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Validation Therapy: An intervention for disoriented patients with Alzheimer's disease

Communication services for long-term care residents with Alzheimer's disease are restricted due to treatment models and assumptions, as well as reimbursement. As the severity of dementia increases, fewer communication management approaches are available. However, demands for functional interventions persist. This article reviews Validation Therapy, a Rogerian intervention approach for patients in the severe stage of Alzheimer's disease. Validation Therapy addresses the patient's need to maintain contact with the environment by confirming the patient's internal emotional state, rather than coercing an external environmental orientation. Techniques and efficacy studies are reviewed; case examples of the application of Validation Therapy are provided. Key words: *aging, Alzheimer's disease, communication, long-term care, nursing home, Validation Therapy*

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MORE THAN 10% of individuals over age 65 have probable Alzheimer's disease (AD) and nearly half of those over 85 years develop Alzheimer's disease (Bayles & Kaszniak, 1987; Evans, Funkerstein, Albert, Scherr, Cook, Chown, Hebert, Hennekens, & Taylor, 1989). With 22% of nursing home residents having a primary diagnosis of mental disorder (senility without psychosis) and with 50% of all dementia cases determined to be of the Alzheimer's type, speech-language pathologists (SLPs) must be prepared to provide services for this communicatively impaired population. Consequently, SLPs are charged with implementing programs ". . . to increase the frequency and quality of communication interactions" while maintaining functional communication for the patient with Alzheimer's disease (American Speech-Language-Hearing Association Committee on Communication Problems of the Aging, 1988, p. 128).

While AD primarily affects the old-old (over 85 years), it also has been identified in 40-year-old mentally retarded persons and

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has been diagnosed in individuals as young as age 25 years (Bayles & Kaszniak, 1987). The progression of the disease varies from 3 to 20 years (Glickstein & Neustadt, 1993). As the baby boom population approaches the ages when AD is most prevalent, the number of individuals affected with dementia will increase dramatically. Consequently, the need for SLPs who are prepared to work with this population will escalate as the caseload of persons with AD increases.

Language and communication characteristics of individuals with AD are identified elsewhere in this issue (see articles by Clark and Shadden). This article will present a rationale for expanding traditional intervention models to include approaches such as Validation Therapy, as well as reimbursement issues associated with less traditional interventions. The principles, characteristics, and efficacy of Validation Therapy will be described. Case examples of utilization of Validation Therapy at various stages of the dementia progression will be discussed, and the role of the SLP will be clarified.

NEED FOR INTERVENTION MODELS

The relatively recent growth of services in the nursing home setting and ASHA's positive position statement on the roles of communication disorders personnel in working with the geriatric population have spurred development of intervention techniques for the Alzheimer's population. Primarily, intervention approaches for this population have been based on the modification and adaptation of traditional speech and language approaches and on the expansion of cognitive and memory strategies that are effective with patients with traumatic brain injury. The importance of a functional model is recognized as critical in working with neurologically impaired patients.

As the severity of the dementia increases, fewer approaches are available for use by communication disorders professionals. Most SLPs do not intervene with patients with severe AD, maintaining that the services are not reimbursable by Medicaid, and that the patient does not benefit from traditional therapy approaches because confusion and/or disorientation decreases the individual's response to the environment. Although these concerns are legitimate, they may be circumvented in many cases.

REIMBURSEMENT ISSUES ACROSS AD STAGES

In response to reimbursement concerns, Glickstein and Neustadt (1992, 1993) have developed a tri-model system of rehabilitation, which asserts that services for "functional maintenance" are reimbursable. Functional maintenance is based on quality assurance issues that subsume a consultative as well as a direct intervention model and that include the interdisciplinary team approach. Therapy goals include "maximizing functional abilities and/or retarding the loss of functional abilities over time" (Glickstein & Neustadt, 1992, pp. 4–5). They note that care must be taken in defining and describing services when completing documentation of services for reimbursement.

The concern that traditional therapy approaches are not effective with individuals with severe AD is based on both therapeutic principles and clinical experiences. Therapy is not a passive experience for the client; it is a two-way process in which the client is

responsible for production, learning, or modifying behavior depending upon the therapeutic philosophy. Traditional therapy approaches depend upon client commitment and voluntary participation in the therapeutic process. If the client is unable or unwilling to participate in the therapeutic process, therapy will not succeed.

This is a legitimate concern for working with patients in the advanced stages of AD. In these later stages, the patient is disoriented and confused in terms of person, place, and/or time. Short-term memory loss, possible reduction in sensory abilities, and acquired intellectual deficits are common. Hitting/slapping, verbal aggression, screaming, pacing/wandering, and repetitive verbalization contribute to the perception that the individual is difficult and uncooperative (Spayd & Smyer, 1988). Nearly 50% of these individuals are "handled" by chemical restraints to reduce aggressive or agitated behavior (Whall, Gillis, Yankou, Booth, & Beel-Bates, 1992). Behavioral problems contribute to these patients typically being underserved by SLPs.

Establishing the client's orientation and responsiveness to the environment is considered critical if SLPs are to provide services for patients in the advanced stages of AD. The greatest challenge to professionals working with these patients is to help the patient maintain contact with all aspects of the environment. Validation Therapy has been developed to address this fundamental need in a humanistic manner.

THE BASIS OF VALIDATION THERAPY

Validation Therapy was developed as a reaction to the perceived ineffectiveness of Reality Therapy when used with severely involved Alzheimer's patients. In Reality Therapy or Reality Orientation, the treatment focus is on orienting clients to person, time, and place. In contrast, Validation Therapy has as its basis the confirmation of the individual's emotional state rather than orientation of the individual's utterance to reflect objective fact. It is rooted in Carl Rogers' concept of client-centered therapy and considers the patient's feelings as paramount (Rogers, 1961).

Feil (1982) created Validation Therapy as a method to affirm self-worth and to communicate with individuals who have late-onset, severe dementia of the Alzheimer's type. According to Feil, individuals who have not reached their life goals and who have unresolved conflicts from the past must resolve these conflicts in old age. To further exacerbate the emotional toil of unresolved conflicts, these individuals may find themselves in a nursing home environment that is not of their choosing. As sensory and physical deterioration further restrict external interactions, internal contemplation may become more prevalent.

As the external environment becomes less clear through failing senses and less desirable through fewer opportunities for meaningful interaction (Lubinski, 1991), the internal world becomes more real. The individual spends more time reviewing the past and reliving pleasant or, sometimes unpleasant, memories. As the individual focuses on past memories, it becomes harder to shift attention to the unpleasant present (old age, nursing home environment, death of a loved one, etc.). When spoken to, the individual may seem confused and disoriented since the focus is on internal reminiscence about the past, and the individual is less attuned to the present situation (Babins, 1988; Feil, 1982, 1991).

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Very old individuals who experience severe disorientation, memory loss, and hallucinations are not helped by traditional approaches such as reality orientation. In these individuals, reality orientation may actually cause concern, agitation, and denial (Dietch, Hewett, & Jones, 1989; Maas, 1988). Goals of factual accuracy and consistent orientation to the present situation may be inappropriate for patients with severe dementia who are not expected to recover. Even advocates of reality therapy like Holden and Woods (1982) acknowledge that response to feelings and disregard of the factual content of the communication may be more appropriate when interacting with some disoriented patients.

There are few approaches available for working with individuals in third phase dementia (Reisberg, 1983) or late level II (hallucinations) or level III (Glickstein, 1988) dementia. Validation Therapy is one approach designed to work specifically with patients in the advanced stages of dementia (Clark & Witte, 1991).

Validation Therapy respects and confirms the patient's feelings. It does not require specially trained psychologists to provide therapy but may be used by family and staff to explore the meaning of the patient's utterances (von Amelsvoort Jones, 1985). Consequently, use of Validation Therapy has been recommended in a wide variety of gerontological, rehabilitation, and practical nursing publications.

EFFICACY OF VALIDATION THERAPY

Although Validation Therapy is used with clients with dementia in over 500 institutions (Morton & Bleathman, 1991), many reports of the effectiveness of the approach are anecdotal. For instance, Dietch, Hewett, and Jones (1989) reported on three confused individuals who were distressed by reality therapy but were comforted and less agitated when Validation Therapy was used.

In early studies of the effectiveness of Validation Therapy in a residential facility, severely demented patients who received one hour of Validation Therapy per week for six months improved in speech, nonverbal communication, and eye contact, while reducing crying and pacing (reported in Feil, 1992). Validation helped some moderate/severe patients stay in touch with reality and change behavior to be more functional in institutional daily life (Peoples, 1982).

In an experimental investigation, Robb, Stegman, and Wolanin (1986) were unable to obtain statistically significant differences between the control and Validation Therapy groups, possibly due to small sample size. However, nonsignificant increases in mental status and morale were seen in the Validation Therapy group, while the control group decreased in these areas. The Validation Therapy group made more demands on the staff for cigarettes and conversation. If the program is to be effective and cost efficient, the authors recommended that the validation approach be integrated into the daily lives of residents by all staff members. Staff members may also need to be made aware of the possibility of increased staff demands and may need assistance in recognizing these behaviors as part of the positive outcomes of Validation Therapy.

Within structured Validation Therapy sessions, direct observations indicate that individuals with moderate to severe dementia increased in talking, eye contact, touching, smiling, and physical participation (Babins, 1988; Babins, Dillion, & Merovitz, 1988). Although no cognitive

changes were observed, the patients were more affective, more communicative, and complained more. In a small study of severely demented patients' interactions within their daily environment, 2 of the 3 patients increased the number of communication initiations and the length of communications following Validation Therapy sessions but not following Reminiscence Therapy; one evidenced the reverse pattern (Morton & Bleathman, 1991). Validation Therapy has been shown to be useful in affirming the individual's feelings and thoughts. In clinical experiences, individuals whose feelings are affirmed are likely to orient to the communication partner, if only for a short time (Benjamin, 1990).

DESCRIPTION OF VALIDATION THERAPY

As noted earlier, Feil (1982, 1991, 1992) developed Validation Therapy for use with late-onset demented patients who are disoriented, confused, and have diagnoses of probable AD. It is a humanistic approach (Babins, 1986; Ronaldson & Savy, 1992) that affirms the dignity of the patients and enhances the quality of their lives. It is an approach to communication that takes into consideration the emotional needs of severely involved individuals by referencing the feelings behind statements rather than the accuracy or truth of those statements.

Feil defined 4 stages of disorientation for clinical purposes. Disoriented patients in the first stage, *malorientation*, resist touch, hoard items, have memory lapses, accuse others of stealing, but want to be aware of the present time and place. The second stage, *time confusion*, includes those patients who have unfocused eyes, are often incontinent, have reduced sensory input, appreciate touch and nurturing, and confuse people in the past and present. Persons in the *repetitive motion* stage often pace, sing, rock, or hum to themselves. The final stage, *vegetation*, includes those severely disoriented patients who also lack muscle tonus and show minimal movement.

When working with Alzheimer's patients, the professional must determine the stage of disorientation. In the maloriented stage, the patient is touch defensive and will not appreciate physical nurturing. With maloriented patients, the professional need not confront the patient with the truth but can listen with empathy. Nonthreatening questions can be posed. Acknowledging the patient's feelings behind the verbalized statements is a way to interact without focusing on the veracity of the content. Cueing into the patient's preferred sense (visual, auditory, or kinesthetic) encourages the patient to explore feelings and to continue to communicate. Paraphrasing the patient's words and asking for clarification allow the patient to express emotional feelings (Feil, 1991).

Since the maloriented person is cognizant of the present surroundings and not disoriented as to time and place, reminiscence can be used. The patient is encouraged to describe feelings, to reflect about similar situations in the past, and to imagine how the opposite situation could occur. The patient can remember coping strategies that were used successfully in the past and can employ those proven strategies in the current situation.

Patients who are experiencing time confusion cherish physical comforting and touch. They confuse past and present time and will often talk about the past as if it were the present. A stimulus may elicit vivid memories and the accomp
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In the case example of one individual seen by the author, an elderly woman, Mrs. B., tells a visitor that she cannot talk any longer, she must go home to make supper for her husband. In fact, the house has been sold; she has been a resident of the nursing home since her husband died 12 years earlier. The visitor, using Validation Therapy, cues in on Mrs. B.'s need to feel useful rather than making an attempt to remind her that she has no husband and no home other than the nursing home. The visitor asks what kinds of foods her husband liked. Mrs. B., in reminiscing about her husband's food preferences, begins to use the past tense. As the conversation progresses, she continues to reminisce by telling the visitor about her husband's death and discussing her food preferences for the dining hall. Her orientation has temporarily improved.

Such empathetic techniques are useful in establishing a caring environment in which the patient can reminisce. Use of ambiguous or vague pronouns allows the uninitiated visitor or staff person to become involved in the conversation. Expression of empathy in nonverbal dimensions is also useful; the staff can reflect the emotion in the vocal tone, imitate the movement, and maintain eye contact. Such an approach is compatible with recommendations made in *Older Voices* (American Speech-Language-Hearing Association, 1991) that include the admonition not to argue with the patient over the veracity of the statement, to increase reassurance to the patient, and to use empathy.

With patients in the last two stages, validation of emotion through verbal and nonverbal channels is one of the few avenues available to enter their world. Touch, eye contact, and singing familiar songs can be keys into the internal world of the demented individual. For example, Mrs. F. continually rocked in her wheelchair and moaned "baby dead, baby dead" as she clutched a blanket in her arms. The visitor, employing Validation Therapy, knelt beside Mrs. F. and placed an arm on her shoulder. When Mrs. F. focused on the visitor, the visitor asked, "Your baby?" Mrs. F., still focused on the visitor, responded, "Baby dead, no priest." The visitor, feeling totally inadequate, responded with "God loves little babies," then with "The baby is with God. The baby is in heaven." Mrs. F. repeated "heaven, heaven" and smiled. The visitor continued with "The baby is in heaven, asleep with God." Together, the visitor and Mrs. F. sang a lullaby. Later, as the visitor was leaving, Mrs. F. had resumed rocking the blanket, but she was humming a lullaby rather than her previous agitated moaning and repetitive crying. Although this example is more directive than Validation Therapy, which is used with earlier stages of confusion and disorientation, it suggests that reflection of feelings can briefly break through the barrier with patients in the final stages of dementia.

CONTRIBUTION OF SLPs

SLPs, experts in communication and its disorders, are ideal professionals to institute a program based on Validation Therapy in the nursing home environment. With Validation Therapy, SLPs have available an approach that is practical for serving those patients who have been considered ineligible

for communication therapy services. SLPs may conduct Validation Therapy sessions, may utilize the approach in conjunction with other therapeutic paradigms, or may use a consultation model to help staff use the validation approach throughout daily activities in the nursing home and to assist family members in their interactions with disoriented and confused loved ones.

Validation Therapy should be used only with those individuals who most likely would not have been served through traditional approaches. Since several studies suggest that Validation Therapy increases the number and quality of patients' communication attempts as a result of as little as an hour per week of group work, and group therapy allows the SLP to provide services for a greater number of individuals, the cost of providing direct services per patient is reduced.

With patients who are maloriented, Validation Therapy may be used in conjunction with other therapies. Life review (Butler, 1980) or reminiscence encourages the patient to remember past life experiences and to come to terms with those experiences. Thus, life review and Validation Therapy are similar in orientation but differ in emphasis, with life review focusing on reminiscence and Validation Therapy focusing on the validation of the feelings associated with those memories. Reminiscence may be incorporated in Validation Therapy to elicit previously used coping strategies that might serve as solutions to current problems. For example, a patient might recall an earlier argument with a parent about permission to go on a date, and might be helped to relate strategies used in that situation to current needs and issues involving nursing home personnel. While life review is still a possible strategy for use with the maloriented patient, it is ineffective with the time-disoriented, repetitive motion, or vegetative patient.

Although Validation Therapy provides a mechanism for increasing communication for many individuals in the later stages of dementia, individual therapeutic sessions without concurrent initiation of the staff into use of the approach will be markedly less effective. The results of Validation Therapy on the later stages of dementia are transitory; validation must occur periodically and frequently throughout the day for maximum results to occur (Feil, 1982). To ensure that validation of the individual's feelings are affirmed throughout the day, a consultative model is recommended either as a supplement to direct group therapy or as the sole means of integrating the approach into the daily lives of severely demented patients.

The SLP needs to gain the administration's support for the concept of validating patients' feelings as a legitimate approach for enhancing quality of life for the patient and for reducing stress for the staff working with these patients. A series of inservices and workshops to introduce the concepts and the approach to the staff are essential. Examples (Bleathman & Morton, 1992; Feil, 1991), discussion of actual cases, role play, and practice are fundamental components of such inservices. Concurrent with and subsequent to the inservices, the SLP must be available to consult with the staff in the use of validation techniques with specific patients.

Finally, workshops for family members are an important part of the consultative model. Family members often feel inadequate and are wounded by deteriorated conversations with demented loved ones.

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By providing family members with a method of communicating and linking with the patient's inner world of memories and feelings, the SLP can provide the family with a technique that may reduce the family's stress when visiting the patient.

In individual consultation with family members and friends, the SLP can provide a safe, accepting environment in which information is provided to the family, feelings are accepted and understood, and ways to interact with the disoriented individual are introduced. The family need not learn techniques for interacting with patients in each stage of disorientation but can focus specifically on those verbal and interactive strategies that are most productive with the particular condition of their loved one. The SLP can demonstrate the use of Validation Therapy in a three-way interaction with family members and the patient.

The involvement of the family in using Validation Therapy is essential in helping the family to understand the patient who is becoming more like a stranger and to adjust to the effects of AD. Any improvement in the patient's interaction resulting from the use of Validation Therapy allows family members to feel that they have made a contribution to improving the patient's quality of life experiences. Finally, those family members who visit regularly will also contribute substantially to the overall impact of Validation Therapy on the patient.

Of course, Validation Therapy is not a cure for dementia; rather, it is a method for affirming the individual and enhancing the quality of life. Consequently, one possible outcome may be extended maintenance of functional living skills for the patient in the later stages of disorientation due to dementia of the Alzheimer's type.

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