Reality orientation

Keeping the aged in touch with reality might arrest or reverse processes of senility

by Robert J. Trotter

Quoting a World War I British Army war song, Douglas MacArthur said, "Old soldiers never die; they just fade away." How right he was. During fiscal year 1972 the Veterans Administration treated 108,500 aged persons. Many of these, says Lars P. Peterson of the VA Hospital in Tuscaloosa, Ala., were suffering from anxieties, depressions, hostilities, confusions, disorientations, lack of concentration and withdrawal from reality. In other words, they were fading away.

The problem is not limited to veterans. In 1970 there were 20 million aged persons (defined as over 65) in the United States. By the year 2000 there will be at least another 8 million. At present, 5 percent of these individuals are in institutions, 5 percent are living a borderline existence outside institutions and another 15 percent need extended care. Many of these older patients are classified as senile (confused and disoriented). Their situation is seen as hopeless and the process as irreversible. Peterson, however, says this need not be the case. At the VA Hospital in Tuscaloosa senescence is handled as more psychological than biological. "What we describe as senescence," he says, "may be more a coping mechanism of age and less the consequences of organic factors."

This reasoning, he says, is based on the typical sequence that brings aged patients to the hospital in the first place. The problem usually begins with a biomedical crisis (stroke, heart attack, pneumonia, etc.) or a psychosocial crisis (economic, social or emotional stress). This situation makes the person dependent on family care and the family reacts by giving extended care even in areas where the patient can function. This, in turn, makes the patient feel and act more helpless and the family begins to see the situation as hopeless. The end result is permanent institutionalization and a gradual fading away.

While the physical disabilities are obvious, says Peterson, we cannot neglect the consequences of the economic and social losses on the behavior of the aged person. It is the interaction of these factors that tend to increase the patients' confusion, disorientation and withdrawal from reality.

This situation need not be progressive, Peterson told the recent meeting of the American Psychological Association (SN: 9/9/72, p. 165). The process can be reversed or at least stabilized by a rehabilitation program known as reality orientation.

The program, explained Peterson, is a two-part treatment specifically designed for the elderly, confused patient. Part one is an around the clock orientation to the surrounding environment with emphasis on time, place and person. When the patient begins to ramble, is forgetful or disoriented, he is returned to reality in a matter-of-fact way. Whenever hospital staff interact with the patient, they call him by name, mention where he is going, who he is going to be with and what he is going to be doing. Even though the patient may not appear to understand, says Peterson, we cannot be certain that he does not.

Part two of the treatment consists of 30-minute class periods, five days a week. The basic classes involve a structured orientation to time, place and person. Various reality activities, with concrete objects and, in the advanced classes, more abstract concepts and ideas are brought into play. A reality board, for instance, is displayed in the class and dayrooms. It consists of place, time, month by calendar, large clock, visual-aid cards depicting various commonly encountered objects and bulletin boards displaying the season. The three or four persons in each basic class are asked to read the board and describe its objects. Peterson admits that this may seem artificial but, he says, it is structured and lasts only 30 minutes.

In the advanced classes, rather than read the board, the patient fills in the blanks on the calendar he keeps as an appointment book. These classes deal with current events, group process, socialization and trips of interest into the community.

A longitudinal study of 125 patients who spent 18 months or more in the program shows that one-third made significant improvements (especially when intervention began as soon as confusion and disorientation became evident). In the remaining two-thirds there was little or no improvement. But this too represents a gain, says Peterson, because the patients were growing older and not to regress is a mark of progress. Only one patient actually regressed while several showed enough improvement to be able to return to the community.

The emphasis of the program is rehabilitation but Peterson suggests it be used as a preventive program in nursing homes and in general medical or surgical situations. While reality orientation is definitely not a cure for senility or the aging process, it is at least a method of keeping the brain from atrophying and for slowing down or even reversing some of the psychological effects of age. So perhaps the old folks' home need not be a last resting place and perhaps old soldiers need not fade away. □