The human face of elderly care?

Linda Miller

Communication is the linchpin of nursing action...

Communication and interactions between nurses and patients with dementia of the Alzheimers type is often inadequate. It would be inappropriate to suggest that nursing staff make no effort to communicate with patients who have dementia, but the communication difficulties that confront them require that a conscious effort is made to invest extra energy to provide meaningful communication. A number of interactive approaches are used by staff, traditionally those of reality orientation, behaviour modification, reminiscence therapy, and more recently, music therapy, touch therapy and aromatherapy. This paper overviews one other therapy which specifically addresses the communication needs of patients who suffer from dementia of the Alzheimers type, validation therapy.

INTRODUCTION

Communication is the linchpin of nursing action, it is a major theme running through pre- and post-registration courses, and yet research studies demonstrate that there is a lack of meaningful interaction between nurses and elderly patients who are physically and/or mentally impaired. Studies also suggest that nurses interact significantly less with confused patients than with lucid patients, and that they find it difficult to work with patients who have dementia (Armstrong-Esther & Browne 1986; Jones 1992).

Dementia is a complex state and not everyone who experiences the disease will present with the complete spectrum of symptoms. Fifty percent of all dementia's are said to be of the Alzheimers type and 10 to 15% are a mixture of dementia of the Alzheimers type and multi-infarct dementia. While experts admit they are a long way off finding the cause of dementia of the Alzheimers type, there is a widely accepted definition of what it is, that there is global impairment of higher cortical functions, memory and personality without clouding of consciousness. The early stages of dementia involve only slight impairment of functioning, but as the disease progresses there is a gradual loss of communication and self care skills (Arendt & Jones 1993). Whatever the cause of dementia, the resulting deficits mean that the patient will have specific communication needs.

Jones (1992) argues that communication between sufferers from Alzheimers type dementia and normal healthy people are unequal and consequently care givers must consciously decide to invest extra energy and input to provide meaningful communication.

There is a heavy reliance for most individuals on verbal skills. Indeed Bartol (1979) suggests that effective communication is dependent upon verbal communication. Individuals who develop dementia of the Alzheimers type are not assured of this basic tool, their sense of self or personhood is threatened as a result. However, the communication process involves both verbal and non-verbal skills. Non-verbal communication (body language) provides an emotional climate for the interpretation of messages. Alzheimer patients often lose the ability to modulate their emotional response to stimuli and situations that they perceive as dangerous and threatening (Bartol 1978). The resulting challenging behaviours can lead to the patient being problematized and identified as difficult to manage. The behaviour, rather than the individual, then becomes the focus of attention, the meanings behind the behaviour are not necessarily sought out. Feil (1992) stresses the importance of the assumption that all behaviours have meaning and that where factual thinking becomes weak, feelings and underlying content survive. It is her belief that feelings and emotions of the disorientated individual should be validated and supported in whatever time and location is real to them. A prime concern for care givers ought to be that they maintain support for individuals with Alzheimers type dementia in order that individuality, self esteem and dignity are maintained (Bartol 1978).

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At times nursing staff may be unsure how to intervene positively in cases of dementia behavioural changes. If staff do not have a full understanding of dementia and resultant behavioural changes they will be unsure how to intervene and communicate positively. Care givers will then avoid focusing on communication and resort to custodial activities.

It would be inappropriate to suggest that nursing staff and others overlook communication difficulties that confront them when

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working with patients who have dementia of the Alzheimers type, however, there are a number of approaches used by staff in dementia care, traditionally those of reality orientation, behaviour modification, reminiscence therapy, and more recently music therapy, touch therapy and aromatherapy that may assist the communication process.

One therapy which specifically addresses the communication needs of patients who suffer from dementia is validation therapy.

VALIDATION THERAPY

Validation therapy is a developmental theory which provides a method for classifying the behaviours of patients who are confused and disorientated into four progressive stages. There are specific helping/communication techniques identified for individuals in each stage, which may be used one to one or in a group setting depending on which stage of disorientation the patient is in. The premise behind validation therapy is that all behaviour, even the confused and disoriented behaviour of the Alzheimer sufferer, has some logic, some meaning which should not be ignored.

Validation therapy is an interactive communication tool which encourages nursing staff to see the person behind the dementia, to accept them as a unique individual whose lifetime of past experiences has shaped their personalities and behaviours, and for whom the experience of dementia has escalated the number of barriers to good communication beyond those normally experienced in old age (Feil 1992; Jones 1992). American social worker Naomi Feil developed the idea of validation therapy when she became disillusioned with the effects of using a reality orientation approach with elderly people who were severely confused and disorientated.

Reality orientation is probably the most widely used approach to the management of dementia and has been the subject of a number of empirical studies, its origins tracing back at least 30 years (Woods 1993). It has attracted a fair amount of criticism over the years, yet it is still used as the main interactive communication tool in continuing care settings. Feil (1972) found that the goal of reality orientation, to achieve existence in reality, was valuable for the elderly person, whose reality held a steady deterioration, disatisfactory, and brought about pain, withdrawal and increased dependency. Bleathman and Morton (1988) believe that the aim of validation therapy is to enter the reality of the disorientated individual rather than impose some other reality from outside (the aim of reality orientation). This they believe, is more likely to ease distress and enhance self esteem. The focus is the emotional and psychological consequences of short-term memory loss (Feil 1992).

The theoretical assumptions underpinning validation techniques are, those of behavioural, analytical and humanistic psychologies (Feil 1992). It appears to be Feil's belief that a Rogerian humanistic psychology provides the framework for validation therapy in that emphasis is placed on the uniqueness of the individual, and on the unconditional positive regard of the therapist for the individual (Morton & Bleathman 1990; Verdult & Visser 1990; Babins 1988). While it is widely accepted that an underlying principle of validation therapy is the reflection of feelings tradition of a Rogerian approach, many commentators question the assumption made by Feil, that the confused elderly replace intellectual thinking with a form of fantasy (Verdult & Visser 1990; Goudie & Stokes 1989; Vanderkooj 1989).

The fantasy according to Van Amelsvoort Jones (1985), may involve the elderly person returning to the past for the purpose of trying to resolve unfinished conflicts, by expressing feelings hidden in youth, in order to relive past pleasures and restimulate sensory memories. This can be construed as an inappropriate attribution with the dementia sufferer being seen to have abstract intellect and powers of analysis which are not actually present (Goudie & Stokes 1989). When one considers that there is general agreement between experts, that in dementia there is acquired global impairment of intellect, memory and personality, it is understandable that this assumption is questioned. What may be acceptable however, is that even though cognitive possibilities decrease, feelings and connected content of those feelings are preserved. Confused elderly people do not necessarily consciously revisit the past, but where long-term memory remains, the past often revisits them (Verdult & Visser 1990). The implementation of validation therapy techniques by nurses can validate and support the individual's feelings in whatever time or location is real to them, even though this may not correspond to the nurses own 'here and now' reality (Feil 1992; Van Amelsvoort Jones 1985). The process of validation helps to determine the meaning of non-verbal communication and enables nurses to verify their perception of the content and feeling aspects of the patient's messages (Kalman & Waughfield 1993). Validation therapy encourages nurses to gain a greater knowledge of the patient's past, their hobbies, their work, family etc, and not just to see them in terms of the picture they

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present today. This is likely to lead to nurses offering high quality interactions with elderly patients which it is recognised are important for the maintenance of orientation (Salmon 1993).

CONCLUSION

While the standards of physical care for patients who live out the latter years of their life in continuing care settings has improved, the level of meaningful interactions with the confused elderly is still reported to be lacking.

Introducing the validation therapy process into patient care programmes can help to address this paucity of nurse–patient interaction. However, the success of any therapeutic intervention may depend upon the nursing staffs' belief in, or enthusiasm for the technique. Verdult and Visser (1990) suggest that nursing staff may be more prepared to implement the techniques if they are encouraged to take ownership of the process involved.

What is unique about validation therapy is that it includes a method of classifying disorientated states readily and includes specific helping techniques for individuals in each stage. 'Once the stages are understood, the recommended communication strategy follows logically' (Van Amelsvoort Jones 1985), the techniques may then be used one to one on a daily basis or in a weekly group session.

Although validation therapy is now widely used in nursing homes, hospitals and communities in other countries such as America, Australia and the Netherlands, it has only recently begun to be used in Britain. The therapy has met with mixed reaction in this country and research into its effectiveness is limited. While there are a number of research studies reported in the literature that is available, most of the information is of an anecdotal nature, but reference is made to the value of implementing validation therapy as a communication technique with patients who are confused and disorientated.

REFERENCES

Arendt T, Jones G 1992 Clinicopathalogical correlations and the brain-behaviour relationship in Alzheimers disease. In: Jones G M M, B'ere L M Meisen (eds) Care-giving in dementia research. Research and Applications. Tavistock/Routledge London 7–28

Armstrong-Esther C A, Browne K D 1985 The influence of elderly patients 'mental impairment' on nurse–patient interaction. Journal of Advanced Nursing 11 (4): 379–387

Babins L 1988 Conceptual analysis of validation therapy. International Journal of Ageing and Human Development 26 (3): 161–167

Bartol M A 1979 Nonverbal communication in patients with Alzheimers disease. Journal of Gerontological Nursing 5 (4): 21–31

Bleatham C, Morton I 1991 The effectiveness of validation therapy in dementia – a pilot study. International Journal of Geriatric Psychiatry 6 (5): 327–330

Bleatham C, Morton I 1988 Validation therapy with the demented elderly. Journal of Advanced Nursing 13 (4): 511–514

Feil N 1992 Validation. The Feil method. How to help the disorientated old-old. Edward Feil Productions. Cleveland, Ohio

Goudie F, Stokes G 1989 Understanding confusion. Nursing Times 85 (39): 35–37

Jones G 1992 A communication model for dementia. In: Jones G M M, B'ere L M Meisen (eds). Care-giving in dementia. Research and Applications. Tavistock/Routledge, London

Kalman N, Waughfield C G 1993 Mental health concepts. Delmar Publishers Inc, USA

Salmon P 1993 Interactions of nurses with elderly patients: relationship to nurses' attitudes and to formal activity periods. Journal of Advanced Nursing 18 (1): 14-18

Van Amelsvoort Jones G M M 1985 Validation therapy: A companion to reality orientation. The Canadian Nurse 81 (3): 20–23

Van der Kooj I 1989 Reality orientation and the reality of a resident in care. Tudshar Gerontol Geriatr 20: 197–201

Verdult R, Visser R 1990 Experiences with validation. TVZ (JC:agh) 15: 474–478

Woods B 1992 What can be learned from studies on reality orientation? In: Jones GMM, B'ere M L Meisen (eds). Care-giving in dementia research and applications. Tavistock/Routledge, London 121–136