an occupation to someone who was at the bottom of the ladder). I did not expect to feel the loss of the job or professional role because I was glad to be moving towards a new vocation. I am the first member of my family to attend university and I was proud of this.

The transition turned out to be psychologically stressful. Having grown into young adulthood at my place of employment and then moving into the unknown was a time of ambivalence and uncertainty. What struck me was that I was relatively young and moving toward a bright future in a different career. I wondered, 'If I had these opportunities yet experienced difficulties in the transition, what it would be like for someone retiring, probably being reminded that the end of his or her career coincides with fewer years left to live?'

A secondary factor was the desire to work with people and develop my clinical skills. Many of my colleagues were conducting studies that had no direct client contact, so they would miss out on the opportunity to develop their clinical skills. If I had likewise chosen that path, I could have gone two years, or more, without working with people. The current study provided the benefit of both conducting research and developing my clinical skills.

The final factor was that I enjoy talking with older adults. My Honours research involved qualitative interviews exploring the role and meaning of spirituality in older adulthood (M age = 75.7 years). I thoroughly enjoyed talking with these older adults and it seemed to

provide some kind of therapeutic benefit to the participants. After my transition experience to fulltime student, I would often ask retirees about their retirement transition.

My age and other factors may have influenced the research. Being female and around the age of the research participants' children could have affected what they discussed with me. For example, male participants could have withheld concerns that they felt were too embarrassing. Another factor was that I am Australian born and from a different generation than the research participants. Most of the research participants were born overseas (six out of nine) so a consideration of cultural influences was necessary. These potentially biasing effects were attempted to be managed through reflexivity and supervision processes. Awareness of potential issues was kept in the forefront of my mind during therapy and supervision. For example, older generations may be more likely than younger ones to have rigid roles for men and women and the impact of retirement on these changing roles was crucial. One participant, Frank, was from Germany and his belief that men do not do "women's work" negatively impacted on his adjustment to retirement. In my relationship, my husband contributes to household labour. We share power and I believe that equity works well for us. I believe that what works for me does not necessarily work for other couples. I did not impose my beliefs on participants, but instead asked them about their situation. For example, I asked Frank if the current arrangement was working for him and this questioning enabled him to explore his situation. Finally, having these awarenesses enabled me to avoid making assumptions. Rather than assuming I knew how the research participants' cultural background was influencing the situation, I could invite them to explore it.

Research may also affect and change us, as people and researchers. The present study was no exception, especially given the nature of therapeutic work. It is my belief that it is unhelpful for a therapist to be detached and not be impacted by their clients; indeed, Young (2003) affirmed that therapists can learn about themselves while working therapeutically. In working with older adults, I better foresee the complications that can arise in retirement and I am better informed about how to avoid depression when I reach this major life transition.

Retirement is a time of life when coming to the end of one's working life is a reminder that the end of life is also approaching. Death was raised in conversation by several participants, but it was rarely explored for long as the participant invariably took the conversation elsewhere. It is possible that the small number of participants discussing death and the brief conversations had something to do with my age – perhaps they thought that death was irrelevant or inappropriate to discuss. Alternatively, participants may have unconsciously avoided a discussion of death because it is a sensitive topic. Kelly and Barratt (2007) referred to this process as denial.

Epistemological reflexivity. This kind of reflexivity prompts the researcher to think about assumptions made during the research and its implications. The first issue that stands out is the design of the current study. Given that there was sufficient research evidence regarding the issues that retirees experience in the transition to retirement, it was feasible to trial an intervention specifically for this population and their unique issues. However, it would have been possible to conduct the study another way. Phase 1 could have been a qualitative study interviewing retirees about their retirement experiences, including well-adjusted and poorly adjusted narratives. Phase 2 could have been the development of a treatment manual. Time limitations may have prohibited a third phase of conducting a pilot study. With this conjectured design, Phase 1 combined with a comprehensive literature search may have resulted in a different manual from the one presently developed.

The literature cites therapists' compliments and complaints about using treatment manuals, so it would be useful to discuss my experiences. I had never before used a treatment manual where I adhered so closely to its directives. Having written the IPT-RM treatment manual, it will be useful to have someone else use it in a Stage 2 manual's development to provide an independent perspective.

Several benefits of treatment manuals are described in the literature including the: standardisation of treatment and training (Najavits et al., 2000), increased internal validity for treatment trials due to consistent treatment delivery (Addis & Krasnow, 2000), and provision of structure and focus for therapists (Godley et al., 2001). The available IPT manuals (Hinrichsen & Clougherty, 2006; Stuart & Robertson, 2003; Weissman et al., 2000) facilitated my training in the modality, but needed to be complemented by face-to-face training and supervision. The IPT-RM treatment manual provided a comprehensive document for treatment issues, for example, therapists can access information needed to assist their clients within the single resource. In those times when I felt unsure of where to take therapy or how best to help the participant, I was able to refer to the IPT-RM treatment manual for direction and was reminded of the best strategies that could be used at that juncture. Having written the manual I am highly familiar with its layout and content, so having someone independent using the manual could provide an impartial perspective.

Three studies looked at therapists' views of using treatment manuals. Addis and Krasner (2000) researched 891 therapists in the United States and found two factors that they perceived as issues with using treatment manuals. The first relates to the therapeutic process. Therapists said that a treatment manual limits the therapist's autonomy within a session and also negatively impacts the therapeutic alliance. The second related to the therapeutic outcomes. Therapists believed that the outcomes of therapy may be negatively affected when

the manual is rigidly followed. In another study, Najavits et al.'s (2000) participants complained that treatment manuals made the therapeutic process formulaic because it emphasised therapeutic techniques over the therapeutic alliance. Godley et al. (2001) found that therapists' main complaint was that treatment manuals had the potential to restrict them from responding to their client's individual needs. In general, I did not experience these complaints as limitations. Since the IPT treatment manuals are principal-based, there is the opportunity, if the therapist has the ability, to remain client-centred and present-focused to work with the client. These factors facilitated a good working relationship, so the therapeutic alliance was not threatened when using the IPT-RM manual.

I believe it is an illusion to say that a therapist acts autonomously. When looking at the Merriam-Webster dictionary definition of autonomy, "the quality or state of being self-governing" and "self-directing freedom," it is evident that few contemporary therapists act with autonomy. Psychologists are bound by the scientist-practitioner model, which means our "freedom" is limited by the practice of utilising evidence-based therapeutic models. Unless someone acts beyond the bounds of ethical considerations in his or her clinical and scientific work and disregards the necessity for evidence-based models, a therapist is not truly autonomous.

Contrary to the complaint found in Addis and Krasnow's (2000) study that therapeutic outcomes may be adversely affected by using a treatment manual, I believe this was not the case with the present study. Given the underlying mechanism for change of the IPT model, focusing on the development and strengthening of the participant's social support resulted in positive outcomes that may have only been achieved by maintaining this focus.

Since the manual is principal-based, it is flexible and broad enough to ensure that I did not feel restricted by its delivery. I assessed the research participants' needs to determine whether or not they could be addressed by this model. If their needs did not fit, then I needed to determine what to do. There were times when some kind of Expressive Therapy or Motivational Interviewing may have better met the research participants' needs, but this lay outside the scope of the current study. For example, one participant had conflict with her husband about the fairness in the distribution of food, another felt shame about an incident that occurred three decades ago, and yet another suppressed emotional issues rather than confronting them. Expressive Therapy may be a good fit to work with these issues. Where health behaviours needed changing (a common example from the present study was the participant's desire to increase exercise), Motivational Interviewing may have worked well. In a real life clinical setting, a therapist has the flexibility to incorporate other skills into their work, which is often labelled as an eclectic therapy model (Clarke, 1995).

The manual was effectively used to treat seven of nine participants in 20 or fewer sessions (average of 12 sessions). This complies with the Australian Medicare system for people accessing psychological treatment through the Better Access to Mental Health Care Plans. Being a time limited therapy, the manual helped me remain on track and focused. While at times I thought we had a lot of work to do in a short amount of time, overall the manual helped to keep me and the participant on track.

The manual was broad and flexible, so most issues arising did not result in a deviation from the treatment manual. For example, life stressors arose during the treatment trial where one participant's partner was diagnosed with breast cancer, but this was processed within the IPT model. Specifically, we discussed the impact of the event on her (the participant was in a 25 year same-sex relationship), and explored coping strategies, with an emphasis on social support.

One exception arose where a deviation was necessary. Participant 10 lacked psychological mindedness and therefore did not respond well to this form of psychotherapy. In consultation with the clinical supervisor, it was agreed to incorporate a behavioural activation strategy of activity scheduling (Lejuez et al., 2001). Commencing in Session 3, the last 10 minutes of each session involved the completion of a Weekly Activity Schedule. The table comprised days of the week listed horizontally and two-hour time slots listed vertically. At the commencement of the following session, the participant started the session by discussing the schedule. While an IPT focus was still maintained by emphasising the development and maintenance of his social support system, it was a necessary deviation from the treatment manual when exploratory techniques failed. By Session 6, the participant's self-report measures indicated that he was no longer depressed.

Overall, I least liked the limitation of being unable to engage in deeper therapeutic work, such as the aforementioned Expressive Therapy, as relevant issues arose. I liked the clear focus provided by the treatment manual and the guiding principles for change. When a clinical question arose in therapy about direction, the basic question I asked myself was, "Does this serve the development and strengthening of this person's social support network?"

Chapter 3

Treatment Manual

The treatment manual has purposefully been excluded from online availability. Please contact suegmiller@gmail.com.

Chapter 4

Results

A treatment manual (IPT-RM) was designed for retirees who experience depression due to a poor adjustment to retirement. The research question being asked was: Does Interpersonal Psychotherapy improve depressive symptomatology for retirees experiencing a poor adjustment to retirement? Nine research participants completed a course of IPT-RM adapted to meet the developmental needs of the target population. Given the pilot nature of the current study, preliminary results are reported in this chapter, which assesses change from pre-treatment eligibility assessment to post-treatment follow-up.

The reporting of results is presented in the same format for each participant: participant synopsis, which includes a brief background and basic demographic data; eligibility assessment; receipt of treatment; clinical improvement, which includes primary (GDS-15) and secondary (DASS21 and WHOQOL-BREF) study outcomes; applied importance of behaviour change; and treatment tolerability. Table 8 presents participants' GDS-15 scores, Table 9 participants' DASS21 scores, Table 10 participants' WHOQOL-BREF scores, Table 11 participants' Retirement Satisfaction pre-treatment and follow-up scores, and Table 12 participants' Treatment Satisfaction Ratings. Graphs for each participant are included for visual inspection and accompanied by text commenting on the indicators of change.

Two indicators of change, magnitude and rate, were used to determine if the intervention had an effect. In this chapter, the indicators are compared over the study's three phases: pre-intervention, intervention, and follow-up. The magnitude of change was established by comparing the change in means and levels in the observed behaviour across phases. In the present study, the observed behaviours were depression, stress, anxiety, and quality of life. Also in this chapter, the rate of change is established by assessing the trend and latency of observed behaviours across phases. The degree of overlap between phases and variability within phases is also discussed. Factors unrelated to experimental control but could affect outcomes are also discussed as relevant.

Ten participants commenced treatment but only nine completed it. As discussed in the Method Chapter, Cynthia (Code 6) ceased treatment after Session 2 due to a sudden and immediate trip interstate. In this thesis, all participants' names are pseudonyms.

Kerry (Code 1)

Participant synopsis. Kerry was 58 and had been retired for three years at the commencement of treatment. Kerry's self-reported health was very good, she held a Ph.D, and had worked at a high level within a tertiary education setting. Kerry had been married for 35 years, lived with her husband, and her two adult children had left home. She was born in the United Kingdom and immigrated to Australia at 10 years of age. Kerry and her husband (59 years of age) retired at the same time. Seeing friends who had died or were diagnosed with terminal illnesses prompted the couple to retire early. Kerry's presenting problems were: (i) marital distress exacerbated by retirement and (ii) problems with retirement adjustment, such as balancing time, activities, and socialisation. Kerry had a low level of social support to help her in facing these enduring challenges and had not told anyone about them. Her social supports were limited because she had typically given precedence to work over friendships.

Eligibility assessment. Mild depression (12) was indicated on the DASS21 but depression was not indicated on the GDS-15. Moderate stress was indicated on the DASS21. Kerry's score on the MMSE screen for cognitive impairment was in the normal range (30). The only medication that Kerry took during treatment was a synthetic hormone. Kerry fitted the inclusion criteria for depression due to a difficult adjustment to retirement and was deemed a suitable candidate for IPT-RM given her low level of social support. The primary problem area was role disputes with a secondary problem area of role transition. Kerry was offered and accepted a course of 12 IPT-RM treatment sessions.

Interestingly, the GDS-15 did not detect depression whereas the DASS21 did. No literature was found that correlated the performance of these two measures. The same pattern occurred with one other participant (Judy, Code 3). Coincidentally, Kerry (58 years) and Judy (64 years) were the two youngest participants.

Receipt of treatment. Kerry attended 16 individual sessions of IPT-RM from 21 October 2010 to 30 May 2011. Kerry moved from weekly to fortnightly sessions from Session 9 onwards due to therapeutic gains made and stabilisation of mood. Kerry and her husband travelled overseas in January 2011, which resulted in a two month break in treatment between Sessions 11 and 12. Upon her return for the final session (Session 12), relationship distress was present and, although depression remained absent, a further four sessions was offered to prevent relapse and capitalise on therapeutic gains. Follow-up measures were completed on 20 June 2011.

Kerry engaged well in treatment and was very psychologically minded. Kerry had been silently struggling with her problems for some time and did not want to get divorced, so she was highly motivated to work towards positive change.

Clinical improvement. Figure 1 provides results for Kerry on the GDS-15, DASS21, and WHOQOL-BREF. Overall, a downward trend on the GDS-15 and DASS21 and an upward trend on the WHOQOL-BREF are noted, which suggests clinical improvement.

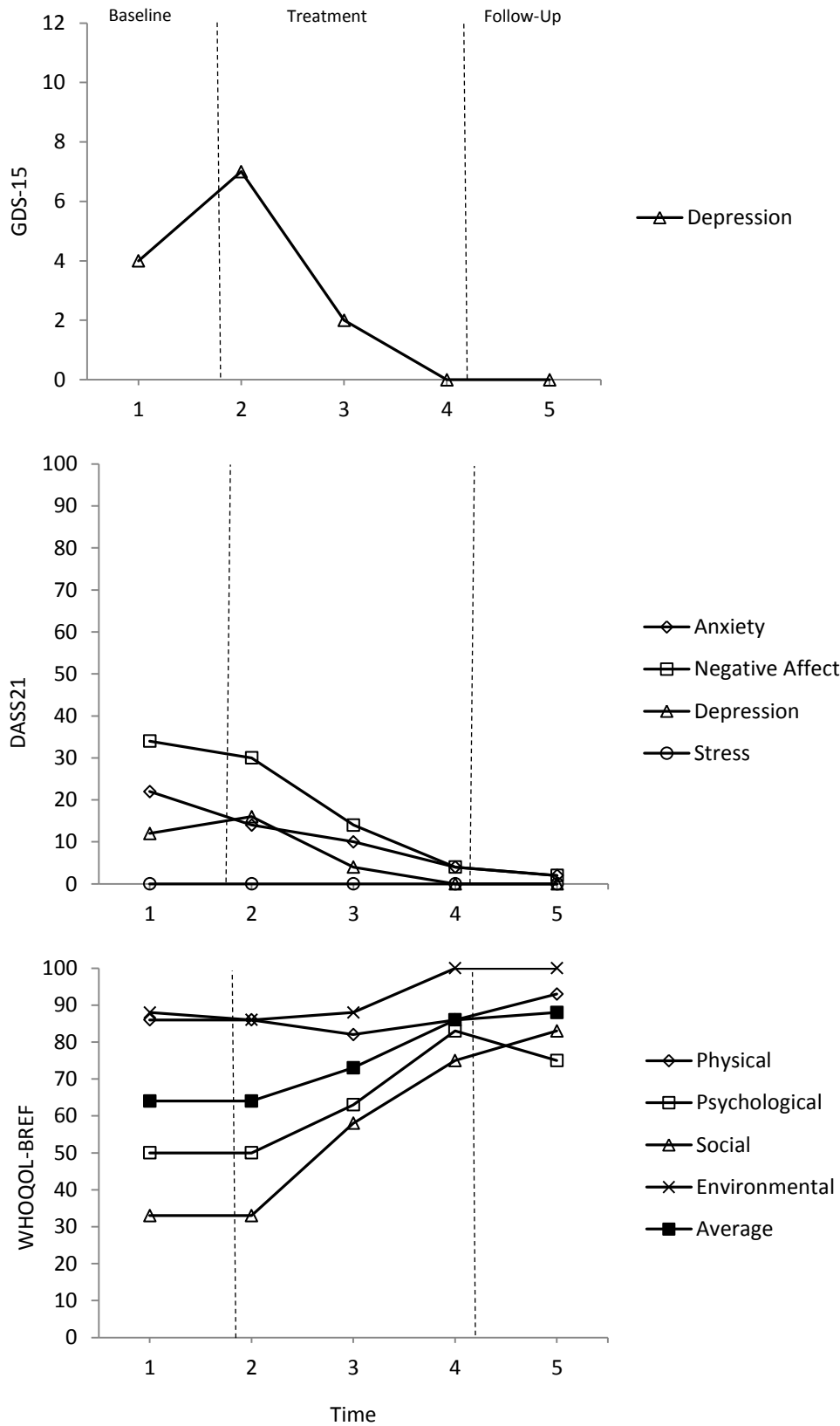


Figure 1. Results of psychological measures for participant Code 1 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

Primary study outcomes. The standout on the GDS-15 graph is at Time 2 (Session 1) when there was an increase in depressed mood reported into the mild range (7). A congruent increase in depression was seen on the DASS21. The change in mean depression scores across phases on the GDS-15 decreased from 4-3-0, indicating a reduction in depressive symptoms. Kerry started treatment in the upper levels of the non-depressed range on the GDS-15 and ended treatment in the non-depressed range with a score of zero.

The change in level of depression was gradual; by Session 6 the reporting of depressive symptoms had reduced to two. Overall, there was a downward trend with a moderate latency of change in the level of depression. The spike in depression at Time 2 created variability within the treatment phase and overlap across phases, which was unexpected. This could be interpreted as data that does not support treatment feasibility. However, Kerry had described a week with high conflict which corresponded with the spike in depressed mood. Given the nature of psychotherapeutic work, the spike in depression and increased conflict may be considered normal.

Secondary study outcomes. On the DASS21, “negative affect” represents the summation of the depression, anxiety, and stress subscales. Negative affect consistently decreased across the study (34, 30, 14, 4, and 2), which indicates an improvement in mood. Anxiety scores also consistently decreased across the study (22, 14, 10, 4, and 2). On all five time points, Kerry scored zero on the stress subscale. Commencing in the mildly depressed range (12) and severely anxious range (22), treatment concluded in the unimpaired range on both subscales (0 and 2, respectively). As with the GDS-15, the trend was downward and the latency was moderate on the DASS21 with overlap only occurring on the depression subscale at Time 2.

On the WHOQOL-BREF, the “average” subscale is the mean score of the physical, psychological, social, and environmental domains. There was an increasing trend on the average subscale across the study (64, 64, 73, 86, and 88), which indicates an improvement in quality of life. Importantly, the psychological and social domains had increasing mean scores (50-65-75 and 33-55-58, respectively). IPT-RM is based on the assumption that interpersonal difficulties are the source of depression, so improvement in the depression scores on the GDS-15, DASS21, and the psychological domain of the WHOQOL-BREF may coincide with an improvement on the social domain to demonstrate treatment effectiveness, as was evidenced with Kerry. The physical and environmental domains also improved, although gains were smaller (86-85-93 and 88-91-100, respectively).

Applied importance of behaviour change. Kerry was classified as a treatment responder. Kerry met the predetermined criteria for treatment success: reduced depressive symptoms and psychological distress, increased social functioning, non-overlapping data points across

phases, and a greater than 20% change in pre-treatment scores. On the GDS-15 and DASS21, all scores fell in the normative range, thus meeting the criteria for high end state functioning. Importantly, before starting treatment Kerry reported on the Retirement Satisfaction Inventory that she was “somewhat dissatisfied” with retirement and at follow-up she was “very satisfied.” Her written comments stated that the “(therapist) gave me the confidence to continue alone once the therapy had finished.” At the final session, Kerry expressed gratitude for the treatment received as she felt it had helped relieve her depression and improve her marriage, and would help her enjoy her future retirement years. Kerry gave the therapist a small gift as token of appreciation at the final session (Session 16).

Treatment tolerability. Kerry engaged well with the treatment and the modality seemed to be a good fit. All five of the participant’s Treatment Satisfaction Ratings were at the highest level (Table 12), suggesting that IPT-RM was well received.

Jillian (Code 2)

Participant synopsis. Jillian was 68 and had been retired for three years at the commencement of treatment. Jillian’s self-reported health was poor, she held a Bachelor’s degree, and had worked at a high level within a primary education setting. Jillian had not planned to retire at 65, but had done so to care for her terminally ill second husband to whom she had been married for 20 years. Jillian had two adult children from her first marriage and two grandchildren, all of whom lived nearby. Jillian lived by herself in an affluent suburb. Jillian’s presenting problems were the most complex of all participants: Jillian’s husband died five months previously, there was a very stressful ongoing court case, significant health problems, interpersonal difficulties with children, and social difficulties. The specific social difficulties included a loss of social contacts following her husband’s death, estrangement from her two step-children following issues related to the court case, and poor utilisation of the few social supports in her network.

Eligibility assessment. Jillian’s GDS-15 indicated mild depression (9). Her DASS21 scores were elevated: moderate depression (20), moderate stress (24), and severe anxiety (24). The WHOQOL-BREF reflected a similar picture with results scoring especially low on the psychological and social domains (33 and 42, respectively). Jillian’s score on the MMSE screen for cognitive impairment was in the normal range (28). Jillian took several different medications for the duration of the study including an anti-inflammatory, and tablets for hypertension and reflux. She was also prescribed Xanax (0.5mg three times a day) for anxiety but chose not to take it. Jillian fitted the inclusion criteria for depression due to a difficult adjustment to retirement and was deemed to be a suitable candidate for IPT-RM given her low

level of social support. The primary problem area was grief with a secondary problem area of role transition. Jillian was offered and accepted a course of 12 IPT-RM treatment sessions.

Receipt of treatment. Jillian attended 20 individual sessions of IPT-RM from 22 November 2010 to 31 May 2011. Sessions were weekly except for a brief gap in treatment in early January and late April when Jillian was travelling. At the end of Session 12, it was evident that further treatment was appropriate. There was a further eight sessions before treatment concluded. Follow-up measures were completed on 28 June 2011.

Clinical improvement. Figure 2 illustrates results for Jillian on the GDS-15, DASS21, and WHOQOL-BREF. Overall, a downward trend on the GDS-15 and DASS21 and an upward trend on the WHOQOL-BREF are noted, which suggests clinical improvement.

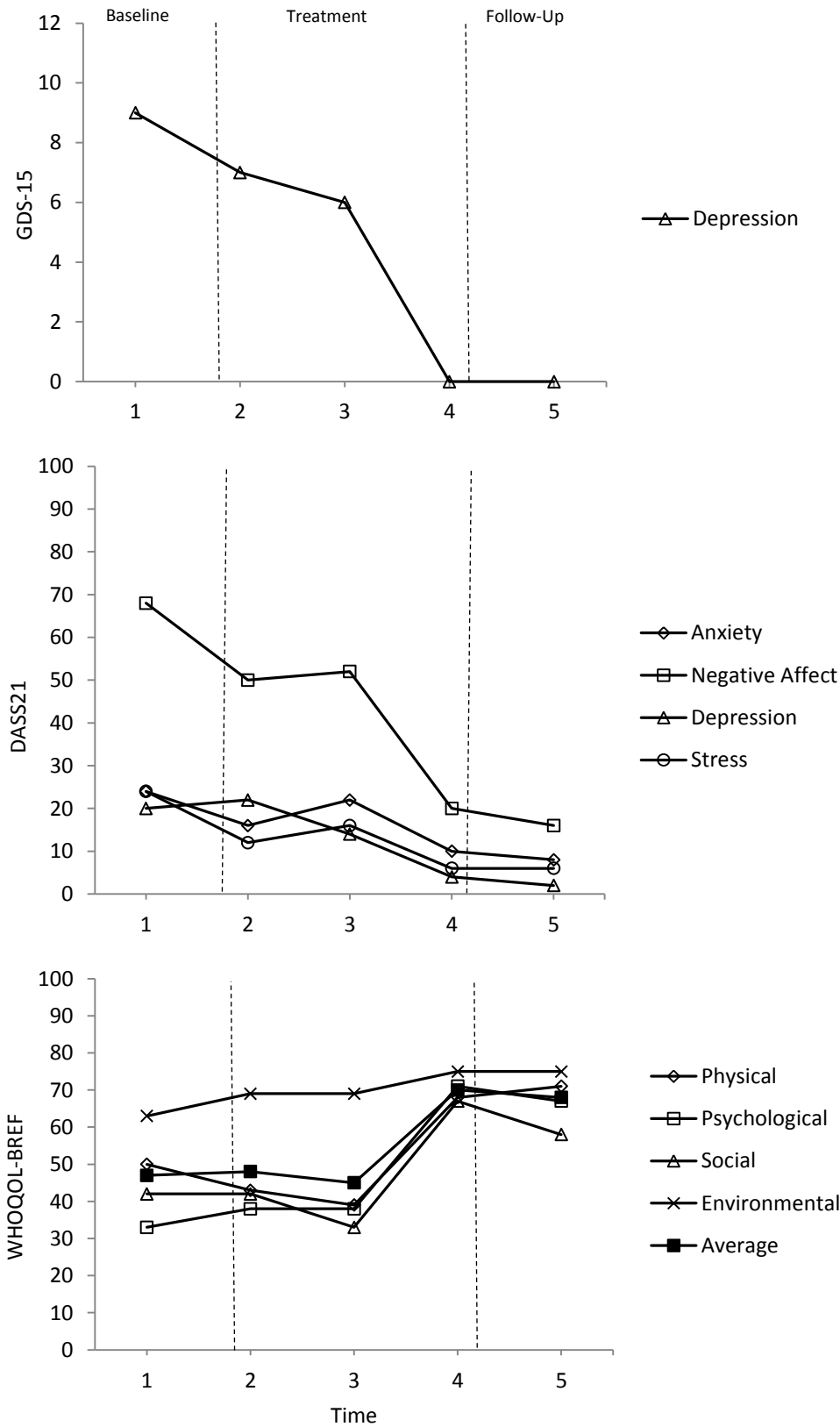


Figure 2. Results of psychological measures for participant Code 2 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

Primary study outcomes. In regard to the GDS-15, there was a downward pattern in the means across the baseline, treatment, and follow-up phases (7-4-0). There was a gradual change in the level of depression following the commencement of treatment. The rate of change in depression was gradual and slow. This was not surprising given the complexity of the presenting problems. The latency of change was high given there was a relatively long delay between the introduction of the treatment and entering the non-impaired range for depression. At Time 3 (Session 6), Jillian remained in the mildly depressed range (6) and it was not until the end of treatment that she was consistently in the non-depressed range. At Time 4 (Session 20) and Time 5 (follow-up), Jillian scored free of depression on the GDS-15. Between the treatment intervention and baseline phases there was no overlapping data.

Secondary study outcomes. There was a downward pattern of the negative affect means across the three phases (68-41-16) on the DASS21, which indicates improvement in mood. While there was some variability and overlap in data points, most notably at Time 3 (Session 6), a trend showing a downward slope of the line tracking affect emerged, which indicates an improvement in mood. Jillian commenced treatment with moderate depression (20), moderate stress (24), and severe anxiety (24) on the DASS21, and concluded treatment (Time 4, Session 20) in the unimpaired range for depression (4) and stress (6), but reported that moderate anxiety (10) remained. IPT-RM did not directly target anxiety and Jillian did not take her prescribed Xanax, yet anxiety symptoms abated from severe to mild across phases (24-16-8).

On the WHOQOL-BREF, improvement was gradual across domains. The means on the average subscale across phases increased 21 points (47-54-68). As with the DASS21, there was some variability and overlap in data points on the WHOQOL-BREF, most notably at Time 3 (Session 6). At Time 3, Jillian reported a decline on the physical and social domains. As was discussed in the literature review (Chapter 1), poor health can limit a retiree's involvement in activities and socialisation, which may have been the case for Jillian. Jillian reported the most improvement on the psychological and physical domains. From pre-treatment (Time 1) to follow-up (Time 5), the psychological domain improved by 34 points across phases (33-49-67) and the physical domain improved by 21 points (50-51-71). It is also interesting to note that there was a gradual trend in improvement of the perception of her environment despite, presumably, the participant's surroundings remaining unchanged (environmental domain mean scores: 63-71-75). Such an improvement suggests that as Jillian's mood improved she had greater ability to perceive positives in her environment.

Applied importance of behaviour change. Jillian was classified as a treatment responder. She met the predetermined criteria for treatment success: reduced depressive symptoms and

psychological distress, increased social functioning, non-overlapping data points across phases, and a greater than 20% change in pre-treatment scores. On the GDS-15 and DASS21, all scores fell into the normative range, with the exception of the DASS21 anxiety subscale, which evidenced a substantial decrease from severe to mild levels. Jillian started treatment feeling “very dissatisfied” on the Retirement Satisfaction Inventory and concluded treatment feeling “somewhat satisfied” with her retirement (Table 11), which is a positive therapeutic outcome. Jillian made good, consistent progress in treatment. Jillian expressed her gratitude for being involved in the study as it helped her work through grief, improved relationships with her children, reduced the distress associated with the court case, and helped her develop a retirement routine with involvement in activities and groups, and initiating social contact. Jillian gave the therapist a small gift as token of appreciation at the final session (Session 20).

Treatment tolerability. Jillian engaged well with IPT-RM, although there was at first reluctance to explore grief issues. It became necessary to process the less threatening and less prominent role transition issues in earlier sessions to develop trust and rapport before working on grief. Although grief was the primary problem area and technically should have been dealt with first, it may be countertherapeutic to force someone to work on an area before they are ready. There was some prompting by the therapist to move into the territory of grief after realising that Jillian would otherwise avoid the painful issue. The Participant Satisfaction Ratings were all ranked at the highest level, except for Question 4 which was rated 3 out of 4 (Table 12).

Judy (Code 3)

Participant synopsis. Judy was 64 years old and had been retired for three years at the commencement of treatment. Judy’s self-reported health was very good. She held a Diploma, and had worked within a primary education setting. Judy was born in the United States and educated in Australia. She had been in a same-sex relationship for 25 years and lived with her partner. She had one adult child from her first marriage. Judy decided to retire because she was advised that, financially, the timing was good. Judy’s partner was planning a partial retirement in late 2011, which Judy was looking forward to. Judy’s presenting problems were a depressed mood and a lack of motivation in the context of adjusting to retirement. Judy had a depressive episode in 1993, which was treated with medication. The current depressive episode was precipitated by retirement for which she had not done any planning and had not relied on existing social supports to buffer the stressors of the transition.

Eligibility assessment. Moderate depression (14) was indicated on the DASS21, but on the GDS-15 depression was only at the upper limit of the normal range (4). The stress and anxiety

subscales on the DASS21 were in the normal range (2 and 6, respectively). It was surprising that the social domain on the WHOQOL-BREF was rated perfectly (100/100) across all five time points because Judy's depression was related to a major change in social circumstances due to retirement. Judy's low rating on the psychological domain on the WHOQOL-BREF (50) reflected a congruent impression of the DASS21 results. Judy's score on the MMSE screen for cognitive impairment was in the normal range (28). The only medication Judy took during the study was for hypertension. Judy fitted the inclusion criteria for depression due to a difficult adjustment to retirement and was deemed a suitable candidate for IPT-RM given her low level of social support. The primary problem area was role transition with no secondary problem area. Judy was offered and accepted a course of 12 IPT-RM treatment sessions.

Receipt of treatment. Judy attended nine individual sessions of IPT-RM from 1 February 2011 to 10 May 2011. Sessions were attended weekly, except for a six week break before the final session (Session 9) due to Judy undertaking casual employment (four days per week) at her former workplace. Follow-up measures were completed on 7 June 2011.

While Judy engaged in the treatment she was not a highly talkative person. Often the therapist was required to keep the momentum of the conversation going. A structured therapy like IPT or CBT may be well-suited to Judy's personality. Hinrichsen (2007a) suggested that the therapist may need to actively prevent significant silences when working with older adults to maintain the therapeutic alliance. At times the flow in communication was stilted and this could be a reflection of how Judy's social contacts experience her.

Clinical improvement. Figure 3 illustrates results for Judy on the GDS-15, DASS21, and WHOQOL-BREF. Although Judy ended treatment in the non-impaired range on the GDS-15 and DASS21, the indicators of change were variable and overlapping. These are now described in more detail.

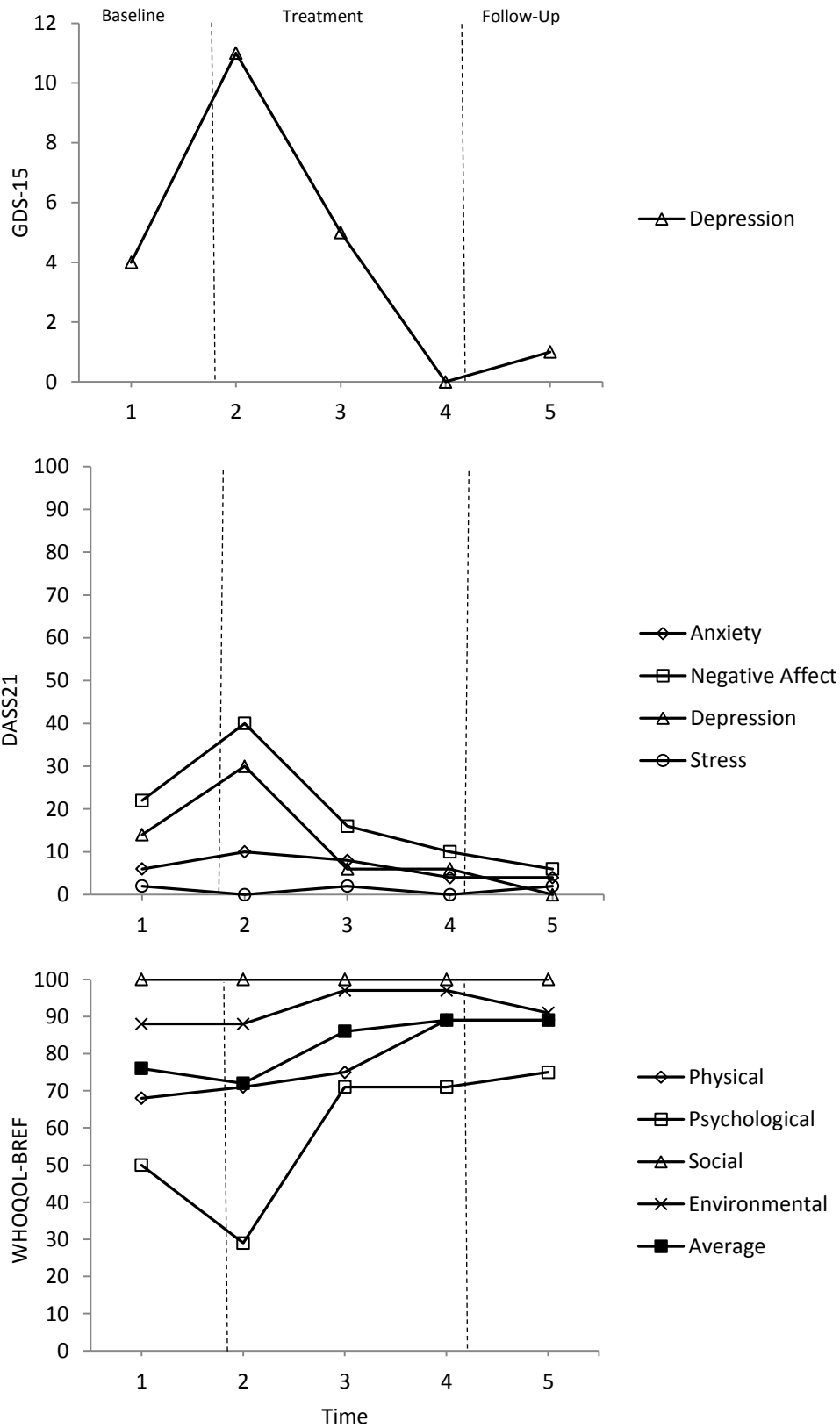


Figure 3. Results of psychological measures for participant Code 3 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

Primary study outcomes. As was seen with Kerry (Code 1), the stand out on the GDS-15 graph is at Time 2 (Session 1) when there was an increase in depressed mood reported into the mild range (11). A congruent increase in depression was seen on the DASS21. The change in mean scores across phases on the GDS-15 was variable (4-5-0). Although the elevation in depression from Time 1 (initial clinical interview) to Time 2 (Session 1) does not add credibility to the treatment feasibility, therapeutically this was productive. The elevation in depression was due to a periodically recurring situation related to Judy's former workplace, which created significant distress. That the event arose enabled therapeutic work to be effected so when it recurred Judy could manage the situation without suffering worsening depression.

Although Judy started and ended treatment in the non-depressed range on the GDS-15, there was variability and overlap between the baseline and treatment intervention phases. At Time 2 (Session 1) and Time 3 (Session 6) depression scores were higher than at Time 1 (initial clinical interview; scoring 11, 5, and 4, respectively). Although this high latency of change could suggest that another unintended factor or a natural process may have influenced the change, a closer look at Judy's circumstances provides a plausible explanation. At Time 3 (Session 6) Judy's partner was diagnosed with breast cancer, which was revealed to the therapist at Session 5. Judy commented that she was in fact coping better than she would have in the past given the work that had been done in-session, as was demonstrated by Time 3 scores on the GDS-15 and DASS21 being lower than Time 2.

Secondary study outcomes. As was seen on the GDS-15, there was overlap across phases on the DASS21 around Time 2 and Time 3. The mean negative affect scores across phases were 22-22-6 with substantial improvement in mood noted by Time 4 (final session) and gains maintained at Time 5 (follow-up). At pre-treatment, the depression subscale on the DASS21 was in the impaired range (14) but treatment concluded with depression in the non-impaired range (0).

There was a low level of improvement on the WHOQOL-BREF when looking at the average subscale mean scores across the study (76-82-89). With Judy concluding treatment in the non-depressed range on the GDS-15 and DASS21, this was congruently reflected in the upward slope of the means on the WHOQOL-BREF psychological domain (50-57-75). The physical domain mean scores evidenced a large improvement across phases (68-78-89).

Applied importance of behaviour change. Judy was classified as a treatment responder because she ended treatment in the non-depressed range and experienced meaningful improvements in social functioning. On the GDS-15 and DASS21, all scores fell in the normative range, thus meeting the criteria for high end state functioning. Although there was some variability within phases and overlap between phases, this is partially explained by Judy's

partner being diagnosed with breast cancer. Before starting treatment, Judy reported on the Retirement Satisfaction Inventory that she was “somewhat satisfied” with retirement and at follow-up she reported being “very satisfied.” At the end of treatment, Judy expressed gratitude for the treatment received because she said it helped to relieve her depression, cope with her partner’s diagnosis of breast cancer, increase her motivation, adjust to retirement, and reconcile the loss of her former work role. Judy gave the therapist a small gift as token of appreciation at the final session (Session 9).

Treatment tolerability. As previously mentioned, Judy was not a big talker and admitted to “mostly listening” when socialising. Judy had had previous counselling experience, so she was generally familiar with the process. Judy reflected on how she enjoyed the IPT-RM treatment sessions as, “I was listened to – really listened to. Useful information given that well suited me. Attentive therapist who always made me feel welcome and useful.” These universal therapeutic strategies (i.e., reflective listening and empathy) are known to create change regardless of the treatment modality. All five of the participant’s Treatment Satisfaction Ratings were rated at the highest level (Table 12), suggesting that IPT-RM was helpful.

Keith (Code 4)

Participant synopsis. Keith was 67 years old and had been retired for eight months at the commencement of treatment. Keith’s self-rated health was very good, he had high school education, and had been a blue collar worker. Keith was born and educated in the United Kingdom, and emigrated to Australia at 22 years of age with his pregnant wife. Keith was married for 45 years, lived with his wife, had four adult children, and five grandchildren. Keith had initially planned to retire at 65 years of age, but when the time came he felt anxious about the impact of retirement and so it was delayed. Keith eventually retired because he felt financially secure and had reached an appropriate age. Keith saw a workplace counsellor prior to retiring to discuss his anxieties about retirement, but he said he found the experience unhelpful as the counsellor did not understand retirement related issues. Keith’s presenting problem was depression due to retirement related maladjustment. Specifically, he lacked structured time, social interactions, meaningful activities, mental stimulation, and motivation to start planned retirement projects. Keith’s social support was extremely limited and he had “no best mates.”

Eligibility assessment. Depression was endorsed as mild on both the GDS-15 (8) and the DASS21 (12). Stress was normal (6) and anxiety was severe (18) on the DASS21. Keith’s score on the MMSE screen for cognitive impairment was in the normal range (29). Keith was not on any medication for the duration of the study. Keith fitted the inclusion criteria for depression

due to a difficult adjustment to retirement and was deemed a suitable candidate for IPT-RM given his low level of social support. The primary problem area was role transition with no secondary problem area. Keith was offered and accepted a course of 12 IPT-RM treatment sessions.

Receipt of treatment. Keith attended eight individual sessions of IPT-RM from 31 January 2011 to 18 April 2011. He attended weekly treatment sessions, except for the last two sessions which were spaced apart. Keith made rapid therapeutic gains and initiated termination as he felt the confidence to progress in retirement without further support from the therapist. Keith's mood had stabilised, relapse appeared unlikely, and there were no risk indicators to retain him in treatment. Follow-up measures were completed on 16 May 2011.

Clinical improvement. Figure 4 illustrates results for Keith on the GDS-15, DASS21, and WHOQOL-BREF. Overall, a downward trend on the GDS-15 and DASS21 and an upward trend on the WHOQOL-BREF are noted, which suggest clinical improvement.

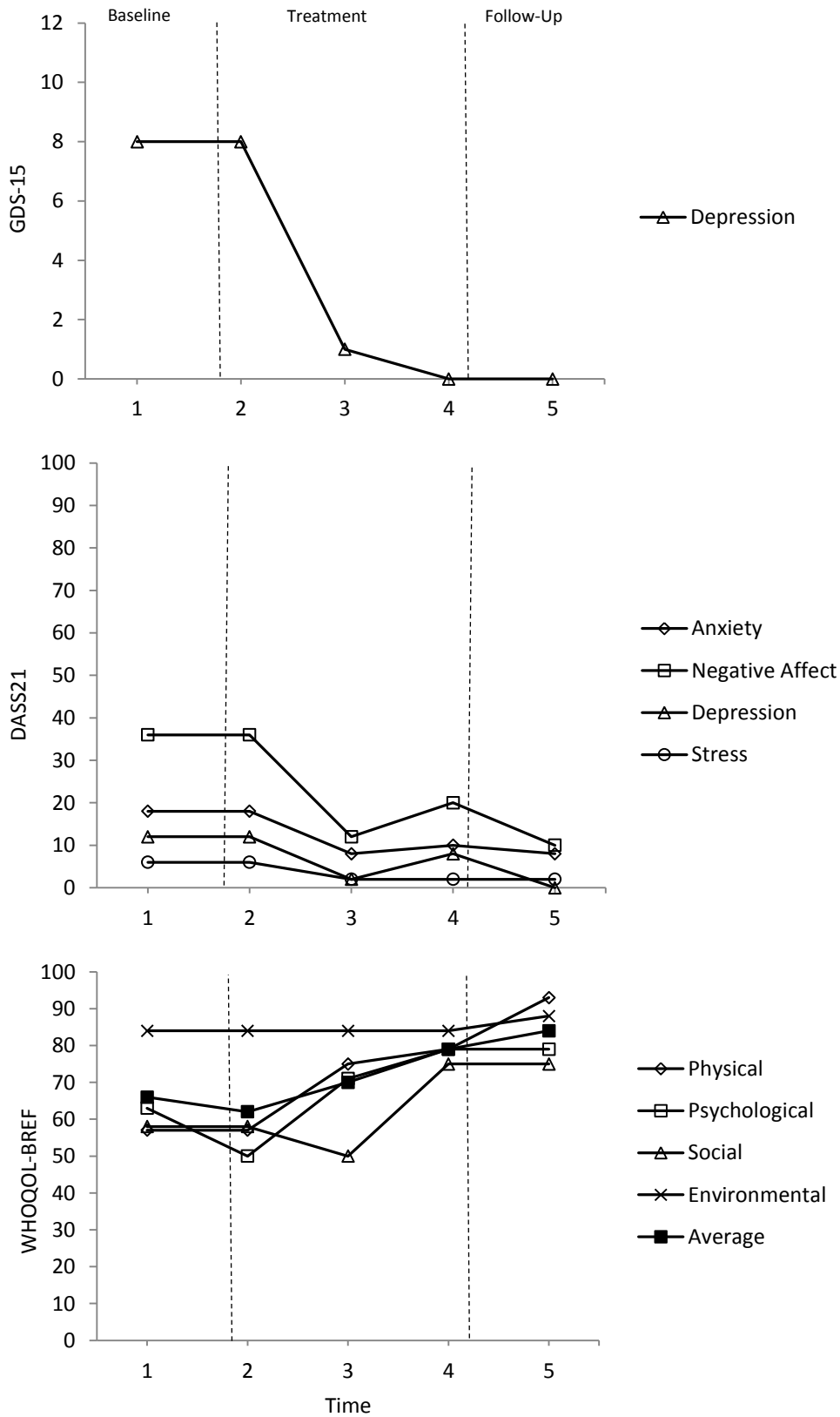


Figure 4. Results of psychological measures for participant Code 4 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

Primary study outcomes. The change in means on the GDS-15 across baseline, treatment, and follow-up phases decreased (8-3-0), which indicates that depressive symptom severity improved during the study. The change in level of depression was gradual and by Time 3 (Session 6) Keith was in the normal range (1). The rate of improvement was indicated in a downward trend with a moderate latency of change. Variability was low. Taken together, the pre-intervention score on the GDS-15 was eight (mild depression) and post-treatment scores were zero.

Secondary study outcomes. When considering the DASS21, there was a downward pattern on the means across phases for all three subscales. The means for depression reduced in severity from mild (12) to normal (7) to normal (0). The means for stress remained within the normal range across phases (6-3-2). Although anxiety was not directly targeted for treatment, the means simultaneously reduced in severity across phases from severe (18) to moderate (12) to mild (8).

On the WHOQOL-BREF, the mean of the average subscale increased across phases (66-70-84), indicating improvements were made. While the psychological and social domain mean scores gradually increased across phases (63-67-79 and 58-61-75, respectively), it was the physical domain that changed the most (57-70-93). When looking at the physical domain, items endorsed pre- to post-treatment, Keith reported reductions in physical pain and the need for medical treatment and improvements in energy levels, sleep patterns, and the ability to perform daily living activities. It is not possible to tease out the effects of improved physical wellbeing on psychological wellbeing, but it seems that Keith's physical wellbeing played an important role. The environmental domain mean scores remained consistent across phases (84-84-88).

Applied importance of behaviour change. Keith was classified as a treatment responder. Keith met the predetermined criteria for treatment success: reduced depressive symptoms and psychological distress, increased social functioning, non-overlapping data points across phases, and a greater than 20% change in pre-treatment scores. On the GDS-15 and DASS21, all scores fell in the normative range, thus meeting the criteria for high end state functioning. On the Retirement Satisfaction Inventory, at pre-treatment Keith reported that he was "somewhat satisfied" with retirement and this improved to being "satisfied" with retirement at follow-up (Table 11).

In a post-therapy letter, Keith wrote, "I do very much appreciate what you have helped me to achieve." Keith specified that he had started his retirement projects, continued to play bowls, joined a Men's Shed (an association that provides a formal opportunity for men to gather), applied for a volunteer position, and initiated a weekly outing with his wife. This

evidences various areas (motivation, fun and engaging activities, and socialising) that Keith found practically beneficial in the treatment.

Treatment tolerability. Keith's only prior counselling experience was with the aforementioned workplace counsellor, which he considered to be of little value, so he commenced treatment with some reservation. Keith's written feedback stated, "(Therapist) was always very welcoming and enthusiastic. She had a very good understanding about retirement emotions. I felt that she was very empathic. All of the sessions were for me very positive."

Keith's wife had previously been hospitalised for Major Depression several times and she had been receiving counselling for over two decades. Keith expressed his concern about receiving long term treatment because, although he felt depressed, he did not see himself as someone with a lifelong mental illness. Therefore, the time-limited nature of IPT-RM was appealing to him. Keith engaged well in treatment although, at times, appeared reserved in his demonstration of sadness. Keith's Treatment Satisfaction Ratings (Table 12) were all scored at the highest level, except for Question 4 which was scored 3 out of four, suggesting that, overall, IPT-RM was of benefit.

Karl (Code 5)

Participant synopsis. Karl was 68 years of age and had been retired for two years at the commencement of treatment. Karl's self-rated health was very good, he had high school education, and had worked in a trade. Karl was married for 40 years, lived with his wife, had two grown children, and two grandchildren. Karl retired because he reached an appropriate age. Karl's presenting problems were marital distress exacerbated by retirement and other retirement related issues, such as having a paucity of social support and few outside activities. Karl had previously attended three workplace counselling sessions in 2008, but reported that "it didn't help the situation."

Eligibility assessment. Depression was endorsed as severe on both the GDS-15 (11) and the DASS21 (42). The other two DASS21 subscales were also highly elevated: stress was moderate (22) and anxiety was severe (36). Karl's score on the MMSE screen for cognitive impairment was in the normal range (27). Karl was the only participant taking anti-depressant medication (Lovan 20mg), which he had been using for three months prior to commencing treatment. Karl also took beta blocker and blood pressure tablets daily. To avoid repetition, the reader is referred to the Method Chapter for a detailed explanation of why this participant was accepted for the study despite his depression scores falling outside the specified eligibility

range. The primary problem area was role disputes with a secondary problem area of role transition. Karl was offered and accepted a course of 12 IPT-RM treatment sessions.

Receipt of treatment. Karl attended 12 weekly sessions of IPT-RM from 15 February 2011 to 17 May 2011. Follow-up measures were completed on 14 June 2011.

Clinical improvement. Figure 5 illustrates results for Karl on the GDS-15, DASS21, and WHOQOL-BREF. Overall, a downward trend on the GDS-15 and DASS21 and an upward trend on the WHOQOL-BREF are noted, which suggests clinical improvement.

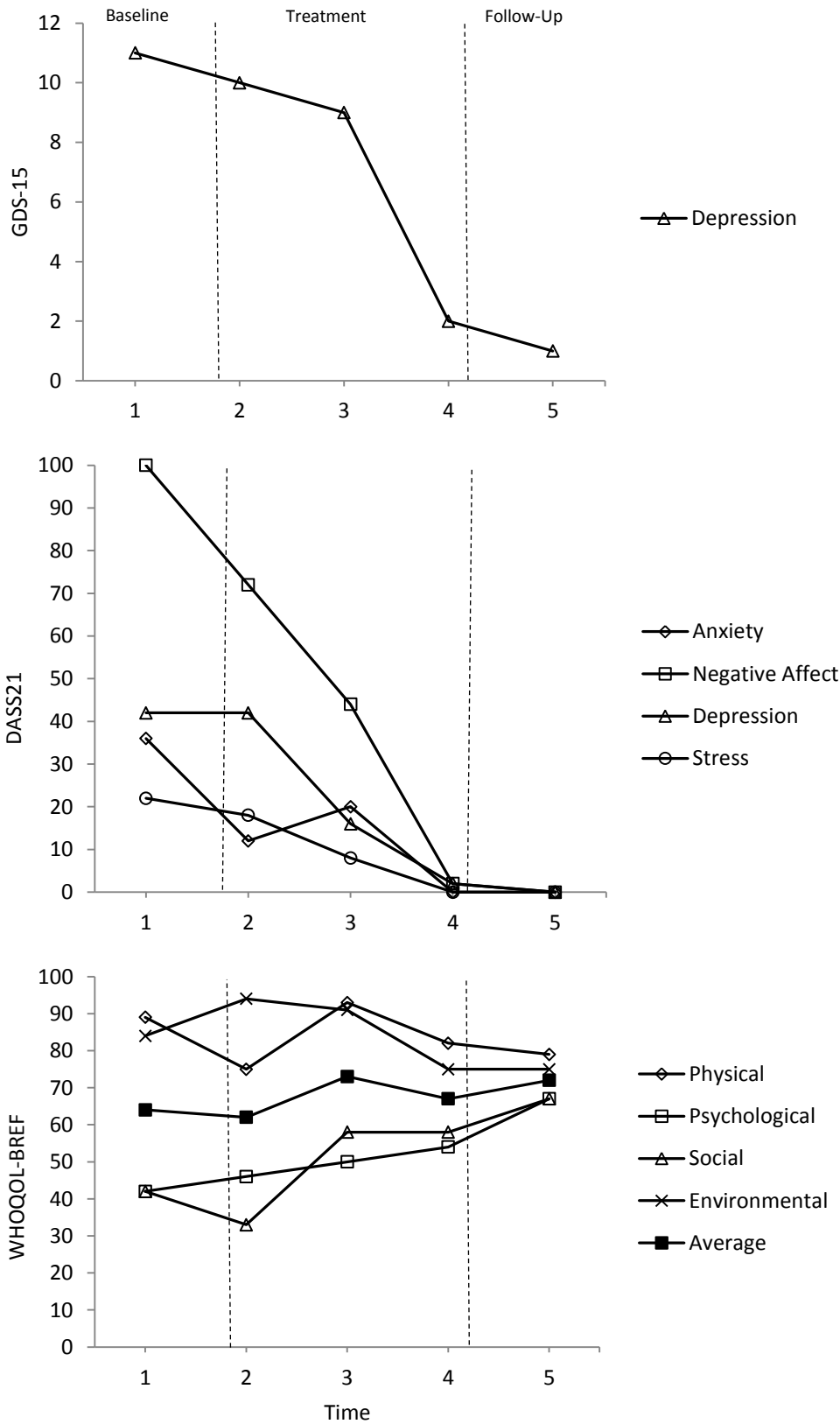


Figure 5. Results of psychological measures for participant Code 5 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

Primary study outcomes. There was a decreasing change in the mean scores on the GDS-15 across baseline, treatment, and follow-up phases (11-7-1), which indicates that depressive symptom severity improved during the study. Initially there was a low level of change in depression, so that by Time 3 (Session 6), Karl remained in the mildly depressed range (7). Since his depression had not remitted, Karl went for a medication review and he reported that his GP was satisfied with his improvement and no change to his medication was made. The rate of change on the GDS-15 continued in a downward trend with a high latency of change. At pre-treatment Karl was severely depressed (11) but by Time 4 (Session 12) he was in the non-depressed range (2), which continued at follow-up (1).

Secondary study outcomes. The DASS21 reflected similar results to the GDS-15 with a downward pattern of means. The negative affect subscale, which is an average of the three mood subscales, is informative in its declining scores (100-39-0). It indicates improvement from the impaired range to the non-impaired range. Depression and anxiety subscale means reduced in magnitude from severe at baseline, to moderate in the treatment phase, and to normal at follow-up (42-20-0 and 36-11-0, respectively), which also indicates improvement from the impaired range to the non-impaired range.

On the WHOQOL-BREF, the means of the average subscale increased minimally across phases (64-67-72). The psychological and social domain means increased across phases (42-50-67 and 42-49-67, respectively), which confirms the improvements in mood seen on the GDS-15 and DASS21. The improvement on both these domain scores is expected given that interpersonal areas are a target of change to improve depressive symptoms in IPT-RM. There were decreases in the mean scores across phases on the physical and environmental domains (89-83-79 and 84-86-75, respectively). It is unclear what impact Karl's reportedly reduced physical and environmental wellbeing had on his psychological and social wellbeing, but they may have had some influence. Interestingly, this pattern of differences between the pre-treatment and follow-up scores was not seen with any other participant. Karl improved by 25 points on both the psychological and social domains, but deteriorated on the physical domain by 10 points and on the environmental domain by 9 points. The reason for this pattern means remains unclear.

Applied importance of behaviour change. Karl was classified as a treatment responder. Karl met the predetermined criteria for treatment success: reduced depressive symptoms and psychological distress, increased social functioning, non-overlapping data points across phases, and a greater than 20% change in pre-treatment scores. On the GDS-15 and DASS21, all scores fell in the normative range, thus meeting the criteria for high end state functioning. On the Retirement Satisfaction Inventory, Karl reported the largest gain in satisfaction of all the

participants (Table 11): at pre-treatment (Time 1) Karl was “very dissatisfied” with his retirement and at follow-up (Time 5) he was “satisfied” with his retirement.

In regard to practical benefits, Karl felt better in mood and in being able to enjoy his retirement. He had an interstate holiday booked, which he had no desire to undertake prior to treatment. It is acknowledged that the pharmacological treatment Karl received blurs the distinction between the degree of change attributable to IPT-RM and to medication. Since Karl had been on Lovan 20mg for at least three months when he commenced treatment and his depression was still severe, it is arguable that IPT-RM was a source of change to some degree.

Treatment tolerability. Karl found treatment uncomfortable at times. The exploratory nature of IPT-RM required Karl to talk about his inner world and emotional state, and answer questions he had not previously thought or talked about. This reticence may have been a function of his personality. Further, it is generally accepted that Australian men are less inclined to disclose their feelings and talk about their inner selves.

Since the initial clinical interview, Karl expressed unrealistic expectations for change. When at the end of the first interview Karl was asked, “How has it been for you with us talking today?” He replied, “It hasn’t resolved anything but it’s been good to talk.” In Session 1, Karl stated there had been “no change.” Karl felt pressured by his wife to change and he brought that pressure into the therapy room. This was dealt with by informing Karl about the purpose of the assessment stage, that change occurs over time and not necessarily immediately, and that this type of treatment has been successful with people in similar situations.

While Karl’s Treatment Satisfaction Ratings were still quite high, they were the lowest of all participants with three questions rated 3/4 and two questions rated 4/4 (Table 12). Karl felt that his therapist understood his problems “very well” (4/4) and that he would “definitely” (4/4) recommend a friend for this treatment. Karl felt the service received was “good” (3/4), that treatment helped him to deal with his problems “somewhat” (3/4), and that treatment met “most of (his) needs” (3/4).

Frank (Code 7)

Participant synopsis. Frank was 71 years of age and had been retired for 13 months at the commencement of treatment. Frank’s self-reported health was very good, he held a Diploma, and had worked in the mining industry. Frank was married for 47 years, lived with his wife, had one adult child, and three grandchildren. Frank was born in Germany and emigrated to Australia when he was 12 years old. Frank retired because of impending heart surgery. Frank’s presenting problem was depression due to retirement related maladjustment. He felt unprepared for his sudden retirement, expected to not like retirement, and had enjoyed his

work. Frank described feeling bored, having no interests, having limited social support, and experiencing a shift in power dynamics with his wife when he became her temporary caregiver after her surgery.

Eligibility assessment. Depression was rated as mild on the GDS-15 (8) and moderate on the DASS21 (16). Stress was normal (1) and anxiety was severe (16) on the DASS21. Frank's score on the MMSE screen for cognitive impairment was in the normal range (26). Frank was on several types of medications during the study for cholesterol, hypertension, and blood clotting. Frank fitted the inclusion criteria for depression due to a difficult adjustment to retirement and was deemed suitable for IPT-RM especially given his low level of social support. The primary problem area was role transition with no secondary problem area. Frank was offered and accepted a course of 12 IPT-RM treatment sessions.

Receipt of treatment. Frank attended six individual sessions of IPT-RM from 21 March 2011 to 30 May 2011. Sessions were attended weekly, except for the last two sessions that were spaced several weeks apart. Frank made rapid therapeutic gains and he remained in the non-depressed range since Session 1 (Time 2), so termination was initiated early. Frank's mood was stable, relapse appeared unlikely, and there were no risk indicators to necessitate continued treatment. Follow-up measures were completed on 27 June 2011.

Clinical improvement. Figure 7 illustrates results for Frank on the GDS-15, DASS21, and WHOQOL-BREF. Overall, a downward trend on the GDS-15 and DASS21 and an upward trend on the WHOQOL-BREF are noted, which suggest clinical improvement. Data from Session 6 were allocated to Time 4 as this was the final session, hence there are no data for Time 3.

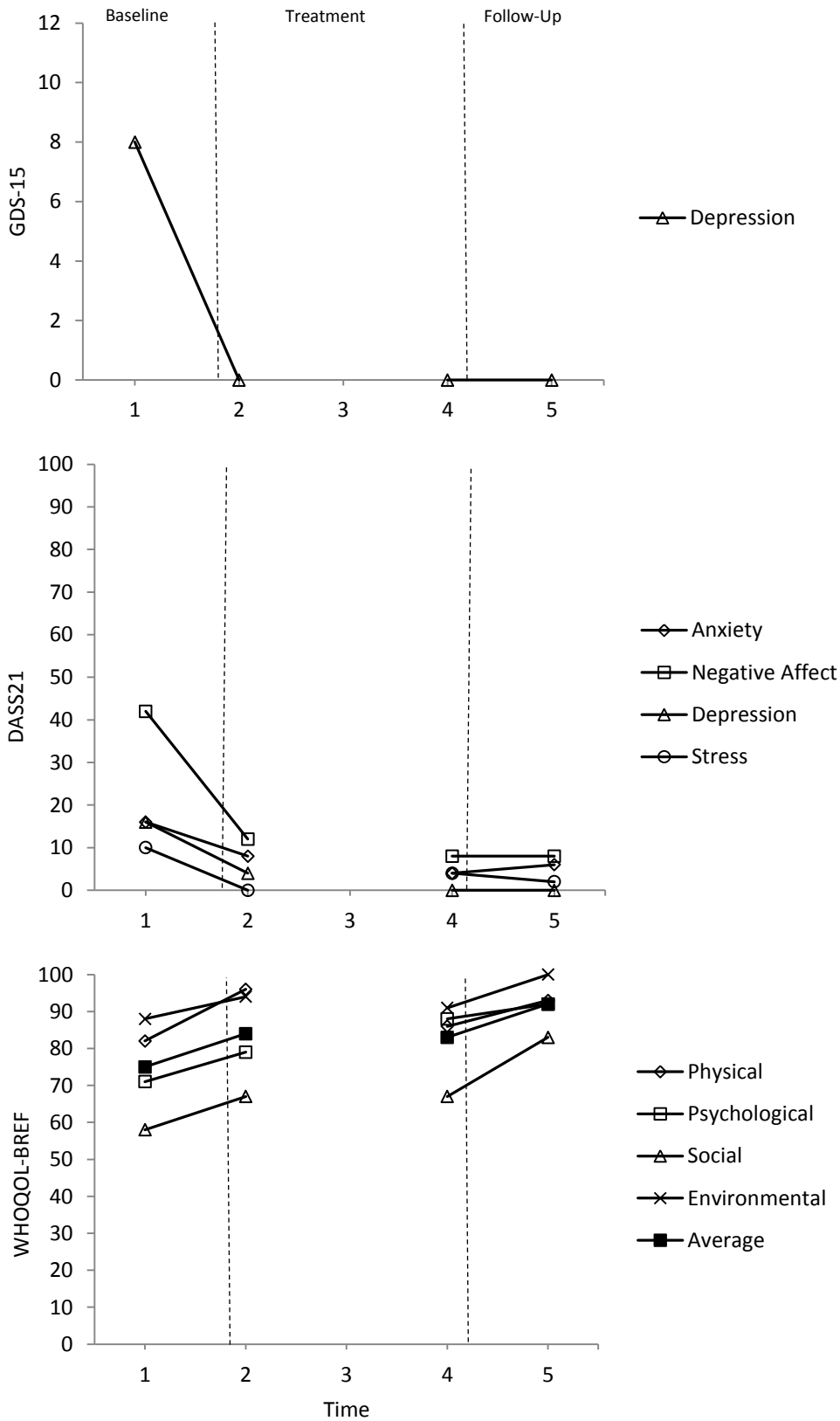


Figure 6. Results of psychological measures for participant Code 7 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

Primary study outcomes. There was a rapid discontinuity in the change in level of depression. At Time 1 (initial clinical interview) Frank endorsed a mild elevation of depression on the GDS-15 (8) and at Time 2 (Session 1) Frank reported having a “good week” and did not endorse any depressive symptoms (0). The latency of change was very low since improvement in mood occurred closely in time following the introduction of the treatment phase. There was no variability within phases or overlap across phases. The trend of scores being in the non-impaired range of depression continued through to follow-up when Frank endorsed zero symptoms on the GDS-15.

Secondary study outcomes. Scores on the DASS21 confirm improvements in mood that were seen on the GDS-15 and these were maintained at follow-up. There was a downward pattern on the means across phases for all three subscales. The declining means of the negative affective subscale demonstrate an improved mood (42-10-8). The means for the depression subscale decreased from moderate to normal (16-2-0), but the means for the anxiety subscale decreased with higher latency from severe to mild and then to normal (16-8-6). The means for the stress subscale remained in the normal range throughout the study (10-2-2).

While each domain on the WHOQOL-BREF evidenced increasing means across phases, it was the psychological and social domains that improved the most. From baseline to follow-up, the psychological domain improved by 21 points (71-84-92) and the social domain improved by 25 points (58-67-83). It is noteworthy that the improvements of the psychological domain were congruent with the improvements in mood seen on the GDS-15 and DASS21. Furthermore, the improvements on the social domain provide support for the treatment intervention because IPT-RM targets interpersonal factors to reduce depressive symptoms. The physical domain improved by 11 points (82-91-93) and the environmental domain improved by 12 points (88-92-100).

Applied importance of behaviour change. Frank was classified as a treatment responder. Frank met the predetermined criteria for treatment success: reduced depressive symptoms and psychological distress, increased social functioning, non-overlapping data points across phases, and a greater than 20% change in pre-treatment scores. On the GDS-15 and DASS21, all scores fell in the normative range, thus meeting the criteria for high end state functioning. Before starting treatment, Frank felt “somewhat dissatisfied” with his retirement on the Retirement Satisfaction Inventory and at follow-up he felt “satisfied” with retirement (Table 11). Frank was involved in interests and clubs, doing volunteer work, had reconciled his work and retirement experience, and had reframed his caregiving role. These are noteworthy functional improvements.

Treatment tolerability. Frank had no prior experiences with counselling. Frank rarely brought issues to the session to discuss but waited for the therapist to initiate topics. Like Judy (Code 3), the structured nature of IPT-RM was probably well suited to Frank's personality. Frank's Treatment Satisfaction Ratings were all at the highest level (Table 12), suggesting that IPT-RM was well received. Specific written comments from Frank were, "Being able to have general discussions with someone outside my normal circle of friends or family, and who also was a good listener and provided some constructive ways to move forward."

Roslyn (Code 8)

Participant synopsis. Roslyn was 70 years of age and had been retired for three years at the commencement of treatment. Roslyn's self-reported health was very good, she had a Master's degree, and had worked in a health care setting. Roslyn had been married for 43 years, lived with her husband, had three children, and five grandchildren. Roslyn's husband, of the same age, retired at 55 years of age and never worked again. He had been diagnosed with cancer and had started treatment at the same time that Roslyn commenced IPT-RM. Roslyn's presenting problem was depression due to retirement related maladjustment. Specifically, negotiating time and space in the house with her husband, being overinvolved in her adult children's lives, experiencing her social relationships as "superficial," and wanting a closer relationship with her only sibling.

Eligibility assessment. Depression was endorsed as mild on both the GDS-15 (5) and the DASS21 (12). Stress was normal (2) and anxiety was moderate (14) on the DASS21. Roslyn's score on the MMSE screen for cognitive impairment was in the normal range (28). Roslyn was taking medication for cholesterol during the period of the study. Roslyn fitted the inclusion criteria for depression due to a difficult adjustment to retirement and was deemed suitable for IPT-RM given her low level of social support. The primary problem area was role transition with no secondary problem area. Roslyn was offered and accepted a course of 12 IPT-RM treatment sessions.

Receipt of treatment. Roslyn attended 12 individual sessions of IPT-RM from 6 April 2011 to 20 June 2011. She attended weekly treatment sessions, with the exception of four sessions that were attended fortnightly due to her husband's cancer treatment. Follow-up measures were completed on 17 August 2011.

Roslyn participated well in treatment and the exploratory nature of the intervention suited her reflective and insightful personality. She commented at the end of the treatment that she wished she had done more work each week during treatment to benefit more. While Roslyn

recognised she had made gains from the treatment, she believed it would have been more beneficial if she had kept a journal.

Clinical improvement. Figure 8 illustrates results for Roslyn on the GDS-15, DASS21, and WHOQOL-BREF. Overall, a downward trend on the GDS-15 and DASS21 and an upward trend on the WHOQOL-BREF are noted, which suggests clinical improvement.

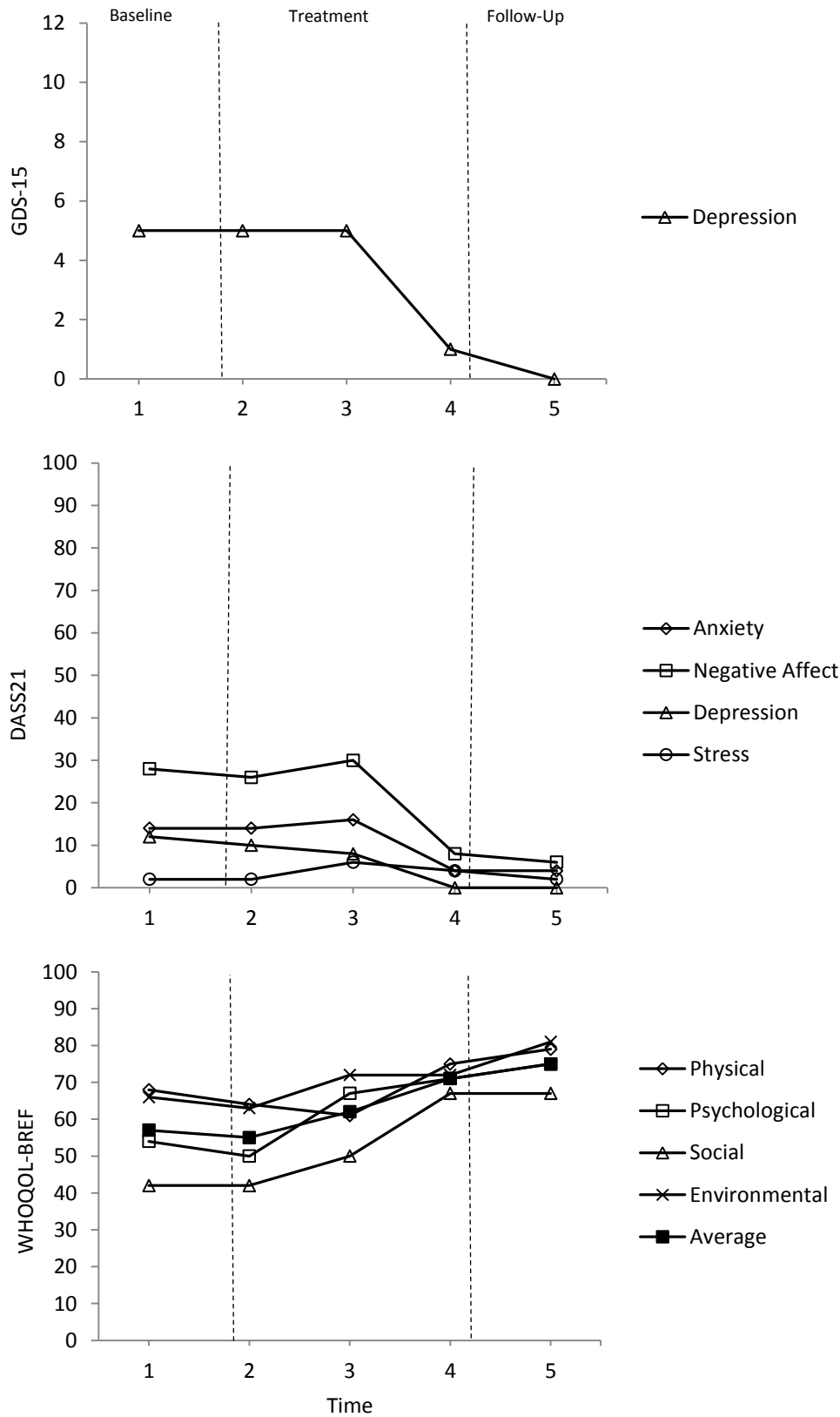


Figure 7. Results of psychological measures for participant Code 8 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

Primary study outcomes. There was a decreasing change in means across phases on the GDS-15 (5-4-0), which indicates improvement in mood. The change in the level of depression occurred slowly. During Times 1, 2, and 3, a mild depression was consistently reported (5, 5, and 5). It was not until the final sessions of treatment that Roslyn entered a non-depressed range. At Time 4 (Session 12) only one depressive symptom was endorsed and at Time 5 (follow-up) further improvement had been made as no depressive symptoms were endorsed. The rate of change on the GDS-15 was a gradual downward trend with high latency.

Secondary study outcomes. For Roslyn, the DASS21 may have been more sensitive to changes in depression than the GDS-15. Where the GDS-15 reported depression levels of 5, 5, 5, 1, and 0, at the five time points, the DASS21 levels were 12, 10, 8, 0, and 0. Furthermore, the DASS21 would have classified Roslyn in the normal range by Time 3 (Session 6) whereas the GDS-15 did not do so until Time 4 (Session 12). Although anxiety was not directly targeted in IPT-RM treatment, the anxiety subscale evidenced a similar decreasing change in means across phases (14-11-4). There was variability in the anxiety scores within the treatment phase ranging from moderate at Time 2 (14), severe at Time 3 (16), and normal at Time 4 (4). The stress subscale remained in the normal range during the study.

While each domain on the WHOQOL-BREF evidenced increasing means across phases, it was the psychological and social domains that improved the most. From baseline to follow-up, the psychological domain improved by 21 points (54-63-75) and the social domain improved by 25 points (42-53-67). As mentioned with Frank (Code 7), the improvements on the psychological and social domains may provide evidence for the feasibility of the IPT-RM treatment in the relief of depression by targeting the interpersonal domain as a site of change. The physical domain showed the greatest variability but still improved by 11 points (68-67-79) and the environmental domain improved by 15 points (66-69-81).

Applied importance of behaviour change. Roslyn was classified as a treatment responder. Roslyn met the predetermined criteria for treatment success: reduced depressive symptoms and psychological distress, increased social functioning, non-overlapping data points across phases, and a greater than 20% change in pre-treatment scores. On the GDS-15 and DASS21, all scores fell in the normative range, thus meeting the criteria for high end state functioning. Before starting treatment, Roslyn felt “somewhat dissatisfied” with her retirement on the Retirement Satisfaction Inventory and at follow-up she felt “satisfied” with retirement (Table 11). At the end of treatment Roslyn reported that she felt more empowered in dealing interpersonally with her husband, sister, children, and friends. These are all meaningful improvements, enabling Roslyn to improve her enjoyment of her retirement years.

Treatment tolerability. Roslyn had a background in the helping professions but had never undergone counselling herself. Roslyn responded well to the role reversal and reflected deeply in-session on the issues that arose. A structured and time-limited therapy was probably beneficial to Roslyn as it kept her focused since she had a tendency to be over-inclusive. Roslyn's Treatment Satisfaction Ratings were supportive of IPT-RM with three out of five questions being rated 4/4 and two out of five questions being rated 3/4 (Table 12).

Lucy (Code 9)

Participant synopsis. Lucy was 65 years of age and had been retired for three years at the commencement of treatment. Lucy's self-reported health was good, she held a Diploma, and had worked within a primary education setting. Lucy had never married, had no children, and lived by herself. Lucy retired because she "wanted time to herself" and financial advice received indicated that it was a good time to retire. Lucy's presenting problem centred on retirement adjustment issues. After 42 years working in a very structured environment, Lucy chose to lead a completely unstructured life in retirement. After three years, however, Lucy felt very dissatisfied with this unstructured lifestyle, "living from holiday to holiday," had no meaningful activities, and utilised her social support network poorly.

Eligibility assessment. When Lucy was phone screened for the presence of depression, she evidenced elevated levels of mood on the DASS21 into the impaired range. Lucy said she was feeling particularly depressed on the weekend the measure was administered because of her temporary circumstances and that she did not typically feel so depressed. Lucy had sunspots removed from her face and she chose not to socialise, which, Lucy said, led her to feeling depressed. When Lucy came to the initial clinical interview (4 April 2011), her mood was in the unimpaired range on both the GDS-15 and DASS21, except for anxiety which was mildly elevated (8). Lucy's improvement in mood between the phone screening and the initial clinical interview was contributed to her having started volunteer work, which provided meaning, socialisation, enjoyment, and structure.

Although Lucy was not depressed at the initial meeting, the therapist's clinical impression was that IPT-RM could have been of benefit to Lucy given that her presenting problems fitted well within the model and she was at risk of the depression returning. Lucy described problems around time, structure, activities, and social networks, which could be addressed with IPT-RM. Furthermore, Lucy had previously had been on anti-depressant medication and was concerned about relapse.

Lucy reported starting a course of anti-depressants for tension in 2006, which she ceased upon retirement in 2008. Lucy's medications during the study were for asthma, reflux, and

cholesterol imbalance. Lucy was offered a course of IPT-RM treatment session with a primary problem area of role transition and no secondary primary problem area. Her MMSE score for cognitive impairment was 29, which is in the normal range.

Receipt of treatment. Lucy attended seven individual sessions of IPT-RM from 11 April 2011 to 29 June 2011. She attended two weekly sessions and then five fortnightly sessions. As was anticipated, since Lucy commenced treatment in the non-depressed range, a dosage of weekly sessions was too intense. Given that treatment was designed to maintain her mood and prevent relapse, as opposed to reducing depressive symptoms, sessions changed to fortnightly. Lucy was not distressed and did not require weekly therapy. Follow-up measures were completed on 27 July 2011.

Clinical improvement. Figure 9 illustrates results for Lucy on the GDS-15, DASS21, and WHOQOL-BREF. Overall, a downward trend on the GDS-15 and DASS21 and an upward trend on the WHOQOL-BREF are noted, which suggest that improvements were made and maintained across the study even though the initial depression level was low.

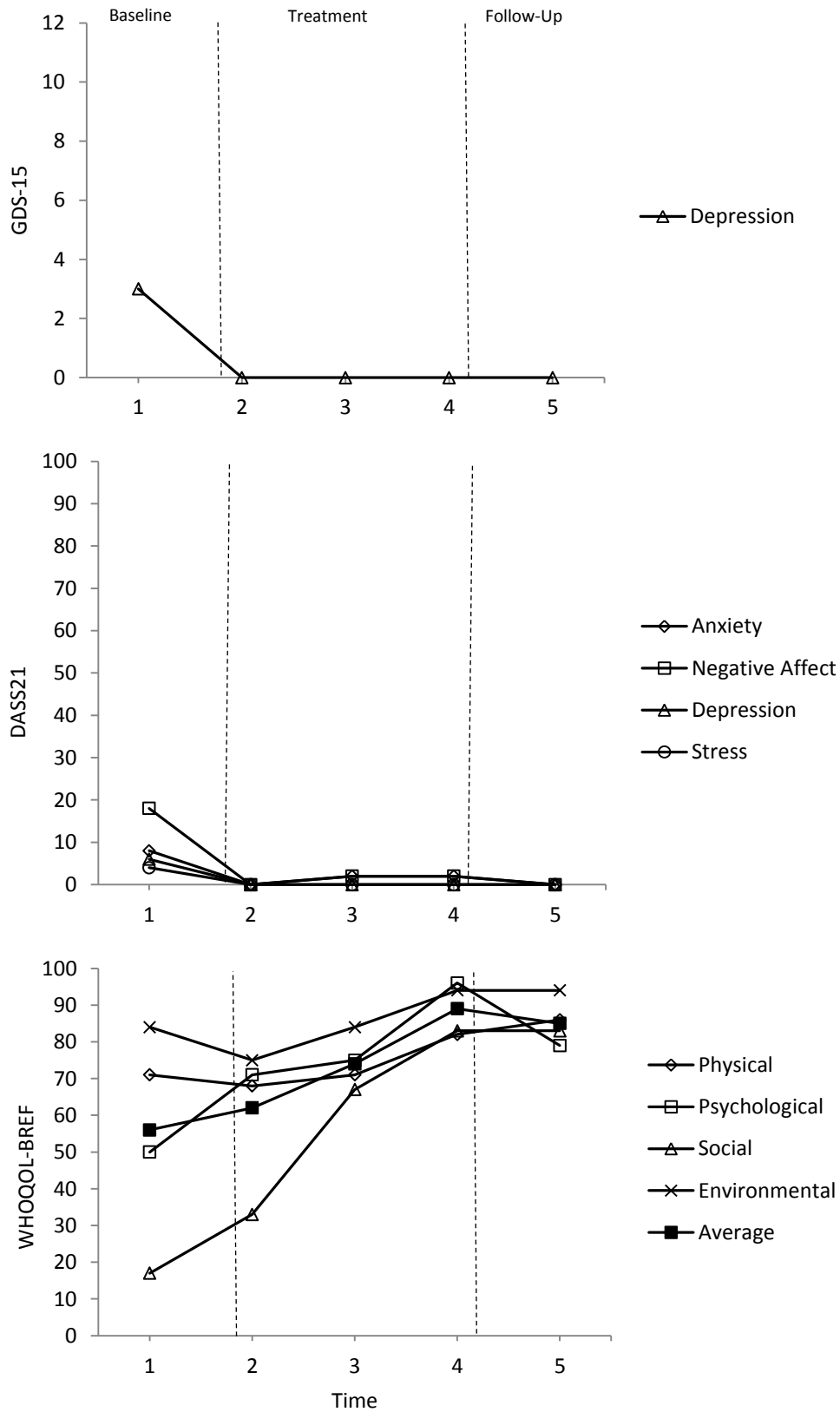


Figure 8. Results of psychological measures for participant Code 9 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

Primary study outcomes. On the GDS-15, Lucy endorsed three symptoms of depression at Time 1 (initial clinical interview) and at Times 2 to 5, none were endorsed. The three items initially endorsed by Lucy were: often feeling bored, preferring to stay at home rather than going out and doing new things, and not feeling full of energy. There was no overlap or variability in the GDS-15 data, and the latency of change was low. Although Lucy commenced treatment in the non-depressed range, the results suggest that gains were still made and maintained by participating in the study. This is useful information because it indicates that IPT-RM may be beneficially applied as a maintenance type of treatment.

Secondary study outcomes. As with the GDS-15, the DASS21 evidenced a downward pattern on the subscale means. Furthermore, there was no overlap or variability in the data, and the latency of change was low. Anxiety was the sole subscale to enter the impaired range at a mild level (8) on Time 1 (initial clinical interview). From Time 2 onwards, the anxiety subscale was endorsed only in the unimpaired range, which is consistent with the reported decrease in depression on the GDS-15 and DASS21.

As with other participants in the current study, the greatest improvements on the WHOQOL-BREF were on the psychological and social domains. The psychological domain means had a 29 point difference between baseline and follow-up (50-81-79). The social domain means had a substantial 66 point difference between baseline and follow-up (17-61-83). The improvements reported by Lucy on these two domains were representative of the changes she made in her life and perceptions of retirement. Apart from Jillian (Code 2) who was recently widowed, Lucy was the only other participant who lived alone and did not have a partner. Involvement in the study helped Lucy realise that she needed to actively create opportunities to socialise. The assumption of IPT-RM is that social problems are the cause of depression. The congruent improvements on the WHOQOL-BREF psychological and social domains appear to have been sensitive to gains made by Lucy. The physical domain improved by 15 points (71-74-86) and the environmental domain improved by 10 points (84-84-94).

Applied importance of behaviour change. Although Lucy did not commence treatment in the depressed range, gains were made and relapse was potentially averted. Lucy's Retirement Satisfaction Ratings made a one point improvement (Table 11) from pre-treatment ("somewhat satisfied") to follow-up ("satisfied"). Lucy's handwritten comments to her therapist reflect the way she felt about the treatment received: "It came at a time in my retirement when I needed, and wanted, to find some direction for my life. It was great to be able to discuss this with (the therapist). I think having been retired for three years meant I was over the honeymoon period of treatment. Any earlier wouldn't have benefited me and I didn't feel depressed earlier."

Treatment tolerability. Lucy had previous workplace counselling for stress in 1995 and 2001. Lucy engaged well in the IPT-RM treatment and the modality appeared to be a good fit. All five of the participants' Treatment Satisfaction Ratings were rated at the highest level (Table 12), suggesting that IPT-RM was well received. At the end of treatment Lucy expressed gratitude for the treatment received and wrote, "Thank you for giving me the opportunity to be involved in the study. I can see it being beneficial to many retirees."

Denis (Code 10)

Participant synopsis. Denis was 71 years of age and had been retired for two years at the commencement of treatment. Denis' self-reported health was very good, he held a Bachelor's degree, and sold his business to retire. Denis was divorced, had one adult son, and had never remarried. He was born in the United Kingdom, lived in New Zealand for 42 years, and later bought a house in Australia and travelled between New Zealand and Australia until retirement. Denis lived by himself although he spent several nights a week with his partner. Denis retired because he no longer had the energy to operate and expand his business. Denis' presenting problem was depression due to retirement related maladjustment. He experienced low motivation and energy, had relocated to another city upon retirement, had a paucity of social contacts, and only one main interest.

Eligibility assessment. Depression was endorsed as mild on the GDS-15 (8) and moderate on the DASS21 (16). The stress and anxiety DASS21 subscales were in the normal range (2 and 4, respectively). Denis' score on the MMSE screen for cognitive impairment was also in the normal range (30). Denis was taking medication for hypertension and asthma during the study. He fitted the inclusion criteria for depression due to a difficult adjustment to retirement and was deemed a suitable candidate for IPT-RM given his low level of social support. The primary problem area was role transition with no secondary problem area. Denis was offered and accepted a course of 12 IPT-RM treatment sessions.

Receipt of treatment. Denis attended 12 weekly sessions of IPT-RM from 18 April 2011 to 13 July 2011. Follow-up measures were completed on 10 August 2011.

Clinical improvement. Figure 10 illustrates results for Denis on the GDS-15, DASS21, and WHOQOL-BREF. Overall, a downward trend on the GDS-15 and DASS21 and an upward trend on the WHOQOL-BREF were noted, which suggest clinical improvement. The primary and secondary study outcomes are discussed next.

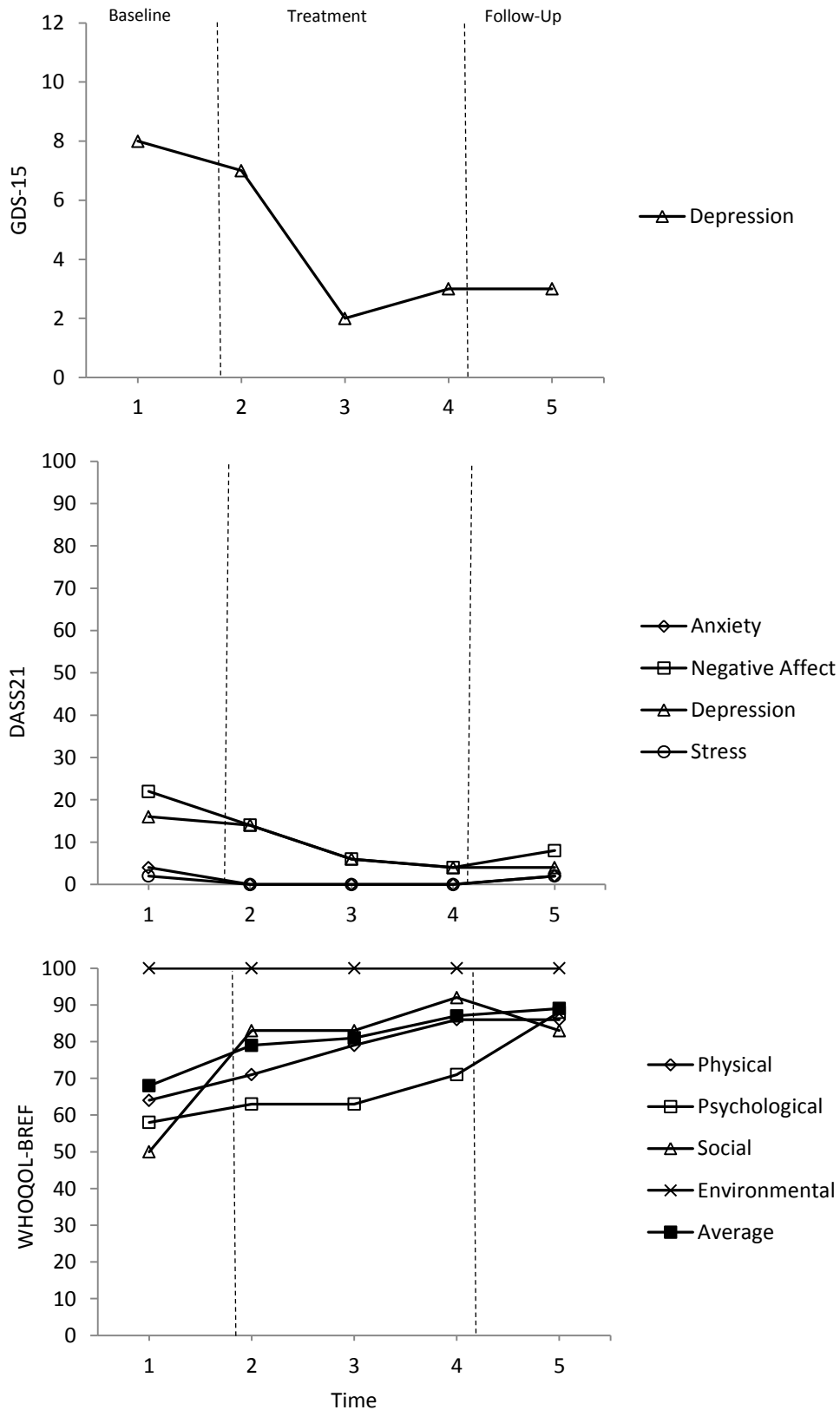


Figure 9. Results of psychological measures for participant Code 10 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

Primary study outcomes. There was a decreasing change in means on the GDS-15 across baseline, treatment, and follow-up phases (8-4-3), which indicates that depressive symptom severity lessened during the study. There was a moderate latency of change with Time 1 and Time 2 depression levels in the mildly impaired range (8 and 7, respectively). By Time 3, the level of depression was in the normal range (2) and remained so for the rest of the study (Time 4, 3; and Time 5, 3).

Secondary study outcomes. When looking at the means of the subscales on the DASS21, only depression entered the impaired range. At baseline, depression was at a moderate level (16), and the treatment (8) and follow-up (4) phases were at the normal level. The anxiety subscale was consistently in the normal range for the means (4-0-2), as was the stress subscale (2-0-2). There was slight overlap on the anxiety and stress subscales between the treatment and follow-up phases. During the treatment phase, anxiety and stress were consistently endorsed at zero, but at follow-up there was a slight rise to two on each subscale.

On the WHOQOL-BREF, the means of the average subscale increased across phases (68-82-89), suggesting improvements were made during the study. The psychological, social, and physical domains all evidenced noteworthy improvements across phases. Most outstanding was the 33 point improvement on the social domain (50-86-83), which is especially meaningful as Denis needed to strengthen the area of interpersonal functioning. A congruent 30 point improvement was notable on the psychological domain (58-66-88), which may provide confirmatory evidence of the reduction of depressive symptoms seen on the GDS-15 and DASS21. The physical domain mean scores across phases improved (64-79-86) while the environmental domain was consistently rated at its maximum (100-100-100).

It appears that the environmental domain was inadequate at detecting problems in retirement due to relocation since it repeatedly scored 100. Part of the therapeutic work done with Denis was on the relocation, which he initially said he regretted, but in working it through (e.g., with an IPT matrix of the pros and cons of his circumstances) he became emotionally reconciled about the move. It would be expected that the environmental domain, if it tapped into problems associated with relocation, would score low at Times 1 and 2, and by Time 3 noticeable improvements would have been endorsed had treatment been effectual.

Applied importance of behaviour change. Denis was classified as a treatment responder. Denis met the predetermined criteria for treatment success: reduced depressive symptoms and psychological distress, increased social functioning, non-overlapping data points across phases, and a greater than 20% change in pre-treatment scores. On the GDS-15 and DASS21, all scores fell in the normative range, thus meeting the criteria for high end state functioning. At a practical level, Denis had a trip to Europe booked with his partner (whereas when he

started treatment he said that he was not interested in travelling), engaged in volunteer work, applied to be on a committee, joined a local group, and started exercising again.

On the Retirement Satisfaction Inventory, Denis improved by one point from being “somewhat dissatisfied” with his retirement to being “somewhat satisfied”. Apart from Jillian (Code 4), Denis was the only other participant who rated their post-intervention satisfaction of retirement as “somewhat satisfied” at number 4 (all the others were 5s or 6s, Table 11). Although Jillian rated her satisfaction as “somewhat satisfied” (4), she initially rated it as “very dissatisfied” (1), so the clinical effectiveness of the treatment suggests benefit because there was a three point improvement. In reflecting on Denis being only “somewhat satisfied” with his retirement, it may relate to Denis’ alcohol consumption, with which he was unhappy but the study did not directly attempt to change. In a letter to the therapist sent with the follow-up measures, Denis commented that he would like to drink less. The IPT-RM treatment is not designed to address alcohol issues. In a non-research treatment setting, a therapist may have used motivational interviewing to help Denis effect the desired changes to his drinking behaviour. Participation in the study made Denis realise that he would like to reduce his alcohol consumption and he said he would seek treatment for it.

Treatment tolerability. Denis was the participant for whom this treatment was least compatible. Despite being an intelligent and financially successful man, Denis had low psychological mindedness and demonstrated little insight. Both are helpful when utilising IPT-RM as it is an exploratory treatment. Furthermore, after working with Denis for a while it became apparent that he displayed Cluster A personality traits, but this was not formally assessed. The indicators were: a paucity of intimate, close, and extended supports; no close male friends; little interest in forming close relationships; a tendency toward emotional aloofness; and there were a couple of notable odd behaviours. On one occasion, Denis suddenly and immediately stood up and left the therapy room saying, “I’ll be back in a moment” with no further explanation. At another time he saw his therapist waiting for him at The Clinic entrance to begin a session but he diverted paths saying he needed to go up the elevator (The Clinic is on the ground floor). In neither situation did he engage in the common social courtesies of apology or explanation.

Denis’ treatment was the only one to deviate from the manual. A behavioural activation strategy (Lejuez et al., 2001) was used to help treat his depressive symptoms (this decision was made in consultation with the therapist’s clinical supervisor), whereby a weekly activity schedule was employed from Session 3. The therapist’s clinical impression was that the combination of a structured increase in activity (behavioural activation) and, social activity specifically (IPT-RM focus), may have worked well for Denis given his trouble engaging with an

exploratory treatment model. The focus on behaviour, specifically social behaviour, resulted in a reduction in depressive symptoms. Denis' Treatment Satisfaction Ratings were all rated at the maximum, with the exception of question four where he responded that the service met "most of (his) needs" (Table 12).

Summary

This chapter reported on the preliminary results of a pilot study focusing on depression caused by retirement related problems. Overall, a claim can be made that there was a reduction in the participants' depressive symptoms during the study as all participants completed treatment in the unimpaired-normal range for depression. However, despite the treatment intervention being replicated with all the participants, the study's non-experimental design precludes claims of causality. The following chapter comprises Clinical Case Studies. These results are discussed at length in the Discussion Chapter.

Chapter 5

Clinical Case Studies

The current pilot study sought to test a treatment manual that was designed for retirees with depression due to retirement adjustment problems. The previous chapter detailed the results with single-case participants acting as their own control. Overall, there was evidence that the treatment had an effect on reducing depressive symptoms. However, a claim for causality cannot be made due to limitations of the design. This chapter details clinical case studies for two (Judy and Frank) of the nine research participants. Originally I had intended to include a case study for each participant ($N = 9$); however due to length restrictions, only four case studies were explored in detail. To eliminate repetition, the other two (Kerry and Keith) were included in Chapter 3. The four selected clinical case studies demonstrate two main aspects: how IPT was adapted for retirees with depression in a retirement context and the implementation of the IPT-RM treatment manual.

Kerry's (Code 1) clinical case study exemplified how treatment was conducted when a role dispute and role transition were respectively the primary and secondary problem areas. Judy's (Code 3), Keith's (Code 4), and Frank's (Code 7) clinical case studies were examples of a course of IPT-RM treatment when a role transition was the primary problem area.

Judy (Code 3)

Clinical Assessment

Background. Judy was a 64 year old divorcee. She was a mother and grandmother and had lived with her same-sex partner, Shauna, of 25 years. Financially, they enjoyed a "comfortable" lifestyle. She had been retired for three years after working as a primary school teacher for about four decades. Over a number of years when in her fifties, Judy progressively reduced her work schedule from full time to one day per week. Judy's partner was planning to partially retire later in the year. Judy was looking forward to the extra time they would have together. The relationship was good and no issues were raised. Moderate depression was endorsed on the DASS21.

Initial clinical interview. Soon after Judy retired, the Global Financial Crisis significantly reduced her retirement assets. "It was a bit of a nightmare." She said that she recovered from the unexpected financial loss through "acceptance" of her situation.

Judy exhibited depressive symptoms such as sleep disturbance, overeating, inability to concentrate ("I can't enjoy reading"), watching too much television ("mindless stuff"), and loss of motivation ("it's hard to keep motivated and follow through on things"). Judy felt "annoyed" with herself because, "I can't finish anything unless there is a deadline." She also felt

“overwhelmed” by the list of projects that she had planned to do in retirement but had not done. Judy explained that she could not get motivated to start any of these projects. A bad day was described as, “Very grey. I have no energy, I get out of bed but I watch TV, and don’t do any chores or exercise.”

By contrast, Judy described a good day as, “having a purpose.” Since her retirement, Judy babysat her grandson one day a week. She also usually worked one day a fortnight as a relief teacher. Judy enjoyed the social interaction of work. “It’s rewarding and I have energy.” In addition, Judy tried volunteer work where she could use her teaching skills; however, she found this experience unrewarding. “Most of the clients referred to the service were mandated by Centrelink, so they weren’t engaged.”

Judy regretted retiring. “Retirement isn’t what I thought it would be. I thought it’d be like being on holidays. Actually, retirement has been purposeless.” In retirement, Judy “expected to find lots of things to do, but (she) didn’t.” Judy stated that she missed collegial social contacts and interactions. That was a major loss for her. “I didn’t realise how important having regular contact with people was until I retired.” In retirement, Judy’s main social contact was with Shauna, but it was difficult to see her because she worked fulltime including evenings and weekends.

Judy’s experiences were validated during the session. For example, the therapist provided psychoeducation, “Work provides a great deal of structure and opportunities for social interactions. We do not realise it until we stop working. Work by its essence structures our time. We often feel motivated at work because we have to complete tasks and achieve goals. These tasks and goals are externally imposed. As a retiree, you are autonomous. Demands come from within and self-discipline is needed to get things done.”

Judy outlined several goals for therapy that she would like to achieve: motivation to follow through on tasks and projects; finding a purpose; feeling useful, more peaceful, and content; and increasing her social contacts, especially on weekdays and weekends if Shauna was working. Given Judy’s admission that motivation and following through were difficult for her, the therapist was concerned about her dropping out of therapy. At the end of the session, this was discussed with Judy. She was encouraged to attend sessions weekly to maximise the benefits of treatment. Judy responded with commitment and felt hopeful, “It must have been meant to be for me to see the (recruitment) ad in the newspaper.”

Psychiatric background. In 1993, while temporarily living in the United States with her partner, Judy experienced a “really bad bout of depression.” She was not hospitalised, but was treated with medication. It appeared that this depression may have been triggered by the following factors: Judy’s mother’s recent death, a hysterectomy, and difficulty adjusting to

living overseas. Judy said she ceased taking the medication without consulting her doctor and “went downhill.” Judy did not want to be medicated. She explained that she preferred a psychological form of treatment for her depression. Although the DASS21 did not reveal elevated levels of anxiety, Judy described herself as anxious. She perceived herself as an excessive worrier, especially about her daughter and grandson, and when she was “away from home.”

Family background. Judy’s father was American while her mother came from Australia. When Judy was eight years old, the family relocated permanently to Australia for “a better life.” Judy’s parents had both died. She had a younger brother whom she described as “reclusive” and “a loner.” He was a single gay man with no children.

Judy married at 22 years of age and she gave birth to her only child, a daughter, at 23. By 26 years of age she was divorced. “That was when I found out I was attracted to women.” Judy then had a 10 year relationship with a woman. She was still in contact with her. Judy had a two and a half year old grandson whose company she greatly enjoyed.

Judy described her current 25 year relationship as “comfortable.” Her partner, Shauna, also had been divorced, had a 30 year old son, but no grandchildren. Shauna was a well-educated woman who held a demanding job. She worked a variety of shifts.

IPT-RM Treatment

Initial phase (Sessions 1-2). In Sessions 1 and 2, role transition issues were explored further. It was highlighted that Judy’s lack of meaningful activities and limited social interactions were related to her depression. In Session 1, Judy reported that she had had a bad week. It was the beginning of a new school year but Judy was not teaching anymore. Since retirement, the beginning of a new school year affected Judy’s mood. “I fall into a deep, dark hole.” Two important issues became evident in the exploration of Judy’s experience.

Firstly, the psychological benefits of work were identified. “The beginning of a new school year is exciting and time consuming. I have a real sense of purpose. I get to reconnect with the children and other teachers.” A therapeutic goal was established to satisfy Judy’s needs for excitement, structured time, purpose, and social interaction.

Secondly, exploring Judy’s retirement experience highlighted a weakness in her interpersonal functioning. For example, Judy did not communicate with Shauna about how bad she felt because she thought she would be a “burden.” Judy kept her negative feelings and thoughts to herself. She only disclosed her feelings when Shauna asked her how she felt. This suggested that Judy did not make effective use of her social supports. As a result, a therapeutic goal was to improve her interpersonal functioning. If Judy disclosed how she felt, she may feel closer to her partner, friends, and family, which in turn could reduce her depression. CBT may

attempt to dispute the maladaptive “I’m a burden” thought. Psychodynamic Psychotherapy may attempt to explore early childhood experiences of the “I’m a burden” thought. Both of these therapeutic strategies are outside the scope of an IPT-RM model, hence the problem was approached from an interpersonal framework.

Judy had already thought about three activities that could satisfy her psychological needs previously met by her work. Those activities were: studying psychology at university, volunteering to help parents with their children, and doing an autobiographical writing project to give to her grandson. Judy had taken some proactive steps towards each of these, but had not completed any. This lack of follow-through, as Judy had mentioned in the initial interview, contributed to her depressed mood. A therapeutic goal was to help Judy take the necessary actions to achieve her goals.

At the end of Session 1, Judy had set her own homework in relation to locating information about the psychology course and volunteer job. Judy sometimes presented herself as being in a helpless position. “I don’t know how to get the information.” Even though, the therapist’s first impulse was to give advice, it was essential to empower Judy by simply asking, “How could you find that out?” The therapist encouraged and validated Judy’s competence and resourcefulness when she then detailed how she could get the information.

In Session 2, Judy reported that she had “a few good days.” Judy had volunteered at a school one day and attended a monthly book club meeting. “Going to school on Monday was a real lift.” The therapist highlighted the link between Judy’s improved mood and her increased social interactions. Although Judy had been involved in the book club for years, she did not socialise with the women outside club meetings. The therapist noted this group as a future opportunity for enhancing Judy’s social network by deepening friendships with selected members.

Up until now, Judy had only spoken about the positive aspects and benefits of work. To get a balanced perspective of her teaching role, Judy was asked about the negatives of the role. She responded, “It can be stressful because you have full responsibility for a classroom of kids. You’re on your feet all day and it’s go-go-go. I don’t have the energy anymore to teach fulltime.”

It was clear from these statements that Judy was facing a dilemma. She wanted to “let go” of her casual relief teaching work, “but I’m not quite ready to let it go...But holding on is not all that comfortable either. I don’t know how to let go and feel good about it.” Judy believed that, “At some time I have to stop working,” but went on to ask herself, “Or do I have to stop?” Judy became aware that although she was retired, she did not have to fully stop working. Later in the session Judy stated, “It feels really good to say that I’ll keep on working.” Judy enjoyed her

teaching position for its social and psychological benefits. Financial remuneration was a secondary consideration.

Judy did not have a social network or enough substitute activities in retirement to replace the workplace losses. "What am I going to do if I stop relief teaching?" Judy was entitled to work in retirement without adhering to her preconceived notions that she should cease work entirely. Therapy could empower Judy to satisfy her needs by either working as a relief teacher or participating in substitute activities.

At the end of the initial sessions, the therapist discussed with Judy her diagnosis of depression. The link between her depressive symptoms and the role transition was made explicit. The therapist encouraged Judy to look after herself by minimising the amount of work and socialisation she was involved in until she felt less depressed. A compilation of the Interpersonal Inventory indicated that Judy had placed family and friends in both her intimate and close support circles. However, Judy mentioned that contact was often irregular and she did "an awful lot of listening" but "not much talking." Judy's goals for treatment were restated, along with the therapist's observations about how treatment could be helpful to her.

Intermediate phase (Sessions 3-7). Judy commenced Session 3 with a review of her homework. She had researched the details of several courses. She also joined a weekly philosophy group. The therapist praised Judy for her proactive initiation. Judy reported that she had not done anything towards the writing project for her grandson. During sessions, barriers to taking action and strategies to facilitate action were discussed. In responding to non-completion of homework tasks, IPT-RM attributes blame to the depression rather than the individual.

Judy reported a story she heard on the radio. It was about a retired woman who travelled the world on a budget while staying with friends. Judy commented that she envied this woman's sense of adventure and how exciting it would be to do that too. The therapist linked Judy's comments from the previous session about missing out on the excitement of the beginning of a new school year and the excitement of the woman's travels. The therapist and Judy explored ways to create excitement in her life. As Judy's initial ideas were on a grand scale (e.g., travel to Europe), she was asked about ideas to create excitement on a smaller scale in her daily life.

In Session 4, Judy raised several concerns related to her retirement. As Shauna was in charge of the couple's finances, Judy had limited knowledge and involvement in managing money. This was a concern for Judy. If something happened to Shauna, Judy might not know what to do. During the weekend, Judy and Shauna went to look at a retirement village. They were considering downsizing; however, Judy said she would not move to a retirement village

until her mobility became limited or her independence restricted in some way. After visiting this retirement village, Judy started to think about death. Judy wondered how she would cope if Shauna died. "I fear living by myself." Judy spoke of concerns about her own health. Her mother and maternal grandparents died of heart disease in their sixties. Judy was 64 years old and had high blood pressure. During therapy, Judy's concerns, fears, and hopes were explored. Her experiences were normalised and validated.

At the beginning of session 5, Judy advised that Shauna had been diagnosed with breast cancer. Within the IPT-RM framework, individual needs can be addressed by exploring the situation and emphasising social support as a way to prevent and improve depressive symptoms. The flexibility of utilising a treatment manual was highlighted by allowing the therapist to respond to Judy's immediate issue of Shauna's breast cancer.

Judy's verbal statements reflected her distress and fear. She was catastrophising about the future. Instead of looking at these maladaptive thinking patterns, the therapist guided Judy to explore her worst fears, greatest hopes, and support systems.

Judy's former partner also had cancer when she was 28 years old. Judy was asked to describe that situation. Judy said she felt "isolated" and that the couple "didn't talk much about it." Judy was asked to consider what lessons she could use from that experience. Judy had learnt that support for herself was going to be important.

Judy's conversation moved from cancer to her career. She found it therapeutic to reflect on her entire career. The following aspects of her career were discussed: her reasons for getting into the field of education, her successes, her personal attributes and resources that she used to overcome difficulties, and her advice to new teachers. The therapist linked the cancer issue with the career discussion by asking Judy about the attributes and resources she could use to cope with Shauna's diagnosis.

Session 6 commenced with an update on Shauna's cancer. Shauna was having surgery the following day. The therapist explored how Judy would cope, what social supports she was going to utilise, and about communication among the couple. Shauna's cousin was visiting from interstate and Judy said he was a good support.

Retirees can have a hard time finding the balance between doing and not doing. The concept of Busy Ethic, where retirees feel they need to be productive to feel entitled to down-time, can interfere with enjoying retirement. Judy commented, "I feel guilty if I relax or do something pleasurable when I haven't exercised or made the bed." Judy wanted time to herself, "...one day (a week) to myself but I find it hard to give myself permission to do nothing." The therapist normalised Judy's ambivalent feelings about both being productive and taking some time-out.

In Session 7, the therapist reviewed the measures that Judy completed at the end of Session 6. Judy was advised that all measures had improved. The DASS21 indicated she was no longer in the range for depression. Judy reflected, "Yes. I feel a lot better in myself compared to when I first came to see you. I've surprised myself at how well I've coped with Shauna's cancer. I would have expected myself to struggle with it, but I've been coping really well."

Judy said that the cancer diagnosis had reinforced Shauna's plans for retirement. Shauna was seven months away from retiring. The therapist explored the impact that Shauna's retirement would have on Judy and the couple. Often couples avoid open and ongoing conversations about what to expect prior to a partner retiring. The questions asked by the therapist were designed to provide Judy with discussion topics to use with Shauna. The discussion topics included: how they plan to spend their time in terms of joint and separate activities/interests, how each will use the space in the house, and their expectations and needs in retirement. Judy also reflected on her parent's retirement experience, specifically that "...Mum didn't like having Dad around. They had a small house, so she didn't have any personal space." Judy expected that Shauna would adjust well to retirement since she "has interests and enjoys her own company." Overall, Judy was looking forward to Shauna's retirement as it would ease her "boredom and provide companionship."

Judy ended Session 7 by raising the issue of termination. She asked if she needed to complete the full 12 sessions. The benefits and consequences of termination were discussed. It was agreed that the next session would be in a fortnight.

Termination phase (Sessions 8-9). Session 8 commenced with an update of Judy's fortnight. Judy said that she had been feeling good and motivated. She had exercised and ate well. Depressive symptoms were reviewed. Judy denied any current concerns about Shauna's cancer diagnosis or treatment. Therapeutic progress was evaluated. During the session, each goal was systematically discussed. The therapist emphasised interpersonal functioning during the review of goals. One of Judy's goals was to increase her social contacts. Opportunities to achieve this goal through existing networks were explored. Judy was encouraged to meet with acquaintances who she wanted to get to know better outside the structured group meeting times (e.g., book club and philosophy group). Judy admitted that she tended to hold back during the philosophy group's discussions. Judy designed an experiment where she had to make at least two verbal contributions to the group.

After 40 minutes of updates and reviews, the therapist asked her, "What else would you like to talk about today?" Judy replied, "Nothing." Judy was encouraged to discuss what therapeutic work she felt was left. She reflected that she thought a lot of work had been done in a short amount of time. "I'm really happy with my progress."

The next session was planned for six weeks later due to Judy's work commitments. She was working as a relief teacher four days a week for several weeks. Judy was asked if there were any foreseeable problems that might arise during this time. Judy did not think so, but she was invited to contact the therapist if needed. The next session would be the final one if Judy's mood remained stable and depression free.

Session 9 commenced with a review of the past six weeks. Judy had enjoyed her extended teaching work. She was also pleased that she had the energy to complete it. Judy and Shauna were going to the east coast of Australia to celebrate their 25th anniversary of being together. Judy reflected that, "The breast cancer has been a wake-up call for us to do what we need to do." The therapist explored what this statement meant to her.

Judy felt ready to end treatment. Depressive symptoms were reviewed and measures completed. Judy's scores placed her in the unimpaired range of depression, which was maintained at follow-up. The therapist emphasised the gains that Judy had made in treatment. Possible problems that could arise were elicited. The therapist asked Judy where she would seek professional help from if needed. Judy reflected that it was good to recover from depression without taking medication. During treatment, Judy had been able to work through issues arising in retirement and reflect on her career. For example, she explored the positives and negatives of both the working and retiree roles. Judy also had the opportunity to discuss ageing and existential issues while receiving emotional support during her partner's cancer diagnosis.

Frank (Code 7)

Clinical Assessment

Background. Frank was a 71 year old married father of one adult son and had three grandchildren. Frank lived with his wife, Amelia. Amelia had been retired for four years and she had wanted Frank to retire too. Financially, they were "comfortable." The decision to retire was quite sudden. Frank needed heart surgery, so he decided to retire. Mild to moderate depression was endorsed on quantitative measures.

Initial clinical interview. Frank was unprepared for retirement and had not done any planning for it. He had expected to work until he was no longer able, so it felt like he "stopped too soon." He had no hobbies, interests, or group memberships. He had no intimate friendships outside his family. Frank had struggled with his adjustment to retirement.

Due to Frank's impending heart surgery, he retired from work in February 2010. He did not realise, however, that he would have to wait six months for the surgery. During this waiting

period, Frank did not create a retirement routine for himself because he was immobilised by fear.

Frank: I didn't do anything during those six months. I felt a lot of apprehension.

Therapist: What were you apprehensive about?

Frank: I feared dying.

Therapist: That must have been scary. Who knew about your fears?

Frank: No one, not even my wife.

Therapist: What held you back from sharing your thoughts and feelings?

Frank: They would think it's silly to feel like that.

Therapist: I don't think it's silly. It's a legitimate fear to have. Are your parents alive?

Frank: No.

Therapist: How did they die?

Frank: My father died of a heart attack and my mother a stroke.

Therapist: I imagine that would have added to your worry about your heart surgery.

Frank: Yes. I didn't put it together.

Further to the factors mentioned about his unpreparedness for retirement and his fear of the impending heart surgery, Frank had left a powerful position in the workforce that he was psychologically unprepared to lose. Frank had worked away from home for three decades (fly-in-fly-out or drive-in-drive-out). With self-importance he commented, "The family revolved around [my comings and goings]." Frank was responsible for "...big projects, lots of people, and lots of money." He had earned over \$200,000 annually.

Frank provided financially for his family and Amelia "took care of the house." He described the division of household labour as "old fashioned." Amelia took care of indoor chores and Frank took care of outdoor chores.

Frank had his surgery and recovered well. In January 2011, Amelia had a major knee surgery and Frank became her fulltime caregiver. "She lost her independence. She can't drive. She can't cook or clean." Frank experienced a change in the power dynamics by taking on the role of "Man Friday," as he resentfully described it. Frank's week was busy but he did not "feel fully occupied." The role reversal meant that Frank was doing all the cooking, cleaning, and shopping, as well as driving Amelia to medical appointments. Although his days were busy, he did not feel satisfied.

Psychiatric background. Frank denied any prior diagnoses or treatment for depression or other mental illnesses. There were no reports of mental illness in Frank's family. When asked about previous times he felt down, Frank said there had been two grief related instances.

Frank's second son died as a teenager when he was hit by a motor vehicle. Also, Frank, with his brother, had to make a decision to turn off his mother's life support system.

Therapist: How did you get back up?

Frank: I tried to put it out of my mind...life has to go on.

Family background. Frank's parents "wanted a better life for the children," so the family emigrated to Australia from Germany in 1952. Frank was 12 years old. Frank retained his native language, but his brother, who was five years younger, did not. His brother lived on the east coast of Australia and they had contact every month or so. Frank had been married to Amelia, an Australian, for 47 years and he was happy with his relationship. Their only son was in his forties and lived five hours drive away. Frank enjoyed spending time with his grandchildren who were aged 16, 10, and 8.

IPT-RM Treatment

Initial phase (Sessions 1-2). In Session 1, with Frank the therapist reviewed his depressive symptoms. Quantitative measures of depression, anxiety, and stress were administered. Frank's phone screen DASS21 ratings and his initial assessment GDS-15 and DASS21 ratings indicated mild to moderate depression. By Session 1, however, Frank made rapid improvement and was in the unimpaired range for depression. In Session 2, these results were discussed with Frank. He commented that he had a "good" week and that "it was busier."

Frank's Interpersonal Inventory revealed he had few supports. His intimate supports were all family members. Three neighbourhood couples were listed as close supports. Extended supports consisted of former colleagues who still worked and he rarely saw them. Frank's education and work history timeline revealed a man who had been continuously employed and had gained promotions. He regretted leaving school at 15 years of age and had completed higher education in his twenties at night school.

An interpersonal Case Formulation was discussed with Frank.

Therapist: From the assessment conducted, it appears you have developed an episode of depression. It seems that a number of factors have interacted to impact your mood. Health problems, including heart surgery, have been linked to depression. You've recently had heart surgery, but it looks like we can rule this out as a cause of your depression because you have recovered well and are generally fit and healthy. The surgery has, however, delayed your adjustment to retirement. Additionally, taking on the role of caregiver following your wife's surgery has made it difficult for you to adjust to retirement. It seems most helpful if we work with your depression from a role transition perspective. What do you think?

It was decided that the focus of treatment would be to help Frank manage the role transition. The goals of treatment were: help Frank establish a retirement routine, identify activities and interests in which he could get involved, process his retirement experience, and help him better cope with the caregiving role. A role dispute was disqualified as a problem area since the focus was on the changing roles experienced in retirement and not a conflictual relationship.

Intermediate phase (Sessions 3-5). In Session 3, the therapist helped Frank to systematically evaluate his former working role and new retiree role. He reflected on the positive aspects of work and what he missed about it. He also spoke about the downsides of work, especially with regard to working away from home. Frank talked about how he announced his retirement and the concern that his colleagues had shown. Opportunities in the retiree role were explored. Frank was interested in mentoring young people in the trades and getting involved in a Men's Shed, but had not yet taken action. The difficulties of being a retiree were aired.

The session concluded with a Decision Analysis of Frank's boredom when he took his wife to medical appointments. He explained that the waiting around "is not a pleasure." The therapist enquired, "Is there some way you could make the waiting time more enjoyable?" Frank had a solution, "taking something to read," which, at a later session, he reported was successfully implemented.

In Session 4, a discussion of the change in power dynamics resulted in a therapeutic outcome. It was very difficult for Frank to do "women's work."

Therapist: What does it mean to you to be doing "women's work"?

Frank: It's menial work. I've never had to do it in my life. Even when I was a bachelor and had left home, I had someone who did the cooking and cleaning.

Therapist: And when you were working, you were the expert on site. Now you are the caregiver for your wife and are carrying out less skilled tasks. What is that like?

Frank: Well, I'm a perfectionist. I like to get the job done right and accurate, but my wife criticises me. If I put the black socks with the white shirts, I get in trouble.

Therapist: Household work is often unpaid and unacknowledged. You've come from a powerful position. Now you can't be the king of your castle because you are caring fulltime for your wife. It's a role reversal. Even though it's temporary, this may be a source of your irritability. Your wife sometimes criticises you and you value yourself as competent.

Frank: But maybe when Amelia gets better and does all the housework again I will miss out. I should look at it as a gain rather than a loss. I could possibly do more in

the house once Amelia is better. There's nothing to stop me doing that once she's better.

The reframe that Frank made for himself was powerful. He came to see a benefit of the role reversal. After this conversation, Frank was not distressed about his caregiving role.

The session concluded with a discussion about the derivation of meaning and satisfaction in retirement. Frank's working life was described as meaningful and productive. A satisfying adjustment to retirement meant he had to find meaning and be productive in some way. Again, Frank had the answers to his problem. He needed to "...remain active, mentally and physically." He was going to attend a Men's Shed meeting and get involved with volunteering. Frank had played a game of golf in the preceding week with a neighbour, which was an enjoyable activity. That was the first game he had had since heart surgery (over one year previously) and it was uplifting. The needs that these activities provided were consistently explored by the therapist. By asking the client to explicate the needs that were being fulfilled the importance of the activity was brought to the client's awareness. The purpose was to encourage involvement and continued participation, which relieves depression. Playing golf fulfilled Frank's needs of "being outdoors and socialisation." He anticipated that Men's Shed would allow him to "...meet new people, occupy [his] time, and do something useful."

In IPT, ageing is considered a role transition as it involves a transition in role (e.g., young adult role to an older adult role or healthy role to an ill role). Ageing and health issues arose for Frank, as they did with other participants in the current study. Frank had been trying to purchase travel insurance for an upcoming overseas trip, but "...encountered obstacles now that [he] was over 70." The therapist asked Frank about his concerns with ageing and illness, and what differences he had experienced so far. In enquiring about the benefits of ageing, Frank replied, "I don't know if there are any." The question permitted Frank to consider the possibility that there are positives. He shared a positive anecdote about ageing and also proffered that wisdom was a benefit.

Session 4 concluded with a review of Frank's depressive symptoms. Frank reported that his mood was "good" since Session 1, which correlated with his quantitative measures being in the non-depressed range. At each session, Frank was asked what he wanted to talk about, but he did not bring any issues to the therapy room. Frank, who was unfamiliar with the process of therapy, was provided with coaching about the roles of therapist and client. It was explained that it was his responsibility to initiate discussion and not the therapist's. Despite this guidance, Frank invariably had "a good week" and did not have an issue to discuss. "Nothing, it's all normal and quiet...it's all good." Frank agreed to Session 5 being spaced out to a fortnight and concluding treatment at Session 6 if his mood remained stable.

Session 5 commenced with a review of Frank's fortnight, which was "good." Frank had participated in Men's Shed meetings and worked as a volunteer at a sausage sizzle. Frank enjoyed "...meeting others and contributing to the club." Frank reflected that "...staying occupied, that's a big thing because I believe you just can't sit at home all day." The therapist asked Frank if he had balance between doing and not doing. "Sometimes I struggle to find time off. But I think it's better to be like that. I'm at risk of doing too much rather than not enough." An exploration of how to find balance ensued.

Depressive symptoms were reviewed. Frank remained in the unimpaired range for depression. Frank appeared to be reconciled about taking on some of his wife's roles. Amelia had begun driving again and this increased independence freed Frank to pursue activities and interests outside the home. Frank was engaged in golf, had joined Men's Shed, was doing volunteer work, and meeting new people.

Termination phase (Session 6). Frank arrived three weeks later for his final session. He said the intervening time was "fine" and there were "no problems." Frank's depressive symptoms were reviewed and quantitative measures were administered. Frank remained in the non-depressed range from Session 1 to follow-up. Frank was very pleased with his progress during treatment. Amelia had commented to Frank that the treatment had been good for him.

Frank: She reckons I'm a lot better than when I first started coming here.

Therapist: What do you think is different?

Frank: I feel more positive in myself. There are things out there I could do...coming here, just talking about this has pushed me in a certain path. I've followed up on things rather than just thinking about it and not doing anything about it."

The work done together was reviewed, along with the gains made by Frank. Potential problems were explored and where he would go to for help if he felt depressed again. Frank commented that therapy helped him to share his thoughts and feelings with others in a way that they can hear them. "Rather than blurting it out or keeping it inside; this got me into trouble in the first place."

This course of IPT-RM was the shortest of all the research participants. Frank made a rapid recovery from his initial depressed mood. It is possible that the conditions were right for this to occur. As Frank's wife's independence increased, so too did Frank's mood. Frank also had an overseas trip, back to his homeland, to look forward to. Frank responded well to the processing of his retirement experience. Being validated and acknowledged helped Frank to reframe his caregiving role, and freed him to take affirmative action to get him out of the house, involved in the community, and interacting with others.

Chapter 6

Discussion

Introduction

Statement of Findings

The findings of this pilot study suggest that an adaption of IPT for retirement maladjustment (IPT-RM) reduces depressive symptoms. With non-complex retirement role transition cases, treatment duration ranged from six to 12 sessions. It is advantageous to provide detailed guidance supplemental to existing IPT manuals for therapists treating depression associated with retirement transition. Furthermore, the duration of up to 12 sessions fits well into the Australian Medicare model for mental health treatment. While the non-experimental design of the current study limits claims of causality, the findings suggest that further study is warranted.

Restatement of the Study's Purpose

The purpose of the current study was to develop and assess a treatment manual for retirees experiencing depression due to a poor adjustment to retirement. A tailor-made therapy may be more effective in treating retirees' depression than the use of a broad-based approach. A benefit of this treatment manual is that it enables the developmental issues encountered by a retiree to be detailed in a single document. Nothing was found in the literature that comprehensively discusses the array of issues a retiree faces in the adjustment to retirement in one, simple document. After reading this treatment manual, therapists may be informed about retirement issues and how to address them from an IPT adapted framework.

One research participant in the current study had sought counselling to address his pre-retirement anxiety prior to leaving the workforce. He complained that the therapist lacked an understanding of retirement issues and, therefore, was unable to help him. With the first of the baby boomers attaining the age of 65 in 2011, therapists may expect to see more clients with retirement adjustment problems. It becomes crucial for therapists to have an understanding of retirement-related problems and of treatment options.

What is Covered in this Chapter?

This chapter concludes this thesis. The next section evaluates the results. References to previous research are made along with theoretical implications, claims, and limitations. The following section then discusses practical implications and recommendations. The final section comprises the conclusions.

Evaluation of Results

Methodological Aspects

This section discusses methodological aspects of the study as they affect the results. Three aspects of note include: treatment manual development, measures, and threats to external validity.

Treatment manual development. IPT has four focal problem areas: role transitions, grief, role disputes, and interpersonal deficits. Typically only one or two problem areas are worked through in a course of IPT. This study was originally conceptualised to treat retirement adjustment problems with a role transition as the primary problem area. However, it became apparent that this was a narrow view of the clinical presentations actually experienced by retirees in their adjustment to retirement. Three of the nine research participants in the current study also experienced non-role transition events in retirement that affected their adjustment to retirement. Those events needed to be addressed therapeutically before working with the role transition issues. One participant's primary problem area was grief. She retired prematurely to care for her terminally ill husband who had died five months prior to her commencing treatment. Another two participants' primary problem area was role disputes. Their marital relationships were distressed as a result of retirement and role disputes needed to be worked through before addressing the role transition as the secondary problem area.

A broadening of the conceptualisation of the treatment manual occurred to meet the clinical needs of retirees with depression. Encompassing rather than excluding meant that research participants with clinically relevant presentations could be helped. Certainly, the aforementioned three research participants evidenced therapeutic benefits by the end of the study.

The development of the treatment manual was designed to be rigorous with empirical support. It was based on the Carroll and Rounsaville (2008) guidelines for treatment manual development. It is highly recommended that manual developers utilise this resource as a basis for their work as it provides a solid foundation for the construction of an evidence-based treatment.

The construction of the treatment manual for the current study involved several processes. The initial content of the treatment manual was derived from the literature; utilising peer-reviewed research articles and books created an evidence-based grounding for the manual. Following its implementation, the treatment manual was then updated to incorporate clinical knowledge. At the conclusion of the current study, the IPT-RM manual is now ready for further testing.

Prior to clinical implementation of a new treatment manual, it is recommended that it be approved by relevant experts. The expert-systems approach was utilised by Morley et al. (2004) who developed a treatment manual for chronic pain. The benefits of the expert-systems approach are that independent therapists experienced in the field may enhance therapeutic outcomes and increase the safety of treatment for research participants. Two supervisory clinical psychologists reviewed the treatment manual for the present study before its implementation. However, following the expert-systems approach, a small panel of independent experts from the field would have been consulted instead. Prior to further testing of this treatment manual, it is recommended that it go through that type of expert-systems process.

Measures. The measures used in the current study were generally appropriate, although several comments are warranted. Depression was assessed with two instruments: the GDS-15 and the DASS21. Although it was anticipated that a majority of the sample would be aged over 65 years, the actual ages of research participants were unknown when designing the current study. It was also expected that some of those sampled would be under the age of 65 years. Two retirees, at 64 and 58 years of age, were under this age.

The GDS-15 was an appropriate measure of depression for the present study given that it was developed specifically for adults aged over 65 years (Brown & Schinka, 2005). The DASS21 has also been validated with older adults (Lovibond & Lovibond, 1995). Interestingly, the GDS-15 did not diagnose depression in the two participants aged under 65 years, whereas the DASS21 did. The reason for this result cannot be determined with the current data nor were any insights gleaned from the literature. It may be coincidental that the GDS-15 failed to diagnose depression for the two participants aged under 65 years. Although this explanation is unlikely, it could be that the GDS-15 is so sensitive that it needs to be reserved for adults aged over 65 years. Since retirement is not restricted to persons aged over 65 years, it is recommended that a measure of depression be utilised in addition to the GDS-15 to avoid false-negatives.

It is also recommended that for this population, a specific health measure be included. This was not done in the present study, but could have been informative since their health status affects retirees' psychological wellbeing and their engagement in activities. The WHOQOL-BREF measured physical health as one of its domains, but a specific measure of health may provide more clinically useful information. It may determine the effect of health on psychological wellbeing and specifically measure capacity for engagement in different types of activities. An instrument such as this could also be used as an outcome measure.

Threats to external validity. The sample, setting, and demand characteristics limit the generalisability of the results. The sample characteristics were relatively narrow: eight out of nine participants were “comfortably off” financially, seven out of nine had a post-high school education, and seven out of nine had very good or excellent health. Four out of nine participants had been employed in the field of education, which raises the question of whether educators may have particular difficulties adjusting to retirement. Most participants only had mild to moderate depression, so the utility of this treatment for retirees with severe depression needs exploration. Finally, six of the nine participants had been retired for approximately three years, which may indicate an average time by which retirees encounter problems and are ready to look for solutions. Therefore, these results are limited to generalisability with White, middle-class, healthy, educated, community dwelling retirees.

One of the key complaints about psychotherapeutic research is that it is not conducted in real-life settings. The present study was conducted in an off-campus, university psychological clinic. While the public receives treatment through The Clinic on a fee-per-session basis, the setting is different from a private therapist’s office. Future trials could be conducted in other settings to reduce threats to validity.

It is possible that demand characteristics have unintentionally biased the results. The principal investigator acted in multiple roles and was the sole contact for the research participants. The recruitment, assessment, and treatment were all conducted by her. This is common in small pilot studies with limited resources (e.g., Heisel, Duberstein, Talbot, King, & Tu, 2009). Given the nature of the positive therapeutic relationship developed, there is potential for the research participants to want the researcher to succeed and therefore ‘fake good.’ It is recommended that future trials incorporate independent personnel to act in the various roles.

Statement of Results

This section provides a statement of the results by discussing clinical improvement, applied importance, tolerability, and treatment dosage.

Clinical improvement. The results suggest that the IPT-RM treatment was feasible in the treatment of retirement-related depression. The results need to be viewed conservatively, however, as this was a small pilot study without an experimental control. Nonetheless, the results are promising and suggest that further study is warranted.

All the research participants evidenced clinical improvement. The GDS-15 and the DASS21 demonstrated an upward trend in the data. The WHOQOL-BREF demonstrated a downward trend in the data. These two trends represent clinical improvement in depression, anxiety, stress, and quality of life. All research participants completed treatment (Time 4) in the

unimpaired-normal range and continued to be depression free at follow-up (Time 5). Even Lucy (Code 9), who commenced treatment feeling distressed but whose depression ratings did not reach a clinically impaired level, evidenced improvements across measures. The Retirement Satisfaction Inventory was the other clinical outcome measure. All research participants rated their satisfaction with retirement higher at follow-up compared to when they commenced treatment. The clinical improvements reported on these measures also translated into practical benefits for research participants.

Applied importance. Since these research participants ended treatment depression free, they have an increased likelihood of enjoying the rest of their retirement years. The research participants entered treatment feeling dissatisfied with their retirement. They often felt disenchanting and experienced a lack of meaning, purpose, and hope. Another common concern was a lack of motivation to start and complete projects. Feeling disillusioned with retirement, some research participants idealised their former work roles. Many of the research participants lacked structure, activities, and social contacts. Significant relationships were sometimes distressed by the transition to retirement from the workplace.

Examples of the practical benefits gained by the research participants from their involvement in the current study:

- engagement with life. Research participants got out of their houses and became involved with their communities. Some joined clubs and others made travel arrangements;
- motivation to start projects. As depression lessened some were able to start engaging in desired projects. These included completing a front-yard landscaping project and cleaning out an office;
- creation of structure. Research participants created fuller lives and routine through involvement in interest groups and increased social activities. Examples were playing golf and enrolling in short courses;
- creation of meaning and purpose. In considering what was meaningful to them since retirement, they set personal goals. Volunteering and planned legacies for grandchildren were two examples of this;
- emotional reconciliation. Research participants felt emotionally reconciled about the losses of the old work role and the gains of the new retiree role. They tended to feel at peace and content with their new retirement lifestyles.

Tolerability. IPT-RM treatment evidenced both clinical and applied importance. The therapist's clinical judgement and research participants' feedback indicated that, overall,

IPT-RM was also a highly tolerable treatment. There were two exceptions to this, as was mentioned in Chapter 4.

The first of these was Karl (Code 7). Treatment was mildly tolerable for him. The therapist's clinical judgement was that any exploratory-based treatment was likely to be uncomfortable for Karl. This may have been due to his unfamiliarity with psychotherapy and his inexperience at exploring his inner world. To maintain Karl's engagement in treatment and acknowledge his feelings, the therapist regularly asked Karl for feedback. This provided Karl with an opportunity to express his thoughts and feelings and have them normalised. The second exception was Denis (Code 10) and IPT-RM was not a good fit for him. The therapist's clinical judgement was that the exploratory nature did not match Denis' low level of psychological mindedness. IPT-RM requires the recipient of treatment to be self-reflective and to have a certain degree of insightfulness. While Denis' depressive symptoms improved during the study, this is attributable to both the IPT-RM manual and structured behavioural activation processes (Lejuez et al., 2001) focusing on the development of social activities, social engagement, and expansion of his social network. This was the only case that deviated from strict adherence to the manual.

Treatment dosage. An unexpected finding was that treatment dosage ranged from six to 12 Sessions for seven research participants. It was expected that research participants would require at least the full 12 Sessions offered. The average latency for change was moderate. That is, by Session 6 (Time 3) most research participants had shown clinical improvement and by Session 12 (Time 4), all but one research participant were in the unimpaired range for depression. The exception was Jillian (Code 2) whose Time 4 was measured at Session 20 (final session). She was depression free at that point. Jillian's case was the most complex so her longer treatment was warranted. Kerry (Code 1) was the only other research participant requiring more than 12 Sessions. Kerry's case was also more complex than the others with a role dispute as the primary problem area and a role transition as the second problem area. If this was a randomised controlled trial, one drawback of the varied dosage would be that it could confound the results. Given the pilot nature of the current study, however, the variability of the treatment dosage provides useful information for future research.

The tailored nature of IPT-RM may more efficiently address depression due to retirement maladjustment than existing treatments. For four research participants the treatment dosages were 6, 7, 8, and 9 Sessions. Three of the research participants' treatment dosages were 12 Sessions. The two most complex cases had dosages of 16 and 20 Sessions. IPT-RM appears to specifically target the developmental needs of the target population and, in doing so, efficiently addresses the presenting problem.

A treatment dosage of six to 12 Sessions fits the Australian Medicare model for mental health treatment. With a Mental Health Care Plan, consumers experiencing depression due to retirement maladjustment could be treated within the Medicare allowance of 12 annual Sessions. Furthermore, up to 18 annual Sessions may be available for some consumers of mental health services. A cautionary note is warranted. The sample size of the present study was small, so definitive dosage rates need to be confirmed in future trials.

No prior studies were found that treated depression in a retirement context. This is a unique treatment that shows promise. Future trials of IPT-RM that are experimental and comparative will help to answer the questions raised by the current research. Comparing IPT-RM with a control group and treatment-as-usual will provide insight into causal links and treatment dosages.

Theoretical Implications

Erikson's psychosocial theory of human development. Erikson's seventh and eighth stages were the most relevant in the present study. The seventh stage, generativity versus stagnation, was originally conceived of as being in "adulthood" without a specified age (Erikson, 1959, p. 129). Theorists typically assign an age range for this stage of 35 to 65 years, however. The eighth stage, integrity versus despair, was categorised as occurring in "mature age" adulthood (Erikson, 1959, p. 129). Likewise, theorists typically assign an age range for this stage from 66 years to death. The age range for the research participants in the current study was 58 to 71 years, with a mean age of 66.8 years. It could be reasonable to say that all the research participants were "stagnating." The self-absorbed states of inactivity and meaninglessness were represented in their depressed mood. In line with Erikson's view of psychosocial human development, the research participants were in a stagnating life situation and treatment helped them to resolve the seventh stage. This positive resolution may allow the research participants to enter the eighth stage with a greater chance of also successfully resolving this stage with integrity and wisdom.

Successful ageing. The three factors comprising Rowe and Kahn's (1997) model of successful ageing are: being disability free, being physically and cognitively functional, and being active and social. This treatment addressed the third factor with retirees. The research participants were stagnating and often lacked motivation, meaning, and activity in their lives. Except for Jillian (Code 2) whose self-rated health was poor, the research participants were disability free and in good physical and cognitive health. Treatment enabled research participants to successfully age by helping them be contributing community members. It is also noteworthy that research participants were aware of the link between their health, ability to

be active, and quality of life. Several research participants expressed their existential fears about “growing old” and how they expected it to limit their functional abilities.

Theoretical perspectives on retirement. Disengagement theory asserts that retirees and society engage in a mutual process of withdrawal. The research participants in the present study were disengaged from society and, consequently, were stagnating and depressed. Being disengaged is psychologically unhealthy. In contrast, being active, as argued by activity theory, is psychologically healthy. Research participants often commenced treatment with a low level of activity and they needed to become engaged and involved again. This finding supports activity theory’s perspective of retirement.

Role theory is a very useful model for understanding the impact of the losses experienced by the research participants. The worker role was replaced by the retiree role but it is the worker role that is valued by the individual and by society. The research participants tended to perceive the retiree role as being devalued. One retiree with a sudden retirement described her changing role as, “Going from being somebody to being nobody.” Treatment facilitated a new appreciation for the retiree role.

Continuity theory argues that retirees continue life as they know it during the transition from work to retirement. This consistency is said to be psychologically healthy. However, for the research participants in the current study there was very little continuity across the retirement transition. Finances, consumption patterns, routine, lifestyle, and identity – these all changed and social contacts were often discontinued. Internal continuity was also threatened as retirees needed to learn new coping strategies to deal with the psychological impact of retirement. However, continuity is relevant if looked at in terms of establishing a retirement routine. Work provides structure, routine, and meaning. If the retiree can *continue* these into retirement, then it is likely they would adjust better to retirement. However, the research participants in the current study needed to establish routines. Because they had not done so, they experienced discontinuity when transitioning from the working role to retirement.

Resource theory states that retirees will try to build up and hold onto resources to cope with the disruptive retirement transition. For example, Keith attempted to build up social resources by joining a club years before actual retirement. The research participants in the current study had exhausted their resources or were not capitalising on existing resources to cope with retirement. In many ways, treatment facilitated a process of gathering resources and better utilising their existing resources. With IPT-RM, the focus is on social resources as a means to reduce depressive symptoms.

Life-course perspective states that retirement is an ongoing process, which occurs in a gendered, interpersonal, and systemic context. In the present study, the multiple elements of the life-course perspective provide a context in which retirement takes place. The interpersonal context could be the most important element as it acknowledges the social losses experienced in leaving the workforce and the impact on family, which includes children, grandchildren, parents, and partners.

Phases of retirement. Of particular relevance to the current study are Phases 3 to 5 of Atchley's phases of retirement model (Atchley & Barusch, 2003). Phase 3 is called "disenchantment" during which retirees feel disillusioned with their retirement and may experience depression. The research participants in the current study could be classified as being in Phase 3. Disenchantment is a congruent descriptor for the retirees involved in the current study. Treatment was helping the research participants move into Phase 4, "reorientation." Treatment helped the research participants to work through their issues and commence the development of a retirement routine. The ideal outcome is for the research participants to remain depression free and, over time, develop a "retirement routine" (Phase 5) where they feel contented and satisfied with their retirement lifestyle. Atchley's six phase model of retirement was a good fit for the experiences of the research participants.

Summary. No single theoretical perspective adequately explains the complexity of retirement. Each theory is complementary to the understanding of retirement and its impact on psychological adjustment. Activity theory, role theory, resource theory, and life-course perspective carried the greatest explanatory value in the present study.

Pathways to Retirement

The situational, structural, and personal factors provide the context of a worker's retirement and influence their adjustment to retirement. This section discusses notable similarities and differences in the clinical presentations of research participants in the present study with previously published work.

Situational factors. Workers who perceive that they have *control over the timing of their retirement* are predicted to have an easier adjustment (Tordera et al., 2010). Only two research participants felt they had low control over the timing of their retirement. They were Jillian (Code 2) who retired to care for her dying husband and Frank (Code 7) who retired to have heart surgery. Most research participants felt they had control over when they would retire but still experienced maladjustment.

Workers who retire *suddenly and unexpectedly* are reported to have a more difficult adjustment to retirement (de Vaus et al., 2007). Most research participants retired abruptly (i.e., they worked one day but not the next), but this sudden withdrawal from the workforce

was planned. Only Jillian (Code 2) and Frank (Code 7) felt they had retired suddenly and unexpectedly.

Retiring *off-time* reportedly hinders adjustment to retirement (Quick & Moen, 1998). An on-time retirement is based on social norms (60-65 years of age) and also on personal preference for the age of retirement. Only three research participants retired on-time, that is, between the ages of 60 and 65 years (Jillian, Code 2; Judy, Code 3; and Lucy, Code 9). One retired very early (Kerry, Code 1), three retired late (Keith, Code 4; Karl, Code 5; and Roslyn, Code 8), and two retired very late (Frank, Code 7; and Denis, Code 10). The two very late retirees were the most likely to express the desire to return to work, but they realised they did not have the physical energy to do so.

In Spain, Tordera et al. (2010) found that having an intention to retire early and then actually retiring early results in a better adjustment to retirement. Theoretically, it may be more accurate to think about it as objective timing and subjective timing of retirement. Objective timing would be based on social norms for retirement age; on-time being 60-65 years of age. Off-time occurs as early- or late-retirement. Kerry (Code 1) considered herself to have retired very early (at 55 years of age) and observed that she and her husband were usually the youngest people in attendance at events. This highlighted her early retirement age. Subjective timing would be related to the retirees' intended, preferred, and actual retirement ages. Jillian (Code 2) intended to work for several more years. She preferred to continue working, but her actual retirement age was 65. Subjectively, Jillian felt she retired off-time, too early, but objectively she retired on-time.

Undertaking retirement financial and lifestyle *planning* reportedly facilitates an easier adjustment to retirement (Moen et al., 2005). A contrasting finding was reported by Donaldson et al. (2010) who concluded that planning was unrelated to retirement adjustment. Similar to the present study, a limitation of the Donaldson et al. study was that the sample was limited to well-resourced, middle-class, educated retirees. The research participants in the present study had planned financially for their retirement, but most had done limited, if any, lifestyle planning. They had not seriously contemplated how retirement would affect their lifestyles, how they would spend their time, who they would spend their time with, and what kind of retirement lifestyle they wanted to create. The lack of planning clearly impacted on the ease of transition to retirement and suggests that lifestyle planning is very important.

Experiencing other major life events at the same time of retirement is reported to affect adjustment to retirement (Calvo et al., 2009; Price & Nesteruk, 2010). With the exception of Keith (Code 4), all the research participants had at least one other significant life event occurring at the time of retirement. The effect of experiencing multiple life events appeared

congruent with Holmes and Rahe's (1967) theory that the individual's coping resources are cumulatively reduced with each stressor. Each of these life events needed to be therapeutically worked through to some degree. For example, all the retirees were affected by the Global Financial Crisis, but Judy (Code 3) and Lucy (Code 9) were the most vocal about its impact. The therapeutic work was generally limited to validation and acknowledgement of its impact. In contrast, Denis' relocation and Jillian's court case necessitated more extensive therapeutic work.

Structural factors. Retirees who perceive they have adequate *financial resources* reportedly adjust better to retirement (Loewenstein et al., 1999). All the research participants owned their house. Eight out of nine reported they were "comfortably off" financially. Loewenstein et al. found that retirees with very low incomes are unhappier than those with higher incomes. The fact that the research participants in the current study were depressed despite having adequate money suggests that financial resources do not protect retirees from maladjustment. However, it is possible that having adequate finances was a resource and not having financial worries may have permitted the research participants to recover more quickly from depression than they would otherwise have done.

For the two research participants whose primary problem area was a role dispute with their partner, conflict over money comprised just one component of their complaints. Both Kerry (Code 1) and Karl (Code 5) were acutely aware that their finances were no longer renewable. Both were more conservative spenders than their partners and conflict arose around their perceived partners' liberal spending habits.

When looking at the individual research participants' levels of *education*, some of the predictions made in the literature did not apply. With higher levels of education, women in the Merkes (2003) study tended to delay retirement. Four of the university educated women did not delay retirement (Kerry, Code 1; Jillian, Code 2; Judy, Code 4; and Lucy, Code 9). In the Vaillant et al. (2006) study, the white collar participants tended to delay retirement. The research participants in the current study who delayed retirement (i.e., retired after the age of 65) were both from blue and white collar occupations. While level of education is thought to be a protective factor (Lusardi & Mitchell, 2006), most of the research participants were well-educated, and, by itself, this was not a buffer from maladjustment in retirement.

A lack of *social integration* was a problem for all the research participants. Carter and Cook (1995) speculated that retirees who lack social contacts outside the workplace would experience more difficulty adjusting to retirement. This was supported by the present study. Research participants had tended to have their social needs met through work and had few intimate friendships outside work. The research participants typically did not predict the social

losses that would occur when they retired. They did not develop relationships with colleagues outside work hours before or directly after retirement. Consequently, the research participants had few alternative sources of quality and regular social contact in retirement. From an IPT framework, this lack of social integration is a precipitating factor for depression.

Previous research made a strong connection between *health* and adjustment to retirement. Research suggests that healthy retirees tend to adjust better to retirement (de Vaus & Wells, 2004; Donaldson et al., 2010; Smith & Moen, 2004). In the present study, only one research participant (Jillian, Code 2) had poor health and it limited her ability to adjust to retirement. Nonetheless, most participants were in very good or excellent health and, alone, this was unable to protect them against retirement maladjustment.

Retirees who held *high status jobs* were predicted to adjust better to retirement (de Vaus & Wells, 2004; Quick & Moen, 1998). They were expected to have access to more resources than retirees who held lower status jobs. Five of the nine research participants explicitly spoke about their high status jobs and the loss of power experienced when retiring. When leaving the workforce, the research participants had few substitutes to derive the self-worth and personal power they had received from work. Creating alternate channels to direct their personal power was a part of treatment. For example, Denis (Code 10) applied to become a committee member at a local club to which he belonged. He could see ways to improve the running of the club. Denis could be influential if he was a committee member and it would be a substitute for the lost status formerly derived through work.

Personal factors. The unity and purpose that the *work identity* provided were lost in retirement. This may contribute to the disequilibrium experienced by the research participants in the present study. Walajtys (2007) found that retirees had higher self-worth when they perceived themselves as having a productive identity. Similarly, research participants in the present study were often struggling to find a balance between being productive and feeling good about having down time and being unproductive.

For four research participants, the work identity was the most salient aspect of how they viewed themselves (Kerry, Code 1; Jillian, Code 2; Frank, Code 7; and Denis, Code 10). They had held high status jobs, their work consumed an inordinate amount of time to the sacrifice of outside interests and interpersonal relationships, they derived most of their self-worth from work, and they wielded a great deal of personal power in their jobs. Few alternative identities, and none as influential as the work identity, were available to replace the lost work identity. IPT-RM facilitated the awareness, expression, and validation of this loss. The research participants were then open to exploring other ways to meet these lost needs.

Price and Joo (2005) found that merely being *married* was a resource. Seven of the nine research participants were partnered (five were married; one was in a long term same-sex relationship; and one in a long term, non-live-in relationship). In some cases, being partnered was a liability rather than a protective factor. All but one of the partnered research participants (Judy, Code 3) expressed discontent with some aspect of their relationship during treatment. However, none seriously contemplated ending their relationship. As found in the Hilbourne (1999) study, these findings suggest that a relationship becomes an asset when it is cohesive and satisfying, as opposed to marital status *per se*.

Retirees who had *activities and interests outside work* were predicted to adjust better to retirement (de Vaus & Wells, 2004). Upon leaving the workforce, these activities and interests may be alternative sources for deriving a sense of belonging. One research participant in the present study was aware of this likelihood and consciously joined a sports club prior to retirement to have this alternative community already in place for when he left the workforce. When Keith (Code 4) left work, he automatically had somewhere to invest more time, which was a positive factor in his adjustment to retirement.

Research participants tended to want to limit the number of activities or groups they were involved in after retirement. Graham (1992) and van Solinge and Henkens (2008) found that being involved in a wide range of activities was a positive factor for retirement adjustment. IPT-RM encouraged research participants to keep their life spheres wide and pursue involvement in different interests, especially while they were physically able to do so. Treatment facilitated research participants getting involved in volunteer work, and this was an optimal way to meet several of their needs. Six of the nine research participants were actively volunteering and they derived many of the benefits found in the Merkes (2003) study, including meaningful activity, structured time, social contact, and mental stimulation.

Summary. When considering pathways to retirement individually, it seems that no single pathway is a risk factor for retirement maladjustment. It is likely to be more useful to consider the various pathways as a set of risk factors. Moen's research from the life-course perspective and Wells' et al. (2006) work considered a large range of variables in their retirement research. When the factors were viewed individually, some findings ran counter to the expected predictions. This may be an artifact of the small sample size of the present study and so findings need to be viewed conservatively.

Alternative Explanations

After receiving a course of IPT-RM, the research participants in the current study reported a decrease in depressive symptoms. This section considers alternative explanations for this finding. In other words, this section answers the question, what else may have caused the

reduction in depression? While these explanations are applicable to psychotherapeutic research in general, it is necessary to consider them.

Alternative explanation 1: Hawthorne effect. In the current study, retirees signed up to participate in a research study on retirement and depression. The Hawthorne effect would suggest that research participants' depressive symptoms improved not due to the implementation of the IPT-RM treatment, but simply because their behaviour was being observed. The assumption is that when people are receiving attention and know they are being monitored, their performance changes. Future studies testing this treatment manual could rule out the Hawthorne effect with a comparative design utilising a control group.

Alternative explanation 2: Dodo bird hypothesis. The dodo bird hypothesis suggests that changes seen in psychotherapeutic research are due to common factors employed by therapists, as opposed to the actual intervention. For example, developing rapport with the client, creating a positive therapeutic alliance, and the use of microskills (e.g., empathy, reflective listening, and asking open questions) are common factors. While these are essential ingredients for creating a working relationship between the therapist and client, it is conceivable that the active ingredients of the treatment intervention (e.g., reconciliation of the old and new roles, strengthening of the social support network, learning new skills to cope with the new role, developing a retirement routine, and creating sources of meaning and self-esteem) accounted for greater improvement than these common factors. This alternative explanation can only be discounted, however, in a future experimental design with a treatment comparison group.

Alternative explanation 3: Client expectations. Some psychotherapeutic research suggests that a client's positive expectations for improvement may cause changes in the treatment outcomes as opposed to the actual intervention being the cause of change (Kuusisto, Knuuttila, & Saarnio, 2011). A study comparing CBT with IPT in the treatment of bulimia nervosa found a correlation between client expectations and the therapeutic alliance (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000). The greater the client's expectations for improvement, the better quality of therapeutic alliance had been established. Measures of client expectations and therapeutic alliance were not taken in the present study. Future trials of the IPT-RM treatment manual could incorporate such measures to assess the validity of this alternative explanation.

Alternative explanation 4: Learning effects. Repeated measures are essential in psychotherapy research, but can also pose a liability. It is possible for research participants to learn from repeated exposure to questions which can result in altered responses. Several problems are that repeated measures can interact with experimenter bias, pleasing the

therapist, and learning effects. An alternative method was to use different measures of the same constructs across assessment times and then counterbalance those across participants. Given that this was a pilot study and only a small number of participants were employed, consistency in administration of measures was deemed a more suitable option so that results could be compared. As an alternative explanation for the findings in this research, learning effects seem unlikely. The time intervals between completing the measures meant that research participants were unlikely to recall their prior responses (a total of 62 questions were answered each time) to manipulate their responses. Furthermore, congruent behavioural changes were seen across measures. For example, depressive symptoms improved on the GDS-15 and DASS21, social and psychological domains on the WHOQOL-BREF improved, and retirement satisfaction reportedly increased on the Retirement Satisfaction Inventory. It is unlikely that this pattern was manipulated by all nine research participants.

Summary. The current study found that research participants' retirement related depression decreased over the duration of the study. Due to the design of the study, a claim that the IPT-RM treatment caused the improvements in depressive symptoms cannot be made. Several alternative explanations for the findings of improved depressive symptoms were considered. The limitations of the current study will now be acknowledged.

Limitations

Several methodological limitations will be discussed in this section covering design, data collection, measures, and treatment adherence.

Design. The greatest limitation was in the study's non-experimental design. The design utilised a series of independent baselines followed by treatment intervention. As has been noted on several occasions, a lack of experimental manipulation means that no cause and effect relationship can be established.

Data collection. The results are limited by the amount of data collected. Instead of having just one data point in the baseline phase, at least three would have been better. Three data points would enable a stable baseline of mood to be established, which would provide a more sound contrast to the intervention phase. Another limitation was that data were collected at the beginning, middle, and end of treatment. While this is quite common in pilot studies (Grote et al., 2004; Koszycki, Lafontaine, Frasure-Smith, Swenson, & Lesperance, 2004; Swartz et al., 2006), administration of weekly measures would provide information about the change process across treatment. Finally, only one follow-up measure, four weeks after treatment concluded, was taken. Depression is an illness that has a high relapse rate (Richardson & Barusch, 2006), so a brief follow-up period of four weeks is inadequate to determine whether

or not relapse occurred. Tracking over several years would be ideal, but this was not possible given the time constraints of the current study.

Measures. The inclusion of an interview based structured assessment would add rigour to the findings. The present study utilised self-report measures (i.e., GDS-15, DASS21, and WHOQOL-BREF). While these are valid measures, in a research protocol an instrument such as the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) would render the screening process more rigorous. The principal investigator learned too late that the SCID-I is used in treatment research (e.g., Jill et al., 2005) and that it would enable comparison across studies.

Treatment adherence. Basic treatment adherence (i.e., treatment integrity and therapist competence) was conducted. A previously established IPT measure was used for the present study (Hill, O'Grady, & Elkin, 1992). Given that IPT-RM is an adaption of standard IPT, however, a treatment adherence scale adapted for IPT-RM would have more accurately reflected the active ingredients of the treatment manual. The addition of interrater reliability scores would have also enhanced the study's rigour. The present study was limited by resources to incorporate an interrater reliability assessment process. It was initially thought that someone from the supervision team would conduct the interrater reliability; however, a supervisor would not be independent from the research process. Stuart (2011) developed an instrument that could be used to measure treatment adherence. It is available on the Interpersonal Psychotherapy Institute's website (<http://iptinstitute.com/wp-content/uploads/2011/09/IPT-Quality-Adherence-Scale-9-6-11.pdf>). After the measure is validated, it could be a useful tool for IPT research.

Practical Implications and Recommendations

Practical Implications

This section discusses how the results of the current study may be practically applied. Recommendations for further studies will then be discussed.

Prevention. Preventative measures can be implemented to avoid or lessen the impact of problems in adjusting to retirement that cause depression. From prior and current research findings, it is known that certain contexts surrounding retirement may act as risk or protective factors in the adjustment to retirement. The problem is that workers may be unprepared for the psychological impact of retirement. A practical application of this research is to use the treatment manual to develop a program to educate workers about retirement adjustment. Raising workers' awareness of potential problems and equipping them with skills and knowledge prior to retirement may be a useful strategy for preventing future adjustment problems.

Several strategies could be developed. (i) Workshops. A face-to-face psychosocial retirement preparation program could be delivered. It would present theoretical concepts but emphasise practical activities that help workers consider psychological issues of the retirement transition. This would give workshop participants an opportunity to think through issues that they otherwise would not explicitly consider. In doing so, the participant may be psychologically prepared for the retirement transition and avoid the pitfalls leading to depression due to retirement maladjustment. (ii) Self-paced learning. A psychosocial retirement preparation program could be delivered in other formats, such as via the internet, DVD, and print media. These alternative media formats could assist remote and rural workers who are unable to attend a face-to-face program.

A proposed example of a psychosocial retirement preparation program: (i) theoretical discussion covering (a) work and the needs it fulfils, (b) Atchley's six phase model of retirement, and (c) warning signs of depression and anxiety and where to go to for help, and (ii) practical issues for a psychologist to facilitate through activities (see Table 13).

It is recommended that such a program be evaluated in a research context. Ideally, the participants would be tracked pre- to post-retirement for at least five years to determine if retirement maladjustment has been prevented. A foreseeable problem is that maturation effects may threaten the internal validity of the study and make it difficult to conclude that the intervention had an effect.

Several opportunities exist for psychologists to access workers to educate them about psychosocial retirement preparation. It is recommended that superannuation providers, seniors and retirement organisations (e.g., Council on the Ageing, the Retirement Village Association, and Alliance for Retired Americans), employers, and *beyondblue* be targeted to disseminate information and provide courses. As an organisation to assist people with depression, *beyondblue* has an informative booklet for consumers titled *Taking Care of Yourself After Retrenchment or Financial Loss* (2008). The current study could usefully inform the development of a similar booklet targeted at workers as a prevention strategy and at retirees as an intervention strategy.

Intervention. A second practical implication of the current study is in the training of therapists. The IPT-RM treatment manual could be used to educate therapists and workplace counsellors, in particular, about retirement. Regardless of a therapist's treatment modality, being informed about retirement and its incumbent issues may enable them to better help their clients. The importance of therapists having knowledge on ageing issues, and retirement in particular, is now of vital importance given the large numbers of Australians who are ageing and potentially seeking the services of psychologists.

Future Research

Stage 2 treatment manual development. The IPT-RM treatment manual is now at Stage 1 of evidence-based treatment manual development. It is ready for further testing. Several recommendations for its future testing are:

- have the IPT-RM treatment manual undergo the expert-systems approach so that several independent reviewers evaluate it and provide constructive feedback;
- follow the Carroll and Rounsaville (2008) guidelines for testing the manual at Stage 2 of treatment manual development
- research sample: (a) utilise a larger sample size. Yon and Scogin (2007) considered a sample of at least 30 participants adequate to classify the treatment as evidence-based; and (b) utilise broader demographics than those in the current study, including retirees from culturally diverse backgrounds. In 2009, the Australian Bureau of Statistics (2010) estimated that 35.5% of the 2,914,902 Australians aged over 65 years were born overseas, so in order to offer culturally sensitive therapy, this manual needs to be tested with culturally and linguistically diverse retirees; and
- address the limitations of the current study by including a treatment adherence scale specific for IPT-RM, a health scale, and a structured interview for screening.

Testing the manual at a Stage 2 level of development under experimental conditions could enable cause and effect conclusions to be drawn. The manual will then need to be tested under Stage 3 conditions (see Carroll and Rounsaville, 2008 for details) before being classified as an evidence-based treatment and be suitable for widespread dissemination. Putting a treatment manual through these rigorous processes is crucial for optimal client outcomes.

Retirement adjustment scale. An instrument could be developed to determine which retirees are at risk for retirement maladjustment. As with the Holmes and Rahe (1967) research on stressful life events and illness, the pathways to retirement could be weighted as protective and risk factors. For example, if considering the timing of retirement, a calculation may be:

Gradual retirement	+ 1 weighting (protective factor)
Expected, sudden retirement	- 2 weighting (risk factor)
Unexpected, sudden retirement	- 5 weighting (risk factor)

Each pathway would be assigned a weighted value dependent upon the predicted psychological impact on the retiree in their adjustment to retirement. The scores would then determine the predicted degree of risk for maladjustment. Future research could explore the utility of such an instrument.

Conclusion

Australia's population is ageing rapidly. The over 65 age group is swelling at never before seen rates because the first of the baby boomers turned 65 in 2011. Sixty-five is considered to be the age of retirement, but is likely to become 67 for Government age pension eligibility. The problem faced by society is that, while most workers adjust well to retirement, research suggests that about 30% of retirees experience psychological difficulties in their adjustment to retirement. Psychologists can expect to see an increasing number of older adults requesting their services, but no evidence-based treatment was identified prior to this study to address retirement related depression. Much research has been conducted about the various pathways leading to retirement, but very little has been done in the area of intervention.

The present research sought to fill this gap. Firstly, a treatment manual was developed that was based on evidence-based practice and research. IPT was chosen to be adapted as it was considered to be developmentally appropriate for the target population. The development of the treatment manual was based on Carroll and Rounsaville's (2008) guidelines for a Stage 1 manual. Secondly, a pilot study was conducted to test the feasibility of the treatment. Individual psychotherapy was conducted with nine research participants who had been retired for less than four years (median three years). A series of single-case independent baselines followed by an intervention phase were conducted. This research design was chosen as its use is advocated by treatment researchers as an efficient way to test the feasibility of a new psychotherapy (Lundervold & Belwood, 2000; Photos et al., 2008; ter Kuile et al., 2009). Validated measures were administered five times during the study to monitor changes in mood and quality of life. Finally, the treatment manual was updated to incorporate clinical knowledge derived from implementing the intervention.

The results of the pilot study suggested that IPT-RM is a potential treatment for retirement related depression. Research participants' depression decreased during the study and all research participants remained depression free at follow-up. In general, research participants found IPT-RM treatment to be highly tolerable. An unexpected finding was that treatment dosage ranged from six to 12 Sessions for non-complex cases. For two complex cases, treatment dosage was up to 20 Sessions. The study is limited by its non-experimental design, so claims of causality cannot be made.

The findings of the current study could be used for practical purposes. For example, a psychosocial retirement prevention program for delivery via workshop, internet, DVD, and print media could be developed. It could also be used to inform therapists about retirement related issues to facilitate therapeutic work with clients experiencing these issues. Opportunities for future studies exist. Testing the IPT-RM treatment manual at Stage 2 level of

treatment manual development under experimental conditions would be the next logical step. Furthermore, there may be a benefit in developing a scale to identify retirees at risk for retirement maladjustment.

Epilogue

The overarching goal of this dissertation was to enable retirees to enjoy their retirement years. Retirement is a major life transition that can unexpectedly create psychological disequilibrium. For some retirees, this leads to depression.

No evidence-based treatment was identified that was tailored to the retirement transition. Given the complexity of this transition and the necessity to be sensitive to developmental issues, a tailored treatment was warranted. The current study adds to the body of knowledge by testing the feasibility of an adapted IPT treatment. Helping retirees to recover from depression means they have greater opportunity to enjoy their retirement years and reach the end of their lives with integrity.

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Tables

Table 1

Summary of the Pathways to Retirement with Commentary

Pathway to Retirement	Summary	Empirical Evidence	Systemic Opportunities to Enhance Retirement Adjustment
Situational Factors			
Degree of control over timing	Workers choice about the timing of retirement varies considerably, ranging from zero choice to complete choice. Workers with high choice tend to adjust better and report greater satisfaction in retirement. They are also more likely to report other benefits in regard to health, marital satisfaction, happiness, and finances. Workers with low choice tend to report the opposite effects: they may be less well-adjusted with lower satisfaction in retirement, and adverse effects on health may be reported, along with a return to the workforce.	(Calvo et al., 2009; de Vaus & Wells, 2004; de Vaus et al., 2007; Donaldson et al., 2010; Quine et al., 2007; Tordera et al., 2010; van Solinge, 2007; van Solinge & Henkens, 2005, 2008)	Employers and Government policy can help retirees adjust easier and have positive psychological outcomes by facilitating personal choice as to when the worker retires.
Suddenness of retirement	A retiree may have an immediate and complete withdrawal from the workforce or enter a period of reduction in hours before complete cessation of work. A worker who has had choice in the mode of exit and time to prepare for it is more likely to report a better adjustment and experience more enjoyment in retirement.	(de Vaus et al., 2007; Gomez, Gunderson, & Luchak, 2002; Schlossberg, 1981)	Enable workers to choose whether they want to reduce their hours or responsibilities before retiring, or have an immediate departure from work.
Reasons for retirement	Workers who retire for high choice reasons (e.g., wanting to pursue other interests or having enough money to stop work) report better adjustment than workers with low choice reasons (e.g., physically	(Markert, 2008; Quick & Moen, 1998; Robinson et al., 2010; van Solinge & Henkens, 2007; Warren, 2006)	Help workers to perceive they are moving toward something in retirement (e.g., a higher purpose goal) rather than away from something, so they perceive the reason for retirement as their

Pathway to Retirement	Summary	Empirical Evidence	Systemic Opportunities to Enhance Retirement Adjustment
	incapable of continuing to work). Retiring under restrictive circumstances may lead the worker to perceive their retirement as involuntary or forced.		choice.
Timing	Workers may retire on-time or off-time based on social norms and individual preferences. The eligibility age to receive a Government pension influences the socially normed age for retirement. Individuals may hold a preferred age to retire that is different to the social norm. Research indicates that workers retiring after the age of 65 rate their satisfaction with retirement lower than those retiring before this age. Furthermore, if a worker's preferred age for retirement is different to their actual age of retirement, it may affect the retiree's adjustment to and satisfaction with retirement.	(Humpel et al., 2009; Quick & Moen, 1998; Tordera et al., 2010; van Solinge & Henkens, 2007; Zappalà et al., 2008)	Positive ageing policies and strong managerial support in the workplace that provides flexibility and freedom to older workers in regard to the timing of their retirement may assist adjustment.
Planning	Most workers intend to retire. As workers age, they tend to become more involved in planning and saving for their retirement. Conducting financial and lifestyle planning is likely to help workers feel prepared and, therefore, adjust easier to retirement, have greater wellbeing, and fewer regrets in retirement.	(Donaldson et al., 2010; Ekerdt et al., 2001; Ekerdt et al., 2000; Hershey, Henkens, et al., 2007; Humpel et al., 2009; Moen et al., 2005; Phua & McNally, 2008; Siegrist et al., 2007; Taylor & Shore, 1995; Tordera et al., 2010; Zaniboni et al., 2010)	Although workers tend to become more active in planning and saving the closer they get to retirement age, encouraging and offering retirement preparation programs at younger ages may facilitate retirees' adjustment to, and satisfaction with, retirement.
Experiencing multiple life	Common life events that occur around retirement	(Calvo et al., 2009; Davies,	Avoid relocation around the time of retirement

Pathway to Retirement	Summary	Empirical Evidence	Systemic Opportunities to Enhance Retirement Adjustment
events simultaneously	include relocation, death of a spouse, illness of self or other, caregiving, and financial losses. Experiencing a series of losses simultaneously can stretch coping resources and create distress. Enjoyment of, and wellbeing in, retirement may be negatively impacted.	2003; Department of Health and Ageing, 2007; Price & Nesteruk, 2010; Warren, 2006)	and seek psychological support to enhance coping as necessary.
Structural Factors			
Financial resources	Retirees are financially supported in a range of ways, including Government pensions, superannuation, and private savings. The Australian Government has incentives to encourage workers to delay their retirement. Retirees with higher pre-retirement incomes tend to report being better adjusted. Retirees with lower pre-retirement incomes tend to report greater disadvantages, such as fewer financial resources, less financial knowledge, engagement in less planning, adjustment problems, and greater unhappiness. Workers equipped with financial knowledge and skills tend to put these to use by saving more money. Couples who have adequate incomes tend to report greater marital satisfaction and less conflict in marriage.	(Australian Government Treasury, 2004; de Vaus & Wells, 2004; Department of Health and Ageing, 2007; Dew & Yorgason, 2010; Donaldson et al., 2010; Hershey, Henkens, et al., 2007; Hershey & Mowen, 2000; Hershey et al., 2003; Loewenstein et al., 1999; McDonald & Donahue, 2000; Smith & Moen, 2004)	Equip workers with financial knowledge and skills, so they may actively plan and save for their financial security in retirement. Focus on attracting lower income earners to pre-retirement preparation programs.
Family structure	Caring for relatives, such as siblings, parents, children, grandchildren, or a spouse in retirement can affect life	(Marshall et al., 2001; Sterns & Huyck, 2001; Walajtsy, 2007)	Provide social support services to grandparents who have fulltime parenting

Pathway to Retirement	Summary	Empirical Evidence	Systemic Opportunities to Enhance Retirement Adjustment
	satisfaction. Retirees may need to return to work to financially support grandchildren.		responsibilities of grandchildren.
Education	Workers with higher education are advantaged in several ways: they are more likely to have financial knowledge and actively apply it to retirement planning, they are more likely to remain in the workforce longer at higher rates of pay, and potentially they have a better adjustment to retirement given their greater availability of resources.	(Lusardi & Mitchell, 2006; Merkes, 2003; Moen et al., 2005; Price, 2003; Price & Joo, 2005)	Equip workers with financial knowledge and target workers with lower levels of education.
Location	Retirees living in larger communities typically have access to courses and seminars offered by a variety of institutions. Retirees living in smaller communities may be disadvantaged as they have less access to these opportunities, including health care services. They also tend to earn less while in the workforce. However, rural retirees tend to become more involved, formally and informally, in community activities which contribute positively to retirement satisfaction. Further, there are increasing opportunities to undertake external study courses.	(Dorfman, 1989, 1998; Humpel et al., 2009)	An opportunity exists to deliver retirement preparation programs via the internet for regional, rural, and remote communities.
Gender	Retirement is a gendered experience. Women typically have interrupted careers, work fewer hours, and earn less pay for the same work than men. Less work and less money means fewer opportunities to save	(Ekerdt et al., 2001; Hershey, Henkens, et al., 2007; Hodes & Suzman, 2007; Humpel et al., 2009; Merkes, 2003; Moen et al.,	Social change needs to occur so that women receive equal pay for equal work. Retirement preparation programs can seek to attract women and design programs around their

Pathway to Retirement	Summary	Empirical Evidence	Systemic Opportunities to Enhance Retirement Adjustment
	for retirement, so women may feel insecure about their financial circumstances in retirement. Married women are typically better off financially compared with other marital status groups, although women in general may have a more difficult time adjusting to retirement. Women also tend to plan less and have greater uncertainty about their retirement plans.	2005; Quick & Moen, 1998; van Solinge & Henkens, 2005, 2008; Warren, 2006)	needs.
Social integration	Social interaction is important for wellbeing and work is a major source of social contact. Social interaction becomes especially pertinent at retirement because leaving the workforce commonly results in an ending of many collegial relationships. Retirees may have a harder time adjusting to retirement if they lack social support resources. Some retirees return to work partly for social contact. Women are more likely to see retirement as an opportunity to increase social contact beyond their working lives.	(Carter & Cook, 1995; de Vaus & Wells, 2004; Diener & Seligman, 2004; Jonsson et al., 2001; Price & Joo, 2005; Taylor et al., 2008; Walajtys, 2007)	Retirement planning must include consideration of the impact of retirement on the worker's social network. Efforts can be made prior to retirement to develop networks of friends outside of work, which will often tap into the worker's interests, such as sports, hobbies, religion, and volunteer work. Since many relationships with colleagues end when the worker retires, consciously developing these relationships outside of work hours may help to maintain them upon retirement.
Age	Australia has a rapidly increasing ageing population. Adjusting to retirement has less to do with a retiree's chronological age, but more to do with the circumstances surrounding their transition. The older a worker gets the more planning he or she is likely	(de Vaus & Wells, 2004; Department of Health and Ageing, 2007; Moen et al., 2006; Schlossberg, 1981)	Different generations may have difference experiences of retirement and more research is needed to fully understand these differences to be able to address specific needs in pre-retirement preparation programs.

Pathway to Retirement	Summary	Empirical Evidence	Systemic Opportunities to Enhance Retirement Adjustment
	to have done, suggesting that retirement carries a greater imperative the closer to retirement age the worker gets		
Health	Workers retiring due to poor health tend to retire at earlier ages and have lower retirement incomes. Retirees in good health typically report greater satisfaction and adjustment to retirement.	(Brown & Warner, 2008; de Vaus & Wells, 2004; Donaldson et al., 2010; Loewenstein et al., 1999; McDonald & Donahue, 2000; Moen et al., 2005; Smith & Moen, 2004)	Help workers to have more disability free years by providing opportunities for education and enhanced wellbeing.
Work factors	Work factors, including occupational status, may influence the retirement experience. Retirees who had stressful, demanding, dissatisfying work roles or environments tend to see retirement as a relief and experience improvements in satisfaction after retiring. Compared with retirees who held lower status jobs, retirees who held high status jobs tend to experience improvements in wellbeing and satisfaction in retirement.	(de Vaus & Wells, 2004; Jonsson et al., 2001; Moen et al., 2006; Quick & Moen, 1998; Shaw et al., 1998; Vaillant et al., 2006; van Solinge, 2007; Wong & Hardy, 2009)	Employers may be able to support workers experiencing occupational stress by improving work conditions and providing wellness benefits (e.g., an onsite gym, massage, providing fresh fruits) to promote greater wellbeing in retirement.
Bridge employment	Retirees may return to work after retiring. The kind of work done may or may not be in their pre-retirement field. They may work parttime or fulltime. Men seem more likely to return to work than women. If retirees are going to undertake bridge employment, they tend to do so after the 12 month honeymoon period has expired. Retirees may return to work for a variety	(Jonsson et al., 2001; Reitzes & Mutran, 2004; Walajtys, 2007; Wang et al., 2008)	Pre-retirement preparation programs need to include lifestyle planning. Workers need to think about how they will structure their time and derive meaning out of life. Volunteer work and group activities are often excellent sources of both meaning and opportunities for socialisation. Employers can create opportunities for retirees to work in

Pathway to Retirement	Summary	Empirical Evidence	Systemic Opportunities to Enhance Retirement Adjustment
	of reasons. These include financial, increasing opportunities to socialise, and to provide meaning and structure to their lives.		age friendly environments for those wishing to work in retirement.
Personal Factors			
Retirement expectations	Retirement anxiety may result when a worker has negative expectations about retirement. Retirement optimism may result when a worker has positive expectations about retirement. Generally, expectations are a self-fulfilling prophecy as workers who hold negative expectations are more likely to experience difficulties adjusting and feel less satisfied with their retirement. On the other hand, workers who hold positive expectations are more likely to have an easier adjustment and feel more satisfied with their retirement.	(de Vaus & Wells, 2004; Fouquereau et al., 2005; Marshall et al., 2001; Taylor et al., 2008; van Solinge, 2007; van Solinge & Henkens, 2005; Walajtys, 2007)	Pre-retirement preparation programs can help workers to reduce anxiety and enhance optimism about the transition by developing realistic expectations for retirement and providing an opportunity to discuss concerns.
Identity	Identity is actively created by the individual and provides a sense of unity and purpose. A worker acquires the identity of retiree upon leaving the workforce. Adjustment appears to be facilitated when the occupational identity is reordered to a lower importance. Alternative identities, such as spouse, parent, friend, or volunteer may facilitate adjustment. Some workers from high status occupations may have a more difficult time with the process of shifting identities in retirement.	(Moen, 1996; Price, 2003; Reitzes & Mutran, 2006; Richardson, 2009; Ritter et al., 1999; Smith & Moen, 2004; Walajtys, 2007)	Pre-retirement preparation programs may facilitate psychological preparation for the process of change that occurs with a worker's identity in retirement. It may be difficult for a worker to predict the impact of an identity change on their wellbeing, but increasing awareness may ease the transition.
Marriage	Marriage can be an asset or	(Davey &	Pre-retirement couples

Pathway to Retirement	Summary	Empirical Evidence	Systemic Opportunities to Enhance Retirement Adjustment
	liability to retirement adjustment. Married women, compared with divorced women, tend to be happier and healthier. Marital cohesion is a resource and retirees who like spending time with their partner tend to be better off. Workers may feel anxious about how retirement will affect their marital relationship with specific concerns around how the couple will relate and spend time together. While about 50% of couples prefer to retire jointly, only about 25% actually do. Retired husbands whose wives continue to work tend to report greater dissatisfaction.	Szinovacz, 2004; de Vaus & Wells, 2004; Hilbourne, 1999; Ho & Raymo, 2009; Kim & Moen, 2002; Kulik, 2001; Kupperbusch, Levenson, & Ebling, 2003; Moen et al., 2005; Price & Joo, 2005; Smith & Moen, 2004; Szinovacz & Davey, 2004; van Solinge & Henkens, 2005)	may benefit from open discussion about how retirement might affect their relationship and about the use of time and space in the house. If retired couples are experiencing conflict, couples counselling may be helpful.
Job satisfaction and work ethic	Not a lot of research has been done in this area. The assumptions yet to be fully tested are: (a) workers with high job satisfaction may remain in the workforce longer and be more likely to create satisfying retirements, and (b) workers with a strong work ethic may have a harder time adjusting to retirement if they are overcommitted to the work role.	(Atchley, 2004; Carter & Cook, 1995; de Vaus & Wells, 2004; Department of Health and Ageing, 2007; van Solinge & Henkens, 2005)	Workplaces may be able to nurture workers' satisfaction with their jobs and provide an age friendly working environment.
Interests and leisure activities outside work	Workers typically continue into retirement the activities they were involved in during their working life. Retirees who participate in activities tend to adjust better as they have opportunities for socialisation, some of their time is structured, and it may provide a sense of	(Berger et al., 2005; Forman-Hoffman et al., 2008; Graham, 1992; Pushkar et al., 2010; Smith, 2004)	Plan for interests and leisure activities in retirement. This is especially important for the retiree who lives alone as they need to actively create social opportunities.

Pathway to Retirement	Summary	Empirical Evidence	Systemic Opportunities to Enhance Retirement Adjustment
Personality	<p>belonging. The number and amount of activity may decrease over time, especially if health problems arise. Retirees make a valuable contribution to society through volunteering, which may form an important part of some retiree's lifestyles.</p>	<p>(Carter & Cook, 1995; Donaldson et al., 2010; Gall et al., 1997; Hershey, Jacobs-Lawson, et al., 2007; Hershey & Mowen, 2000; MacLean, 1983; Reis & Gold, 1993; Robinson et al., 2010)</p>	<p>Pre-retirement preparation programs could be tailored to meet individual's needs. Specifically, a worker who measured low on mastery, self-efficacy, conscientiousness, and high on neuroticism with an external locus of control could be targeted for special intervention given that they may be more vulnerable to a difficult retirement adjustment. Help with planning – financial, social, and psychological – and developing confidence to deal with the transition may be particularly useful.</p>

Table 2

*Objectives for Developmental, Structured Group Intervention for Retirement Transitions
Counselling (from Tinsley & Bigler, 2002, p. 380)*

-
1. Increase your awareness of myths and stereotypes regarding ageism, sexism, and other isms in American culture.
 2. Identify attitudinal blocks and other potential barriers to effective retirement planning.
 3. Learn about a model for dealing effectively with change.
 4. Clarify your understanding of retirement planning tasks.
 5. Learn more about your interests, skills, and personal strengths and the relation of these to potential future roles.
 6. Develop optimism about your ability to handle your changing life roles and responsibilities.
 7. Learn how to create optimally challenging opportunities in your life.
 8. Evaluate your preferences for geographic location and living arrangement.
 9. Assess your social networks and develop new networking techniques.
 10. Explore issues of loss and learn effective strategies for dealing with loss.
 11. Develop your financial management plans.
 12. Develop plans to improve and maintain your physical health and spiritual well-being.
 13. Explore safety issues related to the changes associated with growing older.
 14. Develop your plans and ability to [specify].
-

Table 3

General Outline for a Stage I Manual (from Carroll & Rounsaville, 2008, p. 227-9)

Section	Content area	Issues to be addressed
I. Overview, description, and rationale	A. General description of the approach	Overview of treatment and goals
	B. Background and rationale for the treatment	Theoretical rationale; Empirical underpinnings of treatment; Rationale for application of this treatment to this population
	C. Theoretical mechanism of action	Brief summary of hypothesized mechanisms of action, critical "active ingredients"
II. Conception of the disorder or problem	A. Etiological factors	Summary of treatments' conception of the forces or factors that lead to the development of the disorder in a particular individual
	B. Factors believed to be associated with behaviour change	According to treatment/theory, what factors or processes are thought to be associated with change or improvement in the problem or disorder?
	C. Agent of change (e.g., patient, therapist, group affiliation)	What is the hypothesized agent of change? Who, or what, is thought to be responsible for change in the disorder?
	D. Case formulation	What is the conceptual framework around which cases are formulated and understood?
	E. How is the disorder/symptoms assessed by the therapist?	Therapist strategy for assessment of the disorder/ problem; Specification of any standardized assessment to be used
III. Treatment goals	A. Specification and determination of treatment goals	Specification of principal treatment goals; Determination of primary versus secondary goals; Strategies for prioritization of goals, goal setting with patient;
	B. Evaluation of patient goals	Strategies the therapist uses to identify and evaluate patient goals
	C. Identification of other target behaviors and goals	Clarification of other problem areas that can be targeted as secondary goals of the treatment versus those that must be handled outside of the treatment
	D. Negotiation of change in goals	Strategies for renegotiation of goals as treatment progresses
IV. Contrast to other approaches	A. Similar approaches	What are the available treatments for the disorder or problem that are most similar to this treatment?
	B. Dissimilar approaches	What treatments for the disorder or problem are most dissimilar to this approach?
V. Specification	A. Unique and essential	What are the specific active ingredients,

of defining interventions	elements	which are unique and essential?
	B. Essential but not unique elements	What interventions are essential to this treatment but not unique?
	C. Recommended elements	What interventions or processes are recommended but not essential or unique?
	D. Proscribed elements	What interventions or processes are prohibited or not characteristic of this treatment? What interventions may be harmful or countertherapeutic in the context of this treatment?
VI. Session content	Explication of unique and essential elements	Where appropriate, detailed, session-by-session content with examples and vignettes
VII. General format	A. Format for delivery	Individual, group, family, or mixed; If group, close- or open-ended format?
	B. Frequency and intensity of sessions	How often do sessions occur? How long are sessions? How many sessions should be delivered over what period of time?
	C. Flexibility in content	Are there essential versus "elective" content areas? Is there flexibility in sequencing session content areas?
	D. Session format	Length of sessions; Guidelines for within-session structure
	E. Level of structure	Does the therapist set an agenda for each session? Is this done collaboratively? How structured are the sessions? What determines the level of structure in this treatment? Who (therapist or patient) talks more?
	F. Extra-session tasks	Are extra-session (i.e., homework) tasks part of this treatment? What is the purpose of extra-session tasks? How are specific tasks or assignments selected? How does the therapist present a rationale for the tasks? How does the therapist assess patient implementation of tasks? How does the therapist respond to the patient's completion of an assignment? How is it integrated into the work of therapy? How does the therapist respond to the patient's failure to complete an assignment?

Table 4

Demographic Details of Research Participants

Code	Sex	Age	Length Retired ¹	Health Status ²	Industry ³	Education ⁴	Married ⁵	Perceived Income Adequacy ⁶	Reason for Retiring ⁷	IPT-RM Problem Area ⁸
1	F	58	3 years	Very good	Education	Doctorate	M	1	Fear of never getting to enjoy retirement	RD, RT
2	F	68	3 years	Poor	Education	Bachelors	W	1	Care for terminally ill husband	G, RT
3	F	64	3 years	Very good	Education	Diploma	Df	1	Financially good timing	RT
4	M	67	8 months	Very good	Trade	High school	M	1	Retirement age	RT
5	M	68	2 years	Very good	Trade	High school	M	1	Retirement age	RD, RT
6	F	66	3 years	Excellent	Clerical	High school	M	1	Health	RT
7	M	71	13 months	Very good	Mining	Diploma	M	1	Health	RT
8	F	70	3 years	Very good	Health Care	Masters	M	1	Retirement age	RT
9	F	65	3 years	Good	Education	Diploma	NM	2	Wanted time to self	RT
10	M	71	2 years	Very good	Business Owner	Degree	Dv	1	Did not have the energy to continue so sold business	RT

Note. ¹ The months and years the participant had been retired at the commencement of the study. ² The participant's self-reported health status as specified on question 23 of the demographic questionnaire. ³ Industry relates to the sector that participants were employed in prior to retirement. While listing the actual occupation would be more informative, doing so may compromise confidentiality. ⁴ The highest level of education achieved. ⁵ Marital status codes: M = married, W = widowed, Df = de facto, NM = never married, Dv = divorced. ⁶ 1 = I'm comfortably off, 2 = I have just enough to get along, and 3 = I can't make ends meet. ⁷ The main reason given for the participant retiring. ⁸ Primary and secondary (if appropriate) problem area being addressed in treatment: RD = Role Dispute, RT = Role Transition, and G = Grief.

Table 5

Summary of Each Participant's Screening Results at the Initial Clinical Interview

Code	1	2	3	4	5	6	7	8	9	10
GDS-15	4	9	4	8	11	7	8	5	3	8
DASS21										
Depression	12	20	14	12	42	32	16	12	6	16
Stress	0	24	2	6	22	2	10	2	4	2
Anxiety	22	24	6	18	36	18	16	14	8	4
Negative affect	34	68	22	36	100	50	42	28	18	22
WHOQOL-BREF										
Physical	86	50	68	57	89	68	82	68	71	64
Psychological	50	33	50	63	42	58	71	54	50	58
Social	33	42	100	58	42	75	58	42	17	50
Environment	88	63	88	84	84	91	88	66	84	100
Average	64	47	76	66	64	73	75	57	56	68
MMSE	30	28	28	29	27	26	26	28	29	30

Table 6

Evaluation of the Positives and Negatives of the Worker and Retiree Roles for Keith (Code 3)

Worker Role		Retiree Role	
+	-	+	-
Good work environment	Corporate interference	Doing your own thing	At home now in wife's domain
Colleagues easy to get along with	Self-management of paperwork	Volunteer work	Organisational skills problematic
Previously, not much accountability	Call centre; no one to go to for advice	Don't have to do "obnoxious work"	Getting internal motivation
Sporting competitions, e.g., volleyball	Less personal after centralisation	Choice	Boredom watching TV and drinking coffee
Social contact, "interaction with office women"	Less friendly; installation of swipe cards and became more isolated	More control	Structuring time
Interesting projects: planning, creativity, mental stimulation	Paperwork and reporting	Feeling more relaxed and can rest when needed	
Job satisfaction	Doing jobs that were unenjoyable	Helping out at home	
	Company culture changed over time	Spending quality time with son	
		Relaxed pace of work	

Table 8

Participants' GDS-15 Scores Times 1 to 5

Code	Time 1	Time 2	Time 3	Time 4	Time 5
1	4	7	2	0	0
2	9	7	6	0	0
3	4	11	5	0	1
4	8	8	1	0	0
5	11	10	9	2	1
7	8	0	n/a ¹	0	0
8	5	5	5	1	0
9	3	0	0	0	0
10	8	7	2	3	3

Note. Time 1 = Pre-treatment clinical assessment interview; Time 2 = Beginning of treatment, Session 1; Time 3 = Mid-treatment, Session 6, Time 4 = Post-treatment, final session; and Time 5 = Follow-up four weeks after concluding treatment. ¹ This participant's treatment ceased at Session 6 due to rapid recovery and stabilised mood, hence there were no mid-treatment measures completed.

Table 9

Participants' DASS21 Scores Times 1 to 5

Code	Time 1				Time 2				Time 3				Time 4				Time 5			
	Dpn	Str	Anx	NAf	Dpn	Str	Anx	NAf	Dpn	Str	Anx	NAf	Dpn	Str	Anx	NAf	Dpn	Str	Anx	NAf
1	12	0	22	34	16	0	14	30	4	0	10	14	0	0	4	4	0	0	2	2
2	20	24	24	68	22	12	16	50	14	16	22	52	4	6	10	20	2	6	8	16
3	14	2	6	22	30	0	10	40	6	2	8	16	6	0	4	10	0	2	4	6
4	12	6	18	36	12	6	18	36	2	2	8	12	8	2	10	20	0	2	8	10
5	42	22	36	100	42	18	12	72	16	8	20	44	2	0	0	2	0	0	0	0
7	16	10	16	42	4	0	8	12	n/a ¹	-	-	-	0	4	4	8	0	2	6	8
8	12	2	14	28	10	2	14	26	8	6	16	30	0	4	4	8	0	2	4	6
9	6	4	8	18	0	0	0	0	0	0	2	2	0	0	2	2	0	0	0	0
10	16	2	4	22	14	0	0	14	6	0	0	6	4	0	0	4	4	2	2	8

Note. Dpn = depression, Str = stress, Anx = anxiety, and NAf = negative affect. Time 1 = Pre-treatment clinical assessment interview; Time 2 = Beginning of treatment, Session 1; Time 3 = Mid-treatment, Session 6, Time 4 = Post-treatment, final session; and Time 5 = Follow-up four weeks after concluding treatment. ¹ This participant's treatment ceased at Session 6 due to rapid recovery and stabilised mood, hence there were no mid-treatment measures completed.

Table 10

Participants' WHOQOL-BREF Scores Times 1 to 5

Code	Time 1					Time 2					Time 3					Time 4					Time 5				
	Ph	Ps	So	En	Av	Ph	Ps	So	En	Av	Ph	Ps	So	En	Av	Ph	Ps	So	En	Av	Ph	Ps	So	En	Av
1	86	50	33	88	64	86	50	33	86	64	82	63	58	88	73	86	83	75	100	86	93	75	83	100	88
2	50	33	42	63	47	43	38	42	69	48	39	38	33	69	45	68	71	67	75	70	71	67	58	75	68
3	68	50	100	88	76	71	29	100	88	72	75	71	100	97	86	89	71	100	97	89	89	75	100	91	89
4	57	63	58	84	66	57	50	58	84	62	75	71	50	84	70	79	79	75	84	79	93	79	75	88	84
5	89	42	42	84	64	75	46	33	94	62	93	50	58	91	73	82	54	58	75	67	79	67	67	75	72
7	82	71	58	88	75	96	79	67	94	84	n/a ¹	-	-	-	-	86	88	67	91	83	93	92	83	100	92
8	68	54	42	66	57	64	50	42	63	55	61	67	50	72	62	75	71	67	72	71	79	75	67	81	75
9	71	50	17	84	56	68	71	33	75	62	71	75	67	84	74	82	96	83	94	89	86	79	83	94	85
10	64	58	50	100	68	71	63	83	100	79	79	63	83	100	81	86	71	92	100	87	86	88	83	100	89

Note. Ph = Physical, Ps = Psychological, So = Social, En = Environmental, and Av = Average. Time 1 = Pre-treatment clinical assessment interview; Time 2 = Beginning of treatment, Session 1; Time 3 = Mid-treatment, Session 6, Time 4 = Post-treatment, final session; and Time 5 = Follow-up four weeks after concluding treatment. ¹ This participant's treatment ceased at Session 6 due to rapid recovery and stabilised mood, hence there were no mid-treatment measures completed.

Table 11

Participants' Retirement Satisfaction Scores Pre-Treatment and Follow-Up

Code	Time 1	Time 5
1	3	6
2	1	4
3	4	6
4	4	5
5	1	5
7	3	5
8	4	5
9	4	5
10	3	4

Note. Time 1 = Pre-treatment clinical assessment interview and Time 5 = Follow-up four weeks after concluding treatment. Item number 51 on the Retirement Satisfaction Inventory (Floyd et al., 1992) asks, "Overall, how satisfied are you with your retirement right now?" The Likert 6-point scale response options were: 1 = very dissatisfied, 2 = dissatisfied, 3 = somewhat dissatisfied, 4 = somewhat satisfied, 5 = satisfied, and 6 = very satisfied.

Table 12

Participants' Treatment Satisfaction Ratings at Follow-Up¹

Code	Question 1 ²	Question 2 ³	Question 3 ⁴	Question 4 ⁵	Question 5 ⁶
1	4	4	4	4	4
2	4	4	4	3	4
3	4	4	4	4	4
4	4	4	4	3	4
5	3	4	3	3	4
7	4	4	4	4	4
8	4	4	3	3	4
9	4	4	4	4	4
10	4	4	4	3	4

Note. ¹ Follow-up was four weeks after the conclusion of treatment. ² Participants were asked for written feedback to five questions. How would you rate the quality of service you received from this therapist? The Likert 4-point scale response options were: 1 = poor, 2 = fair, 3 = good, and 4 = excellent. ³ How well do you feel that the therapist understood your problem(s)? The Likert 4-point scale response options were: 1 = no understanding, 2 = limited understanding, 3 = reasonably well, and 4 = very well. ⁴ Have the services you received helped you to deal more effectively with your problems? The Likert 4-point scale response options were: 1 = no, they seemed to make things worse, 2 = no, they didn't really help, 3 = yes, they helped somewhat, and 4 = yes, they helped a great deal. ⁵ To what extent has our service met your needs? The Likert 4-point scale response options were: 1 = none of my needs were met, 2 = some of my needs have been met, 3 = most of my needs have been met, and 4 = all of my needs have been met. ⁶ If a friend were in need of similar help, would you recommend our program to him/her? The Likert 4-point scale response options were: 1 = no, definitely not, 2 = no, I don't think so, 3 = yes, I think so, and 4 = yes, definitely.

Table 13

Proposed Example of a Psychosocial Retirement Preparation Program

Factors	Pathway to Retirement	Practical Issues to Workshop Through Activities
Situational	Degree of control over timing	<ol style="list-style-type: none"> 1. Psychoeducation: the timing of your retirement may be outside your control. If the timing of your retirement is forced, what can be done about it? 2. Psychoeducation: discuss objective and subjective retirement timing. What age do you prefer, expect, and intend to retire?
	Suddenness of retirement	<ol style="list-style-type: none"> 1. Will you withdraw from the workforce gradually or abruptly? What impact will this choice have on you? 2. Will your current employer permit a gradual withdrawal?
	Reasons for retirement	<ol style="list-style-type: none"> 1. Why retire? Are your reasons for retirement restrictive or unrestrictive? 2. For the restrictive circumstances, how can these be reframed so they are perceived positively?
	Planning	<ol style="list-style-type: none"> 1. How much planning (financial and lifestyle) have you done? What planning is left to be done?
	Experiencing multiple life events simultaneously	<ol style="list-style-type: none"> 1. Psychoeducation: other major life events sometimes occur at the time of retirement, e.g., illness (self or family member), death, financial losses, and relocation. It is recommended that major decisions be delayed for at least 12 months while adjusting to retirement. 2. What major life events do you predict could occur at the time of your retirement?
Structural	Financial resources	<ol style="list-style-type: none"> 1. How do you expect your consumption (e.g., entertainment, luxury purchases, household expenses etc) to change once retired? 2. One person in the couple may manage the household's finances. Does a system need to be set up so that both parties know how to manage the finances?
	Family structure	<ol style="list-style-type: none"> 1. How will your retirement impact your family? 2. What family opportunities exist (e.g., social, financial)? What expectations might your family place on you?
	Location	<ol style="list-style-type: none"> 1. What opportunities for retirees exist where you live? For example, free or discount social activities, fitness, and hobbies.
	Social integration	<ol style="list-style-type: none"> 1. Psychoeducation: people with a strong social support network cope better with stressful life situations, such as retirement. Collegial relationships typically end once a worker leaves the workplace. 2. Complete a nested-circle diagram [refer Appendix C, Document of Progress, interpersonal inventory] of your current social supports (intimate, close, and extended supports). Ask yourself, are the amount of social supports rich or sparse? Who will provide emotional and instrumental support?

Factors	Pathway to Retirement	Practical Issues to Workshop Through Activities
		<ol style="list-style-type: none"> 3. Who are your friends at work? How will these relationships be affected by your retirement? Consciously develop chosen collegial relationships by spending time together outside of work hours. 4. Who are your friends outside of work? How will these relationships be affected by your retirement? Consciously develop friendships with people outside of work networks by joining groups related to your interests. 5. Who do you plan to spend time with in retirement?
	Age	<ol style="list-style-type: none"> 1. What major life transitions have you previously experienced? What have you learnt from these that can help you adjust to retirement?
	Work factors	<ol style="list-style-type: none"> 1. What will you miss about work? 2. What will you not miss about work?
	Bridge employment	<ol style="list-style-type: none"> 1. Do you plan to work in retirement? If yes, what kind of work would you like to do?
Personal	Retirement expectations	<ol style="list-style-type: none"> 1. Psychoeducation: retirement is not like a permanent vacation. Filling time with fun activities, or no activities, may soon become unfulfilling and dissatisfying. Some people claim that workers die shortly after retiring, but research evidence does not support this. 2. What do you expect retirement to be like? What are your dreams? What have you heard from others about retirement? 3. What do you look forward to in retirement? What do you expect to be difficult about retirement?
	Identity	<ol style="list-style-type: none"> 1. How do you currently see yourself? Ask yourself, Who am I? What roles do you play? What identities do you hold? 2. Where do you get your self-esteem from while working? Where will you get your self-esteem from in retirement? 3. How will your roles, identity, and self-esteem be affected in retirement?
	Marriage	<ol style="list-style-type: none"> 1. Do you plan to retire at the same time as your partner? 2. If your partner is already retired, how will your retirement affect them? 3. Have ongoing conversations with your partner about life in retirement. For example, <ol style="list-style-type: none"> a. What are you each expecting from retirement? b. How much togetherness and personal space does each person need? c. How will each person use the space in the house? d. What will be the arrangement for the running of the household when both partners are at home?

Factors	Pathway to Retirement	Practical Issues to Workshop Through Activities
		4. If there is conflict in your relationship, what do you plan to do about the situation?
	Interests and leisure activities outside work	<ol style="list-style-type: none"> 1. What are your current interests outside of work? 2. How do you plan to spend your time in retirement? What do you imagine the structure of a typical week to look like? 3. What activities will you participate in that are (a) fun, (b) engaging, and (c) meaningful? 4. What volunteer opportunities have you considered? 5. Psychoeducation: some retirees have trouble feeling good about spending a portion of their time being unproductive. They have a 'busy ethic' whereby they feel they need to be productive to feel good about themselves. What do you like to do in your downtime? How much downtime a day is reasonable for you in retirement?

Figures

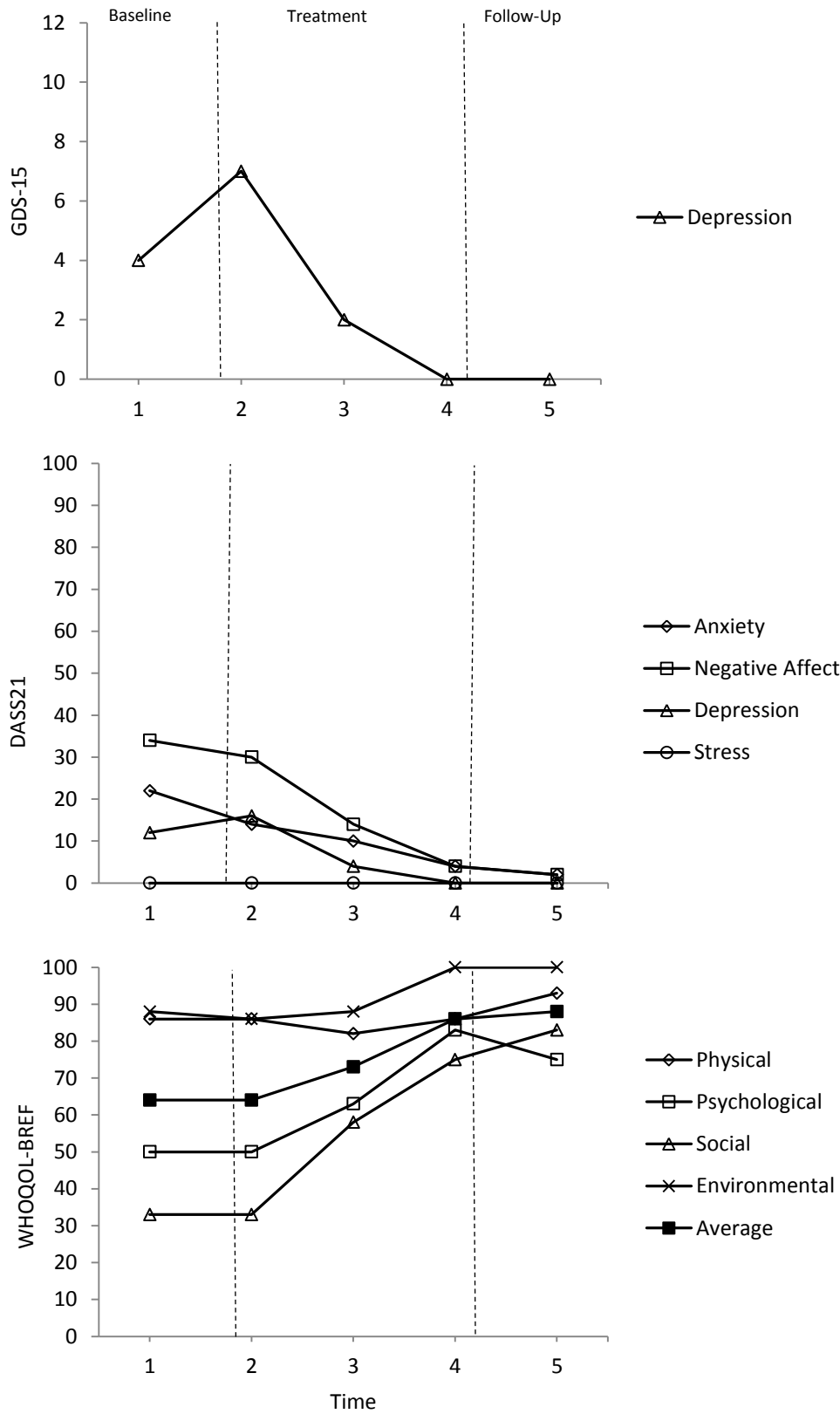


Figure 1. Results of psychological measures for participant Code 1 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

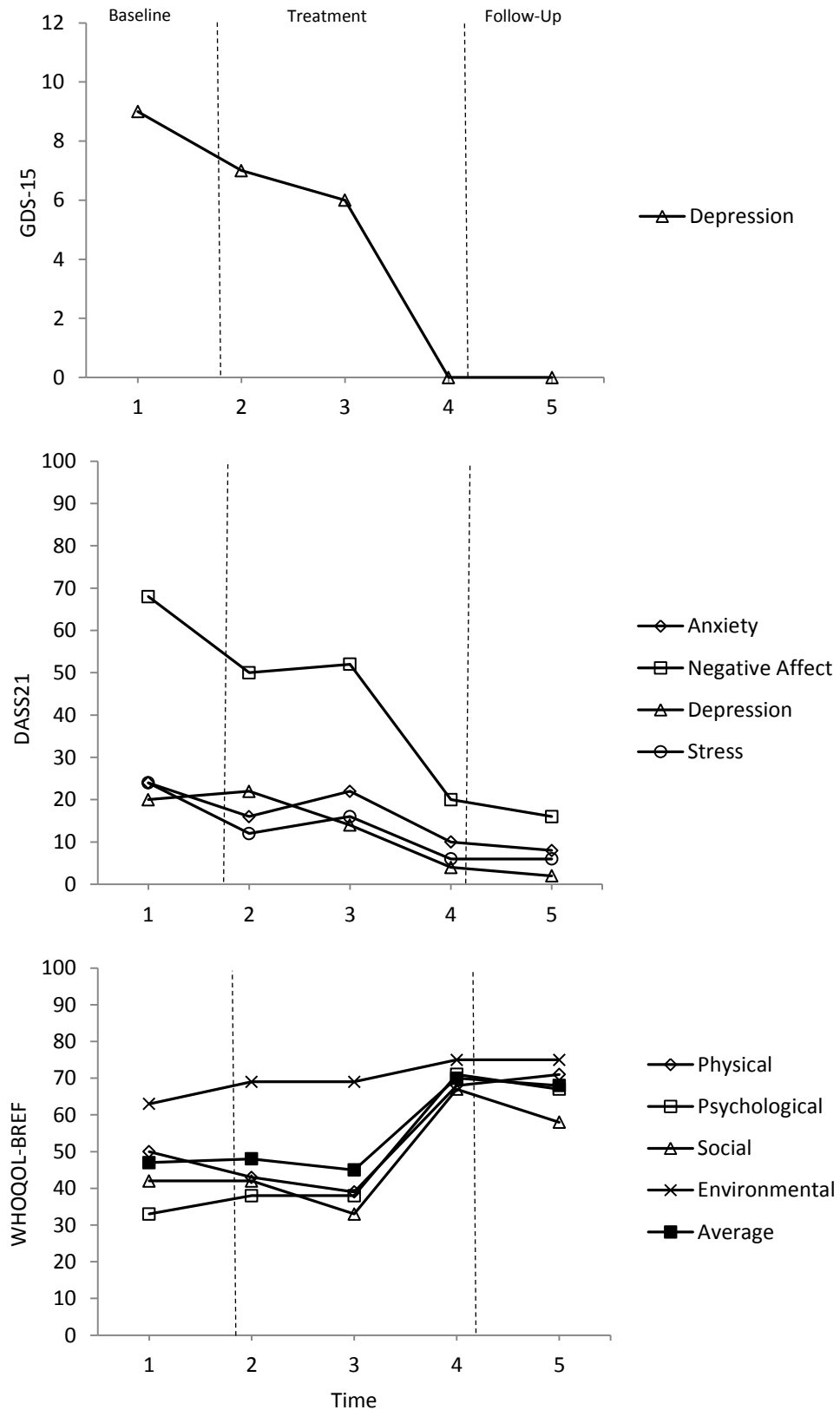


Figure 2. Results of psychological measures for participant Code 2 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

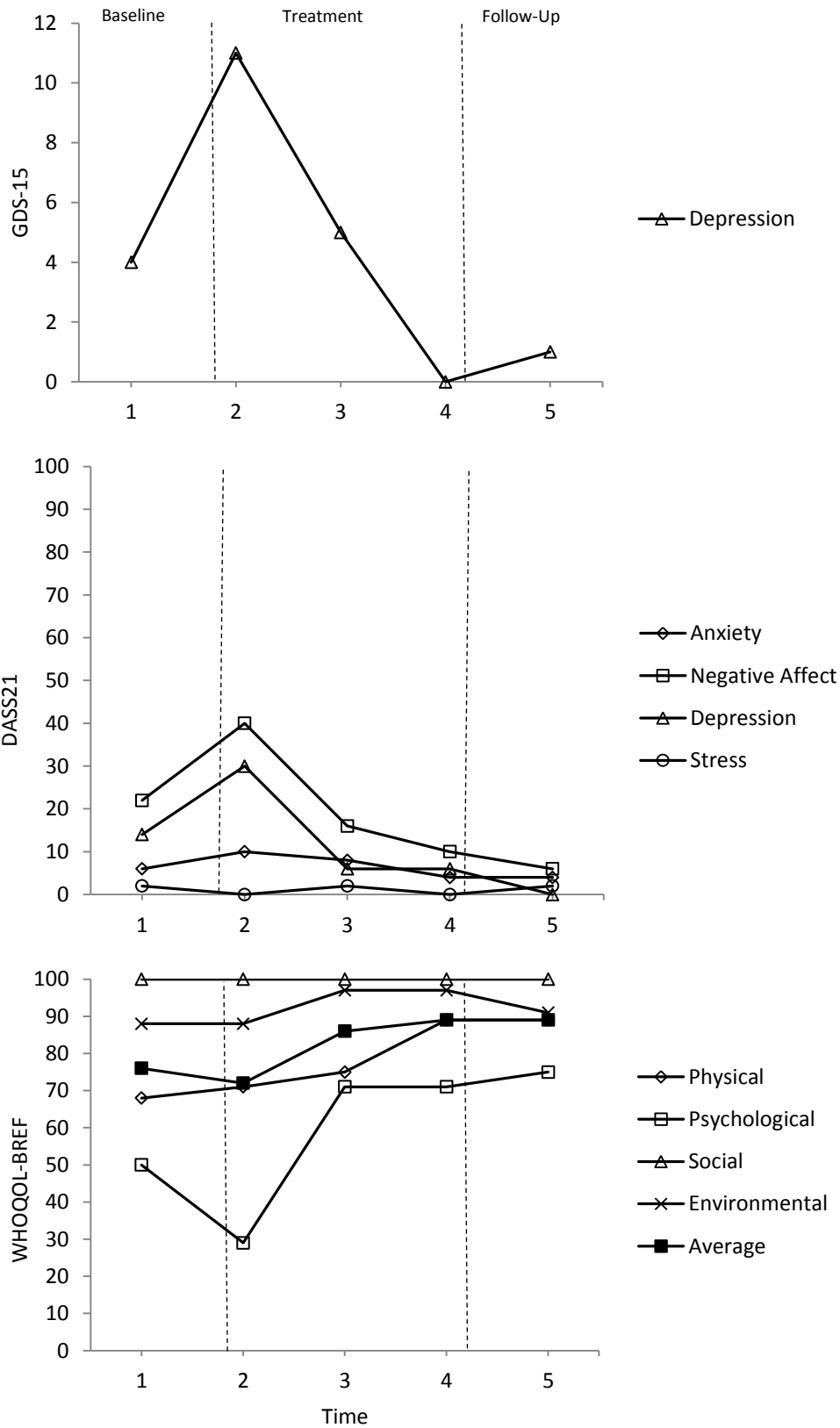


Figure 3. Results of psychological measures for participant Code 3 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

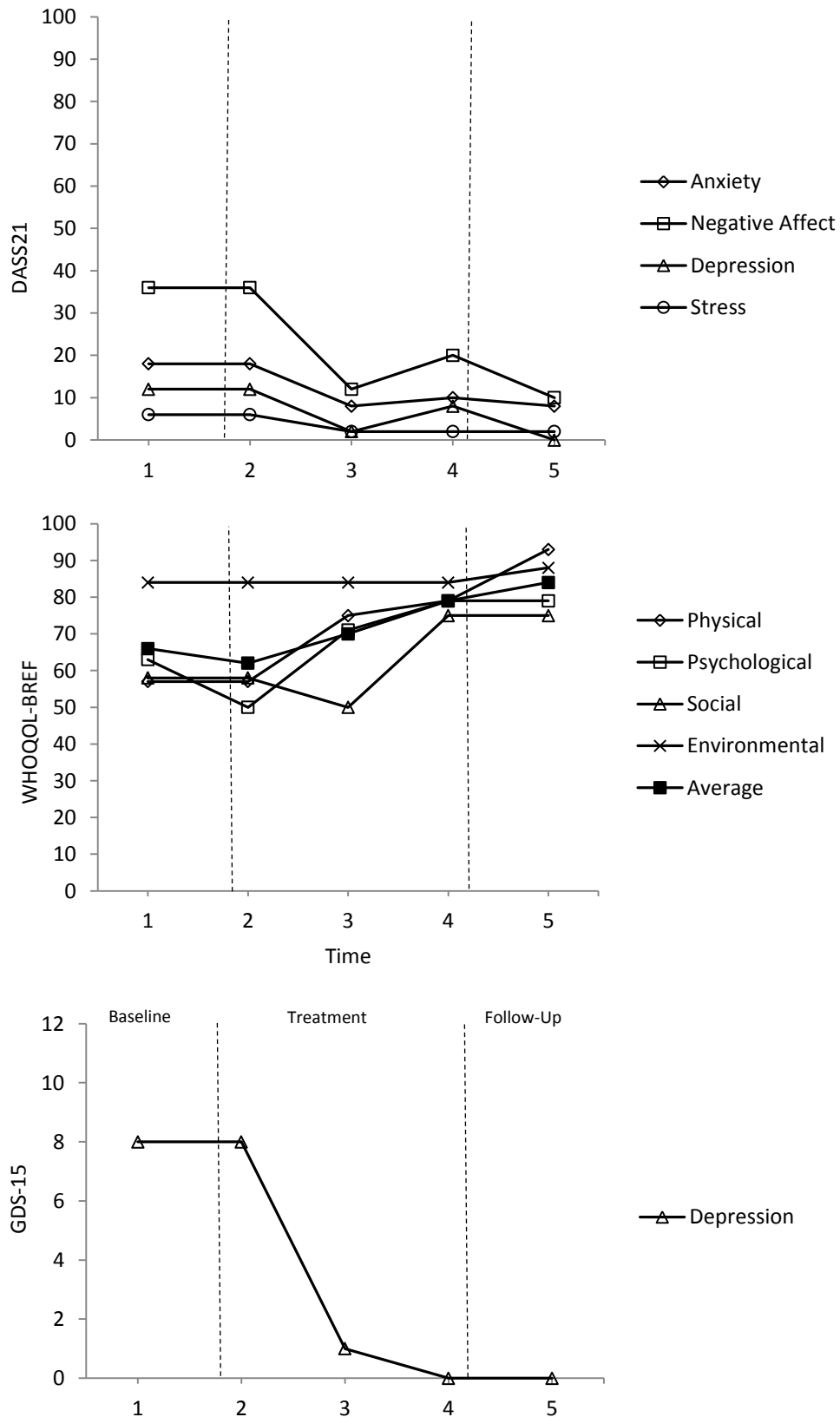


Figure 4. Results of psychological measures for participant Code 4 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

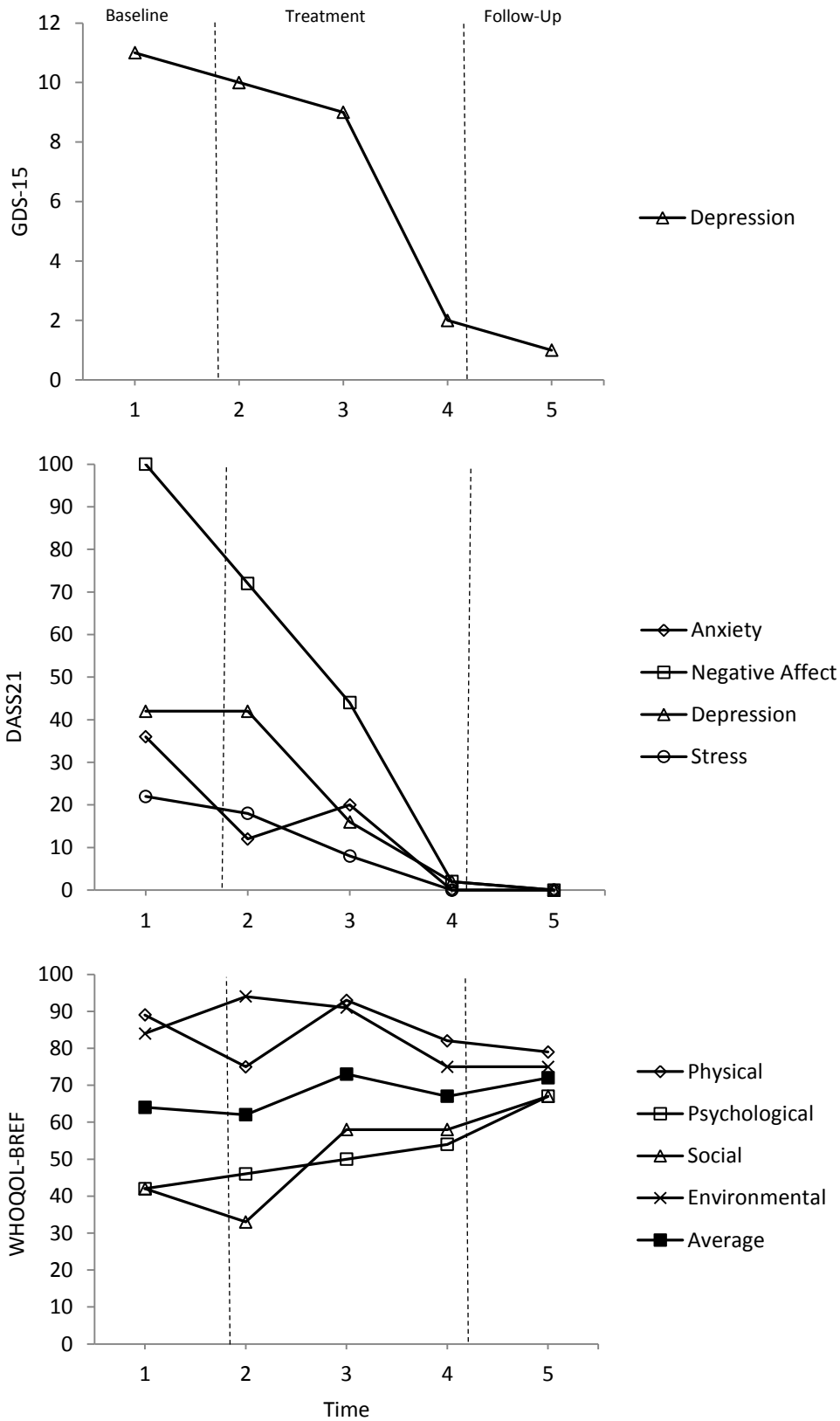


Figure 5. Results of psychological measures for participant Code 5 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

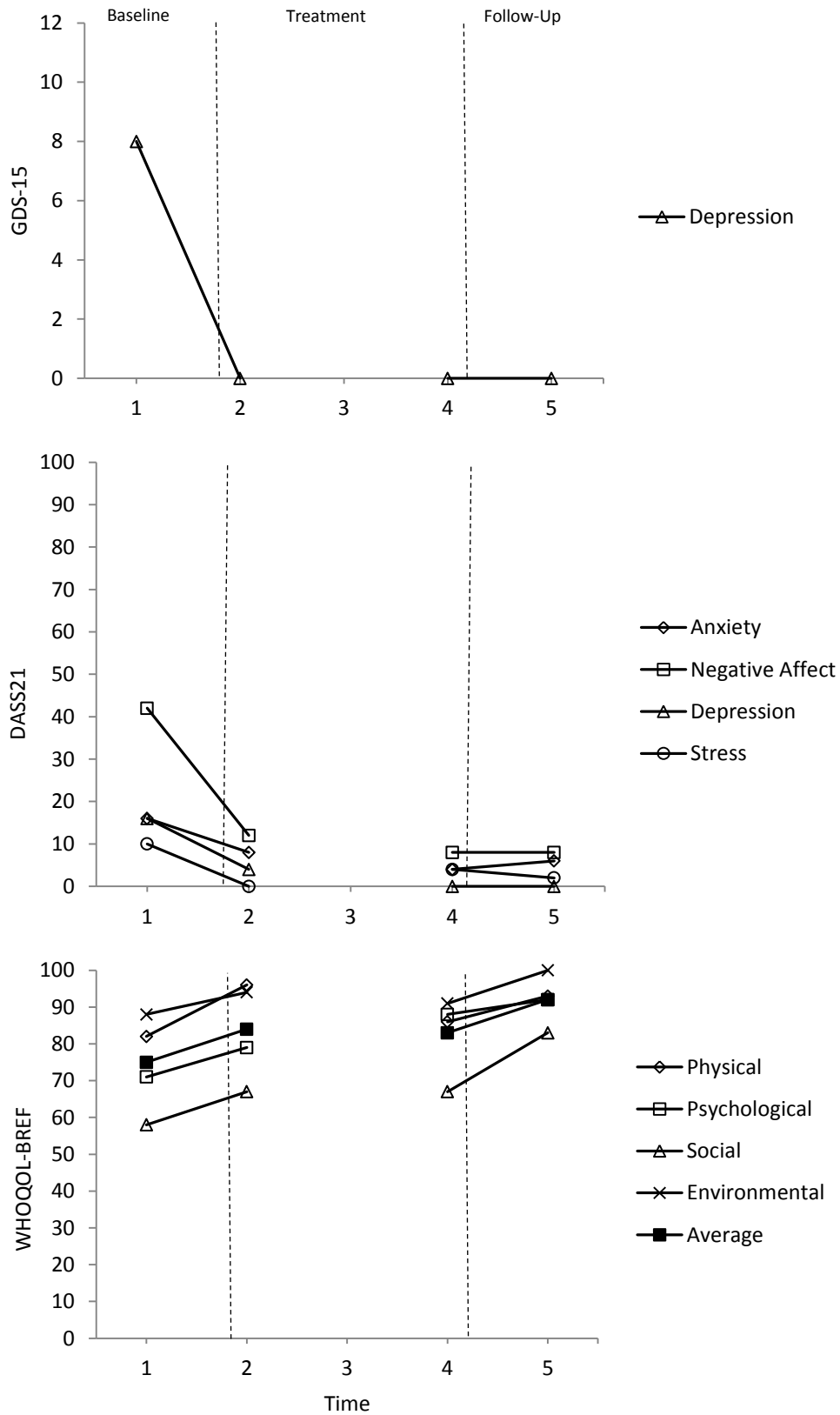


Figure 6. Results of psychological measures for participant Code 7 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

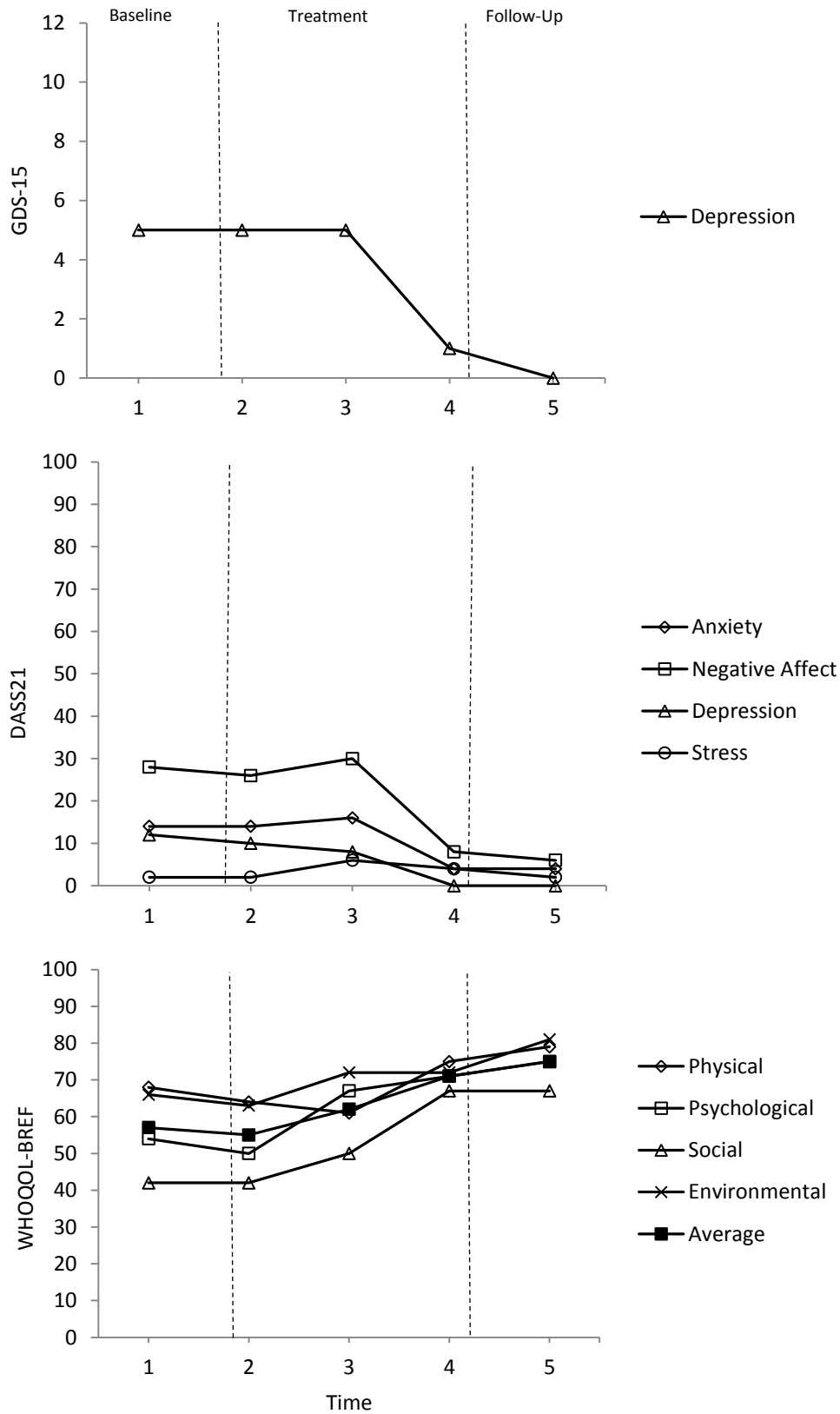


Figure 7. Results of psychological measures for participant Code 8 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

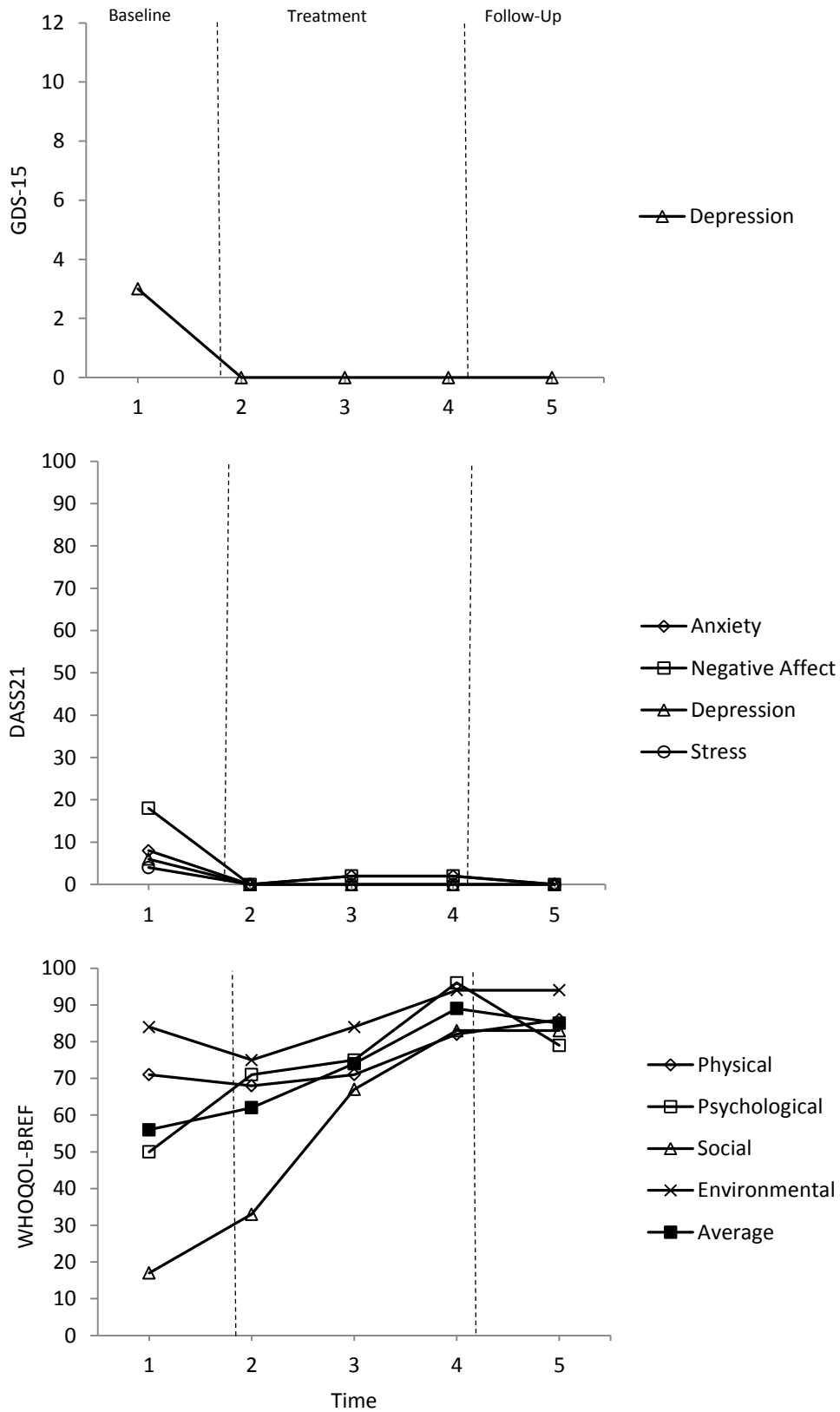


Figure 8. Results of psychological measures for participant Code 9 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

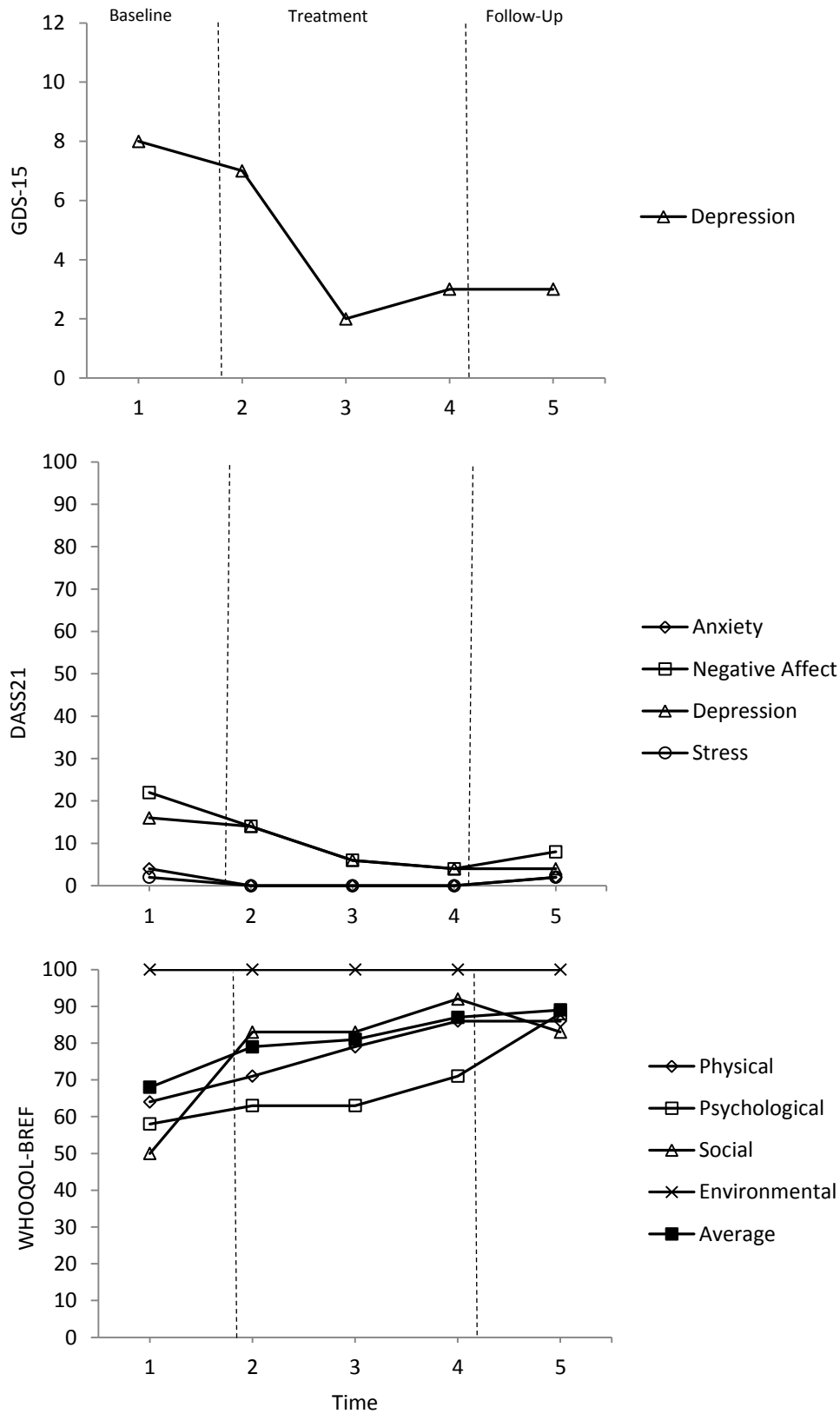


Figure 9. Results of psychological measures for participant Code 10 observed during baseline (A), treatment intervention (B), and follow-up periods. Time 1 = Pre-treatment clinical assessment, Time 2 = Session 1, Time 3 = Session 6, Time 4 = Final Session, and Time 5 = Follow-up.

Appendices
Appendix A
Information Letter

January 2011

Dear Sir/Madam

DEPRESSION IN RETIREMENT – FREE COUNSELLING SESSIONS

Thank you for your interest in this Ph.D psychological research project. This letter will outline details about the study, what is involved in being a research participant, and the benefits and risks of participation.

What's the research about?

Researchers at Edith Cowan University (ECU) are trialling a therapy designed specifically for retirees experiencing difficulties in the adjustment to retirement. Whilst many people adjust well, there are certain circumstances which may lead to difficult adjustment. Specifically, we are looking for people who may be experiencing signs of depression as a result of retirement related issues. You must have retired within the past 4 years. Some changes you have noticed include:

- Feeling sad, down, depressed, or hopeless; or lost interest or pleasure in doing things; and
- Losing weight, poor appetite, sleeping poorly, loss of energy, or trouble concentrating.

What's involved?

Therapy sessions will commence between Oct 2010 and Apr 2011. Therapy involves one hour of counselling for 12 weeks. Attendance at all therapy sessions is encouraged because missing a session may result in treatment being stalled. In the interests of this study, you are encouraged to carefully consider your decision to participate and to volunteer only if you believe you will complete the project. Questionnaires need to be completed 5 times throughout the project. Therapy will be conducted at the ECU Psychological Services Centre (aka "The Clinic") which is located at Joondalup House, 8 Davidson Terrace, Joondalup. With your consent, and to enable the best possible service to participants, it is necessary for sessions to be recorded. Recordings are only used for supervision and treatment integrity protocol; they are subsequently destroyed.

What are the benefits and risks of participation?

Many programs available for retirees focus on the financial aspects and neglect the emotional impact of the retirement transition. This therapy aims to bridge that gap by providing a service that focuses on the psychological adjustment to retirement. The therapy is based on Interpersonal Psychotherapy, which addresses the developmental needs of people adjusting to retirement. The potential benefits will be better adjustment to retirement and more happiness. All parking expenses will be reimbursed upon presentation of parking receipts. Reply paid envelopes will be provided to avoid you incurring postal costs.

Given that this is a trial therapy, potential risks include no improvement to current level of functioning. In the unlikely event that emotional problems arise, counselling is available free of

charge at Lifeline (13 11 14), Crisis Care (9223 1111), Salvo Care Line (9442 5777), and the Samaritans Careline (9381 4444). Private counsellors are also listed in the Yellow Pages.

What else do I need to know?

To assure protection of human rights, this study has received approval from the Edith Cowan University Ethics Committee. As participation in this study is voluntary, participants have the right to withdraw at any time without penalty. Questionnaire data will not contain participants' names. Any information collected will remain confidential, assigned a code, and stored in locked premises at the university. Only the research team will have access to research data. Any published work from this study will not identify any individual.

Strict confidentiality is assured and your relationship with the research study will not be revealed without your prior written consent. However, under certain conditions, the researcher is legally and ethically obliged to release information about a participant whether or not the participant approves. These conditions are: 1. Suspected abuse (physical, sexual or neglect) of children, the aged, and the disabled, 2. Potential high risk of suicide or serious harm to another person, and 3. Where a judge issues a Court Order compelling us to do so.

Are more contacts or information needed?

You may contact the primary supervisor of this research project, Dr. Eyal Gringart, on 6304 5631 or e.gringart@ecu.edu.au. Should you wish to consult with an independent person, here are the details for Professor Craig Speelman, who is the Head of the School, on 6304 5724 or c.speelman@ecu.edu.au. The Clinic's number is 9301 0011.

What next?

Thank you for considering participating in this project. If this study sounds like something you would be interested in, then please contact the principal researcher, Sue G. Miller, on 9403 0264, 0422 505 222, or sgmiller@our.ecu.edu.au. We will then organise a mutually agreeable time to meet at The Clinic where an initial interview will be conducted to confirm eligibility and complete initial forms.

Kind regards
EDITH COWAN UNIVERSITY

Sue G. Miller
Principal Researcher
Ph.D Candidate

Appendix B

Participant Satisfaction Survey

RESEARCH PROJECT “WORKING THROUGH DIFFICULTIES IN RETIREMENT ADJUSTMENT”

INSTRUCTIONS: Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. *Please answer all of the questions.* We also welcome your comments and suggestions. If there is insufficient space, please attach additional pages. Thank you very much, your help is appreciated.

Date:

1.	How would you rate the quality of service you received from this therapist?			
	1 Poor	2 Fair	3 Good	4 Excellent
2.	How well do you feel that the therapist understood your problem(s)?			
	1 No understanding	2 Limited understanding	3 Reasonably well	4 Very well
3.	Have the services you received helped you to deal more effectively with your problems?			
	1 No, they seemed to make things worse	2 No, they really didn't help	3 Yes, they helped somewhat	4 Yes, they helped a great deal
4.	To what extent has our service met your needs?			
	1 None of my needs have been met	2 Some of my needs have been met	3 Most of my needs have been met	4 All of my needs have been met
5.	If a friend were in need of similar help, would you recommend our program to him/her?			
	1 No, definitely not	2 No, I don't think so	3 Yes, I think so	4 Yes, definitely

6. What did you most like about the service? _____

7. What could be done to improve our service? _____

8. Other comments. _____

This is the end of the survey. Thank you for your help.

Document of Progress

(Adapted from Miller et al., 2007)

Client:

- Consent form signed (date)
- Initial screening interview (date)
- Session 1 attended (date)
- Session 2 attended (date)
- Session 3 attended (date)
- Session 4 attended (date)
- Session 5 attended (date)
- Session 6 attended (date)
- Session 7 attended (date)
- Session 8 attended (date)
- Session 9 attended (date)
- Session 10 attended (date)
- Session 11 attended (date)
- Session 12 attended (date)
- Additional session(s) attended (date)
- (date)
- (date)
- (date)
- (date)
- (date)

Comments

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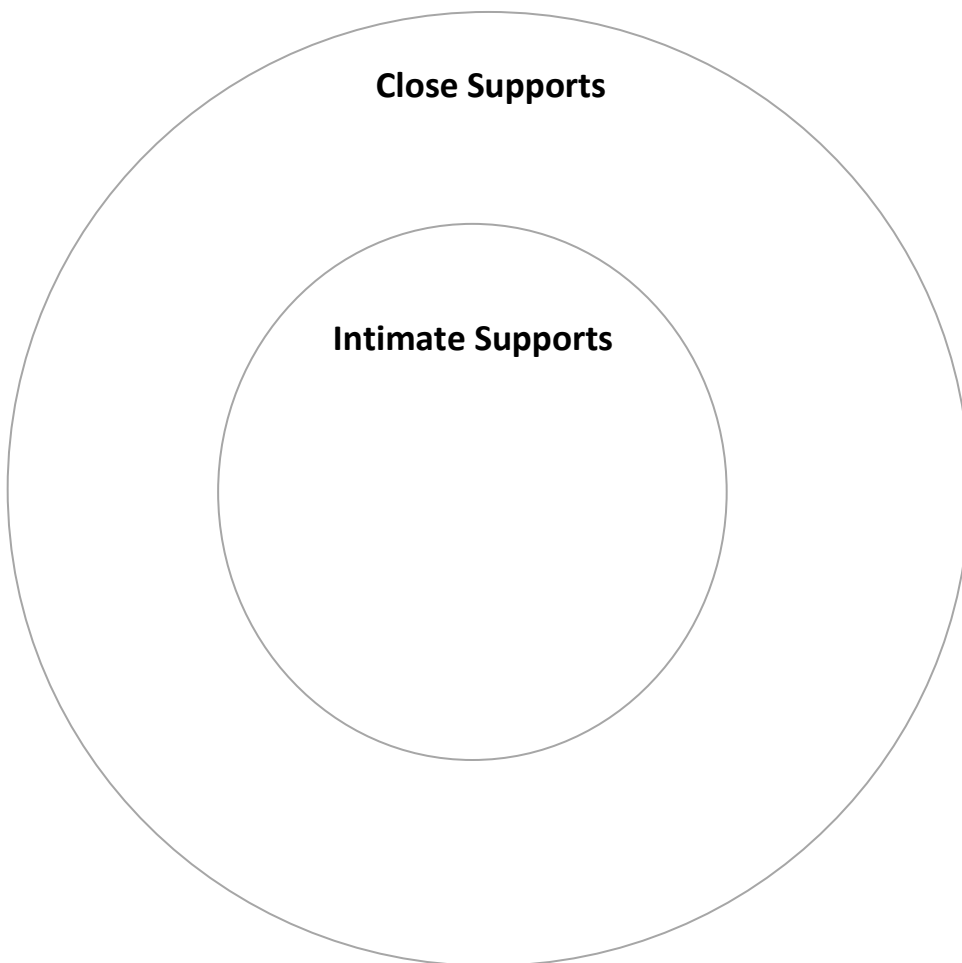
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Interpersonal Inventory:

For reference throughout the course of therapy, record pertinent details about the client's interpersonal relationships. Describe the client's current significant others, sexual relationships, current household composition, and current confidants.

Extended Supports

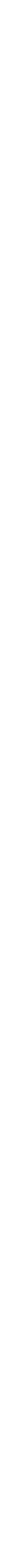


Genogram:

Provide a pictorial representation of the client's family tree together with other relevant details for each person.

Depression and anxiety timeline:

Detailed history of depressive episodes, anxiety symptoms, and medications prescribed.



Education and work timeline:

Detailed history of the client's schooling and career.



SECTION 2

Graphical representation of progress in therapy over time:



TEST	SEVERITY LEVELS	TEST	SEVERITY LEVELS	TEST	SEVERITY LEVELS	TEST	SEVERITY LEVELS
DASS-Dep'n	0-9 normal 10-13 mild 14-20 moderate 21> severe	DASS-Anxiety	0-7 normal 8-9 mild 10-14 moderate 15> severe	DASS-Stress	0-14 normal 15-18 mild 19-25 moderate 26> severe	GDS-15	0-4 normal 5-9 mild >10 severe

Session 3:

Client: _____ Session date: _____ Therapist: _____

IPT Focus 1: RT G RD ID

IPT Focus 2: RT G RD ID (Circle and describe)

Psychotropic medication changes

Treatment Notes:

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Session 11:

Client: _____ Session date: _____ Therapist: _____

IPT Focus 1: RT G RD ID

IPT Focus 2: RT G RD ID (Circle and describe)

Psychotropic medication changes

Treatment Notes:

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SECTION 4

Final summary of case outcomes:

1. Pertinent history of the reason for coming to therapy (chief complaint), recent treatment, past psychiatric treatment, or untreated psychiatric problems including drug and alcohol problems.

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2. Pertinent history of medical problems

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3. Pertinent history of family psychiatric problems

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Appendix D

Declaration of Confidentiality Agreement by Raters of Treatment Integrity

RESEARCH PROJECT "WORKING THROUGH DIFFICULTIES IN RETIREMENT ADJUSTMENT"

ASSESSOR:

I (full name)

Of (address)
.....
.....

Acknowledge that all information seen by me for the purpose of the above named research will be treated with the strictest confidence. I will also ensure that all DVDs or tapes in my possession will be treated with the same level of confidentiality and they will be stored securely. I will return all original recordings to Sue G. Miller and will not make any duplicate copies. I will destroy all data (electronic and hard copies) once Sue G. Miller has confirmed receipt of the assessments. All material relating to the above project, while in my possession, will be accessible only to Sue G. Miller (Principal Researcher).

Assessor's name

Assessor's signature

Date

Researcher's name

Researcher's signature

Date

Appendix E

Therapy Rating Scale

Instructions (Part 1)

GENERAL COMMENTS:

Rating therapist behaviours: The scale is designed to rate therapist behaviour. In rating the scale items it is important to distinguish the therapist behaviour (as much as possible) from the client behaviour in response to the therapist. The rater should attempt to rate the therapist behaviour, not the client response to that behaviour. In rating therapist behaviour, the rater should consider what the therapist attempted to do, not whether those attempts met with success or failure.

Avoid haloed ratings: The scale was designed for the purpose of describing the therapist's behaviour in the session. To use the scale correctly, it is essential that the rater rates what they hear, **not** what they think **ought** to have occurred. The rater must be sure to apply the same standards for rating an item regardless of:

- (1) What type of therapy the rater thinks they are rating;
- (2) What behaviours the therapist engaged in during the session;
- (3) What ratings were given to other items;
- (4) How skilled the rater believes the therapist to be in a particular modality;
- (5) How much the rater likes the therapist; and
- (6) Whether the rater thinks the behaviour being rated is a good thing to do or a bad thing to do.

INSTRUCTIONS TO RATERS:

Rate every item: This scale is designed so that every item can be rated on a scale from one to seven for every therapy session. In other words, **do not leave items blank**.

Listen before rating: Do not rate any item on the scale until the entire session has been listened to.

Take notes: We recommend that the rater take notes while listening to the session. We have found that this procedure enhances the accuracy of ratings both because it helps to remind raters of information which is relevant to rating the items, and because it helps keep the rater focused on what is occurring in the session. Because the items require the rater to make many fine distinctions, it is essential that the rater listens to the session carefully. The rater should not attempt to do other tasks while watching therapy sessions which are to be rated.

Use code sheets correctly: We have developed an answer sheet that can be easily used for data entry. When using this answer sheet it is important to clearly write in the desired response and to avoid any stray marks on the code sheet. It is crucial that raters review their code sheet to ensure that the necessary identifying information has been filled in, that every item is rated, and that no item is assigned more than one response.

Source: Diels, n.d.

THERAPY RATING SCALE (CONTINUED)

- 7) To what extent did the content of the session focus on the client's cognitions?

1	2	3	4	5
totally				not at all

- 8) Did the clinician and patient discuss activities or tasks agreed upon on earlier sessions for the patient to attempt?

1	2	3	4	5
not at all/or none assigned				discussed assignment fully and integrated it into the session

- 9) To what extent did the clinician use silences to encourage the patient to continue talking?

1	2	3	4	5
frequently				never

- 10) Did the clinician end the session by summarizing the main points covered?

1	2	3	4	5
did not				extensive and detailed

- 11) To what extent did the clinician inquire about the extent and adequacy of the patient's social network?

1	2	3	4	5
never				frequently

- 12) To what extent was a "diary" approach used in structuring a session?

1	2	3	4	5
not at all				totally

- 13) To what extent did the clinician encourage the patient to recall important events from previous relationship?

1	2	3	4	5
extensively				not at all

THERAPY RATING SCALE (CONTINUED)

- 14) To what extent did the clinician explore possible changes that could be made in interpersonal relationships and social activities?

1	2	3	4	5
not at all				totally

- 15) To what extent did the clinician aid the patient in a systematic exploration of alternatives when faced with a decision?

1	2	3	4	5
not at all				totally

- 16) The clinician:

1	2	3	4	5
kept the focus of the session on issues decided upon at the outset of the session				no topics were pre-set

- 17) Did the clinician ask for any analysis of specific conversation(s) which occurred outside of therapy?

1	2	3	4	5
much time spent				no time

- 18) Did the clinician attempt to translate the patient's complaints or concerns into interpersonal context?

1	2	3	4	5
always				infrequently

- 19) To what extent did the clinician explore possible unconscious motivations for patient behaviors?

1	2	3	4	5
extensively				not at all

- 20) What portion of the session focused on the type(s) of medication the patient is taking?

1	2	3	4	5
the entire session				less than 10% of the session

THERAPY RATING SCALE (CONTINUED)

- 21) To what extent did the therapist initiate discussion of or attempt to get the patient to elaborate on interpersonal relationships?

1	2	3	4	5
not at all				totally

- 22) How frequently did the clinician inquire as to the feelings associated with the content being discussed?

1	2	3	4	5
never				frequently

- 23) Did the clinician elicit feedback about the client's reactions to the session and/or the clinician on an ongoing basis throughout the session?

1	2	3	4	5
not at all				very much

- 24) What portion of the session focused on the sleep/neuroendocrine or other laboratory studies?

1	2	3	4	5
none of the session				the entire session

- 25) When a communication was described by the patient, to what extent did the clinician seek to analyze it?

1	2	3	4	5
totally				not at all

- 26) Did the therapist (and/or patient) work to set up an experiment for the patient to try (i.e., testing something he/she believes by gathering data relevant to the belief or behaving differently than he/she might typically do)?

1	2	3	4	5
never attempted				carefully designed (a) specific experiment(s) for the patient to try

- 27) To what extent did the session focus on medication dosage?

1	2	3	4	5
not at all				totally

Appendix F
Demographic Questionnaire

Part A – Your Details

Full name	<input type="text"/>
Title	<input type="text"/>
Address	<input type="text"/>
	<input type="text"/>
	Postcode
Home phone	<input type="text"/>
Mobile	<input type="text"/>
Date of birth	<input type="text"/>
Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male
Country of birth	<input type="text"/>
Language spoken at home	<input type="text"/>
Highest level of education	<input type="text"/>
If you have previously seen a counsellor/psychologist, when and for what?	<input type="text"/>

Part B – Relationship Details

1. Relationship status	<input type="checkbox"/> Married
	<input type="checkbox"/> De facto
	<input type="checkbox"/> Widowed
	<input type="checkbox"/> Divorced/separated
	<input type="checkbox"/> Never married
2. Have you ever been divorced?	<input type="checkbox"/> Yes
	<input type="checkbox"/> No
3. If you have children, what are their age/s?	<input type="text"/>
4. If partnered, is your spouse?	<input type="checkbox"/> Retired
	<input type="checkbox"/> Partially retired
	<input type="checkbox"/> Was made redundant
	<input type="checkbox"/> Left their job (but didn't retire)
	<input type="checkbox"/> Works full time
	<input type="checkbox"/> Works part time
	<input type="checkbox"/> Other (please specify)

Part C – Retirement Issues

5. What is your retirement status?	<input type="checkbox"/>	Retired
	<input type="checkbox"/>	Partially retired
	<input type="checkbox"/>	Was made redundant
	<input type="checkbox"/>	Left your job (but didn't retire)
	<input type="checkbox"/>	Works full time
	<input type="checkbox"/>	Works part time
	<input type="checkbox"/>	Other (please specify)
6. What year did you retire?	<input type="text"/>	
7. How suddenly or gradually did you retire?	<input type="checkbox"/>	Very sudden
	<input type="checkbox"/>	Fairly sudden
	<input type="checkbox"/>	Neither sudden nor gradual
	<input type="checkbox"/>	Fairly gradual
	<input type="checkbox"/>	Very gradual
8. Are you looking for other work or extra work?	<input type="checkbox"/>	Yes
	<input type="checkbox"/>	No
9. If employed, how many hours do you usually work in an average week?	<input type="text"/>	
10. Do you have the main responsibility in caring for someone who has a long-term illness, disability or other problem?	<input type="checkbox"/>	Yes
	<input type="checkbox"/>	No
11. If you do regular voluntary work, how many hours in an average week do you work?	<input type="text"/>	
12. Would you say you retired...?	<input type="checkbox"/>	Too early
	<input type="checkbox"/>	About right the right time
	<input type="checkbox"/>	Too late
13. How well prepared for retirement were you?	<input type="checkbox"/>	Extremely well
	<input type="checkbox"/>	Very well
	<input type="checkbox"/>	Moderately well
	<input type="checkbox"/>	Not very well
	<input type="checkbox"/>	Not at all well

14. How much choice did you have about retiring?

<input type="checkbox"/>	Complete choice
<input type="checkbox"/>	Some choice
<input type="checkbox"/>	Not much choice
<input type="checkbox"/>	No choice at all

15. How far ahead did you know when you would be leaving your job?

<input type="checkbox"/>	Years ahead
<input type="checkbox"/>	Months ahead
<input type="checkbox"/>	Weeks ahead
<input type="checkbox"/>	Less than a day

16. Have you taken part in any course or seminar to help you plan for retirement?

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

17. Why did you decide to leave your job and retire?

18. How well did your mother retire?

<input type="checkbox"/>	Very well
<input type="checkbox"/>	Fairly well
<input type="checkbox"/>	Not very well
<input type="checkbox"/>	Don't know
<input type="checkbox"/>	Not applicable

19. How well did your father retire?

<input type="checkbox"/>	Very well
<input type="checkbox"/>	Fairly well
<input type="checkbox"/>	Not very well
<input type="checkbox"/>	Don't know
<input type="checkbox"/>	Not applicable

Part D – Income

20. How well do you think you were prepared financially for your retirement?

<input type="checkbox"/>	Extremely well
<input type="checkbox"/>	Very well
<input type="checkbox"/>	Moderately well
<input type="checkbox"/>	Not very well
<input type="checkbox"/>	Not at all well

21. How well off are you compared with people your age who have retired or have been made redundant?

<input type="checkbox"/>	Better off
<input type="checkbox"/>	About the same
<input type="checkbox"/>	Slightly worse off

22. How adequate is your income?

<input type="checkbox"/>	I'm comfortably off
<input type="checkbox"/>	I have just enough to get along
<input type="checkbox"/>	I can't make ends meet

Part E – Health

23. In general, your health is

<input type="checkbox"/>	Excellent
<input type="checkbox"/>	Very good
<input type="checkbox"/>	Good
<input type="checkbox"/>	Fair
<input type="checkbox"/>	Poor

24. How much do health problems restrict the things you do?

<input type="checkbox"/>	A lot
<input type="checkbox"/>	Some
<input type="checkbox"/>	A little
<input type="checkbox"/>	Not at all

25. How would you compare your general health now with just before you retired?

<input type="checkbox"/>	Better
<input type="checkbox"/>	Same
<input type="checkbox"/>	Worse

26. How many cigarettes do you smoke per day?

<input type="text"/>

27. How often do you drink alcohol?

<input type="checkbox"/>	Never
<input type="checkbox"/>	Rarely
<input type="checkbox"/>	Once a week
<input type="checkbox"/>	2-3 times a week
<input type="checkbox"/>	4-6 times a week
<input type="checkbox"/>	Daily

28. If you drink alcohol, how many drinks would you have in a sitting?

<input type="text"/>

29. What medication do you take and at what dose?

<input type="text"/>

Appendix G
Participant Consent Form

RESEARCH PROJECT “WORKING THROUGH DIFFICULTIES IN RETIREMENT ADJUSTMENT”

I agree to take part in the above mentioned Edith Cowan University research project. I have read the Information Letter outlining what the study involves and all questions have been answered to my satisfaction.

I understand that by agreeing to participate, I am willing to:

1. Attend and participate in a weekly one-hour therapy session for 12 weeks.
2. Complete five sets of questionnaires throughout the program, which will take about 10-15 minutes each time. I will be supplied with reply paid envelopes for the return of questionnaires as necessary.
3. Have therapy sessions recorded for the purpose of supervision and treatment integrity protocol.

I understand that any information I provide is confidential.

I understand that my participation is voluntary and I can withdraw at any time without penalty.

I am aware that research data gathered for this study will be published in a report but I will not be identifiable.

I understand that this is a trial treatment based on an existing treatment and the usefulness of this therapy is yet to be determined.

I understand that, under certain conditions, the researcher is legally and ethically obliged to release information about me whether or not I approve. These conditions are:

1. Suspected abuse (physical, sexual or neglect) of children, the aged, and the disabled.
2. Potential high risk of suicide or serious harm to another person
3. Where a judge issues a Court Order compelling us to do so.

Participant's name

Participant's signature

Date

Researcher's name

Researcher's signature

Date