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Review

Validation approach for persons with acute confusion: A literature review

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Abstract

This paper explores the theoretical background of validation approach as one of the therapeutic emotion-oriented approaches for confused persons. Persons experiencing acute or chronic confusion need physiological interventions as well as psychosocial and environmental interventions. Although the effectiveness of the validation approach is inconclusive and compromised by a limited number of scientific findings, this modality could be an effective approach and technique for a certain type of confusion. In future studies, the research design needs to be modified to provide a higher level of scientific evidence for the validation approach.

Key words: validation therapy, validation approach, delirium, dementia, confusion

Introduction

Elderly persons may be likely to experience mental confusion, especially when they are hospitalized for severe illnesses, have major surgeries, or have pre-existing dementia. Acute confusion is a multi-factorial condition and is typically associated with several acute physiological alternations. Fluid and electrolyte imbalance, infection, and drug toxicity are the three most commonly observed causes for acute confusion (Justic, 2000). Therefore, acute confusion necessitates healthcare professionals' immediate attention and treatment, such as physiological management and also safety and behavioral management. An algorithm for detecting and addressing acute confusion, developed by Foreman (1984), includes the following steps: assess mental and physiological status and behavioral patterns; avoid fluid volume deficit; prevent respiratory insufficiency; assess alterations in temperature; prevent for hyper- and hypoglycemia; consider drug toxicity; and lastly increase orientation by providing a developmental environment.

One of the most challenging aspects of care for persons experiencing confusion is the final component of this algorithm: increase orientation by providing a developmental environment. Traditionally, reality orientation has been believed to be necessary and effective for improving symptoms of disorientation among confused persons, as generally can be seen in healthcare professionals' textbooks or standard care plans. Healthcare professionals who are aware of the patterns of emotional responses in confused persons may wonder what kind of environmental, psychosocial, and emotional interventions are effective for persons experiencing confusion.

Wandering, disorientation, and aggression are commonly observed "behavioral problems" of persons with confusion. Typically, emotional causes of such behavioral problems are as follows (Rader, Doan & Schwab, 1985): (1) the fear engendered by separation from the people and environment with which the person was previously most connected and comfortable; (2) the frustration that develops when the patient's or resident's agenda is thwarted by a nursing staff with an entirely different agenda; and (3) the need to be needed. Rader et al. (1985) referred to these "behavioral problems" as "agenda behaviors" that are aimed at processing and alleviating the above mentioned feelings. A recommended intervention for an "agenda behavior" is to explore and

clarify the underlying meanings and emotions of those confused persons rather than simply stopping or blocking "behavioral problems" by using physical restraints, for example.

Interpretation and validation of a person's reality is a key therapeutic approach for confused persons. An example of these approaches is validation therapy, originated by Feil (1982, 1985). In a review of the literature regarding validation therapy, Taft (1998), and Bleathman and Morton (1996) acknowledged that the effectiveness of validation therapy is inconclusive and controversial. Major criticisms surrounding validation therapy include: evidence of its success remains largely anecdotal (Kelly, 1995); and evidence from randomized controlled trials is insufficient to allow any conclusion about its efficacy for confused persons (Day, 1997; Neal & Briggs, 2003). The purpose of this paper is to outline the definition, theoretical perspectives, and techniques of validation therapy, and to review research findings and discuss implications for clinical practice and future studies.

Definition and history of validation therapy

Validation therapy refers to "the process of communication with disoriented elderly persons by validating and supporting their feelings in whatever time or location is real to them, even though this may not correspond to our "here and now reality" (Jones, 1985; 20). Feil (1985) defines validation therapy by providing specific components of its techniques: "Validation is a combination of empathy, touch, eye contact, mirroring body movements, matching voice and rhythms, picking up cues about feelings and putting them into words, accepting without judging, and genuine, total listening."

Naomi Feil is a social worker and the originator of validation therapy. She grew up at a nursing home where her father, a psychologist, and her mother, a social worker, pioneered services for the elderly in the 1940s. She continued her father's research and practice with disoriented residents. She first tried reality orientation, but found it was unrealistic and an ineffective method for these residents. By 1967, she refocused on her therapeutic interactions by validating and supporting the residents' feelings through listening to them carefully. Her approach was initially called validation/fantasy therapy, currently known as validation therapy (Validation: The Feil Method® 1988) (Feil, 1992). Feil is currently the executive director of Validation® Training Institute, Inc., Cleveland, Ohio (Feil, 1985; http://www.vfvalidation.org/).

Validation therapy and other related terms

The use and effectiveness of validation therapy have typically been discussed in comparison with orientation therapy or reality orientation. According to Feil (1982, 1985), reality orientation was ineffective for confused persons; validation therapy was the better alternative. Reality orientation aims at reorienting person to present reality of person, place and time, focusing on fact and objective reality, and thus confronting factual errors in reality. Validation therapy aims at exploring individual person's reality —— asking who, what, where, when, and how, focusing on emotion and subjective reality, and thus, respecting the individual person's sense of reality (Day, 1997).

Although validation therapy is often considered as a "countermeasure" of reality orientation, validation therapy is also claimed as a "companion" of reality orientation (Jones, 1985). Validation therapy is considered to be a similar approach to reality orientation, if reality orientation is practiced as it should be (Holden & Woods, 1988). Reality orientation also includes acknowledgment and validation of individual persons with emotional needs (Holden & Woods, 1988). Goudie and Stokes (1989) discussed such issues as mentioned above between reality orientation and validation therapy, and suggested the term "resolution therapy" as an alternative to combine the two terms. Resolution therapy represents a model of exploring underlying feeling and concealed meaning in dementia, reflecting patients' feelings toward resolution.

In recent years, "emotion-oriented care" has been used to represent an approach based mainly on the validation approach and also uses insights from reminiscence and sensory stimulation. The results of one clinical trial (Finnema et al., 2005) demonstrated that emotion-oriented care was effective for emotional adaptation of nursing home residents with a mild to moderate dementia, but not for those with severe dementia.

Theories that support validation therapy

According to Feil (1982, 1985), old-old persons (85 years or over) are confronted not only by organic and functional brain deterioration such as dementia, short-term memory loss, or confusion, but also by psychological, mental and developmental problems. Disorientation, confusion, withdrawal, and other behavioral problems are often associated with unresolved or unfinished emotional conflicts or unfinished businesses in early life stages, according to Erikson's (1963) theory of developmental stages.

Underlying assumptions of validation therapy are as follows: (1) all behavior has meaning; (2) early learned emotional memories replace rational thinking in the disoriented old-old; and (3) retreat to the past is purposeful. Aims of validation therapy are the four "Rs," which include: (1) resolving old conflicts; (2) relieving past pleasure; (3) restimulating sensory memories; and (4) retreating from painful feelings of uselessness and loneliness. These four "Rs" allow confused persons' unresolved feelings to be expressed and restore their dignity and self-worth through acceptance.

Psychological theories and memory confusion

Among persons experiencing confusion or amnesia, disorientation is a commonly observed phenomenon. One experimental study (Schnider, von Daniken, & Gutbrod, 1996) supported a theory of temporal context confusion among disoriented persons —— disorientation is associated with a confusion of the temporal sequence of already-stored information within memory (Baddeley & Hitch, 1993), rather than a failure to learn and store new information crucial to the maintenance of orientation (Benton et al., 1964; High et al., 1990). Twenty-one patients with severe amnesia and 15 age- and education-matched control subjects participated in the experimental study. Orientation was tested with a questionnaire, including orientation to person, place, situation, and time. Two runs of visual recognition tasks were utilized to test the subjects' ability to acquire information in the first run of the task and their levels of temporal context confusion regarding already-acquired information in the second run. The total orientation score was much better predicted by the measure of temporal context confusion ($r=.90$) rather than by the ability to acquire information ($r=.54$). The total score of orientation did not significantly correlate with days after brain injury, age, number of years at school, or measures of frontal lobe functions.

Lesion analysis via neuroradiological scan images revealed that disorientation reflected primarily a failure of the orbitofrontal contribution to memory. Defective temporal labeling of information and increased temporal context confusion may result from damage of the circuit connecting the amygdala, the dorsomedial thalamic nucleus, and the orbitofrontal cortex. On the other hand, failed retention of information in memory, or defective item recognition, may result from an interruption of the classic Papez circuit connecting the hippocampus with the anterior thalamic nucleus. Both circuits have spatially close connections in the anteromedial thalamus and basal forebrain, and lesions in these areas may hinder either circuit and produce either type of memory failure (Schnider, von Daniken, & Gutbrod, 1996). These findings support the above-mentioned assumptions of validation therapy —— all behavior of confused persons has meaning because it is based upon their early (or currently) learned experience and emotion that is out of context or out of meaningful sequence. Although they are likely to learn and store some information, they are unable to put newly learned information into a meaningful sequence.

Procedures and techniques of validation therapy

Details of validation therapy procedures were provided by Feil (1982, 1992) for individual and group approaches and techniques. Feil defined four progressive stages of disorientation that should be assessed before using verbal and nonverbal validation therapy: mild confusion–malorientation; time confusion; perpetual–repetitive motion; and vegetation. Verbal combined with some nonverbal validation therapy is said to be effective for those persons with mild confusion, while verbal validation in combination with nonverbal validation is effective for those persons with time confusion and perpetual repetitive motion. Persons in a vegetation stage could be approached mainly by nonverbal validation such as music therapy and touch.

Validation therapy for individuals:

According to the individual validation treatment plan (Validation: The Feil Method©), validation techniques for individual persons are outlined as follows: (1) Assessment: Review the social and medical history; observe physical characteristics; and recognize the psychological characteristics. (2) Implementation: Verbal validation includes: listening; matching their preferred sense and terms; asking when, where, what, who, and how, but avoid asking why (this requires reasoning, which is threatening to those with confusion) and so on. Nonverbal validation includes: centering, observing their underlying emotion, mirroring their motions, linking their behavior with an unmet need, touching, and singing familiar songs that match their feelings.

Validation therapy for groups:

According to Feil (1982) and Taft (1998), the major features of the group therapy are: (1) group work with 5 to 10 members and a leader or therapist; (2) generally meet for 20 minutes to an hour per group session, and one to five times per week; (3) follow a rigid protocol (do not change the orders of programs and environments, including seat arrangements); and (4) roles (greetings, serving refreshments, song leaders, and so on) are assigned to each member.

The use of a rigid procedure provides a group memory in the absence of individual memories. Thus, each group meeting should be held in the same room with the same seating plan, and in the same order as follows: welcoming members, the group song, discussion of common themes or concerns (such as friends, parents, happiness, sadness, losses, or death), closing song, the thanking of members and refreshments (Feil, 1992; Bleathman et al., 1992). The leaders should be directive, leading the group through the procedure, asking the opinion of members and responding to every contribution (Bleathman et al., 1996).

Research findings and implications for future studies and practice

Research findings about the effectiveness of validation therapy provide substantially anecdotal accounts and evidence (Feil, 1982; 1985; 1992; 1993) rather than scientific evidence. Several studies that have been identified as measuring outcomes and effectiveness of validation therapy are reviewed in the following sections.

Quantitative analysis of mental and functional status

Robb, Stegman, and Wolanin (1986) described challenging issues in conducting validation therapy intervention. This interventional study was initially designed to test the effectiveness of intervention (group sessions provided by trained therapists) that were held twice per week for over 9 months. This study ended up with a substantially smaller sample size (experimental n=9; dropped n=6; and control n=12) than the initially planned sample size. No significant changes between pre- and post-intervention were found in scores of mental status, morale, and social behaviors. However, study results revealed slight tendencies toward increased mental status in the experimental group. This study was noted by Robb et al. (1986) as challenging, labor intensive, and expensive because of the cost for therapists and escort services to and from sessions. The other problem was staff nurses' negative perception toward the intervention effectiveness. Some staff nurses felt validation therapy was burdensome to them and their morale changed from positive to negative. They felt frustration when they saw no effective changes in functional status and bladder continence of older persons experiencing confusion despite the fact that validation therapy was not intended to increase these functions.

Scanland and Emershaw (1993) conducted reality orientation and validation group therapies with nursing home residents in order to find out if these modalities positively affected dementia and depression symptoms, and functional status from pre- to post-intervention. This study showed that neither reality orientation nor validation therapy have a significant impact on measures of mental status, level of depression, or functional status. Problems in this study included: (1) the small sample size of the study (reality orientation n=10; validation therapy n=12; and control n=12); (2) no control over dementia subtypes, physical illnesses, medications, lack of family visitation, or death of subjects; (3) exclusion of subjects who had manifestations of wandering and disruptive

behaviors, and inclusion of only moderate dementia subjects; and (4) the study report included no detailed description of group session protocols.

These two studies (Robb et al, 1986; Scanland, 1993) measured the effectiveness of group validation therapy in pre- and post-intervention. However, mental status and behavioral status indicators showed no significant changes. These study designs could potentially benefit from the following modifications. First, sample size needs to be increased in order to gain sufficient statistical power. Second, well-trained validation therapists can be appointed to provide an ongoing comprehensive training program for the unit staff members who can provide 24-hour reality orientation and validation approach, in addition to the weekly group therapy sessions. Third, ongoing education also needs to be provided to family members who should be involved in the care of persons with confusion. Fourth, the timeframe of the measurements should be modified to capture the effectiveness of the intervention. For example, it may be necessary to measure the immediate response after intervention in addition to the longer-term effect of the intervention. Additionally, measurements should include multiple domains of psychological and behavioral changes such as verbal interactions among residents, between residents and caregivers, or sleep patterns.

Descriptive and qualitative analysis of verbal interactions

A pilot study with a small sample (n=5) of nursing home residents was conducted to explore the effects of validation therapy (Morton & Bleathman, 1991; Bleathman & Morton, 1992). They reported descriptive quantification of mood, behavior and sociability change and qualitative data associated with the intervention (1 week of baseline, 2 weeks of validation therapy, and 1 week of reminiscence therapy). Two subjects had increased number and length of interactions during the validation therapy phase, which may imply changes in the quality of interaction toward short and repeated interactions and toward "normal" conversation (i.e., increased continuity of theme or topic). One subject did not show changes during the validation therapy phase; however, during reminiscence therapy, this subject showed the same kind of effect the first two subjects had shown during validation therapy.

Qualitative analysis of the same five subjects with moderate dementia provided a rich context of verbalization during group sessions of validation therapy (Bleathman & Morton, 1992). Excerpts from the transcripts of 20 group sessions demonstrated their ability to share their feelings and problems, follow their group's theme and utilize facilitating skills in this type of group setting.

The effectiveness of validation therapy *per se* remains inconclusive because the above two findings may be attributable not only to validation group therapy (intervention) but also to a healing environment such as group's welcoming atmosphere (side products of intervention), and therapeutic interaction with reminiscence therapists or staff members of the unit. Validation therapy may not be the ultimate or ideal therapy for any type of persons with confusion, and the level of deterioration in cognitive functioning is not the only factor that influences the effectiveness and outcomes of the intervention.

Validation therapy for persons experiencing acute confusion:

The effectiveness of validation therapy has been studied mainly for persons experiencing chronic confusion, or dementia. Scientific evidence of validation therapy for persons experiencing acute confusion, or delirium, is very limited in the literature because acute confusion generally necessitates healthcare professional's immediate attention for physiological factors, as mentioned previously. However, psychosocial, emotional, and environmental interventions are also necessary for persons experiencing acute confusion because acute confusion is considered to be a manifestation of their non-adaptive behavior or response to their environment (Neelon, 1990).

Healthcare professionals, especially staff nurses who are at the bedside of confused persons 24 hours a day, need to provide a therapeutic environment to them, and to talk to and reassure them, in accordance with validation therapy or validation approach. Such a therapeutic approach would help in alleviating symptoms of agitation, restlessness, disorientation, or emotional distress among those acutely confused persons. The validation approach would be effectively

applied to persons experiencing acute confusion if it were used together with safety measures, physiological management, and behavioral and pharmacological interventions.

Rantz and McShane (1995) explored multidisciplinary healthcare professionals' beliefs underlying their clinical practice at long-term care settings. The findings indicated that healthcare professionals have developed their interventions in accordance with what they believe is effective to deal with chronically confused persons in long-term care settings. Four categories of interventions were identified through content analysis of the focus group transcripts: (1) interpreting reality; (2) maintaining normalcy; (3) meeting basic needs; and (4) managing behavior disturbances. Interpreting reality is not to try to convince confused persons to be oriented to "our reality," but rather is to validate "their reality" (i.e., what they perceive and feel).

Protocols for acutely or chronically confused persons, based upon the above mentioned categories of interventions as well as other sources of evidence, have been proposed by Ribby and Cox (1996) and Rapp et al. (2001). Continuous and ongoing education for staff nurses must be implemented, and the effectiveness of the protocols will have to be measured in future studies. The above-mentioned premises in relation to validation therapy and acute confusion need to be further tested and validated in future research.

Conclusions

Validation therapy or, validation approach, is one of the effective approaches and interventions for persons with a certain type of confusion. The therapeutic technique of validation is emotion-oriented and theory-based approach. Research findings about the effectiveness of validation therapy were inconclusive and compromised by a limited number of scientific studies. Anecdotal reports, small sample studies, and qualitative analyses of persons experiencing chronic confusion were the sources of evidence.

Further investigative efforts are needed to include different types of confusion, persons experiencing acute confusion or chronic confusion. The research design and sample size of the studies needs to be improved to provide a higher level of scientific evidence and statistical power. Healthcare professionals are encouraged to critically review the current knowledge-base and incorporate validation approach into their practice.

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