

## Reality Orientation and Reminiscence Therapy

### A Controlled Cross-over Study of Elderly Confused People

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We compared reality orientation with reminiscence therapy for elderly people in a large residential home, using a controlled cross-over design. Both kinds of therapy group were enjoyed by both staff and residents, and enabled staff to get to know moderately and severely confused residents. The group that received reality orientation followed by reminiscence therapy showed improvement in cognitive and behavioural measures which was not found in the other two groups. It may be important to use reality orientation techniques with confused residents before involving them in a reminiscence group.

In spite of the predominantly negative attitude of Western culture to old age (Butler, 1974; Stearns, 1977; Blythe, 1979; Emery, 1981; Thomas 1981) and the many physical, social and psychological difficulties encountered by this age group, the majority of elderly people appear to live busy, meaningful lives. Like younger people, many live relatively independently in the community; either alone, with spouses, or with families or friends. Less than 10% show the kinds of confused behaviour associated with dementia, i.e. disorientation, withdrawal, bizarre habits, or distressed feelings; and even when they do, the majority remain at home or spend only a limited time in hospital (Kay *et al.*, 1964; Kay *et al.*, 1970; Bergman *et al.*, 1978).

Nevertheless, a significant number of elderly people live permanently in residential homes or hospitals, for various reasons. In these populations the proportion of confused residents is much higher than in the community. Recently it has been found that approximately one-third of residents in non-specialist local-authority homes could be described as moderately or severely confused (Evans *et al.*, 1981). These residents tend to be dependent and withdrawn and to take little part in the social and recreational activities provided by the home.

For many years it was felt that nothing could be done to improve the quality of life for these residents, apart from providing good physical care. The situation changed, however, when researchers and other workers in the caring professions began to recognise that the environment could exert a powerful effect on behaviour, even when there was a physical basis for that behaviour. They found that elderly confused people could respond favourably to social and behavioural therapy (Taulbee & Folsom, 1966;

Folsom, 1968; Burnside, 1976; Citrin & Dixon, 1977; Miller, 1977; Hennessey, 1978). The most widely accepted and researched technique up to now has been *reality orientation* (RO) (Greene *et al.*, 1979; Holden & Woods, 1982).

More recently another technique called *reminiscence therapy*, which is based partly on one of the components of RO, has been gaining popularity (Ebersole, 1978; Norris, 1981; Lesser *et al.*, 1981). However, there appear to have been no major studies of the effects of reminiscence therapy on the elderly confused.

Both reality orientation and reminiscence therapy aim to help the elderly confused towards three objectives: relearning conversational skills, co-operating in social activities, and taking an interest in the world. Reality orientation aims also to restimulate basic orientation.

The contents of reality orientation programmes vary but all are based on the idea that certain kinds of basic orientating information are essential if the confused person is to function at a reasonable level. Emphasis is therefore placed on teaching the day, date, weather, time and use of names (Barnes, 1974; Holden & Sinebruchow, 1978; Taulbee, 1978; Greene *et al.*, 1979; Woods, 1979). Reality orientation, conducted individually or in groups, can lead to a significant reduction in disorientation (Harris & Ivory, 1976; Greene *et al.*, 1979; Jeffery, 1981, 1982; Merchant & Saxby, 1981; Powell-Proctor & Miller, 1982) and an improvement in communication for those who are mildly or moderately confused (Brook *et al.*, 1975; Holden & Woods, 1982). However, most improvement appears to be fairly specific to verbal reorientation and there appears to be little measurable behaviour change (Powell-Proctor & Miller,

1982). This could be either (a) because specific intervention techniques lead only to specific and not generalised results (Hanley *et al.* 1981); or (b) because the measures used are not sensitive enough to detect changes in behaviour.

If reality orientation is successful only in improving certain kinds of basic knowledge, it is important to know whether or not this knowledge really is essential for the individuals concerned. Even when the gain in information is accompanied by a more generalised improvement in well-being and an accompanying improvement in staff morale, it may well be that the important elements of an RO programme are not the orientating information but the stimulating influence of the social group. Woods (1979) found that residents in an RO group improved more on tests of information, orientation and various aspects of memory than similar residents in an unstructured social-therapy control-group. It is possible that these improvements were brought about because the RO groups were structured: the actual content of the RO programme may not have been important. Rating-scale assessments of the residents' functioning in the home showed no differential effect; but the staff running the groups felt that the social therapy was more effective and that these groups were easier to lead. This suggests that the staff, and probably the residents, found the social groups more enjoyable. If one of our aims in running groups is to improve the quality of institutional life, it is important that both staff and residents find the experience generally enjoyable or worthwhile; and since the gains achieved during a formal RO programme dissipate quickly once the programme has ceased (Miller, 1977; Feier & Leight, 1981; Powell-Proctor & Miller, 1982), it is important that staff and residents find the experience rewarding so that groups continue and perhaps diversify into different kinds of specialist groups.

This paper reports on an attempt to find out

whether our particular RO programme and reminiscence programme were effective in bringing about cognitive, emotional and behavioural changes in the subjects, and whether the effects of the two programmes could be differentiated. It was hoped also to gain more information about the effects of such programmes upon the staff running the groups, since it has been suggested that the main value of RO may be its positive impact on the staff (Powell-Proctor & Miller, 1982; Hanley *et al.* 1981).

## Method

### Subjects

Subjects were chosen from the residents of a large (62-place) local authority home for the elderly. Out of 20 residents selected by staff as being confused, three were excluded because of severe communication problems. Of the remainder, 15 obtained scores on the 'Information/Orientation' and 'Mental Ability' portions of the Clifton Assessment Procedures for the Elderly (CAPE) (Pattie & Gilleard, 1979) which suggested moderate-to-severe impairment of cognitive functioning. The two with adequate cognitive functioning were excluded from the study. All 15 confused subjects had sufficient sight and hearing to participate in a small group: these 15 subjects were assessed by an independent psychologist, matched for age and cognitive functioning, and randomly assigned to one of three groups.

Some details of the subjects are summarised in Table 1: there were no statistically significant differences between Groups A, B and C. All the subjects had been in the home for some time (mean 3 years 4 months, range 8 months–10 years). Their ages ranged from 72 to 90 (average 81.5), and 14 of the 15 were female. Although the residential home regularly provided activities such as bingo sessions, singing groups and outings, our subjects rarely participated and spent a great deal of time in social isolation.

### Design

The 15 subjects were divided into three matched groups of five, designated A, B and C. The subjects in the control

TABLE I  
*Characteristics of subjects at the beginning of the study. The mean value is given for each matched group of five subjects: there were no statistically significant differences between groups*

	Group A	Group B	Group C (controls)
Age: years	81.4	82.7	80.4
Length of residency: years	3.52	4.6	1.92
Information/orientation score <sup>1</sup>	5.4	5.8	5.9
Mental ability score <sup>1</sup>	6.8	8.2	7.4

1. Measured by the cognitive assessment scale of CAPE (Pattie & Gilleard, 1979)

group (C) received no treatment. Those in Groups A and B were exposed in turn to both reality orientation sessions and sessions of reminiscence therapy, in a cross-over design of study.

Six members of staff were allocated randomly to one or the other of the experimental groups: three worked throughout with Group A and the other three with Group B. Each group session was run by a member of staff and a research clinical psychologist (SB). Preliminary training for the staff consisted of six hours of introductory talks, videos, discussions and hand-outs.

### Procedure

Each group met for half an hour a day at the same time Monday–Friday for two 4-week periods. All sessions were tape-recorded. A comfortable, conventionally furnished sitting room was used. Tea was served at all sessions to help create a social atmosphere.

The *reality orientation* sessions followed the format outlined by Holden & Woods (1982) for the 'standard group'. We used a large board for recording the day, month and weather, as well as writing materials, old and current newspapers, and personal and local photographs from past and present. We also used materials to stimulate all five senses (not just sight and hearing); e.g. substances with a distinctive smell, such as vials of rosewater or sachets of cinnamon; materials with a distinctive feel, e.g. silk or sandpaper; and foods with distinctive taste and texture, like pickles or honey.

The *reminiscence therapy* sessions were based on the format suggested by Andrew Norris (Norris, 1986). We used a set of six audio/slide programmes designed to facilitate reminiscence in the elderly (Help the Aged, 1981), old photographs of local scenes, residents' personal photographs, books, magazines, newspapers and domestic articles.

When reminiscence material was used in the reality-orientation sessions, comparison was always made with the present day. These explicit comparisons were not made in the reminiscence therapy sessions, although some residents spontaneously commented on the differences between past and present. Historical accuracy was not deemed to be important during reminiscence therapy, but it was during reality orientation.

Subjects in all the groups were told that they were helping in an experiment to find out what techniques could help elderly people who were having problems with their day-to-day memory or past memories.

At the end of each session, each staff member made a subjective assessment (on a 5-point scale) of how much each resident had enjoyed the group that day. Staff not running the groups but working closely with the residents involved were asked to make the same assessment, after observing the subjects' behaviour and chatting informally to them about their day.

### Measures

#### Assessment of staff

Staff members running the groups were interviewed individually using a semi-structured open-ended format, and

the interviews were tape-recorded. Staff also completed questionnaires about the perceived effects of reality orientation and reminiscence therapy. This was done three times: before training to run groups; again at the end of Stage I; and again at the end of Stage II (see Fig 1). On each occasion they were also asked to complete a personal information questionnaire for each resident in their group and in the control group, without referring to records. The Personal Information Questionnaire (Hanley, 1982) asks basic questions about the resident's family, former work roles, and past and present hobbies and interests.

#### Assessment of residents

The following measures were taken before and after each period of group therapy, and again one month after sessions ended (see Fig. 1):

1. The Cognitive Assessment Scale (CAS) of CAPE (Pattie & Gilleard, 1979), excluding the Gibson Spiral Maze, and giving measures of:
  - (a) Information/orientation
  - (b) Mental ability
2. Life Satisfaction Indices (Gilleard *et al.*, 1981).
3. CAPE Behavioural Rating Scale (BRS), (Pattie & Gilleard, 1979).
4. Problem Behaviour Rating Scale (Jeffery, 1981), which assesses (on a 7-point scale) specific behaviour patterns associated with confusion.
5. Holden 5-point Communication Scale (Holden & Woods, 1982).

Measures 1 and 2 were completed by the residents with the aid of an independent psychologist. Measures 3, 4 and 5 were completed by staff who knew the residents well but were not involved with the therapy groups.

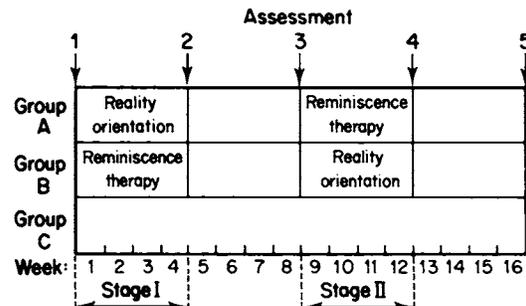


FIG. 1 Design of the study.

### Results

#### End of Stage I

##### Effects on residents

The results after four weeks of regular sessions are shown in Table II (assessment 2). At this stage, Group A (after four weeks of reality orientation) had improved on measures of information/orientation and communication, and on both

TABLE II

Scores on measures of cognitive ability, emotional state and behaviour, assessed every four weeks throughout the study period. Data represent mean  $\pm$  s.d. for each group of five subjects. On measures of information/orientation, mental ability and life satisfaction, higher scores represent improvement; on measures of behaviour and communication, lower scores represent improvement

Experimental group	Assessment	Information/orientation <sup>1</sup>	Mental ability <sup>2</sup>	Life satisfaction <sup>3</sup>	Behaviour <sup>4</sup>	Communication <sup>5</sup>	Problem behaviour <sup>6</sup>
<b>Group A</b>							
(Reality orientation)→	1st	5.4 $\pm$ 2.86	6.8 $\pm$ 4.76	11.0 $\pm$ 2.74	12.6 $\pm$ 2.88	16.6 $\pm$ 5.55	16.6 $\pm$ 9.04
	2nd	6.8 $\pm$ 3.59	5.3 $\pm$ 5.12	9.8 $\pm$ 5.44	*7.8 $\pm$ 2.59	14.6 $\pm$ 5.13	13.0 $\pm$ 7.00
(Reminiscence therapy)→	3rd	5.2 $\pm$ 3.42	5.6 $\pm$ 5.23	9.4 $\pm$ 2.7	9.1 $\pm$ 4.34	13.2 $\pm$ 3.24	11.6 $\pm$ 6.07
	4th	*6.4 $\pm$ 3.65	5.8 $\pm$ 4.97	10.6 $\pm$ 3.78	9.0 $\pm$ 4.53	12.3 $\pm$ 3.99	10.8 $\pm$ 4.87
	5th	*6.0 $\pm$ 3.39	6.0 $\pm$ 5.15	10.2 $\pm$ 3.19	9.2 $\pm$ 3.96	12.1 $\pm$ 2.86	10.6 $\pm$ 4.93
<b>Group B</b>							
(Reminiscence therapy)→	1st	5.8 $\pm$ 3.09	8.2 $\pm$ 3.7	9.6 $\pm$ 4.93	11.2 $\pm$ 4.71	15.4 $\pm$ 4.29	14.4 $\pm$ 6.35
	2nd	5.8 $\pm$ 2.95	7.4 $\pm$ 3.58	10.2 $\pm$ 7.26	*13.7 $\pm$ 9.07	14.7 $\pm$ 4.51	14.0 $\pm$ 7.21
(Reality orientation)→	3rd	*6.0 $\pm$ 3.54	6.8 $\pm$ 3.83	11.2 $\pm$ 7.07	11.4 $\pm$ 6.19	15.4 $\pm$ 4.51	12.6 $\pm$ 5.98
	4th	*5.2 $\pm$ 2.28	6.8 $\pm$ 3.49	8.6 $\pm$ 4.62	11.8 $\pm$ 5.93	15.4 $\pm$ 3.85	12.4 $\pm$ 5.64
	5th	5.4 $\pm$ 2.30	7.4 $\pm$ 3.13	9.6 $\pm$ 6.27	11.2 $\pm$ 6.50	13.6 $\pm$ 3.29	13.6 $\pm$ 5.13
<b>Group C</b>							
	1st	5.9 $\pm$ 4.74	7.4 $\pm$ 4.22	9.4 $\pm$ 3.91	15.8 $\pm$ 3.96	20.4 $\pm$ 10.31	18.2 $\pm$ 8.14
	2nd	6.0 $\pm$ 4.3	6.0 $\pm$ 4.24	9.6 $\pm$ 2.51	*17.0 $\pm$ 8.49	23.0 $\pm$ 7.07	20.0 $\pm$ 9.9
	3rd	*3.6 $\pm$ 3.58	5.6 $\pm$ 5.23	8.0 $\pm$ 6.33	15.8 $\pm$ 3.83	19.2 $\pm$ 7.61	18.0 $\pm$ 7.58
	4th	5.0 $\pm$ 4.53	6.0 $\pm$ 5.61	8.8 $\pm$ 4.87	16.0 $\pm$ 5.29	19.0 $\pm$ 6.94	17.2 $\pm$ 6.30
	5th <sup>7</sup>	*4.2 $\pm$ 4.03	5.6 $\pm$ 5.18	8.8 $\pm$ 5.85	15.2 $\pm$ 5.26	18.9 $\pm$ 5.76	18.2 $\pm$ 7.92

1. Information/orientation: Cognitive Assessment Scale of CAPE (Pattie & Gilleard, 1979)

2. Mental ability: Cognitive Assessment Scale of CAPE (Pattie & Gilleard, 1979)

3. Life satisfaction: Gilleard *et al* (1981)

4. Behaviour: CAPE Behavioural Rating Scale (Pattie & Gilleard, 1979)

5. Communication: Holden & Woods (1982)

6. Problem behaviour: Jeffery (1981)

7. Group C, assessment 5: scores for four subjects only, as one died

\*Statistically significant difference between groups

behaviour scales. The improvement on measure 4 (BRS) was significantly greater than in the other two groups (Kruskal Wallis  $P < 0.009$ , Group A over B and C; Mann Whitney  $P < 0.008$ , Group A over B; Mann Whitney  $P < 0.009$ , Group A over C). Group B (the reminiscence group) showed a slight improvement in life satisfaction compared with the other two groups, but this difference was not significant.

Since it has often been suggested (Miller, 1977; Powell-Proctor & Miller, 1982) that any positive effects of reality orientation disappear rapidly once sessions are discontinued, the residents were tested again a month after the groups ended (Assessment 3). As can be seen from Table II, the improvements shown by the RO group (A) on measures 3, 4 and 5 (BRS, Holden and Problem Behaviour scales) were maintained, but the improvement in information/orientation score was lost. However, both therapy groups did maintain their scores for information/orientation, whereas the no-treatment control group showed a marked decline: this difference from the control group was significant for the reminiscence group (Mann Whitney  $P < 0.0259$ ). It is possible that the therapy groups had some positive interaction with the residents in the control group in the experimental period (see below).

#### *Enjoyment of groups by residents*

The residents in both groups A and B seemed to enjoy the sessions: their daily attendance record was high (mean 82% for Group A residents, range 41%–100%; mean 86% for Group B residents, range 65%–100%). This regular attendance might be interpreted as compliance to staff encouragement. However, it was exceptionally high, and in marked contrast to their previous behaviour. Reitz & Hawkins (1982) found that less than 50% of the nursing-home residents in their study attended group recreation sessions, even when staff personally invited them to attend.

Although there were fluctuations in individual scores, staff assessment suggested that all the residents had enjoyed the groups (see Table III).

#### *Effects on staff*

The results from the Personal Information Questionnaire (Table IV) supported the impressions of staff that taking part in group sessions helped them to get to know the individuals in their own groups. Before sessions began, the staff knew very little about the residents in any of the three groups: out of a possible total of 40 items, an average of only 5.33 was known about each resident. By the end of Stage I staff knew much more about the residents in groups A and B: there was no difference in their knowledge between the two therapy groups, but the difference between them and the control group was very large (Kruskal Wallis,  $P < 0.009$ ).

All six staff were enthusiastic about the positive effects the sessions had on the residents, although they felt the effects were more marked for the less severely confused. The staff themselves enjoyed taking part in the groups. Five out of six felt that the group experience had helped them to talk more freely to residents on a variety of topics, both outside

TABLE III

*Enjoyment of sessions by residents (assessed by staff). Rating scale from 1 (non-enjoyment) to 5 (maximum enjoyment). No significant difference was found between groups or between types of therapy*

	<i>Staff running therapy groups</i>	<i>Other staff</i>
<i>First therapy period</i>		
Group A		
Mean	4.06	4.86
Range	3.25–4.58	4–5
Group B		
Mean	3.58	4.0
Range	3.2–4.0	3–5
<i>Second therapy period</i>		
Group A		
Mean	4.02	4.5
Range	3.31–4.28	3–5
Group B		
Mean	3.67	3.93
Range	3.39–3.85	3–5

and inside the group sessions. They also found it easier to allow residents to express their feelings and found that they were no longer avoiding talking to residents about potentially emotive topics.

#### *End of Stage II and follow-up*

##### *Effects on residents at end of Stage II*

During this stage the treatments were crossed over: Group A residents received four weeks of reminiscence therapy and Group B four weeks of reality orientation. The results are shown in Table II (assessment 4).

Although neither group had met for a month, there was some indication that the previous group experience had affected their behaviour.

Group A residents continued to function as they had done at the end of the previous series of sessions: from the beginning they spoke to one another as well as to staff; they addressed people by name; and they talked spontaneously about current topics of interest in the residential home such as recent illnesses and deaths, and recent or forthcoming outings. They then moved on to the reminiscence topic of the day but continued to compare and contrast past and present.

Group B residents were less willing to use names or discuss day-to-day events and this made it difficult for staff to initiate reality orientation techniques. At first the residents spoke very little to one another and addressed their remarks to the staff. They seemed to remember the room and wanted to talk about their own past experiences, but appeared detached from the other residents. This may explain the drop in information/orientation scores during this period.

TABLE IV  
 Staff's knowledge of residents: Personal Information Questionnaire scores before and after therapy (maximum possible information = score of 40)

	Scores for individual residents <sup>1</sup>					Mean
<b>Group A</b>						
Before group sessions	6	2	5	12	1	5.2
Reality orientation →						
End of Stage I	27	30	29	19	15	24.2*
Reminiscence therapy →						
End of Stage II	37	39	33	22	19	30.0*
<b>Group B</b>						
Before group sessions	4	4	4	11	6	5.8
Reminiscence therapy →						
End of Stage I	28	28	23	24	25	26.6*
Reality orientation →						
End of Stage II	32	34	24	25	27	28.4*
<b>Group C</b>						
Before group sessions	3	4	8	6	4	5.0
End of Stage I	3	4	8	6	4	5.0
End of Stage II	3	4	8	6	4	5.0

\*Statistically significant difference from control group

1. Each score represents the pooled knowledge of the three members of staff involved in the relevant group (A or B); pooled knowledge of all six staff for patients in Group C

Nevertheless, by the end of Stage II they were interacting with one another as well as they had been doing at the end of the first therapy period.

Meanwhile, Group A residents again improved their scores on Information/Orientation, Holden and Problem Behaviour scales: compared with Group B, the improvement Information/Orientation scores was significant (Mann Whitney,  $P < 0.0413$ ). These results support our impression that Group A residents had gained a group identity in the reality orientation sessions which helped them benefit from the reminiscence therapy which followed.

Residents in the control group also improved their Information/Orientation scores but not to the pre-therapy level; and there was no steady improvement on the Holden or Behavioural Ratings, with the exception of one resident who shared a room with a Group A resident. The individual scores of just two residents in the control group were largely responsible for the increase in the mean information/orientation score, and each of these two shared a room with a resident in Group B. No other subjects shared rooms with each other, so it would appear that these residents were obtaining some benefit from the attendance of their room-mates at group sessions.

The changes in the life-satisfaction scores showed the same trend as had been seen in the first experimental period: residents in the reminiscence group improved their scores while those in the reality-orientation group decreased theirs and the control group showed little change.

#### Effects on residents at follow-up

The residents in the three groups were tested again one month after the experimental period had ended. The results are shown in Table II (assessment 5). Although there was a slight decline in their Information/Orientation scores in the follow-up period, Group A maintained most of the improvements gained in the second therapy period. The scores for the other two groups showed little or no change: but on the Information/Orientation measure Group B residents maintained the scores attained at the end of the therapy period while the average scores of Group C residents declined.

#### Enjoyment of groups by residents

As in Stage I, although day-to-day fluctuations in individuals' mood and physical state produced some variation in enjoyment, the generally high level of attendance suggested that on the whole residents enjoyed attending both types of group. The daily attendance rate for Group A was 91.8% (range 58.2–100%), with four of the residents attending every meeting. For Group B it was 75.3% (range 52.9–94.1%). The difference in attendance between the two groups was significant (Mann Whitney  $P < 0.048$ ) and may have been due to shortage of staff rather than residents' unwillingness to attend.

Staff ratings of residents' enjoyment was high for both groups (see Table III).

**Overall effects of therapy programmes**

Over the four-month period of the study CAPE Mental Ability scores declined for all three groups, but less for the two therapy groups than for the control group (see Table II). In spite of this decline, Group A residents improved on the other measure of cognitive ability (CAPE Information/Orientation): By the end of the second stage, Group A residents had improved an average of 18.5%, compared with declines of 10.3% for Group B and 15.2% for Group C (see Figure 2). This improvement was largely maintained one month later, while Group C residents continued to decline, producing a significant difference at this stage between Group A and Group C (Mann Whitney,  $P < 0.048$ ).

On the Holden Communication Scale, which reflected the residential staff's estimates of residents' awareness, responsiveness and communication abilities, Group A residents had improved by an average of 25.9% after the two therapy stages, and by 27.4% at follow-up a month later (see Figure 3). In contrast, Group B residents had improved by only 11.7% at the final assessment, and Group C by 7.4%.

Group A residents also improved markedly on the behavioural measures compared with the other two groups. On the CAPE Behaviour Rating Scale they improved an average of 28.6% over the therapy periods and maintained a 27.0% improvement at follow-up (Fig. 4). In contrast, Group B and Group C scores showed little change. Similarly, on Jeffery's Problem Behaviour Scale (Fig. 5). Group A residents had improved an average of 34.9% by the end of therapy and maintained this at follow-up (36.1%; whereas Group B residents only improved by 13.9% and Group C by 5.5%, and even these slight gains largely disappeared at follow-up.

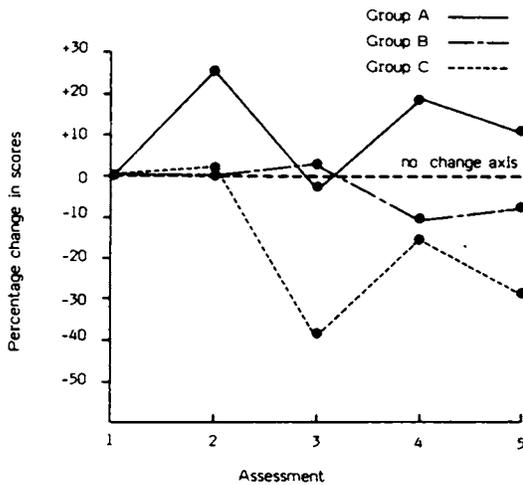


FIG. 2 Changes in mean CAPE "Information/orientation" scores for each of the experimental groups over the 4-month study period, showing percentage improvement (+) or decline (-) compared with the group's initial score.

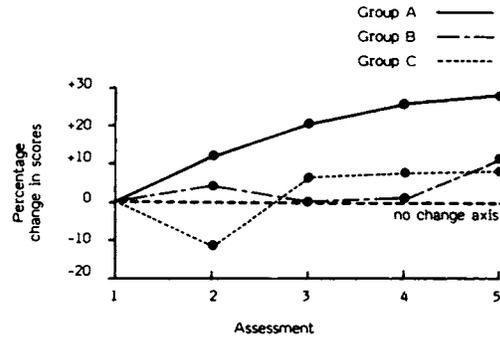


FIG. 3 Changes in mean Holden Communication Scale scores for each of the experimental groups over the 4-month study period, showing percentage improvement (+) or decline (-) compared with the group's initial score.

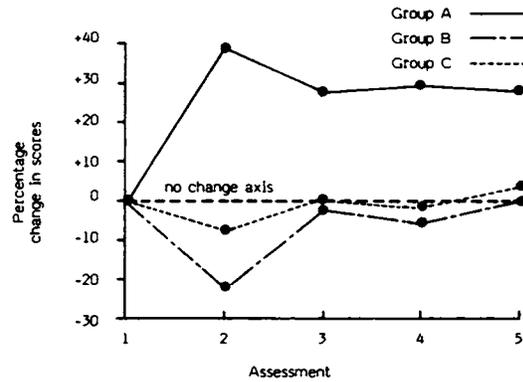


FIG. 4 Changes in mean CAPE Behavioural Rating Scale scores for each of the experimental groups over the 4-month study period, showing percentage improvement (+) or decline (-) compared with the group's initial score.

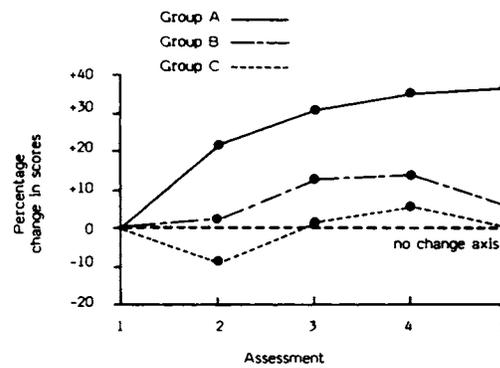


FIG. 5 Changes in mean Problem Behaviour Rating Scale scores for each of the experimental groups over the 4-month study period, showing percentage improvement (+) or decline (-) compared with the group's initial score.

#### Effects on staff

At the end of the therapy sessions the staff involved said that they knew and understood the residents in their own groups better than they had done before. The experimental evidence to support these statements is shown in Table IV. By the end of the study there was a very significant difference in the staff's knowledge about both therapy groups compared with the control group (Kruskal-Wallis  $P < 0.009$ , A vs B vs C; Mann Whitney  $P < 0.009$ , C vs A; Mann Whitney  $P < 0.009$ , C vs B).

All six staff said that they had enjoyed taking part in both types of groups and thought that the groups should be continued, and extended to other residents who were socially isolated but not necessarily confused; for example, to those who were avoided because they talked repetitively.

Once initial difficulties with a few non-involved staff and residents had been openly discussed, staff running the groups had encountered little resentment and much cooperation from their colleagues.

#### Discussion

The results of this study suggest that both reality orientation and reminiscence groups can be effective in helping staff to get to know moderately or severely confused residents. It also seems apparent from the high level of attendance, involvement and commitment that both kinds of group can be enjoyable and stimulating for both residents and staff. There was some evidence that the study had positive long-term effects on the residential staff; six months after the study ended, four of the six staff therapists (two from each therapy group) were running weekly sessions for three groups, using a combination of reality orientation and reminiscence techniques. The officers in charge, the staff who had run the groups (and some other staff) were enthusiastic about the effects of the research on the home: they said they were eager to receive more training of a similar nature and had already re-organised staff meetings so that they occurred regularly and were orientated towards staff training. Our results add some experimental support to previous suggestions that reality orientation (Powell-Proctor & Miller, 1982) and reminiscence groups (Norris & Abu el Eileh, 1982; Lesser *et al.*, 1981) lead to both increased job satisfaction on the part of staff and improved quality of life for elderly institutional residents.

There was also evidence to suggest that some of the positive effects on group members were passed on to their non-participating room-mates, since room-mates improved on several measures during the therapy periods. This could be because of the increased communication skills of staff and group members. Our finding that these improvements in the control group were short-lived is in agreement with

the findings of Brook *et al.* (1975) that active involvement of therapists and clients is necessary for sustained improvement.

Group A residents showed greater overall improvement than Group B residents, which suggests that it may be important to use reality orientation techniques with confused residents *before* trying to involve them in reminiscence therapy. However, the results of our life-satisfaction questionnaire suggest that taking part in reality orientation sessions (as opposed to reminiscence therapy) can, for a short period, cause some individuals to report a lower level of life satisfaction. Even though the effect is not statistically significant, the trend is noteworthy since it was shown by Group A and Group B residents. It could be that initially reality orientation had a depressing effect on the mood of the residents because it forced them to face up to the reality of their situation. Indeed, before the sessions began some staff had expressed doubt about the wisdom of making mentally and physically impaired elderly people aware of the reality of their limited existence: they thought it might be kinder to allow them to continue to believe they were in a different time or place, even though that would mean that they were never able to adjust to the loss of their loved ones/or to the impairment of their own abilities; that they constantly asked for people who would never appear; that they remained isolated from the other residents, failed to recognise their visitors, and rarely participated in activities. However, our results suggest that this temporary but realistic lowering of mood may have been a necessary precondition for enjoyment of the present. Tape recordings from sessions and records of observations made by staff show that, as groups progressed and members got to know one another, members began to discuss openly both negative and positive feelings. They talked, mostly in groups but also after sessions, about themselves, about friends, their families, other residents, about their present situation and about their reasons for entering the home. This new-found ability to express emotions, including anger and sadness, appeared initially to alarm some members of staff and some non-group residents: before matters were resolved by discussion there were isolated attempts to discourage residents from attending group sessions. These discouragers reacted as if the groups were *causing* the anger and sadness, rather than confirming the reality of such factors as infirmity, bereavement and loneliness. The fact that the residents refused to be put off suggests that they felt a need to express these emotions.

The improvements in Information/Orientation achieved by Group A residents during their RO

sessions (Stage I) were lost in the following month: this accords with the results of previous studies, (Miller, 1977; Greene *et al.*, 1979; Feier & Leight, 1981; Powell-Proctor & Miller, 1982). However, in contrast with previous studies (Woods, 1979; Hanley *et al.*, 1981; Zepelin *et al.*, 1981; Powell-Proctor & Miller, 1982) these residents showed a significant improvement in behaviour compared with the other two groups, and this improvement was maintained in the follow-up period. Furthermore, the improvements in cognitive functioning of Group A residents during subsequent reminiscence therapy suggest that skills learned during RO may have continued to have a positive effect on their behaviour in this period. Although staff placed no emphasis on orientation-promoting material during reminiscence therapy, the residents talked spontaneously about topics such as recent events, planned outings, and current gossip about fellow residents at the beginning of each meeting. Similarly, the reminiscence therapy in Stage I for Group B residents seemed to affect their behaviour in Stage II, when they showed a preference for talking about their own past experiences and, initially, little interest in current events inside or outside the home. Many people enjoy reminiscence and, particularly if their present life situation is unfavourable, look back upon the past with nostalgia rather than as a rich storehouse of experience which could help them enjoy the present and look forward to the future. It is possible that reminiscence therapy reinforced the residents' and staff's inclination to avoid potentially upsetting topics, while the reminiscence component of reality orientation, with its emphasis on comparing both good and bad aspects of past and present, helped them to view both past and present experiences more realistically. Thus one might have anticipated our finding that residents who experienced RO first would do better than residents who took part in reminiscence first, and would have a better chance of deriving longer-term benefits.

The results indicate that a reasonably high level of functioning can be maintained for some time after formal sessions have ended and that losses in functioning which occur while residents are not in a group can be made up once groups restart; this suggests that groups need not necessarily run continuously to be effective. This could be important when considering the feasibility of running small groups in residential homes where staff have little time to devote to the social and psychological care of their residents (Evans *et al.*, 1984). When we interviewed staff at the beginning of the study they expressed a desire to spend more time talking to the residents and getting to know them but said there was little opportunity to do so because they spent most of their working hours

doing domestic activities and taking care of the physical needs of residents. Staff were also concerned that time spent talking to confused residents in small groups would be wasted, since the residents would not be able to contribute much and would not remember having taken part. However, our results suggest that the group experience prompted the staff to reappraise the ability of disabled residents to derive pleasure and other psychological benefits from small-group therapy. The staff also discovered that these kinds of sessions could be a useful means of increasing their knowledge and understanding of mentally disabled residents. Since staff continued to run groups and take part in in-service training long after the end of the study period it seems likely that their experience in the research project had caused them to reappraise their roles in caring for the elderly, and had increased their feeling that they were doing a worthwhile, rewarding job.

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