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Validation therapy: A description of the process

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University of Missouri - Columbia, 1992

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VALIDATION THERAPY: A DESCRIPTION OF THE PROCESS

A Thesis

presented to

the Faculty of the Graduate School

University of Missouri-Columbia

---

in Partial Fulfillment

of the Requirements for the Degree

Master of Science

---

by
Elaine Doyle

Alice Kuehn, R.N., C., Ph.D., Thesis Supervisor

AUGUST 1992

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The undersigned, appointed by the Dean of the Graduate Faculty, have examined the thesis entitled,

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a candidate for the degree of Master of Science
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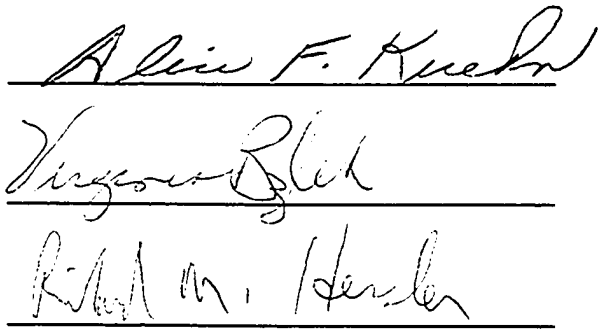

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Thank you to the elderly residents, staff and administrators of the long-term care facility who allowed me to observe. Your interest in quality of care for the aged is refreshing and motivating.

Finally, I thank God for the many opportunities provided me in my nursing career and the challenge to continue to provide quality nursing care to my clients.

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ABSTRACT

This study described the use of validation therapy in one long-term care facility in the rural midwest. An integrative literature review was conducted to provide a comprehensive view of the literature relative to validation therapy. An adjunct literature review of published studies using Orem's self-care deficit nursing theory as a framework for nursing practice with the elderly was also conducted to develop a knowledge base from which to explore the appropriateness of validation therapy for nursing practice.

The study found that a variety of validation therapy techniques were being utilized by certified validation therapists at the study site, most typical of which were exploring, summarizing, life review, and paraphrasing. Residents interacted in the group session, expressing feelings and discussing past life experiences and conflicts. The study supported the appropriateness of validation therapy within a self-care theoretical framework for nursing practice and offered direction for further research.

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CHAPTER I

Introduction

Problem Statement

The purpose of this research was to describe the use of validation therapy in one long-term care facility in the rural midwest. An integrative literature review was conducted to provide a comprehensive view of the literature relative to validation therapy. Validation therapy is a method of communication with the demented elderly 80 years or above. It was developed by Naomi Feil (1989) in the 1960s. The purpose of validation therapy is to assist the demented elderly individual to achieve the goal of reliving past pleasures, resolving old conflicts, and therefore relieving stress (Feil, 1989).

Dementia is now and will continue to be a major clinical problem. Clinicians, patients, and families desire methods to affect behavior of the demented elderly. Dementia afflicts 4% of individuals in the 65-75 age range and 25% of the elderly over age 80 (Carnevali & Patrick, 1986). Kane, Ouslander, and Abrass report that 50-80% of

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the elderly over 65 years living in nursing homes have some degree of cognitive impairment (1989). The incidence of dementia will continue to increase as the number of elderly increases and the number of 80-plus increases.

The basic approach of validation therapy is to acknowledge feelings, current thoughts and concerns of the demented elderly and to accept the individual without efforts to reorient the her/him to current reality. By having feelings, thoughts, and concerns validated, the individual experiences less anxiety and can often cope more readily with reality. Validation therapy consists of several interactive techniques including therapeutic listening, touching, eye contact, recognizing cues about feelings and validating feelings, mirroring body movements, matching voice and rhythm, and empathy. The therapy can be conducted on a one-to-one basis with the individual throughout the day and in weekly group sessions.

There have been no integrative literature reviews or descriptive studies of validation therapy and only a few studies have been conducted to test the efficacy of validation as an intervention. Despite the lack of research validation therapy workshops have been conducted in 26 states in the United States and 11 countries and Feil's book (1989) on validation therapy has been translated into three languages (The V/F Validation Training Institute, Inc. spring 1991 and winter 1992 newsletter). It is important

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that research on validation therapy be conducted to provide clinicians with research-based information to guide their practice. This integrative literature review and descriptive study of validation therapy were intended to add to the research base of validation therapy as an intervention.

Nurses are searching for well-tested theory-based interventions which benefit the demented elderly. Such interventions could then be taught to family caregivers for use at home or implemented in the long term care facility. Validation therapy is one possible intervention. While the developer of validation therapy does not propose the method as a cure for dementia, she believes that the demented elderly will begin to demonstrate less stress and improved cognitive and behavioral patterns as a result of validation therapy (Feil, 1989). This integrative literature review and descriptive study were intended to provide direction for nurses who are considering implementing validation therapy in their practice.

Conceptual Framework

Orem's self-care deficit nursing theory (1990) provided the conceptual framework within which the appropriateness of the use of validation therapy for nursing practice was

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explored. Due to the loss of intellectual functions and memory, the demented elderly individual has a decreased ability to care for self in response to increasing demands. Orem labeled the ability to care for self as self-care agency and the demands to maintain well-being as therapeutic self-care demand (Orem, 1990). When the therapeutic self-care demand exceeds the self-care ability, a self-care deficit exists.

Orem (1990) has identified two types of universal self-care requisites which have relevance for validation therapy: (1) the maintenance of balance between solitude and social interaction and (2) promotion of normalcy in function and development. According to the validation therapy approach, the demented elderly person who is 80 years or over is often withdrawing from interaction and not feeling validated or understood by others as the individual attempts to resolve inner conflicts. The goal of the one-to-one activity and the group sessions is to develop rapport to allow the individual to feel closeness and love, thus encouraging interaction and expression of feelings and thoughts. Attention to promotion of normalcy in function and development in validation therapy can result in enhanced self-worth, and the successful resolution of the conflicts of the past, thus fostering human development.

The second set of self-care requisites which apply to validation therapy are developmental self-care requisites

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which include maturational progress toward a higher level of development. Feil's (1989) final stage of development, resolution vs. vegetation, seems to fit with Orem's (1990) work. The nurse engaged in validating the elderly individual's feelings attempts to promote the process of developmental self-care by assisting the individual to resolve unfinished conflicts of the past or to relive past pleasures. For the elderly, such a psychotherapeutic intervention involves both providing care to prevent deleterious effects of past conflicts and to mitigate or overcome conditions that could interfere with developmental processes during the final stage of life (Orem, 1990).

In validation therapy, the nurse is attempting to enhance the individual's self-care agency, that is, the ability to care for self. Orem (1990) identified power components of self-care agency which include physical, psychological, and social skills critical to performing self-care. In validation therapy, the nurse is attempting to enhance the power component of cognitive, perceptual, manipulative, communication, and interpersonal skills for self-care. The methods by which the nurse assists the elderly client in validation therapy are similar to three of Orem's (1990) methods of assisting, namely supporting, guiding and providing a developmental environment.

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CHAPTER II

Review of the Literature

An integrative literature review of validation therapy was conducted to provide a comprehensive view of the accumulated state of knowledge regarding validation therapy (Cooper, 1982). An adjunct literature review of published studies using Orem's theory as a framework for nursing practice with the elderly was also conducted to develop a knowledge base from which to explore the appropriateness of validation therapy for nursing practice.

A computerized literature search for validation therapy was conducted using the following data bases: (1) Cumulative Index to Nursing and Allied Health Literature (CINAHL) from 1983 to present, (2) Ageline, a data base of geriatric, sociology, and behavioral sciences related to aging, from 1978 to present, and (3) Psychological Abstracts from 1967 to present. A computerized literature search for self-care deficit nursing theory and elderly was conducted utilizing the CINAHL from 1983 to present and Medline from 1966 to present.

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Use of Orem's Nursing Theory as Framework for Practice with Elderly

Several published studies of the elderly based on Orem's nursing theory were found. Using self-care deficit nursing theory, Brock and O'Sullivan (1985) found that old age and lack of a social support network are the distinquishing factors which characterized elderly just admitted to an institution from elderly who remained in the community setting. Chang, Uman, Linn, Ware, and Kane (1984, 1985) used Orem's conceptual framework to study satisfaction with nursing care and the health care practices of elderly women. The patient' participation in the planning of care had the most significant effect on satisfaction with care; widowed marital status, religion, perceived importance of the examination, social network, and preexisting satisfaction with health care had the greatest effect on health care practices. Using Orem's theory of self-care, Sandman, Norbert, Adolfsson, Axelsson, and Hedly (1986) described the behaviors of five patients with Alzheimer's disease and the nurses providing their care. The researchers found that a wide variation exists in the self-care behaviors of the five patients.

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Karl (1982) studied the effect of exercise on the level of independence in self-care functions in elderly patients. Kerkstra, Castelein, and Philipsen (1991) conducted a descriptive study of preventive home visits to the elderly by community nurses in the Netherlands, identifying care to increase the self-care agency of the elderly by giving education or advice. In their study of homeless elderly men, Harris and Williams (1991) found that universal self-care requisites are common to all individuals regardless of age, sex, developmental level, health state, and internal or external conditions.

Jirovec and Kasno (1990) examined the relationship between environmental and personal factors on self-appraised self-care agency of nursing home residents. The authors concluded that self-care agency was affected by race and previous occupation with residents who were black or previously self-employed demonstrating higher self-care agency scores. Residents who viewed the home as encouraging dependence had decreased perception of their self-care abilities. In a descriptive, correlational study, Ward and Bramewell explored the relationship between nurse and elderly client perceptions of the clients' self-care agency. There were significant correlations between: (a) client and nurse perceptions of client's self-care agency; (b) client and nurse perceptions of client's health status; and (3)

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nurse perceptions of client's self-care agency and nurse perceptions of client's health status.

Faucett, Ellis, Underwood, Naqvi, and Wilson (1990) found that data from nursing home care records and interviews suggest that nursing staff using Orem's self-care deficit nursing theory differ in their nursing assessments and goals of care from staff on a control unit. Nurses using Orem's self-care deficit nursing theory are more likely to encourage the resident's self-care abilities. Harper's research (1984) applied Orem's theoretical constructs of self-care to the problem of self-medication behaviors among black, elderly, hypertensive patients. The experimental program initially improved knowledge of medication, perceived control over health, and self-care variables, but the follow-up analysis demonstrated a diminutive effect on these variables.

Conclusion - Literature Review of Orem's Theory as a Framework for Practice with the Elderly

Orem's self-care deficit nursing theory has been utilized as a framework for nursing practice with elderly in several studies. The studies have included describing nursing care needs and health care practices of the elderly, the elderly individual's satisfaction with nursing care and the effects of nursing interventions with elderly

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populations. One study, describing the self-care behaviors of patients with Alzheimer's disease, found that a wide variation exists in their self-care abilities. No studies were found evaluating the promotion of normalcy or developmental needs in the elderly demented patient. No studies of validation therapy and its relationship to self-care deficit nursing theory were found.

Integrative Review of Validation Therapy

History and Description of Validation Therapy

Validation therapy was developed by Naomi Feil (1989), a social worker in Cleveland, Ohio in the 1960s. Feil's (1967) early individual and group work were done at the Montefiore Home for the Aged. Feil observed that reality orientation, a type of therapy in which the individual is reoriented to time, place, date, person, and activities, was not achieving the desired results and began to develop an alternative therapy which was initially called validation/fantasy therapy, but later shortened to validation therapy. Validation therapy has been described most completely in Validation: The Feil Method, first published in 1982. In addition, descriptions of validation therapy were found in several professional journal articles (Babins, 1988; Babins, 1986; Feil, 1990; Jones, 1985).

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Validation therapy has been compared and contrasted with reality orientation therapy in several articles (Bleathman & Morton, 1988a, 1988b; Huckabee, 1990). Reality orientation developed in the 1950s has been the most widely used intervention with demented elderly. Reality orientation therapy can be conducted on an individual or a group basis. The research on the efficacy of reality orientation has been mixed. Burton's (1982) critique of outcome studies of reality orientation with demented elderly patients revealed that reality can sometimes improve orientation, but there is no other behavioral change.

Drawing upon the writings of Rogers, Freud, Maslow, von Frans-Hillman, and Erikson, Feil described basic assumptions behind validation therapy (see Appendix A). Feil (1989) wrote that when the elderly express negative feelings and those feelings are acknowledged and validated by an empathetic listener, the feelings will lessen; but when feelings are ignored or denied, they will increase. Feil emphasized Erikson's belief (Feil, 1989) that each stage of life has a unique task as an individual progresses through the life-span. If a task of one stage of life is ignored or not resolved, it must be addressed at a later stage of life, often creating conflict. She further wrote that as part of the process of attempting to maintain homeostasis, the very old elderly will retrieve well-established early memories to replace lost recent memory.

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Feil explained that behavior that may seem like dementia to the health professional may be the elderly's effort to retrieve early memories. Feil wrote that as eyesight fails, the elderly use the mind's eye to see; when hearing fails, the elderly listen to sounds from the past.

Feil added a final stage to Erikson's list of life stages of development. Feil described the final life stage as resolution versus vegetation (Feil, 1989). She described those elderly who have sucessfully resolved life's conflicts and those who will vegetate by progressive dementia and withdrawal due to incomplete resolution of past conflicts. She offered validation therapy as a method to assist the elderly individual to resolve the conflicts. Feil wrote that while cognitive function may deteriorate in the very old individual, the early emotional learning remains. Feil described this as "seeing with the mind's eye" or using eidetic imagery. As the very old disoriented elderly individual attempts to resolve conflicts, his presenting behaviors and language is often confusing and difficult to understand for the health professionals.

Feil (1985,1989) described four stages of disorientation and identified behavioral characteristics for each stage (see Appendix B). In stage one, labeled malorientation, the individual keeps time, holds onto present reality and is threatened by the possible loss of orientation. In stage two, labeled time confusion, the

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individual does not keep track of time and begins to forget facts, names, and places. The individual in stage three, labeled repetitive motion, shuts out most stimuli and becomes restless and paces. Individuals in stage four, labeled vegetation, demonstrate little movement and do not recognize family and friends.

Feil (1989) reported that reality orientation is more appropriate for stage one individuals as they are attempting to hold on to reality and their orientation; validation therapy is more appropriate for stage two and stage three; stage four individuals respond to touch and sensory stimulation. Validation therapy is to be conducted in groups with the same stage individuals. Feil teaches that Stage one individuals will not benefit from validation therapy because they are denying feelings and maintain social distance in an effort to control their orientation. She further reported that individuals in stage two and three benefit from validation therapy while individuals in stage four do not because they are too severely demented and withdrawn. However, the validity of the behavioral descriptors have not been tested nor has their relationship with valid clinical tools which measure degree of disorientation been determined.

The techniques of validation therapy include verbal and non-verbal approaches. Feil (1989) listed the verbal techniques as follows: paraphrasing, summarizing, life

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review, exploring questions, reminiscing, imagine the opposite, creative solution, listening, observing physical characteristics, matching their preferred sense, and asking the extreme. The non-verbal techniques include mirroring movements, linking the patient's behavior with the unmet need, touch, genuine eye contact, ambiguous pronouns, music and singing. The group techniques are demonstrated in the following films produced by Feil Productions: "Looking for Yesterday," "The Tuesday Group," "The More We Get Together," and "My First Hundred Years" (1978, 1972, 1986, 1984).

The life history is an important part of validation therapy. The life history guides the validation therapist about the individual's losses, past emotional conflicts, perceptions of present reality, and the individual's progress with validation therapy. By having an understanding of the individual's past life experiences such as family, school, and work experiences, the therapist can more readily understand the language and behavior of the demented elderly.

In the film, "The More We Get Together," Feil taught that as often as possible, residents should have roles in the group. Group roles might include welcomer, chairman, and song leader depending on the individual needs and skills. Feil additionally divided a group therapy session into three phases. In phase one, called the birth of the group, the resident welcomes each member to the group.

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In phase two, the life of the group, the topics for each session address basic human needs, including need for love, need for identity, and need to express feelings. Phase three, closing the meeting, occurs with refreshments and closing remarks by the resident hostess/host.

Goudie and Stokes (1989) discussed limitations of validation therapy. First, they did not support Feil's belief that the intellectual thinking in the demented old person is replaced by fantasy in which past events are relived. Second, the authors raised questions regarding Feil's beliefs that the demented old person attempts to resolve unfinished conflicts left from one's youth. Third, they wrote that the elderly demented individual does not have the intellectual and analytical ability necessary for abstract reasoning and fantasy development.

Validation Training Institute and Certification

The Validation Training Institute, Inc. was formed in 1982, with Naomi Feil as executive director (E. Feil, personal communication, June 18, 1992). The institute is a non-profit agency and officers include a president and board of trustees. Membership in the Validation Training Association is available at a nominal fee. Validation therapy chapters have been formed throughout the United

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States, Canada, and many European countries. Members receive a newsletter published at least annually. The format of the newsletter includes a clinical column in which Feil answers questions related to the practice of validation, a listing of upcoming validation workshops to be presented by Feil, a listing of validation activities being conducted by health professionals in their settings, a listing of validation publications and film productions, publication of the bylaws of the Validation Training Institute, and news from validation chapters.

According to Feil (1989), to be effective, validation therapy does not require health professionals; family and care staff can be taught to use validation therapy. An individual may become certified (see Appendix D for eligibility requirements) as a validation therapist by submitting evidence of training and experience in validation therapy, passing a written examination on validation therapy and paying a certification fee to the Validation Training Institute.

The 1991 spring newsletter and the 1992 winter newsletter published by the V/F Validation Training Institute, Inc. (1991, 1992) listed validation therapy workshops being conducted in 26 states in the United States; Ontario, Canada; Saskatchewan, Montreal; Austria; Belgium; Germany; and Australia; England; Norway, Brussels; Finland; the Netherlands; and Nova Scotia. The newsletter further

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stated that Feil's (1989) book, Validation: The Feil Method, has been translated into German and Dutch and was currently being translated into Swedish and French. According to the same newsletter, Validation Associations in Holland, Australia, Austria and France are developing materials to teach validation to health care workers.

Research on Validation Therapy

There has been little research conducted on validation therapy. Most of the findings are anecdotal case reports and evaluation methods based on clinical experiences and impressions. There have been three experimental studies published, but all with small sample size. The first study, conducted by Peoples (1982), involved 31 residents. Reality orientation, validation therapy and a no-treatment control group were compared using a behavioral assessment tool. Developed from the clinical observations of Feil, the Behavioral Assessment Tool was used to determine the stage of disorientation, but has not been standardized or shown to have reliability or validity. The results indicated that the validation therapy group improved in control of bodily functions, improved communication skills, decreased aggressive behavior and increased responsiveness. The

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residents in the reality orientation group showed no improvement.

In comparing a validation therapy group and a no-treatment control group, Robb, Stegman, and Wolanin (1986) found no differences with respect to mental status, morale, and social behavior. Mental status was measured with the Fishback's Mental Status Questionnaire; morale was measured with the Philadelphia Geriatric Center Morale Scale; and social behavior was measured by the Minimal Social Behavior Scale. Thirty-six residents, who were 60 years and older and moderately to severely disoriented and free of documented neurological disorders causing dementia, were randomized to a validation therapy group and a no-treatment control group. Robb discusses the problem of small sample size common to this type of research; Robb was able to identify only 36 participants to randomize from a population of 398 residents in the long-term care facility.
Mitchell (1987) described the verbal response of 15 elderly residents to validation therapy techniques. Mitchell audio taped three different sessions over a two week period in which the researcher used validation therapy techniques. The tapes were analyzed for expression of feeling by the residents. Mitchell found that there was a significant positive correlation between the investigator's use of validation techniques and the extent of the resident's

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self-disclosure. The amount of self-disclosure did not vary based on the resident's disorientation.

Babins, Dillion, and Merovitz (1988) conducted a study of 12 residents with the same stage of disorientation, comparing a validation therapy group and a no-treatment control group. The study included 22 sessions over a 11-week period. The researchers rated the individuals with the Nurses Observation Scale for In-Patient Evaluation (Nosie-30) to measure social behavior and a Group Observation Form used by the therapist after each validation therapy session to record observations of talking in group, making eye contact, touching, smiling, showing leadership and physically participating. The results showed no changes in cognition, but there were some social changes, including an increase in ability to express verbally and nonverbally in the validation therapy group. The NOSIE-30 showed that irritability scores increased and the researcher suggested that the increased irritability was due to the discussion of conflict. The retardation subscale showed that validation therapy had been effective in slowing general mental deterioration, while the deterioration in the control group continued.

Bleathman and Morton (1990, 1991) conducted a pilot study of validation therapy using a single-case study design with five elderly persons over a period of 40 weeks. Baseline measurements were obtained over a 10-week period

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prior to any treatment. Validation therapy was then conducted with the group for 20 weeks, followed by reminiscence therapy for 10 weeks. A variation of the Short Observation Method for the Study of the Activity and Contacts of Old People in Residential Settings was used for data collection. With this method, the observer recorded all verbal contact, including the length of interaction and who initiated the contact, utilizing a small battery-driven device attached to an earplug which beeped at the end of each 10 second interval. Care staff who were blind to the study completed the Holden Communication Scale, the MACC Behavioural Adjustment Scale, CAPE Behavioral Rating Scale at intervals before, during and after the intervention sessions. The group sessions were recorded on audio tapes; three were recorded on video.

Data was available on three residents as one resident died after 23 weeks and another resident did not attend all group sessions. Two of the residents showed marked increase in time spent in interaction and initiated the interaction more frequently after the validation group session period of 20 weeks. The same two residents decreased their interaction and frequency of initiating interaction during the subsequent reminiscence therapy. The third resident decreased interaction during the validation therapy period and increased interaction during the reminiscence therapy period. The assessment data completed by the nursing home

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staff showed no significant change in resident interaction before, during or after the validation treatment period. Bleathman and Morton (1990) reported that the tape recordings yielded interesting data currently being prepared for publication. Based on improvement in two residents, Bleathman and Morton concluded (1990) that validation therapy is a treatment of great potential.

Analysis of Integrative Review and Conclusions

Naomi Feil developed validation therapy as a clinical strategy to work with the demented elderly. The method is based on psychodynamic theories and can occur individually or in groups. The method appears at a time when health care workers are struggling with increasing numbers of demented elderly and desire a clinical tool for appropriate intervention. Validation therapy has received wide acceptance which is evidenced by the development of the validation therapist certification process, the establishment of validation therapy chapters, and the presentation of educational programs throughout the United States, Canada, and Europe.

However, little research on the efficacy of validation therapy exists. Those studies which have been conducted have had small sample size and mixed results. No descriptive studies have been conducted. Descriptive studies of the validation therapy process are needed to

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provide data regarding the use of validation therapy with various groups and in various settings. Data from such descriptive studies would assist to clarify and further develop the conceptual framework of validation therapy.

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CHAPTER III

Methods

Design

Using a qualitative case study design, this study described the use of validation therapy in one long-term care facility in the rural midwest. Previous studies have not described in detail the process of validation therapy in a long-term care setting. Such a qualitative case study design can provide a foundation for the understanding of validation therapy and can point the way for experimental designs to test the efficacy of validation therapy.

Operational Definitions

In this study, validation therapy is the weekly group process of communication between social workers and demented elderly residents in one long-term care setting in the rural midwest. The purpose is to recognize and support the feelings of the residents.

In this study, demented elderly are those individuals, ages 78-89, who demonstrate loss of intellectual functions

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and memory of sufficient severity to cause dysfunction in daily living and have scored five or less on Pfeiffer's Short Portable Mental Status Questionnaire (SPMSQ) during the course of the study at one long-term care facility.

Procedure

Verbal consent was obtained by the researcher several months prior to the study from the administrator of the facility and director of the social work department for participation in the study. Permission to conduct the study was obtained from the Institutional Review Board of the University of Missouri, Health Sciences Section, prior to the onset of the study. Verbal consent to respond to the Short Portable Mental Status Questionnaire was obtained from each resident immediately prior to the first group session. The Short Portable Mental Status Questionnaire was also administered at this time by the researcher.

Immediately prior to the first group session, verbal consent was obtained by the researcher from the social workers who conducted the validation therapy group and the unit charge nurse who was responsible for the daily nursing care of the nursing home residents. Verbal consent to observe the group sessions was also obtained from the residents immediately prior to the first group session. The level of orientation required for this consent included the resident acknowledging the presence of the researcher

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and recognizing that the researcher was observing the group and recording the group process.

The ongoing validation therapy group sessions lasting approximately one-hour were observed by the researcher one time per week for four consecutive weeks. The researcher sat in one corner of the group session room, several feet from the group. Field notes of the verbal and non-verbal interaction of the group were recorded by the researcher in shorthand and typed a few days after the session.

Immediately following each therapy group session, the researcher interviewed individual residents and the two group facilitators (without residents present) and took field notes to further identify data relative to the validation therapy process, such as the techniques of validation and the resident's and facilitator's response to the validation process. Any questions which the researcher had regarding the group session were clarified.

The researcher also interviewed the unit charge nurse, taking field notes, after each validation therapy group session to gain nursing's perspective on the needs and behavior of resident group members and to explore the process of validation therapy used by the nursing personnel.

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Research Instrument

Pfeiffer's (1975) Short Portable Mental Status Questionnaire (SPMSQ) was used to determine the level of dementia (see Appendix E for questionnaire and scoring). The SPMSQ was administered just prior to the first group session to the residents who were participating in the weekly group sessions. Reliability and validity has been established in previous studies by Pfeiffer (1975). The SPMSQ had test-retest correlations of .82 and .83 for two groups tested at four-week intervals (Pfeiffer, 1975). In terms of validity, the SPMSQ was significantly correlated with clinical diagnosis of organic brain syndrome in two study groups and significantly correlated with psychiatrists' clinical evaluations of the presence or degree of chronic brain syndrome (Kathn, Goldfarb, Pollack, & Peck, 1960).

Patient records were reviewed to identify demographic data, record of validation plan, and resident response to validation therapy. All of the data was recorded, utilizing a coding system to avoid identifying the resident, social worker, nurse or long-term care facility by name.

Description of the Setting

The setting for the study was a 200-bed residential and intermediate long-term care facility in the rural midwest.

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A private, comfortable room near the social worker's office was the site for the validation therapy sessions. Validation therapy was provided by social work staff on a one-to-one basis and in weekly group sessions. Ongoing continuing education on validation therapy is provided for nursing personnel and the orientation of new nursing personnel include education about validation therapy. Nursing staff are encouraged to utilize validation therapy as a communication tool with the residents as other nursing care is provided. The nursing staff was not conducting validation therapy group sessions; a validation therapy group conducted by social work staff was observed for this study.

The validation therapy group facilitators were two female social workers who were certified validation therapists; one with nine years experience employed at the facility and certified as a validation therapist for 18 months; the other had five years experience employed at the facility and was certified as a validation therapist for three years. The training of the two social work staff members has been on the job experience in the social work department of the long-term care facility; neither of the social workers had a degree in social work.

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Selection of Subjects

The study group included the following: (a) seven caucasian female nursing home residents, ages 78, 82, 83, 84, 86, 87, and 89, living at a 200-bed residential and intermediate long-term care facility in the rural midwest who were participated in an ongoing therapy group; (b) two social workers who conducted the therapy group; and (c) the unit charge nurse responsible for the care of the selected residents. One of the study residents, age 84, died after the second group session.

Eligibility criteria initially established excluded residents with dementia resulting from neurological disorders and residents with a history of psychiatric illness. Upon arrival at the study site, the researcher found that one of the residents currently participating in the group had a diagnosis of organic affective syndrome with a combination of paranoid ideations, depression and confusion. It was determined that to study the process of validation therapy as it was conducted at the long-term care facility, the criteria needed to be modified. The revised criteria reflected the seven caucasian women currently participating in the group without consideration of diagnosis. Therefore, the selection criteria did not exclude history of psychiatric illness and history of neurological disease. Final eligibility criteria for inclusion in the study included the following: (1) verbal

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consent for participation in the study and (2) current participation in the ongoing validation therapy group sessions at the study site.

Data Analysis

Field notes were analyzed for common themes and patterns descriptive of validation therapy described by Feil (1989). The following categories (see Appendix G) emerged:

1. Validation Techniques
    a. Verbal Validation Techniques
        ambiguous pronouns
        asking the extreme
        creative solution
        exploring
        feeling words
        imagine the opposite
        linking behavior
        life review
        matching the preferred sense
        paraphrasing
        summarizing
    b. Non-verbal Validation Techniques
        caring body language
        mirroring
        music and movement

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2. Group Processes

   group facilitation

   phases

   roles

   topics

To establish the reliability of the code, a second registered professional nurse coded one group session. The second nurse had several years of experience with validation therapy and care of the elderly and was blinded to the study and the study site. The second coding was matched to the researcher's coding. The codes matched 85% of the time.

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CHAPTER IV

Results

This chapter describes the use of validation therapy being conducted at one long-term care facility in the rural midwest. Following the results of the mental status questionnaire, a description of the format of the validation therapy group session is reported. A description of the techniques, with examples of their use in the group sessions, and a rank order of the frequency of use of each validation technique is listed for each session. Each session is described, identifying unique characteristics of that session. Data from the interviews with the social work facilitators and unit charge nurse and the record review are reported.

Results of mental Status Questionnaire

The level of intellectual impairment of each resident involved in the validation group was determined by

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administering the Short Portable Mental Status Questionnaire. With 10 being a perfect score, the scoring on the SPMSQ is as follows:

8-10 correct answers - intact intellectual function
6-7 correct answers - mild intellectual impairment
3-5 correct answers - moderate intellectual impairment
0-2 correct answers - severe intellectual impairment

Two of the women had severe intellectual impairment; five women had moderate intellectual impairment according to the SPMSQ. The scores on the Short Portable Mental Status Questionnaire were as follows:

Number of Residents	correct answers	Level of Intellectual Impairment
2	2	Severe Intellectual Impairment
4	3	Moderate Intellectual Impairment
1	4	Moderate Intellectual Impairment

Description of Validation Therapy Process

General Format of Validation Therapy Group Sessions

Each group session followed approximately the same format. The group met one time per week for 60 minutes from

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10 AM - 11 AM in a sunroom which was comfortable and private. The individuals sat in a close circle as Feil described (1989), with the residents either in their wheelchairs or chairs.

Contrary to Feil's (1989) suggestions, the validation therapy staff at the study site considered two facilitators to be more effective than one, with one facilitator playing the primary role and the second facilitator assisting as needed during the session. The two facilitators sat across from each other in the group to divide the group equally on each side of them.

Most of the residents in the group were classified by the facilitators to be stage one, mildly disoriented. The facilitators stated that contrary to Feil's teachings they have found stage one individuals to benefit from validation therapy. Feil (1989) states that stage one individuals deny feelings and "need to express deep past conflicts in disguised forms" (p.30). She believes that validation therapy group is not helpful in stage one because the stage one individual is threatened by expressing feelings (Feil, 1989). However, when questioned, the facilitators offered no clear criteria by which they determined the stage of each resident. Using Feil's (1989) behavioral descriptors of each stage, the researcher would have classified most of the residents as stage two.

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Group sessions were divided into three phases as outlined in the film, "The More We Get Together," (1986). In the first phase, the facilitator asked a resident to welcome the group, giving the role of welcomer to a resident. In the second phase, the group proceeded to a specific topic previously selected by the facilitator or to the concerns and interest of the residents. The closing phase included the facilitator announcing that it was time to end the group and asking the residents if they would like to meet again. Topics for discussion for the next meeting were solicited. The facilitator asked a resident to close the session. Refreshments were then served to the residents by the group facilitators prior to the residents returning to their rooms.

Roles which the residents assumed included welcoming the group and closing the group sessions, and song leader. Roles for group members were not used as extensively as advised by Feil (1989).

During the group sessions, patients were not reoriented to reality. For example, when Mrs. D. stated, "My mother and father are still living," the facilitator stated, "Your mother and dad are both living. You would like to see your mother and dad."

One group session included a song at the end of the group session with the group members holding hands. Dance and movements were used less than is described in Feil's

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method. The facilitators adapted the dance and movement portion of validation therapy to meet the needs of the community as the community of residents was uncomfortable with dance. Fewer roles were utilized than Feil describes and demonstrates in her films on validation.
A resident welcomed each group and another resident closed each group.

Rank Order of Validation Techniques

The field notes were analyzed for common themes and patterns which are descriptive of validation techniques and group processes listed by Feil (1989). The field notes were coded to identify the validation techniques and group processes. Validation techniques observed during the study period are listed in Table 1 in rank order of total frequency per session. Group processes observed during the study period are listed in Table 2 in rank order of total frequency per session.

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Table 1

Validation Techniques
Listed in Rank Order of Frequency per Session

Technique	Frequency per Session			
	1	2	3	4
Exploring	14	30	27	46
Summarizing	3	22	5	16
Life Review	5	10	18	0
Paraphrasing	6	8	3	13
Feeling Words	1	8	2	2
Caring Body Language	4	3	3	2
Imagine the Opposite	1	0	0	7
Linking Behavior	0	1	3	2
Ask the Extreme	0	1	0	1
Creative Solution	2	1	0	0
Music, Movement	0	0	0	1
Ambiguous Pronouns	0	0	0	0
Mirroring	0	0	0	0
Matching the Preferred Sense	0	0	0	0

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Table 2

Group Processes
Listed in Rank Order of Frequency per Session

Group Processes	Frequency per Session 1	2	3	4
Group Facilitation	7	12	11	11
Phases	5	4	4	3
Roles	3	2	3	3
Topics	2	0	2	0

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Description of Validation Techniques / Group Processes

Validation Techniques Most Commonly Observed

Exploring was the most commonly used technique by the facilitator in each session and included who, what, where, and when questions to encourage the resident to communicate. For example, "what happened to make you feel sad?" encouraged a resident to communicate further about her sad feelings. When Mrs. W. stated that she had a husband at home, instead of reorienting her to the fact that her husband had died several years previously, the group facilitator asked an exploring question, "Do you miss your husband?" to encourage her to discuss her loneliness.

Summarizing was the second most commonly used validation technique. At times the facilitator would summarize a large amount of information which had been expressed by the resident; summarizing was a technique which provided the resident an opportunity to confirm or deny the information and to reflect on the total picture. When Mrs. D. described her life of helping her family, the facilitator summarized by saying, "Sounds like you were a very dedicated daughter and sister and have given a great deal to help them." In another example, as Mrs. W. was grieving over the illness and subsequent death of her young daughter and

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expressing concern if she had had too many expectations of her daughter, the facilitator summarized for another resident, "Mrs. W. was talking about being a mother and she had some questions about being a mother.

Life review, a validation technique used by the group facilitator to encourage a review of past life history, was used extensively. For example, questions by the facilitator such as "Do you have any funny or happy memories of your mother you would like to share with the group?" or "What kind of man was your father?" encouraged the elderly to review memories of their parents. Life review of the topic of mother was encouraged for one group session; the topic of father was encouraged for another.

Paraphrasing was a technique in which the facilitator restated what had just been said in another form which demonstrated to the resident that the information had been heard and respected and encouraged the resident to further explore the memories. As Mrs. W. described the many things her son does to assist, the facilitator paraphrased her statements by saying "Your son takes care of you."
In another example of paraphrasing, Mrs. G. stated that her mother was present when each of her children were born.
The facilitator responded, "She was there to support you in those times."

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Validation Techniques / Group Process Less Often Observed

Group facilitators may use "feeling words" of the universal feelings, such as sadness, happiness, or guilt, to elicit expression of feelings by the resident. Examples of this technique from the sessions observed by the researcher included the following: "Do you think it helps to cry when you feel sad?" or "When your mother died, you felt sad and lonely." The resident was encouraged to go on to further express the feeling.

Imagine the opposite is a validation technique described by Feil (1989) to encourage the resident to consider the reverse situation. For example, "What would you do if the day ever came that you needed help with things?" or "As you look back over your life, is there anything you wished would have been different about it?" Encouraging the resident to consider the opposite facilitated the resident's further exploration of the memory.

Caring body language was a technique used by the facilitators. As a resident was tearfully describing the death of her mother, the facilitator leaned forward and gently touched her knee in a caring manner. As another resident described the many losses she had experienced in her life, the facilitator placed her arm around the resident's shoulders. The caring body language technique by

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the facilitator demonstrated empathy and encouraged the resident to go on.

Topics for the group session, identified as a technique for this study, centered around subjects that would encourage life review and encourage expression of problems, concerns, and feelings. In one group session, the topic was mothers, in another it was fathers. Two sessions began without a topic being selected but flowed with the topics of concern to the residents. The group session on mothers was started with a poem about mothers that was read by the facilitator. The poem facilitated the residents' discussion of memories of their mothers.

By using the technique of asking the extreme, the faciliator encouraged the resident to consider the bad, worst, or best parameters of a feeling or situation. The technique encouraged the resident to explore the topic further. In one group session when Mrs. D. was discussing her childhood experiences, the facilitator asked Mrs. D., "Can you think of a time when it was especially happy?" In another session, as the facilitator was encouraging the group to discuss the difficulty of giving up their homes and moving to the long-term care facility, she asked, "What is the worst thing about giving up your home?" The group members quickly responded to this technique by discussing inherent stresses related to this loss.

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Linking behavior was the technique being demonstrated when the facilitator noted Mrs. D.'s sad affect and commented to the group, "Mrs. D. looks sad today". Using this technique, the facilitator observed the resident's behavior and stated the most likely feeling and unmet need being associated with the behavior. The resident responded by describing her feelings of sadness.

Validation Techniques Described in the Literature but not Observed

The use of the techniques matching the preferred sense, ambiguous pronouns and mirroring were not observed by the researcher in the sessions she attended.

Group Facilitation - Group Process

The facilitators often used a group facilitation technique common to group process, but which is not specifically labeled by Feil. The group facilitators would often encouraged group interaction by repeating what one resident had said to another resident. This assisted the resident who might have a hearing deficit and emphasized a point to encourage communication among group members. For example, "Mrs. S., did you hear what Miss D. said? She feels like she worked all her life and feels like she has lost all of it. What do you do when you get to that point

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in your life? -- people you love are gone. How do you keep going?" This technique is not specifically labeled by Feil, but is a common group facilitation technique.

Observations of the Validation Group Sessions

Session One

All seven residents were present in the first session observed. The most commonly used validation technique was exploring. After a resident welcomed the group as the facilitator requested, the facilitator read a poem about mothers and asked the group to share about mothers. Six of the seven members did share memories of their mothers; no member talked about her own role as mother. Discussion ranged from expressing love for their mothers to describing their experience with their mother's dying.

Session Two

Five of the seven residents were present for the group session; two were absent due to minor illness. While one social worker was the primary facilitator, the two social workers had near equal amounts of participation in session two. There was no established topic for this session. After a resident welcomed the group as requested by the facilitator, the facilitator began the session by using the

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techniques of linking behavior and feeling words, stating, "Miss D. looks sad today." Miss D. began to cry and shared problems related to her childhood. The interaction flowed from this point with the facilitator focusing on feelings of sadness and loneliness and coping skills of caring and love. Other group members expressed caring comments to Miss D. All five of the group members present participated.

Session Three

All seven of the group members were present. The topic for the session was fathers. The facilitator asked if the group members would share some special memories about their fathers. Five of the seven residents shared memories of their fathers, describing fishing trips with father, father's occupation, father's discipline, and love for father. Mrs. W., who had been especially quiet in the two previous sessions, talked about her father. Miss D. became tearful as she talked about her father. The primary facilitator, sitting between Miss D. and Mrs. A., demonstrated caring body language to each as she continued to encourage interaction of group members.

Throughout the session, Mrs.A. continually held her head and neck in a severely hyperextended position, appearing very uncomfortable. Other group members commented on how uncomfortable Mrs. A. appeared. The facilitator often comforted her with touch and asked her if she was

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sick. The second facilitator participated frequently while the primary facilitator was busy comforting either Miss D. or Mrs. A.. Mrs. A. made no response during the session, but had her eyes open throughout. She died that evening of a massive stroke.

During the interview immediately following the group session, the primary facilitator stated that there seemed to be less energy in the group on that particular day. The facilitator stated that it might be related to the gloomy, rainy weather.

Session Four

When Miss. D. was asked to welcome the group, she said, "No, I can't think." The facilitator stated, "Miss D. says she doesn't feel like opening the group today. Mrs. G. would you open the group today?" Mrs. G. welcomed the group. The facilitator asked each of the group members how they felt and gave each resident an opportunity to respond. A topic was not introduced by the facilitator; the interaction flowed with the concerns of the residents and focused primarily on moving to the long-term care facility, "giving-up" their homes, and the desire to stay independent. All seven of the residents were very dependent on others for their daily care.

Mrs. D., who never had children, mumbled for the first time in the session when another resident said to her, "Then

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you have children." Miss D. became tearful as she talked about her life experiences. All of the group members participated.

The death of Mrs. A. was not mentioned by the facilitators or the residents. Mrs. W. became very tearful, expressing sorrow over the death of her 10 year old daughter, which had occurred 40 years ago, and guilt regarding her expectations of her daughter's behavior. The session ended with holding hands while singing a song.

The Staff

Results of Interviews with Social Work Group Facilitators

The social workers indicated that knowledge of residents past life experiences was a strong advantage in conducting validation therapy. Their knowledge of the patient's life history had come almost exclusively from interaction with the resident. The description of Miss D.'s life history as reported by the social workers was a good example. "Miss D. started having many losses as a small child." Her father was sick and eventually died when she was approximately 10 or 11 years old. Other family members subsequently died when she was young. After her sister's death, Miss D. cared for her sister's three children.

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She worked hard with many chores on the farm. As a young adult, she worked in a laundry and lived with an elderly couple, caring for them. Miss D. never married. She had two boyfriends at different times, but "one liked the bottle too much".

Using their understanding of residents' life histories and interactions with the residents, the social workers demonstrated an understanding of the residents' feelings. The facilitator who had developed a relationship with Mrs. A. stated, "She is angry all the time." She went on to explain that Mrs. A. was angry at life and for having to be at the long-term care facility.

The facilitators stated that most of the residents in the group were stage one with a few who fluctuated between stage one and two of Feil's stages of disorientation. The facilitators explained that Feil doesn't recommend validation therapy with stage one individuals, but that they have found that stage one individuals can benefit from validation therapy. No other clinical tools to determine degree of dementia were used. When asked how demented a patient was, the facilitator referred to the resident's stage of disorientation.

When the facilitator went to get one of the residents for the group session, the resident said I can't go today. I'm not clean today. Rather than the facilitator responding, "You are clean, you have a nice dress on, let's

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go," she said, "What do you need to be done so you would feel clean to go?" The facilitator explained that this approach gave the resident choices.

The facilitators reported that interactions center around universal feelings, such as love, hate, fear. While the facilitators routinely asked the residents what they would like to talk about at the next session, the residents did not identify a topic. Examples of topics chosen by the facilitators included mothers, fathers, experiences rearing their children, work, and school experiences. Comparing their methods with Feil, the facilitators stated that "Feil tries to keep it more on one subject than we do. Patients set the agenda to a great extent--can't control the group."

When asked how they know if they are getting positive results from validation therapy, the facilitators reported that residents become more relaxed, facial expressions are more relaxed, residents become more honest with feelings, begin to solve problems and have suggestions for each other.

Results of Interviews with Unit Charge Nurse

The purpose of the interviews with the unit charge nurse was to gain nursing's perspective on the needs and behaviors of resident group members and to explore the process of validation therapy used by the nursing personnel. Nursing's observations of the resident's behavior before and

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after group and throughtout the day and night was sought to gain further understanding of the resident's response to the validation therapy group sessions. However, the interviews with the unit charge nurse yielded little information.

An additional purpose for the interviews with the unit charge nurse was to maintain a relationship with nursing service. Since the researcher was a nurse conducting research for a nursing degree and the group facilitators being observed were social workers, it was felt that the interview was important to create and maintain relationships with nursing service throughout the data collection phase.

There were impressions gained from the interviews with the unit charge nurse. The nurse discussed the residents with a knowledge of their diagnosis. She verbalized more awareness of diagnosis than the social workers. She stated that Miss D. had experienced 2-3 strokes and demonstrated much paranoia.

The nurse gave an example of difficulty in therapy with Miss D. "The staff can't validate Miss D. very well. She becomes more agitated, doesn't trust you very well when you try to validate." The unit charge nurse further explained, "there just isn't enough time to use validation." The nurse explained that continuing education in validation therapy for new nursing personnel was provided at least once/year but usually three times per year in one hour sessions. None of the nurses is a certified validation therapist.

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The Records

The purpose of reviewing the records was to identify whether validation therapy was part of the treatment plan and whether the response to validation therapy was recorded. The general care plan, nursing care plan, and care plans for dietary, social service, and the activities department were in the resident's charts. Feelings, losses, and communication were often cited as problems/needs and validation techniques were often cited as possible interventions. The care plans of social service consistently cited validation techniques and the resident's response to validation.

The emphasis in the record was on level of memory, level of disorientation, and ability to express thoughts, feelings, and conflicts. For example a goal for Mrs. W. included, "Resident will maintain her current level of memory and response for the next 90 days." Planned actions to meet the goal included (a) using life review, (b) using validation to explore her thoughts, asking who, what, when, and where, and (c) inviting her to validation group sessions.

The arrangement of the plan of care included the date of writing the plan, a list of short-term goals, a list of plans to meet the goal, and a brief narrative review of the plan completed at a later date. For example, Mrs D.'s plan first written on 5/6/91 included the short-term goal that

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resident will feel less stressed and have less confusion in 90 days. The plan included identifying triggers, such as boredom or loneliness, that cause resident's stress and anxiety and explore ways to reduce those triggers. The review completed 9/9/91 stated, "Continue care plan. Still has stress and anxiety and feelings of powerlessness."

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CHAPTER 5

Discussion and Summary

Analysis

The Process of Validation Therapy

Meaningful communication appeared to be occurring in the validation group sessions observed in this study. Facilitators created an environment in which residents participated and shared past conflicts, stresses, and problems. Eleven validation techniques, as coded in this study, were used by the facilitators with four being used the majority of the time. It may be that facilitators became comfortable with select validation techniques or found that the selected few techniques used repeatedly were most effective. Perhaps an increased utilization of various validation techniques, such as imagining the opposite, linking behavior, asking the extreme, creative solutions, ambiguous pronouns, music and movement, matching the preferred sense, and mirroring would result in more effective validation of resident's thoughts, concerns, and feelings.

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It was not clear in this study if validation therapy assists the elderly to achieve the goal of resolving old conflicts and relieving stress as Feil proposes. However, basic to mental health maintenance, is the principle that an individual with unresolved conflicts must first recognize and express the conflicts. Having another individual listen to those feelings and concerns in a caring and supportive manner is therapeutic and critical to their resolution. It is possible that group interaction facilitated by social workers was affected by the presence of the observer, such that what occurred does not accurately reflect the process of validation. However, residents seem to ignore the presence of the observer within a short time after her initial arrival. The facilitators did not appear to lead the group differently with the researcher present compared with the researcher's review of videotapes of group sessions taped several months previously at the study site; the videotapes demonstrated similar use of validation therapy techniques and group interaction.

In this study there was a significant discrepancy noted between the level of dementia determined by the SPMSQ and the stage of disorientation identified by the facilitators. Most of the participants were classified by the facilitators to be in stage one of Feil's disorientation, a mild or early stage of dementia, and others were identified by the facilitators to fluctuate between stage one and two.

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However, the researcher found two of the participants to be moderately intellectually impaired and five participants to be severely intellectually impaired based on the Short Portable Mental Status Questionnaire.

There are several possible explanations for this lack of relationship between the SPMSQ and Feil's stages. First, the residents may not have been accurately categorized by the facilitators and would have been more appropriately categorized in stage two or stage three of Feil's stages of disorientation. Second, the mental status as determined in this study by the SPMSQ may not have accurately reflected the true level of intellectual impairment of the resident. Third, Feil's stages of disorientation with the applicable behavioral characteristics may not have accurately reflected the progression of dementia in the elderly. Fourth, Feil's stages of disorientation had little relationship to standardized mental status tools such as the Short Portable Mental Status Questionnaire. Finally, the stage of disorientation may not have been an appropriate criteria for selecting individuals for validation therapy.

It is possible that the residents in the present study did not have the intellectual capacity for abstract thinking and reasoning to resolve past conflicts, the goal of validation therapy. For example, the facilitator commented, "Mrs. W. is hard to reach. She seems to observe everybody. She is denying so much of her past conflicts." Mrs. W's

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mental status score was three, however, indicating that she had moderate intellectual impairment, possibly preventing her from analyzing past life experiences and resolving conflicts. As Goudie and Stokes (1989) emphasize, the elderly demented individual does not have the intellectual and analytical ability necessary for abstract reasoning and fantasy development.

Feil (1989) stated that anyone can provide validation therapy whether social worker, nurse, family member, or nurse aide. This is good news in the long-term care setting, where few professionally educated staff are available.

Opportunities provided to the elderly are often based on expectations of the client's performance (Yuric, Spier, Robb, Ebert, and Magnussen; 1989). Individuals with less nursing and medical education, such as family members and social workers, are not as likely to have the skills to test level of dementia and to understand the role of pathology in dementia and may, as a result, have high expectations of the resident. The health professional with the knowledge of dementia and the mental status score, may lower his/her expectation for the resident inappropriately. Since individuals often strive to meet the expectations of others, the result may be less functional behavior than could have been possible.

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The findings have limited generalizabiliby to other patient populations. The study was conducted in a rural midwest long-term care facility. The study included only female participants. It is likely that the process of validation therapy will vary in different parts of the country, in different settings, with both male and female residents, and with different therapists and different limitations and resources. The study was limited due to the sample size of four observations over a four-week period and the researcher being the sole observer.

Level of Support for Validation in the Setting

There was much support for the implementation of validation therapy in the social service department of the long-term care facility in the present study. Nursing staff did not demonstrate a strong support and application of resources to validation therapy. The unit charge nurse stated that there was not enough time to do validation and that validation can cause patients to be upset and angry. However, it may be that commitment and support for validation therapy in nursing service in this setting would be enhanced if key nurses were prepared as certified validation therapists as has occurred in social service.

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There are many concerns about the quality of care and the nursing shortage which exists in long-term care. There is one registered nurse for every 49 patients in nursing homes (Yurick et al., 1989). Unfortunately, as a result of the shortage of professional nurses, registered nurses in long-term care facilities often spend more time with high visibility tasks and procedures such as baths and medication administration and too little time with therapeutic interaction with patients. There are many reasons for this misdirection of nursing resources. First, registered nurses and the nursing personnel with whom they work often have limited time to provide a psychodynamic intervention, such as validation therapy due to inadequate personnel resources; the tasks such as bathing, feeding, clothing, and administering medications require the majority of the 24-hour nursing day. Ideally, nursing personnel provide therapeutic interaction while providing high visibility care, such as baths and medications.

Second, the impact of profit-making on the quality of care in long-term care influences how nursing functions are valued by administrators (Yurick et al., 1989). Tasks and procedures are often more highly valued by administrators and department heads because those activities are essential to the operation of the facility, and therefore, are given higher priority. The low visibility task of patient interaction is often less valued and given lower priority.

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Third, nurses often become more comfortable with tasks and procedures, not developing and maintaining the psychotherapeutic skill component of nursing care. The lack of skill in and confidence with psychotherapeutic interventions results in nurses referring psychosocial problems to other departments, such as social service.

Administrators and directors of nursing in long-term care who communicate the value of therapeutic nurse-patient communication create an environment where nursing personnel believe that sitting with the patient to talk is valued and worthwhile. Validation therapy can be conducted as the nurse performs tasks throughout the day, but will often require more time given to the nurse-patient relationship. An environment which supplies adequate personnel to perform the high-visibility tasks makes it possible for therapeutic communication to occur with the elderly residents. Long-term care administration who give permission and set the expectation that nurses will conduct group sessions and one-to-one individual sessions will result in a therapeutic milieu for communicating with the elderly.

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Validity of Placement of Validation Therapy Within the Self-care Deficit Nursing Theory

As with any clinical intervention, nursing must question the appropriateness of the validation therapy intervention for nursing practice. Nursing theories, such as Orem's self-care deficit nursing theory, can provide direction to the nurse in choosing to implement new clinical interventions, such as validation therapy. Validation therapy will be discussed within the framework of self-care deficit nursing theory to consider its appropriateness for nursing practice.

The variety of validation therapy techniques demonstrated in the group session are consistent with Orem's (1990) methods of assisting which include supporting, guiding and providing a developmental environment. The group interaction itself contributes to meeting the universal self-care requisite of maintenance of balance between solitude and social interaction. Too often in long-term care facilities the resident becomes withdrawn and socially isolated. The facilitators in this setting do encourage social interaction and the formation of a group community.

It is not known from this study if the self-care requisite of promotion of normalcy in function and development was met with validation therapy as patient outcomes were not studied. However, the mental health

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assumption that social interaction enhances normal function and development would apply. It would appear that the group environment created by the group facilitators would facilitate the promotion of appropriate age and stage growth and development to meet the developmental self-care requisites. Whether or not validation therapy facilitated the progression through a final stage of development of resolution vs. vegetation as suggested by Feil could not be determined on the basis of the present study.

Additional studies of validation therapy must be conducted to demonstrate the efficacy of the intervention before the question of its validity for nursing practice can be answered. While validation would appear to be appropriate for the interpersonal component of nursing practice as identified by Orem (1985), the techniques have not been sufficiently tested to determine outcomes which result in improved self-care. Registered professional nurses are searching for clinical strategies to understand and assist the demented elderly individual and their families. This desire has resulted in various interventions, including reality orientation, reminiscence therapy, and now validation therapy, being quickly adopted and implemented in clinical practice without adequate research to describe the process or to test the efficacy of the intervention.

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Implications for Nursing Practice

Should validation therapy prove to be a valuable intervention for the demented elderly, registered professional nurses, and various nursing personnel for whom the R.N. is responsible, could be educated in and certified as validation therapists. Educational preparation of the registered professional nurse includes basic therapeutic communication techniques which are evident in validation therapy. With further opportunity to learn validation, the registered nurse could provide leadership for the nursing personnel on the unit in validation therapy.

Several opportunities exist for the nurse role with validation therapy in long-term care. The nurse as a teacher of family members could model and demonstrate validation therapy. Community education programs on validation therapy could be conducted by the Registered Professional Nurse for family and health caregivers working with the elderly. Such programs would provide a valuable community service while marketing the services of the facility. Registered Nurses in home health could provide validation therapy on a one-to-one individual basis in the home and teach validation techniques to caregivers.

Discussion of Feil's Conceptualization of Validation

The strength of Feil's validation theory is that it offers a tool to health professionals who are searching for

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a clinical intervention for demented elderly individuals. The theory is well-grounded in psychotherapeutic principles and includes techniques used in basic therapeutic interpersonal relationships.

Several concerns with Feil's validation theory as it relates to treatment of dementia in the elderly were identified. The theory does not give adequate consideration to the pathological changes occurring in dementia whether as a result of multi-infarct dementia, Alzheimer's disease, or another disease process common to mental status changes in the elderly. Feil (1989) wrote that deterioration as a result of late onset dementia lessens when the individual is validated. The theory does not appear to recognize the decreasing intellectual capacity which results from the progressive dementia caused by pathology and its implications for psychotherapeutic interventions. It may well be that no matter what the psychotherapeutic intervention, progressive dementia will continue as a result of the pathology.

Validation theory does not adequately address the limited cognitive ability of the demented elderly to perform the mental tasks of resolution of past conflicts, the goal of validation therapy. Feil (1989) wrote that the demented elderly relive past experiences for comfort and to resolve unfinished issues. As Goudie and Stokes (1989) question, do the demented elderly have the intellectual and analytical

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capacity to resolve unfinished conflicts by discussing feelings and past experiences? Or do such group interactions merely increase irritability as found by Babins (1988)? If demented elderly do not have the intellectual capacity to resolve unpleasant conflicts and memories, the more appropriate intervention would be diversional and recreational therapy.

Validation therapy may be more appropriate for early stages of dementia where intellectual functioning may be adequate for analysis and resolution of past conflicts. In fact, Feil (1989) wrote that validation often helps early onset demented elderly. Or validation therapy may be appropriate for pseudodementia where the underlying cause of the dementia is depression rather than pathological changes. Feil (1989) wrote of the many losses, physical and social, experienced by the elderly which can lead to depression. Kane wrote, "Depression may coexist with dementia in over one-third of outpatients with dementia and an even greater proportion in nursing homes." (Kane et al., 1989. p. 95). Psychotherapeutic interventions, such as validation, would be a valuable clinical tool for this common, and often misdiagnosed, cause of dementia.

Further clarification is needed regarding the apparent lack of relationship between Feil's stages of disorientation and the level of mental status changes shown with well-tested and valid tools such as the Short Portable Mental

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Status Questionnaire (Pfeiffer, 1975). In this study, demented elderly individuals who were thought to be in stage one, an early mild level of disorientation were, in fact, at a level of moderate intellectual impairment according to the SPMSQ. Objective clinical criteria which have been demonstrated to have high validity and specificity and have a high association with Feil's stages of disorientation would be a valuable objective clinical tool for categorizing individuals for intervention. Currently, there is a lack of standardization to Feil's stages and the behavioral criteria of each stage. There is no evidence that the stages accurately reflect the true level of intellectual impairment.

Recommendations for Further Researcher

Further descriptive studies are needed in a variety of settings with different validation therapists to more clearly outline the process of validation therapy being conducted in the field. Further descriptive studies would more accurately refine validation conceptual framework and point to further research questions.

Future research could include questions such as the following:

1. What are the perceptions of families regarding validation therapy when a relative has been involved in validation therapy?

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2. How do different stages of dementia affect the response to validation therapy?
3. How valid are the stages of disorientation as outlined by Feil?
4. What is the relationship between the stage of dementia as outlined by Feil and level of dementia as tested by valid mental status assessment tools?
5. What is the effect of life history on validation therapy for decreasing dementia?
6. What is the effect of length of experience staff have had with validation therapy on effectiveness of validation?

Further descriptive studies are needed to provide a data base for clarifying the validation therapy approach and to further build the conceptual base for validation therapy. Further experimental research is needed to test the efficacy of validation therapy with regard to outcome criteria of functional status and developmental changes. Further study is needed to explore Feil's concepts of stages of disorientation and their behavioral characteristics and to explore Feil's concept of a final life stage of resolution vs. vegetation.

Further research is needed to explore the effect of cultural norms on the implementation of validation therapy. What are the effects of the cultural variations on the group

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process, validation techniques, and effectiveness of validation therapy?

Further research needs to be conducted comparing validation therapy to other treatment modalities and to control groups without treatment. It may be that any intervention - reality orientation, reminiscent therapy, or recreational therapy - which brings the disoriented elderly together in a group session will create an environment for interaction and will result in expression of feelings, and a review of past conflicts and experiences. The key ingredient may be the added attention given to the resident and the coming together in a group lead by a facilitator; the type of intervention may not be the determining factor.

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APPENDIX A

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THE V/F VALIDATION® TRAINING INSTITUTE, INC.

Theoretical Assumptions

Basic principles developed by behavioral, analytical and humanistic psychologies that underlie the theoretical assumptions in Validation®:

1. Accept your client without judgment. (Carl Rogers. *Way of Being.* Boston: Houghton Mifflin Co. 1981.)
2. The Therapist cannot give insight or change behaviors if the client is not ready to change *or if the client does not have the cognitive capacity for insight.* (Sigmund Freud. *De Invloed van ons Onbewuste in ons Dagelijksch Leven.* Dutch Translation: Wereldbibliotheek. 1931) (Freud. *Der Witz und seine Beziehung zum Unbewußten.* Fischer Taschenbuch Verlag.) (Freud, S. Standard edition of the psychological works of Sigmund Freud. London. 1957. Hogarth Press.)
3. Know your client as a unique individual. (Maslow. *Toward a Psychology of Being.* New York. 1968.)
4. Feelings that are expressed, acknowledged, and validated by a trusted listener, will lessen. When feelings are ignored or denied, they gain strength. "The cat ignored, becomes the tiger." (von Frans-Hillman. *Jung's Typology.* Zurich: Spring Publications, 1971.)
5. Each stage of life has a unique task that we must face at a prescribed time in the human life span. We must struggle to accomplish the task, then move on to the next task. (Erik Erikson. *Childhood & Society.* New York: W.W. Norton & Co., 1950, 1963.)
6. An ignored task demands to be heard at a later stage. (Erik Erikson, idem.)
7. Human Beings struggle for balance (homeostasis). (S. Zuckerman. *"The Mechanism of Thought: The Mind and The Calculating Machine,"* in Peter Laslett (ed.) *The Physical Basis of Mind.* New York: Macmillan, 1950.)
8. When recent memory fails, very old humans restore balance by retrieving early memories. When eyesight fails, they use the mind's eye to see. When hearing goes, they listen to sounds from the past. (Wilder Penfield. *"The Cerebral Cortex and the Mind of Man,"* in Peter Laslett (ed.) *The Physical Basis of Mind.* New York: Macmillan, 1950.)
9. Early, well-established memories survive to very old age. (F.G. Schettler and G.S. Boyd. *Atherosclerosis.* Biomedical Press, The Netherlands, 1969.)
10. The brain is not the exclusive regulator of behavior in very old age. Behavior is a combination of physical, social, and intrapsychic changes that happen during the life span. (Adrian Verwoedt. *Clinical Geropsychiatry.* Baltimore: Williams and Wilkings Co., 1976.) See also, Kral, V.A. "Stress and Mental Disorders in the Senium," found in Butler, R.N. and Lewis, Myrna I. *Aging and Mental Health.* St. Louis: C.V. Mosby Co., 1977, page 85.)
11. Autopsies have shown that many very old persons survive significant brain damage and stay relatively oriented. (Charles Wells. *Dementia.* Philadelphia, Pa.: F.A. Davis Co., 1977.) (Dennis J. Selkoe. *Scientific American,* November, 1991.)
12. There is a reason behind the behavior of disoriented very old people. (Naomi Feil. *Validation.* Ohio: Edward Feil Productions, 1982.)
13. Each human being is valuable -- no matter how disoriented. (Naomi Feil, idem.)

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APPENDIX B

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VALIDATION® ASSESSMENT AND TREATMENT CHART

THE STAGE BEYOND INTEGRITY: FEIL'S RESOLUTION vs. VEGETATION STAGE® of Life

	STAGE 1 Malorientation	STAGE 2 Time Confusion	STAGE 3 Repetitive Motion	STAGE 4 Vegetation
BASIC HELPING CUES	-use who, what, where and when type questions -use minimal touch -maintain social distance	-use feeling words (I see...) (I feel...) -use touch and eye contact	-use touch and eye contact -pace to person's movements	-mirror movements -use sensory stimulation
ORIENTATION	-keep time -holds onto present reality -realizes and is threatened by own disorientation	-does not keep track of clock time -forgets facts, names, and places -difficulty with nouns increases	-shuts out most stimuli from outside world -has own sense of time	-does not recognize family, visitors, old friends or staff -no time sense
BODY PATTERNS muscles vocal tones eyes	-tense, tight muscles -usually continent -quick direct movements -purposeful gait -harsh, accusatory, and often whining -can sing -focused, good eye contact	-sits upright but relaxed -aware of incontinence -slow, smooth movements -dance-like gait -low, rarely harsh -signs and laughs readily -clear, unfocused -downcast, eye contact triggers recognition	-slumped forward -unaware of incontinence -restless, pacing -melodic -slow, steady -eyes usually closed -repeats early childhood movements and sounds	-placid -little movement -no effort to control continence -frequent finger movements -eyes shut (face lacks expression) -self stimulation is minimal
EMOTIONS	-denies feelings -usually carries a cane, blanket, or sweater	-substitutes memories and feelings from past to present situations	-demonstrates sexual feelings openly	-difficult to assess
PERSONAL CARE	-can do basic care -seeks personal reminders	-misplaces personal items often -creates own rules of behavior	-few commonly used words -does not listen or talk to others	-responds to tone and touch
COMMUNICATION	-positive response to recognized roles and persons -negative response to those less oriented	-responds to nurturing tone and touch -smiles when greeted	-is not motivated to read or write	-none readily apparent
MEMORY AND INTELLECT RULES	-can read and write unless blind -sticks to rules and conventions	-can read but no longer writes legibly -makes up own rules	-early memories and universal symbols are most meaningful	-difficult to assess
HUMOR	-some humor retained	-will not play games -humor not evident	-laughs easily often unprompted	-difficult to assess

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APPENDIX C

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VALIDATION® TRAINING INSTITUTE, INC.
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NAOMI FEIL M S W A C S A
Executive Director

June 24, 1992

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Ms. Elaine Doyle
7006 Heritage Highway
Jefferson City, MO 65109

Dear Miss Doyle:

You have my permission to copy the table of Validation Stages for your publication.

We currently have Validation Chapters in The Netherlands, Australia, Austria, France, Belgium, Ironton, MO., and in Maine and Mississippi

I look forward to receiving a copy of your publication if this is possible.

Sincerely,

Naomi Feil

Naomi Feil
Executive Director

NF:eg

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APPENDIX D

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APPENDIX D

Eligibility Requirements for the Validation Therapist's Certification

An individual may become certified as a validation therapist by submitting the following to the Validation Training Institute, Inc.:

a. evidence of completing two 7-hour validation workshops, one of which must include a demonstration of validation by a certified validation therapist, or a demonstration of validation therapy by viewing the videotape, The More We Get Together, produced by the Validation Training Institute; and

b. evidence of completing 6 months of experience in forming and leading a validation group which meets at least one time per week with disoriented people, 80 years or older; and

c. a log recording the weekly validation session

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and a statement from the sponsoring institution or supervisor affirming that weekly validation therapy group sessions are being conducted by the individual who is requesting certification; and

d. a letter of intent to the Validation Training Institute, requesting validation certification; and

e. payment of a fee to the Validation Training Institute; and

f. submission of a video of a validation session which the individual conducted for review by a validation board examiner; and

g. successfully passing a written test on validation therapy.

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APPENDIX E

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APPENDIX E

The Short Portable Mental Status Questionnaire (SPMSQ)
Eric Pfeiffer, M.D.

Instructions: Ask questions 1-10 in this list and record all answers. Ask questions 4A only if patient does not have a telephone. Record total number of errors based on ten questions.

1. What is the date today? month day year
2. What day of the week is it?
3. What is the name of this place?
4. What is your telephone number?

4A. What is your street address?
(Ask only if patient does not have a telephone.)

5. How old are you?
6. When were you born?
7. Who is the President of the U.S. now?
8. Who was President just before him?
9. What was your mother's maiden name?
10. Subtract 3 from 20 and keep subtracting 3 from each new number, all the way down.

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Instructions for Completion of the Short Portable Mental Status Questionnaire

Ask the subject questions 1 through 10 in this list and record all answers. All responses to be scored correct must be given by subject without reference to calendar, newspaper, birth certificate, or other aid to memory.

Question 2 is self-explanatory.

Question 3 should be scored correctly if any correct description of the location is give. "My home," correct name of town or city of residence, or the name of hospital or institution if subject is institutionalized, are acceptable.

Question 4 should be scored correctly when the correct telephone number can be verified, or when the subject can repeat the same number at another point in the questioning.

Question 5 is scored correct when stated age corresponds to date of birth.

Question 6 is to be scored correctly only when the month, exact date, and year are all given.

Question 7 requires only the last name of the President.

Question 8 requires only the last name of the previous President.

Question 9 does not need to be verified. It is scored correct if a female first name plus a last name other than subject's last name is given.

Question 10 requires that the entire series must be performed correctly in order to be scored as correct. Any error in the series or unwillingness to attempt the series is scored as incorrect.

Scoring of the Short Portable Mental Status Questionnaire

The data suggest that both education and race influence performance on the Mental Status Questionnaire and they must accordingly be taken into account in evaluating the score attained by an individual.

For purposes of scoring, three educational levels have been established: a) persons who have had only a grade school education; b) persons who have had any high school education or who have completed high school; c) persons who have had any education beyond the high school level, including college, graduate school or business school.

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For white subjects with at least some high school education, but not more than high school education, the following criteria have been established:

0-2 ERRORS	INTACT INTELLECTUAL IMPAIRMENT
3-4 ERRORS	MILD INTELLECTUAL IMPAIRMENT
5-7 ERRORS	MODERATE INTELLECTUAL IMPAIRMENT
5-10 ERRORS	SEVERE INTELLECTUAL IMPAIRMENT

Allow one more error if subject has had only a grade school education.
Allow one less error if subject has had education beyond high school.
Allow one more error for black subjects, using identical education criteria.

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APPENDIX F

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7006 Heritage
Jefferson City, Mo. 65109
June 26, 1992

Eric A. Pfeiffer, M.D.
Dept. of Psychiatry
University of Southern Florida
college of Medicine
12901 N. 30th
Tampa, Florida 33612

Dear Dr. Pfeiffer:

I am requesting your permission to print the Short Portable Mental Status Questionnaire in the appendix of my thesis. The SPMSQ was used to determine the mental status of elderly nursing home residents involved in validation therapy. My thesis is in partial fulfillment of the requirement for graduation with a master of science degree in nursing from the University of Missouri.

Thank you for your assistance in this matter.

Sincerely,
Elaine Doyle, R.N.C
Elaine Doyle, R.N., C.

Yes, I give permission to print the Short Portable Mental Status Questionnaire as requested above.

Eric Pfeiffer
signature

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7006 Heritage
Jefferson City, Mo. 65109
June 26, 1992

Pat Miller
Journal of the American Geriatric Society
770 Lexington Ave.
Suite 400
New York, New York 10021

Dear Ms. Miller

I am requesting your permission to print the Short Portable Mental Status Questionnaire in the appendix of my thesis. I have also contact Dr. Pfeiffer for permission. The SPMSQ was used to determine the mental status of elderly nursing home residents involved in validation therapy. My thesis is in partial fulfillment of the requiremtns for graduation with a master in nursing from the University of Missouri.

Thank you for your assistance in this matter.

Sincerely,
Elaine Doyle, RN, C.
Elaine Doyle, RN, C.

Yes, the Short Portable Mental Status Questionnaire may be printed as requested above, courtesy of the Journal of the American Geriatric Society.

Melissa Silvestri Communications Assistant June 29, 1992
signature

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