

REALITY ORIENTATION IN A SOCIALLY CONSTRUCTED UNIVERSE

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IN A  
SOCIALY CONSTRUCTED UNIVERSE

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## ABSTRACT

This thesis was initially concerned with the theoretical framework and practical application of Reality Orientation--a therapeutic technique currently employed with the mentally impaired aged. On a theoretical level, attention was to be focused upon the manner in which a number of assumptions, inherent within the formal theory were managed in a Reality Orientation programme. Participation in and observations of a Reality Orientation programme which had been introduced in a geriatric centre commenced in order to fully assess the Reality Orientation programme. However, the programme at the centre deviated significantly from the formal principles of Reality Orientation. Moreover, the programme was subject to much resistance particularly from the nursing and health care staff and was eventually aborted on one of the two wards which employed the programme. We were able to consider the management of the assumptions located within the formal theory, the format of the programme at the centre, and provide possible explanations accounting for the failure of and the resistance to the programme at the centre. However, due to the deviations of the programme from the formal theory, a fully comprehensive evaluation of Reality Orientation as a therapeutic approach could not be fully ascertained.

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## CHAPTER ONE

### I N T R O D U C T I O N

Psychological "knowledge is always a part of a general "knowledge about the world".....The import of this proposition can be conveyed by referring to the psychiatric concept of "reality orientation". A Psychiatrist may decide that a certain individual is not adequately "oriented to reality" and, therefore, "mentally ill" .... We may then accept this description, but must immediately ask ---"which reality" (Berger, 1966:14).

In his theory of mind, self and society, Mead (1934) defined the mind in terms of functions. Its reality becomes apparent through behavioural manifestations. Mind, then, dwells in a field of conduct that is existent among individuals and not within them. Berger and Luckmann (1967) have discussed the manner in which people construe the reality of everyday life to exist independently of themselves, through the processes of externalization, objectification, internalization and legitimation. Schutz (1962) has emphasized that the intersubjective or social world is experienced in a taken-for-granted manner in its typicality. Through internalization, an individual obtains the typification schemes that are shared by other members of his collectivity and takes part of the "social stock of knowledge".

Every society has its specific way of defining and perceiving reality -- its overarching organization of symbols. This is already given in the language that forms the symbolic base of the society. Over this base, and by means of it, is a system of ready-made typifications, through which innumerable experiences of reality come to be ordered. These typifications and their order are held in common by the members of society, thus acquiring not only the character of objectivity, but being taken for granted as the only world that normal men can perceive. Yet, the socially constructed world is continually mediated to and actualized by the individual, so that it can become and remain his world as well. The individual is supplied with specific sets of typifications and criteria of relevance predefined for him by the society and made available to him for the ordering of his everyday life. This ordering is biographically cumulative. The world is in need of validation and this validation, while it must be undertaken by the individual himself, requires ongoing interaction with others who cohabit the same socially constructed universe.

Reality Orientation (R.O.) is regarded by its advocates as a significant form of rehabilitation of elderly or brain-damaged patients who are confused, disoriented and experiencing memory loss. With the intention of restoring "reality" to the patient the proponents of R.O. repeatedly "stimulate"



the patient with such basics as his name, date, name of institution, etc. Apart from this continual stimulation, there exist special classes in "reorientation". In accordance with the formal theory of the programme, nursing assistants and aides conduct the specified class (Folsom, 1966), (Taulbee & Folsom, 1966) and (Oberleder, 1969).

Approximately four years ago, the Department of Occupational Therapy of Birchcliffe Hospital, a geriatric centre located in southern Ontario, introduced a R.O. programme. The primary objective of the Department was to acquaint the nursing and health care staff to the formal theory and general mechanics of R.O. It was theorized that the nursing staff would eventually conduct the R.O. classes on West Two (W.2) and East One (E.1.).

Contrary to the Department of Occupational Therapy and to publications (Taulbee & Folsom, 1966; Folsom, 1968; Stephens, 1969; Moses, 1973) stating that such a programme enhances the morale of the hospital personnel involved, the technique was subject to much resistance, particularly from the nursing staff on W.2. The programme on this ward was ultimately aborted. However the programme is currently in operation on E.1.

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\* Birchcliffe is a pseudonym for the Hospital where the study took place.

The purposes of this study are manifold; it is concerned with:

- 1 the theoretical aspects of the R.O. concept as a case study of the social construction of reality.
- 2 the interpretation and application of the formal theory at Birchcliffe Hospital.
- 3 the interpersonal dynamic relating to the organizational aspect of the programme.
- 4 The possible explanations of the failure of the project.

The study will examine a number of assumptions inherent within the framework of the "R.O." programme, and which have been entirely unexamined by the proponents of the therapeutic approach.

Through the perspective of social psychology, particularly those strands of social psychology known as symbolic interactionism and reality constructionism, four assumptions will be subjected to theoretical scrutiny. These assumptions are:

- 1 that "senility" is caused as a reaction to a "reality of a diminished worth"
- 2 that there exists, factically, something which may be described as "reality"
- 3 that the past (as in reminiscence) has no character of "reality"
- 4 that hope must always be offered for the patient's recovery

In examining the final assumption:

- 5 that involvement in a R.O. programme results in a morale boost of the hospital staff;

we will consider the resistance to the programme by the nursing staff and the programme's failure as a whole in terms of the expressive role of nursing, general prevailing ideologies of both wards involved in the programme and the attitudes of the health care staff towards the Department of Occupational Therapy.

Drawing upon relevant sociological literature, we will consider the manner in which concepts such as reality and illness come to be socially defined and relate the data to the theoretical framework of Reality Orientation. We shall, moreover illustrate the ways in which the R.O. theory was put into practice at Birchcliffe. Finally, we shall present a summary of our findings concomitant with our conclusions.

#### A. THE STUDY SPECIFIED: SETTING AND METHODOLOGY

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Birchcliffe Hospital, located in southern Ontario, at the time of this writing has a patient population of one hundred and seventy-eight residents with an estimated length of stay of seven hundred days per patient. Although primarily a geriatric hospital, the Centre has cared for severely mentally and physically impaired youngsters in the past.

The Centre is in a period of transition and expansion and will soon have facilities to accommodate three hundred residents. A number of the younger patients have been transferred to other locations offering long term care services, and there is an increased emphasis on active rehabilitation practices with the planned provision of more facilities on both an in-patient and out-patient basis.

At the time of the data gathering, there were two R.O. classes of a forty-five minute time duration, in operation Monday through Friday on wards West 2 and East 1. The membership of the classes involved on West 2 were comprised of both sexes, although a preponderance of males were present. The classes on East 1 were attended exclusively by women, whose ages were basically higher than those on West 2.

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\* Data provided by Administration.

A detailed description of the sessions and the membership is presented later in the following chapters. Observations and data from the two groups were compared in an attempt to better assess the effects of the various group and demographic characteristics within the programme.

From the inception of the study, the author had no commitment to any specific theory although was influenced by a symbolic interactionist perspective. The author envisioned fieldwork as an opportunity to collect data in a framework which may evolve during the research.

Fieldwork was initiated through introductions to the Medical Director of Birchcliffe, Director of Occupational Therapy and others directly involved in the R.O. programme.

As the Department of Occupational Therapy had introduced the programme to the hospital, and as the Director of the Department seemed very enthusiastic about the programme, I decided to limit my conversations with her as I realized there was a possibility of adopting her perspective.

When talking to hospital staff and patients, my purpose for being at the setting was always explicit. I introduced myself as a student from McMaster University studying the R.O. programme. Moreover, as I participated in numerous R.O. sessions, during the initial stages of my visits, the R.O. instructor would introduce me to the class members in a similar manner. As time progressed, however, the R. O.

instructor dispensed with my introduction to the R.O. members.

Initially, the study was to be carried out through the methodology known as participant observation, a procedure in which an investigator participates in the group he is examining. However, during the periods of data gathering - eighteen months - additional information was gathered to supplement my observations. I was, for example, interested in knowing the operationalized definition of "reality" employed by the staff of the Department of Occupational Therapy and the nursing and health care staff involved in the R.O. programme. This was accomplished by interviewing the individuals assisting the R.O. instructor on West 2, after the R.O. sessions. On East 1, the respondents at the time of questioning were not participating in the programme and so I would interview them individually, prior to the classes which were held in the morning, and when time allowed on several afternoons.

Moreover, as it became evident, that the programme was meeting resistance from the nursing staff, I would question members of the Department of Occupational Therapy to obtain their side of the story and members of the nursing health care staff so as to gain a clearer understanding of the resistance, and not adopt a biased opinion of the situation. However, the information obtained through interviewing was only a supplement to the participant observation technique.

During the eighteen months I recorded thirty-two visits, observing two programmes a visit, during the first seven months of the study. There followed a three month absence from the field. During the following six months twenty-one visits were recorded. An absence of a month occurred as I felt I had most of the data required and thus spent a considerable amount of time researching material and in general familiarizing myself with related research literature. Only seven visits were recorded during the last two months which enabled me to re-examine the setting and to observe any relevant change in the programme.

During my visits to the setting I used several small notebooks in which to record certain aspects of the programme, such as dialogue between the instructor and patients, time spent on various activities, and anything else which I observed during the programme. As I did not wish to disturb the programme, I frequently sought out private places such as a washroom in which to make my recordings. Sometimes this involved writing headlines only, the remainder to be filled in at the end of my day. For example, one morning's session has frequently led to twelve typed-written pages of notes. Once these thoughts were on paper and after a collection of such notes had accumulated I could look for any patterns developing in the programme, or simply heighten my observations. For example, I began to observe certain patients who flatly

denied the information provided for them by the R.O. instructor, such as the fact that they were living at Birchcliffe. I therefore observed the amount of time given to such patients by the R.O. instructor in comparison to other patients who seemingly accepted the fact that they lived at Birchcliffe.

When interviewing the staff members of the Department of Occupational Therapy - there were two qualified Occupational Therapists or (O.T's) and two Occupational Therapy Aides (O.T.A's)-their responses were recorded in a book, frequently verbatim, and in full view. Of the 17 nursing and health care staff interviewed, which included the "Rehab" nurse, Director of Nursing, R.N's, R.N.A's and Aides, notes were not always recorded in their presence. Not that it was planned that way, but frequently, I would speak to them as they were on "the job", thus, I found I could accomplish much more by writing responses in some quiet corner of the hospital and would not be rushed as particularly on West 2 in the initial stages of my investigation, I sensed an unwillingness by several staff members to relate to me. I attributed this to my association with members of the Department of Occupational Therapy and my frequent attendance in the programme on West 2. With time, however there was less reluctance to speak to me.

As a final word, during my data gathering periods at



Birchcliffe, I received no permission to review records or any pertinent hospital data. The data presented in this thesis which pertain to the programme at Birchcliffe are mostly all observed data supplemented by some general interviews.

The prescribed methodology set forth by Glaser and Strauss (1967) broadly influenced the procedures of data gathering, coding and analyzing the material at hand. Moreover, in discussions focusing upon various aspects concerning the five assumptions already alluded to, observations reflecting the assumptions were applied to existing general sociological theory, current literature on aging and other relevant material for purposes of delineating an argument.

During the writing and revision stages of the study, a description has been provided, whenever possible, of the natural development of the conclusions reached, by presenting the evidence as it unfolded and was perceived by the observer during the consecutive stages of the formulation of the areas under study.

## B THEORETICAL CONSIDERATIONS

In order to locate this analysis within a useful sociological perspective this chapter will provide a discussion of illness within a sociological framework. This will be followed by a review of some current rehabilitative techniques

associated with R.O. and a descriptive summary of R.O.

The second chapter will focus upon the application of the R.O. programme at Birchcliffe.

The third chapter will consider the first four assumptions which are inherent within the theoretical framework of R.O. Moreover, we will consider the manner in which these assumptions were managed in the programmes offered at Birchcliffe. Chapter Four is devoted to the fifth assumption already described in an earlier section. We will then present a number of possible explanations for the "resistance" to the programme, as witnessed particularly on West 2.

The final chapter will restrict itself to a summary of our findings along with some conclusions derived from the study,

There exists a wealth of sociological data relating to the social construction of illness (Brickman, 1970, Friedson, 1970, Lemert, 1964, Scheff, 1968, Szaz, 1964). Viewed as a biophysical state, illness involves changes in tissue, bone, etc. in all living organisms. Laymen generally define illness as any impairment of physical well-being that conforms with what society accepts as "being sick". Feeling unwell is not in itself sufficient so long as the individual is not seriously disabled for work and interaction. Only then does being unwell become socially accepted and the role of the patient accorded, permitting the afflicted to receive attention, care and protection. Before such status is acquired,

normative rules of behaviour are invoked to prescribe when and to what degree expressions of pain and unwellness are allowed. A sore throat for example, permits some expression of pain, but typically other symptoms, such as fever and nausea must occur in order for the sick person to obtain the status of illness.

Apart from being a biophysical state, illness is a social state involving changes in behaviour that occur only among humans and vary with culture and other organized sources of symbolic meaning. When a physician diagnoses a human's condition as illness, he changes the man's behaviour by diagnosis: a social state is added to a biophysical state by assigning the meaning of illness to disease. It is in this manner that the physician creates illness just as the lawmaker creates crime; illness is a type of social deviance, distinct from disease. As illness is a type of social deviance, the etiology of illness in part, stems from current social conceptions of what illness is, and is ordered by organizations and occupations devoted to defining, uncovering and managing illness.

Having been labelled ill, an individual may suffer social consequences to his identity. For example, merely having been labelled mentally ill spoils the normal identity of that individual. Once the actor is cured of his illness, his identity is formed by the fact of having been in a

stigmatized role: he is still not just another person, but an ex-mental patient (Goffman, 1963).

In challenging the unexamined assumptions located in Folsom's Theory of R.O. there exist a number of significant sociological data upon which to draw for support.

In considering the factuality of reality, much reliance will be placed on the works of Berger and Luckmann(1966) and Alfred Schutz (1964). Berger and Luckmann maintain that every society has a certain mode of defining and perceiving reality. This is already distributed in the language that forms the symbolic base of society. Over this base and by means of it, exists a system of ready-made typifications, in which the multitudinous experiences of reality come to be ordered. Since these typifications and their order are held in common by the members of society, they acquire not only the character of objectivity but are taken for granted as the only world that normal man can contemplate. Schutz proposes that an individual inhabits not just one reality, but many and that of these realities, several are not meaningful to everyone. Furthermore, each reality exists within the boundaries of its own universe of meaning and one's preference or significant reality is highly dependent upon an individual's biographical situation.

The past may be an important reality for many older

people. McMahon and Rhudick (1963) suggest that reminiscing is positively associated with successful adaptation to old age and freedom of depression and they have recorded the similarity of reminiscing to the normal adaptive processes of fantasy and mourning. Marshall (1974), upon investigating three distinct measures of reminiscence style employed by the aged, concluded that sharing one's reminiscences with others significantly strengthened the styles which, in effect, reflected a general contentment with life.

Kubler-Ross (1974) explains that there are basically two types of hope in existence with respect to the patient and medical team. Upon learning of a terminal illness, hope at this point is associated with cure, treatment and extension of life. When these are no longer probable the patient's hopes take on a different dimension and become short term. She maintains that it is necessary to refrain from projecting one's own hopes on to that of the patient.

In considering the last assumption, we will discuss the "expressive role" of nursing, (Johnson & Martin, 1958) in order to ascertain the attitudes of the nursing and health care staff towards the principles of "restoring reality". Moreover the significance of ward ideology will be seen in light of present sociological studies.

### C. THE IDEAL OF R.O.

At this point, some therapies presently in use in dealing with the mentally impaired aged should be noted. Among the psychotherapies currently in practice in this domain, two are employed in conjunction with R.O. The first is "Attitude Therapy", which is a form of behaviour modification. It utilizes a number of prescribed attitudes in the interaction with elderly patients in order to reinforce "desirable" behaviour. The five attitudes comprising the therapy are: kind firmness, active friendliness, passive friendliness, no demand, and a matter-of-fact approach (Folsom, 1966: 21-34). Active Friendliness - the attitude directed to the withdrawn and apathetic aged - is usually prescribed for patients in a R.O. Programme.

Remotivation is a technique of interaction between a re-motivator and a group of patients. The therapeutic goals are: (1) to stimulate patients to relate to and discuss topics associated with the "real" world and (2) to aid patients to communicate with other individuals. Each session is conducted through a series of five steps. The method includes:

- 1 The climate of acceptance - basically the therapist greets the participants individually
- 2 A bridge to reality - carefully selected topics are introduced, sometimes with the aid of poetry, visual

accoutrements and aids. Topics such as financial problems, sex, and marital difficulties are prescribed.

- 3 Sharing the world we live in - evolves around promoting the discussion in a specific direction.
- 4 Appreciation of the work of the world - is geared to stimulate the patient into thinking about work in relation to himself frequently through discussing jobs that the patients formerly held.
- 5 The climate of acceptance - the key points of the discussion are summarized and the therapist closes the meeting by thanking the patients for attending the meeting.

Remotivation is intended to augment other therapies within the confines of the institution and not replace them. Only when an individual "graduates" from the Reality Orientation programme is he then placed in Remotivation therapy (Barns, Sack & Shore, 1973: 517-519).

Reality Orientation is a therapeutic technique employed in the rehabilitation of elderly individuals who demonstrate a moderate to severe degree of memory loss, confusion and time-place-person disorientation. The technique was introduced in 1958 at Winter Veterans Administration Hospital in Topeka, Kansas, by Dr. James Folsom and was further developed in 1965 at the Veteran's Administration Hospital in Tuscaloosa, Alabama.

The underlying principle of Reality Orientation is the repetition and re-learning of information such as the patient's name, the name of the institution in which he is

confined, the time of the day, day of the week, the date, the next meal, time of bath etc. The repetition and re-learning is conducted in both formal and informal settings.

Informal Reality Orientation is carried out on a twenty-four hour basis. The patient is continually reminded as to his name, where he is and the next appropriate activity. Comments such as, "It's one o'clock in the morning Mr. Lewis, are you having problems sleeping?" or "It's eleven-thirty Mrs. Butler, time to get ready for lunch!" are illustrative of this concept.

In conjunction with the around clock orientation, formal classes in reorientation are maintained. The basic class meets one half hour daily and an advanced class meets once a day Monday through Friday. Both classes are conducted by nursing assistants or aides, who have frequent contact with the patients. During the classes the patients are drilled as to their name, date, place, time etc.

Visual aids are employed in both the classes and where possible, throughout the institution. Reality boards are displayed at nursing stations, day rooms or wherever the patients spend a considerable amount of time. The boards contain information regarding the date, place, weather, next meal, and so forth. Large calendars and mock-up clocks are utilized in instructing the date and time. Other props used in the classroom setting include coloured pictures of food,



plastic numbers, jig-saw puzzles, and anagrams.

All patients involved in the Reality Orientation programme are addressed by the staff in accordance with Attitude Therapy. Following completion of the advanced class, the patient then becomes a candidate for Remotivation (Folsom, 1968; Folsom & Taulbee, 1966).

The descriptions of Attitude Therapy, Remotivation and Reality Orientation may be considered as ideal types (Weber, 1927) and as such allow for comparison of the ideal type to the actual application of these techniques for purposes of classification and analysis. The programme offered at Birchcliffe deviated considerably from the prescription provided by Folsom. Hence, in the following chapter we will turn our attention to the manner in which the principles of these techniques are practiced at Birchcliffe. The remainder of the thesis utilizes the contrast between the ideal and the actual R.O. programmes to aid in a critical analysis.

## CHAPTER TWO

### BIRCHCLIFFE AND REALITY ORIENTATION

The purpose of Chapter Two is to acquaint the reader with the programme offered at Birchcliffe and the manner in which it deviated from the formal theory prescribed by the proponents of R.O. However we will preface this discussion with a presentation of the background of the Department of Occupational Therapy, which introduced the programme at Birchcliffe.

#### A. THE OCCUPATIONAL THERAPY BACKGROUND

The R.O. programme has been in existence at Birchcliffe for over three years and was initiated by the Department of Occupational Therapy. The Department at the present time has a staff of four. Two of the members are qualified occupational therapists and the remaining two women have not received formal training in the occupation and are referred to as occupational therapy aides, commonly abbreviated to O.T.A's. Of the 178 patients currently residing at Birchcliffe, the Department of Occupational Therapy services approximately 135 individuals with things such as workshop activities, arts and crafts and light physio-therapy.

From the outset, it was the hope of the Department of

Occupational Therapy to fully instruct the nursing staff in the techniques of "Reality Orientation", the intention being that the programme eventually be adopted and carried out by the nursing team. Such an objective has never been fully realized.

The R.O. classes were conducted on a Monday through Friday basis. One class was carried out in the East Wing (E.1) and the other in the West Wing (W.2). Attendance at the classes has fluctuated significantly in that on W.2 at one point in the programme over forty patients were registered. Registration as few as fourteen patients on E. 1 was not uncommon. However, registration and attendance were not always equated. A typical programme on E. 1 was attended by nine patients whereas twenty patients were in attendance in the programme on W. 2.

Among the numerous physical activities conducted by the Department of Occupational Therapy is "Ten Pins". Briefly speaking, X number of patients are seated in their wheel chairs in a semi-circle and plastic bowling pins are placed before the group. Each individual is then required to manoeuvre a ball in such a way as to knock the pins down. The game on one hand provides some social interaction and on the otherhand, furnishes a means for physical activity. In an attempt to reduce the number of individuals registered in the R. O. classes on

W.2, it was decided by the Department of Occupational Therapy to place those individuals who seemed physically able and alert into the ball game. With the addition of these patients, the therapist incorporated a principle of R.O., in that prior to the actual ball tossing, she supplied the basic information of the date and name of hospital.

Observer: ... then, I can say that you are trying to equate both the ball game and the R.O. sessions?

Therapist: Yes.

In order to present a broader picture of the Department of Occupational Therapy's perspective with respect to their objectives concerning the R.O. programme, portions of a conversation with an Occupational Therapist, recorded in June, 1974 will be submitted.

Observer: What is the goal you are hoping to achieve in the R.O. programme?

Therapist: Well, first of all we would like to have a good communication between staff and patients. We would like to help the staff become part of it so that, a 24 hour approach will be employed. We'd like to show the value of the programme to the staff(nursing) ... We'd like to help the patients feel secure in the institutional setting ...to have someone to whom they can turn to for expression. The staff (all departments) can create either a good or bad environment. Physical and mental stipulation should be provided for the patients. The patients should be happy in themselves...and make nursing easier so that the nurses have more time (to socialize with the patients).

Observer: How do you know when you have reached these goals?

Therapist: The goals will have been met when: (1) the staff (nursing) if fully participating and using the (R.O.) techniques they have learned; (2) when patients are turning to staff in a friendly way and are communicating; (3) their (the patient's) anxiety is increased when they are ignored.

Observer: Can you tell me how you measure success?

Therapist: We haven't reached the optimum yet. We haven't sat down with the staff (nursing), for example, talking after lunch with staff members.

Observer: Do you have any priorities with respect to the programme?

Therapist: I'd like to see more. A permanent calendar for example on W.2. Did you know there is a fire regulation concerning the placing of paper such as a calendar on the wall? I'd like to see everyone's name placed on the reality board so that the confused patients can read their name. I'd like to see more familiar objects for passing around (in R.O. sessions) so that the (patients) can touch them...For example, seasonal things such as harvest fruit and Christmas ornaments. These could stimulate memories and conversation.

Observer: How do you decide who attends the ball game and who stays in the R.O. programme.

Therapist: Well as you know, most of the patients on W.2 are confused to some degree. Some are disoriented as to time and place, some are belligerent... For example, I wouldn't place Mr.S (patient) in the 'Ten Pins' Ball game. Now he knew the name of the month as you know in this morning's class. But he is confused as to making choices, making good judgements and understanding his own disability. He has a perceptual confusion... Nor Mr.P.S. (patient) has a milder form of confusion... and his memory retention is poor but he doesn't have a perceptual confusion. He does quite well in 'Ten Pins'. You can't generalize about this. Each person has to be considered in terms of their physical and mental functioning.

Approximately two weeks after a patient has been admitted to Birchcliffe, a "Rehab" conference is held at which a patient's needs are evaluated and various recommendations are made. In attendance at such a meeting are the patient's physician, the Medical Director of Birchcliffe and representatives from the different Departments such as Social Service, Pharmacy, Physiotherapy, Recreation, Occupational Therapy and Dietary. These representatives become acquainted with the patient's medical history and any other pertinent data. For example, a patient may have diabetes and may be experiencing difficulties in other ways, such as edema in the legs, depression and financial worries. During the conference various courses of action would then be suggested in an attempt to relieve some of the burdens. A Team conference would follow the "rehab" conference at a later date. The heads of the Departments who attend the meeting would then re-evaluate the patient as to his progress and assess whether the prescribed recommendations made at the "rehab" conference were carried through and with what effect.

All Departments are provided with an Assessment and Placement Service notification, (A.P.S.) regarding any new arrivals to Birchcliffe. The Occupational Therapist, having considered the information and following the passage of a few days as "it takes time to get used to your new surroundings" will then visit the new arrival. Sometimes a number of

visits are required in order to gain the confidence of the new patient. The therapist will introduce herself as a member of the Occupational Therapy team and cognizant of his physical capabilities will attempt to interest the patient in taking part in some of the services and programmes offered by this particular Department.

It is through conversation with the new patient that she determines his candidacy for the R.O. programme. No reliance is placed upon a specific measurement such as Goldfarb's Ten Point Scale (1960) in evaluating the degree of mental impairment of the patient.

I just talk to him and ask him a few questions such as if he knows his name, or the date, where he is and if he knows why he is here... No I don't use any set exam.

Thus, selection into the programme rests with the decision of the therapist on the basis of a few questions asked of the prospective candidate. Any conclusions drawn from the conversation with the new patient, together with any recommendations concerning the patient are brought to the attention of the Director of Occupational Therapy for consideration. However, it is the interpretation of the conversation that is left entirely up to the representative of the Department of Occupational Therapy and it is on this basis that the new arrival is regarded as R.O. material.

This contrasts with the description of placement in R.O. as given by Folsom:

Placement of the Reality Orientation Programme is done by prescription of the Ward Physician after the entire treatment team has reviewed the case at a Treatment Planning Conference (Folsom, 1969:4).

#### B. THE PROGRAMME AT BIRCHCLIFFE HOSPITAL

In an attempt to view the programme in a fully comprehensive manner concomitant with certain deviations from the prescriptions set forth by Folsom, a model of the R.O. classes will be presented. The model is reconstructed by means of excerpts extrapolated from data collected during observations of the sessions - a period of eighteen months.

As previously stated, two classes were held, Monday through Friday on E.1 and W.2. Each session has a time period of forty-five minutes. Folsom (1968) proposes a time duration of thirty minutes for each session. Furthermore, Folsom (1965,1966) and Stephens (1969) report that the sessions are divided into two groups, basic and advanced classes.

...the basic course is about the level of first to third grade classes; the advanced course is comparable to fourth and sixth grade level (Stephens, 1969:2).

A patient typically progresses from the basic into the advanced class and upon graduation - as a diploma presentation ceremony is suggested - only then is he encouraged to attend



a Remotivation programme.

The contents of the programmes on both E.1 and W.2 did not differ significantly and on that basis could not be distinguished as either a basic or an advanced R.O. class. Each session on both E.1 and W.2 typically employed the following format:

- (1) The instructor individually greets the participants of the programme. Due to large membership on W.2, this procedure is frequently directed to the members as a group as opposed to an individual basis.
- (2) The instructor then presents the "basic" information such as the name of the hospital, date, and city. For instruction purposes, this material is placed on a permanent Reality Board on E.1. Moreover, a large bank calendar attached to the board is utilized.

During the initial stage of observation, this information was printed on a portable blackboard which was stored out of sight, following the conclusion of the session. However, as time passed the blackboard was discontinued. Moreover, no R.O. board was utilized. The instructor did bring a calendar, identical to that permanently affixed to the Board in E.1. Like the blackboard, this calendar was not kept permanently in sight, but was removed to the Department of Occupational Therapy following the sessions.

- (3) A great deal of reliance was placed upon kinesi-therapy in terms of breathing exercises, stretching exercises, kicking and tossing balls and throwing bean bags, either to each other or into a receptacle.
- (4) Introduction of selected topics for conversation, frequently taken from the local newspapers; e.g. visits of royalty, demolition of local landmarks, women politicians, conversations centering around patients' careers, such as farming, raising children etc.

Occasionally poetry reprinted from old school books would be introduced. This aspect of the programme is representative of steps two and four of Remotivation.

- (5) Occasionally the introduction of objects for identification purposes was utilised e.g. Chinese fans and lanterns, fake fruit, symbols of certain days such as Jack-o-Lantern on Halloween and vegetables.
- (6) A sing-a-long to the accompaniment of a piano was for all practical purposes, a consistent feature of the programme on E.1, on W.2 however this aspect was a rare occurrence.
- (7) The names of those in attendance were read off loudly so that a person would respond to the sound of his name which was recorded in an attendance book.
- (8) The participants were thanked for attending the programme, sometimes on an individual basis or as a group, depending on the amount of time available. A statement summing up the 'basic' information by the instructor was delivered, e.g. "So remember Ladies and Gentlemen, today is Monday, the 5th. of June, and you're living at Birchcliffe Hospital. I'll see you to-morrow". This would appear to be the fifth step of Remotivation.

The programme at Birchcliffe incorporates a combination of features not prescribed in the formal R.O. literature.

Folsom's programme may be viewed as essentially a drill session, in that when a patient has relearned the basic facts concerning his name, date, time, weather, season and hospital:

...only then should he be given information such as the name of his home town, or perhaps his former occupation. (Stephens, 1964).

Stephens (1969) details a programme leading toward graduation.

Occasionally, a patient from the W.2 session - always a woman - was permitted to attend the class on E.1. However, such a transfer was not due to the fact that she progressed from a basic to an advanced class but rather it was hoped that the patient would elicit a more favourable reaction to the congenial setting of an all-female group, or possibly enjoy the sing-a-long aspect of the programme. Sometimes a woman from W.2 would attend the E.1 classes so that the Instructor could spend more time with the patient as the membership on E.1 was considerably smaller than that on W.2. However, the classes were not geared solely along the R.O.principles. The programme at Birchcliffe employs sing-a-longs, kinesitherapy and undeniable features of Re-motivation. Moreover, on W.2 no R.O. board was used, and due to the size of the group, information was often directed on a group basis.

Various props utilized on the R.O.programme are listed in a Description of Technique and include in addition to the R.O. board such things as:

note pads, anagrams, large-faced clocks,  
plastic numbers, adult picture books and  
flash cards. (Stephens,1969:3).

Props of this nature were not used in the programme at Birchcliffe but were substituted by fresh fruit, fake fruit,

fresh vegetables, a large plastic egg and on occasion various objects signifying other cultures or symbolizing a particular celebrated day.

In terms of class membership, Folsom advises that a limit of three or four patients be maintained in the basic class, whereas six, eight or possibly more comprises the advanced class (Folsom, 1965, 1969; Stephens, 1969). The participants in the programme at Birchcliffe however, far outnumbered the restrictions prescribed by Folsom. For example active participants in the sessions on E.1 maintained an average attendance of nine patients. On the other hand, W.2 had double that number and often exceeded over twenty-two patients in a class.

The women patients involved in the sessions on E.1, were basically older (80's and 90's) than the patients comprising the group on W.2 who ranged in age from twenty-one years to late seventies and early eighties. Although the E.1 patients suffered from some physical maladies, such as arthritis, any brain damage was basically attributed to their age. The patients on W.2 appeared to have more disabilities in that they had brain damage chiefly due to strokes. Included in the session on W.2 was a patient with a chronological age of 21 years but having a mental age of about a three year old child, a woman who could not see and was very hard of hearing, a deaf patient (who used no hearing aid)

and a few patients who could not understand English (frequently patients in both groups would appear to answer or speak in their native tongues).

Only one of the two R.O. instructors, when asked by this observer, could explain Attitude Therapy and describe the difference between Active and Passive Friendliness although Attitude Therapy is a vital component of R.O.

Attitude Therapy is basic to all our treatment programs....When a patient is admitted to a unit an attitude is prescribed for him by the treatment team (Folsom, 1969:3).

Attitude Therapy makes it possible for a patient's individual personality requirements to be met with a degree of consistency that encourages the abandonment of self-defeating behaviours and the learning of new and effective ways of coping with the environment (Oberleder, 1969:3-4).

The following is not representative of any single class but is a composite based on observations collected during eighteen months. The material utilized has been extrapolated from both classes on E.1 and W.2. For purposes of clarification and to avoid duplication, patients were assigned numbers as members of the classes in either E.1 or W.2.

Prior to the sessions, the instructor typically utilizes some time in re-arranging the chairs in a seating pattern - a circle in the case of W.2 and L shaped row in E.1 - occasionally retrieving a patient's glasses from his room or wiping a gluey substance from the eyes of some

patients. When this procedure is finished the instructor begins.

(The key to coding is as follows: the first letter and number in the brackets refer to the Ward, the next letter P (Patient) or S (Staff) identify the respondent's status and the last number refers to the number assigned him in the coding procedure).

Instructor: Well, can anybody tell me what day it is today?

(W.2P.24) Thursday?

Instructor: Yesterday was Thursday so today is .....

(W.2.P.24) Friday!

Instructor: That's right today is Friday. Can anyone tell me the name of the month? Mrs.H. what month is this?

(W.2 P.20) January?

Instructor: No Mr.S.we've passed January. What is the month that follows January?

(W.2,P.11) February.

Instructor: That's right Mr.S. It's February and it's a Friday in February.

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Instructor: Does anyone know the date? It's near the middle of the month?

(E.1.P.8) 15th

Instructor: That's close but it's not the 15th..yet. Tomorrow is the 14th. and so, if tomorrow is the 14th, then today is ...

(E.1 P.4) .. 13th

Instructor: That's right Mrs.B. It's the 13th. of February and it's Friday ... and the year is 1974

At this point, the therapist would arrange the date on the calendar and place a strip of paper with the name of the day printed on it. When the blackboard was used in the initial stage of observation on W.2, the appropriate information would be printed on the blackboard.

Instructor: If today is the 13th of February then what is tomorrow? Can you tell me Mrs.K? (she then repeats her question to the patient)

(E.1.P.1) 14th.

Instructor: That's right but can you tell me what special day is on February 14th?

(E.1.P.5) Valentine's Day

Instructor: Sure, that's right, tomorrow is Valentine's day.

---

In the event of a celebrated day, such as Thanksgiving, St.Patrick's Day, Easter, Valentine's Day etc. with which the instructor could relate the 'basic' information such as the date, the instructor would typically gear the conversation in the area by asking individual patients questions concerning this particular day. Usually every patient would be asked a question on the subject matter at hand in the session on E.1., however, due to the numerous participants on W.2, the instructor would ask questions on either a group level or direct a few questions to some individuals.

Instructor: How many of you gentlemen gave your wife flowers or candy on Valentine's Day. Raise your hand so I can see. Mr.L. you didn't give your wife flowers on Valentine's Day, why not? (he hadn't raised his hand).

(W.2P.17) ...bachelor!

Instructor: Well, that's a good reason. Can anyone tell me the name of the hospital that you are living in?

(W.2,P.28) College.

Instructor: No it's not College, can anybody else tell me where we are?

(W.2,P.19) Birchcliffe!

Instructor: That's right, we are living at Birchcliffe Hospital. What street is Birchcliffe on? Mr.V. can you tell me?

(W.2.P.6) Main Street.

Instructor: No, not Main Street, although the street begins with an M. Mr.S, can you tell me the name of the street that Birchcliffe Hospital is on?

(W.2.P.10) Mayfair?

Instructor: No, not Mayfair.

(W.2P.14) Mary.

Instructor: That's right, Birchcliffe Hospital is on Mary Street.

---

The name of the hospital and city would be printed on the blackboard in W.2. The name of the hospital is affixed to the board on E.1. As time progressed, the blackboard on W.2 was not used and so the patients had no visual aids.



on which to rely.

Occasionally, the instructor would present objects for identification purposes:

Instructor: My husband and I went for a drive in the country the other day and we bought some vegetables from a farmer's stand, right on the highway. Look at this (retrieving an ear of corn from a bag. Can anyone tell me what I am holding?

(W.2.,P.3) That's corn!

(W.2.,P.17) It's Indian corn.

Instructor: Yes, that's right. What's a fair price for this corn Mr.B.

(W.2.,P.16) I don't know.

Instructor: I got six ears of corn for sixty cents.

(W.2.,P.16) You did eh?

Instructor: I also bought a Delacotta squash ... I am going to cook it. (she presents the squash for observation). The farmer told me how ..... you cut off the ends and stuff it with meat. Do you like squash Mrs.H?

(W.2.,P.23) Sure I do, it's good.

Instructor: What about you Mrs.J. do you like squash?

(W.2.,P.7) Yes.

Instructor: What kind do you like (points to another patient)

(W.2.,P.18) Butternut.

Instructor: How is it cooked?

(W.2.,P.13) ... peel and bake it.

---

Instructor: (Holding up an apple for the group to see) What kind of apple am I holding?

(E.1,P.4) Is it MacIntosh?

Instructor: That's right. They are good tasting aren't they?

EE.1,P.4) Yes.

Instructor: Did you ever steal apples as a kid Mrs.H?

(E.1,P.2) Sure, climbed a lot of trees.

Instructor: Ever get a tummy ache from eating those green apples? (pointing to another patient)

(E.1,P.17) Sure did!

(E.1,P.9) ...so did I.

---

Topics of conversation often centred upon news events that were selected from the local newspaper.

Instructor: I see that the Arabs have cut off their oil. There's a fuel crisis. They are rationing gas in the States.

(E.1,P.2) They have?

Instructor: Yes, they have, it's like it was during the War. Remember rationing tickets?

(E.1,P.5) They rationed a lot of things then, soap, sugar, butter.

Instructor: Did you ever drive a car Mrs.B?

(E.1,P.11) Yes I did.

Instructor: What kind of car did you drive?

(E.1,P.11) Chevy, ... a coupe

Instructor: Were you a careful driver?

(E.1,P.11) Careful enough, I guess.

A portion of the programme, particularly on W.2 was geared to physical exercises. As time progressed it appeared that the time spent on activities such as bag tossing, kicking and throwing the ball, etc. increased. It must be stated that during this time the instructor was busy explaining the therapeutic benefits of the exercises to the R.N.A's and aides who were assigned to assist the instructor. Besides manoeuvring the ball or bag, the participants were engaged in breathing and stretching exercises. The instructor would frequently explain to the patients the reasoning behind the exercises, thus, alleviating some of the anxiety experienced by a few patients who considered ball tossing "kid's stuff".

Instructor: Let's exercise those muscles and have some fun too. Here Mr.A. I'll put the ball at your feet and you kick it.

(W.2,P.22) I don't want a ball. What do I want a ball for?

Instructor: We'd like to exercise the muscles in your leg. I'll place the ball at your foot and you give it a push, That's good! Thank you.

(W.2,P.22) (The patient complies with the wish of the instructor).

Instructor: Mr.S. give me a good kick, will you?

(W.2,P.6) I'm not sure. I've got a kick to give you;  
I'll see what I've got.

Instructor: You're always teasing me. Kick the ball and not me. (patient complies). Mr.V. will you throw the ball please? (she hands the ball to Mr.V).

(W.2,P.3) (a stroke victim with the use of only one side of his body) Where do you want me to throw it?

Instructor: Throw it to Mrs.E. she's over here (instructor stands beside Mrs.E. and touches her shoulder, indicating that this lady is Mrs.E).

(W.2 P.19) (Mrs.E. catches the ball) What should I do with it?

Instructor: Toss it back to Mr.V.

(W.2P.3) (throws the ball across the circle to another participant).

---

There are variations of this type of exercise in that sometimes one is required to knock down some plastic pins located in the centre of the circle, or toss bean bags to each other or into a container. Usually everybody has two or three chances with the balls and bags.

On E.1, a sing-a-long accompanied by a patient on the piano typically followed the exercise period. Four songs were the average number sung and included old favourites such as "It's a long way to Tipperary", "Sidewalks of New York", and a hymn.

Sing-a-longs on W.2 were very rare and only three instances were recorded. On two of the occasions a volunteer would accompany the group on a piano. One volunteer

played a selection of Christmas Carols however, as it was July, a more appropriate selection could have been made. Sing-a-longs on E.1 were a daily feature of the programme.

On occasion, the instructor would read some poetry, near the conclusion of the programme, which was taken from a reprint of an old school reader. On W.2, one poetry selection concerning old English and Spanish warships took three sessions to complete, in that a third of the poem was read near the conclusion of the class on three consecutive days.

The programme would then conclude, generally in this fashion. The instructor would read off the names of the participants in the class. Most of the members would respond with the words "present" or "here" upon hearing his name called. Those who were very hard of hearing, had speech problems, or understood little or no English did not react in this manner and so the instructor would check off their names in the attendance book.

She would then say:

Thank you Ladies and Gentlemen for coming today. And remember it's Friday, the 13th, day of February and you are living at Birchcliffe Hospital. You'll be having lunch soon. I'll see you on Monday,

In sum then we are able to provide a summary of differences between the classic model and Birchcliffe and between the two wards involved in the R.O. programme. For purposes

of clarification, this will be done in a simple tabular form.

Classic Model	Birchcliffe	
(formal R.O.programme)	East 1	West 2
Placement in R.O. programme is prescribed by the ward physician following a review of the case by the treatment team.	→Placement decision rests solely with the Department of Occupational Therapy.	
R.O.classes are an adjunct to 24 hour R.O. stimulation and reinforcement.	Emphasis on classes no noticeable 24 hour R.O. stimulation.	
Reliance on Attitude Therapy.	Absence of Attitude Therapy	
"basic" class	Basic and advanced classes are undistinguishable in terms of patient population and format of the programme.	
"advanced" class		
3-4 patients are prescribed for "basic" class	eleven patients	twenty patients
6-12 patients are prescribed for "advanced" class	are usually in attendance	are usually in attendance
classtime duration is thirty minutes	class time duration is forty five minutes	
Classes are conducted by R.N.A's and aides	class conducted by O.T.A.	Classes have been conducted by O.T.A., O.T. (during the latter stages of observation an R.N.A. or aide assisted the O.T. who replaced the O.T.A. in this class.

continued

E.I.

W.2

continual drill session reviewing the "basics"

review of "basics at beginning and closing of programme.

presented on an individual basis

directed on a group level

Active use of R.O. Board and reliance on props such as flash cards, personal calendars, anagrams and paper and pencil activities.

Use of R.O. board with name of hospital, day and large bank calendar permanently affixed to it.

blackboard abandoned no use of R.O. board - large bank calendar presented for a brief time at the beginning and at close of session.

A few props used for identification purposes, e.g. fruit, Chinese lanterns.

graduation from "advanced" class leading to participation in Remotivation Therapy.

Remotivation therapy, kinesiotherapy and recreation incorporated in the classes

daily sing-a-long

sing-a-longs a rarity with most of the geared to "physical oriented" activities.

In this chapter we have considered the background of the programme offered at Birchcliffe, the manner in which it differed from the principles of R.O. as prescribed in the formal literature and a model of the programme for purposes of description and clarification. In the next chapter, we will

consider the first of four assumptions located within the framework of the formal theory of R.O. and the subsequent effect on the programme at Birchcliffe.



### CHAPTER THREE

#### OVERSIGHTS IN REALITY

Problems of old age are of two general kinds: those that older people actually have and those that the experts think they have ... Their intense involvement commonly magnifies older people's problems...Practitioners also oversimplify the problems of the aged... in the process, their perception is often warped (Rosow,1967:1,2).

There exist on a theoretical level, a number of highly significant assumptions, in so far as Reality Orientation as a therapeutic technique is concerned. These presuppositions are almost entirely unexamined by the proponents of the programme.

In this chapter, attention will focus upon the first four of the five assumptions inherent within the formal framework of the Reality Orientation literature. For example, drawing upon a phenomenological approach, we are concerned with the nature of the "reality" that patients are to be oriented to and how it is so defined? In a geriatric setting why must hope for one's future recovery be provided? The management of these assumptions, in terms of the subsequent practice of the programme offered at Birchcliffe will be provided.

The subject matter of this chapter has sociological

significance. By using ethnographic data on behaviour in the classes and outside them we are able to examine several areas of sociological interest. For example, we may consider the impact of patients themselves in trying to negotiate the use of their own reality; the consequences of using symbols as icons for the objects to which they refer; or a death on the ward. Each of the first four assumptions is examined in turn.

Assumption One deals with a generalization that senility is caused as a reaction to a reality of diminished worth induced by a failure of the family to integrate the elderly into the home. Such a supposition is supported by little evidence. In discussing the phenomenon of senility, we will consider the import of self concepts, role loss and the theoretical perspective proposed by Kuypers and Bengtson (1973) for studying the features of aging.

Assumption Two suggests that there exists, factually, something which may be described as "reality". The phenomenological approaches offered by Schutz (1964) in terms of multiple realities, Thomas' (1928) definition of the situation, Berger and Luckmann's (1966) treatise on the socially constructed social order and Chappell's (1973) theoretical analysis of the world of the senile, will be applied to the classroom setting in particular and the confines of the geriatric setting in general.

Assumption Three presumes that the past (as in reminiscence) is devoid of any characteristics of reality. In discussing this aspect, attention is directed towards the Life Review (Butler, 1963) and the importance of reminiscence as a normal adaptational mechanism of the aged in light of current research of this phenomenon. We then take into account the manner in which reminiscence is employed in the programme at Birchcliffe in a way that is contrary to Dr.Folsom's prescription of the R.O.programme.

Assumption Four centres upon the concept that hope must always be offered for the patient's future recovery. In considering the viability of this attitude, specifically within a geriatric centre, research conducted in this area will be examined. Furthermore, the typical mode in which the topic of death in terms of R.O. patients was approached in the classes will be presented, as will the nursing staff's approach of the subject.

### THE FIRST ASSUMPTION

The first assumption to be considered is that senility is a reaction to a reality of a diminished worth. As Folsom argues:

In our society today families often find it difficult to integrate the elderly into their home life. As a result, the elderly individual faces the reality of diminishing importance in the very area where he formerly held authority. This change in reality often leads to confusion and disorientation...The patient's first symptoms of confusion may accompany or follow a physical illness or he may gradually become absent-minded, forget common facts or wander aimlessly... Besides treating the confusion, there are almost always physical disabilities which must also be treated (Folsom, 1965: 1,2).

Folsom neglects to provide either statistics or research findings with which to substantiate his analysis. Moreover, there appears to be little evidence supporting this generalization. However, we shall consider this assumption in light of existing data and current research findings on the subject.

There is evidence to support the fact that knowledge of one's diminishing self esteem can lead to depressive reactions especially when one considers the loss of roles which is very profound on one's advancing years. It is obvious, that the social world of the aging individual changes,

usually contracting with the passage of time. Both numbers and variations of social contacts decrease: roles are literally lost as retirement, widowhood, the death of friends and siblings, and declining physical agility leave the individual increasingly to his own resources. In other words, a shrinkage of role repertoires both within and outside of the family becomes evident. Role loss in old age not only occludes and devalues people but also, undermines their social identity (Rosow, 1967:30-35).

Depressive reactions in old age are quite common and old people frequently react to threats, losses and frustrations with dejection, apathy, and pessimism (Pfeiffer, 1973; Redlich & Freedman, 1966). Neither Redlich and Freedman nor Pfeiffer suggest however, that "the reality of diminished importance" results directly in confusion and disorientation as Folsom reports.

In an attempt to fully appreciate the wide range of reactions among the aged to stressful crises, as some individuals appear to cope, some withdraw while others may become psychotic, Rosow (1973) submits that two areas of investigation may provide a few clues. The first is that an individual's personality traits which have been acquired and developed throughout one's history must ultimately have a significant bearing on one's reaction to stress. This idea is supported by Busse and his associates (1954, 1955)

who reported that, provided there is an absence of organic damage to the brain and nervous system, emotional states in later years remain essentially the same as previous ones, although they may be intensified. The second area is concerned with the view that an individual can withstand stress more effectively provided that he has strong group support. Rosow argues that in the face of major role loss, the fate of old people's group memberships, other than family, is important for both mental and emotional well-being. However, the problem arises in that with increasing age, one's social world diminishes as does those affiliations that sustain people on a psychological basis. As a significant reduction in group memberships occur with age; the buffers with which to combat stress are subsequently frayed.

Yet Folsom fails to consider the individual's personality traits and relevant reference groups other than family in his explanation of senility.

One's self image or concept is highly subject to perceptions held by others.

The term identity expresses such a mutual relation in that it connotes both a persistent sameness within oneself (self-sameness) and a persistent sharing of some kind of essential character with others (Erikson, 1960:38).

Several studies have suggested that morale in old age

may be even more highly related to association with friends as opposed to that of one's children (Blau, 1973; Lowenthal & Haven, 1968; Rose, 1965; Shanas & Streib, 1965; Townsend, 1957).

There exists a relationship between significant physical illness and depression in old age. A number of cross-sectional and longitudinal studies have demonstrated that an old person can accept the loss of love objects and prestige to a greater degree than he can a deterioration in physical health (Busse, 1968). As physical disability impedes mobility, it can be responsible for social isolation. Furthermore, as it also disrupts various pursuits and activities which ordinarily contributes to one's self esteem, physical illness and depression often accompany each other in old age.

Numerous articles refer to the stereotypes of the aged commonly found in our culture. (Butler & Lewis, 1973; Hickey & Kalish, 1968). These stereotypes are usually associated with some sort of stigma. People moreover have a tendency to carry the myths and stereotypes about old age from earlier to the later years. Since individuals believe these misconceptions, they may become self-fulfilling prophecies for many old people (Bengtson, 1973; Rosow, 1967).

Almost any emotional change in older people is often shrugged off as a sign of approaching senility. James Birren suggests that too much misdiagnosing occurs as only about 12 per cent of the population has a gentle predisposition for the type of brain disorders that cause senility, and only about 5 per cent exhibit such disorders.

Yet older people who suffer from things such as occasional memory lapses-- which occur in people of all ages-- are frightened by the bogey of creeping senility, and fall into a vicious circle of worry, depression and physical decline (New York Times, June 21, 1974:89).

Similar sentiments are confirmed by a geriatrician:

...every geriatrician has seen patients with an eminently treatable disease, such as myxoedema... dismissed as senile and denied the treatment which could restore them to normal healthy old age (Isaacs, 1965:14).

These quotations obviously exemplify the labelling process. The latter quote in particular illustrates the manner in which the stigmatized individual's social identity (old person) is distorted to conform with the stereotypes associated with this stigma. In this instance, simply being old is equated with senility.

Kuypers and Bengtson (1973) have introduced a perspective with which to further enhance an understanding of the multi-faceted features of the aging process. They modified Zusman's (1966) "Social Breakdown Syndrome" concept and



applied it to the aged segment of the population in an industrial society. Zusman envisioned a seven stage cycle of "Social Breakdown", from which Kuypers and Bengtson extrapolated four intricate stages, they are:

- 1 A precondition or susceptibility to psychological breakdown; e,g. identity problems
- 2 A social labelling purporting a deficiency or incompetency
- 3 An induction into a sick or dependent role concomitant with an atrophy of previous skills
- 4 An identification with the sick role and self-identification as inadequate (Bengtson, 1973:47)

In terms of the first stage, Kuypers and Bengtson argue that as the elderly experience a lack of reinforcement in terms of identity, expectations, etc. due to the paucity of normative constraints, role loss and appropriate reference groups, they are highly susceptible and subject to social labelling. Secondly, the feedback vacuum produces a weakened position and a dependency upon external sources of self-labelling in which stereotypic images are usually transmitted to the elderly. Thirdly, the aged person who accepts the negative labelling is then inducted into the position of dependency in that he begins to learn the role; i.e. learning to act as old people are supposed to behave, while the art of independence gradually becomes weakened. Finally, having accepted the external labelling as well as the

identification of being less than adequate, the stage is set for another vile cycle (Bengtson, 1973: 47,48).

The impact of role losses or as Folsom proclaims, "the reality of diminished importance" is an integral element in the creation of problems experienced in later years and cannot be defined. However, Folsom's analysis restricts this "reality" solely to the family's failure to integrate the elderly in the home. In determining the cause of senility he neglects other social psychological phenomena which have been presented in this section. That a diminished self esteem may trigger off a depressive reaction, has been established. However, the terms confusion, disorientation, and depression are not synonymous and cannot therefore be used interchangeably. In sum, there are too many factors to be considered in discussing senility and its causes; and speculating about one factor or pinpointing a single agent in order to explain such a complicated subject matter appears highly insufficient.

### THE SECOND ASSUMPTION

The second assumption located within the framework of the R.O. programme is that "reality" is an entity with concrete properties; that is to say, "reality" exists factually.

Orientation to reality is taken at its most basic meaning. If the patient does not know his own name, he is first taught his own name. If he does not know where he is and where he is from, these facts are taught next. Then he is taught such things as the day, week, month, year, his age etc. (Folsom, 1969:4).

Such a quotation reveals that the concept of "reality" as expressed by Folsom centres upon simplicity in dealing with such a complicated subject matter. Let us therefore, consider "reality" in light of what is known of perception and cognition.

Man's perception is highly dependent upon the pre-suppositions brought to any particular occasion and is not only a reaction to stimuli in the environment but rather a transaction with an environment (Dewey, 1922:46). The meanings and significance assigned by individuals to things, symbols, people and to events are the meanings and significances that have built up through one's past experience, and are not inherent or intrinsic in the stimulus itself (Heider, 1958:35).

These significances and meanings interfuse and present us with what may be called, our own "reality world". This "reality world" as we experience it, incorporated among other things, one's aspirations, fears and frustrations.

...these psychological characteristics of life -- as the psychiatrist knows better than anyone else-- are just as real for us in determining our behaviour as the chairs, stones or mountains or automobiles. It seems to me that anything that takes on significance for us in terms of our own personal behavioural centre is "real" in the psychological sense (Cantril, 1957:117).

Moreover, as one sociologist so aptly stated:

If man define situations as real, they are real in their consequences (Thomas, 1928:584).

Harry Stack Sullivan (1947) provides us with the concept of "consensual validation" in which he proposes that meaning is determined by social validation in that, the meanings of symbols and ideas are derived from a consensus among the community using the symbols and ideas. These socially valid meanings are learned by an individual through communication. In normal development, as a child matures he changes his peculiar artistic meanings and definitions to meanings in accordance with those accepted by his social group.

Berger and Luckmann (1966) have interpreted the various ways people construct social order and yet define the reality of everyday life to exist independently of themselves. They

maintain that in every society, people develop a mode of defining and perceiving reality. This is already distributed in the language that forms the symbolic base of the society. Over this base, and by means of it, exists a system of ready made typifications, in which the multitudinous experiences of reality come to be ordered. Since these typifications and their order are held in common by the members of society, they acquire not only the character of objectivity but are taken for granted as the only world that normal men can contemplate.

The phenomenological analysis of Schutz (1962) discloses the contents of the world in modern society. The world of everyday life is characterized by a specific level of awareness or a wide-awake attitude in which an individual gives his attention to life. Such an attitude belongs to an individual who is working in the real world, whose actions gear or mesh with those of other egos, and who tries to change his environment and become modified by it. Since an individual is conscious of a projected state of affairs which he attempts to realize, working is thus, subjectively meaningful for him. The world of daily life (paramount reality) is characterized by wide-awakeness (specific tension of consciousness), work (a prevalent mode of spontaneity), the vivid present (a specific time perspective), a specific

epoché (suspension of doubt concerning the existence of the world of daily life), and a common intersubjective world of communication and social action (a unique form of sociality) (Schutz 1962; 207-234).

Although an individual defines his world from his own perspective, he is a social being that is rooted in an intersubjective reality in that the world of the daily life, into which everyone is born, is an intersubjective world. We experience the world in which we live, not as a private adventure but rather as intersubjective world which involves intercommunication and language. Moreover, the subjective interpretation of meaning is viewed as a typification of the commonsense world, the actual way in which men in daily life do interpret their own and each other's behaviour.

However, an individual inhabits not just one reality, but many in fact, and of these realities, several are not meaningful to everyone. For example, in his analysis of Don Quixote, Schutz describes the manner in which this character utilizes the world of phantasy -- a reality other than the paramount reality as a base. He then illustrates how Quixote, upon leaving his phantasy world is then considered to be a homecomer to the paramount reality (Schutz, 1962: 150-165).

In order to gain a clearer understanding of "senility" a theoretical analysis of the world of the "senile" in

conjunction with Schutz's conceptual framework of social reality was recently undertaken (Chappell, 1973). Access to the "world of the senile" was obtained through numerous conversations with individuals who seemed to demonstrate these characteristics commonly associated with "senility". The interviews were conducted at Birchcliffe Hospital.

Basically the researcher suggests that since everyone, "seniles" included, has a unique biography which has been shaped through various individual experiences, it is not unreasonable to consider that they (seniles) entertain a subjectively defined reality as well, although it may not concur with "others". With this in mind, she argues that it is possible to communicate effectively by either entering the reality of the "senile" through sharing their meanings or by locating an area wherein the reality of the "senile" and that of the paramount reality synchronize. Such shared meanings may consist of gardening, rearing of children and so forth. Any absence of shared meanings would most likely result in an inability to communicate at all; although ineffective communication may also be considered the consequence of a lack of mutual trust between the interactants involved (Schutz, C.P. 2, 1962: 155-156).

The ways in which the second assumption of the factuality of reality became problematic at Birchcliffe are:

- (a) the failure of the nursing and health care staff to maintain a consistent definition of reality
- (b) the impact of patients themselves in trying to negotiate the use of their own view of reality
- (c) deliberate violation by the staff of the programmatic definition of reality
- (d) the use of props which were symbols as icons for the objects to which they refer (ie., a blending of symbol and thing symbolized)
- (e) the limited temporal features of the programme
- (f) fusion of physiotherapy with R.O.

Having actively participated in and observed many verbal exchanges with the "senile" aged within Birchcliffe, I have witnessed several conversations between staff members and patients which could quite possibly be regarded as entering one's reality and sharing certain meanings. Moreover, there appeared to be some prescriptions and proscriptions among the nursing staff in dealing with certain individuals who did not share the "paramount reality". Conversations were witnessed wherein a member of the nursing staff would not only make use of the shared meanings so as to communicate with her patient, but would often reinforce them. Consider the following interaction, recorded on West 2, between a patient and an R.N.A.:

W2,P 14) I'm going to a party today.

(W2, S.4) Are you dear?



(W2,P 14) Yes, I am going with Margaret.

(W2,S.4) Is it a special party ... like a birthday party?

(W2,P 14) Yes, that's right.

When I asked the nursing assistant if the lady was well enough to go to a party, or for that matter, leave her bed, she shook her head and quietly said 'no'.

(W2,P.9) Hey, has anyone seen my car keys?

(W2,S.7) No, I haven't seen them, but if I come across them I'll give them to you.

(W2,P.9) I can't drive my car without them, you know.

This man had been hospitalized for some time, and assuming that he had ownership of an automobile, he was too ill to leave the hospital and subsequently drive the vehicle.

In terms of patient management, it seemed that entering a "seniles" world, was an effective method employed by the nursing staff to "reach" a patient and soothe his anxieties, if only for a short time.

One R.N.A. (W.2.S.5) who could "see no sense in trying to rob them (patients) of their own little world" confided to me that:

Mrs.M., yeah take her for example, it seemed like whenever any of us would go into her room she'd ask one of us to feed her cats... Well what could you do...tell her she didn't have any? Well, she'd get so upset, so that, whenever I went into her room and she tell me her cats weren't fed, I'd tell her I was just going to feed them. I'd walk out of the

room and come back in a few minutes and tell her not to worry cause I just fed them. This would make her happy and she'd settle right down.

Or, as another nursing assistant (El,S.3) recounted an incident to me:

I remember one experience that taught me a lot. I remember this one woman who would sit in her chair for hours in the corridor by the nurses' station. I went over to her once and asked her if she'd like to go to the sun room. She told me that she was waiting for a bus. This was long before that R.O. stuff. I told her that she was in a hospital and that no bus was going to come and stop here for anybody. She got really upset. I felt bad about it. So whenever I saw her I would just say something like, 'I hope you don't have to wait too long for the bus today, or, Where are you going today on the bus'.... I don't think it's wise to tell them the truth.

These examples I believe illustrate the manner in which the health care staff failed to maintain a consistent definition of reality. Moreover in terms of patient management, it appeared to be an effective way of administering to patients so as to not provoke anxieties in the patient and to some extent the health care staff. Chapter Four will consider this area of concern more thoroughly.

It was not an unusual occurrence to witness patients attempt to negotiate the use of their own view of reality, vis-a-vis the staff and sometimes other patients. In a recent study of Reality Orientation, Gubrium and Ksander

(1975) demonstrate the manner in which both patients and aides negotiate for the reality of their roles, prior to the therapy sessions.

One patient involved in the R.O. sessions provides a good example of negotiating his own view of reality. Certain "realities" were to be avoided by the R.O. instructors in order for him to participate in the classes.

The patient (W2,P.16) would readily provide a setting and the circumstances of his universe which seemed important to him. The setting and circumstances would usually revolve around a time when he was younger, actively en route to work, or engaged in work, which in his case was his farm. Such a setting allowed anyone to discuss with him any facet of farm life such as, the best time to plant crops, farmer's market, and indeed anything pertaining to farm life in general. Also, in reinforcing the idea of being younger, he would sometimes refer to his daughters as teenagers when in fact they are probably middle aged grandmothers. If anyone negated or violated his world, that is to say, informing him that he was not at work, that his residence was Birchcliffe and that his years numbered seventy-nine, his immediate response was to become quite agitated, sometimes to the point of swearing and flatly denying that information which had been given to him. Scenes similar to

to the following were recorded on several occasions in the R.O.programme.

R.O.Instructor: Mr.B. can you tell me where we are?

(W2P.16) Sure, I'm at home.

R.O.Instructor: Mr.B. what is the name of the hospital you are living in?

(W2.P.16) I'm not living in any hospital!

R.O.Instructor: Mr.B. you are living at Birchcliffe Hospital in Wellwood, Ontario \*

(W2,P.16) Oh no I'm not. Don't say such foolish things.

R.O.Instructor: Look Mr.B., look at all these people in this room (referring to the R.O.group) Do all these people live with you at your house?

(W2,P.16) I don't know where they live. They don't live with me...Why should I know where they live (spoken angrily).

R.O.Instructor: Mr.B., all these people and you live at Birchcliffe Hospital.

(W2.P.16) I most certainly AM NOT! Leave me alone, I got things to do.

R.O.Instructor: Mr.B. what things do you have to do?

(W2.P.16) Leave me alone, will ya!

Yet, when one would talk to this gentleman about farming and related subjects, he was a most willing conversationalist.

R.O.Instructor: Good morning Mr.B. it's a lovely August morning. The sun is shining and it is 72 degrees outside.

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\* Wellwood is a pseudonym for the municipality in which "Birchcliffe" is located.

(W2,P.16)           It is!

R.O.Instructor: Yes, it is. I was out in the country the other day and saw lots of fields of corn. Did you ever grow corn on your farm?

(W2,P.16)           Sure, lots of it. Sell it at the market.

R.O.Instructor: I love fresh corn. It's really tasty. When's a good time to pick the crop?

(W2,P.16)           Late July you get the first harvest. Most of it is picked in August through September.

R.O.Instructor: What else did you grow on the farm?

(W2,P.16)           Lots of vegetables and peaches.

It was observed that in the last few months of the programme on West 2, the conversations with this patient in the R.O. sessions leaned towards farming and farm related topics such as planting and picking crops, weather and food prices. Less emphasis was bestowed upon his place of residence or the fact that he was not at work. Whether this change was due to the time factor in that the instructor spent much time demonstrating the methodology of the programme to R.N.A's, or possible class size, or a conscious or unconscious wish to avoid further disturbing incidents with this gentleman is difficult to conclude.

Other examples of the patient negotiating his view of reality are in the following illustrations:

(E1,P.11)    I'm on my way home, why don't you come with me?

(E1,S.2)     I can't, I'm very busy today.

(E1,P.11)    Oh, Mother would have liked to meet you. Maybe you can come another day.

(E1,S.2) Well we'll see.

(E1,P.11) Alright.

Or in this instance:

(W2,P.19) (in bed) I want the window closed. Would you please close the window for me? I can't seem to do it myself.

(W2,S.8) The window is closed.

(W2,P.19) No it isn't. Close it for me will you and lock it.

(W2,S.8) (standing near the window goes over to it and makes gestures to convince the patient that the window is being closed and locked), I closed the window and it's locked.

(W2,P.19) Thank you so much.

Although interaction could take place through accepting a patient's "reality world" as a base on which to hold conversations, not all such communication of this kind was therapeutically appropriate. Observations are recorded wherein an individual (hospital employee or patient) utilized the patient's reality in order to tease or "have a little fun" as the following excerpts illustrate.

(W2,S.8) (upon seeing Mrs.E. a retired farmer whose "reality world" appears not unlike that of (W2,P.19)). Hey, Granny E. you forgot to feed the chickens and milk the cows this morning!

(W2,P.18) (agitated) I certainly did! I did it all this morning.

(W2,S.8) No you didn't, you better go take care of them.

(W2,P.18) I told you I took care of them already.

(W2,S.8) No you didn't. The cows are waiting for you!

(W.2,P.18) (inaudible mumble)

Or consider this illustration:

(E1,P.7) Can you tell me when we'll be there?

(E1.S.3) Be where?

(E1,P.7) You know....Oakville....Ask the driver.

(E1,P.12) (patient seated near P.7) Oh, we'll get there soon enough, I'll ask the driver if he can go a little faster, ha,ha.

(E1,P.7) Thank you.

Or in this instance where any of the patients are seated in their chairs in the sunroom, awaiting lunch.

(W2,P.14) Hey L. aren't you going to join us for lunch?

(W2,P.19) (seated in his wheel chair, yet shuffling his feet in quick abrupt movements) I don't have time.

(W2,P.14) Where are you going?

(W2,P.19) I've got to get to work!

(W2,P.14) Well, I hope you're not late! (turning to those who are seated in close proximity to himself) He's crazy!

(W2,P.5) (Seated beside P.14) Hey L., it looks like rain, you better get your galoshes, ha,ha,ha.

(W2,P.19) (no response)

Although not uncommon, such incidents were not an everyday occurrence.

With respect to the programme content as practiced at Birchcliffe, profound incongruities were apparent.

Frequently the R.O.Instructor employed fake objects for purposes of identification.

R.O.Instructor: (having supplied each member of the class with a plastic replica of fruit) Mrs.S. can you tell me what it is that you are holding?

(E1,P.2) I dunno (fondling her piece of fake fruit).

R.O.Instructor: Well it's long and yellow and it's grown in tropical countries and you eat it.

(E1,P.2) Oh I dunno... a banana?

R.O.Instructor: That's right it's a banana. Have you ever had a banana cream pie?

(E1,P.2) Yes.

R.O.Instructor: Mrs.L. what is it that you are holding?

(E1,P.6) ...Rubber?

R.O.Instructor: No, it's a type of fruit.

(E1,P.6) A grape?

R.O.Instructor: No, it's round like a grape but it's bigger, What type of fruit is a damson?

(E1,P.6) Plum?

R.O.Instructor: Yes that's right, it's a plum. Do you like plums?

(E1,P.6) Oh sometimes, I guess.

R.O.Instructor: Mrs.M. can you tell me what you have in your hands?

(E1,P.10) Sure, it's a ball!

R.O.Instructor: No it isn't. It's a type of fruit.

(E1,P.10) Doesn't feel like it. What is it?



R.O.Instructor: It's an apple.

(E1,P.10) (places the object to her mouth)

R.O.Instructor: Oh no, don't...you can't eat it. It's only plastic. It's not real.

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R.O.Instructor: Mr.V. what have I just given you?

(W2,P.9) (no audible response)

R.O.Instructor: It's a turkey egg. (The object was a plastic L'Eggs Egg)

(W2,P.9) That's not a turkey's egg. It's too big.

R.O.Instructor: Well, I know it's not a real turkey's egg but, it looks like one doesn't it?

(W2,P.9) It's too big.

R.O.Instructor: (takes the L'Eggs Egg and shows it to the group while addressing them) Hey, does this look like a turkey egg? What do you think Mr.C.

(W2,P.21) I've never seen a turkey egg.

(W2,P.16) That would have to be one hell of a turkey. It's so large...Are you sure it's a turkey egg?

R.O.Instructor: Well it's not a real egg, just a plastic one.

(W2,P.16) ..oh..

(W2,P.5) (placing some plastic grapes in his mouth)

R.O.Instructor: Oh, Mr.B. You can't eat those, they're not real. (She then yanks the fake grapes from the patient).

---

As of October 1973, reliance upon the identification process of fake fruit had been abandoned presumably due to a paper given by this observer at a gerontological convention in Ottawa (Young, 1973). Furthermore, the naming of the L'Eggs Egg as a turkey egg was eliminated as well. After all, make-believe objects of this nature can indeed be problematic. One could query, "When is a fake plum a real plum"? But of greater significance is the fact that various cues such as smell, taste, and touch could not be called upon in the identification of the object. An individual who is experiencing poor eye sight would have to place greater dependency upon such additional cues. The instructor was forced to supply verbal cues to the patients in order to receive the "correct response". The fake fruit proved to be hazardous because some patients attempted to eat the object. With regards to the "turkey egg" it apparently was the instructor's own interpretation of the symbolic meaning of the object that was considered the "right answer". The instructor in this instance as well was obliged to furnish verbal cues.

Further aspects of the problematic nature of the treatment of the reality concept can be seen in the limited temporal features of the programme. In Chapter Two when we considered the programme at Birchcliffe vis-a-vis the prescriptions set forth by Folsom, we indicated that there were

many deviations from the outlines proposed in the formal literature. Among the differences cited were the format of the sessions, the oversized membership, particularly on West 2, and no reliance upon a Reality Orientation Board. During my initial observation, a portable blackboard was employed for purposes of printing the "basic information" and was stored out of sight when the class finished for the day. Eventually this feature of the programme was abandoned. The large bank calendar, which was utilized in connection with the date, was displayed only for the brief time that the instructor was covering this part of the presentation. As in the case of the blackboard, the calendar was hidden from view from the participants after the session. It is on West 2, that the "basic information" was given, not on an individual basis but rather on a group basis, presumably due to the size of the group.

Barns' (1974) six week study on the effects of R.O. classroom techniques on memory loss, confusion and disorientation in six geriatric patients, concluded that there was no significant improvement in terms of learning. There was however, an increased improvement in patient behaviour which could be attributed to the extra attention paid to the patients during the study. He recommends that the total R.O. programme (classroom techniques and twenty-four hour stimulation) may

produce greater changes in patient behaviour.

The classes at Birchcliffe commenced with the "basic information" and closed with the instructor reminding the participants of the data provided in the session. The format of the programme included remotivation techniques, recreation and physiotherapy. R.O. was limited to the brief amount of time spent on the "basics" in the classroom.

The meaning of reality evoked as many interpretations as there were practitioners of the programme as evidenced by the following staff responses to the question, "What is reality: what do you mean by real?"

The staff of the Department of Occupational Therapy offered these definitions:

Reality refers to what we see and feel in the world around us.

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Well, there are different realities...it's hard to explain... We have different realities and we all see things differently.

---

Reality refers to the real things in the environment, in the world around you and not in the depth things.

---

R.N's, R.N.A's and aides submitted these replies to the question:

It means being alert, not living in the past or some dream world, but functioning in the here and now.

---

I suppose it means that something is factual, provable.

---

Not being confused. Ability to stay in touch with yourself and the world around you.

---

Things that you can see and touch. You know that they're real, like that bed or this blanket. You can touch and see it.

---

Knowing what's going on around you. Understanding where you are and why, like Mrs.M. over there. She doesn't know where she is or why. She's not living in reality. She's living in her own little world. She doesn't realize that she's in a hospital.

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Who knows?

---

Being aware of your surroundings and yourself in these surroundings.

---

It's something everybody agrees on. This is a bed right? It's not a rock or a chair. You sleep on it.

---

Something is real if it's true.

---

...Well it's called Reality Orientation  
 ... What do they mean by reality? ,....  
 I just don't know.

---

To summarize: in discussing the second assumption that reality exists factically, we introduced arguments which failed to support this concept. Chief among the opposing theorists was that of Schutz who proposed that individuals inhabit many realities, many of which are not meaningful to everyone. Drawing upon the study by Chappell we considered the ways in which access to the world of the "senile" could be accomplished. Moreover, we considered the manner in which this assumption became problematic at Birchcliffe in that:

- (1) there was no consistent definition of reality employed by the nursing and health care staff
- (2) the attempt of patients to negotiate the use of their own view of reality
- (3) violation by staff of the programmatic definition of reality
- (4) the use of props which were symbols as icons for the objects to which they refer
- (5) the limited temporal features of the programme
- (6) the blending of physiotherapy, recreation and re-motivation techniques with R.O.

That the programme offered at Birchcliffe was not R.O. has been demonstrated. Generally speaking, in terms of

patient management most of the health care staff were willing to go along with an individual's "own reality world" rather than upset him through disagreement. Observations were made however wherein a staff member "entered the patient's reality" only to tease him (this was not confined only to staff members but included other patients). The usage of fake fruit and eggs could be not only hazardous but the patients on being oriented to reality, were required to define the objects in accordance with the instructor's interpretation of them, e.g. a L'Eggs Egg equals a turkey egg. Typically the identification process was carried out through the verbal cues given by the instructor to the patient. However, acceptance of the instructor's interpretation of the fruit could be perilous, should an individual attempt to eat the object he was holding. Failure to accept the instructor's definition of the object may have been construed as not being oriented to reality, or out of touch with reality. Furthermore, if R.O. is designed to help an individual "get his bearings" within the confines of the institutional setting, then this could hardly be achieved particularly on West 2, when the blackboard was hidden from sight except for the forty-five minute class and when the blackboard was finally abandoned, the information was presented verbally. Moreover, the staff held different concepts of reality which illustrated that there was no line of agreement in terms of the operational objectives of the programme.

### THE THIRD ASSUMPTION

The third assumption inherent within the formal theory is that the past, as in the case of reminiscence, has no character of reality. Memories tend to be something apart from reality, in that reality is only concerned with the present. For in the outline of specific ideas to be followed in the R.O. programme, we find:

Don't let them (patients) stay confused  
by allowing them to ramble in their  
speech and actions (Folsom, 1965:6).

This statement suggests that rambling serves no adaptive purpose, but that it is just an aimless wandering of the mind.

Robert Butler (1963) proposes that the reminiscing phenomena which is characteristic of the aged is a normal adaptive process wherein individuals evaluate and reintegrate their biographies, in readiness for their impending death. Several researchers share Butler's concept that reminiscing is positively related to successful adaptation to old age (Lewis, 1971; Liton & Olstein, 1969; Marshall, 1974; McMahon & Rhudick, 1964). James Birren (1963) writes that the aged more than any other age group, need to talk about, integrate and reconcile their biographies. As he



approaches the end of the life cycle, the aged person requires more psychological support from fewer available sources.

His ability to secure this rapport and support involves not only his skills, but also the capacity of his listener to discern what he is doing and saying, both manifestly and latently (Birren, 1963: 276,277).

The various behaviours and emotional states which are a consequence of the life review can range from depression, constant rumination, a decrease in self awareness and pliability to increase rigidity. These features are usually the result of the life review process proceeding in isolation in those who have experienced a shrinkage of attachments within the environment due to the loss of a spouse, friends and roles (Butler, 1963:490).

Avery Weisman (1972) writes that reminiscences, perceptual deprivation, and simple wishes result in a type of reinstatement for the aged. Reminiscences are not always actual memories; fantasies and historical facts need not be separated. Reminiscences are common in serious illness in that they allow patients to re-evaluate themselves and their future in light of the past.

Marshall (1974) investigating three distinct measures of reminiscence style employed by the aged, concluded that

sharing one's reminiscences with others significantly strengthened the styles which, in effect, led to a general contentment with life.

There is a time then, when aging individuals are highly engaged in "re-writing their biographies", followed by a time when the auto-biographies are largely written... when people get help from others in re-writing their auto-biographies, they are more likely to develop a 'good story' (Marshall, 1943:13).

The events of one's past are no longer greatly accentuated when the goals have been realized in a successfully attained life review process (Gorney, 1968; Marshall, 1974).

The importance of reminiscence as a normal adaptational mechanism has been totally neglected by Folsom and other advocates of R.O. Folsom simply assumes that "ramblings in speech and action" hold absolutely no value for the patient. Such mannerisms are regarded as obstacles which must be overcome so that the patient may gain a glimpse of "reality". This principle, however, was not consistently maintained at Birchcliffe.

In the R.O. classes on both West 2 and East 1, the reminiscence phenomenon was utilized by the instructor whenever possible.

As has been previously demonstrated, the sessions on East 1 placed a great deal of emphasis on nostalgia through

the daily employment of sing-a-longs of old favourites such as 'It's a Long Way to Tipperary', 'In the Good Old Summer-time' and 'The Sidewalks of New York'. The patients would join in and sing (those with speech problems would keep time to the music through hand movements and the like) as one of the group's member would accompany the women on the piano. Occasionally, various members would cite requests for some special song that may have held meaning for them in bringing back memories.

E.1,P.7) Can we sing "Sidewalks of New York"? I was born in the States.

(E.1,S.5) Oh, how long did you live there?

(E1,P.7) I left when I got married. I must have been about eighteen or so. I still have relatives living in Rochester and thereabouts.

(E1,S.5) Have you ever gone back for vacations and things since you married?

(E1,P.7) I have a sister that I used to visit. She's still there. It would be nice to see her again, soon.

(E1,S.5) Well maybe she'll come to visit you here.

(E1,P.7) I don't know, she's not very well herself.

Or in this instance:

R.O.Instructor: .....Hey, has anyone ever been in Leicester Square?

(E1,P.12) Yes, but that was a long time ago. I was born in England you know. It's a lovely country.

R.O.Instructor: How long have you been in Canada?

(E1,P.12)                   Let's see, it must be, we came over in 1911 or 1912. The whole family, my brothers, my parents and me. I was the youngest.

I recorded sing-a-longs on West 2 on three occasions. On two of these, a volunteer pianist was present. Hymns were the only selection played. No nostalgic discussion took place.

On East 1, the instructor would present a few selected news articles to the members. All news items which were chosen for the class were of such a calibre that an individual could relate his past to the present through the use of reminiscing as the stories dealt with such things as the rising cost of meat, the prices of houses, cars and clothes, local landmarks that were in the process of demolition, visiting royalty, women in politics and so forth. These items would frequently provoke a reaction and often lead to favourable interaction.

R.O.Instructor: Well ladies, I read in the paper last night that meat is selling at twelve dollars a pound in Japan.

(E1,P.3)                   What did you say?

R.O.Instructor: That's right, twelve dollars for a pound of meat in Japan and they expect it to go up even more....It could double in price.

(E1,P.15)                 Really! What kind of meat?

R.O.Instructor: Beef.....Do you like, beef Mrs.Y?

(E1,P.15)                 ...Not at twelve dollars a pound.

- R.O.Instructor: What about you Mrs.B., do you like beef?  
(El,P.6) Oh yes, I like roast beef.  
(El,P.4) We used to have roast beef for Sunday dinner.  
Mr.(husband) didn't like bird.
- R.O.Instructor: Sunday dinners....I guess relatives and friends would come over.  
(El,P.6) It was a family day.
- R.O.Instructor: Oh look, here's an ad. for a grocery store (shows full page ad. with large black inked numbers to the group). Bread is selling at fifty-five cents a loaf.  
(El,P.12) Used to be a nickel.
- R.O.Instructor: That must have been a long time ago.  
(El,P.12) Thirteen....Depression....you were lucky if you make eight dollars a week then.
- 
- R.O.Instructor: Oh, here's a picture of a young lady downtown...she's wearing shorts....see (shows the picture to the group).  
(El,F.5) That's terrible...you weren't allowed to go downtown dressed like that before.
- R.O.Instructor: Well, a lot of the younger people do now... A lot of women dress in pant-suits too. Did you ever wear slacks Mrs.A?  
(El,P.9) ..no..
- R.O.Instructor: What about you Mrs.C., did you ever wear slacks?  
(El,P.14) I don't know...I'll have to go back and look,ha,ha,ha.
- R.O.Instructor: Oh you, you're always teasing me,ha,ha,ha. Did you ever wear slacks Mrs.H.?

(E1,P.1) On the farm.

R.O.Instructor: I guess they'd be pretty handy on the farm, but did you ever wear them in town?

(E1,P.1) Oh no, never....ladies never did that.

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R.O.Instructor: It says here that a man from Hamilton was arrested for smuggling something over the border. How many of you smuggled something over from Buffalo? Raise your hands, don't be shy. Mrs.K. did you ever smuggle anything over the border?

(E1,P.2) (no response)

R.O.Instructor: I think we all have at one time or another. (some chuckling is evident among a few group members) What about you Mrs.C. I bet you did, why don't you tell us about it?

(E1,P.14) You could find some good buys there...I may have kept something hidden from customs,ha,ha.

R.O.Instructor: What about you Mrs.B. did you ever smuggle anything over the border?

(E1,P.9) I guess just about everyone did at one time or another.

R.O.Instructor: What about you Mrs.E.?

(E1,P.17) (has a speech impairment, points to herself in a laughingly way and shakes her head, no)

---

R.O.Instructor: They've almost finished building the new building where Birk's was. I think it's an office building...oh, here's a picture of the clock that they took from the old Birk's building (shows it to the woman).

(E1,P.10) ...oh.

R.O.Instructor: Yes, you see, they didn't take it apart, in fact they are going to put it where everyone can see it.

(E1,P.3) That clock used to be a place to meet people. I'd often meet my children under that clock when we'd go shopping.

R.O.Instructor: Well a lot of people didn't want it to be destroyed so they're going to do something about it.

(E1,P.10) That's good.

R.O.Instructor: Do you remember that clock Mrs. F.?

(E1,P.8) Yes, I do... it's a beautiful clock.

(E1,P.10) I think everybody used that clock as a meeting place.

(E1,P.4) I'm glad they didn't scrap it...I guess it holds a lot of memories for a lot of people.

The introduction of news items on West 2 stimulated the interest of some of the members; however, attention proved a little difficult to maintain due to the number of participants in this class.

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\*Folsom, it will be recalled, prescribed that only 3 or 4 patients participate in the basic class and no more than twelve be permitted in an advanced class. The programme on West 2 often had more than twenty participants. The class on West 2 contained a pot pourri of people, some members understood little if any English, some had speech impairments presumably due to strokes, one patient had the mental age of a three year old, and on some occasions patients were brought to the class without their glasses or hearing aids.

When the O.T.A. was replaced on West 2 by an O.T. to conduct the programme, less reliance was placed upon the reminiscence aspect of the programme. However some attention was given to the identification exercises. The programme tended to evolve around physical exercises which were basically recreational in nature, and which followed the "basic facts" of the date, name of the institution etc. It should be mentioned that the instructor spent a good deal of class time each day instructing R.N.A's and aides in the methodology of the programme at Birchcliffe.

In both programmes, it was common to observe someone sit in his chair and "ramble in speech and actions" to use Folsom's terminology. When such an occurrence took place in the classroom setting it was either ignored or attended to.

A "rambling" individual would be ignored by the instructor if (1) he consistently demonstrated such behaviour or (2) he resumed such behaviour after the instructor had "spoken" to him. For example, one patient on West 2 would continue to "talk to herself" quite loudly throughout the programme. Actually most of her waking hours were spent in this manner. Moreover, as she was blind and hard of hearing, she could not participate in many of the programme activities, such as tossing the bean bag, throwing a ball, and identifi-



cation exercises. When the instructor would approach the patient and talk to her, she replied in what appeared to be "coherent" answers. As soon as the instructor left her side to attend to other matters of the programme, the patient would continue her monologue.

An individual's "ramblings" were attended to in basically two ways. One method was based on "going along with the patient".

E1,P.17                She was never any good...Where's the lawyer?  
We should have won that case...I told them  
all about her...we should have won it.

R.O.Instructor: What case was that?

(E1,P.17)            We should have won it.

R.O.Instructor: Well dear I'm sure the lawyer tried.

Or in this instance:

(W2,P.27)            Will you get my mother for me?

(W2,S.7)            Now, where is she?

(W2,P.27)            Over there at the door! (pointing to a nurse  
who was standing at the doorway).

(W2,P.7)            Mother's busy now, but I'll tell her you  
want her.

(W2,P.27)            Oh, thank you.

The second method fell more along the lines of "Reality Orientation".

R.O.Instructor: You seem upset today dear.

(W2,P.18)            Will you help me find my way?

R.O.Instructor: Where do you want to go?

(W2,P.18) Home.

R.O.Instructor: You are at home; this is your new home.  
You are living at Birchcliffe Hospital  
in Wellwood, Ontario.

(W2,P.18) Oh, I am?

R.O.Instructor: Yes, you are living at Birchcliffe Hospi-  
tal. You don't have to worry now.

Theoretically, R.O. is performed on a twenty-four basis and is not limited to the classroom setting. Any individual who "rambled in speech" outside of the classroom setting, was for the most part, ignored by the staff.

Using Folsom's words, "they (were able) to stay confused by allowing them to ramble in their speech and actions".

Since, for all practical purposes, the participants were confined to wheelchairs, their actions were essentially restricted to body movement or wheeling their chairs to other locations.

We have considered the third assumption which maintains that the past, as in the case of reminiscence has no character of reality. We then presented research findings which reveal the importance of reminiscence in the elderly as a normal adaptational mechanism. Furthermore, the manner in which this assumption did not apply to the programme conducted at Birchcliffe was explored. Reminiscence was employed

by the R.O.Instructor in the sessions usually with the aid of newspaper articles and sing-a-longs. This feature of the programme was generally well received in terms of the interaction observed in the sessions on East One. The reception towards the news items in the sessions on West 2 proved less favourable, due to the size and composition of the group which appeared to inhibit interaction among the patients. Of the three observed sing-a-longs on West 2, no traces of nostalgia in terms of discussions were recorded. As the music selections were religious in nature, this may account in part, for the subdued response.

### THE FOURTH ASSUMPTION

The fourth assumption to be found in the R.O. programme is that hope must always be offered for the patient's future recovery. Dr. Folsom writes:

When a patient is admitted to the geriatric ward...a baseline of acceptance, concern and expectation of participation in one's own recovery is established....He can now give up some of his feelings of loneliness, worthlessness, apathy, confusion and disorientation (Folsom, 1965:4).

Herman Feifel, argues that the chance for a dying individual to discuss his feelings helps alleviate irrational fears as well as possible guilt associated with thoughts of death. Any discomfort or self consciousness experienced by us in regarding an individual who is confronting death, compels the extremely ill and dying person to go it alone, with neither help nor compassion from anyone.

Butler has remarked that the greatest fear an old person endures is that of dying alone (Butler, 1963).

Commenting on the reactions and attitudes of terminally ill individuals who were interviewed in seminars within the hospital setting, Kubler-Ross states:

Less than 2 percent of the questioned patients flatly refused to attend the seminar....Many of them reacted to the first meeting as if we had opened a floodgate (Kubler-Ross, 1969:127).

Avery Weisman and Thomas Hackett (1967) studied terminally ill patients who denied the gravity of their illness. These patients appeared "unaware" of their predicament, often impeding rational and possibly life-saving treatment. Yet, in their efforts to contend with danger, their acts of denial not only negated certain events but also affirmed a less threatening alternative version of the truth. The authors maintained that much of the motivation for denial is related to the need to preserve essential personal relationships. Thus, when patients feel threatened by abandonment, the fear of death tends to be most pronounced. If, out of their own anxiety, physicians and others who are caring for the patient treat only the organic aspect of illness, or if they indiscriminately limit their responses to "strengthening denial" without recognizing its social meaning, then the patient's worst dread of being isolated may come true.

....denial is a social act which arises from the attempt to establish reciprocal communication between two people....  
(Weisman & Hackett, 1967:109,110).

It has been suggested (LeShan & Leshan, 1973) that psychotherapists have a tendency to disregard the dying individual. They contend that psychotherapy could help allay certain fears and fulfill specific needs which are peculiar

to a person with a limited life span. Psychotherapy, they maintain has basically assumed an approach aimed at aiding an individual to shape his life in the future, only to take the pragmatic point of view that results measurable in time are the only basis on which to assess success.

In a philosophical vein, Rollo May (1967) proposes that the age of man should not be calculated solely in terms of the length of time one has to live. Within this perspective, the primary emphasis refers to what the person is and what he does during the time he has left -- that is, what is encompassed, as opposed to how long it is, chronologically speaking. Concerning the subject of death, he writes:

Death is an irrelative potentiality which singles man out and individualizes him to make him understand the potentiality of being in others as well as himself, when he realizes the inescapable nature of his own death. (May 1967: 51).

Surely, within the confines of the geriatric setting, one must question whether the pollyanna attitude expressed by Folsom is either desired or realistic. Of what value is a therapy whose aim is to "orient individuals to reality" while, simultaneously cajoling both staff members and patients into playing a game of "make believe". To whom in such a setting, can a troubled, terminally ill patient turn for emotional support?

Kubler-Ross (1974) in discussing "hope" writes that upon learning that one has a terminal disease, then "hope" at this point in time, for both the patient and the medical team, is associated with a cure, treatment and the prolongation of life. When these three are no longer possible, then the terminally ill patient will substitute these "hopes" with concerns that are more short term, which may have something to do with his loved ones; or they may be of a religious nature.

It is imperative that we listen to the patient and strengthen his hopes and do not project our own, otherwise, we cannot really help our patients (Kubler-Ross, 1974:158).

It is to the subject of death, as it was handled at Birchcliffe that we now turn our attention. The patients on W.2 were considered to be the most ill in terms of the total hospital population. They were in fact regarded as being closest to death.

Observer: ....so the patients on this floor are very ill. Where do they go from here?

(W2,S.7) (no response)

Observer: Would you say that their next step is the cemetery?

(W2,P.7) Yes.

Although the patients on E.1 were in need of constant care, their major feature was that they were basically very old.

When asked by me how she handled the subject of death, one R.N.A. (W.2S.6) responded:

See, Birchcliffe has had a reputation for being a place to come and die, but we're trying to change that image now. Some people cringe at the thought of coming here, How do I handle the question of death? Well it's hard to say. The other morning, she (points to Mrs.G.) asked me if she were dying. Well I couldn't come out and say, "sure you are". I told her that we all die, sooner or later. What could I say?

---

The preceding conversations typifies most of the reactions to that type of questioning. Many of the nursing and health care staff provided their patients with non-committal, evasive answers.

(W.2,S.4) I tell them not to worry, they'll be okay.

---

(W.2,S.9) No one's ever asked me that...I'm not sure I'd tell them the truth, though.

---

(E.1,S.3) I just tell them not to worry cause they're in good hands...then I change the subject.

---



Therefore, although the staff may be aware of the patient's true condition, they still maintain a facade in front of the patients. This facade, I would suggest, has little to do with Folsom's concept of hope but a general lack of education in dealing with such matters. Hinton (1971) argues that most medical personnel have insufficient training in this respect so that rather than approaching the subject, they avoid it altogether.

On one of my visitations to W.2, I witnessed the removal of a body. The R.O. session had finished about five minutes prior to this event and I was accompanying the R.O. instructor as she visited patients confined to their bed. While we were in one room, I noticed the curtains were drawn around one bed. Then an R.N.A. began to close the curtains around the other five beds in the room. This seemed unusual in that it was lunch time. The instructor and I were asked to leave the room. In the corridor, I noticed that all the doors leading to the other rooms and the sun room were closed. The instructor disappeared into another room while I went to the nurses' station, as an aide yelled at me to leave the corridor. Within a few minutes, a body was being wheeled out of the room by two attendants. As the body passed the station, an aide who was standing at the doorway of the room from which the body had been removed, shouted "Hey doesn't this go with

the corpse?" Someone replied that it did, whereupon she quickly walked to the attendants and handed over a shopping bag, bearing the name of the deceased. His possessions were presumedly in the bag. When the body was out of sight, the doors were opened and the lunch carts were being wheeled into view. During this event, I noticed three men in the sunroom staring at the proceedings. The sunroom doors were closed, but they are mostly glass, thus allowing for full vision. I followed an R.N.A. to the sunroom. She opened the doors and announced that lunch was ready. One of the men asked me if I knew who had died. I replied that I didn't. He then said: "I think it was the new fellow." This illustrates, I feel, the way a death on the ward is quickly glossed over. The R.N.A. hadn't mentioned anything concerning this event when she entered the sunroom, even though the three men were in the middle of the room, watching the operation. She only said that lunch was ready. However, the management of death in this fashion is not restricted only to Birchcliffe.(Marshall,1975, Townsend,1967).

In his study of homes for the aged in England and Wales, Townsend recounts how in most of the homes studied:

A death was hushed up and the body removed swiftly and silently....the staff were anxious to avoid giving cause for anguish ....Many of the old people were aware that

their lives were drawing to a close..  
The death of others disturbed them less  
than the concealment of it (Townsend,  
1967:51).

Perhaps one of the most vivid reminders of death at Birchcliffe were the flowers donated to the hospital by the local funeral parlour. The flowers would be arranged in small bunches and placed on various tables throughout the hospital. I once asked a patient who was seated in the sun room on E.1 if she could tell me where the flowers came from. She stated that they came from the funeral parlours. A new patient who was seated at a table, winced and pushed her chair from the table.

When a member of the R.O. programme died, sometimes the R.O.instructor would mention the patient's death. But it was told in such a manner as not to encourage a group discussion, for example:

R.O.Instructor: We lost a friend last night, Mrs.G.  
Wasn't it nice to have known her?

Group Member: Yes.

R.O.Instructor: Well, today is .....

---

Perhaps one of the most striking features, with regards to the patients at Birchcliffe was a lack of social interaction among each other. It was very common to see several patients sitting in their wheel chairs which were placed side by side in the corridor. Yet the patients in the chairs would seem to ignore those seated in close proximity. Often in the sunrooms, the patients would be seated in their wheel chairs which were often scattered about the room in silence. No interaction was visible.

A possible explanation for withdrawal behaviour in many patients is that they are already burdened with a "grief load" which includes grief over their own impending deaths (Birren, 1964: Feifel, 1959), and are unwilling to make an emotional investment in others who may die soon.

Gustafson (1972) while reporting on the career of the nursing home patient, writes:

...no staff member or relative will directly discourage the patient from making new friends in the nursing home, he is often not expected or encouraged to do so...(since) admission to the home is usually treated as the end of one's useful social career. (Gustafson, 1972:230).

Goffman (1961:146) suggests that withdrawal behaviour is characteristic of the newcomer to the mental hospital ward. Withdrawal functions to deny the new identity of self with inmates.

Gustafson (1972) suggests that the dying career of a patient would be viewed as consisting of a social stage and terminal stage. Medical staff, relatives and patients themselves typically view the patient career as an "unbroken decline towards death", which in turn causes anxiety for the patient who cannot accept the premature social death forced upon him. He rebels through bargaining in terms of his career.

In studying two residential homes for the aged, Marshall (1975) reported that the setting with less formal temporal structuring of activity demonstrated a higher level of internal interaction which expedited an informal support system among the residents and permitted conversational legitimization of death. In the other setting, another home for the aged, the level of interaction was low and predominantly formal. The residents seemed passively submissive rather than actively accepting of death. The description of the latter residents seems to be illustrative of the hospital population observed at Birchcliffe.

In this section we have concentrated our attention on the fourth assumption. We have presented evidence which would seem to counteract the idea that "hope must always be given for the patient's future recovery." The ways in which the nursing and health care staff dealt with this subject was demonstrated. We further considered the management of

the subject of death in the R.O.Programme and presented some explanations for their lack of social interaction within the hospital setting.

In this chapter we have considered the first four assumptions inherent within the formal framework of the R.O.programme. In considering the first assumption that senility is a reaction to one's diminished esteem we reviewed current and relative data which suggested that there are several factors to be considered in the process. We discussed the factuality of reality and employed the concepts proposed by Schutz and Berger and Luckmann. Moreover ethnographic material was provided to demonstrate that there was no singularly held concept by those staff members involved in the R.O.programme. We then presented significant data which revealed the importance of reminiscence in the later years of the life cycle: a factor ignored by Folsom. Attention was then focused upon the assumption that hope for the patient's future recovery must always be expressed. We now turn our attention to the fifth assumption in the following chapter.

## CHAPTER FOUR

### RESISTANCE AND

### THE FIFTH ASSUMPTION

In this chapter we will focus our attention on the resistance to the R.O. programme by the health care staff employed at Birchcliffe. In the examination, the major factors influencing the resistance can best be explained through the concept of role -- specifically the expressive role of nursing, the attitude towards the R.O. programme by the health care staff and R.O. instructor and the general prevailing ideologies of the wards E.1 and W.2 which were involved with the programme.

Through most of the literature covering the implementation of R.O., as a therapeutic programme one underlying organizational theme emerges. As a consequence of adoption of the programme, benefits are said to accrue to the hospital in terms of improved staff morale (Folsom, 1966: Folsom & Taulbee, 1966: Oberleder, 1968).

...even more amazing was the change in the attitude of employees. Instead of shunning the geriatric ward, so many wanted to work there that a waiting list developed (Folsom, 1966:2).

Moreover, in a study conducted to assess the influence of the R.O. programme on trainees, the researchers reported that there occurred a positive change of attitude among the trainees,;

from one of giving custodial care to a terminal patient to one of accepting the elderly patient with his limitations as a potentially active citizen and a worth while individual (Smith & Barker, 1972:264).

Furthermore the change in attitude among the staff members was readily discernible after a six month follow up.

The enthusiasm which was apparently demonstrated by Folsom's team and change of attitude cited by Smith and Barker were not duplicated at Birchcliffe. There were changes in the attitude of the health care staff involved in the programme, but they were essentially negative in content, particularly on W.2, so much so, that as of September 1974, the R.O. programme on W.2 was aborted.

There existed some resistance to the programme on E.1, especially in its early stages, when the formal theory of R.O. was conveyed to the staff, however, over the ensuing months, as the staff was able to witness the application of the programme as interpreted by its instructor, some reservations regarding the programme at Birchcliffe were dispelled. But, as had been previously demonstrated, the



programmes on both E.1 and W.2 deviated greatly from the prescriptions set forth by Folsom.

In order to gain a clearer understanding of the "resistance" to the R.O. programme, we will begin our investigation with a discussion of the role of nursing.

In their analysis of the role of the hospital nurse, Johnson and Martin (1958) argue that nurses not only help the physician in his instrumental role of "getting the patient well", but they further submit that this need not be their major task. It is the doctor's role which has the instrumental task of giving the patient the technical assistance that he needs to regain his health. Yet, these instrumental activities create high levels of emotional tension in the patient which in turn, may threaten their effectiveness (Dumas, 1964). The role of the nurse is the doctor-nurse-patient triad is defined as being "expressive" (Johnson & Martin, 1958). It is through the nurse's explanations, her attentiveness, her ability to maintain the physical surroundings as reasonably pleasant, and by generally providing comforting care, that the nurse functions not so much to 'cure' the patient but rather to supply the motivational balance while the patient is undergoing technical processes that are designed to improve or restore the patient's health. Although there have been changes within the organizational role of the nurse (E.C. Hughes, 1958:

Etzioni; 1969) such as a trend towards bureaucratic and administrative duties and subprofessionals taking over the traditional nursing tasks, Tagliacozza (1965) found that patients continue to place more value on the nurse who performs the expressive role.

The Director of Nursing at Birchcliffe stated that:

,,,many of the R.N.A's and aides for that matter too, had always wanted to become nurses. The desire was always there, but due to certain obstacles, such as having to quit school at an early age in order to help support the family...or possibly they were blocked from going further in school because of a low I.Q....there are any number of reasons why they were unable to fulfill their ambitions and so when the opportunity presented itself insomuch as they were able to obtain training in this profession, they grabbed it.

Many of the R.N.A's and aides viewed themselves as akin to or in fact extensions of a registered nurse. At one time, Birchcliffe trained individuals who wished to become a R.N.A. in the rudiments of the occupation. These individuals were trained and graduated as R.N.A's without having to write any governmental exam as is the norm for attaining such status. Moreover, as the formally graduated nursing staff, such as nursing specialists, R.N.'s and governmentally approved R.N.A's, was not as complete as it now is, these women, often referred to as "Birchcliffe's Own" enjoyed a broad

realm of influence on the wards. However, with the introduction of more R.N's and accredited R.N.A's, their authority diminished. Birchcliffe no longer graduates R.N.A's and must recruit this section of hospital personnel from other sources. R.N.A. candidates, for example must now complete a ten month course of instruction from an accredited institution and pass the required formal exams.

Multiple factors contributed to the variations in attitudes towards the programme held by the staff on E.I and W.2. On W.2, the ward which was the most vociferous about the programme, the staff (R.N's, R.N.A's and aides) were more than willing to express their views on the subject as the following respondents illustrate:

(W.2S.4) I don't mind the sing-a-longs like they have on E.1, but I don't see the sense in going over the name and date....they(patients) don't remember that.

---

(W.2,S.8) How would their (patient's) relatives feel, would they approve of seeing their parents or grandparents sitting around and playing ball?

---

(W.2,S.5) It's a farce! Most of these people are living on their memories, why replace that with reality?

---

(W.2,S.2) We don't have time to play...the time is needed to clean and care for our patients.

---

(W.2,S.6) Each day is not unlike every other day here so what does it matter if it's March the 3rd. or March the 4th.?

---

(W2,S.7) As far as exercise is concerned they get it. When we wash a patient's hand that is stiff, we have to move the fingers to clean inside their hands...Look when D.came here, all he could do was lie on his back and salivate, now he's wheeling himself in his wheelchair up and down the hall. Did R.O. do that?

---

Similar sentiments regarding the programme, particularly during the early stages of observation were voiced by the staff on E.1.

(E.1,S.3) I really can't understand taking them out of their fantasies...Some of the patients have lived in their own fantasy world for years, after all what good does it do to deprive them of their own little world especially if you don't have much to offer as a substitute?

---

(E.1,S.2) I'm not overly enthusiastic about the dates and stuff like that...I like the sing-a-longs though they(patients) seem to enjoy it... I don't see the sense in going over the date... what use is it?

---

(E,1,S,1) It's questionable if the exercises really help them...Well the girls(Staff) felt threatened

when the R.O. people said they (patients) shouldn't live only in their own reality, after all at this stage in life if you don't have memories to fall back on, then what have you got?

---

(E.1,S.4) The sing-a-longs are O.K.... but the dates are nonsense....the exercises are supposed to be of some help...I like the friendliness of the group, I like to see them smiling and that but I don't think the dates do any good unless you're really alert to begin with and want to know that information.

---

A most obvious factor influencing the ward staff's (R.N's, R.N.A's and aides) disposition towards the R.O. format can be located in the general attitudes towards occupational therapy as a necessary skill in the hierarchy of medical proficiency.

The job classification of an "occupational therapist" according to one reference is described in the following manner:

Plans, organizes and participates in medically oriented occupational programmes in hospital or similar institution to rehabilitate patients who are physically or mentally ill. Utilizes creative and manual arts, recreational, educational, and social activities, provocational evaluations and training in everyday activities, such as personal care and homemaking. Consults with other members of rehabilitation team to coordinate therapeutic activities for individual patients (The Dictionary of Occupational Titles, 1965:496).

In considering the preceding job description, it is evident that the focus of occupational therapy encompasses more than recreation for recreation's sake. Occupational therapy is part of the hospital team and as such has a specific role to play in the rehabilitation of the physically or mentally impaired.

Occupational therapy as a "profession" was seen by a number of the staff as something quite apart from nursing and as such, low in priority in terms of medical care within the hospital hierarchy. Concerning the general topic of occupational therapy, one R.N. stated:

(W.2,S.1) Occupational therapy...well, it's something to occupy one's mind, while one is confined to the hospital...it serves a recreational outlet, I suppose.

An aide on E.1 suggested that:

(E.1,S.2) Well it gives them (patients) something to do.

A R.N.A. from W.2 concluded:

(W.2,S.5) I'm not impressed...nurses do just as good a job. Maybe it's good for some people, but I don't think every one needs it.

Sentiments of this nature may in part explain the reluctance of the nursing team to accept a programme introduced by the Department of Occupational Therapy and to embrace wholeheartedly any authoritative directives from the Department concerning the R.O. programme. However resistance

to the "formal objectives" of Folsom's programme was not limited to the ward staff.

The occupational therapist aide who conducted both programmes on E.1 and W.2 until her dismissal and subsequent replacement by an occupational therapist on W.2 in November 1973 is a R.N.A., a graduate from an institution other than Birchcliffe. Moreover, she attempted to maintain this facet of her identity in that she consistently displayed a graduation pin on her non-uniform clothing; a symbol indicating her achieved status as an R.N.A.

Observer: Doesn't a green headband represent the fact that they are R.N.A's?

O.T.A. Yes, but I call them nurses.

If for some reason, the O.T.A. required the attention of services of an R.N.A. she would most often refer to them as "nurse". Occasionally she would address them by their name; a standard procedure in most hospitals. The other O.T.A. of the Department of Occupational Therapy, who was in charge of arts and crafts and not involved in the R.O. programme never made a distinction between R.N. and R.N.A. either. She was one of "Birchcliffe's Own". As she once explained to me:

Look, they're taking care of patients...  
whether it's making beds or giving pills...  
no matter what the job is, that's nursing  
isn't it?

Observer: What is your official job classification, what are you called? I ask this, as you both don't have the formal education in occupational therapy.

O.T.A. (R.O.Instructor) Well, they want us to be known as occupational therapy aides. But, I'm really an R.N.A. and proud of it.

That the programmes on both E.1 and W.2 deviated significantly from the prescribed methodology set forth by Folsom has been established. I would suggest that part of the reason for this may be related to the O.T.A's strong identification with nursing. The emphasis on physical exercises and recreational aspects of the programme; bean bag tossing, ball throwing, breathing exercises, etc., may be directly related to the bias and ideology of occupational therapy which obviously prevailed among the two formally trained occupational therapists.

Observer: After my initial visit to your programme, I thought that you could be viewed as a hired friend. What do you say to that?

O.T.A. (R.O.Instructor) I never thought of it like that before, but you could be right.

Observer: When do you know that you've had a successful programme or class?

O.T.A. ...When they're (R.O.Patients) happy.

Observer: By the way, can you tell me what Folsom means by Active and Passive Friendliness? (an integral part of his programme).

O.T.A. I don't know.



Observer: I thought that his was important to the success of the programme.

O.T.A. Well I don't go for all that stuff. They (Department of Occupational Therapy) want me to go through the date, name of the hospital and so I do it....Once you tell them(patients) that information a lot of them forget it, right after you tell them. The date is okay for those patients who are more alert ..because they may have relatives that come on certain days so if they are reminded that it's Tuesday and if that's the day they usually get visitors, well then they'll be ready for them. Do you think it matters to Mrs.S. if it's the first of June or sixth of July?

It now becomes clear that among the "resisters" to the formal concept of "Reality Orientation" is the O.T.A.-R.N.A. who conducted the sessions on W.2 until her dismissal and who continues with the classes on E.1. Her prime emphasis was not to "orient patients to reality" but to "make them happy", obviously an objective of the "expressive role".

Although it was generally known by the ward staffs that the O.T.A. had a nursing background, in terms of role conflict, the ward staffs, particularly on W.2 perceived the O.T.A.-R.N.A. as an extension of the Department of Occupational Therapy, concomitant with the expectations pertaining to a member of this department. The instructor on the other hand, never separated herself or identity from the "nursing role".

Concerning the O.T.A. one R.N.(W.2,S.1) reported to me:

It seems like a personality clash. A number of the girls resent her attitudes towards them and their care towards the patients. She would tell an R.N.A. when a patient needed something done. She seemed too overbearing...They felt she was a threat....I guess ...to the way they performed their work. Don't forget, she (O.T.A.) is an R.N.A. too!

---

The Director of Nursing offered these explanations:

Well she's an R.N.A. and the other R.N.A's may resent the fact that she doesn't have shift work... She works Monday through Friday at regular hours.

---

Resentment towards the O.T.A. took a number of forms, for example, verbalizations overheard among peers.

1st.R.N.A. ...oh, here she comes...I can't stand that dame.

Aide: Hey, why don't you ask her what day it is...  
ha,ha,ha.

2nd.R.N.A. Yeah, why don't you, maybe you'll get signed up with the class, ha,ha.

Ward staff, especially in W.2, initiated little interaction such as polite greetings or light conversation with the O.T.A.-R.N.A. Friendly greetings on East 1 however, increased over time. The situation on W.2 remained basically the same in this respect.

As it was the desire of the Department of Occupational

Therapy(following along the lines prescribed by Folsom) for the ward staff, R.N.A's and aides, to gradually take over the programme on W.2, R.N.A's from the floor were assigned to the daily classes in order to learn the mechanics of the procedure through instruction and participation in the classes. This was arranged by the "Rehab Nurse" who was approached by the Department of Occupational Therapy to act as a mediator between them and the staff on W.2. as "they (ward staff) would not go along with it when we (Department of Occupational Therapy) suggested it to them". Frequently during the initial phase of allotment, the personnel assigned to aid and learn from the O.T.A. would be tardy or not appear altogether. When the O.T.A. was replaced on this ward by an O.T. an R.N.A. was always present for the sessions.

Although the patients were seated in their wheelchairs in the sun room, the O.T.A. would go through the daily ritual of placing the chairs, with no assistance, in a large circle, in preparation of the class. This procedure was time consuming as the participants in the sessions numbered over twenty people. As a precautionary measure, the patients were secured to their wheel-chairs by means of a strap in order to prevent them from falling out or attempting to get up and walk with no supervision. The O.T.A.

would often spend time retying the straps that has been previously tied by the staff personnel as there was a prescribed method of discharging this hospital dictate. If the strap was too loose the patient could slide out of the chair thereby incurring body injuries; a strap tied improperly or too tight could result in body irritation. Occasionally patients would come to class without glasses and the O.T.A. would have to retrieve them; sometimes the O.T.A. would wipe an individual's eyes of a gluey film, a procedure which was to have been carried out prior to the session.

Following the classes on W.2., the O.T.A. would then make her "rounds" on the ward in that she would visit patients who were confined to bed. These would include new arrivals, members of the "R.O. programme whose health had declined, individuals with whom she had become acquainted through other activities or programmes conducted by her department. Besides maintaining contact with these individuals she would again lend assistance, in that she would help feed patients who seemed to have difficulties feeding themselves, alert a staff member that someone needed assistance of some kind, read to patient a birthday or Mother's Day card which had been sent by relatives or friends or just chat with a patient.

A few weeks prior to her dismissal from W.2, the O.T.A. was ordered by her superior to discontinue this practice.

O.T.A.            They want me to stop rounds from now on.

Observer:        Were you given any reason for this action?

O.T.A.            I think the nurses must have complained.

The O.T.A. seemed to have a good report with the patients and would at times act as an ombudsman for them. If, for example, a patient expressed a wish to get in touch with another department such as social services, the O.T.A. would relay the message to that department. The role of ombudsman however, evoked negative sanctions on some occasions.

One morning while attending the R.O.session, the O.T.A. received a message to attend a ward other than W.2 or E.1. As there was a good twenty minutes left in the programme it was decided that I should continue with the programme, which I did. When the programme was finished, I took the kit in which the props for the programme are kept to the Department of Occupational Therapy, as was the usual practice when the programmes were terminated for that day. As I entered the activity room the only person in the room was the O.T.A. who was seated at a table, crying. This room is usually a hub of activity, however both the O.T's were on sick leave and thus various activities were temporarily terminated. Thinking that perhaps a patient had died to

whom she had possibly become attached, I asked what was upsetting her. She recounted to me that she had recently lodged an official complaint, on behalf of a few patients who had remarked about the "rough treatment" they had received from a particular aide.

When one patient complains about somebody that's one thing, but when you get a few patients complaining about one person, then it should be looked into.

The clinician specialist to whom the written report had been given, confronted the supervisory nurse of the ward involved. A few days after this incident was the day the O.T.A. was called to go to the floor on which the aide worked. Upon her arrival on the floor, she was ushered into one of the rooms where all the patients had been removed with the exception of one, a woman who had complained about the aide's roughness. An R.N. and two staff members had gathered at her bedside. The two staff members then 'stroked' the patient's face while uttering such things as, "Did we hit you today dear?" Goffman(1961) refers to retaliatory behaviour such as this within an institution as the "looping effect" in that an inmate or in this particular case a patient, is not permitted to show rebellion or disgust for what is happening to his self or any such expression would result in punishment.

This episode was reported in the presence of the other O.T.A. and myself to one of the O.T's by telephone. The following week when the Director of the Department of Occupational Therapy returned to the hospital, an inquiry concerning the incident was initiated. According to the O.T.A. the R.N. involved in the incident stated that her intention was to show the O.T.A. a "confused" patient.

An O.T. replaced the O.T.A. on West 2 in November 1973. This action was an attempt to reduce conflicts between the staff members of this ward. During the initial phases of her attendance, it appeared that tension had subsided and that more co-operation between the ward staff and the replacement transpired. For example, an assistant was always on hand to learn and observe as well as take part in the programme. Frequently, the wheel-chairs were arranged in a large circle by a member of the staff prior to the O.T's arrival in the sun room, allowing for more "class" time. The therapist would spend a considerable amount of time explaining the concepts of R.O. and the purposes of the physical exercises to the assistants.

Under the O.T's direction, approximately thirty minutes of the forty-five minute class time revolved around the exercises or perceived "recreational" aspects of the programme; i.e. tossing the bean bags and balls, breathing and

limb exercises. She began the classes with the date, name of hospital, weather etc. (information which was not presented on an R.O.board). The bank calendar with the date was briefly presented at the beginning of each session and then put back into a kit, for the duration of the programme, out of view of the patients. Less reliance was placed on news from the outside when one compares the methodology of the O.T. to that of the O.T.A. Unlike the O.T.A's "expressive" orientation to the programme, the classes under the O.T's direction tended to reflect the philosophy of occupational therapy in general.

The ward staff seemed more amenable to the O.T. conducting the programme on W.2.

(W.2.,S.4) Well, she's more lady-like....she doesn't interfere.

(W.2.,S.2) She explains things real well...she's okay.

(W.2.,S.5) She's not as pushy as the other one...not a busy body.

Yet, the seeming acceptance of the O.T. as opposed to the O.T.A. on W.2, could not be construed as a new belief or adoption of the programme.

The O.T. for example, always left an extra ball at the nurses station, in the hope that someone would take the time to organize some exercises in terms of a ball game.



I know no one ever takes the time to use the ball. But it's left there just in case.

There were several occasions when the O.T. was unable to attend the programme and so no classes were held on W.2 even though the assistants and aides on the floor had observed and participated in the programmes for several months. For example, when the therapist was on a two week vacation, no sessions were held on the ward although a representative of the Department of Occupational Therapy took the kit with the programme props to the nurses station. As of September, 1974, the programme on W.2 was aborted.

The O.T.A. continues to direct the programme on E.1 at the time of this writing. How can this be explained? Perhaps the most significant factor in the acceptance or rejection of the R.O. programme can be located in the manner in which the patients were viewed by the staff members of the wards involved in the project. It will be recalled that the patients on E.1 were considered as basically "old" whereas the patients on W.2, were generally younger, and very ill. Any brain damage exhibited by those on W.2 was usually attributed to some illness such as a stroke. Brain impairment witnessed in the patients on E.1 was considered a result of aging.

At its inception, the programme was not enthusiasti-

cally accepted on E.1. Rejection of the formal theory of R.O. by the ward staff was visibly discernable, through statements concerning the programme and the general atmosphere of the ward.

O.T.A. (Speaking to members of the R.O.class).. Can anyone tell me today's date?

R.N.A. (Standing in the doorway, watching the proceedings and raising her hand) I can!

During earlier phases of my observations staff members frequently walked into the sunroom during classes to sit down and chat, presumably during a break. Such occurrences were disruptive to the sessions, in that the therapist would have to "talk over" their voices. Although not deliberate, these instances appeared to demonstrate a lack of regard for the instructor and the programme.

During the observations, it became increasingly apparent that the atmosphere concerning the R.O. programme was changing. Any reticence on behalf of the staff on E.1 was diminishing. The programme as it was being conducted by the O.T.A. was meeting with acceptance, specifically so far the social and recreational aspects of it. The R.N.A's and aides frequently participated in the programme on Wednesday and Thursday mornings. Furthermore, on occasions, when the O.T.A. had been unable to attend the programme, a

a staff member would carry out an aspect of the programme, usually the sing-a-long. The R.O. principles of the name and date were typically ignored by the staff.

As an R.N. (E.1,S.1) reported:

...I don't like to assign them(staff) to the programme but rather I prefer to interest them in it. Although I would like go see the patients initiate it as well ....Mrs.P.(patient) is a big boost, when she (instructor) was on vacation she (Mrs.P.) would play the piano for the group and get them singing.

It is significant that the staff on this floor have accepted the programme and take part in it. But adoption of the programme revolved around the O.T.A's own interpretation of the project in terms of her credo of "making them happy", and not Folsom's concept of "restoring reality." In so far as the date, name of hospital, etc. are concerned, the staff are still reticent about "burdening the patients with reality" and so the emphasis continues to be on social and recreational features of the programme. It will be recalled that very little singing ever occurred in the programme on W.2.

The significance of ideology in the organization of hospital work has been documented by several investigators (Perrow,1963: Schatzman & Bucher,1964). Coser(1963) contrasted the behaviour of nursing staffs on wards whose

patients were perceived by the staff as being incapable of improvement with a rehabilitation centre of the same hospital with patients the staff believed could be cured. The dominant ideology governed a great deal of staff behaviour. In the former, the nursing staff found plans to discharge a patient disruptive, for they assumed that the patient would be back. Emphasis was an orderly house-keeping, routinized records, and the mechanical side of nursing tasks. Moreover, there was little interaction with the patients. This contrasted with the rehabilitation centre where an active treatment ideology prevailed. Interaction on a nurse-patient basis was very high.

The Department of Occupational Therapy at Birchcliffe never achieved one objective on W.2., i.e. setting up meetings with the staff on W.2 so that orientation to the programme along with the Department's point of view could be expressed. This however was not the case with the staff members on E.1.

Glaser and Strauss (1964) have reported that a social value is placed on a patient by nurses attending him. Nurses bring into the hospital the values of society and employ these measures in calculating a patient's social loss. The primary characteristic on which social loss is based is that of age. Older people have a low social loss

as compared with that of children or middle-aged adults. The death of low social loss patients will have less impact on the nursing staff than that of a high social loss patients.

Butler and Lewis (1973) have listed a number of reasons for negatively held attitudes towards treating the aged. They include:

The therapist believes he has nothing useful to offer old people because he believes they cannot change their behaviour or that their problems are all due to untreatable organic brain disorders.

The Therapist believes his skills will be wasted if he works with the aged because they are near death and not really deserving of attention.

The patient might die in treatment, which could challenge the therapist's sense of importance.

Beliefs and sentiments such as these may reflect the attitudes of the staffs on both E.1 and W.2. For example, an overriding philosophy on W.2 appeared to be that the patients on this ward are physically declining and close to death. The W.2 staff tended to view the R.O. Programmes conducted by the O.T.A. and O.T. as nonsensical in terms of "playing ball" and being confronted with "reality". Perhaps this is best expressed in a conversation between an R.N. and this observer.

Observer: Hypothetically speaking, what do you think the overall effect would be if somehow the programme actually brought all these patients out of their "own world" and they realized who they were, where they were and why? Do you think that this would create any problems in terms of patient management?

(W.2,S.3) Great Scott...what a thought...reliving one's memories or living in one's fantasy I feel is beneficial in some ways because they don't have to cope with their own predicament ... maybe it's a natural defense...Look at Mrs.E. she's happy "on the farm"...but to answer your question...well, I don't think I can... Maybe some would adjust to and accept the situation...others I fear would find it too much to bear...It's really difficult to say how many of them would react but it's an interesting question, worth thinking about.

As for the staff's gradual acceptance of the programme on E.1, adoption of the programme seemed to centre upon the "time-filling" fun aspects of the classes in which the patients seemed to enjoy themselves as witnessed by the interaction in terms of singing, laughter and general conversation. Moreover, the patients in this ward were considered to be "basically old", with perhaps a less definite termination date in comparison to the very ill patients on W.2. Furthermore the "fun features" of the programme seemed to be the innovations of the O.T.A.-R.N.A. and not prescriptions of the formal R.O.literature, and as such were possibly reflective of similarly shared sentiments of those trained and engaged in the "expressive" role of nursing.

As a final word on the resistance of the ward staffs to the R.O. programme; it seemed inevitable that the manner in which the programme was applied by the Department of Occupational Therapy would be beset with problems and therefore alienate the ward staff to the programme, especially on W.2. For example, the membership in the classes by far outnumbered that prescribed by Folsom for W.2. In such an atmosphere, the classes were geared, not so much on the individual basis but rather as a group, with the emphasis placed on physical exercises. Had the group been limited to the required number specified in the formal literature, more attention could have been given on an individual basis. Moreover, any changes related to the programme would have been more visible to the staff and presumably enhance the programme. However as it was difficult to perceive any major change in the patients due to the number involved in the programme, any attempt on the part of the staff to review the date etc. outside of the class setting, could be viewed as simply time consuming.

Perhaps the introduction of any programme which purported to "restore reality" would have met with some degree of opposition particularly in a setting wherein the patients could be viewed as being close to death or old. It will be recalled that only the visible "fun" features of the pro-

gramme received support by the staff on E.1. Activities such as the sing-a-longs may have gained acceptance by the staff on W.2.

In any case, virtually none of the nursing staff and indeed the O.T.A. could dully support the formal premise of "Reality Orientation".

(W.2,S.8) Why burden them with reality....What good does it do?

In this chapter, we considered the fifth assumption proclaiming that a boost in morale of the hospital staff occurs as a result of the employment of a Reality Orientation programme. However as an increased morale failed to develop at Birchcliffe, we could not, therefore directly assess whether morale would have been enhanced had the programme been successfully and correctly initiated. Resistance to the programme, its abandonment on one ward and its departure from the official R.O. format, do however, indirectly suggest that this assumption is unwarranted. We attempted to explain the "resistance" demonstrated by the health care staff through the (1) expressive role of nursing; (2) the fact that one of the resisters to the formal concept of R.O. was actually one of the two R.O. instructors; (3) the fact that the ideology of the O.T.A.-R.N.A. was not to restore reality as such but rather 'to make her



patients happy", clearly a function of the "expressive" role; (4) the general attitude of the health care staff to the O.T., O.T.A. and occupational therapy in general; (5) the acceptance of the 'fun features' of the programme on E.1; and (6) the prevailing ideologies of the wards.

## CHAPTER FIVE

### CONCLUSIONS

In chapter one we presented the purposes of the study and provided the methodology employed in gaining data. This was followed by a number of theoretical considerations and a description of Reality Orientation as prescribed by the proponents of the therapeutic technique. The rehabilitative approach was elaborated upon in chapter two when we compared the programme at Birchcliffe with the formal theory of Reality Orientation. In chapter three we focused our attention on the ramifications of four underlying assumptions located within the formal framework concomitant with the manner in which they were applicable with the programme at Birchcliffe. Chapter four discussed resistance -- a violation of the fifth assumption -- as it was demonstrated by the health care staff and one of the R.O.instructors. Reasons for the attitudes towards the programme were then explored.

This chapter will restrict itself to a few concluding remarks concerning our findings. However before doing so, it must be reiterated that throughout this thesis, I have tried to demonstrate the manner in which the R.O.programme offered at Birchcliffe deviated so significantly from the

formal theory prescribed by Folsom. Therefore to fully criticize the R.O. programme would be less than fair as the programme I observed at the setting was not R.O., but rather an all encompassing version or interpretation. The attention given to the principles of the formal theory at Birchcliffe by those involved in the programme were too minimal to fully assess R.O. adequately. There appears to be at the present time other research which tends to dispute (Barns, 1973; Ksander & Gubriam, 1975) some of the claims of Folsom's programme. To fully assess Folsom's programme would necessitate an additional study wherein the programme is conducted in accordance with the prescriptions of Folsom. In this thesis I have endeavoured to present five assumptions which are inherent in the theoretical framework and report as to how they were managed in the programme at Birchcliffe.

The ways in which the programme at Birchcliffe deviated from the prescriptions set forth by Folsom has been delineated throughout the preceding chapters. The programme offered at Birchcliffe was in fact not Reality Orientation, but an all encompassing programme in that it included re-motivation, techniques, light physio-therapy, reminiscence, and especially on E.I sing-a-longs. All of these features were then combined with some aspects of Reality Orientation

at the beginning and completion of each programme. Reality Orientation on a twenty-four hour basis was not effectively carried out. In short, the programme at Birchcliffe was an attempt to minister to the perceived needs of many individuals through social, recreational, physical and "reality" activities. To operationalize the programme, the proponents of Reality Orientation, maintain that only a small number of individuals participate in the classroom setting. On this count, the Department of Occupational Therapy did not restrict its selection but included a potpourri of individuals, who, if they did not benefit from the Reality Orientation aspects of the programme, would conceivably profit from the other activities offered in the programme.

To this observer of the programme, the brief amount of time given to the Reality Orientation principles did not appear to have long-lasting effects for those who were considered "confused" and "disoriented". Their impact seemed to be momentary. The recreational segments seemed to find favour among many of the patients. The sing-alongs on E.1 and the covering of news occurrences tended to be received favourably, and prompted reactions which usually led to favourable interaction.

One significant variable which seemed to be overlooked

by the proponents of the programme at Birchcliffe was the expectation that the individual may have of himself and the programme. Folsom emphasized that the individual in a Reality Orientation programme, should be told "what is expected of him". Since expectations are related to performance (Mayada, 1972), it is important that the participants in the programme should be given clearly formulated goals for what they hope to accomplish in the programme. This was done to some extent in the programme at Birchcliffe in convincing the participants of the necessity of physical exercises or a related activity. The instructor would explain that throwing a ball or bag would be beneficial to one's muscles. In such cases, any unwilling participant would reconsider his objection and usually comply. However, on several occasions when a patient would question the reasoning for knowing the date, answers provided by the instructor would be incomplete and untruthful: "Well sometimes I forget the date and have to ask someone what day it is."

The deviations in the programme at Birchcliffe, the oversized group particularly on W.2 and the general pot-pourri of patients may have been contributing factors to the disbelief among staff (onlookers) concerning the practicality of R.O. In introducing a programme of this

nature, a more discriminating selection of participants, smaller group size and strict adherence to the principles of R.O. in the class-room setting may have yielded less resistance, particularly on W.2 where too many patients were placed in a programme wherein the major feature was "ball playing". The "Reality Orientation" tag given to the programme seemed unconvincing.

Schatzman and Bucher (1964) have analyzed the manner in which professionals in state hospitals negotiate the tasks they perform. Influencing these negotiations are (1) the team ideology that is prevalent upon the wards, (2) the division of labour suggested or dictated by the ideology and (3) the professional identifications and hopes of the team members.

The Department of Occupational Therapy in attempting to establish and carry out the R.O. programme on E.1. and W.2 had made "claims" for the introduction of the programme in terms of an ongoing implementation of the programme at various other well known institutions, e.g. Baycrest -- a renowned geriatric centre in Toronto; a desire to adopt the programme for the needs of the patients and a wish to "try it". However in presenting such "claims" and proposals have either "takers" or "no takers" in that the grounds must be shifted depending upon the professional's

general perspective, the claims, and audience. In this case, the audience was that of the nursing staffs on both E.1 and W.2. The formal concepts of R.O. as prescribed by Folsom, were never accepted on either ward although over the ensuing months, the "fun" aspects of the programme on E.1 were gradually accepted by the nursing and health care staff. Moreover, the number of participants and the minimal reliance on the actual prescriptions by the R.O. instructors resulted in a poor curability rate which was observed by the nursing and health care staff which ultimately led to a staff distrust of the programme. The staff on E.1 it will be recalled, gradually accepted the "fun" aspects of the programme, but questioned the significance of the R.O. programme proper. Furthermore, the apprehension exhibited by the staff on W.2 in particular, generated opposition towards the programme and the intent of the Department of Occupational Therapy. As a reaction to the distrust experienced by the nursing and health care staff, the Department of Occupational Therapy introduced some modifications to the programme on W.2 such as the placement of R.O. participants in the "Ten Pins" and the replacement of the O.T.A. by the O.T. Even so, the programme on W.2 was aborted.

The division of labour on any ward influences the

acceptance and development of or rejection of any novel treatment in so much as it is considered to be an invasion of another profession's territory. The treatment ideology on W.2 and E.1 was that of a medical orientation due to the nature of the patients on these wards. W.2 serviced very ill individuals and E.1 looked after those who were basically "old". Both populations however were in need of constant care. The ideology on W.2 has apparently remained the same, that is, catering to the physical needs of the patients. However, acceptance of the fun features of the programme on E.1 by the staff with respect to the old patients on this floor would appear to illustrate an acceptance by the staff of a social orientation in terms of not only servicing the patients' physical needs but lending support to their perceived social needs as well. In short, a struggle for treatment ideology prevailed on W.2 vis-a-vis the Department of Occupational Therapy. West 2 maintained the "medical" orientation towards its patients. On the other hand, the influence of the Department of Occupational Therapy was witnessed on E.1 in terms of the approval by the staff of the "social" aspects of the R.O. programme.

In considering the second assumption that reality exists factically we introduced arguments which could not support this concept. Among the opposing theorists was



that of Schutz who maintained that individuals inhabit not one single reality but in fact, several. Furthermore, of these multiple realities, many are not meaningful to everyone. Drawing upon the study by Chappell (1973) we considered the ways in which access to the world of the senile could be accomplished. We further considered the manner in which this assumption became problematic at Birchcliffe.

We discovered a multiplicity of definitions of reality among the nursing and health care personnel. Any attempts by the staff involved in the R.O. programme to confront or take away "one's own reality world," (sub-universe of meaning) with the intention of substituting it with a less acceptable alternative proved most upsetting to some patients. Furthermore we documented the fact that in terms of patient management, the nursing and health care staff were often willing to go along with an individual's "own reality world" rather than challenge his beliefs and upset him through confrontation. Occasionally however, a staff member or another patient would "enter a patient's reality world" with the sheer intention of teasing him. Sometimes, patients would negotiate the use of their own view of reality thus allowing communication between the instructor and patients. However when the

boundaries provided by the patients were transgressed by others, as in the case of (W2,P.16) and the R.O. instructor, worthwhile communication between the two interactants diminished. Observations in this respect appear to support Chappell's (1973) findings that favourable interaction can take place through the approach of sociability in entering the world of the senile. The senile must be allowed to define the terms. In our study, we presented the patient who insisted he was "at home on the farm". Acceptance of this premise by another, resulted in favourable interaction. However, when this was challenged by the R.O. instructor, we saw that the patient was quick to terminate the discourse. This example would tend to concur with Chappell's proposal, following the lines of Schutz, that rehabilitation programmes which endeavour to impose the paramount reality on the senile patient will most likely end in failure.

We further witnessed the employment of props which were symbols as icons for the objects to which they refer. Aside from the hazards of using such objects, (patients trying to eat fake fruit upon being told they were holding a type of fruit) and disputes concerning the labelling of the object (L'Eggs Egg equated with a turkey egg). Individuals who failed to reach or accept the instructor's

definition of the object may have been construed as not being oriented to reality. One lady for example, when asked what it was she had been given to identify, replied "rubber" and had to be verbally coached by the instructor until she gave the correct response, "banana". As the object was not an actual banana, the woman could not rely upon the additional sense of taste, smell, and so forth. She came to the instructor's definition of the object, via the use of verbal clues given to her by the instructor.

Moreover, we witnessed specifically on W.2 the temporal features of the programme such as, the limited use of blackboard, the bank calendar which was briefly shown to the residents only to be kept out of sight from the participants as it was stored in the Department of Occupational Therapy after each class, and finally the abandonment of the blackboard on W.2 altogether. For these patients with failing memory, there were no reminders of date and place when a class was finished.

The Reality Orientation classes at Birchcliffe deviated significantly from the prescriptions of Folsom, in that, the classes employed physiotherapy, recreation, and remotivation techniques. The classes it appeared were aimed at offering several activities to the many participants. In short they encompassed a number of activities

to serve various needs of the participants. Restoring "reality" was but one of these activities as opposed to the only activity prescribed by Folsom.

In considering the third assumption that the past, as in the case of reminiscence, has no character of reality, we presented research findings in which reveal the importance of reminiscence in the elderly as a normal adaptational mechanism. We further noted that this assumption did not apply to the programme conducted at Birchcliffe in that reminiscence was employed by the R.O. instructor in the sessions usually with the aid of newspaper articles and sing-a-longs. Of significance, was the fact that this feature of the programme was generally well received by the participants on E.1 in that reactions and favourable interaction frequently occurred. On W.2 however, the reception towards the news items proved less favourable, possibly due to the size and composition of the group which appeared to inhibit interaction among the patients.

In considering the fourth assumption that hope must always be given for the patient's recovery, we presented arguments which would seem to counteract the idea. Moreover the manner in which the R.O. instructor, and the nursing and health care staff approached the subject of death were then explored. In a geriatric setting where

aged people, illness and death pervade the environment and yet where a patient is prevented from obtaining any access for emotional support from the nursing and health care staff; it would appear that education in this area is prescribed. Most medical personnel have insufficient training in this regard and rather than approaching the subject, it is avoided. Physical needs are well taken care of and yet the psychological needs tend to be overlooked. We focused our attention on "socially dead" individuals and presented some explanations for this phenomena. It will be recalled that the socially constructed world is in need of validation which is not only undertaken by the individual but requires ongoing interaction with others who coinhabit the same socially constructed world. Thus the question arises as to how these non interacting individuals (socially dead) are to validate or be oriented to the paramount reality when many of them dwell within a sub-universe of meaning and do not interact with others.

The fifth assumption presumed that a boost in morale of the hospital staff occurs as a direct consequence of the employment of a Reality Orientation programme. An increased morale failed to develop specifically on W.2 and we attempted to explain the "resistance" demonstrated

by the health care staff through the general attitude of the health care staff to the O.T., O.T.A. and occupational therapy in general; prevailing ideologies of the wards; and the fact that one of the resisters to the formal concept of R.O. was actually one of the two R.O. instructors. It was the hope of the O.T.A.-R.N.A. not to "restore reality" as such but rather to make the "patients happy", clearly an aspect of the expressive role of nursing.

The O.T.A.-R.N.A. R.O. instructor never separated herself or identity from the nursing role or more explicitly the "expressive" role of nursing. Evidence for this claim were found in recorded statements, her general attitude towards nursing, her role of ombudsman, and her goal in the R.O. sessions of "making them (patients) happy".

It would seem that in recruiting individuals to implement a novel treatment or programme in a setting such as Birchcliffe, the formal theory and any relevant material should be fully examined (the O.T.A.-R.N.A. could not explain the differences between Active and Passive Friendliness, an integral part of Folsom's programme) and the objectives and complete methodology made clear to all involved. It was apparent that the nursing ideology prevailed and influenced her interpretation of the programme, although at the time of data gathering, the instructor was not employed

as an R.N.A. but was a representative of the Department of Occupational Therapy. Furthermore her identification with nursing seemed to create resentment by the nursing and health care staff in terms of her "intrusions".

The role of ombudsman became problematic as we noted in the preceding chapter. The nursing and health care staff seemed to object (particularly at its inception) to directives emanating from the Department of Occupational Therapy in as much as within the hospital priorities, the Department seemed to be equated with recreational activities and less with "important" tasks of nursing patients. Moreover, there appeared to be two somewhat differing ward ideologies. The patients on W.2 were considered to be steadily declining in health, the most ill of the two wards whereas, the patients on E.1 were thought of as being just basically "old". For this reason, "fun" features and recreation came to be accepted by the staff on E.1. However, the staffs on both wards were reluctant to "take them (patients) out of their own reality world". Therefore the resistance to the programme rested not on one single facet or factor but encompassed all of the reasons just listed.

For those individuals who appear to have little if any need of Reality Orientation, maintaining a programme

similar to the one at Birchcliffe or initiating one geared to this segment of the hospital population may be quite beneficial in terms of keeping in touch with the outside world, via newspaper items or similar measures, which in turn promotes social interaction. Moreover the recreational features such as tossing bean bags and balls could further initiate interaction of a kind, particularly when the participants are in smaller more intimate groups such as those on E.1. Singing old favourites appeared to be an enjoyable experience as they frequently seemed to stimulate memories as witnessed when conversations revolved around certain songs or when requests were made by the participants. However, if the objective is to increase involvement within the institution and stimulate the patient's interest in his new residence then, perhaps topics of discussion should be on a more limited scale, revolving around hospital interests.

Senility is a psycho-social-biological phenomenon it would seem. Although there may be limited means for changing the biological component the psychological and social factors could be altered somewhat.

More research, on the empirical level, should be considered in terms of interacting effectively with patients through entering their reality, rather than



forcing the paramount reality on such individuals. Knowledge concerning the art of communication of such individuals would seem to provide at least some insight into the understanding "senility" and perhaps establish groundwork from which to initiate further research.

Hospital employees who deal directly with the patients should be considered for upgrading their education in terms of accepting the natural processes of life and death thus enabling them with more confidence to provide the emotional support that many patients would seem to need, during their stay at the hospital. This may enhance trust and interaction among the patients and staff.

As a final word, although I was unable to present a fully comprehensive report of the Reality Orientation programme as prescribed by Folsom, it is my sincere wish that this analysis of the programme offered at Birchcliffe will in some way prove useful.

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