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A Review of Reality Orientation (RO), Validation Therapy (VT), and Reminiscence Therapy (RT) with the Alzheimer's Client

Diana-Lynn Gagnon, BSc OT, SROT, OT(c)

ABSTRACT. This paper provides a review of the literature on three common treatment approaches used with individuals with Alzheimer's disease: reality orientation, validation therapy, and reminiscence therapy. An operational definition is provided for the three modalities, all of which will be evaluated according to their theoretical rationale, intended therapeutic population, cost of training and implementation, effects of intervention on staff, intensity of intervention, and observed behavioural, cognitive, psychosocial, and functional changes as a result of intervention. It was found that reality orientation and validation therapy fail to provide adequate observable changes in clients to support the cost of implementation, and that more research has to be done into reminiscence therapy prior to its wide-spread implementation. It is suggested that occupational therapists can provide activity groups and specific skills training which will elicit the same, or better, outcomes at a diminished cost. *[Article copies available from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworth.com]*

Presently in Canada, there are approximately 300,000 individuals with Alzheimer's disease (C. Strathy, Alzheimer's Society, personal

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communication, January 13, 1995). In addition, there are many more confused elderly who remain undiagnosed. Treatment of these individuals is difficult, and often involves maintenance, rather than rehabilitation. A review of the literature on three common treatment approaches used with clients with Alzheimer's disease–reality orientation (RO), validation therapy (VT), and reminiscence therapy (RT)–is presented. Alzheimer's disease will be briefly described and operational definitions of the three treatment approaches provided. The approaches will then be evaluated according to their theoretical rationale, practicality of use (intended therapeutic population, cost of training and implementation, effects of intervention on staff, and intensity of intervention), and observed changes as a result of intervention (behavioural, cognitive, psychosocial, and functional). The findings will be used to determine the efficacy of RO, VT, and RT. Finally, alternative treatment methods, based on occupational therapy principles, will be suggested for use with the Alzheimer's population.

ALZHEIMER'S DISEASE

Alzheimer's disease is characterized by a general loss of intellectual capabilities which interferes with the ability to perform activities of daily living (Powell & Courtice, 1986). It presents itself as a slow and steady decline in intellectual functioning (Bleathman, 1988). More specifically, the individual experiences memory loss, inability to think abstractly, impaired judgement, aphasia, apraxia, agnosia, and a change in personality (Powell & Courtice). These intellectual changes are due to physical and chemical changes within the brain. Firstly, neurofibrillary tangles, accumulations of abnormal fibers concentrated in the cytoplasm of a cell, appear in the limbic system, the part of the brain which is responsible for emotions and memory. Next, accumulations of degenerated neural material, called neuritic plaques, begin to appear. And finally, a process called granulovacula degeneration, where the interior of a cell becomes filled with vacuoles containing fluid and granular material, begins to occur. Higher numbers of neurofibrillary tangles and neuritic plaques produce higher impairment in intellectual functioning. In addition to these changes, the brain of an individual with Alzheimer's disease shrinks, the ventricles enlarge, and there is a decrease in the production of acetylcholine, a necessary neurotransmitter (Powell & Courtice).

There are four stages of Alzheimer's disease, as described by Powell and Courtice (1986). The first stage is characterized by a slight decrease in energy, initiative and reactions. Clients in this stage prefer familiar people and surroundings. They may become easily upset and angered, and they often have word finding difficulties (aphasia). The onset is insidious, and relatives are often unaware that anything is wrong.

As the clients move into the second stage, their speech slows, their aphasia increases and they often misunderstand what is said. Planning and decision making becomes extremely difficult. The individual becomes increasingly self-absorbed, seeming to be insensitive to the needs and feelings of others. This individual continues to function, but requires supervision (Powell & Courtice, 1986).

The third stage marks the beginning of an obvious disability. The clients lose orientation to time and place, and become unable to recognize even familiar people or objects. They require repeated instruction and direction to complete any task. Recent memory is severely compromised, but the past is easily and clearly recalled. During this stage, bizarre and exaggerated behaviours begin to appear (Powell & Courtice, 1986).

The fourth stage is characterized by a complete loss of self. The individual requires assistance with all activities of daily living. Recent and remote memories fail, while words and phrases are repeated. The individual does not recognize him/herself, or others, and is often found wandering aimlessly. This stage is marked by depression, delusions, delirium, and by a loss of dignity and confidence (Powell & Courtice, 1986). This paper will focus on treatment modalities used with Alzheimer's clients in the third and fourth stages of the disease.

REVIEW OF THE TREATMENT MODALITIES

This section will provide operational definitions of reality orientation, validation therapy, and reminiscence therapy. The history,

goals, and implementation of each treatment modality will be discussed.

Reality Orientation

Reality orientation was introduced in 1958 by Dr. James Folsom at a Veterans Administration Hospital in Topeka, Kansas (Holden & Woods, 1982). The purpose of RO is to halt the confusion, disorientation, social withdrawal, and apathy which are characteristic of institutionalized elderly (Harris & Ivory, 1976), by attempting to re-orient them to reality (Burton, 1982). This re-orientation is achieved through the use of twenty-four hour RO and classroom RO.

Twenty-four hour RO is a continual process whereby all staff and visitors orient the individual to time, place and person during every interaction (Holden & Woods, 1982). Constant repetition of this information, through verbal interactions and the use of environmental aides, such as clocks and calendars, is essential (Harris & Ivory, 1976). Sentences should be short, simple and specific, and they should encourage a response (Holden & Woods). The repetition of information is disguised, through the use of rephrasing, so as not to be condescending, since the integrity of dignity and self-esteem is vital. The client should be encouraged and praised for all attempts at RO (Harris & Ivory; Holden & Woods).

Classroom RO is a more intensive form of RO which is meant to supplement twenty-four hour RO (Harris & Ivory, 1976; Holden & Woods, 1982). The group should consist of 3-6 clients per leader, depending on their level of confusion, and they should meet for thirty minutes to one hour daily (Holden & Woods). The meeting should be held in a special room with a warm, relaxed atmosphere, comfortable chairs, interesting pictures, and large windows. Clients should be divided into three separate groups, basic, standard, or advanced, according to their level of disorientation. All three levels are designed to help the client succeed, be oriented, and communicate.

Validation Therapy

Naomi Feil introduced validation therapy in 1966 after finding that her attempts with reality orientation with the old-old (80-100 years old) were causing her clients to withdraw even further (Feil, 1992). Validation therapy is a process of communicating with the disoriented elderly by validating and respecting their feelings in whatever time or place is real to them, even though it may not correspond with our reality (Bleathman, 1988). VT focuses on the emotional, rather than on the factual, content of what is said (Bleathman, 1992). VT can be carried out individually or in regular group sessions.

Individual validation sessions occur daily for five to twenty minutes depending on the individual's level of disorientation (Feil, 1992). The workers sit close to the client and speak in clear, warm, loving voices. They use exploring words such as who, what, where, and how to elicit information. Validation workers never lie to their clients. They use genuine empathy to validate only those feelings which are expressed.

In group VT, five to ten disoriented clients gather for discussions meant to elicit the universal feelings of anger, separation, or loss (Bleathman, 1988). These topics allow the individuals to explore unresolved feelings and conflicts. By verbalizing their memories and thoughts, and by having them validated, the client gains a feeling of being accepted. The group should meet at least once a week at the same time and place, for between twenty and sixty minutes (Feil, 1992). Each group member will have a specific role for every meeting. The persistence of time, place, and role provides security for the individual. All groups include four parts: music, talk, movement, and food.

Reminiscence Therapy

Reminiscence is defined as the act of thinking about past experiences, especially those considered personally significant (McMahon & Rhudick, 1964). In 1961, Butler was the first to propose the therapeutic aspects of reminiscence (Kiernat, 1979). Prior to that, reminiscing was believed to be pathological. Reminiscing is now believed to be instrumental in resolving past conflicts and in maintaining social roles, self-esteem and goal-directed behaviour in old age (Poulton & Strassberg, 1986).

McMahon and Rhudick (1964) described three types of reminiscence. Story-type reminiscence involves remembering factual mem-

ories for their own pleasure. Life-review is a naturally occurring process characterized by the return to consciousness of past experiences in order to resolve past conflicts. Halo effect reminiscence involves the recollection of a particular situation over and over due to overwhelming guilt or despair. This paper will focus on the therapeutic effects of story-type and life-review reminiscence.

Reminiscence can occur either as individual or as group sessions (Lewis & Butler, 1974). In individual reminiscence, the therapist aids the client through an already occurring self-analysis in order to make it more conscious, deliberate and efficient. Several methods of evoking memory in the elderly are the use of autobiographies, pilgrimages, reunions, scrapbooks, photo albums, and genealogy.

Group reminiscence allows individuals to re-experience their pasts through the lives of others (Lewis & Butler, 1974). Although many authors make reference to the therapeutic use of group reminiscence (Baker, 1985; Harwood, 1989; Kiernat, 1979; Lewis & Butler; Poulton & Strassberg, 1986; Sullivan, 1982), none indicate specific guidelines to follow when running such groups.

THEORETICAL RATIONALE

Most research into the use of reality orientation has focused on whether it works, and not on how or why it works (Holden & Woods, 1982). RO treatment methods do, however, appear to have their roots based in cognitive theories. Cognitive theories are insight oriented approaches that emphasize recognizing and changing negative thoughts and maladaptive beliefs (Weiten, Lloyd, & Lashley, 1990). Reality orientation seems to be based on cognitive theory as its goal is to halt confusion in elderly clients by re-orienting them to reality (Burton, 1982).

Validation therapy is strongly influenced by psychodynamic theory (Goudie & Stokes, 1989), though Feil herself claims to be eclectic (personal communication, October 22, 1994), and there is some evidence to suggest that VT adopts a humanistic approach (Dietch, Hewett, & Jones, 1989). Humanistic theorists believe that an individual's subjective view of the world is more important than objective reality (Weiten et al., 1990). This belief fits well with validation therapy, as it focuses on the emotional, rather than the

factual content of what is said (Bleathman, 1992). Feil added a ninth stage, resolution versus vegetation, to Erikson's developmental framework in order to incorporate the old-old confused client (Feil, 1992; Jones, 1985). Feil describes this stage as an opportunity for individuals to achieve integrity by justifying life and resolving past conflicts before dying.

Like validation, reminiscence therapy is strongly based in psychodynamic theory (Kovach, 1990). It is based on Erikson's eighth stage of human development, ego integrity versus despair (Boylin, Gordon, & Nehrke, 1976), which occurs when individuals review their life, during late adulthood, and evaluate it as being either primarily positive or negative (Santrock, 1992). The ability to find pleasure and meaning in life upon reminiscing will determine whether an individual attains ego integrity or despair (Kovach). A positive correlation was found by Boylin et al. between the frequency of reminiscence and ego integrity.

PRACTICALITY OF USE

Research findings for each treatment modality are presented in this section according to the intended therapeutic population, the cost of training and implementation, the effects of intervention on staff, and the intensity of intervention.

Intended Therapeutic Population

According to Holden and Woods (1982), reality orientation is specifically designed for disoriented, confused clients. RO is suitable for use in psychiatric and geriatric hospitals, nursing and residential homes, and day hospitals, but it is of no benefit to clients who are deaf, blind, or restless (Holden & Woods; Jenkinson, 1992). A negative relationship has been found between the age (Zepelin, Wolfe, & Kleinplatz, 1981) and disorientation (Brook, Degun, & Mather, 1975) of the client, and positive behavioural changes after RO intervention.

Validation therapy is appropriate for use with individuals who are between the ages of 80-100 years, have led healthy, productive

lives, have denied severe crises throughout their lives, hold rigidly onto familiar roles, have permanent damage to organs, choose to retreat from painful reality, and are in a stage of resolution versus vegetation (Feil, 1992). Individuals suffering from Alzheimer's disease will also benefit from VT (Feil, 1990). Though Feil describes a specific group of individuals whom VT is claimed to benefit, she adds that if validation works for a client, to use it despite the diagnosis (Feil, 1992).

Reminiscence is a naturally occurring process in the elderly who are in Erikson's stage of ego integrity versus despair (Boylin et al., 1976). Lewis and Butler (1974) claim that RT can be used with individuals of any age as long as they are experiencing a crisis, even though reminiscence is most prominent in individuals in their sixties, with the prevalence decreasing slightly as they age. They do specify that RT can be used with the brain damaged client. Although it will not reverse the brain damage, it may be useful in alleviating depression and increasing adaptation.

Cost of Training and Implementation

There is no formal training required before implementing either twenty-four hour or classroom RO, though workers should receive ongoing in-house instruction and support (Holden & Woods, 1982). Due to this lack of formal training, there is no consistency in the care provided to clients. Holden and Woods found that many institutions who believed that they were carrying out RO, in fact were not. The cost of implementing RO for the first time in a facility is high. In a year long study done by Zepelin et al. (1981), the cost of implementing RO was $11,000 plus 500 hours of volunteer work. This cost is mostly incurred by classroom RO, as it requires a special room, special equipment, and a lot of staff time (Hanley, McGuire, & Boyd, 1981; Johnson, McLaren, & McPherson, 1981). Twenty-four hour RO can be implemented at virtually no extra cost since it is to be carried out during normal client/staff interactions (Hanley et al., 1981; Harris & Ivory, 1976).

In order to run a validation therapy group, the leader must be trained by a skilled validation therapist for at least six months (Jones, 1985; Kohn, 1993). However, the cost of implementing a validation group does not stop once the worker is trained. Additional costs involved in implementing validation therapy include a special room, equipment, and extensive amounts of staff time for the preparation and the running of a group (Robb, Stegman, & Wolanin, 1986).

No formal training is required to facilitate reminiscence therapy, however, Lewis and Butler (1974) suggest that leaders be good listeners who can understand the struggles that the client is experiencing. The cost of running a reminiscence therapy group includes a quiet room and several staff hours in preparing and running the group. Preparing the necessary materials for a group, such as old photographs and books, can be a long, hard process (Kiernat, 1979).

Effects of Intervention on Staff

Reality orientation has been found to increase job satisfaction (Baines, Saxby, & Ehlert, 1987) and to enhance work in general (Harris & Ivory, 1976), as was proposed by Holden and Woods (1982). They postulated that this would occur because staff were given an opportunity to provide more than just general physical care. But other studies have failed to find such positive results. Since twenty-four hour RO requires the continual repetition of basic information, staff in a study by Dietch et al. (1989) became bored and began applying techniques in a rote, uninspired way. Holden and Woods admit that RO can become repetitive and boring. The staff involved in a study by Woods (1979) found RO to be demanding and persistent, and therefore less enjoyable. Many care staff find RO frustrating, since improvements are small and quickly forgotten (Morton & Bleathman, 1988). It is for this reason that Holden and Woods suggest that RO workers require constant support from co-workers.

Research done by the Validation Training Institute (Kohn, 1993) and by Feil (1990) show that caregiver burnout decreases through the use of validation techniques with clients. Kohn also notes that staff turn-over decreased by 80% within the first year that validation therapy was introduced in a nursing home in Kansas City. These, however, are the only references to a positive outcome of validation therapy on staff members. Robb et al. (1986) found that validation therapy was labour intensive and demanding on leaders. During a validation therapy group session, leaders relied heavily on

each other as they were required to remain physically and mentally active throughout the entire session. Even Feil (1992) admits that staff may experience burnout if they expect too much from the intervention and are not supported by administration.

Baines et al. (1987) reported that staff experienced an increase in job satisfaction resulting from leading reminiscence therapy groups. In addition, staff felt closer to their clients after hearing about their past experiences, therefore making it easier to talk to them. Staff in the study by Kiernat (1979) reported that the RT groups were fun and educational.

Intensity of Intervention

Reality orientation, as described by Holden and Woods (1982) is a very intensive treatment modality. They suggest that twenty-four hour RO occur during every staff/client interaction, and that classroom RO occur daily for thirty to sixty minutes. No advantages have been found to having more than one classroom session per day. Validation therapy does not appear to be as time intensive. Individual validation sessions range in length from five to twenty minutes per day, depending on the level of confusion of the client (Feil, 1992). Group VT should occur one hour per week. There is no clear definition of how long or of how often reminiscence should occur to produce maximum benefits.

OBSERVED CHANGES AS A RESULT OF INTERVENTION

The purpose of implementing any treatment modality is to produce observable changes in the client. Each treatment modality will be evaluated for its ability to produce behavioural, cognitive, psychosocial, and functional changes. Not all studies cited involve Alzheimer's clients. The author is of the opinion, however, that the findings of the studies cited can be related to individuals with Alzheimer's disease since each treatment modality is intended for use with such a population.

Behavioural Changes

Behavioural changes as a result of reality orientation are limited to communication. Several studies have shown that clients experience a modest increase in verbal orientation after participating in classroom RO (Baines et al., 1987; Citrin & Dixon, 1977; Hanley et al., 1981; Harris & Ivory, 1976). Clients were found to be more talkative (Brook et al., 1975), and to experience less bizarre verbalizations (Harris & Ivory). No other behavioural changes were found as a result of classroom RO (Citrin & Dixon; Hanley et al.; Woods, 1979; Zepelin et al., 1981), and no studies have been done to measure the effectiveness of twenty-four hour RO alone.

Few studies have been done to evaluate the effectiveness of validation therapy, other than those done by the Validation Training Institute, many of which are unpublished. Validation therapy has been found to decrease crying, pounding and pacing (Feil, 1990).

Due to the lack of consensus on what constitutes reminiscence therapy, empirical evidence into its effectiveness is lacking. However, one study by Baker (1985) into the effectiveness of group reminiscence therapy found that clients experienced increases in interaction, eye contact, touching, smiling, and participating after taking part in such a group.

Cognitive Changes

Research into the cognitive benefits of reality orientation has shown several positive results. After four weeks of twenty-four hour and classroom RO, clients experienced increases in information retention and orientation (Baines et al., 1987; Woods, 1979). Other studies have indicated increases in learning, memory (Woods), and orientation (Citrin & Dixon, 1977; Harris & Ivory, 1976), and decreases in disorientation (Zepelin et al., 1981). Negative results include no increase in concentration (Hanley et al., 1981; Woods) or change in performance on the mini-mental state examination (Scanland & Emershaw, 1993).

The only cognitive improvement which was noted following validation therapy was an increase in the recognition of feelings (Robb et al., 1986). Reminiscence therapy, however, demonstrated some increases in cognitive functioning. After participating in reminiscence therapy, clients were found to experience an increase in attention span (Kiernat, 1979; Kovach, 1991) and in mental ability (Hughston & Merriam, 1982).

Psychosocial Changes

Several studies have shown that reality orientation groups are enjoyable for the participants involved (Baines et al., 1987; Zepelin et al., 1981). Staff noticed that most classroom RO members interacted with one another, tried new activities, and revived old interests, though these results were not observable upon assessment. However, RO can sometimes be painful and upsetting for group members (Baines et al.; Dietch et al., 1989). Clients do not always like to be forced to focus on the often unsatisfying present, and are content living in happier times from the past. It has been noted that individuals participating in validation therapy experience a slight increase in social behaviour and interactions (Morton & Bleathman, 1991; Robb et al., 1986).

Evidence supports the improvement of psychosocial functioning following reminiscence therapy. Members enjoyed the reminiscence group (Baine et al., 1987; Harwood, 1989; Havinghurst & Glasser, 1972; Hughston & Merriam, 1982; Kiernat, 1979) for its ability to increase self-esteem (Kovach, 1990; McMahon & Rhudick, 1964), life satisfaction (Baines et al.), and self-identity (Baker, 1985), and for its ability to decrease isolation, and therefore depression (Lewis & Butler, 1974).

Functional Changes

Results for all three treatment modalities were disappointing in the area of functional changes. Zepelin et al. (1981) found no functional improvement following RO intervention. Harris and Ivory (1976) found that positive results in the areas of behaviour and cognition following RO failed to generalize into functional improvements such as bathing or face-washing. Brook et al. (1975) did find, however, that clients participating in reality orientation groups experienced a decrease in incontinence. Robb et al. (1986) found no functional improvements following validation therapy, and no research has been done into the functional benefits of reminiscence therapy.

DISCUSSION

A comparative study between reality orientation and reminiscence therapy was conducted by Baines et al. (1987). The study consisted of a control group that was exposed to no treatment, and two intervention groups that were exposed to both RO and RT sessions in a cross-over design. The largest improvements (mostly behavioural in nature) were made in the group that was exposed first to RT and then to RO. At a one-month follow-up period, the improvements were maintained in the intervention groups, while the control groups continued to decline.

Perhaps the most detrimental aspect of the empirical evidence to support the use of reality orientation is the lack of a consistent operational definition. The definition of reality orientation states that it was specifically designed for the use with the confused client. But Holden and Woods (1982) fail to define the word "confused." There are many different diseases which cause confusion, each of which may not require the same intervention (Bowlby, 1991). By failing to define the word 'confused,' Holden and Woods fail to define for which precise group of people RO is intended (Burton, 1982). There is also no clear definition of what constitutes reality (Burton). Without such a definition, there is no way of measuring if a client has actually been oriented to reality. In addition to these faults, group specifics, such as format, content, size, and staff/client ratio, have not been clearly defined (Bowlby). The same problem exists with reminiscence therapy (Kovach, 1990; Merriam, 1980). Without such definitions, it is difficult to accept the results of studies done on the effectiveness of reality orientation or reminiscence therapy and to generalize them into practice.

Cost of implementing a program is an important variable to consider when choosing a therapeutic technique. The present financial environment of cut-backs and closures cannot afford to establish an expensive new treatment modality with only modest outcomes. Both reality orientation and validation therapy have proven to be costly treatment approaches. Neither method has been successful at justifying these costs through the evidence of major changes in clients. In fact, Hanley et al. (1981) believe the results of classroom RO are far from encouraging, when considering the time and the

cost involved in running such groups. Perhaps the additional money which is required to run these programs would be better used in programs which have proven to be more empirically sound, and which can be of benefit to more clients.

The effects that the implementation of a treatment modality has on the staff members who administer it are important factors to consider when choosing a treatment approach. Staff are less likely to implement a program properly and consistently if they do not enjoy doing so, or if they experience personal problems as a result. Both reality orientation and validation therapy appear to have detrimental effects on the staff who implement these approaches.

Having a strong theoretical basis for why a treatment method was chosen is important in today's environment of justifying intervention and providing outcome measures. Reality orientation fails to provide a strong theoretical rationale for why it works (Bowlby, 1991). This lack of a theoretical basis makes the approach less credible in the eyes of other professionals. Both validation therapy and reminiscence provide strong theoretical rationale. However, the rationale behind validation therapy assumes that clients with dementia are capable of abstract thinking (Goudie & Stokes, 1989) and that all behaviour has meaning (Jones, 1985). This is unlikely.

The majority of the positive changes incurred by the implementation of these three treatment modalities were in the area of self-esteem, self-identity, interaction, and communication. However, it is unknown whether these outcomes are a result of the actual treatment intervention, or if they are a result of the Hawthorne effect. Often, Alzheimer's clients are forgotten, left for long hours sitting alone, considered to be beyond help. Given the opportunity to interact with others, Alzheimer's clients may do so.

Occupational therapists possess the necessary skills to implement and run various sorts of activity and skills based groups, which can produce the same changes that reality orientation and validation therapy do, but at a smaller cost. These groups would provide the opportunity for interaction, while incorporating some RO, VT, and RT techniques. They would provide meaning to the clients' lives, through the use of purposeful occupation. This is important, as dementia is associated with a lack of meaningful roles (Sainty,

1993). As interaction and role functioning increase, so too will self-esteem and self-identity.

Also, it is assumed that the sorts of cognitive, "talking" therapies that were reviewed will have positive behavioural out-comes. In order for this to occur, behavioural changes would have to be dependent on cognitive changes (Hanley et al., 1981). This, however, is not always the case. Perhaps Alzheimer's clients would benefit more from actual skills training (dressing, feeding, toiletting). This training would allow them to become more independent, thereby increasing self-esteem and dignity. Being trained to teach self-care skills, occupational therapists can provide aide to Alzheimer's clients in this way.

CONCLUSION

It can be concluded that reality orientation, validation therapy, and reminiscence therapy all fail to provide adequate positive treatment outcomes to justify their implementation. In today's economy, empirical evidence is required to support the use of treatment modalities. As of yet, no treatment method has proven effective with Alzheimer's clients. Reminiscence therapy shows promise, but a formal operational definition, and more research to determine observable changes, are required prior to implementing widespread use of such a technique.

Occupational therapists can provide help in the treatment of the Alzheimer's client. The use of meaningful occupation and skills training, both of which are cornerstones of occupational therapy, may provide the necessary stimulation to stabilize these confused individuals.

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