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The Validation Training Institute

Who Can We Validate?

The population for Validation and dementia diagnoses

a booklet written by Validation Teachers and Masters for Validation Teachers and Masters

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Introduction

Validation teachers are often faced with the questions: Why can't Validation be used with people who have early onset Alzheimer's disease? Why can't we use Validation with people who have Down's syndrome, who at age 60 seem to show signs of dementia; or those who have Korsakoff; fronto-temporal dementia (which includes Pick's disease and several other subtypes); or middle-aged people who have cancer and are in the final stage of life?

Validation Teachers and Masters from France, Austria, Germany, Japan, Belgium and VTI got together at the 2014 EVA Teacher meeting in Paris and asked ourselves these questions and brought together our collective experiences with using Validation with populations other than Maloriented and disoriented elderly. Over the next year we tried to come up with some guidelines.

The following booklet is meant to be a useful guide to Validation Teachers and Masters in answering these questions.

We begin by describing the various forms of dementia and their defining characteristics. Then a summary of the relationship between Validation theory and these medical diagnoses follows. We also include case studies describing our experiences using Validation with different individuals who do NOT have a diagnosis of late onset Alzheimer's and do not fit into the traditional population that most benefits from Validation. From these case studies, we were able to identify a few, clear guidelines for using Validation.

We all know the goals of using Validation, but which of these goals are realistic for working with other types of people? These are discussed in the next section. And finally, we offer some suggestions for using this extra information when teaching or presenting Validation.

We hope this booklet is useful to you and hope you will send us feedback. Please feel free to send your experiences using Validation with other populations. Additionally, please send feedback on how we can make this booklet more useful to you.
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Different types of dementia – their defining characteristics

Dementia is a syndrome that is caused by a number of different illnesses: vascular dementia, early onset Alzheimer's, late onset Alzheimer's, Lewy body dementia, frontotemporal dementia (used to be called Picks disease), Korsakow, Parkinson's and so forth.

We now know that older people, who have cognitive impairment, have a combination of illnesses. Vascular damage is found in most brains of people over 80 years old. Alzheimer plaques and tangles are found in most brains of people over 80 years old. We can no longer speak of older people having only Alzheimer's disease or vascular dementia. Almost everyone has a mixture of issues. This fits in with Validation theory, that disorientation in later life is a combination of physical, psychological and social problems.

Different types of dementia – their defining characteristics
As of this writing, there have been updates of the two majorly used diagnostic manuals, the DSM-V and the ICD 10 CM. This section discusses the updates and diagnoses they include and gives characteristics of those most often seen in older people.

<table>
<tr><th>ICD-10 CM draft (2015)</th><th>DSM-V (2012)</th></tr>
<tr><td>The term 'dementia' is defined as 'a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions…' Each of the following diagnoses is further differentiated by: 'with behavioral disturbance' and 'without behavioral disturbance.'</td><td>The term'dementia' is replaced with Neurocognitive Disorder (NCD). Each of the following diagnoses is further differentiated by: 'major' or 'minor.' [1]</td></tr>
<tr><td colspan="2">A diagnosis of dementia or NCD is made when there is impaired cognition that has not been present since birth or very early life. Impaired cognition can be in one or more of the following domains: complex attention, executive function, learning and memory, language (including word finding and understanding), perceptual-motor skills (using tools, driving and orientation), and social cognition (i.e. the rules and social conventions that enable individuals to stay together.)</td></tr>
<tr><td><u>Diagnoses or etiologies IDC 10</u>
Vascular dementia
Alzheimer's disease with early onset, with late onset</td><td><u>Diagnoses or etiologies DSM 5</u>
Alzheimer's disease
frontotemporal NCD (neurocognitive disorder)
NCD with Lewy bodies</td></tr>
</table>

[1] From 'A Guide to DSM-V: At the DSM-5 press conference, Dr. Dilip Jeste -- at that point still APA president -- referred to the movement among some psychiatrists to retire the term "dementia" for stigmatic reasons, the literal Latin translation being "without mind." Jeste pointed out that not only does the term hold negative connotations, but it is also simply inaccurate; many patients with diagnosed "dementia" maintain faculties, awareness, and haven't actually "lost" their mind.

It is interesting to compare this 2013 statement to what Naomi Feil wrote in 1982: 'Disoriented old-old are not 'demented' They have intuitive wisdom to survive by restoring the past.' In every workshop since the late 1970s, she explained that dementia means 'without mind' and these people are not without their minds, they are without orientation in our reality.

Cerebral lipidosis Creutzfeldt-Jakob disease Dementia with Lewy bodies Epilepsy and recurrent seizures Frontotemporal dementia (including Pick's disease) Hepatolenticular degeneration HIV disease Hypercalcemia Hypothyroidism Intoxications Multiple sclerosis Neurosyphilis Niacin deficiency (pellagra) Parkinson's disease Polyarteritis nodosa Systemic lupus erythematosus Trypanosomiasis Vitamin B deficiency Unspecified dementia (presenile dementia and senile dementia) Korsakow's syndrome	vascular NCD NCD due to traumatic brain injury substance/medication-induced NCD NCD due to HIV infection NCD due to prion disease (Creutzfeldt-Jakob disease, Gerstmann-Straussler-Scheinker disease) NCD due to Parkinson's disease NCD due to Huntington's disease NCD due to another medical condition NCD due to multiple etiologies unspecified NCD

From this long list of diseases that all have similar symptoms, the ones we will focus on are: Alzheimer's (early and late onset), vascular, Lewy bodies, Parkinson's, and fronto-temporal dementia. The other diagnoses affect such a small percentage of elderly people and so, are less relevant to our discussion.

<u>Early onset Alzheimer's disease – defining characteristics</u>

- Begins anywhere between 40 and 65 years of age.
- Decline in both short term and long term memory.
- Inability to learn new things (working memory doesn't function well).
- Steady, progressive, gradual decline in cognition without plateaus.
- Ability to find words and communicate verbally declines quickly (usually within 3 years).
- Emotional outbursts (without motivation) occur frequently in later stages.
- Mask-like expression or lack of expression.
- Stiff, robot like movements.

<u>Late onset Alzheimer's disease – defining characteristics</u>

- Begins anywhere between 75 and 80+ years of age.
- Decline in short term memory; long term memory remains mostly intact.
- It is possible for there to be plateaus in decline; decline is dependent on physical deterioration, psychological support or lack thereof and the environment.
- Can remain verbal until the end.

- Emotions and needs are expressed increasingly without filters or social controls.
- Inner, personal reality becomes stronger than the external reality.

Vascular dementia – defining characteristics

- Begins usually between 60 and 80 years of age.
- Symptoms depend upon where the brain is damaged: short term and long term memory, verbal expression, making choices, personality changes, ability to focus, concentrate, perception, ability to use objects, emotional lability, and recognition of emotions.
- Sometimes it looks like the person disappears for moments.
- Personality changes
- Difficulty with balance and moving

Dementia with Lewy bodies – defining characteristics

- Begins usually around 65 years of age.
- Difficulty moving, rigid muscles, shuffling walk – very similar to Parkinson's.
- Progressive decline in thinking and reasoning
- Often there are visual hallucinations and delusions
- Memory loss is less significant than in Alzheimer's
- Often experience Rapid Eye Movement sleep disorder: acting out, talking, yelling, hitting, grabbing or jumping out of bed.

Fronto-temporal dementia– defining characteristics

- Begins usually after 60 years of age
- Frontotemporal dementia progresses steadily and often rapidly. The duration of disease ranges from less than 2 years in some individuals to more than 10 years in others
- There are two patterns of behavior for FTD: (1) changes in behavior, or (2) problems with language.

Behavioral variant

- Impulsive (disinhibited) or bored and listless (apathetic) and includes inappropriate social behavior; lack of social tact; lack of empathy; distractibility.
- Loss of insight into the behaviors of oneself and others.
- An increased interest in sex; changes in food preferences; agitation or, conversely, blunted emotions.
- Neglect of personal hygiene.
- Repetitive or compulsive behavior, and decreased energy and motivation.

Primary progressive aphasia variant

- Difficulty making or understanding speech.
- Ability to express through writing can be lost.
- People can lose comprehension of words, find the appropriate words or use word or sound substitution.

The relationship between Validation and these labels

Medical Vision of Humankind versus Validation vision of Humankind

Medical Vision of Humankind : SDAT, senile dementia, dementia of unclear origin, mixed forms	**Validation vision of Humankind: Stage of Resolution**
1.Terminology: Dementia, Demented, Dementia patient	**1.Terminology:** Old person, older person, very old person in the final life stage, unique individual, maloriented or disoriented.
2.Causes: Organic brain, degenerative sickness, degenerative process, amyloid plaques, neurofibrilary tangles	**2.Causes:** Long life filled with losses, crises, conflicts that took place during a long lifetime, missing coping strategies and the inability to face up to old age. Withdrawal into disorientation due to physical, social and psychological losses and the need to resolve.
3.Reasons for behavior: Organic brain-related symptoms	**3.Reasons for behavior:** Needs and feelings from the past are expressed in the here and now, conflicts and crises of the past are re-lived in order to die in peace.
Therapeutic goal: Maintain orientation to reality as long as possible through medication and complimentary methods, dampen symptoms of the illness in later stages and therefore maintain quality of life.	**Therapeutic goal:** Increasing feelings of self-worth, supporting the resolution of conflicts, crises and events that are bonded with painful feelings; nonjudgmental acceptance of the person; prevent vegetation by accompanying the person in the stage of resolution.
Prognosis: Previously incurable disease that progresses steadily. During the process of the illness, the patient continually loses his cognitive abilities including his identity. In the end stage of the illness, the patient is in a stage of vegetation. The disease progresses inexorably. Anti-dementia medication does not help, even though they slow down the process.	**Prognosis:** Validation helps maloriented and disoriented people to heal themselves in the psychological sense. When people feel accepted and worthwhile, they have less distress. This allows them to draw on their resources better and stabilize at the phase of resolution until they die. Validation helps people when they,

	through the disorientation, have to express unfinished business from the past. The person can find peace. When people at the end of their lives can find peace, they can more easily die in peace. They do not have to withdraw into the vegetation phase. Disorientation in very old age is not seen as a static process, instead as an individual, dynamic, unique path.

Case studies where Validation worked with people who did not have the label 'Alzheimer's disease'

CASE STUDY #1

Personal Information:
Mrs. M. is a 63 years old slim, athletic woman.
Profession: Attorney. She ran her own practice for 20 years.

Diagnosis, disease progression and challenging behaviors:
Diagnosis: Frontotemporal dementia

In the last few years, Mrs. Mayer's behavior began to change.

She began to act rudely toward other people and did not keep appointments.
She often left her office or home without saying a word and returned many hours later. When her daughter asked where she was and told her that everyone was worried about her, Mrs. Mayer reacted apathetically and appeared disinterested. She appeared to show no understanding that this behavior was a problem. She also often purchased items that she never used, which was unusual for her.

The family at first thought that Mrs. Mayer was overworked and was "burned-out" or was suffering from depression. After many disturbing incidents in the office, Mrs. Mayer was no longer able to fulfill her duties as an attorney and was no longer allowed to work at her own office.

A year ago, tests were done that led to a diagnosis of 'frontotemporal dementia'.
For the family, particularly the daughter with whom she lived, her behavior was becoming more of a burden. It was her unpredictability that made living together so difficult. Recently, Mrs. Mayer couldn't find her way home and the police had to search for her. It was especially difficult for the daughter to see her mother, who had always been a very elegantly dressed person, now not take pride in her appearance.

Mrs. Mayer could no longer be left alone and needed continual care. She now goes to a daycare center to give the family members some respite. The caregivers at the center find it very difficult to handle her unpredictability, especially how swiftly Mrs. Mayer stands up and tries to exit the day care center. She is very fast and inventive. Even though the front door is not locked, she climbs through open windows or over the fence. Sometimes she announces her departure by saying, for example: "One needs a coat", or "Yes, I must leave now, he will come soon". Her facial expression is searching but her voice tone is flat, without emotion.

When she is offered activities that she enjoys like painting, singing or dancing, she happily stays in the day care center. She can keep busy for an hour painting pictures. She also loves taking part in the singing group and the dancing group.

Validation approach:
Mrs. Mayer is sitting at a table and paints. Suddenly she says: 'I'm not allowed to work anymore. They told me I'm not allowed."

VA: They told you that you are not allowed. (rephrasing and ambiguity)

Mrs. Mayer: Yes, I was a lawyer. Now it is not possible. My brother had an accident. (Mrs. Mayer speaks fast and looks for eye contact)

VA: He had an accident. What happened? (Rephrasing and Open question)

Mrs. Mayer: Climbing in the mountains. He was young.

VA: Was that the worst thing in your life? (polarity)

Mrs. Mayer: Yes.
She turns her eyes away and continues painting.

Conclusion:
Her daughter told that Mrs. Mayer never spoke about her brother and his accident. Only recently has she begun to speak about him frequently. The sessions where Validation is used are short, but one has the feeling that it is good for Mrs. Mayer to express herself.

CASE STUDY #2

Personal Information:
Mr. H., is a 64 years old male. He's an intelligent and a caring individual.
Profession: Department head for a large firm where he was highly valued for his experience.

Diagnosis, disease progression and challenging behaviors:
Diagnosis: Frontotemporal dementia
Stroke 2 years prior to evaluation, resulting in slight weakness left leg

In the last few years Mr. H's behavior started to change:

- He had become abusive, sexually inappropriate and acts out aggressively.
- He had no insight into his behavior.
- He lost his job as department head of a large firm due these behaviors.
- Mr. Huber started to speak often about death. Apparently when he was a young man, he had a serious accident and almost lost his life.

Mr. and Mrs. Huber came for an initial meeting in the day care center one year ago. When the day care center leader asked what they would like to drink, Mr. Huber suddenly yelled very loud, "Coffee, very sweet," and slapped his hand on the table several times. When the coffee was served, Mr. Huber demanded that his wife put 13 sugar cubes in it, and then proceeded to slurp it loudly, making exaggerated sounds with his lips and tongue. Mrs. Huber seemed very

uncomfortable with her husband's behavior and told how loving, proper and helpful he was before his illness.

During the first weeks in the day care center, there were repeated conflicts between Mr. Huber and other guests. For example, Mr. H. often tried to scare other guests by making sudden, loud noises. He also made sexually suggestive remarks to staff and repeated touched them inappropriately. This made the staff uncomfortable and they responded by reprimanding him. When Mr. H. was admonished, he reacted even more strongly and cursed at everyone. Mr. H. was particularly upset when he felt ignored or rejected.

The team held discussions about how to engage Mr. H in a socially acceptable way. They also brainstormed how they could connect with him by trying to understand his behavior. Their first step was to explore and acknowledge the need for closeness and attention that Mr. H. expressed. It was also very clear that he did not feel acknowledged in his role as a man and felt inferior. The second step was for the care staff to "center", stay calm, and try not to take Mr. H.'s behavior personally.

Validation approach:
Mr. H. hurriedly approaches the day care center leader (DL) and says, "You need to get undressed. I want to see you naked." He quickly tries to get close and kiss her.

DL centers herself and says in a calm voice tone, "Mr. H., I'm not going to do that, but how are you?" She gently takes his hands and creates a good distance between them.

Mr. H.: You are a woman, but I'm not a man anymore. Nothing works.

DL: Nothing works anymore?

Mr. H.: No! But you're lovely. You are a good boss. I'm also a boss. (Mr. H. kisses the DL's hand and leaves a bit more relaxed).

The sexually inappropriate behavior towards other guests was refocused using Validation techniques like one does in a Validation group.

Mr. H. approached another guest, Mr. S., and clapped his hands loudly. Mr. S. was busy cutting out a picture and cried out angrily, "leave me alone!" Mr. H. began to clap even louder in a provoking way.

DL: (approaches, clapping her hands as well) NO PEACE!

Mr. S: Right, he should stop.

DL: Mr. H., Mr. S. is bothered by your clapping.

Mr. H.: There has to be clapping. I clap so that he is not dead.

Mr. S.: I'm alive! I know I'm alive because I am busy.

DL: Mr. H., do you want to sit with Mr. S. and make something as well?

Mr. S: Come on, sit down and make something.

(Mr. H. then sat at the table and began to color a picture for a short while)

Third example: Mr. H. and DL were sitting on a bench in front of the day care center and saw another guest who had problems walking.

Mr. H: He can't walk anymore. He is old and should die.

DL: You mean when someone can't walk anymore and is old, he should die?

Mr. H.: Yea – die! I was dead once.

DL: When was that?

Mr. H.: I was young.

DL: Young? What happened?

Conclusion:
The relationship between Mr. Huber and the care staff became less strained. They learned to protect themselves from sexually inappropriate advances in a respectful way and to understand that Mr. Huber had unmet needs to express and that they needed to listen empathetically to those needs. He responded very well to the Validation techniques mirroring and rephrasing. These simple Validation techniques helped the staff connect with him on a deeper level and helped Mr. H express his needs and emotions.

CASE STUDY #3

Personal Information:
Mr. A is a 77-year-old male that lives in a health care/daycare facility for the elderly in Japan. He was a school principal who retired when he turn 65. He was always serious about his job; it was as central part of his life.

Description, disease progression and difficult behaviors:
Diagnosis: Mild vascular dementia

After he retired, he started following his wife everywhere. Mr. A claimed that that his wife was cheating on him. His wife was significantly younger than him. He said that a strange man was coming in through the 2nd floor window to meet his wife and accused her of setting that up. His wife got so tired of his constant accusations that she arranged for him to go to day care. He

refused to go to the center alone because he said his wife would use that time to go out and meet men. I met both him and his wife at the day care center for counseling and support. When they are together, Mr. A seems normal.

Validation approach:
The following is an example of one of our conversations:
Mr. A: I don't have anything to do.

Fumie: You don't have anything to do? When were you the most busy?

Mr. A: I was a Principal in a school. I taught and organized the whole school.
(Mr. A glowed with pride)

Fumie: You were really proud of your job!

Mr. A: They went on reminiscing about his job and enjoyed talking about it. I primarily listened exquisitely, calibrating him. After that, I was able to ask him questions about his present situation and what was enjoyable now.

When he was expressing his distrust of his wife in an angry way, I could not use Validation and instead I worked his wife and supported her. Every time I tried to use Validation techniques, it would only build his anger and distrust of his wife. It seemed like his hallucinations increased.

Conclusion:
Knowing when to use Validation and when to use more traditional approaches with this man was difficult. It can often be difficult to know what is confabulation, what is a hallucination, and when is he using the eidetic image. I used Validation primarily to build trust with Mr. A. Calibration, rephrasing and asking open questions helped develop a trusting relationship. When Mr. A. was expressing anger I used calibration and asking open questions to help him express more. Validation theory helped me understand the underlying psychological needs of Mr. A. I found the Validation techniques normally used with Maloriented people worked the best and mostly in moments when he was not angry and focused on his wife's infidelity. By avoiding confrontation, I was able to build trust.

CASE STUDY # 4

Personal Information:
Mrs. B: I met Mrs. B when she was 57 years old. Now, at 60 years old she is living in a group home. She was a housewife. Once her 3 children were grown up and out of the house, she started working as a chef in a school kitchen.

Description, disease progression and challenging behaviors:
Diagnosis: Frontotemporal dementia

Her husband started noticing some strange behavior. She wasn't able to cook anymore; she started wandering in the middle of the night. She had always been well-dressed, wearing a hat and makeup when going out, and now she dressed sloppily, without care.
Every time her husband asked her to do something like, 'please clean the house', she would start screaming in a high-pitched voice.

After a series of doctor visits and misdiagnoses, she was finally determined to have frontotemporal dementia. At that point she entered a mental institution for assessment and given a treatment plan. After three months, she moved into a group home that specializes in caring for people with this disease. There, she seemed more balanced but her behavior remained unique. Mrs. B was physically active but her ability to speak was diminished. She had issues with food and ate sweets as her staple diet. She constantly wandered and often tried to escape out of her group home. Thank goodness, her sense of direction was still relatively intact and she could always find her way back home. Sometimes Mrs. B would get up in the middle of the night and start preparing a meal.

Validation approach:
The first time I met her, she looked normal, young and healthy despite her disease.
Fumie: Hello, how are you (giving her a normal amount of distance)

Mrs. B: (turned away and avoided eye contact)

Fumie: (I observed her scared expression; I sat beside her instead of in front and gave her a little bit more distance to help her feel safe.)

Mrs. B then started to clap her hands and say, "yes, yes, yes yes, yes" over and over in a sing-song voice.

Fumie: I mirrored her movements, face and vocalizations.

Mrs. B then answered me by changing the vocalization to "ah haha ah haha….." nodding her head up and down.

Fumie: Then I said, using her same rhythm, voice tone and head movement:"Hello Mrs. B, I'm Mrs. Inatani'

Mrs. B: 'quiet, scarey, scarey ah haha ah haha' (moving her head up and down)

Fumie: I'm sorry I'm sorry I'm sorry. I'll just stay here. (using the same sing-song voice tone and head movement)

In a quieter way, she started singing a song a mother might sing to her children.
I joined her in the song and she accepted that I stayed with her.

Conclusion:
I found that singing and moving in a rhythmic way was an effective way to communicate with Mrs. B. She enjoyed singing and moving to a particular rhythm. At those moments, I could make eye contact with her. Sometimes mirroring was effective and rephrasing what she said worked. Like many Maloriented people, she felt threatened when I approached directly from the front, so I learned that sitting next to her was more effective and being very respectful with eye contact. Prolonged eye contact was uncomfortable for Mrs. B.

Non-verbal techniques worked really well with this person: mirroring, music and movement were connections into her world. It was important to keep my distance so as not to scare her so this element of validation was not effective.

CASE STUDY #5

Personal Information:
Mrs. C. is an 82-year-old female receiving home nursing care services in Sweden.

Diagnosis, disease progression and challenging behaviors:
Diagnosis: cognitive impairment (final dx: Lewy body dementia) with hallucinations and anxiety.

Symptoms:
- She worried excessively about keeping track of finances. For example, she hid money in many places around her home and then she would say, "I want you to withdraw some money because I don't have any."
- She also was quite anxious about keeping her dentist appointments and frequently asked about them.
- She became incontinent.
- Her emotions and level of consciousness were very labile.
- She developed visual hallucinations. She was able to clearly describe what she saw, such as; "there are Gypsies in the yard trying to break in to my house", "there is a green monster", and "there is a parent and child sitting on the couch."

It is important to note, when discussing hallucinations associated with Lewy body dementia, that the "images" may simply be a symptom of Lewy body dementia; however, there also are "eidetic images" that may have resulted from the subject's past experience. In Mrs. C's case, the story about Gypsies was probably related to her present uneasiness and fears. According to her sister, her parents used to tell them that bad mannered children would get kidnapped by Gypsies.

Validation approach:
When she worried about not having money, Phase 2 techniques were very effective. When her hallucination was active, personal distance, rephrasing, and open questions were used. Learning about the content of her hallucinations also assisted the caregiver to understand any psychological need/s she may have related to that "image". By doing so, her level of anxiety and sadness were relieved.

Conclusion:
Some of Mrs. C's behavior seemed to be related to her childhood emotional memory. At those moments the Validation techniques we use with people who are time confused proved to be effect for maintaining a relationship and keeping communication.

Experiences of Cecile:
"I find that a person with Lewy body dementia sometimes exhibits behavior that can be likened to Malorientation. Sometimes she has hallucinations, which is the main feature of this type of dementia, and is hardly approachable or even completely closed to contact. At one of these moments, a woman told me while I was visiting that she did not speak to women with glasses, and said that I should go take care of my business with my girlfriends. Clearly, this was an expression of a past experience and she was using me as a symbol.

Rephrasing, asking open questions and other Validation techniques did not work at all and I was forced to interrupt the conversation when the woman told me to 'go away'. However at other times, when this lady is not triggered by my glasses, an empathetic approach and validation techniques allowed for an exchange, which could be seen as a validation session. At these moments, it seems like the losses of life are put in front and signs of Lewy body dementia are set to the background.

I had created a trusting relationship with another person with the same diagnosis before becoming a validation practitioner. She recognized me by the necklace I was wearing and I found that empathic listening had a positive effect on her. She was very sensitive to kindness or the lack of kindness. Many caregivers "laughed" at her strange use of words and her hallucinations. Validation techniques that tested memory, like reminiscing, had a negative effect; she became nervous and the relationship was interrupted."

CASE STUDY #6

Personal Information:
Mr. D is an 89-year-old male with no dementia diagnosis. He is receiving home nursing care services in Sweden. He gets along well with the home health aides and accepts their care well.

Diagnosis, disease progression and challenging behaviors:
Diagnosis: End stage hematological cancer

Approximately 4 years ago, Mr. D's behavior started to change due to the progression of his cancer.

Validation approach:
Mr. D: Pull up my red VOLVO as it is buried in the forest. (Mr. D's son at first thought he was joking.)

Son: Dad, your red VOLVO was sold and now there is a black VOLVO in the garage. (He actually showed his father the car in the garage (Reality Orientation). However, Mr. D ignored that car and kept repeating his comments about the red VOLVO).

(After hearing his Dad repeat the Volvo comment yet again, the son centered, then began using Validation and tried rephrasing)

Son: You want me, your son, to pull up your red VOLVO? Is that car the red VOLVO you had when you were working in the forest?
Mr. D.: (nods deeply, sighing with relief) I leave it to you.

After this exchange, Mr. D never brought up the red VOLVO again.

Conclusion:
The red VOLVO was seemingly associated with Mr. D's identity. It also was the symbol of his past, lively life and the symbol of his masculinity and fatherhood (keeping his family safe)
By passing the role on to his son, Mr. D possibly was released from the sense of responsibility and role as a father.
For this elderly person with terminal cancer, Validation was effective regardless of cognitive status.

CASE STUDY #7

Personal Information:
Mrs. E is a 60-year-old intellectually disabled female living a facility for the intellectually disabled in Japan.

Diagnosis, disease progression and behaviors:
Diagnosis: Down's syndrome

Symptoms:
- Impaired and limited speech function.
- She rarely uses verbal communication.
- She is mostly in her room.
- When she is alone, which is often, she is found crouched down, moving her body back and forth, with her eyes lowered.

Validation approach:
(VP =validating person)
VP: (Approached her and greeted from the front).

Mrs. E: (There was no verbal reply)

VP: (Moved closer to her and called her name. I started to move my body in the same rhythm, then slowly touched her shoulder and called her name again).

Mrs. E. (Made occasional eye contact but no verbal reply/comment.)

VP: (Touched her shoulder, calibrated her emotion) "Are you lonely being by yourself? Do you feel insecure being alone?"

Mrs. E: (After a little while, her body stopped swinging, no verbal comment.)

VP: (I touched her hand).

Conclusion:
For a 60 year old person with intellectual disability, in a state of verbal and psychological withdrawal, non-verbal techniques were effective.

CASE STUDY #8

Personal Information:
Mr. W. is a 65 year old divorced male. He has lived in a nursing home for the past 5 years. He is divorced with no children and has little contact with one of his brothers. His other brothers and sister have not visited him in a long time.

Diagnosis, disease progression and challenging behaviors:
Diagnosis: suffering from Korsakoff's disease for more than 10 years.

Symptoms:

- His movement has replaced most of his speech.
- He can only speak in monosyllables such as haa, hoo, and hmmm.
- The tone he uses depends on his mood, well-being or emotion.
- He is disoriented to time and space.
- He is dependent on caregivers for all activities of daily living.
  His tone of voice scares other residents when he walks down the halls.

Validation approach:
A typical moment where I can use Validation goes like this:
I start by finding eye contact with Mr. W.
MC: Hello Mr. W, how are you today?
I mirror his facial expression and his movement.
I calibrate to the internal state of Mr. W.
Using regular touching on his hand or arm, I'm able to start the communication and give him the feeling that 'we are together' and he is not alone.
I mirror what I see and he responds by nodding.
Then I try saying the emotion that I sense he is feeling in the moment: "You are angry! It's not OK today." Saying it with emotion creates a good response and a grateful facial expression.
When I connect the behavior to his needs and say, "You need something else." Mr. W expresses his agreement non-verbally.

I then end the conversation verbally, 'I'm going to go now, Mr. W. See you next time.' and Mr. W salutes to say 'goodbye'.

Conclusion:
With people who have Korsakoff's disease, it was possible to use several Validation techniques that are usually successful for people in repetitive motion. Regarding Erikson's life tasks, it is likely that Mr. W is still busy with Generativity (to be active and productive) which is appropriate for his age and is not busy with any unresolved past issue. Understanding this helps caregivers have more empathy and make contact even when the client can't respond verbally.

CASE STUDY #9

Personal Information:
Mrs N. is a 30 year old married female who has a torn ligament and is otherwise in good physical and mental health.

Diagnosis, progression of disease, and challenging behavior:
Diagnosis: Delirium following surgery with general anesthetic. The surgery is common and normally takes 2 hours to complete.

Symptoms:
- She breaks out in tears in the recovery room.
- She has acute anxiety, is hallucinating and is demanding to leave the hospital. (At this point, the nursing staff allows her husband to come to her)

Validation approach:
Her husband, a Validation worker, uses Validation to manifest his warmth, his presence. He uses eye contact and touch (hugging her shoulders) so she could feel warm and cared for. This seems to reassure her.

Husband: What happened?
Wife: There were so many people around me.
Husband: Who was there?
Wife: People with white shirts
Husband: Were there other people? Who was closest to you?
Wife: Yeah, there was someone who only looked at the machine. He never looked at me.
Husband: He didn't look at you? What was the hardest?
Wife: I felt so…. like a thing…like I wasn't there.
Husband: You were shocked!
Wife: (She began to cry.)
Husband: You needed caring, someone who cared for you.

Saying the emotion with empathy helps her feel validated, that she is being allowed to cry. Connecting the behavior to the need helps her to calm down in the presence of someone who understands her fear.

Conclusion:
The empathetic attitude and some verbal and nonverbal Validation techniques allowed Mrs. N to express her strong emotions and move through them. Because she is not in the final stage of life and does not have dementia, she was able to gain insight into her behavior. Fear of death is not unusual after having general anesthetic. She is not in the resolution stage but she is faced with a possible end of life situation and was very afraid. Validation helped her express her feelings and feel safe despite the delirium and fear of death.

CASE STUDY #10

Personal Information:
Mr. M is a 59 year old married male, father of 3 children. He worked as an accountant in a company.

Diagnosis, disease progression and challenging behaviors:
Diagnosis: He has been suffering from cancer for several years and is now terminal. After surgery, chemotherapy and radiotherapy, he is now on palliative care. The cancer is spreading and there are no more treatment options. He receives morphine for pain.

Settled comfortably in his chair, he began to make a gesture like he was throwing objects. Then he made a gesture that appeared to look like he was writing and calculating on a calculator

Validation approach:
I began using open questions and rephrasing which allowed Mr. M to talk about what he was doing, which was working – sorting files.

Worker: What are you doing?
Mr. M: I'm busy working. I'm finishing up a file.
(he moved his hands and I mirrored this movement with one hand while the other hand was touching his arm to keep the connection.)
Worker: That really needs to get finished. It's important that it gets finished isn't it?
A bit later: Is it okay for you like this?
After a while, he relaxed.
Mr. M: Yes. I'm at home. I'm not at the office.

Mirroring his movements helped me gain insight into what he was doing and helped him feel that I was on the same wave length. Throughout our contact, I used warm eye contact, touching on the arm or hand and saying the emotion with empathy; these techniques all worked well to maintain a warm and loving relationship.

Conclusion:
The empathetic attitude, the use of verbal and nonverbal techniques worked well to help Mr. M express his emotions and express his need to be useful. Someone who is dying at an early age is indeed in a 'final life stage' and it seems clear that Mr. M was resolving an unfinished life task.

CASE STUDY #11

Personal Information:
Mr. W. is a 55 year old male and a retired geography teacher. He is in excellent physical health.

Diagnosis, disease progression and challenging behaviors:
Diagnosis: Early onset Alzheimer's, occasional disorientation to time and space.

His recent behaviors:
Mr. W became increasingly annoyed that he couldn't follow his class program, so he decided to retire. His wife, rather quickly, reached out for assistance and he started attending a day care center, which helped him channel his energy. Later on when he degenerated further and no longer could be cared for at home, he moved into a small, long-care unit in the same facility. In this long-care facility he was always "busy": taking on manual tasks, exercising, and taking walks because he got bored easily. He frequently asked the staff to "take a walk with him."

Validation approach:
During many of these walks, I used Validation techniques that are normally used with Maloriented people.
MC: You enjoy walking. You have a lot of energy. What did you do for work?
W: I taught geography.
MC: In which school did you teach?
W: I taught high school
MC: What was the most important for you to teach the students?

He began to talk about his classes and about the earth, the heavens, different types of stone – he was in his element and open to sharing his knowledge. He enjoyed sharing his knowledge with me and feeling himself, the teacher once again.

Asking factual, open questions, asking the opposite and using the extreme allowed him to tell me what was important to him. Rephrasing with empathy showed him that I was with him, understanding him and engaged with his issues. At other times, reminiscing was useful, allowing him to tell more about the past. Because Mr. W has early onset Alzheimer's, I paid special attention to keeping a safe distance; I avoided emotional topics and let him lead the conversation, being well aware that his topics can change frequently.

Conclusion:
Trust was gradually built during the conversations that were held while walking with him. The empathetic attitude plus the verbal and nonverbal Validation techniques helped keep the relationship, developing trust. The walks allowed Mr. W to expend his physical energy and find someone to share his feelings during this phase of his illness.

Specific behaviors that can be Validated

Specific Behaviors that can be Validated					
		Diagnosis	**Expresses emotions**	**Expresses human needs**	**Resolving life tasks**
1	Mrs. M	Frontotemporal dementia	Yes	Yes	?
2	Mr. H	Frontotemporal dementia	Yes	Yes	?
3	Mr A	Vascular dementia	?	Yes	?
4	Mrs. B	Frontotemporal dementia	Yes	Yes	?
5	Mrs. C	Lewy body	Yes	Yes	Yes (?)
6	Mr. D	Terminal Cancer	Yes	Yes	Yes
7	Mrs. E	Down syndrome	Yes	Yes	Yes (?)
8	Mr. W	Korsakoff	Yes	Yes	?
9	Mrs. N	After anesthesia	Yes	Yes	No
10	Mr. M	Terminal cancer	Yes	Yes	Yes
11	Mr. W	Early Alzheimer	No	Yes	?

Power point: What elements of Validation can be used in all situations and what elements of Validation can be used in some situations:

What elements of Validation can be us

Short term goals for Validation with people who do not fit the usual population:

Reduction of stress – observable changes could be: relaxation of physical stress, deeper breathing, holding eye contact longer, and letting go of restlessness.

Building trust – observable changes could be: establishing eye contact, allowing greater closeness, verbal expression of issues that were never spoken of before.

Stimulation of well-being – observable changes could be: smiling, singing, relaxed facial expression and posture, taking up fun activities once again; changes that could be heard: a more relaxed voice tone, comments that the client makes about his/her situation.

Stabilizing feelings of self-worth – can be perceived by short-term changes in behavior, see also the changes listed above.

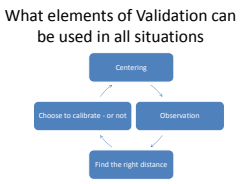
With other populations, we do not see the same long-term effects of Validation that are seen with people in the resolution stage of life. There is no stopping of the 'disease' process. There is no maintaining of the current status; most of these individuals will degenerate and become more disoriented no matter what we do. However, Validation did make a difference in the short-term and that is worth noting.

How do we teach this?

Teaching or presenting the population for whom Validation works best, is integral to all presentations and types of trainings. The amount of information a presenter or teacher offers depends on the time she/he has and what the listeners want or need to hear. The following suggestions are made for 3 different levels of intensity or depth of knowledge and can be adapted for your specific needs.

Simple, short and to the point

Validation was created to help foster communication with people who have late onset Alzheimer's disease or as Naomi Feil describes: old-old human beings who are in the stage of resolution versus vegetation. They are trying to find peace before they die. Elements of Validation can be used with other individuals who are expressing a lot of painful emotions, trying to fulfill basic human needs or resolve unfinished issues in the final stage of life.
(click on the power point slide: What elements of Validation can be used…)



Give examples of how specific Validation techniques can be used with people who have early onset Alzheimer's disease or are in the final stage of life (hospice).

Mid-level information

Validation was developed to build relationships and communication with people who Naomi Feil describes as: maloriented and disoriented people who are in the final stage of life. These people are struggling with unresolved issues from their past, do not have the coping skills to successfully manage all the physical, social and psychological losses that naturally come with aging and find themselves unable to fulfill basic human needs. These people most often have a medical diagnosis of late onset Alzheimer's disease, although we know that great numbers of people are misdiagnosed or given a general diagnosis of 'dementia'.

The validating attitude (showing respect, being non-judgmental and using empathy) is useful with all people who have some form of dementia. We have discovered that some techniques are useful with people who have early onset Alzheimer's disease, fronto-temperal dementia, dementia with Lewy-bodies, vascular dementia and people who are dying of other diseases and find themselves in the final stage of life. Additionally, Validation techniques can be used successfully with older people with Down's syndrome who have dementia symptoms.

The key factors to whether Validation techniques will work with people in these other populations are:

- Is the person expressing basic human emotions?
- Is the person trying to resolve unfinished issues?
- Is the person trying to fulfill basic human needs?

These factors are expressed in moments rather than consistently over time. They can be stimulated by environmental stress or triggered memories. Validation techniques can be used at these moments to help the person express what he or she wants to express and to maintain communication.

More information to share with others learning about Validation

Short term Validation goals apply to both people in the resolution stage of life as well as many people who have other forms of dementia or in some cases, delirium. Long term Validation goals apply to people in the resolution stage of life. You can use the following power point slide to help make this clear to caregivers.

Microsoft Office PowerPoint Slide

In the Worker course

When asked about how Validation works with people with other forms of dementia we suggest the following:
In Block 1:

Answer questions and then remind participants that the focus in this class is on the Validation population and that at the end of the course there will be time to discuss how Validation works with other populations.

In Block 4:
When discussing other methods, one can add 'other populations' and teach how parts of Validation can be used with other populations. This could be based on participants' questions and experiences. Make sure that participants understand the important of focusing on life tasks, human needs and emotions as well as maintaining the validating attitude.

In all Blocks:
Make sure that the choice of clients for practical work (videos, role plays, etc.) is appropriate and when it is not, make sure that the participant understands the differences.

The goal of the worker course is that the certified workers will be able to practice Validation with the Validation population. In addition, **because** they have those skills, they will be able to make a difference with other populations and to use the Validation attitude and the Validation techniques at appropriate moments.

Please use this format for submitting your case studies. Share your experiences of using Validation with people who do not normally fall into the 'Validation population'. Please send to: EdCommittee@vfvalidation.org

Case Study Format

Personal Information: (please include age, sex, family history, work history)

Diagnosis, disease progression and challenging behaviors:

Validation approach: (please describe how and when you were able to use Validation and include a short, typical dialog which demonstrates how you were able to use validation with this person.)

Conclusion: (Please describe how validation helped the person, the relationship or your communication. Also please identify the moments that you were able to validate – i.e. when the person was expressing feelings, needs or resolving life tasks.)

Specific behaviors that can be validated					
	Client name	Diagnosis	Expresses emotions	Expresses human needs	Resolving life tasks
1					