McGILL UNIVERSITY

EFFECTS OF SMALL GROUP ACTIVITY ON THE INSTITUTIONALIZED AGED

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ABSTRACT

This study tested an alternative form of active treatment for the senile geriatric institutionalized patient--a mode of treatment which would do more than merely give custodial care to these patients. Based on the premise that patients function at a better level when they receive active stimulation, a small group activity program was developed. The mode of interaction was based on the concepts of reality orientation therapy. The notion that patients would respond to activities which had some relevance to their early life experience was integrated into the program. The groups involved no more than seven patients to provide a maximum opportunity to individualize treatment.

The aim of the study was to determine whether patients would improve their behavioural responses to a regular daily

activity program. It was thought, as well, that this improvement might carry over in other areas of functioning.

The cross-over design was chosen as a method of testing because it permitted before, after, and follow-up comparisons of treated patients with untreated patients. This design also allowed for comparison of pre and post treatment periods.

The results of the study showed that although there was significant change towards positive behaviour during the treatment period, this improvement was lost after the activity was terminated.

Beneficial effects of small group intervention with senile patients by itself has not been demonstrated. Extended treatment periods, along with a total reality orientation therapy program in which all staff members were trained and involved, is indicated in order to have the effect of not only preventing further regression but also improving the patients' level of overall functioning.

ACKNOWLEDGMENT

We would like to express our special thanks to Dr. E.V. Shiner of the McGill University School of Social Work, without whose support, encouragement, help, and patience, this project would not have been realized. To Dr. Gilbert Rosenberg, Director of Professional Services of Maimonides Hospital and Home for the Aged our thanks for granting us permission to proceed with the study. A special thanks goes to Mrs. Sybil Zanger, P.S.W. formerly Director of the Social Service Department of Maimonides Hospital and Home for the Aged, who offered much support and encouragement. Appreciation is extended to the nursing staff of Maimonides Hospital and Home for the Aged, particularly the third floor nursing staff, for their cooperation and interest in this project. Whatever contribution this study may make to understanding and dealing with the senile geriatric patient, would never have happened without the patients of the third floor. To them we would like to express our appreciation and love.

E. M.

S. R.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF ILLUSTRATIONS

CHAPTER I

INTRODUCTION

The Problem

One of the most critical problems facing practitioners working in the mental health field is the large and growing numbers of geriatric mental patients, particularly those thought to be suffering from "senile dementia." It is estimated that the population over 75 years of age will increase by more than 18 percent in the next decade.[1] In most mental hospitals, half the beds are already occupied by patients over 65 years of age who are suffering from "senility" or "senile dementia." This means that there will be 50,000 to 60,000 additional cases of "dementia" per annum in the next ten years in Great Britain and, it can be assumed, a proportionale number in Canada.[2] This is a problem of great magnitude for society in general.

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[1] "Care of Elderly People with Dementia," British Medical Journal, February 24, 1973, p. 434.

[2] Ibid.

The Study

This study tested an alternative to the traditional custodial method of treatment ordinarily given to such patients. It investigated the effects of an activity program designed for institutionalized senile geriatric patients. Based on the premise that such patients would function at a better level during organized activity, the focus of the study was on the social interactional performance of patients while involved in the activity program. It was also possible that the results of the study would show improvement of the patients' overall functioning on the ward as well.

The method of testing chosen was the "Cross over Design". It permitted comparison of treated patients with untreated patients. It also allowed for before, after and follow-up comparisons, with a baseline of pre and post treatment comparisons.[1]

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[1] J.B. Chassan, Research Design in Clinical Psychology and Psychiatry, Century Psychology Series (Appleton-Century-Crofts Division of Meredith Publishing Company, 1967), pp. 123-132.

Theories of Senility

"Senile" is defined as "1. of old age; 2. showing signs of old age; elderly; weak in mind and body; 3. resulting from old age ...."[1] Most dictionaries equate senility with old age, although many experts now agree that the two "are not inexorably linked."[2] Ward feels that "it is not whether you are senile, but whether others think you are."[3]

In clinical terms, the symptoms characterizing senility are called organic brain syndrome. The symptoms of organic brain syndrome include disorientation, memory loss, disordered intellectual functioning, faulty judgment, liability and shallowness of affect, often followed by personality changes.[4]

There are a large number of disorders included in the category organic brain syndrome, but this study concerns itself

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[1] Webster's New World Dictionary (College Edition, 1957).

[2] D.S. Looney, "Senility is Also a State of Mind," Nursing Digest (1) 5: 12-19, July 1973, p. 12.

[3] Ibid.

[4] T. Eaton Merill, Jr. M.D. and Margaret H. Peterson, M.D., Psychiatry, Second Edition, Medical Outline Series, (Medical Examination Publishing Co., Inc., 1969), p. 300.

mainly with the condition known as cerebral arteriosclerosis chronic brain syndrome, senile and pre-senile dementia.[1] Sadowski writes "that which is commonly known as 'chronic brain syndrome' is doubtless of a group of manifestations secondary to pathological changes in the cerebral tissue. Many older people with a chronic physical disease do not feel disabled by it when their functional capacity is preserved."[2]

Garret described senility as a patient

> who is confused or disoriented from any cause. He may have a moderate to severe degree of organic cerebral deficit, resulting from arteriosclerosis. He may have had a head injury or stroke. He may have a diagnosis of organic brain syndrome. His confusion may be the result of a sensory deprivation or over medication. The patient's first symptoms of confusion may accompany a physical illness or he may gradually become absentminded, forget common facts or wander aimlessly....[3]

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[1]Eaton Merill and Peterson, Psychiatry, pp. 310, 311.

[2]Adam Sadowski, M.D. and Paul Weinsoft, M.D., "Behavioural Disorders in the Elderly," Journal of American Geriatrics, Vol. XXIII, Feb., 1975, No. 2.

[3]Address by Mrs. Irene Garrett, Director of Recreation Home For the Jewish Aged, Philadelphia Geriatric Centre Meeting of the Group Activities Workers Committee. Central Bureau for the Jewish Aged, 31 Union Square West, New York, N.Y., 10003, p. 1.

The notion of senility almost invariably is intended to convey the fact that the individual is deteriorating physically, emotionally and psychologically, in such a manner as to be beyond treatment.[1] This definition of senility is often translated into purely custodial care for those so diagnosed.

Kris has noted that "psychiatrists frequently are reluctant to handle the problems disturbing the elderly. They feel that elderly people do not respond to psycho-therapy, because of their inflexibility of character."[2]

Butler is of the opinion that "many general physicians refer the elderly late in the course of their illnesses to the psychiatrist, or do not refer at all. They believe they cannot do anything because the basis for the "mental" conditions are "irreversible."[3] It is also the case that some

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[1]Al Manaster, "Therapy with the Senile Geriatric Patient," International Journal of Group Psychotherapy, Vol. 22, 1972, p. 250.

[2]Else B. Kris, "Depression in the Aging Patient. The Depressive Group of Illnesses," Canadian Psychiatric Association Journal, Special Supplement, Vol. II, 1966, p. 313.

[3]Robert Butler, "Clinical Psychiatry in Late Life," Clinical Geriatrics, Ed. by Isadore Rossman, J.B. Lippincott Company, 1971, U.S.A., p. 439.

psychiatrists regard mental disorders of old age as primarily physical and beyond the scope of psychiatric treatment.[1]

Instead of using the term senile dementia, MacMillan substitutes the notion of "senile breakdown." He defines it as "a situation in which the resources of the family or community have become inadequate to deal with the needs of the old person concerned. This state is usually gradual in its development and occurs because of physical, psychiatric or social etiological factors...."[2]

Oberleder has gone even further with this last concept. She suggests that "were we to restore the normal props of living to the elderly people, we might very well do away with senility." She, like MacMillan, believes that senility represents an "emotional breakdown or an inappropriate method of coping with loneliness, ill health, and retirement."[3]

There are now some physicians who are able to diagnose beginning symptoms of senility. When they encounter patients

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[1]Butler, "Clinical Psychiatry in Late Life," p. 439.

[2]Duncan MacMillan, "Features of Senile Breakdown," Geriatrics, March, 1969, p. 104.

[3]Muriel Oberleder, "Emotional Breakdown in Elderly People," Hospital and Community Psychiatry, Vol. 20, No. 7, July, 1969, p. 21.

at the early stages of the emotional breakdown, symptoms previously regarded as "organic and irreversible" may be reversible. The patient might respond to prompt therapeutic social measures.[1]

Looney states that "the key to senility is anxiety."[2] Oberleder corroborates this view. "Anxiety underlies all senile symptoms and causes them. In old age, you have more anxiety evoking situations and fewer anxiety reducing opportunities; that formula in itself could account for senility or emotional breakdown in the elderly."[3]

It would seem, then, that emotional factors are found to be predominant because of the devastating affect of loneliness, the feeling of uselessness, and isolation.[4] In almost all cases of gradual senile breakdown the above factors play a very large role in creating the conditions of senility.[5]

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[1]MacMillan, "Senile Breakdown," p. 111.

[2]Looney, "Senility is Also a State of Mind," p. 12.

[3]Oberleder, "Emotional Breakdown in Elderly People," p.21.

[4]Looney, "Senility is Also a State of Mind," p. 13.

[5]Ibid.

Senile symptoms can be substitutes for frustrated impulses or buffers against inner conflicts. Forgetting can be viewed as a means of tuning oneself out of an unbearable situation. Although memory can deteriorate with disuse, it can often be improved if proper treatment and stimulation are given. Even incontinence can be viewed as a symptom of loss of self-esteem and vengeance, and can sometimes be reversed if treated.[1]

According to Looney, the self-fulfilling prophesy, which states that senility is always part of the ageing process, is one of the most damaging ever devised.[2] If senility is thought of as a strong psychological defence against encroaching old age, then senility may be viewed as often avoidable and sometimes reversible.

Along with emotional factors, there often are physical disabilities and social handicaps which complicate the senile breakdown. Following physical illness, there is the problem of differentiating between senile deterioration, which might be permanent, and a condition of a temporary confusional state.

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[1]Oberleder, Emotional Breakdown in Elderly People, p. 23.

[2]Looney, Senility is Also a State of Mind, p. 13.

Sadowski corroborates this view.[1] In a study of 7 cases, he found that the personality structure and defence mechanisms permitted personal adaptation to senescence when life stresses were not unduly severe. However, with repeated serious setbacks, familial or personal, and prolonged loneliness, there can be a total breakdown of personality and severe progressive organic brain syndrome. Oberleder quotes studies in which it has been shown that often there is no difference between the electroencephalogram of a "normal aged" person and one who is suffering from "senile dementia."[2]

Depression in the geriatric patient is also often misdiagnosed by the medical profession as senile dementia. As a result, the patient so diagnosed does not receive the treatment or therapy which would otherwise be used in the treatment of depression in any other age group.[3]

There is evidence that 2 percent of the population has a predisposition to senility, similar to the percentage of

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[1]Sadowski, "Behavioral Disorders in the Elderly," p. 91.

[2]Oberleder, Emotional Breakdown in Elderly People, p.21.

[3]Macmillan, "Features of Senile Breakdown," p. 113.

people in all age groups who suffer from mental breakdowns.[1] Therefore, it would seem that those symptoms associated with senile breakdown are often the same symptoms exhibited by any regressed patient of any age who suffers from a psychosis.

The difference may be the approach to treatment. A young person is regarded as "treatable," that is, he can recover after treatment because his illness is not seen as the symptoms of old age. An older person is regarded as untreatable as his illness is seen as a "natural" progression in the life span. Specialists in the field of geriatrics, such as Looney,[2] Oberleder,[3] and Folsom[4] believe that senility may not be natural to the ageing process, but may very well be a disease that can be treated.

Folsom believes that the concept of senility is an easy way for society to overlook and ignore the treatment of

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[1]Oberleder, "Emotional Breakdown in Elderly People," p. 22.

[2]Looney, "Senility is Also a State of Mind."

[3]Oberleder, "Emotional Breakdown in Elderly People."

[4]J.C. Folsom, "Reality Orientation for the Elderly Mental Patient," Journal of Geriatric Psychiatry, Vol. 1, 1968, pp. 291-307.

the geriatric patient suffering from senile dementia.[1] He, along with a growing number of people working in the field of geriatrics do not accept the old concept of senility. Folsom goes so far as to say that he feels that the word "senility" should be dropped from the vocabulary of geriatric practitioners.[2]

The major problems in dealing with the elderly is the enormous amount of poor advice given to families of the ageing patient by professionals in the health field, and the excessive use of medication for treating aged patients with mental disorders.[3] Folsom writes that "much of the neglect of early symptoms of senility, as well as the widespread view that it is "hopeless" is based on centuries of brain washing about old age, including the sort Shakespeare engaged in when describing the seventh age of man as "As You Like It."[4]

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[1]Margaret Shannon, "Return to Reality," The Atlantic Journal and Constitution Magazine, Jan. 9, 1972, p. 1.

[2]"New Treatment Attacks Myth About Senility," The Montreal Star, Lifestyles, Section B, June 1, 1973.

[3]Ibid.

[4]Shannon, "Return to Reality," p. 9.

The present study also does not regard the symptoms of senility as inevitable and irreversible for old age. The belief that senility is frequently an emotional breakdown for the elderly to be treated as a mental disease is held. This is the theoretical bias and it was from this perspective that the present study was developed.

Related Studies

In the past, programs and services for the senile aged were considered of very low priority by professionals and, at best, these patients were given "good" custodial care. Within the past twenty years, however, attitudes have begun to change. New theories are being formulated and tested with various therapies in the hope that they would help to improve, and perhaps reverse, the "classical" symptoms of old age. Group therapy has emerged as a form of treatment for the geriatric patient, as a way of helping and improving certain disruptive and dysfunctional behaviours.

Ciompi holds the view that when patients cannot remember from one session to the next, when they do not recognize the other members of the group and the therapist, group therapy seems to offer little benefit for the individual

patient.[1] However, numerous studies have shown that even the most regressed patient responds to some form of group therapy. A sense of well-being is carried over if sessions are not too widely separated in time. A pleasant group experience gives the patient a short time in an "oasis in their desert lives."[2] Goldfarb reports that intermittent pleasures offered by a group treatment program appears to have at least a mildly beneficial affect on severely brain damaged persons. It is useful when the emphasis is on increasing social interaction and appropriate behaviour through interpersonal relationships, identification with the group, and encouragement of self-expression.[3]

There is a large range of group approaches being used presently for the treatment of geriatric patients suffering from different levels of senility. These group approaches include as their focus recreation, vocational, physiotherapy,

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[1]Alvin Goldfarb, "Group Treatment of Mental Illness," Group Therapy with the Old and Aged. Modern Group Book VI. Edited by Harold I. Kaplan and Benjamin Saddock (New York: E.P. Dutton & Co. Inc., 1972), p. 117.

[2]Ibid.

[3]Ibid., p. 123.

psychotherapy, sensory stimulation, remotivation, and reality orientation. The goals for such groups include the following: 1) to increase the number of discharges from hospitals and institutions; 2) to decrease disturbing and dysfunctional behaviour on the ward and help the patients and the nursing staff; 3) to increase patients' comfort, sense of well-being, and adaptation to living in the hospital or institution.

Silver, in 1950, was the first to report on group therapy for 7 senile, psychotic patients, between the ages of 70 and 80 years. These patients exhibited a limited attention span, poor memory, and poor understanding, making discussion with them difficult. He found that conversation is not the only mode of treatment which can be used to improve patients' functioning. In order to elicit a response from these patients, who were all women, he introduced the idea of a party atmosphere in which cookies, milk, and music were provided. He found that these patients perked up and became animated. Semi-weekly meetings of this type improved the social behaviour of the patients, increased their attention span, improved their personal hygiene, and made them less of a floor management problem.[1]

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[1]A. Silver, "Group Psychotherapy with Senile Psychotic Women," Geriatrics, Vol. 5, 1950, p. 147.

To enduce socialibity and interaction among patients, Kastenbaum and Chien advocated the use of mildly alcoholic beverages. Kastenbaum theorized that ethnic groups might benefit from having liquor customarily used by them. Chien noted that mentally impaired persons given beer in a pub-like atmosphere improved in sociability and self-esteem. However, it was reported that their improvement did not exceed that of a control group, who received judicious amounts of "thioridozine" and no group treatment.[1]

Linden was the first to report on a controlled longitudinal program for aged persons. He conducted a study using psychotherapy with geriatric patients. He worked with 51 female patients in one large group. The group was also open to any other patient who wished to attend. Criteria for this group consisted of: 1) willingness to join, 2) appearance of relative alertness, 3) fair degree of personal hygiene, 4) ability to understand, 5) ability to walk or be wheeled to meeting room, 6) minimal range affects, 7) evidence of some degree of adult adjustment prior to entrance into present senile state, and 8) a capacity to evoke interest and affection

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[1]Goldfarb, "Group Treatment of Mental Illness," p. 121.

from nursing personnel.[1] The group met for one hour, twice weekly, for two years. The results showed that 43 percent improved, and 16 percent showed moderate gains. The patient who was only occasionally incontinent became controlled. In some, their gait improved and many of them appeared to be more alert to the staff.[2]

Rechtschaffen, Atkinson and Freeman used group therapy. The average age of the sample was 72 years. The criteria for selection was good prognosis for discharge. Along with group psychotherapy sessions held for one hour twice weekly, other forms of treatment were given as well. They included electro-shock, drugs, motivational meetings, occupational therapy and work therapy.[3]

Repeated orientation and informational conversations with the patients were offered by the therapists. The majority of the patients had been diagnosed as suffering from senile

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[1]M.E. Linden, "Group Psychotherapy with Institutionalized Senile Women. A Study in Gerontologic Human Relations," Geriatrics, 9:28, 1954.

[2]Ibid.

[3]A. Rechtschaffen, S. Atkinson and J.G. Freeman, "An Intensive Treatment Program for State Hospital Geriatric Patients," Geriatrics, 9:28, 1954.

psychosis or cerebral arteriosclerosis. Due to the treatment, it was found that staff morale and optimism increased. There was a 38 percent discharge rate. Forty-six patients left after the first six months of treatment to return home and only five of these returned.[1]

Lipsky and Barad attempted to modify vegetative behaviour in a group of aged persons, between the ages of 74 and 95 years, with severe brain syndrome. All had physical impairments such as deafness, poor vision, cerebral accident, along with poor mental functioning. At daily sessions, the patients were placed in a semi-circle and encouraged to talk to the therapist and to each other, as well as to answer simple questions. To reinforce talk, they held hands, stroked arms, and touched faces. They were also encouraged to sing, to dance, and to use percussion instruments to accompany music. Simple occupational activity materials were provided. As a result of this kind of treatment and stimulation, 10 of the 18 women showed general improvement, 4 showed fluctuated changes, and 4 showed no change--that is, they did well when they were stimulated and busy, but this subsided when they were alone

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[1]Rechtschaffen et al., "An Intensive Treatment Program for State Hospital Geriatric Patients."

and not involved in stimulation. Lipsky et al. also reported that episodes of incontinency were improved briefly.[1]

The above study might be termed a multiple sensory stimulation approach as it included stimulation by voice, touch, sight, and movement. However, working with completely disoriented persons who had global memory loss and physical disabilities, required a high patient-staff ratio. It was found to be costly and time consuming and these factors did not allow for the study to be continued.[2]

Downey, working with confused and withdrawn patients, believed that by bombarding the nervous system with carefully chosen stimuli would revitalize the blunted senses of elderly patients. He employed a sensory training method as his form of treatment and he worked with four to seven patients in a group. The patients were encouraged to reorient themselves and to become aware of their bodies by closing their eyes, identifying their limbs, and naming the joints that move different parts of their body. To improve hearing, one member of the group

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[1]Goldfarb, "Group Treatment of Mental Illness," pp. 125-126.

[2]Ibid.

produced a sound by beating a drum or clapping hands, while others were asked to identify the sound without looking. To improve sight, someone would hold a mirror up to a patient and the patient was asked to reflect on what he saw. To enhance taste, patients were given samples of food and asked to identify them as sweet, sour, etc. They were involved in 10 one-hour sessions and participation was regular. Downey reported improvement in patient functioning.[1]

Powell set about trying to test whether the effects of exercise would have positive effects on cognitive and psychological behaviour amongst the aged. His subjects were geriatric patients--17 females and 13 males. The average age of the females was 72 years, while the average age of the males was 66 years. The length of hospital stay for the patients averaged 24 years. All the patients were volunteers. There were three major disqualifying health factors. They were hypertension, history of heart trouble, and debilitating arthritis. Severely regressed and non-communicative mental patients were also disqualified.

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[1]Gregg Downey, "Sensory Training Reawakens Patients to Life," Modern Nursing Home, Oct. 1971, p. 62.

The sample used was typical of geriatric mental patients residing in mental institutions throughout the United States. The treatment groups and one control group were matched according to age, sex, and ward residence. Group 1 was exposed to 12 weeks of mild exercise, such as walking, calisthenics, and rhythmical movements. To control the possible psychological effects of extra attention, the second treatment group consisted of 12 weeks of social therapy, such as arts and crafts, social interaction, music, games, etc.

Three tests of mental functioning and two behavioural assessments were made and patients were retested after an eight week period. The results show that the deterioration of "recall and logical thinking" is not necessarily pathological in nature and often results because of disuse or disinterest. It was assumed that social interaction was not an important factor contributing to improvement in the exercise group, since no such improvement was noted for socialization in the second group. It seemed, therefore, that physical activity had a stimulating effect upon the brain. An unavoidable involvement of the entire brain in physical activity seemed to have been an important factor in the positive effects and changes

in the exercise group.[1]

Mateev, in a longitudinal study, begun in 1964, used four voluntary groups with an average age of 77 years in an old peoples' home. Group I had regular exercise; Group II were involved in irregular exercise; Group III were involved in no exercise but were kept actively mobile; and Group IV received no exercise and were left inactive. The positive response to exercise was clearly demonstrated and the improvement was directly proportional to the amount of physical exercise each group received. The non-exercising group deteriorated. Mateev stressed further that it was important for the elderly to be provided with as many varied stimuli as possible, including cultural, social, creative, and spectator activities. This, he felt, would combat the adverse physical and mental effects of isolation and loneliness.[2]

Wolff reported on 340 patients whom he treated with group psychotherapy. His sample consisted of aged patients

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[1]Richard R. Powell, "Psychological Effects of Exercise Therapy Upon Institutionalized Geriatric Mental Patients," Journal of Gerontology, Vol. 29, No. 2, March, 1974.

[2]Irene Youbotsky Gore, "Physical Activity and Aging. A Survey of Soviet Literature," Gerontology Clinica, 14:65-69, 1972.

who were diagnosed as suffering from chronic brain syndrome, arteriosclerosis of the brain, senility, and organic brain disease. Psychotherapy sessions dealt with discussions on religion, marriage and love life, historical events, food, etc. Forty percent of his 340 patients showed improvement and were discharged from hospital. He reports that some of the confused patients became more coherent.[1]

A study by Boxberger and Cotter showed that music activities had a beneficial effect on the behaviour of geriatric patients. It increased appropriate behaviour and reduced aggression. Patients showed less physical and verbal reaction to hallucinations. In addition, there was a reduction in the frequency of incontinency as well as a lowering of patient noise.[2]

Cesin, Westropp, Mort and Post conducted a study where the attendance of patients in a day hospital was hypothesized to be of benefit to mildly confused old people with senile

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[1]Kurt Wolff, The Emotional Rehabilitation of the Geriatric Patient (Illinois: Charles C. Thomas Publishers, 1970), pp. 154-157.

[2]R. Boxberger and V.W. Coller, Music Therapy for Geriatric Patients. Edited by E.T. Gaston (New York: Macmillan, 1968).

disorders. The aim of the study was to determine whether occupational and social therapies would enhance confused patients' communication between themselves and their surroundings. It was found that occupational and social therapies were well suited to the management of mentally deteriorated patients. This type of treatment stimulated patients toward more appropriate behaviour. Arts and crafts seemed to have a sedative value, but domestic activities, especially when they involved some cooperation with others, produced the most intensive stimulation and satisfaction. Organized social activities were found too complex for some patients. However, events of social significance aroused a good deal of appropriate behaviour. Unfortunately, the effects of treatment were short lived. The scores which reflected increased communication and appropriate behaviour dropped within a few hours after therapeutic stimulation had terminated.[1]

Manaster reported the results of a therapy program on a sample of 20 extremely regressed and confused patients. The

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[1] L.Z. Cosin, Celia Westropp, Felix Post and Margaret Post, Moyra Williams, "Experimental Treatment of Persistent Senile Confusion," International Journal of Social Psychiatry, Vol. IV, Issue 1, July 1958-April 1959.

criteria for the sample selection included confusion; lack of a sense of reality; disorientation to time, place, and person; extreme mood swings; and severe withdrawal. Many patients were in wheelchairs and had severe medical problems. The average age was between 75 and 80 years. The patients' speech was incoherent and they appeared to be withdrawn and apathetic. The group sessions began by having each member give his name and then shake hands with the therapist. In this way, group members identified themselves and could relate to one another. The themes of discussion were: the debilitating effects of old age; awareness of loss of memory; the need to believe in God and its meaning; children; family; early hardships; achievements; etc. The areas of judgment, concentration, and orientation to self all seemed to "blossom." There appeared to be less rambling of speech and less incoherence in those patients exposed to treatment. However, group improvement did not move in a steady progression. There were peaks and dips which indicated many inconsistencies. One session would end on a high note but in the next session, the leader might have to begin all over again. The results reported that in the majority of patients, there was a change of attitude, increased awareness, more interaction and interest in what was going on, and more reality testing.[1]

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[1]Manaster, "Therapy with the Senile Geriatric Patient."

Two specific modes of treatment, remotivation therapy and reality orientation therapy, have been singled out as being the most relevant to the present study.

Remotivation therapy is based on the idea that there are always parts of the patients' personality that remain intact, even though they may be severely regressed. It provides an environment to activate these "healthy" areas of the personality.[1] Remotivation therapy is a structured program in which the distinct feature is the use of objective topics, such as current events, history, geography, holidays, etc., for the purpose of discussion.[2] This type of approach has been implemented with aides, orderlies, and nurses, who have been trained as remotivation therapists, and who participate as leaders in this kind of program. All discussions are planned around specific steps, which are: climate of acceptance; bridge to reality; appreciation of the world of work; and climate of appreciation.[3]

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[1]Ann Bickell, David Shaw, and Caroline Tolpfer, "Remotivation as Behaviour Therapy," Gerontologist, 1974, p. 451. Reprint.

[2]David Birkett, and Peter and Bruce Boltoch, "Remotivation Therapy," Journal of the American Geriatric Society, Vol. XXI, No. 8, U.S.A., p. 368.

[3]Ibid.

A study by Bowers, Anderson and Bloomer showed that of three groups involved in remotivation therapy, all groups improved significantly over a six month period.[1] The authors state: "We cannot overemphasize the necessity for extra group activity and support in maintaining gains initiated in the Remotivation Groups."[2]

Mueller and Atlas conducted a study using the concepts of remotivation, behaviour modification, and components of groupwork with 5 subjects, considered to be elderly and regressed. They report the program as giving positive indication of improving social interactional skills among withdrawn patients.[3]

Reality orientation therapy was developed specifically for geriatric patients who have a moderate to severe degree of memory loss, confusion and disorientation, resulting from any

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[1] Malcolm Bowers, George Anderson, and Ernest Bloomeir, "Brain Syndrome and Behaviour in Geriatric Remotivation Groups," Journal of Gerontology, Vol. 22, 1967, p. 351.

[2] Ibid.

[3] Donald J. Mueller, and Lucille Atlas, "Resocialization of Regressed Elderly Residents. A Behavioral Management Approach," Journal of Gerontology, Vol. 27, No. 3, July, 1972.

cause. It rejects the belief that there are definitive explanations for senility. This kind of treatment is gaining recognition and acceptance among professionals involved in working with the senile patient. Garrett stated that:

> Reality Orientation is a phase of rehabilitation. This philosophy is that each individual patient should make maximum use of his assets and that no one is hopelessly mentally impaired. The best use of the patient's abilities is made when rehabilitation is begun as soon as possible. Patients who need Reality Orientation are found in all age groups. However, a majority are found in the geriatric group. These are the people with whom we are concerned.[1]

Macmillan added that:

> The inactivity and decrease in environmental stimulation, which results when an elderly person withdraws from his surroundings, give rise to a mental deterioration process concurrent with the physiological and cerebral deterioration that occurs in old age. Reality Orientation attacks the deteriorating process by constantly and continually receiving stimulation through repeated presentation of fundamental information of the individual patient.[2]

The development of reality orientation therapy was started in 1961. A pilot project was begun at the Mental Health

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[1]Address by Irene Garrett, p. 1.

[2]Jonathan Barnes, "Effects of Reality Orientation Classroom on Memory Loss, Confusion and Disorientation in Geriatric Patients," Gerontologist, Vol. 14, No. 2, April, 1974, p. 138.

Institute, Mount Pleasant, Iowa, under the direction of Dr. J.C. Folsom. This project set forth many of the ideas used in the present-day concept of reality orientation therapy. Prior to the project, only 3 percent of the patients were able to be discharged from hospital. After the study had been completed, 57 percent of the patients in the program were able to return to their pre-hospital adjustment.[1] In 1965, a modification and refinement of the reality orientation therapy program was introduced and instituted by Dr. Folsom in Tuscaloosa, Alabama.[2]

Reality orientation therapy is achieved through a twenty-four hour a day program. The aim of the program is to improve the level of patient functioning, particularly in the areas of orientation and self-care. The central core of this program involves individualized treatment for each patient. All persons coming into contact with the patient are taught to approach him with a prescribed attitude based on the theory of attitude therapy later discussed. The patient is always reminded of who he is, what he is, and what is expected of him.[3]

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[1]Folsom, "Reality Orientation for the Elderly Mental Patient," p. 295.

[2]Ibid., p. 301.

[3]Address by Irene Garrett, p. 2.

To supplement, this special reality orientation classes are held daily. In order to carry out reality orientation therapy, it has been found that the team approach is the most effective way to help the restoration of faculties of the severely mentally impaired resident.[1]

Attitude therapy, which is part of reality orientation therapy, is used as a method of individualizing treatment of patients. Garrett writes that attitude therapy is easy to teach and to learn. It is based on the premise that any behaviour that is learned can be modified or changed. Desirable behaviour is reinforced and undesirable behaviour extinguished.[2]

The key to attitude therapy is consistency of approach. This consistency enables the patient to recognize those aspects of his behaviour that need to be modified. The effectiveness of the program depends on the consistency with which attitude therapy is practiced by all staff members.[3] There are five

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[1]Irene Garrett, Mamie Chaiffetz, Terrie Fada, "Reality Orientation - Implementation for Use as a Program in the North Wing of the Home for the Aged. Philadelphia Geriatric Centre. Unpublished material, p. 1.

[2]Address by Irene Garrett, p. 4.

[3]Ibid.

prescribed attitudes which are as follows: 1) the attitude of "active friendliness" applies to the behaviour pattern that is withdrawn and apathetic; 2) the attitude of "passive friendliness" is used for patients who are suspicious; 3) the attitude of "kind firmness" is designed for the patient who is depressed and who has turned hostilities inward; 4) the attitude of "no demand" is prescribed for the frightened or suspicious patient who is in an uncontrollable rage; 5) the attitude of "matter of fact" is used for patients who complain to gain sympathy and attention to satisfy their sick needs.[1] Families of patients are informed about reality orientation and are taught how to use the attitude prescribed for their relative.[2]

Barnes conducted a study which examined the effects of reality orientation classes on memory, confusion, and disorientation. It tried to determine how much basic information the patients could regain and retain through these classes. They were held six days a week, for six weeks, with 3 or 4 patients in a class. Results showed no significant improvement

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[1] Address by Irene Garrett, pp. 5-6.

[2] Ibid., p. 4.

in the questionnaire response after the classroom sessions were ended. However, Barnes reports on observed behaviour of patients who showed improvement. "The trend was towards significance and a longer period of therapy could be expected to lead to more noticeable change.... One could interpret the findings as indicating that observable patient behaviour can improve through the provision of a program designed to increase the level of activity."[1]

Phillips reported a reality orientation program in which 55 patients were involved. The results of the study showed that 19 patients improved in terms of retaining what they learned in reality orientation classes. They also showed improved physical appearance and mental outlook. They became more aware and alert and sociable. Another 20 patients showed moderate improvement. They were more alert and less withdrawn, but did not retain as much information as the group that was significantly improved. Five of the 55 showed slight improvement or no improvement at all. Eleven were discontinued because of

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[1]Jonathan Barnes, "Effects of Reality Orientation Classroom on Memory Loss, Confusion and Disorientation in Geriatric Patients," Gerontologist, Vol. 14, No. 2, April, 1974.

illness or because they were disruptive. Every one of the 55 subjects went through some form of positive change.[1]

The results of Folsom's study involving 64 patients in a reality orientation program are as follows: 29 remained in treatment after one year; 3 patients died; 9 were removed from the program because of their physical condition; 4 patients showed regression; and 2 were unable to cooperate in this treatment approach. Of 17 patients that completed both basic and advanced classes, 5 were discharged; 2 were transferred to facilities requiring more self-care; 1 was on a trial visit at home; 1 was in a foster home placement; and 8 remained in hospital but became able to accept and handle privileges.[2]

The literature review has cited studies showing a variety of approaches. These are some of the attempts that have been made to deal with the problems of geriatric patients with symptoms of senility. However, the studies often deal with samples whose characteristics and behavioural symptoms are not well defined. The form of prescribed treatment is also

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[1]Donald F. Phillips, "Long Term Care," Journal of the American Hospital Association, July, 1973.

[2]Folsom, "Reality Orientation for the Elderly Mental Patient," p. 307.

not well described. The results of therapy are often anecdotally told, and follow-up is absent or brief. Therefore, controlled studies on groupwork with the aged remains a continuing challenge. This study was conducted to contribute towards meeting this need.

Hypotheses

Therefore, the focus of this study is to investigate the effects of an activity program on senile geriatric institutionalized patients. The central hypothesis is:

> Through stimulation, defined as regular participation in small group activities, senile geriatric patients improve to a better level of overall functioning.

From the general hypothesis, a number of sub-hypotheses were derived:

1. The improved level of functioning is maintained when treatment ended.
2. If the improvement in functioning is not seen on the ward, it is seen within the confines of the activity program.
3. The improvement in the activity group program is with programs which were primarily verbal in nature, rather than with programs that are primarily nonverbal in nature.

CHAPTER II

THE ACTIVITY PROGRAM

Background and Setting

The present study developed as a result of an increasing concern to give more than "traditional custodial care" to patients who were regressed and described as senile. In attempting to find a model for treatment, it seemed that a small group approach would be more amenable to improving the behavior of regressed patients.

Traditional group psychotherapy is based on the premise of capacity for verbal thought and verbal expression by the patient. It is felt to be, therefore, limited as a mode of treatment for the senile patient.[1]

The review of the literature indicated that groups with emphasis on recreation, exercise, sensory stimulation, and

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[1]Birkett and Boltoch, "Remotivation Therapy," p. 371.

remotivation seem more suitable towards improving the behavior of regressed patients.

The twenty-four hour a day approach of reality orientation therapy seemed to be the best model of treatment. It stresses the team approach and involves all the staff coming into contact with the patient. In addition, it offers a systematic and structured program involving attitude therapy, consistency of approach, reality orientation classes, and an individualized treatment plan for each patient. This program is being tried in many geriatric centers. However, many of the centers have placed emphasis on the reality orientation classes rather than the twenty-four hour a day program.[1]

As a pilot project, prior to the implementation of a full reality orientation program, the investigators devised a small group program based on the concepts of reality orientation therapy. In addition, it was observed that the extent of response to program by the patients seemed to be directly

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[1]The investigators attended the Canadian Gerontological Conference in Fall 1973 in Ottawa, Canada. Reality Orientation therapy was frequently discussed. However, in most instances, the centers claiming use of this mode of treatment were using reality orientation classes only and not a full reality orientation program.

related to their past experience. This notion was highlighted in developing the small group activity program.

The study was conducted at Maimonides Hospital and Home for the Aged, a chronic geriatric hospital. The criteria for admission are that the applicant be at least 65 years of age and require medical supervision at least once a week, in addition to nursing care. The average age of the patient population is 83 years. The vast majority of these patients were Jewish and of Eastern European extraction.

The medical facilities of the hospital include non-surgical medical clinics, dental and chiropody clinics, an x-ray department, a medical research department, and a pharmacy department. In addition, there are departments for physiotherapy, occupational therapy, social service, speech and audiology, groupwork, arts and crafts, and a synagogue.

This particular study concerned itself with the patients of the third floor of Maimonides Hospital and Home for the Aged. The patients of this floor were diagnosed as suffering from senile dementia, arteriosclerosis, organic or chronic brain syndrome, or brain damage. The symptoms these patients exhibited include at least one or more of the following characteristics:

1. Confusion

The patients were disoriented to person, place, and time. They suffered some degree of memory loss, and some of them were completely withdrawn from reality. Some of these patients could be seen wandering aimlessly on the ward, unaware of their surroundings.

2. Tasks of Daily Living

These patients were unable to perform the tasks of daily living. The staff of this ward assumed responsibility for feeding, dressing, cleaning, and grooming the patients. At least 50 percent of them were incontinent.

3. Emotional Functioning

As a result of their confusion, many of these patients were emotionally unstable and could be seen crying one moment and laughing the next moment; or being frightened for no apparent reason; or becoming aggressive without apparent cause.

4. Linguistic Expression

The patients exhibited symptoms of confabulation, reverting back to their first language, verbal perseveration

(endless repetition of a vowel, word, or noise), incomprehensible speech, or loss of speech.

5. Ambulation

Some of the patients of this ward were ambulatory. Others could only walk with assistance. However, the majority were confined to wheelchairs.

All of the patients in the study can be described as depressed, withdrawn, and regressed. In addition to their mental incapacities, all of them suffered from one or more physical ailments such as heart disease, Parkinson's Disease, or diabetes, etc.

The third floor was divided into two wards with a head nurse in charge of each ward, and included Registered Nurses, nursing assistants, and orderlies. There was also a full time social worker assigned to the entire floor. The hospital has a groupwork department, which is separate from the social service department, and is comprised of two non-professional groupworkers. These two workers shared their assignment on the third floor which was on a half time basis. Just before the study began, a full time groupworker, under the auspices of B'nai Brith Hillel Foundation, was employed as a groupworker

for the duration of the study. She was under the supervision of the social service department of the hospital. Aside from the staff specifically assigned to the third floor, other professional staff within the hospital were available for consultation.

The patients of the third floor were often excluded from hospital programs, the rationale being that they were "too out of it" to be able to enjoy or participate in such programs. It was also felt that they would be disruptive and upset other patients because of their deteriorated condition. As a result, very little stimulation and social interaction was provided for them.

The hospital administration showed its concern by allowing a large group activity to take place five times weekly for the third floor patients. This large activity group was one in which patients were wheeled or brought into the large activity room and worked with by one recreational group-worker and sometimes a few volunteers. Due to limited staffing of this activity group, and the large number of patients (about 30), it was not possible for the groupworker to offer much individual stimulation. Consequently, it was difficult to involve a majority of patients in an active way.

The deteriorated mental condition of these patients often caused them to be treated as young children. This was sometimes demonstrated by the way the staff addressed and interacted with them. Dissatisfaction with the large group activity program, expressed by the third floor staff, encouraged the investigators to design a small group activity program based on concepts of reality orientation therapy; activities featuring aspects of sensory stimulation and recreation; and the notion of positive responses of patients to activity programs having relevance to earlier life experiences.

A meeting was held with the two head nurses of the third floor, the nursing supervisor, the two groupwork staff, and the investigators. The meeting focused on the proposed group activity plan and was accepted by all departments involved. This initial endorsement was not sufficient to operationalize the project. Further meetings and contacts were necessary at a higher supervisory level in order to allow a proper flow of communication and understanding to all concerned.

Development of the Activity Program

A review of groups, designed to help the regressed and senile aged, indicated that stimulation is of prime importance

in not only preventing further mental deterioration, but also in improving inappropriate behaviour as well.

It had been observed that patients function at a higher level while attending some form of organized activity.[1] In order to give a maximum amount of personal attention to each individual patient in the study, small group activities were designed. The method of interaction in the small group activity program was borrowed from the principles of reality orientation therapy. It had also been noted that patients responded best to activities having relevance to their earlier life experiences. This is corroborated by Fern: "... things learned late in life disappear first, and those learned early are the last to disappear."[2] This concept was integrated into the activity program.

Beyond the overall aim of preventing further regression and mental deterioration, the goals of the activity program

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[1]Address by Mrs. Irene Garrett, p. 1.

[2]L. Fern (Helsinki), "Behavioural Activities in Demented Geriatric Patients; Based on Evaluations made by Nursing Staff Members on Patients' Scores on a Simple Psychometric Test," Gerontologia Clinic, Vol. 16, No. 4, 1974, p. 193.

were to help senile patients relate better to their environment; to stimulate and motivate them to a better level of overall functioning; and to reawaken appropriate responses and interests.

Each group consisted of no more than five to seven participants. Each patient included in the study was involved in at least one activity group per day, five times weekly. Each session lasted no longer than thirty to forty-five minutes because of the patients' short attention span.

In planning the small group activity program, some of the principles of reality orientation therapy were used. Basically reality orientation therapy involves a set of guidelines to be followed. They are:

1. A calm environment.
2. A set routine.
3. Clear responses to patients' questions.
4. Talk clearly to patients, not necessarily loud.
5. Direct the patient around by clear directions. If need be, guide them to and from their destinations.
6. Remind them of their name, date, time, and place.
7. Don't let them stay confused by allowing them to ramble in their speech, actions, etc.

8. Be firm.

9. Be sincere.

10. Make requests of patients in a calm manner.

11. Be consistent.[1]

Features from these basic processes were adapted to the activity group program. They are:

1. A Calm Environment

In order to provide the necessary "calm environment," the activity groups were held in a small solarium at the back of the ward which was brighter, more cheerful, and quiet, rather than the regular activity room.

2. A Set Routine

Each week, each groupworker planned the activities for the following week so that she would have the necessary equipment and supplies available. Before the patients were assembled, the groupworker brought all the supplies and equipment for that day. Each session began by the groupworker introducing herself to the patients and by having them repeat her name. The patients were also asked to introduce themselves. This was

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[1]Folsom, "Reality Orientation for the Elderly," p. 299.

followed by the groupworker discussing the activity for that day with the patients. The activity was then held, and when the session was over, the patients were told that they would see the groupworker the next day. This was followed by the groupworker expressing thanks to the group members for their attendance. The groupworker then said good-bye to each group member individually, referring to them by their name. The patients were then wheeled or helped to return to their next appropriate place.

3. Clear Responses, Directions, and Proper Orientation to Self, Time, and Place

The groupworker spoke slowly and distinctly to make sure that everyone heard. Often the groupworker repeated phrases to individual patients to be sure that they understood. The patient was given adequate time to respond. The groupworker addressed them in a respectful way, calling them by their last names. Although each session began with a review of basic information such as the patients' name, where they were, and what time of day, week, year, and season it was, the emphasis was placed more on the patients' appropriate responses to the activity being offered. If the patient was unable to give the desired response, the groupworker would give the patient the answer and ask the patient to repeat it.

4. Helping the Patients Return to Reality

When the patients rambled in their speech and performed inappropriate actions, the groupworkers were firm with them in not allowing them to stay confused or to ramble in their speech and actions. Another attempt to help them behave appropriately was to make requests in a calm manner. In spite of this, the groupworkers were constantly aware that the patients were limited in their ability to respond appropriately. By providing them with simple and familiar activity, it enabled them to react desirably to the activity, the other group members, and to the groupworker.

A Description of the Activity Program

The different approaches that were used by the groupworkers consisted of activities which were verbal and nonverbal in their presentation. It was not feasible to expose a patient to equal amounts of a verbal activity or a nonverbal activity. The activities offered to the patients depended on the orientation and preference of the groupworker.

Whether the activity was verbal or nonverbal in nature, common features were present in both forms of activity groups:

1) all groupworkers played an active role in the group sessions. This was necessary to reach isolated and withdrawn patients and to help orientate the patients to the activity. It was often necessary to repeat phrases or words to patients until the groupworker was satisfied that the patient understood and was involved; 2) both types of groups had a small group composition. This allowed for the groupworker to give each member of the group the necessary individual attention; 3) both types of groups had the same set routine. At the beginning of each session a review was made of basic information. All activities had the focus of helping the patient relate appropriately to the activity in which he or she was involved. If the activity was verbal, the patient was expected to listen, understand, and answer questions in a coherent manner. If the activity was nonverbal, the patient was expected to perform not only in the nonverbal aspect of the program, but also to give indication that he was aware of the nature of the activity; 4) all groupworkers, having familiarized themselves with the basic goals of the project, were able to use a consistent approach when dealing with patients in their groups; and 5) touch, eye contact, and verbalizations were used whether the activity was verbal or nonverbal.

Activities which were primarily verbal in nature included storytelling, discussion, religious program and others. Storytelling involved relating a story to the patient in which the content of the story usually had elements which were once familiar to the patient. Discussions were made up of topics that patients could relate to such as their family, country of origin, ethnic festivals and holidays, and what Canada was like fifty years ago. As the groupworker was familiar with each patient, she was able to draw the patients into discussion by asking them what their experiences and opinions were in respect to the topic of discussion. As all the patients were of the Hebrew faith, Jewish festivals, and holidays had special meaning and importance for them. Religious programs helped them relate to reality because religious traditions were so much a part of their lifestyles. Many patients who gave the impression of being very withdrawn and demented seemed to come alive during such programs.

Activities which were primarily nonverbal in nature were cooking sessions, exercises and game sessions, and arts and crafts programs. The cooking activity usually involved women because this had been a major role function of their lives. At the beginning of the session, the groupworker would familiarize

them with what they would be doing during the program. A cooking activity might include making a salad, mixing a cake batter, rolling out cookie dough, and cutting cookies out of dough. In all cooking programs, the groupworker had the group members identify the different articles that the patients would be using. It was the groupworker's responsibility to help the patients engage in some aspect of the activity in an appropriate fashion. Patients performed tasks in accordance with their ability. This might include potato or carrot peeling, washing or cutting of vegetables, or helping to tidy up at the end of the session.

Exercise and games were used to stimulate patients. These activities helped patients to become more physically active. Music frequently was used to accompany the exercise session and evoked positive responses from patients. Games, incorporated as a form of exercise, was another way of helping patients to interact more appropriately. Pitch and catch was found to be useful for very regressed and inactive patients. Catching and throwing a ball for such patients provided them with not only physical exercise but also with tactile stimulation. Basketball throw was adapted for wheelchair patients, as well as for those who were ambulatory. Rolling a ball

across the table to other patients not only made patients aware of other group members, but also made it necessary to concentrate on the task of rolling the ball. Table games such as bingo, dominoes, and checkers, were adapted to the level of the patients' understanding. In some instances, the patients could only participate in bingo by reading the numbers on the card, while others were able, with some assistance, actually to play the game.

Arts and crafts involved patients in tasks at different levels. Some of the simple activities were winding wool around a disc made of cardboard; separating material by size, shape, and colour; placing buttons on drawn forms; making mosaic ashtrays; braiding wool or string; beading; sorting beads according to colour; colouring with crayon; and cutting out pictures from magazines and identifying the pictures.

Other programs included birthday parties, films, and bus tours. At birthday parties, the resident celebrating his birthday would receive a corsage of flowers, often pinned on by one of their relatives who was invited. The groupworker would speak briefly about each resident celebrating a birthday. Singing and dancing would follow. Birthday cake and drinks were always served.

Films on familiar topics were shown. However, the response to such programs was poor. This might have been because the film as a media was remote from the patient and because many patients had difficulty in seeing the screen.

Bus tours to familiar parts of the city elicited very positive responses and behaviour. However, the more regressed patients found this activity a little overwhelming and became frightened.

Other departments in the hospital were asked to participate in the activity programs. As a result, the occupational therapist had a weekly group of seven patients with whom she worked on activities of daily living, such as dressing, and eating. The speech therapist worked with seven patients on a weekly basis and attempted to get them to verbalize and interact.

Process Recordings of Two Activities

In order to present the quality of the intervention used in the small group activity, a process summary recording of a primarily verbal activity at the beginning and end of treatment, and a process summary recording of a primarily nonverbal activity at the beginning and end of treatment are described.

The primarily verbal activity group described is an "Oneg Shabbat" program. "Oneg Shabbat" is a traditional way in which the Jewish People welcome the Sabbath. For the patients in the activity group, a repetition of such tradition helps them back to reality. The first process excerpt shows how the patients were passive and receive support and encouragement from the groupworker. Although they responded to the activity, it was in a minimal way.

Room Setting

The "Oneg Shabbat" program took place in the activity room every Friday afternoon. The patients were seated around the table. The table was covered with a white table cloth. On the table were two bottles of wine (grape juice), traditional bread (chala), and Sabbath candles.

Groupleader: Good Afternoon Mr. A., Mr. B., Mrs. C., Mrs. D., Mrs. E., and Mrs. G.
[The groupworker greets each patient individually and some form of physical contact is made.]
Do you know what day it is today? [Silence]

Mrs. G.: It is Monday, Tuesday, Wednesday.

Groupleader: No Mrs. G. Today is Friday.

Mrs. G.: It is Friday.

Mr. A.: Ya.

Groupleader: Yes, today is Friday and it is a special day.

[The groupworker asks each patient what day it is and has the patient repeat the day if they do not know.]

Since it is Friday and near sundown we will have an Oneg Shabbat program to welcome in the Sabbath. The women will light the candles and the men will recite the blessing over the wine. Mrs. C., will you begin by lighting the candles? Everyone must be quiet so we can hear her. [Mrs. C. rises.]

Mrs. C.: [She recites the blessing without much difficulty. When she is finished she continues to stand.]

Groupleader: Good Shabbat. [Groupleader shakes her hand and smiles.]

Mrs. C.: Good Shabbat. [She continues to stand.]

Groupleader: Mrs. C., you can sit down now. Thank you.

Mrs. C.: I want to light the candles.

Groupleader: Mrs. C., you just lit the candles and recited the blessing, and did very well. You just wished me a Good Shabbat.

Mrs. C.: O.K. Thank you.

Groupleader: You can sit down, Mrs. C. [Mrs. C. sits down with help from the groupleader.]
Mrs. D., will you light the Sabbath candles?

Mrs. D.: [She begins to cry.] I want to go home. Take me out.

Groupleader: [Groupworker takes Mrs. D.'s hand.] This is your home. You are now at an Oneg Shabbat program because it is Friday. Mrs. C. just lit the candles and I would like you to do the same.
[Groupworker begins to recite the blessing for Mrs. D. who just sits and stares at the groupworker. When the leader finishes she says] Good Shabbat.

Mrs. D.: Good Shabbat. [She cries a little as she repeats these words.] [Her agitated crying-like behaviour, typical of the ward, is less frequently present during this program.]

Mrs. E.: [Mrs. E. resists coming to any activity program. However it was easy to have her come to a religious program as it has great meaning for her. Mrs. E. appears usually angry and depressed. She stands up and looks at the group members.]

Groupworker: Mrs. E. will now light the candles and recite the blessing.

Mrs. E.: [She waits for silence and says the prayer.]

Groupworker: Good Shabbat, Mrs. E.

Mrs. E.: Good Shabbat. [She smiles at the groupworker and looks at the group members.]

[The other women present light the candles and when this is finished, the men recite the necessary blessings for the wine and bread.]

Groupworker: Now that we have lit the Sabbath candles, we will make the blessing over the wine. Mr. B. would you like to make the blessing for the wine?

Mr. B.: Sure!

Groupworker: Mr. B., you can stand up if you wish so. [The groupworker helps him up. Mr. B. remembers the first line only and begins to cry. The groupworker repeats the blessing with Mr. B. following her, and his crying stops. When this is finished, wine and cake are served to the patients. The program is followed by singing and dancing.]

The following process, after six weeks of treatment, shows the patients' familiarity of the program and their

spontaneous responses. They have also become more aware of what the program is about and begin to ask for certain items to make the program more ritualistically acceptable.

Groupworker: Good afternoon everyone. Good afternoon Mr. A., Mr. B., Mrs. C., Mrs. D., Mrs. E., Mrs. G. [Groupworker greets them individually and shakes their hand to establish some form of contact.] Do you know what day it is today?

Mrs. G.: Friday.

Groupworker: That's right, Mrs. G. Today is Friday and near sundown. We will have an "Oneg Shabbat" program to welcome in the Sabbath. The women will light the candles and the men will recite the blessing for the wine.

Mrs. C.: Let's start.

Groupworker: O.K. Mrs. C., would you please light the candles? Everyone must be still so we can hear Mrs. C.

Mrs. C.: I need a scarf. [She is given one.]

Groupworker: Mrs. C., you can start.

Mrs. C.: [She stands up and looks around.] It's still light outside and too early to light the candles.

Groupworker: You are right, Mrs. C.

Mrs. C.: God will forgive us. [She recites the blessing and says] I wish everyone health and happiness. [She shakes the groupworker's hand] Good Shabbat. [She turns to the group and says] Good Shabbat.

Groupworker: Good Shabbat, Mrs. C. Mrs. D., will you please light the candles?

Mrs. D.: [The groupworker takes her hand.] [She recites the first two lines of the blessing and the groupworker repeats the rest of the blessing.]

Groupworker: Good Shabbat, Mrs. D.

Mrs. D.: Thank you. Good Shabbat. [She smiles at the groupworker.]

[After the candles are lit by the female group members, the blessing over the wine and bread is performed by the men present in the group.]

Groupworker: Mr. B., will you recite the blessing for the wine?

Mr. B.: Sure. [He stands up]
I need a prayer book. [He is given one.] [He recites the blessing with help from the groupworker reading from the prayer book and wishes everyone a good Shabbat.]

Groupworker: Mr. A., would you say the blessing for the bread?

Mr. A.: [He says the blessing and then asks for salt to put on the blessed bread before he eats it.]

Mrs. C.: I want to say the blessing for the cake. [She takes a piece of cake and recites the blessing.]

The primarily nonverbal activity described is a cooking session. It will be noted that although cooking is the activity and, as such, is considered a nonverbal activity, there is much verbalization involved. In the first session, all of the participants are quite passive, speak only when they are spoken to, although a number of them can peel vegetables almost

automatically. All of them are very dependent on the group-worker. After six weeks of treatment, it will be noted that the patients are very much more aware of their surroundings and each other. During this last session, all of them seem more alert, although some were still able to participate only with direct guidance and help.

Room Setting

Some of the cooking sessions were held in the kitchen of the Day Hospital. It has a stove, frigidaire, washing machine and drier, tables and chairs, as well as cupboards and drawers with basic kitchen articles.

Groupworker: Good morning everyone. My name is S. Mrs. C., can you tell me what my name is?

Mrs. C.: I don't remember.

Groupworker: Well, my name is S. Can you tell me what your name is?

Mrs. C.: Fanny C.

Groupworker: Very good, Mrs. C.
[Groupworker goes around the room and none of the other participants are able to remember the group-worker's name, while two others are able to remember their own names. In each case, the group-worker gives immediate reward by comments like "very good", or "that's right", or repeats to each individual who is unable to remember, the correct answer and then has them repeat it.]

Groupworker: We're going to make a salad today. Does anyone here know what kind of a room this is? Mrs. R.? [Silence] Mrs. C.? [Silence] Mrs. K.? [Silence] Mrs. M., can you tell me what room this is? [Silence]

Groupworker: We're in the Day Hospital Kitchen. [Groupworker has each participant repeat where they are.] Now, can anybody tell me what a kitchen is for?

Mrs. K.: Sure!

Groupworker: Would you like to tell us what a kitchen is for?

Mrs. K.: [confabulating] Don't be foolish.

Groupworker: Does anyone know? [Participants are either "tuned out" or nod no.] Well, kitchens are the place where cooking and the preparation of food takes place.

Mrs. K.: Of course!

Groupworker: What kinds of equipment are there in the kitchen? Mrs. M.?

Mrs. M.: A stove [she points to the stove.]

Groupworker: Good, Mrs. M. That's a stove. It's the kitchen appliance that cooks the food we eat.

[The groupworker goes around to each member again--only one other person, Mrs. P., is able to identify another piece of kitchen equipment, the refrigerator which she calls the "icebox". The groupworker praises her for answering. Then she mentions the name of each piece of equipment in the room, has the participants repeat after she mentions each piece of equipment, and tells them what each thing is used for. As each item is correctly identified by three of the five participants, she gives immediate praise and encouragement.]

Groupworker: We're going to make a salad today. Can anyone tell me what goes in a salad?
[The groupworker has a basket of vegetables--tomatoes, lettuce, cucumbers, shallots, and celery--she takes a head of lettuce out and asks] What is this vegetable called? Mrs. P.? [Silence] Mrs. C.?

Mrs. C.: How should I know?

Groupworker: Mrs. K., can you tell me what this vegetable is called?

Mrs. K.: A lettuce. What do you think I am, a baby?

Groupworker: Certainly not, Mrs. K., but sometimes even grown-up people forget. I'm glad you know the name of the vegetable. It's usually the basic ingredient of a fresh salad.

[The groupworker hands around to all the participants each vegetable as it is named mainly by herself, but she gets most of them to repeat the name. The participants are asked to feel it gently, what colour the vegetable is, what it feels like, what it tastes like, etc. The highest rate of performance until this point are Mrs. K. and Mrs. M.]

Groupworker: Now, we're going to cut up the vegetables.
[The groupworker hands around paring knives and gives each woman a knife. After Mrs. M. names the utensil and after the groupworker has told the group what it is used for, she has each participant name the utensil and its use. Then, she gives each member a vegetable to cut. Mrs. C., Mrs. K., and Mrs. P. start working, after they have been helped a little, and they work quite appropriately. Mrs. M. and Mrs. R. just sit and look at their knives. Mrs. R. starts to doze and drops the paring knife.

Groupworker: Mrs. M., aren't you going to cut your vegetable?

Mrs. M.: I want to go home. My children will soon be home from school. I want to go home. I want to go home.

Groupworker: Mrs. M., your children are all grown up. They're all fine. They even have children of their own.

Mrs. M.: [Starts shouting and crying] You're crazy. I want to go home. Take me home. Maybe something has happened to them. They might be in a fire.

Groupworker: [Gently] Your children are quite safe. They're grown up. My goodness, you're a grandmother with grandchildren! Your home is here, Maimonides Hospital.

Mrs. M.: You're crazy. You don't know what you're talking about.

Groupworker: Mrs. M., I know it's difficult for you to remember that your children are grown up. Perhaps Miss W. [nursing assistant present at the session] will take you back upstairs. Goodbye for now, Mrs. M. I hope you'll feel better tomorrow.

[Mrs. M. is wheeled out. The other participants are apathetic to what has transpired. Three of them are busily engaged in the paring and cutting of their vegetables. The groupworker tries to arouse Mrs. B., but she continues to doze. The groupworker encourages and praises them. From time to time one of them will ask "is it cut properly? What should I do now? The groupworker helps them when they are in need of help and encourages them when they are able to work independently. After everybody contributes their cut vegetable to the big vegetable bowl, she tells them how well she thinks they all did today. She then asks for assistance in cleaning up. Mrs. C., who is ambulatory, is asked to sweep the floor. Mrs. K. is asked to throw the peelings from the counter into a bag held by the groupworker. She cannot do this. Mrs. R. is still dozing, arousing for a minute only when she is shaken.]

Groupworker: Now that we've made our salad and cleaned the kitchen, we're going back upstairs where all of

> you live. Tomorrow, when we meet again, we'll be baking cookies. [She says goodbye to each participant individually by name and shakes hands with each of them. They are wheeled or helped to go back to their appropriate place on the third floor.]

After six weeks of treatment, the behaviour of each of the participants has improved to some extent in the activity. Four out of the five know their own names (all except Mrs. R. Two of the five know, when asked, the groupworker's name. Mrs. R. still does not respond to questions but is able now to roll dough for cookies or peel vegetables, like potatoes, with a little assistance. Mrs. M. no longer cries as much as before. She is more aware of her surroundings, and has begun to participate, especially in the baking sessions. All members have become accustomed to the cleaning up routine and with some assistance, where necessary, perform their duties quite naturally.

Where before, they were quite unaware of each other and of their surroundings, they begin to be aware of their environment and each other. They interact with each other, although minimally, but quite appropriately.

Case Illustrations

Following are two case illustrations to show individual patients' progress at the end of treatment.

Case A

Mrs. C., 79 years, was admitted to Maimonides Hospital a year prior to the beginning of the study. Before her admittance, she had been living at home with her husband. She had begun very gradually to deteriorate both mentally and physically. She lived with her husband who was 82 years of age at the time of her admission. She became incontinent, would wander out of her house into the street, and Mr. C. would have to call the police for help in finding her.

She had been a very good cook and housekeeper in her earlier years, but in her deterioration, began to set fires in the house by putting something on the stove to cook and forgetting about it.

Mr. C., a frail old man himself, with no support from relatives or friends, and only one son living in Israel, was unable to care for her any longer.

At the point of admission, she was confused in all spheres except in her knowledge of who she was (her name) and

who her husband was. She always greeted him warmly, during his frequent visits. She would kiss him and hold his hand and introduce him to whoever was about.

Mrs. C. was involved in two activities during the study--the daily cooking session and the once-a-week Oneg Shabbat for the six week treatment period. At the end of the six week treatment period, she was aware of the group-worker's name, with no prompting. She became more aware of her environment. For example, she would remark when an activity changed location.

Although the nursing staff still found her confused, they remarked that she was more lucid and appropriate more frequently. She became less incontinent as well. This may have been because staff became more aware of her and would remind her to toilet herself frequently.

During the Oneg Shabbat, she was able to recite from memory the blessing over the Shabbat candles. At the last session, she insisted on having a scarf for her head when making the blessing. This is very much a part of the ritual for orthodox Jews. Mrs. C. had always been orthodox.

Case B

Mr. X., age 82, was admitted to hospital five months prior to the beginning of the study. Prior to admission, he had been living in a nursing home for about one year. He still had a wife and two married children. Before his retirement, Mr. X. was a tailor. He was described by his family as a good-humored, pleasant, easy going person. He was a very religious man and had observed all the Hebrew traditions and customs. On the wards,he was found by staff to be confused a good deal of the time, incontinent, and dependent on nursing personnel for self care.

Mr. X. was involved in a variety of verbal and nonverbal programs such as arts and crafts, music, storytelling, and religious programs. It was found that although he responded well and participated in all activities he was exposed to, he appeared to relate best and most appropriately around religious content which was generally the Oneg Shabbat program. Here he recited prayers and blessings from the prayer book as he had been accustomed to doing for many years. He appeared confused and disoriented on the ward, yet in structured activity programs he was more lucid and appropriate in his responses.

CHAPTER III

METHODOLOGY

Population and Sample

The population of central concern in this study was made up of Jewish geriatric patients, all over 65 years, and hospitalized because of their illness and their inability to cope with their own self care. As a general rule, the patients were perceived as deteriorating in physical, psychological, and social capacities.

The sample consisted of 40 persons, 16 males and 24 females, whose average age was 81 years. Primarily widowed, the patients' place of origin was mainly in Eastern Europe. Their residence in Canada averaged 61 years. The females' occupational background was almost exclusively as housewives. The males were generally distributed between self-employed and workers. A breakdown of the demographic characteristics of the two treatment groups, Group A and Group B, are shown in Table 1.

Table 1

DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE

		Group A	Group B	Total
1. SEX:	Female	10	14	24
	Male	8	8	16
2. AVERAGE AGE:		83.0	79.5	81.0
3. MARITAL STATUS:				
	Single	1	1	2
	Married	2	8	10
	Widowed	14	13	27
	Divorced	1	0	1
4. OCCUPATION:	Housewives	9	11	20
	Self Employed	5	6	11
	Worker	4	5	9
5. COUNTRY OF ORIGIN:				
	Central Europe	0	1	1
	Eastern Europe	17	18	35
	Great Britain	0	1	1
	Canada	1	1	2
6. RESIDENCE IN CANADA (Average years)		64	58	61

Research Design

The effects of an experimental group activity program are usually best answered by the classic experimental design.

In this design, one group receives the experimental intervention, while the control group receives no such experience. Random assignment to either experimental or control group is generally made to fulfill the requirements of this type of design. The setting in this study, however, did not allow for the use of random assignment of subjects.

Maimonides Hospital's physical layout is such that patients spend their time in distinct care units or wings. The floor from which the subjects were selected for the study consisted of the north wing and south wing of the third floor. Each wing has a separate Head Nurse and staff and is comprised of 35 patients.

Group A was chosen exclusively from the north wing and Group B was from the south wing. This was done because it was felt that random assignment of patients to the two study groups might contribute to an undesirable influence on the control group by those patients participating in the planned activity in the same wing. In addition, random assignment was not used in order to avoid interruption of patients' schedules and routines. Therefore, Group A consisted of 18 patients from the north wing, and Group B consisted of 22 patients from the south wing. In spite of the foregoing, it was possible to select and

match the two groups according to the different levels of dementia described, as all of the patients were well known to the investigators.

Included in each group were patients who were very regressed in all areas (orientation as to person, place and time; emotional stability; verbal competence; and ambulation), to those who had difficulty in only one or two of the above-mentioned areas. There were no striking differences between Group A and Group B on the distribution of basic demographic characteristics.

During the study, there were 6 new admissions to the floor, and these patients were included in Group B. This increased Group B to 22 subjects. In Group A, there were 4 drop-outs, and in Group B there were 2 drop-outs. This was due to death or illness, making a total of 14 subjects in each group in which all measures were available.

The classic experimental design was extended to conform to the Cross-over Design,[1] developed in drug research and illustrated in Figure 1.

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[1]Chasson, Research Design in Psychology, pp. 123-132.

Figure 1

THE CROSS-OVER DESIGN

	OBSERVATION Time 1	OBSERVATION Time 2	OBSERVATION Time 3
Treatment	Group A		Group B
No Treatment	Group B		Group A

The advantage of the cross-over design in the present application lay in the provision of the post-treatment, follow-up interval for the experimental group, as well as an additional exposure for the control group. After the control group experience, it permitted comparison of the two treatment samples and their possible combination into a larger treatment group. Observations occurred before and after the first treatment period, and also before and after the second treatment period on the selected measures.

Measures

The principle criterion instrument was the Dementia Rating Scale (hereinafter referred to as the D-Scale),

developed by Lawson and Dykes.[1] It provided a basis for observing pathologically related symptoms anchored by behavioural descriptions of patients designated as geriatric, senile, disoriented, and confused.

Lawson and Dykes provided a list of 27 behavioural characteristics; later changed by them to 29 characteristics of encroaching senility.[2] Each behaviour characteristic was rated on a "zero"(0) basis if the observed behaviour was good or completely appropriate; or as a rating of "one" (1) if a loss was manifested on that behavioural characteristic. A total score was then computed. Reliability in terms of inter-rater reliability (3 raters, 25 subjects) achieved a combined estimate of the population correlation coefficient of .95, with a standard error of measurement for a single rater of 1.00 rating points. Test-retest reliabilities of 40 subjects over 2, 6, 10 and 14 weeks were .78, .59, .59, and .69, respectively.

Criterion-related validity of the D-Scale was not reported. They were: Factor 1 Orientation, items 1 to 8, and

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[1]S. Lawson and J. Dykes, "A Dementia Rating Scale (D-Scale)," Kingston Psychiatric Hospital, Kingston, Ontario, 1974. (Mimeographed.)

[2]Appendix B, p. 115.

57 on the D-Scale; Factor 2 Emotional Stability, items 21 to 23, on the D-Scale; Factor 3 Activities of Daily Living, items 10 to 12, and 24 on the D-Scale; and Factor 4 Verbal Competence, items 26 and 27 on the D-Scale. These factors were conceptually compatible with the goals of the measure. They could be viewed as evidence of construct validity.

For the present study, minor modifications were introduced. This involved a different scoring procedure than the original D-Scale. The subjects for whom the original D-Scale was developed manifested less regressed behaviour than those of the present study. In order to permit the rating of more deteriorated behaviour and possible improvement following treatment, the original rating of "one" (1) for inappropriate behaviour was extended. Completely appropriate behaviour all of the time was rated as "zero" (0); appropriate behaviour most of the time was rated as "one" (1); appropriate behaviour some of the time was rated as "two" (2); and completely inappropriate behaviour all of the time was rated as "three" (3).

A manual for use of the D-Scale was prepared. It included descriptive elaborations of each item.[1]

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[1]D-Scale Manual, Appendix A, p. 110.

The Activity Scale (hereinafter referred to as the A-Scale) was developed especially for this study. It was devised to reflect the behavioural responses of the patients to the small group activity program. Since the activity program reflected experiences that were primarily verbal and primarily nonverbal, the A-Scale reflected this division. The primarily verbal activities included story-telling, religious programs and others; while the primarily nonverbal activities included cooking, arts and crafts and others.[1] These two program emphases were separately rated on a scale from "one" (1) for full and appropriate participation, to "four" (4) for no program response at all. Primarily verbal and primarily nonverbal scores were averaged for each patient weekly over the six week testing period. A total activity score was computed by averaging the primarily verbal and primarily nonverbal scores for each patient. Verbal instructions on the use of the A-Scale substituted for a manual.

As there was only one valid rater in the activity group, the groupworker, no inter-rater reliability was computed. Test-

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[1] A-Scale, Appendix C, p. 119.

retest reliability was also considered inapplicable as a test statistic at this time because the groupworker was rating a distinct segment of behaviour immeditely after observing it. To examine a second rating of that same behaviour, say one week later, at a time when the groupworker rater was immersed in another segment of activity the following week, would strain the aims of a test-retest procedure.

In summary, the D-Scale was the central criterion or outcome measure. Both the total D-Scale scores and the D-Scale factor scores were included. The A-Scale was associated more closely with the immediate program response by the patients and, therefore, had some criterion implications for behavioural change.

Administration

The study design required that the criterion measure be introduced before the treatment, after the period of the first treatment (the cross-over), and after the second treatment.

The D-Scale was completed by the nursing staff of the north and south wings at the designated times (Time 1, Time 2, and Time 3) for both Group A and Group B. The groupworkers

rated the subjects at the beginning and end of treatment for Group A at Time 1 and Time 2, and at the beginning and end of treatment for Group B at Time 2 and Time 3. The subjects were rated by the groupworkers on the D-Scale only when they were directly involved with the patients during the treatment period.

The A-Scale was completed by the groupworkers after each activity and handed in at the end of each week during the treatment period. Six ratings on the A-Scale were, therefore, made on both Group A and Group B.

Plan of Analysis

The analysis of data was carried out by computer, mainly by using the SPSS Programs.[1]

The means scores on the D-Scale and A-Scale were computed. The averages scores for the two treatment groups were calculated by SUB-PROGRAMS,[2] BREAKDOWN,[3] and

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[1]Norman H. Nie, and Hadlai C. Hull, Statistical Package for the Social Sciences (New York: McGraw-Hill Publishing Co., 1970).

[2]Ibid., p. 134.

[3]Ibid., p. 97.

CONDESCRIPTIVE.[1] Significance of the differences of means were obtained by using SUB-PROGRAM T-TESTS.[2] The statistics used to examine change in the total D-Scale scores and the four factor scores, as well as the A-Scale scores was the Analysis of Variance, using the STATPAK PROGRAM.[3]

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[1]Nie and Hull, Statistical Package for the Social Sciences, p. 118.

[2]Norman H. Nie and Hadlai C. Hull, Statistical Package for the Social Sciences - Update Manual, A-017-244 (National Opinion Research Center, University of Chicago). Revised July, 1973.

[3]MUSIC STATPAK Reference Manual, First Edition Jarvis Computer Center, McGill University, Sept., 1973, p. 93.

CHAPTER IV

FINDINGS

This study concerned itself with the effect of stimulation on the senile patient using an activity program encompassing some of the concepts of reality orientation therapy as well as the notion of the importance of familiar activity facilitating appropriate behaviour. It was postulated that through stimulation, defined as regular participation in a small group activity, these patients would improve to a better level of overall functioning as measured by the D-Scale.

From this a number of other suppositions were made. They were: the improved level of functioning might be maintained when treatment ended; if the improvement in functioning was not seen on the ward as measured by the D-Scale, it would be seen within the confines of the activity program as measured by the A-Scale; and the improvement on the A-Scale would confine itself to the programs of primarily verbal activity, rather than primarily nonverbal activity.

The Nursing D-Scale

The D-Scale was the main testing instrument used to rate the level of dementia of patients on the third floor. This test was given to the nursing staff to complete at three points in time, to determine if the general performance of patients on the ward would be ameliorated as a result of the treatment intervention.

On the Nursing D-Scale a calculation was made of the total mean score at each of the 3 time periods and the results are presented in Table 2.

Table 2

NURSING D-SCALE TOTAL MEAN SCORES

	Time 1	N	Time 2	N	Time 3	N
Group A	39.9	(18)	45.9	(15)	46.5	(14)
Group B	44.3	(16)	40.3	(21)	40.2	(20)
Group Total	42.0	(34)	42.7	(36)	42.8	(34)

This table shows no significant differences between the experimental and the control group at Time 1 and Time 2. The total D-scores at the beginning and end of treatment show no significant differences for either treatment group. The immediate post treatment and six week follow-up period for Group A indicated no significant level of change. There were also no significant differences for Group B during the control period at Time 1 and Time 2.

The Nursing D-Scale was divided into four factor scores; Factor 1, Orientation; Factor 2, Emotional Stability; Factor 3, Activities of Daily Living; and Factor 4, Verbal Competence. The mean scores for each of the four factor scores at Time 1, Time 2, and Time 3 are presented in Table 3.

Table 3 demonstrates that there were no significant differences for Factor 1, Orientation; Factor 2, Emotional Stability; and Factor 3, Activities of Daily Living, for Group A and Group B at Time 1, 2, and 3. However, only Factor 4, Verbal Competence, at Time 2 in Group A was found to be significantly higher than Factor 4 Group A at Time 1 and Time 3, as indicated by Table 3.

Table 3

NURSING D-SCALE MEAN FACTOR SCORES

	Factor	Time 1	N	Time 2	N	Time 3	N
Group A							
	1	19.7	(18)	22.3	(15)	21.3	(14)
	2	3.2	(18)	3.0	(15)	5.1	(14)
	3	7.3	(18)	7.9	(15)	8.0	(14)
	4	2.2	(18)	4.0	(15)	2.5	(14)
Group B							
	1	20.6	(16)	20.5	(21)	19.8	(20)
	2	4.0	(16)	3.7	(21)	3.3	(20)
	3	5.5	(16)	3.7	(21)	5.3	(20)
	4	4.2	(16)	3.8	(21)	3.9	(20)
Group Total							
	1	20.11	(34)	21.2	(36)	20.4	(34)
	2	3.6	(34)	3.7	(36)	4.1	(34)
	3	6.5	(34)	5.4	(36)	6.4	(34)
	4	3.1	(34)	3.9	(36)	3.3	(34)

The results of Factor 4 for both Group A and Group B were further analyzed by means of analysis of variance,[1] and can be seen in Table 4.

Table 4

FACTOR 4 ANALYSIS OF VARIANCE

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Square	Error Term	F-Value
Time	16.9	2	8.4	Time x Subject in Group	4.08[a]
Group	17.2	1	17.9	Subject in Group	1.95
Time x Group Interaction	18.2	2	9.1	Time x Subject in Group	4.39[a]
Subjects in Groups	229.1	26	8.8		
Time x Subject in Groups	107.6	52	2.07		
Total	389	83			

[a] $.01 \quad p < .05, \quad df.\ 2.5$

Note: Using the more conservative test (df. 1.26) to allow for the possibility of non-homogeneity of covariance, the Time main effect ceases to be significant while the Time x Group interaction remains significant F = 4.22 for p = .05.

[1] MUSIC STATPAK Reference Manual, p. 93.

Table 4 shows no statistically significant differences between Group A and Group B. The difference between the 3 Time periods was only of borderline significance. It is indicated that the interaction between the two treatment groups was shown to be statistically significant, and that Group A behaved differently from Group B in terms of verbal competence.

The Groupworker D-Scale

The groupworkers filled out the D-Scale at Time 1 and Time 2 for Group A, and at Time 2 and Time 3 for Group B. The Groupworker D-Scale total mean scores are presented in Table 5.

Table 5

GROUPWORKER D-SCALE TOTAL MEAN SCORES

	Time 1	Time 2	Time 3
Group A	44.7	42.0	
Group B		40.1	37.5

An examination of this table shows minimal decreases in the total mean scores for Group A, Time 1 and Time 2, and for Group B, Time 2 and Time 3.

The total mean score for each of the four factor scores for Group A, Time 1 and 2, and for Group B, Time 2 and Time 3 are presented in Table 6.

Table 6

GROUPWORKER D-SCALE MEAN FACTOR SCORES

	Factor	Time 1	N	Time 2	N	Time 3	N
Group A	1	20.2	(17)[a]	18.9	(16)[a]		
	2	3.4	(17)	3.6	(16)		
	3	8.5	(17)	8.3	(16)		
	4	3.1	(17)	2.5	(16)		
Group B	1			18.4	(21)[b]	18.5	(21)[b]
	2			3.4	(21)	3.1	(21)
	3			7.0	(21)	6.2	(21)
	4			2.4	(21)	1.8	(21)

[a]Incomplete data on one patient at Time 1, and two patients at Time 2 for Group A.

[b]Incomplete data on one patient at Time 1 and Time 2 for Group B.

This set of factor scores shows that none have appreciable differences between the time periods.

The A-Scale

The A-Scale was used to rate patients' responses during an activity session. The overall mean scores were computed over the six week treatment period, and the results can be seen in Table 7 and graphically in Figure 2.

Table 7

A-SCALE TOTAL MEAN SCORES

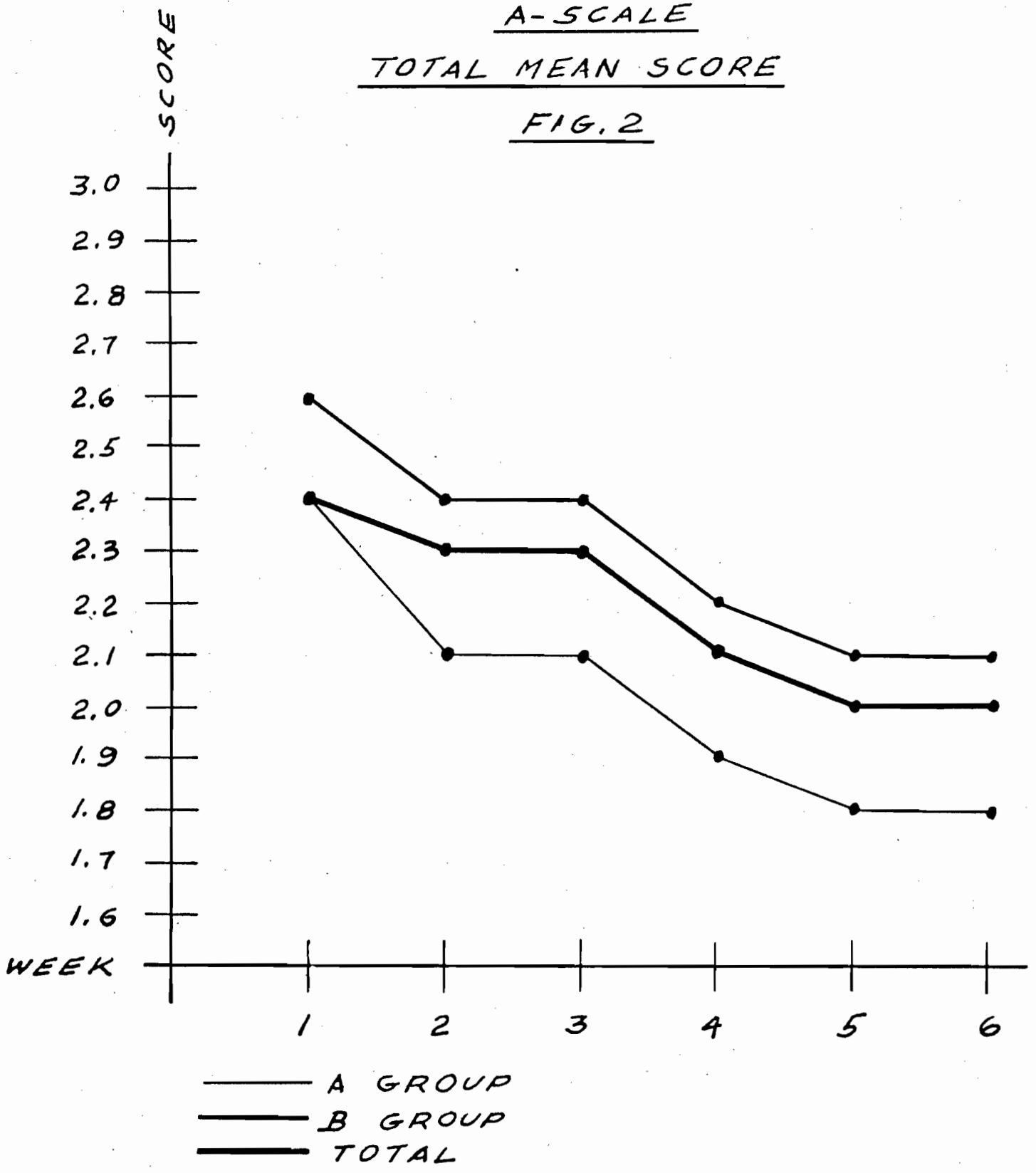
Week	Group A	(N)	Group B	(N)	Total	(N)
1	2.2	(17)	2.6	(21)	2.4	(38)
2	2.1	(16)	2.4	(21)	2.3	(37)
3	2.1	(16)	2.4	(20)	2.3	(36)
4	1.9	(16)	2.2	(20)	2.1	(36)
5	1.8	(16)	2.2	(20)	2.0	(36)
6	1.8	(15)	2.1	(20)	1.9	(35)

In Figure 2 there is an observable decrease in total A-Score for both Group A and Group B over the treatment period.

A-SCALE

TOTAL MEAN SCORE

FIG. 2



The primarily verbal and primarily nonverbal mean scores for both treatment groups were computed, and the results are presented in Table 8, and graphically in Figures 3 and 4.

Table 8

A-SCALE MEAN VERBAL AND NONVERBAL SCORES

Week	Verbal Activities			Nonverbal Activities		
	Group A(N)	Group B(N)	Total (N)	Group A(N)	Group B(N)	Total (N
1	2.2 (17)	2.7 (21)	2.4 (38)	2.5 (17)	2.4 (21)	2.4 (38
2	2.2 (16)	2.6 (21)	2.4 (37)	2.0 (16)	2.2 (21)	2.1 (37
3	2.1 (16)	2.4 (20)	2.3 (36)	2.3 (16)	2.4 (20)	2.3 (36
4	1.7 (16)	2.3 (20)	2.1 (36)	2.1 (16)	2.1 (20)	2.1 (36
5	1.7 (16)	2.1 (20)	2.0 (35)	2.0 (15)	2.2 (20)	2.1 (35
6	1.8 (15)	2.0 (20)	2.0 (35)	2.0 (15)	2.1 (20)	2.0 (35

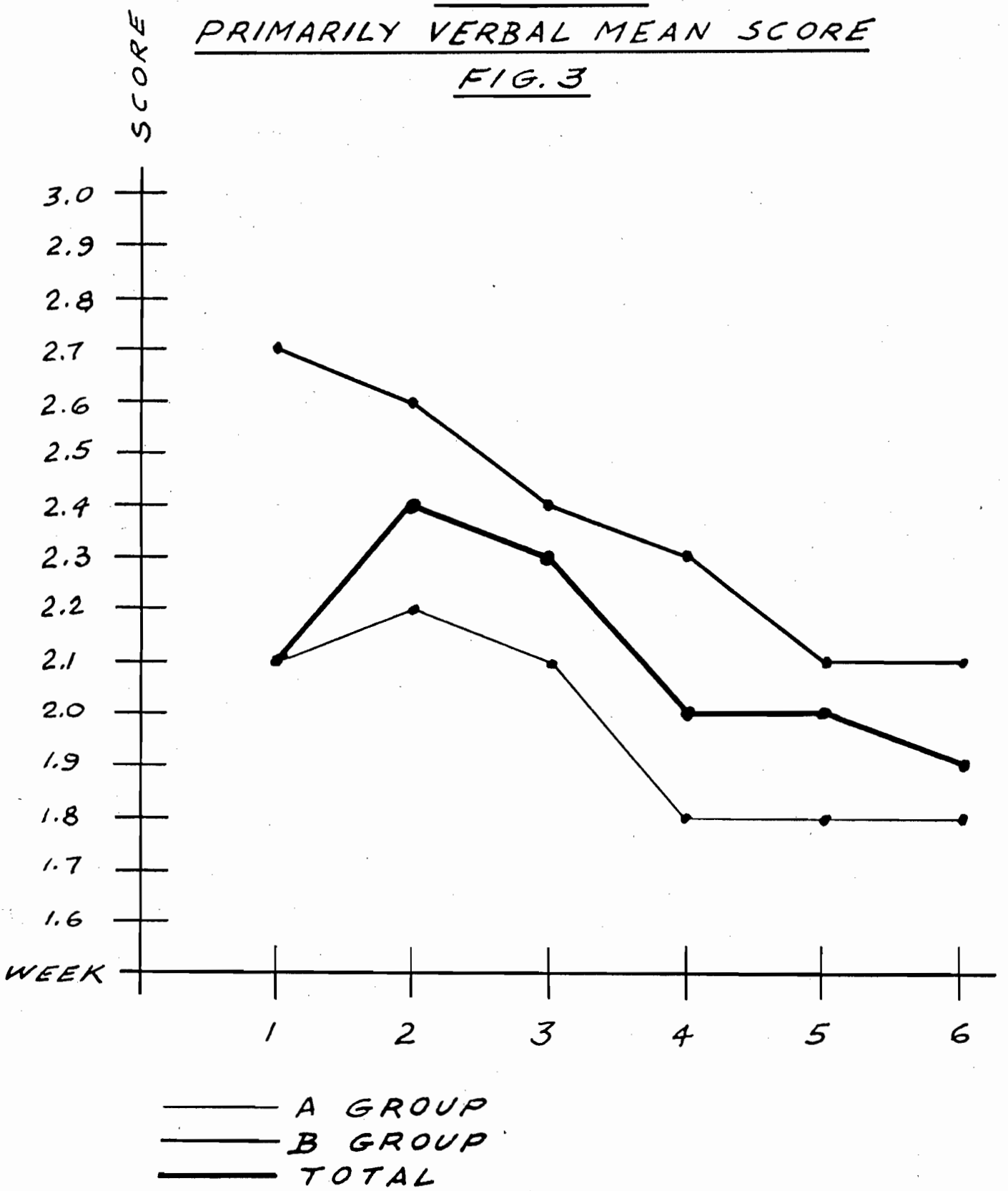
Table 8 and Figures 3 and 4 indicate a clearly visible decrease in the primarily verbal and nonverbal scores over each treatment period for both groups. An analysis of variance[1] was performed on these results. It is presented in Table 9.

[1] Music STATPAK Reference Manual, p. 93.

A-SCALE

PRIMARILY VERBAL MEAN SCORE

FIG. 3



A-SCALE

PRIMARILY NON VERBAL MEAN SCORE

FIG. 4

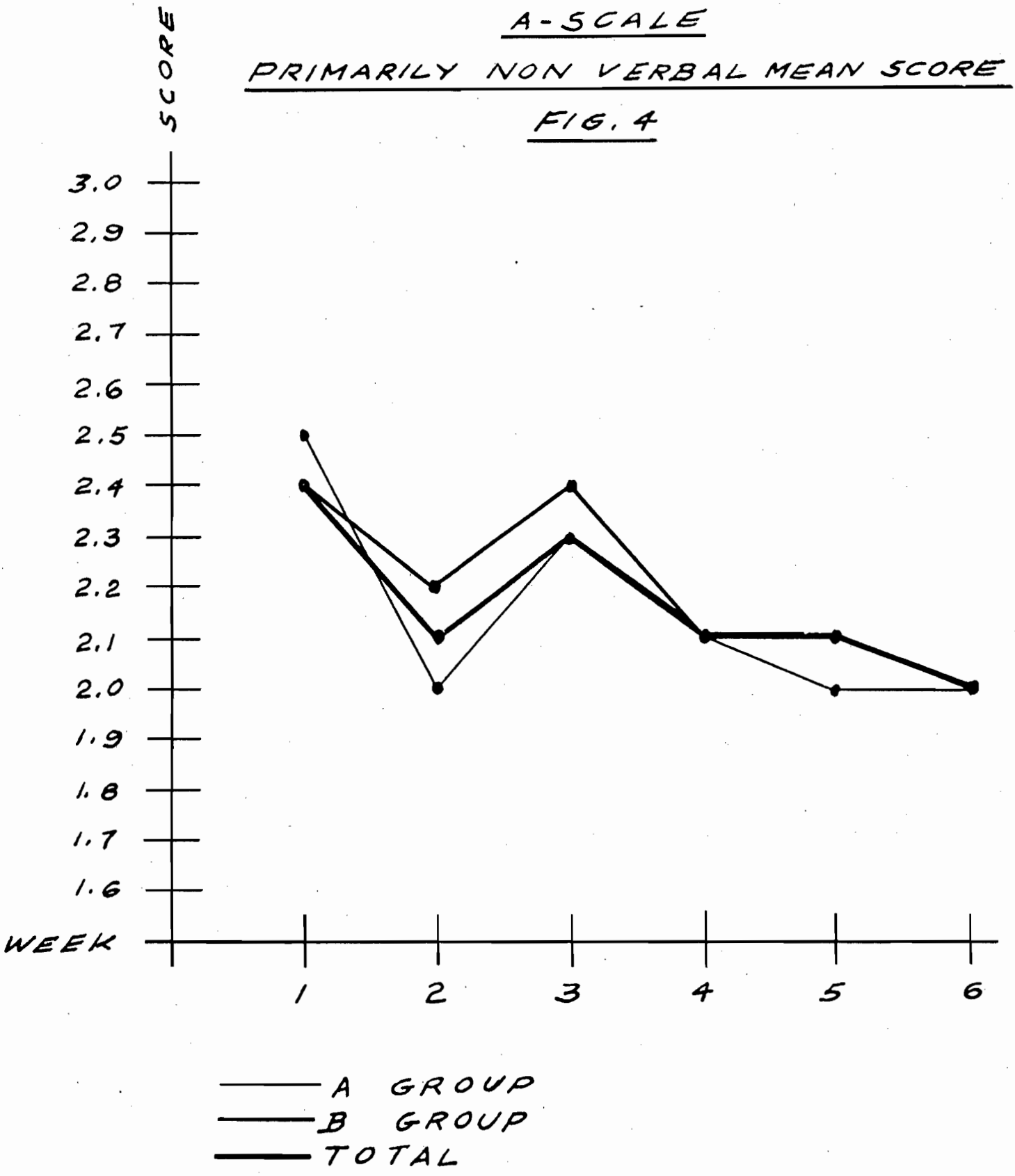


Table 9

A-SCALE ANALYSIS OF VARIANCE

Source of Variation	Sum of Squares	Degrees of Freedom	Mean Squares	Error Term	F-Value
Activity	8.2	1	.82	Activity x Subject Interaction	1.0
Week	14.2	5	2.8	Week x Subject Interaction	14.8[a]
Activity x Week Interaction	.9	5	.17	Activity x Week Subject Interaction	1.3
Subject	190	34	5.6		
Activity x Subject Interaction	27.8	34	.81		
Week x Subject Interaction	32.6	170	.13		
Activity x Interaction	23.0	170			
Total	296.7	419			

[a] $p < .001$ d.f. 5.2

Note: Even using the more conservative test (d.f. 1.34) to allow for the possibility of non-homogeneity of covariance, this is still significant ($p < .01$).

Table 9 showed a significant main effect for Time 1. This demonstrated the difference over time from Week 1 to Week 6 which was of statistical significance for both treatment groups. The analysis of variance indicated that there was no significant overall difference between primarily verbal and primarily nonverbal scores on the A-Scale. Also noted was the fact that there was no significant interaction between type of score and week.

In summary, the key results are that there are no significant changes on the Nursing and Groupworkers D-Scale. Factor 4 Verbal Competence, of the Nursing D-Scale showed a significant level of change at Time 2 for Group A only. The A-Scale showed a significant level of improvement between Week 1 to Week 6, for both treatment groups. There were no significant differences found between the primarily verbal and primarily nonverbal scores on the A-Scale.

CHAPTER V

DISCUSSION

Interpretation of Findings

Until recently, it was felt that very little could be done to help the senile aged. The symptoms of senility were considered part of the aging process, "irreversible," and therefore "untreatable."

A review of the existing studies, especially the literature on reality orientation therapy, lead to the conclusion that besides custodial care, other forms of treatment might help the regressed senile patient. From their personal observations, the investigators had noted that regressed patients seemed to be more alert and responsive during structured activities. From this grew the view that through frequent interaction with, and stimulation of regressed patients, they would begin to function at a better level.

The hypothesis of this study was that through participation in small group activity, the patients' inappropriate

behavioural characteristics would diminish and their overall functioning level improve. More specifically, it was of interest to find out if this improvement would be only within the confines of the activity groups or would be seen in the patients' functioning on the ward as well. The results of this study show that significant gains in patients' behaviour occurred while patients were involved in the small group activity program. The positive effects of the program were not carried over onto the ward.

The importance of almost any kind of stimulation to regressed patients is substantiated not only by the present study, but also by the other studies already cited.[1]

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[1] Supra, pp.4-33.
The various modes of treatment can be summarized as follows: group psychotherapy, such as the studies made by Linden, Rechtschaffen et al.; a multi-sensory approach used by Lipsky et al.; a party atmosphere with food and music used by Silver; the use of liquor to improve sociability and interaction used by Kastenbaum et al.; the sensory training method used by Downey; occupational and social therapies used by Cosin et al.; discussion and sensory stimulation as used by Manaster; exercise as the main form of intervention used by Powell; remotivation therapy as used by Bowers et al.; concepts of remotivation therapy along with components of behaviour modification and groupwork as used by Mueller et al.; and reality orientation therapy as used by Folsom and reality orientation therapy classes only as used by Phillips and others.

The A-Scale was used to determine how well patients performed while engaged in the activity group. The A-Scale total score demonstrated that there was an improvement to a statistically significant degree in the manner in which the patients' behaved at the beginning and conclusion of the treatment period. However, the success of treatment was reflected only during participation in the groups.

The improvement of patients' level of performance in the activity program may be related to the unique aspects of the program. These were based on reality orientation principles, along with the concept of familiar activity related to former life experiences. It had been noted by the investigators that reality orientation classes, although useful and helpful, can become quite mechanical and routinized.[1] By placing heavy

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[1]This had been noted by a social worker during her attendance at a reality orientation training program in Tuscaloosa, Alabama. During an observation of a session, seen through a one-way mirror, the patients were assembled in the room for their daily reality orientation class. One patient commented upon the fact that they were in a new classroom. The groupworker did not pick up the significance of this remark made by the patient, let it pass without reinforcement, and then proceeded with the usual reality therapy routine, such as the basic review of information--that is, name, date, place, etc.

emphasis on a patient's basic information about himself, such as his name, age, marital status, date, time, place, etc., the patient can sometimes be unaware of the meaning of this information. It was found that a patient often repeated information mechanically, rather than seeming to be able to integrate information as having special meaning for himself. In order to avoid this mechanical approach, it appeared that, in addition to having patients relearn basic information about themselves, it was important for the small group activity program to allow for some spontaneity by the group-worker as well as the patients. Engaging the patients in familiar activity seemed to be a better way of reaching them, than just having them repeat information without understanding its relevance.

The A-Scale was divided into primarily verbal and primarily nonverbal activities. The results of the A-Scale scores showed no statistical difference between the primarily verbal activity and the primarily nonverbal activity. This perhaps may be explained by the fact that even in nonverbal activity there was a large verbal component.

In addition, there were many common features in both types of activity. As already noted, all the groupworkers

played an active role in engaging the patients in the group activity on a one-to-one basis; all groups were small in number; a reality orientation approach was used in interaction with the patients; the focus of each activity group was to have the patient be aware and respond appropriately to the activity; and the groupworker used a specific approach when interacting with patients.

The improvement in patient behaviour, as measured by the A-Scale, could be seen by more frequent appropriate responses to verbal commands, contents of the activity, whether verbal or nonverbal, and interactions with each other and with the groupworker. Patients were observed to be less withdrawn and less frightened in some cases, and less noisy and aggressive in others. The feeling tone of the groups toward the end of treatment were calmer, yet, at the same time, the patients were more appropriately animated.

The D-Scale was developed to measure the level of dementia of patients. It was used in this study to determine if patients' behaviour improved after participation in the treatment program.

The results were that no overall significant differences occurred on the Nursing D-Scale for both treatment groups, which reflected no changes in patient behaviour on the ward after being exposed to treatment.

Other studies already cited have shown similar results. Cosin et al. found that positive results observed during treatment were not sustained after treatment was discontinued.[1] Lipsky et al. found that patients did well when they were stimulated and busy but this discontinued as soon as the activity was terminated.[2] Manaster reports that his group's progression was not a steady one. One session might end on a high note and at the next session, the groupworker would have to begin all over again.[3] Barnes felt that although his study did not show a significant level of positive improvement, the trend was "towards significance and a longer period of therapy would be expected to lead to more noticeable change." He concluded that additional stimulation, besides the reality orientation classes, and greater staff involvement would have shown more significant patient improvement.[4]

In order to explain the findings on the D-Scale, one might speculate that the period of treatment (6 weeks) was not long enough. Had the program been continued for a longer testing period, the positive gains made during the activity

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[1] Supra, p. 24.

[2] Supra, p. 19.

[3] Supra, p. 6.

[4] Supra, p. 28.

program might have been transferred to the patients' behaviour on the ward.

Another explanation might be that each activity group was held for no longer than 45 minutes and that most subjects participated in no more than one activity group daily. This is minimal when one considers that there are 24 hours in each day. Due to the short memory span of the patients, it was not possible to have an activity period that lasted longer than 45 minutes. However, it might be suggested that if activities had been offered three times each day--that is, the morning, afternoon and evening--the added activity groups might have improved patients' behaviour which would have been reflected in the D-Scale.

The negative results on the D-Scale may be related to the fact that significant changes in patients' behaviour can only happen if everyone involved with the patients is considered part of the treatment team. Activity groups, isolated from other routines, do not appear to be sufficient. From the results of the D-Scale, one could conclude that any gains made by the patients while participating in the activity groups were lost once they were returned to the ward. Perhaps improved

changes can only occur with total staff involvement. If the staff on the third floor at Maimonides Hospital had been trained in reality orientation technique, the method of interaction used in the groups would have been continued on the ward with an increased treatment potential.

Reality orientation includes reality orientation classes, attitude therapy, consistency of approach, which all involve individualized treatment plans for each patient. All of these ingredients are seen as beneficial. However, the only change suggested by the investigators is that activity groups, as defined by this study, be substituted for reality orientation classes, as defined by Folsom.[1]

The D-Scale was divided into four factor scores. They covered orientation, activities of daily living, emotional stability, and verbal competence. The investigators were interested in finding out whether there would be changes in any of the factor scores as a result of the therapeutic intervention. They speculated that because of the short treatment period there would be no significant changes in the D-Scale. The only factor in which some improvement might occur was Factor 4, item 26

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[1] Supra, p

(linguistic expression) and item 27 (understanding), because of the active and regular intervention between groupworker and patient, and the emphasis placed on patients' interaction with each other.

Contrary to their expectations, the Nursing D-Scale indicated a significant level of change in the unanticipated direction for Factor 4 on the D-Scale for Group A only--a deterioration (increase in score) rather than an improvement (decrease in score) in Factor 4. These unanticipated changes were counter to the results found in the A-Scale, which show a significant level of improvement in patients' participation during the treatment program. Perhaps this occurred because there was a different rater for Group A at Time 2. This rater may have had a different criterion for rating the D-Scale than the rater at Time 1 and Time 3. The basis of judgment of spoken words may have been more vigorously applied by the rater at Time 2. This suggests the need and importance for trained and consistent raters, supporter by inter-rater reliability. The increase of these Factor 4 D-Scale scores can be seen as an artifact of uncontrolled introduction of a rater not oriented to the purposes of the project.

Although the groupworkers' ratings on the D-Scale did not show any significant level of change, the trend seemed to indicate a decrease in total mean score from the beginning to the end of each treatment period for both Groups. This may be related to the groupworkers' vested interest in showing such change. Balancing such bias is the groupworkers' better knowledge of patient functioning in the area of orientation, verbal, and linguistic expression. At the same time, it is important to acknowledge a less adequate appreciation of the physical aspects of patient functioning by the groupworkers. Indeed, the groupworkers were observed questioning nurses about the physical variables during completion of their D-Scale ratings.

As a result of the different orientation and training between groupworkers and nursing staff, it is felt that if this study is repeated, only the nursing staff should complete the total D-Scale, being the most knowledgeable about areas of patients' functioning. It would also be recommended that an abbreviated instrument be devised for the groupworkers to complete, which would test the areas of orientation, verbal and linguistic expression, and understanding.

Observations made During the Study

The nursing staff was very cooperative throughout. Patients' routines were scheduled around the program so that they were always available for their scheduled activity. The staff's keen interest led some of them to observe, to help, and even to participate in some of the activity programs. In addition, they would sometimes initiate simple parallel activities on the ward.

At about this time, special classes were offered to untrained nursing personnel, such as nursing aides and orderlies. The purpose of these classes was to help the aides and orderlies improve the level of care being given to the patients and to place more emphasis on their psycho-social needs. These classes were not related in any way to the study but may have had a positive affect on staff performance and general attitude during the course of the experiment.

While there was an increased general interest in patients by the nursing staff, this interest seemed mostly focused on interactions with those patients who were more alert and more responsive. It was recognized that such selective attention might influence the D-Scale ratings and affect

decisions on whether or not changes in patients' behaviour had occurred. In order to check the possibility, the total Nursing D-Scale scores were separately ranked at Time 1, Time 2, and Time 3. It was found that the highest rank scores were just as likely to show improvement or no improvement as were those with the lowest rank, regardless of the time of the ranking. This negated the observation that those patients who were more alert received more interactional attention from the nursing staff.

The results of this study indicate that small group activity programs for institutionalized geriatric patients have a beneficial effect within the confines of the activity, but that the gains made are not carried over onto patients' behaviour on the ward. Thus, the overall conclusion resulting from the investigation is that the positive effects of the small group activity intervention with regressed senile patients is as yet not firmly supported.

CHAPTER IV

SUMMARY

This study tested an alternative form of active treatment for the senile geriatric institutionalized patient--a mode of treatment which would do more than merely give custodial care to these patients. Based on the premise that patients function at a better level when they receive active stimulation, a small group activity program was developed. The mode of interaction was based on the concepts of reality orientation therapy. The notion that patients would respond to activities which had some relevance to their early life experiences was integrated into the program. The groups involved no more than seven patients to provide a maximum opportunity to individualize treatment.

The aim of the study was to determine whether patients would improve their behavioural responses to a regular daily activity program. It was thought, as well, that this improvement might carry over in other areas of functioning.

The cross-over design was chosen as a method of testing because it permitted before, after, and follow-up comparisons of treated patients with untreated patients. This design also allowed for comparison of pre and post treatment periods.

The results of the study showed that although there was significant change towards positive behaviour during the treatment period, this improvement was lost after the activity was terminated.

Beneficial effects of small group intervention with senile patients by itself has not been demonstrated. Extended treatment periods, along with a total reality orientation therapy program in which all staff members were trained and involved, is indicated in order to have the effect of not only preventing further regression but also improving the patients' level of overall functioning.

APPENDICES

APPENDIX A

MANUAL

FOR USE WITH THE DEMENTIA RATING SCALE (D-SCALE)

Introduction

This manual has been produced in order to provide a more complete list of behavioural descriptions relevant to this scale, and to answer some of the questions which may arise amongst the rating staff.

Included are:

1. a guide to the circumstances under which the rating scale will provide the best results.

2. descriptions of each of the symptoms to be rated.

3. some criteria of symptom severity to provide a guide to more exactly when an item should be scored.

It is suggested that each rater may be interested in reading this pamphlet, and also that it would be useful to keep a copy at the nursing station for reference when necessary. Naturally, questions will still arise which are beyond the scope of this manual. You may also have some useful suggestions as to how the scale could be further improved. In either situation, please do not hesitate--make your thoughts known because the efficient use of this scale can help both patient and staff.

The Scale

The D-Scale consists of 29 items each of which is more or less commonly associated with the patient described as geriatric, senile, disoriented and confused. That is to say these people are elderly with an added impairment due to "encroaching senility". Not all behaviours associated with dementia are included, but a sufficient list is provided to cover most patients.

Each item can be rated as positive or negative with reference to a patient at a particular time. A zero implies that observed behaviour in this area is good, whilst a score of 1, 2, or 3 shows the degree of loss of that ability--1) being a minimal loss, 2) being a moderate loss and 3) being a maximal loss. Thus, over the whole test, the higher the score then the more deteriorated has the patient's behaviour become. (This score can be used in a number of ways. For example, to compare one patient with another, or to look for improvement or deterioration over time.)

Filling in the Scale

It is best to get to know the patients' general level of functioning before filling in the scale then, when completing the items, you will be able to more freely represent just how the patient usually functions. The D-Scale should be used to describe the patient's behaviour over an extended period so as to give an overall view and not a transitory peak or valley.

Following you will find a list of the items, each with a description of the type of behaviour looked for. Alternative questions may be used when necessary, but this alteration of procedure should be noted.

Symptom List

1. This question "Where are you now?" is asked of the patient, with a follow-up query in the event of a doubtful reply. Scoring is defined in the scale, only the reply of "hospital" earning a zero score.

2. Confusion of other patients as staff members, or of the staff as patients sometimes occurs. Clothing can sometimes cause the doubt but if the patient is unable to recognize the uniform or services of the staff members then a positive score is given this item.

3. 3A. 4 & 5 Ask the patient season of the year, month of year (i.e. holiday), day of week and year.

6. This item is explained in the scale.

7. The bathroom is a convenient target in this question, but other disorientation may be noted.

8. "How old are you?" followed by, if necessary, "You were born in _ _ _ _ _ _, how old does that make you?" Note the need for the additional query when used.

9. Loss of memory for own name is the criterion to be used here. This is, of course, a severe loss probably met with in only a few cases.

10, 11, 12, 13, and 14. These behaviours would be seen by different shifts, hence the importance of getting to know "your" patient. Use nursing notes when necessary. Note the phrase "for reasons other than physical illness".

15. Differentiate this item from No. 14)--by the existence of agitation. If confined to a chair, the patient may exhibit a restless head or hand movement in the same agitated manner sufficient to score this item.

16. Lethargic movement, or contentment to stay in one place, are to be noted here. Again remember, "for other than physical reasons". Please note if you consider the behaviour due perhaps to a change in medication or depression, etc.

17, and 18. These may be hard to catch if the patient thinks he (she) is being watched. At other times the behaviour is more blatant and easily observed. The key words here are "purposeless repetition".

19 and 20. This copying is also sometimes difficult to observe. Observation of the patient in his (her) everyday activity is often required to note this adequately.

21. Sudden changes from cheerfulness to tears, or inappropriate emotions triggered by seemingly unimportant happenings, are fairly commonly observed, and may be best noted by engaging the patient in conversation for a short while.

22. Much more profound changes than those noted in No. 21 are sought here. Literally "catastrophic" alterations in usual behaviour may sometimes result from a change of dorm or ward, or even less meaningful events.

23. This item is most difficult to define, and the use of the item is probably most meaningful when accompanied by your description of the behaviour observed. Basically though, inappropriate (in extent or frequency) hostility towards staff or other patients is the criterion. Bear in mind that normal tensions between patients should be ruled out (e.g. where one patient is awakening others in a dorm, etc.).

24 and 25. Fairly self-explanatory.

26. Stumbling over words or inability to name a fairly common object are required to score here. Carry a variety of objects to try out here, e.g. book of matches, coin, or a pin. Often the patient will be able to describe the function of the object without giving the name, but the latter is required for a zero score.

27. Unusual, but worth including, is this item. Scoring this should arise from attempts to administer the other items.

28. Confabulation - seemingly convincing tales found to be untrue but used to conveniently fill in gaps of memory.

29. Hoarding - secretive hiding of non-precious objects, often wrapped in many layers of tissue.

To end, a general warning against thinking that the patient is "same as always". Often a small change is sufficient to alter the clinical picture presented, thereby warranting therapeutic changes, or more close observation. So please, forget the last time that you filled in the 'D' scale for an individual, and start afresh.

APPENDIX B

A DEMENTIA RATING SCALE (D-SCALE)

Symptom List

1. Disorientation to place _____
(Where are you now - If the patient fails to reply or gives irrelevant reply - Are you in a school, a church, a hospital or a house? Only the alternative "hospital" earns a zero score).

2. Disorientation to people _____
(Ability to distinguish staff from patients scores zero).

3. Disorientation to time _____
(Year) _____
(Season) _____

4. Disorientation to time _____
(Month).

5. Disorientation to time _____
(Day).

6. Disorientation to time of day _____
(Morning, afternoon, evening. Consider meals--lunch and supper as cut-off points).

7. Disorientation to inside surroundings _____
(Inability to find bathroom).

8. Disorientation to own age _____
(Within five years earns zero score).

9. Loss of personal identity_____
(Patient does not know who he is).

10. Eating _____
(Inability to feed himself without assistance for reasons other than physical illness).

11. Dressing _____
(Inability to dress himself without assistance for reasons other than physical illness).

12. Incontinence _____
(Incontinence of urine during the day).

13. Sleep_____
(Repeat of P.R.N. hypnotic required).

14. Wandering_____
(Patient roams aimlessly through the hospital or ward).

15. Motor restlessness _____
(Pacing or agitated behaviour).

16. Slowing of motor function_____
(For other than physical reasons).

17. Motor perseveration_____
(Purposeless repetition of a movement).

18. Verbal perseveration _____
(Purposeless repetition of a syllable, word or phrase).

19. Echopraxia _____
(Copies the movements of others).

20. Echolalia_____
(Copies verbal utterances of others).

21. Emotional lability _____
(Inappropriate and sudden change of emotional expression).

22. Catastrophic reaction_____
(Affect of inappropriate intensity in response to inconsequential events).

23. Aggression _____

24. Inability to write own name_____
(Cannot sign name for other than physical reasons).

25. Inability to read_____
(Cannot read "The grass is green" for other than physical reasons).

26. Linguistic expression_____
(Noticeable difficulty in word finding or object naming).

27. Understanding_____
(Inability to understand spoken word).

28. Hoarding _____

29. Confabulation_____
(Talking and answering inappropriately).

APPENDIX C

GROUP ACTIVITY RATING SCALE (A-SCALE)

Rating Instructions

1. Patient responded and participated fully in activity.

   Examples: Patient communicated well on a verbal level.
   Patient showed appropriate verbal behaviour.
   Patient showed appropriate nonverbal behaviour.
   Patient fully aware of group members and leaders.

2. Patient participating in activity some of the time.

   Examples: Unable to engage in activity on his own but would do so with help.
   Needed some encouragement and attention to elicit a response.
   Patient able to participate in the activity for short period of time.

3. Patient aware of activity but not participating actively.

   Examples: Patient unable to engage in activity on his own.
   Patient needed much encouragement and individual attention to elicit a response.

4. Patient did not respond to the program at all.

   Examples: Inappropriate behaviour
   slept during activity
   leader unable to elicit any response
   unaware of group and surroundings.

GROUP ACTIVITY RATING SCALE (A-SCALE)

Patients' Names							
Primarily verbal activity:							
story-telling							
discussion							
religious program							
music							
other							
TOTAL							
Primarily nonverbal activity:							
cooking							
arts & crafts							
exercise program							
games							
other							
TOTAL							
Overall Participation							

Week Ending _____

Groupworker _____

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