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Chapter 12

Validation therapy with late-onset dementia populations

Naomi Feil

SUMMARY

This chapter presents the background, theory base, assumptions and implementation of validation therapy with late-onset dementia populations. The interrelationship of physical losses with developmental coping techniques is also discussed. When recent memory, mobility and sensory acuity fail, the very old disoriented person 'restores' the past in an attempt to find safety and comfort in an increasingly estranged environment, and in order to resolve their life. The validation worker empathizes with the disoriented person, acknowledging the meaning behind the behaviours and works with the emotional content of communication when the factual content is not clear. The validation approach can be used on a one-to-one basis and/or in a group setting. The specific one-to-one methods for the working with the four stages of disorientation are presented in this chapter.

INTRODUCTION

The background to the validation approach is presented first, using specific case histories and clinical studies. The validation approach is compared with reality orientation, behaviour modification and remotivation techniques. Thereafter, the goals, principles and beliefs of validation are presented. Finally, the method for catagorizing behaviours into four discrete and progressive stages is presented along with specific verbal and non-verbal interaction techniques for each stage. The chapter concludes with an overview of research pertaining to the validation approach up to the present time.

The validation approach is now practised in over 6,000 long-term care facilities, community-based support groups, adult treatment centres, and hospitals in the United States, Canada, the Netherlands, Norway and Australia. The interest in validation is not surprising since there are no pharmacological treatments or cures for dementia yet, and given the demographic projections for the dramatic increases in the numbers of

elderly persons, including those with dementia. The goals of validation are to stimulate verbal and non-verbal communication in order to help restore feelings of dignity and wellbeing, and to help persons resolve the meaning of their lives.

DEFINITION

Validation therapy is three things: (1) a way of catagorizing the behaviours that are exhibited by the disoriented elderly into four discrete and progressive stages, (2) a method for communication (verbally and non-verbally) with persons in each stage and (3) a theory of late-onset disorientation in elders who have led relatively normal lives well into their seventh and eighth decades. This latter criteria identifies such elders with those diagnosed as late-onset Alzheimer's disease patients (Jones, 1987). The validation approach means accepting and validating the feelings of the demented old person; to acknowledge their reminiscences, losses and the human needs that underlie their behaviours without trying to insert or force new insights. Validating includes: reflecting a person's feelings, helping them to express unmet human needs, restoring well-established social roles (which in turn help to motivate expression of social behaviours), facilitating feelings of wellbeing and stimulating interaction with others (Feil, 1984; 1985; 1989).

BACKGROUND

The author began to develop the validation approach in 1963, whilst working as a group therapist for the 'Special program for the senile' (Weil, 1966), at the Montefiore Home for the Aged, Cleveland, Ohio. The age range of persons in this programme was between 76 and 101 years; diagnoses comprised of 'senile psychosis' and 'organic brain damage' often complicated by circulatory insufficiency. At autopsy, the majority of these residents had Alzheimer's plaques and neurofibrillary degeneration. The author, in reviewing the case histories of these residents, found that they had led normal lives until their late seventh or eighth decades when symptoms of disorientation began to appear. These residents did not respond to reality orientation, remotivation or insight-oriented group therapy; instead they would 'withdraw, vegetate and become increasingly hostile when confronted with present reality' (Feil, 1967). These observations led the author to develop a new approach which did not insist upon participation in present reality, and which did not result in such withdrawal.

VALIDATION GROUPWORK RESULTS: 1972

After 6 months of using the newly developed validation techniques to work with the disoriented residents in the group programmes already described,

it became apparent that their anxiety was reduced. Validation techniques did not demand cognitive improvement, but rather accepted their loss of: (1) social controls, (2) cognitive thinking, (3) sensory acuity, (4) reflective self-awareness, (5) speech and (6) mobility. Listening to their verbal and non-verbal behavioural messages, the author found a pattern to their behaviour. Their lifelong accumulated wisdom (or crystallized intelligence, as some modern psychologists call it) was often preserved despite severe cognitive deficits. In spite of the substantial brain damage incurred in dementia, persons still try to communicate their feelings of fear and their awareness that 'something is wrong'. Because of the progressive damage to speech that occurs in dementia, such communication is often cryptic, and very symbolic. For example, an 86-year-old Russian immigrant, former housewife, began opening drawers in search of something. When asked 'What are you looking for, Mrs K?' she replied, 'I'm looking for yesterday. I must untangle the noodles in the mirrors of my mind.' Another lady of 93 years, would stop singing whenever she reached the word 'crazy' in the song 'A Bicycle Built for Two' (Daisy, Daisy). At this point, she would laugh, mockingly. When asked why she had stopped singing, she replied, 'It's better to be crazy; then it doesn't matter what you do!'

After 6 months of weekly, 1-hour group sessions, the author found that respecting and validating the accumulated wisdom of such disoriented elderly through both one-to-one (or personal) and group approaches produced diverse, favourable results. Both approaches include the use of (1) touch, (2) close eye contact, (3) a low, caring tone of voice, (4) linking the non-verbal (symbolic) behaviour to the individual's unmet human needs, (5) mirroring non-verbal behaviours and (6) matching the rhythms and repeated movements of the more severely impaired residents with one's own body movements or music.

Results of this early research (Feil, 1972) using the group approach included: (1) heightened energy during interactions using a validation approach, (2) increased verbal communication and (3) improved social behaviour and control of behaviour. In validation group settings residents: assumed new social roles (presumably through tapping memories of previous social interactions); began to communicate with each other instead of with the group worker; and they began to show caring behaviours towards each other. Feelings of wellbeing were expressed in the form of positive comments, smiling, laughing and increases in eye and body contact (Feil, 1972).

VALIDATION COMPARED TO OTHER TECHNIQUES

Three examples of a social worker's notes, made after residents had participated in 6 months of reality orientation sessions, and then contrasted to the validation approach follow:

Example one

Mrs F constantly stared into space, shouting: 'There's Mother! She's got my laundry. I have to leave this place to help her carry it.' Trying to orient Mrs F to present reality, I told her in a quiet, calm voice: 'You are 95 years old and your mother is dead.' Mrs F nodded and said to me: 'Honey, I know that and you know that. But my mother doesn't know that, and I have to help her right now.'

By contrast, utilizing validation techniques and respecting Mrs F's need to help her mother, the social worker achieved the following. 'Mrs F, your mother worked very hard, you wanted to help her, you love your mother very much don't you?' Mrs F nodded, burst into tears, sobbing: 'She was a wonderful mother. I should have helped her. She didn't have to die so young.' Mrs F knew, at some level, that her mother was dead. After she had expressed her grief and guilt, her facial muscles relaxed, her voice became less frantic, and after 6 months she no longer stared into space trying to restore images of her mother. She began to interact with the validation worker (in this instance the social worker) increasingly. Once her feelings had been acknowledged, shared with someone she could trust, and validated, the grief lessened.

Example two

Mr T is worsening after each contact. He is uncontrolled, abusive and refuses to listen to the nursing staff. He must be restrained and medicated for his own, and others' protection. Psychiatric referral requested.

Mr T unties his retraints with magnificent dexterity ... he often slides right down in the chair ... shouting 'God damn SOB let me out of here. I hate her. Stinker John! You stink.'

When using reality orientation to reason logically with Mr T the following pattern occurs.

> John, you are living in a home for the aged; you can't get out of the chair because you might fall. When you shout so loudly nobody wants to sit near you. If you stop shouting we can read the paper. Look at the headline; can you read the date?

Mr T grabbed the newspaper and threw it on the floor, spitting at the social worker: 'I don't give a damn about your f—— paper! You can take your date and shove it.'

Using behaviour modification methods, and walking away whenever Mr T started to swear or become abusive and rewarding him with attention whenever he was quiet, did not work either. Mr T's swearing increased; he began kicking other residents and spitting at them and was only quiet when medicated or sleeping. Ignoring his outbursts increased his 'acting out' or negative behaviours.

Using a validation approach resulted in interactions such as that described next. 'You hate this place don't you Mr T? You can't stand anyone here. You hate this chair, being locked up like this. You can't move. You used to travel; you were a salesman, weren't you?' Mr T replied 'Damn right!' Respecting his anger and linking his aggressive behaviour to his unmet human need (the need to be useful), gradually helped to establish trust and eventually Mr T began to strike out less and to communicate more verbally.

Example three

Mrs K tried to give me some 'play' money (like for the game Monopoly) in honour of the birth of my son. To orientate her, I told her that play money has no value. Her face fell and she began to cry. The lady sitting next to her, also moderately demented, said to me: 'What do you care if it's play money. Giving makes her feel good.' It was true, Mrs K had been a well-known philanthropist in the community. She was restoring her sense of worth by giving me the money.

These old disoriented residents were not helped by remotivation techniques either. They could not relate to the objects and props that I used to stimulate awareness of present reality. Their attention span was too short. They could examine a flower for only a few moments before dropping it. They could not read the newspaper or poems used in the group. They could not look outside to establish the season of the year, yet alone remember the day or the date.

Such residents were unable to achieve new insights into their behaviours because of the cognitive damage to logical- and associative-thinking capacity. Thus, they had also lost reflective self-awareness. Reality orientation, behaviour modification and remotivation methods did not help these moderately demented persons precisely because of the damage to their logical thinking.

THEORY BASE FOR THE VALIDATION APPROACH*

Four theories have relevance to validation techniques. They are: (1) Maslow's (1968) 'universal human needs hierarchy', (2) Erikson's (1950) developmental stage theory, (3) Jones and Zeiss (1985), Jones and Burns (Chapter 5, this volume) reminiscing disorientation theory, and (4) Miesen's (1990) work on 'parent-fixation' and his adaptation of Bowlby's attachment theory to dementia.

It is beyond the scope of this chapter to discuss in detail the relevance of these theories to the validation approach in detail. However, the following brief synopsis should provide the reader with the key associations.

Validation techniques provide a means of helping disoriented elderly

persons to meet the 'higher order needs' in Maslow's scheme, in addition to the custodial care that is so often the sole extent of planning care for them.

Erikson defined the final goal of lifespan development as being that of achieving 'ego integrity or despair'. This seems too global to be useful for work specifically with the disoriented elderly, and so for the purposes of using the validation approach, a ninth stage has been added; that of 'resolution versus vegetation'. Within this stage we can focus care more specifically for persons for whom the past is the predominant focus. They can be assisted to resolve their lives by care-givers encouraging them: to 'wrap up loose ends', to justify having lived and to prepare for death.

Reminiscing disorientation theory describes a mechanism for disorientation, and helps put into a larger context the importance of reminiscing with persons whose focus increasingly becomes lodged in the past. (For a detailed discussion see Chapter 5, this volume.)

Miesen has demonstrated that the dementing process activates attachment behaviour, particularly those behaviours and memories associated with memories of parents. (For a detailed discussion see Chapter 4 in this book.)

VALIDATION GOALS

The primary goal of the validation approach is to help the older disoriented person to be as happy as possible. When their struggle to resolve life is respected and validated by a trusted, significant person in present time, withdrawal inward is halted. With their dignity restored, they feel relieved and make new efforts to respond to the maximum of their ability. Buried emotions often come to light in these persons, and when these old hurts are acknowledged and validated the disoriented elderly begin to communicate (with the person(s) they trust) to the maximum of their potential. The process of validation cannot restore damaged brain tissue, but it can help to stimulate whatever capacities are dormant and yet intact.

The validation worker does not expect disoriented elderly to behave in the same way the younger adults would. The worker does not try to provide new insights into a person's behaviour, or to insert or probe for feelings that are not openly expressed, neither do they judge, analyse or hope to change the disoriented person. Rather, the worker accepts the person wherever they are at the moment, and is committed to help the person to reach their own goal, not the goals of the worker, and not to demand of the person that they become and remain oriented. The validation worker tries to reduce anxiety and to strengthen wellbeing through acknowledging the intuitive wisdom the elderly person still possesses, and by accepting them for the way they are.

ASSUMPTIONS BEHIND VALIDATION

The condition of the brain is not the exclusive regulator of behaviour in old–old age. Validation is based upon the belief that behaviour in old age does not depend solely on the condition of the brain but on a combination of the following physical and psychosocial factors: (1) damage to recent factual memory, (2) damage to eyes, ears, mobility, (3) accumulated losses (loved ones, social roles, job, identity), (4) the 'coping mechanisms' (or coping repertoire) that a person developed throughout their lifetime in response to these losses and (5) the extent to which the person has completed the developmental tasks of Erikson.

Clearly, cognitive functioning in old age is dependent on a multiplicity of factors. Neuroscientists acknowledge that some persons with considerable brain atrophy continue to function quite well whereas normally persons appear to be incapacitated with similar amounts of damage (Wells, 1977; Roth, 1984).

PHYSICAL LOSSES EMPHASIZE EMOTIONAL NEEDS

In 1950 the neurosurgeon, Wilder Penfield wrote: 'The patient, himself, can activate the memory from within, stimulating the same pattern of cortical nerve cell connections without the use of the sense organs.' Similarly, in the disoriented elderly, it seems that dim images, seen through damaged eyes in present reality, can trigger sharp, photographic-like images from the past. 'The earlier an event or image has been imprinted on memory, the longer it is retained', wrote Schettler and Boyd in 1969. Miesen's (1990) research with persons with dementia confirms that early, strong emotional memories, particularly of home and parent, seem to remain intact longest during the progression of dementia.* Brain damage can lead to a return of early, well-established patterns and images. For example, a 90-year-old demented woman with poor eyesight 'saw' her mother through her eidetic memory. A spot on the wall triggered this image of her mother, and temporarily 'became' her mother. She had to tell her mother that she loved her in order to make peace before she died, and this need must have contributed to her visual search and retrieval of her mother's image. A validation worker would accept the need of the 90-year-old lady to 'restore' her mother and would not argue with her or insist that her mother was dead, but neither would the worker pretend that the mother was alive. Often, on a deep level of awareness, the disoriented elderly know that their parents are dead, but they still need to restore them to feel safe or to tie up loose ends. The worker explores without judging by asking such questions as: 'You see your mother? What does she look like? You need to tell her that you love her?'

Damage to the kinesthetic sensory brain areas can also contribute to the

reactivation of past memories in the disoriented elderly. Piaget (Ginsburg and Opper, 1969) wrote that muscles 'perform an abbreviated imitation ... the sensorimotor forerunner of verbal behaviour ... When the object is no longer present, the movements in abbreviated form are the same movements involved in the initial perception.' Body movements can take disoriented old people to the past. A slight flick of the wrist can remind a disoriented man of his work, Mrs G's shiny black purse 'became' her filing cabinet as she tried to restore her identity as a file clerk to survive feelings of uselessness in the nursing home.

Movements trigger memories as well as other stimuli such as food, music and pets. Sometimes, self-stimulation is used to trigger such memories. Mrs K could not see her hand clearly, in addition to dementia her eyesight was very impaired. She held her hand in front of her, caressing it, crooning and rocking it as though it was a baby. This is the way she restored her identity as a mother. The validation worker understood her need to restore her identity as a mother and used touch, close eye contact and mirroring of Mrs K's movements to work with her. The worker said 'You love your baby very much.' Mrs K responded and looked up at the validation worker, and began to talk and sing with her. Mrs K no longer needed to use her hand as a symbol of a baby in order to feel worthwhile, the validation worker had become a significant other for her.

When speech is damaged, body movements are all that is left to communicate with. In the disoriented elderly, body movements express three basic human needs: (1) the need for love and safety, (2) the need to be useful, to restore one's identity and work and (3) the need to communicate strong, basic emotions and to be understood. Strong (raw) emotions often spill out for the first time when a person suffers brain damage. Loss of brain functioning in certain areas leads inevitably to loss of control and disinhibition occurs stimultaneously with extreme expression of emotion. The severely disoriented old person is no longer able to conform to social rules and becomes utterly honest about the expression of their feelings (repressed or current).

It appears that current losses in present time often evoke memories of losses in the past. The losses are different, but the feeling of pain, grief, shame, fear and rage can be the same. Losses fuse into each other when memory becomes impaired. In listening to the expression of feelings of loss, the validation workers does not 'feed the fantasy' or 'buy into the delusion', they only acknowledge that the feelings are real even though the events happened long ago. For example, when Mr S, rocking and pounding away in the arm of his chair, is hammering an imaginary nail to restore his feeling of usefulness as a carpenter and the validation worker says 'You were a fine carpenter', Mr S nods and begins to talk about his work. He no longer feels isolated.

CATEGORIZING BEHAVIOURS INTO FOUR STAGES AND APPLYING STAGE-SPECIFIC COMMUNICATION TECHNIQUES

There are four, generally discrete stages in the behaviour of persons with late-onset dementia. In beginning to work with a resident the validation worker observes their behaviours, collects a 'mini-life review' (Feil, 1982), and identifies which stage a person belongs in by collecting information from family interview and the medical history.

Stage one: malorientation (characterized by confabulation and self-defensive behaviour)

Mrs R, aged 89, with pursed lips points an accusing finger at the housekeeper who has come to clean out her cluttered room. Oranges lie in the toilet bowl; Kleenex tissues are stuffed under the mattress springs; buttons, bits of dried-up food, debris, old bundles of newspapers tied up with 40-year-old hair ribbons, letters and safety pins litter the room. Mrs R is a hoarder and shrieks at the housekeeper, 'You keep out of my drawer! Thief! You stole my oranges. I had six cooling in the toilet.' If the housekeeper was trained in the validation approach she would not argue with Mrs R, but rather acknowledge that there is meaning behind her hoardings and accusative behaviours.

The housekeeper would realize that Mrs R had led a normal life until recently when she began blaming others for any little thing that 'went wrong' or that threatened her. A host of losses have overwhelmed Mrs R simultaneously, for the first time in her life. Her eyesight is worse, her left ear doesn't hear and her recent memory is fading. Her daughter moved 300 miles away last week. The more Mrs R loses, the more she blames others. She blamed others throughout her life when things went wrong, but this was within the realm of normal behaviour. Blaming was her way of coping when life became difficult, and when she could not assume responsibility herself for the things that went wrong. At 89, Mrs R cannot face the multitude of losses that accompany aging and a fading memory. Her blaming is much worse than it ever was. Mrs R is usually oriented to present time although she is becoming forgetful. She is an example of someone in the early, first stage of dementia, someone who is *maloriented*, not yet fully disoriented. Aware that something is 'wrong', forgetful, afraid of losing control over her life and burdened by unacknowledged feelings from the past, she hoards to keep control and blames others for self-defence.

The physical characteristics of malorientation

The following are typical physical characteristics of the first stage: eyeslits narrowed, eyes very focused and directed; general body tension; facial

muscles tight; shallow breathing; direct, purposeful movements; clear speech but because recent memory is beginning to fade there are occasional lapses or repetitions in conversation; no continence, arms folded, fingers often pointing, usually clutching a purse, raincoat, cane, wallet or bags.

Emotional characteristics of malorientation

Typical emotional characteristics of stage one include: rigid (social controls) adherence to social proprieties, avoidance of physical contact or touch, intimacy and exposure of feelings; desperate efforts to hold onto old, familiar social roles; confabulation to hide her increasing confusion from others; threatened by the presence of persons who are more severely affected by dementia themselves and resistant to change because of limited coping mechanisms, and thereby overly dependent on familiar routines and defences.

Maloriented persons often express feelings of fear and insecurity by blaming others. Some persons in this stage blame others for 'poisoning' their food or for stealing jewellery or other items of strong personal value. Memory is waning, and persons in stage one often forget where they put things with the consequence that family are accused of stealing from them.

The validation worker accepts that maloriented persons cannot face so many losses and that their blaming, in this final stage of life is functional. (If Mrs R, for example, were younger, her blaming would be pathological not functional, and the worker would try to help her achieve insight and to help her develop new coping mechanisms.) In very old demented persons the validation worker uses techniques that lessen anxiety, make a person feel safer and reduce their blaming behaviours. These techniques are directed at building trust and facilitating non-threatening communication with maloriented persons.

Helping techniques for stage one

1 Listen with empathy.
2 Explore content of communication using non-threatening questions such as: *Who? What? Where? When? How?* Avoid asking *Why?* because this question implies 'cause and effect' and is cognitively the most complex question of all to answer. Since the maloriented are trying to deny the damage to their memory and logical-thinking ability, this question is very threatening for them. Maloriented persons do not want to be analysed or patronized. Avoid touch other than a handshake with these persons.
3 Use 'repetition' when in doubt, if you cannot think of a reply quickly enough, or, if you have not caught the gist of what the person was

saying. Repeat or paraphrase the key words from the person's most recent conversation.

4 People generally speak using words that relate to their preferred sense: visual, auditory or kinesthetic. It is helpful to be aware of any strong preference and to build trust by choosing words that the person would use themselves. If a person uses 'seeing' or visual words you can use words such as 'look like,' 'appear', 'imagine'. If a person prefers their auditory sense it is helpful to use 'hearing' words such as 'sounds like', 'loud', 'noisy'; persons with a strong kinesthetic sense use mainly 'feeling' words like 'hurts', 'how does it strike you', 'drive you crazy', 'hits you hard'.

5 Using 'polarity' refers to asking questions in the extreme, for example, 'When was it worst?' 'How often did it happen?' 'Was there ever a time when it didn't happen?' Maloriented persons can express anger, sadness and fear without being threatened by exposing their feelings overtly when questions are asked using polarity.

6 Reminiscence is a useful method to use with the maloriented because they do not yet confuse past and present time, although they do experience occasional confusion. Using reminiscence can help to uncover information about how a person coped in the past, for example: 'What happened when you lost your husband? Did you live alone then? What did you do to overcome the loneliness then?'

7 Using 'opposite' imagery can help persons focus on more positive thoughts. Help a person imagine the opposite to the situation they are currently threatened by.

How often do you validate someone?

In a one-to-one approach the validation worker meets the maloriented person for 5 to 10 minutes at least three times a week in long-term care settings, once a week in the community or day-care centres, and twice daily in acute-care hospital settings. In charting the behavioural changes, the worker will find that the anger gradually lessens, accusing behaviours diminish and the person become less anxious as judged by their tone of voice, muscle tone and their communications. A maloriented person will not withdraw inward if they are validated consistently. Instead they will continue to interact with family and peers without accusing others. They will save their accusations and challenges for the validation worker. They are aware that friends and family will reject them if they continue to blame them continually whereas the validation worker will not reject them, but will accept their angry feelings without confronting them.

Stage two: time confusion (characterized by a lack of awareness of the time of day, month or season and increased impairments in recent memory)

Mr L unties his restraints with dexterity. Tall, but stooped at age 94, he wanders frequently. He cannot distinguish clearly between past and present time, and, thinking of his wife he goes into Mrs T's bedroom, takes off his clothes and tries to get into bed with her, as he did for over 70 years with his wife. The nurse arrives in response to Mrs T's shrieking. In her training in the validation approach, she has recognized from the following physical and emotional characteristics that Mr L is in the second stage, and knows how to communicate with him using the six techniques described on pp. 211–12.

Physical characteristics of time confusion

Stage two is characterized by the following physical attributes: unfocused, but bright eyes; fluid movements and relaxed muscle tone; loose facial muscles; loss of sensory acuity; and often bladder incontinence. Speech is unclear, and very few specific nouns are used; a person may switch from past to present tense within the same sentence and even invent new words when they cannot find the correct 'dictionary' word. With the loss of metaphorical speech (the ability to use 'as if' constructions) already begun in the first stage, speech becomes increasingly literal and abbreviated.

Emotional characteristics of the time confused

Disinhibition increases in the second stage and persons experiencing time confusion no longer conform to social rules, and are not motivated or able to conform. With the additional damage to memory, past and present time cannot be consistently differentiated. Instead of keeping track of chronological, or clock time they make associations through the emotional tone of memories. They can jump 60 years in seconds. With eidetic vision, they restore images of people and objects from the past in order to survive the loneliness and boredom of the nursing home or hospital. This restoration of the past is functional to their survival in these environments in light of their cognitive limitations.

In the example of Mr L the nurse might encourage him to talk about his wife, about missing her and about some of his favourite memories of her. She would validate his feelings of loss. If Mr L were younger and had any chance of functioning in the community independently again, it would make sense to try to orient him to present time and place and explain that his wife was dead, but not now that he is 94 and has sustained substantial damage to recent memory.

Helping techniques for the time confused

1 Use touch liberally. Persons in stage two are not threatened by touch, but rather find it comforting. Zuckerman (1950) stated the 'previous stimulation of a group of nerve cells which has led to a state of satisfaction, increased its sensitivity to further stimulation of a like kind'. The amount of touch and the location depend upon the needs of the individual. Touching different areas triggers memories of different relationships. For example: gentle pressure on the cheek with the palm of the hand triggers feelings of a mother relationship (Buhler, 1971), whereas touches on the back of the head with a cupped hand are more likely to trigger feelings of a father relationship. Each person will respond differently depending upon their own early memories and relationships with their loved ones. Through working with touch, the validation worker can often 'become' or replace a significant, trusted person that the person in stage two is reminiscing about.
2 The use of genuine, close eye contact is very important in working with persons in time confusion because of their impaired eyesight. The worker must bend down and be very close to them for optimal interactions. Eye contact in combination with touch and a clear voice can help to stimulate verbal and non-verbal communication.
3 Use simple words to identify and talk about the emotions that persons in the second stage are demonstrating. Unlike persons in stage one, they are not threatened by this because they are not as aware of their cognitive impairments as the damage progresses.
4 In order for a worker to empathize with the resident, it is helpful if they try to match the emotion that the resident is feeling with memories of a time in their life when they experienced the same emotion.
5 Link a resident's non-verbal behaviour to their unmet human need where that is obvious. For example, if Mrs J is kissing her hand and crooning, a validation worker might gently touch her on the back of the neck, bend down and say in a soft, nurturing voice: 'You miss your baby, don't you. You love that baby a lot.' They might continue to sing a lullaby together. Such interactions can occur within a few seconds. The resident does not know who the validation worker is, but she will know that this person makes her feel safe and that her need to restore her mother has been validated. With increased feelings of self-worth she may try harder to talk, and no longer need to use her hand to symbolize a baby.
6 Because it is not always possible to determine what a resident in stage two is doing or meaning, the validation worker can use 'ambiguity' in the form of vague questions (relating to universal human needs), and non-specific pronouns (he, she, it), when trying to establish and maintain contact. The worker must try to identify the feelings that the

resident is exhibiting, even when they cannot be clearly verbally expressed. For example, Mr G points his finger into space, counting from 1 to 30 over and over. His brow is knit in deep concentration and he appears to be working hard. The validation worker moves close to make direct eye contact with Mr G and uses the ambiguous pronouns 'that' and 'it'. 'That is hard work Mr G. Does it take a long time to finish?' Mr G worked in a canning factory, counting the cans as he worked; he looks up at the worker and beams. 'Yup! Thirty cans in 30 minutes!'

Persons in stage two will never be able to participate in present reality for any length of time, in spite of intensive work with validation, because of the nature of the brain damage. However, if validated, they will interact more, talk more, express feelings of happiness and withdraw less. They will also utilize more social controls, act out less and need less restraining and tranquillizing medication. Persons in stage two also benefit from validation groups. Group work is discussed in Feil (1982) in detail and will not be covered in this chapter.

Stage three: repetitive motion (characterized by patterned self-stimulating movements and vocalizations and increasingly contractured posture)

Mr S pounds his fist against the chair. He is 92 and has lost comprehensive speech. For 63 years he was an expert cabinet maker. He sees the hammer, wood and special nails with his eidetic vision, and he uses his kinesthetic memory to move his hand to past rhythms of hammering. He is 'working' to survive the uselessness and loneliness he feels in the nursing home. The validation worker understands that he moves in order to survive and that this behaviour is purposeful for him. Mr S was oriented to present time until he was 86. His eyes failed increasingly, his knees gave out, his wife died and his recent memory became increasingly impaired. Eventually he needed to restore memories of his past work to feel safe and worthwhile.

Characteristics of the repetitive-motion stage

In this stage more damage has occurred to the eyes, ears, brain and to mobility, which is often relatively spared in earlier stages. The person in stage three continually experiences reduced levels of social contact, and, with little stimulation from the outside, withdraws inward even further. In stage three, residents cannot initiate any form of purposeful verbal or non-verbal communication with others. These persons appear to be egocentric and totally unaware of others. They stimulate themselves in the little world they have withdrawn into. Eye contact is much reduced in stage three and persons have an increasingly stooped posture, further forcing their eyes to

be directed downward. Repetitive motions, rhythms, humming, pacing, clucking, moaning and singing replace verbal behaviour. Persons are no longer aware that they are incontinent and incontinence of urine and faeces often occurs in this stage. These persons re-enact former movements related to their work, for example, women in stage three can often be observed using motions resembling cleaning, dusting and waxing the furniture.

Helping behaviours for the repetitive-motion stage

1 Genuinely mirroring the repetitive movements of persons in stage three will help to establish a true and meaningful relationship. The worker knows the social history of the person with whom they are working and so can relate the characteristic movements to events and work from an individual's past. Although persons are very impaired in stage three, and may be almost blind and deaf, they still have a sense of when they are being patronized or ridiculed, and will not form a relationship if they are being treated thus.
2 Persons in the third stage express three universal needs through their movements, rather than using speech; the need for love (by folding, rocking and clucking, etc.), the need to be useful, to work (by making familiar movements to those used for work) and the need to be heard and to express their true emotions to a significant person (by shouting and swearing, etc.). The worker links the behaviour to the human need.
3 Use music and movements that are culturally meaningful. Persons in stage three may not remember the song title, but often can still sing all the words of a song, even though their speech is entirely impaired. (This is because the location of speech and music centres in the brain are located in different places, and the latter is not generally damaged as quickly as the speech centre.) The song must be familiar, with strong emotional memories, i.e. it is not helpful to sing a Jewish song in a Baptist home. Music and movements will often trigger verbal behaviours and temporary awareness of 'clock time', heighten energy and stimulate interaction, thus reducing isolation.

Stage four: the vegetative stage

In this stage, movements are minimal. The repetitive movements have stopped and there is barely enough movement to keep a person alive. The eyes are almost constantly closed in this stage. When persons in stages two and three are left alone for long intervals in care facilities, to sit in geriatric chairs without other stimulation, they progress quickly to the fourth stage. Music and touch may spontaneously trigger some verbal or non-verbal

response, but it is often too late to expect proper speech or purposeful behavioural responses.

RESEARCH AND EMPIRICAL SUPPORT FOR VALIDATION THERAPY

Throughout the 28 years in which validation therapy has been used with disoriented old-old, some formal research studies have been conducted to assess its utility (Alprin, 1980; Peoples, 1982; Fritz, 1986). Two measured research studies are being conducted by The Institute for Life-Span Development and Gerontology in Akrom, Ohio and Dr Colin Sharp at South Port Community Nursing Home in Australia. Two films have been produced documenting results of validation (Edward Feil Productions, 1979 and 1986). These studies included only late-onset dementias of the Alzheimer type or related disorders. Practitioners working with both early- and late-onset dementias report 'younger people (age 40 to 80), behave differently than old-old people in spite of similar damage to brain tissue' (Edward Feil Productions, 1986). Many researchers conclude that 'the earlier the onset ... the more severe the course of the disease' (Roth, 1984).

Conducted with widely differing methodologies, together these studies provide the foundation of a body of empirical evidence supportive of the efficacy of validation therapy.

1 Feil (1972) trained observers (registered nurses and nursing assistants) at the Montefiore Home for the Aged, Cleveland, Ohio. The research team studied twelve severely disoriented nursing home residents, diagnosed organic brain syndrome with senile psychosis. They divided the twelve patients into two groups. Both groups met four times per week for approximately 25 minutes for a period of 6 months.

   Therapeutic goals were to increase positive affect and decrease negative affect in order to promote self-worth. Additional goals were to lessen demands on staff time as self-worth of patients increased.

   Results: All except one group member in the experimental group showed an increase in positive affect. Eight group members showed a decrease in negative affect. Eleven patients rated from plus 1 to 3 in interaction results indicated heightened awareness of self and an increase in feelings of self-worth in all but one group member. The charge nurse on the ward wrote: 'I found the residents less anxious on the ward as compared with those that were not included in the experimental group – and less demanding of nursing time.'

2 Alprin took a very different approach to the assessment of validation therapy. He examined its utility in the organizational level of analysis. He examined the impact of validation therapy on the therapist's attitude and behaviour as well as the disoriented very old nursing-home resident.

Alprin (1980) obtained quantifiable data with regard to behavioural changes of residents and staffs in nursing home settings. He surveyed forty-eight directors, activity personnel and social workers in sixteen homes throughout the United States who were using validation therapy with disoriented, very old residents.

Alprin reports at the conclusion of his survey: 'The evidence obtained thus far would suggest very strongly many positive changes in behavior of resident groups following validation therapy. Almost without exception, shifts in staff behaviour were in a positive direction.'

3 Peoples (1982) compared the effects of validation therapy with reality orientation in a 225-bed nursing Home. She used Hogstel's tool for assessing the degree of confusion.

> Behaviors showed qualitative improvements in behavior for seven of the ten subjects in the Validation group compared with three ofr the eight subjects in the Reality Orientation group. Attendance at the Validation group was better. Validation therapy produced significant improvement in behavior ... whereas Reality Orientation produced no significant difference.
>
> (Peoples, 1982)

4 Most recently, Fritz (1986) performed an analysis of the effectiveness of validation therapy on speech patterns of cognitively impaired very old nursing-home residents before and after Validation groups. Fritz writes:

> I found that Validation Therapy made a significant improvement on the elders' speech patterns. A computer program which measures the number of verbs, nouns, propositions, etc. that a person uses in recorded conversation, and I found that the categories of Malorientation and Time Confusion showed a significant increase in fluency levels and in lucidness, after having participated in Validation groups.
>
> (Fritz, 1986)

CONCLUSIONS

The validation worker can help prevent 'maloriented' persons (in stage one) from voluntarily withdrawing quickly or further into 'time confusion' (stage two) or 'repetitive motion' (stage three). One-to-one techniques can stave off the 'vegetative' fourth stage in those who have withdrawn inward as far as stage three.

There is no formula for working with human beings. The validation worker respects the uniqueness of each disoriented person and realizes that they are trying to survive loneliness and despair by utilizing their crystalized,

intuitive wisdom and past behaviour patterns to cope. The validation worker understands their struggle in this final stage of their life and chooses to walk beside them, wherever they happen to be.

EDITOR'S POSTSCRIPT

It is important to emphasize that when the four stages of dementia were developed to form the validation approach in the late 1960s, purely on behavioural observations, there were no comprehensive stage-specific medical models of dementia to help clinical research and practice. It is reassuring to see, that practical clinical behavioural observations are converging with, and being confirmed by neurobiological advances in understanding dementia.

NOTE

*This section on pp. 203–4, and the sentence on p. 205, has been inserted by the editor. The author prefers the term disorientation instead of dementia, as used in the title and in several places in the article.

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