REALITY ORIENTATION AND VALIDATION THERAPY

Dementia, Depression, and Functional Status

Preparing gerontological nurses for the new century includes assessing demographics, evaluating illnesses, and seeking interventions to alleviate suffering. "Senile dementia of the Alzheimer's type is the fourth leading cause of death . . . currently no specific preventative or ameliorative interventions are known."(Cassel, 1990). The number of elderly persons in the United States with probable Alzheimer's disease will go from 2.9 million in 1980 to as high as 14.3 million in 2050 (Evans, 1990). This article reports on a study that was conducted to evaluate any positive effect of two "therapeutic" measures for the confused elderly: Reality Orientation and Validation Therapy.

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REVIEW OF LITERATURE

Reality Orientation

Reality Orientation (RO), both an individual and a group therapeutic measure, proposes to disrupt cognitive decline by stimulating the confused individual with repetitive activities on an individual or group level. Continuous, or "24-hour RO," reinforces name, date, time, and other facts of orientation, and ideally is used by every person interacting with the confused individual. Classroom RO is scheduled therapy in which a prepared instructor reviews facets of reality with a small group of confused individuals. The classroom setting promotes a social atmosphere (Letcher, 1974).

RO studies revealed no significant improvement in mental status (Hogstel, 1979), mental status and life satisfaction (MacDonald, 1978), or social behavior and activities of daily living (ADL) (Holden, 1978).

Several RO studies found improvement in orientation (Hanley, 1981; Johnson, 1981), and orientation and behavior (Citran, 1977; Harris, 1976). One study identified improvement in mental status, but no change in ADL (Zepelin, 1980).

Validation Therapy

Validation Therapy de-emphasizes the relevance of orientation facts to the confused elder (Feil, 1982). Validation Therapy explores the intro-

BY SUSAN G. SCANLAND, MSN, GNP, RN-C; AND LINDA E. EMERSHAW, RN

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TABLE 1

Subsample Size by Treatment

Treatment	Sample A (n = 19)	Sample B (n = 15)
Reality Orientation	6	4
Validation Therapy	7	5
Control	6	6

spective meaning and motivation for confused statements through the use of specific techniques (Feil, 1972; Feil, 1978; Feil, 1982). Validation Therapy has been evaluated by its developer without recourse to the usual control conditions (Feil, 1982).

The only published study evaluating Validation Therapy was flawed, mainly because of attrition (Robb, 1986). Validation Therapy had no significant effect on mental state, morale, or social behavior.

METHOD

The purpose of this investigation was to determine if either RO or Validation Therapy would have an effect on cognitive status, functional status, or level of depression.

Design

The study was conducted at the Veterans' Administration Medical Center's 120-bed nursing home care unit in northeastern Pennsylvania.

Subject criteria for study inclusion were: nursing home residency, over 60 years of age, and presence of confusion. Confusion was defined by a mini-mental state examination (MMSE) score of 24 or less (Folstein, 1975). Consent was required and was obtained from the veterans' next of kin or legal guardian. The investigation was approved by the appropriate VA committees.

Sample

One potential subject did not participate because the next of kin would not give consent. A nonequivalent control group design was used in the selection of two subsamples. Sample A included 19 patients, who received assigned therapies from September 1983 to January 1984. Two additional patients were lost to death. Sample B had 15 residents, who received assigned therapies from October 1984 to February 1985. Seven patients were lost: four died, and three were resistive after initial compliance with therapies. Combining subjects from both subsamples yielded a total sample size of 34. Sample A and Sample B were combined under controlled conditions because of the relative low numbers of eligible subjects at two separate time intervals. Reasons for exclusion were the following: subject risk for acute exacerbation of illness, severe hearing impairment, wandering behavior, and actions disruptive to group processes. Statistical analysis revealed no disparity between both subsamples.

Intervention

The RO group and the Validation Therapy group in each subsample received 4 months of structured therapy in a classroom-like setting. Therapies for each group were 30 minutes, held five times weekly. The control group received no formal therapy.

Both the RO group sessions and the Validation Therapy group sessions in each subsample were conducted by the same registered nurse, who had a background in group psychotherapy. Pre- and post-testing immediately before and after the appropriate course of therapy for each of the two subsamples was completed using three instruments. Eligibility for post-testing included completing 70 or more of the possible 80 treatment sessions.

Instruments

The MMSE was selected to assess mental status (Folstein, 1975). This test measures five facets of cognitive function: orientation, registration, attention/calculation, recall, and language. The scores range from 0 to 30; a higher score reflects increased function.

Functional status was measured using the Katz Index of ADL Evaluation Form (Katz, 1963) with a Likert-type scale (Kane, 1981). ADL assessed included bathing, dressing, toileting, transferring, continence, and feeding. Subjects were rated on their degree of independence or dependence, with dependency receiving higher scores.

Level of depression was determined using the Modified Beck Depression Inventory (Beck, 1961). The

scale consists of 21 sets of four graded statements, each set ordered to reveal increasing depression. Statements were read to subjects, to compensate for poor visual acuity. Subjects selected what they thought were the most appropriate responses. Scores can range from 0-63, with higher numbers indicating greater depression.

RESULTS

The mean age of study participants was 76.8 years, with a mean education level of 10 years. There were no significant differences in pre- and post-test scores for mental status (Folstein, 1975) or functional status (Katz, 1963). Post-depression scores revealed a slightly higher degree of depression (Beck, 1961).

Two-way analyses of variance were performed to evaluate disparity between the two separate subsamples participating in the study at the two separate time intervals. Results revealed no difference between the two separate subsamples; both groups were combined for statistical analyses.

Analyses of variance (Table 2) were computed to assess for differences between treatment groups. There were no significant differences among the RO group, the Validation Therapy group, or the control group in pre- and post-instrument scores. Results were confirmed by Scheffe's test.

TABLE 2
Analysis of Variance for Difference Between Treatment Groups

Instruments	ss†	df	F	p
Pre/Post Beck (depression)	58.59	2	.54	0.5851
Pre/Post Katz (functional status)	214.90	2	2.97	0.0656
Pre/Post MMSE	102.68	2	2.83	0.0742

Note: Results confirmed by Scheffe's test.
† = sum of squares.

DISCUSSION

The RO method's failure to have an effect on mental status, ADL, or life satisfaction has been identified in three previous studies (Hogstel, 1979; Holden, 1978; MacDonald, 1978). Five studies, however, found some improvement in orientation and/or behavior (Citran, 1977; Hanley, 1981; Harris, 1976; Johnson, 1981; Zepelin, 1980). There are numerous possible reasons for mixed treatment outcomes. Differences in length of treatment, ages of subjects, and categories of dementia may have contributed to the mixed treatment outcomes. Probably the strongest reasons for disparate results are the varying backgrounds of persons conducting groups and the lack of existing detailed guidelines for structuring a RO program.

Results of Validation Therapy are consistent with the only published study on Validation Therapy, which found no effect on mental status or morale (Robb, 1986).

Limitations of the present study include the following:

- Therapy was structured in a specific time frame by one person, as opposed to an ongoing 24-hour therapy by all staff;
- Diagnoses and dementia subtypes (Alzheimer's disease, multi-infarct dementia, reversible dementias) could not be controlled for because of sample size;
- Medications were not controlled; and
- The sample was not randomized.

Long-term care research has its share of difficulties; this study was no exception. It was conducted by a nurse practitioner and a staff nurse in their respective work settings. Research endeavors were perfomed during usual clinical work hours. Patient responsibility was shifted to other staff members during therapy sessions. Staff support was stretched during the second subsample time component. Escorting patients to and from group therapies was difficult. The therapy schedule and setting posed several problems. Many nursing home patients voiced displeasure when moved from their smoking lounge during therapy sessions. Some members of the therapy groups were fatigued at mid afternoon, when sessions were held.

The nurse therapist had to diligently combat fluctuating interest levels of the subjects. The interval length (4 months) caused some subjects' attention span to decrease. Most participants made an effort to continue therapies. Decreased attention

span in some patients can be a communication barrier.

Agitation, which is common with dementia, was another factor that negatively affected group processes. The disruptive behavior of one patient would decrease the attention span of other group members.

Depression in one group member or among several group members influenced the participation of others. The death of a group member would result in increased apathy and decreased participation of surviving subjects. Lack of family visitation tended to negatively affect the attitude, behavior, and emotions of the older person.

Physical illness occasionally interfered with group processes. Acute illness, such as pneumonia, resulted in missed sessions. The therapist had to remotivate the participant to achieve the former level of interest.

Additional research for both Validation Therapy and RO therapy is required. Financial support for such studies, including the hiring of an outside group therapist specifically for the study, is recommended. Budgeting for escort services should be included. Larger patient samples in several nursing homes could be analyzed with attention to categories of dementia. Twenty-four hour RO or Validation Therapy (or longer periods of classroom instruction) would require vast amounts of staff education, administrative resources, and personal commitment. Unfortunately, this is beyond the resources of most long-term care settings.

Reality Orientation and Validation Therapy have been in existence for about 20 years. RO therapy results are conflicting, and Validation Therapy lacks scientific support. The need for research to build a theoretical framework for psychotherapy with the confused is essential, and expensive if neglected.

Lack of family visitation tended to negatively affect the attitude, behavior, and emotions of the older person.

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ABOUT THE AUTHORS

Susan G. Scanland, MSN, GNP, RN-C, is a Gerontologic Nurse Practitioner on the clinical faculty at the Wyoming Valley Family Practice Residency in Kingston, Pennsylvania. Linda E. Emershaw, RN, is currently on extended family leave.

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Address correspondence to Susan G. Scanland, MSN, GNP, RN-C, United Health and Hospital Services, Inc., Wyoming Valley Family Practice Residency, 540 Pierce Street, Kingston, PA 18704.

THERAPEUTIC MEASURES

KEYPOINTS:

Scanland SG, Emershaw LE. Reality Orientation and Validation Therapy: Dementia, Depression, and Functional Status. *Journal of Gerontological Nursing*, 1993;19(6):7-11.

1. This study shows that Reality Orientation (RO) and Validation Therapy have no significant impact on mental status, level of depression, or functional status.
2. Gerontological nurses, administrators, specialists, and practitioners must carefully evaluate and compare all relevant research studies on therapies before implementing therapies in long-term care settings.
3. Gerontological nurse researchers and staff must be aware of the difficulties arising in long-term research: sampling difficulties, patients' behavioral and physical factors, and environmental, staff, and financial resources.

NOTE

In the April issue of the *Journal of Gerontological Nursing*, the Clinical Outlook Column "Understanding and Applying Research to Your Practice" cited only one author on its title page. The co-author (who was cited on page 45) was Marita G. Titler, PhD, RN, Associate Director for Nursing Research, University of Iowa Hospitals and Clinics, Iowa City. The editors regret the omission.