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The Challenge of Validation

with Ronda Oswalt Reitz, PhD

Center for Prevention, Outreach, and Professional Education

Summary

Validation is a critical component of Dialectical Behavior Therapy, and a skill which practitioners will need to learn, practice, and fine tune in order to be truly effective. Dr. Ronda Oswalt Reitz talks with us about who benefits most by the use of validation. She also explains in detail the Six Levels of Validation as proposed by Dr. Marsha Linehan, the architect of Dialectical Behavior Therapy. Understanding and practicing these validation levels will help you as a clinician and the people you serve to engage each other in an open, trusting, therapeutic environment.

Presenter

Ronda Oswalt Reitz, PhD is a consultant and trainer in Dialectical Behavioral Therapy. She specializes in the development and maintenance of DBT treatment programs and teams in mental health delivery systems. She provides public and private trainings and consultation across the United States, focusing on systems including community mental health, instensive outpatient programs, juvenile detention facilities, and acute long term and forensic inpatient programs. Currently, she works for the Missouri Department of Mental Health, in the development of DBT programming statewide, and with Behavioral Tech, LLC, the treatment dissemination company founded by Dr. Marsha Linehan.

Contact Hour

The University of Missouri, Missouri Institute of Mental Health will be responsible for this program and will maintain a record of your continuing education credits earned. MIMH will award 1 clock hour or 1.2 contact hours (.1 CEU) for this program.

MIMH credit will fulfill Clinical Social Work, Counselor and Psychologist licensure requirements in the State of Missouri. Attendees with licensure from other states are responsible for seeking appropriate continuing education credit, from their respective boards for completing this program.

Resources

Behavior Tech, LLC
http://behavioraltech.org/index.cfm?CFID=8495935&CFTOKEN=64297221

National Registry of Evidence-Based Programs and Practices
DBT Page http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=72

www.findingevidence.com

http://www.dbtselfhelp.com/

Koons, C. R., Robins, C. J., Tweed, J. L., Lynch, T. R., Gonzalez, A. M., Morse, J. Q., Bishop, G. K., Butterfield, M. I., & Bastian, L. A. (2001). Efficacy of Dialectical Behavior Therapy in Women Veterans with Borderline Personality Disorder. Behavior Therapy, 32, 371-390.

Linehan, M. M. (1993). Cognitive Behavioral Treatment of Borderline Personality Disorder. New York: Guilford Press.

Linehan, M. M., Schmidt, H., Dimeff, L. A., Kanter, J. W., Craft, J. C., Comtois, K. A., & Recknor, K. L. (1999). Dialectical Behavior Therapy for Patients with Borderline Personality Disorder and Drug-Dependence. American Journal on Addiction, 8, 279-292.

Resources

Verheul, R., Van Den Bosch, L. M. C., Koeter, M. W. J., De Ridder, M. A. J. , Stijnen, T., & Van Den Brink, W. (2003). Dialectical Behaviour Therapy for Women with Borderline Personality Disorder, 12-month, Randomised Clinical Trial in The Netherlands. British Journal of Psychiatry, 182, 135-140.

Linehan, M. (1993). Cognitive-behavioral treatment of borderline personality disorder. New York: Guilford.

Linehan, M. (1993). Skills training manual for treating borderline personality disorder. New York: Guilford.

The Dialectical Behavior Therapy Skills Workbook
http://www.newharbinger.com/productdetails.cfm?SKU=5136

Glossary

Dialectic - the Hegelian process of change in which a concept or its realization passes over into and is preserved and fulfilled by its opposite

Dialectical Behavior Therapy - a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. "Dialectical" refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients. Therapists follow a detailed procedural manual.

Mood Dysregulation - a hypersensitivity to mood which results in impulsivity and strong reactions

Transcript

T: Thom Pancella **RR: Ronda Oswalt Reitz, PhD**

Thom Pancella: Hello, and welcome to this MIMHTraining.com presentation on The Challenge of Validation. I'm Thom Pancella with the Missouri Institute of Mental Health. With me is Dr. Ronda Oswalt Reitz. She is a consultant and trainer in Dialectical Behavioral Therapy. She specializes in the development and maintenance of DBT treatment programs and teams in mental health delivery systems. She provides public and private trainings and consultation across the United States, focusing on systems including community mental health, intensive outpatient programs, juvenile detention facilities, and acute long term and forensic inpatient programs. Currently, she works for the Missouri Department of Mental Health, in the development of DBT programming statewide, and with Behavioral Tech, LLC, the treatment dissemination company founded by Dr. Marsha Linehan. Welcome today, Dr. Reitz.

Ronda Oswalt Reitz: Thank you.

TP: Ronda, most people involved in providing mental health services will probably know what you mean when you say 'difficult client,' but for those who don't, who are these clients?

RR: Well, the ones that I am addressing in this training really are those who not only have difficult diagnoses, but who also make navigating interpersonal interactions with them very very difficult, or even impossible to bear. They're hard to be in the room with sometimes. It's difficult to look forward to sessions with them if you are a clinician. If you are in continuous contact as a provider on a ward or in the community, it can be hard to maintain a positive toward helping them and working with them.

TP: Well how does a person become a difficult client?

RR: We have a number of theories about that. There's a—it's generally considered to be a combination of both environmental and biological factors. I mainly

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focus on folks who have mood dysregulation—some kind of a—either a diagnosable Axis I Mood Disorder, or enough variability in mood that it becomes very difficult to predict, not only for other people, but for themselves, when they're going to be in a positive mood, and have a positive orientation toward life and other people, or when they're going to be irritable or angry or depressed. And these folks have in common great fluctuations in mood, also to include anxiety for the most part—so, people with Post-Traumatic Stress Disorder, Bipolar Disorder, Depression, those kinds of things.

They typically have been brought up in an environments that are what we call 'invalidating environments,' where they are told over and over again that their experience in the world—their experience, perceptions, sensations—is wrong; that they can't trust their own brains and nervous systems to perceive what's going on in the world accurately. And another message that they often get is that what they are thinking about, doing, experiencing are not real. So, for instance, if one of these kids reacts very strongly to something—and they often do as children--often they have diagnoses as Attention Deficit Disorder or other such behavior disorders, and they are often very reactive as children, and are told that they are being overly emotional; they should just sit down and be quiet. And so, over and over again they're told they're wrong for the way they approach the world and the way that they feel about it.

So, another reality for a lot of these kids, is that they make it difficult on the environment, but they typically come into a difficult environment, where the caregivers—whoever those people might be—are just simply not prepared to meet the needs of that child. And so they're told that their needs are wrong, bad and inconvenient.

So it's a combination of mood dysregulation that probably they're born with—a hypersensitivity to mood which results in impulsivity, strong reactions to things—and an environment that is punishing of having any kind of moderate level of response. So if they don't react at all, the family or caregivers or sometimes our mental health system tells them that they're being good, and that that's the right

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reaction. Often they have to suppress a great deal of themselves in order to achieve that. Or, if they have a very strong reaction, they're told that what they're feeling is more legitimate; but if they have some kind of moderate reaction—in between—then no one pays attention.

TP: Some people think that the clients don't really wanna get better badly enough to kind of cooperate with the treatment program. Is it—is there really anything that you can do to help them become more effective in accessing the mental health services?

RR: Yeah, that's a really good point. They are—often are clients that are called Conduct Disordered if they're kids, or Oppositional Defiant Disorder, or they carry some kind of co-existing Personality Disorder along with their Anxiety Disorder, and we often use phrases like, 'sabotaging,' 'afraid of success,' 'yes-butting,' 'they love misery,' things like that. And those are really born out of the mental health world's frustration with trying to help them.

I think that there are definitely some ways that we can help them become more amenable to the services that we provide—help them access them in a way that actually makes our system helpful to them. And mainly we do that by validating them, giving them something that they probably haven't had much in life which is the reassurance that their own perceptions, thoughts, feelings, behaviors sensations—all of those things—are legitimate and valid. Not telling them that every behavior they engage in is valid; not approving of everything that they do, but simply giving them the reassurance that their reality is something solid that they can stand on, make predictions about, and move forward from. It's an enormous step.

Their resistance to help usually come from feeling invalidated; feeling told chronically that they're so wrong and so bad—most of them carry an enormous load of shame and discomfort—and so getting past that shame base and saying, "Well of course you feel this way; and of course it's difficult for you to go along with what other people are expecting you to," sort of opens up their willingness to participate

in treatment better. So we're finding that that's a helpful avenue.

Having worked with individuals who are diagnosed with Borderline Personality Disorder for a number of years, I have found that previously considered impossible to treat clients are very amenable—sometimes these clients are initially extremely hostile—a number of the clients that I've worked with have been assaultive to other people or very self-harming—and if we can open up that door to them and acknowledge their reality before we get caught up in trying to change their behavior, we can, many more times than not, be successful with them in treatment.

TP: We're going to be working our way into the validation. Let's start with dialectics. What are dialectics, and how do they apply to treatment?

RR: Well, dialectics is about as old as time in terms of the concept. And, there were philosophers that started talking about this in the time of the Ancient Greeks and Romans. More currently and more recently, Karl Marx and Hegel and Engle were philosophers that brought the concept into prominence. Bringing it into the mental health realm was Marsha Linehan, and she has talked about that dialectical polarity between acceptance of the client exactly as they are—which is what we're finding is really necessary in treatment—and integrating that with its seeming opposite which is requiring that the client change in order to have a life worth living. So we're holding both of those concepts at the same time, and they're both equally valid even though they seem to contradict each other—and that's really what dialectics is.

When people are opposed to each other, it's largely because they are believing that their own position is correct and the other person's position is wrong. When we bring dialectics into treatment, what we're doing is acknowledging what is true and valid about not only our own opinion, which is the easy part, but also about that client's perspective on the world. And so we're looking for their viewpoint and trying to figure out what is accurate or valid—even if it's a very small portion of what they're saying. Even if it's a tiny—what I call a grain of sand or grain of gold in a big bucketful of sand—we're really wanting to find that, focus on it to

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the exclusion of what we think is wrong with their perspective, to the exclusion of what we think is right about our own perspective, and just stay with that focus for a bit until they feel sufficiently validated, and kind of relax into the work that we're doing.

So it's looking at a bigger picture than what we normally see in treatment. Often we look at our own change-oriented need to bring the client forward in some way. And it's as though we're getting on a bus and leaving the client at the bus stop. We never know what their perspective is; we never understand what is correct and worth holding onto about what they're doing.

TP: So how would a mental health provider, professional, know when it's right, when it's proper to use validation?

RR: Well, I don't think you can go wrong by using validation, so if you're ever in doubt, I think the answer is validate and see if that client softens. You know you've hit a dialectical polarity, you know you've hit a conflict point and you're stuck there, when the client begins to escalate—raising their voice, trying to prove their point to you. If they have to prove their point to you, then they do not feel as though you've received the information that they most need for you to have. So initially I think a clinician needs to be very clear that they're receiving that information openly. So, as much as we get discouraged when clients 'yes-but' us in treatment, we need to make sure that we're not doing that with clients—that we listen with a very open ear, relaxed, pulling from them the essence and helping them find language to express the essence of what they're experiencing. And then we can move on to change.

So we know that we need to do more validating if they're arguing with us; if they're closing off from us. We know that we've validated enough when that client begins to open up, to soften, and to feel less polarized or conflicted with us.

TP: So is validation a difficult skill to learn; are there tools to help with that process?

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RR: I think it's a highly-skilled complex process technically. Initially it can feel easy to do. There are six levels of validation that Marsha Linehan has put in a very well-articulated, easy to understand form in her textbook. The difficulty with it is bringing it into practice in real life. So, what I usually tell people is, learn the six levels of validation, two of which we probably should be using almost all of the time if not all of the time. The other four are more verbal—specific verbal strategies that we use.

Ideally what a clinician would do, what a line staff would do—anyone who works with a client—and I teach this to the dietary staff in the facilities where I work, to the security staff, anyone who has contact with clients—reception staff at community mental health—if they would write down the most challenging, difficult, seemingly impossible to validate statements, and then practice, "What would I say in response to this if I had the ideal response at the tip of my tongue?" And write them down, Levels 2, 3, 4, and 5, and have them ready for the next time that client says one of those things and try them out.

And so, being sensitive to an opportunity for validation is important; understanding when we're not being validating is important; being clued –in to when our own bodies are holding tension and are becoming sort of closed off and resistant to clients; and learning how to make a shift from that closed-off, feeling insulted or invalidated as a clinician or a person, and moving into a more open attitude with the client, is a mechanism that's really important to practice behind closed doors, with people in your personal life, etc. It's not a mechanism that comes easily; it's not natural.

And then having the mechanics of each level of validation down is really critical. And so, for instance, on the first level of validation—that is what we call Staying Awake—and not in the literal sense, but we're talking about a mindful focus on the client that tells that client that, "You are the most important person or focus in my universe at this moment." And what some of the Zen practitioners—who we've borrowed some of these strategies—tell us is that that is really the definition of caring about someone—is being fully present with them in any particular

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moment. It's life-saving for some clients, particularly ones who are at the end of their rope, feel as though they are—that they have nothing worth living for, that no one can connect with them, that they can belong to no one. So, if you're able to just simply be mindful and attentive of that client, in a compassionate and respectful way, sometimes that's all that a client will need in the way of an intervention. It's more than some of our clients in the mental health system have ever experienced. Certainly, if you're in a correctional system, if you are in a state facility, those are very high-stress environments, and many of our clients do not experience that kind of attentiveness on a routine basis. People are working as hard as they can to get their jobs done, and they can't pause for a moment—or they don't feel that they can.

So Level One validation we practice simply by being respectfully attentive and sensitive to the cues of the other person, such that we can really sense nuances and changes in the way they're responding to what we're saying and the way we're interacting with them. And then we need to be open and attentive enough to them that we can be aware of our own changes and respond as effectively as possible to them, keeping that line of communication open; keeping that sense of respect present. So, Level One is just simply hopefully something that we would do every day with people that we're talking to. But most of us are very hurried in our interactions and are more efficient than that; we don't do that as much as might be helpful.

So the second level of validation is really a verbal reflection strategy—very basic counseling skills here, and also something that I think we don't do often enough; we wanna go on to the next step; we wanna get to the punch line; change their lives with an insight. And so this one really has us pull back a little bit and simply repeat what the client has said to us, in their words. So we may repeat a portion of what they said—a phrase, or a word—something like that helps them understand, "I'm still here with you; I'm listening to you." So, particularly during long periods of verbal expression, some kind of storytelling or an outpouring of some sort of experience that they've had, you use that in order to just stay present with them, to anchor their awareness that you're with them. It's not a high enough level of

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validation; it's not enough validation to simply repeat what they said, and I find that it's best used as sort of a marker or a way of buying time with the client. So sometimes I don't know what to validate; sometimes I am really stumped in the moment; I have absolutely no idea what the truth is of what they're saying. So let's say a client has been just outright lying to me about something, and I'm aware of that, but as they're telling me this lie, I'm also aware that there's something else going on underneath that, and I'm wanting to find that piece—that emotional experience or content that is probably more fundamental to what they're saying. So, even if I know they're lying, I think there's something else going on that's more important that I can validate. I can ignore the content of the lie, but I wanna go in and I wanna validate the content. Probably what I would do in that situation, if I weren't yet sure exactly what I was gonna say, is I would just repeat part of what they said; it would be buying me time. And then, as I was able to sort of process, ask some questions, that kind of thing, I might go on to Level Three.

And Level Three validation is stating the unstated. It's saying something out loud in the room, for both yourself and the client that, for whatever reason, the client either wasn't able to say, didn't really fully understand themselves, so you're pulling them forward in insight, or was too ashamed to admit. So your saying that for them out loud for them pulls them forward just a little bit in the process, and it creates this profound sense of relief, and a deep sense of being known. So when somebody says something that we know in our hearts, but we haven't acknowledged to ourselves or to other people, there is no more powerful way of feeling known for most of us. So I might go on with a client, for instance, who's expressing, say, a lot of anger, a lot of hostility, and I might say, "You know, you're really angry; I can hear that; I can see it in your face, hear it in your voice. I'm wondering, though, are you feeling just a little bit hurt? Are your feelings hurt? Or are you feeling a little embarrassed about this? Is there just a tiny part of you that might be feeling embarrassed?" And usually when I approach it that way, the client can acknowledge that feeling; they feel a sense of relief—here it is in the open; we've taken it out of a dark corner—and it's profoundly validating for them.

And Level Three is a great validation strategy to use when you're getting to know

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a client, you're exploring questions with them, you can phrase it in a question form, and if you're incorrect, you just try something else. You say, "Okay, well never mind that then. How about, are you feeling hurt by it? Do you feel as though they don't care about you as much as you hoped this person did?" So you just try a different strategy; you kind of go with your gut instincts, but you trust, really, the client to be your informant about what's accurate.

The fourth level of validation is communicating to the client, "Well of course you felt or said or thought or believed the way you did, behaved the way you did. How could it be any other way based upon where you've come from?" And that 'where you've come from' really defines this as Level Four validation. By 'where you've come from,' we're talking about their diagnosis, some kind of physical or emotional illness that they're experiencing; we're talking about their personal histories, their learning histories, so 'where they come from' may be that invalidating environment. When a client has a difficult time disclosing things to me, for instance if they've been sexually abused or physically abused, if they wonder if their own behavior with their children verges on abuse and they're having a hard time disclosing it—and I know there's something there—there's a good chance that whatever that behavior is, whatever that experience is, they're having a hard time trusting me enough to share that. And so one really common validation at Level Four might be, "I don't know what experiences you would have ever had in your life that would lead you to trust me now. It makes sense that you don't trust me. Who has been trustworthy for you?" So what I'm saying really is, "How could you trust me? How could it be any other way? You don't trust me and that makes perfect sense."

The drawback of this level of validation is that we're really pathologizing that particular client when we do it—or individual—and we're telling them there's something that has been wrong or not healthy about your background or about you, and that's why you behave in this way; that's why this behavior makes sense—in the context of pathology. So it's helpful from a psychoeducation point of view; it's helpful if you have a depressed client who's having a hard time coming to sessions, you say, "Depression really can make you feel as though it's hopeless. Why

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would you bother coming to sessions if it feels hopeless? I really do get that." And that's kind of an example of a Level Four. That is a good level of validation, and it's helpful, but it's important to know when you're using it. So just like when you're learning a new skill, maybe there are a couple of different swings that you can use in golf, and there's one swing that's particularly helpful under certain circumstances—you wanna be able to know very clearly when you're using that swing so that you can use it deliberately. And this is no different. You need to be able to know when this particular intervention's gonna be helpful, and you need to know how best to use it. So practicing that is really helpful.

But ultimately what we wanna try to get to is a Level Five Validation, between the Level Three—sorry, between the Level Two, Four and Five, I think Five is the vest level of validation. Level Three is different enough that I think we infuse that in all the work we do. But if you're going to make a statement to a client, and try to make sense of their behavior, try to help them make sense of their behavior, Level Five is really the way to go. And that is to say, "It totally makes sense to me why you said/did/felt/believed that, because any human being, in the same circumstances, would feel that way." And so you can do that with almost any behavior, but it's tricky; it takes a while to figure out how to do that.

One example of that might be when a client has come to you and acknowledged some terrible behavior—some socially reprehensible behavior. Let's say they abused their children or they are a perpetrator of sexual abuse somehow, and they're talking to you about that, and you're wanting to connect with them; you're wanting to make sure that they feel validated in what they're doing. You don't want to reinforce their behavior. Validation is very different than reinforcement. With reinforcement I'm giving a response to you. For instance, when you nod your head maybe I'm smiling at you or I give you better eye attention—eye contact, so you're going to maybe nod at me more, or smile more at me. I do something that increases the probability of your behavior that way; increases the frequency of your behavior. With validation, we're not necessarily doing that. What we're looking for is a regulation of that emotional arousal. Usually when we're validating it's because the person is in high mood dysregulation and they're

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not feeling very connected to you.

So in this circumstance, what I might want to say to someone who's done something that, you know, most of us would think is pretty awful—hitting someone—I would say something like, "You couldn't think of anything else to do in that moment; there was nothing in your head but hitting that person." Or, "You had such a powerful urge that you didn't feel you could stop it." And so that's a Level Five; that's saying, "Normal people have powerful urges that are hard to stop. It doesn't mean what you did was okay. I'm not approving of any of those things. But I'm saying, wow, it's really, really hard to stop those powerful urges." And then dialectically speaking, on the other side of the intervention, I would say, "And, we are—we have to do it or your life is over; you're going to prison forever," or that sort of thing.

So Level Five validation normalizes what is normal about their behavior. And then, the person softens, relax, feels as though they can trust you not to revile them as a human being, and you go on to talk in behavioral terms about how you can change the behavior itself.

Level Six is the final level of validation, and that is all about what we call Radical Genuineness. And Radical Genuineness means just being your own self in the room with the client, not—not requiring a level of professional distance in order to feel competent or a sense of control, or maybe even some distance from what gets to be pretty powerful emotions sometimes. It means you go right into that interaction with the client, open, willing to kind of go to dark places with them if you need to in your own thinking and awareness. And you never have to be someone other than who you might be in the grocery store or at home, etc. It doesn't require that you provide disclosures about who you are as a person, other than just to be yourself in the room. So there's no talking about your family necessarily, or anything you wouldn't normally say to a client. It's simply having an informal and relaxed manner; and that is sometimes the most powerful message to a client—that we really do care about who they are as a person, and that we value them. We care about them, value them enough, respect them enough to be who

we are when we're with them.

TP: So you mentioned that it's not really natural to the clinician to behave in all of these ways, and yet kind of outlined some really nice ways of behaving. So clinicians will generally have to kind of change their behaviors, and kind of force that change.

RR: Right.

TP: How do they get to that point? I realize we're kind of up against the clock, but how do we get to the point of making that change in the clinician?

RR: It first of all requires a sensitivity to yourself, a mindfulness about, you know, what are the issues that are tripwires for me? What do I notice myself kind of closing off to other people in the face of? So for instance, if it's Eating Disorders, are there behaviors that just don't make any sense to you, that you can't relate to, or that you're uncomfortable with? Powerful emotion is one of those things that for most of us it's very uncomfortable to be in the room with; we wanna make it go away; we wanna make it stop—partially because the other person is uncomfortable and we want them to feel better; partially because we're uncomfortable in the presence of strong emotion. And so I think what's really critical is to develop that awareness of when you're recoiling from emotion or from an issue, and then to do the opposite of what might be natural under those circumstances—what might be self-protective—and that is, rather than closing down and moving away from the client—becoming crisp and professional—we move in; we open up and we move in to the client, and we use validation.

The tricky thing to remember is that that reduces the emotion; it doesn't amplify emotion. It actually helps the client become calm much more rapidly. So being aware of your own cues is absolutely the first step. Noticing when the client is closing off can tell you when you're engaging in some of that closing-off behavior. And then practicing in a deliberate way the levels of validation. And it takes a number of years to become really proficient; and it's actually critical just to jump

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in and try it even though you may be awkward at it to begin with.

TP: Well, thank you Ronda. And thank you for joining us for this presentation. If you're watching this video online and you'd like to receive Continuing Education Credit for it, click on the post-test button on this page, take the post-test and follow the CEU application instructions. If you're watching offline, say on a DVD, the instructions for completing the post-test and the CEU application should have been contained with the materials that came with your DVD. Otherwise you can go online to MIMHTRaining.com, find this program, and take the post-test. At the Missouri Institute of Mental Health, we're always looking for ideas on what kinds of programs you'd like to receive in whatever formats we offer them. If you have any topic suggestions or speaker suggestions, please drop us a note at feedback@MIMHTraining.com. Again, thank you for joining us. And thank you, Ronda.

RR: Thank you.

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