INTERNATIONAL JOURNAL OF GERIATRIC PSYCHIATRY, VOL. 6: 327–330 (1991)

THE EFFECTIVENESS OF VALIDATION THERAPY IN DEMENTIA—A PILOT STUDY

IAN MORTON
Charge Nurse, Felix Post Unit, Maudsley Hospital, Denmark Hill, London SE5 8AZ, UK

AND

CHRISTINE BLEATHMAN
Senior Sister, Felix Post Unit, Maudsley Hospital, Denmark Hill, London SE5 8AZ, UK

SUMMARY

The results of a pilot study investigating the effects of a weekly validation therapy group in demented subjects are presented. Five patients were studied and the effects of the intervention on their mood, behaviour and sociability were quantified using standardized instruments. There was some increase in levels of interaction. These results are discussed and the need for further research into the benefits of this therapy is highlighted.

KEY WORDS—Dementia, group therapy, psychological treatment, validation, reality orientation.

In Britain, the most commonly used psychological treatments for those suffering from dementia are reality orientation (RO) and reminiscence therapy (RT). RO can be used both as a continuous informal interactive technique and as a form of group therapy. A working definition of the former is:

> staff present current information to the person in every interaction, reminding the patient of time, place and person and providing a commentary on events (Holden and Woods, 1982)

This shares with the group therapy the aim of mitigating the disorientation which accompanies the dementing process, and assumes that this will, in turn, alleviate the levels of distress experienced by the sufferer.

RT uses a range of audiovisual aids containing material from the elderly person's younger days which encourages him or her to recall the past (ie to reminisce). Practitioners assume either that reminiscence carries benefit in itself or that the stimulation of the long-term memory can benefit short-term memory.

Both these therapies have as their focus the short-term memory loss which occurs in dementia: RO by emphasizing the importance of current information and orientation material and RT by its recognition that the period best recalled by the sufferer is in the past rather than the present. In Alzheimer's disease, however, most aspects of memory are impaired, including short-term, long-term, remote and semantic memory. This loss of memory has a devastating effect on the sense of self and identity.

Robert Butler's work on 'life review' (Butler 1963, 1974) suggests that all people nearing the end of their lives (and therefore old people in particular) undergo a psychological process of internally reviewing their lives in order to identify and work through unresolved conflicts from their past, and so prepare for death. For those with memory impairment this process cannot take place unless a means is found for both generating the 'forgotten material' for this life review and for providing a sense of self-identity.

VALIDATION THERAPY

In contrast to both RO and RT, validation therapy (VT) has as its focus the emotional and psychological consequences of short-term memory loss. VT was founded by Naomi Feil, who grew up in a residential home for the elderly in Cleveland, Ohio, where her father was the administrator and her mother the social worker. There she saw RO in use and became dissatisfied with its effects on the disorientated residents:

0885–6230/91/050327–04$05.00
© 1991 by John Wiley & Sons, Ltd.

Received 21 May 1990
Accepted 1 November 1990

I found that not only was awareness of reality intolerable for this group of aged whose reality held steady deterioration in functioning, loss of affectional ties, and whose future held death; but sudden insight into reality brought about pain, withdrawal and increased dependency. (Feil, 1972)

This disillusionment led her to develop an alternative interactive technique, in which the goal of achieving a grasp of reality is superseded by the goal of communicating with disorientated people in whatever reality they are in, in order to ease distress and restore self-worth:

Validation means accepting the disorientated old-old adult who lives in the past. The Validation worker helps them sum up their lifetime. The Validation worker helps by listening with empathy.... Accept people where *they* are. The disoriented old-old finally struggle to resolve past conflicts. Their goals differ from the goals of their middle-age caretakers. Validation helps them reach their goal in this last stage of life. (Feil, 1982)

Like RO, VT can be used in one-to-one conversation or as the basis for group work. However used, the assumption is that the behaviour and speech of the disorientated person has an underlying meaning and that the disorientated elderly return to the past in an attempt to resolve unfinished conflicts by expressing feelings previously hidden. In practice this involves the therapist in 'validating' what is said rather than correcting factual errors so that meaningful conversation can take place on the issues that are important to the disorientated person.

In groups using validation techniques, five to 10 members are selected with moderate to severe memory impairment. Each group has a rigid format, beginning with the welcoming of members and the singing of a group song, followed by discussion of a topic and finishing with the thanking of members, a closing song and refreshments. The groups always take place in the same room, with the same seating plan. This procedure seems to provide a sense of group membership and group memory in the absence of individual memory. As the groups progress, members develop roles such as 'welcomer', 'host/ess' (to give refreshments) and 'songleader'. Topics chosen for discussion are those that reflect universal feelings—of anger, separation or loss. Such topics allow the group members to verbalize their unresolved feelings and conflicts about their families, their loss of role, home and faculties, their attitude to dying.

Validation therapy is thought to be in use in over 500 institutions in North America. Feil's claims for the efficacy of Validation are boldly stated:

Our 1971 study (Feil, 1972) showed that after five years of validation, thirty severely organically, brain-damaged, disoriented old-old people became less incontinent; speech improved; less negative affect (crying, pounding, hitting); more positive affect (smiling, talking, helping others); people became more aware of external reality; they talked outside of group meetings; they showed greater contentment.

However, the research method and data to support such claims do not appear to be available.

METHOD

We chose to study whether a weekly VT group had any demonstrable effect on the levels of communication, mood and behaviour of the participants at times between the therapy sessions.

The research consisted of single-case studies of five group members over a period of 40 weeks. An initial period of 10 weeks of baseline measurements was followed by 20 weeks of validation group work, which was then followed by 10 weeks of an alternative form of group work (reminiscence therapy). The groups were held weekly between 11 am and 12 noon. Throughout the entire period we measured the amount of verbal interaction involving each group member for one hour in the afternoon following the group. We developed our own variation of the 'short observation method for the study of the activity and contacts of old people in residential settings' (Macdonald *et al.*, 1985). This involved observing each group member for an hour while listening to a small battery-driven device which 'bleeped' at precise 10-second intervals. On a specially devised chart we recorded all verbal contact involving the group member, with 10 seconds acting as one 'unit of interaction'. Care staff at the residential home from which the group members were selected completed other independent assessment scales—Holden Communication Scale (Holden and Woods, 1982), MACC Behavioural Adjustment Scale (Ellsworth, 1966), CAPE Behavioural Rating Scale (Pattie and Gilleard, 1979)—at intervals throughout the 40-week period of the study. The care staff were not made aware of the change from validation to reminiscence therapy. The researchers completed the CAPE 12-item Information/Orientation Scale (Pattie and

Gilleard, 1979) at five intervals throughout the research period. Group members were initially selected as being unable to score more than 6 on this scale, ie they generally did not know their age, the day, month or year, where they were, nor the name of the current prime minister or American president (Table 1). Each group was recorded on audio cassette and three on video cassette.

Table 1. Results of CAPE

			CAPE Information/Orientation (max. = 12) Week*				
Subject	Age	Sex	0	10	20	30	40
1	83	F	6	8	6	4	3
2	89	F	4	5	6	4	3
3	79	M	6	6	Died	—	—
4	86	F	4	3	5	5	5
5	88	F	1	Refused	3	2	3

*1–10 weeks = baseline measures; 11–30 weeks = validation therapy; 31–40 weeks = reminiscence therapy.

RESULTS

The study was adversely affected by the death of one of the group members (subject 3) after 23 weeks. One other member (subject 5) attended only five groups as she was frequently reluctant to attend. We were therefore only able to obtain complete data on three members (subjects 1, 2 and 4).

There was a marked increase in the amount of postgroup verbal interaction of two of the group members (subjects 1 and 2) during the VT period and a subsequent decline during the RT period. This pattern is inverted, however, in the case of subject 4. An analysis of the proportion of interactions which were initiated by the subjects themselves shows a marked rise in subjects 1 and 2 during the VT period whereas in the case of subject 4 this rise occurs during RT. The mean average length of interaction increased in subjects 1 and 2 during the VT periods followed by declines during the RT period. Subject 4 again shows an inversion of this pattern (Table 2).

The rating scales completed by the care staff showed no changes of statistical significance and were not suggestive of meaningful interpretation.

DISCUSSION

The results of subject 1 show a clear and marked change in the pattern of interactions during the VT period, with a partial return towards the baseline figures during the RT period. During the VT period, subject 1 more than doubles the amount of time spent in interaction. This is a result of an increase in both the length of interactions and the number of subject-initiated interactions. There is virtually no increase in the average number of interactions per week and there is a steady decline in the number of interactions initiated by others. These patterns are based on a sufficiently high sample of interactions to suggest they are a result of the therapy sessions.

Subject 2 offers a much smaller sample, but again shows an increase in time spent in interaction which results from an increase in length, rather than number, of interactions and an increase in the rate of initiation. The decline during the RT period is more marked than in subject 1.

The increases in the length of interactions, as opposed to the number of interactions, may be seen as a change in the quality of interaction. Outside of the groups all subjects showed a tendency towards short, repeated interactions—for example asking the time, asking if tea had been had yet, commenting on the weather—which were less than 'conversational' in form. The increased length of interactions tended to signify a greater contribution from both parties and a continuity of theme and topic which approximates more towards 'normal' conversation.

Subject 4, conversely, shows a decrease in the rate of interactions during the VT period and a marked rise in both the frequency and length of interactions in the afternoons following RT. It might appear that in this case RT is having the effect induced by VT in subjects 1 and 2. This suggests that validation may not be the ideal therapy for everybody, and that the level of deterioration in cognitive functioning is not the only factor which should influence our choice of therapies. Both subjects 2 and 4 were socially isolated between sessions, interacting very little with others, hence the small size of their samples.

The marked decline in the amount of interaction involving subject 5, who rarely attended the groups, is attributable to the death of subject 3,who regularly sat next to her in the lounge area and with whom most of her interactions occurred.

From this pilot study we conclude that the

Table 2. Postgroup observations

Subject	% of time spent in interaction Weeks* 1–10	11–30	31–40	Total number of interactions (initiated by subject/initiated by other) Weeks** 1–10	11–30	31–40	Average length of interactions (s) Weeks* 1–10	11–30	31–40
1	6.6	14.2	7.7	91 (49/42)	201 (169/32)	70 (46/24)	24	46	34
2	0.6	1.4	0.1	9 (4/5)	20 (18/2)	2 (2/0)	17	28	15
3	24.7	13.8†	—	345 (107/238)	180 (70/110)†	—	25	24	—
4	0.9	0.5	1.6	30 (2/28)	27 (4/23)	57 (29/28)	17	14	26
5	19.3	10.4	5.3	238 (210/28)	74 (59/15)	106 (84/22)	27	24	18

*1–10 weeks = baseline measures; 11–30 weeks = validation therapy; 31–40 weeks = reminiscence therapy.
†Died week 23.

therapy appears to have had a sufficient impact on social interaction to justify further research. We are unable to compare our results with those of other studies as we believe that this pilot study is the first attempt at a systematic evaluation of the effectiveness of VT. We did not have the resources to investigate whether the increased rate of interaction continued beyond the afternoon following the session, but we would estimate that any significant effect would be unlikely to be produced by therapy applied for only one hour a week. Further study should involve more frequent use of the therapy and comparative studies of the effects of RO, RT and VT on groups of dementia sufferers. The contrast between the almost total lack of meaningful interaction observed outside of the group and the members' ability to maintain and discuss themes and issues for 45 minutes or more in the group setting convinces us of the potential of VT as a group therapy for those with memory deficits.

ACKNOWLEDGEMENTS

We wish to thank Dr Gemma Jones for her teaching and supervision throughout the project, the Bethlem Royal Hospital and Maudsley Hospital Special Health Authority Research Committee for the financial support and Dr Alistair Burns for his helpful comments on the text.

REFERENCES

Butler R. N. (1963) The Life Review: An interpretation of reminiscence in the aged. *Psychiatry* **26**, 65–76.

Butler, R. N. (1974) Successful ageing and the role of life review. *J. Am. Geriatr. Soc.* **22**, 529–535.

Ellsworth, R. B. (1966) *MACC Behavioural Rating Scale*. Western Psychological Services, Los Angeles, California.

Feil, N. (1972) A new approach to group therapy, research findings. Unpublished paper presented to the 25th Annual Meeting of the Gerontological Society in San Juan, Puerto Rico, December 1972.

Feil, N. (1982) *Validation: The Feil Method*. Edward Feil Productions, Cleveland, Ohio.

Holden, U. P. and Woods, R. T. (1982) *Reality Orientation: Psychological Approaches to the 'Confused' Elderly*. Church Livingstone, Edinburgh.

Macdonald, A. J. D., Craig, T. K. J. and Warner, L. A. R. (1985) The development of a short observation method for the study of activity and contacts of old people in residential settings. *Psychol. Med.* **15**, 167–172.

Pattie, A. H. and Gilleard, C. J. (1979) *Manual of the Clifton Assessment Procedures for the Elderly (CAPE)*. Hodder and Stoughton Educational, Sevenoaks.

Copyright of International Journal of Geriatric Psychiatry is the property of John Wiley & Sons Inc. and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.