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EFFECTIVENESS OF VALIDATION THERAPY: PERCEPTIONS AND OPINIONS OF CERTIFIED VALIDATION THERAPISTS

A THESIS

Presented to the Department of Social Work

California State University, Long Beach

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

By

Janet May Hosey

BSM, 1983, Pepperdine University

May 1999

WE, THE UNDERSIGNED MEMBERS OF THE COMMITTEE,

HAVE APPROVED THIS THESIS

EFFECTIVENESS OF VALIDATION THERAPY:

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CERTIFIED VALIDATION

THERAPISTS

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ABSTRACT

EFFECTIVENESS OF VALIDATION THERAPY:
PERCEPTIONS AND OPINIONS OF
CERTIFIED VALIDATION
THERAPISTS

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This study was a survey of opinions and perceptions of Certified Validation Therapists about the effectiveness of Validation Therapy. Validation Therapy was developed by Naomi Feil especially for the old-old (80-100 years) residents of nursing homes who are afflicted with Alzheimer's disease. Validation Therapy has guidelines for communicating with these victims on an emotional level when it is no longer possible to do so cognitively.

Overall, the Certified Validation Therapists were satisfied with the results obtained with Validation Therapy. They were enthusiastic about making Validation Therapy a permanent part of treatment in nursing homes. They also believed that Validation Therapy was more effective than Reality Orientation with mid-stage and

later Alzheimer's patients. Social Workers must familiarize themselves with the benefits of Validation Therapy and the value of adding Validation Therapy to treatment protocols for Alzheimer's victims.

ACKNOWLEDGMENTS

I present this thesis, with deep gratitude, to the following people.

To my mother, Margaret Mills, who taught me the value of humor in the face of adversity. Your memories are no longer present, but your smile and love of people remain.

To my children, Ted, and Sue, and your families. You have given me love, encouragement, and support. You have been instrumental in my obtaining this master's degree. Thank you for your belief in me.

To my thesis advisor, Dr. Catherine Goodman. Your guidance and direction have been invaluable. I am fortunate to have had the benefit of your expertise, and I am truly grateful.

To my friends who have "walked this walk" with me. I am blessed to have your friendship.

My sincere appreciation goes to the Certified Validation Therapists who participated in this study. Your dedication enables Alzheimer's victims to connect emotionally and to communicate longer.

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CHAPTER 1

INTRODUCTION

On a national level, four million American adults are affected by dementia, which is the fourth leading cause of death after heart disease, cancer, and stroke. It costs society $100 billion annually. Alzheimer's disease accounts for 56% of dementia disorders. Vascular dementia is 14%, and 12% is from multiple causes, including Diffuse Lewy Body. Diffuse Lewy Body refers to a combination of symptoms from Alzheimer's disease and Parkinson's disease. This disease has only been recognized in recent years. Parkinson's disease is 8% of the causes. Other dementia/progressive memory loss causes are from brain injury, metabolic, infectious, traumatic, inflammatory, and mass lesion disorders amounting to 10% (Alzheimer's Association of Orange County, 1997; Hopkins, 1997).

Often, dementia is not recognized in the early stages; there are no blood or other definitive tests or other definitive test that can confirm a diagnosis. There are many types of dementia; however, in more recent years, dementia is usually classified as dementia-Alzheimer's type. Alzheimer's can only be positively

diagnosed if a biopsy of the brain is done or if an autopsy is performed after death. Only brain tissue biopsy reveals the neurofibrillary tangles and degenerated nerve endings called plaques that provide positive diagnosis of Senile Dementia-Alzheimer's Type (Katzman, 1986; U.S. Department of Health and Human Services, National Institutes of Health, 1981 as cited in Lehman, 1987). Brain biopsy, which requires removal of approximately one gram of frontal lobe tissue, can be done without further compromise to the patient's health and functioning. It is regarded as an appropriate diagnostic procedure in England, but is considered too risky in the United States (Lehman).

Alzheimer's Disease is a slow, irreversible deterioration of the brain tissue. It impairs the cognitive functions of the brain, such as language skills, memory, ability to care for oneself (e.g., bathing and grooming) and sense of time and space. Alzheimer's is an irreversible dementia with no known cure. However, many of the symptoms of Alzheimer's Disease, particularly depression, agitation, hallucinations (seeing or hearing things that are not there and cannot be seen by others who are present) and delusions (false beliefs) can sometimes be controlled or alleviated by taking medications (Alzheimer's Association, 1994).

This disease takes an enormous toll, not only on persons with the disease, but on their families and friends as well. Families are under tremendous stress because of the nature of the disease itself, the duration of the disease, and the intensity of the caregiving responsibilities (Alzheimer's Association, 1994; Behar, 1989). Those families providing caregiving duties may consider placing the person with Alzheimer's in an institution, as all those afflicted with this disease reach a point of requiring 24-hour care. It is an overwhelming burden for the caregiver, and the cost of hiring full-time, experienced help is prohibitive for the average family. Institutions providing care for dementia patients are usually designed with different stages of the disease in mind (Gruetzner, 1992).

As a rule, good board and care homes and assisted living facilities have staff who are knowledgeable about dementia and are able to assist the residents in their daily living activities, showering, changing clothes, and toileting (Holmes, Teresi, & Monaco, 1992; Vittoria, 1996). These patients are usually able to walk by themselves or with the use of a cane or walker. They can also feed themselves and follow directions of the staff. There are often activities which are designed to help the patients continue or improve communication with others as

well as helping them use their memory as much as possible. When the patient is no longer able to participate in these functions, he/she is transferred to a nursing facility which provides less social and more medical care. Feeding, dressing, and hygienic duties will often be done by a nursing assistant or family member. Finally, the patient will no longer be able to eat or swallow food, talk, or move about. This is often the time when death comes (Gruetzner, 1992).

This study is about Validation Therapy, a relatively new therapy that was developed and structured for the very old residents of nursing homes. It is specifically for those afflicted with Alzheimer's Disease and related disorders. Alzheimer's Disease causes deterioration of the brain which destroys memory and affects behavior.

Validation Therapy involves communication with these residents on an emotional level. It provides an opportunity for members of Validation groups to express their feelings and have them acknowledged and validated. It does not attempt to help the residents gain insight into their problems. When people reach a stage of Alzheimer's where they become disoriented and confused, they are not able to understand why they behave the way they do.

Validation is a combination of empathy, touch, eye contact, mirroring body movements, matching voice and rhythms, picking up cues about feelings and putting them into words, accepting without judging, and genuine, total listening. Validation can be used as individual or group therapy. Individual Validation is often used with nursing home residents who have limited verbal capacity and may exhibit disruptive behavior. Group Validation works well with persons who are time confused or who exhibit repetitive motion (Feil 1985, 1992b).

Certified Validation Therapists (CVT) must have completed two 7-hour workshops and have had 6 months hands-on experience with disoriented persons with Alzheimer's disease (AD). He/she must also have formed and led a Validation group for these 6 months and passed a written test given by the Validation Training Institute.

Purpose of the Study

This study was a survey of Certified Validation Therapists. The purpose of the study was to obtain the opinion of nurses, social workers, and therapists as to its effectiveness and its impact on staff and patient relationships.

CHAPTER 2

REVIEW OF THE LITERATURE

Elderly people who are disoriented because of dementia pose particularly difficult problems in treatment. Senile Dementia of the Alzheimer's Type (SDAT) is a neurological condition that impairs brain function and causes loss of intellectual abilities (Gruetzner, 1992). Accurate diagnosis is difficult because dementia affects both memory and behavior. Harding and Palfrey (1997) believed that one difficulty in accurate diagnosis is due to uncertainty about how dementia effects behavior. Cohen (1988) pointed out a confusing problem with Alzheimer's Disease. Alzheimer's is a brain disorder, yet most of the clinical symptoms are behavioral.

Currently, there is no way to stop progressive brain damage. Existing treatments are aimed at improving or maintaining as much quality of life as possible. There are few therapies that are effective with cognitively impaired persons. In some nursing homes, social contact groups, Reality Orientation, and Validation Therapy are part of the treatment therapies (Toseland, 1995).

Naomi Feil developed Validation Therapy specifically for institutionalized individuals who are the old-old (80-100 years). They are the disoriented frail who have been diagnosed with senile dementia and cannot return to the outside community (Feil, 1992a, 1992b). Feil stated, "Those with late-onset dementia are what I call the disoriented old-old. Their behavior, speech, gait, and expressions of human needs are different [from early onset]" (1992b, p. 32). "Validation Therapy is a method of communication and group therapy which focuses on the emotional, rather than factual, content of what people say" (Bleathman & Morton, 1992, p. 658).

Origin and Principles of Validation Therapy

Validation Therapy was created by Naomi Feil in 1963 while she was working with the disoriented, old-old residents in the Montefiore Nursing Home in Cleveland, Ohio. There were 170 oriented, elderly residents in one part of the nursing home. These residents had managed to come to terms with the disappointments and setbacks of old age. They were able to enjoy life, remaining oriented to person, place, and time, despite living with the frailties and disabilities of aging (Feil, 1992b).

Feil began working with the 23 disoriented old-old residents who had not adjusted to the daily routines and

were in a separate wing. Early in her work there, Feil (1986, 1992b), like the other staff, used Reality Orientation therapy with these residents. Her initial goals were to help the disoriented to face reality and relate to each other in a group. She discovered that this type of therapy did not work; in fact, it appeared to have adverse effects. Group members either withdrew or continued to deteriorate into vegetation. According to Bleathman and Morton (1992), this caused additional stress between caregiver and resident.

In their study of alternate ways to communicate with cognitively impaired older adults, Fine and Rouse-Bane (1995) found:

> Though well intentioned, RO [Reality Orientation] repeatedly attempts, but seldom succeeds, to correct the perceptions of the cognitively impaired person. Even experienced nurses frequently find these orientation efforts met with withdrawal, vegetation, or increasing hostility; however, RO continues to be suggested frequently as a therapeutic technique. (p. 39)

To validate is to acknowledge the feelings of a person, telling that person the feelings are real. Validation Therapy uses empathy to tune into the inner reality of the disoriented old-old. Feil (1992b) said that empathy builds trust and brings safety. From safety comes strength, which renews feelings of worth, and a sense of worth reduces stress. Using Validation, the

Validation worker picks up clues from the disoriented old and helps put the feelings and actions into words.

Feil described Validation theory as:

> a developmental theory for old-old mal-[oriented] and disoriented people, a method for categorizing their behavior, and specific techniques to help mal-[oriented] and disoriented very old people regain dignity both through individual Validation and through Validation groups. Validation goals: restore self-worth, reduce stress, justify living, work towards resolving unfinished conflicts from the past, reduce the need for chemical and physical restraints, increase verbal and non-verbal communication, prevent withdrawal inward to vegetation, and improve gait and physical well-being. (Feil, 1992b, p. 11)

In addition to the developmental theory and Validation goals, Feil gave the theoretical foundations of Validation Therapy. It is an eclectic therapy of principles based on theories of renowned behavioral, analytical, and humanistic practitioners. As summarized by Feil (1992b, p. 11-12), theoretical assumptions for Validation are:

> 1. Accept your client without judgement (Carl Rogers).
>
> 2. The therapist cannot give insight or change behavior if the client is not ready to change or does not have the cognitive capacity for insight (Sigmund Freud).
>
> 3. Know your client as a unique individual (Abraham Maslow).
>
> 4. Feelings that are expressed and then acknowledged and validated by a trusted listener will become less intense. When ignored or denied,

feelings gain strength. "The cat ignored, becomes the tiger" (Carl Jung).

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).

6. An ignored task demands to be heard at a later stage (Erik Erikson).

7. Human beings struggle for balance (homeostasis; S. Zuckerman).

8. When recent memory (short-term memory) fails, very old humans restore balance by retrieving early memories. When hearing goes, they listen to sounds from the past (Wilder Penfield).

9. Early, well-established memories survive to very old age (F. G. Schettler & G. S. Boyd).

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 Verwoerdt).

11. Autopsies have shown that many very old persons survive significant brain damage and stay relatively oriented (Charles Wells).

12. There is a reason behind the behavior of disoriented very old people (Naomi Feil).

13. Each human being is valuable--no matter how disoriented (Naomi Feil).

Bleathman and Morton (1996, p. 867) wrote that Feil "extended and developed Butler's theory of life review to people suffering from dementia." Butler (as cited in Bleathman & Morton, 1996) suggested that people nearing the end of their lives undergo a psychological process of internally reviewing their lives in order to identify and

work through unresolved conflicts from their past and so prepare for death.

Purpose of Validation Therapy

The purpose of Validation Therapy is to help very old, disoriented persons to achieve goals for living, ease stress, resolve past conflicts, restore feelings of self-worth, and prevent further disorientation. This is done through communication with them and by using the time frame that is their reality. Feil believed we all have our own inner realities, and she said that we return to them to sort things out. We do this by using our body, feelings, and memory (Van Amelsvoort Jones, 1985).

Van Amelsvoort Jones gave her summary of Validation:

> The assumptions behind Validation Therapy are that all behavior has meaning; that early, learned emotional memories replace intellectual thinking in the old-old, and that the disoriented old-old return to the past for the purpose of trying to resolve unfinished conflicts by expressing feelings hidden in youth in order to relive past pleasures, to restimulate sensory memories, and to relieve boredom and stress by retreating from painful feelings of uselessness and loneliness. (1985, p. 23)

Validation Therapists tune in to the world of the elderly, travel back in time with them, and begin to understand the underlying life themes expressed. Validation is a theory about life's final struggles. Very old people change behaviors not only because of

physical deterioration but because they want to return to the past to wrap up loose ends. They need someone to listen to them with empathy in order to complete this final resolution of life before they die. If no one listens, the very old withdraw (Feil, 1985, 1992b).

> Validation techniques demand that one assumes that all behavior has meaning and that even where factual thinking becomes weak, feelings and content survive. Validation Therapy requires that the worker pursue the flow of communication in spite of wrong facts. (Van Amelsvoort Jones, 1985, p. 20)

Resolution Versus Vegetation

Feil developed a stage called Resolution Versus Vegetation. She stated that this stage is like Erikson's Life Task stages and should follow his last stage: Integrity Versus Despair. She stated that those who achieve Integrity do not progress to disorientation. She also likens her stage to Erikson's in that failure to achieve the central task, resolving the past, results in movement to vegetation (Feil, 1992b). Her formulation is based on years of observations and work with disoriented, Alzheimer-type populations. Feil's attempt to make a psychosocial stage does not fully account for neurological impairments and physical brain changes caused by Alzheimer's Disease and related dementias.

At the Montefiore Nursing Home, those disoriented by dementia were not welcomed by the majority of the

residents or staff. They were described as "the blamers, the martyrs, moaners, wanderers, yellers, pacers, and the pounders" (Feil, 1992b, p. 18). Feil stated that these are the people who taught her that there ought to be an additional life task to accomplish in old-old age. She theorized that very old people stuck with deep, unresolved feelings from earlier life stages will often return to the past in order to resolve those feelings.

She stated:

> They pack for their final move. They sort out dirty linen stashed in the storehouse of the past. They are busy, irresistibly drawn to wrap up loose ends. This is not a conscious move to the past, like Erikson's sixth [sic] and final stage. It is a deep human need: to die in peace. Those who achieve integrity in very old age never enter the Resolution stage. But, as humans continue to live longer, there will be a growing number of very old people who fall into the final Resolution stage. They need someone to listen, to validate their feelings. If no one listens, they withdraw to Vegetation. With no stimulation from the outside world, they become one of the living dead in our nursing homes. (Feil, 1992b, p. 19)

Feil explained that when a person enters the Vegetation stage, they shut out the world but still need touch and nurturing. Gruetzner (1992) stated that, in the final stage, touch and a loved one's presence can help an Alzheimer victim remain physically and emotionally alive even when they can no longer reach out to anyone. Feil claimed that, "in helping the disoriented old-old in earlier stages, the worker may prevent

movement to the final stage" (Feil 1992b). Evidence does not support this belief. Moving to a vegetative state happens because of increasing brain damage (Winograd, 1988).

According to Feil, when intense feelings are acknowledged and validated, they dissipate. The feeling memories are there long after the short-term, cognitive functions are greatly reduced. Avoidance and denial are major causes of the very old person's pain and disorientation. Feil believed that people who have faced their problems in life and dealt with them do not become disoriented, even though they have dementia. The disoriented, old-old have not acquired the coping skills which come from facing and dealing with the losses and disappointments that come with each life stage. When the inevitable physical frailties combine with the losses of old age, those in despair have no place left to go except within (Feil, 1985). Ability to think analytically and cognitively decreases with brain changes. These oldest of the old begin to think emotionally. They use sounds and feelings from the past and express their feelings of pain, love, and rage through symbols and movements because they no longer have words for expressions. Feil stated that hindsight helps people survive in old age. Early learning replaces recent memory, and blurry images

from failing sight trigger eidetic memories (Feil, 1992a, 1992b).

Stages of Resolution

Feil created four levels of classification for her life task stage, Resolution versus Vegetation. The classifications are used to determine techniques and types of communication to be used with the disoriented residents. Validation workers observe physical characteristics, review the resident's social and medical history, and interview family members. With this information, they are able to evaluate the resident's stage of confusion or disorientation (Feil, 1990). Feil believed we can identify the disoriented old-old by their physical and psychological characteristics. Each stage is a further retreat from reality; according to her, a slow physical regression.

Stage One: Malorientation. Patients in this stage have cognitive ability that is relatively intact. They are oriented to reality, but not happily, and are usually oriented to person and place. They hold on to socially prescribed rules, except they need to express prior deep conflicts in disguised forms. They sometimes use symbols of people in the present to represent people from the past. They deny feelings. The Validation Therapist does

not analyze or explore their feelings. Maloriented persons do not want insight into why they behave the way they do (Feil, 1992b). People in Stage One are threatened by feelings and by the disorientation they experience, because they are cognitively intact enough to anticipate future deterioration (Feil 1992a, 1992b).

Stage Two: Time Confusion. Brain damage affects the control centers of persons in this stage. When the persons in Stage One suffer too many losses, both physical and emotional, they can no longer hold on to reality, and they enter Stage Two. In this stage, they begin an inward retreat, lose track of present time and adult controls. They lose communication and social skills and no longer conform to social rules or dress codes. There are diminished cognitive abilities, which become more evident as brain damage increases. Fantasy begins, and present reality gives way to early memories. Awareness of painful reality causes further retreat into the past. Feil (1992a, 1992b) believed that Validation, through confirmation and shared feelings in a nurturing relationship, keeps Stage Two persons from withdrawing further and into Stage Three. Gruetzner (1992) stated that memory problems are more evident as the disease progresses.

Stage Three: Repetitive Motion. People in this stage often retreat to basic prelanguage movements and sounds in order to nurture themselves. In effect, they return to the womb. They attempt to resolve the past alone. Speech is lost from disuse, ability and desire to think is lost. The person's speech is replaced by repetitive movement. Memory loss becomes worse. They pace, hum, sing, and rock (Feil, 1992a, 1992b). Gruetzner (1992) also has a stage that he called repetitive behavior. Victim's movement and coordination problems are more evident. Patients display repetitious movements and actually forget how to walk, dress, and eat.

Final Stage: Vegetation. Validation Therapy works to prevent the residents from retreating to this stage, where the person shuts down completely. They make a total inward retreat. They no longer respond to touch, voice, or eye contact (Feil, 1992a, 1992b). In the final stage of dementia, the person has lost all verbal abilities and basic motor skills. The brain seems unable to tell the body what to do (Reisberg, Ferris, Leon, & Crook, 1982). Gruetzner (1992) called this the "final reconciliation." He stated, "Stupor occurs in this terminal stage and leads finally to coma and death" (p. 35).

According to Feil (1993), early onset Alzheimer's victims are not considered for Validation Therapy because of their more rapid deterioration. Feil (1993) stated that her use of Validation Therapy with these residents showed they did not respond to eye contact or touch, and she had not been able to slow their progression to the Vegetation Stage. Residents of nursing homes who are mildly disoriented often respond to Reality Orientation and are not good candidates for Validation Therapy (Feil, 1993). Others who need to be screened out of group therapy are Stage One maloriented, mentally ill, retarded, and chronically ill unrelated to the aging process. Group members should be chosen from Stage Two: Time Confusion, and Stage Three: Repetitive Motion (Feil, 1992a), which are fully described below.

Throughout her Validation stages, Feil (1992b) did not distinguish physical decline caused by dementia and responses that are psychological. While Validation Therapy may provide comfort to these very old people, it cannot prevent the physical/behavioral changes resulting from Alzheimer's and related dementias. Feil (1992b) did not compare or connect her four developmental stages to any like those of the Alzheimer's Association (as cited in Gwyther, 1985) or the seven stages on the Global Deterioration Scale for Assessment of Primary

Degenerative Dementia (Reisberg et al., 1982). This leaves uncertainty as to how Validation stages relate to the stages describing physical decline due to brain damage. Validation Therapy emphasizes relating on an emotional level to enable a human connection when cognitive capacities decline. While it may not prevent deterioration as Feil (1992b) claimed, it may provide a needed human contact as long as possible.

Stages of Alzheimer's Disease

In contrast to Feil's four stages, Reisberg et al. (1982) had seven levels of degenerative dementia. The levels often overlap, and patients may move back and forth between them. The levels are guidelines for assessment and are summarized below.

Levels One and Two cover no complaints of memory deficits to very mild cognitive decline (forgetfulness).

Level Three is mild cognitive decline. Here is the earliest clear-cut memory deficit. The patient may get lost while traveling, coworkers become aware of his/her relatively poor performance. The patient's difficulty finding words and names becomes evident to intimates. He/she may retain little after reading, and a concentration deficit is evident with clinical testing. Objective

evidence of memory deficit is apparent only with an intensive interview.

Level Four is moderate cognitive decline. The patient shows a clear-cut deficit during a careful clinical interview. Deficits are apparent in decreased knowledge of current and recent events, some memory loss of patient's own personal history, and concentration deficits in serial subtractions. The patient remains oriented to person and place and recognizes familiar persons.

Level Five is moderately severe cognitive decline (early dementia). The patient cannot survive without some assistance. During an interview, the patient cannot recall a major relevant aspect of his/her life, such as address or names of close family members. Dressing properly becomes more difficult. The patient is often disoriented to time or place, but does retain major facts about him/herself (Reisberg et al. 1982).

Level Six is severe cognitive decline (middle dementia). The patient is largely unaware of all recent events and personal experiences. Knowledge of his/her past life is very sketchy, and the patient is generally unaware of surroundings, year, and season. The patient requires assistance with activities of daily living and

may become incontinent. Diurnal rhythm is often disturbed. Personality and emotional changes occur. Some changes may manifest in delusional behavior, with the patient talking to imaginary figures and talking to his/her own reflection in mirrors. The patient may exhibit obsessive symptoms, such as continuously repeating cleaning activities. The patient is unable to keep a thought long enough to act on it (Reisberg et al., 1982).

Level Seven is very severe cognitive decline (late dementia). All verbal abilities are lost. There is frequently no speech, only grunting. Basic psychomotor skills are lost. The brain apparently can no longer tell the body what to do (Reisberg et al., 1982).

Feil's Stages and Alzheimer's Disease Stages

Feil is reluctant to provide any relationship between her Resolution Stages and Alzheimer's stages. She said that very old people who have lost their cognitive abilities still use the free association and emotional parts of their mind. Feil (1986) stated, "This does not mean they are demented; they still have their mind, but it is not the logical mind" (p. 19). However, Gruetzner (1992) said: "The first criteria for dementia is the *loss of intellectual abilities* of sufficient severity to interfere with social or

occupational functioning" (p. 11). Feil apparently did not use the term dementia in the same way as Gruetzner. She focused on the emotional and associational capacities of persons classified by the medical profession as "demented."

Therapeutic Techniques of Validation Therapy

Bleathman and Morton (1996) believed that the Validation approach enriches our knowledge and understanding of dementia sufferers. It provides therapeutic techniques for responding to the disoriented persons who refer to their parents in the present tense, as though they are alive now. They stated that Miesen believed constant requests for parents by the demented should be interpreted as cries of distress or a need for security, not sounds from the faded past. He thought they can be explained in terms of Bowlby's Attachment Theory.

Toseland (1995) and Feil (1992b, 1993) described Validation techniques, which can be used individually or in groups. There is no sequence for using Validation techniques, because the therapist always begins where the patient is. Centering is the only exception. The caregiver always centers before any engagement with patients. Centering is a technique for relaxing that is

done by breathing deeply, then expelling the breath and as much anger and frustration as possible before working with the disoriented persons. The caregiver rephrases the resident's statements, uses polarity, and encourages reminiscing. Rephrasing is a way of demonstrating understanding of expression and focuses the attention on the patient. Polarity is asking the patient to think of the most extreme example of his/her complaint. It helps the patient more fully express his/her feelings, which leads to finding some relief from strong feelings. Reminiscing is recalling and exploring memories from the past and sharing them. It can help the person recall past coping mechanisms. Additionally, one must always use a clear, low tone of voice and match the demented person's movements and emotions. The therapist will link the person's behavior to unmet needs, identify the preferred sense, and use touch, music, and movement to stimulate communication. Matching movements and emotions is copying body movements, breathing, facial expressions, and tone of voice. Linking behavior refers to the caregiver seeing the link between behavior and the basic needs to be safe, useful, and express emotions. Identifying the preferred sense is recognizing the kinds of words the patients use to express themselves. "The preferred sense is the one we most often use, and it is

within this framework that we remember and describe our world" (Ronaldson & Savy, 1992, p. 20). Examples of the preferred sense are: Auditory type persons might say they hear someone. Visual type persons would say they see something, and kinesthetic types would use feeling words.

Feil (1992b) stated that Validation Therapy is hard work, and not everybody should attempt to practice it. Caregivers who cannot share intimate feelings with disoriented, old-old people should not work with them. People who are not comfortable with feelings and prefer communication on intellectual, logical levels will not be able to use Validation with empathy. The result of trying to use Validation without meeting the guidelines will be discomfort and distress for caregiver and resident alike.

Symbolic Behavior

Feil taught that the disoriented old-old tend to use symbolism to communicate when they are no longer able to tap into cognitive memories. Using Validation Therapy, the patient's stories are learned and symbolism becomes understandable. When the person is validated, another link has been forged between caregiver and resident.

Feil related the story of an 88-year-old nursing home resident who was in the Third Stage, Repetitive Motion, and the nurse who used Validation techniques with him. This resident kept the staff and other residents upset, because he was constantly pounding his fist on his tray. When he did not have the tray, he pounded on his other hand. In addition, he had lost his ability to speak to anyone. When the nurse used validating techniques of touch, a low voice, and ambiguous pronouns with him, tears began to run down his cheeks, and he very slowly said, "Dad, I got it in straight. Dad, it is only a little crooked, Dad." The nurse had never heard Marvin speak. She told him in a slow, low voice, "You did a fine job. It is in there, straight." Marvin responded with a smile and "I did a good job, Dad." This was the "first time in 9 months he formed dictionary words" (Feil, 1993, pp. 93-94).

People in the third stage, Repetitive Motion, no longer know where they are, and the pictures they see are seen with their mind's eye. Marvin continued to be validated by the nurse for 3 minutes, 4 times a day. His pounding became an occasional thing, and his Thorazine dosage was lowered (Feil, 1993).

Validation Group Therapy

Validation group therapy is different from individual because of its structure. Bleathman and Morton (1992) did a pilot study of the effectiveness of Validation Therapy. The Validation group is highly structured, requiring the same room, seating, and format. The members have the same roles each time, roles such as greeter, opening chairperson, song leader, and napkin passer. Bleathman and Morton (1992) were the group leaders during the study. They found that when they went to get the members for group meetings, the members did not seem to remember who the leaders were or where they were going. However, when the members were seated in the room, the seating and room arrangement appeared to provide cues, which triggered memories of belonging to the group (Bleathman & Morton, 1992).

They described a phenomenon called group memory. The most important factor is adherence to rigid procedure, as this creates group memory in the absence of individual memories (Bleathman & Morton, 1996). When a member of this group died, the other members did not remember him. When his empty chair was "pointed out, it prompted memories of his participation in the group. He was spoken of spontaneously in subsequent groups by name" (Bleathman & Morton, 1992, p. 660).

Cultural Aspects

Feil's books have been translated into Dutch, German, and French, and Validation techniques are used in France, Germany, and The Netherlands. In addition to these countries, Validation Therapy is used in Canada, Australia, and Great Britain (Bleathman & Morton, 1996; Feil, 1992b; Van Amelsvoort Jones, 1985). Van der Kooij (1993) stated that The Netherlands tends toward small nursing homes with 10 to 15 residents per home. In The Netherlands, the choice was made to use Validation Therapy on a large scale and use the 24-hour approach.

> The reason is that there is no tradition for group work among nurses and other daily caregivers. In The Netherlands, we have been trying already [sic] for 20 years to create an environment that meets the demands of the disoriented elderly. (Van der Kooij, p. 6)

They decided to put implementation first and follow with research.

Feil did not address racial or ethnic differences in her writings about Validation, nor did she list gender differences when screening residents for Validation group therapy. In her books and articles, she presents anecdotes about both men and women. Still, there are no anecdotes about people of differing racial and cultural backgrounds (Feil, 1992a, 1992b, 1993). It is true that Hispanics, African Americans, and Asians now make up a very small percentage of residents in nursing homes

(Connell & Gibson, 1997; Nguyen, 1997; Reyes, 1997). Nevertheless, as the aging population increases, so will the numbers of minorities with dementia increase. Feil needs to endorse the inclusion of minorities and bilingual persons as Certified Validation Therapists. If she does not, she will be denying the benefits of Validation Therapy to a number of Alzheimer's victims.

There is a dearth of literature available about dementia and people of African American, Asian, Native American, or Hispanic descent. A major reason for this lack of information is that minorities have not been the focus of many studies on dementia (Connell & Gibson, 1997). Auchus (1997) wrote:

> In the past few years, the National Institute on Aging has funded the development of 'satellite' clinics at existing Alzheimer's Disease Centers (ADCs). These clinics target minority or rural populations and represent potential sources of much needed information on dementia and Alzheimer's Disease in the patient groups. (p. 25)

Perhaps these clinics will provide the data so badly needed in this area.

Reyes (1997) reported, "In the Hispanic culture, families have traditionally been the primary caregivers of their elderly parents" (p. 16). A very small percentage of Hispanics live in nursing homes. Placement usually happens in response to a crisis.

In their study, Connell and Gibson (1997) concluded, "White caregivers of demented relatives reported higher levels of burden and were more likely to institutionalize their relatives than Black caregivers" (p. 356). They reported that Blacks and Hispanics have strong, informal support networks that help them adhere to filial duties to older relatives with dementia.

Information about Asians who have dementia and are in nursing homes appears to be nonexistent. Nguyen (1997) reported that Vietnamese children have the obligation of respect and care for their family elders throughout their lifetime. If the children place an elderly, demented family member in a nursing home, they will be perceived as not having fulfilled their filial duty. That is a cause of shame for the children that extends to the family as well.

Research on Validation Therapy

Toseland, Diehl, Freeman, Manzanares, Naleppa, and McCallion (1997) did a study of Validation group therapy in four nursing homes. This was the largest controlled study of Validation. They used time measures at base-line, 3 months, and 12 months. The nonparticipant observers and nursing staff were blind as to treatment interventions. There were eighty-eight resident/

participants with dementia who were randomly assigned to a Validation Therapy (VT) group, social contact (SC), or usual care (UC) group. The researchers found a significant ($p < .05$) decline in self-care in all groups and a significant ($p < .05$) increase in disorientation. Compared to the SC and UC groups, those in Validation Therapy showed significant ($p < .001$) reduction in physically aggressive behaviors. VT and SC had significant ($p < .001$) reduction in verbal aggression compared to UC. Nursing staffs' perceptions of successful intervention with problem behaviors showed significant ($p < .05$) effect for VT at 3 months and VT and SC at 1 year. Toseland et al. (1997) concluded "that the nursing staff reported reduced physically and verbally aggressive behavior in residents who received Validation Therapy" (p. 46).

The nurses also reported increased success while trying to reduce behavioral problems of Validation group members. "The positive effects reported by the nursing staff may also explain, at least in part, the widespread popularity of VT among nursing and social service staffs in the United States and other Western Countries" (Toseland et al., 1997, p. 47). On the other hand, they said, "The results do not support the hypotheses that participation in VT reduces the use of psychotropic

medications, physical restraints, or nursing time devoted to intervening in problem behavior" (Toseland et al., 1997).

Bleathman and Morton (1992) did a 40-week study with five group members. During the course of the study, one member died, and one became too ill to continue. The study was 20 weeks of Validation Therapy followed by 20 weeks of reminiscence therapy. At the end of the study, 2 participants showed marked, but not statistically significant, changes in interactions after VT sessions, but not Reminiscence. Both almost doubled the average length of interactions and greatly increased the interactions initiated on their own. The third group member was just the opposite, showing improvement with reminiscence, but not VT. There were no significant changes on scales done by the care staff. Bleathman and Morton (1992) concluded, "It had not been expected that people as cognitively impaired as those selected would be able to express such depth of feeling and interact with others at such an intense and, the authors believed, therapeutic level" (p. 666). They recommended that a larger study, a larger sample, and the use of a control group be required.

Fine and Rouse-Bane (1995) studied Validation techniques as an alternate communication tool. They studied residents in a 44-bed dementia unit. The study was for one-to-one staff/resident VT instead of groups. Participants were residents on the unit whose problem behavior required staff intervention. Scales were done on Validation pre-training and post-training of staff. They commented that after Validation training of staff, "communication technique effectiveness in ameliorating problem behavior increased from 47% before training to 73% after training" (Fine & Rouse-Bane, p. 41). They discovered that Validation gives them more options for defusing possible catastrophic behaviors of confused residents. They said, "focused Validation approaches may be more effective than RO type methods of communications so commonly used" (p. 44).

The most significant finding was the greatly improved staff interventions using communication appropriate for the resident's stage of confusion. A surprising statement by them was "Worsening stages of confusion may not be as inevitable as previously believed. If not wholly preventable, the pace of progression through confusional stages may be slowed by consistent use of appropriate Validation techniques which prevent the escalation of problem behaviors" (Fine &

Rouse-Bane, p. 44). It is that Validation may help keep demented persons communicating longer as they progress through the stages, but here again, care must be taken not to confuse the behavior with physical brain deterioration.

Cora Van der Kooij (1993) described the problems in studying Validation Therapy:

> In short, measuring the effects of Validation is still in its early stages. The methodological problems are similar to those of measuring the effects of Reality Orientation, such as lack of scales, a lack of continuity outside the group during the 24-hour approach, and Hawthorne effects. (p. 7)

She believed Validation meets the demands of disoriented people better than Reality Orientation.

Hendrick and Jones (1972) give a possible solution to achieving valid results from studies of human behavior in healthcare situations.

> Hendrick and Jones argued that the basic premise of conceptual generality is that when the same results are found with different subjects, situational factors, and other variations in study procedures, the aggregate results are accepted with greater confidence than the results from any single study. (as cited in Robb, Stegman, & Wolanin, 1986, p. 113)

There is general agreement among researchers of the need for more studies. There are many obstacles to researching Validation Therapy and people with dementia who are residents in nursing homes. Obtaining informed consent from the disoriented, old-old residents, reliable

measures, shortage of staff, attrition rates of subjects, and funding for research are the problems mentioned most often (Bleathman & Morton, 1992; Robb et al., 1986; Scanland & Emershaw, 1993; Toseland et al., 1997)

Summary

Feil's 4-stage theory confuses behavioral and psychological aspects of dementia with degenerative dementia. However, Validation Therapy appears to offer personal connection on some emotional level, between staff and the moderate to severely demented. Validation cannot prevent progression into vegetation, but it appears to improve quality of life for those afflicted with dementia.

CHAPTER 3

METHODOLOGY

The purpose of this study was to survey certified Validation Therapists (CVTs). The survey was conducted to obtain the therapists' opinions about the value and techniques of Validation Therapy.

Design

The survey was descriptive in design. This research design was used to measure the therapist's observations and experiences, acquired while working in nursing homes with people who have dementia.

Sample

Participants came from a list of certified Validation Therapists. Permission to contact the therapists and their locations was obtained from Naomi Feil, Executive Director, Validation Training Institute (Appendix A).

Packets containing the questionnaires (Appendix B), consent forms (Appendix C), and return, self-addressed, stamped envelopes were sent to all therapists on the list. Of the 28 therapists contacted, 13 (46.4%)

participated. Four packets were returned by the post office because of no forwarding address. Because of time constraints, the study was confined to the continental United States.

Measure

The measure had questions about Validation Therapists' satisfactions, frustrations, patient outcomes, and techniques of Validation Therapy.

Questions 1, 4, 10, 17, and 18 related to satisfactions and asked the subjects if they found training others rewarding, got personal satisfaction practicing Validation Therapy, and if they believed it should become a permanent part of treatment. Therapists were asked if they were more comfortable working with disoriented residents and if their feelings about themselves had improved since implementing Validation Therapy.

Questions 3, 6, 8, 9, 15, and 16 asked about frustrations experienced using Validation Therapy. The therapists were asked if Validation Therapy was demanding work, if they felt frustrated working with disoriented residents, and if they did not connect with the disoriented even with Validation. The questions also asked if they were discouraged with some aspects of caregiving using Validation, if they felt depressed working with the

disoriented, and if they have been disappointed in some aspects of Validation Therapy.

Questions 7, 11, 12, 13, and 14 were about patient outcomes since using Validation. They asked the subjects if relationships with residents had improved, if they had observed positive changes in residents, and if Validation Therapy is more effective than Reality Orientation. Subjects were also asked if communication had improved with the disoriented and if they had observed decreased conflict between residents and staff.

Questions 2, 5, 19, 20, 21, and 23 had questions about techniques. The therapists were asked if they practiced group work more than individual, and if they had specific techniques for addressing outbursts by residents. The last questions on techniques asked specifically if therapists used touch, mirrored body movements, matched voice and rhythm, put residents feelings into words, and accepted resident's feelings without judging.

Questions 24-28 asked the subjects to describe their demographic characteristics (gender, age, ethnicity, income, and job description).

Questions 29-34 asked for descriptions in terms of years worked with persons with dementia, years worked in nursing homes, years worked with those with dementia

before and since training in Validation Therapy, and if the therapists also worked with families/friends/ caregivers of the demented.

Questions 35-38 were open ended and asked the therapists to describe what they liked most and least about Validation Therapy and what they would change. The last question asked for their comments and suggestions regarding Validation Therapy.

Data Analysis

Questionnaires were appropriately coded, and data were entered into the statistical program, SPSS, for analysis. Descriptive statistics, means, frequencies, and percentages were used for tabulating demographic data. Correlation statistical tests were used to measure therapists' responses to the questions about using Validation Therapy.

Limitations

This study has limitations, which may have affected the outcomes. Using Certified Validation Therapists' observations and experiences was one way to gather data about characteristics/experiences with Validation Therapy. They are, however, not unbiased in their opinions. Additionally, the small sample size prevents generalization of the findings to Validation Therapy in

general. Asking Validation Therapists for their opinions was used to get data on Validation Therapy because using questionnaires for testing persons who have dementia was not a viable option. Cognitive impairments of persons with dementia preclude clear, objective answers to questions.

CHAPTER 4

RESULTS

Demographic Information

There were 13 Validation Therapists who agreed to participate in this study. As shown in Table 1, they ranged in age from 41 through 64 years. The mean age was 50.6 years. There were 2 males and 11 females. All 13 participants were Caucasian. Their job descriptions were: 2 administrators, 4 nurses, 3 social workers, 1 billing clerk, 1 assistant to director of recreational services, 1 retired therapist, and 1 homemaker. Income ranged from 3 therapists at less than $25,000 to 1 therapist at $70,000+, with no response from 1 therapist. There were 6 therapists reporting wages from $40,000 to $54,999 (46.2%). Income ranged from 3 therapists at less than $25,000 (23.1%), 2 therapists at $25,000-$39,000 (15.4%), and 6 therapists at $40,000-$54,999 (46.2%). There was 1 therapist reporting income at $70,000+ (7.7%), and 1 with no response (7.7%).

Satisfactions and Frustrations

Table 2 reports therapists' satisfactions and frustrations with VT. In general, the therapists showed

TABLE 1

Demographic Information

	f	%
Age		
41-50	8	61.5
51-60	3	23.1
Over 60	2	15.4
Gender		
Male	2	15.4
Female	11	84.6
Ethnicity		
Caucasian	13	100.0
Job Description		
Administrator	2	15.4
Nurse	4	30.8
Social Worker	3	23.1
Other	4	30.8
Income[a]		
<$25,000	3	23.1
$25,000-$39,999	2	15.4
$40,000-$54,999	6	46.2
$70,000+	1	7.7

[a]Contained Missing Data.

TABLE 2

Therapists' Satisfactions and Frustrations With Validation Therapy

Question Number	*M*	*SD*
Satisfactions		
1. Training others in Validation Therapy is rewarding to me.	1.23	.43
4. Practicing Validation Therapy gives me a sense of personal satisfaction.	1.07	.27
10. Validation Therapy should become a permanent part of treatment approach for nursing home residents.	1.15	.37
17. I'm more comfortable working with disoriented residents because of Validation Therapy.	1.07	.27
18. I've experienced improved feelings about myself since Implementing use of Validation Therapy.	1.69	.63
Frustrations		
3. I find that Validation Therapy is demanding work.	2.83	1.19
6. I feel frustrated working with disoriented residents even using Validation Therapy.	3.69	1.25
8. I feel like I don't connect with the disoriented residents even with Validation Therapy.	4.38	.86
9. Some aspects of my caregiving relationship are discouraging even though using Validation Therapy.	3.07	1.25

Table 2--*Continued*

Question Number	*M*	*SD*
15. I often feel depressed after working with disoriented residents even though using Validation Therapy.	4.00	1.00
16. I've been disappointed in some aspects of Validation Therapy.	3.61	1.12

Note. Scale: 1 (Definitely Agree), 2 (Agree), 3 (Neutral), 4 (Disagree), 5 (Definitely Disagree)

strong agreement with all items expressing satisfaction. Validation Therapists gave particularly high endorsements to statements asserting that validation therapy gave a sense of satisfaction and they had increased comfort working with disoriented patients. They were only slightly less enthusiastic that Validation Therapy should be a permanent part of treatment for nursing home residents and that training others in Validation Therapy is rewarding. Question 18 showed the lowest endorsement, that they experienced improved feelings about "myself" with the use of Validation Therapy. There was a mean near to "agree" and other means close to "definitely agree."

The therapists showed less agreement with questions regarding frustrations experienced with the use of Validation Therapy. They gave positive endorsement to Question 3, Validation Therapy is demanding work. They gave lower endorsements to feeling frustration working with the disoriented, being discouraged with some aspects of caregiving relationships, expressing disappointment in some aspects of Validation Therapy, and feeling depressed after working with the disoriented. Question 8, feeling they did not connect with disoriented residents even with Validation got the least agreement. The mean was 4.38 between disagree and definitely disagree.

Outcomes

Table 3 shows therapists' opinions about outcomes using Validation Therapy. Respondents highly affirmed statements about improved relations with disoriented patients, greater effectiveness of Validation Therapy over Reality Orientation, and improved communication. The ratings were only a little lower that positive behavioral changes had been observed in disoriented patients. However, there appears to be less positive answers to Question 14. Question 14 refers to the CVT's observing decreased conflict between residents and staff since implementing Validation. The mean was 2.23 between definitely agree, agree, and neutral.

Techniques

Table 4 refers to the Validation Therapy techniques used by the CVTs.

Respondents almost always used specific techniques for addressing outbursts by the disoriented, used touch, mirroring, matching voice and rhythm, put patient's feelings into words, and accepted patients' feelings without judging. There was less frequent use of group techniques. Question 2 stated, "I practice group work more than individual Validation Therapy." The mean was 3.38 between disagreed and neutral, indicating individual

TABLE 3

Therapist's Opinions About Outcomes With Validation Therapy

Question Number	*M*	*SD*
Outcomes		
7. My relationships with disoriented residents has improved since I began using VT.	1.15	.37
11. I've observed positive changes in residents' behavior since implementing VT.	1.38	.65
12. VT is more effective than RO.	1.15	.37
13. I have experienced improved communication with the disoriented, dementia residents as a result of VT.	1.23	.43
14. Since the implementation of VT, I have observed decreased conflict between residents and staff.	2.23	1.09

Note. Scale: 1 (Definitely Agree), 2 (Agree), 3 (Neutral), 4 (Disagree), 5 (Definitely Disagree).

TABLE 4

Therapist's Use of Validation Therapy Techniques

Question Number	*M*	*SD*
2. I practice group work more than individual VT.	3.38	1.32
5. I have specific effective techniques for addressing out-bursts from disoriented residents when using VT.	1.46	.51
How often do you use the following techniques?		
19. Using touch to communicate.	1.30	.48
20. Mirroring body movements.	1.69	.94
21. Matching voice and rhythm.	1.69	.85
22. Identifying patient's feelings and putting into words.	1.53	.37
23. Accepting patient's feelings without judging.	1.15	.66

Note. The scale for 2 and 5 was: 1 *(Definitely Agree)*, 2 *(Agree)*, 3 *(Neutral)*, 4 (Disagree), 5 *(Definitely Disagree)*. The scale for 19-23 was: 1 *(Almost Always)*, 2 *(Often)*, 3 *(Sometimes)*, 4 *(Seldom)*, 5 *(Almost Never)*.

Validation Therapy was not overshadowed by group Validation Therapy.

Open-Ended Questions

Question 35 asked, "What did you like most about Validation Therapy?" The shortest answer was, "It works!" Other answers were:

> It promotes dignity and respect for a group of very vulnerable people. Validation also has the potential for caregivers to feel rewarded in their work of caring for the old-old disoriented.
>
> I find it to be the most powerful tool to diffuse agitated elderly and also to stimulate residents and develop interest in things.
>
> Residents that have attended group are more aware and feel better connected to the world.
>
> It improves quality of life for demented patients and their families.
>
> The fact it's a dual process. To validate another human being requires the caregiver to validate themself [sic]. They must view themself [sic] as worthy--that they make a difference. Only then can they validate another person. It's very much a win/win approach.
>
> It honors the inherent value of our elders. It gives me an opportunity to be a trusted listener and to learn from wise ones who have much to offer me and each other.

Question 36 asked, "What do you like least about Validation Therapy?"

Answers range from "not helpful for everyone" to "nothing I dislike about Validation." Other responses were:

> Lack of contact with [the] institution--the unavailability of role models.
>
> It needs to have a better teaching program. I became very frustrated that more caregivers would not invest in the certification process. I'm a firm believer in the effectiveness of Validation Therapy.

Question 37, "What would you change?" received the least replies.

They were "nothing." Another participant said, "the certification process." A third answered, "Get the concept into nursing, medical schools, nurse aide classrooms, nursing home administrator-in-training programs." One answer seemed to encompass several replies with: "Need a training center--a gathering place for practitioners to share stress, techniques, and experiences. . . . I would like to have more frequent publication [of newsletter] and input from practitioners."

Comments and Suggestions

Question 38 asked for comments and suggestions from the therapists. It elicited fewer responses; however, the answers given were more extensive.

> In my opinion, what is most needed in order for Validation to flourish is a structure of support for people who want to get trained. Because it requires/demands that the caregiver have a high self-esteem, there is much work/training/development to be done with the caregiver. The caregiver must learn to give up his/her ego (the fundamental commitment to "Look Good") in order to effectively practice Validation. THIS ISN'T EASY!!

The following quotation gives a good summation of some of the major problems facing nursing homes and other caregivers of people with dementia.

> As a Medicare provider and [...], I relied upon VT a great deal while providing direct care to nursing home residents. Turnover of caring nursing home staff is tremendous, since assignments seldom allow the time often needed to successfully utilize this technique. Medicare's reimbursement to providers does not lend to a reasonable cost/benefit ratio for the majority of nursing homes or consultants. Introduction of VT to caregivers with disoriented elders at home, in my opinion, is the primary target--including day care centers, assisted living, elderly housing arrangements, etc. VT gives much confidence to caregivers as well as acknowledgment to the disoriented old-old.

CHAPTER 5

DISCUSSION

Findings in this study showed that social workers accounted for 23.1% of the respondents. At the outset, it was expected that social workers would make up the majority of respondents. This expectation was based on the fact that social workers are mental health practitioners as well as care providers and resources for people in need. The literature review and the information gathered from the respondents of this study indicated, however, that all levels of caregivers can provide Validation Therapy to persons with dementia. According to Feil (1986), Validation Therapy does not have to be done by CVTs, it can be done by all levels of caregivers, including nurses aids. In fact, Feil (1990) believed nurses may be a facility's best source to provide Validation because of their daily interactions with Alzheimer's patients.

Overall, the study revealed that the respondents liked the results they obtained with Validation Therapy. Most felt that practicing Validation was personally satisfying, and they experienced few frustrations with it. However, there were a few Certified Validation

Therapists who expressed some frustrations in the following ways:

> Even when benefits are evident, it is difficult to get the nursing discipline to accept and practice Validation. The nursing discipline is more task oriented. Hard to fit in [a] medical model. Many frustrations in incorporating it to a facility without administrative support. [VT] not 'validated' through clinical research.

Another finding was that group Validation did not overshadow individual Validation. Individual Validation Therapy can be done a few minutes at a time, as needed, throughout the day. Fine and Rouse-Bain (1995) said that before using Validation Therapy, average communication with people who have behavior problems was 4.5 minutes. With Validation, interventions averaged 8 minutes. However, they claimed the additional 3.5 minutes could actually save time by handling the problem and preventing additional interventions in the future. They only use individual Validation, not group Validation.

Additional findings were that most respondents definitely agreed that their relationships with disoriented residents have improved using VT. They also highly endorsed using VT over RO with disoriented residents, as well as accepting residents' feelings without judging.

Throughout her books and journal articles, Feil (1990, 1992a, 1992b, 1993) maintained that continuous use of Validation Therapy could prevent Alzheimer's patients

from progressing into further disorientation. Toseland, et al. (1997) disagreed with Feil. They found that patients continued to decline despite Validation Therapy. Their study revealed that there was a significant increase in disorientation among patients in Validation groups.

Bleathman and Morton (1996) said of their study in 1992, they were surprised by the amount of participation of the subjects in Validation group despite their moderate-to-severe cognitive impairments. They said group members followed themes, resolved past conflicts, and got a great deal of pleasure from giving opinions and sharing wisdom. However, Bleathman and Morton (1996) were not certain if the results were from Validation Therapy or the environment of the group. They said the group participants were actively encouraged to express themselves, and the leaders did not make any corrections of factual errors. The group members also had their contributions acknowledged each time. The group leaders also believed that the physical closeness and use of touch, through hand holding, contributed to the environment of warmth, openness, and acceptance. Bleathman and Morton (1996) said:

> Feil's contribution to current developments in dementia care should not be underestimated. Her enthusiasm and energy have been instrumental in

> opening up the debate of how we can best provide the psychological and emotional care that sufferers need. (p. 868)

Despite the small number of research studies and some of Feil's unjustified claims about preventing further disorientation, Validation is a compassionate way of caring for and connecting with Alzheimer's patients. Validation Therapy should become part of treatment protocols for Alzheimer's patients in nursing homes.

Implications for Social Work

Social workers who work with elderly persons with dementia need to familiarize themselves with the benefits of Validation Therapy. As long as there is no cure for Alzheimer's disease and related disorders, social workers must be in the vanguard searching for treatments to improve the lives of Alzheimer's patients.

It is important for social workers to educate themselves and others about the use of Validation Therapy. They must become Certified Validation Therapists (CVTs) in order to become the teachers and trainers of other caregivers and families of Alzheimer's patients. As CVTs, they can also become consultants to nursing homes and other facilities, such as day care centers.

To become a CVT, one must have training in a health-care or allied field, attend two full-day Validation workshops (approximately $100+/day), and work a minimum

of 6 months with Validation Therapy. CVTs can teach Validation and conduct Validation workshops. They can also consult to healthcare institutions (Feil, 1993). Becoming a CVT appears to be costly in terms of time and money. However, treatment for disoriented, old-old persons is very limited because of their cognitive impairments.

Reality Orientation has not been successful in improving mental status, life satisfaction, or activities of daily living (ADL) in any but the mildly impaired (Scanland & Emershaw, 1993). Social workers must continue exploring alternative treatments for persons afflicted with dimentia.

Since Validation practitioners do not need to be social workers or psychologists, they can teach nurses and nurses aids the techniques of Validation Therapy. Nurses and nurses aids interact daily with confused nursing home residents. When problem behavior occurs, the nursing staff is usually nearby and can provide individual, on-the-spot Validation. Additionally, nurses aids can Validate the residents while assisting them in bathing, dressing, and at mealtimes. The Validation can then be reinforced throughout the day.

Implications for Future Research

In order to have a large enough sample, future research involving CVTs may require methods other than, or in addition to, using a list from the Validation Training Institute. Currently, it appears the institute does not maintain an accurate, up-to-date list of all CVTs. When the researcher obtains the list of CVTs, he/she should also get a list of Certified Validation Workers (CVWs). In addition, the snowball method of sampling may have to be used with the therapists listed in order to locate more subjects. CVTs and CVWs from other countries may need to be included even though there will be added time and expense with the mailings of questionnaires.

APPENDICES

APPENDIX A

PERMISSION LETTER

VALIDATION© TRAINING INSTITUTE, INC.
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CLEVELAND, OHIO 44122
(216) 561-0357 or (216) 561-0040
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A NON-PROFIT TAX EXEMPT AGENCY

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Members in Perpetuity
HELEN WEIL, M.S.W.
JULIUS WEIL, Ph.D.

October 18, 1997

Institutional Review Board
for the Protection of Human Subjects
California State University, Long Beach
Office of University Research

To Whom it May Concern:

RE: Janet Hosey's Master's Thesis

Janet Hosey has my permission to contact Certified Validation Therapists/Trainers and Certified Validation Workers to ask them to participate in her research study: Effectiveness of Validation Therapy: Perceptions and Opinions of Certified Validation workers.

She can interview those who agree to participate, by telephone interview or questionnaires. She has assured me that all personal information she obtains from them will be kept confidential.

Sincerely,

Naomi Feil

Naomi Feil, Executive Director
Validation Training Institute

APPENDIX B

QUESTIONNAIRE

QUESTIONNAIRE

The following statements refer to your perceptions since becoming a Validation Therapist. They also pertain to the relationship between you and nursing home residents who are the very old, disoriented, persons with dementia and are the ones Validation Therapy was designed for. Please select an answer that indicates the extent of your agreement with each statement by circling the number on the scale following the statement.

SAMPLE:

I like rainy weather.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

If you really like it, circle 1. If it doesn't make any difference to you, circle 3.

---

1. Training others in Validation Therapy is rewarding to me.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

2. I practice group work more than individual Validation Therapy.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

3. I find that Validation Therapy is demanding work.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

4. Practicing Validation Therapy gives me a sense of personal satisfaction.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

5. I have specific, effective techniques for addressing outbursts from disoriented residents when using Validation Therapy.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

6. I feel frustrated working with disoriented residents even using Validation Therapy.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

7. My relationships with disoriented residents has improved since I began using Validation Therapy.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

8. I feel like I don't connect with the disoriented residents even with Validation Therapy.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

9. Some aspects of my caregiving relationship are discouraging even though using Validation Therapy.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

10. Validation Therapy should become a permanent part of treatment approach for nursing home residents.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

11. I've observed positive changes in residents behavior since implementing Validation Therapy.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

12. Validation Therapy is more effective than Reality Orientation.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

13. I have experienced improved communication with the disoriented, dementia residents as a result of Validation Therapy.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

14. Since the implementation of Validation Therapy, I have observed decreased conflict between residents and staff.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

15. I often feel depressed after working with disoriented residents even though using Validation Therapy.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

16. I've been disappointed in some aspects of Validation Therapy.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

17. I'm more comfortable working with disoriented residents because of Validation Therapy.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

18. I've experienced improved feelings about myself since implementing use of Validation Therapy.

Definitely Agree	Agree	Neutral	Disagree	Definitely Disagree
1	2	3	4	5

In your experience using Validation Therapy, how often do you use each of the following techniques.

19. Using touch to communicate.

Almost Always	Often	Sometimes	Seldom	Almost Never
1	2	3	4	5

20. Mirroring Body Movements.

Almost Always	Often	Sometimes	Seldom	Almost Never
1	2	3	4	5

21. Matching voice and rhythm.

Almost Always	Often	Sometimes	Seldom	Almost Never
1	2	3	4	5

22. Identifying patient's feelings and putting into words.

Almost Always	Often	Sometimes	Seldom	Almost Never
1	2	3	4	5

23. Accepting patient's feelings without judging.

Almost Always	Often	Sometimes	Seldom	Almost Never
1	2	3	4	5

The following are questions about you. Please answer those you are comfortable with as they give a more complete picture for the research study. There is also a place for your remarks, comments and suggestions.

PLEASE WRITE IN OR CIRCLE THE CORRECT LETTER.

24. WHAT IS YOUR GENDER? M_____ F_____

25. WHAT IS YOUR AGE?_____

26. WHAT IS YOUR ETHNICITY?

A. AFRICAN-AMERICAN/BLACK
B. ASIAN/PACIFIC ISLANDER
C. CAUCASIAN
D. HISPANIC/LATINO
E. NATIVE AMERICAN
F. OTHER_____

27. WHAT IS YOUR ANNUAL INCOME?

A. < $25,000
B. $25,000 - $39,999
C. $40,000 - $54,999
D. $55,000 - $69,999
E. $70,000 +

28. WHAT IS YOUR JOB DESCRIPTION/PROFESSION?

A. ADMINISTRATOR
B. NURSE
C. SOCIAL WORKER
D. TEACHER
E. OTHER_____

29. SPECIFICALLY WHAT IS YOUR JOB?

30. HOW MANY YEARS HAVE YOU WORKED WITH ELDERLY PERSONS WITH DEMENTIA?

31. HOW LONG HAVE YOU WORKED IN NURSING HOME FACILITIES?

32. HOW LONG DID YOU WORK WITH ELDERLY PERSONS WITH DEMENTIA BEFORE YOUR TRAINING IN VALIDATION THERAPY?

33. HOW LONG HAVE YOUR WORKED WITH ELDERLY PERSONS WITH DEMENTIA SINCE YOUR TRAINING IN VALIDATION THERAPY?

34. DO YOU WORK WITH FAMILIES/FRIENDS/CAREGIVERS OF ELDERLY PERSONS WITH DEMENTIA?

A. YES_____
B. NO _____

35. WHAT DO YOU LIKE MOST ABOUT VALIDATION THERAPY?

36. WHAT DO YOU LIKE LEAST ABOUT VALIDATION THERAPY?

37. WHAT WOULD YOU CHANGE?

38. COMMENTS AND SUGGESTIONS:

THANK YOU FOR YOUR PARTICIPATION IN THIS SURVEY.
IT IS GREATLY APPRECIATED.

Prepared by Janet Hosey

APPENDIX C

INFORMED CONSENT FORM

INFORMED CONSENT

I am Janet Hosey, a candidate for a Master's of Social Work from the Department of Social Work, California State University, Long Beach. I invite you to participate in my study about Validation Therapy and it's effects on communication between disoriented old-old persons and their caregivers. Although you are not expected to benefit directly by your participation, it is hoped that this study will provide information which will increase the use of Validation Therapy in nursing facilities.

If you choose to participate in this study, you will be asked to complete the attached questionnaire. It will take about 10 - 15 minutes of your time. The questions to be asked concern your experiences using Validation Therapy with nursing home residents as well as your experiences prior to your training in this technique.

Your decision to participate is entirely voluntary. If you decline or decide to withdraw from the study at any time, you are free to do so without any negative consequences. The study entails no foreseen risks.

Your responses will remain completely confidential. Even when the study results are reported, your name will not be revealed. Questionnaires and consent forms will be kept separately in a secure place. My list of individual names and numbers on the questionnaires will be destroyed at the end of the study.

Please feel free to call me at (714) xxx-xxxx, or my thesis advisor, Dr. Catherine Goodman, at (562) xxx-xxxx, if you have any questions about this study. If you have any questions about your rights as a participant in this research, you may call the Office of University Research, California State University, Long Beach, at (562) 985-5314.

Thank you for considering participation in this study. If you agree to do so, please sign, print your name, and fill in the date below.

SIGNATURE: _____

Printed Name: _____

Date: _____

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REFERENCES

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IMAGE EVALUATION
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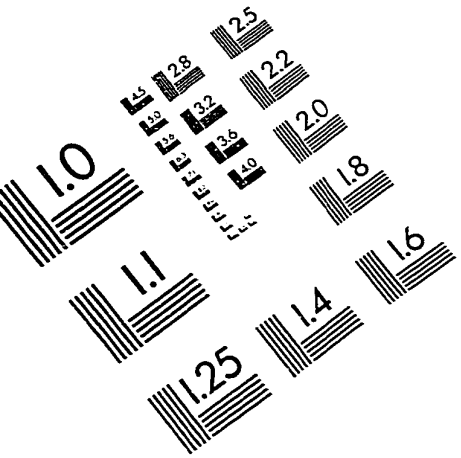

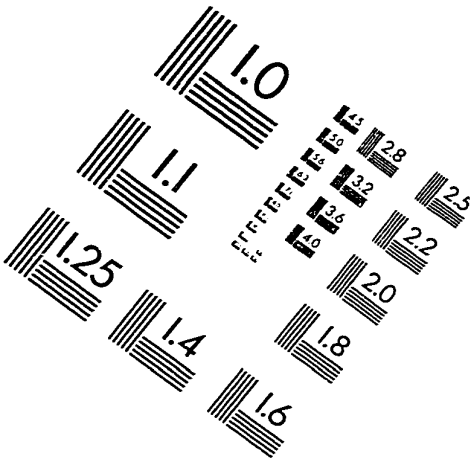

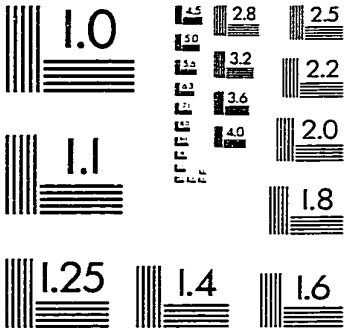

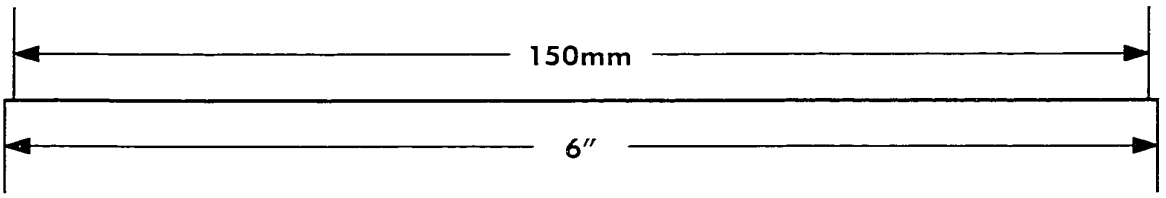

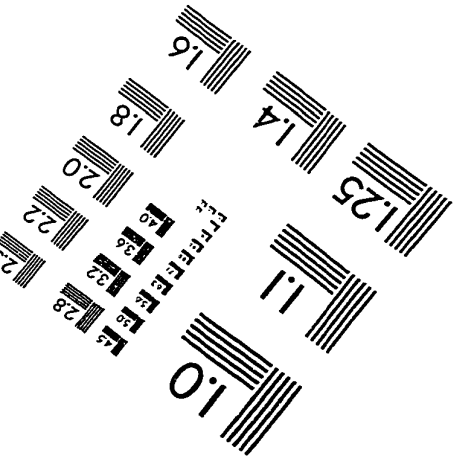

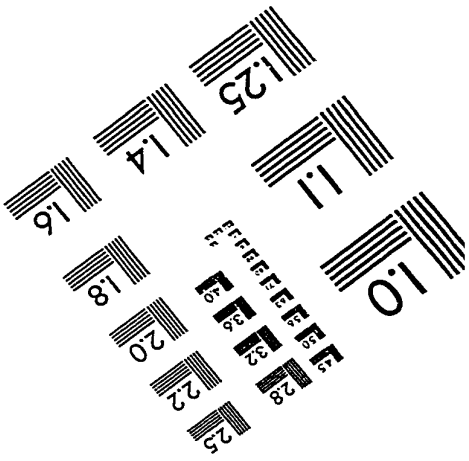

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