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Validation Principles and Practices in Dialectical Behavior Therapy

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Abstract and Keywords

Validation is an essential DBT strategy that communicates acceptance and understanding, and is balanced dialectically with change and problem solving strategies. Successful validation includes: paying attention to the client's behaviour; attempting to understand that behaviour (including context); and expressing that understanding in an authentic manner. Thus, the therapist is responding to a client behaviour and highlighting what is truly understandable, or legitimate (valid), about that behaviour, and in what way(s) it is valid. Because there are many ways that any given client behaviour may be valid (and ways the same behaviour may also be invalid), validating can be tricky. Thus, there are multiple levels or types of validating responses. This chapter will describe the principles and practices of validation in DBT, including how to match the appropriate type of validation to the client's experience or behaviour.

Keywords: Dialectical Behavior Therapy, validation, validating responses, acceptance, understanding, authenticity

Key Messages for Clinicians

- Definition of validation: requires attention, *genuine* understanding, and communicates that understanding which is applied to specific behavioral targets (e.g., emotions, skillful actions, thoughts, etc.).
- Validation is a key social behavior in part because it soothes negative emotional arousal, and thus is essential in any relationship, is part of every modern psychotherapy, and is a key strategy in DBT.
- In DBT we only validate *valid* behaviors; invalidating *invalid* behaviors are part of DBT change strategies.

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- Validation communicates acceptance and understanding, builds the therapeutic relationship, and facilitates and balances change.
- At times, validation may be considered a reinforcer, and facilitates change and learning.
- Validation also may be considered an eliciting stimulus, signaling that a different repertoire of responses is likely to be effective, and inviting different, more regulated responses.
- There are multiple levels, or types of validation; type of validation must fit the situation and goals, as well as be appropriate to the way(s) in which a behavior is valid.

Introduction

The links between validation and healthy social relationships, and the importance of validation in soothing negative emotions, have been understood for generations. Thich Nhat Hanh notes that in the ancient Buddhist writings of the *Lotus Sutra*, “compassionate listening brings about healing” (1998, p. 79). Similarly, validation of one type or another has had an essential role in almost every psychotherapy since Freud’s dominance waned, including Rogerian or client-centred psychotherapy (cf. Rogers, 1961), existentially orientated psychotherapy (cf. Binswanger, 1956), cognitive therapy (cf. Safran & Segal, 1996), behaviour therapy (cf. Kohlenberg & Tsai, 1991), mentalization-based therapy (cf. Bateman & Fonagy, 2004), and, of course, dialectical behaviour therapy (DBT, Linehan, 1993). Indeed, Linehan’s incorporation of aspects of Rogers’ approach to validation (e.g., Rogers & Truax, 1967) was intentional. Nevertheless, the role, implementation details, and theoretical understanding of validation vary widely across psychotherapies. This chapter highlights the role of validation in DBT, and how those principles are put into practice.

First, in DBT the term “validation” (a noun) actually reflects a *process*. This includes several steps: 1) the client engages in some behaviour, which could be doing something overtly (including verbally), experiencing an emotion or desire, thinking, behaving in a pattern, etc.; 2) the client may, or may not, express the behaviour accurately (words, tone, body posture, facial expression, etc.); 3) the therapist pays attention and attempts to understand the client’s experience and behaviour(s) from the client’s perspective; and, finally, 4) expresses that understanding, usually verbally. This last bit is often what is called “validation,” but it is essential to put that activity into context, recognizing that when the therapist validates, he or she is responding to a client behaviour, and highlighting what is truly understandable, or legitimate (valid) about that behaviour (for our purposes, both public/overt behaviours and private ones like experiencing emotion or thinking, will be considered “behaviours”). Thus, validation is really a process that includes the therapist taking the client’s experience seriously and communicating in an honest way that some client behaviour (experience, action, etc.) is understandable and legitimate in one or more ways. Thus, validation is the expression of genuine understanding of a person’s experience or behaviour (emotion, want, thought, sensation, action, etc.), and how that behaviour or experience “makes sense” (Fruzzetti & Iverson, 2004; Linehan, 1993).

We will now describe the theory or principles underlying validation in DBT. Following that we will describe client behaviours and experiences to validate and when to do so, various ways to validate (levels, or types of validation), and finally, discuss what it means (and what to do) when therapist validation apparently fails, or results in increased client distress and dysregulation.

Theory and Principles of Validating in DBT

Validation is a social behaviour with both social and emotional consequences for the person whose behaviour is being validated. Precision requires that we describe specifically how validating and invalidating responses work in DBT, within a behavioural framework. For example, although validation is often considered to be a reinforcer, we will explain how this can be true, but also how much more sophisticated validating responses can be.

Validation can function in a number of ways, including: (1) to increase therapist/client rapport and strengthen the therapeutic alliance, (2) dialectically, as a means of balancing change-oriented strategies by communicating acceptance and understanding, (3) as the key therapist change behaviour in discrimination training, primarily as a reinforcer of nascent skilful behaviour and clinical progress; (4) as an eliciting stimulus (including as an establishing operation); and (5) to model and strengthen self-validation. In addition, we will highlight the important role of *invalidation* (of invalid behaviours) in DBT. However, we will begin by noting the various client behaviours (or targets) that the therapist might validate.

Targets for Validating Responses

Most important in DBT, therapists validate only *valid* behaviours, and *only* in the way(s) that the behaviour is valid. Put another way, it must be clinically effective to validate whatever behaviour is targeted. The therapeutic relationship is a real relationship between two people, who also have distinct roles. Validating something invalid risks significant disruption to the relationship (and possibly reinforcing dysfunction). In addition, validating something invalid could strengthen that invalid behaviour, and risk iatrogenic consequences: “Without a clear understanding of what behaviours are necessary to get from the client’s current state of functioning, to that which the client aspires to, validation is in danger of strengthening iatrogenic outcomes, at worst, or stagnation, at best.” (Linehan, 1997, p. 374).

For example, imagine that a person is extremely anxious getting into his or her friend’s car. The facts are, the friend has an excellent driving record, and has a new car with up to date safety features. It is a sunny day, the roads are clear and dry, and there is little traffic. Is the anxiety valid based on the present moment situation? Clearly, it is not. So, what is valid about the anxiety? First, it has “existential” validity: the person actually feels it. So, just acknowledging his or her anxiety is one way to validate (“you seem really anxious right now”). Maybe the anxiety has nothing to do with getting into the car. Perhaps the person is going to get some extensive medical or dental procedures and has had painful experiences with similar procedures in the past. Then, the anxiety makes sense in another way (anticipatory anxiety). However, imagine the person had a serious car accident a few weeks ago. Then, the anxiety might be based on that recent experience (classically conditioned anxiety). Either way, any validating response beyond an acknowledgment of the reality of the anxiety would require some understanding of the causes and conditions that gave rise to it. The most validating thing to do might be to ask questions, and help the person understand his or her own experience better, which would lead to opportunities to validate more fully (and might lead to opportunities to help alleviate his or her suffering, too). So, validation targets must be valid, not imagined, not patronizing, and must be connected to the person’s history and experiences, as well as understood in the present moment situation.

Colloquially, people often speak about validating a person (e.g., “she validated me”). Although that kind of language speaks to the rather large impact that validation can have, in DBT the therapist is typically validating a specific behaviour or experience of the person. Of course, in DBT, behaviour is anything a person does (or does not do), and includes experiencing emotion, thinking, wanting, talking, other forms of expression, other overt behaviours, sensing, awareness, and so on. In principle, any of these behaviours, or the absence of any of these behaviours, could be validated. The key piece is that the therapist accurately perceives the behaviour (or its absence), and is trying to understand its legitimacy in context.

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For example, the client might simply look sad. The therapist might simply notice this and validate it as part of the client's experience (e.g., "you look really sad"). This can have a variety of salutary effects (as explained below), including helping to soothe the client's painful emotion and perhaps to invite or elicit more fully accurate expression. The client might further explain that his or her plans with a friend fell through, and the client is really disappointed. Knowing how lonely the client is, the therapist might further validate the client's sadness: "It makes a lot of sense that you'd be disappointed. Anybody would in this situation."

Yet, targets for validation can be much broader than this. Thinking, especially non-judgmental thinking and accurate appraisals, are all easily validated because they are not likely provocative and are easy to understand. Of course, judgments, misappraisals, and problematic thinking *can* be validated, but it is trickier, and these must be validated in quite, different ways. If a client says, "I know I'm just a terrible, awful person," the therapist *can* validate what is actually valid about this kind of self-invalidating thinking and statement: "I know you often *think* very judgmentally about yourself." The therapist might add additional, more change-oriented interventions immediately, of course (e.g., "What actually happened? What did you do? Can you be more descriptive?" or, simply, "Can you say that again, without the judgments?"). But, leading with the validating statement may be essential to let the client know that the therapist *does understand* his or her experience, and its importance to the client, prior to targeting it for change.

In addition to emotional experiences (especially painful ones) and thinking, the therapist can also validate what the client wants (even if it's not likely, or even impossible, to get it), how difficult certain tasks might be, his or her point of view (even if ineffective, or logically inconsistent), sense of being out of control, and other private experiences. It is also very important to validate new, more skilful behaviours of all kinds (e.g., mindfulness/awareness, interpersonal skills, managing distress effectively, managing emotions, self-validation, accurate expression, and "wise mind" of any kind). Validating these targets is, of course, the key way that DBT therapists instantiate "acceptance" in DBT, and provide balance to change strategies. Again, as a process, mindful, non-judgmental awareness of the client and his or her experience and patterns, along with curiosity and awareness of treatment targets, all inform what behaviours or targets (and how) the therapist validates.

Validation and the Therapeutic Alliance

Validation communicates acceptance, understanding and legitimacy of an individual's thoughts, feelings, behaviour and experiences. By doing so, validation strengthens the therapeutic alliance. This can make validation a powerful tool even in the early stages of the therapeutic relationship. This communication of understanding, acceptance and legitimacy increases positive affect and decreases negative affect. In experimental social situations, subjects were randomly assigned (without them knowing) to receive either validating or invalidating responses when experiencing distress, and subjected to ongoing

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stressors. Validation reduced negative emotional arousal according to both self-report and psychophysiological indices of negative emotion even while the stressors continued, whereas invalidation resulted in no reduction in negative arousal (Shenk & Fruzzetti, 2011). Thus, validation can have a very soothing effect on negative emotional arousal. Fruzzetti and colleagues have demonstrated the soothing effects of validation in a variety of clinical situations, including with families (Payne & Fruzzetti, 2017; Shenk & Fruzzetti, 2014) and in chronic pain patients (Edlund et al., 2015; Linton et al., 2012).

This is particularly important for dysregulated clients who may have intense and/or dysregulated emotion in the therapy session. By finding the valid part and validating the client's experiences, even if extreme, the therapist can help the client reduce negative affect and dysregulation, improving both the relationship and the client's ability to benefit from treatment. However, further research is needed to determine how much of the alliance is a direct result of validation per se, as opposed to the whole "package" of acceptance and change strategies delivered dialectically.

There are other likely effects of therapist validation, even of dysregulated emotion. By soothing with validation, the client's negative emotion is reduced, which likely not only improves the alliance, but also may help reduce dropout. For example, Wnuk et al. (2013) found that stronger client-reported alliance predicted treatment completion (vs. dropout).

Of course, as noted earlier, dysregulated emotion is not the only target of therapist validation. Validating client desires and goals, increasing use of skills, and in-the-moment wise-mind, as well as validating the reality of dysfunctional behaviours (urges to suicide, relapse, drop out of treatment, etc.) all help to build a strong and therapeutic relationship with the client and set the foundation for effective change.

Validation to Balance Change

Change is difficult, and pressure to change can quickly create friction and become counterproductive. Validation, because it soothes negative emotion and strengthens the relationship, while communicating understanding of the difficulties present, is the “grease” that reduces this interpersonal friction and allows the therapist to keep pushing for needed (and desired) change, even when it is very difficult. It can make sense *both* that the client “feels” like giving up, *and* also wants to climb out of painful situations and emotions. In DBT, the therapist validates the former in the service of the latter.

Thus, the ratio of acceptance and validation to change strategies will be based on the individual client, both in terms of the client’s interpersonal style and his or her progress in the course of therapy. Focusing exclusively on change can communicate to clients that they are unacceptable and are making insufficient progress and/or are not working hard enough (regardless of effort), and can be perceived as overwhelming. This often results in increased fear, anxiety, shame, and hopelessness which can impede change and growth and increase negative reactions toward the therapist. When the therapist-client relationship is newer and more uncertain for the client (and the therapist is less aware of the client’s experiences and patterns), more validation strategies can be more frequent. In later stages of therapy when the client is more comfortable, the therapist knows the client better, and the relationship between client and therapist more stable, the balance can be adjusted to include an increase in change oriented strategies (Linehan, 1997).

New environmental stressors or events, increased demands, and discussion of new, potentially difficult, topics should also be accompanied by increased validation (Linehan, 1997). This increase likely helps clients feel understood and comfortable discussing sensitive topics or when faced with challenges. It is important for the therapist to approach each client and situation individually when determining how to balance change strategies with acceptance and validation, and to determine how much validation, and in what ways, are needed to continue to work effectively on important change targets.

Validation as a Reinforcer

Clearly, validation has enormous acceptance appeal, and acceptance properties: Validation communicates acceptance and understanding of the client's experience. Thus, validation is a potent and positive "stimulus" or event for anyone, including clients. Thus, validation has the potential to function as a reinforcer, a necessary piece of any operant change strategy.

When validation is employed as a reinforcer, it should be contingent on the client showing improved, or at least desirable, behaviour that represents clinical progress. One simple application of this is in discrimination training. In behaviour therapy, discrimination training is a process in which, in a given situation, one behaviour is reinforced and others are not. For example, language learning is almost entirely a process of discrimination training: in the presence of a cup full of water, a small child might say "luf" and be ignored (intentionally, or because the parent or caregiver has no idea what the child wants). However, when the child says "dink" the adult smiles and gives the child the cup, and says, "drink?" Later, the child says, "dink" and the adult says, "drink ... say D R ink" and the child says "drink" (or something closer to that), at which point the adult gives the cup of water to the child. Many, many behaviours are learned through discrimination training.

In DBT for example, the client might appear really angry. The therapist might validate: "you look really angry," and the client might nod, indicating that is correct. When queried about what happened (perhaps formally, by doing a chain analysis), it might turn out that a couple of the teen client's friends ate lunch together earlier that day, while the client was busy making up work that was missed the previous week when the client was home with the flu. After figuring this out, the therapist might query further, "Hmm. I know that you're feeling angry, that you would have preferred to have had lunch with your friends rather than making up missing school work (validating the reality of the client's emotion). If you notice that part ... that you really wanted to have lunch with them and missed out on it, do you notice any other emotion?" The client might notice, and express, "yeah, I suppose ... I really missed out ... they had fun, I am really disappointed, too." The therapist, having directed the client's attention to perhaps the primary emotion in the situation, would likely validate the primary emotion (disappointment) differently than the previous, likely secondary emotion (anger): "Of course ... that WOULD be disappointing ... anybody would be disappointed then." Over time, discrimination training would help this client learn to identify, label, and express primary emotions more accurately. And, validating the emerging, more skilful behaviour is simultaneously likely to reinforce and thus increase that behaviour, while extinguishing older, less skilful alternatives.

This kind of discrimination training around emotion, in particular, is dialectical: yes, you feel that emotion (secondary) AND there is another emotion (primary) that may be important to notice and manage. Anger is not wrong in that situation, but rather is perhaps less justified, less primary, than disappointment, and other people will more

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immediately be able to understand, and hence validate, the primary emotion, by definition. It is more effective to spend more time with primary emotions, which are much more readily regulated (Fruzzetti et al., 2008). In order for this kind of discrimination training to be effective, there must be differential validation for the different behaviours. Thus, secondary emotions would typically be validated in one way (noticed, reflected, acknowledged), whereas primary emotions would be validated differently (with more enthusiasm, normalized, and tied to being effective). These distinctions about different ways to validate will be described in detail in a later section.

Even in situations not warranting discrimination training per se, validation can still be a reinforcer (intentionally or not). For example, a therapist might validate a client who reports having tried using skills but was not particularly successful in its application, yet continued to try, by saying: "It sounds like you tried really hard, and felt really frustrated when it didn't work the way you expected, but you didn't give up!" Note that therapist also could have responded with praise instead: "That's so wonderful that you tried to be skilful in that situations!" Either way, it is very likely that the therapist wants the client to continue to practice skills in that situation (wants to reinforce that behaviour). Clearly, there is at least a bit of overlap between praise (the expression of approval) and validation (communicating understanding about the client's experience). Praise can, at times, have validating components, and validating responses can concurrently communicate approval (praise). However, in DBT, validation is a far more important therapist activity.

Similarly, validation functions to provide clients with feedback more globally, about themselves as acceptable human beings, and their behaviours as not "crazy" (Fruzzetti & Iverson, 2004; Linehan, 1997). It models thinking about oneself, as well as behaviour and the origins of that behaviour, using a non-judgmental and nonpejorative attitude. This can be particularly important for clients who construct a sense of meaning from understanding the development of their behaviour. Clients may also be in need of confirmation that their behaviour is appropriate, reasonable or normal, particularly if they are isolated, or have been raised in, or are currently in, environments which never or rarely provided this information, and may have even punished such behaviour, leading to a preponderance of self-judgments and self-invalidation (Fruzzetti et al., 2005; Linehan, 1997).

Validation as an Eliciting Stimulus to Change Behaviour

It may seem like a strange idea that a therapeutic *response* to a client could also act as an eliciting stimulus. However, behavioural theory tells us that, in a stream of behaviours, various behaviours can have different functions, depending on the analysis (cf. Skinner, 1953).

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In the transactional or bio-psycho-social model for emotion dysregulation and borderline personality disorder, chronic and pervasive invalidation (of valid behaviours and experiences) is understood to be a key developmental feature of the client's family and/or social environment (Crowell, et al., 2009; Fruzzetti, Shenk & Hoffman, 2005; Linehan, 1993). Invalidation, then, is a very common experience for DBT clients, and likely elicits a patterned response that includes: escalating negative emotional arousal (including fear and perhaps anger associated with the person doing the invalidating, and also shame), corresponding reductions in cognitive complexity and flexibility, increased anger and shame, and escape urges associated with social disconnection and rejection, and a variety of other problematic and unskilful reactions. In a sense, being invalidated is a "signal" that the other person is not understanding, and possibly not valuing, your experience, and consequently is likely to proceed in ways that block goals and feel hurtful and disappointing (Fruzzetti & Worrall, 2010). This signal cues up a whole variety of possibly appropriate (but potentially maladaptive) learned responses.

In contrast, it is likely that a validating response, in particular in situations in which invalidating ones have been common, will elicit an entirely different pattern, or repertoire: de-escalating negative emotional arousal, increased awareness, increased capacity for thinking and problem solving, and cognitive flexibility, more connection to the person doing the validating, and increased generally skilful behaviour associated with arousal reduction and social connection. Thus, not only does validation soothe arousal, it may elicit an entirely more skilful set of behaviours because it "signals" that this very different set of responses is warranted and likely will be effective.

Validation to Model and Strengthen Self-Validation

When therapists validate their clients, they provide the initial step in teaching and increasing the clients' abilities to identify and describe their own emotion in a non-judgmental or non-pejorative way (Linehan, 1997). This may be particularly important for clients who have been in especially invalidating environments, as these environments tend to teach the client not to trust their own emotional experiences (Fruzzetti, Shenk & Hoffman, 2005). Validation of their valid experiences helps them learn to trust their own experience, and helps to reduce client passivity, in two ways: first, by modelling appropriate validation the client can learn various ways to self-validate, and the different ways that both public and private behaviours can be valid. Second, by reinforcing clients' mindful awareness (noticing their own internal experiences, without prejudice or judgment), they build trust in themselves as "wise" observers, increase self-awareness, and reduce passivity (Fruzzetti et al 2005; Linehan, 1997).

One risk is that a clinician will validate client self-mistrust. This is most likely to occur when the therapist validates, and therefore reinforces, client self-denigration or self-mistrust, or even very basic self-awareness. For example, a client might seek reassurance from the therapist about what he or she is feeling or wanting, not trusting his or her own self-awareness. If the therapist supplies the "answer" (e.g., by telling the client what it

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looks like the client is feeling or wanting), not only is the opportunity for new learning lost, but the therapist may inadvertently reinforce the client for looking externally for internal answers. In order to prevent this the therapist must generally avoid the use of strong validation strategies immediately following dysfunctional behaviours, in particular those which are maintained by eliciting validation from the social environment.

Therefore, it is especially important that clinicians validate differentially, primarily using stronger validation following valid behaviour that is to be strengthened, including acts of self-awareness and self-trust and client expression of confidence in their own abilities to know what they feel, want, like, and so on (Linehan, 1997).

Early in treatment, the client may have a very poor skill repertoire vis-à-vis private behaviours (what the client thinks, wants, feels, etc.), and the therapist may be willing to provide a lot of help and suggestions based on external cues, normative emotions, and so on. Over the course of DBT, the therapist's role, or help, in the same situation would generally be expected to fade out. Subsequently, the therapist should more and more frequently answer questions about the client's emotions, and even questions about what skills to use, with "what do you think?" and use validation in a dialectical manner more regularly.

The Role of Therapist Invalidating Invalid Behaviours

No discussion of therapist validation would be complete without acknowledging that sometimes it is important for therapists actually to *invalidate* clients' invalid behaviour. For example, a client in her very first session might say, "I can tell that you already regret taking me on as a client, that you don't like me." Assuming, of course, that this is not at all the therapist's experience, there are a number of ways to respond to this, including trying to figure out what the cue for that thought (or fear, or whatever else is being expressed) was, typically by doing a chain analysis, even if brief. This will help the therapist find something valid to validate. A valid "kernel" that might be found through such a chain could be, "given that you've had a lot experiences with relationships blowing up, I can understand how you might worry a bit about me, and our relationship" (or something similar). However, at some point in the conversation, after finding something(s) valid to validate, it is important that the therapist actually invalidate the client's invalid statement (and thought or emotion), and say clearly, "Actually, you've read me wrong. I realize you don't know me well, so I don't expect you to believe me much (likely acknowledging or validating the client's experience of mistrust), but, truth be told, I am actually quite glad to meet you today, and have not had any regrets about us working together."

However, even this "invalidation of the invalid" runs the risk of reinforcing self-judgments and passivity (see above), so if the client were to continue to express these kinds of thoughts and fears, the therapist would offer less and less direct reassurance because doing so would begin to validate the invalid behaviours of the client being passive and unskilful (reacting to the therapist based on historical reactions from others, rather than

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the growing history they have together), and instead increasingly ask the client to rely on his or her own experiences with the therapist (relationship mindfulness, present moment) to answer his or her own question. Subsequently, the therapist could then validate the client's valid experiences and statements. For example, the client, after being queried what his or her experience was right now, might then say, "well, you have not done anything yet to support my fears about this" or "I guess right now it seems like you are just listening to me." The therapist can then validate the valid, "right, you are reading me right." Note that the behaviour being validated is the client's skilful noticing of what is real in the moment (relationship mindfulness), which is relatively unlikely to reinforce dysfunctional requests for reassurance, mistrust of his or her own experience, or general passivity.

Levels or Types of Validation

Linehan (1997) described six levels of verbal validation that together account for most of the acceptance strategies in Dialectical Behaviour Therapy (DBT): (1) paying attention to the client, active listening, and openness to what the client is experiencing; (2) accurate reflection, acknowledgement of the client's experience; (3) articulating client un verbalized behaviour; (4) validating client behaviour based on previous learning or other client limitations; (5) validating the client's behaviour as normative; and (6) radical genuineness. We will add an additional level: (7) selective self-disclosure of the therapist as validation of the client's experience. In addition, doing what is needed in the moment, or being responsive to the client's needs, may be considered "functional" validation (responses that are not verbal per se). Although this framework of levels or types of validation was developed specifically for use in DBT, it could be used across many treatment approaches, all of which utilize one or more types of validation.

Of course, validation is important across all relationships, not just in psychotherapy, and a similar schematic can be employed to understand validation in close relationships (e.g., Fruzzetti, 2006), and validation has similar effects across different relationships. The "higher" levels of validation depend on the therapist already having utilized one or more of the previous levels of validation, and the higher levels are hierarchically both more complex and more complete (Linehan, 1997). However, the most effective type of validation is the level or type that fits the situation, and the therapeutic goals, in the moment.

Level One: Openness, Paying Attention, and Active Listening

Level one validation requires the therapist to listen and observe what the client is saying, as well as the client's emotional expression, with curiosity and openness. The focus of this level is to be interested in what the client says and does, to not make assumptions, and to pay close attention to nuances of response (e.g., expression, posture, vocal tone) during the interaction as well as more clearly demonstrated behaviour. This process of active, interested listening communicates to clients that they are taken seriously and heard. However, it is not without challenges, as it requires the clinician to find a balance between paying close attention to the client and filtering and applying this information based on therapeutic targets, case conceptualization and the client's history (Linehan, 1997).

Level one validation is particularly important during the beginning of treatment as it facilitates the building of rapport and getting to know the client, but is essential throughout treatment for the client, and is similarly essential in other modes of DBT (skill training, generalization opportunities, consultation team, family interventions). Open and active listening requires the clinician to remain largely focused and engaged in the present moment. However, this does not mean that the therapist remains silent. Instead, reciprocal communication strategies should be used to *communicate* this level of attention and openness. Ordinary conversation cues, such as "Mmhmm" or "uh-huh" and nodding, "What happened next?" "What were you thinking while this happened?" further communicates that the therapist is tracking and understanding both the client's story and perspective (Fruzzetti, 2006; Linehan, 1997).

It is important that the therapist participate in the world of the client. The therapist does so by taking the client's perspective. This is frequently achieved by finding an experience or quality within the therapist, or his or her own experience to convey understanding. This might be done through the use of metaphor, analogy, or an imaginal story, which matches and highlights the client's experience in some essential way so that the client knows that the therapist understands. This may require frequent checking in with the client to ensure that the therapist's understanding matches the client's perspective as well as the facts of the situation (Linehan, 1997). However, in order to be effective, the clinician cannot become lost in the client's experience. In order to achieve a balance, it is important to be mindful of the client's goals and compare the content of the client's responses with these goals, never deviating from therapeutic activities that work toward those goals. For example, a therapist can be empathic and take the perspective of a client who reports having engaged in some dysfunctional behaviour which previously had been effective in some way (e.g., self-harm). In addition to finding the validity in the dysfunctional behaviour, the therapist must also determine the ways in which the behaviour is invalid, including how it thwarts the client's long-term goals. Thus, it is important to pay attention both to what is valid (acceptance), and also to what is

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dysfunctional (invalid in achieving long-term goals). Effective therapeutic decision-making can then follow, accordingly.

Level Two: Accurate Reflection and Acknowledging the Experience of the Client

Level two validation requires the therapist to acknowledge or reflect clients' thoughts, experiences, feelings, behaviours and assumptions back to them accurately. In a sense, this is simply acknowledging the client's phenomenology. This conveys (to a greater degree than level one validation) that the therapist understands the context of their experiences and their responses to such experiences. Level two validation corresponds to what the client has actually said, or what can be directly observed by the clinician, with no additions or interpretations, regardless of other knowledge or awareness on the part of the therapist. In order to reflect accurately the therapist must understand the events, and context, of the client's perspective and experience. Through an iterative process of accurately reflecting and acknowledging the client's experience, the client can correct and clarify any misunderstandings, and thus facilitate the therapist and client to work collaboratively from there.

It is important for clinicians to reflect and acknowledge the client's feelings and experiences, without necessarily treating these responses as facts. For a client who is currently suicidal, and says despondently "It's never going to get better!" Rather than reflecting as a fact the idea that the client's situation will not improve, the therapist might instead reflect, "It sounds like you're feeling really hopeless right now, and you're thinking it will never get better." The former is inaccurate, the latter accurate. The therapist must identify both the client's perspective and the facts. However, at this level of validation the therapist does not discuss how the client's experiences and responses correspond to the facts (if they are at all different), but rather simply acknowledges them as the client's experience.

Level Three: Articulating Unverbalized Experiences or Behaviours

In level three validation the therapist is able to articulate the client's unverbalized (unspoken) feelings, wishes, needs or thoughts by "reading" the client's behaviour in context and combining it with their understanding of the client's history and perspective. The client may not have verbalized something for a variety of reasons, and no assumptions are necessarily made about the motivation for not verbalizing them. For example, the client: 1) may simply be unaware of his or her behaviour (e.g., an emotion); 2) may not have the words (or other skills) to verbalize it; 3) may be having a negative and/or judgmental reaction to the behaviour; 4) may be afraid to verbalize it to the therapist, and/or have an aversive history around similar verbalizations; 5) may be overwhelmed; or there may be many other possible reasons.

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This form of validation further communicates to clients that they are understood, and does so at a deeper level than the previous two forms of validation. “Reading” a client accurately requires sensitivity and empathy for the client’s perspective, history, patterns, and responses. Articulating unverballed emotion can also communicate to clients that their responses are predictable and justified in the context of their experiences and environment. However, this is only implied, because at this level of validation the therapist does not explicitly state this. Clients often invalidate their own experiences, even if they are initially able to accurately label them, which makes this a particularly powerful form of validation. When clients are unable to label their thoughts or emotions, particularly in the case of painful emotions, articulating the unverballed may help them gain a better understanding of themselves.

In situations in which clients miss their own primary emotions, the therapist can offer a Level 3 validation, something like, “in that situation, I wonder if you might have also felt ____.” Notice how this is offered as a hypothesis, not something the therapist is 100% certain about. This affords the client the opportunity to “try it on” and see if it is accurate, and provide further accurate expression of his or her own.

It is important that clinicians articulate unverballed responses that represent both client strengths and weaknesses, as this helps to communicate that the client is accepted as is, and understood, by the therapist. In contrast, ignoring, or only validating clients’ strengths, can communicate that client struggles or dysfunctional behaviours (or lack of skills) are unacceptable, and that the therapist is not capable of or interested in completely understanding them.

Therapists should be cautious when using Level 3 validation. The risk is that therapists will become overly attached to a particular theory or may interpret the observed functions of a behaviour as corresponding to a particular intent. For example, a client who threatens suicide at the prospect of being left by a loved one may be viewed as “manipulative,” instead of being perceived as desperate and hopeless. Worse, any protest on the part of the client may be viewed as further proof of the validity of the therapist’s theory. Empathy for the client’s perspective and experience (good Level 1 validation) is important to help prevent this. In addition, developing multiple hypotheses may help the clinician avoid becoming overly attached to a single one, and respond flexibly to disconfirming or contradictory evidence (Linehan, 1997).

Level Four: Validating in Terms of Previous Learning or Other Limitations

This type of validation acknowledges that certain thoughts, feelings, and overt behaviour are understandable in the context of the client’s learning history or current limitations (e.g., medical illness or other limiting client factors), even if the behaviour is otherwise problematic or invalid. Almost all behaviour serves a function, and is adaptive in the

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context within which it is learned, and can therefore be validated. This level of validation is based on the therapist acknowledging the likely previously adaptive function of behaviour.

For example, Jasmine was previously repeatedly assaulted by her former partner, Bob, but she was able to leave him. Now, several years later, she has found a new partner, Bryan, who has never been aggressive or violent with her (nor with anyone else), and they have a generally good relationship. However, when they do have a disagreement, and Bryan gets upset, he does sometimes take a deep breath and appears upset. When he does that, Jasmine becomes overwhelmed with fear. However, because of that fear, she does not tell Bryan about her experience. She does tell her therapist, however, that she is afraid of Bryan and wants to leave him. This occurs many months into treatment, following many examples of Jasmine telling her therapist how loving and kind Bryan is, and having had several sessions that included him because he wanted to know how best to support Jasmine and her treatment. After getting a detailed description of the event, it was apparent that Bryan was never verbally, or non-verbally, threatening. However, his deep breath bore a similarity to what Bob had done many times just prior to exploding in a violent rage. They agreed to have a session with Bryan, and he explained that he was just confused and didn't know what to say, because Jasmine had seemed to withdraw from their discussion and seemed distant and aloof. He described being sad, not angry. The therapist offered a Level 4 validation: "It makes sense that you would be very afraid in that moment, given the awful experiences you had with Bob." Of course, in this situation, they had also successfully identified a change target for Jasmine (with help from Bryan): how to respond to Bryan in the moment, and not to respond to him as if he were Bob. This example highlights the importance of accepting and validating the reality of the client's prior learning without judgment.

Another example might be a client who lacks skills for managing overwhelming emotion, and has been cutting to manage these emotions since her late teens. Despite learning several new skills, and being committed to not self-harming, she is frustrated that she still has such strong urges to cut and says, "What is wrong with me?!" A Level 4 validation might be, "It makes sense that you still have high urges to cut; it's the only thing you had that worked for you to get any relief from your emotional pain for a long time." Depending on the type of behaviour it may also be important for the therapist to add that while the client's behaviour makes sense in the context of his or her history, it may no longer be serving the client's long-term interests and goals. Building on the previous example, the therapist might say "... and now we've got to work on practicing skills and giving you more options that are effective in reducing your dysregulated emotions, so that your brain will learn to rely on those skills instead." Thus, Level 4 validation can often be an acceptance step on the way toward a change goal.

Level Five: Validation as Normalizing the Client's Behaviour or Experience

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Level 5 validation occurs when the therapist acknowledges that the client's behaviour is legitimate, justifiable, and *normative*. The therapist understands, and communicates, that the client's behaviour or experience is essentially how anybody would respond to such a situation. At this level of validation, the therapist must find the "kernel of truth" in the client's behaviour, highlighting aspects of their responses which make sense in the current context (Linehan, 1993; 1997). While the client's response to a situation may also make sense in terms of previous learning, the behaviour is justified based on its own merit and acknowledging previous learning history is not necessary, and in fact may be invalidating.

Level 5 validation can be used when the client's behaviour is based on empirical fact and is normative within the client's culture. For example, imagine a person walking into his or her flat and discovering two burly people inside who are stealing her belongings and ransacking the flat. Fear is completely normal, and running back out the door would make sense ... anybody would be scared in that situation. Even if this client has a severe anxiety disorder, it is important to validate that the fear in this situation is completely normative, and not present because of her generalized conditioning to fear cues, nor is her fear because she has an anxiety disorder, PTSD, and so on. In fact, validating at level 4 ("it makes sense that you were afraid, given your anxiety disorder") would be quite invalidating in this situation, because the situation was truly dangerous.

Some behaviours require a Level 5 validating response, as the example above illustrates. The experience of primary emotions, and the accurate expression of primary emotions, because by definition they are universal and adaptive, typically would be validated in a Level 5 way. For example, feeling sadness and grief at the death of a close relative or friend is normative, as would be shame at being ridiculed in public, or joy upon receiving love and attention from a person you care about. Primary emotions almost always provide at least one "kernel of truth" that can be validated in a Level 5 way.

In fact, most behaviours that are simply normative and do not lead directly to dysfunction are validated this way. However, determining when level five validation is appropriate can be a complex process in some situations. The therapist infrequently has direct access to all relevant empirical facts and must rely on reporting from the client, and as a result may need to conduct a fair amount of sleuthing in order to get a more complete picture in specific situations. In these cases, it is important for the therapist to balance effectiveness with what is right, or correct. The complex nature of validation at this level requires careful examination on the part of the therapist, and constant focus on the client's long-term goals.

One way for the therapist to proceed also overlaps a little bit into Level 6 (below), requiring the therapist to imagine how he or she might feel, what she or he might think, want, or do in a given situation (like the one a client is in, or describing). This activity equalizes the relationship in some ways, instantiating half of the relationship dialectic in DBT: that the therapist and client are equal human beings with equal value, *and* also have very separate roles in the therapy. If the therapist would think, feel, or act in a similar

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manner to the client, that is some evidence that the behaviour is normative. Communicating this shared responding (“I would feel that way/do that/want that too!”) provides both a Level 5 validating response and also carries over into Level 6.

Level Six: Treating the Person as Valid—Radical Genuineness

Validation levels one through five may be viewed as specific ways to validate specific behaviours. Level 6 differs in both level and kind: the individual as a person is validated rather than specific behaviours or even patterns of responses. Level six validation treats the client as a legitimate, capable person of equal status, worthy of respect, while maintaining strong empathy for his or her individual difficulties and challenges, similar to the person-oriented approach pioneered by Carl Rogers (1961). This is in stark contrast to what Stage 1 clients may be accustomed to in their natural environment: being treated as fragile, incompetent, broken, or disgusting, and often in a condescending manner. In Level 6, the client is neither to be feared as overly powerful nor as overly fragile. In a real relationship, we treat the other person as an equal human being, of course simultaneously recognizing his or her pain and limitations on the one hand, and skills, strengths, and competencies on the other. The same is true in DBT.

Level 6 validation requires the clinician to be completely, or radically, genuine within the therapeutic relationship (while still dialectically within the therapist role). Radical genuineness requires that the clinician be mindful of the present moment while reacting to the client spontaneously. In order to achieve this genuineness, the therapist must be willing to abandon certain narrow conceptions about the professional role and respond to the client empathically. In this context, both confrontational (irreverent) and cheerleading techniques can be examples of level six validation, as can expressions of genuine warmth and caring, and helping the client to tolerate painful emotions. By not treating the client as fragile or incompetent, irreverence and confrontation communicates that client is a complete individual, capable of change and who does not need to be handled gently or with fear. Cheerleading also communicates to the client that he or she is capable of change and able to overcome challenges and difficulties in life. By having confidence and believing in the client the therapist validates these capabilities and the client’s individual wisdom. However, it is important that the clinician balance hope and confidence in the client’s abilities with realistic expectations and validation of how hard these difficulties and challenges are for the client. Without this balance, cheerleading can be perceived as invalidating by the client.

In addition, radical genuineness also allows, and may even require, the therapist to push, or simply allow, the client to experience his or her primary emotion, even when it is painful. In this case, it would reflect recognition of the validity of the emotion (Level 5) plus an appreciation for the strength of the client to tolerate even intense emotions *within a validating therapeutic environment* (assuming the client does have sufficient skills to do this productively). Of course, this also requires the clinician to be able to tolerate the

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client's intense emotions, and the therapist's own intense emotions as a genuinely open, caring, and compassionate human being who is empathically present with the client and his or her experience.

For example, sometimes clients tell us about events in their lives that are difficult to hear, and were painful, or even traumatic, for the client. Level 6 validation might include the therapist allowing herself or himself to tear up, be present with the sadness, genuinely feeling a lot of empathy for the client and hold a belief in the client's ultimate ability to move to sadness, with sufficient skills, support, and validation. The therapist might simply say, "I feel so sad hearing this story" (or, "I am impressed how you got through that"). Of course, other responses might be needed if the client does not yet have the capacity to tolerate that much negative emotion. In those situations, validating using Level 2 (noticing, reflecting) and Level 5 (normalizing), followed by coaching to tolerate and reduce the client's arousal using distress tolerance or emotion regulation skills might be required.

Thus, Level 6 is less about specific verbal responses to specific client disclosures and more about the therapist's comportment: respecting the client and his or her strengths at all times and validating the person, even while recognizing even significant skill deficits and dysfunctional repertoires, and acting with awareness of both.

Level Seven: Validating through Self-Disclosure

Level seven validation occurs when the client discloses vulnerabilities that the therapist has also experienced, and shares with the client. Through self-disclosure of his or her own vulnerabilities (reciprocal communication) the therapist validates the client's experiences. This level of validation may be viewed as an extension of levels five and six, since it both normalizes the client's experience and treats them as a legitimate person of equal status, albeit in a very specific way. As a result, it has many of the benefits of both levels, and is a powerful tool for strengthening the therapeutic alliance. In some cases, it may also provide opportunities for modelling effective behaviour and patterns of response for the client. An example of level seven validation for a client who describes consistently evaluating his performance on tasks as poor, and then proceeds to ruminate or withdraw from engaging in other tasks (regardless of the facts of his or her performance), could be "I often have had the thought that I've performed poorly too. It's easy for me to get caught up in that thought and judge myself really harshly and then I end up feeling awful." Of course, this must quickly be followed by honest indications that the *therapist can manage this effectively*, or else the client could begin to worry about the therapist. In this example, the therapist could then facilitate a discussion of observing thoughts as thoughts and other mindfulness strategies the therapist has used successfully (and sometimes even unsuccessfully).

As with all self-disclosure, it is crucial that therapists be genuine and aware of the function of their self-disclosure. If the function serves to communicate to the client that he or she is understood, and not isolated in this experience, then this is likely to be experienced as validating. Of course, validation must primarily serve the client and the client's goals.

When Validation Apparently “Fails”

Sometimes the therapist offers what he or she thinks will be a validating response, but instead of soothed emotions and more collaboration, the client responds with escalated negative emotions. The therapist might think, “validation didn't work!” However, assuming that the client heard our actual words and tone (and that we said what we think we said), we might instead consider the possibility that we *did not understand* the client's experience, and so our communication of understanding was really a communication of misunderstanding. In other words, we were *invalidating*.

The most important step at this point is what *not* to do: Do not insist that your statement was validating. Instead, notice what happened, and use Level 6 validation: “I thought I understood what you were telling me, but you have reacted really negatively, so I have to assume that I missed the boat, that I misunderstood something important. Can you help me understand? I really want to.” Of course, if really dysregulated, it may be important to coach the client to help him or her re-regulate first, then engage in the reparative behaviour.

The point here is that validation, by definition, communicates an understanding of the client's experiences and other behaviours. If the client does not “feel” understood, either the therapist's understanding, or communication, is lacking. Consequently, for clients who have a difficult time expressing themselves accurately, validation can be very difficult (Fruzzetti et al., 2005; Fruzzetti, 2006). Thus, it is important to use the consultation team to practice, stay non-defensive, and keep trying.

Summary and Conclusion

Validation is a complex behaviour. Some client behaviours are valid in one way (e.g., historically), but not others (e.g., in the present situation). Other client behaviours (e.g., primary emotions) are always valid, in every way. Being able to invalidate invalid behaviours (occasionally) gives us credibility and direction to validate valid ones. Validation can be understood with great precision behaviourally, but also includes the humanity and softness of client-centred therapy. Validation in DBT includes validation of the person as a stance and overarching behaviour (Level 6), begins with enormous openness and attention and maintains that activity at all times (Level 1), while still striving to find very specific behaviours in the moment (e.g., emotions, wants, actions, thoughts, sensations) that are valid in a particular way, and to validate them in that particular way (Levels 2-5). Because validating another human being soothes his or her negative emotions, validation is a powerful tool for therapists. And, because therapists and clients are people, validation is also simply the right thing to do, as it is in any relationship.

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