Needs and Opportunities in Rehabilitation

Rehabilitation of the elderly: 2—Mind and body

DAPHNE GLOAG

Two elderly women I knew went on saying "I want to die" while people close to them claimed that they were happy in their good residential homes. "As full of grief as age; wretched in both," says King Lear of himself; and Arie has pointed out that the active inner life and inner suffering of many old people, who have less distraction than younger people from their passions and griefs, are often ignored.¹ Students in his department are urged to read novels about old people to get a more complete picture.

Even though only 1-2% of elderly people may have a persisting depressive illness, feeling depressed and other mood disturbances are common, though perhaps masked by physical preoccupations (p 90¹). In one survey half the people using different types of day units for the elderly were depressed.² A rehabilitation service surely fails if it neglects this central core, and regular case conferences should help to keep psychological aspects in view. Certain of those with more severe disturbance could benefit from psychotherapeutic help¹ but seldom get it; but this could be integrated in some form with ordinary services, maintains Bergmann, since various workers—doctors, nurses, social workers, occupational therapists, psychologists—have the potential, through their human involvements, for giving therapy.¹ He argues that understanding emotional needs and helping people who wish to be independent to cope with stressful circumstances should be at the centre of many therapeutic programmes, and that precise help of this kind should be preferable to more generalised practical support and care that is inappropriate and unnecessary.

Activities are not usually the answer to psychological distress but doing nothing clearly may add to this. Some day centres, however, offer no activities²; and an observation study of elderly people highlighted the amount of isolated inactivity in different care environments, including day care—more than half the observation time in the local authority homes studied.³ Care staff generally did things to or for rather than with the people concerned and rarely promoted any kind of activity, whether recreational or domestic. But attitudes are slowly changing, and even permanent confusion is found to be often greatly helped by a satisfactory social environment.⁴

Mental stimulation

The demented, confused, depressed, and withdrawn clearly come off worst. Active psychological approaches, however, are becoming more widely used. Evidence suggests that they may at least improve the quality of life and may even help functioning to some degree.⁵ Even those suffering from dementia seem to have some capacity for learning⁵; moreover, anything to combat under-functioning, loss of confidence and self esteem, and lack of sensory stimulation can be helpful. Reality orientation in particular has caught on in Britain in the past four years or so, and is now included

Informal reality orientation

Reminders Remind the person who and where he or she is; what time it is; what is happening in the surroundings.

Rambling and confused talk Tactfully disagree on less sensitive subjects, change the subject and discuss something concrete, or acknowledge the feelings expressed but ignore the content.

Communication Speak clearly in short, simple sentences; encourage response and repetition; correct sensory deficits; use all sensory modalities, with eye contact and touch to maintain attention; use past experiences as a bridge to the present; keep conversation specific; encourage humour; provide a commentary on events.

Orienting cues in the environment Use clocks, calendars, signs, and pictures—large, clear, and accurate.

From tables 6.3-5 in Holden and Woods.⁵ *24 Hour Approach to the Problems of Confusion in Elderly People*⁶ is designed for relatives and other care givers.

in the training of care staff. In its informal or "24 hour" form (box) this crystallises what many people have always attempted—namely, the maximum interaction and communication between staff and residents or patients, aimed at keeping the latter in touch with basic facts and with what is going on.⁵ The continuous use of the method may be backed up by formal group sessions, the emphasis being on stimulation of all the senses, varied activities, and social awareness. With both approaches a tangible focus for conversations (photographs, flowers, and so on) and materials for activities are important (figure).

Reality orientation aims to conquer the vicious circle of failure and withdrawal by easing the person, with suitable cues, towards correct responses and modest achievements. Individuals have sometimes shown dramatic improvements. Rigorous evaluations are difficult, not least because in people naturally on a downward course a finding of no change, or even slight deterioration, could really be a victory for rehabilitation that might pass unnoticed. Controlled studies have compared reality orientation with some other kind of staff attention. They have generally shown clear but small, even trivial, improvements, mainly cognitive rather than behavioural^{5,6} except where behaviour was the specific concern (for example, in "ward orientation"); changes have usually been restricted to the aspects specifically covered in the reality orientation programme and have not persisted. But a study in day hospital patients who had two half hour sessions two or three times a week suggested improvement not only in orientation but also in the mood of the patients at home and of their relatives.⁸ In their critical review Powell-Proctor and Miller urge that reality orientation should be used as a stepping stone to the development of more effective

intervention programmes rather than followed blindly as a "sterile exercise."⁶

Controlled studies tend to use formal sessions rather than continuous reality orientation⁹; does the latter have more generalised effects? It has at least the non-specific effect of improving the quality of interaction between staff and patients or residents; an acknowledged benefit is that it shifts the emphasis away from a pessimistic and purely custodial approach and towards the needs and potential of the individual.⁵ For lessening confusion continuous reality orientation would be expected to be more effective than isolated sessions. Arie emphasises the importance of exploiting every opportunity to help orientate and reassure the confused person by setting the scene ("Good morning, Mrs X. Have you had breakfast?" was an example given by a ward sister). Always using a person's name is important here for, suggests Arie, it "comes to the

A word game in progress in a reality orientation session at Meadowbank day hospital for the elderly, Nottingham. The helpers are a nurse and a physiotherapist.

confused often as a beacon of light across a murky fog."⁴ At one local authority home I visited the officer in charge tries to use the informal reality orientation approach despite staff shortages. She emphasises to her staff the quality of interaction with the residents that is needed in all the comings and goings of the day, finding even the less well educated care assistants quite able to get the hang of it. Here a severely demented man who believed he was a lorry driver managed satisfactorily for some years by going round with the handyman member of the staff most of the day.

Thus reality orientation can be a philosophy and a structure of care, and should be only one aspect of the total programme of domestic, social, and recreational activity⁵: a starting point rather than an end in itself. At a private psychogeriatric home, set up five years ago by a psychiatric nurse because of the poor provision for such people at that time, the programme is based on constant mental stimulation. Both formal and informal reality orientation approaches are used and there are activities all day, from domestic chores and visits to the shops to handicrafts and music and movement. Newspapers are discussed and an "orientation" information board of newspaper cuttings and other items is changed daily by the residents. A simple, repetitive pattern of everyday activities is thought important for giving a basic structure to the day. Use of the tea making facilities is encouraged and everyone has a simple but mildly responsible daily job, such as watering the plants, for enhancing their sense of identity and respect.

Would other homes be better for this kind of approach? While less than half the residents may be appreciably demented in most homes many others are confused, withdrawn, or apathetic and might well benefit from more stimulation and activity.⁵ A caveat is that staff need to apply reality orientation and any other programme flexibly and sensitively, treating these old people with dignity and not as if they were children. The elderly must also be free to be left

"to be quiet," as one woman said to me, if that is what they really want. In addition, most homes have not the staff for ambitious programmes. Even so, Godlove and others found an average staff:resident ratio of 1:2.3 in the local authority homes they observed.³ They suggest that changed priorities and less rigid patterns of work are a greater need than more staff: why not, they say, have activity materials (paintings, crafts, games, etc) always at hand in day rooms—in longstay wards as well as residential homes—with care staff and nurses and not only occupational therapists encouraging their use and discussing them? All this clearly applies also to day care, and I have seen good examples. Ideas and materials for activities are available¹⁰⁻¹⁴ (see also *Help the Aged* and Winslow Press catalogues). Holden's booklet⁹ and a booklet from the Alzheimer's Disease Society are helpful for relatives. *Thinking It Through* is a simple, clear handbook for staff working with elderly people that includes suggestions for changes and discussion topics and exercises for staff training.¹⁵ Carter's survey suggested a great need for more training of staff in day centres.²

At one local authority home I visited the fortnightly service taken by a local vicar is said to be the activity the residents would be most sorry to lose. More regularly, informal sing songs and putting on records when someone has a moment are a staple activity in some homes. These encourage reminiscences. "Reminiscence therapy" has been found a useful adjunct to reality orientation. Kits of materials are available from *Help the Aged* and from the Winslow Press. *When We Were Young* (available from *Help the Aged*) is the result of a reminiscence group in sheltered housing led by volunteers.

For those who are mentally alert such activities as play readings and creative writing groups in residential homes are sometimes run by adult education teachers and by volunteers. Carter comments on the shortage of discussion groups and of educational programmes in day units. Help with transport to ordinary adult education classes for those living at home should perhaps receive more attention. Some branches of the fast growing University of the Third Age for the retired have plans to organise home tuition for the housebound.

Both doctors and other professionals and care givers should think seriously about the hobbies that a person could continue or take up with modest aids and adaptations. Gardening may be feasible with raised flowerbeds, trolleys, and special tools.¹⁶ (See 12 January, p 134 (box 1), and 19 January, p 223 (box), for aids for leisure activities.) For musical people the clavichord, which has a light touch and can be portable and used by those in wheelchairs, could be an ideal instrument; a few of those made by Robert Morley and Company have gone to institutions.

Pets have been found to have therapeutic value, both at home and in residential care, in improving the social adjustment and mental health of elderly people.¹⁷⁻¹⁹ Minnesota has a law specifying that residents in State institutions may keep their pets. Should not institutions and centres for the elderly be urged to consider where practicable animals as allies in rehabilitation?

Mobility and physical activity

Even a little exercise may make all the difference in enabling frail people to get to the lavatory unaided or do their own hair. As with other groups of patients, physiotherapy may not always be used to best advantage: the need is often for more intensive treatment, perhaps for a shorter time or intermittently, with plenty of practice between sessions and some kind of maintenance afterwards. In hospital and day hospital physiotherapists can train unqualified helpers—mature people with the right personality—to fill some of the gap. Relatives might be taught to supervise, say, hourly exercises²⁰; but more domiciliary physiotherapy is needed. In a San Francisco project physiotherapists take helpers to patients' homes and teach patients, relatives, and helpers together (G P Mulley, personal communication). To help pinpoint the precise weaknesses needing attention, electronic assessment of gait and balance has been developed by the Birmingham University department of geriatric medicine; it will be used before and after a programme of physical training to study the effectiveness of this.²¹ After discharge

from physiotherapy there may still be music and movement and games at a day unit. Many professionals and elderly people themselves are enthusiastic about the benefits of EXTEND and other systems of recreational exercise (addresses below). Devices such as bicycle ergometers and "rowing" machines, for rehabilitation after illness and for regular use,²² are helpful but expensive.

Longstay wards and old people's homes often have exercise or music and movement classes once or twice a week. I took part in a class in a ward for severely confused and frail women. Some kind of activity through the week is desirable but staff inadequacies too often scotch this ideal. At one local authority home, however, the elderly matron takes some of her residents swimming; some manage visits to shops or park; and at another records are played informally every day, to which many of the residents (aged 70-102) will dance.

Walking is clearly the most natural and useful activity but may need supervision. (Many walking sticks incidentally are the wrong length or dangerous and should be checked as a routine.²³) One frail woman said, "They walk us in the garden"; ideally walks should have some attractive purpose for each person, especially where movement is a battle. For the elderly and debilitated to maximise the function of deteriorated muscles and vital organs where possible would seem to be sensible, and exercise training is said to produce as much relative improvement as in younger people.²⁴ Anxiety has been found to be reduced by exercise too mild to bring about physiological change, and mental function (even in the confused) and self image may be helped,^{5 25} though one study found little evidence of psychological benefit.²⁶ Some of those who are fit enough profit from dancing classes for the elderly. An hour's exercise, including walking, three times a week or half to one hour a day has been recommended²⁴; more common advice is at least 20 minutes' walk three times a week. How is any of this to be achieved? A more widespread interest in the possible value of exercise for well being, among professionals, relatives, and elderly people themselves, with more help from volunteers, might be part of the answer; and out of this might come clearer objective evidence of overall benefit in different groups of the elderly.

Conclusion

Pessimism about what can be done is a feature of poor departments, says a report on psychogeriatric services, and the same could be said of geriatric rehabilitation in general; feeling the need for change and a vision of what needs to be done in those holding key posts are essential for advance.²⁷ Of course more money and more staff, particularly therapists, are needed, but what we have often misfires or could be used to better effect. Aids and home modifications are often too late or wrong; physiotherapy and other treatments may be too dilute to do good and may need reorganisation; staff stick too rigidly within set patterns of work, professional helpers may be too numerous, working at cross purposes in a given case; services are not always integrated with each other. Many frail old people are never even considered for rehabilitation; many wither in lonely inactivity, and many relatives reach the end of their tether. If the body has adequate attention, often the mind does not. Good, simple ideas are plentiful and should have much wider currency; the practices of the best places can often be adapted elsewhere, even at home. Doctors (in particular GPs) and other professionals need to know about the small things and activities that can make life easier or richer—not so often the electric stair hoist as the tilting teapot and other simple tools of daily living that epitomise Wolff's work on low technology for the aged²⁸—and they need to take the initiative in following them up. Relatives and other care givers, as with other groups of handicapped people, have to be supported, educated, and

motivated to help and not overprotect. Above all, everyone, including the patients, should know that something can be done and is worth doing.

I am grateful for help from many people, especially Dr K Andrews, Department of Geriatric Medicine, University of Manchester; Professor T Arie, Department of Health Care of the Elderly, University of Nottingham; Mrs Una Holden, Roadwater, Somerset; Dr R E Irvine, St Helen's Hospital, Hastings; Professor B Isaacs, Department of Geriatric Medicine, University of Birmingham; Dr G P Mulley, Department of Medicine (Elderly), St James's University Hospital, Leeds; Mr R Padgett, Kilncroft Rest Home, Hastings; Miss Zena Ryan, Chestnut Lodge, London W5; Mr R T Woods, Department of Psychology, Maudsley Hospital, London.

Addresses

Alzheimer's Disease Society Bank Buildings, Fulham Broadway, London SW6 1EP
 Help the Aged 1 Sekforde Street, London EC1R 0BE
 University of the Third Age 6 Parkside Gardens, London SW19 5EJ
 Robert Morley and Company 4 Belmont Hill, London SE13

Some systems of therapeutic but recreational exercise (using trained teachers) adapted for the elderly and disabled

EXTEND (Exercise Training for the Elderly and/or Disabled) 5 Conway Road, Sheringham, Norfolk NR26 8DD
 Margaret Morris Movement Suite 3/4, 39 Hope Street, Glasgow G2 6AG
 National Keep Fit Association 33 Senlac Road, London SE12

References

- 1 Arie T, ed. *Health care of the elderly. Essays in old age medicine, psychiatry and services*. London: Croom Helm, 1981;11-9, 71-139.
- 2 Carter J. *Day services for adults: somewhere to go*. London: Allen and Unwin, 1981.
- 3 Godlove C, Richard L, Rodwell G. *Time for action: an observation study of elderly people in four different care environments*. Sheffield: Joint Unit for Social Services Research, 1982.
- 4 Arie T. Confusion in old age. *Age Ageing* 1978;7:72-6.
- 5 Holden U, Woods RT. *Reality orientation*. Edinburgh: Churchill Livingstone, 1982.
- 6 Powell-Proctor L, Miller E. Reality orientation: a critical appraisal. *Br J Psychiatry* 1982;140:457-63.
- 7 Hanley IG, McGuire RJ, Boyd WD. Reality orientation and dementia: a controlled trial of two approaches. *Br J Psychiatry* 1981;138:10-4.
- 8 Greene JG, Timbury GC, Smith R, Gardiner M. Reality orientation with elderly patients in the community: an empirical evaluation. *Age Ageing* 1983;12:38-43.
- 9 Holden U, Martin C, White M. *24 hour approach to the problems of confusion in elderly people*. Buckingham: Winslow Press, 1984.
- 10 Help the Aged. *Handbook of activities for elderly people in residential settings* (with step by step explanations and a guide to resources). London: Help the Aged (in press).
- 11 Rush J, McAusland T. *A guide to training resources for staff working with "confused" elderly people*. London: King's Fund Centre, 1982.
- 12 Cornish PM. *Activities for the frail aged*. Buckingham: Winslow Press, 1984.
- 13 Mercer F. *Handbook of indoor social activities*. Buckingham: Winslow Press, 1981.
- 14 Holden UP. *RO reminders: pocket reference of ideas*. Buckingham: Winslow Press undated.
- 15 Holden UP. *Thinking u through. A handbook for those working with the elderly*. Buckingham: Winslow Press, 1984.
- 16 Chaplin M. *Gardening for the physically handicapped and elderly*. London: Batsford, 1978.
- 17 Corson SA, Corson O. Companion animals as bonding catalysts in geriatric institutions. In: Fogle B, ed. *Interrelations between people and pets*. Springfield, Illinois: Charles C Thomas, 1981.
- 18 Walster D. Why not prescribe a pet? *Geriatric Medicine* 1982; April: 13-9.
- 19 Fogle B. *Pets and their people*. London: Collins Harvill, 1983.
- 20 Cosin LZ. New concepts on rehabilitation for the disabled and elderly patient. *Rehabilitation* 1975;No 95:13-7.
- 21 Nayak USL, Gabell A, Simons MA, Isaacs B. Measurement of gait and balance in the elderly. *J Am Geriatr Soc* Aug 1982;30:516-20.
- 22 Gibbs R. *Exercise for the over 50s*. London: Jill Norman, 1981.
- 23 Sainsbury R, Mulley GP. Walking sticks used by the elderly. *Br Med J* 1982;284:1751.
- 24 Laerum M, Laerum OD. Can physical activity counteract ageing? *Scand J Soc Med* 1982; suppl 29:147-52.
- 25 Ingebreten R. The relationship between physical activity and mental factors in the elderly. *Scand J Soc Med* 1982; suppl 29:153-9.
- 26 Blumenthal JA, Schocken DD, Needels TL, Hindle P. Psychological and physiological effects of physical conditioning on the elderly. *J Psychosom Res* 1982;26:505-10.
- 27 Health Advisory Service. *The rising tide. Developing services for mental illness in old age*. Sutton, Surrey: NHS Health Advisory Service, 1982.
- 28 Wolff HS. Tools for living—a personal view of new status for aids for the disabled in society. *J Biomed Engng* 1981;3:329-30.