

**The Effect of Validation Therapy Training
on Satisfaction with Communication and Quality of
Relationship Between Staff and Family Caregivers and
Demented Residents in Long Term Care**

Prepared by
Robert L. Canon, LMSW

**Institute for Quality Improvement
in Long Term Health Care**

**School of Health Professions
Southwest Texas State University
San Marcos, Texas**

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Executive Summary

Validation Therapy is a method of interacting with dementia patients that is believed to benefit both dementia patients and caregivers. During the 1994-1995 academic year, the Institute for Quality Improvement in Long Term Health Care funded a 6 month dissertation study of Validation Therapy training. This research project sought to evaluate the effect of Validation Therapy training on two aspects of the caregiving relationship; Satisfaction with communication and overall quality of relationship. Both staff and family caregivers were included in the study. To measure the effect of Validation Therapy training, study participants were given two questionnaires; one to assess the quality of their relationship and one to assess their satisfaction with communication with the dementia patients in their care. Thirty six study participants, 13 family members and 23 staff, filled out the two sets of the questionnaires; a pre-test before training and identical post-test after training. To further ensure that it was the Validation Therapy training that influenced any change in questionnaire scores, a group of 6 family and 16 staff caregivers who did not receive Validation Therapy training were also given two sets of questionnaires. Analysis of the data gathered from all study participants resulted in the following findings:

- There were no significant differences between family caregivers and staff caregivers in the amount of change from pre-test to post-test in either quality of relationship or satisfaction with communication.

- Staff caregivers were, in contrast, significantly more satisfied with communication on both the pre-test and post-test. One explanation for this difference is that family members have a greater emotional investment in their relationships and their ability to communicate with increasingly confused loved ones.
- No significant change in quality of relationship was observed when comparing the group receiving Validation Therapy training and the comparison group that did not receive training. An analysis of the questionnaire itself showed that the individual items did not appear to measure the same thing, indicating a poor questionnaire. This, in part, could account for the apparent lack of change in quality of relationship for the group that received training.
- The group that received Validation Therapy training showed a significant increase in satisfaction with communication with dementia patients when compared to the group that did not receive training. An analysis of the questionnaire and its history in other research, indicate that it is a good questionnaire capable of reliably measuring an actual increase in satisfaction with communication.

Abstract

The effect of Validation Therapy training on satisfaction with communication and quality of relationship for caregivers of dementia patients was evaluated in a quasi-experimental design. Subjects were recruited from primary family and staff care givers of dementia patients at 5 central Texas long term care facilities. Training was provided by Naomi Feil at her biennial workshops utilizing a multimedia approach with didactic and experiential components. Quality of relationship was measured by the Dementia Caregiver Quality of Relationship Inventory, an instrument developed by the author, while the Interpersonal Communication Satisfaction Inventory (Hecht, 1978) measured care giver satisfaction with dyadic interaction. A test incorporating several instruments developed by Feil (1992) was used to assess validation skills. Demographic and descriptive variables were also collected. Bivariate analysis indicated a significant increase in communication satisfaction for dementia caregivers who received Validation Therapy training when compared to a group of caregivers who received no training. Although there were no differences between family and staff on change in satisfaction level with Validation Therapy training, staff caregivers were significantly more satisfied with communication at both pre-test and post-test. No experimental or caregiver group status effect on quality of relationship was observed. The Validation Therapy skills instrument demonstrated unacceptably low reliability and were excluded from analysis. Discussion of the psychometric properties of these instruments and the need for reliable measures to assess the effect of Validation Therapy training and practice is provided.

Introduction

The Institute for Quality Improvement in Long Term Health Care, School of Health Professions, Southwest Texas State University, has as a primary focus enhancement of quality of life for nursing home residents in the state of Texas. Through research, consultation, and training, the Institute seeks to improve the quality of care provided by Texas nursing homes. Under direction of the Texas State Legislature, the Institute is specifically charged with conducting needs assessments, comprehensive training of identified personnel, special studies to advance knowledge of long term health care, and the dissemination of findings and other information to long term care professionals, policy makers, and concerned citizens of Texas. In the Fall of 1994 the Institute funded a six month dissertation research project evaluating the effect of Validation Therapy training. Academic literature in the area of geriatric long term care also identifies a need for research into psychosocial interventions for demented elderly and their caregivers. Family and professional partnerships for addressing dementia which improve the quality of life for residents and family members have also been suggested. In cooperation with the Austin, Texas chapter of the Gray Panthers, Institute funding directly provided Validation Therapy training for 33 staff and family caregivers of long term care residents suffering from dementia. In addition to care giver training directly funded by the Institute through this study, additional staff care givers chose to use training funds provided by their employing agencies to attend Validation Therapy training as a result of study participation. This report contains findings of a preliminary descriptive and bivariate analysis of data collected from study participants. Full analysis of the doubly multivariate repeated measures design will be contained in the full dissertation scheduled for completion in January 1996.

Problem Statement

In 1907 a German physician, Alois Alzheimer, first described the disease that would eventually be named for him (Volicer, Fabiszewski, Rheaume, & Lasch, 1988; Leng, 1990). DSM III-R nomenclature for the disease is "Primary Degenerative Dementia of the Alzheimer Type" (APA, 1987, p. 119). Alzheimer's Disease is the "most common irreversible dementia in late life, accounting for 50 to 70 percent of all dementias" (Hooyman & Kiyak, 1993, p. 245). Alzheimer's Disease (AD) is a progressive neurological disorder, causing confusion, loss of memory, changes in mood, personality and behavior, and poor judgement (Haulotte, 1991; Leng, 1990; Turner, 1992). It "involves a multifaceted loss of intellectual abilities, such as memory, judgement, abstract thought, and other higher cortical functions, and changes in personality and behavior" (APA, 1987, p.120). "The intellectual impairment progresses gradually from forgetfulness to total disability" (Mace & Rabins, 1991, p.6) "...until patients become incontinent and require constant nursing care" (Leng, 1990).

As the condition progresses and demands on caregivers escalate, caregivers typically experience embarrassment, guilt, anger, frustration, resentment, fear, sadness, grief and despair. "They are

left feeling emotionally drained as a result of the continued care of the patient without relief or encouraging changes" (Andreae, 1992).

Caregivers have also been found to experience feelings of satisfaction related to caring for their demented family member (O'Connor & Prothero, 1987, p.79).

Placement of AD patients in institutional settings is associated not only with caregiver burden and strain but patient and caregiver demographics, the mental and physical condition of the patient, and the relationship between patient and caregiver (Pruchno, Michaels & Potashnik, 1990). AD patients in placement continue to experience progression of the disease, which may be exacerbated by the institutional setting.

The loss of familiar personal space and belongings removes important references leading to increased disorientation and reduced cognitive functioning (Babins, Dillon & Merovitz, 1988). Wandering, sleep disturbance, incontinence, verbal abuse are all typical as AD progresses (Leng, 1990), leading to increased demands on and frustration of facility staff (Andreae, 1992). Once the AD patient is placed, the stress experienced by the family member providing care

does not necessarily decrease (Brubaker & Brubaker, 1984), and may even increase (Buckwalter & Hall, 1987).

Long term care residents suffering from dementia are not only at risk for the progressive deterioration inherent in the condition, but their behavior can strain or destroy psychosocial supports increasing the likelihood that they will be restrained. A review of the literature indicated that between 25% and 85% of nursing home residents are physically restrained at some time with cognitive impairment the most predictive factor. Restraint has a negative impact on a residents autonomy in addition to other risks including "...strangulation, contractures, pressure sores, anxiety, social isolation and functional decline (Coleman, 1993, p. 2114, citing Evans and Strumpf, 1989).

Patient management is a common approach to caregiving that arises from the demands of caring for AD residents and the accompanying frustration. It focuses more on controlling the demented residents disruptive behaviors than improving their quality of life and does little to improve the relationship between the demented resident, their family and the staff. One author, coming from the biomedical perspective of pharmacological treatment, states: "Although drugs may be helpful at some points, the general approach at the present

time rests largely with management rather than treatment" (Leng, 1990). Others feel that the primary goal of treatment has to be effective control of problem behavior in order to prevent disruption of the entire unit and facilitate other care goals (Sloane & Mathew, 1991).

Reality Orientation (RO) is the most widely used therapy in the care of people with dementia. RO consists of presenting current information about the time, the place and the identities of others to the disoriented person. This process is assisted by placement of signs and memory aids in the environment. RO can be used in group sessions or as a 24 hour treatment. Group sessions, also called Class RO, meet regularly to repeatedly present details of person, place and time in addition to facility routine. In 24 hour RO, staff present this information to the disoriented person in every interaction. Class RO can be used in conjunction with 24 hour RO (Bleathman & Morton, 1988; Dietch, Hewett and Jones, 1989; Leng, 1990).

"Despite the widespread use of RO in long term care facilities, controversy surrounds its actual therapeutic value" (Dietch, Hewett and Jones, 1989, p. 974). Dietch et al maintain that "one of the original purpose of RO was to give staff a sense of 'doing something'

with patients that have bleak futures" (p. 974) and that in spite of initially encouraging findings, RO is currently the object of staff cynicism. Using case studies, Dietch et al "demonstrate that Reality Orientation can have adverse psychological and emotional effects in patients with dementia" (1989. p. 976). Dietch et al concede that RO may be appropriate for some patients, requiring careful evaluation of client response with a willingness to terminate RO "when patients react negatively" (1989, p. 976). "RO is certainly not a waste of time, although obviously it does involve some concerted effort for limited benefit" (Leng, 1990, p. 78).

The social gerontological perspective emphasizes awareness of the power relationship in which caregiving takes place. "Generally, dependency is encouraged and acts of independence are either ignored or punished in long-term care facilities. ...physical and chemical restraints still are commonly used to control wanderers and other 'troublesome' demented in long-term 'care' facilities in the United States" (Lyman, 1989, p.602). Other authors have expressed concern over the "extent management has been interpreted as behavioral control, perhaps more for easy relief of caregivers than patients" and

call for further research in this area (Connolly & Williams, 1993, p.135).

While the impact of AD on family and other care givers is substantial and effective care giver interventions are needed, other authors caution that "Psychosocial inquiry into the disease has been limited to study of its impact on care givers with little attention to impact on patients" (Cotrell, V. & Schulz, R., 1993, p. 205). "Rarely is the afflicted individual viewed as a contributor whose perspective is essential to understanding the impact and course of the disease" (Cotrell & Schulz, 1993, p.210). Issues such as dementia and depression, problem behaviors, and treatment efforts have "received minimal research attention because of the presumed difficulties in obtaining valid and reliable information from persons with dementia" (Cotrell & Schulz, 1993, p. 208). Diana McGowin, early onset Alzheimer's victim, discusses the emphasis of Alzheimer's intervention on caregivers and not on the patients themselves. "I contacted various local organizations to locate a support group for "people like me.' To my dismay, I found none" (McGowin, 1993, p. 117).

The biomedical model of dementia is currently over emphasized in AD research and more emphasis should be placed on social factors

affecting the definition and experience of dementing illness (Lyman, K. A., 1989) and improving the relationship between patients and caregivers (Cotrell & Schulz, 1993). According to Cotrell and Schulz (1993), "We have certainly overlooked the personal and psychosocial needs of those who experience a dementing illness, areas where intervention could maximize the quality of life for patients and families" (p. 205). "Interventions should be assessed not only for their efficacy in altering problem behaviors but also for their potential impact on the recipient's quality of life. ...Treatment with psychosocial interventions ... could yield a better understanding of the individual than the application of behavior management approaches later in the illness. This in turn may result in better adaptation of the person with dementia and fewer problem behaviors later in the disorder" (p. 207). "Additional research on nonpharmacological approaches [to AD patient care] is also needed. These approaches include a variety of environmental modifications, caregiver training in effective communication and compensating behaviors, and the use of day care programs for patient stimulation and caregiver relief. It would be very useful to study the course of the illness and quality of life in

patients managed with pharmacological as contrasted with nonpharmacological approaches" (Connolly & Williams, 1993, p. 135).

Validation Therapy approaches AD intervention from this systemic, humanistic, social perspective. By opening a channel for communication and engaging the client in resolution of emotional content from earlier life stages, Validation Therapy forms the foundation of a relationship between validator and resident. As communication improves, issues are addressed and trust in the relationship is built, providing care givers and the disoriented resident with tangible psychosocial benefits. For the resident, quality of life increases and disruptive behaviors are reduced as social relationships are renewed. For the caregiver, stress and frustration are alleviated as interpersonal communication improves and a more meaningful relationship with the demented resident develops (Feil, 1992).

Validation Therapy: Definitions, Assumptions and Theory base

Validation Therapy was developed out of dissatisfaction with RO (Bleathman & Morton, 1988; Feil, 1992) by social worker Naomi Feil. In various forms of human interaction the term validation is often used in a fairly generic sense to mean acknowledgment, affirmation

and nonjudgmental support of a persons behavior or perceptions.

Validation, while based in part on this concept, is a specific therapeutic intervention based on theory and values. It is an integrated method of helping the disoriented old-old. As an intervention, Validation is a set of "specific techniques to help mal- and disoriented very old people regain dignity both through individual Validation and through Validation groups" (Feil, 1992, p. 11).

Validation is also "a developmental theory for old-old mal- and disoriented people and a method of categorizing their behavior" (Feil, 1992, p. 11).

Validation Therapy is intended for a very specific clinical population, the disoriented old-old. These are people, generally over 80 years of age, who "have significant cognitive deterioration and can no longer function intellectually to achieve insight." (Feil, 1992, p.26). They "have diminished ability to move, control feelings, [and] remember recent events." (Feil, 1992, p.27). Damage to auditory and visual systems and the brain itself accentuates these deficits. Psychological inflexibility, continuation of familiar but outdated roles, unresolved emotional content from earlier life stages and withdrawal from current reality characterize behavior patterns of the disoriented

old-old. Body movements and vivid images from earlier periods in their lives are used to meet their needs for love, identity and expression of feelings. (Feil, 1992)

Feil criticizes current diagnostic labeling of dementia patients as confusing and chronicles the evolution of clinical nomenclature referring to disoriented elderly. The term senile dementia, used in the early nineteenth century, was incorporated, along with pre-senile dementia, into the category of chronic organic brain syndromes by 1978. At that time, Alzheimer's disease was classified as a common form of presenile dementia. The DSM III task force on Nomenclature and Statistics in 1981 eliminated the distinction between senile and presenile dementias and the term organic brain syndrome is rarely used (Feil, 1992, p.29).

Currently, senile dementia and Alzheimer's are generally seen as a single disease and referred to as senile dementia of the Alzheimer's type. One perspective sees Alzheimer's disease not as an inevitable part of the aging process, but a distinct disease entity (Turner, 1992). While Feil agrees that AD is not inevitable, she believes that the disoriented old person's withdrawal inward can be a normal part of aging, that their return to the past is a survival method, a healing

process and a way of easing the blows dealt by aging. In this context she states that "old age is not a disease" (Feil, 1992, p. 32). She distinguishes between early and late onset manifestations of the condition, viewing "early onset Alzheimer's [as] a much more distinctive disease than late onset Alzheimer's" (Feil, 1992, p.31). Behaviors often labeled as delusional and attributed to dementia can more accurately be viewed as age appropriate behaviors for people who have not adequately resolved life tasks from earlier stages (Feil, 1992). She identifies late onset Alzheimer's patients, whom she calls the disoriented old-old, as being much more responsive to Validation Therapy than early onset Alzheimer's patients (Feil, 1992).

The reason for disorientation in the old-old, according to Feil, is denial of physical and social loss. Feil (1992) describes the following litany of physical loss and the cognitive consequences of denying the inevitable:

...in middle age...wrinkles appear, skin fits loosely over shrinking bones, hair thins, night driving becomes difficult and some may develop breast tumors, prostate problems, cataracts, have small strokes and heart trouble. Fatty tissue accumulates. Brain and heart work harder. People who have no repertoire for facing losses are

stuck. Aging will not stop. Denial of these physical, small "deaths" in middle and old age often leads to a final retreat into fantasy in old-old age. (p. 20)

Social losses through the aging process are equally profound, including "death of loved ones, loss of one's job, loss of one's role as a worker, a mother, a child, or a friend..." (Feil, 1992, p.23). As the sensory and kinesthetic nervous system begin to operate less effectively and the social ties which have acted to orient and ground a person are lost, body movements stored in kinesthetic memory and vivid memories from more rewarding periods of their lives are replayed in an attempt to resolve emotional issues from the past and meet needs for love, identity, purpose and expression of feelings (Feil, 1992).

Validation Therapy does not consist of exploring and analyzing feelings, but validating whatever feelings a resident expresses. "To validate is to acknowledge the feelings of a person" (Haulotte, 1991, p.15). "The validation approach means accepting and validating the feelings of the demented old person; to acknowledge their reminiscences, losses and the human needs that underlie their behaviors without trying to insert or force new insights" (Jones &

Miesen, 1992, p. 200). "Treatment is based on the premise that there is some logic behind all behavior, even disoriented behavior.

Awareness of [present] reality is not the goal; the goal is to understand the personal meaning underlying an individual's behavior.

Through empathic listening, the therapist attempts to discover the patients view of reality in order to make meaningful emotional contact" (Dietrich, Hewett, & Jones, quoted in Feil, 1991, p. 89).

"The primary goal of the validation approach is to help the older disoriented person to be as happy as possible" (Jones & Miesen, 1992, p.204). Results from the use of Validation therapy may include increased orientation, improved speech, control of negative emotions, increase in interactions with others, and slowed progression toward vegetation (Feil, 1989, p.11). By encouraging the free expression of feelings, Validation Therapy helps the disoriented old-old to resolve issues held over from earlier life stages. Many disruptive behaviors, such as screaming and pounding, are the result of precognitive attempts to resolve these issues. Validation Therapy ameliorates these behaviors, improving the atmosphere of the facility and decreasing staff work load by precluding the need for restraints and medication. The decrease in these disruptive behaviors is, perhaps

more importantly, indicative of greater peace of mind for the resident (Feil, 1992).

In spite of Validation Therapy's promise, expectations should be tempered by an understanding of the interventions limitations. "The process of validation cannot restore damaged brain tissue, but it can help to stimulate what ever capacities are dormant and yet intact" (Jones & Miesen, 1992, p.204). Validation Therapy is not meant to restore cognitive capacity and return residents to the community, but to engage disoriented old-old in the ongoing task of resolving unfinished life tasks and bringing life to closure. Because the disoriented old-old are nearing the end of their life cycle, the principle task of this life stage is to prepare for a peaceful death (Feil, 1992).

Validation Therapy techniques include attentive listening, mirroring of affect, prolonged eye contact, touch and music. Feil emphasizes that technique, though important, is secondary to worker attitude and interpersonal qualities. To be effective, Validation workers must be able to interact with residents honestly and without pretense. They are nonjudgmental, accepting and respectful of old people. Ageism, discomfort with dementia, previous reliance on Reality Orientation and skepticism toward new clinical methods color existing

attitudes of long term care staff. Validation Therapy training, in part, works to change attitudes toward the disoriented elderly.

Theory Base of Validation

Various theorists have been identified as contributing to the theoretical foundation of Validation Therapy. Feil identifies a number of authors whose personality theories, or other works, have been influential in guiding its development. She lists Carl Rogers, Sigmund Freud, Abraham Maslow, Carl Jung, Erik Erikson and Grinder and Bandler. Also named are lesser known authors; S. Zuckerman, Wilder Penfield, Adrian Verwoerdt, Charles Wells, F.G. Schettler and G.S. Boyd. Jones and Miesen, however, identify four theories relevant to validation techniques: 1) Maslow's universal human needs hierarchy, 2) Erikson's developmental stage theory 3) reminiscing disorientation theory, and 4) Miesen's work on 'parent-fixation' with his adaptation of Bowlby's attachment theory (1992, p. 203).

Although Feil states that "basic principles developed by behavioral, analytical and humanistic psychologies underlie the theoretical assumptions in Validation" (Feil, 1992, p. 11), the psychoanalytically oriented stage based personality theory of Erik

Erikson and the humanistic client centered therapy of Carl Rogers predominate. Using Erikson's stages of psychosocial development as a theoretical foundation for disorientation in the old-old, Feil identifies an additional stage at the end of the life cycle, beyond integrity vs. despair, which she calls resolution vs. vegetation (Feil, 1992).

Although she provides a compelling argument for the existence of this additional and final life stage, Feil introduces some confusion surrounding earlier stages by describing six stages to Erikson's eight. She leaves out the stage 'industry vs. inferiority' and appears to subsume the stages 'autonomy vs. doubt' and 'initiative vs. guilt' into a single time frame she calls "childhood" (Feil, 1992, p. 13).

Feil (1992) provides an eloquent description of the stage resolution vs. vegetation and its primary task: Very old people who are stuck with deep unresolved feelings left over from earlier life stages, often return to the past to resolve those feelings. They pack for their final move. They sort out dirty linen stashed in the storehouse of the past. They are busy, irresistibly drawn to wrap up loose ends. This is not a conscious move to the past, like Erikson's sixth and final stage [sic]. It is a deep human need: to die in peace. Those who achieve integrity in very old age never enter the Resolution

stage. But, as humans continue to live longer, there will be a growing number of very old who people who fall into the final Resolution stage. They need someone to listen, to validate their feelings. If no one listens, they withdraw to Vegetation. (p. 19)

Erikson theorized that resolution of the conflict in a given stage of development resulted in a sense of competency concerning identity and social skills associated with that stage. However, resolution is never complete in a given developmental stage, but continues through succeeding stages (Lefrancois, 1993). The 'Resolution vs. Vegetation' stage, like Erikson's eight stages, is never completely resolved. In contrast to the imperfect resolution of earlier stages in Erikson's model, it is cognitive deterioration and the inherent inability to achieve insight which prevents completion of life's final developmental stage. "Feelings spill, unresolved until death. However, as the various feelings are acknowledged and validated, they dissipate. The old-old continue resolving, always preparing to die in a clean house" (Feil, 1992, p. 19).

For those who have not adequately resolved earlier life tasks, become disoriented, and enter the resolution vs. vegetation stage, Feil identifies four distinct substage; 1) Malorientation, 2) Time Confusion,

3)Repetitive Motion and 4) Vegetation. Each substage represents further progression toward Vegetation. Although each substage is distinct with specific physical and psychological characteristics, boundaries between the substage, and even orientation, are not rigid. A person may be oriented at a given time but disoriented in the same day. Likewise, it is common for a disoriented person to move from one substage to another in a brief period of time. Most of the time, however, a person is in one substage.

In Malorientation, the first of Feil's substage, people maintain socially prescribed behaviors, except for expressing past conflict symbolically through people in the present. Feil is consistent with other psychoanalytic theorists (see Freud, Jung and Erikson) in her emphasis on symbols and their interpretation. She provides a list of symbols and their meanings, both universal and those typically used by the disoriented old-old (Feil, 1992, p. 47-48). She gives the following example: "an old-old woman claims her roommate is stealing her underwear. The roommate symbolizes a sister, of whom she was very jealous" (Feil, 1992, p. 49).

The Maloriented also have the following physical and psychological characteristics. They display tight muscles in their face

and body with a rigid stance, tight lips, shallow breathing, a jutting jaw and frequently a coat, cane or purse clutched in their hands. Eyes are clear and focused with movements which are definite, sustained and precise, even if a walker or wheel chair are used. Vocal tone is clear, harsh, whining or shrill and arms are often either folded tightly or pointing. Sensory and motor losses are relatively minor. Cognitive ability is largely intact with the ability to read, write, figure, categorize, and tell time. The maloriented are aware of current reality and their occasional confusion, which they may deny and attempt to cover with confabulation. In spite of this awareness, people in Malorientation are not able to achieve insight into the reasons behind behavior. They resist change, deny feelings, blame others and become furious with others who do not exhibit self-control. Maloriented people are hypersensitive to their personal space and resent touch or physical intimacy.

People in the second of Feil's substage, Time Confusion, "lose adult controls, communication skills, social skills, no longer conform to dress codes or social rules, and miss stimulation from others because they are frequently ignored or isolated" (Feil, 1992, p. 51). Unique, poetic and creative words are formed and pronouns are used without

specific references. The Time Confused retreat inward into the past of their memories. They move slowly, gracefully, with loose muscles and clear but often unfocused eyes. Shoulders are slumped forward and the person often shuffles. Speech is slow with low, even tones.

Repetitive Motion, the third of Feil's substage, is characterized by a "retreat to basic pre-language movements and sounds to nurture themselves and to work through unfinished conflicts from earlier times. Sounds and movements from the earliest developmental stage are continuously repeated. The disoriented in this stage hum, cluck, moan, tap, beat, pound, button and unbutton. Body parts become symbols and movements replace words in this stage of disorientation" (Feil, 1992, p. 53-54). The person in Repetitive Motion displays loose, graceful movements and often sways or dances even though they are unaware of their movements. The voice is low and melodic with steady, even and rhythmic breathing. Although resigned to isolation and self-stimulation, they respond readily to close physical contact, eye contact and nurturing touch and vocal tone.

In the final substage, Vegetation, "the old-old person shuts out the world completely" (Feil, 1992, p. 56). They do not initiate any activity and sit slumped in a chair or in bed in a fetal position.

Muscles are loose and any movement is barely perceptible. Eyes are usually closed and if open they are unfocused or blank. The old-old person in the Vegetation stage rarely expresses feelings of any kind and does not recognize even close relatives.

Building upon Erikson's stage based theory to develop the theoretical foundation for disorientation in late life, Feil turns to the client centered therapy of Carl Rogers as the foundation of validation therapy's intervention techniques. Client centered therapy emphasizes respect of individuality, a non-authoritarian therapeutic relationship and trust in feelings and intuition. Effective and pragmatic therapeutic methods are preferred over rigid psychological ideologies (Rowe, 1986). Rogers states that "behavior is basically the goal-directed attempt of individuals to satisfy their needs as experienced in their phenomenal fields as perceived" (Rogers, cited in Rowe, 1986, p. 414). As a result, the individuals perceptions of their life experiences take precedence over objective reality (Rowe, 1986). According to Rogers, "the best vantage point for understanding behavior is from the internal frame of reference of the individual" (Rogers, cited in Rowe, 1986, p. 414). Accurate empathy is necessary to understand "the full range of sensations, perceptions, meanings, and memories available to

the conscious mind..." (Rowe, 1986, p. 414-415) which make up the internal frame of reference.

Certain therapeutic conditions must be present for treatment to succeed. An individual has the ability to identify the elements of her life that are problematic and move away from the things that cause distress and anxiety. The clients fundamental drive toward self actualization, self-fulfillment and happiness will automatically proceed if the proper conditions are present. It is the responsibility of the therapist to establish these conditions in a nondirective manner to allow the client to guide her own development. Since behavior is based on ones perception of reality, the therapist must fully understand the clients perception of reality. The basic needs of the client for love and acceptance are the basis for the therapeutic relationship and are fostered by empathetic, respectful, authentic communication by the therapist. This expression of unconditional positive regard from the therapist can strengthen the clients self concept. Additionally, for the efforts of the therapist to be effective, the client must be capable of at least minimally perceiving the presence of these therapeutic conditions (Rowe, 1986).

Additional Theory and Hypotheses

This study evaluates the effect of Validation Therapy training on caregiver satisfaction with dyadic communication between caregiver and dementia patient in geriatric long term care. Also of interest is the effect of Validation Therapy training on caregiver perception of the quality of their relationship with the demented resident.

Communication theory provides the theoretical framework for this study. The field of communication research has experienced a recent, and ongoing, epistemological debate similar to the one in social work and other 'human' or 'social' sciences. Consistent with a focus on communication, different epistemological perspectives have been referred to by some communication researchers as "vocabularies". Various perspectives on the study of interpersonal communication employ different metaphors from these vocabularies to describe social interaction in different ways for different purposes. Selection of a specific approach to the study of interpersonal communication should be based on pragmatic consideration of research goals rather than the researcher's beliefs about the intrinsic nature of reality. Common to the diverse conceptualizations guiding interpersonal communication research are three basic precepts: 1) at least two communicators

intentionally orient toward one another, 2) both act as subject and object, and 3) their actions embody the perspectives of each participant on both self and other (Bochner, Cissna & Garko, 1991). As AD related cognitive deficits accumulate, these underpinnings of interpersonal communication begin to weaken

This study is further guided by the concept of coordinated management of meaning. The premise of this perspective is that interpersonal reality is socially constructed and socially maintained. Underlying this process are three basic propositions: 1) meanings are learned through speech, 2) speech is a social process governed by rules, and 3) without rules there can be no meanings (Bochner, Cissna & Garko, 1991). From this perspective the fundamental impact of AD on communication between care giver and demented family member is that the partners in the communication endeavor are no longer playing by the same rules and meaning is lost. Without the ability to construct shared meaning, communication is unsuccessful and quality of the relationship suffers.

Self reports of caregiver satisfaction with communication and quality of their relationship with demented family members were chosen because, based on the theoretical perspective of socially

constructed meaning, it is the subjective perspective of participants that is of interest. While independent observers are often cited as being more objective, there is ample evidence that observer perceptions of interactions differ from the perceptions of participants. This difference is also systematic, with observers consistently rating events more negatively than participants. Communication researchers state that independent observers attribute conventionalized, normative meaning to observed interactions while participants are aware of idiosyncratic, subjective meanings based on well developed relational knowledge acquired through a history of interaction (Surra & Ridley, 1991). It is these subjective, relationship specific perspectives on satisfaction with communication and quality of relationship which this study seeks to measure.

The value base of Validation Therapy also guides study objectives. Validation Therapy was developed by a social worker and based on values that define disoriented old-old as people with inherent worth. They are seen as having the wisdom of their years, being worthy of help in resolving issues of loss and deserving support of their dignity and worth (Feil, 1992). Accordingly, outcome criteria of this study focus on communication satisfaction and quality

relationships with family caregivers rather than the extent to which residents regain cognitive capacity or reduce 'problem behaviors'.

Consistent with communication theory and the value base of Validation Therapy, this study seeks to assess the effect of Validation Therapy training on satisfaction with communication between caregiver and dementia patient dyads and associated effect on reported quality of relationship. These outcomes are based on the following hypotheses:

Hypothesis 1. Training in Validation Therapy will increase caregiver knowledge of Validation skills as indicated by Validation Skills Assessment.

Hypothesis 2. As knowledge of Validation Therapy skills increases, satisfaction with dyadic interactions between caregivers and demented residents, as indicated on Hecht's Interpersonal Communication Satisfaction Inventory, will also increase.

Hypothesis 3. As knowledge of Validation Therapy skills increases, quality of relationship between caregivers and demented residents as indicated on the Dementia Care Giver Quality of Relationship Inventory will also increase.

Hypothesis 4. Caregivers receiving Validation Therapy training will report greater satisfaction with dyadic interactions with demented residents as indicated on Hecht's Interpersonal Communication Satisfaction Inventory than the no treatment comparison group.

Hypothesis 5. Caregivers receiving Validation Therapy training will report improvement in quality of relationship with demented residents as indicated on the Dementia Care Giver Quality of Relationship Inventory than the no treatment comparison group.

Methods

Population and Sample

Initially, all subjects for this study were to come from the population of family caregivers of dementia patients at Trinity Lutheran Home (TLH) in Round Rock, Texas. TLH is a 179 bed long term care facility comprised of three stations, one of which contains a 22 bed Special Care Unit (SCU). Residents on the SCU pose an elopement risk and have a diagnosis of dementia, although dementia patients also reside on the other two stations. The director of social services and the primary investigator assessed clients to determine their appropriateness for Validation Therapy based on their stage of dementia as defined by Feil (1992). Observation of residents on the unit and chart reviews helped inform this selection process. Of the 179 residents at TLH, the director of social services estimated that approximately three quarters, or 118, suffered some degree of cognitive impairment. Of this number, approximately two thirds, or 78, were believed to be in the time confusion or repetitive motion stages appropriate for Validation Therapy.

The Director of Social Services informed family care givers through the monthly TLH newsletter that a study of Validation Therapy

training would be conducted on November 3, 4 and 5, 1994. Once residents appropriate for Validation therapy were identified, the principle investigator made phone calls to family members soliciting their participation and describing the details of the study. The primary investigator also made presentations at three monthly family support meetings prior to the November training and solicited study participants. During these presentations the topic of the study was disclosed but discussion was limited to a brief description of Validation Therapy and the intervention's intended population.

Rates of consent for participation in similar nonrisk research provided by residents themselves, or by family care givers for demented family members, have been reported to be 86.8% and 91%, respectively (Cohen-Mansfield, Kerin, Pawlson, Lipson & Holdridge, 1988). Attrition in this study was expected to be low due to the limited time and effort required of participants and the brief duration of the study. In addition more than one family member per resident could participate in the study. In spite of these factors, the participation rate from the single long term care facility proved insufficient to produce an adequate number of subjects for the planned statistical analysis.

Before the next scheduled Validation Therapy workshop on April 27, 28 and 29, 1995, subject recruitment was expanded to four additional central Texas long term care facilities: Buckner Baptist Villas and Gracy Woods Nursing Center in Austin, Hearthstone in Round Rock, and Pflugerville Care Center in Pflugerville. These facilities were chosen for inclusion in the study primarily on the basis of support for Validation Therapy by the directors of social services and their expressed desire to assist in carrying out the study. Staff caregivers from all facilities were also included in the study recruiting procedure at this time. The director of social services at each of the facilities assisted the primary investigator in identifying staff and family care givers of clients who were appropriate for Validation, again, based on their stage of dementia as defined by Feil (1992). At each of the two monthly family support meetings that preceded the April Validation Therapy workshops, the principle investigator made a brief presentation on Alzheimer's disease and solicited study participants. Again, the topic of the study was disclosed and discussion was limited to a brief description of Validation Therapy and the intervention's intended population.

Originally planned to be a randomized two group experimental design, it soon became apparent that recruiting sufficient numbers of caregivers willing and able to attend the specific dates of the Validation Therapy training would be difficult enough without losing half of those subjects to a control group. Ethical considerations were also raised as study participants expressed the desperation with which they were seeking methods of communicating with loved ones in the late stages a progressive and fatal disease process.

While talking with the principle investigator about whether they could attend the training, many of the family caregivers stated that they would like to attend, but couldn't because of other responsibilities or a conflict in their schedules. Of these family caregivers, most agreed to participate in a comparison group with the understanding that the principle investigator would provide a presentation on Validation Therapy to the support group at the conclusion of the study. Staff members interested in Validation but unable to attend the specific dates of the workshops were also identified and asked to participate in the comparison group. After consulting with the doctoral committee, the primary investigator decided that weakening the design by dropping randomization was a reasonable trade off for

increasing overall sample size and allowing all of those family members who expressed the desire and ability the opportunity to attend Validation Training.

Instrumentation

Pre-test and post-test measures consisted of one standardized instrument which was modified slightly for this population, an instrument developed by the principle investigator for this study and an instrument composed of items developed by the creator of the therapeutic intervention under investigation. The standardized instrument, Hecht's Interpersonal Communication Satisfaction Inventory (ICSI) (1978a) was used to assess the effect of the intervention on family caregiver satisfaction with communication. It was developed using approximately 1,000 undergraduate students in the introductory communication class at the University of Illinois in four stages: 1) eliciting items, 2) preliminary testing of items, 3) testing of items and factor structure, and 4) establishing reliability and validity.

Reliability and validity data were generated using a final group of 115 students from the remainder of the respondent pool, 58 of whom

were used to determine the reliability of the instrument immediately after an interaction. Split half reliability coefficients of .96 and .97 were reported for the 16 and 19 item instrument, respectively (Hecht, 1978). Other researchers have reported alphas between .88 and .94. (Wheless, Frymier & Thompson, 1992; Onyekware, Rubin & Infante, 1991; Rubin, Martin, Bruning & Powers, 1993). Hecht reports "exceptionally high" convergent construct validity with a coefficient of .87 for the 19 item instrument administered after actual interactions using Kunins (1955, cited in Hecht, 1978) nonverbal Male and Female Faces Scale as a criterion.

For this study the instrument was modified slightly. The 16 item version was used after dropping item 4 and including item 8 from the 19 item version. Item 4 makes no sense in the context of family member interactions and item 8 appears particularly appropriate for this study (see appendix). Although no attempt was made to assess validity of this instrument with this population, the modifications specified above did not significantly affect its reliability. Alpha coefficients for the pretest and post-test administration of the instrument in this study were .80 and .89, respectively, both deemed "very good" (Develis, 1991, p. 85).

The Dementia Caregiver Quality of Relationship Inventory (DCQRI) was developed by the principle investigator for this study because no existing measure for the construct of relationship satisfaction between caregivers and dementia patients could be found. The Hudson CAM-CAF scales have been used with modification previously (Dzegielewski, 1992) in research with a similar population, but Hudson has since refused requests to use modified CAM-CAF scales. Because of the fundamentally different relationships family and staff caregivers have with dementia patients, different item pools were developed for staff and family versions of the instrument. The items were discussed with the director of social services at TLH and the family caregiver of a demented resident there. An adequate development sample (Develis, 1991) was unavailable as all subjects appropriate for instrument development were to participate in the study. Reliability for this instrument was marginal, with alpha coefficients of .59, .58, and .56 for the family pre-test, staff pre-test and the staff post-test administrations respectively. Interestingly, the alpha coefficient for the family post-test administration was quite good at .81.

A factor analysis of the DCQRI was carried out to determine if the majority of items loaded on a single latent variable as intended, or if the low item-total correlations and resulting low alpha coefficient were caused by instrument items actually loading on several factors. Based on examination of scree plots (DeVellis, 1991) for pre-test and post administrations of the DCQRI, no meaningful factors could be extracted. This indicated that instrument items were not tapping a single latent variable.

The instrument used to assess subject grasp of validation therapy technique and theory base consists of 18 items (Feil, 1992) and has not undergone any formal development or procedures to establish reliability and validity. The items are based on Feil's clinical experience and consist of 5 multiple choice items, 5 true false items, and 7 essay items. In order to facilitate scoring and make the essay items less intimidating to subjects, they were changed to a multiple choice format representing the same content. Item 17, which asks for a list of steps necessary in forming a Validation group, was dropped because it is not relevant to family caregivers or nurse aides, a large proportion of the study population.

Psychometric properties for the Validation Skills instrument were disappointingly poor. Alpha coefficients were .20 for the pre-test and .17 for the post-test administrations of the instrument. Factor analysis of this measure also indicated that individual items failed to load on a single factor as expected.

In addition to the DCQRI, the ICSI, and the Validation Therapy skills test, data on selected demographic variables were also collected. Participants filled out a demographic variable data sheet along with the consent to participate during the pretest session with the primary investigator. Demographic variables were gender, age, employment status, number of dependents living at home, and, for family caregivers, familial relationship to client, and degree of satisfaction with relationship prior to onset of dementia.

Data Collection

Pre-test measures for the experimental condition were administered immediately before Validation Therapy training. Because of variability in interactions with dementia patients, subjects were instructed to base responses to study instruments on a typical interaction with their demented family member. The experimental

intervention consisted of training family caregivers in Validation Therapy. Training was provided by Naomi Feil at either a two day workshop consisting of 14 contact hours or a condensed one day workshop lasting 8 hours. Both workshops covered the same content area and utilized a multimedia approach with didactic and experiential components. Prior to training, the primary investigator emphasized to participants in the experimental condition that any discussion of presented material with participants in the comparison condition could compromise study results. Participants in the experimental group were provided with a packet of post-test instruments at the time of training. They were instructed to have two visits with demented family members before taking the post-test to allow practice of Validation Therapy techniques learned in the training sessions.

Control condition participants, in general, took pre- and post test measures during a wider time interval. As directors of social services identified interested family and staff, or as family members attending family support groups expressed a desire to participate in the comparison group, they were given pre-tests and instructed to complete and return post-tests after two weeks. Some post-tests were returned after considerably longer than two weeks, with two

family comparison post-tests not being returned until approximately three months after the pre-test was administered. These subjects stated that they completed the post test within the suggested time frame but did not returned it until later.

Design and Data Analysis

Alpha Level

It can be argued that in applied research investigating the beneficial effects of a promising treatment, a relatively high level of Type I error is acceptable. Demonstrably effective treatments for many practical problems are rare and potentially beneficial interventions should not be too easily dismissed. In this context a Type II error can represent great practical loss (Lipsey, 1990). This is currently the situation concerning interventions for dementia caregivers and dementia patients in long term care. Consequently, the Alpha level for this study was set at .10.

Effect Size

No studies of Validation Therapy training and it's impact on dyadic communication were located. The majority of existing literature on Validation Therapy outcomes is narrative or anecdotal and does not

provided the statistics necessary to compute effect size (Feil, 1967, 1983, 1985, 1991, 1992; Ronaldson & Savy, 1992; Bleathman & Morton, 1988, 1992; Dietch, Hewett & Jones, 1989). Other studies are nonexperimental in design and also do not provide enough information to compute effect size (Morton & Bleathman, 1991; Babins, 1988). As noted in Lipsey (1990) effect size is problematic in that it is generally both unknown and difficult to guess. This dearth of prior research precludes the use of Lipsey's actuarial and statistical translation approaches to judging the minimal effect size a study should be designed to detect. The criterion group contrast approach is also of little use due to this study's novel use of measures with an uncommon intervention.

While the effect size in social science as a whole is generally low, anecdotal evidence indicates that Validation Therapy has a pronounced effect on communication and quality of relationship between caregiver and demented patient. It was assumed that the effect size in this study would be medium (Cohen, 1988), or .50.

Power

As noted in the Population section, the overall sample size of this study is 58 with an experimental group of 36 and 22 in the

comparison group. Based on a projected overall sample size of 60 with equal group size power was estimated to be approximately .60 for a two tailed test. While the estimated statistical power of this study is somewhat low, based on the constraints of limited resources, subject access and the present state of knowledge about Validation Therapy, it is adequate to contribute meaningfully to the existing knowledge base.

Statistical Tests

Reliability of the instruments was assessed by use of alpha coefficients. Based on extremely low alphas, the Validation Skills data was not used in the quantitative analysis. Alpha coefficients for the DCQRI, though higher than those of the Validation Skills test, were also low. Though caution should be used when attempting to generalize findings based on the instrument, it was retained for analysis. Visual inspection of stem and leaf plots and Leven's tests were used to ensure that the data met the homogeneity of variance assumption.

A series of t-tests generated bivariate statistics; first to assess comparability of family-staff caregiver and experimental-comparison groups, then to test study hypotheses. In spite of analysis consisting

of a series of t-tests, because the majority of the tests assessed group comparability and only one test of study hypotheses was based on a reliable instrument, the Bonferroni correction was not used (Stevens, 1992).

Results

Descriptive Statistics

Experimental and comparison groups were equally represented on the variable of gender. Fourteen percent of the of both experimental and comparison groups were male while 86% of experimental and comparison groups were female. With respect to level of education, the experimental group reported higher levels of education than the comparison group. While 65% of the comparison group reported their highest level of education as grade school (9.1%) or high school (54.5%), of the experimental group none reported grade school as the highest level of education and only 13.9% identified high school as the extent of their education. Sixty one percent of the experimental group reported college (50%) or graduate school (11%) as their highest level of education while 31.8% of the comparison group reported attending college and none reported graduate

education.. Of eight LVNs and one RN who participated in the study, all were in the experimental group.

The experimental and comparison group also appeared to differ on level of employment with 81.8% of the comparison group being employed full time compared to 57.1% of the experimental group. Twenty percent and 22.9% of the experimental group reported part time or no employment outside the home, respectively, while only 4.5% and 13.6% of the comparison group reported part time or no work outside the home.

There was no significant difference between experimental and comparison groups on family/staff representation ($\chi^2 = .49$). Staff made up the majority of each group, representing 63.9% of the experimental group and 72.7% of the comparison group. Accordingly, family care givers comprised 36.1% of the experimental group and 27.3% of the comparison group.

Although not retained for bivariate analysis after the inclusion of staff caregivers, two interesting variables were collected from family caregivers; familial relationship to patient and relationship with patient prior to onset of dementia. Of family caregivers, 68.4% were women with the majority being daughters (57.9%) followed by daughters in

law (10.5%) a single wife (5.3%) and a single female extended family member (5.3%). The male care givers (31.6%) were comprised of 2 husbands (10.5%), 1 son (5.3%), and 1 male extended family member (5.3%). Family caregivers consistently reported positive relationships with confused relatives prior to the onset of dementia. Ninety-four percent of family caregivers reported good (26.3%) or very good (68.4%) relationships prior to dementing illness. One respondent reported an "adequate" relationship and none reported a "poor" relationship.

Bivariate Statistics

Prior to analysis, all assumptions for homogeneity of variance were met. Visual assessment of stem and leaf plots for all conditions showed approximately normal distributions. Additionally, Leven's tests for all comparisons failed to reach significance, indicating equality of variance.

No significant difference was found between family and staff on pre-test ($\alpha = .72$), post-test ($\alpha = .95$), or change score ($\alpha = .76$) for the DCQRI. Additionally, no training effect was detected for the DCQRI. No significant difference between the experimental and comparison was observed on the pre-test

($\alpha = .67$), the post-test ($\alpha = .27$) or the change score. It should be noted that Stevens (1992) cautions against the use of change scores as their reliability is generally poor. Based on the average reliability of the two tests and the correlation between them, reliability for the DCQRI change score is only .44. DeVellis calls anything below .60 "unacceptable" (1991, p. 85).

A statistically significant effect for the intervention on the ICSI was found. Analysis showed no difference between experimental and comparison groups on satisfaction with communication for the pre-test ($\alpha = .69$), as desired. The post-test scores on the ICSI, however, also indicated no significant difference ($\alpha = .13$) between experimental and comparison groups. The significant difference between experimental and comparison groups on the communication satisfaction variable appears, however, on the change scores from pre-test to post-test ($\alpha = .03$). Both the experimental and comparison groups showed an increase in satisfaction with communication, but the experimental group, which had a slightly lower mean score on the pre-test, showed a significantly greater increase from the pre-test to post-test score than the comparison group, with a higher communication satisfaction score on the post-test (see figure 1).

Unlike the DCQRI, reliability for the ICSI change score is approximately .70, which DeVellis terms "respectable" (1991, p. 85).

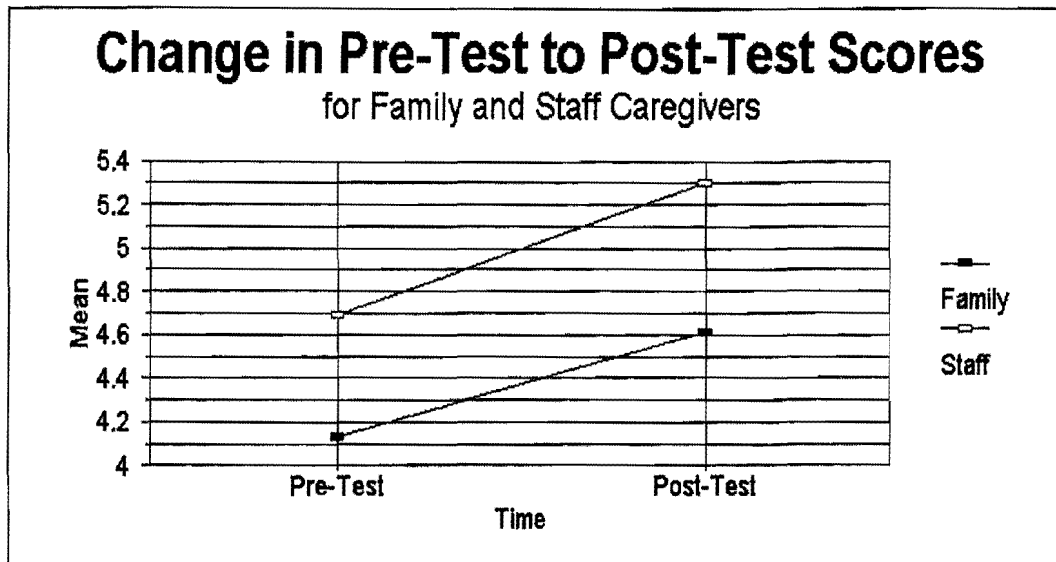


Figure 1

Based on ICSI change scores there was no difference between family and staff care givers ($\alpha = .778$). Although there were no statistically significant differences between staff and family resulting from the effect of Validation Therapy training, there were preexisting and stable differences between family and staff caregivers on communication satisfaction. On both pre- and post-test administrations of the ICSI staff care givers were significantly more satisfied with their communication with dementia patients ($\alpha = .03$ and $.01$, respectively) (see figure 2).

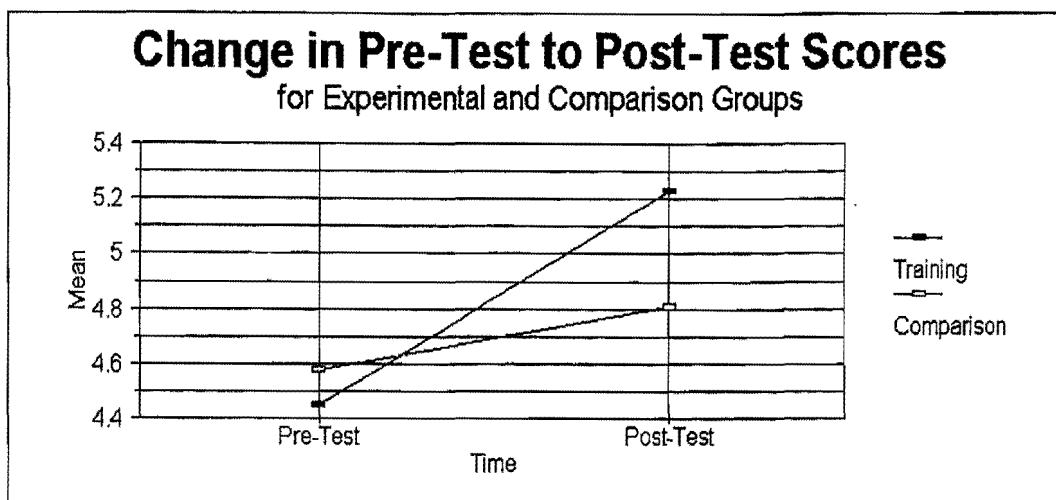


Figure 2

Qualitative Results

Of the 36 participants who received Validation Therapy training, four family caregivers wrote comments on their instrument packet. Each of these respondents provided very positive comments about the effect of the training, although one respondent expressed that she felt that the some of the seminar content was contradictory. One participant stated that his responses on the post-test were "based on my 11/30/94 visit [wth my demented family member]- the best I have ever had". The principle investigator talked at length with this respondent several months after the training, which was also attended by his wife and mother. He stated that his mother felt, as a result of the training, that she was able to have a much more meaningful

relationship with her demented husband , until failing health resulted in her own placement in long term care resulting in fewer visits with her husband.

One respondent thanked the principle investigator "for the opportunity to attend this class. I shared the book and what I learned with my husband. His conversations with his mother have improved immensely. They are both much more content. Many thanks."

Another respondent stated: "My interactions with my mother these past few days have been under different circumstances than the usual since she fell Friday and broke her hip. I've been with her quite a bit since last Friday and I truly feel more comfortable and confident when I'm with her. The session Thursday was very helpful. I feel I have gained a lot of understanding of 'old' people. Thank you for inviting me to participate."

The remaining study participant to make comments was also quite positive about the training in general, but had some concerns about specific content areas. "I got mixed messages from the seminar. Naomi stated that Validation Therapy could not be used with the Alzheimer's patient to stop them from progressing to the final vegetative stage. She said the old-old person could reason more but

someone with Alzheimer's obviously forgets from one moment to the next. I do feel that it can be used to converse with the Alzheimer's person but no progress can be expected."

The same respondent , however, went on to state: "I did love the seminar and felt that every health care worker who deals with the elderly should take it. It gives such a good understanding to [sic] what the residents are going through during the final stages of life. What a respectful way to treat the elderly. I wish more followed the example."

Discussion

Several issues bring the generalizability of study findings into question. Due to existing constraints, this is a preselected, nonrandom sample. Populations of caregivers that place family members with dementing disorders may not be comparable with those in different areas of the country, or those utilizing different social service agencies within an area. As such, even when comparing this population to other populations which refer family members to long term care due to a diagnosis of dementia, some caution in generalizing study findings must be exercised. Little is known about the differences between family caregivers of dementia sufferers remaining at

home, those placed in the general population of long term care facilities and those on special care units. Also of concern with respect to generalizability of study findings is the low reliability of the DCQRI. Assuming that there was no experimental effect on quality of relationship for this sample, low reliability of the DCQRI would make generalizing those findings to a broader population of caregivers questionable. At the present level of knowledge, however, this study still generates useful information.

The positive effect of Validation Therapy training on communication satisfaction for dementia caregivers appears strong based on computed effect size, statistical power and reliability of the instrument used to measure the construct. Based on the reported importance of successful communication in maintenance of psychosocial supports and caregiving relationships, it appears clear that Validation Therapy training for caregivers of dementia patients in long term care can provide an important component for improving quality of care.

That significant findings were not found for Validation Therapy's effect on quality of relationship and grasp of Validation Therapy techniques could speak more to the poor psychometric properties of

those instruments than the lack of effect from Validation Therapy training. Observed reliability for the Validation Therapy skills instrument clearly rendered the data it generated unusable in statistical analysis. Psychometric properties of the Validation Therapy skills instrument were sufficiently poor that rethinking the nature of the underlying construct before further development of an instrument to measure that construct may be in order.

Reliability of the DCQRI was much higher but still low enough that findings based the data it generated are open to question. Marginal reliability of the DCQRI could, in part, reflect the small sample size of the study. Further development of the instrument through generating a larger item pool and administration to a development sample is warranted.

The higher reliability coefficient on the DCQRI post-test administration for family caregivers could be due to chance, but it is also possible that being sensitized to relationship issues by taking the pre-test resulted in a more focused, coherent response to post-test items. That this effect is only evident for family care givers could result from the greater emotional investment family caregivers may

have in relationship with loved ones, compared to the less emotional, professional relationship of staff members.

The level of emotional investment in the caregiving relationship could also explain staff caregivers scoring significantly higher on Communication Satisfaction measures at pre-test and post-test than family caregivers, although there was no difference on change score. With the greater emotional investment in a familial relationship could come greater expectations for depth and meaning in the relationship. Staff members could, with lower expectations for the depth of the relationship, be more satisfied with the level of communication they achieve with dementia patients in their care. Family caregivers, on the other hand, may have equal or even greater ability to communicate with dementia patients. However, due to greater expectations of depth and meaning in their interactions with loved family members, family caregivers could report less satisfaction with equal or greater levels of communication.

Recommendations

That a significant effect was detected after so limited an intervention is particularly promising in light of Feil's recommendation that Validation Therapy be implemented in a broad based, facility wide

fashion. A primary recommendation is the development of a protocol and curriculum for broadly based Validation Therapy training. Feil has a wealth of experience in using Validation Therapy clinically and in presenting the theory and technique of the intervention to caregivers. Her workshop presentations and demonstrations with clinical populations make evident the depth of her knowledge and flexibility with which she presents and uses the techniques. In order for Validation Therapy to be used more broadly, however, increased opportunities for training must exist.

Due to the cost and limited availability of a single person, it is not realistic to bring Naomi Feil to every long term care facility to personally provide training in Validation Therapy. Development of a Validation Therapy training curriculum and protocol which has the flexibility to meet the needs of diverse caregivers should be a priority. Any training protocol should be capable of incorporation into existing training coordinator staff development programs. The content should be flexible enough for use with all levels of caregivers, including family, aides, nurses, administrators, housekeepers and maintenance personnel. In Texas, the bilingual component of curriculum material must not be neglected as many direct caregivers are Spanish speaking.

Trinity Lutheran Home has initiated an innovative program in which a progressive pay scale has been linked, in part, to completion of Validation Therapy training and, perhaps more importantly, verification of actually using Validation Therapy techniques with residents. Initiating programs like this in other long term care facilities could provide some incentive for staff caregivers to not only participate in Validation Therapy training but to demonstrate proficiency in it's use.

Partnerships between family and staff caregivers should also be facilitated by a long term care facility's Validation Therapy training program and associated auxiliary social services. Often, aides are over worked, and underpaid. Family caregivers may be stressed and experiencing guilt over the placement of a loved one. When these caregivers come into contact, conflicts may result surrounding unrealistic expectations regarding long term care. Proper admission counseling to clarify expectations concerning care and ongoing family access to administrative personnel to voice concerns regarding resident care are helpful to alleviate family stress. The previously mentioned pay scale incorporating Validation Therapy training can help aides to feel they are rewarded for their efforts toward quality care for residents.

Validation Therapy training for both staff and family may also help foster a sense of partnership in caregiving by giving them a common foundation for care provision.

In order for meaningful and valid research and training in Validation Therapy to be initiated or continued, reliable and valid instruments assessing validation skills and measuring the effect of those skills on dementia patients and care givers is crucial. The IRCI, although not used with dementia caregivers prior to this study appears to be a robust, reliable instrument with this population. Further work on assessing the ICSI for content, criterion, and construct validity would serve to strengthen it's usefulness in Validation Therapy research. The DCQRI, though not displaying the reliability of the ICSI, appears worthy of further development. Creation of a larger item pool and administration to a development sample would provide necessary data to improve the psychometric properties of the instrument. An instrument to assess grasp of Validation Therapy skills and concepts is perhaps most needed. The items developed by Feil, while appearing to have some face validity, did not hold together as anything even approaching a valid instrument. Rethinking the nature of the construct or latent variable underlying acquisition of Validation Therapy skills is

required before the development and administration of a larger item pool.

Measures and protocols for more directly assessing the impact of Validation Therapy on dementia patients in long term care are also needed. Due to the perceived difficulty of obtaining meaningful information from dementia patients, existing studies of Validation Therapy have focused on the intervention's effect on caregivers. Although procedurally less demanding pen and paper instruments are not realistic for use with dementia patients, a variety of observational measures have been used with other populations. More creativity needs to be brought to bear on developing workable methods of directly assessing the effect of Validation Therapy on long term care residents. Patient medication and restraint are two areas where the effect of Validation Therapy training programs could have a pronounced effect on dementia patient quality of life. These would be appropriate areas for assessing the direct impact of Validation Therapy on demented residents.

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APPENDIX

The Effect of Validation Therapy Training
on Satisfaction with Communication and
Quality of Relationship

Prepared for the Institute for Quality
Improvement in Long Term Health Care,
Southwest Texas State University

The following tests can be given to evaluate potential Validation workers (people who will be working with Alzheimer's type populations) in an institution or organization.

Circle the correct answer.

1. A disoriented resident screams every time she drops her purse. Should you:
 - (a) Try to make sure she has the purse. Explore to build trust. Find out what the purse means to her.
 - (b) Assure her that she has no need for the purse in this place. She isn't going anywhere. She doesn't need money.
 - (c) Take her purse away. "Out of sight out of mind."
 2. A disoriented old-old man unzips his pants in public. Should you:
 - (a) Gently walk with him to his room, and ask, "Do you miss your wife?"
 - (b) Negatively reinforce him. Firmly let him know, "We don't do things like that around here."
 - (c) Mirror his actions.
 3. A disoriented resident hollers, "I want my teeth!" Should you:
 - (a) Find out where her teeth are, or get her false teeth if needed.
 - (b) Tell her that she always takes her teeth out and loses them.
 - (c) Tell her she is too old for new dentures.
 4. When you are with a disoriented person, are you most inclined to:
 - (a) Keep your distance.
 - (b) Touch them softly to elicit interaction.
 - (c) Stand close without touching.
 - (d) Use soft touch together with close eye contact.
 5. When a person is in Stage Three (repetitive motion), I:
 - (a) Mirror their actions using touch and close eye contact.
 - (b) Ask them what they are doing.
 - (c) Ask them to stop.
 - (d) Ignore their actions.
- Please mark either (T) True, or (F) False.**
6. () Almost all old-old people who are disoriented are incontinent.

7. () All old people ought to know their married name, where they are, the present date and time.
8. () People who live in the past are happy that way, so it's better to pretend to believe them.
9. () People who are over 80 years old and disoriented, with physical failures and social losses, turn to the past to resolve old conflicts and to restore old pleasures.
10. () It is important to correct disoriented people when they are mistaken or forgetful.
11. () It is important for older people to have alternative interests to prevent withdrawal.

Please answer the following in essay form. Use additional paper.

12. List Erikson's six life stages and their related tasks.
13. Identify and describe the four stages of disorientation.
14. Describe the goals and needs of old-old people in each of the four stages.
15. Describe the Validation techniques that are useful for each stage of disorientation.
16. List the steps involved in centering yourself.
17. List the steps necessary in forming a Validation group (for the first time).
18. Write a brief introduction of Validation, as you might present it to family members or staff.

Answers to questions 1-11 are on page 121

FIGURE 1
Interpersonal Communication Satisfaction Inventory

Instructions for use with actual conversation:

The purpose of this questionnaire is to investigate your reactions to the conversation you just had. On the next few pages you will be asked to react to a number of statements. Please indicate the degree to which you agree or disagree that each statement describes this conversation. The 4 or middle position on the scale represents "undecided" or "neutral," then moving out from the center, "slight" agreement or disagreement, then "moderate," then "strong" agreement or disagreement.

For example, if you strongly agree with the following statement you would circle 1;

The other person moved around a lot.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

1. The other person let me know that I was communicating effectively.
2. Nothing was accomplished.
3. I would like to have another conversation like this one.
4. The other person genuinely wanted to get to know me.
5. I was very dissatisfied with the conversation.
- *6. I had something else to do.
7. I felt that during the conversation I was able to present myself as I wanted the other person to view me.
- *8. The other person showed me that he/she understood what I said.
9. I was very satisfied with the conversation.
10. The other person expressed a lot of interest in what I had to say.
11. I did NOT enjoy the conversation.
12. The other person did NOT provide support for what he/she was saying.
13. I felt I could talk about anything with the other person.
14. We each got to say what we wanted.
15. I felt that we could laugh easily together.
16. The conversation flowed smoothly.
- *17. The other person changed the topic when his/her feelings were brought into the conversation.
18. The other person frequently said things which added little to the conversation.
19. We talked about something I was NOT interested in.

*The three items not included in the 16-item version are indicated by an asterisk.

Scoring Key:

For items 1, 3, 4, 7, 8, 9, 10, 13, 14, 15, 16: Strongly Agree = 7, Moderately Agree = 6, Slightly Agree = 5, Neutral = 4, Slightly Disagree = 3, Moderately Disagree = 2, Strongly Disagree = 1.

For Items 2, 5, 6, 11, 12, 17, 18, 19: Strongly Agree = 1, Moderately Agree = 2, Slightly Agree = 3, Neutral = 4, Slightly Disagree = 5, Moderately Disagree = 6, Strongly Disagree = 7.

Impact of Validation Therapy Training

STAFF CONSENT FORM

You are invited to participate in an experimental study of Validation Therapy training and its impact on communication and quality of relationship between staff caregiver and dementia patient. **I am a doctoral student at the University of Texas at Austin School of Social Work. This study is the basis of my dissertation research.** You were selected as a potential participant in this study because of your status as a staff member who provides care to confused residents.

If you are attending the Validation Therapy training workshop and decide to participate, I will meet with you for approximately one half hour before the workshop. This meeting will be attended by several study participants. During that meeting I will answer any additional questions you may have and hand out four brief questionnaires for you to complete at that time.

The Validation Therapy training will be provided by its' developer, Naomi Feil. The first component of the intervention will be a one day workshop consisting of 7 contact hours. This workshop utilizes a multimedia approach with didactic and experiential components. **There will be no cost for Validation Therapy training or this study.**

Following training, and after you have completed two trial or practice interactions with confused residents, you will be asked to fill out three additional short questionnaires.

If you choose to participate and are not attending the Validation Therapy training, you will complete the seven brief questionnaires during the same time interval as the group that attends the Validation Therapy training workshop. However, after the last three questionnaires are completed, you will have the option of receiving training in Validation at no cost at the next scheduled Validation Therapy training workshop.

Total time required of participants in either group, including Validation Therapy training contact hours, will be approximately 8 hours over a three week period.

The intervention under study is purely educational in nature with no identified possibility of negative impact. To the contrary, it is hypothesized that the intervention will provide skills, techniques and approaches which will improve communication and the relationship between you and the demented residents in your care.

(Continued on next page)

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. If you decide to participate, you are free to discontinue participation at any time without affecting the relationship between you and the nursing home or The University of Texas at Austin.

If you have any questions, please ask me. If you have any additional questions later I will be happy to answer them at that time. I can be contacted at 471-5456 or 251-4076. If I am not immediately available, you may leave a message at either number and I will return your call as soon as possible. The Chair of my doctoral committee is John McNeil, DSW. He can be reached at 471-8276.

You will be offered a copy of this form to keep.

You are making a decision whether or not to participate. Your signature indicates that you have read the information provided above and have decided to participate. You may withdraw at any time after signing this form, should you choose to stop participation in this study.

Signature of Participant

Date

Signature of Investigator or
Director of Social Services

Date

Staff Participant Demographic Data

Your name _____

Marital Status: 1.) Single (includes divorced) 2.) Married (includes living together)

Your Gender: 1.) M 2.) F

Your Age: _____

Education: (circle most appropriate)

1.) Grade school

2.) High School

3.) College

4.) Trade School

5.) Graduate School

6.) RN

7.) LVN

Employment status: 1.) Full Time (35 hours a week or more)

2.) Part time (less than 35 hours a week)

Number of dependents living at home : _____

Have you ever had Validation Therapy training before today? 1.) Yes 2.) No

Validation Skills

The following items are intended to assess knowledge of validation skills for working with Alzheimer's type populations.

Circle the correct answer.

1. A disoriented resident screams every time she drops her purse. Should you:
 - (a) Try to make sure she has the purse. Explore to build trust. Find out what the purse means to her.
 - (b) Assure that she has no need for the purse in this place. She isn't going anywhere. She doesn't need money.
 - (c) Take her purse away. "Out of sight out of mind."

2. A disoriented old-old man unzips his pants in public. Should you:
 - (a) Gently walk him to his room, and ask , "Do you miss your wife?"
 - (b) Negatively reinforce him. Firmly let him know, "We don't do things like that around here."
 - (c) Mirror his actions.

3. A disoriented resident hollers, "I want my teeth!" Should you:
 - (a) Find out where her teeth are, or get her false teeth if needed.
 - (b) Tell her that she always takes her teeth out and loses them.
 - (c) Tell her she is too old for new dentures.

4. When you are with a disoriented person, you are most inclined to:
 - (a) Keep your distance.
 - (b) Touch them softly to elicit interaction.
 - (c) Stand close without touching.
 - (d) Use soft touch together with close eye contact.

5. When a person is in Stage Three (repetitive motion), I:
 - (a) Mirror their actions using touch and close eye contact.
 - (b) Ask them what they are doing.
 - (c) Ask them to stop.
 - (d) Ignore their actions.

6. When a disoriented resident accuses others of stealing, I would:
- (a) Discourage them because I have heard this before.
 - (b) Ask them why someone would steal their possessions and show them they are wrong.
 - (c) Explore their anger with who, what, when and where words.
 - (d) Tell him/her not to worry.
7. If my disoriented family member thinks I am THEIR parent, I would:
- (a) Correct him/her.
 - (b) Change the subject.
 - (c) Tell him/her my feelings are hurt.
 - (d) Reminisce about the loved one from the past.

Please mark (T) True, or (F) False.

- _____ 8. Almost all old-old people who are disoriented are incontinent.
- _____ 9. All old people ought to know their married name.
- _____ 10. People who live in the past are happy that way, so it's better to pretend to believe them.
- _____ 11. People who are over 80 years old and disoriented, with physical failures and social losses, turn to the past to resolve old conflicts and restore old pleasures.
- _____ 12. It is important to correct disoriented people when they are mistaken or forgetful.
- _____ 13. It is important for older people to have alternate interests to prevent withdrawal.
- _____ 14. Poor vision and hearing can lead to an older person's distortion of present reality.
- _____ 15. It is important to correct the disoriented person when he/she is wrong or forgets or repeats.

Confused Patient and Staff Caregiver Relationship Inventory

Below are statements about the nature of the relationship between you as a caregiver and confused residents. It is common to have a wide range of emotional responses to the impact of confusion on the caregiving relationship. Indicate the extent to which you agree with each of the following statements by circling the appropriate number below each statement.

1.) I have specific and effective techniques for addressing outbursts from confused residents.

Very much		Somewhat		Not at all
1	2	3	4	5

2.) I don't know what to say to confused residents.

Very much		Somewhat		Not at all
1	2	3	4	5

3.) My relationship with confused residents is not satisfying.

Very much		Somewhat		Not at all
1	2	3	4	5

4.) I don't enjoy interacting with confused residents.

Very much		Somewhat		Not at all
1	2	3	4	5

5.) My efforts to calm confused residents are effective.

Very much		Somewhat		Not at all
1	2	3	4	5

6.) I enjoy time spent with confused residents.

Very much		Somewhat		Not at all
1	2	3	4	5

7.) I find some aspects of my caregiving relationship with confused residents rewarding.

Very much		Somewhat		Not at all
1	2	3	4	5

8.) I feel like I don't 'connect' with confused residents.

Very much		Somewhat		Not at all
1	2	3	4	5

9.) I feel frustrated working with confused residents.

Very much		Somewhat		Not at all
1	2	3	4	5

10.) I am able to help confused residents understand my directions concerning the care I am providing.

Very much		Somewhat		Not at all
1	2	3	4	5

Interpersonal Communication Satisfaction Inventory

The purpose of this questionnaire is to investigate your reactions to the conversation you just had. On the next few pages you will be asked to react to a number of statements. Please indicate the degree to which you agree or disagree that each statement describes this conversation. The 4 or middle position on the scale represents "undecided" or "neutral," then moving out from the center, "slight" agreement or disagreement, then "moderate," then "strong" agreement or disagreement.

For example, if you strongly agree with the following statement you would circle 1;

The other person moved around a lot.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

1. The other person let me know that I was communicating effectively.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

2. Nothing was accomplished.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

3. I would like to have another conversation like this one.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

4. I was very dissatisfied with the conversation.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

5. I felt that during the conversation I was able to present myself like I wanted the other person to see me.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

6. The other person showed me that they understood what I said.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

7. I was very satisfied with the conversation.
Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree
8. The other person expressed a lot of interest in what I said.
Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree
9. I did NOT enjoy the conversation.
Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree
10. The other person did NOT provide support for what he/she was saying.
Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree
11. I felt I could talk about anything with the other person.
Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree
12. We each got to say what we wanted.
Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree
13. I felt that we could *laugh* easily together.
Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree
14. The conversation flowed smoothly.
Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree
15. The other person frequently said things which added little to the conversation.
Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree
16. We talked about something I was NOT interested in.
Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

Impact of Validation Therapy Training

FAMILY CONSENT FORM

You are invited to participate in an experimental study of Validation Therapy training and its' impact on communication and quality of relationship between family caregiver and confused resident. **I am a doctoral student at the University of Texas at Austin School of Social Work. This study is the basis of my dissertation research.** You were selected as a potential participant in this study because of your status as the primary family caregiver of a confused long term care resident.

If you are attending the Validation Therapy training workshop and decide to participate, I will meet with you for approximately one half hour before the workshop. This meeting may be attended by several study participants. During that meeting I will answer any additional questions you may have and hand out four brief questionnaires.

The Validation Therapy training will be provided by its' developer, Naomi Feil. The first component of the intervention will be a two day workshop consisting of 14 contact hours. This workshop utilizes a multimedia approach with didactic and experiential components. **There will be no cost for Validation Therapy training for any study participant.**

Following training, and after you have completed two trial or practice interactions with confused family members, you will be asked to fill out three additional questionnaires.

If you choose to participate and are not attending the Validation Therapy training, you will complete pre- and post-test measures during the same time intervals as the treatment group. However, after post-test measures are made, you will have the option of receiving training in Validation at the next scheduled Validation Therapy training workshop.

Maximum time required of participants in either group, including Validation Therapy training, will be approximately 8 hours over a three week period.

The intervention under study is purely educational in nature with no identified possibility of negative impact. To the contrary, it is hypothesized that the intervention will provide skills, techniques and approaches which will improve communication and the relationship between you and your confused family member.

(continued on next page)

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. If you decide to participate, you are free to discontinue participation at any time without affecting the relationship between you or your resident family member and the nursing home or The University of Texas at Austin.

If you have any questions, please ask me. If you have any additional questions later I will be happy to answer them at that time. I can be contacted at 471-5456, ext. 235 or 251-4076. If I am not immediately available, you may leave a message at either number and I will return your call as soon as possible. The Chair of my doctoral committee is John McNeil, DSW. He can be reached at 471-5456.

You will be offered a copy of this form to keep.

You are making a decision whether or not to participate. Your signature indicates that you have read the information provided above and have decided to participate. You may withdraw at any time after signing this form, should you choose to stop participation in this study.

Signature of Participant

Date

Signature of Investigator

Date

Family Participant Demographic Data

Your name: _____

Marital Status: 1.) Single (includes divorced) 2.) Married (includes living together)

Your Gender: 1.) M 2.) F Your Age: _____

Education: (circle most appropriate)

- 1.) Grade school 2.) High School 3.) College
4.) Trade School 5.) Graduate School

Familial relationship to resident: _____

Employment status: 1.) Full Time 2.) Part time 3.) Not employed outside home

Number of dependents living at home : _____

Residents name: _____

Degree of your relationship satisfaction prior to residents dementing illness.

- 1.) very poor 2.) poor 3.) adequate 4.) good 5.) very good

Have you ever received Validation Therapy training before today? 1.) Yes 2.) No

Validation Skills

The following items are intended to assess knowledge of validation skills for working with Alzheimer's type populations.

Circle the correct answer.

1. A disoriented resident screams every time she drops her purse. Should you:
 - (a) Try to make sure she has the purse. Explore to build trust. Find out what the purse means to her.
 - (b) Assure that she has no need for the purse in this place. She isn't going anywhere. She doesn't need money.
 - (c) Take her purse away. "Out of sight out of mind."

2. A disoriented old-old man unzips his pants in public. Should you:
 - (a) Gently walk him to his room, and ask , "Do you miss your wife?"
 - (b) Negatively reinforce him. Firmly let him know, "We don't do things like that around here."
 - (c) Mirror his actions.

3. A disoriented resident hollers, "I want my teeth!" Should you:
 - (a) Find out where her teeth are, or get her false teeth if needed.
 - (b) Tell her that she always takes her teeth out and loses them.
 - (c) Tell her she is too old for new dentures.

4. When you are with a disoriented person, you are most inclined to:
 - (a) Keep your distance.
 - (b) Touch them softly to elicit interaction.
 - (c) Stand close without touching.
 - (d) Use soft touch together with close eye contact.

5. When a person is in Stage Three (repetitive motion), I:
 - (a) Mirror their actions using touch and close eye contact.
 - (b) Ask them what they are doing.
 - (c) Ask them to stop.
 - (d) Ignore their actions.

6. When a disoriented resident accuses others of stealing, I would:
- (a) Discourage them because I have heard this before.
 - (b) Ask them why someone would steal their possessions and show them they are wrong.
 - (c) Explore their anger with who, what, when and where words.
 - (d) Tell him/her not to worry.
7. If my disoriented family member thinks I am THEIR parent, I would:
- (a) Correct him/her.
 - (b) Change the subject.
 - (c) Tell him/her my feelings are hurt.
 - (d) Reminisce about the loved one from the past.

Please mark (T) True, or (F) False.

- _____ 8. Almost all old-old people who are disoriented are incontinent.
- _____ 9. All old people ought to know their married name.
- _____ 10. People who live in the past are happy that way, so it's better to pretend to believe them.
- _____ 11. People who are over 80 years old and disoriented, with physical failures and social losses, turn to the past to resolve old conflicts and restore old pleasures.
- _____ 12. It is important to correct disoriented people when they are mistaken or forgetful.
- _____ 13. It is important for older people to have alternate interests to prevent withdrawal.
- _____ 14. Poor vision and hearing can lead to an older person's distortion of present reality.
- _____ 15. It is important to correct the disoriented person when he/she is wrong or forgets or repeats.

Confused Patient and Family Caregiver Relationship Inventory

Below are statements about the nature of the relationship between you as a caregiver and your family member or significant other with confusion. It is common to have a wide range of emotional responses to the impact of confusion on important relationships. Indicate the extent to which each of the following statements describes your relationship by circling the appropriate number below each statement.

- ___ 1.) I dread visiting my confused family member.
- | | | | | |
|------------------|---|---|-----------------|-------------------|
| Very much | | | Somewhat | Not at all |
| 1 | 2 | 3 | 4 | 5 |
- ___ 2.) I don't know what to say to my confused family member.
- | | | | | |
|------------------|---|---|-----------------|-------------------|
| Very much | | | Somewhat | Not at all |
| 1 | 2 | 3 | 4 | 5 |
- ___ 3.) My relationship with my confused family member is not satisfying.
- | | | | | |
|------------------|---|---|-----------------|-------------------|
| Very much | | | Somewhat | Not at all |
| 1 | 2 | 3 | 4 | 5 |
- ___ 4.) I don't enjoy interacting with my confused family member.
- | | | | | |
|------------------|---|---|-----------------|-------------------|
| Very much | | | Somewhat | Not at all |
| 1 | 2 | 3 | 4 | 5 |
- ___ 5.) I am as close or closer to my confused family member than before the confusion.
- | | | | | |
|------------------|---|---|-----------------|-------------------|
| Very much | | | Somewhat | Not at all |
| 1 | 2 | 3 | 4 | 5 |
- ___ 6.) I feel guilty when I think about my confused family member.
- | | | | | |
|------------------|---|---|-----------------|-------------------|
| Very much | | | Somewhat | Not at all |
| 1 | 2 | 3 | 4 | 5 |
- ___ 7.) I enjoy time spent with my confused family member.
- | | | | | |
|------------------|---|---|-----------------|-------------------|
| Very much | | | Somewhat | Not at all |
| 1 | 2 | 3 | 4 | 5 |
- ___ 8.) I find some aspects of my relationship with my confused family member rewarding.
- | | | | | |
|------------------|---|---|-----------------|-------------------|
| Very much | | | Somewhat | Not at all |
| 1 | 2 | 3 | 4 | 5 |
- ___ 9.) I have no meaningful contact with my confused family member.
- | | | | | |
|------------------|---|---|-----------------|-------------------|
| Very much | | | Somewhat | Not at all |
| 1 | 2 | 3 | 4 | 5 |
- ___ 10.) I feel like I can 'connect' with my confused family member.
- | | | | | |
|------------------|---|---|-----------------|-------------------|
| Very much | | | Somewhat | Not at all |
| 1 | 2 | 3 | 4 | 5 |
- ___ 11.) At times I feel resentment or anger towards my confused family member.
- | | | | | |
|------------------|---|---|-----------------|-------------------|
| Very much | | | Somewhat | Not at all |
| 1 | 2 | 3 | 4 | 5 |
- ___ 12.) I am able to help my confused family member understand my feelings toward them.
- | | | | | |
|------------------|---|---|-----------------|-------------------|
| Very much | | | Somewhat | Not at all |
| 1 | 2 | 3 | 4 | 5 |

Interpersonal Communication Satisfaction Inventory

The purpose of this questionnaire is to investigate your reactions to the conversation you just had. On the next few pages you will be asked to react to a number of statements. Please indicate the degree to which you agree or disagree that each statement describes this conversation. The 4 or middle position on the scale represents "undecided" or "neutral," then moving out from the center, "slight" agreement or disagreement, then "moderate," then "strong" agreement or disagreement.

For example, if you strongly agree with the following statement you would circle 1;

The other person *moved around* a lot.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

1. The other person let me know that I was communicating effectively.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

2. Nothing was accomplished.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

3. I would like to have another conversation like this one.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

4. I was very dissatisfied with the conversation.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

5. I felt that during the conversation I was able to present myself like I wanted the other person to see me.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

6. The other person showed me that they understood what I said.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

7. I was very satisfied with the conversation.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

8. The other person expressed a lot of interest in what I said.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

9. I did NOT enjoy the conversation.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

10. The other person did NOT provide support for what he/she was saying.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

11. I felt I could talk about anything with the other person.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

12. We each got to say what we wanted.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

13. I felt that we could laugh easily together.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

14. The conversation flowed smoothly.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

15. The other person frequently said things which added little to the conversation.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

16. We talked about something I was NOT interested in.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

Staff Post-test Packet

This packet is identical to the one you just filled out. The consent form is a copy for you to keep. The questionnaires are for you to fill out after you have had a week to intersct with confused residents. After you have completed them, give them to the director of social services or activitiy director at the nursing home.

Impact of Validation Therapy Training

STAFF CONSENT FORM

You are invited to participate in an experimental study of Validation Therapy training and its impact on communication and quality of relationship between staff caregiver and dementia patient. **I am a doctoral student at the University of Texas at Austin School of Social Work. This study is the basis of my dissertation research.** You were selected as a potential participant in this study because of your status as a staff member who provides care to confused residents.

If you are attending the Validation Therapy training workshop and decide to participate, I will meet with you for approximately one half hour before the workshop. This meeting will be attended by several study participants. During that meeting I will answer any additional questions you may have and hand out four brief questionnaires for you to complete at that time.

The Validation Therapy training will be provided by its' developer, Naomi Feil. The first component of the intervention will be a one day workshop consisting of 7 contact hours. This workshop utilizes a multimedia approach with didactic and experiential components. **There will be no cost for Validation Therapy training or this study.**

Following training, and after you have completed two trial or practice interactions with confused residents, you will be asked to fill out three additional short questionnaires.

If you choose to participate and are not attending the Validation Therapy training, you will complete the seven brief questionnaires during the same time interval as the group that attends the Validation Therapy training workshop. However, after the last three questionnaires are completed, you will have the option of receiving training in Validation at no cost at the next scheduled Validation Therapy training workshop.

Total time required of participants in either group, including Validation Therapy training contact hours, will be approximately 8 hours over a three week period.

The intervention under study is purely educational in nature with no identified possibility of negative impact. To the contrary, it is hypothesized that the intervention will provide skills, techniques and approaches which will improve communication and the relationship between you and the demented residents in your care.

(Continued on next page)

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. If you decide to participate, you are free to discontinue participation at any time without affecting the relationship between you and the nursing home or The University of Texas at Austin.

If you have any questions, please ask me. If you have any additional questions later I will be happy to answer them at that time. I can be contacted at 471-5456 or 251-4076. If I am not immediately available, you may leave a message at either number and I will return your call as soon as possible. The Chair of my doctoral committee is John McNeil, DSW. He can be reached at 471-8276.

You will be offered a copy of this form to keep.

You are making a decision whether or not to participate. Your signature indicates that you have read the information provided above and have decided to participate. You may withdraw at any time after signing this form, should you choose to stop participation in this study.

Signature of Participant

Date

Signature of Investigator or
Director of Social Services

Date

Staff Participant Demographic Data

Your name _____

Marital Status: 1.) Single (includes divorced) 2.) Married (includes living together)

Your Gender: 1.) M 2.) F

Your Age: _____

Education: (circle most appropriate)

1.) Grade school

2.) High School

3.) College

4.) Trade School

5.) Graduate School

6.) RN

7.) LVN

Employment status: 1.) Full Time (35 hours a week or more)

2.) Part time (less than 35 hours a week)

Number of dependents living at home : _____

Have you ever had Validation Therapy training before today? 1.) Yes 2.) No

Validation Skills

The following items are intended to assess knowledge of validation skills for working with Alzheimer's type populations.

Circle the correct answer.

1. A disoriented resident screams every time she drops her purse. Should you:
 - (a) Try to make sure she has the purse. Explore to build trust. Find out what the purse means to her.
 - (b) Assure that she has no need for the purse in this place. She isn't going **anywhere**. She doesn't need money.
 - (c) Take her purse away. "Out of sight out of mind."

2. A disoriented old-old man unzips his pants in public. Should you:
 - (a) Gently walk him to his room, and ask , "Do you miss your wife?"
 - (b) Negatively reinforce him. Firmly let him know, "We don't do things like that around here."
 - (c) Mirror his actions.

3. A disoriented resident hollers, "I want my teeth!" Should you:
 - (a) Find out where her teeth are, or get her false teeth if needed.
 - (b) Tell *her* that she always takes her teeth out and loses them.
 - (c) Tell her she is too old for new dentures.

4. When you are with a disoriented person, you are most inclined to:
 - (a) Keep your distance.
 - (b) Touch *them* softly to elicit interaction.
 - (c) Stand close *without* touching.
 - (d) Use soft touch together with close eye contact.

5. When a person is in Stage Three (repetitive motion), I:
 - (a) Mirror their actions using touch and close eye contact.
 - (b) Ask them what they are doing.
 - (c) Ask them to stop.
 - (d) Ignore their actions.

6. When a disoriented resident accuses others of stealing, I would:
- (a) Discourage them because I have heard this before.
 - (b) Ask them why someone would steal their possessions and show them they are wrong.
 - (c) Explore their anger with who, what, when and where words.
 - (d) Tell him/her not to worry.
7. If my disoriented family member thinks I am THEIR parent, I would:
- (a) Correct him/her.
 - (b) Change the subject.
 - (c) Tell him/her my feelings are hurt.
 - (d) Reminisce about the loved one from the past.

Please mark (T) True, or (F) False.

- _____ 8. Almost all old-old people who are disoriented are incontinent.
- _____ 9. All old people ought to know their married name.
- _____ 10. People who live in the past are happy that way, so it's better to pretend to believe them.
- _____ 11. People who are over 80 years old and disoriented, with physical failures and social losses, turn to the past to resolve old conflicts and restore old pleasures.
- _____ 12. It is important to correct disoriented people when they are mistaken or forgetful.
- _____ 13. It is important for older people to have alternate interests to prevent withdrawal.
- _____ 14. Poor vision and hearing can lead to an older person's distortion of present reality.
- _____ 15. It is important to correct the disoriented person when he/she is wrong or forgets or repeats.

Confused Patient and Staff Caregiver Relationship Inventory

Below are statements about the nature of the relationship between you as a caregiver and confused residents. It is common to have a wide range of emotional responses to the impact of confusion on the caregiving relationship. Indicate the extent to which you agree with each of the following statements by circling the appropriate number below each statement.

1.) I have specific and effective techniques for addressing outbursts from confused residents.

Very much		Somewhat		Not at all
1	2	3	4	5

2.) I don't know what to say to confused residents.

Very much		Somewhat		Not at all
1	2	3	4	5

3.) My relationship with confused residents is not satisfying.

Very much		Somewhat		Not at all
1	2	3	4	5

4.) I don't enjoy interacting with confused residents.

Very much		Somewhat		Not at all
1	2	3	4	5

5.) My efforts to calm confused residents are effective.

Very much		Somewhat		Not at all
1	2	3	4	5

6.) I enjoy time spent with confused residents.

Very much		Somewhat		Not at all
1	2	3	4	5

7.) I find some aspects of my caregiving relationship with confused residents rewarding.

Very much		Somewhat		Not at all
1	2	3	4	5

8.) I feel like I don't 'connect' with confused residents.

Very much		Somewhat		Not at all
1	2	3	4	5

9.) I feel frustrated working with confused residents.

Very much		Somewhat		Not at all
1	2	3	4	5

10.) I am able to help confused residents understand my directions concerning the care I am providing.

Very much		Somewhat		Not at all
1	2	3	4	5

Interpersonal Communication Satisfaction Inventory

The purpose of this questionnaire is to investigate your reactions to the conversation you just had. On the next few pages you will be asked to react to a number of statements. Please indicate the degree to which you agree or disagree that each statement describes this conversation. The 4 or middle position on the scale represents "undecided" or "neutral," then moving out from the center, "slight" agreement or disagreement, then "moderate," then "strong" agreement or disagreement.

For example, if you strongly agree with the following statement you would circle 1;

The other person moved around a lot.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

1. The other person let me know that I was communicating effectively.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

2. Nothing was accomplished.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

3. I would like to have another conversation like this one.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

4. I was very dissatisfied with the conversation.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

5. I felt that during the conversation I was able to present myself like I wanted the other person to see me.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

6. The other person showed me that they understood what I said.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

7. I was very satisfied with the conversation.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

8. The other person expressed a lot of interest in what I said.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

9. I did NOT enjoy the conversation.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

10. The other person did NOT provide support for what he/she was saying.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

11. I felt I could talk about anything with the other person.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

12. We each got to say what we wanted.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

13. I felt that we could laugh easily together.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

14. The conversation flowed smoothly.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

15. The other person frequently said things which added little to the conversation.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

16. We talked about something I was NOT interested in.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

Family Post-test Packet

This packet is identical to the one you just filled out. The consent form is a copy for you to keep. The questionnaires are for you to fill out after your second visit with your confused family member. After you have completed them, give them to the director of social services or activity director at the nursing home.

Impact of Validation Therapy Training

FAMILY CONSENT FORM

You are invited to participate in an experimental study of Validation Therapy training and its' impact on communication and quality of relationship between family caregiver and confused resident. **I am a doctoral student at the University of Texas at Austin School of Social Work. This study is the basis of my dissertation research.** You were selected as a potential participant in this study because of your status as the primary family caregiver of a confused long term care resident.

If you are attending the Validation Therapy training workshop and decide to participate, I will meet with you for approximately one half hour before the workshop. This meeting may be attended by several study participants. During that meeting I will answer any additional questions you may have and hand out four brief questionnaires.

The Validation Therapy training will be provided by its' developer, Naomi Feil. The first component of the intervention will be a two day workshop consisting of 14 contact hours. This workshop utilizes a multimedia approach with didactic and experiential components. **There will be no cost for Validation Therapy training for any study participant.**

Following training, and after you have completed two trial or practice interactions with confused family members, you will be asked to fill out three additional questionnaires.

If you choose to participate and are not attending the Validation Therapy training, you will complete pre- and post-test measures during the same time intervals as the treatment group. However, after post-test measures are made, you will have the option of receiving training in Validation at the next scheduled Validation Therapy training workshop.

Maximum time required of participants in either group, including Validation Therapy training, will be approximately 8 hours over a three week period.

The intervention under study is purely educational in nature with no identified possibility of negative impact. To the contrary, it is hypothesized that the intervention will provide skills, techniques and approaches which will improve communication and the relationship between you and your confused family member.

(continued on next page)

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. If you decide to participate, you are free to discontinue participation at any time without affecting the relationship between you or your resident family member and the nursing home or The University of Texas at Austin.

If you have any questions, please ask me. If you have any additional questions later I will be happy to answer them at that time. I can be contacted at 471-5456, ext. 235 or 251-4076. If I am not immediately available, you may leave a message at either number and I will return your call as soon as possible. The Chair of my doctoral committee is John McNiel, DSW. He can be reached at 471-5456.

You will be offered a copy of this form to keep.

You are making a decision whether or not to participate. Your signature indicates that you have read the information provided above and have decided to participate. You may withdraw at any time after signing this form, should you choose to stop participation in this study.

Signature of Participant

Date

Signature of Investigator

Date

Family Participant Demographic Data

Your name: _____

Marital Status: 1.) Single (includes divorced) 2.) Married (includes living together)

Your Gender: 1.) M 2.) F Your Age: _____

Education: (circle most appropriate)

- 1.) Grade school 2.) High School 3.) College
4.) Trade School 5.) Graduate School

Familial relationship to resident: _____

Employment status: 1.) Full Time 2.) Part time 3.) Not employed outside home

Number of dependents living at home : _____

Residents name: _____

Degree of your relationship satisfaction prior to residents dementing illness.

- 1.) very poor 2.) poor 3.) adequate 4.) good 5.) very good

Have you ever received Validation Therapy training before today? 1.) Yes 2.) No

Validation Skills

The following items are intended to assess knowledge of validation skills for working with Alzheimer's type populations.

Circle the correct answer.

1. A disoriented resident screams every time she drops her purse. Should you:
 - (a) Try to make sure she has the purse. Explore to build trust. Find out what the purse means to her.
 - (b) Assure that she has no need for the purse in this place. She isn't going anywhere. She doesn't need money.
 - (c) Take her purse away. "Out of sight out of mind."

2. A disoriented old-old man unzips his pants in public. Should you:
 - (a) Gently walk him to his room, and ask , "Do you miss your wife?"
 - (b) Negatively reinforce him. Firmly let him know, "We don't do things like that around here."
 - (c) Mirror his actions.

3. A disoriented resident hollers, "I want my teeth!" Should you:
 - (a) Find out where her teeth are, or get her false teeth if needed.
 - (b) Tell her that she always takes her teeth out and loses them.
 - (c) Tell her she is too old for new dentures.

4. When you are with a disoriented person, you are most inclined to:
 - (a) Keep your distance.
 - (b) Touch them softly to elicit interaction.
 - (c) Stand close without touching.
 - (d) Use soft touch together with close eye contact.

5. When a person is in Stage Three (repetitive motion), I:
 - (a) Mirror their actions using touch and close eye contact.
 - (b) Ask them what they are doing.
 - (c) Ask them to stop.
 - (d) Ignore their actions.

6. When a disoriented resident accuses others of stealing, I would:
- (a) Discourage them because I have heard this before.
 - (b) Ask them why someone would steal their possessions and show them they are wrong.
 - (c) Explore their anger with who, what, when and where words.
 - (d) Tell him/her not to worry.
7. If my disoriented family member thinks I am THEIR parent, I would:
- (a) Correct him/her.
 - (b) Change the subject.
 - (c) Tell him/her my feelings are hurt.
 - (d) Reminisce about the loved one from the past.

Please mark (T) True, or (F) False.

- _____ 8. Almost all old-old people who are disoriented are incontinent.
- _____ 9. All old people ought to know their married name.
- _____ 10. People who live in the past are happy that way, so it's better to pretend to believe them.
- _____ 11. People who are over 80 years old and disoriented, with physical failures and social losses, turn to the past to resolve old conflicts and restore old pleasures.
- _____ 12. It is important to correct disoriented people when they are mistaken or forgetful.
- _____ 13. It is important for older people to have alternate interests to prevent withdrawal.
- _____ 14. Poor vision and hearing can lead to an older person's distortion of present reality.
- _____ 15. It is important to correct the disoriented person when he/she is wrong or forgets or repeats.

Confused Patient and Family Caregiver Relationship Inventory

Below are statements about the nature of the relationship between you as a caregiver and your family member or significant other with confusion. It is common to have a wide range of emotional responses to the impact of confusion on important relationships. Indicate the extent to which each of the following statements describes your relationship by circling the appropriate number below each statement.

- | | | | |
|---------|--|----------|------------|
| ___1.) | I dread visiting my confused family member. | | |
| | Very much | Somewhat | Not at all |
| | 1 | 2 | 3 |
| | | | 4 |
| | | | 5 |
| ___2.) | I don't know what to say to my confused family member. | | |
| | Very much | Somewhat | Not at all |
| | 1 | 2 | 3 |
| | | | 4 |
| | | | 5 |
| ___3.) | My relationship with my confused family member is not satisfying. | | |
| | Very much | Somewhat | Not at all |
| | 1 | 2 | 3 |
| | | | 4 |
| | | | 5 |
| ___4.) | I don't enjoy interacting with my confused family member. | | |
| | Very much | Somewhat | Not at all |
| | 1 | 2 | 3 |
| | | | 4 |
| | | | 5 |
| ___5.) | I am as close or closer to my confused family member than before the confusion. | | |
| | Very much | Somewhat | Not at all |
| | 1 | 2 | 3 |
| | | | 4 |
| | | | 5 |
| ___6.) | I feel guilty when I think about my confused family member. | | |
| | Very much | Somewhat | Not at all |
| | 1 | 2 | 3 |
| | | | 4 |
| | | | 5 |
| ___7.) | I enjoy time spent with my confused family member. | | |
| | Very much | Somewhat | Not at all |
| | 1 | 2 | 3 |
| | | | 4 |
| | | | 5 |
| ___8.) | I find some aspects of my relationship with my confused family member rewarding. | | |
| | Very much | Somewhat | Not at all |
| | 1 | 2 | 3 |
| | | | 4 |
| | | | 5 |
| ___9.) | I have no meaningful contact with my confused family member. | | |
| | Very much | Somewhat | Not at all |
| | 1 | 2 | 3 |
| | | | 4 |
| | | | 5 |
| ___10.) | I feel like I can 'connect' with my confused family member. | | |
| | Very much | Somewhat | Not at all |
| | 1 | 2 | 3 |
| | | | 4 |
| | | | 5 |
| ___11.) | At times I feel resentment or anger towards my confused family member. | | |
| | Very much | Somewhat | Not at all |
| | 1 | 2 | 3 |
| | | | 4 |
| | | | 5 |
| ___12.) | I am able to help my confused family member understand my feelings toward them. | | |
| | Very much | Somewhat | Not at all |
| | 1 | 2 | 3 |
| | | | 4 |
| | | | 5 |

Interpersonal Communication Satisfaction Inventory

The purpose of this questionnaire is to investigate your reactions to the conversation you just had. On the next few pages you will be asked to react to a number of statements. Please indicate the degree to which you agree or disagree that each statement describes this conversation. The 4 or middle position on the scale represents "undecided" or "neutral," then moving out from the center, "slight" agreement or disagreement, then "moderate," then "strong" agreement or disagreement.

For example, if you strongly agree with the following statement you would circle 1;

The other person moved around a lot.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

1. The other person let me know that I was communicating effectively.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

2. Nothing was accomplished.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

3. I would like to have another conversation like this one.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

4. I was very dissatisfied with the conversation.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

5. I felt that during the conversation I was able to present myself like I wanted the other person to see me.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

6. The other person showed me that they understood what I said.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

7. I was very satisfied with the conversation.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

8. The other person expressed a lot of interest in what I said.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

9. I did NOT enjoy the conversation.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

10. The other person did NOT provide support for what he/she was saying.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

11. I felt I could talk about anything with the other person.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

12. We each got to say what we wanted.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

13. I felt that we could laugh easily together.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

14. The conversation flowed smoothly.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

15. The other person frequently said things which added little to the conversation.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree

16. We talked about something I was NOT interested in.

Agree: 1 : 2 : 3 : 4 : 5 : 6 : 7 : Disagree