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REALITY ORIENTATION:

IS IT THE ANSWER TO OLD AGE "SENILITY"?

Kay W. Hardy

April 24, 1981

The only way that an outsider can appreciate the inner turmoil of a confused older person in a nursing home is to imagine a short scene. Think of the lonely old woman who sits alone day after day in the same chair waiting for her husband to come pick her up so that she can go home. At first glance, nothing seems unusual, but in probing deeper into this woman's personality, one finds that her husband has been dead for fifteen years, and furthermore, she does not have any conception of where she is, what city she is in, or the approximate date. This woman is not an unusual case. There are many old people, just like her, who are habitually sitting in plastic chairs uniformly lined up down corridors of nursing homes. These people have little or minimal contact with reality and they are essentially waiting there to die.

Sadly enough, this seems to be the unnecessary fate of many older men and women in our society today. When an older person exhibits any form of confusion, due to senile dementia or organic brain syndrome, they are automatically labeled hopeless and simply left alone to further deteriorate. Dorothy R. Scarbrough is appalled by the attitude of health officials towards the confused and disoriented older adult. When a young person becomes disoriented, help is immediately sought in order that they may recover to their full extent. However, when this same condition occurs in an older adult, no effort is made to secure help for this individual. They are simply labeled senile and forgotten. (Scarbrough, p. 44)

It has been suggested that the term "senility" be discarded altogether in favor of a more appropriate label of "emotional and mental disorders of old age." Viewing disorders in this way would encourage a more careful diagnostic and treatment plan, as well as a broader perspective on the everyday problems and disorders of old age. (Butler, p. 232)

Other critics express disfavor of the usage of "emotional and mental disorders of old age" because they do not consider these types of disorders true forms of mental illnesses. Accordingly, since they are not "bona fide" illnesses, psychological intervention is unnecessary, only custodial care is needed. It seems that it is easier to classify older people as senile and untreatable than it is to attempt to help them. (Butler, p. 232)

Confusion in the elderly can be the result of many different causes. It can occur because of social attitudes toward the aged. Birren and Burnside cite such factors as social deprivation and lack of sensory stimulation as important and possible sources of confusion and disorientation. (Voelkel, pp. 13-18)

Disorientation need not be biological in nature, however, a great deal of disorientation stems from an organic cause. Studies have indicated that from 60 to 80 percent of elderly patients in nursing homes suffer from irreversible organic brain damage. (Brady and Silverman, p. 124) In a 1974 survey conducted by the Social Security Administration, it was found that 45 percent of the residents of nursing homes were occasionally confused and 59 percent were not able to handle such everyday tasks as financial matters without assistance. The Vital Health Statistics report

that as many as 56 percent of nursing home residents are moderately to severely confused due to organic causes. (Brady and Silverman, p. 232)

The reason this is such a devastating problem is because a greater percentage of the United States population is living to older ages. Thus, a greater proportion of the population will become disoriented and be in need of some sort of reorienting rehabilitation. Twenty-nine percent of the population in 1900 was over 75. By the year 2000, one might expect this percentage to jump as high as 43 percent. (Brady and Silverman, p. 232)

The aging of the human brain is a complex subject. Sometimes it is very difficult to distinguish between confusion due to cardiovascular disease or confusion due to senile dementia. However, it seems that a large proportion of confusion is due to organic dysfunction. (Brady and Silverman, p. 232)

There are two kinds of senile dementia, acute and chronic. Acute dementia may result from a variety of causes. Once a person becomes confused and disoriented, the first thing that must be done is to rule out all possible causes that may be medically or psychologically treated. Confusion may result from such conditions as subdural hematomas, benign tumors, infections, nutritional deficiencies, electrolyte abnormalities, cardiac failure, or uremia. A large percentage of the time, medical check-ups are not performed upon admission to an old age institution. Because of this neglect, one could possibly be incarcerated for life in a nursing home because they have something as minor as a bladder infection. (Spencer and Dorr, p. 31)

There are two types of chronic dementias, those related to cardiovascular disease and those not related. (Spencer and Dorr, p.31) Chronic brain syndromes are the result of permanent damage to the brain or cardiovascular system, as in cerebral arteriosclerosis and senile brain disease. They can be treated symptomatically, but they are not able to be reversed. (Butler, p. 226)

Senile Dementia is not a medical diagnosis, but a "wastebasket term" for a range of symptoms including forgetfulness, difficulties with attention span and concentration, and a decline in general intellectual ability. Senile dementia is not an inevitable consequence of old age. However, it is a reflection of many other problems such as cardiovascular disease, improper medications or dosages of medications, poor diet, or depression. For example, an older person may be very depressed. They may keep their depressed state disguised, however, it may be outwardly manifested in disturbed concentration or forgetfulness. (Butler, p. 232)

There is a tremendous need for a treatment that is able to help a person labeled senile to break the "spiral of senility" which has engulfed him/her.

Atypical spiral of senility begins with a normal, healthy adult who is functioning on a rational level. As they age, others demand that older adults relinquish their accustomed roles in life, for example, their occupation and their home. These circumstances lead to a decrease in their sense of identity and self-worth. As the person loses more and more of the important aspects of his/her identity, he/she will begin to show signs of

failing health and brain damage. Because of his/her general deteriorating condition, others insist that he/she become dependent on various institutions for care. This institutionalism leads to further decreases in identity and self-worth, resulting from the social stigma that is attached to being institutionalized. The old person reacts to this change by becoming confused and docile, and he/she begins to accept his/her imposed sense of low self-worth. He/she now begins to retreat into the past and loses interest in the present. This detachment prompts others to label him/her unreachable and hopelessly senile. This process snowballs leading to further vegetation and ultimately death. (Ambrose, p. 36)

In order to break this cycle and reorient the individual back into reality, a program called Reality Orientation was designed by Folsom at the VA Hospital in Tuscaloosa, Alabama in 1965. Reality Orientation is a type of therapy used to remedy such afflictions as memory loss, general confusion, and time-place disorientation. (Philips, p. 1)

Reality Orientation is a very basic concept. If the patient does not know his name, the Reality Orientation therapist teaches him. If he does not know where he is or where he is from, he is taught. He is also instructed in other areas such as the day of the week, month, year, and his age.

Citrin and Dixon state that Reality Orientation draws its "philosophical rationale" from the activity theory of aging, which implies that the older person who ages optimally is the person who stays active and involved with his/her life. A more active involvement for the resident in a (nursing home) program would seem appropriate and necessary for residents at all levels

of orientation. (Citrin and Dixon, p. 42)

Reality Orientation may be administered in two different types of programs. Most nursing homes or any institution that may deal with people who are disoriented, initiate a 24 hour a day Reality Orientation Program. In this type of program, the environment is very structured as far as how the personnel should act towards and communicate with the residents. It is imperative that the staff intervene appropriately and in a consistent manner at all times if the program is going to be a success. Any type of intervention should be either to prevent confusion or to assist a confused individual to regain an awareness of who he is and what is taking place around him. In 24 hour Reality Orientation, the staff is taught to be very warm, but very truthful with the residents. It is very important that the staff not permit the confused resident to believe something illogical, just because that is easier than trying to have him understand the truth. Patients should not be permitted to continue in a confused state. Often, they are disoriented and merely desire assistance in sorting out what is real. Sometimes, they may be testing the attendant when they talk nonsense, to see if they will, in turn, receive additional attention, which they desperately crave at times. (Folsom, pp. 299-300)

A typical example of how to correctly deal with a disoriented individual is as follows: If Mrs. Smith is waiting for her daughter to come take her shopping and the attendant is aware that she does not have a daughter, instead of pacifying her by going along with her story, in practicing Reality Orientation, one should say, "Mrs. Smith, you do not have a daughter, remember, you have a son who lives in

New York. You will not be going shopping today. Why don't you join in the recreation class at 10:30?" Instead of allowing the confused woman to remain confused, a bit of reality is injected to try to jog her memory. Also, just in conversation, the staff member is trained to give the resident as much information as possible. For example: "Good morning, Mrs. Smith. It is a lovely, sunny Tuesday outside today. November gets a little chilly. I bet it is forty degrees outside. We are having chicken for lunch today. Don't forget to eat at 12:30. (Ambrose, p.35)

In addition to continued stimulation by the nursing home personnel, Reality Orientation boards are placed around the institution giving such information as the name of the home, city, month, day, year, next holiday, weather, and next meal. These boards are continuously altered during the day in order to always display correct information for the residents. (Vosburgh, p. 2)

Classroom Reality Orientation is a supplement to 24 hour Reality Orientation. This program is more structured and is implemented in a small group setting of five or six residents per class. Reality Orientation classes are a concentrated group activity that is particularly useful for those individuals with severe person, time, and place disorientation. Classroom Reality Orientation provides those individuals who may have chronic or acute organic brain syndrome or merely an exceedingly short attention span with extra stimulation through structured settings. (Ambrose, p. 37)

Metzler identifies three different levels of Reality Orientation Therapy. The first level is a very basic one. In this setting, the therapist asks such questions as what day it is and what time

it is. Correct responses are praised. On the occasion that the individual should incorrectly answer a question, the question is repeated and a correct response is supplied. (In-service Training and Education, 1973, p. 52)

The person who masters this class graduates to a more advanced class. The procedures in the more advanced class are the same, however, the subject matter that is introduced is of a more advanced nature. Such things as current events are discussed. (In-service Training and Education, 1973, p. 53)

The third level in the Reality Orientation program is the "Remotivation Level". This group is more or less a group therapy session. It is so designed to initiate a social interaction among the residents. The main goal of the therapist is to focus the patient's attention towards specific goals for short periods of time. (In-service Training and Education, 1973, p. 53)

During Reality Orientation therapy, patients may continue to exhibit confusion and lack of orientation for a period of many weeks and then slowly begin to show some evidence of being able to learn and remember information. Once the patient can grasp any bit of information, such as his own name, address, or age, he begins to recall other facts, and is able to handle increasing amounts of learned material. (Folsom, p. 301)

In all levels of Reality Orientation therapy and in 24 hour Reality Orientation, certain guidelines must be followed. A calm, orderly environment is a necessity for any type of a learning situation. A resident who is confused will usually respond to a calm, friendly approach. In a tense environment, the confused individual will only become more disoriented and withdrawn. The therapist must provide a set daily routine and respond with clear replies to the resident's questions. It is very important that the Reality Orientation counselor talk very slowly and distinctly because many times the residents are

hard of hearing. The therapist must not allow the resident to remain confused. The therapist must be firm, but sincere and make requests of the residents in a calm manner. He or she must speak in a friendly tone, but must not speak down to the elderly man or woman as if they are speaking to a child. Even though the individual may be confused, they will sense that they are being belittled and this will cause feelings of resentment. The therapist must make minimal demands on the patient. They need to remember that the resident is already confused, upset, and possibly hostile. Therefore, all nursing home personnel must give clear, concise instructions placing as little demand on the resident as possible. It is imperative that these criterion be followed if an effective Reality Orientation program is to be established. (Folsom, p. 302)

A great deal of research has been implemented in order to establish the effectiveness as well as the significance of the Reality Orientation programs on the mental health of confused older individuals.

Some researchers, such as Taulbee (1976), believe that confusion results from a variety of causes, but he feels that a program in Reality Orientation is beneficial regardless of the etiology of the confusion and disorientation. (Schwenk, p. 373)

In 1976, Harris and Ivory conducted a study in Florida State Hospital with patients suffering from organic brain syndromes and syphilis. Ninety-six subjects were matched with respect to age and medical diagnosis. One half of the subjects served as an experimental group. This group received traditional 24 hour

Reality Orientation therapy, supplementary classroom Reality Orientation therapy, and attitude therapy. The control group received traditional hospital care. The Florida State Hospital Behavior Rating Scale (Harris, 1976) was used to rate the subjects before and upon completion of the treatment. This rating scale measured ward behaviors, verbal orientation behaviors, and the psychiatric aides' verbal impressions of the patients in several behavioral categories. The aides rated the behaviors on a Likert-type scale from one to five, five being a positive evaluation, and one being a negative evaluation. The results of this study overwhelmingly supported the use of Reality Orientation. The subjects in the experimental group significantly outperformed those in the control group in verbal orientation behaviors as well as in the aide's impressional observations. There were no significant differences between the experimental and control groups as far as their ward behaviors. However, it is believed this is due to the lack of standardized procedures by which these behaviors can be elicited and observed. (Harris and Ivory, pp. 496-503)

Citrin and Dixon, in 1977, again proved the effectiveness of Reality Orientation therapy. The subject population for this study was drawn from a geriatric institute near Lincoln, Nebraska. Twelve residents were chosen for the experimental and control conditions. Before the experiment began, the entire staff of this institution was given a course on the rationale and principles of Reality Orientation. The personnel in charge of the experimental group was instructed to use Reality Orientation in their dealings with the residents. The subjects in the experimental group were also given extensive classroom Reality Orientation. The staff in charge of the control

group was told not to administer Reality Orientation in any way. The control group was also deprived of the Reality Orientation class sessions. Two measures were used to assess the effects of the Reality Orientation program after a two month testing period. The Reality Orientation Information Sheet, (ROIP, 1973), which is a 25 question questionnaire, was given to each subject. Also, the Geriatric Rating Scale (Plutchik, Conte, Lieberman, Baker, Grossman, and Lehrman, 1970), which is a measure of behavior, was given to each subject. It can be concluded from this study that Reality Orientation can help reorient confused individuals back into touch with their surrounding environment. (Citron and Dixon, pp. 39-43)

In 1975, Brook, Degun, and Mather conducted a study in order to assess the effects of Reality Orientation. Eighteen residents who were diagnosed as having senile dementia were used in this study. Each subject was initially tested using a scale which was developed in order to test the residents' social and intellectual skills. The subjects were then placed in three groups according to their functioning capacity as measured by the scales. The three groups were then further subdivided into experimental and control groups. Altogether, there were six groups with three subjects in each group. The experiment was conducted for sixteen weeks. Each day the subjects in the experimental group were taken to the Reality Orientation classroom and encouraged to interact and learn. The control group was taken into the Reality Orientation classroom, however, they received no active encouragement or participation of the therapists. (Brook, Degen, Mather, pp. 42-45)

Throughout the experiment, the experimental group's progression

was notable as compared with the control group's progress. The experimenters found some other interesting results from their research. They found that the control groups which were initially rated the highest in social and intellectual skills deteriorated the most throughout the experiment. They also found that the experimental group which initially rated the lowest in these skills did not show marked improvement due to the Reality Orientation programs. This study shows that the very deteriorated patients do not appear to benefit, but those who are medium to high in social and intellectual ratings seem to benefit from the implementation of a Reality Orientation program. (Brook, Degen, and Mather, pp. 42-45)

There have also been numerous studies done to prove the ineffectiveness of Reality Orientation on some types of disorientations due to functional cerebral abnormalities.

In 1977, Zepelin, Wolfe, and Kleinplatz presented a paper to the Gerontological Society evaluating a year long Reality Orientation program. They found that after a year of 24 hour Reality Orientation, that experimental subjects did not do any better on Mental Status Questionnaires than did the control groups. The Mental Status Questionnaire asks for information rehearsed in the Reality Orientation classes. All of these patients had had strokes or organic brain syndrome. (Zepelin, Wolfe, and Kleinplatz, 1977)

In 1975, Zepelin and Wade used the Mental Status Questionnaire to measure orientation before and immediately after six weeks of Reality Orientation classes given to experimental groups. All of the individuals in these groups were severely disoriented from

strokes, dementia, or organic brain syndrome. They found that the six weeks of Reality Orientation had no effect on the residents, who were used as their own controls in this experiment. (Zepelin and Wade, 1975)

Throughout the literature, it seems that studies supporting the effectiveness of Reality Orientation therapy are done with the mildly confused patients. Experiments which have yielded negative results have been done with those persons with severe confusion. Thus, Reality Orientation therapy appears to be more effective with the mildly confused individual. (Schwenk, p. 376)

Wershow (1977) estimates that approximately 50 percent of nursing home residents are confused with irreversible organic brain syndrome. He suggests that our efforts to do more for these persons than to make them comfortable is a waste of time and money. Degree of confusion, type of confusion, and duration of confusion all influence the effect of the Reality Orientation program. The author of this paper assumes this view after working with a group of residents, ranging from mildly to severely confused, at a local nursing home facility. The experimenter worked with six residents over a period of six months. Each resident was exposed to 24 hour Reality Orientation as well as to classroom Reality Orientation. All individuals, except one extremely coherent man, had deteriorated considerably over the past two years according to their Reality Orientation Questionnaires which were administered by the home. (Wershow, pp. 297-302) See Appendix 1

A brief history will be given of each resident in order to show complicating conditions that may exist in their physiology that

could hamper the effectiveness of Reality Orientation on their condition.

Resident 1 is a 73 year old man who is extremely confused, although, he is not diagnosed as organically brain damaged. The only major medical condition he has is Parkinson's Disease. He is currently on a high salt diet with between meal nourishment. Resident 1 is on several different medications which are able to potentially initiate or aggravate his confused state. He is currently taking Dopar, which may cause nausea; Artane, which may cause drowsiness and confusion; Indocrim, which may cause dizziness, drowsiness, and confusion; and Benadryl, which may cause drowsiness, dizziness, fatigue, and tremors. Over the past two years, from February 1979 to February 1981, his Mental Status Questionnaire scores dropped from 49 to 28 out of a possible 51 points.

Resident 1 knows his name, but has no idea where he is, or how long he has been at the nursinghome. He believes the year is 1961, and he also incorrectly believes that he is 61 years old and that he was born in Poland. In reality he is 73 years old and he was born in Russia. In Resident 1's case, his confusion most likely results from the drugs he is taking, so his condition can not be satisfactorily corrected through the use of Reality Orientation therapy. Reality Orientation seems to hinder him more than help him because it serves as a reminder to him as to how much he has forgotten and how confused he actually is.

Resident 2 is an extremely disoriented 78 year old woman. She is totally confused, but she is aware of this disability.. She appears to be very poised and amiable, however, when one speaks

to her, it is very apparent that she is not in touch with reality. She has no idea where she is, and she believes that she still is living in Brookland, New York. She also speaks regularly about her husband coming to see her. In reality, he has been dead for approximately a decade.

As I ask her questions on the Mental Status Questionnaire, she is reluctant to answer because she says that she can not think very well because she has a watermelon in her head. Resident 2 also comments on how her mind is falling apart. She also discusses at length with the experimenter about how she sleeps out in the court yard on the ground. She is concerned about having someone prune the branches of the trees because at night, while she is sleeping, the branches reach down and scratch her face.

Resident 2 was previously diagnosed as being chronically brain damaged by a resident physician. Her confusion stems from this condition and not from a faulty diet, inappropriate medication, or social deprivation. Besides organic brain syndrome, she also experiences hypertension and gall bladder dysfunctions. The only medication that she is on is Paravid, which may cause temporary drowsiness. She is on a regular three meal a day diet plan. The severity of her organic brain syndrome makes the Reality Orientation program useless to her other than as a form of social interaction. She has only been in the home for a year and one half, however, in this short span, her Mental Status Questionnaire dropped from a score of 35 to one of 9, out of a possible 51 points.

Resident 3 is an alert 83 year old man. He is able to carry on a very intellectual conversation. For example, during the

presidential elections, he was able to recall all of the candidates as well as their positions on varying issues. He contributes significantly to the Reality Orientation class discussions, and helps some of the more disoriented individuals reclaim their grasp on their surroundings.

His prominent medical conditions are depression, a hernia, and a mild case of hypochondriasm. The only medications that he takes are multivitamins, Bleph eye drops, and Myoflex creme, none of which have any harmful side effects. He is on a soft bland diet.

Even though Resident 3 is very alert and has no apparent medication or diet problems that would cause confusion, his Mental Status Questionnaire scores occasionally drop a few points. Over the past two years, they have fluctuated between 42 and 51. This fluctuation is possibly due to stages of depression that he goes through. He tends to be less careful and gives the Mental Status Questionnaire less consideration when he is somewhat depressed. He has no signs of organic brain syndrome. He is able to display both instant recall and remote memory. He told the author of this paper, in detail, about a store he had forty years ago on Elm Avenue in Portsmouth, Virginia. He can recall the terror of his entire family being killed in German concentration camps, and about his move to New York where he sold bananas for two cents a piece on the street corner in order to make money. Since Resident 3 is fairly alert and has no signs of organic abnormalities, Reality Orientation therapy would be beneficial for him.

Resident 4 is an extremely alert 73 year old male. He was a dentist in the Richmond area before his retirement approximately four years ago. He is on a regular diet, and the only medication that he is currently taking is Mylanta, which has no harmful side

effects. The only major medical problem that Resident 4 has is cardiovascular atherosclerosis. This disease has not, however, impaired his mental functioning in any way. He comes to the Reality Orientation sessions mainly for a type of recreation. He contributes extensively to the discussions and aids other residents whom he recognizes to be disoriented.

Resident 4 does not need classroom Reality Orientation for any other reason than to keep him remaining alert. Over the past two years, from March 1979 to March 1981, his Mental Status Questionnaires have remained stable. He continuously receives a perfect score of 51 with no degree of difficulty.

Resident 5 is an extremely incoherent 87 year old woman. She found it very difficult to understand the concept of a permission slip. Each resident had to sign such a slip in order to give the experimenter the authority to use them in this study. The experimenter read the permission slip to her. In her very graceful manner, she began expounding on the fact that it was "very necessary to discuss the slip very carefully" in order to see if she could come up with an answer. The experimenter decided to take the questionnaire line by line. When Resident 5 found through the permission slip, that the experimenter was a student at University of Richmond, she digressed into another train of thought about how she wished the experimenter the best of luck. After thirty minutes, the researcher made her understand that she was supposed to sign the slip and then, when she did so, she would be asked to answer a series of questions.

Resident 5 has a very unique method of dealing with the questions that the experimenter asks her. She answered 19 out of 20 questions incorrectly, categorizing her as severely brain damaged. When she

incorrectly responded to a question, the experimenter would promptly repeat the question and supply her with the correct answer. Resident 5 would then use the correct response just given her to answer the next question. For example, a typical dialogue with Resident 5 would be as follows:

"Where are you, Resident 5?" She remained silent, so the experimenter replied, "Resident 5, you are at X Nursing Home." The experimenter progressed in her line of questioning by asking Resident 5 what city she was living in. Resident 5 used the answer to the previous question in order to answer this question. In answering the question concerning the city, she replied that the city was outside X Nursing Home. After correcting her by telling her that she was in the city of Richmond, the experimenter went to the next question. The experimenter asked her who the President of the United States was. Again, she used the corrected response from the previous question, and she replied that the President's name was President Richmond.

Immediately after she was shown a picture of President Reagan, the experimenter asked her who the President was at the present time. After only a matter of seconds, she could not remember his name. However, she cleverly disguised her lack of knowledge again by a very eloquent talk about the necessity of a fair president for our country.

She did not even remember where her room was, and when she was in her room, she did not recognize it as being hers.

Resident 5 has organic brain damage as diagnosed by a physician. Despite intensive classroom Reality Orientation, along with 24 hour

Reality Orientation, her Mental Status Questionnaire scores have dropped from eighteen, two years ago, to one as of March 16, 1981. Reality Orientation does not seem to have any beneficial effect on Resident 5 because her organic brain syndrome is so severe in nature.

Resident 6 is a moderately disoriented male who was diagnosed by a physician as having organic brain syndrome. Besides organic brain damage, he has glaucoma, and a cataract on his right eye. His condition is also complicated by a loss of hearing. Resident 6 was placed on a low salt diet upon admission to the nursing home. This man knows that he is becoming more and more disoriented. He does not like to take the Mental Status Questionnaire because it seems to serve as a reminder to him as to how much he has forgotten. In December of 1979, he made a perfect score of 51 on the Mental Status Questionnaire. When last tested in March of 1981, his score had dropped to 39. It is thought that this drop is due to organic brain syndrome, however, the experimenter feels that his confusion may be compounded by his sight and hearing deficits also. This resident's organic brain syndrome is not at the point where it is so severe that Reality Orientation would not be helpful.

In the past, confusion was thought to be an inevitable consequence of the aging process. When an older adult became confused, they were not given the same psychiatric or medical treatment as a younger person would receive if they manifested the identical symptoms as the older adult. It seemed easier simply to label these disoriented adults as being unreachably senile and leave them to further deteriorate.

Today, an increasingly larger proportion of the population is reaching ages beyond 75. Accordingly, it is very probable that a

larger proportion of our older population will become confused and be in need of some form of rehabilitative assistance. For this reason, it is imperative that beneficial remedial help be available, especially for those who are in nursing homes or institutions, where individual intellectual stimulation tends to be low to moderate. One such program, which has been investigated, is Reality Orientation therapy. This type of therapy is usually administered in two forms; 24 hour Reality Orientation, and classroom Reality Orientation. There is a great deal of support for this phenomena throughout the literature, but in investigating this method thoroughly, one finds that it is not as effective with those patients who experience severe cases of organic brain syndrome or senile dementia.

The author of this paper also has found this to be true through her research at a local nursing home facility. By interacting with the residents of the home and through investigating patient histories, the author also discovered many other factors that might initiate or compound the problem of patient disorientation. Such factors are poor diet, sensory deficits, inappropriate medications or dosages of medications, and depression.

Every aspect of the resident's physical and mental health must be examined and taken into consideration before pinning such a label as "senile" on an older adult. So many of those who have been forgotten because of an incorrect label are potentially able to be reoriented and spend their "golden years" in a very fulfilling way.

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APPENDIX 1

Reality Orientation Questionnaire

Resident's Name _____

Room No. _____

	Initial date	3 months date	6 months date
What is your name? (1).....			
What is the name of this nursing home? (5).....			
How long have you been here? (3).....			
What city is this? (3).....			
What year is this? (3).....			
What month is this? (4).....			
How old are you now? (2).....			
What is your birthdate? (2).....			
Where were you born? (1).....			
Are you married now? (1).....			
How many children do you have? (2).....			
Who is the President of the United States? (5).....			
Where is the nation's capitol? (2).....			
On what day do we fast? (Yom Kippur) (2).....			
How old is a boy when Bar Mitzvahed? (13 yrs.) (2).....			
On what day do we light candles? (Friday) (2).....			
When do we sit shivab? (during mourning) (2).....			
How much is \$4 and \$5 (3).....			
Place your hand over your right eye. (2).....			
What happened to President Kennedy? (4).....			
Total Score.....			
Interviewer's name.....			

8/10/74

jgb

APPENDIX 2

A student from the University of Richmond is very interested in you! She is conducting a study in order to assess the advantages of the Reality Orientation Program at your home. You will be asked to answer questions to determine how helpful this group is to the residents. If you will participate in this study, please indicate by signing this permission slip.

Thank you very much for your help!

signature: _____

Any information obtained through questionnaires will only be used for the purposes of my study. Also, the outcome of this research may be made available to you at your request.