

REALITY ORIENTATION THERAPY FOR THE
DISORIENTED ELDERLY PATIENT

by

Jane Frances Nikolai, B.S.N.

A FIELD STUDY

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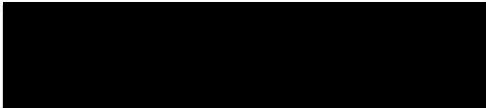
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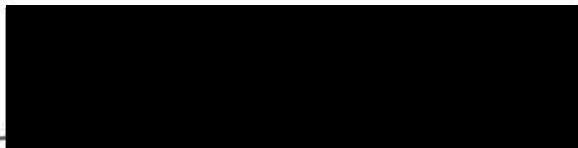
Julia Brown, Ph.D., Associate Professor, Field Study Advisor



May Rawlinson, Ph.D., Associate Professor, First Reader



Sandra Stone, M.S., Assistant Professor, Second Reader



John Brookhart, Ph.D., Chairman, Graduate Council

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Chapter I

INTRODUCTION

Introduction to the Problem

The prevailing attitude toward the aged in our society is largely negative. Among the common preconceptions concerning the aging process is the idea that if elderly individuals enter a nursing home or other long-term facility, they will live a dependent existence there until death. Many of these elderly patients in nursing homes seem confused and disoriented and are diagnosed, therefore, as suffering from chronic brain syndrome. Thus, in a survey of nursing and old age homes in New York City, more than 80 per cent of the patients 65 years of age and older were so diagnosed. Of these, 15 to 30 per cent were judged to be severely impaired (Goldfarb, 1962).

The care that is given these confused, disoriented patients is usually "custodial," meaning that their basic physical needs are met in a protective environment, but that their mental and psychological needs are largely ignored. These elderly patients are often stereotyped as harmless old people who need tender loving care and are dependent on others for assistance with such basic activities as

eating, dressing, toileting, ambulation, grooming and bathing. It is possible that this attitude creates dependency in the aged patients, and because nothing is expected of them, many may forget how to perform these simple tasks of daily living. In the process, these patients are often reduced to an existence lacking all meaning.

There has been considerable research dealing with mental disorders in the aged (Riley, 1969; Stotsky, 1970). However, little actual research has been directed toward determining the effectiveness of proposed ways of treating the confused, disoriented, older patient. Various treatments have been advocated for the mentally ill, such as the creation of a therapeutic environment, promotion of general activity, exposure to remotivation programs, and many sophisticated types of individual and group psychotherapy. However, many older patients are considered to be too deteriorated and too withdrawn to benefit from most of these programs. Unfortunately, many patients are also considered to be too old to warrant expenditure of staff resources in their behalf.

Among the empirical studies which have focused on treatment for the chronic brain syndrome patient are those conducted by Brody et al. (1971), Cosin (1957), and Donahue (1963). Brody et al. (1971) deduced from their research that an individualized program for the treatment of chronic brain syndrome patients is beneficial. These patients not only appeared to be more aware of their environment,

but their competence in activities of daily living also increased. Both Cosin (1957) and Donahue (1963) advocated sensory stimulation, on the argument that the human being is stimulus-oriented throughout life, seeking stimulation and responding to it. This holds for the aged as well as the young, and aged persons presumably should respond if stimulating circumstances are provided.

Another treatment to help the elderly patient with a moderate to severe degree of confusion and disorientation has been developed by Folsom (1968). It is this technique of "Reality Orientation" that served as the focus of the present study. In this project, an attempt was made to assess the effectiveness of "Reality Orientation" in treating a small number of chronic brain syndrome patients in a nursing home.

Review of the Literature

Chronic brain syndrome has long been thought to be associated with arteriosclerosis and therefore to be untreatable. However, according to Warde (1969), it is no longer permissible to attribute the manifestations of chronic brain syndrome exclusively to irreversible organic and biological causes. Therefore, the conclusion that the manifestations cannot be changed or modified is also open to question. Environment, social contacts, and isolation can all be modified and through such changes perhaps, seemingly helpless

elderly patients can be helped to live more productive lives.

Payne et al. (1969) concurred with the view that in many instances problems attributed to organic causes may be functionally based. Moreover, Payne et al. (1969) argue that even in those cases where brain damage exists, it is possible for the individuals so afflicted to maintain themselves in their surroundings and to avoid emotional disturbance.

No one will deny that arteriosclerosis is common in the elderly, but the presence of well-defined arteriosclerotic conditions in a senile psychotic is not of itself, adequate evidence of a causal relationship (Hamilton, 1968). In discussing the clinical assessment of organic brain damage characterized by impairment of orientation, memory, intellectual functions and judgment, Verwoerd (1971) denied a clear-cut relationship between the severity of clinical manifestations and the amount of brain damage found at autopsy. It is possible that personal-psychological and social-environmental factors act as intervening variables, and often interact in a complex interplay with organically based symptoms (Lowenthal, 1967). When diffuse damage develops slowly, when environmental circumstances are supportive, or when there is a minimum of stress, the individual may be able to compensate for functional loss with relatively little psychological upset.

Albrecht (1951) found a strong relation between social

performance and the development of the symptoms associated with chronic brain syndrome. In her sample, those individuals who appeared to have been appropriately socialized at all stages of the life cycle seemed less likely to develop these symptoms. From these data and from her review of the literature, Albrecht concluded that a relatively large proportion of patients suffering from confusion and disorientation can improve rapidly, even in the absence of one-to-one therapy. This improvement is more likely to occur if the environment provides the patient with the opportunity to work out a new and satisfactory definition of himself in the situation, and if the patient is allowed to respond to a variety of stimulating situations. The implications of her study are that the old person's world often becomes too lean, and he therefore retreats into confusion and disorientation as a defense against this relatively featureless environment. When provided with opportunities to react, the older patient can re-enter the real world safely.

Birren (1964) asserted that socially deprived or isolated older persons can and do show an improvement in attitudes and life satisfaction with an increase in social interaction and diversification of social roles.

Burnside (1971), Donahue (1963), Novik (1963) and Gossett (1967) all pointed out the monotony of institutional life in the average long-term hospital, and concluded that the personality deterioration

so often seen in patients is in large part a response to the lack of meaningful stimulation and activity. They strongly recommended stimulation in order to reverse regression and to encourage a more active social life.

Folsom (1968) also believed that the regression so often manifested by patients suffering from chronic brain syndrome can be reversed, at least to some degree, with appropriate treatment, as by "Reality Orientation."

The technique of "Reality Orientation" appears simple because it involves the use of basic facts as tools to break through confusion, apathy, or depression in order to reach the patient and bring him back to reality. It is thought that the older patient often withdraws into himself, breaks off relationships with others, and in general reduces his awareness and concern for even the simplest things. Potentially usable parts of his brain soon cease to function. "Reality Orientation" attacks that process in two ways: by continually stimulating the person by repetitive orientation, and by placing him in a group where he meets and competes with other patients, thus forcing him out of his isolation and back into a social environment. It is assumed that this process can reawaken unused neurological pathways and stimulate the patient to develop new ways of functioning to compensate for the organic brain damage that has resulted from injury or deterioration (Stephens, 1969).

"Reality Orientation" involves a team approach to constant reorientation. It is a technique used daily, 24 hours a day by everyone who comes in contact with the patient, by nurses, aides, house-keeping staff, visitors. It is further reinforced by the physical environment where sensory stimulation in the form of signs, clocks, calendars, menus, and name-tags identify for each patient the date, the place, the hour, the activity, his own name, the names of others and so on. The patient is always addressed by his own name. He is also reminded of the name of the person to whom he is speaking. To supplement the constant orientation given by everyone who comes in contact with the patient, a special "Reality Orientation" class is held daily for one-half hour, 5 days a week. The format for the class (Stephens, 1969) is contained in Appendix A.

At the simplest level, the classes consist of date and place recognition and self-identification. Gradually, various types of object-identification exercises are introduced. Patients are asked to identify various foods, utensils, articles of clothing and so forth. The orientation tasks become progressively more difficult until they include the classification of objects by color, shape, use, and finally, abstract qualities.

The elements of "Reality Orientation" are incorporated into a set of guidelines established when the program was started at the Mental Health Institute, Mount Pleasant, Iowa (Folsom, 1968).

These guidelines are quoted below:

1. A calm environment.
2. A set routine.
3. Clear, simple responses to patients' questions. Questions asked of patients should be clear and simple also.
4. Talk clearly to patients, not necessarily loud and not as to a child.
5. Direct patients around by clear directions. If need be, guide them to and from their destination.
6. Remind them of the date, time, etc.
7. Don't let them stay confused by allowing them to ramble in their speech, actions, etc.
8. Be firm as necessary.
9. Be sincere.

These guidelines were formally stated in 1962. Several months later, the head nurse at the Mental Health Institute, Mount Pleasant, Iowa, added two more admonitions: (Benfern, 1963)

10. Make requests of patients in a calm manner, implying patient will comply.
11. Consistency.

Oberleder (1969a; 1969b) has pointed out that although many hospitals and facilities for the aged have therapeutic programs, many patients are often too deteriorated and too withdrawn to benefit from them. She thinks that "Reality Orientation" has helped to bridge that gap, with the result that patients who formerly would have

vegetated until death are now being restored to a level of functioning that eventually will permit them to be involved in higher forms of therapeutic activity. Oberleder explains that the underlying principle of "Reality Orientation" is that even the most severely mentally impaired patient is capable of improvement when he is exposed to a continuing and consistent program of orientation.

Many successes have been attributed to "Reality Orientation." Taulbee and Folsom (1966) claim to have seen patients who entered the hospital so deteriorated that they were unaware of their own names, yet they responded to "Reality Orientation." Some of these patients continued to exhibit confusion and lack of orientation for a period of many weeks, and then slowly began to show some evidence of learning and remembering information. It is the belief of Taulbee and Folsom that once a patient grasps any bit of information, such as his own name, the name of his spouse, his address, or his birthday, then he will begin to recall other facts and remember increasing amounts of previously learned material.

Taulbee (1968) maintained that a consistent "Reality Orientation" program by nursing personnel is a very effective tool for eliminating or controlling confusion in an elderly person. It is reasonable to assume that the elderly person will benefit more if such a program is begun early, when the first signs of confusion are noted. However, even patients stereotyped as permanent hospital inmates

have been known to improve and to return home, able to care for most of their personal needs.

McCown (1965) described the elation felt by all personnel when a patient with marked regression and much child-like behavior called his nurse by name after several months of "Reality Orientation." This patient had learned to state his own name in a matter of a few weeks. McCown concluded that progress, especially with severely regressed patients, is slow and sometimes discouraging, but the moment of a small success always provides satisfaction and the impetus to continue for staff and patients alike.

Statement of the Problem

Basic human needs do not change with age. There is always a need for recognition, response, social interrelationships, physical activity, and new experience. At the present time, the physical needs of patients in nursing homes are usually satisfied since minimum standards in these respects are enforced by law. However, the psychological and mental needs of patients suffering from chronic brain syndrome are often ignored or forgotten. The social problem posed by large numbers of confused disoriented patients will grow as longevity increases with scientific and medical advances in this country. As this problem becomes ever more imperative, solutions must be sought, both for economic and humanitarian reasons. Treatment

must be developed and evaluated with respect to its effectiveness in reversing the mental deterioration of the aged, and in promoting the patients' self sufficiency in the activities of daily living.

Purpose of Study

The purpose of this study was to determine whether the treatment known as "Reality Orientation" would have any effect on the mental status of a selected group of patients demonstrating a moderate to severe degree of impairment associated with chronic brain syndrome. Since it has been shown in several studies that mental status is related to competence in activities of daily living (Brody, 1971; Goldfarb, 1962; Kahn, 1960; Lowenthal, 1967; Stotsky, 1970), it was the additional purpose of this investigation to ascertain whether or not "Reality Orientation" would affect patients' functioning in activities of daily living.

Hypothesis

The general hypothesis tested here was that those patients diagnosed as cases of chronic brain syndrome who received the "Reality Orientation" treatment would demonstrate over time an improved mental status and increased participation in activities of daily living, whereas patients diagnosed as suffering from chronic brain syndrome who did not receive such treatment would not

demonstrate such changes,

Inasmuch as mental status is here operationalized as a score on Kahn's (1960) Mental Status Questionnaire (MSQ), and participation in activities of daily living is operationalized as a score on the Physical Self-Maintenance Scale (PSMS) of Lawton and Brody (1969), the specific hypotheses tested are:

1. Among patients diagnosed as cases of chronic brain syndrome, those who receive "Reality Orientation" therapy will obtain better scores on the MSQ than patients who do not receive such treatment.
2. Among patients diagnosed as cases of chronic brain syndrome, those who receive "Reality Orientation" treatment will obtain better ratings on the PSMS than will patients who do not receive such treatment.

Chapter II

METHODOLOGY

Setting

The setting for the present study was a 100-bed, skilled, non-profit nursing home. The general atmosphere was one of cheerfulness and interest in the patients. Staff members appeared to be open and willing to initiate programs that might result in improved patient care. Physical and occupational therapy were available to patients on the order of their physician. However, in this as in most nursing homes, these modalities were seldom ordered for patients receiving "custodial care." General activities such as bingo and a cooking class were provided for those physically and mentally able to participate.

The subjects for this study were selected from the 59 patients assigned to the second floor of the nursing home. Assignment to this floor was based on the need for more than minimal care with one or more activities of daily living, such as toileting and bathing. Most of the patients on the second floor were dependent on the nurses for ambulation around the unit. All of the rooms on this second floor

were semi-private. There was no special section for males and females. A recreation room with television and phonograph served also as a dining room for those patients the nurses would bring in for meals. There was one large room with a television and chairs for visitors.

Staffing patterns on the second floor provided four registered nurses and 21 aides to work with patients over a 24-hour period. This nursing home was affiliated with a retirement home on the same grounds. A physician visited the facility three times a week to see the patients needing care in the nursing home and in the retirement center.

Data-Gathering Instruments

Two instruments were used in this study, the Mental Status Questionnaire (MSQ) and the Physical Self-Maintenance Scale (PSMS).

MSQ

The MSQ is a ten-item test of orientation and memory which was established as a quantitative scale for chronic brain syndrome patients by Kahn et al. (1960). It has also been used extensively in research by Brody et al. (1971). The questions test orientation for time, place, person, recent and remote memory and general information. Questions are scored "right" or "wrong" and the

respondent's impairment is determined by total number of errors. Greater MSQ scores imply greater impairment. Thus, the impairment is judged "none to mild" if there are 2 errors or less; "moderate" if errors number 3 to 8; and "severe" if errors number 9 or 10. (See Appendix B for a copy of the MSQ). Before the beginning of the experiment, the MSQ was administered by the investigator to all patients with a diagnosis of chronic brain syndrome, in order to facilitate the selection of matched pairs of subjects. At the completion of the experiment, the MSQ was again administered by the investigator to all members of the experimental and control groups.

PSMS

Adapted from the Langley-Porter Scale, the PSMS assesses the individual's capacities for each of 6 types of behavior--toileting, dressing, feeding, grooming, physical ambulation, and bathing--along a 5-point scale from "most competent," (score of 1) to "least competent," (score of 5). An individual might then receive a score ranging from 6 to 30, on the basis of the judgments of one rater.

Lawton and Brody (1969) claimed that the PSMS meets Guttman-scaling criteria. In other words, the scale has a cumulative property, so that a person who is rated competent with respect to a more complex behavior, is very likely to be rated competent with reference to the preceding, less complex items. Evidence as to the

validity of the scale was also provided by Lawton and Brody (1969) through their demonstration of moderate correlations of the scale with other functional measures such as Waldman's and Fryman's (1964) Physical Classification (PC) and Behavior Adjustment Rating Scales (BA). (See Appendix C for a copy of the PSMS).

Before the beginning of the experiment, each patient with chronic brain syndrome was evaluated on two consecutive days by three judges (two registered nurses and one aide) concerning his or her ability to perform activities of daily living as measured on the PSMS. The two nurses were permanent staff members and well acquainted with all the patients so they evaluated all patients.

Each patient was similarly evaluated by the aide specifically assigned to his or her care. Some aides were responsible for more than one patient and so provided evaluations for more than one patient. In all, six different aides provided evaluations for one to five patients.

This procedure was followed in order to overcome the possible bias of just one individual rater. It was believed that an average rating of a number of judges, in this case three, would provide a more accurate measure of the patients' functioning than would the rating of one judge alone. This procedure also permitted the investigator to check on inter-rater reliability and determine the extent to which independent observers agreed on the behavior of a given

patient. In recognition of the problem of intrarater reliability, each rater was requested to make judgments on two consecutive days. Thus, the consistency of their judgments over time could be checked.

The measure of physical functioning (PSMS) of the patient that was used in the analysis of the data was the total of the ratings given by the three judges on the second of the two days. Note that this procedure permitted a possible range in PSMS scores from 18 (most competent) to 90 (least competent).

Criteria for Selection of Subjects

Since "Reality Orientation" was developed specifically to benefit patients with "moderate to severe" mental impairment due to chronic brain syndrome, the following two criteria were employed in the selection of subjects:

1. The patient was diagnosed as suffering from chronic brain syndrome by the attending physician.
2. The patient manifested "moderate to severe" mental impairment.

The diagnosis of chronic brain syndrome was determined by checking the patient's medical chart. Of the 26 patients so diagnosed, two were critically ill and hence were excluded from the study. This left 24 patients as potential subjects.

The mental condition of the patients who met the first criterion

was measured by performance on the Mental Status Questionnaire. It was found that all 24 patients suffered "moderate to severe" mental impairment by making from 3 to 10 errors on that test. All were, therefore, listed as possible subjects.

Because it was hypothesized that patients who received the "Reality Orientation" treatment would demonstrate over time an improved mental status and increased participation in activities of daily living, it seemed desirable that the two groups, experimental and control, be roughly similar at the beginning of the study in regard to their mental status and in regard to their ability to perform activities of daily living. Accordingly, from the 24 patients, ten pairs were selected for inclusion in the study on the basis of their MSQ and PSMS scores. One additional pair of patients was included in case of attrition by discharge or death. Insofar as possible, it was also attempted to match the pairs by age, sex, and marital status because these are factors that presumably might affect mental status, physical capabilities and reactions to treatment programs. Physical limitations such as contractures and arthritis were noted, as well as the fact that the majority of the patients were receiving some form of tranquilizer. These variables were not controlled, and it is possible they may have affected the results of this investigation.

Only two pairs of males were included in this study, not by intention but because of the predominance of females in the home.

Generally an uneven sex ratio prevails in nursing homes due to the tendency of women to survive men. Most of the subjects were widowed.

Design

In testing the hypotheses stated above, a basic experimental design was used with a pretest and posttest on both experimental and control group subjects. Such a design has the advantage of providing internal validity. However, external validity is jeopardized to the extent that pretesting affects the posttest scores. Hence, generalizations of results from the sample to the unpretested universe remains problematic. (For a discussion of the problems of internal and external validity associated with this experimental design, see Campbell et al., 1963; 13-24). The experimental and control groups each consisted of ten patients suffering from a moderate to severe degree of chronic brain syndrome. These patients were matched on a number of relevant dimensions, age, sex, and marital status, in addition to their ratings on the Mental Status Questionnaire and the Physical Self-Maintenance Scale.

The assignment of one member of each matched pair to the experimental group and the other to the control group was accomplished through the toss of a coin. "Reality Orientation" was then initiated for the ten patients in the experimental group. These

individuals were the targets of the concerted efforts of all staff members, who on every contact emphasized names, dates, places, and generally the here-and-now. These ten individuals were further subdivided into two groups, each of which attended classes five days a week, 30 minutes a day. The classes were conducted throughout by a registered nurse, a staff member of the nursing home. Patients in the control group were not officially designated as targets for treatment but may have incidentally received increased sensory stimulation from the members of the staff as they worked specifically with those in the experimental group. They may also have benefited from the changes made in the physical environment during the subsequent weeks. All subjects remained in their assigned, standard living accommodations interspersed among non-study residents on the second floor of the institution.

After a period of six weeks, the patients of both the experimental and control groups were again rated on the 2 instruments and the scores of the two groups were compared to assess the effectiveness of the treatment, "Reality Orientation" in improving mental status and participation in activities of daily living.

Permission for this study was obtained from the physician who made a note of approval on the patients' medical charts. Permission was also obtained from the administrator of the nursing home.

Chapter III

RESULTS

Attrition of the Sample

As stated in the preceding chapter, ten pairs of patients were initially matched on a number of relevant dimensions as well as on the ratings they received on the Mental Status Questionnaire and the Physical Self-Maintenance Scale. One additional pair of patients was matched and held in reserve in case of attrition of the sample by discharge or death. In the ensuing weeks, one patient in the experimental group did improve sufficiently to warrant her discharge home to her daughter, and her paired control died of a heart attack. The reserved pair then was substituted for these two subjects. Subsequently, two other control patients also expired, one of a heart attack and the other from an upper respiratory infection. Thus, at the conclusion of the 6-week period, ten patients remained alive in the experimental group but only eight in the control group. It was necessary, therefore, to perform the final analyses on just the eight matched pairs that remained.

It would appear from Table 1 that the attrition of the original

Table 1. A Comparison of the Original Sample and of the Sample After Attrition with Respect to Sex, Age, Marital Status, and Pretest Scores on MSQ and PSMS.

Characteristic	Original Sample (N = 20)	Final Sample* (N = 16)
Sex		
Male	4	4
Female	16	12
Age (years)		
Range	70-94	70-94
Mean	85.8	85.9
Marital Status		
Single	3	2
Married	4	3
Widowed	13	11
Divorced	0	0
MSQ Scores on Pretest		
0-2 (mild impairment)	0	0
3-8 (moderate impairment)	9	9
9-10 (severe impairment)	11	7
Mean	8.3	8.1
Range	4-10	4-10
PSMS Scores on Pretest		
Range	30-83	30-78
Mean	61.3	60.3

* Due to the death of two members of the control group, only eight pairs remained at the time the experiment was completed.

sample did not alter substantially the nature of the study population with respect to the characteristics selected for matching. Thus, the mean age of the initially selected twenty patients was 85.8 years, whereas the mean age of the sixteen patients remaining in the sample at the conclusion of the investigation was 85.9. In both the original and final samples, the patients were predominantly widowed or single. With respect to mental status, on the pretest the mean MSQ score was 8.3 for the twenty original subjects, and 8.1 for the sixteen subjects in the final sample. Finally, with respect to functioning in everyday activities, there was no significant difference at the beginning of the experiment between the PSMS score of 61.3 of the entire twenty patients and the mean score of 60.3 obtained by the sixteen who subsequently comprised the final sample.

Therefore, it is concluded that the attrition experienced did not change substantially the character of the study group. The patients of the final sample appeared to be quite similar to the overall total sample, with respect to the selected dimensions.

Mental Status of the Patients

We turn now to a comparison of the mental status of the members of the experimental and control groups immediately prior to the institution of "Reality Orientation" therapy, and again six weeks later. Findings are presented in Table 2.

Table 2. Pretest and Posttest Scores of Experimental and Control Groups on the Mental Status Questionnaire.

Group	Pretest (N = 16)	Posttest (N = 16)	Difference Between Pretest and Posttest Scores
Experimental			
Mean	8.1	7.7	-0.4
Range	5-10	2-10	
Control			
Mean	8.2	8.3	+0.1
Range	6-10	6-10	

In the pretest (before the institution of "Reality Orientation" therapy), the mean score of the eight members of the experimental group was 8.1, and the mean score of the eight members of the control group was 8.2. This near identity of the two groups is, of course, to be expected in view of the effort to match the two groups in this respect.

On the posttest, at the conclusion of the experiment, the mean score of the eight patients in the experimental group had decreased very slightly (-0.4 points). This indicates a very slight improvement. The mean score of the control group rose just a fraction of a point, from 8.2 to 8.3. Obviously, these minute differences, though in the predicted direction, are insignificant and so we cannot reject

the null hypothesis. We conclude, therefore, that the experimental condition, "Reality Orientation" therapy, did not influence mental status.

The actual scores of each matched pair at the completion of the 6-week experiment are reproduced in Table 3. No experimental subject made more errors on the posttest than his paired control subject, and in four instances, the experimental member made fewer errors. But again, the differences are very small and unspectacular. It appears clear, then, that the experimental condition, "Reality Orientation" therapy failed to change the mental status of patients, if the MSQ is accepted as a valid measure of degree of orientation.

The number of times each specified question on the MSQ was answered correctly can be ascertained from Table 4. It is evident from this table that birthdate and birthplace are more frequently remembered than are the other solicited items of information. Although it was not part of the Mental Status Questionnaire, the investigator asked each patient his or her name, on both administrations of the test. Of the sixteen in the final sample, only one person answered inappropriately on either occasion. She was a member of the experimental group and scored ten errors on both the pretest and posttest.

Physical Self-Maintenance Scale Findings

Each patient, on the initial and final scoring of the PSMS, was

Table 3. Differences in MSQ Scores of Matched Pairs of Subjects in the Experimental and Control Groups, at Conclusion of Experimental Period.

Matched Pair	Posttest MSQ Scores of		Difference in Scores of the Two Members
	Member of Pair in Experimental Group	Member of Pair in Control Group	
1	10	10	0
2	10	10	0
3	7	8	-1
4	2	7	-5
5	9	10	-1
6	6	6	0
7	4	6	-2
8	10	10	0

Table 4. Number of Correct Responses to Each Specified Question on the MSQ by Experimental and Control Subjects: Pretest and Posttest.

Questions*	Pretest			Posttest		
	Experi- mental	Con- trol	Total	Experi- mental	Con- trol	Total
1	0	1	1	2	1	3
2	2	3	5	3	2	5
3	0	1	1	1	2	3
4	1	0	1	1	0	1
5	0	1	1	0	0	0
6	1	1	2	3	1	4
7	5	4	9	3	4	7
8	5	5	10	5	4	9
9	1	1	2	3	0	3
10	1	0	1	0	0	0

* The questions are as follows:

1. Where are we now ?
2. Where is this place located ?
3. What month is it ?
4. What day of the month is it ?
5. What year is it ?
6. How old are you ?
7. What is your birthday ?
8. Where were you born ?
9. Who is the president of the U. S. ?
10. Who was president before him ?

evaluated on two consecutive days by three judges. This procedure was followed to overcome the possible bias of one rater. The intra-rater and the inter-rater reliability of the PSMS scorings proved extremely strong. Thus, the Pearsonian correlations entered into Table 5 indicate (1) very high agreement across the three judges as to the functioning of each patient at any given time, and (2) consistency over time by each rater in evaluating a given patient.

Because the correlations were high, probably any judge's ratings on either day might have been utilized as the measure of the subjects' functioning. However, as stated previously, the estimate of the patients' physical functioning used in this analysis was the sum of the ratings given to that patient by the three judges on the second of the two days. Therefore, the potential range of scores was from 18 to 90 with the higher scores representing greater disability.

As may be noted in Table 6, initially the mean score of the experimental group was 62.0 in comparison with the slightly better score of 58.6 of the control group. A *t* test revealed no significant difference between the means of these two scores ($t = .1$, two-tailed test). These scores indicated that both groups needed moderate assistance in activities of daily living before the experiment. Scores of 54 to 72 indicated that moderate assistance was needed.

By the end of the experimental period, the mean score of the experimental group had decreased 8.8 points from 62.0 to 53.2,

Table 5. Pearsonian Correlations Indicating Intra-Rater and Inter-Rater Reliability of Scores Assigned to Patients on the Physical Self-Maintenance Scale by Nurses and Aides: Before and After the Institution of "Reality Orientation."

Pairs of Ratings Correlated	Pearsonian Correlations Between Judges' Ratings at	
	Pretest	Posttest
Intra-Rater Reliability		
Nurse A, Day 1, Day 2	.962	.990
Nurse B, Day 1, Day 2	.972	.972
Aide, Day 1, Day 2	.971	.913
Inter-Rater Reliability		
Nurse A, Nurse B, Day 1	.953	.856
Nurse A, Nurse B, Day 2	.936	.854
Aide, Mean Nurse, Day 1	.939	.877
Aide, Mean Nurse, Day 2	.945	.877

Table 6. Pretest and Posttest Mean Scores, Ranges and Differences on the PSMS for the Experimental and Control Groups.

Group	Pre-test	Post-test	Difference Between Mean Scores on Pretest and Posttest*
Experimental (N = 8)			
Mean	62.0	53.2	-8.8*
Range	39-75	23-67	
Control (N = 8)			
Mean	58.6	59.2	+0.6
Range	30-78	42-73	

* Difference between -8.8 and +0.6 was significant at the .05 level, one-tailed test, $t = 2.17$, $df = 7$.

implying improvement, whereas the mean score of the control group rose a fraction of a point to 59.2. The difference between the two groups in the amount of change noted on the PSMS proved to be statistically significant ($t = 2.17$, one-tailed test, $p < .05$). The control group thus continued to require "moderate" assistance with activities of daily living, while the experimental group progressed from needing "moderate" assistance to needing "minor to moderate" assistance.

Again, when comparison is based on the difference between members of matched pairs, rather than on group means, the findings are similar. Inspection of Table 7 reveals that in seven pairs, the experimental group member demonstrated greater change on the PSMS from pretest to posttest than did his counterpart in the control group. In the eighth instance, the amount of change was equal for both individuals. This difference in amount of change on the PSMS reaches statistical significance at the .01 level. (Wilcoxon test, $T = 0$, one-tailed test, $p < .01$).

A final consideration concerns the nature of the changes that occurred. Are some tasks of daily living more complex than others, so that they may be arranged in a hierarchy with respect to difficulty of performance? In Table 8, the mean scores of the experimental and the control subjects in the six areas of the PSMS are presented and ranked in order of increasing score magnitude or decreasing competence. It may be seen that the greater competence was

Table 7. Ranked Differences of Amount of Change in PSMS Scores from Pretest to Posttest Demonstrated by Matched Pairs.

Matched Pair	Amount of Change in PSMS Scores from Pretest to Posttest Demonstrated by		Difference in Change of the Two Members	Ranked Differences*
	Member of Pair in Experimental Group (N = 8)	Member of Pair in Control Group (N = 8)		
1	-6	-6	0	
2	-3	-2	-1	1
3	-2	+1	-3	2
4	-9	+14	-23	7
5	-14	+2	-16	5
6	-16	+1	-17	6
7	-12	-6	-6	3
8	-8	-1	-7	4
				T = 0

* Ranked differences analyzed by Wilcoxon's Matched-Pairs Signed-Rank Test. (T = 0, df = 7, p < .01, one-tailed test)

Table 8. Ranking of Mean Scores in the Six Areas of the PSMS for Experimental and Control Groups, at Pretest and Posttest.

		Ranking of Mean Scores in Six Areas of PSMS for Experimental Group						Ranking of Mean Scores in Six Areas of PSMS for Control Group						
		Pretest			Posttest			Pretest			Posttest			
Rank*	Area	Score	Rank	Area	Score	Rank	Area	Score	Rank	Area	Score	Rank	Area	Score
1	Feeding	59	1	Feeding	48	1	Feeding	64	1	Feeding	56			
2	Ambulation	75	2	Bathing	70	2	Ambulation	76	2	Ambulation	79			
3	Bathing	86	3	Ambulation	71	3	Toileting	78	3	Bathing	81			
4	Grooming	90	4, 5	Toileting	78	4	Bathing	82	4	Dressing	85			
5	Toileting	93	4, 5	Dressing	78	5	Dressing	84	5	Grooming	86			
5	Dressing	93	6	Grooming	81	6	Grooming	85	6	Toileting	87			

*Rank "1" represents area in which best functioning is observed; rank "6" represents lowest level of functioning.

demonstrated by members of both groups, at both pretest and post-test, in the areas of feeding and ambulation, than in the areas of grooming and dressing. However, the picture that emerges from the data is not one of a clear-cut hierarchy of behavioral competencies.

In Table 9, data are presented concerning the changes that occurred in these six areas of the PSMS. In the case of the experimental group, improvements were noted in every area. Five changes involved 1 full point or more, on the 5-point scale. The greatest improvement occurred, in the judgment of the raters, in the areas of bathing, toileting and dressing; the least in ambulation. For the control group, the situation was rather different. They were judged less changed in general over the six-week period, and as likely to be deteriorated as improved. Members improved most in feeding and deteriorated most in toileting.

Table 9. Pretest and Posttest Mean Scores and Degree of Change for Members of the Experimental Group and for Members of the Control Group in the Six Areas of Functioning of the PSMS.

Area	Experimental Group			Control Group		
	Mean Score		Change	Mean Score		Change
	Pre-test	Post-test		Pre-test	Post-test	
Toileting	11.6	9.8	-1.8	9.8	10.9	+1.1
Feeding	7.4	6.0	-1.4	8.0	7.0	-1.0
Dressing	11.6	9.8	-1.8	10.5	10.6	+0.1
Grooming	11.3	10.1	-1.2	10.6	10.8	+0.2
Ambulation	9.4	8.9	-0.5	9.5	9.9	+0.4
Bathing	10.8	8.8	-2.0	10.3	10.1	-0.2

Chapter IV

DISCUSSION

Attrition of Sample

It is interesting to note that the attrition in the experimental group was due to marked improvement of one member who was then discharged, whereas the attrition in the control group was the result of the poorest possible outcome, namely death. One can only conjecture whether the special attention accorded patients in the experimental group tended to increase their motivation to live, whereas standard nursing home care given the control group members either insidiously undermined their will to live, or at least did little to counter apathy and disinterest in living.

In the literature, one frequently finds the assumption that any experimental treatment administered to one segment of a group may somehow "spill over" onto other segments, thus introducing changes in their situation as well as in the situation of the experimental subjects. Often it is assumed that if the effects are beneficial to the experimental group, then they will be beneficial to the control group as well, albeit not so markedly. This had indeed been the original

assumption of the present investigator who feared confounding of the study results by the tendency of the staff to apply "Reality Orientation" therapy across the board to all patients, to members of the control group as well as the experimental. The investigator now wishes to point up the opposite possibility; at times the institution of a therapeutic program for one group may indeed affect the control group, but in an adverse direction. Thus, it is possible that the added attention to one group may reverberate to the disadvantage of the control group. Less attention may be paid to the control group subjects than was the case before the institution of the experiment, if the staff is deeply involved in the therapeutic endeavor. In fact, in the present study during the 6-week period, the investigator heard complaints voiced by a registered nurse that at least one aide was neglecting other patients in favor of the experimental patients. It would seem useful to pursue the question of the conditions under which the "spill over" effect from a therapeutic program may benefit and the conditions under which it may injure the nonselected individuals. To our knowledge, this problem has never been empirically investigated. In this instance, on the basis of survival rates alone, one might be tempted to conclude that the milieu experienced by the control group members during the 6-week period under consideration was somewhat less salubrious than the milieu experienced by members of the experimental group.

Mental Status of Patients

No difference was found between the experimental and control groups in mental status. The following post hoc explanations are offered for this finding which ran counter to prediction.

One reason for the failure of the experimental group to show improvement might be the effect of the interviewer on the subjects. In this instance, it may have been that unfamiliarity with the investigator inhibited the patients and failed to elicit proper responses. Perhaps the familiar teacher and aides could have done so. In fact, after the administration of the posttest by the investigator, the teacher was asked to repeat the Mental Status Questionnaire to the classes. It was then found that all but one subject scored somewhat higher than they had when tested by the investigator. This finding upholds the merit of the above explanation.

Secondly, the lack of any significant change in mental status may have been a result of the time factor in this study, namely, the 6-week period. The teacher, who had attended the course on "Reality Orientation" at Tuscaloosa, Alabama, was told that a period of 18 months is a realistic time period in which to observe changes in mental orientation.

A third possibility may be that perhaps the MSQ, which appeared to contain the information which would demonstrate level of

alertness to reality, was a poor instrument for this study. It was the investigator's strong impression that the experimental subjects were much more aware of her presence, when rating them on the MSQ, at the end than at the beginning of the experiment. Instead of closed eyes and lack of interest on the part of some severely regressed patients, an inquiring look was evident in their eyes. Other patients who had rambled instead of answering on the initial MSQ test responded with such comments as "I don't know" or "I don't remember" at the time of the second rating.

If the information found in the MSQ is considered important in assessing a patient's awareness, then perhaps a more systematic approach to learning and retaining this material is essential. Goals for specific bits of cognitive information could be set up by the teacher of the class and communicated to the entire staff so that these are the only bits of information asked of the patient at a given time. In class, these same items of information could be transmitted and reinforced a specified number of times for each patient. As it was, patients were repeatedly asked these questions, but no definite goals had been set for them individually. The class may have introduced too many stimuli and failed to follow through by providing techniques to ensure retention of such material. When the patients did answer correctly, their responses might have been the consequence of immediate recall.

As was mentioned previously, birthday and birthplace were the two bits of information recalled by most patients. It is also interesting to note that only one person was unable to state her name. This finding concurs with the common opinion that a person's name is a deeply entrenched part of the self. Not knowing one's name indicates, to most observers, a high degree of disintegration of intellectual functioning on the part of the person concerned.

Competence in Activities of Daily Living

The fact that the experimental group improved in all six areas of the PSMS calls for some explanation. Several studies mentioned in the literature maintained that mental competence appears to be related to competence in activities of daily living (Brody, 1971; Goldfarb, 1962; Kahn, 1960). If this conclusion is indeed true, the validity of the MSQ in measuring alertness and mental competence must be questioned.

It should be remembered that the scoring of the PSMS at the end of the experiment was performed by members of the staff who had been involved in the therapeutic program. Thus, the possibility of bias in the scoring at posttest is definitely present. The raters knew who the members of the experimental group were at posttest, whereas, at pretest, selection had not yet been made. However, comments by a registered nurse (teacher of the class) on each patient in the

experimental group appear to support the view that the higher ratings on the PSMS represented changed behavior. For example, with reference to one patient she stated: "Can hold a glass and drinks well from it now. Still will not read in class but now makes comments as 'That is very nice' after the menu is read to her." Referring to another patient, she stated: "Beginning--had to be fed, incontinent for approximately 6-7 years, read very little in R.O. class. Conclusion--eats well when given 1 dish at a time. At the conclusion of the 30th class, when being returned to her room, she said 'I need to use the toilet.' She has made no request for any such assistance for many years." Comments for the remaining six members of the experimental group may be found in Appendix D.

A second possibility for the apparent improvement in overall functioning of the experimental group members may be the fact that specific goals regarding the patients' physical functioning were set up for the experimental group by the aides and the nurse conducting the class. These goals were evaluated by them every two weeks and revised as warranted. Although these goals and their implementation were not part of "Reality Orientation" per se, most patients appeared to benefit from them. For example, one patient who had ambulated reluctantly only a short distance with the assistance of two nurses and a walker at the beginning of the study, was able to walk alone with the walker a much greater distance at the end of the 6-week

period. This same patient had originally resisted efforts to bathe him and get him out of bed. According to the staff, he later became eager to get up and "go to class." This reaction accords with the findings of several studies, namely, that if the environment offers a stimulating situation, the patient will respond (Albrecht, 1951; Burnside, 1971; Cosin, 1957).

Another patient had been completely dependent on the nurse for bathing and feeding. One day, after setting up goals for this patient, the aide handed her the wash cloth and asked her to wash her face and hands. This the patient did without any urging. When asked why she hadn't been washing herself before, the patient replied: "No one ever asked me to." This again emphasizes that what is expected of a patient often determines his behavior (Brody *et al.*, 1971).

While improvement for the experimental group was noted in all areas, the greatest amount was in bathing, followed by toileting and dressing. The improvement in bathing was most likely due to the nurses' and aides' setting goals for patients and encouraging them to meet these goals.

Regarding the improvement of the subjects in the area of toileting, at least two explanations are possible. First, the improvement might have been due to the increased general awareness of the subjects. A second possible explanation rests on the assumption that incontinence may be used as a stratagem for gaining attention. If

this assumption is correct, then it might be argued that the experimental subjects no longer experienced a strong unmet need for attention. Similarly, the regression in toileting noted for the control group might be explained on the grounds that those patients did not receive an amount of personal attention adequate to their needs.

Finally, the improvement in dressing of the members of the experimental group may be attributed to the implementation of specific goals for patients by the staff, to the increased staff attention available to patients, and to their generally enhanced awareness.

The above findings agree with the results obtained by Brody et al. (1971) in their study of patients diagnosed as cases of chronic brain syndrome who were the objects of an individualized treatment program. While no mention is made of a significant change in bathing, the areas in their study that demonstrated significant change in the experimental group for the pre-post period were toileting and dressing. The results of the present study also show a marked change in these two areas.

As stated earlier, for this study population, the six areas of functioning did not form a clearcut hierarchy of behavioral competencies. However, feeding and ambulation appeared to be the areas of best functioning, generally, and grooming and dressing the areas of least adequate functioning. That a characteristic pattern of functional dependence does exist with respect to activities of daily living

has been suggested by at least two investigators. Thus, Lawton and Brody (1969) have claimed that the PSMS items meet Guttman scaling criteria. This implies a hierarchical ordering of the behaviors with respect to adequacy of functioning. Unfortunately, their presentation does not make clear the precise ordering of the six areas, from least to most adequate, for patients with chronic brain syndrome. Katz (1959) has concluded, on the basis of evaluations of 45 patients with fractured femurs, that assistance is most frequently required for bathing, then for dressing, toileting, transferring, and feeding, in that order. Although his sample differs radically from that of the present study, in both investigations the least assistance was required for feeding and ambulation.

Milieu

A number of broad changes occurred in the nursing home during the six-week experimental period. Doubtless these changes were brought about by the interest of the staff who, enthusiastic over the prospects of "Reality Orientation" for the brain-damaged, searched for therapeutic programs suitable for patients with other problems.

Some of these changes affected patients other than those manifesting chronic brain syndrome. An example was the establishment of a current events class for patients who were mentally alert but physically handicapped. This current events group met three times

a week and the patients took turns in leading the discussions. One obese patient, who had gotten out of bed to take a shower only about three times a month, was persuaded to attend one of these discussions. With great reluctance she attended, found she enjoyed the class, and did not miss a session thereafter. Another depressed patient, after attending a few discussions, stated she thought she had come to the nursing home to die and nothing seemed worthwhile. She is now one of the most active members of the discussion group.

Other changes, such as alterations in the physical environment, affected all patients in the home. Every effort was made to make the nursing home more attractive and stimulating. Instead of neutral colors in the dining room, vivid red and orange colors were seen on the walls and tablecloths. Signs instead of numbers now pointed out the way to various sections of the nursing home. Replacing pictures of flowers and landscapes were wall hangings of old cars, past events and advertisements. Bulletin boards had pertinent information such as date, current and coming events, holidays and so on. A special bulletin board was placed outside the dining room with birthdays of the day with the patients' name and room number. Large blank calendars were placed in each room. The night nurse marked the date each night for the next day.

Staff Morale

McCown (1965) noted that staff involved in a "Reality Orientation" program repeatedly remarked how gratifying they found any improvement in patients. In this nursing home, also, the staff exhibited much involvement in the treatment, and expressed great enthusiasm for its results. Enthusiasm was not restricted to nursing staff, but was shared by other employees of the institution, and by persons from the community at large. A pharmacy aide stated that she thought the program was wonderful and suggested using familiar songs to stimulate conversation in the classes. A floor scrubber was seen talking to one of the patients, asking her name, date, and so on.

Several persons in the community, upon hearing of the program, gathered and prepared signs and pictures for the facility. A group of interested persons asked the nurse teaching the "Reality Orientation" class to speak concerning her experiences, and were so impressed as to ask for a course on that topic at the nearby community college.

Hawthorne Effect

It is difficult to say whether the improvement of the patients, staff morale and milieu was due to the "Reality Orientation" per se. A frequently observed phenomenon in treatment programs is

generalized improvement which may be attributable to the greatly increased attention received by the subjects rather than to specific treatment input. This "Hawthorne" effect cannot be discounted in this study. Whether these same results would have occurred with another therapy is a question unresolved by the present study.

Limitations

Several limitations of this research are apparent. First is the problem of the generalizability of results beyond the sample. Strictly speaking, the findings are applicable only to patients who are similar to those tested here, and who have also been subjected to a pretest before the institution of "Reality Orientation."

A second limitation is presented by the small size of the sample. A larger sample than the present one would probably permit more confidence in findings.

A third limitation involves the failure to obtain "blind" ratings from judges. In another study, a distinct effort should be made to ensure that ratings of competence either in mental status or in activities of daily living be made in the absence of knowledge as to the status of the subjects as experimental or control group members.

Fourthly, the particular instrument utilized to measure mental status may not be appropriate for evaluating the effectiveness of the "Reality Orientation" program. An instrument more directly relevant to goals of those conducting the program should be developed.

Chapter V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

At the present time, due to legal requirements, the physical needs of patients in nursing homes are usually satisfied. However, the psychological and mental needs of patients, especially those with chronic brain syndrome, are often ignored or forgotten. These confused, disoriented patients are often considered too deteriorated or withdrawn to benefit from the various treatments advocated for the mentally ill. Unfortunately, many are also considered to be too old to warrant expenditure of staff resources in their behalf.

It was the purpose of this experimental study to determine whether a treatment known as "Reality Orientation" would have any effect on the mental status of chronic brain syndrome patients or on their participation in activities of daily living. "Reality Orientation" is a therapy specifically developed for brain-damaged individuals. Efforts are made in formal class periods to return the patients to contact with reality by stressing time, place and personal identity. In addition, all personnel coming in contact with such patients are also expected to reinforce such instruction, stressing at every opportunity who the patient is, who the others are, what the time is, the

place, and so on.

The method of investigation was experimental, with a pretest, posttest, and control group. Ten pairs of subjects were matched on the dimensions of sex, age, marital status, severity of brain impairment, and adequacy of physical functioning. One member of each pair was assigned randomly to the experimental group, and his counterpart to the control group. Kahn's (1960) Mental Status Questionnaire was administered to each patient to determine the severity of his brain impairment. Physical functioning was assessed by Lawton's (1969) Physical Self-Maintenance Scale (PSMS). Patient scores on this PSMS were obtained from the combined ratings of two nurses and one aide. These ratings were made before the initiation of "Reality Orientation" and again at the end of the 6-week experimental period.

The prediction was not borne out that mental status improved with "Reality Orientation." However, the second prediction was supported. There was a significant change in participation in activities of daily living in the experimental group in contrast to the control group. Though not predicted, a more stimulating milieu as well as improvement in staff morale were evident after the experiment.

The overall conclusion to be drawn from this research is that therapeutic programs can improve the condition and enrich the lives of elderly persons who are suffering from chronic brain syndrome.

Although the period of experimentation was only six weeks long, many small changes were seen in the patients and in the attitudes of the staff caring for these patients. Before the study, these confused, disoriented patients were given good physical care, but little was expected of them. Due to the patients' inability to communicate clearly, attempts at conversation with them by the staff were few. Staff members would talk among themselves as if the patients were not there, a phenomenon which increases depersonalization. During the experimental period, a concerted effort was made to communicate with the patients, whether they answered or not. A hopeful attitude on the part of the staff toward these confused patients replaced the pessimistic view that nothing could be done for this type of patient.

In conclusion, the following recommendations for future research are suggested. In another study, it would seem highly desirable that raters who are unaware of who belongs in the experimental or control condition might be utilized to evaluate the patients regarding their functioning in activities of daily living and their impairment as measured on the Mental Status Questionnaire. In this way, any possible bias could be eliminated in the scoring.

A larger sample and a longer experimental period would probably yield more accurate results in determining the effectiveness of "Reality Orientation" as a treatment for helping the confused elderly patient.

An instrument other than the Mental Status Questionnaire might be utilized in a future study if the goals of "Reality Orientation" are not the simple evoking of appropriate responses to specific items as the time, place, and so on. If, on the other hand, the questions asked on this questionnaire are considered as valid indicators of orientation, then specific goals might be set up in the "Reality Orientation" class and known principles of learning and education utilized so as to facilitate the learning and retention of these items by brain-damaged subjects.

A study involving two or more similar groups utilizing "Reality Orientation" for one group and a different treatment for each of the other groups might help assess the relative desirability of different types of treatment for the disoriented patient.

Because there was an apparent though unmeasured change in the attitudes and morale of the staff, a future study might investigate the reality of this change by incorporating measures of staff morale and attitudes.

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APPENDICES

APPENDIX A

Basic Guidelines for Reality Orientation Class

(Stephens, 1969)

Basic Guidelines for Reality Orientation Class

1. Introductions

- a. Introduce yourself.
- b. Repeat your name if necessary.
- c. You may ask each patient to repeat your name.
- d. Be sure that each one can pronounce it.
- e. Always call each patient by his name and encourage him to call others by their names.

2. Atmosphere

- a. A confused patient will usually respond to a calm, friendly approach.
- b. Speak slowly and distinctly because many older patients are hard of hearing.
- c. Speak in a friendly manner, but do not talk to patients as if they were children.
- d. Look directly at each patient when addressing him.

3. Treatment Activities

- a. Plan simple activities, something that patients probably have done before.
- b. Use the Reality Orientation board, a blackboard, and a felt board.
- c. Have each patient assemble a calendar notebook. Be sure his name is on it.
- d. Make a new wall calendar each month and mark off the days each morning.

4. Advanced Activities

Advance each patient to a more complex and gratifying activity only after he improves sufficiently, becomes comfortable, and starts showing interest in his surroundings.

5. Give each patient only one simple instruction at a time. Introduce him to only one other person at a time. Remember that he is already confused, upset, and possibly hostile. Don't add to his distress by adding to his confusion.

6. Spend as much time with each patient as possible.
 - a. Don't just get him started on a project and then leave him.
 - b. Return to him often and give him help and instruction; ask about his project and what he is doing. If he has forgotten, remind him kindly.
7. Remember that it may not be the actual activity or project the patient is working on, but more likely the social interaction with others that helps him return to reality as his self-confidence and dignity are restored.
8. Group Projects
 - a. As soon as possible include each patient with other patients who have already been in Reality Orientation treatment.
 - b. Ask each patient to sign in on a daily roster and encourage him to do so.
 - c. Use spelling sessions, discussions, and so on, perhaps with a group seated around a large table. Ask patients to spell the day, week, month, weather, location of the hospital, and the next meal. Anagrams may be used. Keep all words simple and close to reality.

APPENDIX B

Mental Status Questionnaire

(Kahn et al., 1960)

Mental Status Questionnaire

1. Where are we now ?
2. Where is this place located ?
3. What month is it ?
4. What day of the month is it ?
5. What year is it ?
6. How old are you ?
7. What is your birthday ?
8. Where were you born ?
9. Who is the president of the U. S. ?
10. Who was president before him ?

Scoring:

Impairment is judged "none to mild" if there are two errors or less; "moderate" if errors number 3 to 8; and "severe" if errors number 9 or 10.

APPENDIX C

Physical Self-Maintenance Scale

(Lawton and Brody, 1969)

Physical Self-Maintenance Scale

A. Toilet

1. Cares for self at toilet completely, no incontinence.
2. Needs to be reminded, or needs help in cleaning self, or has rare (weekly at most) accidents.
3. Soiling or wetting while asleep more than once a week.
4. Soiling or wetting while awake more than once a week.
5. No control of bowels or bladder.

B. Feeding

1. Eats without assistance.
2. Eats with minor assistance at meal times and/or with special preparation of food, or help in cleaning up after meals.
3. Feeds self with moderate assistance and is untidy.
4. Requires extensive assistance for all meals.
5. Does not feed self at all and resists efforts of others to feed him.

C. Dressing

1. Dresses, undresses, and selects clothes from own wardrobe.
2. Dresses and undresses self, with minor assistance.
3. Needs moderate assistance in dressing or selection of clothes.
4. Needs major assistance in dressing, but cooperates with efforts of others to help.
5. Completely unable to dress self and resists efforts of others to help.

D. Grooming

1. Always neatly dressed, well-groomed, without assistance.
2. Grooms self adequately with occasional minor assistance.
3. Needs moderate and regular assistance or supervision in grooming.
4. Needs total grooming care but can remain well-groomed after help from others.
5. Actively negates all efforts of others to maintain grooming.

E. Physical Ambulation

1. Goes about grounds or city.
2. Ambulates within residence or about one block distance.
3. Ambulates with assistance of
 - a. another person,
 - b. railing,
 - c. cane,
 - d. walker,
 - e. wheelchairIf wheelchair Gets in and out without help.
 Needs help in getting in and out.
4. Sits unsupported in chair or wheelchair, but cannot propel self without help.
5. Bedridden more than half the time.

F. Bathing

1. Bathes self (tub, shower, sponge bath) without help.
2. Bathes self with help in getting in and out of the tub.
3. Washes face and hands only, but cannot bathe rest of body.
4. Does not wash self but is cooperative with those who bathe him.
5. Does not try to wash self and resists efforts of others to keep him clean.

APPENDIX D

Comments of the Registered Nurse Who Conducted
the "Reality Orientation" Class about Members of
the Experimental Group after the Six-Week Experi-
mental Period

Comments of the Registered Nurse Who Conducted the "Reality Orientation" Class About Members of the Experimental Group After the 6-Week Study Period

Patient 1. "Can hold a glass and drinks well from it now. Still will not read in class but now makes such comments as 'That is very nice' after the menu is read to her."

Patient 2. "Beginning--had to be fed, incontinent for approximately 6-7 years, read very little in R. O. class. Conclusion--eats well when given 1 dish at a time. At the conclusion of the 30th class, when being returned to her room, she said 'I need to use the toilet.' She has made no request for any such assistance for many years."

Patient 3. "Has learned to raise her arms high enough to put a dress on over her head with very little assistance. Reads all of the R. O. board most days. Announced one day that she could spell Milwaukee as well as pronounce it and proceeded to do so. (5th week)"

Patient 4. "More alert, urges her nurse to hurry and get her up in time for class. Formerly had a crying session every few days but has had none the past few weeks. Also attends a current events discussion group three times a week and always contributes something."

Patient 5. "Has gone from total care to being able to do part of her bath, assist with dressing and from incontinence, to asking for the

commode, using it and thanking her nurse for taking it away (beginning of 6th week). Slept through first several classes--now reads all of R. O. board and menu; identifies most fruits and vegetables and contributes to discussion of menus when asked."

Patient 6. "Slept through 1st several classes. Now keeps eyes open, is alert and apparently interested in her surroundings. Only word spoken was "Yes" when asked if her name is ----. Missed 7 classes due to upper respiratory infection."

Patient 7. "Has learned to shave himself and do part of his bath. No recent report of him spilling his urinal which was the usual thing 6 weeks ago. Urges his nurse to get him ready in time for class--even on Saturday when there is no class."

Patient 8. "Originally was being lifted from bed to chair and vice-versa. Now brushes his teeth with minimal assistance. Ambulates in the walker with assistance now. Resisted care and 'cussed' at his nurse--does not do this anymore--(once in class is all--none reported during care). Wife was coming to feed him 3 times a day. Now he is usually well finished when she arrives."

AN ABSTRACT OF THE FIELD STUDY OF

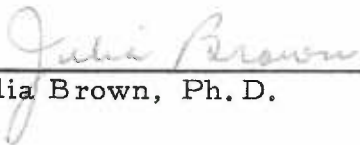
JANE F. NIKOLAI

For the MASTER OF NURSING

Date of receiving this degree: June 7, 1974

Title: REALITY ORIENTATION: THERAPY FOR THE DIS-
ORIENTED ELDERLY PATIENT

Approved:


Julia Brown, Ph.D.

Field Study Advisor

The purpose of this experimental study was to assess the impact of a therapeutic treatment known as "Reality Orientation" on the mental status of a selected group of patients suffering from chronic brain syndrome. It was an additional purpose of this investigation to ascertain whether or not "Reality Orientation" would affect patients' participation in activities of daily living.

The experimental and control groups each consisted of eight patients suffering from a moderate to severe degree of chronic brain syndrome. These patients were matched on the dimensions of sex, age, marital status, in addition to their ratings on Kahn's Mental Status Questionnaire (1960) and Lawton's Physical Self-Maintenance Scale (1969). The assignment of one member of each matched pair to the experimental group and the other to the control group was accomplished through the toss of a coin. "Reality Orientation" was

then initiated for the eight patients in the experimental group. After a period of 6 weeks, the patients of both the experimental and control groups were again tested on the Mental Status Questionnaire and the Physical Self-Maintenance Scale, and the scores of the two groups were compared to assess the effectiveness of the treatment, "Reality Orientation."

The prediction was not borne out that mental status improved with "Reality Orientation." However, there was a significant change in participation in activities of daily living in the experimental group in contrast to the control group. Though not predicted, a more stimulating milieu as well as improvement in staff morale were evident after the experiment.