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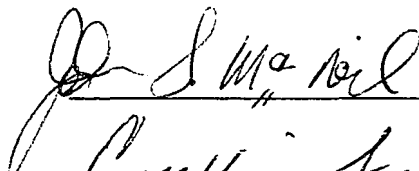
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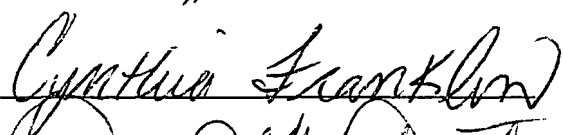
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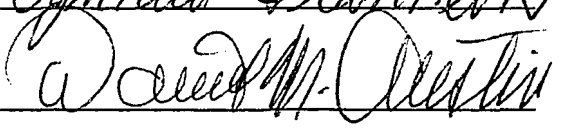
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1995


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


**Approved by
Dissertation Committee**











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on Satisfaction with Communication and Quality of Relationship
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in Long Term Care**

by

Robert Loy Canon, B.A., M.S.W.

Dissertation

Presented to the Faculty of the Graduate School of

The University of Texas at Austin

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of the Requirements

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**The Effect of Validation Therapy Training
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Publication No. _____

Robert Loy Canon, Ph.D.
The University of Texas at Austin, 1996
Supervisor: John McNeil

The effect of Validation Therapy training on satisfaction with communication and quality of relationship for both family and staff caregivers of dementia patients was evaluated in a pretest-posttest design with nonrandom assignment to experimental and comparison conditions. Subjects were recruited from primary caregivers 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 (DCQRI), an instrument developed by the author, while the Interpersonal Communication Satisfaction Inventory (ICSI) (Hecht, 1978) measured care giver satisfaction with dyadic interaction. A test incorporating items from several instruments

developed by Feil (1992) was used to assess validation skills. Data on demographic and other descriptive variables were also collected.

Reliability of the ICSI was very good, while alpha coefficients for the DCQRI and Validation Skills instruments were marginal. Despite the marginal reliability of the DCQRI and Validation Skills instruments, they were retained for analysis due to the exploratory nature of this study. Data analysis consisted of separate repeated measures analysis of variance tests, each with a varying covariate; one for the ICSI and another for the DCQRI. The Validation Skills instrument was used as a single varying covariate in each test.

Findings 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 statistically significant differences between family and staff on change in communication satisfaction level after receiving Validation Therapy training, staff caregivers were significantly more satisfied than family caregivers with communication at both pre-test and post-test. No intervention effect was observed for quality of relationship or Validation Therapy skills.

Psychometric properties of the Validation Therapy skills instrument and the ICSI, the need for reliable measures to assess the effect of Validation Therapy training and practice, and suggestions for future research are discussed.

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Chapter One

Literature Review

Introduction

Dementia is one of the most common and debilitating disease processes of late life. It not only affects patients suffering from the condition, but family members and other caregivers as well. Two areas most deeply affected by the condition are communication and quality of relationship. This study seeks to assess the effect of caregiver training in Validation Therapy, a promising intervention for dementia patients, on those aspects of caregiver relationships with dementia patients. One goal of this study is the development and identification of instruments to measure these constructs in dementia caregiver populations. While the effect of Validation Therapy on dementia patients is of paramount interest, due to the lack of research on the intervention, assessing the effectiveness of Validation Therapy training and its effect on caregiver relationship with patients can add meaningfully to the existing dementia care and Validation Therapy knowledge base.

Background

In 1907 a German physician, Alois Alzheimer, first described the disease that would eventually be named for him (Volicer, Fabiszewski, Rheume, & Lasch, 1988; Leng, 1990). DSM IV nomenclature for the disease is "Dementia of the Alzheimer Type" with subtypes of early onset and late onset (APA, 1994, p. 139). 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, and changes in affect (Haulotte, 1991; Leng, 1990; Turner, 1992). It is characterized by memory impairment and disturbances in one or more of the following cognitive areas: Use of language, motor activities, object recognition, and executive functioning. These cognitive deficits significantly impair social and occupational functioning and represent a significant decline from previous level of functioning (APA, 1994). "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, and 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, and may even increase (Stephens, Kinney & Ogrocki, 1991). Research cited in Stephans et. al. (1991) indicates that the level of

depression and burden experienced by family caregivers does not differ significantly based on whether the demented relative is at home or institutionalized.

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. 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).

Profile of Alzheimer's Disease and Affected Population

Diagnosis

Diagnoses of the disease in living patients remains difficult because "no specific test exists for Alzheimer's disease" (Volicer et al., 1988, p. 1). Diagnoses in living patients is a process of "exclusion" (Haulotte, 1991, p.5) in which other causes are ruled out through extensive testing. Post mortem examination of brain tissue has been called "The gold standard for diagnosis

of AD" (Connolly & Williams, 1993, p. 134). A post mortem diagnosis, while helpful in corroborating and establishing success rates of diagnoses based on other criteria, is of very little use in informing clinical intervention.

Research on a variety of methods of early diagnosis appears in the literature. Medical-technological methods which show promise include cerebral biopsies, magnetic resonance imaging (MRI), single photon emission computed tomography(SPECT), and to a lesser extent computerized tomographic imaging (CTI) (Engle, P. A.,1993; Hulette, C. E., 1992; Tune, L. 1993). Neuropsychological, psychophysical and cognitive measures which show promise in diagnosis of Alzheimer's include delayed recall (Welsh, 1992), visual masking (Schlapfer et al., 1991), cognitive reserve capacity(Baltes et al., 1992), episodic face recognition (Backman & Herlitz, 1990), verbal fluency (Monsch, 1993), and perceptual attention as measured by Gottschaldt's Hidden Figure Test (Capitani et al., 1988). Studies have also shown that several scales targeting cognitive deterioration are capable of identifying and indicating the severity of dementia; The mental status questionnaire (MSQ) , the short portable mental status questionnaire (SPMSQ), the Mini-Mental State Exam (MMSE) and the Blessed Information-Memory-Concentration Test (Ashford et al. 1989). Functional assessments based on Instrumental Activities of Daily Living

(IADL), Performance Activities of Daily Living (PADL), Activities of Daily Living (ADL) and Blessed Dementia Rating Scale scores have also been shown to identify Alzheimer's disease and related disorders (Barberger-Gateau, 1993; Loewenstein et al., 1989). Diagnostic potential of demographic characteristics (Coyne et al., 1990) and the retrospective accounts of dementia symptoms provided by caregivers (La Rue et al., 1992) have also been studied.

Etiology

Hallmarks of the disease are dendritic plaques composed of amyloid proteins deposited on the surface of nerve cells and neurofibrillary tangles within the cells (Blazer, 1990). A study at the Duke University medical school in Durham, N. C. linked the neural damage of Alzheimer's disease to an abnormality on chromosome 19, however a number of scientists still believe that chromosome 21 is linked to the disease (staff, 1991, p.41). "Testing for the triploid genetic material [defects in chromosome 21] may become an important screening test for Alzheimer's disease" (Volicer et al., 1988, p.6). "Still other genetic cases appear linked to neither 19 nor 21, but to an as yet unidentified chromosome(s)" (Phelps, C. H., 1992, p.711).

The risk of developing Alzheimer's disease increases from about one

or two out of 100 cases of people age 65 and older to about eight in 100 cases if a close relative has the disease (Mace & Rabins, 1991, p. 300). A recent study (Ferrer et al., 1991) utilized complex segregation analysis to explain observed clustering of Alzheimer's disease in families. The investigators concluded that in addition to a major genetic locus, other factors played a part in the clustering. Studies of monozygotic twins also indicate that risk for Alzheimer's is multifactorial (Binstock, 1993). Some researchers state that another genetically linked condition, Down's syndrome, "is a clear risk factor in the development of the condition" (Volicer et al., 1988, p. 6). Others, however, report similarities between Alzheimer's disease and Down's syndrome, but say that although some Down's syndrome victims do experience a further decline in intellectual functioning, they do not develop the symptoms of Alzheimer's disease (Mace & Rabins, 1991, p. 299).

Previous head injury has been found to increase the risk of developing AD three times while a history of thyroid dysfunction increases the risk 1.5 times (Kociol & Schiff, 1989 cited in Turner, 1992). Metabolism of the metals zinc (staff, 1993, p.120) and aluminum (Kociol & Schiff, 1989 cited in Turner, 1992) have been associated with Alzheimer's disease in some studies, although "researchers continue to debate whether an

elevated level of aluminum in the brains of Alzheimer's patients is a cause or an effect of the disease..." (Turner. 1992) . Gender and race have been identified as "questionable" risk factors by researchers citing a study that "found a higher prevalence rate of Alzheimer's disease for blacks than whites" (Volicer et al, 1988, p.6). Although there is also mention in Volicer et al's work about geographic location as a possible risk factor, Jones and Miesen believe that the "incidence of dementia shows a clear-cut age dependency," and no geographical or ethnic differences (1992, p. 9).

Because of the uncertain etiology, no definitive preventive measures exist. However, one study has shown estrogen therapy to reduce the risk of Alzheimer's in women by 40 percent (Associated Press, citing Henderson, 1993). Since individuals with organic manifestations of Alzheimer's sometimes show no behavioral symptoms of the disease, it is also theorized that developing neural connections through intellectual pursuits can minimize cognitive deterioration associated with the disease (Friend, 1993). A varied repertoire of mechanisms or strategies for coping with loss has also been theorized to be effective in forestalling the behavioral and cognitive manifestations of AD (Feil, 1991). There is no cure for the disease at this time (Haulotte, 1991, p.1). However, the U.S. Food and Drug Administration recently approved the first drug for the treatment of Alzheimer's disease.

"Tacrine hydrochloride has been shown in two trials to provide small but meaningful benefits for some patients suffering from mild to moderate Alzheimer's" (Cimons, 1993, p. c22).

Epidemiology

The United States will see an increase in Alzheimer's disease as the number of older Americans increases (Volicer et al., 1988). In 1985 there were 2.7 million people over the age of 85 (Atchley, 1988). Volicer et al. estimate that by the year 2000 the number of Americans 85 years and older may be as large as 6.7 million (1988). Projections suggest that by the year 2050 the number of Americans 85 years and older will grow to 15 million (Hooyman & Kiyak, 1993). These estimates are particularly "sobering when taken into account that Alzheimer's Disease is the fourth leading cause of death for people over 75 years old" (Haulotte, 1991, p.1) and that "one in four individuals over the age of 80 are affected by the disease" (Haulotte, 1991, p. 1).

Related Issues

Public Policy

"As the number of persons aged 65 and older increases, so too does

the number of those suffering from Alzheimer's disease; hence the ever-increasing need for available long-term health care policy" (Jarvik & Winograd, 1988, p.147). More than half of the residents of long term health care facilities are persons with a dementing illness (Sloane & Mathew, 1991a, p. XIII). In response to these growing concerns, the Alzheimer's Disease and Related Dementias Services Research Act of 1986 (Title IX, PL 99-660) established a Council on Alzheimer's Disease. This council's main purpose is research and information (Jarvik & Winograd, 1988, p.148).

During a joint hearing before the Select Committee on Aging, Chairman Edward R. Roybal described Alzheimer's disease as a "time bomb" in our health care system (United States Senate, 1992). He goes on to say that "Americans currently spend about \$100 billion a year or one in every seven health care dollars in the care and treatment of Alzheimer's disease" and that despite this increase in cost to take care of Alzheimer's patients, the government is "decreasing monies that are being used for this purpose" (United States Senate, 1992). While Alzheimer's disease gets around \$350 million for research, AIDS gets almost \$2 billion (United States Senate, 1992). Jarvik and Winograd cite studies of elderly done in Massachusetts that indicate "two-thirds of persons 66 years of age and older

who are living alone would become impoverished after only 13 weeks in a nursing home" (1988, p. 148).

Ethical Issues

"Questions of ethical behavior occur frequently in caring for the patient with Alzheimer's disease," especially as patients become incompetent to make decisions concerning advanced directives, pain and suffering, quality of life issues, institutionalization, and life-sustaining therapies (Volicer et al., 1988, p. 10). Families also face an ethical dilemma when deciding whether or not to institutionalize a cognitively impaired loved one (Jarvik & Winograd, 1988, p. 80). The principle of informed consent to treatment is challenged by the difficulty of communicating with Alzheimer patients. "Persons with impaired cognitive function cannot (or seem not to) understand the necessary information and may be unable to communicate a choice" (Jarvik & Winograd, 1988, p. 88). Jarvik and Winograd distinguish between interventions with children unable to make decisions and people with Alzheimer's disease in that "the older person has a lifetime full of evidence about established value preference" (1988, p. 90).

Another author argues for abandoning the concept of informed consent as inadequate, dangerously limited, and of very doubtful relevance

to many practical decisions in long term care (Moody, 1988). Moody (1988) argues for a concept he calls 'negotiated consent' "...which is characterized by the clash and balancing of competing interests: there are multiple, legitimate views to consider (e.g., family, patient, institution); shared or dispersed authority for decision-making: no single party has the exclusive power of decision (e.g., structure of team decision-making, conflict or consensus among family members); a non-algorithmic process: negotiation is not governed by strict deductive rules; it is more heuristic in its cognitive style, implying less reliance on codes of ethics and more attention to opportunities for discussion; sub-optimal outcomes: negotiation is appropriate for situations where the ideal outcome is not obtainable but making the best of a bad situation is the most that can reasonably be expected, a common situation among the frail elderly in long term care; and the need to produce a publicly justifiable rationale for the outcome: that is, decisions are not acts of arbitrary authority but must be recursively redeemed by producing reasons for the outcome." (p. 67)

Current AD interventions can also be discussed in light of an ethical dilemma common in cases where any incurable, progressive disease process is present; "are these diagnostic procedures and treatments prolonging life or merely prolonging dying? The optimal medical care for patients suffering from advanced dementia of the Alzheimer type should balance the benefits of care against the suffering caused by the treatment" (Volicer et al., 1988, p. 168).

Available Services

Special Care Units

One response to taking care of residents with dementia has been the development of special care units. Between 7.6% to 11% of long-term care facilities maintain some form of special care unit for demented residents with the correct figure being determined to some extent on the definition of SCU used (Holmes, Teresi, & Monaco, 1992, p.195). "Since SCUs are a relatively new phenomenon, specific licensure and accreditation standards are in their infancy. There is little to prevent a nursing home from simply calling one of its 'traditional' units an SCU if it so desires" (Ritter & Fries, 1992, p. 186).

Holmes et al concur that there is no consensus regarding characteristics necessary for designating a special care unit. They go on to argue that definitional uniformity is necessary to determine the prevalence of SCUs and their effectiveness. They define two distinct forms of SCU which overlap in admission criteria environment and services provided. Segregated units are completely separate facilities while cluster units are in a segregated wing of a traditional facility. In a cluster unit, staff and dining facilities may be shared between the SCU and residents of the traditional unit (Holmes et al, 1992).

Patients appropriate for SCU placement due to their dementia may be denied services based on other attributes. A recent study found that "residents who may benefit from the specialized cognitive support found on an SCU may be excluded from placement on such units because of their physical conditions" (Riter & Fires, 1992, p. 189). Other authors identify a need to examine the effect of SCU setting on AD treatment citing a lack of empirical research on the effectiveness of segregating residents (Sloane & Mathew, 1991a, p. XV).

Adult Day Care

"Respite services for families of the aged is a very recent

development and is one of a variety of efforts that aim to relieve caregiver's strains, thereby postponing or preventing nursing home placement" (Lawton et al., 1991, p.13). Types of respite include support groups, sitter services, day hospital programs, and day care (Jones & Miesen, 1992, p. 303).

"Day care refers to attendance at day centers ranging from small socialization/sitter programs to large professionally staffed programs with multiple types of services in addition to respite" (Lawton et al., 1991, p. 18). If family members desire to keep the patient at home, day care is a service that may help to avoid premature institutionalization of Alzheimer victims (Jarvik & Winograd, 1988, p. 94). As of 1988, "116 day-care centres served more than 2,600 cognitively impaired elderly clients" (Jones & Miesen, 1992, p.316). In a study of New Jersey adult day care centers a variety of services were provided to demented clients and family care givers. For clients, "exercise, music, and forms of reminiscence, reality orientation, and remotivation are included in the daily routines of most of the programs. All provide a noon meal and snacks, and the majority furnish transportation. Services to caregivers include counseling, referral, educational programs, and support groups" (Engstrom, Greene & O'Conner, 1993, p. 76).

Other researchers have found that there is increasing development of programs which serve only demented adults as only 45% of traditional

centers also provide services for the demented. "This finding is congruent with the observations of the authors, who have noticed a reluctance among many day care providers to admit the demented into programs which were originally developed for the physically frail. Day care providers cited many reasons for limiting the number of participants with dementia, including staff resistance to working with an unfamiliar and misunderstood population, staff expectations that demented clients will adversely affect existing programs, resistance of existing clients to interacting with the demented, and lack of knowledge among providers about how to serve this special population" (Cherry & Rafkin, 1988, p. 116).

Family Based Care

"Approximately 70% of the care given Alzheimer victims is provided by families" (Staff, 1991). The majority of family care providers are adult children of the dementia patients, followed in number by spouses and relatively fewer nephews, nieces and cousins (Dziegielewski, 1992). Most caregivers are women, however approximately 28 percent are male, 13 percent of whom are husbands (Harris, 1993, p. 551). "Besides providing care to its impaired members, the family may also provide support to the family member primarily responsible for caring for the Alzheimer's patient"

(Semple, 1992, p.648).

Care of a family member with Alzheimer's disease has a pronounced emotional impact. Conflict within families with a demented member was found to be closely associated with depression and anger (Semple, 1992, p.648). Respite services can reduce the stress experienced by a family caregiver and postpone institutionalization of the AD patient. Certain cultures, however, may refuse respite because "they believe that it is their responsibility alone to provide the care or that persons of their ethnic, racial or religious groups 'take care of their own'" (Lawton, Brody, & Saperstein, 1991, p.52).

One of the most important emotional needs of family caregivers is to grieve. Grieving takes place when the caregiver-patient relationship is altered by replacement of one family member by another in the role as primary care provider, when the patient is institutionalized, and when the patient dies (O'Connor & Prothero, 1987, p. 71). Anticipatory grief is the progression through the phases of grief prior to the death of a loved one. The anticipation of physical death is compounded by witnessing a succession of other losses including previous levels of functioning, physical health, security, predictability, control, relationships, and opportunities in life. A number of factors effect the anticipatory grief experienced by family

caregivers of dementia patients, including social stigma, ambiguous or psychosocial death, and multiple losses (Walker et. Al. 1994).

Intervention Models

Reminiscence and Life Review

"The term reminiscing usually refers to the vocal or silent recall of events in a person's life, either alone, or with another person or group of people" (Jones & Miesen, 1992, p. 138). Life review is a term referring to "the process of reviewing, organizing and evaluating the overall picture of one's life" (Jones & Miesen, 1992, p. 138).

The work of the life review is determined by unfinished work from earlier stages in life. If a certain task within a life stage is left unaccomplished, it will result in arrested development and will cause emotional distress (Knight, 1986, p. 126). Conducting a life review is a specific reminiscence activity that may require more insight, guidance, and energy than independent reminiscence (Jones & Miesen, 1992, p. 138).

Music Therapy

Music therapy may be summarized as "the planned use of music to reach non-musical goals with those who are disadvantaged" (Jones &

Miesen, 1992, p. 163). Music therapists use music as a means to an end, not as an end itself. Music therapy differs from music used for recreational or educational purposes in that music therapy utilizes objectives, assessments, and evaluation (Jones & Miesen, 1992, p. 163).

This therapy assumes that most persons with dementia, "music function is spared to a greater extent than are most cortical functions" (Jones & Miesen, 1992, p. 163). Music therapy is related to reminiscence. Music selected is often music from the past with meaning for the patient. Jones and Miesen also suggest that persons with dementia may feel more competent engaging in music activities, and may be more open to conversation as a result (1992, p.163).

Dynamic Psychotherapy

Psychotherapy as defined by Webster's New World Dictionary is the "treatment of mental disorders by counseling" (Guralink, 1984, p.482). Dynamic psychotherapy with the older, demented persons "addresses the internal factors that determine a patient's way of adapting and finding restitution" (Jones & Miesen, 1992, p.181). Since "ego resources and defenses are less and less strong and available in Alzheimer's patients as the disease progresses, an overwhelming percentage of demented patients

develop emotional diseases" (Jones & Miesen, 1992, p. 183). These emotional diseases are secondary to the dementia and may include depression, anxiety, and paranoia (Jones & Miesen, 1992, p. 163).

Jones and Miesen (1988) list ten universal goals for dynamic psychotherapy for Alzheimer's patients: (1) a relationship in which the patient feels cared about; (2) emotional outlet of catharsis; (3) enhancement of self-esteem; (4) minimization of psychological and behavioral problems; (5) increase in coping skills; (6) enhancement of role functioning; (7) a sense of control; (8) the ability to grieve over losses of roles, capacities and significant others; (9) development and maintenance of the most mature and productive defenses possible while shedding inappropriate defenses; (10) the development of insight. (p. 184)

Knight (1986) believes the therapist may have to adapt psychotherapy with the elderly. These adaptations are based on developmental change and cohort differences. Developmental change may include slowing with aging, memory changes, increased correlation of psychological and physiological condition, and the increasing inward focus of interiority. Adaptation based on cohort differences may include religious orientations, attitudes toward the family, and the tendency to somaticize complaints (Knight, 1986).

Reality Orientation

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 purposes 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).

Validation Therapy

Validation Therapy, discussed in detail in the following chapter, is an intervention for the disoriented elderly that can be used in any of the care settings discussed earlier. It is also compatible with, and incorporates aspects of, several of the above intervention models. Reminiscence and music are primary elements of Validation Therapy. The exception is reality orientation. One premise of Validation Therapy is that symptomatology of confusion is actually age appropriate behavior directed toward resolution of earlier life issues. From this perspective correction of the confused patient and presentation of current reality is inappropriate and often unnecessarily cruel. Psychotherapy is also incongruent with Validation Therapy in one area, development of insight. While insight is central to psychotherapy, Validation Therapy theory maintains that cognitive deterioration associated with advanced dementia makes insight impossible.

Despite this difference, many Validation Therapy techniques would be compatible with psychotherapy.

Existing Research on Validation Therapy

No experimental studies of Validation Therapy training's impact on dyadic communication or quality of relationship between caregivers and dementia patients were located. The majority of existing academic literature on Validation Therapy outcomes with patients is narrative or anecdotal (Feil, 1967, 1983, 1985, 1991, 1992; Ronaldson & Savy, 1992; Dietch, Hewett & Jones, 1989). Of the experimental or quasi experimental studies found in the academic literature, all point up the challenges of recruiting an adequate number of subjects and measuring the direct effect on dementia patients of a clinical intervention.

A Canadian study comprised of 12 female dementia patients between the ages of 80 and 91 used observational measures of cognitive, social, and behavioral functioning to assess the effect of Validation Therapy (Babins, Dillon & Merovitz, 1988). Seven subjects were selected for the control group while 5 were placed in the experimental group. No mention was made concerning method used for making group assignments or levels of interrater reliability among staff making observational measures. The

intervention consisted of 22, 45 minute Validation Therapy groups over an 11 week period. The authors provided no inferential statistical analysis of data collected in this study. Conclusions were drawn from tabular presentations of descriptive data; the means and standard deviations of subject scores. Based on descriptive statistics generated from observational data collected from a total N of 12 subjects, the researchers concluded there were “no cognitive improvements, and ... some social changes” and that “subjects expressed themselves more during the last three sessions than the first three sessions” (Babins, Dillon & Merovitz, 1988, p73).

An English study (Bleathman & Morton, 1988, 1992; Morton & Bleathman, 1991) observed five elderly dementia patients over a period of 40 weeks with a 10 week baseline, 20 week Validation Therapy intervention period and a 10 week alternative group therapy. Observational measures of three dependent variables, mood, behavior, and level of interaction, were made at 10 second intervals during group sessions.

The group sessions were also tape recorded, providing what researchers felt was the most interesting data. A qualitative analysis of these recordings showed that in spite of an almost total lack of meaningful interaction observed outside the group, subjects were able to maintain discussions of the same themes and issues for 45 minutes or more during

Validation Therapy groups. Researchers remained uncertain of the extent to which the observed improvements in social functioning were the result of Validation Therapy techniques or the rigidly applied group protocol and manufactured group environment designed to maximize subject's remaining social skills.

An Australian study (Sharp, 1989) compared 19 disoriented residents of a nursing home where the staff received over three months of Validation Therapy training and 18 residents of a comparable facility where no such training was provided. Data collection was based on two observational check-lists, one for adaptive functioning, the other for disorientation phase screening, and goal attainment scaling (GAS). Researchers identified no significant differences between groups for changes on adaptive functioning measures but a significant decrease in the amount of time subjects spent in the time confusion disorientation stage. Only residents of the facility with the Validation Therapy training program engaged in goal attainment scaling. Statistically significant improvements were found at 9 weeks for 10 residents with sufficient data collected. Due to incomplete record keeping by nursing staff, only 6 clients had sufficient data for analysis by week 12, when no significant progress was identified. No discussion was provided concerning interrater reliability statistics for staff making observational measures with

the checklists or classifying the level at which residents attained GAS goals. This study also attempted to assess the effect of Validation Therapy training on staff members. Two instruments were used; one composed of multiple choice and true-false items suggested by Feil to assess knowledge of validation and Palmore's (1978, cited in Sharp, 1989)) facts on aging questionnaire. Due to staff turnover and generally poor return rates for these instruments no statistical analyses were performed on collected data.

Another study (Robb, Stegman & Wolanin, 1988) began with random assignment of 16 subjects to a no treatment control group and 20 subjects to a Validation Therapy treatment group. No explanation was provided for the unequal group sizes. Attrition of 25% for both groups due to death or illness resulted in posttest n's of 12 for the control group and 15 for the experimental group. Of those in the experimental group, 6 did not attend most of the scheduled Validation Therapy sessions due to episodic acute illness or disruptive behavior. These subjects were placed in a second experimental group.

Validation Therapy was provided twice weekly for nine months with pretest and posttest measures of three variables; mental status, morale, and social behavior. Problems using the chosen instruments with demented subjects quickly became evident as researchers realized that their

knowledge of specific subject history was inadequate to determine the correctness of subject responses based on current and historical fact. Physical and cognitive deficits associated with the disease process also precluded subjects from completing some instrument tasks.

Differences between the three subject groups on the three measures were not statistically significant at the .05 level. Anecdotally, nursing staff reported no change in subject self care ability, though many of the residents demonstrated changes in their social behavior. These changes were not consistently interpreted by the nursing staff as positive. Due to increased demands on nursing staff for cigarettes and conversation, one nurse commented that tranquilizer dosage may be increased. Despite dissemination of materials describing Validation Therapy and its benefits, staff frequently retained negative attitudes towards observed outcomes. One possible reason identified by researchers for these views on the part of nursing staff was the misguided expectation that bowel and bladder continence would be restored.

Researchers concluded that by the time the investigation was completed, serious methodological flaws compromised study results. In spite of these shortcomings, the study was reported to encourage additional evaluation of Validation Therapy, if necessary also utilizing flawed

methodology, so empirical information based on conceptual generality may emerge.

Chapter Two

Theory

Definitions

Validation Therapy was developed by social worker Naomi Feil out of dissatisfaction with RO (Bleathman & Morton, 1988; Feil, 1992). 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 Therapy, 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 present 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).

As recently as 1993 senile dementia and Alzheimer's were 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" (Dietch, 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 awareness of the intervention's 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 substages, 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

The biomedical model of dementia is currently over emphasized in AD research and care. 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).

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, 1991b).

Social gerontological theory 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).

Validation Therapy approaches AD intervention from a systemic, humanistic, social perspective and focuses on client driven efforts to address unresolved life issues. 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).

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 additional 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 are markedly affected.

Coordinated management of meaning is a concept which further guides this study. The premise of this perspective on communication 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 was these subjective, relationship specific perspectives on satisfaction with communication and quality of relationship which this study sought to measure.

The value base of Validation Therapy also guided 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 primary caregivers rather than the

extent to which residents regain cognitive capacity or reduce 'problem behaviors'.

Hypotheses

Consistent with communication theory and the value base of Validation Therapy, this study seeks to answer the question “does Validation Therapy training affect caregiver satisfaction with communication and quality of relationship with dementia patients. Accordingly, the following hypotheses will be tested:

Hypothesis 1. Caregivers receiving Validation Therapy training, when compared to a no treatment comparison group, will report increased Validation skills as indicated by scores on the Validation Skills instrument .

Hypothesis 2. Caregivers receiving Validation Therapy training, when compared to a no treatment comparison group, will report an increase in communication satisfaction as indicated by scores on Hecht's Interpersonal Communication Satisfaction Inventory.

Hypothesis 3. Caregivers receiving Validation Therapy training, when compared to a no treatment comparison group, will report an increase in quality of relationship as indicated by scores on the Dementia Care Giver Quality of Relationship Inventory.

Chapter Three

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). Although residents on the SCU pose an elopement risk and have a diagnosis of dementia, 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 with caregivers of TLH residents. 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 provided by residents themselves, or by family caregivers for demented family members, for participation in similar nonrisk research 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. Caregivers who expressed an interest in the training but could not attend due to prior engagements were expected to be comparable in their interest and motivation for improving their satisfaction with communication and quality of relationship with dementia patients in their care.

The ethical and sample size issues mentioned previously in addition to the availability of a plausibly comparable comparison group and the fact that random assignment with small sample size does not ensure comparable groups, led to the decision to drop random assignment from the design. In

the end, possibly weakening the design by dropping random assignment seemed a reasonable trade off in an exploratory study 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

Three instruments were administered at both pre-test and post-test: Two to assess the dependent variables, satisfaction with communication and quality of relationship, and a third to assess the extent to which Validation Therapy training imparted the intended skill and concepts. Scores on the Validation Therapy skills instrument would also be incorporated into the hypothesis tests of the other two dependent variables as a covariate.

Hecht's Interpersonal Communication Satisfaction Inventory (ICSI) (1978a), a standardized instrument was modified slightly for this population and used to assess the effect of the intervention on 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 for the ICSI 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. (Wheeless, Frymier & Thompson, 1992; Onyekware, Rubin & Infante, 1991; Rubin, Martin, Bruning & Powers, 1993). Hecht reports "exceptionally high" convergent construct validity for the ICSI 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 administration to the population of dementia caregivers in this study the ICSI 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 while item 8 from the long version of the ICSI appears particularly appropriate for this study because of it's reference to the other person in the interaction showing that they understand what the communicator said (see appendix).

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 (Corcoran & Fischer, 1987) have been used with modification (Dzegielewski, 1992) in previous 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 items were developed for staff and family versions of the instrument. The items were developed through consultation with the director of social services at TLH and the family caregiver of a demented resident there. Because all available subjects suitable for inclusion in a developmental sample were used in the actual study, there were no previously established psychometric properties for the DCQRI.

The instrument used to assess subject grasp of Validation Therapy technique and theory was based on an 18 item instrument developed by Feil, (1992). That instrument has not undergone any formal development or procedures to establish reliability and validity. Based on Feil's clinical experience, it consist of 5 multiple choice items, 5 true false items, and 7 essay items. In order to facilitate scoring and make them less intimidating to subjects, the essay items 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.

In addition to the ICSI, the DCQRI, 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.

Components of Validation Therapy Training

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. Because of low participation rates at the first series of workshops in the fall of 1994, another group of subjects was trained at the Spring 1995 workshops. Both the two day and single day workshops

covered generally the same content area and utilized a multimedia approach with didactic and experiential components. Feil is typically rather flexible in her presentations and does not follow a rigidly scripted program so specific content varies slightly from one session to another. Although not available at the time of the study, Feil is currently developing a Validation Therapy training curriculum.

Feil begins her presentation with an overview of the early learned behaviors and coping strategies she believes affect orientation in late life. Next she presents her stage based interpretation of late life. After presenting the theoretical background for disorientation in late life, Feil augments her didactic presentation by role playing the different stages of disorientation. She places particular emphasis on the stage of malorientation. During the role plays of this stage she heavily involves the audience, giving them a sense of what it is like to interact with dementia patients in the malorientation stage. In the role of a maloriented dementia patient, she makes the type of cutting remarks typical of the stage and has been observed making workshop participants cry. A video demonstrating the specific behaviors associated with the malorientation stage of dementia is typically shown at this point in the workshops.

As Feil presents the different stages of disorientation, she steps out of the characters she role plays to present Validation helping skills appropriate to that specific stage. Her overriding focus when applying Validation helping skills is linking patient behavior to the basic human need the patient is trying to meet. She describes the appropriate use of touch and eye contact in each stage. Observation of raw emotion, reflecting that emotion back to the patient verbally, and matching patient emotional state through mirroring movement are presented. Techniques based on the use of ambiguity, music and rhythm are demonstrated. The session closes with a viewing of the short film "Looking for Yesterday" that shows the interaction and progression of a mother and daughter experiencing dementia in late life.

In the second day of the two day workshops, and to a lesser extent in the one day sessions, Feil focuses on Validation Therapy group process. She begins with a review of the stages of disorientation, their unique characteristics and the appropriate Validation Therapy techniques specific to each. A video showing the beginning of a Validation Therapy group is presented at this time. After the video, Feil describes the criteria and selection process for group members. She emphasizes the need for thorough knowledge of resident history to guide selecting group topics, assigning group roles, identifying evocative songs, movements and seating

arrangements and discovering unfinished life tasks. Feil next outlines the Validation workers role in the group process. The worker is responsible for establishing a group ritual in which each participant has a clearly defined role. Within this structure, the worker builds participant interaction by presenting common feelings, setting limits, clarifying participant contributions, and summarizing group process. The workshop ends with a video showing group process and closure of a Validation Therapy group before workshop participants divide into small groups to practice Validation Therapy techniques.

Data Collection

Pre-test measures for the experimental condition were administered immediately before Validation Therapy training. Because of variability in specific interpersonal interactions with dementia patients, subjects were instructed to base responses to study instruments on a typical interaction with the dementia patient in their care. Some participants expressed confusion over the ICSI's use of the term "conversation" when the dementia patients in their care were in a stage of extremely deteriorated verbal skills. These respondents were instructed to focus on nonverbal components of their interactions when answering these items.

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. Family caregivers 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. Staff caregivers were instructed to complete the post test at the end of the week following Validation Therapy training, also to allow practice of material learned in the training.

Comparison 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 return 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 Estimates

As stated earlier, no studies of Validation Therapy training and its impact on dyadic communication were located. The majority of existing literature on Validation Therapy outcomes is narrative or anecdotal and does not provide 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 or otherwise 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 precluded the use of Lipsey's actuarial and statistical translation approaches to judging the minimal effect size the study should be designed to detect. The criterion group contrast approach was 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 use of 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 Estimates

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, due to constrained resources, limited subject access and based on the present state of knowledge about Validation Therapy, it is adequate to contribute

meaningfully to the existing knowledge base.

Statistical Tests

Prior to tests of hypotheses, reliability of study instruments was assessed by use of Cronbach's alpha coefficients. For the ICSI, this information was used to validate previously reported reliability. In the case of the DCQRI and the Validation Therapy skills instruments, this is the first attempt to establish any psychometric properties. A factor analysis was also run on these instruments to identify items that fit either of two criteria: 1.) The item could be dropped with out decreasing instrument reliability and 2.) Dropping the item would increase reliability. Factor analysis also helped in exploring the number of latent variables, or factors, measured by the instruments and the substantive content or meaning of those factors (DeVellis, 1991).

Hypothesis one, that the group receiving Validation Therapy training would show an increase in knowledge of Validation Therapy skills and concepts when compared to the group not receiving training, was tested with an independent t-test of change scores derived from pretest and post administrations of the instrument. Stevens (1992) cautions against the use of change scores as their reliability is lower than either of the instruments

used to produce them. Based on the average reliability of the pretest and posttest administrations of the Validation Therapy skills instrument (.58) and the Pearson correlation between the two administrations ($r=.77$), a table provided in Stevens shows a reliability of .00 for the change score. In keeping with the exploratory nature of this study, the independent t-test was run anyway, producing nonsignificant results ($t=.52$, $p=.61$).

A design incorporating two separate tests was selected to evaluate the remaining two study hypotheses. Scores on the DCRI and the ICSI were used as dependent variables. Two between subjects factors, each with two levels, control or experimental group status and family or staff group status, were used. Differences in knowledge of validation therapy technique and theory base was controlled for by assigning pretest and posttest administrations of the Validation Skills test as a varying covariate. Statistical terminology describing this design is somewhat unclear. Since each hypothesis test incorporates a single dependent variable, 2 factors and a covariate, they can accurately be referred to as factorial ANCOVA and are based on the same univariate assumptions. However, since the dependent variable in each hypothesis test consists of a separate pretest and posttest administration, the tests can also be correctly thought of as multivariate analysis of variance with a varying covariate. Perhaps the clearest label is

the more general repeated measures analysis of variance with a varying covariate.

Although separate tests were selected in this study, the use of a doubly multivariate repeated measures with varying covariate design in which both dependent variables and both between subjects factors are included in a single test has been suggested in the literature (Stevens, 1992). There are several reasons for using one doubly multivariate test, the first being a theoretical and conceptual link between dependent variables. If differences on dependent variables combine to produce a more reliable difference between groups the multivariate test will be more powerful. Another advantage of incorporating all dependent variables in a single test is that while univariate tests ignore the correlation between dependent variables, the multivariate test incorporates the correlations into the test statistic via the covariance matrix. Multivariate approaches also have the advantage of not inflating Type I errors like multiple univariate tests. Finally, the use of multiple criterion measures can obtain a more complete and detailed description of the phenomenon under study (Stevens, 1992).

After considering the advantages of a single doubly multivariate test incorporating both dependent variables, separate univariate repeated measures tests were selected for the following reasons. Although the

concept of coordinated management of meaning holds that a meaningful and rewarding relationship is based on satisfactory communication, and the quality of a relationship also affects the level of satisfaction with interactions, there is no empirical or strong theoretical support for this link in the unique confines of dementia caregiving relationships. Without strong rationale for including multiple dependent variables in a single multivariate test, small or negligible differences on some variables may obscure real differences on other variables. The effect of multiple dependent variables in a single test on holding down Type I errors is moderated by this study having only 2 dependent variables. Additionally, limiting the number of variables in an analysis of variance design is apt to facilitate interpretation. The decision to use separate tests was further validated by the marginal reliability found for one of the dependent measures, the DCQRI (Stevens, 1992).

There are 3 main assumptions on which univariate ANOVA is based:

1) The observations are independent, 2) The observations on the dependent variables follow a normal distribution in each group, and 3) The population variances for the groups are equal. Sphericity, also called circularity, is not a concern in this design because the repeated measures have only two levels, pretest and posttest.

Correlated observations can have a pronounced effect on Type I error

rate. There is no specific statistical test for the assumption of independent observations, but a discussion of factors which may call the assumption into question for this study is provided in the findings chapter. Normality was assessed by observing stem and leaf plots for each group on the dependent variables and the Shapiro-Wilks statistic although deviation from normality has only a small effect on Type I error (Stevens, 1992).

Violation of the third assumption of ANOVA, homogeneity of variance, has minimal effect on Type I error as long as nearly equal n is maintained. As n becomes substantially unequal, even mild heterogeneity can produce sizable distortions in Type I error rate. Small heterogeneity has an effect on power, even with equal n , with larger heterogeneity producing a more substantial drop in power (Stevens, 1992). The Bartlett Box F and Cochran's C tests were used to determine whether the variances are equal. Plots of the relationship between cell means and variances were also generated to assess the relationship between cell means and cell variances. A proportional relationship between these statistics is another common way the homogeneity of variance assumption is violated. Post hoc estimation of power and determination of actual effect size were also obtained in order to assist in interpretation of study results and inform further research on the effect of Validation Therapy.

Chapter Four

Findings

Descriptive Statistics

Experimental and comparison groups were equally represented on the variable of gender. Fourteen percent of both experimental and comparison groups were male while 86% of experimental and comparison groups were female.

Gender of Subjects

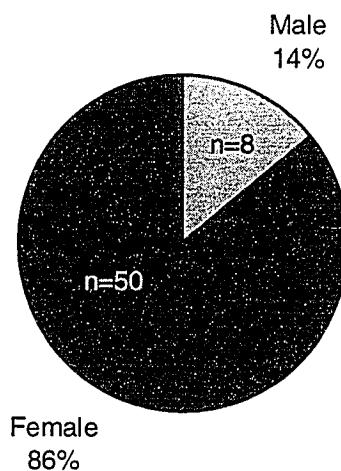


Figure 1

There was no significant difference between experimental and comparison groups on family/staff representation ($\chi^2 = .48, p = .49$).

	Group		Composition
	Experimental	Comparison	(Row Total)
Family	13	6	19 (32.8%)
Staff	23	16	39 (67.2%)
(Column Total)	36 (62.1%)	22 (37.9%)	58 (100.0%)

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. The groups were also comparable in age, with a paired

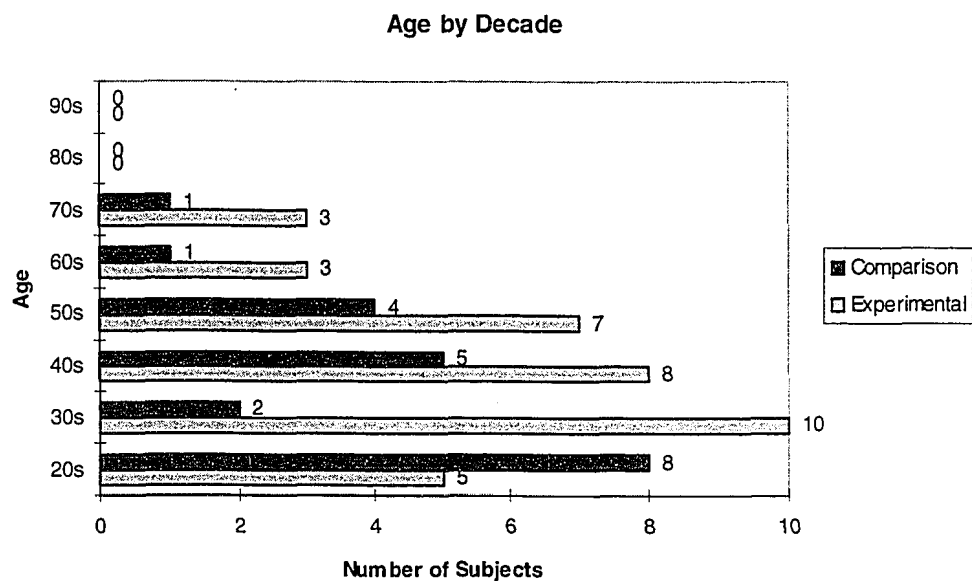


Figure 2

t-test failing to identify a significant difference between experimental and comparison groups on age ($t=.51$, $p=.615$).

Concerning whether they had received prior training in Validation Therapy, the experimental (6%) and comparison groups (5%) were also very similar.

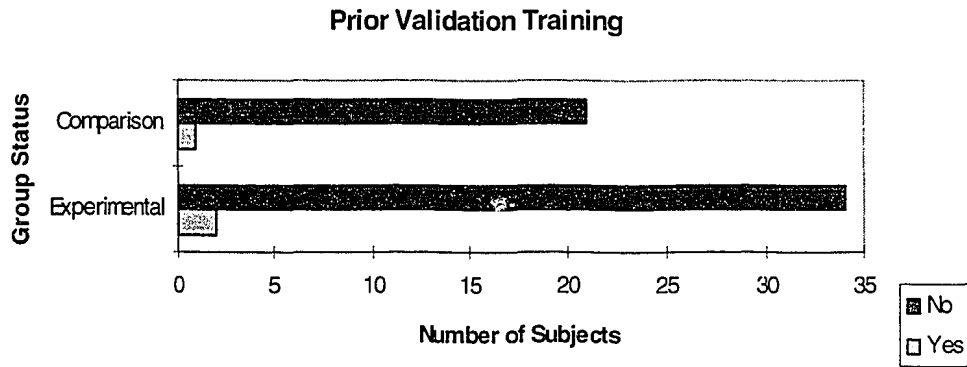


Figure 3

On the variable marital status the experimental and comparison groups were equally divided among those who were divorced or single with nine in each category, but there were twice as many subjects in the experimental group cohabiting (27) than in the comparison group (13).

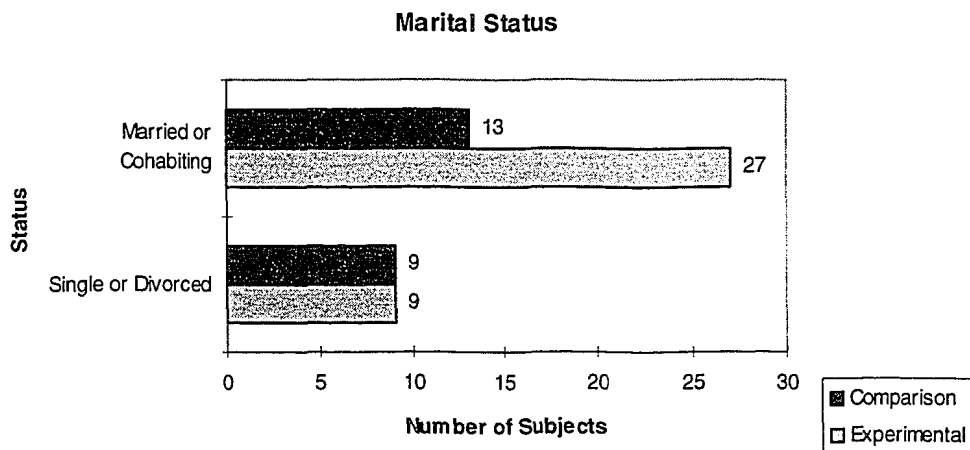


Figure 4

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

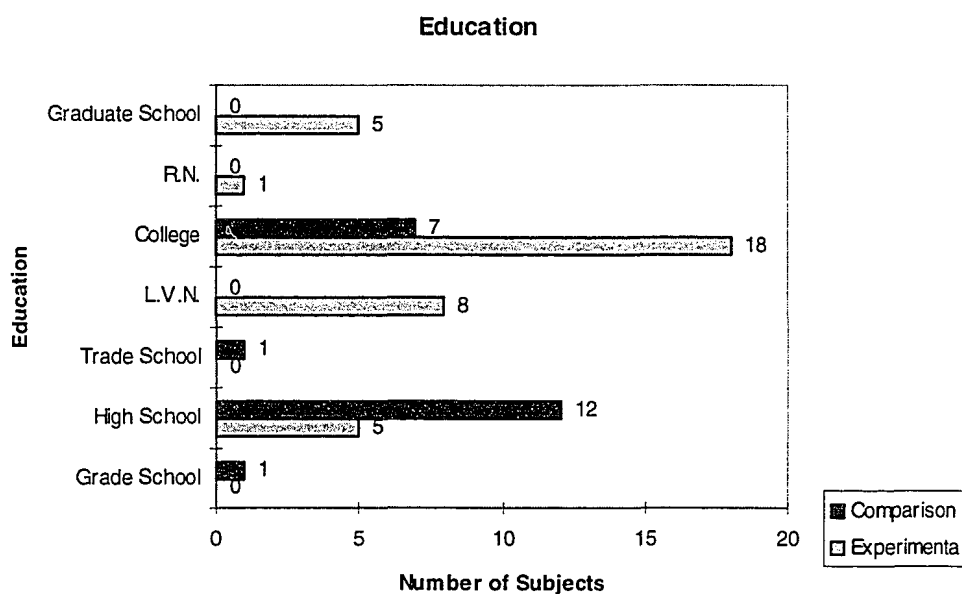


Figure 5

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.

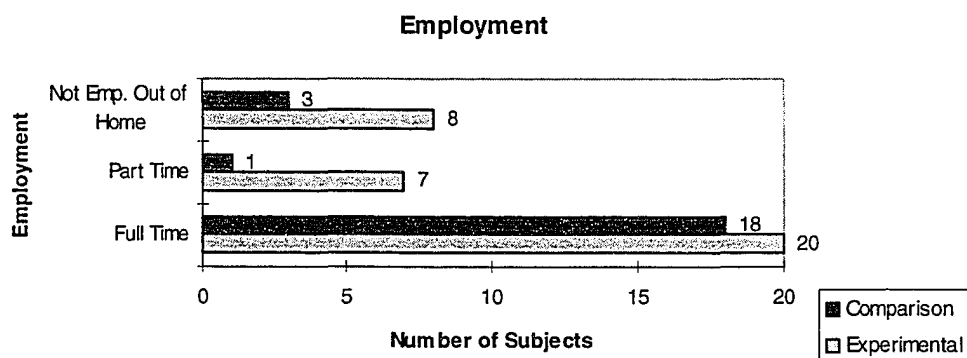


Figure 6

Although not retained for multivariate analysis after the inclusion of staff caregivers, two interesting variables were collected from family caregivers; familial relationship to patient and quality of 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%) one wife (5.3%) and one 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%).

Familial relationship was not evenly distributed between experimental and comparison groups with the largest category, daughters, accounting for

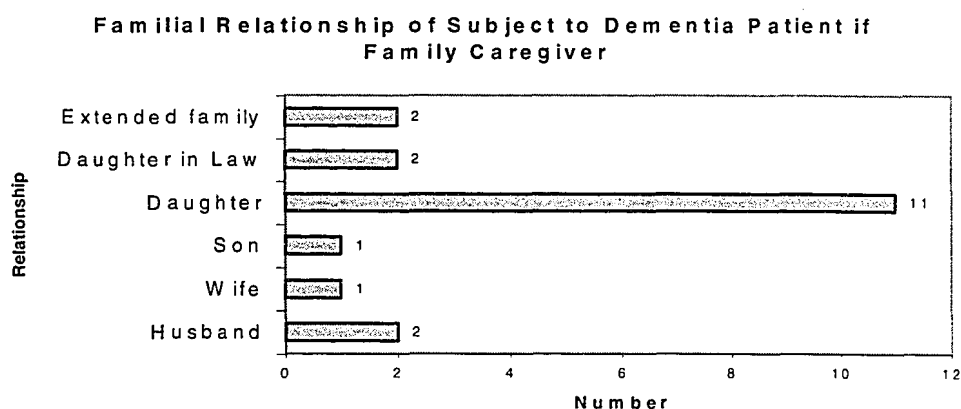


Figure 7

17% of experimental subjects and 23% of comparison subjects. Extended family was represented with one in each group. All other categories, accounting for six subjects, were exclusive to the experimental group.

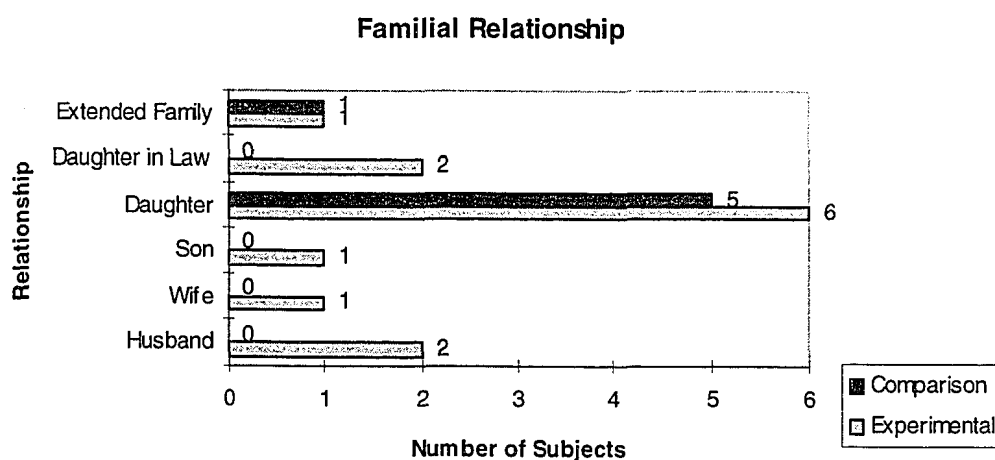


Figure 8

Family caregivers consistently reported positive relationships with confused relatives prior to the onset of dementia. Ninety-four percent of family caregivers reported very good (68.4%) or good (26.3%) relationships

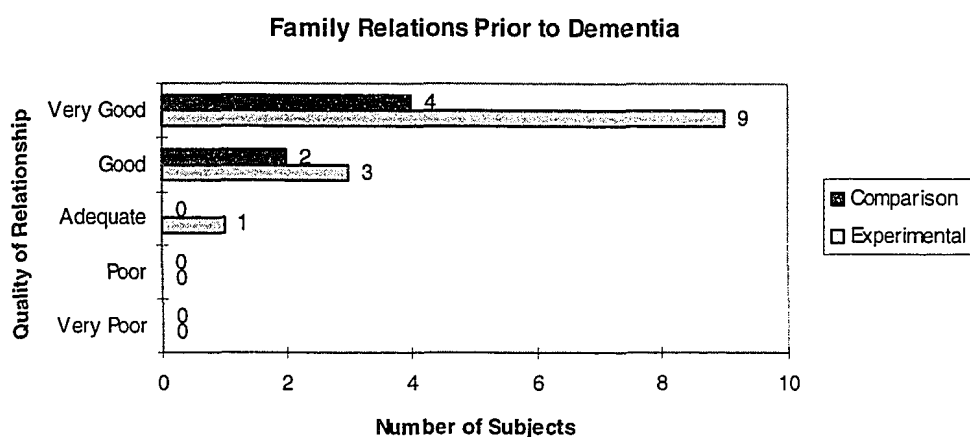


Figure 9

prior to dementing illness. One respondent reported an "adequate" relationship and none reported a "poor" or "very poor" relationship.

Instrument Psychometrics

Although no attempt was made to assess validity of the ICSI instrument with a dementia caregiver population, the modifications specified above in the instrumentation section did not appear to significantly affect its reliability. Alpha coefficients for the pretest and post-test administration of the instrument in this study were .80 and .89, respectively. These scores are in line with alphas reported in other studies using the instrument and both deemed "very good" (Develis, 1991, p. 85).

Table 2 Alpha Coefficients for study instruments

		Pretest	Posttest
ICSI	All Subjects	.80	.89
Validation Skills	All Subjects	.57	.59
DCQRI	Family	.59	.81
	Staff	.58	.56

Alpha coefficients for the DCQRI were 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.

Psychometric properties for the Validation Skills instrument were also marginal. Alpha coefficients were .57 for the pre-test and .59 for the post-test administration.

Factor analysis of both the DCQRI and Validation Skills instrument was carried out to determine if the majority of items for each instrument 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. Several methods are available for primary factor extraction, including two widely used criteria; Kaiser's eigenvalue rule and Cattell's scree test. Both criteria are based on the magnitude of the factors' eigenvalues, which express how much variance the factors explain. The eigenvalue criteria has been found to extract too many factors while, of the readily available, easily performed methods, scree plot inspection has been found to work well (DeVellis, 1991). Based on examination of scree plots for staff pretest and post administrations and family pretest administration of the DCQRI, no meaningful factors could be extracted.

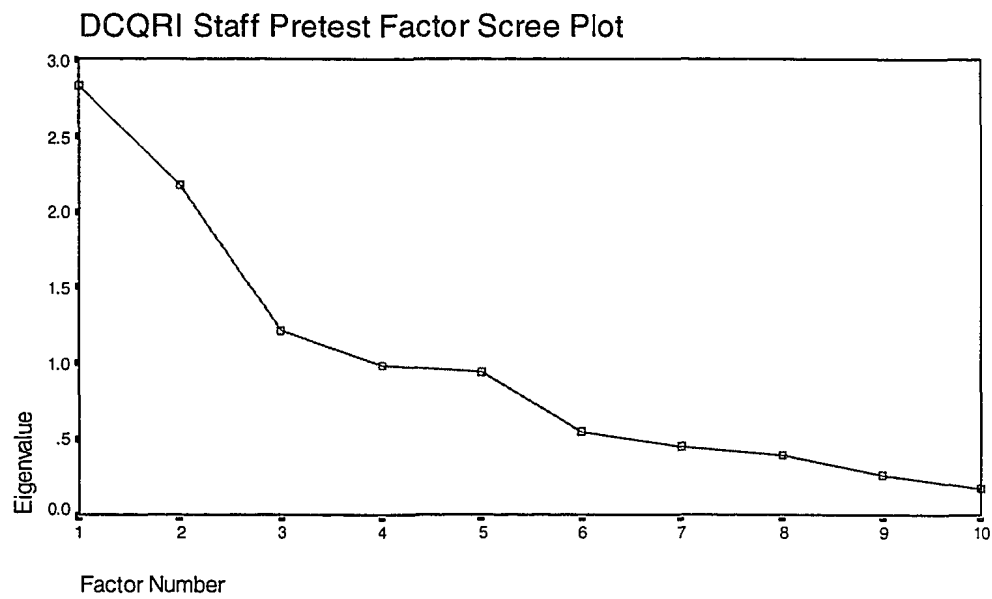


Figure 10

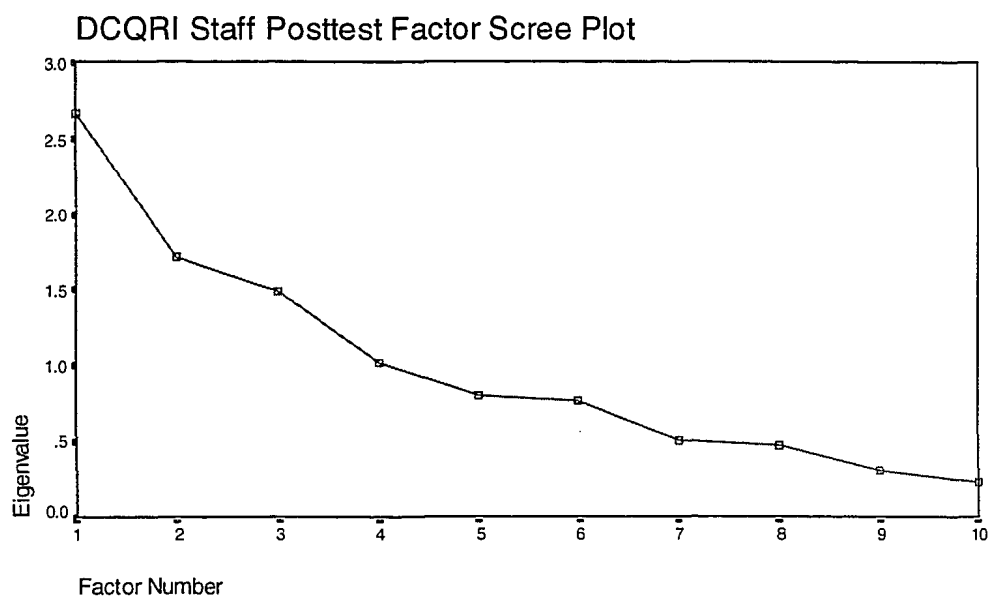


Figure 11

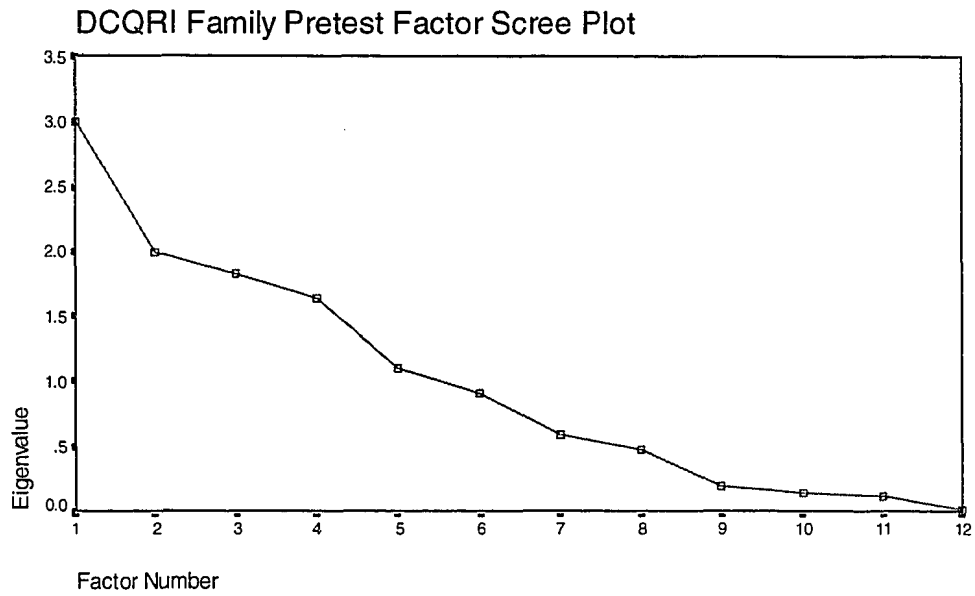


Figure 12



Figure 13

Additionally, no meaningful factors could be identified in the Validation Skills instrument. This indicated that for these particular administrations of each instrument, items were not tapping a single latent variable as desired.

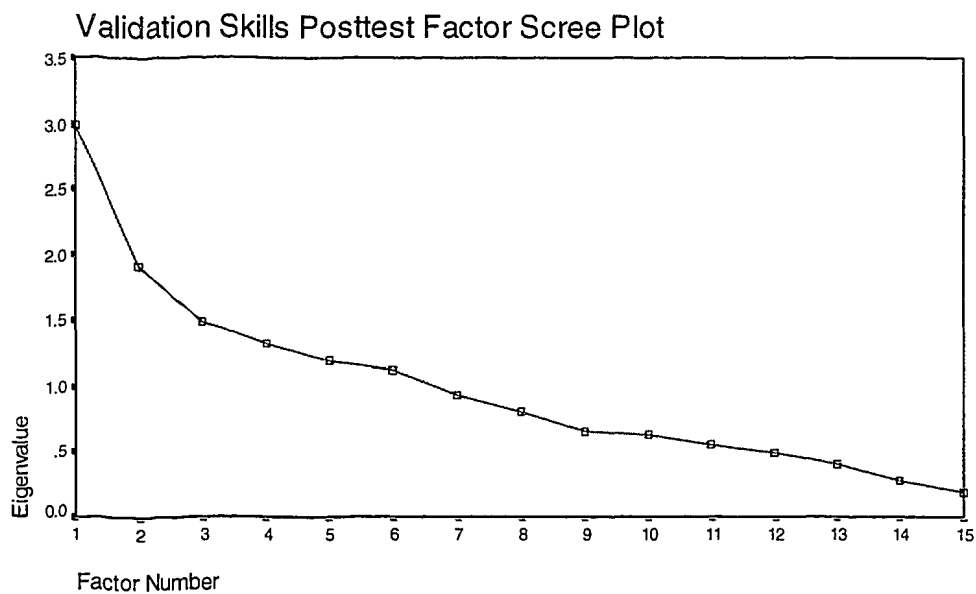


Figure 14

Examination of the scree plot for the family posttest administration of the DCQRI indicated the possibility of at least one meaningful factor, although the elbow of the plot was not as pronounced as desired (see figure 15).

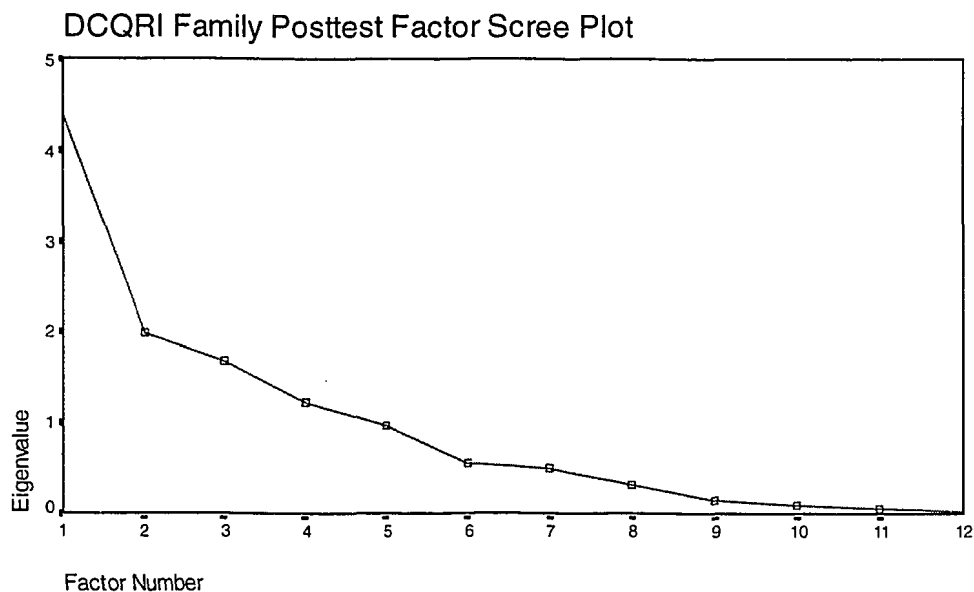


Figure 15

Due to the relatively high values of the scree and the developmental nature of the instrument, the generally more lenient (DeVellis, 1991) eigenvalue extraction method was selected. Of 4 extracted factors, factor 1 accounted for 36.6% of item variance. The remaining three extracted factors accounted for 16.6%, 14.1% and 10.2% of item variance respectively. Varimax rotation of the four factors indicated that four items loaded heavily on factor 1. Item 10 loaded most heavily on factor 1 (.89). followed by Item 2 (.80), item 12 (.65) and item 9 (.55). Inspection of those items revealed that they each target elements of communication, and they are the only items on the instrument which do. Three items, item 1 (.87), item 8 (.84) and

item 6 (.81), loaded heavily on factor 2. Inspection of these items indicated that they appear to be associated with emotional content of the relationship. The words “dread”, “guilty” and “rewarding” are used in these items. Individual items loading heavily on the remaining two factors seem less clear.

Inferential Statistics

Although reliability coefficients for the DCQRI and Validation Skills instrument were marginal and caution should be used when attempting to generalize findings based on these instruments, due to the heuristic nature of this study, they were retained for analysis. Prior to tests of study hypotheses, assumptions for those tests were evaluated.

Tests of assumptions

Correlated observations can have a pronounced effect on Type I error rate and several factors called the independence of observations for the experimental group into question. Although the experimental group did not receive training in a discussion group or group counseling setting, the typical situation where the assumption of independence may not be tenable, it is almost certain that members of the same family and staff from the same

facility who attended training together discussed the content of training.

There was also some interaction between subjects during small group practice sessions that were an element of the training.

The normality assumption was tested with a combination of visually inspecting stem and leaf plots and the Shapiro-Wilks statistic for each cell. All cells passed tests for this assumption.

DCQRI Pretest, Experimental Group			
Frequency	Stem &	Leaf	
.00	2 *		
3.00	2 .	568	
10.00	3 *	0000112223	
15.00	3 .	555556678888899	
5.00	4 *	00114	
2.00	4 .	56	
Stem width:	1.00		
Each leaf:	1 case(s)		
	Statistic	df	Significance
Shapiro-Wilks	.9801	35	.7959

Figure 16

DCQRI Posttest, Experimental Group			
Frequency	Stem & Leaf		
4.00	2 .	5678	
5.00	3 *	02234	
11.00	3 .	55667778889	
12.00	4 *	001122334444	
3.00	4 .	556	
Stem width:	1.00		
Each leaf:	1 case(s)		
	Statistic	df	Significance
Shapiro-Wilks	.9426	35	.0931

Figure 17

DCQRI Pretest, Comparison Group

Frequency	Stem &	Leaf
6.00	2 .	568999
4.00	3 *	0244
7.00	3 .	5567799
4.00	4 *	0114

Stem width: 1.00
Each leaf: 1 case(s)

	Statistic	df	Significance
Shapiro-Wilks	.9630	21	.5595

Figure 18

DCQRI Posttest, Comparison Group

Frequency	Stem &	Leaf
1.00	2 .	6
9.00	3 *	001223344
8.00	3 .	56888999
2.00	4 *	03
1.00	4 .	8

Stem width: 1.00
Each leaf: 1 case(s)

	Statistic	df	Significance
Shapiro-Wilks	.9701	21	.7026

Figure 19

ICSI Pretest, Experimental Group

Frequency	Stem &	Leaf
1.00	Extremes	(2.1)
1.00	2 .	9
3.00	3 *	334
3.00	3 .	889
9.00	4 *	001111344
8.00	4 .	56677889
7.00	5 *	0011114
2.00	5 .	67
1.00	Extremes	(7.0)

Stem width: 1.00
Each leaf: 1 case(s)

	Statistic	df	Significance
Shapiro-Wilks	.9778	35	.7339

Figure 20

ICSI Posttest, Experimental Group

Frequency	Stem &	Leaf
1.00	3 *	2
4.00	3 .	5699
5.00	4 *	11224
3.00	4 .	579
5.00	5 *	00124
8.00	5 .	56678999
6.00	6 *	001113
2.00	6 .	56
1.00	7 *	0

Stem width: 1.00
Each leaf: 1 case(s)

	Statistic	df
Significance		
Shapiro-Wilks	.9545	35
.2679		

Figure 21

ICSI Pretest, Comparison Group

Frequency	Stem	&	Leaf
3.00	3	*	033
2.00	3	.	59
7.00	4	*	0001344
1.00	4	.	8
2.00	5	*	03
6.00	5	.	556688

Stem width: 1.00
Each leaf: 1 case(s)

	Statistic	df	Significance
Shapiro-Wilks	.9351	21	.2311

Figure 22

ICSI Posttest, Comparison Group

Frequency	Stem	&	Leaf
1.00	3	*	4
6.00	3	.	556788
2.00	4	*	04
3.00	4	.	778
3.00	5	*	113
3.00	5	.	558
2.00	6	*	04
1.00	6	.	6

Stem width: 1.00
Each leaf: 1 case(s)

	Statistic	df	Significance
Shapiro-Wilks	.9360	21	.2408

Figure 23

The homogeneity of variance or equality of variance assumption was tested with Cochran's C and the Bartlett-Box F based on the null hypothesis that all population cell variances are equal. Both dependent variables passed these tests of the homogeneity of variance assumption as neither ICSI. (pretest $F = .04552$, $P = .987$; posttest $F = 1.14689$, $P = .329$) or DCQRI (pretest $F = .14158$, $P = .935$; posttest $F = 1.41147$, $P = .238$) statistics warranted rejecting the null hypotheses.

Table 3 Univariate Homogeneity of Variance Tests for ICSI

ICSI Score, pretest		
Cochran's C (13,4)	=	.27797, P = 1.000 (approx.)
Bartlett-Box F (3,2730)	=	.04552, P = .987
ICSI Score, posttest		
Cochran's C (13,4)	=	.38453, P = .260 (approx.)
Bartlett-Box F (3,2730)	=	1.14689, P = .329

Table 4 Univariate Homogeneity of Variance Tests for DCQRI

DCQRI pretest score		
Cochran's C (13,4)	=	.30944, P = .922 (approx.)
Bartlett-Box F (3,2823)	=	.14158, P = .935
DCQRI posttest score		
Cochran's C (13,4)	=	.38462, P = .260 (approx.)
Bartlett-Box F (3,2823)	=	1.41147, P = .238

Another common way the homogeneity of variance assumption is violated is when a proportional relationship between cell means and cell variances exists. This can be identified by plotting cell means against cell variances or standard deviations. The following plots indicate there is no relationship between cell means and variance for the ICSI.

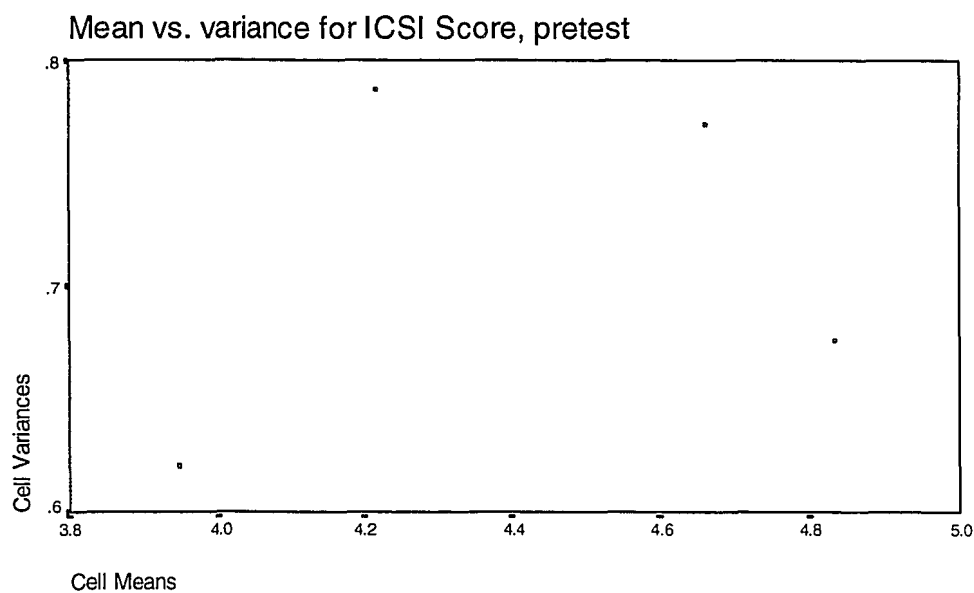


Figure 24

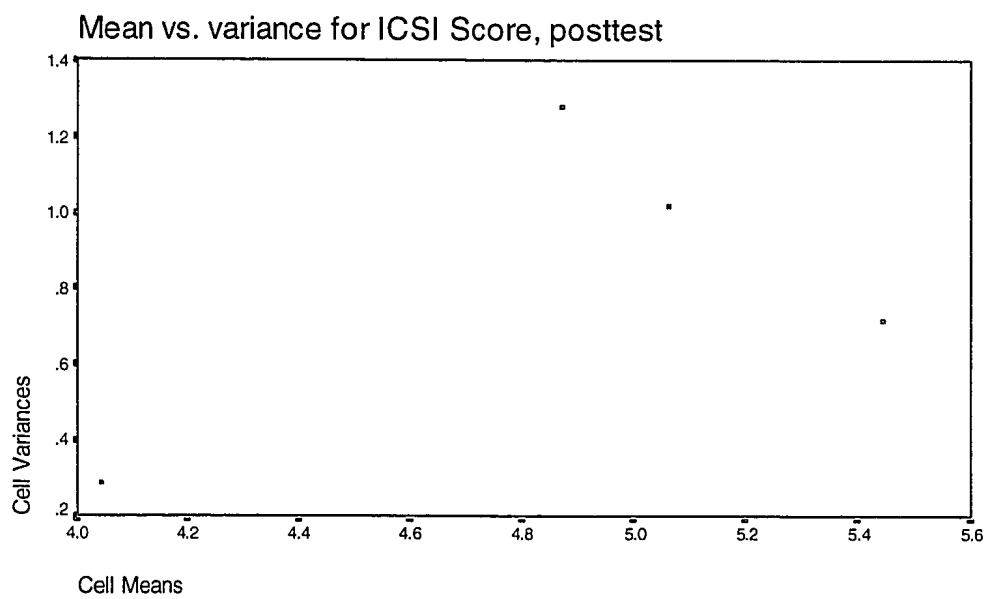


Figure 25

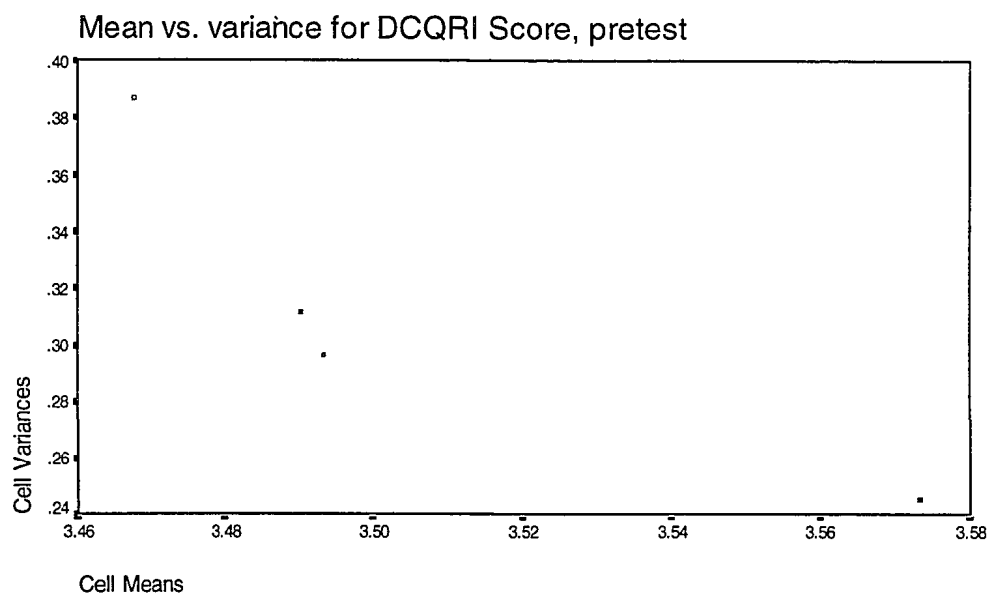


Figure 26

There does, however, appear to be an inverse relationship between the DCQRI cell means and cell variances for the pretest administration of the instrument (see figure 26). Cell means and variances for the posttest administration of the instrument do not appear to be related.

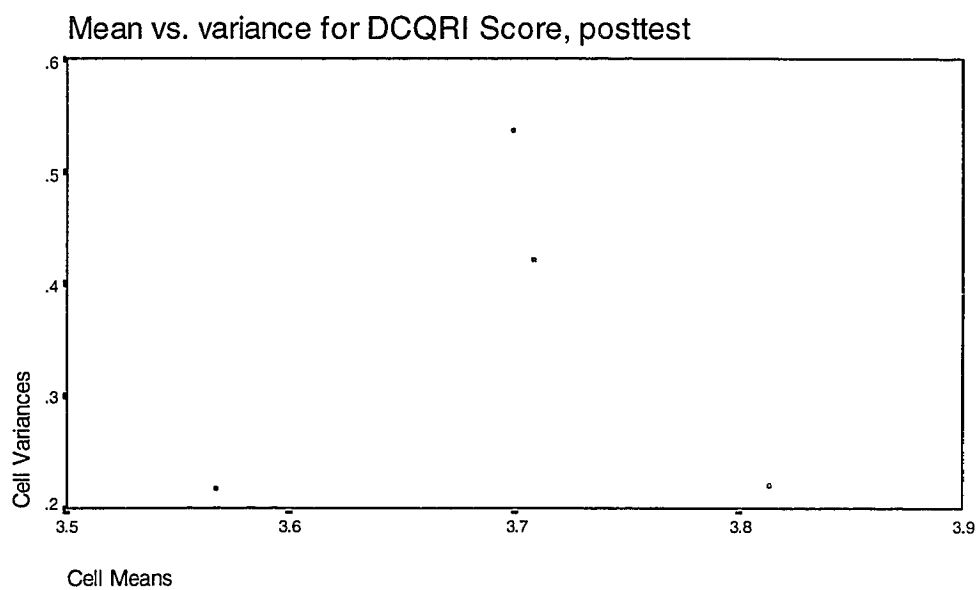


Figure 27

Tests of Hypotheses

Analysis of variance on the ICSI revealed a statistically significant effect for Validation Therapy training on communication satisfaction when

comparing the experimental and comparison groups ($F=4.28$, $p=.04$).

Table 5 Tests of Significance for ICSI with Validation Skills
as a varying covariate

Source of Variation	SS	DF	MS	F	Sig of F
WITHIN+RESIDUAL	22.05	50	.44		
REGRESSION	.40	1	.40	.90	.347
PRE_PST	2.76	1	2.76	6.25	.016
EXP_CONT BY PRE_PST	1.89	1	1.89	4.28	.044
FAM_STAF BY PRE_PST	.16	1	.16	.35	.555
EXP_CONT BY FAM_STAF BY PRE_PST	.01	1	.01	.01	.912

The nonsignificant finding for regression ($F=.9$, $p=.35$) indicates that the covariate may not be useful in controlling for the influence of differing Validation Therapy skills on the between subjects factors, family/staff group membership and experimental/comparison group membership. Based on this finding, a second ANOVA was run after removing the covariate.

Removal of the covariate had the effect of slightly reducing the F value (3.87, $p=.055$) for the effect of the intervention on communication satisfaction, still significant at the established alpha level of .10.

Table 6 Tests of Significance for ICSI *without* Validation Skills as a varying covariate

Source of Variation	SS	DF	MS	F	Sig of F
WITHIN+RESIDUAL	23.78	52	.46		
PRE_PST	4.37	1	4.37	9.56	.003
EXP_CONT BY PRE_PST	1.77	1	1.77	3.87	.055
FAM_STAF BY PRE_PST	.09	1	.09	.21	.652
EXP_CONT BY FAM_STAF BY PRE_PST	.00	1	.00	.00	.989

A plot of pretest and posttest means for the experimental and comparison groups showed that both groups improved on the dependent variable. The experimental group, although slightly lower at the pretest, showed a much greater degree of improvement after the intervention than the comparison group.

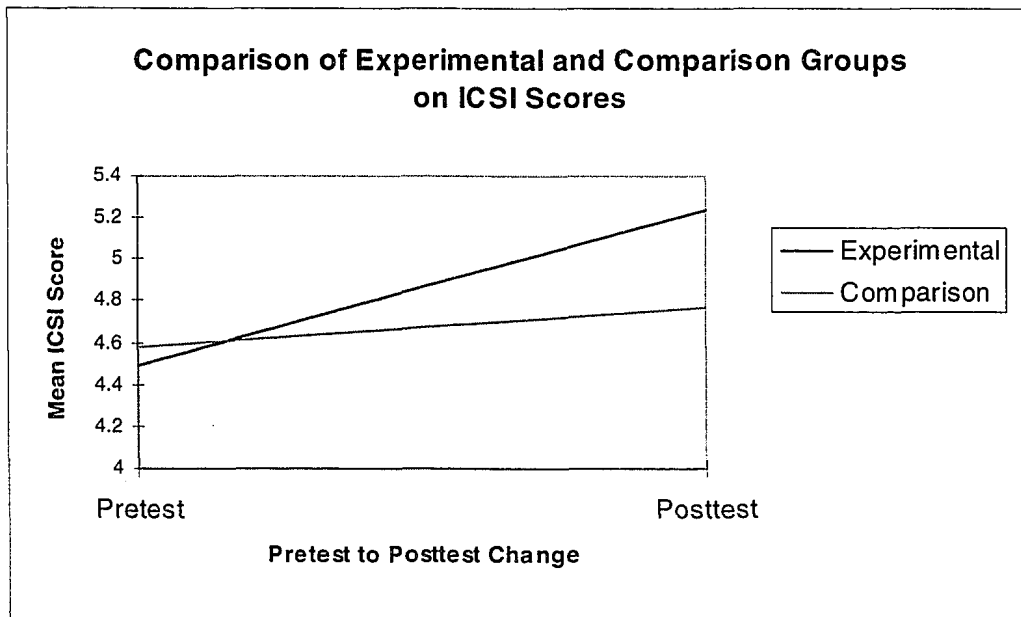


Figure 28

An artifact of this situation, with no practical significance, was a statistically significant effect for pretest to posttest scores independent of experimental or comparison group status ($F=6.25$, $p=.016$). No interaction effect for Validation Therapy training on communication satisfaction and family-staff caregiver group status was found and there was no interaction effect between type of caregiver and experimental or comparison group status. A graph of the mean pretest and posttest scores from the ICSI, however, showed that staff care givers were more satisfied with their communication with dementia patients at both pretest and posttest.

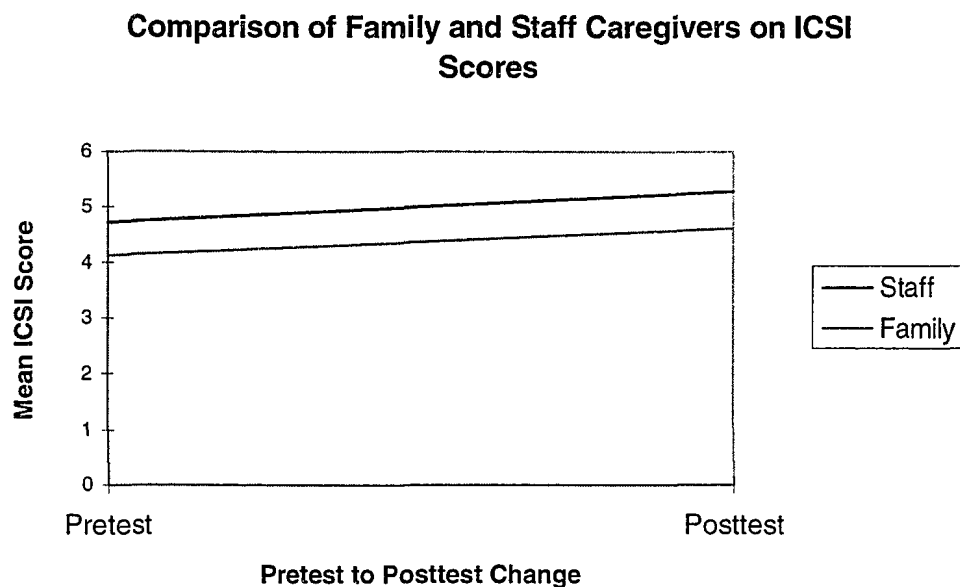


Figure 29

Based on 55 cases used in the analysis with a covariate and alpha set at the .10 level, effect size and power were moderate. Because there are only two levels of the repeated measure, pre and post, the univariate estimate of effect size was used, resulting in a partial eta squared of .08. Cohen (1988) characterizes this score as in the upper range of medium effect size, in line with projected effect size for this study. Observed power based on the fixed effect assumptions was .65, slightly higher than projected.

No significant effect was found for caregiver Validation Therapy training on quality of relationship. There was also no difference in quality of relationship between staff and family groups and interaction effect between type of caregiver and experimental or comparison group status. The F score for regression in this test approaches significance indicating that the covariate may be useful in controlling for the influence of differing Validation Therapy skills on the between subjects factors for the DCQRI. Effect size and power for this test were quite low with a partial eta squared for the intervention effect of .002 and an observed power of .14.

**Table 7 Tests of Significance for DCQRI with Validation Skills
as a varying covariate**

Source of Variation	SS	DF	MS	F	Sig of F
WITHIN+RESIDUAL	6.26	52	.12		
REGRESSION	.42	1	.42	3.50	.067
PRE_PST	.25	1	.25	2.11	.153
EXP_CONT BY PRE_PST	.01	1	.01	.08	.779
FAM_STAF BY PRE_PST	.03	1	.03	.24	.625
EXP_CONT BY FAM_STAF BY PRE_PST	.05	1	.05	.39	.534

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 feeling 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 [with 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."

Chapter Five

Discussion and Recommendations

The positive effect of Validation Therapy training on communication satisfaction for dementia caregivers appears strong based on computed effect size 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 and quality of life for residents and caregivers.

Walker et. al. (1994) emphasize the need for open communication between family caregivers and dementia patients in order to facilitate the completion of unfinished business between caregiver and loved one. Not accomplishing this task has the potential to complicate the grieving process, both before and after death. In light of the current study's indicated improvement in communication satisfaction as a result of Validation Therapy training, future studies assessing the effect of Validation Therapy training on anticipatory grief may lead to useful additions to current intervention strategies.

No significant findings for Validation Therapy's effect on quality of relationship and grasp of Validation Therapy techniques may speak more to the poor psychometric properties of those instruments or the small sample size than the lack of effect from Validation Therapy training. Psychometric properties of the Validation Therapy skills instrument were sufficiently marginal that rethinking the nature of the underlying constructs before further development of an instrument to measure them may be in order. Perhaps a parallel exploration of Feil's belief that knowledge of specific therapeutic techniques may be less important to effective implementation of Validation Therapy than attitudes and interpersonal qualities of caregivers would lead to development of additional items capable of identifying effective validators.

Low reliability of the DCQRI raises concern with respect to generalizability of study findings regarding quality of relationship. Although no experimental effect on quality of relationship was found for this sample, low reliability of the DCQRI and low statistical power would make generalizing those findings to a broader population of caregivers questionable. Marginal reliability of the DCQRI could, in part, reflect the small sample size of the study.

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 a 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.

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. The resulting increase in effect size for such an extensive and intensive implementation of Validation Therapy could provide reasonable power in research with the typically small sample sizes obtainable from dementia caregiver and patient populations.

Several issues bring the generalizability of study findings into question. Due to existing constraints on subject selection, 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 unknown is the extent to which findings from this study, based on caregivers of demented residents in long term care, can be generalized to caregivers of dementia patients in other settings. Training in Validation Therapy may have a different effect for family caregivers providing home-based care or staff caregivers in adult day care. Efforts to assess the composition of the therapeutic milieu in each of the participating long term care facilities may have been beneficial in assessing the extent to which training in Validation Therapy augments other possibly complimentary therapeutic modalities such as reminiscence and music therapy.

A number of procedural and methodological concerns were also present in this study. The possibility of correlated observations arose due to the possibility members of the same family and staff from the same facility who attended training together discussed training content prior to taking the post test. There was also the potential for interaction between subjects during small group practice sessions that were an element of the training. Had the experimental group received training solely in a discussion group or group counseling setting, the assumption of independence would be more suspect. Some interaction between subjects is inevitable as the small group practice in an integral component of the training. In future research it should

be emphasized to the group receiving training that course content should not be discussed outside the training setting.

It is also possible that experimental group members discussed Validation Therapy with comparison group members while in family groups or at work in participating facilities. It is also unknown to what extent the principles of Validation Therapy were incorporated into family groups and staff in-services, although the item asking about prior Validation Therapy training was an attempt to assess this. Contamination may have resulted when a well meaning director of social services presented on Validation Therapy to a family group composed of experimental and comparison group members just prior to the intervention.

The Hawthorne effect was also of concern in this study. The experimental group received more attention from the principle investigator than did the comparison group, in addition to the actual training. In many cases subjects called to get more information concerning the time and location of the training. Prior to the training the principle investigator met with the experimental group to answer questions and assist in filling out the instruments. In many cases the principle investigator never met members of the comparison group as they were recruited and given study instruments by

a facility director of social services. This effect, if any, may have been moderated by use of an attention placebo or alternate intervention.

Comparability of the experimental group and comparison group posttests may have been affected by the delay in comparison group posttest instrument return. Instruments were not logged in as they were returned, and efforts to do so would have been frustrated by the lag between when some subjects turned them into facility directors of social services and when they were collected by the primary investigator. Had the primary investigator logged returns, and enlisted the directors of social services from participating facilities to note the date instruments were returned to them, the effect of late returns could be assessed and possibly controlled for.

Another situation possibly affecting comparability of the experimental and comparison groups resulted from the nature of group assignment. As mentioned in an earlier section, subjects who were available and willing to attend the training sessions were placed in the experimental condition. Subjects who verbalized an interest in attending the training and were willing to complete study instruments, but stated they had a conflicting engagement that precluded their attendance, were placed in the comparison group. It seems likely, at least for some in the comparison group, that the prior engagement was a polite and more comfortable way of declining the offer to

attend training. It could be argued that those who actually made the effort to attend the training, even though it was time limited, were more concerned about their communication and relationship with the dementia patients in their care.

Within the experimental group, some attended the two day workshop and others attended only day. Data was not collected on this, in retrospect, important training intensity variable. In addition to capturing the number of contact hours, a more thorough explication of workshop content and how it differs from the one and two day sessions may be illuminating for future research that uses Feil's workshops for subject training.

Because available Validation Therapy training is necessary for further research, the development of a Validation Therapy training protocol and curriculum is crucial. 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. Greater opportunities for training will in part be based on a widely available training curriculum.

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. Evaluation of a workers use of Validation Therapy principals with residents is currently based on the director of social service's knowledge of Validation principles. 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 care givers come into contact, conflicts surrounding unrealistic expectations regarding long term care may result. Proper admission counseling to clarify family and staff 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 on 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 are crucial. The ICSI, although not used with dementia caregivers prior to this study, appears to be a robust, reliable instrument with this population. Since the DCQRI administration with reasonable reliability also

appeared to target communication in the relationship, rethinking the salient aspects of the construct quality of relationship, and extent to which it is based on satisfaction with communication, may be in order.

An instrument to assess effective Validation of dementia patients by caregivers is perhaps most needed. This may be based on grasp of Validation Therapy skills and concepts or, as Feil suggests, worker attitude and interpersonal qualities. The items developed by Feil, while appearing to have some face validity, are in need of development before they constitute a reliable and valid instrument. Rethinking the nature of the construct or latent variable underlying acquisition of Validation Therapy skills and practice of effective Validation is required before the development and administration of a larger item pool.

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. Further development of the Validation Therapy skills instrument through generating larger item pools, administration to a development sample, and factor analysis is also warranted. Further work on assessing the ICSI for content, criterion, and

construct validity would serve to strengthen it's usefulness in Validation Therapy research.

Measures and protocols for more directly assessing the impact of Validation Therapy on dementia patients are also needed. Due to the difficulty of obtaining meaningful information from dementia patients, this study of Validation Therapy focused on the intervention's effect on caregivers. A parallel situation exists in research on the psychosocial impact of Alzheimer's Disease. While the impact of AD on family and other care givers is substantial and effective care giver interventions are needed, 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).

Although procedurally less demanding pen and paper instruments are probably not realistic for use with many dementia patients, a variety of

observational measures have been used with other populations. Reliance on observing behaviors indicative of stable ongoing improvement in dementia patients is probably unrealistic due to cognitive deterioration associated with the disease process.

In spite of their applicability in research with dementia patients, observational measures in quantitative studies can be methodologically problematic. Sampling behavior by direct observation takes two general forms: Monitoring individuals continuously for a period of time or observing individuals at random times throughout the research period. One recent meta analysis reports that 150 random observations are required for reasonable estimates of the frequency of behaviors, and then only if the following criteria are met: 1.) The number of coded categories is 10 to 15 or below, 2.) The behaviors of interest occur with sufficient frequency, 3.) The accuracy required of the estimate of frequency is less than stringent, and 4.) Fine distinctions between groups or behaviors are not required. The report concludes with a cautionary statement: "The large numbers of observations required for reasonable accuracy are somewhat alarming, and should be taken into account in future experiment design" (Bernard, H. E., 1993, p. 215).

In the absence of well supported studies with the resources to adequately train and field sufficient numbers of observers, and in light of the present scarcity of Validation Therapy research, the generative and emergent nature of more qualitative observational approaches may be more appropriate. Focusing on the quality of specific Validation Therapy based caregiver-patient interactions has the potential to illuminate discreet components of meaningful quantifiable measures.

In addition to qualitative approaches, 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.

Research conducted with dementia patients, rather than caregivers, as subjects raises ethical concerns surrounding the issue of informed consent. These issues are similar, though not identical, to the issues surrounding informed consent concerning medical procedures or other services discussed earlier. In 1978 the National Commission Department of Health, Education, and Welfare produced the Belmont Report, a seminal

document describing three basic ethical principles to guide research with human subjects. These principles are respect for persons, beneficence and justice. Derived from fundamental moral considerations, these principals are applicable to the broad range of human research settings. They also carry implications for evaluation of specific research operations by review committees (Cassel, C. K., 1988).

Respect for persons acknowledges an individuals right to self determination and is the basis for informed consent (Cassel, C. K., 1988). In long term care, particularly with demented residents, obtaining informed consent has several inherent difficulties. "The conditions of valid informed consent are that the subject receive full information, be able to express a free and uncoerced decision, and be able to withdraw with no adverse penalties at any time. All these conditions are called into question in institutional populations where freedom is limited simply by virtue of institutionalization and peer pressures" (Cassel, 1988, p.91, citing Fadden & Beauchamp, 1986). For individuals suffering from dementia, the difficulties of obtaining valid informed consent are compounded by cognitive deterioration and its effect on capacity to consent (Cassel, 1988). Obtaining informed consent from dementia patients is particularly problematic because

cognitive functioning, and hence capacity to consent, may fluctuate (Cohen-Mansfield, Kerin, Pawlson, Lipson & Holdridge, 1988).

"The cognitively impaired seem to have special problems in understanding consent information. This appears so even for the mild to moderately cognitively impaired. Therefore, when health care professionals are faced with consent procedures in the more cognitively impaired, the problems with obtaining a valid consent will be magnified" (Stanley, Stanley, Guido & Garvin, 1988, p. 57). One study of nursing home residents developed a consent process that relied on the social worker and charge nurse of each unit to make an initial decision as to which residents were capable of giving informed consent. The investigators believed that physicians did not have sufficient "acquaintance" with the clients to make the determination of capacity. A final determination of capacity to consent was made by a research assistant trained in social work based on resident comprehension during a discussion of the proposed study. If the research assistant determined that a resident did not have the capacity to provide informed consent for themselves, the primary contact listed in the resident chart was used. Typically, these were the closest relatives or individuals designated by the court in cases where residents had been declared incompetent (Cohen-Mansfield, Kerin, Pawlson, Lipson & Holdridge, 1988).

Despite the procedural, methodological and ethical challenges of studying demented populations directly, significant findings for the effect of Validation Therapy training on caregiver satisfaction with communication is encouraging. As methodology and instruments assessing effect on caregivers are strengthened, a conceptual and methodological foundation for the more challenging task of assessing the effect of Validation Therapy on dementia patients will develop.

That further study of Validation Therapy is needed is clear, however, the findings of this and other studies are encouraging. Social workers working with dementia patients and their caregivers are in a unique position to both implement and study Validation therapy. The inappropriateness of Reality Orientation with this population and Validation Therapy's compatibility with other applicable therapeutic methods, like reminiscence and music therapy, should provide impetus for social workers to seek proficiency in Validation Therapy. Proficiency in the intervention should then be a basis for training both family and staff caregivers and conducting or participating in research on Validation Therapy. The focus of Validation Therapy on systemic intervention and its value base emphasizing dignity and worth of a vulnerable population make it an intervention particularly suited to use by social workers.

APPENDIX

Trinity Lutheran Home

Stacy C. Stidham

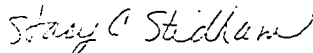
Dear Family Member,

Trinity Lutheran Home is pleased to have Robert Canon, LMSW, conducting his dissertation research in our facility. Mr. Canon is studying the effect of family care giver training in Validation Therapy on satisfaction with communication and quality of relationship with a demented family member. Mr. Canon and Stacy Stidham, Trinity Director of Social Services, have identified your family member as appropriate for, and able to benefit from, Validation Therapy.

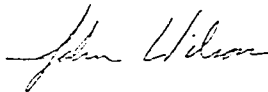
Trinity Lutheran Home is committed to providing the highest level of care possible for our residents. We anticipate that the results of Mr. Canon's research project will assist us in choosing and providing that care. We are pleased to offer you this opportunity to participate in this study as we believe the training you receive can increase your satisfaction with communication between you and your resident family member and improve the quality of your relationship.

If you have any questions contact Stacy at (512) 255-2521

Sincerely,



Stacy C. Stidham, LMSW
Director of Social Services



John Wilson
Administrator

VALIDATION® TRAINING INSTITUTE, INC.
21987 BYRON ROAD
CLEVELAND, OHIO 44122
(216) 561-0357 OR (216) 881-0040

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August 23, 1994

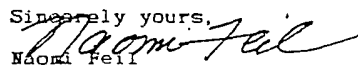
To Whom It May Concern:

Robert Canon, MSW, is currently doing his dissertation research on the topic of Validation Therapy. He has arranged to use my regular Validation Therapy workshops in conjunction with a demonstration of techniques in the extended care facility as the intervention for study subjects.

Additional controlled studies consistent with Validation Therapy principles are needed.

I am pleased with Mr. Canon's efforts to insure faithful implementation of Validation Therapy and fully support his current study.

Sincerely yours,


Naomi Feil
Executive Director

NF:mm

EVALUATING YOUR VALIDATION SKILLS

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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.

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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

Hecht

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.

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

Familiar 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 looses 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. | |
| | <div style="display: flex; justify-content: space-between; width: 100%;"> Very much Somewhat Not at all </div> <div style="display: flex; justify-content: space-between; width: 100%;"> 1 2 3 4 5 </div> | |
| ___2.) | I don't know what to say to my confused family member. | |
| | <div style="display: flex; justify-content: space-between; width: 100%;"> Very much Somewhat Not at all </div> <div style="display: flex; justify-content: space-between; width: 100%;"> 1 2 3 4 5 </div> | |
| ___3.) | My relationship with my confused family member is not satisfying. | |
| | <div style="display: flex; justify-content: space-between; width: 100%;"> Very much Somewhat Not at all </div> <div style="display: flex; justify-content: space-between; width: 100%;"> 1 2 3 4 5 </div> | |
| ___4.) | I don't enjoy interacting with my confused family member. | |
| | <div style="display: flex; justify-content: space-between; width: 100%;"> Very much Somewhat Not at all </div> <div style="display: flex; justify-content: space-between; width: 100%;"> 1 2 3 4 5 </div> | |
| ___5.) | I am as close or closer to my confused family member than before the confusion. | |
| | <div style="display: flex; justify-content: space-between; width: 100%;"> Very much Somewhat Not at all </div> <div style="display: flex; justify-content: space-between; width: 100%;"> 1 2 3 4 5 </div> | |
| ___6.) | I feel guilty when I think about my confused family member. | |
| | <div style="display: flex; justify-content: space-between; width: 100%;"> Very much Somewhat Not at all </div> <div style="display: flex; justify-content: space-between; width: 100%;"> 1 2 3 4 5 </div> | |
| ___7.) | I enjoy time spent with my confused family member. | |
| | <div style="display: flex; justify-content: space-between; width: 100%;"> Very much Somewhat Not at all </div> <div style="display: flex; justify-content: space-between; width: 100%;"> 1 2 3 4 5 </div> | |
| ___8.) | I find some aspects of my relationship with my confused family member rewarding. | |
| | <div style="display: flex; justify-content: space-between; width: 100%;"> Very much Somewhat Not at all </div> <div style="display: flex; justify-content: space-between; width: 100%;"> 1 2 3 4 5 </div> | |
| ___9.) | I have no meaningful contact with my confused family member. | |
| | <div style="display: flex; justify-content: space-between; width: 100%;"> Very much Somewhat Not at all </div> <div style="display: flex; justify-content: space-between; width: 100%;"> 1 2 3 4 5 </div> | |
| ___10.) | I feel like I can 'connect' with my confused family member. | |
| | <div style="display: flex; justify-content: space-between; width: 100%;"> Very much Somewhat Not at all </div> <div style="display: flex; justify-content: space-between; width: 100%;"> 1 2 3 4 5 </div> | |
| ___11.) | At times I feel resentment or anger towards my confused family member. | |
| | <div style="display: flex; justify-content: space-between; width: 100%;"> Very much Somewhat Not at all </div> <div style="display: flex; justify-content: space-between; width: 100%;"> 1 2 3 4 5 </div> | |
| ___12.) | I am able to help my confused family member understand my feelings toward them. | |
| | <div style="display: flex; justify-content: space-between; width: 100%;"> Very much Somewhat Not at all </div> <div style="display: flex; justify-content: space-between; width: 100%;"> 1 2 3 4 5 </div> | |

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

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