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An Evaluation of Validation Therapy with Alzheimer's Patients

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Master's Thesis

5/22/95

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May 17, 1995

Running Head: VALIDATION WITH DEMENTIA PATIENTS

Abstract

This study was conducted to expand the body of methodologically evaluative research on the effects of Validation Therapy (VT) with institutionalized elderly. Single-subject designs were used for three subjects, each in a different stage of dementia (Malorientation, Time Confusion, or Repetitive Motion). Three-week baselines were established, an intervention of VT made for at least four weeks, and behavior was monitored for at least one week without VT. It was expected there would be improvement in personalized treatment goals when VT was given. After VT suspension, it was expected there would be no change or deterioration in goals. Subjective results supported the hypothesis. Improvement was made in almost every treatment goal for each subject when VT was present. When VT was suspended, some treatment goals deteriorated, especially for the Repetitive Mover. The results were extremely helpful in evaluating the effectiveness of VT. Further research is needed. The success of VT is spreading faster by word of mouth than by research.

An Evaluation of Validation Therapy with Alzheimer's Patients

Validation Therapy (VT) is one of the techniques used with the elderly who are diagnosed with Alzheimer's Disease and related dementias. Not only are there few distinctly different types of psychosocial programs for Alzheimer's patients, but those that are available have been developed and adopted primarily on theoretical, not empirical grounds (MacDonald & Settin, 1978). Although there are many informative articles explaining the positive effects of VT (Feil, 1967, 1982, 1985, 1989, 1991, 1992a; Dietch, Hewett, & Jones, 1989), none are based on experimental research. As a consequence, there is inadequate evaluative research on the actual effects of these VT programs.

Validation therapy was developed between 1963 and 1980 by Naomi Feil, a gerontological social worker. Feil was dissatisfied with traditional therapies for older people with dementia (Feil, 1992b). Today, she is internationally recognized for her work. Over 7,000 facilities in the United States, Canada, Europe, and Australia have adopted validation therapy, and nearly 70,000 professional and family caregivers have attended her workshops (Feil, 1993). Certification can be obtained at the Validation Training Institute in Cleveland.

This extended use of VT is surprising if one looks only at research as supporting practice. Perhaps most clinicians use VT because they have personally seen its positive results.

Validation therapy, which is based on an attitude of respect and empathy, has a number of goals for the person with dementia. They include restoring self-worth, reducing stress, justifying living, working towards resolving unfinished conflicts from the past, reducing the need for chemical and physical restraints, increasing verbal and nonverbal communication, preventing withdrawal into vegetation, and improving gait and physical well-being (Feil, 1993). VT was developed for adults with dementia who are between 70-100 years old; who have led relatively happy, productive lives; who have denied severe crises throughout their lives; who show permanent damage to their brain, eyes, and ears; and who are in the Resolution versus Vegetation stage Feil has developed. VT was not developed for people who are oriented to person, place or time, are mentally handicapped, have a history of mental illness, or have suffered an organic trauma (i.e. aphasia after a stroke or fall) (Feil, 1993). Feil incorporated humanistic psychology therapies, Gestalt, T.A., and the writings of Carl Jung into VT.

Validation therapy is based on ten underlying beliefs. 1. All people

are unique and must be treated as individuals. 2. All people are valuable, no matter how disoriented they are. 3. There is reason behind the behavior of disoriented people. 4. Behavior reflects a combination of physical, social, and psychological changes that take place over the lifespan. 5. People cannot be forced to change their behaviors. 6. People must be accepted nonjudgmentally. 7. Failure to complete developmental tasks at earlier stages of life may lead to later psychological problems. 8. When recent memory fails, older adults try to restore balance by retrieving earlier memories. When eyesight fails, they use the mind's eye to see. When hearing goes, they listen to sounds from the past. 9. Painful feelings that are expressed, acknowledged, and validated will diminish. Painful feelings that are ignored will gain strength. 10. Empathy builds trust, and restores dignity (Feil, 1993).

Feil is so convinced of the importance of validating feelings in order to facilitate the resolution of one's life, she added a ninth stage, resolution versus vegetation, to Erikson's developmental framework (Jones, 1985). Feil (1992b, 1993) proposed four stages of resolution consistent with the progression of dementia. Many different physical and psychological characteristics define each stage (see Appendix A). The first is Malorientation, where one is unhappily

oriented to reality. These people need to complete an unresolved relationship and use people in present time to express emotions they have not expressed in the past. Blaming, accusing, whining, and hoarding are some of the familiar ways in which Maloriented people cope when things go wrong. The second stage is Time Confusion, where people lose more cognitive capacities. They suffer from increasing deterioration to the brain; have varying degrees of difficulty in walking, hearing, and seeing; and have lost the ability to keep track of chronological time. The third stage of Resolution is Repetitive Motion, where movements replace speech. Damage to rational thinking frees nonverbal expression and motion stimulates emotion. Speech becomes unintelligible and the lips, tongue, jaw, and teeth move freely to create new words. The last stage is Vegetation, where there is a total retreat inward. Once the stages are understood, the recommended communication strategies follow logically (Jones, 1985). Although a person may fluctuate between stages during the day, this classification helps recognize what stage a person might be in at the moment in response to physical and psychological cues.

Feil stresses that the validation worker need not be a trained professional because validation is as much an approach to being with a person as it is an

attempt to try to understand people who otherwise have difficulty communicating (Jones, 1985). The techniques of VT are simple and require no more than eight minutes a day of genuine, empathic listening (Feil, 1993). The first technique that should begin all VT sessions is centering because it is crucial to release one's own emotions in order to be able to listen empathically. Feil (1993) explains 13 more VT techniques, including using nonthreatening, open gestures; rephrasing; using polarity; imagining the opposite; reminiscing; maintaining eye contact; using ambiguity; mirroring; linking the behavior to an unmet need; identifying and using the preferred sense; touching; and using music. The techniques are used slightly differently depending on the different stages of dementia.

Validation helps older adults who are disoriented as well as their caregivers. People who are validated undergo less inward regression; they communicate verbally and nonverbally more effectively; they cry, pace and wander less; they have a reduced need for chemical and physical restraints; their stress and anxiety are reduced; a sense of humor is restored; there is an increased awareness of reality; and one can facilitate longer independent living (Alprin, 1980; Dietch, Hewett, & Jones, 1989; Feil, 1982, 1992; Fritz, 1986; Kim, 1991; Morton & Bleathman, 1988; Peoples, 1982; Sharp & Johns, 1991). For

professional caregivers, validation can reduce frustration; prevent burnout; promote joy in communicating; increase job satisfaction; increase positive skills such as using lower tones of voice, eye contact, touching, and using the patients' name; improve relationships with their own parents and grandparents; and result in talking with families of the patients more (Alprin, 1980; Feil, Schove, & Davenport, 1972; Prentczynski, 1991; Rubin, 1982). Families who learn validation often experience less frustration, visit their disoriented relatives more, begin to understand their own children better, and examine their own responses to aging (Alprin, 1980; Ronaldson & McLaren, 1991).

Validation is both similar to and different from the other therapies used with elderly who are disoriented. These other therapies include reminiscence, life review, reality orientation, behavior modification, diversion, and psychotherapy. Most important differences are that the caregiver never confronts, never tries to give insight, never orients, never uses reinforcement, and never teaches (Feil, 1993). In comparisons of VT with reality orientation, Peoples (1982) and Dietch, Hewett, and Jones (1989) found that validation was more effective. Reality orientation, was found to be less effective than other techniques (MacDonald & Settin, 1978; Zepelin, Wolfe, & Kleinplatz, 1981; Voelkel, 1978), or had adverse

effects (Dietch, Hewett, & Jones, 1989).

The present study was conducted to expand the body of research on the effects of VT with institutionalized elderly. The purposes of the study were to evaluate and describe the effects of VT for the first three stages of dementia over a four week period by sampling an individual's behavior and impressions. It was expected there would be improvement in achieving personalized treatment goals. After suspending VT for at least one week, it was hypothesized there would be possible deterioration or no improvement in achieving treatment goals.

Method

Subjects

Three geriatric patients with moderate to severe dementia from Mendota Mental Health Institute, a state psychiatric hospital, participated in this study. All subjects met the criteria as described by Feil (1993) for use of validation. Each was in a different stage of Resolution: Malorientation, Time Confusion, or Repetitive Motion.

Maloriented Case History

Mr. M. was a 78-year-old, Caucasian, married male with a diagnosis of Alzheimer's-type dementia. He also had a seizure disorder, arthritis, and untreated

prostate cancer. He had been at Mendota since 8/26/94 and was given VT starting on 2/7/95. He was admitted under an emergency detention after having called the police with suicidal statements. He was agitated at the hospital, where he said if he had a gun, he would "blow my head off." For several early years of dementia, he was cared for at home by his wife and step-daughter. Although he was admitted to a psychiatric unit twice in the recent past because of erratic behavior, he had no prior psychiatric history.

Mr. M. was born in Southern Wisconsin, the fourth of six children, with Swiss parents. He grew up on a farm with two step-siblings. According to his wife, he had a very good childhood. They were married in 1940, and had no children, but his wife had a daughter who he helped raise. Mr. M. was Catholic, had no history of being abused, was a social drinker only, and had an eighth grade education. He retired at age 65 from a cheese factory. In addition to the physical and psychological characteristics of Malorientation (see Appendix A), Mr. M. had unique strengths and weaknesses. He ambulated independently, was continent, had adequate hearing, fed himself, and enjoyed television. His weaknesses included his seizure disorder, prostate cancer, past suicidal ideation, self-isolation, chronic constipation, and aggressiveness.

Mr. M. completed numerous assessments given by the unit's psychologist, who did not know what patients were used for research. On the Geriatric Depression Scale (GDS) (Yessavage et al, 1983), he scored a 28, suggestive of severe depression. On the Barthel Self-Care Assessment, he scored a 50 out of 100. He showed moderate to severe cognitive impairment on a screening for organic mental syndromes (Jacobs et al, 1977), obtaining a score of 15 out of 30. The Mini-Mental State (MMS) (Folstein, et al, 1975), which assesses orientation, registration, attention, recall, and language, suggested severe cognitive impairment as well. His personalized treatment problems included aggression, aftercare, suicidal ideation, social isolation, leg edema, social adjustment, and recently bizarre behavior and unsteady gait.

Time Confused Case History

Dr. R. was a 78-year-old, Caucasian, married male with a diagnosis of Alzheimer's-type dementia. He also had a number of medical conditions including paroxysmal atrial fibrillation, status post laproscopic cholecystectomy, status post bilateral hip replacements, and status post vein ligation. He was admitted to Mendota on 2/13/95 under an emergency detention and had been seen for VT starting on 3/3/95. He was admitted from a nursing home after an alleged

strangulation death of a peer. However, sources suggested this was not an act of overt aggression as much as a possible misunderstanding or attempt to help the peer remove his protective helmet.

Dr. R. graduated from medical school and was a dermatologist in a mid-size Wisconsin city. He retired in 1984 due to beginning memory problems. He was a veteran and a former Army captain. He had no history of abuse, alcohol problems, or past psychiatric history. He had a close and supportive relationship with his wife and four grown children. Both of his parents had memory problems before they died. He was first diagnosed with Alzheimer's in 1992 and had several incidents of violent behavior. He was unable to express any understanding of his admission. Among the physical and psychological characteristics of the Time Confused stage (see Appendix A), Dr. R's most distinguishing features were his soft, slow voice, his confusion with vocabulary (word salad, searching, repeating, and replacing), and his posture. Dr. R's facial expression, body language, and voice intonation suggested that some receptive language was intact. Among his strengths were his supportive family, his ability to ambulate and feed himself, his politeness, his sense of humor, and his ability to remain continent if toileted every two hours. However, he had a recent history of

violent and aggressive behavior associated with his progressive dementia, he sundowned, and had difficulty communicating clearly. Dr. R. was unable to complete the GDS and the Jacobs. He scored a 3 out of 30 on the MMS, suggesting severe cognitive impairment. He obtained a 50 on the Barthel Self Care Assessment. His clock drawing also suggested severe cognitive impairment. His personalized treatment problems included aggression, aftercare, unsteady gait, and social adjustment.

Repetitive Motion Case History

Mr. V. was an 83-year-old, Caucasian, married male with a diagnosis of Alzheimer's-type dementia. His medical conditions included withdrawal dyskinesia, history of EPSE's, cardiac arrhythmia, and hearing impairment. He was admitted on 3/12/91, and was seen for VT on 10/11/94. His admission followed a two-week period of decompensation at nursing home, where he had exhibited aggressiveness towards staff and peers, and catastrophic reactions.

Mr. V. was born in Ohio, was Catholic, and was a high school graduate. He was a welder and a veteran of the Marines. Mr. V. married for the first time while in his 50s and had no children. After his first wife died, he lived in Florida with his second wife, whom he married in 1984. He had no history of being

abused and rarely used alcohol. He had no psychiatric history prior to the onset of dementia in 1986. Mr. V. displayed all of the physical and psychological characteristics of Repetitive Movers (see Appendix A). His most prominent movement was swinging his legs, moving furniture, folding linens, banging on windows, and removing his clothes. He previously spent about 22 hours a day locked in his room alone until his treatment plan was changed. He responded best to low stimulation. His strengths were that he ambulated with assistance, tolerated interactions, passively participated in group activities, and was able to express himself more clearly when he was in a good mood. However, he had cardiac insufficiency, syncopal episodes (fainting), unpredictable aggressive behavior, was incontinent, and did not usually speak. Due to his expressive and possible receptive language impairments, it was not possible to perform any formal psychological assessment. He scored a 30 on the Barthel in 1995. His personalized treatment problems were aggression, dry eyes, fall risk, and social adjustment.

Measures

Ratings sampled the domains of each patient's personalized treatment plan. The plan consisted of a Likert-scale (including deterioration, no change, some

improvement, or significant improvement) that rated improvement of personalized treatment goals. Ratings were made by the consensus of the multidisciplinary team which was unaware which members received VT. The team consisted of a psychologist, psychiatrist, social worker, occupational therapists, recreational therapists, and nursing staff. Although all three subjects had problems of aggression, aftercare, and social adjustment (the VT and counseling goal), other problem areas were individualized.

Procedure

Prior to the introduction of the treatment, members were classified by the experimenter into one of three validation stages (Malorientation, Time Confusion, or Repetitive Motion) using specific physical and psychological characteristics (see Appendix A). Although Vegetation is the last established stage, it was not used in this study because no patients at this hospital fit this classification. All VT was given by this experimenter, a 23-year-old, Caucasian, female who is fulfilling a practicum requirement at Mendota for her Master's in Counseling Psychology.

Validation therapy was conducted using specific verbal and nonverbal techniques designed to fit the stage of disorientation exhibited (see Appendix B).

Each member received individual VT two times a day for at least ten minutes, at least three times a week. The members received VT in addition to traditional hospital care. Traditional hospital care consisted of routine treatment given to all geriatric patients at Mendota, including drug and medical therapy, nursing care, occupational therapy, limited recreational therapy, and contact with a social worker. None of the staff knew which patients were being used for research. Although the patients received different drug therapy from the psychiatrists, no major changes in medication were given during this research period.

For the Maloriented and Time Confused subjects, premeasures of treatment plan problems were obtained for three weeks prior to the introduction of VT in order to form a baseline. After the intervention, VT was suspended for one week in order to monitor improvement or deterioration. Counseling services were not discontinued and the patients received traditional hospital care as usual. The Repetitive Motion subject had been seen for VT prior to the beginning of research. Therefore, a three week baseline of VT was obtained, then behavior during a three week suspension of VT was monitored, and VT returned. The experiment took place on the Geropsychiatric Unit at Mendota Mental Health Institute in Madison, Wisconsin.

Results

Maloriented

For ease of interpretation, Figure 1 charts the progress of treatment goals

for Mr. M. according to dates of research.

Insert Figure 1 about here

An ABA (baseline, intervention, baseline) single subject design was used because Mr. M. had not previously been seen for VT. During the initial baseline dates, Mr. M. mostly isolated himself in his room, and did not participate actively in group or individual interactions. He exhibited deterioration in both aggression and suicidal ideation. He was verbally threatening and physically aggressive to peers and staff, requiring seclusion in a locked room several times. His sister's death had a negative impact on Mr. M. He deteriorated further becoming more aggressive and exhibiting suicidal ideation. He also displayed many of the Maloriented stage coping styles such as blaming, accusing, and hoarding. Staff and peers were visibly frustrated.

During VT, techniques of trust building, rephrasing, using polarity, imagining the opposite, and reminiscing were used. He spoke of his sister's death, his work at the cheese factory, and was quite pleasant during short interactions. When told that this experimenter would come periodically to talk, he said "Oh, yes, that's so nice." This politeness was previously very rare. During the course of treatment, he often made requests for simple things like a phone call or his robe, and said it would be "our secret", demonstrating increasing trust. He later

talked about many feelings, which is uncommon for the Maloriented stage, such as his love for his wife, sadness over his sister's death, his confusion and frustration over his memory loss, and that he "only wanted to be treated like a human being." Improvement was made in all treatment goals except aftercare. He was less aggressive to staff and peers, required less seclusion, and no suicidal ideation was present since the start of VT. His social isolation problem was discontinued because he no longer spent extended time alone in his room. This goal was switched to social adjustment and some improvement was noted. He refused fewer occupational therapy activities and interacted actively in individual sessions.

After VT was suspended, Mr. M. began to display many psychotic-like behaviors, and a new treatment goal was made. He would shield his eyes with a handkerchief or pillow from the "radiation particles" in the air. He walked with a cloth, which was "the holy grail," under his feet to keep his feet from "burning." Aftercare goals deteriorated and he was increasingly unsteady. A new treatment problem was written for unsteady gait because he paced in a driven manner, ran into doorways, lost weight, and fell one time. He tolerated fewer interactions overall, would give short answers, and often spoke tangentially, soft, and fast. One week after suspending VT, there were no improvements in suicidal ideation, social adjustment, or bizarre behavior. Although the etiology of this behavior is unclear, VT resumed after one week in order to help Mr. M. adjust.

Time Confused

For ease of interpretation, Figure 2 charts the progress of treatment goals for Dr. R. according to dates of research.

Insert Figure 2 about here

An ABA (baseline, intervention, baseline) single subject design was used because Dr. R. had not previously been seen for VT. During the initial baseline dates, Dr. R. was mildly aggressive with staff during nursing cares, and mildly aggressive with intrusive peers when confused. After some improvement in aggression, there was deterioration and he was secluded several times. Aftercare and unsteady gait problems remained unchanged during the entire baseline. There was no counseling goal of social adjustment prior to VT because he had not been seen for psychological services.

Dr. R. was very cooperative and receptive to VT when it was introduced. He spoke in a very soft, slow voice, was often hard to understand, and displayed classic Time Confusion characteristics. He often demonstrated memory of doctor skills, such as asking if someone needed his signature, searching for the "medicine and supplies," and making correct dermatological observations of peers. He was extremely polite, saying "I don't want to be a bother, but . . ." He also used the words "fish" and "voting" many times to replace other meanings. Although his

number of aggressions to staff and peers increased during the beginning of VT, he was never threatening or aggressive during VT interactions. Also, there was improvement in aggression towards the end of five weeks of VT, and he was better in group occupational therapy activities.

He improved in all other treatment problems. Regarding aftercare, numerous contacts and discharge placement opportunities were being considered. Regarding unsteady gait, he had no falls and was increasingly cooperative with physical therapy and redirection. Regarding the counseling goal of social adjustment, it was found he responded best to touch, mirroring, eye contact, and rephrasing among all techniques used. Although he was unable to use precise words to communicate needs, he was able to expand and elaborate on what he wanted when asked factual questions. He not only knew what he needed, but he often asked for help in getting his needs met. For example, he said, "I'm looking for bedtime, can you help?" when he wanted to lie down for a nap. He was sometimes aware of his confusion, but always demonstrated a good sense of humor. He smiled and laughed often, sometimes appearing to respond to internal stimuli. He often misinterpreted his environment in a distinctly demented manner. After extensively describing his perception, he said, "Those are all of my fears. Thank you for listening, even if it isn't your problem."

One week after suspending VT, Dr. R. deteriorated in regard to aggression. He was more aggressive to both staff and peers. All other problems

remained unchanged.

Repetitive Motion

For ease of interpretation, Figure 3 charts the progress of treatment goals for Mr. V. according to dates of research.

Insert Figure 3 about here

Mr. V. was seen for VT prior to the beginning of research. For this reason, VT was suspended while the experimenter was gone for Christmas break. Subsequent to her return, VT was reinstated. Results indicated there were many changes in all of his treatment problems during the time that Mr. V. received only traditional hospital care.

During the first treatment period, aggression and aftercare goals were stable. He was physically aggressive towards staff about 80 times per month, almost always from his confusion which precipitated a catastrophic reaction during nursing cares. Discharge placements were not being considered because of his extensive need for a gerichair and seclusion. During 11/8-11/21, he was brought out of his room for more of the day in order to increase the possibility of future placement. His fall risk problem deteriorated further. His social adjustment problem was improving. He was quite talkative, said he liked being out of his room more, and asked "Can you help me?" before attempting to state a

need. Characteristic of a Repetitive Mover, his speech was generally incoherent. He was usually in a pleasant mood and often made eye contact. Validation techniques of eye contact, touch, voice tone, using ambiguity, mirroring, and music were used. He tolerated interactions with a positive affect.

Unfortunately, during the suspension of VT, Mr. V. experienced a general medical decline. He had a syncopal episode with periods of apnea due to cardiac arrhythmia, and suffered a fall that required six sutures. He complained of "feeling lousy," was less alert, and had an irregular sleep pattern. Before his falls, he was much more aggressive. After the falls, his aggressiveness declined. Staff believed that this was because of his physical decompensation. Aftercare and discharge became more likely because of his decreased aggressiveness and little need for seclusion. His problem of social adjustment deteriorated at this time because of a decline in the quality of his interactions and communication.

Upon the return of VT, he was mostly unresponsive, with limited verbal and nonverbal communication. He was unable to release his grip on an arm or an object upon request. However, he smiled often, possibly responding to internal stimuli. His repetitive movements increased, and he once said "It's not easy. Sometimes it's hard." Mr. V. began to respond best to sensory stimulation, touch, mirroring, reflecting, and eye contact. Gradually, eye contact and intelligible speech increased. He was much more responsive when well rested, after meal time, and when in a good mood. On Valentine's Day, he said he would "eat and

stuff." Commenting on a necklace worn by the experimenter, he said "I have a calf for you" and made a circle in the air, demonstrating an increased awareness of his surroundings. Since 2/28, he expressed himself more and communicated his needs by squinting at the television and saying "too far ahead." Although he had significant hearing and vision deficits, he became more alert and clear, and he waved to people or objects passing by. By the end of the research period, he sat upright and forward, expressed contentment both verbally and nonverbally, was much less aggressive, and expressed appreciation of social contact by saying "thank you" and shaking hands. Aftercare possibilities, social adjustment, and aggression improved and fall risk leveled off. After one and a half months of VT which had been started after his falls, Mr. V. began to make significant improvement in social adjustment.

Discussion

The results supported the hypothesis that Validation Therapy was beneficial for dementia patients and that suspending VT had a negative impact on improvement of treatment problems. Validation had different effects on each subject because they each had personalized treatment problems and they represented three different stages of dementia. The treatment plans were the most important tool to determine improvement. It is hoped that this study has expanded the limited body of research on VT.

Mr. M., in the Maloriented stage, showed some improvement in

aggression, suicidal ideation, and social adjustment with VT. When VT was suspended, he deteriorated in aggression and aftercare potential. Most importantly, two new treatment problems were identified after VT was suspended because of other physical and mental deterioration. He began to have unsteady gait and bizarre behavior. The results of this study did not seem to suggest that the onset of bizarre behavior was related to suspending VT. No other subjects experienced bizarre behavior and it has never been documented as an effect of suspending VT. The etiology of this behavior is unclear. Other possible reasons for Mr. M.'s decline in functioning were possible infections, effects of worsening prostate cancer, or poor sleep pattern.

Dr. R., in the Time Confused stage, improved in all treatment goals after he was seen for VT. Discharge placement was being considered, he improved in unsteady gait, and he communicated his needs and his desire for help. Eventually, after a series of deteriorations his aggression improved. After VT was suspended, he no longer improved in aftercare potential, unsteady gait, or social adjustment, and he deteriorated in aggression.

Mr. V., in the Repetitive Motion stage, did not have the same design as the other two subjects because he had been seen for VT prior to the study. During suspension of VT over Christmas break, he had a general health decline and his treatment goals fluctuated greatly. The most obvious benefit of VT for Mr. V. was how all treatment problems stabilized or improved. Fall risk, aggression, and

social adjustment improved and stabilized after VT was restarted and aftercare potential increasingly improved.

Validation had many of the benefits shown by other researchers (Alprin, 1980; Dietch, Hewett, & Jones, 1989; Feil, 1992, 1993; Morton & Bleathman, 1988; and Peoples, 1982) such as improved speech, less repetitive behaviors, more expressive verbal and nonverbal communication, and less need for physical and chemical restraints. Some measurable results of VT are improved gait, sitting more erect, less aggression, and more eye contact (Feil, 1993). All three subjects showed improvements. In addition, according to Feil (1993) other results that are nonmeasurable may include resolving life tasks, less withdrawal, reduced anxiety, greater self-worth, increased awareness of reality, and restored humor. Although this study did not formally monitor these behaviors, they were all noted. It was possible that there was more improvement in nonmeasurable than measurable results.

Certain external variables were controlled for in this study. First, all VT was given by one counselor, so all techniques were used consistently. Although the experimenter was not certified in VT, Feil (1993) stressed that one need not be a trained professional to perform validation. Validation was given only after all possible adjustment reactions to being admitted to a psychiatric hospital were worked through. However, the setting (room, time of day, etc.) varied each time VT occurred. However, all VT consistently took place on the same unit. The

multidisciplinary team who rated improvement in treatment goals was highly skilled, professional, always consisted of the same people, and did not know which patients were being studied. Unfortunately most nurses, including Mendota staff, are trained in Reality Orientation. It was undetermined if their use of Reality Orientation negatively affected the results of VT.

The ABA design represents the simplest single subject research paradigm for demonstrating cause-effect relationships. If after baseline measurement (A) the application of a treatment (B) leads to improvement or conversely results in deterioration after it is withdrawn (A), one might conclude that the treatment variable could have been the agent responsible for observed changes in target behavior (Tawney & Gast, 1980). It probably unlikely that changes observed in this study were due to influences (e.g. some correlated or uncontrolled variable) other than the treatment variable that was systematically changed. Therefore, the improvements in treatment problems, and patients' subsequent declines upon suspending VT, are more likely to be related to the effects of VT.

The ABA design had many advantages. Because the use of a single-subject design for evaluation required repeated data gathering, it enabled the counselor to become aware of changes as the process was "going on" (Cetingok & Hirayama, 1983). This awareness is available to the counselor for more informed care. Since the ABA design allowed for functional analysis of behavior, the intervention may be responsible for changes in target behavior, instead of just a

correlational interpretation. This study replicated the results three times with three different dementia patients. These replications enhanced the external validity of the findings. The most generalizable findings are the improvements gained with the initiation of VT. However, all members represented European-American heritage. Therefore, it is uncertain how they generalize to dementia patients of other cultures. Unfortunately, no research has been done in this area.

There were some limitations to this study. Although the ABA design permitted a functional, rather than a correlational analysis of behavior, there was a remote chance that the introduction and withdrawal of the independent variable coincided with naturally occurring cyclical variations of the target behavior. Some patients had coinciding drug therapy. Although there were no major changes in medication, some improvement may have been a result of an interaction of traditional hospital care and VT. There are practical as well as ethical problems associated with terminating a study in a baseline condition. However, VT was suspended for only one week in the cases of Mr. M. and Dr. R. Termination coincided with a pre-planned absence over Christmas with Mr. V. During this time, all counseling services were not discontinued and all patients received traditional hospital care.

There are a few reasons that make evaluation of VT difficult. First, many results of validation are not easily measurable. Most severe dementia patients are unable to complete present assessment tools that would measure variables such as

anxiety, self-worth, or withdrawal. Therefore, effectiveness will most likely be shown from subjective instead of empirical data. Secondly, although there is recent interest in evaluative research of psychosocial programs, most students are not taught how to do single-case design or qualitative studies. Finally, most nursing and other staff are not trained in VT and may not even be aware of its use with dementia patients.

If this study were to be replicated, a few changes should be made. Nursing staff and other caregivers should be trained in VT. Therefore, no contamination by possible adverse effects of Reality Orientation would be present. This could provide patients with as much improvement as possible. Also, frustration and job related stress could be alleviated. It might also be beneficial to involve more subjects to allow stronger generalization. It would be interesting for caregivers to use self-rating forms on their own frustration or satisfaction in order to evaluate the benefits for caregivers during the VT process. Also, since many benefits for dementia patients are not measurable, techniques should be devised in order to systematically evaluate improvement in such variables as humor, withdrawal, or resolution.

The most important findings from this study were the personal and professional benefits received as a caregiver. As outlined previously in the introduction, validation has many benefits for caregivers, such as reduced frustration and burnout, increased positive communication skills, and increased

job satisfaction (Alprin, 1980; Feil, 1993; Morton & Bleathman, 1988). This study upheld these positive outcomes. This researcher had never witnessed any other therapy that has so many benefits for professional caregivers and families, without involving added individual therapy, extensive training, or family therapy. Validation gives invaluable techniques for communicating with this special growing population of older adults. Validation gives permission to listen, to time travel, and to accept altered psychological and emotional states. It provides concrete and specific communication tips to use at times when nothing else seems to work, and it gives hope. Although validation is a relatively new therapy, its use is growing because of personal testimonies of its success. Validation's effectiveness is being spread by word of mouth faster than by research studies.

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Physical Characteristics of Malorientation:

- Eyes are clear and focused.
- Stance is rigid.
- Movement in space (even in a wheelchair or with a walker) is definite, sustained, precise.
- Face and body muscles are tight.
- Jaw often juts out.
- Fingers and hands are often pointing. The arms often folded.
- Lips are tight.
- Breathing is shallow.
- Voice tone is clear, harsh, whining or shrill.⁴⁷
- Often clutch a coat, cane, or purse.
- Cognitive ability is relatively intact, can categorize, have a concept of clock time.
- Read, write, figure. Use dictionary words.
- Losses to sight, hearing, tactile sensation, mobility are relatively minor.

Psychological Characteristics of M.

- Need to express bottled up emotions.
- Hold onto present reality.
- Want to understand and to be understood.
- Play games with rules.
- Are aware of occasional confusion.
- Deny confusion or confabulate (make up stories to fill gaps)
- Hear, see, talk and move fairly well. Listen.
- Resist change.
- Deny feelings (such as loneliness, rage, fear, sexual long).
- Blame others when losses become great.
- Can not achieve insight into the reasons behind behavior.
- Want validation from authority: staff, friends, family, doctor etc.
- Get furious at others who cannot or will not use self-control.
- Resent touch and intimacy. Do not want their vulnerability exposed.
- Use a "kinesphere", an invisible circle that surrounds every person. Maloriented people feel protected by an inviolable sphere of about 20 inches around the body.

Stage Two: Time Confusion

Physical Characteristics of Time Confusion:

- Muscles are loose. Graceful movements.
- Eyes are clear, but often unfocused, gazing into the distance.
- Breath is slow, sustained.
- Movement in space is slow, indirect, and often questioning: Which way?
- Speech is slow.
- Hand gestures match the feelings, often questioning.
- Voice tone is low and even, seldom whiny or harsh.
- Shoulders tend to slump forward, neck down. The person often shuffles when walking.

Psychological Characteristics of Time Confusion:

- Reality is blurred because of increased deterioration of rational thinking, eyesight and hearing.
- Capable of expressing emotions, but do not remember facts.
- Metaphoric thinking is lost. They do not put people or objects in accepted categories, cannot compare.
- A lifetime of experience has given them crystallized wisdom; they return to an intuitive knowing.⁴⁸
- Know who is genuine and who pretends.
- Remember sensory, pleasurable feelings from childhood.
- Do NOT listen to people in the present.
- Forget recent events, but have excellent recall for past events that hold strong feelings.
- The energy focus is to resolve past unfinished conflicts, to trigger feelings of usefulness and pleasure.
- Use unique word forms from early memories, are poetic and creative. See the "Symfile" story on page 25.
- Cannot play games with rules (such as Bingo).
- Tell time by personal feelings, not by the clock. Time is measured by lifetime experiences.
- Use pronouns without specific references. "He" can refer to God, father, devil, self-identity, the world, authority, masculinity, etc.
- There is an increasing use of symbols to represent people and events remembered from the past. They think in (eidetic) images rather than words.
- Respond to nurturing touch and eye contact with decreased stress.
- Often lose the ability to sing on key.
- Often retain the ability to read, but lose the ability to write.
- Have a short attention span.
- Hear sounds clearly from the distant past, especially when they are deaf.
- Lose adult controls, often demanding immediate satisfaction, instincts such as sex, love and food.

Figure Caption

Figure 1. Mr. M. (Malorientation) progress of treatment goals during treatment periods.

Figure 2. Dr. R. (Time Confused) progress of treatment goals during treatment periods.

Figure 3. Mr. V. (Repetitive Movement) progress of treatment goals during treatment periods.

Figure 1: Mr. M.

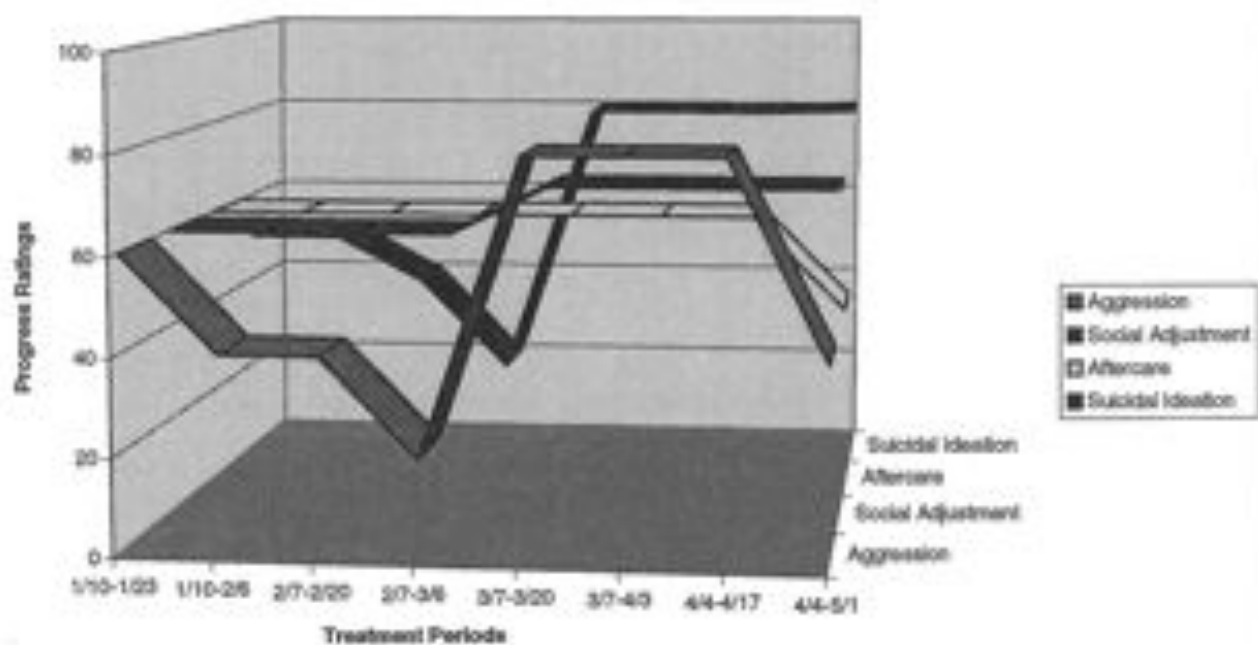


Figure 2: Dr. R.

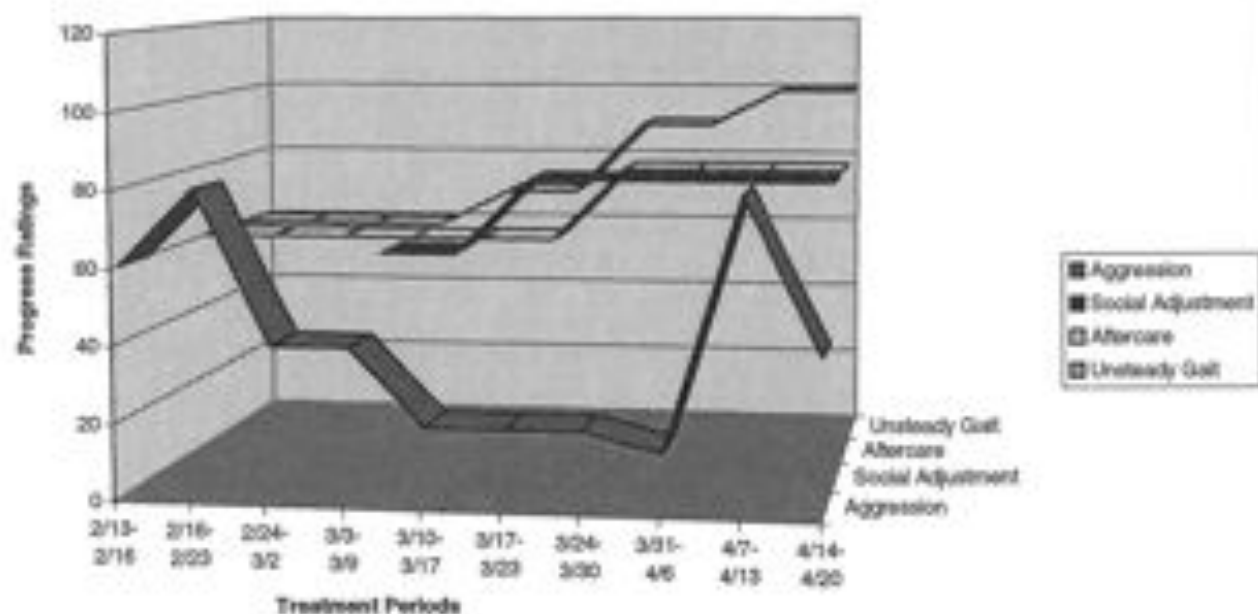
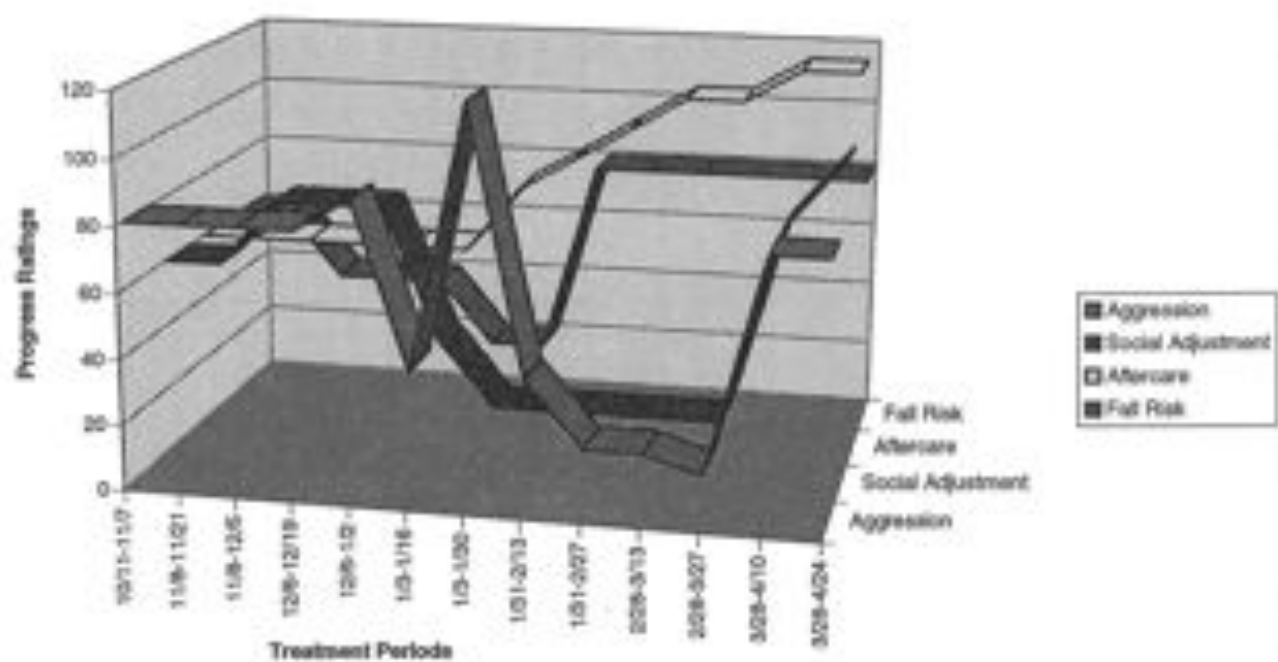


Figure 3: Mr. V.



Appendix B

Techniques of Validation

1. Centering
2. Using nonthreatening, factual words to build trust (who, what, where, when, and how)
3. Rephrasing
4. Using polarity
5. Imagining the opposite
6. Reminiscing
7. Maintaining genuine, close eye contact
8. Using ambiguity and non-dictionary words
9. Using a clear, low, loving tone of voice
10. Observing and matching the person's motions and emotions (mirroring)
11. Linking the behavior with the unmet human need
12. Identifying and using the preferred sense
13. Touching
14. Using music

Malorientation

- A. Use Validation techniques: 1, 2, 3, 4, 5, 6, and 12
- B. Use minimal touch
- C. Maintain social distance

Time Confusion

- A. Use Validation techniques: 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 13, and 14
- B. Use feeling words (I see..., I feel...)
- C. Use touch and eye contact

Repetitive Motion

- A. Use Validation techniques: 1, 7, 8, 9, 10, 11, 13, and 14
- B. Use touch and eye contact
- C. Pace to person's movements