

VALIDATION THERAPY VERSUS REALITY ORIENTATION  
AS TREATMENT FOR THE INSTITUTIONALIZED  
DISORIENTED ELDERLY

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## ABSTRACT

The purpose of this study was to determine which method, validation therapy developed by Feil or classroom reality orientation developed by Eolsom and Taulbee was effective in restoring orientation to institutionalized older persons. Previous research revealed beneficial effects of group therapy with these persons. This study compared therapies from two different theoretical frameworks: a humanistic client centered approach and a behavior modification approach.

Thirteen hypotheses were developed from the literature review: nine to test each therapy's effect on changes in subjects' scores on measures of the three dependent variables; three to compare changes in scores of both treatment groups; and one summary hypothesis. An experimental design was used in which subjects were randomly assigned to one of three groups: validation therapy, reality orientation, or control group. All subjects were tested before and after treatment on each of the three variables. Tools used to gather data included the Tool for Assessing Degree of Confusion in the Elderly developed by Hogstel, and two tools designed by the

researcher: The Ego Integration Scale and the Behavior Assessment Tool. Demographic data were also gathered.

The study was conducted in an urban 225-bed nursing home. Criteria for subject selection included age of eighty years or more, moderate to severe confusion as rated on the Tool for Assessing Degree of Confusion in the Elderly, physical ability to participate in a group, and informed consent to participate. The final sample of twenty-nine subjects (mean age 87.7 years) was divided; eleven in the control group, ten in validation therapy, and eight in reality orientation, which lost two subjects during the study time.

The treatment groups met for thirty minutes Monday through Friday for six weeks. Validation therapy groups were led by the researcher and followed guidelines prescribed by Feil. Reality orientation groups were led by a graduate nursing student and followed guidelines published in the Guide for Reality Orientation. The control group experienced the same conditions as those in the treatment groups except for lack of treatment.

Two of the first nine hypotheses were supported when the non-parametric Wilcoxon Signed Ranks Test was applied to the data. Validation therapy was found to significantly improve group members' scores on the Behavior Assessment Tool. Also, the Ego Integration Tool was found to be subject to a learning curve, since the control

group's scores improved significantly, but neither of the treatment groups' scores improved. No support was found for the three hypotheses predicting positive correlations between changes in scores, when the Spearman Rank Correlation Coefficient was applied to the data.

Behavior of group members, recorded each day on the Therapy Group Observation Form, showed qualitative improvements for seven of the ten subjects in validation therapy, and for three of the eight subjects in reality orientation. The following conclusions were made from analyses of statistical and descriptive data: (1) validation therapy produced significant improvement in behavior but not in orientation or ego integration, while reality orientation produced no significant difference in any of the three measures, (2) validation therapy produced more qualitative changes in behavior than did reality orientation, (3) the most improvement in the three measures made by reality orientation subjects was among those who were less confused before the therapy began.

Recommendations for further study included (1) testing the Ego Integration Scale and Behavior Assessment Tool for validity and reliability, (2) replication of this study using a larger sample, (3) testing validation therapy over a longer period of time, (4) further research on the concept of ego integrity, and on the causes and



treatment of reversible functional confusion in elderly persons.

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## TABLE OF CONTENTS

	Page
LIST OF TABLES . . . . .	xi
LIST OF FIGURES . . . . .	xiii
CHAPTER	
I. DEVELOPMENT OF THE PROBLEM . . . . .	1
Introduction . . . . .	1
Review of Literature . . . . .	3
Conceptual Framework . . . . .	3
Reality Orientation . . . . .	6
Development . . . . .	6
Method . . . . .	6
Assumptions . . . . .	8
Validation Therapy . . . . .	9
Development . . . . .	9
Ego Integration . . . . .	10
Confirmation . . . . .	11
Stages of Disorientation . . . . .	13
Assumptions . . . . .	16
Empirical Studies . . . . .	16
Reality Orientation . . . . .	17
Validation Therapy . . . . .	23
Statement of the Problem . . . . .	24

	Page
Purpose of the Study . . . . .	25
Research Hypotheses . . . . .	25
Operational Definitions . . . . .	29
Summary . . . . .	30
Chapter Notes . . . . .	32
II. METHODOLOGY . . . . .	37
Introduction . . . . .	37
Setting Design . . . . .	37
Sample Design . . . . .	39
Administrative Design . . . . .	41
Experimental Design . . . . .	41
Treatment Therapists . . . . .	43
Preparation of Staff and Families . . . . .	44
Reality Orientation Therapy . . . . .	45
Validation Therapy . . . . .	48
Instrument Design . . . . .	50
Summary . . . . .	52
Chapter Notes . . . . .	54
III. ANALYSIS OF THE DATA . . . . .	56
Introduction . . . . .	56
Description of the Sample . . . . .	56
Analysis of Study Hypotheses . . . . .	62
Discussion of the Study . . . . .	77
Use of Tools . . . . .	77
Validation Therapy Groups . . . . .	81

	Page
Reality Orientation Groups . . . . .	84
Limitations of the Study . . . . .	87
Recommendations . . . . .	89
Implications for Nursing . . . . .	90
Chapter Notes . . . . .	92
IV. SUMMARY . . . . .	93
BIBLIOGRAPHY . . . . .	97
APPENDICES . . . . .	105
A. Informed Consent . . . . .	106
B. Tool for Assessing Degree of Confusion in the Elderly . . . . .	108
C. Ego Integration Scale . . . . .	112
D. Behavior Assessment Tool . . . . .	113
E. Demographic Information . . . . .	116
F. Therapy Group Observation Form . . . . .	117
G. Explanation of Study to Families of Research Subjects . . . . .	119
H. Stages Two and Three of Disorientation According to Feil . . . . .	120
I. Demonstration of Validation Therapy With a Group . . . . .	126
J. Demonstration of Reality Orientation With a Group . . . . .	130
K. Letter to Institution for Permission to Use Facilities . . . . .	133
L. Letter of Permission to Use Tool . . . . .	135

## LIST OF TABLES

TABLES	Page
1. Stages of Disorientation . . . . .	14
2. Distribution of Demographic Characteristics Among Subsample Groups . . . . .	58
3. Summary of Therapy Sessions Attended . . . . .	61
4. Changes on Degree of Confusion of Subjects . . . . .	64
5. Changes in Ego Integration Scores of Subjects Before and After a Program of Validation Therapy . . . . .	64
6. Changes in Behavior Characteristics of Subjects Before and After a Program of Validation Therapy . . . . .	65
7. Changes in Degree of Confusion of Subjects Before and After a Program of Reality Orientation . . . . .	67
8. Changes in Ego Integration Scores of Subjects Before and After a Program of Reality Orientation . . . . .	68
9. Changes in Behavior Characteristics of Subjects Before and After a Program of Reality Orientation . . . . .	69
10. Changes in Degree of Confusion of Control Group Subjects Before and After No Program of Therapy . . . . .	71
11. Changes in Ego Integration Scores of Control Group Subjected to No Therapy . . . . .	72
12. Changes in Behavior Characteristics of Control Group Subjected to No Therapy . . . . .	74

13. Comparison of Items Missed on Tool for Assessing Degree of Confusion Before and After Therapy . . . . .	78
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## LIST OF FIGURES

FIGURE	Page
1. The Pretest-Posttest Control Group Design . .	40
2. Scatter Diagram: Behavior Scores Before and After Validation Therapy . . . . .	66
3. Scatter Diagram: Behavior Scores Before and After Reality Orientation . . . . .	70
4. Difference Between Ego Integration and Behavior Scores Before and After Two Therapies . . . . .	76
5. Ranks of Differences Between Ego Integration and Behavior Scores Before and After Two Therapies . . . . .	76



## CHAPTER I

### DEVELOPMENT OF THE PROBLEM

#### Introduction

Disorientation in persons who are old and institutionalized is often falsely regarded as an expected and irreversible function of aging. Often, little assessment is done before the label of "confused and disoriented" is applied to a patient.<sup>1</sup> Elderly persons who have been relocated from their homes to a nursing care facility lose the comfort of familiar surroundings which they use to maintain orientation. The loss of these familiar surroundings when an elderly person is institutionalized may be a cause for disorientation. Limited space for tangible personal property further reduces memory references for nursing home residents.

Severe mental decline in older people is not inevitable. Many changes can be avoided by correct assessment and timely intervention. There are numerous ecological, social, physical, and emotional causes of disorientation and confusion that can be treated to reverse the condition. Given their age and deteriorating

physical condition, nursing home residents are more or less actively preparing for death.<sup>2, 3</sup>

Evidence is growing for the effectiveness of group therapy to counteract the effects of institutionalization. Research findings suggest that almost any type of group work can be psychosocially beneficial, can facilitate behavior change, and can increase the quality of life for the participant.<sup>4, 5, 6</sup> In her extensive review of literature, Shaw reported that recorded outcomes of group work have included attainment of a former level of cognitive and behavioral functioning, increase in self-esteem, resocialization, remotivation, reality orientation, ability to communicate, increase in the number or depth of socially acceptable behaviors, and detection of physical illness.<sup>7</sup> Gunter and Miller, in reviewing research studies in gerontological nursing, emphasized the need for studies in the management of patients with chronic brain syndrome in institutions.<sup>8</sup> In view of this, the present study was designed to compare the effects of therapies from two different conceptual frameworks on reality orientation, ego integration, and behavior of disoriented elderly persons in a nursing home. These two therapies are reality orientation from a behavior modification approach, and validation therapy from a client-centered approach.<sup>9, 10</sup>

### Review of Literature

The review of literature is divided into two sections. In the first section, literature is reviewed relating to psychosocial needs of elderly persons, and how group therapies can satisfy these needs. The conceptual framework of behavior modification for reality orientation, is then discussed. This is followed by a discussion of the existential client-centered approach as it relates to validation therapy. Within the conceptual framework of each therapy, assumptions, major concepts, and methods that each therapy applies to institutionalized disoriented elderly are also presented.

In the second section, the theoretical frameworks are linked to the practice of the two therapies with the discussion of empirical studies that provide background for the present investigation. Review of empirical literature includes scientific studies that have applied the methods of each therapy in controlled settings.

### Conceptual Framework

Disorientation, confusional states, and chronic brain syndrome are terms often used in the literature to indicate differences in degrees of being out of touch with reality. Although precipitating causes may vary, Burnside identified four conditions that may accompany the confused state in elderly adults: anxiety, grief,

loneliness, and paranoia. The conceptual framework relates how these conditions create psychosocial needs that are satisfied within group therapy settings.

Burnside lists some of the obvious signs of anxiety: chain smoking, pacing, restlessness, inability to sit still, fidgeting, and nervous mannerisms, and physiological signs such as increased pulse rate or respiration.<sup>11</sup> The stages of disorientation described by Feil demonstrate decreasing anxiety behaviors as the depth of disorientation increases. The person may be withdrawing from his environment to screen out the anxiety producing factors with which he can no longer deal.<sup>12</sup>

The preponderance of grief reactions in later life may follow a variety of losses, some of which may overburden the coping ability of an old person. In his classic study of bereaved survivors of a holocaust, Lindemann defined grief as "an acute state of despair and disconsolate anguish because of the immediate loss of a person or object."<sup>13</sup> Deutsch emphasized that ambivalence toward the deceased person is a difficult conflict to resolve during the mourning period. Grief can range from no response at all, a reaction Deutsch termed "omitted grief," to severe depressions and/or suicide.<sup>14</sup> Each aged person tends to develop his or her own pattern for grief, and caregivers would be wise to respect that pattern. Feil observed that disoriented old persons have denied

serious crises throughout their lives, perhaps as a manifestation of omitted grief.<sup>15</sup>

The loneliness experienced by nursing home residents may result from the social isolation felt in a large crowd, where the lack of warm and caring relationships emphasizes their separation from their personal past. Burnside's list of the causes of loneliness includes death of a spouse, loss of a pet, language barriers, physical pain, and reminders that accompany certain times of the day.<sup>16</sup> It is the challenge of the nurse to discover what intervention works best for each individual to relieve the pain of loneliness.

If combined, anxiety, grief and loneliness may be so overwhelming that aged persons develop paranoid behaviors. Studies in sensory deprivation have demonstrated that persons respond differently when there is a lack of "sensory patternism."<sup>17</sup> Especially when they view the world as hostile, disoriented old persons blame others for their many losses. One way in which group therapy can help reduce paranoid behavior is by creating an environment in which threat is reduced because of the empathy communicated to each member.

Ebersole reflected in her survey of the literature on group work with the aged, that nurses have evolved into group therapists with the aged out of necessity and proximity.<sup>18</sup> Group therapy with the aged is not only an

economical approach but also meets their psychosocial needs when used in conjunction with the one-to-one relationship of nurse to patient.

Both validation therapy and reality orientation attempt to help the disoriented person return to reality by forming a therapeutic relationship between the therapist and the person. Both therapies share a basic objective of helping the elderly live their lives with dignity and both use a group approach. They differ in their philosophies, methods, and goals. A discussion follows of the conceptual framework related to each therapy.

#### Reality Orientation

Development. This procedure was developed by Folsom and Taulbee in 1958 and refined in 1965 in the Veterans Administration Hospitals. The therapy is a common-sense behavioral approach designed to eliminate confusion and disorientation.<sup>19</sup> The theory is based on the assumption that, if confused people can be reoriented to their immediate surroundings and can relearn basic activities, they will become more interested in themselves and their environment.<sup>20</sup> The approach is to change behavior by positively reinforcing answers and actions that coincide with reality, which is defined as "that which has objective existence and is not merely an idea."<sup>21</sup>

Method. As described in the literature by Drummond, Kerchhoff and Scarbrough specifically, the reality

orientation program is two-pronged. One aspect is a formally structured classroom-like setting held for 15 to 30 minutes a day, five days a week following Taulbee's recommendation for omitting weekend sessions.<sup>22</sup> During this group procedure, four or five patients are given specific information, visually and verbally, about their environment, for example, day, date, or state of the weather. Each person is then asked questions which require recall of the information provided.<sup>23</sup>

The less structured aspect is called 24-hour reality orientation, a type of milieu therapy. This includes the use of environmental stimuli such as clocks and calendars. It also includes behaviors of the staff aimed at consistently increasing patients' awareness of the environment. Examples of such behaviors are calling the patient by name, telling the person the name of objects in the environment, or asking the patient to name objects, and then rewarding correct responses with verbal or non-verbal praise.<sup>24</sup>

In her critique of reality orientation, Langston identified behavior modification as the program's underlying theory. By providing environmental stimuli and controlling the interaction between the staff and the confused patient, reality orientation proposes to elicit a desired response from the patient. If the response is correct, the patient is rewarded with positive reinforce-

ment. The ultimate performance goal of reality orientation is that patients are oriented and able to function in the environment with socially acceptable behavior. What this method fails to recognize, Langston contended, is that every person responds uniquely to the same reinforcer.<sup>25</sup>

The rigid control of human responses proposed in reality orientation would appear to be anti-humanistic. Kanfer and Phillips defend behavior modification because it "increases the human dignity of the patients as they regain an ability for independent living."<sup>26</sup> They argue further that behavior modification can be used for whatever purposes society wants to accomplish. Therefore it is nonhumanistic rather than antihumanistic, a neutral tool whose value depends on its use.

Assumptions. Some basic assumptions underlying the use of reality orientation were found in the literature. They are:

1. Confusion in the elderly results in behavior that can be changed with positive reinforcement used consistently.<sup>27</sup>
2. Every person has a right to know the truth; and reality orientation systematically provides a confused patient with the present reality or the truth.<sup>28</sup>



3. Confusion and disorientation can successfully be treated with reality orientation, no matter what the cause or causes.<sup>29</sup>

4. People who are labeled confused, senile, or disoriented are not considered capable of making decisions regarding their needs and care. Agreeing with their distortions of reality, often reinforces and increases their confusion.<sup>30</sup>

5. People behave as they are expected to behave.<sup>31</sup>

Given the conceptual framework of behavior modification, the therapist is left to question the humanistic value of presenting the one-sided view of reality that the reality orientation program espouses. Are there other aspects of reality besides the environmental one accepted by oriented persons? Are there not intangible realities in each person's struggle to resolve his or her own life conflicts in the process of becoming? It is these realities that validation therapy addresses.

#### Validation Therapy

Development. Feil developed validation therapy while working with the aged at the Montefiore Home in Cleveland. She used reality orientation as well as other therapeutic techniques to elicit feelings and interaction in persons who were experiencing a "loss of ego contact with reality and regression to early modes of self-

gratification."<sup>32</sup> For these people, she found that the goal of reality orientation was unrealistic because they had regressed to total dependency on the nursing staff and were unaware of time and place.<sup>33</sup> Instead of repeating facts of external reality, they verbalized their inner realities or "fantasies" with the therapist, who accepted their expressions and validated their identities. In this way, they gained a sense of self in knowing that their worlds were meaningful and acceptable.

The conceptual framework of validation therapy is based on an existential humanistic psychology represented by Erikson and Rogers. The approach is client-centered. Rogers expressed the existential philosophy of man as one who "is a person in the process of creating himself, a person who creates meaning in life, a person who embodies a dimension of subjective freedom."<sup>34</sup>

Ego Integration. Since validation therapy deals particularly with disoriented elderly in their last stage of life, Erikson's life stages are especially relevant. Erikson defined the last stage of life as ego integrity versus despair, and describes the possessor of integrity as "ready to defend the dignity of his own life style against all physical and economic threats."<sup>35</sup> The integrated person accepts his life's events and resolves his conflicts. Out of his triumphs and disappointments comes a spiritual sense and a sense of world order. The lack or

loss of this ego integration, Erikson stated, results in fear of death because the person has not accepted the value of his own life cycle.<sup>36</sup>

According to Feil, failure to reach integration means that the person is not able to defend himself against loss. The person avoids facing life-goals and holds onto outworn tasks. That person moves to disorientation in old age, a state that prevents his being able to achieve ego integrity. Without the ability to resolve unfinished past conflicts, he vegetates until he dies.<sup>37</sup> A person can be prevented from reaching this final stage of disorientation; however, the process is reversed with great difficulty.

Confirmation. Implicit in the concept of ego integrity is the acceptance of a person's own definition of himself. The professional nurse as therapist can help a disoriented person accept himself by forming a therapeutic relationship which accepts that person's right to state what he is and what his experiences have made him, a unique person. Engle, a nurse, defined this acceptance as confirmation.<sup>38</sup> Watzlawick, Beavin, and Jackson, studying communication, found this acceptance of the other's right to be unique, as "probably the greatest single factor ensuring mental development and stability" of persons in a relationship.<sup>39</sup> If an older institutionalized person, already suffering multiple losses, is

denied this kind of confirming communication, he risks losing his sense of identity and becoming disoriented.

While confirmation is the attitude of acceptance of an individual's definition of himself and acknowledgement of his worth, validation is a response to what he says. Engel saw confirmation and validation as interconnected. She defined validation as "acknowledgement that one has received the message which the sender transmitted and that from the sender's perspective, it is true."<sup>40</sup> The individual in a state of stress, as is the old-old person who has not yet resolved his life, may have a diminished ability to evaluate the perspective from which he is sending messages. This places the responsibility on the nurse to respond in a validating way to information she perceives to be either true or false.

The opposite of confirmation, disconfirmation, was defined by Watzlawick, Beavin, and Jackson as a pathological form of communication in which the listener denies the individual his self-identification and, in effect, his existence.<sup>41</sup> This happens when labels that do not take into account a person's life experiences are applied to individuals and when validation is not used to discover the person's perspective.

Labeling an old person as disoriented, confused, or senile, without offering him the help he needs to overcome the behaviors described by these labels, may be an

example of disconfirmation. Feil defined the disoriented old-old as those persons over 80 years who have used denial to deal with their losses, and who survive by retreating into the past to substitute for an unbearable present.<sup>42</sup> Oberleder, a psychologist, looking at emotional breakdowns in elderly people, noted that the symptoms of memory loss, disorientation, confusion, aggressive and agitated behavior, senseless rambling, phobias, hallucinations, delusions, and infantile regressive behavior are often equated with senility, an expected and irreversible change in old age.<sup>43</sup>

Stages of Disorientation. Feil divided disorientation into four stages from mild, occasional disorientation to severe and constant disorientation, in which a slow, progressive unfolding of feelings accompanies the course of withdrawal.<sup>44</sup> Each stage is distinguishable on the basis of emotional characteristics, physical characteristics, and feelings characteristically experienced by people in that stage (see Table 1). This theoretical formulation of stages is based on many years of observation, but has not been scientifically tested for validity. Validation therapy has been found to be most successful with patients in second and third stage.<sup>45</sup> The validation therapist is educated to understand the losses that lead to disorientation in old age. That person learns to be open to others' feelings and to be patient, to lay aside

TABLE 1  
STAGES OF DISORIENTATION

Characteristics			
Stages	Emotional	Physical	Feelings
One: Occasional Disorientation	<p>Holds onto present reality Can play games with rules Has sense of humor Denies disorientation, confabulates Can dress, toilet and control self most times Holds onto rules and "proper" ways of behaving</p>	<p>Eyes clear and focused Stance rigid, unmoving Movement in space definite, sustained, precise Face and body muscles tight. Fingers and hands often pointing Arms often folded, protecting the chest</p>	<p>Feelings are denied Speech, reason, rational thinking dominates Considers anyone who shows feelings or uses napkins to represent babies is "demented"</p>
Two: Time Confusion	<p>Expresses feelings. Does not remember facts Remembers sensory, pleasurable feelings from childhood Energy focus is to resolve past unfinished conflicts Loses sense of humor</p>	<p>Muscles are loose Eyes clear, but often unfocused, gazing into distance Movement in space slow, indirect, often questroning Shoulders tend to slump forward, neck down</p>	<p>Returns to universal feelings shared by all: love, hate, fear of separation, struggle for identity Expresses these in symbols and body movements Rhythms and rhymes come without reason, to avoid boredom</p>

TABLE 1 (continued)

Three: Repetitive Movement	Need for speech lost with disuse Ability and desire to think is lost Repetitive sounds stimulate, reassure, help resolve Increasing loss of sense of self-awareness and of body in space. Does not respond unless stim- ulated through a combination of <u>close contact</u> , <u>nurturing</u> <u>touch</u> , <u>voice tone</u> and eye contact	Sways or dances Sings but cannot talk in sentences Moves gracefully with muscles loose, but is unaware of movements Is incontinent of bowel and bladder Eyes often closed or un- focused Fingers and hands pound, tap, beat, button and unbutton	Feels shame, guilt, sexual feelings, repres- sed rage at parents who implanted "bad" feelings for "bad" behavior Feelings stopped-up for a lifetime, overflow Use body to act out un- finished feelings with a goal toward peace
Four: Vegetation	Moves in slow, half-time Murmurs one sound, very weak, very rarely Sleeps or sits with eyes closed most of the time	Eyes closed, dull when open, unfocused, staring Muscles loose, without expression Do not respond to touch, voice tone, eye contact Sits in geriatric chair, or lies in bed to vegetate, often for many years.	Very little evidence of response to validation therapy

SOURCE: Naomi Feil. Validation/Fantasy Therapy: New Manual Tells How to Help Disoriented Old-Old (Cleveland, Ohio: Edward Feil Productions, 1981), pp. 22-31.

rules for adult behavior, and to judge progress according to each person's ability and desire to change behaviors.

Assumptions. According to Feil, the basic assumptions of validation therapy are:

1. Each person is unique and deserves respect regardless of age or disorientation.
2. Disoriented old-old have the right to justify life by returning to the past.
3. The worker validates the disoriented old-old person by acknowledging this right.
4. Rational thinking is not the "only" way. Feelings have a right to be expressed when rational thinking fades.
5. Human beings can change and grow in a genuine, loving relationship.
6. Behind all behavior lies a good, logical reason.
7. Caring is finding the reason; validating; reducing anxiety; healing.<sup>56</sup>

#### Empirical Studies

In this section the theoretical frameworks are linked to the practice of the two therapies in review of empirical studies. First, the studies of reality orientation are presented. Second, unpublished studies of validation therapy written by Feil are reviewed.



### Reality Orientation

Although there are numerous reports in the literature of studies of patient progress through reality orientation, not all of them are scientifically researched. Barnes involved six patients in a nursing home setting in a six-week program of reality orientation for six days each week. His purpose was to determine what effect the reality orientation group technique had on a group of geriatric patients with a moderate to severe degree of disorientation over a six-week period. The mean age of the participants was 81 years. No objective measure was used to determine degree of disorientation. Participants were chosen by the director of nursing service using judgments of behavior. Barnes developed a questionnaire to measure differences in information known before and after the therapy. Using a nonparametric statistical test to determine changes of scores on the questionnaire, he found no significant differences after the therapy. Reports of changes in participants' behavior after the therapy period were not substantiated statistically.<sup>47</sup>

Settle, a nurse in a Veterans Administration Hospital, reported on a pilot study done with four patients using a modified mental alertness test. Not enough details of the study are reported to determine whether the improvements claimed by Settle were ever actually verified.<sup>48</sup>

Folsom reported on a year-long pilot study of a 24-hour program plus classroom procedures initially involving 64 patients, 29 of whom remained in treatment at the end of one year. Of those, four showed regression and two were unable to cooperate. The remaining patients were reported to have shown significant behavioral improvement. However, no statistical results were reported.

Browne and Ritter, studying the effect of reality orientation on 16 long-term chronic schizophrenic patients, reported that seven day, twice-a-day reality orientation classes resulted in marked improvement for 12 of the patients. The behavioral observation scale was rated by those who conducted the therapy for each patient before and after the six month therapy. No statistical results were reported. The remaining four patients in the study repeated the course in new groups where all but one demonstrated further improvement.<sup>50</sup>

Letcher, Peterson, and Scarbrough at Veterans Administration Hospital in Tuscaloosa, Alabama, reported on the results of a combination 24-hour and classroom reality orientation program based on a study of the records of 125 patients who participated in the program between 1965 and 1970. The mean age of participants was 82.8 years, with a range of 44-95. The measure of

progress was a change in level of nursing care based on a four-level grading system. No control group was established. They found that 68 percent of the participants remained at their initial level of functioning, while 32 percent improved. Although only one-third of the group improved, they found the results encouraging because experience had shown that older people generally decline in institutional settings. Reality orientation had prevented the decline of some patients and actually improved the condition of others. Time in the program ranged from two to 56 months. Given this range of time in treatment, generalizations to any other group are not possible.<sup>51</sup>

Hogstel, studying reality orientation with aged confused patients, conducted a controlled four-cell design test with 20 patients in the control group and 20 patients divided into four experimental groups of five patients each given reality orientation. Patients were tested on an 18 question assessment tool scored in the mild, moderate, and severe range of confusion. Confusion was defined as "periodic disorientation to time, place, and/or person together with memory loss for recent events."<sup>52</sup> After three weeks of daily five-times-a-week classes, subjects were again tested on the same questions as before. Analysis of questionnaire results showed no significant difference in degree of confusion between those patients who participated in reality orientation and a control

group of similarly selected patients. Further, of the experimental group, eight patients were less confused, eight were more confused, and four remained the same. Judging from the changes in scores on the test, the moderately confused patients appeared to have greater improvement than either the slightly confused or severely confused patients. She concluded that a period of time longer than three weeks is necessary for definite changes to be measured.<sup>52</sup>

Brook, Degun, and Mather reported on a study of a reality orientation program used with 18 psychogeriatric patients. In their study, the control group members were exposed to all the same stimuli except active interaction with the therapist for 16 weeks. Subjects were rated before therapy and at two-week intervals during the experiment on a rating scale devised for assessing intellectual and social functioning. Subjects included those who scored on three levels of confusion, and who were rated by the staff to possess mild to severe degrees of disability. Results suggested that the most improvement was made by those who had relatively high intellectual and social functioning. Very deteriorated patients did not appear to benefit. Those in the control group did not benefit from merely being in a therapy environment and some of their initially high ratings deteriorated from lack of reinforcement.<sup>64</sup>

A carefully researched study was conducted over a one-year period by Zepelin, Wolfe, and Kleinplatz. Disorientation was assessed using a Mental Status Questionnaire modeled on the Kahn-Goldfarb measure, and activities of daily living were rated on a specifically designed and tested scale, before and after therapy. A combination of 24 hour reality orientation and classroom groups was used. Results showed that post treatment differences on the Mental Status Questionnaire were favorable to reality orientation but not statistically significant. On the Activities of Daily Living measure, post treatment differences were not favorable to reality orientation. The authors concluded that reality orientation slightly alleviates disorientation in the institutionalized elderly and helps prevent further mental deterioration that may otherwise occur.<sup>55</sup>

Voelkel compared improvement in mental status and physical self-care in twenty patients determined by Pfeiffer's Short Portable Mental Status Questionnaire to be severely or moderately impaired. They were randomly assigned to either a reality orientation or a resocialization (social group which stresses reminiscence) group for six weeks. The results indicated that the resocialization group improved significantly while the reality orientation group did not. She concluded that it was not the constant reminder of current information that improved mental

status, but the coming together as a group in a social setting that made the difference.<sup>56</sup>

Another study that compared two psychosocial treatments was done by MacDonald and Settin to compare reality orientation and sheltered workshops. Thirty nursing home residents (mean age 64.4 years) were randomly assigned to one of the two experimental conditions. Program effects were assessed before and after treatment using three measures: Life Satisfaction Index-A, nurses ratings, and behavior observations. After the treatment period of five weeks, meeting three times a week, results on the three measures revealed that the sheltered workshop group gained significantly on the Life Satisfaction Index-A scores. Those in reality orientation decreased but not significantly. Neither treatment produced effects on observer-rated on-ward behavior.<sup>57</sup>

Citrin and Dixon conducted a study that yielded positive results for reality orientation. Milieu therapy of 24-hour reality orientation for mildly disoriented patients was supplemented with classroom reality orientation for a period of six to seven weeks. An experimental and control group were tested before and after the reality orientation program with the Reality Orientation Information Sheet (ROIS). The experimental group improved significantly while the control group declined, although not

significantly on the ROIS. All subjects were mildly dis-oriented.<sup>58</sup>

In summary, many studies have attempted to determine if reality orientation reduces or prevents confusion. Several studies that reported positive results provided only anecdotal evidence. Other supportive studies lacked appropriate control groups. Two experimental studies reporting that reality orientation had positive effects on confusion used subjects who were only mildly confused. In studies that compared two psychosocial therapies, positive results were reported for the therapy other than reality orientation.

#### Validation Therapy

The one published study by Feil explained the preliminary work in remotivation that formed the basis for validation therapy. The study was an anecdotal report of how individuals, who had been the most withdrawn of the nursing home residents, became more comfortable in facing and expressing their feelings, with the help of a supportive therapeutic relationship.<sup>59</sup>

In another early study of group work in formulating Validation/Fantasy Therapy, Feil reported that twelve disoriented old patients were divided into two groups and met four times a week for six months. Behavioral observations were recorded by the geriatric aides at four regular intervals each day on the basis of six positive and

seventeen negative manifestations of affect. Behavioral data were recorded during daily group meetings. The results showed that all but one group member displayed an increase in positive affect. The study, however, lacked methodological controls.<sup>60</sup>

Feil reported from her experience that validation therapy works best with disoriented old persons in stages two and three of disorientation. In stage one, the person is threatened by his confusion and prefers not to explore his fantasies. In stage four, the person cannot be stimulated to re-enter the world of relationship necessary between himself and the therapist.<sup>61</sup>

Feil has continued to develop insights and to refine her methods for conducting therapy in groups. These methods are taught to health workers who deal with the aged in the hope that understanding client-centered therapy and the stages of disorientation will permit the worker to validate the reality of the old-old and thus reinforce their human dignity and identity.

#### Statement of the Problem

This study explored differences in the way two groups of disoriented old-old patients scored on measures of orientation, ego integration, and behavioral characteristics when treated with validation therapy or reality orientation.



### Purpose of the Study

The purpose of this study was to determine whether validation therapy or classroom reality orientation was effective in restoring institutionalized disoriented old-old patients to orientation; in helping the patient to integrate his life in the context of ego integrity versus despair; or in changing behaviors characteristically associated with moderate to severe disorientation.

### Research Hypotheses

Hypothesis 1: Validation therapy changes the disoriented person's score on a measure of orientation.

The purpose of validation therapy does not include a reorientation to accepted reality. A change is predicted based on Feil's projection that, fantasy being a way of structuring his or her world, the disoriented old person may choose to withdraw further into fantasy, or to feel safe enough to accept external reality and become more oriented to the environment, as a result of validation therapy.

Hypothesis 2: Validation therapy increases the disoriented person's score on a measure of ego integration.

According to Feil, validating a person's perception of his own reality repeatedly over time should help that person to develop the courage to face life's unfinished business and to accept the integrity of his own life. Although it is not expected that six weeks of therapy

will really provide enough time for this process, the findings are expected to be positive.

Hypothesis 3: Validation therapy decreases the dis-oriented person's score on a measure of behavioral characteristics.

Since the behavioral characteristics outlined in the Behavior Assessment Tool relate to signs of withdrawal into a world of fantasy, it is expected that validating their world will allow persons experiencing validation therapy to relinquish their fantasies somewhat and to behave in a less withdrawn manner.

Hypothesis 4: Reality orientation results in a positive change in the disoriented person's score on a measure of orientation.

Since the purpose of reality orientation is to increase the confused person's awareness of his environment, and much of the basic information asked in the Tool for Assessing Confusion in the Elderly is also presented in the classes, it is expected that better scores would result from reality orientation.

Hypothesis 5: Reality orientation changes the dis-oriented person's score on a measure of ego integration.

The purpose of reality orientation is not directly related to ego integration. However, because the dis-oriented person is included in a group interaction, it is expected that the person will experience some change.

Hypothesis 6: Reality orientation changes the dis-oriented person's score on a measure of behavioral characteristics.

Because the person is included in a group, even though reality orientation is not intended to affect behaviors, it is predicted that behaviors will change.

Hypothesis 7: There is a positive change in the control group member's score on a measure of orientation due to learning curve.

Since the test is the same one given before and after the treatments, it is expected that scores will improve on the basis of recognition or learning. Because the control group is randomly assigned, it can be assumed that any difference that occurs in the values of the dependent variables for the treatment groups and not the control groups can be attributed to the independent variable.<sup>62</sup>

Hypothesis 8: There is a positive change in the control group member's score on a measure of ego integration due to learning or recognition.

Again, this variable could be subject to a learning curve because the subject is asked the same questions before and after the treatment period. If no significant improvement is found for the control group, then a significant improvement in treatment groups can be attributed to the treatment variable.

Hypothesis 9: There is a beneficial change in the control group member's score on a measure of behavioral characteristics.

Although there cannot be a learning curve associated with this variable because the score is determined by observation, the hypothesis takes into account the positively stimulated environment of the setting as well as the Hawthorne effect.

Hypothesis 10: Higher scores on the ego integration scale after therapy are positively correlated to lower scores on the orientation scale for both the validation therapy and reality orientation groups.

It can be assumed from the literature that if the disoriented person can come to accept his own unique life, he will be able to be more accepting of his environment, and thus more oriented. Thus it is expected that an increase in ego integration will be accompanied by an increase in orientation.

Hypothesis 11: Higher scores on the ego integration scale after therapy are positively correlated to lower scores on the behavioral assessment tool for both the validation therapy and the reality orientation groups

It is hypothesized that a person who achieves a greater degree of ego integration will display fewer symptoms of withdrawal in his behavior. It is therefore expected that an improvement in ego integration will be accompanied by an improvement in behavior.

Hypothesis 12: Lower scores on the orientation scale after therapy are positively related to lower scores on the behavioral assessment tool for both the validation therapy and the reality orientation groups.

It is hypothesized that a person who is more oriented to his surroundings will display behavior less withdrawn as his orientation to his environment increases. It is therefore expected that an improvement in orientation will be accompanied by an improvement in behavior.

Hypothesis 13: Validation therapy groups will produce scores significantly different from reality orientation groups in one or more of the measures of orientation, ego integrity, or behavioral characteristics.

The last hypothesis is a summary statement. It predicts that validation therapy groups will produce scores significantly different from reality orientation groups in one or more of the three measures.

#### Operational Definitions

For the purpose of this study, each of the following terms were defined as follows:

Classroom reality orientation: classes for groups of five to six residents held for 30 minutes five consecutive days a week, taught by a person trained in reality orientation techniques, involving structured orientation to time, place, and person. The purpose of this therapy is to reduce disorientation experiences by the elderly person.

Validation therapy: group therapy for five to six residents held for 30 minutes five consecutive days a week, guided by a therapist specifically trained in validation therapy techniques, following a specified format. The purpose of this therapy is to increase

the disoriented person's sense of identity, dignity and self-worth.

Ego integration: indication of acceptance of one's own life cycle and resolution of past unresolved conflicts as measured by the ego integration scale.

Disoriented old-old: those persons 80 years of age or older who exhibit characteristics of time confusion and/or repetitive motion.

Time confusion: the second stage of disorientation as defined by Feil. (See Appendix G).

Repetitive motion: the third stage of disorientation as defined by Feil (See Appendix G).

Validation: verbal acknowledgement by the therapist that the message sent by the disoriented old-old person is the one received.

Therapist: person specifically trained in validation therapy or reality orientation who guides the validation therapy or reality orientation group.

Disorientation/confusion: failure to adjust one's notions of time, place, and person to accepted reality; memory loss for recent events.

Control group: subjects who were randomly selected and exposed to all the conditions that the experimental groups were exposed to except the treatment.

### Summary

This study proposed to discover which, if either, of two psychosocial therapies used with moderately to severely confused institutionalized old persons, was more effective to improve orientation, ego integration, and behavioral characteristics. Reality orientation, by far the most used and reviewed therapy, has a behavioral theory base. Its purpose is to reorient disoriented people to their immediate surroundings by continual

reinforcement. Validation therapy, on the other hand, has an existential theory base. Its purpose is to validate the uniqueness of the person, giving him a sense of dignity and self-worth to help him resolve his life's unfinished conflicts. Review of the literature revealed that many studies of reality orientation showed no significant change in disorientation after the therapy. Significant improvement in mental status was reported only for studies of moderately confused persons. The only studies found of validation therapy were those done by Feil, but none had a controlled research design. Thirteen research hypotheses were formulated to test the differences between these two therapies.

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## CHAPTER II

### METHODOLOGY

#### Introduction

The methodology of this study will be presented in this chapter. It includes the setting, sample, administrative, and instrument designs.

#### Setting Design

In order to control for as many extraneous variables as possible, it was necessary that this study be conducted in a single nursing home large enough to have a sufficient number of residents over eighty years of age who met the criteria for this study. The 225-bed nursing home that was chosen was located in a large midwestern metropolitan area.

The physical dimensions will be described because environment is often related to orientation.<sup>1,2</sup> The one-story building was constructed in two sections. The older section had three wings built parallel to one another with a nurses' station at the head of each wing. The newer section had four wings constructed like free standing spokes off a central round hub, which held a pleasant

lobby and a central nurses' station for the four wings. The newer wings were each painted a different color, making it easier for residents to identify the hall where their room was located. Each hall had an open alcove furnished with comfortable chairs, a sofa, a television set, and a round table with hard chairs. It was in this alcove on the blue wing where the treatment groups met. Although the alcove was not ideally enclosed, the hall was quiet enough that distractions could usually be kept to a minimum.

All rooms except two on each wing were double occupancy with enough room for two beds, chairs, night stands, and closets. Each room had a window and sink and grooming area. A bathroom between two rooms was shared by four residents. Many residents displayed personal mementos in their rooms, while a few had even a personal chair or bureau. Rooms in the old section were similar to those just described.

Adjacent to the alcove described above was the tub and shower room without a door or curtains to provide privacy. The halls were wide, uncluttered, and generally well lighted, with a handrail to assist walking. The only wall clock in this wing was hung in the lobby, not visible from all angles of the central hub.

Certified for both Medicare and Medicaid, the nursing home had patients from diverse cultural, racial

and ethnic backgrounds. The activities department worked closely with the nursing and social services teams to provide frequent group activities of interest to this diverse group of residents. The residents who were oriented and active generally found outlets. Many who were less oriented received stimulation and attention also.

Because the staff was familiar with reality orientation principles, efforts to stimulate the environment were evident in a multitude of ways. Some of these were an activities calendar posted in the lobby, a monthly newsletter featuring items about many of the residents, monthly birthday parties honoring that month's celebrants, and a reality orientation blackboard on which information was changed daily, placed in the lobby.

In summary, for a long-term care institution the environment within this nursing home was conducive to orientation. These conditions have been noted because the enriched environment must be considered an extraneous variable in a study of this type.

#### Sample Design

In order to be included in this study, nursing home patients met the following criteria: (1) be 80 years or older, (2) give informed consent to participate (closest relative or guardian may do so in cases of extreme disorientation, (3) be physically able to participate in a group, and (4) score on the Confusion Tool (Appendix B) in

the range of 7 to 12 (moderate) or 13 to 18 (severe). A list of all residents in the new wing who were 80 years or older was received from the social service staff.

The researcher approached each of these residents individually, explained the study in simple words adapted to their understanding level and asked for their consent to participate. The Consent Form (Appendix A) was signed by each person who consented.

The researcher then interviewed potential subjects using the Tool for Assessing Confusion in the Elderly (Appendix B). If their scores fell between seven and and eighteen, and they were physically able, the respondents were questioned using the Ego Integration Scale (Appendix C). On both of these measures, the researcher marked the answers of the respondents. These subjects were then assigned to one of three groups (control, reality orientation, and validation therapy), by matching the last two digits of their patient numbers with numbers on a table of random numbers.<sup>3</sup> Unavoidable conflicts in schedules required a change in group assignment for some subjects. While a beginning total of 36 subjects was sought, only 31 were found, out of a total of 78 residents who met the age criterion. For the investigation, there were ten subjects in the validation therapy group, ten subjects in the reality orientation group, and eleven subjects in the control group.



### Administrative Design

This study was granted approval at minimal risk by the Committee for the Protection of Humans in the Area of Research at The University of Akron, in April of 1981. A letter was sent to the Administrator of the nursing home that was conveniently selected to fulfill the conditions of the study (Appendix K). After a telephone call confirmed interest, a meeting was established between the Administrator, the Director of Nursing, the Social Service Director, and the researcher. When the study was explained, the researcher clarified what would be required of the nursing home: a place reserved for meetings of the groups every weekday morning and afternoon, refreshments for each therapy group (usually a can of juice) daily, and provisions made by the staff so that each group member would be dressed and brought to the meeting each day. The researcher also requested access to residents' charts to gather demographic information. Permission was granted for the study and full cooperation was assured.

### Experimental Design

This study employed the true experimental pretest-posttest control group design described by Campbell and Stanley<sup>4</sup> with the added dimension of a second treatment. The design is graphically represented in Figure 1.

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R	O	X	O
R	O	X	O
R	O		O

---

FIGURE 1. THE PRETEST-POSTTEST  
CONTROL GROUP DESIGN

The researcher chose this design to control for factors of internal invalidity (history, maturation, testing, instrumentation, regression, selection, mortality), which directly affected O scores. The fact that the randomization of group members was unavoidably manipulated may have introduced a source of bias. Sources of external invalidity, limiting the generalizability of findings, could not be controlled by this or by any other experimental design.<sup>5</sup> These will be discussed in Chapter III.

During twelve days before the treatment groups were scheduled to begin, the researcher gathered a sample of 31 subjects as explained above. Sixty consent forms had been signed, two by family members and 58 by subjects. Copies of these consent forms were filed in the Social Service office.

The 31 subjects were then rated on the Behavior Assessment Tool (Appendix D) by the researcher while observing each subject in a group setting. All tests were completed before the beginning of treatment groups. Demo-

graphic Information sheets were completed by the researcher during the six weeks of the study. Confidentiality was insured by the use of patient numbers instead of names on all test forms, which were kept at the researcher's home.

Each of these 31 subjects was randomly assigned, as explained above; eleven to the control group, ten to the validation therapy group, and ten to the reality orientation group which lost two subjects during the study time. For the six weeks that the two treatment groups met, no treatment or special attention was given to members of the control group. At the conclusion of the six week treatment course, the researcher tested all of the remaining 29 subjects on the Tool for Assessing Confusion in the Elderly and the Ego Integration Scale. The researcher also rated the behavior of each of the 29 subjects on the Behavior Assessment Scale while they were involved in some form of group activity. All tests were completed within ten days following the conclusion of the treatments.

#### Treatment Therapists

To eliminate treatment bias, different persons administered each therapy. The treatment therapists included the researcher who alone administered the validation therapy, and another registered nurse graduate student who alone administered the classroom reality orientation. The researcher was prepared in validation therapy by taking part in a validation therapy group already

established in another nursing home and by working directly with Naomi Feil, who originated the therapy.

The nurse who administered reality orientation was prepared by a study of the literature, and by observing reality orientation being administered in several area nursing homes.

#### Preparation of Staff and Families

In order to prepare the staff for the therapies that would be administered, two inservice sessions about each therapy, a total of four sessions, were arranged to which staff members from all shifts were invited. One session was held in the late afternoon especially to explain reality orientation to second and third shift staff. The following morning, the same presentation was given for the first shift staff. The same schedule was followed the next week to provide inservice on validation therapy. Nearly 20 percent of the staff from all departments, including nursing, housekeeping, social service, activities, and dietary, were represented at the sessions. The researcher explained validation therapy, and reality orientation was explained by the student who conducted reality orientation groups.

These were the purposes achieved at least partially by these inservice sessions: to enlist the cooperation of the staff in helping patients arrive on time to

their group therapy sessions; to seek staff support for the research project; and to provide them with a model of a therapy that may be useful to them as an intervention technique in helping other disoriented patients.

One further session for the staff was arranged when Naomi Feil came to conduct the groups with the researcher. With the members' permission, staff were invited to participate with the groups. An inservice session was held after the group meetings, led by Mrs. Feil and attended by eleven staff members.

To help families to understand the purpose of the study and the progress of the therapy in which their family member was involved, two separate meetings were arranged, one for each therapy treatment. The researcher contacted families by telephone, using the explanation given in Appendix G to invite them to come to the meetings. Most of the families expressed interest and asked questions, even if they were unable to attend the meetings. Attendance showed family representation of two of eight subjects in reality orientation, and six of ten subjects in validation therapy.

#### Reality Orientation Therapy

The reality orientation therapy was limited to classroom group sessions only, so that its effects could be compared with another type of group therapy. The original sample of ten subjects assigned to reality orienta-

tion was divided randomly into two groups of five members, the number found to be most effective for individual participation.<sup>6</sup> Each group met for thirty minutes, 1:00-1:30 and 2:00-2:30, each weekday for six weeks. The 29 sessions excluded a national holiday.

The therapist prepared name tags to orient members to each other. First and last names made of one-and-a-half inch letters were placed on tagboard, and strings were attached for wearing around the neck. Members were instructed to pick up their own name tags from a table at the beginning of each meeting. The therapist introduced members and herself at each meeting.

A flannel board was used to display the cues of current reality, which included: the name of the nursing home, city, state, day of the week, month, day of the month, year, season, and weather. A calendar was passed around the group and the current day was pointed out for each resident who could not identify it. A clock was also used to orient group members to time of day. Pictures of current government leaders (i. e., president, mayor) were put on the flannel board or passed around. Sheets of paper and felt tip pens were supplied for practice in writing.

Chairs were arranged in a semicircle facing the board. The therapist sat near the hearing impaired to repeat conversation if needed. Juice supplied by the

nursing home was served at each session. toast was proposed by one of the members of the group. The therapist.

Information cues to current reality board formed the basic structure of the session. Other topics were introduced by the therapist spontaneously from the group. Some of the topics included roses, vacations, summer chores, music and hobbies, gardening, military service, farm life, Fourth of July, and Father's Day. During the session members were asked to write their names, citizenship, date, and anything else they chose to write.

The routines and principles used by the therapist followed those published in the Guide for Reality Therapy.<sup>7</sup> The therapist made daily observations of the members, which were recorded on the Therapy Observation Form (Appendix F).

In summary, the elements of each reality therapy session included the following: setting routines in a calm environment; asking clear questions and responding clearly and simply to questions of group members; addressing subjects in a friendly way; giving brief, definite instructions; giving correct and current information; curtailing rambling actions or speech by kindly redirecting to the present; being firm, but kind and considerate.

needs; being consistent; and finally, showing sincerity and caring for group members.

The primary goal of the therapy was to continually reorient the confused person to present reality. (See Appendix J for a demonstration of a sample group session.)

#### Validation Therapy

Validation therapy group members were assigned randomly from the original sample of ten members, to two therapy groups of five members each. The groups remained intact throughout the treatment. Five is the smallest recommended number for a group.<sup>8</sup>

Feil recommends that group members be those who manifest Stage Two or Stage Three behaviors, and that group members be chosen on the basis of certain qualities.<sup>9</sup> No attempt was made to do this because of the experimental choice to randomize groups, and also because the tool to assess confusion was based on orientation to reality rather than on behaviors. It has not been established that moderate to severe confusion is equivalent to Stage Two, Three, or Four behaviors.

Four group members were rated on the Behavior Assessment Tool to be in Stage Two and one in Stage One for each of the groups. Feil recommends that Stage One persons not be included in validation therapy because of their characteristic fear of others' disorientation.<sup>10</sup>



However, results revealed no ill effects for these two members.

The two validation therapy groups met for 30 minutes from 9:30 to 10:00 and 10:30 to 11:00 every weekday morning for six weeks. Again the 29 sessions excluded the national holiday. Feil recommends that groups meet at least once a week, and that the therapy continue for at least three months.<sup>11</sup> It was hoped that the more intense daily therapy would equal or surpass the effects of extended therapy over time. However, no research has demonstrated the length of time that would be most effective.

To implement the therapy groups, the first step was to find roles for each member, such as group leader, song leader, or hostess. Each therapy session followed a ritual, which included opening by the leader, discussion of a topic previously agreed on, singing and movement, closing ritual, and refreshments served at the end of each session. Daily observations were recorded as with the reality orientation groups.

In summary, the validation therapist recognized the logic behind behavior and shared and validated the feelings expressed by the person. The therapist established trust by sharing the thrust of the sensations, rhythms, emotions, and memories the members expressed

rather than emphasizing the truth or non-truth of the facts. The primary goal of this therapy is to give the person a sense of identity, dignity, and self-worth. (See Appendix I for a demonstration of a sample validation therapy group.)

### Instrument Design

The five instruments used to collect data in this study are explained in this section. These include the Tool for Assessing Confusion in the Elderly, the Ego Integration Tool, the Behavioral Assessment Tool, the Demographic Information questionnaire, and the Therapy Group Observation Form.

The Tool for Assessing Degree of Confusion in the Elderly (Appendix B) was developed by Hogstel in a study of reality orientation in a nursing home.<sup>12</sup> This 18-item questionnaire to determine degree of confusion was devised to be used in a semistructured interview-type situation. The questions seek information regarding name, date, location, weather, and selected current events. The test was designed so that a higher score equals greater confusion. The test-retest reliability coefficient of .96 was established when the test was administered twice over a period of two weeks. Permission to use the questionnaire was obtained from the author (Appendix L).

The Ego Integration Scale (Appendix C) was designed by the researcher because a review of the litera-

ture failed to identify an instrument that measured this variable in particular. The ten items for the instrument were obtained from tools developed by Boylin, Gordon, and Nerke.<sup>13</sup> In studying reminiscing and ego integrity in institutionalized elderly males, they used Constantinople's<sup>14</sup> intimacy subscale as a model for the format of the subscale to measure ego integrity vs. despair. The items were considered to have face validity with the concepts they were to measure, based on Erikson. Of the ten items on the scale, five correspond to the positive outcome, and five to the negative outcome. Item analysis of the ego integrity scale by Boylin et al.<sup>15</sup> showed that four out of the five items dealing with ego integrity correlated highly with that subscale. They were items 1, 5, 7, and 9 (See Appendix C), with correlation of  $r = .52$ ,  $.70$ ,  $.58$ , and  $.40$  respectively. Two items that were related to despair, numbers 8 and 10, also had significant correlations with the subscale ( $.27$  and  $.66$  respectively). Item 4, "feel worthless" was found to correlate with all three subscales of ego integrity, intimacy, and generativity, and was considered too vague to discriminate among subjects differing in ego integrity. No alternative was suggested, however. The three-point scale that was used by Boylin et al. of "rarely, occasionally, or often"<sup>16</sup> was considered to require too fine a degree of discrimination for disoriented persons to determine. Therefore, the

"agree, ?, disagree" scale used on the Life Satisfaction Index A developed by Neugarten, Havinghurst, and Tobin,<sup>17</sup> was adopted because it is more easily understood.

The Behavior Assessment Tool was developed by the researcher using selected items from Feil's list of characteristics common to each of the four stages of disorientation, as they relate to ten general categories of behavior (See Appendix D). The inter-rater reliability coefficient established when the researcher and Feil separately tested the same five members of a validation group was 1.0.

The Demographic Information Questionnaire (Appendix E) sought answers to items that have been noted in previous studies to affect the course of therapy. Since not all these extraneous variables could be excluded, they were used in discussion to increase the study's application to other studies. Some items, such as sex and age, were analyzed using descriptive statistics to show patterns of variability.

Finally, the last instrument is a Therapy Group Observation Form (Appendix F) prepared by the researcher to record observations of behavior in the group. It served as a daily check on subjects' variability.

### Summary

In this chapter the methodology of this study has been discussed. The study was conducted in a 225-bed

nursing home in a midwestern metropolitan area where enough residents to meet the study's eligibility requirements were found. The sample design described the protocol for approaching and testing potential subjects. The administrative design explained how the experimental pretest-posttest control group design was applied, and how the tests and the therapy groups were conducted. Finally, the instrument design described how the five instruments were developed and used.

Chapter Notes

<sup>1</sup>Karen Hahn, "Using 24-Hour Reality Orientation," Journal of Gerontological Nursing 6 (March 1980): 133.

<sup>2</sup>Linda Drummond, Lorraine Kerchhoff, Dorothy Scarbrough, "A Practical Guide to Reality Orientation: A Treatment Approach for Confusion and Disorientation," The Gerontologist 18 (1978): 570.

<sup>3</sup>Lyman Ott, An Introduction to Statistical Methods and Data Analysis (North Scituate, Mass.: Duxbury Press, 1977), p. 690.

<sup>4</sup>Donald T. Campbell, Julian C. Stanley, Experimental and Quasi-Experimental Designs for Research (Chicago: Rand McNally, 1963), p. 8.

<sup>5</sup>Ibid, p. 17.

<sup>6</sup>Jaber F. Gubrium, and Margret Ksander, "On Multiple Realities and Reality Orientation," The Gerontologist 15 (1975): 142.

<sup>7</sup>Guide for Reality Orientation (Tuscaloosa, Alabama: Veterans Administration Hospital Nursing Service, 1974), p. 6-8.

<sup>8</sup>Naomi Feil, Validation/Fantasy Therapy (Cleveland: Edward Feil Productions, 1981): 51.

<sup>9</sup>Ibid.

<sup>10</sup>Ibid.

<sup>11</sup>Ibid., p. 36.

<sup>12</sup>Mildred Hogstel, "Use of Reality Orientation with Aging Confused Patients," Nursing Research 28 (May-June 1979): 163.

<sup>13</sup>William Boylin, Susan Gordon, and Milton Nehrke, "Reminiscing and Ego Integrity in Institutionalized Elderly Male," The Gerontologist 16 (1976): 121.

<sup>14</sup>Ann Constantinople, "An Eriksonian Measure of Personality Development in College Students," Developmental Psychology 1 (1969): 357-372.

<sup>15</sup>Boylin et al., "Reminiscing and Ego Integrity in Institutionalized Elderly Males," p. 123.

<sup>16</sup>Ibid., p. 121.

<sup>17</sup>Bernice L. Neugarten, Robert Havinghurst and Sherlin Tobin, "The Measurement of Life Satisfaction," Journal of Gerontology 16 (1961): 141.

## CHAPTER III

### ANALYSIS OF THE DATA

#### Introduction

In this chapter the analytical findings of the study are presented. The sample is described using selected demographic variables. Comparisons of the two therapy groups and the control group on the basis of the three dependent variables are discussed. Tests of the research hypotheses are reported and conclusions are made. Then the results of the study are discussed from a behavioral and an existential framework, as described in Chapter I. Next, limitations of the study are described. Finally recommendations for research and implications for nursing that are drawn from the study are discussed.

#### Description of the Sample

The majority of subjects were female, widowed, and 81 to 97 years of age. Most were given at least two regular medications on a daily basis, and had a physical impairment of sight, hearing, or mobility. Physical and mental diagnoses were almost evenly divided among the sample group. More than half of the subjects had been away from the nursing home within the last six months for



purposes other than being hospitalized. Slightly less than half completed high school, and some did not complete eighth grade; one held a college degree in education. Slightly more than half of the subjects received visitors daily or weekly. The majority participated in scheduled activities or were brought to passive activities such as concerts. A general description of subsample groups in the present study is presented in summary form in Table 2.

An explanation of the information sought by the Demographic Information Questionnaire is given next. Age was listed as the subject's age at the beginning of the study. The third item, "length of stay in previous institution," could not be answered from information provided in the clinical records, therefore was dropped as an item of comparison. Six records indicated placement from another nursing home, but no duration was given. The medical diagnosis was taken from the first two that were listed on each chart, since many indicated multiple diagnoses. "Physical" was defined as those which pertain to the body as distinguished from the mind; "mental" meant any condition pertaining to the mind or brain, including "cerebral arteriosclerosis" because of the unclear interaction of organic and functional causes of mental confusion.

Medications included only those prescribed to be given daily. Of the subjects who were given antipsychotic

TABLE 2  
DISTRIBUTION OF DEMOGRAPHIC CHARACTERISTICS  
AMONG SUBSAMPLE GROUPS

Variable	Characteristic	Control Group Frequency	Validation Therapy Frequency	Reality Orientation Frequency
Gender	Male	3	0	3
	Female	8	10	5
Age	Range	81-97	81-91	81-93
	Mean	89	87	87
Marital Status	Widowed	9	6	5
	Married	1	2	1
	Single	0	2	2
	Divorced	1	0	0
Medical Diagnosis	Physical	9	3	3
	Mental	2	7	5
Regular Medication	Two or more	8	8	8
	Less than two	3	2	0
Physical Impairment	One or more	8	7	6
	None	3	3	2
Away from NH in last six months	Yes	5	5	5
	No	6	5	3
Regular Visitors	Yes	9	8	8
	No	2	2	0
Highest level of education	Grades 1-7	1	2	2
	Compl. Grade Sch.	4	4	1
	Compl. High Sch.	5	3	4
	Attended College	1	0	0
	College degree	0	1	0
	Unknown	0	0	1
Participation in planned activities	Active	3	5	6
	Passive	2	4	2
	Infrequent	2	0	0
	Refuses	4	1	0

drugs daily (Haldol, Mellaril, or Prochlorperazine), one was in the control group, six were in validation therapy, and two were in reality orientation; all but one of these had diagnoses classified as mental. Physical impairments included only those that required extra assistance or attention, such as confinement to a chair or bed, or extreme difficulty hearing or seeing, not corrected by hearing aid or eyeglasses.

Data relevant to diagnosis of mental illness indicated that one subject in validation therapy had "depression" and one was cured who was diagnosed with "psychotic organic brain syndrome". One subject in the control group was reported to have had "shock treatment at Falls years ago,"<sup>2</sup> but no further details were given. Further references to previous mental illnesses were not noted.

Information about when the subjects were last able to care for themselves in own homes yielded incomplete information. From answers that could be found, three subjects in the control group lived in their own homes within eighteen months before the study; two subjects had not lived at home for four years or more. This information was not available for any subjects in validation therapy. For the reality orientation group, information was available on only two subjects: one had not lived in her own home for 23 years, the other for one year.

Reasons given for being away from the nursing home were for social visiting except for physician appointments for two (when family accompanied them). If subjects had visits from family or friends at least weekly, these were considered regular visitors. Many subjects had daily visits from some family member.

On level of education, the control group had the most subjects (6) who had completed high school or more; half of the reality orientation group (4) had completed high school; in the validation group, only three had completed high school. The one subject who had completed college and taught school was in the validation group.

Numerous efforts were made to stimulate the environment, as explained in the setting design. Most subjects participated in some of these activities to some degree. The control group contained the majority (4) of those who refused to go or be taken to activities as well as the greatest number (2) of infrequent participants. Only three in this group participated actively. In the validation therapy group, nine of the subjects participated in active or passive activities. The one subject who refused was wheelchair bound. If taken to activities, she was usually disruptive. In the reality orientation group, all of the subjects participated in activities either actively or passively.

To be included in the study, subjects were required to attend at least fifteen of the treatment sessions. Table 3 gives a summary of session attendance. Of the ten members in validation therapy, four attended all 29 sessions, two attended 28, one attended 26, two attended 24, and one attended 23 sessions. Reality orientation sessions were not so well attended. While none of the eight members attended all sessions, two attended just fifteen, with attendance between these extremes resembling the validation group.

TABLE 3  
SUMMARY OF THERAPY SESSIONS ATTENDED

Members in Each Group	Maximum Number of Sessions Attended							
	29	28	27	26	24	23	22	15
Validation Therapy	4	2	0	1	2	1	0	0
N=10								
Reality Orientation	0	1	1	3	0	0	1	2
N=8								

Reasons given for missing treatment sessions included illness, family and physician visits, failure to be brought by staff to a session, lack of desire to attend, and in one case, boredom with reality orientation.

One of the subjects in the validation therapy group refused to answer the posttest questions for the Ego Integration Scale, but the other two scales were completed. Therefore, on those hypotheses involving the Ego Integration Scale for the validation therapy group, the number will be nine rather than ten.

#### Analysis of the Study Hypotheses

The data for comparison of before and after treatment scores for each of the two treatment groups plus the control group on each of the three dependent variables were analyzed by using the Wilcoxon Signed Ranks Test. This test was used for the first nine hypotheses introduced in Chapter I. The Wilcoxon Signed Ranks Test was chosen since a non-parametric procedure was indicated. The Wilcoxon Test is superior to other available non-parametric procedures because it utilizes both the direction and ranked magnitude of differences. It therefore has higher power than the alternatives. The probability of a Type I error, that is, that a true null hypothesis is rejected, was set at  $\alpha = 0.10$  for a two-tailed test, and 0.05 for a one-tailed test.

To analyze relationships between changes in scores on the three measures, the Spearman Rank Correlation Coefficient, a non-parametric alternative to linear correlation coefficient, was calculated. A more detailed explanation of these techniques is given in Hays<sup>3</sup>, and Johnson<sup>4</sup>. Again, the probability of a Type I error was  $\alpha = 0.05$  for a one-tailed test. The Spearman Rank Correlation Coefficient was used to analyze hypotheses ten through twelve introduced in Chapter I.

Hypothesis 1: Validation therapy changes the dis-oriented person's score on a measure of orientation.

For  $\alpha = 0.10$ , the null hypothesis was not rejected because  $T = 22$  was greater than the critical value of 11. It was concluded that there was insufficient evidence to determine that validation therapy had any effect on orientation scores. Table 4 gives a summary of changes on degree of confusion after therapy.

Hypothesis 2: Validation therapy increases (beneficial effect) the disoriented person's score on a measure of ego integration.

For  $\alpha = 0.05$ , the null hypothesis was not rejected because  $T = 19.5$  was greater than the critical value of 8. It was concluded that there was insufficient evidence to determine that validation therapy made a significant difference in persons' ego integration scores. Table 5 gives a summary of changes in ego integration scores after therapy.

TABLE 4

CHANGES ON DEGREE OF CONFUSION OF SUBJECTS  
BEFORE AND AFTER A PROGRAM OF  
VALIDATION THERAPY (VT)

Subject	Confusion Score Before VT	Confusion Score After VT	Confusion Score Decreased	Confusion Score Increased
A	13	12	1	
B	10	6	4	
C	12	15		3
D	17	16	1	
E	10	6	4	
F	15	17		2
G	12	11	1	
H	17	16	1	
I	12	11	1	
J	9	13		4

TABLE 5

CHANGES IN EGO INTEGRATION SCORES OF SUBJECTS  
BEFORE AND AFTER A PROGRAM OF  
VALIDATION THERAPY (VT)

Subj.	Integration Before VT	Integration After VT	Integration Increased	No Chg.	Integration Decreased
A	15	14			1
B	11	12	1		
C	12	9			3
D	10	15	5		
E	18	19	1		
F	13	10			3
G	10	10		X	
H	9	10	1		
I	19	19		X	



Hypothesis 3: Validation therapy decreases (beneficial effect) the disoriented person's score on a measure of behavior characteristics.

For  $\alpha = 0.05$ , the null hypothesis was rejected because  $T = 0$  was less than the critical value of 11. It was concluded that validation therapy had a positive effect on the behaviors of persons who experienced validation therapy. Table 6 gives a summary of changes in behavior after therapy.

TABLE 6

CHANGES IN BEHAVIOR CHARACTERISTICS OF SUBJECTS  
BEFORE AND AFTER A PROGRAM OF  
VALIDATION THERAPY (VT)

Subject	Behavior Score Before VT	Behavior Score After VT	Behavior Score Improved
A	23	21	2
B	12	10	2
C	19	14	5
D	21	18	3
E	20	12	8
F	23	20	3
G	25	23	2
H	25	19	6
I	18	13	5
J	13	12	1

The scatter diagram in Figure 2 shows graphically that there is a positive correlation between the scores before and after the program of validation therapy. The dotted line represents the set of points for which the

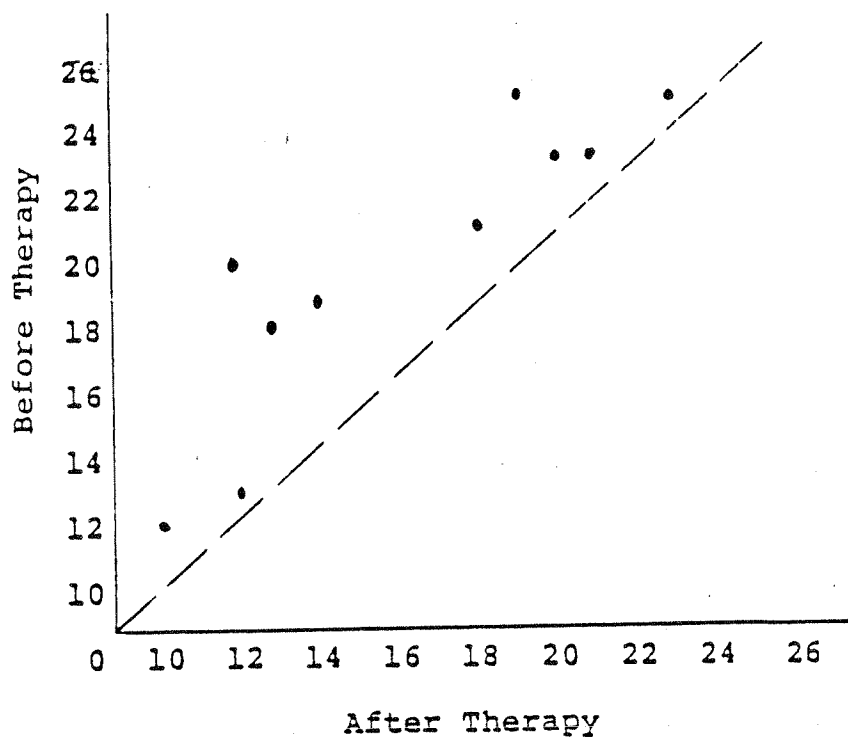


FIGURE 2. SCATTER DIAGRAM: BEHAVIOR SCORES  
BEFORE AND AFTER VALIDATION THERAPY

difference in scores is zero. Any points above the line represent an improvement in behavior.

Hypothesis 4: Reality orientation results in a positive change (decrease in score) in the dis-oriented person's score on a measure of orientation.

For  $\alpha = 0.05$ , the null hypothesis was not rejected because  $T = 7$  was greater than the critical value of 6. It was concluded that there was insufficient evidence to determine that reality orientation made a significant difference in orientation scores. However, since the  $T$  value was so close to the critical value, there was some evidence of such a trend. Table 7 gives a summary of changes in degree of confusion after reality orientation.

TABLE 7

CHANGES IN DEGREE OF CONFUSION OF SUBJECTS  
BEFORE AND AFTER A PROGRAM OF  
REALITY ORIENTATION (RO)

Subject	Confusion Score Before RO	Confusion Score After RO	Confusion Score Decreased	No Chg.	Confusion Score Increased
K	12	10	2		
L	13	13		X	
M	15	14	1		
N	12	15			3
O	8	4	4		
P	7	6	1		
Q	13	11	2		
R	8	4	4		

Hypothesis 5: Reality orientation changes the dis-oriented person's score on a measure of ego integration.

For  $\alpha = 0.10$ , the null hypothesis was not rejected because  $T = 15.5$  was greater than the critical value of 6. It was concluded that there was insufficient evidence to determine that reality orientation had a positive effect on person's ego integration scores. Table 8 gives a summary of changes in ego integration scores after reality orientation.

TABLE 8  
CHANGES IN EGO INTEGRATION SCORES OF SUBJECTS  
BEFORE AND AFTER A PROGRAM OF  
REALITY ORIENTATION (RO)

Subject	Integration Before RO	Integration After RO	Integration Increased	Integration Decreased
J	9	10	1	
K	10	17	7	
L	16	13		3
M	16	14		2
N	16	19	3	
O	14	15	1	
P	11	7		4
Q	16	11		5

Hypothesis 6: Reality orientation changes the disoriented person's score on a measure of behavioral characteristics.

For  $\alpha = 0.10$ , the null hypothesis was not rejected because  $T = 12$  was greater than the critical value of 6. It was concluded that there was insufficient evidence to

determine a difference in behavioral scores that was attributable to reality orientation. Table 9 gives a summary of changes in behavior characteristics after reality orientation.

TABLE 9  
CHANGES IN BEHAVIOR CHARACTERISTICS OF SUBJECTS  
BEFORE AND AFTER A PROGRAM OF  
REALITY ORIENTATION (RO)

Subject	Behavior Before RO	Behavior After RO	Behavior Improved	No Chg.	Behavior Regressed
K	17	19			2
L	18	19			1
M	19	15	3		
N	21	21		X	
O	11	12	1		
P	18	11	7		
Q	18	19			1
R	19	11	8		

Figure 3 is given to show that for this test of hypothesis, the distribution of points around the line of no difference is more symmetric than in Figure 2, therefore the hypothesis of a change in behavioral characteristics is not supported.

Hypothesis 7: There is a positive change (decrease in score) in the control group member's score on a measure of orientation due to learning curve.

For  $\alpha = 0.05$ , the null hypothesis was not rejected because  $T = 24$  was greater than the critical value of 14.

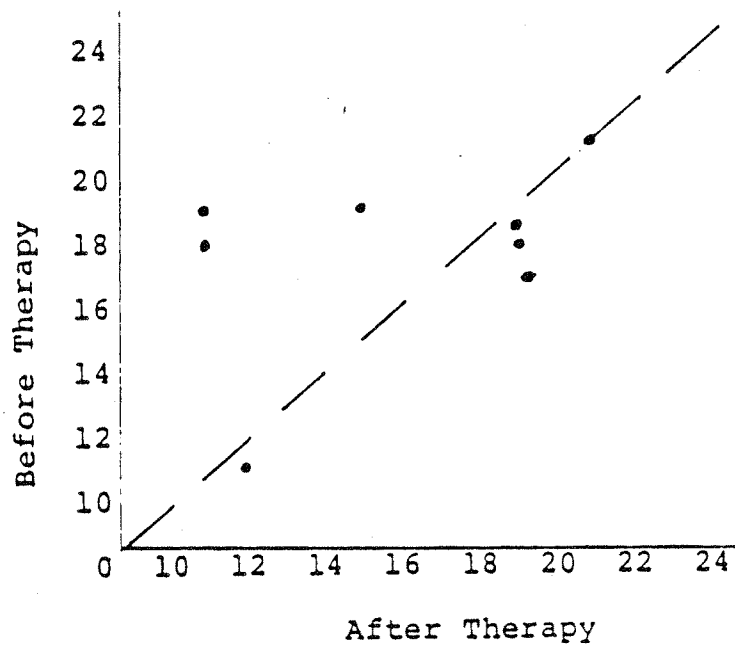


FIGURE 3. SCATTER DIAGRAM: BEHAVIOR SCORES  
BEFORE AND AFTER REALITY ORIENTATION

It was concluded that there was insufficient evidence to assume that a learning curve was operant with the variable and therefore, any significant change that resulted in orientation for the two treatment groups was not due to a learning curve. Table 10 gives a summary of changes in integration scores after the treatment period.

TABLE 10

CHANGES IN DEGREE OF CONFUSION OF CONTROL GROUP  
SUBJECTS BEFORE AND AFTER  
NO PROGRAM OF THERAPY

Subject	Confusion Score Bef. Prog.	Confusion Score Aft. 6 Wks.	Confusion Score Decreased	No Chg.	Confusion Score Increased
S	8	13			5
T	9	13			4
U	8	10			2
V	12	12		X	
W	18	18		X	
X	9	15			6
Y	7	10			3
Z	8	7	1		
AA	10	9	1		
BB	16	10	6		
CC	15	12	3		

Hypothesis 8: There is a positive change (increase in score) in the control group member's score on a measure of ego integration due to learning or recognition.

For  $\alpha = 0.05$ , the null hypothesis was rejected because  $T = 10.5$  was less than the critical value of 14. It was concluded that a learning curve was possible with

use of the Ego Integration Scale. Table 11 gives a summary of changes in ego integration scores after the treatment period.

TABLE 11

CHANGES IN EGO INTEGRATION SCORES OF CONTROL  
GROUP SUBJECTED TO NO THERAPY

Subj.	Integration Bef. Progr.	Integration Aft. 6 Wks.	Integration Increased	No Chg.	Integration Decreased
S	11	15	4		
T	15	18	3		
U	12	16	4		
V	12	12		X	
W	0	0		X	
X	15	14			1
Y	14	18	4		
Z	12	14	2		
AA	12	12		X	
BB	3	16	13		
CC	9	6			3

It was surprising that the change was significant with the control group while it was not with either therapy. This may be explained by the smaller sample size of the treatment groups or by the low power of the test to detect subtle differences. The data on Table 11 show an increase of thirteen points for one subject. This point can be considered an outlier. However, the Wilcoxon Signed Ranks Test considers only the rank of the score, not its magnitude, so the effect of this outlier is lessened. A more important characteristic of the data



is the number of zero differences (3) compared to the size of the control group (11). Because of the nature of the Wilcoxon test, the ranks corresponding to these values must be assigned a sign. If the ranks corresponding to the zeroes are considered positive (as was done originally), the hypothesis of a learning curve is supported. If instead, negative signs are assigned to these ranks, the hypothesis is not strictly supported, though some evidence of such a curve exists.

Hypothesis 9: There is a beneficial change (decrease in score) in the control group member's score on a measure of behavioral characteristics.

For  $\alpha = 0.05$ , the null hypothesis was not rejected because  $T = 17.5$  was greater than the critical value of 14. It was concluded that any significant improvement in behavior shown by either treatment group could be assumed to result from the therapy conditions because an equivalent group subjected to no therapy demonstrated no significant improvement in behavior. Table 12 gives a summary of changes in behavior characteristics after the treatment period.

Hypothesis 10: Higher scores (beneficial effect) on the ego integration scale after therapy are positively correlated to lower scores (beneficial effect) on the orientation scale for both the validation therapy and reality orientation groups.

For  $\alpha = 0.05$ , the null hypothesis was not rejected because  $r_2 = -.0827$  was greater than the critical value of

TABLE 12

CHANGES IN BEHAVIOR CHARACTERISTICS OF CONTROL  
GROUP SUBJECTED TO NO THERAPY

Subject	First Behavior Score	Second Behavior Score	Behavior Improved	No Chg.	Behavior Regressed
S	12	10	2		
T	13	17			4
U	10	18			8
V	25	23	2		
W	28	28		X	
X	23	38			15
Y	11	11		X	
Z	10	10		X	
AA	19	22			3
BB	15	11	4		
CC	22	25			3

-.412. It was concluded that there was insufficient evidence to determine that an improved ego integration score correlated positively with an improved orientation score.

Hypothesis 11: Higher scores (beneficial effect) on the ego integration scale after therapy are positively correlated to lower scores (beneficial effect) on the behavioral assessment tool for both the validation therapy and the reality orientation groups.

For  $\alpha = 0.05$ , the null hypothesis was not rejected because  $r_2 = .266$  was greater than the critical value of -.412. It was concluded that there was insufficient evidence to demonstrate a relationship between improved scores on both variables. For these variables, in fact, the correlation was in the direction opposite that which

was expected. Figures 4 and 5 show the differences in scores and ranks of differences for ego integration and behavior. In addition, Figure 5 can be used to show the sensitivity of the rank correlation coefficient to minor changes in the data. By deleting the two circled points, the correlation actually becomes negative.

Hypothesis 12: Lower scores (beneficial effect) on the orientation scale after therapy will be positively related to lower scores (beneficial effect) on the behavioral assessment tool for both the validation therapy and the reality orientation groups.

For  $\alpha = 0.05$ , the null hypothesis was not rejected because the  $r_2 = .196$  was greater than the critical value of .399. It was concluded that there was insufficient evidence to demonstrate a relationship between improved scores on both variables.

Hypothesis 13: The last hypothesis predicted that validation therapy groups would produce scores significantly different from reality orientation groups in one or more of the three measures. This hypothesis was supported since validation therapy produced significantly lower scores on behavioral assessment tool. No other significant differences were found.

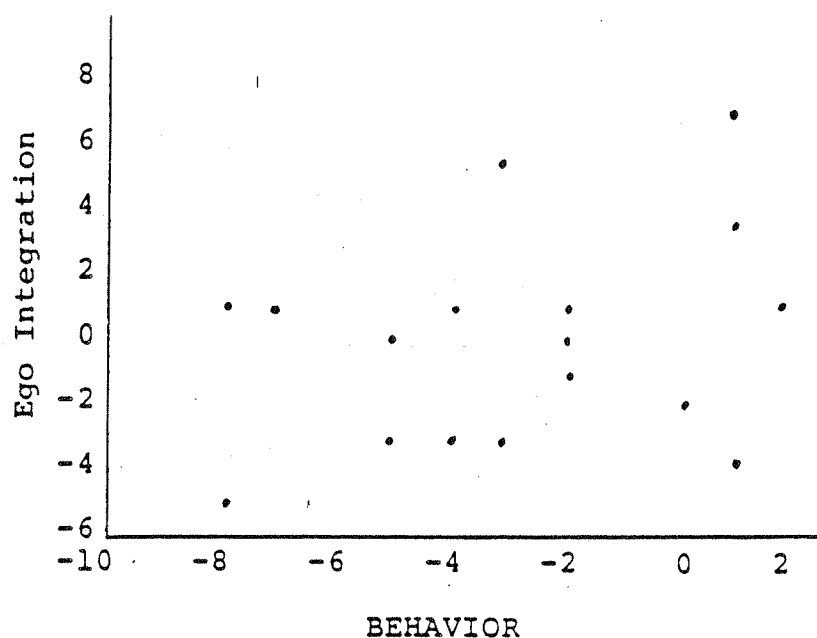


FIGURE 4. DIFFERENCE BETWEEN EGO INTEGRATION AND BEHAVIOR SCORES BEFORE AND AFTER TWO THERAPIES

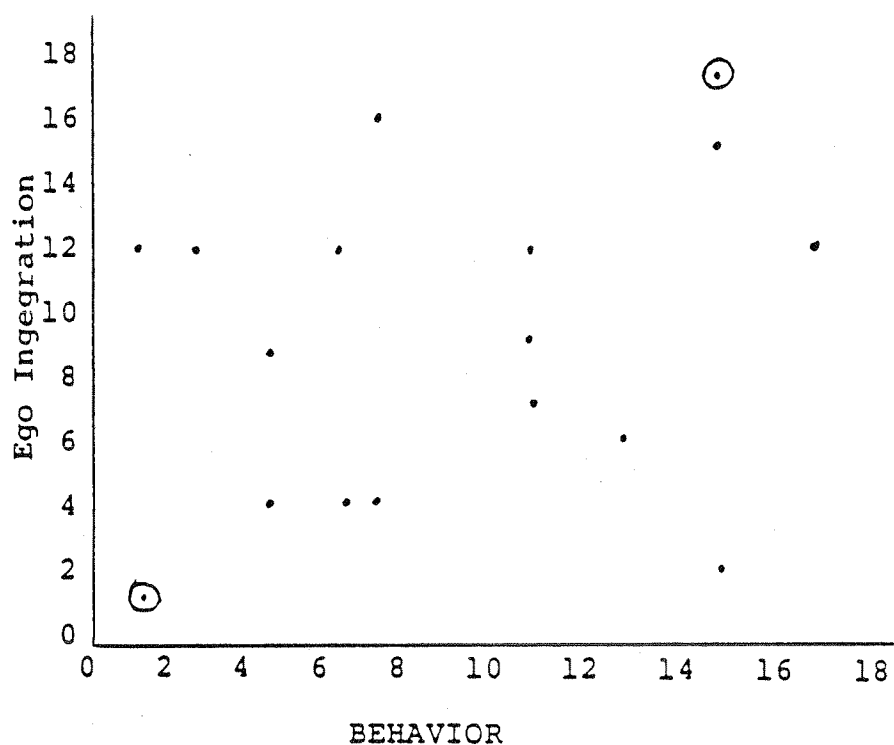


FIGURE 5. RANKS OF DIFFERENCES BETWEEN EGO INTEGRATION AND BEHAVIOR SCORES BEFORE AND AFTER TWO THERAPIES

## Discussion of the Study

### Use of Tools

The tools used in this study to measure the variables included one tool previously developed and used once in a study of confused patients in a nursing home, and two measures developed by the study investigator. In the Tool for Assessment of Confusion in the Elderly (Appendix B) developed by Hogstel, the third question, which asks the name of the doctor was found to be weak. In this study setting, when entering the nursing home, many of the residents were assigned a physician whom they did not know and seldom saw. The question was retained to keep the tool intact, but for the purpose of this study, its effect was eliminated if missing it would have meant the difference between the classification of slightly and moderately confused, and therefore, inclusion of the respondent in the study. Item analysis of the questions most frequently missed revealed the four items most frequently missed before treatment related to time (items 10, 17, 8, 11). This collaborates with Fishback's findings that as mental functioning declines, the first thing to be forgotten is awareness of time, then place, then recognition.<sup>5</sup> Table 13 shows the comparison of missed items before and after therapy and tells whether they refer to time (T), place (PL), or recognition (R) of persons.

TABLE 13

COMPARISON OF ITEMS MISSED ON TOOL FOR  
ASSESSING DEGREE OF CONFUSION  
BEFORE AND AFTER THERAPY

	R	T	R	PL	PL	PL	PL	T	T	T	T	T	T	R	T	R	T	T
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Before	2	21	18	10	12	21	25	27	24	28	27	11	16	14	13	26	28	13
After	1	27	18	11	14	22	28	25	26	29	22	12	11	13	11	27	20	13

N = 29                                      T = Time  
 R = Recognition of persons      PL = Place

The greatest decrease in number missed was in Item 17, a time related question asking what day of the week tomorrow is. The greatest increase in the number missed was in Item 2, which asked for the respondent's age, again a time related question.

The tool to measure ego integrity (Ego Integrity Scale, Appendix C), was found to be subject to a significant learning curve. The range of differences between scores before and after therapy for the validation therapy group was zero to five, for the reality orientation group it was one to seven, while for the control group it was zero to thirteen. However, if the one outlying score was eliminated from the control group, the range would be zero to four, a more expected range. The one person in the

control group whose score improved so vastly, was the only control subject whose scores on all three measures improved. Because of uncontrolled variables, this could be explained by any number of individual reasons, for example, a general improvement in her condition of life, a recent family visit that was agreeable, or the fact that the second day she was tested was a "good day" for her, as opposed to a "bad day" the first time. The results suggested, however, that further testing of the validity and reliability of this tool are needed.

There were difficulties found in using both the above tools in an interview situation. The hearing impairment experienced by many of the subjects presented a barrier. It was not clear if some respondents understood the questions because their replies were unrelated, even after several repetitions of the question. The simple sentences used in the Ego Integration Scale were open to variable interpretations. Many respondents would not tell simply if they agreed or disagreed. It was left to the researcher to judge into which category their response fell. This introduced another confounding variable.

The third measure, the Behavior Assessment Tool, was found to produce scores in the direction expected although they were not all statistically significant. Mean scores for both therapy groups, although they were

not used in statistical tests, showed improvement (validation therapy, 3.7 points, reality orientation, 1.7 points). The control group, subjected to no treatment, showed a 3.1 point decline in behavioral characteristics, a change suggested in the literature, given persons of this age and mental status. Each subject was rated with the Behavior Assessment Tool by the study investigator to reduce the number of extraneous variables that would be introduced if others who were familiar with the subject made the observations. There were also limitations because the researcher made all the observations. First, one observation was made on one occasion of a person who may have characteristically acted differently in other situations. Second, the researcher may have been biased in the posttest observations by knowing the group in which each person belonged. An attempt to correct this latter limitation might have been made by having two independent observers rate the person at the same time using the same tool.

In a behavioral study of this type, strict randomization was impossible to achieve. The requirements for inclusion in the study limited the population from which subjects could be drawn. This limited the study's generalizability in a strict sense, to that population of confused and disoriented persons from which the sample was taken. Although randomized assignment to groups was



attempted, some manipulation was necessary because of the human considerations involved in the nursing home schedules.

#### Validation Therapy Groups

Since the subjects were divided into two groups each of validation therapy and reality orientation, characteristics of each group will be discussed separately. The validation therapy groups will be discussed first. A strong cohesiveness was formed in the first morning group because two of the members became generally aware of the others and of the regularity of meeting. Four of the five members attended every session. All except one recognized the others when they met in the group or elsewhere, whereas they had not done so before therapy. One woman who did not respond to the therapy had been admitted to the nursing home three months prior to therapy. Her daughter had admitted her despite her protest. When she arrived, she was fairly oriented, but soon became hopelessly confused, and denied that the woman who visited her daily was her daughter. According to Feil, this woman was denying her conflicts, replacing them with fantasies that helped her to cope with a situation she was not yet ready to face. The therapy helped her to communicate on some days, while on others, she refused to leave her room. Physically present at the group sessions twenty four of

twenty nine times, she often sat rigidly refusing to take part in the ritual.

The second validation group was less cohesive, but all recognized each other within the group. Three of the five were wheelchair bound; one of these objected loudly to being taken away from her accustomed hall and in the group, often said, "I wanna go home"; another was able to propel herself and sometimes left the group and could not be persuaded to return. The staff noticed the greatest behavior change in two members of this group. Mrs. B., who could propel herself in her wheelchair, displayed much less hostility and obstinacy to the staff. Often she sang while wheeling up and down the halls. As the therapy progressed, she became more socialized, although her level of orientation did not change.

The second member who showed the most benefits was also wheelchair bound. She had customarily sat all day saying nothing, barely responding when approached by anyone. In the group, she became active, talked about her past, interacted with other members, and reached out to touch others. The group therapy was beneficial to her, and she improved on all three variables. However, she also needed the group stimulation to keep her from regressing toward the withdrawal to which she had become accustomed. Another member of this group had become so eager for the meetings that she frequently waited around the

corner of the alcove during the first meeting so she would not miss her time. Her behavior became less confused and belligerent, and she displayed fewer signs of anxiety within the accepting, supportive group atmosphere.

The one member for whom this therapy was apparently ineffective had been diagnosed as psychotic, but had reportedly been "cured." Feil stated that validation therapy is not effective for persons who are psychotic, but this subject was accepted on the basis of the notation above. Although this woman sometimes interacted with the group, at other times she was heard to say, "Who are these people? What am I doing here?" and she removed herself from the group.

Some conclusions can be made on the basis of the validation therapy experience with these ten subjects. First, this humanistic client-centered approach helped some of these moderately to severely disoriented persons to get in touch with their own feelings and self-esteem by validating their own reality. Second, the therapy helped to change the subjects' behavior to more effective functioning. Third, the therapy did not affect the person who was diagnosed as psychotic. Fourth, six weeks of therapy was not enough time to help a person who had chosen denial as a way to deal with an unavoidable conflict to face and resolve conflicts. Finally, the progress that was begun by most members in this therapy

should be continued by validation therapy sessions on a regular basis.

### Reality Orientation Groups

The reality orientation groups had fewer members and more absences than the validation therapy groups. Less emphasis was placed on group interaction because the purpose was to create a classroom type setting in which facts were reviewed. When members talked about events of their past lives, they were helped to see them in relation to their present lives. The Therapy Group Observations Form (Appendix F) was not designed to fit this type of therapy because leadership was not encouraged and physical activities were not a planned part of the therapy, except for writing in some sessions.

In the first reality orientation group, the behaviors exhibited in the early weeks of therapy by all members did not change throughout the six-week period, beyond the daily variability normally experienced. A pattern of change did not emerge which demonstrated any progress. Those who confabulated or interrupted conversation at the beginning of treatment continued to do so until the end. The presence of a man in this group did not affect the three women in any perceptible way. Each member retained a self perceived reality. Although not significant, scores on the orientation measure showed slight improvement.

The second group began with five members, but one chose to stop attending because she did not like the sessions. Two other members attended the minimum of fifteen sessions to be considered part of the group. One of these attended most of the nursing home's activities, and had daughters who visited every day. The other person also had a daughter who visited daily. Although this woman did not attend activities, her bedroom was filled with personal mementos. Both of these subjects scored better after therapy on the ego integration and orientation scales, and either the same or better on behavior. Both scored just barely into the moderately confused range before the therapy sessions. The minimum number of therapy sessions may have been all they needed to improve on the dependent variables.

Of the last two subjects, one's behavior improved but the other did not. The one whose behavior was most improved had the triple disability of poor vision, poor hearing, and slow mobility with the aid of a walker. He enjoyed singing and was encouraged to do so in the group. The social stimulation provided by the group met his needs. His orientation score improved but his ego integration score declined. The other subject liked to play his harmonica and often brought it to the sessions with him. His behavior during the six weeks showed no significant changes. His scores at the end of therapy showed

an increase in orientation but a decline in ego integration and behavioral characteristics.

\*Some conclusions can be made from the reality orientation experience for these eight subjects. First, those who began with a greater degree of orientation improved the most. This agrees with reported findings in the literature. Second, for those with less confusion, reality orientation was not appealing unless the class also satisfied their need for social approval. Finally, for those who were initially severely confused or very near there, reality orientation decreased their orientation scores.

When the overall results of the two therapies are compared, this study confirmed the findings of other studies that have compared reality orientation with another psychosocial therapy: that the other therapy (sheltered workshops and resocialization) produced significant changes in the subjects' scores on a mental status questionnaire and a life satisfaction index, while reality orientation failed to do so. Validation therapy produced significant improvement in behavior but not in orientation or ego integration, whereas reality orientation produced no significant differences in any of the three measures. Validation therapy also produced more qualitative changes in group members than did reality orientation. Seven of the ten members in validation therapy expressed a desire

to continue sessions, whereas only two of the eight reality orientation members expressed a desire to continue. This study concurs with conclusions in other studies that reality orientation may be most useful in preventing a person's withdrawal into a confused mental state represented in Feil's stages two, three, and four of disorientation. It is most successful with persons who are less confused, in stage one. Validation therapy was most helpful to those who exhibited stage two behaviors to draw them back to more functional behaviors. Finally, there was evidence that validation therapy gave the staff a model for an alternative method of communicating with the residents. Staff members were observed using some of the behaviors they had seen demonstrated; e. g. genuinely touching, using eye contact, listening, and validating what was expressed. Many of the staff commented on the progress being made by selected validation therapy members.

#### Limitations of the Study

This study compared the effects of two different kinds of therapy on levels of orientation to reality, ego integration, and behavior change of institutionalized persons who were moderately or severely confused. Some of the limitations of this study are:

1. The small size of the initial sample did not allow sufficiently for subjects who did not complete the study. A larger sample of twelve in each group may have yielded final samples of more comparable sizes than resulted in this study.

2. The small sample size also limited the power of any tests of hypotheses. Power is defined as the probability of rejecting the null hypothesis when in fact it is false.

3. The length of time of the study may not have been sufficient to yield benefits.

4. No attempt was made to control for the effect of the therapists' personalities to determine whether the results would have differed significantly had the therapists reversed therapy methods. Thus effects of the therapist and therapy are confounded.

5. Conditions for the ideal statistical test of analysis of variance for this research design were not met because the data associated with each therapy could not be assumed to come from a normally distributed population. Conclusions have been made that were based instead on comparisons of individual scores using non-parametric procedures.

6. The population from which the sample was drawn for this study consisted solely of persons within one nursing home in a midwestern metropolitan area. The



conclusions of the study therefore apply only to that population, and any generalizations beyond that population should be made with caution.

7. The evaluations were done by the therapist who knew in which group an individual belonged. This knowledge could have influenced the results.

### Recommendations

Several recommendations for further research can be identified from the findings of this study. First, it is suggested that the Ego Integration Scale and the Behavior Assessment Tool be further tested for validity and reliability. The finding of a significant increase in score for the control group but not for the treatment groups casts some doubt on the ability of the Ego Integration Scale to test for ego integration. Second, the study should be replicated using an original sample of at least 36 subjects to allow for subjects who may not complete the study. For purposes of comparison, group sizes should be more equal than was attained in this study. Third, validation therapy should be studied over a longer period of time because, as Feil observed, change in confused behavior is slow. However, if validated over a long time, people become more aware of external reality and more accepting of their lives.<sup>6</sup> Fourth, the variable of ego integrity should be further researched. The behaviors and

attitudes of the persons who have integrated their lives in the last stage according to Erikson need further clarification. Finally, further research needs to be done on the causes and treatment of reversible functional confusion in elderly persons.

#### Implications for Nursing

This study has implications for nursing practice because nurses interrelate with confused elderly in home care, acute care, and extended care settings. While it has been accepted that functional confusion is reversible if the causes are treated, the nurse needs a therapy to use until the cause is treated, or when causes cannot be addressed. Reality orientation has been the method of treatment most advocated in the literature for reversing confusion in the elderly. However, repeated studies have found, as this one has, that reality orientation may not be the treatment of choice for use with moderately and severely confused elderly. Validation therapy has been shown in this study to produce qualitative and quantitative changes in the behavior of moderately and severely confused old persons. There was some indication that reality orientation does increase the orientation of those who are less confused, who have not regressed into the withdrawal of the later stages of disorientation.

For nurses, the strongest suggestion of this study is that an assessment of mental function in the older person should be made, then a choice of alternative therapies should be explored. Confirming the findings of previous studies, this study suggests that reality orientation may be useful in early disorientation to halt progress into further withdrawal from reality. However, validation therapy presents a well formulated, effective alternative for use with those who have already withdrawn into their own world of fantasy, who find facing commonly accepted reality threatening and undesirable. The humanistic philosophical basis of this therapy corresponds with Watson's concept of caring that is the basis of nursing.<sup>7</sup> In validation therapy the nurse is able to use empathy to validate the message being sent by the confused old person and to confirm the value of his uniqueness. This study has shown that validation therapy is an acceptable option for use with the confused elderly to express the caring essence of nursing in assisting the person to resolve life's conflicts in the last stage of living.

Finally, for persons who enter a nursing home with physical disabilities, the best way to counteract disorientation is to prevent it. A program of reality orientation instituted and continued on a routine basis has been proved effective in halting withdrawal from reality into progressive stages of disorientation.

Chapter Notes

<sup>1</sup>Irene Burnside, "Acute and Chronic Brain Syndromes," in Nursing and the Aged, ed. Irene Burnside (New York: McGraw-Hill, 1976), p. 155.

<sup>2</sup>Subject's chart.

<sup>3</sup>William L. Hays, Statistics for the Social Sciences, 2nd ed (New York: Holt, Rinehart and Winston, Inc., 1973), p. 780.

<sup>4</sup>Robert Johnson, Elementary Statistics, 3rd ed (North Scituate, Mass.: Duxbury Press, 1980), p. 509.

<sup>5</sup>D. B. Fishback, "Mental Status Questionnaire for Organic Brain Syndrome, with a New Visual Counting Test," Journal of American Geriatric Society 25 (1977): 170.

<sup>6</sup>Naomi Feil, Validation/Fantasy Therapy: New Manual Tells How to Help Disoriented Old-Old (Cleveland, Ohio: Edward Feil Production, Inc., 1981), p. 9.

<sup>7</sup>Jean Watson, Nursing: The Philosophy and Science of Caring (Boston: Little, Brown and Co., 1979), p. 10.

## CHAPTER IV

### SUMMARY

This study compared the effects of two different psychosocial therapies used with institutionalized confused elderly on the three variables of orientation for reality, ego integration, and behavioral characteristics. Validation therapy from a humanistic client-centered theoretical framework was compared with reality orientation, which has a behavior modification theoretical framework. Thirteen hypotheses were developed from the literature to test which, if either, therapy was most suited to produce changes in subjects' scores on measures of the three independent variables after a six-week course of therapy.

To test these hypotheses, an experimental design was used in which subjects who met the study requirements were randomly assigned to one of three groups: validation therapy, reality orientation, or control group. All subjects were tested both before and after treatment with either or none of the therapies, on each of the three variables listed above. Tools used to gather data included the Tool for Assessing Degree of Confusion in the Elderly developed by Hogstel. The following three tools

were researcher developed: (1) the Ego Integration Scale, (2) the Behavior Assessment Tool, and (3) the Demographic Information questionnaire.

The treatment groups, divided into two groups each of validation therapy and reality orientation, met every weekday for thirty minutes a day for a duration of six weeks. Validation therapy groups were led by the researcher and followed the guidelines developed by Feil. Reality orientation groups were led by a graduate nursing student, and followed the guidelines published in the Guide for Reality Orientation. The control group experienced the same conditions as those in the treatment groups except for treatment. They were simply tested before and after on the same measure used with the treatment groups.

The study was conducted in a 225-bed nursing home in a midwestern metropolitan area, where enough subjects to meet the criteria could be found. To be included, subjects had to be eighty or more years of age, rate as moderately to severely confused on the Tool for Assessing Degree of Confusion with Elderly, be physically able to participate in a group, and give informed consent to do so. The final sample consisted of twenty-nine subjects: eleven in the control group, ten in validation therapy, and eight in reality orientation which had lost two subjects during the study time.

Statistical tests used to test the hypotheses included the Wilcoxon Signed Ranks Test and the Spearman Rank Correlation Coefficient, two non-parametric tests judged to be the most appropriate to use with small sample sizes. The ideal statistical test of analysis of variance could not be used because the small sample sizes could not be assumed to come from a normally distributed population. Only two of the thirteen hypotheses were supported with significant statistical results. First, validation therapy was found to significantly improve group members' scores on the Behavior Assessment Tool. Second, the Ego Integration Tool was found to be subject to a learning curve, as the control group's scores improved significantly. There was no significant improvement found on this measure for either of the therapy groups.

Behavior of group members recorded each day of the therapies on the Therapy Group Observation Form, showed qualitative improvements in behavior for seven of the ten subjects in validation therapy, and for three of the eight subjects in reality orientation. Attendance at validation therapy groups was better than reality orientation, with a range of zero to six sessions missed. The reality orientation attendance showed that one to fourteen sessions were missed. Two subjects in the reality orientation who attended only fifteen sessions (the minimum number for

inclusion in the study) showed improvement on two and three measures respectively.

Several conclusions were made from analysis of statistical and descriptive data. Validation therapy produced significant improvement in behavior but not in orientation or ego integration, whereas reality orientation produced no significant differences in any of the three measures. Validation therapy also produced more qualitative changes in group members' behavior than did reality orientation. This study concurs with conclusions from other studies that reality orientation may be most useful in preventing a person's withdrawal into more confused mental states. The most improvement in the three variables made by reality orientation subjects was made by those who were less confused before therapy.

Recommendations for further study include (1) testing the Ego Integration Scale and the Behavior Assessment Tool for validity and reliability, (2) replication of this study using a larger sample, (3) testing validation therapy over a longer period of time, (4) further research of the variable of ego integrity to delineate behaviors and attitudes characteristic of ego integrated persons, and (5) further research on the causes and treatment of reversible functional confusion in the elderly.



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## APPENDICES

APPENDIX A  
INFORMED CONSENT

Subject's Name \_\_\_\_\_ Date \_\_\_\_\_

Project Title Comparative Study of Reality Orientation  
and Validation

Description and Explanation of Procedure: You will be asked some questions relating to yourself and the world around you, plus some questions about your attitudes toward life. After this, you may be asked to take part in a group meeting every weekday for six weeks, or you may simply be asked to answer some questions again after the six weeks is up, without taking part in the group meetings.

Risks and Discomforts: Moving from your room to the meeting room if you are assigned to a group, may be a source of discomfort. You will be accompanied by a staff person, so risk will be minimal.

Potential Benefits: Increased understanding of how these therapy groups help people who relate to reality at different levels. If you are a group member, you will benefit from belonging to a group which meets regularly.

CONSENT:

I have fully explained to \_\_\_\_\_  
subject/relative/guardian (circle one)

the purpose of the above-described procedure and the risks that are involved in its performance. I have answered and will answer all questions to the best of my ability.

\_\_\_\_\_  
Investigator's signature

I have been fully informed of the above-described procedure with its possible benefits and risks. I give permission for my/my relative's (circle one) participation in this study. I know that Mrs. Marlene Peoples (investigator) or her associate will be available to answer any questions I may have. If, at any time, I feel my questions have not been adequately answered, I may request to speak with either the Head of the College of Nursing or the Committee for the Protection of Humans in the Area of Research (Robert G. Corbett, Chairman,

## APPENDIX A (continued)

375-7666). I understand that I am free to withdraw this consent and discontinue participation in this project at any time without prejudice. I have been informed that there is no compensation available for any physical injury as a result of my participation in this project. I have received a copy of this form.

\_\_\_\_\_  
Signature of subject/relative/guardian  
(circle one)

\_\_\_\_\_  
Witness to signature

# APPENDIX B

## TOOL FOR ASSESSING DEGREE OF CONFUSION IN THE ELDERLY

Patient no. \_\_\_\_\_ Room # \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_ Age \_\_\_\_\_ Physician \_\_\_\_\_

Length of interview \_\_\_\_\_ Lying \_\_\_\_\_ Sitting \_\_\_\_\_ Location \_\_\_\_\_

Total Negative Score \_\_\_\_\_ Circle Therapy Code:

Category of Confusion \_\_\_\_\_ BRO ARO BVT AVT

1-6 A Slightly Confused CBT CAT NONE

7-12 B Moderately Confused

13-18 C Severly Confused

CHECK ( ) APPROPRIATE COLUMN

POSITIVE NEGATIVE  
(Not Confused) or (Confused)

1. What is your name? a. must give last name b. last name only sufficient		
2. In what year were you born? OR How old are you now?		
3. What is the name of your doctor? a. last name sufficient b. must be name of doctor listed on medical chart		

## APPENDIX B--Continued

4. What state are you living in now?  What state is this?		
5. In what city are you living or staying now? OR What is the name of this city?		
6. What do you call this place or building where you are staying now?  a. nursing home <u>or</u> name of nursing home <u>or</u>  b. convalescent home/center <u>or</u>  c. rest home		
7. What is the name of the street where this building is located?		
8. What year is this?		
9. What month is this?		
10. What day of the month is it today?		
11. What day of the week is it today?		
12. How many days are there in a week?		

APPENDIX B--Continued

<p>13. What part of the day is it now?</p> <p>a. 8-12 noon--morning</p> <p>b. 12-6 p.m.--afternoon or evening</p>		
<p>14. What is the weather outside like today?</p> <p>a. hot/warm      f. pretty beautiful/sunny</p> <p>b. cool/cold      g. nice/dry</p> <p>c. fair/clear      h. bad/dreary/stormy</p> <p>d. raining/snowing</p> <p>e. cloudy</p>		
<p>15. What was the last meal you had to eat?</p> <p>a. breakfast <u>or</u> morning</p> <p>b. lunch <u>or</u> dinner <u>or</u> noon</p> <p>c. dinner <u>or</u> supper <u>or</u> evening</p>		
<p>16. Who is the President of the United States now?</p> <p>a. first <u>or</u> last <u>or</u> both names</p>		
<p>17. What day of the week will it be tomorrow?</p>		

## APPENDIX B (continued)

18. What will be your next meal to eat?	
a. breakfast <u>or</u> morning	
b. lunch <u>or</u> dinner <u>or</u> noon	
c. dinner <u>or</u> supper <u>or</u> evening	
TOTAL SCORES	

SOURCE: Mildred Hogstel, R.N., Ph.D. Reprinted with permission from the author, copyright 1981.

Additional comments: (Summary comments, exact quotes of patient, or other observations that would help to clarify the degree of confusion. State whether at beginning, during, or end of interview.)

# APPENDIX C

## EGO INTEGRATION SCALE

Patient Number \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Circle Therapy Code: BRO ARO BVT AVT CBT CAT

Total Score \_\_\_\_\_

	Agree	?	Disagree
1. My life has been good	2	1	0
2. I worry about getting old	0	1	2
3. I am willing to take responsibility for my decisions	2	1	0
4. I most often feel worthless	0	1	2
5. I would not change my life if I lived it over	2	1	0
6. I feel discontented with my life	0	1	2
7. I feel in general that I have reached my goals	2	1	0
8. I think life is too short	0	1	2
9. I accept myself the way I am	2	1	0
10. I often think about my failures	0	1	2



## APPENDIX D

 BEHAVIOR ASSESSMENT TOOL  
 BASED ON FEIL'S STAGES OF DISORIENTATION

Directions: Circle number of  
 behavior in each category which  
 is most characteristic

Patient Number _____	Therapy Code: _____	BRO	ARO	BVT	AVT	CRT	CAT	Total Score _____	
Behavior being assessed	First Stage	Second Stage	Third Stage	Fourth Stage					
1. Control of body functions	Can dress, toilet, and control the self most of the time.  1	Incontinent due to lack of assistance. Cannot control bowel and/or bladder over long periods. Aware of incontinence.  2	Bowel and/or bladder incontinence persistent. Resigned to it or unaware of it.  3	No effort made toward control or awareness of incontinence.  4					
2. Relation to reality	Holds onto present reality. Is aware of self and aware of confusion. Is threatened by confusion of self and others.  1	Forgets facts, names and places from the present immediately. Continues to withdraw inward, creates his own rules.  2	Shuts out stimuli from outside world.  3	Will not recognize staff or family who visit daily.  4					
3. Muscle control	Muscles tight. Stance rigid. Holds himself together to keep in control as defense  1	Sits upright in chair with muscles relaxed. Neck muscles and lips loose.  2	Body slumped. Head bent forward in chair.  3	Completely loose. Little voluntary movement.  4					

4. Appearance of eyes	Eyes are clear and bright. Respond to interpersonal eye contact. Directly focuses on person to whom speaking.	1	Eyes are clear but often unfocused or downcast. Eye contact triggers recognition. Not dependent on recognition of outside environment. Eye contact not necessary.	2	Eyes are most often closed unless stimulated.	Eyes are closed. Face lacks expression.
5. Voice tone	Speaks in harsh, accusatory or whining voice.	1	Voice is low, seldom harsh or whining. Often off-key or distorted when singing or laughing.	2	3	4
6. Body movements	Movements in space are quick and direct, related to events in environment.	1	Movements in space are slow, sustained, indirect or questioning. Dances with rhythm.	2	3	4
7. Response to communication	Seeks reminders of present time and place. May respond with some sense of humor. Responds positively to recognized authority. Responds negatively to behavior or physical disability of less-oriented persons.	1	Responds to nurturing touch or voice tone. When supported in trusting, respectful way may relate in present time with speech. Smiles when greeted. Can initiate communication.	2	3	4

8. Relation to own feelings	Denies feelings by strictly adhering to rules. Usually carries a cane, blanket, purse, or sweater to ward off loneliness.	Expresses feelings through movements and symbols. Is sensitive to voice tones, and feelings from present and past. Can respond positively to sexual feelings. Can substitute memories of feelings from past in present situations.	Expresses longings to return to early childhood sensory experiences by repeating body movements and sounds. Openly acts out sexual feelings without regard for propriety.	Self-stimulation is minimal. Makes no effort to express feelings.
	1	2	3	4
9. Relation to time	Keeps track of present clock time. Desires to adhere to schedule. Confabulates when doesn't know time.	Loses track of clock time. Interprets present time as past time without awareness of doing so.	Never moves in commonly accepted time. Has lost ability to relate to present time. Remembers and relates to early life and events. Always moves in personal time in increments of personal life.	Shuts out all relation to present time. No longer talks to even people from past life.
	1	2	3	4
10. Ability to read and write.	Can read (unless blind) and write well.	Able to read but is losing ability to write legibly.	Does not read or write since no longer motivated to communicate.	Shuts off outside world. Cannot be motivated to try to read or write.
	1	2	3	4
Total of circled scores				

Key: Stage One 10-15

Stage Two 16-25

Stage Three 26-35

Stage Four 36-40

APPENDIX E

DEMOGRAPHIC INFORMATION

Date: \_\_\_\_\_

1. Patient Number \_\_\_\_\_ Therapy Code: RO VT C
2. Sex \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_
3. Length of stay in previous institution \_\_\_\_\_
4. Primary medical diagnosis (List first two): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Daily medications and doses: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Physical impairment: (hearing, sight, immobility, etc.)  
\_\_\_\_\_  
\_\_\_\_\_
7. Ever been diagnosed as having mental illness? If yes, give diagnosis, how long institutionalized, when and if resolved.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. When last able to care for self in own home: \_\_\_\_\_  
\_\_\_\_\_
9. When last away from the nursing home other than for being hospitalized, and for what purpose:  
\_\_\_\_\_  
\_\_\_\_\_
10. How frequently visitors come specifically to visit this person, and who comes (e.g., family, friends) \_\_\_\_\_  
\_\_\_\_\_
11. Highest level of education attained \_\_\_\_\_
12. Efforts made by the staff to stimulate environment \_\_\_\_\_  
\_\_\_\_\_
13. How frequently this person participates in planned group activity \_\_\_\_\_

# APPENDIX F

## THERAPY GROUP OBSERVATION REPORTING FORM

Week _____		Group _____				
Key 0 - Never		1 - Rarely	2 - Occasionally	3 - Frequently	4 - Always	
Name	Talks In Group	Makes Eye Contact	Touches	Smiles	Shows Leadership	Physically Participates
M						
T						
W						
Th						
F						
M						
T						
W						
Th						
F						

M	T	W	Th	F	M	T	W	Th	F	M	T	W	Th	F
---	---	---	----	---	---	---	---	----	---	---	---	---	----	---

## APPENDIX G

### EXPLANATION OF STUDY TO FAMILIES OF RESEARCH SUBJECTS

My name is Marlene Peoples. I am a registered nurse enrolled in Family Health Nursing at The University of Akron. Your family member at Valley View Nursing Home (or you for that person) has agreed to participate in a research project I am conducting. The purpose of this research is to compare the effects of reality orientation therapy and validation therapy on three measures with disoriented patients over 80 years of age.

The research tools measure degrees of orientation, ego integration, and behavioral change. The study is designed to detect changes in any of these three measures, which may be assumed to result from the therapies. To determine that the changes are more likely to result from the therapy than from a learning curve, a control group not given the therapy will also be tested on the three measures before and after the course of therapy.

To explain the therapy in which your family member is participating, I have scheduled a meeting at Valley View Nursing Home. The aim of this session will be to help you understand what the therapy is, its purpose, and how you can continue the therapy in your visits with your family member. I will also answer any questions you have about any facet of this project. The time and place of your meeting will be (different for each therapy group).

You can contact me at 678-3359 if you have any questions during the course of this research project.

## APPENDIX H

### STAGES TWO AND THREE OF DISORIENTATION

Too many physical and social losses create the straw that breaks the camel's back. The person in Stage One suffers too many small deaths. They can no longer deny the losses. They can no longer hang onto reality. They give up trying to hold on. They enter Stage Two. They retreat inward. They lose track of present time. They lose adult controls. They lose stimulation from others. They lose communication skills. They lose social skills. They no longer conform to dress codes or social rules. They create their own inner reality. Fantasy begins. Early memories substitute for present reality.

#### Emotional Characteristics

Increasing damage to rational thinking, eyesight, and hearing blurs reality.

Expresses feelings. Does not remember facts.

Loses metaphoric thinking. Does not put people or objects in accepted categories. Cannot compare. A hand that feels like a baby, becomes a baby. A piece of chalk becomes candy. A cane becomes a man.

Remembers sensory, pleasurable feelings from childhood.

Forgets recent events. Excellent recall for past events that hold strong feelings.

Energy focus is to resolve past unfinished conflicts; to trigger feelings of usefulness and pleasure.

Uses unique word forms from past early memories. Example:  
"This company is Symofile." Mrs. G. points to the red curtains.



The curtains in Feil's group remind Mrs. G. of the curtains in the office where she worked all her life as a file clerk in a company. She combined similar with Feil with file to create Symofile.

Loses awareness of self and others. Damage to sensory cells increase. Expects others to understand the unique language.

Loses sense of humor.

Cannot play games with rules.

Tells time by personal feelings, not by clock time. Measures time by life-time experiences. Example: A person is hungry for love. Love = food. They demand food right after lunch.

Uses pronouns without specific references. "He" can refer to: God, father, devil, self-identity, the world, authority, male-nes, etc.

Body movements, melodies, rhythms, substitute for words.

Increasing use of symbols to represent people and events remembered from the past.

Shows wisdom. Knows who is genuine and who pretends.

Responds to nurturing touch and eye-contact with decreased stress.

Loses ability to sing on key. Voice often off-pitch.

Retains ability to read. Loses ability to write.

Thinks in vivid (eidetic) images; little energy for reasoning.

Hears sounds clearly from the far-past, especially when deaf.

Forgets names, dates, faces from the present immediately.

Loses adult controls. Often demands immediate satisfaction of instincts: sex, love, food.

Responds to the genuine-loving relationship with increased speech, thinking, and feelings of well being.

### Physical Characteristics

Muscles are loose.

Eyes clear, but often unfocused, gazing into the distance.

Breath slow, sustained.

Movement in space slow, indirect, often questioning:  
Which way?

Speech slow.

Hand gestures match feelings. Often questioning.

Voice-tone low, even. Seldom whiny or harsh.

Shoulders tend to slump forward, neck down, person often  
shuffles when moving in space.

Typical Feelings: Universal Feelings. In time confusion, the disoriented old-old person returns to Universal Feelings that all humans share: love, hate, fear of separation, struggle for identity.

Awareness of painful reality causes further retreat inward into past-time. Drugs and restraints often increase withdrawal. Validation through confirmation and sharing feelings in a nurturing relationship often keeps Stage Two from withdrawing to Stage Three. Validation gives the person in time confusion moments of rational thinking, relieves stress, and the need to return to past-time.

### Stage Three: Repetitive Motion

Human beings in Stage Two who cannot resolve their feelings by sharing them with another human being who validates them, often retreat to basic pre-language movements and sounds to nurture themselves. They no longer use words. They give up communicating. They return to the womb. They move to resolve the past all alone by using their body parts to represent people from the past.

### Emotional Characteristics

Need for speech is lost with disuse.

Constant movements keep people alive; give pleasure; control anxiety; relieve boredom; reassure existence.

Ability and desire to think is lost.

Repetitive sounds stimulate, reassure, and help resolve feelings (example: moans, makes "oooo" sounds, clucking sounds, purses lips for sucking sounds).

Can feed the self in validation group.

Has lost more sensory abilities (seeing, hearing) and ability to walk well.

Increasing loss of sense of self-awareness and body in space.

Shuts out outside stimuli

Has energy for dancing and singing.

Little energy for talking or thinking.

Short attention span. Cannot focus on more than one person or object at a time.

Does not respond unless stimulated through a combination of: close contact; nurturing touch, voice-tone, and eye-contact.

Resigned to isolation and self-stimulation.

Energy focus is to resolve unfinished conflicts.

Remembers early experiences.

Paces the floor, looking for yesterday.

Can restore some speech, some rational thinking and interacts with others but only in a loving, validating, genuine relationship.

Cannot play games with rules. Cannot wait. Wants immediate satisfaction of needs.

Has lost sense of humor.

Cannot read or write a sentence.

Physical Characteristics. Feelings and body-movement become intertwined in repetitive movements. Body-movements identify this stage of disorientation where movements replace words. A person who feels emotionally hungry eats chalk to relieve the love-pangs. A person who feels angry at parents, pounds until their anger lessens. The therapist often matches movements in order to relate to the person in repetitive motion since words are lost.

Sways or dances.

Sings but cannot talk in sentences.

Moves gracefully, with muscles loose, but is unaware of movements.

Is incontinent.

Eyes often closed, unfocused.

Cries often.

Fingers and hands pound, beat, tap, button, unbutton.

Anguished pacing.

Repeats one sound over and over.

Breathing shallow but steady, rhythmic, even.

Voice low, melodic, often on key.

Has moments of super-strength when grasping.

Ambidextrous when freeing self of restraints.

To prevent movement to the final stage of disorientation, vegetation, the therapist must use empathy, nurturing and touch to validate the person in Stage Three.

#### Typical Feeling Area

Personal Shame Feelings. Shame, guilt, sexual, feelings, repressed rage at parents who originally implanted "bad" feelings for "bad: behavior lie buried throughout life. These feelings lie hidden, safely controlled. We use our energy for self-control and are motivated to conform to parental rules. IN disoriented old-old age, the "bottom drops out." Each person held different concepts of "bad" behavior.

One disoriented old-old man in Stage Three drops his pants in anger against his wife. He wants to prove that he is virile and potent; to express rage at parent figures or gratify sexual needs that he repressed as an adolescent.

Feelings, stopped-up for a lifetime, overflow. Anger at rigid rules; shame in failure for having "messed-up" during the toilet-training years; guilt in not performing at the right time in the right place for the right person, gets expressed in old-old age in order to finally get resolved. In Stage Three, disoriented old-

old who have not been validated in Stage Two use their body to act out unfinished feelings. They want peace. They move in agitated motion before they cross the finish-line.

---

Source: Feil, Naomi: Validation-Fantasy Therapy: New Manual Tells How to Help Disoriented Old-Old. Cleveland, Ohio: Edward Feil Productions, 1981, pp. 24-30.

## APPENDIX I

### DEMONSTRATION OF VALIDATION THERAPY WITH A GROUP

The therapist greets each person in a circle.

Chairman: "WELCOME TO THE TUESDAY GROUP. NOW  
SHAPE UP! NO MONKEY BUSINESS TODAY."

Song Leader: "DAISY, DAISY...I'M ALL CRAZY."

Mr. T.: "THAT'S RIGHT, LADY. YOU ARE CRAZY."

Mrs. G.: "I HAVE TO GO HOME. WHERE ARE MY  
RUBBERS. WHERE IS MY PURSE.  
H E L P ! ! !" (she screams off-key).

MR. T.: "YOU'RE CRAZY TOO, LADY. YOU'RE ALL  
CRAZY!"

Therapist (Worker strokes Mrs. G., comforting her.)  
"I GUESS WE CAN'T SING TOGETHER  
BECAUSE MR. T. FEELS EVERYONE IS CRAZY."  
(Summarizing feelings) "WHAT MAKES A PER-  
SON CRAZY?" (Exploring, using "What?")

Mrs. G.: "HAVING NOTHING TO DO. GET ME MY  
RUBBERS. I HAVE TO GO TO WORK. THE  
COMPANY WILL PAY THE FARE."

Therapist: "YOU MISS THE COMPANY, DON'T YOU,  
MRS. G? WAS IT A BIG COMPANY?" (Explor-  
ing to travel to the past when Mrs. G.  
felt useful).

Mrs. G.: "MIDDLE SIZE. A FENDALL COMPANY. LIKE  
THE SIMOFIL CURTAINS." (She points to  
the curtains).

Therapist: "HOW DO YOU MEAN? SIMO-FILE?" (Stage Two  
combines word-sounds that have emotion-  
ally loaded meanings).

Mrs. G.: "I FILE EVERYTHING IN THE COMPANY."  
(She pats her purse and stuffs napkins in each compartment).

Therapist: (Patting the purse with Mrs. G.) "YOU ARE ACTING LIKE A VERY EFFICIENT FILE CLERK."

Mr. T.: "SHE'S CRAZY. THAT'S WHAT SHE IS."

Therapist: (Filing with Mrs. G. to mirror genuinely. The movement triggers memories of usefulness for Mrs. G.) "MR. T., MRS. G., WAS A FILE-CLERK. IS IT CRAZY TO WANT TO DO THE JOB YOU DID ALL YOUR LIFE?"

Mrs. G.: "I AM A FILER, LIKE FEIL HERE." (Worker's name "Feil" is pronounced like "File.")

Therapist: "YOU MEAN THE FILES IN YOUR COMPANY ARE SIMILAR TO FILING HERE IN THIS COMPANY? IN MY FEIL COMPANY?" (The worker helps Mrs. G. make sense to others.)

Mrs. G.: "THAT'S RIGHT. SIMO-FILE. FEIL. FILE. FILE."

Therapist: "AND MY NAME IS FEIL. FILE. FEIL. YOU COMBINED THE WORDS."

Mrs. G.: (Smiles and nods gratefully). She is validated.  
(The group understands the meaning behind her behavior. Mrs. G. combines sounds that give pleasure.)

Therapist: "THAT SOUNDS NICE--SYMO-FILE, AND FENDALL." WHAT IS FENDALL?" (Repeating to confirm and validate Mrs. G.)

Mrs. G.: "MEMORABLE FRIENDS FROM THE PAST. THE COMPANY." (Once validated, Mrs. G. is able to speak more fluently).

Mr. T.: I'LL HECK HER WITH MY PECKER. PECKER. PECKER. PECKER. WANTA SEE THE HECK-PECKER, LADY?" (He unzips his pants.)

Therapist: "MR. T., YOU ARE UNZIPPING YOUR PANTS. DO YOU WANT TO SHOW US THAT YOU ARE STILL A MAN WITH A MAN'S FEELINGS. DO YOU MISS YOUR WIFE?" (Confronting sexual feelings openly.)

Mr. T.: "YOU BET YOUR ASS." (He stops unzipping his pants, meeting the worker's eyes.)

Therapist: "I RESPECT YOU AS A MAN. I THINK WE ALL DO. IS THAT RIGHT, MRS. G.? MISS J.? DO YOU RESPECT MR. T. AS A MAN?"

Note: To get a response, the worker must address a specific question to a specific person. Stage Two and Three do not respond to general questions like: "WHAT DOES THE GROUP THINK?" When in doubt, the worker can always trust the group to solve a problem. If the worker despairs, certain people in the group will help. The worker must ask specific individuals for help, telling the group the problem.

Miss J.: "HARRY. HARRY. HARRY. I MISS HARRY."

Therapist: "WAS HARRY YOUR LOVER, MISS J.?"

Mr. T.: "HARRY'S HONEST AS THE DAY IS LONG. HIS PECKER IS LONG. IN DETROIT MICHIGAN.. HONEST AS HIS PECKER. MY WIFE IS A BITCH, LADY."

Therapist: "MR. T., DID YOUR WIFE MAKE YOU ANGRY. WHAT DID SHE DO?" (Helping Mr. T. resolve unfinished angry feelings against his wife, who hen-pecked him all his life. His rage now lashes out in old-old age, and is directed against all women.)

Mrs. T.: "SHE IS A WOODEN DOLL. A DOLL OF WOOD. SHE MAKES COFFINS. I DIED LAST YEAR A THOUSAND DEATHS."

Therapist: (Summarizing feelings to link common feelings.) "MR. T., YOU ARE ANGRY AT YOUR WIFE AND MISS HER, TOO. MISS J., YOU MISS HARRY, WHOM YOU LOVED."



Therapist: (Helping the group find a solution to the problem.) "MRS. G., YOU MISS THE COMPANY WHICH YOU LOVE. AND THE COMPANIONS IN THE COMPANY. WHAT CAN WE DO TO HELP EACH OTHER FEEL BETTER HERE, IN THIS GROUP, WITH EACH OTHER?"

Miss. J.: (She is the emotional, nurturing leader.) "WE CAN HELP EACH OTHER."

Therapist: CAN WE GET CLOSER BY HOLDING HANDS AND SINGING AND MOVING TOGETHER?" (Problem solving.)

Each individual expresses his feeling. The group moves to the Ending Ritual. The therapist helps the group select a topic to solve the problem of finding a loved one. The worker emphasizes the good feeling of being together.

POSITIVE "We all feel close. Let's sing our  
POLARITY: closing song."

Polarity means expressing the extreme pole of a feeling.

---

Source: Feil, Naomi. Validation-Fantasy Therapy: New Manual Tells How to Help Disoriented Old-Old. Cleveland, Ohio: Edward Feil Production, 1981, pp. 57-60

## APPENDIX J

### DEMONSTRATION OF REALITY ORIENTATION WITH A GROUP

Group members are brought to the meeting room at the same time daily escorted by the therapist and staff members.

#### Group Action

#### Reality Orientation Technique

	Therapist: Greets each person by his or her name. Encourages members to greet each other by name. Hello, Mrs. G, Mr. T, Mrs. F, Mr. L, and Mrs. S.
Mrs. G to Mr. T: What are you doing here, Michael (her son's name)? I told you to go to school three hours ago.	Therapist: Mrs. G you are thinking Mr. T is your son, but he is Mr. T and we are all here at _____ Nursing Home. You remember, don't you?
Mrs. G: You mean my son is not here	Therapist: That's right, Mrs. G. Do you know where you are now?
Mrs. G: I want to go home.	Therapist: You are home, Mrs. G. _____ Nursing Home is your home now. You're here at home with all of us.
	Therapist points to Reality Orientation board. Mr. T can you tell us what day it is today.
Mr. T answers "Tuesday" correctly	Therapist: That's right Mr. T. You were right on the first try.
	Therapist points to the date. Mrs. F can you tell us the date today?
Mrs. F gives incorrect response	Therapist: That's close Mrs. F. Today is really June 1. Can you write that on your slate?
Mrs. F is directed to write June 1 on her individual slate	

Therapist continues to review the Reality Orientation board with each member of the group. She uses praise when member's give correct answers and gives answers in a positive way when they are wrong

Therapist showing clock with manual hands. Mr. L, the clock hands are pointing to 12:00. What meal do we eat then?

Mr. L: doesn't answer,  
pounds chair

Therapist: You are having trouble remembering, Mr. L. At noon we eat lunch.

Therapist continues to change clock hands and review activities with individuals, trying to engage them in calm conversation with one another. She then refers to the calendar and asks each member about a particular date. Past activities are discussed in a way that encourages group members to separate present from past events. For example:

Mr. L: I forgot to milk  
the cows this morning

Therapist: You were a farmer, weren't you, Mr. L? You had a herd of cows. Can you tell us about that?

Mr. L talks about his  
farm

Therapist: When did you leave the farm, Mr. L? Remember, you left it when you broke you hip and had to go to the hospital. That was two years ago. It is 1981 now, and you are in \_\_\_\_\_ Nursing Home to get better.

At the end of each session the members are encouraged to look at each other, call each other by name, and to shake hands, or hold hands.

The activities included in each session vary with the level of orientation in the group, but the basic reality orientation board is reviewed each time. Conditions which are incorporated into each session include: maintaining a calm environment and set routine; answering each person's questions clearly; responding to rambling speech or actions by calmly and firmly reminding the person of present reality.

#### EXAMPLE OF REALITY ORIENTATION BOARD

---

##### VALLEY VIEW NURSING HOME

TODAY IS: MONDAY

THE DATE IS: JUNE 15

THE YEAR IS: 1981

THE WEATHER IS: SUNNY AND HOT

OUR NEXT HOLIDAY IS: JULY 4

OUR NEXT MEAL IS: SUPPER

---

The board is constructed with a felt front so that the cards to complete the sentences, also backed with felt, adhere to the surface. The cards are changed to approximately match daily information.

APPENDIX K

LETTER TO INSTITUTION  
FOR PERMISSION TO USE FACILITIES

May 15, 1981

Mr. Michael Bailey  
Valley View Nursing Home  
721 Hickory Street  
Akron, Ohio 44303

Dear Mr. Bailey:

My name is Marlene Peoples. I am a registered nurse enrolled in the graduate program here at the College of Nursing, seeking a Master's Degree in Family Health Nursing. To fulfill part of the requirements, I propose to compare the effects of reality orientation therapy and validation therapy on groups of disoriented patients who are 80 years old or older. The University Committee for the Protection of Humans in the Area of Research has reviewed this study and has concluded that there will be minimal risk to the patients as a result of taking part in this research.

With your permission, I would like to use your nursing home as a test site for conducting both these therapies. If you agree, my colleague Ruth Shiflett, and I would spend a day in orientation to the environment, staff, and patients. Since I will be conducting validation therapy sessions, Mrs. Shiflett, who is also a registered nurse and a graduate student, will be conducting the reality orientation sessions. Because these therapies may be new to your staff, I would like to explain them in separate sessions, perhaps as part of your inservice. This will familiarize your staff with the therapies as we will be conducting them.

After gaining consent from the patients 80 years or older or from their closest relative in cases of severe confusion, I would interview each patient with a tool for determining degree of confusion (Hogstel, 1977). The results of this test would be used to randomly assign confused patients to either one of two therapy groups or to a control group. I would interview these persons again using an Ego Integration Scale, and I would gather demographic information from their charts, and assess their behavior using the Behavior Assessment Tool. All measures would be

administered to those in the groups both before and after the complete experiment to determine any differences.

Five or six patients would be assigned to each group. Once established, each therapy group will meet with Mrs. Shiflett or me for 30 minutes five days a week, Monday through Friday, for six continuous weeks. Together we could establish the time of day that would be most convenient for all concerned.

The benefits to the patients would include the stimulation of group interaction, increased awareness of reality, and increased feeling of self-worth for working with a group of peers. The staff would benefit from familiarity with an intervention they could possibly implement to continue the beneficial effects with disoriented patients.

Confidentially with regard to individuals and their respondent behavior would be maintained, as names would not appear on data sheets. Conclusions would be drawn only in relation to results of group behaviors.

At the conclusion of this research, I would make a copy of the written report available at your request. Any questions you may have at any time during the study could be referred to Mrs. Ella Kick, Chairperson of my thesis committee at 375-7556.

Thank you. I will be in touch with you. Your participation will be greatly appreciated.

Sincerely yours,

*Marlene M. Peoples L.N. BSN.*

Marlene M. Peoples, R.N., B.S.N.  
Graduate Student

MMP/rc

APPENDIX L

LETTER OF PERMISSION TO USE TOOL



TEXAS CHRISTIAN UNIVERSITY

P.O. Box 32899  
Fort Worth, Texas 76129  
817-921-7650

Harris College of Nursing

April 29, 1981

Ms. Marlene Peoples  
1312 Aarons Way  
Kent, Ohio 44240

Dear Ms. Peoples:

A copy of the questionnaire which I used in the study on reality orientation is enclosed. You may use it with proper credit given. I had reviewed several other instruments in preparing for the study, but most of them seemed to be too complicated to use with the type of nursing home residents I planned to select, so I decided to prepare a questionnaire which would be more appropriate for my study. As noted in the Nursing Research article, the test-retest reliability over a two-week period of time was quite high.

Although evaluation of degree of confusion was based on a summary of all of the items, I found that item #12 was particularly a key item in determining those residents who were severely confused. Residents in some degree of social isolation can readily forget the day of the month or the week, but when they cannot remember and state the number of days in a week, they seem to be in a much greater state of confusion.

I hope that this information is helpful. I would be very interested in hearing more about your work in this same area.

Sincerely,

Mildred Hogstel, R.N., Ph.D.  
Professor of Nursing

MH/bkb  
Enclosure

BASED ON FEIL'S VALIDATION/FANTASY  
STAGES OF DISORIENTATION

( PLEASE SEE BOOK, VALIDATION/FANTASY FOR DETAILED HELPING TECHNIQUES AND ASSESSMENT )  
NAOMI FEIL, 21987 BYRON ROAD, CLEVELAND, OHIO 44122 (216) 751-6353

STAGE ONE STAGE TWO STAGE THREE  
Validation/Fantasy Therapy, by Naomi Feil helps caretakers help and feel comfortable with the disoriented 'old-old'. It tells how to recognize the differences between chronic 'old-old' age and Alzheimer's Disease, as well as the physical, emotional and social factors leading to confusion. To order send \$7 (U.S.) to Edward Feil Productions, 4614 Prospect Ave., Cleveland, OH 44103.

HELPING TECHNIQUES

Use: Who, What, When, Touch, Eye-Contact Touch, Eyes, Polarity, Mirroring.  
But, Always, What if Explore Preferred (Match body rhythms.) Explore main  
Repeat main word. Sense. I see, I feel.

Control of body functions	Can dress, toilet, and control the self most of the time.	Incontinent due to lack of assistance. Cannot control bowel and/or bladder over long periods. Aware of incontinence.	Bowel and/or bladder incontinence persists. Resigned to it or unaware of it.	No effort made toward control or awareness of incontinence.
Relation to reality	Holds onto present reality. Is aware of self and aware of confusion. Is threatened by confusion of self and others.	Forgets facts, names and places from the present immediately. Continues to withdraw inward, creates his own rules.	Shuts out stimuli from outside world.	Will not recognize staff or family who visit daily.
Muscle control	Muscles tight. Stance rigid. Holds himself together to keep in control as defense.	Sits upright in chair with muscles relaxed. Neck muscles and lips loose.	Body slumped. Head bent forward in chair.	Completely loose. Little voluntary movement.