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VALIDATION AND PSYCHOTHERAPY

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Perhaps nowhere is the ability to empathize with another person more important than when one is interacting with a person who is on the brink of suicide. This is true whether one views one's task as helping the individual choose continued living over suicide or, more rarely, as helping the individual make a wise choice between suicide and continued life.[1] The ability both to hold a person within life, when that is needed, and to allow a person who has chosen suicide to die, when that is needed, depend on an experiential appreciation of the other's worldview. Finding hidden or obscure ways out as well as seeing that there is no way out require both the ability and the willingness to fully enter the experience of the individual ready to suicide and, at the same time, not become that experience (that is, remain separate from the experience).

Over the past 20 years, I have been developing and evaluating an approach to treatment designed specifically for suicidal individuals, particu-

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[1] In my own practice I have chosen to always be on the side of life over suicide (see Linehan, 1993, for a detailed explanation of this choice), and I make this clear to clients at the beginning of therapy. However, I recognize that, in some cases—for example, in the case of a terminally ill client facing severe physical pain—others may reasonably chose a different or more flexible therapeutic stance.

larly those who are chronically suicidal. Although the treatment, Dialectical Behavior Therapy (DBT; Linehan, 1993; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan & Heard, 1993; Linehan, Heard, & Armstrong, 1993; Linehan, Tutek, Heard, & Armstrong, 1994), is now considered by many to be a general treatment approach applicable to many populations, its origins as a treatment for seriously suicidal clients had much to do with its current form. As the name suggests, DBT is firmly anchored in behavior therapy; the change strategies at its center are standard cognitive and behavioral treatment approaches. In attempting to apply standard behavior therapy to severely and chronically suicidal individuals, however, I noticed two things become immediately apparent. First, focusing on client change, either of motivation or by enhancing capabilities, is often experienced as invalidating by clients who are in intense emotional pain. In many clients, it precipitates noncompliance, withdrawal, and at times, early drop out from treatment, in other clients extreme anger and aggressive attacks on the therapist, and in still others both patterns of behavior. Second, focusing treatment on exploration and understanding, in the absence of a clear focusing of efforts to help the client change, is often experienced by these same clients as invalidating because it does not recognize the unendurability and, therefore, necessity for immediate change of the present unremitting pain. Thus, therapy approaches that focus on acceptance of the client (rather than change) also risk client withdrawal, attack, or both. Either of these client responses, attack in an attempt to change the therapist or passive withdrawal in an attempt to avoid unwanted therapist behavior, typically have a reciprocal invalidating effect on the therapist in turn. The therapist then may unwittingly respond with, at times, almost imperceptible, but none-the-less real, attack or withdrawal from the client. Although unavoidable at times, client or therapist attack or withdrawal interfere with the collaborative working relationship necessary for therapeutic progress.

It was the tension and ultimate resolution of this essential conflict between focusing on client change this very moment versus acceptance of the client as he or she is in the moment that led to the use of dialectics in the title of the treatment and to the overriding emphasis in the treatment on reconciliation of opposites in a continual process of synthesis. The most fundamental dialectic is the necessity of accepting clients just as they are within a context (and, indeed, therapy's *raison d'être*) of trying to help them to change. The emphasis on acceptance as a balance to change flows directly from the integration of a perspective drawn from Eastern mindfulness (primarily Zen) practice with Western psychological (primarily cognitive–behavioral) practice. Although acceptance and change cannot really be as clearly distinguished as I am portraying it here, for reasons of exposition, acceptance of the client in DBT is described under the rubric of three fundamental treatment-strategy groups: validation, reciprocal communication (including warmth, genuineness, and responsiveness), and environ-

mental intervention (i.e., influencing or making changes in the environment to assist the client). These acceptance strategies are balanced by corresponding "change" strategies of problem solving (including behavioral analyses, analyses of alternative behaviors and solutions, commitment and psychoeducational strategies, basic change procedures of skills training, exposure-based procedures, cognitive modification, and contingency-based procedures), irreverent and confrontational communication, and the stance of consultant to the client (rather than to the client's personal or professional network) when interacting with the community outside of the therapeutic dyad. All strategies are applied within a context of overarching dialectical strategies and stance.

It would be difficult to overestimate the importance of validation in DBT. Together with dialectical and problem-solving strategies, it forms the triadic core of the treatment. Although validation encompasses and requires empathy, it is more than empathy. The purpose of this chapter is to describe the meaning and use of validation in DBT. I will start first with a definition of validation. Next, I will contrast that definition with definitions of empathy. I will then further discuss the meaning of validation by describing six levels of validation. Validation can also be communicated explicitly through verbal comments or implicitly by responding to the individual in a manner that implies that one takes the individual's responses to be valid. I will next discuss the importance of both types of validation. Validation can also be directed at various client responses. The importance of validating emotional, cognitive, physiological, and action response patterns (or targets of validation in behavioral terms) will be discussed next. Validation in psychotherapy is always strategic, that is, it serves particular functions. Five functions of validation are presented.

THE DEFINITION OF VALIDATION

The term *validation* is widely used in the social sciences; I found 7,927 citations for the term *validation* compared with 4,436 citations for the term *empathy* in the social sciences index. Interestingly, however, it is a term rarely found in writings on psychotherapy. The *Oxford English Dictionary* (1989) offers several definitions of validation, including, "The action of validating or making valid . . . a strengthening, reinforcement, confirming; an establishing or ratifying" as valid. It proposes synonyms for validate such as *confirm*, *corroborate*, *substantiate*, *verify*, and *authenticate*. The act of validating is "to support or corroborate on a sound or authoritative basis . . . to attest to the truth or validity of something." To communicate that a response is valid is to say that it is "well-grounded or justifiable: being at once relevant and meaningful . . . logically correct . . . appropriate to the end in view [or effective] . . . having such force as to compel serious attention

and [usually] acceptance." Being "valid implies being supported by objective truth or generally accepted authority" (*Webster's Dictionary*, 1991), "being well-founded on fact, or established on sound principles, and thoroughly applicable to the case or circumstances, soundness and strength" (*Oxford English Dictionary*, 1989), the quality of "value or worth; efficacy" (*Oxford English Dictionary*, 1989). These are precisely the meanings associated with the term when used in the context of psychotherapy in DBT:

> The essence of validation is this. The therapist communicates to the client that her responses make sense and are understandable within her current life context or situation. The therapist actively accepts the client and communicates this acceptance to the client. The therapist takes the client's responses seriously and does not discount or trivialize them. Validation strategies require the therapist to search for, recognize and reflect to the client the validity inherent in her response to events. With unruly children parents have to catch them while they're good in order to reinforce their behavior, similarly, the therapist has to uncover the validity within the client's response, sometimes amplify it, and then reinforce it (Linehan, 1993, pp 222–223)

Two things are important to note here. First, validation means the acknowledgment of that which is valid. It does not mean the "making" of something valid. Nor does it mean validating that which is invalid. The therapist observes, experiences, and affirms but does not create validity. That which is valid preexists the therapeutic action. Second, and I feel compelled to say this simply because my behavioral orientation may give a wrong impression, the word *valid* and *scientific* are not synonyms. That is, replicable, controlled, empirical observation of events is not the only way to arrive at a determination of validity. It is, however, one way and is the preferred method when the question is indeed one of empirical validity open to scientific inquiry. If it alone were the criteria for validity, however, much of human experience and import would be ruled out of the therapeutic encounter. Logic, sound principles, generally accepted authority or normative knowledge, and experience or apprehension of private events, at least when similar to the same experiences of others or when in accord with other more observable events, are all basis for claiming validity. In the former case, we can speak of empirical validity and in the latter of consensual validity.

WHAT TO VALIDATE

Validating the Individual

What to validate? A first question here is whether the therapist validates the individual or simply the behavior or responses of the individual. Validation, at least in its purest definitions, can actually mean either. Fur-

ther definitions of validation include (*Oxford English Dictionary*, 1989). "to grant official sanction to by marking . . . also. to declare [a person] elected," where sanction means to approve, support, allow, and empower. When one speaks of validating the individual person (as a whole, as it were), what is being validated? It is the authenticating of the individual as who he or she actually is. (The validation of a person's beliefs about who he or she is will be discussed below.) The question, "Who am I," of course, is a central question in almost all instances of psychotherapy. As deMello (1990) has stated, however, the question is essentially unanswerable in that any answer we give is necessarily incomplete. We are not our race, our age, our roles in life, our position, our relationships, our problems, our joys, our emotions, our actions, our thoughts, or our experiences, even in their sum total, nor are we our "self." Perhaps, as deMello says, we can only say that we are human. Even that, however, is surely a limited view. The very limitations of one's answer to this question, the boundaries on self-definition when there are no true boundaries, suggests an answer to the question. When validating the individual, one validates everything that is. That is, there is nothing that the individual experiences, feels, thinks, does, says, or "is" that is not himself or herself.

One validates the individual when the individual's existence is treated as justifiable and the person is responded to as at once relevant and meaningful, as compelling serious attention and acceptance. The person as he or she is, in the moment, is visible and seen. Therapeutic actions and reactions take into account and are responsive to the individual client rather than determined by the therapist or client roles or arbitrary rules. The person, rather than the constructs brought to the interaction by the therapist, is seen and countenanced. Validation used in this sense perhaps comes closest to the meaning of the term "unconditional positive regard" used by Rogers (1959). Of the individual, unconditional validation is required.

In DBT there is an added emphasis on balancing the therapeutic effectiveness of various interventions with the natural limits of each therapist to provide effective interventions and to weigh these two factors (i.e., the limits of providing effective interventions and therapists' personal limits) more heavily than arbitrary role definitions and arbitrary boundaries when interacting with the client. Such a stance requires responding to the client not only as he or she is in the moment but also in a manner that is responsive to one's own self in the moment. Although the therapeutic role may circumscribe therapist activities and goals, it is nonetheless the therapist as a person that is in the relationship helping the client. Thus, the therapist as a unique individual as well as the individual acting from the role of therapist are the therapeutic relationship as well as the client as a unique individual must be held valid. As I will discuss below, this sense of validation comes closest to Rogers's use of the term *genuineness* Such a position, of course, requires utter clarity on the part of the therapist (which is why ongoing peer supervi-

sion is defined as part of DBT rather than as extraneous to it). Taking care for the client is always the responsibility of the therapist.

It is important to note here, however, that validating what is said, thought, felt, or otherwise experienced to be, but is not, is an instance of validating the invalid. Conversely, by denying that which actually is, it is also an instance of invalidation of the valid. Validation has nothing to do with social desirability and is not a synonym for praise. Therapist fears of confronting clients, of "calling a spade a spade," of acknowledging the painful, undesired, or culturally or personally "unacceptable," is often the basis of validating the invalid. Falsely telling a client who is secretly trying to manipulate you that he or she is not really manipulating you is just as invalidating as calling a nonmanipulating client a manipulator. Except in exceptionally rare instances, validating the invalid is not therapeutic. It is not genuine and, furthermore, it communicates that what is is unacceptable, unendurable, or at least, not relevant and meaningful.

Validating Behavior

As used here and in behavior therapy in general, *behavior* refers to any activity of the individual, including physiological responses (e.g., breathing, beating heart, and tensing muscles), cognitive responses (e.g., expecting, believing, thinking, and assuming), and overt actions. Contrary to what many people believe, behavior does not have to be observable by others to be important to behaviorists. From the behaviorists' perspective, behavior can be private (and observed only by the individual behaving) or public (and observed by others). Both private and public behaviors are important in DBT and in all modern behavioral treatments.

Validation of behavior is the clear and unambiguous communication that an activity, emotion, belief, sense, or other experience or response of the individual, whether private or public, is at once relevant and meaningful to the case or circumstances, and is also (a) well-grounded or justifiable in terms of empirical facts (i.e., those observed and agreed to by generally disinterested observers), logically correct inference, or generally accepted authority; and/or (b) appropriate to the end in view (i.e., efficacious for reaching the individual's ultimate goals).

As can be surmised, behavior can be valid from the perspective of one set of circumstances or for one purpose and not valid from another. In a somewhat simplified way, one can consider behavior (B) valid in terms of either: behavioral antecedents (A) where A are the facts (known empirically or by logical inference or by generally accepted authority), including previous events, responses of the individual, or current context relevant to the behavior (i.e., B is justified by or well grounded in A) or behavioral consequences (C) where B is effective in reaching C that represent ultimate goals or ends in view (B is effective at attaining C).

When considering whether behavior is valid or should be validated, a number of dialectical tensions emerge. Behavior can be valid in terms of one set of antecedents (e.g., historical events) but not in terms of another set (e.g., present events). Behavior can be valid in terms of an individual's private experience of reality (e.g., spiritual experiences) but not in terms of public events seen by the outside observer. Private experiencing, itself, can be valid in terms of the consensus of one set of authorities but not another. Behavior can be valid in terms of antecedents to behavior but not in terms of consequences (e.g., being "right" rather than effective). Behavior can be valid in terms of one set of consequences (e.g., short-term consequences) but not in another set (e.g., long-term consequences). Two points are important here. First, not all behavior is valid in every sense. Second, all behavior is valid in some sense. It is the resolution of these and similar dialectical tensions, without discounting the validity of either end of the polarity, that is at the heart of validation. The therapist may need to search for and find the grain of wisdom in a cup of sand. The guiding premise here is that in any interaction some basis for validity can be found and reflected to the client.

DIFFERENCE BETWEEN VALIDATION AND EMPATHY

There is considerable overlap between the concepts of empathy and validation, yet the two are also quite different. The overlap occurs in two ways. First, empathic communication is itself often validating. Being understood from within one's own frame of reference is inherently validating because it connotes that one is not "crazy," that one makes at least enough sense to be understood. Second, validation always involves accurate recognition, acknowledgment, and authentication of that which is. To validate the other, one must know the other. Empathy is that process whereby one knows another person more completely that the person can verbalize or communicate explicitly. It is requisite to anything but the most simple validation.

There are essential differences between empathy and validation. Although there may be many definitions of empathy, a commonly accepted one is that of Rogers, who defines it as "perceiving the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person but without ever losing the as if condition" (1980, p. 141, referenced by Greenberg & Elliott, Chapter 8, this volume). Contrast this with the definition of validation as communicating to an individual, by word or response, that he or she is heard and seen and that his or her responses and patterns of behavior have inherent validity. Validation is the answer of "yes" to the question "can this be true?" Experiencing what "this" refers to is where the first half of

empathy, "perceiving the internal frame of reference of the other," comes in. Only when the therapist truly understands what the client is actually experiencing, thinking, assuming, believing, expecting, feeling, caring for and about, hoping, doing, and living within, the therapist begin to assess the validity of the "this." Assessing the truth value of "this" is where the second part of empathy, "without losing the as if condition," comes in. The therapist must be able to function as a disinterested, or at least unbiased, observer to assess whether a response is well-grounded in empirical facts, inference, or authority and is likely to be effective in moving toward the client's ultimate ends. Thus, validation in psychotherapy depends on the ability of the therapist to exercise moment-to-moment empathy during interactions with the client.

Although empathy is necessary for clinical validation, it is not sufficient. Needed in addition is an analysis of the client's response in light of its relationship to its context (i.e., the empirical situation) and its function (i.e., as a means to an end). Validation, therefore, is based on a conclusion about an empathic experience. In contrast to empathy, validation is inherently analytical, of truth, of wisdom, of effectiveness. Or, put another way, validation requires a conclusion about the validity of the person as represented (validating the individual) or the behavior or experience of the individual (validating behavior). Although all behavior can be validated at some level, it cannot all be validated at the same level. It is the differences in level that further differentiate validation from empathy.

LEVELS OF VALIDATION

Validation can be considered at any one of six levels. Each level is correspondingly more complete than the previous, and each level depends on one or more of the previous levels. The first two levels of validation encompass activities usually defined as empathic, and the third and fourth levels are similar to empathic interpretations as those terms are used in the general psychotherapy literature. Although I feel sure that most therapists use and support levels five and six of validation, they are much less-often discussed in the literature. They are, however, definitional of DBT and are required in every interaction with the client.

Level One: Listening and Observing

The first step in validation is the listening to and observing of what the client is saying, feeling, and doing as well as a corresponding active effort to understand what is being said and observed. The essence of this step is that the therapist is *interested* in the client. The therapist pays attention to what the client says and does. The therapist notices the nuances

of response in the interaction. Validation at level one communicates that the client per se, as well as the client's presence, words, and responses in the session, have "such force as to compel serious attention and [usually] acceptance" (see definitions of validation above). Level-one validation requires keeping attention focused on the client and attending closely to both verbal and nonverbal content (i.e., to the manner of speaking and of responding to the therapist's communications; to the nuances of expression, and to minute changes in voice tone, posture, facial expression, and so on). It also requires paying attention to what is important to and for the client.

Listening and observing also require that the therapist be adept at maintaining the dialectical tension between unconditional listening and observing, on the one hand, and at filtering what is heard and seen through the lenses of theory and previous words and actions of the client, on the other. Preformed categories must give way to new understandings. And understanding guides further exploration and observation. The therapist lets go of theories, prejudices, and personal biases that get in the way of hearing and observing clearly the actual events unfolding, the emotions, the thoughts, and the behaviors of the client. The therapist listens unconditionally and observes things as they actually are. With no conditions set, the client is seen and countenanced as he or she is in the moment. Using what was gained from prior interactions, remembering what the client has already said and done, how he or she has reacted previously in sessions communicates powerfully that the client is important enough to remember. The client is worth one's efforts to understand. To the extent that one's theories are useful, they can assist the therapist in integrating what is heard into a picture that both informs and completes what the client is attempting to communicate. The resulting discourse validates by communicating that the client is known. Indeed, such communication—informed by theory and integration of previous knowledge—can be so powerful that it is considered a higher level of validation and is described further as a level-three validation.

Listening and observing, at level one of validation, require an engaged, reciprocal interaction pattern. "Tell me more," "I don't understand, explain that," "What were you thinking at just that point?" "What then?" communicate that both the story and the client's rendition of the story are important. Listening in such a manner requires one to stay immediate, where immediate means fully present in this one moment. Validation at the first level encompasses empathic exploration of the client's experiences as well as of the "facts" of the case. The basic idea here is that the therapist actively gets to know the client, both from the perspective of the client and from the perspective of an outside observer. The therapist attempts to understand the phenomenological experience of the client as well as the context in which the experience takes place. To use Greenberg and Elliott's words (p.

168 this volume), the role of the therapist is that of "facilitator of exploration and a companion in the search, a co-explorer." The task here is the same as actively seeking to arrive at empathic understanding of the client when such understanding is, as Rogers (1980) defined it, "perceiving the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person but without ever losing the as if condition" (p. 141). Understanding the context of the experience, including holding a sometimes more objective picture of both events and client responses, requires not "ever losing the as if condition."

The further dialectic in listening and observing is between the perspective of the client and of the observing therapist. The therapist must become a participant in the client's world as well as simultaneously remain an observer of that world. How does the therapist become a participant? The therapist must imagine the experience and perspective of the client. In DBT, therapists are encouraged to find within themselves experiences, either in memory or by way of imagination, metaphor, analogy, or story, that match the client's in some essential way. The therapist covertly rehearses stepping into the client's shoes, adopting imaginally his or her past as well as present. It goes without saying, of course, that such a stance requires moment-to-moment checking to be sure that the therapist's understanding actually does match the experience and facts of the client's experience.

How does the therapist remain an observer, not getting lost in the perspective of the client? By maintaining an overriding interest in the well-being of the client and a constant mindfulness of where the client is headed (i.e., of the client's ultimate goals). In DBT, the therapist is always focusing on both acceptance and change. Thus, at each moment, the therapist must compare the responses of the client to those that would be necessary to achieve the client's goals. The therapist is always asking the essential question: If I were the client how would I respond if I held the client's goals. That is, at each moment the therapist is noticing both what the client is experiencing and how the client is responding to that experience, asking in essence "OK, from here how do I get there?" Listening and observing is figuring out where "here" is.

Level Two: Accurate Reflection

The second level of validation is the accurate reflection back to the client of the client's own feelings, thoughts, assumptions, and behaviors. The therapist conveys an understanding of the client, a hearing of what the client has said, and a seeing of what the client does—how he or she responds. Validation at the second level sanctions, empowers, or authenticates that the individual is who he or she actually is. Generally, reflection in behavior therapy, as well as DBT, stays rather close to what is actually

said by the client or observed directly by the therapist. Thus, although the therapist often summarizes patterns and uses synonyms and stories to communicate understanding and may reorganize what is said into a more coherent package, little is added to the communication of the client. Reflective accuracy, of course, requires that the therapist actually understand the perspective of the client as well as both the events that occurred and the client's responses. By back and forth discussion, with the therapist summarizing and the client correcting and adding to the summary, the therapist helps the client further identify, describe, and label his or her covert and overt response patterns. The essential goal is for therapist and client to come to a shared understanding of the material at hand. The therapist frequently says "Is that right?" testing the hypotheses that hearing is complete and understanding is accurate. The client has a chance to say the therapist is wrong.

A nonjudgmental stance, both verbally and nonverbally, is fundamental to reflection at this level. By nonjudgmental, I mean neither good nor bad. That is, validation at this level does not imply approval or encouragement. Nor does it imply judgment of effectiveness or value. The therapist does not agree that the client's perspective is the only perspective possible. Thus, for example, and contrary to many people's beliefs about empathy, when a client expresses fragility, accurate reflection does not necessarily require a sympathetic voice tone. It is the essential "isness" that is reflected. A matter-of-fact, or "but, of course" voice tone may many times be the most effective approach.

It is extraordinarily important that the therapist accurately reflect just what is being said, felt, done, or experienced by the client. Often, instead therapists confuse the responses of the client with the events or stimuli that are being responded to. Or, as I say to the therapists I train, therapists often fall into the pool with the client rather than get the client out of the pool. The therapist steps into the client's shoes but forgets his or her own shoes. In describing an interaction, the client's says in a desperate voice, "she hates me." This statement may accurately reflect what the client believes and may relate to feelings of the client that the therapist can identify and acknowledge. However the statement "she hates me" is not necessarily a statement of a fact. That is, the person in question may not hate the client. A level-two validation might be a statement such as "so, you are feeling desperate and really certain that she hates you." It is especially easy for therapists with seriously disturbed clients to pick up the client's hopelessness, helplessness, anger at the world, fears, passivity, and other responses that contribute to not reaching the client's goals. A level-two validation is when the therapist acknowledges the facts of the client's experience—that is, the therapist is so in touch with the perspective as to identify it correctly. However, it is not level-two validation to also add in word, deed, or nonverbal response that the client's responses correspond to the empirical facts

when they may not. Feeling angry is different than actually being attacked. Fear is different than actually being threatened. There are any number of reasons therapists confuse the facts of a situation with the client's responses to the facts when the two are actually discrepant. With clients who are highly expressive emotionally, it may be due to emotional contagion. With clients who communicate calmly and are fluent and articulate, it may be simply that the therapist does not pay close enough attention to spot the inconsistencies. Whatever the reason, care must be taken to distinguish emotions, thoughts, and experiences as events worthy of attention and acknowledgment themselves rather than as literal statements about, markers, or signs of the world the individual is reacting to.

Level Three: Articulating the Unverbalized

In level three of validation, the therapist communicates to the client his or her understanding of aspects of the client's experience and response to events that have not been communicated directly by the client. At level three, the therapist "reads" the client's behavior and figures out how the client feels and what the client is wishing for, thinking or doing just by knowing what has happened to the client. It is when one person can make the link between precipitating event and behavior without being given any information about the behavior itself. Emotions and meanings the client has not expressed are articulated by the therapist. The therapist expresses an intuitive understanding of the client derived from all of the information and observations to date. The therapist reads the client's mind, so to speak, sometimes knowing clients better than they know themselves. In level three, the therapist may state out loud what the client observes but is afraid to say or admit. This simple act of reflection, especially when the therapist "says it first," can be a powerful act of validation because clients often observe themselves accurately in the first place, but because of mistrust of themselves, they invalidate and discount their own perceptions.

When someone knows how you are responding, how you feel or think, or what you are likely to do, without your having to tell them directly, it is almost always experienced as validating. First, and at a minimum, such validation communicates that one is known, the therapist authenticates that one is who one really is (i.e., the individual is validated as himself or herself). Articulating unverbalized responses is important for both patterns that represent client strengths as well as client weaknesses. The necessity of this type of validation, however, when the person's emotions, cognitions, or overt behavior are maladaptive, dysfunctional, or reprehensible, is often overlooked by therapists. Putting a positive cast on client behavior—refusing to acknowledge behaviors that have a tremendous negative impact on clients' lives and hopes—has the net effect often of creating in clients a sense that they really must be completely unacceptable, not to mention

that the therapist is naive, uneducated, or not interested enough to figure one out. Level-three validation, when done well, can create the hope that is requisite for clinical progress to occur.

Second, being read can also communicate powerfully that, given all the contexts of the behavior, one's responses to events are normal, predictable, and justifiable. How else would the person know how you felt or thought or what you were going to do? Indeed, the feeling that someone is a soulmate who understands and accepts you is frequently based on this ability. In contrast, when a person cannot figure out how you feel or think, cannot respond empathetically unless you spell it out in detail, or expects you to do things you do not do or assumes you have done things you did not do, it is often experienced as invalidating, insensitive, or uncaring.

Reading behavior accurately requires some familiarity by the therapist with the culture of the client. By culture, here, I mean the fabric of socially transmitted response patterns that can be considered as typical of or an expression of the community or population that the client represents. For example, what is responded to with joy, interpreted as threatening and attacked, or grieved as a loss may be very different among men than among women, between individuals in one social class versus another, and in one country versus another. Similarly, responses that make sense (i.e., can be easily predictable) among individuals whose lives are marked by trauma, biological dysregulation, or specific behavioral disorder, may make little sense to others who have not experienced such conditions.

Knowing the client's current situation or the precipitating situation, together with observations of the client's verbal and nonverbal behavior, can be useful in arriving at a description of the client's emotional responses, intentions, assumptions, or otherwise private responses. The link between events and emotions or other private behaviors (e.g., thoughts and sensations) is in part universal and in part learned. Thus, to the extent that the therapist's and client's learning histories are similar (i.e., to the extent that the therapist and client share a similar culture), the therapist will be adept at reading unarticulated responses. In the absence of a similar history yourself, clinical experience, research reports, first-person accounts and autobiographies, novels, and movies about people like your client can be helpful. A very important task of the consultation group in DBT is to assist the therapist in this work. This type of level-three validation is similar to the "hermeneutics of the everyday." It seeks to articulate the private responses common to the client's own culture through a participant–observer inquiry (see Wilbur, 1995, p. 549, for a similar discussion).

At other times, the simple act of validating the nonverbalized communicates such acceptance that it gives clients permission, so to speak, to know themselves better than they did before. This is particularly likely when the therapist reads responses that the client is only minimally, if at all, aware of making. Unacceptable private responses, in particular, such

as unallowable (socially or to the individual client) beliefs, intents, desires, sensations, and feelings may be unrecognized because observing and labeling accurately is inhibited so early in the chain of self-reflections that the client does not become subsequently self-aware. This is especially the case when the outcome of knowing is the experience of painful emotions such as shame, guilt, humiliation, fear, or sadness. The avoidance of observing and recognizing, as I am suggesting here, is fundamentally no different than avoidance of any other behavior whose immediate outcome is associated with pain. The acknowledgment of these private responses by a nonjudgmental outside observer whose opinion matters allows the client to validate his or her own "unacceptable" and painful experiences and behavior. Level-three validation here is similar to the "hermeneutics of suspicion" (see Wilbur, 1995, p. 549). The therapist voices the suspicion that there might be more going on than meets the eye of either client or therapist. When correct, it constitutes a level-three validation and has the potentional for enormous therapeutic value.

Level-three validation, however, is also fraught with danger and the potential for great harm. The chief danger is that an invalid or only partially valid articulation of the client's private responses will be shoved down the client's throat. A ubiquitous example of such a tendency is the proclivity of many therapists to use consequences or observed functions of behavior as proof of private intent. If the therapist feels manipulated, the client must be manipulating. If the husband who has left home returns to his wife after she cuts her wrists, then the wife must have (secretly or unconsciously) intended such an outcome. It was only a "gesture." To add insult to injury, therapists are sometimes so sure of their beliefs (often because of rigid adherence to a particular theory of motivation) that they assume that the protest at the faulty validation effort is further proof that the articulation was valid in the first place. "Thou doest protest too much." As I have discussed elsewhere (Linehan, 1993), this is the error of affirming the consequent. The best way to prevent iatrogenic level-three validations is for the therapist to have both a good understanding of human behavior, including the large variety of private response pathways to any particular public behavior, and a wealth of theoretical hypotheses that can be tested in any given case. Having more than one good theory reduces the likelihood that any one will be clung to in the face of disconfirming evidence. The dialectical necessity here is for both collaborative exploration of private behaviors and experiences, including intent, on the one hand, and courage, sophistication, and insight into what is actually going on (independently, at times, of what the client claims), on the other.

The ability to know how a client is responding to a therapeutic intervention without necessarily being told is also a requisite ability if one is to effectively communicate validation. The ability to "read" situations and people, to predict how events will make people feel, and to know how one

affects others is usually discussed under the rubric of clinical sensitivity. Its accuracy, however, actually depends on accurate empathy. The more empathic therapist is marked by the ability to know not only when a client is feeling invalidated, or is likely to feel invalidated, by what one is saying but also what type of therapeutic response is likely to produce a sense of validation. Interestingly given the inherent tension between validating a response versus trying to change that response, the ability to move the client quickly through necessary changes requires a very astute moment-to-moment recognition of the client's experience of being invalidated. It is at just those moments when the client is threatened with incapacitating invalidation that the therapist must move quickly to validate and then, as quickly as the validation is experienced, move back to change. The result, at least when immediate change is of the utmost importance (e.g., when suicidal behavior is likely), is a therapy characterized by quick (and hopefully smooth) interweaving of validation with change, often oscillating phrase by phrase and sentence by sentence. Such immediacy is possible only when the therapist is able to keep one foot firmly in the client's experience and the other firmly in the reality of the astute observer.

Level Four: Validating in Terms of Sufficient (but Not Necessarily Valid) Causes

At level four, behavior is validated in terms of its causes. Validation here is based on the notion that all behavior is caused by events occurring in time and, thus, in principle, is understandable. Behavior is justified by showing that it is caused. Even though information may not be available to know all the relevant causes, the client's feelings, thoughts, and actions make perfect sense in the context of the person's current experience, physiology, and life to date. At a minimum, what is can always be justified in terms of sufficient causes. Behavior is adaptive to the context in which it is learned and to the biological responses of the human system. At level four the therapist finds the wisdom of that adaptation. The therapist, in essence, says, "Given X, how could Y be otherwise." In terms of the analyses described above, the question is "Given the antecedents (A) or consequences (C) of behavior, how could the person's behavior (B) be any different."

How does one validate behavior when it is maladaptive, dysfunctional, or ineffective for reaching the client's ultimate ends? If current behavior is destructive or leads away from a life the client can experience as worth living, how does the therapist find the grain of wisdom? When the behavior in question is invalid because of its link to invalid antecedents or its ineffectiveness at achieving life goals, there may be any one of at least three grounds for validation at level four: past learning history, present but invalid antecedents, or biological disorder.

1. *Behavior is valid in terms of historical antecedents ($A_{history}$) but may not be valid in terms of current antecedent events ($A_{current}$).* In the first type, the therapist communicates that the individual's behavior is justifiable and reasonable in terms of the past (i.e., past learning or previous goals that no longer hold). In terms of history, all learned behavior is valid. A focus on early childhood experiences as important in the development of problems as well as transference interpretation are examples (when accurate) of level-four validation. The process of exploring the past, so typical in many treatments, may be therapeutic simply because it weaves a story that makes the present make sense. It validates the present by linking it to previous events such that neither the past nor the present could be otherwise. Indeed, much of psychotherapy is involved with helping clients make just these distinctions. Responses learned in the past and appropriate to the past may no longer be needed or appropriate in the present.

   Take the following examples. A friend was raped in a dark alley one night. Some months later you are walking with your friend to meet some friends in a pub whose main entrance is down an alley. You start down the alley, and your friend says, "No! I can't. Let's go to the other entrance." You say, "But, of course! How insensitive of me. I forgot that you were raped in a dark alley. Let's go the other way." That is level-four validation. Being raped in a dark alley is ($A_{history}$); the apparent safety of the alley entrance to the pub is ($A_{current}$). Or take a clinical example: A client of mine was having marital troubles because, apparently, of her not liking sex with her husband. From all appearances, he was the ideal husband when it came to sex. He bought her lovely silk and satin negligees, put on music, lit candles, was affectionate, talked before sex, and was gentle and kind ($A_{current}$). In a previous marital therapy, it had been identified that during adolescence her parents, particularly her mother, had consistently called her a whore and chastised her whenever she showed the slightest interest in boys or sex. All agreed that her current disinterest in sex with her husband was a result of these experiences with her parents ($A_{history}$) rather than aspects of her husband's current behavior ($A_{current}$). This, too, is a level-four validation.
2. *Behavior is valid in terms of invalid current antecedent events ($A_{invalid}$) but may not be valid in terms of current antecedent events (A_{valid}).* Take the example of a client coming to a therapy appointment. Coming to the therapist's office on Thursday

at 2 p.m. could be considered invalid if the appointment is actually on Friday. The fact is there is no appointment on that day; the behavior is not justified by an empirical fact. However, suppose at the last appointment the therapist mistakenly told the patient the wrong appointment time, inadvertently saying it was on Thursday. The same behavior could be considered valid in the sense that it is based on a logically correct inference from what the therapist said. A similar distinction can be made when looking at emotional responses. Emotions can be reasonable responses to one's premises or beliefs about a situation, even though the beliefs may not be justified by the actual facts of the situation. Panic may be a justifiable response to the certain belief that one is unexpectedly in a life-threatening situation but may not be justifiable in terms of the actual facts when the facts are that one is safe and physically sound. In both cases, the therapeutic process requires one to manage the dialectics of validating and confronting a response on the basis of two independent sets of empirical facts. In the first case, the two sets of facts are the time stated by the therapist ($A_{invalid}$) versus the time actually set aside by the therapist (A_{valid}). In the second case, the two sets of facts are the premises or beliefs of the person ($A_{invalid}$) versus the actual threat value of the situation (A_{valid}).

3. *Behavior is valid in terms of disordered antecedent events ($A_{disorder}$) but may not be valid for achieving important desired goals or consequences (C_{goals}).* This type of level-four validation is most common when the antecedent is some type of biological disorder and the undesired consequence is some sort of disordered functioning. The goal of the client is ordinarily to alleviate the disordered functioning and enhance life satisfaction. The disease view of emotional dysfunction is an example of validating behavior in terms of biological dysfunction. Depressive behaviors, for example, can be viewed as valid response patterns to certain neurochemical brain dysfunctions ($A_{disorder}$) but ineffective in enhancing life satisfaction (C_{goals}). Overly impulsive behavior may interfere with many life goals (C_{goals}) but none the less be an inevitable response to certain genetic characteristics ($A_{disorder}$).

Level-four validation counteracts the tendency of many clients to believe that they "should not" be as they are (i.e., they "should" be different). It models validation of that which may not be admirable and teaches self-validation. The task of countering the client's shoulds is an important part of level-four validation. The first step in countering shoulds is to make a

distinction between understanding how or why something happened versus approving of the event. The main resistance to believing that a particular response or pattern of behavior should have happened, given the circumstances surrounding it, is the belief that, if behavior is understood, the behavior is also approved of. The therapist must emphasize that the act of refusing to accept a given reality means that one cannot act to overcome or change that reality. Simple examples can be given here. The therapist can point to a nearby wall and suggest that, if an individual wants the wall to be chartreuse in color and refuses to accept the fact that the wall is currently purple, not chartreuse, it is unlikely that the person will ever paint the wall chartreuse. A second point is being made here: wishing reality were different does not change reality and *believing* reality is what one wants it to be does not *make* it what one wants it to be. At times, a statement that something shouldn't be is also tantamount to denying its existence. The task is to get the client to agree that neither wishing nor denying will change reality.

A useful step in countering the shoulds is to present a mechanistic explanation of causality indicating that every event has a cause. Go through a number of examples of unwanted, undesirable behavior with step-by-step illustrations of the factors that brought the behavior about. The strategy is to show that thoughts ("I don't want it") and emotions (fear and anger) are not sufficient to keep an event from happening. If wanting to be perfect would make us be perfect, most of us would have been perfect long ago. The notion to be communicated is that everything that happens should happen given the context of the world, or, in principle, everything is understandable.

Validating behavior, especially when painful or seemingly out of control, in terms of sufficient causes in a manner that is heard and accepted by the client, can require a substantial amount of time. Saying that a behavior makes sense is different than assisting the client in seeing the sense of the behavior. Although the active attempt to change the client's understanding of his or her own behavior is, itself, not necessarily validation, it can have the sum effect of validating the client's behavior. That is, it functions as a validating response. When such is the goal, the therapist may need to have many stories and metaphors at hand to illustrate the point (see Linehan, 1993, for a number of typical DBT stories).

Level Five: Validating as Reasonable in the Moment

At level five, the therapist communicates that behavior is justifiable, reasonable, well-grounded, meaningful, or efficacious in terms of current events, normative biological functioning, and the client's ultimate life goals. The therapist looks for and reflects the wisdom or validity of the client's response and communicates that the response is understandable. The thera-

pist finds the relevant facts in the *current* environment that support the client's behavior. The therapist is not blinded by the dysfunctionality of some of the client's response patterns to those aspects of a response pattern that may be either reasonable or appropriate to the context. Thus, the therapist searches the client's responses for their inherent accuracy, appropriateness, or reasonableness (as well as commenting on the inherent dysfunctionality of much of the response if necessary). There are a number of grounds for level-five validation: inherent soundness; skillful means to long-term goals; normative behavior; and efficacious, but limited, means.

1. *Behavior is valid in terms of being well-founded on empirical facts or sound principles and thoroughly applicable to the case.* Level-five validation here focuses on the inherent validity of the behavior in the sense that the behavior is supported by objective truth or generally accepted authority, is logically derived from empirical facts, is well-grounded or justifiable and at once relevant and meaningful to the case or circumstances. The behavior makes complete sense or is verifiable in light of the facts or known truth. Although one can justify the behavior in terms of sufficient causes (such as learning history or genes), such justification is not necessary. It can be justified on its own merits in its relationship to present circumstances.

   The difficulty in much of psychotherapy is that the bias toward finding and treating clients' dysfunction can blind one to the positive aspects of their behavior. Reasonable and valid aspects of behavior are ignored in favor of focusing on that which is disordered and "crazy-making" environments go unrecognized. The nugget of gold is missed in sweeping up the sand off the floor. Go back to the first two examples given in describing level-four validations (p. 368–369). In the situation with a friend who had been raped in a dark alley, if when she says she cannot walk down the dark alley, you say "But, of course! Alleys are dangerous. Let's go the other way," that is level-five validation. In the example of the client who did not like sex, attributing it to previous dysfunctional family learning was a level-four validation. Remember, however, that the husband bought her silks and satins, played music, lit candles, and was gentle and kind during sex. Once I knew the client and this topic came up again, I said, "I don't think you are a person who does not like sex at all. You simply don't want to have a sex with a man who does not want to have sex with you. That is normal and, certainly, reasonable. You are a flannel nightgown woman and want a man who will throw you on a picnic table, "ravish" you, sweat, and be

strong and commanding. You want to have sex with a man who wants to have sex with you, not with the silk and satin sex partner he has in his imagination." That was (because it was accurate) a level-five validation. (I then pointed out how her husband's behavior could be validated at level four by noting how the media kept sending him messages that what he was doing was what a woman wants. He had simply not noticed that she was not the woman in the ads.)

2. *Behavior is valid because it is an effective means to long term goals.* As I noted in the beginning of the chapter, behavior can also be valid because it is efficacious to achieving one's ultimate goals. This is validation in terms of skillful means. Much of therapy involves teaching and validating skills means. The key to this type of validation is to keep an eye on principles of shaping, especially when the client's disorder is severe or intractable. Just noticeable progress (JNPs) must be noticed, reflected, authenticated, and supported. With very difficult or chronically disordered clients, being awake to JNPs can take a lot of energy and vigilance. In DBT, one of the tasks of the consultation team is to keep an eye out for all JNPs and to hold the magnifying glass up, as it were, for the therapist to see more clearly.
3. *Behavior is valid because it is a normative and ordered response.* Communicating that behavior is due to normative biological functioning or that it is usual and normative in a given circumstance is a level-five validation. Take the example of an individual who is experiencing intense anger and is ruminating about the unfairness of being laid off from a job three months before being vested in the company pension plan. One might suggest that anger in this situation is normal. One might also suggest that ruminating about unfairness is a normative aftereffect of anger. It is similar with fear. Increased sensitivity to threat cues is a normal aftereffect. Under high arousal, attention becomes constricted and cognition gets more rigid. Clients are often surprisingly uneducated about normal psychological and biological functioning. Unfortunately, therapists are often uneducated also. This, combined with a prejudice to find at least some disorder in individuals seeking psychotherapy, can lead to pathologizing normative behavior. Not only does the therapist miss validating the valid, but the therapist may also actively invalidate the valid. Nothing, in my experience, so alienates a client as this tendency on the part of many therapists. When combined with deficits in other

types of validation, particularly level one (being awake), therapeutic progress can be seriously impeded.

4. *Behavior is valid in terms of relatively (to long-term goals) unimportant positive consequences, but these consequences simultaneously lead to important or long-term negative consequences.* This type of validation is the therapeutic "yes, but" type of validation. Validation (the "yes") of this type is often followed by confrontation (the "but"). A behavioral pattern can be effective for immediate ends but interfere with long-range ends. Although the behavior solves the immediate problem, it creates other bigger problems in the long-run. Cutting one's arms or overdosing on drugs may be perfectly valid (i.e., effective) as a way to stop unbearable tension and emotional pain in the moment, but is not a valid means to reducing overall suffering and building a life worth living. Even if only a small part of the response is valid (e.g., the expression of emotional pain or difficulty) in a sea of invalidity (trying to reduce pain in ways that cause more trouble in the long term), the therapist searches out that portion of the behavior and responds to it. By finding the validity in the client's response, the therapist can honestly support the client in validating himself or herself.

Although it is usually easy to see that parasuicidal behavior is an invalid method for building a life worth living, it may be difficult at times for others to see that the behavior is exceptionally valid for achieving the desired end of feeling better now. It is normal, however, to desire to feel better when in pain. At times, the problem in a level-five validation is that, although the therapist can see that the behavior clearly works in the short run, the therapist can't understand why the client doesn't inhibit it anyway in favor of long-term gain. What is needed here is to link together level four and five validation statements. "Using cocaine is screwing up your entire life (confrontation, or level-three validation, if true and the client experiences it but hasn't communicated it, or irreverent level five, if corroborating what the client has implied or said) even though, unfortunately, it is really effective at stopping your intense urges and even more intense emotional pain (level five), and, unfortunately, at the moment you can't resist these impulses and inhibit this behavior because you don't (yet) have the necessary self-regulation skills to accomplish the task" ($A_{disorder}$ or $A_{history}$, depending on one's perspective).

Ferreting out what to validate at level five can be exceptionally complex at times. Behavior can be valid in the sense that it is supported by

relevant facts, logic, or authority but not valid in the sense of being effective. Take beliefs and opinions. It is often effective to believe certain things, even though the facts do not support one's beliefs. For example, in treating suicidal individuals, I may reinforce them for saying and believing that suicide is *not* an option (an effective belief for staying alive [C] when the chips are down and a gun is at hand [A]), when the facts of the case are that it is very much an option. Misinterpreting hurtful remarks from others as unintentional may for some ends be much more effective than finding out the truth. As with cognitions, emotional responses can also be justifiable or reasonable for the situation but not effective. Emotional behavior is valid when it is a response justified by the events that elicited it or when it is a response relevant to and effective for achieving one's goals. Take fear of falling (B) while inching along a narrow path on a sheer mountain cliff (A). The fear is certainly well-grounded or justifiable in terms of the objective risk of falling to one's death but, if it interferes with one's ability to take the next step (C), it may none the less be invalid from the point of view of effectiveness. The dialectic between being "right" and being "effective" is central in daily life and must be balanced in any attempt to validate client behavior. Mutually desirable goals can be incompatible with each other in terms of efficacious behavior (i.e., valid means). Fear and fleeing a burning building is justifiable in terms of one's own safety, but running into the fire to save one's children is equally justifiable.

The multiplicity of ends requires that the therapist always hold in mind the client's own ultimate therapeutic goals. Estimates of what constitutes positive versus negative consequences must always be tied to the client's life goals. Without initial assessment and agreement on treatment goals, validation (and the withholding of validation) in terms of effectiveness is in danger of meeting the therapist's ends rather than the client's. Without a clear understanding of what behaviors 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.

A number of specific validation strategies are recommended in DBT that reflect level-five validation. They can be described as follows.

Validating the "Shoulds"

Often one event must occur for a second event to also occur (i.e., the second event is conditional on the first). It is common, and appropriate, to use the term *should* in a statement when one is referring to something that must happen for something else to happen. Thus, the following phrase is appropriate: "A should happen to produce B." One must study (a) to make high grades (b). If the goal is to make high grades, then one "should" study. It is very important that therapists accept clients' preferences about

their own behavior. Clients often prefer to behave in certain ways or want various outcomes that demand prior behavior patterns. In these instances, therapists must be alert to accepting the shoulds and communicate to clients the validity of their preferences (assuming the preferences are not incompatible with ultimate goals). Both therapist and client can explore together the validity of the "should" sequence. At times, a client will be making inaccurate (i.e., invalid) predictions (e.g., "A is not needed for B to occur"). At other times, a client's predictions are quite accurate. It is easy for the therapist to get caught up in validating the client's current behavior without recognizing that it is important to avoid *invalidating* the client's quite understandable disappointment in his or her own behavior. In the context of any brief discussion, it is important for the therapist to alternate between validating the events as understandable and validating the disappointment as equally understandable. Certain behaviors both should and should not occur. When this happens, an appropriate response is disappointment.

Finding the "Kernel of Truth"

The task here is to find and highlight the thoughts and assumptions of the client that are valid or make sense within the context the client is operating in. The idea is not that individuals, including clients, always "make sense" or that they do not, at times, exaggerate or minimize, think in extremes, devalue what is valuable, idealize what is ordinary, and make dysfunctional decisions. Indeed, in both popular and professional minds, individuals in therapy are, by definition, almost prone to just such distortions. But, it is essential not to prejudge the opinions, thoughts, and decisions of clients. When the therapist disagrees with the client, it is all too easy to simply assume the therapist is right and the client is wrong. In finding the "kernel of truth," the therapist takes a leap of faith and assumes that, under proper scrutiny, some amount of validity can be found or reason or sense can be make. Although the client's grasp of reality may not be complete, it is also not wholly incomplete. At times, the client's sense of what is happening, his or her thoughts on the matter, may make substantial sense. Some clients have an uncanny ability sometimes to observe or attend to stimuli in the environment that others do not observe. The task of the therapist is to separate the wheat from the chaff and focus, in this moment, on the wheat.

Respecting Differing Values

At times differences between clients and therapists are of opinions and values. Respecting these differences, while not assuming superiority, is an essential component of validation. It is easy when one is the therapist to assume a "one-up" position whereby one's own opinions and values are viewed as more respectable than the clients, thereby invalidating the client's

point of view per se. For example, one of my client's believed that I should be available to her by phone any time, night or day. She herself had a job in the mental health area and stated that she was available to the people whe worked with because she believed that it was the compassionate and right thing to do. I pointed out to her that the problem here was that she was trying to get me to be like her and have broader limits on what I could give, and I was trying to get her to be more like me and to have and observe narrower limits. Although I did not change my position about my own behavior, I could appreciate the value of her point of view also.

Acknowledge "Wise Mind"

DBT presents to clients the concept of "wise mind" or wise knowing. This is in contrast to "emotion mind," or emotional knowing, and "reasonable mind," or intellectual knowing. Wise mind is the integration of both and includes an emphasis on intuitive, experiential, and spiritual modes of knowing. Thus, an important form of validation is when the therapist acknowledges and supports this type of knowing on the part of the client. The therapist takes the position that something can be valid even if it can't be proved. Just because someone else is more logical than you in an argument, does not mean your points were not valid. Emotionality does not invalidate your position any more than logic can necessarily always validate it. A further definition of wise mind is that it is the state of being where wise behavior (i.e., behavior that is just what is needed at the moment in the present context) is easy. The use and, then, acknowledgment of a construct such as wise mind is also validating in that it communicates to the client that he or she is actually capable of wise behavior. For seriously disturbed populations, this is often a sharp change in how they are usually treated. The concept of wise mind forces the therapist to search for the wisdom in what may appear to be a sea of invalidity. It is based on the ideas that what is a dysfunction for a single individual may be efficacious for the welfare of the community at large and that one's weaknesses are usually also one's greatest strengths.

Validity as Emergent

Giving the therapist the role of determining when behavior is valid in the context in which it occurs and when it is not is, at first glance, giving immense authority to the therapist. Many therapists shy away from this role (i.e., of validator), preferring instead to assume clients can best determine what is valid for themselves. This view often springs from the idea that what is true for one person may not be true for another. Truth is relative to the individual. The alternative extreme is the absolute view of truth: What is true now has always been true, will always be true, and is true for all individuals in all places. Both positions are inherently flawed.

On the one hand, the relativist view is that there is, essentially, no truth and, thus, no basis for recognizing what is valid or invalid. The universe beyond the individual does not influence what is. All roads lead to Rome. The flaw here is that all roads do not lead to Rome. Alternatively, the therapist may assume that once "conditions of worth" are removed (to quote Rogers, 1959), that which is valid will emerge and be seen clearly by the client. The therapist need not inform or intervene except to assist in sweeping away the conditions of worth imposed on the client by others. "Truth is in the air," and the client who does not see it is "resisting." The task of the therapist is to probe the resistances, assuming that once they melt away the client will see clearly and without repression of the truth that is too painful to see. The flaw in the latter is that it presupposes an inference in the absence of assessment of the individual case. It may be true, but it also may not be. The therapist who maintains this position is often experienced by the client as withholding and unwilling to give the help that is needed in the moment.

At the other hand is the absolutist view: Truth once fixed is unchanging. Not only is there truth, but it can be known with certainty. The subjective eye of the beholder can be overcome by the objective eye of the observer. The flaw here is twofold: One cannot ever divorce subject from object and, in a universe that is constantly changing and emerging, what was true in one context may indeed not hold up in another context. Thus, what is valid at one time and in one set of circumstances may not hold at another time or within a different context. The synthesis of these two views is that validity of behavior can be determined only in a collaborative manner with both client and therapist actively interacting to articulate both the fullness of the responses in question and their context at the moment and their relationship to the client's own ultimate goals.

Level Six: Treating the Person as Valid—Radical Genuineness

In level six, the task is to recognize the person as he or she is, seeing and responding to the strengths and capacities of the individual while keeping a firm empathic understanding of the client's actual difficulties and incapacities. The therapist believes in the individual and his or her capacity to change and move toward ultimate life goals. The client is responded to as a person of equal status, due equal respect. Validation at the highest level is the validation of the individual as "is." The therapist sees more than the role, more than a "client" or "disorder." Level-six validation is the opposite of treating the client in a condescending manner or as overly fragile. It is responding to the individual as capable of effective and reasonable behavior rather than assuming that he or she is an invalid. Whereas levels one through five represent sequential steps in validation of a kind, level six represents both change in level as well as kind.

The term *invalid* has two meanings. The first meaning, to be falsely based or reasoned, not efficacious, is the use of invalid as an adjective and is relevant to most of the discussion of validation so far. The second meaning of invalid, when it is used as a noun meaning one who is incapacitated by a chronic disease or disability, is most relevant here. At level six, the therapist does not respond to clients a priori as if they are invalids. Instead, the therapist responds to the client as if he or she will continue (or start) emitting valid behavior. Ability rather than disability is assumed. It is the capacity for validity that is communicated and responded to at level six. In a sense, the therapist validates the capacity for *future* validity. In contrast, at level five the therapist validates the client's behavior in terms of its validity in the present. At level four the therapist validates the client's behavior in terms of its validity in the past but not the present.

Validation at level six is closer to validating the individual than it is to validating any particular response or behavioral pattern. It implies a genuineness on the part of the therapist, the quality of being one's genuine self within the therapeutic relationship. The quality of being one's self that is alluded to here has been described by Rogers as:

> He is without front or facade, openly being the feelings and attitudes which at the moment are flowing in him. It involves the element of self-awareness, meaning that the feelings the therapist is experiencing are available to him, available to his awareness, and also that he is able to live these feelings, to be them in the relationship, and able to communicate them if appropriate. It means that he comes into a direct personal encounter with his client, meeting him on a person-to-person basis. It means he is *being* himself, not denying himself. (Rogers & Truax, 1967, p. 101)

It is described by Safran and Segal (1990) as:

> Therapists who let concepts blind them to the reality of what is truly happening for their patients in the moment are relating to the patient as an object, or in Buber's phraseology, an "It" rather than a "Thou." Therapists who hide behind the security of the conceptual framework provided here rather than risking authentic human encounters, which could lead to therapists' transcending all roles and preconceptions about how they themselves should be, rule out the possibility of the very experiences in human relatedness that will be healing for their patients. (pp. 249–250)

Such a stance of genuineness and validation of the client as he or she is in the moment, therefore, requires the ability to throw off preconceptions of client role and generalizations about psychopathology, to be aware of the present moment in all its complexity, and to respond spontaneously and completely. The ability to be compassionate, effective, and genuine or without role, all at the same time, is extremely difficult. Such naturalness is

especially difficult for therapists trained in schools that emphasize the construction of strict boundaries and "professional" behaviors independent of the individual client. It is difficult for therapists who are uncomfortable with their own personal limits as caregivers, who may find it more comfortable to attribute their inability to respond empathetically to the requirements of their role as therapist rather than their limitations as professionals. It is difficult with clients who communicate unremitting emotional pain when one has only limited tools to alleviate the pain. Yet it is required. I often ask therapists to imagine in a role play that their client is their sister or their brother, coming to them in emotional agony with severely dysfunctional behavior. Invariably, they respond to the person as a whole (and usually quite differently than they respond to clients in the same plight). That is the validation that is at the heart of DBT.

At level six, almost any response to a client can be valid. The key is in what message the therapist's behavior communicates and how accurate the message is. Confrontation communicates to the client that he or she is equal to hearing the truth. Although confrontation may not validate a client's view about the behavior in question, it does validate the client's inherent capability to change. (Sometimes, at these points, it can be useful to add in a level-four validation, suggesting that it is, of course, perfectly understandable how the client would come to engage in the confronted behavior and just as understandable how the client would also not even see the dysfunctionality.) Treating the client with kid gloves, holding back on the truth as the therapist sees it, worrying excessively over timing, and so on communicate that the client is fragile and unable to function at a competent level. Therapist responses that clients experience as condescending are often validating at levels four or five but invalidating at level six.

Cheerleading is a special type of level-six validation. In cheerleading, the therapist validates (i.e., recognizes and confirms) the inherent ability of the client to overcome difficulties and to build a life worth living. Although that life may differ from what is hoped for or even expected at any given point, the potential for overcoming obstacles and for creating value is what is attended to, observed, and reflected. Cheerleading is believing in the client. For some, this will be their first experience of having someone believe and have confidence in them. In cheerleading, the therapist is validating the inner capabilities and wisdom of the client.

Cheerleading is sometimes experienced by clients as invalidating of their emotions or beliefs. If you understood how really awful it is, how really incapable they are, you wouldn't believe that they can change or accomplish anything or do what you are requesting. In cheerleading, the therapist believes the client can (at least eventually) save himself or herself. The client, in contrast, often believes that if you really understood, you would save him or her yourself. The task here is to balance an appreciation for the difficulties of making progress and realistic expectations with hope and con-

fidence that the client can indeed move. Cheerleading has to be laced with emotional validation and a large dose of realism. Without that context, it can indeed be invalidating. Thus, the therapist must be vigilant in recognizing the difficulty of the client's problem, even while never giving up on the idea that the problem can be overcome eventually.

TYPE OF VALIDATION

There are two types of validation: topographical and functional. Topographical validation is explicit and fits the form of validation (i.e., it has the topography of a validating response). In topographical validation, the therapist responds overtly with words that say, either directly or indirectly, that the therapist believes in the validity of the client and the client's behavior: "That makes sense," "hmmm," "I agree," "of course, how could it be otherwise," and longer discussions of how the client's behavior is justifiable or effective. In functional validation the therapist responds as if the client's behavior is valid. A client says he does not want to discuss a topic, and the therapist switches topics; a client describes a problem she want to solve, and the therapist says "let's get to work." Functional validation tends to be implicit. Whereas topographical validation is validating by words, functional validation is validating by deeds. Both are very important in DBT.

In the mistaken impression that validation of all behavior is important for a client to feel accepted, many therapists inadvertently invalidate a client's central message that something has to change if life is to be endurable. An emphasis on acceptance of the client as he or she is (topographical validation), unbalanced by the focus on change that the client is saying is needed (functional validation), therefore, can also, paradoxically, invalidate. If the therapist only urges the client to accept and self-validate, it can appear that the therapist does not regard the client's problems seriously. Pure acceptance-based therapies can appear to discount the desperation of the seriously disturbed individual because they offer little hope of change. The client's personal experience of the current state of affairs as unacceptable and unendurable is thereby invalidated. Exhortations to accept one's current situation offer little solace to the individual who experiences life as painfully unendurable. It is not inconceivable that suicidal behavior in some individuals at some times functions to "wake up" the environment, including the therapist, and get the environment to take the client's problems more seriously. Thus, balancing validation with accurate invalidation is, paradoxically, a necessary validation strategy.

VALIDATING SPECIFIC RESPONSE TARGETS

Like most behavioral treatments, DBT is based on a tripartite model of human functioning that, for convenience, divides behavior into motor

(i.e., action), cognitive–verbal, and physiological systems. It is important that the therapist acknowledge and validate responses across the entire system rather than focus attention on just one subsystem (e.g., cognitive representations or actions) of responding. Although emotions are viewed by many as part of the physiological system, an alternate view embraced by DBT is that they are best considered integrated responses of the total system. The form of the integration in emotional responding is automatic, either because of biological hard wiring (the basic emotions) or because of repeated experiences (learned emotions). That is, an emotion typically comprises behaviors from each of the three subsystems. Thus, emotions are a full-system behavioral response with effects on the full system. In considering what responses to validate, consideration should be given to responses in each system (actions, cognition, and physiological). When emotional dysregulation is an important part of the problem, as I hypothesize with the borderline personality disorder, emotions per se as an integrated set of responses must be attended to commonly and explicitly. For example, DBT therapists repeatedly identify and explore the primary emotions (e.g., fear, anger, sadness, shame, guilt, joy, interest, and disgust) that clients experience and express (see Linehan, 1993, for a fuller discussion of this topic). Because of the important role of emotions in all human relationships, including psychotherapy, both facilitating and inhibiting disclosure, change, and attention to client's emotional functioning is important with all clients.

Validating Action

Validation of overt behavior, or action, focuses on identifying and responding to what clients are doing, somewhat independently of what they are feeling or thinking. Actions are valid at level five when they are an efficacious means to the client's ultimate ends or are relevant and justifiable in light of the context in which they occur. The task here, therefore, is to ascertain whether indeed the client's actions are valid for those ends and then to provide feedback to the client. To use a Zen phrase, the therapist searches for instances of "skillful means" and reflects them to the client. The therapist finds the wisdom in the client's actions and notes when a response pattern is one that would be expected of most anyone in the situation. Level-five validation of action often takes the form of praise (e.g., good job) or of responsiveness (e.g., giving greater privileges to an inpatient who replaces self-destructive behavior with skillful problem solving).

Not all responses, however, are justifiable, relevant, or effective for achieving the end goals one has in mind for his or her life. For each client, therefore, behaviors not meeting that test—that they be justifiable, relevant, or effective in light of purported or agreed on goals or by the facts existing at the time of the behavior—are viewed as invalid in the moment. They are confronted or ignored. The premise here is simple: Not every road

will get you to Rome. No matter how invalid a response may be with respect to its relationship to current facts or future goals, it is indisputably the case that all behavior is as it should be. That is, all behavior has a certain validity in terms of its relationship to its own history. At level four, the therapist communicates this simple fact.

Level-three validation of action is when the therapist uses the information at hand to figure out what the client has already done or is likely to do. An example of this is when a therapist can read when a client is lying about past behavior. Although one would not ordinarily think of this as validating, clients who lie, for example about drug use, often experience the therapist who does not pick up on lies as naive, not bothering to know the client, and unwilling to see and accept the client as he or she really is. A statement of the facts, without judgment of good or bad, is at once confrontational (of one's behavior) and validating (that one is who one purports to be). Knowing and communicating what behaviors are possible for a particular client or are likely to occur also validates the client as who he or she actually is. When, in addition, therapists communicate an intrinsic belief in a client's inherent capacity to emit desired behaviors and faith in a client's ability to overcome difficulties and succeed in reaching goals, level-three validation merges with level-six validation to become cheerleading (see Linehan, 1993, for a fuller description of this point). The dialectical tension here is always between knowing the client well enough to see his or her limitations while simultaneously believing in the client's inherent capacity to overcome obstacles and progress toward life goals. The ability to do both is requisite for validation.

Validating Cognition

The task of the therapist in validating cognitive responses at level five is to recognize, verbalize, and understand both expressed and unexpressed thoughts, beliefs, expectations, and underlying assumptions or rules and to find and reflect the essential truth in all or part of the client's thoughts, beliefs, underlying assumptions, rules, and so on. The strategies for "catching thoughts," identifying assumptions and expectancies, and uncovering rules that are guiding the individual's behavior—especially when these rules are operating outside of awareness—are little different from the guidelines outlined by cognitive therapists such as Beck and his colleagues (Beck & Freedman, 1990; Beck, Rush, Shaw, & Emery, 1979). The essential difference here is that the task is to validate rather than empirically refute or logically challenge. The struggle for clients, then, is to learn to discriminate when perceptions, thoughts, and beliefs are contextually valid and when they are not—when they can trust themselves and when they cannot. The task of the therapist is to assist in this process by ferreting out valid perceptions, assumptions, expectations, and so on and reflecting these back to

the client. "That's reasonable," "that makes sense," "I agree" are typical validations of cognitive–verbal responses.

Level-four validations of cognitive processing must be made with great care. They can at times be quite invalidating of the clients' sense of their own ability to interpret reality (i.e., they can be "crazy making"). A heavy focus on the client's presently invalid beliefs, assumptions, and cognitive styles is counterproductive if it leaves the client unsure of when, if ever, perceptions and thoughts are adaptive, functional, and valid. For example, overinterpreting a client's perceptions as "transference" reactions, projections, or other distortions caused by unconscious processes learned in the past communicates to the client that his or her own thinking and critical evaluation of his or her own thinking is faulty or invalid. Teaching the client the therapist's rules of validating can be quite critical here. Teaching the client how to know when his or her own thinking is valid or invalid, paradoxically, validates the client's inherent capacity to critically evaluate his or her own thought processes (i.e., it is an instance of cognitive validation).

Level-three validations have to do with articulating to (and sometimes for) clients what their assumptions and expectations must be in a given situation. It is hearing and saying aloud clients' unspoken and sometimes hidden thoughts. Cognitive validation is when another person knows what you are thinking before you even say it. It is when the therapist says (with accuracy), "but you don't really believe it do you," "at that point, I'm guessing you were thinking. . . ," "and it seemed to you like. . . ." "so, you figured that. . . ," and so on. It is when the therapist figures out just how a client might interpret a situation and then acts accordingly. Empathetically, the therapist stands in the client's shoes and sees the world from that perspective. It is the essential therapeutic ability if validation efforts are to have their intended effect; validation depends on the ability to communicate to the client such that the client interprets the message as intended. The therapist must be able to simultaneously speak as the therapist, listen as the client, and use what is heard to formulate subsequent words.

Validating Physiological Responses

Like validation of any response, validation of biological functioning at level five has to do with recognition of the soundness of functioning. At this level, validation is based on whether the client's physiological responses are normative for the situation and demography of the individual. The concept of valid here is the opposite of the concept of physiological disorder, disease, or dysfunction. The individual's physiological response patterns are sufficient (i.e., are effective) for achieving outcomes the individual cares about.

The statement that one has a disease is a statement of current invalidity of functioning. Persons with serious diseases are invalids. A level-four validation of such dysfunction might be to provide a genetic-, trauma-, or learning-based explanation for such dysfunction. The biological dysfunction is understandable—it "should" be because factors necessary to impair functioning have occurred. I often tell clients their problem is that their brain (i.e., their biological system) is in love with certain thoughts. I may discuss the effects of learning on cell physiology. I also tell them that psychotherapy will work by changing neural pathways and habitual chemical reactions of the brain. I have spent a fair amount of time discussing whether certain aspects of behavior or orientation can be changed—that is, what can be changed and what cannot be changed in human behavior. Which biological systems are hard-wired and which are not?

Level-three validation of physiological functioning is when the therapist tells clients how they are most likely reacting physiologically either during the current interaction or when their problems surface between sessions. The enormous amount of psychoeducation that accompanies behavioral treatments of panic and other anxiety disorders is an example here. The ability to describe what a panic attack feels like, for example, is highly validating for the individual who experiences frequent panic. It is not uncommon in such instances for a client to exclaim "Yes! That's me." The ability to describe with and for the client the physiological experience of certain emotions or the effects of certain events (e.g., extreme trauma) can be enormously reassuring, normalizing, and, hence, validating. Predicting accurately side effects of medications or interventions is another example.

Validating Emotions

Understanding and validation of emotions is crucial in any psychotherapy. Paradoxically, this is especially the case when the focus of therapy is on helping the individual learn to better regulate (i.e., change) emotional responses. When validating emotions, the therapist communicates to the client that his or her emotional responses are valid, either because it could not be otherwise due to learning or biology (level four) or because they are reasonable or normative responses to the precipitating events; they are based on sound or logical interpretations or processing of events (level five). The role of validation here has two functions: to remove inhibitions to further processing of emotional material and to reduce environmental factors that maintain intense emotional expression. In the first instance (removing inhibitions), validation used judiciously can cut off clients' abilities to invalidate their own primary (in the sense of first in the chain of events) emotional responses to events. Self-invalidation of emotions can function as escape behavior, stopping unwanted emotions. Because the self-invalidation is often automatic and immediate, it can also cut off emotional experiences

before they are sufficiently processed. When this happens, the primary emotion occurs repeatedly in response to the same precipitating events, often in a more intense fashion. The client does not learn to respond differently or to modulate the intensity of the emotion. Emotions that are no longer reasonable responses to events do not change. Although there are many theoretical positions on just what emotional processing involves, the data is accumulating that the activation of emotions appropriate to the precipitating events is crucial in decreasing dysfunctional emotional responses. For example, Foa, Riggs, Massie, and Yarczower (1995) have found that only clients who facially express fear when remembering rape improve with exposure treatments. Those who bypass fear and go straight or quickly to anger do not improve.

It is equally important that the therapist also validate the secondary emotion (i.e., the emotional response to the emotion). For example, clients often feel guilty, ashamed, and angry at themselves or panic if they experience anger or humiliation, feel dependent on the therapist, begin to cry, grieve, or are afraid. It is these emotional responses to emotions that are often the most debilitating for the client.

It is rarely useful to respond to what seems to be an unwarranted emotion by instructing the client that she need not feel that way. Therapists are frequently tempted to do this when clients are responding emotionally to the therapist. For example, if a client calls the therapist at home (according to the treatment plan) and then feels guilty or humiliated about calling the therapist, it is a natural tendency for the therapist to respond to this by telling the client that he or she need not feel this way. This should be recognized as an invalidating statement on the part of the therapist. Although the therapist may want to communicate that calling the therapist is acceptable and understandable, it is also understandable that the client felt guilty and humiliated.

In the second case (validation to reduce emotional expressiveness), understanding the communication function of emotions can be helpful in orienting the therapist to validation. Many therapists believe that validating an escalating emotion will make things only worse (i.e., the emotion will get more out of control). This is only sometimes the case, and it depends on whether the client expects the communication to allay or resolve the situation prompting the emotion. Validating sadness of an irretrievable loss may clarify the fact of the loss and thereby experiencing of sadness, thus increasing emotional intensity. Validating anger at the therapist for repeated neglect by apologizing and promising (credibly) to end the neglect serves to reduce anger. In agreeing with the client that a threatening situation is indeed fearful and backing off of urging the client to encounter the situation, the therapist expects relief from fear, not escalation. Once the emotions are heard and responded to as valid, emotional intensity will usually decrease and may disappear altogether. Validation of emotions can be self-verifying

to the client when the therapeutic message is that the client's perceptions of events precipitating the emotion are valid or the emotional response is normative for the situation described. The resulting increase in a sense of predictability or control, discussed below in reference to self-verification, is often soothing and emotion regulating.

Some clients, of course, do frequently distort, sometimes exaggerate, and sometimes remember selectively. With these individuals it is common for people around them, including therapists, to assume that their thinking and perceptions are always faulty or, at least, when there is a disagreement the individual is most likely to be incorrect. Such assumptions are especially likely when full information about events precipitating the individual's emotional response is not available—that is, the stimuli setting off the individual's reaction is not public. Especially when a person is experiencing intense emotions, it is easy for others to assume that the individual is distorting, somehow. Things are not, or could not be, as bad as the person says. The trap here is that assumptions take the place of assessment; hypothesis and interpretations take the place of analysis of the facts. The other person's, including the therapist's, private interpretation is taken as a guide to public facts. Such a scenario replicates the invalidating environment that many individuals have or currently experience in their lives.

Intense emotions can precipitate emotion-congruent thoughts, memories, and images. Conversely, thoughts, memories, and images can have powerful influences on mood. Thus, once an intense emotional response starts, a vicious circle is often set up where the emotion sets off memories, images, and thoughts and influences perceptions and processing of information that in turn, feed back into the emotional response and keep it going. In such instances, distortions of perceptions, memories, and interpretations of information can take on a life of their own and may color many, if not most, of the individual's interactions and responses to events. Not all mood-related thoughts, perceptions, expectancies, memories, and assumptions, however, are dysfunctional, misinterpretations, or distorted. This point is crucial in conducting psychotherapy.

Most often, therapist invalidation of feelings will arise from therapists' over-anxious attempts to help the client feel better immediately. Such tendencies should be resisted because they are counter to an important message that the therapy is attempting to communicate, namely, that negative and painful emotions are not only understandable but also tolerable. Additionally, if the therapist responds to negative emotions on the part of the client by either ignoring them, telling the client he or she need not feel that way, or too quickly focusing the client on changing the emotions, the therapist runs the risk of behaving in a manner identical to others in the client's natural environment. The attempt to control emotions by will power or to "think happy" and to avoid negative thoughts is a key characteristic of the

invalidating environments. The therapist must be sure not to fall into this trap.

WHY VALIDATE?

Within this wide rubric of what to validate, more specific guidelines for targeting of validation will depend always on the intended function of validation at the particular time it is used. That is, therapeutic validation should be strategic. The strategic floor of therapy is one of the characteristics that differentiates therapy from ordinary other relationships. Thus, the therapist must at all times have a clear view of a number of factors described more fully below but including: the client's fears that change in therapy will not be possible or will make matters worse (validation as acceptance to balance change); the client's level of self-validation or, conversely, self-invalidation, castigation, or attack (validation to strengthen self-validation); the relationship of the behavior currently occurring or being reported to the client's life goals (validation to strengthen clinical progress); the client's understanding of his or her own behavior and knowledge about behavior in general (validation as feedback); and the client's sense of being understood by the therapist (validation to strengthen the therapeutic relationship).

Validation as Acceptance to Balance Change

First, as noted above, validation in psychotherapy functions to balance psychotherapy change strategies. Validation functions as both acceptance and verification of clients' views of themselves and their own world. As such, it likely has the twin effects of bolstering client perceptions of predictability and control and, at least when the verified self-views are positive, tends to increase positive affect (Swann, Stein-Seroussi, & Giesler, 1992) An unremitting focus on change, in contrast, can increase perceptions of unpredictability and loss of control, increasing fear, anxiety, and anger to such an extent that processing of new information is shut off and therapy comes to a virtual standstill. The amount of validation needed per unit of change focus will vary among clients and for a particular client over time. At the beginning of therapy, before a strong relationship has been formed, validation may be the principal intervention. Later, once the client feels secure with the therapist and with the methods and direction of therapy, a sustained focus on therapeutic change may be possible with only minimal attention to active validation. Self-disclosure, important in all psychotherapies, however, can occur only when the client does not feel threatened or overwhelmed by the therapist's emphasis on change. Generally, the client who is nonverbal, unassertive, and tends to withdraw when confronted will

need a higher validation-to-change ratio than the combative client who, while equally vulnerable and sensitive, can "stay the course" when feeling attacked. For all clients, when stress in the environment (both within and outside of the therapy relationship) goes up, the validation–change quotient must also go up accordingly. Similarly, when addressing particularly sensitive topics, particularly topics where the client is vulnerable to loss of emotional control, validation must be increased. Even within a particular session, the need for therapist validation can be expected to vary. Validation can be a brief comment or digression while working on other issues, or it can be the focus of most of the session with only a small effort devoted to eliciting or strengthening change. Therapy with clients can be likened to pushing an individual ever closer to the edge of a sheer cliff. As the back of the person's heel rubs the edge, validation is used to pull the person back from the precipice towards the safe ground near the therapist is in the service of resuming (ASAP!) moving back to the edge.

Validation to Teach Self-Validation

Second, therapeutic validation functions as a first step in the acquisition and the strengthening of skills in nonjudgmental self-observation and nonpejorative descriptions of self (i.e., to teach self-validation). The experience of mistrusting oneself is intensely aversive when it is either long-standing and pervasive or occurs with respect to a topic of life and death importance where there is no more authoritative source of information. At a minimum, as noted by G. Mark Williams (personal communication, May 3, 1991), you have to at least trust your own decision on who to believe—yourself or others. The goal here is to help clients learn to trust themselves and their own reactions to events. I often point out to clients that a major goal in therapy is to help them learn to trust (rather than change) their own responses. This goal is based on the notion that many of the primary or initial responses of clients are in fact valid; often, it is the secondary response of invalidating the initial response that creates so much pain and trouble for individuals. This point of view is very similar to points Greenberg has frequently made about the roles of primary and secondary emotions and will be discussed further below. This function of validation is similar to the function of empathy in client-centered psychotherapy noted by Greenberg and Elliott in chapter 8 of this volume.

Therapist validation of clients' responses works in two ways to increase self-validation. In the first place it models appropriate validation (i.e., how to respond to one's self in a validating manner). At times, it may simply model how to nondefensively and noncritically think through one's own opinions, emotions, or actions to arrive at a conclusion about their validity. Second, to the extent that therapeutic validation is reinforcing, it can also be used to reinforce client self-trust. It is very important, however, to

recognize that validation of client responses does not *ipso facto* teach self-validation. It is possible to inadvertently use validation as a reinforcer for self-mistrust. This is most likely to occur when self-denigration or other acts of self-mistrust are regularly followed by therapist validation. In particular, it is important that the therapist not use validation strategies immediately following dysfunctional behaviors that are maintained by their tendency to elicit validation from the environment. Validation is best used when it follows an instance or report of behavior that is both valid and to be strengthened. In this case, therefore, validation is a response to the client's own acts (however tentative at first) of self-trust or indications of confidence in his or her own veracity or judgment.

Validation to Strengthen Clinical Progress

Third, validation functions to reinforce behaviors other than self-trust that the therapist wishes to strengthen. This is true, of course, only when therapist validation is a reinforcer for the individual. Although it is likely to be reinforcing for most, it is crucial to assess its functions for each client. When reinforcing, it is important that the therapist provide validation contingent on behaviors that represent clinical progress and not validate immediately following dysfunctional behaviors that are maintained by their tendency to elicit validation from the environment. The question arises, can one validate behavior one does not want to reinforce? That is, does it make sense to validate behavior that is dysfunctional or that you and the client want to change? The answer is yes and no. It depends on how you deliver the validation and, especially, what you surround it with. Take the case of the employed woman who tells me about becoming angry and crying when her boss refuses an important request, blocking once again her ability to succeed in her job. I might validate her crying behavior by saying that it is reasonably common for women to respond that way. Whereas men when angry are more likely to escalate their verbal aggression, women are more likely to cry. Therefore, I may comment that her behavior is a "normal" expression of frustration (which, I might add, was also understandable given the behavior of her boss) and expectable; she is not "pathological" or weak. (Parenthetically, I might also say to her that verbal aggression may be more acceptable in the workplace than crying only because men made up the rules for acceptable workplace behavior in the first place.) However, I would then most likely go on and validate her frustration with herself over crying, confirming her view that, if she does not learn another way to handle anger, she is not likely to progress as far as she wants to go in her company. In summary, the message would be "your behavior is perfectly understandable and it is not pathological, but it has to change anyway." So what patent behaviors are being reinforced here? I would analyze the interaction above as follows. First, both telling me about crying and crying when frustrated

are being reinforced when I communicate in essence "but, of course! women cry when they are frustrated; that is normal; don't worry about it." That communication also serves to weaken (or punish) her tendency to castigate and judge herself negatively when she cries. I am validating crying as part of a normal biological response to frustration and anger. Next, when I communicate, in essence, "but, of course, I agree with you also that this is frustrating and has to change!" I am strengthening her resolve to stop crying during interactions with her boss and am also reinforcing her assessment of the effectiveness of her own behavior. I am validating her business judgment: Women crying at the office is not a recipe for breaking through the glass ceiling. What is not being reinforced here is a non-self-accepting stance on the part of the client. I could, however, even validate that by commenting that it is completely understandable in light of her previous learning history. The first validation (crying is normal) is an instance of level-five validation, and the second validation (so is self-blame because of faulty learning) is a level-four validation.

Validation as Feedback

Closely related to validation as strengthening, yet slightly different, is the role of validation in giving clients feedback about themselves and their behavior. Although all behavior can be validated at level four (i.e., all behavior is in principle understandable), not all behavior is valid at level five (i.e., not all behavior is justified by current events or by its effectiveness at achieving desired goals). Both communications (level four and level five) are exceptionally important, however. Both give information. Validation at level four teaches clients a nonjudgmental way of thinking about themselves and also helps them ferret out the probable development factors that influence their current behavior. Such stories (i.e., those that tell us how our behavior was learned or influenced by biological factors) are important for many in constructing meaning to their lives. In this fashion, validation is a change process rather than a purely acceptance strategy. In level-five validation, the therapist is informing the client that specific responses and response patterns are efficacious for achieving desired outcomes or life goals (i.e., they are "appropriate to the end in view") and that cognitive behaviors (e.g., beliefs, opinions, expectations, are perceptions) are "well-founded, in fact, or established on sound principles, and thoroughly applicable to the case or circumstances." Validation of physiological responses gives information about the "soundness and strength" of the individual's biological functioning; normal physiological responses of the client to events and their influence on other response systems are identified and highlighted. For many clients, information about the appropriateness, normality (in the sense of normative or expected), and reasonableness of their behavior is sorely needed. Many have either not received such information while growing up

or are currently living in crazy-making environments where it is difficult to keep their bearings in relation to their own behavior. For some clients, indeed, this information-giving function of validation is all that is really needed from therapy. This might be especially true for clients who are isolated or different from those around them, for example, the only women in an all-male work environment, the liberal who has just moved to a very conservative region, and the only highly emotional member of a very mellow family.

Validation to Strengthen the Therapeutic Relationship

Finally, validation functions to create a positive, attached, therapeutic relationship. This function of validation is primarily a by-product of the previous functions. As noted above, when the therapist validates responses and characteristics of the client that he or she finds admirable and desirable, some increase in positive affect can be expected. Similarly, when the therapist validates the client's own negative views of himself or herself, particularly when some hope of positive change as a result of therapy is also provided, the client's sense of control and predictability is also increased and, thus, also leads to more positive emotional states. Validation here soothes and calms the client. A similar result can also be expected when the therapist validates the client's perceptions of problems in the therapy per se or with aspects of the therapist's behavior. Validation in such instances is the first step in offering hope that favorable changes can be made. The attachment in each case is by way of associating the therapeutic relationship with more positive affect. From a reinforcement perspective, the therapist becomes associated with positive outcomes, thereby becoming positively valenced and moved toward.

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