Description of disorder

Dementia describes a change in a person’s thinking and memory that has many possible causes. These changes in thinking affect everyday life and represent a decline from a previous level of functioning. In addition to thinking changes, the person’s ability to take care of themselves and behavioural problems are common. With dementia, there are a number of different ways the illness can present itself. This depends on a person’s stage of the illness, as well as the severity of the dementia. Thus, one might see a person with mild memory problems at one extreme, with another person who could not care for himself at all and has a limited ability to speak on the other. Alzheimer's disease is the most common type of dementia at any age, with vascular dementia also a frequent type. Dementia can occur at any age, but the occurrence of the disease rises steeply with age, from 1 in 1000 persons having dementia in the age group 40 – 65, to 1 out of 5 person in the over 80's.

Treatment comparison

RO is mainly used with people with dementia. It could, however, be used with people experiencing other forms of cognitive changes. When RO group sessions were compared to social and activity therapies as well as to no treatment, those with RO did better on measures of thinking and memory and behaviour (self-care, etc.). For 24 hour RO, there is less research, but one study showed positive results on thinking and behaviour. People with dementia can learn to find their way on a ward or home, when signposts, orientation aids and brief direct training sessions are used. Persons with very severe dementia and major problems with speech will not be able to take part in RO groups. Studies have been done in different countries, and a number of different settings. However, there is little known about how RO affects sub-groups of people with dementia, such as ethnic minorities.

While none of the controlled studies show negative effects of RO, there have been a few accounts of problems using RO with older people. This may be the result of the insensitive use of RO. Caregivers sometimes try to orient the person to their own view of reality, rather than listening to, and trying to make sense of, the patient’s attempt to communicate. In doing this, they may miss the deeper, emotional meaning of the communication. Approaches such as Validation and Reminiscence Therapies are sometimes preferred to RO, as they are thought to be less likely to be used insensitively.

Treatment description

Two main forms of RO have been described:

- RO group sessions and
- 24 hour RO.
Twenty-four hour RO is an environmental treatment, requiring changes to the physical and social environment.

**RO Group Sessions**

This is basically a programme that stimulates cognition, within a social group. RO sessions usually last from 30 to 45 minutes and typically meet twice a week. Five or six patients meet with one or two group leaders in a comfortable room with a whiteboard. After introductions and welcome, the whiteboard will often be used to act as a focus for discussion of current events and orienting information. There may then be discussion of a particular theme, always with an object or a picture to help patients stay focused on the topic. This could include a game or another activity with a cognitive focus. Stimulating a variety of senses – through vision, sound, touch and smell – is aided by the use of music, preparing simple food and looking at interesting objects, from the present time as well as those that assist reflecting about the past. Refreshments add to the social atmosphere. Patients are encouraged to take an active role in the group, and, if they can, to keep a notebook or diary. RO group leaders do not need a particular professional background in order to lead RO groups. It is important, however, that the leader has a respectful, person-centred approach, sensitive to the individual needs of the group members. It is helpful if the range of cognitive impairment within the group is not too great, to avoid some members becoming bored or frustrated. Persons with severe hearing or vision problems, those who cannot communicate or who have severe agitation would not do well in the RO groups.

**24 Hour RO**

The living situation must first be set up with orientation aids. These might include signposts, which show important locations (such as bedroom, toilet, kitchen etc.). An orientation board with up-to-date information is placed where it can easily be read. Clocks and calendars, with easily readable print, must be provided. Patients may have their own personal memory aids, in the form of a notebook or diary. These might include meaningful photographs and pictures. These can form the basis of orienting interactions with caregivers.

Caregivers must be trained to encourage patients to make use of the meaningful orientation aids, and to help patients in taking in information they need. The original approach to 24 Hour RO had staff orienting patients each time they dealt with the patient, throughout the day. This has now been changed, so that the staff role is more reactive, responding to the patients’ questions, preferably by helping the patient use the correct orientation aid. This change has the goal of keeping the patient from being overwhelmed with information that cannot easily be taken in. Caregivers need to see their role as a helper, and to recognise the importance of keeping orientation aids up-to-date and accurate. The importance of avoiding arguments with the patient, and of being sensitive to emotionally loaded information needs to be appreciated by all caregivers. Respect for the patient’s reality is a key part of a person-centred approach.
Finally, every effort should be made to enrich the environment, by offering a wide range of opportunities and activities. Patients are more likely to want to know whether it is Tuesday or Thursday, if there is a reason to know. If every day follows the same dull pattern there will be no purpose to RO. Patients will have more need to learn where their own room is, and to recognise it as their own, if it is where they keep a number of valued personal belongings, photographs and mementoes. If the room is bare, or shared with several other patients, there will be no desire to learn its location. A rich environment is one that is worth being oriented to.

Bob Woods trained and worked initially as a clinical psychologist in Newcastle-upon-Tyne. Subsequently he combined extensive clinical work with older people with academic appointments at the Institute of Psychiatry, London, and University College London. He was appointed to the first Chair in Clinical Psychology with Older People in the U.K., at the University of Wales, Bangor in 1996. He is Director of the Centre for Social Policy Research & Development and Co-Director of the Dementia Services Development Centre Wales. He is a member of the Medical & Scientific Advisory Panels of the Alzheimer’s Society and Alzheimer’s Disease International. He published his first research evaluation of Reality Orientation in 1979, and with Una Holden, co-authored the book “Reality Orientation: Psychological Approaches to the ‘Confused' Elderly” which first appeared in 1982. The third, extensively revised edition of this book, re-titled ‘Positive approaches to dementia care’ was published in 1995. He is co-author of the Cochrane systematic reviews on Reality Orientation and Reminiscence Therapy in dementia.