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# Adverse Effects of Reality Orientation

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The predominant psychosocial approach to the care of patients with dementia has been Reality Orientation (RO).[1–3] Most proponents of RO advocate a 24-hour system, whereby staff actively provide reorientation and reality cues whenever interacting with a patient. As an adjunct or alternative to the 24-hour method, RO has also been developed as more formal didactic group therapy (Class RO). A staff member presents information such as the date, day of the week, time of day, and current location in an organized, intensive cognitive retraining group for about 30 minutes each day.

Despite the widespread use of RO in long-term care facilities, controversy surrounds its actual therapeutic value.[4,5] When RO was first developed in the late 1950s,[6,7] staff were enthusiastic about its use. Not only did cognitive orientation improve, but positive behavioral changes were noted. In the past 20 years numerous researchers have analyzed the efficacy of RO. A review of the literature by Woods and Britton[8] concludes that RO produces some improvement in verbal orientation, but changes are minimal in other areas of functioning. Hanley, McGuire, and Boyd[5] and Citrin and Dixon[9] have found that while Class RO does improve cognitive function somewhat, it has no effect on other behaviors, such as Activity of Daily Living skills. Woods and Britton[8] speculate that the benefits of RO depend upon the change in the interactional process between staff and patients. In fact, one of the original purposes of RO was to give staff a sense of "doing something" with patients that have bleak futures. Accordingly, the success of RO in any particular treatment setting may depend upon the staff's belief in and enthusiasm for the technique.

In our experience, nursing home staff are cynical about the value of RO and utilize it only because it is an institutional requirement. Staff apply the techniques of RO in a rote, uninspired way. The treatment emphasis focuses on the communication of information and instructions rather than on the human, interactional process.

Removed from its humanistic context, RO can be an aversive approach to patients. For those patients with dementia, the constant relearning of the material necessary to remain oriented is a difficult task that can lead to frustration, anxiety, depression, and a lowering of self-esteem. Butler and Lewis[10] have proposed that confusion can serve adaptive functions by providing a defense against painful realizations. Living in the past may bring the psychological rewards of re-experiencing times when the subject felt a sense of belonging and competency. Seen in this context, RO may attempt to bring unwilling subjects back to an intolerable reality—only to provoke anger, misery, or both. Although some writers[3] have theorized that RO may have a negative impact on patients, illustrations of this phenomenon are lacking. Below we present three cases from a nursing home in which attempts at RO produced deleterious psychological effects.

## CASE REPORTS

**Case 1** An 84-year-old woman with a diagnosis of Alzheimer's disease was interviewed by a state inspector during a recent survey. Alert and animated, the patient related a story to the inspector about her son, whom she said was seven years old. The inspector proceeded to orient her to present time and situation, emphasizing that the woman's son would have to be much older. The patient became furious, cursed the inspector, called her a liar, and then burst into tears. She continued to cry for two hours and could not be comforted by staff.

**Case 2** An 85-year-old woman with a diagnosis of chronic organic brain syndrome cries out for her mother and father, both of whom are dead. This resident is normally continent of urine. If attempts are made to orient her to present time and place, she becomes upset,

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cries, and experiences urinary frequency with incontinence for several hours.

**Case 3** A 74-year-old man with a diagnosis of Alzheimer's disease sees his own reflection in the mirror and thinks it is his brother, who has been dead for several years. When he is told that he is actually looking at himself rather than at his brother, the patient becomes agitated and states that his brother will be very angry. He then becomes quiet and subdued and sits in his chair for several hours, withdrawn from any activity on the unit.

## DISCUSSION

The three cases above demonstrate that attempts to orient patients to objective reality can have adverse effects. These patients became emotionally upset when attempts were made to bring them into the here-and-now. Their emotional reactions were invariably negative whenever such attempts were made. In fact, staff members no longer attempt to use RO with these patients because of the detrimental consequences. Although RO may have some therapeutic benefits when properly and enthusiastically utilized, there are instances in which another approach is needed when working with confused and demented patients.

Validation Therapy (VT) is an approach first proposed by Feil[11] in 1967 and is the object of increasing interest for use in long-term care facilities. Feil proposed this alternative therapy after she observed that severely disoriented older patients failed to respond to attempts at reorientation. Treatment is based on the premise that there is some logic behind all behavior, even disoriented behavior. Awareness of reality is not the goal; the goal is to understand the personal meaning underlying an individual's behavior. Through empathic listening, the therapist attempts to discover the patient's view of reality in order to make meaningful emotional contact.[12] As of this writing, there have not been any well-designed studies assessing the effectiveness of VT.

When working in the validation mode, one does not allow the patient's factual errors to interrupt the expression of psychologically or emotionally meaningful material. In contrast to RO, the interactional focus is on the patient's subjective experience, not on objective facts. Acceptance of feelings and behavior without interpretation or analysis contributes to an increased sense of self-worth and dignity.[13] It is Feil's assertion that the empathic listener can help the disoriented elderly person work through unfinished emotional conflicts, a task that she defines as "resolution."[14] The foundations for VT arise from psychoanalysis and humanistic psychology, but Feil is the first clinician to apply these concepts systematically to working with elderly demented patients.

Below, we illustrate how VT was used by staff in the cases presented above:

**Case 1** When the patient discusses her seven-year-old son, the staff ask questions as if she is discussing a current, actual relationship. The patient is quite animated when she relates stories about her young son. At times she asks the staff when her son is going to visit next. Some staff members tell her that her son will be visiting later in the day; such a response takes her mind off the subject and she does not seem to get upset by the absence of such a visit. One staff member responds to questions about her son visiting by reflecting how much she misses him. At times the patient will continue to talk about her son, but eventually she ends the conversation without incident.

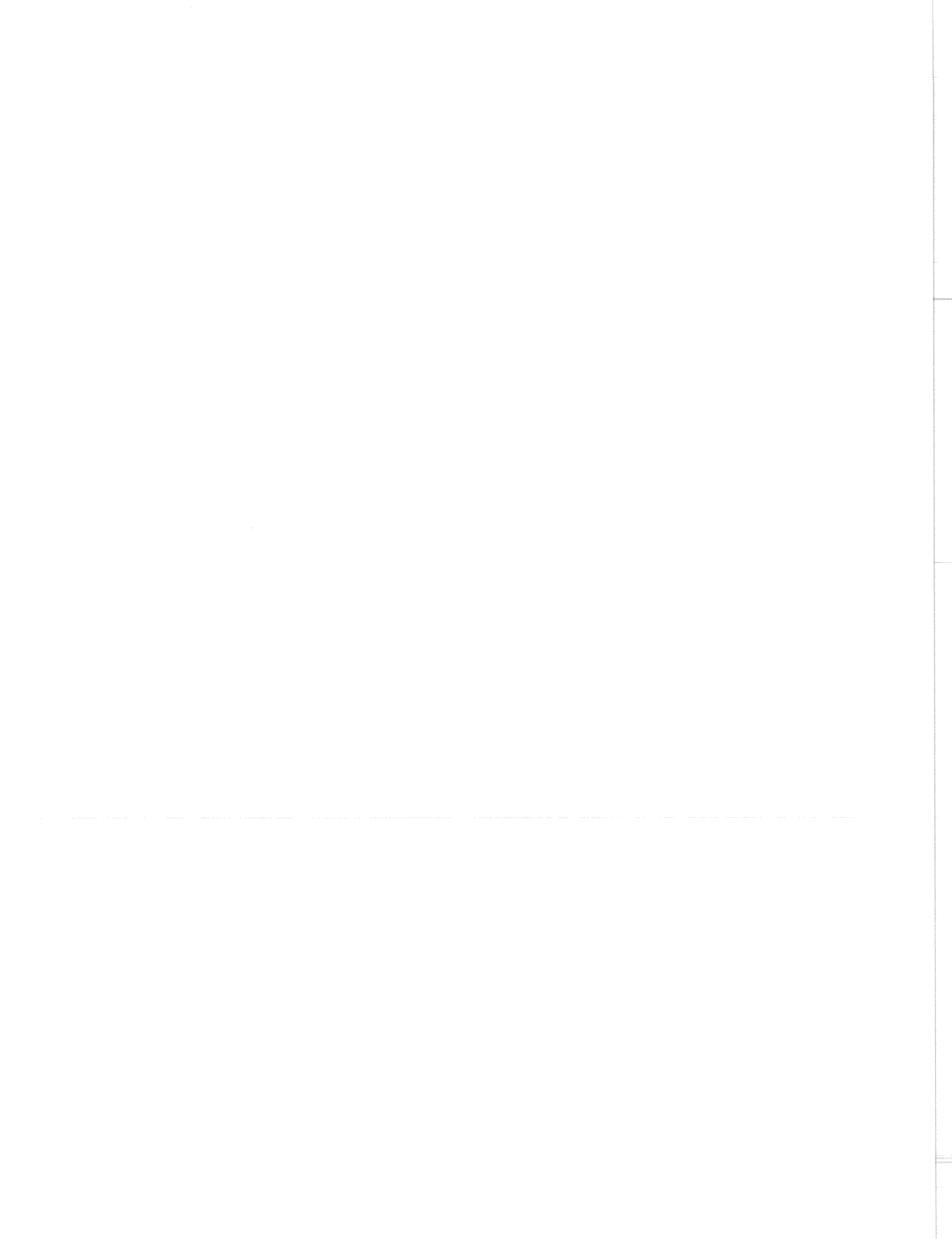
**Case 2** The staff have found that when the patient becomes upset and cries for her parents, she can be comforted by being encouraged to talk about them. The staff respond as if her parents are still alive, which usually results in the patient reminiscing about pleasurable times that she spent with her parents in the past. She tends to recount the same memories repeatedly, but after recounting her stories she can be directed into other activities. On a number of occasions the patient has refused to eat while she insists on knowing whether her mother fixed the meal. Staff have found that she will only eat if told that her mother did indeed prepare the food.

**Case 3** The staff find that they can usually distract the patient from the mirror by encouraging conversation about the patient's brother. The patient talks excitedly and happily about his brother, with whom he was very close, and can soon be focused on another subject of conversation or activity.

In each of the above cases the staff do not attempt to orient the patients to present reality in areas that are emotionally charged. Instead, they take the patients' worldviews and work with them as if there was factual truth to what is being said. This validation approach was found to be more effective than application of RO.

RO was originally designed to improve orientation, alleviate confusion, and increase the potential for discharge of hospitalized mentally impaired patients. Yet for those patients with dementia who live in nursing homes, there is no thought of discharge and little likelihood of an improvement in the capacity to remember. When using RO with demented patients, the goals of treatment must be individualized and clearly established.

As Gubrium and Ksander[4] note, patients and staff perceive different realities. It seems callous to remind a patient constantly of a personal reality that is painful and irrevocable. On the other hand, there may be signif-



icant value in orienting patients to certain aspects of shared reality. It is easier to care for patients who are oriented to their living unit, eg, who know the time when meals and activities occur or where the bathrooms are located. However, staff must keep in mind that even attempts at "practical" reality orientation may have negative consequences when applied without regard to individual patient considerations.

## CONCLUSION

The three cases we present demonstrate that Reality Orientation can have adverse psychological and emotional effects in patients with dementia. Although appropriate for some patients with dementia, the decision to employ RO in any particular patient must be made carefully. Staff need to observe the outcome of RO when it is used, and its use should be terminated when patients react negatively.

Validation Therapy differs radically from RO and appears to be a useful approach in some patients with dementia. Despite positive anecdotal reports, there is still no controlled research assessing the efficacy of VT. With careful planning, selected aspects of VT and RO could be combined to individualize treatment of dementia patients. Staff may benefit by avoiding the repetitive frustration of attempting to reorient patients in areas they are incapable of changing. Greater staff awareness of the individual psychological and emotional needs of dementia patients will result in improved therapeutic care.

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