Current Opinion in Psychiatry
Issue: Volume 10(4), July 1997, pp 326-332

Publication Type: [Geriatric Psychiatry]
ISSN: 0951-7367
Accession: 00001504-199707000-00015

A review of Feil's validation method for communicating with and caring for dementia sufferers

Jones, Gemma M.M.

Author Information

St. Charles Hospital, Mental Health Unit, Department of Academic Psychiatry, Section of Old Age Psychiatry, Exmoor St, London W10 6DZ, UK.
Current Opinion in Psychiatry 1997, 10:326-332.

Abstract

There are approximately one dozen methods, approaches or systems described in the literature to help guide carers in their personal communication with and care-giving for persons suffering from a dementia. The oldest of these are reality orientation, reminiscence, remotivation, life review, and sensory stimulation. Feil's Validation Method is one of a number of newer methods that have sought to advance beyond the past plateau in care-giving methods. Feil's Validation Method is a humane, practical approach based on knowledge about and empathy for the progressively isolating plight of the dementia sufferer, emphasizing stage-specific communication techniques.

Back to Top

Abbreviations

RO-reality orientation

V/F-Feil's Validation Method

Back to Top

Introduction

There are a number of new methods such as Snoezelen, psychomotor therapy, music therapy and psychotherapy that are being advocated for use with dementia sufferers [1,2]. Feil's Validation Method (V/F) [2-11] ('Validation' is a registered trade mark by Naomi Feil) is a composite vision that asserts the need for carers to have a number of skills: specific knowledge for assessing the needs and behaviours of a person in response both to the primary and to the secondary symptoms of dementia [2], the ability to adapt communication in a stage-specific manner as the dementia progresses, and the confidence to evaluate and adapt planned care on a long-term basis. The validation method incorporates both one-to-one communication and V/F group skills.

Although validation techniques are easy to learn, and were developed for use by lay and professional carers alike, they do require practice. (As with all types of interactions, skilled and sensitive communicators are best able to elicit and react to the responses of dementia sufferers.) The validation method was first introduced to the UK in 1987, to nursing staff of the Felix Post Unit of London's Maudsley Hospital [12,13]. In the absence of research studies on V/F this past year, this review outlines the development and growth of validation. This subject is topical in light of the increasing awareness that professional carers need to have specialized training and skills to work optimally with their very fragile care-recipients and families at a time when resources are limited.

Back to Top

What is Feil's Validation Method?

Outline

In a nutshell, V/F incorporates the following: (1) a positive philosophy of supportive, multidisciplinary care with (2) a behavioural staging model of dementia and (3) stage-specific communication techniques both for one-to-one and for group interactions. In an ideal setting V/F can be used as a milieu approach, 24 h a day by all those in contact with a given sufferer. (One does not need to be a nurse, counsellor, or psychotherapist to use this method; volunteers, minibus drivers, receptionists and policemen who collect persons who have wandered are among those who have been taught V/F.) See Figure 1 for an overview of the method.

Figure 1

The main technique utilized in V/F, namely that of validating a person's emotions, is not new; it comes directly from counselling psychology. What is new is the way that Feil adapted and expanded the technique of 'validating' specifically for persons with dementia. Her departure point is that when a carer is not clear as to what the real 'facts' of a story are, the option of speaking about feelings, evident from the verbal and nonverbal communications a person relates to us, is ever present. Validating reminiscences and a person's life story are extensions of the original meaning of the word. These 'deeper' levels of validating a person have been referred to by some [14] as the various 'levels' of using validation.

The principal assumption underlying V/F is that 'all' behaviour, no matter how seemingly inappropriate, has meaning and is not helpfully understood by over-simplistic notions of being 'crazy', 'mindless' or 'memory-less' [9]. The goal of V/F is to make a dementia sufferer as happy as ossible, whatever their level of functioning, by reducing feelings of fear and loss, working with the abilities/functions that are spared, and supporting those abilities/functions that have become weakened. In practice this goal translates into empathy given through the following: sustained relationships; respectful interactions, and positive attention being given without it needing to be demanded to help preserve dignity; giving persons opportunities to resolve 'unfinished business' in their life with whatever cognitive and emotional abilities they have, primarily through listening and responding with interest to what is told; and by encouraging communication in whatever way it can be expressed, even though it may not all be comprehensible [3]. The hope is everyone will die as contentedly and peacefully as possible in whatever stage they might happen to be in.

The overall V/F strategy involves the following: understanding the changing fears and needs that accompany each stage of the dementia process, planning individualized care to minimize these fears, and teaching all those in contact with the dementia sufferer what communication skills work optimally in 'reaching' them (Figure 2). The theory base for validation comes from Rogers [15], Erikson [16,17], Maslow [18], and more recently from the work of Miesen on 'remembered parents' by dementia sufferers [19-22], understood in the context of Bowlby's Attachment Theory.

Figure 2

Back to Top

Background to validation

The V/F was developed by Naomi Feil, social worker, actress, film producer, daughter of the gerontologist Julius Weil. (Originally she called her approach 'fantasy therapy', but changed it to validation therapy in 1978.) Feil's original motivation to find a new interpersonal method both for one-to-one and for group work with dementia sufferers came out of her frustration with the reality orientation (RO) and remotivation methods that were used in the 1960s and 1970s. Feil's first documentation of her new way of working dates back to 1967 [23,24]; her first teaching manual on the method is dated 1981 [9].

Feil has sometimes been misquoted as being an adversary to RO, although V/T is seen as a companion therapy to RO [25]. Orienting a person to reality is the priority until he/she shows that they do not want to be oriented, are distressed by the information being given to them, or their short-term memory is so deficient that they can not retain the information. Peoples [26] first demonstrated that RO groups work best for persons in (behavioural) stage one, and that V/F groups are better for persons in (behavioural) stage two than RO. Feil has always argued for the need for professional carers to use a 'toolbag' type of approach in their work with dementia sufferers, where the tools are familiarity with RO, reminiscence and life review, music and movement therapy and V/F. The validation method is currently being used in over 7000 care facilities in North America, Australia, New Zealand, the Netherlands, Germany, Austria and France, among other countries [3,4,27].

Back to Top

Who can Feil's Validation Method be used with?

V/F was developed from Feil's work with elderly persons suffering from the late onset form of Alzheimer's disease and multi-infarct dementia. [Because of the rapidly changing and ugly labels for the dementing elderly in the past 3 decades (i.e. senile psychotic), Feil originally chose to refer to the elderly with dementia as the 'disoriented old-old'.] It is still not known how useful V/F is for persons with the early onset form of dementia, or for the elderly with long histories of depression or psychiatric illness, multiple types of dementia and other rarer organic forms of dementia such as Picts Disease. In the past decade there have been some single case studies and reports of this method working for individuals with the early onset form of Alzheimer's disease [27], Korsakoff's Syndrome [28] and depression (Morris C, personal communication), but no detailed investigations have yet been conducted. Feil emphasizes that the individual communication techniques comprising V/F come from counselling psychology, and although they may not help a given individual, they certainly can not harm them, 'so if they help, use them'.

Back to Top

What are the behavioural stages?

Before a person can be assessed for their behavioural stage, evidence of short-term memory errors and logical thinking errors is needed. Feil describes four behavioural stages: malorientation, time confusion, repetitive motion and vegetation (or end-stage withdrawal; Table 1). Each stage is named for the 'hallmark' behaviour occurring in it. Persons may be 'high or low level' functioning within a given stage (Figure 2). This staging system was not intended for diagnostic purposes, but to offer carers 'handles' for providing and sustaining optimal care. Persons may show behaviours from several stages when they are in transition between stages, and may show behaviours from a higher stage during 'lucid moments'. The rule for deciding which stage to place a person who is in a transition phase, is to place them in the higher of the two stages until they show only behaviours from the lower stage [3]. Persons with rare or multiple dementias, or with long-standing psychiatric histories, can not readily be placed into a behavioural stage in V/F [9].

Table 1

Although some carers have expressed their concern over 'labelling' persons by placing them into a stage, Feil's own rebuttal is that the only effect of categorizing a person into a stage is that they will receive more careful assessment, empathy, patience and individualized care. Even the label 'stage 1?' (translated into 'is this someone in stage one possibly?'), has the advantage that carers will be alerted to assess a person extra carefully. Stage one seems to be the most frightening stage for most sufferers and the most difficult one for family members to understand and accept. Using a staging label could prevent persons being misunderstood and unsupported until they are further along the course of the dementia process (i.e. obviously suffering from short-term memory deficits).

Back to Top

Sample communication for stage two

It is beyond the scope of this paper to give a complete overview of sample communications in each stage; one common example will be given.

Resident (stage two) calling out to the nurse, 'Please miss, open that door for me. I have to go home. It'll be dark soon and my mother and father will be waiting for me for tea. They'll worry if I'm not back yet and will look for me. It's not far to go. I could get there if you open the door now.'

Back to Top

Sample nonvalidation responses

'You can't go home, you live here now, you're 87, and you can't go back to your parents'; 'This door can't be opened-I haven't got a key'; 'I called a taxi for you about 10 minutes ago-they'll be here in 20 minutes, so meanwhile you can go sit down in the lounge and wait for it'; 'You can go later, I've cooked tea for everyone and you can stay here tonight'; 'Don't worry about that, let's sit down and have a cup of tea now'.

Back to Top

Sample validation-type responses

'You're missing your parents and home?'; 'You'd like to be with them/there now?'; 'Tell me about home/your parents'; 'This place doesn't feel like home does it?'; 'What do you miss most?'; 'Do you think if we sat and talked together (and maybe sang some old songs), you might feel better?'

Back to Top

How has Feil's Validation Method been researched?

Figure 3

The difficulties in studying any interpersonal method will be familiar to readers, most notably the ongoing question about the efficacy of psychoanalysis. In working with elderly dementia sufferers the problems of conducting formal, useful research studies are compounded by factors such as additional physical illness, sensory decline, dementia related changes, moves and death. These limitations have been discussed by a number of researchers [29-33]. Additional problems in researching groups of persons with dementia involve factors, such as very limited financial funding to investigate pilot projects relating to dementia care, and the reality that many professional care-givers implementing 'pilot' ideas are not trained in research or writing skills. Lack of documentation of results may not indicate that an idea is not a useful one [1,34]. To get any idea/method from theory into practice is a complex process involving many types and stages of testing. Figure 3 shows the normal route by which this occurs.

In the case of the V/F method there have been studies of the group V/F method without control groups [23,35], V/F group studies with control groups [26,31,36], individual and multiple case studies [37,38], qualitative reports [39,40], a first attempt at 'conceptual analysis' of V/F [41], and many unpublished accounts of its use. These studies can be criticized for all of the regular pitfalls of clinical research: small group numbers, changing group members, non-blind evaluators etc. However, the overall positive reports of the V/F method seem to indicate that something helpful is happening, whether it be attributed to increases in attention from carers, empathy, frequency of communication attempts, or even to the V/F group process or individual communication techniques. Component analysis could begin to answer some of these questions, but it will be very difficult to get a large enough sample of individuals to study in depth over time.

Summarizing, the positive effects of V/F reported for dementia sufferers included increased overt contentment, verbal abilities, social interaction (spontaneous and elicited), socially appropriate behaviour, awareness of incontinence and requests to be oriented. Reported benefits to staff and families using V/F include increased understanding (leading to increased empathy), patience for repetitious stories and requests/demands, sustaining energy to perform basic care tasks for a person, and a more positive vision of the dementia process [42-45]. Qualitative and single case studies seem to be the most likely types of research that will be reported in the future, given the limited resources for researching care-giving methods for use with dementia sufferers.

Back to Top

What are the main criticisms and rebuttals?

Criticisms of V/F are numerous and very varied; many, but not all, are legitimate [46-50]. Criticisms come from a range of sources: psychologists who see V/F as intruding on their psychoanalytical territory; nursing staff who mistakenly think that V/F is just a fad and is not worth learning because it will be replaced by something else tomorrow; carers who fear that validating emotions is the same as 'colluding with delusion'; academics who are concerned about Feil's postulation that 'resolution' is an extension to Erikson's final life task [7], and doubt that resolution is possible for dementia sufferers; and those who dismiss V/F because they find Feil's American writing style 'too jargonistic and sensational'.

The Dutch literature in particular has highlighted some interesting concerns [51-54]. These include criticisms of Feil's attempt to theorize about 'unresolved life problems' contributing to the possibility of getting a dementia, concerns that perhaps V/F can best be taught only after 'empathy' has been learned, and the view that V/F can more usefully be thought of as an 'attitude' towards care-giving rather than a formal 'approach'.

It seems obvious, given the process depicted in Figure 3, that different types of criticism are relevant to stages of the testing of an idea/method. No innovation would survive if it was abandoned prematurely because of criticism that it had an inadequate theory base, and did not have 'hard' research evidence supporting it.

Back to Top

Conclusion

So great is the need to find a sustainable, positive, measureable way of providing care to the elderly with dementia that lay and professional carers alike readily reach out for new methods. Snoezelen, for example, seems to have taken hold with great speed in the UK, although only one study [55] has demonstrated its usefulness for dementia sufferers. The legitimacy of academics cautioning us to wait until ideas/methods are properly tested is counter-balanced by the need and desperation felt by 'hands on' carers for 'handles'.

V/F has begun to be researched, but much more investigation is needed. Indeed, all the newer interpersonal approaches need to be researched further and evolved for specific types/subtypes of dementia. It will remain a challenge to conduct meaningful research studies with such a fragile group of persons over any duration of time, particularly long-term group studies.

Finally, there seem to be two types of 'evidence' of the success of a method. In reality these types of evidence are collected simultaneously for different purposes. The first type relates to the number of respectable papers published demonstrating the effectiveness of an idea before scarce resources are spent in promoting it; the second type concerns 'seeing is believing' on an individual level (or, 'if it helps me do my work more effectively then I'll use it because I'm desperate'). If the V/F method helps communication between carer and dementia sufferer and increases the overt expressions of well being, practical and clinical interest in its use should not be discouraged, although research is incomplete.

Back to Top

Acknowledgements

The author wishes to thank Dr Ian Jones and Mrs Sue Meese for their help in preparing the manuscript.

Back to Top

REFERENCES

1. Jones G, Miesen B (eds): Care-giving in dementia. London: Tavistock Routledge; 1992. [Context Link]

2. Miesen B, Jones G (eds): Care-giving in dementia. London: Tavistock Routledge; 1997. [Context Link]

3. Feil N: The validation breakthrough. Baltimore, USA: Health Professions Press; 1993. [Context Link]

4. Feil N: The Validation therapy with late-onset dementia populations. In Care-giving in dementia. Edited by Jones G, Miesen B. London: Tavistock/Routledge; 1992:199-218. [Context Link]

5. Feil N: The Validation: an empathic approach to the care of dementia. Clin Gerontol 1989, 8:89-92. LinkResolver | Library Holdings | [Context Link]

6. Feil N: (Interview with L. Sheesley & M. Osis.) The real world of the old-old. Gerontion 1:19-21. [Context Link]

7. Feil N: Resolution: the final life task. Hum Psychol 1984, 25:91-105. [Context Link]

8. Feil N: Communicating with the confused elderly patient. Geriatrics 39:131-132. [Context Link]

9. Feil N: V/F Validation, the Feil method. Cleveland, USA: Edward Feil Productions; 1982. [Context Link]

10. Jones G: Validation therapy for people with late onset Alzheimer's disease or dementia. Alzheimer's Disease Society Newsletter 1991; August: 5-6. [Context Link]

11. Jones G: Caregiving approaches to dementia. Br Holistic Med Assoc Newsletter 1989, 22:6-8. [Context Link]

12. Morton I, Bleathman C: The effectiveness of Validation therapy in dementia-a pilot study. Int J Geriatr Psychiatry 1991, 6:327-330. LinkResolver | Library Holdings | [Context Link]

13. Morton I, Bleathman C: Does it matter whether it's Tuesday or Friday? Nursing Times 1988, 84:25-27. LinkResolver | Library Holdings | [Context Link]

14. Van der Kooij C: De Invoering van Validation. Utrecht, the Netherlands: Bureau opleidingen/NZR Consult; 1989. [Context Link]

15. Rogers CR: Counselling and psychotherapy. Boston, USA: Houghton Mifflin Co; 1942. [Context Link]

16. Erikson E: Childhood and society. New York: W.W. Norton & Co.; 1950. [Context Link]

17. Erikson E: Insight and responsibility. New York: W.W. Norton & Co.; 1964. [Context Link]

18. Maslow AH: Motivation and personality. New York: Harper and Row; 1954. [Context Link]

19. Miesen B: Attachment theory and dementia. In Care-giving in dementia. Edited by Jones G, Miesen B. London: Tavistock Routledge; 1992:138-56. [Context Link]

20. Miesen B: Attachment and dementia [in Dutch]. Almere, The Netherlands: Versluys; 1990:272. [Context Link]

21. Miesen B: Alzheimer's disease, the phenomenon of parent-fixation and Bowlby's Attachment theory. Int J Geriatr Psychiatry, 1993. [Context Link]

22. Miesen B: Meaning and function of the remembered parents in normal and abnormal old age. In The course of life, vol VII. Edited by Pollock GH, Greenspan SI. [Context Link]

23. Feil N: Group therapy in a home for the aged. Gerontologist 1967, 7: Part 1. [Context Link]

24. Feil N: A new approach to group therapy. Paper presented at the 25th Annual Meeting of the Gerontological Society. San Juan, Puerto Rico, December 1972. [Context Link]

25. van Amelsvoort, Jones G: Validation therapy: a companion to Reality Orientation. Canadian Nurse 1985, March:20-23. [Context Link]

26. Peoples M: Validation therapy versus Reality Orientation as treatment for disoriented institutionalized elderly [Master's thesis], College of Nursing Ohio, USA, University of Akron; 1982. [Context Link]

27. Various: Newletters (1980 to present). Cleveland, U S A: Validation Training Institute Inc. [Context Link]

28. Clarke F: Korsakoff Syndrome: a validation approach. [Msc. Thesis] In Speech and language pathology and therapy. Department of Human Communication Science, University College London; 1997. [Context Link]

29. Woods R: What can be learned from studies on reality orientation? In Care-giving in dementia. Edited by Jones G, Miesen B. London: Tavistock Routledge; 1992. [Context Link]

30. Woods R: Reality orientation and staff attention: a controlled study. Br J Psychiatry 134:502-507. [Context Link]

31. Bleathman C, Morton I: Validation therapy: a review of its contribution to dementia care. Br J Nursing 5:866-868. [Context Link]

32. Bleathman C, Morton I: Extracts from twenty groups with dementia sufferers. J Adv Nursing 1992, 17:658-666. [Context Link]

33. Bleathman C, Morton I: Validation therapy with the demented elderly. Adv Nursing 1988, 13:511-514. [Context Link]

34. Van der Kooij C: Validation: the changing strength of a practice-theory [in Dutch]. Tijschrift voor ziekenverzorgenden/vakblad voor verpleegkundigen 1991, 10:339-342. [Context Link]

35. Mitchell GJ: An analysis of the communication process and content with confused elderly clients during Validation Therapy. [Master's thesis], University of Toronto, School of Nursing, Canada; 1987. [Context Link]

36. Pretczynski J: Examining validation. [Doctoral thesis], University of Reims, Reims, France; 1991. [Context Link]

37. Fritz PA: The language of resolution among the old-old: the effect of validation therapy on two levels of cognitive confusion. Paper presented at the Speech Communication Association Convention, Chicago, Illinois, November 12-16; 1986. [Context Link]

38. Miesen B, Jones G: Past trauma re-surfacing in dementia. In Post traumas in late life: European perspectives on therapeutic work with older people. Edited by Hunt L, Marshall M, Rowlings C. London: Jessica Kingsley Publishers; 1997. [Context Link]

39. Copley J: Validation Therapy: AIDS patients with Alzheimer's disease. Adv J Occupational Ther 1987, May:3-5. [Context Link]

40. Jones G: Validation Therapy: another approach for use with EMI residents [in Dutch]. Tijdschrift voor verzorgenden 1988, 21. [Context Link]

41. Babins L: Conceptual analysis of Validation Therapy. Int J Aging Hum Dev 1988, 26:161-168. LinkResolver | Library Holdings | [Context Link]

42. Rubin B: Burnout: causation and measurement. [Master's Thesis]. Michigan: Michigan State University; 1982. [Context Link]

43. Alprin SI: Study of staff attitudes after validation. [Thesis]. Ohio. Cleveland State University; 1980. [Context Link]

44. van der Kooij C: Validation therapy. Denkbeeld: Tijdschrift voor psychogeriartrie 1989, Aug:12-16. [Context Link]

45. Meulmeester F, Moes D, Bijlsma A: Validation, another approach to dementia [in Dutch]. Tijdschrift voor Ziekenverpleeging 1990, 43:673-677. [Context Link]

46. Vanderslott J: Efficacy of Validation is unproven [Letter]. Professional Nurse 1997, 10:5. [Context Link]

47. Kitwood T: How valid is validation therapy? Geriatric Med 1993, April:23. [Context Link]

48. Stokes G, Goudie F: Working with dementia. Bicester, UK: Winslow Press; 1990. [Context Link]

49. Allewijn-Huib Janssen M: Validation ... the new belief? [in Dutch]. Denkbeeld: tijdschrift voor psychogeriatrie 1990, 1:4-6. [Context Link]

50. Verdult R, Visser R: Experiences using Validation [in Dutch]. Tijdschrift voor Ziekenverzorgenden 1990, 15:474-478. [Context Link]

51. Verdult R: Validation: theory and practice [in Dutch]. Tijdschrift voor Zieken verzorgenden/vakblad voor verpleegkundigen 1991, 11:360-361. [Context Link]

52. Verdult R: Reply to Feil and de Klerk [in Dutch]. Tijdschrift voor Ziekenverzorgenden 1991, 3:88-90. [Context Link]

53. Verdult R: Validation as therapy, as approach, as ... development and theory formation [in Dutch]. Activiteitensector 1993, 5:2-6. [Context Link]

54. Feil N, De Klerk-Rubin V: Question marks around Validation [in Dutch]. Tijdscrijft voor Ziekenverzorgenden 1991, 2:44-46. [Context Link]

55. Achterberg I, Kik W: Snoezelen with EMI residents: integration into daily care [in Dutch]. Activiteitensector 1992, 11:16-19. [Context Link]

IMAGE GALLERY

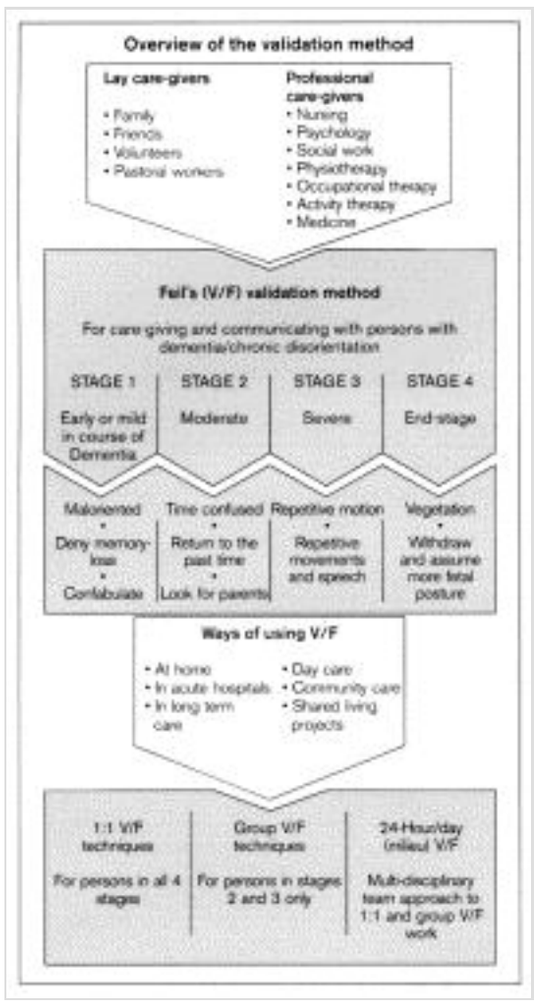

Figure 1

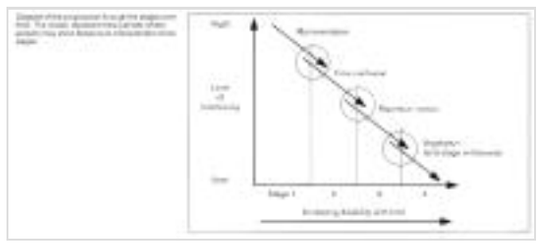

Figure 2

Figure 3

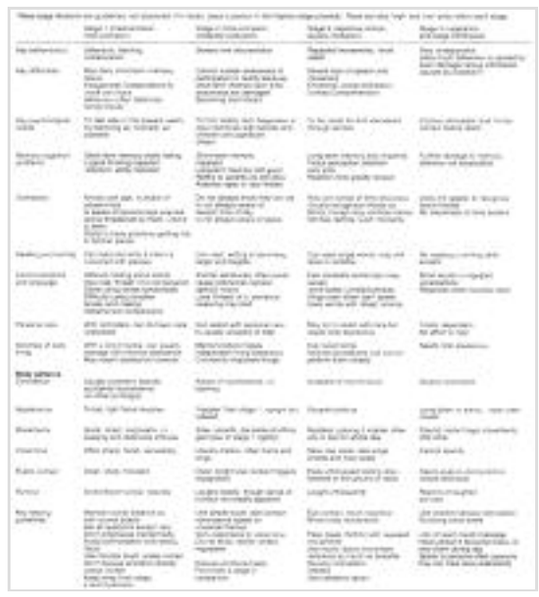

Table 1

Back to Top

« Previous Article | Table of Contents | Next Article »

About Us Contact Us Privacy Policy Terms of Use

OvidSP_UI03.32.02.327, SourceID 118360