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VALIDATION THERAPY

A Review of the Literature

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Validation Therapy (VT) emerged over 25 years ago as a method for communicating with older adults with Alzheimer-type dementia. Naomi Feil, a gerontological social worker and originator of VT, describes it as "the process of communicating with a disoriented elderly person by validating and respecting their feelings in whatever time or place is real to them at the time, even though this may not correspond with our 'here and now' reality" (Vanderslott, 1994, p. 151). The conceptual framework of VT extracts from Rogerian psychology the principle of accepting an individual's right to be unique (Babins, Dillion, & Merovitz, 1988). This method is in stark contrast with Reality Orientation that has been widely utilized by health care providers (Hogstel, 1979) (Table 1). VT is based upon the belief that there is logic behind all behavior. Understanding the meaning underlying the individual behavior, rather than awareness of reality, is the goal in VT (Dietch, Hewett, & Jones, 1989).

Validation is classified into four distinct stages of disorientation. Specific techniques and skills are given to facilitate communication within each stage. These stages include malorientation, time confusion, repetitive motion and vegetation (Feil, 1993). The purported benefits to clients undergoing VT include: a) less regression inward; b) improved speech; c) less crying, pacing, pounding and wandering; d) improved gait; e) more interaction with other people; f) improvement of facial expression; g) smile more and establish eye contact more; h) more effective communication with families; and i) less need for physical restraints or psychotropic medications (Feil, 1993).

In 1980 Alzheimer's disease affected 2.9 million people and Evans, as cited by Scanland, and Emershaw (1993), states the number will continue to increase to as high as 14.3 million by the year 2050. This underscores the necessity to identify all effective strategies of communicating with cognitively impaired clients. Nurses must utilize the most effective intervention based upon the individual client's needs. Therefore nurses working with confused older adults must have an array of proven interventions and techniques. VT is one technique.

PURPOSE

The purpose of this literature review is to examine the research investigations into the effectiveness of VT techniques in communicating with cognitively impaired older adults. Each study will be reviewed in terms of its findings and usefulness for practice. Since its inception there has been little scientific research as to the effectiveness of VT.

TABLE 1
Validation Therapy vs. Reality Orientation

Validation Therapy	Reality Orientation
Explores individual's reality—asks who, what, where, when and how	Reorients to present reality of person, place and time
Emotional Focus	Factual Focus
Subjective Reality	Objective Reality
Respects individual's sense of reality	Confronts factual errors in reality

Long-term care facilities have not been deterred by the lack of research. In the United States, Canada, Europe, and Australia, over 7,000 agencies have implemented it (Feil, 1993). In the Netherlands, implementation was conducted on a large scale basis without regard to research testing of its effectiveness. Reasons stated for early implementation were the enthusiasm of caregivers and the numerous methodological pitfalls of attempting to measure the effects of reality orientation (Van der Kooij, 1993).

LITERATURE REVIEW

The first article proposing the use of VT as an alternative to Reality Orientation appeared in 1967 (Feil, 1967). In 1972, Feil conducted research to measure the response in a VT group. She reported the results in 1992 and noted improvement in "gait, speech, and nonverbal communication." Furthermore she states, "The study group cried less and paced less, resulting in less need for restraints." (Feil, 1992, p. 129). However the research methods and data to substantiate the above claims have never been published. In 1983, the Validation Training Institute was founded. After this time, several articles based primarily on clinical experiences and impressions began to appear in the literature (Feil, 1984, 1986; Morton & Bleathman, 1988; van Amelsvoot-Jones, 1985). These articles stressed pursuing communication without attempting reality orientation. Scenarios were given to demonstrate the manner in which VT could be utilized in clinical practice.

In 1986, Robb, Stegman, and Wolanin conducted the first experimentally designed study to test VT. The purpose of the study was to ascertain the effect of VT on mental status, morale, and social behavior of cognitively impaired older adults. The findings of the single pre- and post-test measurements were nonsignificant for all three variables. However, anecdotal information reported some subjects did demonstrate changes in social behaviors, including an increase in demanding behavior. By the conclusion of the study, the researchers had identified several design problems and reported the results to be severely compromised. Other problems identified include failure to conduct a pilot study, instrumentation problems, attrition of subjects, and difficulty of obtaining informed consent in this patient population. Robb and colleagues (1986) published the findings of their study to provide essential information for possible replication regarding ways to improve study design. The research also provided insight into the difficulty of conducting experimental research in long-term care facilities.

Babins, Dillion, and Merovitz (1988) studied the effect of VT with subjects in stage two, time confusion, and stage three, repetitive motion, of disorientation. They stated Feil had previously reported individuals in these stages appear to benefit more from VT than Reality Orientation. Cognitive, social and behavioral measures were studied. The sample of 12 subjects were divided into a VT group of five and a no-treatment control group of seven. Therapy was conducted for a total of 22 sessions over an 11-week period. Findings were reported by comparing the sum of the scores in the first three sessions to the sum of the scores of the last three sessions. Comparisons between the sum of the first three sessions and last three sessions of the VT group were reported to demonstrate an increase in verbal and non-verbal expression. An increase in irritability scores from 55 to 63 on normalized t-scores was reported. The results must be interpreted carefully since not all of the scales utilized had been standardized. In addition, the small sample size, data being omitted from the middle 16 sessions, and possible lack of instrumentation sensitivity to measure behavioral changes were also problematic.

Morton and Bleathman (1991) conducted a pilot study with five dementia patients to assess the effectiveness of VT in a group setting

upon communication, mood and behavior. The study took place over a period of 40 weeks with comparison of VT and reminiscence therapy. Measurements were obtained: a) upon entry to the study, b) at the end of a non-interventional 10-week period, prior to initiation of VT; c) at the end of the first 10 weeks of VT and again in 10 weeks following completion of VT, prior to reminiscence therapy; and d) at the end of 10 weeks of reminiscence therapy. Two of the subjects demonstrated improvement in social interaction during the period of VT and subsequent decline during reminiscence therapy. One subject demonstrated a contrasting response with improved social interaction during reminiscence therapy and decline during VT. The findings support further research with a larger sample size and equal interventional periods of VT and reminiscence therapy. Controls must be established to allow differentiation as to what extent changes may be due to the therapies or changes in socialization.

VT has been in existence for a quarter of a century but there continues to be very little scientific evidence to support its purported benefits for cognitively impaired older adults.

In 1993, Scanland and Emershaw conducted a quasi-experimental study to determine the effect of Reality Orientation and VT upon the functional status, cognitive status and level of depression in confused older adults. The sample size of 34 was divided into two groups and then subdivided utilizing a non-equivalent control group design. Two-way analysis of the subsamples revealed no differences between the subsamples. From each group, one subsample received VT, and one received RO for a 4-month period at separate points in time. The control group in each subsample received no formal therapy. Analysis of variance between the treatment groups revealed no differences between the Reality Orientation group and VT group. The results supported the findings of Robb and colleagues (1986) that VT had no effect on mental status or morale. A slightly higher degree of depression was recorded in post-depression scoring. This study also indicated that group sessions tended to be labor intensive and attrition was difficult to control. The study's limitations were non-randomized sampling, non-equivalent control groups, inability to control for attrition and sample size. Another criticism of this study is the failure to include the effect of VT upon behavior as previously included in all prior studies.

A quasi-experimental time series design study by Fine and Rouse-Bane (1995) was conducted to determine the effects of VT approaches on cognitively impaired nursing home residents and their caregivers. This is the first study conducted outside of a group therapy setting and provided consistent application of VT techniques for longer periods of time. Fine and Rouse-Bane incorporated the recommendations of Babins and colleagues (1988) by linking specific validation techniques to specific stages of disorientation. Staff members from the dementia unit were taught how to identify the four stages of disorientation and to select the appropriate communication technique for each stage. Pre-training measurements were obtained from staff interventions with a sample of 13 subjects. The measurements included staff's utilization of appropriate technique to client's stage of confusion, and the effectiveness of the technique. Post-training data were collected from interventions with a sample size of 22 subjects. Staff members recorded any interaction with a subject that required the use of a communication strategy in response to a problem behavior. The recording included the specific problem behavior, the approach used, length of the interaction, and the staff's opinion of effectiveness of the approach. "Effectiveness" was defined as an absence of or decrease in the problem behavior after the intervention (Fine & Rouse-Bane, 1995, p. 40). Findings demonstrated an expected increase in staff selecting the appropriate response based on identified level of disorientation from pre-training of 13% to post-training of 80%. The most significant research finding indicated problem behaviors were effectively decreased 73% when the communication technique for the specific confusional stage was utilized. This supports the finding of Babins and colleagues (1988) that linking the specific validation technique to the specific stage of confusion may improve communication. Changes in psychotropic drug utilization also were analyzed. Seven out of 44 residents were receiving psychotrophic medications

TABLE 2

Comparison of Research Studies Investigating Effectiveness of Validation Therapy

Authors	Sample	Variables/Measurement Tools
Robb, Stegman, & Wolanin (1986)	N=20 (male) Mean Age 80 Control: N=16 (male) Mean Age 81	**Cognitive** Mental Status Questionnaire **Morale** Philadelphia Geriatric Center Morale Scale **Social Behavior** Minimal Social Behavior Scale
Babins, Dillion, & Merovitz (1988)	N=5 (female) Age 80-91 Matched Control N=7 (female) Age 80-91	**Social Behavior** Nurses' Observation Scale for Inpatient Evaluation **Cognition and Orientation** Philadelphia Multi-level Assessment Instrument **Stages of Disorientation** Behavioral Assessment Tool
Morton & Bleathman (1991)	N=5 (4 female; 1 male) Mean Age 85	**Verbal Interaction** Short Observation Method for the Study of the Activity and Contacts of Old People in Residential Settings **Communication** Holden Communication Scale **Behavior** MACC Behavioural Adjustment Scale CAPE Behavioural Rating Scale
Scanland & Emershaw (1993)	N=19 Sample A N=15 Sample B Mean Age 76.8	**Mental Status** Mini-Mental State Exam **Functional Status** Katz Index of ADL Evaluation Form **Depression Level** Modified Beck Depression Inventory
Fine & Rouse-Bane (1995)	N=13 Pre-training N=22 Post-training	Not Stated

prior to validation training. One additional resident was receiving psychotrophic medications 5 months post-training. Dose reductions were achieved in 25% of the original sample. This is the first study to explore changes in psychotropic medications related to the use of VT techniques. These findings certainly justify further research. The most problematic limitation of the study cited by the researchers was the inability to make independent, objective observations of resident/staff interactions.

SUMMARY

VT has been in existence for a quarter of a century but there continues to be very little scientific evidence to support its purported benefits for cognitively impaired older adults. The methodological problems of objectively measuring effects and controlling threats to internal and external validity are numerous. Of the studies reviewed, several common problems were identified. One is the lack of appropriate measurement tools in terms of validity, reliability, and sensitivity. None of the studies utilized the same measurement tools for identical variables (Table 2). Other difficulties include: a) the small sample size in one location that meet criteria; b) attrition of subjects related to physical and behavioral factors; c) environmental factors; and d) limited staff and financial resources. Essential to future research in this area is the development of appropriate measurement tools.

Of the studies reviewed, three described negative behavioral changes after the implementation of VT. Robb, Stegman, and Wolanin (1986) stated nursing staff reported an increase in subjects' demanding behaviors. Babins (1988) cited an increase in irritability scores in the validation group. Scanland and Emershaw (1993) reported an increase in post-depression scores after implementation of VT. No conclusions can be made based upon these findings. Further investigation is warranted to determine if similar findings may be replicated with valid and reliable instruments.

The most encouraging findings were those by Babins, Dillion, and Merovitz (1988) and Fine and Rouse-Bane (1995). Improvement in communication was demonstrated when specific interventional techniques were linked with specific stages of confusion. The linking of validation techniques to specific confusional stage warrants further study.

Using VT provides an option in clinical practice to confronting agitated clients and may alleviate the frustration of caregivers due to repeated attempts to reorient clients.

CONCLUSION

Although initial research is promising, there is not an authoritative body of knowledge to support the effectiveness of VT. Fine and Rouse-Bane's (1995) recommendation that VT communication techniques be included as part of the basic curriculum for all health care professionals is not supported by research-based literature. Clearly in an area of research that focuses on human behavior, methodological rigor is difficult to ensure. Even so, the development of a valid body of knowledge is possible through conceptual generality as suggested by Robb, Stegman, and Wolanin (1986). Emphasis must be placed on replication of studies. The pioneering researchers whose studies were reviewed have provided the foundation and direction for future studies. The possibilities for research in this area are numerous but should include: a) applying the technique in long-term care, acute care and community setting; b) changes in psychotropic medication requirements with the implementation of VT; c) assessing the effect of the technique upon the use of chemical and physical restraints; d) assessing the effect of training family and professional caregivers to match interventions to stage of confusion, and e) assessing the effect of the technique on problematic behaviors.

The implications for nursing practice from these initial studies are limited. This is due in part to a lack of conclusive findings in some studies and the small sample size. Even so, the necessity of utilizing individualized approaches with cognitively impaired elders is clear. As Danner, Beck, Heacock, and Modlin (1993, p. 11) so aptly stated "Cognitive changes may be similar in people with Alzheimer's disease, but each person loses abilities differently and each individual responds differently to interventions." VT provides an alternative approach when caring for confused older adults. Using VT provides an option in clinical practice to confronting agitated clients and may alleviate the frustration of caregivers due to repeated attempts to reorient clients.

In spite of all the difficulties in conducting research on the effectiveness of VT, further studies must be undertaken. While this research is underway, nursing must continue to tailor approaches to the unique needs of the individual. An individual does not cease to be unique when they become cognitively impaired.

VALIDATION THERAPY KEYPOINTS

Day, C.R. **Validation Therapy: A Review of the Literature.** *Journal of Gerontological Nursing,* 1997, 23(4):29-34.

1. VT has been implemented in many long-term care facilities with little scientific research to support its effectiveness.
2. Initial research findings indicate linking specific validation techniques to specific stages of confusion may improve communication.
3. The nurse must utilize individualized approaches based upon the needs of the cognitively impaired client.
4. Further research into the effectiveness of VT must be conducted with emphasis on replication of studies.

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