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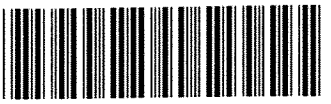

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CHAPTER 7

Barbaranne J. Benjamin

Validation: A Communication Alternative

Validation therapy provides a coherent framework for staff-patient interaction, which may result in improved quality of life for the patient and reduced stress for the healthcare worker. Although group validation therapy should be conducted by a trained professional, the principles of validation therapy are incorporated easily into the daily routine of the long-term care facility as all staff members interact with the elderly patient with moderately severe to severe dementia. The central tenant of validation therapy is that communication can be used to affirm the dignity of the patient and the humanity and humaneness of the healthcare professional.

Most healthcare professionals have chosen their profession because they care about people. Although other reasons may be involved in choosing a career or employment in healthcare, commitment to the welfare of others is the critical ethical foundation for professionals, paraprofessionals, and aides alike. Consequently, the principles and techniques of validation therapy resonate with their need to relieve suffering and respect the individual's worth and dignity and support their empathetic understanding of human interaction and communication.

Need for Validating Communication

Long-term care facilities often provide an impoverished communication environment for patients (for summary, see Kaakinen, 1995; Lubinski,

1995). This environment is further reduced if the patient is considered difficult because of personality, disorientation, agitation, or behaviors associated with dementia.

For example, in a geriatric hospital in Canada, Jones (1992) reported on communication between nurses and patients with dementia during morning and evening care periods, times of day at which the level of communication was considered to be high. Communication was limited, with an average of 26 words spoken between nurse and patient in the 2-hour period under investigation. Nurses averaged five commands, two statements, and 1.5 questions in the time period. Fewer than half of the questions asked by either nurse or patient were answered.

These results are consistent with findings that confused residents were unengaged 85% of the time and that communication interaction was limited primarily to directives and correctives regarding daily living activities (for a summary, see Orange, Ryan, Meredith, & MacLean, 1995.) Such impoverished communication environments contribute to the isolation patients experience in long-term care facilities.

These impoverished communication environments are exacerbated further by sensory impairment. For instance, visual acuity of 20/50 or less in the better eye affects approximately 30% to 35% of persons older than age 69 years. In addition, significant hearing loss affects 60% to 90% of elderly persons in long-term care facilities (Corbin & Eastwood, 1986). Such sensory impairments serve to further isolate the patient by restricting awareness of the environment and by contributing to a reduction of communication and interaction opportunities.

The restricted communication environment and the sensory deterioration combine to isolate the individual from opportunities for meaningful communicative contact. Reduced contact with others in the environment and lack of perceived external stimulation result in a limited contact with the external world and allow the patient to focus on internal mental images. Consequently, the patient may be involved in reverie and oblivious to the muted, nonstimulating environment that surrounds him or her. If the external environment impinges on the internal reverie, the individual must make the transition from mental reverie to the external here and now.

The ease with which the individual, lost in reverie or reminiscence, is able to make the transition from the sharp, clearly focused internal world of memory to the external, perceptually muted world of the present reflects the level of intact cognitive facility including the ability to easily shift attention. The patient whose cognitive abilities have been reduced by the dementing disease has a difficult time in rapidly shifting from the internal to the external world and, thus, may appear "misrepresentational" or "psychotic." Reminiscing disorientation theory suggests that such dis-

oriented behavior in the person with dementia may be the result of decreased sensory perception, reduced social stimulation, and limited cognitive capability for attentional shifts and informational processing rather than indicative of underlying psychotic disassociation (Jones & Burns, 1992).

Description of Validation

In 1963, Naomi Feil began the development of validation therapy for persons with late-onset disorientation caused by dementia who did not respond to reality-based orientation. Today, over 500 facilities throughout the world use validation therapy (Morton & Bleathman, 1991). Validation therapy has been described by Feil in articles (1984, 1989, 1990, 1995), in book chapters (1991, 1992), and in book-length detail (1982, 1993). When inevitable deterioration caused by dementia can no longer be addressed through reality orientation, behavior modification, or other approaches, validation therapy provides a humane alternative that relies on validating the worth of the individual through communication.

All communication relies on the cooperation of communication partners to adapt to each other's knowledge level, attitudes, and emotional states. Communication partners must make assumptions about mutually shared knowledge, understanding, feelings, and intentions. With the onset of dementia in a person, a greater burden is placed on communication partners to assume responsibility for the course of the communication interaction. Too often, the communication partners resort to directives, commands, or even argument in an attempt to direct the course of communication to accomplish a specific task.

Validation therapy provides the healthcare professional with an alternative method for communicating with very elderly, confused, disoriented patients. Rather than directing the communication into safe, reality-based topics, the professional, aide, or family member responds to the topic that concerns the patient. The topic may be a reminiscence; it may be related to feelings of loss. Acknowledging such feelings validates the legitimacy of the feelings and, subsequently, the worth of the individual. Acceptance of the patient's feelings provides the basis for validation therapy and permits the patient to find resolution to achieve final ego integrity (see Babins [1986] and Feil [1982, 1984] for the theoretical bases of validation therapy).

In validation, the healthcare professional or other communication partner accepts the topic of conversation selected by the individual with dementia. For instance, rather than attempting to lead the patient back to reality, the communication partner may discuss recipes with the patient

who started the conversation about making supper for her husband who loves liver and onions. Using validation allows the communication partner to ignore the fact that the husband is dead and focus on the topic of conversation, which validates the patient's worth and self-esteem as a cook and homemaker.

Types of Validation

Validation is both a therapy and an approach. As a therapy, it is formalized, studied, and conducted by professionals who are trained in the method. As an approach, it is an institutional philosophy that permeates communication interactions between professionals, staff, or family members and residents or patients.

Validation-therapy groups are conducted by certified validation therapists. The validation approach is more inclusive than validation therapy and can be applied by validation workers, staff, or family members who interact with the patient on a daily basis to provide a validating environment. For the early stage in which the patient is confused and defensive, guidelines suggest 5- to 10-minute individual sessions three times per week in long-term care institutions or twice daily in acute-care hospitals (Feil, 1992).

Others have suggested that staff members use validation techniques whenever appropriate during the course of their interactions throughout the day. Because this method integrates validation as a normal part of the patient's day, it gives the staff ample opportunity to validate the patient's feelings. In addition, the philosophy of patient worth and dignity is reinforced throughout the day and becomes self-perpetuating. Such an atmosphere of concern and respect can result in reduced stress for staff, decreased staff turnover, and an increase in patient quality of life. Alprin (as cited in Feil, 1992) provided quantifiable data on positive behavior for both staff and patients. In addition, the costs of formal validation therapy could be eliminated "if validation therapy were conducted by all personnel as an integral part of clients' treatment plans" (Robb, Stegman, & Wolanin, 1986, p. 116).

Validation for the Stages of Disorientation

Validation-therapy techniques are adapted to the individual's stage of disorientation. Malorientation, the first stage, is characterized by defensiveness. Succeeding stages include time confusion, repetitive movement, and the final vegetative state. The healthcare professional must determine

the stage of disorientation before selecting the appropriate validation techniques to be used with a patient. Because each stage of disorientation has certain typical characteristics, it is relatively simple to determine a patient's stage of disorientation. Table 7.1 provides a summary of the major characteristics of disorientation stages.

Stage 1: Malorientation

Patients in this first stage of disorientation are occasionally confused but become defensive in situations that are perceived as fluctuating and transforming into hostile environments. These patients rationalize the perceived changes and inconsistencies in their environments by blaming others and by taking defensive actions such as complaining or hoarding (Feil, 1982, 1993).

Patients in this first confusional stage are anxious and tense; they are attempting to maintain normality in a world that they perceive is deteriorating. Physically, the tension is seen in narrowed eyes, which are focused and alert for suspicious behavior in others; breathing is shallow and movements are purposeful and somewhat abrupt. The muscles of face and body reflect the tension of uncertainty and the fear as patients face a world that is becoming unfamiliar and strange. Patients may fold their arms to create a barrier between themselves and the world, or they

Table 7.1. Summary of confusional stages

	Malorientation	Time Confusion	Repetitive Motion
Focus	Externally focused	Unfocused	Internally focused
Behaviors	Purposefully clutching personal object	Muted, limited range of motion	Stereotypical repetitive pacing, moaning
Physical manifestations	Physical tension, narrowed eyes	Relaxed movements, clear unfocused eyes	Stooped posture unaware of incontinence
Verbal manifestations	Harsh, whining	Vague words	Slow
Emotional/ cognitive manifestations	Feels threatened, denies feelings	Confused as to time, person, place	Uninhibited emotion
Communication topics	Blames others	Misidentification	Does not initiate
Physical contact	Anathema	Derives comfort	Notices

may clutch a personal object for security (Feil, 1982). These maloriented patients are the ones who hide their favorite nightgowns, forget where they put them, and blame the nurses' aides for stealing their valuable property. They may accuse staff of trying to poison them, blame the doctors for causing their spouse's death, or charge family members with stealing their money and home.

To deny the feelings of increasing confusion and to alleviate fears of losing control of their mental facilities, these patients adopt a rigid set of social standards. Often, they do not want to associate with persons who display confusion or disorientation; they do not want to be touched nor do they want to touch others. They appreciate routines that help them understand their environments and their roles and provide stability in a world they can no longer trust.

To validate the feelings of defensive, maloriented patients, the healthcare provider should be as nonthreatening as possible. This includes refraining from touching maloriented patients as an indication of concern or support. These patients do not want sympathy but do appreciate tacit acknowledgment of their concerns. They want to be respected as individuals; they want their statements and communications given due consideration by the important people in their environment. To provide nonthreatening communication interactions for maloriented patients, feelings should not be addressed directly. At a time at which they are feeling most insecure, patients in the malorientation stage do not want to acknowledge their feelings but need to have their concerns, whether real or imaginary, given consideration. If authentically felt although imaginary concerns are dismissed by the healthcare workers, maloriented patients become more emphatic in an attempt to have their concerns taken seriously.

Validation therapy for the maloriented patient is designed to reduce patient anxiety by using the patient's remaining intellectual capability to explore the perceived problem and perhaps to identify coping strategies that have been used successfully in the past. To validate the statements and concerns of the maloriented patient, the caregiver need only ask probing questions to continue the conversation—on the patient's terms. Rather than deny the accusations and subsequently dismiss the reality of the underlying insecurity and fear, the healthcare professional can request further information: Asking for additional information validates the patient and the concerns without necessitating that the healthcare worker actually believe that the accusations are true. Requests for additional information should be limited to questions of *who, what, where, when,* and *how*. Questions of *why* are threatening and should not be used. These questions require use of cognitive ability that is deteriorating in these patients and may be associated with past reprimands by parents.

If the staff or family member is uncertain of the patient's meaning,

repetition or paraphrasing is useful. In addition, using the patient's preferred sense helps build a feeling of trust. If the patient describes the scene, the caregiver can paraphrase or question further about the visual aspects, how things appeared, what they looked like. If the patient describes a noise, the caregiver can use auditory questions about the sound and its characteristics. If the patient describes a kinesthetic sense, the caregiver can use such questions as: How does it feel? Where does it hurt?

For instance, with a patient who is unable to find a favorite nightgown and suspects that someone stole it, the caregiver may ask the patient to describe the nightgown. Often, the patient's description reveals underlying values and feelings that will become more important as the cognitive-deterioration dementia progresses. The caregiver further explores the topic by asking when the patient last saw the nightgown, where it was located, and so forth. When the topic has been explored sufficiently to authenticate the patient's concerns, the caregiver can use three techniques to guide the patient to more positive feelings.

Polarity, the first technique, explores the extreme by asking the patient to describe specifically the problem at its worst. For example, the patient may respond by indicating that the aide sneaks into her room at night and steals her nightgowns; she says she is afraid she will have nothing to wear to bed at night.

The second technique is to *reminisce* about related memories in the past. For instance, the caregiver redirects the patient to remembering a favorite article of clothing or possession. During the discussion, the caregiver finds that the patient's sister "borrowed" her clothing and often did not return favorite items. The caregiver asks the patient what she did when confronted with this related problem to discover coping strategies successfully employed in the past.

Finally, the caregiver asks the patient to *imagine the opposite* of the problem to focus on positive situations and feelings. In this example, the patient decided that having a special nightlight would deter the thief from stealing her nightgowns; but she also decided to keep her extra nightgowns under her pillow at night.

Stage 2: Time Confusion

Patients in the second stage are increasingly disoriented as to time, place, and person. The patients who are time-confused are no longer anxious but rather are unfocused. This lack of focus is reflected in the patients' physical appearance. Muscle tone is relaxed; facial muscles are smooth without strain; bladder control is relaxed, with incontinence often occurring in patients in this stage. Eye contact occurs with partners, but the eyes are generally are unfocused, although bright (Feil, 1982, 1991).

The lack of focus extends through the cognitive domain and is reflected in social interaction, language use, and orientation to person, place, and time. Reduced focus on social mores results in patients who may be uninhibited; social conventions are optional. Consequently, these patients are difficult to motivate and often will not conform to the expectations of family and staff.

The lack of focus also is exhibited in the patients' use of language; there is a reduction in the number of specific nouns and an overuse of vague words and unidentified pronouns. Consequently, the topic of an utterance may be unclear to the conversation partner. The tenses of verbs vary from present to past, further contributing to the uneasiness that is felt when engaging time-confused patients in interactional communication. Without warning, time-confused patients alter their conversational topics by unexpectedly jumping from present to past, often in consecutive sentences (Feil, 1993).

The defining characteristic of patients in this stage is the inability to remain focused in the present. Time-confused patients cannot differentiate consistently the present from memories of the past. They easily misidentify persons in their immediate environment as individuals from past memories. The disorientation and confusion become more pervasive as patients progress deeper into this stage.

To gain the attention of the time-confused patient, the healthcare professional should utilize touch to promote a bond between caregiver and patient. Unlike the maloriented patient of stage 1, the time-confused patient is uninhibited and appreciates the human contact and support of physical touch. Touch provides this patient with a gentle anchor to present reality; touch conveys caring and comfort.

The bond created by physical touch can be strengthened further by use of eye contact. Eye contact is not supplementary to interactional communication but primary. The caregiver can assume that the patient's visual ability is impaired. Consequently, it is important to approach the patient from the front to gain the patient's attention. To be seen, the caregiver must get close to the patient so that eye contact can be established. This closeness implies reduced physical distance, face-to face communication with the patient, and similar eye levels between caregiver and patient. Closeness also implies an emotional genuineness in which the caregiver respects the patient; this unfeigned closeness will be reflected in the concern and regard apparent in the close eye contact.

Similarly, the caregiver must consider the patient's probably reduced hearing sensitivity. The caregiver's voice must be clear and moderately loud to surmount the typical reduction in hearing sensitivity associated with aging and any additional impediment caused by hearing loss sustained by the patient. To assure maximum comprehension of the spoken

message, the caregiver should use simple words in short sentences with a slow rate of speech.

To illustrate the nonverbal aspects of communication with the time-confused patient, May, an aide, alerts the patient to her presence by approaching from the front and saying the patient's name: "Good morning, Mrs. C. How are you this morning?" As the patient focuses attention, May provides a comforting touch to the patient's forearm and aligns herself for level eye contact by partially kneeling to the front and side of Mrs. C's wheelchair. May proceeds to talk at a level that is sufficiently loud to be heard by Mrs. C, but she is careful not to offend by speaking too loudly or by allowing the tension of speaking loudly to show as strain in her face.

To validate patients who are time-confused, the caregiver can use simple words to describe emotions the patient presents. Universal feelings of loss of love (of parent, of spouse), loss of esteem (of social role), and loss of usefulness (of job) are reflected in the time-disoriented episodes experienced by the patient. After identifying the underlying emotion reflected in the memory that triggered the confusion, the healthcare professional uses simple language to comment on the inherent feelings. For instance, if the patient is cradling her arm and humming lullabies, the healthcare professional may comment on missing the baby, the love felt for a baby, or the fact that babies are comforted by singing. If the meaning of the patient's comments or actions are unclear, the professional can resort to ambiguous pronoun usage, vague questions, and generalized comments related to the emotions probably felt by the patient. Validation techniques can be used to explore the significance of the expression to determine the underlying emotion. In an example from the literature, a patient pointed his finger and counted to 30 constantly. Using vague language, the validation worker responded with, "That is hard work . . . Does it take a long time to finish?" The patient, who worked in a cannery, responded appropriately to the validation worker: "Yup! Thirty cans in 30 minutes" (Feil, 1992, p. 212). Obviously, the underlying feelings of self-worth and the importance of a job well done are feelings that the staff continued to validate.

Stage 3: Repetitive Motion

Patients in the third stage are focused increasingly internally, with repetitive behaviors a prominent characteristic. Patients primarily engage in repetitive actions or vocalizations, resulting in decreased contact with the external environment. The internal focus, based on emotion and feelings, blocks the patients' awareness of external experiences such as personal incontinence. The overall picture of patients in the repetitive motion stage is one of collapsing in upon one's self.

Patients in stage 3 are withdrawn from social contact; they are often unaware of their environments and oblivious to others in their surroundings. Eye contact is further reduced from that of stage 2 patients because of a stooping posture that results in a lowered head position. Contact with the environment is minimal and rarely initiated by patients in this stage (Feil, 1991).

The defining characteristic of patients in this stage is the pervasive employment of a stereotypical repetitive motion that appears disconnected with the meaningful environment. The repetitive motion may be realized as repetitive behavior such as continual pounding, tapping, rocking, or pacing; the repetitive motion may be verbal with repetition of a single word or phrase, constant moaning, singing, humming, or repetitious clucking, "tsk-tsking," or mouth popping (Feil, 1982, 1993).

At this level of deterioration, the number of possible effective techniques is reduced. Nevertheless, the healthcare professional is able to connect with the patient for brief periods of time. Any meaningful contact in which the patient is engaged contributes to improving the patient's quality of life.

To connect with the patient who displays repetitive motion, the healthcare professional must be sensitive to the emotional meanings underlying the repetitive behaviors. These feelings, related to universal needs, provide the caregiver with avenues for comforting interaction. Family members and case histories also may provide insights into the meaning of repetitive behaviors.

To validate the stage 3 patient who displays repetitive motions, the staff member must be positioned to be accessible, on a level with patient; in this way, the staff member minimizes the isolating impact of sensory deficits and is available for communicative interaction. The caregiver proceeds to imitate the patient's repetitive movements in time with the patient's movements. This reflection of nonverbal repetitive movement acts as a validation of that movement and of the underlying feelings or needs. If the patient becomes aware of the person and the reflected movement, the patient may engage in a brief interaction. This temporary awareness provides a momentary connection with another human being, who affirms the worth of the patient and validity of his or her feelings. The patient's quality of life has been improved momentarily, and the healthcare worker has the satisfaction of appreciably improving the patient's well-being for a brief period.

For the patient who is verbally repetitive, the caregiver should attempt to engage the patient through auditory or verbal means. Although the patient still may understand single words and short phrases, these isolated, fleeting utterances do not make an impact on the patient in the repetitive-motion stage. Sustained, repetitive auditory stimulation can gain

the patient's attention. The most significant and engaging auditory stimulus is music; music that is remembered, meaningful, and relevant to the individual. Consequently, simple songs sung in childhood, songs that were popular during early adult years, or lullabies that mothers sing to infants are potentially engaging for the stage 3 patient. The family may provide songs that were especially meaningful to the individual or songs that are appropriate for patients of a particular culture or ethnic background.

Stage 4: Vegetative

The final state of mental and physical dissolution, vegetative, is realized when the patient further withdraws from interaction with the environment. The patient ceases movement, often assuming a fetal position. The eyes generally are closed and the breathing is shallow. During this stage, only touch and music have been shown to elicit an occasional response.

☐ Case Examples

These case studies provide descriptions of typical patients in various stages of disorientation and illustrate the use of validation as a response in certain common situations.

Differentiating patients who are maloriented from those who demonstrate more consistent confusional states is necessary before appropriate intervention can occur. The anxious maloriented patient is defensive and highly sensitive to skepticism and does not want to be touched. Patients who are time-confused or in the repetitive-motion stage appreciate the comfort of touch but differ in their cognitive abilities and what they can understand of the caregiver's conversation. Figure 7.1 provides a flow chart in selecting appropriate validation techniques for disoriented patients.

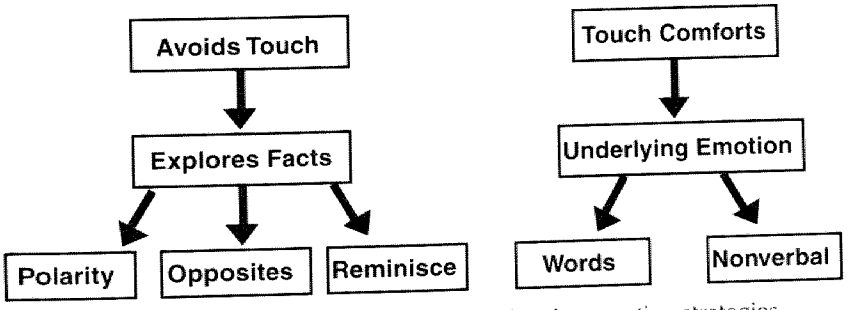

FIGURE 7.1. Flow chart of appropriate intervention strategies.

The Maloriented Patient

Mrs. G, aged 82 years, recently had been admitted as a patient in the long-term care facility because of a broken hip. Before her accident, her niece reported that she was a crotchety old lady who had alienated all of her friends and relatives. Mrs. G blamed her niece for the broken hip she had sustained. According to Mrs G, she would not have broken her hip if Susan had brought her groceries on time.

Mrs. G's blaming expanded to include the doctors who treated her in the hospital and the staff in the nursing home. She was not popular with either the staff or residents. She began to accuse the nurses of stealing her food, nighties, and pictures of her late husband. Mrs. G began hiding things so "those thieving nurses couldn't steal them." Nightgowns, oranges, tissue, and other things were stuffed under her mattress, in her bedclothes, or behind the night stand.

In a partial attempt to validate Mrs. G's concerns, the staff refrained from confronting her with the hidden objects, arguing that no theft took place, or defending each other from her accusations. Refraining from confrontation was not validating and resulted in Mrs. G becoming more insistent in her accusations. Most of the staff members continued to ignore the accusations or changed the subject, but one aide resolved to apply validation techniques when Mrs. G began blaming others. No particular time for validation was set aside; rather, validation occurred when Mrs. G began blaming others.

In a typical interaction, as Tasha, the aide, helped her get dressed, Mrs. G. lowered her voice and confided that "those nurses are stealing my things every night." Tasha did not dismiss the accusation, ignore the statement, or change the subject but validated Mrs G's concern by exploring the problem. Asking a probing question—"What was missing?"—resulted in the response of, "My nighty and my picture of my husband." Because the picture implied a visual sense, Tasha continued to probe by asking for a description of the items, eliciting Mrs. G's preferred sense of vision. Mrs. G responded with, "My best nighty, the one with the pink flowers. It has a little bow, right here."

Tasha turned to the next step, polarity, and asked Mrs. G to imagine the extreme by asking, "When is it worse?" Mrs. G responded, "At night. They come in. They think I'm asleep, but I'm not. They steal my things."

Tasha then applied the next step by asking the opposite: "Is there a time when your things weren't stolen?" This question tapped into Mrs. G's unhappiness being in the nursing home: "No one ever stole from me when I was home."

Rather than dwell on unhappy feelings, Tasha diverted Mrs. G's thoughts to reminiscing in an attempt to identify coping mechanisms that Mrs. G

had used successfully in the past: "You had all your things at home?" Mrs. G responded with, "Yes, and they were safe. Everything had a place." Tasha and Mrs G continue talking as the conversation evolved from treasured objects to the need for organization to run a home to efficient methods for house cleaning.

The entire exchange took nearly 6 minutes from Mrs G's initiation of the subject. During that time, Mrs. G's dressing was completed and she was settled in her wheelchair. After the validation and dressing session, Mrs. G was involved in reminiscing about household duties and continued on this conversational topic at breakfast with another resident patient. By midmorning, the staff noticed that she had reverted to her customary blaming behavior.

This case study of validating the patient in the malorientation stage demonstrates the ease with which validation can occur in conjunction with daily tasks. Tasha discovered that she need not limit her communication to directing Mrs. G's behavior while helping her dress; the physical cues inherent in the process and the habit of the daily ritual were sufficient to lead Mrs. G though the dressing process without the customary directives to keep her on task. Consequently, the concurrent conversation addressed Mrs. G's emotional concerns, while the staff attended to her physical needs.

The Time-Confused Patient

Mrs. A, aged 85 years, sat in the lobby with three other patients, all aged more than 80 years. Conversation was minimal, with each patient slouched in her chair focused on her own thoughts. Mrs. A had been a resident of the long-term care facility for 3 years. Her husband had died over 20 years ago, and her grown children were dispersed throughout the Midwest. One adult daughter who lived locally had been taking care of her mother. Home healthcare, meals-on-wheels, and community partners had supplemented the daughter's frequent visits. When Mrs. A had partially turned on the gas jets, burned a tea pot, and put her safety in jeopardy, her daughter had insisted that she sell the house and reside in the facility, where she could receive appropriate care. Mrs. A had agreed to the move but fluctuated in her acceptance of her status as patient rather than homeowner.

Michele, a local college student participating in a long-term classroom assignment, was designated to provide validation to five residents for 5 minutes a minimum of three times per week. Michele greeted the four residents seated in the lobby and went to sit next to Mrs. A. She repositioned her chair so that she was in Mrs. A's line of sight. Leaning forward

to touch Mrs. A's hand, Michele greeted her and identifed herself: "Good morning, Mrs. A. Remember me? I'm Michele."

Mrs. A raised her bowed head and looked questioningly at Michele saying, "Take me home?" Michele responded to the underlying feeling by saying, "You miss your home." Mrs. A nodded and repeated, "Yes, yes, miss home." With more energy and focus than usual, Mrs. A continued with, "Go home. Go home. Have to make dinner." Rather than attempting to orient Mrs. A to the actual time of day or the fact that she no longer has a home, Michele explored the implicit emotions with, "You like to cook?" "Oh, yes," replied Mrs. A, "He likes my cooking. He's a meat and potatoes man." She then shifted her weight in an aborted attempt to get out of her chair as she said, "I have to go. He'll be mad if it isn't ready. Harriet, you know how he is."

Although Michele had no idea who Harriet was, she suspected that the "he" who will be angry was the husband who died 20 years ago. Michele ignored Mrs. A's confusion regarding person and picked up on the vague pronoun; she redirected Mrs. A's attention as she asked, "He likes your cooking, huh? What's his favorite food?" Mrs. A smiled as she settled back into the chair and said, "Dandelion stew." Michele asked what dandelion stew was, and Mrs. A, with startling clarity, provided her with detailed directions for cooking dandelion greens with bacon and onions. Although the sentences Mrs. A used were short, they were meaningful. In continuing the description (a procedural narrative), Mrs. A began to use the past tense in talking about her husband. The conversation continued and, within a few minutes, Mrs. A was telling Michele about her husband's funeral.

For a brief period, Mrs. A was oriented as to time and place and was communicating with Michele as one competent individual to another. While the validation session lasted, Mrs. A was animated and communicative. Although she became more focused for the brief period of the validation therapy, Mrs. A quickly tired and returned to her revelries. Validation therapy was not a cure but provided the patient with meaningful, nonthreatening interaction and contact with another human being.

The Repetitive-Motion Patient

Patients most in need of validation are those who have unresolved emotional issues from the past. Although such issues are denied in the maloriented patient and underlie the disoriented statements of the patient in the time-confused stage, patients in repetitive motion have deteriorated to a point at which their only expression of these unresolved issues is through nonverbal means.

Before admission to the local nursing home, Mr. W's middle-aged granddaughter would check in on him daily. He was receiving meals at home from the local church, and he and his neighbor from the apartment next door kept an eye on each other. When Mr. W began wandering outside without a coat in subzero temperatures, the family decided they could no longer care for him sufficiently. They had endured his difficult behaviors and accepted his confusion, but now his safety was in jeopardy. Although the support system of nieces, grandchildren, church members, and social services was extensive, Mr. W had deteriorated to a point at which constant care was needed.

In the nursing home, Mr. W continued to wander. He rather quickly deteriorated, with his wandering restricted to slowly pacing back and forth while murmuring under his breath, "Gotta go." Although Mr. W was compliant and would allow himself to be led to a chair to sit, he would resume his slow pacing and murmuring almost immediately. His cooperation saved him from the physical or chemical restraints that are often used, but the frequency of the behavior kept increasing. When asked where he was going, Mr. W either would ignore the questioner completely or turn to him or her, and, with unfocused gaze, continue to repeat, "Gotta go; gotta go."

In an attempt to make meaningful contact with Mr. W, a speech-language pathologist tried validation for the first time. She had returned from a workshop and was intrigued with the concept of validation but was skeptical that it would work.

To validate Mr. W and his behavior, Marty, the speech-language pathologist, mirrored his pacing; she walked next to him as he paced back and forth. After a few turns, she slowly said, "You've got to go," as she walked. Mr. W continued pacing but turned his head slightly in her direction. She continued, "You've got to go, huh?" As this point, Mr. W stopped pacing and looked directly at Marty. Having captured his attention, Marty asked, "Where are you going, Mr. W?"

Shocking Marty, Mr. W responded, "Get to work."

Marty was unprepared, she could not remember what type of work Mr. W had done. In a panic, she commented on the topic striking on the emotion underlying Mr. W's words. "Work's important, huh?"

Mr. W responded, "Can't be late."

Marty responded with, "You worked hard."

"Oh, yes," said Mr. W, "Get to work."

Marty suspected that Mr. W might have worried about being punctual for his job, but she had no idea if this was a particularly important or particularly troublesome issue in his life.

Mr. W seemed to lose focus. Marty led him over to a chair by a window. As they looked out the window together, Marty commented on the beauty

outside, but Mr. W just quietly stared. The period of lucidity was brief, but the focus of attention and the number of coherent utterances was greater than Mr. W had produced in months. Although Mr. W was in the later stages of repetitive motion, he was able to communicate with Marty and cease his relentless movement for a time.

☐ Effectiveness of the Technique

Although validation therapy has been used with disoriented, confused elderly patients for over 35 years, few controlled studies have been conducted to determine the efficacy of the approach. Many anecdotal reports in the literature confirm the effectiveness of the validation approach applied to individual patients; healthcare professionals who have used the techniques of validation with patients attest to the dramatic, although transitory, effectiveness of the approach. Although the underlying philosophy of validation therapy resonates with the belief systems of healthcare professionals, their personal experiences in using validation therapy with specific patients make them advocates for adaption of validation as the basis for a productive, affirming approach for staff when interacting with patients.

The few published studies of the effectiveness of validation therapy focused on the impact of group-therapy sessions on patients' behaviors. The impact of a validation approach, used as a pervasive mode for interacting with patients throughout the day, has not been examined formally or systematically.

Anecdotal Reports

Many healthcare professionals, including the author, have used validation-therapy principles in their dealings with specific patients who were particularly problematic. Professionals, although not conducting systematic investigations of the effectiveness of validation techniques on particular identified behaviors, have documented noticeable changes in patients' behaviors when they are engaged in validating interactions. Clinical evidence and the expert judgment of working professionals should not be dismissed. Anecdotal evidence, although not rigorously controlled, offers testimony of the effectiveness of validation in temporarily reducing the confusion and disorientation of elderly patients in the later stages of dementia.

A literature review provides reports of case studies and anecdotal evidence supporting the effectiveness of validation. Jones (1985) presented

a description of her first use of the validation approach and the immediate impact on her patient. Feil's (1982, 1993, 1995) publications abound with case studies and anecdotal evidence of the immediate effectiveness of validation on the quality of communication between patient and worker. The empathic listening inherent in validation was found to be effective for three confused patients who were adversely affected by a reality-orientation approach (Dietch, Hewett, & Jones, 1989). Individual cases (Gouldie & Stokes, 1989) and cases from group therapy (Bleathman & Morton, 1992) also are described in the literature.

Effectiveness of Validation Therapy

Several studies have been published that investigate the impact of formal validation therapy on selected patient behaviors during and following therapeutic sessions. Limiting the investigation of the effectiveness of validation therapy to encapsulated therapeutic sessions ignores the impact that could occur if validation is used by the staff throughout the day.

Data collected during validation therapy sessions have shown that patients increase their talking in the group; the number of smiles, touches, and eye contact; and the level of physical participation (Babins, 1988; Babins, Dillion, & Merovitz, 1988). In a study reported by Fritz (cited in Feil, 1992), significant increases in fluency and lucidity were found in the speech patterns of maloriented and time-confused patients who participated in validation sessions.

Although statistical significance was not obtained, patients participating in validation-therapy groups improved mental status and morale; control-group patients decreased in these areas (Robb et al., 1986). Carryover into daily interactions occurred as validation patients increased communication by making a greater number of requests. The carryover of communicative behaviors was not viewed as totally positive because the staff, which was untrained in the philosophy and principles of validation, considered the unexpected attempts at communication by the patients to be burdensome. These results underscored the need to involve the entire facility in the validation philosophy. The researchers examined validation-therapy groups in financial terms and suggested that the permeation of validation techniques into all staff interactions with patients on an ongoing basis would prove more cost-effective than provision of validation in a formalized group-therapy session.

In a comparative investigation of validation and reality orientation, 7 of 10 patients involved in validation therapy showed qualitative improvements in behavior; only three of eight patients in a reality-orientation group improved (Peoples, 1982). In a comparative study of the effects of

validation therapy and reminiscence therapy on interactions in the daily environment, two of three patients increased their frequency of initiation of communication and the length of their communications following validation-therapy sessions; one patient increased communication following reminiscence-therapy sessions (Morton & Bleathman, 1991). In a long-term study comparing the effectiveness of group validation therapy with group sessions devoted to social contact, nurses reported that patients receiving validation therapy were less physically and verbally aggressive, less depressed, but more nonphysically aggressive in terms of increased wandering, pacing, and repetitive movement (Toseland et al., 1997).

Conclusion

Validation therapy has been practiced in certain long-term care facilities for 35 years. Although anecdotal and small-sample studies have demonstrated the impact of validation on the behavior of elderly confused patients, major investigations of the efficacy of the approach are lacking. Consequently, validation, which is grounded in a philosophy of humanitarianism, has not been adopted widely.

A validation approach, if used by all staff in their daily contact with patients, can make a significant contribution to the quality of life of both disoriented patients and nursing home staff. Validation offers a practical system for dealing with the disruptive behaviors of demented patients and provides a means for interaction that acknowledges the worth and dignity of the patient.

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