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CONCEPTUAL ANALYSIS OF VALIDATION THERAPY

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ABSTRACT

The present article examines the conceptual aspects of Validation Therapy. Validation Therapy is a humanistic approach used to give disoriented old-old people, eighty years and older, an opportunity to resolve their life's unfinished conflicts by encouraging them to express their feelings. This approach emphasizes the relationship between the old-old person and the caregiver by focusing on empathy, acceptance, and acknowledgment. Four stages of disorientation, ranging from mild to severe, are described on the basis of emotional and physical characteristics. The theoretical assumptions and underlying principals of Validation Therapy are discussed. Finally, research studies are outlined to evaluate the effectiveness of Validation Therapy. It is concluded that although Validation Therapy is a well-formulated, alternative approach to helping disoriented individuals, further research is needed to determine its validity.

Validation Therapy (VT) is a humanistic approach used to give disoriented elderly people an opportunity to resolve their life's unfinished conflicts by encouraging them to express their feelings. The validation approach was originated by Naomi Feil in the 1960s, and has been widely used throughout North America.

The primary goal of VT is to give the disoriented individual a sense of identity, dignity, and self-worth by validating their feelings without analyzing and interpreting their behavior. The underlying principal of VT is Rogerian humanistic psychology, which is based on the individual's right to be unique. This right is most likely to be respected when therapists have a positive attitude toward clients, and are willing to reflect and validate the clients' feelings of confusion, fear, courage, and love [1]. Validation therapy is based fundamentally on the relationship between therapist and client. The importance of this relationship is supported by Strupp and Hadley, who suggest that the quality of

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the therapist-client relationship is the single most important "ingredient" responsible for changes across all psychological treatments [2].

A major premise of VT is that despaired elderly people, as defined by Erikson, often become isolated, withdrawn, and disoriented in institutionalized settings. According to Erikson, the final developmental stage of life is marked by a struggle between "ego integrity" and "despair" [3]. Despaired elderly individuals are unable to accept the fact that they have not reached their life goals. In contrast, integrated elderly individuals have accepted life's events, and are able to resolve life's conflicts.

Feil describes the case of a despaired eighty-five-year-old man, who as a young person was an unsuccessful professional, and who was unable to express his frustrations and resolve his conflicts. Upon reaching old-old age, his physical and mental losses created additional anxiety, and ultimately he was left with feelings of despair. This man acted out his frustrations by breaking objects and by becoming untrusting of nursing home staff and other residents [4]. Feil notes individuals who cannot resolve unfinished conflicts will become more disoriented than those who can resolve them [5].

DEFENSE MECHANISMS

Defense, or coping, mechanisms are those psychological processes that are used to defend one's self against anxiety and fear. These mechanisms tend to provide some temporary security. Often, however, when old people attempt to utilize these coping mechanisms, they are considered difficult, uncooperative, or noncomplacent [6]. Verwoerdt identifies denial as an important coping mechanism. Denial was used by Feil's eighty-five-year-old man so that he would not have to confront his intellectual and physical deficits. The use of denial protects the individual from full awareness of these deficits [7].

A plausible explanation for disorientation is that coping mechanisms, which were effective in providing a psychological equilibrium for young adults, are no longer effective in old age. In reaction to physical and intellectual deprivation, old-old disoriented people may withdraw from present reality, in which they have no role and no future. Zaidel suggests that when this occurs, non-rational or emotional output becomes heightened [8]. During the dream state, one does not use logical thinking, but rather non-rational eidetic images [9]. These images are often used by old-old disoriented individuals to help restore events from the past. If, for example, a ninety-year-old woman never told her mother she loved her, she may recreate her mother through eidetic imagery [9]. Fantasy may be used by disoriented old-old persons in order to compensate for various losses, and may help to restore feelings of usefulness, productivity, and dignity.

Commonly, disoriented elderly people who live in nursing care facilities are not listened to or understood by their caregivers. As a result, when old-old people express unresolved inner conflicts through their disorientation, they are

often labeled psychotic, demented, or insane [10]. In many of these cases, the individual has no history of mental illness. This labeling of old-old people is called disconfirmation [11]. Watzlawick, Beavin, and Jackson define disconfirmation as a pathological form of communication in which the listener denies the individual his or her self-identification [12]. Rather than displaying an attitude of acceptance and worth, mental health professionals apply labels that do not take into account a person's life experiences. In many cases, a climate of warmth and acceptance is not used to discover the person's perspectives [11].

DISORIENTATION

Feil divided disorientation into four stages ranging from mild to severe based on a population of institutionalized old-old people [5, 11]. Each stage is distinguishable on the basis of emotional and physical characteristics that are experienced by the old-old cohorts in that stage. These stages have been developed on clinical observations and case histories. Feil's stages have not been standardized.

In the first stage, called Malorientation, residents maintain socially prescribed rules. These individuals do not readily express their feelings. According to Feil, they would not benefit from VT because they are threatened by their own feelings and by occasional disorientation. Physically, their body postures are characterized by taut muscles and direct and purposeful gestures. The vocal tones of this group are harsh, accusatory, and whining.

In the second stage, called Time Confusion, individuals create their own inner reality by fantasizing. Feil's residents openly expressed their feelings, and were able to recall past events that held strong emotional components. Individuals in this stage are unconcerned with clock time, and often forget names and places. Physically, they move in a "slow" and "loose" manner; their shoulders tend to slump forward and their necks point downwards. Their vocal tones are low, and they sing and laugh readily.

In the third stage, called Repetitive Motion, individuals may moan, make "ooo" or clicking sounds, and may repeat certain words or phrases. They self-stimulate to express their inner conflicts. Physically, members of this group move gracefully and their muscles are loose, but they are unaware of their locomotive behavior. They do not respond easily unless stimulated through a combination of close contact, nurturing touch, voice, and eye contact.

The fourth stage is called Vegetation. Members of this group withdraw from the outside world and give up the struggle of living. They will not recognize family members or caretakers. Physically, they move slowly, and their eyes are either closed, or unfocused and staring. They do not respond to touch, voice, or eye contact. Often, they sit or lie in the same flaccid position for long periods of time, and appear to be sleeping. Feil suggests that this vegetative state is often

forced upon stage three individuals when they receive tranquilizing drugs or are restrained [5].

DEMENTIA

The etiology of dementia is complex. Dementia is a global deterioration of higher mental functions in intellectual, cognitive, and emotional respects [13]. According to Hoyer, "[Dementia] may be caused by cerebrovascular, microcirculatory (multi-infarct) changes in smaller brain vessels. Both illnesses are termed primary dementias" [13, p. 80]. These dementias include those of Alzheimer type and vascular type. Dementias due to extracerebral diseases or due to brain diseases which cannot be accounted for by degenerative or cerebrovascular brain processes should be distinguished in physiological and clinical terms [13]. Soumireu-Mourat suggests that they should be distinguished as secondary dementias [14].

One symptom that is usually common to all dementias is "mental confusion" [14]. Although VT does not include an investigation of the etiologies of confusion, an assumption of VT is that dementia has a number of causes, including social, emotional, and physical losses [15]. Validation Therapy is intended for use with those persons who have never been diagnosed as having any type of psychiatric disorders such as manic-depressive psychosis or schizophrenia. This approach would not be used for individuals who have been diagnosed as having primary dementia or an identifiable medical illness known to cause disorientation.

USE OF VALIDATION THERAPY

The validation approach is intended for old people over eighty who are struggling with various losses and who are expressing conflicts through their confusion. Clinically, it has been suggested that very old people display qualitative differences in the way they deal with their disorientation, as compared to younger old people. For younger old people, Reality Orientation (RO) and Remotivation Therapy have been implemented [4, 5]. Validation Therapy attempts to enhance a humanistic exchange between old-old people and caregivers. This exchange not only requires that therapists receive their clients' messages, but that the clients know that the messages are understood [11].

Validation Therapy involves five or six nursing home residents who meet in a group to discuss unresolved personal conflicts. The group is led by a nurse, social worker, or geriatric worker, who facilitates the discussion. Topics of discussion usually include death, family relations, loneliness, and disappointments with occupations. Topic selection is based on the conflict areas of the group. Asking questions, playing with objects, singing, acting out, and role-playing are methods that can be used by the residents to express themselves [5, 9, 11]. The asking of key questions such as who, what, where, and when offers the residents an opportunity to describe relevant events of their lives [10].

Two experimental studies that have investigated the effects of VT have been done by Peoples [11] and Babins [9]. Peoples compared RO, VT, and a no-treatment control group. Peoples rated thirty-one respondents using the Behavior Assessment Tool. This scale was developed from Feil's clinical observations [5]. The purpose of developing this assessment tool was to determine the stage of disorientation of each individual. The results indicated that VT helped some of the moderately to severely disoriented persons to get in touch with their feelings. Validation Therapy improved the residents' control of their bodily functions, improved their communication skills, decreased their aggressive behavior, and made them more responsive to the staff. Seven of the ten individuals who received VT showed qualitative improvements. These improvements were not seen in the RO group.

A major problem with the Peoples study, however, was that by randomly assigning residents to different treatments (RO or VT), each group contained residents from different stages of disorientation. Theoretically, Validation Therapy is useful only for certain stages of dementia. Feil has found that residents who are in stages two and three benefit more from VT than RO, but that residents in stage one benefited from RO [5]. Peoples did not incorporate this distinction into her design.

In a more recent study, Babins selected individuals for VT on the basis of their stage of disorientation. These participants were compared to a control group suffering from the same stage of disorientation. The total number of sessions was twenty-two, spread across eleven weeks. All participants were rated using two scales: 1) the Nurses Observation Scale for In-Patient Evaluation (NOSIE-30) was used to measure social behavior on the ward [16], and 2) the Group Observation Form was used by the therapist after each VT session to record observations [11]. This measure divides behavior into six categories using the following scale: 0 = never; 1 = rarely; 2 = occasionally; 3 = frequently; 4 = always.

The results from the group observation form (see Table 1) reveal differences between the sum of the first three sessions and the sum of the last three sessions. In all six categories, the validation group's gain score increased, e.g., "physically participates" gained sixteen points, "shows leadership" gained thirteen points, and "touches" gained thirteen points. These changes indicate that group members had more of a tendency to express themselves verbally and non-verbally during the last three sessions than during the first three. A possible explanation for this is that the participants felt better understood by the other residents in the group.

The results of the NOSIE-30 reveal that irritability scores increased from 58 to 78, or approximately 55 to 63 on the normalized *t*-scores. This increase can be explained by the group's discussion of conflicts. Statements which reflected

Table 1. Therapy Group Observation Reporting Forms
Means, Standard Deviations

	Validation Experimental (N = 5)				
	$\bar{X}$	S.D.	Sum of First 3 Sessions	Sum of Last 3 Sessions	Gain Scores
Talks in Groups	1.69	.20	20	29	9
Makes Eye Contact	1.87	.28	23	29	6
Touches	1.15	.32	11	24	13
Smiles	1.49	.41	20	31	11
Shows Leadership	.97	.19	6	19	13
Physically Participates	1.06	.19	7	23	16
Sums			87	155	68

the irritability sub-scale included: "gets angry or annoyed easily:" "is irritable or grouchy;" "is quick to fly off the handle."

One resident who expressed a great deal of anger talked about her husband, and expressed the belief that he would prove his love for her by taking her away from "this awful place." In reality, the resident's husband had left her early in life. A possible explanation for her behavior is that coping mechanisms, which successfully maintained a stable environment for this woman when she was younger, were no longer effective in her old age. The increase in irritability scores, and the fact that anger and hostility was expressed in the group, suggests that VT was effective in uncovering repressed behavior in the residents.

The second change in the NOSIE-30 occurred on the retardation sub-scale. The pretest total score was 100, compared to 74 on the posttest score. Although VT does not purport to reduce mental deterioration, this decrease suggests that VT had been effective in slowing general mental deterioration. The control group increased a total of fourteen points on the retardation sub-scale, suggesting that their deterioration continued.

Although this study revealed some encouraging results, caution must be mentioned on three points. First, a small sample was used. Second, the NOSIE-30 may not be the most sensitive measure by which changes in behavior may be detected. Third, due to these facts, this study must be replicated.

CONCLUSION

In conclusion, the therapist's acceptance of the client's physical, mental, and social losses, based on empathic understanding, validates the client's personal outlook on life [17]. Although one cannot change the life events of an old-old person, it is equally true that in many nursing homes, resident programs attempt to replace the disoriented residents' definitions of reality with those of the institution. Jones [15] and Babins [9] have mentioned that VT can be used as a companion to other resident programs without attempting to change the residents' concept of reality. VT would give old-old people a sense that they are understood, accepted, and respected, which, according to Frank [17], could be a strong antidote to feelings of alienation and demoralization.

In order to understand the characteristics of Validation Therapy, future research is needed to study the interaction between persons conducting VT and those receiving it.

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SOCIAL DIMENSIONS OF MENTAL ILLNESS AMONG RURAL ELDERLY POPULATIONS*

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ABSTRACT

Despite growing concern with rural elderly populations, little attention has focused on their mental health, ways it may correlate with physical health, or how rural mental health patterns compare to urban. Popular wisdom contends that elderly people in general, and rural elderly persons in particular, are at increased risk for mental illness. This article examines these questions. A review of available literature suggests that elderly people may be at only slightly greater risk of mental illness than the population at large, though there are some indications that rates of depression may be somewhat higher among the elderly population. Much of this same literature implies that objective environmental conditions play a significant role in the incidence of depression. Analysis of data gathered in a statewide random poll ($N = 743$) indicates that while physical health tends to be poorer among rural populations, when health is held constant there is actually an inverse relationship between age and depression. Therefore, rural elderly persons are no more likely to be depressed than their urban counterparts despite harsher living conditions. Both conceptual and policy implications are discussed.

* This is a revision of a paper presented to the annual meeting of the Gerontological Society of America.

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