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THE EFFECTS OF VALIDATION VERSUS REALITY ORIENTATION APPROACHES
IN MUSIC THERAPY WITH DISORIENTED ELDERLY ADULTS

by

Debra Diane Harvey

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Master of Music Therapy
School of Music

Western Michigan University
Kalamazoo, Michigan
December 1984

THE EFFECTS OF VALIDATION VERSUS REALITY ORIENTATION APPROACHES
IN MUSIC THERAPY WITH DISORIENTED ELDERLY ADULTS

Debra D. Harvey, M. M.

Western Michigan University, 1984

The purpose of this study was to investigate the effects of Validation and Reality Orientation in a music therapy setting with disoriented elderly adults. Subjects (age 80 and older) were divided into four treatment groups, two each of Validation and Reality Orientation (total $n=19$). The groups met for thirty minutes, five days a week, for six weeks. Pre and posttest measures of orientation, ego integrity, and behavior were compared using a one-way analysis of variance on mean gain scores. Results showed a significant improvement ($p<.05$) on the measure of ego integrity in the Validation treatment groups. No other significant differences were found for either treatment group on the measures of orientation or behavior. Recommendations for further investigation include more attention to specific levels of orientation and behavior prior to treatment, and the use of a larger sample population.

ACKNOWLEDGEMENTS

This project would not be complete without the formal acknowledgment of several people to whom I am deeply indebted. First, I would like to acknowledge Ms. Naomi Feil, who had the wisdom and insight to develop the theory behind Validation/Fantasy Therapy. I must also acknowledge Ms. Marlene Peoples, whose previous research in the field served as a model for the present study.

I would like to extend my heartfelt gratitude to Ms. Corinne O'Heran, whose dedication to quality helped make this study sound and whose assistance played a vital role in implementing treatment. My sincere thanks also go to the entire Health Center staff at Friendship Village, for without their efforts and support this project would not have been possible.

Next, I would like to thank my committee members, Mr. Brian Wilson, Dr. James McCarthy, and Dr. Ellen Page-Robin. Their valuable advice and thoughtful suggestions made significant impressions on almost every aspect of this thesis.

To Dr. Robert Ricci, my friend and mentor, I offer my appreciation for his firm encouragement and support which were the source of my motivation throughout the course of this project and in the years preceding it.

And finally, in the memory of my late father, Mr. Gerald B. Harvey, whose love and talent for music inspired my career, I dedicate this work.

Debra Diane Harvey

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ADULTS

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CHAPTER I

INTRODUCTION

Since Public Law 94-142 mandated that handicapped children receive an appropriate education in the least restrictive environment, mainstreaming has become popular (Latham, 1987). The impact of this legislation on the majority of learning disabled (LD) students is that at least part of their school day is spent in a special education setting receiving instruction designed to improve upon regular classroom performance (Anderson-Inman, 1986). For special education services to be considered successful, academic and behavior gains must transfer or generalize from special education settings to mainstream regular classrooms. Generalization has been defined by Stokes and Baer (1977) as "the occurrence of relevant behavior under different, non-training conditions (i.e., across subjects, settings, people, behaviors, and/or time) without the scheduling of the same events in those conditions as had been scheduled in the training conditions" (p. 350).

Evidence indicates that expectations of naturally occurring generalization across settings are in error; it appears that transfer of training rarely occurs unless it has been purposefully programmed (Ellis, Lenz, & Sabornie, 1987; Horner, Sprague, & Wilcox, 1982; Rose, Lessen, & Gottlieb, 1982; Stokes & Baer, 1977). Inconsistent generalization is one of the factors contributing to the Regular Education Initiative (REI), which advocates leaving many

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PREFACE

What is reality? Each of us has, at some time, identified our own criteria of what constitutes this elusive concept. Often these criteria are as unique as we ourselves are as individuals. In many cases, what to one is reality may indeed be fantasy to another. To the Christian, God is real; to the infidel He does not exist. To the child, Santa Claus is real; to the adult he is only a legend. But have we not, as parents and adults not only contributed to the fictional reality of Santa Claus, but served as the source of his origin as well? Often, we justify this by claiming to heighten the child's enjoyment and thus his quality of life. Unfortunately, however, these justifications cease to exist when dealing with certain elderly adults.

For some elderly, distinguishing the difference between reality and fantasy can often be a frightening encounter. Dreams, memories, the effects of medication and other changes may all act as sources for distorted perceptions of what was once thought of as acceptable reality. But are there not other aspects of reality, perhaps intangible ones, in each person's pursuit of successful aging? Should we not as health care professionals begin to look at how to approach these different aspects? And can we not as music therapists, use our medium as a catalyst for treatment? These questions served as the major impetus for initiating this study.

Debra Diane Harvey

of grading, but practices vary considerably on variables such as educational philosophy, grading purposes, factors evaluated, personal biases, and conformity to administrative policies which influence grade assignment. Different kinds of grading behavior exhibited by teachers may create dissimilar classroom environments, making the transition from the special education classroom to the regular classroom difficult and confusing for the mainstreamed student (Crowl & Berkowitz, 1985). Thus, grading differences across classroom settings could be a factor in generalization problems.

Mainstreaming has stimulated controversy regarding the reporting of grades for handicapped students in regular classrooms. Some educators believe that when a student's handicap affects the ability to learn and perform in regular classes, mainstream teachers should use alternative means to measure learning (Carpenter, 1985; Kiraly & Bedell, 1984). Crowl and Berkowitz (1985) found that special educators were more likely to believe that different standards should be used in grading handicapped students than regular educators. They concluded that mainstreamed students may frequently be moving from an environment where teachers consciously take students' uniqueness into account to an environment where teachers attend to individual differences among students to a far lesser extent. Regardless of mainstream teachers' grading policies and practices, the reality is that students are dependent upon grades as a major indicator of progress. Grades earned by mainstreamed students are therefore an

disoriented. The more they begin to ignore the world around them, the less the world reacts to them. As interaction decreases, the inside world becomes more real and the ability to discriminate reality from fantasy leads to the label of disoriented. (p. 213)

Maloney and Bartz (1982) also add:

Another integral problem among the aged is the diminishing performance of short-term memory. The ability to maintain contact with the environment becomes more difficult as short-term memory loss becomes more prevalent. Failure to meet the constant demands for cognition and perception causes the aging person to develop diminished self-awareness, decreased self-esteem, and perhaps, a pathological state of consciousness. (p. 404)

There is growing speculation, however, that mental decline among the institutionalized elderly is not an inevitable function of aging. Many factors may contribute to confusion and disorientation, and some of these causes can be treated. Certain social, emotional and physical causes may be reversed if appropriate and timely intervention is realized. The many traumas associated with relocation to a nursing home, for example, may lead to symptoms of anxiety, depression and disorientation which can be reduced if recognized and treated.

Mental problems among the elderly can, however, be troublesome when one attempts to determine the appropriate means of treatment. Registered nurses consistently identified patient confusion as the most difficult problem regarding geriatric nursing care (Nourse, Deia, Argual, 1978). Unfortunately, little attention has been directed to research in this area other than that of a pharmaceutical nature.

One form of intervention which has proven beneficial in the treatment of mental health problems for all ages is group therapy. Settin (1982, p. 568) states that "the greatest advantage of group therapy from

a mental health standpoint lies in its theoretical underpinning: to allow dynamic problem sharing and solving to occur within a therapeutic community." While group therapy is not common among the elderly, the effectiveness of the approach is shown in a growing number of research studies. Burnside (1976), Nathanson (1969), and Bowers (1967) all show that group work can have positive effects on psychosocial adjustment behavior and the quality of life among the elderly. And, according to McMordie & Blom (1979), elderly patients respond best in structured group settings.

More specifically, Butler & Lewis (1982) note that groups are especially useful in decreasing the sense of isolation and uselessness felt by many elderly persons. In addition, Lindell (1976) also demonstrated that the self-concept of the institutionalized elderly could be improved through group therapy. Shaw (1979) reported results from a variety of studies which found group work to be effective in attaining a former level of cognitive and behavioral functioning, as well as increasing self-esteem, resocialization, remotivation, reality orientation and communication skills. And, Manaster (1972) also found positive changes in behavior, attitude, expression of feelings and sense of identity in senile, deteriorated patients in group settings. Thus in summary, one can clearly see that a variety of positive results can be attained through group therapy with the elderly.

Other forms of therapeutic intervention have also been used successfully with the geriatric population including music therapy. Needler & Boer (1982, p.9) reported that "the combination of music, movement, and

CHAPTER II

METHOD

Subjects

Three LD students attending a local junior high school were recommended for participation in the study by a special education teacher. All three students were participating in some mainstream classes in addition to special education classes.

Subject 1 was a fourteen-year-old seventh-grade female. She was enrolled in three special education courses including Expressive Writing, Mathematics, and Skill Development. Her mainstream classes were Social Studies, Music, and Physical Education.

Subject 2 was a fifteen-year-old eighth-grade male. He was enrolled in special education Reading, Expressive Writing, and Mathematics classes. His mainstream courses included Science, Home Economics, and Physical Education.

Subject 3 was a thirteen-year-old seventh-grade female. Her special education courses included Comprehension, Skill Development, and Mathematics. Her mainstream courses were Science, Home Economics, and Physical Education.

Setting

The primary method of teaching in all of the subjects' special education courses, except Skill Development, was Direct Instruction.

involves. They found that people breathe more deeply when they vocalize or sing which results in an increased intake of oxygen and improved blood circulation. This in turn stimulates the mental processes. In addition, singing warms the vocal cords according to Bright (1972). Also, when people are comfortable with the sound of their voices, they are more willing to participate more fully both physically and verbally (Needler & Boer, 1982).

A review of the problems and changes noted in the studies above reveals certain specific target areas for treatment intervention. These areas include a variety of appropriate social and emotional behaviors, as well as increased positive attitudes towards one's self and one's environment. In light of the research cited above, the present study was designed to compare two different treatment approaches in a group music therapy setting with disoriented elderly adults. The effects on measures of orientation to reality, ego integration, and observable behavior were compared.

THE PROBLEM AND ITS SETTING

The Statement of the Problem

This study explored the differences in the effects of a Validation/Fantasy Therapy approach and a Reality Orientation approach during music therapy sessions with disoriented elderly adults. Both treatment approaches were measured to determine the effectiveness of reestablishing the subject's orientation to reality; in aiding the subject to reach ego integrity in the context of Erikson's final life stage; and in changing behaviors characteristically associated with disorientation in the elderly.

The Subproblems

The First Subproblem

The first subproblem was to compare mean gain scores of the Tool for Assessing Degree of Confusion in the Elderly for the two treatment groups. This tool measures the subject's orientation to reality.

The Second Subproblem

The second subproblem was to compare mean gain scores of the Ego Integration Scale for the two treatment groups. This scale measures the degree of ego integrity as related to Erikson's final life stage.

Points were assigned to each response recorded by subjects on the self-monitoring checklist. In Part 1 "Yes" responses were scored as 1 point, while "No" or "N/A" responses were scored as 0 points. For Part 2 "All of the Time" responses were scored as 4 points, "Most of the Time" responses were scored as 3 points, "Sometimes" responses were scored as 2 points, "Hardly Ever" responses were scored as 1 point, and "None of the Time" and "N/A" responses were scored as 0 points. The scores for Parts 1 and 2 were each converted on a weekly basis to the percentage of possible points that could be awarded and were plotted on a graph. The total number of points possible per week was 40 for Part 1, and 120 for Part 2.

Independent variable

Criterion-referenced study skill training was the independent variable. Study skill topics were determined by the results of the survey completed by mainstream teachers. The Science teacher for Subject 3 was not surveyed because his student was not originally selected for participation in the study. The Social Studies teacher for Subject 1 and the Science teacher for Subject 2 both identified Concentration, Time Management, and Recall skills as most important for success in their classrooms. These topics were therefore selected as the study skills to teach. They are covered in Chapters 2, 3, and 4 in Bragstad and Stumpf's (1987) book. All exercises and materials described in these chapters were used in study skill

The Delimitations

The subjects in this study were limited to patients in the Friendship Village Health Center during the course of treatment. Caution should be observed when attempting to generalize results beyond the scope of this population.

The intent of this project was to examine differences in two treatment groups. It must be realized that in a short-term project such as this, results are limited accordingly. It is possible that research conducted over an extended period of time would prove more effective, but it was hoped that in the light of stringent daily treatment, this deficiency would be somewhat remedied.

The possibility of confounded effects due to lack of control for the effect of the therapist's personality must also be recognized. No reversal of therapist and treatment group test was made. It was thought, however, that since the approaches differ stylistically and philosophically, effects could reasonably be attributed to the treatment exclusively. This interpretation also eliminated the possibility of researcher bias.

Musical selections for each of the two treatment groups were made in accordance with the particular approach each treatment requires. The purpose of the study was to determine the differences between the total treatment approach and not necessarily the type of music which was utilized within each group.

It should also be noted that the two treatment approaches were not applied in the strict sense of their definitions, but rather that certain

intrinsic aspects of their basic philosophical styles were adopted to accommodate the music therapy setting.

The Definition of Terms

Reality Orientation

This term refers to the procedures, developed by Folsom and Taulbee, designed to eliminate disorientation through a behavioral approach. Structured orientation to the spheres of time, place and person involves the elderly adult in a return to reality.

Validation

This term refers to the procedures, developed by Feil, designed to help the disoriented elderly achieve ego integrity and increase their sense of dignity. The theory is based on an existential, client-centered approach using empathy and acknowledgement of expressed feelings. It may also be referred to as Validation/Fantasy Therapy.

Ego Integrity

This term refers to Erikson's final life stage, wherein a blending of the past and present allows the elderly adult to gain inner strength and a sense of resolution regarding past conflicts.

Disoriented

This term refers to the individual who is confused with regard to his present state of being.

Subject 2 received study skill training from the 20th day through the 34th day of the quarter. The order of his skill training was Time Management, Recall, and Concentration.

Subject 3 participated in study skill training sessions from the 25th through the 38th day of the quarter. The order of her training was Recall, Time Management, and Concentration.

Each subject continued to fill out self-monitoring checklists daily in mainstream classes during training.

Baseline 2

Subject 1 filled out self-monitoring checklists until the 38th day of the quarter. Subjects 2 and 3 filled out checklists until the 44th day of the quarter.

Maintenance

Percentage correct grades in mainstream classes were calculated until the 52nd, or last, day of the quarter.

Agreement

Daily ratings by students and teachers were made on the same self-monitoring checklist form. Ratings were therefore not independent. However, an agreement formula was used to determine how well ratings between subjects and mainstream teachers corresponded. The following formula was used on the first four items in Part 1 and all items in Part 2.

The importance of staying abreast with new treatment modalities in general, and considering the implications they hold for the music therapist is also presented.

CHAPTER III

RESULTS

All subjects met 100% of the study skill criteria in 12 half-hour sessions. Subject 1 turned in 75% of the self-monitoring checklists given to her, all initialed by her Social Studies teacher. She had an 89% turn-in rate prior to the last week of Baseline 2 when she refused to continue self-monitoring. Subject 2 turned in 94% of his checklists; 85% were initialled by his Science teacher. Subject 3 turned in 100% of her checklists with 96% initialled by her Science teacher. Rating agreement on the checklist was 93% for Subject 1 and 100% for Subjects 2 and 3.

Figure 1 presents percentage correct grades recorded by the subjects' mainstream teachers. Grades for all subjects were variable throughout the quarter, with no observable changes in academic performance related to experimental conditions. During some experimental phases there were not enough data points to evaluate student performance. Subject 1 had only one data point in the pretreatment phase and no data points in maintenance. Her Social Studies teacher recorded no grades after the 38th day of the quarter although the quarter continued through the 52nd day. During the time Subject 2 was participating in study skill training sessions his Science teacher recorded only one grade; while 15 grades were recorded during the first 19 days of the quarter, only 6 grades were recorded in the remaining 32 day period. Grades for

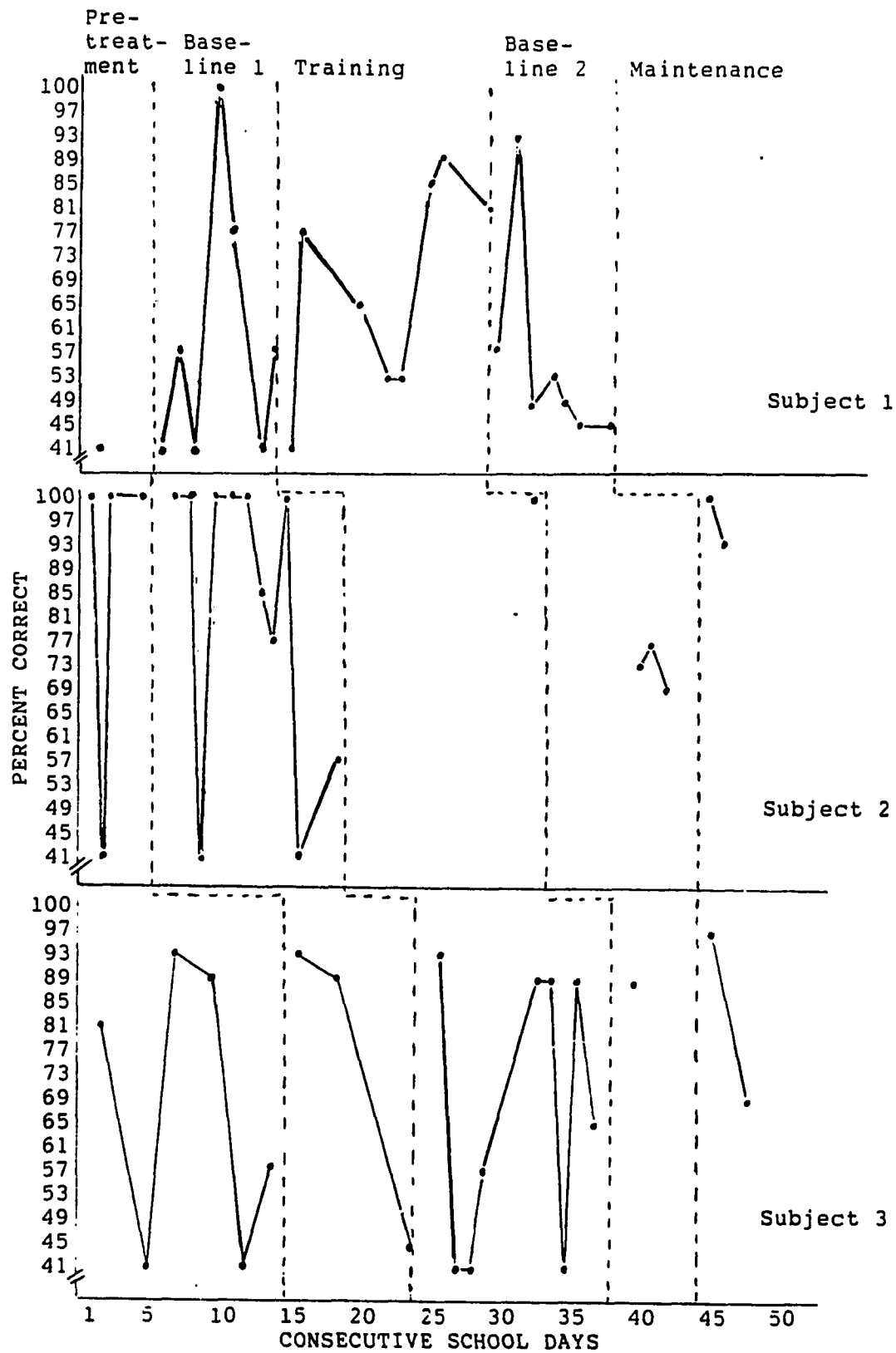


Figure 1. Percentage Correct Grades Recorded by Mainstream Teachers.

procedures can be used successfully with disoriented persons of any age and of any etiology (VA Hospital, 1974).

Reality Orientation, The Empirical Studies

Studies involving the use of Reality Orientation are abundant. Some, however, are not scientifically researched and results tend to be inconclusive in certain areas. In a review of the research involving Reality Orientation, Schwenk (1979, p. 374) noted that "serious methodological problems invalidate the results of most studies." Since that time, more reliable evidence has been documented in the literature. Results, however, continue to be varied on different measures of orientation and behavior.

In 1977, Citron & Dixon conducted the first experimental study of Reality Orientation with confused, institutionalized elderly adults. Using a pretest/posttest control group design with twelve subjects in the experimental group and thirteen in the control group, they combined 24-hour and Classroom Reality Orientation procedures. After a six to seven week treatment period, results of the experimental group indicated an improved orientation to the environment. Behavioral functioning, as measured by the Geriatric Rating Scale, showed inconclusive results.

In a ten week study with 41 confused elderly subjects, Nodhturft & Sweeney (1982) also found significant results supporting the use of Reality Orientation. Subjects were randomly divided into experimental and control groups and pre and posttested for scores on the Mental Status Schedule. Treatment for the four to five member experimental

groups was conducted daily, five days a week, during half hour sessions. A large reality orientation chart was used as the primary focus of the sessions. Other discussion was focused on tangible items such as a picture of the president or holiday decorations. The staff was also encouraged to practice Reality Orientation on an informal basis throughout the day with those patients in the treatment groups. Results indicated that the experimental group showed statistically significant improvements on the measurement scales of orientation to time, place and person. No measure was taken on behavior.

In a similar study, Woods (1979) found Reality Orientation successful with 14 disoriented elderly patients on measures of information and orientation and various aspects of memory when compared with a control group.

Cornbleth & Cornbleth (1979) found Reality Orientation to be successful on both measures of verbal orientation and independent functioning among 22 geriatric residents in a Veterans Administration nursing home. Reality Orientation classes met five days a week for three months. No control group was used.

At the Veterans Administration Hospital in Tuscaloosa, Alabama, Letcher, Peterson and Scarbrough (1974) also noted improvement of both mental and behavioral functioning as a result of Reality Orientation. Their five year study of 206 institutionalized elderly veterans found improvement in thirty-two percent of the subjects. Sixty-eight percent remained the same and one subject regressed. Due to their experience that most elderly patients regress in an institutionalized setting, the

researchers felt these results were encouraging. The length of treatment for individual subjects in this study ranged from two to 56 months. This indicates that care should be taken when attempting to generalize these findings outside the sample group. In another lengthy study, Stephens (1969) reported that Reality Orientation was a successful program with 227 patients over a fourteen year period.

Hogstel (1979) used Reality Orientation for only three weeks with 44 nursing home patients who were over 65 years old. At the end of treatment she reported that of the remaining patients, eight were less confused, eight were more confused and four remained the same. She concluded that a longer treatment period was necessary and that although significant differences in the degree of confusion were not found, patients were interested and cooperative.

While Harris & Ivory (1976) found behavior scores to be erratic and lacking in pretreatment comparability, they did find significant improvement in orientation as a result of an incorporated Reality Orientation treatment procedure. Forty-eight female geriatric patients were rated on ward behavior, verbal orientation behavior and aide therapist observations and impressions. All three aspects of Folsom's Reality Orientation were used: R.O. classes, 24-hour R.O. and Attitude Therapy ("Attitude Therapy consists of a baseline of acceptance, concern and expectation of participation in one's own recovery . . . a feeling of calmness, consistency and security communicated to the patient," Folsom, 1968, p. 404). The authors noted a trend toward more appropriate interaction and suggested that the major clue in reorientation of the

elderly might be due to the Attitude Therapy aspect of Reality Orientation and not the Reality Orientation itself. Nodhturft & Sweeney (1982) suggested that a study be conducted which would compare Reality Orientation and Attitude Therapy as separate approaches.

In her comparison of Reality Orientation and resocialization groups, Voelkel (1978) also concluded that it was not the Reality Orientation procedures which helped to improve mental status, but the coming together as a group in a social setting that made the difference. Her results showed the resocialization group improved significantly on a mental status questionnaire, while a Reality Orientation group did not.

The above mentioned studies tend to support Reality Orientation for success on measures of orientation, but differ in support of Reality Orientation for measures of improved behavior on a variety of scales. All of the studies identify the subjects as being confused or disoriented, but few address the issue of the degree of disorientation experienced by the subjects prior to and after treatment. It is also apparent that most of the studies reviewed, involved subjects aged 65 years or older. This could easily allow an age range of over 30 years. Undoubtedly, a wide variety of disorientation levels might be represented. And, since varying levels of disorientation are often present among any given group of elderly subjects, this issue requires attention.

The ability to judge the passage of time is one of the first losses experienced by the demented patient. The person whose short-term memory is failing forgets quickly and has no way to measure the

CHAPTER IV

DISCUSSION

Although all subjects met 100% of the study skill training criteria and consistently turned in self-monitoring checklists, grades recorded by mainstream teachers did not improve. The most plausible explanations for this outcome are that the general study skills learned were not sufficient to affect specific academic performances, the subjects did not apply skills learned beyond the training setting, or grading procedures precluded demonstration of skill improvement.

Each subject participated in six hours of training, covering three study skill topic areas. Although the acquired study skills may have been applied in mainstream classrooms, the intervention may not have been powerful enough to have an impact on grades. Allotting more time to study skill training and expanding the topic areas covered may lead to more significant results. Individualizing content to incorporate student needs and mainstream classroom expectations may also be important in maximizing training outcomes. Thorp, Chiang, and Darch (1981) contend that special education personnel should routinely visit mainstream classrooms and communicate with regular education teachers to learn about expectations in those settings. This information would help trainers to select examples so that students could practice how to perform skills across the

natural stimulus and response variations they are likely to encounter in other settings (cf. Horner, Sprague, & Wilcox, 1982).

While the subjects demonstrated study skill proficiency during training sessions, they may not have applied the skills in other settings. The self-monitoring checklist designed to promote study skill use in mainstream classrooms had no effect on academic performance alone or in combination with study skill training. The subjects demonstrated that they would self-monitor without artificial incentives by regularly turning in study skill checklists, however. Interobserver reliability was high between all subjects and their mainstream teachers, indicating that teachers either agreed with subject evaluation of behavior or they initialled the checklists without considering the validity of the ratings.

Data generated by the checklist showed that Subject 2 and 3 rated themselves higher on items in Part 2 than in Part 1 across all experimental conditions. Part 1 scores were lower because the subjects awarded themselves few points on the last four items which describe study skill applications beyond the school setting. Subject 1 also awarded herself few points on these items. This information suggests that failure to apply study skills at home may have prevented the subjects from improving upon academic performance.

Another explanation for the lack of treatment effect is that grades may have been subjectively determined so that study skill improvement was not reflected in academic performance ratings. By the last quarter of the school year teachers may have developed

with regard to his or her satisfaction with life and self in general. Schwenk (1979) notes that the few adequate studies available suggest that Reality Orientation does sometimes help to reduce confusion but does not necessarily increase autonomy or happiness among the elderly.

Summary

In summary, the results of the literature on Reality Orientation remain somewhat inconclusive. Many of the studies reviewed (Citron & Dixon, 1977; Nodhturft & Sweeney, 1982; Woods, 1979; Cornbleth & Cornbleth, 1979; Harris & Ivory, 1976; Mitchel-Steven, 1980; Degun-Gian, 1976; Brook, Degun & Mather, 1975) support the use of Reality Orientation for measures of orientation. Other studies which support the use of Reality Orientation in general include: Johnson, McLaren & McPherson (1981), Brown & Ritter (1972), Kerstein & Isenberg (1974), Martwell & Patnaik (1973) and Lee (1976). Some of the studies contend, however, that other factors, such as group processes and the social aspects of a Reality Orientation program are the contributing factors to improved functioning and not the Reality Orientation itself (Voelkel, 1972; and Harris & Ivory, 1976).

It can also be observed that very few of the studies found Reality Orientation helped to improve measures of behavior functioning when indeed this aspect was even considered. Only one study measured improvement on a life satisfaction scale and found that Reality Orientation was not effective in improving this measure, where another psychosocial procedure was (MacDonald & Settin, 1978).

It is also apparent that Reality Orientation tends to be more effective when used with subjects experiencing only mild or moderate disorientation (Mitchel-Steven, 1980; Zeppelin, Wolfe & Kleinplatz, 1981; Degun-Gian, 1976; Brook, Degun & Mather, 1975).

In conclusion, Settin (1982, p. 568) states that "one of the most popular types of intervention for the aging in long-term care is Reality Orientation classes and while it is often effective in reorienting confused clients, it is too often the only treatment provided."

Validation, The Theoretical Framework

In 1963, Naomi Feil began helping disoriented elderly at the Montefiore Home for the Aged in Cleveland, Ohio. She used a variety of therapeutic techniques in her work, including Reality Orientation. Eventually, however, she began to discover that helping her patients face reality was unrealistic because they withdrew and became more irritable. In 1965, she abandoned Reality Orientation after realizing that disoriented elderly would respond better to those who supported or validated their feelings in an atmosphere of empathy and understanding. These discoveries were the beginning of her development of a new treatment approach called Validation/Fantasy Therapy, or Validation.

Feil believes that early-learned memories replace intellectual thinking in the disoriented elderly adult, and that validating these memories will help the elderly regain dignity and justify their lives. Instead of requiring the disoriented person to repeat facts of external reality which hold little meaning, Validation acknowledges the

verbalizations of inner realities. It does not seek to confirm hallucinations, but more to discover and acknowledge the feelings which may contribute to them.

Feil defines fantasy as "a personal view of the world . . . an inner reality" (Feil, 1982, p. 1). "In verbalizing the fantasy or inner reality, individuals gained a feeling of gratification, of being understood and a sense of self in the knowledge that their world was meaningful and acceptable" (Feil, 1972, p. 6).

The conceptual framework of Validation is based on an existential, humanistic psychology using a client-centered approach. The basis of this framework stems from the work of both Erik Erikson and Carl Rogers. Rogers (1963) expresses the existential philosophy of man as one who "is a person in the process of creating himself, a person who creates meaning in life, a person who embodies a dimension of subjective freedom" (p. 74). And, Erikson (1963) describes the person who has successfully reached the final Life Stage as one who is "ready to defend the dignity of his own life style against all physical and economic threats."

"Since Validation deals particularly with the disoriented elderly who are in their last stage of life, Erikson's Life Stages are especially relevant" (Peoples, 1982, p. 10). Erikson's Life Stages theory builds on Freud's psychoanalytic theory of development. It is a psychosocial theory wherein Erikson views development as a progressive resolution of conflicts between an individual's needs and society's demands. He defines the task of the last stage of life as the development of ego integrity. Failure to achieve this results in despair and the inability to accept the value of one's own life cycle (Erikson, 1963).

"Implicit in the concept of ego integrity is the acceptance of a person's own definition of himself" (Peoples, 1982, p. 11). Engle (1980) defined this acceptance as confirmation. "If an older institutionalized person, already suffering multiple losses, is denied this kind of confirming communication, he risks losing his sense of identity and becoming disoriented" (Peoples, 1982, p. 11). "While confirmation is the attitude of acceptance of an individual's definition of himself and acknowledgement of his worth, Validation is a response to what he says" (Peoples, 1982, p. 12).

Feil has added an additional final life stage to Erikson's previous six Life Stages. She calls this new stage the Resolution vs. Vegetation Stage which she defines as a natural occurrence among the disoriented old-old adult who has not achieved integrity. Feil believes that the old-old person wisely avoids despair by expressing old, unfinished feelings. This is the struggle for integrity, where failure to resolve the past leads to Vegetation.

Disorientation

Feil (1981) defined disoriented old-old adults as those persons over 80 years who have used denial to deal with their losses and who survive by retreating into the past to substitute for an unbearable present. She divided disorientation into four stages, each of which are characterized by specific physical and emotional characteristics and typical feelings experienced by persons in that stage (see Table 1).

Table 1

Stages of Disorientation

Characteristics			
Stages	Emotional	Physical	Feelings
One: Malorientation	Holds onto present reality Can play games with rules Has sense of humor Denies disorientation, confabulates Can dress, toilet and control self most times Holds onto rules and "proper" ways of behaving	Eyes clear and focused Stance rigid, unmoving Movement in space definite, sustained, precise Face and body muscles tight. Fingers and hands often pointing Arms often folded, protecting the chest	Feelings are denied Speech, reason, rational thinking dominates Considers anyone who shows feelings or uses napkins to represent babies is "demented"
Two: Time Confusion	Expresses feelings. Does not remember facts Remembers sensory, pleasurable feelings from childhood Energy focus is to resolve past unfinished conflicts Loses sense of humor	Muscles are loose Eyes clear, but often unfocused, gazing into distance Movement in space slow, indirect, often questioning. Shoulders tend to slump forward, neck down	Returns to universal feelings shared by all: love, hate, fear of separation, struggle for identity Expresses these in symbols and body movements Rhythms and rhymes come without reason, to avoid boredom

STUDY SKILLS SURVEY

The following topics have been identified as study skills that may help Special Education students improve their performance in mainstream classes. Please check the three topics that you feel would be most beneficial in helping these students succeed in your classroom.

- _____ 1. Concentration, Learning to Focus
Teaching students how to assess and improve upon concentration.
- _____ 2. Time Management
Assisting students in evaluating, prioritizing, and organizing their time in an effort to meet their study and recreational needs.
- _____ 3. Remembering: Storing and Retrieving Information
Increasing student awareness that memory can be improved upon, analyzing the effect of attitude on remembering, teaching memory improvement strategies.
- _____ 4. Technical Vocabulary
Teaching students effective strategies for understanding and learning technical vocabulary.
- _____ 5. SQ3R (Survey, Question, Read, Recite, Review)
Evaluating students' current approach to study-reading. Teaching SQ3R.
- _____ 6. Note-taking
Discussing the importance of listening and taking notes. Teaching strategy, use of abbreviations, and identification of central thoughts and significant details.
- _____ 7. Outlining
Teaching outlining techniques to aid students in organizing and remembering a passage or discussion.
- _____ 8. Dictionary Usage
Teaching students how to use the dictionary as a reference tool in order to use words effectively.
- _____ 9. Text Look-back Strategy
Training students to return to previously read material to retrieve specific information.
- _____ 10. Other (Please describe)

This theoretical formulation of Stages is based on many years of observation, but has not been scientifically tested for validity. Validation has been found to be most successful with patients in the second and third stage" (Peoples, 1982, p. 13).

While a true Validation group has many implicit procedures, some of the more obvious ones are listed below: (Feil, 1982)

1. Select 5-10 members who should meet at least once a week for twenty minutes to one hour.
2. Roles for group members should be developed in such a manner that the needs of members are fulfilled in some way. (Example: A woman who has a proud history of leading local committees might be selected as the chairperson. A devout Baptist might be selected as a prayer leader, etc.).
3. Choose appropriate songs and music the group will enjoy.
4. Find a universal problem for the group to solve. (Example: Finding Friendship, Expressing Anger, Belonging, etc.).
5. Use genuine eye contact, touch and empathy.
6. Use opening and closing rituals, such as a prayer, song, refreshments, etc.
7. Tune in to the feelings that are being expressed by members either verbally or physically. Do not attempt to overtly correct inaccurate or unrealistic comments. Do not explore feelings that are not expressed and do not analyze the feelings that are expressed. If, for instance, a member (whom the therapist knows is childless) begins to yell and cry about her children who died in a fire, the therapist might respond with: "You must feel awful . . . it must be terrible to have a child die . . . where does it hurt the most? . . . In your heart. . . ? I'm sorry . . . (patient rocks; therapist rocks in rhythm) You always wanted a child didn't you . . . ? Someone you could rock to sleep . . . ? Someone you could be proud of . . . ? You would have made a wonderful mother." (Validation).

In summary, according to Feil (1982), some of the basic assumptions of validation are:

1. The disoriented old-old person has a right to resolve living by returning to the past.
2. Rational thinking is not the only way of behaving. Feelings have a right to be expressed when rational thinking fails.

3. There is a reason behind all behavior. Caring is finding the reason; validating the person; reducing the stress; healing.

Perhaps a quote from Maugham (1959) which states "what makes old age hard to bear is not a failing of one's faculties, mental and physical, but the burden of one's memories" expresses why Validation is so important.

Validation, The Empirical Studies

Feil (1967) has published only one study which forms the basis for Validation/Fantasy Therapy. This report produced anecdotal evidence that many withdrawn nursing home residents became more comfortable in facing and expressing their feelings with the help of a supportive therapeutic relationship.

Other studies on Validation, while also lacking in methodological controls, are worth noting. A five-year study of Validation procedures (Feil, 1972) found results which showed relieved tension, less incontinence, improved speech, less negative or inappropriate behavior and a more positive and happier appearance. It was during the course of this study that Feil began to realize that the "defense mechanisms that had once protected the ego from acting out fantasies diminished with a decrease in brain functioning" (Feil, 1972, p. 2). During the group sessions she observed that "repressed instinctual feelings became verbalized instead of being acted out." She then concluded that "the goal of Reality Orientation was in itself unrealistic." Not only was awareness of reality intolerable for this group of aged whose reality held steady deterioration in functioning . . . but sudden insight into reality brought about pain, withdrawal and increased dependency.

In another early study of group work in formulating Validation/Fantasy Therapy, Feil (1967) reported that all but one of twelve group members showed an increase in positive affect following the group meetings.

A sound scientific study conducted by Peoples (1982) compared Reality Orientation and Validation procedures among 30 nursing home residents for six weeks. She found Validation produced significant improvement in behavior, but not in orientation or ego integration, while Reality Orientation produced no significant differences in any of the three measures. Her design used two experimental groups and one control group. She attributed a lack of further support to an inadequate length of treatment, among other things.

According to Peoples (1982):

Feil has continued to develop insights and to refine her methods for conducting therapy in groups. These methods are taught to health workers who deal with the aged in the hope that understanding client-centered therapy and the stages of disorientation will permit the worker to validate the reality of the old-old and thus reinforce their human dignity and identity. (p. 24)

Feil (1982, p. 12) also reports that "since 1973, 523 homes and hospitals in the United States and Canada now use Validation/Fantasy Therapy with positive results."

While the current literature available on Validation is minimal at this time, there is literature on a related therapy which indirectly supports the use of Validation. This approach is called Life Review. Old age is a time of reflection and allusions to a life-review process can be found throughout historical literature:

They live by memory rather than by hope, for what is left to them of life is but little when compared to the long past. This, again, is the cause for their loquacity.

They are continually talking of the past, because they enjoy remembering. -Aristotle, Rhetoric (367 - 347 B.C.)

The concept of Life Review was developed by Robert Butler in 1963, after observing the elderly and theorizing that they all review their lives; though not necessarily in an orderly fashion. Skipping back and forth, he found, was not unusual. Butler & Lewis (1982) postulate that there is a universal occurrence in older people which is characterized by the progressive return to consciousness of past experiences and particularly the resurgence of unresolved conflicts. They note that there is a renewed ability to free-associate the past and present. In addition, they explain that the life review also occurs in younger people, but that it becomes more intense in old age.

Butler & Lewis (1982) also reasoned that, the natural tendency to reminisce could form the basis for effective therapy for the aged. They contended that "the life review is therapeutic in that it can aide an elderly individual to develop a positive self-concept and enhance the importance of the remainder of their lifetime" (p. 326). In Life Review Therapy, the therapist encourages the patient to recall past memories to engage in reminiscing as a means of evaluating, understanding and accepting the meaning of their life (Butler & Lewis, 1982). And Butler & Lewis (1982) continue by stating "Reminiscence has meaning for the life review that occurs in nearly all people. Feelings of guilt that result from such reminiscence should not be treated as irrational, to be patched up by patronizing reassurance."

Liton & Olstein (1969) also contend that the senile patient is particularly responsive to reminiscence. They claim that this approach

2) What is the system of government in Canada?

d. Farmlands of the United States

1) Where are the four main farming regions in the United States?

2) What important changes have taken place in American farming?

e. Trade, at Home and Abroad

1) Why do people carry on trade within a country?

2) Why do the United States and Canada trade with the rest of the world?

2. Subject 2

a. Work and Energy

1) How is work calculated?

2) Why does a bulldozer use more energy than a garden tractor when work is done?

b. Engines

1) How does a gasoline engine operate?

2) What are the differences between a diesel engine and a gasoline engine?

c. Levers

1) Name the two arms in a lever.

2) What are the three classes of levers?

d. Efficiency

1) How is the efficiency of a machine calculated?

2) Define efficiency.

e. Speed

1) What term refers to how fast an object is moving?

2) How is average speed calculated?

3. Subject 3

a. Food and Health

- 1) Define the terms food and nutrition.
- 2) How can you have a balanced diet?

b. Minerals

- 1) In what form are minerals used by the body?
- 2) Can minerals be harmful to the body?

c. Fats and Oils

- 1) What elements are present in fats and oils?
- 2) What is the function of fat in the body?

d. Food Additives and Food Labels

- 1) Why are preservatives added to food?
- 2) What information must be present on a food label?

e. Vitamins

- 1) What is the best way to obtain the vitamins you need?
- 2) What is vitamin deficiency disease?

D. Activity 9 on p. 52, categorizing index topics, was eliminated.

E. Activity 4 on p. 53, lecture review, was eliminated.

F. Activity 7 on p. 58, mnemonic research, was eliminated.

G. Activity 8 on p. 59, mnemonic teacher survey, was eliminated.

Implications for the Use of Music

The value and support of music therapy with the elderly has been discussed. This section will be devoted to how music therapy techniques have, and can be used in a Reality Orientation or a Validation setting.

Music and Reality Orientation

In her study of music therapy with geriatric residents, Palmer (1977) observed that "in the all important area of mental functioning, music therapy is a basic tool in reality orientation" (p. 191). She used songs such as "Shine on Harvest Moon" to relate the concepts of seasons, day, year and time. In addition, she also used music to help encourage the recall of words to songs from the patient's youth and also to recall the events they associated with the songs. She then put their responses in perspective with reality.

Since music provides a nonthreatening atmosphere, it is often an ideal setting for learning. In a more scientific approach, Riegler (1980) found that "music therapy, with its potential to motivate and reactivate the geriatric patient, could be a valuable addition to a Reality Orientation program" (p. 27). She compared the effects of a traditional versus a music-based Reality Orientation program. Eight residents in a nursing home were randomly assigned to control or experimental groups. A pretest was administered to identify and formulate specific goals and objectives for the treatment. Both groups received two 30 minute Reality Orientation sessions per week for eight weeks. The difference was that the experimental group received music-based

Reality Orientation. Posttest scores showed a significant interaction between the groups and the treatment condition, with the experimental group showing marked improvement and the control group remaining at the same level for the measure of orientation. Staff ratings of overt behavior function did not yield significant results in either treatment group. The degree of disorientation experienced by the subjects prior to treatment was not discussed.

The potential music has to stimulate the geriatric client would also be desirable for Reality Orientation purposes. Songs such as the ones described in Palmer's (1977) study can enhance the learning process and also serve as reinforcement. Rhythm instruments can also be used to accompany these songs and promote learning through active participation. Clearly, there are a multitude of implications for the use of music in a Reality Orientation setting.

Music and Validation

Just as words may generate responses; melody and other more subtle aspects of music create musical imagery that also triggers thoughts and feelings, (Needler & Baer, 1982). This observation is supported by others who have examined the tremendous potential music holds for helping the geriatric patient relive past memories. Gueirn (1982) reasoned that:

Because music was such a part of family life even before the days of radio and television, it is a tremendously useful tool in joining the past with the present. Old songs can stimulate communication by opening the door of remembrance. These songs express a myriad of feelings and associations. (p. 170)

Shapiro (1969) agrees that music leads geriatric patients to express themselves more freely. Often the panorama of memories a single melody can evoke will lead to verbalizations and conversations which would perhaps otherwise be left unspoken.

In the study by Palmer (1977) it was noted that the recall of words to songs from the geriatric patient's youth was aided by the use of music. Those songs also helped to facilitate the recall of past events associated with the music. In addition, Bright (1981) stated that "music is the ideal stimulus for reminiscence" (p. 39). Similarly, Hylton (1983) noted that "music can afford a stimulus for recalling events from the past, both near and distant" (p. 39). Hence, music can serve as a link between the patient and the therapist. Bright (1972) acknowledges this in her discovery that music can be used effectively for intellectual stimulation, using reminiscence to build therapeutic discussion. Later she wrote that "by playing a patient music which dated from his working life, one can help him to look back on his accomplishments with more satisfaction" (Bright, 1981, p. 37).

Bright (1981) also notes that "some elderly are no longer able to express themselves verbally and thus revert to anger and hostility or other nonverbal means of communication" (p. 37). Gaston (1968) also notes that the nonverbal stimulus of simple rhythm is very effective with patients having a diminished rapport with reality. And, Butler & Lewis (1982) recognized that because of the greater likelihood of physical impairment, nonverbal communication can facilitate treatment and in some cases be a dominant part of a relationship. This theory is also

emphasized by Feil, especially when dealing with patients in Stage III of disorientation (Feil, 1982). Undeniably, music could function as this form of nonverbal communication.

It is apparent that music can serve as the catalyst for reminiscence through songs and melodies throughout a patient's life. And, as with Reality Orientation, music provides a nonthreatening atmosphere which aides the facilitation of expression both verbally and physically. The nonverbal aspects of music can serve as communication through rhythmic activities using rhythm instruments and/or chanting techniques. Other elements of music such as tempo and dynamics can also be used as effective means of nonverbal communication. Again, the potential for music, in this case within a Validation setting, is practically limitless.



Western Michigan University
Kalamazoo, Michigan 49008-3899

*Human Subjects
Institutional Review Board*

TO: Kathleen Allen

FROM: Ellen Page-Robin, Chair *EP*

RE: Research Protocol

DATE: April 13, 1988

This letter will serve as confirmation that your research protocol, "The effect of study skills training on the academic performance of learning disabled students in mainstream classes" has been approved as exempt by the HSIRB.

If you have any further questions, please contact me at 387-2647.

Thirty-two subjects were initially sought for the study. However, due to the difficulty in obtaining consent from several patients' responsible parties, the original number of subjects was 24. In addition, the selection of subjects who were physically capable of participating in the groups was more difficult than originally expected. During the course of treatment, two subjects expired and two others were hospitalized. This left a final number of 11 subjects in the Validation groups and 8 subjects in the Reality Orientation groups.

The ages of the subjects ranged from 80 to 94 years with a mean age of 86 years. The most frequently represented primary diagnoses included: stroke (CVA), congestive heart failure, arthritis, fractures of various body parts, Parkinson's and hypertension. Confusion and/or Organic Brain Syndrome were often listed as secondary diagnoses. The length of stay in the Health Center ranged from approximately six months to four years.

The Setting

The Friendship Village Health Center is a licensed, skilled nursing home located in a midwestern city of moderate size. The Health Center is part of a larger complex which houses over three hundred senior citizens living semi-independently in apartments. Two halls of semi-private patient rooms with a central nurses' station and a large dining area comprise the major portion of the facility.

The group sessions were held in the Activity Room which was located just off the dining area. The Activity Room was easily accessible and

well suited for small group sessions. Both entrances could be closed off to insure privacy or opened for easy entrance or exit. A large window, kitchen facilities, storage cupboards, a desk and chairs were included in the room. The subjects were already familiar with this setting as it frequently served as a meeting place for various groups and activities.

The Materials

Two large (2' x 3') professionally printed Reality Orientation Boards were used as the primary focus of the Reality Orientation groups. The board included a display of: the name of the nursing home, city, state, day of the week, month, day of the month, year, season and weather. Name-tags, a large-print calendar and a cardboard clock were also used in this group. In addition, various pictures from magazines, which related to the Reality Orientation information supplemented the sessions.

Other materials, suitable for both groups included musical recordings, rhythm instruments and an autoharp for accompanying the songs. A variety of other props such as pictures, scent bottles, textiles, art materials, etc. were used to promote discussion. Refreshments which normally consisted of fruit juice and crackers or cookies were served at the conclusion of each session.

The Measurement Instruments

Three measurement instruments were used to collect data in this study. They were: the Tool for Assessing the Degree of Confusion in the Elderly (TADC), the Behavioral Assessment Tool (BAT), and the Ego Integration Scale (EIS). The TADC is an 18 item questionnaire, developed by Hogstel (1977) in a study of Reality Orientation in a nursing home. The test is designed to be used in a semistructured interview setting. Items on the test require the subject to answer questions regarding name, date, place and other selected information. A higher score on the test is related to less confusion or a higher degree of orientation. Peoples (1982) found a test-retest reliability coefficient of .96 when she administered the test twice over a period of two weeks. While other tools were considered, this one was selected for its relatively brief but thorough application. Brink (1979) observes that the need for concise and convenient assessment instruments to test the aged for senile confusion is great. It should be noted that a slight modification in scoring this measure was made. The scale is designed so that the total negative (incorrect response) score is computed and then matched to one of the three levels of confusion: slight, moderate or severe. Since the three levels are evenly divided among the 18 items (slight, 1-6; moderate, 7-12; and severe, 13-18) the researcher revised the scoring by counting the number of positive (correct response) scores instead and thus revised the scale to read: slight confusion, 13-18; moderate confusion, 7-12; and severe confusion, 1-6.

The EIS was designed by Peoples (1982). Her review of the available literature revealed a failure to identify an instrument which measured this variable in particular. She writes:

The ten items for the instrument were obtained from tools developed by Boylin, Gordon and Nehrke. In studying reminiscing and ego integrity in institutionalized males, they used Constantinople's intimacy subscale as a model for the format of the subscale to measure ego integration versus despair. The items were considered to have face validity with the concepts they were to measure based on Erikson. Of the ten items on the scale, five corresponded to the positive outcome, and five to the negative outcome.

The three-point scale that was used by Boylin et al., of 'rarely, occasionally, or often' was considered to require too fine a degree of discrimination for disoriented persons to determine. Therefore, the 'agree, ?, disagree' scale used on the Life Satisfaction Index A developed by Neugarten, Havigurst & Tobin was adopted because it is more easily understood. (p. 51)

There are ten items on the Ego Integration Scale, each with three separate score values (0,1,2). A higher score on the scale indicates a higher degree of ego integrity.

The BAT was also developed by Peoples (1982) "using selected items from Feil's list of characteristics common to each of the four stages of disorientation, as they relate to ten general categories of behavior." The inter-rater reliability coefficient, established when Peoples and Feil separately tested the same five members of a Validation group was, 1.0. The BAT is designed such that each of the ten items having a separate score value of 1, 2, 3 or 4, are totaled to show a lower level of behavioral functioning as the total score increases. Thus the highest possible score of 40, indicates a very low behavioral functioning level.

The Procedure

Administrative Design

This study was granted approval at minimal risk by the Western Michigan University Human Subjects Review Board in April, 1984. Full cooperation from the staff at Friendship Village was granted by the Administrator and the Director of Nurses.

Selection of Subjects

The Director of Nurses at the facility provided a list of patients who met the age and physical requirements for participation in the study. The Director also indicated which patients were capable of signing the Informed Consent themselves, and which would require the signature of a responsible party.

The potential subjects were presented with the Informed Consent by the researcher. The form was read and/or explained to the patient in terms adapted to their level of understanding. Eleven forms were mailed to the patients' responsible parties followed by a personal telephone call to answer questions and discuss concerns.

The researcher then administered the Tool for Assessing the Degree of Confusion in the Elderly (TADC) to each qualified subject. Patients whose scores fell between '3' and '18' were considered for actual participation in the treatment groups.

The subjects selected for participation were then questioned by the researcher using the Ego Integration Scale (EIS). Three specified charge

nurses at the Health Center completed the Behavior Assessment Tool (BAT) for individual subjects. These three individual scores were computed to determine a mean score on the BAT for each subject. One of the charge nurses was also designated to act as a subject advocate during the course of the treatment. She monitored the subjects daily (on an informal basis) for signs of distress or other complications which may have been attributed to either treatment group. Should withdrawal from the study have been advisable, the nurse would have made that decision.

After the subjects were assessed on the three measures, they were randomly assigned to either of the two treatment groups. This random selection was accomplished by matching the patients' admission numbers with numbers on a table of random numbers (Games & Klare, 1967). In addition, subjects were evenly spread across the two treatment groups by random assignment based on which Stage (I, II, III) the majority of their scores fell on the BAT. This method was chosen since it has not been established that the degree of confusion as measured by the TADC is equivalent to Feil's Stages of Disorientation.

Further randomization was employed to divide subjects into two different session times for each treatment group. Each session was thus originally comprised of eight group members. Due to the death or hospitalization of certain patients, the final number of subjects for the study was nineteen: eight in the Validation groups (four and four), and eleven in the Reality Orientation groups (five and six). Unavoidable conflicts in two subject's personal scheduling required a minimal number of changes in group assignments.

Treatment Groups

Each treatment group met for 30 minutes, five mornings a week (Monday-Friday) for six weeks. Subjects were required to attend a minimum of 25 of the possible 30 sessions in order to be counted for statistical purposes.

While the schedule was compatible with the recommended procedures for Reality Orientation, Feil recommends that groups meet at least once a week and that the therapy continue for at least twelve weeks (Feil, 1981). It was hoped that the more intense daily group meetings would compensate the effects of an extended treatment period. There is, however, no research which supports which procedure would be more effective.

Treatment Therapists

The two treatment therapists included the researcher who had also served as Activity Director in the Health Center for the past three and a half years, and a music therapy intern at Friendship Village who was in the final six weeks of a nine month clinical training period.

The researcher led the Validation groups while the intern ran the Reality Orientation groups. The researcher was prepared in Validation/Fantasy Therapy by having previously attended numerous workshops, some of which were conducted by Naomi Feil herself. Personal discussions with Mrs. Feil and a Certified Validation Therapist also helped prepare the researcher for administering treatment. The intern was prepared to lead the Reality Orientation groups by a study of the literature and by

informally observing the Reality Orientation procedures at other facilities.

While the staff at Friendship Village was familiar with both treatment approaches, neither approach was formally administered for one year prior to the implementation of treatment for this study, in order that the results would not be contaminated. Both approaches were, however, practiced informally by all staff members as a regular course of daily conversation, but these instances were almost always on a one-to-one basis and in an unstructured setting. It was not expected that the informal application of these approaches as described above would have any effect on the results of this study.

Reality Orientation Groups

Chairs in the Reality Orientation groups were arranged in a semi-circle facing the therapist and the Reality Orientation Board. The Reality Orientation groups opened with a short "Hello" song which was sung by the therapist to each individual group member using his or her name. Other group members were encouraged to sing along. At this time, name tags were also distributed. Following the opening song, a brief movement activity was presented which involved upper body and leg exercises. The exercises were designed to be performed while the group members remained seated. A variety of contemporary musical recordings

were played to accompany these exercises. Some examples included: "Elvira," "Annie's Song," and "Theme from Flashdance." Bright (1981) states that "it would be wrong to assume that the elderly only like music which is familiar . . . many elderly people enjoy 'pop' music."

The focus of the sessions was then centered on information displayed on the Reality Orientation Board. Simple melodies were developed to present the information. Some of the melodies were adapted by using familiar folk tunes and substituting new lyrics. Each topic was explored separately. Following the musical presentation of information, group members were asked individually to repeat the information back to the therapist. Correct responses were reinforced with verbal praise, smiles, etc. Incorrect responses were corrected by the therapist in a firm but friendly and sincere manner. These procedures were modeled after the ones discussed in the Guidelines for Reality Orientation (VA Hospital, 1974).

Often, pictures or props were presented which were chosen for their ability to promote discussion of current events. These props usually accompanied a song selected for the same reasons. If conversation drifted to events of the past, those events were consistently put back into the perspective of the present. Comments and/or other verbalizations which did not pertain to the topics at hand were either ignored or corrected in a kindly manner. The goal was to continually reorient the person to present reality. Example:

Mr. Jones (Group Member): Well, it's been nice meeting everyone here today, but I must be going home now or the 'Mrs.' will be worried.

Therapist: I'm glad you enjoyed yourself today, Mr. Jones, but I should remind you that your home is at Friendship Village now. Mrs. Jones passed away several years ago. I will be happy to show you where your room with Mr. Smith is down the hall if you like.

The group typically ended with a short "goodbye-song" which was sung by the therapist and group members. This was followed by refreshments.

Validation Groups

Prior to and during the first week of treatment, subjects in the Validation groups were observed for the purpose of finding roles for each member. This is an integral part of Validation. Various roles included: Topic Developer, Song Leader, Opening and Closing Chairperson, Nurturer, Hostess, Prayer Leader and Chair Arranger. Role assignments should be compatible with the individual's personality and capabilities according to Feil (1982). Feil (1967) explains:

With residents who have lost their awareness of reality, the worker can gain an expression of deep feeling, relate this feeling to group members, and together explore reasons for bizarre behavior that will promote concern for each other's welfare and stimulate group interaction: for each group member shares, to some extent, the fears and anxieties of another. The worker must also demonstrate to the members of the group each one's assets and strengths and try to give each one a role that will give him status and a new measure of independent functioning. (p. 194)

Actual sessions were formally opened by the Chairperson, although an occasional prompt from the therapist was needed. The therapist would then assist the Song Leader in the opening song. This song and the closing song were chosen by the group from a list provided by the

therapist. Suggested titles of familiar tunes included: "The More We Get Together," "Amazing Grace," "Hello, It's So Nice to Know You," "Good-bye Friends" and so forth.

The opening rituals were followed by a short movement activity. As in the Reality Orientation groups, these activities were designed to be performed in the chair. Actual singing or recordings of popular songs from the 1920's and 1930's accompanied the exercises. Occasionally this activity was substituted for other involvement such as a short art project or the playing of rhythm instruments, in which case appropriate background music was played. This activity was followed by a discussion which was decided upon by the group, with the Topic Developer having final approval. Topics included: Loneliness, Shame, Mother, Friends, Guilt, etc. Procedures for these activities followed those outlined by Feil (1982). The discussion was frequently followed by another song which was selected by group members from choices presented by the therapist. Songs offered for selection were chosen by the therapist for their relevancy to the topic of discussion. The closing song was sung by all, usually while holding hands.

Throughout the group sessions, the therapist emphasized touch, eye-contact and empathy. The validation of expressed feelings, the mirroring of body rhythms and emotions and the sharing of memories were the primary objectives to be met by the therapist. No emphasis was given to the truth or nontruth of comments made by the group members, nor were obvious corrections offered for inaccurate assessments of person, place or time. Rather, the therapist would attempt to redirect

the focus of the group on what feelings were being expressed through the verbalizations. The goal was to give the person a sense of identity, dignity, and self-worth. Example:

Mrs. White (Group Member): I have to go home now, my mother is worried about me.

Therapist: Mrs. White feels she should go home now or her mother will be worried. It's a nice feeling to know that someone cares about us in that way, isn't it? We all need to feel missed, and loved.

Collection of Data

Following treatment, subjects were posttested on the measures of orientation, ego integration and behavior. As with the pretest administration of these measures, the researcher completed the TADC and the EIS, while the specified charge nurses completed the BAT.

RESULTS

The descriptive and inferential statistics regarding the analysis of data gathered in the study are presented in this section. Table 1 shows the means and standard deviations of the confusion scale gain scores for the independent variables.

Table 2

Mean Confusion Pretest, Posttest and Gain Scores
for Treatment Therapies

Treatment	n	Pretest	Posttest	Gain
Reality Orientation	8	7.75 (2.43)	11.38 (2.39)	3.63 (1.60)
Validation	11	9.73 (4.73)	11.63 (4.23)	1.91 (2.43)

Note: Parentheses indicate standard variations.

It should also be noted that there were a possible 18 points on the Tool for Assessing the Degree of Confusion in the Elderly (TADC) scale. Scores of 13-18 were defined as slightly confused; scores of 7-12 as moderately confused; and scores of 0-6 as severely confused. It should be noted that a higher score indicates less confusion, or greater orientation.

Pretest and posttest scores for both treatment groups were in the moderate range of the scale. Table 2 shows that there was no significant difference between the mean gain scores for this measure.

Table 3

One-Way Analysis of Variance on Confusion Gain Scores

Source	SS	df	MS	F	Probability
Between	13.64	1	13.64	3.02	0.10
Within	76.78	17	4.51		
Total	90.42	18			

Table 3 contains the means and standard deviations of the Ego Integration Scale (EIS) scores for the independent variables.

Table 4

Mean Ego Integration Pretest, Posttest and Gain Scores
for Treatment Therapies

Treatment	n	Pretest	Posttest	Gain
Reality Orientation	8	14.88 (2.42)	15.50 (1.77)	0.63 (1.50)
Validation	11	12.18 (3.37)	16.09 (3.59)	3.91 (2.95)

Note: Parentheses indicate standard deviations.

There were a possible 20 points on the EIS. A higher score indicates a higher degree of ego integration. No specific definition of score value was established. Table 4 shows that a significant difference was found between the mean gain scores on this scale. The Validation treatment groups experienced a positive, significant change in ego integration.

Table 5

One-Way Analysis of Variance on Ego Integration Gain Scores

Source	SS	df	MS	F	Probability
Between	49.95	1	49.95	8.26	. 0.01
Within	102.78	17	6.05		
Total	152.74	18			

Table 5 shows the means and standard deviations of the behavior scale scores for the independent variables. Intra-judge reliability was assessed by comparing correlations between the three observers on both pretest and posttest ratings for the Behavior Assessment Tool (BAT). The correlations ranged from .80 to .90 and were judged to be sufficiently high so that the three observers' ratings could be averaged for a single mean score to be used in the data analysis.

Table 6

Mean Behavior Pretest, Posttest and Gain Scores
for Treatment Therapies

Treatment	n	Pretest	Posttest	Gain
Reality Orientation	8	19.38 (4.63)	19.25 (3.88)	-0.13 (1.36)
Validation	11	18.91 (6.27)	18.45 (7.38)	-0.45 (2.46)

It should be noted that there were a possible 40 points on the Behavior Assessment Tool (BAT). A higher score indicated a lower level of functioning. Feil (1982) divides the scale into four stages of behavior. Stage I scores range from 10-15; Stage II scores from 16-25; Stage III scores from 26-35; and Stage IV scores from 36-40. Both pretest and posttest scores for each treatment group showed mean scores falling in the Stage II range of the scale. The standard deviations do, however, indicate a fairly wide spread across the scores. Table 6 shows that there was no significant difference between the mean gain scores on the behavior scale.

Table 7

One-Way Analysis of Variance on Behavior Gain Scores

Source	SS	df	MS	F	Probability
Between	0.50	1	0.50	0.12	0.74
Within	73.60	17	4.33		
Total	74.11	18			

Table 7 displays the correlations between the pretest and posttest scores for the Reality Orientation groups.

Table 8

Correlations among Pretest and Posttest Scores
on the Three Dependent Variables
for the Reality Orientation Treatment Groups (n=8)

Confusion Pretest	1.00					
Confusion Posttest	*0.78	1.00				
Ego Integration Pretest	-0.10	0.08	1.00			
Ego Integration Posttest	-0.67	0.22	*0.78	1.00		
Behavior Pretest	-0.21	-0.48	0.20	0.08	1.00	
Behavior Posttest	-0.20	-0.54	0.28	0.10	*0.96	1.00
	Conf. Pre.	Conf. Post.	Ego Pre.	Ego Post.	Beh. Pre.	Beh. Post.

*p < .05

Not surprisingly, these results show a strong correlation between like pretests and posttests (Confusion 0.78, Ego Integration 0.78, and Behavior 0.96). No other correlations were significantly different. The negative signs in this table are due to the fact that higher scores on the confusion scale indicate a lesser degree of confusion, and higher scores on the behavior scale indicate a lower level of behavioral functioning. Since it can be reasonably assumed that these two measures are related, such that greater confusion and lower behavioral functioning are common to one another, the negative signs in the table are consistent with the reverse scoring procedures.

Table 8 displays the correlations between the pretest and post test scores for the Validation treatment group.

Table 9

Correlations among Pretest and Posttest Scores
on the Three Dependent Variables for the Validation Treatment Groups (n=11)

Confusion Pretest	1.00					
Confusion Posttest	*0.86	1.00				
Ego Integration Pretest	0.29	0.36	1.00			
Ego Integration Posttest	0.48	0.58	*0.64	1.00		
Behavior Pretest	*-0.79	*-0.92	-0.42	-0.54	1.00	
Behavior Posttest	*-0.73	*-0.82	-0.38	-0.57	*0.95	1.00
	Conf. Pre.	Conf. Post.	Ego Pre.	Ego Post.	Beh. Pre.	Beh. Post.
*p <.05						

As with Reality Orientation group, this group's scores also show expected strong correlations between like pretests and posttests (Confusion 0.86, Ego Integration 0.64, and Behavior 0.95). Unlike the Reality Orientation group, however, a strong correlation ($p < .05$) is suggested here between behavior and confusion scores (Pretest -0.79 and Posttest -0.82).

Summary

The results show the following effects on the study's original null hypotheses:

1. There will be no significant difference between mean pre and posttest gain scores on a measure of orientation due to either treatment approach (not rejected).
2. There will be no significant difference between mean pre and posttest gain scores on a measure of ego integration due to either treatment approach (rejected for the Validation treatment groups).
3. There will be no significant difference between mean pre and posttest gain scores on a measure of ego behavior due to either treatment approach (not rejected).

DISCUSSION

The main purpose of this study was to determine some of the effects of Reality Orientation and Validation treatment approaches when using music therapy with confused elderly adults. The support, and lack of support shown for the hypotheses presented earlier is subject to further interpretation and speculation since several factors may have influenced the results.

First, it is important to note that no negative effects were shown for either treatment group on any of the three dependent variables. It may have been expected that subjects in the Validation groups would show a decrease in the level of orientation following treatment, but this was not the case. Indeed, there was a slight improvement. While a bigger improvement was seen for subjects in the Reality Orientation groups, these results may or may not have been significant if a larger sample had been tested. Extremely minimal changes were shown in the area of behavior for both treatment groups. While it was thought that while the length of treatment was sufficient for measuring changes in orientation and ego integration, it was perhaps too brief to measure changes in behavior. Indeed, anyone working with patients in a nursing home setting can attest to the fact that maintenance alone is notable achievement.

It must be recognized that only a small number of subjects were available for participation in the study. This was in part due to the qualifications which required subjects to be at least 80 years old, be

physically capable of participating in a group and grant informed consent. The original intent of evenly spreading the subjects across treatment groups according to Feil's Stages of Behavior was to determine if changes on the three measures were different according to which Stage the subject was in. This idea was not pursued in the data analysis, due to such a small sample representation. In addition, the wide range of standard deviations may also have contributed to the lack of more significant findings, and may have been the result of a small sample population.

The one area in which a significant improvement was shown was that of ego integration in the Validation treatment groups. This result tends to support the theory that Validation may be superior to Reality Orientation when objectives in the area of ego integration are sought. It must, of course, be assumed that these results can only be generalized to the sample population tested, and further generalizations beyond the scope of the sample should be considered with caution.

Another point worth noting is that Reality Orientation has been shown to be more effective with subjects who are only mildly confused (Mitchel-Steven, 1980; Zepplin, Wolfe & Kleinplatz, 1981; Degun-Gian, 1976; Brook, Degun & Mather, 1975). Since the small sample size required that data be collapsed over the scores of all subjects in a group, instead of being broken down by Stages I, II and III, results are shown for a mean score falling in a moderately confused range. This may have contributed to the lack of significance found in the area of increased orientation for the Reality Orientation groups, since the combined level

of orientation was too low. In addition, the significant improvement that was shown in the area of ego integration for the Validation groups may have been influenced in a similar but reverse fashion. Feil claims that Validation is most effective with persons in Stages II or III, since persons in Stage I may still benefit from Reality Orientation techniques, and those in Stage IV are extremely difficult to communicate with at all. As with the Reality Orientation groups, the data for the Validation groups was collapsed over the scores of all subjects, resulting in a mean score falling in the Stage II range of the behavior scale. This mean score is in the ideal range for maximum effectiveness with a Validation treatment approach.

Other factors which complicated the study involved the tools for measuring the three dependent variables. While the Tool for Assessing the Degree of Confusion (TADC) and the Ego Integration Scale (EIS) were administered with little difficulty, problems were encountered on the Behavior Assessment Tool (BAT). The nurses who completed the BAT for each subject were frequently troubled by their attempts to accurately interpret the definitions of the four stages. It was necessary for the researcher to further interpret some of the descriptions, so more accurate assessments could be made. It was also necessary to add a superficial stage, and thus a score of zero (0) for those subjects whose behavioral functioning was above that of characteristics described in Stage I. Once these problems were solved, it was not felt that the alterations would confuse the results.

The strong correlations between behavior and confusion for the Validation groups are not surprising, since it is logical that these variables should be related, although this has not been significantly tested. It is impossible to draw any conclusions as to why these correlations do not appear stronger in the Reality Orientation groups due to the lack of significance in the scores. It should be noted, however, that though no significance was shown, the correlations for the Reality Orientation groups were in a similar direction to those in the Validation groups. The suggested lack of a correlation between confusion and ego integration in both groups, suggests that, among this sample population, one need not be oriented to have a higher degree of ego integration.

While a certain number of problems are inherent in any research project, there are also several positive aspects which result as well. This study was no exception. It would seem inappropriate to conclude that the statistical evidence presented in the Results section is sufficient support or lack of support for either group. There are other more subtle factors which should also be acknowledged.

Subjects in both treatment groups apparently enjoyed the consistency and content of the sessions since many expressed regret over seeing the groups end once the study was completed. Several members of the Validation group also expressed a great desire to continue the groups even if only on a weekly basis. Members of this group were also observed greeting each other (smiling, saying hello) throughout the day, which was not apparent prior to treatment. They were also concerned if an individual was absent from the session. Certain members of the Reality

Orientation groups were observed singing melodies and chanting the rhythmic phrases from their sessions throughout the day as well.

In conclusion, a review of the subproblems is included, with a short summary following:

The first subproblem was to compare mean gain scores of the Tool for Assessing the Degree of Confusion in the Elderly for the two treatment groups. The results did not show significance for improvement or loss on this measure in either treatment group, although slight improvements were indicated in both cases. This scale was shown to be related to the behavior scale, in that higher levels of confusion were consistent with lower levels of behavioral functioning.

The second subproblem was to compare mean gain scores of the Ego Integration Scale for the two treatment groups. The results indicated a significant improvement for subjects in the Validation groups only. This supports the theory that Validation may prove more effective than Reality Orientation in the sample population, regarding the areas of ego integrity.

The third subproblem was to compare mean gain scores of the Behavior Assessment Tool for the two treatment groups. The results showed very minimal changes in either direction for both treatment groups. It was felt that the brief treatment period may have contributed to this result.

Recommendations for Further Study

It is clear that this project holds many implications for further research and consideration. A larger sample population with more

attention given to specific stages of behavior and/or orientation may show further indication for the use of Reality Orientation or Validation. The exclusive testing of subjects with more specific similarities within treatment groups would perhaps yield more significant results. In addition, although this study tested subjects who were eighty years or older, this factor may perhaps be investigated further. The testing of relatively younger subjects who may also qualify through other criteria (behavior, orientation, etc.) should be considered.

The use of other measurement instruments may also yield different results. Since subjects were both selected and tested on behavior, using a tool developed by Feil herself, a more objective or nonrelated measurement instrument might be useful.

The musical selections used in this study were from very different time periods. It may prove interesting to manipulate the selections in order to achieve a sense of control for this factor.

It is also thought that the length of treatment was perhaps too brief, and that an extended treatment period would prove beneficial in obtaining more reliable results, especially in the area of behavioral functioning.

It must certainly be recognized, however, that all elderly are not the same, and knowledge of a variety of treatment approaches is necessary when considering which goals and objectives are to be sought. The music therapist can benefit greatly by becoming familiar with both of the approaches presented in this study.

APPENDIX A

Tool for Assessing the Degree of Confusion in the Elderly

Subject Number _____ Pretest _____ Posttest _____

Date _____ Total Positive Score _____

1-6 Severely Confused 7-12 Moderately Confused 13-18 Slightly Confused

Category of Confusion _____

CHECK (X) APPROPRIATE COLUMN

	Positive (not confused)	Negative (confused)
1. What is your name? a. must give last name b. last name only sufficient		
2. In what year were you born? OR How old are you now?		
3. What is the name of your doctor? a. last name sufficient b. must be name of doctor listed on medical chart		
4. What state are you living in now? What state is this?		

5. In what city are you living or staying now? OR What is the name of this city?		
6. What do you call this place or building where you are staying now? a. nursing home <u>or</u> name of nursing home <u>or</u> b. convalescent home/center <u>or</u> c. rest home		
7. What is the name of the street where this building is located?		
8. What year is this?		
9. What month is this?		
10. What day of the month is it today?		
11. What day of the week is it today?		
12. How many days are there in a week?		
13. What part of the day is it now? a. 8-12 noon--morning b. 12-6 p.m.--afternoon or evening		

<p>14. What is the weather outside like today?</p> <p>a. hot/warm f. pretty beautiful/sunny</p> <p>b. cool/cold g. nice/dry</p> <p>c. fair/clear h. bad/dreary/stormy</p> <p>d. raining/snowing</p> <p>e. cloudy</p>		
<p>15. What was the last meal you had to eat?</p> <p>a. breakfast <u>or</u> morning</p> <p>b. lunch <u>or</u> dinner <u>or</u> noon.</p> <p>c. dinner <u>or</u> supper <u>or</u> evening</p>		
<p>16. Who is the President of the United States now?</p> <p>a. first <u>or</u> last <u>or</u> both names</p>		
<p>17. What day of the week will it be tomorrow?</p>		
<p>18. What will be your next meal to eat?</p> <p>a. breakfast <u>or</u> morning</p> <p>b. lunch <u>or</u> dinner <u>or</u> noon</p> <p>c. dinner <u>or</u> supper <u>or</u> evening</p>		

TOTAL SCORES		
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SOURCE: Mildred Hogstel, R.N., Ph. D. Reprinted with permission.

Additional comments: (Summary comments, exact quotes of patient, or other observations that would help to clarify the degree of confusion. State whether at beginning, during or end of interview.)

APPENDIX B

Ego Integration Scale

Subject Number _____ Pretest _____ Posttest _____
 Date _____ Total Score _____

	Agree	?	Disagree
1. My life has been good	2	1	0
2. I worry about getting old	0	1	2
3. I am willing to take responsibility for my decisions	2	1	0
4. I most often feel worthless	0	1	2
5. I would not change my life if I lived it over	2	1	0
6. I feel discontented with my life	0	1	2
7. I feel in general that I have reached my goals	2	1	0
8. I think life is too short	0	1	2
9. I accept myself the way I am	2	1	0
10. I often think about my failures	0	1	2

Source: Marlene Peoples, R.N. Reprinted with permission.

APPENDIX C

Behavior Assessment Tool Based on Feil's Stages of Disorientation

Directions: Circle number of
behavior in each category
which is most characteristic

Nurse Identification Number _____

Subject Number _____	Date _____	Pretest _____	Posttest _____	Total Score _____
Behavior being assessed	First Stage	Second Stage	Third Stage	Fourth Stage
67 1. Control of body functions	Can dress, toilet and control the self most of the time 1	Incontinent due to lack of assistance. Cannot control bowel and/or bladder over long periods. Aware of incontinence. 2	Bowel and/or bladder incontinence persis- tent. Resigned to it or unaware of it. 3	No effort made toward control or incontinence. 4
2. Relation to reality	Holds onto present reality. Is aware of self and aware of confusion. Is threatened by con- fusion of self and others. 1	Forgets facts, names and place from the present immediately. Continues to with- draw inward, creates his own rules. 2	Shuts out stimuli from outside world. 3	Will not recog- nize staff or family who visit daily 4

3. Muscle control	Muscles tight. Stance rigid. Holds himself together to keep in control as defense.	Sits upright in chair with muscles relaxed. Neck muscles and lips loose.	Body slumped. Head bent forward in chair.	Completely loose. Little voluntary movement.
	1	2	3	4
4. Appearance of eyes	Eyes are clear and bright. Respond to interpersonal eye contact. Directly focuses on person to whom speaking.	Eyes are clear but often unfocused or downcast. Eye contact triggers recognition. Not dependent on recognition of outside environment. Eye contact not necessary.	Eyes are most often closed unless stimulated.	Eyes are closed. Face lacks expression.
	1	2	3	4
5. Voice tone	Speaks in harsh, accusatory or whining voice.	Voice is low, seldom harsh or whining, often off-key or distorted when singing or laughing.	Voice is low, steady, even toned and melodic.	Murmurs in very low, very weak voice.
	1	2	3	4

6. Body movements	Movements in space are quick and direct, related to events in environment.	Movements in space are slow, sustained, indirect or questioning. Dances with rhythm.	If walking, paces restlessly back and forth. Repeats restless, agitated movements.	May move finger slowly. Shows little or no voluntary movement.
	1	2	3	4
7. Response to communication	Seeks reminders of present time and place. May respond with some sense of humor. Responds positively to recognized authority. Responds negatively to behavior or physical disability of less-oriented persons.	Responds to nurturing touch or voice tone. When supported in trusting, respectful way may relate in present time with speech. Smiles when greeted. Can initiate communication.	Responds with little or no use of commonly understood words or phrases. Will not risk listening or talking to others unless stimulated.	Shuts off outside world. Does not respond to eye contact or touch unless stimulated repeatedly day after day.
	1	2	3	4

8. Relation to own feelings.	Denies feelings by strictly adhering to rules. Usually carries a cane, blanket, purse, or sweater to ward off loneliness.	Expresses feelings through movements and symbols. Is sensitive to voice tones, and feelings from present and past. Can respond positively to sexual feelings. Can substitute memories of feelings from past in present situations.	Expresses longings to return to early childhood sensory experiences by repeating body movements and sounds. Openly acts out sexual feelings without regard for property.	Self-stimulation is minimal. Makes no effort to express feelings.
	1	2	3	4
9. Relation to time.	Keeps track of present clock time. Desires to adhere to schedule. Confabulates when doesn't know time.	Loses track of clock time. Interprets present time and past time without awareness of doing so.	Never moves in commonly accepted time. Has lost ability to relate to present time. Remembers and relates to early life and events. Always moves in personal time in increments of personal life.	Shuts out all relation to present time. No longer talks to even people from past life.
	1	2	3	4

10. Ability to read and write.	Can read (unless blind) and write well.	Able to read but is losing ability to write legibly.	Does not read or write since no longer motivated to communicate.	Shuts off outside world. Cannot be motivated to try to read or write.
	1	2	3	4
Total of circled scores				
Key:	Stage One 10-15	Stage Two 16-25	Stage Three 26-35	Stage Four 36-40

APPENDIX D

Informed Consent

TO THE PATIENT:

You are being invited to participate in a research study which will be conducted at Friendship Village by two music therapists. One of the therapists is Debra Harvey who has served as the Activity Director at Friendship Village for the last three and a half years. The other therapist is a music therapy intern at Friendship Village.

The purpose of this study is to help determine if differences exist between two different treatment approaches in a music therapy session. We are trying to find out how to provide the best possible care for our patients. In order to do this we need to measure the effects of each approach in a closely monitored setting. Both approaches have been determined to produce positive results. We want to know which one is better. Neither approach will require that any change in your plan of care or medication take place.

If you consent to participate in the study you may be asked to:

1. Answer some questions relating to the world around you and some questions relating to yourself and your attitude toward life in general.
2. Take part in a group meeting every weekday morning for six weeks. The meetings will last approximately 25 minutes. The meetings will not interfere with your meals or scheduled care.

Your answers to the questions and your level of participation in the meetings will be kept strictly confidential by the group leaders. While it is possible that the content of the group's activities and

conversations may not be kept confidential by other group members, each participant will be specifically requested to maintain such confidentiality. The results of the study will be presented in a manner such that your identity will not be known.

Refusal to participate or the request to withdraw from the study at any time will not result in prejudice of any kind.

Potential Risks or Discomforts

1. Moving to and from the group meeting area may be a source of inconvenience but will be no more difficult than going to a meal or other activity. The meetings will take place in the Activity Room. The staff will assist you each day. The meetings will not interfere with your meals or scheduled care.

2. Other members of the group may be a source of annoyance through yelling, crying, etc., but again this should be to no greater degree than what you might currently experience in the Health Center.

3. Recalling past memories may be a source of emotional discomfort but only the feelings you express freely will be explored. It is hoped that the expression of these feelings will help you to feel better.

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